

ESTABLISHING A CULTURE OF SAFETY: IS YOUR OR SAFE?

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Objectives for Today

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- Explain the role of the perioperative nurse in improving patient safety
- Describe the “top ten” problematic regulations/requirements for perioperative services
- Explain the elements of high reliability organization and critical success factors
- Describe recent changes in clinical practice and quality data that can be used to enhance patient safety

How Do You Establish a Culture of Safety

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- ❑ Top down commitment
- ❑ Commit to required investments/staff/equipment
- ❑ Create a “non punitive” approach
- ❑ Ensure disclosure of unanticipated outcomes to the pt
- ❑ Train staff in disclosure
- ❑ Use process improvement techniques
- ❑ Create paths of least resistance

A Story of Safety

Perioperative Environment

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- Patients are asleep – cannot assist in error prevention – think site side verification
- High velocity environment
- Complex environment
- OR Teams are not “true team”
- Communication is a major issue
- Safety may not be a high level committment

Commitment or Not?

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- ❑ CEO/CFO recognizes that the OR is the financial driver for the organization.....yet
- ❑ They rarely visit the OR
- ❑ Investment in “safety” is limited
- ❑ OR Leadership is torn between efficiency and mandates for safety
- ❑ Culture of punishment – get rid of the bad apple and everything will be ok
- ❑ Error reporting is limited ...so extent of safety errors may not be recognized

Quality Misalignment

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- We have made some progress
- Improvement in some measures
 - SCIP- Core Measures
- Evidence of improvement is scattered
 - Mark a box achieve the goal
 - Is there real change and outcomes?
- Level of public attention has never been higher

Regulations...Synergies & Collisions

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UNITED NETWORK FOR ORGAN SHARING



Health Care Reform Efforts: Improving Quality and Reducing Cost

□ Financial

- Beginning October 2014, hospitals with high HAC rates will be penalized 1% of their total Medicare payments
- 1% represents a \$6M loss in revenue to AMC

□ Reputation

- Loss of trust and patient confidence in staff
- HAC rates will be publicly reported on Hospital Compare

□ Regulatory Compliance

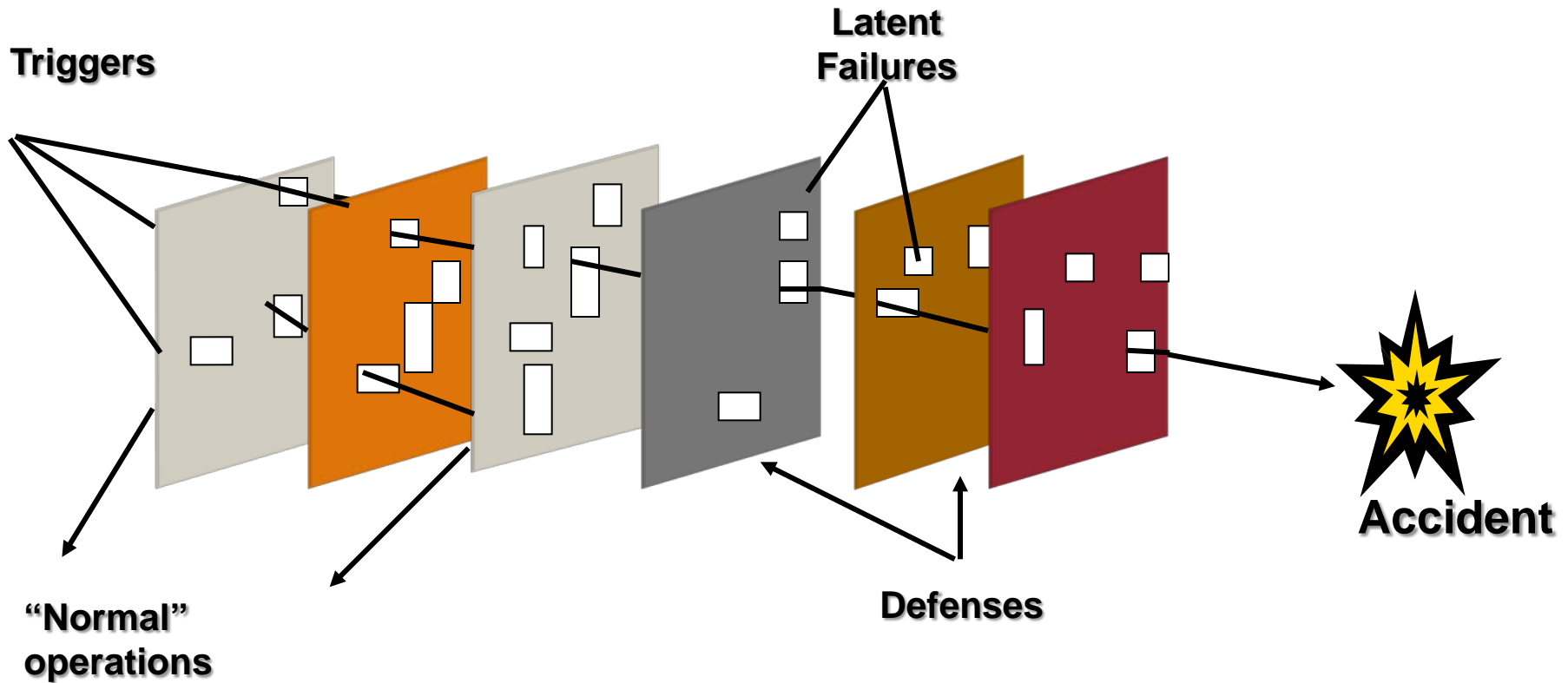
- Patient complaints involving HACs can be used to trigger CMS or Joint Commission survey

WHEN THINGS WERE SIMPLE.....



FROM SIMPLE TO COMPLEX.....





Complex systems fail because of the combination of multiple small failures, each individually insufficient to cause an accident. These failures are *latent* in the system and their pattern changes over time.

Error is Inevitable Because of Human Limitations



- ❑ Limited memory capacity – 5-7 pieces of information in short term memory
- ❑ Negative effects of stress – leads to increased error rates
- ❑ Fatigue and other physiological factors
- ❑ Limited ability to multitask – cell phones and driving-cell phones/texting in the OR

Mistakes Even Happen At Elite Hospitals

St. Joe's fined in wrong-site surgery

by James T. Mulder / The Post-Standard

Tuesday September 16, 2008, 8:41 PM

SYRACUSE, NY -- The state has fined St. Joseph's Hospital Health Center \$6,000 for operating on the wrong hip of a patient.



Man's Surgery Performed On The Wrong Ankle

(CBS) A Minnesota man is permanently disabled because of a medical mistake at a Twin Cities hospital when a surgeon operated on the wrong body part. Surgical mistakes like that happened more than 200 times in Minnesota over the last five years.

"In 2008, this is one of those things that really just should not happen," said the patient's attorney Reid Rechmiller.

After years of pain from a warehouse work injury, a 57-year-old Minneapolis man, who didn't want to be identified, decided to let doctors fuse his right ankle solidly together. His surgeon even signed the ankle with permanent marker moments before the operation last month.

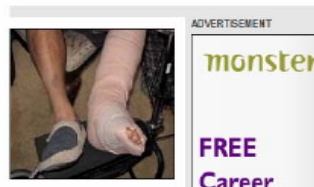
Yet still, the surgeon somehow, cut into and irreversibly locked together the bones in his healthy left ankle.

"We can't have this happen again. It's devastating for the patient and for our staff," said HealthEast Medical Director Robert Beck, M.D.

Beck is the medical director for all of HealthEast's Hospitals, including St. Johns in Maplewood, Minn., where the operation took place. He said any one of the operating room staff could have spoken up and prevented the error.

"Over time people can get a little lax and we think that's probably what had happened," Beck said.

In reviewing this case, Beck said every person in that operating room did exactly what they were supposed to do according to safety procedures. And yet, he said, they didn't take those



- ❖ Jessica Santillan
- ❖ Ben Kolb
- ❖ Quaid Twins

Learn From Others' Mistakes

- Near Misses
- Adverse events on other units or at other sites
- Events at other hospitals
- Sentinel Event Alerts
- “Don’t Let This Happen To Us”
 - vs “This Could Never Happen to Us”
 - or “This Hasn’t Happened to Us Yet”



What will we cover today

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- HAC's
- Retained Foreign Objects
- Patient Verification/Identification
- Medication Safety
- Universal Protocol
- Communication among care givers
- HAI's
- Tips for a safer OR/Perioperative Setting
- High Reliability for Our Patient's

What are Hospital Acquired Conditions (HACs)?

- HAC is a condition that a patient developed during his/her hospital stay for which there are care guidelines and protocols that makes this condition **reasonably preventable**
- A serious adverse event is an **error in medical care** that is clearly identifiable, preventable, has serious consequences for a patient, and represents a real problem in the safety and credibility of a health care facility

What Can You Do?

- **Understanding Breaks in Process**
 - Thorough case review and root cause analysis
 - Feedback from front-line staff
 - Process change
- **Quality Initiatives**
 - Reducing infections, pressure ulcers, falls, retained foreign bodies
- **HAC Workgroup**
 - Interdisciplinary team that reviews monthly HAC cases
- **Documentation Improvement**
 - Conditions “present on admission” are not counted as a HAC

RETAINED FOREIGN BODY



Scenario

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- In 2000, doctors at the University of Washington Medical Center removed a tumor from Donald Church's abdomen. But something wasn't right.
- "As soon as I got home, I was like, what the heck, I couldn't eat, I was in pain," he said. "I said, 'Oh my gosh, what is going on here, this is terrible.'"
- After two months of agony, Church got an apologetic call from his surgeon. A surgical instrument, 13 inches long and an inch and a half wide, had been left inside his midsection.

Gossypiboma (GAWS-i-puh-boh-muh)

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- This is the technical term for a surgical sponge accidentally left inside a patient's body. It is derived from the Latin word "gossypium" (cotton) and the Swahili word "boma" (place of concealment)



On cross section, it is clear that the "mass" is actually a piece of retained surgical gauze around which a fibrous capsule has formed.

Making it Real

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- 88% of cases that had an RFO had a documented correct surgical counts - 70% of RFOs are sponges
- Legal settlements - \$250,000 average, up to \$10,000,000 (January 2008 – Macon, GA)
1 in 5,500 procedures – some sources document as high as 1 in 1,500 procedures
- RFO is the most common adverse surgical event reported
- Evolving public reporting (access to) of these events

Common Retained Objects

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- ❑ Sponges, laps, towels (most common - 70%)
- ❑ Cottonoids, peanut sponges, dissectors
- ❑ Needles, Instruments, Cautery scratch pads
- ❑ Guide wires, Device tips, Vessel loops
- ❑ Suture Boots
- ❑ Packaging components – activation prevention parts
- ❑ Potentially anything on the sterile field can be left behind



Most common body cavity:
Abdomen
Pelvis

Reported cases:
Vagina
Thorax
Spinal Canal
Face
Brain
Extremities



Many Professional Organizations Guidelines

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- Association of Operating Room Nurses (**AORN**)
- The Joint Commission (**TJC**)
- American College of Surgeons (**ACS**)
- Institute for Clinical Systems Improvement (**ICSI**)
- Veterans Health Administration (**VHA**)

Counting Protocols

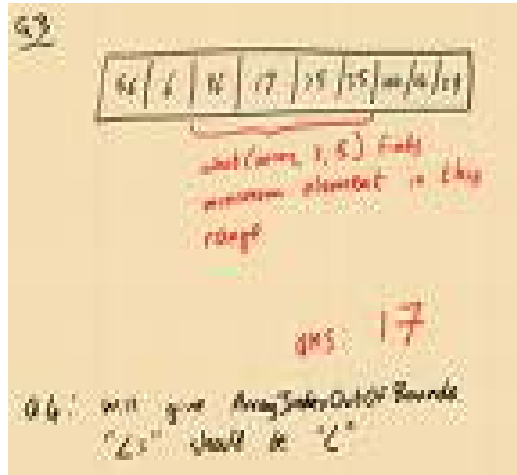
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- Sponge counting protocols:
 - ▣ Date to the 1940's
 - ▣ Have utilized racks, carousels, mats and plastic bags
- AORN protocols:
 - ▣ Were established in 1976 – Recommended guidelines
 - ▣ Policies and procedures are developed by hospitals based on their interpretation of the recommendations
 - ▣ Policies vary from facility to facility
 - ▣ Not everyone requires counts on ALL items for ALL procedures
- More & more items are being added to count protocols but sponges still remain the #1 item left behind – 70%

Typical Count Technology Used Today

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- Supplies are managed by Materials Management with bar code technology but Nursing has different technology available...



Whiteboards



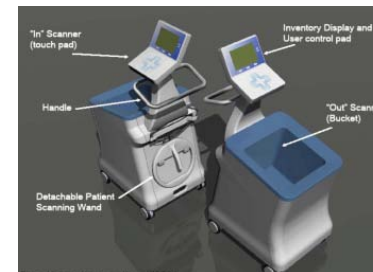
Handwritten Notes

All currently available new technology is intended to supplement manual counts, not replace them

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Current Solutions:

- Bar Coding Technology- Computer assisted counting using serialized data matrix bar-coded product
- RF (Radio Frequency) Technology- Non-serialized RF detection
- RFID (Radio Frequency Identification) Technology- Computer assisted counting and detection using serialized RFID product



What Can You Do?

- **Accurate Documentation in Medical Record**
 - Accuracy of conditions “present on admission” (e.g., pressure ulcers, infections)
- **Safety “Always”**
 - No shortcuts in processes
 - Intervene, involve supervisor, report in hospital event reporting system
- **Teamwork**
 - Hand-off Communication – is a patient at risk for a fall or pressure ulcer?
- **Compliance**
 - Understand and follow policies and protocols

PATIENT VERIFICATION / PATIENT IDENTIFICATION



Patient Identification

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- NPSG.01.01.01: Use at least two patient identifiers when providing care, treatment and services.

- *Applies to: Ambulatory, Behavioral Health Care, Critical Access Hospital, Home Care, Hospital, Lab, Long Term Care, Office-Based Surgery*

- NPSG.01.03.01: Eliminate transfusion errors related to patient misidentification.
 - *Applies to: Ambulatory, Critical Access Hospital, Hospital, Office-Based Surgery*

Why Pt ID



- There is room for improvement in patient verification across all areas of the hospital, units, and functions, as evidenced by recent focus groups, interviews/observations, and events reported
- The program elements include
 - Policies
 - Systems and tools
 - Metrics
 - Education
 - Culture

Guiding Principals

- Create an environment supporting correct patient verification 100% of the time
- Ensure proper systems, policies, and practices are in place
- Educate 100% of the staff who work with patients and/or patient information
- Recognize that getting to 100% patient verification will require changing mindsets and behaviors as well as policies and processes

Guiding Principals cont.

- Be consistent across all of sites, but recognize the nature of the work done by different units and functions will require varying emphasis
- Make performance measurements transparent in order to highlight places that are performing well and identify issues that require continual improvement
- Update on a regular basis to adapt to a changing environment

Six Types of Wristband Errors



- ❑ Absent wristband
- ❑ Wrong wristband i.e. another patient's wristband
- ❑ More than one wristband – wrist bands contain conflicting information
- ❑ Partial missing information on the wristband
- ❑ Erroneous information on the wristband
- ❑ Illegible identifiable information on the wristband

Key Components

CHECK

- Always use 2 unique identifiers
- For patients who wear ID bands use:
(1) full name and (2) medical record number
- For patients who do not need to wear ID bands use:
(1) full name and (2) date of birth

Key Components

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CONFIRM

- Before every test, procedure, treatment, medication, etc.
- Match both patient identifiers to a second source to verify the intended treatment (e.g. medical record label, MAR, meal ticket, specimen label, patient list or order)

Key Components

COMMUNICATE

- In person or over the telephone, always use the two (2) identifiers
- Get readback verification: ask person receiving the patient information to read back to you the patient's name and MR number (two unique identifiers)

COMPARE TWO UNIQUE IDENTIFIERS (Name and MRN / Name and DOB) TO A SECOND SOURCE

<i>CLINICAL CARE</i>	<i>TWO UNIQUE IDENTIFIERS COMPARED WITH:</i>
Test/procedure or treatment	Order, requisition or prescription
Medication Administration	Medication administration record, Medex view, medication order
Breast milk	Label on breast milk
Blood/blood product administration	Blood bag label & blood bag crossmatch or component derivative tag
Venipuncture/specimen	Lab requisition or prescription and label
Patient meals/diet	Meal ticket
Patient transport	Patient tracking request and medical record accompanying patient
Medical rounds	Unit census list

In Practice

- “Source Documents”: Use of source documents such as patient lists. The ID band and “source document” accomplish the verification - not the patient stating their name in an in-patient setting.
- Include the Patient in the process:
Posters in the outpatient areas explaining the process and that they will be asked multiple times during the visit: name and Date Of Birth

Re-Design The Process

Make It Easier For Everyone

NEW ID Band

NEW ID BAND

And Remember- Who's Who

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MEDICATION SAFETY



Reconcile Medications

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- Accurately and completely reconcile medications across the continuum of care

Medication Safety

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Improve the safety of using medications.

- NPSG.03.04.01: Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

- Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions **ON** and **OFF** the sterile field.
- **Includes all medications, solutions, and containers:**
 - **Even if there is only one**
 - **Even if it is “obvious”**
 - **Even anesthesia medications**



Rationale

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Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers

- ❑ **Medications or other solutions in the unlabeled containers are unidentifiable**



Which one is the heparin?

It Does Happen

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- **During coil placement under cerebral angiography to repair a brain aneurysm, a 69 year old patient was accidentally injected with an antiseptic skin prep solution, chlorhexidine, instead of contrast media. Both solutions were clear and available on the sterile field in unlabeled basins. Patient died a few days later**
- **Seven-year old boy died due to a mix-up in which he was inadvertently injected with epinephrine 1:1,000 instead of lidocaine 1% with epinephrine 1:100,000 at the start of a routine surgical procedure**
- **Patient received lidocaine instead of contrast media during angiography, leading to a grand mal seizure**

How are medications documented?

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- ✓ Marcaine .25%
- ✓ .25% bupivacaine
- ✓ 0.25% Marcaine
- ✓ Bupivacaine 0.25%
- ✓ 0.25% Sensorcaine
- ✓ 0.25% bup.
- ✓ Marcaine 0.25%
- ✓ Bupivacaine .25%

Sources of Error

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- ❑ Instructions
- ❑ Abbreviations
- ❑ Timely updates
- ❑ High risk drugs
- ❑ Zero to the left of a decimal
- ❑ Non-metric units
- ❑ Similar drug names

▪ Dawson A, Orsini MJ, Cooper MR, Wollenburg KG. *Medication safety- Reliability of preference cards. AORN J 82. (September 2005) 399 – 414.*

What Should Be on the Label?

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- ❑ Required for **all** settings:
- ❑ Mediation name
- ❑ Strength
- ❑ Quantity
- ❑ Diluent and volume (if not apparent from the container)
- ❑ Preparation date
- ❑ Expiration date when not used within 24 hours
- ❑ Expiration time when expiration occurs in less than 24 hours
- ❑ Verify all medication or solutions labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will administer it.

Medication Safety

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- NPSG.03.05.01: Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

HEALTH CARE ASSOCIATED INFECTIONS



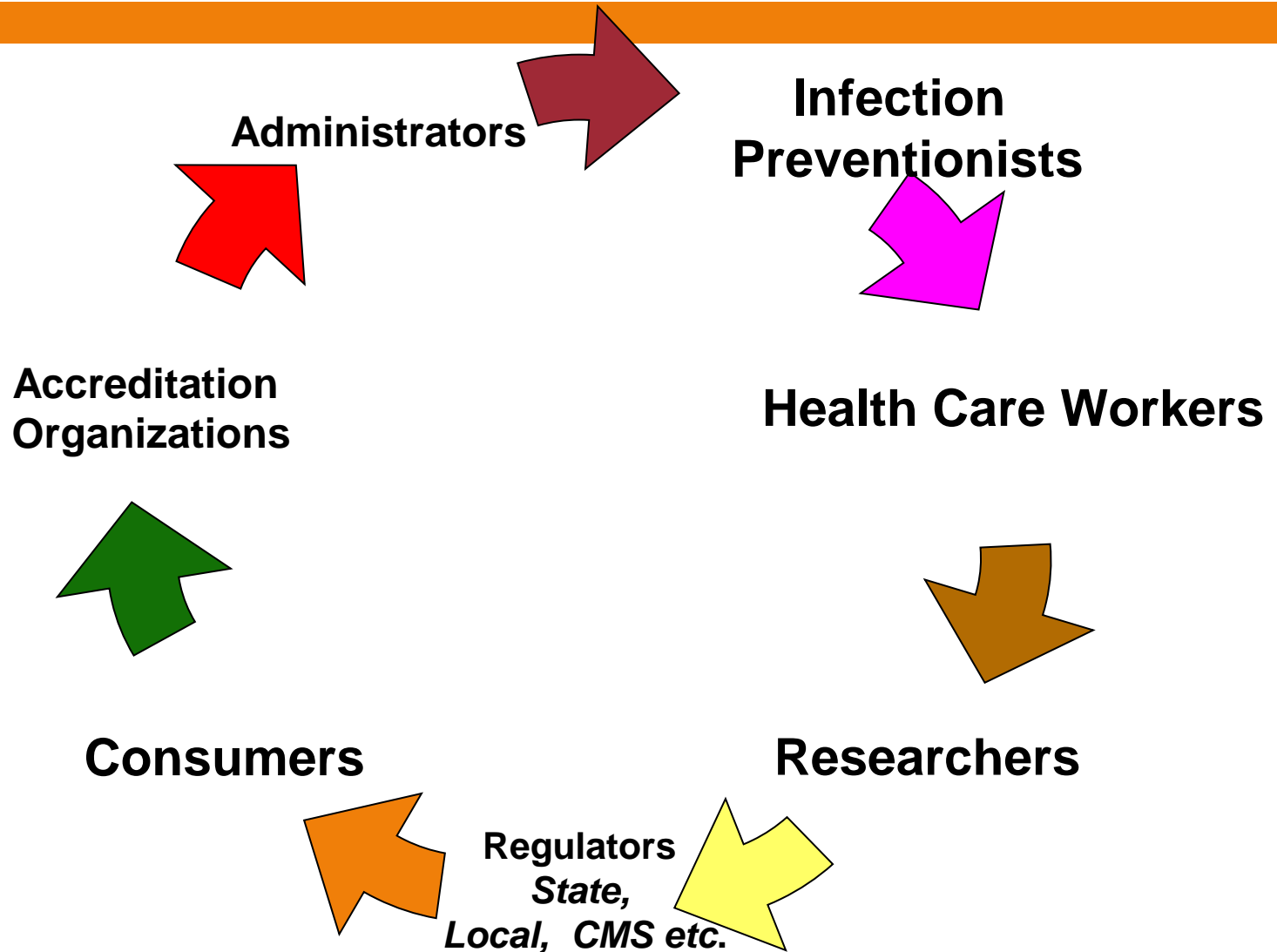
THE JOINT COMMISSION HEALTH CARE ASSOCIATED INFECTIONS



Joint Commission Standards

- In 2011 the JC has 93 distinct Infection Prevention & Control standards and the NPSG focus on preventing HAIs
- Thirty-two of these standards are C elements and require data to demonstrate 90% compliance
- Eighteen of the C element standards are **Direct Impact** on patient care
- Not meeting these standards can result in a recommendation for Conditional Accreditation or Preliminary Denial of Accreditation
- Most importantly the Leadership standards emphasizes that infection prevention is everyone's responsibility from leadership down to staff

So Who is Preventing Infections??



Why Infection Prevention?

- 5% of hospitalized patients in the U.S. develop healthcare-acquired infections each year.
- 90,000 patients die as a result.

Infection Prevention is Our Goal!



Costs of Infections

- Charges to Patient
- Conversion from Charges to Hospital Costs
- Actual Cost to Consumer
- Ethical consideration
- Reputation to health care providers

Cost of Resistant HAIs

Antimicrobial resistant HAIs may have higher costs of :

- ▣ \$6,000- \$30,000/patient²
- ▣ \$2,294 - \$259,385³

²Maragakis, LL, Perencevich, EN, Cosgrove, SE, *Clinical and economic burden of antimicrobial therapy* “ Expert Rev Anti Infect Ther. 2008 Oct;6(5):751-63.

³Cohen, BC, Stone, PW, Neidell, M, PhD, Glied, S., PhD., *Variation in Estimates of the Cost of Resistant Infections*, Medical Care, 2010 Sept. 48(a)

Prevention of Healthcare Associated-Infections: Shouldn't we have zero tolerance?

- ❑ UTI
- ❑ Pneumonia
- ❑ Bloodstream Infection
- ❑ Surgical Site Infection
- ❑ Multi-drug Resistant Organisms



Health Care-Associated Infections

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- Reduce the risk of health care-associated infections
- NPSG.07.01.01: Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.

Health Care-Associated Infections

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- NPSG.07.03.01: Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care organizations.
- NPSG.07.04.01: Implement evidence-based practices to prevent central line-associated bloodstream infections.



Patient Safety



hand hygiene saves lives

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
SAFER • HEALTHIER • PEOPLE™

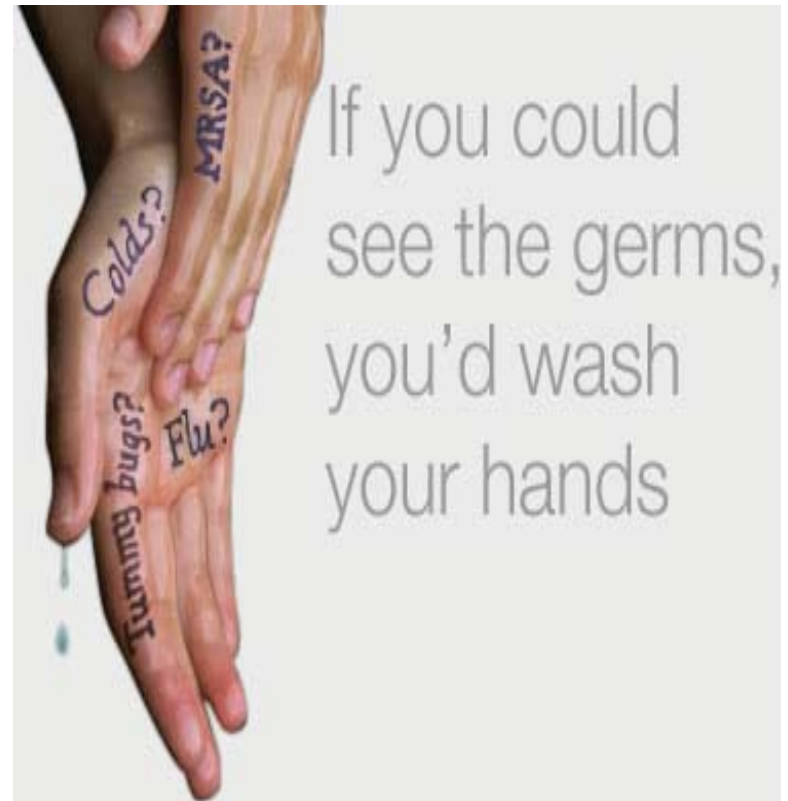
What Do We Mean By Hand Hygiene?



- Hand de-germing
- Hand washing
- Surgical hand preparation

Hand Hygiene Opportunities

- ❑ Before patient contact, even if gloves are worn
- ❑ After patient contact
- ❑ After touching equipment or environmental surfaces
- ❑ After removing gloves



Hand De-Germing

Alcohol-Based Hand Gel or Foam

Alcohol is well documented as an effective means to reduce bacterial counts on hands

In other words, it works!

It's the method of choice for hand hygiene (but there are exceptions—stay tuned!)

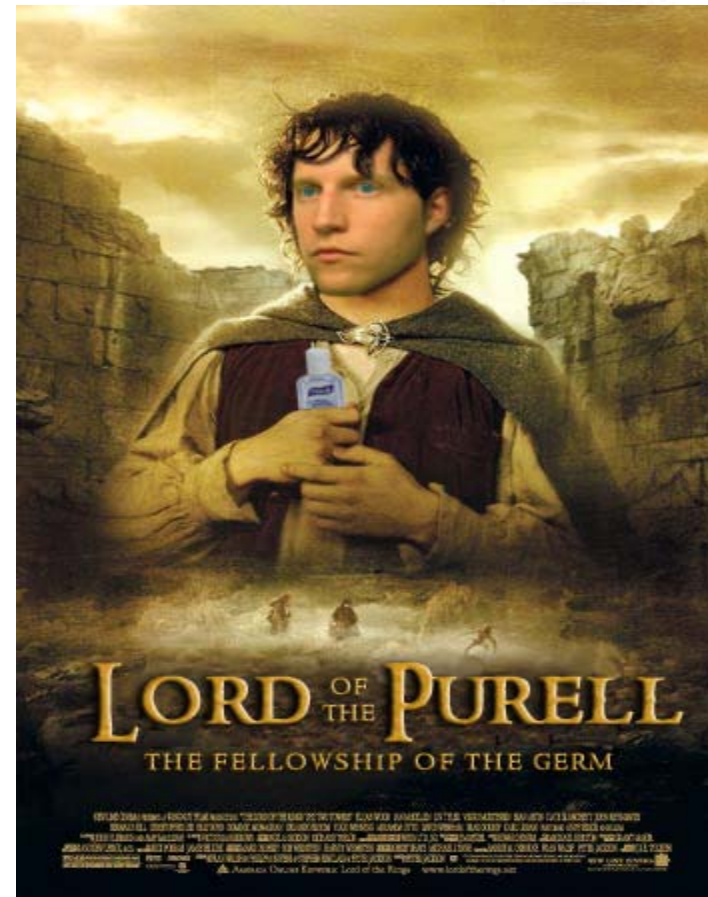


Dr. Einstein: Using an alcohol-based sanitizer is the smart thing to do!

Alcohol Hand Sanitizer

How to use:

- ▣ Dispense enough of the product to cover the surfaces of the hands and fingers,
- ▣ And under fingernails
- ▣ Rub hands together
- ▣ Until dry



Hand Hygiene

- A standardized surgical hand scrub procedure should include:
 - Removal of jewellery
 - Don a surgical mask
 - If hands are visibly soiled, prewash with soap and water or antimicrobial agent
 - Clean subungual areas of both hands under running water
 - Rinse hands and forearms under running water

HandHygiene

- When using an alcohol-based surgical hand rub:
 - Dry hands and forearms after rinsing
 - Dispense the surgical hand rub product
 - Apply product to hands and forearms
 - Repeat as directed
 - Rub thoroughly until completely dry

Hand Hygiene

- When performing a traditional surgical hand scrub:
 - Dispense the antimicrobial scrub agent
 - Apply the agent to wet hands and forearms using a soft, nonabrasive sponge
 - A three or five minute scrub should be timed to allow adequate product contact with skin
 - Visualize each finger, hand and arm as having four sides and wash all four sides effectively
 - Rinse hands and arms under running water in one direction from fingertips to elbows
 - Hold hands higher than elbows and away from scrubs

NYPH Approach: Sanitarians

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- ❑ The Sanitarians (aka: mystery observers) conduct anonymous rounds on all hospital in-patient units and patient's participate in all ambulatory settings
- ❑ Data recorded in Palm Pilots
- ❑ Monthly observations
- ❑ Monthly reports on the Hospital Infonet
- ❑ Healthy competition
- ❑ Peer Pressure



Health Care-Associated Infections

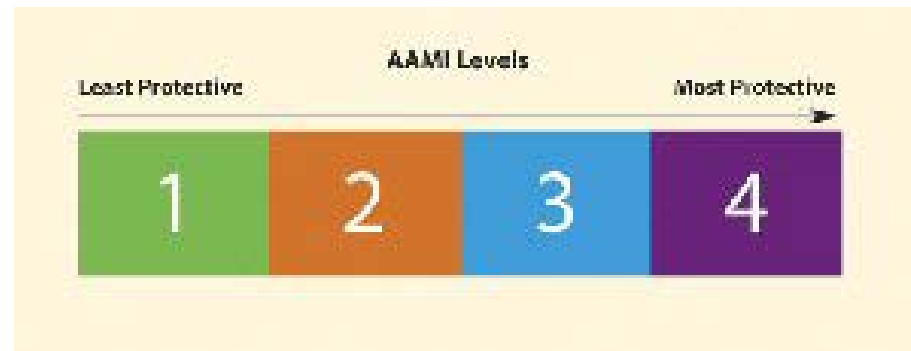
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- NPSG.07.05.01: Implement evidence-based practices for preventing surgical site infections.

AAMI Standards

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- The AAMI Standard classifies surgical gowns into four categories based on their liquid barrier performance using a combination of industry standard tests Level 1 is the lowest level of protection, while Level 4 is the highest level, offering impervious protection
- Over 100 technical components and working groups that produce these standards, recommendations and practices, technical information for medical devices



To Gown or Not to Gown cont

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- All health care personnel who participate in invasive procedures should routinely use appropriate barrier precautions to prevent skin and mucous membrane contact with blood and body fluids of all patients
- Sterile barrier equipment should be used as appropriate
- Hand washing using an antimicrobial cleansing agent should be performed prior to the performance of any invasive procedure
- Sterile gloves must be worn for all invasive procedures.
- Surgical masks should be worn for all invasive procedures

Draping Requirements and Standards

- All drapes should be AAMI Level 4 (impervious around the fenestration), there are a number of other important factors that should be taken into account when selecting drapes, including:
 - **Size and design** – Because coverage of the patient is critical to creating an appropriate sterile field, the size and proportion of the drape is very important to consider. Procedure-specific drapes should cover the patient entirely, from the finger tips to the toes. Any areas not covered by the drape should be covered with additional non-fenestrated drapes

Appropriate Draping for the Procedure

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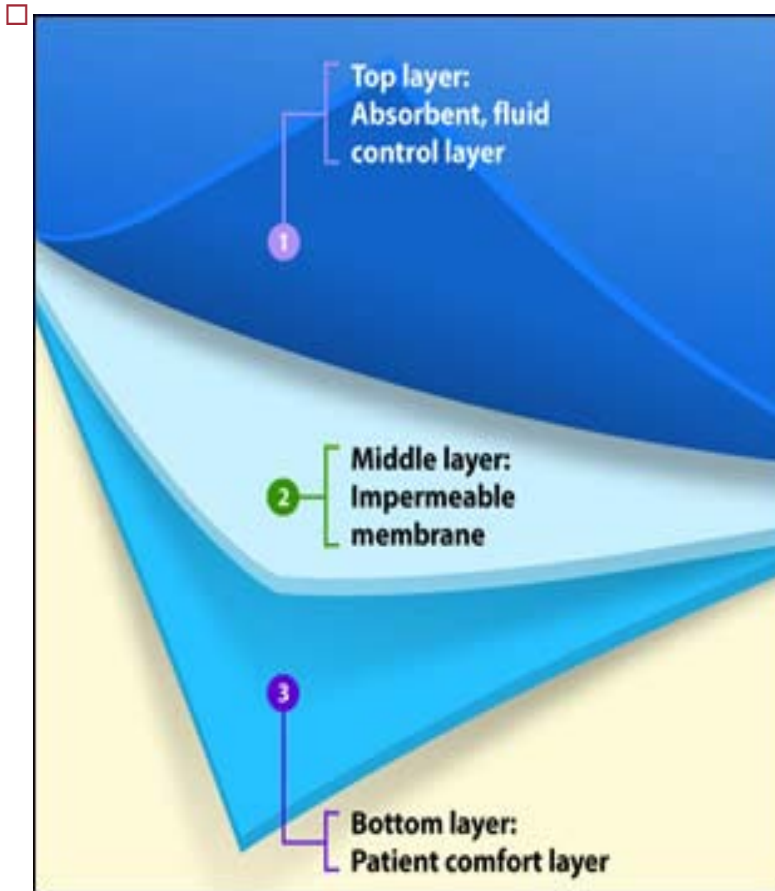
Controlling Fluids

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- **Fluid direction or control** – There are a number of features on surgical drapes that enable fluid management
- The first of these mechanisms is the reinforcement around the fenestration, which should absorb fluid fast enough to prevent it from reaching the base fabric of the drape and be large enough to hold a sufficient amount of fluid so that it doesn't reach capacity
- Other important fluid management features of drapes are pouches and troughs, which vary in size and shape by procedure and often contain ports that allow for a suction hose to be attached to remove fluid from the surgical field."

Industry Standards

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- Engineered to pass the industry standard tests that measure fluid and synthetic viral penetration, which helps to provide the maximum in clinical and patient safety
- Is resistant to abrasion and puncture, yet its flexible, cloth-like properties allow it to drape naturally, following the contours of the patient
- Classified as a level 4 device under the new AAMI guidelines for barrier performance

FLUID MANAGEMENT



- ☑ In 1988, improperly disposed medical debris washed up on beaches in New Jersey. This spurred Congress to enact the Medical Waste Tracking Act.
- ☑ EPA estimates that there are approximately 1 million medical waste generators in the United States who produce 4 million tons of medical waste each year.
- ☑ Included in those 4 million tons of medical waste produced annually is 500,000 tons of “infectious” medical waste.
- ☑ In August 2000, several beaches in Nassau County, New York were closed because of needles and other medical-related debris found along the shoreline.

Requirements

- Disposing of liquid waste is a task that every facility must perform with an eye toward efficiency and cost effectiveness while protecting healthcare workers (HCWs) from exposure to potentially infectious agents

Definition of **Regulated Medical Waste (RMW)**:

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Regulated Medical Waste is a subset of all medical wastes and include seven distinct categories:

1. Cultures and stocks of infectious agents.
2. Human pathological wastes (e.g. tissues, body parts)
3. Human blood and blood products
4. Sharps (e.g. hypodermic needles and syringes)
5. Certain animal wastes
6. Certain isolation wastes (e.g. wastes from patients with highly communicable diseases)
7. Unused sharps.



OSHA/CDC

RMW can not be mixed with Non Regulated Waste

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What Are The 4 Routes of Exposure?

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- Absorption
- Ingestion
- Inhalation
- Injection

EXPOSURE CONTROL PLAN

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- ✓ Required when employees may be exposed to blood borne pathogens.

- ✓ This plan includes:
 - ▣ Determination of employee exposure
 - ▣ Implementation of methods of exposure control, including:
 - Universal precautions
 - Engineering and work practice controls
 - Personal protective equipment
 - Housekeeping
 - ▣ Hepatitis B vaccination
 - ▣ Post-exposure evaluation and follow-up
 - ▣ Communication of hazards to employees and training
 - ▣ Record keeping
 - ▣ Procedures for evaluating the exposure incident.

What do we mean by “good fluid management”?

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Closed Systems are Safer

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- Fluid trap shutoff valve
- Overflow protection
- Three-stage, HEPA-rated air filter

IMPROVE COMMUNICATION



Improve Communication

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Goal 2:

Improve the effectiveness of communication among caregivers.

- NPSG.02.03.01: Report critical results of tests and diagnostic procedures on a timely basis.

Reporting Communication Errors

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- Patients being brought to the OR without proper identification
- Discrepancies between OR schedule and the consent form
- Site markings being done without the patient's or surgeon's involvement
- Regional blocks being performed on the wrong side
- Surgery being performed without original diagnostic test results or films available
- Time outs being performed with team members present, while the surgeon is in the next OR finishing another case
- Site markings obscured by surgical drapes during the time out

**Dangerous
Practices
Staff
Beware!**

Speak-Up for Safety using ARCC

Use the lightest touch possible...

Ask a question

Request a change

Voice a **C**oncern

Chain of command

When asserting, use a safe word such as concern or safety
If not, then use chain of command

Option: More smart talk in tough times

- CUS words
 - ▣ Concerned – “I’m concerned”
 - ▣ Uncomfortable – “I’m uncomfortable”
 - ▣ Scared – “I don’t think this is right?!”

- “Help me to understand”

- “I need some clarification”

Clarifying Questions

Ask 1 to 2 clarifying questions

When in *high-risk* situations

When information is *incomplete*

When information is *ambiguous*



WHY: To reduce the probability of making a wrong assumption. Asking clarifying questions reduces the risk by 2 1/2 times!!

HOW: Phrase your clarifying questions in a positive way and in a manner that will get an answer that improves your understanding of the information

Briefings and Debriefs

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- Enhance operational efficiency
- Provide a shared mental model
- Provide the ability to correct and adjust the clinical plan
- Help avoid – surprises!
- Q&A in an atmosphere devoid of tension

CONFLICT RESOLUTION





Does your OR look like this?

The Joint Commission Sentinel Event Alert

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Behaviors that undermine a culture of safety.....

- ❑ Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments
- ❑ Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment
- ❑ To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team

Culture of Safety and Quality- Leadership 3.01.01

(Jan 2009)

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- Leaders create and maintain a culture of safety and quality throughout the hospital
- The hospital has a code of conduct that defines acceptable and disruptive and inappropriate behaviors
 - Leaders create and implement a process for managing disruptive and inappropriate behaviors
 - Behaviors that get rewarded get repeated

Conflict Management Leadership 2.40

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The organization manages conflict between leadership groups to protect the quality and safety of care....

Profane language

Name calling

Sexual comments or inappropriate touching

Racial or ethnic jokes

Anger outbursts

Throwing instruments, charts or objects

Criticizing other care givers in front of pt/or other staff members

Deliberate failure to adhere to P&P

Failure to address safety concerns

Interventions

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- Patient safety comes first – immediate intervention may be needed
- Counsel in private-never in public
- Never when tempers are flared
- Listen, listen, listen- don't interrupt
- Share the blame if necessary
- Discuss the problem at hand not the employee
- Set future expectations – be clear
- Monitor future behaviors
- Give appropriate feedback
- Know when to get senior leadership involved

UNIVERSAL PROTOCOL



Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery

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- UP.01.01.01: Conduct a preprocedure verification process.
- UP.01.02.01: Mark the procedure site.
- UP.01.03.01: A time-out is performed before the procedure.

Universal Protocol: The Basics

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- Ensure patient safety by identifying the correct:
 - Patient
 - Surgical or Invasive Procedure
 - Site and/or Side
- Communication is **CRITICAL**
- Each team member is responsible



The JC UP Requirements

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- The Universal Protocol applies to all surgical and nonsurgical invasive procedures
- A robust approach using multiple, complementary strategies is necessary to achieve the goal of always conducting the correct procedure on the correct person, at the correct site.
- Active involvement and use of effective methods to improve communication among all members of the procedure team are important for success
- To the extent possible, the patient and, as needed, the family are involved in the process

The JC UP Requirements cont

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- The Universal Protocol is implemented most successfully in hospitals with a culture that promotes teamwork and where all individuals feel empowered to protect patient safety
- A hospital should consider its culture when designing processes to meet the Universal Protocol
- In some hospitals, it may be necessary to be more prescriptive on certain elements of the Universal Protocol or to create processes that are not specifically addressed within these requirements

Problem

The JC UP Requirements cont

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- Hospitals should identify the timing and location of the pre procedure verification and site marking based on what works best for their own unique circumstances
- Pre procedure verification, site marking, and the time-out procedures should be as consistent as possible throughout the hospital
- Note: Site marking is not required when the individual doing the procedure is continuously with the patient from the time of the decision to do the procedure through to the performance of the procedure

The Revised 10 Time Out Elements

1. Identification of the patient using two identifiers
2. Correct side/site
3. Correct procedure
4. Correct position
5. Verification that equipment and implants are available
6. Relevant images are properly labeled and displayed
7. Allergies
8. Antibiotics administered
9. Safety precautions based on fire, hazards, patient history, or medication use
10. Verbal agreement that the Time Out elements have been met

Review

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- ❑ Universal Protocol (The Joint Commission)
- ❑ NYSSIPP (New York State Surgical and Invasive Procedure Protocol)
- ❑ BOTH: For Prevention of Wrong Patient, Wrong Site, Wrong Side & Wrong Procedure Events



Is this where I make the mark?

Requirements

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Universal Protocol :

- ▣ Pre-Op verification process
- ▣ Surgical site marking
- ▣ “Time-out” immediately before procedure

NYSSIPP:

- ▣ Scheduling
- ▣ Consent
- ▣ Pre-Operative/ Pre-Procedural Verification processes
- ▣ Marking of the operative/procedural site
- ▣ Exceptions to site marking
- ▣ “Time out” immediately before the procedure
- ▣ Resolution of discrepancies/disagreements
- ▣ Compliance monitoring

What Can Go Wrong Will Go Wrong

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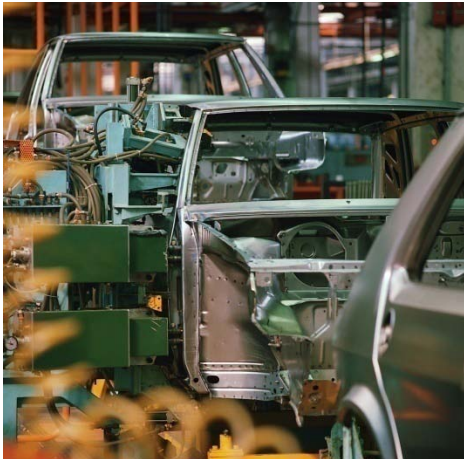
- ❑ Wrong patient, operative, side, part
- ❑ Marked incorrectly from memory
- ❑ Anesthesia blocks wrong side before time out
- ❑ Patient turned over after time out
- ❑ Failure of proper time out secondary to confirmation bias
- ❑ Wrong size or side prosthesis (IOL -R/L TKR)
- ❑ Failure to complete operation because of incomplete information

HIGH RELIABILITY



Reliability

- Reliability principles - evaluating, calculating, and improving a complex system - have been used effectively in other industries (i.e. manufacturing) to improve both safety and the rate at which a system consistently produces appropriate outcomes
- Reliability = Number of actions that achieve the intended result ÷ Total number of actions taken



High Reliability Organization

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- Safe practices
- Consistent processes
- More consistent outcomes
- Transparency
- Safety over Convenience

High Reliability Organizations

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- Safe practices
- Consistent processes
- More consistent outcomes
- Transparency
- Safety over convenience
- Merging Operations with Quality

High Reliability = “cultural change”

Accountability

HROs have a high degree of accountability when an error occurs that has severe consequences. In this respect, hospitals differ somewhat from many HROs, because medical errors tend to affect single patients rather than large groups of people at once. Moreover, despite flawless care, patients in hospitals do die, so distinguishing those whose deaths were inevitable from those whose deaths the hospital could have averted is not easy.

Hypercomplexity

HROs exist in complex environments that depend on multi team systems that must coordinate for safety. The safety of a hospitalized patient depends on the effective coordination of physicians, nurses, pharmacists, medical technicians, technicians who maintain equipment, support staff who provide meals and maintain the physical environment, and many others. Hypercomplexity describes hospitals as well as it describes nuclear power plants.

Nuclear Power Plants

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Tight Coupling

HROs consist of tightly coupled teams in which the members depend on tasks performed across their team. A safe surgery depends on the ability of nurses, medical technicians, the surgery team, housekeeping, and transport to coordinate their efforts so that the patient arrives in surgery at the right time, with the right preparation, and with the right tools and supplies available for the operation to proceed smoothly. Every hospital leader recognizes that this coordination is critical, but is often far from perfect.

Air Craft Carriers/Submarines

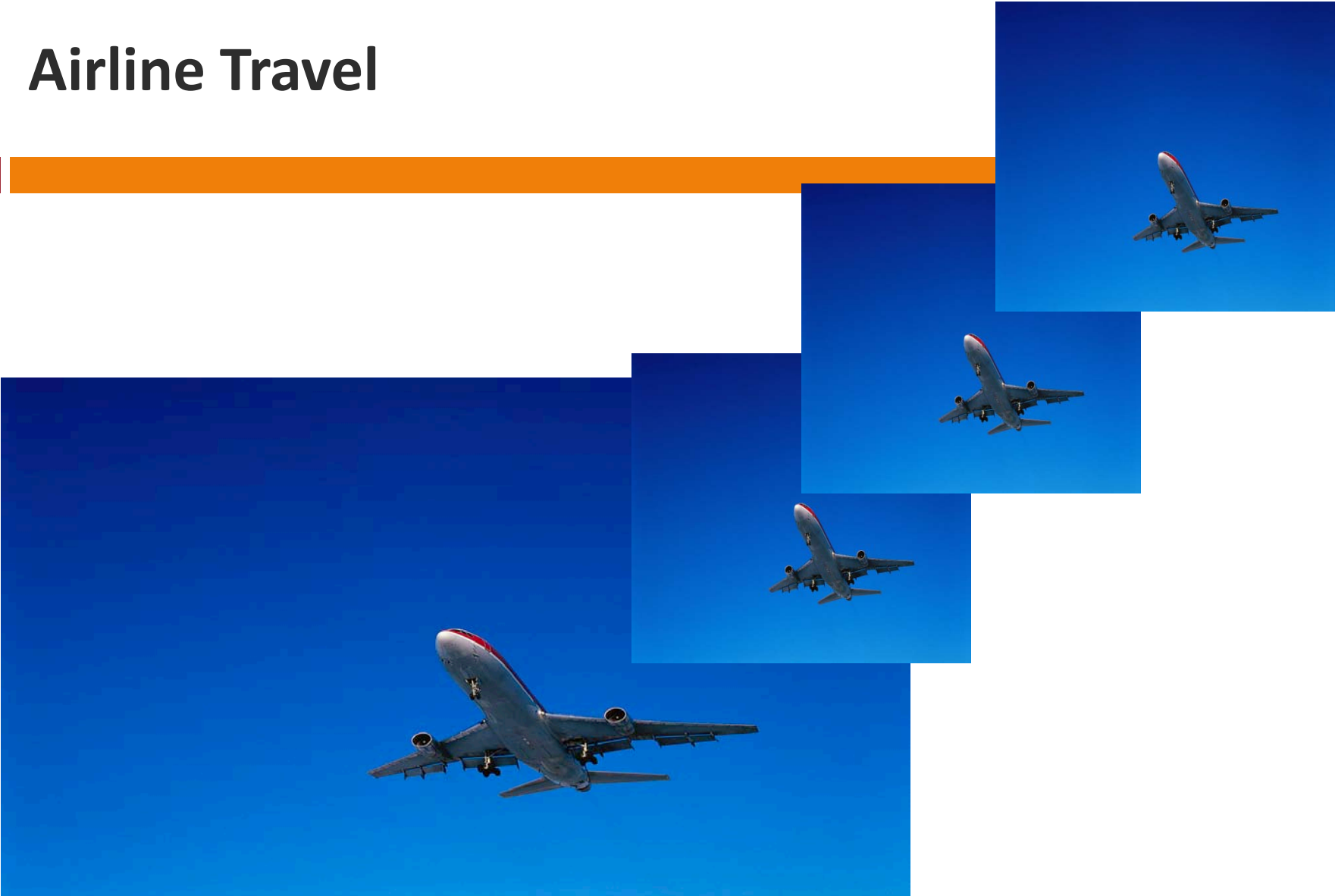
119



Extreme Hierarchical Differentiation

In HROs, roles are clearly differentiated and defined. Intensive coordination efforts are needed to keep members of the teams working cohesively. During times of crisis, however, decision making is deferred to the most knowledgeable person on the team, regardless of their position in the organization.

Airline Travel



Complex Communication Network

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HROs consist of many decision makers working to make important, interconnected decisions. Like all hospitals, HROs must develop processes that allow these decision makers to communicate effectively with each other.

Feedback

HROs exist in industries where team members must receive frequent feedback at all times. This feedback and the opportunity to make continuous adjustments based on it are essential to anticipate and avert problems before they become crises. Hospitals also are filled with equipment and personnel offering this type of feedback to staff. For them to function as HROs they need systems and a mindset that will allow people to receive and respond to feedback, rather than being overwhelmed by information.

Time Constraints

Time constraints are common to many industries, including health care. In HROs, the systems and culture allow people to identify when they lack time to reliably complete all needed tasks and obtain additional assistance. Hospital staff face the same challenge but do not always have staff with the resources and training needed to maintain high reliability when facing a significant time constraint.

**Reliability = failure-free
operation over time**



Reliability

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- Reliability principles - evaluating, calculating, and improving a complex system - have been used effectively in other industries (i.e. manufacturing) to improve both safety and the rate at which a system consistently produces appropriate outcomes.
- **Reliability = Number of actions that achieve the intended result ÷ Total number of actions taken**

Nolan T, Resar R, Haraden C, Griffin FA. Improving the Reliability of Health Care. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2004.

The Crash of US Airways Flight 1549

January 15, 2009

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Why and How?

Walk Rounds: A Leadership Management Tool

- Leadership “carries the banner of safety”
- Promote communication of patient safety issues between providers, senior leaders, and Board of Trustees
- Promote culture of patient safety
- Encourage staff to share ideas and concerns
- Create a culture where employees:
 - Feel valued
 - “What it means to me”
 - Have adequate information regarding patient safety
 - Feel that the leaders are approachable
 - Have the knowledge, tools, equipment and support to promote patient safety
 - Assume responsibility and accountability for creating a safe care environment

The Critical Elements

- A true commitment to patient safety by the organization's leaders
- Safety as a system property, not a project or initiative
- Creating an organization that builds patient safety into its fabric
- Frontline workers need to be free from blame for human factor or system flaws
- Communication and teamwork training
- Simulation
- Walk Rounds

WHAT STAFF ARE SAYING: *LEADERSHIP*

- “Senior Leadership's engagement in this indicates that we really do want to enhance our culture of safety.”
- “A strong sense of team spirit is nourished throughout hospital leadership. A good sense of humor is a strong facilitator.”
- (I like) “that management are getting out on the wards and clinics and seeing what is going on.”
- (I like) “The Management Team working together on a large scale for a common purpose. This is true team building.”

High Reliability for Our Patients

- Daily Check-Ins – short focused meetings-infonet
- Executive Rounding – visibility of senior staff on the units
- Safety Huddles – all units members focusing on safety issues they are concerned about
- Performance Management – rigorous processes/reward and recognition for desired behaviors
- Consistency/Communication/Teamwork

So, in Order to Succeed.....

- ❑ Senior leadership support and involvement
- ❑ Appropriate leader selection
- ❑ Project selection aligned with strategic initiatives
- ❑ Resource commitment
- ❑ Ongoing measurement
- ❑ Effective communication

***The future belongs to those
who see possibilities before
they become obvious***

John Sculley

Former CEO of Pepsi and Apple Computers

Questions?

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