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Case Study

"*Failure to Rescue*" A Life Support Case Presentation Dilemma

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Abstract

"*Failure to Rescue*" is a foreboding concern that compromises patient safety and encourages morbidity and mortality from iatrogenic interrelated medical errors. The enquiry with the presentation of a case study, addressed in this short communication is, "why are patients "failing to be rescued" by healthcare providers (HCP)?" "*Failure to Rescue*" is a measure of quality of care and postulates that, while obstacles may replicate both the seriousness of the patient illness and the associated health care dynamics. The capacity to "rescue" patients once harm occurs is closely associated with the quality of health care provided. Sub-standard care, and risk incidents are often coupled with "*Failure to Rescue*" settings. One such "*Failure to Rescue*" and safety occurrence links to non-compliance by HCP when verifying and documenting correct and truthful inspections on "*crash carts*". Failure to do so not only compromises patient safety, but also constructs the potential to injure patients, due to a failure of crash cart readiness. Research into the causes of "*Failure to Rescue* "reveals the complexity of the dilemma, with comparisons that reflect expertise into contextual factors such as organisational failure, deficit knowledge and skills, a dearth of supervision and inadequate staffing levels which in combination with excessive workloads creates time management burdens for HCP making it problematicfor them to prioritise their responsibilities. However, despite these contextual aspects it is the author's belief, that "*Failure to Rescue*" related to untruthful checking and documentation on "*crash carts*" correspondingly involves a "failure in ethics." That failure being a deficit in an HCP obligation to their duty of care which safeguards patients and protects them from harm if advanced life support is required. The author assumes there is a predicament with ethics where theory and practice integrate, and consequently, malfeasance. We as HCP are forsaking our duty as patient advocates.

Keywords: Emergency Trolley; Ethics; *Failure to Rescue*; Practice; Theory

Introduction

As nurses, and healthcare care professionals (HCP), we have or will at some point in our careers, past, present and future have heard or will hear the alarming words "I need help", Activate 911", "Quick, get the crash cart, "Call a Code Blue", "Get the emergency trolley " and when the rapid response team, or Code blue team arrive, the emergency trolley was not ready, and the patient was not rescued and consequently harmed.

Look closely at the emergency trollies in your area and decide if they are ready for a life-threatening emergency. Countless emergency trollies have concealed concerns that could promote a patient safety incident.1 While substantial investigate literature on emergency trolley related safety events exists, it concentrates on medication related errors [1,2], this short communication will focus on "*Failure to Rescue*" and patient safety risks in respect to non- conformity by HCP when verifying and documenting accurate and truthful equipment checks on emergency trollies. It is therefore

worthwhile to remember that the objective of an emergency trolley is to ensure that the correct emergency equipment, medications, and stocks are readily available to deal with any emergency.1 Patient injury related to safety in healthcare is a concern and a leading source of morbidity and mortality internationally [3].

The world health organization (WHO) defines patient harm as "an incident that results in harm to a patient such as impairment of structure or function of the body and/or any deleterious effect arising there from or associated with plans or actions taken during the provision of healthcare, rather than an underlying disease or injury, and may be physical, social or psychological" [4]. The health liability related to patient harm is comparable to omnipresent diseases such as multiple sclerosis and cancer in developed countries, and tuberculosis and malaria in developing countries [2].

Patient safety is defined as "the avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of health care" [5]. Patient safety is interrelated to quality of care, but these two concepts are not the same. Safety is a fundamental constituent of quality [5]. Quality of care integrates other factors such as effectiveness, patient focus, timeliness, efficiency, and equity [6]. Care can be of inferior quality, and still be safe, but unsafe care can never be considered of trustworthy quality [7]. Patient safety in health care related to medical errors were became apparent in the publication of the Institute of Medicine's (IOM) report "To Err is Human": Building a safer health system.6 Successively stratagems to improve clinical practices and guidelines were pursued as a approach to improve safety and the quality of patient care. These proceedings led to the creation of the Nationwide Alliance of Patient Safety Organization (NAPSO), which aimed to eliminate preventable harm and improve quality of care in healthcare systems [8]. However, since the publication "To Err is Human": Building a safer health system [6], it remains a concern that healthcare associated errors cannot be abolished and therefore the focus is on decreasing its impact [8-12]. Escalating mindfulness about this issue has focused on identifying and amending futile dysfunctional systems to encourage patient safety, with approaches to safety being directed at entire organisations. Studying the rudimentary causes of error and near misses is regarded as central for fostering both 'single loop' learning, that is, correcting problems within existing structures and processes and the less common 'double loop' learning, which questions assumptions and goals, reconfigures structures, and processes [13]. Identifying and addressing futile dysfunctional systems are recognized as priorities [13]. Dr. Lucian Leape's article, "Error in Medicine," introduced the concept of systems rather than individual-based failures as the cause of medical errors and he examined the outcomes of errors on the individuals who made them. His efforts involving patient safety has advanced the propagation of the theories related to human factors and systems theory, which has provided meaningful understanding and progress within the domain of health care [14].

In spite of the academic insights proposed by Dr. Lucian Leape's publication, "Error in Medicine," it is the author's belief, which will be addressed in this short communication, that perceptions related to human factors and systems, cannot be held exclusively responsible for medical errors within the domain of health care. As such an added consideration called 'Ethics' must be contemplated when reviewing the ongoing unacceptable health care practices [15]. A unique paradigm denoted in the literature as the "theory-practice-ethics gap" suggests an ethical dilemma which links undesirable actions by HCP and their advocacy role [15]. One such deplorable patient safety dereliction is "*Failure to Rescue*" a patient. "*Failure to Rescue*" is a non-action that affects patient safety and encourages patient morbidity and mortality from an etiology allied to medical errors. The question with the substantiation of the presented case study, addressed in this short communication is, why are patients "failing to be rescued" by HCP?

Background

As patient care becomes more specialized, technical, and complex, there is evidence that a patient's migration through the health care system can be challenging and problematic. This is particularly so when HCP, sponsor *Failure to Rescue* incidents, which ultimately affect the quality of care and patient safety. Patient safety and quality care are indispensable aspects for all healthcare practices. When people are admitted to hospital, they anticipate having their infirmity treated successfully, in addition to receiving safe, high-quality care. They do not expect to be harmed or put at risk [15]. The primary goal of healthcare is to maximize safety and health, and so enhance the quality of a person's life [16,17].

Hazards for patient safety can be in the domains of the 'task' or the 'team', or in terms of 'situational', 'organisational' or 'institutional'

factors [18,19]. Sources of hazards are multidimensional and can be entrenched in factors such as inadequate training, ineffective communication or information discrepancies, equipment design, management systems and work processes.5 The IOM report (2000) 'To Err Is Human: Building a Safer Health System' spawned numerous questions about patient safety and a duty for HCP to supply high quality, safe healthcare [20,21]. Over the last two decades, this declaration has been a stratagem for healthcare organizations around the globe. The Joint Commission International (JCI) is one such organization that works to recover patient safety and quality of care for the global community. Nonetheless, despite the awareness which was created by the IOM report and strategies by such organizations as JCI, patients continue to encounter preventable harm and unacceptable, substandard care [16,22]. Alarmingly, Makary and Daniel, (2016), agreed that the medical errors, slips, oversights, and blunders were still prevailing and stated that they were the third leading cause of death in the USA, after heart disease and cancer [23].

"Failure to Rescue"

The concept of "rescue" has traditionally been associated with the ethics of rescue, such as advocacy, quality, safety, early recognition, teamwork, communication, organizing, and culture which apply to all patients generically [27,28]. In juxtapose, "*Failure to Rescue*" is the failure to prevent a clinical decline, such as death or infirmity, from a complication of a causal illness or a problematic medical care consequence. It was first defined in a study that examined medical competence when managing complications post operatively [29]. It is thought the quality of care may impinge on both the seriousness of the patient's illness and the related health care factors [30]. The ability to "rescue" patients when complications surface is related to the quality of health care being provided. Sub-standard care, and risk issues are often associated with "*Failure to Rescue*" circumstances [31]. One such "*Failure to Rescue*" and risk issue relates to non-compliance by healthcare professionals when verifying and documenting accurate and truthful equipment checks on "emergency trollies" [32]. Failure, compromises patient safety, and generates the potential to harm the patients. Research into the root analysis for "*Failure to Rescue* "reveals the complexity of the problem, with similarities that reflect insight into contextual factors such as organisational failure, deficiency of knowledge and skills, a deficit of supervision and inadequate staffing levels which together with excessive workloads create time demands for HCP making it challenging to prioritise duties [33]. To grasp the extent of "*Failure to Rescue*" in the setting of life support, emergency situations, and truthful equipment checks the concept of an "emergency trolley" will be explained.

What is an emergency trolley?

Simply, an emergency trolley is a mobile filing cabinet on wheels that contains all the equipment and medications required for an emergency cardio-pulmonary resuscitation. They are typically individualized and segregated for pediatric and adult populations and are conveniently located throughout healthcare facilities so that they can be accessed rapidly in the event of an emergency (Figure 1).

Figure 1: Example: Emergency trolley.

Why is an emergency trolley necessary?

An emergency trolley or crash cart is normally located in a setting where a patient may unexpectedly experience a medical emergency. This could include a severe allergic reaction, cardiac or respiratory arrest, or both, and conditions with an unexpected sudden deterioration of vital signs. This would require equipment and medications located on and in the crash cart which would

be provided by a credentialled life support provider, such as the American Heart Association. While an emergency trolley can vary depending on their location, in an operating theatre, emergency department, ICU, clinics, and the population they cater too, neonatal, pediatric, adult, geriatric, the fundamentals for the emergency trolley will contain similar equipment and medications.

How is an emergency trolley organized?

Although the organization of requirements for an emergency trolley is not generic, the following is an example for organization, as there is a fundamental standard which provides effortless access to emergency medical equipment and medications. Note that all these organizational points are checked, dated, and signed by the staff member who performed the daily routine inventory and inspection.

Emergency trolley top shelf

The top section of all *crash carts* typically has the most frequently used equipment employed in a resuscitation event such as the following:

- The defibrillator/AED which connected to power outlet and charging batteries for portable use.
- ECG cable/Electrodes/Transcutaneous pacing cable
- Multi-purpose pads that can be employed for hands-off defibrillation, and transcutaneous pacing. There should also be separate infant pads and paddles in paediatric care facilities.
- Non-sterile rubber gloves as for personal protection equipment (PPE)

Emergency trolley sides/rear

The sides and back of the *crash carts* are typically allocated the following equipment, but can vary depending on the setting

- The oxygen cylinder should be secure on the side of the cart, with a full oxygen pressure level.
- A suction apparatus/charging the battery for portable use.
- A Sharps container should be secure on the side of the cart, empty or below the safe recommended level.
- A rigid, plastic/fiberglass backboard for chest compressions located on the rear.

Emergency trolley Recommended equipment [RCUK, 202243, AHA 2021] [34].

- Airways/oral and nasal/all sizes
- McGill forceps, large and small
- 3 laryngoscope and endotracheal tubes
- Bag valve mask (adult and paediatric)
- Nasal cannula (adult and paediatric)
- Nonrebreather oxygen face masks (3 sizes)
- IV start packs
- Normal saline solution (1000ml bags)
- IV tubing
- Angiocaths (various sizes)
- 10ml normal saline flush syringes (3)
- Gauze
- Alcohol preps
- Monitor with defibrillator/AED.
- Syringe nasal adaptor (nasal Naloxone atomizer)
- A checklist confirming inventory on the cart.

RCUK 2022, AHA 2021: Follow manufacturer guidelines on use of the organization's equipment.

Emergency trolley: Recommended Medications [RCUK, 202243, AHA 2021] [34]

Medications may vary by organization

- Aspirin 81mg Tablets (4)
- Nitro-glycerine spray or 0.4mg sublingual tablets (3)
- Dextrose 50% (dextrose 25% if treating paediatrics)
- Narcan 1mg/ml (6)
- Epinephrine 1:10,000 auto injector (10)
- Atropine Sulphate 1mg (3)
- Amiodarone 150 mg Vial (3)
- Epinephrine 1:1,000 (2)
- Solumedrol 125 mg (1)
- Benadryl 50 mg vial (2)
- Adenosine 6 mg (3)

- Lopressor 10 mg (2)
- Cardizem 20 mg vial (2)
- Procainamide 1g (1)
- Lidocaine 100 mg (3)

RCUK 2022, AHA 2021: Follow organizational guidelines for medications.

Emergency trolley: Recommended maintenance [RCUK, 202243, AHA 2021] [34].

- Check expiration dates on equipment and medications as per organizational policy and procedure and replace as required.
- Keep all equipment that requires portable power such as the Defibrillator, AED, ECG monitor, and Portable suction) fully charged.

RCUK 2022, AHA 2021: Follow organizational guidelines for crash cart maintenance.

Emergency trolley: Scheduled inventory check

The purpose of a emergency trolley inventory is to organize a schedule of when to check for expiration dates of equipment, supplies and medications, and as such to replace items as required (Figure 2).

EMERGENCY TROLLEY CHECKLIST

Unit:	
Month:	
Year:	

Drugs	**Amount**	**Exp Date**	**Date**	**Date**	**Date**	**Date**	**Date**
Adrenaline 1:1000	5						
Biperiden HCL (Akineton)	2						
Atropine 0.6mg/ml	5						
Calcium Chloride 10ml	2						
Dextrose 50% 20ml	2						
Diazepam 10mg/2ml	5						
Disprin -tablets	5						
Plasmalyte B (Baisol) 1Litre	1						
Flumazenil (Anexate)	2						
Furosemide 20mg/ml	5						
Lignocaine 2%/5ml (100mg)	2						
Magnesium Sulphate 50% solution	2						
Naloxone (Narcan)0.4mg/ml	2						
Nitrolingual Spray	1						
Potassium Chloride 40mmol	2	(High alert drug)					
Promethazine (Phenergan)25mg/ml	2						
Lenamet 200mg	4						
Salbutamol 5mg	2						
Solu-Cortef 100mg/2ml	2						
Normal Saline 10ml	10						
Sodium Bicarbonate 8.5% (50ml)	1						
DEFRIBILATOR							
Battery charge light on							
Battery date							
Adult Defib Pads - sealed	1pkt						
Cables							
Paeds Defib Pads - sealed	1 pkt						
Cables							
CIRCULATION							
CPR Board	1						
INTRAVENOUS THERAPY							
Jelco`s 14 G	2						
Jelco`s 16 G	2						
Jelco`s 18 G	2						
Jelco`s 20 G	2						
Jelco`s 22 G	2						
Jelco`s 24 G	2						
Tegaderm (1625 +1626)	4						
Butterflies 21 G, 23 G, 25 G	6						
Insulin Syringes 1ml	2						
Syringes 2ml	2						
Syringes 5ml	2						
Syringes 10ml	2						
Syringes 20ml	2						
Needles 18G	2						

Figure 2: Example: Emergency trolley inventory.

Also, to check that equipment is operating as required in the event of an emergency. In addition to recording who performed the inventory checks, with dates, times, and signatures. There should also be a record of what was replaced and when. An alarming situation for healthcare personnel requiring a emergency trolley is to find unusable equipment or expired medications in an emergency. Ensuring that an up-to-date, accurate, and truthful inventory record can avoid potential patient safety situations such as absence of equipment such as laryngoscope blades or handles, equipment failure due to expired batteries, expired or missing medications, empty oxygen cylinders.

Failure to Rescue emergency trolley: Scheduled inventory check.

The objective of this short communication is to highlight the patient safety risk incident which relates to "*Failure to Rescue*" which is perpetrated by HCP when they do not check an emergency trolley accurately. In the hospital setting, standards for checking may vary, but are globally governed by hospital policy and procedure. Failure to do so, not only compromises patient safety, but also creates potential to harm patients, as underscored by the Patient Safety Authority, (2010), which revealed that contributing factors to patient safety and emergency trollies included, but were not limited to missing, expired, damaged, contaminated, and unavailable equipment and/or medications, empty or defective oxygen tanks, depleted batteries on equipment or equipment failure, unsecured carts or carts that had been tampered with, incorrect size of equipment, which ultimately indicated that emergency trollies were not checked, inspected or documented according to organizational policy and procedure which resulted in delays getting equipment and medications and as such "*Failure to Rescue*" [3,5].

The "failure to recue" dilemma which will be reviewed in the following case study which illustrates events that placed a middle-aged female patient in harm's way. The case study focuses on the truth that HCP are provided with knowledge, such as organizational policies and procedures for emergency trolley checking which can be simplified and called "Theory" and HCP are also required to demonstrate competence and organizational compliance, with check lists before allocated this routine, yet critical task, which can also be made simpler and called "Practice". However, HCP continue to sponsor an attitude of non-compliance or unethical practices which create "*Failure to Rescue*" medical errors and place the patients' safety at risk [1,15,31,32].

Case study

A 48-year-old female patient was assessed in a Southeast Asian general hospital Emergency department (ED). On clinical examination, she was anxious, had an irregular pulse rate of 135 beats per minute; a 3rd heart sound, and an intermittent arrhythmia which was diagnosed as paroxysmal atrial fibrillation [PAF] on the cardiac monitor. Her blood pressure [BP] was 140/80 mmHg; an elevated jugular venous pressure [JVP] was noted, as was hepatomegaly and ascites. Peripheral edema was also observed in her legs and ankles, as was shortness of breath with a respiratory rate of 32 breaths per minute: a SpO2 of 93% on room air, and audible crackles on auscultation in global lung fields. Chest x-ray confirmed cardiomegaly, CCF with interstitial edema (Figure 3). An echocardiogram revealed an ejection fraction of 35%. A 12 lead ECG revealed sinus tachycardia, with no further indication of PAF. She was referred to a specialist cardiac center with a diagnosis of congestive heart failure [CCF], however, with no vacant beds she was admitted to a medical ward until a bed became available.

Figure 3: Chest x-ray Congestive Heart failure.

That evening, she complained of chest pain with nausea, which the medical team attributed to angina pectoris, and she was prescribed and treated with narcotic analgesia with immediate relief. When she had further chest pain that night, her heart rate was irregular and increased to 145 beats per minute, and she was diagnosed with new-onset atrial fibrillation (Figure 4). She was connected to a telemetry monitor and cardiology was consulted externally. The consulting cardiology service prescribed medications to control her heart rate and a systemic anticoagulant, both for her atrial fibrillation.

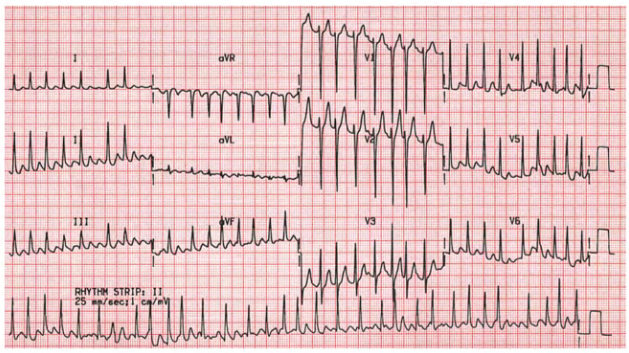

Figure 4: 12 Lead ECG: New onset atrial fibrillation.

The next morning, her chest pain and nausea returned, and she collapsed while ambulating to the bathroom. Nurses could not get a response from her, and she was pulseless. The emergency medical response was activated, and CPR commenced. The emergency trolley was brought to the scene, the patient was connected to the defibrillator's ECG monitor by the nursing staff, and dysrhythmia ventricular fibrillation was observed (Figure 5).

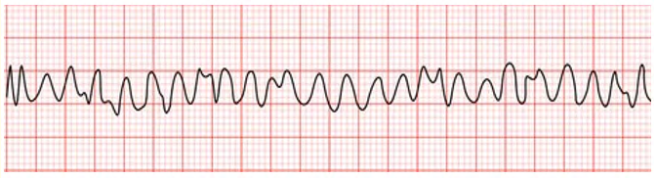

Figure 5: Defibrillator monitor ECG rhythm strip: Ventricular fibrillation.

The Code team arrived, and the team leader wanted to defibrillate the ventricular fibrillation, however, only pediatric paddles were available, the adult paddles and the pads cable were missing. CPR continued until another defibrillator was obtained from another department, this required 7 minutes. CPR was stopped and a rhythm check was performed, the patient was now in asystole, and despite maximal efforts by the code team, she could not be resuscitated (Figure 6).

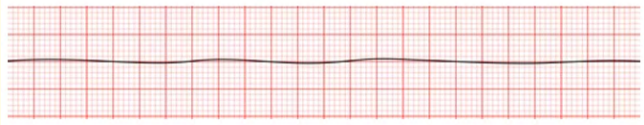

Figure 6: Defibrillator monitor ECG rhythm strip: Cardiac asystole.

The healthcare organization concerned, performed a multidisciplinary root cause analysis, and determined that numerous issues and events contributed to the patient's untimely death. Those events being, her unstable cardiac condition, which was complicated by new onset atrial fibrillation, and the missing equipment on the crash cart, that caused the delay in the defibrillation of ventricular fibrillation which promoted the deterioration of her cardiac condition into asystole. Additional information obtained from the root cause analysis discovered that the emergency trolley had been checked that morning by the responsible staff member and all equipment and supplies had been verified as available and operating on the checklist.

Root cause analysis [RCA] recommendations from this case study were based on the frequency of an emergency occurring in a known clinical area, and the risk to patient safety associated with "*Failure to Rescue*". The RCA findings related to checklist knowledge, correct use, and missing equipment on the emergency trolley. This signified that staff were not adequately prepared and required further training, as well as continuing education. In the opinion of the RCA committee, such staff training, when used effectively, can create accountability among both clinical and nonclinical staff members and can cultivate a proactive team approach. In addition, periodically auditing checklists at scheduled intervals may also

prevent the incidence of faulty equipment, missing items, or outdated medications on emergency trollies and reduce "*Failure to Rescue*" situations.

This case study exposes two issues of concern which relate to patient safety, the first a medical dilemma, which involved "*Failure to Rescue*" a patient due missing equipment on the emergency trolley which had been verified and checked as available and operating. The second, a conflict of professional ethics and a duty of care within a paradigm called the 'theory-practice-ethics gap"15 This paradigm acknowledges that all HCP are provided with theoretical knowledge and practical skills, yet these same HCP continue to be ethically non-compliant with organizational policy and procedure which creates places patients in harm's way. Without adherence to organizational policy when performing essential procedures such as a emergency trolley check, it creates a situation which promotes "*Failure to Rescue*" events and as such compromises patient safety. This case study also serves as a prudent reminder that everything we do to or for the patient has potential complications associated with it. Ultimately the goal of all professional HCP is to provide safe, evidence-based quality care because all patients regardless of their religion, race, culture, age, or gender are entitled to safe, quality care.

Discussion

Healthcare has reliably considered medical errors as failings on the part of individual HCP, which has exposed inadequate HCP knowledge or skill. The modern-day field of systems analysis that was founded by the British psychologist James Reason, whose analysis of errors exposed that safety failures are almost never caused by isolated errors committed by individuals. Instead, most accidents result from multiple, smaller errors in environments with serious underlying system flaws [36].

Reason introduced the Swiss Cheese model to describe this phenomenon, errors made by individuals result in outcomes due to flawed systems, the holes in the cheese, not by individuals (Figure 7) The model compares human systems to layered slices of Swiss cheese, that are stacked side by side. 36 In the Swiss cheese model, an establishment's safeguards against failure are modeled as a series of obstacles, represented as slices of cheese. Holes in the slices represent weaknesses in individual parts of the system and are continually varying in size and position across the slices. The system produces failures when a hole in each slice momentarily aligns, permitting "a trajectory of accident opportunity", so that a threat passes through holes in all of the slices, leading to a failure 37 Although the Swiss cheese model is respected and considered to be a useful method of relating concepts (Reason, 1990, 1995, 2000), it has been subject to criticism that it is used vaguely [Eurocontrol. 2006].

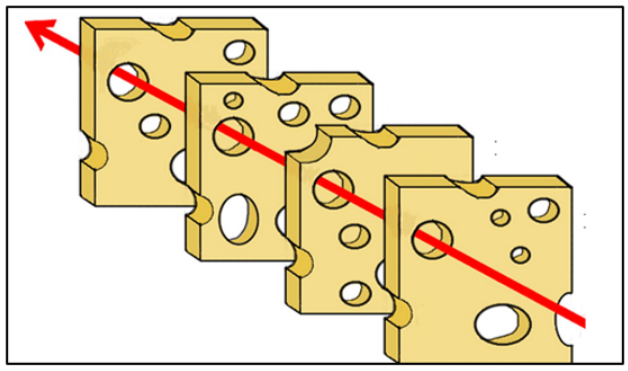

Figure 7: The Swiss Cheese model (Reason 2000) [37].

Since the IOM report "To Err is Human": Building a safer health system [6], it is accepted that medical errors cannot be eliminated and therefore the emphasis is on controlling or moderating the effect [6,8,9,33,38]. Which supports Reason's fundamental conjecture was that human error is inevitable, especially in systems as complex as health care, and to expect a faultless performance from human beings in multifaceted, high stress setting such as healthcare is unrealistic. However, it is the author of this short communications belief that in an perfect world, healthcare would happen in a highly reliable system where no one is harmed, and everyone gets the care they need. But, in reality, patients continue to be harmed with the experts choosing to state that "we're all human and make mistakes" and, of course, to "Err is Human" [39-43].

In actuality, HCP are provided with evidence-based healthcare information called "theory", such as organizational policies and procedures, and are expected to demonstrate evidence-based practice called "practice" which validates competence

and organizational compliance [15]. Evidence-based healthcare practices, ensures patient safety, and prevents potential patient harm 44 There are no routine medical procedures in healthcare, every intervention could place the patient at risk and/or in harm's way. This case study involved a patient who was "failed to be rescued", a patient who could not be resuscitated due to missing equipment on the emergency trolley which had been previously verified by the responsible HCP as operational. The patient in this case study was a 48-year-old female patient who went to an ED in a Southeast Asian general hospital. She was anxious, and probably terrified because she could not breathe effectively. Once admitted to the hospital, the author speculates that the patient was comforted and reassured that she would receive the required care, endorsed by the ethics of rescue. Those ethics being, advocacy, quality, early recognition, teamwork, communication, organizing, and a culture of safety which applies for all patients generically [27,28]. However, following the patient admission to the hospital, a medical and an ethical dilemma occurred that involved an event of "*Failure to Rescue*" where the patient could not be resuscitated due to missing equipment on the emergency trolley.

Conclusion

Health care miscalculations, medical errors, blunders, oversights, booboos, faults, or slip-ups, whatever term attached to these patient safety consequences. The concept of a "theory-practice-ethics gap" recognizes that healthcare professionals are prepared with theoretical knowledge and realistic skills to practice competently and safely. However, HCP continues to be non-compliant towards patient safety issues which is an ethical dilemma. An obligatory objective for HCP is to deliver safe, evidence-based high-quality care. Why? Because all patients, no matter what their race, culture, religion, gender, or age, are eligible to be provided with safe, high-quality care. Measures must be taken to inspire and urge HCP to reflect on their ethical behaviors, and to eliminate this proposed 'theory-practice-ethics gap'. If we as health care professionals and patient advocates don't care or act ethically, who will.

Do onto others as you would have them do unto you (Matthew 7:12).

Author's note

For this short communication and case study, formal consent was not required, as it does not identify the organization, or the individuals involved.

Declaration of Interests

The author declared no potential conflicts of interest with respect to authorship, and/or publication of this article.

Key Points

- Validating and documenting reliable equipment checks on emergency trollies must be accurate for patient safety.
- All health professionals have a moral obligation to 'do the right thing' to ensure patient safety
- Given that health professionals understand the theory related to their clinical practices, ethical responsibilities require constant emphasis.
- For patient safety to be a valid goal, health professionals such as nurses must embrace their role as patient advocates.

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