LISTEN UP

A success story from Hannibal Regional Hospital, Hannibal, Missouri

Daily safety huddles have been shown to be an effective tool in helping healthcare organizations develop a culture of safety, an essential characteristic of a High Reliability Organization. Late last year Keith Griffeth, Quality Director at Regional Hospital, shared their story during a national webinar.

Hannibal Regional Hospital’s pursuit of high reliability took a step forward when the first daily safety huddle was held on March 3, 2014. Several hospital leaders learned the details about daily leadership safety huddles at the 2013 IHI Annual Conference. While huddles had been previously discussed, they had not been implemented at the hospital. Energized by the results other hospitals had achieved, the wheels went into motion and the quick stand-up meetings began. The VP of Nursing leads each 15-minute session with representation from all clinical departments as well as senior leadership.

LEARNING FROM OTHERS

Department managers report on four topics:

1. Has there been any safety/quality issue in the last 24 hours?
2. Anticipated safety/quality issue in next 24 hours?
   - High-risk, non-routine procedures/tasks/situations/conditions?
   - Deficiencies in equipment, supplies or staffing that will make it hard to deliver safe, high quality care?
3. Stop the line story
   - Safety success story about practices or safe behaviors in the last 24 hours that prevented patient harm.
4. Service Recovery
   - Is there anyone in the organization that would not give us an “excellent” rating on our patient satisfaction survey?

TAKING ACTION

Issues that need attention are divided into two categories: “Fix today” or “Need time to fix”. Responsibility is assigned and all actions are tracked on a smart board in the conference room, which provides visual reminders as well as supports accountability when the list is reviewed during each huddle. In addition, an electronic resolution log of issues is available in a shared folder for all department managers to access.

RESULTS

Leaders have embraced the opportunity to be forthcoming with errors, omissions and mishaps on their units and in their departments, taking advantage of a non-judgmental atmosphere aimed at problem-solving rather than placing blame. Leaders have also gained valuable insight into the challenges faced by other units, enabling them to place their interactions with those units in the context of the operation of the entire organization. All attendees have gained from the exposure of their reports to the perspectives of their colleagues, and many problems have been readily solved that might not have been addressed before the advent of safety huddles.

As this process matures, a structured analysis will be undertaken and more will be learned about its effectiveness in quantitative terms. To date 100% of “fix today” items and 94% of “need time to fix” items have been completed. It is readily apparent that gains have been made in promoting a culture of patient safety at Hannibal Regional Hospital.

Hannibal Regional has shared a poster outlining the safety huddle process. To learn more details about implementing daily safety huddles, contact:

Keith Griffeth
Quality Director
Hannibal Regional Hospital
keith.griffeth@hrhonline.org
573-248-5265
CPS SHARES SUCCESSES AT ANNUAL AHRQ PSO MEETING

The Center for Patient Safety (CPS) Executive Director, Becky Miller, and staff, Alex Christgen and Lee Varner, joined other PSO representatives from around the country at the Agency for Healthcare Research and Quality (AHRQ) Headquarters in Rockville, Maryland for the 7th Annual AHRQ PSO Meeting.

As one of 85 PSOs certified nationally, operating within 30 states and District of Columbia, CPS continues to be a leader in PSO activity.

CPS is:
- 1 of nine PSOs with more than 250 PSO contracts
- 1 of only 44 PSOs receiving reports
- 1 of 16 PSOs with more than 10,000 reports
- 1 of 38 PSOs providing services to all specialties
- 1 of 2 PSOs providing services to EMS services
- 1 of 13 PSOs receiving reports in all AHRQ defined safety categories

HIGHLIGHTS OF THE MEETING:
- AHRQ and CMS representatives stated the regulations for Section 1311(h) of the Affordable Care Act are in the process of being written for an effective date of January 1, 2017. The Section requires hospitals with more than 50 beds to participate in a PSO in order to be eligible to participate in Health Insurance Exchanges.
- AHRQ Director, Dr. Richard Kronick, noted that the AHRQ and CMS have “reached an agreement in principle” regarding coordination of PSO activity and protections and needs of CMS state surveyors to ensure regulatory compliance. Additional information should be available to surveyors, providers and PSOs in the near future.
- A mock trial highlighted recent challenges to the PSO protections, raising points from both the plaintiff and defendant perspectives. Presenters cautioned that PSO participants need to have well-defined policies and report to their PSO in order to successfully claim the federal protections of the Patient Safety and Quality Improvement Act of 2005 in court. If you need help updating your PSO policy, contact Eunice Halverson.
- CPS presented on a panel with the Michigan Keystone Center PSO and the Maryland Hospital Association PSO highlighting best practices to perform Safe Tables, the challenges and successes, and how each organization performs its Safe Tables.
- The AHRQ has provided, and will continue to develop, resources to help providers better understand PSOs and select a PSO on its website at www.pso.ahrq.gov.

June 10 Webinar: Featuring Hospital Success Stories From Patient Safety Organizations (PSOs)

AHRQ is hosting a webinar June 10 from 1 to 2 p.m. CT to highlight the AHRQ Patient Safety Organization (PSO) program and present success stories from hospitals that are members of one or more PSOs. Hospital leaders, including Vereline Johnson from Saint Francis Medical Center in Cape Girardeau, will share how their organizations have used their PSO for meaningful patient safety and quality improvement.

REGISTRATION IS OPEN

Speakers:
- DIANE COUSINS, R.PH.
  Agency for Healthcare Research and Quality (AHRQ)
  Rockville, Maryland (Moderator)
- VERELINE JOHNSON, R.N., M.S.N.
  Saint Francis Medical Center
  Cape Girardeau, Missouri
- CHRIS DICKINSON, M.D.
  University of Michigan Health System
  Ann Arbor, Michigan

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.
PSO LEGAL UPDATE

FOR MORE INFORMATION, contact Kathy Wire, JD, MBA, CPHRM.

Two cases covered in earlier news articles continue to make their way through the courts. They have similar themes and findings. These cases arose in Florida and Kentucky, states without significant privilege or confidentiality for quality improvement work and with some animosity in their court systems for those protections. Accordingly, the cases acknowledged that the Patient Safety and Quality Improvement Act (PSQIA) supersedes state law (even a state constitutional amendment in Florida), but they interpret the protection offered by that law very narrowly.

Both Kentucky and Florida mandate reporting of certain events to their respective Departments of Health. The PSQIA clearly excludes information developed for reporting to the state from PSWP protection. The cases revolve around the scope of that exclusion. The providers have argued that only the information actually submitted to the state lies outside of PSQIA protections. The KY and FL courts have held that, in addition to the reportable data, much of the work involved in developing the reported information is outside the scope of the PSQIA privilege.

The Center’s Board of Directors has approved the Center signing on as amicus curiae to support the healthcare providers in those cases because of our belief in the importance of keeping the law’s protections as broad as possible for all PSO participants. However, it is important to remember a few key points that underscore the indisputable ongoing value of PSO participation:

- No case has threatened the protection of information in the hands of the PSO. In other words, the act of reporting to a PSO creates no additional risk of disclosure of any work product. The Florida and Kentucky cases only address the protection of information that resides in the providers’ files.
- These cases have no precedential impact outside their respective states.
- Every case interpreting the PSQIA recognizes that the law supersedes less protective state law.

PSO participants need to define and document their PSES carefully so that the court has a clear roadmap to understand its scope and its relationship to other work. Where possible, PSO-related work should take place outside of the workflow that supports state reporting with state reporting defined as narrowly as possible.

- Remember that in addition to privilege and confidentiality protection, PSO participation also provides benefit to all participants through the sharing and learning that takes place. These activities are not affected by decisions about the protections.

The defendant in the University of Kentucky case, Tibbs v. Bunnell, has petitioned the US Supreme Court to hear the case. The Florida case, Charles v. Southern Baptist Hospital, has been appealed to the Florida District Court of Appeals. The Kentucky state Supreme Court opinion as well as any new PSO legal developments will be reported on the CPS website.

Court cases involving PSOs confirm the importance of having current policies in place which define an organization’s patient safety evaluation system (PSES) and patient safety work product (PSWP). Most Missouri hospitals joined the Center’s PSO in 2010, when state law required certain events be reported to a PSO in order to receive Medicaid funds. Since that law was rescinded, it’s important that policies be updated. Contact Eunice Halverson at the Center for assistance.
CPS has launched its Patient Safety Organization for long-term care! Any licensed provider of long-term care can participate in this opportunity to share learning and collaborate with others to improve safety. The PSO will collect participants’ information about adverse incidents, near misses and safety concerns in a confidential space. CPS will share anonymized provider learnings as well as its own analysis to contribute to safer care for residents. Funded by a grant from the Missouri Foundation for Health, this new initiative is available at no cost for Missouri providers.

The long-term care PSO will join the existing hospital and EMS components, which have been gathering data and sharing learnings for more than five years. CPS looks forward to supporting safety in each of these settings and, most importantly, supporting all providers’ efforts to work together for the advancement of better and safer care. CPS staff members have begun discussions with a number of providers to launch collaborative improvement efforts across the spectrum and across communities. Now LTC can be at the table.

MORE INFORMATION
For more information, contact Kathy Wire, JD, MBA, CPHRM  
LTC Project Manager.

CPS’ Long-Term Care Project Manager, Kathy Wire, presented “PSO: Powerful Protection for LTC Safety/Quality Work Product” at Long-Term Care and the Law, a conference sponsored by the American Health Lawyers Association in February. Long-term care attorneys from around the country learned how PSO participation can support their clients’ quality and performance improvement programs.
The work that many organizations started years ago in Missouri is now expanding coast to coast. 2014 brought two national contracts into the Center’s PSO: Paramedics Plus and Lifeteam Air Evac. The Center is now providing EMS PSO services in 19 states including, most recently, the state of New York.

We are excited to welcome Canandaigua Rescue Squad (CRS) to our PSO family. CRS is a progressive EMS service with a keen interest in patient safety and quality. Chief Ken Beers quickly saw the importance and value of PSO services. Within days of first seeing an overview from the Center, he completed his PSO contract and policy.

Congratulations to Canandaigua, Paramedics Plus and Lifeteam Air Evac for taking proactive steps and supporting patient safety in their communities. We look forward to announcing new participants in the near future.

We have seen significant interest in PSOs over the past year as more EMS leaders learn the benefits and opportunities for PSO participants. One EMS leader who has taken interest is Allison Bloom. Bloom is a recognized writer, attorney and board member of the National EMS Management Association (NEMSMA). She shares broad experience in EMS and has a high degree of passion and interest in Mobile Integrated Healthcare. This interest has led to several published articles in “EMS Insider”. Watch for more articles as EMS patient safety and quality continues to become an important topic.

If you missed Bloom’s articles, you can find them on the Center’s website. We are also excited for her to be a speaker at the Center’s EMS Patient Safety Conference on October 30.

The Center for Patient Safety provides EMS PSO services to hundreds of air and ground EMS locations in 19 states across the U.S.

MORE INFORMATION
For more information, contact Lee Varner, BS EMS, EMT-P
EMS Project Manager.
PATIENT SAFETY: IT'S IN THE CARDS!
A success story from Mercy Hospital, St. Louis, Missouri

Written by:
Julie Binder, RN, MSN
Clinical Outcomes Manager
Mercy Hospital St. Louis
314-251-3887

The landmark 1999 Institute of Medicine report, “To Err is Human” introduced patient safety into the national spotlight, tasking hospitals with assessing their patient safety efforts. The core of these efforts is to understand what may be hindering the development of a strong patient safety culture.

Mercy Health is the 5th largest Catholic health care system in the US, with 35 acute hospitals across Arkansas, Kansas, Missouri, and Oklahoma. As part of Mercy’s commitment to continuous improvement in patient safety, we routinely ask ourselves “How do we improve our safety culture to continually reduce harm to patients?” In 2013, results from the AHRQ Culture of Safety Survey showed Mercy leaders perceived safety culture more positively than frontline co-workers. This disparity between leadership and co-worker perception is common across healthcare organizations.

To close this gap, Mercy launched an awareness campaign to help coworkers connect with current patient safety activities and to stimulate discussions about patient safety.

In developing the campaign, coworkers asked us to embed safety discussions where they work. This feedback led Mercy to build upon the concept of a new patient safety message each week to span a one year timeframe. Our team landed upon the concept of using an oversized deck of cards (like playing cards) to facilitate the safety message. In all, 55 cards were developed; including one to describe how to use the deck of cards and four Jokers or “Wild Cards”. Safety topics included facts about healthcare harm, adverse event and near miss reporting, accident causation, drift, perception of risk, use of checklists, fall prevention, use of restraints, hand hygiene, safe patient handling, second victim, teamwork, assertive statement, and more. The four Wild Cards were dispersed throughout the deck to let leaders and co-workers share a recent patient safety event or Great Catch. The Wild Card offered the opportunity to develop a more transparent culture where we share what we’ve learned from reported events.

Each card features a co-worker friendly front with an engaging title, content and picture that
compliments the topic. The back of each card provides the leader with background information on the topic and discussion points to be used with co-workers. The cards were ordered intentionally throughout the 52 weeks to build an awareness of the science of patient safety first followed by the importance of reporting events and leaving the remainder of the deck for safe behaviors and safe practices. We encouraged leaders to incorporate the cards into their existing unit huddles and to post the cards on their unit’s improvement board or other visible location.

The cards were rolled out in June 2014 in conjunction with a leader Patient Safety Tool Kit. Leaders will complete the deck of safety cards in July 2015. After three months, we conducted a brief survey with leaders to get feedback on the cards. 75% of leaders felt the card content was applicable to their department. 58% of leaders felt the cards were effective in facilitating patient safety discussions. One of the biggest challenges to successful rollout is the time factor. Initially, some leaders felt there was not enough time during huddles to cover the safety topic.

We are eager to see the impact of the program on the results of our AHRQ Culture of Safety Survey conducted in April 2015. While we do not have a final report, the initial (unscrubbed) data from co-workers, leaders, and physicians is showing improvement in the percentage of positive responses.

<table>
<thead>
<tr>
<th>Survey item</th>
<th>2013</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are actively doing things to improve patient safety</td>
<td>75%</td>
<td>82%</td>
</tr>
<tr>
<td>Hospital management provides a work climate that promotes patient safety</td>
<td>71%</td>
<td>80%</td>
</tr>
<tr>
<td>Staff will speak up if they see something that will negatively affect patient safety</td>
<td>70%</td>
<td>76%</td>
</tr>
<tr>
<td>Our unit discusses ways to prevent errors from happening again</td>
<td>63%</td>
<td>72%</td>
</tr>
</tbody>
</table>

The co-worker experience survey also showed positive gains between September 2013 and 2014. The study reports the % of excellent responses and the percentile ranking. Percentile ranking is displayed in the table below:

<table>
<thead>
<tr>
<th>Study item</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall perception of patient safety</td>
<td>17</td>
<td>35.1</td>
</tr>
<tr>
<td>Appropriateness of safety measures put in place</td>
<td>15.4</td>
<td>34.5</td>
</tr>
<tr>
<td>Environment for communicating medical errors</td>
<td>26.1</td>
<td>42.3</td>
</tr>
<tr>
<td>Initiatives to improve quality of care relative to safety</td>
<td>25.6</td>
<td>35.7</td>
</tr>
</tbody>
</table>

What’s next? We are currently deciding how to refresh “Patient Safety: It’s in the Cards” for another year of patient safety discussions with co-workers. Feedback from leaders demonstrates that there would be value in going through the topics again. We are also thinking about new ways to use the cards or reorder the deck to better emphasize specific safety concepts.

To learn more about implementing a program to enhance patient safety discussions, contact:

Kathryn Nelson
Mercy Hospital St. Louis
(314) 251-1910
kat.nelson@mercy.net.
PATIENT AND FAMILY INVOLVEMENT CONTRIBUTES TO SAFER CARE

Do you include patients or family members on your committees or improvement teams? While it might seem threatening to share details and ask for input from patients and family members, high performing hospitals are intentionally and systematically partnering with these individuals as advisors for improvement efforts. Hospitals that include patients and family members in their committee infrastructure report better care, better health and lower costs. Hospitals in Pursuit of Excellence (HRET) offers a free step-by-step guide to help hospitals get started.

OR FIRES – THEY STILL OCCUR

AHRQ provides tips on how to prevent an OR fire. During laparoscopic colon surgery, a patient’s bladder was accidentally lacerated. Surgeons repaired it without difficulty. However, as the bladder irrigation equipment was set up, no one noticed that a bag of solution was dripping into the power supply of an anesthesiology monitor. Suddenly sparks and flames began shooting from the monitor, and the OR filled with black smoke. Fortunately, the fire was extinguished quickly and neither the patient nor OR staff was injured. Sonya P. Mehta, MD, MHS, of Group Health Cooperative, and Karen B. Domino, MD, MPH, of the University of Washington, review factors that increase risk of OR fires and recommend ways to prevent them.

HEADS UP – PSO FOR PHYSICIANS

Does your hospital own or partner with medical clinics? Health Attorney Alice Gosfield has shared two article explaining why physicians should participate in a PSO: “Five Reasons Physicians Should Use Patient Safety Organizations” and “Using PSO’s to Further Clinical Integration”. Belonging to a PSO provides a safe environment for patient safety and quality improvement work, while protecting the information from discovery and subpeona. Contact the Center for more information to learn how physicians and medical offices can benefit from participating with a PSO.

MEDICAL EQUIPMENT REPROCESSING CHANGES

Several disastrous infections from medical devices have recently been reported in the news. The U.S. Food and Drug Administration published updated guidelines to help hospitals meet the challenge of safely and thoroughly cleaning medical equipment that is designed for repeated patient use. Be safe – update your protocols and practices!

IMPROVEMENT FATIGUE - MYTH OR FACT

A very factual scenario, improvement fatigue has developed in recent years due to the increased focus on improving quality measures. Hospitals & Health Networks (H&HN) Daily released an article from Ian Morrison in which he discusses the topic and ways to maintain focus. Read the full article “What do Do About Improvement Fatigue.”

AHRQ WEB MORTALITY & MORBIDITY CASE STUDIES

The Agency for Healthcare Research and Quality (AHRQ) releases monthly WebM&Ms, morbidity & mortality rounds on the web. Recent cases and commentaries include Errors in Sepsis Management. Review the case in its entirety online, take a short exam & earn CME and CE:

An elderly woman with pulmonary hypertension, COPD on home oxygen and coronary artery disease enters the hospital with left abdominal pain and shortness of breath and is diagnosed with pneumonia. Twenty-four hours after her admission and initial treatment her cultures begin to grow MRSA, her condition worsens to the point of requiring mechanical ventilation and she expires four days after admission.

This case study and many others can be found at http://webmm.ahrq.gov/.
The Center for Patient Safety (CPS) continues to build on culture services to support adverse event reporting and the learning that results from increased reporting.

JUST CULTURE

Just Culture, the balance between human and system accountability, is a hot topic in patient safety and reduction of errors in today’s medical industry. CPS fully supports the implementation of a Just Culture in healthcare organizations across the continuum of care. Reporting events is important as it leads to knowledge and process changes that contribute to future error prevention. Organizations with cultures that support open communication of errors in a non-punitive environment, a “just” culture, are more likely to see high levels of improvement in patient safety.

The Center has provided and supported the education of hundreds of healthcare individuals across the country to implement Just Culture in hospitals, long-term care, EMS services, individual organizations, and state agencies.

MORE INFORMATION

For more information on any of the Center for Patient Safety’s culture services, contact the Center at 888.935.8272 or info@centerforpatientsafety.org.

SAFETY CULTURE SURVEY SERVICES

CPS has added a new provider survey to the suite of culture assessments it administers from the Agency for Healthcare Research and Quality (AHRQ). The latest survey release is for ambulatory surgery services (ASC) survey. In general, the AHRQ surveys are designed to measure the culture of an organization. The survey captures opinions and attitudes of staff, while the results identify cultural strengths and weaknesses. CPS supports this diagnostic tool and provides survey administration services for hospitals, LTC and home care organizations, medical offices, pharmacies, and ASCs.

SECOND VICTIMS

Being a health professional often requires putting emotions aside for the sake of patients. Despite the emotional resilience that allows healthcare providers to care for their patients under stressful, high-stakes circumstances, sometimes an unexpected clinical event or outcome creates a heavy emotional impact.

In collaboration with the University of Missouri Health System Second Victim Program, the Center for Patient Safety is pleased to host two upcoming workshops. See our Upcoming Events on page 12 of this newsletter for dates and locations.

THE SECOND VICTIM EXPERIENCE

Train-the-Trainer Workshop

The Center for Patient Safety is pleased to offer another dynamic workshop, hosting trainers from the University of Missouri who will teach peer support skills for staff members and physicians who are impacted by adverse and/or unexpected clinical events and outcomes.

Participants will gain insights into the “second victim” experience as well as supportive interventions. Attendees will also acquire the knowledge, skills and techniques necessary to implement a “second victim” program for peers within their own organization.

Space is limited to 40 participants, available on a first come, first served basis.

Date: Thursday, September 24, 2015
Location: Mid-America Transplant Services
St. Louis, Missouri

REGISTRATION AVAILABLE
www.centerforpatientsafety.org
PSO.DAT.A.UPDATE

2014 CPS ANNUAL REPORT & PSO SUPPLEMENT

CPS again released its PSO supplement report in conjunction with the release of the annual report. The PSO Supplement summarizes the full PSO database and takes a deeper look at the individual event types for hospitals, ASCs, and EMS. Event scenarios are presented with research and resources to raise awareness and prevent similar events in the future.

PSO DASHBOARDS

PSO participant dashboards will be sent via secure email in June. If you do not receive a dashboard, or have questions about your dashboard, please contact Alex Christgen at the Center for Patient Safety.

STATS

With more than 27,000 events from 110 healthcare organizations, medication events continue to be the highest reported event type, followed by falls.

Six percent of reported events are near-misses and unsafe conditions, in which a mistake or error was about to occur, or could have occurred, but was caught before it reached the patient.

Nearly eighty percent of incidents submitted to the PSO resulted in no harm.

The most commonly reported factors contributing to adverse events are lack of communication or miscommunication, inexperience or incompetence, and unclear policies.

Harm Levels

- No Harm: 79%
- Moderate Harm: 11%
- Mild Harm: 8%
- Severe Harm: 8%
- Death: 0%

Events Submitted to CPS PSO

www.centerforpatientsafety.org
REMINDER
PSO adverse event reporting cannot be used for comparison of individual organizations. The purpose of PSO adverse event reporting is to learn what events occur and why, and to use that information to prevent future occurrence and patient harm. The value is in the quantity, quality, and details. The more reports obtained by the PSO containing detailed information about errors, near misses, and unsafe conditions, the greater potential for learning, sharing, and proactively preventing future harm, costs, and liability exposure.

IMPROVING SAFETY CULTURE THROUGH HUDDLES & ROUNDS
On March 12, PSO Participants joined presenters to discuss “Improving Safety Culture through Patient Safety Huddles and Rounds.” Topics included Safety Walk Abouts, Patient Safety Rounds, Safety Briefings, Safety Leadership Rounds, Senior Leader Executive Rounds, and Safety Huddles. This webinar was cohosted by CPS PSO and the North Carolina Quality Center PSO (see related story on page 1). PSO PARTICIPANTS can watch the recording online.

SURVEY ON PATIENT SAFETY CULTURE
PSO participants receive 20% off culture survey services from CPS. Interested in scheduling your 2015 survey for your hospital, ASC, medical office, pharmacy, long-term care, or home care locations? Contact Alex Christgen at the Center for Patient Safety, or submit a request for a free estimate.

ELECTRONIC SUBMISSION IS SUCCESSFUL!
CPS is excited to share success of the electronic PSO data submission pilot project! “Thank you!” to the participants that contributed their time and resources to the project!

During the pilot, CPS contracted with NextPlane Solutions, LLC, to securely and confidentially support electronic PSO data mapping for the CPS PSO data platform, ShareSuite, powered by VergeSolutions. CPS is now continuing its work with NextPlane to streamline data submission for the pilot sites and other interested organizations.

Electronic submitters can now simply export selected data fields from their event reporting system for mapping into the ShareSuite platform.

Benefits of electronic reporting include:
- no duplicate event entry;
- no dedicated IT resources needed;
- initial set up takes about two hours; consecutive submissions take only minutes, and;
- send more information to PSO to increase learning opportunities.

CPS is excited to move forward to streamline participation, provide better support, and create greater learning opportunities for our PSO participating organizations.

Contact Eunice Halverson if you are interested in electronic submission.

Two pilot spots remain available to take advantage of electronic submission setup at no cost! Don’t wait!

HIGH ALERT MEDICATIONS
In a case submitted to the CPS PSO, a pediatric patient received a higher than standard dose of Propofol and required resuscitation. In another case, a battery failed on an insulin IV pump and went unnoticed. Approximately one in every five reported PSO medication events involved a high alert medication such as anticoagulants (warfarin, heparin, Lovenox), Propofol, insulin, hypoglycemic agents, opioids and so forth. Events related to prescribing, dispensing, administering and monitoring errors.

High-alert medications are drugs that bear a heightened risk of causing significant patient harm when used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating. Use lists provided by the Institute of Safe Medication Practices (ISMP) to determine which medications require special safeguards to reduce the risk of errors.

<table>
<thead>
<tr>
<th>Events by Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venous Thromboembolism</td>
</tr>
<tr>
<td>Surgery or Anesthesia</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
</tr>
<tr>
<td>Perinatal</td>
</tr>
<tr>
<td>Medication or Other Substance</td>
</tr>
<tr>
<td>Healthcare-associated Infection</td>
</tr>
<tr>
<td>Fall</td>
</tr>
<tr>
<td>Device or Med/Surg Supply</td>
</tr>
<tr>
<td>Blood or Blood Product</td>
</tr>
</tbody>
</table>

HIGH ALERT MEDICATIONS
![Image](https://via.placeholder.com/150)

<table>
<thead>
<tr>
<th>Incident</th>
<th>Near Miss</th>
<th>Unsafe Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood or Blood Product</td>
<td>Device or Med/Surg Supply</td>
<td>Fall</td>
</tr>
<tr>
<td>Healthcare-associated Infection</td>
<td>Medication or Other Substance</td>
<td>Pressure Ulcer</td>
</tr>
<tr>
<td>Surgery or Anesthesia</td>
<td>Perinatal</td>
<td>Venous Thromboembolism</td>
</tr>
<tr>
<td>Total</td>
<td>4000</td>
<td>4500</td>
</tr>
</tbody>
</table>

**Incident**

**Near Miss**

**Unsafe Condition**
UPCOMING events..

JUNE 10
BENEFITS OF AHRQ PSOS: SUCCESS STORIES
Webinar
REGISTER

JUNE 22
EMS JUST CULTURE TRAINING
Central Jackson County Education Center
Blue Springs, Missouri
REGISTER

JUNE 30
EMS QUALITY MANAGEMENT: IT’S EVERYBODY’S GAME
Webinar
REGISTER

SEPTEMBER 3
EMS SECOND VICTIM: CARING FOR THE CAREGIVER
Webinar
REGISTER

SEPTEMBER 24
SECOND VICTIM TRAIN-THE-TRAINER
Mid-America Transplant Services
Saint Louis, Missouri
REGISTER

OCTOBER 30
EMS PATIENT SAFETY CONFERENCE
Hollywood Hotel & Convention Center & Casino
Saint Louis, Missouri
REGISTER

CPS SPEAKERS on the circuit

CPS staff are always on the go, sharing their expertise at national, state, and local conferences, events, and meetings. If you see them at an upcoming event near you, stop and say hello!

- Lee presented at Chillicothe Fire Department in Chillicothe, Missouri in February on Patient Safety and the Culture of Safety
- Dr. Michael Handler was a keynote speaker at the UMCK School of Medicine in Kansas City, Missouri on the importance of patient safety in March
- Becky presented at the Annual Agency for Healthcare Research and Quality PSO Meeting in Rockville, Maryland in April
- Becky and Kathy spoke to the Society of Healthcare Risk Managers in Wisconsin on “Balancing PSO Protections, Transparency and State Reporting” in April
- Lee presented Protecting Learning and Preventing at the Zoll Summit in Denver, Colorado in May
- Becky presented at the Hospital Association’s Strategic Quality 101 Conference in Missouri in May
- Becky and Kathy will be presenting to students at the UMSL College of Nursing on Safe System Processes and High Reliability Organizations in June
- Kathy will present High Reliability: The Key to Quality and Value for LeadingAge in St. Louis, Missouri in June
- Lee will present Protecting Learning and Preventing at the Kansas EMS Conference in Topeka, Kansas in August
- Becky and Dr. Handler will be presenting to the Missouri Chapter of the American College of Physicians in Osage Beach, Missouri in September
- Kathy presents twice in Texas this Fall, first on Patient Safety Organizations and then Just Culture
- Kathy will conduct a half-day pre-conference session for LeadingAge in St. Louis, Missouri and again in Kansas City, Missouri on Root Cause Analysis: Fertilizer for a Safe and Just Culture
- Becky and Kathy will be presenting, “PSO’s: Your Partners for Managed Care Success” at the Annual Conference of the American Society of Healthcare Risk Managers in Indianapolis, Indiana in October
- Lee will present Protecting Learning and Preventing at the Air Medical Transport Conference (AMTC) in Long Beach, California in October

FOR MORE INFORMATION, CONTACT ANY MEMBER OF OUR PSO TEAM

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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 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.

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