

# RADIOLOGY

## Safety Update

The Radiology Safety Committee is proud to extend to the department of Radiology an update on various initiatives that seek to improve the quality of care and prospectively identify safety solutions in our department for our patients and our employees.

Millie Leblanc, Radiology Nurse Manager, heads the committee with membership including Karen Acerra, Kristien Bonagura, Stephen Brodette, Bill Burke, John Hergenrother, Sherry Piskadlo, Dr. James Rhea, Dr. Arthur Waltman, Janice Wright and Richard Ziegler.

### Education Boards

John Hergenrother, Operations Manager  
Nuclear Medicine/PET Imaging

The Radiology Safety Committee has developed an education board that will be displayed in all of the clinical areas within the department. The intention of the board is to provide ongoing information related to the safety of patients who are having diagnostic and interventional studies in the Radiology Department. The first subject for the displayed will be proper patient identification procedures highlighting the need for both verbal and visual identification. In the coming months other patient safety related issues will be presented on the education board for all staff to review. The Radiology Safety Committee would welcome your suggestions and ideas for future topics for the Education Board displays.

### Patient Identification is Priority #1

The Department of Radiology has made **Patient Identification** a number one priority! All patients are receiving an ID band, stamped with their blue card when they check in. Patients that forgot their blue card are to have their date of birth verified in IDX-Rad and an ID band hand written. Information included is the patient's name, medical record number (MRN) and date of birth (DOB). Technologists are required to perform both a verbal identification, by asking the patient's name and confirming their DOB, and visual identification by checking the patient ID bracelet for name, MRN and DOB. It is the mission of the Safety Committee and the Department of Radiology to have 100% compliance in patient identification throughout the department! No ID Bracelet = No Procedure.

### Patient Safety Update from Radiology Surveillance Round

Working with the Radiology Safety Committee, the Radiology Surveillance Rounds Committee is continually working on providing a safe and healthy environment in which potential hazards are eliminated for employees, patients, and visitors. Since the beginning of this fiscal year, the monthly inspections have identified 201 potential issues and resolved 176 issues; an 87% resolution rate.

Since the inception of the Radiology Safety Committee we have revised the Radiology Rounds Survey to include seven new audits. These new questions range from inspection of patient call lights in bathrooms to assuring the bedrails are secure on stretchers. These new inspections can only help in minimizing hazards for patients especially spills. "According to research obtained by JCAHO, patient falls are often cited as the second most-frequent cause of harm for patients, topped only by medication errors. Such research suggests that 2% to 4% of all patients fall, and between 2% -6% of those falls result in serious injury such as a fracture."

Minimizing obstacles and clutter near patient routes, improving lighting, being attentive to patient bedrail security are all parts of the Radiology Surveillance Committee. This is a great first step in minimizing the risk of patient falls.

## O.O.P.S. FORM

# Ongoing Operational Problems and Solutions

The Safety Committee and the Department of Radiology are fostering the concept of “blameless reporting.” This is an initiative to encourage all staff members to participate in increasing patient and employee safety within the Radiology Department. O.O.P.S forms are available in each area of Radiology. Any employee should feel comfortable in filling out this form to bring a potential safety issue to the attention of the Safety Committee. Please help us correct issues before they become a safety problem. Solutions to the identified problem are welcome also. If you identify a potential safety issue, fill out a form and submit it to your Operations Manager.

## SAFE HAND-OFF

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BETTER COMMUNICATION  
BETTER PATIENT CARE

*As most of you know, Radiology, in collaboration with Patient Care Services, is participating in the Safe Hand Off Program. Safe Hand Off is part of a series of initiatives being developed by the Safety in Motion committee to maintain better continuity of care, better communication of patient care issues and safer transport and patient flow.*

### What is the Safety in Motion committee?

Safety in Motion is an interdepartmental and interdisciplinary committee that has been working on issues of patient travel throughout the hospital, with a focus on keeping patients safe during the travel as well as when they are in a diagnostic or testing site.

### Why is Safe Hand Off important?

Safe Hand Off gives the testing and receiving sites across the hospital the “big picture” of each patient’s needs and history, allowing these sites to give the best possible care while the patients are in their departments. It also provides critical information about the patient that receiving sites may need within a standardized placement in the record.

*The information that we receive as a result of Safe Hand Off will help us to take better care of our patients and will help us to keep them safe while they travel.*

### How does Safe Hand Off work?

When a patient is being prepared to leave their floor, the following checks are done. The necessary allergy, precaution and safety stickers are on the outside of the patient chart. The life sustaining order sheet is directly inside the patient record for easy access. The patient’s ID band will be verified. The patient’s bedside chart, containing medication sheets and current vital sign sheets is also sent. Most importantly, the patient’s nurse is required to write a transfer note when the patient is leaving the floor. It is meant to include any information that the nurse feels is needed to care for the patient. The note can be very short for uncomplicated patients or longer for the more complex patients.

### What is the responsibility of the receiving site?

The receiving site is expected to review the nursing transfer note. Here in Radiology, there is one further step. The technologist or nurse who cared for the patient during their test or study is also expected to write a return transfer note when the patient is returning to their floor. The return note is meant to let the patient’s other caregivers know the test was completed or, if not, why. If a test cannot be completed a phone call to the primary nurse is required and needs to be documented.