OREGON PATIENT SAFETY COMMISSION

February 2015

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What's New at the Commission?

Patient Safety Awareness Week runs March 8-14 and is marked by the theme United in Safety. “Everyone in the health care process plays a role in delivering safe care and by uniting together and sharing that common goal, we can make a difference in patient safety,” says the National Patient Safety Foundation.

Organizations across Oregon and the nation are collaborating to ensure safe care for patients. These collaborations are accelerating the speed with which we can reduce and ultimately prevent the events that cause patient harm. To get creative ideas for recognizing Patient Safety Awareness Week in your organization, visit the National Patient Safety Foundation’s website.

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Oregon Announces Healthcare Patient Safety Leaders

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February 26, 2015

On February 27, 2015, the Oregon Patient Safety Commission honored exemplary healthcare facilities at its Fourth Annual Patient Safety Breakfast. The facilities were recognized for being leading participants in Oregon's Patient Safety Reporting Program. The reporting program focuses on learning from the events that cause patient harm rather than simply measuring the number of events reported.

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In 2011, the Commission established recognition targets to guide facilities participating in the reporting program and to ensure that the Commission receives enough reports to build a strong database for shared learning. For the 2014 calendar year, nine healthcare facilities and one healthcare corporation received the Commission's Leading Participant Award for consistently investigating patient harms, developing solutions to prevent future patient harm, and submitting reports that effectively contribute to shared learning by healthcare facilities across Oregon. The 2014 Patient Safety Reporting Program Leading Participants are:

- Hiron's #1 Pharmacy, Eugene
- Marquis Corporation
- Marquis Newberg, Newberg
- Maryville, Beaverton
- Molalla Manor Care Center
- Northbank Surgical Center, Salem
- Oregon Outpatient Surgery Center, Portland
- Pioneer Memorial Hospital, Prineville
- Salem Hospital
- Samaritan Albany General Hospital

The event also recognized an additional 43 facilities that met or exceeded the 2014 recognition targets. Lists of all ambulatory surgery centers, hospitals, nursing facilities, and pharmacies that met or exceeded the 2014 reporting targets are available on the Commission's website, http://oregonpatientsafety.org.

The Commission would like to thank the following Gold Sponsors who made this event possible:

Marquis Companies & Consonus Health

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Education and Engagement Vital to Patient Safety at Marquis Newberg

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February 26, 2015

In June 2014, leadership at Marquis Newberg moved all of their existing staff and 19 long-term residents to a new facility in one day without any interruption in service. This is a testament to the collaborative spirit and safety-oriented mindset of their employees, explains Director of Nursing Services Nikki Edwards. “Our staff, both new and old, have been great in working through changes and the growing pains of a new building, and continue to be open to change.”

Targeted education supports changing needs of staff

In light of increased responsibilities brought on by the facility change, Nikki Edwards asked Marquis Companies leadership to provide more in-depth training for her employees. Now, all Marquis Newberg nurses are enrolled in a pilot program called Geri Resident RN, which includes 16 modules covering many levels of skilled nursing. This program was created to encourage recent resident nursing school graduates to pursue long-term skilled nursing as a career. As each nurse advances in the program, Nikki checks in to monitor progress individually and offer support.

Teamwork generates better solutions

In 2014, Marquis Newberg also focused on staff education regarding medication management and medication error prevention processes. “When an error occurs, we ask what the team can do to solve the problem versus placing the blame on an individual,” says Nikki Edwards. “We try to support each other during mistakes. We work best as a team and we are all here to provide excellent care to our residents.”

Attentive leadership builds trust

Leadership staff at Marquis Newberg emphasizes building trust between patients and providers. Each member of the leadership team is assigned a select group of residents with whom they establish an intimate connection upon admission to the facility. That staff member makes daily rounds to check in on each resident in their group to assess individual needs. This personalized attention enables staff to better address safety issues as the resident’s preferences and habits become apparent.

“The Commission’s Patient Safety Reporting Program is very useful in addressing adverse events in the Marquis Newberg facility,” says Nikki Edwards. Addressing the adverse event report questions helps Nikki interact with her staff to understand exactly what happened in the course of the event. “It makes us focus in on how we can better implement our systems and make improvements together.”

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Creative, Data-Driven Fall Prevention at Molalla Manor

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February 26, 2015

Many factors contribute to the strong patient safety culture at Prestige's Molalla Manor Care Center. Like other Prestige Care facilities, Molalla Manor uses risk management information software to conduct effective root cause analysis investigations, identify system-level action plans, and integrate reporting to the Patient Safety Reporting Program into their patient safety strategies. According to Mary Miller, Molalla Manor's Director of Nursing Services, "The feedback we receive from the Commission's Patient Safety Reporting Program makes us want to do better. The resident care managers all go through the reports together, which helps drill down to the details of the events." Molalla Manor staff focuses on providing personalized, patient-centered care; using data to identify and address issues for individual residents; and applying identified solutions organization-wide.

A recent patient story from Molalla Manor highlights just how staff has used creative thinking to solve a persistent patient safety issue. An elderly, long-term resident with dementia wanted to maintain his independence, yet was struggling with weakness and mobility. Due to his independent nature, he was disinclined to use the call button to signal for help and disliked wearing an intrusive fall alarm device–especially on dates with his wife.

After multiple unsuccessful attempts to prevent recurrent falls, the attentive staff began to think creatively. By examining the resident's fall trends, staff learned that one-third of his falls were related to reaching for something and losing balance, especially his TV remote. Staff purchased a TV remote attached to a bungee cord so that it wouldn't fall to the floor. This allowed the resident to pick up his remote without having to call for assistance and without suffering a fall. The success prompted staff to consider installing the same solution for all residents with reach-related fall issues. Spurred by this effort, staff continues to pursue innovative ways to reduce falls in the facility.

Molalla Manor has 63 skilled beds and an innovative Expressions Program Dementia Care Unit. As the Prestige facility with the highest staff retention, Molalla is especially proud of their thoughtful and close-knit staff and continuously strives to strengthen their patient safety efforts. Molalla Manor received a five star rating for quality from CMS in 2014 and the Bronze Award from the American Healthcare Association for quality care.

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Marquis Companies Moves to Electronic Prescription Ordering

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This year, six Marquis Corporation nursing facilities exceeded the Commission's Patient Safety Reporting Program 2014 Recognition Targets. April Diaz, Director of Clinical Services for Marquis Companies, attributes much of this quality work to teams led by Nurse Consultant Vicky Nordby, and to their highly engaged facility and pharmacy teams, who are active in system-wide quality and safety initiatives. Marquis strongly encourages open dialogue and communication between all residents and staff, especially when things do not go as planned. "Our patients' and staff members' trust is invaluable to us," says April.

Marquis' most recent patient safety initiative involved replacing their fax-based pharmaceutical ordering process with a fully integrated Consonus Pharmacy electronic system. The new system is more streamlined and requires more safety double checks, resulting in a reduction in medical errors. Pharmacists also now have more time to conduct complex medication reviews to prevent errors from occurring in the first place. While the initial transition was challenging for both nurses and pharmacy, the outcomes have been significant in processing and the delivery of medication orders. Consonus Pharmacy, in partnership with Marquis Companies, is continually reviewing outcomes to ensure ongoing patient safety and quality.

According to April, the Patient Safety Reporting Program's mission of shared learning also closely aligns with Marquis' patient safety vision of open and honest communication. When it comes to individual facility participation in the Patient Safety Reporting Program, Marquis Companies attributes much of their success to facility team engagement and their belief that "No one is going to learn unless we all share our experiences."

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Pioneer Memorial Hospital Revises Approach to Address CAUTIs and Falls

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February 26, 2015

Last year, Pioneer Memorial Hospital in Prineville prioritized the reduction of catheter-associated urinary tract infections (CAUTIs) and patient falls. The critical access hospital has improved in both areas and attributes its progress to more personalized, in-depth examination of adverse events and increased staff engagement.

Revised Approach Eliminates CAUTIs

In June 2014, the hospital experienced its first CAUTI in over a year. Caregivers were upset, but used the infection as a learning opportunity to steer improvement. “Staff really cared and wanted to get to the cause. That is just great to see as a leader,” said Director of Patient Care Karen Ellis. Caregivers involved in the patient’s care worked together to identify the cause of the infection and strategies to prevent future infections from occurring. As a result, the hospital updated its catheter care policy, implementing ongoing catheter necessity assessments for patients and improving catheter insertion technique. These updates were shared with caregivers across the organization. As a result, Pioneer Memorial has been 100 percent compliant with catheter bundle implementation with zero occurrences of CAUTIs since July.

Hourly Rounding Helps Prevent Falls

Caregivers have also shifted their thinking about the prevention of falls. Instead of viewing falls as an inevitable factor of hospital stays, they are now viewed as entirely preventable. In September, three consecutive falls occurred. Caregivers reviewed past cases to identify trends and found that many falls occurred when patients tried to use the restroom independently. As a result, they implemented a more structured hourly rounding. Now, leadership reviews each fall and near miss to identify areas for improvement. As of February, more than 130 days have passed since the hospital’s last fall event. Metrics are posted each day to inspire caregivers to continue their good work, resulting in a 20 percent reduction in falls over the last year.

These improvements demonstrate Pioneer Memorial’s culture of strong caregiver involvement. “We are very blessed to have extremely engaged frontline caregivers as well as engaged physicians,” Ellis said. The Commission’s Patient Safety Reporting Program has also enhanced event investigations at Pioneer Memorial, streamlining the process and clearly linking action plan items with the responsible caregivers. Caregivers are encouraged to make each case personal and near misses are discussed openly so they can proactively think about prevention efforts.

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Leadership and Organizational Focus Change Culture and Practice at Salem Hospital

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February 26, 2015

Salem Hospital's patient safety reporting success is due to the focus that leadership, from the Board of Trustees to the frontline teams, places on preventing patient harm. Reducing harm to patients has been a long-term goal for the organization made even more visible by incorporating this work into organizational strategies.

Salem Hospital uses the Lean Management Model to continuously improve processes and add value to patients. These principles have been applied to the patient safety program to develop more efficient reporting of patient safety events and improve patient safety. The program uses a collaborative approach and partners with members of the health care team across all disciplines to develop effective strategies to reduce the risk of harm to patients. Some of the approaches the patient safety program took this year include:

"Stop the Line" Improves Culture

The "Stop the Line" awards program was established to acknowledge and honor staff members who speak up about unsafe patient situations. "It is important to recognize the courage and commitment it takes to further the culture of patient safety," says Rebecca Betz, Patient Safety Consultant. Every Salem Hospital staff member is eligible for the award and anyone on staff can nominate their peers. Although the program is relatively new, staff are fully engaged in recognizing their colleagues; new nominations are submitted to leadership for review every couple of days. This program reduces the chances of medical error and ensures that staff feel empowered and valued.

FMEA Helps Change Lab Labeling Process

In early 2014, staff conducted a Failure Mode Effect Analysis (FMEA) to understand gaps in their lab labeling process and drive best practice at the bedside. The analysis pinpointed some mislabeling issues within their system and, in September, Salem began using bedside handheld labeling printers to eliminate errors that are caused by printing in another location. To date, Salem has seen great improvements and is currently rolling out handheld printers organization wide.

This is the second year in a row that Salem has received the Commission's leading participant award for large-sized hospitals. "Patients deserve to come to a hospital that is constantly improving patient safety," says Kristy Bond, Accreditation and Patient Safety Manager.

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Cleaning and Fall Prevention Strategies Increase Safety at Samaritan Albany Hospital

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February 26, 2015

In 2014, Samaritan Albany General Hospital focused on engaging multidisciplinary staff throughout their organization to expand patient safety best practices. By focusing on a culture of open communication, employees are empowered to actively strengthen their patient safety culture and every staff member is made responsible for patient wellbeing. “Promoting a culture of community, inclusion, and shared responsibility is vital at Samaritan Albany,” says Director of Quality Resources Jennifer Vig. “We encourage employees to speak up, even if your voice shakes.”

Environmental Cleaning

Ensuring appropriate cleaning and disinfection of the healthcare environment is a critical patient safety component. To improve the facility’s sanitation practices, Samaritan Albany conducted an in-depth assessment of the terminal cleaning process for patient rooms. A task force comprised of members from both environmental services and the infection control department identified high touch areas in each room, which were then marked with a luminescent solution. After cleaning the room using their usual process, a black light identified areas that were missed. The task force then developed improved techniques and proficiency guidelines to address the identified gaps. After seeing the results, staff members are enthusiastic about implementing the updated procedures and actively volunteer to have their work checked.

Falls Prevention

Ninety percent of patients admitted to Samaritan Albany are considered to be at high risk for falls. To tackle this problem among patients at greatest risk for harm, Samaritan Albany instituted the Look at Me, Please (LAMP) program. In the LAMP program, signs are placed on the outward facing doors of particularly high-risk patients’ rooms. The signs alert each staff member, regardless of their role in the hospital, to check in on the patient as they walk through the hall, which adds a layer to traditional rounding techniques and brings everyone in the organization, from physicians and nurses, to nutrition staff and housekeeping, into the care of that patient.

This is the second year Samaritan Albany has received a Leading Participant award from the Commission. Samaritan Albany has also received Samaritan Health Service’s Hospital Consumer Assessment of Healthcare Providers and Systems Award for two consecutive quarters, and the 2014 Partnership for Patients Achievement in Patient Safety Outcomes Award.

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FDA MedWatch Accelerates Prevention Efforts at Northbank Surgery Center

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Northbank Surgery Center focuses on in-depth follow through with patients, beginning with the question “What is your primary concern?” during their pre-operation call and ending with a thank you note signed by staff upon discharge. When it comes to adverse event reporting, Quality Coordinator Pat Clark appreciates the individualized root cause analysis support offered by the Patient Safety Reporting Program’s patient safety consultant. Pat Clark describes Northbank’s philosophy of investigating patient harm as: “You just start at the beginning and dig until you get to the bottom of it.”

Last year, a defective instrument burned a Northbank patient during surgery. Upon investigation through the FDA MedWatch program, Northbank learned that use of this instrument had also caused burns in other cases. Leadership immediately discontinued use of the device and shared their experience at their next regional meeting to prevent the possibility of further patient harm at other facilities. They also shared the usefulness of MedWatch as an adverse event investigation resource with their colleagues.

Other patient safety efforts at Northbank have included:

- Improving the verbal pre-operative to operating room hand-off. Implementation of a safety checklist has increased accuracy of information communicated between departments.
- Launching a new patient satisfaction program. Northbank saw a 50 percent increase in their patient survey responses in 2014, which contributed to targeted changes to improve care.
- Emphasizing the sense of caring and community in their team culture. At the last regional meeting held at Northbank, the whole team worked together, making 48 quilts for foster children in the Marion/Polk county area to carry with them from home to home.

In 2014, Northbank received the Clinical Quality award for the Northwest Extreme Leadership Team. In 2013, Northbank received an award for the Best Places to Work from Becker’s Hospital Review.

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Safety First at Oregon Outpatient Surgery Center

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February 26, 2015

In 2014, Oregon Outpatient Surgery Center (OOSC) decided to review ways to prevent venous thromboembolism (VTE) development in their patients. Since OOSC primarily conducts orthopedic surgeries, which are known to have a higher incidence of VTE, OOSC wanted to be sure that they were taking the proper measures to prevent patient harm.

Infection Control Nurse Cathryn Chapman participated in a workgroup convened by the Commission to assess the incidence of deep vein thrombosis (DVT) and VTE in ambulatory surgery centers. The workgroup identified best practices and opportunities to improve current DVT/VTE risk assessment processes and developed four key recommendations to effectively assess patient risk related to surgery in Oregon ambulatory surgery centers. Cathryn worked with leadership at OOSC to increase awareness and provide education to reduce the incidence of DVT/VTE.

Implementation of these strategies has directly influenced the patient experience at OOSC. In one case, a woman developed a DVT and was feeling exceptionally anxious about her future. Cathryn has felt more knowledgeable and better equipped to address the patient's concerns about DVT/VTE. "Because of my involvement with DVT/VTE prevention, I was able to ease the patient's fears, educate her about her risk factors and options, and help her to feel empowered about her condition," says Cathryn.

Jesseye Arrambide, Administrator at OOSC, understands the importance of creating a strong culture of patient safety. OOSC recently added a new total joint replacement program. Safety is monitored through strict management of patient selection criteria, robust patient education, and a strong physical therapy program that is coordinated with Providence Health System.

When adverse events do occur, the Commission's patient safety consultants are especially valuable to OOSC as they assist with completing reports, developing action plans, and recommending system changes. "Reporting was very intimidating at first and I am so thankful to have been able to work through it with a knowledgeable consultant," says Cathryn.

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PSRP Corner: Where can I find definitions for the contributing factors in PSRP?

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February 26, 2015

How can I clarify the meanings of contributing factors to an adverse event?

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Contributing factors are defined in two places: Info Buttons in the PSRP online system, and in the PSRP Data Dictionary.

Info Buttons

You can find definitions while completing a report by clicking on the little blue "i" Info Buttons on the contributing factors tab.

The Info Button next to the heading for the contributing factor category will show you a list of the factors in that category. The Info Button next to the heading for the list of factors will show you the specific definitions for each factor in that category.

Data Dictionary

If you'd prefer to see all the definitions for all categories in one place, each reporting segment's Data Dictionary includes an appendix containing the same information as the Info Buttons described above.

To access the Data Dictionary, log in to PSRP, click on "Tools and Resources" at the top of the page, and select "Data Dictionary." Contributing factor definitions can be found at the end of the document in an appendix. You may also download the Data Dictionary as a pdf that can be saved to your computer if you need an off-line reference.

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EDR Insider: Leilani's Story

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February 26, 2015

A compelling case for disclosure and transparency in healthcare

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According to a study in the Journal of Patient Safety, preventable adverse events cause the death of 210,000 to 400,000 patients in hospitals each year. Leilani Schweitzer lost her son as a result of such an event. She now uses her unique perspective to talk about the patient and family experience when something goes wrong in healthcare. Listen to her compelling story highlighting the importance of disclosure and transparency.

Watch Leilani tell her story »

For additional videos and other resources related to discussion and resolution, see the Early Discussion and Resolution (EDR) Provider Resources page on the EDR website.

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