The Emily Jerry Story

“Let The Healing Begin”
The father of Emily Jerry. A beautiful two year old little girl who died from a tragic medication error in 2006, during what was suppose to be her final day of chemotherapy.

Shortly after her death I became a full-time patient safety and caregiver advocate.

Established The Emily Jerry Foundation www.emilyjerryfoundation.org, in an effort to identify ways to help reduce the “human error” component of medicine that often lead to tragic medical errors like Emily’s.
Presentation Objectives

• Discuss the events surrounding the medical error that resulted in Emily Jerry’s death and a subsequent criminal prosecution.

• Discuss the importance of error reporting.

• Describe how the criminalization of medical errors negatively affects error reporting.

• Describe the “lessons learned” from Emily’s tragic death.

• Identify and discuss the qualities of a safety culture that enhance harm prevention.
The Emily Jerry Foundation

Our Mission

The Emily Jerry Foundation is determined to help make our nation’s, world renowned, medical facilities safer for everyone, beginning with our babies and children. We are accomplishing this very important objective by focusing on increasing public awareness of key patient safety related issues and identifying technology and best practices that are proven to minimize the “human error” component of medicine. Through our ongoing efforts The Emily Jerry Foundation is working hard to save lives every day.
Emily’s Initial Diagnosis in October of 2005

“Any parent’s most shocking scenario for their child”
Emily’s Proposed Course of Treatment
Chemotherapy with Possible Follow Up Surgery

Course of Treatment

• Emily to be brought into facility once a month for approximately 3 or 4 days for chemotherapy.

• After 5 or 6 months of chemotherapy, if tumor responded well, surgery would most likely be required to remove some of the residual scar tissue that would remain.
Emily’s Treatment Begins
“Parent’s Expectations Set by Oncology Team”

Core Expectations During Chemotherapy

• Emily would exhibit “flu-like” symptoms immediately after each chemo treatment.

• Emily would experience significant weight loss.

• Emily would lose all of her beautiful blond ringlets.
In Actuality, What Really Occurred?

During Emily’s Chemotherapy Regimen:

• Aside from a low-grade fever, immediately after each treatment, she really had no “flu-like” symptoms.

• Emily did not lose ANY weight during the course of her chemotherapy. In fact, she was this facilities very first pediatric oncology patient to actually gain a pound during the course of treatment!

• Emily did not really start to lose her until shortly after her third treatment.
After Five Month’s of Chemo

• Emily is run through the MRI at the beginning of February of 2006.

• Large tumor has completely disappeared, not even any residual scar tissue remains.

• One final round of chemotherapy is recommended to make sure no residual cancer cells remain in Emily’s body that could arise later in her life and cause problems.
• The decision is made to bring Emily in for her final round of chemotherapy on her 2\textsuperscript{nd} birthday, February 24\textsuperscript{th} 2006.

• Everything goes well the first and second day of her chemotherapy regimen.

• On February 26\textsuperscript{th} 2006 the worst possible scenario begins to unfold.
Emily is Overdosed on Sodium Chloride Solution

• Instead of using a standard off the shelf bag of saline with 0.9% Sodium Chloride, a pharmacy technician utilizes 23.4% hypertonic saline as the base solution for Emily’s chemotherapy.

• Pharmacy technician does not have the proper training and was not even aware that sodium chloride “salt” could even harm someone let alone kill them.
Objectives That Tie to HEN Work

• If we are to design and modify systems in healthcare to lower the incidence of “human error” that lead to tragedies like Emily’s, it is imperative that we improve overall error reporting in medicine.

• These “data points” are vital if we want to design systems that lower the probability of “human error” creeping into the equation during the course of treatment for any patient.

• Additionally, hospitals and medical facilities also need to report and share what programs and methods that are working at their individual facilities to gain compliance not only with “error reporting” requirements but also with things as simple as hand washing, etc.