



# TIPS

Volume 2, Issue 3

Topics in Patient Safety

May/June 2002

## PSRS Roll Out Completed

VA and the National Aeronautics and Space Administration (NASA) have now rolled out the new Patient Safety Reporting System (PSRS) throughout all VA's hospitals. Developed in a partnership with NASA, PSRS is an independent and external reporting system that is complementary to VA's internal reporting system.

All facilities received PSRS display holders during the month of May that contained reporting forms and brochures; these are being posted throughout all VA hospitals. Facilities will also be receiving PSRS posters, a CD containing automated PowerPoint presentations on PSRS, and a ten-minute introductory videotape on PSRS. These materials were produced to help educate VA employees about PSRS.

The guiding principles of PSRS are voluntary participation, confidentiality of information submitted, and non-punitive reporting. "When individuals feel uncomfortable reporting to the internal systems, they have a safety valve they can use - PSRS," stated Dr. James Bagian,

Director of the VA National Center for Patient Safety. All a reporter needs to do is fill out the pre-addressed and postage-paid PSRS form and drop it in any mailbox. Reports submitted to PSRS are confidential and privileged quality assurance documents protected under the provisions of 38 USC 5705.

Currently, 100 VA facilities have received endorsements from their labor unions for PSRS. For facilities that have not received union endorse-

ment, the program is still available for all non-union employees.

Please note that PSRS is designed to identify system vulnerabilities, but not to provide detailed solutions for local facility adverse events and close calls. For more information about PSRS, please contact your facility Patient Safety Manager or PSRS directly at NASA/PSRS, P.O. Box 4, Moffet Field, CA 94035-9958 or visit their website at [psrs.arc.nasa.gov](http://psrs.arc.nasa.gov).

## Total Care Bed System Notice

On January 30, 2002, Hill-Rom issued a notice to 43 VA facilities that had purchased their Total Care Bed System beds between November 1, 1997 and October 5, 2001. In this notice Hill-Rom identifies two potential failure modes associated with the Total Care Bed System bedside rails. The first involves unintentional up or down movement of the bed during cleaning if fluids enter the side rail and short circuit electrical components. The second failure mode may result in the bed not operating due to flexing of the P.C. board after repeated operation of the bed assembly.

As of May 13, 2002, all VA facilities known to have these beds have been contacted; a list of these VA facilities is posted on the NCPS intranet site (<http://vawww.ncps.med.va.gov>) along with a copy of the notice from Hill-Rom. If you have this equipment and have

not taken corrective action please follow the instructions in this notice.

### CPRS Patch Training Need

In April 2002 a new national patch (EAS\*1\*3) was released for the VistA Enrollment Application Systems (EAS) software. This enhancement generates letters to veterans at designated times prior to the expiration of their means test and prevents the scheduling of future appointments for patients without a current means test.

Concern was expressed by a Patient Safety Manager that a patient's immediate follow-up care could be delayed due to an

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# HFMEA™ Golden Nuggets

The following tips or “golden nuggets” have been put together from lessons learned during Healthcare Failure Mode Effect Analysis (HFMEA™) training sessions and by reviewing early HFMEA™ reports. NCPS believes conducting a proactive risk assessment is a worthwhile exercise and expenditure of staff time. NCPS has reviewed several RCAs on the problems surrounding timely administration of medications

when facilities have lost their BCMA capacity. When they had to actually implement their contingency plan, facilities found that their plans were inadequate and had not considered all failures. A thorough HFMEA™ can avoid these shortcomings.

- Think of failure **modes** as “what could go wrong” that would prevent the process or sub process step from being successfully completed.

- Think of the failure mode **cause** as “why” the failure mode would occur.
  - Present failure modes as a problem statement that needs to be corrected (e.g., inadequate printer power supply vs. utility failure.)
  - When doing the process flow diagram ensure the team is diagramming the process steps that **actually occur and not the ideal process**.
  - After the team develops the process diagram, have some team members visit the work area to observe staff performing the process to verify that their assumptions are correct.
  - Follow the numbering and lettering format for the process and sub process diagrams. This is essential to keep the team organized when they move on to identifying failure modes!
  - The goal of the performance measure is ensuring the timely administration of medication in the event of partial or complete failure of BCMA; make sure that your HFMEA™ addresses the vulnerabilities of your BCMA contingency plan.
  - Chronological event flow diagrams used in RCAs are different from process flow diagrams used in HFMEA™. Event diagrams are specific to what actually happened on the day of the event. Process diagrams depict the usual activities needed to complete the task(s).
  - In order for a failure mode or failure mode cause to be classified as “detectable” on the HFMEA™ Decision Tree, it must be so visible and obvious that it will be discovered **BEFORE** it interferes with completion of the task or activity.
  - As required on Table 19 for RCA
- continued on page 4*

## Facility Feedback

(Patient safety feedback from throughout the VHA. Please send any comments you'd like to share with us to [ncpstips@med.va.gov](mailto:ncpstips@med.va.gov).)

### TIPS Tips

We have come up with some great ideas for improving distribution of TIPS in our facility. We've added a question sheet that says “List three things you learned from reading this issue of TIPS” and put TIPS on the staff education page of our intranet site. We've also added TIPS, along with the questionnaire, to our monthly newsletter. Our staff sends a copy of the questions to me, the patient safety officer, and a copy to their TEMPO person to earn patient safety training credits by reading TIPS.

-- Judith O'Neal  
Reno VAMC

### Patient Safety Awareness Week

The nation's first Patient Safety Awareness Week was celebrated March 10-16, 2002. Northport VAMC staff, along with a host of other VA medical centers, held activities to celebrate this event.

Patient Safety Awareness Week activities at Northport included a

Patient Safety Health Fair highlighting VA and local safety projects, and a Safety Forum featuring a panel discussion on error disclosure.

Patient Safety Awareness Week was the idea of Ilene Corina, the founder and director of Persons United Limiting Substandards and Error in Health Care (PULSE) of New York, a national group devoted to improving patient safety. The State of New York issued a proclamation establishing Patient Safety Awareness Week, and the Week was also endorsed by the VA National Center for Patient Safety and the National Patient Safety Foundation.

Don't forget to set aside the date for the next Patient Safety Awareness Week -- March 9-15, 2003. We are already beginning plans on our activities for next year's event.

-- Mark Graber, M.D.  
Northport VAMC

*(NCPS Note: Planning any special activities for next year's Patient Safety Awareness Week? Please drop us a line at [ncpstips@med.va.gov](mailto:ncpstips@med.va.gov) so we can highlight in future issues of TIPS how facilities will be celebrating this event.)*

# SAFETY SPOTLIGHT

(On a regular basis we feature teaching examples pulled from medical literature and similar RCAs that we feel are applicable and of interest to the entire VHA health care system. The following represents information taken from an aggregate of RCAs; it is presented to spark discussion and does not represent NCPS policy. Depending on the specific circumstances at any given facility, there are various systems-level solutions that will be most appropriate.)

## Wrong Code Team Called Description

A patient who had recently had a knee replacement arrived for a scheduled rehabilitation session in Physical Therapy, which is located on the fourth floor of Bldg. D. Shortly after the session began the patient started complaining of shortness of breath. The patient then started feeling hot and started vomiting. The resident physician on call was summoned and requested that oxygen be administered, but the patient continued to deteriorate. The patient arrested and CPR was administered by ACLS protocol. At the same time, a call was placed to the VA police stating there was a code in Physical Therapy. For code calls, all areas of Bldg. D are covered by the community ambulance except for Physical Therapy, which is covered by the code team. The police officer hearing the request, who was trained in arrest team procedure but was new and had no previous experience in handling code calls, called the

community ambulance team instead of the hospital code team. During this time, there was difficulty with completely inflating the reservoir of the manual resuscitation bag with oxygen because the regulator did not go past 8 liters per minute. Use of an oxygen tank with a flowmeter that delivered 15 liters per minute of oxygen solved this problem.

The community ambulance EMTs arrived on the scene and assisted, but the staff at the scene still requested that the hospital code team be called. It was decided to continue CPR and transport the patient to the Cardiac Care Unit on the fifth floor. The hospital code team met the patient while in transport to CCU. The operator of the surgical elevator was called but did not respond, so the patient was taken on the freight elevator. The freight elevator malfunctioned, going up a few floors, and then descended back down to the fourth floor. The team and patient got off on the fourth floor and found the surgical elevator operator who took the group and patient to the fifth floor CCU. The patient went into cardiac standstill shortly upon arrival in CCU and expired.

## Identified Vulnerabilities

The following vulnerabilities and systems weaknesses are identified:

- The procedure for responding to codes in Bldg. D, along with VA police experience in notifying code teams, with the stress of a real emergency situation, led to the wrong code team being called.
- The flow rate on the oxygen regulator was not sufficient to inflate the reservoir on the manual resuscitation bag.

- The delay in locating the surgical elevator operator in conjunction with the malfunctioning freight elevator caused a critical delay in the patient arriving at the CCU.

## Actions Taken

In response to this case, the following actions were taken:

- A senior officer will always be assigned to the police station desk and Physical Therapy will place a test call quarterly to the police desk to check what code team the police would call.
- Crash carts will only have "Thorpe" regulators that can deliver more than 15 liters per minute of oxygen for use with the manual resuscitation bags.
- A second surgical elevator operator will be added to each shift and a new elevator repair contract will be initiated.

## NCPS Comments

*The RCA team might have also considered:*

- *Conducting drills with each police officer on summoning code teams to Bldg. D.*
- *Integrating code team response in Bldg. D by simplifying the process so that the internal team responds to all areas of the building would eliminate the vulnerability.*
- *Eliminating the need for a surgical elevator operator by updating equipment.*

*In summary, we would emphasize the importance of routine end-to-end tests and drills to make sure that published procedures and policies dealing with high risk events can be and are actually carried out as planned.*

## HFMEA™ Golden Nuggets

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- reports, a single individual should be identified as being responsible for follow up on the corrective actions identified on the HFMEA™ Worksheet.
- Use the most current version of the HFMEA™ Worksheet, visit [vaww.ncps.med.va.gov](http://vaww.ncps.med.va.gov) if you are unsure. The Worksheet was significantly modified from the one used during the original roll out of the program in August of 2001.
  - Some medical centers have found it effective to have more than a single representative from key disciplines on the team. This increases the chance that necessary disciplines will be represented at all meetings and that work can be completed in a timely fashion.
  - Remember to conduct the hazard analysis on the failure mode before identifying failure mode causes. This will prevent you wasting time

identifying and assessing causes that don't need to be addressed. Use the arrow on the Worksheet as your cognitive aid!

- Check the NCPS intranet (<http://vaww.ncps.med.va.gov>) or internet ([www.patientsafety.gov](http://www.patientsafety.gov)) as we periodically update the HFMEA™ training materials.



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## CPRS Patch

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expired means test. The delay could result from the inability to immediately schedule a follow-up appointment due to expired means test data. Selected individuals at the medical center, generally supervisory personnel, hold an EAS MTOVERRI DE security key that allows overriding this appointment block if required due to extraordinary circumstances.

Individuals at your facility responsible for scheduling appointments should receive training and know the identity of the supervisory staff capable of overriding this blocking function. For additional information on training materials visit the Enrollment Training Initiative web page at [vaww.vistau.med.va.gov/enrollment/default.htm](http://vaww.vistau.med.va.gov/enrollment/default.htm). We also recommend that a cognitive aid identifying individuals holding the security key be developed and made available to assist staff.

## Spring is a Good Time to Review Elopement Risks

In most parts of the country we are now welcoming spring. The leaves are on the trees and lilacs and tulips dot the landscape. People long to be outside enjoying the fresh air and feeling the warmth of the sun on their shoulders. This long awaited desire to be outdoors brings with it a heightened concern of patient elopements.

Patients are taken onto porches, into courtyards, and down walkways where they tour the grounds with volunteers and staff. But when patients are out of their familiar surroundings the stimulus of a different environment has the potential to create distractions for everyone. In the interest of patient safety, this is a good time to review the topic of missing patients and patient elopements.

Last year all VA hospitals received copies of the VHA Escape And Elopement Management flipbook, a tool to assist facilities in conducting elopement risk assessments. This book is helpful for risk assessments and identifying specific at-risk patient behaviors. It also provides corresponding activities and environmental enhancements that may mitigate escape elopement risk. To request additional copies of the flipbook, e-mail [NCPScognitiveaids@med.va.gov](mailto:NCPScognitiveaids@med.va.gov).