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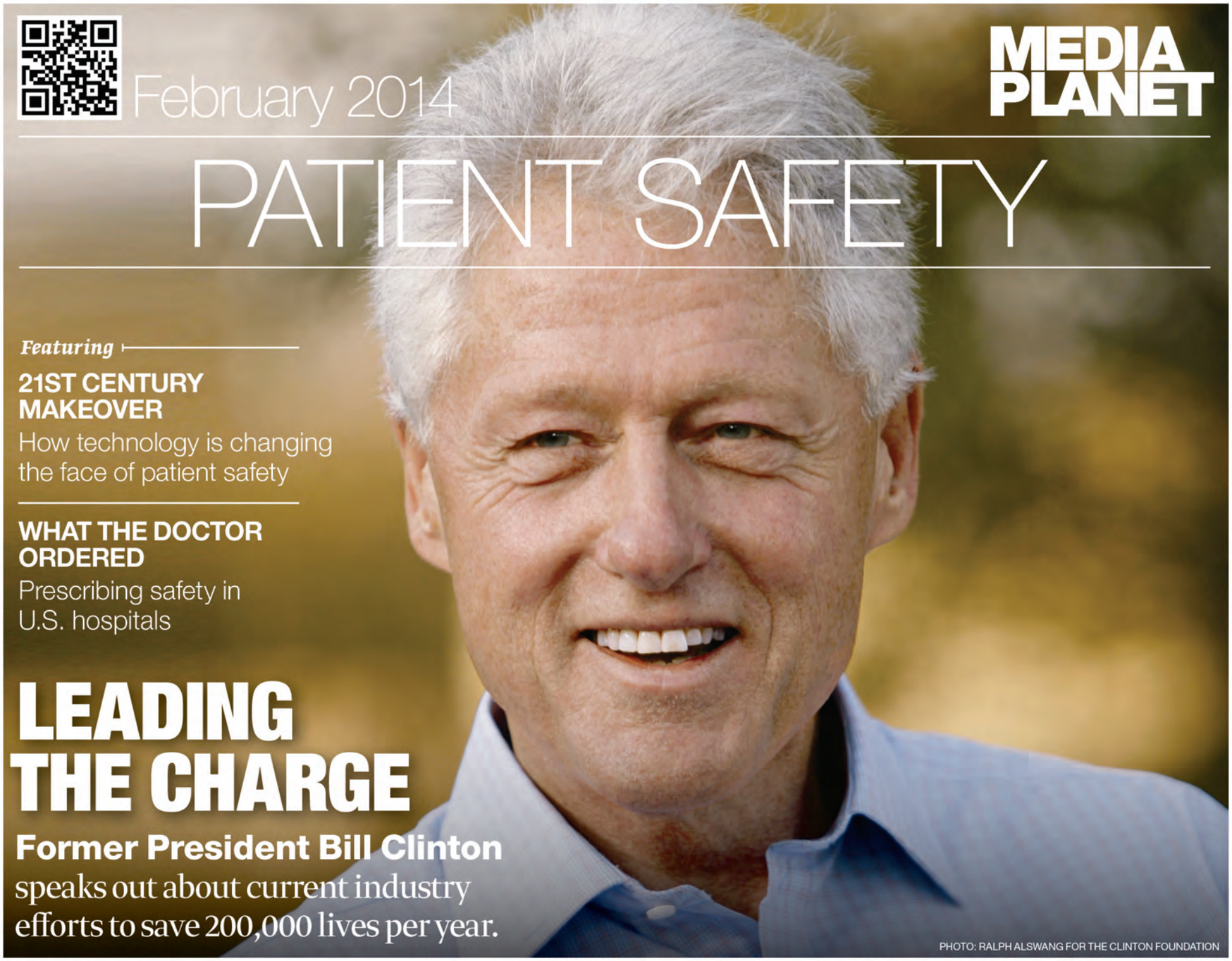

February 2014

MEDIA PLANET

PATIENT SAFETY

Featuring

21ST CENTURY MAKEOVER
How technology is changing the face of patient safety

WHAT THE DOCTOR ORDERED
Prescribing safety in U.S. hospitals

LEADING THE CHARGE

Former President Bill Clinton speaks out about current industry efforts to save 200,000 lives per year.

PHOTO: RALPH ALSWANG FOR THE CLINTON FOUNDATION

CHALLENGES

There are more deaths in hospitals each year from **preventable medical mistakes** than there are from vehicle accidents, breast cancer and AIDS. As a patient, how can you protect yourself?

Check it out before checking in

Leah Binder, MA, MGA
PRESIDENT AND CEO,
THE LEAPFROG GROUP

"You have the right to a hospital stay that is free from harm and error."

Accidents,errors and infections occur far too often in hospitals, killing as many as 200,000 people every year and injuring millions more. Fortunately, many hospitals across the country excel at keeping patients safe from harm — and there are ways you can spot them. Here's what to look for the next time you or a family member enters the hospital:

Do all of your care providers wash their hands?
It seems so simple, but one of the easiest ways of preventing infections is thorough and repeated handwashing. Every doctor, nurse and technician who cares for you while in the hospital should wash their hands before and after seeing you. Don't hesitate to speak up and ask your provider to wash their hands if it looks like he or she forgot; it could very well prevent an infection and save your life.

Does the hospital have technology to prevent medication errors?
Medication errors are the most common form of hospital error. On average, Medicare beneficiaries experience one medication error per patient every day. Many hospitals have adopted computerized prescriber order entry (CPOE) systems and bedside barcoding technologies to ensure patients receive the correct medication and proper dosage. Ask if your hospital has this technology in place.

Does the hospital use checklists for surgery and patient care?
Hospitals are fast-paced, complex environments where it's far too easy for the most capable surgeons to make terrible errors, such as operating on the wrong body part or leaving a sponge in the body cavity. Research shows that when surgeons go through a simple checklist before they wield the scalpel, patients are safer. The use of a checklist can make all the difference.

Does the hospital actively involve you and your family in your care?
The safest hospitals recognize that patients often know best when it comes to how they are feeling and the treatments that make the most sense for their values and their lives. The hospital staff should encourage you and your family members to speak up if you sense something is amiss. Bring a notebook to the hospital with you to write down everything your doctors and nurses say, as well as how you are feeling so that you can better protect yourself and your providers if something goes wrong.

Start your research with the Hospital Safety Score to determine which is the safest for your family, then look for other ratings as well. Let your doctor know that hospital safety is important to you, and work together to find the best hospital. You have the right to a hospital stay that is free from harm and error.

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EDITOR'S PICK

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Foundation for change: Paving the way for proactive patients

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When Seconds Count...

Physician Anesthesiologists Save Lives.™

Over the past century, physician anesthesiologists have advanced patient safety through innovative research, science and technology advancements. Whether in the operating room, procedure room, intensive care unit or pain clinic, physician anesthesiologists are committed to delivering the safest medical care that every patient deserves before, during and after surgery.

To help ensure the highest quality and safest care, physician anesthesiologists lead the Anesthesia Care Team to supervise non-physician providers. Even though anesthesia is safer than ever, the administration of anesthesia is a complex and technically demanding medical procedure. It requires a physician who has the extensive medical education (at least 14 years) and clinical training (12,000-16,000 hours) to evaluate your medical condition, recommend an appropriate anesthesia plan, diagnose and treat problems that might surface during a procedure, and make critical, split-second decisions that can save your life.

Physician anesthesiologists prevented 6.9 excess deaths per 1,000 cases in which a surgical or anesthesia complication occurred.

Who is in charge of your life? You have a right to know. Before undergoing a surgical procedure, you need to know who will be providing your anesthesia and ask for your physician anesthesiologist. It is also important to follow all pre-operative instructions from your physicians, especially regarding eating, drinking and taking your medications. Your physician anesthesiologist will need to know your past medical history, surgical history, anesthesia experiences, allergies and current medications. For more information, visit **asahq.org/WhenSecondsCount**.

Your safety, your life ... it's our top priority.

American Society of Anesthesiologists®

Your Path to ZERO starts here

The SurgiCount Safety-Sponge® System is clinically proven to help eliminate retained surgical sponges by enabling surgical staff to account for each and every sponge used in a procedure.

Five of the top 10 2013-2014 *U.S. News & World Report* Best Hospitals Honor Roll Recipients use the Safety-Sponge® System

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INSIGHT

BILL CLINTON: HOW TO SAVE 200,000 LIVES

GALVANIZING A MOVEMENT
Bill Clinton speaks out for patient safety measures.
PHOTO: PATIENT SAFETY MOVEMENT FOUNDATION

Imagine your husband goes into the hospital for a routine surgery, but contracts a deadly infection resulting from unwashed hands.

Because it is seemingly arbitrary, many people shrug off such tragedies as isolated events. In reality, 200,000 patients die annually from preventable causes in America's hospitals.

A step forward

The Patient Safety Movement Foundation is aiming to eliminate preventable death by 2020, and the organization recently held the Patient Safety, Science and Technology Summit in an effort to fulfill its goal.

The event brought together political and industry leaders, including former President Bill Clinton. In his keynote address, Mr. Clinton underscored the urgency behind the Patient Safety Movement Foundation in terms of saving lives, as well as reducing costs associated with readmitting patients. "I think it's improving the quality of care, making fewer mistakes and having to undo less," he explains. Clinton says he supports the movement because, "You stood up and said you wanted to save 200,000 lives and were convinced you could do it. You had what I believe is the only way to do anything like this; you were going to get all these people involved."

The summit was an important step toward eliminating preventable deaths that feel anything but arbitrary to affected families.

VISIT PATIENTSAFETY UPDATES.COM FOR EXCLUSIVE EXTENDED CONTENT

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A father's vow to prevent the preventable

After a medical error claimed the life of his young daughter, Christopher Jerry honors her short life by trying to save others.

In 2006, when my daughter Emily died because of a preventable medical error, I knew there would be no bringing back my beautiful little girl. I also knew there had to be formidable ways — through the implementation of technology solutions and best practices — to modify the internal systems and processes in medicine that would prevent the same types of fatal errors.

Medical mistakes

Ever since I began my full-time work as a patient safety advocate, it has been extremely important to me — as Emily's father and one who has been working very hard to effect positive change in medicine through the Emily Jerry Foundation — to truly focus my efforts on being an active part of the solution to preventable medical errors. My primary motivation has always been to find ways to prevent others from suffering a similar fate as Emily.

According to recent studies more than 200,000 people a year die in the United States from preventable medical errors, making it the third leading cause of death in our nation after heart disease and cancer. Medication errors are the foremost preventable error affecting patients today.

No price on human life

Emily's death was tragic and what made it even more heartbreaking was finding out that technology was available at the time of her death that would have prevented the pharmacy technician from making the lethal compounding error that took my daughter's life. Patient safety should not be the subject of budgeting. What price can be put on safety? Isn't one life lost too many? I truly believe that once a technology's efficacy is proven to reduce the chance for error, the solution should be adopted immediately as a "standard of care" and become a requirement for all of our nation's facilities. Had these proven technologies been implemented into the clinical pharmacy workflow at the facility where she was treated, I am convinced, without a shadow of a doubt, Emily would still be with us today.

A LIFE CUT SHORT
A blonde-haired, bubbly two-year-old, Emily Jerry was rendered brain dead because of a compounding error.
PHOTO: THE EMILY JERRY FOUNDATION

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200,000 patients die each year from preventable causes in US hospitals

Our goal is to get to ZERO by 2020.

More than 100 hospitals, clinicians, patient advocates, and technology companies have made Commitments to get to ZERO.

WILL YOU JOIN THE MOVEMENT?

www.patientsafetymovement.org

MAKE A COMMITMENT

Make your Commitment to ZERO preventable patient deaths by 2020 at

www.patientsafetymovement.org/commitments

Patient Safety MOVEMENT

zero preventable deaths by 2020

MASIMO Foundation for Ethics, Innovation & Competition in Healthcare

twitter.com/0x2020

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A CLOSE-KNIT FAMILY
LEFT: Louise Batz poses proudly with first-born grandchild, Ella Townsend. RIGHT: Louise Batz spends quality time with daughter Laura (left), daughter-in-law Ginger (middle), and grandchildren Ella and Sawyer.
PHOTOS: COURTESY OF LAURA TOWNSEND

An untimely death spurs a timely mission

The tragic death of Louise Batz after a routine procedure prompted her family to advocate for change through the Louise H. Batz Patient Safety Foundation.

In 2009, after a successful knee replacement surgery, all signs indicated that Louise Batz would make it out of the hospital in time for the birth of her fourth grandchild. Yet, when she returned to her room, she was unnecessarily prescribed a combination of sedatives and opioids that resulted in respiratory depression and an anoxic brain injury. Louise was placed on life support and 10 days later, tragically lost her life.

While Louise was on life support, her children asked countless questions and it didn't take long for them to realize that their mother's deteriorating condition was caused by a preventable medical error. "I wondered, 'Does this happen to a lot of people, or are we just the most unlucky people in the world?'"says Laura Townsend, daughter of Louise Batz. "I started doing research and I couldn't believe what I was reading: Almost 200,000 people a year die from preventable medical errors, that it is the third leading cause of death in this country. How did we not know until it was too late?"

Taking action

In her honor, the family founded the Louise H. Batz Patient Safety Foundation with Townsend as president. She describes her mother's death as the most devastating moment of her life. "It felt like my mom had just been hit by a drunk driver. It was all so sudden, all so unexpected and tragically, could have been avoided," she says.

By partnering with healthcare facilities, Townsend and her staff are looking to promote a culture of teamwork, increase the health literacy of patients and families, empower patients to ask the most critical questions, track and log medication use and vitals and learn how to be an extra set of eyes for the medical team.

"I wish every day that I could just have five hours back. If I only knew then what I know now, my mom would be with us," Townsend says. Although Louise's family asked thousands of questions in the days leading up to and after the accident that took her life, like many patients, they simply never asked the right ones.

In Louise's case, this meant that nobody on the medical team or in the family thought to check if she was one of the more than 25 million Americans with undiagnosed sleep apnea, which — if discovered earlier — would have led to more vigilant monitoring and the avoidance of certain drugs. "Preventable errors are no one person's fault," says Townsend. "My mom had great nurses, great doctors and a great family, but great players don't always make a great team. What happened to my mom was 100 percent preventable. The time is now to work together to help our doctors and nurses, and to truly become part of the healthcare team. If we are going to make a difference in the staggering numbers of preventable medical errors that happen each year, we can no longer be spectators in our own healthcare."

A community united

This Patient Safety Awareness Week, in memory of Louise and the thousands of other Americans who lost their lives to preventable medical errors, we urge patients to educate themselves on what they can do to become a stronger member of their care team.

"She was just the best mom in the world," Townsend says through tears. "She taught me how to love, respect and care for others, to never give up, to always persevere and most importantly, never to lose hope. She was my hero. She saved my life everyday and still does. I hope her story and legacy will inspire the hero in all of us."

To learn more, please visit Louisebatz.org

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NEWS

Safe and ultrasound

Why the ultrasound-guided approach to central vein catherization (CVC) is replacing the landmark method.

Ironic, but true: Each year, 5 percent of all hospitalized patients develop healthcare-associated infections (HAIs), and almost 100,000 die as a result. The most deadly of all HAIs are central line-associated bloodstream infections (CLABSIs). The associated mortality rate hovers between 30,000 and 62,000 deaths per year, with an average treatment cost of $26,000 per case.

A double-edged sword

Central vein catherization (CVC) allows large-scale therapeutic interventions for patients who require intensive nutritional, chemotherapeutic, antibiotic or transfusion-related support. CVC is intended to save lives, but patients with CVCs are at high risk of infection.

> "Ultimately, it is the sickest, most vulnerable patients who require CVC. They are also the patients who stand to benefit the most from a best-practices approach."

Now the good news: In 2001, the Agency for Healthcare Research and Quality reported that "real-time ultrasound guidance increases the success rate and decreases the complication rate associated with CVC placement." Subsequently, in 2005, the Institute for Healthcare Improvement introduced the "bundle" approach for decreasing bloodstream infections. Five main interventions include hand hygiene, maximal barrier precautions, chlorhexidine skin antisepsis, optimal catheter site selection and an ongoing daily review of whether or not the line is necessary.

A two-pronged approach

Mounting evidence has made it clear that "bundle" procedure, combined with ultrasound-guided CVC placement, is the optimal approach to reducing the risk of CLABSI. Many top academic medical centers are now implementing ultrasound-guided CVC placement as a best practice, though many community-based hospitals still lag behind.

Ultimately, it is the sickest, most vulnerable patients who require CVC. They are also the patients who stand to benefit the most from a best-practices approach to central line management based on ultrasound-guided CVC.

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DON'T MISS

No sponge left behind

Unintended retention of foreign objects (URFOs) happens more often than you might think and can cause severe physical harm — even death.

In the hectic, stressful setting of an operating room, it can be easy to lose track of the dozens of surgical items—needles, scissors, retractors, sponges—used in a patient during a typical surgery. And indeed, each year 4,000 cases of retained surgical items are reported, the majority of these retained items being sponges.

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Location courtesy of THE HEART HOSPITAL Baylor Plano.

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