Contra Costa
Regional Medical Center
& Health Centers
A Division of Contra Costa Health Services

To: Professional Affairs Committee Members
From: Supervisor John Gioia – District I
Supervisor Diane Burgis – District III
By: Samir Shah, Chief Executive Officer
Contra Costa Regional Medical Center

Date: May 3, 2021
Subject: Meeting Notice
Professional Affairs Committee

This meeting will go to Closed Session.

PROFESSIONAL AFFAIRS COMMITTEE-VIA ZOOM

Due to the Covid-19 Public Health Emergency, this meeting will not be held in person. You may access the meeting remotely by using the Zoom information on page 2 of this agenda.

AGENDA

May 3, 2021, from 2:00 to 3:00 pm

AGENDA ITEM	RECOMMENDATION
I. **CALL TO ORDER** Meeting Chair- Supervisor John Gioia, District I	
II. **ADJOURN TO CLOSED SESSION** Supervisor Gioia	
III. **APPROVAL OF MINUTES** Supervisor Gioia	Inform/ Action
IV. **PATIENT SAFETY UPDATE** Sonia Sutherland MD, Medical Director of Quality and Safety Chair of Patient Safety and Performance Improvement Committee **A. Executive PSPIC Report**	Inform
V. **ADJOURN**	
Next Meeting: August 2, 2021	

****Reminder, this is a closed meeting.****

Please do not share the meeting information with anyone.

Zoom Webinar Meeting Instructions

Please click the link below to join the webinar:

https://cccounty-us.zoom.us/j/82173445327?pwd=bnQxcG1xZXNOWmJoampoK1YxdWtDUT09

Passcode: 540523

Or Telephone:

Dial:

USA 214 765 0478 US Toll

USA 888 278 0254 US Toll-free

Conference code: 154228

Or an H.323/SIP room system:

H.323: 162.255.37.11 (US West) or 162.255.36.11 (US East)

Meeting ID: 821 7344 5327

Passcode: 540523

SIP: 82173445327@zoomcrc.com

Passcode: 540523

EXEC PSPIC Report

Professional Affairs Committee

May 2021

Dr. Sonia Sutherland

SPEAK UP for SAFETY

Root Cause Analysis

RCA is a process of evaluation used to identify system issues in critical patient care events.
Applied to sentinel events, near-misses, and events requiring multidisciplinary case reviews.

Delayed Depo Provera Injection

Patient missed scheduled Depo Provera injection for contraception. Had a follow-up appointment but did not receive Depo Provera in a timely manner resulting in an unplanned pregnancy.

Actions/Preventive Measures

- Embed patient ed materials in AVS including, What to Do if you Miss a Depo Provera Injection, automatically with initiation of Depo Provera – *Completed*
- Appointments scheduled at Day 84 for Depo Provera – *Completed*
- No auto calculation presets in AVS – Only next appointment date – *Completed*
- Emergency Contraception prescription embedded in order set and given at start of Depo Provera program.- *Completed*
- BPA alerts for patients with orders but not given Depo Provera injection – *Completed*
- Reinvigorate Nursing break relief handoffs - *Completed*

ANNUAL SUMMARY

ROOT CAUSE AND SYSTEM ANALYSIS HIGHLIGHTS 2019-2020

The **Quality and Safety Team** uses a retrospective multidisciplinary systematic approach, **Root Cause Analysis (RCA)** to understand the **system causes** of SERS-reported adverse events/near misses and generate a list of **recommended corrective actions** that will prevent the errors from happening again **(Swiss Cheese Model of Medical Errors,** AHRQ and James Reason**)**.

We **thank our staff** who help us periodically in our RCA sessions by identifying situations or factors that may have produced the human errors and proposing changes to our systems of care to reduce the occurrence of errors or minimize their impact on patients. We are sharing with you some Hospital, Health Center, and Detention **RCA** highlights for 2019 - 2020 as the **themes are universal and the actions are applicable across units**.

OPIATE MANAGEMENT

- **Actions:** Review Opiate Withdrawal protocols – Medication Assisted Treatment with Suboxone; 12 steps; Chaplain services; Mental Health Triage; Temporary PM Mental Health shift.

PRE-OP CODE BLUE

- **Action**: ICU patients will be seen by Anesthesiologist in ICU before going directly to the OR and not Pre-op holding for a surgery.

PSYCH MEDICATION MANAGEMENT

- **Actions**: Email Psychiatrists about adjusting the dosing of emergency meds; Include patient care and safety concerns during Safety Huddle, Leadership Meeting; MH & Medical Staff communication.

SELF-HARM – DETENTION HEALTH

- **Actions**: Update mental health assessment, follow-up and consistency with track level assignments, incl training; ccLink banner identifying patients who have been on self-harm precautions during stay; Develop standard workflow for communicating trial outcomes and sentencing hearing dates; Patient education on mental health services; Referral to Psychiatry for medication related mental health referrals at intake; Communication to staff of immediate changes; Constant observation; Ligature resistant practices.

TRANSPORTATION ASSISTANCE - CANCER PATIENTS

- **Actions**: Cab vouchers are now available for urgent patient needs c/o MCS; Transportation Contact List Posting; Rideshare Service Program Access for eligible patients.

WORKPLACE VIOLENCE

- **Actions**: Directors & Managers offer support and assistance to staff members; Security forward possible crime reports/criminal charges to the DA's office as applicable. Standardize Personal Alarms for all staff at 4C, 4D, and PES.

MONTHLY SUMMARIES

SERS SUMMARY AND LESSONS LEARNED
MARCH 13 – APRIL 20, 2021

CA Code 1157, *For CCRMC/HC Use Only*; Contact Sonia.Sutherland@cchealth.org

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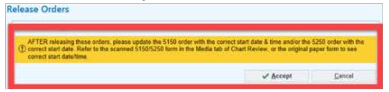
BIOPSY REQUISITION - RENAL/MUSCLE/NERVE/EYEBALLS/SKIN STANDARDIZED WORKFLOW – UCSF SEND OUTS

- Roles and Responsibilities Clarification: The **Hospitalist** will determine biopsy site and consult with the Surgeon and Pathologist to expedite the preparation of the biopsy samples and completion of the pathology specimen processing form. The **Surgeon** schedules the biopsy submission on Mon– Thurs before 10 AM. The **Pathologist** will contact UCSF if special transport time needs to be arranged in collaboration with the Hospitalist and Surgeon.
- **Shoutouts: Dr. David Longstroth** for communicating the workflow to the Hospitalists; **Dr. Michael Gynn** for communicating the workflow to the Surgeons; **Dr. Shweta Das** for updating the Send-Out Specimen Form and incl. all specimens.

HOSPITAL BED SAFETY AND BED RAILS

- According to FDA, the potential **benefits of bed rails are**: aids in turning and repositioning within the bed; provides a hand-hold for getting into or out of bed; provides a feeling of comfort and security; reduces the risk of patients falling out of bed when being transported; and provides easy access to bed controls and personal care items.
- **Tip:** When bed rails are being used, perform an **ongoing assessment of the patient's physical and mental status**; closely **monitor high risk patients** to optimize bed safety.

NEW BEST PRACTICE ALERT (BPA): 5150/5250 ORDERS FOR INPATIENT PSYCH, 4C AND 4D



- When a patient is admitted to 4C or 4D, the **Admitting RN** will release the Signed and Held 5150/5250 Orders Placed Prior to Admission.
- After releasing the order, the new BPA will appear reminding the **staff** to modify the 5150 Order with the correct start date and time and the 5250 order with the correct start date based on the official 5150/5250 paper/scanned document. After clicking Accept, the **RN** will modify the order, complete the ordering information, & sign the order as verbal w/ readback: cosign. The storyboard updates w/ the correct expiry date/time, 72 hours after the start date/time. **Shoutout: Psych Team**

HYPERKALEMIA ORDER PANEL CLARIFICATION

- Prevent delays by using the **Hyperkalemia (elevated potassium) Order Panel** while administering Insulin as a treatment for Hyperkalemia. The ccLink Order Panel **includes the orders for immediate glucose check** to assess for hypoglycemia. Standard use of order panels by providers helps prevent ordering errors.

AMBULATORY PATIENT TRANSPORATION ARRANGEMENT WORKFLOW REVISION

Submit Transportation Request to CCHP – **Care Coordinator** Arranges/Schedules Transport – Transport Occurs – **CCHP approves retroactively** for last minute requests & reconciles with claim when **Transport Provider** submits claim. **Shout Outs: Dr. Dennis Hsieh** for clarifying the CCHP Transportation Process. **Dr. Nichole Boisvert** for patient advocacy

Committee Name: Professional Affairs Committee
Meeting Date: May 3, 2021

Issue Name:	Presenter(s):
Patient Safety & Performance Improvement Committee (PSPIC)	Dr. Sonia Sutherland, Chair

Situation: Regular Report to the Committee
Background: PSPIC meets monthly.
Assessment/Findings:

Root Cause Analysis - Delayed Depo Provera

Event: Patient missed scheduled Depo Provera Injection for contraception. She had a follow-up appointment but did not receive Depo Provera that day due to a series of miscommunications, irregularities in the order, overbooked and busy clinic, and handoff issues with break relief staff.

She was rescheduled for treatment room appointment several weeks later. At this appointment she reported unprotected sex. Per protocol her pregnancy test was negative, and she received the Depo Provera injection. She was also given a prescription for Emergency Contraception which she did not pick up. Per protocol, she had a follow-up pregnancy test 3 weeks later that was positive. She is moving forward with the pregnancy & has begun prenatal care with Healthy Start. Depo Provera is a low-risk exposure to the pregnancy.

Key Lessons Learned:

- Patient education at the onset of Depo Provera contraception program is important. Review missed or late dose instructions to ensure patient is adequately informed and a good candidate.
- After visit summary (AVS) auto calculates a next dose due date based on first date initiation of Depo Provera which can be inaccurate and confusing for patients who are off schedule.
- Depo Provera appointments are scheduled 91 days after previous dose so if the patient missed the appt and reschedules their dose would already be late.
- If a patient misses her scheduled appointment, outreach by an appropriate staff member in addition to a phone message may be helpful for expedited follow-up.
- Communication from provider to primary nurse and primary nurse to relief nurse is essential.

Key Preventative Measures:

- Embed patient ed materials in AVS including, What to Do if you Miss a Depo Provera Injection, automatically with initiation of Depo Provera – Drs. D. Weinrich, T. Kaji, S. Sutherland; and L. Watts (Completed)
- Appointments scheduled at Day 84 for Depo Provera – Drs. A. Sandler, D. Weinrich (Completed)
- No auto calculation presets in AVS – Only next appointment date – Drs. A. Sandler, A. Buck (Completed)
- Emergency Contraception prescription embedded in order set and given at start of Depo Provera program. – Drs. A. Sandler, D. Weinrich (Completed)
- BPA alerts for patients overdue for Depo Provera injection – Dr. T. Kaji (ETA 3/15/21)
- Standardize handoffs - G. Bhandal, C. Killough, D. Kaufman (Completed)

Timely Depo Provera

Attached – Annual RCA Summary 2019-2020; Monthly SERS Summary – January & February & March

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Recommendations/Actions: What actions should the committee take?

Who	What	When
Committee	Accept the Report	Upon Presentation

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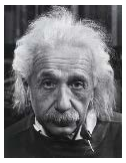
SERS SUMMARY AND LESSONS LEARNED DEC. 17, 2020 – JAN. 29, 2021

"The only mistake in life is the lesson not learned" – Albert Einstein



DELAYED DEPO PROVERA INJECTION AND UNPLANNED PREGNANCY

Patient missed scheduled Depo Provera injection for contraception. Had a follow-up appointment but did not receive Depo Provera in a timely manner resulting in an unplanned pregnancy.

Lesson Learned…***Communication and verbal check-ins between nurse and provider facilitate safety in a busy & overbooked clinic; Handoff that is both verbal and written between nurse and break-relief is key; Patient education around the risks of delayed depo injections, and Emergency Contraception prescription at home for immediate use just in case of unprotected sex and late Depo.***

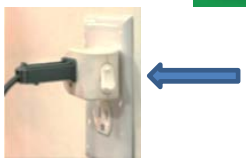
Next Steps! ***Updates to Smart set including patient friendly education sheet, clear instructions for pregnancy test needed for Depo Provera after 91 days; reinvigorating handoffs between relief staff; and schedule depo follow-up appointments 12 weeks out rather than the 13-week cycle which is already one week late.***

WRONG MEDICATION NEAR MISS

Wrong patient almost received Remdesevir. Near miss for the wrong patient because the error was caught and med not infused. However, scare, and expensive medication had to be wasted and remade. Delay in treatment to the right patient with Covid.

Lesson Learned…***Take the time to get it RIGHT!***
Shout Out! ***Pharmacy for quickly preparing the replacement Remdesevir***

TRANSLATION PHONE AND DROPPED CALLS



During an end-of-life discussion with a critically ill ICU patient's family to address issues of withholding and withdrawing care, the translation phone used for the discussion dropped the call multiple times.

Lesson Learned…***Reboot! Going forward Facilities will reboot translation phones on a regular basis to prevent faulty connections***

Shout Out! ***Dr. David Brody, Medical Social Worker Carolyn Brooks, and staff for persistence/ completion of the family meeting.***

An apology to the patient, the family, and the staff for the equipment issues that interrupted a delicate discussion of life and death matters

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SERS SUMMARY AND LESSONS LEARNED JAN 30 – FEB 16, 2021

COVID CLARITY

INADEQUATE WARM HANDOFF RESULTED IN POTENTIAL HIGH RISK COVID EXPOSURE (Patient selectively disclosed Covid exposure after initial screening).

Continue warm handoffs of any potential Covid exposure and wear appropriate PPE.

MEDICATION NEAR MISS – WRONG PATIENT ALMOST RECEIVES REMDESIVIR RESULTED IN COVID PATIENT'S TREATMENT DELAY

Take the time to get it right.

MEDICATION

OPEN VIALS OF MEDICATIONS WITHOUT AN EXPIRATION LABEL INCREASES THE RISK OF CONTAMINATION AND INFECTION

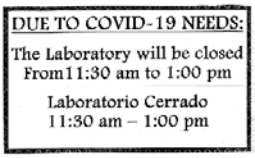
Personal accountability. No way around manual process to label by Nursing.

UNCLAMPED IV LINE THAT LED TO DELAY IN ANTIBIOTICS TREATMENT

Avoidable with visual inspection of IV lines during shift-to-shift handoff and intentional rounding.

PATIENT EXPERIENCE

LAB CLOSES UNEXPECTEDLY, CLOSED FOR LUNCH WITHOUT CLEAR COMMUNICATION THAT CREATED ADVERSE PATIENT EXPERIENCE



The unexpected may happen but communicate immediately. WCHC signage

SUICIDE PREVENTION

TEENAGER REPORTED DEPRESSION AND SUICIDAL THOUGHTS SAVED BY QUICK STAFF ACTIONS

Youth crisis line; Behavioral Health Therapist; admission and treatment.

Suicide is 2nd leading cause of death in ages 15-24 per CDC 2019

Youth Mobile Response Team

877 441-1089

SHOUTOUTS FOR "A JOB WELL DONE" IN SUPPORTING SAFE OPERATIONS

- **Dr. Olga Kelly; CSM Kelley Taylor, RN; B.H. Therapist Cheryl; & Concord Health Staff** for **preventing** potential teen suicide.
- **Dr. Andrea Sandler for sharing patient's lab closure concern Arturo Hernandez, WCHC, and Lynnette Watts** for developing **lab signage**.
- **Dr. David Longstroff and RN Yupa Assawasuksant** for **confirming Contact Isolation Precautions** with **Infection Control**.
- **Dr. Lauren Wondolowski** for reporting safety concerns.
- **Drs. Mark Willie, Oliver Graham, and Troy Kaji** for updating ccLink with guard rails – 6-week limit on High Dose Vit D Therapy to prevent hypercalcemia in Hyperparathyroid patients.
- **Kenneth L. Edmark** for **Self-Reporting** a Near Miss.
- **Pharmacy** for **quickly** preparing the replacement Remdesivir.
- **Rabbert Allan A. Bala** for identifying a wound as **POA** (present on admission).

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SERS SUMMARY AND LESSONS LEARNED

FEB 17 – MAR 12, 2021

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COVID TESTING CLARITY FOR PATIENTS WITH COVID + SWAB WITHIN 3 MOS PRIOR TO ADMISSION

Covid testing is not warranted if the patient is asymptomatic (per **CDC Guidelines and Infection Control**).

COVID VACCINES in CA IMMUNIZATION REGISTRY (CAIR)

Review CAIR System to accurately identify, date, location, and type of vaccine for any patient in our system.

CRASH CART STOCKED, LOCKED, AND READY TO GO

Every minute counts in a Code Blue. To ensure readiness after each code, **Sterile Processing Department (SPD)** will check all drawers prior to calling Pharmacy to lock the Crash Cart. **Pharmacy** will do a redundant check of all drawers before locking cart.

EXTERNAL SPECIALTY REFERRALS FOR MEDICARE ONLY PATIENTS – Acute Back Pain & Severe Stenosis

ccLink External Specialty Referrals for Medicare Only patients are now being processed by **CCHP & CCRMC Care Coordinators.**

LATEX ALLERGY – OPERATING ROOM (OR)

To prevent use of a latex foley catheter in a patient with a latex allergy, these immediate actions were taken: Elimination of latex foley catheters in the OR; Latex allergies added to surgery schedule; Allergies written in red on OR white board; **Circulator Nurse & Scrub Tech** verify type of foley before placement.

PRESENT ON ADMISSION (POA) DOCUMENTATION

To improve the quality of care and patient outcomes, **Medicare** requires hospitals to submit **POA documentation** for claims to be approved for certain diagnosis (in addition to clear patient history and patient exam).

SPECIMEN CHAIN-OF-CUSTODY – LEEP Procedure

To ensure the integrity and security of the specimen from the point of specimen collection and transition to storage and analysis at the lab, follow the universal protocols and documentation that include: ccLink checkbox affirming the specimens collected are confirmed; labeling of the specimen; identification of all persons who handle the specimen; dates; security of the specimen.

SHOUTOUTS FOR "A JOB WELL DONE" IN SUPPORTING SAFETY

- **Dr. Alan Siegel, Kristin Burnett, Grace Dwyer & ccLink Team** for verifying patient's Covid Vaccine site.
- **Dr. James Walls** for initiating & clarifying the External Specialty Referrals workflow for **Medicare Only** patients.
- **Drs. Tara Lehman & Judy Bliss** for standardizing the specimen collection process and accountability.
- **Drs. Tara Lehman & Troy Kaji** for revising ccLink to incl. checkbox affirming specimens collected are confirmed.
- **Dr. Tara Lehman & Cheryl Standley** for standardizing the provider-nurse handoff and labeling of specimen.
- **Dr. Troy Kaji** for modifying ccLink to redirect external specialty referrals to appropriate staff.
- **Donna Kaufman** for coordinating the specimen chain-of-custody improvement work.
- **Gino Rogers, NPM** Periop for implementing the strongest level of corrective action in safety events.
- **Grace Ma, NPM** for ***immediate SERS review, follow-up, and documentation*** of Covid testing status.
- **Shideh Ataii, Pharm D.** for standardizing workflows, roles, and responsibilities of Pharmacists.
- **SPD staff & Pharmacist, Kristie Tran** for ***speaking up for safety*** and reporting cart ***near miss.***
- **Orlando Rodriguez, Marina Shenouda, Eddie Mendoza-Ong, Jennifer Sanchez, Lindsay Tock, & Angela Cottone** for identifying a wound as **POA (*present on admission*)**.

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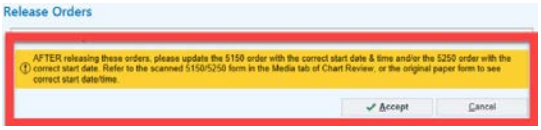

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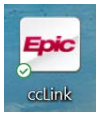

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