

2021

Facilitator Guide: Do No Harm: An Interprofessional Patient Safety Event



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Do No Harm: An Interprofessional Patient Safety Event

Information for Small Group Facilitators and Faculty Monitors

Event Schedule and Logistics

Texas Tech University Health Sciences Center's IPE virtual event Do No Harm: An Interprofessional Patient Safety Event on *September 17, 2021; 1:30 – 4:00 PM*

Airmeet Event Link: https://www.airmeet.com/e/62c06c40-05b5-11ec-9536-3558b07499cb

Thank you for being a student, resident, and/or faculty facilitator for Do No Harm: An Interprofessional Patient Safety Event. High-quality interprofessional education (IPE) for our TTUHSC student population would not be possible without the commitment and dedication of our exemplary student leaders, residents, and faculty. Preventable medical errors are the third leading cause of death in the U.S., claiming the lives of over 400,000 patients each year. These numbers underscore the need for patient safety training and education for healthcare professionals. Interprofessional education and practice are critical to patient safety and improved patient care. The purpose of this interprofessional patient safety event is to highlight the role of team-based care in order to identify and resolve potential medical errors as a team.

Schedule for Do No Harm

- 1:30 1:40 Welcome and Introduction
- 1:40 2:30 Interprofessional Team Breakout Activity 1: Ice Breaker and Rooms of Hazards
- 2:30 2:35 Break
- 2:35 3:15 Keynote: Amy Loveless, CPPS Regional Patient Safety Officer, Covenant Health
- 3:15 4:00 Interprofessional Team Breakout Activity 2: Case Study Ellie and Error Disclosure Role-Play

Student Peer Facilitator Role Responsibilities

- Student Peer Facilitators will lead a small interprofessional group of ~7-8 students.
- Student Peer Facilitators will be responsible for taking and submitting a role sheet, leading the introductions for the group, and assigning roles to team members during the case study activity (scribe, timekeeper, debrief leader, observer, etc.) and share files and videos within the team.
- As a student peer facilitator, your role is to encourage and facilitate an open discussion focusing on potential medical errors and hazards, discussing root causes in cases of medical error, and practicing disclosure of medical errors as a team.

Faculty Monitor Role Responsibilities

- Faculty Monitors will be assigned to monitor two different small interprofessional groups.
- Faculty Monitors will be responsible for assisting student peer facilitators as needed.
- As a faculty monitor, you are encouraged to share your thoughts around error prevention and management and represent your profession.

Preparation Before Do No Harm

- Review this facilitator guide and the content materials found in the Student Prework (below):
 - Watch the Josie King medical error video at: <u>http://bit.ly/josiestory</u>.
 - Read the article from John Hopkins Medicine, which was in response to the Josie King story.
- Attend or review the Do No Harm facilitator training event.
- Be familiar with your team assignments and team members.
- Email additional questions to <u>ipe@ttushc.edu</u>.
- If you cannot attend the event (emergency), contact the TTUHSC Office of Interprofessional Education (ipe@ttuhsc.edu or 806.743.2028) as soon as possible.

Virtual Logistics During Do No Harm

Do No Harm will occur virtually on the Airmeet conferencing application. Before the event day, you will need to log in to Airmeet, the virtual event platform, to create your user account. This will allow you to leave the event and come back, or allow you to re-enter if you have any technical difficulties.

To access Airmeet, participants will log in through their TTUHSC email, Google, Apple, Facebook, Twitter, or LinkedIn accounts. The link to access Airmeet is below and will be included in an email sent to all groups before the event. <u>https://www.airmeet.com/e/62c06c40-05b5-11ec-9536-3558b07499cb</u>

An Airmeet Users Guide is available to view through this link: <u>https://www.ttuhsc.edu/interprofessional-education/documents/Airmeet_User_Guide.pdf</u>



Once you have logged in and created your user account, you will be prompted to fill out your user profile (university, school, classification, campus location). This information will be your online "business card" allowing others to see what school and campus you are from as you interact throughout the event.

After you have created your account you can preview the event, see the speaker line-up, schedule, and take a look around the lounge where the small team breakout activities will occur. *The LIVE HELP DESK is located at the first table in the Team Lounge* and assistance will be available throughout the live event.



Day of Event Logistics for Student Peer Facilitators

- Log into Airmeet by 1:15 pm (at least 15 min early) to find your team table and explore platform resources/options.
- Following the *Welcome and Introduction*, students will meet at their assigned breakout tables in the Airmeet Team Lounge.
- All students should keep both audio and video on throughout the team activity and actively participate in the discussion to receive an IPE certificate. Encourage students to embrace opportunities to work with other professions, as well as develop patient safety and collaboration skills.
- Technical and content assistance will be available at all times by going to the *Live Help Desk* located at the first table in the Airmeet Team Lounge.
- Have this information guide available during the event so that you have links, case information, and debrief questions.
- You will lead two breakout activities with your team. Interprofessional Team Breakout Activity 1 is at ~1:40 pm CST and Interprofessional Team Breakout Activity 2 is at ~3:15 pm CST. *Please take roll for your team during both breakout activities.*
- Before leaving the *Interprofessional Team Breakout Activity 2* at the end of the event, have students complete the Post-Test survey in Qualtrics. https://tthsclubbock.co1.gualtrics.com/jfe/form/SV_eXgXMVxKEvRmDvU
- Email roll sheets to <u>ipe@ttuhsc.edu</u> for student IPE credit. If students do not actively participate (i.e., keep their cameras off, do not contribute to the conversation, etc.) note it on the roll sheet.

Do No Harm Event Overview & Information

Student Learning Objectives

Student learning objectives for this event include:

- Participate as a member of a team to identify safety hazards in health care and provide patient-centered solutions to reduce medical errors.
- Discuss a medical error in a blame-free way as an interprofessional team.

• Plan for and disclose a medical error as an interprofessional team with honesty, compassion, and respect for team members. Articulate each team member's role in this patient's care and each team member's contribution to a medical error.

IPEC Core Competencies Targeted in this Event

- <u>Interprofessional Communication:</u> Communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease.
- <u>Roles and Responsibilities:</u> Use the knowledge of one's own role and those of other professions to appropriately assess and address the health care needs of patients and to promote and advance the health of populations.
- <u>Teams and Teamwork</u>: Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable.
- <u>Values/Ethics for Interprofessional Practice</u>: Work with individuals or other professions to maintain a climate of mutual respect and shared values.

Student Prework for Do No Harm

- Watch the Josie King medical error video at: <u>http://bit.ly/josiestory.</u>
- Read the following article from John Hopkins Medicine, which was in response to the Josie King story.
- Reflect on the Josie King story by thinking through the provided reflection questions.

Article from John Hopkins Medicine: No Room for Error

By Karen Nitkin and Lisa Broadhead; additional reporting by Linell Smith and Patrick Smith on 01/08/2016 retrieved from https://www.hopkinsmedicine.org/news/articles/no-room-for-error

On March 4, 2001, George Dover stood outside a Baltimore county home, rang the doorbell, and changed the future of Johns Hopkins Medicine.

The director of the Johns Hopkins Children's Center had come to the home of Tony and Sorrel King to apologize to the grieving parents.

Six weeks earlier, the Kings' 18-month-old daughter Josie had wandered into an upstairs bathroom, turned on the hot water, and climbed into the tub. By the time her screams brought her mother, Josie had second-degree burns on more than half of her body. The toddler was rushed by ambulance to The Johns Hopkins Hospital, where she received skin grafts and healed. Within weeks, she was acting like her old self. Then her condition deteriorated. Josie grew pale and unresponsive. She died on Feb. 22 of what was ultimately identified as septic shock, just days before she was scheduled to return home.

The day Josie died, her Johns Hopkins-affiliated pediatrician, Lauren Bogue, walked into Dover's office. She encouraged him to visit the King family and accept the responsibility on behalf of Johns Hopkins. The unusual proposal quickly won full support from Johns Hopkins leadership—even its lawyers. Bogue arranged the meeting and accompanied Dover.

"I remember it was pouring rain and cold," says Bogue. "Baltimore at its worst." The pain inside the house was palpable, she recalls.

"The first thing I said to the Kings was that I was terribly sorry," says Dover. "In those days, that was not fashionable. We told Tony and Sorrel we would find out exactly what had happened, we would communicate what we found and we would do our best to make sure it never happened again."

Dover kept his word, telephoning Sorrel every Friday morning, even when there was little to report.

On June 2, a second tragedy occurred. Ellen Roche, a healthy 24-year-old, died of lung failure less than a month after inhaling an irritant medication while participating in an asthma research study.

Ten days after Roche's death, the U.S. Office for Human Research Protections suspended all federally funded human subject research at Johns Hopkins, halting nearly 2,500 investigations for several months. The two deaths shattered Johns Hopkins, propelling what some consider the most significant culture change in its history. "These events created a moral moment where we had to make a choice," says Peter Pronovost, director of the Armstrong Institute for Patient Safety and Quality. "It was: Are we going to openly address our shortcomings? Or are we going to hide behind our brand and say all is well? Leadership stood up and said, 'We need to start talking about this.'"

In the 15 years since that fateful crossroads, as the health care system expands, Johns Hopkins Medicine has pioneered a culture of accountability and patient safety advances. By 2015, all six Johns Hopkins hospitals were recognized by the Joint Commission in its Top Performer on Key Quality Measures program. Johns Hopkins programs and safety metrics were adopted around the world.

But before that could happen, safety had to become the top priority.

Research oversight became more stringent; two Institutional Review Boards became seven.

"We have a whole process to identify a high-risk protocol like the one Ellen Roche was in," says Dan Ford, vice dean for clinical investigation—a position created after Roche's death. "We conduct research in the safest possible setting. Each research team has to know how it would handle an emergency."

On the clinical side, opportunities for error continue to be systemically eradicated by changing procedures, equipment, even the culture within units. The Armstrong Institute, founded in 2011, leads this effort while training a new generation of patient safety innovators. Clinicians receive emotional support after adverse patient events. Family members are encouraged to assist with care and speak up if something doesn't look right.

Josie King Story

The Johns Hopkins Hospital admitted Josie King on Jan. 30, 2001, her 18-month-old body covered in second-degree burns from a bathtub accident.

The first few days were rough, but over time the little girl healed. Then, just days before her scheduled release, Josie's heart stopped. She died on Feb. 22.

An initial in-depth review, called a root cause analysis, pinpointed dehydration and an unnecessary dose of methadone as the culprits. A second analysis, released in 2010, revised that conclusion, adding septic shock from a hospital-acquired infection and saying that the narcotic was not to blame. The larger picture: Systems had failed. Communications had broken down, and a parent's repeated pleas that her daughter was thirsty were not heeded.

Josie's parents, Tony and Sorrel King, channeled their grief into action, creating the Josie King Foundation to fight against medical errors.

Sorrel gave time and money to Johns Hopkins, working closely with Peter Pronovost to bring patient safety programs to the institution that had caused her so much pain. Her 2009 book, Josie's Story, is both memoir and call to action. She created the Josie King Hero Award for caregivers who create a culture of safety and gave the first one to Pronovost.

Fifteen years after her daughter's death, Sorrel King offers this advice to everyone involved in patient care: "Slow down and take your eyes off the computer. Look at the patient in the bed and listen. Listen to that mother who is saying something is wrong."

Self-Guided Reflection Questions

- What safety factors contributed or may have contributed to Josie King's death?
- With those contributing factors in mind, how could Josie's death have been prevented, and what process changes would you recommend to prevent a similar error from occurring in the future?
- How do healthcare teams empower patients and families to participate in health care decisions?
- Put yourself in the shoes of one of the healthcare professionals who cared for Josie. How would you have reacted when Sorrel said, "You did this to her and now you must fix her"?
- How did the reaction of the team at John Hopkins Medicine impact your view on error disclosure and the roles of the team on error disclosure?

Interprofessional Team Breakout Activity 1: Ice Breaker and Rooms of Hazards

During this breakout room activity, your team will introduce themselves and then complete a short ice breaker activity. Next your team will watch a series of videos, first as an individual and then as a member of the team. The videos are simulated rooms of patient safety hazards. The rooms were filmed as 360-degree video, so they will be able to look in all directions to find patient safety hazards.

Ice Breaker Activity

You will have 10 minutes for this ice breaker activity.

- Have each member of the team quickly look around them and pick one item that represents them and one item that represents, or reminds them of, patient safety.
- Have each member of the team share:
 - o Name
 - School and profession
 - o Item 1 and why it represents them
 - Item 2 and why it reminds them of patient safety

Rooms of Hazards Activity

You will have 30 minutes for the Room of Hazards activity. For your reference, there are two lists of hazards for the videos in Appendix A. Note, the lists are not exhaustive and may not represent safety hazards related to all professions.

- 5 minutes Have participants watch the first room of hazards video (*Patient Safety Begins with Teamwork Acute Care: A Room of Hazards*: <u>https://youtu.be/HgaYPBb51PU</u>) by themselves without sharing their screen and quickly note as many patient safety hazards as possible in 5 min.
 - Put the link to the video <u>https://youtu.be/HgaYPBb51PU</u> in the *Table Chat* function within the team breakout room (see picture below)



- Ask team members to mute their video and then click on the video link. They can now watch the video in a new browser tab. Ask them to *not* close the Airmeet browser tab while watching the video. The video is a 360-degree video and team members can look for hazards around the room by moving the mouse within the video window.
- Have members of the team report the total number of errors they found in the video.
- Quickly strategize on how the team wants to watch the video together. Have the team agree on a viewing strategy, as well as a scribe to take notes of hazards.
- 10 minutes Have the team watch the video together, using the predetermined strategy. Have the team scribe list the errors noted while the team watches the video together. You, or one assigned person, will share your screen on Airmeet at your team's table. To share your screen, select the arrow icon. Click on the "Chrome Tab" option, select the YouTube page with the video. Select "Share tab audio." Then click "Share." See pictures below. The person sharing their screen will manipulate the video on YouTube rather than on the screen share window in Airmeet.





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- 5 minutes Have participants watch the second video by themselves, just like they did for the first video, and note patient safety hazards. (*Patient Safety Begins with Teamwork Acute Care Rehabilitation: A Simulated Room of Hazards*: <u>https://www.youtube.com/watch?v=3d0476IGkEA</u>).
- 10 minutes Have team members report how many errors they noted. Share your screen again and have the team watch the video together using the pre-determined strategy.
- 10 minutes Lead the team through the discussion questions below.

Discussion Questions for Room of Hazards

- Were there differences in the number of errors identified by individuals, as compared to the team? Why or why not?
- Were there errors that you noticed related to your health care profession that others didn't notice? Why does patient safety begin with teamwork and communication?
- What can we do better as a health care team to keep patient safety at the forefront of team-based care?
- What is one take-home message in regards to patient safety and team-based care that you will take away from this activity?

Interprofessional Team Breakout Activity 2: Case Study - Ellie and Error Disclosure Role-Play

You will have 20 minutes to discuss the case study of Ellie. Have your team take a minute to read through the provided case study to determine the root cause of the medical error. Then, lead your team through the discussion questions listed below.

Case Study - Ellie

Ellie is a 73-year-old resident who returned to a skilled nursing facility from the local county hospital following a left hip replacement. Ellie sustained a left hip fracture resulting from a fall sustained while getting out of bed unassisted. She was found on the ground by her daughters, Camilla and Shirley, who came to visit shortly after the fall. Ten days before the fall, Ellie had been admitted to the skilled nursing facility for rehabilitation related to poor mobility and reduced participation in ADLs resulting from chronic, severe low back pain and peripheral neuropathy. She has a history of systolic heart failure with frequent exacerbations; atrial fibrillation; asthma; sleep apnea; chronic and severe low back pain; and hypertension. Her past surgical history included a hysterectomy and multiple caudal epidural injections for low back pain. She was on a blood thinner in the form of Xarelto (Rivaroxaban). Her other medications included Lasix (Furosemide), Butrans (Buprenorphine) Transdermal Patch, Ventolin (Albuterol) Inhaler, Prinivil (Lisinopril), and Toprol XL (Metoprolol Succinate).

While in the hospital, Ellie underwent an open reduction internal fixation (ORIF) of the left hip. Her vital signs at the time of discharge back to the skilled nursing facility were as follows.

Height—5ft, 2 in; Weight—197 lb; Temperature—99.0°F; Pulse—88; Respirations—20; Blood pressure—115/76; Pain—5 (scale 1–10); O2 saturation—94% on room air; INR – 2.9.

Ellie's transfer orders from the hospital included an order for Lasix on a new therapeutic schedule, resumption of all remaining medications, as well as a new pain medication, Tramadol (Ultram), as needed for hip pain. Lasix was part of Ellie's original medication list prior to being transferred to the hospital; however, the new order indicated an updated therapeutic schedule and sliding scale. All medication orders from the hospital were entered into Ellie's electronic medical record, but the old medication orders were not removed as she was readmitted into the same rehabilitation stay per Medicare requirements. The following then occurred:

Dr. Finn, the medical director for the facility, reviewed all the re-admission documents and approved the medication list.

Dr. Dore, the pharmacist for the facility, reviewed the medication list but did not reconcile the list to remove the old Lasix order.

JoAnna, Ellie's nurse, checked the new orders. She mistakenly interpreted the new Lasix order as an unintentional duplication and discontinued the new schedule for Lasix.

JoAnna was then interrupted to take a phone call and did not complete the process of checking all the medication orders. JoAnna asked Sam, another nurse on the unit to complete the remaining review of Ellie's medications. Sam double-checked the medication orders and noted the old order for Lasix was still active. He discontinued the old order for Lasix and let JoAnna know he had completed the task

Mary-Catherine, the medication nurse at the skilled nursing facility, noted that both orders for Lasix were discontinued. Mary-Catherine removed the Lasix from the medication cart to be sent back to the pharmacy.

Ellie was weighed two days later with a noted 3 lb. weight increase from admission. The weight was recorded in her chart with an indication that a call would be placed to Ellie's physician. No new orders were recorded following that entry. A standing INR order for every 14 days was placed on admission.

Greg, the physical therapist, noted that the dressing on Elle's hip was becoming more frequently soiled and there was increased drainage. He noted this in his daily therapy note and asked JoAnna to keep an eye on Ellie's hip. Greg also noted increased pedal edema when walking with Ellie during therapy, which he also noted in his daily note.

Maurine, the occupational therapist, noticed that Ellie was bruising more easily than normal and also noticed that Ellie's hip was more bruised than expected. She noted the increased bruising in her daily therapy note.

On day six, Ellie was noted to be having extreme difficulty breathing. She had +4 pitting pedal edema bilaterally. Her vital signs were as follows.

Height—5ft, 2 in; Weight—211 lb; Temperature—101.8°F; Pulse—122 with arrhythmia; Respirations—32; Blood pressure—140/90; Pain—8 (scale 1–10); O2 saturation—88% on 4L via mask; INR 4.4.

Her lungs were assessed and were moist with crackles throughout. Dr. Finn was called, who ordered Ellie to be transferred back to the hospital. While awaiting the ambulance, Ellie sustained a massive stroke and could not be resuscitated.

Discussion Questions for Case Study - Ellie

- Identify the contributing safety factors and root cause(s) for this event.
- What additional information would you want to know to better understand the root cause of this preventable medical error?
- How could Ellie's death have been prevented?
- How is this story similar to the story of what happened to Josie King from the pre-work?
- What patient safety initiatives would you recommend to prevent a similar medication error from occurring at this facility in the future?
- What teamwork, communication, leadership, situation monitoring, and/or mutual support strategies and tools should be implemented in this facility to increase patient safety?
- What does the team need to consider when disclosing this medication error to Ellie's family?
- What specific information will the team need to share with the family and why?
- What is one take-home message in regards to the prevention of medical errors and team-based care that you will take away from this activity?

Error Disclosure Role-Play - Ellie

You will have 20 minutes for this activity. Assign roles within your team and prepare to role-play the error disclosure to Ellie's two daughters Camilla and Shirley. Have the team review the key steps in error disclosure listed below. Together as a team, role-play the disclosure as a skit. Practice using the key steps in error disclosure during the role-play exercise.

Characters for Role-Play of Error Disclosure – Ellie

- Camilla (daughter)
- Shirley (daughter)
- Dr. Finn (physician)
- Dr. Dore (pharmacist)
- JoAnna (nurse)
- Greg (physical therapist)
- Maurine (occupational therapist)
- Sam (nurse), if a sufficient number of people are on your team
- Mary-Catherine (nurse), if a sufficient number of people are on your team

Key Steps in Error Disclosure

- 1. Team Discusses the Error
 - a. Acknowledges error
 - b. Conducts blame-free communication during team conversation
 - c. Demonstrates team-oriented communication
 - d. Negotiates differences of opinion collaboratively
 - e. Recognize the emotional impact of errors on team members
- 2. Team Plans the Disclosure
 - a. Advocates for full disclosure
 - b. Plans roles for disclosure

- c. Anticipate patient's questions and reactions
- d. Plans responses to patient/family
- 3. Team Discloses the Error
 - a. Conducts explicit disclosure of error to the patient (or family)
 - b. Responds forthrightly to questions about the event
 - c. Apologizes upfront and early in the conversation
 - d. Conducts blame-free disclosure, acknowledges personal role
 - e. Offers plans to prevent future errors
 - f. Plans follow up with patient (or family)

Discussion Questions for Role-Play - Ellie

You will have ~5 minutes to debrief the role play as a group using the following questions.

- What went well in regards to teamwork and interprofessional communication during this activity?
- What did you learn in this role-play of an error disclosure?
- How could the use of role-playing help prepare for these types of situations?
- What are some values and ethical issues around team-based disclosure of medical errors?
- What is one take-home message in regards to team-based disclosure of medical errors that you will take away from this activity?

Post-Event Survey

Before your team leaves, have each participant complete the post-event survey. Certificates for IPE credit will be emailed to participants following the completion of the survey. You can also add the link to chat within the breakout room.

https://tthsclubbock.co1.qualtrics.com/jfe/form/SV_eXqXMVxKEvRmDvU

Appendix A – Room of Hazards List

The following is a list of hazards for the two rooms of hazard. The lists are not exhaustive and may not represent safety hazards related to all professions

Patient Safety Begins with Teamwork – Acute Care

- Steps over something on floor when entering room
- Patient's name is not Mr. Jones according to board, Mr. Smith
- Only 2 bed rails are up
- Patient is lying flat on the bed but has a nasal cannula (should be above 35 degrees)
- Using nasal cannula with 6L of oxygen
- Oxygen is not flowing
- Pulse ox not on fingers
- Call button out of patient's reach
- Foley bag on the bed
- Over the counter pills or vitamins are in the room
- Home medication is shown in the room
- Patient information board says fall risk but no fall risk bracket or colored gown.
- Bed is very high for a patient with fall risk.
- Bed not locked
- Patient information board says thickened liquids, no straw, and puree diet, but a bottle of water with straw is on the bedside table along with regular food.
- Crackers on bed
- Soda spilled on the floor
- Towels, gloves, trash on the floor
- Medication administered is noted as an allergy on board.
- Glasses out of reach
- Suction tube is lying on the bed but not connect to the suction on the wall
- Cigarettes among personal items but the patient is on O2
- Gloves are on side of the trash can and spilling onto the floor

- Dressing on the patient is soiled and needs changing
- Syringe not in the sharps container
- Regular socks instead of no-skip socks
- Nurse stepping over things in the way at the door
- Nurse did not introduce herself by name
- Patient just looks uncomfortable
- Cash lying out
- No receptacle for linens
- No family contact info on board
- No physician or nursing info on board
- Palpates pulse through socks
- Socks falling off
- Nurse did not cover him back up after pulse
- Nurse uses jargon
- Nurse not wearing gloves and takes off mask
- No hand sanitizer
- Does not ask pain level
- Does not clean IV with alcohol or follow safety protocols for needles
- Does not put a used needle in the sharps container
- Does not check patient identifiers before giving medications
- No computer documentation of medications administered
- Doesn't flush IV line
- Nursing to get water but patient on thickened liquids
- Private information is given about other patients in the unit
- Leaves without cleaning up and making the area safe
- Medical supplies left in the room
- Puts materials from a pocket on patient

Patient Safety Begins with Teamwork - Acute Care Rehabilitation

- Never uses gait belt
- Flip flops
- Wheelchair brakes not locked
- Patient not in skid-proof socks/footwear
- Does not confirm O2 requirements with nursing
- O2 NC on over patient's mask
- Leaves foley catheter behind
- Never confirmed walker height for patient
- Does not educate on weight-bearing limitations before standing
- Poor patient guarding throughout
- Trash on floor
- PT inappropriately changes the weight-bearing status
- Leaves patient unattended in the hallway several times
- HIPAA violation with patient names on doors
- Cart drawers open with supplies all over the place, including the floor
- Obstacles on the floor
- Computer not plugged in
- No gloves or obvious hand hygiene before or during patient care (standard precautions)
- Fall risk bracelet on removable boot instead of wrist
- Gloves (used?) on the floor and hanging off carts/computer
- O2 tank secured to an IV pole with an ace wrap
- Trash hanging out of a can in the hallway
- PT answers the phone and discusses patient information, with name, in another patient's room
- Calls patient by incorrect name when enters room
- Dirty (?) mask hanging from IV pole in the hallway
- IV pole not secured and lowers when pt uses for stability
- Name badge/keys on the floor
- PT pulls out IV