psrs
Patient Safety Reporting System
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PATIENT SAFETY
FEEDBACK

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The Drama of Communications

In a hospital setting, communication involves multiple "players" and "scripts" featuring doctors and patients, staff and patients, staff and staff, medical departments and staff and other communications. With all of this activity, occasions arise when effective lines of communication may not be in place or are not utilized. Let's raise the curtain on several incidents reported to PSRS, in which miscommunications altered the health care script and may have decreased safety.

A Case of Wayward Warfarin

In 2005, the Joint Commission created the National Patient Safety Goal # 8 for Medication Reconciliation. It was meant to ensure that a patient's medication regimen was communicated across all medical services. Reconciling medications through proper documentation and communication can save a patient's life. In this scenario, the breakdown in these processes resulted in an emergency hospitalization and transfusion of a patient.

A Pharmacist reports:

- [Spouse] *takes care of the patient's medication. Pt. goes to lab every month to monitor bleeding time. Doctor sees results of lab, results are too high and verbally tells* [spouse] *to decrease dose, and documents this in chart. No new prescription with new directions is issued. For several months, the dose is decreased* [verbally] *at each visit* [by the physician]... [Spouse] *goes into the hospital. The patient then reads directions on the bottle of Warfarin, which are no longer correct and takes an overdose.*

This pharmacist is concerned that in the clinic setting this is a common occurrence. In this reported event, the outcome was an inadvertent overdose by the patient. According to the reporter, this facility is speaking with providers at weekly staff meetings to raise their awareness concerning this issue. By reporting to PSRS, this reporter has provided good information so that everyone with similar issues at all facilities can correct them.

Upcoming VA Guidance - In a recent VA study, it was found that patients overseen by Coumadin Clinics have a greater propensity for appropriate monitoring and achieving therapeutic levels of anticoagulation. The VA's NCPS is currently conducting a national query of anticoagulation services to determine best practices and anticipates sharing its information in 2008.

"Fire in the Hole!"

As the Joint Commission raises awareness around fires related to oxygen therapy, this report becomes very helpful in understanding why the 2007 National Patient Safety Goal # 15B is one that demands attention, in the home AND in the hospital. A Support Service staff member with over 30 years experience reported to PSRS stating:

- *A fire occurred at the hospital... when an employee attempted to refill a patient's portable Oxygen tank* [with liquid oxygen] *from the larger supply tank* [Dewar] *located in the unit's closet... While filling the portable tank, the check valve on the supply tank froze open allowing O_2 to vent into the storage closet. High humidity conditions were present this day... They attempted to warm the frozen valve by placing a cotton towel around. When this failed... a staff* [person brought] *a warm wet washcloth ... per company instructions... When the warmed washcloth was placed around the valve, spontaneous combustion occurred, igniting the washcloth and the O_2 filling instructions posted on the interior side of the O_2 closet door.*

This report shows that when the "script" is understood, players are more likely to follow the prompts. Fortunately, no one was injured during this incident. The employees realized that they did not follow the procedure for reseating the portable unit back onto the supply tank valve. According to the reporter, the facility took the following actions to help prevent this from happening again:

1) *Retrain staff*
2) *Post signage in closets affirming the proper way of handling the freeze up of the automatic shutoff valves*
3) *Explore the installation of a manual shutoff valve on fill line*
4) *Look into centralizing fill area off the patient ward*

FEEDBACK shares excerpts of reports sent to PSRS. Actual quotes appear in italics. In May 2000, NASA and the VA initiated the PSRS, a voluntary, confidential, and non-punitive reporting system. PSRS encourages personnel to describe safety issues from their firsthand experience and to contribute their information to PSRS.

For more information on the various requirements for refilling oxygen tanks, please refer to chapters five and nine of the NFPA 99 Standard for Health Care Facilities via the VA Intranet: (http://vaww.ceosh.med.va.gov/fire_safety/NFPAWarning.shtml).

For more information on another incident regarding transfilling liquid oxygen, refer to VHA Advisory AD06-04.

The Patient in Room 'X'

This next report reveals how communication breakdowns can result in unexpected consequences. It is important for multiple disciplines to have access to each other's information. The following excerpt from a report by a physician describes an event related to communication. The reporter states:

- *Pt. in room X was an elderly diabetic admitted for intractable diarrhea. Pt. was placed NPO for an abdominal CT scan the next morning, but inadvertently pt's oral diabetes medications (Glyburide and Metformin) were not held. Later that morning, the pt. developed symptomatic hypoglycemia (glucose 47).*

During a PSRS Analyst Callback, this reporter stated that although the MD should have DC'd the oral hypoglycemic agent, there is a more persistent system issue in that the pharmacy software package does not communicate with the nutrition package. When a patient is NPO, alerts do not show up in CPRS to remind the MD.

If this is an issue at your facility, the VAOI would like you to submit a New Service Request (NSR) at http://vista.med.ga.gov/NewITRequestForm.asp. Provide a detailed write up, including a description of the safety risk and which health services are affected.

New Supporting Role

The PSRS wants you to join us in welcoming a new Deputy Program Manager, Jessica Arias. Her background is in patient safety, having most recently been responsible for implementing the Joint Commission National Patient Safety Goals at one of the Northern California Kaiser Permanente Facilities. She has experience with analysis of patient safety reports, training hospital staff on patient safety initiatives and HIPAA regulations, and conducting education and outreach activities related to patient safety. Jessica believes that the information obtained from reporters regarding safety concerns can be extended to improve and strengthen patient safety.

Jessica is a native New Yorker who moved out to California 6 years ago. She has developed a passion for snowboarding, biking and is still adjusting to the much calmer California lifestyle! She is a great addition to the PSRS team and we are looking forward to her contributions.

PSRS report forms and past issues of *FEEDBACK* are available on the VA intranet as well as the PSRS website.

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