Reflection Paper 1
The Case of Lewis Blackman and A Hospitalization from Hell:
A Patient’s Perspective on Quality

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The story about Lewis Blackman is one that left a lasting impact on me and is one that I have never forgotten. It has affected the way in which I approach the care that I provide to each and every patient and family member. The Lewis Blackman story illustrated the failure of the health care delivery system and patient safety on multiple levels. There was impaired communication between the hospital and the family. There was a lack of advocacy for Lewis and his family. There was lack of monitoring of Lewis’s vital signs. There was also a lack of education which existed among the medical and nursing teams responsible for his care regarding the appropriate use of medication given to Lewis post his surgical procedure which may have contributed to his death from septic shock.

There were similar unfortunate events that occurred in the “A Hospitalization from Hell: A Patient’s Perspective on Quality”. Mr. Q was a patient who like Lewis Blackman was admitted to the hospital for a planned surgical procedure. Mr. Q stated that the failure of the health care delivery system began the moment he and his wife checked into the surgery center. He found it overcrowded and disorganized. Mr. Q. who has a history of hemophilia was required to receive factor VIII prior to his surgery. The pre-operative team was unfamiliar with how to mix the medication so Mr. and Mrs. Q had to direct them. After his surgery, there was a long wait before Mr. Q was admitted to his room which was not on the orthopedic unit because there was not an available bed on the unit. There was a lack of communication to Mrs. Q. who had to search the unit in order to find her husband’s hospital room. The patient found the hospital not to be cleaned and he was not offered a bath or a change of linens during his stay. In addition, Mr. Q. pain was not adequately addressed until the second day of his hospitalization. Mr. Q. and his wife also found the discharge process to me confusing and unacceptable.

There were failures reflected in both the Lewis Blackman and Mr. Q.’s hospitalizations which should and could have been avoided. Both health care organizations failed to provide adequate quality patient care. There was failure to provide Patient Centered Care to their patients. In Mr. Q.’s case his needs were not met in multiple incidents. There was a lack of coordination in addressing his need for the important Factor VIII that had to be given prior to his surgery. The surgery center should have ensured that appropriate staff was available to mix and administer or the staff should have been adequately educated in how to administer the medication. In the case of Lewis Blackman the staff should have been educated in the use of Ketorolac for a pediatric patient and the associated negative side effects that may occur such as renal failure. The hospital also failed in Providing Quality Patient Care by not addressing Mr. Q.’s pain adequately. The staff failed to demonstrate understanding of Mr. Q.’s history of using pain medication and understanding his tolerance level may not controlled with the ordered pain medication post-surgery. In Lewis’s case the hospital failed to adequately address the repeated concerns of his parents that something was wrong until it was too late.

The failures in providing Quality and safe patient care had profound effect in both cases. But what was fortunate for Mr. Q. was that he was able to be discharged and address his concerns. His concerns were heard and the hospital responded by making fundamental changes to the patient experience so that his negative experience would not be repeated. The failures in providing quality and safe patient care led to the death of Lewis Blackman. This tragedy led his parents to fight for changes to improve the safety of all patients and led to the development of the Hospital Patient Protection Act, also known as the Lewis Blackman Hospital Patient Protection Act. This act has served as the foundation to the many quality and safety standards that exist today.

References

Cleary, P. D. (2003). A hospitalization from hell: A patient’s perspective on quality

*Annals of Internal Medicine, 138(1)*, 33-39

QSEN Institute (2009). *The Lewis Blackman Story*. Retrieved from

http://qsen.org/faculty-resources/videos/the-lewis-blackman-story/