CHPSO
California Hospital Patient Safety Organization

Patient Safety News
February 2012
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Register Now for Annual Meeting

Accelerate patient safety initiatives at your hospital by joining your colleagues at CHPSO's Annual Meeting — Take a Stand for Patient Safety: Eliminate Preventable Harm — March 13, 2012, in Glendale. Nationally renowned experts will share patient stories, case studies and critical elements to achieving a culture of safety. The program is designed for hospital executives; quality, risk and patient safety leaders; and physician, pharmacist and nurse leaders.

Participants from CHPSO-member hospitals may register for $200. Non-members are $400. Registration fees will increase $100 after February 13.

Partners include the California Hospital Association, the Hospital Association of San Diego and Imperial Counties, the Hospital Association of Southern California and the Hospital Council of Northern California. Sponsors include the California HealthCare Foundation and Kaiser Permanente.

The brochure and registration form are available at www.chpso.org/images/201203bro.pdf . To register online go to www.cvent.com/d/8cq8p2/4W.

Attendees can receive up to 5.75 hours of continuing education credits through the National Association of Healthcare Quality (NAHQ) and the American Society for Healthcare Risk Management (ASHRM).

Responding to Serious Adverse Events

The Institute for Healthcare Improvement recently released an important document: *Respectful Management of Serious Clinical Adverse Events* (2nd ed). This is the third in a series of articles discussing crisis management.

The four hallmarks of a strong crisis response are immediacy, transparency, apology and accountability. Internal and external communications around serious clinical events are essential.

Risk Assessment and Root Cause Analysis

In a crisis situation, first address the patient's and family's immediate needs. The organization should be prepared to ask and respond to: How likely is this to happen again, and is there clear and present danger? Triaging the risk using tools such as the event debriefing in TeamSTEPPS should occur even before or as an organization commences a root cause analysis. In some situations short-term precautions need to be taken such as to alter a process in the short term or remove a potentially dangerous caregiver while the organization is more thoroughly investigating the event. Informing the patients and families in the early stages that precautions have already been taken, even before the full investigation has occurred, is comforting and satisfying to them. Keeping caregivers safe is also an organizational priority. Early actions to prevent recurrence serve their interests and affirm the leaders' responsibility to the caregivers.

Root cause analysis (RCA) is an essential tool of system investigation, assessment, learning and improvement. The RCA process should begin immediately after a serious event led by a skilled and trained facilitator. Ideally, the RCA should be completed within 30 days. Executive leadership should be included to ensure the RCA is a comprehensive, fair and balanced process to remove barriers and to provide support. When looking to solve a problem, it helps to begin at the end result, reflect on what caused that, and question the answer five times. The "Five Whys Technique" helps provide accurate and complete statements of problems, complete honesty in answering questions and the determination to resolve the problems.

Given the RCA's focus is on learning and improvement, staff close to the front line of the event, as well as the patient and/or family, should be included in the process. The extent of inclusion will be determined on a case-by-case basis. Staff, patients and families have all commented that, in addition to informing learning, inclusion supports healing. To ensure follow-through on the plan of correction, the RCA should be fully integrated into the processes of the board and executive leadership. The board should specifically decide how it wants to be involved in the RCA as a matter of policy.

Key Points:

- Address patient and family immediate needs
- Start RCA process immediately after serious event
- Include patient and family in RCA process

- Integrate RCA plan of correction into board and executive leadership processes

— Bobbie Dietz, bdietz@chpso.org

References

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Conway J, Federico F, Stewart K, Campbell M. *Respectful Management of Serious Clinical Adverse Events (Second Edition)*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. Available at www.IHI.org.

Serrat O. *The Five Whys Technique*. Available at: www.adb.org/documents/information/knowledge-solutions/the-five-whys-technique.pdf.

Special Note

We are pleased to have one of the authors of *Respectful Management of Serious Clinical Adverse Events* conduct a web seminar this month (February 28) to discuss this important subject.

All CHA and Regional Hospital Association members are welcome, in addition to all CHPSO members. See *February Calendar Notes* in this newsletter for additional details and registration information.

Upcoming educational sessions

CHPSO is committed to identifying and providing best-in-class resources assisting hospitals' efforts to improve patient outcomes. This month's offerings include a leader at the Institute for Healthcare Improvement (IHI) discussing preparing for and responding to serious clinical events. This web seminar is open to all CHA, Regional Hospital Association and CHPSO members at no charge.

Also, for our second in our hand-off series, we have a physician from the University of Chicago discussing lessons learned from examining how hospitals successfully (or not) implement a reliable hand-off program. Note the time change (now February 28 8:30–9:30 AM) to accommodate the speaker. This is free to CHPSO members.

The third and fourth web seminars in the handoff series also will feature special guests. The third, scheduled for March 20 9:30–10:30 am (note date change), will feature a speaker from Duke to explain their comprehensive hand-off program, including structure and evaluation. The fourth, scheduled April 24 9:30–10:30 AM, will feature a speaker from the Joint Commission's Center for Transforming Healthcare to discuss the Center's hand-off project and hospital participation opportunities.

February Calendar Notes

CHPSO

Member Call February 13 10:00–11:00 AM. Subjects will include a presentation on results to date of the retained surgical items project and upcoming changes to focus the project on the identified challenges. There also will be a discussion of the significant upgrades to our member services.

Hand-off Web Seminar Series Part 2 February 28 8:30–9:30 AM PST (*note time change*). Vineet Arora, MD, MAPP, Associate Professor of Medicine, University of Chicago will discuss findings of her research: how to successfully design and implement a standardized hand-off protocol, the benefits of using a standardized form and the role of human factors in hand-off quality.

Respectful Management of Serious Clinical Adverse Events February 28 Noon–1:00 PM PST. The presenter will be Frank Federico, RPh, Executive Director, Strategic Partners, IHI, and coauthor of the IHI report on this subject.

Case example: You just heard at this morning's CEO leadership meeting that a 40-year-old father of five children died in the Surgical ICU last night, hours after receiving medication intended for another patient. Everyone is upset. Questions are flying around the hospital: What does the family know? Who did it? What happened? What can we say? Would the patient have died anyway? (He was very sick.) Has anyone gone to the press?

Subscription service: www.chpso.org/lists/
Questions or comments: Rory Jaffe, MD MBA rjaffe@chpso.org

No charge for registration. All CHA and Regional Hospital Association members welcome, in addition to all CHPSO members. In order to allow more organizations to participate, there will be a limit of one registration per hospital, but no limit on how many can listen at a given location.

Please contact Colleen Meacham at cmeacham@chpso.org or 916.552.7651 to register. The Member Call and Handoff Web Seminar are for CHPSO members only. *Respectful Management of Serious Clinical Adverse Events* is open to all CHA and Regional Hospital Association members in addition to all CHPSO members.

Hospital Council of Northern and Central California

Patient Safety First San Francisco Bay Area Regional Meeting February 14 in San Mateo. Topics include surviving sepsis, eliminating elective pre-39 weeks deliveries, and HAI prevention. Among the speakers are:

- Building a Culture of Safety and Continuous Learning: Michael Leonard, MD, Pascal Metrics
- Improving HAI Surveillance: CDPH Data Validation Study: Lynn Janssen, CDPH Liaison Program Coordinator, HAI Program
- Moving toward High Reliability in Perinatal Care: Russel Jelsema, MD, Risk Management & Patient Safety Institute, West Michigan Obstetricians & Gynecologists

LEAN Practitioner Course, starting February 20 in Fresno or February 22 in Oakland. This course introduces the principles, methods, and tools that can be used to eliminate waste, reduce costs, improve quality and deliver greater value to health care organizations and their customers.

Participants learn how to manage a LEAN project using Six Sigma (DMAIC: Define, Measure, Analyze, Improve, and Control), run a Kaizen team event and use appropriate tools to improve and standardize processes.

Please contact Jenna Fischer, at jfischer@hospitalcouncil.net or 925.746.5106 to register for any of these offerings or for more information.

Hospital Association of Southern California

Southern California Patient Safety Collaborative, Track I — Hospital-Acquired Infections, Sepsis & Surgical Care Improvement Project (SCIP) February 7 in Industry Hills. There are several interactive sessions and speakers, including:

- A Program to Reduce Hospital Acquired Urinary Tract Infection, Alan Rothfeld, MD, Hollywood Presbyterian Medical Center
- Pharmacist-led Sepsis Management Program, Angela Rosenblatt, MS, PharmD, BCPS, BCNSP Clinical Pharmacy Specialist - Critical Care Riverside County Regional Medical Center
- Hand Hygiene — Science or Fiction? William Petty, MD, Professor of Anesthesiology, Retired

Please contact Julia Slininger, at jslininger@hasc.org or 213.538.0766 to register. There is no charge for this event. This is open to all Patient Safety First Collaborative hospitals. Additional limited space is available for other hospitals.

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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 are archived on the CHPSO website (www.chpso.org).

Prospective authors may submit articles to Rory Jaffe, MD, MBA: rjaffe@chpso.org, 916.552.7568. Typical articles will be brief — between 200 and 600 words. A completed publication agreement form must be submitted prior to publication.

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