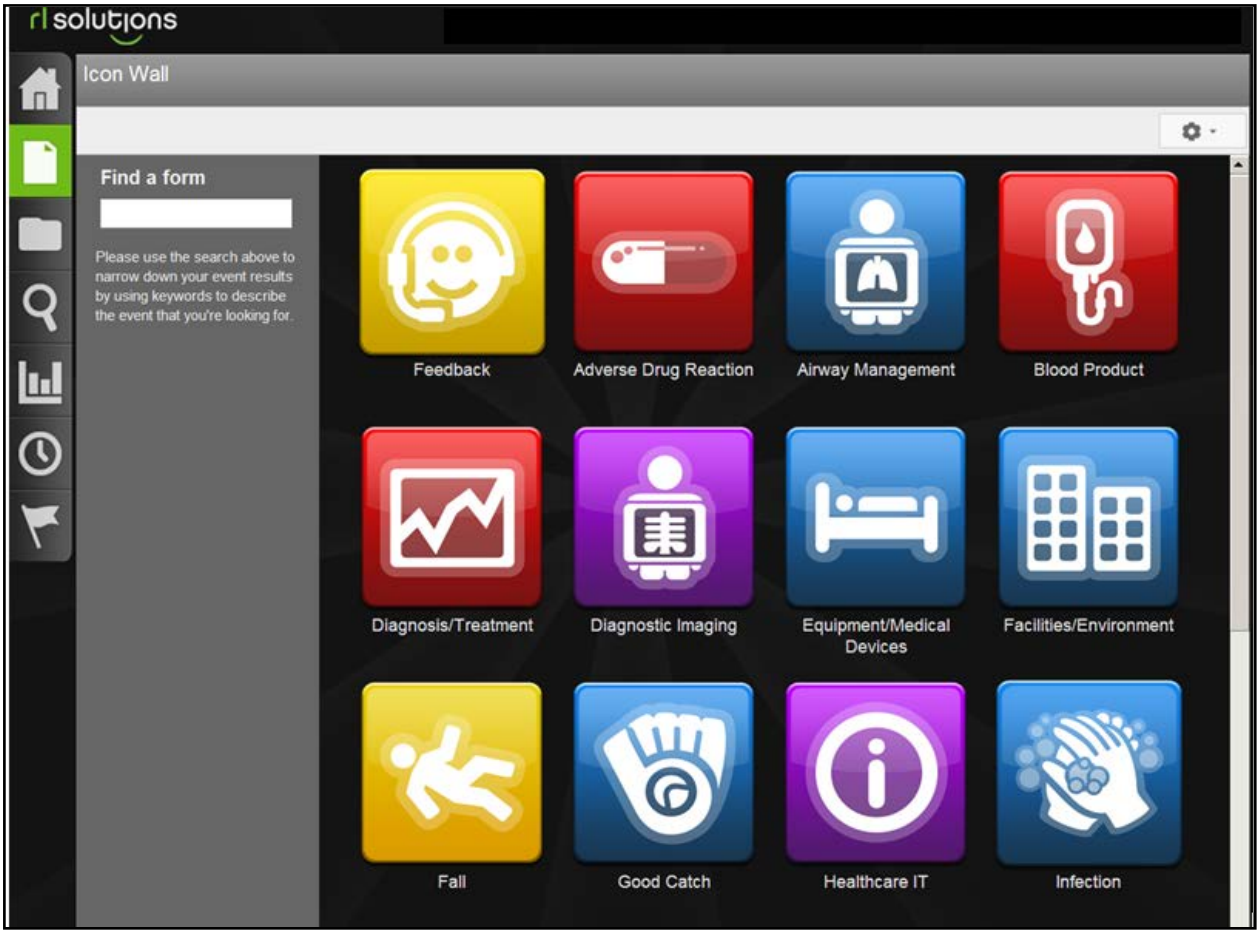
RL6 – Risk



Staff Reference Manual

WRHA Quality Improvement & Patient Safety
Version: 2, December 19, 2013

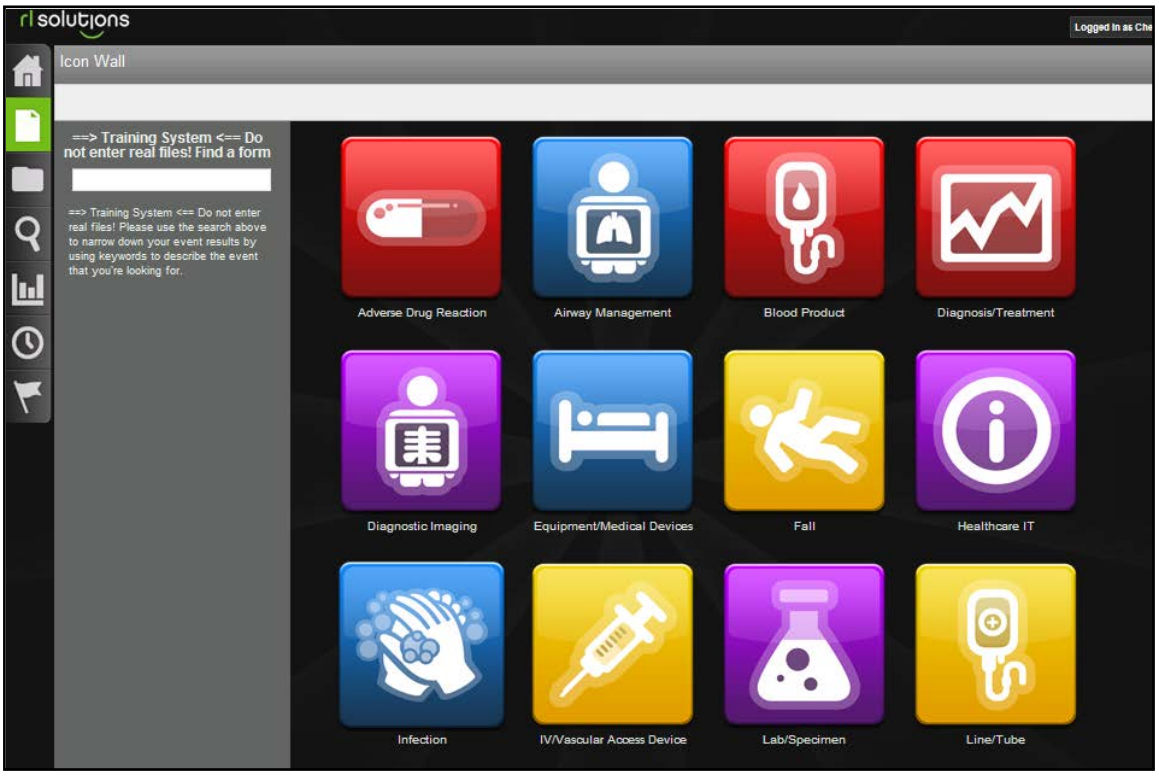
GETTING STARTED WITH RL6 RISK

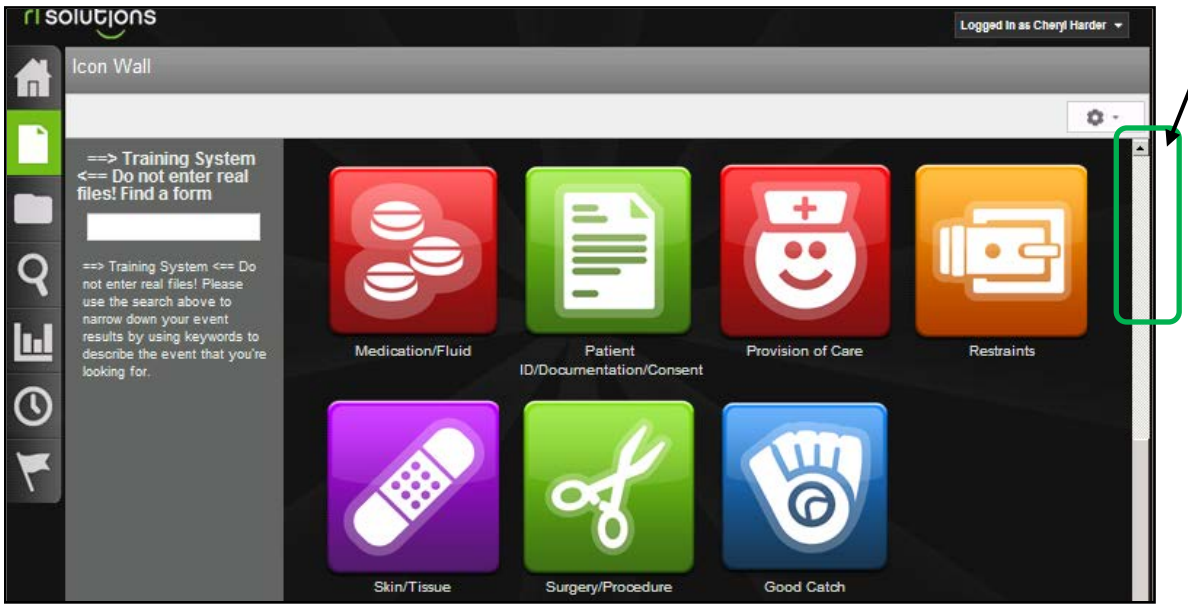
Logging In

1. Double-click on the **RL6** icon on the Desktop.

2. Double-click on the safety event type you want to report on from the **Icon Wall**.
   Hover over the Icons with your mouse to view a tip for the types of reports.

Icon Wall

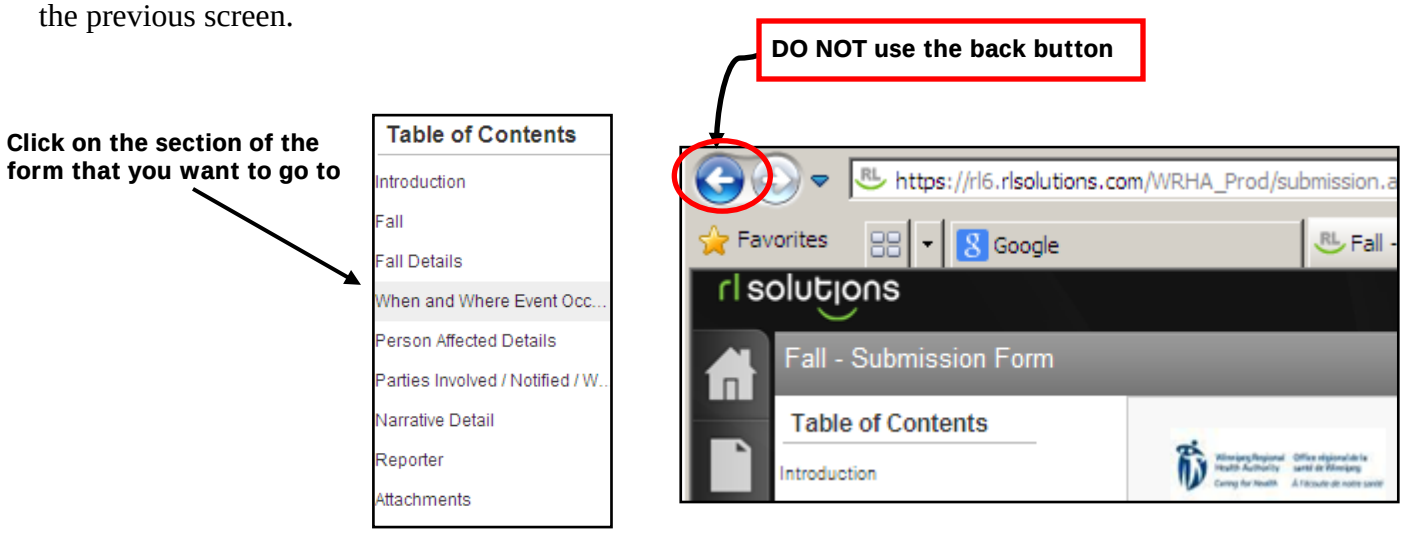


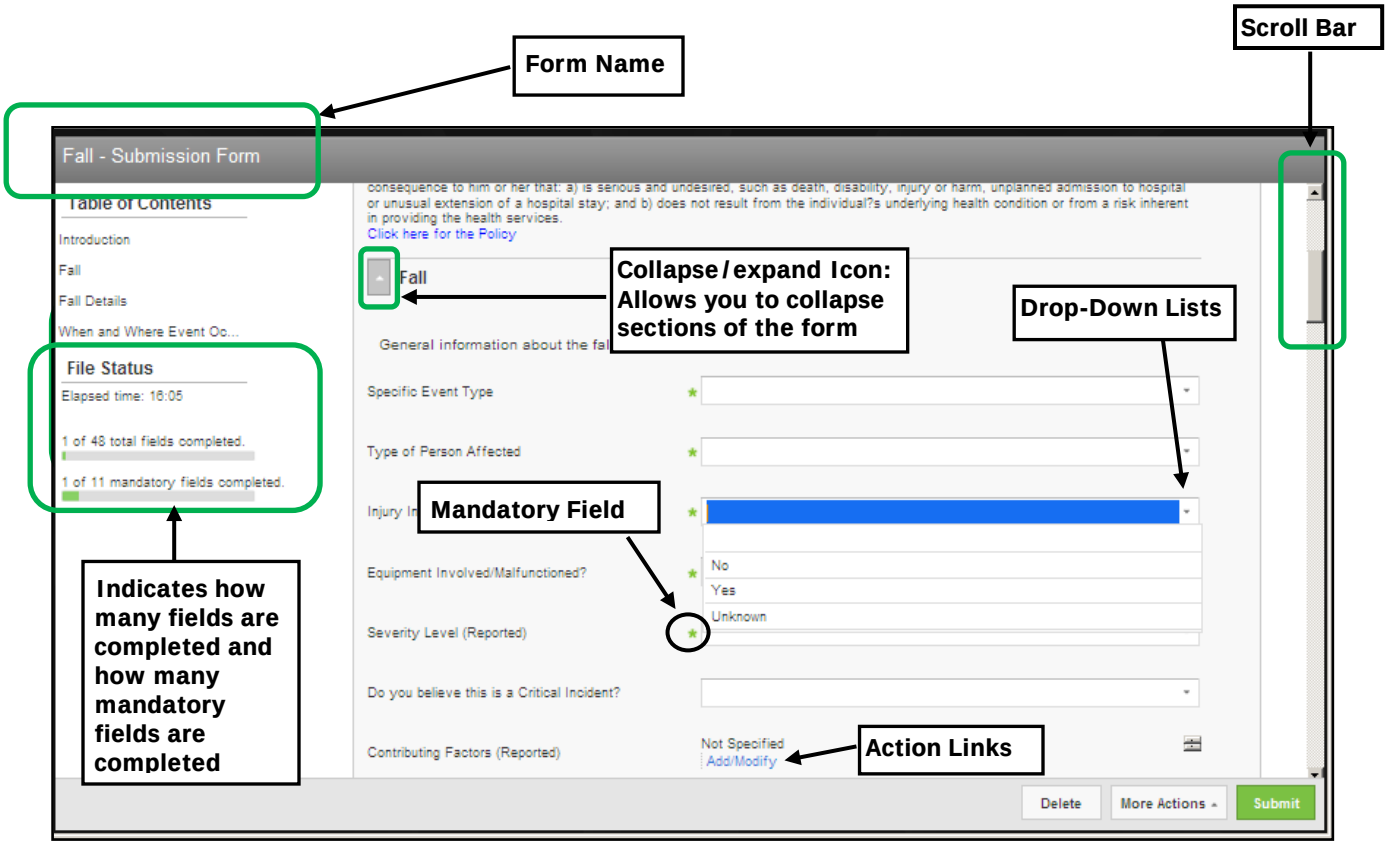


Use the scroll bar to move down to view more icons

NAVIGATING IN RL6

Use the left-side widgets to navigate within the event form. Do not use the **Back** button to go to the previous screen.





3. Complete the report ensuring all mandatory fields are entered (fields with a green *). Please provide as much information as possible in non-mandatory fields as well.

4. Click the Submit button.

   Once the report is submitted the file reference number appears on the screen. After the report is submitted you cannot add additional information to it. If you want to follow-up on the report or add additional information you can reference the file number with your manager.

What Next?

Once the form is submitted, the appropriate manager will be notified by email.

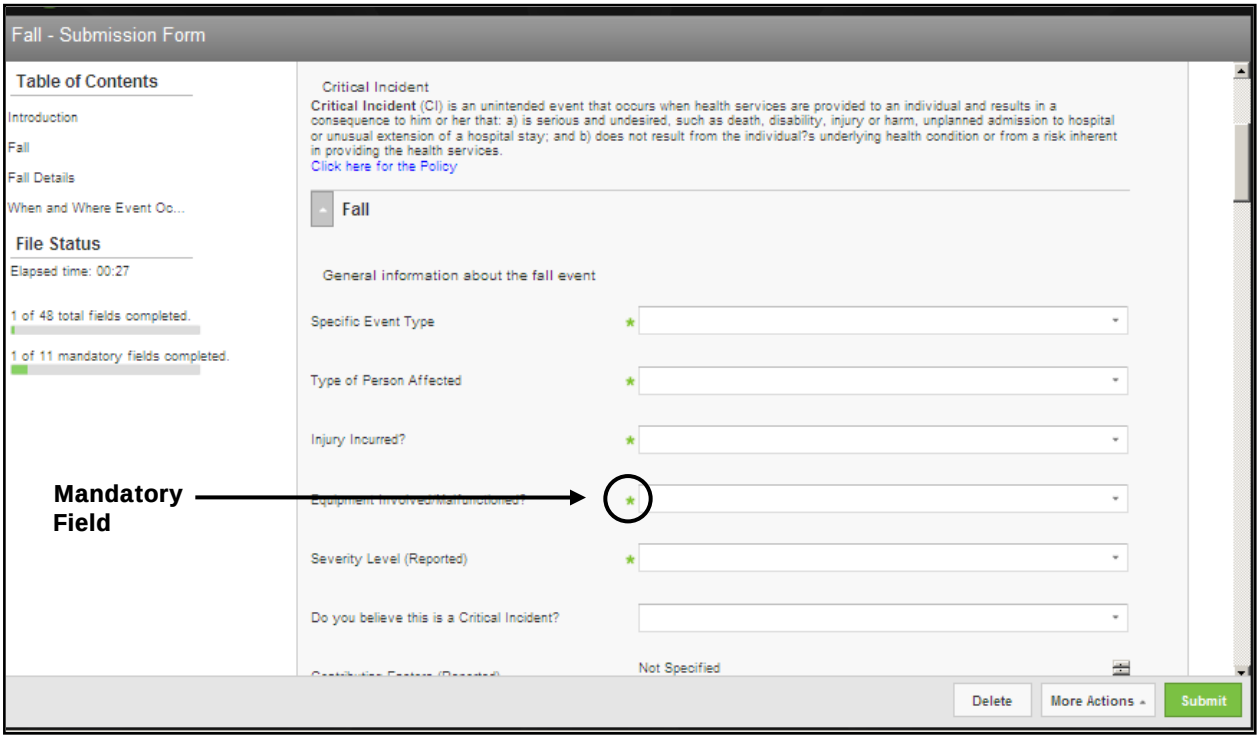
If you believe this was a critical incident, there is a section to declare that on the form. The submission will then be automatically sent to the WRHA Regional Intake Coordinator (not on-site management). This process does not replace established communication processes for CI's – please ensure you communicate incidents to your manager/patient care manager

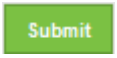
FALLS EVENT FORM

(Instructor Demo)

1. Double-click the **Fall**  icon on the *Icon Wall*.

2. Complete the *Fall-Submission Form* ensuring to fill in all mandatory fields.

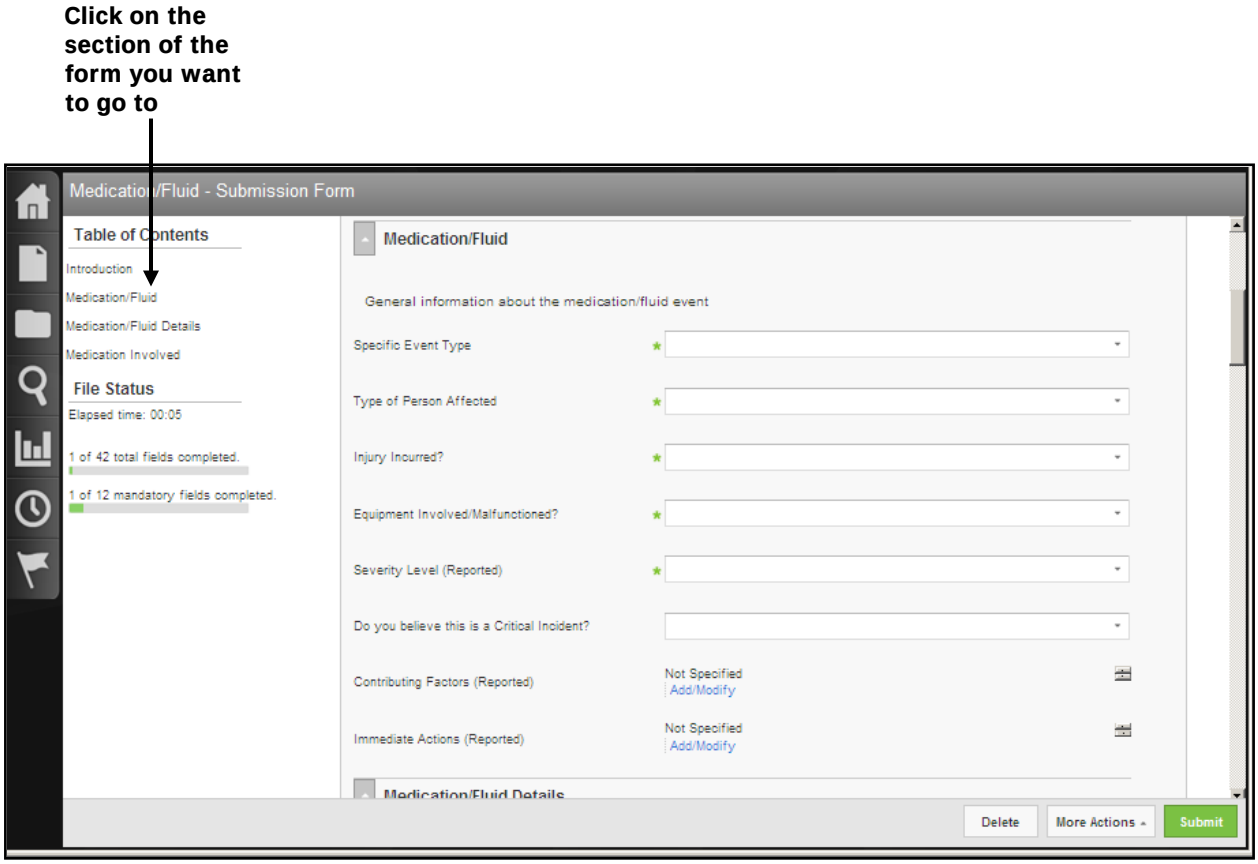


3. Click the  button.

MEDICATION/FLUID FORM

(Instructor & Class work through example together)

1. Double-click the **Medication/Fluid**  icon on the *Icon Wall*.



2. Complete the *Medication/Fluid – Submission Form* ensuring to fill in all mandatory fields.

3. Click the Submit button.

Case Study #1 - Fall

On February 1, 2013 at 2130, Fran Walker (in patient) born August 8, 1949, fell in her room from her bedside sleeping chair. This took place at Victoria General Hospital, Medicine, in Unit 5 South.

Her injury was moderate. She suffered a fractured left arm and bruising. Two hours prior to her fall she received sedation medication.

After the fall Fran, was seen by a doctor, and at the time her care plan was reviewed and revised. The standard of care code was met.

There were no witnesses to the fall. Fran was found approximately 10 min after she fell by Mark Jackson from housekeeping.

Fran uses a cane for mobility. Her last fall risk assessment was 22 hour prior to her fall with a score of 40. She doesn't need assistance rising from a chair and has no restraints in place. She has no history of falls in the last month. A bed alarm and call bell are in place for safety precautions.

1. Enter the event details in the appropriate submission form.

2. Submit the completed form.

Case Study #2 – Medication/Fluid Event

On March 14, 2013 at 1345, James Smith was administered metformin in the Emergency department. While being monitored, his blood sugar and blood pressure dropped. He required IV dextrose.

Mr. Smith's medications had been administered as per orders on the physician's order sheet. These were based on the patient's home meds. The wrong information was used and the patient received medication that was not his.

- The patient eventually recovered.
- Mr. Smith's date of birth is May 15, 1955.

Case Study #3 - IV/Vascular Access Device Event

On November 24, 2012 at 0745, Mary Dobbin was administered metformin in the Emergency.

The patient had an intravenous (IV) that went interstitial at 1600 hrs. The IV was infusing heparin. The IV was re-established in the right hand. At 0230 on November 24th, the patient got up and accidentally pulled out this IV. The IV was re-established in the left arm again. At 1330, the left arm was noted to be swollen with a lot of bruising from the top of her arm to her forearm. The patient was experiencing a great deal of pain and had decreased range of motion. The IV was stopped and re-established in the right arm. Compartment syndrome was ruled out.

- The patient has ongoing pain and a limited range of motion.
- Ms. Dobbin's date of birth is August 20, 1946.

Case Study #4 – Skin/Tissue Event

During the course of care the patient Michael Jones fell and fractured a hip, requiring uneventful surgery. On January 19, 2013 (6 days post surgery) bilateral black heel ulcers were noted on the patient's heels when the support stockings (TED) were removed during morning care. Skin care was immediately put into place and the change was not expected to delay discharge.

- The patient had a blackened heel. This was noticed during a bed bath. A wound care consult is pending. Heel boots are being applied.
- Mr. Jones' date of birth is November 2, 1933.