Draft Rule Shapes Patient Safety Organizations

BY DENISE NAPOLI
Assistant Editor

According to the proposed rule, a patient safety event may include an error of omission or commission, mistake, or malfunction in a patient care process; it may also involve an input to such process (such as a drug or device) or the environment in which such process occurs. The term is intentionally more flexible than the more commonly used “medical errors” to account for not only traditional health care settings, but also for patients participating in clinical research, in their homes, in clinics, and even locations where a provider is not present, such as a patient’s home, according to the rule. Until now, there has been no clear guidance on how an organization can become a PSO. But according to the proposed rule, public and private entities, both for-profit and non-profit, can seek listing as a PSO. This includes individual hospitals, hospital networks, professional associations, and almost any group related to providers with a solid network through which safety information can be aggregated and analyzed, said Dr. Munier.

Surgeons, accreditation boards, and licensing agencies cannot be PSOs because of potential conflicts of interest.

“We know that clinicians and health care organizations want to participate in efforts to improve patient care, but they often are inhibited by fears of liability and sanctions,” said E.J. Carman, director. “The proposed regulation provides a framework for (PSOs) to facilitate a shared learning approach that supports effective interventions that reduce risk of harm to patients.”

Dr. Munier said that the rule took a long time to issue partly because its authors had to be sure it didn’t conflict with state reporting requirements and the Health Insurance Portability and Accountability Act (HIPAA).

In a statement, Rich Umbenstock, president and CEO of the American Hospital Association, said that his group was in strong support of the creation of PSOs. “Hospitals have already waited 2 years for this rule and this is only a first step in the process toward establishing PSOs. We will continue to work with HIT to ensure the timely creation of PSOs,” he said. Dr. J. James Rohack, a board member of the American Medical Association, agreed. In a statement, he said, “Since the passage of patient safety legislation in 2005, the American Medical Association and other patient safety advocates have eagerly awaited guidance for implementation from the administration. The proposed rule will allow health care professionals to report errors voluntarily without fear of legal prosecution and transform the culture of blame into one of open communication and prevention.”

To view the proposed rule and learn how to comment, go to regulations.gov/fdmspublic/component/main?main=6/DocketDetail/d=41RQ-2008-0001. Comments will be accepted until April 14.

Hospitals Tackle Joint Commission’s 2008 Patient Safety Goal

BY MARY ELLEN SCHNEIDER
New York Bureau

The Joint Commission’s new 2008 patient safety goal of requiring a process to respond quickly to a deteriorating patient is being mistakenly interpreted at some hospitals as a mandate for “rapid response teams” or “medical emergency teams.”

Further, at some organizations that already have rapid response teams, staff have expressed concerns they will need to redo their established systems.

Dr. Peter Angood, vice president and chief patient safety officer for the University of California, San Francisco, said that need to add staff. If no professional staff was there at 2 a.m. before, said Dr. Angood, the hospital now needs to take on the additional task. Investment is required to using rapid response teams, according to the rule.

A number of hospitals have already made a commitment to establishing some type of rapid response teams. Establishing these teams is one of the strategies advocated as part of the Institute for Healthcare Improvement’s 5 Million Lives Campaign, a national patient safety campaign designed to reduce harm in U.S. hospitals.

Of the 3,800 hospitals enrolled in the 5 Million Lives Campaign as of January, about 2,700 have committed to using rapid response teams, according to IIHI.

This idea is catching on, said Kathy Duncan, R.N., faculty for the 5 Million Lives Campaign. The cost of implementing these types of teams varies, she said. About 75% of hospitals in the campaign have done this with zero increase in full-time employees for most staff involved, this is just an additional task. Investment is required for training team members, which can be costly at the outset, she said. Hospitals also need to invest time to educate the rest of the staff on when and how to call for assistance.

Ms. Duncan’s advice for implementing whatever process a hospital chooses is to start by assessing what resources are available. She advises figuring out how people will request assistance, when to make that call, and who should respond. “Start small with a pilot process,” Ms. Duncan said.