Clinical Safety
No Room for Error
Behaviors & Systems that Prevent Harm

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Why are Shared Values Important?

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

Shared Values:
- 0 Harm
- 100% Reliability
- All...Ability & Motivation
To Influence Culture & Change Behaviors

Start With A Story

Shared Values: 0 Harm • 100% Reliability • All...Ability & Motivation
The Swiss Cheese Model demonstrates how failures in barriers to prevent events can align to cause patient harm.

Adapted from James Reason, *Managing the Risks of Organizational Accidents* (1997)
Cause & Effect Analysis: Human Error is systematically connected to an individual’s values, tools, tasks, and operating environment

Adapted from Cook & Woods and Healthcare Performance Improvement
Cause & Effect Analysis
To Understand Failure

Reconstruct the world in which they found themselves at the time

Ask Why 5 times

IF  Individual Failure  SF  System Failure
It is not enough to do your best; you must know what to do, and THEN do your best. — W. Edwards Deming

- Stop focusing on the outcome!
- Speak-up about the reliability of best practice behaviors
- Identify and fix system failures preventing reliability
Focus on Vital Behaviors

Not the End

• Once you find the vital behaviors, all challenges are NOT over

• It’s a whole new challenge to influence people to actually do the behaviors.

Recognize Background Forces:

Enabling and Encouraging the Correct Behavior
Blocking and Discouraging known Wrong Actions
Evidence Based Safety Tool

Examples

- Hand-hygiene expectations
- Ventilator care bundle
- Central line insertion and maintenance bundles
- Surgical Safety Checklist
- Questioning Attitude during Handoffs
- Attention to Detail Habit - STAR
- Structured Communication - SBAR
- Speak Up & 5:1 Feedback

Safety Tools and Checklists aren’t enough to save lives
The Silent Treatment: Why Safety Tools and Checklists Aren’t Enough to Save Lives
2011, VitalSmarts, AORN, AACN

4235 registered nurses (832 managers) surveyed:

- 4 of 5 are concerned about dangerous shortcuts, incompetence or disrespect
  - 50% spoke up to their managers
  - 31% spoke up to the person of concern
- Disrespect: 1 of 2 say disrespect has prevented them from getting others to listen or respect their professional opinion
- Dangerous short cuts:
  - 84% state they work with people who “take shortcuts that could be dangerous for patients”
  - 26% state these shortcuts have harmed patients
Cause & Effect Analysis of Safety Tool Failure

Wrong Behavior

Nurse checks blood unit at station

Peer sees shortcut and does not say anything

Short-Cut to accelerate task performance

Failure to Speak up
Cause & Effect Analysis of Safety Tool Failure

Nurse checks blood unit at station

Why Shortcut?

Short-Cut to Accelerate Task Performance

Choses Wrong Behavior

Perceived Effort

Individual Bad Habits

Low Risk Awareness

Culture < 200% Accountability

Ask why 5 times to get to the Root Cause
IDENTIFY INFLUENCE SOURCES FOR 200% Accountability

I’m 100 percent accountable for my own best practices & I’m also 100 percent accountable for your best practices.

Personal Motivation & Ability

Influence Sources

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<td>6 Change the Environment</td>
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Habits & Skill required for EBP
The influence of skill ease and difficulty in changing habits.

From Influencer: The Power to Change Anything
Personal Motivation & Ability

work on me first

- Use self-reflection and positive self-talk
- Plan and implement habits that increase attention and assure questioning attitude
- Practice effective speak-up skills.
Developing Skills & Habits

Step 1: Reflect on the habit to change
Step 2: Make a Plan
Step 3: Self-reflection

Cue, trigger, or situation → Action, tool, or behavior

Cue

Trigger

Action

Habit

Outcome

Feedback

Outcome, reward, or motivation
# Social Motivation & Ability

## Influence Sources

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### Peer Support & Accountability

The influence of other people – through modeling, praise, helping, and enabling

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*From Influencer: The Power to Change Anything*
Social Motivation & Ability

collaborate with & influence my environment and work team

- 200% Accountability
- Discuss real life stories supporting shared values and evidence based behaviors
- Develop the 5:1 feedback habit
• Accountability has many sources and is critical for sustainment & process control

Personal, Social & Structural Motivation

Sources of Accountability

Leaders

*Vertical* Accountability & Performance Management

Individual

*Intrinsic* Accountability & Internal Motivation

Peers

*Horizontal* Accountability & Peer/Team Feedback
Do you have a Target on Your Back?

Why is 5:1 Important?
An accountability structure and performance management process with instant 5:1 feedback reduces human error rate!

- **Strong Reward Systems**
- **Instant Feedback & Constant Reinforcement**
- **Strong Punishment Systems**
There are two Kinds of Feedback.

Positive Feedback

*Encouraging* someone to continue practicing an observed behavior

- **Head nod**
  - “Yes”
  - “Thank you”

**Do more motivating than money**

5:1 Feedback

Negative Feedback

*Discouraging* someone from continuing to practice an observed behavior

- **Furrowed brow**
  - “No”
  - Offering a practice tip

**Do Helps them Learn**

5:1 Feedback

Adapted from *Bringing Out the Best in People*, by Dr. Aubrey Daniels (1994)
Continuous 5:1 Feedback Reduces Variability in Performance

- Learning is doing with feedback
- Decrease cycle time for feedback
What do you do when other people aren’t doing what they’re supposed to be doing? How do you deal with non-compliance with safety behaviors, broken promises, violated expectation, and bad behavior?

• A Crucial Confrontation may be necessary to protect patient’s from harm.
  – To confront means to hold someone accountable, face to face.
  – A Speak Up behavior using a questioning attitude where both parties talk candidly and respectfully.
System Structure

• Cause & effect analysis after event
• Structured checklists assure EBP safety behaviors
• Standard of practice education addresses both technical and adaptive challenges
• Clear accountability/performance management structure
• Robust process improvement structure that includes individuals closest to the process
• Leadership support for speak-up and escalation
Behaviors that Protect Patients

- STAR
- Questioning Attitude
- Speak Up
- Checklist and tool compliance
Role of Leaders

- Vertical Accountability for EBP
- Support education in EBP
- Encourage self-reflection
- Recognize stress and burn-out
- Influence using 5:1 feedback
- Recognize/redirect bullying
- Performance Improvement teams include staff closest to the process
- Support Speak-up and escalation efforts every time!
- Change management includes technical and adaptive challenges
To Make Every Day a Safe Day

BUILD & SUSTAIN A HIGH RELIABILITY CULTURE THAT CREATES SAFETY