



FIRST

Do No Harm

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Quality and Patient Safety Division, Massachusetts Board of Registration in Medicine

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I-PASS: Development of an Evidence-Based Handoff Improvement Program for Physicians and Nurses

For the I-PASS Study Group

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Introduction.

The Joint Commission has identified communication as the leading root cause of "sentinel events," the most serious adverse events in hospitals.¹ To address this problem, hospitals have tried a range of potential strategies including providing teamwork and handoffs training to staff (e.g., TeamSTEPPS)², introducing verbal mnemonics and other structured communication processes, and implementing written or computerized tools to improve handoffs.³ Each of these three strategies has appeared promising in improving communication in early research studies, but clear data demonstrating that implementing handoff interventions can improve patient safety has been lacking.

Development of I-PASS.

At Boston Children's Hospital, we sought to develop a comprehensive solution that would effectively address handoff miscommunications. We were initially prompted to do so by concerns that the number of handoffs for resident physicians in particular had increased following recent reductions in residents' work hours. As no single intervention had been shown to concurrently address written miscommunications, verbal miscommunications, and other teamwork failures, we chose to introduce a "handoff bundle" that brought together several different promising strategies, including team training, introduction of a verbal mnemonic, changes in verbal handoff structure, and a computerized handoff tool that was integrated into the electronic medical record.

With funding from the Harvard Risk Management Foundation (CRICO), we carried out a study of the effects of our handoff bundle on patient safety, rates of miscommunications, and resident work flow. On two general pediatric wards at Boston Children's Hospital, we found that medical errors fell 40% following introduction of the bundle, and that there were significant decreases in both verbal and written miscommunications. Moreover, residents' workflow was streamlined by introduction of the new program.^{4,5}

While this initial success was encouraging, adoption of our initial handoff program was incomplete, and we felt that it could be improved in several respects. Moreover, we wished to un-

derstand how effective it would be in residency programs beyond our center, and whether it might be adapted for use by other disciplines. We consequently sought to identify additional hospitals in the U.S. and Canada willing to partner with us on this endeavor. Through the Pediatric Research in Inpatient Settings (PRIS) hospitalist network, and with the support of the Initiative for Innovation in Pediatric Education (IIPE), we identified a group of 10 pediatric residency programs strongly invested in addressing handoffs, and sought grant funding from the U.S. Department of Health and Human Services for the I-PASS project (IIPE-PRIS Accelerating Safety Sign-outs), which was awarded in 2010.

The multicenter I-PASS study.

The goals of the I-PASS study are to: 1) determine if introduction of the I-PASS handoff bundle leads to reductions in rates of serious medical errors, verbal and written miscommunications, time spent by residents gathering and signing out data, and resident dissatisfaction with sign-out; and 2) to determine the manner in which the I-PASS Handoff Bundle's adoption and effects on primary and secondary outcomes are modified by hospital and patient factors. Across all participating intervention sites, these outcomes are being measured using an established systematic surveillance methodology, with data collection and analysis coordinated by the Center for Patient Safety Research and Practice at Brigham and Women's Hospital.

The I-PASS curriculum.

I-PASS serves not only as the name of our multi-center handoff improvement project, but is also a mnemonic used to structure verbal handoffs:

- I: Illness Severity
- P: Patient Summary
- A: Action List
- S: Situational Awareness & Contingency Planning
- S: Synthesis by Receiver

This parsimonious mnemonic, intended to standardize and streamline transmission of critical information, is paired with transmission of a computerized or written handoff tool.

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In the process of developing the I-PASS intervention, extensive efforts were invested in building a robust handoff and teamwork training curriculum. Resident and faculty workshops were developed, along with on-line materials, handoff simulations and interactive materials, campaign materials to promote institutional adoption of a refined I-PASS process, and tools for faculty to evaluate resident handoffs. All of these materials are now available free of charge at www.ipasshandoffstudy.com.

Adapting I-PASS for nurses, physicians across specialties, and handoffs at change of location.

Recently, we have also begun adapting I-PASS for use by nurses at change of shift, as well as when patients change locations within the hospital (e.g. emergency room to floor, or post-anesthesia care unit to intensive care unit). We modeled the nurse's handoff after the resident I-PASS process. We started with the nurses in the ICUs at Boston Children's Hospital and created a handoff tool using the mnemonic. The tool was a way for nurses to structure shift to shift handoff and speak the same language. We then increased our scope by adding patient transfers from the ED to ICU and then ED to inpatient unit. Again we created an I-PASS tool meant to streamline the information and standardize communication from the nurse in the ED to the receiving nurse. We found that satisfaction on the receivers' end was increased with the use of the I-PASS tool. The receiving nurse was able to get the information they needed to safely care for the patient.

Moving forward, we anticipate further adapting I-PASS to be useful for other specialties, all inpatient areas of nursing and to be used as a common platform for interdisciplinary rounds. Surgeons, obstetrician-gynecologists, internists, neurologists, and medical student clerkship directors have approached the I-PASS Study Group, asking that I-PASS be adapted for their use. While I-PASS can be used across settings and special-

ties, some modifications are needed to optimize its use in different contexts. We hope that as time goes by, we will be able to develop a full suite of educational materials that can be paired with systematic re-structuring across settings to optimize communications and improve patient safety.

References

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- ⁴ Starmer AJ, Sectish T, Simon D, Landrigan CP. Impact of a Resident Handoff Bundle on Medical Error Rates and Written Handoff Miscommunications PAS Annual Meeting 2011, Denver, Colorado, Abstract 4145.2
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Engage EMS to Raise the Bar on Quality and Safety for Patient Transports

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Situation

A detailed review of recent cases involving patient transfer from the hospital setting to other facilities via Emergency Medical Services (EMS) revealed some challenging situations regarding hand-off communications between hospital staff and EMS. Discussions with several EMS providers further revealed that the EMS industry has no tangible requirements for hand-off process expectations between EMS and hospital staff.

Background

As a regional provider of healthcare services in Southeastern Massachusetts, Southcoast Hospitals Group (Southcoast) worked with a group of its contracted EMS providers to bring a degree of standardization to facilitate a smooth transition from hospital to EMS provider for its patients, with expectations to

deliver an effective handoff communication process when the hospital's patient is transported to another healthcare facility or destination.

Actions

At the time of booking, EMS dispatch agents have been instructed to request the patient's full name and date of birth from hospital staff so that a two-identifier process can be used upon arrival at the hospital. Hospital staff members are instructed to use patient name and date of birth (the hospital's standard identifiers at the bedside), with EMS staff prior to the patient's transport.

Upon arrival at the hospital, every patient care area has a log

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book for EMS staff to record their name(s), agency name, on-unit arrival time (for QAPI - quality assessment and performance improvement purposes) and the patient's name. The next phase of development will convert the manual log book to an intranet-based application to allow for electronic recording of this information.

To improve communications at the bedside, the hospital's electronic SBAR communication tool was duplicated and slightly revised to provide an EMS-specific SBAR document, with information geared to key patient data elements that may be crucial during the transport process. Hospital staff members are expected to generate the EMS-SBAR report prior to EMS arrival so that the most up-to-date patient information is provided to EMS in a structured, printed document.

When the transfer requires an exchange of patient medical equipment from hospital equipment to EMS equipment, and when time safely permits, EMS staff is requested to maintain the patient in the hospital setting for 10-15 minutes to assure that the EMS equipment is functioning properly before the patient leaves the building.

Immediately prior to departure from the hospital, hospital staff is expected to obtain and record ending vital signs, which are documented in a designated space on the EMS-SBAR report and in the hospital information system. The hospital's ending vital signs are intended to serve as the starting vital signs for EMS documentation to assure that there are no discrepancies in communications at this point in the patient transfer process.

Upon arrival at the patient's destination, EMS providers are requested to use an SBAR handoff process with licensed staff at the receiving facility. The hospital's EMS-SBAR report may be provided to the receiving facility along with the standard EMS documentation forms. Some EMS providers have indicated a desire to create an SBAR document within their own electronic documentation systems, feeling that the SBAR approach provides a standard method of communication which would enhance the traditional transfer process.

Requirements For Internal Quality Reporting

MA OEMS (Office of Emergency Medical Services) regulations (105 CMR 170.300 A(4)) requires the inclusion of EMS case reviews into the hospital's QAPI standards and process. Southcoast is changing its approach to the following format in efforts to improve QAPI effectiveness:

1. EMS case reviews between EMS providers and the associated hospital medical director will be documented for all medical staff peer review activities. The EMS reviews will be forwarded through medical staff processes to the hospital's Medical Executive Committee and the Board of Trustees.

2. Findings from EMS operations reviews, which are conducted a few times per year between contracted preferred providers and hospital leadership, will be presented to the

highest level quality committee within the hospital. Reviews include EMS provider refusal rates, on-time responsiveness and other quality-related metrics or issues. A summarized review of these data is then forwarded to the quality committee of the Board of Trustees.

Future Plans

Discussions are underway with our EMS preferred providers, with a goal of creating a standardized, regional peer review document, so as to create uniformity for questions, concerns and improvement needs for patient care during transport. The goal includes the development of standard language that can facilitate a determination of whether the care during patient transport was provided as expected or may have been provided differently.

As a related step to the patient transfer process involving EMS, a documentation process is under development for occasions when patients have their federally controlled substance(s) from home with them in the hospital. To avoid opportunities for controlled substances diversion, a strict sign off process will be implemented, so that two witnesses acknowledge the presence of a patient's medications from home, which will be sealed in a serial-numbered bag by the hospital pharmacy. The documentation tool will include a space for signature by an individual at the patient's destination to acknowledge receipt of the medications, whether the destination be the patient's home or another healthcare facility. Both the hospital and the EMS provider will be required to maintain the signed document as proof of hand-off of a patient's federally controlled substances.

Findings from both peer and operational reviews may be used during future contracting considerations.

Summary

Hospitals bear a responsibility in the safe transfer of patients. While state-required ambulance affiliation agreements typically define each party's responsibilities, operational processes may be needed to supplement the responsibilities in order to ensure safe patient identification, communication of patient information and applicable QAPI activities for continuous quality improvement.

For questions, comments, suggestions, please contact Mr. Gannon at gannonp@southcoast.org.

QPS Notes:

Jordan Hospital expanded its PCA Committee membership to include members of its Patient Family Advisory Council.

At Boston Medical Center (BMC), patient advocates participate on The Better Alignment of BMC Patient Care Resources committee and the Patient Education Media and Technology workgroup. BMC also has a very active Patient, Family Advisory Council (PFAC) that routinely reviews patient experiences.



Bedside Handoff – Improving Professional Practice through Communication

Judy Thorpe, MSN, RN, NE-BC

Associate Chief Nursing Officer, Hallmark Health System

The Hallmark Health System (HHS) interdisciplinary care delivery model focuses on collaboration, which includes working with others (patient, family, healthcare providers, colleagues, community) in a way that promotes and encourages each person's contributions. Gaps in collaboration or communication can precipitate a cascade of events that exposes a patient to harm, while causing needless expense. Ineffective handoffs can compromise patient care and patient safety. Each hospitalized patient encounters multiple handoffs, with the most frequent being at change of shift. As adverse events are analyzed and reviewed, a breakdown in communication is frequently identified as a contributing factor. The issue of handoffs has become so prominent that the Joint Commission introduced a related National Patient Safety Goal effective January 2006. This safety goal requires hospitals to implement a standardized approach to handoff communications, including an opportunity to ask and respond to questions. While the goal is simply stated, it is a challenging goal to implement in a comprehensive and meaningful way.

In September 2010, HHS conducted a root cause analysis of a 'near miss,' which highlighted clinical hand-off as a major contributing factor. An oxygen dependent patient was transported to the radiology department with an oxygen tank that could not deliver the required amount of oxygen for the estimated period of time that the patient would be off the unit. Rather than looking at this issue from the individual scenario perspective, the nursing department decided to approach the broader topic of patient handoff. The Patient Handoff Project Team was developed. I chaired the team and representation included direct care nurses, clinical leaders, educators and directors.

HHS defines patient handoff as the transfer of information (along with authority and responsibility) during transitions in care across the continuum; each handoff includes an opportunity to ask questions, and clarify and confirm the plan of care. The complexity of the type of information, communication methods and the skill level of various caregivers impact the effectiveness and efficiency of the handoff and patient safety. The team quickly identified the lack of consistent approach to handoff across all units. As the majority of patients are cared for on the medical/surgical units, the team made the decision to begin the process improvement project with the structure of the change of shift report on the medical/surgical units.

The team further agreed that a consistent handoff process was needed and that staff nurses are subject matter experts on the content of the shift report. In addition, the team acknowledged the existence of regulatory requirements that needed to be incorporated into the structure and approach. A review of the evidence demonstrated that bedside shift report

was best practice. This complex, important practice change had the potential to significantly impact patient safety, patient satisfaction, quality and nurse satisfaction. The team identified the following goals for the different phases of the project for all HHS medical surgical and telemetry units.

PHASE ONE (June 2011 go live)

- ◆ 100% of staff will have completed competency checklists.
- ◆ 75% of appropriate change of shift reports will be at the bedside.

PHASE TWO (October 2011 good to better)

- ◆ 100% of appropriate change of shift reports will be at the bedside.
- ◆ 100% of staff will embrace the model.
- ◆ 5% increase in Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scoring in:
 - (1) Communication with Nurses; and
 - (2) Pain Management.

PHASE THREE (January 2012 better to best)

- ◆ Sustained improvement in HCAHPS scoring.
- ◆ Sustained reduction in the number of variances.
- ◆ 100% of staff will use the standardized change of shift reporting structure.

The team realized the challenges of making this change. Many units did not have a standard reporting structure; this lack of consistency can make it difficult to implement bedside nurse report. The team developed a robust plan to build support for this project. For example, the team developed a "What's in it for me" approach that could be tailored to each key constituency group. These were discussed during staff meetings and at the Clinical Practice Leader Council meetings. Examples are outlined below.

STAFF NURSE "What's in it for me" talking points.

Bedside reporting, a consistent framework for patient handoffs and staff engagement:

- ◆ Reduces patient anxiety; patient understands that the nursing staff is working together as a team; patient is given the opportunity to ask questions and/or add information that can be vital to plan of care.
- ◆ Reduces surprises when report doesn't match patient's condition; oncoming nurse instantly confirms the previous nurse's report by visualizing the patient and getting a baseline assessment to compare against changes during the shift.
- ◆ "Eyes on" patients earlier in the shift.
- ◆ Ability to ask questions about a new piece of equipment.

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- ◆ Consistent report structure from nurse to nurse; reduces likelihood that extraneous information is communicated, while vital information is excluded.
- ◆ Reduces nurse anxiety by identifying a standard approach for challenging scenarios (e.g., giving report on a patient just told of a terminal diagnosis or on a patient requesting multiple narcotics).
- ◆ Engages and informs patients during the shift report process.
- ◆ Participates in evidence based practice.
- ◆ Enhances the image of the nursing profession.

CLINICAL LEADER (in addition to understanding the staff nurse perspective)

Bedside reporting, consistent framework for patient handoffs and clinical leader engagement:

- ◆ Positive impact on patient satisfaction (evidence based).
- ◆ Positive impact on patient safety; reduction in novice to expert variability in reporting.
- ◆ Increases RN to RN accountability.
- ◆ Positive impact on RN skill development.
- ◆ Positive impact on teamwork.
- ◆ Positive impact on staff perception of culture of safety at HHS.

Strategies for Clinical Leaders to use:

- ◆ “Let’s go in together.”
- ◆ Clarify expectations for engaging the Director when a staff nurse is not responding to the Clinical Leader direction.
- ◆ Engage Supervisor for support “in the moment.”

The team developed and implemented a communication strategy. Planning included time to talk and listen to concerns of the nursing staff, such as confidentiality, length of time to give report, and multiple patient interruptions. The team developed a vision for nurses at all levels. Education was provided to 100% of the staff on the “why-how-what,” with clear communication of expectations. In order to assure hard wiring of the process, every shift change was monitored for 30 days. Clinical Leaders and Directors spoke with patients about bedside shift report during leader rounds. The process was incorporated into nursing orientation, as well as the annual performance appraisal for all nurses. The leadership team identified strategies to help Clinical Leaders ad-

dress compliance and accountability issues.

In June 2011, the system-wide roll out began on the Lawrence Memorial Hospital campus. Each nurse received a packet of information, including a research article and a handout with the key information. During the implementation phase, each nurse was observed and baseline competency assessed.

At the end of the pilot phase greater than 75% of handoffs were occurring at the bedside. Clinical Leader rounding on patients elicited very positive feedback from the patients. Initial HCAHPS scores on key metrics showed improvement. At the end of the pilot, Phase One roll out to all HHS units on both campuses began and was completed by the end of 2011.

While the roll out continued, the team began to focus on phase three of the project, which included the use of a standardized, checklist approach to report. Although the team had standardized the location of report, the next task to tackle was standardizing the report itself, using the airline checklist approach. A group of staff members were brought together to identify a standard approach to be piloted. The team did not want this to equate to another form to fill out, but rather a standard approach of communication. For example, the diagnosis would always be stated after the patient’s armband was checked. The team realized that this step was as big as moving the location of the report. The team identified specific roles and responsibilities of all levels of nurses within the organization. Having the staff nurses as the subject matter experts provided credibility to the process.

As a result of Bedside Handoff, the HHS HCAHPS scores have demonstrated a sustained increase above 75% in patient satisfaction related to communication with nurses.



QPS Notes:

At North Shore Medical Center, a multidisciplinary team worked to redesign the flow and effectiveness of patient care in the Emergency Department; a team huddle at the patient’s bedside to discuss the admission assessment was piloted that has improved time in the ED and patient satisfaction.



Strengthening RN Hand Off Communication to Advance High Quality, Patient and Family Centered Care

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During the winter and early spring of 2011, the Nurse Directors and Professional Development Educators at Brigham and Women's Faulkner Hospital worked collaboratively to review current nursing practice, select resources for evidence based best practice and ultimately identify specific RN core competencies for department

wide implementation within the upcoming year.

Strengthening RN Hand off communication was identified as one of the essential department wide core competencies. The driving forces and guiding principles for implementing a standardized and improved hand off communication process were patient safety, patient and family centered care, patient satisfaction and the "Nurse of the Future Nursing Core Competencies." The concept of department wide RN competencies was refined by the Professional and Practice Development Educators and then the framework for the handoff communication competency was completed.

Three phases to the implementation process were developed and implemented.

Phase 1 – A representative group of educators developed the curriculum, teaching methodologies and implementation plan for this new competency. A one hour education program was then presented to all RN staff. The program included a didactic presentation, small group work on case scenarios across patient care areas and a time block for questions and answers. The didactic presentation and case scenarios placed the topic in the context of high quality, safe, patient and family centered care and provided RNs with perspectives across units. Key points involving the role of the sender and receiver were emphasized. Providing anticipatory guidance to a less experienced nurse on important components of care following a transfer was also spotlighted. Active learning strategies were utilized to engage staff and invest them as stakeholders in improving the process for hand off communication.

Phase 2 – Three standardized hand off communication tools were presented to staff for review and further consideration. A survey was sent to RN staff to determine the standardized tool staff wanted to use. The tool they selected was the RHAPP for-

mat – Reason, History, Assessment, Progress and Plan. Reference sheets for the RHAPP format were then developed and posted in each unit and our nurses were provided with pocket reference guides. A sample reference sheet is included at the end of this article.

Phase 3 – A strategy to integrate best practices into unit-based protocols was next implemented. The Educators conducted unit based discussions with staff to identify specialty based high risk situations and develop communication guidelines for these situations. They evaluated what was currently working well for hand off communication and what opportunities existed to further strengthen hand off communications.

Sustainability

The program evaluations for the one hour competency sessions were very positive. RN staff remained engaged in the unit-based work to integrate best practices. However, the importance of measuring and sustaining the use of a standardized hand off communication tool and assuring that a strong hand off communication process is valued and assimilated into practice is well recognized.

Our strategies to sustain this work are as follows.

Data for the number of safety event reports being filed under the hand off communication coordination of care category is being monitored. Data will be trended and reported to the Patient Safety Committee.

An Emergency Department and ICU RN Task Force has been established to address opportunities for improvement in providing hand off communication on higher risk patient transfers.

At the unit level, Nursing Leadership will continue to monitor the implementation of RHAPP and the quality of hand off communication shift to shift and across units.

The Educators will continue to review the literature for best practices related to hand off communication. A journal article from *Advanced Critical Care* titled, "Ethics of Nursing Shift Report" has been recently reviewed and will be recommended as an article for unit based journal clubs.

A copy of the Brigham and Women's Faulkner Hospital RHAPP Reference Sheet is included on page 7.

QPS Notes:

There may be opportunities for guidelines and Rapid Response Team (RRT) practitioner education regarding communication and next steps when a RRT is repeatedly activated for a patient. These situations have occurred when the nursing staff recognized that a patient was deteriorating, but there was insufficient response from the RRT. For patients requiring more than 1 or 2 activations of the RRT in a short period of time, hospitals might consider requiring another practitioner to participate in the second response.



BRIGHAM and WOMEN'S FAULKNER HOSPITAL HAND-OFF COMMUNICATION REFERENCE SHEET

REMEMBER:

Standard elements of handoff communications include:

- ◆ Patient name and date of birth, or medical record number
- ◆ Physician name
- ◆ Pertinent medical patient information including:
 - Diagnosis
 - Recent medical or surgical history
 - Current condition
 - Anticipated changes in condition or treatment
 - Expected clinical observations during the next interval of care
- ◆ Opportunity to ask and respond to questions



Interruptions and distractions during the handoff should be minimized in order to eliminate opportunities for error during handoff communications

Handoff communications should be interactive and allow each care provider to ask questions and to have their questions answered.

Handoff communications include, but are not limited to, the following occurrences in transfer of patient responsibilities:

- | | |
|--------------------------------|---|
| Shift-to-shift report | Communication of critical test results |
| Relief of staff for breaks | Physician/resident transfer of patient care |
| Transport for diagnostic tests | Physician resident transfer of on-call responsibility |
| Unit to unit transfers | Nursing/Physician handoff from ED to unit |
| Admissions | EMT/nursing handoff upon ED arrival |

RHAPP:

R: Reason	H: History	A: Assessment	P: Progress	P: Plan
Covers basics of patient's current condition.	Provides relevant history, context & objective data and to patient's current condition.	Summarizes patient's current health status issues.	Relates current health status and issues to patient's progress towards goals in plan of care.	Addresses needs for follow up care and necessary interventions.
Patient name, DOB, & medical record number	PMH and relevant situations	Assessment of abnormal findings	Progress toward goals	Priorities and goals for the next shift or different care team
Room number	Physician(s)	Significant recent lab or test results	Response to medications and treatments	Consults or physicians follow-up
Diagnosis	Vital signs	Functional ability/activity	Priority interventions	Interventions to be completed
Surgery/Procedures	Allergies	Diet	Discharge/transfer readiness	Pending orders, treatments, & tests
Admit date	Rhythm	Pain assessment /reassessment need	Coping/Psychosocial issues	Future teaching needs
Current length of stay	Pain scale	Psychological/family/Teaching needs	Priorities and goals for the next shift or different care team.	Preparation for transfer or discharge
Current condition	I&O	Pending results	Pending orders, treatments, & tests	Notifications for physicians
Current issues/problems	IV's/type of access	Falls/Fall Risk	Teaching	Scheduled procedures or surgeries
	Drains & wounds	Safety risks	Core measures	Current Interventions
	Skin condition/areas of breakdown	Pain management issues	Code status follow-up	Plan for existing and new therapies
	Diet		Review of charting	
	Activity		Anticipated actions	
	Food and fluid restrictions			
	Restraints			
	Relevant prior tests/procedures/surgery			
	Psychosocial issues			



QPS UPDATES

Noble Hospital has taken steps to improve staff compliance with reporting on the use of rescue medications. A clinical pharmacist has been assigned to investigate rescue drug use in real-time, and provide follow-up with education for each event. These activities are supported by the OIG recommendations to promote better use of incident reporting systems to capture patient harm. (See Hospital Incident Reporting Systems Do Not Capture Most Patient Harm. January 2012, OEI-06-09-00091. <https://oig.hhs.gov/oei/reports/oei-06-09-00091.pdf>)

QPSD has noted a trend in SQRs involving patient complications associated with insufficient equipment or resources to care for obese patients. Hospitals need to assess their staffing, facility and equipment for their ability to safely care for obese patients prior to their admission.

We have also received reports involving complications associated with cement leakage during kyphoplasties. Please be sure that you are tracking and reviewing these complications.

“Gain Full Value From Your Root Cause Analysis” Workshop

Held November 16th in Marlborough, a third full day workshop, co-sponsored by the Quality and Patient Safety Division, Massachusetts Society for Healthcare Risk Management and the Massachusetts Hospital Association. The program awarded physicians six continuing professional development credits in risk management. The workshop was facilitated by Patrice Spath, MA, RHIT, of Brown-Spath & Associates. Ms. Spath described the elements of a “thorough” root cause analysis, discussing what is often missing from investigations. She presented the analytical tools caregivers need to identify the event’s root cause and latent conditions. Lastly, Ms. Spath discussed how to identify effective strategies for designing sustainable corrective actions and follow-up monitoring activities. Over four hundred people have now attended the workshop over three dates.

Leading on Quality and Safety: Briefing for Hospital Trustees

Held November 6th in Burlington, a Quality and Patient Safety Division co-sponsored event with the Massachusetts Hospital Association. James Conway, MS, FACHE, Principal, Governance and Leadership Group, Pascal Metrics and Tracy Gay, JD, Director, QPSD spoke to hospital and health system board members on their role and accountability in the governance and leadership of quality and patient safety.

The following topics were addressed:

- ◆ What are the leading edge issues of quality and patient safety involvement?
- ◆ How does the culture of an organization drive quality?
- ◆ How should we manage Serious Adverse Events?
- ◆ How has the Office of Inspector General for Health and Human Services recently focused on Adverse Event Reporting?
- ◆ What are the regulatory requirements of the QPSD within the Board of Registration in Medicine?

CONTACT THE QPSD

To be added to the QPSD Newsletter and advisory mailing list, update hospital contact information, submit an article, request an SQR form, or obtain additional information, contact QPSD: Jennifer.Sadowski@state.ma.us or (781) 876-8296.

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