

2016 ANNUAL REPORT

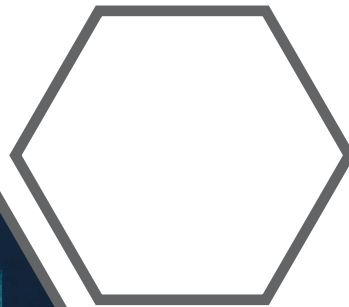


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EXECUTIVE DIRECTOR

We're back at it, stronger than ever.

The last two years were a rollercoaster of change! But the passionate team of staff at the Center for Patient Safety (CPS) was on board to embrace all of the changes and use them as a rare opportunity to step back and look at where we were, and consider closely the direction we wanted to go.

We found our way back to our roots of doing what we do best: helping providers improve patient safety. And we're back at it, stronger than ever with innovative new programs and an enhanced mission. Our core competency remains our ability to support providers across the continuum of care in a non-punitive environment.

While the journey in a non-profit organization is arduous, it is unequivocally rewarding. Our team members face pressures of minimal resources, financial constraints and high expectations, but their ideals and commitment to patient safety never waiver. They are passionate about what they do and it shows in the way they amaze and inspire the individuals and groups that we work with every day.

We were excited about the ability to rediscover our organization over the last year, but we also knew the next critical objective was to secure funding. I know, through inroads and allies with many individuals and organizations, we have a bright and sustainable future.

At this time, I would like to personally thank all of the supporters and healthcare providers we have had the pleasure of working with throughout 2016. You are the promise we have for our patients and the inspiration we have for one another. You are the result of hard work and dedication. You are the reason I look forward to going to the office every day! You are a Rock Star!



Alex Christgen, CPPS, CPHQ
Executive Director, The Center for Patient Safety

"In the waves of change, we find our true direction." - unknown

BOARD CHAIRMAN

The Center for Patient Safety entered its 11th year of operation with expanded and diversified services designed to help health providers with their utmost goal, namely patient safety. Now, following reorganization of the Board and under the able leadership of the new Executive Director, Alex Christgen, the Center emerges as, not only a traditional PSO, but also as a visionary and proactive think tank for both patients and providers. Our programs, services, and data collection places our Center in the top 5 in the USA, providing our enrollees with maximum benefits and the best outcomes available in the field.

On behalf of our Board, I want to thank our staff and customers for their respective contributions to the Center and promise to continue to lead the industry with existing and evolving services to our community and nation.

Edmond B. Cabbabe, M.D., FACS

Chair, Board of Directors, The Center for Patient Safety

MEDICAL DIRECTOR

A few weeks ago, I had the privilege of attending the annual meeting of the National Patient Safety Foundation. Each year when I attend that meeting, it is always heartwarming to me to see the hundreds of people who take time away from their busy lives to network and further their learnings on a topic which is so important to us. The meeting always has the very top people in our field there and they are always free to network and converse with the participants as well as to share some of their learnings. And it was an added bonus this year to see the active participation of the leadership of the Center for Patient Safety and that made me very proud.

So, as I think of the topics that were on the agenda this year, there were indeed many. There were several programs dealing with medication safety including trigger tool methodology, insulin safety and opioid overuse. The hottest topic for medication use, however, was the issue of medication reconciliation in the electronic health record and I feel sure that this is a critical topic for anybody that has had to undergo an electronic health record transition in their institution. The overwhelming solution that we heard recurrently is to focus more pharmacy staff on the issue and involve them in the solution. There were, of course, many topics addressing the patients' involvement in patient safety, and the highlights here involved patient representatives on patient safety committees as well as the concept of "open notes," one which many health care providers are scared to death about.

For our non-hospital based members, there was a lot of discussions this year about patient safety across the continuum and I think that this area has increasing importance as we try to keep our patients safe. A hearty salute to our EMS, ambulatory care, long term care facilities and home health colleagues as they work to make strides in those various arenas to keep our patients safe.

The highlight to me this year, however, was the strong emphasis on the culture of safety and the continued role that this must play. We were reminded by Dr. Charles Stokes, from Memorial Hermann Health System in Texas, that avoidable deaths in U.S. hospitals are still well over 200,000 per year, or the equivalent of a fully loaded Boeing 737 crash every 7 hours despite all of our efforts, and our goal must still be to reduce that number to zero harm. He emphasized that we must move from safety as a priority to safety as a core value and it takes the commitment of every single one of us. We also heard a moving speech from Dr. Don Berwick about many of the errors in our approach to patient safety. He spoke of these errors as "missteps" and included such things as the "displacement by cost concerns," the illusion of completeness (our work is never complete until there is zero harm), the glut of metrics (it is not all about the numbers), the separation of safety from quality (it is not separate) and the incredibly wrong assumptions that link error to blame (look at Dr. Jim Bagian's work.)

In conclusion, in the words of James Reason, "safety is not a goal; it is a continually emerging, dynamic property of a system." Thanks for all you do in the relentless journey of keeping every single patient safe. I appreciate your support of the Center for Patient Safety and wish you all a safe year.

Michael Handler, MD, MMM, FAAPL

Medical Director, The Center for Patient Safety

BY THE NUMBERS

We use a hands-on approach whereby we function more as an extension of the patient safety and quality departments for the organizations with which we work. This allows participating organizations to have a direct connection to our patient safety experts and access the latest information on industry trends and resources.

CPS Contracted Services



300
hospitals



20
LTC facilities



1,000s
medical offices/ASCs



255
EMS agencies



23 Speaking Engagements



182 Facebook Followers



1,696 Twitter Followers



4,329 LinkedIn Group Members



27,548 Website Visitors

30 Second Victim Train-the-Trainer



28,867 Surveys Administered

"We have been involved with the Center for AHRQ Survey Process, conferences, use of newsletters and interaction with the staff on various issues. Staff is highly professional, great customer services skills and knowledgeable experts." -Debbie Vossenkemper, SSM Health

SERVICES AND BENEFITS

The Center offers PSO services for hospitals, ambulatory surgery centers, emergency medical services, medical offices, home health, hospice, and long-term care facilities.

Protecting:

The Center's PSO services offer a seamless way for licensed health-care providers to work collaboratively to learn how to reduce serious events and patient harm within the federal confidentiality and privilege protections of the federal Patient Safety and Quality Improvement Act of 2005.

- PSO Services

Learning:

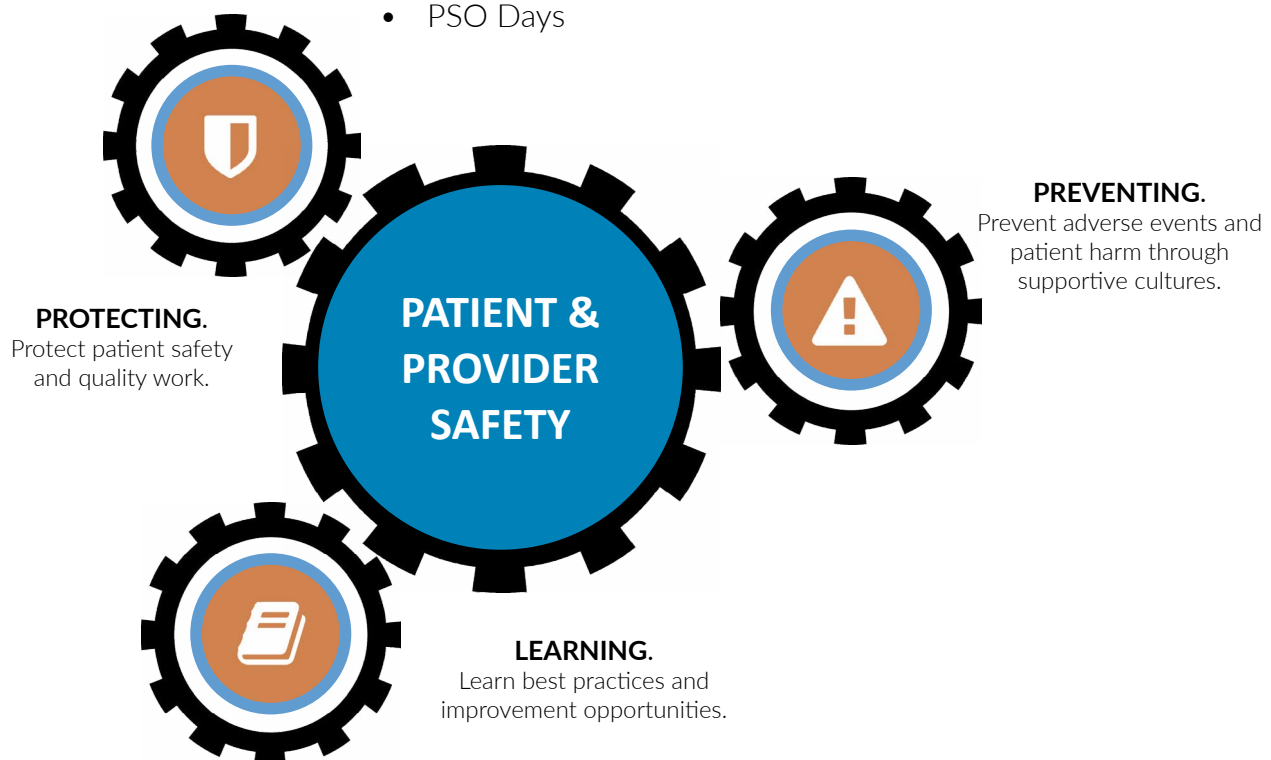
The Center provides learning and education through tools, resources, webinars, training sessions, consultation, research and analysis:

- Quarterly Newsletters
- Online Resources
- Safety Alerts and Watches
- Webinars
- Patient Safety Experts
- Patient Safety Snapshots
- Annual PSO Report
- Safe Tables and Huddles
- PSO Days

Preventing:

The Center promotes and encourages a strong cultural foundation that supports communication, teamwork, and leadership. This open and positive culture is a key step to improving patient safety in any environment:

- Safety Culture Survey
- Comprehensive Unit-based Safety Programs (CUSP)
- Just Culture
- Second Victims
- TeamSTEPPS



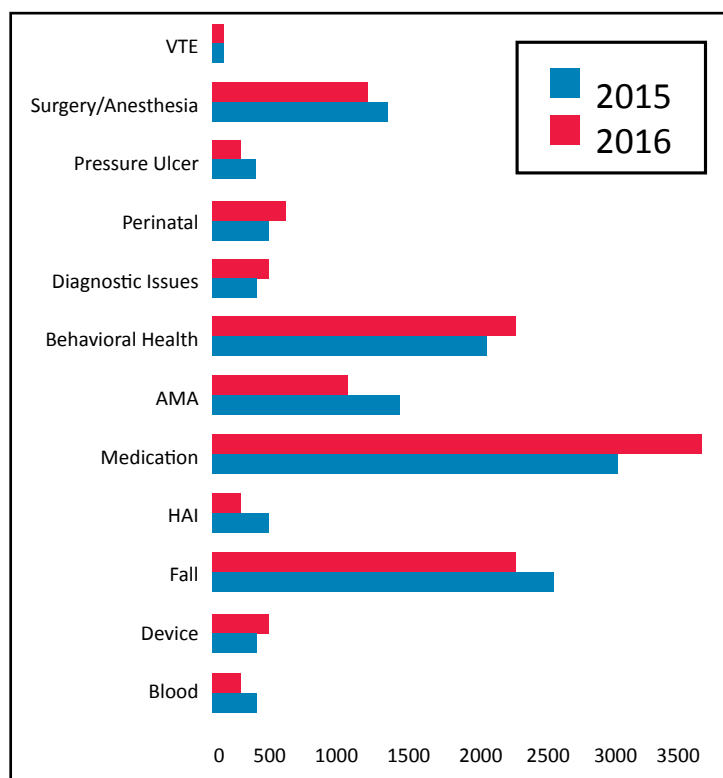
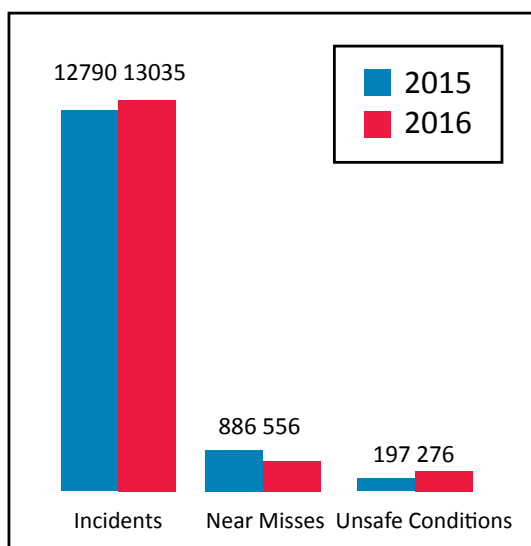
PSO SERVICES: HOSPITALS, MEDICAL OFFICES & LONG TERM CARE EVENTS

Participation in the Center’s PSO continues to expand across the care continuum. No harm is most often reported, but it is within the analysis of these events that we can learn the most. More details and learnings can be found in our supplemental PSO Annual Report:

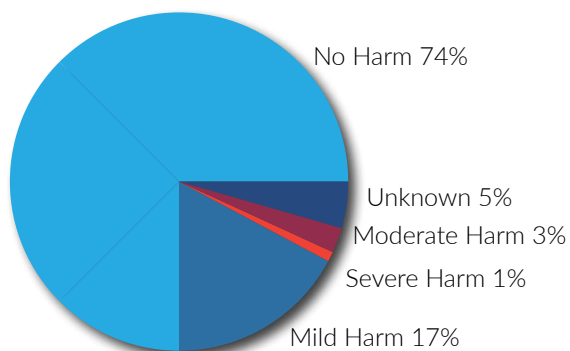
<http://www.centerforpatientsafety.org/psonews/>

“Our work with the CPS PSO has far exceeded our expectations...The CPS PSO provided much needed assistance in creating our work processes”

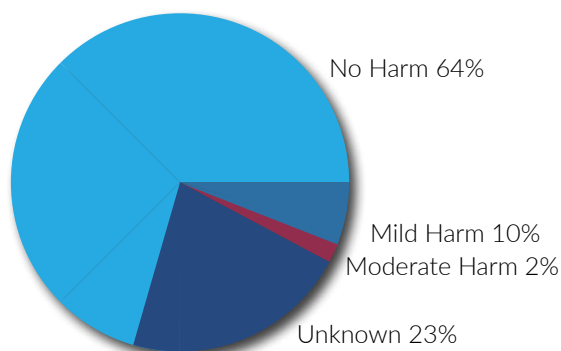
2015-2016 events by the numbers:



Harm Level 2015



Harm Level 2016



Watches/Alerts Issued:

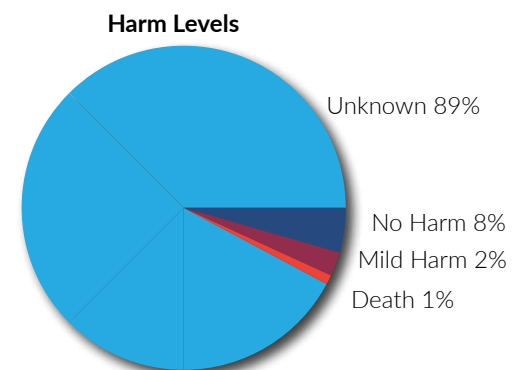
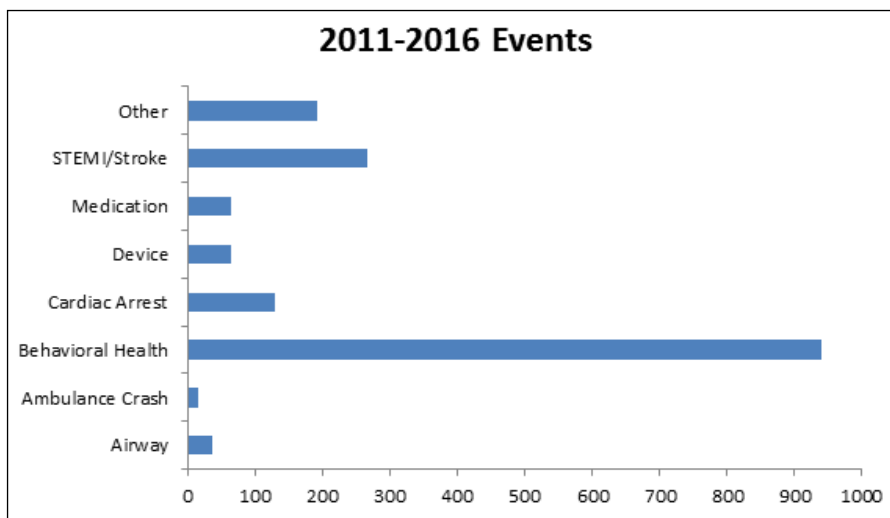
PSO Alert: Fall Risk, PSO Alert: Home Health Medication Management, Safety Alert: Reprocessed Flexible Bronchoscopes Pose Risk, Safety Alert: High Alert Medications, Safety Watch: AHRQ Guidance, Safety Watch: Contaminated Supply, Safety Watch: EKG strip, Safety Watch: Expressed Breast Milk, Safety Watch: Prevent Violent Behavior.

PSO SERVICES: EMS EVENTS

Emergency Medical Services (Air and Ground) continue to take interest in patient safety. With more than 1700 events submitted from EMS members, there is much analysis still to be conducted. The EMS care environment is very unique, which requires the collection of event information different from other care providers. The Center developed a set of formats through the support of our EMS PSO Advisory Committee. We continue to update and grow these formats to ensure we are monitoring the most relevant issues.

The Center for Patient Safety's 2016 PSO report is available online at:
<http://www.centerforpatientsafety.org/psonews/>

You can also find more information in the 2017 release of the #EMSForward campaign with ten topics that will move patient safety forward in EMS. www.emsforward.org/emsforward



Watches/Alerts Issued:

Safety Watch: Bariatric Patients, Safety Watch: AHRQ Guidance, Safety Watch: Patient Destination Decisions, Safety Watch: EKG strip, Safety Watch: Intranasal Medication Administration, Safety Watch: Missing & Lost Equipment in EMS, Safety Watch: Prevent Violent Behavior.

SAFETY CULTURE ASSESSMENT

“I am very impressed with the reports. I know my leadership team will be thrilled to have the individual reports by their division. This has been a very positive experience for me.”

“We love the Center’s patient safety culture survey feedback reports. The department level reports give a level of granularity we were lacking with previous surveys.”

The Center focuses heavily on culture to support patient safety improvement. A punitive environment discourages open communication of events and near misses, creating a barrier to learning about the mistakes that are occurring.

The Center has been administering the AHRQ Surveys on Patient Safety (SOPS) since 2011. Since then, we have administered hundreds of thousands of surveys and provided survey support, feedback reports, and consultation to hundreds of organizations.

A select group of 42 hospitals were selected from the 2016 database. These organizations were selected based on their activity level and extended use of the Center’s resources and services for PSO participation, webinar attendance, resource usage, and consulting. An analysis of their patient safety culture scores are compared to the national compare database from AHRQ. More than 14,000 surveys were analyzed.

- 7 dimensions were equal to or higher than the 50th AHRQ Percentile
- “Nonpunitive Response to Error” ranked in the 75th AHRQ Percentile
- 23 questions were equal to or higher than the 50th AHRQ Percentile
- “We are actively doing things to improve patient safety” ranked in the 90th AHRQ Percentile

The top strengths for these organizations align with the top strengths from the 2016 AHRQ Hospital Compare Database:

Dimension	CPS	National Database
Teamwork within Units	84.2%	82%
Supervisor/Manager Expectations and Actions Promoting Patient Safety	78.6%	78%
Organizational Learning– Continuous Improvement	72.7%	73%

SAFETY CULTURE ASSESSMENT

However, the areas with potential for improvement, or the lowest scoring dimensions, indicate variation in two of the composite scores:

Dimension	CPS	National Database
Handoffs and Transitions	42.6%	48%
Nonpunitive Response to Error	50.4%	45%
Staffing	54.0%	54%

The Center has had a long history with a focus on creating a nonpunitive environment. The dimension includes the question “Staff worry that mistakes they make are kept in their personnel file.” The higher score for the composite “Nonpunitive Response to Error” is statistically significant (>5%). Compared to the national average, the organizations in our select group are in the 75th percentile nationally.

While most of the respondent demographics for the hospitals included in the Center’s summary align with the AHRQ Compare Database, it is worth noting:

- 15% of staff indicated they report 11-20 event reports per year; 29% indicated they report 3-5 events per year (statistically significant variation from AHRQ National Compare Database)
- Higher numbers of reports suggest an environment that supports open communication without a fear of retribution or punishment.

Reporting Events in Past 12 Months	CPS	National Database
None	44%	55%
1 to 2	8%	27%
3 to 5	29%	12%
6 to 10	3%	4%
11 to 20	15%	2%
21 or more	1%	1%

Additional notes:

- 85% of respondents had direct patient care
- 41% of staff worked 1-5 years in the current work area
- 36% of staff worked 1-5 years in the current hospital; 13% worked 21 years or more in the current hospital
- 44% of staff indicated they were a Registered Nurse

The full report can be downloaded here:

<http://www.centerforpatientsafety.org/safety-culture-survey-services/>

BOARD OF DIRECTORS



Chair: Edmond B. Cabbabe, MD
Plastic Surgery Consultants, LTD



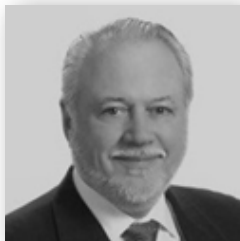
Mark Alexander
Director, CoxHealth EMS



Thomas L. Holloway
Executive Vice President,
Missouri State Medical Association



Susan M. Kendig
Attorney, Nurse Practitioner



Richard A. Royer
Chief Executive Officer, Primaris



Stephen R. Smith, MD
Anesthesiologist

CALL TO ACTION

Call-to-Action

We have several key initiatives underway that are receiving interest from the healthcare community nationwide. We encourage you to take a look and sign up, attend, follow, or contact us for more information. Register in advance for any of our upcoming events, or check out our website for more information. www.centerforpatientsafety.org/events/

Be proactive. Assess your patient safety program regularly and build patient safety into programs that are culturally sensitive and include shared accountability.

Be engaged. Support the work of your units and teams. Attend meetings and share best practices.

Be aligned. Organizations with strategic plans that include patient safety have the ability to function at a higher level with sustainable results that impact quality, financials, safety, and satisfaction and engagement.

Upcoming Events:

- [Leadership Engagement Webinar](#)
- [Employee Engagement Webinar](#)
- [PSO 101](#)
- [Safety Culture Surveying 101](#)
- [Second Victim Workshop](#)
- [Patient Safety Boot Camp](#)
- We are happy to host a webinar or in-person presentation for your organization on the value of patient safety and the importance of leadership engagement, or the impact on quality, financials, employee engagement, patient satisfaction, etc

CONTACT

About the Center

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

CPS was created to serve as a hub for collaboration among stakeholders to improve the safety of care.

CPS was of the first federally-listed PSOs in November 2008, and is now one of the largest and most active PSOs in the country.

Our mission is to provide creative solutions and resources to improve patient safety.

573.636.1014

centerforpatientsafety.org

info@centerforpatientsafety.org

find us on:  

2410A Hyde Park Rd., Jefferson City, MO 65109

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