Missouri Center for Patient Safety

PSONEWS

From the Missouri Center for Patient Safety

SUMMER 2012 EDITION

Patient Safety Organization:
Safe havens for safety culture

In 1999 the Institute of Medicine estimated that between 44,000 and 98,000 people were dying in hospitals each year as a result of medical mistakes. The sobering statistics prompted the Institute to call for healthcare providers to decrease the number of medical errors by 50 percent.

Ten years later, the Consumers Union Safe Patient Project noted, "… a million lives have been lost and billions of dollars have been wasted because efforts to reduce the harm caused by our medical care system are few and fragmented." [1] An estimated 13.5 percent of hospitalized Medicare beneficiaries experienced adverse events during their hospital stays in 2008. Approximately 1.5 percent experienced an event that contributed to their deaths, which projects to 15,000 patients in a single month.[2]

As healthcare providers, we have an ethical responsibility to do everything possible to reduce the number of medical errors. That's where participation in a PSO benefits hospitals, as PSOs are specifically designed to improve the quality and safety of America's health care in a confidential and protected environment.

WHAT IS THE PURPOSE OF A PSO?

The Patient Safety and Quality Improvement Act of 2005 established a framework by which hospitals, doctors, and other healthcare providers may voluntarily report patient safety event information to a PSO on a privileged and confidential basis, for aggregation and analysis. The Act provides safety by decreasing the fear of malpractice litigation and inadequate protection by state laws.

Because of the built-in confidentiality and protection, PSOs offer external advice for healthcare providers seeking to understand and minimize the risks and hazards in delivering patient care.[3] This means healthcare providers can safely discuss events and share lessons learned, resulting in the rapid dissemination of information and quick implementation of reliable interventions for improving patient safety.

WHAT ARE THE BENEFITS TO HEALTHCARE PROVIDERS TO PARTICIPATE IN A PSO?

1. A confidential and reliable framework
Before the establishment of PSOs, there was limited and often unreliable or nonexistent legal protection for patient safety and quality improvement data and information. Today healthcare providers can submit information to PSOs as independent, external experts that collect, analyze, and aggregate the data. This information is shared locally, regionally, and nationally to identify root causes of patient events. All data, documents and communication among PSO participants are protected, allaying fears of increased risk of liability, and expanding sharing and prevention opportunities.

2. Lessons for improvement
Healthcare providers learn from the PSO and from one another. With the legal protection, PSOs can work with multiple providers to aggregate larger numbers of patient safety events to better understand the underlying causes of patient harm. Sharing processes and lessons learned results in the development of more reliable interventions to improve patient safety across the continuum of care. The more events and data that are submitted to the PSO, the better the framework for analysis and the greater the opportunities for learning.

IN THIS EDITION

The Agency for Healthcare Quality and Research (AHRQ) wants data submitted to PSOs to increase our understanding of the nature of risks and successful risk-reduction strategies across the nation. While PSO data cannot support the establishment of rates, true benchmarking or trending, it does provide participants with qualitative information that can enhance the culture of safety, accelerate learning and support safer, higher quality care.[3]

3. Anticipating ACA
Effective January 1, 2015, under the Accountable Care Act (ACA Section 131, (h)(1), health plans participating in the health insurance exchanges (HIEs) may only contract with hospitals with more than 50 beds when the hospital utilizes a patient safety evaluation system (PSES). Hospitals create and define their PSES when they work with a PSO, so current participants are in a favorable position for when this regulation becomes effective.

WHAT SHOULD BE REPORTED TO THE PSO?

Participants are encouraged to submit any type of patient event, including:
- incidents that reach patients
- near-misses that don't reach the patient
- any unsafe conditions that increase the probability of a patient event

In addition, PSOs provide a haven for hospitals to safely submit and discuss events, root cause analyses, defect analysis tools and other information, which previously have had no legal protection. To be successful, senior leaders should support and encourage staff to report medical errors and near-misses both within their facility and to the PSO, without fearing that their reports will be used against them. Taking this step will contribute to improved safety culture within your hospital and ultimately reduce patient harm.

HOW CAN THE MISSOURI CENTER FOR PATIENT SAFETY (MOCPS) HELP?

The MOCPS PSO is a seamless and safe way for licensed health care providers to add federal confidentiality and privilege protection to quality and patient safety data. We also can help you collaborate with other organizations to reduce the frequency of serious events.

MOCPS has partnered with Quantros to offer a web-based system for easy reporting, management and submission of eligible event data to the PSO, providing the framework of a Patient Safety Evaluation System (PSES) for each participating provider.

MOCPS fosters collaboration and knowledge-sharing opportunities among providers within Missouri and around the country, promoting discussions under the umbrella of PSO protections. ■

Reference:
1 - www.safepatientproject.org/2009/05/to_err_is_humanto_delay_isdea_1.html
2 - http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf
3 - http://www.pso.ahrq.gov/psos/fastfacts.htm#ff03

Senior leaders should support and encourage staff to report medical errors and near misses both internally within their facility and to the PSO, without fearing that their reports will be used against them.

Taking this step will contribute towards improving the culture of safety within your hospital and ultimately reduce patient harm.

Missouri Supreme Court Strikes Down Limits on Non-Economic Damages in Medical Malpractice Cases:

Increasing Liability and Value of PSO Participation

On July 31, 2012, the Missouri Supreme Court struck down Missouri's statute imposing a $350,000 cap on noneconomic damages in medical malpractice cases. The court acted upon the cases of Watts v. Lester E. Cox Medical Center, and overruled its previous decision in the 1992 case of Adams v. Children's Mercy Hospital. The court indicated that the statute imposing limits on noneconomic damages "infringes on the jury's constitutionally protected purpose of determining the amount of damages sustained by an injured party."

This action increases the monetary exposure of health care providers for medical malpractice cases, increasing the value of providers to work with a PSO to eliminate system flaws that can result in error, and most appropriately document efforts towards improvement. ■

PSO Federal Protections Upheld in Walgreen's Case

On May 29, an Illinois appellate court upheld a lower court's decision that patient safety work product (PSWP) is privileged and not subject to discovery under the 2005 Patient Safety and Quality Improvement Act (PSQIA).

CASE OVERVIEW

- The Illinois state department responsible for professional licensing (IDFPR) subpoenaed "all incident reports of medication error" involving certain Walgreen pharmacists.
- Walgreens asserted these materials were submitted to its Patient Safety Organization (PSO) and therefore part of PSWP and not subject to discovery rules under the PSQIA.
- IDFPR sued Walgreens, arguing that the documents were retained for purposes other than reporting to a PSO, and thus not protected.
- The lower court dismissed IDFPR's petition and declared the incident reports to be protected as PSWP, as defined by Walgreen's PSO policies.
- IDFPR appealed.

The Illinois appeals court's decision in favor of Walgreens is based on two provisions of the PSQIA:

1. The purpose of the PSQIA is to encourage *"a culture of safety" and quality in the U.S. healthcare system by "providing for broad confidentiality and legal protections of information collected and reported voluntarily for the purposes of improving the quality of medical care and patient safety."*
2. PSWP is defined as *"any data, reports, records, memoranda, analyses, or written or oral statements which are assembled or developed by a provider for reporting to a PSO and are reported to a PSO, and that information collected, maintained, or developed separately, or that exists separately, from a patient safety evaluation system is not considered PSWP."*

In making its decision, the appeals court determined that two affidavits prepared by Walgreens clearly satisfied the requirements of the PSQIA, resulting in protection for the subpoenaed documents. The court cited the broad language of the PSQIA in protecting PSWP from discovery in connection with a federal, state, or local civil, criminal, or administrative proceeding.

WHAT DOES THE RULING MEAN FOR HEALTHCARE PROVIDERS?

- The ruling recognizes the intent of the PSQIA to establish a "culture of safety" to encourage reporting of medical errors for the purpose of learning and improvement.
- It reinforces the value of participating in a PSO to secure protection of PSWP generated for the purpose of improvement.
- This state court ruling applies the federal PSQIA protections more broadly than the state privilege laws, highlighting the opportunity for PSQIA protections to fill gaps in state peer review law protections.
- Licensed health care providers, such as hospitals, physicians, emergency medical services, ambulatory centers, nursing homes, and pharmacies can take advantage of the discovery privilege by contracting with a PSO, establishing a Patient Safety Evaluation System (PSES), collecting and submitting documents, data, evaluations and conducting other protected activities.

The ruling further reinforces the recommendations for PSO participants to ensure maximum protection:

- Carefully review policies to ensure the PSES and PSWP are clearly defined
- Segregate and secure PSWP
- Clearly label PSWP to prevent unauthorized disclosure
- Submit PSWP to the PSO with appropriate documentation.
- Establish a process to evaluate and manage requests for PSWP from organizations and individuals outside of your organization's defined "workforce." ■

Reference: Illinois Department of Financial and Professional Regulation (IDFPR) v. Walgreen, Company, 2012 IL App (2d) 110452, No. 2-11-0452 (May 29, 2012)

Unexpected Death: Suicide on Medical Floor

Inpatient suicide is rare, but it is an event that hospitals dread. A patient can take his or her own life at any hospital, in any area, on any given day. Even under the care of experienced staff, 1500 suicides occur in hospital inpatient units in the U.S. every year.[1]

The numbers on this tragic event serve as a wake-up call:

- There have been 598 suicides reported as sentinel events to The Joint Commission between 2004 and 2011.
- Of those, 484 indicated assessment was a root cause and 349 noted communication as a root cause. [2]
- **Five suicides/suicide attempts have been reported to the MOCPS voluntary database since its inception in 2010.** One Missouri hospital shared its heart-breaking story so others can learn and mitigate the risk of patient suicide.

CASE STUDY: A SUICIDE STORY

THE EVENT

Mary (fictitious name) appeared to be an "easy" patient. She was pleasant, compliant, and quiet. She had run into some bad luck in her late forties, resulting in unemployment and loss of medical insurance. She had been admitted to the hospital through the Emergency Department for a facial injury.

Her initial assessment, which included a suicide risk screening, was uneventful, although she was "stressed out" about her inability to pay her hospital and doctor bills. The hospital staff assured Mary that financial services would work with her to arrange a payment plan.

Mary's friends visited her the second day of her hospital stay and everything appeared to be normal. Still worried about her lack of insurance and income, she reluctantly agreed to have tests performed. Again, the physician and staff reassured Mary that financial counselors would work with her, and a consultation was arranged.

On the night shift of Mary's second day in the hospital, a new RN named Sue (fictitious name) cared for Mary. Sue had recently successfully completed her orientation and was considered an exemplary nurse, always wanting to be sure she did everything right for her patients. Sue had time to visit with Mary that night and felt good about their relationship. Mary was pleasant and quiet, but certainly not overtly withdrawn.

During routine hourly rounds in the early morning, Sue found Mary's bed empty and the bathroom door locked. She knocked on the door but got no response. Her initial thought was that Mary had fallen and was unresponsive so she quickly called for help. Upon opening the bathroom door, hospital staff found Mary hanging from the shower rod. They could not resuscitate her. Even looking back, hospital staff determined Mary displayed no signs of depression, suicidal ideation or changes in behavior.

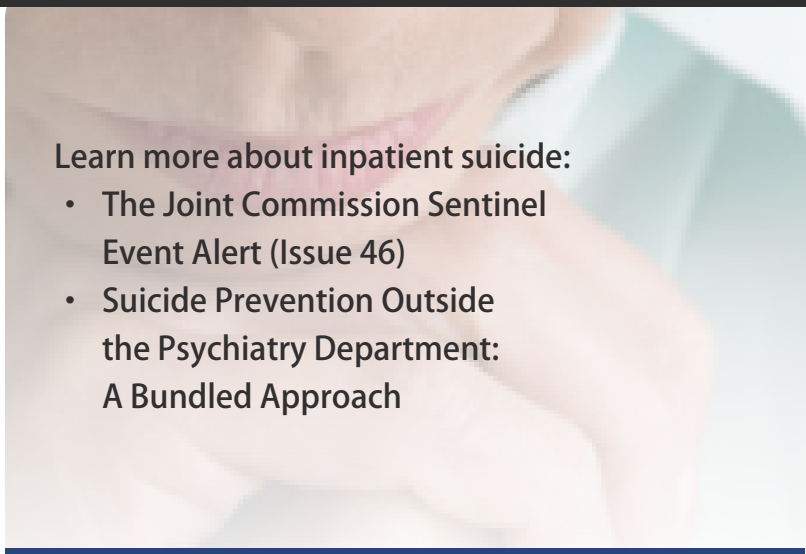
THE AFTERMATH

The three nurses and physician who attended Mary were devastated. During the RCA, it was determined that Mary displayed no overt suicide warning signs. But, there had been a few subtle clues: she was unemployed and uninsured; had no immediate family members; a remote history of depression; and, had experienced abuse.

There was nothing "missed" during the assessment, and careful retrospective review confirmed the caregivers provided appropriate care. However, that knowledge did not remove the pain of the second victims. Their biggest frustration remains: there is no sure-fire formula to accurately and consistently identify who might be suicidal.

The coroner was helpful, assuring the caregivers that suicide can be very impulsive, often occurring within five minutes of the decision. The caregivers were offered employee assistance and counseling services. Hospital leaders offered the staff numerous opportunities to discuss the incident, expressed support, and took action to address potential rumors and accusations.

Suicide is a major public health concern and awareness is everyone's responsibility.



Learn more about inpatient suicide:

- The Joint Commission Sentinel Event Alert (Issue 46)
- Suicide Prevention Outside the Psychiatry Department: A Bundled Approach

The biggest frustration is that there is no magic key to identify who might be suicidal.

LESSONS LEARNED AND ACTIONS TAKEN

1. Make awareness training mandatory for all employees and physicians so they can spot subtle clues that might lead to self-harm. These might include pacing, wringing hands, change in behavior, increased pain, feeling of hopelessness, and social isolation. Clear communication avenues and handoff requirements must be identified so anyone can easily share red flags with the patient's caregivers. At Mary's hospital, the senior leaders created a video to share their story with all new employees to heighten awareness of subtle suicidal clues. It truly "takes a village," as acts can be impulsive. Everyone needs to be aware if a patient is not coping well, offers a small hint or shows changes in behavior.

2. Use effective suicidal risk screening tools for all patients, teaching staff how to ask the appropriate questions. Suicide risk is not exclusive to patients on behavior health units. Staff must avoid preconceived judgments based on the patient's social or medical history. Clarify for nurses and physicians what actions they should take if a patient exhibits suicidal risks, especially on medical/surgical units where staff may not be trained in behavioral treatment. Provide person-centered care, engaging the patient and his or her family in planning and decision-making.

3. Support the "second victims" among your employees and medical staff members. Their feelings of personal failure can be devastating, both personally and professionally. Be proactive by instituting a "Second Victims" train-the-trainer program at your hospital (see page 4 for Second Victim Workshop info).

4. Conduct a comprehensive environmental assessment of all patient care areas. Hanging is the number one method of inpatient suicides--most frequently from doors, door hardware, or shower rods.[1] Consider reducing opportunities for self-harm by eliminating as many risks as possible.
   a. Use break-away shower rods
   b. Remove furniture or artwork which can be broken and used as sharp tools
   c. Remove cords or cloths that can be used for suffocation
   d. Replace light fixtures, sprinkler systems or furniture that can be used as anchor points.

5. Educate family, friends and sitters about suicide risks and warning signs. Asking people who know the patient best to report any changes in behavior helps staff identify patients at risk for suicide. Sitters assigned by the hospital to observe patients should receive the same awareness training as employees (see above).

As the number of individuals who become aware of suicide cues and can comfortably talk directly about it increases, the opportunities for health care providers to appropriately assess and take action increases, resulting in safer care for all patients. ■

Reference:
1 - http://www.jointcommission.org/assets/1/18/SEA_46.pdf
2 - www.suicideproofing.com

DID YOU KNOW the Federal Health Reform Bill Requires PSO Participation by 2015?

Effective January 1, 2015, health plans participating in the health insurance exchanges (HIEs) under the Accountable Care Act (ACA Section 131, (h)(1)) may only contract with hospitals with more than 50 beds that utilize a patient safety evaluation system (PSES). A PSES is only established through working with a PSO. MOCPS PSO participants are in a favorable position and ready for this requirement. ■

Medical Errors are a Tragedy

In July 2005, the late Sen. Edward Kennedy spoke to his colleagues on the U.S. Senate floor:

> *"For even one American to die from an avoidable medical error is a tragedy. When thousands die every year from such errors, it is a national tragedy, a national disgrace, and an urgent call to action."*

Seven years have passed and medical errors are still a top priority for hospitals. You can do your part by sharing your patient safety successes.

- Submit your stories to MOCPS by secure e-mail and we'll share them anonymously with other PSO participants. ■

Hospital Patient Safety Ratings

In the past month two different patient safety ratings were published:

- The August edition of Consumer Reports provides scores for U.S. hospitals from 0-100
- On its website, The Leapfrog Group provides a link to a rating scale of A through F from Hospital Safety Score. ■

National Quality Forum (NQF) Endorses 14 New Complications-Related Patient Safety Measures

These measures address a range of quality concerns, including events that occur in ambulatory settings:

- medication safety
- venous thromboembolism
- surgical safety
- care coordination

In all, 27 measures were evaluated against NQF's endorsement criteria over the past three years. Fourteen received endorsement status and three are still under consideration. The NQF measures also now include measures in ambulatory settings.

MOCPS PSO participants also have access to an updated matrix and crosswalk between the Common Data Formats used for PSO reporting, Hospital-acquired Conditions and the new NQF Serious Reportable Events. ■

PSOs: A National Perspective, Past, Present and Future

MOCPS hosted a webinar, "PSOs: A National PErspective, Past, Present and Future" with AHRQ staff on July 26, 2012. Access the audio and presentation of the session. ■

Congratulations on Patient Safety Certification!

Deborah Smith, Patient Safety Coordinator at Phelps County Regional Medical Center, recently passed the patient safety certification test administered through the National Patient Safety Foundation. Way to go, Deb!

See page 5 for information about special discounts to MOCPS participants on ASPPS membership, curriculum, and certification. ■

The SECOND VICTIM Experience:

Train-the-Trainer Workshop

REGISTER TODAY!

http://www.cvent.com/d/6cq232/4W

The Missouri Center for Patient Safety is pleased to offer this unique workshop in September at two locations to learn and teach the skills to support staff members and physicians who are impacted by adverse and/or unexpected clinical outcomes.

Participants will gain insights into the "second victim" experience as well as supportive interventions from faculty who developed and implemented the University of Missouri Health System's successful "Second Victim" program.

Participants will also acquire the knowledge, skills and techniques necessary to implement a "second victim" program for peers.

Space is limited to 40 participants at each location and will be made available on first come first serve basis. Minimum required attendance is 20.

Select one of two locations:
September 21 @ Saint Luke's Northland Hospital
Kansas City, MO ($375)
OR
September 28 @ SSM St. Clare Health Center
Fenton, MO ($375)

University of Missouri Health System

forYOU team

Upcoming Events

Fall 2012

Sept. 6	Last day to register for October round of SOPS
Sept. 6-7	Missouri HEN Collaborative Session (Columbia)
Sept. 20	MOCPS — PSO Advisory Committee (Columbia)
Sept. 21	Second Victim Workshop (Kansas City)
Sept. 28	Second Victim Workshop (St. Louis)

Winter 2012

Dec. 6	Last day to register for January round of SOPS
Dec. 6-7	Missouri HEN Collaborative Session (Columbia)

Spring 2013

March 7	Last day to register for April round of SOPS
April 16	7th Annual MOCPS Conference (Columbia)
April 17	4th Annual MOCPS PSO Participant Day (Columbia)

FOR MORE INFORMATION

Hospital PSO participation and implementation:
Eunice Halverson, ehalverson@mocps.org

EMS PSO participation and implementation:
Carol Hafley, chafley@mocps.org

PSO data system and technical support:
Alex Christgen, achristgen@mocps.org

For additional information on the Center's PSO activities, resources, toolkits, upcoming events, Survey on Patient Safety, and more, please visit our website at www.mocps.org or follow us on Twitter @MOPatientSafety for the most up-to-date news.

MISSOURI EMS-PSO PROJECT

EMS Corner

EMS-PSO Maintains Momentum in Missouri

The Missouri EMS-PSO project is gaining momentum with the addition of five services. The Center commends the following agencies that are now joining their colleagues in improving EMS quality and safety for recently completing the first step in their PSO implementation:

- Dekalb-Clinton Ambulance District (Maysville)
- Kearney Fire and Rescue Protection District
- Madison County Ambulance District (Frederickstown)
- Pemiscot Memorial Health System (Hayti)
- Steelville Ambulance District

Several other EMS services in Missouri are currently in the contracting process.

If you have an EMS affiliation at your health care organization, please contact Carol Hafley at chafley@mocps.org about the next step to provide them with PSO services and protections. ■

Discounts for Missouri Participants on Membership, Curriculum, and Certification

The Center is pleased to partner with the National Patient Safety Foundation (NPSF) by offering a special **10% discount** on initial one-year membership in the American Society of Professionals in Patient Safety (ASPPS).

ASPPS members that elect to take advantage of other discounts can access the NPSF Online Patient Safety Curriculum (including available CE and CME) at a **$200 discount** and seek certification from the Certification Board for Professionals in Patient Safety at a **$50 discount**, among other benefits.

Through this offering, the Center and NPSF are striving to further advance patient safety science, practice, and community of Missouri practitioners by providing professional development opportunities through learning from national leaders and obtaining the credential of a Certified Professional in Patient Safety.

For more information, see the flyer available on the MOCPS Web Site, including how to access the discounted ASPPS membership. ■

ABOUT MOCPS

The Missouri 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 health care environment safe for all patients, in all processes, all the time.

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