

# Room of Horrors



## 1<sup>st</sup> Resident or Patient on Entry to Room (with slippers)



- √ Dirty commode
- √ Needle in bed
- √ Urinal on table
- √ Epidural infusion running on a triple channel pump, which cannot be put into epidural personality. Risk is that general ward personality would allow too much volume to be accidentally infused if programmed wrong.
- √ Fentanyl dose in Epidural infusion is Excessive

- √ Epidural is running through the wrong IV line – should have No Ports to reduce chance of accidental IV infusion
- √ No ability to have the Colleague Guardian pump showing Epidural on the screen if you don't have a single channel pump set in Epidural personality

- √ IV Pole set too high
- √ No epidural label on tubing
- √ Height of bed too high
- √ Rate on pump is Too High – 50 ml per hour could never go through Epidural space. Maximum rate is 20 ml per hour
- √ Bedside table incorrect height (way too low)
- √ Dressing tray set up incorrectly
- √ Sterile gloves open and on pt bed
- √ NPO sign at head of bed (meal consumed, pt has sucker)
- √ Slider left under resident
- √ Slippers – improper footwear
- √ Walker too far away
- √ Dirty linen
- √ O2 tubing on commode
- √ Call bell cord across neck and safety-pinned to patient
- √ Meds on meal tray
- √ Bed rails are down

### Child in bed



- √ Mismatched wristband to name on chart
- √ Purse at bedside containing money and medication
- √ Epidural incorrectly connected to patient for IV administration
- √ Strength of Fentanyl too high
- √ Allergy record confusion (New chart has an allergy record on it which states “no allergies”, but no one has checked the old chart for an existing allergy record which states the pt is allergic to Penicillin)
- √ Sharp left on bedside
- √ Venous blood incorrectly collected for glucose testing

## OR Patient

- √ Wrong side surgery (left leg draped, consent form states right leg)
- √ Patient did not sign the consent form
- √ Formaldehyde spill on floor



## Medication Station

- √ Levothyroxin 150 mcg in same drawer as 88 mcg
- √ Quinine 200 mg and Quinidine 200 mg mixed in same drawer
- √ 6 meds in patient's purse only 3 home meds written on physician's order
- √ Losec 20.0 mg should be written as 20 mg (no trailing zeros allowed)
- √ The abbreviation *IU* is not allowed. The word *units* should be written out. (Refer to Lente insulin order)
- √ The abbreviation *SQ* is not allowed (The word 'subcutaneous' or 'subcut' should be written)
- √ The abbreviation 'Dig' should be written as 'Digoxin'
- √ Patient's name transcribed incorrectly from physician orders to Medication Administration Record (MAR)
- √ Losec incorrectly transcribed from the physician's order sheet to the MAR (200 mg recorded when order for 20 mg)
- √ Digoxin incorrectly transcribed (0.125 mg should be 0.25 mg)
- √ Furosemide 40 mg qid incorrectly transcribed as Q.O.D.
- √ *QOD* should be written as 'every other day'

### Sink Area

- √ Isolation sign (but no cart available)
- √ Empty paper towel holder
- √ Garbage overflowing
- √ Garbage contains confidential patient information
- √ Glue dropper left on sink following repairs to sink in pt room
- √ Container for dialysis solution filled with cleaning fluid and marker slash through label on bottle
- √ Garbage can and sharps container side by side

