

### Guidewires Left Behind

CHPSO is beginning to receive reports of retained surgical items. The goal is to understand better the causes and steps to reduce their incidence. Of the initial 20 reports, only two involved sponges or instruments; the rest were of miscellaneous items, some of which were left intentionally. For example, a micro-needle that fell into the incision may be left behind when the risks involved with attempted retrieval are judged to outweigh the risk of retention.

Several of the reports involved guidewires for central venous catheterization. In these cases, a central venous line was placed under emergent conditions, and it appears that the wire was not secured in one hand while the other advanced the catheter over the wire.

Retained intravascular guidewires are typically retrieved via a percutaneous intravascular procedure. Retrieval is important, as guidewires tend to migrate centrally and may provoke cardiac arrhythmias. Also, a retained guidewire can act as a microwave antenna during an MRI, creating unwanted local heating. If the guidewire is left in for a prolonged period, it may become fibrosed to the vessel wall or cardiac chamber and difficult to remove.

We do not know if the incidence of retained guidewires is changing. However, one recent patient safety initiative may have, as an unintended consequence, increased the risk of retained guidewires.

Efforts to reduce sepsis mortality include early placement of a central venous line to guide fluid therapy. Given the urgent

need for central venous catheterization, more physicians are placing these lines than before. Some of the physicians may have less experience with the procedure and may be more prone to losing the guidewire when distracted or rushed by the urgency of the situation. We suggest that organizations with an early sepsis treatment program evaluate whether they need to include additional training or other support for less experienced physicians (e.g., an intra-procedure checklist) to address this potential risk. CHPSO also invites those with models for support of safer central venous catheterization to submit those for sharing with others.

— Rory Jaffe, MD MBA, [rjaffe@chpsso.org](mailto:rjaffe@chpsso.org)

## First Annual CHPSO Meeting

FOR ALL HOSPITALS

Take a Stand for  
Patient Safety

Eliminate Preventable Harm

CHPSO

California Hospital Patient Safety Organization

[www.chpsso.org](http://www.chpsso.org)



**Save the date:** March 13, 2012 Glendale, California

## Participation Open for Retained Surgical Items Project

Several other states are joining in this important effort. All CHPSO members are invited to participate. Details and the data collection form are at [www.chpso.org/rsi/index.php](http://www.chpso.org/rsi/index.php). Contact [Rory Jaffe](mailto:Rory.Jaffe@chpso.org) with any questions.

## Learning to Improve Safety

### From QA to QI

In my last column, I highlighted the fundamental differences between the old, dysfunctional QA style of peer review and the more effective QI Model. Let's now put that in the context of how healthcare leaders create the learning necessary to improve patient safety.

The figure shows the three primary modes by which you and your organization learn: from defects in the delivery of care (aka adverse events, no harm events, near misses and hazardous conditions); from taking advantage of what others have learned and what worked or didn't work for them; and from measuring clinical performance (what the "numbers" say). These three modes parallel the themes of no blame for human error, collaboration and accountability that dominate the safety literature. Ultimately, these three sources of learning must get translated into better care processes to actually impact safety.

Many of you have participated in a collaborative learning project with folks from other organizations. This has become a common way for adopting new approaches. We also tend to get ideas by going to conferences and by reading the "literature" to learn what others have done or discovered. While we may be

dependent on the research community to further expand evidence-based practice, this mode of learning needs little additional improvement.

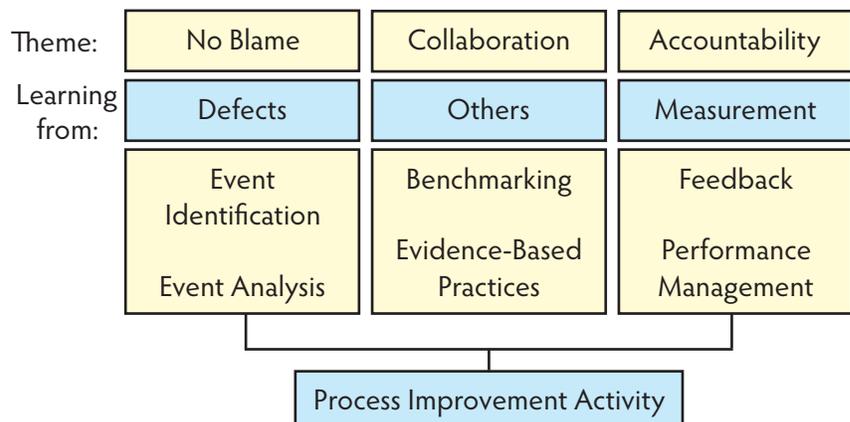
On the other hand, we have serious difficulties with event identification. For example, most hospital event reporting systems capture only about 10 percent of adverse events identifiable by detailed record review. Since we have even bigger problems with the conventional methods of event analysis via peer review and root cause analysis (RCA), it's easy to appreciate the potential value of improving this path to learning. And on the other side of the diagram, we're not doing that much better in translating measurement into accountability. Most healthcare managers and leaders lack the training and skill to have the conversations that inspire others to learn and adopt new behaviors. Thus, although there certainly is good value in collaborative projects and in ongoing learning from others, most organizations need to pay more attention to adopting better methods to learn from defects

and measurement. These activities are necessary to uncover and address the real problems at home.

There is also good opportunity in better connecting these various pieces. For example, it is relatively easy to measure clinical performance during peer review. More than ten times the information can be captured with minimal additional effort. Such data can be used to promote self-correcting behavior through timely performance feedback. Subjective methods of clinical performance measurement can be just as valid and useful as objective measures like CMS Core Measures, NSQUIP data, etc. Nevertheless, they are not widely understood. More on that next time.

*Coming Next: Measuring Clinical Performance*

— Marc T. Edwards, MD MBA, [QA to QI Consulting](http://QAtoQI.com), [marc@QatoQI.com](mailto:marc@QatoQI.com)



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## Hospital-Wide Measures Do Not Tell the Whole Story

Building on earlier research showing broad variation in patient safety culture within individual hospitals, Dutch investigators evaluated the rate of preventable adverse events, both between hospitals and between hospital departments. Twenty percent of all Dutch hospitals were included in the study. 7,113 patient admissions to 300 hospital departments in 21 hospitals were reviewed. A trained team of 66 nurses and 55 physicians participated in a structured record review process, and two physicians reviewed each possible adverse event to confirm it, evaluate preventability and assign a responsible department.

After correcting for risk factors and hospital type, variance between hospitals was not significant while variance at the department level was. The corrected event rates at the department level varied from 1.0 to 9.6 percent, and the interclass correlation (a measure of event clustering) was almost three times higher when measured at the department level than at the hospital level.

The authors recommend that: “Hospitals with an overall low rate of adverse events may have departments with the high rates of adverse events. Measurement at the department level is also more appropriate to formulate interventions and implementation strategies tailored to the problems of specific hospital departments. Hospital managers should identify high-risk departments and safety programs should focus on patient groups or clinical areas with a higher risk of preventable adverse events, such as elderly patients and patients that undergo surgical procedures.”

— Rory Jaffe, MD MBA, [rjaffe@chpso.org](mailto:rjaffe@chpso.org)

## Reference

Zegers M, Bruijne MC De, Spreeuwenberg P, et al. Variation in the rates of adverse events between hospitals and hospital departments. *International journal for quality in health care: journal of the International Society for Quality in Health Care*. 2011;23(2):126–33.

## CHPSO News Briefs

### *Just Culture Toolkit Update*

The last workgroup call on September 21 completed review of the Just Culture Roadmap. During the two months of workgroup calls, organizations shared their Just Culture tools and other resources. Most recently, some health systems offered to share their Just Culture tools to be considered in the development of a statewide toolkit. On October 14, an ad hoc Just Culture team consisting of representatives from CHPSO and these health systems held a conference call to review tools/resources currently available.

The next steps are for CHPSO to match the current tools with action items in the Just Culture Roadmap and to continue discussions with outside vendors for potential items that could be included in the statewide toolkit. Once the ad hoc team has results of the roadmap gap analysis, they will determine if additional tools need to be developed. We anticipate having an initial draft toolkit ready for review with the Just Culture Workgroup members during first quarter 2012.

It is not too late to submit materials for review with the potential of being incorporated into the statewide toolkit. Any Just Culture educational PowerPoints, policies, templates, or training materials that you would like to share, send them to Bobbie at [bdietz@chpso.org](mailto:bdietz@chpso.org).

### *First Annual CHPSO Meeting for All Hospitals*

The first annual CHPSO meeting for all hospitals is planned for March 13, 2012. The meeting will be held at the Hilton Los Angeles North, Glendale, California. There is complimentary shuttle to/from Burbank Bob Hope Airport.

Theme of the meeting is Take a Stand for Patient Safety — Eliminate Preventable Harm. The targeted audience is Hospital Executives, Quality, Risk and Patient Safety Leaders, Nursing Leaders and Physician Leaders. Presenters include a patient advocate, nationally-recognized patient safety experts and healthcare professionals. Main topics include Board and Leadership role, current state of patient safety, CEO roundtable, The Hospital Associations’ statewide patient safety efforts and an interactive patient safety case.

The speakers will be:

James Bagian, MD, PE, a former NASA astronaut and Director of the Center for Healthcare Engineering and Patient Safety at the University of Michigan; Founding Director, VA National Center for Patient Safety.

Allan S. Frankel, MD, is co-Chief Medical Officer at Pascal Metrics. A cardiac anesthesiologist by training, he is also senior faculty at both the Brigham and Women’s Hospital Patient Safety Center of Excellence in Boston and the Institute for Healthcare Improvement (IHI).

Dan Ford, MBA, FACHE, speaks frequently on the subjects of leadership, executive search and patient safety and is an active volunteer with a number of patient safety, patient/family-centered care and quality committees regionally, nationally and internationally.

C. Duane Dauner, President/CEO  
California Hospital Association.

Rory Jaffe, MD, MBA, Executive  
Director CHPSO.

Save the Date Card was mailed on  
October 26. The meeting brochure along  
with registration information will be  
available the first part of December. Look  
for updates on the CHPSO website.

—Bobbie Dietz, [bdietz@chpsso.org](mailto:bdietz@chpsso.org)

## WHO Releases Patient Safety Curriculum Guide

The World Health Organization has  
released a curriculum guide with tools  
and resources for clinical education. The  
guide includes teaching slides and covers  
the following topics:

1. What is patient safety?
2. What is human factors and why is it  
important to patient safety?
3. Understanding systems and the  
impact of complexity on patient care.
4. Being an effective team player.
5. Understanding and learning from  
errors.
6. Understanding and managing clinical  
risk.
7. Introduction to quality improve-  
ment methods.
8. Engaging with patients and carers.
9. Minimizing infection through  
improved infection control.

10. Patient safety and invasive  
procedures.

11. Improving medication safety.

The guide and additional materials are  
available at [goo.gl/4wfnVv](http://goo.gl/4wfnVv).

## Calendar

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

### November

**2:** PSCSD&IC (Patient Safety Council  
of San Diego & Imperial Counties):  
Preventing Rehospitalizations Network  
(PRN). San Diego.

**8:** SCPSC (Southern California Patient  
Safety Collaborative): Track I — Hospital  
Acquired Infections in the ICU Setting,  
Sepsis and Surgical Care Improvement  
Project. Industry Hills.

**8:** PSCSD&IC: Lean Practitioner Course.  
San Diego.

**14:** CHPSO: Members Call. 10–11 AM

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

**15:** PSCSD&IC: Ending Elective  
Deliveries Before 39 Weeks Gestation.  
San Diego.

**29:** PSCSD&IC: Lean Practitioner  
Course. San Diego.

### December

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

**12:** CHPSO: Members Call. 10–11 AM

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

**13:** PSCSD&IC: Lean Practitioner Course.  
San Diego.

**13:** PSCSD&IC: Sepsis/HAI Elimination.  
San Diego.

**15:** PSCSD&IC: Standardizing Dosing  
Limits. San Diego.

*For further information on these  
events:*

CAPSAC: John Keats [John.Keats@CHW.edu](mailto:John.Keats@CHW.edu)  
or [www.capsac.org](http://www.capsac.org)

CHPSO: Rory Jaffe [rjaffe@chpsso.org](mailto:rjaffe@chpsso.org)

PSCSD&IC: Lindsey Wade [lwade@hasdic.org](mailto:lwade@hasdic.org)

SCPSC: Julia Slininger [jslininger@hasc.org](mailto:jslininger@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.chpsso.org](http://www.chpsso.org)).

Prospective authors may submit articles  
to Rory Jaffe, MD, MBA: [rjaffe@chpsso.org](mailto:rjaffe@chpsso.org), 916.552.7568. Typical articles will be  
brief — between 200 and 600 words. A  
completed [publication agreement form](#)  
must be submitted prior to publication.