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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:

Taking Stock and Moving Ahead: PHO Certification

The Public Health Officer released the [2008 Certification Report](#) for the Oregon Patient Safety Commission's Adverse Event Reporting Programs on Tuesday August 11, 2009, providing a clear statement of the successes of hospital reporting, and challenging the Commission and its participating hospitals to continue to improve. The Commission sees the Certification as creating public accountability for our work. We appreciate the thoughtful analysis of the program and recommendations for action.

The Commission is proud of its progress with its reporting program and the many hospitals whose work and commitment to patient safety have supported that progress. Over the past three years we have seen a maturing of the reporting programs for hospitals; both nursing homes and ambulatory surgery centers also are reporting data. We expect to have renal dialysis facilities actively participating by early 2010. We see the voluntary and confidential nature of the programs as a strength. For many years we were the only state with a voluntary model; now four others have begun or are implementing such a system. In all, 30 states have (or are building) reporting programs. The Commission believes that our voluntary program, as designed, is useful - to create learning opportunities, to develop and spread critical information, to encourage organizations to develop cultures of safety by investigating and sharing information.

As we move forward, hospitals can expect more individual attention. In addition to sending information related to specific reports as it seems appropriate, the Field Coordinator will provide individual hospitals with a summary describing their reports on at least an annual basis. The summary will include types of events and harm levels, a comparison with similar hospitals, and comments regarding each of the quality criteria. These criteria are described in both statute and rules, and a common application to assure inter-rater reliability was agreed upon last December between the Commission and the Public Health Officer. We will be posting the criteria on [this page](#) of our website; it is also in the PHO Certification report.

This year will see increased efforts in understanding the impact of action plans and barriers to disclosure. We will begin asking hospitals to let us know their successes and challenges with implementing action plans for serious adverse events. We will be sampling the action plans, looking at getting information on one to four action plans from the preceding six months. We will also be talking with hospitals regarding the difficulties and barriers that prevented written disclosure for specific reported adverse events.

Taking Stock and Moving Ahead (cont'd)

The reporting program does not stand alone. While reporting reflects a hospital's patient safety culture and commitment, reporting in and of itself is not sufficient to drive the necessary change. Rather, reporting forms the foundation for the essential work of implementing best practices, overhauling system designs, aligning incentives, and involving consumers; all of which signal a significant culture change. To that end, the Commission has taken a stronger, more active role in working with hospitals; for example, promoting the WHO checklist, defining other approaches to event investigations that allow more time to implement prevention strategies, and shifting implementation to the provider and unit level as appropriate. Recognizing the importance of culture-based assumptions contributing to adverse events, the Technical Advisory Committee for hospitals is engaged in a culture initiative and will be working closely with the Quality Committee of the OAHHS board.

As we begin our fourth year of reporting, the Commission will be more active in engaging hospitals, and will continue its strong partnership with OAHHS in safety and quality initiative. We are also looking to hospitals to engage proactively with the Commission and each other. What is helpful, what is needed for the Commission to better support hospitals in meeting their own goals for patient safety? What patient safety initiatives, now done in 58 different ways, might provide more reliable care if taken on as a joint effort?

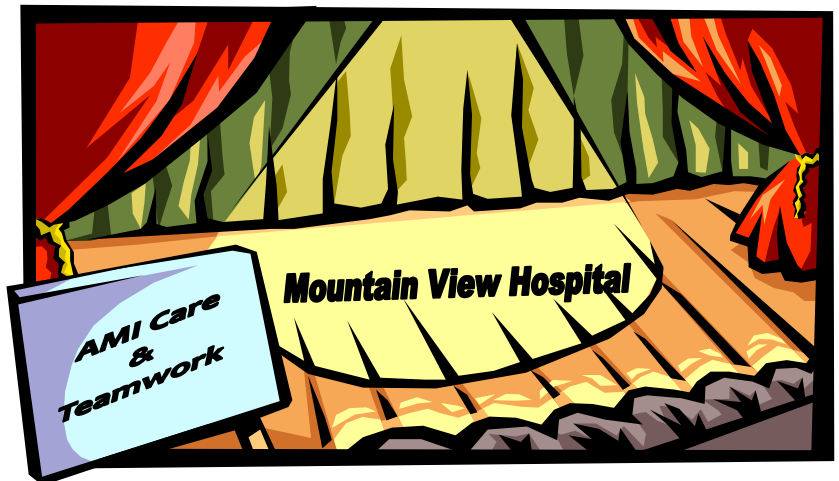
[Let us know.](#)

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Spotlight on Practice:

AMI Care and Teamwork at Mountain View Hospital

As part of the Oregon Rural Healthcare Quality Network (ORHQ), Mountain View hospital embarked on an AMI care improvement project. They also began work to improve communication and teamwork through the Department of Defense program TeamSTEPPS. These two projects came together in a way no one predicted and in doing so, enhanced both.



The first opportunity came right after the team returned from training, before they had shared the strategies and insights at the hospital. By coincidence, three team members were in the Emergency Department when a patient with an AMI came through the door. They immediately began using their TeamSTEPPS training by starting with a "Briefing" led by Dr Ricci Pardini before seeing the patient. Within minutes, staff were clear on their roles and the actions that needed to occur. According to Will Bean, department manager, the briefing was so effective they did not need to call a code and achieved their shortest door-to-needle time yet. From the time the patient entered the ED to the time he received thrombolytics was 24 minutes, well under the 30 time limit. The patient was flown to a larger hospital, reperfused while in flight, and is doing well.

In addition to the Briefing, staff used a "Huddle" in which they briefly reconvene to bring one another up to date on where they are. In this case the Huddle took place with the patient and staff noticed he became much more calm as he saw and understood what actions were being taken and why. Staff formally went through the thrombolytic checklist out loud, providing an opportunity for "Cross-monitoring" in which

collegial checks improve the accuracy of patient care. As a final step, staff debriefed at the end and identified how a mistake correction while caring for the patient indicated a need to change current practices. Their Acute MI protocol and storage methods for thrombolytics were both changed as a result of meeting briefly to answer two questions: What went well?; what could be better?

Since that event, the team is completing training of all hospital staff and physicians. Having such positive examples to share has helped increase receptiveness to a different communication process. The team is also training at other hospitals and has found a positive response. A recent training for physicians recounting specific successes at Mountain View resulted in the audience moving from polite resistance to cautious enthusiasm as they could see benefits. The team has also trained some of the Jefferson County paramedics.

Several of the various strategies taught in TeamSTEPPS can be used even if not all staff have been trained. Many hospitals nationally have moved to using the phrase "I need clarity" when needing the physician or other staff to stop and reconsider some aspect of care. A nurse at Mountain View used it with success with a physician who had not yet received the TeamSTEPPS training.

Overall, the Mountain View team is enthusiastic about the effectiveness of these communication strategies and sees the benefit particularly for complex cases when things are busy, but not crashing. They believe the challenge will be to have such strategies evolve to being "just the way we communicate" at Mountain View — part of the patient safety culture.

Mountain View is not alone in their journey to effective communication. Acumentra's 9th Scope of Work includes TeamSTEPPS training for several of their facilities. A number of hospitals are also engaged in specific communication initiatives, including Kaiser Sunnyside Medical Center, OHSU, Salem Hospital, and two critical access hospitals, Grande Ronde and West Valley. West Valley is seeing some great results with having daily briefs with all of their departments. They are finding it only takes a few minutes and they have some great processes in place to make sure that even the staff who come in later for work have needed information for the day. In addition, staff commit to select one of the communication strategies to work on for the year. The commitment list is posted so staff can encourage each other in use of the strategy or help others who would like to use it.

For more information, please contact [Will Bean](#) at Mountain View Hospital, [Julia Fontanilla](#) at West Valley Hospital or [Leslie Ray](#) at the Commission.

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Journal Brief: Universal Protocol

The article below summarizes experience with the Universal Protocol (UP) and comments on the challenges in its implementation. The authors outline the requirements of the UP and offer practice recommendations. The authors also suggest that lack of institutional commitment or full and complete participation by members of the surgical team contribute to failure of the protocol to prevent surgical "never" events. The WHO surgical checklist provides a structure for assuring participation, and as such, complements the UP quite well. Oregon too continues to see adverse events related to the UP (see Commission report below). The work of the Oregon IHI Network, the Columbia River Region chapter of the AORN, and the Metro Managers group of OR directors have made strides in moving the checklist and achieving standardization of UP elements across hospitals. The packet of surgical tools is available on both the [Commission](#) and [Columbia River AORN](#) websites.

The 5th anniversary of the "Universal Protocol": pitfalls and pearls revisited.
Stahel PF, Mehler PS, Clarke TJ, Varnell J. Patient Saf Surg. 2009;3:14.
<http://www.pssjournal.com/content/pdf/1754-9493-3-14.pdf>

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Resources:

The Oregon State University College of Pharmacy sends out monthly newsletters on behalf of the DUR (Drug Use Research and Management) Board. It provides drug utilization reviews, drug and therapeutic guideline reviews, and cost-effective prescribing recommendations to Medicaid providers and pharmacies throughout Oregon. Each newsletter is offered in PDF format for viewing and printing. Monthly Oregon DUR Board Newsletters are available by email subscription through the [OSUPHARMDI Listserv](#).

The most [recent newsletter](#) addresses differences among drugs to treat GERD (gastroesophageal reflux disorder).

[Patient Safety in Plastic Surgery](#) is a new textbook co-authored by a member of the Commission's Technical Advisory Committee, Dr. Richard Botney. Dr Botney is an anesthesiologist at OHSU, former chair of the OHSU Patient Safety Committee and an active patient safety champion.

Citation: Young, V.L, & Botney, R. (Eds.). (2009) Patient safety in plastic surgery. St. Louis: Quality Medical

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In the News: Dead by Mistake

The Hearst newspapers just released a major story on Monday August 10, 2009 (and created a supporting website) on medical errors, called "Dead by Mistake" (<http://www.chron.com/deadbymistake/>). While the focus is on California, Connecticut, New York, Texas, and Washington, it is easy to imagine that The Oregonian or other local media will pick it up. Following on the heels of two other unfavorable reports on healthcare quality, this creates even greater pressures for hospitals to make progress quickly in identifying and responding to adverse events.



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Heard on the Net: Color-coding Providers?

RNs in [Blue](#) was the subject line for a number of posts on the NPSF listserve. Comments from hospitals across the nation suggested that this may be an increasing trend. Most of the comments were favorable, noting the increase in patient satisfaction, because they knew to whom to direct their questions or concerns. Color coding is not the only way. One RN said that all of the RNs at her hospital wear easily readable tags below their name badges to help patients identify who is caring for them. Apparently this is something the Navy has instituted for their flight deck personnel (see <http://www.navy.mil/navydata/ships/carriers/rainbow.asp>) and one RN saw the value for similar areas in hospitals where there is controlled chaos, such as in emergency departments. Putting aside the all-too-obvious issue of acceptance, are there patient safety related issues should a hospital move in this direction? Only one person brought up the issue of color-blindness, but a perhaps more subtle issue is standardization across hospitals in the same area. Confusion would abound for staff and patients alike with cranberry scrubs for respiratory therapists in one hospital and RNs in another. Still, the concept is an intriguing one.



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From the Commission

Reports Received The Commission received nine adverse event reports in July. See Table for breakdown of the types of events. Of note is the report of three surgical events, including one report of a retained object and one report of wrong site anesthesia. This brings to 18 the number of these two types of events, representing 26% of the reports during the first seven months of 2009. Two of the retained objects related to defective equipment. Contributing to the remaining 16 events were factors that could be eliminated or reduced by consistent effective use of, at a minimum, a Time Out, and even better, the complete surgical safety checklist from WHO. The Commission is continuing to promote use of the surgical checklist and is working with the Oregon IHI Network to achieve 100% use by the end of 2009.

Type of Event	July
Fall	1
Care Delay	2
Wrong Site	1
Retained Object	1
Med Error	2
Perforation	1
Perinatal	1
TOTAL	9

Upcoming Events

Commission Meeting

October 13th, 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

September 8th, 2009 from 8:30-9:30 Culture initiative teleconference.

October 13th, 2009 from 9 to 11:30 am at the [Wilsonville Training Center of Clackamas Community College](#).

Patient Safety Officer Executive Development Program. Institute for Healthcare Improvement. September 10-16, 2009; The Charles Hotel, Cambridge, MA.

<http://psnet.ahrq.gov/resource.aspx?resourceID=11133&sourceID=1&emailID=8140>

2009 Saward Lecture - Kaiser Permanente Center for Health Research. Wednesday, September 23, 2009. Dr. Atul Gawande will present at the Arlene Schnitzer Concert Hall, 1037 SW Broadway, Portland, Oregon, at 7:30 pm. To request tickets, please send your name, title, organization, mailing address, and number of tickets requested to mary.l.harper@kpchr.org. Tickets are on a first-come, first-served basis. There is no charge to attend.

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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 with subject "Hospital Unsubscribe."

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