

Improved Instrument Identification with Enhanced Labeling

THF Quality and Patient Safety:
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Objectives

- Review SBAR associated with a near miss patient safety event
- Review enhanced labeling process that was used to improve instrument identification
- Review Error Prevention Tools used in this event that prevented patient harm
- Review process improvement strategies that assisted with the enhanced labeling process

(No conflict of interest)

SBAR – Labeling Process

S: Nurse identifies a labeling process concern

B: A nurse was assisting with a circumcision. The physician requested a particular clamp size (Gomco), and the nurse could not locate it initially. Upon further inspection using the Error Prevention Tool STAR (Stop, Think, Act, Review), the nurse realized the labels on the outside of the sterile packaging were incorrect. She retrieved the correct size and provided the physician with the correct clamp. After the procedure, she reviewed the other clamps and noted that many were mislabeled. She notified the Sterile Processing Department using the Error Prevention Tool CUS (I'm concerned, I'm uncomfortable, This is a safety issue) and sent the clamps to them. Then she reported her findings in the event reporting system.

A: The nurses prevented a delay in the infant's procedure and identified a process issue. Her report of this near miss in the event reporting system informed management of the process concerns and provided an opportunity for them to fix the issue before patient harm occurred.

R: The leaders from the Mother Baby Unit and the Sterile Processing Department collaborated to determine the best process to correctly and efficiently label the instruments for each circumcision set. Historically, they were labeled with a series of colorful stickers used on the circumcision sets for the size identification. However, those became sticky and would come off over time. The team implemented a new process to permanently etch the set to easily identify the correct equipment.

Error Prevention Tools

Self-Check using STAR

What it is and Why we do it:

Self-checking is a habit of the mind that keeps our attention on task. Self-checking prevents skill-based errors, those unintended slips and lapses when we perform well-known, familiar, routine acts we do on auto-pilot without even thinking.

How we do it:

Stop Pause for one or two seconds

Think About your actions

Act Perform the act

Review Check for right response

When we do it:

Conditions that increase the probability of errors when performing a familiar, routine task:

- Working under time pressure
- Doing multiple things at the same time
- Distractions
- Task complexity
- Interruptions
- Boredom
- Mental or physical exhaustion
- Disorientation

Speak Up Using CUS

What it is and Why we do it:

Patient safety is our first priority. We need to be aware of each others' work. We are all equals when it comes to patient safety and personal safety. If we observe a situation we believe compromises safety of a patient or employee, we have a responsibility to raise a concern.

How we do it:

Speaking up using CUS is a communication tool that can help us assert a concern in a non-threatening way.

CUS stands for:

- I'm Concerned
- I'm Uncomfortable
- This is a Safety Issue

When we do it:

When we need to assert a concern in a non-threatening way, to avoid coming on too strong when a simple question may work. CUS also helps escalate the concern if it is not addressed.

Process Improvement

- Gomcos have 4 different pieces that must be the same size
- SPD staff found it difficult to keep the correct size pieces together and visually identify the sizes on the instruments marked on the bells and bottom of the clamps
- SPD found that the taping process was not adequate to identify the correct size pieces and tape would inadvertently be placed wrong
- Leaders collaborated with a repair technician vendor that agreed to etch the size on each piece
- Technician scheduled time to be at the organization and remove the sets from the units at various intervals 1 of each size at a time, until all etching was complete
- Sets were then reprocessed and placed back into the nursery
- Staff and providers were educated on the new process to mitigate any further or future safety risk associated with wrong size procedural equipment and avoid any delays in care or treatment related to these instruments.

Gomco Images After Etching

Before



After

