

OREGON PATIENT SAFETY COMMISSION

Oregon Patient Safety Commission Advances Nursing Facility Reporting Program**Lewis McCoy, M.B.A., M.A.****Oregon Patient Safety Commissioner**

As we start the new year, the profession of Long Term Care can count on many opportunities for change and growth. This is especially true for providers in Oregon who are working to advance patient safety efforts. The following article provides an update on the work of the Oregon Patient Safety Commission and describes your opportunity to play a key role in patient safety in 2007.

Background

The Oregon Patient Safety Commission was established to accomplish three important tasks: first, to develop a voluntary and confidential reporting system for serious adverse events that occur throughout the health care continuum; second, to establish quality improvement techniques aimed at reducing system errors; and third, to disseminate evidence-based prevention practices to improve patient outcomes. Groups defined in the legislation include nursing facilities, hospitals and pharmacies, as well as outpatient renal dialysis, ambulatory surgery, and freestanding birthing centers.

Progress

The Commission has made significant progress over the past year. We initiated the hospital reporting program, including defining reportable events, developing the reporting template, drafting administrative rules, and conducting a pilot program. In an overwhelming demonstration of interest in the program, over 95% of the state's hospitals agreed to participate in the reporting program. Almost immediately, hospitals began to share information about errors and utilized the Commission to alert one another of potentially serious adverse events.

For nursing facilities, the Commission has made progress in much the same way as the hospital constituency. Over the past year, we have worked with several groups of long term care and allied professionals to develop the foundation of our program. These groups collaborated on the development of reporting tools, advised on the program's implementation, and pilot-tested materials in several facilities. Throughout this process we have refined the reporting framework and have identified ways to incorporate and honor existing reporting so as not to duplicate administrative efforts. We are now focusing on drafting administrative rules for the program and will be seeking your facility's participation in the program later this spring.

Next Steps

As we look to the new year, we have another excellent opportunity to define ourselves as leaders in quality by welcoming the Oregon Patient Safety Commission into our current systems of resident care. By sharing our information with the Commission, we can learn from each other about the nature of adverse events. We will be able to broadcast alerts immediately to other facilities about potential causes of serious errors. We can also continue to advance conversations about resident care away from abuse taxonomy and towards quality improvement. By participating, you will demonstrate your commitment to identifying best practices in our profession; you will also gain a process to share those experiences and observations with all facilities in Oregon. Look for future information about how your facility can participate in the future of patient safety efforts in Oregon.

For more information, please contact Jim Dameron, Oregon Patient Safety Commission Administrator, at 503-224-9226, or Lewis McCoy at Town Center Village, 503-654-4500. Please also visit <http://www.oregonpatientsafety.org>.