

2014

Achieving the Next Level in Patient Safety

Geri Schimmel

Baptist Health South Florida, geris@baptisthealth.net

Yvonne Zawodny

Baptist Health South Florida, YvonneZ@batisthealth.net

Gina Vogt

Baptist Health South Florida, GinaVo@baptisthealth.net

Follow this and additional works at: <https://scholarlycommons.baptisthealth.net/se-all-publications>



Part of the [Nursing Commons](#)

Citation

Schimmel, Geri; Zawodny, Yvonne; and Vogt, Gina, "Achieving the Next Level in Patient Safety" (2014). *All Publications*. 582.
<https://scholarlycommons.baptisthealth.net/se-all-publications/582>

This Conference Poster -- Open Access is brought to you for free and open access by Scholarly Commons @ Baptist Health South Florida. It has been accepted for inclusion in All Publications by an authorized administrator of Scholarly Commons @ Baptist Health South Florida. For more information, please contact Carrie@baptisthealth.net.

Presented by:
 Geri Schimmel, RN, MS, LHRM, CPPS
 Yvonne Zawodny, RN, LHRM, CPHRM
 Gina Vogt, RN, MS, CPPS



Achieving the Next Level in Patient Safety

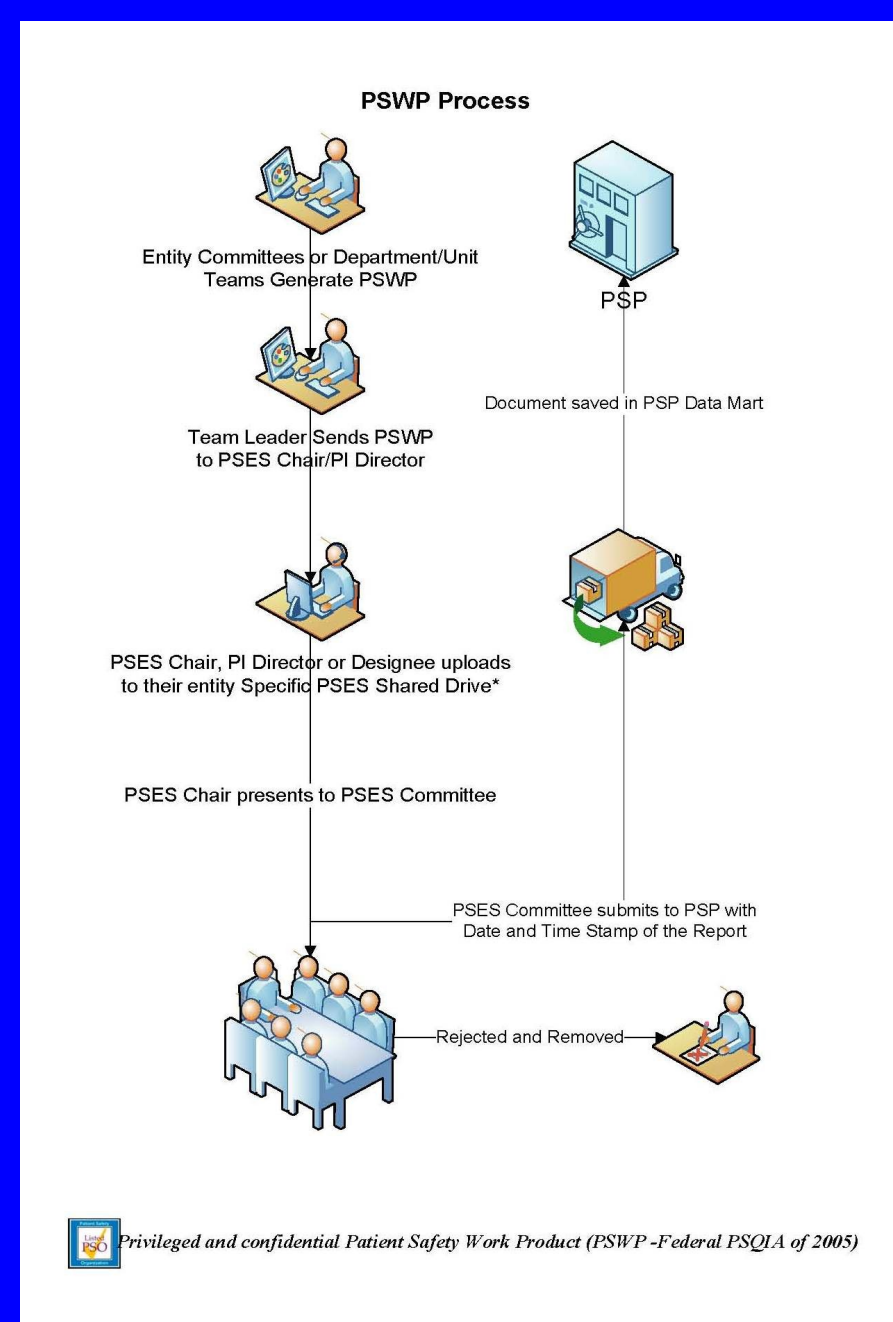
...building a component Patient Safety Organization (PSO)

BHSF established a component PSO named Baptist Health Patient Safety Partnership (PSP). Certified in 2010 by AHRQ, the PSP entered into contracts with BHSF hospitals and outpatient facilities (each individually the "Provider" or collectively the "Providers") to receive and review patient safety information which is defined in the PSQIA as patient safety work product ("PSWP"). The information that is collected or developed for the purpose of reporting to a PSO, and that has actually been reported by a Provider to the PSO, has enjoyed the privilege and confidentiality protections of the Act. The PSP offers its consultative expertise to the Providers (facilities) regarding patient safety events and quality improvement initiatives.

The Baptist Health PSP has been able to identify issues in a proactive manner from the information housed in the PSP data mart. In some cases, accelerated change teams were formed to address the issues, while others resulted in policy change. Best practices have been harmonized across the health system to ensure that BHSF provides the highest quality care to our patients and their families.

Privileged and confidential Patient Safety Work Product (PSWP - Federal PSQIA of 2005)

Background:
 Patient Safety Organizations (PSOs) are designed to help clinicians, hospitals and healthcare organizations improve the care they deliver to patients by encouraging them to conduct quality and safety analyses. Through federal protections of legal privilege and confidentiality, authorized by the Patient Safety and Quality Improvement Act (PSQIA) of 2005, PSOs foster a culture of safety and create a secure environment where providers can collect and analyze data to identify and reduce the risks and hazards associated with patient care. PSOs also are designed to aggregate data across multiple healthcare providers. This helps identify issues quickly and allow improved early warning and communication about ways of reducing risk and improving patient safety.

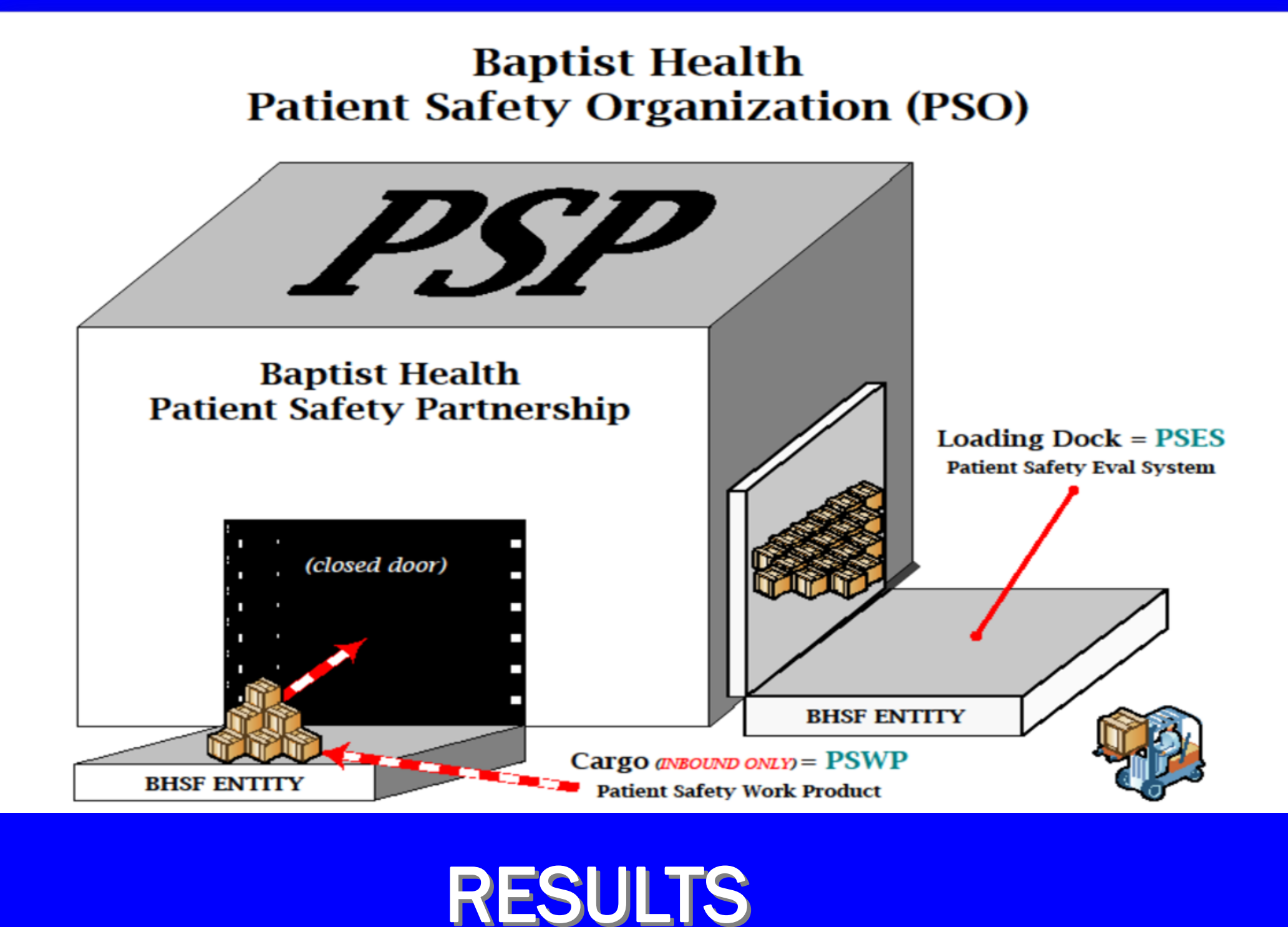
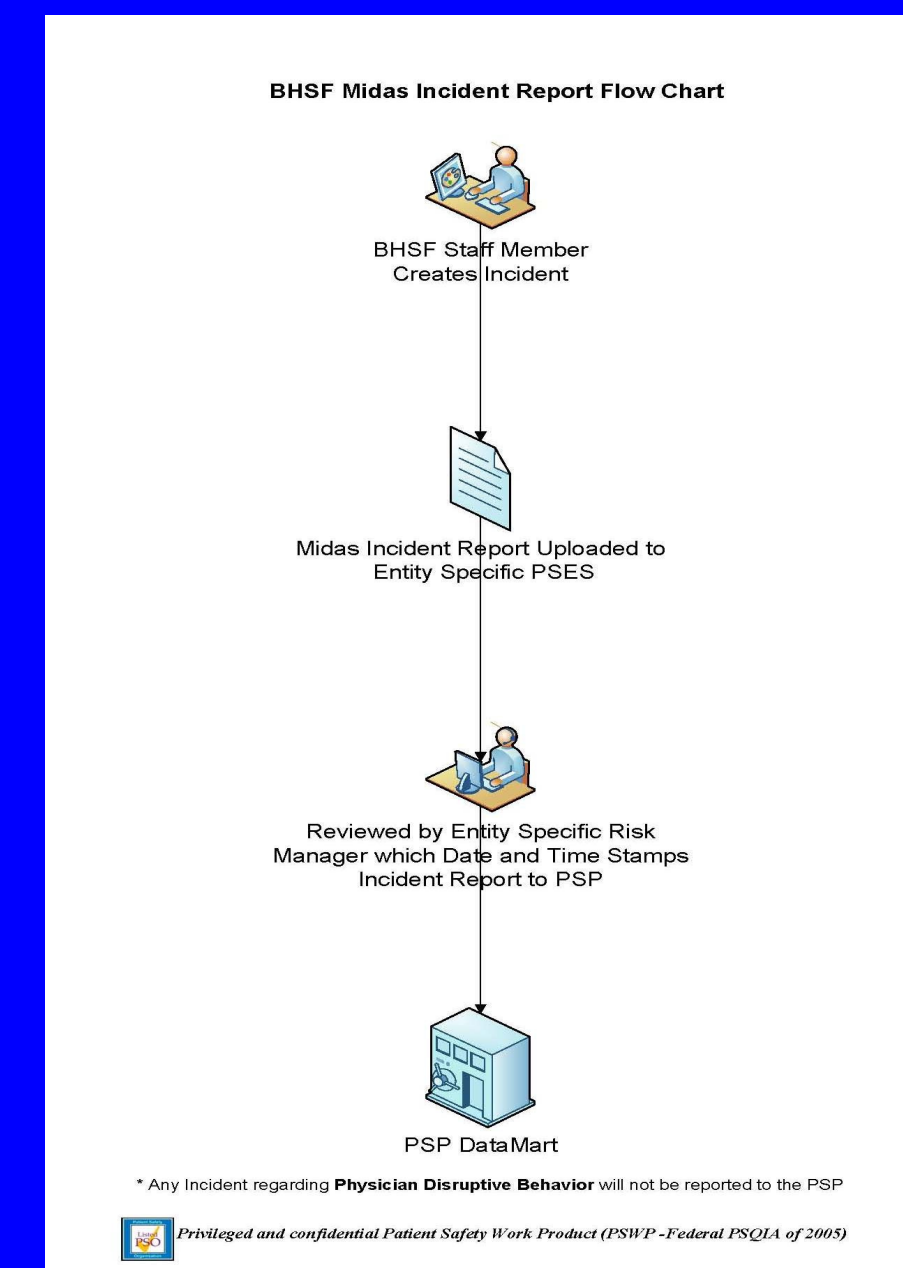


Baptist Health Patient Safety Partnership

OUR MISSION
 The mission of the Baptist Health Patient Safety Partnership is to improve patient safety and quality health care delivery, promoting health and well-being of individuals, their families and the communities we serve. The Patient Safety Partnership is committed to providing its consultative expertise in accordance with the Patient Safety and Quality Improvement Act and certification by the Agency for Healthcare Quality and Research.

OUR GUIDING PRINCIPLE
 Continue to advance patient safety across Baptist Health for the well-being of our community.

OUR VISION
 The Patient Safety Partnership will bring value and lead the organization in promoting healthcare innovation to ensure patient safety, quality care and superior evidence-based outcomes. Through shared learning/best practices across Baptist Health and improving overall clinical care processes we will protect our patients, families and the community from harm.

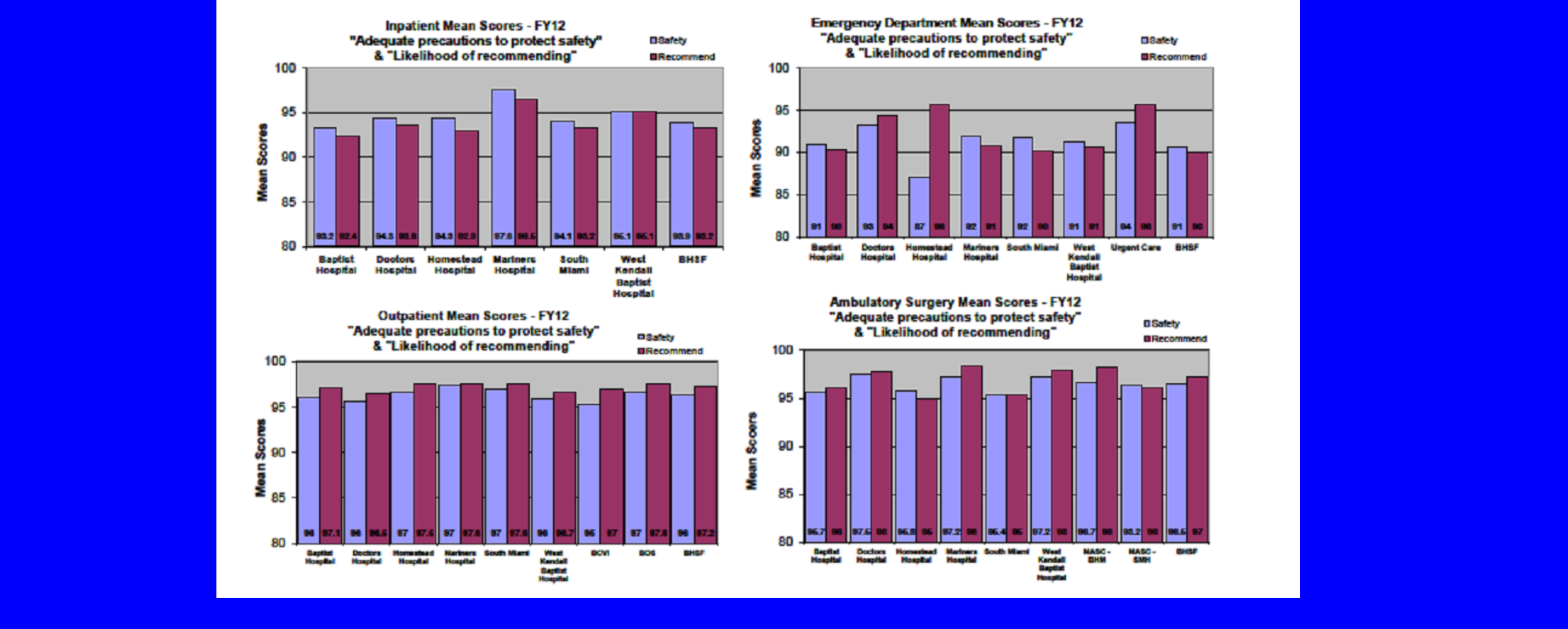
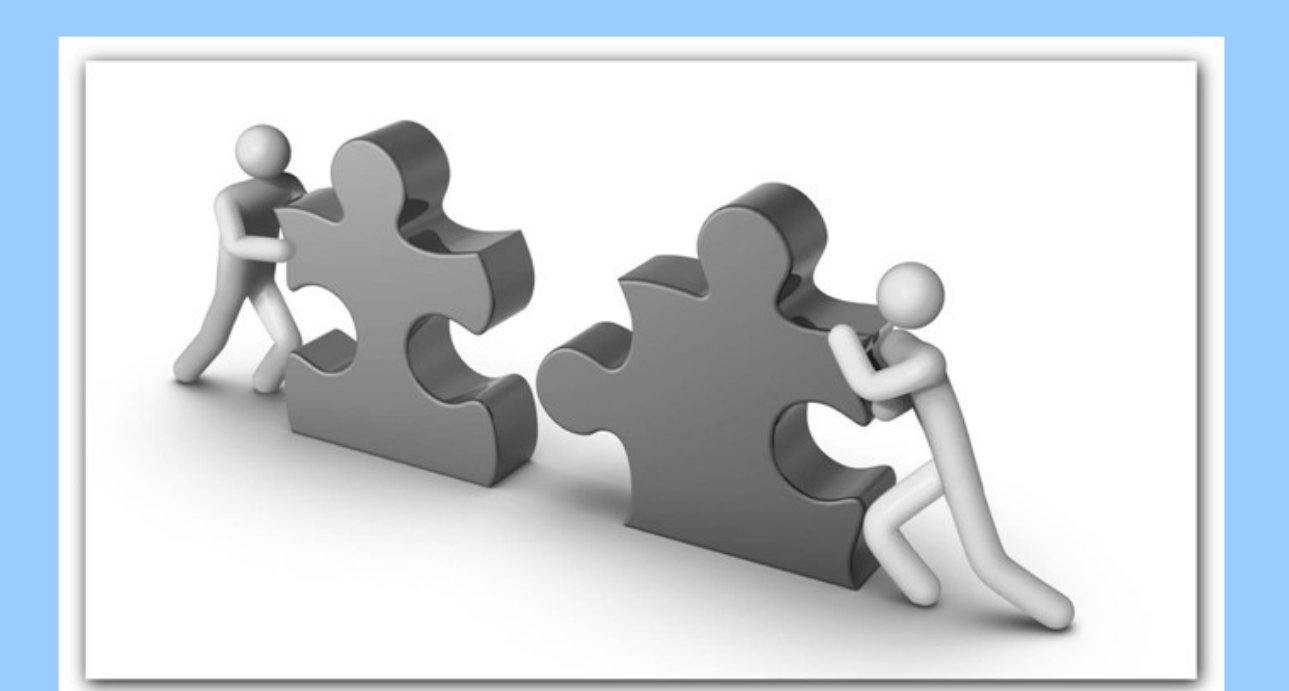


Definition of Patient Safety Work Product (PSWP) includes any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material), which could improve patient safety, health care quality, or health care outcomes, that are assembled or developed by a provider for reporting to a PSO and are reported to a PSO. It also includes information that is documented as within a patient safety evaluation system that will be sent to a PSO and information developed by a PSO for the conduct of patient safety activities.

Patient safety work product does not include a patient's medical record, billing and discharge information, or any other original patient or provider information; nor does it include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system.

PSP Communications:
 Midas Incident Reviews
 Reports/best practice materials in response to SEA's
 Quarterly Newsletter
 Educational Activities including:
 Lunch & learns
 Patient Safety Champion Training
 Leadership Patient Safety Updates

- Establishing Your Patient Safety Evaluation System (PSES)**
1. PSES Chair/Committee Membership
 2. Confidentiality Agreement with each PSES member
 3. Quarterly Meetings
 4. Policies Collection and Analysis of Patient Safety Work Product in the PSES
 5. Provider Policies- PSO Program Details
 6. Communication Flow Charts
 7. Uploading to Entity Specific PSP Approved folder. (RCA's, Code 15, Process Analysis and other data)
 8. Midas Incident Report Date/Time Stamp (All Incidents except disruptive physicians)
 9. Midas Peer Review Module Date/Time Stamp to PSES
 10. PSP/PSES Priorities List
 11. PSP Completed folder (Includes all PSWP sent from the PSP to entity)



Employee Opinion Survey BHSF 2012

Custom Question- Patient Safety
 (These questions have been added to the survey since 2004)

I feel comfortable reporting safety issues that might put patients and others at risk to my supervisor or administration.

BHSF Overall: 2004 = 4.57 2012 = 4.66

When a safety issue or error is reported, my supervisor or administration takes appropriate actions to fix the problem.

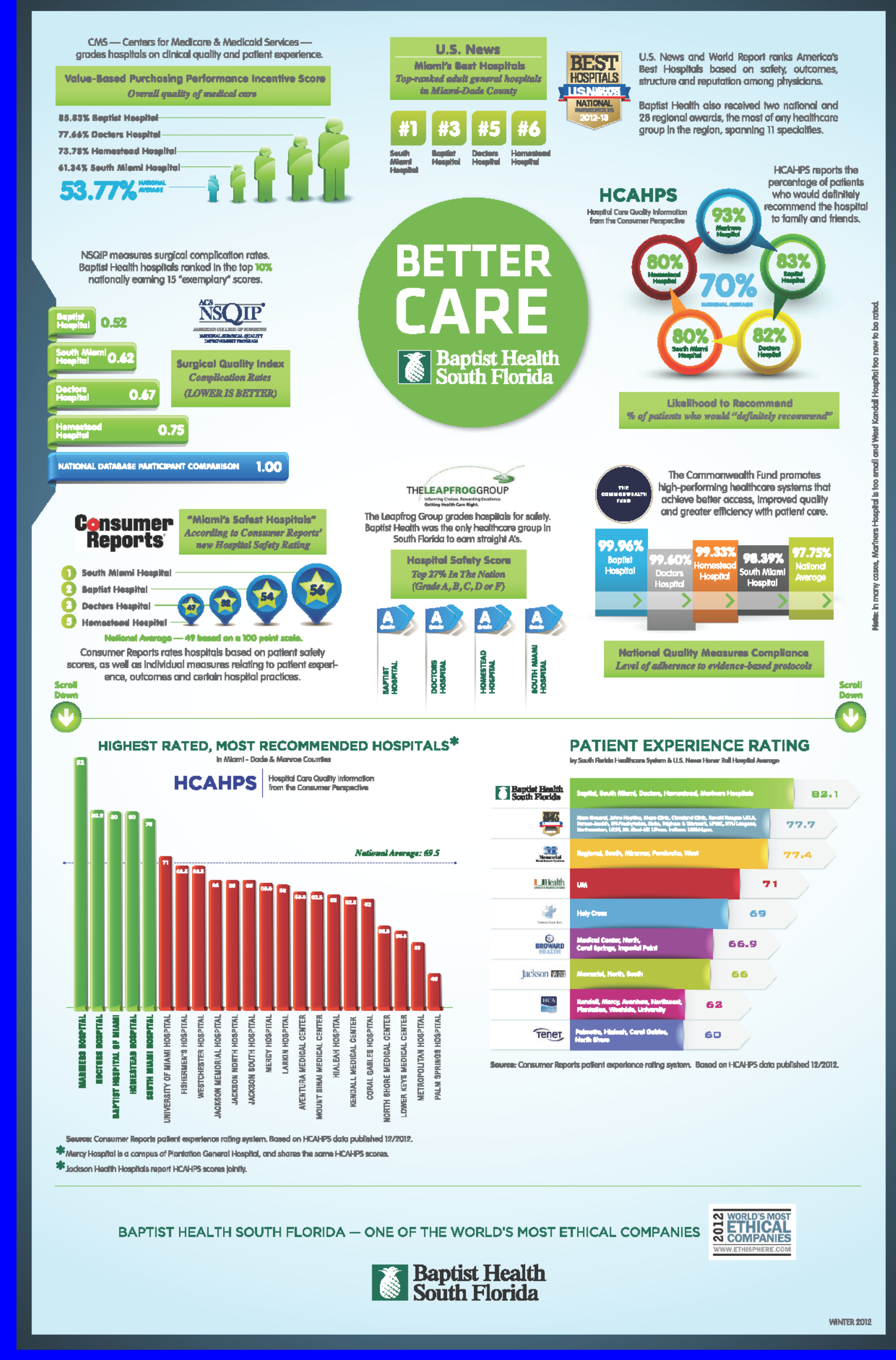
BHSF Overall: 2004 = 4.43 2012 = 4.60

Baptist Health — 2012

Six hospitals (1,728 beds):
 2,231 Private practice physicians
 15,104 Employees
 72,681 Inpatient admissions
 10,671 Births
 209,886 Urgent care center visits
 292,795 Emergency room visits

History:
 In 2003, BHSF embarked on its patient safety/quality journey ahead of changing national standards. With various strategies from our patient safety champion program, CEO rounds, rapid response teams, patient safety officers to leadership training and engagement, we continued working.

Our system wide patient safety efforts built through a shared learning process, developing best practices throughout the organization. Our goal, with almost 15,000 employees is to eliminate the opportunity for error/system failure to occur providing the highest quality patient- and family-centered care possible.



For Your Safety Patient safety is Everyone's Job!