Today's Objectives

1. Share with you what we mean by "building and sustaining our patient safety culture"
2. Give you an understanding of why people experience errors in complex systems
3. Introduce you to our Patient Safety Behaviors and error prevention tools

A Deadly Dose of Human Error

44,000 to 98,000 patient deaths per year due to medical error
(IOM To Err Is Human, 2000)

298,865 patient deaths in from 2001-2003 due to patient safety incidents
(Healthgrades, 2005)

380,000-450,000 preventable adverse drug events in hospitals each year
(IOM Preventing Medication Errors, 2006)

Recommended care received about 54.9% of the time based on chart reviews
(Rand / New England Journal of Medicine, 2003)

Josh Barron
17 mo M expires on hospital day 5

Josh received an adult dose of a medication to stop his seizure. Nothing is known in the public domain as to how this happened.

Hydraulic Fluid Facts

Contract elevator maintenance employees drained the fluid from elevators into containers that had held surgical detergent. The containers were not properly re-labeled or securely stored. The containers were restocked and shipped as detergent back to Durham Regional Hospital and Duke Health Raleigh Hospital.

In November and December of 2004, the elevator hydraulic fluid was used as detergent in one step of a multi-step cleaning and sterilization process of surgical tools.
Three Ways Humans Perform

Knowledge Based Performance
(Figuring-It-Out Mode)

Rule Based Performance
(If-Then-Response Mode)

Skill Based Performance
(Auto Pilot Mode)

Why Do Events Happen?

Past errors result in latent weakness in "defence in depth" of organizations, programs, and equipment

Active errors by individuals result in initiating action(s)

From Managing the Risks of Organizational Accidents, James Reason (1997)

Skilled-Based Errors

What We're Doing At The Time
We are doing tasks so routine and familiar that we don't even have to think about the task while we are doing it.

<table>
<thead>
<tr>
<th>Type of Error</th>
<th>Error Prevention Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slip - Without intending to we do the wrong thing</td>
<td>Stop and think before acting</td>
</tr>
<tr>
<td>Lapse - Without intending to, we fail to do what we meant to do</td>
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Rule-Based Errors

What We're Doing At The Time
We choose how to respond to a situation using a principle (rule) we were taught or learned through experience.

<table>
<thead>
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<tr>
<td>Used the wrong rule - We were taught or learned the wrong response for the situation</td>
<td>Education about the correct rule</td>
</tr>
<tr>
<td>Misapplied a rule - We knew the right response but picked another response instead</td>
<td>Think a second time</td>
</tr>
<tr>
<td>Chose not to follow the rule - Usually because we thought not following the rule was the better option at the time</td>
<td>Reduce burden, increase risk awareness, improve coaching</td>
</tr>
</tbody>
</table>
Knowledge-Based Errors

What We're Doing At The Time
We're problem solving in a new, unfamiliar situation. We don't have a skill for the situation; we don't know the rules or no rule exists. So we come up with the answer by:
- Using what we do know (fundamentals)
- Taking a guess
- Figuring it out by trial-and-error

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<tbody>
<tr>
<td>We came up with the wrong answer (a mistake)</td>
<td>STOP and find an expert whom that knows the right answer</td>
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</tbody>
</table>

Create a Safe Day

Safety As Our Core Value

Safety impacts every aspect of care we provide

Safety Comes First

1. We believe that all harm is preventable.
2. We believe that DeVos will achieve zero harm.
3. We view safety as both a moral imperative and an operational standard.
4. We believe that safety is more important than any other competing priority.
5. We believe that safety must be "lived" 24 hours a day, 7 days a week.
6. We believe that everyone is responsible for patient/family safety as healthcare providers and as fellow human beings.
7. We believe that everyone can be a leader in achieving outstanding safety.
8. We believe that "leaders" must "walk-the-talk" and reinforce our safety culture.
9. We believe that outstanding safety performance should be heavily weighed in assessing overall individual performance.
10. We believe that "speaking up", halting unsafe practices, teaching, and helping are expectations of performance.

Culture and Safety

Culture
is the shared values and beliefs of the individuals in the organization
(the way we act when no one is looking)

Behaviors

Outcomes

Our Patient Safety Toolkit

1. Support the Team
   - Peer Checking and Peer Coaching
   - Speak Up Using ARCC

2. Pay Attention to Detail
   - Self-Checking Using STAR

3. Use a Questioning Attitude
   - Validate & Verify
   - Know & Comply with Red Rules

4. Communicate Clearly
   - 3-Way Repeat Back and Read Back
   - Clarifying Questions
   - Phonetic & Numeric Clarifications
   - SBAR

What should we do?
Help others to do the right thing, and expect that they will help us to do the right thing, too

Why should we do this?
To help everyone perform at their individual best
To help our team perform at it's best

Error Prevention Tools:
1. Peer Checking and Coaching
2. Speak Up Using ARCC
Peer Checking & Peer Coaching

Look out for your team member...
1. Offer to check the work of others
2. Point out unintended slips and lapses
3. Point out work conditions (hazards) that your team members may not have noticed

Support your team member by coaching...
1. **Encourage** safe and productive behaviors x 5
2. **Correct** unsafe and unproductive behaviors x 1

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2. 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, distractions, fatigue, or stress

Error Prevention Tools:
**Self Checking Using STAR**

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Mo Cheeks Video

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Self Checking Using STAR

<table>
<thead>
<tr>
<th>Stop:</th>
<th>Pause for one second</th>
</tr>
</thead>
<tbody>
<tr>
<td>Think:</td>
<td>Focus attention on task</td>
</tr>
<tr>
<td>Act:</td>
<td>Concentrate and perform the task</td>
</tr>
<tr>
<td>Review:</td>
<td>Check to see if did it right</td>
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Speak Up for Safety Using ARCC

A responsibility to protect in a manner of mutual respect –
an assertion and escalation technique

Use the lightest touch possible...
  - **Ask** a question
  - **Make a Request**
  - **Voice a Concern**
  - **If no success...**
  - **Use Chain of Command**

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Let’s Practice

**Stroop Test: Power of the Pause**

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<tr>
<th>RED</th>
<th>BLUE</th>
<th>GREEN</th>
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<tr>
<td>YELLOW</td>
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3. 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.

Error Prevention Tools:
1. Validate & Verify
2. Know and Comply with Red Rules

Verify – A Check With A Second Source

When should you verify?
1. When your detector goes off
2. In every high-risk situation
3. When there is a change in the patient condition or plan of care

It's okay not to know...
It's NOT okay not to find out.

Validate & Verify Technique

Validate: Does it make sense to me?
Verify: Check with an independent, qualified source

Let's Practice

What is wrong with this picture?
What is the meaning?

Validate – An Internal Check

Our internal detector...
1. Does this make sense to me?
2. Is it right, based on what I know?
3. Is this what I expected?
4. Does this information “fit-in” with my past experience or other information I may have at this time?

Get in the habit of asking yourself these questions every time...it takes a second.

Know and Comply with Red Rules

What is a Red Rule?

An act that has the highest level of risk or consequence to patient or employee safety if not performed exactly, each and every time.

"Red" designates the highest standard for exact compliance.
Reference Use Policy & Protocol

Guidance documents that provide information about standards and procedure expectations

Performance Expectation
- Learn the standards or procedure expectations for the work we do
- Know where to find the guidance documents
- If we’re ever not sure – or can’t remember – look it up

As the policies and protocols become knowledge “in the head,” we don’t need to refer to the document. They are “reference use” documents.

Create a Safe Day

Continuous Use Job Aids

Do lists, checklists, flowsheets that list tasks or action steps for infrequently performed or high-risk procedures

Performance Expectation
- We have the job aid in hand while performing the task
- We perform the tasks or steps as written

Why It’s A Good Thing
- Helps ensure that we don’t forget a step
- Keeps us out of knowledge-based performance and puts us in rule-based performance, reducing the probability that we’ll experience an error!

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3-Way Repeat Backs

When information is transferred...
1. Sender initiates communication using Receiver’s Name
2. Receiver acknowledges receipt by a repeat-back of the order, request, or information.
3. Sender acknowledges the accuracy of the repeat-back by saying, “That’s correct!” If not correct, Sender repeats the communication.

A DeVoS Safety Phrase:
“Let me repeat that back.”

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Ask Questions

Ask one to two clarifying questions:
1. In all high risk situations
2. When information is incomplete
3. When information is not clear

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 DeVoS Safety Phrase
“Let me ask a clarifying question.”

Create a Safe Day

Encourage Questions

Encourage questions by inviting questions and positively reinforcing questions when asked.

Asking a question is primarily an emotional security issue. We can foster a culture of critical thinking by encouraging questions. Invite questions, and use positive reinforcement when questions are asked.

Top 3 Statements to Encourage Critical Thinking
1. “What do you think?”
2. “That’s an interesting question”
3. “Let’s explore this”


Create a Safe Day

4. Communicate Clearly

What should we do?
Speak the language of safety: communicate complete and accurate information in a timely and appropriate manner

Why should we do this?
1. To ensure that we hear things correctly
2. To ensure that we understand things correctly
3. To prevent wrong assumptions and misunderstandings that could cause us to make wrong decisions

Error Prevention Tools:
1. 3-Way Repeat Back and Read Back
2. Clarifying Questions
3. Phonetic & Numeric Clarifications
4. SBAR

Create a Safe Day
Phonetic Clarification

For sound alike words and letters, say the letter followed by a word that begins with the letter:

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

Numeric Clarifications

When communication involves sound alike numbers, say the number and then the digits.

For example:

- 15...that's one-five
- 50...that's five-zero

SBAR, quick & to the point

**Situation:** What is the problem or patient or project?

**Background:** What is the relevant information?

**Assessment:** What is your read of the problem or patient?

**Recommendation:** What is your request or recommendation?

5Ps for Handoffs

DeVos Children's Hand-off Protocol:

- **Picture** -- Patient's clinical situation with emphasis on what is different or unusual
- **Purpose** -- Main reason for being here / diagnosis
- **Priority** -- Current clinical focus / the main effort
- **Plan** -- Long-term goal / the end state
- **Part** -- Who will be doing what with the plan?

Use anytime care of a patient is transferred from one person to another - even temporarily!

Making It Stick

By the time we finish construction we will be....

....the safest hospital in the United States!