CHPSO
California Hospital Patient Safety Organization

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CHPSO Forming Workgroup on Report Corrections in PACS Systems

CHPSO recently received an incident report involving a serious miscommunication engendered, at least in part, by the way in which a correction to the initial reading was displayed by the radiology PACS display. Additional discussion during CHPSO member calls identified this as a potential systemic issue with certain PACS (picture archiving and communication system) systems. Some PACS systems may have a higher risk of miscommunication of corrections than with paper records.

As a result, CHPSO is forming a workgroup to evaluate the current methods of displaying corrections in PACS and to provide guidance on safer use of these systems, including looking at workflow to minimize risk and evaluating vendor systems for safety. The workgroup may also provide feedback to PACS vendors to assist in making systems safer nationwide.

Both CHPSO members and non-members may participate in the workgroup. Since non-member hospitals do not have signed agreements with CHPSO, non-member representatives will need to sign confidentiality agreements covering the deliberations of this workgroup.

Contact Rory Jaffe, 916.552.7568 or rjaffe@chpso.org, if you are interested in participating or wish more information.

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

OIG Report Reveals Vaccine Storage Failures

CHPSO continues to monitor the problem of incorrect storage temperatures for vaccines (for the latest of several articles on this issue, see the March 2012 CHPSO Patient Safety News). Many vaccines include an adjuvant that will separate from the immunogen when frozen, reducing or eliminating its efficacy. This article focuses on a recent Office of Inspector General (OIG) report, Vaccines for Children Program: Vulnerabilities in Vaccine Management (OEI-04-10-00430).

The results of an OIG audit of the Centers for Disease Control's (CDC's) Vaccines for Children program reveal vaccine storage issues nationwide. It is important to note that only two of the 45 locations reviewed for compliance were hospitals; the majority were private practice clinics. While the overall statistics below are not representative of hospital performance, they do point out risk areas worthy of review.

CDC's Vaccines for Children (VFC) program provides free vaccines to eligible children. In 2010, program providers administered approximately 82 million vaccines to an estimated 40 million children.

The OIG found that vaccine storage issues were widespread. Investigators measured prolonged (> 5 hours) inappropriate storage temperature at 76 percent of the locations. Roughly half of the locations' temperature monitoring systems were significantly inaccurate, with recorded readings at least 5 degrees Fahrenheit off from the independent, calibrated measurement.

Providers of the Vaccines for Children program must perform required activities in 10 management categories: vaccine storage equipment, vaccine storage practices, temperature monitoring, vaccine storage and handling plans, vaccine personnel, vaccine waste, vaccine security and equipment maintenance, vaccine ordering and inventory management, receiving vaccine shipments and vaccine preparation.

None of the providers satisfied all of these requirements. The most common deficiencies were in storage equipment, storage practices, and temperature monitoring, with 96 percent of all providers failing to meet the requirements for storage equipment, 93 percent for storage practices, and 89 percent for temperature monitoring.

Deficiencies were also common in the other categories, excluding vaccine preparation, for which only one provider was deficient.

OIG recommendations contained in the report include the following:

- Ensure that freezers and refrigerators can maintain vaccines at the required temperature ranges and have accurate temperature-monitoring devices that are regularly calibrated and centrally placed within freezers and refrigerators.

- Immediately remove expired vaccines from freezers and refrigerators used to store nonexpired vaccines to prevent inadvertent administration of expired vaccines.

- Improve inventory systems and management to reduce excessive inventories and resulting waste of expired vaccines.

Hospitals participating in the Vaccines for Children program have additional management requirements (see Appendix B of the report). The complete OIG report, *Vaccines for Children Program: Vulnerabilities in Vaccine Management (OEI-04-10-00430)* is available to download at oig.hhs.gov/oei/reports/oei-04-10-00430.asp.

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

California Hospital Engagement Network Announces New Staff

The California Hospital Engagement Network is pleased to announce the addition of Craig Laser, Martha Ackman and Sandra Trotter as network facilitators. "We are truly excited to have these highly experienced people as part of the team," stated project director, Ann Marie Giusto, RN. "The network facilitator is vital to the success of the program's initiatives. Hospitals can and will rely on the facilitators' expertise to help them achieve the goals of reducing patient harm and readmissions."

Hospitals have been participating in one-on-one assessment interviews to confirm clinical areas of improvement, and discuss strategies for meeting their goals. To date, approximately 75 hospitals have completed their assessment interviews with facilitators; interviews will continue with the remaining members of the network in August.

"Getting started" materials, which outline action steps for hospitals, have been released and are posted to the website. Evidence-based "change packages" for each clinical area of improvement will be released over the next few weeks. For more information visit www.calhospital.org/network or contact Ann Marie Giusto at 916.552.7657 or agiusto@calhospital.org.

CHPSO Annual Meeting April 8–9, 2013 in Sacramento

Save the date!

CHPSO's 2013 Second Annual Meeting will take place April 8-9 at the Hyatt Regency Sacramento. Based on attendee feedback from this year's Annual Meeting in March, next year's program will be extended a half day to include breakout sessions. The meeting will begin the afternoon of April 8 and conclude the following day. If you would like to serve on the CHPSO Annual Meeting Planning Committee, please contact Frances Sutz Brown, director of Operations and Communications, fsutzbrown@chpso.org or 916.552.7598.

CHPSO and ECRI Institute Announce Free New Service for Members

CHPSO and ECRI Institute are offering a new service to simplify data submission and save staff time. Our team will work with you to develop an automated process to convert data from your Adverse Event Reporting System into a file ready to submit to the CHPSO/ECRI database.

The conversion is accomplished through mapping the fields in your Adverse Event Reporting System to the fields captured in the CHPSO/ECRI Institute PSO System. This process eliminates the need for manual data entry and ensures that the data already in your reporting systems flows to the right place in the PSO system, vital for reporting and analysis.

This service supports your quality, risk and safety teams, and conserves your IT resources. Minimal hospital staff time should be needed to assist in this process — we anticipate the primary need will be to identify the meaning of the fields in your current system.

Currently this service is free of charge. If you are interested in taking advantage of this offer, please contact ECRI's CHPSO project manager Gail Horvath soon at 610.825.6000, ext. 5578, or ghorvath@ecri.org.

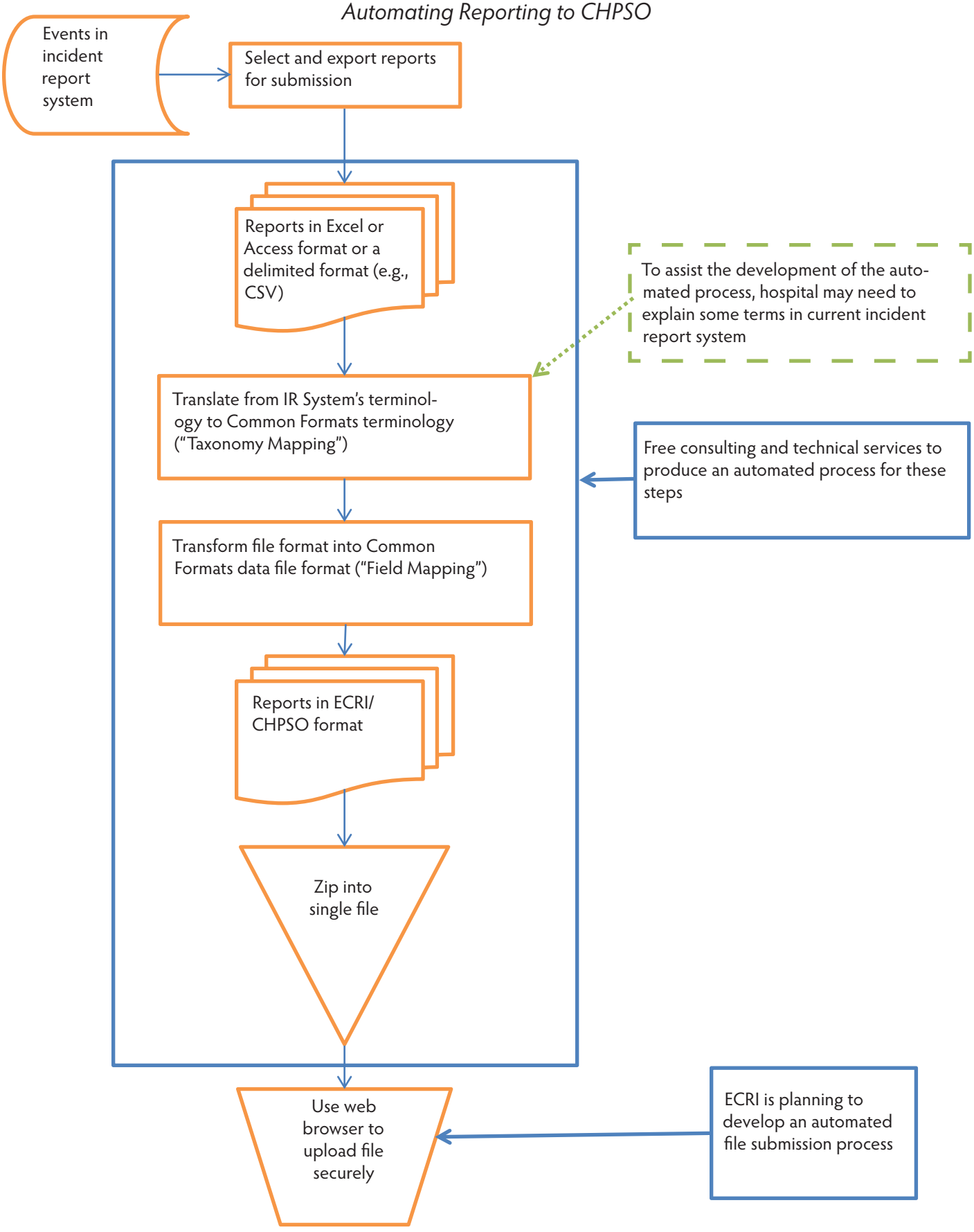
Certain Adverse Event Reporting System vendors (e.g., Midas+) supply ready-made integrated solutions for reporting to CHPSO that you may find preferable. Please contact Rory Jaffe at 916.552.7568 or rjaffe@chpso.org if you have any questions about your vendor's CHPSO support.

Automating Reporting to CHPSO

See next page for flow chart that illustrates which reporting steps can be automated.

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

Automating Reporting to CHPSO



CHPSO/ECRI Offers Benefits Beyond Data Collection and Analysis

Earlier this year CHPSO contracted with ECRI Institute to support confidential patient safety data collection and analysis. Working with ECRI has expedited the data collection process, better serving the needs of CHPSO's growing membership. Rapid collection and in-depth analysis of data allows hospitals to learn from near misses and adverse events and accelerate patient safety improvements.

Currently, one-third of CHPSO hospitals are actively working on setting up electronic reporting. CHPSO and ECRI are now offering a free service that provides a customized reporting solution for a hospital's particular incident reporting system. (See article on page 2.)

Even before reporting into the CHPSO/ECRI database begins, ECRI provides many services to CHPSO members. In addition to monthly web seminars, services include:

Root Cause Analysis evaluation

ECRI provides a written critique of an organization's RCA including assessment of thoroughness, identification of root causes and effectiveness of the action plan.

How: CHPSO-member hospital uploads an RCA to a secure ECRI website.

Limits: Six RCA evaluations per hospital per year.

Custom research

ECRI completes custom research in response to a CHPSO member request. For simple requests, ECRI responds to a hospital within 1-2 business days. Extensive research requests typically take 1–4 weeks and include a 10–40 page report with specific recommendations and resources.

How: Hospital contacts ECRI, either by phone or through the CHPSO/ECRI member portal.

Limits: Simple requests are unlimited (e.g., request for an article, list of sources, or document). Extensive research requests are limited. CHPSO will prioritize these requests if the volume exceeds available resources.

Educational materials

Through the CHPSO/ECRI portal, members can access newsletters and publications, including a quarterly 10-page publication focusing on a key patient safety issue; monthly web seminars on a variety of evolving patient safety topics; web seminar archives; safety alerts and reports; and monthly updates on hazards, recalls and news.

How: Enrollment is by the designated "ECRI access manager" at each hospital. The person responsible for oversight of the CHPSO contract assigns the access manager.

Limits: An unlimited number of people can be enrolled.

For more information, contact Gail Horvath at 610.825.6000, ext. 5578, or ghorvath@ecri.org

— Frances Sutz Brown, fsutzbrown@chpso.org

CHPSO/QI Path Web Seminar Available in Archive

You can now listen to a recording of the July 23 web seminar, FMEA — Intro to QI Path Software and Lessons Learned from St. Joseph's of Stockton Pilot Project. The web seminar introduced QI Path's offerings and provided 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 shared lessons learned from using the software to identify and address risks related to managing patients who bring their own insulin pumps into the hospital.

Online Survey to Help Improve CHPSO Website

CHPSO is redesigning its website to improve usability and deliver content and resources of value. Your input will help us create a website that supports our collaborative work in accelerating safety improvements and eliminating preventable harm. Please take this brief survey now.

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.

August

13: *CHPSO*: Members Call. *Cancelled this month.*

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@chpso.org, 916.552.7651

HASD&IC Calendar Notes

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.chpso.org).

Prospective authors may submit articles to Frances Sutz Brown: fsutzbrown@chpso.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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