about us

Our Mission: Eliminating preventable harm and improving the quality of health care delivery.

CHPSO membership remained steady in 2018 with over 400 members in 10 states: AZ, CA, CO, HI, NM, NV, OR, RI, TX, and WA. These members contributed to a growing database of over 1.9 million safety events.

As part of the Hospital Quality Institute (H.Q.I.), CHPSO cross-pollinates with the HSAG-HIIN, and Partnership for Patient Engagement (P4Px) programs.

participate

CHPSO works with members to facilitate and streamline the data submission process. CHPSO partners with NextPlane Solutions for members to connect to the CHPSO database, saving hospitals the cost of specialized solutions.

With NextPlane Solutions, members generate an Excel spreadsheet or plain text report delimited by commas or other characters.

The entire process, including taxonomy mapping, generally takes up to three hours for the initial submission.

For more information, contact CHPSO at info@chpso.org or visit our website www.chpso.org

benefits

• Patient Safety Work Product (PSWP) privilege
• Collaborate and problem solve with other providers
• Periodic safety event evaluations
• Bi-weekly Safe Table meetings
• Custom research requests
• Event feedback and consultation
• Educational webinars
• Alerts and bi-monthly newsletters
• Legal counsel discussion group
• Job board
CHPSO celebrated its 10-year anniversary November 5

Originally named the California Hospital Patient Safety Organization, CHPSO, now known simply by its acronym, operates under the Patient Safety and Quality Improvement Act of 2005. More than 80 Patient Safety Organizations (PSO) are listed by the Agency for Healthcare Research and Quality (AHRQ).

CHPSO, a division of the Hospital Quality Institute, is one of the first, largest, and most transparent PSOs, providing healthcare organizations with federal protection of Patient Safety Work Product (PSWP). Members share their safety events with CHPSO and in return, CHPSO analyzes and de-identifies these events, sharing information and resources with members and the public.

Founded in November 2008, with the support of the California Hospital Association and the regional hospital associations in California, CHPSO serves over 400 healthcare organizations in 10 states: Arizona, California, Colorado, Hawaii, New Mexico, Nevada, Oregon, Rhode Island, Texas, and Washington. With over 1.9 million safety events submitted to the CHPSO database so far, members receive specific evaluations and analyses of these events.

One of CHPSO’s benefits to members are the Safe Table forums. These meetings are typically one hour in length via teleconference and a topic is preselected to allow attendees to share cases or feedback. With over 20 meetings offered each year, attendees can learn of new safety issues, understand that other providers may experience similar issues, and share the lessons learned with their teams. These frank discussions are protected under PSWP privilege and attendees are free to share safety events with their peers.

Another area where members widely benefit from sharing safety events is CHPSO’s history of collaborating among PSOs, and other regional, state, and national organizations. As the convener of the Nationwide Alliance for Patient Safety Organizations (NAPSO), CHPSO meets quarterly with other PSOs with the purpose of providing a platform for collaboration and support. The CHPSO team also works with AHRQ, the Office of the National Coordinator, the Association for the Advancement of Medical Instrumentation, the California Maternal Quality Care Collaborative, and the National Quality Forum.

Thank you to our members and colleagues for making CHPSO a success. Your support and contributions to patient safety sustain and drive CHPSO in its mission to eliminate preventable harm!
Dr. Rory Jaffe, CHPSO Founder & Executive Director, Retired

Dr. Rory Jaffe, Executive Director and Founder of CHPSO, retired in January 2019.

Dr. Jaffe and the “small but mighty” CHPSO team have built our PSO to become the longest tenured and largest in the United States with more than 400 members across the country, from Hawaii to Rhode Island.

Thanks to his diligence, CHPSO has a database of more than 1.9 million safety reports for review, study and research. The database allows CHPSO to share alerts and lessons learned on how to improve health care reliability and safety with the public and the CHPSO community.

Dr. Jaffe pioneered the Safe Table discussion format which employs a case study method to facilitate frank, open discussions among CHPSO members about patient safety issues in a confidential, legally protected environment.

Prior to founding CHPSO, he was the Executive Director of Medical Services for the University of California system. In this role, he served as the senior physician providing oversight on HIPAA and regulatory compliance, as well as quality of care at the hospitals, medical profession schools, medical research activities and student health centers.

Dr. Jaffe’s experience has served California hospitals and the nation well, aiding in understanding risk and creating systems for greater safety and resilience in all aspects of care delivery. He has additionally served on many federal and state advisory committees and expert panels in a broad array of topics.

His name is synonymous with PSO leadership and innovation, evidenced by being asked to work with AHRQ for a year to improve the PSO system and advance the field of safety. Just recently, Dr. Jaffe was successful in leading a multi-year multi-site $2.8 million grant to improve prescribing safety in the ambulatory setting. The work will continue under his team of colleagues at CHPSO.

At Dr. Jaffe’s retirement party, he was presented with an Achievement Award for excellence in patient safety. He will be missed not only for his extensive contributions to patient safety and quality improvement, but also for his willingness to share his extensive knowledge with which he was so generous.
member listing

- Mercy San Juan Medical Center, Carmichael
- Methodist Hospital of Sacramento, Sacramento
- Methodist Hospital of Southern California, Arcadia
- Mid Valley Comprehensive Health Center, Van Nuys
- Miller Children’s and Women’s Hospital Long Beach
- Mills Health Center, San Mateo
- Mills-Peninsula Health Services, Burlingame
- Mills-Peninsula Medical Center, Burlingame
- Mission Heritage Medical Group, Mission Viejo
- Mission Hospital Laguna Beach, Laguna Beach
- Modor Medical Center, Altadena
- Montclair Hospital Medical Center, Montclair
- Monterey Park Hospital, Monterey Park
- MPHP Senior Focus, Burlingame
- Natividad Medical Center, Salinas
- Nix Behavioral Health, San Antonio, TX
- Nix Hospitals System, LLC, San Antonio, TX
- Nix Medical Center, San Antonio, TX
- Nix Specialty Health Center, San Antonio, TX
- NorthBay Healthcare Corporation, Fairfield
- NorthBay Medical Center, Fairfield
- NorthBay Vac Valley Hospital, Vacaville
- Northridge Hospital Medical Center, Northridge
- Novato Community Hospital, Novato
- O’Connor Hospital, San Jose
- Ojai Valley Community Hospital, Ojai
- Olive View – UCLA Medical Center, Sylmar
- Olympia Medical Center, Los Angeles
- Orange Coast Memorial Medical Center, Fountain Valley
- Orange County Global Medical Center, Santa Ana
- Ose Adams Medical Pavilion, Sacramento
- Our Lady of Fatima Hospital, North Providence, RI
- Pacific Alliance Medical Center, Los Angeles
- Pacific Central Coast Health Centers, San Luis Obispo
- Pacific Diagnostic Laboratories, Santa Barbara
- Palmdale Regional Medical Center, Palmdale
- Palo Alto Medical Foundation, Palo Alto
- Palomar Health, Escondido
- Palomar Medical Center Downtown, Escondido
- Palomar Medical Center, Escondido
- Palomar Medical Center Poway
- Paradise Valley Hospital, National City
- Parkview Community Hospital Medical Center, Riverside
- Petaluma Valley Hospital, Petaluma
- PH Health Hospital – Whittier, Whittier
- Pioneers Memorial Healthcare District, Brawley
- Platte Valley Medical Center, Brighton, CO
- Plumas District Hospital, Quincy
- Pomona Valley Hospital Medical Center, Pomona
- Prebys Cardiovascular Institute, La Jolla
- Providence Health & Services – Southern California, Torrance
- Providence Holy Cross Medical Center, Mission Hills
- Providence Little Company of Mary Medical Center, San Pedro, San Pedro
- Providence Little Company of Mary Medical Center Torrance, Torrance
- Providence Saint Joseph Medical Center, Burbank
- Providence Tarzana Medical Center, Tarzana
- Queen of the Valley Medical Associates, Napa
- Queen of the Valley Medical Center, Napa
- Rady Children’s Hospital—San Diego, San Diego
- Rancho Los Amigos National Rehabilitation Center, Downey
- Redlands Community Hospital, Redlands
- Redwood Memorial Hospital, Fortuna
- Rideout Memorial Hospital, Marysville
- Riverside County Regional Medical Center, Moreno Valley
- Saddleback Memorial Medical Center, Laguna Hills
- Saddleback Memorial Medical Center – San Clemente, San Clemente
- Saint Agnes Medical Center, Freeman
- Saint Francis Memorial Hospital, San Francisco
- Saint Louise Regional Hospital, Gilroy
- Salinas Valley Memorial Hospital System, Salinas
- San Antonio Regional Hospital, Upland
- San Bernardino Mountains Community Hospital District, Lake Arrowhead
- San Dimas Community Hospital, San Dimas
- San Fernando Health Center, San Fernando
- San Gabriel Valley Medical Center, San Gabriel
- San Gorgonio Memorial Hospital, Banning
- San Joaquin Community Hospital, Bakersfield
- San Juan Regional Medical Center, Farmington, NM
- San Leandro Hospital, San Leandro
- San Mateo Medical Center, San Mateo
- Santa Barbara Cottage Hospital, Santa Barbara
- Santa Paula Hospital, Santa Paula
- Santa Rosa Memorial Hospital, Santa Rosa
- Santa Ynez Valley Cottage Hospital, Solvang
- Scripps Green Hospital, La Jolla
- Scripps Memorial Hospital Encinitas, Encinitas
- Scripps Memorial Hospital La Jolla, La Jolla
- Scripps Mercy Hospital, San Diego
- Scripps Mercy Hospital Chula Vista, Chula Vista
- Sequoia Hospital, Redwood City
- Sethon Coastalside, Moss Beach
- Seton Medical Center, Daly City
- Sharp Chula Vista Medical Center, Chula Vista
- Sharp Cordova Hospital and Healthcare Center, Corona
- Sharp Grossmont Hospital, La Mesa
- Sharp HealthCare, San Diego
- Sharp Home Health, San Diego
- Sharp Mary Birch Hospital for Women & Newborns, San Diego
- Sharp McDonald Center, San Diego
- Sharp Memorial Health, San Diego
- Sharp Mesa Vista Hospital, San Diego
- Sharp Rees - Stealy Medical Group, San Diego
- Shasta Regional Medical Center, Redding
- Sherman Oaks Hospital, Sherman Oaks
- Shriners Hospitals for Children Northern California, Sacramento
- Sierra Nevada Memorial Hospital, Grass Valley
- Sierra View Medical Center, Porterville
- Sonoma Valley Hospital, Sonoma
- South Coast Global Medical Center, Santa Ana
- South Valley Health Center, Palmdale
- Southern California Hospital at Culver City, Culver City
- Southern California Hospital at Hollywood, Los Angeles
- Southern California Hospital at Van Nuys, Van Nuys
- Southern Inyo Hospital, Lone Pine
- Stanford Health Care – ValleyCare, Pleasanton
- Stanford Health Care – ValleyCare-Livermore, Livermore
- Stanford Health System, Palo Alto
- St. Bernardine Medical Center, San Bernardino
- St. Elizabeth Community Hospital, Red Bluff
- St. Francis Medical Center, Lynwood
- St. Helena Hospital Center for Behavioral Health, Vallejo
- St. John’s Pleasant Valley Hospital, Camarillo
- St. John’s Regional Medical Center, Oxnard
- St. Joseph Health, Irvine
- St. Joseph Heritage Medical Group, Orange
- St. Joseph Home Care Network, Sonoma
- St. Joseph Home Health Network, Orange
- St. Joseph Hospital Acute Rehabilitation Unit, Eureka
- St. Joseph Hospital, Eureka
- St. Joseph Hospital, Stockton
- St. Joseph’s Behavioral Health Center, Stockton
- St. Joseph’s Hospital and Medical Center, Phoenix, AZ
- St. Joseph’s Medical Center, Stockton
- St. Joseph’s Westgate Medical Center, Glendale, AZ
- St. Jude Medical Center, Fullerton
- St. Mary High Desert Medical Group, Victorville
- St. Mary Medical Center, Apple Valley
- St. Mary Medical Center, Long Beach
- St. Mary’s Medical Center, San Francisco
- St. Rose Dominican Hospital – San Martin Campus, Las Vegas, NV
- St. Rose Dominican Hospital – Siena Campus, Henderson, NV
- St. Rose Dominican Hospitals – Rose de Lima Campus, Henderson, NV
- St. Vincent Medical Center, Los Angeles
- Stewart and Lynda Resnick Neuropsychiatric Hospital at UCLA, Los Angeles
- Sulpho Cardiovascular Center, La Jolla
- Summit Campus of Alta Bates Summit Medical Center, Oakland
- Sutter Amador Hospital, Jackson
- Sutter Auburn Faith Hospital, Auburn
- Sutter Care at Home, Emeryville
- Sutter Center for Psychiatry, Sacramento
- Sutter Coast Hospital, Crescent City
- Sutter Davis Hospital, Davis
- Sutter Delta Medical Center, Antioch
- Sutter East Bay Medical Foundation, Lafayette
- Sutter Gould Medical Foundation, Modesto
- Sutter Health, Sacramento
- Sutter Lakeside Hospital, Lakeport
- Sutter Maternity & Surgery Center of Santa Cruz, Santa Cruz
- Sutter Medical Center – Sacramento, Sacramento
- Sutter Medical Foundation, Sacramento
- Sutter Memorial Hospital, Sacramento
- Sutter Pacific Heart Centers, San Francisco
- Sutter Pacific Medical Foundation, San Francisco
- Sutter Physician Services, Sacramento
- Sutter Refub Institute, Roseville
- Sutter Roseville Medical Center, Roseville
- Sutter Santa Rosa Regional Hospital, Santa Rosa
- Sutter Santa Rosa Regional Hospital – Warrack Campus, Santa Rosa
- Sutter SeniorCare, Sacramento
- Sutter Solano Cancer Center, Fairfield
- Sutter Solano Medical Center, Vallejo
- Sutter Surgery Center Division, Sacramento
- Sutter Surgical Hospital, Yuba City
- Sutter Tracy Community Hospital, Tracy
- Tahoe Forest Hospital District, Truckee
- Tillamook County General Hospital, Tillamook, WA
- Torrance Memorial Medical Center, Torrance
- Tri-City Medical Center, Oceanside
- Trinity Hospital, Weaverville
- UC Irvine Health, Orange
- UC San Diego Thornton Hospital, La Jolla
- UCLA Medical Center, Santa Monica, Santa Monica
- UCSD Health, La Jolla
- UCSF Benioff Children’s Hospital, Oakland
- UCSF Children’s Hospital, San Francisco
- UCSF Medical Center, San Francisco
- University of California, Oakland
- University of California — Ronald Reagan UCLA Medical Center, Los Angeles
- University of California San Diego Health System, San Diego
- University of California, Davis Medical Center, Sacramento
- Valley Children’s Healthcare, Madera
- Valley Presbyterian Hospital, Van Nuys
- Vaughn School Based Health Center, San Fernando
- Ventura County Health Care Agency, Ventura
- Ventura County Medical Center, Ventura
- Verity Health System, Redlands
- Vibra Hospital of Sacramento, Folsom
- Vibra Hospital of San Diego, San Diego
- Victor Valley Global Medical Center, Victorville
- Walla Walla General Hospital, Walla Walla, WA
- Washington Hospital Health System, Fremont
- West Anaheim Medical Center, Anaheim
- Whittier Hospital Medical Center, Whittier
- Wilmerding Health Center, Wilmingtom
- Woodland Healthcare, Woodland
- Zuckerberg San Francisco General Hospital and Trauma Center, San Francisco
The CHPSO Database had 1.9 million reports by the end of 2018. Nearly 440,000 reports were submitted to CHPSO in 2018 and we continue to share trends and lessons learned among our community.

**Key Points to Consider When Reviewing Event Data**

1. **Volume of reports does not equal prevalence.**

   It is easy to assume that a higher number of a certain type of event means that there are more of those types of events occurring. However, given the nature of safety event reporting, it simply means that hospitals have submitted more of those types of events to the CHPSO database.

2. **Every organization collects internal event data differently.**

   Prior to PSO participation, hospitals collected event reports for their own patient safety, quality, and risk management purposes. Therefore, these reports were not designed or collected with the intention of external reporting. As a result, we receive information in various degrees of thoroughness and quality.

**Tips to Improve Safety Event Reports and Analyses**

- State the facts. Following the “SBAR” format — Situation, Background, Assessment, Recommendation — is a communication model useful for both internal review and for the PSO review. The write-up does not have to be lengthy.

- Spell out abbreviations and acronyms, if possible. For instance, PT is used for both Physical Therapy and patient.

- No blaming or shaming. A patient safety culture does not point out who is right and who is wrong.

- **CAPS ARE NOT NECESSARY FOR THE ENTIRETY OF THE REPORT.**

- State whether the event happened for the first time or if it has occurred multiple times.

- Include the follow-up. If a call light was no longer working, mention whether the Facilities and Maintenance team fixed it.

- Report near misses and no harm events. Staff often do not report no-harm and near-miss events. These represent “free lessons” and often are precursors of serious events.
Establishing and maintaining a culture of safety is an essential component of patient safety and quality improvement efforts. In the absence of such a safety culture, there may be a hesitancy to report errors or unsafe conditions. If such events or conditions are not reported, organizations will find progress toward the elimination of preventable harm difficult, if not altogether impossible.

One of the primary functions of a federally-listed patient safety organization, such as CHPSO, is to encourage and assist health care organizations in developing a culture of safety. CHPSO provides feedback on the tone and the content of the safety events submitted to the CHPSO database. The tone analysis refers to the level of bias present in the safety events submitted to the CHPSO database. The content analysis refers to the thoroughness of the reports.

In 2018, CHPSO provided members with a tone and content analysis of a random sample of events they submitted during the 2017 calendar year. A total of 10,071 events were reviewed and scored based on the following criteria:

**Content Analysis**

- **Thorough**: Logically described, easy to follow and addresses at least four of five Ws: who, what, when, where, and why.
- **Standard**: Logically described, easy to follow, and addressed two to three of the five Ws.
- **Limited**: Lacks organization, difficult to follow, and/or only one to two of the five Ws are addressed.

**Tone**

- **Biased**: Included vocabulary such as “fault” or “error” to describe medical team members who may have been involved in the event. Tone emerged as finger-pointing to avoid disciplinary action on the author’s part. Indicative of a blame and shame culture.
- **Semi-biased**: Tone described the event facts. There is some mention of team members who may be “at fault” for an event.
- **Unbiased**: Tone described the event facts. There was little to no mention of team members or other departments who have been “at fault” for event.

The vast majority of the reports had either standard or thorough content. In the tone analysis, more than 90 percent of the safety event reports were scored as unbiased. These results indicate that the majority of the reports submitted to the CHPSO database were relatively complete and unbiased.
Other / Uncategorized

Periodically, CHPSO systematically analyzes safety reports submitted to its database. In 2018, one of these analyses was of the Other category. The Other category of reports is one of the largest in the CHPSO database. It is intended for those reports that do not fit into any of the eight specific categories in the national standard for event databases (the “Common Formats”):

1. Blood or Blood Product
2. Device or Medical/Surgical Supply, including Health Information Technology
3. Fall
4. Health care associated Infection
5. Medication or Other Substance
6. Perinatal
7. Pressure Ulcer
8. Surgery or Anesthesia (including invasive procedure)

To determine which elements were present in the Other category, we analyzed a sample of reports submitted to CHPSO in Q1 2018 (30,373 reports). Four categories accounted for more than half of the events.

- Behavior and workplace violence (4,446)
- Expected and unexpected deaths, codes, rapid response (4,008)
- Left without being seen (LWBS) or against medical advice (AMA) (3,569)
- Delay or lack of response (3,475)

The most common category involved behavior and workplace violence (15 percent). This included reports of patients threatening, assaulting, and verbally abusing staff or peers, and patients punching walls or damaging property. Other reports commonly overlapping this category included patients leaving or wanting to leave AMA, and patients being classified as danger to self or others. In addition to behaviors attributed to patients, this category also included reports of inappropriate staff or provider behavior (e.g., rude, offensive, and unprofessional). Reports mentioning highly agitated or aggressive family or visitors were also included.

The next most common category (13 percent) involved expected or unexpected deaths, codes, and rapid response team calls. These included reports of patients having expired. Reports of death after withdrawal of life support, as well as reports related to organ procurement following brain death, were also included in this category. In addition, there were reports of rapid response calls, code blue, code STEMI (ST elevation myocardial infarction), code stroke, code sepsis, and code airway.

Leaving AMA or LWBS was the third largest category in the dataset, representing about 12 percent of the safety event reports. These cases often contained elements related to behavior or workplace violence. Events involving patients requesting to leave or actually leaving AMA were often related to long delays in care. Wanting to go outside to smoke was also an issue associated with patients leaving AMA. Some of the reports were associated with patients refusing to sign the required AMA forms.

Delay or lack of response was evident in about 11 percent of the cases. As mentioned above, many cases involved patients leaving AMA or becoming irate after long delays in care or testing. Other events involved delays potentially associated with severe harm or death. Delays were associated with a variety of other factors including: communication failures (e.g., critical values, codes, provider notification); lab studies; medication administration; lack of timely provider response; refusal to treat or assess patients; provider, staff, or bed availability, and delays in calling code or rapid response teams.

Following this analysis, all CHPSO facilities were provided with a report summarizing the trends and patterns in the aggregate. Facilities were offered the opportunity to request an individualized analysis of their reports in this category. A number of facilities, as well as large health systems, took advantage of this opportunity and were provided with a facility specific analysis. These reports allowed organizations to identify trends and patterns which may provide insight into opportunities for improvement.
Advanced Analytics in Medication Safety

As of the end of 2018, the number of safety events in the CHPSO database reached nearly 2 million. A database of this size gives CHPSO the ability to identify patient safety issues early by picking up on statistical signals in the data.

Previously, CHPSO had used such analyses to emphasize the need for caution when combining opioids and benzodiazepines.

Utilizing a similar analytic approach, CHPSO detected a potential relationship between age greater than 65 and the mention of antipsychotic medications in a safety event. Also noted in this analysis was a correlation between antipsychotics and higher levels of patient harm.

These findings prompted a deeper dive into the data and a Safe Table on the use of antipsychotic medications in elderly patients. The data analysis provided a measure of the scope of the patient safety risks associated with the use of antipsychotics in the elderly and the Safe Table provided a platform for discussion among CHPSO members. In this review we examined 1019 cases from the CHPSO database in which antipsychotic medications were mentioned in the care of patients 75 years of age or older.

These data show that haloperidol (Haldol) was mentioned in 53.3 percent of the cases (n=543). The second most common factor was a mention of safety concerns (e.g. aggression, agitation, combativeness) which occurred in 24.3 percent of the patient safety event reports. QT was mentioned in 14.1 percent of the cases, most commonly with the writer reporting that appropriate cardiac monitoring was not performed.

This type of advanced analytic capacity, developed by CHPSO, is an example of how patient safety event reporting data can be used toward the goal of eliminating preventable harm. As the CHPSO database grows we look forward to being able to expand our ability to pick up on such signals so that we can continue to provide early warnings to members regarding patient safety issues and concerns.
**Harm Reporting Ratio**

Spontaneous reporting systems are ill-suited to calculating rates, as changes in numbers of reports could indicate either more issues to report or better reporting of existing issues.

CHPSO has developed several metrics that are independent of reporting propensity, allowing comparisons and benchmarking between disparate organizations.

One metric in particular, the Harm Reporting Ratio (HRR), is simple to calculate and can readily be calculated by any organization with an electronic reporting database.

To calculate the HRR, all events for which a harm level (from no harm to death) was recorded are added to all reports of risks that do not involve patients and thus no need to assess harm (e.g., near misses and unsafe conditions) to provide the denominator. The numerator is all events for which the harm level was severe harm or death. This measure is premised on the assumption that most high-harm events get reported, so that changes in the ratio will either be due to a shift in reporting low-harm events, or a decrease in the absolute number of high-harm events.

CHPSO is tracking the HRR for reports submitted to the CHPSO database by date of occurrence. Notably, there is a temporal trend toward a lower HRR. A decreased HRR represents one or more of the following occurring, all of which are positive developments:

- Increased reporting due to improved reporting culture.
- Increased reporting due to increased sophistication in identifying low-harm and no-harm events that could be precursors to significant events.
- Decreased number of high harm events.

Organizations are encouraged to track this metric, with a goal of achieving an HRR less than 1.5 percent.

**CHPSO Harm Reporting Ratio**

![Graph showing the CHPSO Harm Reporting Ratio from May-07 to Sep-18. The target is ≤ 1.5%.]

Note: Data show through Sept. 2018 due to lags in event reporting during recent months.
Perinatal Event Analysis

Under federal law, CHPSO provides confidentiality and privilege protection to providers that submit safety event data. In turn, CHPSO analyzes these data, providing specific feedback to members and sharing generalizable, de-identified information to the health care community at large.

In 2018, CHPSO looked at perinatal events to identify common issues and themes with an emphasis on finding safety event reports that represented an opportunity for improvement (OFI). This identification of OFIs allowed the CHPSO team to provide feedback to members and informed future work such as Safe Table forums, webinars, and newsletter articles.

Among the 4,955 cases, there were 157 cases mislabeled as perinatal and those were excluded from the analysis. The remaining cases were reviewed to determine if they represented a potential OFI. For example, a mother whose care was appropriately managed after presenting with a pre-viable fetal demise would not be coded as an OFI. Likewise, a multiparous woman who arrives in advanced labor and has a precipitous, nurse-assisted birth moments after arrival would not be coded as an OFI. However, a nurse-assisted birth complicated by a shoulder dystocia following repeated attempts to contact the provider would be coded as an OFI. The categories with the highest percentage of OFIs included those associated with nonclinical human factors related issues such as communication, team dynamics, and person-centered care.

These data, while the events were perinatal in nature, provide valuable lessons learned across the spectrum of care. In particular, organizations may find it helpful to examine incidents that fall into categories of events with high rates of OFI such as communication, team dynamics, and person-centered care.
Data Submission Update

Member organizations continue to find the NextPlane system simple to use, as evidenced by the steady increase in number of entities reporting as well as total reports (above). CHPSO teams with NextPlane Solutions to provide a simple reporting interface, needing minimal to no IT assistance at the facility.

Members submit Excel spreadsheets with one report per row. Data requirements are minimal, and members do not need to collect any data not already present in their incident reporting systems. Column headers and row contents are as produced by the member’s report database, without any need for manipulation at the facility and eliminating barriers to full participation in the Patient Safety Organization.

All mapping to standardized taxonomy is done by NextPlane with the guidance of the facility. A drag-and-drop interface is used by the facility to identify the initial mapping, and subsequent submissions need no work unless new fields or answer codes are included. Typically, it takes less than three hours to develop and complete the initial submission, with telephonic assistance throughout the process. Subsequent submissions take much less time (typically 15 minutes) and are often performed monthly.

CHPSO’s Data Analysis

This large data set enables CHPSO to identify unusual and emerging issues. For example, CHPSO issued an alert after detecting a safety signal involving concomitant opioid and benzodiazepine use, and that alert came before the FDA issued its black box warning for the combination.

CHPSO also uses the information to provide substantiation of members’ concerns regarding equipment design and drug packaging, enabling more impactful discussions with manufacturers.

And the large database allows better support for members dealing with specific issues, as CHPSO can identify patterns and potential solutions that would not be apparent at even a health system level. This also feeds into our Safe Tables, and increases the value of those discussions.
At Safe Tables, members discuss cases on pre-selected topics in a confidential and privileged setting. These forums enable members to return to their health care organizations with lessons learned and valuable resources.

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<tr>
<th>Date</th>
<th>Topic</th>
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<tr>
<td>01/18</td>
<td>Behavioral Health – Inpatient Setting</td>
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<td>Telemetry Monitoring Criteria</td>
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<td>Mass Transfusion Protocol</td>
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<td>Alarm Management</td>
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<td>Medication Reconciliation</td>
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<td>POLST Form Use with End-of-Life Care</td>
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<td>Surgical Fires</td>
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CHPSO hosted 21 Safe Tables in 2017 and 22 Safe Tables in 2018 with a significant increase in attendance, CE credits provided, and hospitals represented.

- 42% increase in the number of hospitals represented at the Safe Table forums
- 46% increase in the number of attendees at Safe Table forums
- 40% increase in the number of CE credits provided

Quotes from attendees:

“**This discussion helped me to evaluate our processes and supportive systems to ensure patient safety, specifically antipsychotic medications in the elderly. I’d like to evaluate our order sets and review what decision support features we have that could help facilitate sound decision making.**”

“I thought this presentation was phenomenal and I was very encouraged and inspired by the creative, collaborative approach to a significant challenge in health care.”

“We are in the process of designing a pharmacy-driven medication reconciliation program at our facility and the content of the webinar was exactly what we were looking for.”

“The discussion on Language Barriers will definitely inform the way I consider using family members (especially youth) as translators in practice.”

“Discussion with other facilities give us a better chance at finding the best practice. Sometimes we think we have thought of everything then we learn from other facilities things that we may not have thought of.”
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