



JOSIE KING FOUNDATION at BCF
creating a culture of patient safety, together



www.josieking.org



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On February 22, 2001, eighteen-month old Josie King died from medical errors.

98,000 people die every year from medical errors, making it the fourth leading cause of death in the United States.

The Josie King Foundation's mission is to prevent others from dying or being harmed by medical errors. By uniting healthcare providers and consumers, and funding innovative safety programs, we hope to create a culture of patient safety, together.

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- Josie King Patient Safety Program
- Arrest Team
- The Josie King Story DVD
- Condition H
- Maryland Disclosure Program
- Care for the Caregiver
- Nursing Award
- Care Journal

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Disclosure Statement

There are no actual or potential conflicts with regard to the content of this presentation.

www.josieking.org

“A wonderful book, written with deep insight into the uncertain world of medicine. The tale of this family grips the heart and illuminates the mind.” —Dr. Jerome Groopman, Professor of Medicine at Harvard Medical School; contributor to The New Yorker; and author of How Doctors Think



JOSIE’S STORY

A Mother’s Inspiring Crusade to Make Medical Care Safe

Sorrel King

- **Sorrel King and the Josie King Foundation have been at the forefront of the campaign to make health-care organizations safer**
- **Across the country, health-care organizations invite Sorrel King to speak at training sessions, conferences, and seminars on patient safety**
- **Josie’s Story includes a resource guide for patients, families, and health-care providers**

• **18-city tour**

(Boston • New York City • Philadelphia • Washington, D.C. • Baltimore • Raleigh/Durham/Chapel Hill • Atlanta • Miami • Pittsburgh • Cleveland • Chicago • Louisville • Nashville • Houston • Phoenix • Los Angeles • San Francisco • Toronto)

- **national TV and radio coverage**
- **major off-the-book-page coverage**
- **Web and blog marketing campaign**
- **online promotion**
(www.josieking.org)

\$24.00 (Canada: \$27.50)

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“Sorrel King is a heroic figure in the health-care movement. Josie’s story and Sorrel’s determination are making care safer for millions of patients. At its core, this is a powerful and immensely moving love story.”

—Charles Kenney, quality and safety consultant to Blue Cross Blue Shield of Massachusetts

Ninety-eight thousand people die every year from medical errors, making it a leading cause of death in the United States, but the subject has long been taboo. All that changed with Josie.

Sorrel King was a young mother of four when her eighteen-month-old daughter was badly burned by a faulty water heater in the family’s new home. Taken to the world-renowned Johns Hopkins Hospital, Josie made a remarkable recovery. But as she was preparing to leave, the hospital’s system of communication broke down and Josie was given a fatal shot of methadone, sending her into cardiac arrest. Within forty-eight hours, the King family went from planning a homecoming to planning a funeral.

Dizzy with grief, falling into deep depression, and close to ending her marriage, Sorrel slowly pulled herself and her life back together. Accepting Hopkins’ settlement, she and her husband established the Josie King Foundation. They began to implement basic programs in hospitals emphasizing communication between patients, family, and medical staff—programs like Family-Activated Rapid Response Teams, which are now in place in hospitals around the country. Today Sorrel and the work of the foundation have had a tremendous impact on health-care providers, making medical care safer for all of us, and earning Sorrel a well-deserved reputation as one of the leading voices in patient safety.

The account of one woman’s unlikely path from full-time mom to nationally renowned patient advocate, *Josie’s Story* is the startling, moving, and inspirational chronicle of how a mother—and her unforgettable daughter—are transforming the face of American medicine.

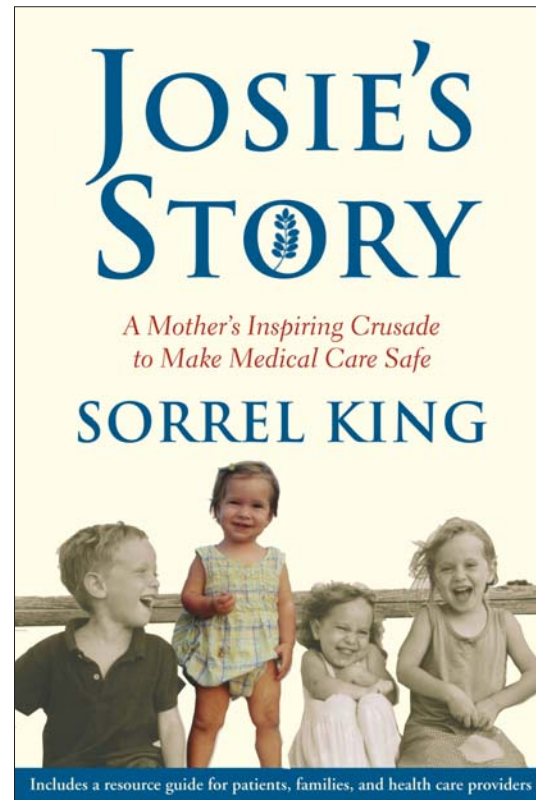
Excerpt from
JOSIE'S STORY

“People need to hear the story,” one doctor told me at a patient-safety conference in Florida. “But I think they’d be interested in hearing about all the work you’ve been doing with the foundation. Start focusing the talks more on those accomplishments. Tell them all of the good that has come from Josie’s death. Inspire them to do the same.”

Throughout the rest of the day I thought about what he had said. Josie’s story was becoming more than the story of a horrible tragedy. Her death had inspired change, real change. The foundation was growing and amazing things were happening. Yes, he was right. *This* was what I wanted to talk about.

From that day on, my message changed. I no longer focused solely on Josie’s death. I talked about the foundation’s projects and programs. And while I had the attention of change makers, I began spinning other topics into my speech, one of which was disclosure.

“It’s not about the money,” I told audiences. “It’s about telling us the truth, apologizing and fixing the problem. There may well be a lawsuit. But by doing the right thing, families might give back to the hospital that harmed them, if it means no one else will be hurt.” I said this over and over, in front of thousands of health-care providers, hoping that maybe, just maybe, they would get the message and treat their patients and families the way Hopkins had treated us.



SORREL KING is a patient-safety advocate and cofounder of the Josie King Foundation, a not-for-profit organization aimed at increasing patient safety and eliminating medical errors. She lives with her husband and their children in Baltimore, Maryland.

PRAISE FOR SORREL KING AND JOSIE'S STORY:

“Josie’s story has served as a beacon for me and thousands of other health-care professionals.”

—DR. LOUISE LIANG, FORMER SENIOR VICE PRESIDENT, QUALITY AND CLINICAL SYSTEMS SUPPORT, KAISER PERMANENTE

“Sorrel’s story . . . teaches us that listening is as important as doing, reminding us that our learning is a journey, and that our true teachers sit in front of us in hospital beds and on exam tables each day.”

—DR. DAVID SHULKIN, PRESIDENT AND CEO, BETH ISRAEL MEDICAL CENTER

“I am confident that Sorrel has saved countless lives by sharing her story and challenging physicians and administrators to critically examine how they provide care. She made a difference for our Children’s Hospital and we are forever grateful.”

—CRAIG CORDOLA, CEO, CHILDREN’S MEMORIAL HERMANN HOSPITAL OF HOUSTON

“Sorrel King took the tragic death of her daughter and used it to transform the culture of the nation’s top hospital—and ultimately the entire world of medicine.”

—DR. ROBERT WACHTER, PROFESSOR OF MEDICINE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

“A riveting and poignant account of the impact of preventable harm in our health care system.”

—ROSEMARY GIBSON, AUTHOR OF *WALL OF SILENCE* AND SENIOR PROGRAM OFFICER AT THE ROBERT WOOD JOHNSON FOUNDATION

Keynote: A Mother's Journey
Sorrel King

- 1) The Josie King Foundation's website (www.josieking.org) provides which of the following features for health care providers?
 - a. Mechanism to report safety issues to accrediting authorities
 - b. Foundation-sponsored programs that health care providers can implement at their institutions
 - c. IOM's *To Err is Human* Report
 - d. All of the above

- 2) The Josie King Foundation's Care Journal includes which of the following features:
 - a. Safety tips
 - b. Space to write down medical team members' names
 - c. Space to write down questions to ask the medical team
 - d. All of the above

- 3) Which of the following is an example of an appropriate use of a patient- or family-activated rapid response team?
 - a. Patient's medical status is deteriorating and their loved ones are concerned that the patient's needs are not being met
 - b. Food tastes bad
 - c. Television is broken
 - d. Roommate is noisy

- 4) Which of the following is not an effective communication tool in patient safety:
 - a. Listen to patient's concerns and fully address them
 - b. Ensure that all medical team members receive updates on the medical plan
 - c. Refrain from informing patients and their families of an error
 - d. Explain procedures, medications, potential side effects, etc. to patients and their families.