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 impt 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

Hughes. Am Med Assoc Journal Ethics, 2013

Team Based Patient Safety in the PICU

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- Lisa Fuzy, RN, BSN, CCRN (ACNP)
- Robin Kelly, RN
- Marcia Buck, PharmD
- Sam Addison , RT, ECMO Specialist
- Ross Thomas, RT, ECMO Specialist
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UVA PICU Room of Errors: Objectives

1. Enhance Patient Safety UVA-HS PICU
2. Improve Interprofessional Collaboration
3. Engage & Educate

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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 of 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 impt
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

PICU ROE

TABLE 1	N	Average	Std Dev
This is a fun way to learn about patient safety	48	4.85	0.86
I learned about potential errors that I did not know about prior to this activity	48	4.40	0.76
I enjoyed doing this activity with others from different professions	40	4.82	0.45
I learned something from one of my colleagues from a different profession	40	4.65	0.58
I learned something from one of my colleagues in my own profession	41	4.20	0.98
I plan to incorporated something I learned today into my daily work	47	4.60	0.62
I believe that all team members are important in ensuring patient safety	47	4.8	0.46

Follow-Up Survey

1 week later	N	%
The ROE promoted teamwork & enhanced awareness of IP teamwork in assuring patient safety	39	97%
Incorporated something learned into practice	39	85%

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