2024 I AM PATIENT SAFETY ANNUAL ACHIEVEMENT AWARDS

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[1]Patient Safety Authority

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The Patient Safety Authority (PSA) established the annual I AM Patient Safety Achievement Awards[1] to recognize Pennsylvania healthcare staff who have shown an extraordinary commitment to improving the well-being of patients. Even as we strive toward a goal of zero harm, it is also essential to recognize when things go right in hospitals and facilities. The IAPS contest is an opportunity to celebrate and share those stories, that they may inform and inspire others in their work.

Although there can be only one winner in each category, every person or team nominated by their peers and grateful families deserves recognition for their committed efforts, accomplishments, and influence on patient safety. In addition to acknowledging the runners-up for this year's awards, many of the nominees' stories are published on the PSA's Changemakers: Stories That Made a Difference site, which highlights examples of how event reporting can trigger change that improves care within a facility, a health system, or even nationwide.[2]

The 2024 IAPS awards were judged by patient safety advocates; government, university, and patient representatives; and healthcare executives, who carefully evaluated 130 nominations from 74 healthcare facilities for innovation, impact, sustainability, and scalability. In addition to the nine juried awards, PSA Executive Director Regina Hoffman, MBA, RN, selected a Choice Award winner for special recognition.

Executive Director's Choice Award

Nikki Verkleeren and the Pharmacy Team

Forbes Hospital, Allegheny Health Network

Nikki Verkleeren, one of the *Executive Director's Choice* award winners, from Allegheny Health Network Forbes Hospital

When a patient received high amounts of a narcotic due to their patient-controlled analgesia (PCA) pump being reprogrammed for an ordered increase, Nikki Verkleeren, PharmD, and the Pharmacy team at Forbes Hospital became passionate about addressing this safety risk. Their efforts turned into a network-level project with multiple facets that ultimately led to not only a new and improved and standardized PCA order set, but also a standardized drug library, standardized epidural orders, and a networkwide equipment upgrade.

Steps involved in this very lengthy process involved a PCA order set redesign including the following components: review of ISMP recommendations and data analysis, design of orders to limit need for higher concentration/admixed bags to lessen the chance for medication errors, and extensive work with the information technology department to define the build and validate on numerous occasions. In addition, Verkleeren and her team updated and personally built the PCA library, employing double checks by Pharmacy and incorporating recommendations from the epidural library reviews. The extensive work with the library was duplicated for pediatric populations as well.

Education was systemwide, with Verkleeren working with a physician advisory group to ensure provider education was adequate and order set wording was clear from a physician standpoint. She and the team reworked verbiage on high-dose PCAs to ensure the practice was feasible at all hospitals, even if palliative care is not available, and worked with all disciplines on education regarding this important safety measure. Verkleeren coordinated with the vendor and the installation of software and was the point person for the overall network go-live.

The work and leadership required to carry this project through while Verkleeren conducted her normal day-to-day responsibilities was immense, but patients are safer across the entire system for it.

Sepsis Award

Crystal Ratkovsky, CCRN

UPMC Hamot

Crystal Ratkovsky, CCRN, is a dedicated nurse at UPMC Hamot with over 15 years of experience who has a focused passion around sepsis. She led the initiative to introduce a sepsis alert for patients meeting the criteria of sepsis/systemic inflammatory response syndrome (SIRS) and developed a sepsis screening tool and checklist. Recognizing the need for staff on all units to be well versed on the topic of sepsis, early recognition, and proper and timely treatment, she also developed a sepsis committee to focus on active staff participation in providing sepsis education to clinical and medical staff.

Sepsis award winner, Crystal Ratkovsky, from UPMC Hamot

Through this committee, Ratkovsky was able to engage nurses and physicians to commit to being a sepsis coach and champion in any sepsis alert and drive sepsis awareness. She collaborated with other disciplines for their buy-in and engagement around this initiative. She went above and beyond to not only make this team, but also to help them be successful with the implementation of sepsis protocol for the sepsis alert. Following staff feedback on how they will be most responsive to answering to the sepsis conditions, the alert is text paged in addition to being announced on the overhead speaker, and a sepsis checklist bundle enables them to act appropriately and with confidence.

She continues to drive sepsis recognition and staff education by engaging the sepsis committee and unit-based clinicians. She put together an entire sepsis awareness campaign and started an annual sepsis walk. She held a one-hour sepsis lecture in which two sepsis survivors spoke about their experience, underscoring the importance of early recognition and timely sepsis treatment. Ratkovsky monitors all sepsis patients, and outcomes, and sepsis bundle treatment, and provides constructive feedback to staff on any outliers in treatment.

Her sepsis initiatives have had a significant impact on reducing further harm and improving patient care and outcomes, and it is sustainable, reliable, and scalable. The sepsis alert alone has helped staff become more knowledgeable in identifying the signs and symptoms of sepsis, and they have become more confident in collaborating with providers with their assessment. The team of sepsis coaches and champions she developed has educated their peers on sepsis recognition and improved the treatment of sepsis.

Individual Impact Award

Dawn Goodwin and Shamaine McGlone

Jefferson Torresdale Hospital

At Jefferson Torresdale Hospital, Dawn Goodwin, patient care technician, and Shamaine McGlone, patient safety associate, worked closely with a patient whose behavior was not initially favorable to receiving safe care in the hospital to being receptive to inpatient care and treatment. They were able to do this by building a good rapport with the patient, and this connection comforted and redirected the patient. Their patience and caring greatly improved the situation for the patient and their colleagues.

Individual Impact award winners, Dawn Goodwin and Shamaine McGlone, from Jefferson Torresdale Hospital

Long–Term Care Facility Award

Patients at Risk Committee Members: Rosie Minniti, Senida Nuhanovic, Angela Wright, Jodie Roese, Suzanne Sawicky, Sarah Leuch, Jillian Wagner, DJ Turner, Brianna Houck, Dina Alexander, and Dawn Snyder

Providence Point, Baptist Senior Family

In October 2022, Baptist Senior Family decided to close its Mt. Lebanon campus, a facility with 125 years of service and a five-star rating, displacing approximately 90 residents and the staff. During the transition, many of its dedicated staff members from all departments transferred to a sister location, Providence Point. Mixing two unique cultures is never an easy task; however, these individuals did so with grace and dignity and came together to provide optimal outcomes to our residents with a focus on use of clinical data.

The Patients at Risk (PAR) meeting was formed as a way for the new interdisciplinary team to engage in meaningful discussions and formalize residents' individual plans of care, considering their emotional, social, and spiritual needs. Healthcare truly takes a team to deliver the best experiences to residents. This often begins before a resident steps foot through the facility's doors. This team, being relatively new to one another and to the facility, strived for the best outcomes for the residents and worked together to identify resident risk and swift intervention to promote positive outcomes.

The team met weekly and proactively identified residents at risk using analytical data derived from clinical software, such as review of residents triggering on the quality measure reports, infections, falls, grievances, weights, therapy concerns, and medical record documentation.

The kick-off meeting was held in June 2023 and the team determined to focus on falls with major injuries, associated in-house acquired infections, and antipsychotic medications.

Reviewing first quarter data, the team

- Conducted training on falls and fall prevention
- Identified residents at risk for falls via assessment and event reports
- Updated care plan with specific, resident-centered interventions in mind
- Implemented telehealth (Third Eye Health) with physician access 24/7, leading to a 92% treat-in-place rate
- Formed a monthly infection control meeting with the interdisciplinary team and medical director
- Provided in-services by the infection preventionist on handwashing and urinary tract infection (UTI) prevention, including Foley catheter care, peri-care, incontinence care, increasing fluid intake, Enhanced Barrier Precautions

Long–Term Care Facility award winner, Patients at Risk Committee members, from Providence Point

- Increased access to eye washing stations in community soiled utility rooms
- Held a monthly Antipsychotic Stewardship Meeting that included the pharmacy consultant, psychiatric nurse practitioner, social service, medical director, and nursing administration, to monitor generic dispersion ratio, behaviors, 14-day stop dates, and to avoid PRN ("as necessary") use

Below is the analytical data and outcomes benchmarked as a result of formation of PAR Meetings beginning first quarter 2023 on the areas of focus:

Quality Measures	Quarter 1	Quarter 2	Quarter 3
Falls with major injury	3.57%	3.3%	0%
UTI	6.9%	5.08%	0%
New antipsychotics (ST)	15.6%	0%	0%

This team's commitment to patient safety and continued dedication to provide the best outcomes for residents, and their ongoing efforts in identifying, planning, educating, and coaching, will continue to have a positive impact on the resident experience.

Ambulatory Care/Surgery Facility Award

The Staff of the Reading Hospital SurgiCenter at Spring Ridge

Reading Hospital SurgiCenter at Spring Ridge

Ambulatory Care/Surgery Facility award winner, the staff of the Reading Hospital SurgiCenter at Spring Ridge

According to The Joint Commission, wrong-side or -site surgery accounts for about 6% of all sentinel events reported in 2022; however, these statistics do not include near misses. The fast-paced environment of an ambulatory surgery center lends itself to creating opportunity for error. Recognizing this, the staff of the Reading Hospital SurgiCenter at Spring Ridge made it their mission to prevent future wrong-patient, -implant, -side, and -site surgery—and supplied a solution to a potential patient safety threat.

Quarterly audits were conducted on a variety of surgical specialties for staff to identify ways to decrease the chance for wrong-side or -site surgery. Audits include the pre-procedure verification, where the focus is on correctness of the consent and history and physical examination (H&P), in addition to surgical site identification and site marking. The second phase includes the operating room (OR) staff and the time-out (final pre-procedure pause). An average of 45 cases per quarter are observed and reported.

The findings revealed that patient identification, documentation verification, and site marking are completed without incident in preop. Findings from the OR revealed the staff were engaged during the time-out process, meaning all work stops except ventilation, and verbal acknowledgement occurred.

The greatest area of concern noted from the audits involved surgeons: The results revealed physician engagement during the time-out process was at 83% (calendar year 2021).

Knowing that there was the potential for a wrong-site surgery, staff ran with ideas on how to improve engagement. Staff were reeducated on the importance of all work stopping and focusing on the time-out. Administration empowered staff to speak up if they noted someone was distracted. Surgeons who did not properly perform the time-out were identified. Our results increased to 86% (CY 22).

Staff next decided to do a deeper dive into the results. Additional questioning of staff found that during the time-out phase, surgeons were verbally acknowledging the specific patient information; the problem was getting the surgeon to stop what they were doing and give their undivided attention to the circulating nurse who was conducting the time-out. To combat this situation, staff decided they would have the surgical technician keep the back table away from the surgical field, thus creating an environment where the surgeon could be more engaged during the time-out process. Our current surgeon engagement rate sits at 92% (CY 23, quarters 1–3).

Throughout the patient encounter from scheduling until surgical start time, staff are responsible and empowered to speak up if they have a concern. Registration staff will seek clarification from the surgeon's office when scheduling the case. Preop staff question the surgeon if the consent varies from the H&P. As an added safeguard, the patient participates in the process. Even when everything goes accordingly with pre-procedure verification and the time-out, mistakes can still occur. Staff stay vigilant in the OR when moving to different phases of the surgery.

This project was staff driven and received full support from administration. Staff are awarded "Good Catches" when finding inconsistencies in the documentation, and their stories are shared with the unit.

Improving Diagnosis Award

Jessica Schumann, DO, Parmjyot Singh, DO, Neophytos Zambas, DO, Benjamin Slovis, MD, MA, and Jaclyn King, MS, RT

Jefferson Torresdale Hospital

Emergency department (ED) clinicians routinely use clinical calculators and scores to aid in medical decision-making, and these evidence-based tools are built into Jefferson's electronic health record (EHR). An ED physician, residents, and EHR experts at Jefferson Torresdale Hospital conducted a laborious review of the existent tools and updated clinical scores and assessments. These updates are more user-friendly and help clinicians create patient care plans more quickly and efficiently across 11 Jefferson EDs.

Improving Diagnosis award winners, Neophytos Zambas, Jessica Schumann, and Parmjyot Singh
Not pictured: Benjamin Slovis and Jaclyn King, from Jefferson Torresdale Hospital

Time–Outs Award

The Department of Surgery

Jefferson Abington Hospital

Time–Outs award winner, the Department of Surgery, from Jefferson Abington Hospital

The Department of Surgery at Jefferson Abington Hospital identified an opportunity to revise its time-out policy when there is a change in surgical modality, such as minimally invasive surgery (laparoscopic or robotic) to open surgery. When there is a pivot from one procedure to another, a mandatory second time-out will occur. This is an innovative solution to a low-volume, high-risk situation and puts patient safety first.

Transparency and Safety in Healthcare Award

OB/Newborn Patient Safety and Quality Committee

UPMC Hamot

A young couple came to UPMC Hamot to deliver their first child—what is supposed to be one of the most exciting moments of their lives. The labor was long and complicated, requiring a vacuum delivery due to recurrent significant variable decelerations, but he arrived, and his parents held and snuggled their perfect baby boy. Although he met the criteria for a healthy newborn, several post-delivery medical errors resulted in him going undiagnosed with a subgaleal hemorrhage which led to his death.

Transparency in healthcare is so important to patient safety and yet it is so challenging when things go dreadfully wrong. Despite how daunting the task was, the team had a duty to reflect on their errors, identify process improvement strategies for implementation, and share the story. That has been the guiding principle of their OB/Newborn Patient Safety and Quality committee.

A subgaleal hemorrhage is a rare but potentially lethal event in newborns: a life-threatening emergency caused by bleeding that accumulates between the skull and the scalp. The hemorrhage is typically caused by a rupture of the emissary veins (especially with vacuum-assisted births). It can lead to hypovolemic shock, anemia, coagulopathy, and death. Treatment includes bandage compression, aggressive administration of blood products, and surgery. This team learned from its extensive review of this case that opportunities existed in education, assessment skills, and the need for the development of a tool that would enable the staff to identify potential brain bleeds in these cases more quickly.

For future patient safety in the hospital's most vulnerable population, this committee developed necessary education and a tool that is now mandatory for all staff in the maternity departments. All newborns delivered with an instrumental assist are to have surveillance observations and examination at 1, 2, 3, 4, 6, 8, and 12 hours of age. In addition to baseline newborn observations (activity, color, heart rate, respiratory rate, and temperature), examination of the head includes visual inspection of the scalp and palpating the head to note any ballotable mass or movement of fluid (gravity dependent) in the scalp. Staff also notes the color and head shape, including displacement of the ears or pitting edema, and a head circumference. If there are any changes in the newborn from the immediate baseline, staff is to reach out for a bedside evaluation by the neonatal intensive care unit (NICU) or pediatric provider and a complete blood count is to be ordered.

An open culture of transparency and patient safety allows for greater innovation to occur, as demonstrated by this committee in sharing the unfortunate, but impactful story with other newborn facilities for awareness and education to avoid another newborn tragedy in the future.

Transparency and Safety in Healthcare award winner, the OB/Newborn Patient Safety and Quality Committee from UPMC Hamot

Physician Offices Award

Dr. Mohamed Shitia, Dr. Kevin Colleran, Dr. Arron Wey, and Dr. Shazad Shaikh

Geisinger Orthopaedics and Sports Medicine Scranton

Physician Offices award winners, Dr. Mohamed Shitia, Dr. Kevin Colleran, and Dr. Arron Wey, from Geisinger Orthopaedics and Sports Medicine Scranton. Not pictured: Dr. Shazad Shaikh

Terri Krevey writes: My daughter has been a patient with this orthopedic group for the past five years. She is a senior this year. She played intermural soccer for two years and travel for 11. During her travel career she played on two teams within her club, in two different age groups. She played ODP [Olympic Development Program] for two years as well as guest played for other teams. Practice was twice a week and two to six games on the weekend. We traveled all over eastern Pennsylvania, New Jersey, and Delaware. Tournaments and league games were all year round. We were deeply invested in soccer.

In her 8th grade year, at a tournament, she went for a block tackle and went down. She had to be carried off the field. We went to urgent care and they recommended orthopedics. She saw an awesome orthopedic physician, Dr. Kevin Colleran. He was comforting and informative. He felt it could be one of two things: a fracture or an ACL [anterior cruciate ligament] tear. We all were scared. After an MRI, our biggest fear was an ACL tear, but to our hope and surprise it was two slight fractures in her growth plate of the femur. Dr. Colleran followed her through the recovery process, and she was back to playing soccer in the fall, both travel and now high school.

On a Saturday in the spring of freshman year, her travel team was in the semifinals for the State Cup Championship. They won. On that same weekend she played for the Level Up team within the club; with two minutes left in the game, she went for a block tackle and went down. Again, carried off the field. Back to the orthopedic office. MRI#2 showed an ACL tear. Because of her age she saw the pediatric orthopod, Dr. Shazad Shaikh. He was so compassionate, caring, and friendly. He explained everything. She missed her entire sophomore year of high school. She was back on the field for her junior year thanks to Dr. Shaikh. It was a long haul, but she was back to playing and they won Conference and District titles that year.

In the winter of our daughter's junior year, in a league game, she rolled her ankle over the ball. MRI#3 and another big injury, tears to the tendon and ligament in the ankle and an issue with the medial talar dome. Dr. Arron Wey steps in after Dr. Shaikh left the area. He was friendly and compassionate. High school track season had started. she made it through half of the season before having to be non-weight bearing for six weeks. Then back to the soccer field she went after not being able to finish the track season.

She still had pain and it was getting worse. A sports medicine specialist then stepped in, Dr. Mohamed Shitia. With a complete and detailed examination, he made several recommendations that helped our daughter through her senior year—conference and district titles for the third straight year. The Scranton orthopedics team members were incredible beyond words. The future is hers to take thanks to this group of physicians.

Safety Story Award

The Emeritus Nurse Program

Penn State Health Milton S. Hershey Medical Center

Safety Story award winner, the Emeritus Nurse Program at Penn State Health Milton S. Hershey Medical Center

The Emeritus Nurse Program has arguably prevented harm in hundreds of vulnerable patients. Emeritus nurses (E-RNs) are seasoned and often retired registered nurses who work on a per diem basis, primarily supporting the bedside nursing staff in reviewing and delivering discharge instructions directly to patients. Originally created and launched as an innovative staffing strategy, the E-RNs have emerged as safety champions. They have documented and helped resolve over 215 near miss events related to discharge instruction errors. These great catches are frequently found in conversation with the patient and through investigation into the electronic health record, including home medication reconciliation, inpatient orders, and physician progress notes. Because their time is dedicated to this work, E-RNs have been able to stop and resolve many discharge medication errors related to duplication, omission, and appropriate dosing. Below are several examples of specific patient interactions that highlight their nomination for the Safety Story award.

On the surgical care unit, an E-RN identified that in the written instructions the provider stated the patient would be discharged on Lovenox [an anticoagulant that helps prevent blood clotting] injections. However, when the medication list was reviewed, Lovenox had not been ordered. The E-RN contacted the physician directly to clarify the orders. The provider placed the correct orders and the patient was given correct discharge information with the correct prescriptions. It could have been very dangerous had this been missed, as this postoperative patient was likely at high risk for a pulmonary embolism, stroke, or heart attack.

On the medical oncology unit, an E-RN noted that a patient was ordered sliding scale insulin and nitroglycerin tablets on discharge. The sliding scale did not have clear dosage times, and the nitroglycerin tablets did not clarify when to stop taking the medication and call 911, especially if their chest pain continued. The E-RN contacted the covering physician, who updated the orders, and a new discharge document was printed. Both these medications require this key information to keep patients safe at home. Unknown insulin administration times could lead to hyper- or hypoglycemia [high or low blood sugar, respectively], and not notifying 911 could delay lifesaving care.

Other examples include rectifying double orders of narcotics with differing doses, clarifying orders for medications with conflicting diet instructions, and even hand-delivering discharge instructions to patients in the main lobby after they were forgotten accidentally. Even small corrections to discharge instructions and understanding can prevent future harm, including readmission or death.

While not all 215 examples can be provided, it is clear that E-RNs utilize their nursing experience to reduce harm events by reviewing discharge instructions away from a traditional assignment and independently requesting changes as needed from providers. In a time when technology can be slow, incomplete, complicated, and expensive, E-RNs have been able to intervene as a final safety barrier in the continuum of care. Discharge can be a confusing time for patients and their families, but E-RNs' knowledge and diligence have been a true gift to them and the organization over the last year.

Runners–Up

Sepsis

Sepsis Improvement Team, *Regional Hospital of Scranton, Commonwealth Health*

Emergency Department, *Grove City Hospital*

Ambulatory Care/Surgery Facility

Einstein Endoscopy Center Blue Bell, *Jefferson Health*

Randi Shupp, PA-C, *Lehigh Valley Health Network–Tilghman*

Long–Term Care Facility

Georgina Philbin, RN, *Willow Brooke Court Skilled Care Center at Brittany Pointe Estates*

Juniper Bucks Skilled Nursing Rehab: Theresa Bush, RN, Stephanie Nemeth, RN, Nicole Sokolowska, Emily Kielar, Princy Vaidyan, RN, Heidi Burk, Dr. Neal Mermelstein, *Juniper Village at Bucks County Rehabilitation and Skilled Care*

Transparency and Safety in Healthcare

Magdalena Moyer, *Penn State Health St. Joseph - Cancer Center*

Surgical Services and Executive Leaders, *UPMC West Shore*

Improving Diagnosis

The Center for Diagnostic Leadership Team: Dan Hyman, MD, Kathy Shaw, MD, Eileen Ware, MSN, RN, Meghan Galligan, MD, Cara Jefferies, MSN, RN, Irit Rasooly, MD, Jill Krause, MD, Morgan Congdon, MD, Rich Scarfone, MD, *Children's Hospital of Philadelphia*

Emergency Department, Emergency Department Registration, and Cardiology Department EKG Techs, *Saint Vincent*

Safety Story

Lyndsay Horwedel, BSN, RN, Olivia Johnson, PharmD, Kelly Romano, Carlos Ayala, *Jefferson Einstein Montgomery*

Emergency Response Team, *WVU Medicine–Uniontown Hospital*

Individual Impact

Chelsea Johns, RDN, *Hamilton Health Center*

Ruchi O'Reilly, MSN, RN, *Thomas Jefferson University Hospitals*

Physician Offices

Medical Oncology Department: Jill Ranochak, RN, Maggie Spaeder-Hodges, RN, Danielle Klingerman, RN, and Valerie Dietz, *Jefferson Einstein Montgomery Hospital*

Lindsay Liggett, *WellSpan Franklin ENT*

Time–Outs

Joanne Braswell, Forbes Hospital, *Allegheny Health Network*

Abbe Seidel, RN, *Lehigh Valley Hospital–Cedar Crest*

IAPS 2024

I AM PATIENT SAFETY

Thank you to this year's judges:

Mike Bruno, MD, *Penn State Milton S. Hershey Med. Center*

Sophie Campbell, MSN, RN, *PADONA/LTCN*

Dan Degnan, PharmD, MS, *Purdue University*

Diane Frndak, PhD, MBA, *Robert Morris University*

Regina Hoffman, MBA, RN, *Patient Safety Authority*

Stephen Lawless, MD, *Nemours Children's Health*

Ariana Longley, MPH, *Patient Safety Movement Foundation*

Dwight McKay, *Patient representative*

Adam Novak, MA, *Michigan Health & Hospital Association*

Marty Raniowski, MPP, *PAMED*

Rob Shipp, PhD, RN, *HAP*

Stanton Smullens, MD, *Retired*

Eric Weitz, Esq., *The Weitz Firm*

References

1. Patient Safety Authority. I AM Patient Safety 2024 Winners. PSA website. https://patientsafety.pa.gov/NewsAndInformation/Brochures/Pages/I-AM-Patient-Safety-2024-Winners.aspx. Accessed June 6, 2024.

2. Patient Safety Authority. Changemakers: Stories That Made a Difference. PSA website. https://patientsafety.pa.gov/EventReporting. Accessed June 6, 2024.

About the Author

Eugene Myers (eugmyers@pa.gov) is the associate editor of Engagement and Publications for the Patient Safety Authority. He previously served as editor-in-chief of Communications, Office of Institutional Advancement, at Thomas Jefferson University and Jefferson Health. He earned his bachelor's degree from Columbia University, is a graduate of the Clarion West Writers Workshop, and is an award-winning author of seven novels for young adult readers.