

FINAL MINUTES

MEETING OF:

PATIENT SAFETY AUTHORITY

ONE HACC DRIVE
WILDWOOD CONFERENCE CENTER
HARRISBURG, PENNSYLVANIA

TIME: 10:05 A.M.

DATE: September 8, 2009

PATIENT SAFETY AUTHORITY
Public Meeting
September 8, 2009

Agenda

- I. Call to Order
- II. Approval of June 9, 2009 Meeting Minutes
- III. Report of the Board Chair
- IV. Report of the Executive Director
- V. Initiative/Committee Reports
 - HAI initiative
- VI. PA-PSRS Update
 - Comparison of HAI Data, Nursing Home through PA-PSRS and Hospital through NHSN – Bill Marella MBA, PA-PSRS Program Manager
- VII. Old Business
 - Overview of CUSP/CLABSI Collaboration – Sharon Muscatell, Director Quality and Accreditation Services, HAP and Fran Charney, RN, MSHA, CPHRM, CPHQ, CPSO, FASHRM, Director of Educational Programs
- VIII. New Business
 - PA – National Safety Quality Improvement Project Collaboration Presentation – James Reilly, MD
 - Overview of Stimulus Programs, Barbara Holland Esq.
 - Review of Patient Safety Authority Bylaws, Barbara Holland Esq.
- IX. Public Comments
- X. Adjournment

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Patient Safety Authority

September 8, 2009

Ana Pujols-McKee, M.D., Chair
Stanton Smullens, M.D.
Gary A. Merica, R.Ph. (absent)
Anita Fuhrman, R.N., B.S. (phone)
Joan Garzarelli, R.N., MSN (phone)
Cliff Rieders, Esquire
Lorina Marshall-Blake (phone)
Marshall W. Webster, M.D. (phone)
Roosevelt Hairston, Esquire
Terry Hyman, Esquire

Also Present:

Mike Doering, Executive Director
William Marella, ECRI Project Manager
Barbara Holland, Esquire, Board Counsel
Sharon Muscatell, HAP
Fran Charney, PSA Director of Educational Programs
James Reilly, M.D., Lehigh Valley Hospital, NSQIP
Pam Braun, HCIF
Phenelle Segal, ECRI Infection Prevention Analyst

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2 PATIENT SAFETY AUTHORITY

3 The regularly scheduled meeting of the Patient
4 Safety Authority was held on Tuesday, September 8, 2009.
5 Ana Pujols-McKee, M.D., Chair, called the meeting to
6 order at 10:05 a.m.

7 ***

8 The motion to approve the minutes of June 9, 2009
9 carried unanimously.

10 ***

11 Report of Executive Director

12 [Mike Doering said the September advisory contains many
13 articles, including medication monitoring errors about
14 the inappropriate dosage of levofloxacin, errors in
15 radiation therapy, and safe patient outcomes that occur
16 with timely and standardized communication of critical
17 values. Mr. Doering noted Cliff Rieders had made a
18 suggestion at the last Board meeting to develop patient
19 focused consumer tips related to how patients can obtain
20 medical records and other issues to promote patient
21 empowerment, and he stated those are in the process of
22 being developed. Regarding education, training and
23 outreach, Mr. Doering noted the second basic foundation

1 program for patient safety officers has been conducted
2 and there will be ongoing presentations of this program
3 at various locations in the state prior to the end of
4 the fiscal year. He said the three final pilots for the
5 board of trustee education program being conducted in
6 collaboration with HAP and American Hospital Association
7 have been scheduled. Mr. Doering reported on the
8 patient safety liaison program and noted the three
9 patient safety liaisons visited 209 facilities in the
10 past three months. He noted at least 15 presentations
11 are scheduled to be held in the next several months. In
12 terms of collaborations, he discussed the CLABSI
13 (central line associated blood stream infections)
14 initiative and NSQIP (National Surgical Quality
15 Improvement Project), a nationally recognized
16 information database source for its member hospitals.]

17 ***

18 [Mr. Doering gave a report on the HAI initiative. In
19 particular he discussed nursing home reporting which
20 went live in June. He stated there was a total of 669
21 nursing homes out of 715 that have reported at least one
22 HAI. As of last Friday, over 8,200 reports from the
23 nursing facilities had been received. He noted a set of

1 analytical reports is being developed to be made
2 available to all the nursing homes to review and analyze
3 their individual facility data. Mr. Doering stated a
4 copy of all submitted infection data from the nursing
5 homes is being provided to the Department of Health, and
6 they are working on a process to receive that data
7 electronically each day. Regarding standardization and
8 recommendations, he noted that the Board at the last
9 meeting voted to recommend 12 of the principles to DOH
10 and recommended a letter be sent to all facilities
11 identifying the 12 principles. However, as several
12 Board members noted, there still appears to be
13 additional work to be done with several of the issues
14 which did not get resolved. Concerning hiring, Mr.
15 Doering noted there is a desire to hire three additional
16 patient safety liaisons, one in the southwest and two in
17 the southeast. Interviews have already begun for a
18 person in the southwest, and ads are being published in
19 the Philadelphia papers to solicit applicants for the
20 southeast positions. Mr. Doering is hopeful all of the
21 positions will be filled within the next several
22 months.]

23

1 PA-PSRS Update

2 [Bill Marella gave a presentation on the effort the

3 Authority has been putting forward regarding nursing

4 home HAI report collection. Mr. Marella discussed the

5 differences between the way infection data is collected

6 from hospitals using the CDC's NHSN and the way it is

7 collected from nursing homes using PA-PSRS. He

8 identified the longer term educational objective of

9 identifying the facilities that seem to have high or low

10 rates for any particular infection and try to correlate

11 these infection rates with known best practices and to

12 use this data to validate what are known to be the

13 practices which lead to lower infection rates. The

14 Authority wants to work with the facilities that have

15 higher infection rates to identify how they can improve

16 using best practices. He explained the high-performing

17 facilities will be recruited to help transfer knowledge

18 from their successful programs to other facilities. Mr.

19 Marella discussed some of the key differences between

20 hospital and nursing home reporting, including types of

21 infections, nursing home criteria being more clinical,

22 training, and methods of collecting data. He noted the

23 next stage in the implementation process is addressing

1 data integrity issues. Some data integrity is being
2 addressed through automation as the system automatically
3 prompts users to enter their facility's utilization data
4 and it alerts as to facilities not entering this data in
5 a timely manner.]

6 ***

7 Old Business

8 [Sharon Muscatell (from HAP) and Fran Charney gave an
9 overview of CUSP (Comprehensive Unit Safety Based
10 Program)/CLABSI Collaboration. Ms. Muscatell stated the
11 program started out with ten state hospital
12 associations, ten hospitals in each of the ten states
13 selected for the program, but because of the expansion
14 there was further outreach to some other hospitals. She
15 noted the aim of the program is to reduce central line
16 associated blood stream infections. Fran Charney
17 discussed the CUSP, noting the Authority's patient
18 safety liaisons, along with the infection control
19 analysts, will assist in the implementation. She stated
20 the patient safety liaisons will share evidence-based
21 practice to reduce the CLABSI rate, ensure checklist
22 completions and compliance and assist with staff
23 empowerment for checklist compliance. They will also

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1 assist with evaluating the AHRQ's hospital survey on
2 patient safety and the culture. Ms. Muscatell advised
3 the focus is on culture of safety, identifying the care,
4 learning from one another, and really committing to the
5 program.]

6 ***

7 New Business

8 [James Reilly, M.D. gave a presentation on the National
9 Surgical Quality Improvement Project and the potential
10 for collaboration with the Authority. He noted the
11 project resulted from a mandate from Congress to look at
12 health care in the VA hospitals in the early 1990's and
13 made its way into the general public arena just a few
14 years ago. The project employs a system that uses a
15 scientifically proven random selection process to sample
16 the surgical population. The PA NSQIP collaborative
17 wants to compare the data from the central NSQIP
18 databases among their member hospitals. He noted the
19 interest is in improving patient safety. Dr. Reilly
20 advised the purpose of the presentation was to make the
21 Authority aware of the consortium and what it is doing,
22 and to look for opportunities where they may be able to
23 work together on specific projects and achieve common

1 goals. Dr. Stanton Smullens stated he supported the idea
2 of the Authority setting up a group to work with the
3 consortium and decide how it might best help them.]

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5 [The meeting adjourned at 12:07 p.m.]

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PATIENT SAFETY AUTHORITY
BOARD OF DIRECTORS
REFERENCE INDEX
SEPTEMBER 8, 2009

TIME	COUNTER NUMBER	AGENDA
10:05	0150	Call to Order
10:06	0267	Approval of Minutes of the June 9, 2009 meeting.
10:07	0283	Report of the Executive Director
10:30	0552	HAI Initiative
10:50	1888	PA-PSRS Update
11:20	5148	Overview of CUSP/CLABSI Collaboration
11:30	6674	National Safety Quality Improvement Project Collaboration
12:07	1562	Adjournment