CHPSO
California Hospital Patient Safety Organization

Patient Safety News
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Telemetry Standby: Potential Danger

California law requires hospitals to report certain events to the Department of Public Health, which may issue administrative penalties in certain cases. The California Hospital Association maintains a database of those reports that elicited a penalty. CHA members can access the database at www.calhospital.org/ij-catalog/reports.

One recent report involved a delay in detection of an arrhythmia on a monitored patient due to the equipment being in standby mode. In this telemetry unit, like many others, there was a central station without bedside displays.

The system's design makes communication to the telemetry technician of a patient's current status (e.g., "away for a scan") critical. As one manufacturer's manual states: "Standby suspends monitoring, and you won't get any waveforms or alarms." If the technician does not know that a patient has returned from a procedure or that a new patient has been admitted to a previously empty "standby" bed, the lack of central monitoring could be undetected by both the nurse and the technician.

CHPSO suggests that hospitals assess whether their telemetry system has a similar vulnerability. In this particular report, the hospital responded to the issue by putting in place a structured communication protocol to improve communication reliability and reduce the risk of an unmonitored event.

In their protocol:

- Guidelines identify specific criteria for being placed in the standby mode, which includes who notifies the technician when patient leaves and returns to unit and for a documented projected return time.

- The telemetry technician will contact the assigned nurse to determine the location and status of the patient if the patient does not return by the projected time.

- When handing off to the next telemetry technician, the technicians will validate the patients who are on telemetry and who are off for procedures and their projected return time.

— Rory Jaffe, MD MBA, rjaffe@chpso.org

CHPSO Annual Meeting

Take a Stand for Patient Safety — Eliminate Preventable Harm.

Save the Date! March 13, 2012, at the Glendale Hilton.

Audience: C-suite and quality, risk, safety, nursing and physician leaders.

Presenters include: Patient advocate, nationally-recognized patient safety experts and a leaders' roundtable.

Main topics: Culture change and its role in speed, breadth and sustainability of improvement. The leader's role in fostering a pervasive culture of safety. Focusing on the patient.

More information will soon follow.

Strategies for Moving to a Fair and Just Culture

Complex systems, such as hospitals, are inherently unsafe and culture is the key to getting and keeping patients safer. A Just Culture is defined as an environment of trust and fairness where it is safe to report and learn from mistakes and system flaws. It is where we are clear about the difference between human error in complex systems and intentional unsafe acts.

A Fair and Just Culture is where reporting and learning are valued, people are encouraged and rewarded for providing essential safety-related information and leaders and human resource systems assure we achieve it.

Lessons for Leaders

Know who is accountable and in what respect. Employees, leaders including human resource leaders and physicians are accountable for a creating a Fair and Just Culture.

Employees are accountable to act in ways that avoids harm to patients; to report critical events and good catches-our own our others; to identify and stop unsafe systems or accidents waiting to happen; and to participate fully when adverse events happen to learn what went wrong and how to prevent in the future.

Leaders are accountable to be a role model for all employee accountabilities by holding themselves to the same standards; to promote a fair and just culture; to assure respectful behavior for all; to set high performance standards, enable employees to achieve the standards, and coach employees to improve performance; and

to provide equipment and resources so that each person can work safely and reliably.

In addition, leaders are accountable to develop teamwork skills; to note when behaviors drift from safe to at-risk; to actively seek and listen to employee's concerns with unsafe systems that may harm patients or staff; to take action to address the concerns; to develop reliable systems in partnership with staff, patients, and families; to role model leadership behaviors when things go wrong — both immediate response and patient disclosure; and to fully review and learn from all critical events and good catches with those involved — get to a deeper understanding of how the system failed or the 'second story'.

Human Resource Leaders are accountable to design systems that support leaders and employees in achieving a Just Culture; for systems that include: leadership development based on Just Culture principles; performance management systems that assure skilled application of Just Culture principles; and respectful work environment systems and consequences for all.

Physicians are accountable to develop reliable systems in partnership with and work with staff, patients, and families; to role model leadership behaviors when things go wrong — both immediate response and disclosure to patient/family; to fully review and learn from all adverse events and good catches with those involved — to get to a deeper understanding of how the system failed.

Know the Basic Requirements: identify safety content experts — staff and executive; display teamwork and respectful communication skills, enhance performance improvement skills and share stories. Know what to do when things go wrong: implement immediate response systems, ensure transparency — disclosure and apology, conduct event reporting and analysis and provide support for patients, families, and caregivers after an event.

Know the Action Items for Leaders: First Steps: describe Fair and Just culture to colleagues — talk with senior team about the fundamentals of a Fair & Just Culture; and identify what actions you will take with an adverse event.

Be Courageous: join a causal analysis review as a learner; talk to a caregiver involved in an event; meet with a family to apologize after an event; teach Fair and Just Culture to the Board; and talk with your healthcare media contact.

Celebrate the Milestones: tell two stories of patient harm and what happened afterwards in the next two weeks; tell a story of learning from an error — your own and others; thank someone for speaking up: for telling the truth; and share stories of harm and impact on the patient, family, and caregivers at the Board.

— Bobbie Dietz, bdietz@chpso.org

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Note: CHPSO is developing a Just Culture Toolkit designed to assist hospitals in the successful adoption of this important component of a culture of safety. Contact Bobbie Dietz for details.

Wrong-Site Surgery: Impact of Practices

The Pennsylvania Patient Safety Authority evaluated recent wrong site surgery reports to see which of their recommended safety practices would have had the most impact on preventing the events. In order from highest impact to lowest, the practices are:

Provider verifies. All information that should be used to support the correct patient, operation, and site, including the patient's or family's verbal understanding, should be verified by the nurse and surgeon before the patient enters the operating room (OR).

All engaged. All members of the operating team should verbally verify that their understanding matches the information in the relevant documents.

Reference mark. The site mark should be visible and referenced in the prepped and draped field during the time-out.

Voice concerns. Operating team members who have concerns should not agree to the information given in the time-out if their concerns have not been addressed.

Circulator verifies. All information that should be used to support the correct patient, operation, and site, including the patient's or family's verbal understanding, should be verified by the circulating nurse upon taking the patient to the OR.

Stop activities. All noncritical activities should stop during the time-out.

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Confirm mark. The site should be marked by a healthcare professional familiar with the facility's marking policy, with the accuracy confirmed both by all the relevant information and by an alert patient, or patient surrogate if the patient is a minor or mentally incapacitated.

Mark with provider's initials. The site should be marked by the provider's initials.

Site on history and physical. The correct operation and site should be noted on the record of the history and physical examination.

Time-out for each procedure. Separate formal time-outs should be done for separate procedures, including anesthetic blocks, with the person performing that procedure.

Site on schedule. The correct site of the operation should be specified when the procedure is scheduled.

Site on consent. The correct operation and site should be specified on the informed consent.

Active responses. Verification of information during the time-out should require an active communication of specific information, rather than a passive agreement, and be verified against the relevant documents.

Verify with images. Verification of spinal level, rib resection level, or ureter to be stented should require radiological confirmation, using a stable marker and readings, by both a radiologist and the surgeon.

Provider empowers. The surgeon should specifically encourage operating team members to speak up if concerned during the time-out.

Access office records. The surgeon should bring copies of supporting information uniquely found in the office records to the surgical facility the day of surgery.

Provider resolves discrepancies. Any discrepancies in the information should be resolved by the surgeon, based on primary sources of information, before the patient enters the OR.

Address concerns. Any concerns should be resolved by the surgeon, based on primary sources of information, to the satisfaction of all members of the operating team before proceeding.

Reconcile discrepancies. Anyone reviewing the schedule, consent, history and physical examination, or reports documenting the diagnosis, should check for discrepancies among all those parts of the patient's record and reconcile any discrepancies with the surgeon when noted.

Ask active questions. All verbal verification should be done using questions that require an active response of specific information, rather than a passive agreement.

Two identifiers. Patient identification should always require two unique patient identifiers.

See goo.gl/okjpM for more information.

Calendar

October

10: *CHPSO*: Members Call. 10–11 AM

11: *PSCSD&IC* (Patient Safety Council of San Diego & Imperial Counties) : Lean Practitioner Course. San Diego.

20: *PSCSD&IC*: Standardizing Dosing Limits. San Diego.

25: *SCPSC* (Southern California Patient Safety Collaborative): Perinatal Monthly Webinar. 12:15 PM

26: *PSCSD&IC*: ICU Improvement Collaborative. San Diego.

November

2: *PSCSD&IC*: Preventing Rehospitalizations Network (PRN). San Diego.

8: *SCPSC*: Track I — Hospital Acquired Infections in the ICU Setting, Sepsis and Surgical Care Improvement Project. Industry Hills.

8: *PSCSD&IC*: Lean Practitioner Course. San Diego.

14: *CHPSO*: Members Call. 10–11 AM

15: *SCPSC*: Track III — Perinatal Care. Industry Hills.

15: *PSCSD&IC*: Ending Elective Deliveries Before 39 Weeks Gestation. San Diego.

29: *PSCSD&IC*: Lean Practitioner Course. San Diego.

December

2: *CAPSAC*: California Patient Safety Action Coalition meeting. Torrance.

12: *CHPSO*: Members Call. 10–11 AM

13: *SCPSC*: Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

13: *PSCSD&IC*: Lean Practitioner Course. San Diego.

13: *PSCSD&IC*: Sepsis/HAI Elimination. San Diego.

15: *PSCSD&IC*: Standardizing Dosing Limits. San Diego.