



TIPS

Volume 1, Issue 3

Topics in Patient Safety

May/June 2001

VA/QuIC Patient Safety Summit

Under the auspices of QuIC (see related article), the VA National Center for Patient Safety (NCPS) is organizing and convening the Summit on Effective Practices to Improve Patient Safety. The symposium will present information on findings, methods, and systems that can be used to improve patient safety, which participants can put to rapid and widespread use in health care settings. This will be held September 5-7, 2001, at the Washington (DC) Hilton and Towers. Including VA and non-VA participants, the summit can accommodate up to 500 participants. We expect that about 200 participants will be from VA, with the rest coming from other QuIC member agencies, state and local governments, and the private sector.

NCPS staff are in the process of organizing the details of the

conference. Key speakers at the summit will include Dennis O'Leary, President of the Joint Commission on Accreditation of Healthcare Organizations, Donald Berwick, M.D., M.P.P., CEO and President of the Institute for Healthcare Improvement, and Michael Cohen, Pharm D, President of the Institute for Safe Medication Practices.

The topics and presentations planned (some for plenary sessions, some for breakout sessions) will include:

- Patient Safety Obstacles and Solutions/Lessons Learned by the VA
- Failure Modes Effects and Analysis (FMEA) as Applied to Patient Safety
- Root Cause Analysis (RCA) Teams Presentation
- NCPS RCA Tools and Safety Assessment Code

- Report from AHRQ Evidence-Based Practice Patient Safety Study
- New JCAHO Patient Safety Standards
- VA/NASA Patient Safety Reporting System
- Using Human Factors and Usability Testing to Improve Patient Safety
- New NCPS RCA Software Demos
- Patient Safety Alerts and Advisories
- Effective Management of Medical Teams
- Methods to Reduce Falls

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What is QuIC?

The Department of Veterans Affairs (VA) is one of 11 members of the federal government's Quality Interagency Coordinating (QuIC) Task Force (see www.quic.gov). QuIC was established in 1998 with the goal to ensure that all Federal agencies that purchase, provide, study, or regulate health care services are working in a coordinated way toward the common goal of improving the quality of health care.

QuIC seeks to provide information to help people make choices, to improve the care purchased and delivered by the government, and to develop the infrastructure needed to improve the health care system. QuIC was responsible for the 2000 report Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact, which presented the federal government's response to the Institute of Medicine's 1999 report To Err Is Human: Building a Safer Health System, which raised the public's awareness of the need for major improvements in patient safety.

Dental X-Ray Film Warning

The FDA has issued a Public Health Notification warning of the potential for harmful lead exposure from dental film stored in tabletop containers lined with unpainted or coated lead. These containers are usually the size and shape of a shoebox, are made of wood, and are lined with lead that has apparently not been painted or coated.

Film stored in these containers has

been found to be coated with a whitish film that is about 80% lead. These highly dangerous lead levels are enough to potentially cause serious adverse health effects -- including anemia and serious neurological damage -- in patients and healthcare professionals.

The FDA recommends the following:

- Discard any dental film that has been placed in these containers. None of this film should be used. Wiping the film does not significantly reduce the lead levels.
- Remove the containers and dispose of them properly.

For more information on this contact your facility Industrial Hygienist.

VA/QuIC Summit

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- Health Care Provider Performance and the Effects of Fatigue
- Use of Simulations and Simulators to Improve Patient Safety
- Methods for Increasing Medication Safety
- Results of the VA Survey on Patient Safety Attitudes
- Improving Quality: The Rest of the Iceberg

The sessions will be organized so that those new to patient safety as well as those with experience in the field can both benefit from attending. We expect the conference to be especially valuable to staff newly hired or reassigned as patient safety managers.

Registration for the VA/QuIC Summit on Effective Practices to Improve Patient Safety is available via the NCPS intranet website (vaww.ncps.med.va.gov) or go directly to vaww.rev.lrn.va.gov/conferences/safety/index.cfm. Please coordinate your registration in cooperation with your VISN as soon as possible to ensure that you get one of the slots assigned to VA. If you are unsure of who to contact in your VISN, a list of contacts for the symposium is available at the registration website.

Facility Feedback

(Patient safety feedback from throughout the VHA. Please send any comments you'd like to share with us to ncpstips@med.va.gov.)

Unannounced JCAHO Survey

We recently had our first random, unannounced Joint Commission survey for Home Care/Durable Medical Equipment. From the patient safety perspective, we were scored on Improving Organization Performance Home Care Standards, specifically aggregation and analysis.

This was where we had the opportunity to "brag" about our RCA process and walked the surveyor through the SAC score process of all incidents, including close calls and the RCA format. The surveyor was very impressed with our front line staff and senior management involvement.

We also pulled our current storyboard circulating to staff regarding "Lessons Learned" from RCA's, listing all staff who participated, whether it was a close call or actual event (over half of our

RCA's are close calls), what the RCA incident was, and then the improved outcome (all sanitized of patient identifiers, of course).

We scored "substantially compliant" for standards PI.4.3 (undesirable patterns of trends in performance and sentinel events are always evaluated) and PI.4.4. The organization uses the information from the evaluation to develop an action plan that will improve performance or reduce the risk of future sentinel events.

Needless to say, we impressed the surveyor with having all this info available on a random, unannounced survey. (I think we knocked his socks off).

Thank you to you and your staff for helping us "shine" during this survey — especially a random, unannounced survey — and wanted you to share in our success.

P.S. We're actually getting good at RCA's and we have several that have been completed in 20 hours or less that are excellent. Thanks again.

-- *Sandy Brestowski
Wilkes-Barre VAMC*

SAFETY SPOTLIGHT

(On a regular basis we will feature teaching examples pulled from medical literature and similar RCAs that we feel are applicable and of interest to the entire VHA healthcare system. These cases are intended to be used for learning purposes only.)

Failure to obtain consent for surgery

Description

A patient was scheduled to receive a paracentesis, and the resident discussed with the patient the procedure along with the incumbent risks. The veteran, who had experienced relief before with this procedure, was seeking this treatment and consented verbally. The resident had been working a long shift, and failed to receive the written consent. At the time of the procedure, the resident explained to the attend-

ing physician that verbal consent had been obtained, and the resident went and got a procedure tray from the open supply room. They performed the surgery without incident, and following the surgery the resident documented that verbal consent had been given.

Upon discussion, the resident confirmed that she knew that you should get informed consent, but couldn't remember any orientation regarding the policy and described the atmosphere as relaxed regarding informed consent.

Vulnerabilities

The following vulnerabilities and system weaknesses were identified:

- A cultural norm (especially among the residents) of a lax approach to informed consent
- Non-enforcement of existing policies
- No training or discussion of the informed consent process and its value were built into the orientation

- A lack of incentives or disincentives to change the current behavior
- Lack of barriers in the environment as the procedure kits/trays can be retrieved from an unlocked supply room regardless of patient consent status, and no individual to verify that the consents have been received
- Fatigue on the part of staff
- The process often breaks down during off tour times
- Insufficient alerts to remind of policy

Actions To Consider

The following actions were recommended:

- Brightly colored sticker placed on each tray stating "STOP—an informed consent must be completed for this procedure"
- Included informed consent on procedure tray
- Supply room locked so that supply/procedure trays cannot be taken
- Procedure tray will not be issued until signed consent obtained
- Eye-catching promotional literature in team conference room about informed consent
- Additional resident and staff educational sessions

Conference Calendar

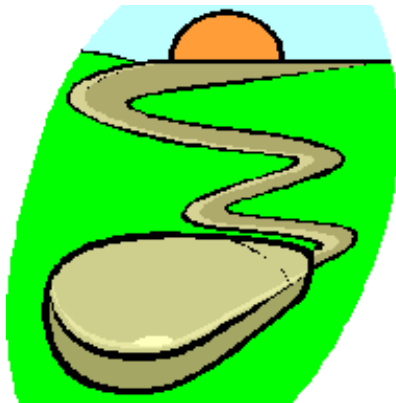
CONFERENCE	DATE	LOCATION
NCPS Patient Safety Improvement Training	6/5-7/01	Chicago, IL
VA/QuIC Summit on Effective Practices to Improve Patient Safety	9/5-7/01	Washington, DC
NCPS Patient Safety Improvement Training	9/11-13/01	Chicago, IL

Learning Links

We have recently come across interesting articles and websites on patient safety issues that we want to pass on to you.

The British Medical Journal

The British Medical Journal recently published an article titled "Adverse Events in British Hospitals: Preliminary Retrospective Record Review" (<http://bmj.com/>



[cgi/content/full/322/7285/517](http://bmj.com/cgi/content/full/322/7285/517)).

This article highlights preliminary findings from a pilot study conducted in the United Kingdom that examined the feasibility of applying U.S. and Australian adverse event reporting methods in the U.K.

FDA Bulletin

The Food and Drug Administration publishes a quarterly bulletin called

"User Facility Reporting" (<http://www.fda.gov/cdrh/fusenews.html>). The purpose of this publication is to assist hospitals and other medical device user facilities in complying with their statutory reporting requirements under the Safe Medical Devices Act of 1990 and the Medical Device Amendments of 1992.



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VA National Center for Patient Safety
P.O. Box 486
Ann Arbor, MI 48106-0486
Phone: (734) 930-5890
Fax: (734) 930-5899
E-mail: ncpstips@med.va.gov
Websites:
Internet: www.va.gov/ncps
Intranet: vawww.ncps.med.va.gov

NCPS Director ... James Bagian, M.D., P.E.

TIPS Editor Don Jarosz

TIPS Editorial Board James Bagian, M.D., P.E.
Joseph DeRosier, P.E., C.S.P.
John Gosbee, M.D.
Don Jarosz

Other NCPS Contributors Caryl Z. Lee, R.N., M.S.N.
Erik Stalhandske, M.P.P., M.H.S.A.

Nitrogen or Nitrogen NF?

Do you use nitrogen to power operating room surgical equipment or dental office tools? If you answered "yes" to this question, is the nitrogen medical gas grade or industrial, non-medical grade? Does it make a difference? YES!!

The Compressed Gas Association (CGA) identified two patient related incidents involving gaseous nitrogen that was used to power tools. These incidents involved the presence of a substance in non-medical grade Nitrogen that gave a strong odor. In one case a patient in a dentist's office required hospitalization. In both cases the odorizing substance was found to be toxic in nature.

FDA does not specifically require that nitrogen used to power

surgical or dental equipment be listed as either a Medical Device or be Nitrogen NF (medical grade). However, based on these two events CGA recommends that only Nitrogen NF be used.

Medical grade Nitrogen NF production procedures require testing for odor prior to distribution, and industrial non-medical grade nitrogen does not.

It is recommended that you review the type of Nitrogen gas you use to power this equipment in your hospital **and switch to Nitrogen NF if it is not currently being used.**

If you would like more information on this issue please refer to CGA Safety Alert SA-6-1998.