

Lehigh Valley Health Network

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Recognizing Staff Accomplishments for Patient Safety.

Lehigh Valley Health Network

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RECOGNIZING Staff Accomplishments FOR PATIENT SAFETY



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Patient Safety website

Find on the LVHN intranet under
Departments, Non-Clinical.

LVHN Colleagues Stand United for Patient Safety

At Lehigh Valley Health Network, we strive to encourage a culture of safety for our patients. Part of that culture is to report patient safety concerns. Colleagues are encouraged to report near misses and great catches to help identify potential risks for patients. A near miss is an event that could have happened but was stopped before reaching the patient. A great catch is the recognition of those near miss events that may have caused harm to a patient but due to recognition of the safety concerns, the harm to the patient was avoided. Not only is it important to identify the near misses, but it is also important to recognize our colleagues that have made a "Great Catch". The National Patient Safety Foundation's theme for 2016 Patient Safety Week is again "United in Safety". Through our efforts to provide safe care, we strive to be 'United in Safety'.

This publication is dedicated to our colleagues who have identified potential patient safety events and made a great catch while enhancing safer care for our patients. In 2015, there were a total of 83 colleagues recognized for a great catch, spanning all levels of care within the network. Those colleagues are listed in this newsletter along with the many efforts departments are focusing on to implement and make changes for safer care. These departments exemplify patient safety efforts within the network.

We are honored and proud to share that one of our colleagues has been identified by the Pennsylvania Patient Safety Authority for their great catch this past year. Nurse Adebola Onanuga (7B) was recognized for her great catch at a special celebration in Harrisburg on March 8, 2016 and was also recognized at a reception sponsored by the Patient Safety Authority at LVH-CC site on April 19, 2016.

Anyone in the network may submit a colleague's name for a great catch by using the event reporting system, utilizing the 'Great Catch' icon. If the individual recognized a potential for harm and intervened to avoid harm that deserves recognition. It is important that exceptional care and efforts to keep patients safe is recognized.



3/8/16 - Pennsylvania Patient Safety Authority Representatives Mike Doering, Executive Director and Stan Smullens, MD, Vice Chair with LVHN's Adebola Onanuga, 7B RN.

Remember: Patient Safety 24/7, 365 days for every patient, provider, and healthcare worker!

Gwen Browning
Director/Patient Safety Officer

Marie Gutekunst
Patient Safety Officer

GREAT CATCH CRITERIA

- Nominated by staff/manager or identified by patient safety/risk management.
- **Colleague identified a potential for patient harm within their role/scope.**
- Prevented near miss that could have caused an adverse event resulting in patient harm or injury.

Tier 1

Examples:

- Recognized allergy not identified during initial assessment
- Assisted patient to prevent fall
- Discovered medication in IV bag was not the same as on the label

- Nominated by staff/manager or identified by patient safety/risk management.
- **Colleague prevented an adverse outcome for patient(s)**
- Event can be relatable across the Network

Tier 2

Examples:

- Connects allergy to latex precaution (patient has existing allergy to chestnut, banana, etc.).
- Recognizes change in condition and utilizes chain of command to push for actions.
- Recognizes an equipment issue, e.g., bed check plugs

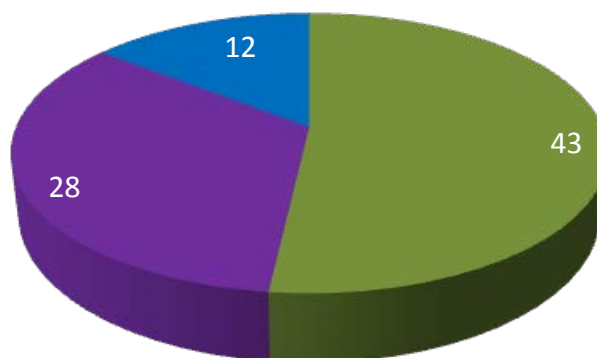
- Nominated by staff/manager or identified by patient safety/risk management.
- **Colleague portrayed exemplary actions that prevented an event which could have caused a permanent catastrophic injury or death.**

Tier 3

Examples:

- Adult dose prepared for pediatric patient
- Medication dose in ten-fold
- Behavioral Health team identifying and preventing suicide pact

2015 Great Catch Award Recipients



■ Tier 1 ■ Tier 2 ■ Tier 3

Great Catches

FOR PATIENT SAFETY

Each of the following individuals were recognized in 2015 for a great catch for patient safety; their attention to detail prevented serious harm to patients.

They have received recognition for their great catches by their peers and depending on tier awarded are eligible to receive a certificate, coffee mug and pin as a way of demonstrating the health network's appreciation for keeping our patients safe.

Join us in recognizing their efforts to put patient safety first!

TIER 3 RECIPIENTS

Adebola Onanuga, RN, Medical-Surgical Geriatrics

A patient was being prepped for surgery on our 7BP General Medical Surgical Unit. The surgeon placed new orders for an insulin drip for this patient. Although we have a well-defined protocol for surgical procedure which includes precautionary measures to maintain our patient's normoglycemic, Adebola questioned the order, noting that the patient did not have a history of diabetes. The patient's lab work was reviewed by her and by our Patient Care Coordinator and it revealed that the patient's serum glucose level was elevated at 386mg/dl. It is noted that the patient was currently receiving dextrose through her maintenance IV fluids. Adebola performed a POC capillary glucose level which read 84 mg/dl. She then notified the patient's surgeon to make him aware of her recent findings. It was suspected that the morning's lab work may have been collected upstream from where the intravenous Dextrose was infusing, causing a falsely elevated serum glucose result. The surgeon ordered a STAT BMP to confirm the capillary glucose level performed by Adebola, which showed a serum glucose level of 100mg/dl. The surgeon discontinued the insulin drip order appropriately. Adebola's prompt actions and critical thinking prevented the patient from receiving an un-necessary treatment.



Adebola is a winner of the Pennsylvania Patient Safety Authority's "I Am Patient Safety" poster contest for National Patient Safety Awareness Week 2016

You wouldn't just decide to forget about recovering the black box after an air crash. So why should it be thought so strange to want to learn from every accident in healthcare.

Sir Liam Donaldson, 11/2001

TIER 3 RECIPIENTS

Heather Adams, RN, Emergency Department-Cedar Crest

The Patient arrived to the LVHN ED from a long term facility with a Withholding of Therapy Order Sheet that indicated that patient was to have "no CPR, no electrical defibrillation, no tracheal intubation for any reason and no mechanical ventilation for any reason". The patient was stable upon arrival to ED but declined shortly after. When the patient's next of kin was contacted by the ED physician, Dr. Sexton, the next of kin/Power of Attorney stated "That's not correct, he's supposed to be intubated. He's been intubated many times before." Power of Attorney's wishes were upheld and the patient was intubated.

After the patient was stabilized, the received documents were further investigated by Heather to notice that a box with small print at the bottom was checked that said "discontinue the above orders immediately. She contacted the nursing supervisor at the long term care facility who further investigated by looking in the patient's chart. She found an updated and more current "Withholding of Therapy Order Sheet" that should have been sent with the patient's chart but was not. She faxed it to the ED so it could accompany the patient for the remainder of his hospitalization. Had the ED provider not contacted the POA, an outdated living will may have been followed, which also would have followed the patient throughout his hospital stay.



Susan Kavusak-Clark, RN, Neonatal ICU

On June 20, 2015 Susan needed to prepare an IV fluid solution for one of her neonatal ICU patients. When retrieving the solution she needed for her patient, she discovered a stock bin in the supply room that had been stocked with the wrong IV fluid solution type. The storage bin in question contained several 50 ml Normal Saline Solution IV bags intermingled with 50 or more bags of 5% Dextrose solution bags. Knowing the potential injury this could cause if another nurse or provider had not noticed this stocking error, she promptly removed the Dextrose bags from the bin and informed the nurse manager of the error. The Supply Distribution manager was also notified to determine if a process issue needed to be looked at. Her attention to detail prevented a serious patient safety event. Although a small volume in the adult world, 50 ml IV infusion bags in the NICU world can mean a life or death situation.



*To err is human, to cover up is unforgivable
and to fail to learn is inexcusable.*

Sir Liam Donaldson 10/2004

TIER 3 RECIPIENTS

Christopher Hand & Erica Romig, Radiation Technologists, Radiology Department/CT Scan

While conducting their daily duties, Christopher and Erica noticed small streak artifacts after an x-ray tube had just been replaced by the service engineer at our LVHN-Cedar Crest facility. The service engineer stated that technologists normally do not pick up on this type of artifact which could indicate a possible high voltage tank failure. Christopher and Erica's attention to detail prevented the rescanning of patients due to artifact on the images.



Dawn Smith, RN, Progressive Coronary Care Unit

On June 18, 2015 Dawn was caring for a patient who was high risk for hypoglycemia with a restricted diet that had been placed on a more aggressive diabetes medication treatment plan. The patient did become hypoglycemic the morning after admission. The patient had an order placed for Amaryl which she recognized would have caused further problems with the hypoglycemia. Dawn held the Amaryl dose and the oral agents ordered, and advocated for an endocrinology consult for her patient. Dawn's excellent judgment and nursing skills prevented an adverse effect for the patient.



PATIENT SAFETY HOTLINES

Lehigh Valley Hospital-CC/17th/Muhl
610-402-2830 or 484-884-2830

Fairgrounds Surgical Center
610-969-3111 or 484-357-6159

LVHN Surgery Center-Tilghman
610-402-3903

Leave brief message with the following information:

- Patient name and medical record number
- Patient location
- Nature of serious event/incident
- Patient involved
- Your Name (not required)

TIER 3 RECIPIENTS

Amy Roth, RN/Care Manager, Pediatrics-Center Valley

In the Spring of 2015, when Amy was caring for a patient who was admitted to the Pediatrics Unit, and presented to the LVHN Children's ER as a transfer from another facility. There were no orders for IV fluids or lab work on admission to our facility. While performing the admission work-up, she noted that the patient had several hypoglycemic episodes at the outlying hospital, as well as in our Children's ER. She questioned the physician about the lack of IV fluids or glucose level orders. The physician gave Amy approval to obtain a capillary glucose level checked which resulted at 19 mg/dL. The test was repeated and resulted low again at 20 mg/dL. The child was subsequently transferred to the Pediatric Intensive Care Unit for treatment. Her quick assessment, intervention, and attention to detail, prompted quick intervention for a very ill child.



Kayla Ahart, Registrar, ED-CC

Kayla entered a room to finish registering the ED patient and she noted that his ID band had an incorrect birthdate. Upon further investigation, Kayla discovered that the patient had been registered, triaged, and assessed under another patient's MRN. Kayla exited the room and notified the RN. Kayla discovered the incorrect DOB and prevented labs being run and medication being administered to the wrong patient. This catch also prevented incorrect information from being entered into another patient's record.



TIER 3 RECIPIENTS

Jessica Rush, PA-C, Muhlenberg

A patient's home medications were entered erroneously in medical record on the day of admission. Medications were initially ordered based on these old prescriptions. The patient received the prescribed dose of Lantus insulin which, unknown to the RN, was more than double his daily amount of Lantus Insulin. Later that night, Jessica was reviewing the patient's old records and had noticed the dosage discrepancy. Jessica contacted the patient's RN in the middle of the night to immediately check the patient's blood glucose. The patient's blood glucose was 46 and we were able to treat the patient immediately before his blood glucose had dropped even lower.



Christina Talbot, Exercise Physiologist, Cardiac Rehab/RHCM-Muhlenberg

Christina Talbot is the Cardiac Rehab Exercise Physiologist on Regional Heart Medical. She was in the room when the nurse was giving Plaquinil to a patient. She always wants to know what medications are given to a patient and why, so she researched Plaquinil and found out that it was used for gout, among other diseases. She then researched the patient's comorbidities and found none that matched why the patient was receiving Plaquinil. She asked the primary team why the patient was receiving this medication, and it was subsequently discovered that this patient should not have been receiving it. When the system was converted to EPIC, some discontinued meds had "jumped" to the active screen. The patient was absolutely not supposed to receive this medication. Due to Christine's dedication and attention to detail, this patient only received one dose of a medication which could have potentially harmed her.



TIER 3 RECIPIENTS

Douglas Jensen, RN, 7A/Neuroscience Unit

On the evening of Monday, October 12, 2015, a male visitor entered the front lobby at Cedar Crest after being dropped off by a friend, and requested directions to the Emergency Room. As he complained of stroke symptoms, the Welcome Desk attendant of the Guest Services Department immediately called the Emergency Department for help. While still awaiting a security officer, the desk assistant continued to observe the visitor and helped him lie down on a lobby bench. At about the same time, Douglas Jensen, RN, who appeared to be leaving the facility through the lobby, immediately came to his assistance, assessed the condition of the visitor and took the necessary actions to maintain the safety and health of this visitor. The patient was transported to the Emergency Department where he was cared for and admitted with a diagnosis of stroke.



Ashley Sneed, RN, PCU:

A Patient Observation Assistant was on PCU one night in November 2015, and the patient being observed just didn't seem right! The patient's nurse, Ashley Sneed, felt strongly that something was going on and so she kept checking in on him and kept communicating with the providers until a CAT scan was ordered. The patient was diagnosed with a pulmonary embolism that night, and care was initiated quickly, thanks to Ashley's diligence and great care.



TIER 2 RECIPIENTS

Robin Aldinger, Technical Partner, Orthopedic Unit: Robin was rounding on patients and entered patient's room to complete vital signs. She noticed that the patient was acting strangely. Robin alerted the RN caring for the patient that patient had stroke-like symptoms. RN assessed the patient and called a Stroke Alert. Patient had a CT scan that confirmed a Left-sided CVA.

Nichole Brocj, RN, Operating Room-CC: Nichole was provided information on two patients that were to have surgery with the same surgeon. She recognized that the patient information did not correlate. Nichole researched the situation. She confirmed that the information provided was incorrectly and she proceeded to get the right patient prepped for the OR.

Elena Brinker, RN, 7C: Elena's patient was ordered to receive Benadryl prior to blood transfusion. Order was verified and dispensed to the unit. Elena noted that the dose was unusually large dose and called to question the physician. Physician identified that he meant to order 25 mg of Benadryl for the elderly patient.

Rose Ann Clark, Administrative Partner, ICUM/RHCS: Rose Ann was working at the front desk when she noticed out of the corner of her eye the patient across the hall was using their mitts hands to pull at their ET tube. She called the Respiratory Therapist to come assess the patient. Patient had worked the tube loose from their AnchorFast and was very close to self-extubation. Rose Ann's quick thinking allowed the care team to re-secure the tube so that the patient did not lose their airway.

Yvette Dixon, RN, 6th Tower: Yvette questioned the ordered dose of Labetolol. She called the pharmacy to clarify the dosage. Pharmacist evaluated the dose of Labetolol to be 10-fold what the patient was to receive. Yvette then had the dosing corrected and administered the correct amount of Labetolol IV.

Jessica Duval, RN, 7BP: Jessica reviewed a patient's lab work that was receiving dialysis and identified that their iron level pre-hospital was elevated. Jessica informed the physician that the patient was receiving a supplement with elevated iron levels. Physician further investigated and ordered lab work. It was identified that the patient's iron levels were still elevated and that the supplement needed to be discontinued.

Kristy Fegley, Pharmacist, Pharmacy-CC: In reviewing the patient's previous administrations, Kristy identified that the patient's next chemotherapy dose was to be 1mg not 2 mg. Kristy prevented this patient from potentially having increased neuropathy.

Joan Finno, Nurse Practitioner, ExpressCARE-Tilghman: Patient presented with complaints of chest pain, shortness of breath, pallor and diaphoresis. Patient explained to Joan that a family member had died from an Aortic Aneurysm. Joan quickly assessed the patient and arranged transport to Cedar Crest. Patient was diagnosed with Type A Aortic Dissection with Aneurysmal Ascending Aorta and Abdominal Branch Vessel involvement. Patient was immediately taken to the OR.

Lauren Fliszar, RN, 5ATT: During patient care, Lauren discovered a mass on the patient's groin and informed the surgical resident. The surgical team identified the mass as an Inguinal Hernia and attempted to manually reduce the hernia. The patient had emergent surgery to fix the hernia and also needed an appendectomy. Lauren's astute assessment prevented the patient from having further injury.

Kerri-Ann Foley, Technologist, Radiology, Ultrasound-Muhlenberg: Kerri-Ann identified that the patient's symptoms did not correlate with the test that had been ordered. Kerri-Ann called the ordering physician and clarified the test and facilitated the correct test being ordered.

Chelsey Freed, RN, Pediatric-Unit: Chelsey noticed that the pain medication order for her patient seemed a higher dose than normal. She checked Lexicomp for dosing. The order was written for 0.5mg/kg but was intended to be 0.05 mg/kg. Chelsey initiated the order change and prevented a serious medication event.

Grace Gerrouge, RN, 3A/ICU: Grace identified that a patient was ordered 600 mg of an anticoagulant daily when the dose should have been 75 mg daily. She had the order corrected prior to the patient being discharged.

Grace Gerrouge, RN, 3A/ICU: Patient was on Humalog 75/25 with coverage in the morning and night. Patient was to be discharged on the same plan. Grace identified that the incorrect instructions and prescriptions were prepared for the patient. The needed corrections were made and Grace discharged the patient home safely.

Cynthia Hager, Technician, 4KS: Cynthia was performing routine vital signs on a patient. She noticed the pulse oximetry readings were fluctuating. She tried a different pulse ox and utilized the forehead monitor to verify the readings. Cynthia reported her findings to the Respiratory and the physician. The patient received emergency diagnostic tests.

TIER 2 RECIPIENTS

Donna Hill, RN, 3A/PCU: Donna identified a medication omission on the patient's discharge instructions. She called the provider and addressed the missing anticoagulants. The medication was ordered and patient received a prescription for the anticoagulant, potentially preventing the patient from serious complications.

Debra Knappenberger, RN, Radiation Oncology: Patient arrived for their radiation treatment. During Debra's assessment, she identified that the patient had a pacemaker placed in 2010. Patient confirmed the placement of the pacemaker. Patient's physician was contacted and the company representative came after the treatment to interrogate the patient's pacemaker to assure proper function.

Rosemarie Mcgeehin, Technologist, Radiology, Ultrasound-Muhlenberg: Rosemarie received an order for a fasting renal artery Doppler. Rosemarie noted that the symptoms and mass did not correlate with this study. Rosemarie called the physician to clarify and the exam was canceled.

Michaelene Panzarella, Risk Manager, Risk Management: Michaelene attended a meeting that discussed the results of a tracer audit. During the committee discussion it was identified that the wrong issuance slip was the root cause of the event. Michaelene identified that units were stocking the incorrect revision of the issuance slip. She identified that the revised issuance slip had been misplaced and the previous version was being distributed.

Jacqueline Priest, RN, Radiology, Interventional-Muhlenberg: Jacqueline was removing medications for her patient. As she checked the medication vials, Jacqueline discovered that the Versed 2mg vials were actually Versed 5 mg vials. Jacqueline contacted the pharmacy and the Pyxis machine was reloaded with the correct doses.

Kimberly Santee, RN, 5ATT: Kimberly identified that a patient had a Tdap ordered that was not charted as administered. The patient was involved in a serious traumatic injury which warranted Tdap administration. Kimberly alerted her leadership team to further investigate. If not for Kimberly's astuteness this vital medication may have been missed.

Jasmine S. Santi, Mental Health Technician, Behavioral Health 1: Jasmine was completing 15 minute checks when she identified that a newly admitted patient was not in their room. The bathroom door was closed but Jasmine instinct made her open the door. Upon entering the bathroom she discovered the patient was about to attempt to harm them self. She calmly redirected the patient and alerted others for assistance.

Julie Seagraves, Radiology Technologies, Radiology, CAT Scan-CC: Julie was checking the patient que and questioned why a patient had an exam to be completed without a prep. Through further investigation, Julie identified that the patient had the scan previously completed but the images had not been linked. Julie prevented the young patient from being rescanned.

Jennifer Steward, Technologist, Radiology, CAT Scan-CC: Jennifer was interviewing a patient and identified that she did not present or complain of symptoms that would warrant a CT scan of the head. Jennifer called the physician to clarify the order and identified that the ordered was inadvertently placed. She spared the patient from unnecessary radiation exposure.

Brittany Wilson, RN, Neuroscience ICU: Brittany requested Amiodaron from the pharmacy. When Brittany received the medication, she identified that the patient label did not match the medication in the IV bag. Brittany's attention to detail prevented this patient from having the incorrect medication administered.

Sai Yang, RN, Neuroscience ICU: Sai accompanied her patient for a CT scan of the head. Sai identified a change in the patient's scan from previous. Upon returning to the unit, Sai pulled up the scans side by side and saw a significant change. Sai immediately alerted the PA-C who agreed with her findings and came to the bedside to assess. The patient's overall condition was changing and emergent surgery was required. Sai's meticulous attention to detail allowed for early intervention.

Amy Yaple, RN, 7C: Amy was caring for a patient that was receiving Methylene Blue. Amy had cared for the patient the night before and recalled administering a dose of 5 mls. On this night the patient was to receive a dose of 50 mls. Amy questioned the dose which was identified to be incorrect. Amy received the new 5 ml dose and safely administered the Methylene Blue.

TIER 2 RECIPIENTS

Alice Yatsko-Heiney, Technical Partner, Float Pool-Muhl:

Alice entered a patient's room to perform routine vital signs. The patient asked for their belongings and seemed to act differently than before. Alice sensed something was wrong and stayed outside the patient's room to observe their actions. She saw the patient remove something from their jacket. Alice entered the patient's room right before they were able to self-administered medication from home. Alice summoned assistance and was able to re-inventory the patient's belongings. Due to Alice's heightened observation skills her actions avoided the patient from ingesting additional medication outside of their hospital regimen.

Jim Yost, RN, Radiology, Interventional-Muhlenberg: Patient was ordered a kidney biopsy and was provided pre-procedure instructions. While John was reviewing the pre-sedation work up, he identified that the patient had a renal mass. John shared this information with the physician and they agreed that the incorrect test had been ordered. Orders were addressed and the correct study was then completed on the patient.

TIER 1 RECIPIENTS

Andrea Burkhardt, Radiology, Diagnostic-17th

Mary Cipolle, Diabetes Education-CC

Alexis Clauss, 4K

Erica Contreras, Pediatric Unit

Monica Coyle, Pharmacy-Bangor

Cindy Cox, Radiology, CAT Scan-CC

Victoria Daltrui, Pediatric Unit

Kim Deluca, Diabetes Education-Muhl

Theresa Elwell, Pre-Admission Testing

Kelly Ely, 5K

Theresa Engelhardt, Float Pool-CC

Jeanne Florian, 4KS (2 Awards)

Kerri Ann Foley, Radiology, Ultrasound-Muhl

Greg Gable, Transport Team-CC

Carol Galloway, Pediatric Ambulatory Surgery Unit

Margaret Gergar, Diabetes Education (3 Awards)

Veronica Giel-Scocca, 5K

Donna Grimes, Fairgrounds Surgical Center-OR

Jane Halpin, Behavioral Health 1

Carole Handley, Post Anesthesia Care Unit-CC

Patricia Harley, Emergency Department-Muhlenberg

Denise Janis, Ambulatory Surgery Unit-Staging

Kristen Keane, ED-Muhlenberg

Kristine Keblish, Radiology, Ultrasound-Muhlenberg

Karoline Korah, Pediatric Unit

Carol Lacek, Ambulatory Surgery Unit-OR

Sofia Lopez, Labor and Delivery

Donna Maldonado, ExpressCARE-Tilghman

Tami Meltsch, 7th Tower

Christina Merrell, Neuroscience ICU

Perpetua Mwangi, 6th Tower

Vicki Naugler, Home Care

Nicole Pasquarello, Children's ER

Nancy Schneider, Ambulatory Surgery Unit-Staging

Jocelyn Seier, 7A/Neuroscience Unit

Alica Seyfried, Radiology, Interventional-Muhlenberg (2 Awards)

Randi Shupp, ExpressCARE-Tilghman

Margaret Solis, Labor and Delivery

Michelle Townsend, Float Pool-CC

Michale Wojkowski, Pharmacy-Bangor

Nicholas Yanckanicz, Pharmacy-CC

Amy Yaple, 7C

Nora Zappe, Ambulatory Surgery Unit-Muhlenberg

LVPG Medication Safety Committee: Monitoring, Mentoring, Maintaining Excellence

By: Julie Kaszuba, MSN, RN – LVPG Clinical Procedure & Products Nurse Specialist



LVPG Medication Safety Committee has re-defined the culture of medication safety in our network physician practices. Collaboration with practice leadership has transformed individual practice stock medication lists into an LVPG Approved Medication Formulary. The formulary is an accurate, concise and transparent listing of stock medications and vaccines deemed safe to administer by clinical staff or providers in the physician practice setting. Medications and vaccines on the formulary list have been evaluated by the committee in order to provide better care, better quality and better cost to our patients.

The committee is comprised of an interdisciplinary group of network colleagues. A shared governance model is observed by committee members, as decisions are made by consensus. Maintaining a group of subject matter experts from a variety of specialty areas is an essential component to ensure that clinical staff, providers and patient roles are considered in decision making related to safe medication handling and administration. Active membership includes representation from LVPG Clinical Coordinator(s), LVPG Administrator(s), LVPG Clinical Services, Pharmacy, Risk Management and Nursing Informatics.

Primary operational function of the committee is to oversee a standard process for approval of new medications for use in LVPG physician practices. Committee members use a medication request document that serves as a template for standard work. Practice leadership requesting a new medication/vaccine to keep on hand, completes the form and submits for review. Effective communication strategies promote the expectation that all LVPG practices follow standard work as it relates to medication request process.

Utilizing the request document guides committee members in analysis of current literature, identify appropriate scope of practice and examine any safety considerations related to the specific medication/vaccine requested. Additional clinical expertise is sought as needed. Maintaining excellence in medication safety through an accurate, concise and transparent medication formulary is aimed to promote skill competency among clinical staff and prevent medication errors.

Regular review of the medication formulary and timely updates are the responsibility of the committee. Patient Safety Reports are evaluated for trends in medication related errors, near miss events and potential system failures. In collaboration with LVPG Clinical Educators, the LVPG Medication Safety Committee will provide hands-on review of *The Eight Rights of Medication Administration* at LVPG Clinical Staff Annual Education Days in May 2016.

Right Drug
Right Patient
Right Dose
Right Time

Right Route
Right Reason
Right Response
Right Documentation

LVPG Medication Safety Committee serves as a dedicated resource for clinicians who handle and administer medications in the practice setting. Standard work combined with monitoring and mentoring continues to promote a culture of medication safety throughout LVPG.

Catching Depression While in the Doctor's Office: A Community Care Team Initiative

*By: Christopher W. Nine, MSW, LSW - Community Care Team Behavioral Health Specialist;
Thomas L. Michaels, MSW, LCSW – Community Care Team Clinical Coordinator*

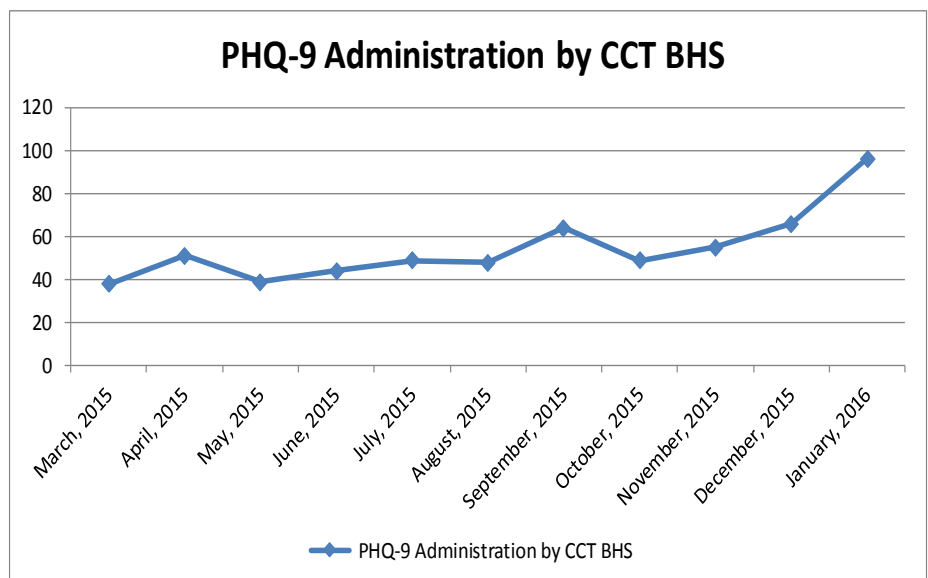
With greater national attention to mental health and suicide awareness, screening and early intervention for high risk behavior presents both a challenge and a responsibility for our health care community. The gateway of preventative healthcare has the potential to be a critical point in which self-harm and depression can be triaged and cared for safely. One tool, the PHQ-9, has been repeatedly validated as a concise, impactful measure of both depression and the improvement that treatment can yield. Specifically, the PHQ-9 was designed and validated to be used in primary care offices. It is a diverse tool that has been shown to be effective across gender, age bracket, and ethnicity. It has been translated into multiple languages. This makes it a reliable instrument regardless of the patient population served. In addition to being an effective tool in primary care, the PHQ-9 has also been studied as illustrative in linking depression with specific disease states in broader health care such as patients having suffered a stroke and diabetic management.

High risk patients navigate not only the physical health system but often also the mental health system as they address the conditions with which they deal. Multiple competing needs for the patient, medical and non-medical, often leave mental health needs pushed to a lesser priority. Community Care Teams (CCT) of Lehigh Valley Health Network (LVHN) are multidisciplinary healthcare teams encompassing behavioral health specialists, nurse care managers, pharmacists, and social workers in primary care practices tasked with reducing hospital admissions and increasing patients' overall health.

The CCT Behavioral Health Specialists (CCT BHS) have implemented an ongoing initiative to closely monitor patients with a positive PHQ-9 score. The overall aim of the initiative is to be able to monitor patient progress to ensure their emotional needs and safety are being addressed as accomplished through referrals to appropriate levels of care or short-term therapy services within the primary care setting. Patients referred to the CCT BHS complete a PHQ-9 at initial intake. For those patients with a positive score, repeat screening with the PHQ-9 is used to monitor course of treatment. By having patients monitored for depression, more rapid interventions can be employed with the target of

successfully addressing the mental health needs of the most vulnerable populations. Between March, 2015 and January, 2016 CCT BHS administered the PHQ-9 to a total 599 unique patients. Of these, 129 (22%) patients were given the PHQ-9 at least one more time in order to help monitor their overall mental health and progress in treatment.

Each administration of these questionnaires represents an opportunity to engage patients in a discussion about their current mental health and help patients access and initiate care effectively and efficiently. By commencing and maintaining a safe and open dialog about mental health, CCT BHS strive to partner with patients to address all aspects of health care.

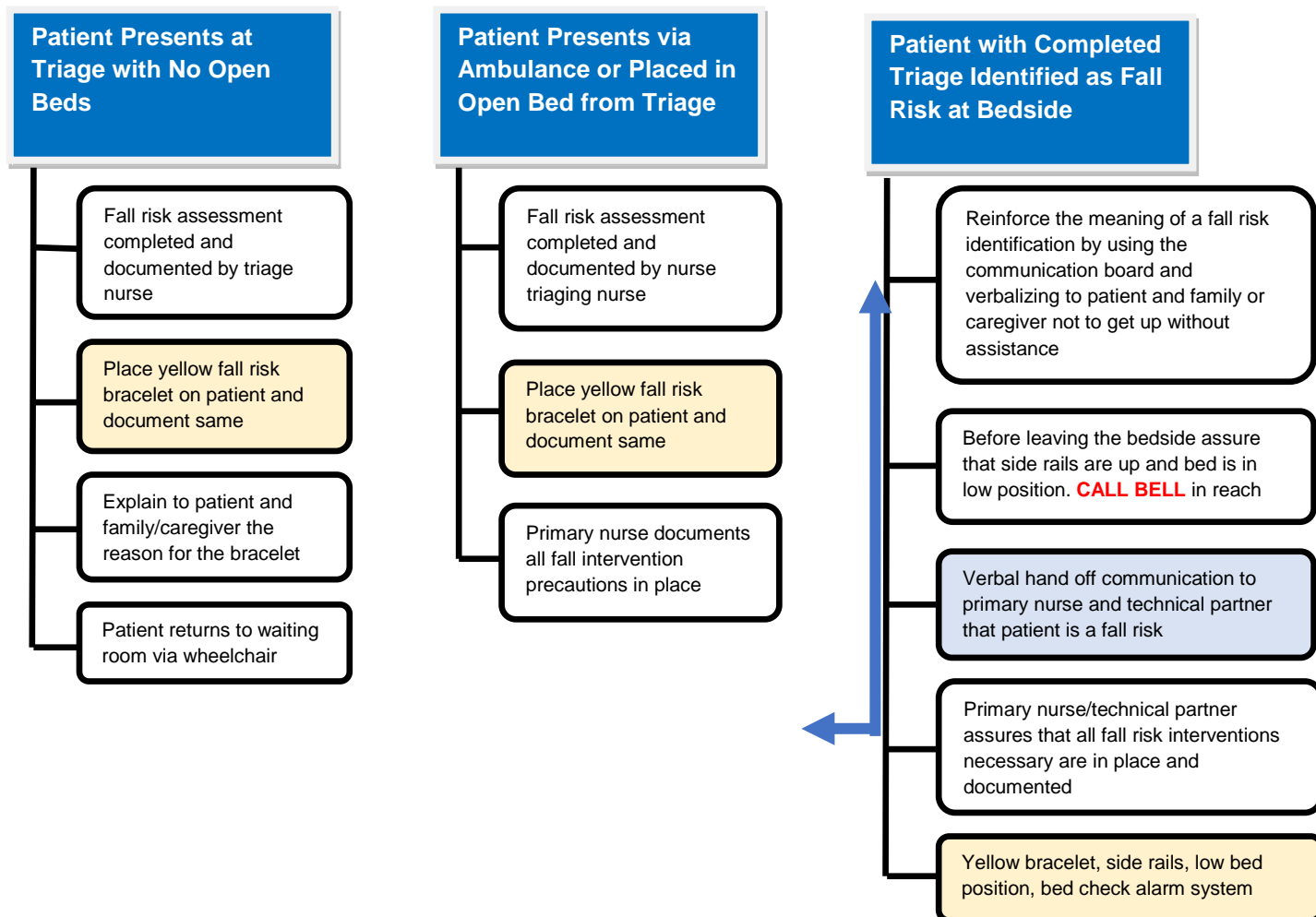


Influence of Standard Work Processes on Fall Risk Interventions in the Emergency Department

By: Krista Amey, RN, BSN; Kaley Blatt, RN, BSN; Amanda Mertz, RN, BSN; Ashley Mood, RN, BSN; Sandra Sabbatini, MSN, RN, CEN

The Nurse Residency Group that graduated in February 2016 completed an Evidence Based Practice project that focused on decreasing falls in the Cedar Crest Emergency Department. The group consisted of: Ashley Mood RN, BSN, Kaley Blatt RN BSN, Amanda Mertz RN BSN, and Krista Amey RN, BSN. In FY15 there were 37 falls in the Emergency Department. Data shows that falls are one of the most common adverse events that are reported in hospitals and fall risks screenings should be implemented in triage. Once someone is identified as a fall risk, interventions should be put in place. This group focused on creating a fall risk algorithm for use in triage that would help nurses identify fall risk promptly and increase communication and use of interventions for patients at risk for falls. The algorithm had been originally devised for ED 17th Street but was customized for ED Cedar Crest. Surveys pre and post algorithm intervention were given to staff to find out if the algorithm was working. Fifty chart reviews were completed, along with corresponding patient room checks to confirm if the fall risks were communicated and if interventions were in place. From these chart reviews it was found that there was a significant increase in documentation of interventions, however communication boards are not being utilized as well as they could be. It is now an initiative of another Evidence Based Practice project in the ED's at 17th Street and Muhlenberg to standardize bedside shift report utilizing the communication board.

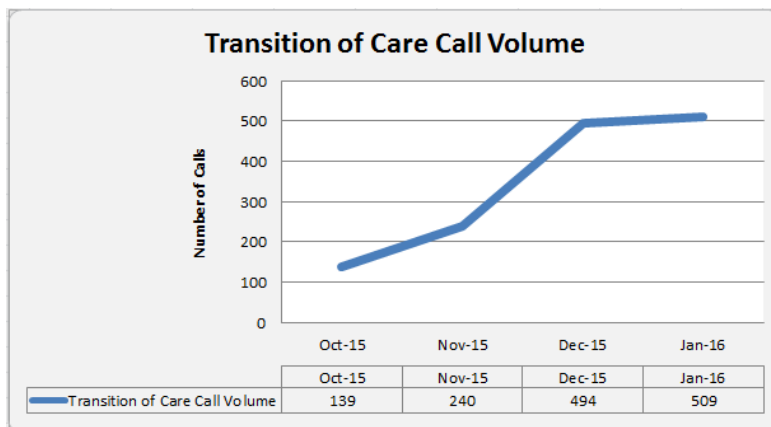
Overall, the project was successful in helping to decrease falls in the Cedar Crest Emergency Department. The number of falls in FY16 year to date is 26. We were able to meet and exceed our goal to decrease our fall rate by 10%. Although it is not possible to say that the algorithm was the main reason for the decrease we can safely say that it brought awareness to the staff.



Transition of Care Calls: The Population Health Safety Net

By: Victoria Chestnut, BSN, RN; Josefina Clark, BBA; Alisa Matthews, RN;
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This country's aging population consists of people with multiple chronic conditions who oftentimes require complicated regimens that are managed by numerous specialists. This can lead to confusion and frustration for the patients and their families, putting them at risk for relapse. A patient is most vulnerable when transitioning from one care setting to another, especially from an inpatient admission to home. This transition period can be unsafe, leaving the patient susceptible to readmission. Transitional care is defined as care intended to ensure continuity as patients move across a variety of health care settings, the most common being from hospital to home¹.



Community Care Team (CCT) care managers have been providing Transition of Care (TOC) calls to patients since 2012 in the primary care setting. In October of 2015, the Population Health department began the process of centralizing these calls within the Population Health Care Management Call Center (PHCMCC). The staff place calls to patients within 2 business days of discharge. The TOC call has multiple components, including: assessing the patient's health status and support needs; confirming home health services and blood work orders; medication reconciliation; scheduling post-discharge follow-up appointments, and creating a

plan for any issues that may arise. After completion of the call, the staff notifies the primary care provider to resolve any ongoing concerns and provide continuity of care.

TOC calls are placed to all inpatient and observation patients discharged from LVHN sites with the exception of psychiatric and obstetrics/gynecology. Acting as a safety net, these calls help to identify any issues and allow for appropriate follow up which can ultimately reduce readmission rates. LVHN colleagues published a study demonstrating that the probability of a readmission was reduced in patients who received a hospital discharge call by a PHCMCC care manager³. These TOC phone calls have succeeded in decreasing readmissions by approximately 48% for that same group of patients².

One example of a situation a care manager recently faced during a TOC call includes that of a 23 year old male admitted with persistent nausea and vomiting. He was discharged home after a 23-hour stay. His home happened to be his car, as he was currently homeless. He answered the phone sounding in acute distress. He struggled to speak in complete sentences, and admitted he was experiencing severe abdominal pain. During the conversation, the care manager discovered he was parked on the side of the road somewhere in New Jersey. The CM instructed him to immediately hang up and call 911. Additionally, she called the CCT practice-based care manager to explain the situation. The practice-based care manager called the patient later that day and found out that he was admitted to an outside Hospital. The provision of a TOC call to this patient prevented a potentially life-threatening situation from worsening. Additionally, the patient will continue to receive follow-up after hospital discharge and across the care continuum. The CCT social worker and care manager have collaborated to assist the patient with the underlying concerns for housing and food security.

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The Core of Patient Safety: Education

By: Emilie Bree Croft, BHS; Amy Smith, PhD; Amy Droskinis, MSN, RN, CCRN; Valerie Holt, Ed.D, MBA; Kathleen A. Zamietra, MLIS; Lori Yesenofski, MSN, RN, CCRN, CTC

The Department of Education (DoE) provides training applications along with resources to find solutions that meet the needs of the network and help keep patients and those who care for them safe. The DoE is comprised of several teams; Medical Education, Education Infrastructure, Library Services and Education Services. Each of these teams provides interdisciplinary services that aide in the training and development of colleagues, visiting healthcare students, medical residents, and fellows, and helps to better serve our patients by recognizing the impact of education on patient safety.

The DoE also assists in enhancing patient safety by incorporating everything from evidence based patient education at the bedside, to the use of the latest technology. The DoE incorporates patient safety into the education of clinical students, but also non-clinical learners and patient's education as well. It is our vision to promote a culture of ongoing growth and curiosity that produces transformational change in the teaching, learning, and the application of gained knowledge across all care continuums. For example, the recent roll out of EPIC brought an incredible advantage to our patients, bedside providers and educators by allowing the utilization of an extraordinary medical record system. Providing improved access to health information improves patient accountability and engagement and increases the quality of care. The DoE EPIC team provides software application training to all colleagues and continues to play an important role in the integration of EPIC throughout the network.

Additionally, the Library Services team contributes to our safety goals by providing network-wide 24 hour access onsite, remotely, and through mobile devices to the latest clinical information and evidence-based resources at the bedside and in outpatient offices. The Library staff also offer literature search consultations for evidence-based practice projects. Each DoE team works collaboratively to enhance, promote and develop LVHN staff and students which lead to better serving our patients. Even our everyday practices such as routine hand washing and the following of standard safety guidelines can set examples that make a difference.

Recently, LVHN'S Designated Institutional Official (DIO) for Graduate Medical Education (GME), Dr. Elaine Donoghue, became aware of a rise in the incidence of sharps injuries for new residents and fellows. Dr. Donoghue collaborated with Dr. Joseph Patruno, OB/GYN Residency Program Director, on creating a solution to educate residents and fellows on the importance of reporting sharp injuries and to help program administrators understand the process for performing sharps investigations. This initiative was guided by Clinical Safety Education Specialist, Laura Walker, MSN, CCRN and Mark Flamisch, MS, Senior eLearning Designer who helped to create a sharps safety video which has since been incorporated into a TLC training module. Moving forward, should any sharps exposures occur coordinators/managers/supervisors will be able to access a link directly in the exposure investigation email that will allow them to view this supportive tutorial.



Another example of how education integrates into patient safety can be seen in the recently launched cervical collar video. Trauma clinicians identified the need for additional education based on observations by clinical staff and providers pertaining to cervical collar care and maintenance. The goal is to prevent adverse effects related to improper use. The short comprehensive care video project was managed by patient education specialist Lori Yesenofski, MSN, RN, CCRN, CTC, at the request of trauma and spine clinicians who also supported the creation of the film in the DoE simulation lab. The film is used to augment existing printed resources. In addition to targeting trauma and spine patient education, the video has been uploaded to TLC for clinical caregivers, is accessible on the My LVHN portal, and patients and their caregivers can use their smart devices to view the instructional video anytime via YouTube. Future plans include sharing this cervical collar video with Home Care, long term care facilities and rehabs.



Creating a safe healthcare environment for our patients involves a team effort from our nurses, physicians, clinical care providers, educators and leaders. By uniting together all the teams and affiliates of the Department of Education make a difference impacting the health and safety of our patients. We share in this common goal because we know that through education, the practice of exploring change and the implementation of innovations can we achieve the highest quality of care.



If you would like to watch the videos featured in this article, please follow the links below;

Cervical Collar video: https://youtu.be/8Wh3_IbGA

Sharps Safety Video: http://lvhelearning2.lvh.com/Remotecontent_prod/Data/0338/Sharps Injury.mp4

“United in Safety” Women and Children Service Line Super Huddle

By: Suzanne Puentes, BSN, CCRN – Patient Care Specialist ChER and PICU

On October 1, 2015 the Women and Children service line implemented a tiered huddle system to improve quality, communication, accountability, empowerment and a sense of community. On February 29, 2016 the huddles expanded to daily Monday through Friday. The ultimate goal of the Women & Children service line huddle is to reduce failures and eliminate patient harm.

The 15-20 minute coordinated huddle began on designated days and times in the 6th floor Jaendl pavilion. Unit representatives from areas that care for women and children including the OR, Children’s ER, Neonatal ICU, Labor and Delivery, Perinatal Unit, Mother Baby Unit and Inpatient Pediatric Units briefly and systematically report out using a standardized tool. Patient census, issues that have occurred over the last 24 hours, patient safety events, and daily metrics are discussed. Workflow processes and the sharing of ideas help provide well-coordinated and safe care.



Various disciplines are represented including bedside and charge nurses, physicians, directors, managers, educators, pharmacist and administration. The frontline staff closest to situations can bring their concerns to people with multiple perspectives and levels of experience. Leadership supports the structure of the huddle, protects a fair culture and encourages the team to take the time to attend huddles. Increased situational awareness can reveal factors that contribute to adverse patient outcomes such as medication errors and near misses.

There are many learnings from the implementation of the huddles. The real time sharing of quality information has increased communication and collaboration across participating units. Assigning members to follow-up on problems has increased accountability. The huddles have empowered bedside and charge nurses to publicly express their concerns to administrative leadership. This forum has provided a credible voice for nursing. The huddle has encouraged a sense of community for the Women & Children’s service line. The group has a common goal for patient safety and preventing harm. It has provided staff with a wider view of what each unit deals with on a day to day basis. Overall it has helped staff appreciate and respect others working toward a common goal of preventing harm.

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Decreasing Patient Falls One Assisted Step at a Time

By: Katie Best, BSN, RN – Patient Care Specialist; Brandi McMillan, RN; Caitlin Thalassinos, Technical Partner

According to the Journal of Emergency Nursing, over one million hospital patients fall yearly in the United States (Murphy, L, 2015). Increased falls results in increased length of stay, higher mortality rates, decreased quality of life and higher healthcare costs.

In the last fiscal year, the emergency department at Muhlenberg experienced an increase in the total number of patient falls resulting in a year-end total of thirty five. The number of falls ranked our emergency department as one of the highest fall rates for hospitals of our size in this region.

So how could we as a department ensure a safer environment for our patients? Our first step was to evaluate the reason our patients have fallen. We created a fall assessment report which provides: the date of the fall; the classification; assisted vs. unassisted; injury; and the root cause for each fall. From this report, we were able to identify that a little more than one quarter of our falls resulted from the toileting process.

After discussion with our director, Neil Kocher, we decided to educate our staff on the “No One Toilets Alone” process. In June 2015, a staff education was disseminated amongst nursing and technical partners using The Learning Curve. The education centered on the process of all patients being accompanied to the bathroom by a nurse or technical partner. Along with the staff education on the new process, emphasis was placed on fall interventions being initiated and the importance of

post fall assessments and documentation. The process and the fall assessment report were discussed at our staff and core charge meetings. Once this was shared, many staff members were surprised by the overall census of the falls. It was clear “No One Toilets Alone” was a safety

intervention needed to help decrease our total fall numbers and increase patient safety. Once the education was provided to all staff, a secret shopper monitored staff compliance with the new process. Since June 2015, our staff compliance continued to improve directly related to a decrease in total falls in the department.

As of the date submitting this article, the emergency department at Muhlenberg reports a total number of twelve falls for the fiscal

year, none resulting in injury to our patients. According to our assessment two falls resulted from a patient walking to the bathroom alone to date, one in the waiting room and one while a patient’s family member assisted the patient without staff knowledge.

With continued attention to falls, and the falls safety report to the staff, we as a department strive to decrease and prevent further falls. As a department we continue to seek out safety improvements. In this upcoming year all emergency room beds will have a bed-check system incorporated into the call bell system. The new system in combination with the “No One Toilets Alone” will hopefully result in a continued downward trend in department falls.



Reference:

Murphy,L; Murphy, S,Hastings, M, Olberding, A. (2015, September) Journal of Emergency Nursing retrieved from <http://resolver.ebscohost.com>

Being prepared to intervene for patient safety is the best way to avoid harm for our patients. Utilizing the following patient safety tools will assist you to provide interventions needed, as well as supporting colleagues. **We all have been empowered to make a difference and we encourage you to do so.**

LEHIGH VALLEY HEALTH NETWORK

Patient Safety Tools

PATIENT SAFETY MEANS DOING THE RIGHT THING, THE RIGHT WAY, FOR EVERY PATIENT, EVERY TIME.

1 Pay attention to detail – self-checking using STAR

- STOP: Pause for one second and focus.
- THINK: Consider the action you are about to perform.
- ACT: Concentrate and carry out the task.
- REVIEW: Check to make sure that the task was done correctly.

2 Communicate clearly – three-way communication

- SENDER starts communication using the receiver's name – providing an order, request or information to receiver
- RECEIVER repeats/reads back using the safety phrase, "Let me repeat that back."
- SENDER says "That's correct" or repeats the request if not correct.
- Use SBAR when a decision is needed:
 - Situation:** Describe current condition or situation.
 - Background:** Brief description of history
 - Assessment:** State your view of situation, best judgment
 - Recommendation:** Your suggestion for action; What do you want to happen next?

3 Practice with a questioning attitude

- Validate and verify
 - Validate by asking yourself, "Does this information make sense to me?"
 - If not, verify by confirming with an independent source or an expert.
- Ask clarifying questions in high-risk situations or when information is incomplete or not clear.
 - Use the safety phrase, "Let me ask a clarifying question."

4 Everybody checks everybody – never leave your wingman

- Be willing to be coached.
 - Check the accuracy of other's work.
 - Identify human error.
 - Point out unusual situations or hazards
 - Encourage safe behaviors.
 - Discourage and correct unsafe behaviors.
 - Use the safety phrase, "Thank you for saying something."

5 Speak up for safety

- Speak up using CUSS – everyone should speak up or "stop the line" when there are safety concerns
 - C** – I have a concern.
 - U** – I am uncomfortable.
 - S** – This is a safety issue.
 - S** – Stop the line.
- Use these phrases to get the attention of the team if your concern is not addressed.

LVHN PATIENT SAFETY PHRASES – PATIENT SAFETY STARTS WITH ME.

- ▶ Let me repeat that back.
- ▶ Does this make sense to me?
- ▶ Let me ask a clarifying question.
- ▶ Thank you for saying something.
- ▶ I have a concern...

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Safety culture assessments are new tools in the patient safety improvement arsenal. These tools can be used to measure organizational conditions that lead to adverse events and patient harm, and for developing and evaluating safety improvement interventions in healthcare organizations. They provide metric by which the implicit shared understandings about "the way we do things here" can be made visible and available as input for change. Safety culture assessment should be viewed as the starting point from which action planning begins and patient safety change emerges.

Dr. VF Nieva and Dr. J Sorra, 12/2003