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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:

Pediatric and Adult Dose Mix-ups

At its last meeting, the Technical Advisory Committee (TAC) reviewed a case of pediatric medication error. A newborn received clonidine to attenuate the symptoms of opioid withdrawal, but was given an adult dose instead of the pediatric dose. The nurse recognized the error almost immediately and the appropriate measures were quickly taken to prevent harm. Many pediatric medications come in adult doses and need to be reformulated in the pharmacy. In this case, the TAC identified key aspects contributing to the adverse event among the complexity of factors involved. One aspect was the importance of creating physical distinctions and separations between pediatric and adult medication practices. Several actions to assist in this separation might include: 1] Clear identification that the prescription is for a child, either through different colored prescription pads, different labels, flags or alerts in the electronic record; and/or 2] Physical separation in the pharmacy between where adult prescriptions enter and where pediatric prescriptions enter if not on an electronic system; and/or 3] Dedicated pharmacists and pharmacy technicians familiar with pediatric doses to review the prescriptions.

A second aspect noted was the impact of missed communications among and within the various disciplines involved in the newborn's care. While the Joint Commission has long raised communication problems as contributing to adverse events -- and the Oregon Patient Safety Commission has seen similarly high proportion of communication factors in its adverse event reports -- this area is the most difficult to address. At the heart, of course, are the traditional professional and organizational cultures that hinder teamwork and the high volume workload that blocks taking what providers perceive as "extra" time to make a call or ask a question. Some relatively straightforward processes can be implemented to improve communication. One such is structured handoffs with shift changes, including special considerations around current medications. The larger issue of culture, however, requires dedicated management and senior leadership attention.

The Joint Commission has recently posted a [Sentinel Event Alert](#) on pediatric dosing errors. It offers a brief review of the issue and recommends several risk reduction strategies. The alert also cites a [2008 study](#) that found an 11% adverse drug event rate with use of a pediatric trigger tool. The usual occurrence reporting mechanisms in the study hospitals had identified only 3.7% of the events. The need is clear for development of care processes that lower the risk of adverse drug events in this vulnerable population. [Return to Top](#)

Best Practices: Reducing Patient Falls

Falls represent a significant risk to patients, especially the elderly, and there is a large and growing literature on incidence of falls, patient characteristics, and prevention strategies. Falls with serious harm are one of the “Never Event” categories defined by the National Quality Forum. The Commission has had 17 falls reported to us since beginning the reporting program in May of 2006. Four of the reported falls occurred the first quarter of 2008 and an increasing number of reports about falls is likely, given the increased attention to eliminating charges and payments for Never Events. In a study published last summer, the investigators reported an average cost of \$6,606 per fall-related injury. Not only are there high costs associated with treatment for injuries caused by falls, falls can have a significant impact on life expectancy. Falls with hip fractures have been associated with death within a year.

One health system, Ascension Health, began a system-wide improvement effort in 2002. They reported on the success of their program July 2007 in *The Joint Commission Journal on Quality and Patient Safety*. The article is available from Ascension Health by clicking [here](#). Ascension implemented four key strategies: 1] continued assessment of fall risk factors throughout patients’ stays with change in care-giver or patient status, 2] multiple visible cues of patients at risk for falling, 3] increased communication of fall risk with staff handoffs and increased communication with patients regarding needs and safe actions, and 4] increased and repeated communication with families and visitors regarding fall risk and safe actions. Data collected approximately four years after beginning the falls prevention initiative showed Ascension’s average rate of falls with serious injury was less than 0.10 per 1,000 patient days. As compared with national rates of falls with serious injury, Ascension Health’s rates were less than 10% of expected. [Return to Top](#)

See also the [Fall Case & Commentary](#) on the AHRQ website.

Journal Brief: Task Design for Reducing Falls

Tzeng, H-M & Yin, C-Y (2008). Innovation in patient safety: A new task design in reducing patient falls. Journal of Nursing Care Quality, . 23, 1, 34–42

This novel study used a human factor engineering approach to improve patient safety and prevent patient falls. They compared the safety levels of two task designs to help patients get out of hospital beds: the traditional sitting-standing position and the prone position. It is assumed that when patients’ conditions are comparable, using the prone position is safer. When the prone position is used, if patients lose their balance, they will fall back to the surface of beds. [Return to Top](#)

Heard on the Net: The Patient’s Voice

Over the past couple of months, a discussion has raged on the NPSF listserv about listening to patients and their families and the role/need for every patient to have a patient advocate. I can no longer recall exactly how the discussion began. However, its length and the passion of the responses from health care professionals and patients/family members point to this being a crucial conversation. Some excerpts:

“It is difficult for us[the patients] to constantly hear that the “system” is to blame and that we don’t understand the barriers to fixing this broken system. The “system” is made up of people who have the ability to champion the changes we want and need...These are not pie-in-the-sky dreams or demands, but realistic goals.” One family member posted a 30-item list of what she believed were important changes, and commented: *“...consumer advocates have been working on everything on this list for years...Mostly nobody in the health care industry will listen to us, or when they do we’re offered lip service as to why these things can’t happen.”*

These animated conversations suggest that a divide between patients and providers sometimes remains. They suggest that the core patient safety philosophy really is changing for the better (system thinking, non-punitive actions), but that we have much work to do. And they also remind us – sometimes poignantly, sometimes pointedly, that we need to listen to these patients’ voices. To be sure, this can be hard work – those voices are sometimes angry, sometimes muted, sometimes at odds with what we might believe. Still, this discussion on the listserv has helped remind me that we do this work because of the patient. Ultimately, care that does not keep the patient front and center will not be safe care.

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From the Commission

North Star Goal: The Commission has received a favorable response to our defining a goal that Oregon will have *the safest state health care system in the country by 2010*. We recognize the enormous challenge and the work that is ahead for hospitals, nursing home, ambulatory surgery centers, and others to achieve this goal. The Commission is committed to providing the information and assistance that will make this possible. A group is working on a beginning set measures for the goal that includes outcomes, patient/consumer involvement, evidence-based processes, improvement, culture of safety, and community empowerment. The first set of measures will set the baseline for Oregon so that we can record our improvement along with comparisons to other states.

Improving Reporting: The web-based tool for reporting adverse events to the Commission is finalized and I would like to thank those who tried it out and provided very helpful feedback. The database is under construction and the ever-optimistic field coordinators are hopeful it will be available by late spring. Plans for increasing the number and quality of reports received from hospitals are being made and staff anticipates bringing a draft plan to the Commission at its next meeting.

Reports Received: The Commission received 29 adverse event reports during the first quarter of 2008, including six reports of falls. Of the 29 reports, 15 were Serious (harm levels of 7, 8, or 9) and 14 were Less Serious (harm levels of 6 or less). [Return to Top](#)

Upcoming Events

Oregon RCA Trainings – Oregon Association of Hospitals and Health Systems, Oregon Patient Safety Commission:

- April 22, 2008. Smullin Center, Medford Oregon. Sponsored by Asante Health System; flyer [here](#)
- June 3, 2008 Willamette Falls Hospital, Oregon City. Registration flyer can be found [here](#). Oregon 5 M Lives Spring Conference – May 8th, Oregon Medical Association Offices, Portland, OR. This year's theme: *Transforming Health Care*. The conference is supported by funds from IHI and there is no charge for attendance. Registration flyer [here](#).

2008 Northwest Patient Safety Conference. June 12, 2008 Seattle WA. Conference information and registration at www.wapatientssafety.org [Return to Top](#)

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