



Medical Staff Education

Zero Harm – Safety Tools for All

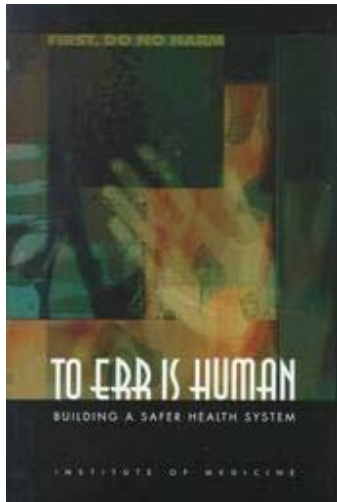
Clinton Memorial Hospital
RegionalCare Hospital Partners

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Today's Objectives

1. Share with you what we mean by “building and sustaining our patient safety culture”
2. Provide an understanding of how and why people experience error in complex systems
3. Introduce you to our RegionalCare safety behaviors and safety tools



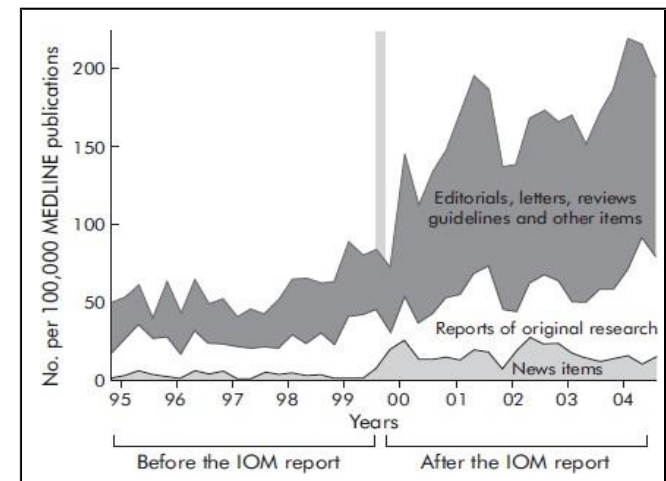
Death By Numbers

44,000 to 98,000 patient deaths per year from medical errors

To Err is Human, Institute of Medicine (1999)

A Lot of Talk

Patient safety publications before and after the IOM report, *To Err is Human* Quality & Safety in Health Care (2006)



TO ERR IS HUMAN – TO DELAY IS DEADLY

Ten years later, a million lives lost, billions of dollars wasted

“Based on our review of the scant evidence, we believe that preventable medical harm still accounts for more than 100,000 deaths a year... the Centers for Disease Control and Prevention (CDC) estimates that hospital-acquired conditions alone kill 99,000 each year...

In this report, we give the country a failing grade on progress...”

Consumers Union (2009)



Published Cases

Memorial
H E A L T H

- 89% reduction in 2 years
- \$ 10 M savings first year
- \$ 11 M savings second year



CLINICAL ADVISORY BOARD

Clinical Strategy Watch

Advisory.com

News in Review

March 24, 2005
Vol. 3, Issue 6

PATIENT SAFETY

Care quality: MHUMC stems preventable errors through hospitalwide efforts



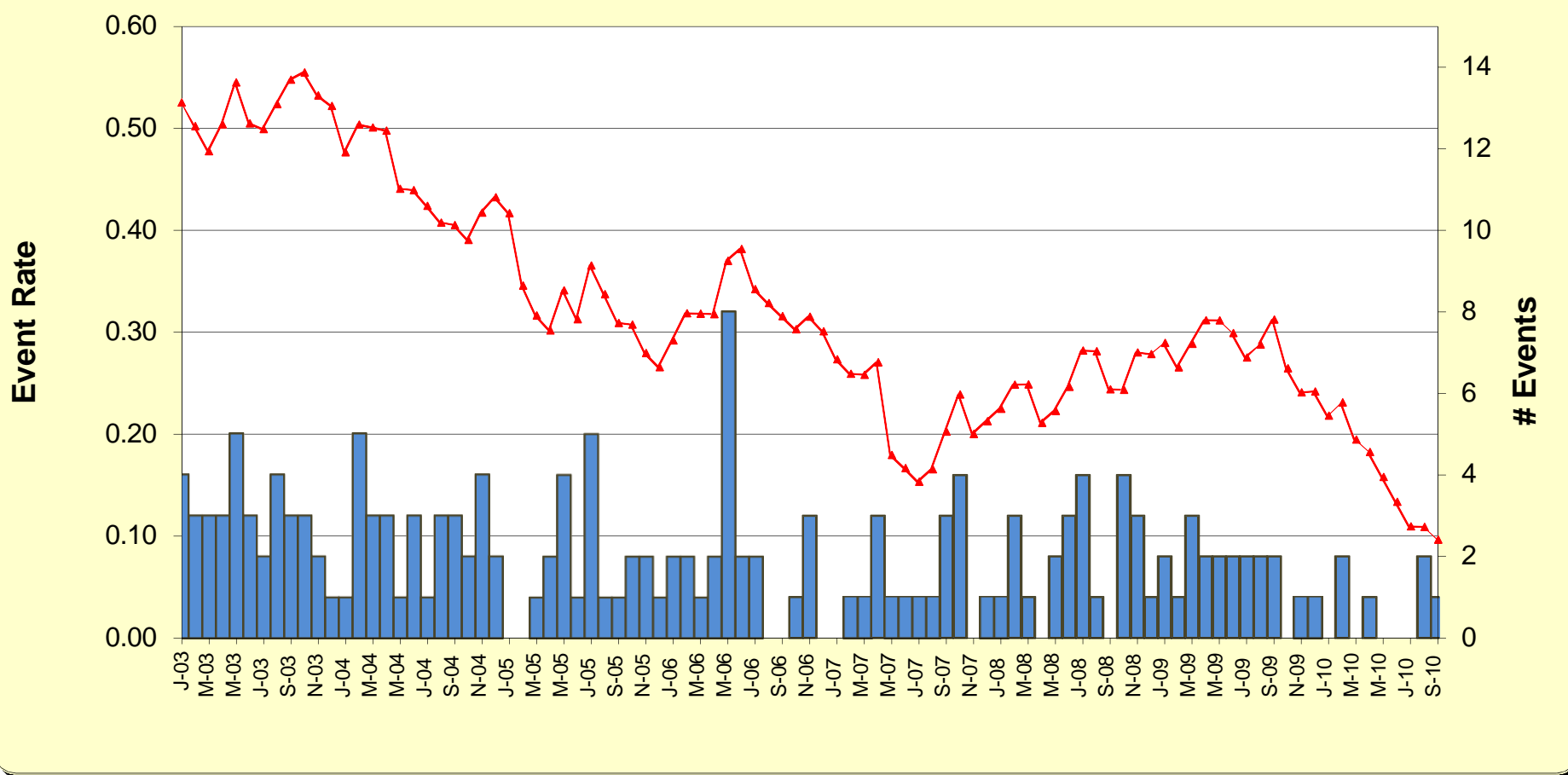
SENTARA™

- 50% reduction in 18 months
- AHA Quest for Quality Award 2004
- JCAHO Eisenberg Quality Award 2005

 *Advocate Health Care*

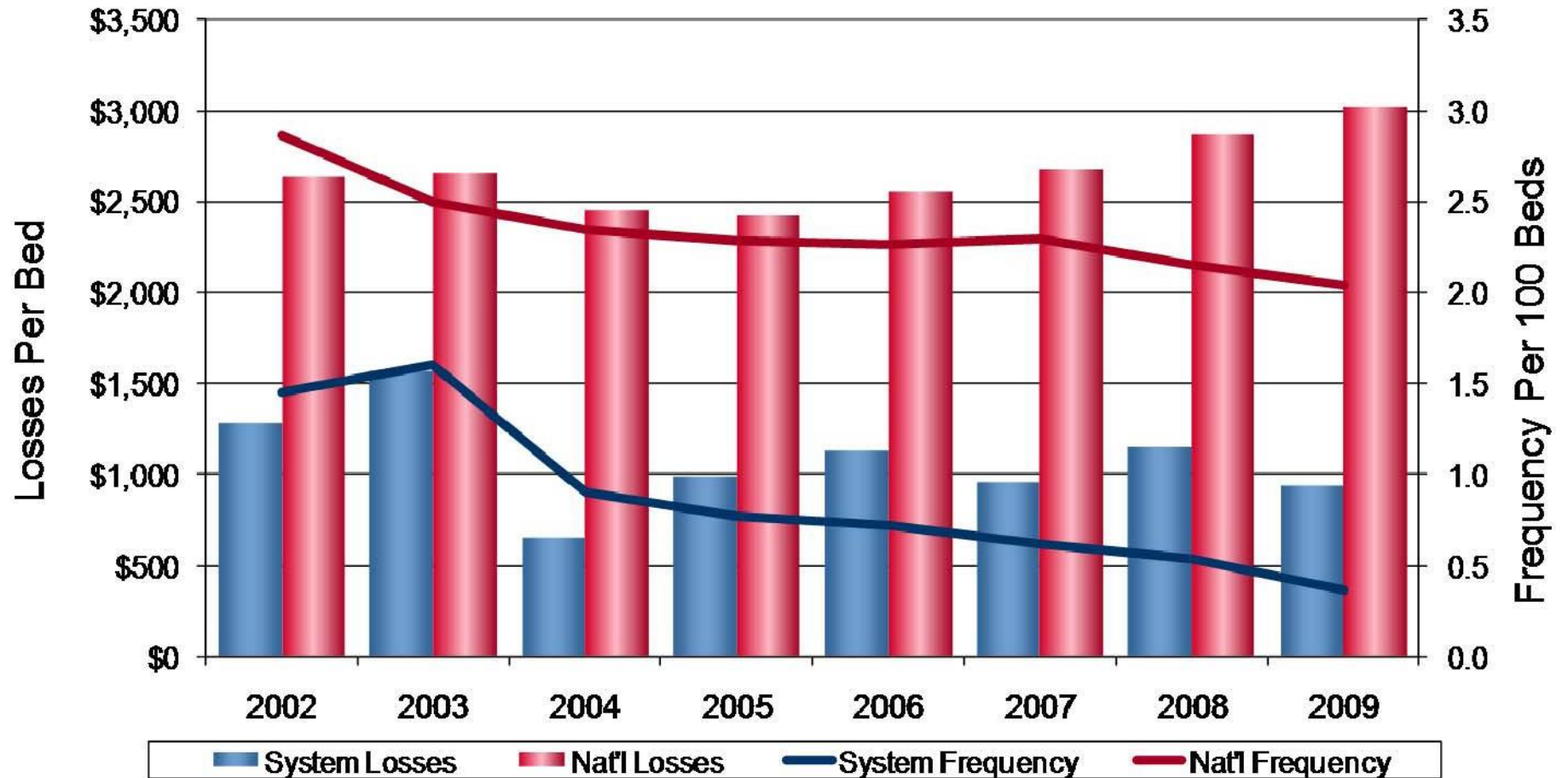
“Can Your Nurses Stop a Surgeon?”
Hospitals & Health Networks, September 2007

7 Hospital System – East Coast



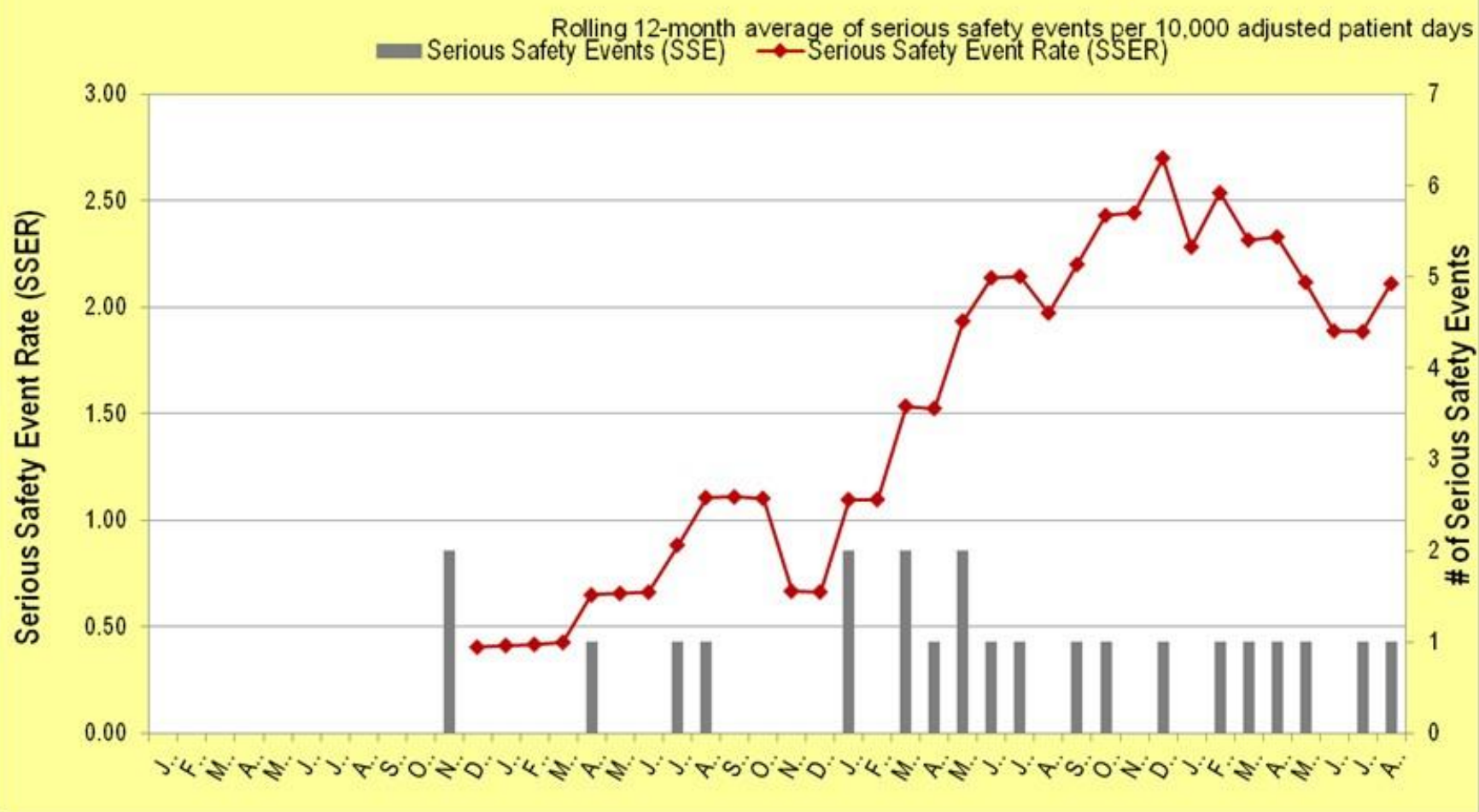
Finance's Interest in Safety

Multi-Hospital East Coast System



National Data Source: ASHRM Hospital Professional Liability & Physician Liability 2009 Benchmark Analysis

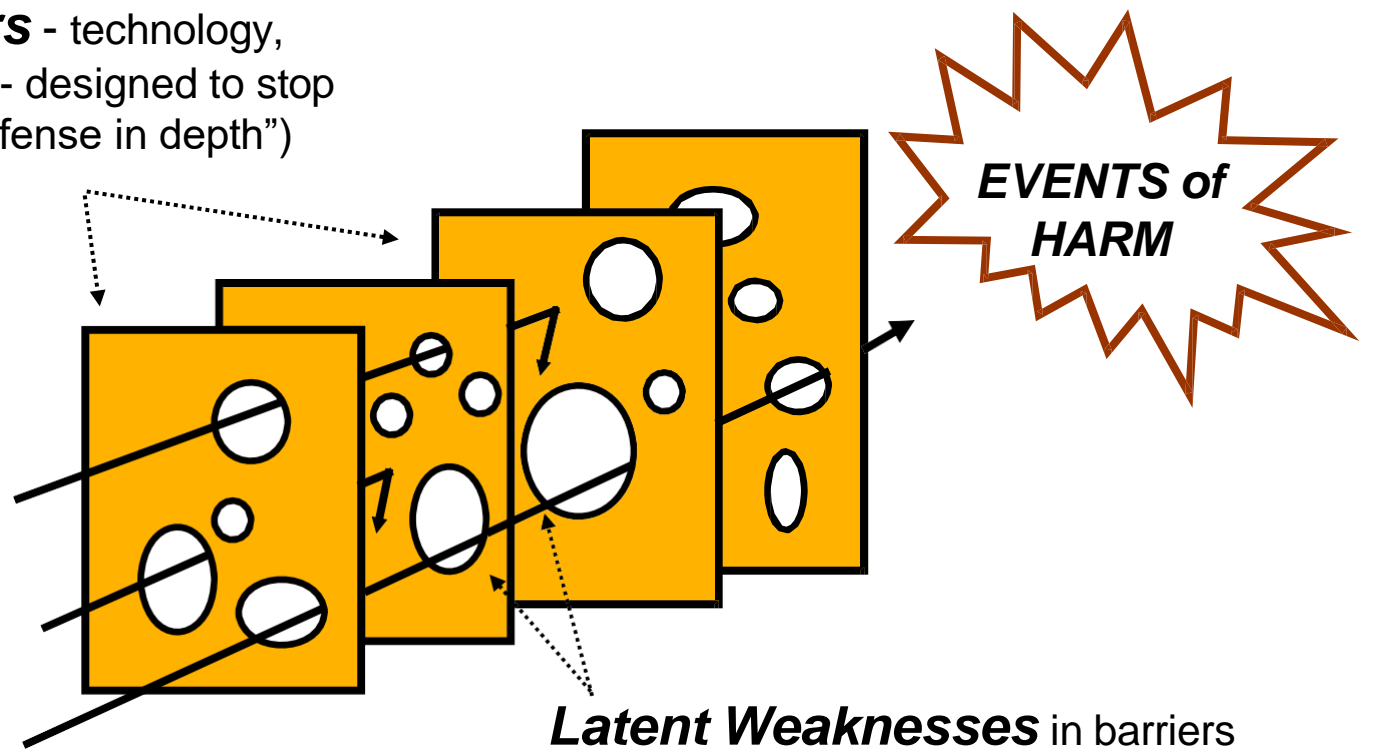
Serious Safety Event Rate (SSER) Clinton Memorial Hospital January 2011 - August 2014



Anatomy of a Safety Event

Multiple Barriers - technology, processes, and people - designed to stop active errors (our “defense in depth”)

Active Errors
by individuals result
in initiating action(s)

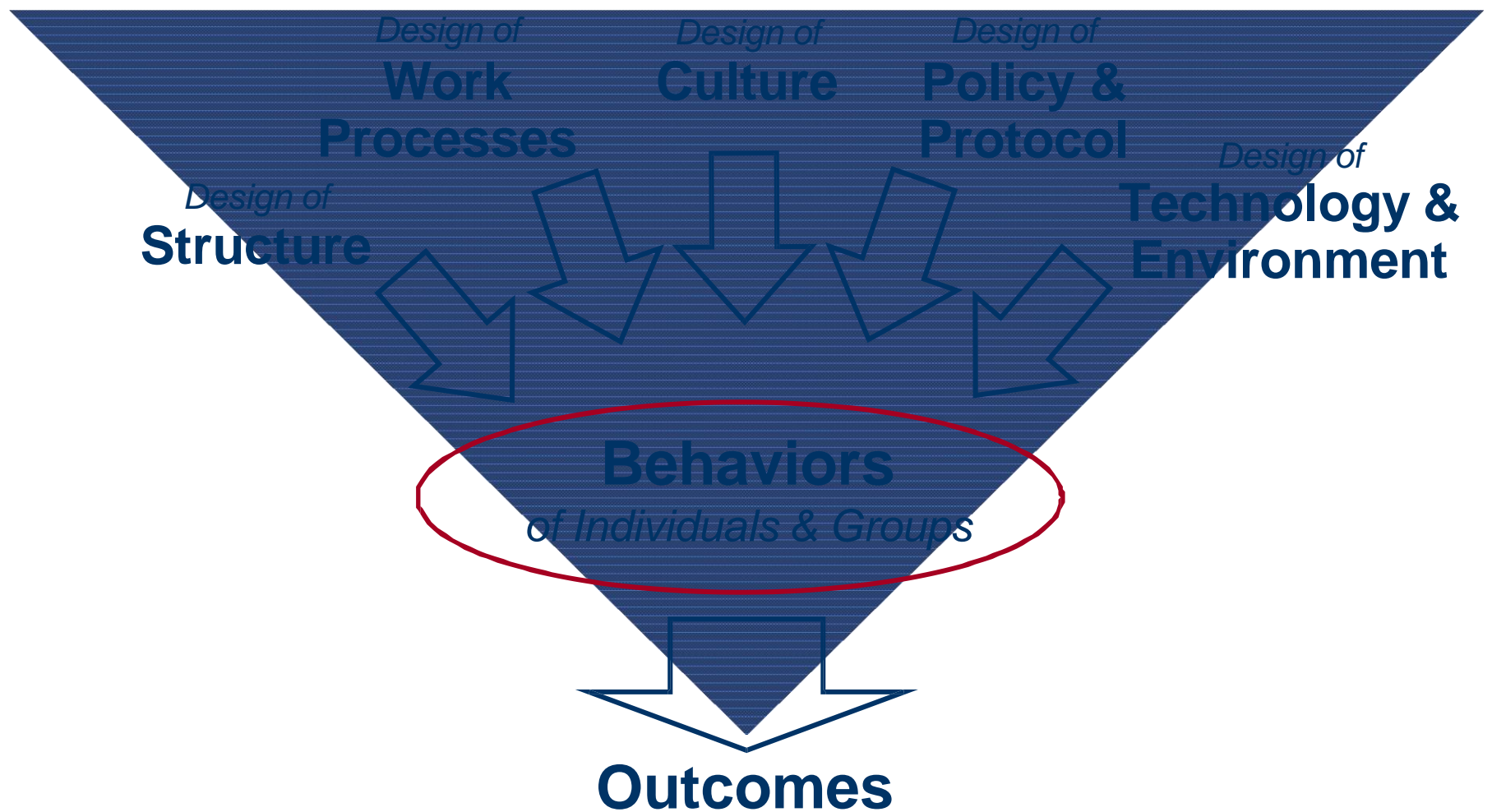


PREVENT
The Errors

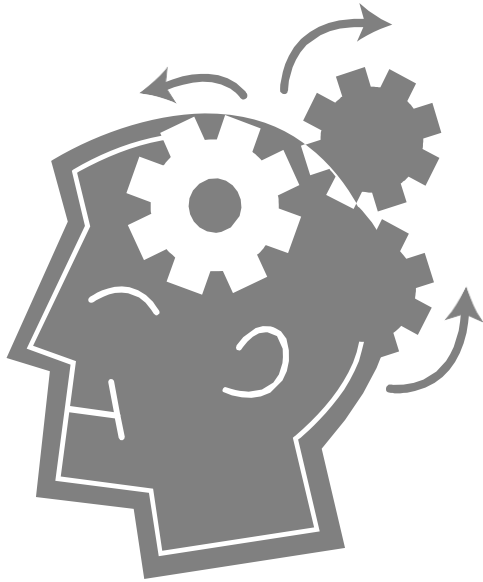
DETECT & CORRECT
The System Weaknesses

From James Reason, *Managing the Risks of Organizational Accidents*, 1997

Shaping Behaviors at the Sharp End



As Humans, We Work in 3 Modes



Skill-Based Performance

“Auto-Pilot Mode”

Rule-Based Performance

“If-Then Response Mode”

Knowledge-Based Performance

“Figuring It Out Mode”

Skill-Based Performance

What You're Doing At The Time

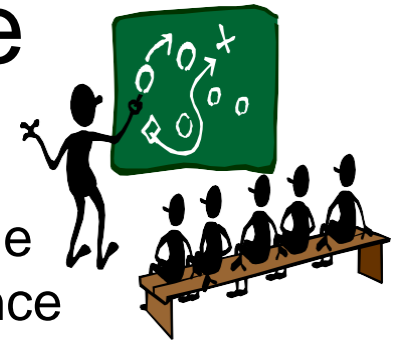
Very familiar, routine tasks that you can do without even thinking about it – like you're on auto-pilot



Errors We Experience	Error Prevention Strategy
<p>Slip – <i>Without intending to</i>, you do the wrong thing</p> <p>Lapse – <i>Without intending to</i>, you fail to do what we meant to do</p> <p>Fumble – <i>Without intending to</i>, you mishandle or blunder an action or word</p>	<p>Stop and think before acting</p>

3 in 1,000 acts performed in error
(pretty reliable!)

Rule-Based Performance



What You're Doing At The Time

Responding to a situation by recalling and using a rule that you learned either through education or experience

Errors You Experience	Error Prevention Strategy
Used the wrong rule – You were taught or learned the wrong response for the situation	Educate about the right rule
Misapplied a rule – You knew the right response but picked another response instead	Think a <i>second</i> time
Non-compliance – Chose not to follow the rule (usually, thinking that not following the rule was the better option at the time)	Reduce burden, increase risk awareness, improve coaching

1 in 100 choices made in error
(not too bad!)

Knowledge-Based Performance

What You're Doing At The Time

Problem solving in a new, unfamiliar situation.
You come up with the answer by:

- Using what we do know
- Taking a guess
- Figuring it out by trial-and-error



Errors You Experience	Error Prevention Strategy
You came up with the wrong answer (a mistake)	STOP and find an expert who or that knows the right answer

30-60 of 100 decisions made in error
(yikes!)

Safety as Our Core Value

A Powerful Driver of Individual Decision Making



People First is about providing a high level of care and compassion, the exact reason we all went into healthcare in the first place.

People First is important to our company and the communities we serve because it's the right thing to do. People First is the framework and structure we use to make sure that we are constantly focused on the meeting the needs of everyone who walk through our doors.

When people come first – safety must come first. The last thing we want to do to another person is to cause harm. **First Do No Harm**. The safety of our patients, people, visitors, and neighbors is our first concern.

Right Priority

- Don't harm me
- Heal me
- Be kind to me

+

High-Reliability

- Competent people working together
- Right mix of people, process, and technology
- Leaders continuously involved in operations

=

Care that is:

- Safe
- Effective
- People-centered

Safety Behaviors <i>I am accountable for and commit to ...</i>	Safety Tools <i>... by practicing our safety tools:</i>
1. Pay attention to detail	<input type="checkbox"/> Self-check (<i>stop, think, act, and review</i>) <input type="checkbox"/> Peer check
2. Communicate clearly	<input type="checkbox"/> 3-way repeat back/read back <input type="checkbox"/> Phonetic and numeric clarification <input type="checkbox"/> Clarifying question <input type="checkbox"/> SBAR (<i>situation, background, assessment, and request</i>)
3. Practice with a Questioning Attitude	<input type="checkbox"/> Validate and verify
4. Use and comply with policy, procedures, and checklists	<input type="checkbox"/> Continuous use/reference use
5. Speak-up for safety	<input type="checkbox"/> 5:1 feedback <input type="checkbox"/> ARCC (<i>ask a question, request a change, voice a concern, and chain of command</i>)

Safety Tools for All – staff, medical staff, and leaders

Revision B, 3 February 2014

1. Pay attention to detail

- Self-check
- Peer check

2. Communicate clearly

- 3-way repeat back
- Phonetic and numeric clarification
- Clarifying question
- SBAR

3. Practice with a Questioning Attitude

- Validate and verify

4. Use and comply with policy, procedures, and checklists

5. Speak-up for safety

- 5:1 feedback
- ARCC

1. Pay Attention to Detail

What should we do?

Focus our attention before we act

Why should we do this?

- To avoid unintended slips or lapses
- To reduce the chance that we'll make an error when we're under time pressure or stress

Safety Tools:

Self Checking *using* STAR (Stop Think Act Review)

Peer Checking

Self Checking Using STAR

Stop

Pause for one second to focus attention on task

Think

Visualize the act and think about what is to be done

Act

Concentrate and perform the task

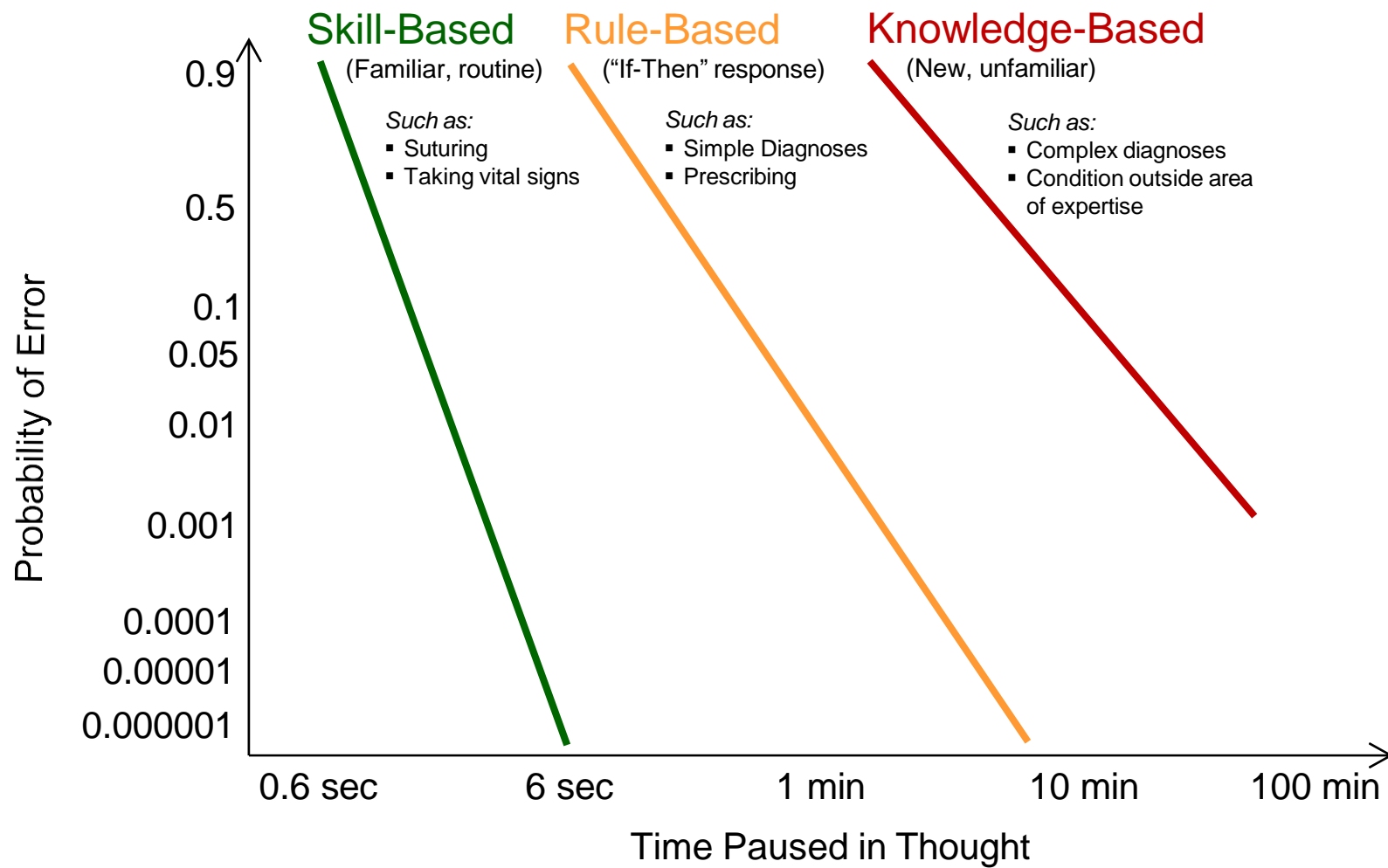
Review

Check for the desired result

Self Checking

The most effective way to avoid slips and lapses.
It takes **one second** to do and reduces the probability of making
an error by a factor of 10 or MORE!

Time Reliability Correlation



Source: R E Hall, et al. "Post Event Human Decision Errors: Operator Action Tree/Time Reliability Correlation," NUREG-CR-3010, November 1982

Peer Check

Take advantage of working together

- Check the accuracy of each other's work
- Identify slips and lapses
- Point out unusual situations or hazards

Individual reliability is limited:

1 defect per 1,000 opportunities
(or 0.001)

Peer Checking multiplies the
error probability:

$0.001 \times 0.001 =$
1 defect per one million



Key to Successful Peer Checking

Be willing to check others AND
be willing to have others check us

2. Communicate Clearly

What should we do?

Ensure that we hear things correctly and understand things accurately

Why should we do this?

To prevent wrong assumptions and misunderstandings that could cause us to make wrong decisions

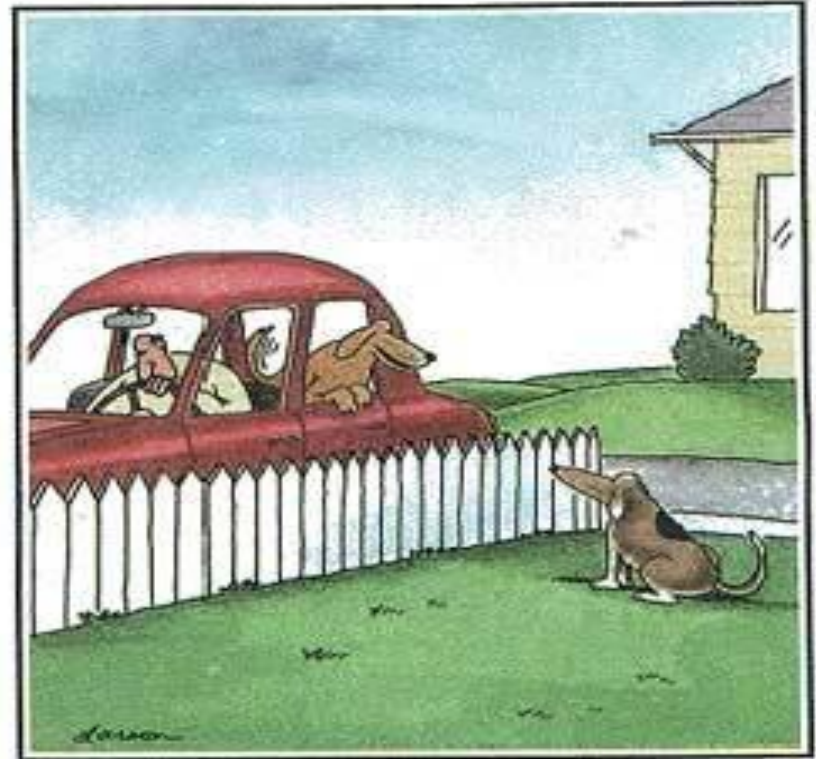
Safety Tools:

3-Way Repeat Backs & Read Backs

Clarifying Questions

Phonetic & Numeric Clarifications

SBAR



"Ha ha ha, Biff. Guess what? After we go to the drugstore and the post office, I'm going to the vet's to get tutored."

3-Way Repeat Back



Sender initiates communication using Receiver's Name. Sender provides an order, request, or information to Receiver in a clear and concise format.



Receiver acknowledges receipt by a repeat-back of the order, request, or information.



Sender acknowledges the accuracy of the repeat-back by saying, **That's correct!** If not correct, Sender repeats the communication.

A Safety Phrase:
"Let me repeat that back..."

3-Way Read Back

The same thing as a 3-Way Repeat Back, BUT...

Receiver **documents** the information, request, or order and **reads** it back.

Don't rely on your memory...

write it whenever you receive critical information that might be difficult to remember.

This is *so critical* that The Joint Commission requires this for communication of critical test results, verbal orders and telephone orders.

Ask Clarifying Questions

Ask one to two clarifying questions:

- In all high risk situations
- When information is incomplete
- When Information is not clear

Asking clarifying questions can reduce the risk of making an error by $2\frac{1}{2}$ times!

Why...

To make sure that you really understand what's being communicated so that you don't make a decision based on a wrong assumption.

How...

Phrase your questions in a manner that will give an answer that improves your understanding of the information.

A Safety Phrase:

"Let me ask a clarifying question..."

Phonetic Clarifications

For *sound alike words*, say the letter followed by a word that begins with the letter. For example:

A	Alpha	J	Juliet	S	Sierra
B	Bravo	K	Kilo	T	Tango
C	Charlie	L	Lima	U	Uniform
D	Delta	M	Mike	V	Victor
E	Echo	N	November	W	Whiskey
F	Foxtrot	O	Oscar	X	X-Ray
G	Golf	P	Papa	Y	Yankee
H	Hotel	Q	Quebec	Z	Zulu
I	India	R	Romeo		

Numeric Clarifications

For sound alike numbers,
say the number and then say the digits

15...**that's** one-five

50...**that's** five-zero

45...**that's** four-five

425...**that's** four-two-five

4 to 5...**that's** the range four dash five

And **always** use leading zeroes – as in 0.9

SBAR Briefing Format

When you need to communicate about a problem or issue that needs resolution...

Situation

- Who you're calling about, the immediate problem, your concerns

Background

- Review of pertinent information: procedures, patient condition

Assessment

- Your view of the situation: *"I think the problem is..."* or *"I'm not sure what the problem is"*
- Urgency of action: *"the patient is deteriorating rapidly - we need to do something"*

Recommendation

- Your suggestion to or request of the other person

3. Practice with a Questioning Attitude

What should we do?

Use good judgment at all times
to ensure our actions are the best.

Why should we do this?

- Reduces the chance that we'll make a mistake in a high-risk situation
- Helps ensure that work activities are stopped when uncertain and unsafe conditions are identified

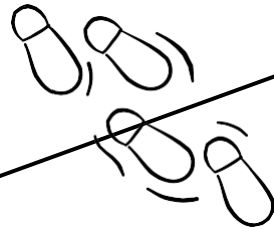
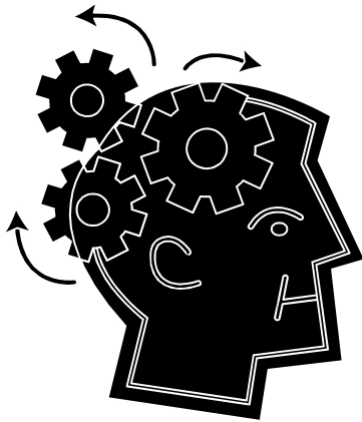
Safety Tool:

Validate & Verify

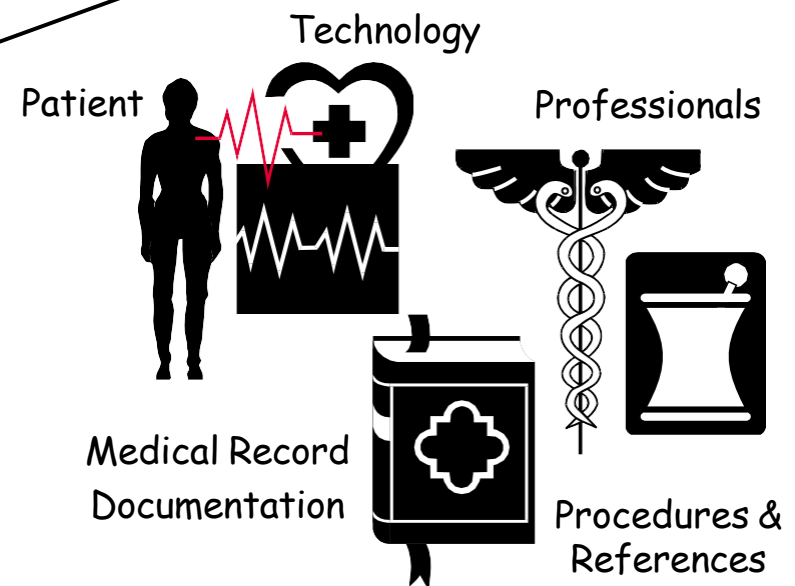
Validate & Verify Technique

Validate: Does it make sense to me?

- *Does it fit with what I know?*
- *Is it what I expected to see?*



Verify: Check it with an
independent, expert source



4. Use And Comply With Policy, Procedures, And Checklists

What should we do?

- Know the correct policy, procedure, action, or checklist
- Perform according to specifications

Why should we do this?

- They help us perform tasks consistently, efficiently, correctly, and safely and avoid reliance upon memory.

Safety Tool:

Continuous Use / Reference use

Policy/Procedure/Checklist Compliance

Continuous Use

- For Procedures that are:
 - Safety critical
 - Complex
 - Performed infrequently
- Read the entire protocol before taking any action.
- Ensure that the entire team understands all the steps
- Use tool/checklist/job aid each and every time.

Reference Use:

- For procedures that:
 - Consist of small segments easily performed from memory
 - Not safety critical
 - Not complex or infrequently performed
- Read the entire protocol before taking an action
- Ensure that you understand all the steps before taking any action

5. Speak up for Safety

What should we do?

- Monitor the actions of other team members for the purpose of sharing the workload and reducing or avoiding errors
- Act on a responsibility to protect in a manner of mutual respect – an assertion and escalation technique

Why should we do this?

Help maintain situation awareness

A way of “watching each other’s back”

Helps ensure that work activities are stopped when uncertain and unsafe conditions are identified

Safety Tools:

5:1 feedback

ARCC (ask a question, request a change, voice a concern, and chain of command)

Peer Coaching using 5:1 Feedback

Positive Feedback

Encouraging someone to continue practicing an observed behavior

Negative Feedback

Discouraging someone from continuing to practice an observed behavior

Top Positive Reinforcements

1. Head nod
2. “Yes”
3. “Thank you”

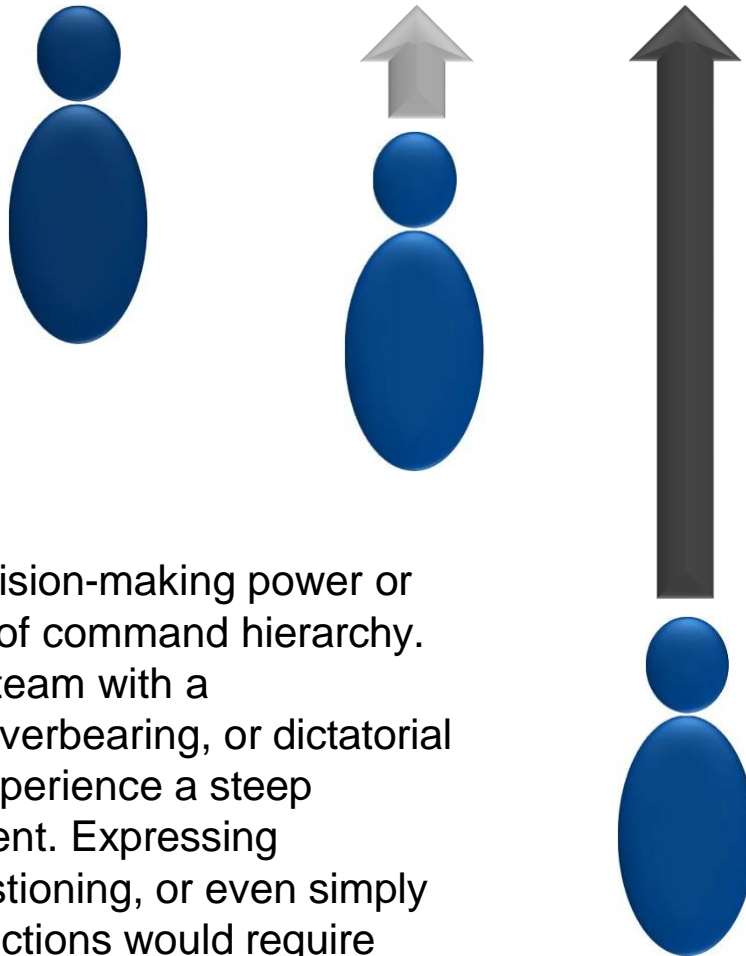
Top Negative Reinforcements

1. Furrowed brow
2. “No”
3. Offering a practice tip

Adapted from *Bringing Out the Best in People*, by Dr. Aubrey Daniels (1994)



Authority Gradient



The **perceived** steepness – not necessarily the real – as seen by the **subordinate**

Balance of decision-making power or the steepness of command hierarchy. Members of a team with a domineering, overbearing, or dictatorial team leader experience a steep authority gradient. Expressing concerns, questioning, or even simply clarifying instructions would require considerable determination...

Most teams require some degree of authority gradient; otherwise roles are blurred and decisions cannot be made in a timely fashion.

Challenges in “Speaking Up For Safety”

“Communication Openness” Dimension results demonstrate that approximately 37% of staff believe they ***might not be comfortable speaking up*** about something even if a patient might be harmed*

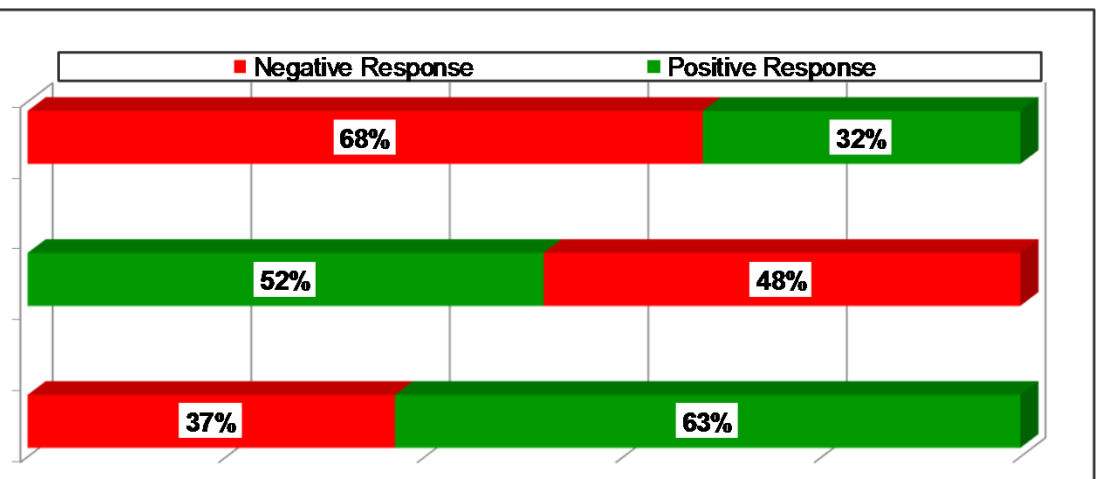
Why?

Primarily finding difficulty in ***asking questions, particularly to those in authority*** (68% said “sometimes or never”)

Staff feel free to question the decisions of those with more authority

Staff are afraid to ask questions when something doesn't seem right

Staff will freely speak up about things that may negatively affect patient care



*From the 2013 AHRQ Safety Culture Survey

Speak Up for Safety Using ARCC

Something I do to help our team prevent a safety event

Use the lightest touch possible...

Ask a question

Make a Request

Voice a Concern



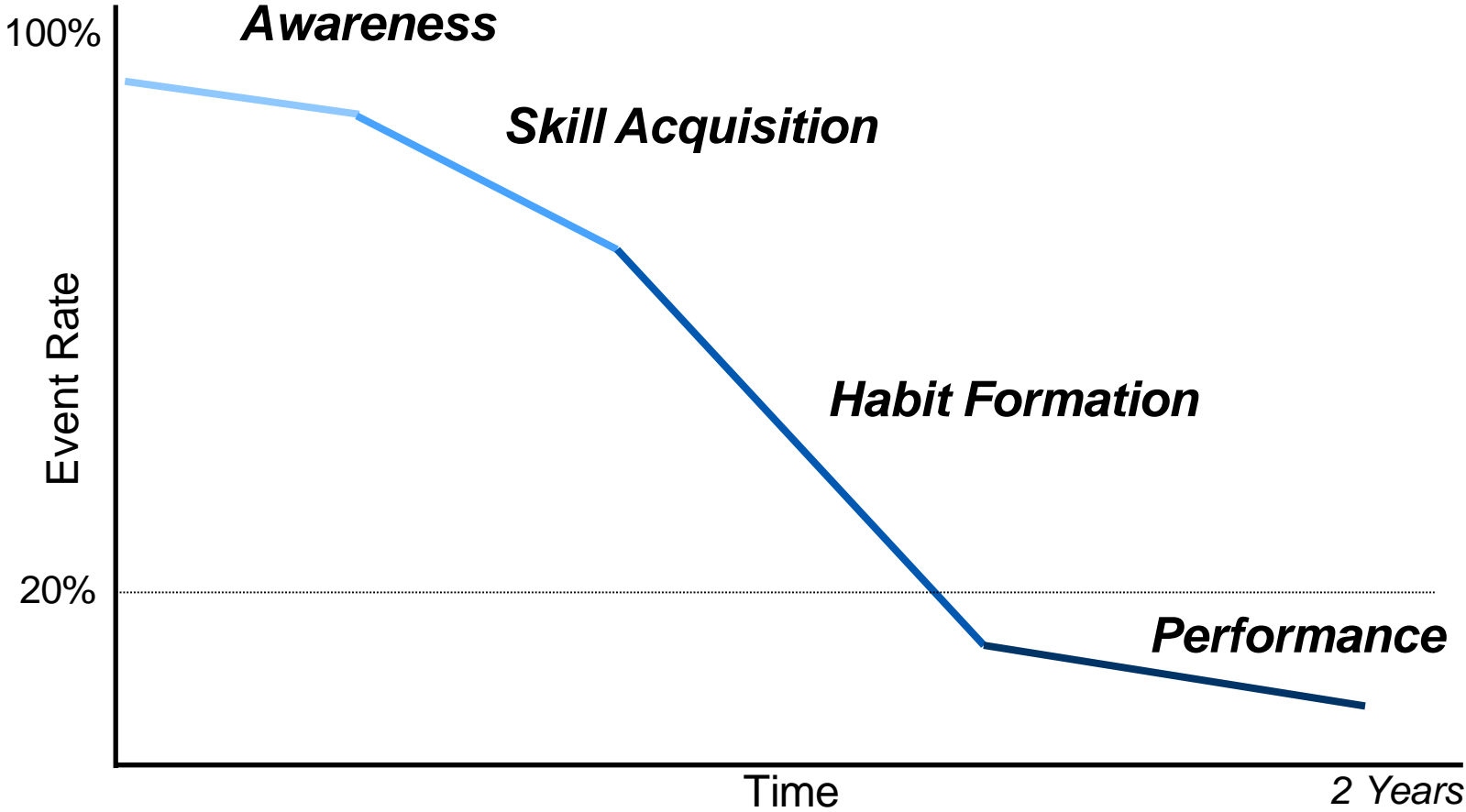
If no success...

Use Chain of Command

A Safety Phrase
"I have a **concern**..."

Making it Stick - "It's Hawthorne Until Habit"

Dr Glenn Bingle, CMO of Community Health Network



Next Steps

- Think about what you will do differently in your work environment as it pertains to patient safety.
- Practice these error prevention techniques-take care of each other!
- Make Clinton Memorial Hospital and your work environment the safest place for our patients.

Thank you for choosing to practice at CMH.