Nebraska Coalition for Patient Safety

Improving the safety and quality of healthcare delivery in Nebraska

Fifth Annual Report
November 2014

Nebraska Coalition for Patient Safety

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Acknowledgments

A Message from the Executive Director

- NCPS membership has reached 54 members in two states – Nebraska and Iowa.
- NCPS received another record number of events in 2013, with eighty-seven events reported.
- NCPS continues to collaborate with the Nebraska Association for Healthcare Quality, Risk and Safety (NAHQRS), the National Alliance of Patient Safety Organizations (NAPSO), and CIMRO of Nebraska to expand the knowledge of Nebraska healthcare organizations related to patient safety, develop mutually beneficial programs, and reduce organizational expenses related to patient safety education for staff.
- In 2013, based on patterns in reported events, education was focused on retained surgical items (RSIs), second victim, root cause analysis education, health information technology safety, and alarm fatigue.
- NCPS disseminates evidence-based patient safety practices and tools to members via member calls and the NCPS website www.nepatientsafety.org
- NCPS provides de-identified events to members in order to provide a system-wide view of contributing causes, as well as to accelerate learning across member organizations.
- NCPS collaborated once again with CIMRO of Nebraska to conduct its 2014 annual meeting in conjunction with the 2014 Nebraska Healthcare Quality Forum in La Vista, NE in June 2014. Over 400 healthcare professionals attended educational sessions conducted by NCPS presenters.
- NCPS joined the Alliance for Quality Improvement and Patient Safety (AQIPS), a national non-profit association that assists PSOs and members in building a safer healthcare system.
- NCPS will co-lead a just culture collaborative in 2014-2016 in Nebraska, with support from Outcome Engenuity.™ The collaborative will utilize the framework of the NCPS Issue Strategy Group and educate healthcare professionals and leaders in just culture principles.
- NCPS participated in the National Patient Safety Foundations' (NPSF) pre-congress session titled, "Using PSOs to Improve Quality, Safety, and Efficiency in Healthcare," in Orlando, FL on May 14, 2014. Attendees learned how to create a learning system from the best practices of health systems and other providers who are operating PSOs.
- NCPS presented at the Wyoming Hospital Association's Annual Trustee Education Program in Casper, on May 16, 2014, along with Nancy Foster, Vice President of Quality & Patient Safety Policy with the American Hospital Association, and Kelly Court, Chief Quality Officer for the Wisconsin Hospital Association.
- NCPS presented to the Rural Nebraska Healthcare Network Joint Board of Trustees on April 7, 2014 in western Nebraska regarding the specifics of PSO membership and patient safety.

Federal Legislation

The Patient Safety and Quality Improvement Act (PSQIA) was signed into law by President George W. Bush on July 29, 2005. The Act represents the first federal legislative attempt to directly address patient safety. The law established a medical error reporting system and provided federal privilege for data collection. By providing federal and state privilege and confidentiality, the PSQIA permits PSOs to create a secure environment where healthcare personnel can freely share and analyze patient safety events without fear of liability or professional sanction. The Department of Health and Human Services issued the final regulations in December 2008. NCPS is responsible for analyzing reported patient safety events and ensuring compliance with the PSQIA. Every entity seeking to be a PSO must certify to AHRQ that it has policies and procedures in place to perform specific patient safety activities identified in the Patient Safety Rule. In addition, an entity must also, upon listing, certify that it will comply with seven additional criteria specified in the Patient Safety Rule.

Litigation Perspective

The Patient Safety and Quality Improvement Act was passed in 2005 to expand voluntary, provider-driven initiatives to improve the quality and safety of health care and to promote rapid learning about the underlying causes of risks and harm in healthcare. One of the roles of a PSO is to share those findings, thus speeding the pace of improvement among its members.

Two cases addressed various aspects of and challenges to the federal Patient Safety and Quality Improvement Act of 2005 protections with each challenge upheld in the courts:

- Illinois Department of Financial and Professional Responsibility v. Walgreens (2011)---Walgreens could not be forced to disclose adverse events sent to the PSO because of *strong documentation establishing the nature of the Patient Safety Work Product (PSWP) and the relationship between the information sought and the PSES/PSO process.*

- Schlegel v. Kaiser Foundation Health Plan, (2008)---Kaiser was ordered to disclose PSO adverse events because the Court *could not find that the adverse event reports were prepared for and reported to a PSO.*

Three types of Patient Safety Work Product:
1. Information collected or developed must be for the 'purpose of reporting' to a PSO
2. Information developed by a PSO for the conduct of patient safety activities
3. Data, records, memoranda, memos, analyses, which include deliberations and analysis

Congressional Day – 2014

The United States Capitol – April 22, 2014

Senator Fisher (R-NE) helped introduce the Preventing Regulatory Overreach To Enhance Care Technology (PROTECT) Act of 2014, which is the beginning of a framework for the regulation of Health Information Technology (HIT). PSOs are part of this framework for the surveillance of HIT safety with the goal of making health care safer through HIT.

Senator Johanns' (R-NE) office (Carly Bayne, legislative correspondent) met with PSOs to discuss the PSQIA and the work that PSOs are doing across the country.

<u>**Other constituent meetings and committee meetings attended:**</u>

Senator Harkin (D-IA) voted for passage of the PSQIA. Senator Harkin is retiring at the end of 2014.

Senator Hatch (R-UT) has been very responsive to the issue of healthcare organizations maintaining compliance with the Centers for Medicare and Medicaid Conditions of Participation (CMS CoPs), while not eroding the privilege of the PSQIA.

Representative Upton (R- MI) was a sponsor of the PSQIA and is leading the negotiation of the Sensible Oversight for Technology Which Advances Regulatory Efficiency Act of 2013 SOFTWARE Act.

Benefits of PSO Membership

NCPS values all of our members and participating organizations. Get the most out of your membership by focusing attention on the areas where the data suggests it is needed the most. In the following pages, NCPS has provided a number of areas in which we have taken a 'deep dive' look at events that happen frequently (e.g. falls) or those that occur and may cause substantial harm (e.g. wrong site surgery). Increase knowledge sharing and awareness in your organization by sharing monthly de-identified events sent out to members by NCPS.

1. **PSO membership offers peer to peer/case study programs.**

2. **PSO membership allows for healthcare organizations to create learning systems.**

3. **PSO membership allows for aggregate data to be predictive and potentially lower healthcare costs.**

4. **PSO membership tells your patients, staff, and governing boards that patient safety is a priority.**

Regulatory Update

On December 2, 2013, the Centers for Medicare & Medicaid Services (CMS) published long-awaited rules pertaining to Section 1311 of the Affordable Care Act (ACA). This provision requires hospitals with more than 50 beds to participate with a PSO in order to be eligible to participate with health plans that are part of the Health Insurance Exchanges (HIEs). A two year phase-in period begins January 1, 2015 and extends through January 1, 2017.

The Agency for Healthcare Research and Quality (AHRQ) is the oversight body for PSOs across the U.S. At this year's annual PSO meeting, the issue of CMS Survey and Certification surveyors seeking PSWP was once again in the spotlight. AHRQ acknowledged that they are actively working with CMS to resolve the issue and expect a solution in 2014.

How to Use This Report

The information in this report is important to healthcare providers and patients alike. Patients and their families and/or friends can use it to learn about questions they might ask to make sure that the care they receive is the best and most appropriate to their needs. This report can also be used to learn about what healthcare organizations are doing, and should be doing, to keep patients safe. The last page of this report lists websites to visit in order to find even more information to help patients and families make wise healthcare choices.

This region has some of the best hospitals and health care workers in the country, but it is everyone's job to pay attention to safety. NCPS believes that its reporting system is helping organizations to be safer. If organizations can learn from mistakes and make sure that patients, doctors, nurses, and others speak up about risks they see, we can make our health care the safest in the country.

The most important part of this report is not how many events occurred or have been reported, but rather the learning that occurs from the event. Because of what is learned, organizations can make many changes in how they provide care. They can also share their solutions with others. These changes will make health care safer for all patients.

Has Your Organization Considered These Best Practices?

Address limits and interval settings on sedation orders.

Ask patients/families open-ended questions about medications, such as, "Tell me the name and dose of the Insulin you take," versus questions regarding medications that require a 'yes' or 'no' response.

Consider the use of (Behavioral) Rapid Response Team implementation to de-escalate potential volatile situations. This allows for easier treatment of behavioral health patients. The behavioral emergency response team (BERT) consists of staff from behavioral health services who have experience in caring for patients with acute psychiatric disorders as well as competence in management of assaultive behavior.

Implement a two-person independent double-check for IV medications intended for patients weighing less than 5 kg.

Provide a process by which nurses can communicate to nurse aides at change of shift, enabling all staff to be aware of diagnoses, and other patient needs.

Implement a process by which the radiologist and surgeon communicate directly with each other if there is a suspected retained foreign item or sponge, so that the radiologist is aware of what he/she is looking for on the film.

Review the Pediatric Early Warning System (PEWS) to implement in various departments (including the Emergency Department), to aid in assessment of pediatric patients. The scoring system takes into account the child's behavior, as well as cardiovascular and respiratory symptoms. The tool is available at: http://pediatrics.aappublications.org/content/125/4/e763.full.pdf

Review patient allergies prior to, and as part of, the Time-Out process in the Operating Room.

PSO Highlights

The 6th Annual Meeting of PSOs was held on April 23rd-24th, 2014 in Rockville, MD at AHRQ headquarters.

2013	2014
77 listed PSOs	84 listed PSOs
29 states and the District of Columbia	31 states and the District of Columbia

Elizabeth (Liz) A. Hunt, MD, MPH, PhD, Director, Johns Hopkins Simulation Center, provided the keynote address to members attending the annual conference. Her presentation, "Using Simulation to Translate to Safer Care in Our Most Vulnerable Patients" focused on her love of the pediatric patient and how simulation can be used for novices, intermediate and expert clinicians (Chart 1). Dr. Hunt explained that medical students at Johns Hopkins receive 60 hours of simulation training "before they touch patients." She also emphasized that proponents of simulation training should ask, "Are participants learning to do or are they learning to change their practice? Participants in simulation labs learn to do it right," she stated, "so that it becomes muscle memory."

Dr. Hunt provided some excellent examples of types of scenarios that can and should be re-created in the simulation laboratory. Some examples include:
1. All sentinel events (example: shock management)
2. Rapid Response Team activations, listening to each taped call to provide specific input for the scenarios
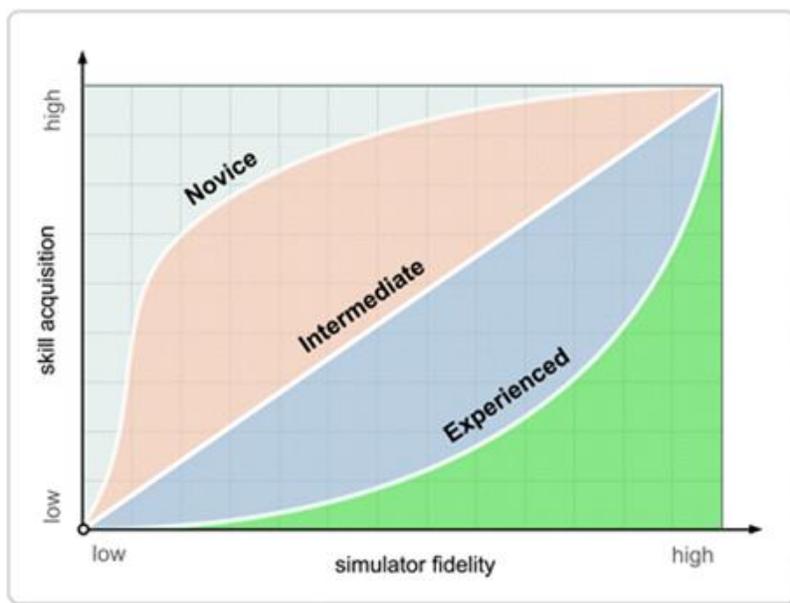3. CPR and AED use

Chart 1: A novice practitioner will gain most from a low-fidelity simulator that has the ability to teach generic skills. An experienced practitioner will require task refinement, which is more likely to be gained from a higher-fidelity simulator that can simulate complex or crisis scenarios such as bleeding.

Quality Forum: NCPS Break-Out Sessions

Katherine Jones (pictured here) presented on the topic of "Collaboration And Proactive Teamwork Used to Reduce (CAPTURE) Falls", taking place in 17 Nebraska hospitals, 16 of which are Critical Access Hospitals (CAHs) with 25 or fewer beds. This session summarized lessons learned from implementing coordinating teams to be accountable for hospital fall risk reduction including the need to conceptualize fall risk reduction into reliable structures and processes at the unit and organizational level. The toolkit containing resources for fall risk is posted at http://www.unmc.edu/patient-safety/capturefalls/ .

Carol Wahl (pictured here) presented on the topic of "Engaging the Patient and Family in Care." This session identified national priorities and examples of initiatives that are changing the culture of patient/hospital partnerships. Several examples of initiatives discussed included patient/family advisory councils, patient Rx (patient orders), touch base/discharge rounding, and bedside shift reports.

Dr. Ann Polich (not pictured) spoke to attendees of this session on specific patient safety challenges providers face in order to manage populations of patients within complex systems. Dr. Polich emphasized the importance of moving toward a 'we' mentality with physicians in your organization, while enhancing patient safety.

Kathy Corbett, (not pictured) presented an introduction to the first standard, "Skilled Communication", in the Association of Critical Care Nurses (AACN) Healthy Work Environment Standards. Poor communication has been identified as one of the major contributors to adverse events in the healthcare setting.

Aggregate Data Analysis

The number of member organizations belonging to the Nebraska Coalition for Patient Safety (NCPS) increased from 37 in 2008 to 54 in 2013. The number of events reported annually has more than tripled---from 24 in 2011 to 87 in 2013 (Figure 1).
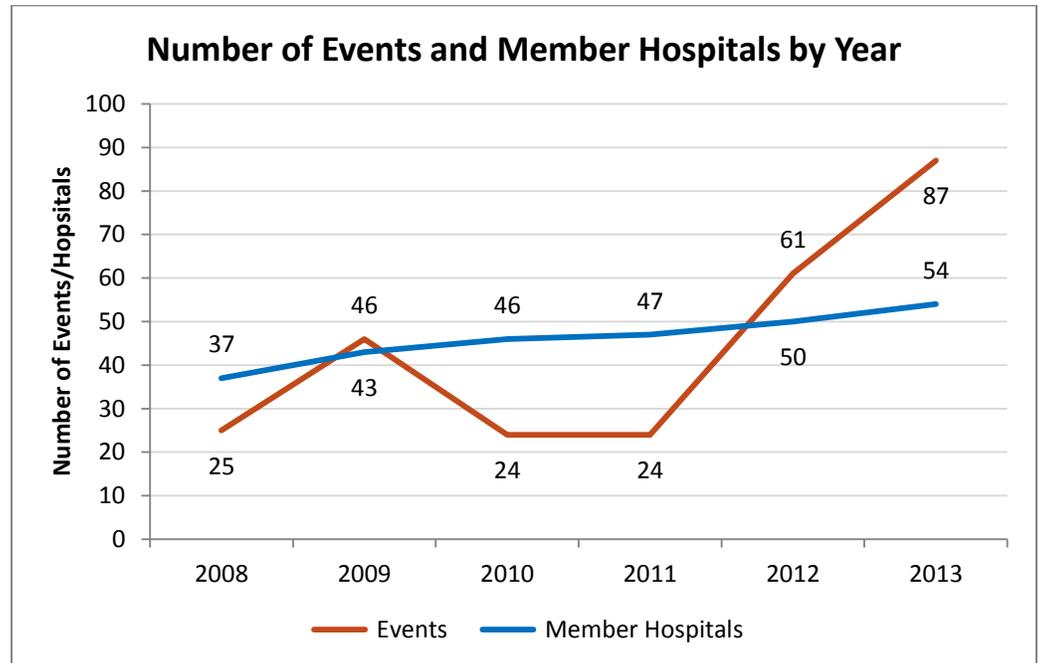

Figure 1. Number of reported events and member organizations by year.

While the percentage of hospitals reporting from 2012 to 2013 appears to have declined slightly (Figure 2), the number of members has increased. There has been an increase in the number of member hospitals reporting in 2013 compared to 2012.
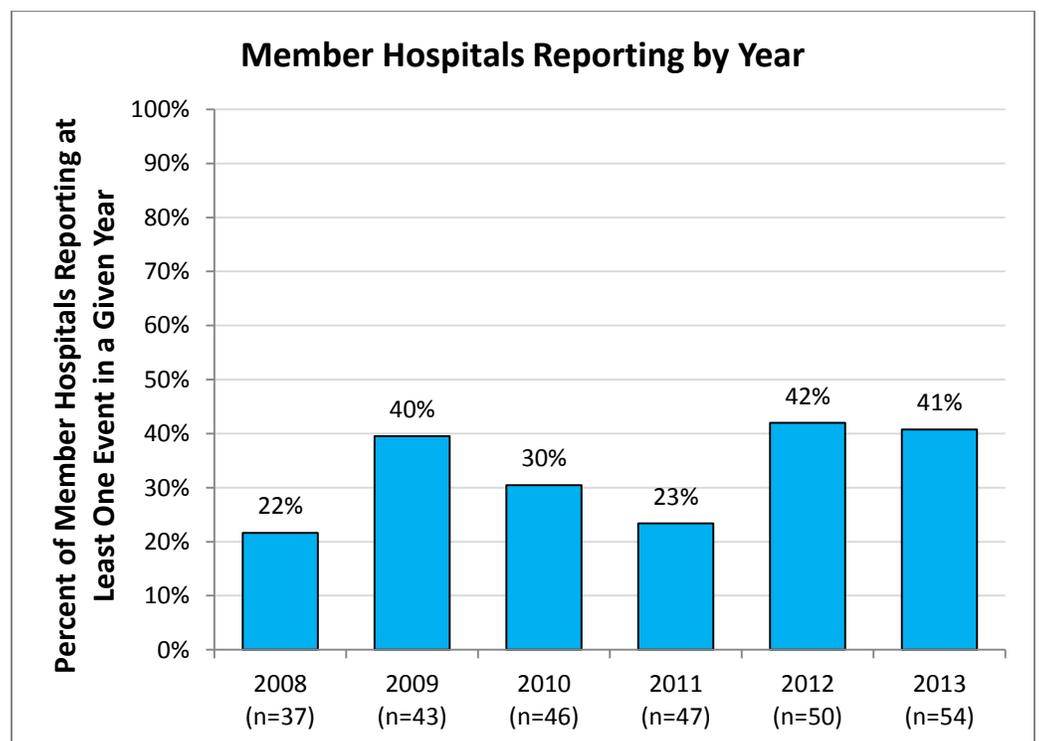

Figure 2. Percentage of member hospitals reporting by year.

Table 1. NCC MERP* Index of Error Severity

HARM	**A**	Circumstances or events occur that have the capacity to cause error.
	B	An error occurred, but the error did not reach the patient.
	C	An error occurred that reached the patient, but did not cause patient harm.
	D	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient, and/or required intervention to preclude harm. Harm does not reach patient.
	E	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.
	F	An error occurred that may have contributed to or resulted in temporary harm to the patient and required an initial or prolonged hospital stay.
	G	An error occurred that may have contributed to or resulted in permanent patient harm.
	H	An error occurred that required intervention necessary to sustain life.
	I	An error occurred that may have contributed to or resulted in patient death.

* Because all member hospitals report events using the same categories or taxonomies, NCPS is able to validly aggregate the data. To categorize severity, NCPS uses the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) index of error severity, which assigns an alphabetical ranking, A through I, based on the severity of the outcome to the patient (Table 1).

Because reporting unsafe condition (A) and near miss (B) events result in learning and no harm to patients, NCPS has worked with members to increase reporting in those areas, so that root causes and contributing factors might be uncovered. In 2012, only 5% of events reported were A & B events. In 2013, those event types increased to 8.6% of all events (Figure 3).

Event Severity for All Events

Number of Events vs Event Severity:

Event Severity	Number of Events
A	15
B	8
C	51
D	47
E	57
F	30
G	10
H	14
I	35
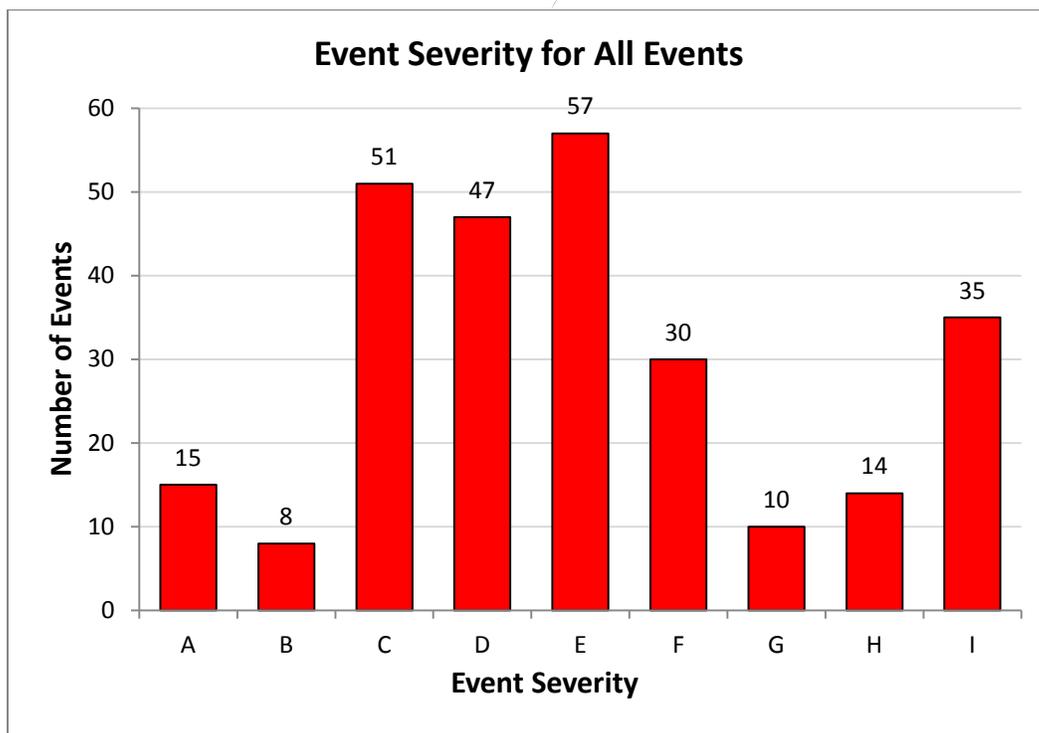
Figure 3. Severity of events reported by NCPS members 2008-2013.

Adverse events appear to increase with advancing age. Every patient is at risk of an adverse event as evidenced by the age distribution of events 2008-2013 (Figure 4).

Age Distribution for All Events

Number of Events vs Patient Age:

Patient Age	Number of Events
< 10	18
10's	11
20's	11
30's	17
40's	17
50's	31
60's	30
70's	30
80's	37
≥ 90	15

Figure 4. Age distribution of all events reported to NCPS 2008-2013.

Spotlight on Falls

Approximately 2% - 3% of hospitalized patients fall each year resulting in nearly one million falls in U.S. hospitals, and approximately one-third of these falls result in injury (Oliver, Healey and Haines, 2010). The cost of care for the 2% of fallers who sustain serious injury is nearly $14,000 greater than for nonfallers (Wong et al., 2010). From 2008 – 2013, 21 hospitals reported 32 fall events to NCPS 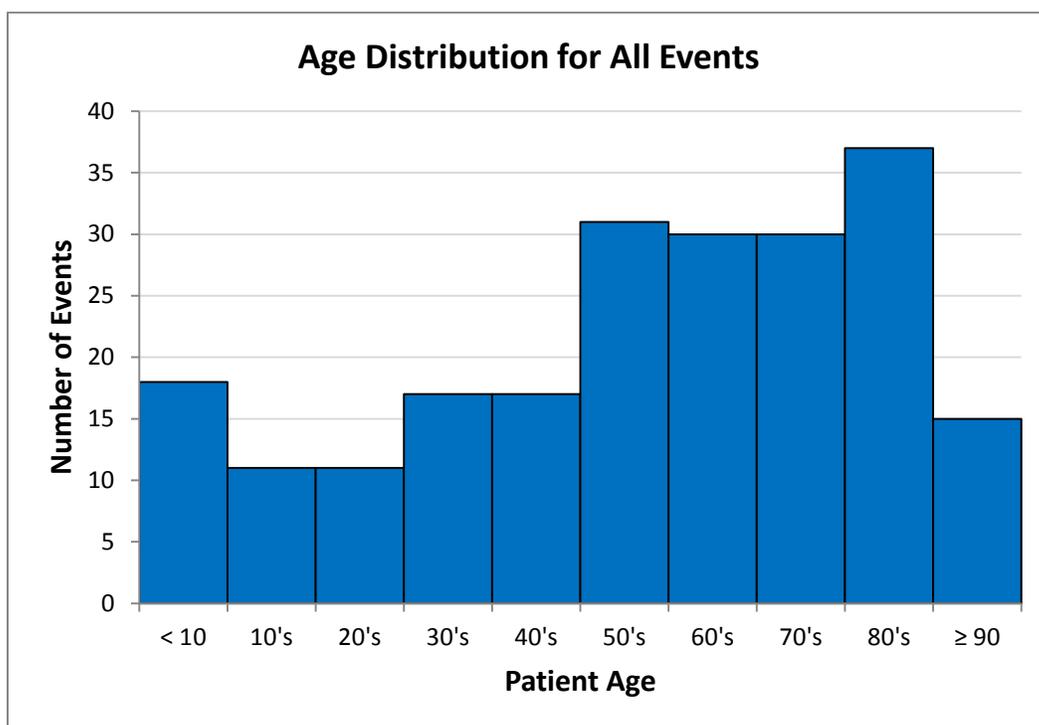(Table 2.). Twenty-five percent of these reported falls resulted in permanent harm or death. The majority of the falls (88%) were unassisted, and the average age of the patient was 79.1 years.

Table 2. Characteristics of Fall Events by Hospital Type 2008 - 2013

Fall Event Variable	Reported by All Hospitals n=32 (%)	Reported by Non-CAHs n=13 (%)	Reported by CAHs n=19 (%)
Harm Level			
Up to Temporary Harm	24 (75%)	9 (69%)	15 (79%)
Permanent Harm, Death	8 (25%)	4 (31%)	4 (21%)
Root Causes			
Environment	22 (69%)	12 (93%)	10 (53%)
Communication	17 (53%)	11 (85%)	6 (32%)
Not Following Rules	17 (53%)	7 (54%)	10 (53%)
Unassisted	28 (88%)	11 (85%)	17 (89%)
Age, Mean (range)	79.1 (36-93)	75.9 (36-93)	81.5 (65-93)

Lessons Learned

1. All staff can monitor the environment
   - Confused patients should not have access to stairs (two patients fell down the stairs while in wheel chairs)
   - Do not assume patients who are acutely ill or on hospice will not attempt to become mobile…always keep the bed in the lowest position, use bed rails appropriately, and consider floor mats
   - Use pad alarms that detect weight shift on beds and chairs…patients easily remove TABS alarms
   - Never leave a patient at high risk for falls alone in the bathroom (hard surfaces increase risk of injury)
2. Know the plan, share the plan, review the risks
   - Level of assist and precautions for transfers must be communicated and posted for all on the white board (two assisted falls involved personnel who did not know how to properly transfer a patient)
   - Screen for and communicate risk of injury using the ABCS (Quigley et al., 2009):
     - **Age** 85+
     - **Bone** (osteoporotic)
     - **Coagulation** (on an anticoagulant)
     - **Surgery** (recent surgical procedure)

3. Annually conduct training and competency assessment for transfers including use of patient lift equipment (one assisted fall occurred due to inappropriate use of a Hoyer Lift). Videos demonstrating principles and techniques for safe transfers and mobility are available at:
   http://www.unmc.edu/patient-safety/capturefalls/tool- inventory.html
4. Routinely conduct audits to determine the reliability of intended interventions and hold personnel accountable according to principles of Just Culture.

Spotlight on Wrong Site Surgeries

Wrong Site Surgery (WSS) is a term that encompasses surgery performed on the wrong site or side, wrong procedure and/or wrong patient.
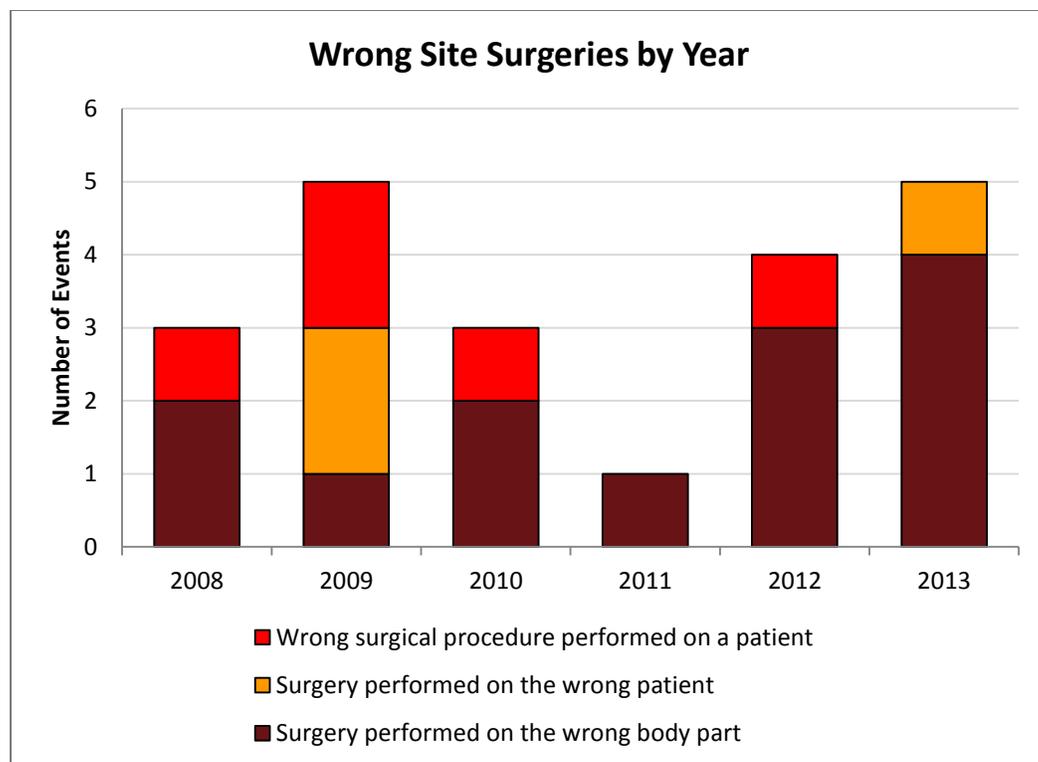
Wrong Site Surgeries by Year

Figure 5. Number of wrong site surgeries by year.

Tufts University Medical Center in Boston, Massachusetts sought to measure compliance with the universal protocol. They used real-time, clandestine observation and compared those findings with chart audits. Results of their real-time observational findings were as follows:

- In 8.2% of cases the surgical site was unmarked
- In 10% of cases a time out was not performed
- In 13% of cases the pre-operative checklist was incomplete before incision
- In 18% of cases the entire surgical team was inattentive during the time-out
- In 18% of cases surgical images were not displayed
- In 49% of cases the OR whiteboard was not filled out completely
- In 87% of cases the surgical team failed to make introductions prior to incision

There is no substitute for direct, real-time observation of critical processes in healthcare organizations. Direct observation provides a granular and very accurate view of compliance with specific components of the universal protocol across various departments involved. Direct observation also engages staff in a two-way dialogue about issues they face in meeting the requirements of this and other critical processes that safeguard your organization and your patients.

Targeted Education

NCPS members learn of adverse events, causal factors, and actions taken to reduce recurrence in a variety of ways. One method that NCPS uses is to de-identify an event that has been reported and email it to our members, monthly. Another method is via 'safety alerts' also published by NCPS to its members. The alerts are a result of more than one of the same type of event being reported to NCPS and, therefore, trigger an alert to members about the specific event type. Last, but certainly not least, NCPS provides education based on the event types reported. Below are the educational sessions offered in 2013:

- **February 2013 – Retained Surgical Items Webinar**
  Retained Surgical Items is the preferred term and includes four categories including soft goods/sponges, needles, instruments and miscellaneous small items. Dr. Verna Gibbs provided NCPS and six other PSOs across the U.S. with strategies to prevent retention of surgical items.

- **June 2013 – Second Victim Education**
  Second victims are healthcare providers who were involved in adverse patient events/medical errors and are traumatized, as a result.

- **October 2013 – Root Cause Analysis Education**
  Each year NCPS provides NCPS and Nebraska Association of Healthcare Quality, Risk and Safety (NAHQRS) members root cause analysis education.

- **November – Health Information Technology (HIT) Safety Webinar**
  The *Health IT Patient Safety Action and Surveillance Plan* addresses the role of health IT within HHS's commitment to patient safety and builds upon recommendations made in the 2011 Institute of Medicine (IOM) Report, *Health IT and Patient Safety: Building Safer Systems for Better Care*. The Plan has two related objectives:
  1. Use health IT to make care safer, and
  2. Continuously improve the safety of health IT.

- **December 2013 – Alarm Fatigue Webinar**
  Alarm fatigue occurs when clinicians become desensitized to clinical alarms. Some experts agree that safety can be enhanced by establishing alarms as an organization priority and identifying the most important alarms to manage based on their own internal situations.

NCPS Member Organizations (as of Publication Date)

Antelope Memorial - Neligh
Avera Creighton Hospital - Creighton
Avera St. Anthony's - O'Neill
Beatrice Community Hospital - Beatrice
Boone County Health Center - Albion
Box Butte General Hospital - Alliance
Brodstone Memorial Hospital - Superior
Bryan Health - Lincoln
Butler County Health Care Center - David City
Cherry County Hospital - Valentine
CHI Health Bergan Mercy -Omaha
CHI Health Creighton University Medical Center - Omaha
CHI Health Good Samaritan - Kearney
CHI Health Immanuel - Omaha
CHI Health Lakeside - Omaha
CHI Health Mercy Corning - Corning
CHI Health Mercy Council Bluffs - Council Bluffs
CHI Health Midlands - Papillion
CHI Health Missouri Valley - Missouri Valley
CHI Health Nebraska Heart Hospital - Lincoln
CHI Health Plainview - Plainview
CHI Health Schuyler - Schuyler
CHI Health St. Elizabeth - Lincoln
CHI Health St. Francis - Grand Island
CHI Health St. Mary's - Nebraska City
Columbus Community Hospital - Columbus
Community Hospital - McCook
Cozad Community Hospital - Cozad

Faith Regional Health Services - Norfolk
Fillmore County Hospital - Geneva
Fremont Health Medical Center - Fremont
Great Plains Regional Medical Center - North Platte
Harlan County Health System - Alma
Howard County Medical Center - St. Paul
Jefferson Community Health Center - Fairbury
Lexington Regional Health Center - Lexington
Lincoln Surgical Hospital - Lincoln
Litzenberg Memorial County Hospital - Central City
Memorial Community Health - Aurora
Memorial Health Care Systems - Seward
Nebraska Medicine - Omaha
Nebraska Methodist Health System - Omaha
Nebraska Orthopaedic Hospital - Omaha
Nemaha County Hospital - Auburn
Osmond General Hospital - Osmond
Pawnee County Memorial Hospital - Pawnee City
Pender Community Hospital - Pender
Phelps Memorial Health Care System - Holdrege
Providence Medical Center - Wayne
Saunders Medical Center - Wahoo
St. Francis Memorial Hospital - West Point
Thayer County Health Services - Hebron
Tilden Community Hospital – Tilden*
Tri Valley Health System - Cambridge
West Holt Medical Services - Atkinson

*Hospital closed in 2014

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The National Quality Forum's Serious Adverse Events in Healthcare

Surgical Events

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure on a patient
- Retention of a foreign object in a patient after surgery or other procedure
- Intraoperative or immediately post-operative death in a normal healthy patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologists patient safety initiative)
- Artificial insemination with the wrong donor sperm or donor egg

Product or Device Events

- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility
- Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility

Patient Protection Events

- Infant discharged to the wrong person
- Patient death or serious disability associated with patient elopement (disappearance) for more than four hours
- Patient suicide or attempted suicide resulting in serious disability, while being cared for in a health care facility

Environmental Events

- Patient death or serious disability associated with an electric shock while being cared for in a health care facility
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility
- Patient death associated with a fall while being cared for in a health care facility
- Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility

The National Quality Forum's Serious Adverse Events in Healthcare

Criminal Events

- Any instance of care ordered by, or provided by, someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
- Abduction of a patient of any age
- Sexual assault on a patient within or on the grounds of a health care facility
- Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care facility

Care Management Events

- Death or serious disability associated with a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products
- Maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a health care facility
- Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility
- Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates
- Stage 3 or 4 pressure ulcers acquired after admission to a health care facility
- Patient death or serious disability due to spinal manipulative therapy

Patient and Family Perspective: Apps, Checklists, and More!

Healthcare is complex. It can be overwhelming to keep track of everything you or your family need to ask your doctor. Then there's everything you need to get organized: what medications to start or stop taking, your ride home from the hospital, all of your appointments, and other crucial details that help make the days and weeks leading up to, during, and after surgery smoother and less stressful.

Better communication and shared decision-making between patients and doctors are two solutions that can help guide patients and families through surgery and prevent medical errors. Improving communication can also strengthen the relationship between doctors and patients. Research shows that patients who have a good relationship with their healthcare providers receive better care and are happier with their care.

Doctella™ helps patients be better partners in their own care with one simple tool: a checklist. Doctella was created by experts from Johns Hopkins with content provided by leading surgeons from around the world. Content is free for all patients. Check it out at http://www.doctella.com

The National Patient Safety Foundation (NPSF) partners with patients and their families, as well as other stakeholders to provide resources that can be used when visiting a doctor or other health care provider, or when admitted to the hospital for care. http://www.npsf.org/?page=patientsandfamilies

Checklists are a useful tool but care must be taken not to overemphasize their importance. Even when used appropriately, there are co-interventions that are necessary to maximize the checklists' impact. Successful implementation of a checklist requires extensive preparatory work to maximize safety culture in the unit where checklists are to be used, engage leadership in rolling out and emphasizing the importance of the checklist, and rigorously analyze data to assess use of the checklist and associated clinical outcomes. An emerging issue is whether adherence to evidence-based checklists should be elective: a *New England Journal of Medicine* editorial by two safety leaders recommended that providers be held accountable for failing to use such checklists. By standardizing the list of steps to be followed, and formalizing the expectation that every step will be followed for every patient, checklists have the potential to greatly reduce errors due to slips.

Member Resources

Agency for Healthcare Research and Quality
AHRQ is the Agency for Healthcare Research and Quality—the Nation's lead Federal agency for research on health care quality, costs, outcomes, and patient safety. www.ahrq.gov

Institute for Healthcare Improvement
An independent not-for-profit organization based in Cambridge, Massachusetts, IHI focuses on motivating and building the will for change; identifying and testing new models of care in partnership with both patients and health care professionals; and ensuring the broadest possible adoption of best practices and effective innovations. www.ihi.org

Institute for Safe Medication Practices
This nonprofit organization is devoted entirely to medication error prevention and safe medication use. Newsletters are available on the website. www.ismp.org/

Minnesota Time-Out
http://www.health.state.mn.us/patientsafety/ae/wsssummaryfs.pdf

National Patient Safety Foundation
The National Patient Safety Foundation's mission is to improve the safety of care provided to patients. www.npsf.org

Patient Safety & Quality Healthcare
This online journal publishes a variety of articles, which reflect work being done in the patient safety field.
www.psqh.com/

The Joint Commission
An independent, not-for-profit organization, The Joint Commission accredits and certifies more than 20,500 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. www.jointcommission.org

The National Quality Forum
A non-profit organization that operates to improve the quality of American healthcare by building consensus on goals for performance improvement, endorsing standards for measuring and reporting performance, and providing education and outreach. www.qualityforum.org

VA National Center for Patient Safety
The center was established in 1999 to develop and support a culture of safety throughout the Veterans Health Administration. Their goal is the nationwide reduction and prevention of inadvertent harm to patients as a result of their care. http://www.patientsafety.va.gov/

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