Patient Safety

Assessing Clinical Risk

- The health protection agency has suggested that one in ten hospital patients experience an incident that puts their safety at risk, around half of which could be prevented.

- That fact alone should tell us how important it is for all health care providers to be assessing risk in the clinical setting.

Errors

- Three factors about errors
  - Everyone makes errors, even seasoned professionals.
  - High risk situations increase the odds of making errors.
  - Practicing low risk behaviors and using error prevention tools reduce the chance for making an error.

Assessing Risk

- The patients safety is dependent on everyone continually assessing the risk of the patient that they are caring for and for being alert to risks that can occur.
- Assessing clinical risk is everyone's job.
- Risk Management is only effective if everyone is in the Risk Management role.

Risk Prevention

- While it is not possible to eliminate all risks as health care providers we have a duty to protect patients as far as reasonably practical.
- Avoid unnecessary risk
- Focus on risks that matter, those with the potential to cause harm.
- Risk Management is only effective if everyone is in the Risk Management role.

Obligations as a Risk Manager

- Know the risks associated with the patients you are caring for.
- Report any event that has the potential to cause harm or has caused harm (verbal/incident report).
- Communicate immediate concerns to other providers involved in the care of the patient.

Risk Manager

- Practice low risk behaviors
  - Patient safety first and foremost by putting efforts on safety precautions.
  - Working well together, when we work well as a collaborative interdisciplinary team we are more reliable and we prevent errors from occurring.
  - Better every day
    - Own our personal and professional development.
    - Report safety events and problems.
    - Help to fix problems (it's not someone else's job).
    - Learning from others experiences.

Communicate, Communicate, Communicate!

- You can never do it enough.
- Lack of communication among healthcare providers and with the patient is frequently a major factor in why things go wrong.
- We are not very good at it and we need to get better.
- It is also a big factor in why patients complain.
- When I am responding to patient grievances I can always find an opportunity for communication to improve.

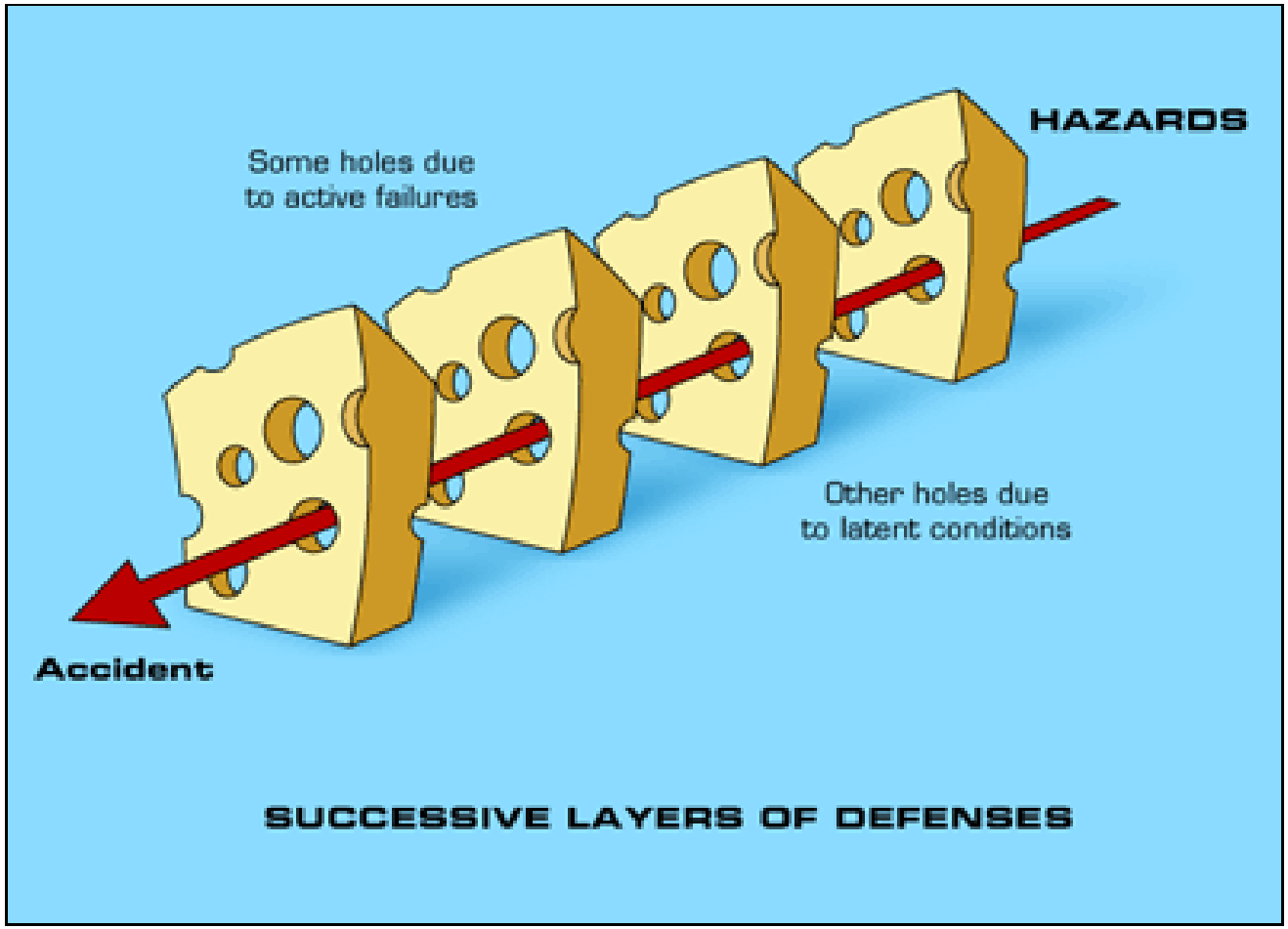
Risky Behavior

- Not knowing your patient.
  - Just following orders is not enough.
- Not paying attention to the task at hand.
- Failure to communicate with other providers.
- Failure to take ownership for following through with concerns.
- Failure to report events.
- Failure to take ownership for your own professional development/competency.

Risky Behavior

- Not having a questioning attitude
  - Something does not feel right.
  - Information is incomplete.
  - High risk situation.
- Failure to utilize safety practices that are part of our standards.
  - Property identifying the patient, always using the Five Rights
  - Following appropriate protocols for performing testing
  - Making sure abnormal results are reported
  - Always thinking about the safety of the patient first.
- Listening to patient and addressing their concerns.

Swiss Cheese Affect



Swiss Cheese Affect

- You become aware of a concern about the patient but you do not tell anyone because you are busy.
- The next provider is very busy and does not monitor the patient properly and they are unaware of the concern. They hand off to another provider.
- The other provider is unaware of the issue and does not have the appropriate information in order to properly monitor the patient.
- Patient crashes and ends up with an adverse event.

Error Prevention Tools

- Self-checking with **STAR**
  - Stop – pause 1 – 2 seconds
  - Think – focus your attention to the task
  - Act – concentrate and perform the task
  - Review – check for correctness

Clarifying Questions

- Ask 1 – 2 questions
  - In all high risk situations
  - When information is incomplete
  - When information is not clear
- Reduces the risk of making an error by 2 ½ times.
- Use the safety phrase, “Let me ask a clarifying question..”
- Question and Confirm
  - Does it make sense to me?
  - Check it with an independent, expert source.

Cross Monitoring

- Situation monitoring: the process of continually scanning and assessing what is going on around you to maintain situation awareness.
- Situation awareness: knowing what is going on around you at all times. All team members should be on the same page.
- Cross Monitoring - a strategy to reduce errors:
  - Monitor actions of other teammates
  - Provide a safety net within the team
  - Ensure mistakes or oversights are caught quickly and easily
  - Watch each other's backs

Speaking Up

- CUS when it's critical
  - C – I am concerned
  - U – I am uncomfortable
  - S – Stop! This is a safety issue!

- Focus on the common goal: safe patient care.
- Depersonalize the discussion.
- Avoid judging who is right or wrong.
- Focus on what is right for the patient.

Handoff Communication

- SBAR – communicating with physicians
  - S – Situation
  - B – Background
  - A – Assessment
  - R – Recommendation

- Hall Pass
  - For communicating relevant clinical data about patients that are being transported from department to department. The Hall Pass is used by the transporter and receiving department.

Handoff Communication

- PASS ME SAFELEE
  - For handing off nurse to nurse, shift to shift, or department to department.

Patient	**S**afety and quality concerns
Admitting symptoms & diagnosis	**A**DLs
Significant History	**F**amily/Social Concerns
Systems assessment	**E**quipment
Meds & Allergies	**L**abs & Diagnostics
Expectations	**E**ducation
	Exit Plan

Case Study

48 year old trauma patient was admitted to the hospital on 2/1 as a result of MVA. Report indicated that he was transporting supplies utilizing a golf cart and he was struck by a motor vehicle. He was ejected from the golf cart and he landed in a ditch filled with water. Patient was alert and oriented and denied any loss of consciousness at the scene.

Trauma workup included:

- CT of head
- CT of C Spine
- CT of chest
- CT of abdomen
- CT of pelvis
- Labs

Case Study

After evaluation and workup by trauma the patient was noted to have the following injuries.

- Maxillary sinus fracture
- Mandibular condyle fracture
- Rib fracture, 4^{th} - 10^{th} with several flail segments noted

History provided on admission was hypertension. He was a non-smoker and used alcohol socially.

General physical exam revealed well nourished obese black male. He was awake, alert and oriented with Glasgow coma scale of 15.

Case Study

Plan included the following:

- Admission to the floor
- Standard trauma orders that included GI & DVT prophylaxis
- Analgesia, antiemetics & anxiolytics as needed
- Consults with Oromaxillary Specialist
- NIF and forced vital capacities in AM x3 days
- Aggressive pulmonary toilet
- Pain control with IV and oral medications
- Possible rib plating surgery

Case Study

2/2 at 10:00am

Patient advised trauma provider that he wants to have surgery to repair ribs.

Orders include

- O_2 via NC, keep Sat $\geq$ 93%
- PCXR on 2/3 at 6:00am
- Albuterol 2.5mg with EzPap Q6
- BMP in AM
- PT for bed mobility/gait
- Keep HOB $\geq$ 30˚

Case Study

2/2 at 8:00pm

Trauma provider evaluates patient and gives following orders.

- Patient advised that he has history of sleep apnea and uses BiPAP at home.
- NPO after midnight
- D5 0.9 NS @ 100cc/hr
- Coags and BMP in AM
- CPAP every HS
- Consent for Thoracotomy, pleural wash out, rib plating and other indicated procedures

Case Study

2/2 at 10:00pm

Respiratory therapy note

- Asked patient if he wanted to use BiPAP and patient told me that he only wears it every other week. RT advises patient that CPAP was ordered and patient refused CPAP that night and maybe he would have his wife bring it in tomorrow. RT also advised patient that if his wife did not bring it in then we would have to use ours for him.

Case Study

2/3 at 11:00am

Trauma provider evaluates patient and advises patient that surgery can not be done that day due to OR schedule. Patient complaining that he is having significant pain despite pain medications.

Orders given to change pain medication to Morphine IV PCA 1mg/ml

Basal 2mg/hour, demand dose 1mg, lockout 10 minutes

Case Study

2/3 at 9:00pm

Respiratory therapy note

- Patient refusing BiPAP at this time. Wife will bring tomorrow. Asked patient to let me know if he changes his mind. Patient also refusing 1:00am breathing treatment.

2/3 at 10:00pm

Nursing assessment completed

2/4 at 1:30am

Patient found unresponsive, code called, admitted to ICU

Case Study

- What are the risk factors for patient upon admission?

Case Study

- What are the risk factors for patient on the second day of admission?

- What could we have done better in terms of patient management after refusal?

Case Study

- What are the risk factors for the patient on the third day?

- What could we have done better in terms of patient management at the time of the 2nd refusal?

Learn from our experience

80 year old male patient admitted to the hospital with bowel obstruction secondary to mass and underwent bowel resection with colostomy.

History included

- Diabetes Mellitus
- Hypertension
- Chronic A-Fibrillation
- Vascular dementia
- Pancreatic lesions
- Multi infarcts of brain

Learn from our experience

9 days post admission patient started to have respiratory difficulty and the physician was notified.

Orders included:

- Chest x-ray
- ABGs
- Place patient on non-rebreather
- Insert foley
- Administer Lasix

Learn from our experience

ABGs were drawn by Respiratory Therapist and based on those results (PCO_2 65.9, PH 7.229) the physician was notified and agreed to recommendation that patient be placed on BiPAP. Order was given to transfer patient to ICU.

There were no beds available in ICU at that time. Patient began to deteriorate again and MET Team was called.

Learn from our experience

When bed became available nurse was preparing for transfer and questioned whether she should have assistance with transfer. She was advised that she did not need assistance from ICU to transfer patient. Nurse was unfamiliar with BiPAP machine and shutoff the machine in preparation for transfer.

When she arrived in ICU which took approximately 4-5 minutes patient was struggling to breathe and heart rate was in the 30s.

Patient was coded but was unresponsive to resuscitation measures.

Learn from our experience

What did we do as a result of this event?

- Event was reported immediately.
- Investigation was initiated.
- Rapid response team was called.
- Code 15 was reported.
- Root Cause Analysis was conducted.
- Plan of correction was initiated.
  - Labels were placed on all machines
  - Staff were educated about process for transporting patient on BiPAP and/or CPAP
  - Policy was changed

Medical Record

- "Your Best Friend or your Worst Enemy"
- The patient's medical record is the primary source of information concerning the care which is given.
- Juries often make decisions based on the quality of medical record.

Medical Record

- Part of the respiratory therapists legal duty to the patient is to chart the care given to the patient accurately and in a timely manner. Because the chart's primary use is to communicate among care givers, patients can be harmed when charting is not accurate or timely. Risk Management Handbook For Health Care Facilities

Medical Record

- Because it is the major communication tool among the health care team, completeness and accuracy of the medical record are critical to the safe treatment of the patient.

- Because the medical record is the major communication tool concerning the care of the patient, institutional policies and procedures regarding medical record documentation should be followed consistently.

Documentation

- Know (and follow) policy on documentation
- Know (and use) approved abbreviations
- Know (and follow) policy on changing documentation

Documentation

- If it **isn't** in the chart, it **wasn't** done!
- Proper documentation is the Healthcare Practitioner's first line of defense.

Documentation

- Altering or destroying a medical record in Florida is a second degree misdemeanor.

- Is also grounds for licensure action.

Confidentiality

- Entries in the patient's medical record should be written with the expectation that they could be read in court and by the jury in a medical malpractice case, and should therefore be as accurate, respectful, pertinent and professional as possible.