Vizient PSO MHA Members
Quarterly Report

June 13, 2017

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Introduction to PSO

The Vizient Patient Safety Organization (PSO) has over 230 participating members. More than 100 members participate through the Missouri Hospital Association. We know reporting to a PSO helps to improve patient safety, healthcare quality and outcomes and accelerate the pace of improvement across organizations. Here's why. The Patient Safety Act makes Patient Safety Work Product (PSWP) privileged and confidential. The Patient Safety Act and the Patient Safety Rule generally bar the use of PSWP in criminal, civil, administrative, or disciplinary proceedings except where specifically permitted. Strong privacy and confidentiality protections are intended to encourage greater participation by providers in the deep examination of patient safety events. By establishing strong protections, providers may engage in more detailed discussions about the causes of adverse events without the fear of liability from information and analyses generated from those discussions. Vizient PSO shares these learnings to help members prevent similar events in their organization. Greater participation by health care providers will ultimately result in identification of more opportunities to address the causes of adverse events, and improve patient safety.

The Patient Safety Act allows flexible participation models with PSOs. In a similar fashion, the Vizient PSO works with our members to engage in ways to best help them improve patient safety, healthcare quality and outcomes.

Each member has the opportunity to receive an annual feedback report or a quarterly feedback call based on the type of data submitted. The Vizient PSO will provide a feedback report to all organizations who report in the specified common format. Common format reporting allows Vizient PSO to provide meaningful comparative data. Organizations that are unable to report data to the PSO in the specified format, may submit a quarterly report to Vizient that will help the provider and Vizient examine their performance and offer leading practice recommendations.

Coming July 1, 2017

In July 2017, members will also be able to report root cause analysis, Failure Modes and Effects Analysis (FMEA) and other safety process improvement data with the PSO through the Secure File Transfer Protocol (SFTP). The PSO team will review the additional reports and incorporate recommendations related to these reports into the quarterly, annual feedback meetings and aggregate learnings. To take advantage of these new opportunities, please contact Jessica Schoenthal.

Overview of PSO Data in this report

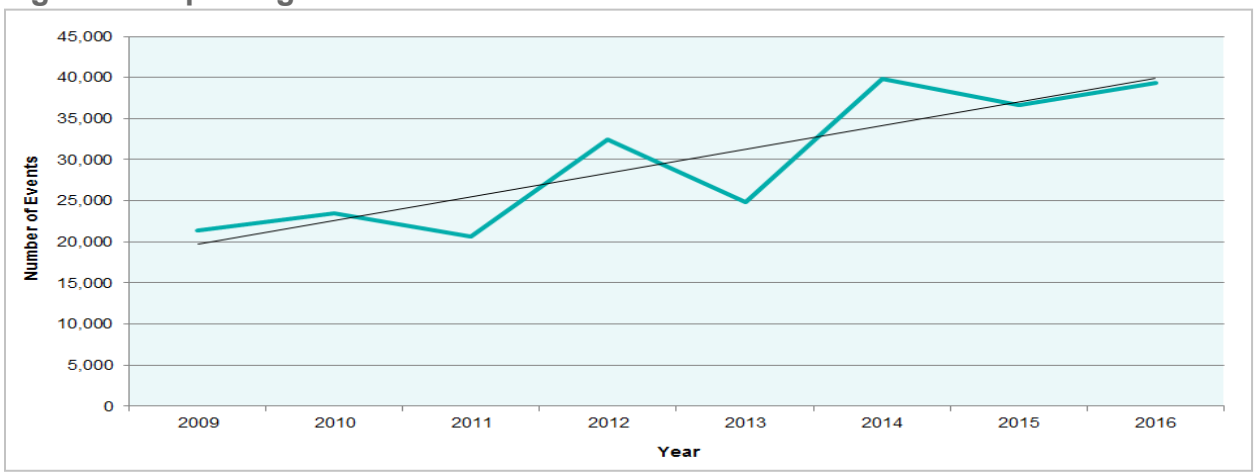
The data in this report is aggregated from PSO members across the nation who submit information using the AHRQ Common Format. Highlighted below are details of reporting trends by event types, event categories, harmful event types, and all events by extent of harm. Use of a standardized format across members facilitates analysis and identification of common safety issues at individual organizations and across members. Comprehensive analysis of the narrative descriptions in these specific categories uncovers common themes and contributing factors. Analyzing near miss and no harm events promotes a proactive approach to mitigating harm to patients. The PSO uses this data as a compass to guide safety projects and highlight common issues across organizations. This year Vizient PSO has focused on safety

in high risk areas in medication safety, fall prevention, and care coordination and seeks expert guidance to understand the safety issues and identify leading practices for PSO members.

Reporting Trend to PSO

As of February 2017, there has been a consistent increase of voluntarily reported events to the Vizient PSO. **Figure 1** displays the trend in the number of reports in the PSO data base by year from 2009 to February 2017. Growth in membership and reporting to the PSO speeds our learnings and improves our ability to provide comparison data to our members.

Figure 1. Reporting Trend

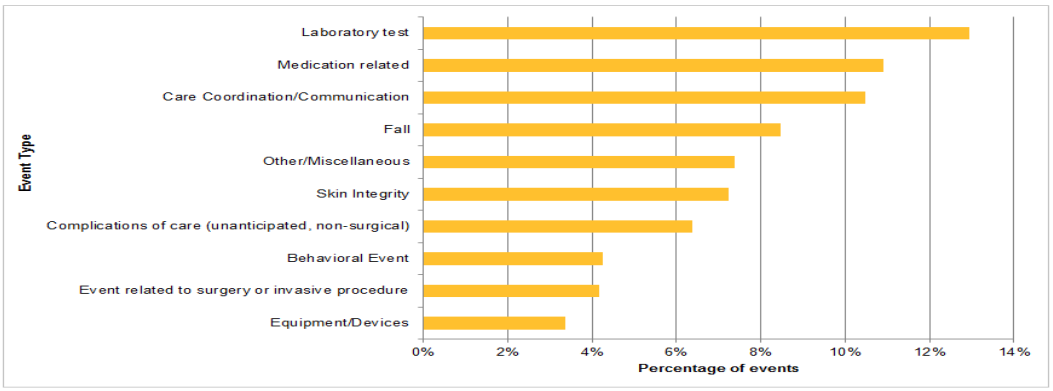


Event Reporting Trend from 2009 through 2016;

Event Type

In order to provide the most current trends in safety event data, the remainder of the data in this report represents events submitted from January 2014 through February 2017, 168,080 total events. For events these events, the most commonly reported event types are shown below in **Figure 2**. The top five event types were laboratory, medication related, care coordination/communication, patient falls, and "other miscellaneous."

Figure 2. Most Common Patient Event Types and Unsafe Conditions (2014- February 2017)

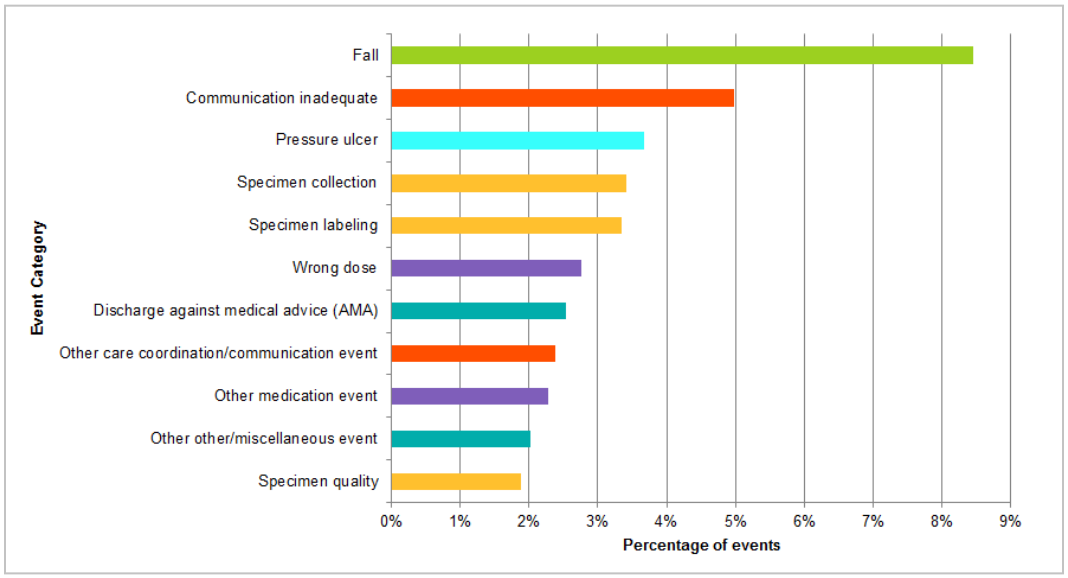


Total event reports from January 2014-February 2017 =168,080

Event Category

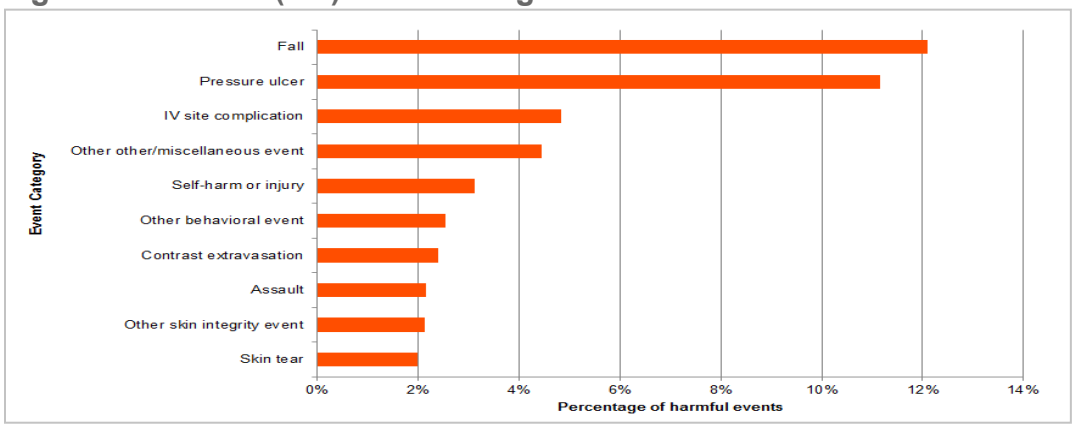
The event category is the second level of the taxonomy and provides greater specificity for each event type.. Within the event types, there are event categories. This provides a deeper level of analysis. The event categories that were more commonly reported to the PSO were patient falls, inadequate communication, pressure ulcers and specimen collection/labeling and medication safety (**Figure 3**) from 2014 through February 2017. **Figure 4** displays event categories with harm (6-9) for the same time period. Falls with harm represented approximately 12% of events categories with harm and pressure ulcers account for over 10% of event categories with harm.

Figure 3. Event Categories and Unsafe Conditions



Total event reports from January 2014-February 2017 =168,080

Figure 4. Harmful (6-9) Event Categories

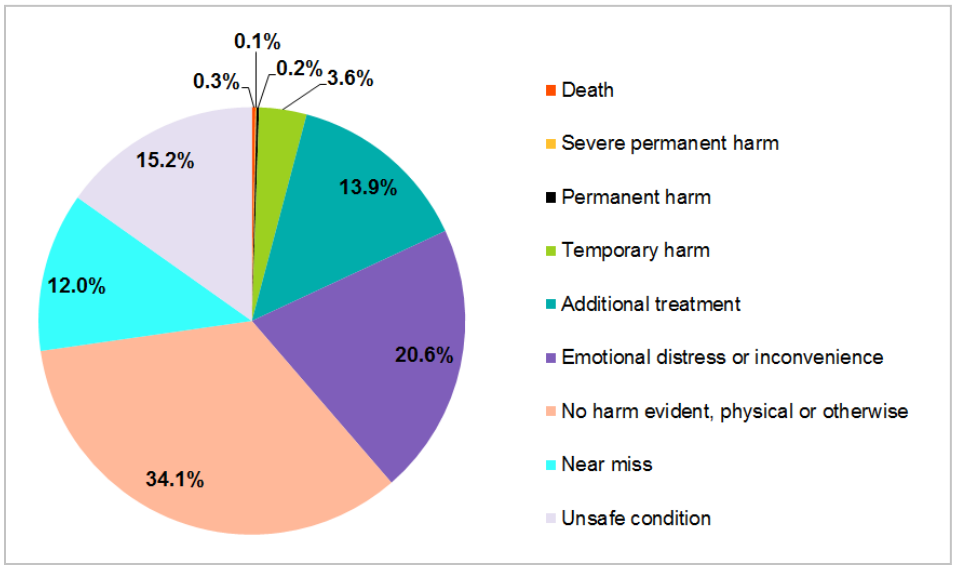


Total event reports from January 2014-February 2017 =168,080; Harm Score 6-9

Events by extent of harm

Figure 5 displays the extent of harm for events reported to the PSO from January 2014 through February 2017. There was no harm evident, physical or otherwise for 34% of events reported and 12% of reported events were considered near miss events. Greater than 50% of all reported events were indicated to have caused emotional distress or inconvenience to patient death.

Figure 5. Events by level harm



Total event reports from January 2014-February 2017 =168,080; Harm Score 6-9

Results of PSO Data Analysis

The safety events submitted to the PSO is used as a compass to identify opportunities for our members to improve patient safety, healthcare quality and accelerate the pace of improvement across the nation. As a result of this data, in 2017, Vizient PSO is collaborating with clinical and safety experts to bring practical and leading practice solutions to our members on ways to sustain a patient centered fall prevention program and ways to improve medication safety and care management for patients taking Direct Oral Anticoagulants, improving care coordination and safe use of electronic communication among the healthcare team.

Reducing Falls with Injury

Vizient PSO data suggests and our expert team agrees that the biggest opportunity for improvement is related to preventing unassisted falls with injuries. Unassisted falls accounted for nearly 80 % of total falls and resulted in some type of harm. The top contributing factors for unassisted falls with injuries were that the patient did not call for help and/or abnormalities of gait or balance and/or altered elimination. Not surprisingly, at the time of the fall, patients were most commonly ambulating **without** assistance and/or without assistive device/medical equipment, or, were performing toileting related activities. While there are many evidenced based practices that have been successful at reducing the rate of patient falls with injury, many organizations have express that maintaining improvements can be a challenge. Our goal is

to partner with our members and experts in fall prevention to identify ways to successfully sustain results. It is conceivable that lessons learned regarding sustaining results could be spread to other projects.

The expert advisory committee is currently creating solutions for our PSO members to assist in **sustaining a patient centered fall prevention program**. Until those solutions are ready, consider including the following in the fall prevention program at your organization:

- Universal fall precautions, including scheduled rounding protocols (AHRQ Tool Kit section 3.2).
- Standardized assessment of fall risk factors (Universal fall precautions, including scheduled rounding protocols (AHRQ Tool Kit section 3.3).
- Care planning and interventions that address the identified risk factors within the overall care plan for the patient (Universal fall precautions, including scheduled rounding protocols (AHRQ Tool Kit section 3.4).
- Post-fall procedures, including a clinical review and root cause analysis (Universal fall precautions, including scheduled rounding protocols (AHRQ Tool Kit section 3.5) and reporting event reports and RCAs conducted related to falls to a PSO.
- Patient and caregiver participation and agreement in the creation of an individualized fall prevention plan with patient teach back at each bedside shift report. This includes visual cues and reminders in the patient room of individualized fall prevention plan for both the patient and healthcare team.

If you have a success story related to reducing falls related to injuries and or sustaining results, please contact Jessica Schoenthal.

Direct Oral Anticoagulants

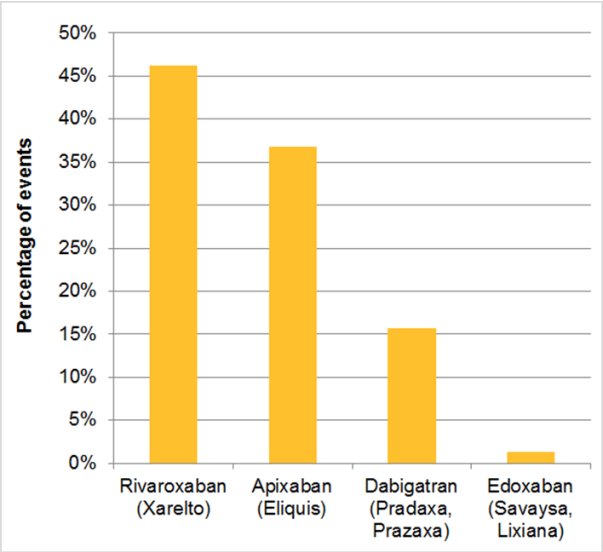
When asked, "*What medication safety events keep you up at night*," experts in medication safety all voiced their concern about the use of Direct Oral Anticoagulants such as dabigatran, apixaban, and rivaroxaban. Patient safety events related to newer direct oral anticoagulants across the care continuum have become more apparent in reported events to the Vizient PSO (**Figure 6**) and also documented in an ISMP study on behalf of the FDA (ISMP Quarterly Watch, 2016). Nearly 150 voluntarily reported events to the PSO highlight gaps in accurate dosing, provider knowledge gaps, coordinating anticoagulation therapy during transitions in level care, and opportunities to actively engage patients and staff in importance of safe medication practices specific to the direct oral anticoagulants (**Figure 7**).

Through data analysis, literature review, safe table sharing and aggregation of leading practices across the county, the Expert Medication Safety Expert Advisory Team is partnering with Vizient PSO to create a series of safety alerts specific to safe practices in inpatient and outpatient settings, when initiating DOAC therapy, addressing key elements during admission, discharge, peri-procedural management and ambulatory care considerations.

Some early steps that organizations can take related to the DOACs are to assess the following:

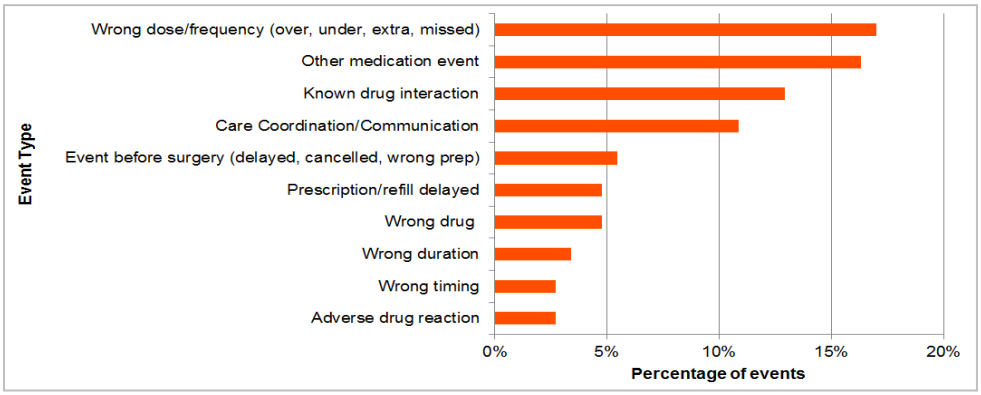
- Consider placing DOACs on your high alert medication list and ensure your organization takes special precautions for high alert drugs.
- Review events in your organization related to DOACs and identify specific measures that you can take to make it safer to use these high alert drugs.
- Share lessons learned from DOAC events at your organization with front line nursing, pharmacy and providers to raise risk awareness related to the DOAC.
- Please review the first in a series of DOAC safety alerts, which is attached.

Figure 6. Data DOAC related Safety Events



Vizient PSO data January 2014- December 2016, total number of events = 147

Figure 7. Event Type/Category of DOAC Reviewed Events



Vizient PSO data January 2014- December 2016, total number of events = 147

Safety Huddle Pilot

Vizient PSO recently held a topical webinar on safety huddles. One key take away was that safety huddles teach employees that if they identify opportunities, and leadership assigns responsibility to those with the capability to solve the issue, real time improvement in patient care can occur. Vizient PSO is now taking lessons learned from the Children's PSO and implementing a pilot of twice monthly safety huddles. We are leveraging concepts of a daily safety huddle and teaching organizations how to share opportunities and collaborate across organizations to develop, implement and refine leading practices with the hope of reducing patient harm, thereby accelerating the pace of improvement across our membership.

We are looking for additional members to participate in the safety huddle. If you are interested working with our pilot team or need help with internal safety huddles, please contact Jessica Schoenthal.

ISMP Self-Assessment: Coming Soon!

Vizient PSO is partnering with ISMP to offer Vizient PSO members the opportunity to participate in the new ISMP High Risk Medication Self-Assessment tool that is being released soon. This will allow organizations to complete a risk assessment related to ISMP's identified high risk medications, including anticoagulants, allowing organizations to identify areas to focus improvement efforts. The self-risk assessment will be available for members to complete a reevaluation after improvement efforts have been implemented to measure success and determine next steps for improvement efforts.

Upcoming Events

Please see our updated calendar of events in the appendix with embedded links to register for the webinars. All webinars begin at 1p.m. CST unless otherwise stated. Visit our webpage to access recordings of PSO Officer Training Webinars and PSO Safety Topic Webinars. www.Vizientinc.com.

In Person events in Missouri!

July 13, 2017- Making Sense of the PSO Privilege-Post HHS Guidance in Columbia, MO
Jane Drummond will discuss Missouri state law peer protections, Missouri mandatory state reporting and other external record keeping obligations. Ellen Flynn will discuss HHS Guidance regarding PSWP and Providers External Obligations and what are the benefits of working with a PSO.

September 26, 2017- Excellence in Clinical Care Series- Patient Safety Day Lake Ozark, MO
The day will begin with case law updates by Wes Butler Esq, a presentation on how organizations have successfully sustained Falls Reduction program success, and PSO project updates. Please come prepared to discuss your 2018 safety priorities and ideas for how we can help you advance your efforts. The day will close with an in person PSO Safe Table to discuss challenges and successes of reliable communication among the healthcare team in a complex electronic environment. Pre-conference homework will be sent to all attendees so that everyone comes prepared for a robust discussion. We will start by identifying improvement opportunities.

We would like to ensure you are taking full advantage of your PSO membership. In the appendix, please find the PSO Calendar of events for MHA members. Continued education credits are offered for all topical webinars and PSO officer education. *Please share the calendar with your staff and encourage them to attend Vizient PSO webinars.*

Please email Jessica Schoenthal with ideas for future webinar topics or resources needed to impact patient safety, healthcare quality or outcomes in your organization.

Resources

2017 ACC Expert Consensus Decision Pathway for Periprocedural Management of Anticoagulation in Patients with Nonvalvular Atrial Fibrillation available at http://www.onlinejacc.org/content/early/2017/01/05/j.jacc.2016.11.024

AHRQ Patient Safety Tools and Resources
https://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/index.html

AHRQ Preventing Falls in Hospitals; A Toolkit for Improving Quality of Care. (2013)https://www.ahrq.gov/sites/default/files/publications/files/fallpxtoolkit.pdf

California Hospital Association; Workplace Violence Prevention. http://www.calhospital.org/workplace-violence-prevention

Guidance for the practical management of the direct oral anticoagulants (DOACs) in VTE treatment available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4715848/

The ISMP anticoagulation self-assessment is now live at
http://www.ismp.org/selfassessments/Antithrombotic/2017/Default.aspx

ISMP Quarterly Watch: Perspectives from new adverse event reports available at
http://www.ismp.org/QuarterWatch/pdfs/2016Q2.pdf

Management of Patients on Non–Vitamin K Antagonist Oral Anticoagulants in the Acute Care and Periprocedural Setting: A Scientific Statement from the American Heart Association available at
http://circ.ahajournals.org/content/early/2017/02/06/CIR.0000000000000477

Miake-Lye, I.M., Hempel, S., Ganz, D.A., Shekelle, P.G. Inpatient Fall Prevention Programs as a Patient Safety Strategy: A systemic review." Annals of Internal Medicine 158.5 (2013) 390-97.

Project BOOST® Implementation Toolkit:
http://www.hospitalmedicine.org/Web/Quality___Innovation/Implementation_Toolkit/Boost/Clinical_Tools/Toolkits.aspx

[i]Trombetti, A., Hars, M., Herrmann, F., Rizzoli, R., and Ferrari, S. "Effect of a multifactorial fall-and-fracture risk assessment and management program on gait and balance performances and disability in hospitalized older adults: a controlled study." *Osteoporos Int.* 24 (2013) 867-76.

Washington State Department of Labor and Industries; Workplace Violence Prevention in Healthcare Settings
http://www.lni.wa.gov/Safety/Topics/AtoZ/WPV/wpvhealthcare.asp

Appendix

Expert Medication Safety Team:

- Elena Meeker, Medication Safety Pharmacist, University of Washington
- Timothy Lesar, Director of Clinical Pharmacy Services, Patient care Services Director, Albany Medical Center
- Michelle Then, Pharmacy Manager, Medication Safety, Quality & Regulatory, Pharm D, MBA, Denver Health
- Melissa W. King, Medication Safety Manager, BS Pharm, Duke Hospital
- Adeline Saliba, Pharm D, MBA, CPPS, CPHQ, Continuous Quality Improvement Lead, Seha Emirates Hospital
- Rachel Hensley, Pharm D, MBA, Director of Pharmacy, SSM Health
- Christi Quarles Smith, Pharm D, Assistant director of Pharmacy for medication safety, University of Arkansas
- Vanessa B. Bibbs, Accreditation Nurse Specialist, BSN, Vidant Health
- Cheryl Edwards, BS Pharm, Pharm D, MBA, Medication Safety Manager, PHD, MBA, Parkland Health and Hospital
- Luba Burman, Pharm D, BCPS, CDE, Rush University
- Steven B. Meisel, PharmD., CPPS, Director of Patient Safety, Fairview Health Services
- Joe Melucci, MBA, RPH, Medication Safety Officer, the Ohio State University Wexner Medical Center
- Ketan Patell, Pharm D, DHS-Pharmacy Affairs, LA County
- Scott Murray PharmD, Senior Pharmacist, Medication Safety and Pharmacy Transitions Coordinator, Emergency Department Pharmacy Manager, Upstate University Hospital
- Tejaswini More Dhawale, M.D. Assistant Professor, Division of Hematology Scholar, Center for Scholarship in Patient Care Quality and Safety; Attending Physician, Platinum/Immunotherapy Service. UWMC, Seattle, WA.
- John W. Cromwell,M.D., FACS, FASCRS Associate Chief Medical Officer, Director of Surgical Quality and Safety University of Iowa Hospitals & Clinics; Director, Division of Gastrointestinal, Minimally Invasive, and Bariatric Surgery Clinical Professor, University of Iowa Carver College of Medicine; Faculty, Interdisciplinary Graduate College
- Robert M. Dean, MD Vizient Inc.
- Robert Sikorski, MD, Assistant Professor, The John Hopkins School of Medicine, Medical Director of Trauma Anesthesiology, Department of Anesthesiology and Critical Care Medicine, The Johns Hopkins Hospital.

- Jim Lichauer, Pharm.D., BCPS, FASHP Project Manager, PI Collaborative & Advisory – Pharmacy
- Syeda Wasima, PSO Intern,Vizient PSO PharmD/MPH Student Candidate School
- Tammy Williams RN, MSN, CPPS, Collaborative Advisor, Vizient PSO
- Jessica Schoenthal, RN, MSN, CPPS, Collaborative Advisor, Vizient PSO
- Ellen Flynn, RN, MBA, JD, CPPS, AVP Safety Program

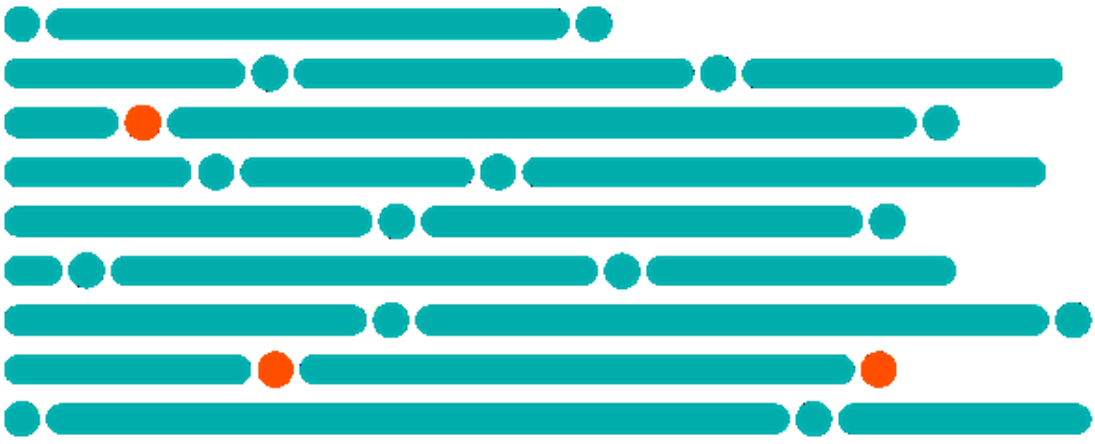
Expert Fall Prevention Team:

- Dorri Bierley, RN, MSN, CNRN Nursing Professional Development Specialist, UAB Hospital
- Eileen Costantinou, MSN RN-BC, Practice Specialist, Senior Coordinator, Barnes-
- Jewish Hospital
- Megan Duckworth, BA, Research Assistant, The Center for Patient Safety research and Practice, Brigham & Women's Hospital.
- Patricia C. Dykes PhD, RN, FAAN, FACMI, Sr. Nurse Scientist, Program Director, Center for Patient Safety Research and Practice Program Director, Center for Nursing Excellence, Brigham & Women's Hospital
- Ellen Flynn, RN, MBA, JD, CPPS, Associate VP, Safety Programs, Vizient Inc.
- Donna Guillaume PHD, RN, Regulatory and Public Reporting Project Manager, UMASS Memorial Medical Center
- Kristine Harper, MSN, Manager Safe Patient Handling Program, Medical University of South Carolina
- Amy L. Hester, PhD, RN, BC, Director of Nursing Research and Innovation, UAMS Medical Center
- Patricia Lavin, Director of Quality and Outcome, NYU Hospital
- Adam Meier BSN, MSN, Nurse Manager, University of Kansas Hospital
- Jessica Schoenthal, RN, MSN, CPPS, Collaborative Advisor, Vizient Inc.
- Linda Stevens, DNP, RC-BC, CPHQ, CSPHP, Director Nursing Quality and Safety, UW Health
- Eric Weiskoph, Continuing Education with focus upon ergonomics, Mercy Springfield within MHM Support division
- Tammy Williams, RN, MSN, CPPS, Collaborative Advisor, Vizient Inc.
- Lauri Wolf, PhD in Human Factors Engineering and Ergonomics, Barnes-Jewish Hospital

If you are interested in joining as an expert advisor in Medication Safety, Fall Prevention, or Care Coordination please contact Jessica Schoenthal.

2017 VIZIENT PSO CALENDAR

Month	PSO Officer Training*	Safe Tables	PSO Operations	Safety Web Conference*
June		JUNE 28: Care Coordination	JUNE 6: PSO Orientation JUNE 21: PSO User Group	
July	JULY 18: Teamwork and Deference to Experts		JULY 13: Making Sense of the PSO Privilege-Post HHS Guidance (Columbia, MO)	JULY 27: Patient Engagement and Activation
August	AUGUST 17: Identifying and preventing "Unacceptable Harm"		AUGUST 8: PSO Orientation	
September		SEPTEMBER 26: Electronic Communication *(Excellence in Clinical Care Series, Lake Ozark, MO)*	SEPTEMBER 26: PSO User Group Meeting *(Excellence in Clinical Care Series, Lake Ozark, MO)*	
October	OCTOBER 19: Crew Resource Management		OCTOBER 3: Documenting PSES	OCTOBER 25: Opioid Safety
November			NOVEMBER 7: PSO Orientation	NOVEMBER 30: Preventing Diagnostic Errors
December	DECEMBER 8: Incorporating Three Defense Evaluations Into Improvement Process		DECEMBER 19: PSO User Group	DECEMBER 12: Safeguarding Precious Specimens



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