

# University Hospital Annual Physician Safety Training



**Note: This training has been totally re-done and most topics include a case report of a safety event that actually happened at UH within the past year or two. This is not just a bureaucratic requirement – this stuff really matters! Please spend some time with it.**

This course meets University Hospital Annual Physician training requirements for:

**Blood Borne Pathogen Training  
General Workplace Safety  
University Hospital Annual Review (STAR)  
National Patient Safety Goals**

There will be 12 questions at the end of this presentation.

# Blood Borne Pathogens



Personal Protective Equipment (PPE) is easily accessible and provided by the hospital at no cost for use when the potential for occupational exposure exists.

**Make sure you are wearing gloves, gowns, masks, eye protection, surgical caps, hoods and shoe covers where necessary.**

**Place Blood and other Infectious Waste in Red Biohazard containers.**

## **Case Report:**

In 2010, a PCSA in the OR found blood in a regular trash can bag. When they picked up the plastic bag to dispose of it correctly, there was a hole in the bag (caused by improperly disposed sharps), which caused the blood to splash in the PCSA's mouth, nose and eyes.

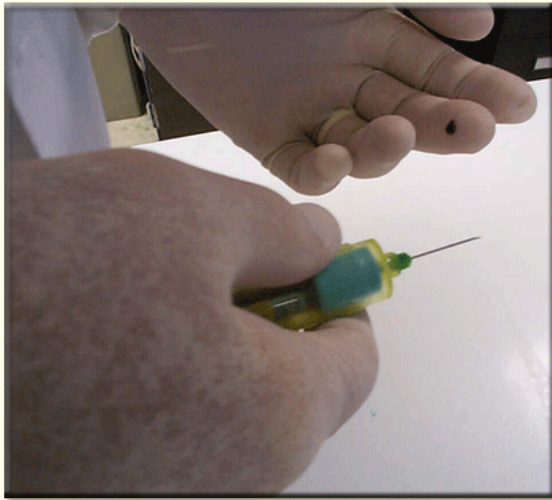
The hospital received an OSHA violation for this incident, and we were fined \$26,500. Please make sure you dispose of items correctly.



# Sharps

In 2010, there were 174 sharps related exposures, as well as 135 needlestick exposures reported to employee health. 64 of the sharps exposures were to residents and fellows.

## Here is what to do to reduce your risk of sharps injuries



- Place sharps carefully in proper containers.
- Do not overfill sharps disposal containers. Containers should be replaced when 3/4 full.
- Be sure nothing sticks or spills out of the container.
- Dispose of sharps disposal containers in bio-hazardous trash container, NOT in regular trash.
- Clean reusable sharps carefully.
- Put sharps away in their proper places.

**Do not recap or bend needles.**

# Fire Safety

## *Case Report:*

In 2010, a trauma patient was undergoing surgery and had been prepped chin to knee with a betadine scrub and paint. A decision was made to enter the chest intraoperatively and Chloroprep was applied to the skin by a member of the surgical team. The scrub nurse verified Chloraprep to the MD before application. An incision was made with a knife and a Bovie was used to cauterize bleeders. A fire occurred at the incision and involved a lap sponge that was extinguished on the floor. The wound was examined by the surgeon, re-draped, and the procedure continued. There was no apparent harm to the patient.

**Every MD needs to be aware of the flammability risks associated with medical solutions, gases, surgical materials, and electrocautery devices.**

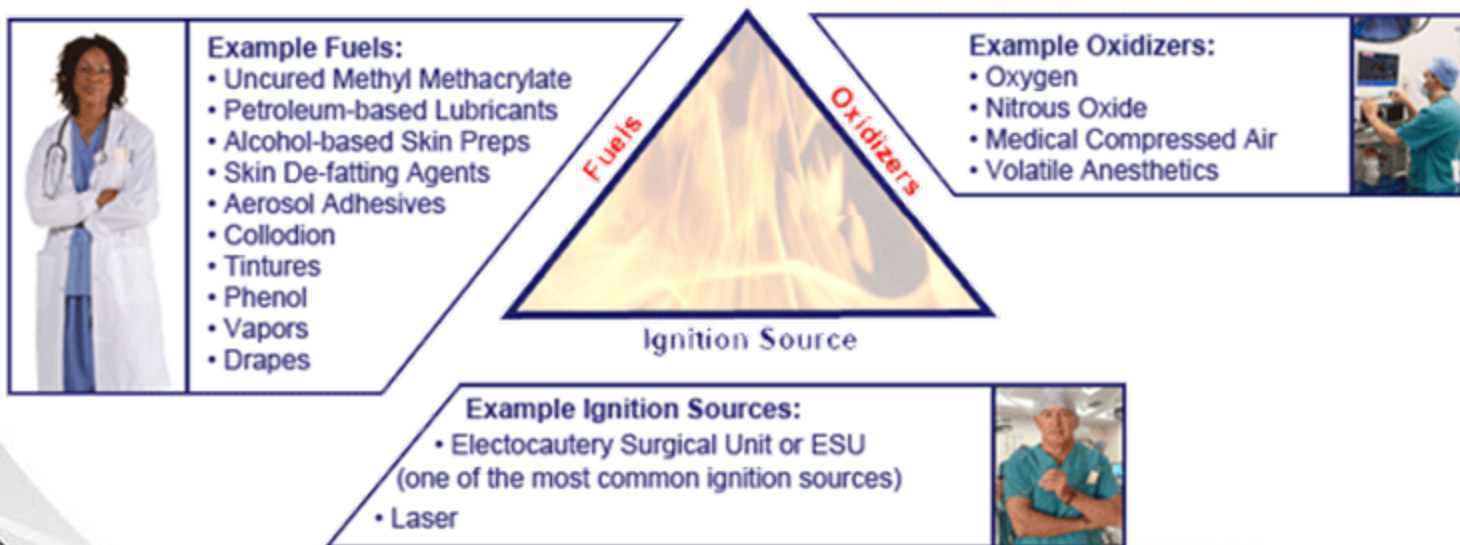


# Fire Safety in the Operating Room

Fire can occur when an **ignition source**, **oxidizer** and **fuel** are combined. These three elements constitute the **Fire Triangle** and are abundant in the Operating Room.

Different members of the Operating Room Team have primary control over various items included in the Fire Triangle. All Surgical Team Members must be vigilant and communicate when any of these factors or procedures are in effect. Remember, what Team Members do individually may be safe, but when particular procedures are combined, the risk of fire may increase!

The Fire Triangle diagram below shows examples of each element, as well as, Team Members who commonly use or have control over these elements.



# Patient Identification

## ***Case Report:***

Earlier this year, orders were placed on a wrong patient via CPOE. Labs for type and screen were drawn and a chest x-ray was done on the incorrect patient. The mistake was caught prior to the infusion of blood which was intended for a different patient. Thankfully, no blood or medications were given.

## ***Lesson Learned:***

Double Check who you've activated in CPOE before writing orders.

## Universal Protocol / Time Out

The challenge is not doing time outs, it's doing them well. Pay Attention!

### *Case Report:*

A patient was scheduled to have his left kidney removed. The left side was marked correctly, but the patient was positioned in the OR with his left side down. The circulating nurse noticed that there were no markings during the time out, and the patient was repositioned correctly.

**Time Outs matter - do them with care and your full attention!**



# Keeping Verbal Orders Safe

## ***Case Report:***

Earlier this year, a verbal order to "give terbutaline" was given. The physician did not give, and the nurse did not ask for the amount and the route. 1mg was given IM when the physician intended for 0.25 mg to be given SQ. Additional monitoring had to be performed because of the excessive dose.

**The use of verbal orders when a Physician is on the unit is discouraged, except in an emergency situation.**

**If verbal orders are used, always do the following:**

- **Give a complete order.**
- **Insist that the nurse read back and verify their understanding of what you said.**
- **Confirm that what you heard was correct.**

# Heparin Protocol

There are 4 protocols for Heparin.

Using Protocols reduces mistakes.

Try to use a protocol whenever possible.

	Standard	Low
Bolus	✓	✓
No Bolus	✓	✓

# Medication Reconciliation

## **Case Report:**

In 2010, a Medication Reconciliation Error at Admission occurred. A patient's correct dose of levothyroxine was 150mcg at admission #1. The home medication list completed by nursing listed the dose as 0.15mcg (should have been mg) but it does not appear that this information was used by anyone else. The MD's medication list in the H&P listed the dose as 25mcg and that is what he ordered for the patient. The patient had a tremor and thyroid tests during that stay showed a low TSH and high free T4 so that an order was written to decrease the dose to 12.5mg and that is what the patient was sent home on. He was readmitted 17 days later with altered mental status and thyroid tests done then showed a low T4 and a high TSH. The patient's wife confirmed that the patient had been taking just a half of a 25mcg tablet of levothyroxine at home as directed.

## **Key Elements of Medication Reconciliation:**

- Medication Reconciliation is a **Physician Responsibility**
- Complete list of current medications upon admission
- Compare the current list of medications with any orders or prescriptions to assure no duplication, omission, or potential interaction
- Communicate the list of reconciled current medications to the patient/family and next provider of care



# Reconcile Allergies

## *Case Report:*

In 2009, a 46 year old patient was given an IM dose of ceftriaxone in a UH Clinic. Shortly thereafter, the patient collapsed from anaphylaxis. Although the current clinic records, as well as the patient's response to the question of allergies, did not include an allergy to ceftriaxone, there was documentation of this allergy in the inpatient LASTWORD system. The allergy was identified during an ER visit in April 2008, where he developed hives after getting ceftriaxone.

**Currently there are multiple systems in use, which means multiple lists of allergies.**

**Physicians need to be aware, and double check all allergies before placing orders for meds.**

# Restraints

It is a patient right to be free from restraints and seclusion.

Less restrictive measures must be considered before ordering restraints.

All restraints require a physician order, initial assessment, and interval reassessment.

**Order and Re-Order them appropriately.**

**Document Why**



# Blank or Pre-dated Forms

## **Case Report:**

This Discharge Summary form was found in a patient's chart. It was pre-dated and signed before it was completed.

This is considered falsification of records, and is a serious offense with the Ohio Department of Health and other regulatory agencies.

• **Do Not** sign or pre-date/time any blank forms in the patient's chart.

THE UNIVERSITY HOSPITAL  
INPATIENT PSYCHIATRY SOCIAL WORK  
DISCHARGE SUMMARY

Patient Name: [Redacted]  
Admission Date: 9/10  
Medical Record #: 090210

SOCIAL WORK INVOLVEMENT

FAMILY CONTACT/INVOLVEMENT

DISCHARGE INFORMATION  
Recommended Treatment  
 Individual  Group  Family  Case Mgmt  Other (Specify)

Plan discussed with patient  
 Yes  No If no, why?

Disposition  
 Own Home  Crisis Housing  Nursing Home  Care Facility  
 Relative's Home  Residential Treatment  LH Medical Unit  Homeless  
 Friend's Home  Group Living  Other Hospital  Other  
 MH  IAH

Type of Referral  
 MH  Alcohol/Drugs  Forensic  Other  
 IAH  Nursing Home  No Referral, Why

Insurance Information  
 Employment  Family Insurance  SSI/SSD  GALDA  Other  
 AFD  #  #  #  #  None

Appointments/Where Referred  
Contact Person: \_\_\_\_\_ Appointment Date/Time: 9/10

Signature: [Signature] Date: 9/10

WHITE COPY—MEDICAL RECORDS YELLOW COPY—SOCIAL WORKER FILE

# HIPAA



## *Case Report:*

A patient with HIV had asked that no one in his family be informed of his diagnosis. The patient's sister was visiting and a staff member came to the patient's room to discuss something she was working on for him and asked if the patient had an HIV case manager. The patient tried to discreetly shake his head to get her to stop talking about his HIV, but it was too late.

**DO NOT discuss anything about HIV or similar topics with the patient if others are around.**

### **Reasonable Safeguards to protect privacy:**

- Ask visitors to step out of the room when discussing PHI
- Pull the curtains
- Talk quietly
- Provide counseling in a private area

# Pain Management

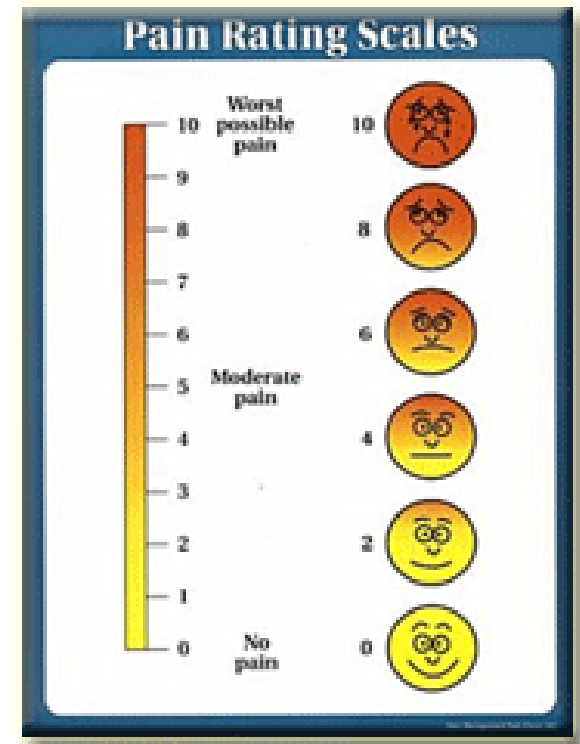
All patients at University Hospital have the right to:

- Information about pain management
- A staff educated and committed to pain prevention and management

Pain can not be measured objectively

Pain scale is used to assess and reassess patient's perception of pain

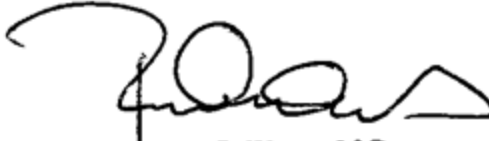
Behavioral scale is used for non-responsive patient



# Time, Date, Signature and Credentials

Medical Records must be legible and authenticated with Name, Credential, Date and Time.

Use a name stamp as a legibility aid for paper records



Robert G. Wones, M.D.  
Date 12/15/09 Time 9AM

Include your credentials (MD, PA, NP, etc.)

Date and Time are required

CPOE orders are automatically authenticated

APN or PA orders in CPOE must be signed by MD **within 48 hours** if the APN/PA does not have prescriptive authority (Ohio Pharmacy Board Regulations)

# Documentation

## *Case Report:*

Healthgrades™ lists University Hospital as an average 3-Star hospital for stroke mortality and virtually every other hospital in town has 5-Stars (better than average).

How is this possible given that many hospitals transfer their most severe strokes, especially hemorrhages, to University Hospital?

Answer: Diagnosis and outcomes data based on claims we submit which in turn are based on physician documentation are being used by external organizations to judge our quality!

**Documentation for quality is a key priority in 2011.**

# Patient Safety Hotline

## **Patient Safety Hotline** **584-2109**

**Press #1 for Duty Hour Issues**

**Press #2 for Patient Safety/Staff Concerns Specific to the Emergency Department**

**Press #3 for Staff Safety Issues**

**Press #4 for Patient Safety Issues**



**Anyone wishing to identify a potentially unsafe act, process, procedure or system can call into the hotline from any hospital phone line. This can be used for reporting near misses, or when you are unsure of the proper channel to report an incident. Any report may be anonymous.**

Revised: 10/10

# Review

[Click Here to Take Test](#)

Your browser will open up a new window for the test.  
When you are finished, click the “Done” button to submit your results.