What You Need to Know

Our quarterly special editions feature articles, stories, interviews, and more from our journal, Patient Safety. In this issue you will find out how one patient learned the importance of speaking up for her own health, follow a mother’s painful journey from losing a child to becoming a patient safety advocate, and read evidence-based research and data analyses that will help you prevent harm and improve patient safety.

I Am the Zebra

“It’s probably just in your head.” That’s essentially what one physician told Missy Adams when she sought a diagnosis for her almost-daily, excruciating stomachaches. He told her to see a psychiatrist. Another doctor suggested removing her gallbladder, but that didn’t help. After five years of visiting multiple experts and undergoing numerous tests and diagnostic procedures, while the symptoms and pain only grew worse—often leaving her curled up crying on the floor for hours—Missy finally found out what was wrong. It wasn’t her imagination. It was cancer. Missy and her husband, Solomon Adams, share their long, difficult journey in search of a correct diagnosis and beyond, to treatment, recovery, and ongoing support—highlighting the importance of being your own healthcare advocate. “If I wouldn’t fight for someone to keep listening to me and tell me truly what to do,” Missy says, “then no one would.”
Perspectives — Self-Directed Death by ESRD Patients

One morning in 1989, when Tony Salvatore arrived at a hemodialysis center for a business meeting with clinical staff, he found them in tears; one of their long-term patients had committed suicide at home the night before. Salvatore learned that while patients in dialysis did not commit suicide often, most centers had experienced it, and this knowledge launched him on a path of understanding and preventing such deaths. Here, he explains the differences between suicide, assisted suicide, and voluntary termination of hemodialysis, and provides some useful information and crisis intervention and suicide prevention strategies related to patients with end-stage renal disease (ESRD).

264 Hours

James Matthew Mannix was born on October 2, 2001. By October 13, he was gone. While the country was still reeling from 9/11, Mary Ellen Mannix and her family were struggling with a life-shattering crisis of their own. James was diagnosed with a congenital heart condition, though it was relatively common and treatable. However, his 11 short days in the hospital involved a series of unfortunate events: medical mistakes, miscommunications, and ultimately a death that should never have happened. Although James’ story tragically ended after only 264 hours of life, it was just the beginning of his mother’s story of discovery and her journey toward patient safety advocacy.

Research — Clearing the Air on Airway Management

Inserting an endotracheal tube (intubation) into a patient's airway is a life-saving measure for those who are critically ill or injured, as well as a common practice for administering general anesthesia. However, the unplanned, uncontrolled removal of the tube (extubation), particularly by the patient, can cause grave harm, including aspiration pneumonia, arrhythmias, brain damage, and death. While complications with intubation have been widely documented, extubation largely has gone unstudied, especially related to intensive care units. In this study, two physicians examine the risks and offer strategies and resources for preventing this $5 billion per year problem.

Data Analysis — Injecting Safety Into Vancomycin IV Therapy

Vancomycin is one of the most ubiquitous antibiotics in U.S. hospitals to treat a broad range of infections, so it’s critical that every dose is administered correctly; however, intravenous (IV) vancomycin presents many unique complexities that must be well understood to keep the patient safe. This therapy requires an accurate patient weight for dosing, continuous monitoring of drug levels and renal function, and carefully timed delivery. Some of the safety hazards throughout this process include errors in dosing, monitoring, IV administration, and workflow and communication. In a recent study, researchers analyzed patient safety event reports describing IV vancomycin-related issues and then developed a self-assessment tool to raise awareness of potential issues and improve patient safety.
One Size Does Not Fit All

Do you know the weight limit for a standard CT scanner? What about for the largest one commercially available? How about for an MRI scanner? Despite 1 in 3 Pennsylvanians being obese, some healthcare facilities lack the necessary equipment to provide adequate care—which can cause embarrassment for patients, delays in care, and even patient injuries. In a recent analysis of 107 events related to monitoring and patient care for obese patients, submitted to the Pennsylvania Patient Safety Reporting System (PA-PSRS) from 2009 through 2018, imaging equipment (e.g., MRI and CT scanners), was implicated in nearly 50% of reports. Equipment that was too small for patients caused minor injuries, such as cuts, abrasions, and burns, in 41.1% of incidents. Understanding the problem, assessing your facility, and updating equipment may prevent harm and embarrassment for patients. Learn the most common risk factors to always be prepared.

Patient Safety Initiatives — Creating a Safe Night

What's in a word? One team at a facility discovered that using the word “watcher” to identify patients at high risk for clinical decline overnight helped create clarity and focus for priority setting across all disciplines. This was just one of the team-based changes they implemented to improve transition of care and patient outcomes and safety, as part of their Create a Safe Night Program. Overall, the education, training, and process measures from this initiative enhanced communication and teamwork, decreased their rate of inpatient mortality, improved efficiencies—and even brought staff more joy in their work.

Weight Documentation Errors: Adhering to Best Practices

Errors in documenting patient weight can lead to incorrect dosages of medicine being administered, with serious consequences—even death if they go unnoticed. Some of the causes include measuring weight in imperial units (e.g., pounds) instead of metric (e.g., kilograms), recording them incorrectly, labeling medicines incorrectly, using outdated information from a patient’s electronic health record (EHR), and so on. Although the Institute for Safe Medicine Practices (ISMP) has issued best practices to prevent weight-based dosing errors, one institution that updated their processes still found room for improvement. Their review and the changes implemented to close safety gaps resulted in a nearly 50% reduction in weight documentation errors, from an average of 115 to 60 per month. Here, a pharmacist shares her step-by-step plan to help ensure you always get it right.

Eight Super Tips to Defeat Pressure Injuries

In 2004, Christopher Reeve, Superman in four major motion pictures, died from pressure injury-related complications. Despite years of research and development of evidence-based practices, pressure injuries continue to kill 60,000 Americans each year. Think you already know everything you can do to protect your patients? Don’t be so sure. But following the eight strategies in this article will help you develop a real-life superpower: preventing avoidable hospital-acquired pressure injuries.
Safe Healthcare for All Patients

“I'm a trans male and constantly misgendered in the GYN office back in Maryland. My mom has never seen me break down so badly in the bathroom.”

“I have had a pretty positive experience with healthcare, but I do know people who feel that their sexuality or gender identity has caused providers to shame or treat them as insignificant.”

“At my last ER visit, I expressed my desire to be called my preferred name and they did not have a way to put that in the system, so I kept getting deadnamed and having to request each person to stop.”

These are comments from attendees of the 2019 Philadelphia Trans Wellness Conference (PTWC), just a few of the voices the Patient Safety Authority heard that reveal stigma and discrimination against LGBTQ patients as an ongoing problem in the healthcare system. This article amplifies many more voices like these, highlights challenges in providing a safe and inclusive experience for all patients, and shares the Top 5 strategies for creating a more welcoming environment at healthcare facilities.

2020 I AM Patient Safety Award Winners

Tyrone Hospital is the quintessential community hospital: created with community donations of volunteer time and funding, to serve the community. One of the hospital’s core values is “continued improvement and learning,” and no one demonstrates this shared commitment better than its staff, which recently rallied together to improve surgical safety for their patients. The success of the Surgical Infection Reduction Team won them the Patient Safety Authority’s 2020 I AM Patient Safety Executive Director’s Award. This enduring spirit of community and collaboration also applies to the other nine groups and individuals who received awards for their inspiring and life-changing accomplishments in patient safety in the last year, selected from among 156 nominations from 79 facilities throughout PA. These are their stories.