CHPSO
California Hospital Patient Safety Organization

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Joint Commission Statement: The WHO Surgical Checklist

The Joint Commission would like to clarify compliance with the Universal Protocol in comparison with the World Health Organization (WHO) Safe Surgery Checklist.

Compliance in comparison with the WHO Safe Surgery Checklist

Recently, the WHO released its Safe Surgery Checklist. There have been questions regarding whether this checklist can fulfill the requirements of The Joint Commission's Universal Protocol, which was updated based on feedback received at the Wrong Site Surgery Summit in 2007. The requirements of the Universal Protocol and the WHO Checklist do not conflict. However, they were created for different purposes, so there is not a one-to-one correspondence between the two documents.

- The intent of the Universal Protocol is to prevent wrong site, wrong procedure and wrong person surgeries, and it focuses on those issues in great detail.

- The intent of the WHO Safe Surgery Checklist is to promote safe surgery, and it addresses other aspects of surgery.

- Both the WHO Checklist and the Universal Protocol cover pre-procedure verification, marking the site, and conducting a time out before the procedure. However, the WHO Checklist includes unique issues such as post-procedure sign out while the Universal Protocol contains more details about the performance of the time out.

Therefore, while not in conflict, compliance with the WHO Safe Surgery Checklist does not ensure compliance with the Universal Protocol so accredited health care organizations are still required to meet the Universal Protocol requirements.

— The Joint Commission

The Joint Commission Supports Use of WHO Checklist

Both CHPSO and the California Hospital Association consider the improvement of surgical safety as essential to public health, and endorse the concept of the WHO (World Health Organization) Surgical Safety Checklist. CHPSO recently surveyed hospitals to assess their status with adoption of the WHO Surgical Safety Checklist. Among the issues identified were some concerns about the relation between the WHO Checklist and The Joint Commission's Universal Protocol.

- Does the WHO Checklist meet Joint Commission elements of performance as it pertains to the Universal Protocol?

- Is the Universal Protocol all we need to do?

- What does The Joint Commission think of the WHO Checklist?

As a result, CHPSO has been in discussions with The Joint Commission to clarify the relation between the two initiatives and its recommendations regarding the WHO Checklist. To summarize The Joint Commission's position:

- The Joint Commission supports the use of the WHO Surgical Safety Checklist.

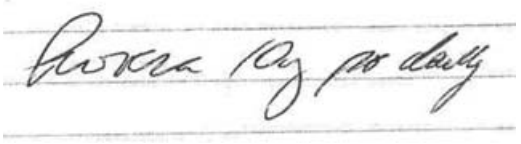
- The WHO Checklist is consistent with the goals of The Joint Commission standards, but in and of itself does not completely address the standards addressed by the Universal Protocol.

- The WHO Checklist addresses some patient safety issues not addressed by the Universal Protocol.

Also, in response to our discussions, The Joint Commission has issued a statement, which is included in this month's issue.

— Rory Jaffe, MD MBA rjaffe@calhospital.org

Name That Drug
(answer on last page)



WHO 'SAVE LIVES: Clean Your Hands'

May 5, 2010, is only six months away. That date marks the first anniversary of the World Health Organization's (WHO) "SAVE LIVES: Clean Your Hands" campaign. WHO has more than 5,000 hospitals registered for the campaign, and its new target is to increase registrations to 10,000. For more information about the current registration process, visit the WHO web site at www.who.int/gpsc/5may/register/en/index.html.

For "SAVE LIVES: Clean Your Hands" tools — organized by system change, training and education, evaluation and feedback, workplace reminders and institutional safety climate — to help with the campaign, visit the CHPSO web site at www.chpso.org/hygiene/index.asp.

— Rory Jaffe, MD MBA rjaffe@calhospital.org

The Power of Followers

Who is Patrick Harten? Surely you know. He was a key player in a headline story earlier this year that captured the nation's attention. Almost nobody knows Patrick's name because he was not deemed the "hero" in this story; he was *merely* a member of the team. We are a nation that loves heroes. We build monuments to George Washington, but none of us can name those killed in the Boston Massacre. Iacocca, Berwick, Reagan and Obama are cited as leaders of vision, and credited with sweeping changes and heroic accomplishments, yet the truth is that a leader without followers is merely someone going for a walk.

To quote the India Poised campaign, "This is that rarely-ever moment. History is turning a page." The ongoing digital revolution has given us instant access to information, shared ownership of public opinion, diversification of media, and a growing fascination with the intimate details of ordinary people. This is a fundamental democratization of ideas, of tastes, of values. Riding this wave successfully requires that we adopt a system that facilitates what Eric Von Hippel calls "democratizing innovation."

Synthesizing these two principles is essential, and some of the best practices to facilitate this culture change have clearly emerged. There are five steps necessary, but they may not be sufficient. Successful adoption requires resolving the I/we dichotomy, servant leadership, team skills, hardwired innovation and accountability. In the coming months, I'll share what I've learned from health care organizations worldwide about adopting these concepts.

Who is Patrick Harten? Patrick is the air traffic controller who handled US Air 1549, the "Miracle on the Hudson" flight. Listen to the widely available ATC tapes from that day and tell me Patrick isn't a heroic member of the team. Transcripts and the recording are available at www.faa.gov/data_research/accident_incident/1549/.

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

Oh Schnocks!

Healthcare Human Factors of Canada has released a video montage of usability testing clips highlighting user frustration with current health care technology. The two-minute video is located at vimeo.com/6834539.

Introducing CHPSO Web Interface

CHPSO and its data partner, Quantros, its data partner, will soon be scheduling a web seminar to introduce hospitals to the CHPSO web interface. The web seminar will be free of charge.

Member hospitals will have free access to a number of valuable services and information through this web interface, including:

- Simple point-and-click submission of incident reports to CHPSO.
- Hospital-specific analysis of their submitted incident reports, with benchmarking.
- Peer collaboration through secure access to web communication and social networking portals.
- A patient safety resource library, including topical content for general items, event-specific resources, regulatory changes, and alerts.

CHPSO and Quantros will also be scheduling a second free web seminar to help IT departments understand the XML format for data transmission to CHPSO and facilitate the production of automated processes to prepare incident reports for potential submission.

The date and time for each of these web seminars will be announced soon.

— Rory Jaffe, MD MBA rjaffe@calhospital.org

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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.

November

4: *CHPSO & CAPSAC* (California Patient Safety Action Coalition): 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.

11: *BEACON* (The Bay Area Patient Safety Collaborative): PSQI, Practical Skills for Quality Improvement. San Francisco.

12: *BEACON.*: Leadership Council. Location to be determined.

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

13: *BEACON*: CA-UTI. Webinar, 1 PM – 2 PM.

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

17: *BEACON*: "Beacon Blitz" Day of Web Seminars: Sepsis 9 AM – 10:30 AM, Hospital Acquired Pressure Ulcers 11 AM – noon, Falls 1 PM – 2 PM, Physician Engagement 2:30 PM – 3:30 PM

December

2: *BEACON*: PSQI, Practical Skills for Quality Improvement. San Francisco.

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 2010

13: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

14: *BEACON*: Compass Series course day 1 (of 4). Location to be determined.

26: *BEACON*: Quarterly Meeting. South San Francisco.

28: *HASC* (Hospital Association of Southern California): Southern California Patient Safety Colloquium. Pasadena.

February 2010

10: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

11: *HASD&IC*: San Diego Patient Safety Taskforce. Location to be determined.

11: *BEACON*: Compass Series course day 2 (of 4). Location to be determined.

18: *BEACON*: Key Contacts Meeting. Location to be determined.

March 2010

4: *BEACON*: Physician Leadership Meeting. Location to be determined.

5: *BEACON*: CNE Meeting. Location to be determined.

10: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

11: *BEACON*: Compass Series course day 3 (of 4). Location to be determined.

12: *CAPSAC*: California Patient Safety Action Coalition Meeting. Sacramento.

April 2010

7: *HASD&IC*: San Diego Patient Safety Taskforce. Location to be determined.

14: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

15: *BEACON*: Compass Series course day 3 (of 4). Location to be determined.

27: *BEACON*: Annual Meeting. Santa Clara.

May 2010

12: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

13: *BEACON*: Compass Series course day 1 (of 4). Location to be determined.

13: *BEACON.*: Leadership Council. Location to be determined.

June 2010

2: *HASD&IC*: San Diego Patient Safety Taskforce. Location to be determined.

9: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

10: *BEACON*: Compass Series course day 2 (of 4). Location to be determined.

11: *CAPSAC*: California Patient Safety Action Coalition Meeting. Location to be determined.

July 2010

8: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

9: *BEACON*: Compass Series course day 3 (of 4). Location to be determined.

27: *BEACON*: Quarterly Meeting. Location to be determined.

August 2010

11: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

12: *HASD&IC*: San Diego Patient Safety Taskforce. Location to be determined.

12: *BEACON*: Compass Series course day 4 (of 4). Location to be determined.

September 2010

8: *BEACON*: PSQI, Practical Skills for Quality Improvement. Location to be determined.

9: *BEACON*: Compass Series course day 1 (of 4). Location to be determined.

10: *CAPSAC*: California Patient Safety Action Coalition Meeting. Location to be determined.

10: *BEACON*: Key Contacts Meeting. Location to be determined.

23: *BEACON*: Physician Leadership Meeting. Location to be determined.

24: *BEACON*: CNE Meeting. Location to be determined.

October 2010

6: *HASD&IC*: San Diego Patient Safety Taskforce. Location to be determined.

December 2010

1: *HASD&IC*: San Diego Patient Safety Taskforce. Location to be determined.

3: *CAPSAC*: California Patient Safety Action Coalition Meeting. Location to be determined.

For further information on these events:

BEACON: Pamela Speich pspeich@hospitalcouncil.net or www.beaconcollaborative.org

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

CHPSO: Rory Jaffe info@chpso.org

HASC: Catherine Carson ccarson@hasc.org

HASD&IC: Nancy Pratt nancy.pratt@sharp.com

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

SCPSC: Catherine Carson ccarson@hasc.org

About CHPSO

Mission: Dedicated to eliminating preventable harm and improving the quality of health care delivery in California hospitals.

Vision: CHPSO will lead California to provide the nation's safest and highest quality hospital care.

Name That Drug

(answer)

The prescription was intended to be for **Provera.** From the ISMP error analysis:

"The patient received 1 dose of Prozac. The physician discovered the error the next day while he was reviewing the patient's medication list (which is a highly recommended form of redundancy that has detected many errors). The handwritten order was shown to several nurses, pharmacists, and physicians. Most read the order as Provera but one physician thought it was Prozac. One nurse guessed it was Provera but also said it could be Proscar (finasteride). Poor handwriting was a contributing factor, as was the fact that Provera is infrequently prescribed whereas Prozac is a commonly prescribed drug, perhaps biasing the reader's interpretation as 'Prozac' on the handwritten prescription."

— Rory Jaffe, MD MBA rjaffe@calhospital.org

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.