PSO NEWS

SWARM
BEHAVIOR

A UNIVERSITY OF MISSOURI HEALTH CARE INITIATIVE HELPS INCREASE EFFECTIVENESS AND ACCELERATE THE ROOT CAUSE ANALYSIS PROCESS. PAGE 10

ON THE COVER:

WHAT ABOUT A SWARM

Root Cause Analyses (RCAs) are important underpinnings of patient safety. However, thorough investigations of the medical record and intensive interviews with numerous, key staff members are time consuming and often repetitive. But a new University of Missouri Health Care initiative has helped increase effectiveness and accelerate the overall process. **10**

IT'S AN EXCITING TIME FOR PSO LAWYERS!

Lawyers think of an opportunity to argue at the U.S. Supreme Court as a pinnacle of practice. For a federal law, the Supreme Court is the source of ultimate interpretation. When a law comes before the court, it usually means that some uncertainty will be put to rest. By the time you read this, the PSO community may know whether the Supreme Court will decide how the PSQIA applies in states with strict reporting requirements.

The Court is preparing to rule on an application for a writ of certiorari, or a request for the Court to review an issue that relates to Federal law, in Tibbs v. Bunnell, No. 2012-SC-000603-MR (Ky. Aug. 21, 2014). The Court is not obligated to hear the case, but has taken several steps that suggest it is seriously considering the application.

The case arose from specific provisions of Kentucky law that require hospitals to gather and report certain information to the state. The Kentucky Supreme Court ruled that the PSQIA could not protect any information gathered and maintained as part of the reporting and analyzing process, whether or not it was actually submitted to the state agency. The briefs submitted to The Supreme Court state the issue before the court in these terms:

Whether state law may nullify the federal "patient safety work product" privilege, or whether, instead, the Kentucky Supreme Court erred by interpreting [the PSQIA] not to protect information "normally contained in" documents subject to state reporting or recordkeeping requirements.

The PSO community and their attorneys believe that the Kentucky decision ignores clear language in the PSQIA and the Final Regulation. It is also believed that, if the Supreme Court decides to hear the case, they will see a conflict between the Kentucky decision and the Federal law.

Florida also has several similar cases, which have led to conflicting opinions in that state. If the Supreme Court hears the Tibbs case, its decision will also govern the Florida situations. If The Supreme Court decides not to hear Tibbs, then the Florida Supreme Court will have to resolve the conflict there.

It is important to remember that these cases look at issues which are specific to the state laws of Kentucky and Florida. The decisions are irrelevant for states without mandatory reporting requirements, like Missouri. They are also irrelevant for states like Illinois, where the state reporting law specifically preserves all available protections (410 ILCS 522/10-25). And the cases interpreting the PSQIA have uniformly held: 1) the law supersedes less protective state laws, and 2) material that has been reported to a PSO cannot be subpoenaed or otherwise extracted from the PSO. All the cases have reviewed the confidentiality of materials in the files of the providers.

THE CENTER FOR PATIENT SAFETY will continue to issue immediate legal updates about important decisions. If PSO participants or their attorneys have any questions, please contact Kathy Wire at kwire@centerforpatientsafety.org.

SMART PUMPS SAVE LIVES

BY RENEE TREWYN, PHARM-D, BCPS
Citizens Memorial Hospital

ntravenous infusion pumps have been used for many years to deliver medications at precise rates or in specific amounts. However, "smart" pumps that have software that calculates doses and alerts users to potential errors are becoming more prevalent. They include a library of medications that includes dosing guidelines, dose limits and clinical advisories. The pumps collect data about medication administration, which allows organizations to analyze pump use, identify opportunities to provide safer care, and proactively take action. While smart pumps are not fool-proof, they have been known to decrease the likelihood of harm caused by incorrect medication dosage calculations.[1]

[1]http://www.ismp.org/Tools/guidelines/smartpumps/default.asp#general

Citizens Memorial Hospital (CMH) is an 86 bed acute care facility with Medical-Surgical, ICU-Telemetry, The Birth Place and Geriatric Psychiatric inpatient units. CMH adopted smart pumps more than three years ago, but utilization had deteriorated over time to about 50%. In early 2014, Lesa Stock, Chief Clinical Officer, asked Pharmacy Director Renee Trewyn to analyze utilization to understand what could be done to increase smart pump usage across the organization. Stock felt strongly that the decreased use of the pumps could be compromising patient safety. At that time, utilization rate of pumps was dependent primarily on the nursing staff, with pharmacy's role having evolved into editing the library at the request of nursing. It was a reactive versus proactive process, which frustrated Trewyn.

WHAT CHANGED?

Pharmacy decided to adopt increasing utilization of smart pumps as a performance improvement project in FY 2014. Pharmacists had been providing routine clinical oversight for PCA pumps and heparin drip utilization, but now expanded that role to identify missed opportunities for utilizing the smart pump drug library. Pharmacists interviewed nursing staff in each unit to understand why smart pumps were not used for some medications and which drug entries in the drug library were problematic with routine use. Pharmacists addressed the nurses' concerns about specific medications and dosages routinely used in each department making edits to the drug library, and continued to re-emphasize the increased safety afforded when smart pumps are appropriately and consistently used. Focused education that all infusions should be administered utilizing the smart pump by choosing the drug from the appropriate drug library, and making minor edits such as allowing for overfill with biologics resulted in a 40% increase in compliance on two nursing units,

but at year end the system overall compliance remained below goal.

In the second year of the project, reducing unnecessary alerts was identified as a strategy to increase smart pump utilization and increase patient safety. Pharmacists worked with each unit to review the drugs and dosages routinely used for their patients and to set alert levels appropriately, which decreased annoyance. Review of monthly detail reports by physicians, nurse managers and pharmacists allowed identification of medications for which hard and soft limit hits resulted in alarms. Records for the infusions demonstrating hard limit hits were examined to see if a simple edit was required, such as weight based dosing limits that were edited to allow for heavier patients than expected, or if a potentially serious adverse event may have been averted.

> **"Physicians and nurses often don't realize how a simple push of a button can risk a life. Data show us how invaluable the smart pumps are in helping us to reduce human error and to increase patient safety,"** says Lesa Stock, Chief Clinical Officer at CMH.

Pharmacists reviewed the parameters for drugs demonstrating multiple soft limit alerts and reset those limits to alarm at safe, reasonable levels where possible. Adding an entry with higher limits and restricting its use to cardiac cath lab allowed safe use of dobutamine throughout the rest of the hospital while reducing alerts when used for stress testing. In this second year of the project, the overall compliance with smart pump utilization demonstrated a sustained and steady increase, reaching the interim goal at six months. It is ex-

pected that the reduction in numbers of alarms will lead to increased attention to those that do alert.

According to Trewyn, possibly the most significant contributor to the success of the project is that the project is important to so many stakeholders. CMH utilizes outcome report cards across the organization, and the CCO directed that unit smart pump utilization be added as a safety metric for all hospital nursing managers. The overall utilization rate is reported on the pharmacy director's report card. Individual pump utilization rate has been added to performance evaluations for nurses on some units. Overall utilization rate and "Good Saves" are reported to the Pharmacy and Therapeutics Committee and by the CCO to all medical and nursing staff. Hospital-wide focus on utilization and transparency of results has driven increased use.

UTILIZATION INCREASES— LIVES SAVED!

Smart pump utilization is measured on a monthly basis at Citizens, and is routinely addressed with medication events by the Medication Administration Committee. Utilization has increased to about 70% hospital wide, with some departments scoring higher. Clinical staff is confident that the pumps are more often used appropriately. When an alert goes off because the hard limit is reached, staff knows action must be taken, avoiding a medication error and potential harm to the patient. Kudos is given to the pharmacy and nursing staff who now work more collaboratively to provide a safer environment for their patients. Increased focus and team work have paid off!

RENEE TREWYN is the Pharmacy Director at Citizens Memorial Hospital in Bolivar, Missouri. You can reach her at renee.trewyn@citizensmemorial.com.

ONLINE: Go to the Center for Patient Safety website to see table "Medication Great Catches with Safe Pump Use" from this story (for CPS PSO Participants).
http://www.centerforpatientsafety.org/for-pso-participants/

C. DIFF BE GONE!

BY LINDA S. MALY, RN, BSN, CIC
St. Luke's Hospital

The Centers for Disease Control and Prevention reports that almost half a million people in the United States were diagnosed with hospital-acquired Clostridium difficile (C. diff) in 2011; and 29,000 died within 30 days of the initial diagnosis. Those most at risk are older individuals who take antibiotics and get additional medical care.[1] While deaths from C. diff were unusual in the past, they have become more prevalent due to the virulence of the organism.

DEATH STRIKES CLOSE

Prior to 2008, there was little focus on C. diff infections in hospitals – they just happened and patients recovered. That year, however, a patient died from the infection in a St. Louis area hospital. While the death did not occur at St. Luke's Hospital in Chesterfield, Missouri, the hospital formed a multi-disciplinary improvement team with representatives from the microbiology lab, risk management, nursing, environmental services, pharmacy, clinical education, the emergency department and the medical staff to address the issue. At that time, there were no evidence-based practices available anywhere; so the team did their research, both inside and outside the hospital.

EARLY IDENTIFICATION AND ISOLATION

One of the first process improvements was to define and require use of a C. diff bundle, which included bleach to clean the environment and hand washing with soap and water. The team had done their homework correctly, as the nationwide bundles later published in 2009 and 2010 included the same elements. In addition to the bundle, the team developed a diarrhea algorithm, to allow for early identification of patients who might have C. diff.

If patients meet the C. diff criteria, they are immediately placed on isolation. The team found that early identification and early isolation in private rooms were important in reducing infection rates. Since these changes positively impacted the C. diff rates, the hospital has since adopted similar practices for patients with norovirus, Ebola, CRE and gastroenteritis of unknown etiology. Their philosophy: don't over isolate, but isolate early and rule out infection.

LABORATORY TESTING CHANGES

The team included in the bundle limitations on the frequency of laboratory testing and the consistency of the specimen. Because patients may have false negative tests for up to six months, repeat

[1]http://www.cdc.gov/HAI/organisms/cdiff/Cdiff_faqs_HCP.html

testing for a negative result was no longer protocol. This created a challenge because many nursing homes would not accept patients until they had a negative test. But the team learned from its research that it was more accurate to make the determination based on the patient's condition. Therefore, patients were required to be symptom free, but they did not require a negative C. diff test to be moved out of isolation. This meant re-educating all the hospital staff and physicians as well as nursing home staff. St. Luke's provided education for the nursing homes to which most of their patients are discharged. If a nursing home asked for a negative C. diff test, Linda Maly, St. Luke's assistant director of clinical performance improvement, would personally explain their new-found research with the nursing home's infection prevention nurse or director of nursing. Now, patient transfer refusals based on C. diff history are no longer an issue for the hospital.

Healthcare Associated Clostridium difficile Rates (per 10,000 patient days)

CDI Bundle Implemented

Clostridium difficile Bundle
• Education
• Hand Hygiene – Soap/Water
• Early Recognition / Isolation
• Environmental Cleaning with Bleach 2x a day
• Prudent Antibiotic Usage
• Specimen Collection & Testing Guidelines

January 2009 to June 2015

C. diff at St. Luke's Hospital

EDUCATION: IT TOOK A VILLAGE

Ensuring that the newly-defined C. diff bundle was used by all staff and physicians was a big challenge. Everyone was educated, including the medical staff and all patient care employees as well as those in health information services and patient financial services. Numerous communication modes were used, including posters, newsletters and online training for clinical non-clinical staff. Everyone needed to know the new process and their personal responsibilities.

SUCCESS!

In 2012, the national C. diff benchmark was 10 cases/10,000 patient days. While C. diff has not been wiped out completely at St. Luke's, the hospital has accomplished significant success (see graph with results). For example, the hospital experienced several quarters in 2012-2014 with no incidences of the hospital-acquired infection. The culture has also changed at St. Luke's: The entire healthcare team is now aware of the C. diff bundle requirements and the quarterly rates. When there is even a small peak in the C. diff rate, questions immediately arise from the nursing units, senior
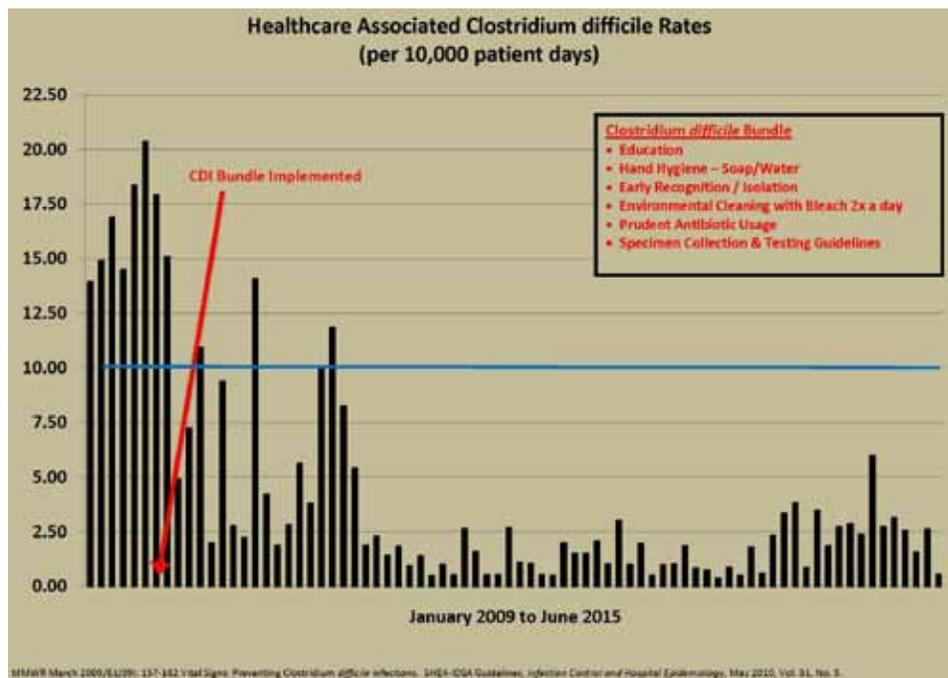
leaders and board of directors, all curious to know what happened so any preventable defects can be corrected.

"St. Luke's Hospital is committed to improving the quality of life for our patients, and that's why we use a comprehensive, 'bundled' approach to preventing and managing healthcare-associated infections. It is a journey of constant improvement," said Linda Maly, assistant director for clinical performance improvement.

A WORK IN PROGRESS

Improvements continue to occur. The algorithm has been updated, and testing for antigen and toxin are now performed. A rapid test is done; if that is negative for toxin, it is sent out for cytotoxicity, and the patient stays on isolation until ruled negative. The team continues its vigilance regarding the C. diff rates and is now de-

termining the lowest rate over which they have control, as patients need antibiotics, which sometimes makes them more susceptible to C. diff.

Congratulations to St. Luke's for continuously improving care for their patients!

ABOUT ST. LUKE'S HOSPITAL

St. Luke's Hospital is an independent, nonprofit healthcare provider committed to improving the quality of life for its patients and the community. In its nearly 150-year history, St. Luke's has grown from a single hospital location to an advanced network of care. It provides personalized healthcare services in over 60 specialty areas at its 493-bed hospital in Chesterfield, Mo. and offers 25 other locations across the greater St. Louis area, bringing quality healthcare services close to home. St. Luke's is nationally-recognized for quality care and consistently earns high patient satisfaction scores.

LINDA S. MALY is the Assistant Director for Clinical Performance Improvement at St. Luke's Hospital. You can reach her at Linda.Maly@stlukes-stl.com.

PATIENT FALLS IN MISSOURI:
THE CHALLENGE CONTINUES

Despite a multitude of toolkits and resources, patient falls remain a prevalent safety issue. Over the past three years, falls have consistently been in The Joint Commission's top ten reported sentinel events. In 2013 falls were the fifth most commonly reported sentinel event, rising to the second most reported event in 2014. Currently falls are the fourth most reported sentinel event through 3rd quarter of 2015.[1] This is concerning in two regards: 1. Increased avoidable injury to patients, 2. Financial risk for the facility due to increased length of stay and cost of treating the fall injury.

The Missouri Hospital Association and the Center for Patient Safety (CPS) began a collaborative effort the summer of 2015 to review claims data and patient safety event data to see if Missouri was following the national landscape trend of an increasing number of falls. The time frame reviewed was October 1, 2013 through March 31, 2015. By correlating the data collected by each organization, it was hoped that a trend could be identified; and that by analyzing causal/contributing factors, there could be lessons learned in regards to falls in the state of Missouri and how to prevent them from occurring in a healthcare facility.

As this collaborative effort was going forth, The Joint Commission issued Sentinel Alert Event #55 on September 28, 2015.[2] This alert highlighted the fact that fall prevention is a complicated process involving many moving parts.

The Missouri Hospital Association utilized HIDI Analytics claims data pertaining to falls and trauma-related harm in the state of Missouri for the time frame noted above, while CPS analyzed falls submitted to the PSO. As the Sentinel Event noted an increase in the number of falls reported as sentinel events, Missouri also noted an increasing trend in falls. A full report in collaboration with the Missouri Hospital Association is available on the Center's website.

HIGHLIGHTS OF THE ALERT INCLUDE:

■ Every year hundreds of thousands of patients fall in hospitals, with injury resulting in 30-50%

■ Injuries from falls can add an additional 6.3 days to the hospital stay

■ The cost of one fall with injury is approximately $14,000

The most common causal factors for falls:

■ Inadequate assessment

■ Communication failures

■ Lack of adherence to protocols and safety practices

■ Inadequate staff orientation, supervision, staffing levels or skill mix

■ Deficiencies in the physical environment

■ Lack of leadership

[1] *www.jointcommission.org/assets/1/18/General-Information_1995-3Q-2015.pdf*
[2] *www.jointcommission.org/assets/1/18/SEA_55.pdf*

HOME HEALTH QUALITY IMPROVEMENT OVERVIEW

The Center for Patient Safety (CPS) is excited to announce a collaborative partnership with the Home Health Quality Improvement (HHQI) National Campaign. The Center has joined as a stakeholder committee member to work together in promoting patient safety and a positive patient safety culture.

In short, the HHQI National Campaign is a movement that fosters a shared vision of improved home health quality across America. This vision is backed by evidence-based tools, timely data reports, and a wealth of ongoing educational opportunities to drive action and improve outcomes. Working together, the Center and HHQI will continue to make a real difference in patients' health care and ultimately, their quality of life.

WHAT IS HHQI?

Since 2007, HHQI has been dedicated to improving the quality of care provided to America's home health patients. It assists home health practitioners who directly provide patient care, and works closely with allied partners who have a stake in improving the quality of care received by home health patients. All resources are absolutely free and readily available to anyone who registers with the campaign. Resources include:

EDUCATION:

Tested format of using evidence-based, multimedia Best Practice Intervention Packages, which provides free education, tools, and resources focusing on home health, but are applicable across settings. Many health-literate patient tools are available in multiple languages; and most of the online courses available through HHQI University are incentivized with free nursing Continuing Education credits.

DATA:

Proprietary HHQI Data Access system ties providers' actions to outcomes in a free, secure, and easy-to-use online portal. HHQI provides free, individualized, downloadable HHQI Data Access reports that show performance and trends related to acute care hospitalization, oral medication management, immunizations, and other measures.

NETWORKING:

Strong partnerships with key local and national stakeholders, who regularly tap into these longstanding relationships to engage the right people at the right time, and coordinate messaging related to home health quality improvement. Relationships are maintained through traditional grassroots means, coupled with a wide array of innovative social networking platforms, including Facebook, Twitter, YouTube, Pinterest, and more.
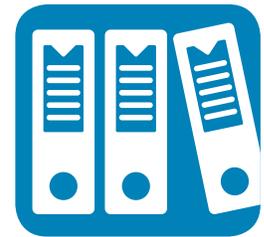
ASSISTANCE:

A large pool of subject matter expertise and mechanisms are available to efficiently provide technical assistance to home health providers, both virtually and face-to-face. Effective customer service has been, and will continue to be, the cornerstone of HHQI's approach to helping home health providers improve care quality and preserve resources. The key focus is on underserved populations; and small, non-profit home health agencies; and those that serve a high proportion of health disparate patients.

FOR MORE INFORMATION, please contact Tina Hilmas at thilmas@centerforpatientsafety.org or visit www.homehealthquality.org.

WHAT ABOUT A SWARM?

BY STACI WALTERS, RN, MSN, CNL
University of Missouri Health Care

Root Cause Analyses (RCAs) are important underpinnings of patient safety. An RCA is essential to explore the reasons why a care delivery process failed. It also provides insights into necessary change processes that will help to ensure that safe patient care is delivered to future patients. The course of a traditional RCA can extend over several days to weeks to maybe even months. Thorough investigations of the medical record and intensive interviews with numerous, key staff members is time consuming and often repetitive. The schedules of different team players are difficult to coordinate and can extend the date of the review even farther. Recall can be diminished and key event facts that lead to the adverse event are forgotten. Even though University of Missouri Health Care's average event to RCA timeline averages 22 days, in the spirit of performance improvement, it searched for opportunities to increase effectiveness of the overall process.

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[1]Li, J., Boulanger, B., Norton, J., Yates, A., Swartz, C., Smith, A.,...Williams, M. (2015). "SWARMing" to improve patient care: A novel approach to root cause analysis. *Joint Commission Journal on Quality and Patient Safety, 41* (11) 494-495.

RCA ALTERNATIVE: QUICK –FIRE SWARM

Perhaps an alternative to the traditional RCA is an expedited RCA, otherwise known as a "SWARM". The initial concept was shared by patient safety staff from the University of Kentucky (Li et al., 2015). [1] This RCA model has two main principles that were selected to incorporate into the University Hospital's RCA processes: 1- decrease the amount of time from adverse event to case review, and 2- bring the bedside staff and stakeholders to the review as soon as possible while memories are fresh.

WHAT'S ALL THE BUZZ ABOUT?

To learn more about University of Missouri Health Care's SWARM strategy, and see a poster explaining the SWARM concept, visit www.centerforpatientsafety.org/wp-content/uploads/2015/12/SWARMposter3.9.pdf, or contact Staci Waters at walterss@health.missouri.edu.

The SWARM process has been used in a variety of adverse events. UMHC found that there are benefits to this 'quick-fire' approach to an RCA; but in turn, there are events best left to the traditional RCA approach. Recommendations for SWARMing on an adverse event include responding to a single department issue and having a seasoned facilitator to ensure multi-disci-plinary participation. Frequently a SWARM is conducted when a serious pressure ulcer is identified so front-line personnel can be engaged, making a true difference to that patient's care.. It is helpful to have a list of "always invited" departments, such as IT and Therapies, so that additional care insights can be incorporated into the identified action plan. One area of caution is that sometimes a SWARM is scheduled before all involved staff members can be evaluated for exhibiting potential signs and symptoms of second victimization. As always, observe for Second Victims, since there will not be time to interview and identify prior to the SWARM. Taking the RCA in a prompt manner to the bedside staff allows the team to develop ownership of the problem and gain valuable insights into the many challenges of providing safe patient care. Allowing these staff members to think "outside the box" in problem solving acute patient care issues creates new and innovative ideas for improving patient safety for future patients.

So, take a chance and consider utilizing the SWARM process for an adverse event at your facility!

STACI WALTERS is the Performance Improvement Professional, Patient Safety at University of Missouri Health Care. You can reach her at walterss@health.missouri.edu.

ONLINE: Go to the Center for Patient Safety website to see more content from this story.
http://www.centerforpatientsafety.org/for-pso-participants/

SAFETY CONFERENCE BRINGS EMS LEADERS TOGETHER

Patient safety was the key message at the annual EMS Patient Safety Conference held in St. Louis on October 30. The conference is one of a kind event that gathers EMS leaders, providers and medical directors to learn, listen and participate in safety-centered activities. This year's conference was no exception as national experts spoke about some of the most pressing issues facing EMS today.

The conference started with an EMS medical directors' breakfast that focused on developing "Safety Huddles" or meetings that allow for sharing and learning while maintaining the privileges provided with PSO participation. Dr. Alexander Garza kicked off the conference with a presentation called "Transforming Quality in EMS". His presentation focused on the current state of data in EMS as well as how it will drive future medical care and policy. Allison J. Bloom, Esq. followed with PSO Hot Topics that are influencing the EMS, one of which is the importance of participating with a PSO to protect data as well as shared learning. Fatigue is a major concern in EMS and Dr. Daniel Patterson presented compelling information about fatigue and how it affects EMS providers. Dr. Peter Antevy closed the conference with information about pediatric complexities and EMS. Specifically, he discussed obstacles that EMS providers face when encountering this patient population and strategies to take implement to prevent pediatric care mistakes.

Mark Alexander, Cox Health, presented information about Just Culture. This important session offered an overview of improving safety and minimizing risk with shared accountability. The Center also offered Safe Tables to PSO participants, which allowed for detailed discussion and analysis of de-identified adverse events for shared learning as well as identification of best practices.

The Center's staff offered various updates and current safety watches as well as data around adverse events, near misses and unsafe conditions in the industry. In addition, Lee Varner shared several key accomplishments including a collaborative effort with Washington University School of Medicine and the National Registry of EMTs with the development of a survey tool to measure safety culture. Also mentioned was the T-10 report that will be released in early 2016 and will feature the top ten areas of safety concern in EMS, including resources and education to draw awareness.

THE CENTER FOR PATIENT SAFETY is a private not for profit organization that works across the continuum of care to improve quality as well as greater patient and provider safety. To learn more contact Lee Varner at lvarner@centerforpatientsafety.org.

ED DEPARTURE

The Center for Patient Safety (CPS) has seen tremendous growth under the leadership of Executive Director, Becky Miller, over the last ten years. Under direction and support from the Missouri Hospital Association, Primaris, and the Missouri State Medical Association, CPS was founded in 2005 to act as a central hub for stakeholders to collaborate and improve the safety of care.

As the first Executive Director, Becky focused on growing the CPS Team by onboarding top patient safety experts and working with leading national organizations. In 2008, Becky registered CPS as one of the first federally listed Patient Safety Organizations (PSOs). This allowed CPS to move forward with critically important efforts to bring healthcare providers together to assess and improve the culture for safety and use data, information and evidence-based practices to improve the safety of care and reduce harm.

Under Becky's guidance, CPS built a curriculum around patient safety in hospitals that is now applicable across the continuum of care - and and there's no slowing down!

CPS is now recognized as one of the most trusted resources in patient safety and one of the most active PSOs in the country, working with hospitals, EMS, LTC, home care, pharmacies, and medical offices across the country.

Becky has left the Center to pursue a career closer to the delivery of quality and safe care but her vision continues as we push towards a healthcare environment safe for all patients and all healthcare providers in all processes, all the time.

"It has been a pleasure establishing and growing the Center over its first decade and I expect it will continue to grow and flourish under new leadership into the future."

BECKY MILLER
CPS Executive Director, 2005-2015

ALEX CHRISTGEN is the interim executive director for the Center for Patient Safety. You can reach her at achristgen@centerforpatientsafety.org.

ON THE TRAIL | WHERE CPS SPEAKERS ARE HEADED LATELY

January 9 - Kathy Wire providing a PSO Update at St. Louis Area Health Lawyers' Association
January 11-17 - Lee Varner attending NAEMSP Annual Meeting in San Diego
January 26 - Eunice Halverson providing a PSO overview at AHFSA January Membership Meeting in New Orleans

CALENDAR OF UPCOMING EVENTS

December 24 & 25 - Office closed in observance of Holiday
January 1 - Office closed in observance of New Year
January 13 - LTC Advisory Committee Meeting
February 11 - CPS Advisory Committee Meeting
March 13-19 - Patient Safety Awareness Week
April 6 - PSO Day
April 7 - 2016 CPS Annual Patient Safety Conference

SAVE THE DATE
April 7, 2016

CPS 10TH ANNUAL
PATIENT SAFETY CONFERENCE
KEYNOTE SPEAKER:
DAVID MARX, OUTCOME ENGENUITY

WWW.CENTERFORPATIENTSAFETY.ORG/2016CONFERENCE

ILLINOIS COURT RULES THAT A CONTRACT IS NOT ENOUGH

The Center for Patient Safety again thanks attorney Michael Callahan for sharing current events relative to the Patient Safety and Quality Improvement Act and PSO involvement. The latest case is Johnson v. Cook County, N.D. IL, Eastern Division, No. 15 C 741, 2015 WL 5144365.

The first thing to note is that the federal court refused to apply the state peer review protection statute, a common occurrence. One of the reasons the PSQIA is celebrated is that without it, litigants in federal court often have no strong protection. Another interesting aspect of the case arises from the venue of care: the county jail. Because the plaintiff alleged systemic failures in the correctional system, the court distinguished the case from an ordinary state malpractice action and evaluated it as a federal civil rights issue.

This is the first case that looks deeply at functional reporting, the provision in the Final Rule that can protect information that has not been submitted to the PSO. The Court held that the defendant (Cook County) did not meet its burden of establishing that the information at issue was protected Patient Safety Work Product. The contract between the defendant and its original PSO defined all peer review work as "functionally reported" in the sense that it gave the PSO access to the information. However, the defendant could not (or at least did not) produce any other information suggesting that it had reported anything to the PSO.

The court's language is worth noting:

Defendant essentially is asking the Court to presume, with no supporting documentation, that it (1) maintained a patient safety evaluation system, (2) made the Report part of its patient safety evaluation system, and (3) provided [the PSO] access to its patient safety evaluation system. In other words, Defendant is asking the Court to presume Defendant complied with the PSQIA's reporting obligations by virtue of presenting the Court with a copy of a contract. That is not enough.

Defendant has not shown in any way that the report was generated with a PSO or patient safety evaluation system in mind. Nowhere does the policy mention the report will be provided to a PSO or a patient safety evaluation system, that the review and report are completed for the purpose of providing information to a PSO or patient safety evaluation system, or even that a PSO will have access to the report.

These issues will sound familiar to CPS participants, who are probably tired of CPS staff haranguing them to complete their policies and submit reports. But this case now joins others that require evidence of a valid PSES. These take-aways, adapted from Michael Callahan' suggestions, should also be shared with any attorney defending a PSO participant:

- Courts will not rely on a party's mere assertion that they have established a PSES and are participating in a PSO.
- Detailed affidavits are critical in establishing compliance. Also consider submitting the template reporting forms or screen shots of the forms utilized for PSO reporting.
- Attach the PSO agreement. It should make reference to the compliance obligations of both the provider and the PSO, and it should address the issue of functional reporting.
- Be prepared to provide the provider's PSES policy, and perhaps that of the PSO, which hopefully identifies the documents or category of documents the parties are seeking to protect.
- Consider including an affidavit prepared by the PSO demonstrating compliance with the Act.

An affidavit and/or a memorandum of law needs to explain the concept of functional reporting to the court and demonstrate that the documents in question were, in fact, functionally reported. (Documenting when this occurs is a requirement under the Act.) Although information collected within a PSES remains privileged and confidential as soon as it is collected and before it is reported, one way or the other, most courts do not understand this concept.

PSOs and providers need to work together when faced with these discovery challenges.

WANT TO KNOW MORE?
More information about the case of Johnson v. Cook County is available online at available at: https://casetext.com/case/johnson-v-cook-cnty-3.

THE CENTER FOR PATIENT SAFETY will continue to issue immediate legal updates about important decisions. If PSO participants or their attorneys have any questions, please contact Kathy Wire at kwire@centerforpatientsafety.org.

"**Nowhere does the policy mention the report will be provided to a PSO or a patient safety evaluation system, that the review and report are completed for the purpose of providing information to a PSO or patient safety evaluation system, or even that a PSO will have access to the report.**"

— From the United States District Court For The Northern District Of Illinois Eastern Division ruling on Johnson v. Cook county.

MAKE IT EASIER: ELECTRONIC DATA SUBMISSION TO THE PSO

Joe at The Hospital loves working with the Center for Patient Safety's (CPS) PSO. He knows there is value in submitting his information for aggregate analysis with other participating hospitals. He is very good about keeping his risk reporting system up-to-date and spends time daily reviewing and updating the information. Each time he goes in and updates information in his risk-reporting system, he also logs in to Verge Solutions to update the PSO information there, too. While Joe's ambition is commendable, it's also not realistic.

Kim at Another Hospital also knows there is value working with the CPS PSO, but she's just too busy to focus on what the Center would like reported. Her resources are stretched and, besides, she submitted something at the beginning of the year. She gets the safety alerts from the PSO, although she doesn't have time to look at them either. While Kim's thoughts are an extreme example, we've all had similar moments when we lost sight of our patient safety priorities. The CPS knows you're busy, your staff is busy, your days aren't long enough, and demands come from every department in the hospital. Yesterday you were lucky to get to spend time with your own family, but you made time to give peace of mind to a family that lost a loved one. Your priorities are admirable.

A BETTER WAY

As an option to meet the needs of the PSO and to better assist your patient safety efforts, organizations can take advantage of electronic submission. Organizations that are contracted with the Center's PSO remain dedicated to submitting information that promotes learning and leads to improved patient safety. Just this year, more than 20,000 events have been collected by the Center, and the majority of events were submitted electronically.

The electronic submission of event information bypasses the need for an individual to manually enter information into the CPS online PSO portal, saving both time and money and allowing you to focus your attention where it is most needed. The electronic submission process allows an organization to extract data from its risk reporting system and send batches of events to the CPS PSO. Since most risk reporting systems don't talk the same language as PSOs, a "translator" is necessary to recode the information. CPS works with and recommends NextPlane Solutions to map your risk-reporting files to the PSO required formats. NextPlane will work closely with you and maintain confidentiality and accuracy of your data.

HOW IT WORKS

Joe at The Hospital runs an Excel file from his risk reporting system. He logs into NextPlane Solutions and uploads the data file. NextPlane Solutions prompts Joe to answer a few simple questions about his data to make sure the translation is accurate. Since Joe authorized the CPS to use his data, it is moved from NextPlane to the PSO. Joe's data is now available for the PSO to review and perform aggregate analysis with the other data in the database. Joe used to spend hours every week manually updating the events in the PSO database. Now he spends a few minutes once a month and he's done. Joe can begin to implement some of the best practices he learned from the last PSO Safe Table.

Kim at Another Hospital realizes she must become proactive in order to improve patient safety. She needs to learn why mistakes are happening. She now submits electronically and has been made aware that rare events occurring at her hospital are also occurring at other hospitals. She's now working with a group of peers in the PSO to develop a process to mitigate the issue. With electronic reporting taking only a few minutes every month, she's seeing improved patient safety and fewer events. She also left work early today to go to her son's baseball game.

INTERESTED IN LEARNING MORE ABOUT ELECTRONIC SUBMISSION? Contact Eunice Halverson at ehalverson@centerforpatientsafety.org

PSO REPORTING AND TRENDS

Events continue to roll into the CPS PSO Database. More than 42,000 events have been reported the CPS PSO since 2009 and more than 10,000 have been submitted in 2015. Reporting is expected to increase due to reporting efficiencies via various submission options (see page 15: "Make it Easier: Electronic Data Submission to the PSO"), and an increasing awareness of the benefits of participation. CPS currently provides PSO services for hundreds of hospitals, EMS, LTC, home care, and medical offices in thirty-five states.

EVENTS BY HARM LEVEL IN 2015

■ 0.4% ■ 1% ■ 3%

5%

16%

75%

- ■ Death
- ■ Severe harm
- ■ Moderate harm
- ■ Mild harm
- ■ No harm
- ■ Unknown
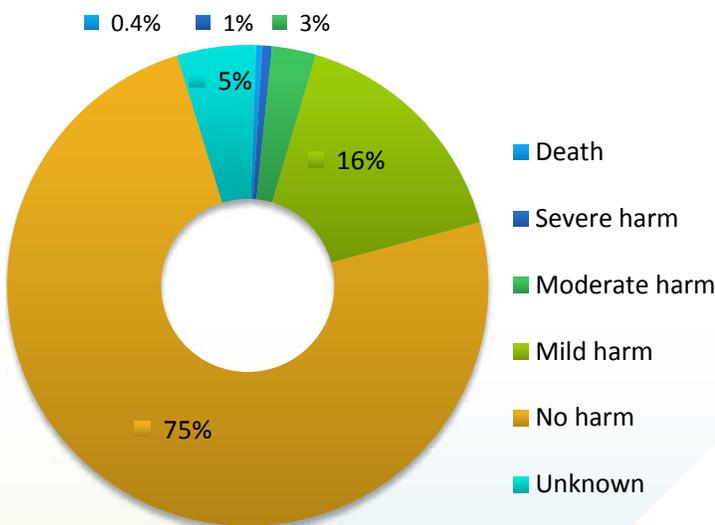
HOSPITAL EVENTS WITHOUT HARM

■ From January to November 2015, more than 600 near misses and unsafe conditions were reported to the CPS PSO. Approximately half of these events were related to medications or other substances.
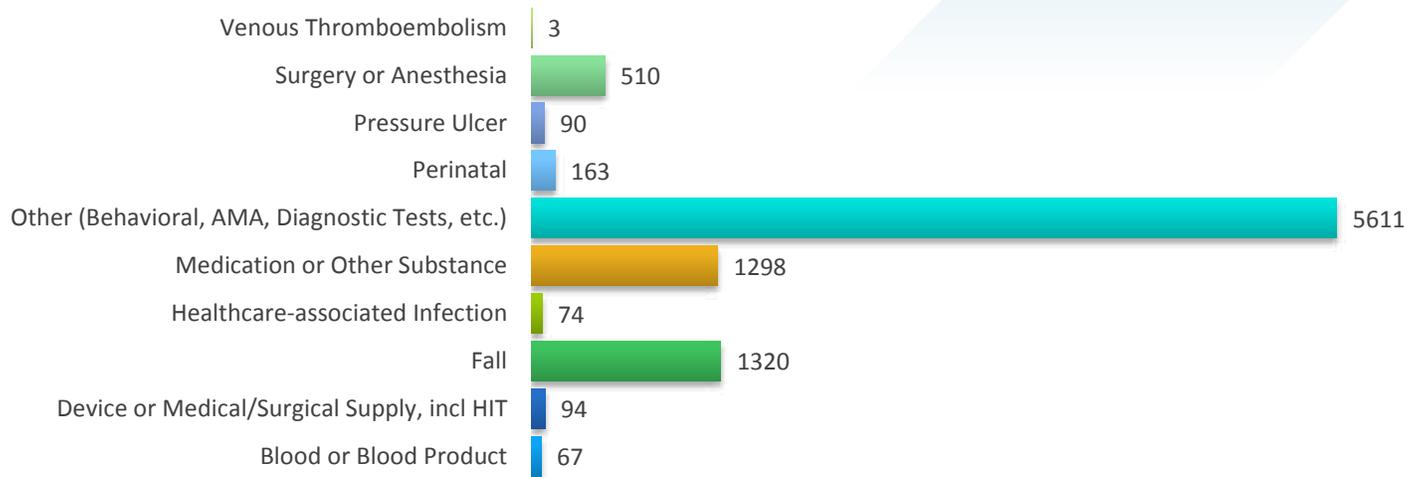
HOSPITAL EVENTS WITH HARM

■ From January to November 2015, nearly 2,000 healthcare events were reported to the PSO which resulted in harm to a patient.

■ Thirty-nine patients died, most often from a medication- or surgical-related event, or as the result of an injury sustained from a fall.

■ Fifty-eight patients experienced severe harm, most often from a medication-related event, or as the result of an injury sustained from a fall.

■ More than 1,700 patients experienced mild-to-moderate harm, most often from a medication- or surgical-related event, or as the result of an injury sustained from a fall.

EVENTS BY CATEGORY IN 2015

Category	Value
Venous Thromboembolism	3
Surgery or Anesthesia	510
Pressure Ulcer	90
Perinatal	163
Other (Behavioral, AMA, Diagnostic Tests, etc.)	5611
Medication or Other Substance	1298
Healthcare-associated Infection	74
Fall	1320
Device or Medical/Surgical Supply, incl HIT	94
Blood or Blood Product	67

A significant number of events are reported in the "Other" category and include events such as behavioral-based, left AMA, and diagnostic tests (Labs, Radiology, EKG, etc). The second most often reported event is falls, followed closely by medication- or other substance-related events.

CPS PSO Participants will receive their organizational Dashboard in late December with more information on the full database as well as trends specific to their organization.

Center for Patient Safety

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Find us. Follow us. Like us.

Visit www.centerforpatientsafety.org for additional information on the Center's PSO activities, resources, toolkits, upcoming events, safety culture resources, and more.

If you have questions about any Center resources or articles within this newsletter, please contact the Center for Patient Safety at: info@centerforpatientsafety.org or call 888.935.8272

NOTE: Some articles contained within this newsletter may reference materials available to Center for Patient Safety PSO participants only.

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Center for
Patient Safety
Delivering PSO Solutions

The Center for Patient Safety,
established in 2005, is an
independent, not-for-profit
organization dedicated to
promoting safe and quality
healthcare through the
reduction of medical errors.