CHPSO
California Hospital Patient Safety Organization

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CEO Holds Key to Improved Outcomes

Research in nuclear energy, aviation and other innovative industries indicates that these high-reliability industries place a premium on safety as an integral part of the organization's culture, and the CEO occupies the leading role in fostering that culture. CEO involvement takes two primary forms: high-visibility leadership promoting organizational safety attitudes, behavior and performance and participation in industry-driven initiatives and activities whose results could be felt industry wide. These industries rely on peer pressure created by open communication and mutual accountability, which drives the development of safety standards and best practices that yielded behavior change and impressive results.

In the healthcare industry, there is an opportunity to develop a robust patient safety culture. The vision and visibility needed to drive a cultural transformation belongs to the CEO. Organizations can focus on the needs of CEOs in this area by supporting top executives' efforts to enhance their patient safety leadership skills and delivering this support in ways that they would find most effective given their busy schedules.

A market research survey of hospitals and system CEOs indicated:

- They feel a responsibility to highlight patient safety as more than just another management challenge.
- Most indicated no formal training or a clinical background in safety issues and expressed a desire to develop knowledge and skills in this area.

Examples of what different health systems have implemented to improve CEO involvement in patient safety:

- Offer a safe, confidential forum through which CEOs can accelerate their patient safety leadership skills by exploring ideas and sharing experiences with those whose professional judgment they value most highly — other CEOs
- Recognize that the culture of safety needs to come from the top down and from the bottom up
- Don't talk about safety as a priority; think about it as a core value.
- Include safety goals in the strategic plans for every executive.
- Have the Board of Trustees review quality and safety updates every meeting.
- Place quality and safety before finance on the board agenda.
- Start a senior leadership huddle.
- Reinforce key behaviors as well as addressing system issues.
- Believe in the power of story telling and the impact it has on behavior.
- Remove barriers between administrative and clinical staff by having CEOs:

  Participate daily in rounds of selected clinical units to see the problems and improvements.

  Reinforce patient safety messages.

  Commend units that have performed well and communicate that commendation in person.

It is the responsibility of the CEOs and goes to the core of what their jobs are all about: improving the healthcare of the people in their communities.

— Bobbie Dietz, bdietz@chpso.org

Reference

Birk S. Creating a culture of safety: why CEOs hold the key to improved outcomes. *Healthcare executive*. 24(2):14-6, 18, 20 *passim*.

QA vs. QI: The Battle Royale

From QA to QI

In my last column, I told the story of how I first came to test my assumption that clinical peer review would be forever antithetical to quality improvement. Today, I'd like to outline for you the characteristics that differentiate a QI model for peer review from the dysfunctional, legacy QA model. The QI model frames peer review as a quality improvement activity, not only to improve the process itself, but to better support the effort to improve clinical performance and patient safety. It's a battle for the hearts and minds of the medical profession that will affect nursing as well: the way we know vs. the way it could be.

In both national studies, I found that the more peer review looks like QI instead of QA, the more effective it seems to be. As you can see from the table of comparisons, the qualitative differences are dramatic.

Paradoxically, for all the fear it has generated, the QA model has done little to generate accountability for improvement. This is probably because the threshold for action is so high that only the most egregious situations are addressed. In part, this stems from the poor reliability of the typical approach case review which looks only at whether the standard of care was met. It also confuses performance with competence.

The QI model holds that a single case review speaks primarily to situational performance. It deploys a more reliable, balanced methodology that is suited to data aggregation and seeks to extract whatever can be learned to improved clinical performance.

The QI model continues to evolve. For example, case identification has long been a problem. Most programs still rely on inefficient generic screens. Recognizing the sad reality that physicians always know when an adverse event occurs, but are often blocked from sharing and learning for fear of recrimination, I added case identification via self-reporting. The federal protections of the Patient Safety and Quality Improvement Act of 2005 offer a simple mechanism to make it safe to self-report. I'll share more about that in a future column. Meanwhile, evaluate your own peer review program against the QI model at QAtoQI.com/set.htm.

The theme of personal and organizational learning turns out to be critical to safety culture and quality improvement. Peer review is only part of the story.

Coming Next: 3 Modes of Learning

— Marc T. Edwards, MD MBA, QA to QI Consulting, marc@QAtoQI.com

QA & QI Models Compared

Dimension	QA Model	QI Model
Focus	Outliers	Shift the curve
Identify	Substandard care	Learning opportunity
Determine	Competence	Performance
Inputs	Single case	Multiple cases
Case Finding	Generic screens	Self-reporting
Method	Judgment	Measurement
Process	Variable	Standardized
Reliability	Low	Good
Leverage Point	Expert opinion	Aggregate data
Orientation	Reactive	Proactive
Cultural Drivers	Fear, Punishment	Trust, Fairness, Collegiality
Data Capture	"Leveling" against care standards	Multiple elements of performance
Relation to QI process	Isolated	Highly interdependent
Governance	Laissez faire	Attentive
Accountability	Low	High
Ultimate Process Outputs	Corrective action	System improvement, Recognition of clinical excellence, Performance feedback
ROI	Low	High

Fentanyl Patch Use Guide Released

The document High Alert Medication Guideline — FentaNYL Transdermal Patch, developed by the California Hospital Association's Medication Safety Committee, summarizes strategies to reduce preventable harm to patients in the hospital setting. These strategies address all stages of the medication process: (a) ordering/prescribing, (b) transcribing and verifying, (c) dispensing and delivering, (d) administering and (e) monitoring and reporting. If you would like to provide any feedback on the fentanyl guideline, please email dharms@calhospital.org.

"Despite warnings from the FDA, manufacturers, and various patient safety agencies, fentanyl transdermal patches continue to be prescribed inappropriately to treat acute pain in opiate-naïve patients, sometimes in large doses or in combination with oral or intravenous opiates." — ISMP (Institute for Safe Medication Practices)

To subscribe: join-chpso@lists.calhospital.org (subject and message will be ignored)
Questions or comments: Rory Jaffe, MD MBA rjaffe@chpso.org

Fentanyl patches are only for patients who are opioid-tolerant for the management of persistent, moderate to severe chronic pain that requires continuous, around the clock opioid administration for an extended period of time and cannot be managed by other means. The patches are *not* to be used to treat sudden, occasional or mild pain or pain after surgery.

— Rory Jaffe, MD MBA, rjaffe@chpso.org

About the Medication Safety Committee

The Medication Safety Committee is a statewide, multi-disciplinary collaboration of health care providers, regulatory agencies, patient safety organizations and organizations representing pharmacists, physicians and nurses. The Committee has focused on acting as a source of medication safety expertise, providing a venue for the coordination of medication safety activities and making recommendations related to medication safety legislation and regulations.

Brief Notes

da Vinci Surgical Devices

Over a four year period the FDA has received 26 adverse event reports associated with the da Vinci computer-assisted surgical device manufactured by Intuitive Surgical, Inc. The reports were submitted by 15 hospitals between January 2004 and May 2007. The most common reported device problems were instrument breakage, particulate matter falling off instruments and failure of the electromechanical arms to manipulate instruments.

CHPSO has developed a single-page event review form (similar to the Retained Surgical Items form) to collect information to help us understand how and why there might be problems with the computer-assisted surgical devices. Learning from both near misses and actual events will help us better protect our patients.

This is a voluntary data collection program for those CHPSO members electing to participate. To avoid potential overlap of data collection with the Retained Surgical Items program, we are asking that for a single episode you fill out one form or the other, but not both forms. Please use the da Vinci data collection form when the issue is a device malfunction.

We anticipate having the da Vinci Surgical Device data collection form ready to roll out the week of September 12.

September 12 Member Call Agenda

Initiative Updates:

- Retained Surgical Items (RSI)
- Just Culture Roadmap & Toolkit

New Initiatives:

- Da Vinci Surgical Devices
- Handoff Survey
- CHPSO Annual Meeting Agenda Topics Survey
- FMEA Pilot Project

Member Time for Requests/Feedback/Concerns

Quantros SRM Customers

Current Quantros SRM (incident report system software) customers should contact Quantros support if interested in activating technology to automate transmission from SRM to the CHPSO database. Contact information is support@quantros.com.

Handoff Survey

Handoffs are a frequent daily occurrence as patients transverse the healthcare system for procedures and tests, changing levels or types of care, change of shift and so forth. The Joint Commission recently identified 37 percent of handoffs as defective. Communication between the sender and receiver is often cited as major contributing factor to the success of handoffs. In a collaboration with the North Carolina Center for Hospital Quality and Patient Safety, CHPSO is making available to its members a survey (available September 12) to see how organizations are dealing with this issue. Your answers will help determine how we can assist members with this relevant topic and also has the potential for shared learning among PSO members.

CHPSO Annual Meeting

We are planning the first annual California Hospital Patient Safety Organization statewide meeting that will be held first quarter 2012.

A Planning Committee has been created to advise on meeting goals, speakers and to draft agenda topics. The Planning Committee is requesting CHPSO members to provide feedback on topics of interest they would like presented at the annual meeting. We strive to have agenda topics and discussions that meet the needs of your organization.

On September 12, CHPSO will release an Annual Meeting survey for agenda topics. Your feedback is important to us and this survey is an opportunity to help establish the meeting agenda topics that would be beneficial to your organization towards eliminating preventable patient harm.

MERP Survey Information

As a reminder, the California Department of Public Health has a Medication Error Reduction Plan (MERP) Program web site with useful information about the survey. Additionally, MERP-related questions or comments may be sent to MERP@cdph.ca.gov.

Calendar

The following upcoming events are still open for enrollment. For more information or to enroll, use the contacts listed below.

September

7: *CHPSO*: Just Culture Roadmap and Toolkit workgroup call. 9–10 AM

9: *CAPSAC*: California Patient Safety Action Coalition meeting. Sacramento.

12: *CHPSO*: Members Call. 10–11 AM

13: *SCPSC* (Southern California Patient Safety Collaborative): Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

14: *PSCSD&IC* (Patient Safety Council of San Diego & Imperial Counties): Preventing Rehospitalizations Network (PRN). San Diego.

21: *CHPSO*: Just Culture Roadmap and Toolkit workgroup call. 9–10 AM

27: *SCPSC*: Perinatal Monthly Webinar. 12:15 PM

27: *PSCSD&IC*: Sepsis/HAI Elimination. San Diego.

October

10: *CHPSO*: Members Call. 10–11 AM

11: *PSCSD&IC*: Lean Practitioner Course. San Diego.

20: *PSCSD&IC*: Standardizing Dosing Limits. San Diego.

25: *SCPSC*: Perinatal Monthly Webinar. 12:15 PM

26: *PSCSD&IC*: ICU Improvement Collaborative. San Diego.

November

2: *PSCSD&IC*: Preventing Rehospitalizations Network (PRN). San Diego.

8: *SCPSC*: Track I — Hospital Acquired Infections in the ICU Setting, Sepsis and Surgical Care Improvement Project. Industry Hills.

8: *PSCSD&IC*: Lean Practitioner Course. San Diego.

14: *CHPSO*: Members Call. 10–11 AM

15: *SCPSC*: Track III — Perinatal Care. Industry Hills.

15: *PSCSD&IC*: Ending Elective Deliveries Before 39 Weeks Gestation. San Diego.

29: *PSCSD&IC*: Lean Practitioner Course. San Diego.

December

2: *CAPSAC*: California Patient Safety Action Coalition meeting. Torrance.

12: *CHPSO*: Members Call. 10–11 AM

13: *SCPSC*: Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

13: *PSCSD&IC*: Lean Practitioner Course. San Diego.

13: *PSCSD&IC*: Sepsis/HAI Elimination. San Diego.

15: *PSCSD&IC*: Standardizing Dosing Limits. San Diego

For further information on these events:

CAPSAC: John Keats John.Keats@CHW.edu or www.capsac.org

CHPSO: Rory Jaffe rjaffe@chpso.org

PSCSD&IC: Lindsey Wade lwade@hasdic.org

SCPSC: Julia Slininger jslininger@hasc.org

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About This Newsletter

CHPSO Patient Safety News provides lessons learned from reviews of patient-safety events and news of patient-safety activities in this state. We hope you will find it useful in your efforts to improve patient outcomes. This newsletter may be freely distributed in its original form. Copies of each newsletter are archived on the CHPSO website (www.chpso.org).

Prospective authors may submit articles to Rory Jaffe, MD, MBA: rjaffe@chpso.org, 916.552.7568. Typical articles will be brief — between 200 and 600 words. A completed publication agreement form must be submitted prior to publication.