We are all painfully aware of the problem of patient safety in health care. More specifically is the growing number of preventable deaths that occur in our nation’s hospitals at an alarming rate. Some estimate there are over 200,000 preventable deaths. This may be a conservative guess as other studies have put preventable deaths at over 400,000 annually according to James et al.1 This is a 100,000 increase over the past decade. The problem is getting worse, not better.

These preventable incidents occur, according to James, in five categories: errors of commission, omission, communication, context, and diagnostic. When looking at this even more closely, however, the causes seem better aligned to:

- Failure to diagnose and treat a complication in a timely manner
- Medication errors
- Overuse of blood transfusions
- Infections related to IVs
- Overuse of supplemental oxygen to infants
- Late or missed diagnosis of congenital heart disease in infants
- Hospital-acquired infections
- Lack of communication between care providers
- Need for a better reporting mechanism for errors and unsafe conditions.2

The Patient Safety Movement is in its second year of existence and has taken this problem head on. Founded by Masimo CEO Joe Kiani, this movement has gathered significant attention and support by the government, The Joint Commission, clinicians, hospital administrators, payers, manufacturers, and most importantly, patients. By getting all interested parties to work together to reduce and eliminate these deaths, the movement is getting credible commitments, and changes are starting to be noticed. Their stated goal is to bring to zero the number of preventable deaths by 2020.

**Patient safety checklists**

In January of 2014, a Patient Safety Movement Summit was held. Over 400 invited guests were present to hear some of the best minds in health care talk about how we can help bring these numbers down. One of the presenters was Patrick Dunne, MEd, RRT, FAARC, who shared the two safety initiatives that the AARC developed. They come in the form of checklists and are available for anyone to use and to customize in their own institution.3

There are three checklists. One is an adult risk assessment for patients being discharged from the ICU, and the other two are for patients who are transported within the hospital. The transport checklists were developed after a systematic review of the literature with the intention of finding the most common safety error that related to oxygenation in the hospital. It was patient transports that emerged as the common thread. There may be many reasons for this, but chief among them is that RTs are frequently not present during house transports. RTs prepare the patient for the transport but are not always with them during the transport — instead leaving this role to transporters and nurses.

The main components of the transport checklists are categorized into:

- Patient readiness for transport
- Monitoring equipment: device readiness
- Oxygen supply.
While these precautions may seem rudimentary to a respiratory therapist, it is essential that all components be assessed and functional by anyone who has anything to do with the transport. These checklists can and should be modified for your own institution as no two hospitals and procedures are ever alike.

The other checklist was developed for patients about to be discharged from the intensive care unit. It was developed with a team of physicians, nurses, and respiratory therapists. It allows the RT to use an objective tool that will classify risk pre-discharge. As a long-practicing respiratory therapist and department director myself, I often observed that there were some patients who, due to the need for bed space, were released from the ICU (perhaps prematurely) and were not adequately followed on the floors post discharge. In fact, once my medical director insisted that because we were seeing an increase in readmissions for respiratory-related problems that it was a problem that the respiratory care department needed to address and solve. This checklist can do this as it takes into consideration the key components of patients’ readiness. Included is:

- Level of consciousness
- Gag reflex
- Ventilator status
- Vital signs
- Gas exchange.

There is also an assessment of known risks that are considered. They include:

- Patient was mechanically ventilated
- Sleep apnea
- Supplemental oxygen over 50% FiO2
- Time in the ICU
- Dialysis.

Based on these assessments, the patient’s risk classification is determined and scored. From this the clinician can make a reasonable recommendation of egress from the ICU. Additionally, we recommend the use of protocols that the RT can use post discharge. In doing so, the patient will still have a periodic assessment from the respiratory therapist.

**Get on the team!**

ICU readmissions are associated with dramatically higher hospital mortality rates, and the best predictor of ICU readmission is the patient’s vital signs. I would also add that because respiratory and cardiac conditions are the most common reason for readmission, that it is incumbent on the respiratory therapy team to be part of the solution to this problem.

We will be hearing more about the Patient Safety Movement in the years to come. While this is one of many initiatives that have been put in place, I do urge you to learn more about it. Become a front-and-center knowledgeable clinician in your hospital who will be sought after for your expertise in respiratory management and who — with the rest of the team — will help us bring down preventable patient deaths to zero by the year 2020.

**REFERENCES**