PATIENT SAFETY BOOTCAMP

ONE-OF-A-KIND WORKSHOP THAT EDUCATES ATTENDEES ON PATIENT SAFETY FOUNDATIONS AND THEORIES.
ABOUT THE CENTER:
The Center for Patient Safety, 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.

Brian Froelke, MD, FACEP, FAEMS
Dr. Froelke graduated from University of Cincinnati School of Medicine in 2002, graduated from his Emergency Medicine Residency at Washington University/Barnes-Jewish Hospital in 2006 as chief resident, and was the inaugural fellow in EMS at Washington University graduating in 2007. Dr. Froelke is board certified in Emergency Medicine and holds a subspecialty certification in EMS. He is the Medical Director for EMS as well as the Community Health Access Program at Christ Hospital. He has served as the regional EMS Medical Director for the East Central Region since 2007, has served as the State EMS Medical Director from 2013-2016, and is the President of the Interstate Disaster Medical Collaborative. Dr. Froelke accepted his newest role as EMS Medical Advisor to the Center for Patient Safety in 2017.

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NOTE: Some articles contained within this newsletter may reference materials available to Center for Patient Safety P50 participants only. 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 573-636-1014.

ems patient safety bootcamp
The program builds the framework and understanding of patient safety that concludes with a customized patient safety plan for attendees.

also inside:

PSWP - WHAT TO PROTECT?
The Center’s staff has been fielding a lot of questions.

ADMINISTERING A CULTURE SURVEY:
If it’s easy, you’re probably not doing it right.

SAFETY TIDBITS:
Improvement tips: benchmarking, antibiotic stewardship, c/section reduction and hand washing.

ALSO IN THIS ISSUE:
DATA BYTE
UPCOMING EVENTS

ems medical advisor
CPS is excited to announce its first EMS Medical Advisor, Dr. Brian Froelke. He shares this message:

Today, I am excited to accept the privilege of becoming the EMS Medical Advisor to the Center of Patient Safety. As I consider these new responsibilities, I also take the opportunity to issue three challenges to my fellow EMS providers.

I challenge the EMS Medical Directors in their role as both patient and provider advocates to become champions of patient safety. From the creation and maintenance of safe reporting environments, to recognition and support of provider health, medical directors play a critical role in the safety and quality of EMS—OUR EMS.

2. I challenge the EMS providers at all levels to commit to actively participate in the quality improvement process. Without your insights, we may not find new solutions to improve our patient care. The mistakes we are willing to recognize are mistakes that others may never have to make.

3. I challenge the EMS agencies to build a Just Culture workplace where system and human errors may be recognized in a patient centered environment. From duty hours and unit hour utilization, to provider stress resources, the agencies hold the key to a healthy work environment, which in turn reduces errors and improves patient care.

One of the fundamental principles in medicine we often quote is “First Do No Harm.” We also know that medicine and its providers are imperfect. Committing to our protection of patients, we must develop personal insight to address those imperfect areas within ourselves and our systems. Recognition and anticipation of adverse outcomes and dangerous events must become a habit.

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Our expanded role for EMS branching out from transport alone to mobile integrated health and community medicine provides us with both a risk and an opportunity. As most of you know, the patient safety movement as we know it was started in 1999 with the report “To Err is Human” and was followed in 2001 by its second report, “Crossing the Quality Chasm.”

The Florida Supreme Court has issued its opinion in Charles vs. Southern Baptist.

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The Florida Supreme Court has issued its opinion in Charles vs. Southern Baptist, in which it analyzes the relationship between the Patient Safety and Quality Improvement Act (the Act) and Florida laws that govern the development and protection of potential Patient Safety Work Product (PSWP). The Court’s opinion is available here. Because the Charles information was collected or maintained for a purpose other than submission to a PSO or for dual purposes, the Court held it is excluded from the definition of PSWP contained in the PSQIA and the final rule.

This finding is important when examining the next issue, whether the PSQIA pre-empts Florida Amendment 7, which eliminates any protection for “any records made or received in the course of business by a health care facility or provider relating to any adverse medical incident.” This discussion won’t delve into the detailed interaction of the PSQIA definitions and Amendment 7, though the relationship is complicated. The important thing for PSOs and their participants in other states is the Florida Court’s somewhat gratuitous finding that the PSQIA could not supersede or pre-empt Amendment 7. There are several reasons why PSO participants should not view this as established doctrine – also known as a “done deal”:

• The Court’s pre-emption finding may well be dicta—an opinion stated by a court that is not necessary for its decision. Dicta can be informative, but carries little true weight as precedent. Viewed narrowly, this is just the Florida Supreme Court stating its opinion where it doesn’t really matter.

• The Florida finding directly contravenes language in the PSQIA (Section 922): “(a) PRIVILEGE.—Not withstanding any other provision of Federal, State, or local law, and subject to subsection (c), patient safety work product shall be privileged.” This sets up a potential US Supreme Court appeal. The US Supreme Court could either (1) accept the case and decide the pre-emption question or (2) find that the Florida Court’s statement was dicta and did not raise a real issue.

• It only applies in Florida. If you are not in Florida, the opinion has no direct effect on PSQIA protections in your state. If you are in Florida, a threshold question for you is what FL state requirements apply to your operations in the state. A second question is what work and documents are required for your organization. We don’t recommend that our participants assume that Amendment 7 has pre-empted the PSQIA.

First, let me say that I am not a licensed FL attorney. So, if you are affected by Florida law, I recommend that you consult someone who deals with these issues in your state for specific legal advice. The PSO community was disappointed that the Court reversed a very favorable decision from the Court of Appeals, but this opinion leaves many options for PSO participants, even in Florida.

CPS has always advised its participants to divide their safety and quality work into 3 categories:

1. Reports that have to be submitted under state or other federal law,
2. Work that is required to be done and related documents that must be generated but not reported under state or other federal law, and
3. Work that is not required by other law.

Charles follows the narrow interpretation of PSWP set forth in the KY cases and the AHRQ guidance. Documents produced to meet an independent state law requirement (Category 1) are not eligible to be PSWP. Work product that results from other state-required activities is in a gray zone and the answer may depend on state law and how you have structured the work. If you have questions, contact CPS. Review your mandatory activities and reports (one and two above) and design your PSES to include work outside those categories. Your PSES can always consider non-PSWP; the deliberations and analysis within the PSES can be protected, but the non-PSWP work product cannot.

There remains an open issue of admissibility in court for any of this information. That is another fight for another day.

CPS will keep you advised of new developments.

KATHY WIRE is the Project Manager for the Center for Patient Safety. Got questions? You can reach her at kwire@centerforpatientsafety.org
DIAGNOSTIC ERROR

BY MICHAEL HANDLER, MD, MMM, FAAPL
CENTER FOR PATIENT SAFETY

As most of you know, the patient safety movement as we know it was started in 1999 with the report “To Err is Human” and was followed in 2001 by its second report, “Crossing the Quality Chasm.” The third report in that series was published in September, 2015 and that report, entitled “Improving Diagnosis in Health Care”, was another landmark report in patient safety and the culmination of many years of study of the important process of medical diagnosis.

Basically, this publication addresses in great detail the top-ic of diagnostic error. Diagnostic error is defined by the IOM as the failure to establish an accurate and timely explanation of the patient’s health problem(s) OR the failure to communicate that explanation to the patient. Although the definition is somewhat controversial in the scholarly circles, the implication of some type of discrepancy in diagnosis is the common denominator and can include over-diagnosis, under-diagnosis or misdiagnosis. And the prevalence is quite staggering. Errors of this type are estimated to be responsible for 40,000 to 80,000 deaths/year in this country. Seventeen percent of adverse events are related to diagnosis and 20% of readmissions are related to the wrong diagnosis. Five percent of primary care visits involve a preventable diagnostic error and ten patients are harmed every day in clinics or emergency departments. It is likely that most of us will experience at least one diagnostic error in our lifetime, sometimes with devastating consequences.

So, I know what you are thinking. It is always the other clinician—not me—who makes errors in diagnosis. In fact, fewer than 10% of physicians admit to one diagnostic error per year and some physicians deny ever making an error. So, what are some of the more common missed diagnoses? Well, missed CVA, epidural abscess, meningitis, sepsis, acute coronary syndrome, abdominal pain and failure to diagnose a cancer, to name a few. Professional liability carriers state that diagnostic errors are second in the number of closed claims and the highest category of average indemnity payment.

When you look at why diagnostic errors occur, you must look at patient variables, system variables and practitioner variables. Patient variables include the stage of disease, how it manifests, how it is described and when help is sought. System complexity includes discounted care, communication barriers, production pressure and difficult access to care and expertise. Finally, practitioner variables include knowledge and experience, access to patient data, tests, consults, skill in clinical reasoning and stress, distractions, mood and time to think. We must also understand the concepts of cognitive biases of providers which lead to error. These biases include such things as anchoring bias which means relying on your initial diagnostic impressions, despite subsequent information to the contrary. These types of biases can lead to errors which perpetuate themselves.

How can we reduce errors? There is not one clear answer, but we can implement processes such as double checks and checklists to reduce reliance on memory and accept feedback from other clinicians whether from physicians, nurses or other professionals. We must also remember to work on improving teamwork, communications and handoffs.

The IOM report concluded with several goals to improve diagnosis and reduce diagnostic error, and these span the entire health care spectrum:

1. Facilitate more effective teamwork in the diagnostic process among professionals, patients and their families.
2. Enhance health care professional education and training in the diagnostic process. Educators are being asked to be sure their curricula include skills in clinical reasoning, teamwork and communication.
3. Ensure health information systems support patients and health care professionals in the diagnostic process. Special reference was made to the elimination of such things as copy and paste, meaningless alerts and templates from the record. Instead, health IT vendors should be encouraged to work together with us to ensure that health IT demonstrates usability, incorporates human factors knowledge and fits well with clinical workflow.
4. Develop and deploy approaches to identify, learn from and reduce diagnostic errors and near misses and establish ways to provide systematic feedback to physicians and other providers in the system. The goal is to find specific actionable items in a root cause analysis and actually fix them.
5. Establish a strong culture of safety that supports the diagnostic process and improvements in diagnostic performance.
6. Develop a reporting environment and medical liability system that facilitates improved diagnosis through learning from errors and near misses.
7. Develop a payment and health care delivery system that supports the diagnostic process and the final goal is to provide dedicated funding for research on the diagnostic process and errors.

The area of diagnostic error continues to be a very dynamic area in patient safety and many unanswered questions remain. We must continue to look for opportunities to help minimize these errors to help keep all our patients safe.

MICHAEL HANDLER, MD, MMM, FAAPL, is the Medical Director for the Center for Patient Safety. He is an OB/Gyn physician since 1985, operating private practices in Missouri through 2007. The last ten years Dr. Handler has served as house obstetric physician, medical director for quality improvement, and chief medical officer for several SSM Health hospitals in the St. Louis area. In early 2017 he accepted the position of chief medical officer for Amita Health Alexian Brothers Medical Center and Amita Health St. Alexius Medical Center in suburban Chicago. Dr. Handler earned his medical degree at University of Missouri-Kansas City School of Medicine. He completed his internship and residency in Obstetrics and Gynecology at St. Louis University Hospitals; he has a Master of Medical Management degree from Tulane University and is a fellow of the American College of Physician Executives.

So, what are some things that you can do to reduce the incidence of diagnostic errors?

• Work together with all members of the health-care team to identify, learn from such errors and reduce diagnostic errors. This includes collaboration with all members of the team including physicians, nursing, pharmacy and all other possible sources of information to help with the right diagnosis.
• Sharpen communication skills and improve handoff communication so that nothing is missed which may lead to the right answer.
• Use the electronic health record as a communication tool and not copy and paste just to get the documentation done—make it sure it is correct and true.
• Be willing to accept suggestions and feedback from others, always keeping the best care of our patient top of mind.

The area of diagnostic error continues to be a very dynamic area in patient safety and many unanswered questions remain. We must continue to look for opportunities to help minimize these errors to help keep all our patients safe.
The Center’s staff has been fielding a lot of questions about what information can be protected under the Patient Safety and Quality Improvement Act and how that relates to reporting to the PSO. The basic rules have not changed, but there is some new focus on reporting, which is the touchstone for all the definitions in the Act and the Final Rule. So, this explanation will start at the beginning.

The Act defines Patient Safety Evaluation System (PSES) as “the collection, management, or analysis of information for reporting to a patient safety organization.” The PSES can collect, manage, and analyze; it need not just gather information and report it in its “virgin” form. Inside the PSES, information can be aggregated, sorted, evaluated or otherwise processed as part of the organization’s patient safety activities.

The Act has a two-pronged definition of Patient Safety Work Product (PSWP). The first prong is information “assembled or developed by a provider for reporting to a patient safety organization, such as a report to a patient safety organization staff member,” which refers to this as the “reporting pathway.” That information needs to be gathered for purposes of reporting and actually reported. The language itself does not address non-reported material.

The second prong of the PSWP definition, though, is the source of much value for PSO participants, as it is what protects the actual work within their PSES. The Act also defines as PSES items “which identify or constitute the deliberations or analysis of, or which identify the fact of reporting pursuant to, a patient safety evaluation system.” To meet this definition, the PSES must conduct some deliberations and analysis of information that it has acquired. And since the purpose of the PSES is to develop reportable information, the deliberations and analysis must take place in the course of (and generate material related to) synthesizing reported material.

Another reason to assess your culture is because many regulatory and certifying bodies now require or recommend measurement of an organization’s patient safety culture. This is because they, too, recognize the clear connection between strong cultures with open communication and the effective implementation and sustainability of patient safety and quality improvement programs.

1. Which Commission
   • The Joint Commission
   • Leap Frog
   • CMS Merit-based Incentive Payment System (MIPS)
   • CMS Quality Assurance and Performance Improvement (QAPI)

The Center for Patient Safety has been administering culture assessments since 2010, and we understand the most successful organizations have a fine-tuned process for administering the survey and analyzing their results. In this article, we’ll discuss some of the most pertinent planning details when preparing to launch a survey. Subsequent articles will include diagnostic tips for evaluating your survey data.

While standard online survey templates may ease the burden of survey administration, there are four key areas that, if addressed upfront, can save time, resources, and frustration in the long run.

1. Which Tool?
   The Center has always supported the Agency for Healthcare Research and Quali- ty’s (AHRQ) Survey on Patient Safety (SOPS) tools though there are many other surveys that can provide a similar analysis. The SOPS tools have been developed for a multitude of healthcare provider types with specific, relevant questions asked, based on varying care settings, such as nursing homes, hospital, ambulatory surgery centers, pharmacies and medical offices. These surveys have also been psychometrically tested and validated and are available in more than 40 languages.

2. Which Medium?
   How do you normally administer surveys to your staff? Are they at ease with an online version, or are they most comfortable with a paper survey? While this seems like an insignificant question, it is quite important. If staff are fearful, they will hesitate to write unfavorable feedback on a paper survey because they think their handwriting will be recognized. However, they may also think the organization will track their online response back to them for purposes of punishment. Using a third party vendor often works best and creates a neutral environment for staff to respond. Consider offering a combination of online and paper surveys. Allow staff to take the survey in a confidential environment with a third-party option if a better choice is for a third party to conduct the survey. They will hesitate to write unfavorable feedback if they are fearful of their handwriting or other identifying information being tracked.
professional competency in patient safety science and application,” said Tejal K. Gandhi, MD, MPH, CPPS, President, CBPPS. “This achievement demonstrates their expertise in this critical discipline and positions them among those committed to and leading patient safety work.”

Each staff member earned this credential in part by passing a rigorous, evidence-based examination that tests candidates on their competency in patient safety science and application. With the conferring of certification, Alex Christgen, Eunice Halverson, Tina Hilmas, Lee Varner and Kathy Wire are now privileged to use the CPPS credential.

For more information about the CPPS credential, contact the Certification Board for Professionals in Patient Safety at (617) 391-9927 or write to info@cbpps.org.

Congratulations to SSM St. Mary’s Health Center
SSM St. Mary’s Health Center in St. Louis MO was recently recognized for its low c-section rate – in fact, second lowest in the nation!

Consumer Reports conducted an analysis of C-section birth rates at more than 1,300 hospitals among first-time mothers at low risk, or those who are having one full-term child who is positioned head first. It found 203 U.S. hospitals had low-risk C-section rates of 18.4 percent or less. The national average is 25.8 percent and the national target, set by HHS, is 23.9 percent. Consumer Reports considered hospitals who delivered at least 3,500 babies annually or had at least 750 low-risk births in 2015 or the nine months ending September 2015 or June 2016. SSM St. Mary’s Health Center’s c-section rate is 12 percent! Contact Pam Lesser, Labor and Delivery Director, for more information.

Wet, Lather, Scrub, Rinse Dry

Congratulations to Providence Health and Services Alaska, who won the seventh annual Film Festival competition sponsored by the Association for Professionals in Infection Control and Epidemiology (APIC). Use this super cool video, “Look at Me,” to emphasize the importance of hand hygiene for your staff, physicians, patients and visitors. Have fun – thanks to Providence!

Benchmark to Excellence

You can move your safety and quality indicators to the next level by using benchmarks. Often comparisons and benchmarks are used synonymously, but they are different. Comparisons are just that – comparing your results to someone else’s. Benchmarking, however, is a way to discover the best performance being achieved, whether by your competitor or an entirely different industry. Comparing your metrics to the “best in class” helps you identify gaps in your processes, thereby giving you a competitive advantage. Benchmarks can be difficult to identify and some organizations use that excuse for not using them. Don’t get caught in that trap! Search for the best fit and use it. Becker’s Journal provides benchmarks for commonly measured metrics in the acute care setting – use them to move your metrics to excellence!

Congratulations! CPS Staff Earn Patient Safety Certification

All professional staff at the Center for Patient Safety are now certified patient safety professionals as recognized by the National Patient Safety Foundation. “Earning this credential attests to the CPS staffs’ professional competency in patient safety science and application,” said Tejal K. Gandhi, MD, MPH, CPPS, President, CBPPS. “This achievement demonstrates their expertise in this critical discipline and positions them among those committed to and leading patient safety work.”

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DATA BYTE

Medication errors continue to be a serious problem across the country.

Please read the Center’s Annual Report for more information and case examples, but medication events are one of the most frequently reported safety events nationally and are also the most frequently reported patient safety event in the CPS data. The CDC predicts that medication errors/events may continue to increase due to the development of new drugs and also the aging of the American population.

- 91% of medication events reached the patient
- 10% resulted in harm to patient
- 77% of events with contributing factors cited either communication or human factors
- 6.5% of events that reached the patient are associated with antibiotics
- 11% of events that reached the patient are associated with opioids
- 10% of medication events that caused harm are associated with opioids
- The 2 most commonly reported opioids in the CPS data base are fentanyl and morphine
- The 2 most commonly reported antibiotics are Levaquin and Vancomycin

Actionable items to help mitigate risk:

- Reach out to all providers across the continuum to identify barriers to medication reconciliation/education
- Standardize medication reconciliation form across the continuum
- Standardize education for patients
- Standardize a communication process across the continuum to all providers to improve hand-offs
- Initiate improvement collaboratives between hospitals and community resources, such as pharmacies, home health organizations, long term care facilities and EMS organizations to reduce medication errors
- Review processes for handling, storing and administering look-alike, sound-alike medications

ON THE TRAIL | UPCOMING EVENTS

- EMS PSO 101 – What you should know, August 15 @ 12:00 pm - 1:00 pm
- Leadership, Louder than Words: C-Suite Ambassadors of Patient Safety, August 22 @ 12:00 pm - 1:00 pm
- Long Term Care PSO 101 – What you should know, September 7 @ 12:00 pm - 1:00 pm
- Safety Culture Assessment-Long Term Care, September 14 @ 12:00 pm - 1:00 pm
- Patient Safety: A Practical Approach from CPS Experts, October 3 @ 12:00 pm - 1:00 pm
- Hospital PSO 101 – What you should know, October 10 @ 12:00 pm - 1:00 pm
- 2017 PSO Day, October 17 @ 12:00 pm - 5:00 pm
- Mid-America Transplant, 1110 Highlands Plaza Dr E #100, St. Louis, MO 63110
- Patient Safety Boot Camp, October 18 @ 7:30 am - 4:00 pm
- Mid-America Transplant, 1110 Highlands Dr. E Ste 100, St. Louis, MO 63110
- EMS PSO 101 – What you should know, November 7 @ 12:00 pm - 1:00 pm
- Second Victim Train-the-Trainer Workshop, November 10 @ 7:30 am - 4:00 pm
- Saint Luke’s North Hospital – Barry Medical Park Building, 5800 Northwest Barry Road, Kansas City, MO 64154
- Leadership, Louder than Words: C-Suite Ambassadors of Patient Safety, November 14 @ 12:00 pm - 1:00 pm
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.