The University of Missouri Health System is committed to improving patient safety. This commitment is integral in our mission to advance the health of all people and to pursue exceptional clinical service within an environment that fosters integrity, respect, trust, openness, fairness, quality performance, accountability and dedication to quality care for patients and their families. In doing so, University of Missouri Health Care is committed to the six columns of operational excellence: Quality, People, Service, Growth, Community and Finance.

Over the years patient safety has become a major focus and concern for all. This came to prominence in 1999 when the Institute of Medicine's (IOM's) report “TO Err is Human: Building a Safer Health System” was released. This report highlighted the risks of medical care in the United States and estimated that 44,000 to 98,000 deaths occurred each year due to medical errors. At UMHC we committed to improving our processes to ensure that safe and quality care is provided. One way we try to accomplish this is by ensuring that all staff are aware of the National Patient Safety Goals (NPSG) and understand the potential risk that they have with their patient population. In 2010 each monthly newsletter will focus on a NPSG creating greater awareness of potential risk and measures that can help minimize safety hazards.

### Understanding how errors can occur…

**Errors that can occur within the health system include:**

<table>
<thead>
<tr>
<th>Number</th>
<th>Error Type</th>
<th>Contributing factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Misunderstanding information</td>
<td>Poor documentation/communication</td>
</tr>
<tr>
<td>2.</td>
<td>Medication</td>
<td>Slips, lapses and knowledge errors which can be minimized by following the recommendations for medication prescribing and administration, following protocols and double checking doses</td>
</tr>
<tr>
<td>3.</td>
<td>Procedural</td>
<td>Insufficient preparation and supervision</td>
</tr>
<tr>
<td>4.</td>
<td>Specimen mislabeling</td>
<td>Not following the recommendation for specimen sampling and labeling</td>
</tr>
</tbody>
</table>

**Questions to consider…**

- What are the most common errors in your area?
- How are you reducing their occurrence?

### Lessons to learn about Communication…

Many mistakes are made when communication is not clear, particularly during the various handoffs that occur during patient transfers, patient rounding, when orders are given, and any time there are conversations with patients, families, or between staff.

**Don’t assume that the other person knows what you mean.**

**Tip:** Make sure your thoughts are clear when communicating with others and always verify communication you receive; don’t forget to write things down. Ask clarifying questions.
In 2010 we would like to highlight your unit. Please email examples of safety improvement projects from your unit, safety issues that you have identified in your area, and how you are reducing errors.

If you have any questions regarding a patient safety concern, just let us know!

Newsletter Contact: Laura Hirschinger, RN in Office of Clinical Effectiveness (OCE) (573) 884-2152 hirschingerl@health.missouri.edu.

Pharmacy Alert
Safe Practice for Phenergan
Submitted by Kelly Royston, RN, IV Therapy Safety SEAL

Promethazine (Phenergan) is a phenothiazine derivative that possesses histamine H1-blocking, anti-muscarinic, sedative, antimotion sickness, anti-emetic and anti-cholinergic effects. Use can result in severe tissue damage!

Phenergan should be administered cautiously to reduce the risk the following recommendations should be followed for intravenous (IV) administration:

- Maximum concentration should be no greater than 25 milligrams/milliliter, administration rate no greater than 25 mg per minute. At UMHC promethazine is administered in IV form that is mixed with 10mL of Normal Saline and is infused over 10 minutes.
- Administer ONLY through a large-bore vein preferably via a central venous access site. NEVER in a hand or wrist vein. Administer through a running IV line at a port furthest from the patient’s vein.
- Insure patency of site before administration.
- Instruct the patient to immediately report any burning or pain during or after injection and stop administration immediately.
- In pediatric patients (17 years and younger), it is recommended that the dose of promethazine be added to an equal volume of fluid and infused at a rate no greater than 25 milligrams/minute. Patients should be monitored for blood pressure changes.

(Reference: Micromedex)

“Hot Topic”
Risk factors that may cause an error to occur:

- Having many tasks to complete in a short time
- Being interrupted while concentrating on a task
- Complex patients requiring many activities e.g. many medications, procedures, interventions.
- Care by multiple clinical units
- Language barriers between staff and patients/family/caregivers
- Taking short cuts that have ‘worked before’ but lower the safety barrier

How to protect yourself……
Policy and rules are in place to help increase the detection of errors.

Fast Facts—Medication Safety

- Multiple dose containers are formulated for multiple content removals because they usually contain preservatives such as alcohol or sodium citrate.
- Discard the remaining contents 28 days after initial opening or entering (e.g., needle punctured) of the container.
- Record the date of entry AND the beyond-use date on the outside of the container.