An inside look at patient safety resources, best practices, and industry happenings across the healthcare continuum from the Center for Patient Safety
A LETTER FROM THE EXECUTIVE DIRECTOR

I am excited to announce that the Center for Patient Safety (CPS) is experiencing a significant period of growth, reaching new provider groups and in many new areas across the nation as well as the World. We are grateful to each new client and partner that extends an offering to support our work and promote our mission: reducing preventable harm.

Over the last year, we’ve focused on three priorities to continue our growth and ensure sustainability:

1. Partnerships,
2. New services, and
3. Thought-leadership

Our partnerships now support efficient outreach to new communities and underserved populations. We are also pleased to recognize several new arrangements with highly recognizable and established groups like Ninth Brain, Elevating Home, and ESO to name a few. Earlier this year, during Patient Safety Awareness Week, we had the pleasure of working closely with the amazing team at Medtronic to develop and present the first national Patient Safety Forum. Providers from across the care continuum came together to discuss patient safety in a new and innovative way.

Our new services include programs that are integral to patient safety improvement but where we discovered inefficient program execution within healthcare organizations. To address the gaps, CPS developed customizable on-site training programs, virtual support services, and enhanced program offerings that are administered individually or together as a larger initiative. We’ve also launched the EMSForward360, a follow up to our EMSForward campaign and recently developed a HealthcareForward campaign to raise awareness across the care spectrum.

With the diversity of our team members, CPS is contacted regularly to attend speaking engagements around the world, offering thought-leadership on topics dedicated to patient safety, culture improvement, and effective leadership. Our team has addressed pharmacists, healthcare attorneys, patient safety organizations (PSOs), doctors, emergency medical service providers, home care and hospice providers, hospitals, health systems, nursing homes, medical offices, state-based agencies, and more.

I’d like to recognize the Center’s founding members, Primaris and the Missouri State Medical Association, and our board members. These organizations and groups of individuals support our mission daily and have proven to be the foundation for our success. We would not be where we are without these amazing groups that volunteer their time and energy to support so many in the cause to reduce preventable harm in healthcare. Together, we will make a difference.

ALEX CHRISTGEN, CPS, CPHQ

NEW NEWS!
The Center for Patient Safety Launches Safety Culture Assessment for EMS Agencies

The Center for Patient Safety recently launched a Culture Assessment for EMS agencies. Recognizing the need for EMS agencies to continuously improve their safety culture while understanding the challenge of knowing how to get started, CPS developed the Safety Culture Assessment specifically for this market.

FOLLOW THE CENTER FOR PATIENT SAFETY

COVER STORY

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ABOUT THE CENTER:
The Center for Patient Safety was founded in 2005, 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.

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For additional information CPS activities, services, resources, toolkits, upcoming events, and more, visit our website at centerforpatientsafety.org or follow us on Twitter #PatientSafety for the most up-to-date news.

NOTE: Some articles contained within this newsletter may reference materials available to Center for Patient Safety (CPS) participants only. If you have questions about links to 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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AHRQ Opinion: The Patient Safety Act (PSQIA) Supersedes Florida Amendment 7

Florida has been a hotbed of PSQIA litigation, largely because its state protection is so weak due to Amendment 7, which mandates disclosure of much quality and safety work product. A number of state cases danced around the issue but failed to result in a definitive finding on the question of whether the state constitutional provision can overcome the Federal law’s language. This left Florida providers with the difficult choice of either producing information they felt was Patient Safety Work Product (PSWP) in violation of the PSQIA or objecting to production, usually unsuccessfully, in state court.

Recently, some Florida defendants filed federal declaratory judgment actions against Health and Human Services (HHS) (parent agency of the Agency for Healthcare Research and Quality, which oversees the PSQIA implementation), seeking a federal court ruling regarding the status of their PSWP. If the federal court approved the disclosure, it would shield the hospitals from liability under the PSQIA for inappropriate disclosure. If it did not, then the hospitals would have stronger arguments to protect their PSWP in state court.

In its motion to dismiss the actions, HHS argued that (1) the clear language of the statute indicates that it applies notwithstanding contrary state law, and (2) this provision is constitutional under the Supremacy Clause of the US Constitution. While the federal courts have not decided the case, this clear statement from HHS indicates the federal government’s position on the issue and makes it likely that Amendment 7 will indeed be pre-empted by the PSQIA.

Links to the HHS motion and supporting memorandum of law are below.

Thanks to Attorney Michael Callahan for his ongoing efforts to circulate new information about PSQIA legal developments to keep us all up-to-date.

EVENT CALENDAR
Check out some of our upcoming events to catch the CPS team near you!

<table>
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<tr>
<th>SEPTEMBER</th>
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<tr>
<td>EMS BOOT CAMP - A CPS Event</td>
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<td>September 12</td>
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<td>WEBINAR: EMS PATIENT SAFETY: MOVING THE NEEDLE TO ZERO HARM - EMS World Webinar</td>
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<td>September 12 @ 12:00 pm CDT</td>
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<td>REGISTER NOW</td>
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<td>INDIANA EMERGENCY RESPONSE CONFERENCE</td>
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<td>September 12 - September 15</td>
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<td>MISSOURI BOARD OF PHARMACY REGIONAL MEETING</td>
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<td>September 13</td>
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<td>PATIENT SAFETY COACHING WORKSHOP</td>
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<td>ASHRM</td>
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<td>October 7 - October 10</td>
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<td>MISSOURI BOARD OF PHARMACY REGIONAL MEETING</td>
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<td>October 24 - October 26</td>
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<td>EMSWORLD BOOT CAMP - A Preconference Event from CPS and Laerdal</td>
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<td>October 29</td>
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<th>NOVEMBER</th>
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<tr>
<td>SECOND VICTIMS EXPERIENCE - A CPS Event</td>
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<td>November 5</td>
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HEALTHCARE FORWARD
FREE eBook! Together we can move #healthcareforward.

This booklet covers various patient safety scenarios and asks questions intended to promote thought and lead to deeper discussions for building action plans around areas that are not appropriately addressed currently in your organization.

DOWNLOAD

This image contains information about events and updates related to patient safety, including a calendar of events and a call to action for promoting healthcare forward. The text highlights the Patient Safety Act (PSQIA) and its implications for Florida, particularly regarding Amendment 7 and the preemption of state law by the federal law. It mentions the role of the Agency for Healthcare Research and Quality (AHRQ) and the efforts of Attorney Michael Callahan to keep professionals informed about legal developments. The image also includes a call to action for downloading a free eBook titled “Together we can move #healthcareforward.”
PATIENT SAFETY JOURNEY CONTINUES AT LEE COUNTY EMS

LEE COUNTY EMS IN FT. MYERS, FL RECEIVES CPS’ PATIENT SAFETY FIRST AWARD

More than 86,000 patients who live along Southwest Florida’s waterways or within 1,200 square miles of Lee County EMS (LCEMS) benefit from their excellent medical services each year. This prestigious EMS service runs both ALS and BLS ambulances as well as one air medical program. But something is different at LCEMS— an intentional focus on improving patient safety. What does that mean? Providing the best possible care in the safest manner for all patients.

LCEMS’ patient safety journey was recognized on May 24 during EMS Week when the organization received the Patient Safety First Award from the Center for Patient Safety (CPS). Alex Christgen, CPS Executive Director, expressed congratulations and explained, “The award captures an organization’s commitment and spirit to improve their safety culture and dedication for taking proactive steps in systematically using data as the basis for increased learning and improvement.

Lee County Manager, Roger Desjarlais, presented the Patient Safety First Award to members of Lee County EMS Patient Safety Employee Engagement Team. More than 100 providers were in attendance.

LCEMS’ patient safety program is focused heavily on a “just culture” framework which encourages employees to self-report errors and near misses, which are non-punitive. LCEMS’ patient safety program is focused heavily on a “just culture” framework which encourages employees to self-report errors and near misses, which are systematically used as the basis for increased learning and improvement.

Patient safety has always been a core value for LCEMS, but the focus was heightened in March 2017 when Lee County invited the CPS to pilot its first EMS Patient Safety Boot Camp. This day-long interactive session focuses on the how leaders set the patient safety tone by improving two-way communication and changing the culture to be non-punitive.

It Takes Teamwork

LCEMS has established Employee Engagement Teams for increased communication and improvement across the entire organization, and one specifically focuses on patient safety. This team, composed of a team leader, road crew members and an administrative sponsor, uses a “grass-roots” approach to identify patient-safety issues and make recommendations to other teams for changing policies, guidelines, protocols and products. Monthly incidents are analyzed, and opportunities for improvements are identified and shared via internal public service announcements, safety alerts or short videos. Recently the team emphasized the importance of appropriate stretcher strap use and what might happen if the policies are not followed. The team has fun too: They developed a skit portraying the importance of the six patient medication administration rights and a reminder to always use a cross check prior to giving medication. Monthly in-service programs always include a short patient safety story that occurred during the previous month, heightening the constant awareness of patient safety.

What’s Next?

LCEMS recently finished an employee patient safety survey, which was completed by more than 50 percent of the frontline providers. Strengths of the organization were recognized and celebrated: teamwork, communication during a response and staff training. And the survey confirmed opportunities for improvement: staff fatigue and information exchange with longterm care facilities.

Work already has begun to improve communication and to address the fatigue factor, a known challenge across the EMS industry. During the last six months, LCEMS has run three BLS ambulances for 12 hours/day to reduce the call volume for the 911 ambulances, reducing standbys and leaving them available for the more severe calls. Patient safety is a journey and the Patient Safety Engagement Team will continue improvements to address these challenges.

Where to Start?

Capt. Colin Johnson, Patient Safety Team Leader, encourages other EMS agencies to start by “embracing and adopting the ‘crawl, walk, run’ mentality. Changing the culture and improving patient safety does not happen overnight. Adoption of a non-punitive, just culture is necessary to engage front-line providers, whose trust will increase as they see medical errors used for improvement and not punishment. LCEMS has experienced a 50 percent increase in the number of events reported since March 2017. We truly are trying to improve our culture for the betterment of the people we serve, to keep everybody safe.”

For more information, contact Captain Colin Johnson, Office of the Medical Director, in Lee County EMS.

“I think back when I started my EMS schooling. We were taught to ‘do no harm.’ While that statement is important, its meaning didn’t really resonate with me. Patient safety has become much more real to me. Working at LCEMS gives me a sense of pride and comfort knowing that the patients we serve in this county – including my family members – are served by my peers who are passionate about providing the best possible, safe care.”

Capt. Colin Johnson, MS, EMT-P, EMT-T, TP-C
HELP.....I CAN’T BREATHE!

BY SCOTT BOURN, PhD, RN, FACHE
SECURISYN MEDICAL

Respiratory Arrest is the second most frequent cause of avoidable patient safety events

EMS was called to a private residence to evaluate a 79 y/o male complaining of difficulty swallowing for 5 days and shortness of breath for 2 days. He presented alert and oriented with normal skin color and temperature. His radial pulse was strong, but he had 2-word dyspnea and visible use of his accessory muscles. His family informed EMS that he had myasthenia gravis. Further exam revealed pulse 110, RR 48, and blood pressure 160/88. SpO2 was 92% and etCO2 was not assessed. He had minimal airflow in the lower lobes and quiet wheezes in the apex. Based on their assessment, the paramedic placed the patient on 6 lpm of supplemental oxygen via nasal cannula, started an IV, and administered nebulized Ventolin.

When they arrived in the ED the patient’s respiratory distress was significantly greater and his SpO2 had dropped to 88%, RR had dropped to 36, and pulse had increased to 120. His condition was clearly deteriorating, and the etCO2 was 60 (evidence of significant hypoventilation). The patient was orally intubation, sedated, and placed on a mechanical ventilator to provide support for his myasthenic crisis. He recovered completely after 48 hours in ICU.

What happened?
Following transfer of patient care, the EMS crew had a discussion with the ED staff. They felt as though they had missed something in their assessment and, as a result, failed to recognize the patient’s deteriorating condition. The ED physician noted that their lack of knowledge about myasthenia gravis (a progressive neuromuscular disease) contributed to their under-assessment, but that they had missed important indicators of Respiratory Compromise. The remainder of their discussion focused on this emerging and important condition.

What is Respiratory Compromise?
Respiratory compromise is defined as “a state in which there is a high likelihood of decompensation into respiratory failure or death, but in which continuous monitoring and early intervention might prevent or mitigate decompensation”1. There are several key elements of this definition:

- Respiratory compromise is a well-defined syndrome comparable to compensatory shock. If not recognized, the patient’s condition will decompensate.
- Decompensation leads to respiratory failure, which is heralded by the need for advanced life support interventions such as intubation or mechanical ventilation.
- Decompensation can be prevented or reversed by careful monitoring of both ventilation and oxygenation, with appropriate intervention.

Respiratory compromise is one of the top five causes of increased hospital costs and the second most frequent cause of avoidable patient safety incidents2. Further, 75% of adults experiencing cardiac arrest have underlying respiratory failure, suggesting that better recognition of respiratory compromise might reduce the incidence of cardiac arrest3.

Identifying the at-risk population
Physiologic causes of respiratory compromise include1:

- Impaired control of breathing (most notably are opioid/sedative overdose and neuromuscular diseases such as myasthenia gravis)
- Impaired airway protection (upper airway trauma, edema, foreign bodies)
- Parenchymal lung disease (diseases that affect the lung tissue that surrounds the air sacs) such as infection, malignancy, environmental or occupational exposure, collagen vascular disease) which may affect airflow, oxygen exchange, or both.
- Increase airway resistance (asthma, COPD)
- High pressure (cardiogenic) pulmonary edema
- Right ventricular failure

As can be seen from the causes, respiratory compromise may result in impairment of ventilation, oxygenation, or both. As a result, early recognition of respiratory compromise—in time for intervention to prevent decompensation—requires careful monitoring of clinical signs that are associated with hypoxia and hypoventilation including4-6:

- Abnormal and/or changing respiratory rate
- Abnormal and/or variable heart rate
- Abnormal (high or low) work of breathing
- Breath sounds (because of the prevalence of chronic respiratory causes changes in breath sounds may be most important)
- Altered mental status
- Pallor/cyanosis
- Trending/abnormal SaO2/SpO2 (the most accurate indicator of oxygenation)
- Trending/abnormal PaCO2/etCO2 (the most accurate indicator of ventilation)
Applying these criteria to the opening case is informative. The initial tachypnea coupled with use of the accessory muscles of respiration and quiet breath sounds is highly suggestive of impaired ventilation. Further assessment, including the evaluation of etCO₂ or SpO₂, would have confirmed that the patient was inadequately ventilating, and would have likely resulted in assisted ventilation and/or airway control, both of which could have reversed the patient’s progression into respiratory failure. Fortunately, in this case, the failure of the EMS crew to recognize these signs of respiratory compromise did not contribute to a poor outcome. However, establishment of assisted ventilation earlier could have, at the very least, reduced the degree of respiratory distress and panic the patient was experiencing.

Lessons Learned
Respiratory compromise is a common and identifiable stage that often precedes respiratory failure, which may result in death. Early recognition requires a high incidence of suspicion when evaluating patients at risk, coupled with the initiation of monitoring may result in decompensation and respiratory failure, both of which have high complication and mortality rates. Prevention of respiratory failure requires:

- Recognition of patients at risk
- Early application of assessment and monitoring
- Early and proactive interventions to establish and maintain ventilation and oxygenation
- Consistent reporting of monitoring results and trends to providers receiving the patient in a transfer of care.

References

About the author: Scott Bourn, PhD has a rich and diverse background in emergency medical services, emergency & critical care nursing, and education. His career roles include: field paramedic, emergency department and critical care nurse, EMS system coordinator, director of a university EMS degree program, and senior clinical executive for two large national health delivery organizations. He has also published over 200 articles, columns, and video learning modules, and has delivered lectures throughout North America. His research, writing, and lecture topics focus on defining, measuring, and improving patient outcomes and experience.

The 10-YEAR CYCLE OF TRANSLATING RESEARCH INTO CLINICAL PRACTICE

WHAT THE MEDICAL FIELD CAN LEARN FROM THE BEHAVIOR OF NORWEGIAN RATS

PETER ANTEVY, MD
HANDTEVY - PEDIATRIC EMERGENCY STANDARDS

Are there things you do every day because it's how you've always done them? Do you wonder why great ideas and evidence based solutions take decades to become widespread and incorporated into practice? Furthermore, how do novel discoveries get distributed beyond the initial journal publication? These seemingly simple questions are deeply rooted in the human psyche, and if understood, could lead to important discoveries.

Consider that in 1847, a Hungarian physician named Ignat Semmelweis proposed the practice of hand washing when delivering babies in the clinic. Amazingly, it took more than 20 years for the scientific community to prove this theory to be correct and for other doctors to accept it as standard practice. Today, it seems quite obvious, but at the time of the discovery many clinicians refused to incorporate hand washing into their daily practice. What Semmelweis initiated then is no different than what most health care researchers do today - isolate a problem, formulate a hypothesis, and then study it; first as a pilot, and then as an expanded clinical trial. But what happens next is a slow and oftentimes negligible clinical adoption, 10 years or more in duration - it's a decade lost to knowledge translation.

A better understanding of this process by exploring "new" terminology and tying it to rodent behavior in Norway, may just help us crack the code to this important problem. The term neophobia is defined as the fear of something new. What is it about "new" clinical information that makes it scary, or difficult to incorporate into one's practice in a relatively short time frame, even when the evidence is overwhelmingly supportive? Neophobia, it turns out, provides an evolutionary advantage. Norwegian rats, for example, are very resistant to trying any new foods because humans have gotten much more clever with rat poison. On the other hand, rats who are neophilic (like to try new things) aren't going to live too long, and will not pass on any protective genes to the next generation of rats. This "protective mechanism" is true for humans as well. We are genetically wired to process new ideas the same way that Norwegian rats consider trying new foods - we steer clear because we know its "safe." Our mammalian brain ushers us through life with skepticism and a reluctance to change from scientifically sound.

Stories like this are not uncommon in the medical profession, even today. There is a disconnect between the evidence and clinical practice. As you are reading this, a patient is receiving a treatment that will provide no value, or even worse, one that may cause them harm. The book Ending Medical Reversal: Improving Outcomes, Saving Lives by Cifu and Prasad, describes numerous "gold standard" practices that have been reversed, and some that are still being practiced today to the detriment of quality patient care (e.g., knee arthroscopy and spinal surgery).

Similarly, in pediatrics, national guidelines state that outcomes from out-of-hospital pediatric arrest haven’t changed since the 1980’s. This, even with mountains of evidence directing EMS professionals to stay on scene and...
provide high quality resuscitative care. "Scoop and run" remains the rule, rather than the exception in this country today, leading to substandard care for children in cardiac arrest. Current evidence supports equal care for children and adults, giving those who are most vulnerable patients the same, high quality care in the field as their adult counterparts. This is accomplished by staying on scene for non-traumatic cardiac arrest, providing high quality CPR, administering epinephrine early (within 10 minutes), and rapidly securing the airway. The evidence is clear that these measures should be taken, yet most EMS agencies today still have difficulty doing it; instead doing what they’ve always done.

So how do we as health care providers help usher good evidence based solutions into practice in a timely manner? The neophobes (late adopters) need a better vehicle to help them transition from ‘what they’ve always done’ to ‘doing what’s right.’ In other words, they need better guidance. Medical associations and influencers within those organizations must disseminate best practices to reach even those who practice in remote locations. One good example is the NAEMSP who works to ensure that their members are kept abreast of best practices by providing timely research and policy statements as the data becomes available. Medical associations like this can have a powerful impact by remaining current, creating policies based on evidence, and by suggesting prescriptive action plans to healthcare providers, both in the field and in the hospital. Alternatively, social media should be used as a vehicle for rapid knowledge translation. Podcasters like Ken Milne, MD of The Skeptics Guide to EM, aim to “cut the knowledge translation window from over 10 years down to less than 1 year.” Clinicians like Dr. Scott Weingart, Eric Bauer, Ginger Locke, and Dr. Rob Dickson have also gained significant traction in the FOAMed community, significantly closing the healthcare knowledge translation gap. Savvy researchers now use the social platforms to their advantage instead of relying on the journal publication alone.

Moreover, relevant progress requires progressive thinkers at the local level as well. Pre-hospital leadership and medical direction must have their finger on the pulse of the best evidence to be able to affect change. This is how high quality evidence based care reaches the front lines. An excellent example of this can be found in Central Florida, where Polk County Fire Rescue embraced a “new” evidenced based strategy in 2014 and in 2017 reported 3-year outcome data. The agency’s pediatric medical cardiac arrest statistics, rose from 0% neurologic intact survival to 35% year after year. The department’s findings will be published in a peer-reviewed journal later this year. The question is, what will happen next? How will survival data, that dwarfs historical norms, get translated into clinical practice rapidly so that other agencies can save more lives?

Translation of clinical research into everyday practice takes a predictable path towards full scale adoption, and contrary to popular belief, a single study in a reputable journal will not change clinical practice. It’s the first step in, what history proves to be, a 10-year struggle towards mass adoption. Dr. Semmelweis learned this the hard way back in 1847, when he saw his “life saving” finding (hand washing) take 20 years to become the widely accepted standard. Another notable historical example is hands-only CPR, which took over 10 years from the first study until it became standard of care. More recently, e-CPR, which stands for ECMO CPR, is early in its translational life-cycle, and will likely not get to scale for at least 5 to 7 more years, even though the evidence supporting it is overwhelming.

As medical professionals, understanding the gaps that exist in clinical translation is critical. Digging deeper into why (and how) change occurs in medical practice will allow high quality, evidence based items to be ushered in quickly so that clinicians can more readily “let go” of harmful or outdated practices. The ever changing body of information that healthcare must be handled in a deliberate fashion, from creation, through adoption, and then mass distribution so that clinicians can more readily “let go” of harmful or outdated practices. The ever changing body of information that healthcare must be handled in a deliberate fashion, from creation, through adoption, and then mass distribution so that clinicians can more readily “let go” of harmful or outdated practices. The ever changing body of information that healthcare must be handled in a deliberate fashion, from creation, through adoption, and then mass distribution so that clinicians can more readily “let go” of harmful or outdated practices. The ever changing body of information that healthcare must be handled in a deliberate fashion, from creation, through adoption, and then mass distribution so that clinicians can more readily “let go” of harmful or outdated practices. The ever changing body of information that healthcare must be handled in a deliberate fashion, from creation, through adoption, and then mass distribution so that clinicians can more readily “let go” of harmful or outdated practices. The ever changing body of information that healthcare must be handled in a deliberate fashion, from creation, through adoption, and then mass distribution so that clinicians can more readily “let go” of harmful or outdated practices. The ever changing body of information that healthcare must be handled in a deliberate fashion, from creation, through adoption, and then mass distribution so that clinicians can more readily “let go” of harmful or outdated practices.

In the Medication category, many events are associated with high risk medications such as anti-coagulants, opioids, and insulin. The utilization of Narcan was also noted with the opioid events.

Overall communication, leadership and culture are causal factors associated with many of the reported events. Some of the takeaways include, evaluating processes regarding communicating medication reconciliation, leadership support and a culture that supports healthcare workers in the face of abusive/violent behavior by patients.

For more information please download our CPS PSO Annual report and also our Healthcare Forward Report.
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. Using a standardized survey tool can provide measurable and meaningful feedback. CPS has been a longtime supporter of the Agency for Healthcare Research and Quality’s (AHRQ) Survey on Patient Safety (SOPS™) Culture assessment. With international acceptance and available benchmarks, the assessment tool is a valid and sound option for culture measurement. CPS administers all of the AHRQ-developed surveys, including hospitals, ambulatory surgery centers, pharmacies, medical offices and nursing homes.

CPS recently collaborated on the design of an assessment specifically for EMS to provide a measurable snapshot in time of the agency’s safety culture. Developed in conjunction with the National Registry of EMTs, the survey questions used in the assessment were tested extensively to ensure their relevance and appropriateness. CPS utilized the familiar dimensions of the AHRQ surveys in the development of the EMS survey and now supports a national database of survey results to provide benchmarks to the EMS industry. The survey is available through the CPS website.

BY ALEX CHRISTGEN, CPPS, CPHQ
CENTER FOR PATIENT SAFETY

You can only improve what you measure.
Without measuring, you have no way to know if you are improving. These statements are especially true when it comes to assessing your culture. It may be easy to take a quick poll of staff and extrapolate their perceptions to that of the entire organization, but there’s no certainty in your results.

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.

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

HOW DOES YOUR ORGANIZATION MEASURE UP?

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. Using a standardized survey tool can provide measurable and meaningful feedback. CPS has been a longtime supporter of the Agency for Healthcare Research and Quality’s (AHRQ) Survey on Patient Safety (SOPS™) Culture assessment. With international acceptance and available benchmarks, the assessment tool is a valid and sound option for culture measurement. CPS administers all of the AHRQ-developed surveys, including hospitals, ambulatory surgery centers, pharmacies, medical offices and nursing homes.

CPS recently collaborated on the design of an assessment specifically for EMS to provide a measurable snapshot in time of the agency’s safety culture. Developed in conjunction with the National Registry of EMTs, the survey questions used in the assessment were tested extensively to ensure their relevance and appropriateness. CPS utilized the familiar dimensions of the AHRQ surveys in the development of the EMS survey and now supports a national database of survey results to provide benchmarks to the EMS industry. The survey is available through the CPS website.

BY ALEX CHRISTGEN, CPPS, CPHQ
CENTER FOR PATIENT SAFETY

You can only improve what you measure.
Without measuring, you have no way to know if you are improving. These statements are especially true when it comes to assessing your culture. It may be easy to take a quick poll of staff and extrapolate their perceptions to that of the entire organization, but there’s no certainty in your results.

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.

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

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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.