CHPSO Membership remained steady in 2019 with more than 450 members in 13 states: Arkansas, Arizona, California, Georgia, Hawaii, Iowa, New Mexico, Nevada, Ohio, Oregon, Tennessee, Texas and Washington. A total of 93 new facilities/organizations from seven states are pending or in progress. These members contributed to a growing database of more than 2.5 million safety events.

**Participate**

CHPSO works with members to facilitate and streamline the data submission process. CHPSO partners with NextPlane Solutions to allow members to connect to the CHPSO database, saving hospitals the cost of specialized solutions.

With NextPlane Solutions, members can generate an Excel spreadsheet or plain text report delimited by commas or other characters.

The entire process, including taxonomy mapping, generally takes up to three hours for the initial submission.

For more information, contact CHPSO at info@chpso.org or visit our website, www.chpso.org.

**Benefits**

- Patient Safety Work Product (PSWP) privilege
- Collaborate and problem solve with other providers
- Periodic safety event evaluations
- Bi-weekly Safe Table meetings
- Custom research requests
- Event feedback and consultation
- Educational webinars
- Alerts and quarterly newsletters
- Legal counsel discussion group
- Job board

**ABOUT US**

**CHPSO Mission**

Eliminating preventable harm and improving the quality of health care delivery.

**CHPSO Vision**

CHPSO's members will lead the nation in providing the safest and highest quality health care.
**Key Points When Reviewing Event Data**

CHPSO staff are frequently asked to provide rates of different event types for benchmarking. However, unlike many other measures of quality and safety, voluntarily collected and submitted event reports cannot be utilized in this fashion.

A number of concepts are helpful to understand when reviewing safety event reports and other data types collected by patient safety organizations. One is that the volume of reports does not equal prevalence.

It is easy to assume that a higher number of a certain type of event means there are more of those types of events occurring. However, given the nature of safety event reporting, it simply means hospitals have submitted more of those types of events to the CHPSO database.

It is also important to understand that CHPSO does not require members to change the way they collect event reports for their own patient safety, quality, and risk management purposes. In addition, CHPSO does require members to submit information in specific fields. As a result, we receive information in various degrees of thoroughness and quality.

**Tips for Safety Event Report Collection**

Consider following a standardized format. One that many have found helpful is the “SBAR” format, which stands for situation, background, assessment, and recommendation. This communication model is useful for both internal review and patient safety organization review.

Remember the report needs to be complete but does not need to be lengthy. Whenever possible, spell out abbreviations and acronyms. For instance, PT might be used for both physical therapy and patient.

Stick to the facts and avoid blaming or shaming. In a culture of safety, event reports are not meant to point out who is right and who is wrong.

Indicate whether the event happened for the first time or if it has occurred multiple times — this helps CHPSO pick up on themes related to event frequency. It is also helpful to include relevant follow-up in the report.

Encourage the submission of reports of near-misses and no-harm events. Staff often do not report no-harm and near-miss events. These incidents, however, represent “free lessons” and may turn out to be precursors of serious events.

**Medication Safety Event Report Analysis**

**Overview**

“Event Type” — Data Element 21 in the Agency for Healthcare Research and Quality (AHRQ) Common Formats for event reporting — represents the primary classification for each safety event report. Currently, this field can have values for the following categories:

- Blood or Blood Products
- Device/Medical Surgical Supplies
- Falls
- Healthcare Associated Infection
- Medication or Other Substance
- Other/Uncategorized
- Perinatal
- Pressure Ulcer
- Surgery or Anesthesia
- Other/Uncategorized

In 2019, “Medication or Other Substance” was the second-largest category in the CHPSO database, behind “Other/ Uncategorized.” As part of our continual efforts to improve our understanding of safety event reports submitted by our members, CHPSO has completed an analysis of a subset of these medication-related events.

For this report, we analyzed a subset of the safety event reports in the “Medication or Other Substance” category submitted to CHPSO in 2019. For inclusion in this analysis, events had to meet the following criteria: a maximum of 50 random events per facility where DE21 = “A54” and event load date occurred in 2019. These data included 7,470 medication safety event reports from 168 individual CHPSO member facilities. This is an overview of frequently mentioned drug categories and areas identified as opportunities for improvement as well as a discussion of clinically relevant topics associated with these events.

As with previous analyses of safety events, many events in this dataset were multifactorial. Therefore, the total number of events in each category is greater than the total number of events in the dataset. For example, a case involving delays in care and access to appropriate medication for a child with a Tylenol overdose awaiting an air lift transport contained elements related to availability of medications, automated dispensing cabinets, communication issues, and the mention of the relevant medications (e.g., acetaminophen and ace-tycysteine). Likewise, a case related to a dosing error of a vasoconstrictor used to treat life-threatening hypotension (often in the setting of septic shock) contained elements related to an overdose, the programming of the infusion pump, a reference to barcode medication administration (BCMA) technology, a comment regarding the facility’s electronic health record vendor, and the medication involved (Levophed).

**Medications**

<table>
<thead>
<tr>
<th>Medication or Other Substance</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood or Blood Products</td>
<td>4431</td>
<td>89.7</td>
</tr>
<tr>
<td>Device/Medical Surgical Supplies</td>
<td>897</td>
<td>17.86</td>
</tr>
<tr>
<td>Falls</td>
<td>842</td>
<td>17.01</td>
</tr>
<tr>
<td>Healthcare Associated Infection</td>
<td>237</td>
<td>4.81</td>
</tr>
<tr>
<td>Medication or Other Substance</td>
<td>165</td>
<td>3.38</td>
</tr>
<tr>
<td>Other/Other Substance</td>
<td>13</td>
<td>0.26</td>
</tr>
<tr>
<td>Perinatal</td>
<td>3994</td>
<td>80.64</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
<td>4437</td>
<td>89.58</td>
</tr>
<tr>
<td>Surgery or Anesthesia</td>
<td>3994</td>
<td>80.64</td>
</tr>
<tr>
<td>Other/Uncategorized</td>
<td>76</td>
<td>1.56</td>
</tr>
</tbody>
</table>

For the purposes of this analysis, medications were classified based on the active ingredient and its use.

**Event Severity**

<table>
<thead>
<tr>
<th>Event Severity</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident</td>
<td>3294</td>
<td>64.10</td>
</tr>
<tr>
<td>Near Miss</td>
<td>897</td>
<td>17.86</td>
</tr>
<tr>
<td>Unsafe Condition</td>
<td>842</td>
<td>17.01</td>
</tr>
<tr>
<td>Null</td>
<td>2437</td>
<td>47.62</td>
</tr>
</tbody>
</table>

For the purposes of this analysis, events were classified based on their severity.

**Age**

<table>
<thead>
<tr>
<th>Age</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonate (0 - 28 days)</td>
<td>27</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Infant (&lt;28 days -1 year)</td>
<td>47</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Child (1 - 12 years)</td>
<td>646</td>
<td>9.56</td>
</tr>
<tr>
<td>Adolescent (13 - 17 years)</td>
<td>41</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Adult (18 - 64 years)</td>
<td>1279</td>
<td>17.12</td>
</tr>
<tr>
<td>Mature Adult (65 - 74 years)</td>
<td>438</td>
<td>5.66</td>
</tr>
<tr>
<td>Older Adult (75 - 84 years)</td>
<td>359</td>
<td>4.81</td>
</tr>
<tr>
<td>Aged Adult (85+ years)</td>
<td>202</td>
<td>2.70</td>
</tr>
<tr>
<td>Null</td>
<td>4431</td>
<td>59.32</td>
</tr>
</tbody>
</table>

For the purposes of this analysis, events were classified based on the age of the patient.

**Harm**

<table>
<thead>
<tr>
<th>Harm</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>4</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Severe harm</td>
<td>13</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Moderate harm</td>
<td>181</td>
<td>2.42</td>
</tr>
<tr>
<td>Mild harm</td>
<td>1197</td>
<td>16.02</td>
</tr>
<tr>
<td>No harm</td>
<td>2081</td>
<td>27.86</td>
</tr>
<tr>
<td>Null</td>
<td>3994</td>
<td>53.47</td>
</tr>
</tbody>
</table>
Frequently mentioned drug categories included Opioids (n=1363), Antimicrobials (n=1082), Anticoagulants (n=848), Acetaminophen (n=678), and Benzodiazepines (n=481). Opioids and benzodiazepines were frequently associated with safety event reports related to controlled substance accountability and management of the inventory in dispensing cabinets. At first glance, acetaminophen appeared to have been an issue in many of the events in the dataset, by virtue of the number of times it was mentioned. However, upon further investigation, we found acetaminophen was most frequently mentioned because it is an ingredient in opioids. In fact, when we counted only events in which acetaminophen was specifically mentioned in the event descriptions (free-text fields) — based on key words such as acetaminophen, Ofine, and Tylenol — we found a significant decrease (n=172) in the number of events.

Events related to antimicrobials included a variety of subcategories and factors. These included missed or delayed doses due to medication availability, omissions or delays due to roller clamps left closed, allergic and adverse reactions, dosing errors, and laboratory-related issues (e.g., peak and trough for aminoglycosides). There were also a variety of issues related to the electronic health record (EHR) and computerized provider order entry (CPOE).

Not surprisingly, issues related to EHR and CPOE were not limited to antimicrobial medications. In fact, missing or inaccurate documentation, issues related to EHRs, CPOE, and BCMA comprised the largest category in this analysis (n=2092).

Some of the subthemes in this category included:

- **EHR-related dose calculation errors**
- **Auto discontinue functions**
- **Weight-based medication calculation errors**
- **Decimal place errors**

Other issues in this category included duplicate orders/therapeutic duplication (e.g., Toradol and ibuprofen), errors related to verbal and telephone orders, and orders based on location (e.g., ED-Only orders). Errors in transcription from a paper/faxed provider order to the EHR were also noted in this category.

Medication dispensing and administration errors were also commonly found in this dataset (n=1387). These included errors related to wrong drug, wrong frequency/dose, wrong patient, and wrong dose.

CPOE- and EHR-related issues often overlapped during these events (e.g., weight-based dosing errors). Also overlapping with this category were issues related to the management of IV lines (n=352) and infusion pumps (n=142). While not the largest categories in the dataset, we found these issues worth mentioning due to the high risk for patient harm. Examples in these subcategories include:

- **Guardrails and medication libraries were not used or were unavailable**
- **Availability of infusion pumps and/or infusion pumps malfunctioning**
- **Incorrectly programmed infusions (e.g., wrong drug/rate/concentration)**
- **Tubing misconnections (e.g., epidural lines connected to IV ports)**
- **Incompatible medications infusing in the same line**
- **Medications infusing through the same line as blood or blood products**

Other relevant categories of events in this dataset included issues related to communication and teamwork (n=523), patient identification issues (n=174), missed assessments (n=99), and the mention of contingent workers (travelers/registry) and float pool staff (n=75).

We encourage members to review the “Medication or Other Substance” events in their systems and consider how this analysis might provide insight into issues and potential opportunities for improvement in their own organizations. As with other aggregate analyses completed for the annual report, CHPSO will provide hospital-specific evaluations for member organizations that submitted data into the “Medication or Other Substance” category in 2019. Those interested in further exploring their facility’s data in this category may contact info@chphso.org to arrange for a consultation.

## Assessing Event Reporting Data Quality

Like other federally listed patient safety organizations, CHPSO is dedicated to encouraging and assisting health care organizations in developing a culture of safety. By the end of 2019, the CHPSO database had accumulated in excess of 2.5 million safety event reports. In past years, CHPSO provided feedback to members based on the tone and content of safety events submitted to the CHPSO database. The tone analysis refers to the level of bias present in the safety events submitted to the CHPSO database, while the content analysis refers to the thoroughness of the reports.

Over the years, these analyses have become unnecessary, as most events assessed indicate the majority of reports submitted to the database were relatively complete and unbiased. However, these content and tone analyses uncovered another area of event reporting quality that could benefit from further analysis by the CHPSO team — minimum standards for data submission. The content and tone analyses, along with other periodic reports produced to provide feedback to CHPSO members, were limited to events with sufficient content included for analysis. Through a series of iterative, painstaking analyses — which often involved CHPSO staff reviewing tens of thousands of reports — the team arrived at a minimum database required to support and complete a thorough analysis of safety event reports.

CHPSO recommends submitting all event fields collected within the member’s event reporting system. However, certain fields and data characteristics are essential for analysis and member feedback.

### Recommended Minimum Data Elements

- **Event Number** — This must be unique to the event. Members encountering duplicate event identification numbers within their systems — which generally come from different locations within a larger system — can reach out to the CHPSO team for assistance.
- **Event Type** — This field represents the overarching category of the event. CHPSO maps events to the AHRQ Common Formats for event reporting. In that context, this field currently includes Blood or Blood Products, Device/Medical Surgical Supplies, Falls, Healthcare Associated Infection, Medication or Other Substance, Other/Uncategorized, Perinatal, Pressure Ulcer, and Surgery or Anesthesia. Only 1% of the events in the CHPSO database return a null result for this field.
- **Date Event Occurred** — This field is typically well-populated (Null=5%). This is helpful in analyses because, while date ranges for analysis are usually based on the date the event is received by CHPSO, there are times when organizations may upload large, retrospective datasets. The inclusion of this field allows CHPSO to determine which events should be included in each analysis.
Event Severity – This field allows CHPSO to determine whether the event reached the patient. This field is comprised of three categories: Incident, Near Miss, and Unsafe Condition. Incidents are safety events that reach the patient, regardless of the level of harm. A “near miss” is a safety event that did not reach the patient, such as a medication error that was caught before the drug was administered. An “unsafe condition” refers to any circumstance that increases the probability that a safety event might occur. This field is null in 15% of the safety event reports in the CHPSO database.

Event Description/Comments – These descriptive, free-text fields are the most important in the CHPSO database. For this field, looking at whether it is null is insufficient in determining its value in event analysis. For example, some reports might meet the criteria of “Not Null” – but contain unhelpful or minimally helpful information, like:

- N/A or NA
- Meaningless punctuation like “---” or “* * * *
- Vague information like “Reviewed by ED Director”

Clearly auto-populated dropdown menu-generated information These findings prompted CHPSO to lock further into the descriptive fields to determine the frequency with which the descriptive fields contain a certain number of characters. From this analysis, we have determined that — while only 4% of the safety event reports in the CHPSO database are null — 6.5% have fewer than 30 characters, 10.9% have fewer than 50 characters, and 22% have fewer than 100 characters. Currently, CHPSO is limiting many analyses to only those that contain a minimum of 30 characters in the descriptive fields.

Age – This is frequently null in the CHPSO database, with 45% of Incident (DE3 = A3) event reports containing no value for patient age. However, it is a very important field as age may impact many event analyses. Therefore, CHPSO is undertaking an effort to impute null values by utilizing date occurred and subtracing patient date of birth (DOB). However, there are many limitations. For example, some safety event reports have an event date occurred that is earlier than patient DOB; at times this may be off by decades. For example, an event included in one of the datasets for the annual report had a DOB in the year 2047. We have also observed inconsistency in imputed patient age for events with null patient age values (e.g., patient age by imputation was A108/Child (1-12 years), but the original value for patient age was listed as A102/Neonate (0-28 days)).

Gender – This is null in 17% of the incident events submitted to the CHPSO database. Like age, gender may be legitimately absent in some reports, such as unsafe conditions or near misses that were not specific to an individual patient. For both age and gender, one data quality metric to consider is the frequency with which age and gender are null for events with an Event Severity equal to “A3” (meaning that there was an incident that reached the patient, even if no harm occurred). The chart below provides the percentage of nulls vs. not nulls for all incident events in the CHPSO database to date. Notably, only 52.1% of the safety event reports have both patient age and patient gender populated.

### Age and Gender Null vs. Not Null — CHPSO 2012 to 2019

<table>
<thead>
<tr>
<th></th>
<th>% Null</th>
<th>% Not Null</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age and Gender Null Not Null</td>
<td>45%</td>
<td>17%</td>
</tr>
<tr>
<td>Age and Gender Null</td>
<td>55%</td>
<td>83%</td>
</tr>
</tbody>
</table>

Harm – This is divided into four categories based on the AHFS Common Formats. These include No Harm, Mild Harm, Moderate Harm, Severe Harm, and Death. In the CHPSO database, 12% of the safety event reports are null for this field. Ideally, harm would be provided with each incident safety event report, as it is determinable in nearly all incident cases. Moreover, this field is essential in many of the analyses CHPSO runs against the database. For example, to conduct certain analyses related to harm and other variables such as specific medications, CHPSO creates a variable called “High Harm” by collapsing events for which harm is either Severe Harm (DE5=A165) or Death (DS5=A162). For these analyses, events are excluded when Harm is null. This limits the number of events that can be included in a given analysis and decreases CHPSO’s ability to detect relationships between harm and other variables, such as medications or age.

Other/Uncategorized Safety Event Report Analysis

**Overview**

In addition to the analysis of medication, CHPSO analyzed the Other/Uncategorized category of event type. Similar to past years, the Other/Uncategorized group of event reports continues to be the largest in the CHPSO database. Continued interest in better understanding these events compelled a closer look.

This report is an analysis of a subset of the safety event reports in the “Other” category submitted to CHPSO in 2019. For inclusion in this report, the events had to meet the following criteria: a maximum of 50 random events per facility where DE2 = “A66” and event load date occurred in 2019 and the length of the descriptive field met a minimum criteria. These data included 6,517 safety event reports from 162 individual CHPSO member facilities. A total of 30 event categories were revealed in the analysis, and this report provides details on the top five.

**Note:** It is very important to understand that many events in this dataset were multifactorial. Therefore, the total number of events in each category is greater than the total number of events in the dataset. For example, a case involving delays in care for a patient with a malignant spinal cord tumor contained elements related to documentation and HIT; communication issues between the emergency department, infusion center, and oncology provider; and references to clinical concepts (e.g., hemodilution and sepsis). Likewise, a case related to a patient suffering from acute alcohol withdrawal contained elements related to outside law enforcement, restraints, a rapid response team call, refusal of treatment/leaving against medical advice, and workplace violence.

Similar to the last time CHPSO analyzed the Other/Uncategorized event type, the largest category was related to behavior and workplace violence (n=1152), representing 18% of events. These included reports of patients threatening, assaulting, or verbally abusing staff or peers and patients; punching walls; or damaging property. One event described a patient covered in blood running through the emergency department with sharp objects after assaulting several staff members. These cases often contain elements related to patients leaving or wanting to leave against medical advice (AMA) and patients being classified as a danger to self or others. Also included in this category are reports of highly agitated and/or aggressive family members and visitors.

Other issues of note related to inappropriate, rude, or offensive staff or provider behavior. This was not surprising, considering that one of the most popular Safe Tables in 2019 was “Workplace Bullying and Unprofessional Behavior.”

The top four Safe Tables of 2019 were:

1. **Smart Pump Issues**
2. **Handoff – Shift Change and Internal Transfers**
3. **Medical Device Associated Pressure Injuries**
4. **Workplace Bullying and Unprofessional Behavior**

Organizations may want to consider reviewing their events.
for cases related to workplace violence, bullying, and unprofessional behavior to determine how well they are addressing these issues.

The second-largest category in this analysis was related to communication issues (n = 1042), representing 16% of the safety event reports in the dataset. These safety event reports involved events describing breakdown in communication during handoff, communication failures between departments, inability of nursing staff to contact providers, confusion regarding on-call coverage, provider assignments, and messages not reaching providers or not being responded to in a timely manner. Also included in this category of safety event reports were those related to communication of critical values. This is a major patient safety issue, as the potential risk to patients is very high when communication breakdown impacts the response time to critical lab values. Examples included positive cultures found in a placenta and not being communicated to the provider, which resulted in a newborn not receiving appropriate antibiotic treatment; radiology results not being called to the provider; and critically low blood glucose values not reported in a timely manner, resulting in delayed treatment by the nursing staff. Documentation issues, including those related to HIT and CPOE, were frequently overlapping themes in the category of communication.

Reports related to documentation issues (n=851) represent the third-largest category of safety event reports in this report, at 13%. As mentioned above, elements of communication issues were frequently found in these events. The types of events in these cases include missing or incomplete documentation, such as consent forms, pre- and post-operative progress notes, vital signs, and other assessments. Another pattern in this category was issues with orders, such as issues with CPOE, verbal and telephone orders, order status issues, duplicate orders, and utilization of order sets. Orders placed based on location or pre-/post-procedure timing were issues, particularly “ED–Only” or “On-Call to OR” orders. Other HIT issues included in this category were those related to census boards, schedules, or “On-Call to OR” orders. Other HIT issues included in this category were those related to census boards, schedules, or “On-Call to OR” orders. Other HIT issues included in this category were those related to census boards, schedules, or “On-Call to OR” orders.

The fourth-largest category in these safety events is associated with general quality of care concerns. This category included complaints from patients or family members, sometimes in response to bills received for what they deemed substandard care. Also included in this category were reports from staff or providers expressing concern regarding care quality. Concerns about the plan of care for patients came from staff, providers, patients, and families, inappropriate discharges were reported in this category, as were concerns regarding the competency of staff or providers.

Because the “Other/Uncategorized” events represent such a large proportion of the safety event reports received by CHPSO every year, facilities may want to consider reviewing data in this reporting category to look for trends and patterns related to the issues described above or may reveal yet unidentified concerns. This may motivate patient safety and quality improvement activities. In addition, staff reporting such occurrences are more likely to continue to report their concerns when there is adequate follow-up from events they have submitted.

As in past years, CHPSO is happy to provide members with a facility-specific report in the “Other/Uncategorized” event type. If you are interested in further exploration of this category specific to your facility’s data, contact us at info@chpso.org.

The fifth-largest category included in these events is associated with workplace violence, bullying, and unprofessional behavior. These safety event reports described patients requesting to leave/leaving AMA, patients wanting to go outside to smoke, and patients refusing to sign the required AMA forms. These events also included refusal of care by the patient or by family members.

Unfortunately, statements regarding an inability to afford the recommended care were noted in several of these events. The fifth-largest category included in these events is associated with general quality of care concerns. This category included complaints from patients or family members, sometimes in response to bills received for what they deemed substandard care. Also included in this category were reports from staff or providers expressing concern regarding care quality. Concerns about the plan of care for patients came from staff, providers, patients, and families, inappropriate discharges were reported in this category, as were concerns regarding the competency of staff or providers.

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The most common PSWP data type submitted to CHPSO is safety event reports. As in past years, members submit Excel spreadsheets with safety event reports structured in one report per row. Data requirements are minimal, and members do not need to collect any data not already present in their incident reporting systems.

Column headers and row contents are submitted as produced by the member’s report database. This eliminates any need for manipulation by members and helps to minimize barriers to full participation in the patient safety organization.

All mapping to standardized taxonomy is done by our HIPAA- and PSQA-compliant vendor, with the guidance of the facility and support from CHPSO staff as needed. For the safety event reports, the facility uses a drag-and-drop interface to identify the initial mapping, and subsequent submissions need no work unless new fields or answer codes are included.

It typically takes under three hours to develop and complete the initial submission, with real-time, telephonic assistance throughout the process. Subsequent submissions take much less time (typically 15 minutes) and are performed as often as the facility deems appropriate.

CHPSO continues to make submission of data a simple and seamless process for our members. As in past years, members submit Excel spreadsheets with safety event reports structured in one report per row. Data requirements are minimal, and members do not need to collect any data not already present in their incident reporting systems.

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CHPSO Safe Table Activities 2017, 2018, 2019

At Safe Tables, members discuss cases on pre-selected topics in a confidential and privileged setting. These forums enable members to return to their health care organizations with lessons learned and valuable resources.

CHPSO hosted 21 Safe Tables in 2017, 22 Safe Tables in 2018, and 23 Safe Tables in 2019. Over time, attendance, continuing education (CE) credits provided, and hospitals represented significantly increased:

- **Attendees**: increased by 48%
- **Hospitals Represented**: increased by 71%
- **CE Credits Offered**: increased by 54%

Our hospitals are diverse, but our safety and quality concerns are shared. CHPSO provides member organizations with a protected environment in which they are able to share and learn from one another via the discussion of safety events and other quality of care concerns. Rady Children’s Hospital has benefitted greatly from its participation in the facilitated conversations made possible through CHPSO.

Dr. Glenn Billman, Chief Quality Officer
Rady Children’s Hospital - San Diego
Eliminating preventable harm and improving the quality of health care delivery

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