EMSPSONEWS

From the Center for Patient Safety

SPRING 2014 EDITION

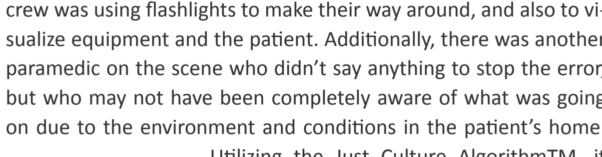
IN THIS EDITION

Learning & Sharing 1
Legal Update 2
Highlights from AHRQ Annual Meeting 3
Center Tidbits 4
Upcoming Events 6

Learning and Sharing: Defibrillation vs Synchronized Cardioversion

It cannot be emphasized enough how much culture can influence safety, safe practices, and self-reporting of errors. Case in point: Crew responded to a 60 year old male with shortness of breath and palpitations. Cardiac monitoring was connected to the patient and he was found to be in unstable ventricular tachycardia. The attending paramedic, with only a few years of experience, was preparing to synchronize cardiovert the patient. The attending paramedic's partner, a medic with many years of experience and also a flight medic, stopped him and said "You don't synch it." The attending paramedic hesitated, but followed his partner's direction, and defibrillated instead. This sent the patient in to ventricular fibrillation and he lost consciousness. The crew immediately defibrillated the patient again (the correct action), and brought the patient back in to a normal sinus rhythm. Patient was transported to the hospital, was conscious, and had no complaints upon arrival. The incident was reported to the ED physician.

The crew immediately reported the error when they arrived back to the station. The senior paramedic readily admitted he was wrong, apologized to his partner, and felt horrible about making the mistake. Upon investigation, it was noted this was a 3 AM call, and the patient's home was filled with debris and clutter and had extremely poor lighting. The crew was using flashlights to make their way around, and also to visualize equipment and the patient. Additionally, there was another paramedic on the scene who didn't say anything to stop the error, but who may not have been completely aware of what was going on due to the environment and conditions in the patient's home.



Utilizing the Just Culture AlgorithmTM, it was determined this was a human error, and all system issues were analyzed contributing to this event. This agency has taken this case and utilized it for training and skills validation, and most importantly, to emphasize the importance of situational awareness and speaking up if something seems amiss. They have also discussed communication techniques if there is a disagreement in following appropriate steps in a protocol.

Supporting and consoling your staff when they make an error is crucial to fostering a culture of safety. If the manager's reaction in this situation was in any way punitive, it places an element of fear and the temptation to "cover it up" – thereby removing any chance of learning and preventing this same error from reoccurring. Continuous encouragement, support, and feedback on learning from errors will propagate more reporting, open discussions, and improvements to patient safety.

LEGALUPDATE

-and discovery tips-

As Patient Safety Organizations (PSOs) had hoped, all the courts examining the Act continue to recognize its protection of properly developed Patient Safety Work Product (PSWP), in both state and federal courts. As more cases invoke Patient Safety and Quality Improvement Act (PSQIA) protections, their many factual situations show how broadly that protection can apply. In a recent Tennessee case, a doctor was accused of conducting an improper body cavity search of a patient brought in by the police. The court held that the PSQIA could apply to protect information developed during the investigation of that and other events at the hospital.

In California, a hospital found itself at odds with one of its unions, as it tried to clarify the proper use of reporting forms to clearly differentiate data generated for its Patient Safety Evaluation System (PSES). Another clear theme from the case: **PSWP can be used judiciously inside the organization for other purposes; it just can't be disclosed outside the workforce of the PSO participant.**

As these cases illuminate the widespread practical issues that arise from PSO participation, they also emphasize the importance of discipline and consistency in designing and implementing a PSES. Whether the concern is clearly including an investigation in the PSES or making sure that employment issues are reported on a non-PSES form, **PSO participants need to make sure their procedures are clear and are followed.**

INCLUDE YOUR LEGAL COUNSEL

The cases have also shown how important it is for legal counsel to understand the law and your own procedures. Here are some basic tips, if you find yourself in litigation where the PSO protection may be relevant:

- Counsel should review the provider's PSES policies, so that discovery responses accurately reflect the structure of the PSES and workflow for PSWP.
- Counsel and the provider's staff need to have a clear common understanding of both how the PSES works and how they will describe it.
- Make sure that the provider has reported to the PSO or is taking essential steps to do so. Courts look at that, and consider it a threshold event for protection. **Providers need not necessarily have reported the information for which they seek protection, but they have to be reporting something.**
- Counsel should work with provider staff to make sure they are taking the best advantage of the PSQIA's protections.

CPS staff are happy to work with any participant or its attorneys facing litigation about their own structures, their relationship with the CPS or the PSQIA. There is always information on current written decisions on the CPS website and PSO email alerts will describe any new developments.

CPS strives to provide the best and most current information about the legal decisions that will further refine our understanding of the Act. To do that, CPS staff seek out many sources of information about legal developments involving the PSQIA. For example:

- Executive Director Becky Miller and Carol Hafley attended the AHRQ annual PSO Conference in April, where several attorneys described recent decisions.
- Kathy Wire, an attorney with CPS, participates in an American Health Lawyers Association work group of PSO attorneys. That group is chaired by Michael Callahan and includes attorneys such as Wesley Butler, who often work at the forefront of PSQIA cases.

Through working connections with a number of other PSO's, CPS staff obtain direct information about legal developments affecting them.

NEW OPINION OFFERS GUIDANCE

The District Court for the Western District of Kentucky has issued an incredibly helpful opinion for PSO's and their participants. (Tinal v. Norton Healthcare, No. 3:11-CV-596-S, May 8, 2014) A copy of the opinion is available and a summary of the opinion by one of the law firms involved is also available. The court reviewed the law and its history comprehensively. Lawyers defending PSO participants should read it for guidance on how to approach PSWP protections.

The court noted that the statute uses "plain and unequivocal terms" to set out the privilege, and stated, "No ambiguity can be read into….the privilege statute." The plaintiff's claim was for employment discrimination under the federal civil rights statutes, and she claimed that the PSQIA should only apply in medical malpractice cases. The court disagreed, finding that "[w]e have no authority to go behind the plain meaning of the statute."

Norton had prepared a privilege log, listing the documents for which it claimed the privilege, and the court held that it need not describe the content of each one, other than to describe its preparation and sourcing as PSWP. The court did review the documents in camera, and litigants should be prepared for that step. Once again, the case relied on a finding that the provider had (1) defined a PSES, (2) performed its analysis and generated the documents as part of the PSES, and (3) reported to the PSO per hospital policy.

Though this decision does not control any cases outside its own district, we hope that it will be an influential analysis, and one that participants and their counsel can use to construct their own arguments.

[1] Gulley v. Lapaglia, 2014 U.S. LEXIS 7074. The court did not hold that any documents were protected, and indicated that the doctor would still need to produce a privilege log listing them by categories, so the court could make a more detailed determination.

[2] Garcia ex rel. NLRB v. Fallbrook Hosp. Corp., 952 F.Supp.2d 937 (S.D. CA June 7, 2013).

Have you noticed this icon?

Look for this icon to find additional resources in the articles. You'll find links to downloadable templates, websites and other resources.
Available in the electronic version of this newsletter.

Did You Know

Interested in receiving more information about PSO services available to you? Visit our website at www.centerforpatientsafety.org

Highlights from the 2014 Annual AHRQ PSO Meeting

AHRQ Invites Center for Patient Safety to Share

Becky Miller and Carol Hafley presented the Center's work at this meeting in Maryland on April 23rd, specifically highlighting work with EMS and long-term care providers, in addition to hospitals. Carol highlighted the enthusiasm and desire which stemmed from the EMS community in initiating this program, and the great amount of progress which has been made.

AHRQ Develops Website to Assist Providers in Selecting a Patient Safety Organization (PSO)

The AHRQ has established an online tool designed to help healthcare providers select a PSO. The tool contains information, as submitted by each PSO, regarding their scope of service and business structure.

AHRQ Submits Common Data Formats (CDFs) to NQF for Surveillance

The AHRQ-developed CDFs mirroring those used by PSOs for event reporting have been submitted to the National Quality Forum for evaluation for the purpose of population-based surveillance of patient safety events. These CDFs would be used, through a retrospective review of medical records, to replace CMS' current Medicare Patient Safety Monitoring System to establish rates of adverse events in the United States.

"PSOs are becoming a more integral part of the patient safety landscape and a more important role in patient safety research... AHRQ is committed to continued support for the program"

- RICHARD KRONICK
Agency for Healthcare Research and Quality (AHRQ) Director

80 number of PSOs in the nation

4,357 number of healthcare providers contracted with a PSO

CPS COMPARED TO OTHER REPORTING PSOs:

- 1 of 7 with more than 250 contracts for PSO services
- 1 of 12 with more than 10,000 events reported
- In the majority (1 of 38) collecting events electronically
- In the majority (1 of 39) as a not-for-profit organization
- In the minority (1 of 11) as an independent organization (not part of another company)
- In the majority (1 of 36) collecting data in all specialty areas
- In the minority (1 of 10) collecting all types of event categories of Common Data Formats

CPS is very proud of their active participants and the strong commitment to submit event information.

Be a Safety Sponsor: How you can help!

The Center for Patient Safety values partnerships with organizations and individuals who want to support improvement in healthcare quality and patient safety. Because the Center is a not-for-profit organization, donations are tax-deductible.

There are three ways to join the effort to spread safety culture throughout the healthcare community: individual donation, organizational sponsorship levels, and/or supporters can sponsor an event or initiative.

Opportunities include:

- Education and training activities
- Patient Safety Awareness Month activities and events
- Clinical collaboration
- Surveys, analysis, and reports
- Adverse event reporting system
- Research and analysis
- Publications and reports

The Center makes the process easy; you can donate online in minutes. And, of course, any of the Center staff can answer your questions and provide more information.

Center Tidbits

CPS WELCOMES AIR EVAC LIFETEAM

The Center for Patient Safety (CPS) is excited to announce its first national contract from Air Evac Lifeteam! Air Evac joined CPS on April 1, and currently has 115 bases in 15 states. "By participating with CPS, Air Evac is clearly indicating its commitment to improving patient safety and quality in pre-hospital care," Miller said. "PSO participation affords the benefit of protected sharing and learning with other EMS providers, and regional collaboration with many other healthcare providers. We are thrilled to be working with them."

"We are very excited and honored to have additional air medical expertise to contribute to our work with EMS," said Carol Hafley, assistant director for CPS and director of the EMS business line. "They provide a very broad-based view of patient safety issues in the air medical industry with their national presence."

Additionally, Air Evac will participate in the Center's EMS PSO Advisory Committee, as well as the Data Development Committee for valuable input and expertise as the Center continues to modify and expand the EMS database.

EMS DATA COMMITTEE RESUMES

Data, data, data! The EMS Data Committee has been meeting again to work on modifications to existing forms and the development of new ones. The committee is looking at new topic areas of protocol deviations, dispatch errors, stretcher drops, and ambulance mechanical issues. Work on developing these new forms will continue over the summer and into the fall.

COMING SOON!

PSO SERVICES FOR REPORTING BY LONG TERM CARE FACILITIES

Do you have an affiliation with a long-term care facility (LTC)? The value of participating in a PSO is spreading across the continuum of care. CPS has historically offered PSO services to hospitals, ambulatory surgery centers and emergency medical services. Starting this summer, LTC providers may join the PSO. Many are already taking advantage of Just Culture training and measuring their culture with the safety culture survey. Watch for official announcements! For further information, contact Kathy Wire, kwire@mocps.org.

SAVE THE DATE!

EMS PATIENT SAFETY CONFERENCE COMING TO COLUMBIA, MISSOURI

Join us on Wednesday, November 12, 2014 in Columbia, Missouri for our fifth annual EMS Patient Safety Conference! Our keynote speakers include Tom Judge from Lifeflight of Maine who will discuss Safety Culture and Management of Risk; as well as David Williams of TrueSimple and faculty for the Institute for Healthcare Improvement, who will present on using the Improvement Model for Impact in EMS. For the very first time, CPS will introduce "Safe Tables", exclusively for our EMS PSO participants, where attendees will participate in group case discussions of real events submitted in the CPS PSO database. We will also have vendor booths and attendance prize drawings. You won't want to miss it!

CERTIFICATES AVAILABLE

(CPS Members only)

Each PSO member can print a certificate that recognizes its participation with the Center for Patient Safety (CPS). Just answer a few questions to confirm your participation and you'll receive immediate access to a printable certificate. Complete the PSO Participation Validation survey.

"For Air Evac Lifeteam, participating with CPS was an easy choice... CPS has the most experience working with emergency medical services and is the only PSO with an established event reporting system specific for EMS."

-JENNIFER FLETCHER
Director of Patient Care Services
Air Evac

Did You Know

If you are interested in receiving the latest news and information from the Center, click here to subscribe and receive updates direct to your Inbox.

CENTER PRESENTS AT MISSOURI STATE MEDICAL ASSOCIATION CONVENTION

Michael Handler, MD, Medical Director, and Becky Miller, Executive Director, presented at the Missouri State Medical Association Meeting on April 5. The importance of teamwork and communication in improving safety was highlighted along with activities of Patient Safety Organizations (PSOs) in support of Accountable Care Organizations (ACOs). Elements of the Center's White Paper "PSOs: Essential to ACO Success" were highlighted.

SHARE*SUITE* HAS A NEW LOOK

Share*Suite*, powered by VergeSolutions, has a new look but the functionality is still the same! Log in and check out the new look! Updated User Guides will be released in June.

Q/A - I've misplaced my username. How can I receive it again? Send an email to Eunice Halverson, ehalverson@mocps.org, and request your username to be resent.

Q/A - What if I forgot my password? Access the Share*Suite* log-in screen, powered by VergeSolutions, and select: *Forgot my password*

PSO ANNUAL REPORT

The Center for Patient Safety released its 2013 Annual PSO Report, which included an overview of EMS event data submitted up through December 31, 2013. 87 events had been submitted, 67 percent of which were patient safety events. Of particular note are the number of events classified as "other" – there are a total of 28 events reported. These events represent a variety of issues, including communication challenges with dispatch and medical control; mechanical failures of the ambulance causing delays in transport; protocol deviations and others. The EMS Data Committee is in the process of examining these issues, and will be working on further development of new event types to foster the collection of more robust data.

SURVEY ON PATIENT SAFETY CULTURE

Remember, as a CPS PSO participant, you receive 20% off our culture survey services. We administer culture surveys for EMS agencies, hospitals, medical offices, pharmacies, long-term care facilities, and home care organizations. **Missouri EMS agencies that are also contracted with the Center's PSO are eligible for FREE culture survey administration available under grant.**

Email Alex Christgen at achristgen@mocps.org to get started!

PARTICIPATION UPDATE

The Center for Patient Safety now has 107 agencies participating in the EMS PSO in addition to the 115 bases within Air Evac Lifeteam. This brings the total to 222 total locations in 15 states which are a part of the Center's PSO! If you have not submitted any data of late, please take a moment and do so now!

CPS WELCOMES LEE VARNER AS NEW EMS PROJECT MANAGER

The Center is excited and proud to announce Lee Varner as our new EMS Project Manager as of May 21! Lee most recently worked as the EMS Outreach Coordinator for Mercy St. Louis where he managed a multitude of projects, including the development and implementation of "EMSource" a Mercy smart device application for EMS agencies to quickly access protocols and other useful information. Lee is a licensed paramedic with over 20 years of field experience, and also serves on the Missouri State Clinical Conference Board and the St. Louis County EMS and Hospital Communications Commission. Lee will be managing all of the Center's work related to emergency medical services safety culture and PSO activities. Please join us in welcoming Lee!

Have you noticed this icon?

Look for this icon to find additional resources in the articles. You'll find links to downloadable templates, websites and other resources.

Available in the electronic version of this newsletter.

UPCOMING EVENTS..

2014

June 27, 2014 – Just Culture Manager's Training

8:00AM to 4:00 PM at St. Charles County Ambulance District. Contact Kim McKenna at kmckenna@sccad.com for more details.

July 10 - 11, 2014 - Missouri Ambulance Association Board Member Training - Look for the CPS booth!

July 22-24, 2014 – MEMSA Combined Clinical Conference and Expo

Branson, MO – Come out and meet Lee Varner, our new Project Manager, EMS Services, and get important Center info.

November 12, 2014 – CPS Fifth Annual EMS Patient Safety Conference, Columbia, MO

November 17 - 19, 2014 – American Ambulance Association Convention and Trade Show, Las Vegas, NV

Did You Know

Are you interested in getting regular updates from the Center? Follow us on Twitter @ PtSafetyExpert.

Special note of thanks...

As many of you have heard, I am leaving the Center for Patient Safety on June 6. I would like to say thank you to all who have been involved and contributed to getting the EMS PSO program off the ground in 2009 and who have continued to be a voice for patient safety and quality improvements in EMS. You have taught me a great deal about EMS and it has been an honor and privilege to work with a group of highly dedicated and passionate individuals. I am happy to report our new Project Manager, EMS Services, Lee Varner, is equally passionate about this work. He has a myriad of ideas to take this project to the next level and really hit the "home run" we were all envisioning when we first started out.

Carol Hafley

FOR MORE INFORMATION, CONTACT ANY MEMBER OF OUR PSO TEAM

Executive Director, **BECKY MILLER, MHA CPHQ, FACHE, CPPS**
bmiller@mocps.org

Project Manager, EMS Services, **LEE VARNER, BS, EMS, EMT-P**
lvarner@mocps.org

Patient Safety Specialist, **EUNICE HALVERSON, MA**
ehalverson@mocps.org

Project Manager, **KATHRYN WIRE, JD, MBA, CPHRM**
kwire@mocps.org

Project/Operations Manager and Analyst, **ALEX CHRISTGEN, BS-BA**
achristgen@mocps.org

Medical Director, **MICHAEL HANDLER, MD, MMM, FACPE**

Contractor, **AMY VOGELSMEIER, PHD, RN, GCNS-BC**

Administrative Assistant, **DIANA PHELPS**
dphelps@mocps.org

Patient Safety Listed PSO Organization

For additional information on the Center's PSO activities, resources, toolkits, upcoming events, safety culture resources, and more, visit our website at www.centerforpatientsafety.org or follow us on Twitter @PtSafetyExpert for the most up-to-date news.

NOTE

Some articles contained within this newsletter may reference materials available to Center for Patient Safety PSO participants only. If you have questions about any Center-resources or articles within this newsletter, please contact the Center for Patient Safety at info@mocps.org or call our office at 888.935.8272.

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ABOUT THE CENTER:

The Center for Patient Safety, was founded by the Missouri Hospital Association, Missouri State Medical Association and Primaris as a private, non-profit corporation to serve as a leader to fulfill its vision of a healthcare environment safe for all patients and healthcare providers, in all processes, all the time.