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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:

### Technology and Adverse Events



The Commission has received a number of events in which newly introduced technology was a significant factor in the event. While one event involved a malfunctioning heart valve, most of the technology-related events concerned the impact of the technology on work processes and the flow of information. In one event, computerized alarm bells to notify laboratory technicians of a new lab order was so distracting that staff members turned off the bell, not realizing that it also turned off notification; a stat order was missed for several hours. One CPOE system for medications did not indicate patient age or hospital unit and when checking the entry, the computer automatically put in an adult dose that was initially missed because the pharmacy tech did not have information regarding the patient's age. In yet another event, important data regarding a patient's kidney function was not linked to an order for a diagnostic test involving contrast media.

Different hospitals, different uses of the technology, but with a common thread – each was an unintended barrier to information important to safe patient care. In reviewing the most recent event, the Technical Advisory Committee (TAC) commented on a current gap in implementation of technology. When adding technology, it is not only important to know what it does, but what formal and informal work processes it will change and what the potential impact on patient care is. In each of the cases above, the informal processes and staff interactions that supported and made up for weaknesses in the system had been supplanted by the new process. As a result, unanticipated problems arose. Some of the problems may have been anticipated through use of a [Health Care Failure Effects and Mode Analysis](#) (HCFMEA). Proactively searching for ways in which a new technology can fail prior to (or in the pilot stages of) implementation can be an effective strategy for decreasing unintended adverse events. [Return to Top](#)

## Journal Brief: Leadership WalkRounds



The importance of senior leadership attention to patient safety and quality cannot be understated. The two studies noted below support the contention that patient safety starts at the top. However, despite demonstrated positive impact on safety attitudes and recommended time for the rounds at an hour a week ( $\leq 2.5\%$  of a workweek), leaders in most of the study hospitals had difficulty sustaining the rounds. Consistent senior leadership concern with patient safety and quality will drive a culture of patient safety. IHI, also, has emphasized the [role of leadership](#) in driving patient safety, especially through [Getting Boards on Board](#) and [Patient Safety Leadership WalkRounds](#).

*Revealing and resolving patient safety defects: the impact of leadership [WalkRounds](#) on frontline caregiver assessments of patient safety.* Frankel A, Grillo SP, Pittman M, et al. Health Services Research. 2008 Jul 29; [Epub ahead of print].

**Objective.** To evaluate the impact of rigorous WalkRounds on frontline caregiver assessments of safety climate, and to clarify the steps and implementation of rigorous WalkRounds.

**Data Sources/Study Setting.** Primary outcome variables were baseline and post WalkRounds safety climate scores from the [Safety Attitudes Questionnaire](#) (SAQ). Secondary outcomes were safety issues elicited through WalkRounds. Study period was August 2002 to April 2005, seven hospitals in Massachusetts agreed to participate, and the project was implemented in all patient care areas.

**Study Design.** Prospective study of the impact of rigorously applied WalkRounds on frontline caregivers' assessments of safety climate in their patient care area. WalkRounds were conducted weekly and according to the seven-step WalkRounds Guide. The SAQ was administered at baseline and approximately 18 months post-WalkRounds implementation to all caregivers in patient care areas.

**Results.** Two of seven hospitals complied with the rigorous WalkRounds approach; hospital A was an academic teaching center and hospital B a community teaching hospital. Of 21 patient care areas, SAQ surveys were received from 62 percent of respondents at baseline and 60 percent post WalkRounds. At baseline, 10 of 21 care areas (48 percent) had safety climate scores below 60 percent, whereas post-WalkRounds three care areas (14 percent) had safety climate scores below 60 percent without improving by 10 points or more. Safety climate scale scores in hospital A were 62 percent at baseline and 77 percent post-WalkRounds ( $t=2.67$ ,  $p=.03$ ), and in hospital B were 46 percent at baseline and 56 percent post WalkRounds ( $t=2.06$ ,  $p=.06$ ). Main safety issues by category were equipment/facility (A [26 percent] and B [33 percent]) and communication (A [24 percent] and B [18 percent]).

**Conclusions.** WalkRounds implementation requires significant organizational will; sustainability requires outstanding project management and leadership engagement. In the patient care areas that rigorously implemented WalkRounds, frontline caregiver assessments of patient safety increased. SAQ results such as safety climate scores facilitate the triage of quality improvement efforts, and provide consensus assessments of frontline caregivers that identify themes for improvement.

An [earlier study](#) focusing on nursing attitudes toward safety also showed a positive impact on safety attitudes with executive rounding for patient safety. (Thomas, E.J., Sexton, J.B., Neilands, T.B., Frankel, A., & Robert L Helmreich, R.L. (2005). *The effect of executive walk rounds on nurse safety climate attitudes: A randomized trial of clinical units.* BMC Health Services Research. 5:28) [Return to Top](#)

## Heard on the Net: Requirements and Cultures of Safety

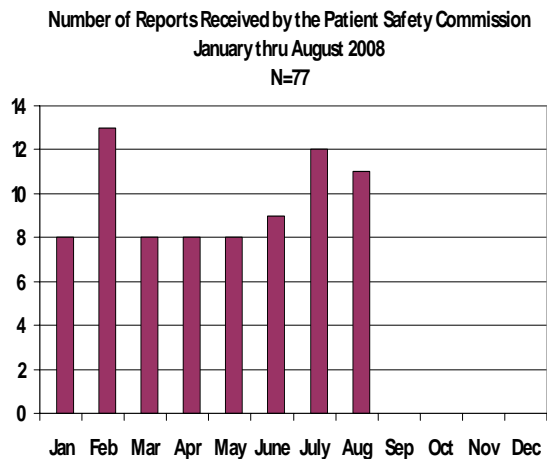
A recent posting on one of the listservs asked for input on whether it was necessary to do a time out with procedures in an ambulatory setting. I was struck by the question, as it seemed to be backwards, much like what happened 20 years ago in the Challenger catastrophe. Before the launch, when concerns were being raised about frigid early morning temperatures and O-rings, NASA wanted proof that it was *unsafe* to launch; the engineers were concerned that it would *not be safe*. Two very different perspectives and it is clear which perspective precipitated the tragedy.

That same perspective seems to be guiding the outpatient procedure question. Though the potential harm is usually lower, risks of outpatient procedures are similar to those with inpatient procedures. It would make sense, then, to apply known inpatient safe practices to a range of settings irrespective of external pressures. We will know we truly are moving to a culture of safety when we stop asking, "Do we have to do it?" and start asking, "Why shouldn't we do it?" [Return to Top](#)

## In the News: Medications that Increase the Risk of Falls

A New York Times [article](#) mentions the work of a research team at the University of North Carolina, Chapel Hill that has identified 103 medications that increase the risk of falls in people over the age of 65. The article, *Methodology of an Ongoing, Randomized Controlled Trial to Prevent Falls Through Enhanced Pharmaceutical Care*, appears in the [June 2008 issue](#) of the American Journal of Geriatric Pharmacotherapy and is available as a PDF document. The study investigates the effectiveness of a community pharmacy-based falls prevention program. This paper describes the intervention and will be followed by a second paper reporting the effectiveness of the intervention after one year of follow-up. A list of the medications, also in PDF, can be downloaded [here](#). [Return to Top](#)

## From the Commission



Reports Received – In August 2008 the Commission received 11 reports of adverse events, including six surgical events: four wrong-site surgery, and two reports of retained objects. These events were all related to actions inconsistent with the Universal protocol and recommendations by the Patient Safety Commission in its report on [Prevention of Unintentionally Retained Objects](#).

Strengthening the reporting program: In August of this year the Public Health Officer released his annual certification report of the Commission's reporting program. In that report the Public Health Officer praised the Commission and its hospital participants for jointly "...transforming the concept of reporting serious adverse events into a trusted statewide quality improvement

program." However, the Public Health Officer also identified room for much improvement. First, the Public Health Officer suggested that the number of reports being submitted is below expectations. Second, the Public Health Officer also commented on report quality, noting that reports needed to better identify system/root causes and offer stronger action plans.

In response the Commission will soon begin providing more active feedback to hospitals about their level of adverse event reporting. We will offer each hospital a comparison of their reporting levels to an average for their size cohort. We will ask hospitals to review our numbers and to offer comments about barriers to reporting. We will also ask hospitals to share these benchmarks with their Boards of Directors. Our Administrator, Jim Dameron, will be sending letters to each hospital CEO within the next two weeks.

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## Upcoming Events

### Commission Meeting

September 23rd 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](#).

### AHRQ'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 AHRQ.

**IHI Rural Grand Rounds Webex** begins September 25, 2008 at 11 am Pacific Time. Future Grand Rounds will be held at 10 am Pacific Time on: Thursday, October 16 (1 pm ET); Thursday, November 20 (1 pm ET); and Thursday, December 18 (1 pm ET). For more information on Webex login and password, contact IHI at [Campaign@ihi.org](mailto:Campaign@ihi.org) or Kathy Duncan at [KathyDDuncan@comcast.net](mailto:KathyDDuncan@comcast.net).

### ASHRM Annual Conference & Exhibition.

October 2-5, 2008; Hynes Convention Center, Boston, MA. Information [here](#).

### 2008 CareOregon CSSI Conference

Oct. 9, Oregon Convention Ctr. Contact [Debra Sexton](#) for registration form and 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. To unsubscribe, please [E-mail Linda Goertz](#) with subject "**Hospital Unsubscribe.**"*

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