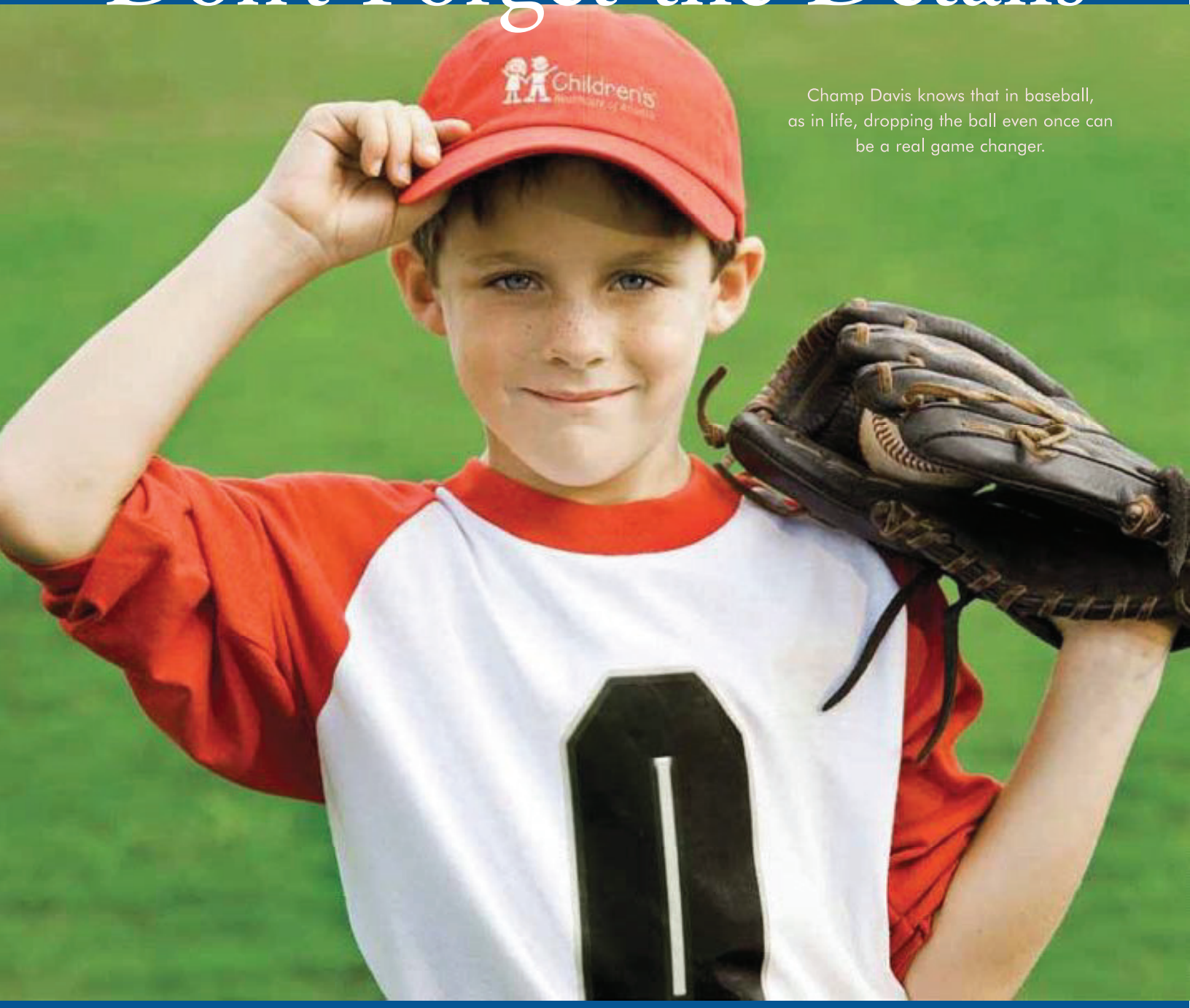
Don’t Forget the Details



Champ Davis knows that in baseball, as in life, dropping the ball even once can be a real game changer.

When it comes to patient safety, attention to detail is everything. Here’s the case for doing the small details to save lives.

During the night, Noah's* condition began to deteriorate. His breathing became labored, and he seemed to be retaining fluid. In response, his physician ordered a diuretic to reduce his fluid load, and put Noah on oxygen support. The cause of Noah's deterioration, however, was baffling. And for the next 12 hours, his caregivers watched and waited.

Then, at shift change, Noah's oncoming nurse put the puzzle pieces together. His IV nutrition was being delivered at 10 times the ordered rate. Thankfully, Noah suffered no lasting harm, but the mistake could have been catastrophic—and it did temporarily strain his already-weakened body.

What went wrong? "This was an example of a High Alert safety process—double checking the infusion rate—being documented as 'completed,' but it was obviously not completed correctly," said Lisa Davis, Medication Safety Officer.

It's also a prime example of what happens when humans get busy, distracted or simply let their focus slip. We make mistakes. And in the world of pediatric healthcare, the consequences can be devastating.

We'll say it again: One is Not Zero

When Gary Frank, M.D., Medical Director, Quality and Medical Management, gives patient safety presentations, he starts with numbers that define the complexity of Children's: 520 inpatient beds, three hospitals, 16 neighborhood locations, more than 25,000 annual inpatient admissions, and more than 500,000 annual outpatient visits. Then, he shows a picture of just one child—his son. "Here's the number that matters most: one. My child. Your child. And *no* child, not even one, should be harmed," he said. "When we make decisions to engage in risky behaviors, we have to ask ourselves how we'd feel if our own child was on the receiving end. When we say 'One is Not Zero,' this is what we mean."

Paying attention to processes

Fully recognizing that to err is human, Children's takes responsibility for putting in place processes, policies and safeguards that help staff avoid mistakes. "One of the first things we ask when there's a patient safety incident is, did we as an institution fail our caregiver and how can we alter the environment to avoid errors," said Renee Watson, Director, Infection Control. "We're continuously striving to improve safety processes."

In addition to creating a safe environment, Children's Quality department—guided by the Quality cabinet, Quality committee of the board, and a Quality strategic plan—strives to ingrain safe behaviors. "We can put up all the guardrails we want, but we need our employees' help to keep everyone safe. Sometimes, you know you're supposed to do something a certain way, but when pressed for time, you're tempted to take short cuts. Nobody wants to make a mistake, but inattention can be disastrous," Dr. Frank said. "Point is, if we hardwire safe processes—both simple and complex—into our brains, they'll become automatic."

And when safety becomes automatic, even during an emergency, preventable errors will fall dramatically—even to zero, in most cases.

These patient safety alert stories illustrate the point:

Patient safety alert: breast milk mix ups

When Angie* realized she'd inadvertently given her patient breast milk from the wrong mother, she was devastated. "Honestly, I wanted to throw up. It was awful. The more I thought about how this mother trusted me to care for her baby—and I totally let her down—the more heartsick I felt."

The incident happened several days after baby Isabel* was admitted to the ICU, long enough for Angie to have established a strong rapport with the very anxious mom. "I'd finally convinced her to go home and get some rest, reassuring her I'd take great care of Isabel," said Angie, a nurse with several years of ICU experience. At feeding time, Angie went to the fridge and verified the name on a container of breast milk, as she should. Continuing to follow protocol, she searched all containers' dates, selecting the oldest (it's a first in, first out system). Then, Angie got distracted. A therapist stopped by to evaluate the feeding, and the two discussed Isabel's progress while Angie attached the nipple to the container. When the therapist offered to feed Isabel, Angie gratefully accepted and hurried to her next patient.

Twenty minutes later, the therapist noticed the name on the container didn't match Isabel's ID band. Isabel had

PICU Staff Nurses Emily Carlton and Kim Hillmer, Children's at Egleston, take no chances and routinely double check every patient's medication prior to administering it.

just drunk milk from another mom—milk that could have contained a contagious disease.

"For about two seconds after the therapist pointed it out, I had that panic-induced 'if I don't tell anyone, nobody will ever know' thought," Angie said. "But I quickly considered my own child. I couldn't have lived with myself if I hadn't spoken up."

After informing the proper people (including her charge nurse, attending physician and risk management), and explaining to both distraught mothers that months of blood testing was needed to assure Isabel and the other mother were disease-free, Angie broke down. "I never, ever cry at work, but I just lost it. I cried inconsolably in front of all my co-workers for about an hour. The guilt was that bad. I'd always prided myself on being detail-oriented, but I'd let it slip."

Fortunately, blood tests came back negative. And details of the incident helped the System's breast milk task force as they sought to determine the cause of such mix ups. "We discovered current processes weren't working," said Chief Medical Officer Dan Salinas, M.D. "It was imperative to shift the status quo so that not even one error would occur, because one isn't zero."

The task force also looked at parents' role in patient safety. "I was shocked that only a small percentage of parents were checking the milk their child received, even when they were present in the room. We should be partnering with patient families—in all areas of patient safety—as much as possible," Watson said. "We want them to realize it's OK to double-check us."

In this particular case, process change coupled with increased vigilance will give caregivers the tools they need to keep patients safe.

Patient safety alert: medication errors

According to the Institute of Medicine, medical errors result in up to 98,000 deaths annually in the United States,

with medication errors being a major component. And here's another scary number: Children's has millions of opportunities a year to make medication errors. "We administer more than three million medication doses annually. With each dose, there's the possibility of having the wrong order, preparation, dose, form, frequency…so on," said Davis. "And in pediatrics, the risk is even higher because children have a big range of weights and their bodies are less tolerant of medication."

In a sense, medications are accidents waiting to happen.

To make sure they don't, Children's has many strategies and technologies in place around medication safety.

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Computerized physician order entry and the use of smart pump technology, for instance, have cut errors drastically. Tighter safety protocols for High Alert (most potentially dangerous) medications require extra checks by caregivers. And, most recently, the "MedZone" campaign is gearing up to heighten awareness around how distractions and interruptions contribute to errors.

When caregivers are working with medications—ordering, preparing or administering—even a brief interruption can cause a mistake. "It might be a parent with a question, or a physician who pops up asking about test results, or simply a co-worker wondering how it's going," said Davis. "Any

distraction can cause someone to miscalculate or miss a step in the safety protocol."

To eliminate interruptions, Children's is launching the "Shh, We're in the MedZone" campaign. Posters, window stickers and other reminders will help everyone be more attentive to holding their interruptions—or politely deflecting them—during medication handling.

Children's commitment to eliminating medication errors is working, as serious medication errors have decreased by approximately 50 percent in the past three years. It's good news, but don't become complacent. "If we have only a few serious medication events a year, we could get all puffed up because we met the target," said Davis. "But if my kid is involved in one of those events, it is not OK. One does not equal zero. Excellence in patient safety begins with really believing that, not just saying it."

Patient safety alert: dress to protect

Your patient has a bacterial illness and is on contact precautions, so you're supposed to don protective gown and gloves when entering her room. But you're super busy and you just need to run in, set something down, and scoot out. You can skip the dress-up routine and save a minute, right? Dead wrong. In addition to deaths due to medical errors, approximately 100,000 people die in this country every year as a result of infections they acquire in a healthcare setting. That's one death every eight minutes. And children (especially neonates) are among the most vulnerable population.

In this scenario, a number of misperceptions are in play, all of which could threaten the health of caregivers, patients and families. For instance, a virus that's generally harmless to adults can be fatal to a child. So if you unknowingly picked up a virus on your sleeve in one room, then deposited it on the child in the next room (or your own child after work), he's in trouble. "Just because these are

Prior to feeding an infant in the Children's at Egleston NICU, Staff Nurses Kate McGinnis and Dawnyale Phifer check the patient's ID band against the mother's breast milk ID label.

little people doesn't mean they don't have big diseases," Dr. Frank said.

Another false belief is that you won't come in contact with germs if you don't come in contact with the patient. "You don't know where in the room that patient has been and left his germs behind," Dr. Frank said. "Our 'Dress to Protect' campaign serves as a reminder to take the time and wear the appropriate coverings."

"Although it sometimes feels burdensome to comply, in reality there's strong epidemiological evidence behind Dress to Protect guidelines," Dr. Frank said. "Improving compliance will reduce infections, which will lower morbidity—even mortality—rates. In other words, when we follow the guidelines, we're doing even more to protect the children we've been given the privilege of caring for."

To help us adhere to this and other safety measures, a group of infection control advocates perform observations in patient areas, noting safety non-compliance. "Knowing that someone is paying attention helps people do the right thing," said Dr. Frank. "And by doing the right thing repeatedly, it becomes a habit."

Our patients deserve it

It's often said the devil is in the details, which is certainly true for patient safety. Losing sight of the small but ultimately crucial details will undo your efforts to care for our patients. Paying attention to them will make you the outstanding and respected caregiver you intend to be.

"Everyone here is fantastic at loving children and passionate about wanting to help them. But we're humans, carrying out high-stakes human processes every day," said Dr. Frank. "We have to remember to use that passion—minute by minute—to keep our attention laser-focused on doing what it takes to keep every one of our children safe."

*Names have been changed.