Safety Starts with Me

Connecticut Hospital Association
Safety Culture Workshop for Outpatient and Medical Office Practices
16 December 2014

Staff Engagement in Safety Culture
December 16th Agenda

1. Safety – *Not a new focus but an expanded focus*
2. Safety in our Connecticut outpatient facilities and medical office practices
3. The Science of Safety
4. The Culture Connection
5. Behavior Expectations for Safety & Reliability – Your Input
6. What comes next?
Our Deliverables

- Gain a deeper understanding of **Safety Behaviors** and **Human Error Prevention Techniques** (a Patient Safety Toolkit) as they apply in the outpatient environment

- Establish a commitment for taking lessons back to individual work areas to share with coworkers

- Build enthusiasm for upcoming outpatient CHAMP Safety Habit training

Warm Up Exercise

- Introduce yourself to your fellow table mates
  - Tell them where you work

- Show them the picture of someone you care about that you brought in today
  - Tell them a little bit about that person and why you chose that picture
Warm Up Exercise

“The number one priority for Connecticut healthcare organizations is ensuring patient safety and delivering the highest quality of care. Patients and their families depend on our healthcare organizations to deliver outstanding care under the safest possible conditions.”

Our patients are all somebody’s “picture” person

From Our Patient’s Perspective

Don’t hurt me
Heal me
Be nice to me
...in that order
Hospital’s are Dangerous Places…

Death By Numbers

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

*To Err is Human, Institute of Medicine (1999)*

James Estimate

210,000 to 440,000 patients, each year, suffer from preventable harm that contributes to their death.

*James, John, A New Evidence-based Estimate of Patient Harms… Journal of Patient Safety, September 2013, Volume 9, Issue 3*

Josie King

February 22, 2001

Admitted to Johns Hopkins Medical Center after suffering first and second degree burns from climbing into a hot bath.

Healed well, but died two days before she was to return home of severe dehydration and misused narcotics.
...So are Outpatient Practices

Sebastian Ferrero – Medication Error
Darrie Eason – Misdiagnosis
Patrick Sheridan – Misdiagnosis

Patient Exposure

35 million hospital discharges annually

900 million clinic visits annually

Outpatient visits occur 25 times more frequently than hospital admissions!
Office Practices in the Literature

Adverse Drug Events in Ambulatory Care


- Study of 661 patients
- 162 had adverse drug events (25 percent)
- 13% were serious
- 28% were ameliorable
- 11% were preventable

Outpatient Harm

Most widely documented ambulatory errors include:

- Medication errors (incorrect drugs or dosages)
- Diagnostic errors (missed, delayed, and wrong diagnoses)
- Laboratory errors (including patient follow up errors)
- Clinical knowledge errors (skill and performance)
- Communication errors
- Administrative errors (scheduling appointments and managing patient records)

Family Medicine Experience

Identification of Medical Errors by Family Physicians During Outpatient Visits

- Errors and preventable adverse events were identified in 24% of visits.
- Wide variation in how often physicians identified errors (3% to 60% of visits).
- Harm occurred as a result of 24% of the errors, and was a potential in another 70%.
- Most harm was believed to be minor, but questions arose as to whether emotional discomfort and wasted time count as patient harm.

Table 1: Preventable Adverse Events and Errors Identified by Family Physicians During Patient Visits (N = 351)

<table>
<thead>
<tr>
<th>Classification</th>
<th>Examples</th>
<th>Patient Visits With Errors No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office administration errors</td>
<td>Any part of chart is not present, is in the wrong place, in time chart is missing.</td>
<td>57 (16.5)</td>
</tr>
<tr>
<td>Charting</td>
<td></td>
<td>37 (10.9)</td>
</tr>
<tr>
<td>General office administration</td>
<td>Staffing problems, missing or incorrect forms or paperwork, laboratory or radiograph processing errors.</td>
<td>21 (6.0)</td>
</tr>
<tr>
<td>Physician-related errors</td>
<td>Skill problems, timing problems (interrupted, feeling rushed).</td>
<td>28 (8.0)</td>
</tr>
<tr>
<td>Patient communication errors</td>
<td>Problems communicating with patient by physician, staff, or other physicians, appointment and image errors.</td>
<td>16 (4.5)</td>
</tr>
<tr>
<td>Preventable adverse events</td>
<td>Missed diagnosis, misdiagnosis, delayed treatment, incorrect treatment.</td>
<td>15 (4.3)</td>
</tr>
</tbody>
</table>

Note: More than 1 error was identified in 22 patient visits.


Causes of Diagnostic Errors

<table>
<thead>
<tr>
<th>Process Errors</th>
<th>Contributing Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to order test - 55%</td>
<td>Judgment failures - 79%</td>
</tr>
<tr>
<td>Inadequate follow-up - 45%</td>
<td>Vigilance/Memory - 59%</td>
</tr>
<tr>
<td>Inadequate H&amp;P - 42%</td>
<td>Knowledge - 48%</td>
</tr>
<tr>
<td>Result interpretation - 37%</td>
<td>Patient factors - 46%</td>
</tr>
<tr>
<td></td>
<td>Handoffs - 20%</td>
</tr>
</tbody>
</table>

There was an average of 3 process errors and contributing factors in each case.

In 43% of errors - two or more clinicians contributed and in 16% - three or more clinicians contributed.

Abnormal Results Follow-up

- In a national survey 11% of patients reported they received delayed or no reports of their abnormal test results.
- After reviewing 5,434 medical records, a research team could not confirm that abnormal test results were reported in 7.1% of patients.

Electronic health records (EHR) alone are not the cure (VA study)

- 18.1% of alerts unacknowledged
- 7.7% of alerts without timely follow-up
- Multidisciplinary approach needed


What About Us – our Data?
**Serious Safety Event**
- Reaches the patient
- Results in moderate to severe harm or death

**Precursor Safety Event**
- Reaches the patient
- Results in minimal harm or no detectable harm

**Near Miss Safety Event**
Does not reach the patient – error is caught by a last strong detection barrier designed to prevent event

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**CHA Pilot: 3 Organizations - Medical Group Practices**

**January 2012 - June 2014**

Rolling 12-month average of serious safety events per 10,000 adjusted patient days

- **Diagnostic SSER**: 0.33 (June 2014)
- **Ave Days between SSEs**: 122 days (CY 2013)
- **Ave Days between SSEs**: 26 days (CY 2014 YTD)
Serious Safety Events
Diagnostic Baseline Results

Medical Group Practice Pilot Sites
January 2012 – June 2014

<table>
<thead>
<tr>
<th>LEVEL OF HARM</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSE1 Death</td>
<td>3</td>
<td>21%</td>
</tr>
<tr>
<td>SSE2 Severe Permanent Harm</td>
<td>1</td>
<td>7%</td>
</tr>
<tr>
<td>SSE3 Moderate Permanent Harm</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>SSE4 Severe Temporary Harm</td>
<td>4</td>
<td>29%</td>
</tr>
<tr>
<td>SSE5 Moderate Temporary Harm</td>
<td>6</td>
<td>43%</td>
</tr>
</tbody>
</table>

SSE Breakdown

<table>
<thead>
<tr>
<th>CY (Jan - Dec)</th>
<th>CY 2012</th>
<th>CY 2013</th>
<th>CY 2014 (Jan - June)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of SSEs</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Number of SSE-Free Months</td>
<td>8</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Average Days Between SSE</td>
<td>91.3</td>
<td>121.7</td>
<td>26.1 YTD</td>
</tr>
</tbody>
</table>

Serious Safety Events Case Examples:

- Delay in diagnosis and treatment of abdominal abscess requiring IV Abx therapy
- Failure to recognize a series of critical lab results resulting in failure to rescue and patient demise
- Failure to implement fall precautions for patient assessed at high risk resulting fall with hip fracture requiring surgical intervention
- Failure to recognize clinical compromise resulting in post encounter ED visit for emergent treatment of septic shock and subsequent patient demise
- Delay in work-up for patient seen frequently with complaints of continued symptomology and subsequent diagnosis of stage III cancer
### Event Types

<table>
<thead>
<tr>
<th>Event Type</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>PR1</td>
<td>1</td>
<td>4.2%</td>
</tr>
<tr>
<td>PR2</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>PR3</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>PR4</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>PR5</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>PR6</td>
<td>2</td>
<td>8.3%</td>
</tr>
<tr>
<td>EE1</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>EE2</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>EE3</td>
<td>2</td>
<td>8.3%</td>
</tr>
<tr>
<td>EE4</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>EE5</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>EE6</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>PP2</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>PP3</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>PP4</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>PP5</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>CM1</td>
<td>3</td>
<td>12.5%</td>
</tr>
<tr>
<td>CM2</td>
<td>1</td>
<td>4.2%</td>
</tr>
<tr>
<td>CM3</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>CM3.1</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>CM3.2</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>CM7</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>CM8</td>
<td>10</td>
<td>41.7%</td>
</tr>
<tr>
<td>CM10</td>
<td>4</td>
<td>16.7%</td>
</tr>
<tr>
<td>PD1</td>
<td>1</td>
<td>4.2%</td>
</tr>
<tr>
<td>PD2</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>PD3</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>CE2</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>CE3</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>CE4</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>24</td>
<td>100%</td>
</tr>
</tbody>
</table>

1. The HPI Taxonomy of Safety Events is intended to be a mutually exclusive and comprehensively exhaustive list of event types for classification of patient harm experienced. The taxonomy is based in part on the National Quality Forum’s (NQF) Serious Reportable Events (SRE). The taxonomy is revisited from time to time to maintain the integrity of purpose.

### Top 10 Patient Safety Event Types

<table>
<thead>
<tr>
<th>#</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Compare</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>17.8%</td>
<td>21.7%</td>
<td>38.1%</td>
<td>23.7%</td>
<td>23.6% Delay in Diagnosis or Treatment (CM8)</td>
</tr>
<tr>
<td>2</td>
<td>44.4%</td>
<td>52.2%</td>
<td>23.8%</td>
<td>28.9%</td>
<td>21.3% Medication Error (CM1)</td>
</tr>
<tr>
<td>3</td>
<td>6.7%</td>
<td>4.3%</td>
<td>19.0%</td>
<td>-</td>
<td>15.2% Other Care Management (CM10) - HAI</td>
</tr>
<tr>
<td>4</td>
<td>8.9%</td>
<td>4.3%</td>
<td>4.8%</td>
<td>10.5%</td>
<td>10.2% Fall (EE3)</td>
</tr>
<tr>
<td>5</td>
<td>4.4%</td>
<td>-</td>
<td>-</td>
<td>5.3%</td>
<td>7.4% Other Procedural (PR6)</td>
</tr>
<tr>
<td>6</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5.3%</td>
<td>4.2% Retained Foreign Object (PR4)</td>
</tr>
<tr>
<td>7</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5.3%</td>
<td>2.2% Wrong Site Surgery (PR1)</td>
</tr>
<tr>
<td>8</td>
<td>13.3%</td>
<td>9.0%</td>
<td>-</td>
<td>-</td>
<td>2.2% Wrong Patient Surgery (PR2)</td>
</tr>
<tr>
<td>9</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2.6%</td>
<td>1.2% Suicide or Attempt (PP3)</td>
</tr>
<tr>
<td>10</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1.1%</td>
<td>Grade 3 or 4 Pressure Ulcer (CM7)</td>
</tr>
</tbody>
</table>

TOTAL: 45 23 21 38 1,1613
### Our Patients...

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jennifer</td>
<td>20 y/o</td>
<td>Wrong Site</td>
</tr>
<tr>
<td>Frank</td>
<td>60 y/o</td>
<td>Medication Error</td>
</tr>
<tr>
<td>James</td>
<td>2 y/o</td>
<td>Procedural Error</td>
</tr>
<tr>
<td>Joseph</td>
<td>18 y/o</td>
<td>Fall</td>
</tr>
<tr>
<td>Linda</td>
<td>59 y/o</td>
<td>Medication Error</td>
</tr>
<tr>
<td>Mindy</td>
<td>87 y/o</td>
<td>Procedural Error</td>
</tr>
<tr>
<td>John</td>
<td>71 y/o</td>
<td>Delay in Treatment</td>
</tr>
<tr>
<td>Tommy</td>
<td>4 y/o</td>
<td>Delay in Treatment</td>
</tr>
<tr>
<td>Ellen</td>
<td>30 y/o</td>
<td>Care Management</td>
</tr>
<tr>
<td>Joseph</td>
<td>18 y/o</td>
<td>Fall</td>
</tr>
<tr>
<td>Linda</td>
<td>71 y/o</td>
<td>Care Management</td>
</tr>
<tr>
<td>Edith</td>
<td>60 y/o</td>
<td>Fall</td>
</tr>
<tr>
<td>Mary</td>
<td>78 y/o</td>
<td>Delay in Treatment</td>
</tr>
<tr>
<td>Sally</td>
<td>73 y/o</td>
<td>Medication Error</td>
</tr>
<tr>
<td>Joshua</td>
<td>8 m/o</td>
<td>Wrong Patient</td>
</tr>
</tbody>
</table>

24 cases of preventable harm / 14 serious / 3 deaths

### Safety Culture Diagnostic Assessment

**Common Cause Analysis (CCA) of past safety events**

An indicator of *past performance*

- Identify common causes of past events for target in the intervention plan
Common Cause Analysis
A collective examination of past events for “common causes”
(not common outcomes)

Event (E): a condition that results from a deviation from practice expectations or standard of care

Inappropriate Act (IA): a human error that violates performance expectations or takes a task outside acceptable limits

Analyze by:
Profession, Organization, Key Process, Key Activity, System Failure Mode, Individual Failure Mode, Human Error Type

Human Error Types in GEMS*
“How” the brain was functioning at the time the person experienced the error

GEMS*:
*Generic Error Modeling System; Rasmussen and Reason

<table>
<thead>
<tr>
<th></th>
<th>GEMS Groups</th>
<th>HPI COMPARE **</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skill-Based:</td>
<td>10%</td>
<td>14%</td>
</tr>
<tr>
<td>Rule-Based:</td>
<td>64%</td>
<td>70%</td>
</tr>
<tr>
<td>Knowledge-Based:</td>
<td>26%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Opportunity: Operational leaders enhance interview & investigation skills further to identify the “because” (“why”)

N = 42 IAs
GEMS Fill Rate: 88%

N = 4874 IAs
GEMS Fill Rate: 65%

** HPI Compare: Historical Aggregate of 168 sites
**Individual Failure Modes**

Analyzing the “holes”...

<table>
<thead>
<tr>
<th>DIAGNOSTIC RESULTS</th>
<th>Medical Groups</th>
<th>HPI COMPARE (RANKING)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPETENCY</td>
<td>29%</td>
<td>3</td>
</tr>
<tr>
<td>CONSCIOUSNESS</td>
<td>12%</td>
<td>4</td>
</tr>
<tr>
<td>COMMUNICATION</td>
<td>2%</td>
<td>5</td>
</tr>
<tr>
<td>CRITICAL THINKING</td>
<td>36%</td>
<td>1</td>
</tr>
<tr>
<td>COMPLIANCE</td>
<td>21%</td>
<td>2</td>
</tr>
</tbody>
</table>

**Opportunity:** Operational leaders enhance interview & investigation skills further to identify the “because” (“why”)

<table>
<thead>
<tr>
<th></th>
<th>N = 42 IAs</th>
<th>CCA Fill Rate: 68%</th>
<th>N = 4754 IAs</th>
<th>CCA Fill Rate: 65%</th>
</tr>
</thead>
</table>

**System Failure Modes**

Analyzing the “holes”...

<table>
<thead>
<tr>
<th>DIAGNOSTIC RESULTS</th>
<th>Med Groups</th>
<th>HPI COMPARE (RANKING)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRUCTURE</td>
<td>11%</td>
<td>3</td>
</tr>
<tr>
<td>CULTURE</td>
<td>36%</td>
<td>1</td>
</tr>
<tr>
<td>PROCESS</td>
<td>43%</td>
<td>2</td>
</tr>
<tr>
<td>POLICY &amp; PROTOCOL</td>
<td>2%</td>
<td>4</td>
</tr>
<tr>
<td>TECHNOLOGY &amp; ENVIRONMENT</td>
<td>8%</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>N = 62 IAs</th>
<th>N = 6828 IAs</th>
</tr>
</thead>
</table>

* Ranking = Top Five IFM  
** HPI Compare: Historical Aggregate of 168 sites
Take Home Points

- Office-based care has risks of patient injury and physician liability
- Diagnostic delays/errors and medication-related errors are particularly common
  - solutions likely require improvements in both system support and physician practice
- Research into patient safety in the ambulatory setting lags behind the hospital
  - There is little formal research on effective interventions in ambulatory care settings, but there are several promising approaches…

Questions for Reflection

- Do people get well before being discharged from our hospitals?
- Have I prescribed life-saving meds?
- Has EMS transported a patient to my office from long-term care? And back?
- Has my team ever transferred a patient onto an exam table?
- Have I done procedures in the office that would require a time-out in a hospital?
BREAK

THE SCIENCE OF SAFETY
“Safety is not a lucky system. It is a system of science, analysis, and facts.”

Mark V. Rosenker, Chairman
National Transportation Safety Board

commenting on the March 1977 runway collision at Tenerife of a KLM 747 and a PanAm 747 that claimed 583 lives

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Do you know how many mistakes you have made in the past hour?

1. **Everyone makes errors** – even experienced, professional people.
2. We work in **high-risk situations** that increase the chance we will make an error.
3. We can avoid most errors by practicing **low-risk behaviors**.
4. **Culture** affects how we behave, and our behaviors determine outcomes.
5. Most near-misses and significant events are due to **system or process problems**.

Adapted from *Excellence in Human Performance*, The Institute of Nuclear Power Operations, 1997
The Swiss-Cheese Effect

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

*Active Errors* by individuals result in initiating action(s)

*Latent Weaknesses* in barriers

**EVENTS of HARM**

**PREVENT** The Errors

**DETECT & CORRECT** The System Weaknesses

Adapted from James Reason, *Managing the Risks of Organizational Accidents* (1997)

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**Case in Point**

Manager fails to ensure a process in place to verify returned test results

Lab tech sends positive pathology report to wrong physician's office

Patient calls and is told radiology report is negative by well-meaning non-clinical staff member

Physician orders lung biopsy and CT scan for 71 year old male patient complaining of chest pain

Clinical assistant fails to follow up on missing pathology report

Physician fails to notify patient of positive pathology report

1 year later wife comes in to report patient dying of undiagnosed end-stage lung cancer
Influencing Behaviors at the Sharp End

Adapted from R. Cook and D. Woods, Operating at the Sharp End: The Complexity of Human Error (1994)

Design of Structure

Design of Policy & Protocol

Design of Culture

Design of Work Processes

Design of Technology & Environment

Behaviors of Individuals & Groups

Outcomes

Safety - It Doesn’t Just Happen

High Risk Situation + High Risk Behavior = Event of Harm

Lucky Photograph © by Craig Grant

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## Optimizing Reliability

<table>
<thead>
<tr>
<th>Reliability Culture</th>
<th>Process, Protocol &amp; Technology</th>
<th>Behavior Accountability</th>
<th>Human Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety as the core value</td>
<td>Resource allocation</td>
<td>Safety as the core value</td>
<td>Safety as the core value</td>
</tr>
<tr>
<td>Behavior expectations for error prevention</td>
<td>Evidence-based practice (e.g. bundles)</td>
<td>Behavior expectations for error prevention</td>
<td>Behavior expectations for error prevention</td>
</tr>
<tr>
<td>Collaborative Interactive Teams</td>
<td>Technology enablers</td>
<td>Collaborative Interactive Teams</td>
<td>Collaborative Interactive Teams</td>
</tr>
<tr>
<td>Leadership behaviors for reliability</td>
<td>Technology enablers</td>
<td>Leadership behaviors for reliability</td>
<td>Leadership behaviors for reliability</td>
</tr>
</tbody>
</table>

Design to Optimize Human Performance at the point of people interface:
- Easy to do the right thing – impossible to do the wrong thing
- Intuitive design
- Mistake proofing by design (i.e. poka yoke)

### High reliability organizations (HROs)

“operate under very trying conditions all the time and yet manage to have fewer than their fair share of accidents.”

*Managing the Unexpected* (Weick & Sutcliffe)

**Risk** is a function of *probability* and *consequence*.

By decreasing the probability of an accident, HRO’s recast a high-risk enterprise as merely a high-consequence enterprise. HROs operate as to make systems ultra-safe.
Five Principles of HROs

**Preoccupation with Failure**
Operating with a chronic wariness of the possibility of unexpected events that may jeopardize safety by engaging in proactive and preemptive analysis and discussion

**Sensitivity to Operations**
Paying attention to what’s happening on the front-line – Ongoing interaction and information-sharing about the human and organizational factors that determine the safety of a system as a whole

**Reluctance to Simplify interpretations**
Taking deliberate steps to question assumptions and received wisdom to create a more complete and nuanced picture of ongoing operations

**Commitment to Resilience**
Developing capabilities to detect, contain, and bounce back from errors that have already occurred, before they worsen and cause more serious harm

**Deference to Expertise**
During high-tempo operations, decision-making authority migrants to the person or people with the most expertise with the problem at hand, regardless of rank

---

Reliability – U.S. Nuclear Power

**Significant Events per Plant**

*Annual Industry Average, Fiscal Year 1988-2011*

INPO Principles for a Strong Nuclear Safety Culture
1. Everyone is personally responsible for safety
2. Leaders demonstrate a commitment to safety
3. Trust permeates the organization
4. Decision making reflects safety first
5. Nuclear technology is recognized as special and unique
6. A questioning attitude is cultivated
7. Organizational learning is embraced
8. Safety undergoes constant examination
Commercial Aviation

U.S. and Canadian Operators Accident Rates by Year

Source: Boeing, 2012 Statistical Summary, August 2013

Naval Aviation Mishap Rate

776 aircraft destroyed in 1954
Angled Carrier Decks
Naval Aviation Safety Center
NAMP est. 1959
RAG concept initiated
NATOPS initiated 1961
Squadron Safety program
System Safety Designated Aircraft
ACT
HFC’s 1.64

Source: www.safetycenter.navy.mil/AAH Risk Mishap Rate

Slide 43

Slide 44
Reliability Culture - Genius of the AND

Safety Focus + performed as intended consistently over time = No Harm

Evidence-Based Process Bundles + performed as intended consistently over time = Clinical Excellence

Patient Centered + performed as intended consistently over time = “Satisfaction”

Financial Focus + performed as intended consistently over time = Margin

The Epidemic of Under Reporting

Report Finds Most Errors at Hospitals Go Unreported

By ROBERT PEAR
January 6, 2012

Hospital employees recognize and report only one out of seven errors, accidents and other events of harm.

Typical reasons for low reporting are:

- Fear (of retribution because we haven’t established a fair culture)
- Burden (because the reporting system is too time consuming or difficult to use)

According to HHS, the additional reasons for failure to report are:

- Hospital employees do not recognize “what constitutes patient harm” or do not realize that particular events harmed patients and should be reported
- Employees assumed someone else would report the event
- Employees thought that the harm or event was so common that it did not need to be reported (yikes!)

Who knows how much goes unreported in outpatient practices?
Striking the Right Balance

Questions for Reflection

- How aware of risky situations are you and your coworkers in your facility?
- Do you sometimes see risky behaviors on the part of your coworkers? On the part of providers?
- Do errors and events get reported in your practice?
  - If so, does the response feel punitive or is there a focus on learning from events and system corrective actions?
Human Error 101
Understanding why we make errors and how to prevent errors

Humans Work in Three Modes

Knowledge-Based Performance
“Figuring It Out Mode”

Rule-Based Performance
“If-Then Response Mode”

Skill-Based Performance
“Auto-Pilot 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

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

1-3 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

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

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

<table>
<thead>
<tr>
<th>Errors You Experience</th>
<th>Error Prevention Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>You came up with the wrong answer</td>
<td>STOP and find an expert who or that knows the right answer</td>
</tr>
<tr>
<td>(a mistake)</td>
<td></td>
</tr>
</tbody>
</table>

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

BREAK
THE CULTURE CONNECTION

What Does Culture Have to Do With Safety?

**Shared Values & Beliefs**

- A superior experience for patients, employees, physicians and our community
  - Keeping our patients and employees free from harm is our #1 responsibility

**Behaviors**

- The actions and interactions of the individuals in the group
  - Behavior expectations that help us perform at our individual best and our team best

**Outcomes**

- Zero events of harm to patients and employees

“Culture is what we do when no one else is around”

Admiral Harold Gehman
Safety as Our Core Value
A Powerful Driver of Individual Decision Making

The loudest message wins...

System Causes - “Why” Data

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Compare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure (job design)</td>
<td>8.9%</td>
<td>4%</td>
<td>-</td>
<td>5.8%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Culture (people &amp; people interaction)</td>
<td>57.4%</td>
<td>62%</td>
<td>100%</td>
<td>57.7%</td>
<td>57.3%</td>
</tr>
<tr>
<td>Process</td>
<td>15.8%</td>
<td>12%</td>
<td>-</td>
<td>19.2%</td>
<td>19.3%</td>
</tr>
<tr>
<td>Policy &amp; Protocol</td>
<td>5.9%</td>
<td>10%</td>
<td>-</td>
<td>7.7%</td>
<td>8.2%</td>
</tr>
<tr>
<td>Technology &amp; Environment</td>
<td>11.9%</td>
<td>12%</td>
<td>-</td>
<td>9.6%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Acts coded for system cause</td>
<td>101</td>
<td>66</td>
<td>12</td>
<td>52</td>
<td>2,444</td>
</tr>
<tr>
<td>Culture Preventable</td>
<td>72.7%</td>
<td>75%</td>
<td>100%</td>
<td>74.0%</td>
<td>76.3%</td>
</tr>
</tbody>
</table>
Safety Culture

What safety culture sound bites do you hear?

Write them down as you watch the video.

Safety Culture Sound Bites:

- Safety for the right reasons – not just to meet regulatory requirements
- Safety is the most important thing we do…if we can’t do it safely, we’re not going to do it
- Want to understand the hazards and potential hazards before we get to the field
- Stop Work Ability in the hands of each and every individual – responsibility and moral obligation
- Culture: consistent, predictable behavior that takes time to develop – have to break old paradigms
- Not a “check in the box” but something we really believe in
- Quiz people’s knowledge and their understanding of what’s right and what’s wrong
- Goal: ZERO lost-time accidents
- Tout our safety program when we go out to win new work
- Easy to talk about safety but to actually do something about safety, that’s where the rubber really meets the road
A Sign of the Times

Safety Culture

Envision the future...
Safety Culture in your office practice
2019

What *Behaviors and Cultural Elements* will be on our Ashtray List?

Report back in ____ minutes.
Our “Ashtray” List –
Threats to Safety throughout CHA

What have you observed in your facility that puts our patients or employees at risk for harm – and needs to be put on the “Ashtray List”? 

<table>
<thead>
<tr>
<th>Individual Behaviors</th>
<th>Team Behaviors</th>
<th>Work Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rushing around and not paying attention</td>
<td>1. Complete information not handed off</td>
<td>1. Too many things to do</td>
</tr>
<tr>
<td>2. Afraid to ask questions when not sure what to do</td>
<td>2. People don’t work together</td>
<td>2. Hard to get answers to questions</td>
</tr>
<tr>
<td>3. Don’t speak up when something isn’t safe</td>
<td>3. Folks go to “silence or violence” and dialogue stops</td>
<td>3. People don’t have the knowledge to do the job</td>
</tr>
<tr>
<td>4. Don’t follow the rules</td>
<td>4. Poor communication between members with different communication styles</td>
<td>4. Always focused on putting out fires</td>
</tr>
<tr>
<td>5. Focusing on “getting it done” rather than focusing on how it gets done</td>
<td>5. Afraid to speak up to those in authority</td>
<td>5. Need to do more with less</td>
</tr>
</tbody>
</table>

Strategy for Building a Culture

1. Establish Expectations
   Establish behavior-based expectations consistent with the practice’s mission, goals, and high management standards for event-free performance

2. Educate - Develop Knowledge & Skills
   Educate individuals at all levels of the practice on behavior-based expectations and error prevention techniques

3. Build & Reinforce Accountability
   Establish an accountability system to convert behaviors to work habits
The “Why” in Culture Change

1. More care is delivered in the office setting
2. Sicker patients are seen and more complex care is delivered in physician offices than ever before
3. Harm to patients occurs in physician offices
4. Harm can be severe and types and severity of harm can mirror that seen in hospitals
5. Resources in reliability and safety have tended to be hospital centric
6. Leadership safety behaviors are critical
7. Safety behaviors for all in the office setting are vital

WORKING LUNCH

Please take a break, get your lunch and return to your tables so we can continue our workshop
ESTABLISHING EXPECTATIONS FOR ERROR PREVENTION

Making Reliability a Reality

Recommendation 3: Error Prevention

- Adopt Safety Behaviors for Error Prevention (Safety Habits) as clear expectations that guide individual and team actions, interactions, and decision making.

- Educate and train all associates – leaders, staff, and medical staff – on these behavior expectations.

- Establish effective accountability systems to engrain behaviors as individual and team work habits.

- Define and implement Red Rules for safety – acts that bear the highest level of direct risk to the safety of a patient or employee and for which exact compliance is expected and valued.
Non-Technical Skills

**Non-technical skills** describe how people interact with technology, environment, and other people. These skills are similar across a wide range of job functions. These skills include attention, information processing, and cognition.

**Generic non-technical skills:**
- Situational awareness
- Attention
- Communication
  - repeat backs
  - call outs
  - phonetic & numeric clarification
  - clarifying questions
  - inquiry, advocacy, assertion
- Critical thinking
- Protocol use
- Decision-making

---

Proven Error Prevention Techniques

- Self-checking using STAR *(Stop, Think, Act, Review)*
- Read Back/Repeat-Backs
- Clarifying Questions
- Phonetic/Numeric Clarifications
- SBAR *(Situation, Background, Assessment, Recommendation)*
- Critical thinking using Validate & Verify
- Red Rules
- Speak-Up Using ARCC *(Ask a Question/Make a Request/Voice a Concern/Use a Chain of Command)*
- Structured hand-offs using 5P’s *(Patient/Project, Plan, Purpose, Problems, Precautions)*
- Peer Checking & Peer Coaching
- Scanning
- Brief/Execute/Debrief
- Stop in the Face of Uncertainty
- Checklists
Safety Starts with Me

C - Communicate Clearly
- Repeat Backs / Read Backs with Clarifying Questions
- Phonetic and Numeric Clarifications
- SBAR (Situation, Background, Assessment, Recommendation)

H - Handoff Effectively
- ETA (Exchange Information, Transfer Responsibly, Acknowledge the Transfer)

A - Attention to Detail
- Self-check using STAR (Stop, Think, Act, Review)

M - Mentor Each Other – 200% Accountability
- Cross-Check and Coach teammates
- Speak up for Safety: ARCC it up – “I have a Concern” (Ask, Request, Concern, Chain of Command)

P - Practice and Accept a Questioning Attitude
- Validate and Verify
- Stop the Line – “I need clarity!”

Be a safety “CHAMP” for our patients

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

Error Prevention Tools
- Repeat-backs & Read-backs
- Clarifying Questions
- Phonetic & Numeric Clarifications
Closed-Loop Communications

Clear
Complete
Accurate
Sent and Received

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

When information is transferred...

Sender initiates communication using Receiver’s Name. Sender provides a request or information to Receiver in a clear and concise format.

Receiver acknowledges receipt by a repeat-back of the 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...”

Train our ears to listen for “That’s Correct!” – it’s a codeword for “we understand each other”
3-Way Read Back

The same as the Repeat Back, except…

The Receiver *writes down* the information, request, or order and *reads back what they have written*.

Don’t rely on your memory…

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

Steve Martin on Repeat Backs

[Image of Steve Martin and a young girl]
Clarifying Questions

Ask one to two clarifying questions:
- In all high risk situations
- When information is incomplete
- When information is not clear

Why…

How…

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

Use the Safety Phrase: “Let me ask a clarifying question...”

Phonetic Clarifications

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

| 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 |   |         

Adopted by NATO, International Civil Aviation Organization, Federal Aviation Administration, International Telecommunication Union, and US Nuclear Power Industry
Numeric Clarifications

For *sound alike* numbers, say the number and then 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 zeros – as in 0.9

A Repeat Back Failure

27
29

“The Same”
Information Transfer using **SBAR**

An outline for planning and communicating information about a patient condition or any other issue or problem.

First, introduce yourself and the patient.

- **Situation:** The bottom line (DX, current condition)
- **Background:** What do you know? (medical history, past tests/treatments)
- **Assessment:** What is happening now? (current findings, pt. needs/tests/treatments)
- **Recommendation:** What is next? (recommend for plan of care)

Always ask if either party has any questions.

---

**SBAR Outpatient Example**

You’re a nurse and receive a critical value from the lab. You find the provider coming out of an exam room and say:

- “Dr. Greene, here’s the **Situation** – I just got a call from the lab with a critical potassium value on Mr. Smith of 5.7 in a non-hemolyzed specimen.
- By way of some **Background** – Mr. Smith came in earlier today with a history of diabetes and hypertension.
- For my **Assessment** – According to the office notes, we had increased his potassium supplements at his last visit.
- My **Recommendation** is I think he needs to come back in or go to the ED.
- **Question** – what would you like me to do?”
Do you think these tools can help reduce communication errors and misunderstandings in an outpatient office environment?

What are the barriers to having frequent and formal communications in our day?

**Safety Starts with Me**

**Communicate Clearly**
- Repeat Backs / Read Backs with Clarifying Questions
- Phonetic and Numeric Clarifications
- SBAR (Situation, Background, Assessment, Recommendation)

**Handoff Effectively**
- ETA (Exchange Information, Transfer Responsibly, Acknowledge the Transfer)

**Attention to Detail**
- Self-check using STAR (Stop, Think, Act, Review)

**Mentor Each Other – 200% Accountability**
- Cross-Check and Coach teammates
- Speak up for Safety: ARCC It up – “I have a Concern” (Ask, Request, Concern, Chain of Command)

**Practice and Accept a Questioning Attitude**
- Validate and Verify
- Stop the Line – “I need clarity!”

*Be a safety “CHAMP” for our patients*
Handoff Effectively

We provide effective handoffs of patients, tasks and materials to ensure understanding and ownership

Effective Handoffs in an outpatient setting:

- Act on results in a time appropriate manner
- Ensure 24-hour follow-up for tests, studies, referrals or treatments
- Escalate a lack of follow-up on the part of other care providers
- Close out follow-up items by End-of-Day
- Ensure a proper transition of care

Keep it Simple

To ensure Effective Handoffs, remember the following:

- E – Exchange Information
- T – Transfer Responsibility
- A – Acknowledge the Transfer
Safety Starts with Me

How do you currently handoff patients within your practice, between practices or during a transition of care?

Do you have a structured process, tool or checklist to ensure information is reliably exchanged?

Do you see test results or follow-up items missed due to failed handoffs? Would a more structured handoff tool help avoid these failures?

BREAK
Safety Starts with Me

C  Communicate Clearly
   - Repeat Backs / Read Backs with Clarifying Questions
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Be a safety “CHAMP” for our patients

Attention to Detail

What should we do?
Pay attention to the task at hand to avoid unintentional skill-based errors

Why should we do this?
- To avoid those slips or lapses where the hand is operating before the head
- To reduce the chance that we’ll make an error when we’re under time pressure, distracted or stressed

Error-prevention tool
- Self Check Using STAR
Self-Check Using STAR

Stop  Pause for 1 to 2 seconds to focus our attention on the task at hand

Think  Consider the action you’re about to take

Act  Concentrate and carry out the task

Review  Check to make sure that the task was done correctly and that you got the correct result

STOP is the most important step. It gives your brain a chance to catch up with what your hands are getting ready to do.

Pause for the Cause

The Time-Reliability Correlation

- **Skill-Based** (Familiar, routine)  
  - Such as:  
    - Suturing  
    - Taking vital signs

- **Rule-Based** ("If-Then" response)  
  - Such as:  
    - Simple Diagnoses  
    - Prescribing

- **Knowledge-Based** (New, unfamiliar)  
  - Such as:  
    - Complex diagnoses  
    - Condition outside area of expertise


1-2 sec pause
Slap-Your-Head Moments

Conditions that increase the chance you will experience an unintended error when performing a familiar, routine task:

• Working under time pressure
• Doing multiple things at the same time
• Distractions
• Interruptions
• Boredom
• Mental or physical exhaustion
• Disorientation
• Just not paying attention

Any sound familiar???

STAR reduces your chances of making an unintended mental slip or lapse by more than 10 times...

Count the F’s

Read this sentence:

FINISHED FILES ARE THE RESULT OF YEARS OF SCIENTIFIC STUDY COMBINED WITH THE EXPERIENCE OF YEARS.

Count the F’s one time and one time only – DO NOT go back and count them again.
Add the numbers....

Add the numbers. Say your answer as a group:

+ 1000
+ 40
+ 1000
+ 30
+ 1000
+ 20
+ 1000
+ 10

And the answer is....

5000 ?
or is it...
4100 ?
Let’s Check It Out….

+ 1000
+ 40 = 1040
+ 1000 = 2040
+ 30 = 2070
+ 1000 = 3070
+ 20 = 3090
+ 1000 = 4090
+ 10 = 

4100

Visual Cognition
The Power of the Pause

Say the color…

<table>
<thead>
<tr>
<th>RED</th>
<th>BLUE</th>
<th>GREEN</th>
<th>BLUE</th>
<th>BLACK</th>
</tr>
</thead>
<tbody>
<tr>
<td>YELLOW</td>
<td>GREEN</td>
<td>ORANGE</td>
<td>GREEN</td>
<td>RED</td>
</tr>
<tr>
<td>PINK</td>
<td>BLACK</td>
<td>BROWN</td>
<td>YELLOW</td>
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<td>ORANGE</td>
<td>BLACK</td>
<td>BLUE</td>
<td>GREEN</td>
<td>RED</td>
</tr>
</tbody>
</table>


A Shining STAR Success Story

My 13 year old daughter was struggling with 7th grade. Her frustration over grades and calls from her school advisor had my family on edge. It's hard to see your child struggle.

I have always told my daughter she is a bright and shining star, so when I approached her about using the STAR method on homework and tests, she accepted the idea. We discussed how she would write STAR at the top of her paper and after reading a question or problem, she would Stop, Think about it, Act/Answer, and then Review her answer before moving to the next problem.

Almost immediately, we noticed an improvement in her grades - enough that the advisor called me to ask why "STAR" was written on her papers. She was so excited about the concept she asked me if she could shared STAR with other students who struggle with tests.

How has S.T.A.R. helped my daughter? Her math grade improved more than one grade level in a period of less than 30 days and we couldn’t be happier. She writes - and is committed to write - “STAR” at the top of each test and follow the steps..
Safety Starts with Me

In 3 minutes as a group, identify as many skill-based activities or errors you make at home or at work.

How can you apply STAR in your office or facility?

BREAK
Safety Starts with Me

C Communicate Clearly
- Repeat Backs / Read Backs with Clarifying Questions
- Phonetic and Numeric Clarifications
- SBAR (Situation, Background, Assessment, Recommendation)

H Handoff Effectively
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- Validate and Verify
- Stop the Line – “I need clarity!”

Be a safety “CHAMP” for our patients

Mentor Each Other – 200% Accountability

What should we do?
Look out for one another to catch each other’s mistakes while building a greater sense of accountability for our actions

Why should we do this?
- To catch and trap honest errors before they reach our patients
- To hold each other accountable for meeting practice expectations

Error Prevention Tools
- Peer Check
- Peer Coach
Cross Check

Cross Check =
Watching out for each other
Peers check each others’ work and ARE WILLING TO BE CHECKED

Look out for your team members…
- Offer to check the work of others
- Point out work conditions (hazards) your team member might not have noticed
- Point out unintended slips and lapses
- Say “Thanks for the Cross Check!”

Cross Checking in Health Care

Individual reliability is limited: 1 defect per 1000 opportunities

1/1000 (my error probability) x 1/1000 (your error probability) = 1/1,000,000 (our combined reliability!!)

We are better together…
Peer Coaching

*Encourage* safe and productive behaviors  
*5 times as often as you…*

*Correct* an unsafe and unproductive behavior

Tips
- Be willing to give feedback to others…*and* be willing to have others give feedback to you!
- Provide feedback based on observations
- Use the “lightest touch” possible

*Remember – without saying a word:*  
“What you permit, you promote.”

Good Peer Coaching

[Image of a football team during a practice session]
ARCC it up – I have a Concern

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

A Safety Phrase – “I have a Concern…”

Power Distance

Geert Hofstede’s Power Distance
- Extent to which the less powerful expect and accept that power is distributed unequally
- Leads to strong Authority Gradients, which is the perception of authority as perceived by the subordinate

United States
- Moderate to low Power Distance (38th of 50 countries)
- High between certain professional groups:
  - Some physicians and nurses
  - Some nurses and other clinical staff
  - Some leaders and staff

Cultural differences are a nuisance at best and often a disaster.”
Geert Hofstede, Emeritus Professor, Maastricht University
Tenerife Disaster
A Speak up for Safety Failure

ARCC in the Office Practice

A triage nurse takes a call from a patient that requires a response by the end of the day. She approaches the provider who is busy between seeing patients:

- **Nurse**: Dr. Jones, I just took a call from Mrs. Smith who didn’t get her prescription this morning. Were you waiting for a test result before writing that prescription? (**Asks** question)
- **Physician**: No, I saw the result but haven’t had time to write the script. I’ll get to it later.
- **Nurse**: Can I get the chart for you so we can get her the prescription? (**makes a Request**)
- **Physician**: No – I’ve got the chart but am 3 patients behind right now.
- **Nurse**: Dr. Jones I’m **CONCERNED**. It’s Friday afternoon and the patient is out of her meds. I don’t want her to get into trouble with her congestive heart failure.
Speak Up for Safety
You have our permission!

Safety Starts with Me

Are staff comfortable checking and coaching each other, pointing out errors or voicing safety concerns?

Is coaching just a manager role, or are we all responsible to coach one another?

What are the reasons people are hesitant to speak up or voice safety concerns? Do we have problems with Power Distance in our outpatient facilities?
Safety Starts with Me

**Communicate Clearly**
- Repeat Backs / Read Backs with Clarifying Questions
- Phonetic and Numeric Clarifications
- SBAR (Situation, Background, Assessment, Recommendation)

**Handoff Effectively**
- ETA (Exchange Information, Transfer Responsibly, Acknowledge the Transfer)

**Attention to Detail**
- Self-check using STAR (Stop, Think, Act, Review)

**Mentor Each Other – 200% Accountability**
- Cross-Check and Coach teammates
- Speak up for Safety: ARCC It up – “I have a Concern” (Ask, Request, Concern, Chain of Command)

**Practice and Accept a Questioning Attitude**
- Validate and Verify
- Stop the Line – “I need clarity!”

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**Practice and Accept a Questioning Attitude**

**What should we do?**
Think critically by questioning information we hear and see if it doesn’t fit with what we know

**Why should we do this?**
- To detect incorrect information and assumptions that can lead to erroneous decisions or actions
- To help ensure work activities are stopped when faced with uncertainty or unsafe conditions

**Error Prevention Tool**
- Validate and Verify
- Stop the Line – I need clarity

It’s not about asking questions – It’s about questioning the answers!
Validate and Verify

**Validate:** Qualify the source and ask yourself, does it make sense to me?

**Verify:** Check it out with an *independent, expert* source

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**Validate: Internal check**

*Internal smoke detector…*

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

Get in the habit of asking these questions all the time - It takes only seconds
Verify: *External* check

When should you Verify?

- When your detector goes off
- In every high-risk situation
- When there is a change in the patient condition or plan of care

*It’s OK not to know*

*It’s not OK not to find out*

Validating and Verifying

- A nurse was preparing the EKG unit for her patient one morning and noticed that the protective coating on one of the EKG lead wires was broken.

- She *Stopped* and thought about it – *Validate*. Her internal smoke detector went off because the situation “didn’t seem right.”

- She checked to *verify* with a coworker whether the EKG unit could be used, and the coworker said she didn’t think it was a problem.

- The nurse still didn’t feel right about it, so she put a *Do Not Use* sign on the machine and *verified* with her supervisor that the machine could cause an injury to a patient or employee. The supervisor made arrangements for patients to receive EKG’s using alternate equipment that day while the machine was being fixed.

*How long should you Verify?*

*As long as your smoke detector is still going off!*

HPI

Slide 119

Slide 120
Non-Clinical Example

Nelson Meador
Food & Nutrition Services
Holy Redeemer Health System

The day we changed sanitizing chemicals at our pot sink, Nelson displayed a questioning attitude by asking if the new chemical was at the right concentration.

The old chemical made the water a bright blue color, and the new chemical barely changed the color of the water.

We tested the concentration and both agreed that the concentration was correct.

Thanks, Nelson, for Validating and Verifying!

Stop the Line – I need clarity

Similar in concept to the “Stop the Line” or “Stop Work Authority” concept promoted by most high-risk industries

If you are uncertain about what you are about to do…
If you have questions…
If someone raises a concern or question...

STOP

• Review your plan
• Resolve the concern
• Reassess your actions
Safety Starts with Me

Do we want people to have a good questioning attitude?

If so, how can we encourage staff to practice with a questioning attitude?

What are the barriers to people having a health questioning attitude?

Know Five, Save Lives

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Be a safety “CHAMP” for our patients
Creating Vertical Alignment

For example:
- **Safest Medical Group in the country**
- **Zero events of harm**
- **Communications required by processes and protocols**
- **“Communicate Clearly”**
  - Repeat & Read backs
  - Clarifying questions
  - Phonetic & numeric clarifications

Making Safety Come Alive
Safety Starts with Me

A – Ask
R – Request
C - Concern
C – Chain of Command

S – Stop
T – Think
A – Act
R – Review

SPEAK UP FOR SAFETY

Bozeman Deaconess HOSPITAL

S – Situation
B – Background
A – Assessment
R – Recommend

COMMUNICATE Clearly

Helen DeVos children’s hospital
Create a Safe Day

Safe Keeping
Every child, every day.
Building a Culture of Patient Safety at the Novant Medical Group
Becoming Transparent & Risk Awareness

Great catch

This success story showcases our Safety Behaviors and Tools:
More stories are listed on the Safety Moments page of the Team Up for Safety section of the Riverside Intranet.

Situations: At Riverside
Taggart Memorial Hospital, a cafeteria staff member noticed a relative warning to buy food for a patient who was on a liquid diet. The employee was also a registered nurse serving patients. She informed nursing staff, and they were able to prevent the patient from receiving the food.

Background: Patients on full liquid diet must not have solid food per physician order.

Assessment: Continue to educate family members about the dietary restrictions in the diet prescribed by physician because it is for the safety of the patient.

Recommendation: Make sure all team members know what it is that they practice a questioning attitude and get involved if things don’t seem right.

Submit your own safety story: Go to the Team Up for Safety page on the Riverside Intranet and click on Safety Moments Submission on the left.
What If?

Next Steps

- Share your lessons-learned and feedback to your colleagues in your unit and departments
- Provide feedback to your manager
- January 2015 – Leadership Education and Training
  - Directors, office managers, lead providers and clinicians
- February – March 2015 – Train the Trainer
- March – December 2015
  - Local education and training
  - Deeper dive sessions at CHA
  - Providers will be trained too!
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