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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](#)

Hospital Field Coordinator  
Leslie Ray:  
503.224.9227

[E-mail Leslie](#)

Administrator  
Jim Dameron:  
503.224.9226

[E-mail Jim](#)

## *From the Reporting Program:*

### Communicating Across Care Settings

An event recently reported to the Commission illustrates the risks to patients when they move from one care setting to another. In this case, an elderly patient residing in a nursing home came to the ED of a local hospital with a fever. The patient was admitted for treatment of pneumonia and delirium with orders that included a Fentanyl patch. On admission to the unit, the RN reviewed the nursing home documentation prior to getting the patch for the patient. An initialed entry dated five days previous to hospital admission gave a site placement; an initialed entry dated four days later gave no indication of site placement. She interpreted the earlier date as the last time the patient had a patch and, following the order from the ED for a Fentanyl patch, placed a new patch without noticing the prior one. The patient returned to the nursing home two days later where they found and removed the second patch when the patient seemed more confused than usual.

Adequate response to this case requires attention to both medication practices and organizational communication.

Medication Practices: Fentanyl has been the topic of a number of alerts and advisories from several authorities. The [June 2007 Advisory](#) from the Pennsylvania Patient Safety Authority provides a detailed overview, offering suggestions for safe prescribing, administration, and patient education. ISMP's safe practice [recommendations](#) for Fentanyl transdermal patches advise hospitals to •Create prescribing and dispensing guidelines •Determine the indication •Set dosing limits •Assess concomitant use of opiates •Limit prescribing privileges •Mandatory patient education •Know the signs of overdose. The FDA has also issued an alert related to Fentanyl patches and their website includes a 3 ½ minute [video clip](#) for providers on the factors contributing to serious harm and death.

Organizational Communication: A key factor in this case was incomplete medication reconciliation. Two opportunities existed for clarification of the patient's status regarding the patch — in the ED prior to the written order for a new patch, and on the unit prior to placement of the patch. Medication reconciliation is a thorny issue that many hospitals have yet to implement effectively. That considered, this case illustrates a larger, all-too-common, communication gap in patient care. Omissions of significant patient information that place the patient at risk for serious harm are characteristic of nursing home to hospital and hospital to nursing-home transfers.

## Communicating Across Care Settings (cont'd)

In a study of nursing home admissions from 25 Long Island hospitals, investigators found significant gaps in information:

- 22% of transfers had no formal summary of information;
- Legible summaries were available only 56% of the time;
- Secondary diagnoses were missing from 30% of transfers;
- Only 51% had allergies documented;
- Mental status was missing in 33% of cases;
- Lab, chest x-ray, and EKG results were missing 31%, 67%, and 61% of the time, respectively;
- Do-not-resuscitate (DNR) orders and advanced directives were absent from 87% of transfers;
- Dietary information was missing 19% of the time; and
- Clarification of information was difficult because identification of hospital physician was only legible 41% of the time and phone numbers only 33% of the time.

Foley C. Falling through the cracks. Symposium. Program and abstracts of the American Geriatrics Society 2003 Annual Scientific Meeting; May 14-18, 2003; Baltimore, Maryland. Noted in Lee, VK, Westley, CJ, Fletcher, K. (2004). If at first you don't succeed: Efforts to improve collaboration between nursing homes and a health system. [Topics in Advanced Practice Nursing eJournal](#). September 1.

One health system (University of Virginia Health System) has [reported](#) on their efforts to improve communication, thus providing better continuity of care for patients admitted from and discharged to local skilled nursing facilities. Their initiative considered three different aspects of care: (1) transfers from hospital to nursing home, (2) transfers from nursing home to hospital, and (3) issues in the emergency department (ED). Among the lessons learned were the need for continued focus on the patient and keeping the process moving; starting with a few nursing homes in order to address issues as they arose; and having an identified advocate at each facility to help foster trust and communication.

Oregon has begun a similar nursing-home-to-hospital journey with the Pressure Ulcer Prevention initiative. A collaborative effort among the organizations involved in Advancing Excellence and the Oregon IHI Node began in the summer of 2007 to identify best practices and develop a common data set of information to accompany patients as they transition between care facilities. The pilot testing is complete and the expert panel is currently finalizing the handoff data set. This has been an exciting project and we will be sharing the group's work in early Fall.

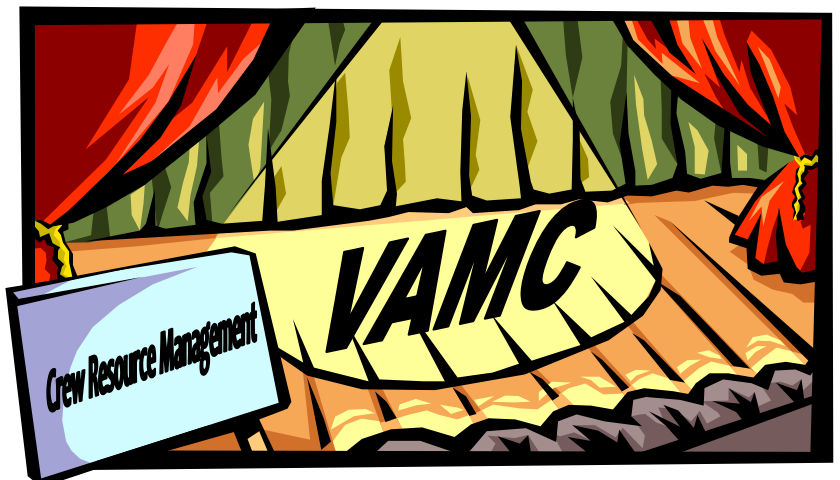
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### *Spotlight on Practice:*

#### **Medical Team Training Using Crew Resource Management Principles Enhances Provider Communication and Stimulates Improvements in Patient Care**

Last year we spotlighted Salem Hospital's work with Crew Resource Management (CRM) in their Family Birthing Center and described their learnings in changing old patterns and habits of communication.

Oregon critical access hospitals have also begun to use team communication strategies to improve care delivery and, while early in their efforts, have anecdotal reports of success.



A recent initiative by the VA National Center for Patient safety involving 79 VA Medical Centers across the nation to improve communication is showing strong indicators of improved care in the 10 pilot hospitals that began the project in 2006. The VA embarked on this initiative when analysis of over 14,000 adverse event reports showed communication problems contributing to over 75% of the events. These numbers are consistent with The Joint Commission data and Oregon's adverse event reporting experience.

Briefly, the pilot facilities noted improvements in post-surgical infection and deep vein thrombosis prevention. They also reported improvement in starting time for the first case of the day and increased efficiency with streamlined instrument packs directly resulting from debriefings. In at least two cases, patients with medical contraindications were identified during the surgical briefing and the surgery cancelled. A fuller description of this project is available on [AHRQ's Innovations Exchange](#) website. Click [here](#) for specific information about the project, implementation strategies, results, and adoption considerations.

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## *Journal Brief*

### **Medication Discrepancies**

The very timely paper below describes frequency of medication discrepancies in patients admitted to a nursing home and indicates the area of discrepancy; for example, the discharge summary did not match the referral form.

Tjia J, Bonner A, Briesacher BA, McGee S, Terrill E, Miller K. (2009). [Medication discrepancies upon hospital to skilled nursing facility transitions](#). J Gen Intern Med. 24:630-635

**BACKGROUND:** Failure to reconcile medications across transitions in care is an important source of harm to patients. Little is known about medication discrepancies upon admission to skilled nursing facilities (SNFs).

**OBJECTIVE:** To describe the prevalence of, type of medications involved in, and sources of medication discrepancies upon admission to the SNF setting.

**DESIGN:** Cross-sectional study.

**PARTICIPANTS:** Patients admitted to SNF for subacute care.

**MEASUREMENTS:** Number of medication discrepancies, defined as unexplained differences among documented medication regimens, including the hospital discharge summary, patient care referral form and SNF admission orders.

**RESULTS:** Of 2,319 medications reviewed on admission, 495 (21.3%) had a medication discrepancy. At least one medication discrepancy was identified in 142 of 199 (71.4%) SNF admissions. The discharge summary and the patient care referral form did not match in 104 of 199 (52.3%) SNF admissions. Disagreement between the discharge summary and the patient care referral form accounted for 62.0% (n = 307) of all medication discrepancies. Cardiovascular agents, opioid analgesics, neuropsychiatric agents, hypoglycemics, antibiotics, and anticoagulants accounted for over 50% of all discrepant medications.

**CONCLUSIONS:** Medication discrepancies occurred in almost three out of four SNF admissions and accounted for one in five medications prescribed on admission. The discharge summary and the patient care referral forms from the discharging institution are often in disagreement. Our study findings underscore the importance of current efforts to improve the quality of inter-institutional communication.

[PubMed citation](#)

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## Resources:

### WHO Checklist for Treating Influenza A (H1N1) Patients

The World Health Organization has developed a new Patient Care Checklist for Influenza A (H1N1) for use by hospitals worldwide for the treatment of suspected or confirmed cases of this new virus. You can download in English or Spanish via this link: [http://www.who.int/patientsafety/activities/ah1n1\\_checklist/en/](http://www.who.int/patientsafety/activities/ah1n1_checklist/en/) For questions about the checklist please contact WHO Patient Safety at the following email address: [patientsafety@who.int](mailto:patientsafety@who.int)

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## Heard on the Net:

### RN Administration of Propofol

There was a flurry of emails on the NPSF listserv last week regarding the safe administration of propofol (Diprivan). The key issue is the relatively narrow therapeutic range and the sudden occurrence of life-threatening side effects, as well as the importance of having a trained healthcare professional to respond instantly, should these occur. The overall tenor of the very thoughtful discussion was a belief that trained anesthesia providers who can carefully monitor the patient's status should administer the medication for surgeries and procedures. Some states limit RN administration to ventilated ICU patients while others ban the bolus or IV push administration by RNs. An [ISMP Alert](#) dated November 5, 2005 concluded: *The debate about who should be allowed to administer propofol may continue, but one thing is clear: whenever propofol is used for sedation/anesthesia, it should be administered only by persons who are: (1) trained in the administration of drugs that cause deep sedation and general anesthesia, (2) able to intubate the patient if necessary, and (3) not involved simultaneously in the procedure itself.*

Note: Oregon State Board of Nursing [policy](#) allows administration by RNs provided they have been adequately trained and it is allowed by hospital policy.

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## From the Commission

### 2009-2011 Budget

The Commission's Board of Directors has just approved its biennial budget for 2009-2011. That budget is consistent with recent operating expenses, and actually represents a reduction over the last biennial budget forecast. We have publicly pledged that hospital fees will remain at current levels for the next two years. Those fees:

- \$1,000 for a hospital with 3,000 or fewer patient discharges per year
- \$3,500 for a hospital with 3,001 to 10,000 patient discharges per year
- \$8,500 for a hospital with more than 10,000 patient discharges per year

### Reports Received – January thru June, 2009

The Commission has received 61 reports during the first half of 2009. The single most frequently reported event was Fall, accounting for almost one quarter of the reports. Falls occurred equally in men and women, ranging in age from 57 to 95 years (average age 74), and caused nine deaths and two cases of permanent harm. Surgical-related adverse events as a group, (including retained objects, wrong-site anesthesia or surgery, surgical injuries, and wrong procedures) accounted for 26% of the total number of reported events. See table following for a more specific breakdown of the events.

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## Number and Types of Adverse Events Reported to the Commission in 2009

Reported Adverse Event	1 <sup>st</sup> Q 2009	2 <sup>nd</sup> Q 2009	Total
Fall	7	8	15
Retained Object	2	6	8
Wrong Site	2	4	6
Med Error	2	4	6
Care Delay	3	2	5
Pressure Ulcer	0	5	5
Other	2	3	5
Iatrogenic Injury	2	1	3
HAI	1	1	2
Hypoglycemia	0	2	2
Perforation	1	0	1
Suicide	0	1	1
Perinatal	1	0	1
Burn	1	0	1
Wrong Procedure	0	1	1

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## *Upcoming Events*

### Commission Meeting

August 11, 2009 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 11, 2009 from 9 to 11:30 am at the [Wilsonville Training Center of Clackamas Community College](#). The group will be reviewing a case and discussing strategies for supporting development of a patient safety culture in hospitals.

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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."

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