



TIPS

Volume 2, Issue 1

Topics in Patient Safety

January/February 2002

National Roll-out of Aggregate RCAs

As of January 1, 2002, the VA National Center for Patient Safety (NCPS) expanded their aggregate root cause analyses (RCAs) roll-out nationally. VHA facilities are now collecting data to be used for their aggregate RCAs. In preparation for this, NCPS, in addition to giving aggregate RCA training during their 3-day patient safety improvement training sessions, coordinated a national two-hour teleconference training session with accompanying materials last December.

"The aggregate reviews conducted during the pilot phase confirm the value of the aggregated approach. Facilities in Network 8 and elsewhere have made substantive improvements in patient safety by reviewing the data and looking for trends and opportunities for improvement," stated Erik Stalhandske, NCPS Program Manager.

The aggregate RCAs will be phased in over the next four quarters along with just-in-time training provided by NCPS. The topics for which aggregate reviews may be done will be phased in the following

order: falls, missing patients, adverse medication events, and parasuicides.

"Our experience as a pilot network for the

aggregate RCAs supports this phased-in approach," stated Mary Huddleston, VISN 8 Patient Safety Officer. "This will allow patient safety managers to get their feet wet with an initial

Four Categories of Aggregate RCAs

VA has identified four categories of events that can be reviewed through a quarterly aggregate root cause analysis (RCA): falls, missing patients, adverse medication events, and parasuicides (suicide attempts). The events are eligible for aggregate RCAs if there is not a serious outcome. Within the VA, these are events that receive a Safety Assessment Code (SAC) potential score of 3. For example, a missing patient that ends up seriously harmed requires an individual RCA, whereas if he is discovered unharmed, it is appropriate for an aggregate RCA.

aggregate RCA on falls, and have some early successes."

Jacqueline White, Patient Safety Manager for the

Honolulu VAMROC, presented during the teleconference training and offered the following advice. "We've found it successful to have some continuity in the aggregate

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VA Patient Safety Program Receives National Recognition

VA's patient safety program was nationally recognized last December when it was selected as a winner of the 2001 Innovations in American Government Award. VA was one of five winners selected and the only federal program to receive this honor.

"This award validates VA's dedication to patient safety," said James Bagian, M.D., P.E., Director of NCPS. "The credit for winning this award belongs to the employees across VA who pioneered the implementation of uniform methods for reporting, analysis and system level corrections of vulnerabilities leading to improvements in patient

safety. I am glad to see that many health care organizations in this country and overseas are interested in pursuing improvements in patient safety and benefiting from our work."

The Innovations award program promotes creative problem solving in the public sector and is sponsored by Harvard University's John F. Kennedy School of Government in partnership with the Council for Excellence in Government. As a winning program, VA will also receive a \$100,000 grant to be used to help communicate their patient safety program to outside health care organizations.

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SAFETY SPOTLIGHT

(On a regular basis we feature teaching examples pulled from medical literature and similar RCAs that we feel are applicable and of interest to the entire VHA health care system. The following represents information taken from RCAs; it is presented to spark discussion and does not represent NCPS policy. Depending on the specific circumstances at any given facility, there are various systems-level solutions that will be most appropriate.)

Transporting patients with oxygen tanks

(We have seen a number of adverse events and close calls while patients are being transported with oxygen tanks, here is an example of one.)

Description

Patient was placed on a stretcher by members of the nursing staff to await transport from unit to ultrasound and provided with a portable O2 tank. The RN on duty assessed patient's O2 prior to transport. Escort arrived and delivered patient to ultrasound and notified ultrasound tech the patient is present and on O2. The same escort later transported the patient back to the unit, leaving patient on a gurney outside the

nursing station. Escort then told nurse that the patient is back. A resident later found the patient still on the gurney and with the O2 tank empty. The patient was not breathing and had low blood pressure. The resident then moved the patient to his room and connected him to 100% O2 via facemask. Patient recovered and actual injury from incident was assessed as minor.

Facility Identified Vulnerabilities

The following vulnerabilities and systems weaknesses were identified:

- Consistent and timely communications between nurse and escort staff would support ongoing evaluation of the patient's status and prevent O2 tank emptiness
- Training for O2 management (flowmeters and regulators) needs to be consistent in all exam areas and across clinical services
- Need for respiratory therapy policy/procedure to provide consistent monitoring of O2 tanks for volume and availability
- Ultrasound is a room without an independent O2 source. Therefore, patient's only source of O2 is a transport tank

Actions Taken by Facility

In response to this case, the facility took the following actions:

- Develop and implement a standard protocol requiring that all patients on portable O2 tanks be connected to a larger O2 source upon arrival at destination.
- Hospital leadership to consider the installation of inline suction and O2 in all direct patient care areas
- Identify additional storage space on nursing units so that the number of available O2 tanks can be increased
- When patients are being transported with portable O2 tanks, the nursing unit sending the patient will notify the receiving area that the patient will be coming with portable O2
- Nursing supervisor for escort staff reinforces that escort staff notify clinical staff when a patient has arrived and that the patient is on O2
- Develop and implement a standard protocol requiring that when patients are connected to portable O2 tanks, the tank capacity must be checked
- Training will be established which includes how to prop-

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Safety Spotlight

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erly open an O2 tank and read a regulator for volume

- Develop and implement a policy/procedure for O2 tanks and regulators, including weekly maintenance rounds of O2 storage levels, locations, etc.

NCPS Comments

Some of these specific actions are important and will improve patient care. However, they do not directly address the issue at hand — to prevent patients supplied with 100% O2 from running out of O2. The team might also have considered specifying minimum cylinder tank levels for patients who are being transported (i.e. start with a full cylinder) and identifying and communicating the oxygen cylinder level at each transfer or handoff point. Look for additional information on this topic in upcoming NCPS publications.

Aggregate RCAs

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teams; otherwise, you start from scratch each quarter. I also give the teams a calculator, current articles and JCAHO alerts relevant to their topic. Involving the patient care line managers has also proven to be an effective process step to help gain buy-in."

"The SPOT software provides a single place to store, retrieve, and analyze the data elements required for the four types of aggregate RCAs," stated John Gosbee, Director of NCPS Patient Safety Data Systems. "Facilities may record the data with paper forms or your own custom electronic methods, but we encourage facilities to try using SPOT".

Visit the NCPS intranet site at vaww.ncps.med.va.gov/PPT/AggRev.html to see the aggregate review schedule, bibliography, a sample aggregate RCA, and other materials.



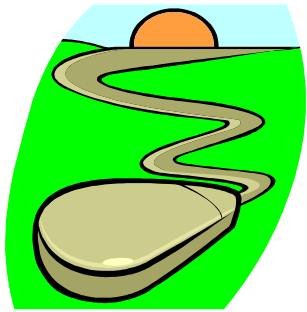
ALOHA SPOT -- *The folks at the Honolulu VAMROC are really getting into the spirit of using the RCA software SPOT. Here is their own SPOT mascot and Patient Safety Manager, Jacqueline White, recently seen walking through their facility.*

Conference Calendar

CONFERENCE	DATE	LOCATION	CONTACT
Univ. of South Florida/VA Third Annual Evidence-Based Falls Conf.	3/4-6/02	Clearwater, FL	www.cme.hsc.usf.edu/falls/
FDA/VA New Developments in Hospital Bed Safety	4/7-8/02	Clearwater, FL	www.cme.hsc.usf.edu/bed/
VA NCPS Patient Safety Improvement Training	4/9-11/02	Las Vegas, NV	(734) 930-5890
Annenberg IV -- Patient Safety: Let's Get Practical	4/22-24/02	Indianapolis, IN	www.npsf.org
Association for the Advancement of Medical Instrumentation (AAMI) 2002 Annual Conf. and Expo	6/1-4/02	Minneapolis, MN	www.aami.org
Human Factors and Ergonomics Society Annual Meeting	9/23-27/02	Pittsburgh, PA	www.hfes.org

Learning Links

We have recently come across an interesting website that we want to pass on to you. The American Society of Anesthesiologists (ASA) has a website called the ASA Closed Claims Project (<http://depts.washington.edu/asaccp/>), which offers an in-depth investigation of closed anesthesia malpractice claims designed to identify



major areas of loss, patterns of injury, and strategies for prevention.

The intention of the project is to:

- Identify causes of loss
- Reduce the cost of professional liability insurance
- Improve patient safety

Although it is quite specific to anesthesiology, the project offers a very interesting analysis of aggregate reviews of adverse event data.

You might also like to check out ASA's monthly periodical, the ASA Newsletter at <http://www.asahq.org/NEWSLETTERS/>.



NCPS TIPS is published bi-monthly by the VA National Center for Patient Safety (NCPS). As the official patient safety newsletter of the Department of Veterans Affairs (VA), it is meant to be a source of patient safety information for all VA employees. All pictures are VA photos unless otherwise identified. Opinions of contributors are not necessarily those of the VA. Suggestions and articles are always welcomed and readers can contact us at:

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Another Way to Look at Close Calls

At the VA, we define close calls as events or situations that could have resulted in an adverse event but did not, either by chance or through timely intervention. We feel that recognizing those whose good headwork resulted in timely intervention and prevented a close call from becoming a tragedy is a worthwhile activity as it is a critical part of enhancing and insuring

patient safety.

It is always interesting to see what other health care organizations are doing in this respect. The staff at Rice Memorial Hospital in Willmar, MN, have started using the term "good catch" when referring to just such close calls because they feel that it removes any stigma of guilt.

"The 'good catch' terminology emphasizes that the human - the health care worker - is the last line of defense and therefore has a vital role in creating a safe environment," stated Peggy Sietsema, the associate administrator of clinical services at Rice Memorial Hospital. "It has been a way for us to encourage reporting of the 'almost event' and thereby more quickly identify the processes where safety improvements are needed."

Viewed from this slightly different perspective, the close call not only helps provide us with the best opportunity to learn about system weaknesses and correct them before tragedy occurs but also can help us to recognize those whose good catch may have saved the day.

Use of Statins

Baycol® (cerivastatin) was voluntarily withdrawn from the U.S. market because of a significantly higher number of cases of cerivastatin-associated rhabdomyolysis (skeletal muscle disease) compared to the other available statins. As a result, a letter was sent to VA health care providers including information on the potential risk factors for myotoxicity with statins and recommendations for the use of statins in patients receiving medications with the possibility for drug-drug interactions. The complete letter may be found at <http://www.vapbm.org/alerts/rhbdalart.pdf>.