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## Our North Star Goal:

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

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## From the Reporting Program:

### Overlooking System Issues in Adverse Events



Disentangling individual responsibility from system characteristics that contribute to adverse events is a formidable task. From the adverse events reported to us over the past three years, it is clear that Oregon hospitals mostly have moved away from individual blame. However, there is still a subtle preference for focusing prevention efforts on changing the individual rather than correcting the system. We see this preference in findings and action plans such as:

*"Lack of competence and failure for continued education to meet current standards of practice."*

*"All affected staff required to complete education packet correct policy & procedure, pass competency test w/score at least 91%."*

*"Conduct education for unit and critical care staff on clinical issues in the immunocompromised patient."*

To be sure, continuing education and competency testing are important assurances for maintaining practice standards. However, focusing on individuals' knowledge levels puts change activities at the individual, rather than system, level. Individual level changes alone are not sufficient to drive patient safety and assure reliability in health care organizations. System level analysis of individual-related factors (like knowledge deficits) is not immediately intuitive, but is necessary to effect system level change. Action plans that come from this analysis will then not only 'correct' the involved staff, but also prevent other events by altering processes and practices.

Two common RCA tools are helpful in surfacing the underlying system issues in staff knowledge deficits. Both **5 Why?**s and **Barrier** analyses could be useful, in asking why there was a knowledge deficit, or what the barrier to adequate knowledge was. These types of analyses could uncover factors involving systems for tracking competencies, content and timing of orientations, and practice updates, or processes for management to maintain awareness of staff abilities/practice gaps.

In the last example above, educating staff regarding an infrequently encountered patient condition is excellent. However, using the 5 Why?s will allow a deeper understanding of the issues, leading to system changes designed to prevent other staff from similar events in the future. Using this approach leads to somewhat different actions than providing staff training on specific content — immunocompromised patients.

## System Issues in Adverse Events (cont'd)

### 5 Why's Analysis:

*Why* did staff delay in responding quickly to immunocompromised patient's symptoms? — *Staff did not understand meaning of the patient's symptoms.*

*Why* didn't staff understand the meaning of the symptoms? — *Staff encounter immunocompromised patients infrequently.*

*Why* did the frequency of having immunocompromised patients matter? — *Since staff encounter some conditions infrequently, they are less aware of what are the critical indicators.*

In just 3 levels of *Why?* we move from staff knowledge to low frequency as a key finding. With this finding, action plans will focus on responding to low frequency events — what system supports are available when another patient is admitted who has a different or unusual diagnosis?

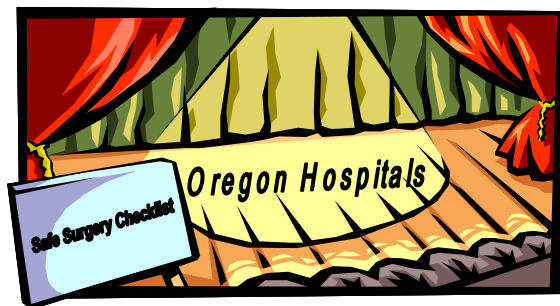
Addressing needs for system resources when staff encounters such a patient is critical. It creates a more reliable healthcare process, and decreases the risk of future events. Possible actions when such patients are encountered might include considering assignment changes depending on familiarity of unit staff with the diagnosis; increasing available resources on unit, such a electronic reference guide similar to that available to physicians; setting up a mechanism for consultation, perhaps with a Clinical Nurse Specialist or the House Supervisor.

This finding also opens up the investigation to questions regarding the culture. How is speaking up regarding uncertainty or lack of knowledge seen by colleagues, leadership, and other disciplines? If there are tacit rules against acknowledging imperfections, they will be almost insurmountable barriers unless addressed.

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## Spotlight on Practice: Safe Surgery Checklist

The Safe Surgery Checklist is rapidly becoming one of the most well-known advances in patient care. Articles have appeared in the Wall Street Journal, the NY Times, and in the Oregonian. Fears that this evidence-based practice might languish for 17 years (the average time between appearance in the literature and use in practice) before adoption seem unfounded, as Oregon hospitals are moving quickly to evaluating the tool for their systems. The evidence for its effectiveness is available in the New England Journal of Medicine article, *A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population*, published 29 January 2009 and available free from the publisher. [Click here](#).



The Oregon IHI Network has modified IHI's recommended US version and added additional SCIP items to the checklist as well as the "invitation to raise concerns" in an Oregon Version. Some considerations in testing/implementing the checklist:

1. the evidence is for the checklist, not individual pieces of it, so any modifications should keep the tool intact;
2. there is other evidence that team introductions increase the likelihood someone will raise concerns if they have them, so keeping the introductions despite the initial awkwardness is important;
3. while the checklist was developed and tested in in-patient settings, the implications for its use in day surgeries or ambulatory surgery centers are clear;
4. intent of the checklist is to assure against distractions, interruptions and memory slips, so consider a poster format that everyone in the OR can easily see, rather than another required piece of documentation.

The Network, through a generous donation by the [Oregon Medical Association](#), will provide 11x17 laminated posters to Oregon hospitals to use in testing the checklist. Please contact [Leslie Ray](#) if you need additional posters. We will send as many additional posters as we are able.

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### Journal Brief:

## A Reengineered Hospital Discharge Program to Decrease Rehospitalization



Brian W. Jack, MD; Veerappa K. Chetty, PhD; David Anthony, MD, MSc; Jeffrey L. Greenwald, MD; Gail M. Sanchez, PharmD, BCPS; Anna E. Johnson, RN; Shaula R. Forsythe, MA, MPH; Julie K. O'Donnell, MPH; Michael K. Paasche-Orlow, MD, MA, MPH; Christopher Manasseh, MD; Stephen Martin, MD, MEd; and Larry Culpepper, MD, MPH [Ann Intern Med.](#) 2009 Feb 3;150(3):178-87.

**Background:** Emergency department visits and rehospitalization are common after hospital discharge.

**Objective:** To test the effects of an intervention designed to minimize hospital utilization after discharge.

**Design:** Randomized trial using block randomization of 6 and 8. Randomly arranged index cards were placed in opaque envelopes labeled consecutively with study numbers, and participants were assigned a study group by revealing the index card.

**Setting:** General medical service at an urban, academic, safety-net hospital.

**Patients:** 749 English-speaking hospitalized adults (mean age, 49.9 years).

**Intervention:** A nurse discharge advocate worked with patients during their hospital stay to arrange follow-up appointments, confirm medication reconciliation, and conduct patient education with an individualized instruction booklet that was sent to their primary care provider. A clinical pharmacist called patients 2 to 4 days after discharge to reinforce the discharge plan and review medications. Participants and providers were not blinded to treatment assignment.

**Measurements:** Primary outcomes were emergency department visits and hospitalizations within 30 days of discharge. Secondary outcomes were self-reported preparedness for discharge and frequency of primary care providers' follow-up within 30 days of discharge. Research staff doing follow-up were blinded to study group assignment.

**Results:** Participants in the intervention group ( $n = 370$ ) had a lower rate of hospital utilization than those receiving usual care ( $n = 368$ ) (0.314 vs. 0.451 visit per person per month; incidence rate ratio, 0.695 [95% CI, 0.515 to 0.937];  $P = 0.009$ ). The intervention was most effective among participants with hospital utilization in the 6 months before index admission ( $P = 0.014$ ). Adverse events were not assessed; these data were collected but are still being analyzed.

**Limitation:** This was a single-center study in which not all potentially eligible patients could be enrolled, and outcome assessment sometimes relied on participant report.

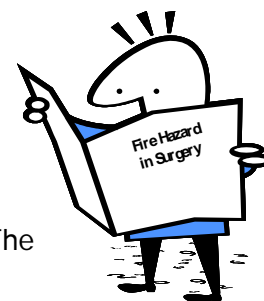
**Conclusion:** A package of discharge services reduced hospital utilization within 30 days of discharge.

[Pub Med Citation](#)

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## In the News: Surgical Fires and Burns

Last month we reported on injuries caused by infant warmers in bassinets. A Wall Street Journal article three weeks ago — [In Just a Flash, Simple Surgery Can Turn Deadly](#) — noted that event and a number of other serious burns resulting from unrecognized risks for fires. Several groups are addressing this serious risk. Burn prevention is one of the top five safety indicators for surgery by the National Quality Forum, and the AORN is making available its fire safety toolkit free to its members. The WSJ article provides an easy-to-read overview and includes illustrations.



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## Resources: Medication Safety Newsletter



The Institute For Safe Medication Practices (ISMP) is offering their newsletter **Nurse Advise-ERR®**, free to US hospital nurses in 2009 through educational grants from McKesson and Baxter Healthcare. ISMP encourages hospitals to designate a primary RN subscriber who will then redistribute the newsletter to as many nurses as possible. [Click here to subscribe](#). Back issues of the newsletter available at: <http://www.ismp.org/Newsletters/nursing/backissues.asp>.

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## From the Commission

**Reports Received** – The Commission received eight reports of adverse events from eight Oregon hospitals in February. They represented a range of harm levels and types of events, though four of the events were related to surgery. Five were finished reports (the Commission accepts preliminary reports within the 45 day timeline), three of which did not meet the criteria for acceptable reports, primarily because of incomplete information provided in the event description.

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## Upcoming Events



### Commission Meeting

April 14<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 list of meeting dates.

### Technical Advisory Group meeting

April 14<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](#)

Washington Patient Safety Coalition 2009 Northwest Patient Safety Conference Thursday, June 4, 2009, at the Hilton Seattle Airport & Conference Center. Keynote Speaker: Dr Robert Wachter. All attendees who [register](#) by April 3, 2009, will receive a \$50 discount off the registration price.

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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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