

# 2021

## Participant Guide: Do No Harm: An Interprofessional Patient Safety Event



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### Do No Harm: An Interprofessional Patient Safety Event

#### **Information for Participants**

#### **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

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 and hazards, discuss root causes in cases of medical error, and practice disclosure of 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

#### **Preparation Before Do No Harm**

- Be sure you have completed your pre-work and are prepared for the event.
- Be familiar with your team assignment.
- Have this information guide available during the event, so that you have links and case information.
- Log into the Airmeet at least 15 minutes early.
- Embrace opportunities to work with other professions, develop patient safety and collaboration skills.
- At the conclusion of the event, complete the post-event survey. The survey generates your participant certificate.
- Contact us with questions at <u>ipe@ttuhsc.edu</u> or (806) 743-2028

#### 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 Participants**

- 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.

#### **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 <a href="https://www.hopkinsmedicine.org/news/articles/no-room-for-error">https://www.hopkinsmedicine.org/news/articles/no-room-for-error</a>

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, you will introduce yourself to your team and then complete a short ice breaker activity. Next you 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 you will be able to look in all directions to find patient safety hazards.

#### Links to Rooms of Hazards Videos

1. Patient Safety Begins with Teamwork – Acute Care: A Simulated Room of Hazards: https://youtu.be/HgaYPBb51PU 2. Patient Safety Begins with Teamwork – Acute Care Rehabilitation: A Simulated Room of Hazards: https://www.youtube.com/watch?v=3d0476IGkEA

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

As an interprofessional team, you will read through the provided case study to determine the root cause of the medical error. As a team, you will answer discussion questions and then prepare a role-play of the error disclosure with the patient's family.

#### **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.

#### Error Disclosure Role-Play - Ellie

After reading the case study of Ellie and completing the discussion questions, prepare a team role-play of the error disclosure with Ellie's two daughters Camilla and Shirley.

- 1. Review the key steps in error disclosure below.
- 2. Assign roles within your team and prepare disclosure information.
- 3. Role-play the disclosure as a team.
- 4. Debrief the role play as a group.

#### 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)

#### **Post-Event Survey**

Before you leave, complete the post-event survey. Certificates for IPE credit will be emailed to participants following the completion of the survey. The link to the survey will be provided by your team facilitator and will also be made as an announcement on Airmeet.