January 2024

	Area- Topic	Observation	Negative Effect	Details
	Pre-operative Preparation	Pre-Op testing included nasal culture - Positive and placed on antibiotics for 5 days prior to the procedure. Also provided chlorhexidine bath for 5 day prior to the procedure including the morning of the procedure. I was provided chlorhexidine wipes in pre-op just prior to the procedure.	N/A	Good practice prior to surgery to prevent infection / MRSA. No preoperative warming performed which is standard in some facilities prior to surgery. One warm blanket prior to the procedure does not constitute pre-operative warming.
	Infecton Prevention	Drain to knee not secure post operatively	Operative day - Resulted in accidental disconnection when tubing got caught in the reclining chair- Tubing became disconnected - primary tubing from secondary tubing / Hemovac. 1st post op day accidently pulled entire drain out from wound. Tubing caught in reclining chair.	First time - Nurse notified- with gloved hands wiped the two connections with Alcohol and placed them back together again. Did not provide any way to secure the connection - The tubing did not come apart again during the hospital stay. I stood up from the chair on the first day post op and the tubing caught on the chair. I pulled the drain completed from the wound. It was almost time for the drain to be removed anyway.

	Bleeding from dressing	Blood emerged from dressing based on the fact that the hemovac was full and lost its ability to provide suction. The compression devices were then creating pressure and the blood had no where to go but out through the dressing. Once the vacuum was created- the bleeding stopped.	Caused the dressing to become saturated	Dressing was removed / reapplied. Secured by Ace Bandage. Intermittent Compression Devices were changed from Leg to foot. ***Sequential Compression Devices are superior to intermittent compression devices but may be more expensive.***
	Clot Prevention	I had to request compression devices	Increased chance of clots of compression device not used	I requested the devices and they were applied. No one actually checked to see if they were on or working following the initial application.
	Meal Service Program	System of ordering meal was not discussed or explained until 1st post op day.	Potential nutritional deficit	

	Quality of Educational Materials	Discharge information and list of Physical Therapy options were of poor quality.	Impression made on consumer regarding the quality of other components of the program	Information was legible but several of the copies had been over copies resulting in a less than quality outcome. The Orthopedic Joint Academy handout was well organized and presented well. The Home Care Orientation was also well organized and presented. List complied with JC requirement to provide a list of DME / Physical Therapy options to the patient which would allow the patient options.
	Hydration	Provided with one large cup of ice / water per shift.	Potential dehydration	Medium sized cup with lid and straw provided. No additional fluids offered or provided between shifts.
	Physical Therapy didn't respond to 1st Day Post-operative	It was near the end of the day when I was told that physical therapy would not see me but would see me on 1st day post op.	Potential inability to start physical activity	I was up ambulating to the bathroom and walking in the room hours after surgery. ***I was not affected by the lack of physical therapy the post op day. It may have affected others different.***

	Nurse involvement with technical issues did not allow focus on preventable issues like clots, pneumonia, ambulation, pulses, positioning, and medication timing.	My assigned nurse was always the charge nurse which meant that not only did she have responsibility for me but also other patients on the unit, including problem solving, and relief of other nursing personnel.	This additional responsibility prevented my focusing on other compontents of care. Her primary focus was specific to task. Giving medication, and asking questions that she needed to chart. Items to assess were overlooked regarding such things as pulses, chest sounds, ambulation, positioning, & medication timing	Nurse primary function of taking vital signs, and medication administration. The nurse apologized several times for the lateness of my antibiotic and blood thinner related to workload.
	Instructions regarding consumption of Dietary Supplement	No coordination of dietary supplement (2 / day) during hospitalization.	Planned additional nutrients may not have been supplied if I didn't provide my own.	Purchased and brought protein drinks to the hospital
	Walker	Was told to purchase walker prior to coming to the hospital and to bring the walker on the day of surgery	Physical Therapy brought a walker to the room for me to use. Confusion why I had two walkers.	We had an extra walker which caused some confusion with phyical therapy and the staff. PT finally took the other walk back (and I assumed credited me for the equipment.

	Incentive Spirometry ignored	No asssessment or encouragement to perform incentive spirometry	Potential pneumonia if not use immediately post op	I actually performed baseline and indicated the results in the paperwork provided. No one checked or encouraged me to perform procedure. Since I'm a respiratory therapist I knew the importance and consistently used it during the hospitalization and immediately when I got home for the first couple of days.
	Communication board / phone	Board was completed routinely however I was not instructed on how to contact my nurse other than to use the nurse call light on the TV remote.	Some delay in obtaining nurse at times because I was not aware of the system.	On the second day I found that I had a phone and then were able to contact my aid and nurse directly versus going through the TV Nurse Call system. It was faster and direct. I didn't have to rely on the person on the other line to contact my nurse and explain exactly what I needed.

	CPAP / BiPAP	I put the unit together and filled the unit with water.	Potential lack of rest / oxygenation post op because of the delay in initiating Bi-Pap	I just got back from surgery and really did not have the whereabouts to obtain the unit from my luggage and put it together. I could have used it immediately post-op. It would have been nice for RT to assist in putting it together and making it available to me to reduce my sleep apnea and improve my oxygenation.
	Hand Sanitizer while using urinal	Immediately post-op I stayed in bed but needed to use the urinal. I also used the urinal at night sometimes rather than getting up to the toilet. There was no way to sanitize my hands after I handle my urinal.	Unsanitary condition	Would have been nice to have a bottle of sanitizer at the bedside to assist in my basic hygiene.
	Pain Management	Staff used the 1-10 scale and were responsive to providing pain assessment and offering pain medication.	N/A	They asked during the sessions with vital signs and were responsive in getting me pain medication when asked.
	Technical Knowledge and Nurse Skills	I observed competency with every nurse and assistant. They all were preceived as knowing what they should know to be a outstanding nurse.	N/A	It's not that the nursing staff did not have the credentials or education - many of the staff were unable to provide anything extra because of their other assignments and obligations.