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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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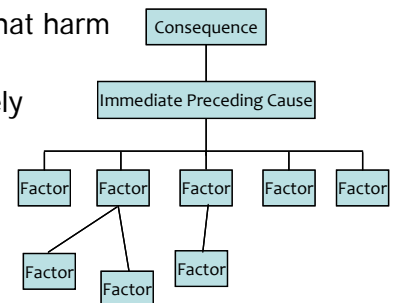
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From the Reporting Program:

A Tool to Help Identify Root Causes

Over the past 18 months, the Commission's Technical Advisory Committee has had the opportunity to review a number of adverse event reports and provided the analysis for feedback to hospitals, newsletter items, and two case studies. It has also been using a specific set of questions common to the nuclear industry to analyze the reports. Through use of these questions, the event is reconstructed, allowing the analysis to move beyond individual actions and identify the underlying system processes — the root causes. Though seemingly straightforward, each of the questions can stimulate deep discussion and allow previously unrecognized processes and practices to be discovered.

1. What was the consequence of the event? (What harm occurred as a result of the event?)
2. What was the action/situation that immediately preceded/caused the event?
3. What do we know (or can assume) about the factors leading to the action/situation?
4. Which of the factors, if eliminated, would have prevented the event or consequence?



The questions should not be used to guide data collection about an event. Complete all data collection and sequencing of the event before using the questions and reconstructing the event. The TAC is interested in providing learning opportunities in use of this strategy and is inviting hospital personnel involved in root cause analysis of adverse events to participate in an analysis at one of the meetings. If you are interested, please contact [Leslie Ray](#). [Return to Top](#)

Journal Brief: More on Hourly Rounding: *Emergency Departments*

Hourly rounding by nurses on inpatient medical-surgical floors is gaining acceptance as a practice that effectively reduces falls (see [August 2008 newsletter](#)). The article below describes a study of three different types of rounding in an Emergency Department. All three rounding strategies showed positive effects, with a rounding strategy that included eliciting patient expectations having the greatest impact. While this is a single study, the findings are consistent with other hourly rounding. The authors encourage further work to determine an optimal design for ED rounding, given the staffing and patient flow characteristics of emergency departments.



The Effects of Emergency Department Staff Rounding On Patient Safety and Satisfaction Meade CM, Kennedy J, & Kaplan J., *Journal of Emergency Medicine*, 2008 Oct 7. [*Epub ahead of print*]

Background: Two recent inpatient studies documented that regular nursing staff rounding increased patient safety and satisfaction. However, the effect of systematic emergency department (ED) staff rounding on patient safety and satisfaction has not been adequately tested.

Study Objective: The objective of this study was to test the effectiveness of three different rounding techniques.

Methods: An eight-week study using a quasi-experimental, non-equivalent group, time-sampling design was conducted in 28 EDs. The three rounding protocols were: 1) rounds every 30 min; 2) rounds every hour; 3) rounds every hour with an Individualized Patient Care tactic (IPC; patients were asked to name their most important expectation for the ED visit). Baseline data were collected the first four weeks; rounding was done the second four weeks. Outcome measures compared the baseline to the rounding period data for patients who left without being seen (LWBS), those leaving against medical advice (AMA), patient satisfaction, call light use, and nursing station encounters.

Results: The three rounding protocols combined reduced LWBS by 23.4%, leaving AMA by 22.6%, falls by 58.8%, call light use by 34.7%, and approaches to the nursing station by 39.5%. Patient satisfaction ratings for overall care and pain management increased significantly. The protocol using the IPC tactic produced the most significantly improved outcomes.

Conclusions: Rounding in the ED reception and treatment areas is effective and improves outcomes. Further research should determine the optimal design for rounding considering the mixed shifts in EDs, seek ways to increase communicating delays to patients, and investigate how to integrate rounding with physician activities.

Last month's newsletter included a journal article on pediatric medication errors. See also the recent publication of findings from the California Pediatric Patient Safety Initiative:

Characteristics of medication errors and adverse drug events in hospitals participating in the California Pediatric Patient Safety Initiative. Takata GS, Taketomo CK, Waite S; for the California Pediatric Patient Safety Initiative. *Am J Health Syst Pharm.* 2008;65:2036-2044. [Return to Top](#)

Heard on the Net: Anesthesia and MRIs

Tobias Gilk, President, and Safety Director, Mednovus, Inc. shared the following on the NPSF listserv: "The American Society of Anesthesiologists (ASA) has a draft Practice Advisory regarding the unique risk factors facing anesthesia care in the MRI environment (many of you will undoubtedly remember the infamous [2001 MRI fatality which involved an anesthetized patient](#)). The Practice Advisory contains a number of recommendations, one of which is the establishment of level designations for MRI providers (similar to what exists for ICU facilities or nurseries) based on levels of patient sedation and acuity." The document is open for public comment and is available from the ASA's [website](#)." [Return to Top](#)

In The News:

Both Providence Women & Children's Program and Tuality Community Hospital are Recipients of 2008 VHA Awards

Providence received the Diamond Award for Innovative Clinical Work for the Newborn Falls Initiative.

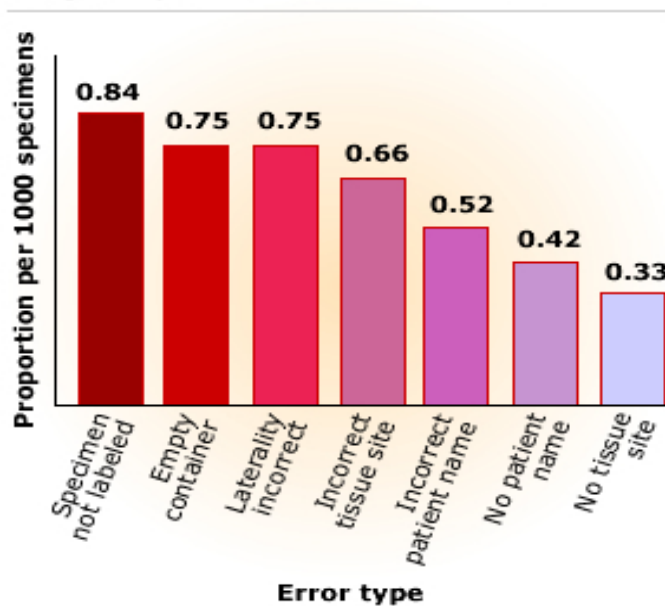
Tuality received a Certificate of Recognition for their Physician Champions, Vince Reyes, M.D. (Cardiac Improvement) and Daniel Isenbarger, M.D. (Reduction in Door to Balloon Time) and Nurse Champion, Pamela Michalowski, RN. Tuality also received an Award Trophy for High Reliability in the prevention of central line infections. Our congratulations to both systems for their fine work. [Return to Top](#)

Did You Know?

Rate of surgical specimen identification errors.

Source: Makary MA, Epstein J, Pronovost PJ, Millman EA, Hartmann EC, Freischlag JA. *Surgical specimen identification errors: a new measure of quality in surgical care.* Surgery. 2007;141:450-455. Epub 2007 Jan 24. [[go to Pubmed](#)] [Return to Top](#)

Surgical specimen identification errors

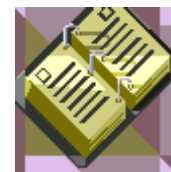


From the Commission

Reports Received — In October 2008 the Commission received eight reports of adverse events. Two of the reports involved medication errors. The other events were a missed diagnosis, suicide, equipment-related, healthcare acquired infection, laboratory error, and a fall.

Web-based Reporting -- We have begun using the new web-based reporting form on a limited basis and plan a larger, statewide rollout of the new system in the beginning of December. This will include distribution of an electronic **Guide to Adverse Event Reporting for Oregon Hospitals**, and a series of webinars to describe the new system and elaborate on reporting requirements. [Return to Top](#)

Upcoming Events



43rd ASHP Midyear Clinical Meeting and Exhibition. "The Power of You"
December 7-11 Orlando, Florida. Click [here](#) for registration and meeting information.

Commission Meeting

December 16th from 12:30 to 3:30pm at the [Wilsonville Training Center of Clackamas Community College](#) Room 218. To request an agenda, please contact [Linda Goertz](#). Beginning in 2009, meetings will be held the second Tuesday of even-numbered months (e.g. February, April, etc.)

Technical Advisory Group Meeting

Preceding the Commission meeting, December 16th from 9 to 11:30 am. (CCC Wilsonville Training Center, Room 218). The meeting will be open to interested hospital quality, risk, and patient safety personnel on a limited basis. If you are interested in attending the next meeting, please contact [Leslie Ray](#) by December 5, 2008.

IHI Rural Grand Rounds Webex

Last session of the series. Thursday, December 18, 10am Pacific Time. (1 pm ET). For more information on webex login and password, click [here](#).

Patient Safety Officer Executive Development Program

Institute for Healthcare Improvement. March 5-11, 2009; The Charles Hotel, Cambridge, MA. Click links for [brochure](#) and more [information](#).

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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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