PSO Florida Overview

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Director PSO Florida

PSO Florida Goals

- Improve patient care
  - Medical errors often caused by system breakdowns

- Assist providers in pay-for-performance era
  - Payment changes make medical errors far more costly
  - Hospital associated conditions
  - Readmission rates and bundled payments
  - Quality studies and surgical care

Patient Safety and Quality Improvement Act

- Act passed in July 2005
- Final regulations: Published Nov. 21, 2008; effective Jan. 19, 2009
- ECRI Institute PSO federally certified 11/5/08; PSOF 2/25/09
- Agency for Healthcare Research and Quality (AHRQ), Office for Civil Rights (OCR)

Patient Safety and Quality Improvement Act

- **LEARN** from data aggregation, in-depth patient safety analytics and Advisories, statewide and national comparisons
- **SHARE** information about events so you can learn from them
  - facilitate learning about best practices from your peers
- **PROTECT** patients from harm through evidence-based solutions
  - Get legal protection and confidentiality for data submitted under PSO

Patient Safety Activities

PSO Florida Program and Benefits

- PSO Florida Web portal
- Patient safety data collection and reporting system
- Comparative Reports PSO Florida and ECRI PSO
- PSO Florida and National Navigators
- Publications: Deep Dives, Top Ten and Compass Point
- Webinars
- Custom Research Requests and posted responses
- RCA Feedback and Analysis

Event Types

- AHRQ 1.2 Common Formats
  - Blood or Blood Products
  - Device or Medical/Surgical Supply/HIT
  - Fall
  - Healthcare-Associated Infection (HAI)
  - Medication or Other Substance
  - Perinatal
  - Pressure Ulcer
  - Surgery VTE
  - Other: (Please specify)

- ECRI Enhancements
  - Emergency Services
  - Environment
  - Laboratory Test/Radiology
  - Security/Safety

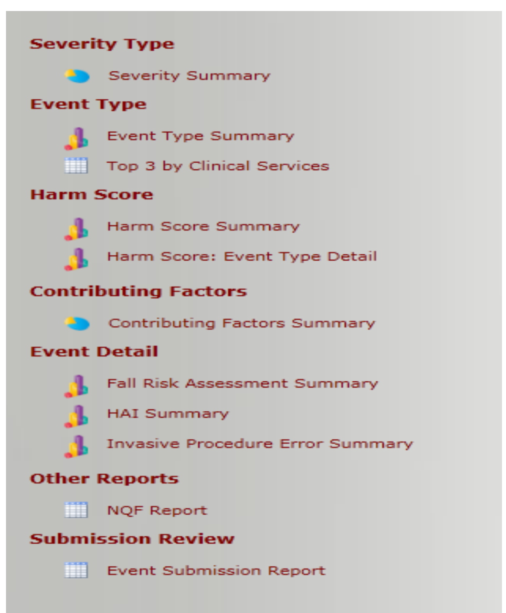
Sending Data to PSO Florida

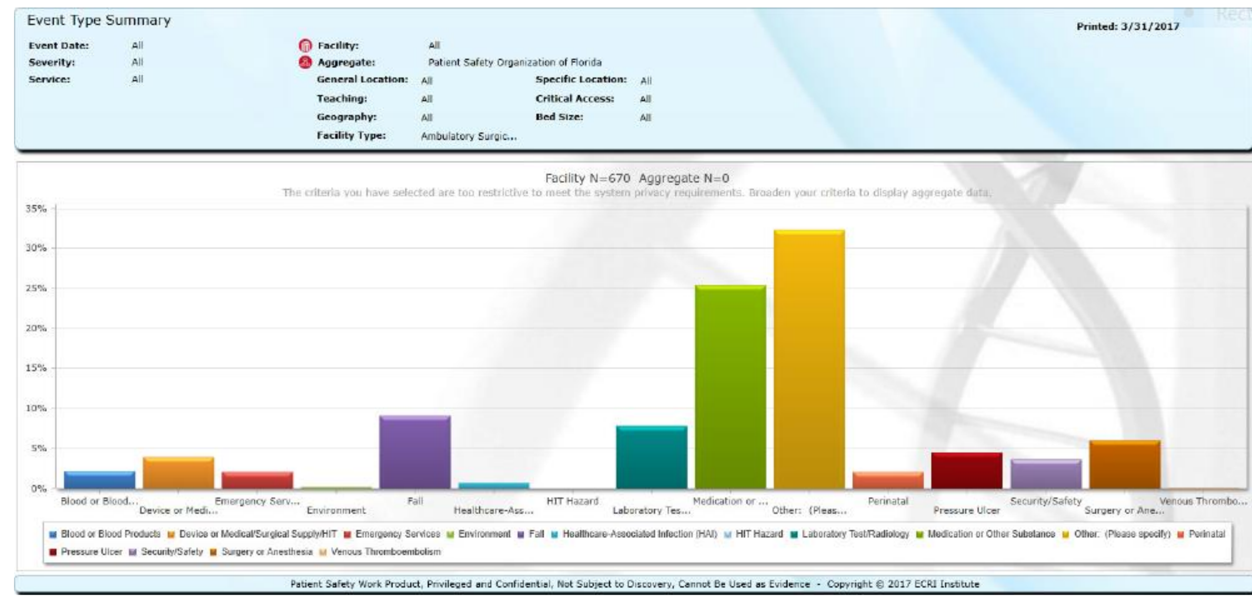
- Upload data from your hospitals event reporting system
- ECRI Institute has worked with reporting system vendors and has a mapping service
  - Omits the need to enter data manually
- Data submission will provide you with comparison to:
  - PSO Florida
  - ECRI PSO

PSO Florida Member Services

➢LEARN

- Aggregate and Facility-based Real-time Reports





PSES Pathway

- Toolkit to guide PSES definition, implementation and management
- Contains
  - How to get started
  - Key concepts, recommendations, questions
  - Template policies and forms
  - Moving from concept to action

Patient Safety Evaluation System (PSES) Pathway

This toolkit supports the definition, implementation and management of a patient safety evaluation system.

- PSES Pathway Overview

Forms that may be downloaded and customized:

- PSES Operational Plan Template
- PSES Organizational Survey Template
- PSES Component Inventory - Form A
- PSES Component Evaluation - Form B
- PSES Component Management Plan - Form C
- PSES Policies and Procedures Template

Resources: Webinars

WEBINARS AND USER GROUPS

Hear ECRI Institute experts and others discuss the latest risk management topics, from social media to drug shortages to integrating quality and risk management.

View Archived Webinars and User Groups >

View Upcoming Webinar Schedule and Registration >

Effective Physician Peer Review To Improve Patient Safety

This webinar will provide Patient Safety leaders with information about the evolving approaches to evaluating physician competency through peer review with the ultimate goal of improving patient safety.

Patient Identification: Building And Developing Safe Practices

This webinar will review the safe practice recommendations developed by the Health IT Partnership for the safe use of health IT for patient identification. The evidence based literature, implementation strategies and the Health IT Safe Practices Toolkit for the Safe Use of Health IT for Patient Identification will be shared for dissemination.

Resources: Custom Research Postings

CUSTOM RESEARCH RESPONSES

Access custom Research Responses compiled by ECRI Institute PSO patient safety analysts in response to queries from member organizations.

View Custom Research Responses >

Medical/Surgical Competencies For The Medical Psychiatric Unit Nurse

Medical/Surgical competencies for the Medical Psychiatric Unit nurse — Research Response literature search for standards and guidelines.

Managing Test Results In Outpatient Care

Timely follow- up on abnormal test results ordered in the outpatient setting continues to present a challenge to physician practices and hospital outpatient clinics. There are direct implications for patient safety overlooked, misread, misfiled, or simply missed test results can contribute to or result in delayed diagnosis and treatment, other adverse events, emergency department visits, or hospital readmissions. It is important therefore to adopt methods of care transition management to ensure high quality in the continuity of care.

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Custom Research Requests

- Level I Unlimited
  - Does the PSO have any resources on Retained Surgical Items?
- Level II- 6
  - What processes can be used for alternative site marking?
- Level III – 2
  - Multiple questions related to a topic and extensive literature search
  - Specific comparison of your data to the data in the data base

Resource: Deep Dives

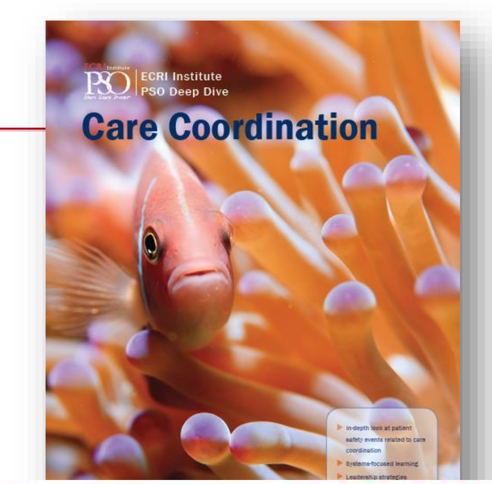
ECRI INSTITUTE PSO DEEP DIVE ARCHIVE

Access materials from past deep dives, including presentation slides, handouts, and other supplementary resources.

View ECRI Institute PSO Deep Dive Archive >

ECRI INSTITUTE PSO DEEP DIVE: MEDICATION SAFETY

ECRI INSTITUTE PSO DEEP DIVE: HEALTH INFORMATION TECHNOLOGY



ECRI INSTITUTE PSO DEEP DIVE: LABORATORY TESTING

- In-depth look at patient safety events in the laboratory testing process
- Systems-focused learning
- Leadership strategies
- Online resources

ECRI Institute PSO

Share Learn Protect®

Deep Dive Medication Safety

ECRI INSTITUTE PSO DEEP DIVE:
MEDICATION SAFETY—TOOLKIT

LEADERSHIP STRATEGIES				
	Safety Practice	Action Required	Assigned To	Deadline
Low Impact	Show leadership support for medication safety initiatives by providing the resources to support change and attending meetings to work on improvement initiatives.			
	Conduct patient safety walkarounds to learn about providers' and frontline staff's concerns about medication administration safety.			
	Provide resources and support for educational programs about medication safety for all staff involved in the medication-use process.			

Deep Dive Patient Identification

- [ECRI INSTITUTE PSO DEEP DIVE: PATIENT IDENTIFICATION—SELF ASSESSMENT QUESTIONNAIRE]
  - This section is excerpted from ECRI Institute PSO's Deep Dive Patient Identification. This self assessment can help you evaluate your organization's practices and target opportunities for improvement.

Policies and Procedures

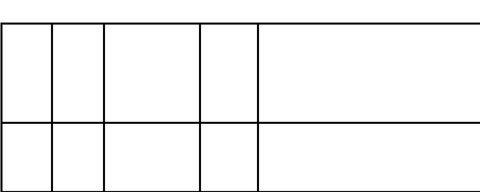
13. Does the organization periodically review its patient identification policies and procedures to ensure they are clear and reflect current practice?

14. Are patient identification policies and procedures applied to all phases of the patient's healthcare visit (i.e., intake, healthcare encounters, post-encounter)?

15. Does the organization's patient identification policy address all of the following:

    a. The use of at least two patient identifiers when patients are provided with care, treatment, or services?

    b. Acceptable (e.g., name, date of birth) and unacceptable (e.g., room number, bed location) identifiers for



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PSO NAVIGATOR ARCHIVE

View current and recent issues of *PSO Navigator*.

View PSO Navigator Archive >

National

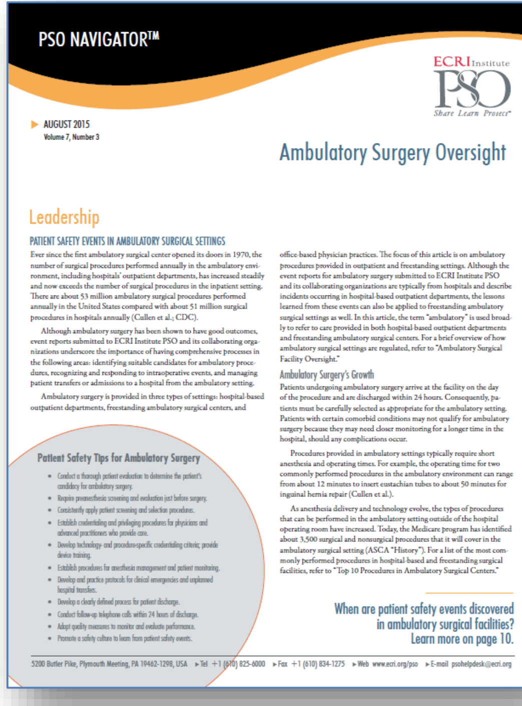
Misreads Of Imaging Studies Among Top Radiology Events

Event reports submitted to ECRI Institute PSO suggest that diagnostic errors in radiology are among the most frequently reported type of radiology incident. The errors, involving problems in reading or interpreting radiology studies, can have severe consequences for patients when they lead to mistakes in diagnosing a condition or in a patient's treatment. Strategies to prevent radiology misreads are discussed.

PSO Florida

When Seeing Clearly Doesn't Solve The Problem: Wrong-Site Imaging

Although inadvertent imaging of the wrong site is rare, it may have significant effects on the patient—largely ranging from delayed diagnosis to unnecessary additional exposure to radiation. Wrong-site imaging errors may be attributed to breakdowns in communication, reluctance to seek clarification from the ordering physician, and productivity pressures.



PSO NAVIGATOR™

ECRI Institute PSO Share Learn Protect

AUGUST 2015
Volume 7, Number 3

Ambulatory Surgery Oversight

Leadership

PATIENT SAFETY EVENTS IN AMBULATORY SURGICAL SETTINGS

Ever since the first ambulatory surgical center opened its doors in 1970, the number of surgical procedures performed annually in the ambulatory environment, including hospitals' outpatient departments, has increased steadily and now exceeds the number of surgical procedures in the inpatient setting. There are about 53 million ambulatory surgical procedures performed annually in the United States compared with about 51 million surgical procedures in hospitals annually (Cullen et al.; CDC).

Although ambulatory surgery has been shown to have good outcomes, event reports submitted to ECRI Institute PSO and its collaborating organizations underscore the importance of having comprehensive processes in the following areas: identifying suitable candidates for ambulatory procedures, recognizing and responding to intraoperative events, and managing patient transfers or admissions to a hospital from the ambulatory setting.

Ambulatory surgery is provided in three types of settings: hospital-based outpatient departments, freestanding ambulatory surgical centers, and office-based physician practices. The focus of this article is on ambulatory procedures provided in outpatient and freestanding settings. Although the event reports for ambulatory surgery submitted to ECRI Institute PSO and its collaborating organizations are typically from hospitals and describe incidents occurring in hospital-based outpatient departments, the lessons learned from these events can also be applied to freestanding ambulatory surgical settings as well. In this article, the term "ambulatory" is used broadly to refer to care provided in both hospital-based outpatient departments and freestanding ambulatory surgical centers. For a brief overview of how ambulatory surgical settings are regulated, refer to "Ambulatory Surgical Facility Oversight."

Ambulatory Surgery's Growth

Patients undergoing ambulatory surgery arrive at the facility on the day of the procedure and are discharged within 24 hours. Consequently, patients must be carefully selected as appropriate for the ambulatory setting. Patients with certain comorbid conditions may not qualify for ambulatory surgery because they may need closer monitoring for a longer time in the hospital, should any complications occur.

Procedures provided in ambulatory settings typically require short anesthesia and operating times. For example, the operating time for two commonly performed procedures in the ambulatory environment can range from about 12 minutes to insert eustachian tubes to about 50 minutes for inguinal hernia repair (Cullen et al.).

As anesthesia delivery and technology evolve, the types of procedures that can be performed in the ambulatory setting outside of the hospital operating room have increased. Today, the Medicare program has identified about 3,500 surgical and nonsurgical procedures that it will cover in the ambulatory surgical setting (ASCA "History"). For a list of the most commonly performed procedures in hospital-based and freestanding surgical facilities, refer to "Top 10 Procedures in Ambulatory Surgical Centers."

Patient Safety Tips for Ambulatory Surgery

- Conduct a thorough patient evaluation to determine the patient's candidacy for ambulatory surgery.
- Require preanesthesia screening and evaluation just before surgery.
- Consistently apply patient screening and selection procedures.
- Establish credentialing and privileging procedures for physicians and advanced practitioners who provide care.
- Develop technology- and procedure-specific credentialing criteria; provide device training.
- Establish procedures for anesthesia management and patient monitoring.
- Develop and practice protocols for clinical emergencies and unplanned hospital transfers.
- Develop a clearly defined process for patient discharge.
- Conduct follow-up telephone calls within 24 hours of discharge.
- Adopt quality measures to monitor and evaluate performance.
- Promote a safety culture to learn from patient safety events.

When are patient safety events discovered in ambulatory surgical facilities? Learn more on page 10.

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COMPASS POINTS AND E-LERTS

PSO Compass Points offer concise reviews of patient safety topics, featuring a discussion of contributing factors and recommendations from the PSO. See archives of Compass Points e-mails as well as past Patient Safety E-Lerts.

View Compass Points and E-lert Archive >

Making The Wrong Call: Diagnostic Errors

Diagnostic errors have the potential to cause serious harm or result in death. According to the National Academies of Medicine, diagnostic errors occur in 1 out of 10 diagnoses made and account for 40,000 to 80,000 deaths annually in the United States. These errors occur frequently but are not widely recognized and are underreported.

Releasing The Clamp: Omitted And Delayed Intravenous Infusions

When administering intravenous medications with the use of an electronic infusion device, a common error is a failure to open the clamp, resulting in a delay and/or omission of therapy. ECRI Institute PSO analyzed 330 events reported in 2015 and 2016 that were related to administering IV infusions using electronic infusion devices. The data demonstrated that the majority of the events were related to scheduled medication doses being delayed or omitted because a clamp on intravenous tubing was not opened after setting the infusion pump.

Operating Room Medication Safety Practices: Don't Skip Safety

Welcome to ECRI Institute PSO Compass Points, incisive reviews of patient safety topics. We welcome your comments; please send them to psohelpdesk@ecri.org.

During anesthesia time-out, I mentioned cefoxitin 2 gm as pre-op antibiotics. After skin prep, anesthesia approached me to verify the pre-op antibiotic for Surgical Care Improvement Project (SCIP) measures. It was discovered that ceftriaxone 2 gm was administered instead of cefoxitin 2 gm.

Member Resources

- ECRI Institute PSO Deep Dive: Medication Safety

Situation

In the fast-paced setting of the operating room (OR), use of standard safety checks is often lacking because of the perceived time pressures of the OR. Checks include order review, pharmacy approval of specific drugs before administration, and verification at the time of administration.

Background

ECRI Institute Patient Safety Organization (PSO) received and reviewed 101 events during 2015 that involved medication errors in the OR. These events revealed the following:

- 41% involved errors in antibiotic administration.
- 36% were the administration of the wrong antibiotic.
- 18% were an antibiotic administered to a patient with a known allergy.
- Mislabeling did not play a significant role; it was noted in only a single case.

Assessment

Medication safeguards that are applicable to the unique setting of the OR should be implemented.

Recommendations

ECRI Institute PSO recommends the following:

Resource: Patient Safety Tools

PATIENT SAFETY TOOLS

These tools can be used to manage risks and improve patient safety.

View Patient Safety Tools >

Top 10 Patient Safety Concerns for Healthcare Organizations

To help guide organizations in deciding where to focus their patient safety efforts, ECRI Institute has developed a list of the top 10 patient safety concerns confronting healthcare organizations.

- Top 10 Patient Safety Concerns for Healthcare Organizations 2016
- Top 10 Patient Safety Concerns for Healthcare Organizations 2015

Top 10 Hospital C-Suite Watch List for 2016

Find out which technology-related issues you should keep an eye on this year:

- ECRI Institute's 2016 Top 10 Hospital C-Suite Watch List

Top 10 Health Technology Hazards Tools

- Top 10 Health Technology Hazards for 2017
- Top 10 Health Technology Hazards for 2017: Solutions Kit
- Top 10 Health Technology Hazards for 2016
- Top 10 Health Technology Hazards for 2015
- Top 10 Health Technology Hazards for 2014
- Webinar: Top 10 Health Technology Hazards for 2014

Top 10 Patient Safety Concerns for Healthcare Organizations 2017

ECRI Institute
The Discipline of Science. The Integrity of Independence.

ECRI Institute's Top 10 Patient Safety Concerns for 2017

1. Information management in EHRs
2. Unrecognized patient deterioration
3. Implementation and use of clinical decision support
4. Test result reporting and follow-up
5. Antimicrobial stewardship
6. Patient identification
7. Opioid administration and monitoring in acute care
8. Behavioral health issues in non-behavioral-health settings
9. Management of new oral anticoagulants
10. Inadequate organization systems or processes to improve safety and quality

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RCA Analysis and Feedback

6

- Evaluate RCAs
- Process Summary
  - How thoroughly did you evaluate the event?
- Comprehensive Summary
  - Detailed analysis of the RCA process including opportunities for improvement
- Root Cause Identification
  - Were the key root causes identified?
- Scoring of RCA Recommendations
  - How effective and sustainable are the action recommendations?
- Evaluation of Methodology
  - Advantages and disadvantages and limitations of RCA approach (e.g. Joint Commission method)

RCA Analysis and Feedback

Example: How thoroughly did you evaluate the event?

Measure	Your RCA	Maximum* Points	Your Percentage
Immediate response	0	2	0%
Investigation	2	4	50%
RCA response	3	3	100%
Incident basics	1	3	33%
Incident description	2	9	22%
Identification of the event	3	8	38%
Identification of proximate causes/causal factors (performance gaps at the sharp end of the process)	5	11	45%
Identification of intermediate and root causes (performance gaps at the blunt end of the process)	6	13	46%
Investigation techniques	2	8	25%
Review of related incidents and investigations	0	5	0%
Barrier/safeguard assessment	3	7	43%
Extent of condition/cause	3	12	25%
Total	**30**	**85**	**35%**

***Maximum Points possible are calculated based on the items submitted.**

Patient Membership Safety Update

PATIENT SAFETY MEMBERSHIP UPDATE ARCHIVE

Twice-monthly membership news on patient safety, quality improvement, and more.

Mar 10, 2017

How A Children's Hospital Increased The Frequency Of Discharge Communication With Primary Care Providers

An academic children's hospital met and sustained its goal of attempting spoken discharge communication with the PCPs of 80% of patients within seven days of discharge in pediatric medical services.

Mar 10, 2017

What Happens When Patients With Cardiac Devices Unapproved For MRI Scanning Undergo MRI?

In a study involving MRI of patients with implanted pacemakers or ICDs not approved by the FDA for MRI scanning, no patients who underwent protocol-driven screening and device programming before MRI experienced device or lead failure.

Mar 10, 2017

Smoke In The Operating Room: A Persistent Problem

Lack of ventilation during electrosurgery and laser surgery is putting healthcare workers at risk for serious health problems.