



True North
Patient Safety Organization
ANNUAL REPORT 2022



A COMPONENT ORGANIZATION OF NORTHWELL HEALTH

I. About Us

True North Patient Safety Organization, Inc.

True North Patient Safety Organization, Inc. is a component organization of Northwell Health, which acts independently. True North Patient Safety Organization's (PSO's) mission is to constantly improve patient safety and quality of care by collecting and analyzing patient safety information and sharing best practices to eliminate preventable harm. True North PSO's goal is to be recognized as a gold standard for patient safety within national health systems.

In January, True North PSO welcomed Peter Silver, MD, MBA, FCCM, as the new Executive Director. Prior to his appointment as Senior Vice President and Chief Quality Officer for Northwell Health, he served as medical director at Cohen Children's Medical Center (CCMC). Dr. Silver has experience working with PSO's as CCMC has been participating with Child's Health PSO since 2013. Dr. Silver is board certified in pediatrics and pediatric critical care medicine. He is a Fellow of the American Academy of Pediatrics (AAP), the American College of Critical Care Medicine (ACCM), and the American College of Chest Physicians (CHEST).

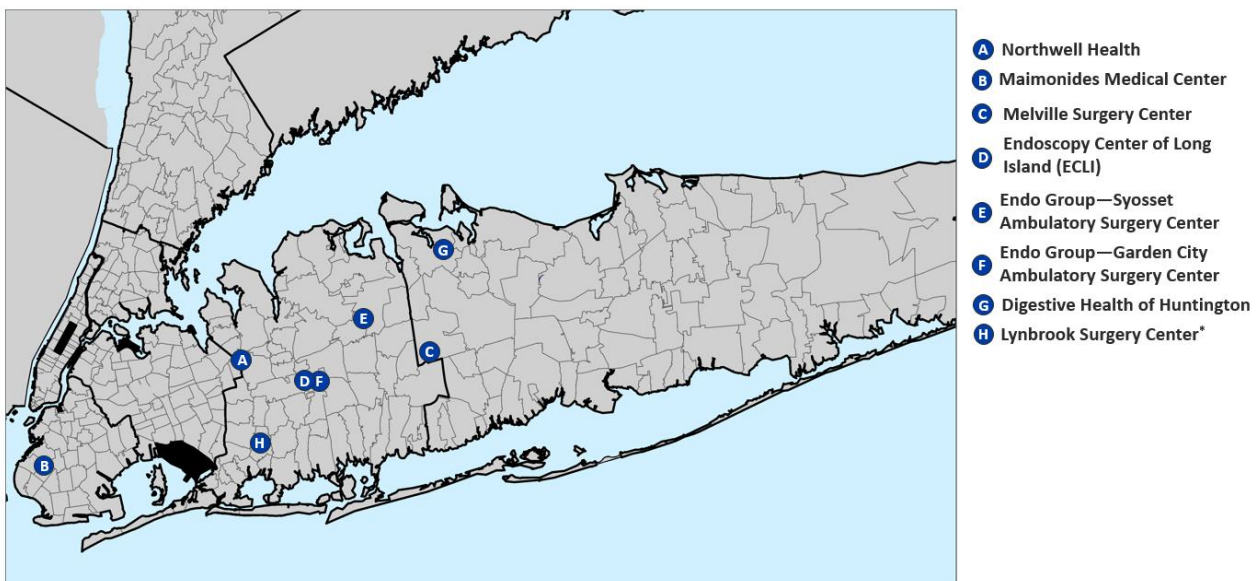
"True North PSO, which spans several different types of healthcare settings, is an extremely valuable resource for organizations to share data and safety events in a protected manner, so that we may all learn from each other and continue to improve the quality of health care we deliver to our patients. I am proud to be part of this organization, where all members are committed to safety, and quality of care is the overriding priority."

- Peter Silver, MD, Executive Director

During 2022, True North PSO was selected for a compliance assessment by the Agency for Healthcare Research and Quality (AHRQ). It was concluded in December without any deficiencies.

Membership

True North PSO has 8 members, comprised of 2 health systems, and 6 ambulatory surgery centers (ASCs). New members for 2022 are noted with an asterisk (*).



II. True North Quality and Patient Safety Reporting Tool

True North PSO welcomes the submission of any patient safety event or near miss that could provide a learning opportunity to other PSO members. Events and quality data submitted are reviewed on a quarterly basis by the PSO Quality and Patient Safety Committee to identify learning opportunities that can be disseminated to the larger PSO membership. When possible, safety events are collected consistent with the AHRQ Common Formats allowing for de-identified data to be submitted to the PSO Privacy Protection Center (PPC) for inclusion in the [Network of Patient Safety Databases \(NPSD\)](#).

In 2022, participating ambulatory surgery centers (ASCs) continued to submit patient safety events to the PSO using the Quality and Patient Safety Tool. Improvements were made to the tool, including an automated email confirmation of submissions, and the ability to directly connect to the support team. Additionally, a process was established for a member site to populate information from their event reporting system, reducing the burden of duplicative manual entry in order to submit events.

III. Safe Tables

Safe Tables are confidential meetings of PSO participants where a specific adverse or near miss event is presented and analyzed. Contributing factors, root causes and risk reduction strategies along with other best practices are discussed. Applicable resources are disseminated post meeting to assist organizations in proactive risk mitigation. These meetings also allow for the demonstration of different quality management tools that can be employed to further identify and reduce risk. During 2022, True North PSO hosted and facilitated three Safe Table meetings on topics of concern for participating ASCs.

In March, the PSO hosted a Safe Table meeting on **What's That Sound?: Importance of Alarm Management in the OR**. A participant organization shared a case where an active alarm on the main oxygen system was incorrectly attributed to the oxygen switching to reserves. The root cause and associated opportunities for improvement were explored. Highly reliable risk reduction strategies were presented that may successfully decrease the likelihood of a similar event. Post meeting distributions included relevant literature, a process map, and sample documentation provided by the presenting site.

The next Safe Table meeting was held in June titled **Are we over-reliant on technology?** A case was presented where a dysfunctional medication label-maker and the lack of a standardized back-up system contributed to an error. Participant discussion focused on sharing ideas and lessons learned towards preventing medication errors in the surgical setting. A pro-active risk assessment was reviewed and distributed as a pilot to assist sites in identifying potential vulnerabilities and considering risk reduction strategies. Additionally, resources were shared related to Just Culture, System Design, and Medication Safety.

In September, a participating site presented **Anticipating the Unexpected: Management of an Emergent Complication in an ASC**. This was a case where there was a delay in obtaining emergent blood products and the necessary instrumentation to the surgery center to manage a patient with an unexpected surgical complication. Risk reduction strategies to successfully reduce the likelihood of these types of events were presented. A proactive risk assessment was distributed to help sites identify potential vulnerabilities and implement risk reduction strategies.

Post-meeting surveys were favorable with feedback including:

- “Excellent presentation and I will definitely bring these lessons learned back to my sites. Thank you”
- “Glad I could participate. The information provided, put into action, will truly benefit our ASC patients.”
- “Excellent and very valuable presentation with important lessons learned and opportunities for improvement identified.”

95%

of survey respondents felt able assess their local risk for a similar event after the safe table

IV. Participant Engagement

The PSO offers a member webpage for PSO participants. In 2022, the member’s webpage was updated to include the following subpages making for easier navigation:

- Training & Resources
- Safe Tables
- Reporting Tool
- Newsletters
- Policies
- Call for Help

True North PSO News was distributed for Healthcare Quality Week in the Spring and Patient Safety Week in the Fall. The Spring edition welcomed our new Executive Director and shared updates made to the Quality and Patient Safety Tool. It also included sections on Recommended Reads and Industry Updates & Offerings related to patient safety. The Fall edition announced the updates on the members webpage and a link to register. The Download section shared upcoming enhancements to the Quality and Patient Safety Tool. The Questions and Answers section focused on how sites can locally assess risk and work with the PSO if they have a case that has the potential to be a good Safe Table presentation.

V. Thank You

Truth North PSO thanks Northwell Health, the True North PSO board, and all the member sites for making this year’s accomplishments possible. We look forward to continuing to work together to improve patient safety.