

In This Issue:

- [From the Reporting Program: Strong and Stronger Action Plans](#)
- [Best Practices: Unit Safety Champions](#)
- [Journal Brief: Pediatric Medication Errors](#)
- [Heard on the Net: The Zero Defect Approach](#)
- [In The News](#)
- [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:

Strong and Stronger Action Plans



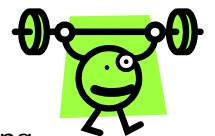
The best action plans not only correct the current problem, but also prevent recurrences as well as prevent occurrences in other parts of the hospital. They ensure that providers will not make the same or similar mistakes in the future. Often, reports to the Commission detail action plans that rely on correcting the immediate problem without considering how to prevent similar events.

In one event reported to the Commission, the RCA revealed that conversion to an electronic information system inadvertently omitted important patient information from the computerized order for radiology. The hospital identified a strong, system-level plan, including forcing the input of information before the order could be submitted, but did not explore where else in the computerized system similar problems might occur.

The strength of action plans increases as their reliance on individual attention and memory decreases. The VA National Patient Safety Center provides a description of three different types of action plans in their [RCA Toolkit](#) (click the *Actions & Outcomes* tab). *Weaker Actions* rely on individual behavior and include adding policies, procedures, training, and further study. *Intermediate Actions* are those that modify the practice processes in some way. Examples include redundancies, software enhancements or modifications, and cognitive aids such as checklists. *Stronger Action Plans* are those that alter the practice environment, such as controls that force the correct action, simplified processes, care practices, physical plant changes, and standardization of equipment.

A strong action plan, such as requiring specific patient information on the lab order screen before submitting the order has only limited effect if it is narrowly confined to that one incident. To receive the most from the investment in an RCA, look broadly across patient care areas. In this case, seeing if there are other lab tests or types of orders (such as medications) where patient information is needed would significantly increase RCA effectiveness. The impact of action plans depends upon considering not only how to correct the presenting problem, but also how to prevent future occurrences by addressing why the problem occurred and where else that or similar problems might arise. The three questions to ask are:

- 1] How do we fix this particular problem?
- 2] Are there similar problems to consider?
- 3] Does this problem exist in other areas?



[Return to Top](#)

Best Practices: Unit Safety Champions



Several hospitals have identified patient safety-related activities as an essential component of practice and include the role of patient safety champion or coach in staff activities. There are varied role definitions and expectations, but in general the coaches are involved in on-going audits (hand hygiene, NPSG, etc); share patient safety information with their peers; bring patient safety concerns to the hospital patient safety committee; and coach peers, physicians, other staff, and families in patient safety as they notice a need. Dana-Farber Cancer Institute has a role for Clinician Champions that includes participation in patient safety rounding. See their [website](#) for a full description of the role.

Allocating time for these activities is a priority. As one patient safety specialist noted, "I think the key to our program is having support from the top. Managers know they are expected to help this happen." [Return to Top](#)

Journal Brief: Pediatric Medication Errors



Does culture make a difference? According to the study below, implementation of a safety culture, along with a non-punitive environment error management and medication prescribing and administration recommendations resulted in a 4% drop in medication errors on pediatric units.

Medication errors in pediatric inpatients: prevalence and results of a prevention program. Otero P, Leyton A, Mariani G, Ceriani Cernadas JM; and Patient Safety Committee. Pediatrics. 2008; 122: e737-e743.

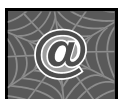
OBJECTIVE: The objective of this study was to assess the prevalence and characteristics of medication errors in pediatric and neonatal inpatients and to measure the impact of interventions to reduce medication errors.

METHODS: A preintervention and postintervention cross-sectional study was conducted of a sample of prescriptions that were ordered by physicians and medications that were administered by nurses to patients at the NICU, PICU, and general pediatric settings at the Hospital Italiano de Buenos Aires Department of Pediatrics in 2002 and 2004. Number and type of errors, time shift on which they occurred, and whether they had any kind of adverse event on the patient were recorded. Medication errors were stratified according to physicians' and nurses' status. Several interventions, including incorporating a positive safety culture without a punitive management of errors and specific prescribing and drug-administration recommendations were implemented between the 2 phases of the study.

RESULTS: A total of 590 prescriptions and 1174 drug administrations for 95 patients in the first phase of the study and 1144 prescriptions with 1588 drug administrations for 92 patients in the second phase were evaluated. The prevalence of medication error rate in the second phase was 7.3% (199 of 2732) and 11.4% (201 of 1764) in the first phase. The risk difference was -4.1%.

CONCLUSIONS: The development of a program mainly centered on the promotion of a cultural change in the approach to medical errors can effectively diminish medication errors in neonates and children. [Return to Top](#)

Heard on the Net: The Zero Defect Approach



There was an interesting discussion recently regarding the importance or value of striving for zero defects in patient safety. One comment raised concerns over the cost benefit of getting that last 1% in any given area compared to moving some other

need up from only 50%. Given how far we in healthcare are from achieving zero defects, it may seem more realistic to aim lower; zero defects seem unattainable. But is a lower goal acceptable? Even getting close to zero with a defect rate of 0.1% (or a reliability of 99.9%), still makes healthcare as less reliable than commercial aviation.

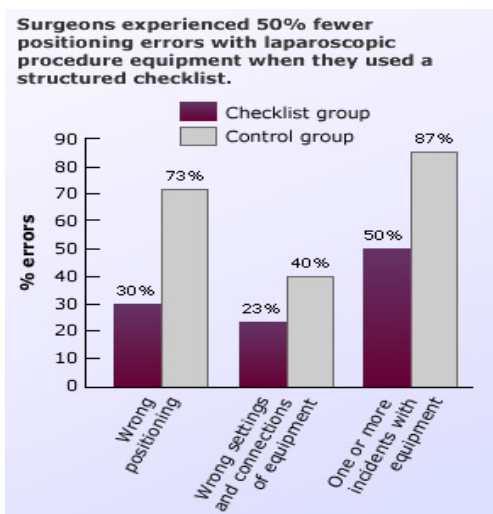
In 2005, Virginia Mason Medical Center in Seattle Washington set zero defects as the single organizational [goal](#). Hospital leaders went to Toyota in Japan to learn about a zero defects approach and provide this [description](#) – “zero defects” means:

- ◆ Pursuing what the customer really wants
- ◆ Distinguishing mistakes from defects
- ◆ Eliminating defects with source inspection:
 - Check each product (one-by-one)
 - Check at the source
 - Stop and fix at the source

Barnes-Jewish Hospital at Washington University Medical Center in St. Louis is taking a zero defects approach to infections. According to their VP for Safety and Quality, “If you know the protocols required to avoid infection, if you follow them precisely every single time, then zero infections are possible. When you’re talking about something that can cost people their lives and zero is possible, no other benchmark makes sense.” See their approach and that of several other hospitals described by IHI in [What Zero Looks Like: Eliminating Hospital-Acquired Infections](#). [Return to Top](#)

In The News

[Acumentra Health](#) announced early this month that all 33 of Oregon’s hospitals “... that receive payment from Medicare under the acute-care, inpatient prospective payment system (PPS) qualified for full payment for their services billed to Medicare. Only 20 other states had all of their hospitals qualify for full payment.” These hospitals met all of Medicare’s three criteria for transparency and excellence. The criteria require hospitals to collect and report quality data on 30 measures; have 80% or higher accuracy for submitted data, and agree to have the data available for public viewing on [Hospital Compare](#).



Did You Know? Structured checklists can prevent problems with laparoscopic equipment. Source: Verdaasdonk EG, Stassen LP, Hoffman WF, van der Elst M, Dankelman J. Can a structured checklist prevent problems with laparoscopic equipment. Surg Edosc. 2008. Links to this article in both .pdf and HTML formats are available [here](#).

[Return to Top](#)

From the Commission

Reports Received – In September 2008 the Commission received two reports of adverse events, one of a delay in responding to a changing condition and the other an unintentionally retained object.

Web-based Reporting: At long last Oregon's web-based system for reporting adverse events is close to completion. Staff has tested the tool and web interface and we are beginning user testing with several facilities submitting "creative" reports to assure the web link is stable and there will be no surprises when we go live. The rollout of the new system will include a Guide to Adverse Event Reporting for Oregon Hospitals, which explains how to use the system, expands descriptions of the required information with examples, and gives an algorithm to assist in deciding what events to report. We will also be holding a series of webinars to orient all participants to the new system and the reporting requirements. [Return to Top](#)



Upcoming Events

Commission Meeting

Tuesday, November 4th 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](#).

IHI Rural Grand Rounds Webex 10am Pacific Time.

Thursday, October 16 (1 pm ET)

Thursday, November 20 (1 pm ET)

Thursday, December 18 (1 pm ET)

For more information on webex login and password, go [here](#).

OAHHS & ONA "Nurse Staffing Conference: Safety in Numbers"

November 6, 2008, 7 am to 5 pm Keizer Renaissance Inn North Keizer, Oregon Click [here](#) for registration and meeting information

OSHRM Membership Meeting - OAHHS "Nonpayment for Adverse Events," November 14th 11:45-1pm, Oregon Medical Association. Contact [Diane Waldo](#) for meeting information and registration.

43rd ASHP Midyear Clinical Meeting and Exhibition

"The Power of You," December 7-11, Orlando, Florida. Click [here](#) for registration and meeting information. [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