

Quality & Safety Update

MOONSHOT : WERE !!

Dr. Sam Flanders is the senior vice president and chief quality and safety officer for Beaumont Health. He will post blogs monthly about quality and safety topics and encourages everyone to share their ideas.

Celebrating our great catches—all Beaumont team members are Eagle Eyes

Since we're recognizing Health Care Week, I thought it would be a great time to spotlight some of the great catches we've seen recently from around the system.

Each of these was reported as a <u>Quality-Safety Report in RL Datix</u>. This batch of reports shows how everyone in the system can contribute to improving patient safety. While we frequently receive reports from clinicians, we also see great catches from a wide variety of jobs. This batch includes reports by nurses, nursing assistants, a surgical technologist, MRI technologist, pharmacy technologist, office coordinator, speech pathologist and a security officer.

Here's a sample we just shared with the Beaumont Board of Directors Quality Committee:

| SITE | AWARDEE | EVENT DETAILS |
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| Dearborn | Casterials DNI | While providing routine care to a patient's new leg amputation, Jennifer recognized that there was pus coming from the edge of the wound and discovered the source of infection that had been evading the patient's medical and surgical team for weeks. She promptly notified surgery and the patient was taken for debridement. |
| Dearborn | Amber Zapawa, surgical technologist | While preparing the room for a surgical procedure, Amber recognized that a patient with a bee venom allergy may also have a reaction to bone wax. The package of bone wax was removed from the field which saved the patient from a potential allergic reaction. |
| Farmington Hills | Larry Crunk, MRI | Before starting an MRI of the brain, Larry reviewed the patient's previous scans and noted they had the same test 17 days prior. Concerned it may be an incorrect order he contacted the ordering physician and clarified the patient was to have a MRA of the Brain, not an MRI preventing the patient from having an unnecessary test. |

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| Farmington Hills | Pam Hunter, Specialty Pharmacy Technologist | Pam contacted the EC nurse when she suspected the patient may have been registered under the wrong name because the information the patient was providing about demographics, home meds, pharmacy used etc. did not match what was in the EMR. The error was corrected, and patient was registered under the correct name preventing incorrect pre-admission meds being ordered for the patient. |
| Grosse Pointe | Heidi Nehra, Office Coordinator | A prostate biopsy was sent to Royal Oak for processing and slide preparation. Slides were returned to Grosse Pointe. When Heidi was assigning pathology cases for the day, she noted that slide 1 had a Grosse Pointe accession number with patient "A"s information on it. Slide 2 had a Royal Oak accession number (linked to patient B) with patient "A"s name. |
| Royal Oak | Nicole Dupuis, Speech Pathologist | Nicole completed a Barium Swallow test. She reviewed the video and asked the radiologist specific questions. However, she remained concerned. She reviewed the images with her supervisor. Following that, Nicole contacted the attending physician who ordered an ear/nose/throat (ENT) specialist consult. It was found the patient had a hematoma at the base of his tongue and the ENT was able to manage the treatment plan accordingly. |

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| Taylor | Kerry Arnold, Security Officer | During security rounds, Kerry noted a clear colorless liquid syringe in the restroom after a patient left and questioned the contents. Upon further investigation it was found to be heroin. The patient was questioned and admitted that he went to the restroom to use the rest of it. Proper follow up was conducted. |
| Taylor | Scott Hickman, RN | Scott assisted transportation with preparation for transfer to an inpatient bed. Scott noticed that the patient's mask was soiled and provided the patient with a clean mask. At this time, he noticed the patient had a facial droop. Stroke protocol was initiated and was caught prior to the patient leaving the EC, expediting the patient's care. |
| Trenton | Brenna O'Rourke, RN | A patient was admitted after a recent admission the month prior. During the current admission, the physicians were unable to find the previous admission lab values. During this time, Brenna recognized the patient and realized she had taken care of the patient during the previous admission and identified that the new chart had the patient's DOB, address, and arm band incorrect. The error was reported to admitting who corrected the information. If Brenna had not recognized her patient, this error would not have been caught. |

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| Troy | Alexandra Torres, RN | Alexandra noticed that the IV Chemotherapy was mixed in 500cc fluids rather than 1000cc. The bag was mistakenly prepared in a 500ml bag. The label read it was to be dispensed in 1L bag. That was consistent with MAR instructions and is our typical method of dispensing. Alexandra, doing the chemo double check/time out process noted the discrepancy. The bag was sent back to pharmacy to be remixed in the proper dilution. |
| Wayne | RN | Crystal noticed a physical finding that was clinically significant and needed immediate intervention. Crystal's early clinical finding helped to prevent complications and ensured safe and timely care to the patient. |
| Trenton | Estrada, nursing assistant | Mercedes was in a patient room taking vitals when the vital machine showed the patients heart rate as 35. Mercedes went to look at the telemetry screen to compare readings when she recognized that the patient was not connected to their telemetry, it was on the patient, just not turned on/admitted. The patient's heart rate in fact was 35 and a RRT was called. |

Thanks very much for keeping your Eagle Eyes open and for speaking up! You are all health care heroes!

Sour

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Join the Beaumont Quality Academy

Are you interested in learning more about improving quality, safety and operations? Or looking to be involved in performance improvement in your area (clinical or support departments)? Please consider joining us at the Beaumont Quality Academy in 2021. Dates, more information and sign-up is available on HealthStream (search for Quality Academy). For questions, email Kristi.Ayotte@beaumont.org. Hope to see you there!