PSI: Patient Safety Investigators

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INTRODUCTION

Emphasizing patient safety, Catawba Valley Medical Center (CVMC) created an innovative strategy for educating graduate nurses on the Joint Commission on Accreditation for Hospital Organizations' (JCAHO) National Patient Safety Goals (NPSG).

CVMC's approach provides the graduate nurse with the opportunity for hands-on experience investigating and identifying situations that could compromise patient safety. The graduate nurse assumed the role of Patient Safety Investigator (PSI) in these staged patient safety scenarios.

A simulated patient room was created to depict scenarios compromising patient safety. PSI's were expected to investigate and identify these situations. Scenarios were developed based upon recommendations from the NPSGs and historical risk incidents at CVMC.

Following this simulation activity, group collaboration was facilitated by CVMC Risk Managers to evaluate the PSI's findings at the scene and discuss what should have been done to avoid a compromise in patient safety.

This activity resulted in excellent participation, collaboration and communication among PSI's (graduate nurses) at CVMC. Design and implementation of this education strategy is validated by the Institute of Medicine's report *To Err Is Human* recommending application of human factors to improve performance such as the use of simulation training.

Institute of Medicine. *To Err is Human.* Washington, D.C.:National Academy Press, 2000.

EDUCATION ON NATIONAL PATIENT SAFETY GOALS

Improve the accuracy of patient identification

Utilizing a simulated patient chart, multiple errors were created in documentation including incorrect patient identification labels on specific forms.

Improve the effectiveness of communication among caregivers

Chart reflected critical value not reported to the physician. Using role playing, a simulated physician called the patient's room with new orders. PSI's were observed by Risk Manger to ensure read back policy compliance.

Simulated chart also reflected numerous MD orders and other entries with prohibited abbreviations.

Improve the safety of using medications
CELEBREX 100 mg BID on MD orders; however, Medication Administration Record (MAR) reflected CEREBYX 100 mg BID.

Unsecured and unlabeled medications were in the patient's room.

Reduce the risk of patient harm resulting from falls

Patient identified as high risk for falls indicating the need for fall prevention interventions.

- Bed exit alarm not activated
- Appropriate signage not displayed
- Identification bracelet did not reflect high risk fallstatus
- Bed not in lowest position

ADDITIONAL PATIENT SAFETY ISSUES DISCOVERED AT THE SIMULATED SCENE

- Blood bank bracelet not on patient, taped to the head of the bed
- Patient restrained; however, documentation for restraints not complete and restraints tied incorrectly
- IV Fluids out of date and incorrect IV fluids being administered
- Code designation bracelet not consistent with MD order
- Heel protector device not activated on bed despite the patient having a large heel decubitus

CONTACT INFORMATION

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