Oregon patient safety Commission

Patient Safety Topics

January 2011 Volume 5 No 1

In This Issue:

Oregon will have the safest healthcare system in the nation

The 3 R's of Patient Safety

Risk Recognition – **R**eliable Care – **R**edesigned Work Processes appear repeatedly as root factors in adverse events. The latter, **R**edesign of Work, is particularly difficult to get traction on in efforts to improve patient safety. The majority of solutions to patient safety problems identified in RCAs involves the nursing staff doing something, but do not fundamentally address the design of the work itself. Because nursing care is central to the patient's hospitalization and nursing is charged (implicitly and explicitly) with coordinating the care, nursing-focused action plans are logical. However, many times this leads to concern about how much time is available to accomplish the required actions. (See **below**) And, that leads to the inevitable circular and non-productive discussion regarding staffing levels and budget constraints.

Two other options are available. The first, which can be implemented somewhat easily, is to ask with each plan requiring additional actions by nursing, "Is this our best/only option for decreasing risk?" A recent example comes to mind when an Oregon hospital responded to an HAI event. Already implementing a multi-pronged approach to eliminate central line infections, the RCA team believed additional efforts in environmental cleaning would be useful. So, they recommended that the critical care nurses wipe down all high touch surfaces at the beginning of each shift. Even putting aside the impracticality of adding another activity to the number already occurring at shift change, the probability of sustaining this practice change for any length of time is very low. A better option would be to engage the environmental cleaning staff, already partners in infection prevention, and develop a plan for routine once-overs of high touch areas in critical care during each shift.

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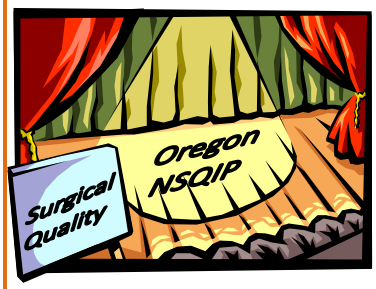
National Surgical Quality Improvement Project (NSQIP)



Eight Oregon hospitals* participate in a national effort to identify predictors of postoperative morbidity and mortality. **NSQIP**, sponsored by the American College of Surgeons, is a validated, risk-adjusted, outcomes-based program. It uses a prospective, peer controlled, audited clinical database that allows for valid comparison of outcomes among all hospitals in the program. It developed from a surgical risk study at the VA in the early 90's. In the 10 years following their initial study, VA hospitals saw declines of 45% in postoperative mortality and 27% in postoperative morbidity.

Consistent with an Oregon culture that believes in sharing good ideas and best practices, Oregon NSQIP hospitals formed a consortium in 2007 to look at Oregon-specific data. The Oregon NSQIP Consortium's (ONC) initial evaluation of Oregon data showed a 54% reduction in complications for patients with known diabetes.

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Redesign (continued)

The second option, which is more long term, involves redesigning work processes. Two major initiatives are available to hospitals: *Transforming Care at the Bedside*, a joint IHI and RWJ Foundation initiative; and *Releasing Time to Care – The Productive Ward* from the National Health Service in England.

Transforming Care at the Bedside (TCAB) was designed to develop new interventions to improve the hospital work environment, with the goal of improving the quality of care provided by nurses at the bedside through involving nurses and other front-line staff in the redesign of care delivery models and systems.
http://www.ihi.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm

The Productive Ward focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency.
http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html

The major strides in patient safety – moving the big dots of morbidity, mortality, and adverse events – will come from fundamental redesign such as those noted above that develop new models of care based on empowerment and teamwork.

NSQIP (continued)

The complete report, **Reducing Surgical Complications: Risk-based Perioperative Screening for Diabetes and Glucose Management** identifies three recommendations:

- Screen preoperatively for undiagnosed diabetes and prediabetes:
- Measure perioperative glucose to identify hyperglycemia
- Treat hyperglycemia in the hospital using safe and effective glycemic control strategies and NOT predominantly by giving sliding scale insulin (SSI).

The ONC, chaired by Jim Schwarz, MD, is continuing to look at blood glucose considerations and beginning to look at VTE (venous thromboembolism) more closely. NSQIP is expanding its enrollment options to include smaller and rural hospitals. If you are interested in learning more about the Oregon NSQIP Consortium and the benefits of joining for your hospital, please contact **Sydney Edlund**, who will put you in touch with the Consortium.

* Kaiser Sunnyside Medical Center, Legacy Emanuel Hospital & Health Center, Legacy Good Samaritan Hospital, OHSU, Providence Portland Medical Center, Providence St. Vincent Medical Center, Sacred Heart Medical Center @ Riverbend, and Salem Hospital.

Journal Brief

When tackling seemingly intractable challenges – "wicked problems" – we often blame the safety culture (or lack of a safety culture). However, demonstration of a clear association between a culture of safety and adverse events is just beginning. Two recent studies examining this relationship have appeared in the literature.

Hansen LO, Williams MV, Singer SJ. (2010) Perceptions of Hospital Safety Climate and Incidence of Readmission. Health Services Research. Nov 24. doi: 10.1111/j.1475-6773.2010.01204.x. [*Epub ahead of print*]

Abstract

Objective. To define the relationship between hospital patient safety climate (a measure of hospitals' organizational culture as related to patient safety) and hospitals' rates of rehospitalization within 30 days of discharge.

Data Sources. A safety climate survey administered to a random sample of hospital employees (n=36,375) in 2006-2007 and risk-standardized hospital readmission rates from 2008.

Study Design. Cross-sectional study of 67 hospitals.

Data Collection. Robust multiple regressions used 30-day risk-standardized readmission rates as dependent variables in separate disease-specific models (acute myocardial infarction [AMI], heart failure [HF], pneumonia), and measures of safety climate as independent variables. We estimated separate models for all hospital staff as well as physicians, nurses, hospital senior managers, and frontline staff.

Principal Findings. There was a significant positive association between lower safety climate and higher readmission rates for AMI and HF ($p \leq .05$ for both models). Frontline staff perceptions of safety climate were associated with readmission rates ($p \leq .01$), but senior management perceptions were not. Physician and nurse perceptions related to AMI and HF readmissions, respectively.

Conclusions. Our findings indicate that hospital patient safety climate is associated with readmission outcomes for AMI and HF and those associations were management level and discipline specific.

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PubMed Citation

See also

Mardon RE, Khanna K, Sorra J, Dyer N, Famolaro T. (2010) Exploring relationships between hospital patient safety culture and adverse events. Journal of Patient Safety. Dec; 6(4):226-32.

PubMed Citation

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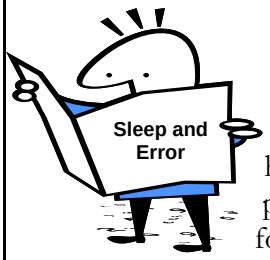
In the News



A CNN item late last month, **Researchers urge doctors to disclose sleep fatigue before surgery**, highlighted a New England Journal of Medicine **article** addressing the risk to patients from physicians who are sleep-deprived. The item included findings from a 2009 JAMA study* that found "…patients of sleep-deprived faculty surgeons faced an 83% increased risk of complications..." Responding to statements that fatigue is less of a problem in simple procedures, Charles A. Czeisler, chief of the Division of Sleep Medicine at the Brigham and Women's Hospital in Boston, Massachusetts noted that

> "The adverse effects of fatigue on performance are greatest when an individual is performing a routine, highly overlearned task, whether it be automobile driving, piloting an airplane, doing something you've done over and over again…So the suggestion that a 'relatively simple' procedure would be less susceptible to the effects of fatigue is completely erroneous."

*Risks of complications by attending physicians after performing nighttime procedures. Rothschild JM, Keohane CA, Rogers S, et al. JAMA. 2009;302:1565-1572. Available at: **http://jama.ama-assn.org/content/302/14/1565.abstract?sid=baea5e9b-4541-4ede-9c7e-1ab3c48ed731**

Heard on the Net

The recent **NEJM article** about lack of progress in decreasing harm has prompted a flood of postings on the NPSF listserve regarding "Why We Still Kill Patients at US hospitals" This thread quickly focused on "Why We...don't wash our hands." Much of the back and forth in these thoughtful responsive postings is summed up in the motto suggested by William Hyman: *Healthcare – Too Busy to be Safe.* One posting, reflecting the reality of bedside care listed the circumstances preventing handwashing:

Someone has fallen and I have to rush to assess them
A patient is crashing
A patient needs something *now*
My colleague needs help *now*

Other than the second circumstance, all spring from a deeply held cultural belief everything has to happen instantaneously. This harms patients. In Oregon, an anesthesiologist, wanting to save time passed over the time out and performed a femoral block on the wrong side. A NICU nurse wanting to respond quickly with pain meds for a baby having a PICC line inserted passed over the independent verification and gave 10X the dose. A transport aide, not wanting to waste time checking the patient record or ID, brought the wrong patient to the imaging department. Add to this actual time requirements for hand washing; for example, a nurse with five patients and hourly rounding will need to devote a minimum of 40 minutes in eight hours, hand washing to "Happy Birthday." For those who believe multitasking can carve off some of the time, consider the effort and practice required to pat your head and rub your stomach at the same time, and the harms that are caused by distracted brains.

Resources

Sepsis Alliance

The Sepsis Alliance is an organization dedicated to "Raising awareness of sepsis by educating patients, families, and healthcare professionals to treat sepsis as a medical emergency." Their website included information for the public and healthcare professionals and includes the video **Sepsis Emergency**

SEPSIS ALLIANCE
Suspect Sepsis. Save Lives.

Web-based FMEA

QI Path offers a web-based FMEA (Failure Mode and Effects Analysis) system as a free service to healthcare provider organizations and researchers. According to improvement consultant Tom Leifer, those familiar with FMEA have found this system to be extremely intuitive. There is help available for those with more limited FMEA experience to walk you through the demo. If you decide to use the system, QI Path will create a secure, private account for up to 12 users. To request demo login go to: **http://www.qipath.com/request-a-demo**.

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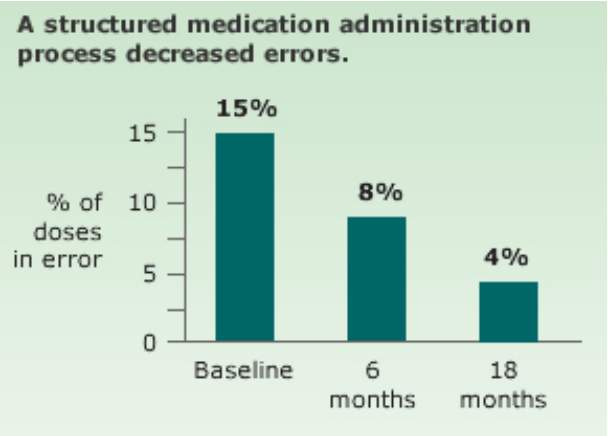
Did You Know?



Source: Kliger J, Blegen MA, Gootee D, O'Neil E. Empowering frontline nurses: a structured intervention enables nurses to improve medication administration accuracy. Jt Comm J Qual Patient Saf. 2009; 35:604-612. **PubMed Citation**

From the Commission

New patient safety consultant for nursing homes.

The Commission welcomes Valerie Van Buren as our new patient safety consultant for nursing homes. She has an MPH from Oregon State in Health Policy & Management with a specialization in gerontology. Ms Van Buren comes to the Commission from Acumentra Health where she led the restraint reduction program for nursing homes and, as a quality specialist, worked with nursing homes on a variety of other issues, including patient safety culture. She also was a member of the Commission's Expert Panel, which developed a Falls Investigation Toolkit.

Work Group on Narcotic Oversedation begins.

The Commission's Narcotic Oversedation Work Group had its first meeting in December. The group's charge is to develop a set of best practices to reduce the risk of adverse events that the Commission's Board can recommend to Oregon hospitals. In defining their scope, the group is focusing on medical-surgical and critical care patients in acute in-patient facilities. The first meeting was taken up with defining the problems/factors contributing to oversedation events. The group will revise/refine these at January's meeting and begin to address potential solutions. Members of the work group include Lynn Belcher RPh, Legacy Health System; Rick Botney MD, OHSU; Bob Cutter PharmD, St. Charles Healthcare; David Hickam MD; PVAMC/OHSU; Stephanie Jackson MD, PeaceHealth; Dianna Pimlott RPh, Peace Harbor Hospital; Paul Roche, RPh, Sacred Heart Medical Center @ Riverbend, Joe Schnabel PharmD, Salem Hospital; LuAnn Stahl, MS, CNS, Legacy Health System; Jo Stuart Pharm D, Three Rivers Community Hospital (Asante); and Ray Willey, Silverton Hospital. The group is looking for med-surg and critical care nurses to join the discussion. Please contact **Leslie Ray** if you are interested.

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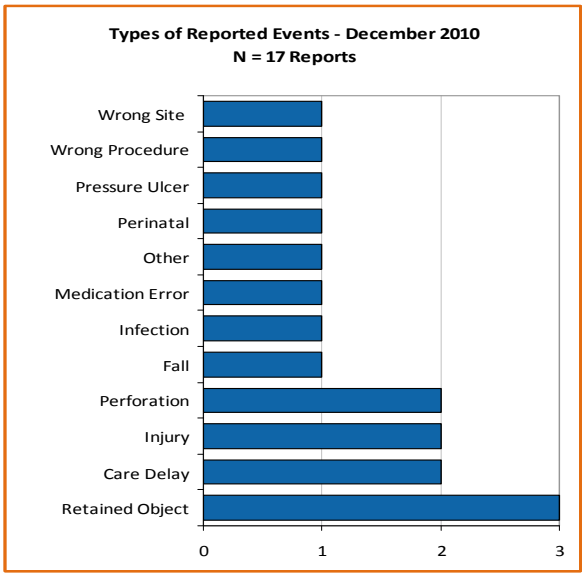
We want to hear from YOU…

Building on the first five years of its reporting program, the Patient Safety Commission is developing a vision for the future. In February, we will be sending a brief survey to hospital and other participants to better understand your patient safety and reporting challenges. We will be asking you to identify specific activities or support you would find most helpful. Thank you in advance for taking a few moments to respond to the upcoming survey!

As always, we welcome your comments and reflections any time; you may contact any of the staff below with your feedback.

Adverse Event Reports



Eleven hospitals submitted 17 adverse event reports representing 12 different types of events to the Commission in December. All but three were serious harm events and included five patients with permanent harm and three deaths.

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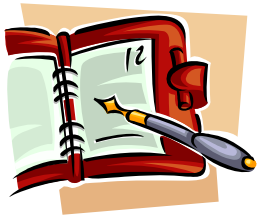

Upcoming Events

Commission Meeting

February 8th 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.

Patient Safety Rounds

February 1st from 12:10 to 12:55 – "Sleep Apnea Recognition" 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

January 12 through February 23, 2011 – Safe Care of the Very Large Patient Weekly WebEx teleconference during the Noon lunch hour. Washington Patient Safety Coalition. For registration and conference information, click **here**. Cost to non-WPSC members is $40 per teleconference line, $160 for the entire series.

February 9, 2011 **Improving Medication Safety through Effective Error Reporting**
Wednesday, from 1:30pm - 3:00pm Eastern Time

April 5-8, 2011 – 2011 International Forum on Quality and Safety in Healthcare. Amsterdam, the Netherlands: Institute for Healthcare Improvement and the BMJ Publishing Group;
Conference Information

May 25–27, 2011 – 13th Annual NPSF Patient Safety Congress. *Sharing Accountability and Responsibility in Pursuit of Patient Safety*. National Patient Safety Foundation; Gaylord National Hotel & Convention Center, National Harbor, MD. **Conference information**

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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."