FY 2015 VA NCPS Patient Safety Centers of Inquiry (PSCI) Accomplishments

The **VA NCPS Patient Safety Centers of Inquiry (PSCI)** are research and implementation centers within VA funded to develop practical tools to improve patient safety at the bedside. To be successful, a center is expected to develop, disseminate and, most importantly, implement clinically relevant innovations that improve patient safety in VHA facilities. Successful PSCIs provide specific tools for the field that can help to improve patient safety. The PSCIs had a total of 89 peer-reviewed publications in FY 2015.

In FY 2015 they achieved the following:

1. **Improved the process of safety planning for suicidal patients.** This helps suicidal Veterans make a plan to seek help if they become actively suicidal. PSCI efforts continued via conducting four projects, all focusing on safety planning for patients known to be at high risk for suicide, and six pilot projects (two in FY 2014 and four in FY 2015).
2. **Developed and evaluated a pilot patient safety dashboard.** The current version of the GPS date display tool includes overall event rates and rates within categories. The tool has been revised in FY 2015, and customized in collaboration with each facility to: 1) identify system-level factors impacting safety, 2) track hospital-level surgical errors, 3) monitor patient safety improvements, and 4) benchmark hospitals' performance against national rates.
3. **Updated the NCPS Falls Toolkit and developed protocols for reducing injurious fall, hazardous wandering and improve patient handling**. Evaluated the properties of commercially-available medical helmets; conducted an analysis of wheelchair falls, and integrated falls data into a data display tool.
4. **Developed and piloted tools to promote safe opioid therapy prescribing in primary care, including point-of-care decision support and an opioid dashboard.**
5. **Developed a toolkit to improve timely communication of test results, developed guidance to reduce "missed" test results as well as delays in diagnosis and treatment**. They are currently refining and testing trigger algorithms to identify missed opportunities for follow-up of abnormal thyroid stimulating hormone (TSH) tests in outpatients. Our ultimate goal is to develop a portfolio of triggers for multiple test results, which can be applied to all VA facilities. Development of prototype software system called AWARE (Alert Watch And Response Engine) to support providers by presenting reminders and recommendations to providers if a specified type of abnormal alert notification has not been addressed.
6. **Development and piloting of a delirium toolbox to better identify and treat delirium in VHA.** Build an electronic delirium risk measure using the VA Corporate Data Warehouse (CDW).
7. **Development and piloting of a program to reduce rates of catheter-associated urinary tract infections.** Develop a comprehensive list of appropriate indications for the initial placement and continued use of indwelling urinary catheters, using the best available scientific evidence and a systematic rating process of appropriateness by a multidisciplinary expert panel. Developed effective strategies for implementing an evidenced-based CAUTI prevention program within VA; and developed effective strategies for implementing an evidenced-based CAUTI prevention program in long-term care
8. **Development and national roll-out of a kiosk-based system to improve medication reconciliation (MR).** The PSCI continues to focus on facilitating dissemination of tools and knowledge regarding medication safety and MR. We also continue to provide consultative support to VISN 20 leadership and VISN 20 facilities in completion of deployment of the VetLink kiosk in anticipation of MRAR. The PSCI continues to lead the way in developing and implementing organizational change management tools and activities to assure successful MR implementation.
9. Development of a human factors-based system to study and reduce hospital-acquired infections.

Patient Safety Centers of Inquiry in FY 2015

PSCI Topic	Facility	VISN	Key Contact	Web-links
Delirium Toolbox . To help identify and treat delirium and reduce adverse events associated with delirium.	VA Boston HCS	1	James Rudolph, M.D.	www.heartbrain.com/delirium
Patient Safety Measurement. Surveillance of CAUTIs, use of AHRQ patient dafety indicators, patient safety data display, and use of IHI trigger tools.	VA Boston HCS	1	Amy Rosen, Ph.D.	http://www.choir.research.va.gov/affiliated_center_PSC.asp
Preventing adverse events related to mobility. Twelve proposed projects on prevention of injurious falls and hazardous wandering.	Tampa VAMC	8	Tatiana Bulat, M.D., Pat Quigley, Ph.D. and Gail Powell-Cope, Ph.D.	http://www.visn8.va.gov/visn8/patientsafetycenter/
Preventing Catheter-Associated Urinary Tract Infections. Developing strategies for the appropriate use and removal of urinary catheters.	Ann Arbor VAMC	11	Sanjay Saint, M.D., support Karen Fowler	www.catheterout.org – website focusing on catheter-associated urinary tract infection prevention www.improvepicc.com – website highlighting findings from Michigan Appropriateness Guide for Intravenous Catheters (MAGIC) http://i-aasc.org/ -international – Ann Arbor safety collaborative, highlighting international work of our team http://psep.med.umich.edu/ - VA-UM Patient Safety Enhancement Program, highlighting all work done by our team www.va-hope.org – Hospital Outcomes Program of Excellence (HOPE) initiative website focusing on preferred practices for our gold medicine team and improving inpatient care
Improve Outpatient Safety Through Effective Electronic Communication. Includes management of alerts and reducing treatment delays and lost information.	Houston VAMC	16	Hardeep Singh, M.D.	**Communication of Test Results Toolkit SharePoint site** **VA employees can click to:** http://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NC/10NC3/CTR/default.aspx **Ten strategies providers can use to improve management of "View Alert" notifications in CPRS**

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				VA employees can click to: https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NC/10NC3/CTR/Shared%20Documents/Communication%20of%20Test%20Results%20Toolkit%20and%20Appendices%20(published%20June%202012)/Appendix%20A2-Ten%20Strategies%20Providers%20Can%20Use%20to%20Improve%20Managment%20of%20View%20Alert%20Notifications%20in%20CPRS.pdf **Eight recommendations for policies for communicating abnormal test results** **VA employees can click to:** https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NC/10NC3/CTR/Shared%20Documents/Communication%20of%20Test%20Results%20Toolkit%20and%20Appendices%20(published%20June%202012)/Appendix%20A-Eight%20Recomendations%20for%20Policies%20for%20Communicating%20Abnormal%20Test%20Results.pdf **VHA Directive 1088** http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3148 This policy provides guidance for VISNs and facilities for setting up local policies and procedures for communicating test results to providers and patients. **The Power and Perils of Electronic Health Records** VA Research Quarterly Update (Fall 2014) *A Chat with Our Experts* http://www.research.va.gov/pubs/varqu/fall2014/fall14-4.cfm **An interview with Dr. Hardeep Singh** Veterans Health Administration Office of Informatics and Analytics *The Human Factors Quarterly* (Issue 12, Fall 2015) Christopher Petteys, MBA, Human Factors Engineering, Office of

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				Informatics and Analytics http://www.ehealth.va.gov/docs/HFNL/HF_NL_F15_I12.htm#article3 **Center for Innovations in Quality, Effectiveness and Safety** Hardeep Singh, M.D., MPH. http://www.houston.hsrd.research.va.gov/bios/singh.asp **SAFER Guides** https://www.healthit.gov/safer/
Using Human Factors Science to Reduce Vascular Access Device (VAD) Complications. Also providing education in human factors.	Salt Lake City VAMC	19	Frank Drews, Ph.D.	**VA employees can click to:** http://vaww.va.gov/humanfactors/
Medication Reconciliation. Leading the national rollout of the kiosk-based medication reconciliation program.	Portland VAMC	20	Blake Lesselroth, M.D.	http://www.portland.va.gov/Portland_Informatics_Center.asp
Opioid Therapy. Point-of-care clinical decision support system - ATHENA-OT, metrics to facilitate monitoring of opioid therapy.	VA Palo Alto Health Care System	21	Jodie Trafton, Amanda Midboe and Eleanor Lewis, Ph.D.	http://www.chce.research.va.gov/Default.asp
Suicide Prevention. Coordinated with the national suicide prevention group. Studying safety planning with high-risk patients.	VACO suicide prevention	VHA	Dr. Monica Matthieu and Dr. Ira Katz	**VA employees can click to:** http://vaww.mentalhealth.va.gov/rc-suicideprevention.asp