An inside look at patient safety resources, best practices, and industry happenings across the healthcare continuum from the Center for Patient Safety.

FROM REACTIVE TO PROACTIVE

CENTER FOR PATIENT SAFETY HELPS IMPROVE EMS
MakIng Moves | CPS Update

CPS Partners With Ninth Brain For EMS Data Submission

Participating with a Patient Safety Organization (PSO) is recognized as an overall strategy to reduce preventable harm. An important part of participation includes submitting data for learning and improvement. The data collected by a PSO allows for aggregated and de-identified learnings for the reduction of patient harm. This is one of the many benefits of working with a PSO.

Ninth Brain Suite offers an integrated software solution designed for the EMS Industry that offers a one-stop shop for data management needs. CPS and Ninth Brain are pleased to announce a partnership to ease and improve the reporting of events. The partnership allows Ninth Brain clients who utilize their QI module and are also contracted with CPS’ PSO to utilize a streamlined process to submit patient safety events.

Are you working with Ninth Brain but not contracted with CPS for PSO services? Contact Lee Varner for more information.

For more information, contact any member of our PSO team:

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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.

NOTE: Some articles contained within this newsletter may require an account available to Center for Patient Safety PSO 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.

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www.centerforpatientsafety.org

CPS helps improve EMS

CPS began working with EMS providers to improve patient safety about five years ago and the Center’s work has now spread across the nation.

Public Safety in Behavioral Health: Suicide prevention

Consumers of public mental health services in Missouri die every day and these deaths are expected, unexpected or suspicious.

INSIDE THE ISSUE:

PSO Legal Update: Courts in Florida and Kentucky have been busy, but moving in different directions.

Lessons Learned: The primary purpose of PSO participation is to be pro-active and learn from others who, unfortunately, experienced a near miss or medical error.

Data Byte: It’s so helpful when analyzing events to know the contributing factors.

Also Inside:

CPS HELPS IMPROVE EMS

ON THE COVER:

PUBLIC SAFETY IN BEHAVIORAL HEALTH: SUICIDE PREVENTION

INSIDE THE ISSUE:
Courts in Florida and Kentucky have been busy, but moving in different directions. As CPS has previously reported, these two states have the most activity regarding PSO protections because their state laws provide so little protection for safety and quality information. In the past, both states’ Supreme Courts have issued opinions that significantly restricted the extent of protection under the PSQIA for their healthcare providers.

Florida has doubled down on its view that very little can be protected under any privilege, including the PSQIA, in light of Amendment 7. The most recent opinion, Edwards v. Thomas, did not address protection under the PSQIA. However, it once again expressed that Court’s view that almost everything related to an adverse patient event is discoverable. The plaintiff in the case had requested, and was granted, access to an outside expert report that was prepared at the request of counsel in anticipation of litigation. The case reconfirms the state’s status as an outlier on privilege issues.

The Kentucky Court of Appeals issued the other key decision in response to a request by the University of Kentucky for a Writ of Prohibition, seeking protection of documents requested by the plaintiff in a medical malpractice action University of Kentucky v. Bunnell. The Court seems to have reversed direction from the earlier Tibbs case from the Kentucky Supreme Court, in an incredibly detailed and thorough analysis. CPS recommends that providers make sure their defense counsel reviews this case, as it provides a blueprint for the analysis of many issues arising from efforts to obtain PSWP. It also dismisses the authority and accuracy of the guidance issues by AHRQ, rejecting AHRQ’s “sole purpose” doctrine. The case has settled, which means that it will not be appealed to the Kentucky Supreme Court.

The Kentucky Supreme Court also issued a new opinion that seems to apply privilege more broadly than its earlier cases would indicate. In Baptist Health Richmond v. Clouse, the court held that once the provider established that the requested information was created in a Patient Safety Evaluation System and otherwise qualified to be PSWP, the burden shifted to the requesting party to establish that Patient Safety Work Product is required for a state or other reporting obligation, which would eliminate the protections. This essentially eliminates the “sole purpose” doctrine, allowing PSWP to be used for other allowed purposes, as long as it doesn’t have to be reported to an outside entity.

Those interested in Florida law should also follow future developments in Shands v. Price, a declaratory judgment action filed in the Federal District Court for the Northern District of Florida. The PSQIA is a federal law which clearly states it supersedes any less protective state law. Only state courts have interpreted it in Florida. One of the key issues is the asserted pre-emption of the PSQIA by Florida Amendment 7, which grants broad access to records about adverse medical events. In this action, Shands asked a federal court to weigh in on that issue. A decision by the federal court that contradicts the state court decisions could set up an appeal to the U.S. Supreme Court.

As we have pointed out before, these legal developments only control cases in Kentucky and Florida. However, PSO participants in other states can follow the courts’ analysis to strengthen their own policies and legal responses to any challenges.
Diagram 1. Incident Management Model

Unexpected Deaths

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<th>Year</th>
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<th>Suicide</th>
<th>Homicide</th>
<th>Accident</th>
<th>Undetermined</th>
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<td>Total</td>
<td>162</td>
<td>14</td>
<td>37</td>
<td>9</td>
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</tbody>
</table>

Source: Missouri Department of Mental Health Client Information Management, Outcomes & Reporting

Mental Health Fatality Review Panel

Since 2010, the Mental Health Fatality Review Panel (Panel) reviewed the unexpected deaths of 222 Department consumers (Table 1). Seventy-three percent of these unexpected deaths were determined to be “natural” by a coroner, medical examiner or certifying physician; and the cause and manner of death are recorded with the Missouri Department of Health and Senior Services, Bureau of Vital Statistics. A natural death occurs due to disease or the aging process and may be reasonably anticipated. The Panel meets quarterly and is briefed with a summary of each unexpected consumer death which includes, but is not limited to, the cause, manner and circumstances surrounding the death; any pertinent medical history; the service/program with an open episode of care; and any action taken in response to the death event. The focus is on developing systemic interventions for prevention.

Table 1. Department unexpected deaths reviewed by the Panel.

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Source: Missouri Department of Mental Health Client Information Management, Outcomes & Reporting

Zero Suicide

The 222 fatalities reviewed by the Panel, six percent were suicide, as documented on the death certificate and/or autopsy report. Department consumers are high risk for suicide with diagnoses such as depression, bipolar disorder, schizophrenia and borderline personality disorder among the risk factors for suicide. This prompted the Department to join the national Zero Suicide initiative in its earliest stages in 2014 by attending the first Zero Suicide Academy and participating in the national Zero Suicide learning collaborative. Zero Suicide is designed for Health and Behavioral Healthcare systems and is a commitment to make suicide a never event for individuals receiving services. Statistically significant, research shows:

In the month before their death by suicide:
- Half saw a general practitioner
- Thirty percent saw a mental health professional in the 60 days before their death
- Ten percent were seen in an emergency department

Source: Suicide Prevention Resource Center

In state operated psychiatric facilities, the Joint Commission (TJC) requires the submission of a completed RCA for review and approval for all suicides and suicide attempts. A 2016 sentinel event alert published by TJC embeds Zero Suicide concepts. Psychiatric SoP suicides are reviewed at the executive level and receive a Panel review in addition to the TJC oversight. Many community providers are CARF accredited. CARF too, embeds Zero Suicide concepts in a 2017 publication.

Zero Suicide concepts applied in practice improves suicide care in health and behavioral healthcare by making it a never event. In a Zero Suicide culture, leadership is committed to reducing suicide within the system of care through the support of the seven essential elements of Zero Suicide.

In 2016, the Department, in collaboration with the Coalition of Community Behavioral Healthcare Centers (Coalition), established the Show Me Zero Suicide learning collaborative by hosting a Zero Suicide Academy for Community Behavioral Healthcare Centers (CBHC’s). A second academy hosted in 2017, included CBHC’s, psychiatric SoP’s, acute care hospitals and established a second learning collaborative. Missouri is the first state to have all of its contracted CBHC’s trained in Zero Suicide. For more information regarding Zero Suicide, visit the Suicide Prevention Resource Center at http://zerosuicide.sprc.org/ or contact Jacquelyn A. Christmas, MPA, Fatality Review Coordinator at the Office of the Chief Medical Director - Missouri Department of Mental Health.

Essential Elements of Zero Suicide

1. LEAD - Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles.

2. TRAIN – Develop a competent, confident, and caring workforce.

3. IDENTIFY – Systematically identify and assess suicide risk among people receiving care.

4. ENGAGE – Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.

5. TREAT – Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.

6. TRANSITION – Provide continuous contact and support, especially after acute care.

7. IMPROVE – Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

Source: Suicide Prevention Resource Center

References:

Diagram 2. Case Fatality Management

Medication Management

Case Fatality Management

In-Person

Investigation

Medical Examination

Narrative Report

Medical Examination

Narrative Report
CPS began working with EMS providers to improve patient safety about five years ago and the Center’s work has now spread across the nation. Lee Varner, EMS Patient Safety Director, recently shared the Center’s story in an interview by EMS World. Varner, a seasoned paramedic with a Master of Science in EMS, is passionate about helping his profession across the country provide consistently safer patient care.

While the Center started working with EMS by offering participation in its Patient Safety Organization (PSO), the Center’s services have significantly expanded. In addition to the PSO, culture assessment, consulting, learning and sharing, the Center offers two important “tools” to assist all EMS providers along their patient safety journey.

EMSForward

Earlier this year the Center published the second edition of EMSForward, which is a publication highlighting ten safety topics that will move “EMS Forward”. New laws and a changing health care system mean EMS professionals are being called upon to change their processes. To meet these new expectations, the advancement of safety in EMS must be a focal point for EMS leadership across the nation.

“Patient safety rests with the attitudes, beliefs and perceptions of everyone across the healthcare continuum”, said Varner. “This year’s campaign is about making the culture connection and identifying the importance of organizational culture when it comes to safety.”

The ten patient and provider safety topics are projected to be of greatest concern in EMS and include areas such as bariatrics, pediatrics, and airway management. The campaign is not an all-inclusive list of safety concerns, but rather a mechanism to drive awareness, support open dialogue, and promote improvement activities.

Each topic is delivered in a real-life scenario and concludes with a question to encourage deeper reflection on the reader’s own organizational culture. As the campaign unfolds throughout the year, CPS will provide support and resources about the topics.

“Patient safety is largely committed to improving safety, and CPS is positioned to support them,” said Alex Christgen, CPS Executive Director. “The EMS Forward campaign is one way to focus our combined efforts. Together, we’ll make an impact in a new and profound way.”
LESSONS LEARNED

The primary purpose of PSO participation is to be pro-active and learn from others who, unfortunately, experienced a near miss or medical error. One of the Center’s PSO member hospitals shared the following:

Failure to change Peripheral IV Site
Nurses failed to change a peripheral IV site within 7 days as required by best practice and the hospital’s policy. The site was used only twice a day for antibiotics. On day 13 a nurse realized the catheter had been in too long. When the catheter was removed, it was found fractured and dislodged from the hub. The patient required surgical intervention to remove the catheter.

Issues:
- IV sites were not consistently labeled with the date/time of insertion.
- Although there was a site assessment every shift, the electronic medical record did not prompt the nurse to document the date/time of insertion and due date for changing the site.
- The antecubital site is frequently used and is not the ideal site for non-emergent peripheral IV therapy.

Fixes:
- The hospital leveraged its electronic medical record so now nurses must indicate at every shift assessment if the IV site was changed. The system will pull forward the date of the last IV site change and indicates when the next one is due, based on the documentation.
- Nurses were not labeling the IV site, as per best practice. The hospital found that labeling the site was not included in the policy. Policy was updated and staff were educated accordingly.
- The IV was also placed in the bend of the elbow resulting in frequent movement, thus contributing to the fracture of the catheter. Staff are now coached to not to use the antecubital site, if possible.

Do you have a Lesson Learned to share?
Contact Eunice Halverson
Inattention is another factor cited in many adverse events. Analysis of many medication events reveals that nurses are distracted when trying to multi-task, which contributes to errors. Have you considered implementing “no chat on the mat”? This process requires no communication with a staff member standing on a red mat while focusing on medication preparation and selection. Or consider having nurses wear an orange vest, which indicates they are in the process of administering medications and are not to be distracted.

Lastly, the promotion of a culture of safety by management is another frequently cited factor. It’s important to learn from errors, near misses, and unsafe conditions. If staff notice an unsafe condition or experience a near miss and they don’t feel safe speaking up to their immediate supervisor, the procedure, process or policy may not be evaluated until after an incident occurs. By encouraging transparency, without fear of punitive harm, an organization has an opportunity to review the process which may need revision before an incident occurs.

PSOs depend on their participants for data. CPS encourages you to continue, or start, entering the contributing factors for your events and near misses. It will significantly support the learning from the events that is shared with all PSO participants.

You know that evaluating your organization’s patient safety culture can provide insight into staff perspectives and support the development of plans for organizational growth and sustainability. And you know that tools for assessing and improving your patient safety culture come in many forms. But every organization is unique. How do you know which tools are best for your organization?

The Center recognizes the value in selecting the right tools, the right measures and the right improvement programs for you. You know that evaluating your organization’s patient safety culture can provide insight into staff perspective and support the development of plans for organizational growth and sustainability. And you know that tools for assessing and improving your patient safety culture come in many forms. But every organization is unique. How do you know which tools are best for your organization?

1. We will work with you to tailor a program that fits your unique needs.
2. We assess your current cultural climate through the administration of customized patient safety culture survey.
3. Our patient safety experts review all incoming responses, and prepare robust feedback reports that give you actionable next steps.
4. We’ll walk you through the entire process and continue working with you on improvement plans and culture change. We want you to be successful!

New clients can save 15% by signing up March 31*.

*Cannot be combined with other offers.
UPCOMING EVENTS | CALENDAR

MARCH 11-17: PATIENT SAFETY AWARENESS WEEK

MARCH 14: PATIENT SAFETY FORUM, 8AM-4:30PM
HTTP://WWW.CENTERFORPATIENTSAFETY.ORG/EVENT/PATIENT-SAFETY-FORUM/

MARCH 19: SECOND VICTIM WORKSHOP, 7:30AM-4PM
HTTP://WWW.CENTERFORPATIENTSAFETY.ORG/SECOND-VICTIMS/

MARCH 20-22: JUST CULTURE CERTIFICATION COURSE
HTTP://WWW.CENTERFORPATIENTSAFETY.ORG/EVENT/JUST-CULTURE-CERTIFICATION-COURSE/

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.