CHART Institute PSO, initially listed in 2009, is one of 85 federally listed patient safety organizations. The PSO is exclusive to CHART member hospitals with 38 members; 3 new members joined in 2016-2017.

- ACMH Hospital
- Arnot Health
  - Arnot Ogden Medical Center
  - Ira Davenport Memorial Hospital
  - St. Joseph’s Hospital
- Bassett Healthcare Network
  - A.O. Fox Hospital
  - Bassett Medical Center
  - Cobleskill Regional Hospital
  - O’Connor Hospital
  - Tri-Town Regional Hospital
- Blue Mountain Health System
- Boone Memorial Hospital
- Butler Memorial Hospital
- Clarion Hospital
- Cole Memorial
- Evangelical Community Hospital
- Fulton County Medical Center
- Grafton City Hospital
- Grove City Medical Center
- Highlands Hospital
- Indiana Regional Medical Center
- J.C. Blair Memorial Hospital
- Meadville Medical Center
- Mon Health System
  - Mon General Hospital
- Mount Nittany Medical Center
- Penn Highlands Healthcare
  - Clearfield
  - Elk
- Punxsutawney Area Hospital
- St. Joseph’s Hospital of Buckhannon, Inc.
- St. Lawrence Health System
  - Canton-Potsdam Hospital
  - Gouverneur Hospital
- Summit Health
  - Chambersburg Hospital
  - Waynesboro Hospital
- The Ellwood City Hospital
- Titusville Area Hospital
- Tyrone Hospital
- Uniontown Hospital
- Warren General Hospital
- Wayne Memorial Hospital

In 2016 the PSO redesigned the member-specific feedback report. The redesigned report includes a comparison of top events for two years, a review of event follow-up information and recommendations or resources, as applicable. Additionally, the PSO contracted with two consultants, Siders Healthcare Consulting, LLC and PYA Consulting, PC, to improve the review of patient safety work product and member feedback.
In 2016 members submitted 34,432 events

Event Types

- **Other/Miscellaneous**: 11,618
- **Error Procedure/Treatment/Test**: 6,947
- **Complication Procedure/Treatment/Test**: 4,828
- **Medication Error**: 3,113
- **Fall**: 2,715
- **Infrastructure Failure**: 1,659
- **Skin Integrity**: 1,414
- **Equipment/Supplies/Devices**: 805
- **Adverse Drug Reaction**: 683
- **Transfusion**: 553
- **Employee/Affiliate**: 97

1,449 events were classified as *patient harm*, 4% of events submitted

- Temporary harm requiring treatment or intervention
- Temporary harm requiring increased length of stay
- Permanent harm
- Near-death
- Death

Top 5 Events: Patient Harm

- **Complication Procedure/Treatment/Test—Healthcare Associated Infection**: 805
- **Complication Following Surgery/Invasive Procedure**: 683
- **Adverse Drug Reaction**: 553
- **Fall**: 97
- **Skin Integrity**: 97
15,663 events were classified as no patient harm, 45% of events submitted

- No harm reached the patient
- Monitoring required to confirm no harm

**Top 5 Events: No Patient Harm**

- Fall
- Skin Integrity
- Error Procedure/Treatment/Test — Laboratory Test Problem
- Complication Procedure/Treatment/Test — Emergency Department

15,156 events were classified as near miss or unsafe condition, 44% of events submitted

- No harm reached patient because of active recovery
- No harm reached patient because of chance alone
- Circumstances that could cause adverse event

**Top 5 Events: Near Miss or Unsafe Condition**

- Medication Error
- Error Procedure/Treatment/Test — Laboratory Test Problem
- Other/Miscellaneous — Other
- Other/Miscellaneous — Against Medical Advice
- Other/Miscellaneous — Unanticipated Transfer to Higher Level of Care
Top Events

Top 10 Event Types/Specific Event Types*

1. Unanticipated Transfer to Higher Level of Care (Other/Miscellaneous)
2. Laboratory Test Problem (Error Procedure/Treatment/Test)
3. Medication Error
4. Fall
5. Emergency Department (Complication Procedure/Treatment/Test)
6. Against Medical Advice (Other/Miscellaneous)
7. Skin Integrity
8. Deviation from Policy/Procedure (Other/Miscellaneous)
9. Radiology/Imaging Test Problem (Error Procedure/Treatment/Test)
10. Surgery/Invasive Procedure Problem (Error Procedure/Treatment/Test)

* Excludes Other/Miscellaneous—Other Category

Review

Medication Error

3,113 medication error events were submitted, with the top categories of Other, Wrong, Dose Omission, Extra Dose and Medication Reconciliation Issue at Admission. Over 36% of the events occurred during the administration stage in the medication process, and the most common high alert medications involved were opiates/narcotics (33%), insulin (23%) and intravenous unfractionated heparin (17%). The harm score category distribution was harm (1%), no harm (66%), near miss (15%) and unsafe condition (16%).

Fall

2,715 fall events were submitted, with the top categories of Found on Floor, Assisted Fall, Ambulating, Toileting and Other. In 69% of the events, fall precautions/protocols were in place, 38% had a prior history of falls and 76% had a fall risk assessment completed. The harm score category distribution was harm (8%), no harm (84%), near miss (3%) and unsafe condition (3%).

Skin Integrity

1,414 skin integrity events were submitted, with the top categories of Pressure Ulcer, Skin Tear and Other. Of the pressure ulcer events, 20% were present upon admission from home, 18% were present upon admission from another facility, 3% occurred less than 24 hours after admission and 59% occurred longer than 24 hours after admission. The harm score category distribution was harm (9%), no harm (76%), near miss (3%) and unsafe condition (10%).

Other/Miscellaneous—Other

2,249 events were submitted as Other/Miscellaneous—Other, with approximately 91% of the events appropriate for another event type: Error Procedure/Treatment/Test (17%), Infrastructure Failure (16%), Complication Procedure/Treatment/Test (12%), Medication Error (6%), Equipment/Supplies/Devices (4%), Skin Integrity (2%) and Fall (1%). Approximately 31% of the events fit the Other/Miscellaneous category with a different specific event type such as Combative/Violent Behavior, Delay in Service, Patient Self-harm and Deviation from Policy/Procedure.
In 2016 the PSO conducted a member survey regarding the need for root cause analysis educational offerings. 100% of the respondents indicated a need for offerings. In 2017 the PSO will be working with a consultant to develop a root cause analysis curriculum that will be available in Summer 2017.

Throughout the year the PSO will be offering educational information on patient safety organization topics such as patient safety work product, confidentiality and disclosures and the patient safety evaluation system. Additionally, the PSO will be investigating educational offerings that align with the 2016 Top 10 Event Types.

### Educational Offerings

- **Patient Safety Work Product** (video)
- **Disclosures and Confidentiality** (video)

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