

Hospital Room of Horrors Assignment

Learning Objectives and Outcomes		
Area	Objective	Course Student Learning Outcome (CSLO'S)
Knowledge	Identify actual and potential safety risks at patient bedside environment.	CSLO 1, 2
Skills	Create safe patient bedside environment. Adhere to safety protocols. Implement standards of care for patient safety.	CSLO 5
Attitudes	Value own role in preventing injury/illness	CSLO 3

Instructions:

Silently review the patient environment and the scenario presented. You may walk around the bed and look at the patient, medication list, equipment, etc. You will have 15 minutes to complete this task. Identify as many safety risks in the patient environment as you can and document on this sheet within this chart. In the chart you will identify the safety risks, causes, prioritize them in order of greatest safety risk to minor safety risk, list the responsible party (delegation), and if you need to report the safety risk to another healthcare member. There will be an answer key and discussion when instructed by your instructor. Utilize critical reasoning skills to discuss potential risks that may not be as obvious as actual risks.

Safety Risk	Causes	Priority	Responsible Party (delegation)	Do you need to report to a member of the healthcare team (inter-professional collaboration)
Oxygen cords are wrapped around clients neck. With addition to the prongs not being in the patient's nostrils.	Patient could have moved around in bed and found themselves tangled in the oxygen cords.	This is at number one because it is putting the patient's airway at risk. Remember ABC's.	Patient	Yes the charge nurse should be aware of this because this was a severe endangerment to the client.
An uncapped needle was left out on the bedside table.	Nurse forgot to cap the needle after injection and put the needle in the sharps container.	This is number two because an uncapped needle can be a danger to anyone who walks into the room. A nurse, CAN, doctor, patient, patient visitors. Any one of these people could have been stuck by the needle.	Nurse	Yes this needs to be reported especially if someone got stuck by this uncapped needle.

<p>Open medications were left unattended.</p>	<p>The nurse could have forgotten one of the patient's medications. The nurse went back to get it but left the medications unattended, or those could be another patient's medications, and the nurse forgot to take them.</p>	<p>This is at number three because as a nurse medication should never be left unattended with the patient. The nurse should watch the patient take their medications.</p>	<p>Nurse</p>	<p>Yes this should be reported because all nurses should know that medications should not be let unattended, Especially if this client were to take these medications and they were the wrong ones.</p>
<p>Name on band does not match the white board.</p>	<p>Healthcare team members who wrote on the board wrote the wrong name, or the patient in the bed is supposed to be in a different room.</p>	<p>This is number four because this is an easy way for medication errors to happen, and giving the wrong medication to a patient can create severe adverse reactions.</p>	<p>Nurse/CNA/ Support member</p>	<p>Only should be reported if wrong medications were given to the patient because of this board. If not then erase but the correct name. Verify the correct patient.</p>
<p>Urinary catheter was pulled out and the bag was touching the floor.</p>	<p>Patient could have pulled catheter out.</p>	<p>This is number five because of the infection that could occur.</p>	<p>Patient</p>	<p>If the client pulled the catheter out the nurse should let the doctor know so the doctor can put in a new order for a catheter.</p>
<p>IV catheter was tapped on top of patient's hand not inserted.</p>	<p>The Healthcare member who was in charge of IV insertion did not insert the needle into</p>	<p>This is six because without the insertion of the IV we can not deliver fluids or</p>	<p>Nurse</p>	<p>Yes this should be reported because the nurse trying to insert the catheter did not</p>

	the skin.	medications.		know what they were doing.
IV cartilage was not inserted into the IV pump. The port was not attached to the catheter either.	The healthcare member did not run the line through and lock the cartilage. No fluids were being run, and if they were the fluids would be everywhere because the port was not connected to the catheter.	This is seven because without the pump correctly working and the port attached to the IV catheter the patient is not receiving their prescribed medications or fluids prescribed by the doctor.	Nurse	I don't think this one needs to be reported just fixed immediately, so that the patient's fluids or medications can run.
Bed was not locked.	When the bed was moved back into the room, they forgot to lock the wheels.	This is number eight because regardless of the height of the bed when the patient goes to get out of bed the bed will move on them.	Whoever moved the bed last	This does not need to be reported just lock the bed wheels. It does need to be reported if the patient falls because of the unlocked wheels.
Bed was not in lowest position.	After giving care the nurse or CNA forgot to lower the bed to the lowest level.	This is number nine because this is a fall risk for the patient when the bed is not all the way lowered.	CNA/Nurse who ever gave care to the client last. The patient could have pressed the raise button on the side bed controller.	Only needs to be reported if the patient falls. If not just lower the bed into the lowest position if seen it is not.
Clean sheets just laying down at the end of the bed.	The nurse or CNA forgot to change the clients dirty sheets.	This is number ten because it puts the patient at list risk, but still, it is a sanitary issue; clean sheets should be put on the bed, and	CNA/Nurse	This does not need to be report just the nurse or CNA needs to change the sheets.

		old ones should be taken off.		

Reflective Activity

What are the major take-home lessons for you today?

My major take-home lesson is that safety risks will and do occur in hospitals. Significant to minor errors such as sanitary issues, some not intentional, but most are accidental. As a nurse, I need to be aware of these safety risks and look out for them. I also need to know what safety risks I can cause and how to avoid safety risks when giving care to clients. I learned that anyone and everyone could be at fault for safety risks; even the own patient can put themselves in harm. I learned how to identify safety risks more efficiently and faster than before.

How did this experience change your view of preventing risks?

This experience changed my views tremendously. After seeing the hospital room of horror has made me more aware of looking for safety risks. When I am in a room, I am always looking for safety risks not to report but so that the patient or anyone else who walks into that room is safe. It has made me more aware of double-checking everything I do not to create a safety risk. Everything that I do, I am more aware of making sure there is no safety risk. After giving a Lovenox shot, I retract the needle right away and put it in the sharps container. After I give someone a bed bath, I lower the bed right away. This experience has opened my eyes more to not creating or looking out for safety risks.

(Grading Criteria)

Points	If...
5	The student found all 10 actual safety risks in addition to identifying potential safety risks in the patient environment.
4	The student found all 10 actual safety risks but did not identify any potential safety risks in the patient environment.
3	The student found 7-9 actual safety risks and/or potential safety risks in the patient environment.
2	The student found 4-6 actual safety risks and/or potential safety risks in the patient environment.
1	The student found 1-3 actual safety risks and/or potential safety risks in the patient environment.
0	The student did not find any safety risks in the patient environment.

Prioritization/Delegation/Communication Chart

__ Points out of 5 Total

Reflective Essay

__ Points out of 5 Total

Debriefing

Did student actively participate in debriefing by reflecting and discussing experience?

Yes: 5 points

No: 0 points

TOTAL POINTS

20

Hospital Room of Horrors: Post Exercise Evaluation (Likert scale 1-5, least to most)

- 1) I feel prepared to diligently watch for patient's safety and quality of care.
1 2 3 4 **5**

- 2) I have improved in my ability to synthesize nursing theory and content to the clinical setting as a result of the "Safety Day Simulation" exercise.
1 2 3 4 **5**

- 3) Debriefing with faculty provided an opportunity to self -reflect, which improved my knowledge, skills, and attitude/confidence.
1 2 3 4 **5**

- 4) Faculty was prepared and facilitated enhanced learning during the debriefing period
1 2 3 4 **5**

- 5) I recommend the continuation of "Safety Day Simulation" and feel it is a valued learning experience.

1 2 3 4 5

Suggestions:
