2019 ANNUAL REPORT

CHPSO™
Collaborative Healthcare Patient Safety Organization

Eliminating preventable harm and improving the quality of health care delivery

■ A DIVISION OF THE HOSPITAL QUALITY INSTITUTE

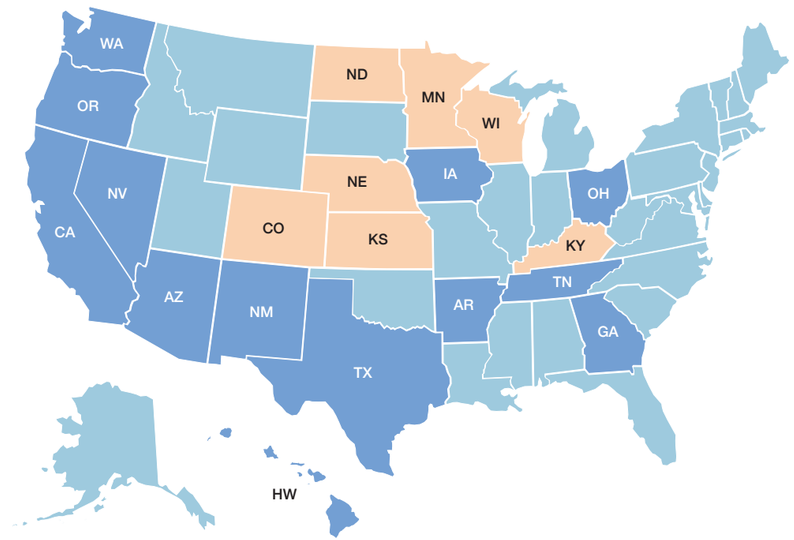
ABOUT US

CHPSO Mission

Eliminating preventable harm and improving the quality of health care delivery.

CHPSO Vision

CHPSO's members will lead the nation in providing the safest and highest quality health care



CHPSO Membership remained steady in 2019 with more than 450 members in 13 states: Arkansas, Arizona, California, Georgia, Hawaii, Iowa, New Mexico, Nevada, Ohio, Oregon, Tennessee, Texas and Washington. A total of 93 new facilities/organizations from seven states are pending or in progress. These members contributed to a growing database of more than 2.5 million safety events.

Participate

CHPSO works with members to facilitate and streamline the data submission process. CHPSO partners with NextPlane Solutions to allow members to connect to the CHPSO database, saving hospitals the cost of specialized solutions.

With NextPlane Solutions, members can generate an Excel spreadsheet or plain text report delimited by commas or other characters.

The entire process, including taxonomy mapping, generally takes up to three hours for the initial submission.

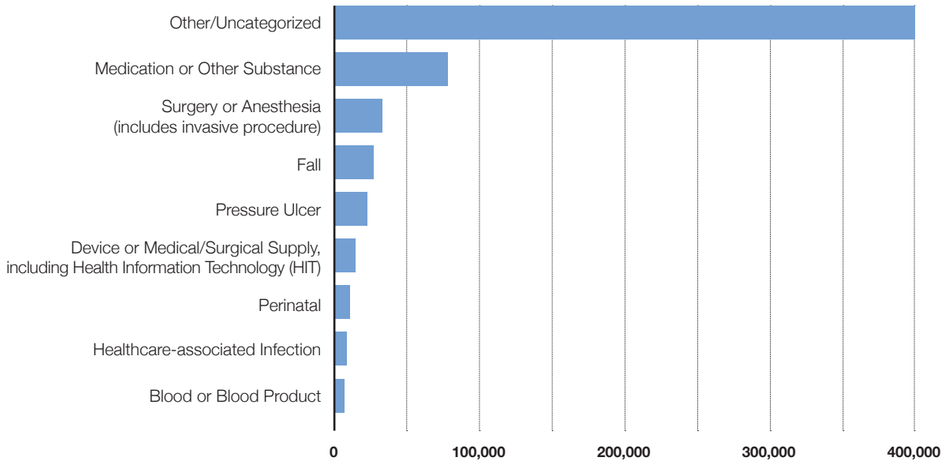
For more information, contact CHPSO at **info@chpso.org** or visit our website, **www.chpso.org**.

Benefits

- **Patient Safety Work Product (PSWP) privilege**
- **Collaborate and problem solve with other providers**
- **Periodic safety event evaluations**
- **Bi-weekly Safe Table meetings**
- **Custom research requests**
- **Event feedback and consultation**
- **Educational webinars**
- **Alerts and quarterly newsletters**
- **Legal counsel discussion group**
- **Job board**

EVENT REPORTS

2019 events by category



The CHPSO database had 2.5 million reports by the end of 2019. Nearly 605,000 reports were submitted to CHPSO in 2019. We continue to share trends and lessons learned among our community.

CHPSO Database: "Other/Uncategorized" includes events not covered by the standard categories such as laboratory and radiology. Device reports include Health Information Technology (HIT).

Key Points When Reviewing Event Data

CHPSO staff are frequently asked to provide rates of different event types for benchmarking. However, unlike many other measures of quality and safety, voluntarily collected and submitted event reports cannot be utilized in this fashion.

A number of concepts are helpful to understand when reviewing safety event reports and other data types collected by patient safety organizations. One is that the volume of reports does not equal prevalence.

It is easy to assume that a higher number of a certain type of event means there are more of those types of events occurring. However, given the nature of safety event reporting, it simply means hospitals have submitted more of those types of events to the CHPSO database.

It is also important to understand that CHPSO does not require members to change the way they collect event reports for their own patient safety, quality, and risk management purposes. In addition, CHPSO does require members to submit information in specific fields. As a result, we receive information in various degrees of thoroughness and quality.

Tips for Safety Event Report Collection

Consider following a standardized format. One that many have found helpful is the "SBAR" format, which stands for situation, background, assessment, and recommendation. This communication model is useful for both internal review and patient safety organization review.

Remember the report needs to be complete but does not need to be lengthy. Whenever possible, spell out abbreviations and acronyms. For instance, PT might be used for both physical therapy and patient.

Stick to the facts and avoid blaming or shaming. In a culture of safety, event reports are not meant to point out who is right and who is wrong.

Indicate whether the event happened for the first time or if it has occurred multiple times — this helps CHPSO pick up on themes related to event frequency. It is also helpful to include relevant follow-up in the report.

Encourage the submission of reports of near-misses and no-harm events. Staff often do not report no-harm and near-miss events. These incidents, however, represent "free lessons" and may turn out to be precursors of serious events.

MEDICATIONS

Medication Safety Event Report Analysis

Overview

"Event Type" — Data Element 21 in the Agency for Healthcare Research and Quality (AHRQ) Common Formats for event reporting — represents the primary classification for each safety event report. Currently, this field can have values for the following categories:

- **Blood or Blood Products**
- **Device/Medical Surgical Supplies**
- **Falls**
- **Healthcare Associated Infection**
- **Medication or Other Substance**
- **Other/Uncategorized**
- **Perinatal**
- **Pressure Ulcer**
- **Surgery or Anesthesia**

In 2019, "Medication or Other Substance" was the second-largest category in the CHPSO database, behind "Other/Uncategorized." As part of our continual efforts to improve our understanding of safety event reports submitted by our members, CHPSO has completed an analysis of a subset of these medication-related events.

For this report, we analyzed a subset of the safety event reports in the "Medication or Other Substance" category submitted to CHPSO in 2019. For inclusion in this analysis, events had to meet the following criteria: a maximum of 50 random events per facility where DE21 = "A54" and event load date occurred in 2019. These data included 7,470 safety event reports from 186 individual CHPSO member facilities. This is an overview of frequently mentioned drug categories and areas identified as opportunities for improvement, as well as a discussion of clinically relevant topics associated with these events.

As with previous analyses of safety events, many events in this dataset were multifactorial. Therefore, the total number of events in each category is greater than the total number of events in the dataset. For example, a case involving delays in care and access to appropriate medication for a child with a Tylenol overdose awaiting an airlift transport contained elements related to availability of medications, automated dispensing cabinets, communication issues, and the mention of the relevant medications (e.g., acetaminophen and acetylcysteine). Likewise, a case related to a dosing error of a vasoconstrictor used to treat life-threatening hypotension (often in the setting of septic shock) contained elements related to an overdose, the programing of the infusion pump, a reference to barcode medication administration (BCMA) technology, a comment regarding the facility's electronic health record vendor, and the medication involved (Levophed).

Event Severity	n	%
Incident	3294	44.10%
Near Miss	897	12.01%
Unsafe Condition	842	11.27%
Null	2437	32.62%
Age	**n**	**%**
Neonate (0 - 28 days)	27	<1%
Infant (>28 days <1 year)	47	<1%
Child (1 - 12 years)	646	8.65%
Adolescent (13 - 17 years)	41	<1%
Adult (18 - 64 years)	1279	17.12%
Mature Adult (65 - 74 years)	438	5.86%
Older Adult (75 - 84 years)	359	4.81%
Aged Adult (85+ years)	202	2.70%
Null	4431	59.32%
Harm	**n**	**%**
Death	4	<1%
Severe harm	13	<1%
Moderate harm	181	2.42%
Mild harm	1197	16.02%
No harm	2081	27.86%
Null	3994	53.47%

Frequently mentioned drug categories included Opioids (n=1363), Antimicrobials (n=1082), Anticoagulants (n=848), Acetaminophen (n=678), and Benzodiazepines (n=481). Opioids and benzodiazepines were frequently associated with safety event reports related to controlled substance accountability and management of the inventory in dispensing cabinets. At first glance, acetaminophen appeared to have been an issue in many of the events in the dataset, by virtue of the number of times it was mentioned. However, upon further investigation, we found acetaminophen was most frequently mentioned because it is an ingredient in opioids. In fact, when we counted only events in which acetaminophen was specifically mentioned in the event descriptions (free-text fields) — based on key words such as acetaminophen, Ofirmev, and Tylenol — we found a significant decrease (n=172) in the number of events.

Events related to antimicrobials included a variety of sub-categories and factors. These included missed or delayed doses due to medication availability, omissions or delays due to roller clamps left closed, allergic and adverse reactions, dosing errors, and laboratory-related issues (e.g., peak and trough for aminoglycosides). There were also a variety of issues related to the electronic health record (EHR) and computerized provider order entry (CPOE).

Not surprisingly, issues related to EHR and CPOE were not limited to antimicrobial medications. In fact, missing or inaccurate documentation, issues related to EHRs, CPOE, and BCMA comprised the largest category in this analysis (n=2092).

Some of the subthemes in this category included:

- **EHR-related dose calculation errors**
- **Auto discontinue functions**
- **Weight-based medication calculation errors**
- **Decimal place errors**

Other issues in this category included duplicate orders/therapeutic duplication (e.g., Toradol and ibuprofen), errors related to verbal and telephone orders, and orders based on location (e.g., ED–Only orders). Errors in transcription from a paper/faxed provider order to the EHR were also noted in this category.

Medication dispensing and administration errors were also commonly found in this dataset (n=1387). These included errors related to wrong drug, wrong frequency/time, wrong patient, and wrong dose.

CPOE- and EHR-related issues often overlapped during these events (e.g., weight-based dosing errors). Also overlapping with this category were issues related to the management of IV lines (n=352) and infusion pumps (n=142). While not the largest categories in the dataset, we found these issues worth mentioning due to the high risk for patient harm. Examples in these subcategories include:

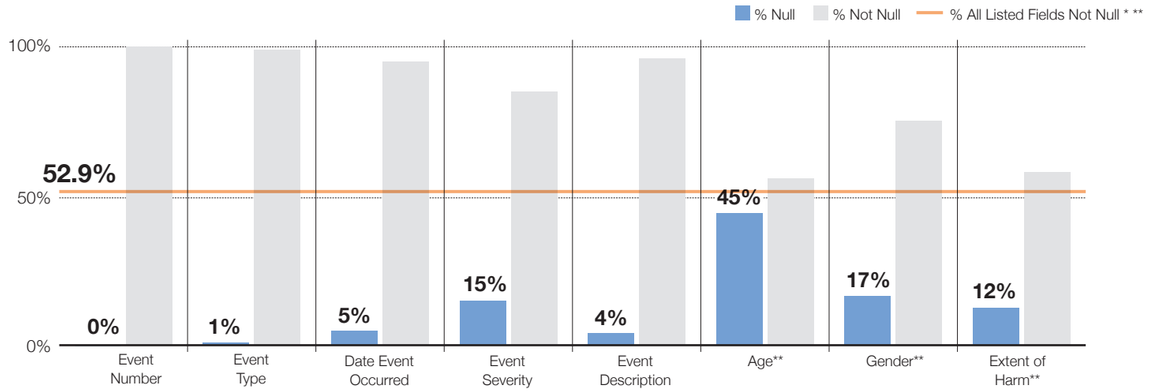
- **Guardrails and medication libraries were not used or were unavailable**
- **Availability of infusion pumps and/or infusion pumps malfunctioning**
- **Incorrectly programed infusions (e.g., wrong drug/rate/concentration)**
- **Tubing misconnections (e.g., epidural lines connected to IV ports)**
- **Incompatible medications infusing in the same line**
- **Medications infusing through the same line as blood or blood products**

Other relevant categories of events in this dataset included issues related to communication and teamwork (n=523), patient identification issues (n=174), missed assessments (n=99), and the mention of contingent workers (travelers/registry) and float pool staff (n=75).

We encourage members to review the “Medication or Other Substance” events in their systems and consider how this analysis might provide insight into issues and potential opportunities for improvement in their own organizations. As with other aggregate analyses completed for the annual report, CHPSO will provide hospital-specific evaluations for member organizations that submitted data into the “Medication or Other Substance” category in 2019. Those interested in further exploring their facility’s data in this category may contact **info@chpso.org** to arrange for a consultation.

DATA QUALITY

Percentage of Fields Null vs. Not Null — CHPSO 2012 to 2019



** Only reports with no missing values on all the fields listed above are included for calculation.*

*** Age/Gender/Extent of Harm field is calculated only for incident event reports. Refer to Age/Gender section below for more information.*

CHPSO database analysis of the number of events with null fields in specified categories

Assessing Event Reporting Data Quality

Like other federally listed patient safety organizations, CHPSO is dedicated to encouraging and assisting health care organizations in developing a culture of safety. By the end of 2019, the CHPSO database had accumulated in excess of 2.5 million safety event reports.

In past years, CHPSO provided feedback to members based on the tone and content of safety events submitted to the CHPSO database. The tone analysis refers to the level of bias present in the safety events submitted to the CHPSO database, while the content analysis refers to the thoroughness of the reports.

Over the years, these analyses have become unnecessary, as most events assessed indicate the majority of reports submitted to the database were relatively complete and unbiased. However, these content and tone analyses uncovered another area of event reporting quality that could benefit from further analysis by the CHPSO team — minimum standards for data submission. The content and tone analyses, along with other periodic reports produced to provide feedback to CHPSO members, were limited to events with sufficient content included for analysis. Through a series of iterative, painstaking analyses — which often involved CHPSO staff reviewing tens of thousands of reports — the team arrived at a minimum dataset required to support and complete a thorough analysis of safety event reports.

CHPSO recommends submitting all event fields collected within the member’s event reporting system. However, certain fields and data characteristics are essential for analysis and member feedback.

Recommended Minimum Data Elements

Event Number – This must be unique to the event. Members encountering duplicate event identification numbers within their systems — which generally come from different locations within a larger system — can reach out to the CHPSO team for assistance.

Event Type – This field represents the overarching category of the event. CHPSO maps events to the AHRQ Common Formats for event reporting. In that context, this field currently includes Blood or Blood Products, Device/Medical Surgical Supplies, Falls, Healthcare Associated Infection, Medication or Other Substance, Other/Uncategorized, Perinatal, Pressure Ulcer, and Surgery or Anesthesia. Only 1% of the events in the CHPSO database return a null result for this field.

Date Event Occurred – This field is typically well-populated (Null=5%). This is helpful in analyses because, while date ranges for analysis are usually based on the date the event is received by CHPSO, there are times when organizations may upload large, retrospective datasets. The inclusion of this field allows CHPSO to determine which events should be included in each analysis.

Event Severity – This field allows CHPSO to determine whether the event reached the patient. This field is comprised of three categories: Incident, Near Miss, and Unsafe Condition. Incidents are safety events that reach the patient, regardless of the level of harm. A "near miss" is a safety event that did not reach the patient, such as a medication error that was caught before the drug was administered. An "unsafe condition" refers to any circumstance that increases the probability that a safety event might occur. This field is null in 15% of the safety event reports in the CHPSO database.

Event Description/Comments – These descriptive, free-text fields are the most important in the CHPSO database. For this field, looking at whether it is null is insufficient in determining its value in event analysis. For example, some reports might meet the criteria of "Not Null" — but contain unhelpful or minimally helpful information, like:

- **N/A or NA**
- **Meaningless punctuation like "---" or "***"**
- **Vague information like "Reviewed by ED Director"**
- **Clearly auto-populated dropdown menu-generated information**

These findings prompted CHPSO to look further into the descriptive fields to determine the frequency with which the descriptive fields contain a certain number of characters. From this analysis, we have determined that — while only 4% of the safety event reports in the CHPSO database are null — 6.5% have fewer than 30 characters, 10.9% have fewer than 50 characters, and 22% have fewer than 100 characters. Currently, CHPSO is limiting many analyses to only those that contain a minimum of 30 characters in the descriptive fields.

Age – This is frequently null in the CHPSO database, with 45% of incident (DE3 = A3) event reports containing no value for patient age. However, it is a very important field as age may impact many event analyses. Therefore, CHPSO is undertaking an effort to impute null values by utilizing date event occurred and subtracting patient date of birth (DOB). However, there are many limitations. For example, some safety event reports have an event date occurred that is earlier than patient DOB; at times this may be off by decades. For example, an event included in one of the datasets for the annual report had a DOB in the year 2047. We have also observed inconsistency in imputed patient age for events with not null patient age values [e.g., patient age by imputation was A108/Child (1-12 years), but the original value for patient age was listed as A102/Neonate (0-28 days)].

Gender – This is null in 17% of the incident events submitted to the CHPSO database. Like age, gender may be legitimately absent in some reports, such as unsafe conditions or near misses that were not specific to an individual patient.

For both age and gender, one data quality metric to consider is the frequency with which age and gender are null for events with an Event Severity equal to "A3" (meaning that there was an incident that reached the patient, even if no harm occurred). The chart below provides the percentage of nulls vs. not nulls for all incident events in the CHPSO database to date. Notably, only 52.1% of the safety event reports have both patient age and patient gender populated.

Age and Gender Null vs. Not Null — CHPSO 2012 to 2019

DE3='A3': Incident	Patient Age	Patient Gender	
% Null	**45%**	**17%**	
% Not Null	**55%**	**83%**	
*% Age and Gender Not Null			**52.1%**

Harm – This is divided into four categories based on the AHRQ Common Formats. These include No Harm, Mild Harm, Moderate Harm, Severe Harm, and Death. In the CHPSO database, 12% of the safety event reports are null for this field. Ideally, harm would be provided with each incident safety event report, as it is determinable in nearly all incident cases. Moreover, this field is essential in many of the analyses CHPSO runs against the database. For example, to conduct certain analyses related to harm and other variables such as specific medications, CHPSO creates a variable called "High Harm" by collapsing events for which harm is either Severe Harm (DE55=A166) or Death (D55=A162). For these analyses, events are excluded when Harm is null. This limits the number of events that can be included in a given analysis and decreases CHPSO's ability to detect relationships between harm and other variables, such as medications or age.

OTHER/UNCATEGORIZED

Other/Uncategorized Safety Event Report Analysis

Overview

In addition to the analysis of medication, CHPSO analyzed the Other/Uncategorized category of event type. Similar to past years, the Other/Uncategorized group of event reports continues to be the largest in the CHPSO database. Continued interest in better understanding these events compelled a closer look.

This report is an analysis of a subset of the safety event reports in the "Other" category submitted to CHPSO in 2019. For inclusion in this report, the events had to meet the following criteria: a maximum of 50 random events per facility where DE21 = 'A66' and event load date occurred in 2019 and the length of the descriptive field met a minimum criteria. These data included 6,517 safety event reports from 162 individual CHPSO member facilities. A total of 30 event categories were revealed in the analysis, and this report provides details on the top five.

Note: It is very important to understand that many events in this dataset were multifactorial. Therefore, the total number of events in each category is greater than the total number of events in the dataset. For example, a case involving delays in care for a patient with a malignant spinal cord tumor contained elements related to documentation and HIT; communication issues between the emergency department, infusion center, and oncology provider; and references to clinical concepts (e.g., hemodialysis and sepsis). Likewise, a case related to a patient suffering from acute alcohol withdrawal contained elements related to outside law enforcement, restraints, a rapid response team call, refusal of treatment/leaving against medical advice, and workplace violence.

Similar to the last time CHPSO analyzed the Other/Uncategorized event type, the largest category was related to behavior and workplace violence (n=1152), representing 18% of events. These included reports of patients threatening, assaulting, or verbally abusing staff or peers and patients; punching walls; or damaging property. One event described a patient covered in blood running through the emergency department with sharp objects after assaulting several staff members. These cases often contain elements related to patients leaving or wanting to leave against medical advice (AMA) and patients being classified as a danger to self or others. Also included in this category are reports of highly agitated and/or aggressive family members and visitors.

Event Severity	n	%
Incident	3297	50.59%
Near Miss	480	7.37%
Unsafe Condition	1433	21.99%
Null	1307	20.06%

Age	n	%
Neonate (0-28 days)	25	<1 %
Infant (>28 days <1 year)	33	<1 %
Child (1-12 years)	509	7.81%
Adolescent (13-17 years)	31	<1 %
Adult (18-64 years)	1244	19.09%
Mature Adult (65-74 years)	353	5.42%
Older Adult (75-84 years)	236	3.62%
Aged Adult (85+ years)	156	2.39%
Null	3930	60.30%

Harm	n	%
Death	18	<1 %
Severe harm	16	<1 %
Moderate harm	83	1.27%
Mild harm	1072	16.45%
No harm	2093	32.12%
Null	3235	49.64%

Other issues of note related to inappropriate, rude, or offensive staff or provider behavior. This was not surprising, considering that one of the most popular Safe Tables in 2019 was "Workplace Bullying and Unprofessional Behavior." The top four Safe Tables of 2019 were:

1. **Smart Pump Issues**
2. **Handoff - Shift Change and Internal Transfers**
3. **Medical Device Associated Pressure Injuries**
4. **Workplace Bullying and Unprofessional Behavior**

Organizations may want to consider reviewing their events

for cases related to workplace violence, bullying, and unprofessional behavior to determine how well they are addressing these issues.

The second-largest category in this analysis was related to communication issues (n =1042), representing 16% of the safety event reports in the dataset. These safety event reports involved events describing breakdown in communication during handoff, communication failures between departments, inability of nursing staff to contact providers, confusion regarding on-call coverage, provider assignments, and messages not reaching providers or not being responded to in a timely manner. Also included in this category of safety event reports were those related to communication of critical values. This is a major patient safety issue, as the potential risk to patients is very high when communication breakdown impacts the response time to critical lab values. Examples included positive cultures found in a placenta and not being communicated to the provider, which resulted in a newborn not receiving appropriate antibiotic treatment; radiology results not being called to the provider; and critically low blood glucose values not reported in a timely manner, resulting in delayed treatment by the nursing staff. Documentation issues, including those related to HIT and CPOE, were frequently overlapping themes in the category of communication.

Reports related to documentation issues (n=851) represent the third-largest category of safety event reports in this report, at 13%. As mentioned above, elements of communication issues were frequently found in these events. The types of events in these cases include missing or incomplete documentation, such as consent forms, pre- and post-operative progress notes, vital signs, and other assessments. Another pattern in this category was issues with orders, such as issues with CPOE, verbal and telephone orders, order status issues, duplicate orders, and utilization of order sets. Orders placed based on location or pre-/post-procedure timing were issues, particularly "ED–Only" or "On-Call to OR" orders. Other HIT issues included in this category were those related to census boards, schedules, and informatics/information technology support availability and end-user training.

The fourth-largest category in these safety event is the reports related to leaving AMA or Left Without Being Seen (LWBS) (n=785), representing 12% of reports. As in the previous analysis of the "Other/Uncategorized" events, these reports frequently included elements related to the most common event type in this analysis described above: behavior or workplace violence. These safety event reports described patients requesting to leave/leaving AMA, patients wanting to go outside to smoke, and patients refusing to sign the required AMA forms. These events also included refusal of care by the patient or by family members. Unfortunately, statements regarding an inability to afford the recommended care were noted in several of these events.

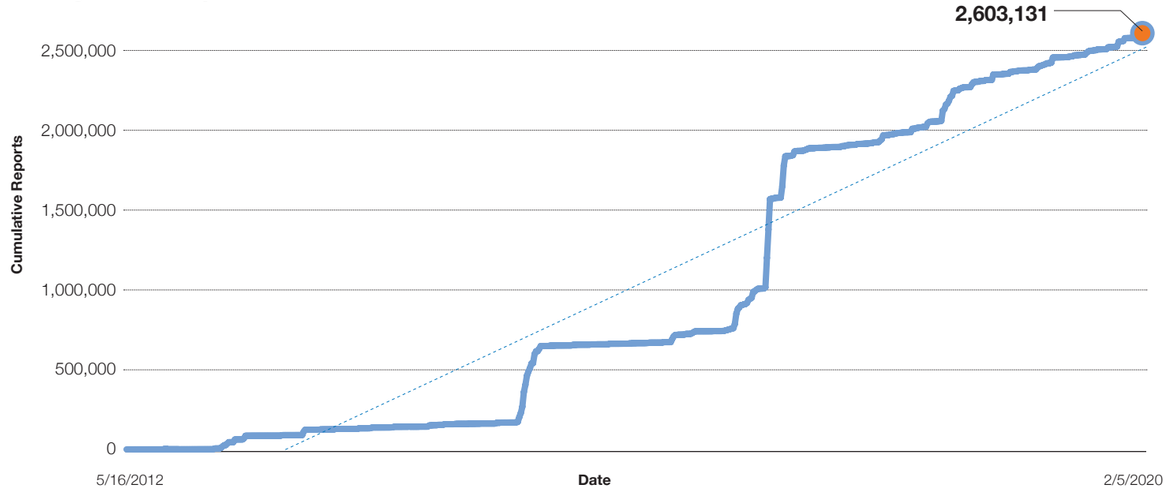
The fifth-largest category included in these events is associated with general quality of care concerns. This category included complaints from patients or family members, sometimes in response to bills received for what they deemed substandard care. Also included in this category were reports from staff or providers expressing concern regarding care quality. Concerns about the plan of care for patients came from staff, providers, patients, and families. Inappropriate discharges were reported in this category, as were concerns regarding the competency of staff or providers.

Because the "Other/Uncategorized" events represent such a large proportion of the safety event reports received by CHPSO every year, facilities may want to consider reviewing data in this reporting category to look for trends and patterns within their organization. Such analyses may well offer organizations insight into opportunities for improvement related to the issues described above or may reveal yet unidentified concerns. This may motivate patient safety and quality improvement activities. In addition, staff reporting such occurrences are more likely to continue to report their concerns when there is adequate follow-up from events they have submitted.

As in past years, CHPSO is happy to provide members with a facility-specific report in the "Other/Uncategorized" event type. If you are interested in further exploration of this category specific to your facility's data, contact us at **info@chpso.org**.

REPORTING TRENDS

Safety Event Reports Submitted to CHPSO



Data Submission Update

CHPSO continues to make submission of data a simple and seamless process for our members. As in past years, members submit Excel spreadsheets with safety event reports structured in one report per row. Data requirements are minimal, and members do not need to collect any data not already present in their incident reporting systems.

Column headers and row contents are submitted as produced by the member's report database. This eliminates any need for manipulation by members and helps to minimize barriers to full participation in the patient safety organization.

All mapping to standardized taxonomy is done by our HIPAA- and PSQIA-compliant vendor, with the guidance of the facility and support from CHPSO staff as needed. For the safety event reports, the facility uses a drag-and-drop interface to identify the initial mapping, and subsequent submissions need no work unless new fields or answer codes are included.

It typically takes under three hours to develop and complete the initial submission, with real-time, telephonic assistance throughout the process. Subsequent submissions take much less time (typically 15 minutes) and are performed as often as the facility deems appropriate.

Non-Event Domain Data Submission

The most common PSWP data type submitted to CHPSO is safety event reports. However, as CHPSO has long recognized, not all PSWP exists in an event report format.

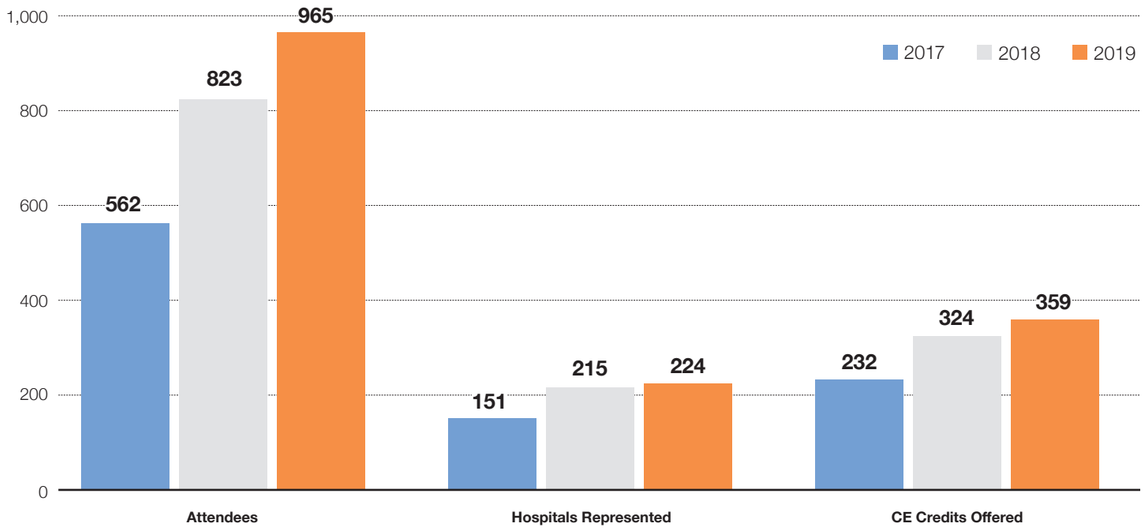
Therefore, in addition to standard safety event reports, CHPSO encourages organizations to share information that can help others improve the quality of health care delivery. To facilitate these efforts, CHPSO added a new domain to the database submission options in 2019.

This new domain is designed to allow organizations to easily report or disclose PSWP that is not in the format of an individual safety event report. For ease of use, it is designed so members can upload these data in a manner similar to the process described for safety event reports.

Examples of data types that can be submitted via this domain include best practices, recordings, audits, causal analysis, and any other PSWP not associated specifically with an individual safety event report. If you are interested in learning more about the submission of data to this new domain, contact us at **info@chpso.org**.

SAFE TABLE SUMMARY

CHPSO Safe Table Activities 2017, 2018, 2019



CHPSO Safe Table Activities 2017, 2018, 2019

At Safe Tables, members discuss cases on pre-selected topics in a confidential and privileged setting. These forums enable members to return to their health care organizations with lessons learned and valuable resources.

CHPSO hosted 21 Safe Tables in 2017, 22 Safe Tables in 2018, and 23 Safe Tables in 2019. Over time, attendance, continuing education (CE) credits provided, and hospitals represented significantly increased:

48%
increase in the number of hospitals represented

71%
increase in the number of attendees

54% **increase in the number of CE credits provided**

> Our hospitals are diverse, but our safety and quality concerns are shared. CHPSO provides member organizations with a protected environment in which they are able to share and learn from one another via the discussion of safety events and other quality of care concerns. Rady Children's Hospital has benefitted greatly from its participation in the facilitated conversations made possible through CHPSO.

Dr. Glenn Billman, Chief Quality Officer
Rady Children's Hospital - San Diego

The Value of Safe Tables

Quotes from recent attendees:

"Learning you're not alone and others are struggling with the same issues. I always pick up tips or strategies I hadn't thought of that are pertinent. This Safe Table offered great guidance and tools."

"Safe Table forums are incredibly valuable as we get to hear from those intimately involved and hear the action plans. We all benefit from each other's failures and successes in a safe forum."

"As we are working on meeting the state mandates regarding addressing the needs of homeless patients, it is extremely helpful to hear and see how other facilities are addressing these issues and to use these ideas in enhancing our existing program."

"A safe confidential way to share and learn from others having experienced the same safety events. I had a recent event very similar to the first two cases presented today but was uncomfortable presenting it myself. I liked the format, completely devoid of details and presented by a CHPSO representative."

"With falls being a focus in the majority of facilities, I found this to be an excellent presentation. There were great ideas on the use of bed alarms. We definitely have depended on alarms, which has not improved our falls. We found the telesitter program very interesting."

"The discussion gave me an opportunity to reflect on how robustly our organization tracks the failure to rescue events. This will be something I will be discussing with the quality director. A very timely discussion as well as to the use of MEWS/NEWS systems as this is currently a work in progress for our organization and the insights from the other organizations were helpful."

2019 Safe Table Activities Calendar

Date	Topic
1/16	Medical Device Associated Pressure Injuries
1/30	Failure to Rescue and Early Warning Systems
2/13	Cardiovascular Disease in Pregnancy
2/20	Sepsis Alerts
3/13	Care of the Conserved Patient
3/27	Falls and Immobility
4/10	OB Triage Issues
4/24	ED Boarding of Psychiatric Patients
5/7	Limitations of Bar Code Medication Administration
5/22	Patient Identification
6/12	End of Life Care
6/26	Workplace Violence
7/10	Discharge Planning for Homeless Patients
7/18	Alarm Management
8/21	Telemetry Monitoring
8/28	Handoff - Shift Change and Internal Transfers
9/12	Workplace Bullying and Unprofessional Behavior
9/26	Smart Pump Issues
10/9	Safe Pathology Specimen Management
10/23	Tubing Connectors
11/7	Patient Safety Issues in Rural Hospitals
11/20	Medication Reconciliation
12/11	Pediatric Behavioral Health

CHPSO Member Listing

Membesr as of February 5, 2020

Company	State
Acute Rehabilitation Unit	CA
Adventist Health	CA
Adventist Health and Rideout	CA
Adventist Health Bakersfield	CA
Adventist Health Castle	HI
Adventist Health Clear Lake	CA
Adventist Health Feather River	CA
Adventist Health Glendale	CA
Adventist Health Hanford	CA
Adventist Health Howard Memorial	CA
Adventist Health Lodi Memorial	CA
Adventist Health Portland	OR
Adventist Health Reedley	CA
Adventist Health Selma	CA
Adventist Health Simi Valley	CA
Adventist Health Sonora	CA
Adventist Health St. Helena	CA
Adventist Health Tehachapi Valley	CA
Adventist Health Tillamook	WA
Adventist Health Tulare	CA
Adventist Health Ukiah Valley	CA
Adventist Health Vallejo	CA
Adventist Health White Memorial	CA
AHMC Anaheim Regional Medical Center	CA
AHMC Healthcare, Inc.	CA
Alameda Hospital	CA
Alhambra Hospital Medical Center	CA
Alta Bates Summit Medical Center, Alta Bates Campus	CA
Alta Bates Summit Medical Center, Herrick Campus	CA
Alta Bates Summit Medical Center, Summit Campus	CA
Alta Bates Summit Medical Center, Summit Campus, Hawthorne	CA
Alta Hospitals System, LLC	CA
Alvarado Hospital Medical Center	CA
Anaheim Global Medical Center	CA
Annadel Medical Group	CA
Antelope Valley Health Center	CA
Antelope Valley Hospital	CA
Arizona General Hospital Laveen	AZ
Arizona General Hospital Mesa	AZ
Arrowhead Regional Medical Center	CA
Arroyo Grande Community Hospital	CA
Bakersfield Behavioral Healthcare Hospital	CA
Bakersfield Heart Hospital	CA
Bakersfield Memorial Hospital	CA
Ballard Rehabilitation Hospital	CA
Banner Lassen Medical Center	CA
Barlow Respiratory Hospital	CA
Barton Memorial Hospital	CA
Bayview Behavioral Health Campus of Paradise Valley Hospital	CA
Bear Valley Community Hospital	CA
Bellflower Health Center	CA
Brazosport Regional Health System (St. Luke's)	TX
Burleson St. Joseph Health Center	TX
Burleson St. Joseph Manor - Caldwel	TX
California Cancer Center	CA
California Hospital Medical Center	CA
California Pacific Medical Center – Mission Bernal Campus	CA
California Pacific Medical Center, California Campus	CA
California Pacific Medical Center, Davies Campus	CA
California Pacific Medical Center, Pacific Campus	CA
Catalina Island Medical Center	CA
Cedars-Sinai Marina Del Rey Hospital	CA
Cedars-Sinai Medical Center	CA
Centinela Hospital Medical Center	CA
Chandler Regional Medical Center	AZ
Chapman Global Medical Center	CA
CHI Memorial Hospital - Chattanooga	TN
CHI Memorial Hospital - Fort Oglethorpe	GA
CHI St. Alexius Health - Bismarck	ND
CHI St. Alexius Health - Garrison	ND
CHI St. Alexius Health - Turtle Lake	ND
CHI St. Luke's Health Baylor Med Ctr	TX
CHI St. Vincent - Morrilton	AR
CHI St. Vincent Health Services - Little Rock	AR
CHI St. Vincent Medical Center North	AR
Children's Hospital Los Angeles	CA
Children's Hospital of Orange County	CA
Chinese Hospital	CA
Chino Valley Medical Center	CA
CHOC Children's at Mission Hospital	CA
City of Hope	CA
Clovis Community Medical Center	CA
Coastal Health Center Group	CA
College Medical Center	CA
CommonSpirit Health	IL
Community Behavioral Health Center	CA
Community Health Center - Sierra	CA
Community Hospital of San Bernardino	CA
Community Hospital of the Monterey Peninsula	CA
Community Medical Centers	CA
Community Memorial Health System	CA
Community Memorial Hospital	CA
Community Regional Medical Center	CA
Community Subacute and Transitional Care Center	CA
Cottage Health	CA
Cottage Rehabilitation Hospital	CA
Covenant Behavioral Health Unit	TX
Covenant Children's Hospital	TX
Covenant Health	TX
Covenant Hospital Levelland	TX
Covenant Hospital Plainview	TX
Covenant Medical Center	TX
Covenant Medical Center — Lakeside Campus	TX
Covenant Medical Group	TX
Covenant Specialty Hospital	TX
Covenant Surgery Center	TX
Covenant Women's and Children's	TX
Delano Regional Medical Center	CA
Deran Koligian Ambulatory Care Center	CA
Desert Valley Hospital	CA
Dignity Health	CA
Dignity Health Medical Foundation	CA
Dollarhide Health Center	CA
Dominican Hospital	CA
East Los Angeles Health Center Group	CA
Eden Medical Center	CA
Edward R. Roybal Comprenhensive Health Center	CA
Eisenhower Medical Center	CA
El Camino Hospital	CA
El Camino Hospital Los Gatos	CA
El Centro Regional Medical Center	CA
El Monte Comprehensive Health Center	CA
Emanate Health	CA
Emanate Health Diagnostic Imaging Center	CA
Emanate Health Ferguson Outpatient Surgery Center	CA
Emanate Health Foothill Family Practice Medical Group	CA
Emanate Health Foothill Family Practice Medical Group	CA
Emanate Health Foothill Presbyterian Hospital	CA
Emanate Health Hospice & Home Care	CA
Emanate Health Inter-Community Hospital	CA
Emanate Health Inter-Community Hospital Heart Center	CA
Emanate Health Orthopedics - Chino	CA
Emanate Health Orthopedics - Glendora	CA
Emanate Health Orthopedics - West Covina	CA
Emanate Health Queen of the Valley Hospital	CA
Emanate Health Sports Medicine & Rehabilitation - Chino	CA
Emanate Health Sports Medicine & Rehabilitation - Glendora	CA
Emanate Health Sports Medicine & Rehabilitation - West Covina	CA
Encino Hospital Medical Center	CA
Enloe Medical Center	CA
Enloe Medical Center — Cohasset Campus	CA
Enloe Regional Cancer Center	CA
Enloe Rehabilitation Center	CA
Fairchild Medical Center	CA
Fairmont Campus of Alameda Health System	CA
Foothill Regional Medical Center	CA
French Hospital Medical Center	CA
Fresno Heart & Surgical Hospital	CA
Garden Grove Hospital and Medical Center	CA
Garfield Medical Center	CA
Gateways Hospital and Mental Health Center	CA
George L. Mee Memorial Hospital	CA
Glendale Health Center	CA
Glendale Memorial Hospital and Health Center	CA
Glendora Community Hospital	CA
Goleta Valley Cottage Hospital	CA
Good Samaritan Hospital - Bakersfield	CA
Good Samaritan Hospital - Los Angeles	CA
Greater El Monte Community Hospital	CA
Grimes St. Joseph Health Center	TX
H. Claude Hudson Comprehensive Health Center	CA
Hazel Hawkins Memorial Hospital	CA
Healdsburg District Hospitals	CA
Hemet Valley Medical Center	CA
Henry Mayo Newhall Hospital	CA
High Desert Regional Health Center	CA
Highland Campus of Alameda Health System	CA
Highland Hospital	CA
Hoag Hospital Irvine	CA
Hoag Medical Group	CA
Hoag Memorial Hospital Presbyterian	CA
Hoag Orthopedic Institute	CA
Hollywood Presbyterian Medical Center	CA
Hubert H. Humphrey Comprehensive Health Center	CA
Huntington Beach Hospital	CA
Huntington Memorial Hospital	CA
Incline Village Community Hospital	NV
Jerold Phelps Community Hospital	CA
Joe Arrington Cancer Center	TX
John C. Fremont Healthcare District	CA
John George Psychiatric Pavilion Campus of Alameda Health System	CA
John Muir Medical Center - Concord Campus	CA
John Muir Medical Center - Walnut Creek Campus	CA
Kāhi Mōhala Behavioral Health	HI
Kaweah Delta Health Care District	CA
Kaweah Delta Medical Center — South Campus	CA
Kaweah Delta Mental Health Hospital	CA
Kaweah Delta Rehabilitation Hospital	CA
Kentfield Rehabilitation & Specialty Hospital	CA
Kern Medical	CA
Kern Valley Healthcare District	CA
Kindred Hospital — Brea	CA
Kindred Hospital — San Diego	CA
Kindred Hospital — San Francisco Bay Area	CA
KPC Healthcare	CA
La Palma Intercommunity Hospital	CA
La Puente Health Center	CA
LAC/Harbor - UCLA Medical Center	CA
LAC+USC Medical Center	CA
Lake Los Angeles Community Clinic	CA
Langley Porter	CA
Littlerock Community Clinic	CA
Loma Linda University Children's Hospital	CA
Loma Linda University Medical Center — Murrieta	CA
Lompoc Valley Medical Center	CA
Long Beach Comprehensive Health Center	CA
Long Beach Memorial	CA
Los Angeles Community Hospital at Bellflower	CA
Los Angeles Community Hospital at Los Angeles	CA
Los Angeles Community Hospital at Norwalk	CA
Los Angeles County Department of Health Services	CA
Los Angeles County Olive View - UCLA Medical Center	CA
Lucile Packard Children's Hospital Stanford	CA
Mad River Community Hospital	CA
Madera Community Hospital	CA
Madison St. Joseph Health Center - Madisonville	TX
Mammoth Hospital	CA
Marian Regional Medical Center	CA
Marian Regional Medical Center West	CA
MarinHealth Medical Center	CA
Mark Twain Medical Center	CA
Marshall Medical Cameron Park	CA
Marshall Medical Center	CA
Martin Luther King, Jr. Community Hospital	CA
Mayers Memorial Hospital District	CA
Memorial Hospital Los Banos	CA
Memorial Hospital of Gardena	CA
Memorial Medical Center	CA
Memorial Medical Center - Livingston	TX
Memorial Medical Center - San Augustine	TX
Memorial Medical Center of East Texas	TX
Mendocino Coast District Hospital	CA
Menifee Valley Medical Center	CA
Menlo Park Surgical Hospital	CA
Mercy General Hospital	CA
Mercy Gilbert Medical Center	AZ
Mercy Hospital of Folsom	CA
Mercy Hospital Southwest	CA
Mercy Hospitals - Bakersfield	CA
Mercy Medical Center Merced	CA
Mercy Medical Center Mount Shasta	CA
Mercy Medical Center Redding	CA
Mercy Medical Pavilion	CA
Mercy San Juan Medical Center	CA
MercyOne Des Moines Medical Center	IA
MercyOne West Des Moines Medical Center	IA
Methodist Hospital of Sacramento	CA
Methodist Hospital of Southern California	CA
Metro Health Center Group	CA
Mid Valley Comprehensive Health Center	CA
Miller Children's & Women's Hospital Long Beach	CA
Mills Health Center	CA
Mills-Peninsula Health Services	CA
Mills-Peninsula Medical Center	CA
Mission Bay Hospital	CA
Mission Heritage Medical Group	CA
Mission Hospital Laguna Beach	CA
Mission Hospital Mission Viejo	CA
Modoc Medical Center	CA
Montclair Hospital Medical Center	CA
Monterey Park Hospital	CA
MPHS Senior Focus	CA
Natividad Medical Center	CA
NorthBay Healthcare Corporation	CA
NorthBay Medical Center	CA
NorthBay Outpatient Clinics	CA
NorthBay VacaValley Hospital	CA
Northern Inyo Hospital	CA
Northridge Hospital Medical Center	CA
Novato Community Hospital	CA
O'Connor Hospital	CA
Ojai Valley Community Hospital	CA
OLE Health	CA
Olympia Medical Center	CA
Orange Coast Memorial Medical Center	CA
Orange County Global Medical Center	CA
Orchard Hospital	CA
Oroville Hospital	CA
Ose Adams Medical Pavilion	CA
Pacific Central Coast Health Centers	CA
Pacific Diagnostic Laboratories	CA
Palmdale Regional Medical Center	CA
Palo Alto Medical Foundation	CA
Palomar Health	CA
Palomar Medical Center Downtown Escondido	CA
Palomar Medical Center Escondido	CA
Palomar Medical Center Poway	CA
Paradise Valley Hospital	CA
Parkview Community Hospital Medical Center	CA
Petaluma Valley Hospital	CA
PIH Health Hospital — Whittier	CA
Pioneers Memorial Healthcare District	CA
Plumas District Hospital	CA
Pomona Valley Hospital Medical Center	CA
Prebys Cardiovascular Institute	CA
Providence Health & Services — Southern California	CA
Providence Holy Cross Medical Center	CA
Providence Little Company of Mary Medical Center San Pedro	CA
Providence Little Company of Mary Medical Center Torrance	CA
Providence Saint Joseph Medical Center	CA
Providence Tarzana Medical Center	CA
Queen of the Valley Medical Associates	CA
Queen of the Valley Medical Center	CA
Rady Children's Hospital — San Diego	CA
Rancho Los Amigos National Rehabilitation Center	CA
Redlands Community Hospital	CA
Redwood Memorial Hospital	CA
Riverside University Health System - Medical Center	CA
Ronald Reagan UCLA Medical Center	CA
Saddleback Memorial Medical Center - Laguna Hills	CA
Saint Agnes Medical Center	CA
Saint Francis Memorial Hospital	CA
Salinas Valley Memorial Healthcare System	CA
San Antonio Regional Hospital	CA
San Bernardino Mountains Community Hospital	CA
San Dimas Community Hospital	CA
San Fernando Health Center	CA
San Gabriel Valley Health Center Group	CA
San Gabriel Valley Medical Center	CA
San Gorgonio Memorial Hospital	CA
San Juan Regional Medical Center	NM
San Leandro Hospital	CA
San Mateo Medical Center	CA
Santa Barbara Cottage Hospital	CA
Santa Clara Valley Medical Center	CA
Santa Paula Hospital	CA
Santa Rosa Memorial Hospital	CA
Santa Ynez Valley Cottage Hospital	CA
Scripps Green Hospital	CA
Scripps Health	CA
Scripps Memorial Hospital Encinitas	CA
Scripps Memorial Hospital La Jolla	CA
Scripps Mercy Hospital	CA
Scripps Mercy Hospital Chula Vista	CA
Select Specialty Hospital - San Diego	CA
Sequoia Hospital	CA
Seton Coastside	CA
Seton Medical Center	CA
Sharp Chula Vista Medical Center	CA
Sharp Coronado Hospital and Healthcare Center	CA
Sharp Grossmont Hospital	CA
Sharp HealthCare	CA
Sharp Home Health	CA
Sharp Mary Birch Hospital for Women & Newborns	CA
Sharp McDonald Center	CA
Sharp Memorial Hospital	CA
Sharp Mesa Vista Hospital	CA
Sharp Rees – Stealy Medical Group	CA
Shasta Regional Medical Center	CA
Sherman Oaks Hospital	CA
Shriners Hospitals for Children - Northern California	CA
Sierra Nevada Memorial Hospital	CA
Sierra View Medical Center	CA
Sonoma Valley Hospital	CA
South Coast Global Medical Center	CA
South Valley Health Center	CA
Southern California Hospital at Culver City	CA
Southern California Hospital at Hollywood	CA
Southern California Hospital at Van Nuys	CA
St. Bernardine Medical Center	CA
St. Elizabeth Community Hospital	CA
St. Francis Medical Center	CA
St. John's Pleasant Valley Hospital	CA
St. John's Regional Medical Center	CA
St. Joseph Assisted Living	TX
St. Joseph Health	CA
St. Joseph Health Center - College Station	TX
St. Joseph Heritage Medical Group	CA
St. Joseph Home Care Network	CA
St. Joseph Home Health Network	CA
St. Joseph Hospital Acute Rehabilitation Unit	CA
St. Joseph Hospital, Eureka	CA
St. Joseph Hospital, Orange	CA
St. Joseph Manor - Bryan	TX
St. Joseph Regional Health Center - Bryan	TX
St. Joseph's Behavioral Health Center	CA
St. Joseph's Hospital and Medical Center (Barrow Neurological Institute)	AZ
St. Joseph's Medical Center of Stockton	CA
St. Joseph's Westgate Medical Center	AZ
St. Jude Medical Center	CA
St. Louise Regional Hospital	CA
St. Luke's Hospital at the Vintage	TX
St. Luke's Lakeside Hospital - Woodlands	TX
St. Luke's Patients Medical Center - Pasadena	TX
St. Luke's Sugar Land	TX
St. Luke's Woodlands Hospital	TX
St. Mary High Desert Medical Group	CA
St. Mary Medical Center - Apple Valley	CA
St. Mary Medical Center Long Beach	CA
St. Mary's Medical Center	CA
St. Rose Dominican Hospitals — Rose de Lima Campus	NV
St. Rose Dominican Hospitals — San Martin Campus	NV
St. Rose Dominican Hospitals — Siena Campus	NV
St. Vincent Medical Center	CA
Stanford Health Care - ValleyCare	CA
Stanford Health Care - ValleyCare-Livermore	CA
Stanford Health Care System	CA
Stewart & Lynda Resnick Neuropsychiatric Hospital at UCLA	CA
Sulpizio Cardiovascular Center	CA
Sutter Amador Hospital	CA
Sutter Auburn Faith Hospital	CA
Sutter Care at Home	CA
Sutter Center for Psychiatry	CA
Sutter Coast Hospital	CA
Sutter Davis Hospital	CA
Sutter Delta Medical Center	CA
Sutter East Bay Medical Foundation	CA
Sutter Gould Medical Foundation	CA
Sutter Health	CA
Sutter Lakeside Hospital	CA
Sutter Maternity & Surgery Center of Santa Cruz	CA
Sutter Medical Center — Sacramento	CA
Sutter Medical Foundation	CA
Sutter Medical Foundation - Central	CA
Sutter Pacific Heart Centers	CA
Sutter Pacific Medical Foundation	CA
Sutter Physician Services	CA
Sutter Rehab Institute	CA
Sutter Roseville Medical Center	CA
Sutter Santa Rosa Regional Hospital	CA
Sutter SeniorCare	CA
Sutter Solano Cancer Center	CA
Sutter Solano Medical Center	CA
Sutter Surgery Center Division	CA
Sutter Surgical Hospital	CA
Sutter Tracy Community Hospital	CA
Tahoe Forest Hospital District	CA
Torrance Memorial Medical Center	CA
Tri-City Healthcare District	CA
Trinity Health System dba Trinity Hospital Holding Co	OH
Trinity Hospital	CA
Trinity Hospital Twin City	OH
UC San Diego Health	CA
UC San Diego Health - Ambulatory	CA
UC San Diego Health - Jacobs Medical Center	CA
UC San Diego Health Hillcrest – Hillcrest Medical Center	CA
UCLA Medical Center, Santa Monica	CA
UCSD Health Sciences	CA
UCSF Benioff Children's Hospital Oakland	CA
UCSF Children's Hospital San Francisco	CA
UCSF Medical Center	CA
UCSF Medical Center at Mount Zion	CA
University of California	CA
University of California Davis Medical Center	CA
University of California Irvine Medical Center	CA
Valley Children's Healthcare	CA
Valley Presbyterian Hospital	CA
Vaughn School Based Health Center	CA
Ventura County Health Care Agency	CA
Ventura County Medical Center	CA
Verity Health System	CA
Vibra Hospital of Sacramento	CA
Victor Valley Global Medical Center	CA
Warrack Campus of Sutter Medical Center of Santa Rosa	CA
Washington Hospital Healthcare System	CA
Watsonville Community Hospital	CA
West Anaheim Medical Center	CA
Whittier Hospital Medical Center	CA
Wilmington Health Center	CA
Woodland Memorial Hospital	CA
Zuckerberg San Francisco General Hospital and Trauma Center	CA

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