Adverse Events — When the Patient is to ‘Blame’

Over the years, one of the biggest changes in approach to patient safety has been the substitution of individual blame with individual and system accountability through development of a Just Culture. Tools such as David Marx’s Just Culture Algorithm or the U.K. National Patient Safety Agency’s Incident Decision Tree provide a helpful way to distinguish between human error and risky actions. While we have become more sophisticated in understanding individual and system contributions to adverse events in some regards, we too often remain mired in the individual blame perspective when it comes to the patient’s role.

From June of 2006, when the Commission received its first adverse event report, through June of this year, 38% of the reports noted some type of patient factor as contributing to the event. Some of these patient factors obviously did not contribute to the event, but were included to give some contextual information about the situation. For example, there were no clear causative relationships between the anxiety noted in a 40 year old and his wrong site surgery; the dementia in a 90 year old and the wrong route medication event; or between lymphedema and a delay in care in a 55 year old. In other reported events, it is easy to see how the patient-related factors might lead or contribute to the event, such as when patients (even when cognitively intact) and/or family members consistently disregard staff instructions or omit relevant information.

However, the majority of the patient factor-event relationships are not easy to classify into one or the other of those two groups. Various patient factors clearly make care more difficult, but as a reasonable rationale for why the adverse event occurred, they are questionable. For example, the Commission has received reports that seem to indicate that falls have occurred because of patients’ dementia MRI burns because the patient was morbidly obese, and medication errors because the patient had multiple co-morbidities and required a complex medication regimen.

That a patient with dementia cannot remember to call for assistance means patient education as a safety strategy is inappropriate. Equipment appropriate to the very small or very large patient needs to be available. Attributing adverse events, either wholly or in part, to patient factors can lead to a slippery slope that pays insufficient attention to healthcare practices and system influences. While all of these factors can increase risk for an adverse event, that risk is due to our systems of care. These systems need to be reliable enough that the process protects not only the relatively healthy, but also the most vulnerable of our patients.
Using the RCA to Prevent Pressure Ulcers

Legacy Health System is piloting an innovative approach to pressure ulcers and root cause analyses (RCAs) — one that brings the investigation of a pressure ulcer to the unit level, engaging staff and providers in quickly determining the factors contributing to the pressure ulcer and identifying solutions. Modifying slightly an easily completed form from Sinai Hospital, Legacy is using this approach to increase staff engagement in pressure ulcer reduction in addition to identifying system changes to improve care. Each involved staff member and provider completes the form and sends it to the Quality Specialist who then collates the information. If necessary, huddles or a quick meeting are held to resolve any differences. By moving investigations closer to the event, information is obtained more quickly and staff become part of designing a solution. The response has been positive, and it is now being trialed for early stage pressure ulcers as well. For more information on Legacy’s work, contact Oga Northeimer, RN, Coordinator Clinical Risk Management. See also the Braden Scale for predicting pressure ulcer risk and the "Save Our Skin" program from OSF Saint Francis Medical Center.

Journal Brief


Abstract

Objective: To determine whether patients who are not admitted to hospital after attending an emergency department during shifts with long waiting times are at risk for adverse events. Design Population based retrospective cohort study using health administrative databases. Setting High volume emergency departments in Ontario, Canada, fiscal years 2003-7.

Participants: All emergency department patients who were not admitted (seen and discharged; left without being seen). Outcome measures Risk of adverse events (admission to hospital or death within seven days) adjusted for important characteristics of patients, shift, and hospital.

Results: 13 934 542 patients were seen and discharged and 617 011 left without being seen. The risk of adverse events increased with the mean length of stay of similar patients in the same shift in the emergency department. For mean length of stay ≥6 v <1 hour the adjusted odds ratio (95% confidence interval) was 1.79 (1.24 to 2.59) for death and 1.95 (1.79 to 2.13) for admission in high acuity patients and 1.71 (1.25 to 2.35) for death and 1.66 (1.56 to 1.76) for admission in low acuity patients). Leaving without being seen was not associated with an increase in adverse events at the level of the patient or by annual rates of the hospital.

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Conclusions: Presenting to an emergency department during shifts with longer waiting times, reflected in longer mean length of stay, is associated with a greater risk in the short term of death and admission to hospital in patients who are well enough to leave the department. Patients who leave without being seen are not at higher risk of short term adverse events. [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3106148/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3106148/)

**In the News**

*Medicare Claims Show Overuse of CT Scanning.*

A recent article in the New York Times, drawing on a Medicare database of outpatient records, discussed risks to patients from radiation exposure due to unnecessarily receiving multiple scans. According to the article:

“The rate [of duplicate scans] is typically less than 1 percent, or in some cases zero, at major university teaching hospitals. Performing two scans in succession is rarely necessary, radiologists say.”

An interactive feature, [Scanning Twice](#), shows the rates for individual hospitals in each state. Another NY Times article in February of this year described adverse events in which neonates were exposed to total body X-Rays without gonadal shielding. These ‘babygrams’ are no longer acceptable practice because of the radiation dangers.

Patient safety risks from radiotherapy has been estimated at 1 in 600 compared to the 1 in 10 million risk to passengers on US commercial airline carriers. ([See Ford & Terezakis, 2010](#))

See also:


**Resources**

Craig, C, Eby, D, Whittington J. [Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs](#). IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. People with multiple health and social needs are high consumers of health care services, and thus drivers of high health care costs. This white paper outlines methods and opportunities to better coordinate care for people with multiple health and social needs, and reviews ways that organizations have allocated resources to better meet the range of needs in this population. The role of strong partnerships between health care and community organizations is highlighted and innovative test ideas are included.
Heard on the Net: Unsafe Improvement?

Several people on the NPSF listserv responded to a recent inquiry regarding the rounding interval by nursing staff. Most responses noted an hourly rounding schedule on days and evenings, with a two-hour interval at night. Some offered that registered nurses and nursing assistants alternated rounding on each patient. Particularly interesting were the six rounding components one hospital included:

- Standard introduction - words that work (scripted) and managing up at handoffs
- Patient ID
- Tasks - meds, treatments, care etc., all while listening and observing patient
- Address: Pain, Position, Personal needs, Placement (water, call light, phone, etc.)
- Standard words - "anything else"
- State next round and who will be rounding

What was noteworthy was the institutionalization of multitasking. Long an unchallengeable assumption of nursing (e.g., we can assess the patient while…) it is being replaced slowly by an understanding of human factors and the recognition that one cannot do two — or more — things at once. The third item on this list makes clear that there is still much work to do. Especially with high-risk activities such as medication administration, nurses need to focus on that activity alone. We will know we are serious about keeping patients safe when our basic care processes are consistent with emerging patient safety evidence.

The Director’s View

In June 2010, The Oregon Patient Safety Commission initiated the Oregon Healthcare-Associated Infection Prevention Collaborative, convening nine hospitals from around the state to support each other in tackling the prevention of Central Line Associated Blood Stream Infections (CLABSI), Surgical Site Infections (SSI) and Clostridium Difficile Infections (C Diff.). These nine hospitals made a bold commitment to work together for 18 months. They have been learning from each other and implementing best practices to maximize prevention efforts for these specific infections. In addition to this sharing and learning, they have also been focusing on the foundational elements of hand hygiene, environmental cleaning, and antibiotic stewardship.

Just over a year into the process, we are excited to share that our efforts are yielding strong results. Over the collaborative as a whole, we are meeting our goal of 20% reduction in CLABSI rates and greatly exceeding our goal of 10% reduction in SSI rates (showing nearly 40% reduction); hand hygiene rates are much higher across the board. C Diff efforts were introduced later, but we expect to see similar results.

At the conclusion of the HAI Collaborative, we look forward to sharing some key learnings from this effort for the benefit of all hospitals in Oregon. If you have any questions regarding the HAI Collaborative work, please feel free to email Melissa Parkerton at melissa.parkerton@oregonpatientsafety.org.

Also, we are especially interested in your feedback related to the Progress toward Robust Reporting (http://www.oregon.gov/OPSC/docs/Reports/Progress-toward-Robust-Reporting-fin.pdf) to develop adverse event reporting standards for quantity, quality, and timeliness. Within the month you will receive your own hospital’s summary report with content that describes your ability to meet the proposed standards. Please contact Leslie.Ray@oregonpatientsafety.org with any questions about this process.

Bethany Higgins, Executive Director

July 2011
Upcoming Events

Commission Meeting

August 9th 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

August 4th from 12:10 to 12:55 – “Recognizing Over-Sedation” A monthly 45-minute case presentation and discussion of best practices. Safe Table Webinar format provides an opportunity to learn what others around the state are doing and share information. Click here for registration information.

Other Events


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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.”