airway safety movement

The True Impact Of Unplanned Extubation

There are

33,000 deaths

that occur in the U.S. every year that are completely preventable. These deaths occur as a result of unplanned extubation (UE).

The Impact Of Unplanned Extubation

121,000

unplanned extubation events annually in adult U.S. ICUs alone

Unplanned extubation leads to...

- **33,000** preventable deaths every year
- **36,000** cases of ventilator-associated pneumonia
- **$4.9 billion** in unnecessary healthcare costs
- **2x** length of stay in ICU
- **$41,000** additional cost per unplanned extubation

Deaths from Firearms*	39,000 /yr
Deaths from Unplanned Extubation	**33,000 /yr**
Deaths from Catheter Associated Urinary Tract Infections*	13,000 /yr
Deaths from Medication Errors*	7,000 - 9,000 /yr
Deaths from Surgical Site Infections*	8,200 /yr
Deaths from Central Line Associated Blood Stream Infections*	3,600 - 7,800 /yr
Deaths from Opioid Induced Respiratory Depression in Hospital*	3,000 - 5,000 /yr

The Case That Sparked A Movement

Drew Hughes was one of the 33,000 who unnecessarily lost his life in 2013.

On June 28, 2013, 13-year-old Drew suffered a head injury while skateboarding.

In the ER he was awake, alert and appeared to be fine. The doctor ordered a CT scan of his brain and found a possible basilar skull fracture. For Drew's safety, he was to be transferred to the Level 1 Trauma Center and a breathing tube was placed for the transfer by ambulance...

Drew's breathing tube was accidentally removed during transport and not replaced properly.

His oxygen levels fell and his heart rate slowed.

By the time they diverted to a nearby hospital, it was too late.

Drew suffered anoxic brain injury and lost his life.

But Drew's legacy lives on. His story inspired a movement...

airway safety movement the campaign to zero.

In 2015...the Do It For Drew Foundation forms.

In 2018...

- The Airway Safety Movement forms.
- The Patient Safety Movement created the Actionable Patient Safety Solutions (APSS) #8B to establish best practices for hospitals to use to improve their rate of unplanned extubation.
- A Core Data Set for tracking unplanned extubation rates is created.

In 2019... 19 medical and patient safety and quality improvement organizations joined forces to target preventable deaths from unplanned extubations.

Coalition for Unplanned Extubation Awareness & Prevention

Who can commit to help.

Patient Safety & Quality Improvement Departments | **Healthcare Executives** | **Providers** | **Patients & Patient Advocates** | **Electronic Health Record (EHR) Companies**

Patient Safety & Quality Improvement Departments:

- Track intubated patient data
- Take assessment of your UE rate
- Talk to your leadership to get support
- Track UE and implement the Patient Safety Movement Foundation's APSS #8B

Healthcare Executives:

- Commit to empowering your quality and safety teams to elevate UE to the status of a key performance measure and provide the resources necessary for this process to occur
- Take assessment of your facility's UE rate
- Become an ambassador for UE data tracking, quality measures and best practices
- Develop a core team to reduce UE and engage staff
- Talk to EHR companies about integrating UE data tracking

Providers:

- Become a cheerleader of UE best practices and data tracking
- Advocate for the IHI model for improvement

Patients and Patient Advocates:

- Ask your hospital providers how important UE is to them
- Ask what quality measures they have in place and how they prevent UE from occurring

Electronic Health Record (EHR) Companies:

- Add the Unplanned Extubation Core Data Set to your software
- Educate system users about UE data tracking and its importance

Let's Commit to end UE-related deaths.

Learn more and get involved at airwaysafetymovement.org

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Sources

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