

No One Should Die or Be Disabled Due to Preventable Medical Error

3rd

Research indicates that medical error may be the third leading cause of death in the U.S.!

Preventable Medical Error At-a-Glance

Root Causes

Healthcare-Associated Infections (HAIs)

Poor Communication

722,000
Cases Annually

Healthcare-associated infections in acute care settings equating to 1 in 25 patients. Half of these occurring outside the Intensive Care Unit.²

70%

of sentinel events reported to the Joint Commission have been found traceable to communication failure as the primary root cause.⁵

Medication Errors

Breakdown in Teamwork

1.3 Million Annually
Medication errors cause at least one death every day in the United States³



80%

of patient harm is traceable to a breakdown in teamwork and communication during patient handoffs.⁶

Obstetrics

Misdiagnosis

360,000
or approximately 9%

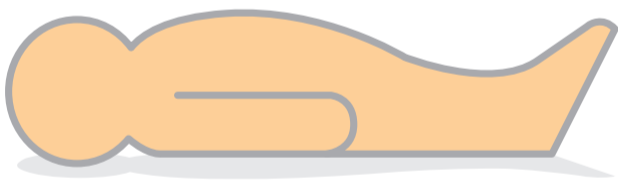
Obstetrical adverse events annually in the US. "About half of these are considered preventable."⁴

17%

Diagnostic error or delay in diagnosis contributes to 17% of the most common types of preventable error⁷

To err is human.

The patient doesn't have to be!



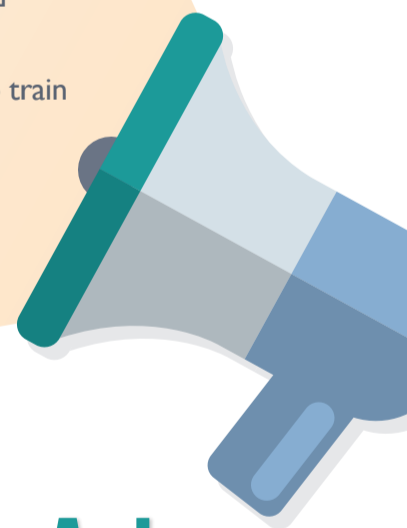
The Institute of Medicine Report, *To Err is Human: Building a Safer Health Care System*, specifically recommends simulation as a strategy for preventing medical error.⁸

What our customers tell us

Simulation can turn a team of experts into an expert team

- Use simulation to train for better teamwork and communications
- Take simulation to where care is given, in situ, to train for your real-world environment
- Simulate handoffs and the patient journey to understand the complete risk picture

If you want to identify and reduce risk of patient harm, simulate it.



Patient Safety Questions You May Want to Ask



Does your staff....

- Regularly practice a uniform teamwork and communications protocol?
- Know their individual strengths and weaknesses within the context of the teams they serve in?
- Feel confident that they can perform optimally in emergency situations or situations that would disrupt their normal team dynamics?
- Practice making decisions across the team rather than in isolation as individuals?
- Practice debriefing and learning from each other through the kinds of cases your institution encounters?

Every Life saved is a step towards improving patient safety. We believe that by working together, we can make the greatest impact on helping save lives. Please join us in raising awareness about this important cause.