Denver Health Safety Intelligence (SI) Reports

What to Report, Resident Report Examples

What to Report

Incidents related to administrative issues or planning:

- Incorrect agreements and/or conventions
- Mix-up of patient data in medical records
- Lack of a resuscitation statement or referral in place

Incidents related to patient examination:

- Delayed/incorrect examination results
- Incorrect examination application
- Digression from protocols and working agreements

Incidents related to the treatment of the patient:

- Contracting an infection
- Fall incident, e.g. because the patient falls out of bed or is not mobile enough for a toilet visit
- Wrong diagnosis and/or incorrect treatment plan

Incidents related to the dispense of medication:

- The wrong dose of prescription indicated
- Wrong medication supplied
- Incomplete or incorrect medication handoffs

Incidents related to internal communication:

- Communication issues regarding the intake, transfer, and discharge of a patient
- Miscommunication or misunderstanding of orders

Incidents related to healthcare workers:

- Needle, cutting, and splashing incidents
- Aggression by patients or their families

SI Resident Report Examples

1. Report: We were using a Standburger Bipolar Cautery device during this septoplasty when we noticed the suction was not working. When we looked at the suction, there appeared to be leftover tissue from another case. We immediately stopped using the device.
2. Report: Xxxx is a 16 yo pregnant woman who went to an appointment on 7/28 and had a urinalysis that was positive for nitrites and leuks. This was not sent for culture and I do not see that she was treated. She then was admitted to the PICU on 7/30 with urosepsis 2/2 pyelonephritis.
3. Report: Patient had urine tests (urine electrolytes and UA) ordered ~06:30 while the pt was in a procedure. All orders were held in the MAR after the procedure. All orders were transferred and unheld when the pt arrived back on the floor. The team was able to see the urine tests in the orders section, but they were not showing up for the pt's bedside nurse. The team checked in as the patient's urine labs were not drawn by 1PM, and discovered the discrepancy between the physician and nurse view.
4. Report: Patient had potassium ordered and was NPO for procedure. Nurse sent secure chat to resident who was listed on AMION but was not working 7 hours later, the resident saw the message and forwarded to the resident working. The patient had not been given the potassium yet because no one had responded to the nurse.
    a. Reporter Comments: There needs to be a more standardized way to see who is the first call for the patient. The resident who was working that day was signed into the patient's chart and had written his note the day prior. She had also signed the order. At UCH there is the option to sign into the patient as "first call" rather than just resident, which could have helped in this case. thanks!

5. Report: "Patient had urinary retention. Nursing staff could not bladder scan as there is no bladder scanner in the ED Patient was not catheterized for ~8 hours with 900cc UOP".
    a. Reporter Comments: It would help to have a bladder scanner in the ED
6. Report: Pt had CT abdomen done showing interval development of possible colonic perforation with recommendation of "Prompt surgical consultation is strongly advised." This was not called out to me. The image was read at 1930. The day resident who was looking at the patient's chart from home saw the result around 2200 and notified me of the need to consult surgery. The patient had no change in clinical status/no acute abdomen. Surgery was consulted and did not recommend urgent intervention.
    a. Reporter comment: process for calling out urgent recommendations to covering providers should be implemented.
7. Report: Multiple lab orders were placed for serial (q30 min to 1 hr) serum and urine electrolytes for water deprivation test requiring close laboratory monitoring. Labs were discontinued by "lab user" repeatedly due to duplication without any notification to ordering provider or RN, thus RN unable to print labels leading to delays in important laboratory results that could have compromised patient safety.
    a. Reporter comments: There should be a process for verifying if duplicate lab orders are intentional with provider prior to automatic deletion as they may be intentional and this could severely compromise patient care. If they are deleted, at a minimum the ordering provider should be notified of the change.
8. Report: Pt had a testicular ultrasound for a mass which was c/f malignancy. Followed up with radiology after the scan had not been read 1 week after the scan had been completed. The radiology resident reported that the images were not in the cue to be read but kindly read the images for me on the phone. This was then sent to an attending for an over-read but again did not make it into the right list so this was delayed until I called again to radiology to ask about when the read would be back. No harm came to the patient but it seems that this scan ended up in the wrong queue twice.
9. Report: On cross cover for the evening for Spruce, Aspen, and Juniper. Was reviewing new results flags for patients and discovered that a patient had a notification for a positive blood culture. Looking at the culture my name was listed for call back verification for the positive culture, however I never received a call, page, or secure chat for this.
10. Report: In the ED, RNs are able to do standing orders for over-the-counter medications such as Tylenol or ibuprofen however when it allows them to order this it is based on the patient's actual recorded weight rather than the ideal body weight. In this situation, patient's weight is very high for age (IBW for age at 50th percentile 20 kg, pt's actual weight is 63 kg) hence recorded weight-based dosing is likely inappropriate for this patient. In this case, there is no flag or warning for the RN hence she very appropriately ordered the 15 mg/kg dose but this ended up being probably too much (~900 mg) when taking the IBW into account. Is there a way to have EPIC flag this or do a hard stop to have a provider do a double check in cases like these?
11. Report: Patient 1 presented at the same time as another patient with the first name. The other patient (patient 2) did not show up for his visit. They were similar in age though had different birth days and last names. Patient 1 was checked in and roomed under the name and chart of patient 2. When I got to the patient, I asked a first name but did not use two identifiers. All orders, charting was done under patient 2's chart instead of patient 1's chart. Patient then went to the lab, and the lab caught the error because they used the proper 2 patient identifiers. The mistake was realized and all charting and orders were converted to the proper patient and deleted from the patient who did not show up to their visit. No harm was done to the patient other than needing to wait longer for his labs and paperwork.
    a. Reporter Comment: Everyone needs to do the two-patient identifier even if you think others have.