PATIENT SAFETY
FEEDBACK

Patient Safety Reporting System
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FEEDBACK shares excerpts of reports sent by VA personnel to PSRS. Actual quotes appear in italics. Created by an agreement between NASA and the VA in May 2000, PSRS is a voluntary, confidential, and non-punitive reporting system. PSRS encourages VA personnel to describe safety issues from their firsthand experience and to contribute their information to PSRS.

Clinicians Contribute Reports

All reports in this issue have been voluntarily submitted by physicians, nurse anesthetists, physician assistants and nurse practitioners from VA facilities across the country.

Alert Advice... Act One

A PSRS reporter feels that current VA technology could send clinicians additional alerts about abnormal results. The clinician evaluated a patient for stomach problems at the end of a busy clinic day. Noting that the patient had a rapid heart rate, the clinician ordered an EKG.

- *The next day... I thought to check the EKG,* [but forgot due to] *the amount of work and increasing acuity of patients.*

The overlooked EKG was abnormal.

- *Subsequently the patient was seen in the emergency department and admitted to the hospital with an abnormal heart rhythm and congestive heart failure.*

The reporter had a suggestion:

- [Abnormal] *EKG reports could be forwarded to providers as a view alert or part of email similar to the way critical lab results are reported.*

Alert Advice... Act Two

A PSRS reporter believes thresholds for critical values used by the laboratory to alert clinicians should be reevaluated:

- *I had a patient who was suffering from hematemesis and melena for several days...* [When the patient] *came to the VA for blood tests, hemoglobin was 7, and hematocrit was 22.*

The reporter was concerned that these abnormal values did not prompt an alert to the clinician. Fortunately, the patient returned for follow-up three days later.

- *The blood test results were evaluated and the patient was admitted for anemia and given a blood transfusion.*

The reporter suggested that tighter thresholds could be set, alerting the clinician when:

- *Patient has a hemoglobin less than 8 and hematocrit less than 24 or a marked change from a previous value, for example, a 20% or 25% decrease.* [This would identify] *a life threatening blood test abnormality that cannot wait until the* [next] *appointment.*

Alert Advice... Act Three

Two PSRS reporters found that adverse effects result when clinicians override caution alert screens when ordering medication. In the first instance:

- *Patient* [who] *went to ER for hematoma to lower leg as a result of injury at home, was a Coumadin patient… Patient was given 20 pills of naproxen (NSAID) 500 mg. bid prn… The prescriber of the naproxen overrode a significant drug-drug interaction: naproxen and warfarin, and it was dispensed by pharmacy.*

When the patient came in for an urgent clinic visit to treat a worsening hematoma, lab tests were taken:

- *INR was 9.2. Patient was subsequently admitted to hospital for over-anticoagulation… The patient was given Vitamin K after admission (antidote)… It took several days of hospitalization to regulate the anticoagulant therapy.*

In the second instance, the PSRS reporter found that a clinician ordered Megace for an emaciated patient.

- *Drug was listed in patient's allergies. Physician received an alert about the allergy, but entered an override… Medication was issued by pharmacy, but intercepted by nursing.*

The reporter felt that the situation identified several issues:

- *Large number of alerts already in CPRS (as many as 50-60).*
- *Alerts are not prioritized as to severity. For example, a drug allergy like a minor skin rash has the same significance as an anaphylactic reaction.*
- *Alerts are too easily overridden, without any requirement for justification.*

Stony Silence

A recent report concerned "patients slipping through the cracks" due to lack of communication between providers:

- *Not reading the referring provider's notes … puts patients at risk, and in the long run is more time consuming.*

The PSRS reporter cited a recent example after receiving a patient's KUB x-ray results:

- *The x-ray report from the radiologist* [showed] *a large kidney stone that would probably need excision or pulverization… On exam* [the patient] *was found to have exquisite flank pain.*

The reporter documented the findings and sent the patient to the Urology Clinic. Half an hour later, the reporter read that clinic's intake note:

- *The note made no mention about kidney stones, only that the patient complained of back pains and had some incontinence…* [The nurse] *obviously never read my consult or my note.*

Later the reporter checked the physician's progress notes for that clinic visit.

- [The physician] *indicated that the patient complained of incontinence and ... placed the patient on ditropan and scheduled* [the next] *appointment for 6 months.* [That physician] *did not read my progress notes, or the consult I sent.*

Through an intermediary contact, the patient saw another physician who scheduled a lithotripsy.

To Be or Not to Be a PEG Tube

A PSRS reporter was concerned about confusing orders written for a dialysis patient. A physician incorrectly identified the patient's CAPD catheter as a PEG tube for enterostomy (gastric) feedings, and wrote an order to use the CAPD catheter as a feeding tube. The reporter noted the reason that such an order posed a risk:

- *A CAPD catheter is for intra-abdominal peritoneal dialysis. It is never used for anything but dialysis and must be very, very clean to prevent acute bacterial infection in the belly.*

Although the progress notes did not record that the CAPD catheter was used for feedings or administering medications, it had been modified:

- *It appeared the tube had been used for other than dialysis because there was a three-way stopcock on the tube. A three-way stopcock is not part of equipment for intra-abdominal peritoneal dialysis.*

Small Note, Large Effect

A PSRS reporter described a situation where responding to a lab value without awareness of a critical qualifying note led to an unneeded clinical intervention.

- *Patient remained hypokalemic (reflecting poor nutrition), requiring some potassium supplementation, potassium repeatedly in the range of 3.3 - 3.6.*

A later potassium value showed a marked change:

- *Potassium of 5.8 noted on daily labs, interpreted as new hyperkalemia. Potassium treated with Kayexelate… Potassium next am was 2.*

However, the lab result was inaccurate, due to hemolysis of the specimen:

- *Lab results noted that this specimen was grossly hemolyzed, but this notation is small, at the bottom of the sheet, and was not copied over to the progress note during the copy/paste process.*

The reporter recommended:

- *Hemolyzed specimens should be reported as such, without a value, with notification to repeat the test.*

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