

Court Affirms Patient Safety Work Product

Decision overrides state and local laws to contrary

Patient Safety Work Product (PSWP) privilege was affirmed in the first reported appellate decision of its kind in the country, one in which CHPSO participated as an *amicus curiae*. In this Illinois case, the Department of Financial and Professional Regulation subpoenaed incident reports involving three pharmacists. Walgreens had collected these reports as part of its Patient Safety Evaluation System (PSES) and submitted them to its Patient Safety Organization (PSO). The court noted that Congress clearly intended to provide broad protection for information collected and reported voluntarily to a PSO for improving health care quality and safety.

The PSWP privilege is new and relatively untested. This decision supports the principle that once information is proven to be PSWP, its privilege protections override state and local laws to the contrary.

CHPSO recommends that providers review their policies regarding their PSES to ensure that they clearly identify what is PSWP and what is not. CHPSO offers a model policy at no cost to members and also provides free support to members who have questions about their policies. Contact Rory Jaffe at rjaffe@chpso.org with policy requests or questions.

CHPSO also recommends that providers continue to work on connecting their incident reporting system to the CHPSO database. Reporting to a PSO is an important component of establishing the PSWP privilege and an important goal of the

Patient Safety and Quality Improvement Act. CHPSO and ECRI provide extensive free support for this effort.

A full report on the Illinois case prepared by Michael Callahan of KattenMuchinRosenman LLP, the lawyer who drafted our *amicus curiae* brief, can be found at chpso.org/ooii.

—Rory Jaffe, MD, MBA, rjaffe@chpso.org

Self-Reporting

From QA to QI

In the May issue of *CHPSO Patient Safety News*, this column focused on the importance of learning from defects and pointed out the problem with identifying adverse events, near misses and hazardous conditions. This is not a small problem. Typically, only about 10 percent of adverse events are reported. This means that either much effort must be expended to identify such cases by other means or that many learning opportunities will be missed.

Remember that peer review is the dominant mode of event analysis in hospitals and generic screens are the dominant method by which cases are identified for peer review. These screens include hospital readmission, death, unplanned return to the OR, unplanned transfer to critical care, etc. Generic screens were initially developed to identify instances of patient harm to test whether a no-fault medical malpractice system might be viable. They have low specificity and have never been validated for use in peer review. The generic screens were, however, used in the Harvard Medical Practice Study to identify rates of harm and substandard care. The Institute for Healthcare

Improvement Trigger Tool is an updated version of this method.

In the Harvard study, 26 percent of all admissions fell out on the screens. The study's staged review process ultimately led the investigators to declare that 3.7 percent of admissions were associated with patient harm and 1 percent with negligence, i.e., substandard care. In other words, they had to look at 26 records to find about four instances of harm and one instance of substandard care. This is why a large proportion of hospitals do secondary pre-review screenings before assigning cases for peer review. None of this is getting us to the goal of the QI Model: To identify and act on learning opportunities to improve the quality and safety of care. To be quite frank, as a means of identifying cases for peer review, the generic screen process stinks.

About 20 years ago, the aviation industry woke up to the problem of underreporting and came to recognize that fear of reporting was poisoning efforts to improve safety. This resulted in the birth of aviation safety programs that granted immunity from sanctions to pilots who made good faith safety reports. Together with the introduction of crew resource management training, the aviation safety programs were key to the dramatic progress that followed. At least one study suggests that a non-punitive environment would be critical to the ability to replicate this in health care.

There is only one published example of a successful self-reporting program in health care. The example comes from a department of anesthesia at an academic medical center, which was able to sustain high rates of self-reporting (90 percent of cases reviewed, 70 percent of

events identifiable by all means) over several years. The authors assert that, “Anesthesiologists will comply with a system of self-reporting if they understand the process, if there is institutional and departmental encouragement and support for the process, and if the process is non-punitive and can result in real improvements in patient care.”

My latest national study of peer review practices (under review for publication) found that self-reporting is beginning to be promoted more broadly. Moreover, hospitals in which the practice is taking hold are realizing the expected improvement in quality and safety.

Coming next: How to promote self-reporting

— Marc T. Edwards, MD, MBA, [QA to QI Consulting](#), marc@QAtoQI.com

References

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Participate in CHPSO-led Project on Retained Surgical Items

Call for action

CHPSO is leading a multi-state retained surgical item project to provide a collective analysis that will help hospitals reduce the risks of retained surgical items. PSOs in five states — Illinois, Michigan, Missouri, North Carolina and Tennessee — have joined the effort. Learning from both near misses and actual events will help us better protect our patients. CHPSO and its allied PSOs will present the findings of the project in the fourth quarter of 2012.

CHPSO will collect data July 1 through Oct. 31, 2012. Hospitals may submit events that occurred prior to the start date.

Submit data electronically or manually

CHPSO is collecting event reports on retained surgical items (other than sponges) such as micro-needles, broken drill bit fragments and guidewires. Reporting this information is important because these retained surgical items, in aggregate, occur more frequently than retained sponges and it is not well known how to prevent these events.

There are three ways to submit data: 1) hospitals connected to the CHPSO/ECRI database may submit this information electronically, 2) alternatively, hospitals may submit this information through their current incident reporting system

and send a copy to CHPSO via mail or fax, and 3) hospitals may use CHPSO’s data collection form. If you use your incident reporting system, please include the device information (manufacturer, lot number, etc.).

For the CHPSO form and instructions on how to confidentially send reports, please call Colleen Meacham at 916.552.7651.

Data collected on incidences, near misses and unsafe conditions

CHPSO is asking hospitals to report retained surgical items that fall under these categories:

Incident — An item is left in the patient that is not supposed to be left there as part of the procedure. For example, a staple dropped into the wound and not retrieved would constitute an incident. A properly placed staple would not.

Near miss — A fragment is generated and retrieved. For example, a drill bit breaks in the patient and the pieces are found and removed.

Unsafe condition — A hitherto unidentified hazard that could result in a retained surgical item. For example, a new model of retractor has a removable section that could be left behind.

Types of information collected

Please include the following information for each incident, near miss, or unsafe condition:

Subscription service: www.chpso.org/lists/

Questions or comments: Rory Jaffe, MD, MBA rjaffe@chpso.org

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Event category — Incident, near miss or unsafe condition.

Event location and time — Where and when the item was left behind (not when it was discovered).

Event discovered — Before incision closed, in operating room after closure, in recovery room, during the hospital stay, after discharge or in a subsequent hospitalization.

Procedure — What procedure was planned, and, if different, what procedure was performed.

Case length — Reported in minutes.

Procedure urgency — Elective, urgent, emergent, unknown.

Description of retained item — Name, size, manufacturer, and other identification such as lot number.

Reason left behind — Why the retained surgical item was left behind (if known).

Factors contributing to the event — Such as defective device or operator error.

If you have questions about this project, please contact Rory Jaffe, rjaffe@chpso.org.

—Rory Jaffe, MD, MBA, rjaffe@chpso.org

Software Reduces Effort to Perform FMEAs

CHPSO affiliation with QI Path to benefit members

CHPSO has reached an affiliation agreement with QI Path, a Colorado-based software company that helps hospitals conduct more efficient and effective risk assessments.

“Critical to eliminating preventable harm is anticipating what can go wrong, then mitigating those risks by adjusting procedures, training, and systems,” said CHPSO Executive Director Rory Jaffe, MD, in an announcement about the affiliation. “Techniques to prospectively anticipate failures have traditionally been difficult and time-consuming, discouraging their use. Simplifying prospective risk analysis (e.g., Failure Modes and Effects Analysis — FMEA) provides a practical tool to plan ahead, rather than wait for an event and patient harm. QI Path presents a tool that can significantly reduce the effort to perform FMEAs, and we hope that its use will encourage widespread implementation of preemptory risk mitigation.”

QI Path will offer CHPSO member hospitals significant discounts on web-based software subscriptions and service packages. CHPSO will augment the value of these services through additional analysis of risk assessment data. All information generated by CHPSO member hospitals on the QI Path platform will be protected as Patient Safety Work Product under the Patient Safety and Quality Improvement Act of 2005.

CHPSO hospitals participate in trial program

Over the last year, several CHPSO hospitals participated in a trial program

using QI Path’s web-based software. One hospital, St. Joseph’s Medical Center in Stockton, used the QI Path system to conduct a large-scale FMEA project to identify and address risks related to managing patients who bring their own insulin pumps into the hospital.

“The QI Path system was very easy to use, even for some of our staff with limited electronic literacy,” says Susan White, risk manager at St. Joseph’s Medical Center.

“The system eliminated many of the frustrations associated with ‘traditional,’ paper-based FMEAs. The intuitive web interface allowed our team to collaborate on the project online — team members could log into the project asynchronously to complete project tasks. Project information was always up to date. Aside from saving us meeting time, the QI Path system allowed us to visually sort failure modes by hazard score, which resulted in a more focused analysis. I particularly appreciated the system’s action planning features, which allowed our team to define, assign and track the interventions we devised to address the issues identified in the project.”

Learn more during July 23 Web seminar

A CHPSO member Web seminar on July 23 from 10–11 a.m. will introduce QI Path’s offerings and provide insights and lessons learned from the St. Joseph’s project. Members will receive an invitation to participate in the Web seminar in early July.

If you would like to see a demonstration of the software, contact QI Path President Tom Leifer, 720.583.2857, tom.leifer@qipath.com.

— Frances Sutz Brown, fsutzbrown@chpso.org

Quality Improvement and Patient Safety Positions Open

The California Hospital Patient Safety Organization (CHPSO) and the California Hospital Engagement Network are recruiting for hospital quality and patient safety professionals. We have immediate openings for candidates interested in working to improve patient outcomes on a statewide level.

CHPSO Director, Quality and Patient Safety

This Sacramento-based position will foster multi-facility collaboration for quality improvement and facilitate patient safety initiatives throughout California. As an expert resource for members, the director will analyze incident reports and root cause analyses; identify patient safety best practices, models, and other strategies; enable peer-to-peer connectivity; and bring practitioners and industry leaders together to share knowledge and foster innovations in quality and patient safety. To learn more, visit home.eease.adp.com/recruit2/?id=689401&t=1.

Director, Quality Improvement Network Facilitator

The California Hospital Engagement Network is looking for experienced hospital quality professionals to work one-on-one with hospitals to facilitate quality improvement efforts throughout the state. These field-based positions are funded by a grant from the Centers for Medicare & Medicaid Services' Partnership for Patients Initiative. The network facilitators will ensure hospitals achieve success in the area of patient safety, will develop individual hospital improvement plans, convene resources and teams, ensure the execution of the project plan, track and document results,

and support the collection of data. Both full-time and part-time candidates will be considered. To view the full job description and to apply, visit home.eease.adp.com/recruit2/?id=1510481&t=1.

For more information about either opening contact Delma Giroski, CHA Human Resources manager, dgiroski@calhospital.org, 916.552.7663.

CHPSO Seeks Input on Website

CHPSO is redesigning its website and is looking for a few more volunteers to provide input and test usability. If you're interested in participating, please contact Frances Sutz Brown, director, Operations and Communications, fsutzbrown@chpso.org or 916.552.7598. The new website will be easier to navigate and will include member-only features.

Affordable Care Act Ruling Keeps PSO Participation Mandate Intact

The Supreme Court's June 28 ruling upholding the Affordable Care Act leaves intact the mandate that hospitals with 50 beds or more must participate in a PSO by Jan. 1, 2015 in order to contract with health plans in state insurance exchanges. Except for the ruling that allows states to forgo Medicaid expansion, the decision keeps the entire Act in place.

California was the first state to create an insurance exchange after the Act passed and continues to be a change agent for improving patient care and safety while reducing costs. California plans to have its Health Benefit Exchange operational by Jan. 1, 2014, when exchange

participants will benefit from federal tax subsidies and credits. The exchange is a new insurance marketplace in which individuals and small businesses can purchase competitively priced health plans.

The California Hospital Association held a Web seminar July 2 highlighting the statewide impact of the Act. CHA members can access the presentation at calhospital.org/program-recordings later this month.

— Frances Sutz Brown, fsutzbrown@chpso.org

CHPSO Calendar Notes

All events are for CHPSO members only. Members will receive an email a few days before each event with information on how to participate.

July

9: CHPSO: Members Call. Issues Related to CHPSO Hospital Incident Reports.

10–11 AM

Join a discussion on how best to address two key issues that have arisen from hospital incident reports to CHPSO: 1) corrections to electronic reports may result in a higher risk of miscommunication than with paper records; and 2) using complex equipment (e.g., surgical robots) presents significant risks related to their complexity.

16: CHPSO/ECRI: User Group Meeting. Knowledge Transfer: A Patient Safety Essential — Training as a contributing factor in adverse events. 11:30 AM–12:30 PM

Discuss and share ideas about patient safety events that occur because of a clinician's or caregiver's (including agency nurses and locum tenens physicians) unfamiliarity with the facility, its equipment and procedures.

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Suggestions will be provided on how to improve orientation and training programs.

23: CHPSO/QI Path: Web seminar. FMEA — Intro to QI Path Software and Lessons learned from Pilot Project, 10-11 AM

This Web seminar introduces QI Path's offerings and provides insights from St. Joseph's Medical Center in Stockton, a CHPSO-member hospital that participated in a trial program using QI Path software. St. Joseph's will share lessons learned from using the software to identify and address risks related to managing patients who bring their own insulin pumps into the hospital.

August

13: CHPSO: Members Call. 10–11 AM

20: CHPSO/ECRI: User Group Meeting. Same Name/Look-alike Name Alerts. 11:30 AM–12:30 PM

September

10: CHPSO: Members Call. 10–11 AM

TBD: CHPSO/ECRI: Strategies to Prevent Falls. Web seminar time TBD.

October

8: CHPSO: Members Call. 10–11 AM

15: CHPSO/ECRI: User Group Meeting. Topic TBD. 11:30 AM–12:30 PM

November

12: CHPSO: Members Call. 10–11 AM

19: CHPSO/ECRI: User Group Meeting. Topic TBD. 11:30 AM–12:30 PM

December

10: CHPSO: Members Call. 10–11 AM

TBD: CHPSO/ECRI: Radiology Patient Safety. Web seminar time TBD.

For further information on these events:

Colleen Meacham cmeacham@chpsso.org, 916.552.7651

Hospital Council Calendar Notes

July 10 — BEACON San Francisco Regional Meeting, Marriott San Mateo, 9:00 AM – 3:30 PM

Join the Hospital Council for a day of networking and learning with peers, as hospitals share their successful efforts in reducing sepsis mortality, hospital acquired infection and perinatal harm. More information on the meeting is available at www.hospitalcouncil.net/post/beacon-san-francisco-regional-meeting-1.

HASD&IC Calendar Notes

July 27 — Perinatal Collaborative Meeting: Ending elective deliveries before 39 weeks gestation, National University Spectrum Learning Center, noon – 3:30 PM

Sept. 19 — Perinatal Collaborative Meeting: Ending elective deliveries before 39 weeks gestation, National University Spectrum Learning Center, noon – 3:30 PM

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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.chpsso.org).

Prospective authors may submit articles to Frances Sutz Brown: fsutzbrown@chpsso.org, 916.552.7598. 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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