Welcome

PATIENT SAFETY CHAMPIONS

Baptist Health South Florida

"Raising The Bar" On Patient Safety

PATIENT SAFETY IS EVERYONE'S JOB!

Why are we here?

- To learn more about BHSF's commitment to patient safety
- To further understand your role in patient safety and reducing patient injury
- To learn about BHSF's direction in creating a just culture to <u>assist providers</u> and to <u>reduce patient harm</u>

To encourage and motivate you to make a difference for patient safety

Surgical Tools Washed With Hydraulic Fluid

- Durham Regional Hospital in Durham, N.C., photographed here on Monday, June 13, 2005, is one of two hospitals run by Duke University Health System that put patients in "immediate jeopardy" last year by failing to detect that surgical instruments were being washed in used hydraulic fluid instead of detergent, a mistake that affected nearly 4,000 patients. SARA D. DAVIS

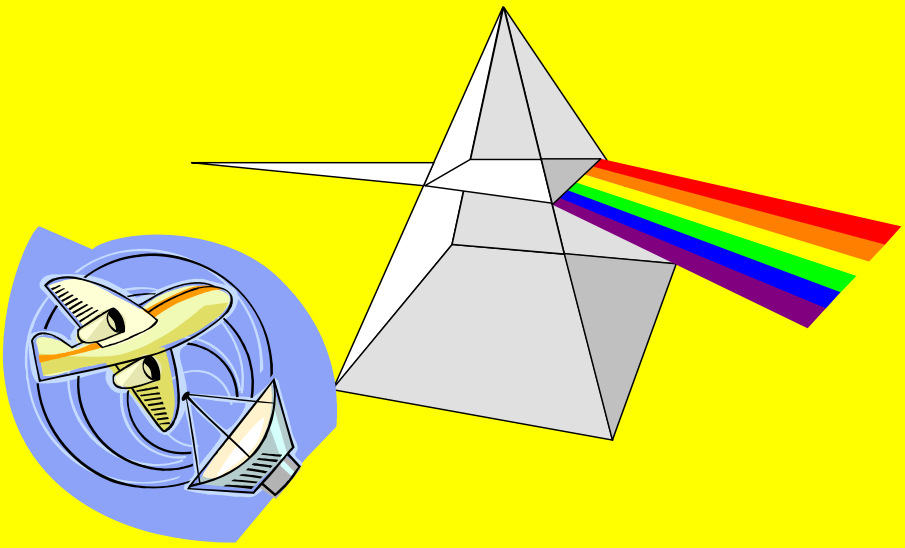
Patients may have hard time suing Duke form has arbitration clause

- Patients exposed to surgical instruments coated in hydraulic fluid at two Duke hospitals could find it difficult to take legal action.
  They might already have waived their right to sue.
  Duke University Health System hospitals ask patients, before treatment, to sign a form that says they agree to binding arbitration if a dispute over care arises. Patients aren't required to sign the forms, which are becoming more common at hospitals nationwide

Duke to Air Fluid Data: The health system responds to critics in the case of improperly washed instruments.

- Dr. Victor J. Dzau tries to dispel the fears of patients. Duke University Health System officials on Wednesday answered criticism that they have been unresponsive to concerns of patients whose surgeries were performed with instruments washed in hydraulic fluid.

Magnitude of the Problem



The IOM Numbers

- Medical error is the 8th leading cause of death in the U.S.
- Medical errors cause 98,000 deaths per year
- More people die from medical error than from breast cancer, HIV or MVAs

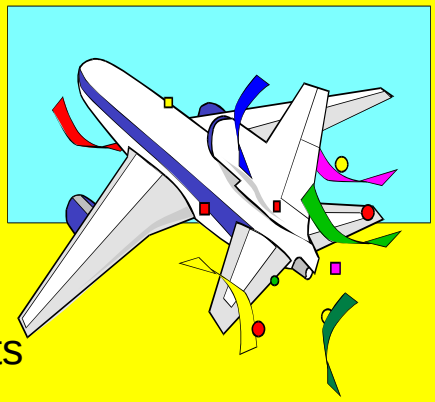
What is error?

- IOM – error – failure of a planned action to be completed as intended (error execution) or use of the wrong plan to achieve an aim (error of planning).
- Adverse Event – causes harm to the patient.
- Ke must recognize what an error is to report them.

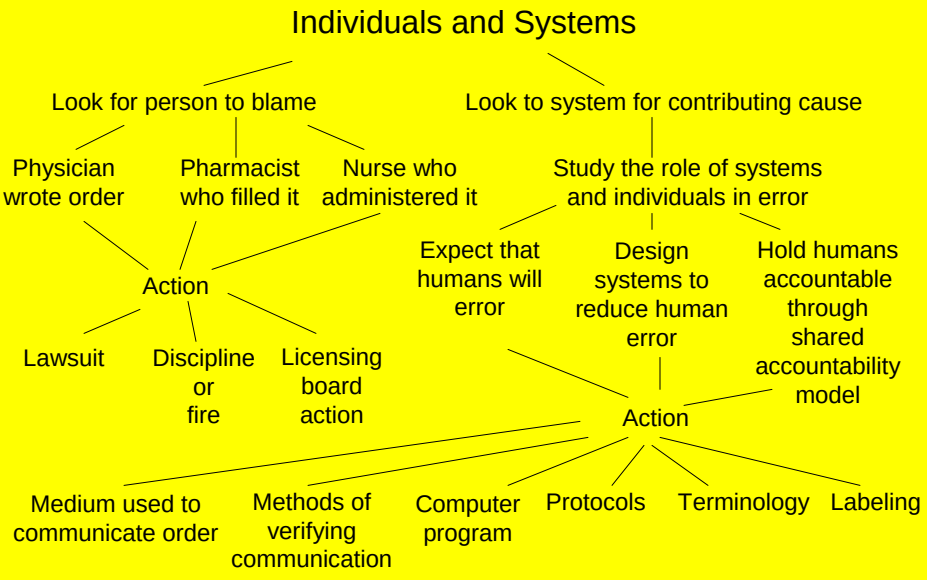
Processes

May fail & lead to Error!

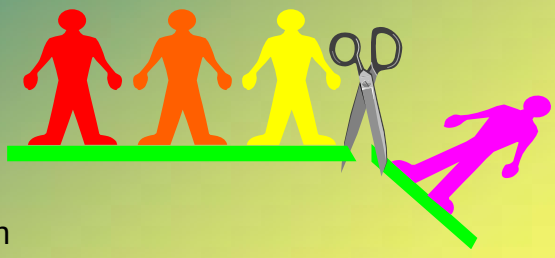
- Variable input
- Complexity
- Inconsistency
- Human Intervention
- Tight Coupling
- Tight Time constraints
- Hierarchical culture



Error – Causes/Paths



Why People Make Mistakes



- Fatigue
- Illegibility
- Using past solutions
- Inattention/Distraction
- Communication gaps
- Familiarity causing “blindness”
- Unfamiliar situations/new problems
- Equipment design flaws
- Poor working conditions
- Mislabeling/Instructions

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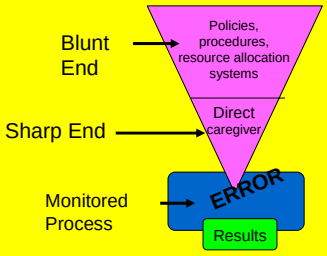
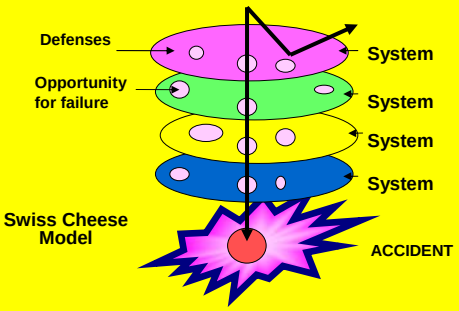
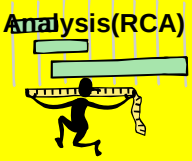
The Science of Patient Safety





Root Cause Analysis(RCA)

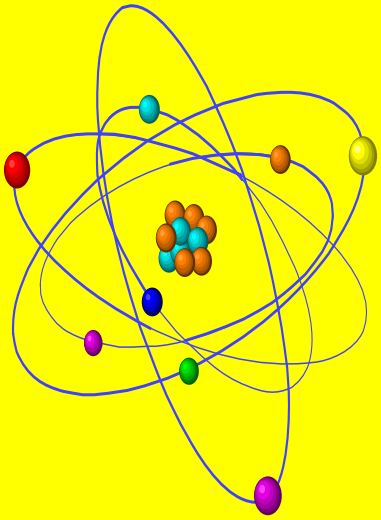


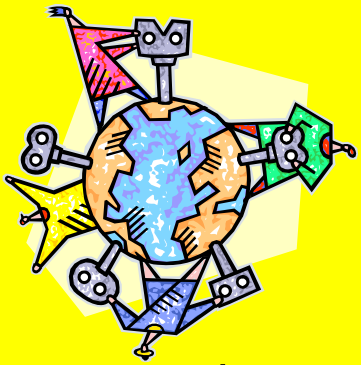
- FMEA
- Failure Mode
- Effects
- & Analysis

Creating Change & Improving Safety

Process Changes to Consider

- Simplify
- Standardize
- Reduce reliance on memory
- Checklists
- Constraints and forcing functions
- Eliminate “look alike” & “sound alike”





A "Just Culture" to Enhance Patient Safety

Baptist Health South Florida

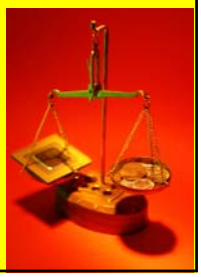
Michelle Hoppes, RN, MS, AHRMQR, DFASHRM

President

The Risk Management & Patient Safety Institute

What is a just culture?

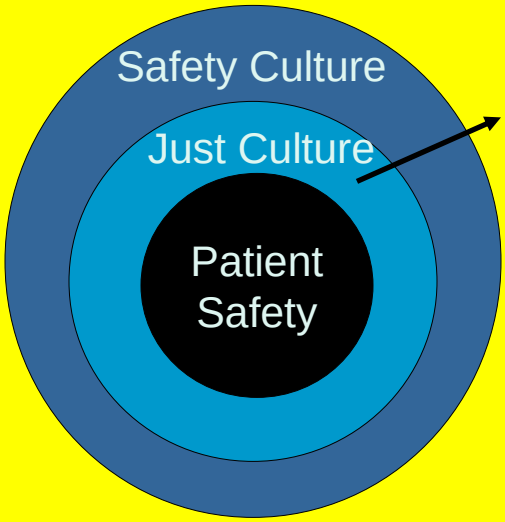
- An environment/culture/understanding of how acceptability of individual behavior is to be determined
- How accountability is evaluated
- Ultimately it is a shared accountability
- A balance between human factors, individual practice & system issues



Why have a just culture?

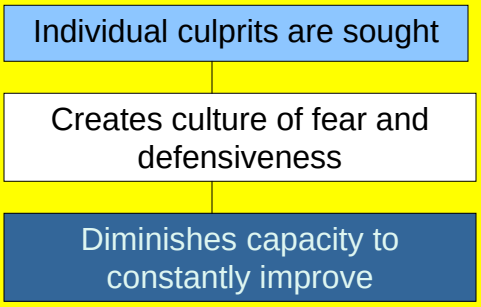
Primary key for risk identification (and ultimately patient safety) and it is the right thing to do for healthcare providers.

Just Culture – Key Component of a Safety Culture

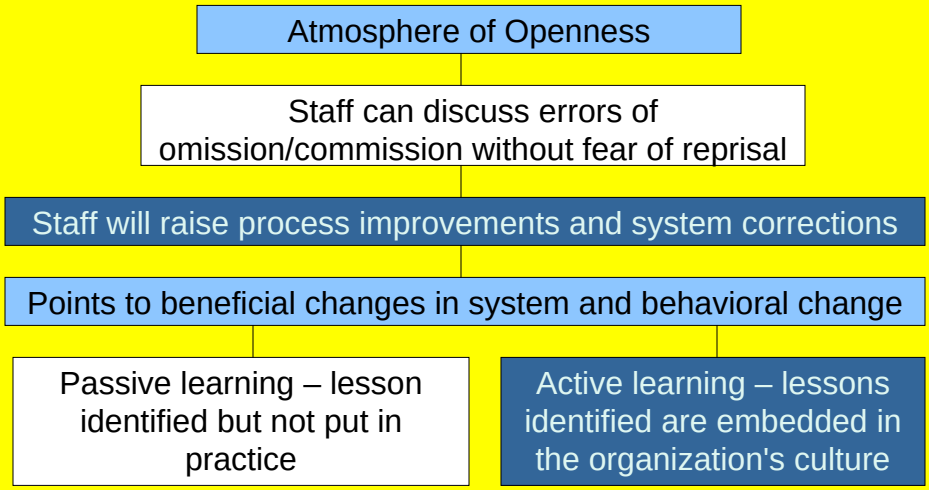


Shared understanding of how the acceptability of individual behavior is to be determined and how accountability/ culpability is evaluated. Ultimately a shared accountability.

Blaming Environment

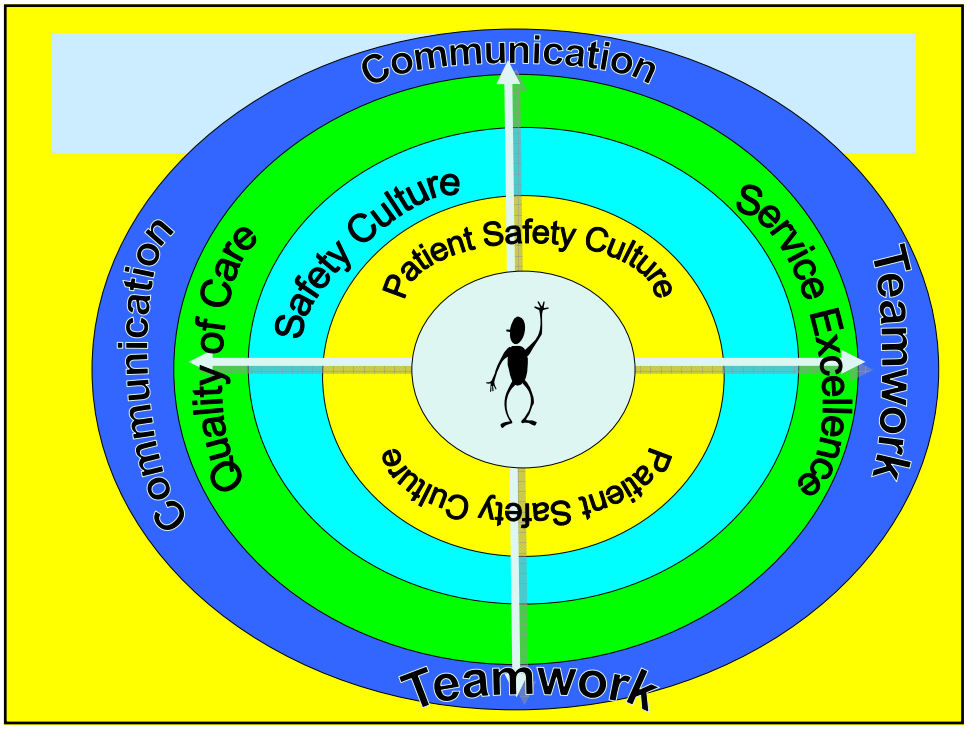


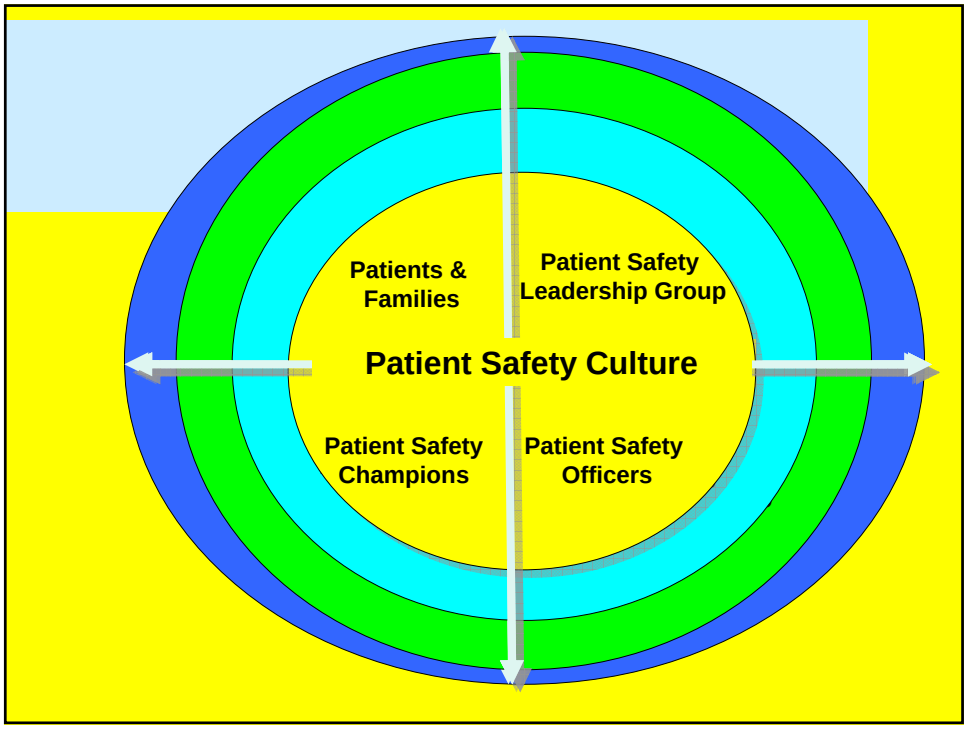
Learning Environment



Benefits of a Just Culture

- Reduces staff emotional distress, guilt and loss of confidence
- Enhanced patient satisfaction (note: patients who experience an incident require an average 3-8 extra days of hospitalization)
- A reduction of cost for treatment – a “business case for safety”
- Increased reporting in an environment where staff do not fear placing themselves or colleagues in risk of punishment
- Establishes a framework for assessing culpability
- Resources allocated more effectively on targeted trends





Guiding Principles for Patient Safety

- ✓ *Safety First*
- ✓ *Reporting Errors and Equipment or System Failures*
- ✓ *Teamwork*
- ✓ *Fail Safe Approaches*
- ✓ *National Patient Safety Goals*
- ✓ *Standardization*

PATIENT SAFETY IS EVERYONE'S JOB!

6 Key Patient Safety Concepts

- Work within your scope of practice and job description.
- “Stop – the - Line”
- Know your chain of command
- Get back to basics.
- Work to build an effective team.
- If you don’t know – ask!

“Medical errors most often result from a complex interplay of multiple factors. Only rarely are they due to the carelessness or misconduct of single individuals”

Lucien L. Leape, M.D.
Harvard School of Public Health

Culture Change

Watch

Is there a mishap, accident, or error waiting to happen?

Listen

To what your patient, family or colleagues have to say!

PATIENT SAFETY IS EVERYONE'S JOB!

Ask

If you don't

- know.
- remember.
- understand.

Report

- mishaps.
- accidents.
- errors.
- near misses.