FAQ

Patient Safety MOVEMENT
zero preventable deaths by 2020

WHO

Joe Kiani, Founder & Chairman, Patient Safety Movement Foundation

WHAT

Founded in 2012, the Patient Safety Movement Foundation (PSMF) is a nonprofit 501(c)(3) dedicated to eliminating preventable patient deaths in U.S. hospitals by 2020 (0X2020). The Foundation convenes the annual World Patient Safety, Science & Technology Summit. The Summit brings together the world's leading clinicians, hospital CEOs, patient advocates and government leaders to identify main challenges and provide tested solutions called Actionable Patient Safety Solutions (APSS). Attendees are asked to make a formal commitment or pledge and report on progress annually.

WHERE

The Patient Safety Movement Foundation
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www.patientsafetymovement.org

WHY

It is estimated that 200,000 – 400,000 preventable patient deaths occur each year in U.S. hospitals.[1] The Patient Safety Movement Foundation has made a public commitment to eliminate preventable patient deaths by the year 2020.

HOW

- Identify current patient safety challenges facing hospitals and develop Actionable Patient Safety Solutions (APSS) in order to address these challenges
- Encourage healthcare technology companies to share data
- Ask hospitals to make a commitment to implement APSS

RESULTS

COMMITMENTS

Over 69,519 lives have been saved as a result of the APSS that Patient Safety Movement Foundation participants have implemented. To date, more than 3,526 healthcare organizations have made public commitments to eliminate preventable patient deaths by 2020.

U.S. Healthcare Organizations include:

- Baylor Scott & White Health Care System
- Children's Hospitals' Solutions for Patient Safety
- Christiana Care Health System
- Cleveland Clinic
- Emory Health
- HealthInsight
- Hospital Quality Institute (HQI)
- Inova Heart and Vascular Institute
- Intermountain Healthcare
- Johns Hopkins Medicine
- Kaiser Permanente
- March of Dimes
- Massachusetts General Hospital
- Mayo Clinic
- Medstar Health
- Parrish Medical Center
- Sheppard Pratt Health System, Inc.
- University of Pittsburgh Medical Center
- University of Vermont Medical Center

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International Healthcare Organizations include:

- A.C. Camargo Cancer Center, *Brazil*
- Centre Hospitalier de Melun-Senart, *France*
- Chiang Mai University Hospital, *Thailand*
- Children's Hospitals' Solutions for Patient Safety, *US, Canada*
- City International Hospital, *Vietnam*
- Cloudnine Hospital, *India*
- Edna Adan Teaching Hospital and Edna Adan University, *Somaliland*
- Ibero American Society of Neonatology (SIBEN), *Latin American Countries*
- IRCCS Istituto Ortopedico Galeazzi, *Italy*
- Karolinska Institutet, Institutet Södersjukhuset, *Sweden*
- Laerdal Global Health, *Norway*
- Medical University of Vienna, Vienna General Hospital, *Austria*
- Newborn Foundation & Research Institute, *Phillipines, China, US*
- Radja Ahmad Thabib General Hospital, *Indonesia*
- Scottish Patient Safety Programme, *Scotland*
- Secretaría de Salud, *Mexico*
- SENSAR, *Spain*
- Seoul National University Hospital, *South Korea*
- Sign up to Safety, *England*
- Tokyo Women's Medical University, *Japan*
- Toronto Western Hospital University Health Network Canada
- University Hospital Heidelberg, *Germany*
- Vilnius University, *Lithuania*

PLEDGES

To date, 69 medical technology companies have made a public "Open Data Pledge" to share data their products are purchased for, with no interference or charge.

69 Medical Technology Companies That Made A Public Pledge to Share Data

- Admetsys
- AirStrip
- ATL Technology
- BD Intelliport
- Bernoulli Health
- BrainStem Biometrics
- Cercacor
- Cerner
- Certa Dose
- Codonics
- CorCardia Group
- CrossChx
- DebMed
- Doctella
- Dräger
- DynaLabs LLC
- EarlySense
- eBroselow, LLC
- ExCor Technologies
- FUJIFILM Sonosite
- GE Healthcare
- Healthcentrix
- Heartin Inc.
- Hyginex
- IBM Watson Health
- ICUcare
- Innara Health
- Iradimed
- KnectIQ Inc.
- Kolkin
- LumiraDX USA Inc.
- Masimo
- Medical Intelligence Holding Corp
- Medical Simulation Corporation
- Medtronic
- Modulated Imaging
- Monarch Medical Technologies
- NeurOptics
- Oracle
- Patient Valet
- Pegwin
- PerceptiMed
- Philips Healthcare
- Pieces Technology
- Predixion Software
- Rapid Healthcare
- RGP Healthcare
- RightPatient
- S.E.A. Medical Systems
- SafeCare Group
- SecuriSyn Medical
- Smiths Medical
- Sotera Wireless
- Stanley Healthcare
- Stibo Systems
- SurgiCount Medical
- Talis Clinical
- True Process
- Welch Allyn
- ZOEX NIASG
- ZOLL Medical
- Deltex Medical
- Hamilton Medical AG
- LiDCO Group
- NGPod Global Limited
- Phoenix Medical Systems Pvt. Ltd.
- Pooyandegan Rah Saadat Co., Ltd.
- Remote Diagnostic Technologies Ltd.

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EXAMPLES OF PREVENTABLE DEATHS/MEDICAL ERRORS

- Failure to rescue – a patient dies due to a complication that was not identified in a timely manner
- Healthcare-associated infections – 1 out of 20 hospitalized patients will contract an HAI, according to the Centers for Disease Control and Prevention
- Medication errors – inaccurate or incomplete diagnosis or treatment
- Handoff communications – 80% of serious medical errors involve miscommunication during hand-off's between clinicians
- Overuse or unnecessary red blood cell transfusions (RBC) – studies have shown that transfusions can increase mortality by 69% and morbidity (disease) by 88%
- Failure to detect critical congenital heart disease – an estimated 2,000 infants per year die or have missed diagnosis in the U.S. and 65,000 infants per year die or have missed diagnosis globally

2017 Challenges

Pediatric Adverse Drug Events

- Evidence on medical errors shows that 50% to 70.2% of such harm can be prevented through comprehensive systematic approaches to patient safety[1]
- The most common types of harmful pediatric medication errors were: improper dose/quantity (37.5 percent), omission error (19.9 percent), unauthorized/wrong drug (13.7 percent), and prescribing error (9.4 percent), followed by wrong administration technique, wrong time, drug prepared incorrectly, wrong dosage form, and wrong route[2]
- Human error has been implicated in nearly 80% of adverse events that occur in complex healthcare systems[3]
- A new study, the first to evaluate a trigger tool to detect adverse drug events in an inpatient pediatric population, identified 11.1 percent rate of adverse drug events in pediatric patients[4]
- 22 percent of adverse drug events are preventable, 17.8 percent could have been identified earlier and 16.8 percent could have been mitigated more effectively"[6]
- 20-50% of all antibiotics prescribed in U.S. acute care hospitals are either unnecessary or inappropriate[5]

Mental Health

- Adults living with serious mental illness die on average 25 years earlier than other Americans, largely due to treatable medical conditions[6]
- Nearly 20% of the hospital beds for the nation's most severely ill and dangerous psychiatric patients were eliminated in the last five years[7]
- 11.7 beds remain per 100,000 people. This means there are fewer state hospital beds per capita than at any time since before the nation stopped criminalizing mental illness in the 1850s[9]
- One in four adults, approximately 61.5 million Americans, experiences mental illness in a given year[8]
- Approximately 20% of youth ages 13 to 18 experience severe mental disorders in a given year[10]
- Approximately 60% of adults and almost one-half of youth ages 8 to 15 with a mental illness received no mental health services in the previous year[10]
- In 2005 there were 17 public psychiatric beds available per 100,000 population compared to 340 per 100,000 in 1955. Thus, 95 percent of the beds available in 1955 were no longer available in 2005[9]

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Venous Thromboembolism

- Every year, there are approximately 10 million cases of Venous Thromboembolism (VTE) worldwide[10]
- In the U.S. there are 100,000-300,000 VTE-related deaths every year[11]
- In Europe, there are 544,000 VTE-related deaths every year[12]
- In the U.S. and Europe, VTE-related events kill more people than AIDS, breast cancer, prostate cancer and motor vehicle crashes combined[13]

View all 13 APSS: patientsafetymovement.org/apss

Patient Stories: By sharing their stories, families and friends have turned their tragedies into positive action. View a complete list of our patient stories here. patientsafetymovement.org/patient-stories/

@0X2020 @JoeKiani #PatientSafety #WPSSTS #0X2020

[1] World Health Organization. Data and statistics. Retrieved from: http://www.euro.who.int/en/health-topics/Health-systems/patient-safety/data-and-statistics [2] Joint Commission. (2008). Preventing pediatric medication errors. *Sentinel Event Alert*, 39, 1-4. [3] Palmieri, P. A.; DeLucia, P. R.; Ott, T. E.; Peterson, L. T.; Green, A. (2008). The anatomy and physiology of error in averse healthcare events. *Advances in Health Care Management*. 7. pp. 33–68. doi:10.1016/S1474-8231(08)07003-1. ISBN 978-1-84663-954-8. ISSN 1474-8231. [4] Joint Commission. (2008). Preventing pediatric medication errors. *Sentinel Event Alert*, 39, 1-4. [5] Centers for Disease Control and Prevention. Core elements of hospital antibiotic stewardship programs. Retrieved from: https://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html [6] National Association of State Mental Health Program Directors Council. (2006). Morbidity and Mortality in People with Serious Mental Illness. Alexandria, VA: Parks, J., et al. Retrieved January 16, 2015 from http://www.nasmhpd.org/docs/publications/MDCdocs/Mortality% - See more at: http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers#sthash.emQpo9jn.dpuf [7] Fuller, D. A., & Sinclair, E. G. J., Quanbeck, C., & Snook, J.(2016). Going, going, gone: Trends & consequences of eliminating state psychiatric beds, 2016. Treatment Advocacy Center. [8] National Institutes of Health, National Institute of Mental Health. (n.d.). Statistics: Any Disorder Among Adults. Retrieved March 5, 2013, from: http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml [9] Torrey, E. F., Estsminger, K., Geller, J., Stanley, J., & Jaffe, D. J. (2015). The shortage of public hospital beds for mentally ill persons. 2008. The Treatment Advocacy Center. Arlington, VA. [10] Jha, A. K., Larizgoitia, I., Audera-Lopez, C., Prasopa-Plaizier, N., Waters, H., & Bates, D. W. (2013). The global burden of unsafe medical care: Analytic modelling of observational studies. *BMJ Quality & Safety*, 22(10), 809-815. [11] Office of the Surgeon General (US. (2008). The Surgeon General's call to action to prevent deep vein thrombosis and pulmonary embolism. [12] Heit, JA. Poster 68 presented at: American Society of Hematology, 47th Annual Meeting, Atlanta, GA, December 10-13, 2005 [13] Cohen AT, Agnelli G, Anderson FA, et al. Venous thromboembolism (VTE) in Europe. Thromb Haemost. 2007;98:756-764.

FOUNDER: Masimo Foundation for Ethics, Innovation & Competition in Healthcare