CHPSO
California Hospital Patient Safety Organization

Patient Safety News
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Preventing Learning

Problems at the point of care frequently arise. How the front-line staff addresses those problems affects the capability for organizational learning. The most common staff response to a problem is one that prevents learning.

"Fixing the problem" is a first-order response. It serves its purpose for that specific event but does little to prevent future problems. Typically, a nurse will work around the problem or correct it so that the patient gets what is needed. If the nurse does not know how to fix the problem, he or she will typically ask a colleague for help. Once the problem is fixed or obstacle surmounted, it receives no more attention and any underlying causes (e.g., an unrealistic policy or a difficult-to-use device) are not addressed.

The second-order response is to identify the cause of the problem and take steps to prevent future problems. For any but the most isolated problem this is preferred, although a temporary fix may be necessary for current care.

However, one study showed that 92 percent of the time nurses stop with the first-order response. The study identified three factors causing this and suggested some solutions.

> Nurses tend to embrace personal responsibility to overcome obstacles and deliver care, which can lead to overreliance on self-help.
>
> Time-pressures and lack of readily available front-line improvement resources make it difficult to start working on causes.
>
> An authority gradient between nurses and administrators, or nurses and doctors, can inhibit "speaking up."

The authors provide six suggestions:

> Make root cause removal part of the job expectation and allocate time for it.
>
> Open up lines of communication between front-line workers and those that supply them resources (e.g., materials management, information technology) to provide spontaneous feedback opportunities.
>
> Increase attention to front-line complaints and attach a positive connotation to being a complainer.
>
> Provide system improvement resources for front-line workers. For example, give a person knowledgeable in performance improvement the responsibility to assist the workers' problem solving.
>
> Openly encourage solution identification, but with an appreciation for its effect on other departments. Localized solutions otherwise may ignore adverse system consequences.
>
> Publicize front-line workers' successes to encourage others to participate.

— Rory Jaffe, MD MBA, rjaffe@calhospital.org

Reference

Tucker A, Edmondson A, Spear S. Why your organization isn't learning all it should. *Harvard Business School Working Knowledge*. 2001:4.

Smart Phones, Unsmart Choices

Which is easier, driving a car or performing surgery? For those of you who went back and reread the question above because you thought, "I must have misread that," you did not. I ask this because, while many states (like California) have banned texting or handheld cell phone use, I'm not aware of any state law banning those activities during surgery. "Ridiculous," you say. Why would any state need such a law? Those of you who regularly care for patients in the operating theater know better.

It's rare for me to audit surgical cases for a full day and not see at least one clinician either texting or talking on the cell phone. And let's be honest, this happens every day in OR's across the country. Why is it that we're appalled when we read about a railroad engineer who was texting and missed a switch signal, but we tolerate this behavior from medical professionals? I think there are a few reasons.

The first reason is that some don't perceive the behavior as dangerous. Perhaps the surgeon is using a hands-free device (in compliance with traffic laws… if only there was a steering wheel on the patient). According to Christopher Chabris and Daniel Simons (*The Invisible Gorilla: And Other Ways Our Intuitions Deceive Us*), researchers have found that "there are few if any differences between the distracting effects of handheld phones and hands-free phones. Both distract in the same way, and to the same extent." How distracted are we? Both experimental and epidemiological studies show that driving impairments caused by talking on a cell

phone are comparable to the effects of driving while legally intoxicated. Who would sign a consent that says it's okay for their surgeon to operate on them if they were drunk? Nobody would, and that leads to the next reason it's tolerated.

If you're not using a hands-free device while driving, and the California Highway Patrol sees you, they'll pull you over and give you a ticket. So where's CHP when you really need them in the OR? Let's face it, there's nobody with sufficient authority to "pull the surgeon over" in the OR. Even if there were, what law would they cite? Does your hospital have a policy prohibiting cell phone use while performing a procedure on a patient? Is it because the patient is under anesthesia that we let this happen? Can you imagine a nurse starting an IV on a patient while having a conversation on his cell phone?

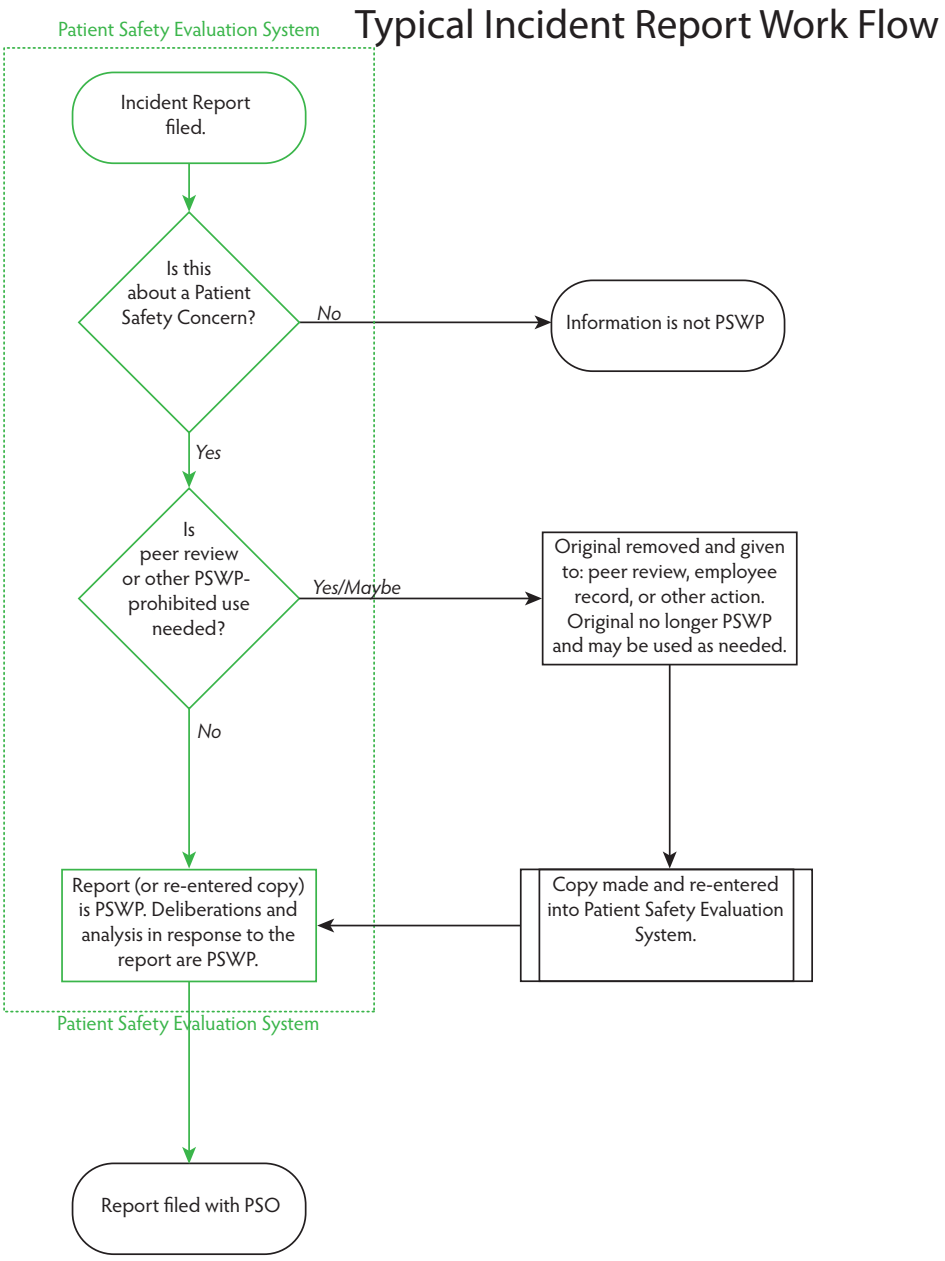
What about the Anesthesia provider? Is it okay for her to be texting, or surfing the web on her iPhone? How about the Circulator? I've seen these things routinely, and if you're an experienced OR clinician I'll bet you've seen it more times than you can count on one hand.

For the short term, I think the only practical solution is mutual accountability provided by the clinicians in the OR. It's up to the surgeon to look over the drape and tell the Anesthesiologist, "Hang up and Monitor the Patient." It's up to the PA to pull the surgeon over and say, "It's not safe for you to talk on the cell phone during surgery." It's up to the perfusionist to tell the circulator, "Hey, it's not okay for you to be texting during the case." This isn't a pleasant conversation. It's certainly not easy. The patient is expecting it from us, and it's the professional thing to do.

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

Template Policy for CHPSO Participants Released

As part of its support for member hospitals, CHPSO has released a sample policy and procedure for PSO participation. The teleconference archive contains the audio recording and slides from the recent teleconference discussing this policy. Below is a figure showing a suggested workflow for incident reports that provides broad protections but retains the potential to use incident reports for uses in which PSWP is not permitted.



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Protecting Against Misconnections: Status Update

The April 2010 *CHPSO Patient Safety News* discussed the risks of using standard Luer fittings for non-intravenous uses. Inappropriate connections can occur, such as intrathecal injection of an intravenous medication (e.g., vincristine). Developing non-interoperable connectors, so that connectors for fundamentally different uses cannot connect with each other, will prevent most of these incidents.

Since that report, some progress has been made. The basic standard (ISO 80369-1) has just been issued, establishing six classes of fittings that must only connect to fittings within its class: driving gases and breathing system ancillary ports, enteral feeding, urological access, limb cuffs, neuraxial access and vascular access.

Work is progressing on the standards for enteral feeding and neuraxial fittings, but some standards committee members are expressing concern about meeting the California legal requirement for non-compatible fittings by 2013 for enteral devices and 2014 for neuraxial devices. Early availability of these devices might not occur. For example, the proposed neuraxial fittings are not currently produced by anyone.

For additional information:

Nass, R. Making progress on connector standards. *Medical Device and Diagnostic Industry News*. Dec 2010.

Value Plastics, Inc., ISO 80369 — News Hub.

ISO Technical Committee 210 (Quality management and corresponding general aspects for medical devices) status.

Calendar

The following upcoming events are still open for enrollment. For more information or to enroll, use the contacts listed below.

March

This month's Just Culture support call is cancelled. In order to provide the best value to participants we are revising how we conduct these calls in response to suggestions provided in our recent survey.

4: *CAPSAC*: California Patient Safety Action Coalition meeting. Napa.

9: *PSCSD&IC* (Patient Safety Council of San Diego & Imperial Counties): Reduce Preventable Readmissions through Networking (PRN). San Diego.

10: *BEACON*: Compass Series 3 of 4. Fremont.

14: *CHPSO*: Just Culture Support Call. Cancelled this month.

15: *SCPSC* (Southern California Patient Safety Collaborative): Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

23: *BEACON*: Practical Skills for Quality Improvement. Santa Clara.

24: *SCPSC*: Perinatal Monthly Webinar. 12:15 PM.

29: *BEACON*: Excel for Quality Improvement: Basics for Beginners. Fremont.

31: *BEACON*: Excel for Quality Improvement: Beyond the Basics. Fremont.

April

7: *SCPSC*: Track III — Perinatal Care. Industry Hills.

10: *CHPSO*: Just Culture Support Call. 10–11 AM.

14: *BEACON*: Compass Series 4 of 4. Oakland.

20: *PSCSD&IC*: HAI Elimination. San Diego.

25: *BEACON*: Annual Exchange Pre-Conference. Burlingame.

26: *BEACON*: Annual Exchange. Burlingame.

May

9: *CHPSO*: Just Culture Support Call. 10–11 AM.

11: *PSCSD&IC*: Reduce Preventable Readmissions through Networking (PRN). San Diego.

24: *SCPSC*: Perinatal Monthly Webinar. 12:15 PM.

24: *SCPSC*: Track I — Hospital Acquired Infections in the ICU Setting, Sepsis and Surgical Care Improvement Project. Industry Hills.

25: *PSCSD&IC*: Ending Elective Deliveries Before 39 Weeks Gestation. TBD.

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June

13: *CHPSO*: Just Culture Support Call. 10–11 AM.

15: *PSCSD&IC*: HAI Elimination. San Diego.

17: *CAPSAC*: California Patient Safety Action Coalition. Pasadena.

21: *SCPSC*: Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

28: *SCPSC*: Perinatal Monthly Webinar. 12:15 PM.

July

11: *CHPSO*: Just Culture Support Call. 10–11 AM.

13: *PSCSD&IC*: Reduce Preventable Readmissions through Networking (PRN). San Diego.

13: *SCPSC*: Track III — Perinatal Care. Industry Hills.

August

8: *CHPSO*: Just Culture Support Call. 10–11 AM.

9: *SCPSC*: Track I — Hospital Acquired Infections in the ICU Setting, Sepsis and Surgical Care Improvement Project. Industry Hills.

17: *PSCSD&IC*: HAI Elimination. San Diego.

23: *SCPSC*: Perinatal Monthly Webinar. 12:15 PM.

24: *PSCSD&IC*: Ending Elective Deliveries Before 39 Weeks Gestation. TBD.

September

9: *CAPSAC*: California Patient Safety Action Coalition. Sacramento.

12: *CHPSO*: Just Culture Support Call. 10–11 AM.

13: *SCPSC*: Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

14: *PSCSD&IC*: Reduce Preventable Readmissions through Networking (PRN). San Diego.

27: *SCPSC*: Perinatal Monthly Webinar. 12:15 PM.

October

10: *CHPSO*: Just Culture Support Call. 10–11 AM.

19: *PSCSD&IC*: HAI Elimination. San Diego.

25: *SCPSC*: Perinatal Monthly Webinar. 12:15 PM.

November

8: *SCPSC*: Track I — Hospital Acquired Infections in the ICU Setting, Sepsis and Surgical Care Improvement Project. Industry Hills.

9: *PSCSD&IC*: Reduce Preventable Readmissions through Networking (PRN). San Diego.

14: *CHPSO*: Just Culture Support Call. 10–11 AM.

15: *SCPSC*: Track III — Perinatal Care. Industry Hills.

23: *PSCSD&IC*: Ending Elective Deliveries Before 39 Weeks Gestation. TBD.

December

2: *CAPSAC*: California Patient Safety Action Coalition. Torrance.

12: *CHPSO*: Just Culture Support Call. 10–11 AM.

13: *SCPSC*: Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

14: *PSCSD&IC*: HAI Elimination. San Diego.

For further information on these events:

BEACON: Petrina Aiello paiello@hospitalcouncil.net or www.beaconcollaborative.org

CAPSAC: John Keats John.Keats@CHW.edu or www.capsac.org

CHPSO: Rory Jaffe rjaffe@calhospital.org

PSCSD&IC: Lindsey Wade lwade@hasdic.org

SCPSC: Catherine Carson ccarson@hasc.org

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. 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 are archived on the CHPSO website (www.chpso.org).

— Rory Jaffe, MD MBA rjaffe@calhospital.org