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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:

Decreasing the Risk of Falling



Falls remain a difficult challenge for hospitals. Despite your best efforts, patients continue to fall and in many cases suffer serious harm. In a discussion with one hospital's medical director for quality, he raised an interesting question that could have an impact on reducing falls. To what extent do we see nighttime falls in people who are on IV fluids? Moreover, do they really need those IV rates set at anything other than TKO (to keep open?) Given the fall risks at night – sleepiness, pain and/or sleep medications, some disorientation, low light levels, lower staffing levels, among others – should adults who are not dehydrated (or don't have other reasons for needing a faster infusion) receive fluids at night? As you investigate falls, add this question to your considerations; it could be that our routines with IVs at night need to be re-examined in relation to the risk for falling.

One other strategy for preventing falls that has been reported recently is the use of hourly rounding to check on patients, particularly for any needs for pain relief, toileting, and positioning to avoid pressure ulcers. A Nursing Spectrum article in 2006 reported on the results of the Studer Group's research on hourly rounding. The article is posted on the Studer Group website [here](#).

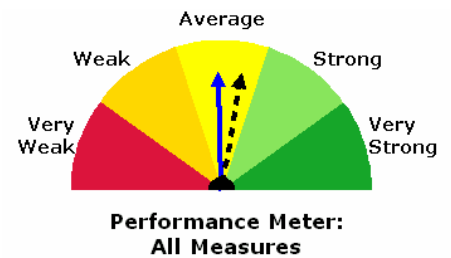
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Best Practices: Hospital Quality

With the IOM report nearly 10 years ago, people are asking whether patient quality and safety has improved. Asking the question nationally, Cohen and his co-investigations surveyed the Chief Quality Officers (CQO) at 470 hospitals (*Cohen AB, Restuccia J, Shwartz M, et al. [2008]. A survey of hospital quality improvement activities. Medical Care Research and Review. May 29; [Epub ahead of print]*). The CQOs responded that they believed care had significantly improved over the past three years. However, only 68% indicated they would feel comfortable having a member of their family treated at their hospital without being present to monitor their care. Further, only 28% thought patient

satisfaction levels were where they needed to be. A [summary](#) of their findings is available on the AHRQ website.

The amount of attention and effort given to patient safety has certainly increased. Here in Oregon, a majority of hospitals are participating in the IHI campaign, implementing the best practice bundles that apply to their settings. However, the most recent *National Healthcare*



Quality Report (NHQR) from the Agency for Healthcare Research and Quality (AHRQ) places Oregon in the average category for [overall healthcare quality](#). The Commission is certain that Oregon can do better and has developed a set of goals to move Oregon ahead: The North Star Goal – Oregon will have the safest healthcare system in the country by 2010. (See [below](#)) [Return to Top](#)

In the news: Machines that talk to one another

What if you had an x-ray machine that could sense when a patient had completely inhaled or exhaled and would automatically take the x-ray then? On the other hand, what if you had monitors in the ICU that could communicate with one another so that an alarm would only go off if sensors in *both* the patient's pulse oximeter and respiratory monitor indicated a problem? Such integration is the goal at the Center for Integration of Medicine and Innovative Technology's [Medical Device Interoperability Program](#). [Return to Top](#)

Journal Brief: "Safe" Patient Education

The following article raises a disturbing question about safe provider-patient communication and the common strategy of asking patients if they understand the information given to them prior to discharge. The authors, in interviewing 140 emergency department patients, found a difference in the type of information likely to be understood. More importantly, the investigators found that most of the time that patients were deficient in their understanding, they were unaware of that deficiency; about 80% of the time, they did not know what they did not know. While results of a single study are not conclusive, adding a "repeat-back" strategy to discharge teaching -- whereby patients say back what they understand -- would enhance patient safety. This is especially important with, for example, understanding symptoms to report anticoagulant dosing, insulin dose and administration techniques, and any other safety-critical information.

Engel KG, Heisler M, Smith DM, Robinson CH, Forman JH, Ubel PA. (2008). Patient Comprehension of Emergency Department Care and Instructions: Are Patients Aware of When They Do Not Understand? [Annals of Emergency Medicine](#) July 10. [Epub ahead of print]

Study Objective: To be able to adhere to discharge instructions after a visit to the emergency department (ED), patients should understand both the care that they received and their discharge instructions. The objective of this study is to assess, at discharge, patients' comprehension of their ED care and instructions and their awareness of deficiencies in their comprehension.

Methods: We conducted structured interviews of 140 adult English-speaking patients or their primary caregivers after ED discharge in two health systems. Participants rated their subjective understanding of four domains: (1) diagnosis and cause; (2) ED care; (3) post-ED care, and (4) return instructions. We assessed patient comprehension as the degree of agreement (concordance) between patients' recall of each of these domains and information obtained from chart review. Two authors scored each case independently and discussed discrepancies before providing a final concordance rating (no concordance, minimal concordance, partial concordance, near concordance, complete concordance).

Results: Seventy-eight percent of patients demonstrated deficient comprehension (less than complete concordance) in at least one domain; 51% of patients, in two or more domains. Greater than a third of these deficiencies (34%) involved patients' understanding of post-ED care, whereas only 15% were for diagnosis and cause. The majority of patients with comprehension deficits failed to perceive them. Patients perceived difficulty with comprehension only 20% of the time when they demonstrated deficient comprehension.

Conclusion: Many patients do not understand their ED care or their discharge instructions. Moreover, most patients appear to be unaware of their lack of understanding and report inappropriate confidence in their comprehension and recall.

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From the Commission - Reports Received

In July 2008 the Commission received 12 reports of adverse events, covering eight different types of events. Two were medication-related (one of which involved diagnostic imaging media), two were perinatal events, two involved equipment, and two involved wrong-site surgery. Others included a fall, wrong-site surgery, retained object, pressure ulcer, equipment and delay in communicating a test result. Five of the events caused serious harm, with one death. [Return to Top](#)

From the Commission - North Star

North Star Goal – *Oregon will have the safest health care system in the country by 2010.*

For several months, the Commission has been talking about its North Star Goal. The Commission proposed this challenge goal in January and, in consultation with hospitals, nursing homes, and ambulatory surgery centers, has developed a way to benchmark progress. To do this the Commission unbundled patient safety into six key dimensions: *Outcomes, Safe Practices, Risk Assessment, Culture of Safety, Patient/Resident Empowerment, and Community Connectivity*. For each of these six areas the Commission selected one or two measures. Our intent was to keep it simple, and to avoid data burdens on Oregon hospitals. Following are the questions each dimension is meant to address and our proposed measures:

1. Can we demonstrate that we are eliminating preventable harm events? (*Outcome*). Will be measured by the number of times a foreign body was left in during surgery.
Goal is 0 – no foreign bodies unintentionally left in during surgical procedures.
2. Are we using evidence-based best practices? (*Safe Practices*) Will be measured by the number of hospitals that have adopted SCIP 1, 2, 3 surgical care infection prevention practices.
Goal is to be in the top 10% of CMS hospitals – Oregon hospitals will have fewer surgery-related infections than 90% of hospitals, according to the Centers for Medicare and Medicaid.
3. Are we assessing risk and learning from experience? (*Risk Assessment*) Will be measured by the number of events reported to Commission
Goal is 100% of acute care hospitals – all acute care hospitals will regularly report adverse events to the Commission.
4. Do we have a culture that supports learning and improvement? (*Culture of Safety*) Will be measured by the number of hospitals that initiated a patient safety culture survey within the last three years, and the number of hospitals working on IHI's "Boards on Board"
Goal for both measures is 100% – all Oregon hospitals will have completed a patient safety culture survey within the preceding three years, and all will be actively working to engage their Boards in patient safety and quality.
5. Are patients and consumers playing an active role? (*Patient/Resident Empowerment*) Will be measured by the number of hospitals that track the safety concerns of their patients.
Goal for the first measure is 100% – all Oregon hospitals will track such concerns.
6. Are we working to create connected systems of care? (*Community Connectivity*) Will be measured by the extent to which hospital use electronic information systems and the extent to which the systems "talk" with one another.
Goal for the first measure is 100% – all hospitals will have some electronic health information and will be actively working toward spreading and integrating their electronic health records. [Return to Top](#)

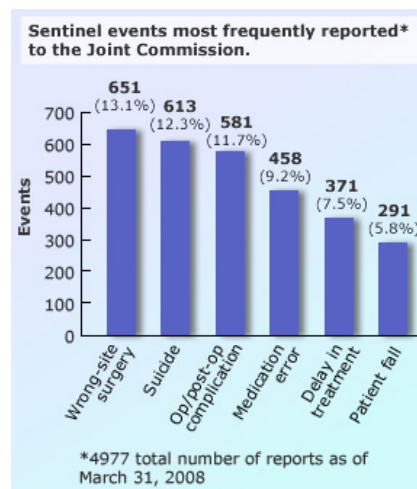
From the Commission - Did You Know (DYK)

Sentinel Events most frequently reported to The Joint Commission:

The most recent posting by The Joint Commission identifies the top six events reported since 1995. Taken together these represent nearly 60% of all reported adverse events.

Also, check out the [AHRO website](#) DYK and the [DYK archive](#) for other interesting patient safety information.

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Upcoming Events

Commission Meeting: August 12th from 12:30 to 3:30pm at the Wilsonville Training Center of Clackamas Community College, Room 112. To request an agenda, please contact [Linda Goertz](#).

AHRO's 2008 Annual Conference Promoting Quality — Partnering for Change: September 7-10 at the Bethesda North Marriott Convention Center, in Bethesda, MD. Conference is free, but you need to register. A preliminary agenda is available from [AHRO](#).

ASHRM Annual Conference & Exhibition: October 2-5, 2008; Hynes Convention Center, Boston, MA, <http://www.ashrm.org/ashrm/annual2008/>. [Return to Top](#)



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