DO NO HARM

An Interprofessional Patient Safety Event

September 17, 2021 | 1:30 - 4:00 PM

SEPT 17, 2021
World Patient Safety Day

TTU HSC
INTERPROFESSIONAL EDUCATION

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INTERPROFESSIONAL EDUCATION

THANK YOU!

- Planning committee
- Keynote speaker
- Peer facilitators
- Faculty facilitators
- Staff
- Simulation center

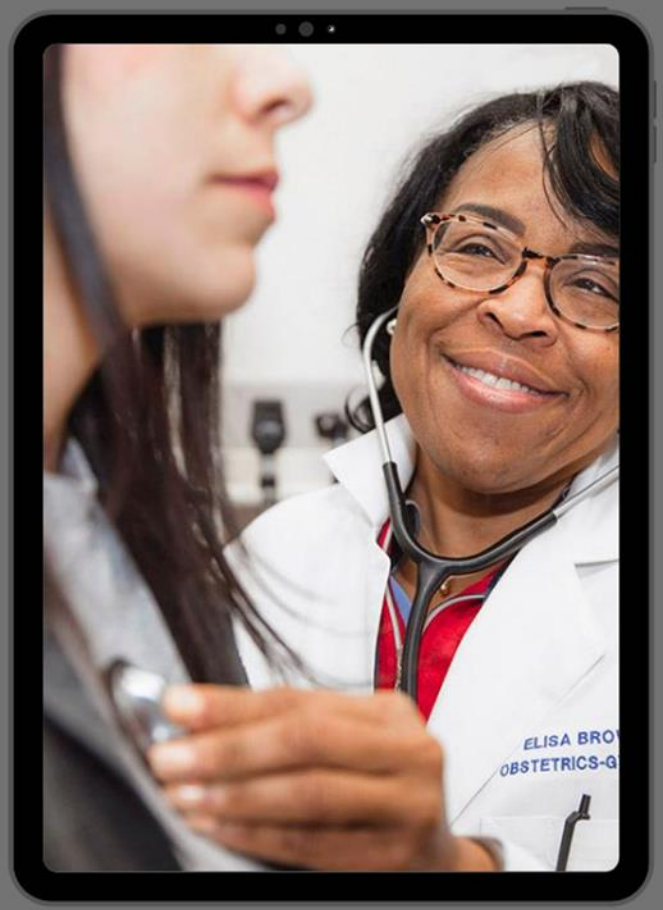
YOU!

BRIEF

- Welcome and Introduction
- Breakout Room 1: Ice Breaker & Room of Hazards
- Break
- Keynote with Q&A
- Breakout Room 2: Case Study Ellie and Error Disclosure Role-Play
- Post-event Survey

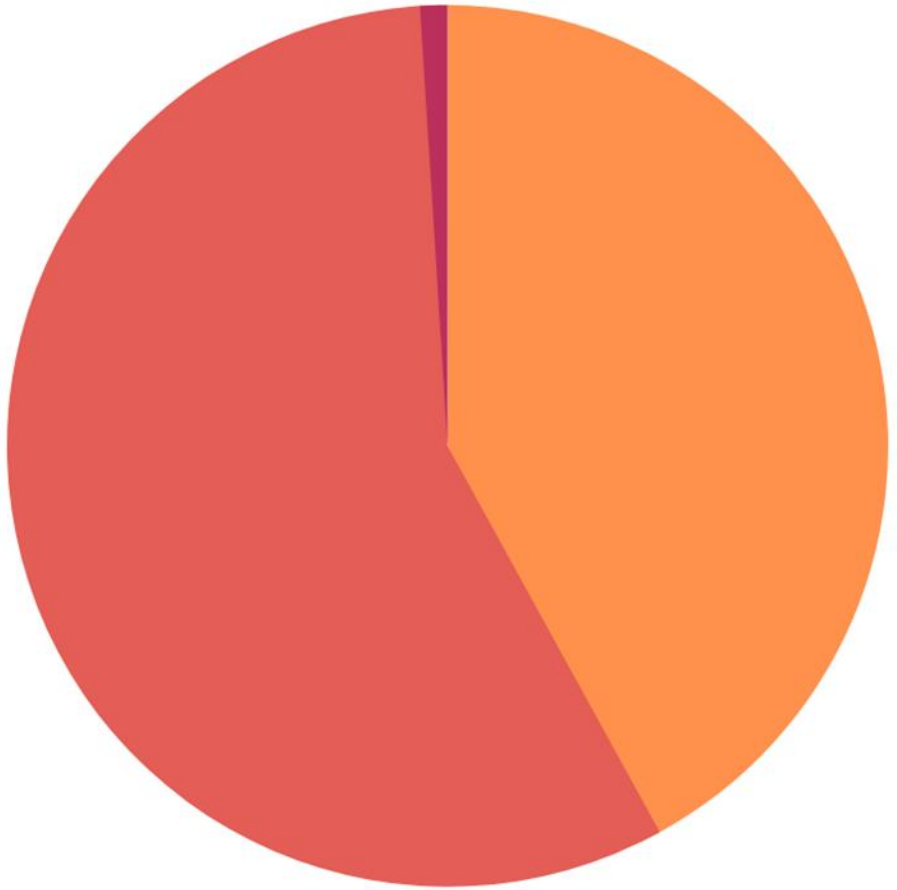
01

Poll

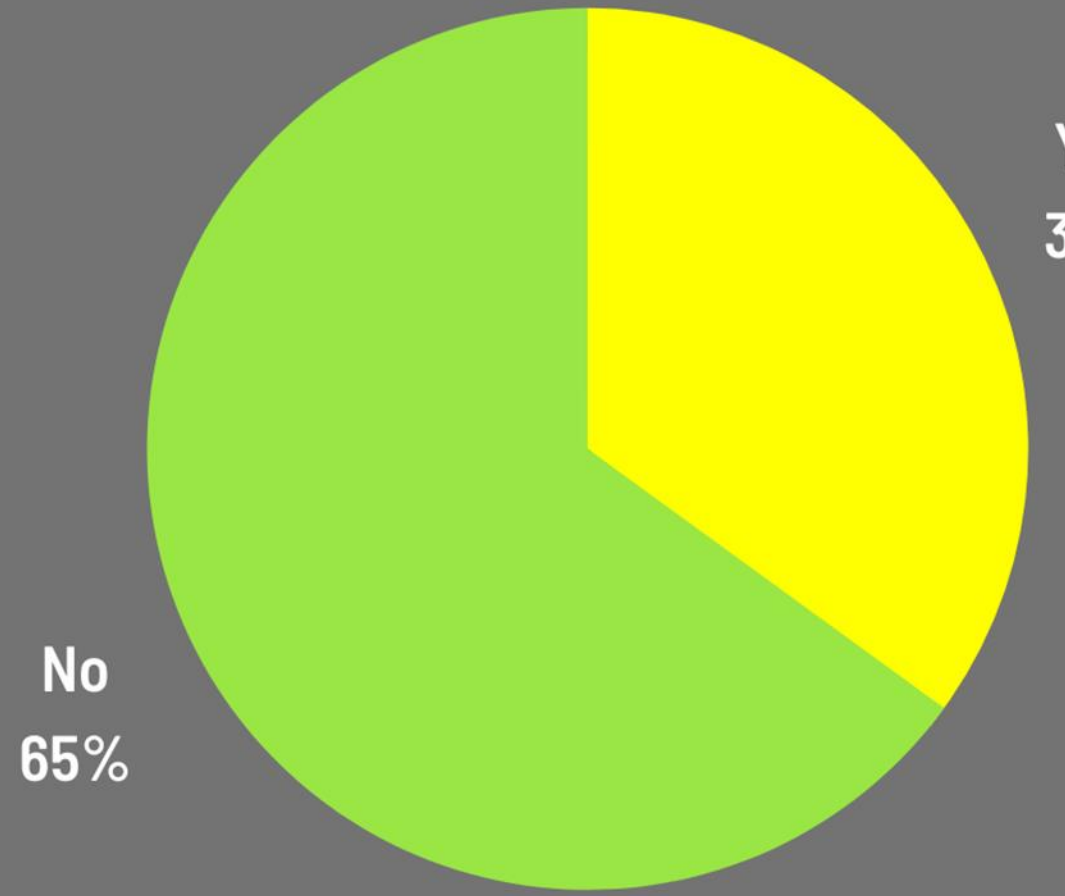


Have you been personally involved in a situation where a preventable medical error was made in your **own** medical care or that of a **family member**?

Public



Physicians



Blendon, R.J., Desroches, C.M., Brodie, M., Benson, J.M., Rosen, A.B., Schneider, E., Altman, D.E., Zapert, K., Herrmann, M.J., Steffenson, A.E., 2002. Views of Practicing Physicians and the Public on Medical Errors. New England Journal of Medicine.. doi:10.1056/nejmsa022151

5:46

AA google.com

NEW YORK POST

NEWS

Walgreens store mistakenly injects saline instead of COVID-19 vaccine

By Jackie Salo

April 19, 2021 | 11:58am

A "limited number" of people were given the saline solution at a Walgreens in Monroe, North Carolina.

Google Maps

6:33

5CHICAGO AA

LOCAL

Wrong Vaccine For Second Dose Given at Suburban Chicago Mariano's

by Lauren Petty

Published Apr 21, 2021 at 4:58 PM

A small number of people scheduled Tuesday to receive a second dose of the Moderna vaccine at Mariano's in Aurora were given the Pfizer vaccine instead.

Jeff Chaney and his son were among

10:42

AA google.com

abc4.com

ABC4 Utah

Davis Co. to issue 3rd shot of COVID-19 vaccine after mixing error

Emma Johnson 2 days ago

This picture taken on November 17, 2020 shows a syringe and a bottle reading "Vaccine Covid-19. (Photo by JOEL SAGET/AFP via Getty Images)

DAVIS COUNTY, Utah (ABC4) – Residents in Davis

10:44

AA beckershospitalreview.com

BECKER'S HOSPITAL REVIEW

Top 10 preventable medication errors from last year

Katie Adams - Wednesday, February 3rd, 2021 Print | Email

Share Tweet Share 15

Prescribing extended-release opioids to patients who are not educated about the addictive drugs' effects was the top preventable medication error in 2020, according to the Institute for Safe Medication Practices.

The Institute for Safe Medication Practices on Jan. 27 released its list of the top 10 medication errors from 2020, selecting errors and hazards that have not only been consistently reported, but also can be avoided or minimized through operational improvements.

The 10 preventable medication errors:

1. Prescribing, dispensing and administering extended-release opioids to patients who are opioid-naïve

6:10

FOX NEWS AA

Ohio hospital gives wrong patient a kidney, employees placed on leave

Brie Stimson | Fox News

Published on July 14, 2021

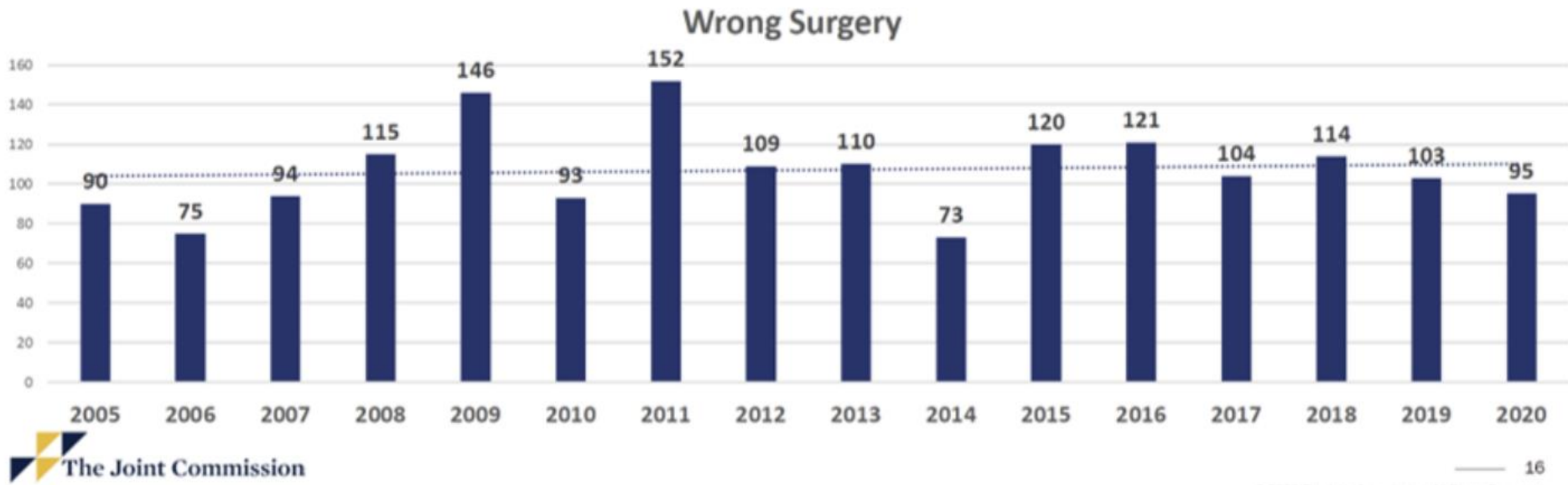
An **Ohio** hospital placed two employees on administrative leave this week after admitting the wrong **patient** received a kidney **transplant earlier this month.**

Wrong Surgery:

Wrong patient, Wrong site, Wrong procedure, Wrong implant

Wrong-patient, wrong-site, wrong procedure events are preventable events that can lead to catastrophic harm to patients. In late 2018 the categorization was expanded to include delineation for wrong-implant.

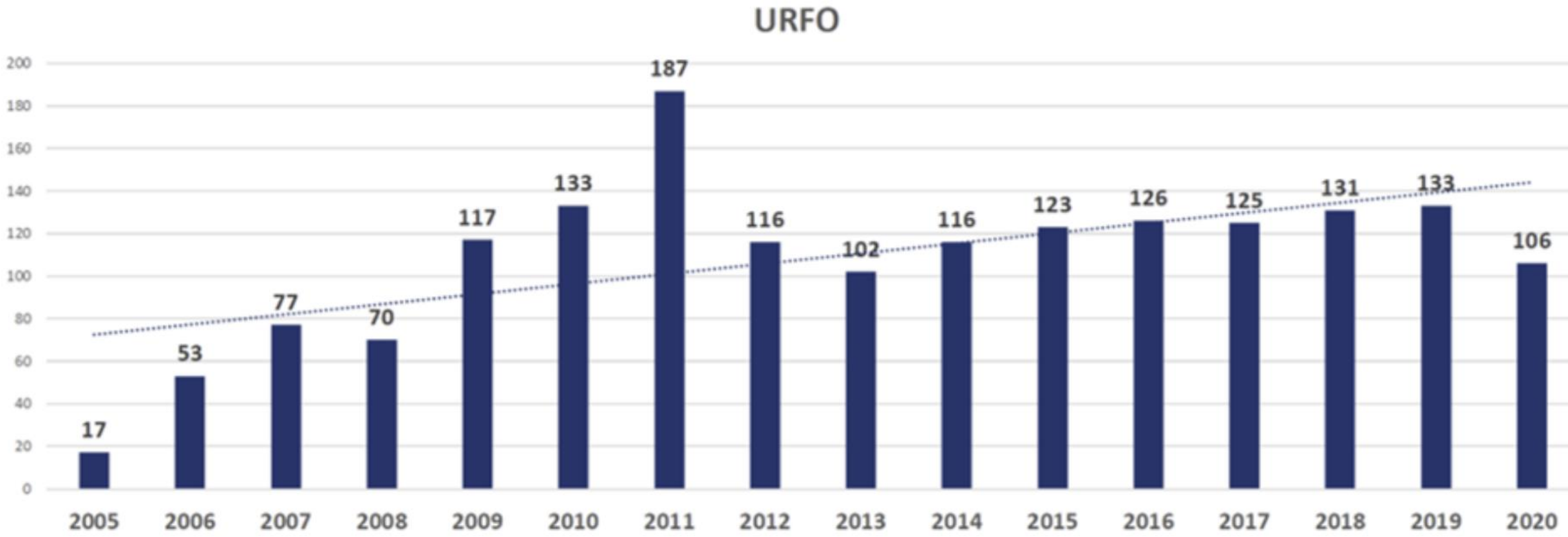
The Joint Commission's Universal Protocol, the Center for Transforming Healthcare's Targeted Solution Tool for Safe Surgery, and the World Health Organization Surgical Safety Checklist are well established procedures and processes that can help prevent these types of events from occurring.



The Joint Commission

Unintentionally Retained Foreign Object (URFO)

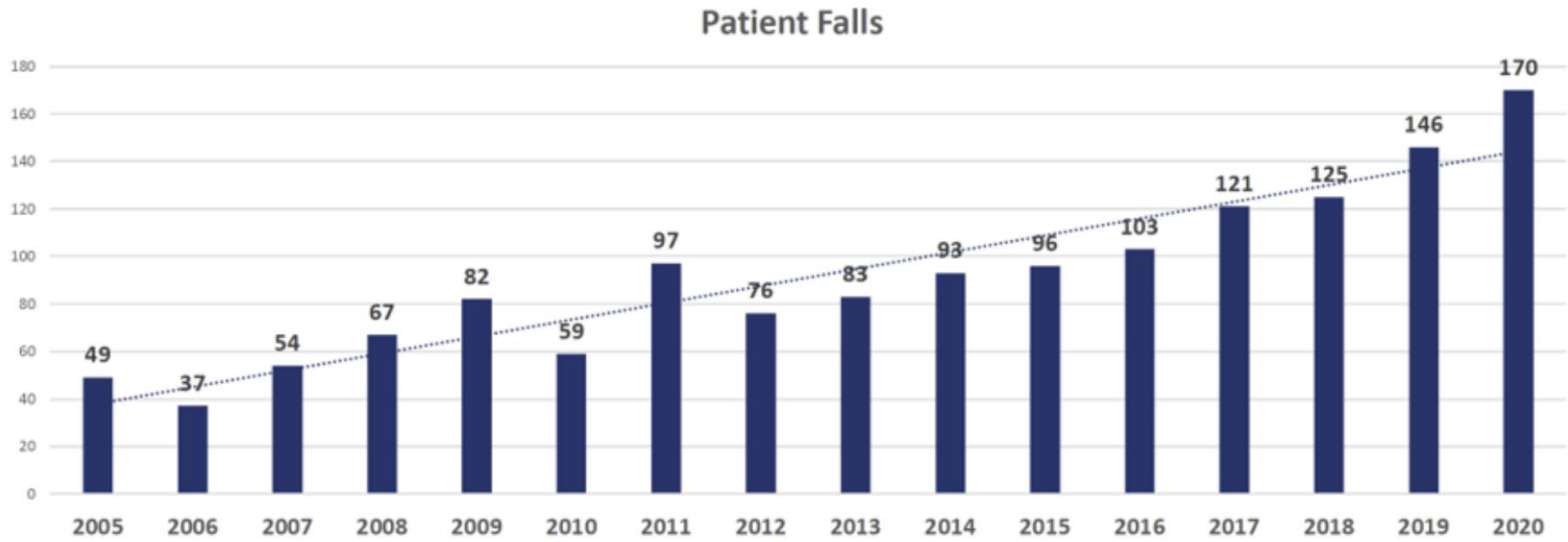
Unintentionally Retained Foreign Object (URFO) was the most frequently reported sentinel event to The Joint Commission in 2017 and 2018. URFOs dropped to second most frequent in 2019 and 2020



The Joint Commission

Patient Falls

Patient falls resulting in injury are consistently among the most frequently reviewed Sentinel Events by The Joint Commission. Patient falls remained the most frequently reported sentinel event for 2020.



The Joint Commission

WHY DOES PATIENT SAFETY BEGIN WITH TEAMWORK?

Josie King - Died February 22, 2001

Medical error is the 3rd leading cause of death in the US behind heart disease (1) and cancer (2).

Root Causes of Medical Error

Sentinel Events – Root Causes

SE - Top 10 contributing factors	2016	2017	2018	Total
Human Factors	950	885	650	2485
Leadership	806	741	580	2127
Communication	645	658	575	1878
Assessment	431	379	240	1050
Physical Environment	144	176	127	447
Health information technology-related	56	72	60	188
Information Management	58	52	44	154
No Root Cause Identified	37	48	42	127
Medication Use	54	44	28	126
Care Planning	46	24	35	105
Total	**3227**	**3079**	**2381**	**8687**

HOSPITALS

When hospital inspectors are in town, fewer patients die, study says

By CASEY ROSS @caseymross / MARCH 20, 2017

Barnett ML, Olenski AR, Jena AB. Patient Mortality During Unannounced Accreditation Surveys at US Hospitals. JAMA Intern Med. 2017;177(5):693–700. doi:10.1001/jamainternmed.2016.9685

PATIENT SAFETY STUDY

Study finds significantly fewer patient deaths during inspection week than the weeks before and after the inspectors' visit. Researchers at Harvard University found the disparity was particularly pronounced at major teaching hospitals, where the heightened response, if applied for an entire year, would translate to **3,600 fewer deaths**.

Breakout Room 1

Ice Breaker & Room of Hazards

Main Lounge | Event Schedule | Team Lounge | Booths | Moderation | Feed | People | Messages | Alerts | Settings

TTUHSC
INTERPROFESSIONAL EDUCATION

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TEAM LIST

STUDENT GUIDE

Walkthrough

Join your team for Breakout Room Activities!

Take a seat at your team's table.

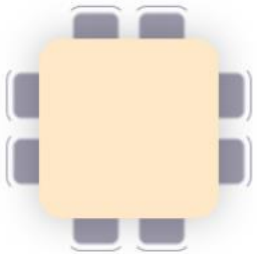
LIVE HELP DESK

Join

TEAM 2

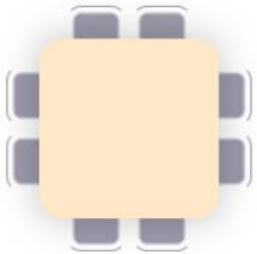
Join

TEAM 3



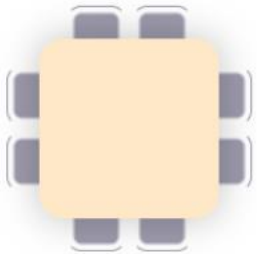
Join

TEAM 4



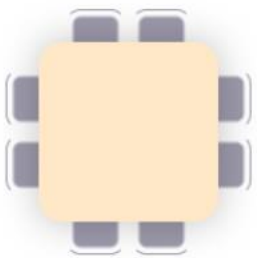
Join

TEAM 5



Join

TEAM 6



Join

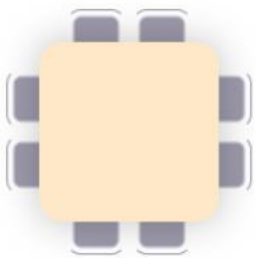
TEAM 7

Join

TEAM 8

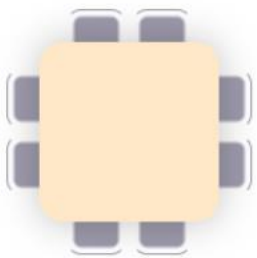
Join

TEAM 9



Join

TEAM 10



Join

TEAM 11

TEAM 12

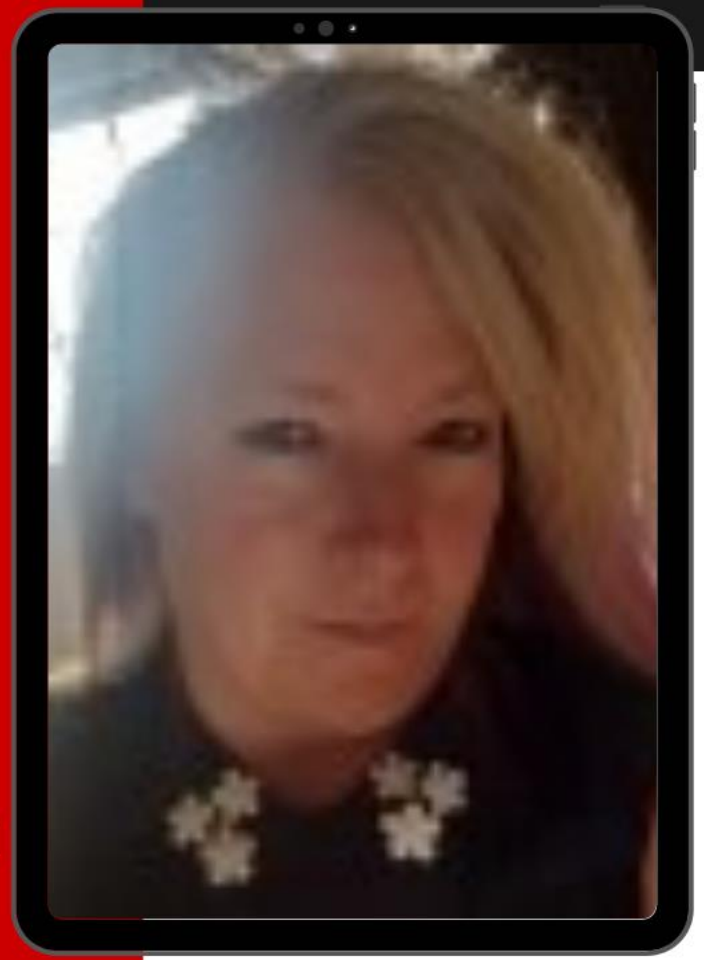
TEAM 13

TEAM 14

TEAM 15

AMY LOVELESS - BSRS, RT(R), CPPS

SPEAKING UP: Creating a Culture of Patient Safety



Regional Patient Safety Officer – TX/NM Region
Covenant Health

SPEAKING UP:
Creating a Culture of Patient Safety

Amy Loveless BSRS, RT(R), CPPS
Regional Patient Safety Officer TX/NM

What is a Patient Safety Officer?

- Partners with *Risk Management, Quality Management and Infection Prevention,* to investigate errors made in the organization.
- Collaborates with leadership and staff to proactively implement a plan of action to reach zero *preventable harm.*
- Creates reduction strategies for harm events.
- Ensures that when an error is made, the employee is treated with fair and accountable action.
- Report Serious Safety Events to The Joint Commission and TX Dept. of Health.

Tools or behaviors to use to prevent harm "Speaking Up"

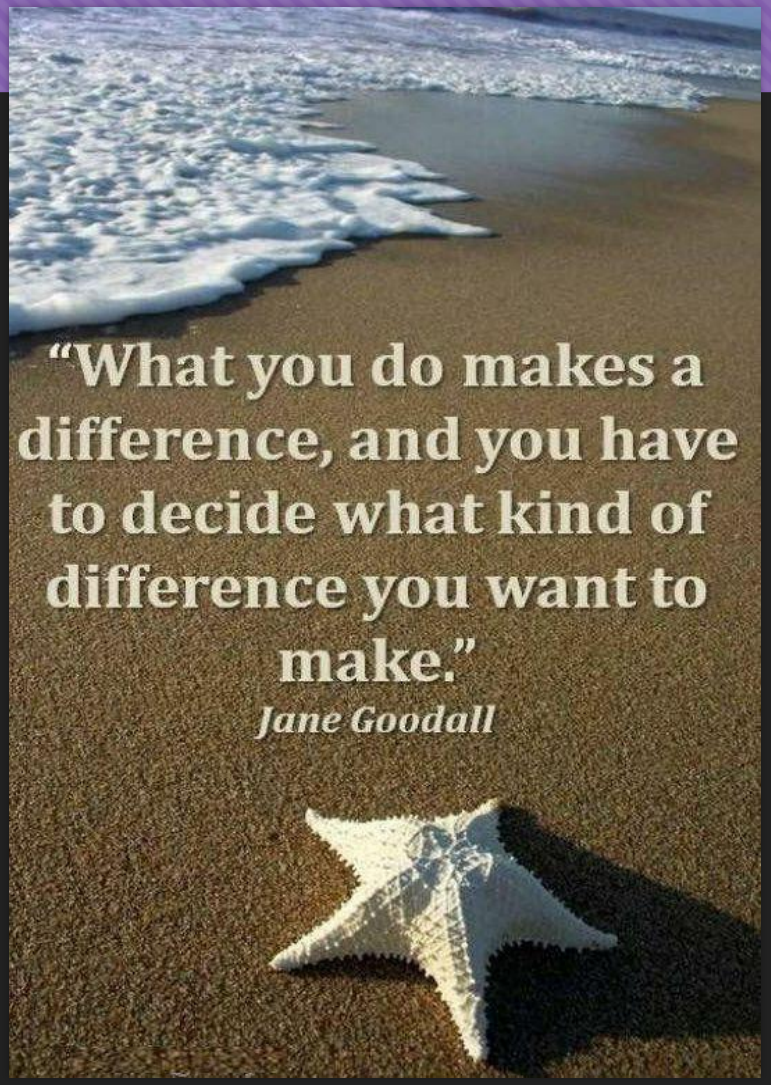
Josie King-
"Nitkin, K & Broadhead, L. 2016, Johns Hopkins Medicine News & Publication"

- ***Deference to Expertise***-Who is the expert in the room?
- ***Questioning Attitude-*** Trust your gut!
- ***Assume Good Intent-*** See the positive!
- ***Validate & Verify-*** Double checks!!
- ***Fair & Just Culture-*** Hear their side of the story.

What if?

- ***What if-*** Josie's mom had decided to let her grief overrule her life, and end the pain?
- ***What if-*** Josie's family had decided to sue rather than educate and ensure another family never had to endure this pain?
- ***What if-*** Healthcare staff treated **EVERY** patient as they would want their self or their family care for?
- ***What if-*** Healthcare organizations could actually achieve **ZERO** preventable harm?

Final Thoughts



Breakout Room 2

Case Study Ellie, Error Disclosure Role-Play, & Post-Event Survey