A Common Fatal Pathway

The answer is yes, it would have. For Amanda’s story, please see:

For Lenore’s article on her daughter, please see:
http://ppahs.org/2011/08/18/would-monitoring-have-saved-justin-micalizzi/

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Dr. Krish Ramachandran (Carilion Clinic)
Dr. Elliot Krane (Stanford)
Dr. Frank Federico, RPh

Four Essentials for Patient Safety:

- Make sure patients/families understand why they are using PCA and what triggers/alarms are and what to do when they go off.
- Ensure patients/families are provided information on proper use of the PCA pump, so they understand:
  - Why alarms sound and what to do when they do
  - How to contact staff if they have questions or concerns
  - The resort-to PCA algorithm
  - No PCA by proxy

Dr. Andrew Kofke (University of Pennsylvania)


The safe and secure storage of opioid analgesics in the home.

Accidental duplication of opioid prescriptions;

administration of opioids in order to prevent confusion and reduce the risk of a medication error. As mentioned above, safer storage practices must be in place, especially if the opioid needs to be given parenterally. Pain management providers are encouraged to use opioid alternatives or reduce opioid doses when possible. The use of multimodal analgesia and nonpharmacological interventions should be considered as well. It is important to remember that opioid therapy is not the only way to manage pain.

Fractures that increase risk of cardiopulmonary depression

ASA Abstract (Oct 14, 2012) ar=2012&index=15&absnum=3452

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Patient Safety Checklist Addresses OPIOID WARNINGS FROM JOINT COMMISSION, Physician-Patient Alliance for Health & Safety (PPAHS)

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