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University HealthSystem Consortium
Joint Council Meeting

PSOs: To Participate or Not: Advantages, Disadvantages and Questions Answered

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Michael R. Callahan
Katten Muchin Rosenman LLP
525 West Monroe Street
Chicago, Illinois 60661
(312) 902-5634
michael.callahan@kattenlaw.com

Objectives

- Discuss the advantages/disadvantages of participating in a PSO
- Articulate the confidentiality and privilege provisions
- Review hypothetical scenarios on how PSO protections can be applied
- Examine what risk management work product materials would and would not be eligible for protection
- Describe other quality of care benefits achieved through PSO participation

The Patient Safety Act

- **Background**
- **Purpose**
- **Who is Covered under the Act and What is Required**
- **The PSES and Reporting to a PSO**
- **Confidentiality and Privilege Protections**

Background

- **Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act)**
  - **Signed into law July 29, 2005**
- **Final rule published November 21, 2008**
- **Rule took effect January 19, 2009**

Impetus for the Act

- Healthcare workers fear disclosure
- State-based peer-review protections are:
  - Varied
  - Limited in scope
  - Not necessarily the same for all healthcare workers
- No existing federal protections
- Data reported within an organization is insufficient, viewed in isolation and not in a standard format

Patient Safety and Quality Improvement Act (PSQIA) Purpose

To encourage the expansion of voluntary, provider-driven initiatives to improve the quality and safety of health care; to promote rapid learning about the underlying causes of risks and harms in the delivery of health care; and to share those findings widely, thus speeding the pace of improvement.

- Strategy to Accomplish its Purpose
  - Encourage the development of PSOs
  - Establish strong Federal and greater confidentiality and privilege protections
  - Facilitate the aggregation of a sufficient number of events in a protected legal environment.

Why Participate in a PSO?

- **Regulatory mandates**
- **Employer and payer demands**
- **Just Culture – Joint Commission Sentinel Alert**
- **It's good business**

Why Participate in a PSO? Regulatory Mandates

Illinois Health Care Adverse Event Reporting Law

- **Implementation in 2010**
- **Calls for reporting of twenty-four specific "never" events to the state, along with root cause analysis and corrective action plans**
- **PSO participation will enable learning from experience of others and consultation in developing these mandatory resources**
- **PSO provides protection for supporting documents but not the RCA and action plan submitted to state (unless re-created)**

Why Participate in a PSO? Employer and Payer Demands

Leapfrog Group challenge to all providers: adopt a four-pronged transparency strategy with patients when a "never" event occurs, including:

- **Apology**
- **Internal root cause analysis**
- **Waiver of related charges**
- **Reporting for learning - can best be met through a PSO**

Denial or reduction of reimbursement by payers and PHP initiatives

Why Participate in a PSO?
TJC Sentinel Event Alert

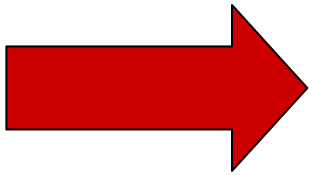
- Leadership Committed to Safety
  - "A safe clinical environment is strengthened when work processes allow leaders and staff to discuss and learn about safety issues together."
  - "A thorough and appropriate evaluation of adverse events is necessary to help prevent future occurrences."
  - Suggested Actions:
    - "….hold open discussions …that focus on learning and improvement….."

Why Participate in a PSO? It's Good Business

- **Consumer groups and advocates have called for substantially more engagement of the patient and the public in improving healthcare systems**
- **Better and safer care should be more efficient care which costs less in dollars as well as in patient suffering, clinician frustration and unhappiness**
- **Healthcare providers want to provide the best possible care, but at times the fear of disciplinary action and/or liability prevents this. PSO provides a safe environment where providers can learn.**

Long-Term Goals of the PSQIA

- **Encourage the development of PSOs**
- **Foster a culture of safety through strong Federal and State confidentiality and privilege protections**
- **Create the Network of Patient Safety Databases (NPSD) to provide an interactive, evidence-based management resource for providers that will receive, analyze, and report on de-identified and aggregated patient safety event information**

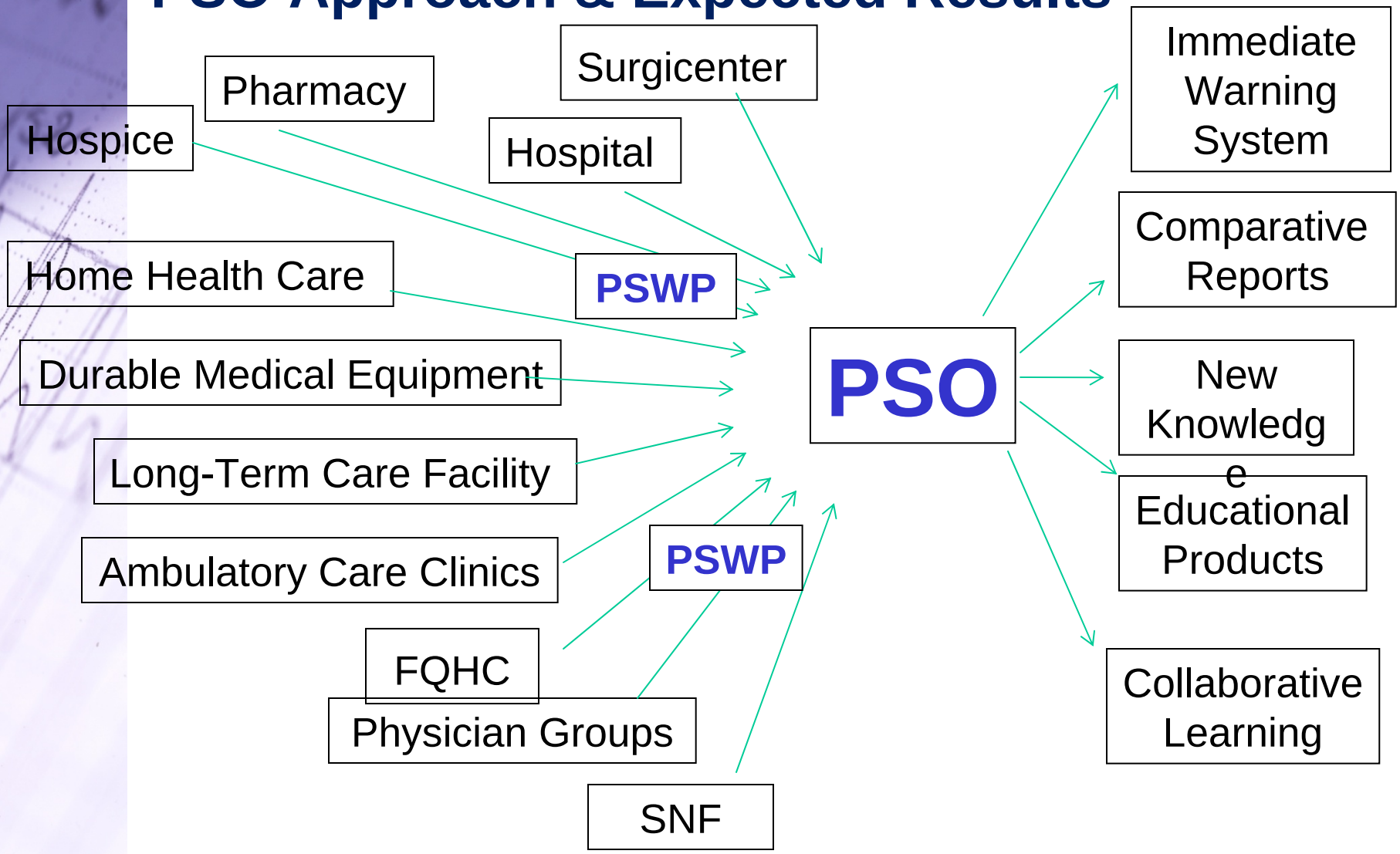


Further accelerating the speed with which solutions can be identified for the risks and hazards associated with patient care through the magnifying effect of data aggregation

Who or What Does the Act Cover?

- **Provides uniform protections against certain disciplinary actions for all healthcare workers and medical staff members**
- **Protects Patient Safety Work Product (PSWP) submitted by Providers either directly or through their Patient Safety Evaluation System (PSES) to Patient Safety Organizations (PSOs)**
- **Protects PSWP collected on behalf of providers by PSOs, e.g., Root Cause Analysis, Proactive Risk Assessment**

PSO Approach & Expected Results



Essential Terms of the Patient Safety Act

- **Patient Safety Evaluation System (PSES)**
- **Patient Safety Work Product (PSWP)**
- **Patient Safety Organization (PSO)**

Patient Safety Evaluation System (PSES)

PSES Definition

Body that manages the collection, management, or analysis of information for reporting to or by a PSO (CFR Part 3.20 (b)(2))

- **Determines which data collected for the PSO is actually sent to the PSO and becomes Patient Safety Work Product (PSWP)**
- **PSES analysis to determine which data is sent to the PSO is protected from discovery as PSWP**

Patient Safety Work Product (PSWP)

PSWP Definition

Any data, reports, records, memoranda, analyses (such as Root Cause Analyses (RCA)), or written or oral statements (or copies of any of this material) which could improve patient safety, health care quality, or health care outcomes;

And that:

- **Are assembled or developed by a provider for reporting to a PSO and are reported to a PSO, which includes information that is documented as within a PSES for reporting to a PSO, and such documentation includes the date the information entered the PSES; or**
- **Are developed by a PSO for the conduct of patient safety activities; or**
- **Which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a PSES**

What is NOT PSWP?

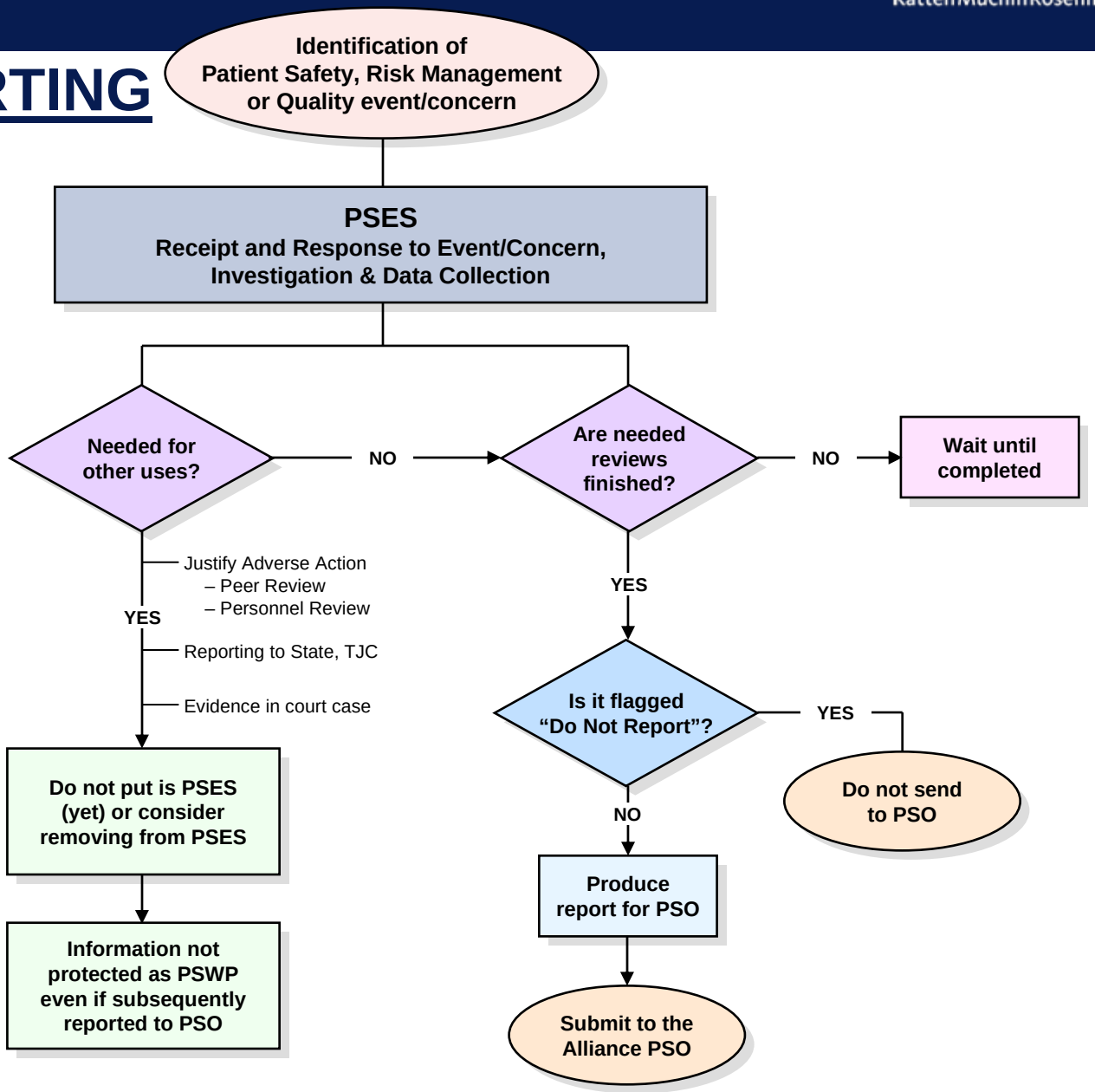
- **Patient's medical record, billing and discharge information, or any other original patient or provider information**
- **Information that is collected, maintained, or developed separately, or exists separately, from a PSES. *Such separate information or a copy thereof reported to a PSO shall not by reason of its reporting be considered PSWP***
- **PSWP assembled or developed by a provider for reporting to a PSO but removed from a PSES and no longer considered PSWP if:**
  - **Information has not yet been reported to a PSO; and**
  - **Provider documents the act and date of removal of such information from the PSES**

What is Required?

Establish and Implement a Patient Safety Evaluation System (PSES), that:

- **Collects data to improve patient safety, healthcare quality and healthcare outcomes**
- **Reviews data and takes action when needed to mitigate harm or improve care**
- **Analyzes data and makes recommendations to continuously improve patient safety, healthcare quality and healthcare outcomes**
- **Conducts RCAs, Proactive Risk Assessments, in-depth reviews, and aggregate RCAs**
- **Determines which data will/will not be reported to the PSO**
- **Reports to PSO(s)**

PSO REPORTING



Designing Your PSES

- Events or Processes to be Reported
  - Adverse events, sentinel events, never events, near misses, HAC, unsafe conditions, RCA, etc
- Committee Reports/Minutes Regarding Events
  - PI/Quality committee, Patient safety committee, Risk Management committee, MEC, BOD
- Structures to Support PSES
  - PI plan, safety plan, RM plan, event reporting and investigation policies, procedures and practices, grievance policies and procedures

Event/Incident Reporting Policy

- **Modify existing policies as needed to reflect the purpose of internal event reporting is to …**
  - **Improve patient safety, healthcare quality and patient outcomes**
  - **Provide learning opportunity through reporting to a PSO**
- **Include a process (through the PSES) for the removal of incidents from PSES or separate system for …**
  - **Disciplinary action**
  - **Just culture**
  - **Mandatory state reporting**
  - **Independent/separate peer review**

Questions To Answer When Developing PSES Policy

Who or What Committee(s)

- **Collects data that will be reported to a PSO?**
  - **Single source or multiple sites?**
  - **Single department or organization wide event reporting?**
- **Analyzes data that will be reported to a PSO?**
- **Removes data from PSES prior to reporting to a PSO?**
- **Submits the data from the PSES to the PSO(s)?**
  - **Committee or individual authorized submission?**

Questions To Answer When Developing PSES Policy

What data should be …

- **Collected to report to a PSO?**
  - **Patient safety data, healthcare quality and outcomes data**
    - *** Data cannot be used for adverse disciplinary, versus remedial, employment action, mandated state reporting**
- **Removed from PSES prior to reporting to a PSO?**
  - **Criteria based or subjective case-by-case decision making**
  - **Peer review information that could lead to disciplinary action**
- **When is data …**
  - **Reported to PSES?**
  - **Removed from PSES?**
  - **Reported to PSO?**
    - *** Each date must be documented**

How Does a Provider Determine Which Data Should Be Reported To A PSO?

Criteria-based Prioritization

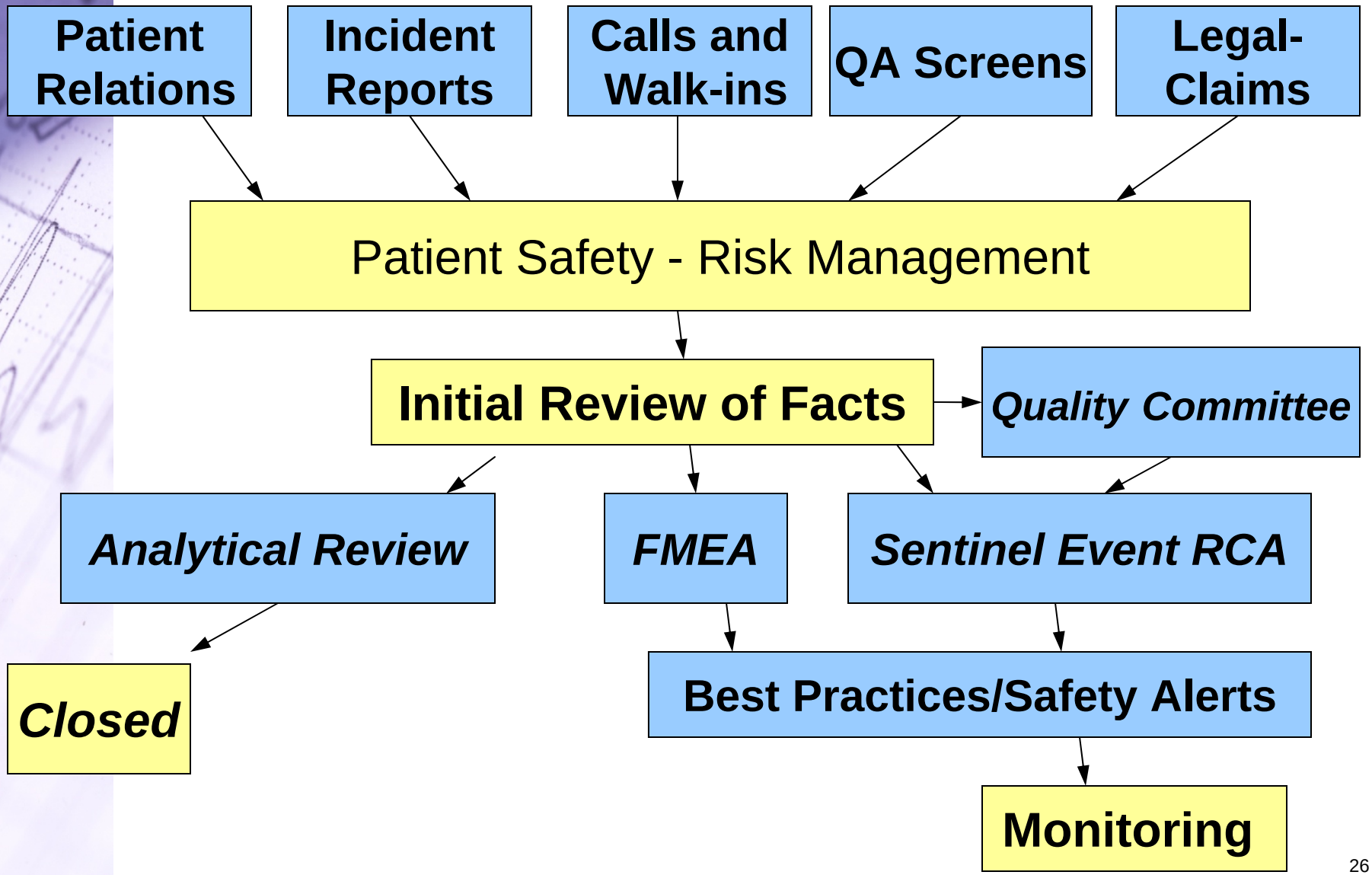
Suggested criteria

- **Promotes culture of safety/improves care**
- **Impressions/subjective data that is not available in the medical record**
- **Information that could be damaging during litigation**
- **Not required to report elsewhere**
- **Required to report elsewhere, but data for reporting could be obtained from medical record**
- **Data will not be used to make adverse employment decisions**

Types of Data PSES May Collect and Report To The PSO

- **Medical Error, FMEA or Proactive Risk Assessments, Root Cause Analysis**
- **Risk Management – incident reports, investigation notes, interview notes, RCA notes, notes rec'd phone calls or hallway conversations, notes from PS rounds**
- **Outcome/Quality—may be practitioner specific, sedation, complications, blood utilization etc.**
- **Peer Review**
- **Committee minutes–Safety, Quality, Quality and Safety Committee of the Board, Medication, Blood, Physician Peer Review**

Risk Management & Patient Safety Events Flow

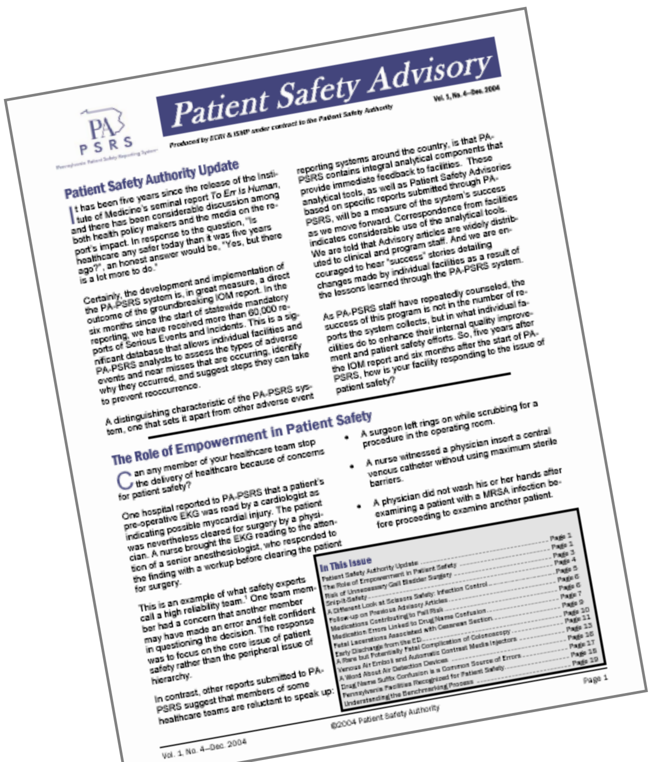


PA Patient Safety Authority: Why report? It provides useful information

- About 200,000 reports/year in PA-PSRS, and 97% are near misses or no-harm events
- The things that make adverse event reports useful are the same things that make near miss reports useful
- Purpose of both is the same: to identify the problems that need your attention
- The purpose is not to collect reports

Reporting provides information that is meaningful to others

- Resulted in dozens of articles in the Patient Safety Advisory: www.psa.state.pa.us



PA PSRS

Pennsylvania Patient Safety Reporting System

Patient Safety Advisory

Produced by ECRI & ISMP under contract to the Patient Safety Authority

Vol. 1, No. 4—Dec. 2004

Patient Safety Authority Update

It has been five years since the release of the Institute of Medicine's seminal report To Err Is Human, and there has been considerable discussion among both health policy makers and the media on the report's impact. In response to the question, "Is healthcare any safer today than it was five years ago?", an honest answer would be, "Yes, but there is a lot more to do."

Certainly, the development and implementation of the PA-PSRS system is, in great measure, a direct outcome of the groundbreaking IOM report. In the six months since the start of statewide mandatory reporting, we have received more than 60,000 reports of Serious Events and Incidents. This is a significant database that allows individual facilities and PA-PSRS analysts to assess the types of adverse events and near misses that are occurring, identify why they occurred, and suggest steps they can take to prevent reoccurrence.

A distinguishing characteristic of the PA-PSRS system, one that sets it apart from other adverse event reporting systems around the country, is that PA-PSRS contains integral analytical components that provide immediate feedback to facilities. These analytical tools, as well as Patient Safety Advisories based on specific reports submitted through PA-PSRS, will be a measure of the system's success as we move forward. Correspondence from facilities indicates considerable use of the analytical tools. We are told that Advisory articles are widely distributed to clinical and program staff. And we are encouraged to hear "success" stories detailing changes made by individual facilities as a result of the lessons learned through the PA-PSRS system.

As PA-PSRS staff have repeatedly counseled, the success of this program is not in the number of reports the system collects, but in what individual facilities do to enhance their internal quality improvement and patient safety efforts. So, five years after the IOM report and six months after the start of PA-PSRS, how is your facility responding to the issue of patient safety?

The Role of Empowerment in Patient Safety

Can any member of your healthcare team stop the delivery of healthcare because of concerns for patient safety?

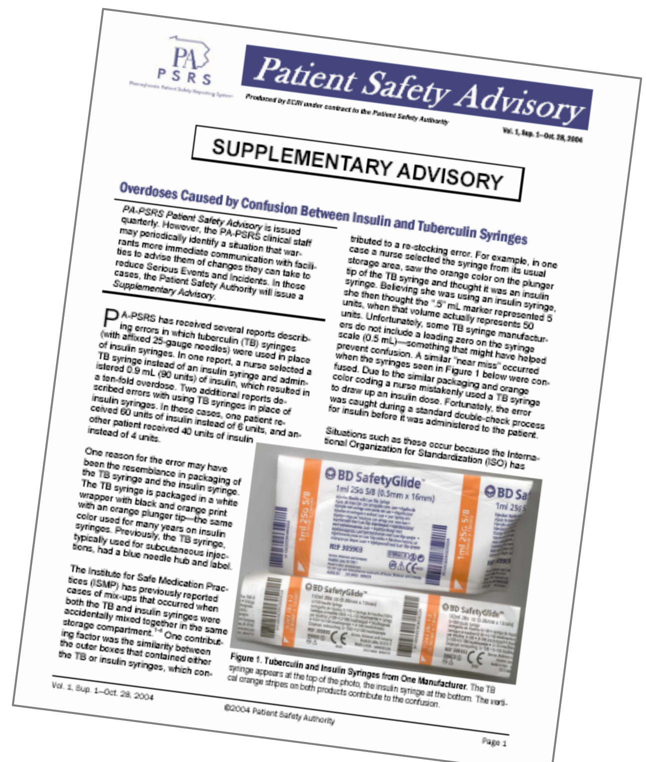
One hospital reported to PA-PSRS that a patient's pre-operative EKG was read by a cardiologist as indicating possible myocardial injury. The patient was nevertheless cleared for surgery by a physician. A nurse brought the EKG reading to the attention of a senior anesthesiologist, who responded to the finding with a workup before clearing the patient for surgery.

This is an example of what safety experts call a high reliability team.[1] One team member had a concern that another member may have made an error and felt confident in questioning the decision. The response was to focus on the core issue of patient safety rather than the peripheral issue of hierarchy.

In contrast, other reports submitted to PA-PSRS suggest that members of some healthcare teams are reluctant to speak up:

- A surgeon left rings on while scrubbing for a procedure in the operating room.
- A nurse witnessed a physician insert a central venous catheter without using maximum sterile barriers.
- A physician did not wash his or her hands after examining a patient with a MRSA infection before proceeding to examine another patient.

In This Issue



PA PSRS

Pennsylvania Patient Safety Reporting System

Patient Safety Advisory

Produced by ECRI under contract to the Patient Safety Authority

Vol. 1, Sup. 1—Oct. 28, 2004

SUPPLEMENTARY ADVISORY

Overdoses Caused by Confusion Between Insulin and Tuberculin Syringes

PA-PSRS Patient Safety Advisory is issued quarterly. However, the PA-PSRS clinical staff may periodically identify a situation that warrants more immediate communication with facilities to advise them of changes they can take to reduce Serious Events and Incidents. In those cases, the Patient Safety Authority will issue a Supplementary Advisory.

PA-PSRS has received several reports describing errors in which tuberculin (TB) syringes (with affixed 25-gauge needles) were used in place of insulin syringes. In one report, a nurse selected a TB syringe instead of an insulin syringe and administered 0.9 mL (90 units) of insulin, which resulted in a ten-fold overdose. Two additional reports described errors with using TB syringes in place of insulin syringes. In these cases, one patient received 60 units of insulin instead of 6 units, and another patient received 40 units of insulin instead of 4 units.

One reason for the error may have been the resemblance in packaging of the TB syringe and the insulin syringe. The TB syringe is packaged in a white wrapper with black and orange print with an orange plunger tip—the same color used for many years on insulin syringes. Previously, the TB syringe, typically used for subcutaneous injections, had a blue needle hub and label.

The Institute for Safe Medication Practices (ISMP) has previously reported cases of mix-ups that occurred when both the TB and insulin syringes were accidentally mixed together in the same storage compartment.[1-4] One contributing factor was the similarity between the outer boxes that contained either the TB or insulin syringes, which contributed to a re-stocking error. For example, in one case a nurse selected the syringe from its usual storage area, saw the orange color on the plunger tip of the TB syringe and thought it was an insulin syringe. Believing she was using an insulin syringe, she then thought the ".5" mL marker represented 5 units, when that volume actually represents 50 units. Unfortunately, some TB syringe manufacturers do not include a leading zero on the syringe scale (0.5 mL)—something that might have helped prevent confusion. A similar "near miss" occurred when the syringes seen in Figure 1 below were confused. Due to the similar packaging and orange color coding a nurse mistakenly used a TB syringe to draw up an insulin dose. Fortunately, the error was caught during a standard double-check process for insulin before it was administered to the patient.

Situations such as these occur because the International Organization for Standardization (ISO) has

Figure 1. Tuberculin and Insulin Syringes from One Manufacturer. The TB syringe appears at the top of the photo, the insulin syringe at the bottom. The vertical orange stripes on both products contribute to the confusion.

PA Patient Safety Authority: Reports Identify Trends

- Hidden sources of Latex in Healthcare Products
- Use of X-Rays for Incorrect Needle Counts
- Patient Identification Issues
- Falls Associated with Wheelchairs
- Electrosurgical Units and the Risk of Surgical Fires
- A Rare but Potentially Fatal Complication of Colonoscopy
- Fetal Lacerations Associated with Cesarean Section
- Medication Errors Linked to Name Confusion
- When Patients Speak- Collaboration in Patient Safety
- Anesthesia Awareness
- Problems Related to Informed Consent
- Dangerous Abbreviations in Surgery
- Focus on High Alert Medications
- Bed Exit Alarms to Reduce Falls
- Confusion between Insulin and Tuberculin Syringes (Supplementary)
- The Role of Empowerment in Patient Safety
- Risk of Unnecessary Gallbladder Surgery
- Changing Catheters Over a Wire (Supplementary)
- Abbreviations: A Shortcut to Medication Errors
- Lost Surgical Specimens

PA Patient Safety Authority: Reports provide useful information

- Examples:
  - One misunderstood colored wristband led to regional standardization
  - A hospital had a “sandbag” fly into the MRI core & screened their other sandbags throughout the facility
  - A report from a behavioral health unit of patients getting implements of self-harm in the ED

Learning lessons the easy way

- Examples:
  - Insulin given to the wrong patient
  - Wrong patient taken to the OR/procedure room
  - Patient with pacemaker scheduled for MRI
  - Patients found with multiple fentanyl patches
  - Neonates or infants given excessive doses of heparin
  - Wrong tissue type

Don’t limit focus to outcomes

- What types of near miss reports would have predicted your last Sentinel Event?

NEAR MISSES	SENTINEL EVENTS
• Wrong infant taken to mother’s bedside	• Infant discharged to wrong family
• Unlabeled bag of donor blood found in blood bank	• Transfusion-related death from ABO incompatibility
• Sites not being marked	• Surgery on wrong body part
• Pain medication given too soon	• Death from opiate/narcotic overdose

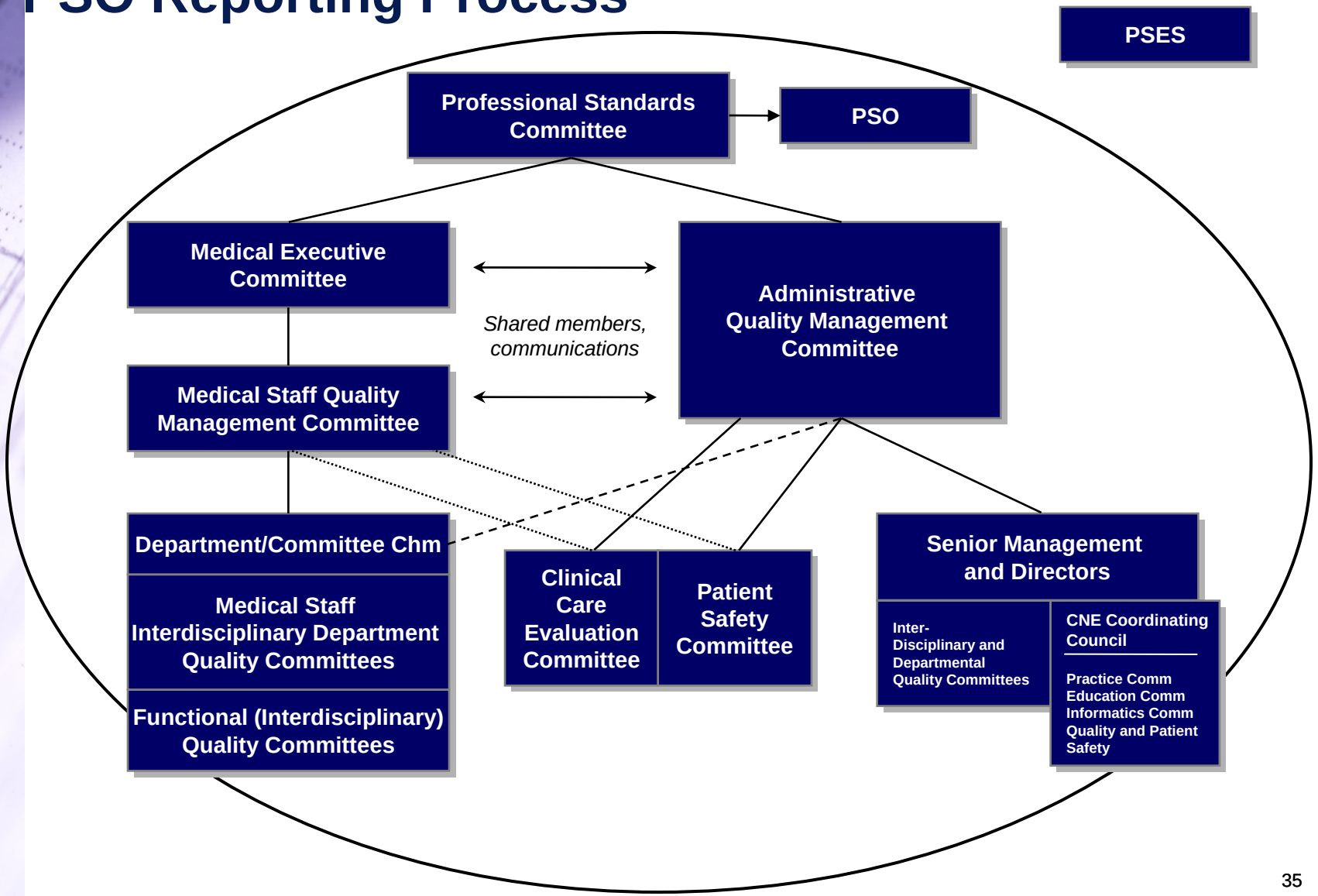
Steps to PSO Reporting

- **Inventory Data Currently Collected**
  - **Patient safety, quality of care, healthcare outcomes**
- **Prioritize Data that will be submitted to a PSO and become PSWP; what data will do the most to support improving the culture of safety**
- **Establish a system for data collection and review**
  - **Standardized data collection will both enhance benchmarking comparisons and ultimately comply with AHRQ's mandate for PSOs to collect standardized data; AHRQ's "Common Formats" or another common format**
  - **Agree to the processes that the PSES will follow to determine PSWP**
- **Create appropriate policies: Event Reporting; PSES, PSO Reporting**

Inventory of Data to Improve Patient Safety, Healthcare Quality or Outcomes

Indicator	Data Source	Data Collected by	Reported to	Frequency
Allegation of abuse	Incident reports	Staff witness or aware	VP Nursing, If confirmed State Board of Nursing	Upon occurrence and 3 reports per year
Medication errors	Incident reports, Medical Record	Provider that made the error, Staff witness or aware	Risk Management, RM committee, Patient safety officer, Medication Safety Committee, Harm score I – State adverse event reporting	200 per month
Unplanned Returns to Surgery	Surgery log, Peer Review worksheets, Medical Record	QI Specialist	Risk Management, Patient safety officer, RM committee, Quality committee, MEC, Surgery Peer Review Committee, National Surgical Outcome Project If due to Retained Foreign Object, State adverse reporting	10 per month

PSO Reporting Process



Mandatory Reporting to State Agencies

- **Providers have flexibility in defining and structuring their PSES, as well as determining what information is to become PSWP and, thus, protected from disclosure**
  - **Use information that is not PSWP to fulfill mandatory reporting obligations e.g., Medical Records, Surgery Logs, etc.**
  - **Report subjective incident report data to PSO for protections**
    - **Investigation notes, interview notes, forensics, etc.**

Disclosure of Medical Errors

Disclose to Patient/Family

- Objective facts that are also documented in the medical record
- Actions taken to prevent harm to another patient

Report to PSO

- Event report that contains staffs impressions on why this event may have happen
- Additional analyses to determine why the event happen
- RCA recommendations

Medical Staff Evaluation

Learning and Quality Improvement

Report to PSO:

- **Physician specific reports**
- **Findings, Conclusions, Recommendations from individual case peer review**

Reappointment/ Renewal of Privileges

- **Do not report to PSO:**
  - **Ongoing professional practice evaluation (OPPE)**
  - **Focused Evaluation (FPPE)**

Confidentiality and Privilege Protections

Patient Safety Work Product

In order to optimize protection under the Act:

- **Understand the protections afforded by the Act**
- **Inventory data from all sources to determine what can be protected**
- **Internally define your PSES**
- **Complete appropriate policies on collection, analysis and reporting**
- **Develop component PSO and/or select listed PSO**

Patient Safety Work Product Privilege

PSWP is privileged and shall not be:

- **Subject to a federal, state, local, Tribal, civil, criminal, or administrative subpoena or order, including a civil or administrative proceeding against a provider**
- **Subject to discovery**
- **Subject to FOIA or other similar law**
- **Admitted as evidence in any federal, state, local or Tribal governmental civil or criminal proceeding, administrative adjudicatory proceeding, including a proceeding against a provider**
- **Admitted in a professional disciplinary proceeding of a professional disciplinary body established or specifically authorized under State law**

Patient Safety Work Product

Exceptions:

- **Disclosure of relevant PSWP for use in a criminal proceeding if a court determines, after an in camera inspection, that PSWP**
  - **Contains evidence of a criminal act**
  - **Is material to the proceeding**
  - **Not reasonably available from any other source**
- **Disclosure through a valid authorization if obtained from each provider prior to disclosure in writing, sufficiently in detail to fairly inform provider of nature and scope of disclosure**

Patient Safety Work Product Confidentiality

Confidentiality:

PSWP is confidential and not subject to disclosure

Exceptions:

- **Disclosure of relevant PSWP for use in a criminal proceeding if a court determines after an in camera inspection that PSWP**
  - **Contains evidence of a criminal act**
  - **Is material to the proceeding**
  - **Not reasonably available from any other source**
- **Disclosure through a valid authorization if obtained from each provider prior to disclosure in writing, sufficiently in detail to fairly inform provider of nature and scope of disclosure**

Patient Safety Work Product Confidentiality

Exceptions (cont'd):

- **Disclosure to a PSO for patent safety activities**
- **Disclosure to a contractor of a PSO or provider**
- **Disclosure among affiliated providers**
- **Disclosure to another PSO or provider if certain direct identifiers are removed**
- **Disclosure of non-identifiable PSWP**
- **Disclosure for research if by a HIPAA covered entity and contains PHI under some HIPAA exceptions**
- **Disclosure to FDA by provider or entity required to report to the FDA regarding quality, safety or effectiveness of a FDA-regulated product or activity or contractor acting on behalf of FDA**

Patient Safety Work Product Confidentiality

Exceptions (cont'd):

- **Voluntary disclosure to accrediting body by a provider of PSWP but if about a provider who is not making the disclosure provider agrees identifiers are removed**
  - **Accrediting body may nor further disclose**
  - **May not take any accrediting action against provider nor can it require provider to reveal PSO communications**
- **Disclosure for business operations to attorney, accountants and other professionals who cannot re-disclose**
- **Disclosure to law enforcement relating to an event that constitutes the commission of a crime or if disclosing person reasonably suspects constitutes commission of a crime and is necessary for criminal enforcement purposes**

Enforcement

- Confidentiality
  - Office of Civil Rights
  - Compliance reviews will occur and penalties of up to $10,000 per incident may apply
- Privilege
  - Adjudicated in the courts

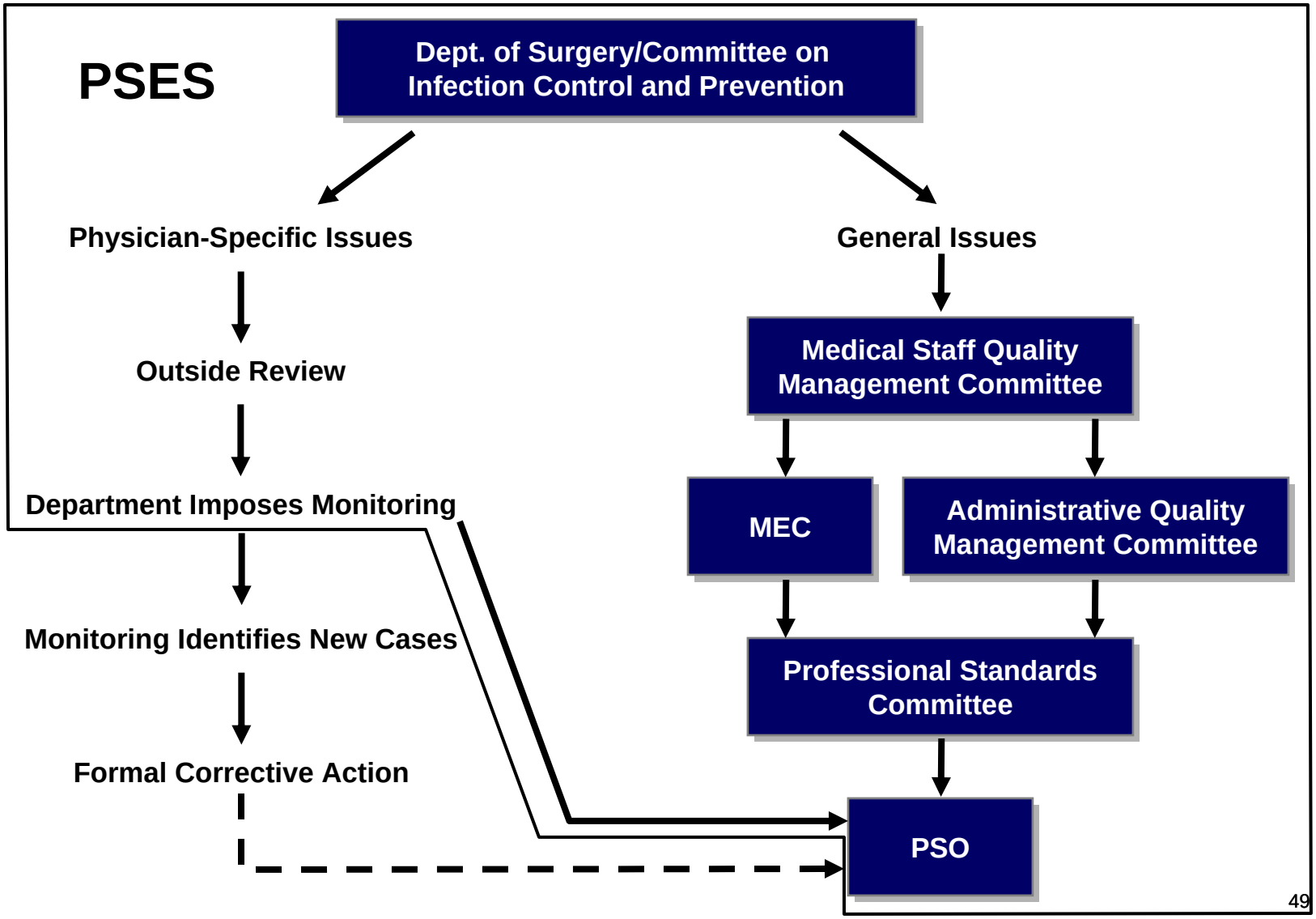
Hypothetical: Post Op Infections

- Ortho group identified as having several post op infections as per screening criteria.
- Department of Surgery and Committee on Infection Control and Prevention decide to conduct review of all ortho groups in order to compare practices and results
  - Data and review collected as part of PSES
- Review identifies a number of questionable practices generally, which are not consistent with established infection control protocols
  - Data and analysis and recommendations eventually reported to PSO
- Review also discloses member of targeted ortho group as having other identified issues including:
  - Total shoulder procedures in elderly patients
  - Questionable total ankle procedures

Hypothetical: Post Op Infections

  - Untimely response to post op infections
- Issues identified are significant enough to trigger 3rd party review
- Third party review identifies and confirms issues that may lead to remedial/corrective action
- Decision is made by Department Chair that physician's cases need to be monitored for six month period
  - Monitoring reveals repeat problems relating to questionable judgment and surgical technique which have resulted in adverse outcomes
  - Department Chair recommends formal corrective action

Hypothetical: Ortho Post Op Infections



Hypothetical: Wrong Breast Milk

- 3 month old premie in NICU received 15ccs of breast milk in an IV line
- Infant weighed 5lbs, 3 oz.
- Infant in isolette through which all lines (feeding tube, IVs, EKG cord, arterial line, etc). were fed through
- Within 20 minutes the baby exhibited signs of respiratory distress and was placed back on the ventilator

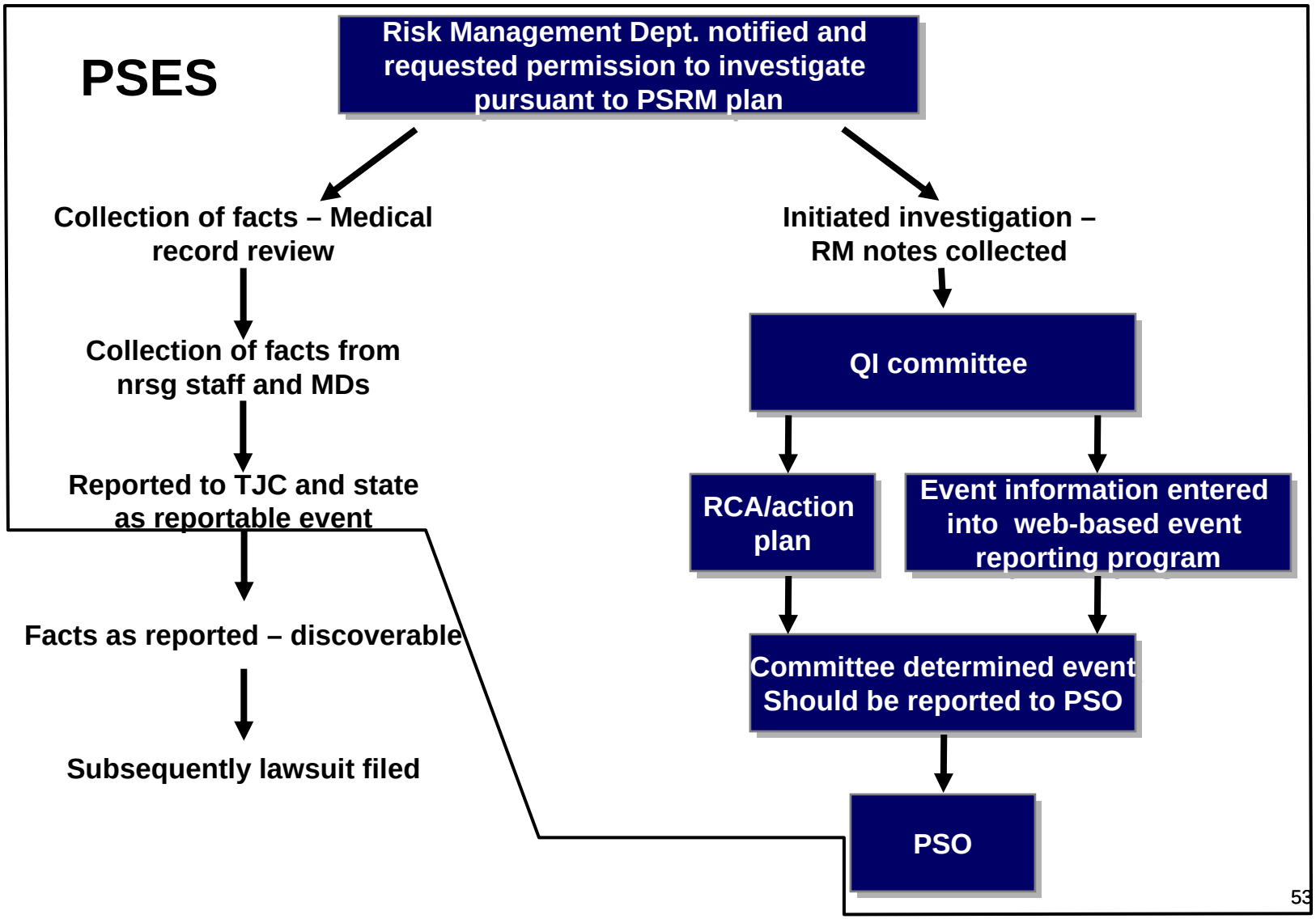
Hypothetical: Wrong Breast Milk

- Risk management rec'd call at 6:15AM – notes taken to capture details of event
- Medical record reviewed by RM – notes taken
- Staff interviewed – RM notes taken
- IV line equipment changed out and sequestered - sent to forensics lab with expected report in 2 weeks
- Chair of QI committee requested RCA - Group pulled together and started within 24 hours of event
- Graphics of room design/layout as well as position of isolette and lines submitted as part of RCA

Hypothetical: Wrong Breast Milk

- Risk management communicated with national databank for neonatal events and obtained date and time in which to expect a call from another organization that experienced same event
- Risk management and several staff participated in that subsequent phone call – notes taken
- After phone call course of treatment significantly modified to match experience of other organization and that reflected the lessons learned
- Infant survived

Hypothetical: Wrong Breast Milk



PSO: Advancing Patient Safety

Positive Trajectory of Change