

About This Newsletter

CHPSO Patient Safety News provides lessons learned from reviews of patient-safety events and news of patient-safety activities in this state. Our newsletter includes regular columns from the California Department of Public Health and LifeWings. We hope you will find it useful in your efforts to improve patient outcomes. This newsletter may be freely distributed in its original form. Copies of each newsletter will be archived on the CHPSO website (www.chpso.org). Send subscription requests (additions, deletions) to ltate@calhospital.org. Article submission information is at the end of this newsletter.

Medication Errors Still Occur With Bar-Code Administration Technology

Bar-code medication administration (BCMA) systems can improve medication safety by verifying that the right drug is being administered to the right patient. Studies have shown that BCMA technology can reduce medication errors by 65% to 86%. But BCMA technology alone does not ensure a safe medication-use system. A number of reports submitted through the Pennsylvania Patient Safety Reporting System describe medication errors that occurred in organizations that used a bar-code system for administration. Some of these errors result from failures to use this technology appropriately, employing workarounds or overriding alerts, disruptions in the medication administration process, and

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Retained Foreign Objects: The Minnesota Experience

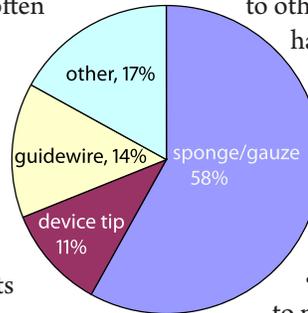
When people think about objects that have been retained in a patient's body during surgery, they most often think of surgical clamps or scissors. The reality, however, is that the most commonly retained foreign objects are small sponges or absorbent pads or, less commonly, guidewires or the small tips of instruments that have broken off during a procedure. The most common type of procedure linked with retained objects in Minnesota is childbirth; nearly a quarter of the retained foreign objects involved sponges left behind after a vaginal delivery.

Key Findings

The most common reason why objects are retained is because items were not included in the pre-procedure or post-procedure counting process, because the counting process was inaccurate, or because no policy was in place to require counting of objects for a particular type of procedure. At the beginning of the year, the lack of a policy for counting sponges after vaginal deliveries was quite common. Most facilities also did not have a standard of a visual inspection after childbirth to identify any potential retained objects at that time, which meant that retained sponges were often found by the patient one to three days later.

Communication breakdowns also often play a role in retained objects, as when an object is placed in the body by one team member but either the placement

or the removal is not documented properly or is not communicated adequately to other team members. This happened both in emergency situations and in routine procedures.



Corrective Actions Included:

- Implementing policies to measure guide or localization wires before and immediately after procedures.
- Managing distractions during the count process by limiting presence in the OR to essential personnel only.
- Providing training for staff on any new device with multiple parts that may break off and be retained.
- Clarifying policies related to items required to be written on the white board and counted after being placed into a body cavity.
- Replacing devices that include tips that may break off, or that are difficult to visually differentiate from the body of the device.
- Revising sponge count policies to require that each individual sponge be counted, rather than "fanning" packs of sponges to count them without removing from the package.

— Full article is in the Minnesota Department of Health, Adverse Events in Minnesota, Fifth Annual Report

Medication errors, continued from page 1

dispensing errors that arise in the pharmacy....

New technology will not be a panacea for medication errors, but it can provide safeguards not possible with fully manual processes. Organizations may consider some of the following steps to maximize BCMA's impact on medication safety.

Analyze BCMA logs, and evaluate all overrides to identify system weaknesses and areas in need of process improvement.

Monitor and measure compliance with the technology to identify and remove any barriers to the safe and appropriate use of BCMA.

Conduct focus groups and satisfaction surveys to solicit nursing feedback.

Conduct executive rounds and direct observation of medication administration to help identify and correct workarounds. Keeping an open door policy will allow staff opportunities to discuss barriers and workarounds. The nurse executive should encourage staff participation in the continuing process improvement activities that follow the implementation period.

Dispense patient-specific doses with bar codes whenever possible. This includes half tablets, oral syringes that contain the exact dose of an oral solution, and IV syringes that contain the patient's exact dose.

Scan all medications upon arriving in the pharmacy to verify that the bar code is part of the current database, and scan medications before dispensing.

Develop a mechanism to alert pharmacy when there is a problem scanning medications on the patient care units.

Computer screens that display patient information, including allergies and medication lists, should be positioned so that they can be easily viewed and read by nurses.

Bar-code label equipment, including printers and batteries, must be continually checked for accuracy and readability and undergo routine preventive maintenance by information technology (IT) or biomedical staff.

Do not have healthcare clinicians view the verification that BCMA provides as a nice but unnecessary feature. The alerts that arise from the system should not be allowed to be bypassed without serious consideration. For every error like those described [in this article], many more have been prevented because BCMA has been employed. There is little doubt that BCMA can save lives if properly implemented and used appropriately.

For those organizations that plan on introducing BCMA into their facilities, conduct a readiness assessment or other proactive risk assessment to gain commitment and create enthusiasm for BCMA, identify challenges and plan accordingly, and remedy process problems before implementation. A bar-code readiness assessment tool is available free of charge from ISMP. To obtain a copy, visit: www.ismp.org/selfassessments/barcoding.asp.

Establish a multidisciplinary team, including nursing, IT, and pharmacy staff, as well as frontline practitioners, to determine best practices and guide implementation.

—Pennsylvania Patient Safety Authority.
Full article available at: www.patientsafetyauthority.org

[tyauthority.org/ADVISORIES/AdvisoryLibrary/2008/Dec5\(4\)/Pages/122.aspx](http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2008/Dec5(4)/Pages/122.aspx)

A Message from the California Department of Public Health (CDPH)

To enhance communication, CHPSO invited CDPH to publish notices or articles in this newsletter. This is the first in a series. This article directly represents the viewpoint of the CDPH.

CDPH Invitation: Best Practices for Prevention of Adverse Events

The California Department of Public Health (CDPH) is dedicated to optimizing the health and well-being of all Californians. As such, the Department values new information and progressive solutions that provide greater protection for the people served in our communities.

CDPH recognizes and appreciates that hospitals often go to great lengths to prevent the occurrence of adverse events. Yet despite these efforts, between July 1, 2007, and June 30, 2008, CDPH received more than 1,000 reports of incidents involving adverse events in California hospitals. CDPH believes that hospitals can successfully reduce inadvertent risk to patient health and safety through the development of comprehensive policies and practices.

The Department would like to acknowledge the efforts of hospitals that have developed and implemented successful adverse event prevention policies or practices for their facilities by sharing their best practice policies statewide. Best
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Questions or comments: RoryJaffeMD@calhospital.org
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practices may include policies or practices hospitals have implemented and that have succeeded in preventing the occurrence of adverse events.

This collaborative effort would allow hospitals to demonstrate their successful practices while providing the Department quality examples to display statewide. Through such partnership, the hospital community can contribute to the CDPH mission of achieving a safer environment for California patients.

The Department, therefore, cordially invites all hospitals that have successfully implemented best practices or policies for the prevention of adverse events, to submit samples of these proven policies for display on the Department's website.

Hospitals should include information regarding:

- The policy or procedure (practice) implemented, and the adverse event(s) prevented.
- The method of measurement implemented to determine the success of the practice.
- The length of time the practice has been proven effective.

Hospitals interested in participating in this endeavor may submit best practice documents electronically to Leslie Fullerton at Leslie.Fullerton@cdph.ca.gov or by mail at:

CDPH
Attention: Leslie Fullerton
P.O. Box 997377, MS 0512
Sacramento, CA 95899-7377

The Department's All Facility Letter 09-11 can be viewed at: www.cdph.ca.gov/certlic/facilities/Pages/LnCAFL.aspx.

Additional information on developing successful practices can be found on the Centers for Medical & Medicaid Services (CMS) website at: www.cms.hhs.gov/SurvCertPromPractProj/.

Thank you for your considerate attention and ongoing dedication to the preservation of patient safety.

— California Department of Public Health

OIG and Health Care Compliance Association Release Quality Roundtable Report

A government-industry roundtable, Driving for Quality in Acute Care: A Board of Directors Dashboard, was held on November 10, 2008. A report was issued March 23, 2009, and is available at tinyurl.com/oighcca. The report summarizes the participants' views on constructing quality dashboards and on using dashboards to improve patient care.

Highlights from the report:

- **Measuring quality presents challenges.** No one really knows exactly how to define or measure quality. Without good definitions, measurement and management are difficult. Also, getting data that are accurate, valid and reliable involves multiple, complex, expensive processes.
- **The board must lead the way.** The board sets the tone for an institution, and helps build organizational will.
- **Dashboards can be an important strategic tool.** The dashboard can help establish specific system-level goals and be used as a tool for change.

- **Establish the business case for quality.** Hospital boards historically have concentrated on financial measures. A financial analysis of the quality issues helps focus the board's attention.

- **Educate the board on quality.** Explain to board members the clinical elements of the quality measures, the basis for selecting the particular measures, and how the results relate to the organization's strengths or risk areas.

- **Accountability should permeate the hospital.** Many parties share the responsibility for quality outcomes, and all should feel responsible.

- **Establish a culture of quality.** Each individual in the facility should be able to articulate how his or her job ties into the quality goals of the hospital.

- **Transparency is essential.** Organizations benefit when quality information is routinely shared, both within and outside the organization, to raise awareness and create learning opportunities. However, there are significant challenges when presenting data to the public, including understandability and context (e.g., risk adjustment, impact of the measure on outcomes).

- **Sharing data is helpful.** Some areas of the country have state or regional systems that share best practices in quality and patient safety among organizations (e.g., CHPSO). Comparisons within a locality or community also are useful.

A prior roundtable addressed the same questions in long-term care and the report is available at tinyurl.com/oighcca1.

— Rory Jaffe (rjaffe@calhospital.org)
California Hospital Patient Safety Organization

Five Actions to Improve Patient Safety Reporting

Give Feedback to Staff

Staff need to see that the effort they make to report incidents is worthwhile and used by the organisation to make services safer. Without feedback, reporting can be seen as a bureaucratic process, rather than a powerful mechanism for change.

Focus on Learning

The focus of reporting should be on analysing the root causes of incidents, robust local learning and action to mitigate risks to patients, rather than blame. Serious incidents yield important lessons about changing systems and processes to reduce risks.

Engage Frontline Staff

Training on the 'what, how and why' is key to increasing levels of reporting and getting meaningful data which can be analysed and actioned.

Make it Easy to Report

Many risk managers in high-reporting organisations had designed forms which were as simple as possible, while capturing required information for analysis and follow-up. Organisations using web-based systems found greater consistency and efficiency throughout the reporting cycle. Staff may still need the option of a paper form – for instance, in busy wards where access to computers is restricted. Some organisations have also developed new ways of encouraging staff to report – for instance, by developing a short form on drug trolleys for immediate reporting of medication errors.

Make Reporting Matter

High-reporting organisations demonstrate strong and visible safety leadership from their boards and senior managers. This means investing in robust systems and using incident data to support decisionmaking at the highest level.

— UK National Health Service (NHS), National Patient Safety Agency (NPSA). Excerpted by Rory Jaffe. The full report is available at <http://www.npsa.nhs.uk/EasySiteWeb/GatewayLink.aspx?allId=12018>

Process Improvement — A Human Factors View

One of the most frustrating jobs in health care today has to be "Process Improvement." The reason is because in order to improve a process, you must have a process. Note that this word is singular, not plural. Almost every hospital I've ever visited responds in the affirmative when I ask, "Do you have a process for accomplishing the Joint Commission Universal Protocol?" However, the reality is that if you emphasize singular vs. plural, the clinicians in various procedural areas typically stop and reflect and then say, "Oh, uh, no." What causes greater concern are organizations that continue to insist they do have a single standard process, because without exception when members of my staff perform an audit we find significant variance in compliance, including complete omission of any timeout.

This emphasis on a single standard process or protocol is vital, and until recently very unpopular. Yet there is growing evidence that a single standard based upon best practices is exactly what health care needs to reap low-cost, or even no-cost, improvements. Whether you are looking at implementing the central-line bundle, the World Health Organization surgical

safety checklist, or any other protocol or Joint Commission standard, the first step on the road to success is defining the standard.

Next month: Kaizen.

— Steven Montague (lifewings@verizon.net), Vice President, LifeWings

Beacon Collaborative Invites You to Attend Patient Safety Conference

Beacon extends an invitation to join representatives from Northern California hospitals for an exciting day of peer-to-peer sharing, education and inspiration on how to lead your organization in creating a culture for safer patient experiences.

This patient safety conference will be held April 21, 2009, at the South San Francisco Conference Center located at 255 S. Airport Blvd. in South San Francisco. This year's theme, "Power of Creativity," focuses on using the power of creative thinking to establish and accelerate innovative practices in improving patient safety and the quality of health care. International speakers, health care leaders and practitioners will address critical issues, quality-management techniques, leadership roles and strategic approaches.

Hospitals are encouraged to send a team to participate in this premier conference with 18 breakout sessions and six tracks, including teamwork, clinical innovations, leadership strategies, emerging technologies, innovative trends and culture of safety. Keynote speakers will include Paul Plsek, author, developer of DirectedCreativity and well known for his pioneering efforts in bringing modern quality-management techniques to health care organization *continued next page*

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zations. Lynne Maher, head of Innovative Practice for the National Health Service in the UK, will speak on the “Sustainability Model” devised to assist in assessing the successes of outcomes when new ways of working become the norm, and exploring solutions for sustaining change in complex situations. Molly Coye, MD, MPH, is founder of the Health Technology Center (HealthTech), a nonprofit research organization and expert network that develops forecasts and planning tools for emerging technologies in health care. Dr. Coye will discuss how the adoption of technology-enabled innovations can make health care better, safer and more affordable.

The Beacon Collaborative is sponsored by the Hospital Council of Northern and Central California in partnership with Convergence Health Consulting and funded by the Gordon and Betty Moore Foundation.

Please visit the Beacon Collaborative website for registration, an agenda and more information: www.beaconcollaborative.org/events, or contact Beacon at info@beaconcollaborative.org or (925) 746-0728.

Creating Best Practices for ICU Sedation

Sharp HealthCare in collaboration with the Center for Safety and Clinical Excellence and the San Diego ICU Sedation Task Force invite you to

Creating Best Practices for ICU Sedation
Friday, April 10, 2009, 8:00 a.m. – 2:00 p.m. Scripps Green Hospital Amphitheater, 10666 N. Torrey Pines Road, San Diego, California

Target Audience: Critical Care and Internal Medicine Physicians, Anesthesiologists, Pulmonologists and Physicians on Rapid Response Teams.

Education Objectives: Following this activity, learners should be able to:

- Review ordering, assessing, administering and monitoring of Intensive Care Unit (ICU) sedation;
- Recognize ICU sedation practices may be out of alignment with best practices;
- Identify emerging drugs and technology impacting the safety and effectiveness of ICU sedation practice;
- Discuss novel multi-disciplinary programs to reduce sedation complications.

Event Calendar

Following is a list of upcoming events that are still open for enrollment. For more information or to enroll, use the contacts listed at the bottom of this article.

March

31 WHO Surgical Checklist, Free Webinar
8:30-10 am, *Hospital Council*

April

10 Creating Best Practices for ICU Sedation, San Diego, *Sharp HealthCare in collaboration with the Center for Safety and Clinical Excellence and the San Diego ICU Sedation Task Force*

21 Patient Safety Conference: “Power of Creativity.” South San Francisco, *Beacon Collaborative*

May

5 Best Practices to Reduce Preventable Readmissions. Webinar 10–11 am, *Hospital Council*

19 Addressing “Disruptive” Behavior Among Health Care Professionals. Pleasanton, *Hospital Council*

June

2 Developing, Measuring and Documenting Employee Competence (audience: HR and ancillary support staff). Oakland, *Hospital Council*

3 Developing, Measuring and Documenting Employee Competence (audience: Nurse Leaders). Oakland, *Hospital Council*

July

5 Coalition meeting. Los Angeles, *CAP-SAC*

September

11 Coalition meeting. Napa, *CAPSAC*

December

4 Coalition meeting. Los Angeles, *CAP-SAC*

For further information on these events

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Hospital Council: Cheree Muñoz,
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