CHPSO
California Hospital Patient Safety Organization

Patient Safety News
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AHRQ Looks for Reasons Behind Improved HSOPS Scores

The Agency for Healthcare Research and Quality (AHRQ), as reported in its 2010 User Comparative Database report on the Hospital Survey on Patient Safety Culture (HSOPS), interviewed representatives from some of the hospitals that notably increased their HSOPS scores, looking for explanations for the improvement. The responses grouped into the four following themes.

Hospitals improved their communication between management and staff on patient safety.

Sample Actions and Illustrative Quotes

- Conducted walk-arounds to learn about staff concerns regarding patient safety.
- Focused on patient safety during staff meetings.
- *"The engagement of our department heads and nursing coordinators in making sure patient safety culture is on everyone's mind."*
- Started conducting monthly staff meetings.
- Implemented Open Book Management and participated in biweekly "huddles" to review the hospital budget, financial statements, and patient-safety issues and concerns.
- *"Open Book Management has had the biggest impact of all their initiatives. It affected everything we do. Employees are much more aware."*

Hospitals focused on improving error reporting systems, responding appropriately to reports and applying nonpunitive "Just Culture" principles.

Sample Actions and Illustrative Quotes

- Educated hospital leaders on making error reporting anonymous, easy and convenient.
- *"When we went from a paper system to an electronic system, our reporting increased about 40 percent — part of it was education, because we had to do a lot of education as we rolled out the electronic system — part of it is because it's very easy."*
- Set up a hotline for reporting errors and developed anonymous reporting forms for medical errors.
- *"We got management to buy into that it was OK for a staff person to not provide their name, so they wouldn't be afraid to report."*
- Trained staff to use the new reporting systems.
- Provided training on "Just Culture" and taught managers to use an algorithm when examining patient-safety error incidents.
- *"The algorithm helps management more than anything else."*

Hospitals engaged staff in developing solutions to patient-safety problems.

Sample Actions and Illustrative Quotes

- Directly involved staff in designing solutions to handoff problems.
- Started an employee engagement committee that includes senior leaders.
- Instituted nursing peer review to promote open communication.
- *"I personally think it is a combination of the employee engagement committee where employees have a voice. I think it's the peer review. Having peers to go to, to voice your concerns."*
- Assigned staff to a scheduling team to accommodate staff preferences.
- Allocated resources for safety needs identified by staff — for example, buying safer beds.

Hospitals developed, implemented and monitored action plans, in some cases focusing on specific survey items.

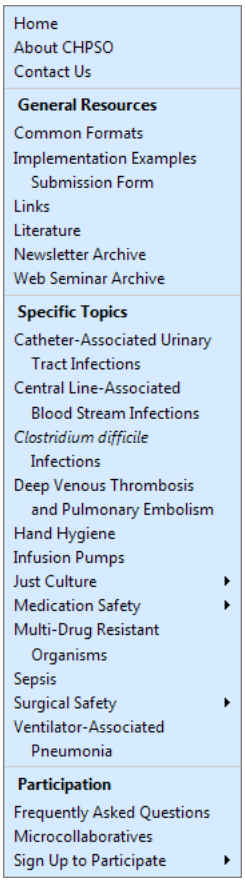
Sample Action

- Charged department managers with developing and implementing an annual action plan and held them accountable.

For more information and the full report, go to www.ahrq.gov/qual/hospsurvey10/.

— Rory Jaffe, MD MBA rjaffe@calhospital.org

Touring the CHPSO Web Site



CHPSO's web site — www.chpso.org — is very popular, averaging 100 page views a day, and is the most-recognized Patient Safety Organization (PSO) web site. This brief guide will help visitors make the best use of the resources there.

On the left of every page is the same navigation menu. This menu is broken into four sections: 1) Home, About CHPSO, Contact Us, 2) General Resources, 3) Specific Topics, and 4) Participation. Except for the title text in bold, everything in the menu is a clickable link. Links with right arrows also have submenus that will appear when the mouse pointer stops over the link without clicking.

Information about the PSO rule and CHPSO web seminars and newsletters are found under "General Resources." "Specific Topics" contains information about improvement targets, including protocols, implementation examples, and educational materials. "Participation" includes information on how organizations become CHPSO members and a copy of the current standard contract agreement.

The web site is continually updated.

— Rory Jaffe, MD MBA rjaffe@calhospital.org

Sanity

Albert Einstein defined insanity as "doing the same thing over and over again and expecting different results."

I had this in mind when I read an article posted by Dr. Rory Jaffe in the April 2010 edition of this publication. He discussed the practice recommendations recently published by the American Heart Association (AHA) intended to reduce medication errors in acute cardiovascular medicine.

AHA recommends standardized order protocols, interdisciplinary teams, staff education on safe medication practices and an organizational culture of safety. My first reaction upon reading these recommendations was an emphatic "Yes!"

That reaction lasted until I was working with a large academic medical center in the Midwest a few weeks ago. The Medical Director of the SICU has been implementing the recommended culture of safety for several years now. When discussing a new interdisciplinary rounding tool that his medical center has instituted, he said, "If it feels normal you're probably not doing it right."

Circling back to Einstein's oft-used quote, my physician friend would tell us that if we want different results, including a different culture, then we need to take different actions. I think this gets to the very core of the AHA practice guidelines; educated interdisciplinary teams using (i.e. doing) standardized best-practice protocols will create an organizational culture of safety. Doing is becoming.

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

CHPSO and the Collaboratives

The three Regional Hospital Associations and Anthem Blue Cross have created a statewide collaborative: *Patient Safety First… A California Partnership for Health*. The collaborative and CHPSO complement each other in providing hospitals patient safety improvement resources.

Patient-safety collaboratives give hospitals a peer-to-peer networking environment to improve care based on evidenced-based medicine and to share experiences supporting successful change implementation.

CHPSO helps hospitals evaluate events and near misses, and develop effective strategies to improve patient safety. It also provides hospitals with a new legal protection that enables increased sharing of privileged confidential information.

For information on collaboratives in your area, please contact:

Hospital Association of San Diego and Imperial Counties: Lindsey Wade lwade@hasdic.org

Hospital Association of Southern California: Catherine Carson ccarson@hasc.org

Hospital Council of Northern and Central California: Mary Lopez mlopez@hospitalcouncil.net

For information on CHPSO membership, contact Rory Jaffe.

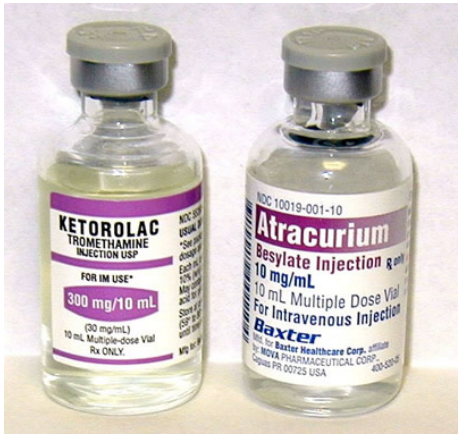
— Rory Jaffe, MD MBA rjaffe@calhospital.org

Subscription service (additions and removals): La Shon Tate ltate@calhospital.org
Questions or comments: Rory Jaffe, MD MBA rjaffe@calhospital.org

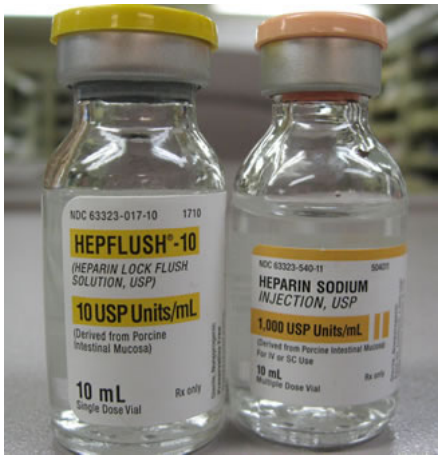
FDA Changing Drug Packaging Standards to Improve Patient Safety

Challenge: Designed Environment

Not all patient safety issues can be directly addressed by the health care provider. The current design of purchased items, such as drug packages and devices, may create or augment safety threats. In the past few issues of this newsletter, CHPSO has reviewed a number of these threats, including several drug-packaging problems. Improved packaging that accounts for human factors can reduce these risks.



Similar packaging of a high-alert medication and an unrelated medication: atracurium (a paralyzing drug) and ketorolac (a pain reliever).



Heparin 10 Units/ml and 1,000 Units/ml.

The Food and Drug Administration (FDA) is developing guidance on naming, labeling and packaging practices to reduce medication errors: (edocket.access.gpo.gov/2010/2010-8233.htm), and is holding a public workshop June 24–25 in Bethesda, MD, to discuss the guidance.

The meeting will include four different panel discussions:

- Container label and carton labeling design as they relate to reducing the risk of medication errors.
- Study design, conduct and interpretation of human factors analysis, Failure Mode and Effects Analysis (FMEA), usability studies, and other studies specifically focused on evaluating the safety of container label and carton labeling designs to reduce the risk of medication errors.
- Manufacturers' packaging used for medications as they relate to the safe use of the medicine from a medication errors perspective.
- Developing proprietary names as they relate to reducing medication errors.

By the end of fiscal year (FY) 2010, the FDA will publish draft guidance on best practices for naming, labeling and packaging drugs and biologics to reduce medication errors. Final guidance will be published by the end of FY 2011. In addition, by the end of FY 2012, the FDA will publish the draft guidance on proprietary name evaluation best practices, with final guidance to follow as soon as feasible.

— Rory Jaffe, MD MBA rjaffe@calhospital.org

Submitting Patient Safety Alerts

One of CHPSO's primary goals is to rapidly share alerts among California hospitals. As the recent Viaspan alert shows, hospitals benefit from learning of a significant event, near miss or unsafe condition at one hospital that may recur elsewhere. Hospitals can help by recognizing these and notifying CHPSO that an alert may be in order. CHPSO can be contacted at 916.552.7568, or, for CHPSO members, through the CHPSO/Quantros website. Confidential unencrypted information cannot be sent via regular e-mail.

Alerts can be handled in several different ways, depending upon the level of confidentiality requested by the originating hospital. Patient confidentiality rules will be followed in all cases. The originating hospital's identity will not be disclosed without express permission. Additionally, any provider identification requires the written consent of that provider.

The primary consideration is whether the announcement is Patient Safety Work Product (PSWP) or is non-protected.

Non-Protected Information

All the information in the Viaspan alert already had been supplied by the hospital to the manufacturer and CDPH, and thus was not protected. This alert, from the recognition of an unsafe condition not involving a specific patient, did not use any PSWP.

Even when a report is distributed without identifiers, a recipient might identify the originating hospital. Broad distribution of non-protected information, while preferred, increases the chance that reidentification will occur. CHPSO will work with the reporting hospital to identify the best breadth of distribution for the alert.

Patient Safety Work Product

CHPSO member hospitals may submit privileged information for an alert. The PSO rule maintains legal privilege for identifiable information though it has been distributed as an alert, since it remains PSWP regardless of who receives it. Inappropriate use or disclosure by the recipient is subject to a fine.

Unless CHPSO receives written provider consent, if the alert will be distributed to anyone other than PSO participants, the PSWP will be made non-identifiable as specified in the Federal PSO regulations. Again, CHPSO will work with the reporting hospital to identify the best breadth of distribution for the alert.

— Rory Jaffe, MD MBA rjaffe@calhospital.org

CHPSO LinkedIn Groups

Connect, Communicate and Collaborate

CHPSO sponsors a public forum for news updates, networking, sharing ideas and learning from others. Anyone interested in joining can at www.linkedin.com/groupRegistration?gid=2174322.

Public forums are not appropriate places to discuss confidential information. Please respect everyone's privacy rights by not discussing specific cases.

CHPSO is setting up a separate, secure site for member collaboration and sharing of protected information, and will announce its availability soon.

There also is a subgroup that provides a news feed of the latest literature in patient safety, as well as providing a forum for discussion of the literature. To join that group, go to www.linkedin.com/groupRegistration?gid=3033757.

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.

June

2: *HASD&IC* (Hospital Association of San Diego & Imperial Counties): San Diego Patient Safety Council; Sepsis. San Diego.

11: *CAPSAC*: California Patient Safety Action Coalition Meeting Pasadena.

29: (Date change — was June 15) *SCPSC* (Southern California Patient Safety Collaborative): Track II: Pressure Ulcers. City of Industry.

July

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

August

10: *SCPSC*: Track I: Surgical Care Improvement Project, Sepsis, Hospital-Acquired Infections in the ICU Setting. City of Industry.

12: *HASD&IC*: San Diego Patient Safety Council; Sepsis. San Diego.

September

1: *SCPSC*: Track II: Pressure Ulcers. City of Industry.

10: *CAPSAC*: California Patient Safety Action Coalition Meeting Napa.

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

6: *HASD&IC*: San Diego Patient Safety Council; Sepsis. San Diego.

November

16: *SCPSC*: Track I: Surgical Care Improvement Project, Sepsis, Hospital-Acquired Infections in the ICU Setting. City of Industry.

December

2: *SCPSC*: Track II: Pressure Ulcers. City of Industry.

3: *CAPSAC*: California Patient Safety Action Coalition Meeting. Torrance.

15: *HASD&IC*: San Diego Patient Safety Council; Sepsis. San Diego.

For further information on these events:

BEACON: Petrina Aiello paiello@hospitalcouncil.net or www.beaconcollaborative.org

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

HASD&IC: Lindsey Wade lwade@hasdic.org

SCPSC: Catherine Carson ccarson@hasc.org