Several times in recent years, this newsletter has brought up the issue of balancing individual patient care while keeping the larger context of care in mind. (See Situation Awareness April 2009; Too Task Focused? September 2009; and Mindfulness May 2010). Two reports submitted last month bring this to the fore again, though within the context of caring for an individual patient – providing the specific tasks of care while taking into account the meaning of those tasks and implications for care.

The patients, aged 60 and 75, suffered pressure ulcers and the hospitals noted the absence of policy as well as patient behavioral factors as contributing causes. In considering how to respond to these events in a way that will prevent future events, the hospitals developed plans to increase staff and physician awareness of the risks involved related to each of these patients. In addition, they sought to identify and implement practice guides for assessment and care. While these findings and action plans are responsive to the individual events, a commonality between these two events points to another, more subtle cause.

Patient Safety Wall @ Salem Hospital

At Salem Hospital, implementation of Root Cause Analysis (RCA) action plans to prevent adverse events engages the entire organization, including Senior Leadership. The goals are to

- be more transparent about adverse events,
- accelerate implementing changes that are identified during the RCA process,
- spread those changes more broadly if needed, and
- increase organizational learning about patient safety.

To accomplish that, the hospital has set up a Patient Safety Wall in one of the conference rooms in which they post all current RCAs (not all are sentinel events) along with the identified action items. All clinical directors and related department heads attend the weekly stand up meeting – usually about 15-20 people. The Director responsible for each action reports on progress and any still-to-be-resolved issues. Specific problem solving related to implementation of action plans occurs both during and between meetings. Most reports detail progress and what needs to occur to close out action items, according to Dan Grigg, Director, Center for Patient Safety & Clinical Effectiveness.
Pressure ulcer focus (cont’d)

The commonality in question was a patient care focus that obscured a broader look at the patient, specifically skin integrity risks, resulting in pressure ulcers. In one case, nursing care focused on fall prevention and wound care around a feeding tube. In the other, the focus was healing of a leg wound. Initial judgment may tend to individual’s failure in care. Possible responses to individual failure are threefold: 1] fire the employee, 2] educate around the failure, and 3] admonish to be more careful. These, as we know all too well, do little to prevent other staff from the same failures.

Too much focus can result in relevant information going unrecognized with potentially disastrous results.

That the events involved different staffs, at different hospitals, taking care of patients with different clinical presentations, imply underlying systemic professional and industry-wide issues – issues that seem too large to address in a meaningful way. Interestingly, some helpful suggestions come from psychology blogs that discuss balancing a task-focus with goal focus. We can see parallels to patient care as we consider the specific tasks needed in caring for a patient as part of a larger aim. The task-goal dichotomy is also consistent with the need for situational awareness, where staff consciously scan the environment for information in addition to performing specific tasks. continued ➜

While assuring appropriate attention and focus in a complex and changing care environment is a complex and difficult issue to address, two actions are possible:

Recommendation.

1. Provide house-wide, discipline- and department-specific training in situation awareness. This raises awareness about the difficulty in moving between immediate task and larger goal of care and the risks that poses. Staff may then be more likely to recognize situations with potential risks. (Moderate, if integrated into the culture).

2. Develop prompts1 that help staff “think of everything.” These might include checklists, structured handoffs, pre-printed order sets, pre-printed care sheets, etc. (Moderate)

1See the Pressure Ulcer Transitional Care work, which includes a toolkit that may be helpful.

Patient Safety Wall (cont’d)

This transparent approach also provides the opportunity for others to identify areas of common interest. Senior Leadership, including the Chief Nursing Officer, the Chief Financial Officer, and the Chief Operating Officer, attend these meetings regularly. Generally, the meetings last about thirty minutes. Other hospital employees and medical staff can also visit the wall at any time to learn about these events and actions that are being taken to prevent reoccurrence.

For more information on how to start a Patient Safety Wall at your facility, contact: Dan Grigg

Senior Leadership focuses on removing barriers. From left to right are Charlie Cooper, Cheryl Nester-Wolfe, RN, David Holloway, MD and Lori James-Nielson.
Journal Brief

Interruptions and multitasking in nursing care.

ABSTRACT

BACKGROUND: The environment surrounding registered nurses (RNs) has been described as fast-paced and unpredictable, and nurses' cognitive load as exceptionally heavy. Studies of interruptions and multitasking in health care are limited, and most have focused on physicians. The extent and type of interruptions and multitasking of nurses, as well as patient errors, were studied using a natural-setting observational field design. The study was conducted in seven patient care units in two Midwestern hospitals--an academic medical center and a community-based teaching hospital.

Interruptions and multitasking in nursing care.(cont’d)

METHODS: A total of 35 nurses were observed for four-hour periods of time by experienced clinical nurses, who underwent training until they reached an interrater reliability of 0.90.

FINDINGS: In the 36 RN observations (total, 136 hours) 3,441 events were captured. There were a total of 1,354 interruptions, 46 hours of multitasking, and 200 errors. Nurses were interrupted 10 times per hour, or 1 interruption per 6 minutes. However, RNs in one of the hospitals had significantly more interruptions--1 interruption every 4 1/2 minutes in Hospital 1 (versus 1 every 13.3 minutes in Hospital 2). Nurses were observed to be multitasking 34% of the time (range, 23%- 41%). Overall, the error rate was 1.5 per hour (1.02 per hour in Hospital 1 and 1.89 per hour in Hospital 2). Although there was no significant relationship between interruptions, multitasking, and patient errors, the results of this study show that nurses' work environment is complex and error prone.

DISCUSSION: RNs observed in both hospitals and on all patient care units experienced a high level of discontinuity in the execution of their work. Although nurses manage interruptions and multitasking well, the potential for errors is present, and strategies to decrease interruptions are needed.

PubMed Citation

See also


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In the News

Increasingly, new hospitals and those being renovated are taking into account design features that improve safety, decreasing length of stay and increasing staff effectiveness. A recent item in the Cleveland Plain Dealer describes these efforts:


The two resources noted in the article are located here: LitReview-EvidenceBasedHCDesign and here: HospitalPhysicalEnvironment

What do Jeopardy! and medical diagnosis have in common? The answer may be Watson, IBM's new computer with algorithms that mimic human information processing, opening the door to truly useful medical AI. See Bob Wachter's blog at http://community.thehospitalist.org/blogs/wachters_world/archive/2010/10/01/what-is-wegener-s-granulomatosis.aspx and be sure to watch the video clip on YouTube.

Resources

**Toolkit for Condition H(elp)** – family-activated RRTs – from the Maryland Patient Safety Center offers a large selection of resources for making the case, leadership guide, planning tools, measurement strategies and more. It also includes a video clip with Sorrel King commenting on the importance of family-initiated RRTs. (The video clip does not show within Firefox – you will need to use Internet Explorer. However, the clip is a listed resource for downloading.) The toolkit is available here:


**Implementation Strategies for Condition H** are described in a recent in-depth article that includes the evidence-model used, guidelines, algorithm for calls, and specific implementation strategies. The article ends with examples of calls received and learnings from the first quarter the program was in place. Surprisingly, only one call was triggered by a deterioration in patient condition; other calls were prompted by communication/systems issues, including concerns about comfort and pain.


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Oregon Patient Safety Commission
Did You Know?


*Excerpted from the abstract:*

Misunderstanding dosage instructions on prescription drug labels is common. While limited literacy is associated with misunderstanding, the instructions themselves are awkwardly phrased, vague, and unnecessarily difficult. Prescription drug labels should use explicit dosing intervals, clear and simple language, within a patient-friendly label format.

**PubMed Citation**


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**From the Commission**

At their October 8th Patient Safety Convocation in Portland, the Oregon Medical Association presented the first Dr. **George E. Miller Patient Safety Award** to Nancy Clarke, Executive Director, Oregon Health Care Quality Corporation and Jim Dameron, Administrator, Oregon Patient Safety Commission. The award, honoring individuals who have made a significant contribution to improving patient safety in Oregon, is named in honor of Dr. George Miller, a Salem physician who was a tireless champion for patient safety. Following creation of the Oregon Patient Safety Commission in 2003, Governor Kulongoski appointed Dr Miller to the Board, which elected him Chair for 2004-2006. He continued on the board until his death in 2007.
**Adverse Event Reports**

The Commission received reports of 16 adverse events during September. One-third of the events were less serious harm, one-third serious temporary or permanent harm, and one-third resulted in death. ‘Other’ events included an unnecessary procedure and two unexpected deaths.

*Adverse Event Reports* — the following synopses are provided with the request to identify similar opportunities for occurrence and to develop precautionary actions:

**Burn (2)** — see *September Patient Safety Topics* for description and discussion

**Other (3)** — These included an unnecessary procedure and two unexpected deaths. For the unnecessary procedure, the primary contributing factor was lack of a 2 person identifier prior to the procedure and the **action plan** included developing a Ticket To Ride to insure important information is available and reinforce patient identification. For the unexpected deaths, one of the contributing factors identified was allocation of staff — nursing in one case, medical staff in the other. **Action Plans** Both hospitals developed policies regarding staff assignments. In the one instance this involved identifying specific roles and responsibilities for responding to ED requests and in the other, identifying mechanisms for assuring patient follow up by the discharging specialty for patients returning to the ED within a month of discharge.

**Pressure Ulcer (2)** — see above

**Fall (2)** — both occurred in elderly patients who stood unassisted, but subsequently fell with healthcare staff nearby; neither resulted in serious harm. **Action Plans** included reinforcement of using gait belts and appropriate handoffs to convey fall risk. **Comment:** gait-belt use or lack of use has been raised in several reports recently and prompt the following **Recommendation:** review gait belt usage and the triggers that indicate that a specific patient could benefit from its use.

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**Upcoming Events**

**Commission Meeting**

December 14th from 12:30 to 3:30pm at the **Wilsonville Training Center of Clackamas Community College**. To request an agenda, please contact **Linda Goertz**. All Commission meetings are on the second Tuesday of even-numbered months. Click **here** for a listing of meeting dates.

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Upcoming Events (cont’d)

**Patient Safety Rounds**

November 4th from 12:10 to 12:55 – “Safe Patient Handoffs” A monthly 45-minute case presentation and discussion of best practices. Safe Table Webinar format on the first Thursday of the month through December 2010. Click [here](#) for more information.

**Other Events**

October 20-22, 2010 – ORHQN TeamSTEPPS Master Trainer Workshop, Ameritel Inn, Old Mill District, Bend Oregon. For information, click [here](#)

December 5–8, 2010 – 22nd Annual National Forum on Quality Improvement in Health Care. The Institute for Healthcare Improvement.; Orlando World Center Marriott Resort & Convention Center, Orlando, FL.

**Conference Information/Registration**

March 6-12, 2011 Patient Safety Awareness Week. National Patient Safety Foundation


Contact Us

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This newsletter is 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. If you wish to unsubscribe, please send an E-mail to linda.goertz@oregonpatientsafety.org with subject “Hospital Unsubscribe”