Patient Safety Storybook
2011
Chapters

Closing the Loop for Patient Safety

Great Catch Awards Program

Patient Stories

Patient Safety News Highlights from 2011

Reporting Patient Safety Events & Concerns

This Story Book is a celebration of “Great Catches” by John Muir Health staff and a sharing of “Patient Stories.” As a learning organization, telling these stories is intended to generate dialogue among frontline caregivers who may be able to prevent a similar occurrence.

Published by Quality Management – April 2012
Stephanie Bailey, Director of Accreditation/Patient Safety
Marlowe Flora, Risk Manager, Walnut Creek Campus
Jonathan Stewart, Risk Manager, Concord Campus
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You Told Us... We Listened

John Muir Health is committed to providing feedback and communication about error. This “Closing the Loop for Patient Safety” report is one mechanism for communicating to the broader audience of hospital staff and clinicians about patient safety events and actions taken. We hear about these events mostly from Patient Safety Alerts/RDEs, and the information is used to track and find patterns and trends, which help us learn how we can improve our systems to prevent future mistakes. As of 2012, the “Closing the Loop for Patient Safety” report will be published quarterly.

Because patient safety is everyone’s responsibility, everyone has the duty to report his or her concerns. By reporting our concerns, we are helping each other improve safety together. Patients trust us with their lives; family members trust us with their loved ones. Nothing we do is more important than working together to ensure the safest environment possible for our patients. Thank you for doing your part to make our culture of patient safety part of your daily work life.

Closing the Loop Publications are available on the Intranet at:

Cross Campus Depts ➔ Quality Management ➔ Patient Safety/Risk Mgt ➔ Closing the Loop
<table>
<thead>
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<th>When</th>
<th>What Was Reported</th>
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<th>Site(s)</th>
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<tbody>
<tr>
<td>Jan-11</td>
<td>Non-Invasive Cardiology (NIC) staff concerned about outpatient NIC patients without ID bands</td>
<td>New process implemented for ID banding NIC outpatients</td>
<td>CC</td>
</tr>
<tr>
<td>Jan-11</td>
<td>Drug shortages with the potential for impacting patient safety</td>
<td>New formal drug shortage response plan for highest priority medications implemented by pharmacy</td>
<td>CC/WC</td>
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<tr>
<td>Jan-11</td>
<td>Patient safety risk with use of patient furnished ventilatory equipment</td>
<td>New policy about use of patient furnished ventilatory equipment</td>
<td>CC/WC</td>
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<tr>
<td>Feb-11</td>
<td>Patient had blood drawn from an arm with a fistula</td>
<td>New use of pink extremity alert wristbands implemented</td>
<td>CC/WC</td>
</tr>
<tr>
<td>Feb-11</td>
<td>Cardiac surgery patient's anticoagulant not stopped day prior to surgery</td>
<td>New alert to Pharmacy when pre-op cardiac surgery orders are processed and active therapeutic anti-coag meds are on the patient's profile</td>
<td>CC</td>
</tr>
<tr>
<td>Mar-11</td>
<td>Bedside nurse concerned about potential patient ID errors involving H&amp;P reports</td>
<td>Patient's date of birth added to dictated H&amp;P reports as a second patient identifier</td>
<td>CC</td>
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<tr>
<td>Mar-11</td>
<td>Suicide risk patient found in possession of items that could be used for self-harm</td>
<td>New &quot;SEC-Search and/or Seizure...&quot; policy implemented</td>
<td>CC/WC</td>
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<tr>
<td>Mar-11</td>
<td>NICU infant given wrong medication</td>
<td>Perinatologists now order &quot;multivitamin&quot; instead of &quot;polyvisol&quot; and new independent double check of ICN orders in pharmacy</td>
<td>WC</td>
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<tr>
<td>Mar-11</td>
<td>Patterns of daily IV banana bags being missed</td>
<td>A banana bag reminder line was created in Care Manager to remind RNs to hang IV banana bags at 2000 each night</td>
<td>WC</td>
</tr>
<tr>
<td>Mar-11</td>
<td>ISMP reported errors where nimodipine liquid was accidentally given IV, leading to patient harm (If patient is unable to tolerate oral capsule, RN would extract liquid to administer, which is unsafe for patients and nurses)</td>
<td>Pharmacy started preparing nimodipine liquid in oral syringes with appropriate labeling</td>
<td>WC</td>
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<tr>
<td>Apr-11</td>
<td>It takes too long to enter a medication Related Patient Safety Alert/RDE in Midas</td>
<td>Midas medication event form fields reduced by 60%</td>
<td>CC/WC</td>
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<td>Apr-11</td>
<td>Patient transferred from WC to CC without needed records</td>
<td>&quot;Acute to Acute Facility Transfer&quot; form revised to embed essential components in checklist fashion</td>
<td>CC/WC</td>
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<tr>
<td>May-11</td>
<td>Patient attempted suicide while under our care</td>
<td>New suicide prevention precautions &amp; staff education implemented</td>
<td>CC/WC</td>
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<tr>
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<tr>
<td>May-11</td>
<td>Concern about potential for tubing misconnections</td>
<td>New tubing safety policy &amp; staff education implemented and risk assessment done</td>
<td>CC/WC</td>
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<tr>
<td>May-11</td>
<td>Unit RNs unaware of post-op care for a patient undergoing a new operative procedure</td>
<td>New approval/preparation process for new procedures implemented to assure adequate staff education occurs prior to caring for patients</td>
<td>CC/WC</td>
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<tr>
<td>Jun-11</td>
<td>Seriously ill patient inappropriately admitted directly to inpatient unit</td>
<td>New direct admit screening tool/process implemented to assure seriously ill patients are seen in ED prior to admission</td>
<td>CC/WC</td>
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<tr>
<td>Jul-11</td>
<td>Patient received Precedex at the incorrect bolus rate</td>
<td>New Precedex sheet guides RNs to appropriate dosing of Precedex using Smart Pump</td>
<td>WC</td>
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<tr>
<td>Jul-11</td>
<td>ED patient given wrong dose of reconstituted Ampicillin</td>
<td>HMM med label with instructions now sent along with medications from pharmacy to ED</td>
<td>WC</td>
</tr>
<tr>
<td>May-11</td>
<td>Pediatric patient received subtherapeutic dose of Oxacillin</td>
<td>New second pharmacist double check for pediatric orders implemented</td>
<td>WC</td>
</tr>
<tr>
<td>May-11</td>
<td>Nurse Practice Council recommendation about Nicotine transdermal patch</td>
<td>New Nicotine transdermal patch removal reminder entry on MAR for either daily 0900 or 2100</td>
<td>CC</td>
</tr>
<tr>
<td>Jun-11</td>
<td>Post-operative PCI patient did not receive Plavix</td>
<td>New alerts established within Pharmacy, including the Vigilanz system and an order entry reminder</td>
<td>CC/WC</td>
</tr>
<tr>
<td>Jul-11</td>
<td>Patient received the wrong chemotherapy drug</td>
<td>New second pharmacist independent double check for chemo drugs implemented</td>
<td>CC/WC</td>
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<tr>
<td>Jul-11</td>
<td>Not enough emergency supplies for patients with difficult airways</td>
<td>New difficult airway cart was created and placed into service by Respiratory Therapy</td>
<td>WC</td>
</tr>
<tr>
<td>Jul-11</td>
<td>Patient with &quot;NPO&quot; status received PO medication in error</td>
<td>Adopted new standard definition for &quot;NPO&quot; and educated JMH staff and physicians</td>
<td>CC/WC</td>
</tr>
<tr>
<td>Jul-11</td>
<td>It takes too long to enter a fall-related Patient Safety Alert/RDE in Midas</td>
<td>Midas falls event form fields reduced by 47%</td>
<td>CC/WC</td>
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<td>Jul-11</td>
<td>Patient who fell did not receive a comprehensive post fall assessment</td>
<td>New post fall assessment/intervention screen added to Meditech to guide post fall actions by RN</td>
<td>CC</td>
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<tr>
<td>Jul-11</td>
<td>OB hemorrhage case revealed opportunities for improvement</td>
<td>OB hemorrhage simulation training provided for physicians and nurses</td>
<td>WC</td>
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<tr>
<td>Aug-11</td>
<td>Multiple med errors involving look-alike/sound-alike medications Bactrian and backtracking</td>
<td>New alert added to prompt pharmacist to double check entry</td>
<td>WC</td>
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<tr>
<td>Aug-11</td>
<td>Patterns of med errors involving infusions which may have been prevented with use of drug library</td>
<td>Infusion pump library was streamlined with cross campus standardization</td>
<td>CC/WC</td>
</tr>
<tr>
<td>Aug-11</td>
<td>Patient given am dose of Lovenox which was not Physician's intent when DC order was written</td>
<td>New policy that meds discontinued on a specified date will be implemented on that day at 00:01</td>
<td>CC/WC</td>
</tr>
<tr>
<td>Sep-11</td>
<td>Physician concern that Pancuronium vials in L&amp;D anesthesia trays look like Oxytocin vials</td>
<td>Pancuronium vials removed from anesthesia trays</td>
<td>WC</td>
</tr>
<tr>
<td>Sep-11</td>
<td>Patient received Heparin even though order was to d/c when INR&gt;2</td>
<td>New &quot;rule&quot; added to VigiLanz system to alert Pharmacy</td>
<td>CC/WC</td>
</tr>
<tr>
<td>Sep-11</td>
<td>Current fall risk assessment tool may not effectively distinguish fall risk patients</td>
<td>Pilot of new Johns Hopkins' fall risk assessment tool began</td>
<td>CC</td>
</tr>
<tr>
<td>Sep-11</td>
<td>Preventable patient fall in Cath Lab</td>
<td>New fall prevention policy and staff education provided for Cath Lab</td>
<td>CC/WC</td>
</tr>
<tr>
<td>Oct-11</td>
<td>NICU infant given wrong vaccine</td>
<td>New newborn vaccine order sheet implemented</td>
<td>WC</td>
</tr>
<tr>
<td>Oct-11</td>
<td>Coumadin patient received IM injection and developed a hematoma</td>
<td>New alert added to Allscripts to warn against administering IM injection to patients with INR&gt;3.</td>
<td>CC/WC</td>
</tr>
<tr>
<td>Oct-11</td>
<td>Concerns about time consuming event reporting process</td>
<td>Midas Patient Safety Alert/RDE fields reduced on 18 forms by 39% overall</td>
<td>CC/WC</td>
</tr>
<tr>
<td>Oct-11</td>
<td>Phone &amp; computer outage event caused communication breakdowns contributing to delays in patient care</td>
<td>Code triage internal policy revised to include opening the command center for events involving significant phone and computer outages</td>
<td>CC/WC</td>
</tr>
<tr>
<td>Nov-11</td>
<td>Patient received excessive dose of Ativan</td>
<td>Alcohol Withdrawal form revised to read &quot;1 mg or 2 mg or 3 mg&quot; to prevent all three doses from being ordered</td>
<td>CC</td>
</tr>
<tr>
<td>Dec-11</td>
<td>Pediatric patient on non-peds unit almost received excessive dose of Vancomycin (a Great Catch)</td>
<td>New alert added to warn pharmacist when a pediatric patient is in a unit other than pediatrics</td>
<td>WC</td>
</tr>
<tr>
<td>Dec-11</td>
<td>Lipid not resumed on a TPN patient when Propofol was discontinued</td>
<td>New alert added to warn pharmacist to consider resuming Intralipid when Propofol is discontinued.</td>
<td>CC</td>
</tr>
</tbody>
</table>
The John Muir Health Great Catch Program, sponsored by the Quality Management Department, recognizes individuals who demonstrate commitment to our culture of patient safety. The award program honors employees, medical staff and volunteers who intercept an error before it reaches a patient and those who take extraordinary action to protect a patient or visitor from a potentially unsafe situation. Not merely an award recognizing clinical excellence, the Great Catch award celebrates instances of individuals recognizing an adverse event in the making and intervening to protect a patient or visitor.

Great Catch Awards are available on the Intranet at:

Cross Campus Depts ➔ Quality Management ➔ Patient Safety/Risk Mgt ➔ Great Catch Awards
Great Catch - Quarter 1, 2011

Concord: A3 (Medical Oncology)

We proudly recognize Colleen Mazzuca, RN for helping to save the life of a choking patient on A3 (Medical Oncology). Colleen had just given report on her patients and was going off duty, when her inner voice told her to check on her elderly patient. She walked to the door of his room and saw that he was unconscious. She rapidly determined that he was pulseless, called a code blue, and started CPR. The code blue team extracted a piece of steak from the patient’s airway and resuscitated him. He was later discharged with no neurological injury from the near-death experience. We commend Colleen for heeding her gut feeling and making this lifesaving great catch!

Walnut Creek: Pre-Admission Clinic

A patient arrived in the Pre-Admission Clinic for her pre-operative work-up for total hip surgery. An EKG was performed which showed atrial fibrillation with rapid ventricular response (basically, an irregular heartbeat). Sue Neugold reviewed two prior studies, an EKG and a Stress Test, both of which showed normal sinus rhythms. She knew something wasn’t right and conferred with a colleague, Susie Potter, and requested a STAT reading by a Cardiologist. Upon reading the EKG, the Cardiologist recommended the patient be immediately evaluated in the ED, where the patient was found to have a large clot in her leg.

The patient was taken to Angio, placed on Heparin and sent to CCU. By recognizing the atrial fibrillation and acting on her findings, Sue Neugold very likely saved this patient’s leg if not her life.
Concord: Ultrasound

Karen Connolly, clinical coordinator in ultrasound, is the recipient of Concord’s Great Catch Award for the second quarter of 2011. Karen received an order for a repeat abdominal ultrasound, which surprised her, since patients don’t normally need more than one. She called and got a copy of the physician’s order and realized that it was ambiguous. She checked the patient’s record and surmised that the physician probably meant to repeat the pelvic ultrasound. She called to discuss with the patient’s nurse, and when that didn’t work, she contacted the charge nurse, who ultimately clarified the order with the physician and the patient received the study she needed the first time. Had Karen not taken this extra step, the patient would have received an unnecessary test, causing a delay in the actual test the patient required to diagnose her condition.

Walnut Creek: Emergency Department

A 91 y/o female presented to the ED accompanied by her daughter. Her symptoms included fever and weakness on and off over the previous four days. The patient suffered from some dementia. Neither mentioned any other complaints of pain. She was seen by the ED physician and admitted by the hospitalist for further work-up including concern over possible UTI. During initial assessment, Lillian Maina, the bedside nurse and recipient of the second quarter Great Catch Award, repositioned the patient and noticed that one leg seemed to be shorter than the other and her left hip appeared misaligned and swollen. Lillian called the doctor who ordered a CT of the hip, revealing a fracture. Later, the daughter said her mother had fallen at home but did not mention it to either physician. The patient had surgery to stabilize the fracture. Lillian is to be commended for her attention to detail during her assessment and follow through by calling the physician.
Concord: Cardiac Cath Lab

We proudly recognize nurses Patty Stockton and Patty Watson for preventing an invasive procedure on a patient who was anticoagulated. The patient’s physician had ordered that her Lovenox be held, and the floor nurse sent the patient to Special Procedures with the report that the patient had not received Lovenox that morning. These two nurses, however, did not rely upon the verbal report alone, but also checked the MAR and found documentation that the patient had received a dose of Lovenox that morning. The procedure was postponed and a potentially serious bleeding event was prevented by these two nurses taking personal responsibility for the safety of their patient.

Walnut Creek: 3N Staff

Prompt and thorough action by Ahdia Herawi, 3 North RN, possibly saved a patient’s life and, for that, she is deserving of the Great Catch award. Ahdia received a call from the Telemetry Tech that her elderly oncology patient was in A-Flutter. She quickly assessed the patient and recognized a change in her condition and she immediately called the cardiologist and oncologist to report her findings. The cardiologist ordered a STAT echocardiogram which showed she was positive for cardiac tamponade (when blood or fluid builds up in areas around the heart). Within the hour, the patient was taken to the OR for emergency cardiovascular thoracic surgery. She recovered and was eventually discharged. Had it not been for a thorough assessment and follow-up communication with the physicians, this patient may not have survived. JMH is very proud to recognize Ahdia for her outstanding attention to this patient.
Concord Float Pool

We are proud to present the great catch award for Q4 2011 to float pool nurse Tanya Earls. Tanya had accompanied a patient to MRI, where he received an injection of contrast media. Tanya stood by to watch for signs of allergic reaction, correctly interpreted ambiguous signs that the patient was developing distress, and spoke up to stop the MRI and pull the patient out for assessment. She called a code blue and the patient was rescued from a severe anaphylactic reaction.

Along with other members of the treatment team, Tanya also made helpful recommendations at the subsequent Intense Analysis meeting to improve our capacity to respond rapidly to allergic reactions in MRI and Medical Imaging.

Walnut Creek, Hyperbaric Oxygen Therapy

WC is proud to present the Great Catch Award for Q4 2011 to Quyen Lam, RN and Maria Castillo, RN who together, prevented a potentially catastrophic event involving a patient undergoing Hyperbaric Oxygen Therapy. During the intake process, a patient failed to mention that he had an implanted medical device. When this was discovered after his treatment, nurse Quyen immediately informed of her Director and other staff in the department. During a subsequent treatment a few days later, the patient again failed to disclose the device Nurse Castillo, who remembered the first incident, did a pat down and discovered the pump and removed it before he received his treatment. The collaboration and communication among Hyperbaric staff epitomizes these two nurses’ commitment to safety.
Great Catch Honor Roll

Thank you to these 40 Walnut Creek Campus employees who intercepted an error or problem and reported it – you improved patient safety!

- Zenaida Cabrales
- Daphne Bocaling
- Nicole Herrera

- Andrew Stewart

- Valerie Briscoe

- Unjoo Lee
- Ahdia Herawi

- Zenaida Cabrales

- Paula Werne

- Harry Moreno

- Andrew Stewart
- Daphne Bocaling

- Corrine Coder
- Karen Kremesec
- Zenaida Cabrales

- Teresa Wyeth
- Adrienne Peters
- Christina Mashore

- Deborah Parnoff

- Sheri Prater

- Randi Conners
- Barbara Rubrecht
- Nicole Herrera
- Laura Loving

- Rebecca Musgrove

- Quyen Lam
- Maria Castillo

- Sarka Johnova

- Heidi Mayer

- Marcy Dixon

- Susan Obayashi
- Amy Chiu

- Sue Neugold
- Lisa Vencill

- Kevin Rautenstrauch
- Jessica Medsger

- Ma.Adelfa Bollozos
- Kimberly DeVeria
- Mira Patel
- Yolanda Ramirez
Great Catch Honor Roll
Thank you to these 47 Concord Campus employees who intercepted an error or problem and reported it – you improved patient safety!

A3
- Kimberly Aguirre
- Stella Ho
- Barbara Leone

A3E
- Colleen Mazzuca
- Diane Stauffer
- Sussan Kotsos
- Daphne Burman
- Catherine Masajo

B4
- Dawn Della Camera
- Hiroko Arfaa
- Jod’L Cruz

B6
- Elena Malecdan
- Arlene Thigpen

Biomed
- Ken Conser

Cath Lab
- Patricia Stockton
- Patricia Watson

CCU
- Elizabeth Yared
- Jodi Moss
- Lori Smith
- Christine Morata

E3 & A3W
- Terrie Baltzell-Ewald
- Heather Moore-Diaz
- Jordan Wright
- Myra Torres
- Chezette Reilly
- Melissa Winger
- Kendra Khouri
- Merissa Auguston

Float Pool
- Cheryl Gremban
- Tanya Earls

Medical Staff
- Ramesh Veeragandham
- William Hoddick

Medical Imaging
- Karen Connolly

NIC
- Barbara Craft

Pharmacy
- Francine Josephson
- Steve Gomez
- Teresa Halperin

Security
- John Enomoto
- Tim Sickler

SSU
- Diane Church
- Judy Donahue
- Birgitte Young
- Joy Moore
- Ruth Stankowski

Surgery
- Cheryl McDermott
- Sarah Keller

Transporter
- George NnaNna
Patient Stories
Published in 2011 & 2010

Patient Stories Publications are available on the Intranet at:
Cross Campus Depts → Quality Management → Patient Safety/Risk Mgt → Patient Stories
One Patient’s Story
The Case of the Disconnected Bed Exit Alarm
Issue 27 January 2011

SUMMARY OF EVENT

- An elderly patient was on fall precautions for dementia and impulsiveness.
- The patient was found seated on the floor beside her bed; her rectal tube and IV had been pulled out when she fell to the floor while trying to climb out of bed.
- During the fall huddle immediately afterward, it was discovered that there was no bed exit alarm sensor in the patient’s bed.

WHY DID THIS EVENT HAPPEN?

- The bed exit alarm was plugged into the wall so caregivers assumed this meant the alarm was turned on correctly.
- Nobody checked to confirm that the connections were correct and the alarm was turned on.

HOW YOU CAN PREVENT THIS

- When you assume care for a patient, always check to confirm that lines, tubes, and cables are in place and connected appropriately.
- Keeping patients safe is the responsibility of all staff at the bedside – be sure to check, on a frequent basis, that bed alarms are set properly.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

- Advocate for patient safety! Speak up if a safety procedure is not being followed
- Document events that pose a risk to patient safety or cause harm as a MIDAS Patient Safety Alert/RDE -- if warranted, notify your supervisor and Risk Manager.
- For general [not case specific] safety concerns, submit a “Culture of Safety Report” available through the Quality Management intranet page.

The story presented above is an example of patient safety events occurring in hospitals across the country. As a “learning organization,” telling these stories and sharing with all staff is intended to educate and generate dialogue among front line caregivers, who may be able to prevent a similar occurrence.

John Muir Health Quality Management Department
Stephanie Bailey, Director, Accreditation/Patient Safety, Cross Campus (x22372)
Marlowe Flora, Risk Manager, Walnut Creek (x35036) | Jonathan Stewart, Risk Manager, Concord (x22027)
Cathy Werner, Risk Manager, John Muir Physician Network (x32028)
One Patient’s Story
The Case of the Missed Medication Patch
Issue 28 February 2011

SUMMARY OF EVENT

- A patient was seen in the Emergency Department for congestive heart failure. A nitroglycerine (NTG) patch, which can lower the patient’s blood pressure and help manage the symptoms, was applied to the patient’s chest.
- The patient was admitted to a medical unit. After shift change, the patient began to develop dangerously low blood pressure.
- Fluid was given to the patient to raise the blood pressure; it was unsuccessful. The patient was transferred to Critical Care.
- During her initial patient assessment, the Critical Care nurse found the NTG patch on the patient and removed it. The patient’s blood pressure soon returned to normal.

WHY DID THIS EVENT HAPPEN?

- The medical unit nurse either was unaware of the presence of the NTG patch or underestimated how profoundly the NTG patch could lower blood pressure.

HOW YOU CAN PREVENT THIS

- Perform a quick skin inspection, check the medication administration record to see if a patch has been applied and ask the patient if they have a patch on prior to applying a new patch.
- Communicate medications given during handoffs.
- If your patient develops hypotension, remember to check for transdermal nitroglycerine or opioid patches.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

- Advocate for patient safety! Speak up if a safety procedure is not being followed
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SUMMARY OF EVENT

- A patient was admitted for surgery. She developed rapid atrial fibrillation/flutter, requiring treatment.
- A diltiazem drip was ordered and started to keep the patient’s heart rate under 100.
- The patient’s heart rate remained unchanged, despite the medication infusion.
- An hour after change of shift, the oncoming nurse found the patient’s sheets soaked with diltiazem; the IV was not connected to the patient but was under her pillow, infusing into the bedding.

WHY DID THIS EVENT HAPPEN?

- Nursing staff failed to connect the IV luer connection to the patient’s IV hub.
- The IV connection was not reassessed, even though the medication infusion was not having the expected effect.

HOW YOU CAN PREVENT THIS

- Always trace a tube or catheter from the patient to the point of origin before connecting any new device or infusion.
- Before initiating an infusion, check your lines to make sure they are securely connected to the right ports.
- If an IV medication infusion is not having the expected effect, quickly re-check your tubing connections.
- When assuming care of a patient, re-check connections and trace all patient tubes and catheters to their sources. This applies to new admissions, transfers (including transfers from other hospitals) and shift-to-shift handoff.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

- Advocate for patient safety! Speak up if a safety procedure is not being followed.
- Document events that pose a risk to patient safety or cause harm as a MIDAS Patient Safety Alert/RDE – if warranted, notify your supervisor and Risk Manager.
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One Patient’s Story
The Case of the Patient Tumble
Issue 30 April 2011

SUMMARY OF EVENT

- An elderly patient was on fall precautions for altered mental status, history of falls, and decreased mobility.
- The patient needed to use the bedside commode – so staff assisted him onto the commode.
- The staff member’s phone rang regarding another patient who needed help.
- The patient’s wife, who was in attendance, said she would stay with her husband.
- The staff told the patient and wife to call if they needed any help and to call before attempting to get up.
- The patient got up on his own, slipped and fell.

HOW YOU CAN PREVENT THIS

- Never leave a patient who is on fall precautions – even if a family member or the patient says it’s okay to do so.
- Staff should always stay within arm’s reach of a patient who is on fall precautions.
- If another patient calls for help while you are attending to a fall risk patient, ask another staff member to assist.
- Remember the importance of education to patients and families about risk of falls in the hospital and the unfamiliar surroundings which is why staff always stays with the patient.

WHY DID THIS EVENT HAPPEN?

- Staff left a fall risk patient to assist another patient.
- Staff may have assumed that having the wife by his side would prevent a fall.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

- Advocate for patient safety! Speak up if a safety procedure is not being followed
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Cathy Werner, Risk Manager, John Muir Physician Network (x32028)
One Patient’s Story
The Case of the Missing Interpreter
Issue 31 May 2011

SUMMARY OF EVENT

- A non-English speaking patient presented with chest pain to the ED. While in the ED a family member served as interpreter.
- The patient was admitted to the hospital for cardiac workup. The physician documented in his H&P that the patient was non-English speaking.
- Nursing documented the need for an interpreter.
- On day 2 of the patient’s admission, the patient signed an informed consent written in English without an interpreter’s assistance.
- The patient’s daughter arrived at the hospital on the day of the test only to find that the test had been stopped as the patient had become combative during the test because he was frightened.
- The daughter was able to calm him down in his preferred language.

WHY DID THIS EVENT HAPPEN?

- Staff assumed the patient could read and understand English [because they heard the patient speak in English] and did not use an interpreter.
- The patient may not have understood the test he “consented” to leading to the combative behavior.

HOW YOU CAN PREVENT THIS

- Remember that patients have the right to qualified interpreters so they understand tests and procedures as part of the informed consent process. Family members should not be used as interpreters for informed consent and other activities where interpreters are mandated.
- Facilitate use of an interpreter for non-English speaking patients—use phone interpreters or Qualified Employee interpreters (for Spanish speaking patients).
- Don’t assume that a patient can read and understand English if they are able to converse in English.
- Remember that interpreters are provided at no cost to patients and are available 24/7.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

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SUMMARY OF EVENT

- A patient presented to the Emergency Department and underwent an appendectomy that night.
- The surgeon typed out post-op orders that included an order for post-discharge pain medication.
- The next morning, oncoming day nurse understood the night nurse to have said during handoff that the patient was to be discharged that day.
- The day nurse prepared the patient’s discharge, even calling the surgeon to complete the discharge medication reconciliation.
- When the surgeon arrived that afternoon to round on his patient, he was surprised that the patient had been discharged, less than 24 hours post-op, since he had not written a discharge order.
- The patient returned to the hospital that evening and was readmitted with abdominal pain and fever.

WHY DID THIS EVENT HAPPEN?

- There were two similar patients of the same surgeon on the unit, one of whom did have a discharge order; the night nurse and/or the discharging nurse may have confused the two.
- The discharging nurse did not check to confirm that there was a physician order to discharge in the patient’s medical record.

HOW YOU CAN PREVENT THIS

- Don’t rely solely on what you [think you] hear in handoff report; Repeat what you hear to confirm you have the correct information.
- Before discharging a patient, always verify that there is a physician order to do so.

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SUMMARY OF EVENT

- A physician order for an ultrasound was written as “u/s in am F/U from one in ER. Any change.”
- The unit secretary entered the order as an abdominal ultrasound to follow up on the one done in the emergency department two days earlier.
- The ultrasound technologist recognized that it is uncommon to repeat an abdominal ultrasound so quickly and obtained a copy of the physician’s order. She saw that the order did not specify what part of the body was to be studied.
- The tech checked the patient’s record and saw that she’d also had a pelvic ultrasound so she called the patient’s nurse to seek clarification.
- The nurse was reluctant to call the physician for clarification, so the technologist spoke to the charge nurse. The charge nurse was also reluctant, but did call the physician to clarify.
- An order for a pelvic ultrasound, which is what the physician intended, was obtained. The study found that her condition was worsening and the doctor recommended surgery.

WHY DID THIS EVENT HAPPEN?

- An ambiguous order was not clarified; instead an (incorrect) guess was made as to what the physician intended.

HOW YOU CAN PREVENT THIS

- If you receive an ambiguous or unclear physician order, contact the physician to clarify.
- Be mindful that incorrectly interpreting orders can result in necessary tests or treatments being delayed and the patient receiving unnecessary and potentially harmful tests or treatments instead.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

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SUMMARY OF EVENT

- A Coumadin patient with chronic pain presented to the Emergency Department for treatment for his pain.
- The physician ordered an intramuscular (IM) injection of Dilaudid, which the nurse administered in the patient’s gluteus.
- The patient later developed a hematoma, requiring hospital admission for management of the associated pain.

WHY DID THIS EVENT HAPPEN?

- Although the patient’s PT/INR had been checked and found to be elevated, neither the physician nor the nurse considered the risks of giving an IM injection to this anticoagulated patient.
- Because this patient was being seen in the Emergency Department, no pharmacist review of the order took place.

HOW YOU CAN PREVENT THIS

- If your patient is on any anticoagulant therapy or prophylaxis, don’t assume that a physician who has ordered an IM injection has taken the patient’s anticoagulation status into account – confirm that the physician is aware.
- Withhold IM injections in patients who are receiving intravenous anticoagulants (such as Heparin) and work with the ordering physician and Pharmacy to choose an alternate route.
- Pharmacy recommends not giving IM injections to patients with INR >3.0.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

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One Patient’s Story
The Case of the Double Dose
Issue 35 September 2011

SUMMARY OF EVENT

- A patient had an appropriate order for Dilaudid 1-2mg IV every four hours PRN for severe pain.
- At 1800, Nurse A administered a 2mg dose and documented it in the eMAR.
- At 1915, the patient was still complaining of 10/10 pain and requesting additional Dilaudid. Nurse B gave another PRN dose.
- When she logged on to the eMAR to document her medication administration, Nurse B realized she had given the dose early.

WHY DID THIS EVENT HAPPEN?

- Nurse B gave a PRN dose without checking the eMAR to see when the last dose was given.
- The patient was verbally abusive and threatening, placing significant pressure on the nursing staff to give him additional Dilaudid.

HOW YOU CAN PREVENT THIS

- Check the eMAR before giving a PRN medication to make sure you are not giving it before the next dose is permitted.
- If a patient is not getting adequate pain relief from the analgesic regimen ordered, contact the physician to discuss alternatives.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

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SUMMARY OF EVENT

- The patient’s nurse left the unit to attend a meeting.
- Before leaving, she informed the Charge Nurse and left her phone at the nurse’s station.
- The Charge Nurse answered a call light for one of the patients assigned to the nurse who left.
- The Charge nurse and the CNA placed the patient, who was a fall risk, on a commode and left the patient alone.
- When the patient was finished, she called the phone number for her nurse but no one answered. Then the patient she then called the number for the CNA but no one answered.
- She finally used her call light and someone responded. Thankfully, this patient didn’t try to return to bed on her own.
- The nurse’s phone was inadvertently in the “off” mode.

HOW YOU CAN PREVENT THIS

- Never leave a patient who is at risk for falling alone – remember that fall risk patients must be in arms reach when toileting.
- Hand off your phone to the covering RN [don’t just leave it at a nursing station].
- Before leaving the unit, RNs should communicate with the assigned CNA.
- Double check that portable phones are properly assigned to the correct patient rooms and are “on”.
- Remember to look for alerts (i.e. colored wrist bands and signage) when caring for patients.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

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One Patient’s Story
The Case of the Expired Home Medication
Issue 37 November 2011

SUMMARY OF EVENT

- The patient being admitted in October 2011 takes multiple anti-retroviral medications at home.
- One of the injectable anti-retroviral medications is not available from our Pharmacy and so the patient was asked to bring in her home supply.
- The home medication is sent to the pharmacy for review and labeling for administration during the hospital stay.
- The patient received three subcutaneous injections of the home anti-retroviral medication administered by two different RNs.
- Prior to the administration of the 4th dose, the RN noted the original packaging expiration date of 10/2010. It was confirmed that all 48 vials of medication in the box were expired.
- The patient admitted she knew it was expired, but someone said it was okay to use anyway.

WHY DID THIS EVENT HAPPEN?

- Pharmacy staff who reviewed the home medication didn’t catch that the product was expired.
- The two RNs who administered the 3 doses didn’t check the expiration before administration.

HOW YOU CAN PREVENT THIS

- Pharmacy to check the integrity of the product, including expiration date when processing patient’s own meds for inpatient use.
- RNs to check the integrity of medications, including original packaging expiration dates, prior to administering medications.
- Don’t assume that patient’s own home meds have been correctly labeled by Pharmacy – always double check.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

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SUMMARY OF EVENT

- A patient with multiple pulmonary emboli was being treated in the ED; decision made to admit the patient.
- The ED physician ordered Heparin infusion.
- The admitting hospitalist saw the patient in the ED and ordered Lovenox and Coumadin.
- Heparin, Lovenox, and Coumadin orders were scanned to the Pharmacy.
- The scanned orders were received and reviewed by different pharmacists.
- The patient’s nurse administered the Heparin.
- The same nurse administered the Lovenox and the Coumadin.
- Pharmacy discovered the duplicate orders and contacted a physician who gave an order to discontinue the Lovenox and continue the Heparin.

- The bedside nurse was unaware that Lovenox and Heparin together would over anti-coagulate the patient.

HOW YOU CAN PREVENT THIS

- Nurses should familiarize themselves with anti-coagulant medications and be aware of potential duplicate therapies.
- Nurses should clarify orders for multiple anti-coagulants with the physician and/or pharmacy.
- Physicians should always review any orders previously written by other physician(s) caring for the patient to guard against duplication or conflicting orders.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

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SUMMARY OF EVENT

- Patient A is being treated for uncontrolled atrial fibrillation. While the patient’s primary nurse is on break, the physician orders Digoxin 0.5mg IV.
- The break relief nurse administers the Digoxin but before s/he can chart it, the relief nurse is called away to attend to Patient B in another room.
- The primary nurse returns from break and sees the order for Digoxin. Since the relief nurse is busy with another patient, the primary nurse does not check with the relief nurse before administering the Digoxin.
- As Patient A’s heart rate drops into the 30s, the primary nurse hears the relief nurse say from the next room, “Oh, I still need to chart the Digoxin I gave in there….”

WHY DID THIS EVENT HAPPEN?

- The relief nurse did not chart the medication administration right away (note: this unit was not using bedside medication barcode scanning).
- The primary nurse resumed patient care without receiving handoff from the relief nurse, assuming that the ordered medication had not been given.

HOW YOU CAN PREVENT THIS

- When handing off responsibility to a relief nurse, communicate both the key information about the patient and expectations about what the relief nurse will do while you’re on break.
- When receiving report as relief nurse, insist upon getting the critical information you need to provide safe care during the primary nurse’s break.
- When returning from break, get a report from the relief nurse before resuming patient care. Ask for:
  - Any changes in the patient’s condition
  - Any medications or treatments given
  - Any new orders received
  - Any other patient-specific information you need

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One Patient’s Story
The Case of the Incorrectly Adjusted Insulin
Issue 16 February 2010

SUMMARY OF EVENT
- An elderly patient with diabetes is admitted to an inpatient unit.
- Insulin Infusion orders for elevated blood sugar were started.
- Insulin infusion rate not adjusted according to protocol 5 times during a 24 hour period.
- Three episodes of hypoglycemia occurred during that 24 hour period.
- Hypoglycemia was not treated according to protocol on 2nd hypoglycemic episode.
- Insulin drip discontinued after 3rd hypoglycemic episode.

WHY DID THIS EVENT HAPPEN?
- Independent verification process by two RNs was not used to determine the correct infusion rate.
- Without verifying the correct infusion rate independently, the two RNs did not utilize a safe process to confirm the protocol was being followed correctly. Had this independent verification been used accurately, this would have resulted in a “great catch” rather than a hypoglycemic event and patient safety risk.

HOW YOU CAN PREVENT THIS
- 1st RN reviews protocol and determines infusion rate.
- 2nd RN reviews protocol independently from the 1st RN and determines the infusion rate.
- Both RNs compare results to ensure accuracy.
- If results do not match through independent verification process, both RNs must separately re-evaluate and recheck results.

1st RN reviews protocol and determines infusion rate.
2nd RN reviews protocol independently from the 1st RN and determines the infusion rate.
Both RNs compare results to ensure accuracy.
If results do not match through independent verification process, both RNs must separately re-evaluate and recheck results.

Any variation from the preprinted order or physician order requires a new physician order.

Nursing judgment may not be substituted for the Insulin Protocol

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY
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One Patient’s Story
The Case of the Misused Range Order
Issue 17 March 2010

SUMMARY OF EVENT
- A physician ordered “Dilaudid 1-2 mg IV PRN for severe pain and Vicodin 1-2 tabs for moderate pain.”
- The patient reported his pain as a 6 out of 10 and the nurse documented this pain level.
- The nurse gave the patient Dilaudid 2 mg IV because the patient was grimacing and requesting pain medication.
- When the nurse returned to check on the patient 10 minutes later, the patient was not breathing and required resuscitation.

WHY DID THIS EVENT HAPPEN?
- The reported pain rating of 6 is moderate pain – the correct medication based on the order is Vicodin 1 mg.
- The nurse chose to start with the maximum dose of Dilaudid, which overwhelmed the patient despite his pain and caused respiratory arrest.
- The patient was opiate naïve.
- The patient was not closely monitored after administration of Dilaudid.

HOW YOU CAN PREVENT THIS
- Remember that everything must match: the order, the assessment findings, the documentation and the choice of medication and dose.
- When a range order is given, dosing must start at lower end and titrate up based on patient response in specified increments.
- For opiate naïve patients, recommended starting dose of Dilaudid IV is no more than 0.5 mg IV q2h PRN for pain. Note:
  - An opiate naïve patient is one who has been taking <60 mg/day of oral morphine – or the equivalent – for <7 consecutive days.
  - Dilaudid 2 mg IV given above equals morphine 13 mg IV.
- Whenever possible, the existence and intensity of pain is measured by the patient’s self report. Behavior is observed to assess pain only in the absence of self-report. For specific patient populations, an age appropriate behavioral assessment tool may be used to determine the presence of pain. Be sure to document which tool was used.
- Never combine two pain scales – Believe the patient’s self report.
- Monitor opiate naïve patients closely after parenteral administration of opiates.

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27
One Patient’s Story
The Case of the Double Dose of Heparin

Issue 18 April 2010

SUMMARY OF EVENT

- A dialyzed patient was admitted and a physician wrote an initial order for Heparin 5000 units BID.
- The same physician completed a standardized order form and wrote 5000 units Heparin TID.
- Pharmacy entered both orders on to the patient’s drug profile.
- The nurse who received the initial order gave one dose and addressed the other dose as not given, but did not contact the Pharmacy.
- The information on the MAR revealed that the patient should have received 5000 units at 2100 and 5000 units at 2200.
- The night nurse checked the MAR and gave both doses totaling 10,000 units.
- While the patient received double the intended dose, there was no harm to the patient.

WHY DID THIS EVENT HAPPEN?

- Physician wrote contradictory orders at the time of admission.
- Nurse did not clarify the initial orders with the doctor or Pharmacy.
- Pharmacy didn’t question the orders from the physician.
- The night nurse questioned the doses one right after the other but didn’t act on her concern.

HOW YOU CAN PREVENT THIS

- Always clarify orders when there is any uncertainty involving the order or any part of the order is incomplete. Do not assume that physicians don’t make mistakes when writing orders.
- Do not hesitate to question orders or processes when critical thinking leads you to be concerned.
- Slow down when you feel overwhelmed and take the time to question orders that do not appear to be correct.
- Do what you have been trained to do – delivery of safe patient care.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

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One Patient’s Story

The Case of the Incomplete Time Out

Issue 20 June 2010

SUMMARY OF EVENT

- A post-op patient arrived at the recovery area having just undergone a left side fistulogram.
- The nurse caring for the patient noticed that the paperwork associated with the surgical procedure all indicated right side fistulogram (surgery schedule, physician order, practitioner certification form, verification of consent form).
- Concerned about this discrepancy, the nurse contacted staff involved with the procedure. It was verified that the fistula was on the left side and the procedure was done on the left side so no harm came to the patient.
- When questioned about whether a time out was done, the procedure nurse said “yes, they confirmed that they were doing a fistulagram, but they did not discuss side.”

WHY DID THIS EVENT HAPPEN?

- Three safety steps in the surgical/invasive procedure process failed.
- During pre-procedure verification, the incorrect side was entered on the schedule and on consent forms.
- Side/Site marking was not done by the practitioner.
- The time out process did not include confirmation of the correct side/site.

HOW YOU CAN PREVENT THIS

- Double-checking the correct side/site must be done at the earliest stages, including scheduling the procedure.
- Side/Site marking should include verification against the consent form(s) as a double check.
- The time out process must include verifying the correct side/site. The time out is the last opportunity to catch a mistake.
- For complete Universal Protocol requirements, see JMH policy “PS-Universal Protocol for Surgical and Invasive Procedures.”

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

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Cathy Werner, Risk Manager, John Muir Physician Network (x32028)
SUMMARY OF EVENT

- An elderly patient was scheduled for surgery and was given the following printed instruction by a nurse in the surgeon's office: “Stop taking ASA/NSAID, blood thinner, and herbal medication for 10 days before surgery.”
- The patient continued to take Plavix until three days before the date of surgery.
- When the anesthesiologist called the patient the night before surgery to confirm she had not been taking blood thinners, she stated that she was not on blood thinners.
- Plavix was not listed on the H&P.
- Plavix was listed on the patient’s medication reconciliation form, but this was not viewed by the surgeon prior to surgery.
- The patient bled excessively during surgery.

WHY DID THIS EVENT HAPPEN?

- The anesthesiologist asked “are you taking any blood thinners?” instead of “what medications are you taking?”
- The patient was unaware that Plavix was a “blood thinner.”
- Plavix was not listed as a home med on the patient’s H&P; the surgeon was unaware that his patient was taking Plavix.
- The nurse who made the pre-op call noted that the patient had been taking Plavix and called the surgeon’s office but the message was not communicated to the surgeon.

HOW YOU CAN PREVENT THIS

- Promote health literacy! Take every opportunity to teach your patient about the medications they are taking, including the purpose of the medication being prescribed.
- Do not use abbreviations on written patient instructions.
- Redundant checks of home medications by multiple caregivers is a safe practice. It’s best to ask the patient to list their medications instead of or in addition to asking “are you taking a blood thinner?”
- Don’t assume that other members of the health care team – including physicians– know everything that they should about the patient’s status. When in doubt, confirm that physicians have the critical patient information they need to make decisions.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

- Advocate for patient safety! Speak up if a safety procedure is not being followed.
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**SUMMARY OF EVENT**
- A post-op patient was transferred from PACU to the nursing unit with a Foley in place.
- The float nurse received the patient and also picked up all her order sheets. Among the orders was an order to discontinue the Foley.
- The nurse questioned the appropriateness of the order and asked another nurse if discontinuing a Foley on a post op patient was common practice. Her colleague told her yes.
- The nurse went to the patient’s room to discontinue the Foley. The patient told the nurse that the doctor said the Foley would be in for a couple of days and asked that she check with the doctor.
- The nurse dismissed the patient’s concerns and discontinued the Foley.
- It turned out that the order to discontinue the Foley was actually for another patient on the unit.
- The error was not discovered until change of shift.
- The physician was contacted and the error disclosed to the family.
- The Foley was re-inserted.

**WHY DID THIS EVENT HAPPEN?**
- The nurse assumed that all the orders sheets she picked up were for the same patient.
- The nurse did not check the name on the order sheet with the name of the patient.
- When the nurse asked her colleague about the order, she did not mention that it was a fresh post-op patient.
- When the patient questioned the nurse about removal of the Foley and asked that her doctor be called, the nurse did not contact the physician.

**HOW YOU CAN PREVENT THIS**
- Always check the name at the bottom of the order sheet with the name of the patient - confirm you have the right patient.
- When picking up a collection of orders don’t assume they are all for the same patient.
- When asking for assistance from colleagues, be sure to provide all the pertinent facts/information – so you get an informed answer.
- If a patient questions the procedure you are about to perform because the patient was provided with other information, check with the doctor before proceeding.

**HOW YOU CAN SUPPORT THE CULTURE OF SAFETY**
- Advocate for patient safety! Speak up if a safety procedure is not being followed.
- Document events that pose a risk to patient safety or cause harm as a MIDAS Patient Safety Alert/RDE – if warranted, notify your supervisor and Risk Manager.
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SUMMARY OF EVENT

- On admission, the physician wrote an order for Lovenox 40 mg, which was different from the 110 mg dose that the patient took at home according to the Medical Record.
- Physician wrote an order to d/c Lovenox prior to a procedure.
- On the day of the procedure, Lovenox was not addressed in post procedure orders.
- Post op day #1, RN questioned the hospitalist, who asked the RN to obtain a Lovenox order from the cardiologist.
- RN left a note in the chart for cardiologist.
- Post-op day #2, cardiologist wrote an order to “resume Lovenox” without dose, route or timing parameters.
- A nurse called the Pharmacy to confirm the dose/frequency and the pharmacist said to check with the cardiologist. Lovenox resumed at 110 mg, based on the active home medication list.
- Post-op day #3 hospitalist changed Lovenox to 40 mg during the AM shift and the order with dose/frequency was scanned to the Pharmacy.
- At the shift change later that day the medication dosage information was not communicated nor was it changed on the med list (MAL/MAR).
- Patient was given Lovenox 110 mg on PM shift.
- Error discovered during NOC shift chart check.
- The doctor was notified of the error.

WHY DID THIS EVENT HAPPEN?

- No one questioned the difference between the home dose of Lovenox and what the doctor ordered on admission.
- MD failed to provide an appropriate order by writing “resume Lovenox” and RN should have called to clarify the dose and frequency upon seeing this order.
- The RN left a note on the chart for the cardiologist – the nurse should have notified the MD by phone and obtained a verbal order for Lovenox.
- Nurse did not note change on the Med list (MAL/MAR) when the doctor changed the Lovenox dosage to 40 mg.
- Pharmacy didn’t catch the order on multiple scans.

HOW YOU CAN PREVENT THIS

- Question orders that are inconsistent.
- Make sure any changes in medication order are noted in the MAL/MAR.
- Remember to communicate changes in medication during shift change/hand off.
- Talk to the physician instead attempting to communicate through a note in the chart when dealing with medication safety issues/concerns.
- MD order to “resume” a medication is not allowable. RN should call physician to clarify the dose and frequency of the med order.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

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SUMMARY OF EVENT

- A patient was brought to the Emergency Department by ambulance for a medical complaint. During transport, the paramedic started an IV in the patient’s left forearm.
- The ED staff noted that the patient arrived with an IV and after the patient was admitted, each shift documented its presence.
- By hospital day #2, the IV had been converted to a saline lock; no IV medications were ordered.
- On the morning of hospital day #3, the patient notified her nurse that her IV site was sore and itchy and asked her to remove it. The nurse did not examine the IV site, but merely told the patient that if she took it out she would have to put in another because the patient was on telemetry.
- By the time the patient was discharged on hospital day #4, the IV site was red, painful and swollen.
- The day after she was discharged, the patient was seen at an Urgent Care and diagnosed with Staph aureus cellulitis at her IV site, which required an expensive course of antibiotics and a painful recovery.

WHY DID THIS EVENT HAPPEN?

- The patient’s pre-hospital IV was not removed and replaced according to policy.
- The nurse dismissed the patient’s complaint of discomfort at her IV site and did not take responsibility for assessing and responding appropriately.

HOW YOU CAN PREVENT THIS

- Remove peripheral IVs that were started outside of JMH within 24 hours, the best practice as recommended by Infection Prevention.
- Be aware that pre-hospital IV insertion is a risk point because inadequate aseptic technique is more common outside the hospital setting.
- If a patient reports signs or symptoms of a healthcare-acquired infection, listen to them! Assess the area and take appropriate action.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

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One Patient’s Story
The Case of Unchecked Wristband

Issue 25 November 2010

SUMMARY OF EVENT

• An alert, oriented and communicative patient was registered for her hospital care.
• By mistake, she was banded with a different patient’s ID wristband.
• During her first nine hours in the hospital, she received medications, had blood drawn, provided a urine specimen, received a breathing treatment and a meal tray, underwent an x-ray, was examined by a consulting physician, and was transported off the unit.
• An alert employee at the receiving unit made a “Great Catch” by identifying the error.

WHY DID THIS EVENT HAPPEN?

• There were a total of 10 missed opportunities where a caregiver should have, but did not, use the patient’s ID wristband to verify the correct patient before providing care, treatment or services.
• There were a total of six different caregivers who assumed the patient’s ID wristband was correct.

HOW YOU CAN PREVENT THIS

• When applying an ID wristband, confirm that you are banding the correct patient. Ask the patient or family member (if patient unable to respond) to state their name and birth date and verify the information with the name and birth date on the wristband. Only after these two positive identifications have been made should the wristband be applied.
• The two approved identifiers for patients with an ID wristband are name and medical record number or account number (not date of birth). Check the wristband for this information before giving medication, blood, treatments, or food; before drawing blood or taking any other specimen; and before transferring the patient to another area of the hospital.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

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One Patient’s Story
The Case of Misprogrammed Pump
Issue 26 December 2010

SUMMARY OF EVENT

- New physician order written to start a Heparin drip at 1250 units/hr IV.
- The first bag was hung by the administering RN with “verification” by a second RN.
- About six hours later, the administering RN checked the patient chart at the same time the APTT was drawn and noticed that the pump was actually programmed at a rate of 2250 units/hr.
- The RN took immediate corrective action.
- Charge RN called the physician and the patient’s family was notified of the error.

WHY DID THIS EVENT HAPPEN?

- The nurse programming the pump did not verify the pump setting against the original physician order.
- The nurse verifying the pump settings did not compare the programmed pump against the actual physician order during the verification process.

HOW YOU CAN PREVENT THIS

- Follow the JMWC policy “MM-Transcribing Medication Orders,” which requires that any NEW medication order obtained while in acute care be verified against the original written MD order prior to first administration dose.
- Follow the JMWC policy “MM-High Alert Medications,” which requires a minimal double check of a copy of the MD’s order or MAL list and the 5 rights of medication administration.

HOW YOU CAN SUPPORT THE CULTURE OF SAFETY

- Advocate for patient safety! Speak up if a safety procedure is not being followed.
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Each month a Patient Safety Newsletter is published with articles and information about patient safety-related topics. Some of the more noteworthy articles from 2011 were compiled for inclusion in this annual Patient Safety Storybook.

Patient Safety News publications are available on the intranet at:

Cross Campus Depts → Quality Management → Patient Safety/Risk Mgt → Patient Safety News
The modern hospital work environment is turbulent – i.e. characterized by unrest, disturbance, agitation, or commotion. Unfortunately, errors follow turbulence like night follows day. Patient safety researcher Bonnie Jennings writes that turbulence in the hospital work environment comes from two sources: workload and communication. She writes, “reducing workload and improving communication, with particular attention to minimizing interruptions, could have dramatic effects on stabilizing the practice setting.”

**Workload.** One study of med-surg nurses found that, on average, the nurses were holding in their memory 11 patient care activities that needed to be done (called cognitive “stacking”); the average maximum was 16. Time pressure, simultaneous demands, difficult and unfamiliar work, missing supplies, malfunctioning equipment, and patient turnover have all been identified in the literature as significant sources of turbulence in hospitals.

**Communication.** Interruptions are commonplace in patient care areas and its relationship to errors – particularly medication errors – is well established. Other major communication-related sources of turbulence include inadequate handoff (lost information), disruptive behavior and interpersonal conflict, noise, distractions and information overload.

**What Can We Do?** Reducing workplace turbulence in a hospital requires collaboration at all levels. Many changes have to come from the ground up, such as nurses, pharmacists, and physicians all recognizing that they may be putting patients at risk when they interrupt one another’s work. The hospital’s culture should encourage and support caregivers to let teammates know when they should not be interrupted. Leaders also have a key role when new processes are developed or existing workflows are redesigned – these are opportunities to assure workflows minimize the potential for distractions. If you see opportunities to reduce turbulence in your area, do something about it! Speak to your manager, or take it to your unit council or to one of the numerous committees that are always working to improve patient safety and to make John Muir a great place to work and to receive care.

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Patient Safety

Drifting into Danger

If you flip a quarter four times and get four heads in a row, what are the odds the fifth flip will also be heads? If you work around the safety features of equipment or take shortcuts four times in a row without making an error or harming a patient, what are the odds the next time you do it will also be harmless? The odds of the fifth coin toss coming up heads are 1 in 2, exactly the same as they were for the first coin toss. Similarly, the odds of any single unsafe act resulting in harm are the same no matter how many times you’ve gotten away with it before. Interestingly, most people are inclined to say that a series of heads makes tails more likely, but that a series of bending the rules makes it less likely that bending the rules one more time will result in a bad outcome. Why?

Part of the answer lies in a common cognitive error: outcome bias. Simply put, it seems to be human nature that when a small risk is taken and there are no negative outcomes, we tell ourselves that we must have overestimated the risk. The next time, based on our revised risk assessment, we take a slightly bigger risk and if everything is okay, we tell ourselves that again, we overestimated the risk. The outcome biases our judgment, and our behavior drifts further and further from being safe. This pattern often continues until one is forced to stop, either by someone pointing out that one’s behavior has become reckless or when a bad outcome finally occurs. In these circumstances, when looking back, there is frequently a trend of drift into recklessness that happened over time. Drift occurs continually in hospitals. Think of the first few times you transported a patient to a procedure – you probably checked two patient identifiers, including their wristband, against the transport order to make sure you are transporting the right patient to the right place. Or the first few times you gave IV push medications – you almost certainly swabbed the IV port with alcohol. But after skipping a safety step once or twice with no bad effect (that you were aware of), it makes it easier and more likely for you to take shortcuts again, not realizing that each time you’re flipping a coin on your patient. Drift is a powerful and constant threat and the first step in preventing drift is recognizing when you do it.

Take this opportunity to check yourself and see if you’ve drifted away from any safe practices.
New Pink Wristband Protects Patients with Extremity Restrictions

Both Walnut Creek and Concord Medical Centers began using a new pink colored wristband on February 8, 2011. This wristband, imprinted with “Use This Arm Only” identifies patients with an extremity restriction due to PICC lines, past mastectomy/lymph node removal and dialysis fistulas or as ordered by the physician. These patients should not have venipuncture or blood pressure measurement using the restricted extremity. The pink wristband is placed on the unrestricted (good) arm and the same arm as the patient ID band.

An NPO Order means:
The patient shall receive absolutely nothing in the upper gastrointestinal tract, including enteral feedings and medications.

JMH Adopts Formal Definition of NPO

In simpler times, nil per os (abbreviated NPO) meant exactly that – nothing by mouth. But that was before percutaneous feeding tubes and oral beta-blockers on the morning of surgery. Misunderstandings about what was intended by an NPO order have resulted in patient harm events and near-misses at JMH. Therefore, medical staff and hospital leaders adopted a standardized meaning: as of July, 2011.

Any exceptions, such as medications (including beta-blockers and swish & spit medications), enteral feedings (NG, PEG, G-tube, or J-tube), or sips of water and ice chips, must be ordered explicitly.

To prevent ambiguity and improve safety for our patients, please note the following:

- All NPO orders, including those for procedures, require qualification of medication status (i.e. NPO except meds) by the physician
- If the NPO order is not qualified, all oral medication administration times will be removed from the eMAR (electronic Medication Administration Record used by nursing)
- NO blanket orders will be accepted (e.g. “resume held meds”)
- For the purpose of clarity, when an NPO order is discontinued, each medication will need to be rewritten fully as a new medication order or via use of transfer medication reconciliation report form
✓ **Handoff Communication:** Make your handoff communication clear and unambiguous. Safety information important enough to communicate is important enough to communicate clearly. Handoff is a time for information and questions – don’t hesitate to ask questions no matter how “small” they may seem at the time.

✓ **Handoff for Break/Lunch Relief:** When handing off responsibility to a relief nurse, communicate both the key information about the patient and expectations about what the relief nurse should do while you’re on break. When receiving report as a relief nurse, be sure to get the critical information you need to provide safe care during the primary nurse’s break. When the break is over, always get a report from the relief nurse before resuming patient care.

✓ **Range Orders:** When a range order is given, dosing must start at the lower end and titrate up based on patient response in specified increments.

✓ **Unapproved Abbreviations:** If you encounter an unapproved abbreviation among physician orders, clarify the order with the prescriber – even if it seems obvious to you what was meant. Familiarize yourself with John Muir’s list of unapproved abbreviations. They’re listed on the top of the blue physician orders. A poster is available on the Quality Management Safety & Risk intranet page.

✓ **Allergy Checking:** Always confirm patient allergy information at the point of medication administration. Whenever possible, ask the patient to verbalize the medications they’re allergic to at the point of medication administration. Remember that redundant double checks of allergy information may be the key to catching a medication error.

✓ **Independent Verification for High Risk Medications:** Consistently use the process of independent verification when administering high risk medications. The independent verification process requires the first RN to review the order and determine the correct dose and/or infusion rate and the second RN to review the order independently from the first RN and determine correct dose and/or infusion rate. Then, both RNs compare results to confirm accuracy.

✓ **SmartPump Drug Library Use:** Always use the drug library when programming an infusion pump. On average, it takes 32 seconds longer to use the drug library and that 32 seconds might just avert a programming error resulting in a medication error. Effective in August, the drug libraries were “trimmed” in an effort to make them more user friendly.

✓ **Opiate Naïve Patients:** Evaluate response to opioid administration by assessing pain intensity/rating, opioid sedation level, O2 saturation and respiratory rate within timeframe of predicted peak effectiveness of medication.
Patient Safety

Be Aware of Health Technology Hazards

Health technology offers countless benefits to patient care. It also presents numerous risks. Most of these can be avoided – with work. The ECRI Institute assists hospitals in prioritizing our efforts to make our use of health technology as safe as possible for patients. Each year, the ECRI Institute publishes a list of “Top 10 Health Technology Hazards.” The publication includes recommendations hospitals should consider in each of the health technology hazard areas. John Muir Health’s Patient Safety Program convenes teams of subject matter experts who review the ECRI Institute recommendations, compare them with our practice, identify gaps, and implement improvements. The following describes some of the hospital-wide Health Technology Hazards identified in the 2011 and/or 2012 report by ECRI Institute. If you work in areas where the following potentially hazardous conditions exist, please read on.....

Radiation Overdose and Other Dose Errors during Radiation Therapy → Radiation dose errors can take the form of delivering the wrong dose, treating the wrong site on the patient, or treating the wrong patient. These “three wrongs” can be caused by human error, software-related problems and inexperience with complex, newly introduced technologies;

Alarm Hazards → Alarm-related adverse incidents are all too common, and the consequences can be serious. These incidents typically involve one of the following: (1) Staff becoming overwhelmed by the sheer number of alarms resulting in improper modification of alarm settings or staff desensitization to alarms; (2) Alarm settings not being restored to their normal levels after being modified to accommodate temporary conditions; and (3) Alarms not being properly relayed to ancillary notification systems (e.g., paging systems, wireless phones);

Cross-Contamination from Flexible Endoscopes → Patient cross-contamination from improperly reprocessed flexible endoscopes can lead to life threatening infections. Such incidents are almost always associated either with failure to follow established cleaning and disinfection/sterilization guidelines and instructions or with the use of damaged or malfunctioning equipment;

High Radiation Dose of CT Scans → The high radiation doses generated during computed tomography (CT) are believed to increase a patient’s risk of cancer. The crux of the problem is that a delicate balance must be achieved between keeping doses low and maintaining adequate image quality;

Luer Misconnections → Tubing and catheter misconnections can be harmful to patients because they can allow gases or liquids to be introduced into the wrong lines or by unintended routes of administration. Prevention requires that clinicians exercise constant vigilance and safe practices;

Oversedation During Use of PCA Infusion Pumps → The most significant danger when using PCA pumps with delivering opioids is oversedation, which can lead to potentially life-threatening narcotic-induced respiratory depression. Oversedation can result from misprogramming the PCA pump, but it can also occur when the pump is programmed as intended, since patients respond to opioids in different ways;

Needlesticks and Other Sharps Injuries → Despite the implementation of safety devices and the continued emphasis on staff training, clinicians continue to stick themselves and one another when trying to activate needlestick-prevention devices;

Surgical Fires → Virtually all surgical fires can be avoided. Not all surgical fires result in patient injury, but when they do, the consequences can be severe, including potentially fatal airway burns and facial disfigurement. Recommendations focus on surgeries to the head, face, neck and upper chest, during which oxygen accumulation creates an enriched atmosphere;

Defibrillator Failures in Emergency Resuscitation Attempts → Defibrillators are critical resuscitation devices. Their failure to perform effectively may result in the death of a patient who could have been saved. Measures to help ensure that defibrillators are ready for use at a moment’s notice include performing regular preventive maintenance and conducting the routine (e.g. daily) checks recommended by the supplier;

Anesthesia Hazards Due To Incomplete Pre-Use Inspection → Thorough pre-use inspection of anesthesia units has long been accepted as a standard procedure. However, in actual practice, such inspections can be inconsistent or incomplete, leading to problems such as misconnected breathing circuits, ventilator leaks, and empty gas cylinders that, if unnoticed, may lead to patient injury.
John Muir Health is committed to an environment in which co-workers and physicians are full partners in the job of improving the safety patient care processes and systems. The organization’s primary response to adverse events is to learn from them, not to assign blame or impose discipline. One of the best ways to reduce adverse events is to take advantage of lessons present in close calls, where things almost go wrong but no harm is done. A culture of safety where people are able and willing to report both adverse events and close calls without fear of punishment will lead to a safer environment for not only patients, but also co-workers, physicians and visitors.

Recognizing that humans make mistakes, John Muir Health encourages co-workers to report adverse events and close calls – not to assign blame, but to learn what happened so we can keep it from happening again. Most mistakes occur as a result of ineffective, improperly designed or flawed systems. When co-workers report events and close calls, we are able to track them to find patterns and trends, which help us learn how we can improve our systems to prevent future mistakes. The success of this effort depends on each co-worker’s willingness to participate, to contribute, and to be open to sharing and receiving information about safety events and close calls. John Muir expects and requires that all co-workers fully take part in building our culture of safety.

“Medical errors most often result from a complex interplay of multiple factors. Only rarely are they due to the carelessness or misconduct of single individuals”

Lucian L. Leape M.D. Harvard School of Public Health
Serious Adverse Events Requiring **Mandatory** and **Immediate** Reporting to Quality Management

Adverse Events occur in hospitals every day – some are preventable and some are not. There are state and federal laws which govern reporting of serious adverse events to regulatory agencies. There are also Joint Commission standards which require an internal review of sentinel events. If a serious adverse event on the list below occurs, notify your department/unit supervisor and **immediately** report it to Quality Management by:

- Calling a Risk Manager (x35036/WC or x22027/CC) and
- Completing a Patient Safety Alert/RDE in

**Definitions**

(References: JMH Policy “AD-Reportable Events” and JMH Policy “PS-Sentinel Events”)

**Adverse Event:** A negative consequence of care that results in unintended injury/illness, which may or may not have been preventable.

**Sentinel Event:** An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. They are called “sentinel” because they signal the need for immediate investigation and response.

**Serious Disability:** A physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

This flyer is available on the intranet:

**Cross Campus** > **Quality MGT** > **Patient Safety & Risk Mgt** > **Educational Materials** > **Adverse Event Flyer**

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2/2012

1=if event results in death; 2=if event results in serious disability; 3=Sentinel Event by Joint Commission definition
**Instructions for Completing a Patient Safety Alert/RDE**

Complete a Patient Safety Alert/RDE if the following happens:

- An “Adverse Event” occurs that results in death or harm to a patient

  *Always notify your supervisor and call the Risk Manager whenever an adverse event (defined above) occurs!*

- Any incident, error or omission: (1) that harms a patient; (2) that could have harmed a patient; or (3) that you believe is a patient safety issue

- A “Great Catch” where an error occurred but harm was prevented because of discovery and action

How to access the Midas PSA/RDE form.

- From the INTRANET, click on Reference Links
- Click on Midas-RDE Patient Safety
- Click the Midas – RDE button
- Select “Risk”

Select the appropriate Risk form based on the event being reported:

- AMA/AWOL
- Behavior Event & Code Grey
- Code Evaluation Form
- Device / Equipment
- Documentation
- Fall Event – Inpatient Only
- General/Outpatient Falls/Other
- Infection Control/Isolation
- IV Sites
- Laboratory
- Medication
- Moderate Sedation
- Newborn
- Pressure Ulcer/ Skin Condition
- Surgery/PACU
- Transfusion
- Treatment/Procedure
- Used by Physicians Only**

Call ITS Support Services @32222 with technical support questions
Instructions for Submitting a Culture of Safety Report

- Do you have a patient safety concern that you feel is not being addressed?
- Do you have an idea or suggestion for a patient safety improvement?

The Director of Patient Safety wants to hear from you!

How to Complete a Report:

- From the INTRANET page, click on Cross Campus Depts
- Click on Quality Management
- Select Patient Safety/Risk Mgt.
- Select ‘Click here to submit a "Culture of Safety" Report to the Director of Patient Safety’
- Complete the form and click “Send message to Stephanie”

Note: Please do not use this to report patient-specific event information. Use Midas Patient Safety Alert/RDE for patient-specific safety events.

Building Blocks of Patient Safety…
Right Care, Right Patient, Every Time