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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:

Looking to 2009: High-Quality Reports



Over the past two and a half years, the Commission has received more than 240 reports covering a range of different types of adverse events; the reports show significant variability in terms of quality.

Overall, about 83% of the reports have met the criteria for acceptable reports – they are complete, thorough, credible, and have action plans likely to decrease the risk of future events. (*Complete* includes a description that explains the final understanding of causes of the event. *Thorough* is seen in the identification of system-level contributing factors and at least 1 root cause. *Credible* reports indicate some involvement of leadership and the report is internally consistent. *Action plans* are strong and clearly related to the findings.)

Since the program began, we have seen an increase in plans that emphasize system-focused solutions and less reliance on training to prevent recurrences. We have also seen an increase in reports, reflecting an increased willingness on the part of hospitals to identify and learn from their own and others' adverse events.

As we move into 2009, the Commission will focus more strongly on developing and sharing learnings from the reports and providing feedback to improve subsequent reports. Beginning with the use of the web-based reporting form, staff will formally review each submitted report for 1] learnings to share with other hospitals and 2] the quality criteria given above. See the [reporting guide](#) for more information and examples for completing a high quality report.

We will also be working with hospitals in 2009 to better define effective and efficient investigations. From reports submitted to date, the number of hours reported spent on the investigation seems unrelated to either event severity or report quality.

A working group will examine different models and approaches to improve the cost benefit of investigating adverse events, such as the three-meeting model, bundled/aggregated RCAs, and stable analysis teams. While there will be adverse events requiring 100+ hours of investigation, it is possible to do the analysis and identify root causes for many events in less time. The working group will develop a list of strategies and tactics to increase effective time on adverse event investigations.

As part of our continuing commitment to transparency and partnership,

the Technical Advisory Group (TAC) in 2009 is opening its meetings to interested hospital personnel. On a limited basis, we invite others to participate in the discussion and analysis of a submitted adverse event report. The reports are redacted of identifying patient and hospital information and the participants sign a confidentiality agreement. The group meets to discuss reports from 9-11:30 the second Tuesday of even-numbered months at the Wilsonville Training Center of Clackamas Community College. (see below)

If you are interested in participating in the RCA working group or attending a TAC meeting, please email [Leslie Ray](#) or call her at 503.224.9227.

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Journal Brief: Workarounds to Barcode Medication Administration

The article below (linked [here](#)) describes 15 different types of barcode workarounds used by nurses in administering medication for 31 different reasons. While many accept bar codes for medication administration as an important part of safe medication practices, this article clearly describes how the safety features can be subverted, and for a variety of practical reasons. As there is more pressure on hospitals to move to bar coding, considerations of how it might fail are particularly important. As with the introduction of any new process, an HC-FMEA done prior to introducing medication administration bar codes may prevent some of the system defects noted in this article.



Koppel R. Wetterneck T. Telles JL. Karsh BT. (2008). Workarounds to barcode medication administration systems: their occurrences, causes, and threats to patient safety. Journal of the American Medical Informatics Association. 15(4):408-23

ABSTRACT: The authors develop a typology of clinicians' workarounds when using barcoded medication administration (BCMA) systems. Authors then identify the causes and possible consequences of each workaround. The BCMAs usually consist of handheld devices for scanning machine-readable barcodes on patients and medications. They also interface with electronic medication administration records. Ideally, BCMAs help confirm the five "rights" of medication administration: right patient, drug, dose, route, and time. While BCMAs are reported to reduce medication administration errors--the least likely medication error to be intercepted--these claims have not been clearly demonstrated. The authors studied BCMA use at five hospitals by: (1) observing and shadowing nurses using BCMAs at two hospitals, (2) interviewing staff and hospital leaders at five hospitals, (3) participating in BCMA staff meetings, (4) participating in one hospital's failure-mode-and-effects analyses, (5) analyzing BCMA override log data. The authors identified 15 types of workarounds, including, for example, affixing patient identification barcodes to computer carts, scanners, doorjams, or nurses' belt rings; carrying several patients' prescanned medications on carts. The authors identified 31 types of causes of workarounds, such as unreadable medication barcodes (crinkled, smudged, torn, missing, covered by another label); malfunctioning scanners; unreadable or missing patient identification wristbands (chewed, soaked, missing); nonbarcoded medications; failing batteries; uncertain wireless connectivity; emergencies. The authors found nurses override BCMA alerts for 4.2% of patients charted and for 10.3% of medications charted. Possible consequences of the workarounds include wrong administration of medications, wrong doses, wrong times, and wrong formulations. Shortcomings in BCMAs' design, implementation, and workflow integration encourage workarounds. Integrating BCMAs within real-world clinical workflows requires attention to *in situ* use to ensure safety features' correct use. [Return to Top](#)

Heard on the Net: MRI Hazard Summary



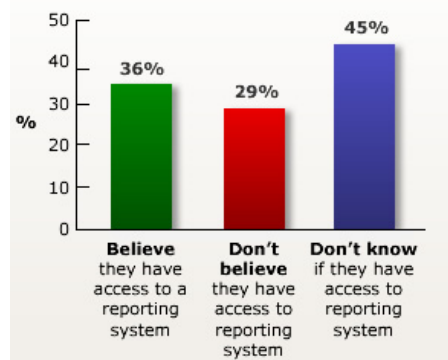
The VA National Center for Patient Safety has a very good summary of MRI hazards and recommendations to improve safety. In addition to risks to patients and staff, MRI-related adverse events are costly, with the VA reporting the average cost of a projectile event at \$43,172. The authors describe five types of hazards (projectile effect, twisting, burns, image artifacts and device malfunction) associated with MRIs and offer examples: a paper clip or hair pin near a 1.5 Tesla MRI can reach speeds of up to 40 mph; metals in tattoos or mascara can cause safety problems. The paper explains the new terminology for “MRI Safe” and offers recommendations for a systems approach to MRI safety. In addition to redesign and training tips, the NCPS lists a number of procedural and purchasing recommendations. See <http://www.va.gov/ncps/SafetyTopics/MRHazardSummary.pdf> . [Return to Top](#)

In the News

As of November 26th the Oregon Patient Safety Commission is a Patient Safety Organization (PSO) certified by the Department of Health and Human Services. This designation further strengthens confidentiality protections for submitted data by inclusion under federal protections as well as the Oregon state protections. PSOs will build voluntary adverse event reporting programs and offer expert consultation to clients. Oregon is in a unique position because the federal law so closely matches the charter of the Patient Safety Commission and because we already have two and a half years of experience running a reporting program. [Return to Top](#)

Did You Know?

Fewer than 50% of physicians believe they have access to a reporting system in their organization to report medical errors.



Source: Garbutt J, Waterman AD, Kapp JM, et al. Lost opportunities: how physicians communicate about medical errors. Health Aff (Millwood). 2008;27:246-255. [\[go to Pubmed\]](#)

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From the Commission

Reports Received – In November 2008 the Commission received nine reports of adverse events. Of these, seven were related in some way to surgery, including medication errors, retained objects, wrong site surgery, and surgical injury. One death was reported and three other events resulted in permanent harm.

Web-based Reporting: Participants in the Commission's reporting programs are now able to submit reports online through use of a new "smart" pdf form. Our heartfelt thanks to hospitals that helped us pilot the form and the submission process and those of you – too many to name – whose patience as we worked to get everything working correctly was much appreciated. The form requires Adobe Reader 8.1.2 or later and completion of required information is facilitated by check boxes and drop-down lists. We will be sending each hospital contact person a copy of the new form with the facility type and unique identifier code entered into the form by the middle of the month. [Return to Top](#)

Upcoming Events

Commission Meeting

February 10th 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](#). All 2009 Commission meetings are held on the second Tuesday of even-numbered months. Click [here](#) for a listing of meeting dates.



Technical Advisory Group meeting

February 10th from 9 to 11:30 am. at the [Wilsonville Training Center of Clackamas Community College](#) 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](#).

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](#).

Washington Patient Safety Coalition

[2009 Northwest Patient Safety Conference](#) Thursday, June 4, 2009, at the Hilton Seattle Airport & Conference Center.

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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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