



In 1999 the Institute of Medicine estimated that between 44,000 and 98,000 people were dying in hospitals each year as a result of medical mistakes. The sobering statistics prompted the Institute to call for healthcare providers to decrease the number of medical errors by 50 percent.

PATIENT SAFETY ORGANIZATIONS:

*Safe havens for your quality
& safety data*

Ten years later, the Consumers Union Safe Patient Project noted, "... a million lives have been lost and billions of dollars have been wasted because efforts to reduce the harm caused by our medical care system are few and fragmented."¹ An estimated 13.5 percent of hospitalized Medicare beneficiaries experienced adverse events during their hospital stays in 2008. Approximately 1.5 percent experienced an event that contributed to their deaths, which projects to 15,000 patients in a single month.²

The sad fact is, in emergency medical services (EMS), we don't really know the number of errors that are occurring, which also means we don't know the number of lives we are negatively impacting.

As healthcare providers, we have an ethical responsibility to do everything possible to reduce the number of medical errors. That's where participation in a PSO benefits EMS, as PSOs are specifically designed to improve the quality and safety of America's healthcare in a confidential and protected environment.

WHAT IS THE PURPOSE OF A PSO?

The Patient Safety and Quality Improvement Act of 2005 established a framework by which hospitals, physicians, and other healthcare providers including EMS, may voluntarily report patient safety event information to a PSO on a privileged and confidential basis for aggregation and analysis. The Act provides safety by decreasing the fear of malpractice litigation due to inadequate protection by state laws.

Because of the built-in confidentiality and protection, PSOs offer external advice for healthcare providers seeking to understand and minimize the risks and hazards in delivering patient care.³ This means healthcare providers can safely discuss events and share lessons learned, resulting in the rapid dissemination of information and quick implementation of reliable interventions for improving patient safety.

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WHAT ARE THE BENEFITS TO EMS PROVIDERS TO PARTICIPATE IN A PSO?

1. A CONFIDENTIAL AND RELIABLE FRAMEWORK

Before the establishment of PSOs, there was limited and often unreliable or nonexistent legal protection for patient safety and quality improvement data and information. Today EMS and other healthcare providers can submit information to PSOs as independent, external experts that collect, analyze, and aggregate the data. This information is shared locally, regionally, and nationally to identify root causes of patient events. All data, documents and communication among PSO participants are protected, allaying fears of increased risk of liability, and expanding sharing and prevention opportunities.

2. LESSONS FOR IMPROVEMENT

Healthcare providers learn from the PSO and from one another. With the legal protection, PSOs can work with multiple providers to aggregate larger numbers of patient safety events to better understand the underlying causes of patient harm. Sharing processes and lessons learned results in the development of more reliable interventions to improve patient safety across the continuum of care. The more data that is submitted to the PSO, the better the framework for analysis and the more opportunities for learning.

The Agency for Healthcare Quality and Research (AHRQ) intends for data submitted to PSOs to increase our understanding of the nature of risks and successful risk-reduction strategies across the nation. While PSO data cannot support the establishment of rates, true benchmarking or trending, it does provide participants with qualitative information that can enhance the culture of safety, accelerate learning and support safer, higher quality care.³

WHAT SHOULD BE REPORTED TO THE PSO?

Participants are encouraged to submit any type of medical error or patient event, including:

- incidents that reach patients
- near-misses that don't reach the patient
- any unsafe conditions that increase the probability of a patient event

In addition, PSOs provide a haven for EMS providers to safely submit and discuss events, root causes and other information, which previously have had no legal protection.

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Utilizing Checklists for Intrahospital Transport Decreases Patient Events

Checklists are being utilized for many things throughout health-care, including EMS. A study recently published in the October 2012 issue of the American Journal of Emergency Medicine showed the use of a checklist for intrahospital transports decreased the overall incidence of unexpected events from 36.8% to 22.1%. The checklist addressed such items as making sure patient name band was in place; an adequate oxygen supply; functioning blood pressure and EKG monitoring; presence and function of stretcher side rails; vital signs and mental status, among other items. This checklist also accounted for a decrease in unexpected events related to clinical status of the patient from 9.1% to 5.2%. Specific education and training took place for all staff involved in the use of the checklist, both in EMS and in the hospital ED setting, prior to them being put in to place.

If you have a checklist you use at your agency for any process, procedure, or protocol, and would like to share it with other EMS PSO participants, please contact Carol Hafley or Eunice Halverson at the Center!

ECRI Institute Patient Safety Center. Retrieved Nov. 13, 2012 from https://www.ecri.org/PatientSafety/HrcReports/Pages/AlertListing.aspx?alert=6194&ref=https://www.ecri.org/PatientSafety/HrcReports/Pages/HRC_Public_Alerts.aspx&cm_mid=1806143&cm_crmid=%7bABB0C9F-1DAF-E111-B6DB-005056930045%7d&cm_medium=email

EMS PSO UPDATE

We are proud to report we now have contracts with 64 ambulance services, and are anticipating this number to continue to grow through the end of 2012 and well in to 2013. We also have 11 more agencies that have completed their PSO policy, attended training, and are now ready to report medical error information to the PSO. Congratulations to all! ●

EMS Agencies Participating in Medication Administration Practices Research Study

The Center has been working with Sedgwick County EMS in Wichita, Kansas, on a medication administration practices research study. Paul Misasi, Deployment and Quality Improvement Manager with the agency, is heading up the study and asked for participation from Missouri agencies, along with other from across the nation.

Through your participation in the PSO, the CPS is able to facilitate this survey and provide PSO protection for the survey respondents and results. Six of our agencies have elected to administer the survey. It is only 20 questions, and should take no longer than 10 minutes to complete.

If you are interested in having your agency participate, please contact Carol Hafley at the Center. The survey is scheduled to begin Monday, December 3. ●

PSO Federal Protections Upheld in Walgreens Case

ON MAY 29, 2012, AN ILLINOIS APPELLATE COURT UPHELD A LOWER COURT'S DECISION THAT PATIENT SAFETY WORK PRODUCT (PSWP) IS PRIVILEGED AND NOT SUBJECT TO DISCOVERY UNDER THE 2005 PATIENT SAFETY AND QUALITY IMPROVEMENT ACT (PSQIA).

CASE OVERVIEW

- The Illinois state department responsible for professional licensing (IDFPR) subpoenaed "all incident reports of medication error" involving certain Walgreens pharmacists.
- Walgreens asserted these materials were submitted to its Patient Safety Organization (PSO) and therefore part of PSWP and not subject to discovery rules under the PSQIA.
- IDFPR sued Walgreens, arguing that the documents were retained for purposes other than reporting to a PSO, and thus not protected.
- The lower court dismissed IDFPR's petition and declared the incident reports to be protected as PSWP, as defined by Walgreen's PSO policies.
- IDFPR appealed.

In summary, the Illinois appeals court determined that the purpose of the law is to encourage a "culture of safety" and quality in the U.S. healthcare system by providing broad confidentiality protections of information collected and reported voluntarily for the purpose of improving patient care. They upheld the protection of patient safety work product based upon two affidavits prepared by Walgreens which clearly satisfied the requirements of the law, resulting in protection for the subpoenaed documents. The court cited the broad language of the PSQIA in protecting PSWP from discovery in connection with a federal, state, or local civil, criminal, or administrative proceeding.



WHAT DOES THE RULING MEAN FOR EMS PROVIDERS?

- It reinforces the value of participating in a PSO to define and secure protection of your quality improvement work being carried out for the purpose of improving patient care
- This state court ruling applies the federal PSQIA protections more broadly than the state privilege laws, highlighting the opportunity for PSQIA protections to fill gaps in state peer review law protections.
- Licensed health care providers, such as hospitals, physicians, and emergency medical services, can take advantage of the discovery privilege by contracting with a PSO, establishing a Patient Safety Evaluation System (PSES), collecting and submitting documents, data, evaluations and conducting other protected activities.

The ruling further reinforces the recommendations for PSO participants to ensure maximum protection:

- Carefully review policies to ensure your patient safety evaluation system and patient safety work product are clearly defined
- Segregate and secure PSWP
- Clearly label PSWP to prevent unauthorized disclosure
- Submit PSWP to the PSO with appropriate documentation
- Establish a process to evaluate and manage requests for PSWP from organizations and individuals outside of your organization's defined "workforce." ●

Reference: Illinois Department of Financial and Professional Regulation (IDFPR) v. Walgreen, Company, 2012 IL App (2d) 110452, No. 2-11-0452 (May 29, 2012)

GET HELP WRITING YOUR PSO POLICIES AND PROCEDURES

So your PSO contract is signed, all is good, right? Wrong. You're not finished yet. If you have not written your agency's PSO policy, AND you have not reported any information to the PSO, then you do not have your confidentiality protections in place. Why, you ask? It is because of the way the Final Rule, or regulations which implement the Patient Safety and Quality Improvement Act, are written. Every provider who is participating with a PSO must define a patient safety evaluation system for their organization AND declare what documents are considered to be patient safety work product. This allows you to "custom-fit" those protections around as much or as little of your current quality improvement practices as you wish.

Think about your current procedure for reviewing trip reports. If you are a smaller service, you may perform a quick review of every call, checking for a few key points, and when you see deviations from your protocols, you send them on to your Medical Director for review. Your Medical Director may utilize a paper comment form to provide feedback, or perhaps you have an electronic trip reporting system that also features a QA module, which your Medical Director can access to pull up the trip report, enter comments and send them directly to the crew who ran the call. This is the type of information you can protect within a patient safety evaluation system. An easier way to think about it – picture an umbrella sitting over your current quality improvement process, protecting those documents from a rain storm – or from an attorney.

CPS has a policy template you can use to build this process specific to your agency's needs. For assistance, please contact Jason White; Eunice Halverson; or Carol Hafley for assistance. ●

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To be successful, agency administrators and managers should support and encourage staff to report medical errors and near-misses both within their agency and to the PSO, without fearing that their reports will be used against them. Taking this step will contribute to an improved safety culture within your agency and ultimately reduce patient harm.

HOW CAN THE CENTER FOR PATIENT SAFETY HELP?

The Center PSO is a seamless and safe way for EMS providers to add federal confidentiality and peer review protection to quality and patient safety data. We also can help you collaborate with other EMS agencies to reduce the frequency of serious events.

The Center has partnered with Quantros to offer a web-based system for easy reporting, management and submission of medical error data to the PSO, providing the framework of a Patient Safety Evaluation System (PSES) for each participating provider.

The Center fosters collaboration and knowledge-sharing opportunities among providers within Missouri and around the country, promoting discussions under the umbrella of PSO protections. ●

- 1 - www.safepatientproject.org/2009/05/to_err_is_humanto_delay_is_dea_1.html
- 2 - <http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf>
- 3 - <http://www.pso.ahrq.gov/psos/fastfacts.htm#ff03>

FOR MORE INFORMATION

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For additional information on the Center's PSO activities, resources, toolkits, upcoming events, and more, please visit our website at www.emspso.org or www.centerforpatientsafety.org or follow us on Twitter @PtSafetyExpert for the most up-to-date news.

UPCOMING EVENTS

NOVEMBER 27 - 28, 2012 – American Ambulance Association Convention, Las Vegas, NV. The Center is hosting booth #418. Please come and visit us!

DECEMBER 4, 2012 – EMS PSO Advisory Committee Meeting, 10am-2pm at Primaris in Columbia (*invitation only*)

MAY 7, 2013 – Fourth Annual EMS Patient Safety Conference - at Stoney Creek Inn, Columbia, Missouri, featuring:

- **Paul LeSage**, Outcome Engenuity
- **Ivan Pupilidy**, Human Performance Specialist with the US Forest Service, former EMT and active US Air Force Reserve member
- **EMS Culture of Safety**, update on national project
- **and much more - so save the date and stay tuned for more information!** ●

ABOUT THE CENTER

The Missouri Center for Patient Safety, dba Center for Patient Safety, was 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 health care environment safe for all patients and healthcare providers, in all processes, all the time.