Eliminating preventable harm and improving the quality of health care delivery

September 2013

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Webinar Schedule Change

The September 9 CHPSO monthly member call and webinar "Monitoring for Effectiveness" has been rescheduled for Monday, October 14, 2013 from 10–11 am. We apologize for any inconvenience and hope you are able to join the presentation in October.

The Unintended Consequences of Health Information Technology

Over a decade ago, the Institute of Medicine (IOM) report *To Err is Human* raised an alarm about the failure of health care to recognize and reduce the large number of avoidable medical errors harming patients. The ability of health information technology (health IT) to reduce medical errors is one of the reasons for the creation of the Office of the National Coordinator for Health Information Technology (ONC) under the Department of Health and Human Services (HHS) through the Health Information Technology for Economic and Clinical Health (HITECH) Act. In addition to creating ONC, the HITECH Act also provided economic incentives for eligible health care providers to adopt and meaningfully use certified electronic health record (EHR) technology.

A key premise of these initiatives is that health IT, when fully integrated into health care delivery, facilitates substantial improvements in health care quality and safety as compared to paper records. For instance:

- EHRs eliminate prescription and other errors resulting from illegible handwriting, while capabilities such as clinical decisions support (CDS) and computerized provider order entry (CPOE) provide clinicians with best practice guidance and information on the allergies and medications of specific patients as part of the clinical decision-making process.
- Patient records can be stored centrally and easily accessed from multiple locations, making crucial health information available when and where needed as patients move within and between health care organizations. When a patient arrives at an emergency room, providers can begin treatment with electronic access to historical patient records.
- Health IT can be used to more efficiently report, track, and aggregate patient data within and across organizations. This allows providers to more efficiently track and manage hospital-acquired illnesses.

While health IT presents many new opportunities to improve patient care and safety, it can also create new potential hazards. Health IT can only fulfill its enormous potential to improve patient safety if the risks associated with its use are identified and if there is a coordinated effort to mitigate those risks. Recognizing this, ONC commissioned an IOM study to determine how government and the private sector can maximize the safety of health IT-assisted care. The IOM Report, *Health IT and Patient Safety: Building Safer Systems for Better Care*, was published in November 2011. The report recognizes that the full extent of health IT hazards is unknown because of a lack of reported information about health IT-related events.

How does reporting of health IT-related patient safety events to a PSO benefit a provider?

Unfortunately, since health IT is still fairly new, the associated hazards are not generally recognized or reported as such. For example, a patient underwent a repeat procedure because a physician note had been copied and pasted several times in the patient's EHR without being updated. This resulted in the misunderstanding that the patient had not undergone the procedure and it was therefore repeated. However, this event was only reported as a surgical event and it was not until a causal analysis was completed that the associated health IT issues were identified.

Within a single hospital an event such as this may be uncommon and not appear to be a significant trend. When a PSO collects several associated incidents, however, a trend can be identified that may not have been recognized by an individual provider. CHPSO, as well as other PSOs, have identified such trends and have developed a multi-state, multi-PSO project to increase recognition and reporting of health IT-related safety events. The initial phase of this project is aimed at raising awareness. Educational flyers and webinars are being created and dispersed through a collaboration of 26 PSOs participating in the Nationwide Alliance of Patient Safety Organizations (NAPSO). The first of these ready-to-share educational flyers, Risky Workarounds, is available to members and non-members and is posted on the CHPSO website. http://www.chpso.org/sites/main/files/file-attachments/2013_risky_workarounds_20130712_revise_0.pdf

We encourage you to share this flyer with your staff so that they are more aware of and recognize potential health IT hazards, report them through your incident reporting system, and understand how to avoid them or prevent them from causing patient harm. More educational materials will be dispersed in the near future through *CHPSO Patient Safety News* and the CHPSO website.

Teamwork: Pulling it all together

Most members of the health care community would be hard-pressed to believe that one single aspect of health care accounts for most errors that occur in medicine; that fixing and perfecting this aspect could lead to an almost error-free health care practice. But recent research suggests that this is the case and that one aspect of health care is teamwork.

Communication failures are the leading cause of inadvertent patient harm. Analysis of 2455 sentinel events reported to The Joint Commission for Hospital Accreditation revealed that the primary root cause in over 70 percent of all events was communication failure. Reflecting the seriousness of these occurrences, approximately 75 percent of these patients died. All too often, clinicians providing care had very divergent perceptions of what was supposed to happen. (1)

These statistics not only reflect the problem with the teamwork culture in health care institutions, but the great importance of effective communication between team members in health care delivery. The health care environment has become more complex as the acuity of hospitalized patients rises and technology becomes a significant presence. The system still relies on humans communicating with each other. Each member has influence on the health care process and, therefore, must work in harmony in order to provide quality care.

Individual mistakes are inevitable. Psychology tells us that the inherent limitations of human memory, effects of stress, impact of fatigue, and limited ability to multi-task ensure that even skilled, experienced providers will make mistakes. *Individually*, we as human beings are inherently error-prone. However, *a team* is not. A well-synchronized and collaborative health care delivery team creates a well-understood plan of care, and greatly reduces the chances of errors becoming consequential and injuring patients.

There has been a great deal of research in health care on the limitations of the current way most health care teams function, and steps that can be put into place to eliminate these limitations. Research done by the Department of Defense's Patient Safety Program in collaboration with the Agency for Healthcare Research and Quality (AHRQ), the World Health Organization (WHO), and other research have all yielded a common theme in the problems of the modern day health care delivery team. They have all identified the following key areas in healthcare that need to be addressed:

- Communication gaps
- Cross monitoring (“I’ve got your back.”)
- Assertion of view
- Team dynamics

Because ineffective teamwork and communication have been identified as leading causes of adverse events reported to CHPSO, the CHPSO Patient Safety News will publish a series of articles addressing these concerns over the next few months.

References

[1]Leonard, M., S. Graham, and D. Bonacum. "The human factor: the critical importance of effective teamwork and communication in providing safe care." *Quality and Safety in Health Care* 13.suppl 1 (2004): i85-i90.

CHPSO is Hiring: Patient Safety Coordinator

CHPSO is seeking a Patient Safety Coordinator to join the team. Qualified, interested candidates should apply online.

The Patient Safety Coordinator is primarily responsible for analyzing reported incident information, providing feedback to members and assisting them in identifying and addressing areas of improvement. Serves as a member resource on quality and patient safety matters. Assists members in the development of their patient safety evaluation systems. Develops and presents reports, educational, and resource materials. Assists with website maintenance. Identifies industry best practices and shares those with member hospitals. Assists with quality and patient safety program development. Coordinates and facilitates member group discussion. Tracks CHPSO's strategic goal measures. Performs all assignments in a professional, accurate and timely manner.

To be successful, you will need to have the following education, skills and talents:

- Bachelor's degree in clinical practice (RN preferred) with minimum of 5 years clinical experience and knowledge of the complexity of hospital processes and in working within the hospital environment
- Experience in event investigation, causal analysis, and human factor engineering
- Data analysis & quality experience; knowledge in lean, six sigma or other process improvement techniques desired
- Excellent ability to effectively manage projects and initiatives and to provide anticipated outcomes
- Demonstrated ability to foster teamwork and bring diverse groups together in a collaborative and effective manner
- Ability to work independently as well as part of a team
- Excellent verbal and written communication skills in order to develop and present reports and educational materials

If this sounds like a good fit with your background and career interests, we'd love to hear from you! To apply, please apply online at https://home.eease.adp.com/recruit/?id=6054501. Be sure to include your resume, cover letter and salary requirements. EOE.

About CHPSO

The California Hospital Patient Safety Organization ("CHPSO") was created by the California Hospital Association to lead California's efforts towards eliminating preventable patient harm and improving the quality of health care delivery in hospitals. CHPSO is one of the largest Patient Safety Organizations in the nation and has access to data from over 700 hospitals. CHPSO's initiatives include providing a collaborative and privileged environment where hospitals can share data and best practices, analyzing adverse outcomes and developing corrective actions to prevent re-occurrence, developing education materials, and serving as a statewide resource for patient-safety initiatives in California.

Ask CHPSO

We have found that many of our members have the same questions. The "Ask CHPSO" column is intended to provide answers to these common inquiries. If you have a question, please contact us at (916) 552-2600 or info@chpso.org.

Dear Dr. Jaffe,

We have recently joined CHPSO and are excited about our new partnership. Can you please clarify for me how much information we are required to submit to CHPSO?

Thanks,
Excited New Member

Dear Excited,

There is no requirement. Each organization decides what information and how much it will submit to CHPSO during the development of its Patient Safety Evaluation System (PSES). Of course, we would like for your organization to send as much relevant information as possible. The more information deposited into our database, the more we will be able to learn. Through analyzing the event information submitted to us, whether it is finding a significant trend or a small number of high-risk events, we are able to identify safety issues and hazards that are occurring within health care and then collaborate with providers to identify mitigating strategies.

By contributing more information, you help not only yourself, but everyone else as well. CHPSO actively shares its findings worldwide, through its participation in the global patient safety alerts system, its newsletters and email alerts, and its web site.

Thanks for your question and welcome to CHPSO!

Regards,
Dr. Jaffe

Have questions for Dr. Jaffe? Submit them to info@chpso.org with the subject line "Dear Dr. Jaffe". All inquirers will remain anonymous.

Informed Consent: It's more than a piece of paper

CHPSO / ECRI Webinar

September 16, from 11:30am to 12:30pm Pacific Time

The goals of this webinar presentation are to:

1. Share information reported from members about issues with informed consent as they relate to patients' rights to self-determination and autonomy.

2. Suggest methods to improve patient safety by ensuring the informed consent contains the essential elements.

All data will be deidentified. Members are encouraged to participate in the polling questions and discussion at the end of the webinar to share challenges and success stories.

This call is for members only. Registration is required and can be found at www.chpso.org/event/informed-consent-its-more-piece-paper. Please note that a website member account is a requirement to sign up for member-only webinars. Registrants will receive an email by noon on Friday, September 13. Members registering on or after Friday, September 13 should contact CHPSO for participation information at (916) 552-2600.

Continuing Education
Nursing-This activity has been approved for 1.0 California State Nursing contact hours by the provider, Debora Simmons, who is approved by the California Board of Registered Nursing, Provider Number CEP 13677. Information on obtaining credit will be presented at the beginning of the webinar.

Free Alarms Systems Management Webinar Series

In order to help facilities understand and successfully comply with The Joint Commission's 2014 National Patient Safety Goal, AAMI's Foundation, the Healthcare Technology Safety Institute, is pleased to announce it is teaming up with several organizations to offer a series of seven free webinars on alarm management. Click here for more information about the series.

The Joint Commission's National Patient Safety Goal on Alarm Management: How Do We Get Started?

Wednesday, September 25, 2013, from 10 to 11 a.m., Pacific Time

Register for this event

This first webinar will set the stage for the series and briefly outline the complexity of issues related to alarm systems and the events that have occurred in the past two years that have led to the spotlight on alarm systems and alarm "fatigue." The opening webinar will also lay the groundwork for the objectives of the series, expectations for the participant, and the requirements to receive continuing education units. Secondly, this first webinar will cover the overall scope and requirements of the Joint Commission's National Patient Safety Goal (NPSG) on Alarm Management, the timeline for meeting the requirements, and the way the webinar series will help the participant get started on meeting the goal.

Speakers
- Patricia Adamski, RN, MS, MBA, Director of Standards Interpretation Group, The Joint Commission
- Marjorie Funk, PhD, RN, FAHA, FAAN, Professor, Yale University School of Nursing (Moderator)
- Sue E. Sendelbach, PhD, RN, Abbott Northwestern Hospital
- Rikin Shah, ECRI Institute

Causal Analysis Learning Series: Monitoring for Effectiveness

October 14, from 10 to 11 a.m. Pacific Time

Are you tracking and/or measuring the success of your corrective action plan? Many facilities do not and risk recurrence of the identified problems. During this webinar, we will review tools and processes that can be used to determine if your changes were fully adopted into practice and whether or not they were effective at addressing the problems.

Registration

This call is for members only. Registration is required and can be found at www.chpso.org/event/causal-analysis-learning-series-monitoring-effectiveness. Please note that a website member account is a requirement to sign up for member-only webinars. Registrants will receive an email by noon on Friday, October 11. Members registering on or after Friday, October 11 should contact CHPSO for participation information at (916) 552-2600.

Continuing Education

Provider approved by the California Board of Registered Nursing, Provider #CEP 16084, for 1.0 contact hour.
Full attendance, completion of online survey, and attestation of attendance is require to receive CE for this webinar. CE is complimentary for registrants.

Past Webinars

Content from the previous four webinars in this series, along with other past webinars, is available to members at www.chpso.org/webinar-archive.

Upcoming Patient Safety Events

California Hospital Patient Safety Organization

Unless noted, all CHPSO events are for members only. Members will receive an email a few days before each event with information on how to participate. All times are for the Pacific Time Zone. For more information, contact info@chpso.org or call (916) 552-2600.

September 16 11:30 a.m.–12:30 p.m.	Informed Consent: It's more than a piece of paper CHPSO / ECRI Webinar
October 14 10–11 a.m.	Causal Analysis Learning Series: Monitoring for Effectiveness CHPSO monthly member call

Hospital Council of Northern and Central California

September 12 11 a.m.–12:30 p.m.	PFCC: Partnership from the Bedside to the Boardroom

Hospital Association of Southern California

September 26 8 a.m.–12 p.m.	Charge Nurse Education Series: Managing Change

Hospital Association of San Diego and Imperial Counties

For more information visit www.patientsafetycouncil.org **or contact** Alicia Muñoz**.**

September 11 6–8 p.m.	Reducing Perinatal & Neonatal Mortality
September 26 1–4 p.m.	Readmission Forum
September 26 6–8 p.m.	California's Call to Action: Prevent Retained Surgical Items