Chasing Zero: Winning the War on Healthcare Harm
TMIT Patient Safety Documentary Transcript

Dennis Quaid VO:
Most of us think of hospitals as cathedrals of healing and hope and we stand in awe of the doctors and nurses who work in them, as the architects of miracles.

But even the best hospitals can be dangerous places with unknown hazards that can cause catastrophic harm. They are the battlefield of a war with an invisible enemy that never sleeps. Failing support systems that can't keep up.

Host: I'm Dennis Quaid. I found out about healthcare harm because it happened to my family.

Host: Since 1999 we've known that more than one hundred thousand Americans die every year because of healthcare harm, every year.

Host: That's the equivalent of more than ten jumbo jet airliners crashing every single week. And that number doubles if you include infections patients get from hospitals.

Dennis Quaid Voice Over: The shear number of deaths is shocking, however what's even more shocking is that it is possible to bring this to almost zero. So why isn't it happening? You will meet just a few of the many leaders who *are* making it happen.

Host: They call it "chasing zero" and they are preventing the enemy from shattering other families' lives the way it almost shattered mine.

Dennis interview:
Our twins were born happy and healthy and so were we. We had just got them home and it wound up that they had a staff infection. They had to go back into the hospital. They were overdosed twice with a thousand times the amount of Heparin than they should've received. Our little twins were the victims of preventable harm. They came very very close to dying.

I've been in the hospital in my life. I had never given a thought to my own safety about being there. I always trust the doctors and the nurses and they knew what they were doing and they never make mistakes but this is preventable error. That was a wake-up call for my wife and I to try to do as much as we could to try to make sure this doesn't happen to other families.

CSPAN footage of Dennis testifying to Congress:

"When the twins were in the hospital, they had made it, it made me feel that they had survived for a reason. That um, first off, I really thank God that they pulled through. But they survived for a reason, that they were maybe going to change the world in a little way that might wind up saving more lives."

Dennis Quaid Voice Over:
I was looking for a way to help prevent harm to other families and children when I met Dr. Charles Denham, the leader of TMIT a medical research organization in patient safety. He introduced me to the heroes in the movement and I have found the role I can play. I've joined the army of those who are chasing zero harm together.

Chuck: "These are the group of leaders you can ask to step up."

Dennis: "I'll tell you what I'm excited about. I'm excited to be working with people like you, Chuck, because you've taught me quite a lot."

Chuck: "We are so grateful to have somebody that's a voice."

Dennis: "Well, thank you."

Dennis Quaid Voice Over:
Fear is a major barrier to action. But the great ones like the Mayo Clinic are ever vigilant and humble champions of high performance. They are just one of the Chasing Zero role models.

Steve Swenson:
"I'll never forget the day that we learned of the Quaid accident. A cold chill came over me when I asked myself could this happen at the Mayo Clinic? The answer was yes."

Dennis Quaid Voice Over:
The collaborative empowering culture of Mayo allows nurses to redesign their workflow; they adopt safe practices, and even allow their cleaning staff to get involved. They developed their own new cleaning checklists of high contact surfaces to prevent infections using culture methods from other industries.

Cleaning Lady at Mayo:
"If we can help them not to get more infection, we're not just we are not just cleaning rooms, we are saving lives."

Steve Swenson:
"This is a Pyxis medication dispensing unit. It's another system safety net that we have to protect patients from the frailties of competent human beings. Our nurses enter the identification number and the patient name to make sure that the right medication is taken out of the Pyxis unit and the pharmacists put the medication in only after they've bar-coded it to make sure it's the right medication for the right patient at the right dose."

Dennis Quaid Voice Over:
Despite the efforts of places like the Mayo Clinic, healthcare harm still occurs in many hospitals. Sue Sheridan is a great example of someone who has turned her family's tragedy into triumph by putting aside her anger and resentment…moving forward to make things better.

Sue Sheridan:
"In 1995 my son Cal was born a healthy baby, a normal delivery.

"When we were home he started to change before our eyes. And eventually Cal was readmitted to the hospital. It was discovered that his jaundice was – I remember the nurse's term- off the charts. One of the highest they'd ever seen at the hospital.

They treated Cal's jaundice with traditional treatment with phototherapy. However, on the second day he was there, about 24 hours, Cal started arching backwards. They were classic signs of the onset of brain damage from jaundice.

Cal now has a condition called Kernicterus. It is brain damage from jaundice. And he has significant cerebral palsy, he's hearing impaired, he's speech impaired, um very bright very witty, but his lifelong challenges were totally preventable.

Ajish Jah:
"We just finished a survey, we surveyed over a thousand hospitals across the country. And when you look at the bottom, the worst performing hospitals in America, not a single board chair from any of those hospitals, not one thought they were below average. These are hospitals that are at the very bottom of performance. They are terrible quality and yet most thought they were better than average, a few thought they were about average but not a single one thought they were below average. It's a level of denial and a lack of knowledge about their own performance that I think is shocking."

Dennis Quaid Voice Over:
Business performance guru Jim Collins has documented how even the Mighty Fall in his recent best seller. The principles are frighteningly applicable to hospitals.

Jim Collins:
"How do institutions fall? How do they go from great performance to good to mediocre to bad and maybe even irrelevant? What we found is it is actually a little bit like a staged disease. That there's...that you go through the early stages of the disease, still looking healthy on the outside. You can more easily deny that you're sick because you look healthy. Now, if you look inside, you might not look so healthy. But, if you look on the outside and you can still say, 'See? We're still doing well."

Dennis Quaid Voice Over:
If our healthcare leaders can get through their denial about their failing systems, it becomes a David and Goliath story. Goliath is fear – fear of shame, fear of malpractice, and fear of cost.

To win the war on harm we must activate the inner David in our hospital leaders. They will find that Goliath is not as big as they think he is.

The weapons against healthcare harm are leadership, safe practices, and technology.

Great leaders take risks. They confront their fear to drive adoption of best practices and they invest in technologies that make it easier to be safe. Has this been done before? Do we have role models? Absolutely!

Many agree that the Institute for Healthcare Improvement's 100 Thousand Lives Campaign, led by Dr. Don Berwick, ignited the passions of America's healthcare leaders to save lives and put us on a path to zero harm.

Chuck:
“Don, take me back to when you stepped up to the podium and announced the 100,000 Lives Campaign. Were you scared? What was it like?”

Don Berwick:
“Well, when we in the Institute for Healthcare Improvement thought of the 100,000 Lives Campaign, we knew we were going out on thin ice. And I was scared. I stood in front of 5,000 people at IHI's annual National Forum on Quality in Healthcare and I was going to lay out this challenge.”

“Here’s the number, 100,000 and here’s the time, June 14, 2006, 9 AM.”

“I really didn't know what the reactions would be. Denial, anger, silence. Of course, what happened was just the opposite. We got more involvement and more enthusiasm and more buoyancy in the pursuit of healthcare improvement than I had experienced in my entire career.”

Chuck:
“What was it like to realize that the 100,000 Lives Campaign, then, was achieved? The goal was met?”

Don Berwick:
“The biggest surprise in the 100,000 Lives Campaign and the 5,000,000 Lives Campaign that followed it was the reservoir, the immense reservoir of good will, commitment, courage, intention in the healthcare workforce. Doctors and nurses, technicians, pharmacists, managers all over the nation...eventually, all over the world, really wanting to make care safer and better, not angry that we were challenging them to do it, but grateful that we would...we would put a stake in the ground and...and that we would say let's go do this. That...that energy, it still awes me.”

Dennis VO
Many of the main elements to the 100 Thousand Lives Campaign have become key National Quality Forum Safe Practices. A leader’s blue print to chasing zero.

Janet Corrigan:
"The safe practices are a road map. There's no need for every hospital to reinvent the wheel. These are practices that have been proven. There's a strong evidence base. They can be implemented in every single hospital immediately."

Dennis VO
Leading organizations such as the Mayo Clinic, Cleveland Clinic, Vanderbilt, Catholic Healthcare Partners, and Brigham and Woman’s Hospital are working with TMIT to validate the financial business case for adoption of the safe practices so that leaders will “Greenlight” investment in safety.

David Bates:
"For boards and administrators, I think the Green Light approach will help them justify the hard decisions that need to be made about investing in changes that are going to tangibly improve safety."

Don Berwick:
"We have some great action lists for leaders, like the National Quality Forum Safe Practices. That is, we know what to implement. So far, we're approaching that as a matter of volunteerism. We're saying, please, do this. We know it works, saves lives, reduces injuries. Ultimately, we're going to have to mature, I think, to the point where a safe practice that's well known is no longer an optional matter. You have to be safe because we know how to do it. We owe it to our patients."

Dennis interview:
“It’s an honor really to be a part of authoring the NQF Safe Practices. What I really appreciate is that they are involving patients because patients are a part of the healthcare team. An often-unused one. So it’s really great that they are involving patients in the process.”

CSPAN footage of Dennis testifying before Congress:

Congressman Henry Waxman:
“Mr. Quaid, to understand what happened to your twins you had on the screen the two vials, I do have them right here. They look very, very much alike. The one that was 1,000 times more was the one administered to your children, is that right?”
Dennis:
“Yes sir, not once but twice over an 8 hour period.”

Waxman:
"Not once but twice?"

Dennis:
"Now how could this have happened? Well, the answer became very clear to us after talking to doctors and nurses and doing a little bit of research on our own. The ten units of Heplock and ten thousand unit of Heparin are deadly similar in their labeling and size. The ten thousand unit of Heparin is dark blue and the ten-unit bottle is light blue. And if the bottles are slightly rotated as they often are when they are stored. They are virtually indistinguishable. Since this brush with tragedy my wife and I have found out that such errors are unfortunately all too common.

Dennis Quaid Voice Over:
Since our accident the labeling on the vials has dramatically changed. Our twins, Zoe Grace and T. Boone Quaid are already protecting other kids and saving lives.

While my wife Kimberly and I have been on this journey we've had the privilege of learning about many other families who have gone through similar tragedies.

Steve Rel: "Braxton always had a smile and he just, you know, he loved life. He was putting in the time and the dedication… he spent hours at the stairs um 'Dad, throw some pucks at me, dad'. You know, I think the difference between an athlete and a professional athlete is their heart and their dedication and I think Braxton could've been one to take it real far."

Chuck: "Now let's go back to the beginning. Braxton needed the surgery for sleep apnea, was Braxton worried?"

Steve Rel: "He always put on a tough face but yeah, he was concerned. He was very worried."

Chuck: "What did you tell him?"

Steve: "That he was gonna be okay. And it wasn't true."

Steve: "We brought Brax home from the hospital and everything seemed fine. You know, he wasn't complaining much of pain. He was resting and we watched some TV. We sat with him. Watched some cartoons. At about 4 o'clock he said dad, I'm hurting. So I gave him his pain medicine. And everything seemed all right. He fell asleep which seemed normal to me and he woke up at 7:30 and he said dad my chest hurts. You know, I'll never forget that I sat and just comforted him and I asked him Braxton are you all right? Are you in pain? Do you need something for pain? Do you need something for pain? And he said, no dad I'm fine. That's the last time I saw him alive. We went months and months without any word from the medical examiner and all we wanted to know was what happened to our son. "

Dennis Quaid Voice Over:
The Rels went for 4 months without answers and then they were forced to seek legal help. The system failed them. 13 months after Braxton's death all they had was an autopsy report sent in the mail.

Steve Rel:
"When I went to get the medical records I was given two or three pages and I was told that they don't keep anesthesia records and nursing notes. And it just didn't seem right to me so I talked to some experts and was given some advice on how to get the complete set of medical records. Which I did. You know, it really erodes your trust and it makes you fearful. You think you would have answers right away when something adverse happens to your loved one. It's been 13 months and we still don't have all the answers."

Chuck: "So you don't have closure?"

Steve Rel: "No closure at all."

Interview of Dennis:
"A lot of times I think the lawyers get involved, the hospital lawyers get involved and the focus seems to be on risk management after an accident occurs. Not to say that they weren't doing everything they could to right the situation but as a human being I felt that the last thing I want to do is focus on legal issues. And somebody's liability."

Steve Rel:
"The last thing we wanted was to hire an attorney. Just to get the answers that we should've had all along."

"The NQF Safe Practices states that hospitals and caregivers should reach out to the family within 24 hours of an adverse event. Without any type of communication it makes us feel that Braxton didn't mean anything to anybody but us. You have to communicate, you know, it's the most important thing there is."

Dennis interview:
"Its understandable that a hospital reacts the way that they do because it is a business and there is liability involved and yes, they have to protect themselves and protect that entity but what happens in the end is that a lot of times the problem ends up not getting fixed because a lot of things get swept under the carpet. They don't want people to talk. They don't want the nurses to talk. They don't want the staff to really talk. So the investigation into what really happened is stifled."

Dennis Quaid Voice Over:
For Sue, preventable harm struck her family not once but twice.

Sue Sheridan:
"Shortly after Cal's injury, my husband Pat had a pain at the base of his skull, his cervical spine. They removed, actually a tumor from the base of his skull. Sent it to pathology. The surgeon came out when my husband was in the operating room and he shared with me that it was a benign tumor And six months later my husband was in pain again. We got another MRI and it was discovered that Pat had a mass the size of the surgeon's fist.

Dennis Quaid Voice Over:
The final pathology report from his initial surgery indicated that Pat had cancer. This miss-placed path report was yet another error that shattered the future for the Sheridan family ending Pat's life prematurely.

Sue Sheridan:
We to this day still don't know what happened to it. It appears that it got filed in my husband's chart without anybody seeing it except the pathologist."

Sue Sheridan:
"Pat underwent 5 more surgeries. They basically removed his spine. He became disabled. So I had a son using a walker and a husband using a walker. But after about a year and a half of treatment, Pat's cancer came back explosively. And he woke up paralyzed one day from his waist down.

"Pat had always told me that if he was going to die from his cancer that he wanted to die family and friends and a bunch of really good wine. And he, after a long, long pause said I want to go to Disney World. I want to watch my kids and my family have the time of their lives. And so, after I collected myself, I picked up the phone and I called Disney World. And within 4 days 53 of us flew to Disney. They put the kids in parades. They sent up Minnie, Mickey, Pluto. It was a truly a celebration. On the third day, Pat died at Disney World."

Carolyn Clancy:
"One of the biggest barriers to getting to safe care all the time, everywhere, is fear. We're trained if we make mistakes not to come forward, that this is something to hide and feel badly about. And sometimes people are punished when they acknowledge mistakes, a very powerful lesson gets learned immediately when that happens."

Dennis interview:
"Kimberly and I tried to put ourselves in the nurse's shoes. I'm sure no one wanted to harm our kids. Human error is a part of the system. They should not be criminalized. All it's going to do is alienate the very people that we are trying to bring in to help make things better. And they shouldn't be punished."

Julie Thao:
"I wanted to be a nurse and with babies since I was a little girl. In 1990 I graduated from nursing school. I had 4 little babies. Until about 4 years ago when this happened my life was full of babies."

"On the 4th of July I worked a double shift and we were busy and it was almost 1 AM before I was able to kind of wind down and I was too tired to drive home. And I lived a long way from the hospital I decided I was too tired to drive home and I needed to be back in a few hours to do the day shift I was scheduled for and so I laid down in a patient room in a patient bed and tried to sleep. And got up to start the next day. And at 9 o'clock I met the patient. She was just a young 16 year old girl and she was so scared."

"The plan was that they were going to break her water and start some pitocin and she was going to deliver her baby."

Dennis Quaid Voice Over:
Julie followed nursing unit guidelines designed to improve readiness of patients for anesthesiologists to give an epidural injection. She adhered to a checklist of the guidelines and prepared the anesthetic medication at the same time that she had antibiotic medication ready to go. A number of systems flaws led to Julie's absolutely predictable human error.

Julie Thao:
"So I got her IV, her antibiotic and her epidural bag. Both bags had ends that received IV tubing. I had her antibiotic in my hand I knew that. But I didn't have her antibiotic in my hand; I had her epidural medication in my hand. And after it started running I heard a sound and turned to her bed and she was already arresting."

"People came to her room immediately, many many many people. Dozens of people who are familiar with both those medications that we used. Everyone saw that hanging there. In fact I said, I just hung this antibiotic and I think she's reacting to the penicillin."

"And then somebody cleaning the room found the bag and brought it to me and they were crying and put it in my hands. And it didn't make sense for a while and I kept looking and it just crumbled."

Dennis Quaid Voice Over:
Julie administered the wrong medication. Fatigue, identical medication tubing connectors, similar IV fluid bags, and a sub-optimal bar code process, all spelled death for the young mother. The hospital fired Julie. She was criminally indicted. As a single mother of 4 and with no resources to defend herself, she had to plead a misdemeanor to avoid prison.
What happened to her led to the development of the new National Quality Forum Safe Practice called Care of the Caregiver.

Lucian Leape:
"The Julie Thao story because she was hung out to dry for making a mistake which was clearly caused by a whole host of very bad systems. She was truly the second victim in two ways, she was the victim of bad systems as well as being emotionally a second victim. She was devastated by her error as anyone would be but in addition she was the person who was the victim of these bad systems. And the lesson, I think is, not just that hospitals need to be responsible for their systems and fix them which is clearly what they ought to do but there is a second lesson here and that is Julie Thao was fired, she was indicted, she lost her license because she was presumed to be incompetent. There's no evidence that she was incompetent. No evidence was ever produced that she was incompetent."

Dennis Quaid Voice Over:
Eric Cropp, is a hospital pharmacist convicted of involuntary manslaughter after a two year old girl received a fatal injection of saline solution more than 20 times the intended concentration. A pharmacy technician working under Eric on a very busy day accidently mixed the clear saline solution incorrectly. By signing off on her work, Eric sealed his fate.

Eric Cropp:
"I wish I could change it. I wish I could change places with Emily. I wish I was the one that was dead. And it's just hard because I didn't have anybody there for me either. And it hurts."

Lucian Leape:
"I think criminalization is a terrible thing because the examples that I know. Fortunately there have only been a few, but in every case there were obvious explanations for why a mistake happened and those explanations all have to do with the systems they were working in."

Don Berwick:
"We now have a safe practice around care of the caregiver, which defined good ways to deal with the people involved at the providing end of care...involved in an injury. They need help, they need healing, they need support. And you need them. Sometimes, the best knowledge you could ever get, that will allow you to redesign the care system for which you are responsible, will come from the very people who've been trapped in this spider web of cause and effect that's led to the injury."

Dennis Quaid Voice Over:
3 years after the death of Julie's patient, the hospital published an independent study revealing that multiple systems issues contributed to setting up Julie's error. An honest mistake, anyone could have made.

Never shirking her accountability for causing a death, Julie has moved on as a TMIT patient safety fellow to help save other lives. She is helping measure lives saved and dollars invested in safety from the impact of video stories now being used in thousands of hospitals, deployed by TMIT. One of many video stories is about a little girl named Josie King.

Sorrel King:
I would like to share my story with you. I do this with the hope that what I'm about to tell you will make a difference in how you care for your patients and how strongly committed you and your hospital are to patient safety. Josie was admitted after suffering first and second degree burns from climbing into a hot bath. Josie's death was not the fault of one doctor or one nurse. It was the result of a total breakdown in the system."

Dennis Quaid Voice Over:
The power of stories is incredible. In Story Power: The Secret Weapon—our article targeting healthcare leaders—we share some of the secrets of the power of connecting the head to the heart to prompt action. In it we present the preliminary results of the Josie King story and its impact on 2000 hospitals. It revealed that the majority of users have seen lives saved and money invested as a direct result of viewing it.

Dennis interview:
"Well the battle is one little life at a time I think. That's what the battle is. One mistake at a time, one little life at a time. And the war is really…the end result of the war would be taking medical errors down to zero."

Dennis Quaid Voice Over:
So you need three things. You have to start with engaged leaders. Then practices that work. Then if you implement the practices with great technologies that make it easier to be safe, you have the winning combination in the war on preventable harm.

Here lies the sweet spot of high performance and safe care. Many hospitals are getting extraordinary results from ordinary things they already have today.

Bill Rupp:
"My biggest lesson has been to empower the staff. We spent two months listening to 250 people in this organization about what we could do to make it better. We came up with a list of 72 recommendations. Seventy-one of those came from the staff. That's what we're implementing, and that's why things are getting better."

Dennis Quaid Voice Over:
An example of staff led innovations is Share Rounds developed at the Mayo Clinic in Rochester, Minnesota which helps nurses include the patients in the process of passing on information during shift change, making the patient and family part of their own safety net.

Nurse:
"It's really hard to understand how your day is gonna go without visualizing a patient. We used to give report right out at the nurse's station or in the back room. The nurse would sometimes write report or tell you in person, but you can't really assess a person or be prepared for your day until you actually see the patient in person."

Nurse:
"The first thing we do is we can get an overall picture of how the patient is doing."

Nurse:
"You can see that he's doing well, his pain is under control, and maybe address any needs right away."

Nurse:
"I'll be leaving now, but Amanda's gonna take great care of you tonight."

Nurse:
"This way before I leave, the patient is comfortable with who his next nurse is."

Patient:
"I feel more involved. Makes me feel reassured, that the nurse coming on knows exactly what's going on with me, and they are in coordination."

Patient Wife:
"I can ask questions as well, and if there's something that I'm concerned about or I am thinking about, I can bring it up because the nurse that's going off knows perhaps something that we've discussed earlier and, and then that sort of reminds all of us to pass it on to the nurse that's coming on."

Nurse:
"No problem. Have a good evening. She'll take good care of you."

Nurse:
"I definitely think that this could be done at any hospital."

Nurse:
"Knock, knock. Good morning Ms. Hunt."

Nurse:
"Hi there. This is Casey. She's gonna be your nurse this morning from 7:00 to 3:00."

Nurse:
"Just by changing the routine a little bit, and that might be a bit of an adjustment, it actually is just that simple. It's just bringing it in to the patient."

Nurse:
"And then her IV was changed yesterday, so that's good."

Nurse:
"I don't just think it should be done, I think it needs to be done. I mean it provides for the safest way to care for the patient."

Dennis Quaid Voice Over:
Another great, cost free initiative is the IHI Open School, which puts healthcare students into the safety game – literally thousands are joining the action.

Dr. Don Berwick:
"Check a box, safe a life. That's a program devised by medical students, nursing students and pharmacy students who realized that students, when they're in training in hospitals, can introduce the surgical checklist as sort of change agents from the inside. They calculated, the medical students calculated that a medical student, during their surgical clerkship, when they're learning surgery, is involved in enough operations that if you do the math, if they could get the checklist used in all the operations they're involved in, one life would be saved. Check a box, save a life."

Charles Denham:
"Dennis are you surprised that we're just starting to use checklists in healthcare? You're an experienced pilot you know the value of a checklists."

Dennis:
I can't believe it to tell you the truth that it's not there. How much does this cost?"

Chuck:
"Exactly."

Dennis:
"It's the most important piece of equipment really on the airplane."

Charolette Guglielmi:
"We're taking the World Health Organization checklist and we're combining it with the regulatory requirements, so that we can use it in every operating room in America. Checklists help make things simple, predictable, standardized. They enhance communication, just like they do in airplanes.

Dennis:
"We were just going through the checklist right, you were calling it out and we got to Beacon and I said off. What does the checklist say?
Chuck:
"On."

Dennis:
"On. So we missed that."

Chuck:
"We missed something on the checklist."

Dennis:
"Yeah, that's why checklists are important. But they always have to be backed up by humans."

Chuck:
“Exactly.”

Dennis:
“It’s human error.”

Chuck:
“Good point.”

Charolette Guglielmi:
“We're using checklists in our operating rooms so that we can make sure that we don't miss an element of care, that we provide safe care and that we do it the same way every time.”

Chuck:
“I feel like we haven't even touched what checklists could do for us in medicine, is that a fair statement or is that unfair?”

Peter Pronovost:
“No it's absolutely a fair statement Chuck. Healthcare is grossly under-standardized, and checklists are a tool to help us do our work, but they standardize processes. In healthcare we have a very autonomous culture that is grossly under-standardized. We've got to make sure we have a checklist and ensure it's done on every patient, every day, all the time.”

Michael Henderson:
“When I see when I come down is we're functioning much more as a team in the operating rooms and I think that's huge.”

Allan Sipperstein:
“If something’s not working quite right it can be reported and acted upon before the next case.”

Michael Henderson:
“Yeah, the checklist has been a real way of getting to that. I think one of the biggest patient safety things we've certainly seen in the ORs in my lifetime. I think it's fantastic.

Chuck:
“Avionics Master.”

Dennis:
“Avionics Master is on.”

Chuck:
“Emergency Lights.”

Dennis:
“Emergency Lights on.”

Chuck:
“Beacon.”

Dennis:
“Beacon on.”

Dennis Quaid Voice Over:
Technologies make it easier to be safe. Once you have engaged leaders and staff, open to improve their own practices, they deliver great impact.

Nurse:
Currently there's just a handful of hospitals within the nation that have the bar code technology. If they did have this technology in place, I do believe that it would save more lives. I'm just going to double check here. The software matches the bar code on the medication to the bar code profiled for the patient, but does that safety check of the five rights: The right medication, the right dose, the right time, the right patient and the right route. It does not do the critical thinking for the nurse; however, it does ensure that those five

things are matching for the medication and for the patient.

Nurse:
Before we had the smart pump we had a pump that looked similar but did not have a drug library. We'd go on the information we have on paper essentially, as far as how to give a medication. Now that we have the smart pump, we're still responsible for knowing how to give these drugs, to follow the policy and procedure. However this is a double check for us. We're able to program the pumps, to know this is the way to safely give this medication. This is the rate, this is how fast you want to run it. You're going to use the bar coding system to scan your medication, scan your patient. Once you get all your checks and everything matched up, you're then ready to hang your med. At the end of the day this is what double-checks your work and covers you as a nurse when you're hanging medications.

Dennis Quaid Voice Over:
The Computer Prescriber Order Entry or CPOE allows doctors and other caregivers to automatically check for accurate dosage, allergies and drug interactions when prescribing medications for their patients. Without CPOE this is a manual paper process with no safety net. This sophisticated technology, however may not always be implemented well and can be less effective or even cause unintended harm. A real breakthrough, developed by leading experts is The CPOE Flight Simulator that allows hospitals to verify their performance before they use it on real patients.

Charles Denham:
You and I have had the wonderful privilege to work together with doctors like Dr. David Classen and others on the CPOE flight simulator. Just to put it in layman's terms, what is it, and what's the value?

David Bates:
"The flight simulator basically lets hospitals get a sense of how good the checks for problems are around medications when a doctor is ordering a medication. And what we did was to develop a set of orders for medications that have harmed patients, and looked to see how often the computer would warn about those errors."

Carolyn Clancy:
"There's no question that simulation is the future of medical care. I think it's the future in everything from surgical operations to the use of sophisticated devices to actually making sure that the computerized order entry system works as we expected to it. You can't know until you check it and better to know ahead of time then to find out that our expectations didn't come about. For everything from surgical operations to team work in emergencies to the use of very sophisticated devices, to the use of computers effectively, simulation and practice and rehearsal and getting it right in the laboratory, so to speak, will definitely be the way we move forward. This is going to be transformative in terms of getting to safer care."

Dennis Quaid Voice Over:
One of the most powerful innovations in healthcare are Automated Infection Identification and Mitigation Systems called AIIMS for short. They are being used to identify and prevent the impact of infections using computer systems.

Don Wright:
"I manage the Office of Health Care Quality. Really, the mission of this office is to strengthen the nation's health system and to promote quality care within this country. We're targeting a variety of areas. The reduction, prevention and hopefully elimination of health care associated infections is a prime focus, as is medication error and coordination of care in this country."

Chuck:
"Is zero the number? Is it rhetoric or reality? Can the reality meet the rhetoric?"

Don Wright:
"Absolutely, it's reality. And we are focusing on total elimination. When I received my medical training, hospital acquired infections were considered inevitable. But in the decade since that period of time, we now recognize that they are largely preventable. And our goal is complete elimination."

Sue Sheridan:
"Pat died at 45 years old in 2002 with a 4 year old daughter and a 7 year old son. You know, he had a sense of humor until the very end. And he said Brown, he said, you know, what ever you do you'll be successful but whatever you do, don't give up on patient safety. And he went on to say, go out and kick some butt."

Sue Sheridan:
"So I started speaking up about what happened to my family and calling for change. And had unique

opportunities to testify. At one of the testimonies I met the WHO. Soon after they invited me to join them and lead a program of patients from all over the world just like me who had experienced tragedy in healthcare but wanted to contribute in a really productive, positive way. In effect it was a call to action by patients to the healthcare system to partner with the healthcare system to work with the healthcare system."

"This is the exciting part. This is the part that inspires and united people. And for those of us here who have lost family members or children this is the piece that gives us hope. That the WHO says to us patients you're important and your voice, your collective wisdom is important to the WHO. That's a powerful thing for us to hear."

Julie Morath:
Our future in healthcare to create safer more effective healthcare depends on partnerships with patients and their families. We need patients and families and consumers who are not yet patients or family members to become advocates in the ownership of their own health their own healthcare. And to hold us accountable.

Hockey Coach:
"When Braxton passed away it was pretty tough for a lot of the kids and it still is tough for some of them. We wanted to run a tournament that sort of exemplified what we felt he was all about and that's sportsmanship. Kids that understand that you're out there to compete and they are going to play against you hard but you're still kids and you're still out there playing a kid's game having fun and that's what it's all about."

Steve Rel:
"The Braxton story hasn't finished but I think there's a chance for a happy ending. That we and hospitals have a working relationship and no one would have the feel the pain that we've gone through."

Dennis Quaid Voice Over:
14 years after Cal's birth the hospital and Sue Sheridan agreed to join forces and put the past behind them to save future patients' lives. This may lead to them becoming a national role model.

Sue Sheridan:
"The harm that our family experienced was of course unintentional. What we really struggled with was what happened after the harm occurred. And the wall of silence and the isolation that we felt. It was very much like a hit and run. We expect the truth and a sincere attempt to make every effort that that will never happen again to another family."

Barton Hill:
"When we had the opportunity to connect, for me it was actually relatively easy because I didn't have a lot of history. But I was representing the hospital and I know that it's a difficult time but it's also an awareness that it is time to move forward. Sue, we've come a long way in healthcare. Safety events were considered the cost of doing business. That transition from the cost of doing business is no longer an acceptable option. The challenge that we are facing now is not fully understanding how we get to that point where none will occur. The overriding sense is that it's the right thing to do. And it's an opportunity to see what we can create together."

Sue Sheridan:
"I am absolutely convinced that we can make a huge difference. So I'm thankful. I'm excited. I look forward to a relationship where we can challenge each other, learn from each other. That we are going to create a model that others are going to wanna copy from Boise, ID."

Sue Sheridan:
"Pat would say right on. He'd say right on Brown. It is true that when there's profound grief the best medicine for grief is doing something productive. When something bad happens in life we kind of have a choice. We can shrivel up and disappear in life or you can come out fighting like hell. I don't know if it's strength per se but considering what my family has been through I don't see any other route for me. You can come out challenging life. And thank God I'm hopeful. You know, without hope it would be a pretty miserable life."

Dennis Quaid Voice Over:
Chasing zero is the quest to ensure that accidental death and harm like what happened to my kids are a thing of the past. Zero is within our reach if we have leadership, the right practices in place and we leverage innovative technology.

Rosabeth Moss Kanter:
Visionaries CEOs that are willing to adopt new principles of management and leadership and deploy them

quickly are going to be successful. They will be the innovators, they're the pioneers. But more than that, they will have the feeling of pride and accomplishment in what they've done for their own organization. I want everybody to remember the essential purpose of why people go into healthcare. It's because they care about people. They care about health status. They care about saving lives.
Allan Korn: If the future looks like the past, we'll achieve nothing. In the past 10 or 12 years, we've written a great deal about safety and we've done very little about it. The future has to be roll up your sleeves, let's get going. Those who supply to the hospital and medical industry need to make certain that they not only have safe products and devices, but they're used as safely as possible. Those who use these things must be certain that they're used only to achieve the best possible outcome that they can achieve. And those of us who pay for this care must assure all those families that were paying premiums...that we're using these dollars as wisely as possible to lead to the best possible outcomes in the safest possible environment.
David Hunt: We are really bringing the forces, the energy, the resources that we need into this really, really important sphere that now is the time. There is enough knowledge, there is enough energy, we have enough money in the system currently to do what we need to do. What we don't have enough is action.
Koh: "We should do everything we can so that people can reach their full potential for health, that's what chasing the zero is all about and that's why it's such an inspirational, aspiration and realistic goal."
Don Berwick: I get asked a lot by normal consumers of care what they can do to make their healthcare safer. I generally advise them take someone with you. Make sure that you're not alone in your care system. But I think I'm more and more thinking that the answer is speak up. We have standards. We know, like the National Quality Forum safe practices. We know what standards hospitals should be adopting. As a consumer of care, ask your hospital. Ask them if they're using the kinds of standards that we know can make your care safer.
Koh: "So the National Quality Forum Safe Practices are a tremendous opportunity for all leaders now to unleash their full potential, to improve patient safety and healthcare quality and it's time to act now."
Dennis Press Club Speech: "I have found the role that I can play and it is to partner with the best experts and drive awareness of what we can do if we act now."
Dennis Quaid Voice Over: The Quaid Foundation has merged into TMIT to apply the power of stories to bring consumers and leaders together to act now. Our mission is to save lives, save money and bring value to the communities we serve.
Host: Facts, figures and statistics reach the head but nothing happens unless we reach the heart through stories of real people that put the hands to work. Join us in the war on preventable harm…. Zero is the number….now is the time.