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PATIENT SAFETY REPORTING SYSTEM NEWSLETTER

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Sharing Experiences and Preventative Measures

Overview: Sharing Experiences and Strategies to Prevent Adverse Events

Patient Safety is one of the nation's and New Jersey's most pressing healthcare issues. New Jersey has received over 3,000 reports of serious preventable adverse events. Preventing these events from occurring is not a solitary goal but one shared by all healthcare facilities and the Department of Health and Senior Services.

One way of achieving this goal is by sharing knowledge and information on preventative measures that work. In December 2008 the Patient Safety Reporting System began posting Preventative Strategies on its website to impart ideas that have worked for other facilities in preventing serious events.

We request that facilities continue to send the Patient Safety Reporting System preventative and corrective measures that they have found worked for their facility. These measures are de-identified and posted on the Patient Safety Reporting System's website from which everyone can learn.

The Prevention Strategies and other useful information can be found at: **http://nj.gov/health/ps**. To submit a prevention strategy or to leave a comment, please click on the Contact Us link on the left-hand side.

Second Look: Review of Prevention Strategies

1. **Event**: *The patient fell while being transferred from the commode to the bed. The patient had a previous amputation above the knee and he refused to wear his prosthesis. The patient care technician assisted him to the commode. He pivoted toward the side of his intact leg to get to the commode but pivoted toward the side of his amputation to get back to bed. He fell during the transfer back to bed.*

   Facility Strategy: The RCA Team discovered that training for patient care technicians included transfers but did not specifically address certain patient populations, such as amputees. The training now addresses special populations and includes role playing and demonstration of transfers. The hospital has also started a Situation Background Assessment Recommendation (SBAR) report for patient care technicians to include specific information, such as the amputee status.

2. **Event**: *Lack of continuity of medical care for patients in Behavioral Health Units has contributed to delayed medical treatment, resulting in increased morbidity and mortality.*

   Facility Strategy: Hospitals have implemented daily mandatory interdisciplinary rounding on each patient with medical problems who is admitted to the Behavioral Health Unit. As an alternative strategy in some hospitals, patients are followed by one medical doctor throughout the hospitalization. Monitoring is performed by the VP of Medicine and Nurse Managers.

3. **Event:** *The lack of a sponge count and the lack of an examination following a spontaneous vaginal delivery led to retention of a sponge in two cases. This resulted in discomfort, fever, and a foul smelling vaginal discharge, which required a repeat admission and treatment with antibiotics.*

   Facility Strategy: Some NJ hospitals have implemented a sponge count before and after a spontaneous vaginal delivery presenting the argument that a manual examination prior to discharge is painful to the patient. Other NJ hospitals have indicated that the sponges used during a vaginal delivery absorb more than just blood, i.e., feces, amniotic fluid, and therefore performing a sponge count is not practical. They have instituted a manual vaginal examination in the Delivery Room. Either approach is appropriate and will help decrease the number of retained sponges after a vaginal delivery.

4. **Event:** *A delay in care for a patient with a Stage II Pressure Ulcer led to its progression to Stage IV, because the system's communication failed to obtain a wound care nurse, dietary consults, and the specialty equipment needed for off-loading pressure in susceptible skin areas.*

   Facility Strategy: The root cause of the delay was related to the lack of appropriate laboratory data and pressure ulcer risk scores in their EMR which would automatically trigger the dietary and wound care nurse consults. The solution was to work with the RNs and the IT unit to coordinate the information so it was clearly presented on the computer screen and programmed to produce the automatic request for these consults. Additionally, the physicians agreed that RNs collaborating with the wound care nurse could order the specialty beds based on agreed upon criteria.

5. **Event:** *Two patients were unexpectedly hospitalized following procedures at ambulatory surgery centers. One patient developed wheezing and stridor; the patient failed to mention a recent diagnosis of asthma and prescribed inhaler. The second patient vomited and aspirated immediately post-op; he had failed to follow the (NPO) no eating/drinking/ medication instructions prior to the procedure.*

   Facility Strategy: Both root causes were related to availability of information; a failure to identify important information related to the patients' procedures. After a review of their pre-admission assessment processes both facilities developed improvement strategies such as: 1) additional trigger questions to help the patient recall physician visits and any newly prescribed medications; 2) more focused patient education on NPO instructions prior to surgery including the potential consequences of not following this rule.

6. **Event:** *A newborn boy of immigrant parents had a circumcision performed. The father later stated that he did not want his son circumcised. The nurse discussed the circumcision with the mother and father in the delivery room immediately after the child was born while helping the mother breast feed the baby. The mother did not speak English; the nurse did not feel there was a language barrier with the father. The mother signed the permission form and a covering obstetrician performed the circum-cision.*

   Facility Strategy: The facility now requires documentation of the discussion regarding circumcision during the prenatal period. If the parents do not want the procedure, the Attending will document NO CIRC in the medical record. In addition, the need for and availability of proper translation facilities for communication with patients who have limited English proficiency will be stressed with all staff.

7. **Event:** *The lack of understanding by new staff regarding the difference between Advanced Directives and the "Do Not Resuscitate" (DNR) order resulted in the death of a patient who wished to be resuscitated. In other cases, patients who had a DNR order have been resuscitated with resulting morbidity due to lack of communication.*

   Facility Strategy: Prevention strategies include re-education of nursing staff on Advance Directive and DNR policies with subsequent competency testing. Some facilities use a designated strategy (such as a red dot on the patient's chart) to indicate the patient has a DNR order. The New Jersey Hospital Association and

the New Jersey Department of Health and Senior Services partnered with industry experts to standardize patient alert bands which are used by many facilities in New Jersey. Purple color-coded wristbands indicate the patient has a DNR order.

8. **Event:** *A lack of communication led to a delay in surgery for a trauma victim which contributed to his death. The on-call Trauma Surgeon was in surgery when the patient arrived in the ED and failed to notify the second on-call Trauma Surgeon in a timely manner. Once called, there was an additional delay because the second on-call Trauma Surgeon had a distance to travel.*

   Facility Strategy: The Trauma Second On-Call policy was amended and now states that if the Trauma Surgeon is going into surgery, he/she must notify the second on-call Trauma Surgeon. Upon notification, the second on-call Trauma Surgeon must promptly present to the hospital to provide coverage. Elective surgeries are not scheduled for the on-call Trauma Surgeon, unless a second Trauma Surgeon is immediately available to provide coverage.

9. **Event:** *Several suicide attempts have occurred on units that have locks on bathroom or patient room doors. One patient locked himself in the room while attempting to harm himself. The staff had to scurry to find a key to open the door and rescue the patient. Even with an aide on 1:1 duty standing at the door, another patient was able to slam the door closed and lock it before the aide could respond.*

   Facility Strategy: Although many facilities consider locks on bathroom doors a privacy issue for patients, it is also a safety issue. The safety issue not only affects suicidal patients; patients may have a syncopal or ischemic episode while behind a locked door delaying staff access to them. Therefore some facilities have systematically removed all locks from bathroom doors. All facilities should reconsider the use of locks on patient rooms and bathroom doors. At the least, there should be a prepared plan for emergency access to locked rooms.

10. **Event:** *The lack of a process for counting devices pre and post knee replacement and the assumption that the surgeon reviewed post-operative x-rays resulted in the retention of a fixation pin for 3 days after surgery. Two surgeons simultaneously performed bilateral knee replacements. Surgeon A finished first and left the facility. He assumed his partner would check the post-operative films. The radiologist saw the foreign body and did not call either surgeon, assuming they would check the films.*

    Facility Strategy: Hospital policy now mandates pre- and post-procedure fixation pin counts. The surgical group has mandated review of post-operative x-rays on the day of surgery. Radiology will contact the surgeon directly when an unusual finding is noted on a post-operative x-ray.

11. **Event:** *Failure to verify the location of a triple lumen catheter placed in the femoral vessel of an edematous ICU patient by a resident led to the patient receiving 18 hours of pressor and other medications without effect. The catheter placement was verified when the patient's leg became cold and mottled and ABG's verified that it was in the artery.*

    Facility Strategy: The ICU Attending must review the procedure log of each resident working in the unit at the beginning of each shift. Since the opportunity to place these catheters is quite limited, the Attending must also supervise the resident during each procedure. In addition, the ICU Attending staff must develop guidelines to verify the proper placement of the catheter.

12. **Event:** *Failure to inspect and measure guide wires and cardiac stents before and after use resulted in retention of part of the device. Breakage of guide wires is a frequent adverse event requiring a repeat procedure to retrieve the retained portion.*

    Facility Strategy: The Cath Lab will now visually inspect all non-deployed stents after removal to be sure that the stent has not broken off. The OR Staff will measure all guide wires before and after use to be sure that the entire guide wire has been removed.

13. **Event:** *The patient developed anesthetic toxicity (tonic-clonic seizures) following injection of a local anesthetic mix (lidocaine with epinephrine and bupivicaine). The episode was successfully aborted with the use of a lipid emulsion in combination with established ACLS protocols.*

    Facility Strategy: In addition to storing the lipid emulsion in the Emergency carts, the facility is now also keeping it in the Pre-Op area with syringes for immediate administration. Before starting a block, the closet is unlocked, and the medication is checked for integrity and its expiration date. In addition, before the second syringe of local anesthetic, the patient is specifically asked about early symptoms of toxicity. Recent reports in the literature suggest that lipid emulsion is an effective treatment for local anesthetic toxicity.

14. **Event:** *Failure to clarify the site of entry of the angioplasty in a busy Cardiac Cath Lab led to an attempted peripheral artery angioplasty on the wrong side.*

    Facility Strategy: The staff could not distinguish if "site" referred to the site of entry or the site of the angioplasty. Re-education was necessary to address the misconceptions about laterality in the newer procedures being performed. Multiple channels of communication between the physician's office and the lab had to be standardized, including the various forms used. The need to have a complete history and physical on the chart prior to the day of the procedure was also identified.

Resources:

Thank you to all the facilities for their continual pursuit of preventing adverse events and for their willingness to share their ideas.

To submit a prevention strategy to the Patient Safety Reporting System please contact us at: **http://nj.gov/health/ps**

NEW JERSEY DEPARTMENT of HEALTH and SENIOR SERVICES

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For more information or comments on this issue or past issues of the *Patient Safety Initiative Newsletter* please contact:

Patient Safety Reporting System Tel: **(609) 633-7759**

Patient Safety Web Site: **www.NJ.gov/health/ps**

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