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Patient Safety Net

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University of Connecticut Health Center

September 2006 *263 Farmington Avenue, Farmington, Connecticut 06030-3806* ***Volume XII***

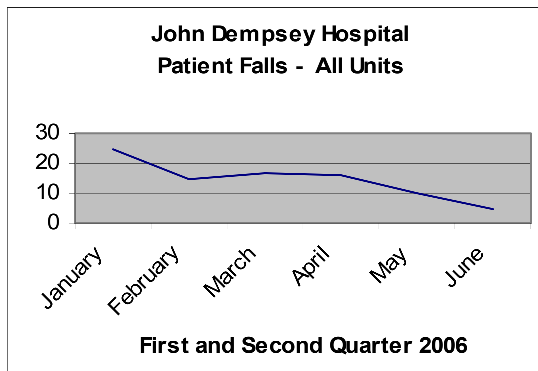
Collaborative Center for Clinical Care Improvement

Coming Soon to John Dempsey Hospital: University HealthSystem Consortium's "Patient Safety Net"®

What is Patient Safety Net®?
As part of our ongoing focus on patient safety and the best quality of care we provide at John Dempsey Hospital, we have obtained a license through UHC (University HealthSystem Consortium) to implement **"Patient Safety Net®("PSN"),** a web-based, real-time reporting tool.

How Will Patient Safety Net® Help Us?
This new system will allow for easy reporting of adverse events, near misses and unsafe conditions that involve patients. Reviewing these issues helps us to identify ways to prevent errors from occurring.

- We will be able to compare our data based on the reports generated with other organizations to identify areas of concern.
- Since our goal is to be the safest hospital in the State of Connecticut, this will help us track our progress.



An example of the type of data that PSN will help us track.

Why Do We Need PSN?
Our current system for reporting adverse events is using the "Risk Identification Report" (RIR) forms. The data from the forms has to be entered and reports generated. This takes time. With PSN, the reports will be available immediately. Managers will be able to modify or add information on factors contributing to the event. The system will be able to immediately generate reports on all pending and submitted events in various formats (i.e., tables or graphs). Most clinical areas will able to use this web-based tool; some areas will still have to submit adverse events on the RIR forms.

When will PSN be Fully Implemented?
We expect the new system to be fully operational by November 1, 2006.

What is the Next Step?
Training sessions for all appropriate staff have been scheduled for October 25-26, 2006. UHC staff will be on-site to provide training as part of our license agreement. Unit managers and their designees will be trained first.

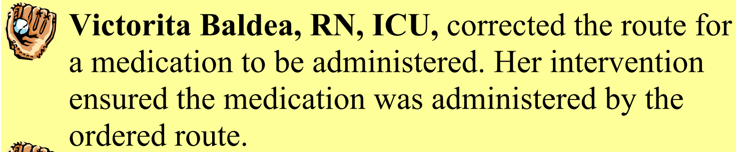
"The new Patient Safety Net® system will significantly decrease the number of patient care areas that use the paper "RIR" (Risk Identification Report) forms to report adverse events."

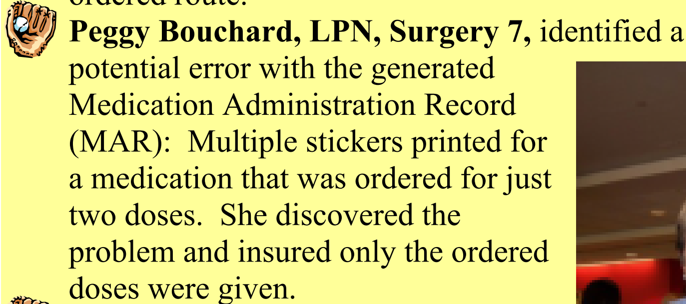
Rhea Sanford, RN, Ph.D.
Co-Director, C4I

The Collaborative Center for Clinical Care Improvement ("C4I") is dedicated to making John Dempsey Hospital the safest hospital in the State of Connecticut. We'd like your feedback and comments! Call us at Ext. 7650
James O. Menzoian, MD and **Rhea Sanford, RN, PhD, CS**—Co-Directors

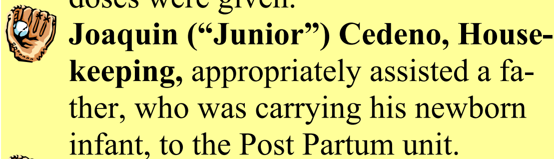
September 19, 2006
18 New "Good Catch" Award Recipients

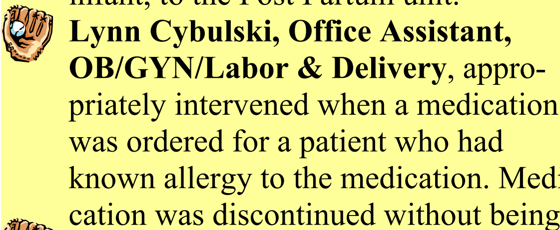
We thank the following individuals for their "Good Catches" and dedication to patient safety!

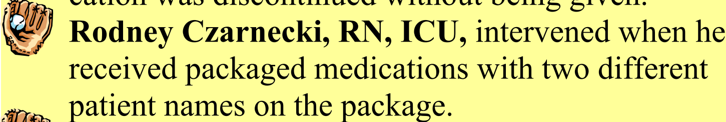

Victorita Baldea, RN, ICU, corrected the route for a medication to be administered. Her intervention ensured the medication was administered by the ordered route.

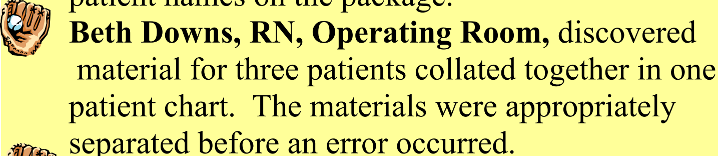

Peggy Bouchard, LPN, Surgery 7, identified a potential error with the generated Medication Administration Record (MAR): Multiple stickers printed for a medication that was ordered for just two doses. She discovered the problem and insured only the ordered doses were given.

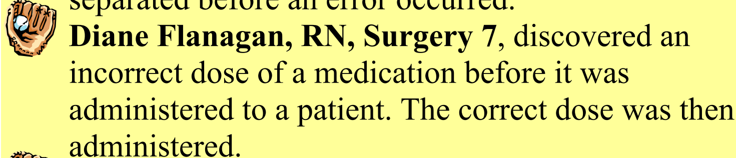
Ellen Oliver, RN

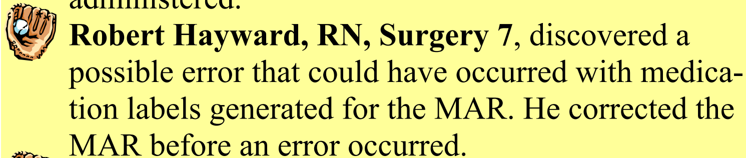

Joaquin ("Junior") Cedeno, Housekeeping, appropriately assisted a father, who was carrying his newborn infant, to the Post Partum unit.

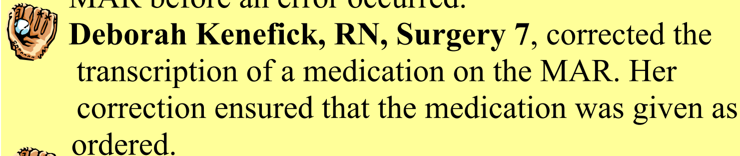

Lynn Cybulski, Office Assistant, OB/GYN/Labor & Delivery, appropriately intervened when a medication was ordered for a patient who had known allergy to the medication. Medication was discontinued without being given.

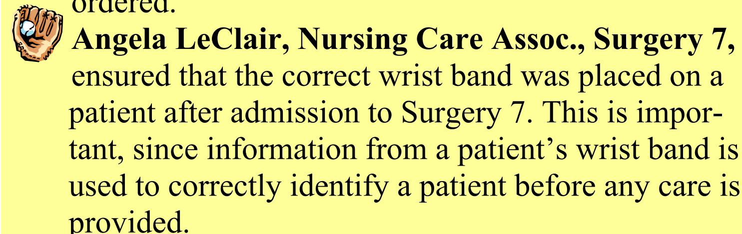

Rodney Czarnecki, RN, ICU, intervened when he received packaged medications with two different patient names on the package.

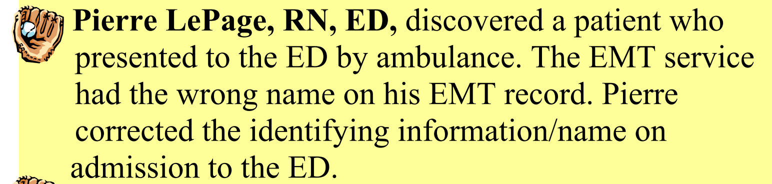

Beth Downs, RN, Operating Room, discovered material for three patients collated together in one patient chart. The materials were appropriately separated before an error occurred.

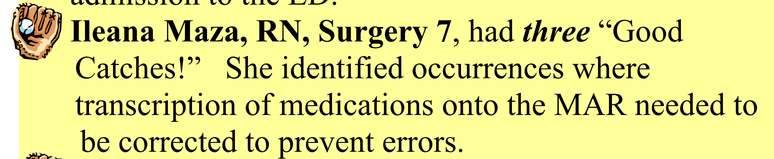

Diane Flanagan, RN, Surgery 7, discovered an incorrect dose of a medication before it was administered to a patient. The correct dose was then administered.

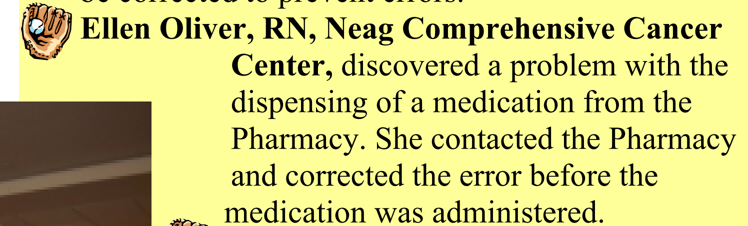

Robert Hayward, RN, Surgery 7, discovered a possible error that could have occurred with medication labels generated for the MAR. He corrected the MAR before an error occurred.

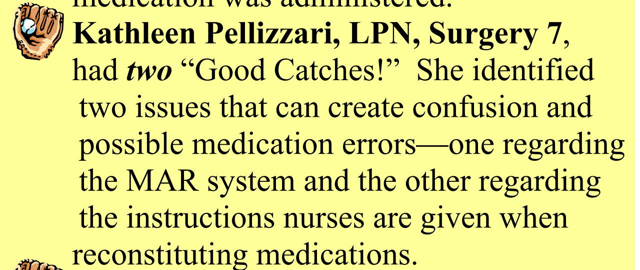

Deborah Kenefick, RN, Surgery 7, corrected the transcription of a medication on the MAR. Her correction ensured that the medication was given as ordered.

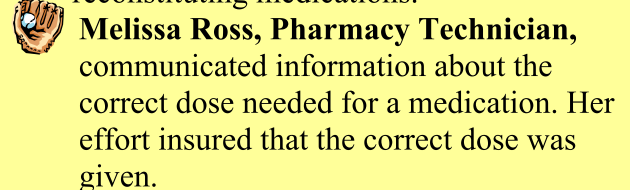

Angela LeClair, Nursing Care Assoc., Surgery 7, ensured that the correct wrist band was placed on a patient after admission to Surgery 7. This is important, since information from a patient's wrist band is used to correctly identify a patient before any care is provided.

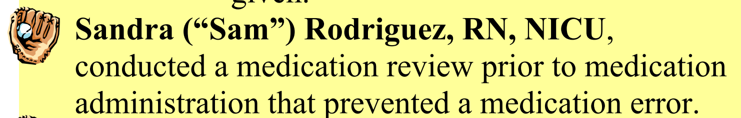

Pierre LePage, RN, ED, discovered a patient who presented to the ED by ambulance. The EMT service had the wrong name on his EMT record. Pierre corrected the identifying information/name on admission to the ED.

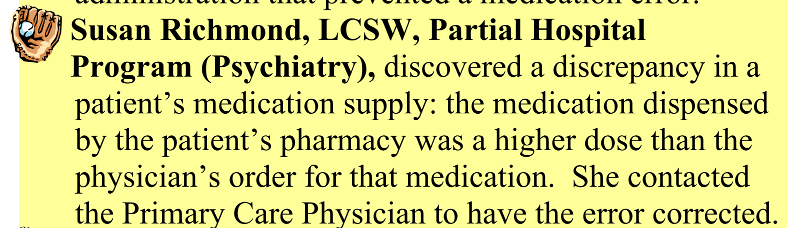

Ileana Maza, RN, Surgery 7, had ***three*** "Good Catches!" She identified occurrences where transcription of medications onto the MAR needed to be corrected to prevent errors.

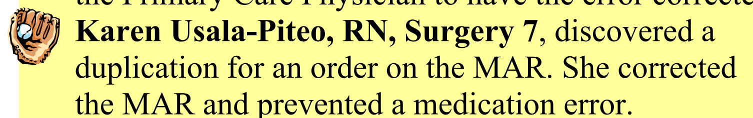

Ellen Oliver, RN, Neag Comprehensive Cancer Center, discovered a problem with the dispensing of a medication from the Pharmacy. She contacted the Pharmacy and corrected the error before the medication was administered.


Kathleen Pellizzari, LPN, Surgery 7, had ***two*** "Good Catches!" She identified two issues that can create confusion and possible medication errors—one regarding the MAR system and the other regarding the instructions nurses are given when reconstituting medications.


Melissa Ross, Pharmacy Technician, communicated information about the correct dose needed for a medication. Her effort insured that the correct dose was given.


Sandra ("Sam") Rodriguez, RN, NICU, conducted a medication review prior to medication administration that prevented a medication error.


Susan Richmond, LCSW, Partial Hospital Program (Psychiatry), discovered a discrepancy in a patient's medication supply: the medication dispensed by the patient's pharmacy was a higher dose than the physician's order for that medication. She contacted the Primary Care Physician to have the error corrected.


Karen Usala-Piteo, RN, Surgery 7, discovered a duplication for an order on the MAR. She corrected the MAR and prevented a medication error.

Brand New: "Patient Safety Alert"

The C4I Medication Safety Committee is pleased to announce a new process for submission of patient safety concerns that staff feel need to be shared with other units/departments.
Please send any such concerns to the following e-mail address in the Global listing:

"Patient Safety Alert"
(patientsafetyalert@exchange.uchc.edu)

C4I will make sure that the information is shared appropriately.