CHPSO
California Hospital Patient Safety Organization

Patient Safety News
September 2012
Volume 4 Number 8

CHPSO Member Organization Opportunities

Managing Health Information Technology Risks

CHPSO's partner in data collection and analysis, ECRI Institute, is part of a team recruiting hospitals, health systems and physician office practices to participate in a two-year nationwide collaborative project to integrate health information technology (HIT) safety into effective organizational safety and risk management programs. Once the project receives funding, the team will select 10 hospitals/health systems and 10 physician practices.

Participating organizations will receive HIT-risk management tools (e.g., checklists, best practices, assessment tools, guidelines, benchmarks or dashboard indicators), technical assistance and training throughout the study period and participate in an evaluation of the effectiveness of the programs. The results of the project will be shared publicly, though sensitive information will be aggregated and not attributed to institutions by name.

The Institute of Medicine (IOM), in a recent report, *Health IT and Patient Safety: Building Safer Systems for Better Care*, called attention to the potential for safety problems to arise from using HIT systems. HIT can be a powerful means to improve safety, however, adoption and meaningful use of HIT potentially introduces new and different safety risks, into health care settings.

Heading up the project is a team of scientists from ECRI, RAND Health, the University of Texas and Baylor College of Medicine. For more information or to volunteer to participate, contact Jane Kelly, project manager, at janekelly@ecri.org, 610.825.6000, or Karen Zimmer, MD, at kzimmer@ecri.org or Bill Marella at wmarella@ecri.org, ECRI Institute co-principal investigators.

Learning about Peer Review Indicators

CHPSO and several other PSOs throughout the nation are collecting peer review indicators such as metrics and trigger tools to develop a compendium of monitoring techniques. Hospitals can then use the compendium to take advantage of the collective wisdom when evaluating their own peer review monitoring.

To participate, describe your peer review indicators in an electronic document (e.g., Microsoft Excel or Word) and submit them through the CHPSO/ECRI web portal, accessible through CHPSO's website, www.chpso.org. Once logged-in, click "Submit other Documents" to open your in-box in a secure communications screen. From there, click on "New Message," and follow the prompts.

The information collected is privileged Patient Safety Work Product, which will be de-identified prior to sharing with others.

Root Cause Analysis Web Seminar

Learn about common issues associated with root cause analyses (RCAs) and how to submit an RCA for critique during this Sept. 24, 10–11 AM web seminar. The CHPSO/ECRI seminar, Explaining the Adverse Event, is open to members and non-members. For details, see the CHPSO Calendar Notes section on page three.

As part of CHPSO membership, ECRI provides complimentary written critiques of a hospital's RCA document, including assessment of thoroughness, identification of root causes and effectiveness of the action plan. This thorough evaluation is based upon ECRI's expertise in reviewing more than 2 million events to date. CHPSO member hospitals can submit up to six RCAs per year to ECRI through a secure CHPSO/ECRI portal.

The evaluation reviews the RCA's

- systems analysis process,
- root causes identified by hospital compared to those identified by ECRI,
- strength of recommendations in response to the identified root causes, including scope, timing, potential extent of risk reduction, administrative implementation, and measures of effectiveness, and
- system analysis methods used.

How to Promote Self-Reporting

From QA to QI

If you've been following this column, you know that the majority of hospitals suffer from a culture of blame that poisons efforts to improve quality and safety. The dysfunctional Quality Assurance (QA) Model for Clinical Peer Review is a major part of the problem. It perpetuates the negative cycle of blame and fear by focusing on competence and punishment rather than on performance improvement. We can't "learn from defects" if fear of discovery inhibits reporting and open dialogue. This poses a challenge: if learning from defects is critical to the process of advancing patient safety and if self-reporting of adverse events, near misses and hazardous conditions is needed to make learning possible, how do we get there — particularly if we're stuck in a culture of blame?

At Mount Sinai in New York, Katz and Lagasse(1) found 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." Other work tells us that the reporting process must be simple and quick. I believe this prescription can be generalized to all physicians, nurses and allied health care providers.

The key ingredients of understanding, encouragement, and ease of reporting are not hard to obtain. Encouragement comes from a simple act of leadership. Leadership, or its lack, is reflected in the qualities of how we speak and interact with colleagues. Anyone can choose to act like a leader. Event reporting need not be complicated. If the hospital has a cumbersome electronic or paper system, a confidential, recorded hotline can be used as a by-pass. Clear communication of the process and the program sparks understanding.

Two additional ingredients, no blame and visible improvement, take a bit more work, but come naturally out of the Quality Improvement (QI) Model for clinical peer review and event analysis, which we'll explore in future columns. Other actions can also help. To eliminate fear of repercussions from self-reporting, the hospital can adopt policies that unequivocally protect the reporter. For the medical staff, I suggest language such as, "No medical staff member shall be subject to disciplinary action in relation to cases that are self-referred for peer review, in the absence of reckless disregard for patient safety." With small changes, this also can be used for nursing staff. While a policy alone might be useful to promote self-reporting, the open question will be whether physicians and nurses will trust management to abide by it.

Here, then, is an opportunity to gain more value from your PSO relationship. The Patient Safety and Quality Improvement Act protects reporters. Be it for peer review or general event reporting, the commitment to PSO reporting reinforces the intent of the program, testifies to the integrity of leadership, and provides additional collateral to build trust even among skeptics.

To pull this all together, your Patient Safety Evaluation System (PSES) should define the process. I believe it makes sense to maintain most case review activity as Patient Safety Work Product (PSWP). Recall that PSWP may not be used for disciplinary action. In states with strong protections against legal discovery, such as California, some would argue to pull peer review cases out of the PSES. The rationale is to avoid encumbering any potential disciplinary action. But what kind of message does that send? Disciplinary action is the exception not the rule. Only minimal additional effort is needed to re-review cases outside of the PSES for use in such proceedings. By packaging peer review within the PSES, you gain the opportunity to promote self-reporting and learning from defects in a way that builds credibility and trust.

For more information about self-reporting, contact me at marc@QAtoQI.com for a free reprint of my latest article from the Physician Executive Journal: *Engaging Physicians in Patient Safety through Self-Reporting of Adverse Events*. Before we move on to look more deeply into the QI Model and how to promote it, we'll pause to learn how the QA Model came to dominate practice for the past 30 years.

— Marc T. Edwards, QA to QI Consulting, marc@QAtoQI.com

Reference

1. Katz RI, Lagasse RS. Factors Influencing the Reporting of Adverse Perioperative Outcomes to a Quality Management Program. *Anesth Analg.* (2000); 90: 344–350.

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

CHPSO Annual Meeting April 8–9, 2013 in Sacramento

Save the date!

Planning is underway for CHPSO's Second Annual Meeting April 8–9, 2013, at the Hyatt Regency Sacramento. Based on feedback from this year's Annual Meeting, next year's program will be extended a half day to include breakout sessions. Special thanks to the planning committee (see below) for working to put together an informative and inspiring program.

The planning committee welcomes additional input on topics and speakers. Please send suggestions to Frances Sutz Brown, CHPSO's director of Operations and Communications, fsutzbrown@chpso.org or 916.552.7598.

CHPSO Calendar Notes

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

Take Note

Three articles in this month's CHPSO Patient Safety News describe member opportunities: learning about peer review indicators, reviewing the results of RCAs, and improving patient safety through information technology. This is in addition to other opportunities already available, such as mitigating risks associated with the manner in which PACS systems display corrections to study interpretations.

As part of our web site redesign, we are developing a place where you can go to find active opportunities. Until then, please contact Rory Jaffe if you have any questions about member benefits: rjaffe@chpso.org or 916.552.7568.

September

10: *CHPSO*: Members Call. *Cancelled and replaced by special call on RCAs, see September 24 calendar entry.*

24: *CHPSO/ECRI*: Root Cause Analysis (RCA): Explaining the Adverse Event. Web seminar open to nonmembers. 10–11 AM. As part of CHPSO membership, ECRI provides complimentary written critiques of an organization's RCA documents (six per year), including assessment of thoroughness, identification of root causes and effectiveness of the action plan. Learn about common issues in RCAs, how to submit an RCA for critique and hear about opportunities for improvement. To view the Internet portion of the event, click the attendee meeting URL: www.livemeeting.com/cc/Worktank/join?id=8586&pw=ATT8586. Audio: 1-800.619.0324, PCode 092412.

25: *CHPSO/ECRI*: Your Falls Data and Strategies: Learn a New Pearl from Your Peers Web seminar. 11:30 AM–12:30 PM

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

CHPSO Annual Meeting Planning Committee Members

Warren Browner, MD, CEO, California Pacific Medical Center

Jenna Fischer, VP, Hospital Council of Northern and Central California

Ann Marie Giusto, RN, VP, Quality, California Hospital Association

Rory Jaffe, MD, Executive Director, CHPSO

Kenneth Kizer, MD, Director, Institute for Population Health and Improvement, UC Davis Health System

Helen Macfie, PharmD, Senior VP, Performance Improvement, MemorialCare Health System

Alicia Munoz, FACHE, VP, Quality and Patient Safety, Hospital Association of San Diego & Imperial Counties

David Perrott, MD, DDS, Senior Vice President and Chief Medical Officer, California Hospital Association

Nancy Pratt, RN, Chief Quality Officer, St. Joseph Health System, Orange County

Julia Slininger, RN, Director of Quality, Hospital Association of Southern California

Hospital Council Calendar Notes

November 13 — BEACON Fall Exchange, South San Francisco Conference Center, 9 AM–4 PM

Join peers from hospitals throughout Northern and Central California for a day of networking, knowledge exchange and sharing of best practices to improve patient safety. Renew your spirit, your commitment and get inspired to try new ideas. Keynote presenters and topics include Kathleen Bartholomew on Leading a Patient Safety Culture: Beyond the Statistics; J. Bryan Sexton on Caregiver Resilience and Quality Improvement: A Double Edged Sword; and Richard Davies DeBronkart, Jr. on Discovering the e-Patient movement: How Patient Engagement Can Improve Safety and Quality. For more information go to www.hospitalcouncil.net/post/beacon-fall-exchange.

HASD&IC Calendar Notes

October 17 — Perinatal Safety Council Meeting: Ending Elective Deliveries Before 39 Weeks Gestation, Rady Children's Hospital, 3–5:30 PM

October 17–21 — IDWeek, Advancing Science, Improving Care, San Diego Convention Center

This week long program features the latest science and bench-to-bedside approaches in prevention, diagnosis, treatment, and epidemiology of infectious diseases, including HIV. The region's Patient Safety First collaborative is offering up to $700 reimbursement per hospital for sending its infection preventionist and/or Antimicrobial Stewardship Program representative to the event. For more information, contact Alicia Muñoz at amunoz@hasdic.org or 858.614.1541.

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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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