Interprofessional Patient Safety Instruction Using a Unit-Specific Room of Errors

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Pediatric Critical Care: High Risk Population

- AHRQ – Pediatrics (AHRQ, 1999)
  - 1.8-2.9 errors/100 ped inpts (Slonim, 2003)
  - PICU: 59% adverse events, 36% preventable (Larsen, 2007)
- Intensive Care Units (Stockwell, 2006)
  - 1.7 errors/pt day (Donchin, 1995; Rothschild, 2005)
  - 45% preventable
- Quality of teamwork is imp factor in error prevention (Thomas, BMJ Qual Safety, 2013)
Team Cognition

- Team members “on the same page”
- Awareness of ability & function
- Role of team-based training

Team Based Patient Safety in the PICU

- Sandy Neumayr, MSN, CNS
- Lisa Fuzy, RN, BSN, CCRN (ACNP)
- Robin Kelly, RN
- Marcia Buck, PharmD
- Sam Addison, RT, ECMO Specialist
- Ross Thomas, RT, ECMO Specialist
- IPE Consultants: Valentina Brashers, MD
  John Owen, DEd
UVA PICU Room of Errors: Objectives

1. Enhance Patient Safety UVA-HS PICU

2. Improve Interprofessional Collaboration

3. Engage & Educate
PICU Room Of Errors:
Infant s/p Congenital Heart Surgery
Examples of Staged Errors

- **General**
  - Unlabeled blood samples on counter
  - No alcohol gel in dispenser
  - Contaminated sharp not disposed of properly
  - Oxygen tank lying on floor

- **PICU Specific**
  - Art line transducer hanging off side of bed
  - Central line not dressed appropriately
  - Epi drip programmed incorrectly
  - Wrong sized bag & mask
Examples of Staged Errors

- Patient Population Specific
  - Had tachydysrhythmias, still on Epi
  - Wrong potassium dosing, signs of hyperkalemia on monitor
Process

1. Work alone in room
2. Identify 3 most impotent
3. Discuss & Merge lists
4. Debrief & Evaluation

- Scripted Facilitation
- Color Coded Answers
- TeamSTEPPS® T-TAQ
Qualitative Data

List Consolidation

- “I didn’t even look at that”
- “I looked at that and didn’t see it”
- “That’s an immediate danger – I didn’t catch it, but that’s bad!”
- “I’m glad you were on our team”
Debrief Comments

- “Good to see what everyone say”
- “Time crunch makes it real”
- “Every member of the team sees the same patient differently”
- “We all looked at our ‘thing’”
- “We work as a team – that’s how it should be”
- “Great experience”
Objective Data

- Avg # errors found by Individual 18
- Avg # errors found by team 36
- All but 2 reported changing their “most important” errors after discussion with colleagues
<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>N</th>
<th>Average</th>
<th>Std Dev</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is a fun way to learn about patient safety</td>
<td>48</td>
<td>4.85</td>
<td>0.86</td>
</tr>
<tr>
<td>I learned about potential errors that I did not know about prior to this activity</td>
<td>48</td>
<td>4.40</td>
<td>0.76</td>
</tr>
<tr>
<td>I enjoyed doing this activity with others from different professions</td>
<td>40</td>
<td>4.82</td>
<td>0.45</td>
</tr>
<tr>
<td>I learned something from one of my colleagues from a different profession</td>
<td>40</td>
<td>4.65</td>
<td>0.58</td>
</tr>
<tr>
<td>I learned something from one of my colleagues in my own profession</td>
<td>41</td>
<td>4.20</td>
<td>0.98</td>
</tr>
<tr>
<td>I plan to incorporated something I learned today into my daily work</td>
<td>47</td>
<td>4.60</td>
<td>0.62</td>
</tr>
<tr>
<td>I believe that all team members are important in ensuring patient safety</td>
<td>47</td>
<td>4.8</td>
<td>0.46</td>
</tr>
</tbody>
</table>
### Follow-Up Survey

<table>
<thead>
<tr>
<th>1 week later</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ROE promoted teamwork &amp; enhanced awareness of IP teamwork in assuring patient safety</td>
<td>39</td>
<td>97%</td>
</tr>
<tr>
<td>Incorporated something learned into practice</td>
<td>39</td>
<td>85%</td>
</tr>
</tbody>
</table>
Conclusions

• A simulated patient care room highlighting multiple actual and potential errors enhances safety awareness for participants.
• Participants learned from IP colleagues about potential patient safety concerns.
• IP training activities can emphasize the importance of teamwork in assuring pt safety.
Conclusions

- Pt safety activities can be fun & engaging
- Difficult to get IP groups together at same time
- Can be adapted
  - Expertise of involved participants
  - Practice Environment
  - Educational level of learners
- Facilitators always learn something