

In This Issue:

- [From the Reporting Program: Evidence-Based Practice - Pt. 2](#)
- [Spotlight on Practice: More on Surgical Safety](#)
- [Journal Brief: Cost of retained sponges](#)
- [Resources: Patient Safety Culture Survey](#)
- [From the Commission](#)
- [Upcoming Events](#)

Our North Star Goal:

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

Contact Us

[Patient Safety website](#)

Hospital

Field Coordinator

Leslie Ray:

503.224.9227

[E-mail Leslie](#)

Administrator

Jim Dameron:

503.224.9226

[E-mail Jim](#)

From the Reporting Program:

Evidence-Based Practice - Pt.2: Having evidence isn't enough.

As anyone can tell you knowing the right thing to do and being able to do it are very different. It is the same in health care. IHI's President and CEO Don Berwick noted last year that the average time between evidence appearing in the literature and its wide-spread adoption is 14 years. An example is the pulse oximeter, now so standard in US operating rooms, that it is not included in the US version of the WHO Surgical Safety Checklist. The first device was built in 1935, a major breakthrough occurred in 1972, but it was not marketed in 1981, and was not in widespread use until the late 1980s. (see [Kamat, V. \(2002\). Pulse Oximetry. Indian Journal of Anaesthesia. 46, 4 p261-68](#))

Putting evidence into practice sooner than the eight-plus years it took for pulse oximeters is essential. Once the evidence is (more or less) clear, the focus is on implementation, with three aspects to attend to for success:

1. Know the evidence and its limitations. In order to be convincing about a new practice, the limitations of the evidence need acknowledgement and a response. For the Surgical Safety Checklist (SSC), limits include not being able to identify what specifically about the checklist drove the dramatic decrease in post surgical morbidity and mortality. Response: true, and until we know from other studies what might safely be changed, we need to go with this evidence.

2. Counter the natural inclination of health care staff to tinker under the guise of individualizing. It is likely some modification is needed, but it is just as likely the modification needs to occur with existing processes, not necessarily with the new evidence. Prudence in making changes assures that the practice remains evidence-based. Some examples of the SSC from other states have only two phases, a modification that removes their version from its evidence base.

Sometimes modification stems from not seeing how the new process/policy/procedure can work or not be disruptive. Here, acknowledgment of the degree of change can help. Nursing staff moving to hourly rounding, for example, is not trivial. It requires nurses who have developed an effective and efficient way of working to toss that out and re-organize around a different schedule while other organizational processes and demands do not change.

[Return to Top](#)

Evidence-based Practice - Pt 2 (cont'd)

3. Use an effective improvement strategy; Lean Method, or the [IHI Model for Improvement](#) are two that come immediately to mind. Both use cyclic change cycles ([PDCA/PDSA](#)) that start small and gradually expand to include more staff and departments. The key is starting small - one patient, one clinician/staff interested in trialling. You can work out any initial glitches or bumps in the process that arise – and they will arise. Then, ask one shift on one unit to try it, again fine-tuning the process; keep doing these cycles until you are satisfied that it works in different areas/shifts, etc. Along the way share the successes and plan a roll-out to other units/divisions, one by one. Continue to fine-tune, but at some point there will be a balance between unit-specific modifications and house-wide consistency.

Because most hospitals are dealing with a number of projects and efforts, an Improvement Tracking Grid might be helpful to senior leadership in planning as well as to staff so can see where they fit in the larger picture. Used for individual projects and all projects, it provides an immediate, easily-understood picture of project status: number of projects each unit is committed to, progress on the projects, and the organizational emphasis. For the hypothetical hospital below, the grids show that the organization is currently focused on preventing catheter-associated urinary tract infections (CAUTI); Unit 1 is involved in a large number of projects and but is having some difficulty in with patient rounding; Unit 2 is right on track with rounding, Unit 3 is only involved in a single project and is having some difficulty.

All Projects	CAUTI	CLBSI	EMR	Rounds	Shift Handoff	Etc...
Unit 1	Green	Yellow	Orange	Orange	Yellow	Yellow
Unit 2	Yellow	White	White	Green	White	White
Unit 3	White	Red	White	White	White	White
Unit 4	Green	White	White	White	Green	Yellow
Unit 5...etc	Green	White	Yellow	White	White	White

Rounds	Phase 1	Phase 2	Phase 3...etc
Unit 1	Green	Orange	White
Unit 2	Green	Green	White
Unit 3	White	White	White
Unit...etc	White	White	White

With the overall picture and detail, it is possible for management to respond early and quickly to help faltering projects get back on track. Units that either over- or under-commit are easily identified for appropriate management responses.

[Return to Top](#)

Spotlight on Practice: More on Surgical Safety

The WHO Surgical Safety Checklist 1.0 is now out for use. Adapting the Oregon version, a group of surgical nurses led by the Columbia River Chapter of AORN has come out with their recommended version that incorporates elements of The Joint Commission Universal Protocol requirement. While keeping to the evidence-based checklist from WHO, the group added some elements, took out some of the SCIP measures that had been added



earlier, and rearranged some of the elements to fit with current practice. Please contact [Leslie Ray](#) for a copy of the new version.

In addition, The Columbia River Chapter of the Association of peri-Operative Registered Nurses (AORN) and the Metro Area Surgical Services Management Organization teamed together to standardize key elements of the Joint Commission's Universal Protocol. Their recommendations:

Standard Elements of Universal Protocol:

1. Identification of the patient using two (2) identifiers
2. Physician marking of the surgical site with their initials
3. Use of a paper diagram for alternate site marking
4. Physician shall lead the "Time Out"
5. All activity stops during the "Time Out"
 - a. Use of a script, including identification of patient allergies, is encouraged
6. Anyone can stop the process at any time to voice concerns or questions
7. The "Time Out" shall occur immediately prior to the start of the procedure

Seventeen hospitals in the Portland Metro area have signed on to the recommendations. Facilities participating in these guidelines include:

Columbia Memorial, Astoria Legacy Emanuel Hospital & Health Center Legacy Good Samaritan Hospital & Health Center Legacy Meridian Park Hospital Legacy Mt. Hood Medical Center	Legacy Salmon Creek Hospital Oregon Health & Science University Portland Shriners' Hospital Portland Adventist Medical Center Portland VA Medical Center Providence Portland Medical Center	Providence St. Vincent Medical Center Providence Milwaukie Hospital Providence Newberg Hospital Samaritan Health Services Southwest Washington Medical Center Tuality Community Hospital
--	--	---

The team included representatives from nearly all the hospitals from Vancouver, Washington to Corvallis, Oregon. Click here for the [press release](#) and the [complete position statement](#).

[Return to Top](#)



Journal Brief: Costs of Unintentionally Retained Sponges

The Surgical Safety Checklist has been widely discussed and recent recommendations from the Oregon surgical nurses make the following article very timely. In addition, one of the [Commission's recommendations](#) regarding retained objects was for hospitals to consider emerging technologies in their efforts to prevent sponges, surgical instruments, and other surgical equipment from being retained following a surgery. The article below provides some new data comparing cost-effectiveness of three different strategies for preventing retained surgical sponges.

Regenbogen SE, Greenberg CC, Resch SC, Kollengode A, Cima RR, Zinner MJ, Gawande AA. (2009) Prevention of retained surgical sponges: a decision-analytic model predicting relative cost-effectiveness. Surgery. 2009 May; 145(5):527-35. Epub 2009 Mar 21.

Background: New technologies are available to reduce or prevent retained surgical sponges (RSS), but their relative cost-effectiveness are unknown. We developed an empirically calibrated decision-analytic model comparing standard counting against alternative strategies: universal or selective X-ray, bar-coded sponges (BCS), and radiofrequency-tagged (RF) sponges.

Methods: Key model parameters were obtained from field observations during a randomized-controlled BCS trial (n = 298), an observational study of RSS (n = 191,168), and clinical experience with BCS (n ~60,000). Because no comparable data exist for RF, we modeled its performance under two alternative assumptions. Only incremental sponge-tracking costs, excluding those common to all strategies, were considered. Main

outcomes were RSS incidence and cost-effectiveness ratios for each strategy, from the institutional decision-maker's perspective.

Results: Standard counting detects 82% of RSS. Bar coding prevents $\geq 97.5\%$ for an additional \$95,000 per RSS averted. If RF were as effective as bar coding, it would cost \$720,000 per additional RSS averted (versus standard counting). Universal and selective F-rays for high-risk operations are more costly, but less effective than BCS—\$1.1 to 1.4 million per RSS event prevented. In sensitivity analyses, results were robust over the plausible range of effectiveness assumptions, but sensitive to cost.

Conclusion: Using currently available data, this analysis provides a useful model for comparing the relative cost effectiveness of existing sponge-tracking strategies. Selecting the best method for an institution depends on its priorities: ease of use, cost reduction, or ensuring that RSS are truly “never events.” Given medical and liability costs of $> \$200,000$ per incident, novel technologies can substantially reduce the incidence of RSS at an acceptable cost. [Return to Top](#)



Resources: Patient Safety Culture Survey

One of Oregon's North Star Goals is a strong patient safety culture in all hospitals and recently The Joint Commission has moved to requiring annual culture surveys. These surveys can provide information that helps senior leadership identify both strengths and weaknesses in their current culture and make the necessary changes. Hospital-wide surveys are usually met with groans, both from staff and management. However, the Tennessee Center for Patient Safety has developed an easy-to-access online AHRQ (Agency for Healthcare Research and Quality) Patient Culture Survey tool. For a small fee, Tennessee is making this tool accessible to hospitals in other states. They will provide an analysis of the data and a report that suggests possible actions for identified areas of improvement. The Oregon Office of Rural Health is providing an informational webinar July 7th at noon. Please email [Kassie Clarke](#) if you wish to attend. [Return to Top](#)

From the Commission

Reports Received —

The Commission received nine reports of adverse events in May. Falls again were the most frequent type of event reported (four) followed by wrong site surgery/anesthesia (two) and a medication error, pressure ulcer, and unexpected death.



Upcoming Events

Commission Meeting

August 11th 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

August 11th from 9 to 11:30 am at the [Wilsonville Training Center of Clackamas Community College](#).

[Return to Top](#)

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 with subject "Hospital Unsubscribe."

Oregon Patient Safety Commission, 1020 SW Taylor St., Suite 375, Portland OR 97205