PATIENT SAFETY
FEEDBACK

Patient Safety Reporting System
P.O. Box 4
Moffett Field, CA
94035-0004

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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.

Nursing Staff Contribute Reports

All reports in this issue have been voluntarily submitted by nursing staff from VA facilities across the country.

Reviving an Expired Protocol

A nurse's memory of a patient's previous care plan led to reinstatement of a protocol to prevent complications:

- *I noted my immobile ICU patient wasn't on DVT prophylaxis (either subQ/IV heparin or compression stockings). I recalled* [the patient] *had been* [on subQ heparin] *2 weeks earlier.*

The reporter investigated the reason for the change.

- *The subQ heparin had expired (by hospital policy it has to be renewed every 7 days) one week before. The MD had ignored a 'med expiration' reminder in CPRS.*

Their pharmacists found a successful reminder strategy:

- *The pharmacist places printouts of meds that are going to expire on the paper chart.*

Facing the Fear Factor

A reporter observed that some nursing, laboratory, and pharmacy staff avoid questioning specific physicians.

- *The question is: "Do you give or don't you give* [medication]*?... The staff fear having to call* [some physicians] *to clarify* [their orders]. *The condescending remarks and tone of voice cause nursing staff to guess rather than ask. The fear factor is a common communication safety issue with a handful of providers that makes the environment unsafe.*

The Institute for Safe Medication Practices issued two relevant reports in March 2004. The first report found 49% of respondents altered the way they handled order clarifications or questions about medication orders due to intimidation. The second report outlines eleven suggestions to change the culture, such as a verbal code, (e.g. "red light") to put an immediate stop to the behavior. (See www.ismp.org.)

Plugging Away with Danger

Observing electrical cords across walking pathways in patients' rooms concerns a PSRS reporter:

- *Outlets exist to the side and the head of the patient's bed. But many staff choose to plug equipment into the most convenient sources at the side* [of the bed] *creating a fall risk for everyone.*

The reporter felt this is both a local and a national issue:

- *No policy exists in my facility regarding this issue and I see this as a risk to the* [entire] *VA.*

Double Drugs

In two cases, alert nurses prevented repeat medication dosing. The first case was inpatient:

- *Problem arose because resident initially wrote order for med (atenolol) on admission. Another resident wrote order for same medication. Both orders appeared on BCMA. Physicians unable to visualize previous orders. Pharmacy not questioning duplicate order. Physician notified and discontinued one of the orders.*

The reporter's solution:

- *Doctors should have access to medications as they appear on the BCMA or should be able to access BCMA.*

The second case described the hand-off between outpatient and nursing home caregivers:

- *A VA contract nursing home patient came to a specialty clinic at the VA... The patient returned to the nursing home ... with a now order for pamidronate ... and erythropoietin ... The next day it was learned the patient had already received both meds at the VA.*

The second page of the VA clinic report was missing, so the nursing home staff did not know the drugs had already been given. To prevent future recurrences, the nurse reporter is working with IT managers to redesign the report into a single summary sheet. Less paper ... less risk.

Trading Places...

Three reports contributed input about employees working without related specialty training. The first described:

- *This VA has adopted the practice of pulling RNs from the psych unit to work med-surg units. Most psych nurses have been in psych only for many years and not competent to work med-surg. In the private sector people were asked if they wanted to cross-train, and if so, were trained. I feel this seriously jeopardizes patient safety and needs to stop.*

The second reporter described substitute staffing of a 2 RN med-surg unit:

- *One RN from ICU and one RN from* [a short-stay unit] *were floated to run the ward. Neither were trained on this floor but were forced into team leading roles where they were not familiar with the skills needed for this situation. Patient safety was definitely an issue.*

The third reporter had similar concerns:

- *On-going problem utilizing OR nurses to monitor patients undergoing arteriograms and angiograms. This type of nursing care is out of the OR nurse scope of practice and does not meet community hospital standards.*

The reporter was concerned about responses to medical crises:

- *Radiologists are not ACLS certified and during emergencies are unable to adequately* [provide] *care ... This critical issue continues to be a very serious situation.*

Searching for Information in the Online Haystack

Two PSRS reporters searched their patients' online records. The first one was not successful:

- *Two units phoresis platelets ordered for patient,* [but I was] *unable to locate a consent form in chart... Notified covering ... MD ... to obtain consent for record. To correct this we need a system wherein we can easily locate this information. A previous consent may exist, but no one was able to locate it.*

The second reporter eventually found the needed information, but it took a lot of time:

- [When a] *patient came from another VA hospital/clinic, it took me 3 hours to find the immunization record in the computer. If this patient had been older, confused or had poor short-term memory, this patient could have gotten a repeat pneumovax within one year of each other (making this patient at high risk for a severe allergic reaction).*

The reporter had a suggestion to increase efficiency and reduce errors:

- *Allergies and immunizations need to be one of the first things noted in the computer chart.*

Unsafe Shortcuts

A PSRS reporter wrote about concerns in assuring sterility of reprocessed surgical instrument packages:

- *When opening sterile instruments, we sometimes find that the indicator tape on the inside is outdated.*

The reporter discovered that a step in the resterilization process is apparently not consistently done:

- *What we are finding often is that when instruments are sent to be sterilized because they are outdated, that these instruments are not opened up, but that a new date is put on them and sent back to us. I am concerned that if a patient has an infection and all elements are looked into, we would be in question.*

PSRS Report Forms are available at VA Facilities and online at:
http://psrs.arc.nasa.gov

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National Aeronautics and
Space Administration
MS IHS 262-7
Ames Research Center
Moffett Field, California 94035-1000