Center for Patient Safety
Delivering PSO Solutions

WINTER 2014 EDITION

PSO*NEWS*

From the Center for Patient Safety

IN THIS EDITION

AHRQ Report Finds 1.3 Million Fewer Patient Harms

A recent AHRQ report finds that patient safety improvement efforts have led to 1.3 million fewer instances of patient harm, and that the reduction in hospital-acquired conditions resulted in a $12 billion savings in health care costs between 2010 and 2013.

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

PSO *ALERT*

Morphine vs. Midazolam

Reports of medication errors to the PSO are not uncommon; however, when a trend is noticed we want to notify you. Recently, there have been errors pertaining to the administration of the incorrect medication involving Morphine and Midazolam. Specifically, there is confusion between the names of two medications that leads to administering the wrong medication.

Possible reasons for the error:

- Similar names
- Similar packaging or containers
- Similar route of delivery
- Medications were stocked together
- No cross check process in place or "time out" taken before administration

Please review your medication administration policy and discuss with your medical director.

Links with helpful information:

- Patient Safety Authority
- FDA.gov - Drug Safety
- Journal of Emergency Medical Services - Preventing Drug Events
- Preventing Medication Errors in EMS
- EMS Insider - Tracking Medication Errors
- EMS1 - Criminalizing Medical Errors
- Medication Administration Cross Check with No Error

SAFETY*WATCH*:
Be Prepared for Emergent Situations

Recent reports submitted to the Center for Patient Safety PSO database show a new area for concern. A number of events of harm and even death have been reported; the common denominator is staff who are not being sufficiently prepared for emergent situations.

Reported events include:

- Unnoticed changes in patient's condition resulting in emergent attention
- Unfamiliarity with the use of an alternative paper patient chart during electronic health record downtime
- Lack of knowledge about how to use equipment
- Medical equipment unavailable or not working properly

Don't be the next organization to suffer an adverse event because staff is not prepared.

1. Changes in patient's condition

- Implement a rapid response medical team (RRMT) if not already in place
- Consistently analyze data from RRMT calls, including obtaining staff input regarding culture of acceptance of those calling the RRMT
- Include a scenario of a patient's changing medical condition in training and simulation
- Use technology to assist providers in recognizing patient deterioration
- Implement an Early Warning Symptoms process

2. Alternative paper chart during electronic health record downtime

- Re-evaluate your organization's emergency paper form process with input from staff
- Reduce and simplify downtime paper forms
- Consider use of checklists to assist providers
- Include use of paper forms during orientation and annual skills training
- Consider simulation practice
- Review and implement recommendations in SAFER Guide

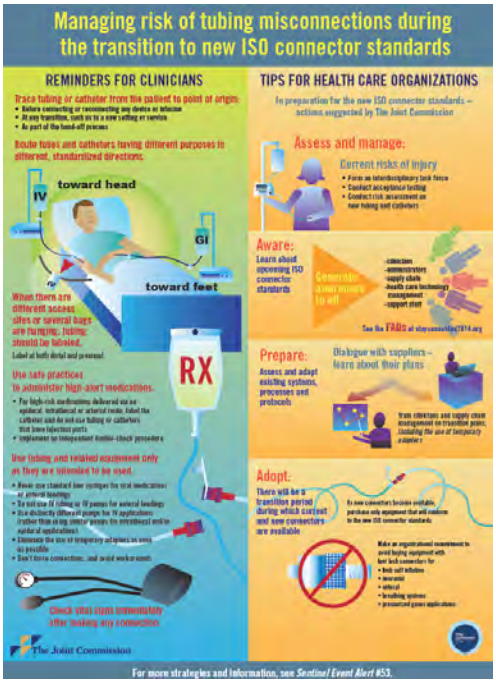
3. Lack of knowledge on how to use medical equipment

- Include providers in medical equipment purchase decisions; consider equipment fairs to gather as much information from users as possible
- Be transparent with staff and ask for their input regarding equipment issues
- Identify types of medical equipment used in each patient unit and include in orientation and ongoing training
- Ensure adequate training with teach-back for any new equipment
- AHRQ provides additional guidance

4. Medical equipment not available or not properly working

- Implement a process improvement team to study the current state of equipment including availability and whether it's working
- Take an inventory of current medical equipment and identify what equipment is needed in each location; monitor on regular basis
- Ensure an ongoing process for maintaining, inspecting and testing equipment
- Rank equipment for preventive maintenance; considering function, failure risk and corrective history
- Predict life of batteries and proactively replace
- Remind staff to report events of medical equipment not being available or not working properly to proactively identify trends
- Learn from a Lean Team at Barnes Jewish Hospital

Joint Commission Alert: Tubing Misconnection Risks



In August of 2014, The Joint Commission issued *Sentinel Event Alert #53*, regarding medical tubing misconnection risks that can result in serious harm or death to a patient: "Managing Risk During Transition to New ISO Tubing Connector Standards."

According to the alert, since most patients admitted to a hospital receive an IV, the risk for tubing misconnections is high. However, the risk is not limited to hospitals. The risk is seen occurring in long-term care and in patients' homes.

One example of an action that led to the Sentinel Event Alert was the misconnection of a feeding tube to a tracheostomy tube. Another example included an intravenous tube misconnected to an epidural site. These types of events have inititiated the development of International Organization for Standardization (ISO) tubing connector stardards for manufacturers.

The complete list and text of past issues of Sentinel Event Alerts can be found on The Joint Commission website. *See also:* New ISO Tubing Connector Standards: A Follow-up to the *Sentintel Event Alert #53*.

Health IT Safety Webinar Series

The Office of National Coordinator IT Safety Team has announced the first of ten free webinars on health information technology (IT) and patient safety. The webinars will cover a wide range of topics, research, and programs, all related to the objectives of using health IT to make care safer and of continuously improving the safety and safe use of health IT.

DATE: **Thursday, December 18, 2014**

TIME: **NOON-1:30 PM Central**

TITLE: **The Role for the EHR in Patient Safety: What does the Evidence Tell Us?**

COST: **There is no cost to attend the webinars in this series**

REGISTER

MORE INFORMATION

LOOKING FOR A GREAT GIFT IDEA THAT KEEPS ON GIVING?

Your tax-deductable donation to the Center for Patient Safety supports onging patient safety education and resources to thousands of healthcare providers across the country. Make a donation and support safer care today!

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

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

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

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

INSULIN PENS: Are your patients safe?

A success story from CoxHealth, Springfield, Missouri

Insulin pens were designed for convenience to permit a single person to administer multiple self-injections, using a new needle each time. Many hospitals began using the pens because of their convenience and accuracy. However, reports from several hospitals indicated that the pens were being reused, placing thousands of patients at risk. An alert from the Center for Disease Control in 2009 warned that the pens should be used on a single patient only and are not to be shared between patients. Despite this alert, inappropriate use in hospitals continues, indicating that some healthcare personnel do not adhere to safe practices and may be unaware of the risks to patients.

After reading recommendations from the Institute for Safe Medication Practices in 2013 to consider transitioning away from pens back to vials, CoxHealth initiated a multi-disciplinary team to investigate how the pens were being used at their hospital. The team completed an analysis audit to better understand the risk of vials versus pens, and found that the risk of transitioning back to vials due to dosing errors outweighed the risk for inadvertent sharing of pens. During the initial pen audit, it was identified that only 69% of patients who used insulin pens had all identified safety measures in place. The initial audits indicated that nurses consistently knew to use one pen per patient, but they found unlabeled pens in patients medication drawers and the practice of "borrowing" unused pens from another patient's medication drawer for efficiency.

Two process improvement opportunities were identified and tracked:

- Pens with no label or patient identification
- Multiple pens in a patient's medication drawer which made it easy to "borrow" an unused pen for another patient

A Failure Modes and Effects Analysis identified causes of the failures, which were further understood using a flowchart.

"We found that everybody wants to do the right thing for their patients, but some nurses didn't realize that an unlabeled insulin pen is a dangerous risk."

Susan Houk, RN-BC, BSN
Patient Safety Facilitator, CoxHealth

IMPROVEMENTS

Based on the team's audit findings and research, CoxHealth implemented the following improvements:

1. Pharmacy changed the way pens are labeled so a label could not be peeled off for unused pen use on another patient, and to prevent the label from covering the barcode on the pen.

2. Pharmacy no longer sends a new pen when there is an insulin dose change. Instead, the labels default to "zero"; if a new pen is needed, it is requested by Nursing.
3. All Novolog orders are treated as STAT orders so the insulin is readily available, decreasing the need for nurses to "borrow" from other patients' medication drawers.
4. Decentralized pharmacy technicians audit and monitor the insulin pen process, acting as a resource for nursing staff and assuring STAT insulin orders are quickly processed.
5. All nursing and pharmacy staff were educated on the improved process, and training was added to the annual credentialing requirements. An on-line module as well as hands-on training were developed in conjunction with a Novolog representative.
6. Patient Safety prepared an Insulin Pen Poster as a constant reminder for staff.
7. Insulin pen audits are performed monthly, with plans to move to a quarterly audit when acceptable results are achieved.

The results of the analysis show improved compliance with all pens having a patient label from 77% in February 2013 to 100% in November of 2014. Overall compliance for all safety requirements is at 92%, with the outlier being multiple pens in the patient medication drawers. The goal is to remove the temptation to use an 'extra' unused pen in order to administer mealtime insulin on time without having to wait for pharmacy to distribute the pen.

Kudos to CoxHealth for ensuring insulin administration safety for their patients.

For more information contact Susan Houk at 417-269-5431 or Susan.Houk@CoxHealth.com.

EMS Corner

The Center is Breaking New Ground

SAFE TABLES

The Center's EMS Patient Safety Conference evaluations and comments indicate it was a success! This was a year of great speakers, all of whom brought new ideas and concepts that help stretch the imagination of attendees.

Speakers encouraged the audience to use science instead of trial and error to implement change within their organizations.

New to the EMS Conference this year were PSO Safe Tables, sessions which offer a safe and confidential environment for PSO participants to take a deep dive into adverse events. Cases involving stretcher issues, wrong medication orders and missing equipment were analyzed using a Learning From Defects tool. Participants identified tips to implement so similar events might be prevented in the future. Each group reported on what happened, why it happened, and how preventative processes might be adopted.

One participant commented, "This is a great way to learn; in fact I'm making changes at our organization when I get back to prevent this from happening in our community."

PARAMEDICS PLUS

The Center is pleased to announce a patient safety partnership with National Provider of EMS Services, Paramedics Plus. Read the full press release.

AHRQ Issues 2014 Report on Nursing Home Safety Culture

Healthcare leaders who have worked to improve safety in their organizations know that the culture can ease the process or make it much harder. Because the culture exists throughout the entity, it can be hard to evaluate. So AHRQ developed its Survey of Safety Culture with specialized versions for hospitals and nursing homes.

AHRQ has collected data from thousands of nursing home safety culture surveys, representing 263 communities. In October, the agency released a comprehensive report of all that data. It contains a number of interesting patterns based on the size, ownership (for profit or not-for-profit—the homes in the database are split about 50-50) and location (urban or rural) of respondents, and is available to anyone. It also includes helpful material on how to analyze the results of your own survey and tools to use in developing action plans to improve safety culture.

Some key takeaways:

- Respondents consistently rated their homes high for providing safe care to residents and their willingness to tell someone if they see something that would harm a resident.
- The scores reflect a strong sense that there is good communication and feedback about incidents and how to respond to keep residents safe.
- On the other hand, many respondents felt their homes have a punitive response to errors, punishing the person rather than looking at the event.
- The highest scores came from the Midwest, but these scores still have room for improvement.

Scores from those who identified themselves as management tended to be much higher than scores from CNA's and other front-line workers, indicating that managers see the culture as more supportive of safety than the staff does. This difference might suggest a need for leadership to explore the views of the staff through discussions or interviews to see why the perceptions differ.

Here are some management/staff score differences:

- "Management Support for Resident Safety"-- 24% difference
- "Supervisor Expectations and Actions Support Resident Safety" –16% difference
- "Teamwork"—19% difference
- "Communication Openness" – 31% difference

CPS offers the survey for nursing homes at no cost for Missouri licensed providers through a grant from the Missouri Foundation for Health. Learn more!

Anyone interested in administering the safety culture survey through the Center for Patient Safety can get more information here or contact Alex Christgen or Kathy Wire at the Center. The Center for Patient Safety also provides assistance in interpreting the survey data and developing responses.

WIPE OUT CAUTI

A success story from Golden Valley Memorial Hospital, Clinton, Missouri

Indwelling urinary catheters lead to both infectious and non-infectious complications. Despite these potential harms, various studies have reported that initial catheterization was inappropriate 21% to 50% of the time and that continued catheter use was inappropriate almost half of the days that patients are catheterized.

TAKE ACTION

Four years ago Golden Valley Memorial Hospital (GVMH) took on elimination of catheter-associated urinary tract infections (CAUTI) as their rate was as high as 4.9/1000 catheter days with a catheter prevalence rate that averaged between 25-30% organization-wide and up to 39% in the ICU. While their initial CAUTI improvement team made some progress, they were unable to achieve their goal of zero infections. Determined to be successful as a member of the HRET-Hospital Engagement Network (HEN), GVMH realigned their team and joined the CUSP initiative to eliminate CAUTI's lead by the Center for Patient Safety.

WHAT WAS DIFFERENT?

Front-line staff joined the improvement team; strict protocol aligned with APIC's Guide to Preventing Catheter-Associated Urinary Tract Infections and the CDC's Indications for Urinary Catheters was implemented; insertion competencies were verified for all staff who insert catheters; in-depth CAUTI Prevention education and training was provided to all patient care staff; a CAUTI Prevention Bundle was developed and implemented; departmental and organization results became transparent; along with a little fun.

FIND THE SOURCE

Through participating in the HRET-HEN CUSP initiative to eliminate CAUTI project, it was learned that there is a prevailing culture to insert catheters in Emergency Departments across the nation. Data collected by the GVMH team showed that most Foley catheters present in its medical and ICU patients had been placed in the Emergency Department prior to admission. While auditing medical records of patients being admitted from the ED, it was also learned that often the receiving physician did not know the catheter had been placed in the ED and inpatient unit nurses did not communicate the presence of the catheter to them either. This lack of communication contributed to increased length of catheterization which, in turn, increased the risk of patients developing a CAUTI. The team went to work immediately to engage the ED and added emergency room staff to the improvement team. The ED's commitment to changing their culture related to excessive catheter usage became a catalyst to the success that GVMH has achieved.

When catheter prevalence in the ICU remained high despite the team's efforts, it was learned that the ICU had a standing admission order for a Foley Catheter PRN and chart audits revealed that many catheters were being inserted by nursing without an appropriate indication. This led to the Medical Staff eliminating this PRN order which resulted in a breakthrough reduction in inappropriate catheter usage in the ICU. To ensure that new processes were hardwired, the infection prevention nurse began weekly audits of all patients with a Foley catheter and provided consistent feedback reports to department managers for follow-up with nurses not following the protocol. To sustain the gain, quarterly validation audits continue in all inpatient units at GVMH.

IDENTIFY CHAMPIONS

Any initiative is more successful with senior leader support and champions. At GVMH, the hospital's leaders stepped up to ensure proper use of Foleys. In addition, a certified nurse assistant from the medical floor became a natural champion as she cheerfully and convincingly asked nurses and physicians why Foleys were being used for specific patients and if they could be removed. She was effective! The medical floor decreased catheter utilization from approximately 25% to 8% and has sustained this for over a year.

SUCCESS

GVMH has gone 402 days without a CAUTI. They recommend the following interventions leading to success:

- Engage front-line staff as members of the improvement team as all caregivers must "own" the process. Don't forget to include staff from the ED, OR, and ancillary departments such as PT/OT and imaging in any CAUTI improvement efforts.
- Make sure all caregivers understand and practice the CDC's Indications for Urinary Catheters and APIC's Guide to Preventing Catheter-Associated Urinary Tract Infections.
- All Foley catheter orders require the reason for use, which must meet the medical staff approved CDC criteria.
- Foley insertion requires the presence of two nurses to ensure aseptic insertion.
- Assess and document (at least daily) the continued need for a catheter and the indication.
- Promptly remove catheters that do not have an appropriate indication. A nurse-driven Foley removal protocol is ideal.
- Remove any PRN Foley orders from order sets/admitting orders.
- Measure, measure, measure and display results publicly by nursing unit.
- Be transparent as it increases accountability.
- Root cause analysis required for any CAUTI, using standardized form
- Make it fun and recognize success (see sidebar story).

GVMH is committed to sustaining their goal of zero CAUTIs. For more information, contact GVMH Infection Preventionist, Mary Oyler RN, BSN, moyler@gvmh.org

MEET FRED & FRAN FOLEY

Fred and Fran Foley live at Golden Valley Memorial Hospital, moving from unit to unit as determined by the best CAUTI rate each month. They seem to hang out a lot on the medical floor who has had no CAUTIs for 688 days. The Surgical floor has gone 564 days! Senior leaders formally recognize staff and physicians for their excellent care resulting in no CAUTIs for the last 402 days across the entire hospital! Kudos to Golden Valley Memorial Hospital!

Center for Patient Safety

PATIENT SAFETY AWARENESS WEEK

March 8-14, 2015

Find Patient Safety Awareness Week Resources at
www.centerforpatientsafety.org/2015conference

Downloadable Awareness Week Toolkit

March 8-14, 2015 is Patient Safety Awareness Week! In recognition, the Center for Patient Safety is encouraging the acknowledgement and celebration of efforts to improve safe care across the healthcare spectrum that occur 24 hours a day, 7 days a week, 365 days a year!

The Toolkit contains a checklist of suggestions for activities to gain awareness of safety efforts at your organization, along with templates for banners, posters, tent cards and buttons/stickers that can be used as is, or customized with your organization's logo.

Download the 2015 Patient Safety Awareness Week Toolkit

Poster Sharing

Any healthcare professional or provider organization is invited to submit an Application of successful safety activities and projects for sharing. This includes health systems, academia, pharmacists, nurses, physicians, hospitals, clinics, nursing homes, home health agencies, EMS agencies, ambulatory surgery centers and others with learning of how to improve the safety of care delivery worthy of sharing with others.

To submit your Poster Application, complete the application form. An electronic version of this form and other conference details, including agenda, speakers, and sponsor/vendor opportunities are available at www.centerforpatientsafety.org/2015conference.

Sponsor & Vendor Opportunities at Annual Conference

Show your support for safe care and showcase your organization as a sponsor and/or vendor at the Center's 9th Annual Conference, "Safe Care: Our Focus 24/7/365"! The Center's 2015 Conference is one way that the Center will Celebrate its Founding in 2005, ten years ago; therefore, the 2015 Conference is expected to be even bigger and better that previous years. For recognition in promotional materials, the Safe Care Sponsor form must be submitted by Friday, January 9, 2015. Sponsors and vendors are welcome after January 9, however preconference recognition cannot be guaranteed after this date.

JOIN US!

For the 9th Annual Patient Safety Conference

Held on Friday, March 13th, during Patient Safety Awareness Week

Find Patient Safety Awareness Week Resources at
www.centerforpatientsafety.org/2015conference

MARCH 13, 2015
CROWNE PLAZA • ST. LOUIS AIRPORT
11228 LONE EAGLE DRIVE • BRIDGETON, MO 63044

2015
Center for Patient Safety
9th Annual Conference
Safe Care: Our Focus 24/7/365

Keynote Speakers

"Diagnostic Error - It's Here"
Mark L. Graber, MD, FACP

Dr. Graber is a Senior Fellow at RTI International and Professor Emeritus of Medicine at the State University of New York at Stony Brook.

Dr Graber is a national leader in the field of patient safety and originated Patient Safety Awareness Week in 2002, an event now recognized internationally. He is also a pioneer in efforts to address diagnostic errors in medicine. In 2008 he originated the Diagnostic Error in Medicine conference series; in 2011 he founded the Society to Improve Diagnosis in Medicine (www.improvediagnosis.org); and this year he launched a new journal, DIAGNOSIS, devoted to improving the quality and safety of diagnosis, and reducing diagnostic error.

"Reclaiming Passion for a Life's Work in Healthcare; Improving Safety, Satisfaction and the Bottom Line"
Allison Massari

Named One of the Top 10 Best Speakers in North America for "Motivation" – Meetings & Conventions Magazine 2012, 2013, 2014

Mentored in the field of medicine from an early age by her mother, a nurse, and her father, a surgeon, Allison spent nearly 16 years interning and working in hospitals and medical office settings. Then, at age 32, her life was turned upside down by two tragic events, which caused her to spend over 400 days in hospitals, physical therapy centers, and doctors' offices as a patient giving her deep insight into the impactful and delicate nature of patient-centered care and its inpact on safe recovery.

Also Including:

Christine Goeschel, ScD, MPA, MPS, RN - "Keys to Improving Safety of Care in the Next Decade – Bringing the Science to the Real World"

Panel Sessions:

"Diverse Stakeholders in Patient Safety – The Past and Future of Improving Patient Safety"
and;
"Implementation of Safe Practices, Making Lasting Changes & Continuously Improving"

Recommended Audience:

Those who have a vested interest in improving health care safety, including executives, professionals and clinicians, and representatives from government, business, public, insurance and health plans.

Early registration discount

Sponsor & Vendor Opportunities

www.centerforpatientsafety.org/2015conference

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 PARTICIPANTS-ONLY:
PSO Dashboards will be delivered via secure email to PSO Primary Contacts in December. Contact the Center if you have questions.

PSO.DATA.UPDATE

DATA ANALYZED FROM OCTOBER 2013-SEPTEMBER 2014

Information continues to flow steadily into the Center for Patient Safety (CPS) PSO. On a daily basis, the CPS PSO collects information on near misses, unsafe conditions, and incidents that may, or may not, result in harm to a patient. This information is provided by healthcare organizations across the country that partner with CPS for PSO services. CPS analyzes the incoming information and issues Safety Alerts and Safety Watch's for any trending issues or uncommon situations. *(See page 1-3 for recent alerts.)*

Events by Category/Type	Q3-2014			Q4-2013 to Q3-2014		
	Incident	Near Miss	Unsafe Condition	Incident	Near Miss	Unsafe Condition
Blood or Blood Product	0	0	0	80	3	0
Device or Med/Surg Supply/HIT	3	0	0	167	13	0
Fall	114	2	0	868	19	0
Healthcare-Associated Infection	7	0	0	67	0	0
Medication or Other Substance	68	7	0	715	106	22
Other	133	8	7	1825	109	46
Perinatal	1	0	0	60	0	0
Pressure Ulcer	3	0	0	65	0	0
Surgery or Anesthesia	8	0	0	224	10	0
Grand Total	**342**	**17**	**7**	**4080**	**260**	**68**

FALLS

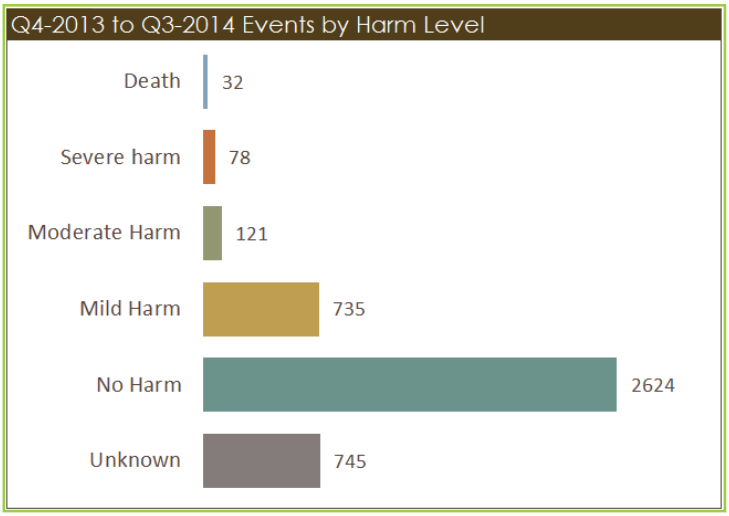
Falls are the most frequently reported incident. About half of reported falls result in harm. In the four quarters of data used for this analysis, falls contributed to nine deaths and 12 events that resulted in severe harm to patients.

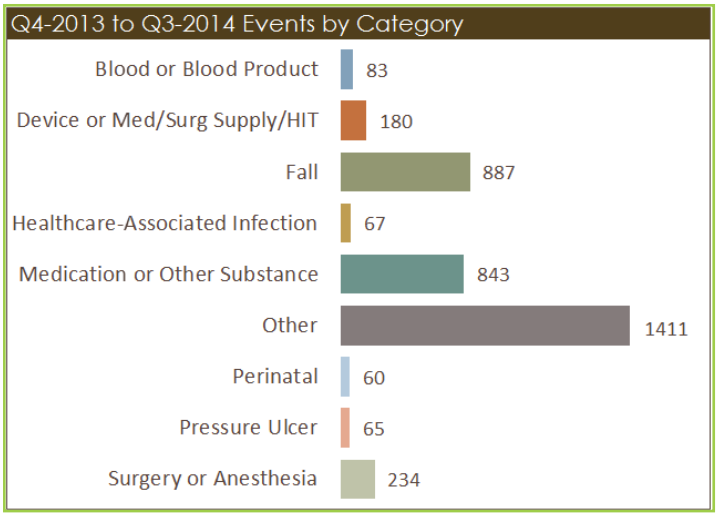
MEDICATION

Medication events, or other substance-related events, account for a significant number of near misses and unsafe conditions. The majority of medication events reported do not result in serious harm levels, but do occur with high frequency.

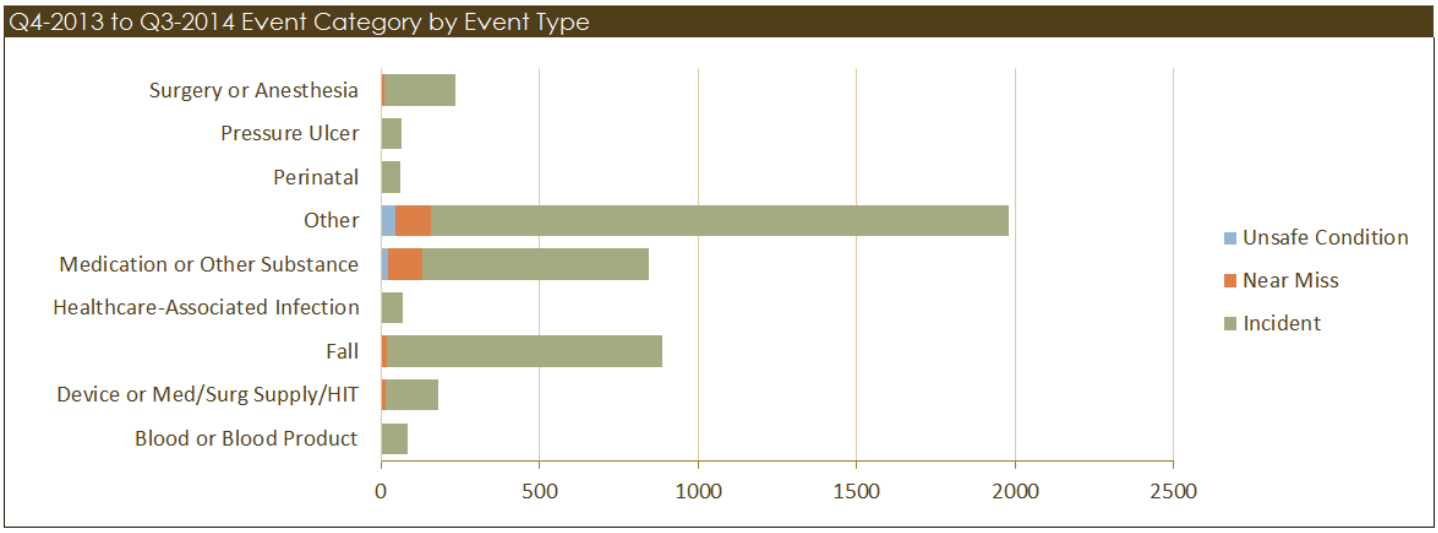
BLOOD

Blood or blood-product events are most often reported as resulting in severe harm to the patient. Eighty-three (83) blood-related events were reported to the PSO in the four quarters for this analysis, 36 resulted in severe harm and three patients died. Events occurred as





PSO.DATA.UPDATE continued on page 11



a result of various issues from lack of documentation, verification and sign off, patient reactions, etc. For example, one patient death was the result of a severe allergic reaction.

OTHER

The "Other" category is the most frequently reported group. This group includes behavioral events, patients that left against medical advice (AMA), diagnostic-related events, and other event types that do not fall into the other main event types.

ABOUT THE DATA

The deidentified data that makes up this report was obtained from the Center's PSO database using the following criteria:

- events were entered into the CPS PSO database between October 1, 2013 and September 30, 2014.

REMINDER

PSO adverse event reporting cannot be used for comparison of individual organization. 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.

A MESSAGE FROM THE EXECUTIVE DIRECTOR:

BECKY MILLER, MHA, CPHQ, FACHE, CPPS
Executive Director
Center for Patient Safety

We are excited about approaching the Center for Patient Safety's 10th year as a part of the solution to address the multitude of issues surrounding patient safety. Safety culture is the KEY! Medical error prevention and reduced patient harm occurs in organizations with a strong safety culture, supporting and encouraging the reporting of adverse events, near misses and unsafe conditions; reporting that leads to learning what and why errors occur and to sharing of solutions.

We hope you will join us as the celebration continues throughout 2015, including our March patient safety conference and available resources during Patient Safety Awareness Week!

Center for Patient Safety
Celebrating 10 YEARS 2005-2015

FOLLOW OUR CELEBRATION!

Have you noticed this icon?

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

Available in the electronic version of this newsletter.

UPCOMING EVENTS..

2015

MARCH 8-14 – Patient Safety Awareness Week

MARCH 13 – Annual CPS Patient Safety Conference at the Crowne Plaza in Saint Louis

OCTOBER 30 – EMS Patient Safety Conference at the Crowne Plaza in Saint Louis

PSO Education & Training (for PSO participants only - register online)

- **PSO 101 – Intro to PSOs: 3rd Wednesday of January, April, July, October**
- **PSO 102 – Policy Completion/Review: 3rd Wednesday of February, August**
- **PSO 103 – How to Enter Events: 2nd Thursday of every month**
- **PSO 104 – How to Run Reports: To be announced**

FOR MORE INFORMATION, CONTACT ANY MEMBER OF OUR PSO TEAM

Executive Director, **BECKY MILLER, MHA CPHQ, FACHE, CPPS,** bmiller@mocps.org
Patient Safety Specialist, **EUNICE HALVERSON, MA,** ehalverson@mocps.org
Project Manager, **KATHRYN WIRE, JD, MBA, CPHRM ,** kwire@mocps.org
Project/Operations Manager and Analyst, **ALEX CHRISTGEN, BS-BA,** achristgen@mocps.org
Project Manager, EMS Services, **LEE VARNER, BS, EMS, EMT-P,** lvarner@mocps.org
Medical Director, **MICHAEL HANDLER, MD, MMM, FACPE**
Researcher/Data Analyst, **AMY VOGELSMEIER, PHD, RN, GCNS-BC**
Office Coordinator, **JENNIFER LUX,** jlux@mocps.org
Administrative Assistant, **DIANA PHELPS,** dphelps@mocps.org

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.

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.