CHPSO
California Hospital Patient Safety Organization

Patient Safety News
October 2009
Volume 1 Number 8

Common Formats Version 1.0 Issued

"Common Formats" Version 1.0 is now available, replacing Version 0.1 beta. The Agency for Health Research and Quality (AHRQ) Common Formats are intended to provide a means for all health care providers to collect and submit patient-safety event information using common language and definitions.

PSOs are required, to the extent practical and appropriate, to collect information from providers in a standardized manner in order to permit valid comparisons of similar cases among similar providers. While the Common Formats are not mandatory, virtually all PSOs will be collecting information in this format, and the National Patient Safety Database will only include data in this format. As a result, it is likely that the industry will gravitate toward this. AHRQ's long-term hope is to develop a well-defined set of data definitions that will cover much of the reporting for quality and patient safety, eliminating the recoding, rework and confusion that can occur when providers participate in multiple reporting efforts. From AHRQ:

> "The Common Formats optimize the opportunity for the public and private sectors to learn more about trends and patterns in patient safety and to identify risks and hazards to patients, with the purpose of improving health care quality and safety. The Common Formats facilitate the ability of health care providers to participate in such efforts and set the stage for breakthroughs in understanding how best to improve patient safety.
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> "AHRQ convened an interagency Federal Patient Safety Work Group (PSWG) to assist AHRQ with developing and maintaining the Common Formats. The PSWG includes major health agencies within the Department of Health and Human Services (HHS)—Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service (IHS), National Institutes of Health, National Library of Medicine, Office of the National

CHPSO and Quantros Launch Hospital Event Reporting Program for Small California Hospitals

While improving patient safety is a priority across health care facilities of all sizes, the reality is that too often very tight budgets prevent small institutions from using high-value software solutions for improvement efforts. To combat this challenge, CHPSO has worked out an arrangement with Quantros to provide patient-safety event management software access at deeply discounted pricing for California health care providers with 50 beds or fewer to make it affordable for even the smallest hospitals.

Quantros Safety and Risk Management (SRM) for patient event reporting is used by more than 800 health care facilities throughout the United States. This solution holds many benefits for smaller health care providers, including:

- Built-in, defined and managed taxonomy, assuring alignment with national standards.
- Seamless submission of data to CHPSO.
- Software provided without any additional IT expenditures as this system is hosted and maintained by Quantros as part of the license.
- One-page online event entry form for efficient data capture of events.
- Real-time alerts to different stakeholders within the organization via e-mail, cell phone and/or pager.
- Complete workflow management, including follow-up forms, RCAs, attachments.
- A full complement of reporting options for analysis of event data, including standard and ad-hoc reporting.
- CHPSO developed this program as part of its ongoing mission to help California hospitals improve patient safety.

For additional information on this program, including special discount pricing for your facility, e-mail info@chpso.org or call 916-552-7568.

Coordinator for Health Information Technology, Office of Public Health and Science, Substance Abuse and Mental Health Services Administration—as well as Department of Defense (DoD) and Department of Veterans Affairs (VA).

"AHRQ reviewed existing patient safety event reporting systems from a variety of health care organizations. Subsequently, AHRQ, in conjunction with the PSWG, developed, piloted, and released Version 0.1 Beta of the Common Formats on August 29, 2008.

"Through a contract with AHRQ, the National Quality Forum (NQF) solicited feedback on the Common Formats from private sector organizations and individuals. The NQF, a nonprofit organization that focuses on health care quality, then convened an expert panel to review the comments received and provide feedback to AHRQ. Based upon the expert panel's feedback, AHRQ, in conjunction with the PSWG, further revised and refined the Common Formats. These revised formats are now available as Version 1.0."

Version 1.0 may be obtained at www.psoppc.org/web/patientsafety/paperforms. Soon, detailed definitions of each field will be available at the United States Health Information Knowledgebase Metadata Registry (usually referred to as "USHIK") at ushik.ahrq.gov/registry/index.html?system=ps&Referer=RegistriesPSO.

—Rory Jaffe, MD rjaffe@calhospital.org

Errors Involving Drug-Related Clinical Monitoring

The Pennsylvania Patient Safety Authority recently analyzed event reports related to clinical monitoring of medication administration.

Levofloxacin was the medication most commonly involved in these events, closely followed by heparin (see table). For levofloxacin, 92 percent of the event reports involved dose adjustment due to renal function.

Most commonly reported medications	Percent of all reports
Levofloxacin	32%
Heparin	30%
Vancomycin	14%
Insulin	13%
Coumadin	11%

Potential contributing factors included:

- Prescribers may not be aware of the need to assess renal function and adjust doses as necessary.
- Clinical laboratory values may not be readily available to practitioners at the time of prescribing, dispensing and administering. Even in facilities with electronic systems, laboratory computer systems may not interface with computerized prescriber order-entry (CPOE) and pharmacy computer systems. If the systems do interface, CPOE and pharmacy computer systems may not generate alerts to warn practitioners about high doses with respect to serum creatinine levels.
- CPOE systems may not have effective computer-based clinical decision support to help guide appropriate dose selection for patients with renal insufficiency or advanced age.
- The clinical status of the patient may require administration of a first dose of an antibiotic before an accurate assessment of renal function is available.

Risk-reduction strategies include:

- Determine the microbiological indication for levofloxacin.
- Obtain baseline patient information, such as age and renal function information (e.g., serum creatinine, CrCl). Continue to assess renal function throughout therapy and over time to obtain a true picture of the patient's renal function. Adjust the dose as necessary for patients with renal impairment.
- In the event that CrCl data is not available, consider dosage adjustments based on age. It can be expected that elderly individuals may have lower CrCl values due to age-related reduction in renal function.
- Use appropriate assessment techniques (and/or patient information such as age or laboratory values) before drug administration.
- Ensure that current laboratory and testing information is available to all practitioners. Work with physicians' offices to develop a process for communicating this essential patient information timely and efficiently.

Subscription service (additions and removals): La Shon Tate ltate@calhospital.org
Questions or comments: Rory Jaffe MD MBA rjaffe@calhospital.org
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- Work with vendors to interface the laboratory system with CPOE and pharmacy systems. During order entry, computer systems should warn practitioners when these agents are about to be used for patients with decreased renal function. Computer-based clinical decision support to help guide medication dosing for patients with renal insufficiency can result in improved dose and frequency choices.

- Expand organizational medication-use policies to include the provision that medications are not prescribed, dispensed or administered unless relevant clinical information, such as critical laboratory values for patients are available and considered by practitioners.

- Provide essential patient information, including patient age, height (cm), weight (kg), allergies with descriptions of the reactions, previous adverse drug reactions with manifestations, diagnosis and comorbid conditions (e.g., renal impairment) at the top of all preprinted order sets, medication administration records and pharmacy patient profiles, as well as screens within future CPOE systems.

—The full report (Pa Patient Saf Advis 2009 Sep;6(3):74–8) is available at patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Sep6(3)/Pages/74.aspx

'No problems is a problem'

The quote, "No problems is a problem," attributed to a Toyota executive while touring an automotive plant in the U.S. many years ago, occurred when the manager guiding the tour was asked what problems they were having in a particular area and he responded, "No problems."

Fear of retribution, disengagement, frustration with reporting systems or a "what's the use?" attitude are all possible reasons for a perception that there aren't any problems. Middle managers, sometimes perceived as the "layer of clay" because nothing flows through in either direction, may inhibit reporting in order to curry favor. Regardless of the reason, if your perception of your organization is that there are "no problems," it makes sense to take a closer look for yourself.

Rounding, or "leadership by walking around," is what many leaders use to try to get a sense of the organization. If you're still getting "no problems," try asking different questions. One technique to gain awareness of problems is to ask your people what "others" might think is a problem. While people may be intimidated, or even just reluctant to complain, they're far more comfortable discussing what others would think.

For example, say to one of your staff nurses, "I'm going to the medical staff meeting on Wednesday, what do you think they'll tell me is a problem?" An opening line with the medical staff may be, "Some of the nurses expressed concern that (problem) may be causing frustration for you and your colleagues. Has it been a problem?" This technique works the other way around too, so that you can dig deeper with your nursing staff.

The road to high-quality care is a journey, not a destination. Along the way there will be rewards. The Japanese have another saying that offers encouragement, "Every defect, a treasure."

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

New FaceBook CHPSO Group

CHPSO has opened a public forum on the FaceBook social network. This network is useful for getting news updates, networking with peers, sharing ideas and learning from others. However, public forums are not appropriate places to discuss confidential information. Please respect everyone's privacy rights by not discussing specific cases.

To participate in the CHPSO FaceBook group, go to www.facebook.com/group.php?gid=130728094433.

There are several ways to participate in the network after joining the group. For example, you can start or participate in discussions, and you can post links to useful resources.

The LinkedIn group is also active, and you can join it by going to www.linkedin.com/groups?gid=2174322.

—Rory Jaffe, MD rjaffe@calhospital.org

Calendar

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

October

12: *CHPSO & CAPSAC* (California Patient Safety Action Coalition): 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—originally November 3) *SCPSC* (Southern California Patient Safety Collaborative): 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* (Hospital Association of San Diego & Imperial Counties): ICU Sedation Task Force Meeting. San Diego.

December

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

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

January

28: *HASC* (Hospital Association of Southern California): 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

Just Culture Event Investigation: www.chpso.org/just/eventinv.pdf

SCPSC: Catherine Carson ccarson@hasc.org

Microcollaboratives Now Offered by CHPSO

Background: Providers have been inhibited from openly talking about patient events by current protections (e.g., peer review or attorney-client privilege). While that inhibition may be appropriate in cases involving a workforce member who is at fault, when dealing with systems issues, open discussion is appropriate because systems issues are not isolated problems. When working with a PSO, providers can broadly share information — both within an organization and with other providers. Systems issues are by their very nature widespread — sharing can speed learning and help develop best practices.

Microcollaborative: A grandiose name for a simple concept, microcollaboratives occur when colleagues informally gather to discuss a few cases and common issues, and help each other. This structure provides objectivity and shared expertise, along with shared improvement. Experience shows that these informal meetings are valuable in facilitating patient-safety improvements. The gathering can be of any group from more than one hospital, and can even vary from meeting to meeting. The group may include CMOs, CNOs (or the two together), CEOs, pharmacists, respiratory therapists — the choice is up to the participating hospitals, and may vary depending on the cases selected for discussion.

Ground Rules:

1. Only hospitals with a signed CHPSO contract may participate.
2. Start with a few cases (one to three) per hospital.
3. Choose cases that involve systems issues.
4. Only discuss cases in which a report of the incident has been or will be sent to CHPSO.
5. In the discussion, concentrate on systems issues, not on an individual's culpability (even if an individual is at least partially culpable for the event).
6. A report on the discussion during the microcollaborative is not needed.
7. Documentation of the discussion is optional.
8. Do not identify any of the providers involved.
9. Participants may go back to their institutions and talk about the cases for the purposes of improving patient safety or quality of care, but cannot identify the originating hospital or any of the involved providers.

Protection: Everything produced by this activity (verbal discussions, documents, subsequent discussions at other hospitals, etc.) is Patient Safety Work Product and is protected.

Startup Assistance: These meetings can be self-sustaining, but assistance will be provided for the first few meetings to facilitate discussion and help choose cases. There is also the opportunity to involve outside experts (e.g., human factors experts) in some of these meetings.

For more information, contact Rory Jaffe, MD rjaffe@calhospital.org.