SCRMC
Patient Safety Module

SCRMC Patient Safety Module

Please return this module to the Nurse Educator or Nursing Administration within 7 days from the checkout date. If the module is not returned timely or is damaged or lost, a replacement fee of $10.00 will be payroll deducted. Verification of the module will require an 85% successful completion of a safety quiz. Please do not write in this module. If you have any questions, please contact the Nurse Educator at extension 4929.

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*** refers to nurse specific information**

Introduction

Hospitals are complex facilities, made up of specialized, highly technical and interdependent processes. This complexity causes many factors that threaten the safety of patients. Safety threats occur when mistakes are made by people, but may also occur when everything is done correctly. It has been reported that as many as 44,000 people die every year from medical mistakes. Some believe the best way to prevent patient injuries is to acknowledge that safety risks are inevitable. If safety risks to patients are inevitable, we must design ways to make it harder for nurses and other health care workers to do the wrong thing, and easier for them to do the right thing. Good communication and reliable documentation are key to identifying what the risks are and what preventive measures are needed.

South Central is committed to providing a safe patient environment and conducts an interdisciplinary safety program coordinated by our Safety Committee. Nursing personnel must continuously monitor patients and recognize situations that place patient's safety at risk. Any safety concerns should be reported immediately to the unit director who will follow up. Any incident or occurrence that is outside normal operations should be reported.

The Joint Commission establishes National Patient Safety Goals annually. Addressed within these pages are SCRMC's guidelines related to these safety goals and other items deemed relevant to patient safety.

The emphasis on safety for our patients, visitors, and staff is of utmost importance. If you become aware of a safety issue that needs to be addressed, take action! If it is a spill on the floor and you are capable of wiping it up, do so. If it is an issue that needs other attention, report it to your Charge Nurse or Unit Director so the appropriate action may be taken. Safety is the responsibility of EVERY employee and each is urged to do one's part.

Chain of Command

As with any business, South Central has a ***chain of command*** in effect. Should an issue arise regarding patient safety, interpreting physician's orders, assessment findings, diagnostic results, or other questions or concerns, one is admonished to follow the ***chain of command*** in resolving the problem. Each inpatient unit has a Charge Nurse readily available to the staff. The Unit Director or Clinical Nursing Coordinator is also available. Should a patient care issue not be resolved to the satisfaction of the staff nurse, Charge Nurse, or Clinical Coordinator, the Associate Executive Director of Nursing or the Administrative Executive on call may be contacted. Clinical, medical, and administrative personnel are available 24 hours a day, seven days a week as resources when needed.

Communication

Patient care is complex and involves multiple people. Because of this, good communication is critical to the patient's safety and well-being. **Errors in communication have been identified as the number one cause of medical errors that harm patients.**

"SHARED"

SCRMC has adopted the ***"S-H-A-R-E-D"*** process to exchange patient information between one care giver and another. This allows for pertinent information to be exchanged and questions clarified between care givers. This process is used to "hand-off" patient information in a variety of circumstances; i.e., shift-to-shift report, meal breaks, transfer between departments, and others. This information may be verbal or written, but it is critical to patient welfare that appropriate, pertinent information is "shared" by care givers.

Below is a brief description of the ***"S-H-A-R-E-D"*** process:

- ***"S"*** - Situation or subject. What needs to be addressed? What is the purpose for the exchange of information?
- ***"H"*** - History. What information in the patient's history is relevant to this communication?
- ***"A"*** - Assessment. What pertinent findings need to be exchanged? VS, lab results, complaints, signs and symptoms, other?
- ***"R"*** - oRders, results, requests. Were orders given to address the specific situation?
- ***"E"*** - Evaluate. Has the situation changed? Do other resources need to be informed?
- ***"D"*** - Document. What were the specifics of the information exchanged and the outcome of the communication?

Do Not Use Abbreviations

Communication is passed on through many ways, one of which is written. SCRMC has a list of ***"Do Not Use Abbreviations"*** in an attempt to minimize misinterpretations. These are not to be used by any employee that documents on the patient's medical record.

Do Not Use	Use Instead
U or u (unit)	Write "unit"
IU (international unit)	Write "International unit"
Q.D., QD, q.d. ,qd (daily)	Write "daily"
Q.O.D., QOD, q.o.d., qod (every other day	Write "every other day"
Trailing zero (X.0 mg)	Write "X mg"
Lack of leading zero (.X mg)	Write "0.X mg"
MS, MSO_4,	Write "Morphine sulfate"
$MgSO_4$	Write "Magnesium sulfate"
Additional Considerations Not to Use	**Use Instead**
> (greater than); < (less than)	Write "greater than" or "less than"
Abbreviations for drug names	Write drug names in full
@ (at)	Write "at"
cc (cubic centimeter)	Write "ml" or "milliliter"
µg (microgram)	Write "mcg" or "microgram"

Door Signs

Another method of patient communication is door signs. Information such as NPO, Fall Risk, Stop - Check With Nurse Before Entering, and other signs are used to alert all that enter the patient's room of general information. None of these signs violate the HIPAA regulations regarding confidentiality.

Patient Identifiers

The two patient identifiers of ***name and date of birth*** are used and can be found on the patient's identification band. One may **ask** a patient's name out of courtesy, but there is no substitute for checking the arm band for identification. Patient identification must be verified before administration of medications, specimen collection, blood administration, surgery, or any other specific intervention for that patient only. Even if the patients' vital signs are checked, be sure it's the correct patient - not just the patient in Room #X.

Should there be a difference between the ***name and date of birth*** on the identification armband and the lab slip, meal tray card, medication administration record, or other piece of data - STOP! Do not proceed with the intervention until the discrepancy is resolved! Errors in lab results or medication administration can have life-threatening consequences. ALWAYS check for the correct patient identification!

Each patient must have an identification armband on at all times. On admission, the presence of an armband is initially documented on the nursing admission papers, then it's presence reassessed each shift and documented on the nursing daily flowsheet. Each care giver is responsible for educating patient and family on the importance of an armband being in place. **Many patient care errors would have been avoided if the basic step of patient identification had not been omitted!**

Healthcare Associated Infections

Healthcare associated infections are those that are attributed to being in the hospital. The greatest occurrence is usually a "*staff*" infection - one that is transmitted from health care worker or "*staff*" to patients. Many practices help prevent infections in a hospital; some of these are environmental cleanliness, proper hand hygiene, use of appropriate personal protective equipment (PPE), standard precautions, transmission-based isolation precautions, and use of sterile or aseptic technique. Adherence to these and other practices reduce and/or prevent the spread of disease and infection.

Hand hygiene **is the number one way to prevent the spread of infection by destroying microorganisms on the hands**. Hands should be washed with soap and water for at least 15 seconds when visibly soiled. Alcohol-based hand cleaner is used when the hands are not visibly soiled, before and after gloves, before and after patient contact, and between patient encounters. SCRMC's ***hand hygiene*** policy also addresses the length of nails, nail polish, and jewelry . Nails should not be visible above the fingertips when looking at the hand from the palm side; no nail polish or artificial nails are permitted; and jewelry is limited.

Personal protective equipment (PPE) is used to protect the care giver from many forms of contamination. The most commonly used are gloves and masks. The PPE should be appropriate for the situation - no more or less than is needed. One has access to gloves, masks (with and without eye shield), gowns, and hand sanitizer. (More will be discussed with transmission based precautions.) All PPE should be removed and discarded before exiting the patient's room.

Standard precautions are indicated and practiced on all patients as though they were infectious. Because the health care provided cannot determine if a patient has some illness or infection by looking at them, all patients are considered potentially infectious and require standard precautions be utilized. This includes the same PPE as discussed previously. Again, **good hand hygiene is essential!**

Transmission-based precautions are aimed at containing and preventing the spread of infectious organisms from patient to staff to another patient. These precautions are frequently referred to as types of "isolation." In order for transmission to occur, the organism from one infectious source enters a "host" (healthcare worker) and the "host" transmits the infection to another patient. Transmission may occur from direct contact with the patient or source of infection, i.e., wound, or from contact with an inanimate object in the patient's room, i.e., siderail. Regardless of the source of infection, the chain of transmission MUST be broken for the welfare of patients and staff alike.

SCRMC has 3 types of ***transmission-based precautions: Contact, Droplet, and Airborne.*** For each of these, a door sign would be used stating "STOP - check with nurse before entering the room." This alerts all who enter if specific actions must be taken prior to entering. This *does not* violate HIPPA because no confidential information is given. If an employee from another department, visitor, or family member wishes to enter the patient's isolation room, he/she will need the same protection as the nursing staff. The nurse will be responsible for educating those who enter on the safety precautions to use.

Contact Precautions

Contact precautions are taken when the patient has an infection that may spread by touching the patient or touching things in the patient's room. This would include MRSA (Methicillin Resistant Staph Aureus) in a wound, VRE (Vancomycin Resistant Enterococci) in urine or stool, HIV (Human Immunodificiency Virus) in blood or body fluids, or some other GI, GU, or skin infections. Gloves should always be worn as well as a gown if splattering or contamination is possible. Equipment for this isolated patient should be restricted to this patient only when possible. Central Supply will provide a stethoscope, blood pressure cuff, thermometer, and IV pump for this patient. Any other equipment that enters the patient's room must be wiped down with an antimicrobial wipe and allowed to dry before being used on another patient, i.e., Accucheck monitor. After discharge, the reusable equipment is wiped down to remove gross contaminants then taken to Central

Supply for disinfecting before other patient use. Disposable items are "red-bagged" if contaminated.

Droplet Precautions

Droplet precautions are implemented when the patient's infection is in the airway and therefore transmitted by moisture droplets from the upper respiratory system. When the patient speaks, coughs, sneezes, and sometimes just breathes, the infectious organism is propelled from the upper respiratory tract by way of the moisture droplets. Gravity causes these droplets to fall on surfaces usually within 5 - 8 feet. This may be MRSA in the sputum, TB, or other respiratory or oral/nasal infections. In addition to gloves, the person entering the room should wear a mask with protective eye shield. Gowns may be worn if contamination of clothing is expected as with a patient with a tracheostomy.

If a patient has TB, he/she will be placed in a negative-pressure room that pulls the air into the outside atmosphere. This decreases the concentration of the organisms and exposes the organisms to ultraviolet light. These rooms MUST have the door to the hallway closed for the negative-pressure to be activated. Emergency Department, Critical Care Unit, and 3 West have such rooms. These patients must wear a mask when transported from one department to another and the staff of the receiving department must use the same protective measures while the patient is in their care.

Airborne precautions

Airborne precautions are indicated when patients have infectious organisms transmitted from the respiratory tract into the air, i.e., TB. The contaminated organism can travel great distances on dust or other microscopic particles in the air. These contaminated particles may infect someone not in close proximity to the patient. Gloves and masks are necessary to use; eye shield may be necessary if potential contamination may occur. The masks (N95) worn are to be airtight to prevent any airborne particles from being inhaled. These patients will be placed in a negative-pressure room as mentioned above.

Reverse isolation may be implemented for patients who are

immunosuppressed or otherwise predisposed to infections. These patients are protected from others who might introduce an infection to them. They are placed in a well ventilated room and strict hand hygiene should be used when providing care to these patients. Masks are worn to protect the patient from the health care provider's respiratory droplets.

If any patient is transported from an isolation area to another area of the hospital, inform the receiving department of the protective steps needed while the patient is in their care. The patient may need to wear a mask during transport if droplet or airborne precautions are in effect.

Two of the more common healthcare associated infections nationwide are ***UTI's*** (urinary tract infections) and ***pneumonia***. Most **UTI**'s occur in patient's with a foley or indwelling catheter. The best preventive action is to discontinue the catheter as soon as possible. In addition to strict aseptic technique during insertion, other measures that may decrease or prevent a hospital-acquired UTI are as follows:

- using strict hand hygiene when touching any part of the catheter,
- stabilizing the catheter to prevent movement in and out of the urethra,
- positioning the tubing along the length of the bed to prevent dependent loops,
- positioning the drainage bag at the foot of the bed,
- maintaining a closed system,
- preventing the exit portal of the bag from touching the floor, and
- providing catheter insertion site care at least twice a day and PRN

Healthcare associated UTI's cost extra money for treatment as well as extra patient care days. Proper insertion and maintenance is essential to reducing this infection.

Another frequently occurring healthcare associated infection is **pneumonia**. Many of our patients are elderly and any cause for immobility increases the risk of acquiring pneumonia. Patients should be turned frequently, encouraged to cough and deep breathe, and become as active as possible as soon as possible. Care in feeding should be taken to avoid aspiration. Head

of the bed should be elevated 30°or higher if appropriate for the patient. Good oral hygiene not only improves the patient's sense of well-being but also decreases the microorganisms in the mouth. Ongoing assessments are necessary to detect cough, rhonchi, fever, sputum production and other potential symptoms of pneumonia. Again, strict hand hygiene plays an important role in decreasing transmission of organisms from one to another.

Equipment/Clinical Alarms

As with any hospital, South Central has a multitude of equipment used directly or indirectly in patient care. Each manufacturer has built-in alarm systems to alert the user to possible problems. Our own Bio-Med department routinely checks each piece of equipment for proper functioning, preventive maintenance, and testing of the clinical alarm systems. Alarm systems may activate to alert the staff and patients of potential safety risks. Many pieces of equipment have a "silence button" to stop the audible sound of the alarm for a few seconds, but ***NO alarm should be turned off completely***. The sound of the alarms should be loud enough to be heard over the routine noise of the day.

Nurses are responsible for assuring that clinical alarms are activated on equipment in use and that the sound is sufficiently audible with respect to distance and competing noises on the unit. Some alarms reset automatically, but a frequently occurring alarm demands attention. With multiple pieces of equipment in use at the same time, the nurse cannot become desensitized to the sounds and take them for granted. Serious harm can be caused by malfunctioning equipment - each alarm deserves a thorough check to determine the problem and potential risk. If the equipment malfunctions, it should be removed from patient use after like equipment is replaced. Tag the equipment as "Defective" and notify the Bio-Med department.

Hospital-acquired Injuries

Hospitals desire a safe place in which patient care is delivered, as well as a safe environment in which staff may work. Falls head the list for hospital-acquired injuries for patients and staff. This has led to a comprehensive fall prevention policy at SCRMC.

All hospitalized patients will be assessed for risk of falling at the time of admission and reassessed every 24 hours. Fall risk will be determined using a modified Morse Fall Risk Assessment Scale and a low, moderate, or high category will be determined by the score obtained. $\geq$ 40 indicates a "HIGH" fall risk.

Preventive measures will be initiated on all patients as follows:

Low risk (score 0 - 20)

- 3 of 4 bed rails should be raised
- personal items within easy reach
- non-skid foot wear to be worn when up

Moderate risk (score 21 - 39)

- all low risk measures as above
- instruct patient to call for assistance - "Call before you fall."
- address toileting needs before bedtime
- round on these patients at least every 4 hours
- do not leave this patient unattended in the bathroom

High risk (score ≥40)

- all low and moderate risk measures above
- pharmacy referral for fall risk medication review
- round on these patients at least every 2 hours; document on the toileting schedule when rounds were made and the person's initials
- have a planned toileting schedule
- supervise when toileting, ambulating, and transferring
- encourage families to stay with high fall risk patient
- place visual of falling star inside front of chart cover and inside the patient's room on the bulletin board or at the head of the bed
- communicate from one care giver to another during hand-off reporting

Post Fall Management

The first priority after a patient fall is to assess the patient for any obvious injuries. Observe the skin for any breaks or abrasions, look for abnormal bone or joint alignment, and observe for restrictions in mobility. Intracranial injury should be considered for patients who are taking anticoagulants and hit their head during the fall. Hip fracture may be considered if the patient's leg is misaligned and their foot is externally rotated. A blood sugar may be checked on diabetic patients who fall. Seek assistance if needed and use lifting equipment to get the patient off the floor. The patient should be observed closely following a fall; vital signs and neuro checks may be obtained as needed. (Refer to policy/procedure # 28.4)

Skin Safety

Nationally 14% of all patients hospitalized have skin breakdown. Half come to the hospital with breakdown; the other half develops breakdown while in the hospital. The cost of care and the length of stay for patients with decubitus is greater than that for patients without decubitus ulcers. Many of our patients have risk factors that contribute to problems with skin integrity, such as poor nutrition, dehydration, incontinence, and immobility.

All patients should have a thorough head-to-toe skin assessment on

admission. The “Braden Scale”, a nationally recognized assessment tool, is used to predict the risk of developing impaired skin integrity. Risk categories of sensory perception, moisture, activity, mobility, nutrition, and friction and shear are reviewed and a numerical ranking is given to each area. If the score is $\geq$17, no action is needed. If, however, the score is 15 - 16, the patient is at mild risk for potential skin breakdown and the Skin Care Standard #32 should be initiated. A score of $\leq$ 14 indicates moderate to severe risk and a referral to the Wound-Ostomy-Continence-Nurse (WOCN) is made. For some patients, even the best of care may not prevent impaired skin integrity, but preventive measures must be implemented and followed in an effort to prevent this safety risk.

Skin tears are another form of skin impairment that deserves careful attention. Many of the elderly and chronically ill have very thin, frail skin that is easily damaged. Obtain help from another member of the nursing team to assist in turning, transferring, and toileting these patients. Even the slightest touch on these patients’ skin can result in a tear, which is considered a hospital acquired injury. WOCN consult can help both in treatment but especially in prevention of these types of skin impairments.

Restraints

Policy under revision- please refer to pages 22-27 in this manual.

Patient Participation In Safe Care: "Nothing about me without me!"

At SCRMC, we encourage patient and family participation in their care; this includes keeping them informed and answering their questions. Patient and family education should be integrated into your care. As patients and families become more aware and educated on their healthcare needs, the potential grows for increased compliance. Interdisciplinary team members contribute to the patient's and family's understanding of the many facets of their individual care; some of these are Diabetic Education, Dieticians, Wound and Ostomy Nurses, and Social Services. Remember, "Nothing about me without me" means to keep the patient and family informed and involved in their treatment decisions.

Patients and Families Have a Voice About Concerns In Care

At times, patients and families may feel their concerns about the care or condition of their loved one are not being adequately addressed. Patients and families are encouraged to express their concerns to the staff rendering the care. If concerns are not addressed satisfactorily, the situation is referred through the hospital chain of command for a rapid response and resolution. As with any concern within the hospital, the Chain of Command is in effect with the medical staff and the hospital in general.

The nursing Clinical Coordinator is available 24 / **7** to review the patient's current condition and areas of concern. The Coordinator then may address the situation personally or refer to other disciplines as needed to resolve the issue at hand.

Suicide Risk Assessment/Prevention

The Emergency Department and inpatient nursing units assess each patient for suicide risk factors. If a patient has made a suicide attempt, has thoughts of suicide, or a suspected psychiatric diagnosis, a SAD PERSONS scale is completed on these individuals. The SAD PERSONS scale allows the care giver to arrive at a numerical ranking of the patient's suicide risks factors along with recommended guidelines for interventions.

The nurse on the inpatient units enters the fact that the SAD PERSONS scale was done and the patient's score on the Interdisciplinary Care Plan for the Dr. to review. The scale is filed under the Interdisciplinary Progress Notes in the paper chart along with the nursing admission papers. After review by the physician, further treatment/interventions may be ordered.

The SAD PERSONS scale consists of the following categories:

Risk Factor	**Low Risk**	**0**	**High Risk**	**1**
Sex (gender)	Female		Male	
Age	20 - 45 years		< 19 or > 45	
Depression	Mood is NOT significantly depressed		Mood IS significantly depressed	
Prior attempts	No prior attempts		1or more prior attempts	
ETOH	Not ETOH or drug dependent		Is ETOH or drug dependent	
Rational thought (loss of) or Psychosis	No psychotic symptoms		Psychotic symptoms	
Support/Lack of	Has emotional &/or social support		No significant emotional or social support	
Organized plan	Simple ideation or impulses		Articulates an organized plan	
No spouse	Family support or significant other is available		No spouse or significant other	
Sickness	No medical problems causing stress		Medical problems not well controlled & source of stress	

Recommended guidelines for interventions based on points given:

0 - 2 Outpatient follow up; assist with appointment

3 - 4 Supervised, supported outpatient follow-up; hospitalization for some pts

5 - 6 Hospitalization unless safe alternative arranged and verified; psychiatrist consult

7 - 10 Hospitalization; may need involuntary commitment; psychiatrist consult

NURSE SPECIFIC

In addition to the above general safety information, nurses are responsible for the following as well.

Verbal/phone orders

Verbal orders are discouraged because it creates an opportunity for an addition or deletion from what was said. If , however, a verbal or phone order is taken, the nurse (or other listed below) is to **"read back"** the information obtained to verify and clarify the information given. Verbal orders may be taken by the following disciplines according to their scope of practice and by SCRMC's medical staff bylaws:

- Registered Nurses
- Licensed Practical Nurses
- Pharmacists
- Physical Therapists & Speech/Occupational Therapists
- Registered Dietitians
- Registered Respiratory Therapists
- Licensed Radiologic Technicians
- Emergency Medical Technicians/Paramedics
- Certified Registered Nurse Anesthetists

Only a physician or his/her designee may give verbal orders; only those credentialed by the medical staff may give orders for medications. The verbal order is to be recorded in the patient's medical record immediately and signed by the prescribing physician **within 24 hours.**

Critical Lab Values

As with verbal orders, verbal or phone lab values should be **"read back"** as well - especially critical lab values. Critical lab values are defined by laboratory standards and a list of critical values at SCRMC are found in the lab manual. When a critical lab value occurs, the lab will call the appropriate patient care area to alert the staff that a critical value has been identified. Usually the lab does not report the value over the phone but alerts the staff to be on the look-out for the critical results to be reported by fax from the lab or resulted under the flowsheet tab in Cerner, the electronic medical record. After the nurse receives the critical lab value, a physician involved it the patient's care must be notified within **one (1) hour**. Before physician notification, be sure no other labs have critical values on the same patient - ask the lab regarding other tests being done in a different lab department; i.e., CBC, BMP, etc. Check the patient's medical record for previous lab results (the previous result could have been critical also but this one may show improvement). **The nurse must notify a physician of the critical lab**

values within one hour unless there is a written order on the chart not to do so.

Ten laboratory results will populate to the eMAR or CareMobile in Cerner to alert the nurse of these specific findings:

Hemoglobin	Hgb
Hematocrit	Hct
White blood cell count	WBC
Partial pressure of CO_2	pCO_2
Glucose	Glu
Potassium	K
International normalized ratio	INR
Vancomycin trough	
Troponin I	
Creatinine	Cr

These plus other lab findings will be resulted in the computer and may be found under the "Flowsheet" tab in Cerner for that specific patient. Abnormal results are recorded in red with either an "H" (high), "L" (low), or "C" (critical) noted beside the result. Normal results are recorded in blue.

Medication Safety

Safe and accurate medication administration is an ongoing goal at SCRMC. Multiple steps have been taken to ensure maximum safety in this regard. Again, as a reminder, the 2 patient identifiers are ***name*** and ***date of birth***; both of which are found on the patient's identification bracelet. Many medication variances could have been prevented if healthcare providers had adhered to this basic step. The "five rights" (patient, medicine, dose, route, and time) of medication administration are enhanced by the use of electronic documentation of medicines through Cerner using the eMAR or CareMobile. These checks are done at the point of care - at the patient's bedside; thereby decreasing the inadvertent occurrence of a medication variance.

High Alert Medications

The acronym **"P-I-N-C-H"** has been adopted to remind the nurses of SCRMC's high alert medications. These are meds with a narrow margin of safety and a heightened occurrence of potential harm if not administered carefully. Each of these meds require a "nurse witness"; that is, a second nurse must review and document the dosage needed ***before*** administered to a patient. The following explains the acronym and situations when a nurse witness is required:

- "P" - potassium or other concentrated electrolytes when given in an IV to a patient $\leq$ 13 years or $\geq$ 80 years of age
- "I" - insulin with each dose, whether IV or subcutaneously
- "N" - **narcotics** when given to a patient $\leq$ 13 years or $\geq$ 80 years of age; all **neuromuscular blocking agents (paralytics)**
- "C" - chemotherapy when given parenterally
- "H" - heparin with each dose whether IV or subcutaneously

IV infusion pumps are used on all IV admixtures (except for multivitamins or MVI), especially on all high alert meds. Any dosage calculations should be checked and verified by another nurse or pharmacist when needed. If a verbal or phone order was given, **"read back"** the order for verification. Note the alert labels placed by Pharmacy on medications when the order is such that the standard concentration is not used.

Look alike/Sound alike Medications (LASA)

With an increase of medication development comes the increase of potentially confusing names. A list is maintained by Pharmacy of look-alike/sound-alike meds and these meds are "stickered" with a precaution when dispensed from the Pharmacy. This sticker alerts the nurse to double check to be certain the med being given is the one desired.

Two frequently administered medicines that look-alike/sound-alike are ***Heparin*** and ***Insulin*** preparations. All Insulins are kept in compartmentalized containers in the medication refrigerator with each specific type kept separate from the others. Heparin dosages are labeled with the sticker to call attention to the strength of the medicine. **There is NO SHORTCUT for checking the label of the med when you pick it up,**

when you draw it up, and before you administer it! Don't ever forget the basics!

Medication Reconciliation

Medication reconciliation helps prevent patient harm from medicines. ***Medication reconciliation*** is the means by which the patient's medications and how taken at home are verified and made available for the physician to continue, modify, or discontinue while in the hospital. When a patient is transferred from one level of care to another (CCU to nursing unit or Surgery to nursing unit), their medicines are reconciled. At the time of discharge, a complete list of all the patient's medicines to be continued is generated for the patient's information or that of the next health care provider. This insures safe and accurate medication instruction before, during, and after the patient's stay.

Upon presentation to the hospital, the patient or his/her representative is asked about current medications being taken. If bottles or a list are provided, the staff carefully questions the patient regarding how the medicines are *actually* taken in comparison to the directions on the bottle or list. A ***"Home Medication List"*** is recorded *as the patient takes the meds* for the physician to review including the medicine, dosage, route, frequency, and purpose.

After the review of this ***"Home Med List",*** the physician indicates the meds to be continued or discontinued by checking the appropriate blank beside the medication. Once *dated, timed, and signed,* the sheet is prepared for faxing to the pharmacy.

Anticoagulant Safety

Multiple steps are taken to ensure safe anticoagulant therapy. ***Heparin*** is one of the **"PINCH"** or high alert meds that requires a nurse witness before the dose is given. The INR is one of the lab results that populates to the eMAR alerting the nurse to this result. Reducing the likelihood of patient harm associated with the use of anticoagulant therapy requires an interdisciplinary approach. The nurse should always check the anticoagulant therapy order closely noting the dose, route, frequency and the appropriateness for the

patient's clinical situation. The Heparin protocol outlines the standards of care for Heparin therapy.

Avoiding Wrong Site Surgery/Wrong Procedure

Normally before any invasive procedure/surgery can be performed, the patient or another acting on the patient's behalf must give consent. The physician provides "informed" consent regarding the specifics of the procedure and a licensed person witnesses the signing of the consent. At times, telephone consent is obtained, necessitating that two licensed persons must verify the consent and both witness the consent form. This begins the process of correct patient, procedure, and site.

If laterality is involved, the site will be marked with an indelible, latex-free marker. The patient is encouraged to participate in this verification process by stating "which part" and "what" is going to be done. *Only if the practitioner, who is performing the procedure, is in continuous attendance with the patient from the time the decision is made to do the procedure and consent is obtained, until the procedure is completed, can the site marking be exempted.*

A "time-out" is performed just prior to the procedure as a final verification of the correct patient, procedure, and site. This process is also used when procedures are done at the patient's bedside; i.e., chest tube or PICC line insertion. Any discrepancy identified will result in an immediate halt to the procedure until the discrepancy can be resolved. A "Reportable Event" form should be used to report the discrepancy.

Error Reporting

At times, events develop outside the expected. Any variance from normal operations which may result in an actual or potential risk to patients, visitors, or staff should be reported by completing a **"Reportable Event"** form. This will be reviewed by your director and then sent to Administration. Employee injuries should be reported on an **"Employee Occurrence Report"** and sent to Employee Health. Any variance related to medications should be reported

on the **"Error Hotline" at 4227** or on a **"Medication Variance Report."**

Nurses may be responsible for reporting *Sentinel Events*. A *sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.* Serious injury specifically includes loss of limb or function. The phrase *"or risk thereof"* includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Types of *sentinel events* may include but are not limited to: any patient death, coma, medication error, suicide, patient elopement, procedure performed on wrong patient or wrong site, any assault, falls, and hemolytic transfusion reactions. Report "near misses" that could have resulted in any of these outcomes. Report these events immediately to your director or supervisor. ***Your most important action following a reportable event or medication variance is to assess your patient and respond to their needs.*** A report should be filled out with documentation of the situation. A complete investigation of the incident will include ways to prevent the error from recurring.

RESTRAINTS FOR MEDICAL HEALING AND BEHAVIOR CONTROL

The use of restraints can be clinically important for patients to receive needed interventions, but restraints can also cause injury and even death. Most deaths related to restraints result when patients struggle against the restraint and get tangled in the device cutting off their airway. Nurses must recognize the potential risk to patients in restraints. With the revised Initial Admission Assessment, patients are now assessed for restraint risk. Patients who pull at their IV or other lines or tubes, and those that attempt to climb out of bed are at risk for the use of restraints for medical healing. Patients who display behavior that is identified as dangerous to themself or to others are at risk for restraint use to control these behaviors. Nurses have a very important and significant role in recognizing when a patient might require restraints. Nurses can have a profound impact on the number and length of time restraints are used.

When restraint risk factors are identified the nurse should intervene to prevent the use of restraints if possible. This includes providing verbal instructions to the patient/family. The instructions should emphasize the importance of the patient/family calling for help when assistance is needed. The family should be encouraged to stay with the patient as much as possible to help prevent injury. The patient's call light should be conveniently located and the bed should be in the lowest position. Positioning the patient may help to deter harmful movements. The nurse should review current medications that may contribute to the patient's altered sensorium and if possible work with the physician to adjust these medications. Diversionary activities such as TV, music, visitors, or activities may help prevent the need for restraints for some patients while these activities may irritate others. The high-risk patient should be checked on frequently, preferably a minimum of every two hours.

If the patient's clinical assessment suggest the need for restraints, the RN

may initiate restraints and then notify the attending physician. A physician's order must be obtained within 12 hours of the initiation of restraints used for medical healing. Medical restraints are those used to prevent the patient from pulling out tubes or climbing out of bed.

If restraints are applied for the primary purpose of behavior control and not for medical healing, a face-to-face evaluation by a physician must be done within one hour. Using restraints at South Central is considered a “special intervention” that must be used safely and appropriately. Restraints should only be used when medically necessary and limited to clinically appropriate situations.

Not only are wrist, ankle belts, and chest vest defined as restraints, but also hand mitts, bed rails and even certain medications. A device is determined to be a restraint only by the device’s intended use, and its involuntary application. Restraint standards do not apply to:

- standard practices that include limitation of mobility or temporary immobilization related to medical, diagnostic, or surgical procedures and the related post-procedure care

- adaptive supports such as postural support, orthopedic appliances, helmets
- forensic and correction restriction used for security purposes.

If all four bed rails are raised, the patient is restricted from getting out of bed, the side rails serve to restrain the patient. Severe injury may result when patients attempt to climb over side rails. Leaving one of the four rails down helps prevent the risk of severe injury. Medications used for the purpose of controlling a patients behavior may be considered chemical restraints. If a sedative-hypnotic, anti-anxiety, or anti-psychotic is ordered to control a patient’s behavior, and the medication is not a part of the patients identified care plan, the medication is considered a type of restraint. Medications used at SCRMC for this purpose include Geodon or Haldol. Monitoring and documentation should follow the policy for Behavior Control Restraints.

Two categories of restraints are used at SCRMC based on the **PRIMARY PURPOSE** for their use. Restraints may be used for:
1. **Medical Healing** or 2. **Behavior Control.** In most cases at South Central restraints are used for the primary purpose of medical healing. These are restraints used to promote healing and to keep patients from interfering will interventions being used to assist in the healing process. When restraints are used for security of lines or tubes or to keep the patient from climbing out of the bed they are considered *medical-healing* restraints. For example, if a patient in CCU is intubated and on the ventilator, or has life-sustaining IV lines and a restraint is used to keep the patient from pulling out their lines, the use is for *medical-healing.* If the restraint is to keep the patient from getting out of bed or falling out of bed, or otherwise injuring themselves unintentionally, the purpose of the restraint is *medical-healing.*

When a restraint is used for the primary purpose of managing a patient's behavior is the restraint considered a **behavior-control restraint**. Only in rare situations would a *behavior-control* restraint be used at SCRMC. Suicidal or drug overdose patients are often admitted to the critical care unit for close observation. If these patients are restrained to prevent the pulling of therapeutic lines or tubes, the restraint is for the purpose of medical healing even when the patient is admitted with a behavior health diagnosis. When these patients no longer have lines or tubes, and the need of restraints continue for the purpose of controlling behavior, the Behavior Control Restraint policy for monitoring and documentation applies. **Using restraints to control a patient's behavior is limited to emergencies in which there is an imminent risk of a patient physically harming themself or others.**

Below is a chart that outlines the differences in restraints used for medical healing and those used for behavior control.

Requirement	**Medical Healing**	**Behavior Control**
Physician's Order	*Requires a physician's order which must be obtained within 12 hours of application*	*Requires a physician's order which must be obtained within one hour of application*
Order must include	*Purpose of the restraint, the time limit, type of restraint, and clinical indications.*	*Purpose of the restraint, time limit, type, and clinical indications*
Time Limitation	*Medical- healing restraints are limited to 24 hours without a physician re-ordering the restraint*	*Behavior -control restraints are limited to 4 hours. After 4 hours the restraints must be removed or re-ordered*
Initiation	*Medical-healing restraints may be initiated by a RN based on patient assessment*	*Only trained clinical staff may initiate behavior-control restraints*
Physician Notification	*The physician must be notified within 12 hours of the initiation and a verbal or written order is obtained. If the restraints are based on a significant change in the patient's condition, the physician is immediately notified.*	*The physician is notified as soon as possible but no longer than one hour after the initiation of the restraint.*
Physician Assessment	*The patient must be evaluated by a physician within 24 hours*	*The physician must do a face-to-face evaluation of the patient within one hour*
Monitoring of the Patient by Nurses	*These patients are observed by the nurse every 2 hours*	*Must be continuously monitored by one-on-one observation*
Documentation	*Monitoring is documented every 2 hours in the medical record*	*Monitoring is documented every 15 min*

Preprinted physician orders for restraints are available for the physician's use. These preprinted orders help capture each requirement of restraint orders including the purpose of the restraint, the type, the time limitation and the clinical indication for the restraint**. PRN restraint orders do not meet these requirements and must not be written nor honored by the nurse.**

The "Restraint Flow-Sheet" was designed to help meet the documentation requirements for restraints. The flowsheet allows nurses to select and check information that applies to the patient in restraints. Each time the patient is monitored, the nurse documents the patient's position, circulation, motor function, and sensory function on the extremity to which the restraint is applied. Range of motion to the restrained extremity, mental status of the patient, level of consciousness, and patient needs are also documented. Monitoring of the patient in *medical healing* restraints should be documented every 2 hours and monitoring of the patient in *behavior control* restraints should be documented every 15 minutes. The nurse should document patient behaviors which support continual use or removal of the restraint. When restraint is no longer indicated, the time restraints were removed or discontinued should be clearly documented in the patient's record.

Nurses have a significant role in recognizing when a patient's behavior suggest the need for possible restraint use. Nurses can have a profound impact on the number and length of time restraints are used.

Anatomy of a Hurricane

A Sentinel Event Story
taken from the MS Hospital Association's
Fourth Annual Societies Conference and
Healthcare Forum
Bay St. Louis, MS, April 23, 2004

Could this happen at SCRMC? Could you prevent an event like this from happening to one of our patients?

At 1900 (7:00 PM) on Friday evening, a male patient, LaMont D. Sanford, presents to the Emergency Room and is triaged immediately. He came to the Emergency Room by private vehicle and was ambulatory. The patient was deemed “non-urgent” and had complaints of headache and body ache since Tuesday. Mr. Sanford’s vitals were essentially normal and he was noted to have a past history of alcohol/tobacco use, thyroid disease, insulin dependent diabetes and a family history of arthritis and chest pains (father).

The emergency room was busy and Mr. Sanford was not placed in a room until 2035. He was given the only available room and was placed in the room furthest from the nurses station down an 8 room hall. The ER physician saw Mr. Sanford at 2105. A blood glucose resulted at 2145 revealed a glucose level of 327 (normal 70-110). The nurse made the ER physician aware of the glucose and a separate order was written for Humalin (insulin) at 2148.

The nurse questioned the order upon receiving it. The ER physician told her that he did not want the “standard” sliding scale insulin for this patient and wanted his own sliding scale exactly as he had written it on the order sheet (attached). The nurse conferred with another nurse in the ER, both interpreted the order as *500 R Humalin in 500 cc NS*. The other nurse suggested questioning the physician again. His response, when questioned, was that there were a lot of sick people in the ER and some of them were going to leave if he had to discuss every order he wrote 3 times, and instructed the nurse to send the order to pharmacy STAT. At no time did the physician review the written order or make any amendment to it.

The pharmacist received the STAT order and called to the ER to question the order. The nurse treating Mr. Sanford indicated that she had discussed the order with the physician and that he wanted it exactly as written. The emergency room physician overheard a portion of the conversation, took the phone from the staff nurse and instructed the pharmacist that it was not her job to question the physician orders, but to fill them and told her to get it up to the ER STAT. The pharmacist attempted to page her manager after speaking with the physician. After 10 minutes, the page had not been answered, the ER contacted the pharmacy again for the medication, the pharmacist prepared it and sent it to the ER at 2230. The medication was hung and began infusing at 50 ml/hr.

The nurse, concerned about the dose of insulin, began additional checks on the patient. The patient had begun to appear sleepy at the time the infusion was begun. The nurse placed Mr. Sanford on a cardiac monitor even though no order was given to do so. The nurse instituted 30 minute glucose checks. At 2305, the glucose level was 252; at 2330, it was 178; and at 2358, it was 118.

At 0020, the patient in the room adjacent to Mr. Sanford coded. Mr. Sanford's nurse was also the primary caregiver for the coding patient and participated fully in the code which lasted 25 minutes. At the end of the successful code, the nurse exited the coded patient's room, and, for the first time, heard an alarm coming from Mr. Sanford's room.

Mr. Sanford was unresponsive, a code was immediately initiated, but Mr. Sanford expired.

The Name of the Storm: Profiles of the People Involved

The Primary Care Nurse: Nurse P is a nurse who decided to go to nursing school at the age of 38. She has worked for the hospital since graduation from nursing school 18 months ago. She has been in the ER for 13 months. She is very outspoken and has at times been confrontational. She had a better than average rating for a person of her experience level at her last evaluation for both clinical knowledge and critical thought. Recently, however, her file reflects that she had received a verbal citation for voicing a disagreement with the physician that was on duty the night of this incident. The citation incident involved the nurse enforcing a written policy within the ED against the physician's wishes. The physician felt the policy should not have been applicable to the circumstance. A heated verbal disagreement ensued between the two. Ultimately the Nursing Supervisor made an exception to the policy for that one limited circumstance. The nurse was verbally counseled and cited, not for attempting to uphold the policy, but for the manner in which she handled the situation.

The Physician: Doctor A is part of a group of contracted Emergency Room

Physicians. He is credentialed by the hospital and has Emergency related privileges. He has worked at the hospital for 4 years (all as a contract physician), and is currently the chief spokesperson for the group at the hospital. Dr. A is felt to be an excellent clinician by his peers and the emergency room staff. However, since he has been working at the hospital, there have been 5 - 10 incident reports written which relate to impulsive, impatient, and in some instances, aggressive non-physical behavior. None of the files maintained in Medical Staff Services reflect these incident reports, nor his behavior, but it is well known to the Medical Staff Services Director and employees. The above prior incident with *Nurse P* was reported to Medical Staff Services and the Administrative head of the contract group, but no formal documents are available evidencing what discussion or action(s), if any, were taken. There are also no documents which, in any way, address the physician's longstanding poor handwriting.

The Pharmacist: Pharmacist R has 6 years of experience with 5 of those years being at the hospital. Pharmacist R recently had her first child and returned to work 2 weeks before this incident after being off work for 12 weeks. Prior to maternity leave, she had worked a day shift, but asked to be moved to nights to balance child care responsibilities with her husband. She has worked 6 shifts as a night pharmacist. She has consistently displayed good clinical skills.

Patient: LaMont D. Sanford: Mr. Sanford is a 31 year old male who has been married for two years. He lives with his wife and one year old son in a house adjacent to his father (Fred G. Sanford) and his Aunt Esther and Uncle Woody. Mr. Sanford is an antique dealer who hosts a popular television show on antiques and collectibles. His wife is the daughter of a local State Senator. Mr. Sanford had driven himself to the hospital on the night of this incident so that his wife could stay at home and tend to their son. He does not have a private insurance plan and is listed as a "patient pay".

Storm Surge

The patient's father, wife, and Aunt arrive after being contacted and asked to come immediately to the hospital. They are met and taken to a private room at 0130. The physician involved goes into the room with the family

without any hospital personnel present, introduces himself and tells the family, in a very straight forward manner, that the nurse gave Mr. Sanford too much medication and that he died as a result of the medication. The physician indicates that he is sorry and that the family can contact the hospital for any additional information. He indicates that someone will come in shortly and allow them to view Mr. Sanford, and then excuses himself.

He communicates to the unit secretary that he has spoken to the family but gives no details and indicates to her that the family is ready to see the patient. He asks the unit secretary to ask the nurses to assist them.

The pharmacist indicates that she attempted to contact her supervisor via pager. It is later discovered that the Pharmacy supervisor received a new pager 1 month ago. The pharmacist on duty was not aware of the change, as she was on maternity leave when the change was made. The schedule for the Pharmacy Supervisor is posted in the pharmacy work area; however, the pager change was posted on the bulletin board in the pharmacy administrative area. That area is separate from the work area and is, for all intents and purposes, closed when the Director leaves at 6:30 PM.

The Nursing Supervisor was not contacted by the pharmacist. The unwritten practice in the Pharmacy has always been to contact the Pharmacy Supervisor, not the house-wide Nursing Supervisor when problems arise. Contact with the Nursing Supervisor has been discouraged unless direction to do so is given by the Pharmacy Supervisor.

The nurse for the patient indicates that she was in a code in the next room and did not hear the monitor alarming. Upon checking, it is discovered that the monitor alarmed at the nurses station, and the staff at the desk looked at the display screen, believed it was the monitor for the room in which a known code was taking place, and the staff silenced the alarm.

The alarm at the desk is programmed so that it may be silenced for 3 minutes at the desk (which does not affect the monitor in the room). Staff at the nurses station indicate that they silenced the alarm many times. They also comment that it seemed as if the monitor alarms were able to be silenced for 3 minutes at first, but that about half way through the code (in

the adjacent room), they seemed to be going off quicker than every three minutes.

The monitor at the desk displays 8 monitors per screen. The display reflects each room on top of the other in chronological order. The room number is indicated on each “strip” in the upper left hand column and displays room number, account number for the patient, and that patient’s last name.

The door to Mr. Sanford’s room was left open by the primary care nurse. The in-room alarm volume settings are set by Biomedical. The silencing intervals are also set by Biomedical. Neither setting is at the maximum allowed by the manufacturer.

This story demonstrates that multiple errors can be made that not only jeopardize the health, but in this case, the life of a patient. Nurses must constantly be on alert for safety risks for our patients.

QUESTIONS TO PONDER .....

What would you do if this happened on your unit?

How many medical errors can you identify in this event?

If this had happened at SCRMC, how many different safety policies would have been violated?

Could the ER nurse have done anything differently to prevent this?

What could the Clinical Coordinator in the story have done differently?

What responsibility does the hospital’s Administrator have?

What was the Pharmacist’s responsibility?

What responsibility did the ER physician have in the error?

If you worked with a physician like this ER doctor, would you have questioned his order?

Should the nurse have been fired from her job because of this incident?

Should any disciplinary action be taken against the physician?

Should the pharmacist have a disciplinary action?

How would you have explained the death of Mr. Sanford to his family?