PATIENT SAFETY

Winter Special Edition
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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 read how a tragic healthcare journey led to positive change, learn about the Camden Coalition's efforts to build a field of complex care, and arm yourself with evidence-based research and data analyses that will help you prevent harm and improve patient safety.

What's Your One Thing?

When the pediatric dermatologist called Kristin Aaron, she carefully wrote down one word on a Post-It Note: "histiocytosis." The word didn't mean anything to her at the time, but it soon would redefine her family's entire life. Langerhans cell histiocytosis is a rare but deadly blood disorder—and a devastating diagnosis for Kristin's 2-year-old son, Jenson. What followed were years of chemotherapy, as well as multiple healthcare-acquired infections. The tragic outcome inspired Kristin, and many others, to change patient safety, "one small step at a time." In her own words, Kristin shares the emotional story of Jenson's healthcare journey and asks everyone to "imagine if each of us picked one way to make it safer for patients, and that one thing turned into the next thing, and we started a patient safety revolution."

Perspectives — First Do Not Be Harmed

Despite all the advancements in patient safety, safety for healthcare workers seems to be getting worse. According to the International Association for Healthcare Security and Safety Foundation, assault rates are at an all-time high since 2012, at a rate of 11.7 per 100 beds, and so is disorderly conduct, at 45.2 per bed. Other reports from around the United States show high rates of injury among healthcare workers, and that a significant number of these victims are working in fear—and there's good reason to assume these incidents are grossly underreported. Patient Safety Authority Executive Director Regina Hoffman, MBA, RN, examines one of today's biggest issues and raises the question: How can we reduce danger and violence in the workplace?

How a Coalition is Revolutionizing Patient Care

Cait Allen, MPH, director of Engagement at the Patient Safety Authority, recently sat with Kathleen Noonan, chief executive officer of the Camden Coalition of Healthcare Providers. They discussed how this nonprofit, multidisciplinary healthcare innovator has been improving care for people with complex health and social needs in the city of Camden, New Jersey, and beyond. "We call what we do complex care," Noonan says. "There are a lot of different reasons why people use the emergency room. What our care team tries to do is figure out what is driving the patient. What will allow them to get stable in their life, and in a way then that could help improve their health situation."

Research — Trigger Warnings

Adverse drug events (ADEs)—harm due to a drug-related medical intervention, such as a medication error, allergic reaction, or an overdose—are the most common source of patient injury, affecting 19% of inpatients. They are also preventable. One tool that can identify potential ADEs quickly and accurately is trigger methodology, which searches for "flags" such as administering a reversal agent. But one group of researchers wondered if trigger tools could also be used to discover the underlying causes and trends of ADEs and prevent them from happening again. The resulting study examined adverse event triggers for elevated INR, hypoglycemia, and naloxone and revealed a number of contributing factors which may be helpful in reducing future ADEs.

Eyeing Endophthalmitis

Although cataract surgery is a straightforward procedure that most people will undergo at some point in their lives, the surgery can lead to serious complications. Analysts from the Patient Safety Authority recently used data from the nation's largest event reporting database to complete a groundbreaking study examining both the rates and key details of post-cataract infectious endophthalmitis events. Over a 10-year period, events related to this severe eye infection resulted in a high number of serious events that harmed patients, including one case that required removal of the affected eye. The risk factors and risk reduction strategies identified in this study may help to prevent future occurrences of this acute postoperative condition.

Data Analysis — Who Watches the Watchers?

Telemetry monitoring of heart rates and rhythms was introduced in intensive care units in the 1960s, and since then it has expanded into patient rooms and units in noncritical care settings. It allows healthcare workers to watch the condition of many patients all at once and intervene quickly when their condition changes; however, if the technology is not used appropriately or the equipment malfunctions, relying on telemetry monitoring also risks patient harm. A recent study looked at real-life cases of breakdowns in the processes and procedures regarding telemetry monitoring, such as user errors and miscommunication, and equipment failures, including broken transmitters and dead batteries. The lessons learned can help improve training and best practices to improve the safety of patients being monitored.

Faces of Falls

One in 56 patients fall every year in Pennsylvania hospitals, resulting in serious injuries and even death—but they are more than just statistics. In this analysis, the Patient Safety Authority takes a look at and behind the data to consider the people affected by falls, which are among the largest contributors to patient harm and the most commonly reported events. The results reveal just how dangerous falls are to hospitalized patients and which patients are most at risk.

Clearing Up Confusion Around Infusion Errors

Every day in every hospital, infusion pumps deliver vital medications and nutrients to patients. But what happens when these lifesaving devices stop working? The risk of medication errors with infusion pumps is well established, but to better understand the scenarios and factors associated with them, analysts studied the frequency of medication errors with infusion pumps in Pennsylvania. Among their discoveries: Most wrong rate errors led to medication being infused at a faster rate than intended, and user programming was the most common contributing factor.

After the Fall

With all the things new parents have to learn and worry about, dropping their baby probably seems unthinkable—and yet, newborn falls are a very real danger, even in the hospital. Annie and Brad Donnelly learned firsthand just how easily and suddenly a child can fall, particularly when mom and dad are exhausted. “While Brad was holding Connor in the bed, he became so comfortable that he accidentally fell asleep,” Annie shares. “The railing was up on one side but not the other, and that’s where Connor slipped out of Brad’s hands and received a contusion on the left side of his head. It happened very fast.” An analysis of data concerning newborn falls in Pennsylvania reveals the surprising prevalence of this problem and its causes, as well as some actionable prevention strategies.

Patient Safety Initiatives — Resisting the *Use* of Antibiotics

Antimicrobial resistance—when bacteria are no longer sensitive to drugs that have killed or inhibited their growth in the past—is one of the top 10 global health threats. Infections caused by antibiotic-resistant "superbugs" have higher morbidity and mortality, are harder to treat, and cost more to treat than infections caused by susceptible organisms. Inappropriate antibiotic use contributes to the development of these organisms. Antibiotics are frequently prescribed in long-term care facilities; approximately 70% of residents receive at least one course of antibiotics each year. Learn how Pennsylvania nursing homes addressed the crisis, and ask yourself, "Are you prepared?"

Inpatient Suicide Prevention

What do IV pumps, clocks, and faucets have in common? They've all been used as ligature points in attempted suicides. It takes less than five minutes and 18 inches from the ground for a person to self-asphyxiate from hanging. According to the American Foundation for Suicide Prevention, suicide is the 10th leading cause of death in the United States and 11th in Pennsylvania, and of those deaths, hanging from a ligature point is the most common method of suicide in inpatient healthcare facilities. Think you know all the risks? Read about the Patient Safety Authority's 2018 keystone project to be sure.

Medical Humanities — Cancer for Christmas

The typical reactions following a cancer diagnosis include devastation, anger, and paralysis—but not for Casey Quinlan. Five days before Christmas in 2007, Casey Quinlan got something she didn't want nor could send back: breast cancer. Rather than succumbing to feelings of helplessness, the "Mighty Casey" chose to chronicle her adventures navigating treatment and the healthcare system—which was also immortalized by artist Regina Holliday in a jacket painting for The Walking Gallery of Healthcare. Quinlan hopes that the lesson she learned from her parents and her experience will help guide others on similar journeys: "Your health is your responsibility and you must ask questions and work to understand the answers."

Patient Safety Authority

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