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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:

Evidence-Based Practice - Pt.1 When is the evidence good enough?

A basic tenet of patient safety is adoption of evidence-based best practices. However, as a review of adverse events reported to the Commission shows, there can be gaps between what the literature reports and the action plans implemented following an adverse event. As examples, consider two current recommendations: hourly nursing rounding to prevent falls and the WHO surgical safety checklist to decrease post-operative morbidity and mortality. Since the Commission receives frequent reports of both patient falls and inadvertently retained objects/wrong-site surgery, these recommendations are particularly salient. Both have received widespread attention and interest, though they are yet to receive widespread adoption.

The reason may lie in misunderstanding of what it means for a recommended practice to be “evidence-based.” Evidence is rated on Quality – with expert opinion lower than a randomized control trial (RCT) and on Strength – quantity and consistency. See table below for one commonly used rating system.

Table 1. Strength of Recommendation and Quality of Evidence

Strength of recommendation	
A	Good evidence to support a recommendation for use
B	Moderate evidence to support a recommendation for use
C	Poor evidence to support a recommendation

Quality of evidence	
I	Evidence from ≥1 properly randomized, controlled trial
II	Evidence from ≥1 well-designed clinical trial, without randomization; from cohort or case-control analytic studies (preferably from 11 center); from multiple time series; or from dramatic results from uncontrolled experiments
III	Evidence from opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

So, where would our two recommendations fall? Neither is supported by RCTs; both are supported by single studies, with relatively dramatic results; the rounding study design was less strong than the checklist study; there are anecdotal reports of success with hourly rounding and some of the checklist elements are supported by additional studies.

Both seem to fall into the B-II category, though the checklist study is a stronger study, given the number of study sites and strong support of respected authorities.

When is the evidence good enough? (cont'd)

Is this evidence strong enough to recommend changes in practice? Yes. Care needs to be taken, however, in how the evidence is introduced and implemented. In Part II we will discuss the effective implementation of evidence in practice. [Return to Top](#)

Spotlight on Practice:

Decreasing Harm from Falls

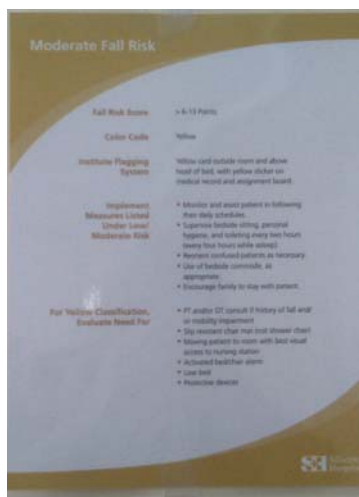
Preventing falls and decreasing the harms occurring with a fall in hospitalized patients is an ongoing challenge for staff. Silverton Hospital staff have had help from a new policy and fall risk assessment tool. Following house-wide implementation, Silverton has noted a significant reduction in falls and a more

significant reduction in harm from falls. Falls dropped from a high of 11 falls in one quarter, to four in the fourth quarter of 2008, two of which resulted in only minor harm. In the most recent six-month period, there have been only four falls, three of which had very minor injury (edema, skin tear, and a contusion). Greg Bench RN, MSN, Nursing Practice & Quality Coordinator at Silverton, attributes this significant reduction in frequency and harm to their new falls management project that revised the usual practices at the hospital to incorporate identified best practices. They are still working to mitigate each causal factor identified, with a goal of no falls with injury.



The project had four main features:

1. Goal was development of a Falls Management plan that would significantly reduce the number of falls and result in zero (0) falls with harm. The plan is applicable to all hospitalized patients on admission and at regular intervals throughout their stay, including patients seen in the Emergency Department and in the Family Birthing Center.
2. An assessment tool that included all pertinent contributing factors, reflected best practices, and provided direction for fall prevention interventions. Silverton chose to use the Johns Hopkins fall risk assessment tool. It was chosen primarily because it was a validated tool that included both medications and equipment in its seven assessment categories and also provided direction for interventions at all levels of risk (Low, Moderate, High).
3. Regular nursing rounding to assess patient needs. Following the Johns Hopkins recommendations, nurses round every two hours on Moderate Risk patients and hourly on High Risk patients.
4. A phased trial and implementation plan that began with post-op total knee and total hip replacement patients and was followed in their identified high risk units until it was working well and implemented house-wide.



As part of the Falls Management program, Silverton developed placards for both moderate and high risk patients; these are placed on patients' doors to assist staff and family members with plans for decreasing fall risk. The laminated placard shown here is for Moderate Fall Risk and includes the Fall Risk Score, Color Code, Flagging System, Prevention Measures, and specific Evaluation Needs with descriptions. A similar placard is used for patients at high risk.

The Johns Hopkins tool is one of several tools available, including the Heindrich II Morse and Morse Scale. In addition to Silverton's experience, anecdotal comments on the NPSF listserve support use of the Johns Hopkins tool because of its sensitivity to patients at moderate risk. Two articles may be of interest with regard to Fall Risk Assessment tools, the Johns Hopkins study and a comparison of three other tools, including the Heindrich II and Morse — see below.

Fall Risk Assessment Tool articles:

Poe S.S., Cvach M., Dawson P.B., Straus H., & Hill EE. (2007) The Johns Hopkins Fall Risk Assessment Tool: postimplementation evaluation. *Journal of Nursing Care Quality*. 22(4):293-8.

Ang N.K.E., Mordiffi S.Z., Wong H.B., Devi K. & Evans D. (2007) Evaluation of three fall-risk assessment tools in an acute care setting. *Journal of Advanced Nursing* 60(4), 427-435.

The Commission has received 11 reports of falls in 2009 and the Technical Advisory Committee (TAC) will be addressing these types of events beginning with its June meeting. Following a review of the events and known best practices, the TAC will issue a set of recommendations to Oregon hospitals on Fall Management. A similar effort is underway for Oregon nursing homes, which includes recommendations for event investigation recommendations. [Return to Top](#)



Journal Brief:

Inpatient suicide: preventing a common sentinel event

Over the past three years of hospital adverse event reporting, the Commission has received a number of reports related to suicides. Most of these reports involved suicides during or immediately following in-patient admission. The article below describes the results of a systematic review of the literature and concludes with a number of recommendations in the following areas: Environmental; Patient Care - Screening; Patient Care - Treatment; Staff Training; and Hospital Policy.

Tishler, C.L. & Reiss, N.S. (2009) Inpatient suicide: preventing a common sentinel event. General Hospital Psychiatry 31:103-109

Objective Suicide in the hospital is one of the most common types of sentinel events, and hospitals can (and should) take steps to decrease the likelihood of experiencing this type of crisis.

Method MEDLINE, Cochrane Library, National Electronic Library for Mental Health, and PSYCHINFO searches were conducted. In addition, manual and phone queries were used to identify relevant empirical and clinical publications. Reference sections of published articles were also searched.

Results The current article discusses the rates of suicide in hospitals, related risk factors, methods of suicidal behavior, and factors which contribute to this tragic event.

Environmental, patient care, staff training, and hospital policy recommendations for decreasing the number of inpatient suicides are presented.

Conclusion Inpatient suicide is a traumatic event. Although it is a relatively rare occurrence that is often difficult to predict and prevent, continuing to refine our efforts to assist the population at risk is imperative.

(From Science Direct - available at <http://www.sciencedirect.com/science/journal/01638343>) [Return to Top](#)



Resources

Pandemic Supplies Calculator

The recent concern raised about a possible epidemic of H1N1 flu has focused attention on public health preparedness and preparations that hospitals must make to handle a sudden influx of patients. Offered on the [JCAHO-Watch listserve](#), this tool from [James A. Gomez](#), Director of Process Improvement at Bert Fish Medical Center in Florida, calculates necessary supplies during a pandemic. He used AHRQ's pandemic

supply list and added some calculations. Simply input the expected influx of patients, hit <Enter> and it will automatically calculate which items and how many you'll need for each unit, rounded to the next whole number for ease of understanding. The tool is posted at

http://www.hipaabootcamp.com/Joint_Commission.html

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In the News: Perioperative Glucose Management

The Oregon National Surgical Quality Improvement Program Consortium (ONC) and the Oregon Patient Safety Commission will shortly be releasing a white paper outlining a Call to Action for better perioperative care based on lessons learned by the National Surgical Quality Improvement Program (NSQIP) and other relevant studies. The ONC is calling on all Oregon surgeons to improve outcomes by:



1. Preoperatively screening surgical patients for poorly controlled diabetes and undiagnosed diabetes and prediabetes;
2. Measuring perioperative glucose in patients with diabetes or known risk-factors;
3. Treating perioperative hyperglycemia using safe and effective glycemic control strategies.

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From the Commission

Reports Received — The Commission received 10 adverse event reports (eight resulting in serious and two in less serious harm) in April from seven hospitals. Three events were retained sponges, two of the events were falls, and two others were wrong-site anesthesia and laminectomy; the remaining events included administration of Dilaudid instead of Morphine, a mis-positioned feeding tube, and an unexpected death.

Surgical Safety Checklist: With its partners in the Oregon IHI Network, the Commission is surveying hospitals in Oregon to learn about their experiences with the evidence-based surgical checklist from the World Health Organization. The results of the survey will be available next month. Our initial information suggests that several hospitals have been working hard to trial the checklist and are looking to full implementation over the next several months. Others are in the beginning stages of planning, with some holding back until the early adopting hospitals can share their experiences. Also, unfortunately, there are a few hospitals that currently plan to maintain their previous practices. The biggest challenges in incorporating this evidence-based best practice are maintaining its evidence base by keeping its basic structure and elements, and resisting the temptation to turn it into a method of documentation for the medical record.

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Upcoming Events



Commission Meeting

June 9th 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

June 16th from 9 to 11:30 am at the [Wilsonville Training Center of Clackamas Community College](#). The group will be looking at reports of Falls over the past 3 years and will be describing Oregon's experience regarding causes and recommending approaches to decrease fall risks in hospitals.

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. [Click here to register](#)

Hospital to Home: Optimizing the Transition. Institute for Healthcare Improvement. June 15-16, 2009; Orlando, FL. [Conference information](#)

Nursing Leadership Conference <http://www.nursingleadershipcongress.com/2009Info.asp> [Return to Top](#)

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