GAME OF ERRORS: CHANGING A CULTURE OF SAFETY BY BRINGING ERRORS TO THE FRONTLINE

EXECUTIVE SUMMARY

WHAT WE LEARNED: A mobile, incident specific and interactive Roving Patient of Errors (RPoE) is an effective and novel approach to improve frontline nursing awareness, understanding, and engagement in critical organizational patient safety findings.

OBJECTIVES
- Disseminate critical organizational patient safety lessons to frontline nursing
- Deliver an efficient and meaningful educational experience
- Foster positive practice change

RELEVANCE/SIGNIFICANCE
- Errors in practice repeated over time suggested the lessons learned from internal safety events may not be reaching all clinical nurses at the sharp edge.
- Clinical nurses have historically been challenged to plan time away from patient care.
- It was determined the information needed to go to where the nurses were to deliver indispensable information and safety awareness

METHODS
1) Nursing Quality and Patient Safety Core Council (NQPSCC) members:
   a. Reviewed recent internal patient safety reports
   b. Identified trending opportunities for improvement (i.e. mismatched labels on medications, non-matching identification bands, and improperly applied central line dressings)
   c. Outfitted manikins with functioning medical equipment
2) Two RPoE teams deployed to 25 units, called a huddle, and simulated handoff report.
3) Over the next three minutes, staff examined the manikin to identify errors
4) A debriefing followed, and all errors on the manikin were identified. Additionally, presenters explained how errors originated from recently reported internal incidents. Total time per unit averaged 10-15 minutes.

RESULTS
- Four presenters reached 256 staff over a four hour time period.
- Qualitative feedback revealed the format was not only acceptable, but appreciated, novel, engaging, insightful, directly applicable, and relevant.
- 100% of participants agreed or strongly agreed that they would participate in this activity again.
- 100% of participants agreed or strongly agreed that this activity increased transparency and awareness of patient safety issues.
- 82% of participants rated this activity overall as “Excellent”, 18% rated this activity as “Good”

CONCLUSIONS
- Utilizing recent patient safety incident reports in this mobile education promoted organizational transparency and practice awareness through a more informed staff.
- This program is generalizable, and can be replicated and customized for any clinical environment to enhance quality patient care.

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Game of Errors: Changing a Culture of Safety
...by Bringing Errors to the Frontline

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Presentation Outline

- Introduction to Hospital of the University of Pennsylvania
- Objectives
- Relevance and Significance
- Strategies and Implementation
- Interactive Activity
- Evaluation
- Implications for Practice
Hospital of the University of Pennsylvania
Objectives

- Disseminate critical organizational patient safety lessons to frontline nursing and foster positive practice change
- Deliver an efficient and meaningful educational experience
Relevance and Significance
Strategy: The Scenario

It is 7:35 pm and the day shift nurse Greg F. provides you the following patient report for your night shift...

This is John Doe, a 62 y/o G dx w/ heart failure, EF 15%. He is on a Milrinone drip at 0.25 mcg/kg/min, & Heparin drip at 2100 units/hr

PMH: A-fib, HF, DVTs Bilateral LE, failure to thrive, NKA

Today’s Events: c/o of ↑SOB, with ↓O₂ sats in the 80s.

Neuro: AAOx 2-3, PERRLA, MAE, ambulates with 2 person assist, denies pain

CV: HR 88/controlled A-fib; BP 90/58 (MAPS 55); +2 bilateral LE edema; +2 pedal & radial pulses

Access: Right SC TLC (dressing 11/18, caps & tubing 11/17)

Resp: 4L nasal cannula, O₂ sats 95%; breath sounds clear throughout; no cough; resp-18; denies SOB at this time

GI: Hypoactive bowel sounds; BM pre-admit; DHT w/ TEN infusing @ 55 ml/hr

GU: Voids w/o difficulty; clear yellow

Skin: Intact

Labs: PTT is therapeutic; no Δ to drip rate today

Greg F. asks, “Do you want to go see Mr. Doe?”
You reply, “No that’s okay, I will go see him shortly.”

A few minutes later Mr. Doe’s pumps begin to alarm, and you enter his room to find...
Implementation: The Game of Errors
What’s Wrong with this Picture?
What’s Wrong with this Picture?

Ordered for 2100 units/hr
What’s Wrong with this Picture?

Patient’s name is John Doe
Evaluation

- Four presenters reached 256 staff
- The staff were extremely engaged and very willing to participate in the event.
- They were grateful and appreciative that they did not have to leave patient care.
- The activity made staff aware that these errors were possible and fundamentally changed their perspective on their own practice.
I would participate again in this activity

Strongly Agree 86%

Agree 14%

n=188
Average 4.86
I will change my practice by…

- Double checking med labels with stickers on bag
- Insulin Pen Exp. Dates Double checking insulin pen labels
- That there needs to be constant vigilance to patient safety
- Check Lab labels Check Patient Identification
- Remember alcohol IV port caps Not wearing alcohol IV port caps on ID
- Double check med calculations & dosage with order

Patient Safety Starts with me!
Implications for Practice
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Questions?

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