

Agenda Item:6.2
Prepared by: M.B. Thomas
Meeting Date: January 19,20 2006

Report of the Health Alliance Safety Partnership

Summary of Request:

The Board is requested to review Attachment One, which is an update from the Patient Safety Pilot Health Alliance Safety Partnership as authorized under the Texas Occupation Code Section 301.1606.

Historical Perspective/Background Information:

Attached is the Error Review Action Plan for an incident that involved a medication error in one of the participating institutions. The patient should have received a biologic drug on transplant day + 7 but the dose was administered on day +6. The Event Review Committee of the Health Alliance Safety Partnership found numerous systems issues which contributed to the error including two sets of physician's orders and a large, multi-page medication administration record.

Pro's: The report provides an update on the Health Alliance Safety Partnership.

Con's: None.

Staff Recommendations:

None. This report is for information only.

Event Review Action Plan for HASP Report 20050818

Attachment One

Institution – 20050818I			
Theme / Issue	Evidence from HASP review	Action Plan Suggestion	Action Plan Return Date
1. Complex MAR without reliable visual cue to identify drugs not due	The multi-day MAR is complex and there is no systematic way of identifying medications that are active, but not due. In the presence of multiple pages of medications the lack of systematic differentiation presents a problem for reconciliation and administration..	<p>A. Consider automating / standardizing the manner in which drugs that are not due are identified / differentiated on the MAR, preferably by incorporating the identification into the Pharmacy procedure for checking medications.</p> <p>B. Ensure there is one standard way of indicating a drug is discontinued or not due—records viewed appeared to have some days marked through, some highlighted and some written “not due”.</p>	60 days
3. MAR reconciliation process	Relying on the night shift nurse alone is a high-risk single point failure.	D. Consider the value of performing a nurse / pharmacist MAR reconciliation daily. Would this add value &/or safety?	60 days
5. Order Sets / Terminology	<p>Two sets of admission orders were part of the patient’s record. The ERC found it difficult to mesh the orders in a sense-making manner.</p> <p>Transplant terminology within medical record could easily be misinterpreted.</p>	<p>F. Consider the value / safety of combining admission order sets by investigational protocol.</p> <p>G. Examine the transplant terminology used. Perhaps orders would be more clear if the + / - (plus / minus) were spelled out and the days in relation to transplant were listed on the MAR?</p>	90 days

The information provided in this document is part of the HASP Quality Improvement process. As such, this information is confidential, privileged and protected from discovery.

Event Review Action Plan for HASP Report 20050818

Institution – 20050818I			
Theme / Issue	Evidence from HASP review	Action Plan Suggestion	Action Plan Return Date
8. Patient Assignments	The assignment for the nurse newly off orientation was busy and complex and may have contributed to the error.	I. Consider establishing a review of assignments for new hires / orientees by the charge nurse and preceptor to ensure that assignment is commensurate with new nurse's experience & capabilities. Also ensure that the new nurse has resources for assistance, as needed during the shift.	30 days
These observations do not require formal action but are offered for consideration by the ERC.			
10. Drug that was not due was available on unit	If the medication was not available it would add a "forcing function" to prevent administration.	A. The committee commends the software upgrade installed 8/10/05 eliminating the printing of labels of predated medications. The drug will not be dispensed accidentally or available if label is not available.	N/A
2. Multi-day MAR	Multi-day MAR is complex	C. The committee commends the single day MAR now in use on unit at the facility	N/A
4. Unit Medication Refrigerators	Though the refrigerator itself was not found to be a contributing factor, the bins are one color and the delivery/sorting process leaves multiple medications close together, which seems to present some patient risk and might contribute to an error.	E. Recommend consultation with visual control specialist to ensure a safe environment for refrigerated medications. F. Consider the policy and roles for delivery, sorting and storage of refrigerated medications on the inpatient unit-review, its effectiveness, and possibilities for improvement.	N/A

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Institution – 20050818I			
Theme / Issue	Evidence from HASP review	Action Plan Suggestion	Action Plan Return Date
7. Shift to Shift Communication	No standard for shift to shift report exists within the Institution. Drug was discussed in report.	H. The committee commends the use of SBAR and suggests a standard shift to shift report format to assist healthcare providers in prioritizing information / issues to communicate with other providers.	N/A

Nurse - 20050818			
Theme / Issue	Evidence from HASP review	Actions to be taken / Changes to be made	Action Plan Return Date
1. Effect of fatigue / hours worked on performance	Nurse worked 52 hours total at 2 different healthcare facilities.	A. Reflect on the present error by considering if the number of hours worked the week of the error and/or working at 2 facilities may have contributed to the error. B. Please share any suggestions about communicating issues about fatigue / other human factors to your peers with the HASP Team.	Please report back the nurses comments regarding the possibility of fatigue as a contributing factor

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