1st Annual
Scott & White Quality Improvement
in Healthcare and Patient Safety Symposium
September 13 – 14, 2013
Temple, Texas

Featuring
Brent C. James, MD, MStat
Chief Quality Officer
Executive Director, Institute for Healthcare Delivery Research
Intermountain Healthcare
Salt Lake City, Utah

September 13
Temple College Simulation Center and Standardized Patient Pavilion

September 14
Mayborn Auditorium at Scott & White Hospital
had never been seen before at any other facility. Nurse Jane triaged the patient and
Patient was brought in by the mother whom is Spanish speaking only. The patient
Junior a 2 year old male presented to the ER with respiratory distress and hypoxemia.

Scenario C: Pediatric Code

Scenario A: Time Out
This scenario takes place in an ICU setup. Your hospital had a sentinel event that
occurred in the ICU. Patient Jane Rogers was admitted with sepsis 3 days prior to
the event. She developed a ventilator associated pneumonia and ARDS. Patient was
intubated at the time and family was not present. Patient Jane Rodgers was in the
ICU and had a similar diagnosis, close in age and same gender. Jean Rodgers was
scheduled for chest tube placement times three. The pulmonologist along with the
patient’s nurse pulled up Jean Rodgers’ chest x-ray prior to placement of chest tubes.
MD proceeded to enter Jane Rogers’ room along with nursing staff and placed three
chest tubes into the patient. It was discovered after placement of chest tubes that the
wrong patient received the chest tubes.
Issue: No time outs were performed and patient wrist band was not verified. Jean
Rodgers expired three days later. Your chief of patient safety and the chief of the
medical staff from your hospital task your simulation center to come up with a team
training scenario to improve proper hand-off policies and procedures.

Scenario B: Wrong Site Surgery
Your hospital risk management was notified of a sentinel event that happened 3 days
prior. Miguel Martinez is a 23 year old male that was admitted to the hospital after
a motorcycle accident. It was raining and Miguel lost control of his bike while taking
a curve. He slid approximately 20 feet on concrete and sustained a burn rash on the left
leg. He hit a tree and had an injury to the right knee requiring surgical intervention.
Consent was obtained and the patient was prepared for surgery. The case was later
on a Friday afternoon and the staff felt “rushed”. Upon prepping the site for surgery,
the anesthesiologist placed the femoral nerve block on the left leg and the surgical
procedure, the surgeon encountered bleeding complications that could not be
corrected through the laparoscope and the decision was made to quickly proceed with
an exploratory laparotomy with a vertical incision. The surgeon became anxious and
corrected through the laparoscope and the decision was made to quickly proceed with
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corrected through the laparoscope and the decision was made to quickly proceed with
an exploratory laparotomy with a vertical incision. The surgeon became anxious and
found a negative health history except for an anaphylactic reaction to penicillin. This
information was obtained via translator. It was change of shift and the ER was on
diversion due to high patient volume. Nurse Jane did not place an allergy armband
on patient. Nurse Jane gave a verbal report to the oncoming shift and forgot to
mention the penicillin allergy. The physician came into the room and was unable to
communicate with the patient’s mother due to the language barrier. Upon examination
it was determined that the patient had community acquired pneumonia. Patient was
admitted overnight and treated with ampicillin 130 mg IV every 6 hours (first dose to
be started in ER) along with scheduled nebulizer treatments. The nurse administered
the ampicillin and immediately left the room to attend another emergency. The
patient then started to have difficulty breathing, became cyanotic and rapidly lost
consciousness. The mother left the room to get help. When the nurse returned, she
found the patient to be apneic with no pulse. A Dr. Blue was announced and the
patient was successfully resuscitated and transferred to PICU. It was discovered
after the family had questioned why the child had received ampicillin when he had an
anaphylactic reaction to penicillin that Nurse Jane failed to relay the information to
other staff members.
Issue: Poor communication during hand-off. Your chief of patient safety and the chief
of the medical staff for your hospital task your simulation center to come up with a team
training scenario to improve proper hand-off policies and procedures.

Scenario D: Retained Surgical Foreign Body
Your hospital recently experienced an event with a retained object left in the abdomen
during an emergency surgical procedure. Betty Hightower is a 44 year old female with
a BMI of 52 that was scheduled for a routine laparoscopic cholecystectomy. During the
surgical procedure, the surgeon encountered bleeding complications that could not be
corrected through the laparoscope and the decision was made to quickly proceed with
an exploratory laparotomy with a vertical incision. The surgeon became anxious and
somewhat impatient due to the blood loss and wanted to rush to correct the bleeding.
At the end of the procedure, there was no mention that there was a discrepancy of the
counts. The patient developed fever and abdominal pain in POD3 and the surgeon
ordered a CT scan of the abdomen. The scan showed a retained lap sponge.
Issue: Due to the change from laparoscopic to exploratory, the initial count was
overlooked. Your chief of patient safety and the chief of the medical staff for your
hospital task your simulation center to come up with a team training scenario to re-
emphasize current existing policies and procedures in spite of emergency situations.

**PROGRAM**

**Friday, September 13, 2013**
Temple College Simulation Center and Standardized Patient Pavilion

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>8:30 am</td>
<td>On-site Registration</td>
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<tr>
<td>9:00</td>
<td>Introduction and Welcome - Russell K. McAllister, MD</td>
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<tr>
<td>9:05</td>
<td>Opioid Safety-Avoiding the Pitfalls of Opioid Prescribing</td>
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<td>Emily H. Garmon, MD</td>
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<tr>
<td>9:25</td>
<td>Introduction to the Role Simulation Can Have in Patient Safety in Your Hospital</td>
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<td>Jose Pliego, MD</td>
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<tr>
<td>9:45</td>
<td>Rare, but Potentially Devastating Perioperative Mishaps</td>
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<td></td>
<td>Russell K. McAllister, MD</td>
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<tr>
<td>10:05</td>
<td>Break</td>
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<tr>
<td>10:20</td>
<td>Instilling a Culture of Safety in Your Hospital</td>
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<tr>
<td></td>
<td>Stephen Sibbitt, MD</td>
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<tr>
<td>10:40</td>
<td>A Patient’s Perspective of Adverse Event: A Patient Tells Their Story</td>
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<tr>
<td>11:00</td>
<td>Q&amp;A Session with Panel Speakers</td>
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<tr>
<td>11:30</td>
<td>Lunch Distribution</td>
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<tr>
<td>11:45</td>
<td>Lunch Ethics Lecture - Disclosure: When good things go bad (Disclosing an Adverse Medical Event)</td>
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<td>Lisa Havens, MSN, RN, JD, CPHRM</td>
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<tr>
<td>12:45 pm</td>
<td>Orientation to Simulation - Neil Coker, Director of S.T.A.R Program</td>
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<tr>
<td>1:00</td>
<td>Introduction to Clinical Simulation Breakout Sessions</td>
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<td></td>
<td>Objectives</td>
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<td></td>
<td>Jose Pliego, MD</td>
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<tr>
<td>1:15</td>
<td>Simulation Breakout Concurrent Sessions Scenarios A &amp; B</td>
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<tr>
<td>2:45</td>
<td>Break</td>
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<tr>
<td>3:00</td>
<td>Simulation Breakout Concurrent Sessions Scenarios C &amp; D</td>
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<tr>
<td>4:45</td>
<td>Wrap-up</td>
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Saturday, September 14, 2013
Mayborn Auditorium

7:30-8:00 AM  One day Registration/Continental Breakfast/Exhibitor
8:00-8:15 AM  Opening Remarks - John Erwin III, MD
8:15-9:15 AM  Keynote Speaker
   Brent James, MD from Intermountain Healthcare/IHI
9:15-9:45 AM  Q&A with Dr. James
9:45-10:00 AM  Break
10:00-10:30 AM  Future Payment Policy/Value Based Purchasing
   Tiffany Berry, MD
10:30-12:00 PM  Three Podium Presentations of Quality Improvement Projects
   (30 minutes each)
12:00-12:15 PM  Awards
12:15-1:15 PM  Box Lunch & Poster Session
1:15-1:45 PM  Creation of National Quality and Safety Standards: A Primer on the Process of Policy Converting into Accountability – J. James Rohack, MD
2:00-3:00 PM  Concurrent Session One
3:00-3:15 PM  Break
3:15-4:15 PM  Concurrent Session Two
4:15-4:30 PM  Break
4:30-5:30 PM  Concurrent Session Three
5:30-5:45 PM  Evaluation/Adjourn

* Denotes ethics credit

Title  Presenter
Infection/Sepsis  Christopher Spradley, MD
Hospital Engagement: Network and Readmissions  Lucy Savitz, PhD
Surgical Safety  Harry Papaconstantinou, MD
Pharmacy Advisory Services  Emory Martin, PharmD
Lean Management System  Cindy Dunlap, RN, MPA, NEA-BC, FACHE
S&W House Staff Quality Council  Jennifer Dixon, MD
ED Reduction through the 1115 Medicaid Waiver DSIRIP Program  Kevin Leeper, Gentry L. Woodard, Jennifer Mertz, RN
Money & Medicine PBS Video  Russell Fothergill, MD
Surgical Safety  Harry Papaconstantinou, MD
OR-ICU Handoffs  Jay Shake, MD
Lean Management System  Cyndy Dunlap, RN, MPA, NEA-BC, FACHE
Lean Management Strategies to Improve Quality  Margaret Henry
ED Reduction through the 1115 Medicaid Waiver DSIRIP Program  Kevin Leeper, Gentry L. Woodard, Jennifer Mertz, RN
Risk Management  Paula Shiroma-Bender, MSN, RN, JD
Lisa Havens, MSN, RN, JD, CPHRM
Ethics and Quality/Patient Safety Improvement*  Angie Hochhalter, PhD
Hospital Engagement: Network and Readmissions  Lucy Savitz, PhD
OR-ICU Handoffs  Jay Shake, MD
Pharmacy Advisory Services  Emory Martin, PharmD
Lean Management Strategies to Improve Quality  Margaret Henry
Infection/Sepsis  Christopher Spradley, MD and Team
How to Design a QI Project  Angie Hochhalter, PhD
Sepsis and ICU Delirium  Andrew Masica, MD, MSCI

CONCEPT
The ever increasing and important focus in healthcare is in improving quality of care as opposed to quantity of care. In addition to the important implications that Quality Improvement has for the care of our patients and for their health outcomes, we in the healthcare field will be increasingly scrutinized for our quality metrics. Our reimbursement will also be directly impacted by our ability or inability to follow best practices. This course will utilize simulation scenarios in Scott & White Healthcare's world class simulation facility, didactic lectures, review of P-D-S-A cycle research, and interactive workshops to help participants improve their understanding of the importance of developing efficient systems, effective communication, problem analysis tools, and the importance of front-line personnel involvement in solutions.

OBJECTIVES
As a result of attending this course, the participant should be able to:
• Discuss prevalent practice of evidence based approach to patient care.
• Describe how to effectively use PDSA cycles to improve quality of care and patient safety.
• Outline the potential uses of simulation training in quality improvement/patient safety.
• Design an effective use of personal outcomes data to guide care and counsel patients.

MEETING AND LODGING
The Friday Scenario portion of this activity will be held at the Temple College Simulation Center and Standardized Patient Pavilion located on the Temple College Campus at 2600 S. First St. Temple, TX 76504. The Saturday session for this activity will be held in the Mayborn Auditorium on the Scott & White Campus at 2401 S. 31st St, Temple, TX.
Local hotels for lodging include the Hilton Garden Inn, located directly across the street from Scott & White at 1749 Scott Boulevard, Temple, Texas, 76504 and can be reached directly at 254-773-0200. Another option for your stay is Candlewood Suites, also conveniently located at 1850 Scott Blvd, Temple, Texas and can be reached by calling (254) 773-8342

ACCREDITATION
Physicians - Scott & White is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

CREDIT DESIGNATIONS
Scott & White designates this live activity for a maximum of 13.75 AMA PRA Category 1 Credits™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

This activity meets Texas Ethics Requirements for physicians and will provide 1 hour ethics credit.

Application for CME credit has been filed with the American Academy of Family Physicians.

Nursing – Scott & White is an approved provider of continuing nursing education by the Texas Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.

This activity provides 14.25 contact hours.

Other allied healthcare providers and healthcare administrators will receive a certificate of attendance.

GUEST FACULTY:
Dr. Brent C. James, MD, M.Stat  Chief Quality Officer
Executive Director, Institute for Healthcare Delivery Research
Intermountain Healthcare
Dr. Andrew Masica, MD, MSCI  Vice-President, Clinical Innovation
Baylor Health Care System

SCOTT & WHITE HEALTHCARE & TEXAS A&M UNIVERSITY
HEALTH SCIENCE CENTER FACULTY

Jennifer Dixon, MD
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Russell Fothergill, MD
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Stephen Sibbitt, MD
Paula Shiroma-Bender, MSN, RN, JD
Christopher Spradley, MD
Gentry L. Woodard

Due to the ever increasing importance of quality improvement, this course will fulfill the following requirements:

1. Scott & White designates this live activity for a maximum of 13.75 AMA PRA Category 1 Credits™. Physicians should claim only credit commensurate with the extent of their participation in the activity.
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September 13-14, 2013 • Temple, TX

Scott & White Healthcare
Scott & White Memorial Hospital
Continuing Medical Education
2401 South 31st Street, MS-26-A229
Temple, Texas  76508

TAMU
HEALTH SCIENCE CENTER
COLLEGE OF MEDICINE

REGISTRATION
Scott & White Quality Improvement in Healthcare and Patient Safety Symposium
September 13-14, 2013      Temple, TX

For administrative use only:
Reg. # ____________ Amount ____________
Date _____________ Ck/Chg. # __________

☐ MD ☐ DO ☐ PA ☐ RN
☐ Other ______________

REGISTRATION FEE:

<table>
<thead>
<tr>
<th>Category</th>
<th>Full Program</th>
<th>Friday</th>
<th>Saturday</th>
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<tbody>
<tr>
<td>Physicians</td>
<td>__ $300 or __ $175</td>
<td>__ $175</td>
<td>__ $175</td>
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<tr>
<td>Hospital Administrators</td>
<td>__ $300 or __ $175</td>
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<tr>
<td>Residents, Physician Assistants, Nursing and other Allied Health Professionals</td>
<td>__ $125 or __ $75</td>
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Signature _______________ Exp. Date _______________

Mail or Fax to: Dept. of Continuing Medical Education, Scott & White, 2401 South 31st Street, MS-26-A229, Temple, Texas  76508
Phone (254) 724-7609, (800) 724-7280, FAX: (254) 724-1753.

Please let the CME Department know, in writing, of any special accommodations you may need.

☐ Check if you require a vegetarian diet.