Great Catches for Patient Safety

Lehigh Valley Health Network

RECOGNIZING

Staff Accomplishments

FOR PATIENT SAFETY

EVERY DAY IS PATIENT SAFETY DAY

UNITED for Patient Safety

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Patient Safety website

Find on the LVHN intranet under Departments, Non-Clinical.

LVHN Colleagues Stand United for Patient Safety

At Lehigh Valley Health Network, we strive to encourage a culture of safety for our patients. During the recent COVID-19 pandemic, it has been made clear that this culture of safety is present and stronger than ever. The Patient Safety Department would like to extend a well-deserved THANK YOU to all who have worked so hard the last few months to keep our patients safe!

In addition to the care of our patients, part of the culture of safety is also to report patient safety concerns. Colleagues are encouraged to report near misses and great catches to help identify potential risks for patients. A near miss is an event that could have happened but was stopped before reaching the patient. A great catch is the recognition of those near miss events that may have caused harm to a patient but due to recognition of the safety concerns, the harm to the patient was avoided. Not only is it important to identify the near misses, but it is also important to recognize our colleagues that have made a "Great Catch".

This publication is to acknowledge our colleagues who have identified potential patient safety events and made a great catch while enhancing the safety and care for our patients last year. **In 2019, there were a total of 181 colleagues presented with a Great Catch Award, spanning all levels of care within the network.**

It is important that the exceptional care and efforts that keep patients safe is recognized. Anyone in the network may submit a colleague's name for a Great Catch by using the RL event reporting system, utilizing the 'Great Catch' icon. Remember, if the individual recognized a potential for harm and intervened to avoid harm that deserves recognition!

Remember: Patient Safety 24/7, 365 days for every patient, provider, and healthcare worker!

Dr. Matthew McCambridge
Chief Quality & Patient Safety Officer

Gwen Browning
Administrator/Patient Safety Officer

Megan Snyder
Sr. Patient Safety Officer

Rachel Drzewiecki
Patient Safety Officer

GREAT CATCH CRITERIA

Tier 1

- Nominated by staff/manager or identified by patient safety/risk management.
- **Colleague identified a potential for patient harm within their role/scope.**
- Prevented near miss that could have caused an adverse event resulting in patient harm or injury.

Examples:

- Recognized allergy not identified during initial assessment
- Assisted patient to prevent fall
- Discovered medication in IV bag was not the same as on the label

Tier 2

- Nominated by staff/manager or identified by patient safety/risk management.
- **Colleague prevented an adverse outcome for patient(s)**
- Event can be relatable across the Network

Examples:

- Connects allergy to latex precaution (patient has existing allergy to chestnut, banana, etc.).
- Recognizes change in condition and utilizes chain of command to push for actions.
- Recognizes an equipment issue, e.g., bed check plugs

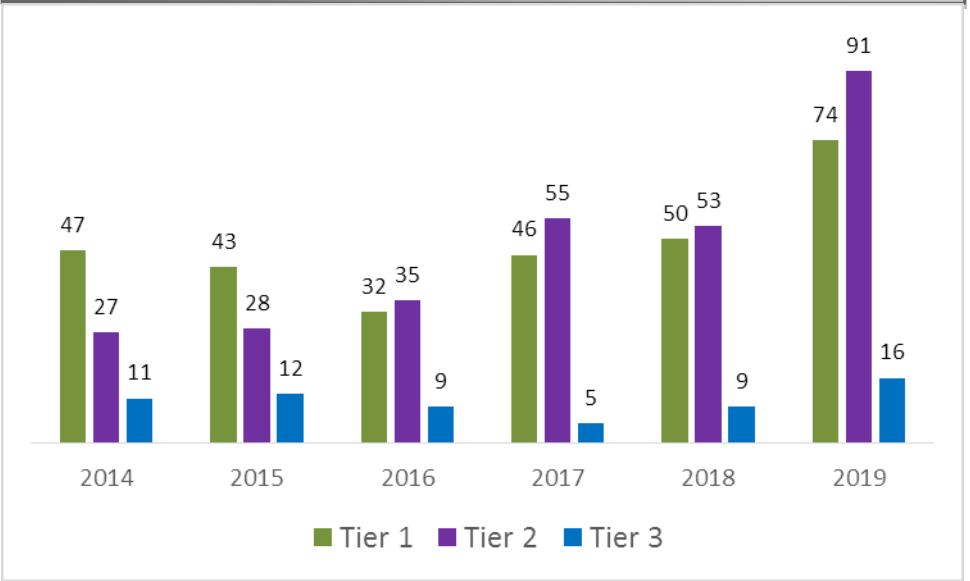
Tier 3

- Nominated by staff/manager or identified by patient safety/risk management.
- **Colleague portrayed exemplary actions that prevented an event which could have caused a permanent catastrophic injury or death.**

Examples:

- Adult dose prepared for pediatric patient
- Medication dose in ten-fold
- Behavioral Health team identifying and preventing suicide pact

GREAT CATCHES BY TIER



Great Catches FOR PATIENT SAFETY

Each of the following individuals were presented with a Great Catch Award for patient safety; their attention to detail prevented serious harm to patients.

They have received recognition for their great catches by their peers and depending on tier awarded are eligible to receive a badge holder, tumbler, and "I am Patient Safety" pin as a way of demonstrating the health network's appreciation for keeping our patients safe.

Join us in recognizing their efforts to put patient safety first!

TIER 3 RECIPIENTS

Rebecca Brown RN, TNICU-CC

Rebecca's patient was admitted with severe anemia and scheduled for an EGD the next day. Rebecca recognized that the patient had never had an INR drawn since admission and upon interviewing patient, that the patient was on Coumadin PH and this was missed. She immediately notified the provider and an INR was drawn. The result was 8.0 (dangerously elevated). Rebecca notified the resident and then worked up the chain of command in order to obtain appropriate orders for her patient so that the EGD would be safe to perform. The patient required Vitamin K and 4 units of FFP prior to the procedure.

Terri Cuth RN, Home Care

Terri was seeing patient with known depression who had been visited by Home Care MSW twice at which times she denied suicidal ideation. Home Care RN visited, at which time she noticed patient had not been taking her medication, collected several and had cans of beer hidden under a towel next to her chair. Home Care RN reported, "Completed depression screen of 3 and suicide risk. Initially patient denied any thoughts of harm but with further discussion she stated she wasn't taking her meds and she knew all she had to do was take them all slowly a few at a time." Patient agreed to inpatient behavioral health stay related to depression and inability to care for herself. Patient was transferred to Emergency Department voluntarily by ambulance. Home Care RN received call stating the patient was scheduled for discharge home. Home Care RN called Emergency Department and communicated her concern related to patient's disclosure of suicidal ideation with plan and means. Home Care RN then went to ED to advocate for a 302, which was eventually completed, due to suicidal ideation with plan and means which was not communicated by patient to Psychiatric Evaluation Services when evaluated.

TIER 3 RECIPIENTS

Elida Derhammer, RN, 6th Tower-Muhl

Elida was reviewing her patient's lab results and noted that the results were very different from previous results. She then checked the patient lab results in the previous room and saw that this patient's labs were also very different. As she compared both set of labs it was found that the lab specimens were incorrectly labeled with the other patient's information. She notified the unit director and the physician before the results were acted upon. Labs were redrawn on both patients and results corrected in their medical records.

Emily Hebrock, Physical Therapist, Physical Therapy-CC

Emily was evaluating a patient and noted the patient had acute right sided weakness, which was a significant change from her previous assessments. Emily notified the nurse and together they called a Rapid Response which was quickly upgraded to a Stroke Alert. The patient was sent for a STAT CT scan of her head which revealed an acute left thalamic intra-cranial hemorrhage and the patient was transferred to Neuroscience ICU for close monitoring.

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TIER 3 RECIPIENTS

Sean Heintz, RN, Emergency Department-CC

Sean was caring for a patient in the Emergency Department who had known perinephric hematoma and was complaining of increasing abdominal pain despite medication administration. Sean continued to medicate the patient following the physician orders with frequent assessments and updates to the admitting team. The patient continued to be in pain without relief. Sean asked the physician to re-evaluate the patient and a repeat CT scan was ordered. The CT revealed the patient had substantial arterial and venous bleeding that were new findings from the previous CT scan. The patient required immediate intervention and was emergently taken to the operating room and later interventional radiology venous and artery repairs.

Jonathan Kyte, RN, Burn Center-CC

Jon was caring for a pediatric patient who was admitted with ascending and aggressive muscle weakness to upper and lower extremities. The patient's potassium was 2.0 and he received 40mEq K+ PO and 20K+ in IV fluid. Repeat labs showed the K+ to be 2.0 after supplements. As the MD's were ordering MRI's, lumbar puncture and multiple labs, Jon's main concern was the potassium level. He questioned the residents about ordering more supplements because he believed the patient was experiencing hypokalemic periodic paralysis. When supplements were not ordered, Jon encouraged the patient to keep drinking POWERADE to hopefully help bring the potassium up. Once the patient was transferred, Dr. Sheik (neurologist) saw the patient and said he believes he has hypokalemic periodic paralysis (which he hasn't seen in 25 years) and treatment is to supplement and monitor K levels.

TIER 3 RECIPIENTS

Tracey Lightner, RN, ICUM/RHCS-Muhl

Patient transferred from LVH-Schuylkill on 8/3/19. On 8/5/19 at 1322 and 1323 labs that were drawn at Schuylkill on 8/2/19 posted to the patient's electronic medical record (date/timed for 8/5/19 at 1322 and 1323). Upon reviewing her labs, Tracey realized there was an error and immediately began investigating what happened. At first, she suspected labs were drawn on another patient and labeled with her patient's labels; however, after contacting the lab she quickly realized this was not the case. Health Network Lab (HNL) staff reported they were unable to see the labs she was questioning. Therefore, the labs were not processed through HNL. The lab values had somehow been scanned into Epic, but the HNL staff were unable to see them and therefore unable to delete/change them. This raised concern because the patient was on Argatroban which is titrated based on PTT (which was one of the erroneous labs resulted at 1323). The erroneous PTT was below therapeutic range, when in fact the patients actual PTT was supratherapeutic. Tracey immediately reported this error to the physician team as the erroneous value showed the patient's values were improving which was incorrect. To note, IS was contacted and together with HNL they corrected the values in the medical record.

Juan Mendiolina, Anesthesia Tech, Post Anesthesia Care Unit-CC

Juan was transporting a patient from Post Anesthesia Care Unit (PACU) to an inpatient med/surg bed via wheelchair. The patient had an appendectomy overnight and was held in the PACU for several hours before a bed became available; the patient was stable enough at the time that discharge from PACU was considered at one point. However, a bed became available before that happened. When Juan reached the elevator to take the patient upstairs, the patient reported feeling sick. Juan stopped and looked at the patient and noted he seemed very pale and looked like he might pass out. He immediately took the patient back to PACU, rather than continue to the med/surg floor, for evaluation. The patient was found to have extremely low BP– SBP was in the 50's. The patient was emergently taken back to the OR where a hematoma was drained and active bleed repaired.

Tori Moyer, COTA/PTA, Home Care

Tori was performing a full medication reconciliation during her initial encounter visit with an elderly patient. She discovered that the patient was taking Tylenol, which was not listed on his med profile. While discussing this with the patient, she discovered that he was taking (3) 650mg tabs of Tylenol every 4 hours for his joint pain. This would equal 11,700mg daily. His primary care provider was notified immediately and instructed the patient to immediately stop taking the Tylenol.

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TIER 3 RECIPIENTS

Alyssa Parker, Medical Assistant, ExpressCARE-Fogelsville

Alyssa was completing orders on a patient being seen for unspecified chest pain. She completed the EKG per protocol and took the tracing to the provider as standard procedure. She then informed the provider that the EKG, which printed as normal, was not indeed normal when the patient moved or spoke. This prompted the provider to look at the EKG while it was running, and subsequently helped determine the plan of care. The patient was directed to the Emergency Department where it was confirmed there was an active myocardial infarction. The patient subsequently underwent a cardiac catheterization, angioplasty and stent placement. The provider was adamant that the Alyssa's actions helped for a more in-depth evaluation of the patient ultimately getting them the care needed and leading to a positive outcome.

Nancy Peacock, RN, 5ATT-CC

Nancy was caring for a patient with intellectual disability who was planned for discharge the next day and noticed that her heart rate was slightly elevated and had extension of existing bruising on her chest and abdomen (patient with a positive "seatbelt sign" on admission 6 days prior). She asked the patient how she felt, and the patient only stated that she felt tired and sore. Nancy also noted that the patient hadn't had labs drawn recently. She reported her findings to the provider and requested follow-up labs be drawn. The patient was found to have a Hgb of 4.7 and WBC count of 32; followed by a CT scan that revealed a 38cm expanding abdominal wall hematoma. The patient was taken emergently to the OR and then to the ICU. She was discharged 11 days later in stable condition.

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TIER 3 RECIPIENTS

Maria Rodriguez, MRI Technologist, Radiology, MRI-Muhl

An MRI checklist was sent to MRI department, reviewed, and cleared for the patient to come for his MRI. Upon arrival Maria noted that the patient was unable to communicate in order to review the MRI checklist. Maria called the patient's son in order to review the patient's history and in doing so found out that the patient had a temporary pacemaker which had been removed but the leads had been cut and left inside the patient. If Maria had not taken the extra step to confirm the medical history of this patient, if she had simply taken the word of the checklist sent to MRI from the outside facility, this patient could have been seriously injured.

Elizabeth Shober, Pharmacist, Pharmacy-CC

A resident entered an order for quarter normal saline (1/4 NS) IV at a rate of 100ml/hr for a newborn baby weighing 2 kg and staying in the PICU. Elizabeth called and spoke with resident regarding the order that was placed. She explained to the MD that 1/4NS is consider a hypotonic fluid, and there is a significant increase in the risk of hemolysis when using hypotonic fluids. She also explained that the rate of 100ml/hr is a dangerous amount of fluid for a 2 kg baby, and the max IV fluid rate should be around 16ml/hr (two times maintenance). Ordering 100ml/hr of 1/4NS is 100x the recommended maximum, and has the potential for severe adverse consequences. Per discussion with the Resident, the actual intention for the order was to be given ORALLY, and not via an IV line. The pharmacist recommended calling pharmacy in the future to help navigate orders when they are unsure how they should be placed to minimize risk of med errors. The order was changed by the pharmacist so that PO was listed on the label and MAR to ensure it was not inadvertently given intravenously.

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TIER 3 RECIPIENTS

Zainab Soonasra, RN, LVPG Pediatrics-Fogelsville

Patient's Mom called the office to return as a new patient. Zainab proceeded to triage the child's symptoms and schedule an appointment. After triaging the phone call, she sent the patient to the Children's ER due to symptoms of headache 9/10 and vomiting. Mom took the child to the ED where he was seen and transferred to Children's Hospital of Philadelphia (CHOP) due to diagnosis of a brain tumor.

Amalia Villarreal, Technical Partner, Invasive Cardiology Staging & Recovery-CC

Amelia noticed that a hematoma was forming underneath the dressing to the patient's brachial venous access site after a cardiac catheterization procedure. She immediately held pressure and notified the RN. The RN asked the provider to assess; they came to the bedside and applied a pressure dressing. The hematoma completely resolved.

Elsie Wright, RN, Mother Baby Unit-Muhl

One of Elsie's patients was on magnesium and complained of a headache after delivering, which is not unusual and was treated. The following day, Saturday, Elsie had taken over care for this patient in the afternoon, and she also cared for her Sunday during the day. She was still complaining of a headache and Elsie found this alarming and told the obstetrics team. She also talked to the patient more about this and discovered that she had several family members with a history of MS and that she was suffering from a headache for 2 years, neither of which were noted in the medical record. Elsie felt something else could be wrong, so she suggested a neurology consult, which was then ordered for the patient. Neurology ordered several tests and her discharge was delayed by one day. Her tests came back abnormal and she was being worked up for MS. The patient was discharged home with her baby, but Elsie's persistency and intuition lead to alerting the medical team that something was wrong that allowed for additional testing being done while the patient was still in the hospital. To note, the patient has a new diagnosis of MS and is currently following with Neurology.

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TIER 2 RECIPIENTS

Bridgette Appleby, RN, RN Triage/Access Healthcare Navigation: Bridgette was reviewing Emergency Department orphaned labs and noted that the patient has a medication allergy to Flagyl and had a new prescription for Metrogel (which is another brand name for Flagyl) to treat an infection. Bridgette notified the APC and a new script was obtained. The patient was called and advised not to take the Metrogel and to start the new prescription.

Jillian Bankas, Pharmacist, Pharmacy-Muhl: During check of cart fill medications in pharmacy, it was noticed that patient was ordered to receive many bags of 20 mEq potassium, more than the typical few bags for hypokalemia. Jillian looked up the patient and noticed the patient was to be given 20 mEq potassium every hour for total of #25 doses. Nurse had already given #8 bags at that time. Pharmacist called nurse and notified her that order should not continue. She then paged the Hospitalist on-call and recommended discontinuing order and recheck potassium. Order was discontinued and STAT potassium level returned within normal limits at 4.5.

Freda Barnes, RN, MP Cancer Services-Bangor: Freda was reviewing the record of a very ill patient who was to arrive for a transfusion at the Bangor location. There is a requirement that the patient have a blood type & screen drawn within 72hrs prior to the transfusion at the Bangor site due to no lab capability there, and Freda noted this was not completed. She immediately took steps to notify the patient and family to have them re-routed to the Muhlenberg location where the bloodwork could be obtained and the transfusion completed on the same day, preventing an unnecessary trip for a very sick patient.

Amanda Becht, Technical Partner, 4T-Muhl: Patient was a new admission to the unit, and while speaking with the patient, Amanda noticed that his reactions were slowing, and he stopped responding as quickly as he initially had been. She immediately reported this to the nurse who called an RRT. The patient was found to be having an absence seizure, which developed into a tonic-clonic seizure during the RRT. Providers were able to manage the patient safely due to Amanda's quick thinking.

Vicki Beck, RN, Tilghman Surgery Center: A patient was scheduled for surgery where implants would be used; specifically, Synthes 3.0 headless compression screws. Vicki noted pre-operatively that the patient has a nickel allergy. She contacted the Synthes rep and confirmed these implants contain Nickel. She found a substitution that was available and contacted the surgeon to advise of the allergy and the proposed substitution. Surgery moved ahead as scheduled using titanium implants.

Tabitha Bennick, Patient Representative, LVPG Hematology Oncology-Muhl: A provider entered order for MRI brain to rule out metastasis to the brain for a patient who is Spanish speaking. Interpreter services was contacted to obtain an interpreter to facilitate scheduling with the patient on the phone. When Tabitha asked the patient about metal in the body, she said she has tissue expanders. Not all expanders prevent MRI, so RN called the plastic surgeon's office and they said no MRI because they use a magnet to find the port. The scheduler told Tabitha that was not the case and she could have it done. Tabitha went the extra step and called the MRI department and was told that the patient could not have MRI. Had she not pursued it the patient may have had her expander damaged or dislodged.

Victoria Broscius, Occupational Therapist, Occupational Therapy-CC: Vicki was working with a patient who had shoulder surgery at LVH-OrthoMed and was for discharge home. He had been complaining of shortness of breath and abdominal pain since the prior day but the plan remained home with home therapy. Vicki spoke with providers due to patient's continued difficulty breathing and living alone at home. The patient was ordered additional testing and was transferred to Open Heart Unit-CC for a paralyzed diaphragm.

TIER 2 RECIPIENTS

Bonny Brownstein, Pharmacist, Pharmacy-CC: Attending physician entered order for 3ml (equal to 4ml/kg based on 0.7kg weight) hypertonic saline 3% IV for one dose. In the comments, the MD entered "for IPV treatment." IPV treatment is a respiratory treatment requiring nebulized medications. Patient had no apparent indication for IV treatment with hypertonic saline. Bonny called the MD to see if IV was correct route. Per MD, wanted the nebulized formulation of 3% hypertonic saline. Order adjusted, and IV dose not given.

Bonny Brownstein Pharmacist, Pharmacy CC:
Bonny was reviewing medications for an 8-hr old NICU baby and noted that fluids were ordered which included sodium and potassium. These electrolytes are not normally provided to newborns until after the first 48 hrs. of life when lab work is resulted, and kidney function is known. Bonny called the provider to clarify if the newborn was producing urine yet or if lab values were known. Since the newborn hadn't met these criteria, she recommended removing the electrolytes from the fluids. The provider changed the order. On day 2 of life, the newborn's potassium level was elevated at 7.8 and sodium was normal. If the baby had received the electrolytes, the potassium level would have had the potential to cause a cardiac event.

Kristen Casey RN, LVPG Obstetrics and Gynecology-Pond Road: A provider sent the message that patient had fetal demise, when in fact it was the incorrect patient. Kristen identified this by doing a chart review and noting the ultrasound recorded a fetal heart rate of 135 beats per minute. She clarified with the provider and spared the mistake from causing any further adverse reactions/communications with the patient and allowed for the correct patient to be notified.

Susan Clark RN, NICU-CC: IVF was supposed to be written to have lower sodium on a hypernatremic 23wk old premature infant but was inadvertently ordered higher dose; verified by pharmacy despite note to decrease sodium amount. RN barcoded and hung med. Noted concentration seemed inaccurate and asked ordering provider who called pharmacy. Error caught and medication changed to appropriate dose.

Jesenia Colon EKG Technician, Heart Station-Muhl:
Jesenia was performing outpatient EKG's and noticed after the fourth one that all the diagnoses stated, "cannot rule out anterior infarct, age undetermined." She contacted clinical engineering and after trouble shooting, determined that the modular on the machine had to be replaced. She contacted the ordering providers and the patients so their EKG's could be repeated.

Annie Cooper RN, Radiation Oncology-CC: Annie received a call where the provider requested a patient be set up that day for CT with IV Contrast in Radiation Oncology. There were no available slots except for 0800 the next day. Radiation Oncology nursing, not having seen the patient in the past, decided to come in at 0700 and have the patient come at 0715 so a thorough CT questionnaire, meds, allergy, and IV insertion could be accomplished to have the patient on the table by 0800 for the planning CT in Radiation Oncology. By following the nursing process on medication, allergy review, using the Radiation Oncology CT Questionnaire and questioning the patient, Annie was the first to identify the patient had a severe allergic reaction to prior IV Contrast administration.

TIER 2 RECIPIENTS

Jeanine Correll, RN, RN Triage/Access Healthcare Navigation: Group A Strep resulted for patient seen on 5/22/19 at the Emergency Department-CC. Result date showed 5/23/19 however Jeanine noticed the negative throat culture result date was from 3 months ago. She routed it back to the ED Advanced Practice Clinician (APC) documenting this discrepancy. ED APC was unsure why this happened and told Nurse Triage team to contact patient and let them know the result was negative and no change in treatment. Jeanine's colleague reached out to the ED APC who then called Health Network Labs (HNL). HNL investigated and found that the date was input into the system incorrectly by HNL. HNL credited the 2/22/19 result and created a new result with the correct date. (Jeanine's colleague also received this award.)

Allison Daywalt, Radiation Therapist, **Radiation Oncology-CC:** Allison was performing a block verification simulation on a patient and she noticed an overlap of a portion of the field. She then contacted the physics department and dosimetrist for them to review the radiation treatment plan. The procedure was then aborted, rescheduled and re-planned. If she had not caught this overlap an increased dose would have been given to that area.

Erika Deangelis, RN, Inpatient Rehab-M: One of Erika's patients complained of nausea and a headache. After assessing the patient, she noted the patient's heart rate was in the 40's and auscultated an irregular pulse. She called the provider and obtained an order for a 12 lead EKG. It was noted that the patient was in a Second-degree Type 2 heart block. The patient was transferred to another unit later that day for telemetry monitoring and the patient went on to receive a permanent pacemaker.

Lauren Eckert RN, RHCM-Muhl: Lauren was caring for a patient who was experiencing alcohol withdrawal and noted that the concentration of sodium in the prescribed IV fluids seemed too high. She questioned the morning provider prior to hanging the medication and questioned the ordered treatments as they were not the standard alcohol withdrawal treatments. The provider agreed and discontinued the order (150mEq sodium bicarb in NSS).

Cara Eckhart, RN, Float Pool-CC: Cara noticed during her morning medication pass that her patient had both oral hypoglycemic medication, sliding scale insulin orders in addition to her insulin drip. She notified the provider who cancelled the oral medications and sliding scale orders and prevented a potential hypoglycemic event.

Susan Emerson, COTA/PTA: During a patient visit for routine medication reconciliation, Susan discovered that patient had been incorrectly taking 5 tablets of 5 mg of Warfarin. Patient was prescribed to take 1 tablet of 5 mg Warfarin. A repeat INR was drawn that day and future doses held.

Carol Faust, Pharmacist, Pharmacy CC: Carol noted a newly admitted patient was ordered labetalol and the dose was changed from 200mg every 12hrs to 500mg every 12hrs. She paged the provider to clarify, and provider stated the patient had become orthostatic and they intended to change the dose to 50mg every 12hrs. The error was caught before reaching the patient.

Jessica Goodrich, RN, LVPG Pediatric Specialists, Pulmonology: The pediatric pulmonology department received a batch of syringes from Health Spectrum Pharmacy with PO prednisolone. Jessica was reviewing the medication delivered and came across a syringe of promethazine-dextromethorphan (Phenergan-DM) that should not have been in the batch. The medication syringes look identical and if someone was moving quickly, they may have missed this.

Rachel Haja RN, Inpatient Rehab Center 7KS-CC: Rachel's patient noted her DOB was incorrect in the computer and stated it has been that way for years; the month and date were reversed. Rachel called the patient's husband who confirmed the patient's statement. She then went back through old records and noted the DOB has been incorrect since 2012 and that even her residency card scanned in is incorrect. She revealed that the patient's native language is Greek and the practice there is to state the day, then the month, then the year, leading to the error. The patient's husband brought proof of her birthdate and records are now correct.

TIER 2 RECIPIENTS

Mobena Hassan RN, 4T-Muhl: Mobena is a Churn Nurse and while covering lunch for another RN, she was asked to correct an elevated blood glucose with insulin based on the point of care test which resulted in an elevated glucose level. As Mobena proceeded into the patient's room with the intention of administering the insulin coverage based on the blood glucose, she did not feel comfortable administering that high of a dose of insulin. She decided to look at his previous glucose results and noticed none of the results were elevated to that number. She changed to a different glucose monitor and rechecked the glucose level. The result was much lower than the previous reading taken approximately 30 minutes prior. No insulin coverage was given, and the primary nurse was notified of the discrepancy. A quality control check was done on the equipment and it passed the test.

Sloan Hawk RN, 2KS-CC: Sloan noticed that an ABG collected during the previous shift for his patient did not correlate with previous ABG's. He alerted the day shift RN who alerted the Clinical Nurse Leader. After investigation it was determined that the ABG had been drawn in another department on a different patient using Sloan's patient label.

Jessica Hernandez, RN, NICU-CC: Jessica's patient was due to receive their fourth dose of gentamycin. She identified patient never had a gentamycin trough drawn to check the levels of the drug in the patient's blood (to detect toxicity). This is typically done prior to the third dose. Jessica informed the doctor and this great catch altered the patient's plan of care.

Kimberly Hill RN, Float Pool-CC: Kim had a patient who experienced a hypoglycemic event for previous shift and hypoglycemic protocol was in place and the patient was receiving carb coverage insulin every meal. The patient was sent angel food cake with whipped cream for her birthday, which was identified on the tray slip as 76gms of carbs. Both Kim and the patient felt this was too high an amount of carbs for such a small piece of cake. Kim called the kitchen to verify, who confirmed it was indeed 76gms. Kim also researched values that were consistently ranging from 25-36 gms for that size cake.

(Continued)

Kimberly Hill RN (continued):
Kim spoke with the endocrinologist about her findings and was instructed to give the dose based on the 76 gms of carbs, which Kim followed. Kim rechecked the BG 2 hours later and patient's Blood Glucose was 49. Kim followed the post-hypoglycemic protocol again and submitted a patient safety report outlining the event and her thoughts. Changes have since been made in the kitchen regarding the correct number of grams in the angel food cake, which was changed to 18gms.

Logan Hones, Technical Partner, 5ATT-CC: Logan was working with a confused elderly patient who was a poor historian. The patient complained of left calf pain, which was a new complaint. Logan quickly notified the primary nurse, who notified the provider. The patient was taken to the vascular lab and the study there revealed an occlusive deep vein thrombosis (DVT).

Trina Jacoby, Technical Partner, 5ATT-CC: When obtaining morning vitals Trina identified that the patient was having an increased O2 need. She looked back over night and noticed that the patients O2 had been increased throughout the nightshift and now needed another increase which was not resolving the low SPO2. Trina notified the nurse she was working with, then she saw the PA in the hall and notified him directly of her concerns for the patient’s condition. The PA ordered a STAT chest X-ray which identified a 50% pneumothorax which needed a chest tube for treatment. The patient reported feeling afraid for the CT insertion, and Trina stayed by her side and held her hand through the procedure.

TIER 2 RECIPIENTS

Cassie Johns, Medical Assistant, LVPG Pediatrics-Palmer Township: Patient and sibling in for new patient well and problem visit, and Cassie noticed that there were no legal custody/ guardianship documentation papers on file for grandparent or aunt to consent for any medical treatment/communication. Cassie questioned the identity of whom the child was accompanied with at the visit while working them up due to not finding this information in the medical record. She spoke with her supervisor and the provider and together they discussed this with Grandma and Aunt in the room. They provided resources and direction to help her out and to be able to properly care for these kids and provide further services, to finalize this to no or little cost. To note, patient was seen in multiple LVHN locations over the last 6 years and this information did not get obtained anywhere, or resources provided for grandparent to properly obtain this info as mother is deceased and dad not involved.

Anna Jurbe, General Services, 5ATT-CC: Anna was working on the unit today, in her rounds she entered room 11. She came upon a patient who was having trouble breathing and appeared unwell. She immediately notified the first person she saw. The nurses and tech were able to act quickly due to Anna being prompt about reporting. Without Anna's quick thinking and actions, the patient could have had a grave outcome.

Denise Kelly, RN, OR-CC: Circulating nurse reviewed surgical consent in the holding area. Nurse noted laterality marked on consent was different from what the patient stated when interviewed by the nurse. Nurse reviewed consent with anesthesia and holding room nurse. Nurse paged surgeon to inform her of the consent discrepancy. The consent stated possible right oophorectomy which was incorrect since the patient confirmed the problem was on her left side. Surgeon corrected the consent and clarified the procedure with the patient. This great catch prevented a possible wrong site surgery based on the original consent.

Malaysha Kelly, CNA/Home Health Aide, Home Care: Malaysha was providing personal care for her patient (who has dementia) when she noticed her patient's wife massaging her face/jaw area. She asked her patient's wife if she was feeling OK, and she stated that she woke up with pain in her face and ear and that now it was radiating to her chest area. Malaysha immediately called for assistance and then called 911 on behalf of her patient's wife. She also then called the patient's daughter. After EMS transferred the wife to the hospital, Malaysha stayed with her patient until the daughter arrived.

Dr. Shanique Kilgallon, Anesthesia, OR-CC: 6-year-old pediatric patient arrived in surgical staging for rectal biopsy. Patient alert and talkative during the admission process. Patient quickly became lethargic and pulse ox started dropping. Dr. Kilgallon arrived and directed nurse with orders for Hydrocortisone shot IM, blood glucose check. Patient was noted to be in an adrenal crisis. Patient quickly started becoming more responsive after treatment. Surgeon and anesthesiologist at bedside and decided to cancel surgery for a future time. In future patient will be pre-admitted to hospital and then have surgery.

Kara Kohler, RN, Surgical Staging Unit-CC: Patient came in for a urological procedure and had labs completed at an outside facility. Upon reviewing the labs prior to the IR/OR case, Kara noticed the values seemed grossly abnormal. She followed up by checking in Media to see if the original was scanned. The entered labs read: PT 0.4 INR: 11.5. The actual results that were on the scanned form from the outside facility read: PT 11.5 INR 0.94. The results were incorrectly transcribed. The lab was notified but unable to change the entry. Both the OR and IR were aware of the discrepancy and the original document was printed and placed on the chart for accuracy.

TIER 2 RECIPIENTS

Melissa Kowatch, RN, Float Pool-CC: Melissa was caring for a patient on telemetry who alarmed for bradycardia. Upon assessing the apical pulse, Melissa noted that the heart rate was in the 70's. At this point, Melissa investigated what was happening with the telemetry box and noted that the incorrect box number was on her patient. She found out that 2 patients moved to each other's rooms in order for the other patient to be placed on airborne precautions and the boxes weren't switched to the opposite rooms.

Jared Kratz, RN, Emergency Department-CC: Albumin was ordered by a PA-C, approved by pharmacy, and sent up from pharmacy for a patient in the ED. This albumin that was ordered and sent up was at the incorrect dosage for the patient. Before administrating the medication Jared, the primary nurse, believed that this order was wrong and called pharmacy to verify. Pharmacy then agreed that the dosage was the incorrect dose (under-dosage) and then spoke to the PA-C to correct the order.

Alyssa Kromer, PA-C, Hospital Medicine-Muhl, Behavioral Health: Alyssa was caring for a patient newly admitted to Behavioral Health from inpatient hospitalization who had new complaints of abdominal pain. The patient had an extensive PMH and PE's and was receiving injections for anticoagulation. After valium was ineffective for her abdominal pain (when it had been for similar previous symptoms due to stiff man syndrome), Alyssa further assessed the patient and noted one side of the patient's abdomen was larger than the other. Alyssa set up a STAT CT A/P which revealed a rectus abdominis hematoma with hemoperitoneum and active bleeding. She called Interventional Radiology and made the provider aware of the situation and need for immediate embolization and inpatient admission.

Christine Kucharek, Technical Partner, 5ATT-CC: A General Services colleague notified Christine and 2 RNs that a patient was in distress. Upon entering the room, it was apparent that the patient was in a critical situation. She quickly assessed the situation and identified that the chest tube tubing had come undone which was the cause of the rapid decline. Christine's rapid identification of the event allowed the nurses to quickly re-attach the tubing and ultimately save the patient's life.

Andrea Kushnir, RN, 2KS-CC: An RN asked Andrea to evaluate an abdomen and flank area of bruising with her to see if seemed worse from the prior day. This was the RN's first day with the patient, but Andrea had cared for her the prior day. Andrea noted that the patient's flank was unchanged but that the patient's left leg was significantly firmer than it had been the prior day. Providers were notified, and the patient was taken for CT which revealed a large hematoma. Patient was then taken to Interventional Radiology for an embolization and monitoring for possible fasciotomy. Without Andrea's assessment and notice of the change, the hematoma may not have been discovered.

Meghan LaClair, RN, RHC Medical-Muhl: A patient was transferred to RHCM from med/surg for higher level of care. The patient arrived and rapidly became hypoglycemic, bradycardic, hypothermic, lethargic and a rapid response was called. Meghan did a very quick review of the chart prior to the patient arriving and by the time the patient had arrived on the floor, had several possible causes of which she alerted the team. She figured out that the patient had received too much Lantus for her appetite that the patient didn't have a blood sugar check prior to her meal and so the nurse was not alerted to subtract insulin dose, and the patient received insulin CHO 1:8 instead of 1:15. Her quick assessment and critical thinking identified that the patient needed a quick change in level of care, requiring transfer to ICU within 20 minutes of arrival to RHCM.

Kelly Larue-Vassallo RN, Pediatrics: Kelly was reviewing discharge paperwork and noticed that the dose of Keppra ordered for the 13 month-old child was ordered as 5 mL instead of 0.5mL. Kelly notified the provider and the correction was made prior to discharge.

TIER 2 RECIPIENTS

Kyle Laudenslager, RN, 2KS-CC: Kyle noticed that on a patient's X-ray of the shoulder it was noted that the left shoulder was positive for fracture (clavicle). It was a study of the right shoulder, and the injury was present on that side. Kyle assured the medical record was updated to reflect the correct side.

Mary Leo, RN, LVPG Hematology Oncology-Muhl: A patient was to start a new oral drug, Xalkori, and Mary realized this patient (who was in her 80s) had not had labs drawn in a couple of months. She asked the provider to order standard labs and they revealed the patient's kidney function was elevated, requiring a lower dose of Xalkori. Not checking labs and proceeding with full dose could have resulted in further harm to the patient's kidneys.

Theresa Link, Case Manager, Pediatrics-CC: Case Manager identified that patient's weight seemed inappropriate and notified clinical staff. Weight of pounds entered instead of Kg which could have resulted in an overdose of Tylenol and Motrin**.**

Vanessa Machik RN, Neonatal ICU-CC: Pharmacy sent medication to NICU in bag labeled with NICU patient information and medication information for meds included in the bag. Two oral syringes were in bag; one for a NICU patient and another for a 9-year-old patient on the pediatric floor (and this was a different medication). Pharmacy notified, both medications not used, returned to pharmacy and new medication requested.

Jennie Mansfield, Technician, MPS Cancer Center: Pharmacist gave a label to Jennie for Gammagard brand of Intravenous Immunoglobulin (IVIG) to prepare for a patient. When she received the label, she realized that patient should get Gamunex brand of IVIG and notified the pharmacist. The pharmacist then entered the order for the correct preparation of IVIG. Jennie is very knowledgeable regarding which brands of IVIG products each patient gets and because of this knowledge, an error was prevented.

Mia Martinez, RN, Home Care: Mia was visiting a patient discharged from Transitional Skilled Unit after open heart surgery with new prescriptions. During home care visit 2 days post discharge, the patient's blood pressure was noted to be low and concerning. Mia reviewed all medications and other discharge paperwork and noticed discrepancy between documented dosage of Lasix 20mg vs medication received of Lasix 40mg. Mia contacted cardiology office to confirm correct dosage and then coordinated necessary steps to correct and obtain correct dosage of 20mg.

Elaine McCambridge, Diagnostic Technologist, Diagnostic Radiology-CC: Elderly patient was scheduled for UGI and small bowel. The history did not match up with that study. Elaine called the office, spoke with ordering provider. She found out an obstruction series was what the provider really wanted to order. The order was changed before the incorrect study was performed.

Allison McKelvey, Radiation Therapist, Radiation Oncology-CC: While performing a CT simulation for radiation and tattooing, Allison discovered that the lasers were sent to the opposite side of the body. She spoke with the appropriate colleagues to ensure that the contours and treatment planning were correct thus ensuring the radiation treatments were delivered correctly.

Jen Mesker, Pharmacist, MPA Cancer Center: Patient arrived in infusion area for doxil and carboplatin chemotherapy. Patient had mild reaction to carbo last treatment (hives). Jen spoke with the doctor's office because she felt the patient should not be getting the carbo today. It also turned out, the patient had 6 doses of carbo in 2013 and had some reaction at that time. Patient was not given chemo and was scheduled to go in-patient the next day for desensitization and administration of chemo with monitoring.

TIER 2 RECIPIENTS

Catherine Quinn Messere, RN, 7C-CC: Patient admitted early Saturday morning from the Emergency Department with neutropenic fevers, recently having received chemotherapy. The patient was given one-time doses of IV vancomycin and cefepime (antibiotics), but no standing orders were placed. Catherine was reviewing the chart and Family Medicine and Hematology Oncology's note stated patient's plan was to continue IV cefepime and vancomycin. Catherine then paged on-call Family Medicine provider who noted patient should be on IV antibiotics and placed the necessary orders.

Gloria Miller, RN, 5K-CC: Gloria noticed an invasive (IR) procedure was ordered on her patient. Upon further research, she could find no evidence her patient had a history of pancreatic cancer. She notified the provider, who cancelled the order. The provider who placed the order was then made aware it was placed on the incorrect patient.

Shierley Miller RN, Open Heart Unit-CC: Shierley's patient was receiving heparin gtt infusing at 20 units/kg/hour. Hand off and reconciliation were done at shift change with the previous RN. Report was received that the patient was therapeutic. Upon review of the chart the nurse noted the patient's PTT from 0300 as 64.3, which was sub-therapeutic and should have been increased by 1 unit/kg/hour, which would have resulted in a rate of 21 units/kg/hour. She adjusted the rate and ordered PTT per protocol for a recheck in 6 hours. The PA was notified of the discrepancy.

Shierley Miller RN, Open Heart Unit-CC: Shierley noticed that her patient's INR had been 1.1 over several days. Knowing that the patient had a mechanical valve, she knew that the INR should be higher. Shierley did further investigation to see if the patient was on Coumadin. She called the Nurse Practioner to question why the patient is not on a heparin gtt. After researching the chart, the patient was recommended to have Coumadin with INR goal 2.5. No contraindications for anticoagulation. The patient was placed on a heparin gtt as a result of her inquiry.

Katrina Mills, RN, 5ATT-CC: Katrina was assessing her patient 6 days into his admission after a fall with multiple rib fractures. She identified decreased breath sounds on the side of the fractures and notified the trauma team. The provider ordered a CXR, resulting in a 30% pneumothorax with hemothorax which required an immediate chest tube insertion. Without her assessment, this patient may have decompensated and had an adverse event.

Jennifer Molchany, RN, 4K-CC: RN received two bags of Ceftriaxone with a patient label that indicated Cefepime. The patient label placed on the medication correctly matched the MAR for person, drug, and dose. The medication in the bag did not match the label. Pharmacy was notified and the correct medications issued. Two hours later, two additional bags of Ceftriaxone were sent with a patient label that indicated Cefepime. Again, the label placed on the medication correctly matched the MAR for the person, drug, and dose. The medication in the bag did not match the label. Pharmacy was notified a second time of the issue and corrected medications were re-issued.

Erin Moore RN, Neonatal ICU-CC: Erin scanned Potassium Chloride dose of 1.33meq/1ml. Scanned correctly. Dose amount in syringe 1.5ml, not 1ml as ordered and scanned. RN noted overfill and wasted/witnessed with second RN to 1ml prior to giving dose to patient. Notified pharmacy of near-miss and questioned overdose in syringe and additional syringes on unit. Pharmacy requested return of overfilled syringes. New 1ml syringes supplied to unit for next dose. Not sure if proper dose or overfilled syringes were supplied with prior doses. MD notified and monitored pt.

Emma Morasco, RN, 7BP-CC: Emma questioned a heparin gtt order on her patient because she had been told the patient had an MRI which revealed an intracranial hemorrhage. None of the providers had addressed those results at that point. She didn't start the medication and called the provider. The patient was sent for a follow-up CT of the head which confirmed the bleed. The patient was transferred to higher level of care and the medication order was cancelled.

TIER 2 RECIPIENTS

Gabriel Natalini, RN, Open Heart Unit-CC: Gabe received a patient post-operatively and noted that there were lab results in this patient's medical record that weren't drawn. He contacted the OR and found that his patient's labels were scanned for another patient's labs that were run on an ACT machine. The results were removed from his patient's medical record and placed on the correct chart.

Juliane Neifert, RN, RN Triage/Access Healthcare Navigation: Juliane noted a positive urine culture in Emergency Department (ED) lab results and notified the ED APC. APC sent a script to the Pharmacy. However, the prescription was for Keflex and the organism in the culture was resistant to Keflex. The APC was made aware and sent a script for Cipro. The patient was made aware to start the new medication.

Lindsay (Baker) Oates, RN, MPA Cancer Center: Lindsay was reviewing orders for a patient and found that it was her first day receiving Perjeta in over a year, and patient was not prescribed a loading dose. Lindsay reached out to the ordering provider and had the dose corrected before administering the medication.

Brianna Penrod, RN, Wound Care Specialty Float Pool--Pediatric Unit: Brianna noted that the immunization screening tool that is used for flu season was not up-to-date with the latest CDC recommendations for flu shots. The screening tool navigator led the user to believe that the 0.25mL dose should be given for patients aged 6 months to 36 months. Brianna made the Epic team aware that the buttons directly to the right of the navigator need to be updated to reflect the new CDC guideline that all patient's aged 6 months and greater will receive the 0.5mL standard dose.

Jennifer Pool, RN, Float Pool-Muhl: Jennifer was caring for a patient overnight who had an insulin pump in place and was experiencing hyperglycemia. The patient had a diagnosis of Type 1 DM and DKA was a concern. The patient's blood sugar levels were in the 200's during the day but were over 300 by the evening. Jennifer asked the patient if she had supplies to refill her insulin pump and she admitted that she didn't. She called Endocrine to make them aware. They discharged the pump until additional supplies could be obtained and started the patient on Lantus and correction insulin; the patient's blood sugar levels were in the 100's by morning.

Brittani Powers, RN, 5CP-CC: Brittani's patient complained of 10/10 low back pain and stated it had been occurring for the last 3 hours but not reported. Brittani knew patient had a past medical history of an abdominal aortic aneurysm (AAA) and notified the vascular resident. Patient was assessed by vascular. A STAT CT scan revealed a 6.4cm AAA with retroperitoneal hematoma. The patient was transferred to ICU and went to the OR that evening for repair.

Alicia Quigley, RN, Float Pool-CC: The lab printer was not working properly on the unit. Alicia printed a lab order for her patient, then printed it again when she noticed the form was not on the printer. (The patient she was caring for had a bleed and the Hemoglobin level came back higher than it should have been.) Alicia investigated and determined that another RN took her first label order form off the printer and sent it down with her labs. The lab was erroneously processed under the wrong patient. It took Alicia about 3 hours to correct the problem. The problem was corrected before any treatments (or lack of) were provided to either patient.

Katie Rakaczewski, Pharmacist, **Pharmacy CC:**
Katie was reviewing anticoagulation records and noted that a patient was ordered 12.5mg Coumadin daily while inpatient. However, the patient takes this as their weekly dose, not daily. The patient alternates 1.25mg and 2.5mg daily. Katie called the provider to clarify the dosing and the order was changed.

Nairobys Ramirez, Technical Partner, Float Pool-CC: During a code event Nairobys spoke up and asked the nursing supervisor if anyone had checked the patient's blood sugar. No one had yet at that time and the blood sugar was 30. The patient was able to be treated. It was a great call for her to speak up and draw attention to this important code detail that is sometimes over looked.

Malissa Ringer, Technical Partner, Emergency Department-CC: Malissa was new in her role and helping to settle a new patient in the hallway when she noticed a large abscess on the patient's back. The patient had been admitted with new onset confusion and dizziness. She reported the wound to the primary RN who then obtained orders for a wound culture, and antibiotics were started in the ED. The patient was admitted for this wound, which was determined to be the cause of the patient's confusion and dizziness.

Lehigh Valley Health Network

TIER 2 RECIPIENTS

Tracy Riccio, RN, RN Triage/Access Healthcare Navigation: Group A Strep resulted for patient seen on 5/22/19 at Emergency Department-CC. Result date showed 5/23/19 however Tracy's colleague noted the negative throat culture result date was from 3 months ago. She routed it back to the ED APC documenting this discrepancy. ED APC was unsure why this happened and told Nurse Triage team to contact patient and let them know the result was negative and no change in treatment. Tracy opened the result note and read the APC's response and was concerned about calling a patient with a result from 3 months prior. Tracy reached out to the ED APC who then called Health Network Labs (HNL). HNL investigated and found that the date was input into the system incorrectly by HNL. HNL credited the 2/22/19 result and created a new result with the correct date.

Erika Robinson, Technical Partner, Inpatient Rehab Center, 7KS-CC : Erika noticed that her patient's right calf was more edematous than the left, and that there was redness present that hadn't been before. She brought it to the primary nurse's attention. The nurse made the provider aware, and an ultrasound was performed. The results revealed an extensive DVT in the RLE, and the patient had a filter placed the next day.

Tara Rogers, Pharmacy Tech, Pharmacy-Bangor: A patient arrived for a medication infusion to prevent renal transplant failure, but the ordered dose was questioned due to a change in the patient's weight. It took some time reaching the office and having the dose changed while the patient waited. Finally, the order was changed, and the label printed. Tara asked why dose decreased when the patient's weight had increased. This question prompted the pharmacist to investigate and realize that the patient was due for one more dose at a higher weight before titrating the medication. They called the office again and sent a new order for the higher dose.

Lynn Roth, RN, ED Triage: Patient was prescribed Keflex during ED encounter. Urine culture result positive post ED discharge. Result note routed to ED APC with documentation from RN that culture was positive, prescribed antibiotic resistant. ED APC ordered Macrobid and did not stop Keflex. APC was unaware Keflex was ordered during ED visit. RN re-routed result note back to APC and made APC aware that Keflex was already ordered and to clarify which antibiotic to continue. Keflex was discontinued and Macrobid was ordered and communicated to patient by RN.

Jean Sales, RN, Pediatric Unit-CC: Jean received a 1-year-old patient transferred from the ICU and weighed the patient on admission. She noted that the weight documented in the medical record was 7kg higher than the weight she obtained. Jean alerted both the provider and the pharmacist so that medication dosages could be adjusted accordingly (Tylenol and antibiotics).

Terri Sanders, Pharmacist, Cancer Center-Muhl: Patient arrived for a monthly infusion that is usually given every 4 weeks. Infusion RN inserted an IV and released the orders to give the patient the infusion. Terri (pharmacist) noticed it had only been 3 weeks since last infusion and called to confirm plan with office. The medication was held, and patient was rescheduled until next week.

Tammy Selby, RN, 7C-CC: Tammy was preparing to administer chemo to a new patient and noted that two doses were hand-delivered by the pharmacist. This is not unusual, as some patients receive the dose Q12 hours so the night shift's dose would be delivered as well. However, Tammy called the pharmacy to verify. It was prepared in error and meant to be the next day's dose. Typically, the next day's labs are reviewed before that day's dose is prepared so the extra dose was picked up by pharmacy.

Richard Shambo, RN, 2K-MSICU: Rich received a patient who was transferred from med/surg. While switching the nasal cannula tubing to the wall oxygen, Rich noticed there was a hole in the O2 tubing so new tubing was obtained. It was determined that since the other tubing was faulty, it possibly hindered the actual amount of oxygen the patient had been receiving. Once the tubing was changed the patient maintained O2 sats at 98%. Without Rich catching this, the patient would have been placed on a high flow oxygen, which he didn't require, and increase his length of stay.

Lehigh Valley Health Network

TIER 2 RECIPIENTS

Jane Sipple, RN, LVPG Anticoagulation Management Services: A patient with a past medical history of mechanical heart valve with previous stroke while on Coumadin with low INR was being evaluated at an LVPG office for illness. The patient needed an antibiotic, but this medication could interfere with the patient's Coumadin level, so a point of care INR was done in the office. The result was low, 2.1 (patient's goal range is 2.5-3.5). The patient reported his result to the anticoagulation office. Jane felt this was an incorrect result and requested that the patient go to the lab for a STAT serum INR to correlate. His result was 3.2. The result was called into the other office so that the provider could treat the patient appropriately.

Colleen Skochko, RN, Radiation Oncology-CC: Colleen received a call where the provider requested a patient be set up that day for CT with IV Contrast in Radiation Oncology. There were no available slots except for 0800 the next day. Radiation oncology nursing not having seen the patient in the past, decided to come in at 0700 and have the patient come at 0715 so a thorough CT questionnaire, meds, allergy, and IV insertion could be accomplished to have the patient on the table by 0800 for the planning CT in radiation oncology. By following the nursing process on medication, allergy review, using the radiation oncology CT Questionnaire and questioning the patient, Colleen was the first to identify the patient had a severe allergic reaction to prior IV Contrast administration.

Amy Smerekar, RN, Pediatrics-CC: Pharmacy placed correct label for ophthalmic polysporin cream on the incorrect polysporin cream vial. It would not have been safe to use around the eyes and for teaching the parents the same thing. Called pharmacy and they sent correct medication up to be used. Educated parents on the correct ointment for the burns on his face and around his eyes.

Laura Snow RN, Pediatric ICU-CC: Laura received a 1-year-old patient from Emergency Department with weight significantly higher (by 4 kg) than the weight per growth curve and previously listed in medical record. Laura discovered the error on admission to PICU and recognized the need to have all weight-based medication doses adjusted to reflect the actual weight of baby.

Shellie Stahler, Technical Partner, Progressive Coronary Care Unit-CC: Shellie was asked by a group of physicians that were bedside to obtain a set of vital signs right away because the patient appeared to be lethargic after a procedure. The patient's vitals were stable, so the physician group left the bedside. Shellie noticed there was a change in the patient's mental status, because the patient had been verbalizing minutes before how she would like to get out of bed and have something to eat and drink. Shellie then went to the patient's primary nurse to report the changes. An RRT was called, CT obtained, and it was noted that the patient was having a stroke. Interventions were quickly provided, and the patient was moved to critical care. Shellie's rapid response of that patient's change in neurological status will hopefully prevent long term effects from the stroke.

Caitlin Stasiw, RN, MPA Cancer Center: A patient was receiving a medication infusion and appeared drenched in sweat and flushed. The medication was put on hold and the hypersensitivity reaction protocol was almost started when Caitlin came to assist the primary RN. Caitlin asked the patient if she was diabetic. The patient stated she was, and her blood sugar was checked, and result was 48. Oral dextrose administered and the hypoglycemic protocol implemented. This prevented the patient from unnecessary interruption in her care and extra medication that was not needed.

Doris Sultren, Patient Transport, Transport Team-CC: Doris was taking a patient to Radiology and noted that the patient's IV pole had a bag of medication with another patient's name on it. Doris notified the Radiology Tech who called the primary nurse on the unit and made her aware. Medication was removed from the IV pole and no harm came to the patient.

Angela Werley RN, Labor & Delivery-Muhl: Angela was floated to the Neonatal ICU at Muhlenberg and at the start of her shift she noticed that the twins she was caring for were in the incorrect beds. During chart review, she saw that Baby B's vital signs were flowing into Baby A's chart, as only Baby B was supposed to have automatic vital signs. The vital signs were moved to the correct chart.

TIER 2 RECIPIENTS

Kathleen Wesser, Pharmacist, Pharmacy-Muhl: Kathleen was reviewing a patient's medication orders and noticed that orders for ceftriaxone and pantoprazole were discontinued upon patient transfer from Short Procedure Unit after EGD procedure. Kathleen reviewed the notes for the patient and saw that the Gastroenterology (GI) fellow recommended continuation of the medications daily for 5 days. She paged the GI fellow and explained the situation to RN informing her that pharmacy was awaiting a page from the physician. The physician returned the page shortly thereafter and requested that both medications be reordered and started this evening.

Maria Whitfield, RN, Post Anesthesia Care Unit-CC: Maria identified post-operatively that blood was not given pre-op by calling several departments. Maria also identified that there was no blood consent. Hospital Medicine was contacted, and all was resolved. Patient was administered blood, remained hemodynamically stable and a potential poor outcome was avoided.

Dana Whitman, Medical Secretary, MPA Cancer Center: Dana has previous financial registration experience, and when a new patient checked in for an infusion and handed her a new insurance card, Dana inquired if the patient's insurance had recently changed. The patient was previously on PATHS, and their Highmark was new, so there wasn't a pre-authorization for that day's treatment. Dana advised the patient that the infusion that day would not be covered and recommended the patient re-schedule. By doing this, Dana prevented the patient from receiving a large bill.

Amanda Yenser, Technologist, Diagnostic Radiology-CC: A batch of 10cc syringes were contaminated with an unknown powder substance. Amanda was the first one to notice, removed all the 10cc syringes with that lot number and notified supply chain and managers.

Lori Young, RN, Operating Room-Ortho Med: The surgeon changed the implants being used for the case from a titanium implant to a stainless-steel implant. While reviewing her patient's chart pre-operatively, Lori noted that the patient had a nickel allergy which would require titanium implants. Lori immediately notified her manager of this issue. The case was ultimately rescheduled for 3 days later when the required titanium implants would be available.

Stacey Zellner, RN, LVPG Obstetrics and Gynecology-Pond Road: A patient called the office stating labs were ordered on her by mistake by provider and there were results for a pregnancy test as well as a type and screen on her record. Manager unable to identify correct patient they should have resulted on, and action/follow up care was needed. Manager asked nursing to let her know of any charts they came across where the patient was looking for results that may not be ordered to help narrow down the search. Stacey, who was a new nurse there, quickly identified a patient she recalled another nurse speaking with that morning. Her quick action led the team to see the two patients involved shared the same date of birth and their medical record numbers were only one number different. Because of this, the correct patient was able to be identified, and follow up care was able to be provided without a delay in care. Furthermore, we were then able to clarify the orders were not placed incorrectly, but rather interfaced incorrectly from the lab (which was able to be rectified).

TIER 1 RECIPIENTS

Stephanie Achenbach, RN, 5T-Muhl
Tori Ackley, RN, Neonatal ICU-CC
Natalie Alegant, RN, Neonatal ICU-CC
Storm Asbury, Medical Assistant, LVPG Pediatric Specialists-Gastroenterology
Melissa Barna, RN, Ambulatory Surgery Unit-Muhl
Janine Barnaby, Pharmacist, MPA Cancer Center
Erin Beers, RN, MPS Cancer Center
Kristen Bentzen, RN, Pediatrics-CC
Darlene Bjelobrk, Pharmacist, MPA Cancer Center
Jennifer Botwin, RN, Emergency Department-CC
Carolyn Bozsolak, RN, MPA Cancer Center
Shaina Briel, Respiratory Therapist, Respiratory-CC
Carmen Campione, RN, Short Procedure Unit-CC
Kimberly Cooper, RN, MPA Cancer Center
Tracy Crivellaro, RN, Trauma/Neuro ICU-CC
Ammie Davidheiser, COTA, Home Care
Emily Drissel, Technologist, Radiology-CC
Teruna Everk, RN, Post Anesthesia Care Unit-CC
Kaitlyn Freed, RN, 7B-CC
Sarah Jayne Freitas, Technologist, OR-Muhl
Melissa Fye, Technologist, Radiology-CC
Nina Godfrey, RN, Neonatal ICU-CC
Sarah Gustafson, RN, Emergency Department-CC
Melissa Hahn, RN, Emergency Department-CC
Kevin Hartman, RN, Float Pool-CC
Heather Heim, RN, ICU-Muhl
Amandeep Kaur, RN, Access Triage RN
Catrina Kemmerer, RN, LVPG Hematology Oncology
Janis Kiniery, RN, OR-Children's Surgery Center
Amanda Kirchoff, Technologist, CT Scan-CC
Jon Kyte, RN, Burn Center-CC
Chiakii Lewis, RN, Open Heart Unit-CC
Kristen Lindberg, RN, Perinatal Unit-CC
Laurel Lovelace, RN, 2KS-CC
Dana Markowitz, Administrative Partner, 2KS-CC
Marlene Martin, Administrative Partner, 2KS-CC
Stacy Mesics, Pharmacist, Clinical Pharmacist
Stacy Michalik, RN, Trauma/Neuro ICU-CC
Melissa Motz, RN, Labor & Delivery-CC
Danielle Moux, Medical Assistant, ExpressCARE- Quakertown
Jennifer Nagle, RN, LVPG Family Medicine
Amanda Pointon, RN, Express Admit Unit-CC
Marlene Martin, Administrative Partner, 2KS-CC
Stacy Mesics, Clinical Pharmacist, Pharmacy-
Stacy Michalik, RN, Trauma/Neuro ICU-CC
Melissa Motz, RN, Labor & Delivery-CC
Danielle Moux, MA, ExpressCARE-Quakertown
Jennifer Nagle, RN, LVPG Family Medicine
Amanda Pointon, RN, Express Admit Unit-CC
Gisele Raphael, RN, Medical Oncology
Jacqueline Raub, RN, Ambulatory Surgery Unit-Muhl
Mary Grace Richard, RN, Emergency Department-CC
Lauren Rivera, RN, MPS Cancer Center
Jeanne Marie Rocchino, Office Coordinator, LVPG OBGYN
Cindy Rock, RN, Pediatrics-CC
Alison Rubin, RN, LVPG Pediatric Specialists-Gastroenterology
Patrice Schaffer, RN, Neonatal ICU-CC
Leauna Schaner, Support Tech, Radiology-CC
Antje Schwartz, RN, Post Anesthesia Care Unit-OrthoMed
Margaret Scott, RN, Express Admit Unit-CC
Kimberly Shannon, RN, MPA Cancer Center
Komkai Soombonsong, Pharmacist, Pharmacy CC
Janell Souder, RN, 5K-CC
Cindy Talago, RN, Post Anesthesia Care Unit-Muhl
Kimberly Tyler, RN, 2KS-CC
Candice Veale, RN, Inpatient Rehab Center-Muhl
Amanda Yenser, Ultrasonographer, Radiology, Ultrasound-CC
Michele Volkert, Office Coordinator, LVPG Family Medicine-West End
Kimberly Walker, RN, 2KS-CC
Lisa Wetzel, RN, Post Anesthesia Care Unit-OrthoMed
Michael Wiesel, RN, OR-Muhl
Tarah Wisser, RN, 5CP-CC
Anna Yanisko, RN, Emergency Department-CC
Ellen Zampino, RN, Open Hearth Unit-CC
Melissa Zeliznik, Clinical Coordinator, LVPG Family Medicine-Brodheadsville

Lehigh Valley Health Network

Being prepared to intervene for patient safety is the best way to avoid harm for our patients. Utilizing the following patient safety tools will assist you to provide interventions needed, as well as supporting colleagues.

We all have been empowered to make a difference and we encourage you to do so.

LEHIGH VALLEY HEALTH NETWORK

Patient Safety Tools

PATIENT SAFETY MEANS DOING THE RIGHT THING, THE RIGHT WAY, FOR EVERY PATIENT, **EVERY TIME.**

1 Pay attention to detail – self-checking using STAR
a. STOP: Pause for one second and focus.
b. THINK: Consider the action you are about to perform.
c. ACT: Concentrate and carry out the task.
d. REVIEW: Check to make sure that the task was done correctly.

2 Communicate clearly – three-way communication
a. SENDER starts communication using the receiver's name – providing an order, request or information to receiver
b. RECEIVER repeats/reads back using the safety phrase, "Let me repeat that back."
c. SENDER says "That's correct" or repeats the request if not correct.
d. Use SBAR when a decision is needed:
Situation: Describe current condition or situation.
Background: Brief description of history
Assessment: State your view of situation, best judgment
Recommendation: Your suggestion for action; What do you want to happen next?

3 Practice with a questioning attitude
a. Validate and verify
i. Validate by asking yourself, "Does this information make sense to me?"
ii. If not, verify by confirming with an independent source or an expert.
b. Ask clarifying questions in high-risk situations or when information is incomplete or not clear.
i. Use the safety phrase, "Let me ask a clarifying question."

4 Everybody checks everybody – never leave your wingman
a. Be willing to be coached.
- Check the accuracy of other's work.
- Identify human error.
- Point out unusual situations or hazards
- Encourage safe behaviors.
- Discourage and correct unsafe behaviors.
- Use the safety phrase, "Thank you for saying something."

5 Speak up for safety
a. Speak up using CUSS – everyone should speak up or "stop the line" when there are safety concerns
C – I have a concern.
U – I am uncomfortable.
S – This is a safety issue.
S – Stop the line.
b. Use these phrases to get the attention of the team if your concern is not addressed.

LVHN PATIENT SAFETY PHRASES – PATIENT SAFETY STARTS WITH ME.
- Let me repeat that back.
- Does this make sense to me?
- Let me ask a clarifying question.
- Thank you for saying something.
- I have a concern…

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Dr. VF Nieva and Dr. J Sorra, 12/2003

Safety culture assessments are new tools in the patient safety improvement arsenal. These tools can be used to measure organizational conditions that lead to adverse events and patient harm, and for developing and evaluating safety improvement interventions in healthcare organizations. They provide metric by which the implicit shared understandings about "the way we do things here" can be made visible and available as input for change. Safety culture assessment should be viewed as the starting point from which action planning begins and patient safety change emerges.

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