CENTER FOR PATIENT SAFETY NEWS

CPS NEWS

FALL 2016 NEWSLETTER

SPEAKING ON THE MISSION

EUNICE HALVERSON, PATIENT SAFETY SPECIALIST FROM THE CENTER FOR PATIENT SAFETY (CPS), RECENTLY PRESENTED INTRIGUING INFORMATION ON THE IMPORTANCE OF TRANSPARENCY RELATIVE TO IMPROVED PATIENT SAFETY CULTURE AT VERGE HEALTH'S CONFERENCE IN CHARLESTON, SC.

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JOIN OUR MISSION:
BE A PART OF THE FUTURE

BY ALEX CHRISTGEN, BS, CPPS
Executive Director, Center for Patient Safety

They say the only constant thing in life is change, and it's no different at the Center for Patient Safety (CPS). Since the first IOM report was released in 1999, patient safety concerns have been in the spotlight, and the CPS was created to address the issues in that report confronting healthcare. Since we opened our doors in 2005, we have supported thousands of organizations across the country with their patient safety programs; and now, years later, we continue our mission.

I assumed the position of Executive Director of CPS in July of this year, and it has been an incredible journey. What appealed to me most about the opportunity to lead CPS is the ability to energize, engage, and inspire health care providers across the country, and throughout the world, to reduce avoidable patient harm.

Our team has been hard at work this year, developing some of the most innovative concepts ever to reach the front line staff, and I can't wait to share them with you. Our team has so much to offer the healthcare community.

The energy that comes from the clients and providers we work with through CPS daily is absolutely amazing! Each provider is dedicated to promoting patient safety in their organization. They are driven by compassion and a selfless desire to improve care. They are an inspiration to our team and to their communities.

Each person that contacts us has their own barriers, concerns, and issues that keep them up at night. Many of these issues are some of the same things our team dealt with during their many years of experience. Our team knows how you feel, and we know how to help.

This will certainly be an exciting time as CPS continues to grow and improve culture and patient safety across the country.

We strive for excellence in our delivery of services, which is achievable through our revised mission of providing creative culture solutions to improve patient safety. Join our mission today by following us on LinkedIn, Facebook or Twitter, or contact our office to find out how you can engage with CPS today!

I invite you to be an active participant with the Center for Patient Safety in a manner that best fits your abilities:

- **Host a patient safety boot camp in your region**
- **Join us for any of our ongoing educational webinars**
- **Share a success story and best practice in our newsletter**
- **Be a part of our PSO to share and earn protections**
- **Be a sponsor for an organization or program**
- **Ask us about our culture improvement opportunities**

ALEX CHRISTGEN is the Executive Director for the Center for Patient Safety. She has over 20 years of strategic planning, management, process improvement, communication and marketing experience in both non-profit and for-profit organizations. Alex has worked in a large hospital as well as the Department of Health and Senior Services in the Regulatory Division. She is also a strong supporter of the Malcolm Baldrige model, having assisted with two award winning healthcare applications for organizational performance excellence. She is currently pursuing her Masters from Columbia College.

Alex can be reached at: **achristgen@centerforpatientsafety.org**.

THE CENTER FOR PATIENT SAFETY (CPS) is a non-profit organization working with healthcare providers across our nation. CPS provides culture improvement and PSO services to hospitals, health systems, Emergency Medical Services (both land and air), clinics, pharmacies, home health and hospice, in 38 states. CPS conducts patient safety improvement consulting, educating, and supporting. More information is available on the CPS website.
www.centerforpatientsafety.org.

SYMPTOMS OF SEPSIS

S	Shivering, fever, or very cold
E	Extreme pain or general discomfort ("worst ever")
P	Pale or discolored skin
S	Sleepy, difficult to rouse, confused
I	"I feel like I might die"
S	Short of breath

A NEED FOR SPEED

BY LYNNETTE TORRES, RN, BA, CPHQ
MEMORIAL HOSPITAL, CARBONDALE, IL

Sepsis – a dreaded word for patients, families and health care providers alike. Sepsis is an infection caused by microorganisms or germs (usually bacteria) invading the body. It can be limited to a particular body region or be widespread in the bloodstream.

ADDRESSING THE CHALLENGE

In addition to outcomes, the Agency for Healthcare Research and Quality lists sepsis as the most expensive condition treated in U.S. hospitals, costing more than $24 billion in 2013 increasing on average annually by 11.9%. It has been estimated that if the U.S. as a whole achieved earlier sepsis identification and evidenced based treatment, there would be 92,000 fewer deaths annually, 1.25 million fewer hospital days annually, and reductions in hospital expenditures of over $1.5 billion.[2] Research has shown that mortality from sepsis increases 7% every hour that treatment is delayed. As many as 80% of sepsis deaths could be prevented with rapid diagnosis and treatment.[3] Understanding this severity, Memorial Hospital of Carbondale, Illinois, began addressing the sepsis challenge several years before it became a focus for the Centers for Medicare Services (CMS). A multi-disciplinary improvement team began studying sepsis, and realized how much more difficult and unique it is to meet all the requirements than the previously required core measures from CMS.

MAKING IT EASIER

The team began working on revising all order sets that are used for patients who may be septic, including the required measures of the Sepsis Bundle: blood cultures, lactic acid, antibiotics, fluid resuscitation, and vasopressors. A Kaizen project focused on the work flow for septic patients as well as components of the evidenced-based sepsis care bundle. Revised sepsis order sets for patients in triage, the ED and inpatient nursing units now include the required measures. These changes make it easier to ensure the proper care is provided in a timely manner.

All nursing staff, hospitalists and ED physicians were educated on the sepsis requirements and new order sets. One-on-one education was provided when necessary. "Cheat sheets" and guides for sepsis care were created for physicians and nursing staff. The sepsis care path was laminated and placed on computers as a visual reminder. A checklist was created for nurses and physicians in the ED; these checklists double as a hand-off tool to communicate the continuum of care between providers.

Memorial Hospital of Carbondale is a 140-bed tertiary care hospital and the flagship hospital for Southern Illinois Healthcare (SIH) and regional referral center for the 16 county southern Illinois region.

"There are approximately 750,000 new sepsis cases each year in the US, with at least 210,000 fatalities. As medicine becomes more aggressive, with invasive procedures and immunosuppression, the incidence of sepsis is likely to increase even more. Reducing mortality due to severe sepsis requires an organized process that guarantees the early recognition of sepsis along with the uniform and consistent application of evidence-based practices."

Memorial has concurrent and retrospective nurse abstractors in the Quality Department. The concurrent abstractor reviews the patients who meet sepsis criteria daily, along with tracking use of the sepsis order sets. Order set compliance data is shared with the providers.

MOVING FORWARD

The team continues to meet and seek ways to simplify the order sets to increase compliance. One of the challenges is missing the required lactic acid timeframe for admitted patients who have the first blood drawn in the ED but are not in their inpatient room when the Lab phlebotomists go to draw for the second order. The phlebotomists now place a sign above the bed indicating that they have been there, asking nurses to please contact the Lab so the second draw may be done in a timely manner.

THE RESULTS

Since the sepsis core measure is "all or nothing" for compliance, it is a challenge. However, the results at Memorial Hospital are consistently improving. Use of the revised sepsis order sets started in the low teens and has increased to about 65%. Total compliance with the Sepsis Bundle has increased to the mid-50's. The team continues to meet every other week and gather input from the ED physicians and hospitalists to address the challenges, one of which is early recognition of sepsis so the timeframes can be met.

LYNNETTE TORRES is the Quality Improvement Manager for Memorial Hospital of Carbondale. For more information, including the tools used by Memorial Hospital, contact Lynette at 618-549-0721 Ext. 65472 (MHC) 618-684-3156 Ext. 55610 (SJMH)

MEMORIAL HOSPITAL OF CARBONDALE is a 140-bed tertiary care hospital, serving as the flagship hospital for Southern Illinois Healthcare and regional center for the 16-county southern Illinois region.

REFERENCES:

1. http://www.ihi.org/Topics/Sepsis/Pages/default.aspx
2. http://www.world-sepsis-day.org/CONTENTPIC/2015_WSD_FactSheet_long_English.pdf and http://www.sepsisalliance.org/news/2016/new_us_government_report_reveals_cost/
3. http://www.medicinenet.com/sepsis/page6.htm

MAKING CARE BETTER: PEER REVIEW FOR EMS

BY JOHN ROMEO, BSN, RN, EMT-P
St. Charles County Ambulance District

For decades physicians in hospitals have conducted peer review defined as individuals in like-professions examining the care provided by a peer and determining whether the standards of care were met. The peer review process is designed to improve quality and patient safety by learning from past performance, errors, and near misses. However, peer-to-peer review has not been routinely conducted in the Emergency Medical Services environment.

Meet St. Charles County Ambulance District (SCCAD). It is one of the few agencies in Missouri with an active peer review process. While SCCAD historically has had good quantitative and qualitative QI work, they wanted a robust format whereby paramedics could provide valuable peer feedback to one another. SCCAD's ultimate goal is to deliver the right care at the proper time in the best fashion possible with the best outcomes.

The Emergency Medical Service Peer Review Committee is responsible for analyzing patient care data and outcome measures to evaluate the ongoing quality of patient care, system performance, and medical direction within an EMS system. Clinical peer review is segmented by discipline so paramedics review other paramedics' care.

St. Charles County Ambulance District (SCCAD) is the largest district in Missouri, serving all of St. Charles County and its population of nearly 370,000. SCCAD is committed to excellence in providing extraordinary mobile healthcare to their community.

GETTING GOING

John Romeo, EMT-P, RN, BSN, Deputy Chief and Medical Officer for SCCAD, previously worked in an acute hospital setting and understands the benefits of peer review. He began talking about the concept with his peers, members of upper management and the union executive leadership. In 2014 he presented the idea of paramedic peer review to the agency's Steering Committee, explaining the Peer Review Committee's purpose, membership make-up and member requirements. Upon approval, committee members were selected, including paramedics from each shift, the part-time transfer division paramedics and a training officer liaison. The Medical Director and Medical Officer are advisors, participating only if expertise is needed. Each committee member must sign a confidentiality agreement.

THE PROCESS

The committee has streamlined its process to keep it as simple as possible:

- Criteria is used to identify five random trips each month; cases may be self-referred or referred by any other provider. Generally, the training officer, medical director or medical officer are pulled in to meet the number of cases defined by category. Identifying information is redacted and a unique identifier is assigned to each case.
- Committee members review each trip and determine whether the standard of care was met.
- Committee makes recommendations for any issues not meeting the standard of care.
- Committee chair personally meets with each provider to discuss outcome and answer any questions.
- Because the review and discussion are peer to peer, discipline is kept out of the discussion.
- Peer review outcomes are maintained in separate files, not in routine employee files.

Center for Patient Safety PSO participants may access SCCAD's policies and forms here.

PROTECTION FOR PEER REVIEW WORK

The 2005 Patient Safety and Quality Improvement Act provides protection and confidentiality for patient safety and quality analysis and deliberation for any licensed health care provider. SCCAD has taken advantage of this protection by joining the Center for Patient Safety's PSO. Romeo states, "If it wasn't for the federal protections that are allowed through the PSO, we would not even be having these conversations. It allows us to focus on prevention, sharing and learning in a protected environment."

BENEFITS

SCCAD has experienced many benefits from the Peer Review Committee's work. The lessons learned from the review have led to individual provider improvement as well as system and process improvements. The agency uses the feedback to focus its training on specifically identified opportunities for improvement. The face-to-face outcome discussions between the committee chair and the individual provider is a best practice among all health care providers conducting peer review. This process contributes to the enhancement of SCCAD's patient safety culture and environment, supporting its purpose to deliver the right care at the proper time in the best fashion possible with the best outcomes.

MAKING IT BETTER

SCCAD continually reviews its processes to identify opportunities for improvement. The next step for the Peer Review Committee is to increase membership to about 10 paramedics to ensure sufficient participation at the monthly meetings. Romeo encourages other agencies to consider developing a Peer Review Committee.

FOR MORE INFORMATION contact **John Romeo** by email or by phone at 636-344-7638.

ONLINE:
Watch Lee Varner's story, "The Code".

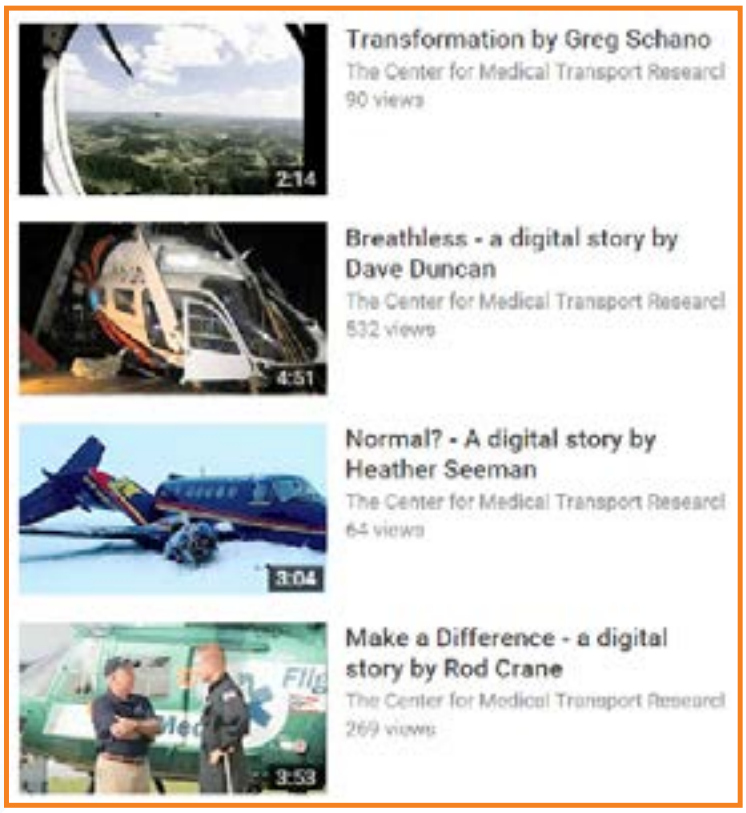
THE POWER OF STORYTELLING

BY LEE VARNER, M-EMS, EMT-P
Center for Patient Safety

Digital storytelling is a new and innovative way for everyday people to tell stories. It allows integration of a wide range of content such as photographs, music and voice into a video story. Digital stories can be used for many purposes and serve as a powerful medium to share topics such as patient safety.

Every year in Denver, Cathy Jaynes PhD, RN, hosts a safety story workshop. The 3-day workshop brings highly skilled storytelling experts together with attendees to facilitate the development of their personal story. Over the years the workshop has brought together a diverse group of healthcare providers who want to share their stories. While most of the stories have focused on air medical events, today's stories are wide ranging with a common theme of safety.

Many of the digital safety stories are available online and are free to use to support greater safety.



FOR MORE INFORMATION, or if you would like to learn about the next workshop, please email Cathy.

PATIENT SAFETY COMMUNITY

VERGE SOLUTIONS ANNOUNCES CHANGE TO VERGE HEALTH

The Center's PSO database vendor has changed its name from VergeSolutions to Verge Health, expressing its dedication and focus on the healthcare industry. In addition to the name change, several other enhancements have been announced. The new and improved data platform, previously called VSuites, is now called Converge. It offers additional report templates and the ability to easily share custom entry views. This means that running reports from Verge is simple! The Center will also be able to securely communicate with its PSO participants via the platform, which is easier than using encrypted e-mail. The Center's EMS participants have already been moved to the new platform, and hospital PSO participants will be moved soon.

To read more check out Verge's new website.

CPS PARTERS WITH NAEMT FOR PATIENT SAFETY IN EMS REPORT

The Center is excited to be part of the most recent National Association of Emergency Medical Technicians (NAEMT) report, Patient Safety in EMS, which helps the EMS community understand the role of Patient Safety Organizations (PSO's) in supporting an environment in which patient safety issues are reported and used as a basis for improvement and policy change.

In addition, the National Registry of Emergency Medical Technicians (NREMT), in collaboration with the Center for Patient Safety, has developed an EMS patient safety survey to measure and develop data in important areas of safety. Details and analysis of its results will be published, after which the Center will be offering administration of the patient safety survey to EMS agencies across the country.

DO YOU KNOW A SECOND VICTIM? - THERE'S HELP

In today's complex healthcare settings, clinicians face a multitude of demands requiring personal resiliency that relies on emotional defenses to carry them through the workday, just to get the job done. Healthcare providers who are involved in an unanticipated adverse patient event, medical error or a patient-related injury become victimized in the sense that the provider is traumatized by the event. Frequently, these individuals feel personally responsible for the patient outcome. Many feel as though they have failed the patient, second guessing their clinical skills and knowledge base. It is difficult to go on.

To address this safety challenge, the Center for Patient Safety has partnered with University of Missouri Health Care's patient safety and risk management experts in Columbia, Missouri, to provide a Second Victim train-the-trainer workshop.

Early in November twenty-eight attendees from across the nation learned from Dr. Sue Scott how she and her team have successfully implemented and continue to grow the program for the University Hospital, known as "forYou". Participants are given information, tools and resources to implement a similar program for their organization.

Two Second Victim workshops will be offered in 2017 – watch the CPS website for dates and registration.

To read more about the University of Missouri's forYOU program visit their website.

EVENTS ON THE HORIZON?

- 01/12/17 12:00pm-1:00pm CST Hospital PSO 101 What You Should Know
- 01/19/17 12:00pm-1:00pm CST Survey on Patient Safety – Hospitals

For additional event information please check the CPS website.

PATIENT SAFETY CASES IN THE COURTS

BY KATHY WIRE, JD, MBA, CPHRM, CPPS
Center for Patient Safety

The biggest recent developments regarding the Patient Safety and Quality Improvement Act came from the Agency for Healthcare Research and Quality (AHRQ) this summer. The first addressed the interface of the PSQIA and state-mandated patient safety activity—situations such as those that led to the Tibbs case in Kentucky. AHRQ's general advice was that information that is likely to be needed to satisfy state (or other) requirements cannot be protected patient safety work product (PSWP). AHRQ indicated that only information developed for the sole purpose of generating information for a PSO can be protected PSWP. The Guidance document is available here. In addition, CPS collaborates with its participants to define their patient safety evaluation system (PSES) and PSWP for the broadest functionality while still compliant with AHRQ's expectations.

AHRQ also released a second guiding document about parent organizations and affiliated providers. Generally, a parent organization can actively participate in a PSES via PSO membership and use PSWP if it has an appropriate relationship with subsidiary participating providers. This allows the organizations that are part of a larger entity, such as a health system, to collaborate by sharing PSWP. The new document clarifies the nature of the relationship that must exist among the parties; generally, the parent must have an appropriate level of control of the subsidiary groups. AHRQ specifically indicates that its standards are not those applied in corporate law analysis of parents and subsidiaries. The document is available here.

There are a few other new developments, which all relate to the issue addressed in the AHRQ Guidance: when can information generated for outside purposes be protected?

1. Tibbs v. Bunnell (Kentucky)

The U.S. Supreme Court asked the Solicitor General's office to submit a brief in this case, in which the Kentucky Supreme Court had declined to recognize PSQIA protection for information developed by the provider pursuant to Kentucky requirements to generate event investigation reports. The brief, available here, contains analysis very consistent with AHRQ's Guidance described above. The U.S. Supreme Court decided not to hear the case.

2. Charles v. Southern Baptist Hospital

The Florida Supreme Court has decided to accept the case on appeal. A decision is expected any time. The appellate court (which is PSO-favorable) rejected the Tibbs rationale. The trial court had followed Tibbs and found that any document or other work produced as part of compliance with a state requirement could not be protected PSWP. The appellate court rejected that claim.

3. Baptist Richmond v. Agee

The Kentucky Supreme Court has issued a decision in this case which is very consistent with Tibbs, described above. The opinion is available here.

THE CENTER FOR PATIENT SAFETY issues regular updates for its PSO participants as legal developments occur. If PSO participants or their attorneys have any questions, please contact Kathy Wire at **kwire@centerforpatientsafety.org**.

Benefits of CPS Safety Culture Survey Services:

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PRICING IS AFFORDABLE FOR ORGANIZATIONS OF ALL SIZES

NO MORE MANDATORY ARBITRATION IN LTC

BY KATHY WIRE, MBA, JD, CPPS
Center for Patient Safety

CMS-certified skilled nursing facilities can no longer enter into binding pre-dispute arbitration agreements with residents or their families. Without mandatory arbitration, facilities face more potential litigation, so it's important to position themselves for productive disclosure and negotiation after bad outcomes.

5 THINGS

Research shows that a patient/resident who has suffered an injury from an error wants to know five things, without having to ask:

- What happened?
- Why did it happen?
- What does it mean to me and my future health?
- What are you going to do for me?
- What are you doing to make sure it doesn't happen again?

Providers who address these issues in a timely and forthright way have demonstrably better liability outcomes and lower defense costs.

How does this aspect of CMS' final rule relate to resident and patient safety? Prompt and effective investigation of events allows staff to readily answer the first three questions. The fourth question requires input from leadership and possibly a malpractice carrier. A great discussion of the fifth question helps the patient/resident and family understand that their experience mattered and that the provider's hard work to analyze and improve will make things better for others.

CPS staff are experienced in all aspects of disclosure as it relates to safety programs, and can work with providers to maximize its benefits, while taking maximum advantage of the protections available through a PSO.

QUESTIONS about the information contained in this article? Please contact Kathy Wire at **kwire@centerforpatientsafety.org**.

SAFETY ALERT TOPIC

Take Action.

Fall Risk

The Center for Patient Safety issues this alert regarding falls based on our data analysis.

Falls are a difficult and long-standing challenge for providers. While the majority of events report no harm, falls continue to result in severe life-changing injury or even death. The CPS recommends you re-evaluate your fall risk program, considering the following best practices:

- Ensure the fall risk assessment tool correlates to the daily workflow and all nurses are trained in appropriate utilization of the tool
- Include all staff (dietary, housekeeping, maintenance personnel also) and physicians in your falls prevention program
- Utilize a standardized communication tool to communicate the patient's fall risk potential to the entire team
- Make certain the preventative measure match the patient's risk factors
- Individualize/tailor preventative measures to meet the patient's needs (i.e. bed alarms are not effective for all patients)
- Include consistent patient rounding as part of your preventative measure
- Implement a quick post-fall huddle process to quickly identify contributing factors that require a system/program change
- Routinely/daily review medications and their effect on each patient's fall risk potential

This alert is provided to increase awareness regarding the complex considerations required for a successful falls prevention program.

Resources:

AHRQ Preventing Falls in Hospitals: http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html

VA National Center for Patient Safety; Falls Toolkit: http://www.patientsafety.va.gov/professionals/onthejob/falls.asp

AHRQ The Falls Management Program: A Quality Improvement Initiative for Nursing Facilities: http://www.ahrq.gov/professionals/systems/long-term-care/resources/injuries/fallspx/fallspxman1.html

Identifying and Reducing risk of falls in older adults: http://centeronaging.med.miami.edu/documents/Evidence-BasedStrategiestoReduceFallRisk.pdf

Home Health Quality Improvement National Campaign Best Practice Intervention Package – Fall Prevention http://www.champ-program.org/static/Falls_BPIP.FromHHQIWebsite.pdf

CDC STEADI Program: https://www.cdc.gov/steadi/

Center for Patient Safety's Mission:

To be a leader in providing creative solutions and resources to improve patient safety.

Center for Patient Safety's Values:

Integrity
Culture of Patient Safety
Excellence
Advocacy

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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.

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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.