

Recognizing Staff Accomplishments for Patient Safety

Lehigh Valley Health Network

Follow this and additional works at: <https://scholarlyworks.lvhn.org/historicalarchives>

Let us know how access to this document benefits you

Published In/Presented At

(2015). Recognizing Staff Accomplishments for Patient Safety...LVHN Scholarly Works.

This Report is brought to you for free and open access by LVHN Scholarly Works. It has been accepted for inclusion in LVHN Scholarly Works by an authorized administrator. For more information, please contact LibraryServices@lvhn.org.

Patient Safety AWARENESS WEEK

2015
PATIENT SAFETY AWARENESS WEEK™
UNited in Safety

March 8-14

sponsored by
NPSF

Table of Contents

- 2 ...Great Catch Criteria
- 3 ...Great Catch Recipients
- 9 ...Contributing to Patient Safety Initiatives through Education: Early Code Blue Response Drills in Simulation
- 10 ...2KS Collaborating to Make Patients Safer
- 11 ...Keep a Grasp on Patient Safety
- 12 ...Accuracy of Patient Meal Tray Delivery
- 13 ...Preventing Errors in CADD Pump 5FU Administration
- 14 ...Compounding at Health Spectrum Pharmacy
- 15 ...Collaborative Interdisciplinary Rounding at the Bedside
- 16 ...From Hospital to Home: Easing the Transition for Heart Failure Patients
- 17 ...Preventing Falls on an Inpatient Behavioral Health Unit
- 18 ...Reducing Hypoglycemia and Severe Hypoglycemia Rates for Hospitalized Adults
- 19 ...DNA-VC Creates Situational Awareness and Staff Safety at the Bedside
- 21 ...Patient Safety Tools
- 23 ...Infection Control Word Search

RiskMgmt/PtSfty/Claims website

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

Recognizing Staff Accomplishments 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 2015 Patient Safety Week is "United in Safety". Through our efforts to provide safe care, we strive to be 'United in Safety'.



Gwen Browning, Patient Safety Officer with Alice Notis, RN, NICU

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 2014, there were a total of 70 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 three of our colleagues have been identified by the Pennsylvania Patient Safety Authority for their great catches this past year. Nursing colleagues, Christine Reese (MSICU), Gloria Mazzie (BH), and Kathleen Cochrane (NICU), were recognized for their great catches at a special celebration in Harrisburg on March 10, 2015 and will also be recognized at a reception sponsored by the Patient Safety Authority at LVH-CC site on March 12, 2015.

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.

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

Kristie Lowery
Director/Patient Safety Officer

Gwen Browning
Patient Safety Officer

A PASSION FOR BETTER MEDICINE



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

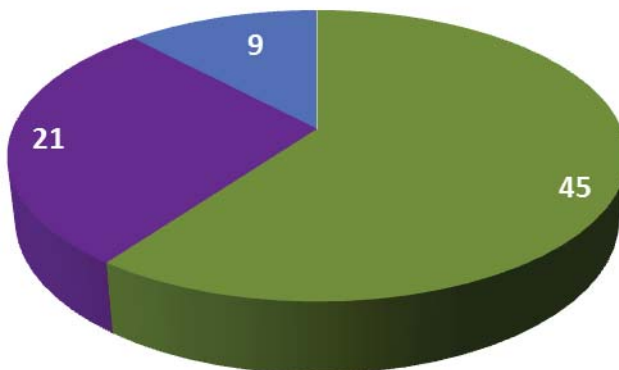
- Nominated by staff/manager or identified by patient safety/risk management.
- **Colleague portrayed exemplary actions that prevented an event which could have caused a permanent catastrophic injury or death.**

Tier 3

Examples:

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

2014 Great Catch Award Recipients



■ Tier 1 ■ Tier 2 ■ Tier 3

Great Catches

FOR PATIENT SAFETY

Each of the following individuals were recognized in 2014 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

Kathleen Cochrane, RN, Neonatal ICU:

Kathleen identified that the Recombivax vaccine did not appear to be the same as what was normally stocked. She investigated, and determined that the dosage was incorrect for infants and had it replaced.



Kathleen is a winner of the Pennsylvania Patient Safety Authority's "I Am Patient Safety" poster contest for National Patient Safety Awareness Week 2015.

Gloria Mazzie, RN, Behavioral Health 1:

Gloria identified the bag handles on the paper bags used to store patient belongings could be tied together to use as a belt. She determined that the cord was strong enough that a patient could use it to cause harm to themselves and others. She alerted the team and initiated a search for a safer bag solution for the behavioral health patients.



Gloria is a winner of the Pennsylvania Patient Safety Authority's "I Am Patient Safety" poster contest for National Patient Safety Awareness Week 2015.

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

Sir Liam Donaldson 10/2004

TIER 3 RECIPIENTS

Christine Reese, RN, Medical/Surgical ICU: While reviewing a chest x-ray, Christine identified that the patient's partial plate was lodged in the pharynx. She notified the medical team and the plate was removed. Ten days later while caring for another patient, she identified that the physician had placed an order for insulin that was much higher than what the patient had been receiving. She contacted the physician to question the order and obtained an order for a decreased dose. Her attention to detail prevented two potential serious patient safety events.



Christine is a winner of the Pennsylvania Patient Safety Authority's "I Am Patient Safety" poster contest for National Patient Safety Awareness Week 2015.

Amy Droskinis, Educator, Division of Education: Amy was conducting the AED station during an education session. She was questioned about the pediatric use of hands-free pads. Amy recognized that the defibrillator manual recommended not using the AED mode on children under the age of 8. She then initiated a network wide notification informing clinical staff of the AED limitations when utilizing the Heartstart XL. Her attention to detail may have prevented a potential serious patient safety event for our pediatric population.



Emily Keim, RN, Pediatric ICU and Melissa Pisarek, RN, Pediatric ICU: Emily and Melissa realized that the syringe size was not correct for the antibiotic ordered for the infant. They questioned it and obtained the correct dose, preventing harm to an infant.

PATIENT SAFETY HOTLINES	
Lehigh Valley Hospital-CC/17 th /Muhl 610-402-2830 or 484-884-2830	Leave brief message with the following information:
Fairgrounds Surgical Center 610-969-3111 or 484-357-6159	<ul style="list-style-type: none"> Patient name and medical record number Patient location Nature of serious event/incident Patient involved Your Name (not required)
LVHN Surgery Center-Tilghman 610-402-3903	

TIER 3 RECIPIENTS

Faith Edwards, RN, Behavioral Health 2:

Faith was caring for a patient in the Behavioral Health unit whom was having flu-like symptoms and was placed on droplet precautions until positive confirmation for influenza could be obtained. While assessing the patient, the nurse noticed that there was a rash on the patient's arms that was not indicative of influenza. The nurse notified the physician who immediately transferred the patient for further testing/treatment. The patient was diagnosed with meningitis. Her attention to detail helped to expedite a diagnosis for the patient but also triggered a full investigation by infection control and employee health to determine who had been exposed to the patient and would need prophylactic treatment.



Justiana DeJesus, Housekeeper, General Services:

While conducting her daily duties, Justiana found contraband (a razor) hidden in the patient's bathroom. She immediately notified staff. Because of her quick actions, staff conducted a room search and prevented any possibility of harm done by patient.



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

Joseph Ciminelli, Technical Partner, 5K: The nursing unit was experiencing an increase in falls and some of them had been related to the bed alarm not being on. Joseph Ciminelli took the lead on the 3-11 shift along with his other Technical Partner peers and went around the unit and inspected each bed to ensure the alarms were working properly. Joe found a bed that the bed alarm green light was off when entering the room. Joe informed the nurse who stated she had turned on the alarm when she left the room. Joe reset the alarm and when he returned about 5 minutes later the alarm was off. The bed was removed and the patient was placed in a new bed. Due to his commitment to patient safety, potential harm to the patient was avoided.

TIER 2 RECIPIENTS

Helen Cherewaty, Respiratory Therapist,

Respiratory-Muhl: A patient was moaning and attempting to get out of bed. Helen heard him and entered his room. The patient was not able to speak to her. The patient lifted his right arm using his left hand and let his right arm fall to the bed. Helen immediately called for help and stated, "I think this man is having a stroke!" Because of Helen's immediate response to a patient in need, a stroke alert was called and the patient received all of the appropriate interventions for an acute stroke in a very timely fashion.

Krysta Christman, Technical Partner, 2KS:

Krysta identified a wrong patient name and medical record number on the telemetry monitor. A new admission to the unit was identified on the telemetry system as the previous patient who was discharged from the unit. Her attention to detail avoided the potential for treatment of cardiac arrhythmia for incorrect patient.

Marion Daku, RN, ICU-Muhlenberg: While receiving an unmasked patient on the unit Marion noticed a droplet precaution sticker on the patients chart. She questioned if there was a need for droplet precaution and acted quickly to implement required measures for protection of patients and colleagues.

Robin DeWalt-Brown, RN, Surgical Staging Unit:

Robin identified a medication that was necessary to be given prior to patient discharge home while reviewing the patient chart. The patient had an unusual history of Angioedema and this first dose of medication was needed following surgery to treat the disease. Robin informed anesthesia of the preoperative note on the chart that stated the necessity of the medication Berinert IV. This medication was then ordered. Robin recognized the need to research this medication further as she was unsure of its mechanism of action, precautions and nursing considerations. She looked up Berinert in the on-line medication reference tool, consulted with 2 pharmacists as well as the Patient Care Specialist. It was determined that Epinephrine should be available while this medication was given. Robin assured that Epinephrine was at the bedside during the administration of this drug, administered the Berinert and monitored the patient during and after the administration.

Jen Diproperzio, RN, 4K: Jen received orders for her patient that did not seem correct. Jen who is an RN less than a year, questioned this and found out the orders were placed on the wrong patient. The orders included IV insulin; her attention to detail avoided potential serious harm to the patient.

Sarah Earl, Radiology Technologist, Radiology, Diagnostic-17th: Patient was sent to X-ray from the Diagnostic Care Center. The script stated "x-ray right foot". The patient did not speak English as a first language. Sarah, along with the department secretary determined that the patient had in fact already been x-rayed the previous week and was requesting a disc of the images. Through her diligent efforts to determine what was needed, the patient avoided an unnecessary radiation exposure.

Marisa Greggo, Radiology Technologist, CAT

Scan-Muhl: Marisa Greggo was preparing to inject contrast through an existing IV. She identified that the patient had a DVT in that arm. Rather than use that IV and possibly cause the patient irrevocable harm, she requested the IV be removed and started another one in the other arm.

Angela Haines, RN, 3K/TOHU: Angela avoided a medication event by recognizing a discrepancy in the labeling of medication for a patient.

Alicia Hanes, RN, ICUM/RHCS: Insulin U500 16 units BID subq was ordered for the patient. The insulin was sent to the nursing unit. Alicia was concerned about the amount of insulin and referred to the home medication list noting that the patient was not on U500 insulin at home but rather on Lantus and Humalog. Discussion with the patient confirmed that U500 insulin was not part of the home medication regimen. The PA-C was notified and the correct type of insulin was ordered.

Marsha Kvacky, RN, Cardiovascular Holding &

Recovery-Muhl: Post procedure physician ordered antiplatelet medication (Plavix 600mg) on a patient that was already on another type of antiplatelet (Effient) medication and had a history of bleeding issues. Marsha questioned the order and spoke with the physician directly regarding the situation. Orders were obtained to discontinue the additional medication.

TIER 2 RECIPIENTS

Rosane Leonardo, RN, Fairgrounds Surgical

Center-OR: Functioning as the circulator for a laser procedure, Rosane discovered the patient was ordered eye drops to dilate the eyes that are dangerous to a patient with narrow angle glaucoma. She notified the surgeon who ordered the correct drops and the procedure was completed without harm to the patient. On the same day she also noted that another patient was scheduled for left eye surgery but the patient indicated surgery was to be done on the right eye. She intervened and confirmed the correct surgical site.

Kimberly Mink, Radiology Technologist, MRI-

Muhl: Kim was on-call on a Sunday and came in to complete a STAT MRI exam on an ED patient. The ED RN called the MRI department to notify Kim that the patient had an intraosseous infusion system placed in the tibia. This system is placed by the ambulance crew for immediate vascular access in emergencies. The technologist researched this new and unfamiliar access system on the manufacturer's website. In the warnings and precautions, it stated that the Stylet and Catheter are not MRI compatible. Kim notified the patient's RN who came to the MRI department to remove the access. An IV was started, allowing the patient's MRI exam to be completed safely. Kim took the next steps to notify LVI-MRI Services at Cedar Crest of this new device and its precautions. The Emergency Department was also educated on the lack of MRI compatibility. MRI screening forms at all LVHN MRI centers have been adjusted to include the new device.

Joyce Najarian, Care Manager, Diabetes

Inpatient/ED Education-Muhl: Joyce identified that a patient had been discharged with instructions to resume his NPH insulin BID as well as coverage with meals and at bedtime. She called the discharging provider and reviewed the insulin coverage. The provider then contacted the patient and gave instructions to change the insulin dosing. Joyce prevented a hypoglycemic event that may have resulted in a readmission.

Monica Quitinsky, RN, Fairgrounds Surgical

Center-OR: While preparing to take a patient back to the OR for orthopedic surgery, Monica noted that the patient stated he was having surgery on his left knee but all the paperwork indicated surgery was to be completed on the right knee. She intervened, notified the physician and confirmed the correct site of surgery.

Gloria Reenock, RN, Perinatal Unit: Gloria became aware of a medication order that could have caused respiratory arrest on a pregnant patient. An order was placed for Magnesium Sulfate for an electrolyte imbalance, but the dose ordered was for a pre-eclamptic patient. Gloria questioned the order and discussed the dose with two providers. Her persistence prevented potential harm to the patient.

Jill Rickard, Image Management Assistant,

Breast Health Services-CC: An imaging CD from an outside institution arrived. Jill noticed when uploading the CD to PACS that the report on the CD associated to the images belonged to a different patient with a similar name. Jill called the institution to have this corrected, thus avoiding a possible error during reporting of patient's imaging studies.

Mary Gail Smith, RN, (Cardiovascular Holding & Recovery-Muhl): During the pre-procedural phone call, Mary Gail reviewed medications with the patient and identified that the patient was not taking their Xarelto medication as prescribed. This can reduce the effectiveness of the drug by 30%. The patient was scheduled for a cardioversion the following day. Mary Gail contacted the physician office and made them aware of the issue. The decision was made to postpone the procedure due to increased risk of thromboembolus or stroke.

TIER 2 RECIPIENTS

Maureen Smith, PCS, Neuroscience ICU: A young mother was a critically ill patient on Neuroscience ICU. Maureen Smith was present in the room when the resident was seeing the patient. She had a conversation with the resident regarding the symptoms and suggested obtaining an ECHO on the patient which resulted in a diagnosis of CHF. Due to her critical thinking skills, a stat cardiac consult and swan placement occurred in the cath lab. Appropriate cardiac interventions were provided to the patient.

Jennifer Strouse, RN, Neuroscience ICU: Jennifer had an order to insert a Dobhoff tube into a patient. The Dobhoff tube that was found in the clean utility room was different than the usual Dobhoff tubes that the unit has in stock. Jennifer's patient was scheduled for a MRI of the cervical spine and Jennifer asked if the new Dobhoff was MRI compatible. The letter from the manufacturer related to MRI compatibility was unclear. Since the patient was having an MRI of the area where the Dobhoff was located, the patient may have experienced an adverse outcome if she had not asked about the new tube and compatibility; her attention to detail avoided possible harm to the patient.

Sherry Walker, RN, ICUM/RHCS: Sherry realized while doing CRRT on her patient who had large fluid volume loss from the wound vac, that the charted output was not being calculated in the Metavision I+O's. Sherry notified the attending physician and then the Metavision support person. This resulted in a change to Metavision to reflect wound drainage as part of the I&O.

James Wu, MD, Department of Surgery: During a cardiothoracic procedure, Dr. Wu recognized that the oxygenator was not functioning correctly and alerted staff to check connections avoiding potential harm to the patient.

TIER 1 RECIPIENTS

Linda Adams, Radiology, Nuclear Medicine-Muhl
Alice Ashman, Pediatric Unit
Sandra Blackledge, Diabetes Education
Chantal Branco, 2KS
Samantha Breining, 2K-MICU/SICU
Carmine Campione, Progressive Coronary Care Unit
Sara Case, Neuroscience ICU
Carmel Castagna, Fairgrounds Surgical Center
Monique Coyle, Labor & Delivery
Megan Derr, 7C
Caroline Dunlap, ASU-Staging
Nancy Duro, Diagnostic Imaging
Sarah Earl, Radiology, CAT Scan-17th
Cheryl Eisley, Home Care
John Feller, Behavioral Health
Joanna Ferreri, 7C
Jeanne Florian, 4KS
Vivian Foulke, Neonatal ICU
Eva Fox, ICUM/RHCS
Kim Goff, Radiology, Ultrasound-17th
Grace Gerrouge, 3A/IPCU
Stephanie Grant, ICUM/RHCS
Michelle Kelly, 6B
Caroline Klepeisz, Neonatal ICU
Tracey Lightner, ICUM/RHCS
Andrea Long, 4KS
Todd Malseed, RHC Surgical & Vascular
Rachael Marouchoc, ICUM/RHCS
Janet Mest, ICUM/RHCS
Heather Miller, 4KS
Lerin O'Connell, Perinatal Unit
Rita Pechulis, 2K-Medical/Surgical ICU
Elizabeth Pereira, Radiology, Diagnostic-Muhl
Barbara Pickersgill, 7C
Lindsay Poncavage, ICUM/RHCS
Mary Ellen Sandholm, Radiology, Diagnostic-Muhl
Patrice Schaffer, Neonatal ICU
Deana Sewald, Neonatal ICU
Marlene Shields, Neonatal ICU
Jean Snyder, ED-17th
Lisa Stengel, Cardiac ICU
Maureen Unser, Radiology, Interventional-Muhl
Cade Upanavage, Health Spectrum Pharmacy
Nancy Wagner, Radiology, Ultrasound-17th
Kelly Wright, Labor & Delivery

Contributing to Patient Safety Initiatives through Education: Early Code Blue Response Drills in Simulation

By: Amy Droskinis, MSN, RN, CCRN, Education Specialist



This year the Division of Education embarked upon implementing a new teaching modality in the adult Critical Care Course. Adapted from the recently published simulation technique the “First 4 Minutes” drill (Rudy, S., Sinz, E., & Moyer, J., 2011), this technique was executed as part of this course in addition to Advanced Cardiac Life Support certification to promote early Code Blue response and best practice techniques for newly licensed RNs as well as RNs new to progressive and critical care. The increased emphasis on code blue skills evolved from multiple different avenues including course evaluations completed by the learner, Casey Fink survey results collected through the LVHN Nurse Residency Program, and anecdotal reports of increased desire for education about this topic from hospital leadership and committees.

In collaboration with the LVHN Interdisciplinary Simulation Center, the Clinical Staff Development Education Specialists created a simulation scenario that is four minutes in length and allows for execution of immediate Basic Life Support skills and techniques. Each learner who completes the critical care course participates in this simulation drill. The learners are separated into small groups in which they complete SBAR handoff report and are immediately exposed to a resuscitative emergency. The focus of the scenario are the immediate interventions and care that should be carried out during a code blue including CPR and airway management, AED application and use, documentation, medication administration, team work and communication. Effectiveness of chest compressions including appropriate timing and depth, and appropriate bag-valve mask usage is evaluated by the high fidelity simulation mannequin which provides a direct and accurate report of learner performance and skill technique. The report is then reviewed with the learners at the completion of the scenario.

In order to promote the optimal learning experience, the scenario is video recorded using the technologically advanced METI viewing system. This system allows the simulation scenario to be recorded and then immediately watched by the learner. By viewing their scenario, the learner is able to see their performance and techniques for themselves. Additionally, the learners then complete the same exact scenario a second and sometimes third time to allow for them to correct technique and skill, and to repetitively implement the appropriate actions. Following each scenario and METI viewing, a debriefing session driven by learner response and conversation occurs with the learners and facilitator of the scenario. During this debriefing session the learners are encouraged to express their experience in the scenario, discuss clinical performance and skill execution, and to bridge any existing knowledge and performance gaps that may have existed prior to this learning opportunity.

Immediate and appropriate code blue response is a patient safety initiative of the utmost importance. Early and effective CPR and defibrillation, as described by the American Heart Association, are key factors that contribute to positive patient outcomes and resuscitation. This simulation technique is a unique teaching modality which prepares frontline nurses to respond and implement the most pertinent lifesaving skills. Teaching these appropriate techniques during the adult Critical Care Course in conjunction with the learner’s overall clinical unit orientation and exposure to patient emergencies, is one instance of many in which the Division of Education unites and contributes to LVHN patient safety initiatives and standards.

Reference: Rudy, S., Sinz, E., & Moyer, J. (2011, May). Penn State Hershey first four minutes BLS drill: A novel introduction to team communication and resuscitation skills. Poster presentation.

2KS Collaborating to Make Patients Safer

By: Adaline Piotrowski, BNS, RN, CCRN ♦ Christine Hartner, BSN, RN ♦ Krysta Christman, Technical Partner

What is a NO PASS Zone?

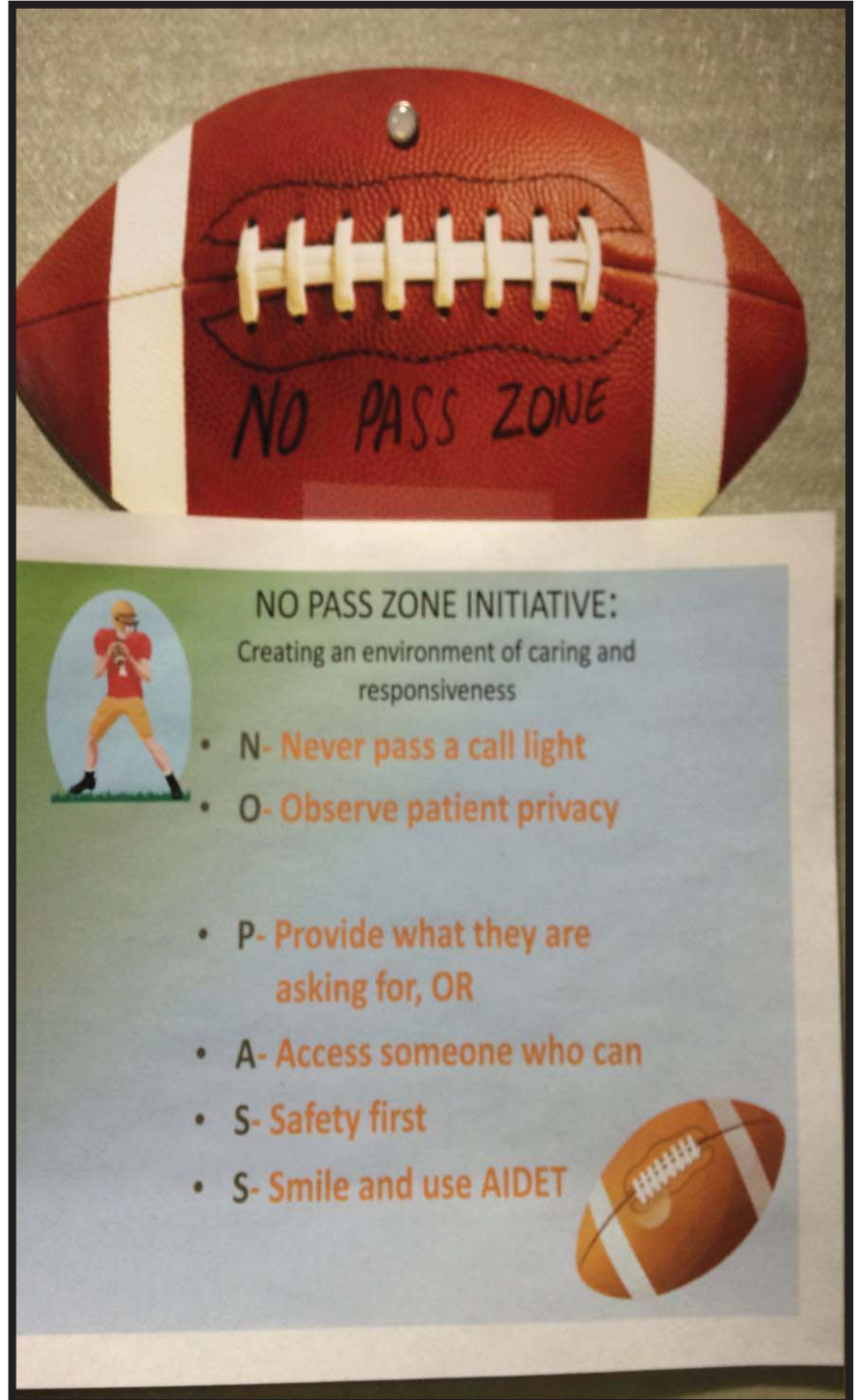
When I reflect on the theme “United in Safety”, I cannot help but think about how 2K South (2KS) united in establishing a NO PASS ZONE on the unit.

2KS is a critical care unit in the Kasych Pavilion. We currently have eight critical care beds and 4 progressive care beds; soon to ramp up to all critical care. We have a mix of patients that we take care of and we provide services such as ECMO.

My name is Adaline, I am the chair of the Education Council on 2KS. I was approached by Krysta Christman, a Technical Partner on nightshift, who also represents 2KS in the hospital wide fall committee, regarding a program that can help decrease falls on our unit. I collaborated with our Director, Christine Hartner, about educating our colleagues on our unit about a NO PASS ZONE. This is not a new novel concept, but how we implemented it is what makes it exceptional.

Our team took advantage of football season and developed innovative football themed graphic art posters and strategically placed them on our unit to remind staff about the initiative. We also developed an educational PowerPoint and discussed the initiative with our staff at our monthly unit meeting and Education Council meeting.

This education was targeted to help reduce falls on our unit. This safety initiative that was embraced by all of our staff had positive outcomes not only in our fall rates but also on staff morale. 2KS received an award at the fall retreat for a 10% decrease in our fall rates. The award certificate is proudly displayed adjacent to our Quality Board! This initiative also solidified team cohesiveness since we all feel like every patient is our patient! **Come tour our unit and see our Footballs!**



Keep a Grasp on Patient Safety

By: *Laura Walker, RN, BSN, Clinical Safety Education Specialist* ♦ *Mary Ellen O’Connell, RN, MSN, MBA, Clinical Quality Specialist*

The fall prevention workgroup, in collaboration with rehabilitation staff, has made efforts over the past few years to use gait belts more often in patient transfers and ambulation, but we had no qualitative evidence to demonstrate an increase in their use. Our intent with this project was to remove barriers to gait belt use by making the belts more accessible and visible. We hoped to enhance communication among bedside caregivers by providing a visual cue—a wall hook in each patient room to encourage gait-belt compliance during ambulation.

RHCM offered to participate in this project. Some of the interventions included educating staff on the project’s goal and processes and reassigning a TLC video to refresh skills and knowledge about gait belt use and proper patient selection. Wall hooks were installed in a visible area in all 36 patient rooms.

For evaluation and reinforcement, real-time chart and visual audits were completed. Audits were performed six times over a 4-month period with results being disseminated to unit leadership and staff to maintain engagement

In February 2014, the Plan-Do-Study-Act (PDSA) framework for developing and implementing the project was adopted by the workgroup. The Plan and Do processes began with selection of the target unit. We chose a progressive cardiac care unit because patients typically admitted there have cardiac-related diagnoses and cardiac rehabilitation is strongly encouraged.

In March 2014, the “Do” phase began when unit-based education was provided to inform staff of project goals and processes. **A poster with this information was placed in a centralized area on the unit.** Audit-screening tools were developed.



Wall hooks were installed on the closet door of every patient room for maximal visibility.

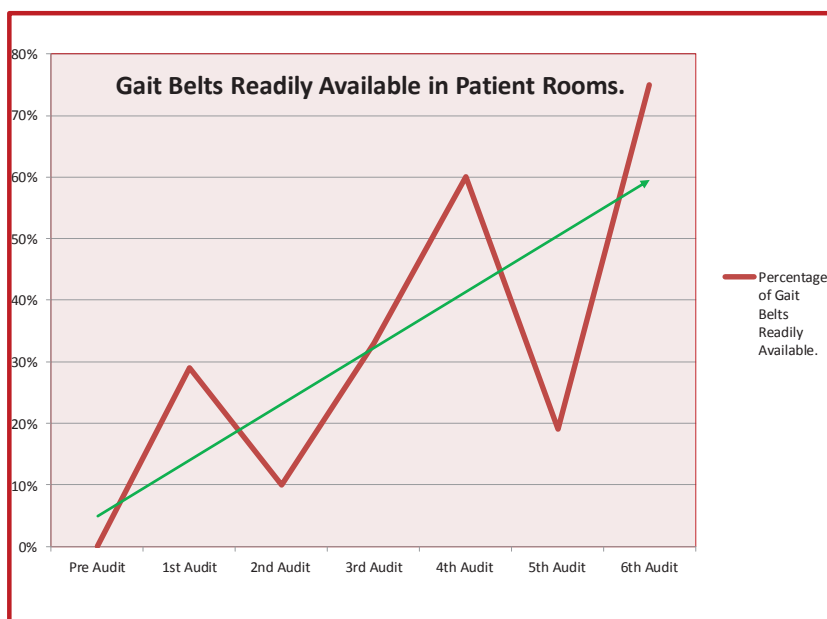
Using the audit screening tool, pre-audit data were collected 2 weeks before launch of the pilot program to provide a baseline on current gait belt practices.

The “Study” phase began after data were collected and disseminated from the initial audit. Project design complied with the organization’s defined criteria for a quality-improvement project, so an institutional review board review wasn’t necessary. To eliminate bias, a project team member who didn’t represent the selected unit performed all chart audit data collection. Evaluation metrics included a risk-for-injury screening tool and a review of the patient’s fall risk score, risk for injury score, current mental and mobility status, and any use of assistive devices. These tools allowed us to determine missed opportunities for patients who could have benefited from gait belt use but a gait belt wasn’t readily available.

The “Act” phase began when we identified gaps from the initial audit analysis. Throughout the PDSA cycles, we collaborated with unit leadership and fall prevention champions to find opportunities to foster staff engagement and accountability. We made a concerted effort to stress that using the gait belt protects staff as well as patients from injury. Using the cycles, we formulated strategies to eliminate barriers revealed by data analysis.

Data analysis from six serial audits revealed that nurses were accurately identifying patients at risk for falls according to our health network’s policy. We saw an overall 38% increase in staff placing gait belts in the rooms of patients who were at risk for falls and would benefit from gait belt use, compared to pre-audit results.

We used morning safety huddles, small incentives, and other efforts to inject fun and enhance staff engagement.



Nurses are committed to developing and implementing practices to encourage ambulation and promote safety, but we need to be innovative in eliminating barriers to meeting these goals. Direct bedside caregivers need tools to assist patients who fall unexpectedly during ambulation. At LVHN, gait belts are a nurse-driven intervention, and nurses are encouraged to use the belts when ambulating a patient identified at risk for falling. Gait belts can protect the caregiver by providing a handle to control and manage patients during an assisted fall, which can occur when attempting to impede the fall.

“Keep a Grasp on Patient Safety” showed that improving the accessibility and visibility of an effective safe-patient handling tool can encourage its use and augment patient and staff safety. Interventions that support or enhance existing fall prevention practices promote the overall goal of eliminating patient falls and related staff injuries.

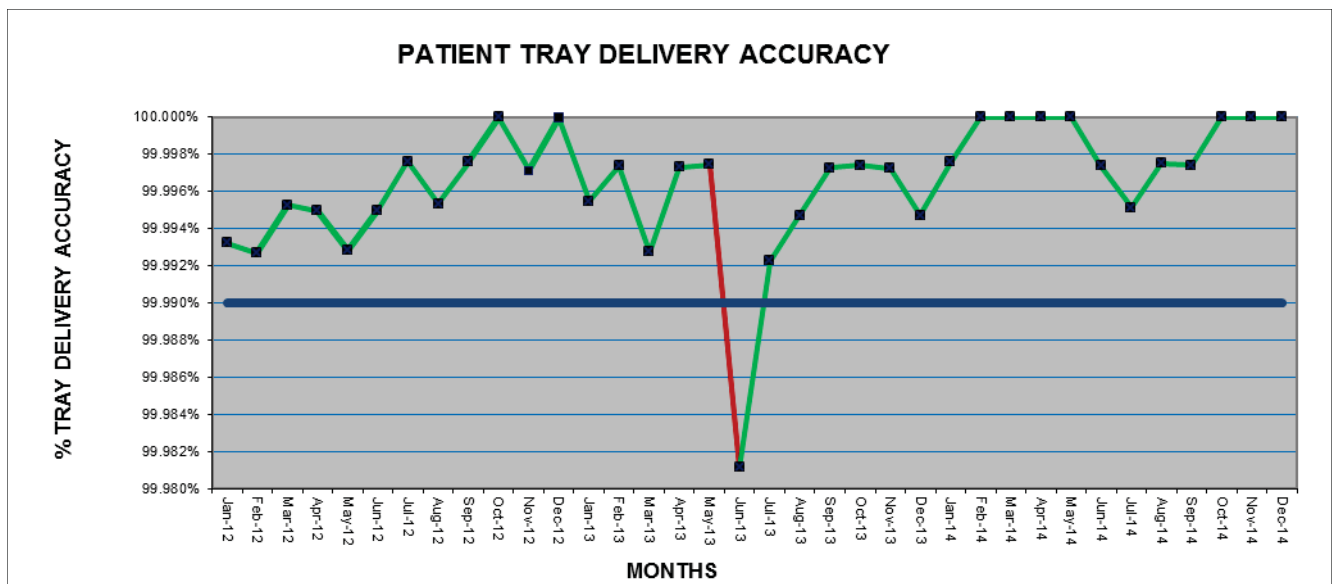
Thanks to the efforts of RHCM we have spread this project to 4T!

Accuracy of Patient Meal Tray Delivery

By: Judy DeHaven, General Manager, Food and Nutritional Services

For the safety of our patients, the Sodexo Food Service Staff utilize two patient identifiers when delivering a meal tray to a patient’s bedside. This ensures that the food provided adheres to the patient’s diet allowance for therapeutic and texture modifications. This also prevents patients from accidentally receiving food when they are NPO or only allowed clear liquids for the purpose of testing or medical conditions.

Upon hire the staff are oriented and trained on using 2 identifiers. They also receive annual in-servicing on this topic. Additionally, they are measured on their performance and held accountable through monthly manager auditing and nurse feedback reporting. Thorough and ongoing training and auditing of the food service staff has resulted in increased patient safety. Over the past year we have safely delivered 477,320 patient meal trays at LVH-CC without error, equating to a 99.999% compliance and no patient injuries.



Team Members:

Judy DeHaven, General Manager ♦ Kyle Kramlich, Patient Services Operations Manager ♦ Solvey McMillan, Patient Services Manager ♦ Karen Crow, Food Manager ♦ Pedro Jose, Food Manager ♦ Tran To Moniz, Human Resources Manager

Preventing Errors in CADD Pump 5FU Administration

By: Freda Barnes, RN, BSN, OCN ♦ Maura Price, RN, BSN, OCN

The outpatient infusion centers (MPA/MPS/MPB) treat patients with colorectal cancer who commonly undergo treatment with CADD pumps, an infusion pump that administers 5FU chemotherapy over 46+ hours. The patient receives IV chemotherapy in the infusion area and a CADD pump is prepared and delivered for use by a retail pharmacy, such as Health Spectrum Pharmacy. The CADD pump is connected to the patient while in the infusion center and the patient is discharged with a continuous chemotherapy infusion pump that they manage at home. After noticing an increase in the volume of safety reports submitted involving the care of patients with CADD pumps, a team was created and charged with identifying issues with the current CADD pump process. These issues included: 1.) changes in the CADD pump dosage the day of treatment with no notification to pharmacy, 2.) delays in CADD



pump delivery due to pharmacy not receiving notification of CADD hookup time, 3.) no double check that the CADD pump was infusing prior to patient discharge, 4.) lack of patient education on troubleshooting the pump (i.e. low battery, what to do if pump is leaking, what phone number to call with questions, etc.)

The team created a CADD pump standard work document. The standard work was reviewed and discussed with all infusion colleagues at their annual education day, and was also reinforced by the performance improvement (PI) teams. After the education was complete and standard work was implemented, the infusion area's PI members held a meeting with the oncology quality team and the nurse informaticists to discuss feedback and ideas presented by colleagues. Based on feedback from the core team and infusion colleagues, a CADD pump checklist was created and incorporated into the outpatient EMR system. This simple checklist now serves as a reminder and double check to ensure that all items are completed prior to discharging a patient home with a CADD pump. This checklist went live in January 2015 and staff feedback has been great so far. Going forward the infusion areas will monitor compliance with this checklist via PI audits. Our ultimate goal is safe patient care and to decrease the number of safety report entries related to CADD pumps.

Team Members:

Freda Barnes, RN, BSN, OCN ♦ Maura Price, RN, BSN, OCN ♦ Trish Brenan RN, BSN, OCN ♦ Becky Bartholomew RN, OCN ♦ Susan Ohi RN, BSN, OCN ♦ Rose Lowitzer RN, OCN ♦ Jane Cappiello-Culp RN, OCN ♦ Jill Korn RN, BSN, OCN ♦ Angela Miller RN, MS, OCN ♦ Amy Levan RN, BSN, OCN ♦ Nicole Grossmann RN, BSN, OCN ♦ April Gheller RN, MSN, FNP-BC, OCN ♦ Melissa Kratz RN, MSN, AOCN ♦ Mandy Hendricks RN, MSN, OCN ♦ Donna Colabroy RN, MSN, OCN ♦ Bobbi Werkheiser RN, OCN ♦ Allie Zolynski RN, OCN ♦ Dave Freeman RPh



Compounding at Health Spectrum Pharmacy

By: Kaitlyn Kiniery, Pharmacy Technician ♦ Lauren Grantz, Pharmacy Director ♦ Matthew Yost, Pharmacy Manager ♦ Ryan Sutliff, Pharmacy Technician

In 2014, Health Spectrum Pharmacy changed the way that we log our compounded medications in an effort to improve patient safety. Previously, we kept a minimal log book in which we would generically track prescription numbers, compound ingredients, and dates of preparation. As part of our new safety initiative, a specific compound worksheet is now printed by a data entry pharmacist for each new and refilled compound medication. With these worksheets, we are now able to keep track of the expiration dates and lot numbers of each individual ingredient, in addition to prescription numbers and dates of preparation. As the compounding technician prepares a medication, they sign off on each ingredient they are using. After everything is prepared, a pharmacist also checks and signs off on each component of the compound. This is all done before the compound is mixed. Upon completion of the compound, an additional pharmacist will then verify it for a third and final time before it is dispensed to a patient.

In addition to the multiple checks during preparation, the worksheets are also beneficial should the patient have any questions after they have received their medication. All worksheets are logged and sorted by date, and then stored in the pharmacy compounding area. If a patient were to call with a question days, or even months, after they picked up their prescription, we can easily locate the worksheet as a reference. A specific example would be if there was a recall on a medication that we may have used for compounding. We can not only see exactly when and to whom it was dispensed, but our worksheets allow us to track the lot number of the specific stock bottle that was used. We can then contact patients as appropriate if they may have received an affected lot.

These detailed compounding worksheets are one of many ways that Health Spectrum continues to strive to make patient safety one of our highest priorities.

Collaborative Interdisciplinary Rounding at the Bedside

By: Alyssa S. Campbell, MBA, MSN, RN, CMSRN ✦ Sue Neiman, RN, CRNAC, CMSRN

Interdisciplinary Rounds at the bedside are completed weekly here on TSU. The Interdisciplinary Team, including members from Nursing, PT, OT, Case Management, Nursing Leadership and the TSU Medical Director, meet at the bedside with the TSU resident to ensure the team is providing patient-centered care. During Rounds, the resident's individualized goals in each discipline are discussed, updates in progress are shared in a way that the resident can understand, and the care team encourages resident participation and accountability in their own personalized plan of care.

The TSU Rounding process first began in 2010 in preparation of MDS 3.0 and replaced day long care conferences. The purpose of meeting has always been on care planning present issues and assessing readiness for discharge and safety concerns. However, rounding at the bedside presented opportunities to address medical concerns and functional status to ensure safe discharge more so on the residents' own terms.



Rounding has provided an all-inclusive opportunity to address resident specific safety concerns amongst the team, along with obstacles as perceived by the patient and all others who may be participating in their care. Therefore, concerns and issues related to safety can be proactively discussed and managed prior to the resident returning home.

Rounding in Action: A Case Study

A 78 year old resident was admitted to TSU with an admission diagnosis of decreased mobility secondary to pneumonia. Shortly after admission, case management met with the resident to explain Interdisciplinary Rounds, and encourage family members or caregivers to come to a designated time to express their concerns and have their questions discussed with the team. After receiving a few days of therapy, nursing care and medical team observation, the resident and team were ready to discuss the resident's plan of care during Rounds. A family member, one of this resident's care givers, was present and participated in the Rounding process because she was made aware of the date and time of Rounds early during the resident's stay. After the team received permission to enter the resident's room, each care team member engaged the resident and caregiver in a discussion regarding that discipline of care. During the Round, the resident and their family member were able to discuss issues related to skin, and shared with the team that the resident frequently developed redness on the sacrum when at home. From this information, the team was able to share assessment findings and discuss the best treatments for this resident. Skin breakdown prevention strategies that were amenable to the resident and his caregiver were implemented by nursing and led to caregiver education. New onset incontinence was identified by the CNA and discussed with the family member who then shared with the CNA a toileting schedule that worked well at home. Therapy was able to offer a specialty cushion and planned to work on positioning techniques, and nutrition was contacted for appropriate dietary supplements that met the resident's preferences.

Nursing Participation and Buy-In

Ongoing leadership presence and encouragement were critical for nursing staff participation and buy-in. It was found to be essential that the nursing team caring for the resident- both RN and CNA- be present for Rounds. Nursing staff were educated on highlighting important aspects of care that are critical to share with the team, and therefore nurse specific scripting was developed to assist staff in preparing for and making the most of their Rounds.

From Hospital to Home: Easing the Transition for Heart Failure Patients

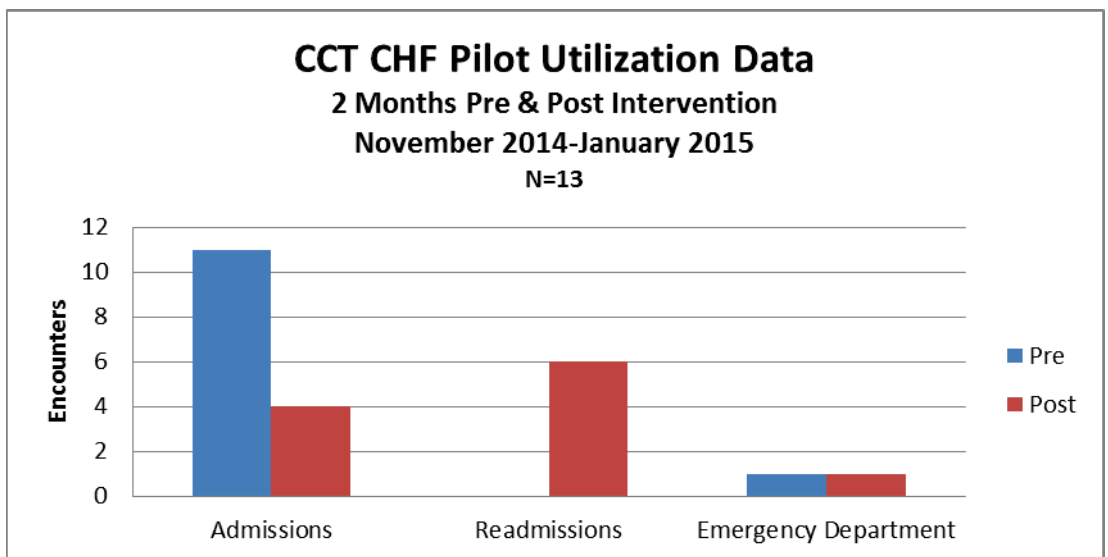
By: Kay Werhun, DNP, MBA, RN, NE-BC, Director of Population Health Services ♦ Meredith Dempsey, PharmD ♦ Barbara Dubyk, BS, RPh ♦ Laura Williams, BS, PharmD

When patients transition from one health care setting to another, there is often disconnect between hospitalists, primary care physicians, patients and caregivers. This lack of communication can result in both increased adverse events and hospital readmissions. Community Care Teams (CCT) of the Lehigh Valley Health Network (LVHN), which are multidisciplinary healthcare teams comprised of behavioral health specialists, nurse care managers, pharmacists, and social workers, work together with primary care practices to help reduce these hospital readmissions and improve patients' overall health.

The CCT recently initiated a congestive heart failure (CHF) transition of care pilot program to closely follow-up with CHF patients by telephone upon discharge from the hospital. The overall goal of the program is to increase patient safety through medication reconciliation and education (i.e., disease state management and lifestyle changes) as well as reduce hospital readmissions. Nurse care managers (CM) on the CCT perform the initial outreach to patients within two business days of discharge from the hospital. The CM educates patients about their disease state, reviews their hospital discharge instructions and medication list, and ensures follow-up appointments are scheduled. After the initial outreach is made, a CCT clinical pharmacist (CP) is consulted. The CP communicates with the patient over a series of phone conversations, which occur on Days 7, 14, 21 and 28 post-discharge. During these follow-up phone calls, the CP performs comprehensive medication reconciliation, collaborates with physicians to ensure appropriate therapy is being utilized, and educates patients about their CHF utilizing teach back method.

The CCT provides a safety net for patients with CHF who are frequently admitted to the hospital and may see multiple physicians, including specialists. Through frequent contact, patients are educated on the importance of daily weight monitoring, diuretic therapy, and dietary restrictions. Education on disease state management and warning signs allows patients to seek treatment quickly in the ambulatory setting and avoid unnecessary hospitalizations

The pilot program, initiated on November 1, 2014 in two Lehigh Valley Physician Group (LVPG) primary care practices, has enrolled 30 unique patients to date. Data was collected and analyzed for the first month (November 1st to November 30th; n=13 patients) to compare two



months pre- and post-data. A 63% overall reduction in admissions was noted. There was an increase in readmissions, mostly due to complex disease states and/or end stage disease. In these cases, a referral to palliative medicine may be appropriate. Based on the results of this short-term data, the CCT may need to intervene on patients earlier in the disease process. Utilizing CHF registries within our health system is one way we can start to proactively reach out to this high-risk population and improve not only utilization, but patient's overall health.

Preventing Falls on an Inpatient Behavioral Health Unit

By: Nicole Urban-Miller, RN, BSN

Patient falls are a major cause of injury among hospitalized patients, often prolonging and complicating their stay and impacting their well-being beyond hospitalization. A gradual rise in fall rates prompted the nurses on the behavioral health unit to translate new research into their fall prevention practices. Behavioral Health has worked over the past few years on trying to decrease falls on the units. Data collected in fiscal year 2012 and 2013 showed an average of about a total of 35 falls on our adult behavioral health two unit. The implementation of both staff and patient involvement helped to decrease falls within the next fiscal year 2014 and decreased to an average of less than 20 falls.

We are an acute care area with an average length of stay of about a week; during this time one of the main things that happens are drastic medication changes/adjustments. Our patients are mobile and move around the units freely, which makes it a daily challenge to prevent patients from falling. The staff on the unit started looking at ways to decrease patient falls and increase patient safety. One initiative was to implement high fall risk patients into the huddle process, which takes place at the beginning of each shift. Each patient on high fall risk precautions are discussed with the whole team during the huddle process checking to ensure that interventions are in place and if not what could be utilized to prevent falls. We include the patients that are on fall risk during the education process by reviewing a fall contract with them. The fall contract describes ways to move around the unit freely and ways to prevent falls.



There is a sign posted in every patient room on how to prevent falls as well.

High risk patients are assessed every shift for any change in status especially syncope episodes which are frequent. Even though the behavioral health unit utilizes rounding on every patient every fifteen minutes, the registered

nurses must assess their patient every hour as well. They must verbally ask them if they have any needs that need to be met at that time. The mental health technicians and nurse aide completes rounding on the units to check the rooms to ensure that they are clutter free.

Identified concerns included falls were occurring around the beds. A safety measure was implemented to make sure all beds are in the lowest position. Falls in the shower resulted in the use of fall mats, shower chairs if

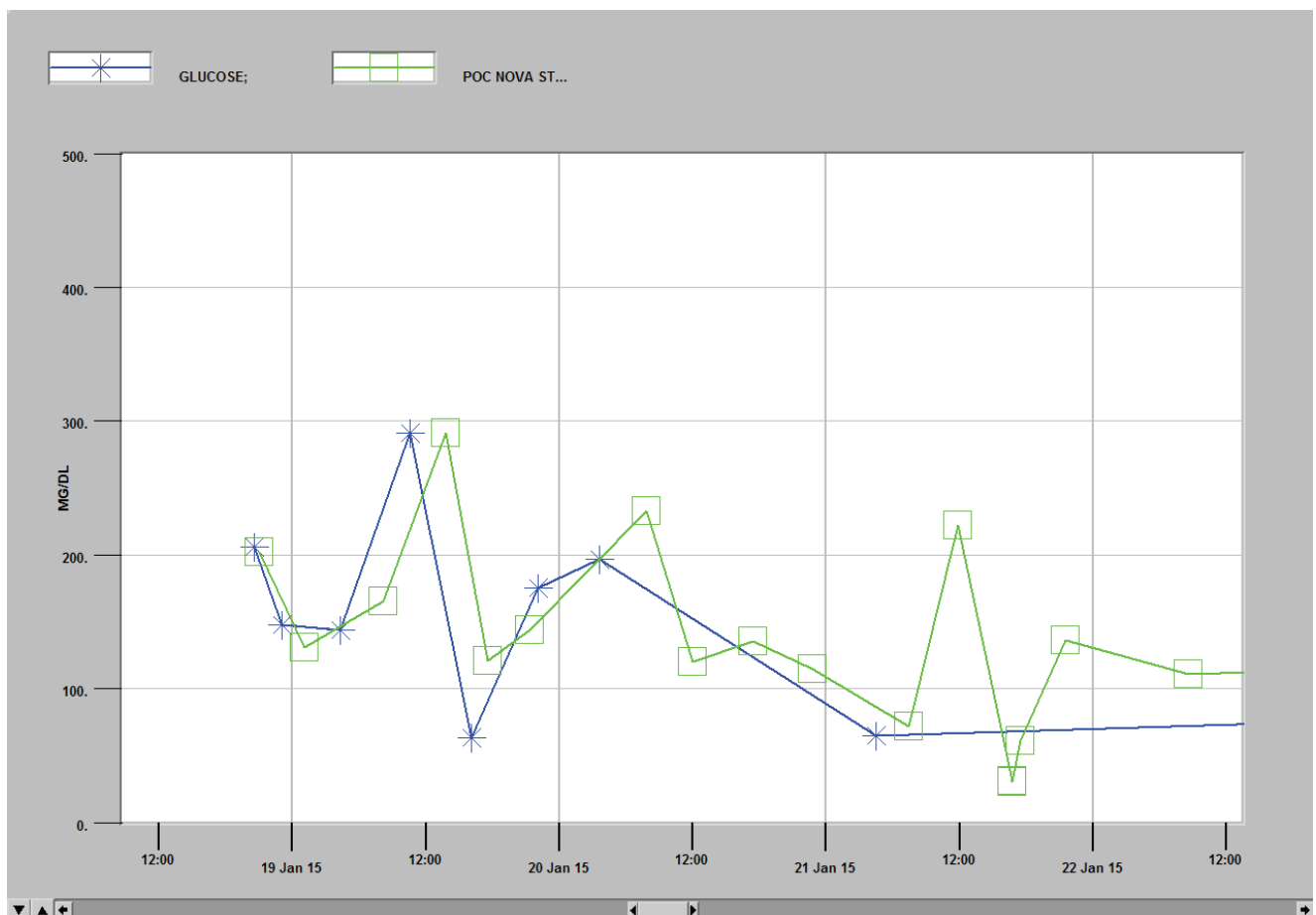
needed, and staff assistance. We again encourage the patients to be a part of this process and educate them on safe position changes and tidying up their rooms to maintain clear paths around the room.

The continued use of the huddle process, engaging all staff and the patients in the process of preventing falls, utilizing the appropriate interventions and tools available, and meeting daily to discuss any other strategies, suggestions, or ideas to prevent falls has helped to decrease the number of falls on our unit. The research completed identifies that patients who perceive engagement and involvement with both staff and their treatment program experience a greater sense of value in their recovery.

Reducing Hypoglycemia and Severe Hypoglycemia Rates for Hospitalized Adults

By: Joyce Najarian, MSN, RN, CDE ♦ Sandra Blackledge, MSN, RN, CDE ♦ Sharnee Cederberg, MSN, RN, CDE ♦ Mary Cipolle, BSN, RN, CDE ♦ Kim DeLuca,, MSN, RN, CDE ♦ Margaret Gergar, MSN, RN, COCNurse, CCWCNurse, CDE ♦ Cara Habeck, BSN, RN, CDE

Starting in FY2013, the inpatient RN/CDEs on the inpatient diabetes education team implemented a new workflow process aimed at reducing LVHN hypoglycemia rates and potential harm to our patients. Utilizing Senti 7 ®, a pharmacy web based tool, the team performs Monday-Friday screening of hospitalized adults who have had a blood glucose value < 70mg/dl. The educators graph the blood glucose trends on a worksheet and review the medical record to identify potential hypoglycemia triggers.



If needed therapy adjustments have not yet been made, the educator either makes suggestions to providers, and/or provides 1:1 education with team members on actions that may have contributed. In the event of severe hypoglycemia (BG < 40 mg/dl), the team completes an in-depth assessment, collects data, and reports trends to the network's multi-disciplinary Diabetes Management Quality Improvement Team. This surveillance has resulted in multiple process changes. Some examples include: reducing hs correction scales, changing daily basal insulin times, developing new guidelines post hyperkalemia insulin administration, implementing q 2 hr glucose monitoring of diabetes patients in the ED, and facilitating upcoming changes to LVHN Hypoglycemia Management.

The combined interventions have heightened staff awareness of hypoglycemia risks and triggers, and contributed to the reduction of LVHN hypoglycemia rates since implementation.

Why is all this important?

Hypoglycemia is a common, but preventable, acute complication of insulin or oral medications, such as sulfonylureas or meglitinides. Common hospital hypoglycemia risk factors include, but are not limited to: a mismatch in timing of insulin to BG values and nutritional intake; reduction of steroid doses without adjusting insulin; significant changes in caloric intake, tube feedings, or TPN; incorrect insulin dosing; disproportionate basal and nutritional insulin; poor communication or hand over communication; acute, chronic or worsening renal or liver status; improvement of infection, illness, glucose toxicity; sepsis; adrenal insufficiency; fluoroquinolones; and use of oral secretagogues or insulin mixes with variable oral intake.

Hypoglycemia increases fall risk. It also contributes to increased cost and LOS, varying from one event adding 2.5 days, to multiple events adding as much as 8.8 days. Severe hypoglycemic events have been shown to increase mortality, both in hospital and up to 1 year post discharge. Of equal importance, bear in mind that overtreatment of hypoglycemia, hyperglycemia (BG > 180mg/dl), and extreme glycemic variability all contribute to increased LOS/cost and poor clinical outcomes.

Literature recommends that hospital regimens be modified following any BG < 70 mg/dl, and that therapies be evaluated when BGs trend 70-100mg/dl. Our own reviews demonstrate that more than 55% of our severe hypoglycemic events were preceded by one or more low BGs < 70mg/dl in the prior 24-48 hrs. A key step in preventing recurrent or more severe events is making sure that discussions are held with the provider to identify causes and possible dose changes before administering the next scheduled dose. Reducing hypoglycemia is our passion, but we can't do it alone. Prevention, risk factor reduction, early recognition, and provision of appropriate treatment are shared responsibilities!

DNA-VC Creates Situational Awareness and Staff Safety at the Bedside

By: Jody Shigo, MSN, RN, Director

What is Workplace Violence? You will find a multitude of definitions in the literature. The National Institute for Occupational Safety and Health (NIOSH) defines it as “violent acts (including physical assaults) directed toward persons at work or on duty” (Department of Health and Human Services [DHHS], 2002). Others use similar wording such as violence or the threat of violence against workers; acts of aggression or physical assault; threatening behaviors; or behavior that causes emotional or physical harm. Still others describe workplace violence as an act of aggression, physical assault or threatening behavior that occurs in a work setting and causes physical and/or emotional harm to customers, coworkers or managers (DHHS, 2002). Common themes have remained constant, essentially suggesting that the violence occurs at work and refers to a broad spectrum of behaviors (i.e.: violent acts by patients, visitors and/or coworkers) that result in a concern for personal safety. In fact, according to Papa and Venella, 2013, the second leading cause of death of women while at work is workplace violence homicides from assaults and other violent acts.



Workplace violence is a significant occupational hazard in healthcare (Catlette, 2005). Violence in the healthcare workplace commonly occurs at the patients' bedside. However, data on workplace violence tends to be underreported and relatively scarce (Danesh, Malvey & Fottler, 2008). Nursing staff that experience workplace aggression are challenged on a daily basis. Although no employee is immune to workplace violence, as the largest group of employees in healthcare, nurses are particularly vulnerable to workplace violence (Catlette, 2005).

Despite recent attention by regulatory and industry groups, little is known about the underlying theory or interventions to reduce acts of aggression in healthcare settings. An increase in threats and violent acts by patients and visitors on a 30-bed medical-surgical transitional trauma unit (TTU) prompted the need to enhance safety in the care environment.

The first step was formation of an interprofessional work group who determined how patients are associated to violent behavior, how they are managed from point of entry through discharge and how security is managed at the bedside. Simultaneously, staff on units with 'high-risk for violence patients' also completed a survey to identify concerns and knowledge deficits of caring for patients associated with violence. In response to the work group's analysis and staff survey findings, patients determined to be associated with violent crimes were identified: cases of penetrating trauma; physical or sexual assault; child abuse; recipients of an actual threat; or, those in the victim protection program. All of these interventions led to environmental safety enhancements and a process to identify patients associated with violent crimes. This heightened sense of situational awareness prompts nurses to recognize conditions with the potential for

violence and initiate appropriate actions to maintain a safe environment for themselves, their patients and visitors.

Staff survey results were: 28% of staff was unaware that processes to identify this population were already in place; 21% felt unsafe in their environment; and, 54% were unaware of a firearms policy. Additionally, staff reported that existing locked units are easily accessible to visitors most of the time. Environmental safety enhancements included: emergency pull switches; directional door locks; new signage; a badge system for all non-employees on high risk units; and, the replacement of receptionists with security officers in high risk waiting rooms. To alert staff of a patient associated with violent crimes, and thus, potential for violence, these patients are flagged upon admission as 'DNA -VC' (Do Not Announce - Violent Crime) in both the electronic record and bed management system. Finally, standard work, including environmental safety assessments, enhanced communication and education processes were implemented in all departments

Workplace violence is not part of the job. While we understand there is inherent risk with patients experiencing behavioral health emergencies, dementia and other organic complexities, or perhaps visitors who are under stress, we cannot become complacent (Papa & Venella, 2013). It is important to recognize there is not one simple solution, but rather this issue requires an interprofessional approach to mitigate workplace violence. What is most important is the understanding of the impact of workplace violence has on the healthcare provider. We must provide real time support and ongoing resources to protect bedside staff and to ensure the person on the receiving end of a violent act feels valued, respected and safe.

Outcomes

Post-Implementation Staff Survey
July 2014 (n=25): Less than 32% of staff thought the process to identify a DNA-VC patient admitted to the unit was "unclear."

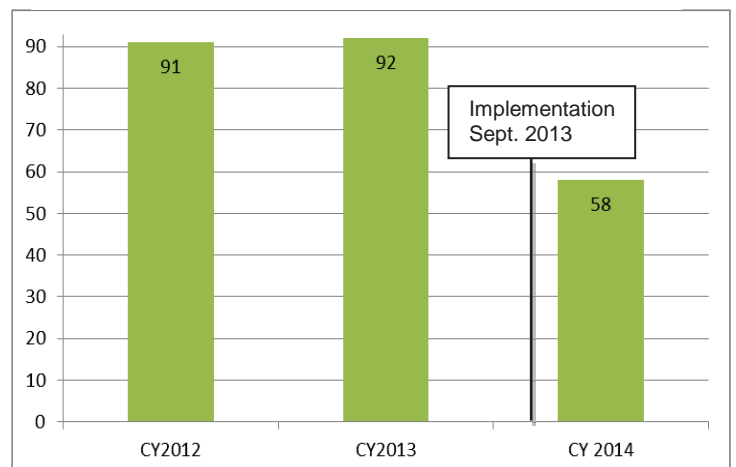
Lessons Learned

A heightened sense of situational awareness prompts nurses to recognize elements possessing the potential for violence.

Knowledge empowers nurses to initiate appropriate actions to maintain a safe environment for themselves, their patients and visitors.

Decreased Total Employee Injuries CY2014

(caused by intentional assault by patient)



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...

A PASSION FOR BETTER MEDICINE.™

Lehigh Valley
Health Network

610-402-CARE LVHN.org

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

THANK YOU FOR TAKING THE TIME TO READ THE
2015 PATIENT SAFETY AWARENESS WEEK
PUBLICATION RECOGNIZING STAFF
ACCOMPLISHMENTS FOR PATIENT SAFETY.

IF YOU COMPLETE AND RETURN THE FOLLOWING
PATIENT SAFETY & INFECTION CONTROL WORD
SEARCH, YOU WILL RECEIVE A SURPRISE IN THE MAIL!

Patient Safety & Infection Control

To receive a surprise, return your completed word search to:

Elaine Walz, Infection Control & Prevention,
1251 S. Cedar Crest Blvd., Suite 204,
Allentown, PA 18103

Or scan & e-mail to:
Elaine_L.Walz@lvhn.org

To claim your surprise provide:

Name:

Dept:

Interoffice Mailing Address:

G Q B H L H S Y F Y A A P H M T H S T J N F D E I
 Y H U D D L E B I Z C A N W V T V L T H Q I G V N
 H T F J Q R P V N J H A S W L W U F P A S R Y I F
 T Y I A H H E E S R O R R E D E M I G I N Z U D E
 J X I L L T U N P D Z U W U I P B R N Y P E G E C
 T D Z A I L X L T Z A Q S S C T Q F I Q S W C N T
 L B M V F B S U X R L S O Q P C E C D T G D A C I
 J V Q N M M I I U E V L H X E C A X N G C U W E O
 C D I F E V Y S J S A N M B T T S D U D N T Q B N
 F O P F J T S I I T R L O I O T N O O E J A N A L
 D U L T I R B J I V D D O X G A L M R C J Q F S U
 R G F L T J Q O V V S N M C S X R G S I C C H E N
 A Z A Z A E N E I G Y H D N A H N D Q J B J U D H
 K U L U Y B E D U C A T I O N R O Z B O P D A P B
 Q H L G W Z O H B Q L U X X B S I I Q E Q U R G C
 L T E I E P T R P S I R S D D L T W L D W O S M N
 W F U O C T U X A I O E M O D V N V A L B X P K K
 G O Q L F U H Z M T S J H D E C E A M Y S U N U H
 P M X D A S D B X Q I Z B I C N V O Q D T F X O X
 T P D M H J Y C Q F Y O S H Z S E I X X R O D N G
 V K T R M F L N I O W C N N S Q R M K Z Y I Z F U
 O F Y T O X G V H S T Q E L S R P R L N B L N J L
 S W I B U H J D X V A Q K M V B W F N O W F D J Q
 I L N J C R O R I S K A S S E S S M E N T H L M V
 L D E W L F B Y L X G Z R J P U W G X I C Z H L A

ACCURACY
 DISINFECTION
 FALLS
 INFECTION
 MED ERRORS
 QUALITY
 TJC

COLLABORATION
 EDUCATION
 HANDHYGIENE
 INFLUENZA
 NPSG
 RISKASSESSMENT
 VISIBILITY

DASHBOARD
 EVIDENCEBASED
 HUDDLE
 ISOLATION
 PREVENTION
 ROUNDING