Department of Nursing
Penn Medicine

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

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

This is John Doe, a 62y/o ♂ dx w/ heart failure, EF 15%. He is on a Milrinone drip at 0.25mcg/kg/min, & Heparin drip at 2100units/hr	
PMH:	A-fib, HF, DVTs Bilateral LE, failure to thrive, NKA
Today's Events:	c/o of ↑SOB, with ↓O_2 sats in the 80s. He is now on 4L nasal cannula and stable.
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 @ 55ml/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…

Name: Doe, John
MR#: 3469222
DOB: 06/15/1948

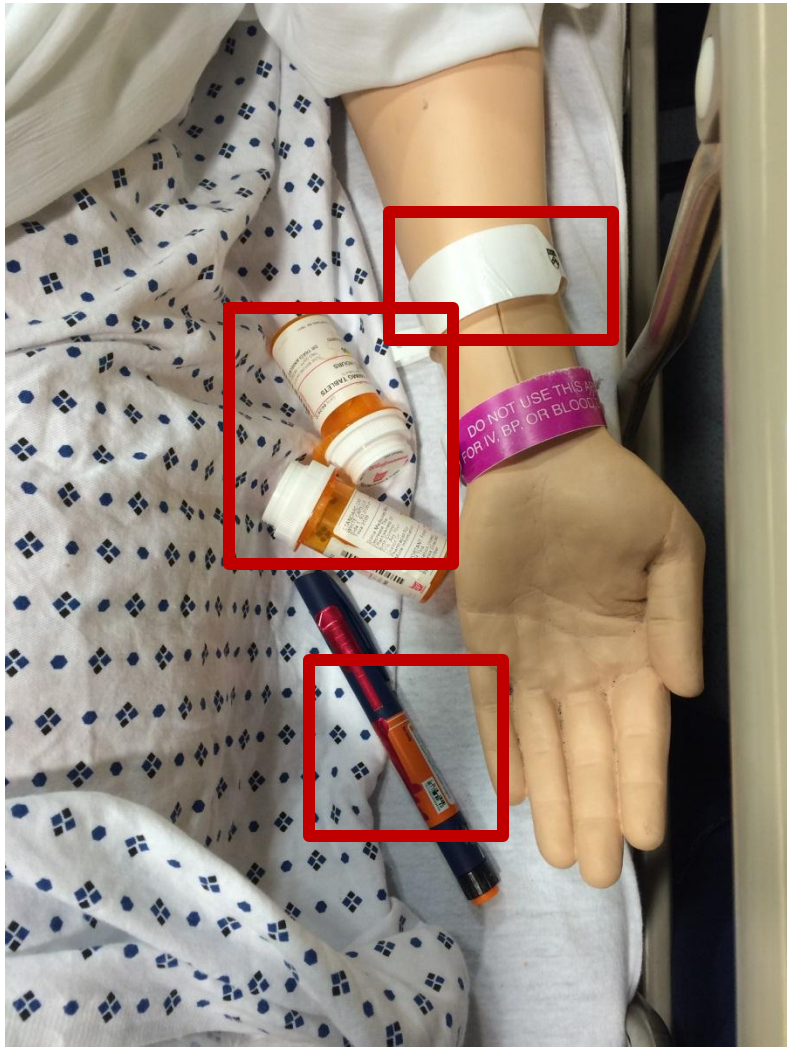
Height: 5'11"
Weight: 113.6kg
Allergies: Morphine

Ordered	IV Therapy	Order Start-Stop	Status
Today	**Heparin 25000units/250mL** High Alert Medication IntraVENOUS Infusion Ordered Dose Rate: 2100units/hr Concentration = 1000 units/mL	Today	ACTIVE
Today	**Heparin Injection** 5000 unit(s) subcutaneous every 8 hours	Today	ACTIVE
Today	**Milrinone Infusion 40mg/D5W 200mL** IntraVENOUS Infusion Ordered Dose Rate: 0.25 MICROgram/kg/min Concentration = 0.2mg/mL Must USE Guardrails	Today	ACTIVE
Today	**vaNCoMYCin IVPB** 1 Gram(s) in sodium chloride 0.9% 250mL IntraVENOUS Infusion	Today	ACTIVE

Ordered	Diet	Order Start-Stop	Status
Today	**Peptamen 1.5 (Continuous)** Route: orogastric tube Starting rate: 55mL/hr Goal rate: 55mL/hr, infuse over 24 hours	Today	ACTIVE

Implementation: The Game of Errors

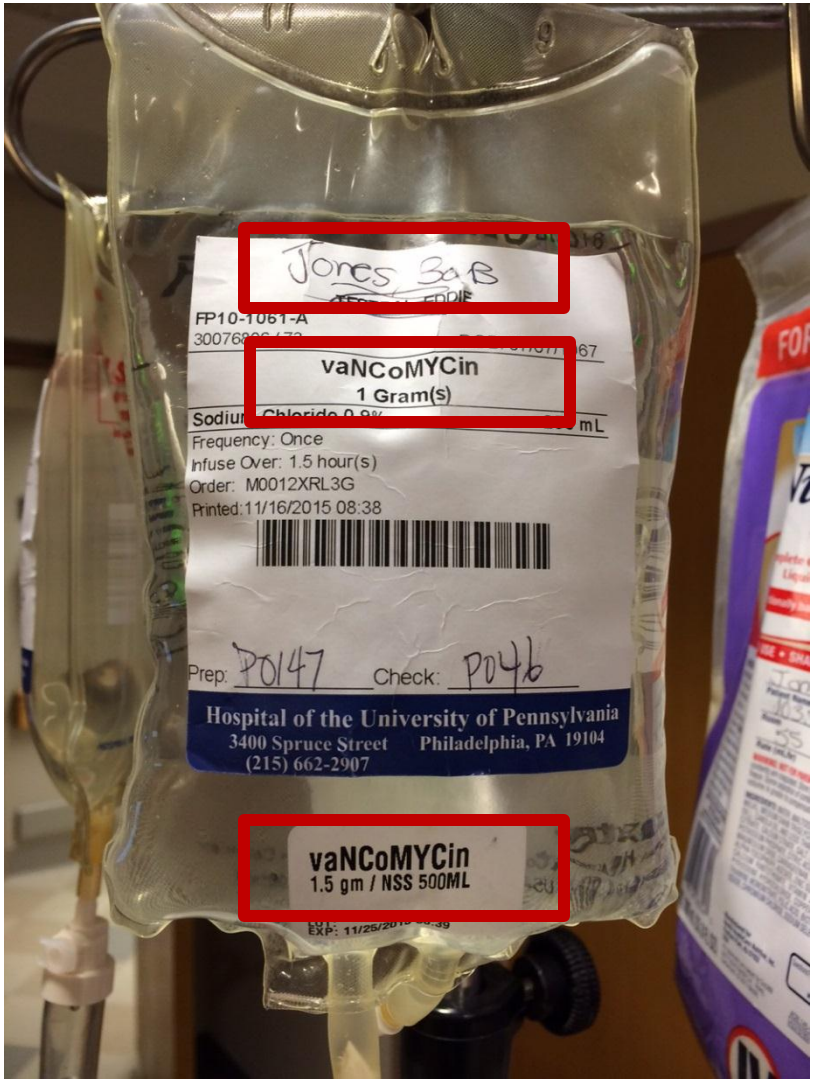
What's Wrong with this Picture?



What's Wrong with this Picture?

Ordered for 2100 units/hr

What's Wrong with this Picture?



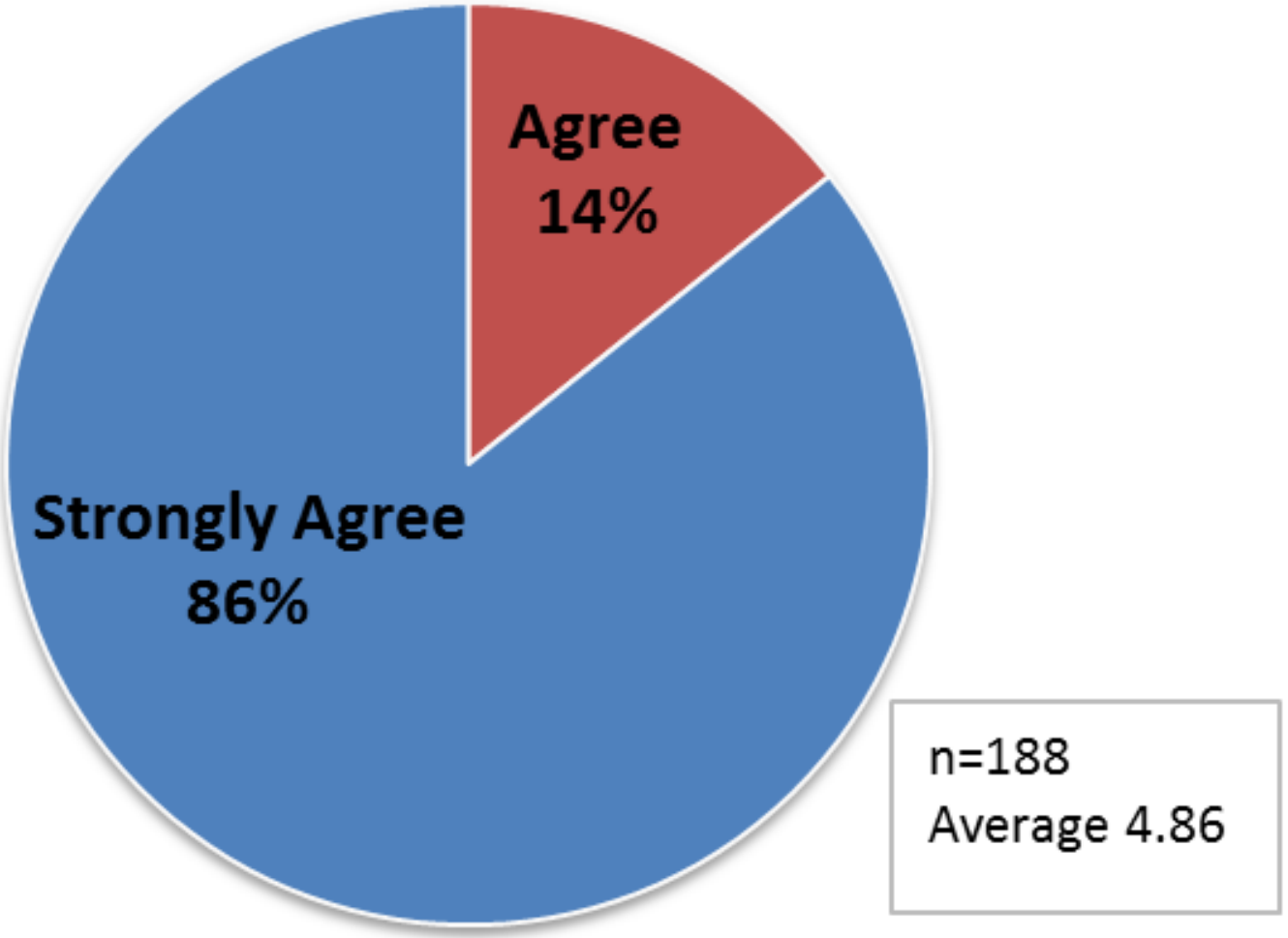
Patient's name is John Doe

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.

Evaluation Survey

I would participate again in this activity



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

Implications for Practice

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Thank you!

Questions?

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