Do you know what a Root Cause Analysis (RCA) is?

It is a process used to identify the root cause(s) (or the most fundamental reason a problem has occurred) that resulted in a sentinel event, near miss or an undesirable event that could be prevented by using a structured methodology to improve upon a system or process.

Do you know what a sentinel event is?

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.

What do you do when a sentinel event occurs?

– Complete a Patient Safety Net Report.
– Perform a root cause analysis.
– Develop an action plan to implement improvements to reduce risk.
– Implement the improvements.
– Monitor the effectiveness of those improvements.

Do you know what a Failure Modes & Effects Analysis (FMEA) is?

It is a proactive analysis of a process to identify potential system failures.

Do you know what FMEAs SHC has performed?

2002: Oxygen Regulators
2003: Sponge Counts, PCA Pumps
2004: Behavioral Emergencies, Instrument Count

SHC uses what Performance Improvement model?

FOCUS-PDCA: Be able to talk about the most recent performance improvement project in your service area.

What has the organization done to improve upon our culture of safety?

– Culture of Safety surveys were performed in 2001, 2002, 2003.
– Instituted Patient Safety Net in 2002 to address problem areas identified in Culture of Safety surveys.
– Culture of Safety team was formed in 2003.
– Charged each SHC physician, staff, contractor, and volunteer to be a Patient Safety Officer.

Does SHC have a policy for unanticipated outcomes?

SHC has a policy called Unanticipated Outcomes. The policy gives us the guidelines for disclosing and documenting any unanticipated outcome to the patient and family members and/or significant others.

What is your role in patient safety at SHC?

– Abide by the 7 Patient Safety Goals implemented by SHC
– Ensure I have the right patient by checking two identifiers when providing direct patient care: Ask patient name, check armband and MR number and compare with your charting (use DOB instead of MR number in outpatient setting).
– Improve communication by listening and confirming read-backs of our 12 defined critical test results.
– Improve communication by not using our unacceptable abbreviations.
– Eliminate wrong site, wrong patient, wrong procedure.
– Ensure pre-op checklist is complete.
– Ensure procedure site is marked (if appropriate) and visible after draping.
– Lead a time-out prior to incision.
– All infusion pumps at SHC have an anti-free flow mechanism.
– Clinical alarms on patient monitoring equipment are audible, maintained and responded to appropriately for each care setting.
– Reduce risk of infection: Follow Center for Disease Control (CDC) hand hygiene guidelines; no artificial nails; sentinel events including health-care acquired infections.
– Identify and participate in PI activities.
– Abide by SHC Documentation Guidelines.
What abbreviations have SHC deemed unacceptable?
- µg (for Microgram)
- U or u (for Units)
- Do NOT use trailing zeros
- Q.D., q.d., Q.O.D., q.o.d. (for every day or every other day)
- MSO4, MgSO4, MS (for Morphine Sulfate, Magnesium Sulfate)
- IU (for International Units)
- c.c. (for cubic centimeters)
- SQ, SC (for subcutaneous)
- DO use leading zeroes.

How do you access the Ethics Committee off hours or weekends?
- Call the SHC Page Operator and have the Ethics Committee member on-call paged.

How do you ensure patient rights are maintained while you are on service?
- Knock on patient doors before entering.
- Use privacy curtains.
- Do not discuss patient care in public areas.
- Follow SHC restraint policy and standards.
- Do not leave patient information on computer screen.
- Do not leave patient information on fax machine.
- Use your own personal password and log-in.
- Do not leave patient records unattended.

Who is our Safety Officer?
Vicki Running

Who is our Patient Safety Officer?
You, me, and everybody

Name a few of our organizational-wide Performance Improvement initiatives?
- Core Measures (CHF, AMI, CAP)
- Behavioral Emergencies

What drugs trigger Food-Drug Interaction Education?
- Education is provided by the Pharmacy for:
  - Monoamine oxidase (MAO) inhibitors
  - Isoniazid
  - Lithium

What is our practice for medications brought from home?
- Family members are discouraged from bringing medications from home.
- Medications brought with patients are sent to Pharmacy for identification and storage.
- If these stored medications are ordered by a physician to be taken during the hospital stay, the clinical pharmacist is contacted to identify and inventory the medication.

How do you report an Adverse Drug Reaction?
- Complete a Patient Safety Net report and contact clinical pharmacy for additional assistance.

How are medications secured in your area?
- Stored in the locked PYXIS and/or locked medicine carts. All emergency medication is stored in the locked crash carts.

How and when do you screen for pain?
- Pain is screened upon each admission or visit using the pain scale that is age appropriate and translates to the SHC 1-10 scale. Pain is assessed and reassessed by nursing personnel as the fifth vital sign. As a physician, pain management is an integral part of patient care. ❖