The SPS Journey:
Intersection of High Reliability Culture and Reducing Harm

Carol Kemper, RN, PhD, CPHQ
Daniel Hyman, MD, MMM
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Intersection of High Reliability Culture and Reducing Harm

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We have no financial conflicts to disclose.

(and any pictures of Colorado are not meant as a recruitment strategy)
Kansas City Sunrise

We don’t have mountains but look at this beautiful sunrise!
Solutions for Patient Safety

Our Mission:

Working together to eliminate serious harm across all children’s hospitals
National Children’s Network Goals
2015/2016

• 40% reduction in Hospital Acquired Conditions (HACs)
• 10% reduction in Hospital Readmissions
• 25% reduction in Serious Safety Event rate

*All goals are reductions from final 2014 rates
Develop Ohio Network

Initial HAC improvement work
SSE reduction; efforts to address organizational culture
Creation of pediatric patient harm index

Create National Children’s Network

Expand network to include 25 leading children’s hospitals outside Ohio (Phase I)
Active improvement work on 10 HACs
Efforts to address organizational culture
“All Teach, All Learn”
Develop mentor hospitals
Begin to publicly disseminate change efforts

2014
80+

(2013->)

(2012->)

(2008-2011)

Scale

Spread

Add 50 hospitals (Phase II) to data sharing and network learning opportunities (2013); expand to 82+ hospitals nationwide (2014)
Share network best practices with all (2012->)
Disseminate at national meetings (2012->)
Develop strategies with national organizations (2012->)
Establish other regional collaboratives (2013)
80+ Children’s Hospitals
Greater than 50% of Admissions
Our Approach

• Leadership Matters
• Our mission motivates all that we do
• Network hospitals will NOT compete on safety
• All Teach/All Learn
• Network hospitals must commit to building a “culture of safety”
Reduce the readmit rate by 10% across the SPS National Children’s Network by 12/31/16

Reduce HACs by 40% across the SPS National Children’s Network by 12/31/16
Our Journey Toward Zero Harm

Active Network Improvement

**PIONEER**
- Early adopter network hospitals
- Establish pediatric definition for new HAC
- Develop best practices & prevention standards

**Aviator (Actively Implementing)**
- All network hospitals adopt HAC goal, definition, measurement, & prevention standard
- Focus on implementation
- Achieve network reduction goal

**HIGH RELIABILITY CULTURE** *
- All network hospitals adopt the standard measure of serious safety event
- Cause analysis, error prevention, & leadership methods trainings

**ORBITING** *
- All network hospitals focus on sustaining improvement
- Monitor performance & additional best practices

**EXPLORER**
- Spread pediatric standards & best practices outside network to all hospitals across the United States

**DISCOVERY**
- Led by innovators & researchers
- Idea testing using QI methodology
- Identify new HACs to introduce to network

*All SPS network hospitals participate*
SPS Prevention Bundles

• Surgical site infections
• Serious falls
• Pressure ulcers
• Central line-associated blood stream infections
• Catheter-associated urinary tract infections
• Ventilator Associated Pneumonia
HIGH RELIABILITY
High-Reliability Organizations

Environment rich with potential for errors

Unforgiving social and political environment

Learning through experimentation is difficult

Complex processes

Complex technology
High-Reliability Organizations
Creating a Mindful Infrastructure

Principles of Anticipation—stay out of trouble

1. **Preoccupation with Failure**—treat any lapse as symptom that something might be wrong within the system
2. **Reluctance to simplify**—increased perspectives and world views
3. **Sensitivity to operations**—attentive to the front line where real work gets done

Principles of Containment—get out of trouble

4. **Commitment to resilience**—develop capabilities to detect, contain, and bounce back from inevitable errors
5. **Deference to expertise**—authority migrates to those with the most expertise
RESULTS
CLA-BSI MAINTENANCE BUNDLE
PLACEHOLDER
SERIOUS HARM EVENT
PLACEHOLDER
Percent Reductions in HACs

- CLA-BSI: 11%
- ADE: 42%
- VAP: 47%
- Falls: 81%
- SSI: 19%
- CA-UTI: 25%
- VTE Events: 27% increase
- PU: 3% increase
- Readmissions: 0%

Reductions calculated from baseline to current centerline on rate chart
FINANCIAL SAVINGS PLACEHOLDER
A deviation from generally accepted performance standards (GAPS) that...

**Serious Safety Event**
- Reaches the patient *and*
- Results in moderate harm to severe harm or death

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

**Near Miss Safety Event**
- Does not reach the patient
- Error is caught by a detection barrier or by chance
SERIOUS SAFETY EVENT RATE
PLACEHOLDER
What is Target Zero?

Target Zero is a multi-year effort to progressively eliminate preventable harm at Children’s Hospital Colorado.
How the Pieces Fit Together

Best-practice clinical care
supported by
Behaviors designed to prevent error
reinforced by
Leaders who model, support, recognize and redirect
informed by
Ongoing measurement/analysis to show what’s happening, and ongoing learning about what needs to happen next on the journey
will achieve

70+% decrease in preventable harm in 4 years
Information about Bundles

- **Development:**
  - best-available evidence
  - cross-functional groups of subject matter experts
- **Available on Target Zero site on Planet**
- **All bundles follow standard format:**
  - Bundle trigger
  - Bundle elements
  - Process Steps

---

**Pressure Ulcers: Braden Q Score is between 17 and 22 indicating Moderate Risk for Skin Breakdown**

- **Apply Mepilex border sacrum dressing**
  - Mepilex border sacrum comes in two sizes 7.2 and 9.2. The 7.2 would be for a smaller child, while the 9.2 would be for a teenager or adult.
  - Mepilex border sacrum can be ordered in EPIC under "order entry" by typing 194008 for the 7.2 and 124008 for the 9.2.
  - For an infant or toddler, Mepilex border #4 dressing can be placed if a Mepilex Sacrum dress is too large.
  - Dressings should be changed at least.

- **Reposition Patient every 2 Hours**
  - Pt should be turned from their L side to supine to R side every 2 hours.
  - Repositioning can be done with use of pillows or Z flo positioners to offload pressure.
  - NICU patients should be repositioned with care so as not to over stimulate.

- **Reposition Movable Devices every Shift**
  - Movable devices such as pulse oximetry probes and blood pressure cuffs should be rotated from extremity to extremity each shift to reduce pressure to one area.
  - Devices that cannot be moved should be padded with mepilex or duoderm.

- **Z flo Positioners**
  - Z flo positioners should be placed under bony prominences in bed bound patients. Examples of bony prominences to consider are heels and elbows. They can also be used under the occiput in infants or toddlers.
  - Z flo positioners can be ordered through central supply under "order entry" in EPIC by typing 211375 for the 12x20 size and 211377 for the 7x10 size.
Target Zero Bundles: Implementation

Do now:
- Clearly expectations about bundle use
- Our goal is standard care- all elements for all applicable patients
- Ensure staff know where to locate bundle documentation
- Reinforce these expectations on leader rounds
  – ask whether staff are encountering barriers to practice

Next Steps:
- Continue bundle education/ close knowledge gaps; continue observation/audit, real time feedback to improve reliability
Target Zero: Safety Practices and Tools

**Personal Commitment**
Introductions
Pause to Care
ARCC: Ask, Request, CUS, Chain of Command

**Clear, Complete Respectful Communication**
SBAR, Read-backs (Repeat backs)

**Questioning Attitude**
ART, Stop and Resolve
Target Zero Leadership Practices

Practices which leaders use to ensure a reliably safe environment:

1. **JUST CULTURE**: Respond to errors and deviations in practice in ways that promote learning and are perceived to be fair and just

2. **ROUNDING TO INFLUENCE**: Actively observe and speak with staff about safety practices

3. **EFFECTIVE FEEDBACK**: Give positive feedback when safety practices are demonstrated, corrective feedback when not
Cause Analysis

• Ongoing measurement and analysis to identify root cause and apparent cause of errors and deviations in practice

• Explores both individual and systemic causes

• Identifies specific opportunities for ongoing learning about becoming safer
PATIENT SAFETY
WHAT PATIENTS AND FAMILIES NEED TO KNOW!

HAND WASHING
This is the most important way to prevent the spread of infections in the hospital and at home.

What can you do?
- Expect everyone to wash their hands or use hand sanitizer when entering and leaving your room.
- If you are unsure, please ask.
- Wash your hands:
  - When entering and leaving your child’s room
  - Before and after preparing food, eating, or feeding your child
  - After using the bathroom or changing a diaper

“Excuse me, I didn’t see you wash your hands. I’d like to be sure everyone’s hands are clean. Please wash them before caring for my child.”

RAPID RESPONSE TEAM (RRT)
This is a team of healthcare providers from our intensive care areas. They can be contacted anytime you are concerned that your child’s medical condition is worsening and you are worried that the situation is not being addressed by the patient’s primary team.

What can you do?
- Recognize when you have a gut feeling that something just doesn’t seem right with your child’s medical condition.
- CALL AN RRT by dialing 7-5555 FROM THE NEAREST PHONE and tell the operator that you are asking for an RRT for your child. Give the child’s full name and room number.

“I am concerned that my child’s medical condition is worsening. I am calling an RRT and dialing 7-5555.”

PATIENT IDENTIFICATION (PATIENT I.D.)
This is our way to confirm that we are providing the correct care to your child. We require two forms of identification, like name and date of birth, to be used with each test, treatment, or medication.

What can you do?
- Make sure your child is wearing their patient I.D. armband at all times, and that the name and date of birth are correct. The armband should be on your child and not in the crib or bed.
- Ask to see your child’s photo in the medical record.
- Participate in our patient I.D. process:
  - Expect staff to confirm name and date of birth.
  - Stop us if you don’t see us check your child’s armband when we are about to give a test, treatment, medication, or transport, etc.
  - Ask questions if a caregiver wants to do something that you are not expecting (test, treatment, medication or transport, etc.).

“Excuse me, I did not see you check or ask for my child’s two forms of identification. Please double-check.”

FALLS
These are common causes of injuries in hospitals and most can be prevented. All children are at risk for falls.

Your child is at higher risk for falling if he/she:
- Is 5 years old or younger
- Is connected to any type of wires or tubing such as IV’s, feeding tubes, monitors, or drain tubes
- Is receiving medication that makes him sleepy or dizzy
- Has a condition that affects their balance and ability to walk safely on their own

What can you do?
- Call for help when you move your child from one place to another.
- Keep side rails up at all times.
- Make sure your child is assisted while using the bathroom.

“I am concerned that my child might fall. Please tell me what I can do.”

PRESSURE ULCERS (BED SORES)
These are caused by pressure from sitting or laying in one position for too long. They can also be caused by a cord or device that puts pressure on the skin. They are most likely to happen on skin over bony areas.

What can you do?
- Help your child change positions regularly to help avoid pressure ulcers. Call your nurse if you need help moving your child.
- Call a nurse to help change the position of any devices that put pressure on your child’s skin.
- Keep your child’s skin clean and moistened.
- Change your child’s diaper often.
- Pay close attention to your child’s body, especially in areas where they have no feeling.

“I am concerned about my child’s skin. Please look at it with me.”

QUESTIONS?
Be an active member in your child’s healthcare team and SPEAK UP if you have any questions or concerns.

Approved by the Patient Family Education Committee   ©2013 Children’s Hospital Colorado, Aurora, CO Sept 2012   cns_120222
<table>
<thead>
<tr>
<th>Target Zero</th>
<th>Right care, tests, and treatments</th>
<th>Infections</th>
<th>Room/Bed Safety</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnering with Families for Safety</td>
<td>☑ Right patient</td>
<td>☐ CLABSI</td>
<td>☐ Pressure Ulcers (sores)</td>
<td>☐ Clots</td>
</tr>
<tr>
<td></td>
<td>☑ Right drug, dose</td>
<td>☐ CA-UTI</td>
<td>☐ Falls</td>
<td>☐ PIV</td>
</tr>
<tr>
<td></td>
<td>☑ Right plan of care</td>
<td>☐ Other infections</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>☑ Hand hygiene</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FAMILY SECTION**
Sección para la familia

Please include me in:
Agradezco se

Daily care team rounds
Visitas médicas diarias

Nursing bedside shift report
Informe de enfermería al cambio de turno
El paciente correcto
Identificación del paciente
¿Qué puede hacer para proteger a su hijo de un error respecto a la identificación?
argüese de que su hijo use el brazaletes de identificación todo
niace en la cuna o cama.
esario actualizar la foto de su hijo en el expediente médico.
si el personal está por hacer algo que usted no anticipaba y,
medicina o transportación, etc.)
el personal?
de identificación de su hijo y el número de expediente médico.
tratamientos, procedimientos, pruebas y medicinas

Bed/Room Safety
Pressure Ulcers
A wound to the skin (also called a bed sore)
What can you do to protect your child from a pressure ulcer?
- Work with staff to change your child’s position at least every 2 hours
- Keep your child’s skin clean and moisturized
- Work with staff to make sure your child’s diaper is changed often
- Check your child’s skin for redness or damage
  - Check and change the placement of devices
  - (like pulse ox or masks)
  - Change your child’s position every 2 hours
  - Use skin protectors under equipment or on skin if indicated
TARGET ZERO

is a multi-year effort to progressively eliminate preventable harm at Children’s Hospital Colorado.

TARGET ZERO COMPONENTS

- Target Zero Analysis
- Patient Assessment
- Target Zero Bundles
- Risk Management
- Patient Safety
- Target Zero Ventures
- Target Zero Partnerships
- Designing Learning
- Target Zero Community

16 patients harmed September 2013

TARGET ZERO
ELIMINATING PREVENTABLE HARM
Making performance visible
- unit outcomes

<table>
<thead>
<tr>
<th>Focus on Quality</th>
<th>One day at a Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of days since our last:</td>
<td></td>
</tr>
<tr>
<td>CA-BSI</td>
<td>88 Days 0:15</td>
</tr>
<tr>
<td>unplanned extubations</td>
<td>3 Days 0:04</td>
</tr>
<tr>
<td>Patient ID errors</td>
<td>257 Days 0:15</td>
</tr>
<tr>
<td>Pressure ulcers</td>
<td>44 Days 0:15</td>
</tr>
</tbody>
</table>
Hospital Acquired Conditions, CHCO 2012-13

Children's Hospital Colorado
Total Pillar Goal HACs by Month 2012 and 2013

2013 Target Goal (10% reduction from 2012 baseline) = <177

- 2012 Cumulative
- 2013 Cumulative

Reduction 21%
2014 Progress to Goal

Children's Hospital Colorado-System
Total Pillar Goal HAC Events by Month
2013 and 2014

2014 Target Goal (10% reduction from 2013 baseline) = <186

This document is quality management information relating to the evaluation or improvement of health care services, and is part of a quality management program as described in C.R.S. 25-3-109(2). It is confidential and protected under C.R.S. 25-3-109(1) and -(3), and is to be used for Children’s Hospital Colorado purposes only.
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2014 Pillar Goal HAC Rate-CHCO System

![Graph showing 2012-2014 Pillar Goal HAC Rate by Month. Rate per 10,000 APD U Chart.]
Conclusions for us

• Leadership at a board and senior team level is necessary to launch a full scale program to advance patient safety organization wide.
• Integrating training of staff and leaders in culture and improvement methods is necessary and enhanced with a strong cause analysis program.
• Collaboration is a huge plus- externally and internally.
• Family and patient engagement is a huge plus.
• After training 6000 staff members over 18 months, we are safer, but not safe enough.... The Target is ZERO.
Strategic Alignment

Mission, Vision, Values Goals

Vision 2022
Be a national and international leader recognized for advancing pediatric health and delivering optimal health outcomes through innovation and a high-value, integrated system of care

Reliability

Public-Private Leadership
Innovation
Goals 2017

Strategic Goals

- Demonstrate Quality Outcomes
  A. Demonstrate quality, safety, and clinical effectiveness

- Improve Performance
  B. Improve processes, increase capacity for innovation and service excellence, and strengthen financial position

- Strengthen Market Position
  C. Maintain CMH’s market position in the Metro area and grow it throughout the region

- Deliver Value
  D. Develop an integrated pediatric health care system that demonstrates value, expertise, and efficiency

- Elevate Academic Profile
  E. Enhance the research capabilities and accomplishments of CMH and strengthen the quality of the educational experience

Values
Accountability • Clinical Excellence • Continuous Improvement • Empowerment

Mission
Improve the health and well-being of children by providing comprehensive family-centered health care, committing to the highest level of clinical and psychosocial care, and exhibiting research, educational and service excellence

4/17/2015
Play it Safe

• **Structure & Deployment**
  – Hospital Acquired Condition Teams
    • Nurse/Physician leaders
    • Family Representative
    • QI Program Manager
    • Data support
  – Meeting on the Mound
    • Senior Leaders, HAC, and Culture leaders
    • Oversees & integrates HAC progress and Culture work
  – Who’s on First
    • Tactical team
Quality & Safety Committees

• Quality/Safety Committees
  – Quality & Safety Committee of the Board
• Quality Council
  – Patient Safety Evaluation System Committee
    » Serious Safety Event Classification Committee
  – Meeting on the Mound
    » HAC Teams
    » Culture Domain Teams
3. Central Line Associated Blood Stream Infections

**IMPROVING PREVENTION RELIABILITY**
- Average Insertion Bundle Adherence = 95.72%
- Average Maintenance Bundle Adherence = 96.09%
  (Measuring 1 out of 4 bundle elements)
- Implemented Passive Disinfection caps for line entry antisepsis
- Implemented standardized tubing change process
- Developing measurement system hospital wide
- Updating nursing and physician documentation to support practice changes

**IDENTIFYING OPPORTUNITIES THROUGH EVENT ANALYSIS**
- Developing a standardized infection investigation tool to be utilized in follow-up of each BSI
- Reviewing heparin flushing of central lines

Number of bloodstream infections occurring in patients with a central venous catheter. Formula = (Number of CLABSI/number of central line days) times 1000
Building Reliable Systems

• **Leadership**
  – Daily Safety Update
    • 7 days/week organization level huddle
  – Senior Leader Walk Rounds

• **Communication**
  – Great Catch
  – Days Between SSEs & HACs
Building Reliable Systems

• **Cause Analysis**
  – SSE Classification Committee – SSE Rate
  – RCA/ACA processes

• **High Reliability Units**
  – QI Program Manager & Patient Safety leader coaches
  – Physician and nurse leader
  – Increase bundle reliability
## PICU Rounding Checklist

### PICU Bedside Quality Inventory

<table>
<thead>
<tr>
<th>CVL</th>
<th>CVL: Yes □ No □</th>
<th>Day #: Type:</th>
<th>CVL still needed?: Yes □ No □</th>
<th>Lab frequency reduction: Yes □ No □</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of entries AM PM Total</td>
<td>What meds can change route from IV to enteral?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meds</td>
<td>1. 2. 3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Labs</td>
<td>4. 5. 6.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep Flush</td>
<td>Line sluggish? Yes □ No □</td>
<td>TPA used last 24 hours? Yes □ No □</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Foley</th>
<th>Foley: Yes □ No □</th>
<th>Day #:</th>
<th>Foley still needed?: Yes □ No □</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Vent</th>
<th>Vent: Yes □ No □</th>
<th>Vent Day #:</th>
<th>Weaning Support?: Yes □ No □</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Skin integrity</th>
<th>Skin care issues related to devices?: Yes □ No □</th>
<th>Which devices? 1. 2.</th>
<th>Can it be removed? Yes □ No □</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Other Concerns</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient Goals</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
</tr>
</thead>
</table>
Family Engagement

• **Family Advisory Board**
  - HAC presentation co-lead by HAC team leaders and family representative

• **Bedside Bundle**
  - Family Friendly Medication Administration Record
  - Clear Care Board
Clear Care Board

Treatment & Discharge Goals

Things About Me

Important Information

Phone Numbers

- Rapid Response: 11911
- Room Service: 51414

Allergies / Restrictions
**My Child’s Daily Medication List**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>How Often</th>
<th>Scheduled Times*</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>bacitracin/neomycin/polymyxin B topical (Triple Antibiotic)</td>
<td>1 application</td>
<td>Affected Area(s)</td>
<td>3 times a day</td>
<td>8:00 am, 2:00 pm, 8:00 pm</td>
<td></td>
</tr>
<tr>
<td>calcitriol (calcitriol)</td>
<td>0.15 mcg</td>
<td>Oral</td>
<td>2 times a day</td>
<td>9:00 am, 9:00 pm</td>
<td></td>
</tr>
<tr>
<td>calcium carbonate (calcium carbonate)</td>
<td>200 mg</td>
<td>Oral/Gastrostomy</td>
<td>2 times a day</td>
<td>9:00 am, 9:00 pm</td>
<td></td>
</tr>
<tr>
<td>cephalexin (Keflex)</td>
<td>60 mg</td>
<td>Oral</td>
<td>every day</td>
<td>9:00 am</td>
<td></td>
</tr>
<tr>
<td>clonidine (clonIDINE)</td>
<td>16 mcg</td>
<td>Oral</td>
<td>every 8 hours</td>
<td>1:00 am, 9:00 am, 5:00 pm</td>
<td></td>
</tr>
<tr>
<td>furosemide (Lasix)</td>
<td>4 mg</td>
<td>Oral</td>
<td>every 8 hours</td>
<td>1:00 am, 9:00 am, 5:00 pm</td>
<td></td>
</tr>
<tr>
<td>lorazepam (Ativan)</td>
<td>0.3 mg</td>
<td>Oral</td>
<td>every 12 hours</td>
<td>9:00 am, 9:00 pm</td>
<td></td>
</tr>
<tr>
<td>methadone (methadone)</td>
<td>0.3 mg</td>
<td>Oral</td>
<td>every 12 hours</td>
<td>2:00 am, 2:00 pm</td>
<td></td>
</tr>
</tbody>
</table>
### Expected Safety Behaviors
- Practice a questioning attitude
- Pay attention to detail
- Support each other
- Communicate clearly

- **Play It Safe**
- **Let’s Talk**
- **Service Excellence**
- **Shared Values**: Accountability, Empowerment, Respect, Teamwork, Transparency, Clinical Excellence, Continuous Improvement
- **Support Evidence-Based Practice Guidelines**
- **Follow Children’s Mercy Policies and Protocols in our daily work**: Nursing Back-to-Basics, Healthcare Acquired Conditions (HACs) prevention practices, Department-specific

### Four Error Prevention Tools

<table>
<thead>
<tr>
<th>ARCC:</th>
<th>SBAR:</th>
<th>STAR:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask a Question</strong></td>
<td><strong>Situation:</strong></td>
<td><strong>Stop</strong></td>
</tr>
<tr>
<td><strong>Make a Request</strong></td>
<td><strong>Background:</strong></td>
<td><strong>Think</strong></td>
</tr>
<tr>
<td><strong>Voice a Concern</strong></td>
<td><strong>Assessment:</strong></td>
<td><strong>Act</strong></td>
</tr>
<tr>
<td><strong>If no success...</strong></td>
<td><strong>Recommendation:</strong></td>
<td><strong>Review</strong></td>
</tr>
<tr>
<td><strong>Use Chain of Command</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **ARCC**: Use the lightest touch possible
- **SBAR**: Stop, Pause for 1 to 2 seconds to focus attention on the task at hand.
- **STAR**: Think, Consider the action you’re about to take.
- **QVV**: Qualify the Source: Do I trust the source? Validate: Does it make sense to me? Verify: Check it with an independent, expert source.

### Five Error Prevention Practices

- **Name Game:** Introduce yourself to team members, your patient and their family—and everyone explains their role.
  - Set a tone of approachability.

- **Team Member Checking:** Get a fresh pair of eyes OR Be a fresh pair of eyes.
  - 3-Way Communication/Repeat-Back:
    1. Sender initiates communication.
    2. Receiver acknowledges receipt by a repeat-back of the order, request or information.
    3. Sender acknowledges the accuracy by saying, “That’s correct!”

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

- **Stop and Resolve:**
  - If you’re uncertain what to do... STOP
    - Resolve the concern/get the right people involved
    - Reassess your actions
Achieving High Reliability – Integration with Lean Approach

• Leadership - the leadership's commitment to the ultimate goal of zero patient harm,

• Safety Culture – incorporation of all the principles and practices of a safety culture throughout the organization (everyone supports a questioning attitude)

• Robust Process Improvement - the widespread adoption and deployment of the most effective process improvement tools and methods
  – Change Management
Lean Leader Training

• February, 2015
  • Lean Leader Training conducted on-site
  • 25 CMH leaders participated (4 ½ day event)
    – Learned Lean Principles
  • Purpose – create a culture of high reliability and continuous process improvement
  • Fundamentals
    – Deliver value to our patients (as viewed by patient and family)
    – Respect and engage staff
Lean Leader Training

• Role of leaders – Leader standard work and alignment with Leadership Methods
• High Reliability Units
QUESTIONS?
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