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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:

What Makes a Good Root Cause Analysis (RCA), Part III

In this third of three brief notes on RCAs, we focus on conducting an investigation that fosters full information and consideration of the data collected. Part I described the first element of an effective RCA: drill down in understanding the contributing factors until the most basic (root) cause/causes are found. Part II described matching action plans to the identified root causes. Here, in Part III, we describe the foundation of a good RCA – full and accurate information collected through effective investigation techniques.



An effective investigation has a key characteristic: it focuses on what happened and how it happened, not “who did it.” An open-minded attitude combined with preparation and speed will go a long way toward ensuring both efficiency and effectiveness.

Before you interview –

- ♦ Make sure that you clearly understand the issue, concern, or allegation at hand.
- ♦ Identify any people who might have information, any documentation that may be relevant, and any personal observations (regarding equipment, general conditions, etc.) that you can make that will contribute to your understanding.
- ♦ Plan the interviews – it can help to make a simple list of what you hope to learn from each source
- ♦ Suspend any judgments about how or why it may have happened until you have gathered all the information; start with a “clean slate” attitude.

As you interview –

- ♦ Start the interviews with the people least involved in the event to have as much information as possible when talking with the people most central to the event. This reduces the number of second and third interviews needed to clarify information.
- ♦ Use your best interviewing skills, being sure to
 - Provide a standard opening statement to ensure consistency for all interviews.
 - Ask the interviewee to describe the events in his or her own words prior to asking specific (open-ended) questions.
 - Be clear in responding to concerns about what the information is for and what you will do with the information.
- ♦ As you gather the data, watch out for any indicators of --
 - Emotions of grief and fear altering perceptions
 - Rote responses assigning blame or denying responsibility
 - Making assumptions about the cause of the event [Return to Top](#)

Best Practices: Pressure Ulcer Prevention - An Emerging Best Practice?

In contrast to past newsletter issues, in which we reported identified best practices and/or good ideas from hospitals, this issue asks YOU to let us know about your experiences in pressure ulcer prevention. Two Oregon hospitals, supported by CareOregon funds through their Care Support and System Innovation program, have identified a long-standing practice that, in certain circumstances, may be detrimental to good skin care. That practice is the use of moisture barriers commonly known as “plaid pads.” We are interested in hearing about your experiences with moisture barriers and pressure ulcer prevention in general. Please email [Leslie Ray](#) and share your information and practices related to pressure ulcers. We will be collecting the information and sending out a longer case description of plaid pad use and pressure ulcer prevention. [Return to Top](#)

Journal Briefs: Safety and Systems

It is a truism in current patient safety work that adverse event root causes are more likely to be related to system problems and failure rather than to individual competencies. With that in mind, the following two article abstracts have special relevance. The first reports a recent study supporting the importance of front-line staff experiences in identifying areas for increasing safety and efficiency, even though the identified areas are not currently on any of the national priority lists. The second study examines nursing work and the frequency of system-related failures, noting that nurses experience 8.4 work system failures per eight-hour shift. These studies suggest that, in addition to RCAs and HC FMEAs, a worthwhile focus for improvement activities is unit level evaluation of work system failures.

Tucker AL, Singer SJ, Hayes JE, Falwell A. (2008) Front-Line Staff Perspectives on Opportunities for Improving the Safety and Efficiency of Hospital Work Systems. [Health Services Research Jun 3. \[E-published ahead of print\]](#)

Objective To contrast the safety-related concerns raised by front-line staff about hospital work systems (operational failures) with national patient safety initiatives.

Data Sources Primary data included 1,732 staff-identified operational failures at 20 U.S. hospitals from 2004 to 2006.

Study Design Senior managers observed front-line staff and facilitated open discussion meetings with employees about their patient safety concerns.

Data Collection Hospitals submitted data on the operational failures identified through managers' interactions with front-line workers. Data were analyzed for type of failure and frequency of occurrence. Recommendations from staff were compared with recommendations from national initiatives.

Principal Findings The two most frequent categories of operational failures, equipment/supplies and facility issues, posed safety risks and diminished staff efficiency, but have not been priorities in national initiatives.

Conclusions Our study suggests an underutilized strategy for improving patient safety and staff efficiency: leveraging front-line staff experiences with work systems to identify and address operational failures. In contrast to the perceived tradeoff between safety and efficiency, fixing operational failures can yield benefits for both. Thus, prioritizing improvement of work systems in general, rather than focusing more narrowly on specific clinical conditions, can increase safety and efficiency of hospitals.

Tucker, Anita L. Spear, Steven J. (2006). Operational failures and interruptions in hospital nursing. [Health Services Research 41\(3 Pt 1\):643-62](#)

Objective: To describe the work environment of hospital nurses with particular focus on the performance of work systems supplying information, materials, and equipment for patient care.

Data Sources: Primary observation, semi-structured interviews, and surveys of hospital nurses.

Study Design: We sampled a cross-sectional group of six U.S. hospitals to examine the frequency of work system failures and their impact on nurse productivity.

Data Collection: We collected minute-by-minute data on the activities of 11 nurses. In addition, we conducted interviews with six of these nurses using questions related to obstacles to care. Finally, we created and administered two surveys in 48 nursing units, one for nurses and one for managers, asking about the frequency of specific work system failures.

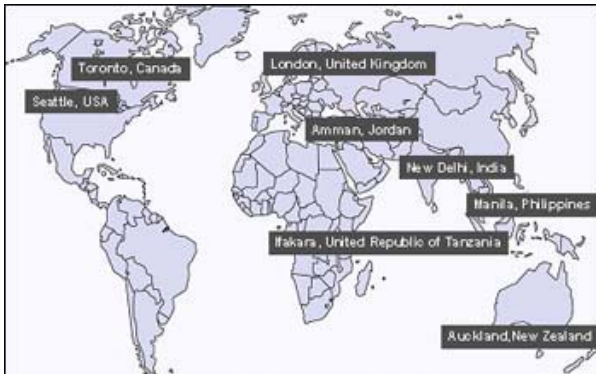
Principal Findings: Nurses we observed experienced an average of 8.4 work system failures per eight-hour shift. The five most frequent types of failures, accounting for 6.4 of these obstacles, involved medications, orders, supplies, staffing, and equipment. Survey questions asking nurses how frequently they experienced these five categories of obstacles yielded similar frequencies. For an average eight-hour shift, the average task time was only 3.1 minutes, and in spite of this, nurses were interrupted mid-task an average of eight times per shift.

Conclusions: Our findings suggest that nurse effectiveness can be increased by creating improvement processes triggered by the occurrence of work system failures, with the goal of reducing future occurrences. Second, given that nursing work is fragmented and unpredictable, designing processes that are robust to interruption can help prevent errors. [Return to Top](#)

Heard on the Net: Transparency Blog on Adverse Event

Even for those of you less than enamored with weblogs, this one from the CEO of Beth Israel Deaconess Medical Center in Boston is worth a read. In response to a wrong-site surgery in his hospital, the CEO sent an email to all employees at the hospital describing the event and findings from their investigation. He asked that they consider how the lessons learned might apply to their own work. He then went further, posted the email on his [blog](#) and added a brief commentary. Comments from BIDMC employees and others are also posted and the Boston Globe printed a [news story](#) about the incident. [Return to Top](#)

In the News: Safe Surgery Checklist



The World Health Organization officially launched a [safe surgery initiative](#) June 25th, promoting Peter Pronovost's "Surgical Safety Checklist" as a world standard. The checklist is currently being piloted in each of the six WHO regions and is available for [download](#) along with a training manual and video.

Washington State is beginning an initiative to promote use of the checklist for surgeries and procedures in all of its hospitals. Some Washington hospitals are using the tool with modification to include a number of the CMS measures as a way to insure as wide a capture of important quality and safety factors as possible. Prevention of wrong site

surgeries and retained objects continue to be a challenge for Oregon hospitals-see below. Commission staff encourages all Oregon hospitals to review the checklist for possible implementation as they continue their efforts to assure safe surgery. [Return to Top](#)

Patient-Centered Care: Coumadin Guide

AHRQ (Agency for Healthcare Research and Quality) has released a new consumer publication, [Your Guide to Coumadin®/Warfarin Therapy](#). According to AHRQ, the "...easy-to-read patient brochure explains what patients should expect and watch out for while undergoing Coumadin®/warfarin therapy. This brochure educates patients about their medication therapy and potentially dangerous side effects, explains how to communicate effectively with their health care providers, and provides tips for lifestyle modifications. It also provides information on remembering when to take the medicine, learning how to stay safe while taking the medicine, maintaining a consistent diet, and alerting health care providers to concurrent drugs and/or supplements patients are taking to avoid any potential adverse interactions." To receive a print copy, send an e-mail to AHRQ (ahrqpubs@ahrq.hhs.gov). [Return to Top](#)

From the Commission

Emergency Code Standardization –

This cooperative initiative among OAHHS, the Patient Safety Commission, and the Washington State Hospital Association is moving forward. In a meeting held July 9th the group, which included a number of hospital representatives, developed a draft set of recommendations. The guiding principles were to limit the number of code types, be consistent with emerging national consensus, and to avoid confusion with current wristband colors. We will be sending out the draft recommendations and seeking comments within the next few weeks. The group's goal is to have a finalized set of recommendations by the end of August.

The survey of Oregon hospitals regarding emergency codes showed a great deal of variation in the 52 hospitals that responded. Hospitals use from five to 17 different codes. The two codes used by 51 of the hospitals were for Fire ("red" was used in 82% of the hospitals) and Combative Person (10 different codes). The most variation was seen with 14 different codes indicating Bomb Threat used by 31 hospitals.

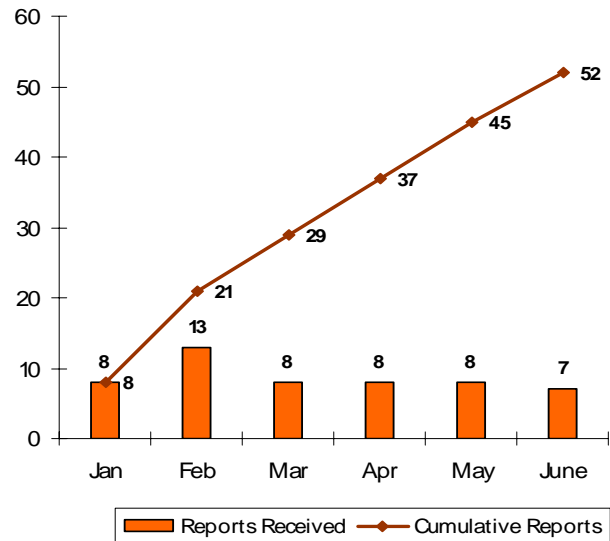
Reports Received --

In June 2008 the Commission received eight reports of adverse events, including five deaths. Two of the events were medication errors and two were wrong site surgeries. Over the first two quarters of the year, we have received 52 reports, 11 of which were falls, and 17 (one-third of reported events) involved retained objects, wrong-site surgery, or wrong surgical procedures.

Last November the Commission issued a set of recommendations for preventing unintentionally retained objects. Many of those recommendations serve well for safe surgery in general. The [recommendations](#) are available as a .pdf file and include development of a surgical checklist. See the WHO-recommended checklist mentioned [above](#) for an approach to checklist content.

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Monthly and Cumulative Frequency of Reported Adverse Events in 2008



Upcoming Events

Commission Meeting

August 12th from 12:30 to 3:30pm at the Wilsonville Training Center of Clackamas Community College, 29353 SW Town Center Loop East, Wilsonville.. 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](#).

ASHRM Annual Conference & Exhibition.

October 2-5, 2008; Hynes Convention Center, Boston, MA. [More information here.](#) [Return to Top](#)

This newsletter is being sent to you because you are a participant 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 program. If you wish to unsubscribe, please sent an E-mail to linda.goertz@oregonpatientsafety.org with subject "Hospital Unsubscribe."

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