

CHPSO and CAPSAC Sponsor Just Culture Investigation Training

CHPSO is pleased to join CAPSAC in sponsoring just culture investigation training. One challenge with establishing a “Just Culture” is drawing the line between acts deserving personnel actions, such as discipline or remedial training, and acts representing normal human error, in which the culprit is the system not the person.

This training is in the model developed by David Marx and Outcome Engineering, Inc, that was discussed in the July issue of CHPSO Patient Safety News. In this model, acts are categorized as human error, at-risk behavior or reckless behavior, and the response is tied to the mechanism or error.

During the Just Culture Event Investigation Regional Training, you will learn about event investigation and how to determine what happened to cause a medical error or “near miss.” Once you have identified how mistakes can happen, you will learn ways to develop strategies to reduce the likelihood of these mistakes and reduce patients’ risk of harm.

Training is available in 10 different locations, lasts four hours and registration for any but the October 22 session is \$150. The October 22 session is an all day comprehensive Just Culture training session available for \$195. The training schedule can be seen in this issue’s Calendar. More information and a registration form are available at www.chpso.org/just/event-inv.pdf.

Working With CHPSO: Navigating Privileges, Protections and Reporting Requirements

Free teleconference August 6, 2009, 11 a.m.–Noon

The Patient Safety and Quality Improvement Act of 2005 offers health care providers a new protection—Patient Safety Work Product (PSWP) privilege—to conduct patient-safety activities so health care providers, working in cooperation with a Patient Safety Organization (PSO) such as CHPSO, can analyze quality and safety issues to improve care and reduce risk to patients.

With a few narrow exceptions, PSWP is:

- Not subject to subpoena or order.
- Not subject to discovery.
- Not subject to disclosure.
- Not admissible as evidence.
- Not admissible in professional disciplinary proceedings.

How does the new PSWP privilege affect current protections and reporting requirements? Under what circumstances can the privilege be waived? When should a provider take advantage of the PSWP protection, and when should it not? Is it possible to effectively multi-purpose your patient-safety, peer-review and reporting activities?

Registered participants will receive a copy of CHPSO’s “white paper” analyzing these important issues and providing a recommended roadmap for interactions between health care providers and the PSO.

Presented by: Ann O’Connell, Partner, Nossaman, LLP

To register, contact La Shon Tate at ltate@calhospital.org.

Checklist Can Help Standardize Emergency Response

A 31-year-old woman presents in the ER at 2 a.m. and is immediately referred to L&D triage. She is at 40 weeks and in the early stages of labor having received limited prenatal care at an outside clinic. The OB hospitalist is awakened. A physical exam suggests placenta previa, so the OBH announces her decision to prepare for a Cesarean section. What would your OB team do right now? Would the answer depend upon who the OBH is? Who the charge nurse is? What if it was a weekend or holiday?

If you have incorporated team training into your perinatal standard of care, you have a ready answer to all of these questions. One hospital where I worked created a C-section checklist to ensure the same best practices are used **every** time the obstetrician makes this decision. A well-designed checklist ensures that the most important or time-sensitive tasks happen first. It also specifically spells out exactly who does what, when and how.

Some clinicians believe this process cannot be standardized because there are too many variables and sometimes there is not enough time to use a checklist. Interestingly, several key stakeholders at this

hospital thought that way too and were concerned a checklist wasn't in the best interest of the patient. What they found was that if the physicians and nurses who created the checklist were careful in its construction, they could standardize most practices, while leaving placeholders in the process where decisions could be made to address the variable elements of each case. Regarding time concerns, they found their decision-to-incision times dropped by more than 12 percent. Most importantly, their diligence was rewarded by knowing they were providing **one** standard of care that incorporated known best practices.

— Steven Montague (lifewings@verizon.net), Vice President, LifeWings.

Retained Foreign Object Analysis Form Available

The Pennsylvania Patient Safety Authority has published a form for general use in retained foreign object events. The form asks a series of questions to help develop a structured view of the event. Hospitals are encouraged to review the form to determine if it would augment their current approach to these events.

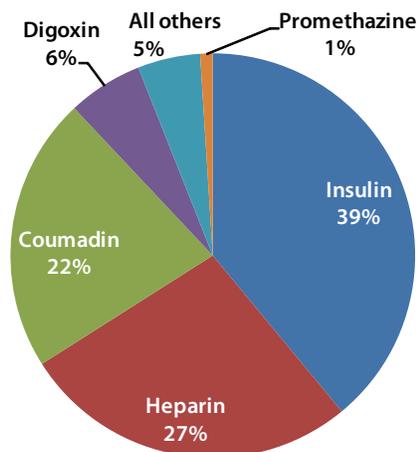
The form includes specific questions about possible contributory factors, as well as questions to elicit information about the nature of the counts and response to any discrepancies.

For a copy of the form, visit the Patient Safety Authority website at patientsafety-authority.org/EducationalTools/Patient-SafetyTools/rfo/Documents/audit.pdf.

— Rory Jaffe rjaffe@calhospital.org.

High-Alert Medications

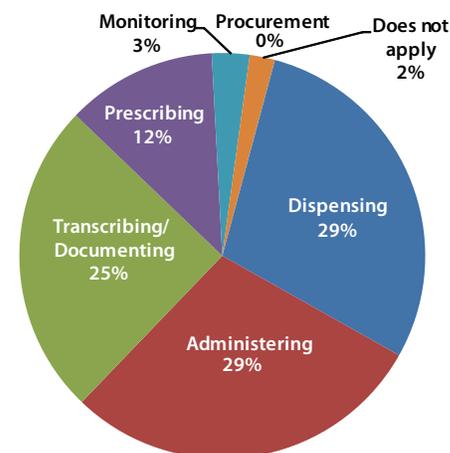
MEDMARX™ is a web-based, anonymous and voluntary medication error-reporting system used by many health care facilities to report medication error data. It was the source for findings presented in the July/August 2009 issue of *Patient Safety and Quality Healthcare* (PSQH) titled “High-Alert Medications: Error Prevalence and Severity.”



The publication presented results from analysis of high-alert medication errors. Based on a review of more than 400,000 errors for a three-year period, 32,546 (7 percent) were related to the high-alert medications. The most commonly reported drug from the high-alert medication list was insulin, with 39 percent of the high-alert medication events with harm, followed by heparin and coumadin, at 27 and 22 percent, respectively (see figure).

The most common errors were omission (26 percent), wrong dose (22 percent) and wrong or unauthorized drug (17 percent). Less common errors included prescribing error, wrong time, extra dose and wrong patient, with incidences of 9 percent, 7 percent, 7 percent and 5 percent, respectively. The process steps most frequently associated with errors were

dispensing, administering, and transcribing/documenting (see figure).



Read more about this topic on the PSQH website at www.psqh.com/julyaugust-2009/164-data-trends-july-august-2009.html.

— Juliana Heart, jheart@quantros.com.

Calendar

Following is a list of upcoming events that are still open for enrollment. For more information or to enroll, use the contacts listed at the bottom of this article.

August

4: HASC (Hospital Association of Southern California): Central Line Blood Stream Infection, MRSA, Sepsis Mortality, and Surgical Care Improvement Project. Industry Hills.

6: CHPSO: Free Teleconference on PSO Privileges, Protections and Reporting Requirements. 11 – noon.

September

2: HASC: Clostridium difficile-Associated Diseases, High Alert Medications,

Subscription service (additions and removals): La Shon Tate ltate@calhospital.org
Questions or comments: Rory Jaffe MD MBA rjaffe@calhospital.org
Copyright © 2009 California Hospital Patient Safety Organization. This newsletter may be freely distributed in its original form.

Hospital Acquired Pressure Ulcers and Medication Safety. Industry Hills.

11: (Date change — was set for September 18) CAPSAC (California Patient Safety Action Coalition): California Patient Safety Action Coalition Meeting. Napa.

29: HASD&IC (Hospital Association of San Diego & Imperial Counties): ICU Sedation Task Force Meeting. San Diego.

October

12: CHPSO & CAPSAC: Just Culture Event Investigation Training. La Jolla.

13: CHPSO & CAPSAC: Just Culture Event Investigation Training. Newport Beach.

22: CHPSO & CAPSAC: Just Culture Event Investigation Training. Redding.

23: CHPSO & CAPSAC: Just Culture Event Investigation Training. Sacramento.

29: CHPSO & CAPSAC: Just Culture Event Investigation Training. Fresno.

30: CHPSO & CAPSAC: Just Culture Event Investigation Training. Glendale.

November

4: CHPSO & CAPSAC: Just Culture Event Investigation Training. Fremont.

5: CHPSO & CAPSAC: Just Culture Event Investigation Training. Los Angeles.

10: (Date change — was originally set for November 3) HASC: Central Line Blood Stream Infection, MRSA, Sepsis Mortality, and Surgical Care Improvement Project. Industry Hills.

12: CHPSO & CAPSAC: Just Culture Event Investigation Training. Orange.

13: CHPSO & CAPSAC: Just Culture Event Investigation Training. Palo Alto.

17: HASD&IC: ICU Sedation Task Force Meeting. San Diego.

December

4: CAPSAC: California Patient Safety Action Coalition Meeting Los Angeles.

15: (Date change — was originally set for December 3) HASC: Clostridium difficile-Associated Diseases, High Alert Medications, Hospital Acquired Pressure Ulcers and Medication Safety. Industry Hills.

January

28: HASC: Southern California Patient Safety Colloquium. Pasadena.

For further information on these events:

CAPSAC: Theresa Manley, manleyt1@pamf.org or www.capsac.org

CHPSO: Rory Jaffe, info@chpso.org

HASC: Catherine Carson, ccarson@hasc.org

HASD&IC: Erin Curtis erin.curtis@cardinalhealth.com

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 will be archived on the CHPSO website (www.chpso.org). Send subscription requests (additions, deletions) to ltate@calhospital.org. Submit articles to rjaffe@calhospital.org.

CHPSO

- Provides a voluntary confidential and privileged incident and near-miss reporting system.
- Works with hospitals to identify, analyze and reduce the risks and hazards associated with patient care.
- Aggregates event reports in a protected legal environment, accelerating the identification of patient safety improvements.
- Focuses on the laws, regulations and patient safety initiatives specific to California and coordinates its efforts with the Regional Hospital Associations and existing patient safety collaboratives across the state.

Participation benefits

- **Improved communications.** All deliberations and communications about incidents can be privileged, regardless of committee structure or breadth of communication. And hospitals can share experiences to learn from each other.
- **Proactive response to Immediate Jeopardy fines and adverse publicity.** CHPSO participants will be able to share information about significant risks to identify solutions before an adverse event occurs.
- **Pooled expertise.** Working together, California hospitals possess an unprecedented depth of knowledge and expertise. Collaboration on patient safety events can freely occur in a privileged confidential environment. This leverages each hospital's investment in expertise.
- **Publicity for our achievements.** California's hospitals and the Regional Hospital Associations devote significant resources to improving patient safety. CHPSO broadly disseminate lessons learned and publicize their work.