

VA NCPS Patient Safety Centers of Inquiry (PSCI) Funded for FY 2016 Through FY 2018

VA NCPS manages the centers, which are an integral part of our program since 1999,

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.

PSCI Topic	Facility	PI	Goals for PSCI
Falls and Wandering	Tampa VAMC	Tatjana Bulat, M.D.	<p>FALL INJURY PREVENTION FOCUS:</p> <ol style="list-style-type: none"> 1. Fall Risk Assessment for Home Based Primary Care (HBPC) 2. Novel Compliant Flooring for Fall Injury Prevention 3. Stand Bar to Improve Safety and Independence in Power Wheelchair Users <p>HAZARDOUS WANDERING /MISSING INCIDENTS FOCUS:</p> <ol style="list-style-type: none"> 4. Wandering Behaviors and Negative Outcomes Among Early Trajectory of Wandering Study Participants <p>SAFE PATIENT HANDLING AND MOBILITY FOCUS:</p> <ol style="list-style-type: none"> 5. Safe Patient Handling and Mobility (SPHM) Technologies in Rehabilitation to Improve Patient Mobility and Function
Catheter and PICC Safety, Preventing Device-Associated Harm	Ann Arbor VAMC	Sanjay Saint, M.D.	<p>Project 1. Reduce the incidence of urinary catheter-related complications (e.g., CAUTI) in VHA by developing effective strategies for implementing a recently developed comprehensive list of appropriate indications for the use of indwelling urinary catheters, with a focus on critically ill Veterans</p> <p>Project 2. Reduce the incidence of PICC-related complications (e.g., CLABSI, VTE) in VHA by developing effective strategies for implementing a newly developed comprehensive list of appropriate indications for the use of PICCs</p> <p>Project 3. Identify future areas for improving patient safety within VHA by identifying and comparing current infection prevention practices among all VHA hospitals</p>

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Prevention of Multidrug-Resistant Organisms (MDROs) in VA Using Human Factors Methods	Madison, Middleton VAMC	Nasia Safdar, M.D.	<ol style="list-style-type: none"> 1) Use a human factors engineering approach to implement daily chlorhexidine bathing using 4 percent liquid chlorhexidine in the following patient care environments in VA <ol style="list-style-type: none"> i) Non-ICU medical-surgical units ii) Long-term care iii) Spinal cord injury unit 2) Evaluate the implementation and impact of the daily chlorhexidine bathing intervention using a multiple case study approach 3) Assess the costs of daily chlorhexidine bathing by undertaking a budget impact analysis.
Chronic Kidney Disease - Pre-Dialysis CKD Population Safety	Baltimore VAMC	Leslie Katzed, M.D.	<p>Focus on reducing adverse events unique to the pre-dialysis older CKD population, with dissemination of successful innovations and practice across VHA</p> <ol style="list-style-type: none"> 1a) Develop CKD-specific safety management protocol 1b) Create implementation plan to disseminate through VHA 2a) Develop CPRS surveillance protocol to identify CKD patients at risk of adverse events 2b) Evaluate effectiveness of CPRS-based protocol 3a) Develop decision support algorithms for prevention of common CKD adverse events (e.g., hypoglycemia, hyperkalemia, falls) 3b) Evaluation of effectiveness of decision support system
Center for Usability and Safety Testing Using Human Factors Engineering (HFE)	Pittsburgh VAMC	Jamie Estock	<ol style="list-style-type: none"> 1. Develop standardized HFE evaluation protocols that allow VHA to compare medical product use-related hazards across manufacturers 2. Conduct HFE evaluations to support the purchase and implementation of safe medical products at VHA 3. Develop a Web-based product comparison tool to provide stakeholders from across VHA ready access to medical product safety information 4. Disseminate findings outside of VHA to guide the future design, development and approval of safe medical products
Reduction of Perioperative Opioid-Related Adverse Events	Durham VAMC	Karthik Raghunathan	<ol style="list-style-type: none"> a) Identify interventions that are objectively associated with reduced short- and long-term opioid utilization and significantly fewer adverse effects b) Adapt effective interventions from 'successful' VAMCs to other VAMCs where there is objective room for improvement in care c) Assess the effectiveness of these innovative plans via ongoing surveillance for PORADEs and POFS throughout the VHA

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Measurement of Patient Safety	Boston VAMC	Amy Rosen, Ph.D.	Project: <ol style="list-style-type: none"> 1. Development and assessment of Guiding Patient Safety (GPS) data display tools project 2. Electronic surveillance of Hospital-Acquired Infections (HAIs) project 3. Creating a composite patient safety measure of HAIs project 4. Detecting Intraoperative Adverse Events (IAEs) using retrospective and prospective methods: a step towards better surgical outcomes assessment
Houston - Diagnostic Error	DeBakey, Houston VAMC	Hardeep Singh, M.D.	Aim 1. Develop and evaluate a diagnostic safety surveillance system (Safer Dx Watch) for measurement of diagnostic missed opportunities Aim 2. Develop and evaluate a proactive risk-assessment guide to assess institutional practices related to measurement and feedback of diagnostic safety (Safer Dx Guide)
Cancer Care Tracking System (CCTS)	New Haven, VA Connecticut	Cynthia Brand, M.D., Michal Rose, M.D., and Tamar Taddei, M.D.	<ol style="list-style-type: none"> 1. Develop a standardized process for implementing a cancer coordination and tracking system to improve patient safety by preventing delays in diagnosis and treatment 2. Facilitate the implementation of CCTS app as a cancer care coordination tool to all stations in the region and improve its user interface 3. Develop metrics and management tools to evaluate the impact of implementing this system of care on the key stakeholders (patients and providers)
Suicide Prevention	White River Junction VAMC	Brian Shiner MD, MPH and Natalie Riblet MD, MPH	Aim 1. Review the literature in order to identify strategies shown to have the greatest effect in preventing completed suicide Aim 2. Review RCAs of suicides occurring within seven days of discharge from a VA facility Aim 3. Incorporate the findings of Aim 1 and 2 to develop an intervention to be piloted locally Aim 4. Validate and test a medical records-based linguistic measure of suicide risk for operational use within the VHA

Examples of Contributions to VA’s Patient Safety Efforts Include:

- Improving electronic communication and alerts
- Improving patient safety during moderate sedation
- Improving home safety for high-risk patients as well as using human factors principles to reduce hospital-acquired infections and improve the sterilization of reusable medical equipment
- Teamwork and simulation training
- The application of usability testing and human factors design to bar-code medication administration

- Breakthrough series collaboratives designed to reduce patient falls, reduce adverse drug events, and improve safety in high-risk settings
- Extensive work in the areas of safe patient handling and movement and patient fall prevention and management
- Studies of fatigue and its effects on clinicians' performance
- Improvement in the safety of drug prescribing practices and medication administration
- Providing interventions to decrease preventable ADEs, including medication reconciliation and reduction in medication errors related to the ordering of chemotherapy for treatment of malignancy
- Improving patient safety in the use of the electronic medical record
- Reducing hospital-acquired infections
- Using human factors principles to improve patient safety
- Improving the safety of sterilization of reusable medical equipment

PSIC staff members also routinely publish articles in scholarly journals (more than 85 articles were published in FY 2015 alone)

Expectations for PSCIs

- Develop, implement and demonstrate interventions in multiple VHA facilities to promote practices that improve patient safety by reducing adverse events or that replace or improve practices known to be associated with patient safety problems
- Document changed practices and/or systems that reduce the likelihood of adverse events in multiple VHA facilities
- Document the methods employed to foster changing practices and systems so that other VHA facilities can implement similar or identical changes to improve patient safety
- Develop, test, refine and facilitate active distribution of tools and products specifically designed to promote patient safety, such as: clinical tools, cognitive aids, educational materials, measures of patient safety, policy reports; VHA information letters, handbooks, and/or directives; and others
- Tools and other output should be evaluated for effectiveness and impact

Learn More

The PSCI program is funded through VA NCPS on a three-year cycle. Please contact Peter.Mills@va.gov for more information.