Patient Safety
MOVEMENT

Actionable Patient Safety Solutions #8B
Airway Safety: Unplanned Extubation

Start with Why

Drew was vibrant, talented, intelligent, and loved by everyone he met. He had a very promising life in front of him, yet he died at the young age of 14. Not from a minor head injury that occurred earlier that day, but from the preventable complication of airway management known as Unplanned Extubation (UE) — the uncontrolled removal of his life-sustaining breathing tube. Every year in the United States alone, UE causes 33,000 to needlessly die. The good news is these deaths are preventable. That's why we are tirelessly working to make sure stories like Drew's, and countless others, never happen again.

Unplanned Extubation is common and costly.

It affects all ages from neonates through adults.

Annually in the US, UE occurs more than 120,000 times, causes more than 36,000 pneumonias (VAPs), more than 33,000 deaths and increases healthcare costs by nearly $5B.

These events are preventable.

Hospitals must take action.

Do your part in eliminating these preventable deaths by deploying these actionable patient safety solutions.

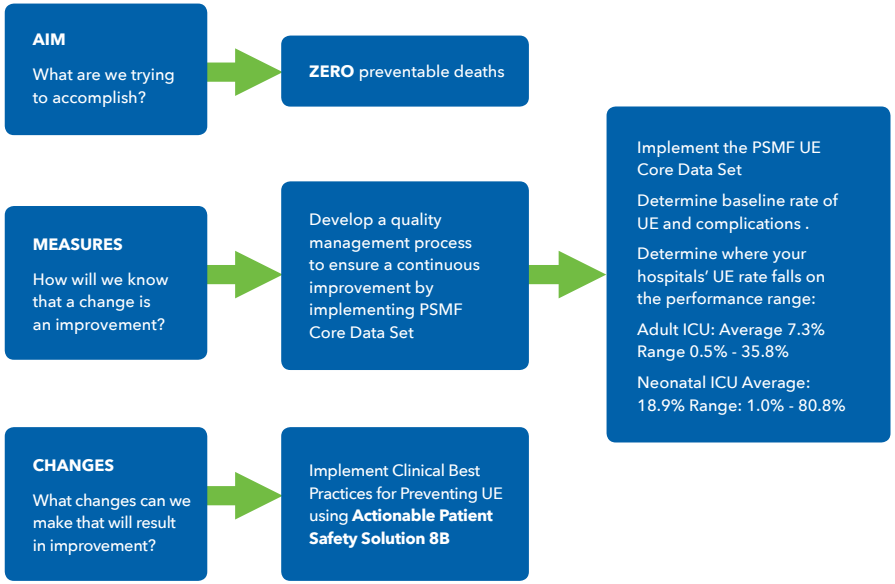
FOUNDER:

Masimo | Foundation for Ethics, Innovation & Competition in Healthcare

BENEFACTOR:

Medtronic

1. **Hospital Governance and Senior Administrative Leadership Must Commit to:**
    - Reduce the incidence of unplanned extubation with a goal of zero preventable deaths
    - Drive awareness regarding the seriousness of unplanned extubation
    - Determine their hospitals' rate of UE through reporting and tracking within a formal QI program
    - Implement clinical best practices for preventing UE; continue tracking to determine which implemented practices have a positive effect on reducing UE
    - Create a Leadership Plan where C-Level Executives and the Board regularly review a dashboard of occurrences of UE and the cost of those occurrences in morbidity, mortality and healthcare dollars.
2. **Assemble a Core Multidisciplinary Airway Safety Leadership Team**
3. **Use the IHI Model for Improvement to Accomplish Goal of Zero Preventable Deaths**



Core Data Set

Data is best collected through electronic capture of data fields from electronic patient care reports. This requires having an Electronic Health Record System that includes all the core data elements.

Does the patient have a history of a Difficult Airway? ❑ Yes ❑ No

What method was used to identify the Difficult Airway Patient?
❑ EHR ❑ Hospital Database ❑ National Registry ❑ Medic Alert
❑ Other (Specify)_____

Was a pre-intubation assessment predictive of a difficult airway? ❑ Yes ❑ No

Route of Intubation: ❑ Oral ❑ Nasal

Was an in-room / bedside "Difficult Airway" sign posted? ❑ Yes ❑ No

Date of Intubation:_____

Method of tube restraint:
❑ Adhesive Tape ❑ Twill Tie
❑ Commercial Device or other (specify):_____

Type of Extubation: ❑ Planned/Controlled ❑ Unplanned/Uncontrolled

If unplanned/uncontrolled, specify type: ❑ Self-Extubation ❑ Accidental Extubation

Date of Extubation:_____

If UE, specify location extubation occurred (i.e GI suite, elevator) :
_____

Did UE occur while …
❑ being transported ❑ being moved ❑ undergoing a procedure
❑ Other (Specify)_____

Was the patient restrained at the time of UE? ❑ Yes ❑ No ❑ 2-point ❑ 4-point

Was the patient sedated at the time of extubation? ❑ Yes ❑ No

What type of sedation regimen? ❑ Continuous with Daily Interruptions ❑ Continuous
❑ Intermittent ❑ No Sedation

What team members were present with the patient when the UE occurred?
❑ MD ❑ Nurse ❑ Respiratory Therapist

Was the patient on / had the patient completed a spontaneous breathing trial when UE occurred?
❑ On ❑ Completed but Unsuccesful ❑ Completed Successful ❑ Not yet attempted

If spontaneous breathing trial completed, was there a delay in extubation due to a delay in physician ordering the extubation? ❑ Yes ❑ No

Was reintubation required? ❑ Yes ❑ No

If yes, was reintubation attempt... ❑ successful ❑ unsuccessful

Complications: ❑ Hypoxemia ❑ Pneumonia ❑ Vocal cord injury ❑ Brain injury ❑ Death

You can help your hospital reach **ZERO** preventable deaths from Unplanned Extubation.

Make a Commitment

The Movement is not just about information, it's about **ACTION!**

Make a commitment to **ZERO** by implementing best practices to eliminate preventable deaths from unplanned extubation.

The Actionable Patient Safety Solutions (APSS) for Unplanned Extubation can be found at the following link:

patientsafetymovement.org/challenge/airway-safety/unplanned-extubations

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