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## Our North Star Goal:

*Oregon will have the safest health care system in the country by 2010.*

## Contact Us

[Patient Safety website](#)

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## Special Topic: Patient Safety Awareness Week

March 8-14 2009

## Patient Safety Awareness Week

This week brings a time to celebrate achievements and recommit to zero defects in patient care. It is an opportunity for hospitals, providers, and patients to pause in the journey to safe, reliable health care and celebrate the safety improvements in clinical care that have been accomplished.



The Commission has shared some safety improvement stories in the past. For example, Tuality Healthcare shared their changes to skin care practices that allowed them to eliminate moisture barrier pads ("plaid pads") — traditionally used but a risk for patients. We have recently heard about Silverton Hospital's significant reduction in the severity of fall-related injuries and will be describing their efforts in a future newsletter. As we embark on this next year of safety improvements, please let us know about your successes so we can share them with other Oregon hospitals. Contact [Leslie Ray](#).

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## Patient Safety Awareness Week Activities

Patient safety activities involve all levels and units of the organization as well as patients and their families. Some ideas:

### Hospital Leadership:

Include North Star metrics on your hospital dashboard for the senior team and board

Ask each unit/department to submit a patient safety idea and select three or four for immediate implementation

Publicize safety improvements made in the past year and provide awards for the best

### Units/Departments:

Implement the [Safe Surgery Checklist](#)

Hold a contest for the best idea for promoting hand hygiene

Recognize physician patient safety/quality champions with awards, celebrations

## Patient Safety Awareness Week Activities (cont'd)

### *Clinical Staff*

Pair up with a "hand hygiene buddy" and help each other to achieve 100% hand hygiene

Hold a patient safety roundtable with colleagues and identify how you can improve practices to improve patient safety – include food and drinks

### *Patients/Families*

Hold a Safety Fair - provide information on hand hygiene; safety measures the hospital is taking; give out samples (e.g., hand sanitizer) with the hospital logo; and/or promote [Ask Me 3](#) (three questions every patient should ask).

Provide hand sanitizer dispenser at each entrance to hospital, cafeteria - have a volunteer available to encourage use and answer questions

Develop a set of Safe Patient Practices (e.g. Know your Medicines, Safe Surgery) for information cards and distribute widely

Check out the Patient Safety Awareness Week [website](#) for more ideas and descriptions. [Return to Top](#)

## What is your Patient Safety IQ? (answers at end)

1. Which national organization sponsors Patient Safety Awareness Week?
  - a. NSA
  - b. NPSC
  - c. NPSF
  - d. Are you kidding me, they all sound alike?
2. Who in hospitals is responsible for patient safety?
  - a. CEO and Board of Directors
  - b. quality and/or risk department
  - c. staff
  - d. physicians
3. Approximately what percentage of physicians nationally believe they have access to a reporting system in their organization to report medical errors?
  - a. 20%
  - b. 36%
  - c. 52%
  - d. 60%
4. Though there is conflicting evidence regarding active surveillance testing of patients for MRSA, experts consider screening patients to be
  - a. less effective than screening healthcare workers
  - b. most effective after compliance with basic prevention practices is obtained
  - c. unnecessary for surgical patients who will be receiving antibiotics
  - d. too costly for widespread use
5. Which of the following medications are commonly confused with one another?
  - a. Lisinopril and Diazepam
  - b. Glucosamine and Chondroitin
  - c. Acetaminophen and Ampuride
  - d. Morphine and Dilaudid
6. What is the most common contributing factor to adverse events in Oregon as well as nationally?
  - a. Lack of Communication
  - b. Breakdown in Teamwork
  - c. Inadequate Staffing
  - d. Lack of compliance with policy

## Patient Safety IQ (cont'd)

7. How many retained objects occurred in Oregon hospitals in 2007?
  - a. 20
  - b. 36
  - c. 50
  - d. 62
  
8. Two key elements for a successful patient safety program are having a strong internal reporting program *and*:
  - a. Having a combined Quality/Risk department
  - b. Using the IHI Model for Improvement (from API)
  - c. Applying Six Sigma analysis to improvement projects
  - d. Consistently using an improvement strategy on all projects

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## In the News: Safety concern with bassinet warmers

The Minnesota Hospital Association sent out an alert January 16<sup>th</sup> regarding a potential hazard associated with the use of bassinet warmers. In a January 2008 incident that burned a baby, national experts concluded "...the design and construction of the radiant warming device did not adequately safeguard the bassinet from potential causes of fire. The flames were most likely caused by a hot particle falling from part of the bassinet into the oxygen-enriched space near the infant's head." For the complete article, click [here](#).

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## From the Commission

**Reports Received** — The Commission received 10 reports of adverse events from six Oregon hospitals in January. All were serious, with three deaths and two permanent harms. The events included three falls, two medication errors, delay in care, burn, retained object, unintended surgical perforation, and newborn death.

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## Upcoming Events

### Commission Meeting

February 10<sup>th</sup> from 12:30 to 3:30pm at the [Wilsonville Training Center of Clackamas Community College](#). To request an agenda, please contact [Linda Goertz](#). All 2009 Commission meetings are on the second Tuesday of even-numbered months. Click [here](#) for a listing of meeting dates.



### Technical Advisory Group meeting

February 10<sup>th</sup> from 9 to 11:30 am at the [Wilsonville Training Center of Clackamas Community College](#). The meeting will be open to interested hospital Quality, Risk, and Patient Safety personnel on a limited basis. If you are interested in attending please contact [Leslie Ray](#)

### Patient Safety Officer Executive Development Program IHI

March 5-11, 2009; The Charles Hotel, Cambridge, MA. Click links for [brochure](#) and [more information](#).

Washington Patient Safety Coalition 2009 Northwest Patient Safety Conference Thursday, June 4, 2009, at the Hilton Seattle Airport & Conference Center.

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### Answers to Patient Safety Quiz

1. c National Patient Safety Foundation
2. trick question, all are essential
3. b 36% see [AHRO Did You Know](#)
4. b most effective if basic practices compliance See [Hospital Infection Control & Epidemiology](#)
5. d [Morphine and Dilaudid](#) (Ampuride is a made-up name)
6. a Lack of communication
7. c 50 see [NorthStar benchmark report](#)
8. d consistently using an improvement strategy on all projects

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*This newsletter is being sent to interested parties and participants in the Oregon Patient Safety Commission's adverse event reporting program for hospitals. Your E-mail address will not be shared or used for any purpose unrelated to the Commission's activities. If you wish to unsubscribe, please send an E-mail to [linda.goertz@oregonpatientsafety.org](mailto:linda.goertz@oregonpatientsafety.org) with subject "Hospital Unsubscribe."*

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