Franck Guilloteau: Good day, everyone. My name is Franck Guilloteau. I am the Chief Technology Officer for the Texas Medical Institute of Technology. It is a privilege for me to be the moderator of today's program entitled "A Hospital Accident: Lessons Learned – A Death, A Conviction, and A Healing." We're excited to have over 1,500 registrants today...For those of you who haven't downloaded the slides yet, please go to www.safetyleaders.org; and, in the menu panel to the right of the video view window, you can click on upcoming events and follow the link to today's webinar, and there you will have a page to download the necessary information and the slides. Also, after the webinar is completed, you will have the opportunity to download a transcript of this program, as well as the slide set; some other assets that relate to the topic discussed today; and, also, this is where you would request the continuing education credits. Finally, if you would like to join the conversation during the webinar on Twitter, use #safetyleaders, and on Facebook under SafetyLeaders. I think the slide shows TMIT1, but it should be #safetyleaders.

TMIT is happy to host this webinar that is in keeping with our mission to save lives, save money, [and] build value in the communities we serve and the ventures we undertake. In order for us to address some of the issues related to disclosure, I will now go through a slide that shows disclosure of the participants and before we move forward, our panelists today include Dr. Denham and Matt Listiak from TMIT; Christopher Jerry, who is the president of The Emily Jerry Foundation; and Eric Cropp from Cleveland, Ohio. We will also hear, through a recorded message, from Captain "Sully" Sullenberger who is the Founder of Safety Reliability Methods. And, finally, Frank Federico, Executive Director for the Institute for Healthcare Improvement. The following slide is the disclosure statement for each of our speakers and panelists. No products or services will be addressed in this presentation.

As we always do in our webinar, we would like to recognize patients first by opening this webinar with a couple [of] words from our patient advocate. In this case, we have Chris Jerry who will also be sharing his story later on this webinar. Chris.

Christopher Jerry: Thank you very much, Franck. I would just like to thank everyone for joining and participating in our webinar today to discuss the very, very important topic of patient safety. This is something that I've committed my life's work to and really do appreciate everybody getting involved and doing everything that we can to work together to make our nation's medical facilities safer for everyone.

Franck Guilloteau: Well, thank you, Chris; and, on this note, I would like to turn it over to our first speaker, and, in this case, we have Dr. Charles Denham, who is the Chairman and CEO of TMIT, and Matt Listiak, our Senior Producer, who will be providing some context for this webinar via a pre-recorded message, as Dr. Denham was called to Washington, D.C., to participate in a meeting on the Partnership for Patients, which was recently launched by HHS.

Charles Denham: You know it is a real honor and a privilege to undertake this webinar today. We have two absolutely courageous men who will share their stories about the same young child who lost her life due to a preventable error. These two men are going to share both versions of their story: the father of this young child, and the pharmacist who was criminally indicted and went to jail because of her death. We will tell the story of how both of them have decided to come together and join forces to help you and [me] out at the front line prevent such events from happening again in hospitals, and we know there are so many predisposing factors that put us all at risk for these events to happen.
First off, however, I would like to share with you just a background and a background story of an article that we had written in the *Journal of Patient Safety*, “TRUST: The 5 Rights of the Second Victim.” This article was written to establish the framework at a foundation that would allow us to then develop a National Quality Forum Safe Practice for better healthcare, which, indeed, happened, and is, although not a mandatory practice or requirement, many hospitals have taken it up to actually create a safety net for our caregivers after bad events occur. Historically, we refer to the “Five Rights” when we consider medication safety: we deliver treatment to the right patient, with the right drug, at the right time, with the right dose, and use the right route.

The purpose of the article was to propose the five rights of our caregivers, the five human rights that our healthcare leaders must consider as an integral part of a fair and just culture when patients are harmed in the process of care. We use the acronym TRUST to represent treatment that is just; respect; understanding and compassion; supportive care; and transparency, which would be the opportunity to contribute to learning. Not only must we bear in mind the sacred trust of our patients, which is foremost in all caregivers’ minds, but we also have to honor the sacred trust of our caregivers who serve in our hospitals and healthcare organizations. You know, unintentional human error and system failures account for the most preventable harm to patients. Intentional negligence and harm because of malice is extremely rare. However, we treat our caregivers who are involved in human error and system failures with blame, shame, and what must be the most harmful experience, [which is] that of abandonment. In the article we explore the systems issues of caregiver fatigue; technology adoption without proper validation in a clinical setting; and the unintentional impact of workload re-engineering that can contribute to systems vulnerability and increase the risk of human error. In this article we addressed using the story of Julie Thao, the nurse who was involved in the loss of another young patient’s life; the impact on caregivers of unintentional human error; and system failures that can result in patient harm, an impact that can cause a very real medical emergency for the caregiver or the second victim. If the first victims are the patients and families who are harmed, then the second victims are the caregivers and staff, who sustain psychological harm when they have been involved in treating patients, when they have been trying to help them.

Further, we submitted in the article that the third victim is our healthcare organization that sustains a wound in its culture due to these preventable errors, and what they can do to our organizations. After this article was developed and was in the marketplace, and after we had started to develop the ideas for a documentary, we moved forward with a National Quality Forum Safe Practice that is known as the Care of the Caregiver Practice, [which] undertook a deeper dive and addressed each of these elements. So the National Quality Forum Safe Practice established key elements that spell the word TRUST: treatment that is just, which is really a well-organized, evidence-based process to really assess the behaviors of individuals after an event and [ensure] that they aren’t just due to overt, reckless behavior, or intentional issues, or issues relating to substance abuse. The R was respect, and that is developing a formalized process that could be followed by designated administrative senior leaders immediately after an incident. You know, the fog of war sets in after these terrible events, and we really need to have an organized process that administrators can follow. The third was U: understanding and compassion, which is a formalized process that could be followed by a designated administrative leader to invite co-workers to express personal understanding and compassion, because forgiveness and that connection between human beings is very healing, especially after such terrible events that, as we said, are in the majority unintentional and not due to overt reckless behavior. Then the S represents supportive care, because we found that, after these events, caregivers really have a psychological emergency and actually need assessment for fitness to work and really be cared for as patients, even those involved in near misses. Then T, transparency, is: do we really need to involve the caregivers in the analysis of what happens so that we can prevent that from happening again in the same organization? And it also is healing to be involved in moving forward and giving meaning to these terrible events that occur.

We are so privileged to have both the father of Emily Jerry and Eric Cropp, the pharmacist involved in this terrible mishap, share their stories from their perspectives and what happened to them. We had the wonderful opportunity at the Cleveland Clinic to bring them together, and this is a courageous moment that they undertook together to relive this experience and to really join forces – from Chris Jerry’s standpoint, to relive the death of his child and to exhibit what is the amazing forgiveness that can occur.
that is so healing to our system and to individuals involved; and Eric Cropp to take full responsibility for his role in this death and to be able to express his regret that such a thing could happen. This was truly a healing moment for all of us [who] observed it and to the hundreds of doctors and administrators in the Cleveland Clinic [who] actually witnessed this publicly and acknowledged them with a standing ovation.

Matt Listiak: I am Matt Listiak, the producer for TMIT. As Dr. Denham mentioned, we had the privilege of filming Chris Jerry and Eric Cropp when they met in Cleveland in May, just over a month ago, for our upcoming Discovery Channel documentary, Out of the Danger Zone*. I am going to share some audio clips from the meeting just to give you a sense of the healing moment that we all experienced, but first, I'd like to thank Chris and Eric for joining us today to share their stories. It takes tremendous courage.

Being behind the camera with TMIT, I've had the honor of working with numerous heroes of patient safety, and sharing their stories to change healthcare for the better is a calling that I don't take lightly. But as a filmmaker, you still try and stay objective, so you set aside your emotions and you can perform your job. But there was something different about this shoot. Seeing their interaction was a truly moving experience for our entire crew and, knowing that there can be a reconciling moment after deep tragedies like this, it gives me hope. I personally took this lesson to heart, and I have since been applying this power of forgiveness and compassion in my life. So, Chris and Eric, thank you. Thank you for your courage.

On the day of our interview, before Chris Jerry and Eric Cropp met, Dr. Denham spoke to Chris about his expectations for the day:

Charles Denham: So what do you hope to accomplish?

Chris Jerry: I'm going to try to be a role model for other families with respect to how to deal with tragedy or this type of loss.

Charles Denham: Forgiveness is so important. When you and I talked about getting together with Eric, what feelings went through your head?

Chris Jerry: I was a little nervous, but, at the same time, I want him to know that I truly forgive him from the bottom of my heart.

Charles Denham: These system failures that occur, the invisible support systems that really aren't in healthcare, are really the culprit. Has that been something you've learned in the past months, in the time since you've lost Emily?

Chris Jerry: Most definitely, most definitely. I believe that people like Eric are also victims of what's been traditionally an ineffective patient safety system.

Matt Listiak: As Eric arrived, Dr. Denham spoke with him in the hallway and then he went into the room to meet Chris.

Charles Denham: So this is exciting to bring the two of you together, but I know you have to be feeling a little bit. As you were coming to meet with us, what was going through your mind and your heart?

Eric Cropp: Anxiety, anxiousness. Excitement actually, though, because it is going to be nice to finally get in touch with Mr. Jerry and have a sit-down with him. I am really looking forward to getting my side to him, so he understands where I'm coming from, but also see some of the things that he's going to say to me. I want to understand their feelings — him, as well as his wife, what they were feeling in the past, as well as what he's feeling right now.

*N.B.: The documentary is now titled Surfing the Healthcare Tsunami: Bring Your Best Board™.*

[01-25-12]
Charles Denham: You talked about how healing this can be for you. You’re kind of looking forward a little bit to the…

Eric Cropp: Yeah, I need that because I never was able to speak with the Jerry family. I was advised [by] the hospital, as well as my lawyers, not to speak to them, and, though plenty of times I think if we would have talked early on, this whole situation probably wouldn't have spiraled out of control like it did to a point; and I think that now that I can talk to him that some healing can happen.

Charles Denham: Well, good. Let's go meet him. I know he is excited to meet you and this takes a lot of courage and we are just proud to be with you, and we know that it does, and it’s exciting to know that this is almost like a new chapter in your life, isn't it?

Eric Cropp: Yes, definitely.

Charles Denham: Chris, I want you to meet Eric Cropp.

Christopher Jerry: Hi, Eric. Good to see you.

Eric Cropp: You too.

Charles Denham: It’s so great to see you two coming together, and this healing that can occur is the kind of healing that everyone needs. So often we don’t have an opportunity for this.

Christopher Jerry: I know it was a mistake buddy. I do.

Eric Cropp: Thank you.

Christopher Jerry: I know that in my heart, and I want you to move on with your life and make some good come out of this.

Eric Cropp: I hope that something comes good out of this.

Christopher Jerry: I know something good will come out of this. A lot of things good will come out of this, but I want you to know that I forgive you from the bottom of my heart, and I know that's what Emily would want me to do. Emily wants us both to move on. But the big thing is we've got to keep our heads up, and we've got to make sure that there is some positive change as a result of this.

Eric Cropp: Yes, exactly.

Christopher Jerry: I am now starting a public speaking campaign, and I would like to have you there by my side.

Eric Cropp: That would be wonderful, because I think it needs to be the whole story.

Christopher Jerry: It does. I view you and what’s happened with your life as part of the overall tragedy.

Eric Cropp: Yeah.

Christopher Jerry: I really do. I know that you entered the healthcare realm, went to school to become a pharmacist because you cared about people and helping people.

Eric Cropp: I did. I wanted to help, especially kids.

Christopher Jerry: I want you to know that you can continue that.
Eric Cropp: Thank you.

Matt Listiak: After their meeting, Chris left, and we spoke to Eric about this healing moment.

Charles Denham: So how does it feel now that you've had a chance to visit with Chris Jerry?

Eric Cropp: I feel a lot of closure has occurred. I feel the healing process can get started. I feel that now I can help him out and may make an impact with his Foundation for Emily. So I'm feeling a lot, lot better inside. I'm not so nervous, and I feel confident after being able to talk with Christopher, so it will be a good outcome.

Charles Denham: It was wonderful that he gave you a hug when you came into the room and immediately forgave you. My heart leapt when I heard that.

Eric Cropp: It was very moving and it actually brought tears to my eyes. He made me feel very good again about myself. It was a lot of burden that was lifted off me, the fact that he was giving me some forgiveness that I guess I really needed.

Matt Listiak: The next day, Dr. Denham was delivering a keynote address to the Cleveland Clinic. He invited Chris and Eric to join him in the audience and the reception from the Cleveland Clinic was wonderful.

Charles Denham: That pharmacist who was subject to our criminal court system, who went to prison for a systems issue that is predictable, absolutely predictable, and the father of that child, Emily Jerry, had a healing moment where they decided that the systems aren't there, but they can do something. These two men had the courage to get together and relive this terrible event to move forward to help people like you and those across the nation to let their stories actually move us to start to own these systems. I want to acknowledge them and these two courageous men who have re-lived this and not moved on, but re-lived this, so that they can do that for the rest of us, so that other pharmacists and nurses won't go to jail and other families won't have to go through this and are right here this morning. I would just like to acknowledge them. Eric, thank you for your courage for coming today and just standing up for and doing the right thing in helping us understand those things and not holding bitterness in your heart and helping us with this story. And Chris, I know reliving this with your family is the same, and I would just like the caregivers in this room to acknowledge these two courageous men for moving forward because this is showing leadership.

Franck Guilloteau: That was a very touching segment, and now we actually have the privilege of hearing directly from Chris Jerry, who, as you heard, following the death of his daughter from a medication error, decided to retire from a very successful business career in medical imaging and become a patient safety advocate and to establish The Emily Jerry Foundation. He now devotes all of his time to patient safety advocacy and the Foundation's effort to improve overall patient safety in our nation's hospitals and pharmacies. So he will now share with us Emily's story.

Christopher Jerry: Thank you very much, Franck, and thank you all for the kind words.

This has been an incredible journey, to say the least. It has been the toughest thing that I think any person can go through. Emily was a very, very special little girl. I have been blessed with three wonderful children, but Emily was a little bit different. Emily was the most outgoing, beautiful, beautiful baby. From the time she was born, I can't remember her ever really fussing about much of anything. She was just always happy, always smiling, and just – she would walk into the room and everybody in the room would light up. She had that effect on people, and, as you all can tell from the logo for my Foundation, I truly believe that she is now my guardian angel, and she is a lot of other people's guardian angel as well. She is watching over what I am doing, and I think I'm trying to make as many positive things come out of these horrible circumstances as I can. I believe that God doesn't mean for any of these tragedies to occur. I believe that he allows life to play out, and I believe that God is there to help guide us through the
aftermath and to try to make positive things happen. And that is the core reason why I decided to retire from a successful business career and become a patient safety advocate.

It is kind of ironic how things have evolved, because, as I have done my research over the years since Emily's death, now that I have a good understanding of these tragedies and how they occur and what have you, I'm finding myself advocating just as passionately for the caregiver as well – people like Eric Cropp. Anyone who gets involved with healthcare is there to serve people and to try and help people through sickness and illness, and nobody intends for human error to come into the equation. So through our efforts, we are trying to do everything we can to minimize that human error component and that is the reason for our webinar today.

Anyway, with respect to Emily – Emily was diagnosed in the fall of 2005 with a grapefruit-sized tumor in her abdomen. It was completely shocking to my former wife and me because Emily appeared on the outside to be a completely healthy, vibrant little girl – very active, very energetic, very happy. But, occasionally, she would wince and stop. When she would be playing with her brother and sister, she'd stop and wince in pain and grab her side. I came from a medical imaging background and realized that we needed to get her in and have her imaged, that something wasn't quite right. I just had this gut feeling. To our dismay, we found, after they imaged her, that there was a grapefruit-sized mass in her abdomen. It was a yolk sac tumor. She was diagnosed at one of the nation's leading children's hospitals, and, initially, the physicians discussed for her treatment chemotherapy with follow-up surgery. Actually Emily responded – I use this term quite often – “miraculously” to the chemotherapy. By that, I mean, I am not a radiologist, but I've viewed thousands of films during my career and usually, when somebody responds well to chemotherapy, when they have a mass that large in their body, there is usually some residual scar tissue remaining in the abdomen.

In February 2006, shortly after Emily began the chemotherapy, they re-imaged her, and there wasn't even any residual scar tissue on those films. It was as if you were looking at a perfectly healthy pediatric patient. Emily's oncologist had recommended maybe one more round of chemotherapy just to make sure that there weren't any residual cancer cells in her little body that could rise up later in life and cause her some problems. My former wife and I agreed that maybe one more round would be a good thing, but we would be taking our beautiful little girl home afterward, and we could celebrate Emily being cured of cancer. Unfortunately, a pharmacy technician, who really didn't have adequate training at the time, instead of using a standard, off-the-shelf bag of saline with 0.9% sodium chloride, she used an empty compounding bag and filled it full of 23.4% sodium chloride or hypertonic solution. This caused Emily to go into a coma as a result of the cerebral edema that caused, or the brain swelling. Once she was admitted into the ICU, in the ensuing days, there were two EEGs that showed no activity, and so the decision was made to take her off life support. I can't begin to explain the feelings that we all had. From one minute I'm thinking my beautiful daughter is cured, thank God, and the next moment, her life is taken; and it was just devastating.

The subsequent outright support that we received from the hospital was great. They were very forthcoming. In fact, the treatment team even attended Emily's funeral. In the wake of her death, I found that each of us [grieves] differently. With that being said, it impacted our whole family differently, and it motivated us in different directions. I didn't feel anger toward any one individual. I just immediately – I have a very science-oriented mind, and I'm thinking, how could the process break down? How could this happen? I had a feeling in my heart that it was something systemic that caused this; not one individual with any type of malice or anything like that. With that in mind, I wanted to get to the root cause of what happened, and that is when I embarked on a path to get Emily's Law passed in the state of Ohio, which I was able to get successfully passed in January 2009 and signed off on by our Governor, which provides some regulation and oversight by the Ohio Pharmacy Board, some basic testing requirements, and things like that.

Prior to Emily's Law, there were no requirements for pharmacy technicians whatsoever, and that was very shocking to me. Anyway, I embarked on that path and then I decided I really wanted to do more for the patient safety movement, because what I was finding, doing my research, was that there are so many of these errors that occur as a result of the human error component in medicine that are very preventable if
we all join together and work to, in a productive way, and collaborate together, we can find ways to reduce or minimize that human error component, and that is why I established The Emily Jerry Foundation in Emily's name, and that is why I devoted my life to this. Unfortunately, my other family members became very angry and very vengeful, and that's what led to the criminal charges against Eric Cropp. I decided very early on that was so wrong to do. Eric did not deserve to go to prison for what happened, and what he did was not criminal at all. There was no malice involved whatsoever on his part, nor was there any malice involved on the part of the pharmacy technician. With that being said, I believed that eventually there were two tragedies that occurred with respect to the incident with my daughter, and those two tragedies are the death of my daughter and, secondly, the criminalization of what happened to Eric Cropp. Anyway, with that being said, I would like to turn everything back over to Franck.

Franck Guilloteau: Thank you so much for sharing with us, Chris, Emily's and your story, too, and obviously some insight as to how to address this issue on the care of the caregiver.

Our next speaker is Eric Cropp, and Eric Cropp has over 16 years of experience working in the field of pharmacy; and the majority of that time was spent in the oncology field, working to manage pain for patients. He has worked several years at a compounding pharmacy, managing that pharmacy, and, shortly before the incident that is the subject of this webinar, he was working to get his PharmD degree with a focus on pediatric oncology. So, Eric, if you wouldn't mind sharing with us your story and Emily's story.

Eric Cropp: Thank you very much. This is a real honor to be here and to be able to share what has happened to me. I appreciate Chris Jerry stepping forward and apologizing to me and being a great support system in the last month that I really needed. It's helped me grow healthier and be able to do what's the right thing by being able to talk to other professionals, other laypeople, and other victims [who] have gone through what I have gone through.

During this whole ordeal, I walked in just like a normal day. I knew we were going to be in trouble because the computer system had been down for ten hours; and I was working with a pharmacist [who] was fairly new; and I wasn't even scheduled for that morning. I came in extra because I knew they were shorthanded that day. I, being the typical step-forward-type person, jumped into everything and was dealing with the phones ringing off the hook because the nurses were missing doses on other patients, and we hadn't been able to print any labels from the night before when I left. It just continued to be a crazy, hectic day, and around 10 that morning, the system started to go back up and all the labels printed. But unfortunately, in my situation, the labels from the night before printed out that morning, rather than the afternoon doses, so I was already having to have the technicians sort through that and see what was needed right now, what already should have dispensed; and so again, there was another challenge. Given the fact that I had really great technicians, they all jumped forward and were doing their best to try to fill as many of the IVs and the oral syringes, as well as IV syringes that we would dispense. The small IV area that we had started [began] to grow pretty tall. I'm a short guy, and standing up to the table, it was already up past my chest of things to check. So there were bins piled on top of bins to be checked, and I jumped in trying to answer the phone and check things at the same time, which – right there was a warning flag. I was overwhelmed and had too much on my plate right away.

Then, around 11 o'clock that morning, I got a request that they needed Emily's chemotherapy that they were going to dispense at noon that day; and when I went to see if the base solutions were ready – because the labels didn't print out, the pharmacist during the night didn't make the base solutions – so I asked the technician who was in charge of making the chemo, would she start making the base solutions and I would go pull the chemotherapy meds that would be added to two different base solutions that we had to do. Constantly being interrupted; the phone was ringing off the hook; techs were asking me questions. On weekends, we usually try to deliver the medications every hour to hour-and-a-half, and I was running into problems where we were two hours behind and people were just constantly, you know, they need it, they need it – and, in the process, when I was checking Emily's base solution, I kind of had this where you go into the car and you drive home mode, where you have done it over and over and over, and you're not looking at the obvious; there is something not there or there is something wrong there. When I checked the IV solutions that were to be used as a base, I asked the technician, "Is this normal
I called the physician and let her know what had happened because she had already ordered a test to see what concentration of sodium was in the bag. I spent the rest of that evening in a panicky, crazy mode, but I had to finish the shift because I had all these other patients to take care of. I was constantly calling the physician to see what Emily's progress was, and I was assured she was doing okay, that they were giving her fluids to flush out the sodium chloride. I was kind of put a little bit at ease because I was being told by the physicians that things were all going all right. I was not aware until hours later how quickly Emily's condition changed, and she ended up in the ICU unit and was eventually put on life support. I had gone home by then; was called in to work my next day's shift; and was then told I had to go home after questioning on what happened that day. The technician and I were both sent home. We really did not hear from the hospital for days after that. It wasn't until that Wednesday one of my coworkers called me and said, "I'm so sorry to hear what happened," and I was like, "What? What happened?" and that was the first time I learned that Emily had died.

In that state, I was horrified. I was hysterical. I broke down. My two roommates came and were trying to figure out what was wrong with me, and I told them the situation, and I just was devastated. I was just wishing I was in her place. I wished that this had happened to me and not her, and I didn't know what to do. That following week, I was called back into the hospital, and the technician and I were both dismissed. They didn't go over anything; they just said that, because we didn't follow policy and didn't make the IV they way we were supposed to, we were dismissed. In that state, I really needed to be counseled, and this is something that both Chris and I want to work on in the future, as we want to develop a group that when a situation like this occurs, we make sure that, not just the family, but the caregiver, are given the right counseling and the right support system, and they are there so that caregiver knows they have someone to talk to. I didn't have anyone to talk to. It was a really bad situation. They had me, just before I left, talk to a social worker, and, unfortunately, last day at the job, and I kind of got lost in the system. When I tried calling around to get help and support, everybody said, "Well, we have a waiting list – it's going to be a couple weeks, it might be up to six weeks." During that six weeks, I lived through hell, because nobody around knew what I was going through and nobody had gone through the experience that I had gone through, so it was really hard. I didn't want to leave my room. I was an emotional mess. Even to this day, I see a commercial for St. Jude's Hospital, and I think of Emily all the time. I think of "why couldn't we have done this differently? Why couldn't that day be different?" It's always going to be there, always in my mind. I always will think about this.

I thought everything was fine. I was interviewed by the hospital lawyers that summer, and they said definitely it was a mistake by the technician and everything, so I didn't think anything of it; but that following September, the pharmacy inspectors came by and they said that they questioned my story and the technician's story and things didn't match up. I said, well, now it's nine months later almost. I don't
remember every exact thing I have done. I don't remember exactly how much we added to this and that. It became known that I definitely was going to have to appear for the pharmacy board.

That April, the following year, I did appear for the board. I was advised not to show my emotions, don't get upset, be strong. Well, that came off to the family, as well as to the pharmacy board, that I was coldhearted, that I was not a caring person, which is totally the wrong idea, because I would have broken out and said everything possible to help the Jerry family. I wanted to speak to them, but I was advised, "Don't talk to them, don't say anything." I wish I could have been there, held them, and told them how sorry I was. It was – again, there were systems where you're not supposed to associate with the families of victims and I think – that is something that we have talked [about]. Chris and I, that we need to get the family and caregiver together and have them talk. There is going to be anger and frustration, but I think it is going to help both of the groups heal and go forward; and it won't lead to what had happened to me, because eventually, after I lost my license from the pharmacy board, the court system got involved, and then I was sent to – what was – eventually, I took a bargaining, because I was told I was going to have to go to jail for five years, and I was told, if I pleaded out, that I would just have probation and community service. Well, eventually the judge changed his mind and added six months of jail and six months' home arrest, which I served for a year; and also he assigned that I needed to do 400 hours of community service where I would go out to the public and tell my story.

From doing those hours of community service, I realized there was just definitely a need – beyond those 400 hours – that I needed to go out and talk and share my story and make sure that I make a difference, that this doesn't happen again to another professional, to another family member. There is definitely a need out there to have a support system. So recently, I've just been keeping myself busy trying to talk to different pharmacy organizations, medical institutions, and just recently started working with Mr. Chris Jerry, and he has given me even more of a reason to go out there and take this with all of my heart and be there for that professional [who] has done the same thing, or be out there to make sure that they don't make that mistake, that we start recording these near misses and use them as a teaching method instead of a punishment. Everybody is human and we make errors, so we need to use those errors as a teaching tool so that no one else will have to go through what Emily had to go through, I had to go through, the whole Jerry family, and my family. I also wanted to stress that we need to use me as an example and say that I don't want to be an Eric Cropp situation. If you are working where I was and you are working in a situation where you feel it is a dangerous environment, there are too many distractions, there is not enough work area, you're not getting enough time to maybe take a 15-minute break – speak up. I know, I worked retail, I've worked the hospital, and I now don't have anything to lose, so I'm out there now being an advocate for the pharmacists, the doctors, the nurses, the family members, and the patients, because I don't want anybody else to go through what I went through.

I just want to close this by saying that I want to thank Chris Jerry for coming out last month and forgiving me. It meant a lot, and for Chuck Denham for getting this organized so that we could sit down and start that healing process. I thank Chris also for offering me this opportunity to work with him, so we can make a difference, and, hopefully, maybe we can save one or two peoples' lives or prevent an accident from occurring. I thank you.

**Franck Guilloteau:** Thank you so much, Eric, for your willingness to share your story; and thank you, Chris, also, for participating in this program. We look forward to working further with you to spread the message through these similar venues, as well as the Safe Practices that we've been developing. The Care of the Caregiver, which is one of the National Quality Forum Safe Practices, we will continue to update, and you all will be able to contribute; and, hopefully, we'll be also pursuing some publications through the *Journal for Patient Safety* on the story and the impact, and what we can do about this.

Our next speaker is an individual who probably does not need an introduction, and really the purpose of having Captain “Sully” Sullenberger join us is to try to see how we can apply some of the learnings from aviation, in an event that everybody remembers as a miracle landing of his airplane after a bird strike that took both engines out and, amazingly, having all the passengers and crew making it out safely. What he is going to share with us are some thoughts about what happened not only during the event, but after the event, and how the crew was taken care of, and how he felt the event could have gone.
Matt Listiak: Sully, you and I have had wonderful conversations with Dennis Quaid and others and leaders in patient safety and quality about how much we can learn from aviation; and one big area is care of the caregiver. And you understand that we do have voluntary processes and systems in place, but they have not been adopted across our industry, and we have so much to learn from what you have accomplished and what aviators have accomplished in aviation. Can you share with us the power of this systematic approach after a bad event?

Captain Chesley B. “Sully” Sullenberger, III: We make every outcome that is not optimum a learning experience. It is part of the continuous improvement process. As tragic as it is to lose a life, it only compounds the tragedy if you don’t learn the lesson or if you have to subsequently re-learn a lesson that has already been purchased at great cost, with the loss, often, of lives.

So in aviation, what we do is we take care of each other; and the day after our Hudson River landing, I insisted that the pilots and flight attendants on my crew, a total of five, get together with our pilot peer volunteers who had been trained in our critical incident response program team, to come to New York and to assist us. I insisted that the pilots and the flight attendants be together as a team, as we had worked as a crew together. That was important because the flight attendant critical incident response people hadn't yet arrived. So when we all met quietly in a conference room with the peer volunteers, I asked them for a road map of what to expect, and they gave us a very detailed and, it turned out, a very accurate road map of what our experiences were going to be in the next few days, weeks, and months. We were going to be deep in the throes of post-traumatic stress and the inability to sleep more than a few hours at a time. For me, personally, this was such a traumatic event that during the flight, when we had the lost the thrust, I could feel even as it was happening, my blood pressure, my pulse, spike, my perceptual field narrow; and my blood pressure remained elevated for many weeks, as did my pulse. We had the inability to shut off our minds.

I would try to read, in those first few days, a magazine or a newspaper article, and I would re-read the same sentence five times, and my thoughts kept drifting back to the events of the flight, and I would finally stop and give up, and this kind of distracted thinking lasted for some time. This what-if-ing, this natural second-guessing of ourselves, took place many days, particularly late at night; again, the inability to shut off our minds, to think of anything other than this important, traumatic event in our lives. So we all were told what to expect. The fact that it was an absolutely normal human physiological response of this sudden life-threatening stress, this trauma that we had experienced, and not just our crew, of course, but everyone on the airplane, the passengers, all our families. This was a life-changing event for everyone, and it changed our lives instantly, completely, and, if not forever, for a very long time. So having this foreknowledge of what to expect, and the fact that it was a normal process that we had to go through, was very helpful to us. And process is the word that we used to describe it. It took time, and we had to think about it. We had to begin to integrate this event, with all its trauma, into our psyches. We had to eventually put it in perspective, learn from it, and make it a part of ourselves.

In each of our lives, we are formed by the events that we experience; and this, too, would be an important event that would shape the course of our lives and be available to us to draw upon. We also participated [in] and questioned the NTSB (the National Transportation Safety Board) investigation, which is, for aviation, a formal lessons-learned process, and that was a very healing experience also. Being part of the root cause analysis, being a part of this learning experience, knowing that because of our experiences other crews will be better prepared to handle whatever challenges they might face. Other passengers would be better kept safe because of what we learned from Flight 1549. So in many ways, this formal process that we went through as individuals, as a team, as an industry, was very healing and transformative; and ultimately, we came out the other end, not the same people who went into it, but whole and intact.

For many of us, there were lingering after-effects that lasted to this day. Of the five of us, four of us eventually went back to flying; one retired rather than go back to flying; but we are all okay. We all have recovered from our physical injury that the one flight attendant had and from the experience of this post-
Charles Denham: So, Sully, after the event, there was a formal process for evaluating and preparing fitness for work. Do you think that is something that is valuable for us in healthcare after a bad event when we've harmed a patient?

Captain Chesley B. “Sully” Sullenberger, III: Absolutely. You’re not ready to go back to work immediately. You have much help that you need to get; you have much processing and work and thought that you have to do on your own. We had made available to us important resources in terms of the psychological help and the peer help, to help us put this in perspective. We also did much work on an individual basis to integrate this into ourselves and to learn from it and to become a stronger person when you come out the other end.

So I think – even though this is a traumatic experience for each of us – it was a growth experience; and when we looked at it in a very positive way, knowing that not only would our industry learn from it, not only would our colleagues and our passengers benefit from it, but that we would grow from it personally, I think helped give this event purpose; and from that purpose, we could derive meaning, and ultimately it would help us to come out successfully at the other end.

Charles Denham: Final question. When you and I were at MIT recently, we talked about the invisible systems, the systematic training that you had that allowed you the mental bandwidth to really deal with a novel problem that you had never prepared for. Any recap on that? I thought that was a very powerful concept you communicated – those invisible systems that we don’t have in healthcare that you have in aviation that allowed you the bandwidth to really accomplish something really miraculous in 208 seconds.

Captain Chesley B. “Sully” Sullenberger, III: And not only is it training, it's culture. We have a culture in which we take this collection of individuals who may not have met each other before, and we quickly form a team when we begin a week of flying together, and we become a crew. We have responsibilities to each other. We have roles to fulfill. We have a shared sense of responsibility for the outcome and for each other. We look out for each other. As the captain, as the leader of this team, it is my responsibility to ensure their welfare and the passengers’ welfare in every way, in every respect. So we had this collective sense of self going into this. So that, as much as anything, helped us to look out for each other, helped us to realize that we weren't left adrift on our own, that we were part of something greater than ourselves, and that we would collectively and individually survive not only the event, but this intense aftermath.

Charles Denham: And Sully, just as we close, you are writing another book that will be very exciting for those of us in healthcare. Any bit of a tease you want to give us?

Captain Chesley B. “Sully” Sullenberger, III: Well, you know, it's a book about leadership examined not only through the lens of my experience, but the experience of about 13 or 14 other people, some well known, some not, but who all have very intense, personal, moving, illustrative stories that really help weave through this narrative common themes that we can bring into clear focus at the end. I think it's one that is very exciting for me and my publisher, and I'm hoping it's going to be an important work.

Charles Denham: Well, we would like to invite you back with this audience to do a full webinar on it when you can, and thank you for your gift of your time today.

Captain Chesley B. “Sully” Sullenberger, III: You're very welcome. It's great talking with you.

Franck Guilloteau: Our final speaker, whose experience in this field is really going to bring it together, is Frank Federico. Frank is the Executive Director and safety faculty at the Institute for Healthcare Improvement in Cambridge, Massachusetts. His primary areas of focus include patient safety application of reliability principles that we have heard in healthcare, and preventing surgical complications. He's also [on] the faculty for the Patient Safety Officer Training Program at IHI and a pharmacist by training. Frank?
Frank Federico: Franck, thank you very much; and before I go on, I just want to thank and congratulate both Eric and Christopher – one, for showing forgiveness, and two, for taking an opportunity to channel their work into improving safety for many other patients, and thank you for that courage that you’re showing.

I want to take this opportunity to share with you a white paper that we developed at the Institute for Healthcare Improvement. It was done under the leadership of Mr. James Conway, a Senior Fellow at IHI, and the former COO at the Dana-Farber Cancer Institute, and with the contributions of many in the healthcare field who generously contributed cases, examples of how to handle serious events, editorial reviews of the paper, and even tested the model that I’m about to share with you. The good news is that this paper now has been downloaded from our website by many people, thousands, and also, it's being adapted for application in other countries based on their systems and how they function.

The development of the white paper was really motivated by three objectives. One is [that] we want to encourage and help every organization to develop a clinical crisis management plan before they need to use it. We also want to provide an approach to integrating this plan into an organizational culture of quality and safety, with a particular focus on patient- and family-centered care, and a fair and just treatment of the staff. We have just heard quite a bit around talking about the engagement and the impact an event has on patients and families. We can't forget the impact that it has on staff, just as Dr. Denham started our session today. We also developed this paper to provide organizations with a concise and practical resource, especially to inform them when they have a serious event and don't have a clinical crisis management in place, or don't have a culture of quality and safety in place, and are required to respond to some serious events. The way the paper is structured is that it offers a checklist; it offers a work plan; it offers an assessment tool; and there are numerous resources and practice guides that are available to provide any organization in the phases of developing a plan to look at references, to learn from others how this could work. The white paper is designed to help healthcare executives and other leaders, such as CEOs, COOs, CMOs, CNOs, legal counsel, etc., to develop a plan to deal with the adverse event, and so that they are able to respond effectively and to turn every event into a learning opportunity that helps the organization improve safety.

The way we look at this, and the reason that we started working on this paper, is that we sometimes realize that there are many things that are going on in an organization, and that the realities are that the organizations are really complex; [that] there is a lot going on; and that many events sometimes occur; and no matter how much we have invested in making our system safer, there is still the opportunity that there might be serious harm. There might be harm to one patient or there might be harm to many patients as the result of the care that we give. There might be some fatal rare complications that were just not anticipated, and we need to deal with that and share. There may be a violent crime, whether it be staff to patient, patient to patient, staff to staff, whatever. There might be fires that occur in an organization that must be dealt with. Drug diversion is of a particular concern. In particular, we worry about whether or not a patient might have been harmed by somebody who is diverting drugs and is now continuing to care for patients. There is also an example of identity theft – something that happened at the Dana-Farber Cancer Institute, where there was an individual who was taking advantage of the information that they were gathering about patients and using that to steal and set up accounts to be able to take money from others.

In order to make this work, what we had to do was really think of an operational definition of “what is a serious clinical event and what is something that we would include in our crisis management?” Our definition is that it is serious harm, potential serious harm, death, or a clear and present danger to one or more patients. And again, we emphasize that sometimes the crisis could be more than one patient, and it could also be something to a community – some kind of impact that might, in fact, have an influence on everybody who works and lives around the hospital. The way that we could describe that harm is we could use the harm categories from the NCC MERP council, the harm index GH&I, that is lifesaving measure, permanent harm, or death. We could also use the sentinel events as defined by The Joint Commission. We could look at the National Quality Forum Serious Reportable Events as a baseline list for the serious clinical events; or we could look at the HPI Safety Classification, which, again, is an amalgam of all of these in a way. So it is up to you to decide which of these events is most important.
Now, why is this important? Because that is when you know to kick into the plan; when it's important to identify the opportunity; when it's important to notify the individuals who need to be involved and put the plan in place.

What is also important is that the harm that we're dealing with is usually preventable, but not exclusively, because, even though we may not be able to prevent certain harms, the impact that outcome has on patients, families, and clinicians is still significant and still must be dealt with.

Why did we start working on this paper? Well, it usually goes something like this. Jim, or I, or other people at IHI might get a phone call, and the phone call might say we just had a terrible error in the ICU. A patient died who shouldn't have. What should we do? What we find is that many times organizations don't have a plan. They aren't organized; they don't know what to do with this; and the most striking attributes of all of these calls are that there is a personal devastation for the person calling. The person who is calling us now is experiencing – and although they may not be the ones who were directly involved in the care, they're experiencing some significant impact as a result of that. There are similarities to all the stories, that when we get together here to discuss with each other what did we learn, what could we do, many of the underlying causes, the underlying causes are usually the same. The organizational response as we have learned usually begins from scratch. There is not a significant plan in place that allows them to carry forward with something that is already standardized and helps address the organization's problems in a very direct way. The style is usually reactive and not balanced. That is, they are reacting to the individual event rather than using this as part of a larger system goal of learning; and overall, what we found is that the responses that we get from the individuals, when we talk to them, have totally underestimated the kind of harm experienced by all in the organization. And again, Dr. Denham mentioned trust at the beginning of the session, which really goes deeper into understanding that there is harm that many in the organization, the second, and even third, victims encounter.

The things that we try to address in our paper include the questions that are here. What should we do in the first hour, the day, week, month? What we have realized is that the first 24 hours after an adverse event really are an indicator both to the staff of a hospital, as well as to the patients and families, as to how the hospital will react – the kind of respectful response that we would provide to patients and families – and also sets up the future relationship that we have with patients and families. We have to plan moving forward. What happens to the care we provide? We just heard our pharmacist talk about how he continues to be in the workforce; and should that person really have been given the time to stop and think and reflect, or just pull himself away to pull himself together as to what needed to be done? “Who should do it” becomes a big question. Should we involve the chief executive of the hospital? What is the role of the clinicians involved, the doctors, the nurses, the risk managers? Who needs to be able to communicate with the family and the patient? What should we say and to whom? This again goes back to the whole discussion of communicating with a patient after an adverse event. What are the things that we need to put together, and whose problem is this? Well, I'm going to say that it is everybody's problem. Every organization has to deal with all of the things that happen as a system and not blame individuals for what's happening.

We have developed, as a part of this work, a number of checklists, and this one in particular is one of the first ones that were developed. This really deals with communicating with patients after an adverse event. There are nine components to it. One: thinking of dealing with the internal culture of safety, malpractice carriers, etc. In my own experience, we have done a lot of work about training individuals on how to communicate with patients and families, and sometimes we forget all of the other supporting mechanisms that are necessary in order for an organization to be successful.

This is just a quick screenshot of some of the elements that are in that list. When we are talking about internal culture or safety, we are thinking about the organization's ability to have the board and leadership grounded in the core values of compassion and respect. We're talking about the malpractice carrier. We are thinking about a commitment to a rapid disclosure. How were they involved? Is there a written understanding of how cases will be managed? Are there policies and guidelines and procedures in place? [Is there] a policy on the patient and family partnership? [Are there] policies on disclosure and documentation? We also ask questions about training. Of course, there is the need to train all individual
staff members, and the expectations, and policies, and procedures, and guidelines that are necessary. And is there also just-in-time coaching for disclosure? How are we supporting clinicians when they have to talk to families in the most immediate sense?

Then for the respectful crisis management itself, the overall larger plan, we also have another checklist, and this checklist has as many as 44 different dimensions, and this looks at probing at all steps of preparing the plan, the internal notification, the crisis team activation, setting priorities, etc. A closer look at that, for example, will give us, when we are talking about internal notification, “Have we notified the CEO? Have executive leaders been notified? Has the Board of Trustees been notified?” All critical notifications that need to be done, but is there a plan and who makes sure that all these are done? We look at the priorities, and much as we heard earlier in the conversation, the priorities really are the patient and family first. These are the individuals [whom] we must support, we must provide care for; and we must be able to make sure we're having good communications with them. That we are providing that ongoing support, it's not just the immediate support.

The second area that we think is a really important priority is the front-line staff. We have just heard, from Eric and Christopher, the need to have that discussion, to have that support; and we firmly believe that, without that support, we are going to lose some very good clinicians every time one of these events happens. We really need to provide them the support immediately and also as an ongoing support.

There is also a third priority that we need to address. That the organization, as a whole, needs to ensure that they've done the root cause analysis; that they've understood what has contributed to the event; that they have a plan for internal and external communication; that there is a plan to engage with the media. Of course, there may be an opportunity there to get the message across, dealing with external notification. Of course, the notification of accreditation agencies, departments of public health, and others who need to be notified. Unannounced visits that may occur and how the organization deals with that. And of course, ultimately the most important thing is the organization's need to have guidelines for continuing communications with patients and families.

The reason that we need to have this kind of a crisis plan is that a crisis can occur at any time. Our hospitals operate 24/7, 365 days a year. No matter when the crisis occurs, our response should be the same. It should be supported by a good, well-organized plan. It should be supported by individuals who can manage the situation, provide support to the patient and the family; it should be in a manner that provides support to the clinicians; and ultimately every organization, as we heard even from our speakers, needs to use these opportunities as a learning opportunity to then improve the system and prevent similar events from happening again in the future.

Franck, thank you for the opportunity to share our paper. It is available on our website, IHI.org, and I know that others will also be able to link to it through the Patient Safety website that TMIT has put together.

**Franck Guilloteau:** Frank, thank you very much for bringing it together. I think these tools are going to be very useful as organizations take this journey; and, as Frank was saying, we will make sure to include a link to these resources from the webinar page and also add the link on the slide set, so that, for folks who downloaded subsequently, it will be available.

At this point in time, we will be taking some questions from the audience; and to submit your question look at the Q&A box on the right-hand side of your WebEx control panel, and we will do our very best to filter and provide those out as quickly as possible. We've got about 15 minutes here.

I have a question here that came through for Frank from Rosemary Gibson. Can you comment on the point that hospital leaders should be held accountable for ensuring they provide workplace and work processes that enable the staff to do their work safely and reliably?

**Frank Federico:** Thank you, Franck, and Rosemary, thank you for your question. I think that leaders – and as you know, IHI has worked very strongly with engaging the boards, that there is an accountability at
all levels of the organization, but, in particular, at the highest level. There needs to be an accountability around “What is going on in our organization? What are we doing to support safe practices?” Because the clinicians at the front line are all working within the system that they've been hired to work into; and as much as they can try to improve safety and quality within their work areas, they really need an organizational commitment that demonstrates, much as Captain Sully said, [that] we are here to provide safe care; that is our standard; this is our expectation for how individuals work; and it is our responsibility to ensure that we have the right processes and the right systems; or, at least, that we're supporting them in a way that has been developed by those who have to do the work. Without that, our experience has been that there have been pockets of excellence within an organization where there might have been some local leadership; but it is difficult to see that kind of improvement spread throughout the organization, unless there is an organizational commitment and a leadership commitment. That leadership commitment is more than just saying, “Get the work done.” It's really getting involved and understanding what's going on in each of the work areas, to the extent of at least having a good picture; and things like executive walk-arounds and huddles are different ways that leaders can learn about what's going on in their organization.

Franck Guilloteau: Thank you, Frank. I have a question for Eric. Would you mind commenting on the current state of the mandatory reporting systems for pharmacists and how [those] data could be used to identify some of these systems failures?

Kyle Kemp: Looks like Eric's lost the phone.

Franck Guilloteau: Okay, we might have dropped Eric. Well, then, I'll move over to Chris. If there was a takeaway to the caregiver of the message and Emily's story, what would it be?

Christopher Jerry: Well, the takeaway is that we all need to clearly join together and continue to make these commitments to find ways to improve the overall safety and quality in our nation's facilities. It is so very, very important. People need to feel, as patients, when they're in your facilities for treatment and care, that they are in the safest, best environment that they could possibly be in during their illness or during their time having procedures done and what have you. They really need to feel secure. So any way that you all can join together and continue to find ways to reduce that human error component in medicine, you all need to step up to the plate and do everything within your power to treat those patients as though they're your loved ones, they're your parents, they're your children, so on and so forth; and you really can't put a dollar amount on safety and quality. You need to allocate the necessary resources that you can to reducing the human error component anyway you can.

Frank Federico: Franck, can I add to that?

Franck Guilloteau: Absolutely.

Frank Federico: Yeah, as I think about it and listen to it, patients come to us and they are at their most vulnerable point. Many of them are quite ill. They are trusting us to provide good care, and this is not to say that patients don't have a role in safety. Of course they do. They should be part of all our safety work, and, as a matter of fact, can contribute to help us design systems and processes that make it safer, because they are the recipients of the care. And I wholeheartedly agree and support that it is our responsibility to make sure patients are safe. It is our responsibility to engage them; but let's remember that they are in a position at that point where they are really trusting us to be able to provide that care and that safe care, and really we need to do everything possible to make sure that happens.

Franck Guilloteau: Well, actually Frank, I have a follow-up question. This relates probably more [to] leadership. This is a question from Monica Gordon here about reckless behavior. Essentially, the reckless behavior includes breaches [of] following policies because everybody else does it. How do you handle that? Because we know it's pervasive, all the work-arounds and the like, so how do you handle that as a system versus a process versus a leadership issue?
Frank Federico: Well, there are several things, and that's always a challenge. I think that every time somebody is circumventing a policy or a procedure that's been put in place, that ought to set off alarms for the leaders, and I'm talking about the hospital leaders, department leaders, local leaders, that every time somebody has to do a work-around, maybe there is something wrong with the procedure. Maybe it's something that is not workable. We oftentimes develop these policies and procedures without fully appreciating how difficult it may be to carry out. Now, policies are important; I'm not saying they're not. They are extremely important because that's how we stand, that's what we stand for. It's “how do you develop the appropriate procedures to make sure that we can adhere to those policies?” The issue of reckless behavior, I think, is really important, that organizations think about using a just culture model. Now, Marx has created a just-culture model. James Reason has the unsafe acts algorithm. Without one of those, it becomes more difficult to judge whether or not this is behavior that many others would have done the same thing in that situation. Is it something that is truly reckless? And clearly, if you are doing something that is causing patient harm, that's inexcusable. You cannot do something purposely to hurt patients. But if you are in a position where you have made an error or you are violating a policy, and then you find that three other nurses or three other pharmacists are also doing the same thing because the policy is just not workable as it's been designed, then I think it is really important for leadership to be examining that, because otherwise, it's just going to continue and it becomes the way we do our work, rather than the way it was intended to be done.

Franck Guilloteau: Thank you, Frank. That's a very good point. There are some, I guess, some questions coming through regarding, and I know that Eric may have dropped off the call, and Chris, you may have some insight as to. Eric, are you there? Okay. Would you mind sharing with us whether or not, or maybe, Chris, you know the answer to this question, in terms of subsequent to the incident whether there were any processes that were implemented at the organizations where it happened?

Christopher Jerry: As a result of the incident?

Franck Guilloteau: Yes, I apologize, as a result of the incident. That was the question. Were there any interventions put in place subsequent to …

Christopher Jerry: Yes. Many of the medical facilities in Ohio have actually stopped stocking the hypertonic saline solution, and, as I understand it, if they do still stock the 23.4% solution, that is kept under lock and key. Also, there has been the addition of Emily's Law, which did get watered down a little bit. I believe that there is still much work to be done with respect to legislation and training requirements for pharmacy technicians. However, I believe it is a starting point. Hospitals and facilities, even retail pharmacies in Ohio, are all aware of the incident that happened with my daughter. I think even if – above and beyond not stocking the hypertonic solution, just the mere fact that they know Emily's story and that we're getting the word out there, I think that this is helping people to think twice. Again, I have to believe it helps to reduce that human error component a little bit.

Franck Guilloteau: Great. And Eric, there was an earlier question regarding mandatory reporting of errors in the current systems that are in place. Would you like to make a comment about that?

Eric Cropp: Can you hear me now?

Kyle Kemp: We can, yeah.

Eric Cropp: I know, from talking with other pharmacists, that it is still in the early process, at least in Ohio, where most of the retail and a majority of the hospital pharmacies have a program that they are supposed to utilize as more of a teaching method, not to use as a way to prosecute the person. They're trying to use it to find if there are repeating errors that occur, if there is a system problem, or something wrong with the labeling, that kind of thing. In the beginning, when it was going to be a law, they bought it and it wasn't rejected, so that it wouldn't be a mandatory thing where everybody had to report. It's still supposed to be private between the caregiver and the institution that they work at, and it can be shared if it is something that becomes a problem with the individual caregiver, and they keep repeating the same errors or mistakes all the time.
Christopher Jerry: May I respond to that also, Franck?

Franck Guilloteau: Absolutely.

Christopher Jerry: I've been working with Senator Grendell. Senator Grendell was the sponsor who helped me to get Emily's Law in place; and shortly after Eric's conviction, he had tried to introduce the mandatory error-reporting bill into the Ohio Senate. Eric was right, it did get shot down; and I believe, as does Senator Grendell, that one of the big reasons it got shot down was due to the publicity surrounding what happened to Eric. All of a sudden the caregivers are not only concerned about having this type of horrible ... having an oversight effect one of their patients, but now they have to be concerned with, "Geez, if I report this error, this oversight, I might lose my job, I might lose my career, I may even go to prison now." It set a horrible precedent, and through Eric's efforts and mine, we're trying to reverse that whole thought process, if that makes any sense.

Franck Guilloteau: Yes, absolutely.

Well, we are coming up on our time and the conclusion of this webinar. I have just one question that is going to be directed to one of my team members here, Matt Listiak. There is a question about when the documentary, Out of the Danger Zone documentary that includes Eric, Chris, and Emily's story is coming out. Can you comment on that?

Matt Listiak: This documentary is slated to be released this December on the main Discovery Channel, so look for it there. You can also find us at safetyleaders.org for more information, or actually follow us on Twitter specifically for Out of the Danger Zone, and the hashtag for that is #outofthedangerzone, all together.

Franck Guilloteau: Great. Well, on behalf of TMIT, I would like to thank our panelists for their time and their insight on what is a very difficult and emotional topic, and for closing comments, I'd like to turn it over to our patient advocate, Chris Jerry.

Christopher Jerry: On behalf of everyone who's experienced healthcare harm in some way, and on behalf of The Emily Jerry Foundation, I want to thank everyone who has participated in today's very important webinar. Most of all, I want to thank all the healthcare professionals who are clearly joining together in making the real commitments to find ways that we can improve safety and quality in our nation's medical facilities. I believe that all of you, everything that you are doing, in a very strong way, memorializes my daughter's death and makes her death less senseless and less tragic. If we can use Emily's story as an example and really learn from it and implement some safe practices and quality, then, potentially, we all stand to save thousands and thousands of lives, which is the core objective.

Franck Guilloteau: This concludes our webinar. For slides [and] transcripts, and to request CE credits, please go to safetyleaders.org. Thank you all for joining us today.