Changing Work Cultures to Improve Patient Safety: Do No Harm

Kathleen Vollman
ADVANCING NURSING THROUGH KNOWLEDGE & INNOVATION

Kathleen M. Vollman MSN, RN, CCNS, FCCM, FCNS, FAAN
Clinical Nurse Specialist / Educator / Consultant
ADVANCING NURSING
kvollman@comcast.net
Northville, Michigan
www.vollman.com

- Consultant-Michigan Hospital Association Keystone Center
- Subject matter expert HRET: CAUTI, CLABSI, HAPU, Sepsis, Safety culture
- Consultant and speaker bureau:
  - Sage Products a business unit of Stryker
  - Eloquest Healthcare
- Baxter Healthcare Advisory Board

Objectives

- Discuss factors that contributed to quality and safety challenges
- Determine strategies to assess organizational and unit culture
- Identify organizational and unit infrastructure necessary to support a quality and safety culture
- Compare and contrast tools and techniques used on the front line to build a quality and safety culture

From the Field

“We're on our knees here, and it's really difficult and we're all trying the best we can and we don't feel... we feel like we could be doing more, and I know we can’t ... We’re staying away from our families and we're putting ourselves in danger to try and save other people's loved ones. It feels like a losing battle but it's not, we've all got hope and we're all trying to do what we can.”

Maben J, Bridges J. Covid-19: Supporting nurses' psychological and mental health. Journal of Clinical Nursing. 2020; 29: 2742-2750. doi:10.1111/jocn.15307

R's for Today

Reflect

Reboot/Reset

Impact of COVID on CLABSI's: NHSN

- April, May & June 2020 (compared to same period in 2019)
- 2986 hospitals (13,136 inpatient units)
- Results:
  - 28% ↑ SIR from .68 to .87
  - Device utilization ↑.21 to .23
  - ICU's ↑ SIR .75 to 1.04 (39%)
  - Wards ↑ 13%
  - Hospitals in all bed sizes saw increase
  - Highest regional SIR 1.07 -Region 1/Upper Northeast (CT, ME, MA, NH, RI, VT)

Patel PR, et al. *Infect Control Hosp Epidemiol*. 2021;1-4.

Impact of COVID on HAI's in 2020 Compared to 2019: Data from NHSN

	2020 Q1	2020 Q2	2020 Q3	2020 Q4
CLABSI	↓ -11.8%	↑ 27.9%	↑ 46.4%	↑ 47.0%
CAUTI	↓ -21.3%	No Change[1]	↑ 12.7%	↑ 18.8%
VAE	↑ 11.3%	↑ 33.7%	↑ 29.0%	↑ 44.8%
SSI: Colon surgery	↓ -9.1%	No Change[1]	↓ -6.9%	↓ -8.3%
SSI: Abdominal hysterectomy	↓ -16.0%	No Change[1]	No Change[1]	↓ -13.1%
Laboratory-identified MRSA bacteremia	↓ -7.2%	↑ 12.2%	↑ 22.5%	↑ 33.8%
Laboratory-identified CDI	↓ -17.5%	↓ -10.3%	↓ -8.8%	↓ -5.5%

Consistent reporters

Weiner-Lastinger LM, Pattabiraman V, Konnor RY, et al. The impact of coronavirus disease 2019 (COVID-19) on healthcare-associated infections in 2020: A summary of data reported to the National Healthcare Safety Network. *Infection Control & Hospital Epidemiology*. 2021:1-14. doi:10.1017/ice.2021.362

Qualitative Feedback on Rationale for Increase

Shortage of PPE

Staffing changes

- Travelers
- Non-ICU clinicians

Reduced frequency of contact

- Less chlorhexidine bathing
- Alterations in line care due to IV pumps in the hallway
- Scrub the hub compliance

Line and dressing integrity gaps related to prone positioning of patients

Increase in line draws for blood cultures

Less line rounding/competing priorities

Fakih MG, et al. Infection Control & Hospital Epidemiology, 2021;:1-6
Patel PR, et al. *Infect Control Hosp Epidemiol*. 2021;1-4.

Life after a Crisis

Life is about how much you can take and keep fighting, how much you can suffer and keep moving forward.~ Anderson Silva

Don’t dwell on what went wrong. Instead, focus on what to do next. Spend your energies on moving forward toward finding the answer. ~Denis Waitley

If everyone is moving forward together, then success takes care of itself. ~Henry Ford

One day? Or day one. You decide.

Reboot/Reset

Safety and Quality

- **Safety** has to do with lack of harm. **Quality** has to do with efficient, effective, purposeful care that gets the job done at the right time.
- **Safety** focuses on avoiding bad events. **Quality** focuses on doing things well.
- **Safety** makes it less likely that mistakes happen. **Quality** raises the ceiling, so the overall care experience is a better one.

How Safe is Your Health Care Environment?

WHO

- 1 out of 10 patients are harmed in hospitals in high income countries
- 134 million adverse events occur each year in hospitals in LMICs, contributing to 2.6 million deaths annually due to unsafe care
- Medication errors cost an estimated 42 billion USD annually

World Patient Safety Day 17 September 2021

https://www.who.int/patientsafety/en/

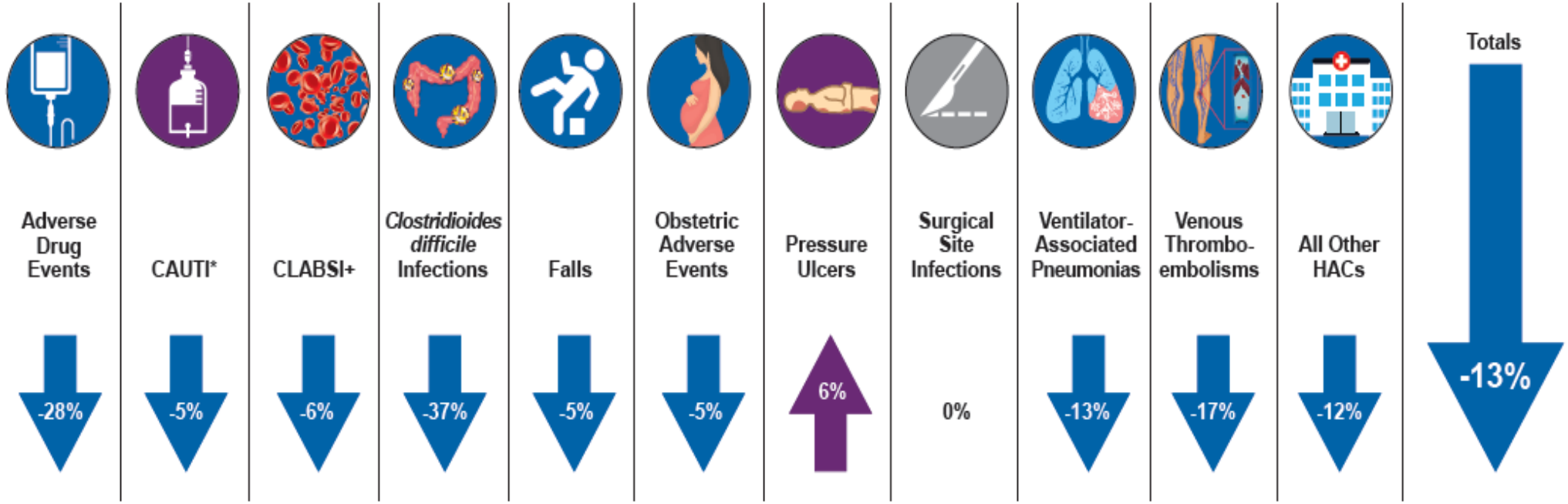
We Need to Keep the Journey Going!!

- As many as **440,000** people die every year from hospital errors, injuries, accidents, and infections
- Every year, **1 out of every 23** patients develops an infection while in the hospital—an infection that didn't have to happen.
- A Medicare patient has a **1 in 4** chance of experiencing injury, harm or death when admitted to a hospital
- Today alone, more than **1000** people will die because of a preventable hospital error

Declines in Hospital-Acquired Conditions

Agency for Healthcare Research and Quality

National efforts to reduce hospital-acquired conditions such as adverse drug events and injuries from falls helped prevent 20,500 deaths and saved $7.7 billion between 2014 and 2017.



Prior to the Pandemic—on the Right Track

High Reliability Organizations

- High Reliability: consistent performance at high levels of safety over long periods of time
- Possess “Collective mindfulness”
  - Individuals & teams are acutely aware that even small failures in safety protocols or processes can lead to catastrophic adverse events.
  - Eliminate deficiencies in safety processes using powerful tools to improve their processes
  - Create an organizational culture that focuses on safety, remaining constantly aware of the possibility of failure

Chassin & Loeb, Health Affairs, April 2011

High Reliability Organization – What Does It Mean?

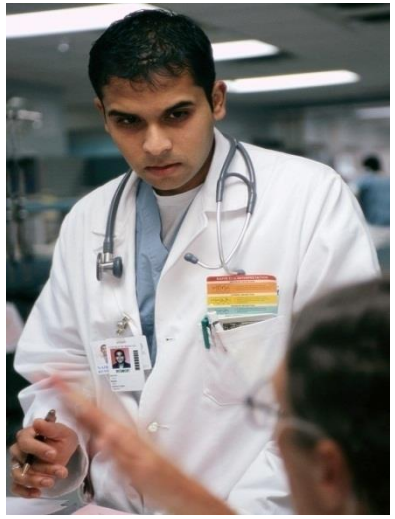
- A Leader where we stand
- Role model right behavior
- Correct the wrong behavior

For the Patient and Your Peers

How Do We Get There?

- It's a JOURNEY
- Examine your current framework for achieving health care quality
- 3 critical changes must take place
  - Leadership commitment
    - Must focus on the journey from low to high reliability by making it their highest priority and requiring all levels of management to do the same
  - Safety Culture
    - Frontline workers trust each other in order to feel safe to identify and report problems
    - When a problem is reported it will be fixed
    - Reported problems lead to safety improvements
  - Robust Process Improvement
    - Six Sigma, Lean and Change Management

What is Culture?



That's not the way we do it here!!!

Represents a set of shared attitudes, values, goals, practice & behaviors that makes one unit distinct from the next

Culture Assessment is Critical

Assessment of Safety & Work Culture

- SAQ (Safety Attitudes Questionnaire)
  - Teamwork
  - Safety
  - Working conditions
  - Job satisfaction
  - Stress recognition
  - Perception of upper management
  - Perception of unit management

Strive for 80%, if < 60% SAQ scores correlates to decreases in clinical outcomes

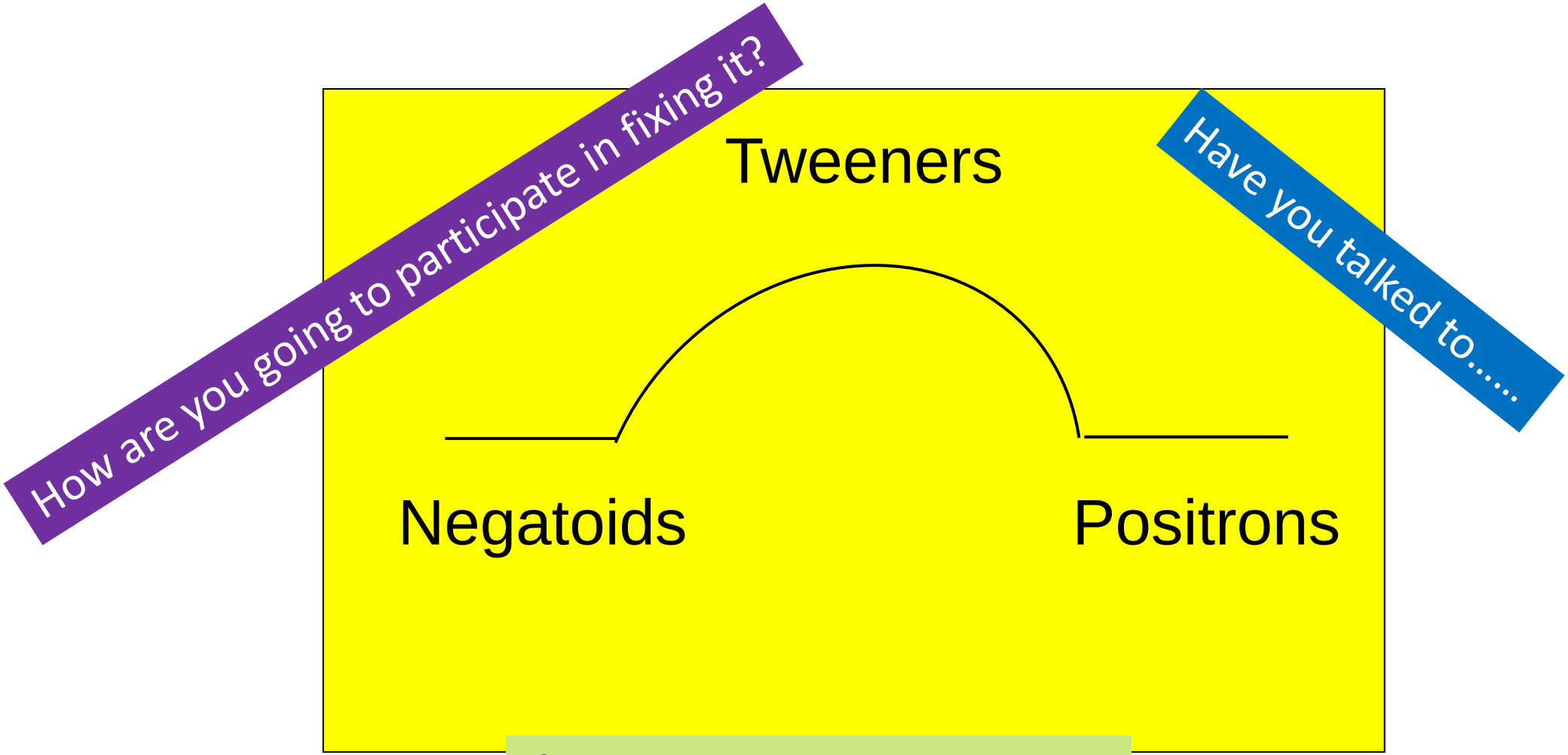
AACN Healthy Work Environment Assessment

- Skilled communication
- True collaboration
- Effective shared decision making
- Appropriate staffing
- Meaningful Recognition
- Authentic Leadership

https://mini.aacn.org/dm/HWE/TabbedAdminHome.aspx

Number	Question
1	Administrators, nurse managers, physicians, nurses and other staff maintain frequent communication to prevent each other from being surprised or caught off guard by decisions.
2	Administrators, nurse managers, and physicians involve nurses and other staff to an appropriate degree when making important decisions.
3	Administrators and nurse managers work with nurses and other staff to make sure there are enough staff to maintain patient safety.
4	The formal reward and recognition systems work to make nurses and other staff feel valued.
5	Most nurses and other staff here have a positive relationship with their nurse leaders (managers, directors, advanced practice nurses, etc.).
6	Administrators, nurse managers, physicians, nurses, and other staff make sure their actions match their words□they "walk their talk."
7	Administrators, nurse managers, physicians, nurses, and other staff are consistent in their use of data-driven, logical decision-making processes to make sure their decisions are the highest quality.
8	Administrators and nurse managers make sure there is the right mix of nurses and other staff to ensure optimal outcomes.
9	Administrators, nurse managers, physicians, nurses, and other staff members speak up and let people know when they've done a good job.
10	Nurses and other staff feel able to influence the policies, procedures, and bureaucracy around them.
11	The right departments, professions, and groups are involved in important decisions.
12	Support services are provided at a level that allows nurses and other staff to spend their time on the priorities and requirements of patient and family care.
13	Nurse leaders (managers, directors, advanced practice nurses, etc.) demonstrate an understanding of the requirements and dynamics at the point of care, and use this knowledge to work for a healthy work environment.
14	Administrators, nurse managers, physicians, nurses, and other staff have zero-tolerance for disrespect and abuse. If they see or hear someone being disrespectful, they hold them accountable regardless of the person's role or position.
15	When administrators, nurse managers, and physicians speak with nurses and other staff, it□s not one-way communication or order giving. Instead, they seek input and use it to shape decisions.
16	Administrators, nurse managers, physicians, nurses, and other staff are careful to consider the patient's and family's perspectives whenever they are making important decisions.
17	There are motivating opportunities for personal growth, development, and advancement.
18	Nurse leaders (managers, directors, advanced practice nurses, etc.) are given the access and authority required to play a role in making key decisions.

Understanding Your Culture & Communication Strategies



If you Permit it you Promote it

Driving Components in a Work Culture

Number 1 Respected Profession

Nursing

So Why Don’t We Feel Respected?

Reclaiming Professional Respect

Work Environment

Quality of Care You Provide to Patient & Families

What Behaviors or Communications Make You Feel the Recipient of Respect?

Feeling of Respect or Not being Respected

Respected

- Feeling listen to
- Feeling revered for their knowledge
- Feeling trusted
- Feel part of the group
- Being acknowledged
- Sense of belonging/contributing
- Persons look out for each other and their support
- Fairness
- Free to speak
- Opportunities to excel

Not Being Respected

- Disregarded
- Not revered
- Not trusted
- Not supported
- Not recognized
- Closed conversation
- Speaking in a tone that is demeaning
- Ideas and opinions not considered a value priority
- Unsafe, guarded, pressured, put down

Bournes DA, et al. Nursing Science Quarterly, 2009;22(1):47-56

Respect

Self Respect

Self Respect

Internal Dialogue

External Dialogue

Culture of Respect

- Initiating cultural changes needed to prevent the episodes
- Disrespectful behavior must be addressed consistently and transparently
- Organization set up a code of conduct and it must be enforced
- Culture of respect requires building a shared vision

The Road to Respect

I spoke.

You listened.

I felt valued and honored.

You shared your opinion.

I trusted your wisdom.

The circle of respect was complete.

We saw in each other's eyes are common humanity.

Now, moving to a zone of mutual affirmation, we felt safe to trust and learn and nurture in the give-and-take of life.

Yasmin Morais 2006

Driving Components in a Work Culture

How do We Get There?

Grass Roots Unit-Based Culture Change

Re-valuing & recognition of nursing unique contribution

Engagement
Safety Climate

Creating an Environment that Fosters Autonomy

- Nurses sense of control over their own practice (CNS & Manager)
  - Ability to make decisions about daily nursing practices
  - Ability to perform their job independently by creating clinical decision-making guidelines
  - Through participative leadership support shared governance, involvement in interview process, involvement in evidence-based practice, policy and procedures and find creative ways to engage staff and get opinions.
- More staff engagement over their work (Manager)
  - Self scheduling
  - Open/closed units, on call
  - Set value structure-family, school, etc
  - Time to participate

Tang JHC, et al. Journal of Gerontological Nursing, 2019;45:11-19

Florence Nightingale …

An expert in nursing's autonomous scope of practice

- Surveillance & monitoring of patient conditions for early detection of problems
- Preventing complications

"I use the word nursing for want of a better. It has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet—all of these at the least expense of vital power to the patient"

Notes on Nursing (1860/1969 p. 8)

Florence Nightingale on:

"… so deep-rooted and universal is the conviction that to give medicine is to be doing something or RATHER EVERYTHING; to give air, warmth, cleanliness, etc., is to do nothing."

(emphasis added) Notes on Nursing, (1860/1969, pg. 9)

Missed Nursing Care

- Any aspect of required patient care that is omitted (either in part or whole) or significantly delayed.
- A predictor of patient outcomes
- Measures the process of nursing care

Kalish, R. et al. (2012) Am Jour Med Quality, 26(4), 291-299.

Hospital Variation in Missed Nursing Care

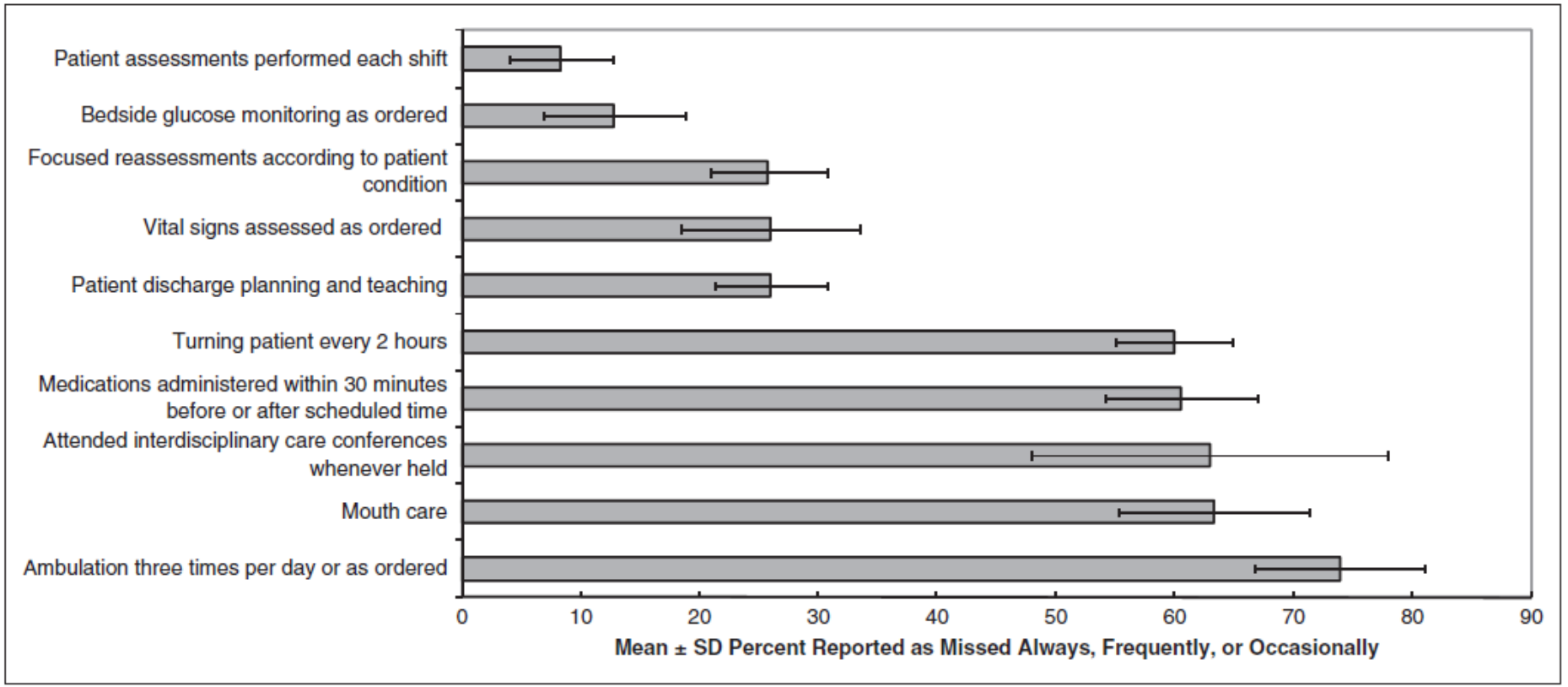


Figure 2. Elements of care most and least frequently missed. The solid bars represent the means across all 10 hospitals, and the range lines indicate the standard deviations.

Kalish, R. et al. (2012) Am Jour Med Quality, 26(4), 291-299

Outcomes of Missed Nursing Care: A Systematic Review

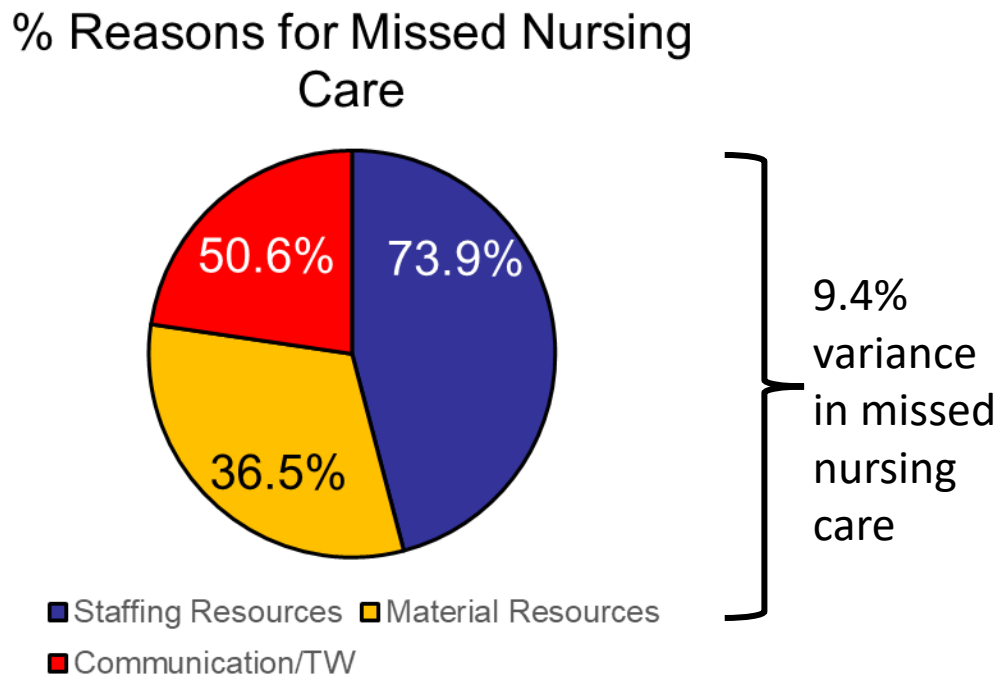
- 14 studies connecting missed nursing care with at least 1 patient outcome
  - Patient Satisfaction ↓
  - Lower quality of care reported by nurses with greater missed care
  - Clinical Outcomes
    - Medication errors
    - CLA-BSI's
    - Pneumonia
    - UTI's
    - Pressure Injuries
    - Falls
    - Failure to rescue

5 nurse sensitive adverse events in 22 med-surg units added 1300 additional hospital days for 166 patients & $ 600,000 in excess costs

Tchouaket E. JAN. 2017;73:1696

Kalisch, BJ, et al. American Journal of Medical Quality. 2011; 26(4), 291–299

Reasons for Missed Nursing Care



- Qualitative Review
  - Interruptions/multitasking/task switching
  - Fatigue & physical exhaustion
  - Cognitive biases
  - Lack of patient & family engagement
  - Lack of physician resources
  - Leadership issues
  - Moral distress & compassion fatigue
  - Documentation load
  - Large proportion of new nurses on unit
  - Complacency

Practice environment correlates to missed nursing care

Kalisch, BJ, et al. American Journal of Medical Quality. 2011; 26(4), 291–299
Ball JE, et al. BMJ Quality and Safety 2014 Feb;23(2):116-25.

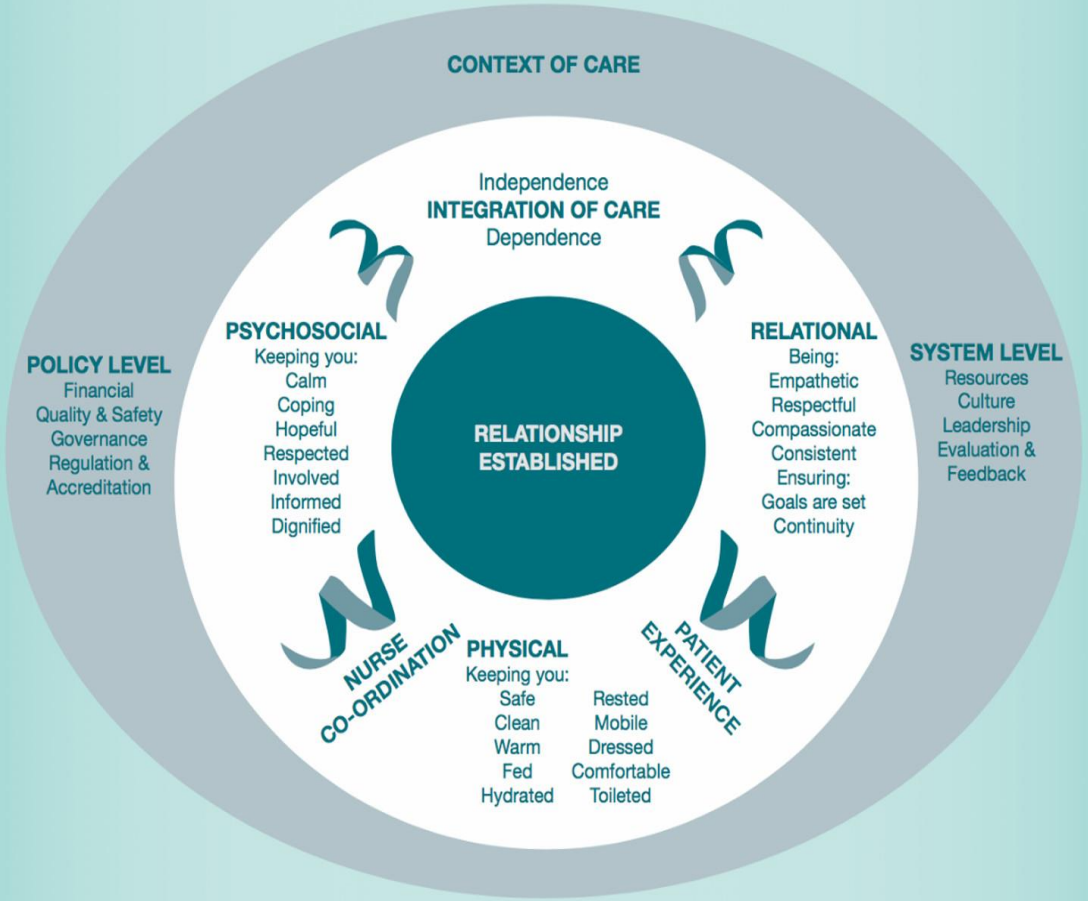
Rationing Care-How we Prioritize

- Highest priority activities for nurses
  - Those which are likely to have an immediate negative impact
    - Administering meds
    - Medical directed treatments
    - Procedures-wound dressings, labs
- Lower priority activities for nurses
  - Those which show no immediate negative harm
    - Ambulation
    - Oral hygiene
    - Emotional support
    - Teaching

Rationing contributes to functional and cognitive decline

Bail K, et al. International Journal of Nursing Studies. 2016;63:146-161

Fundamentals of Care Framework



The Fundamentals of Care Framework. Reprinted from Conroy, Feo, Alderman, and Kitson (2016)

- Fundamental care
  - Involves actions on the part of the nurse that respect and focus on a persons essential needs to ensure their physical & psychosocial wellbeing.
  - These needs are met by developing a positive & trusting relationship with the person being care for as well as their families/carers

Feo R, et al. J of Clin Nurs. 2018;27:2285-2299

Patient Perceptions of Missed Nursing Care

Table 2. Elements of Nursing Care by Ability of Patient to Report and Extent Missed*

	Fully Reportable	Partially Reportable	Not Reportable
			■ Patient assessment ■ Surveillance ■ IV site care
Frequently Missed	■ Mouth care ■ Listening ■ Being kept informed	■ Ambulation ■ Discharge planning ■ Patient education	
Sometimes Missed	■ Response to call lights ■ Response to alarms ■ Meal assistance ■ Pain medication and follow-up	■ Medication administration ■ Repositioning	
Rarely Missed	■ Bathing	■ Vital signs ■ Hand washing	

* IV, intravenous.

Kalisch, B et al. (2012). TJC Jour Qual Patient Safety,38(4), 161-167

Reconnect With Our Professional Purpose

"It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm."

Florence Nightingale

Advocacy = Safety

Protect The Patient From Bad Things Happening on Your Watch

Implement
Interventional Patient Hygiene

INTERVENTIONAL PATIENT HYGIENE

Hand Hygiene

- Hygiene…the science and practice of the establishment and maintenance of health
- Interventional Patient Hygiene….nursing action plan directly focused on fortifying the patients host defense through proactive use of evidence-based hygiene care strategies

Catheter Care

Bathing & Assessment

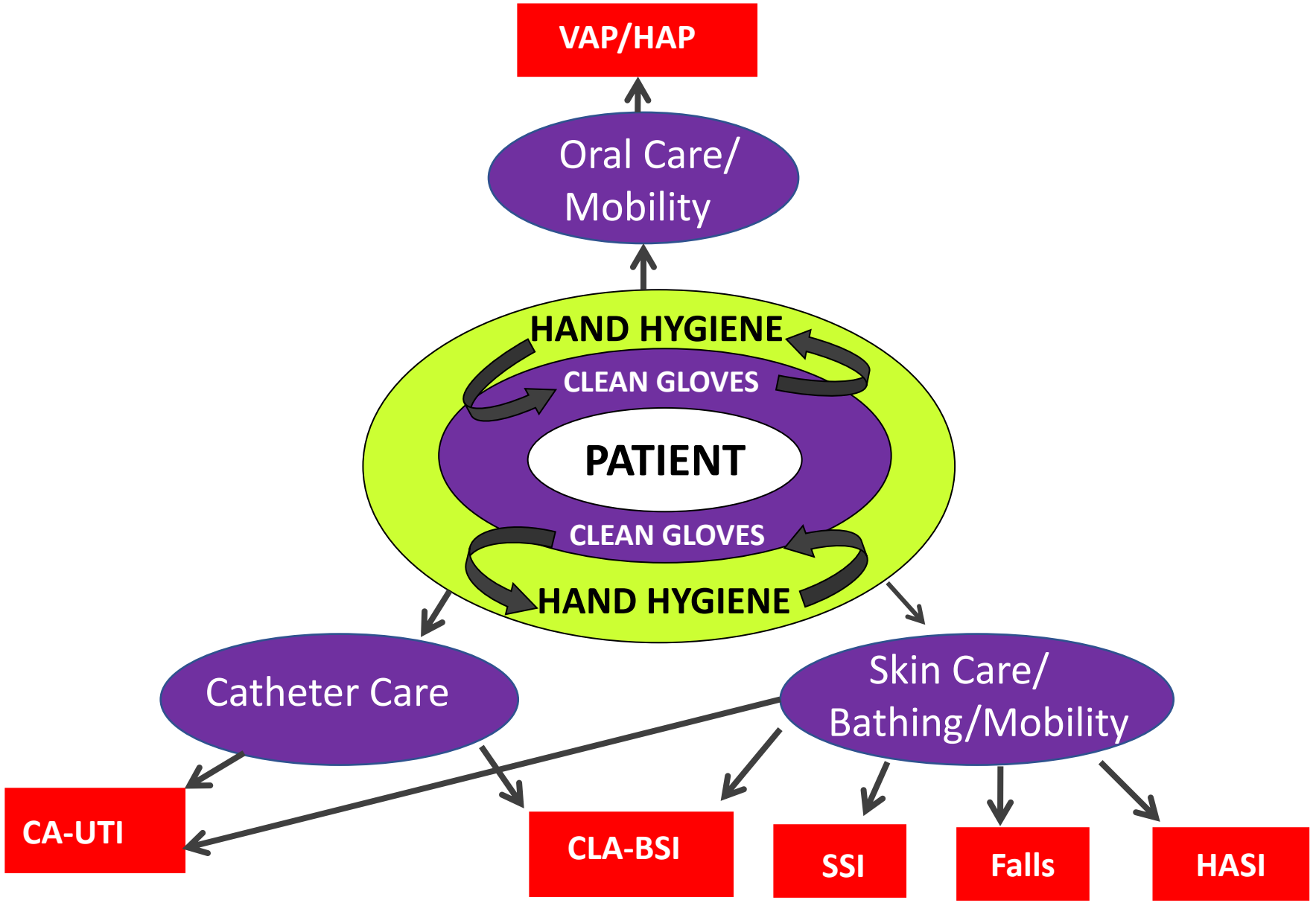
Comprehensive Oral Care Plan

Incontinence Associated Dermatitis Prevention Program

Pressure Ulcer Prevention

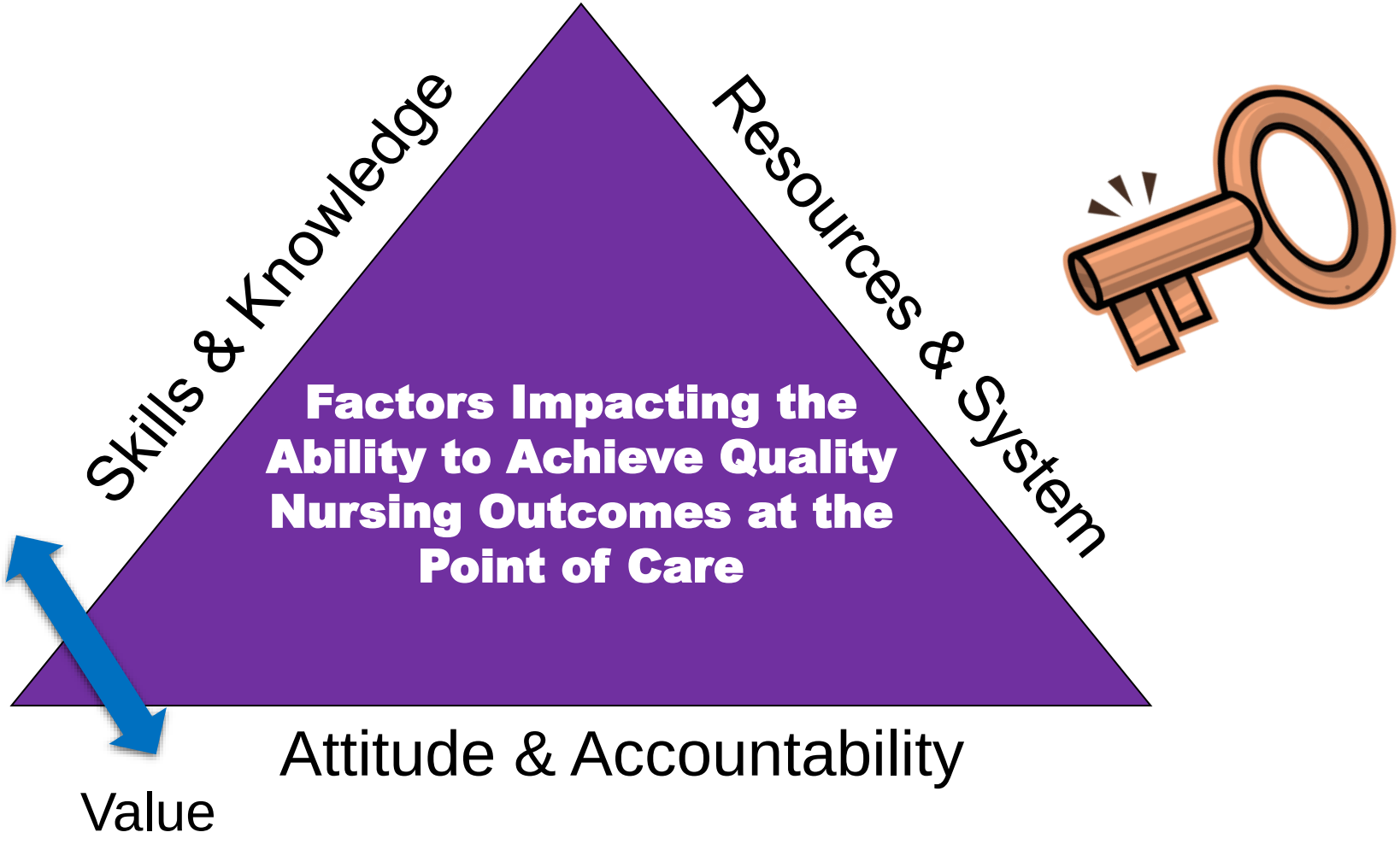
Vollman KM. Intensive Crit Care Nurs, 2013;22(4): 152-154

INTERVENTIONAL PATIENT HYGIENE(IPH)



Vollman KM. Intensive Crit Care Nurs, 2013;22(4): 152-154

Achieving the Use of the Evidence



Vollman KM. Intensive Crit Care Nurs, 2013;22(4): 152-154

How do We Get There?

Grass Roots Unit-Based Culture Change

Re-valuing & recognition of nursing unique contribution

Engagement
Safety Climate

Organizational & Unit Structures that Supported the Empowerment & Engagement

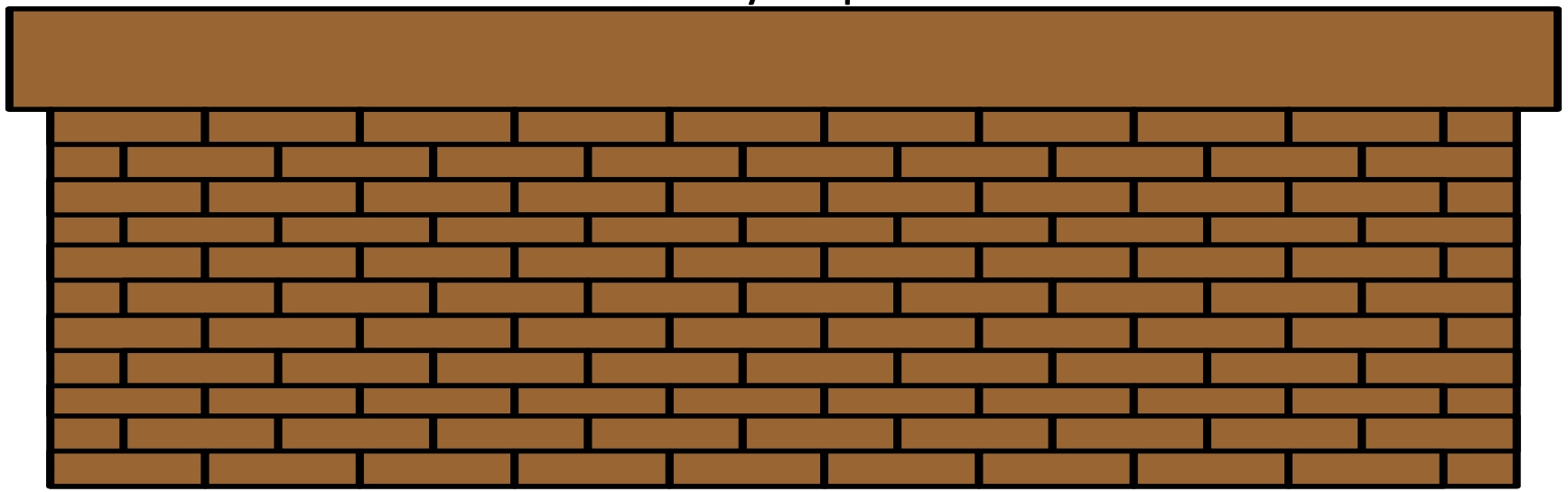
Shared Governance Model

Professional Practice Model/Clinical Ladder

Unit Based Leadership Model

Educational Support

Continuous Quality Improvement Model

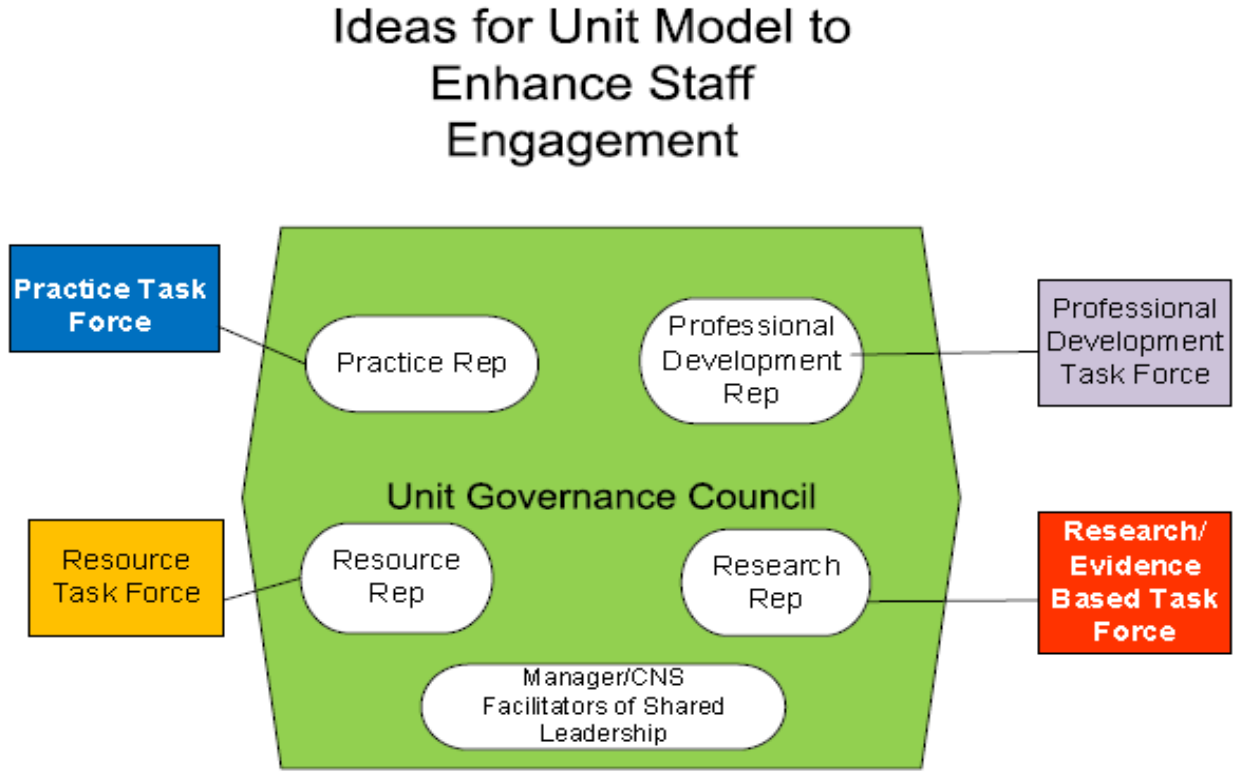


Foundational Principles to Maximize Staff Empowerment & Engagement

- Share Governance = Shared Leadership of Practice/Ownership
- Shared governance is a structural model that frames the professional practice within health care settings (Porter-O'Grady, 2012).
- Shared governance empowers nurses to participate in decision making, nursing practice, and development of nursing policies (Bednarski, 2009).
- The Unit is the center of a shared governance model..the locus of control is at the point of service

Foundational Principles to Maximize Staff Empowerment

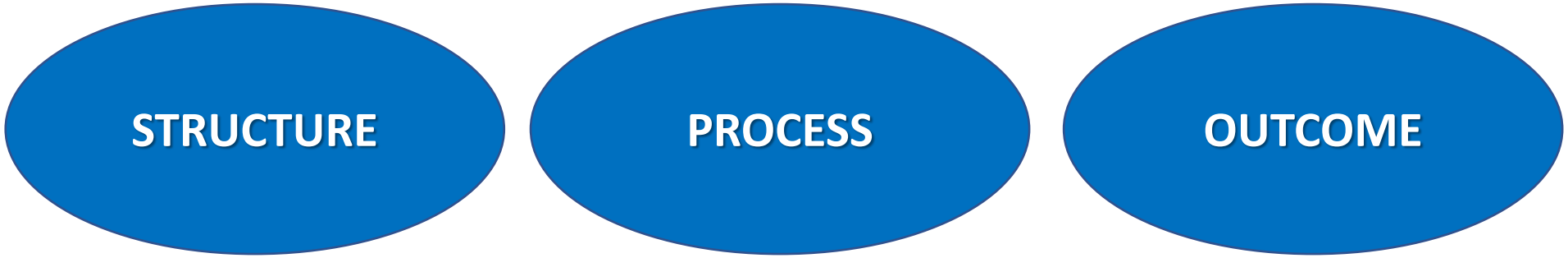
- Staff need mentoring and leadership coaching
- Shared leadership means the clinical and administrative lead of the unit are part of the unit practice/governance council
- Defined accountability of all members
- Sufficient time in meetings to formulate ideas and plan work (unit meeting 4hrs)



- The number of staff/size of the unit determines the number of members of the UGC
- Representatives to the UCG will be elected for a 2 year term with election rotations that permit only half of the members to off the council at anyone time
- Each member of the UGC (other than leadership) has 5-6 staff that are thier constituents for feedback coming to & from the UGC

Communication

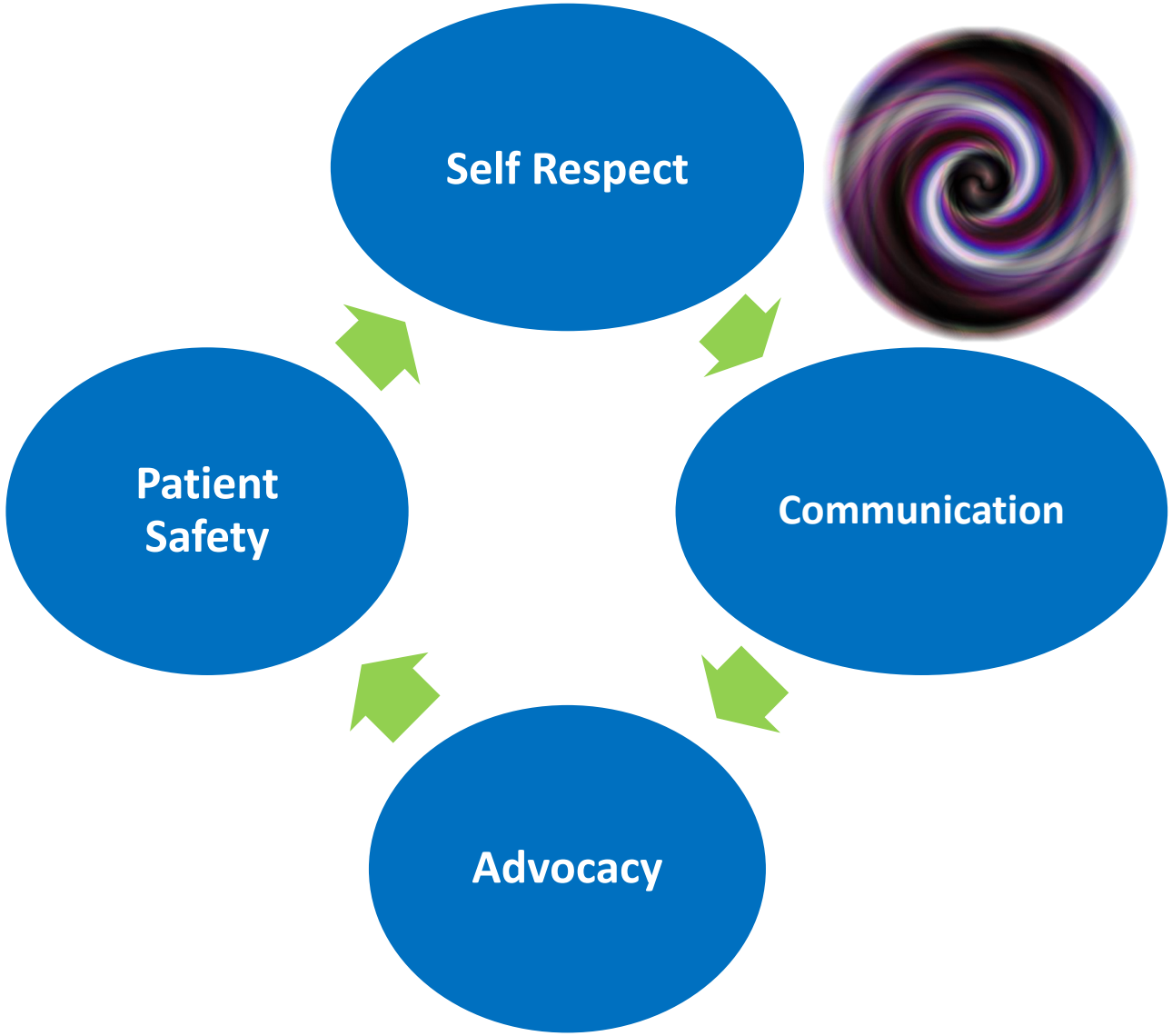
Health Care Quality
Donabedian Framework



- Having the right things in place
- Doing the right things
- Having the right things happen

Quality of care is represented by an entire systemic integration from structure to process and to outcome, but not by one or the other independently

Why Effective Communication May Be Challenging for Nursing



The single biggest problem with communication is the illusion that it has taken place

George Bernard Shaw

The Silent Treatment: April 2011

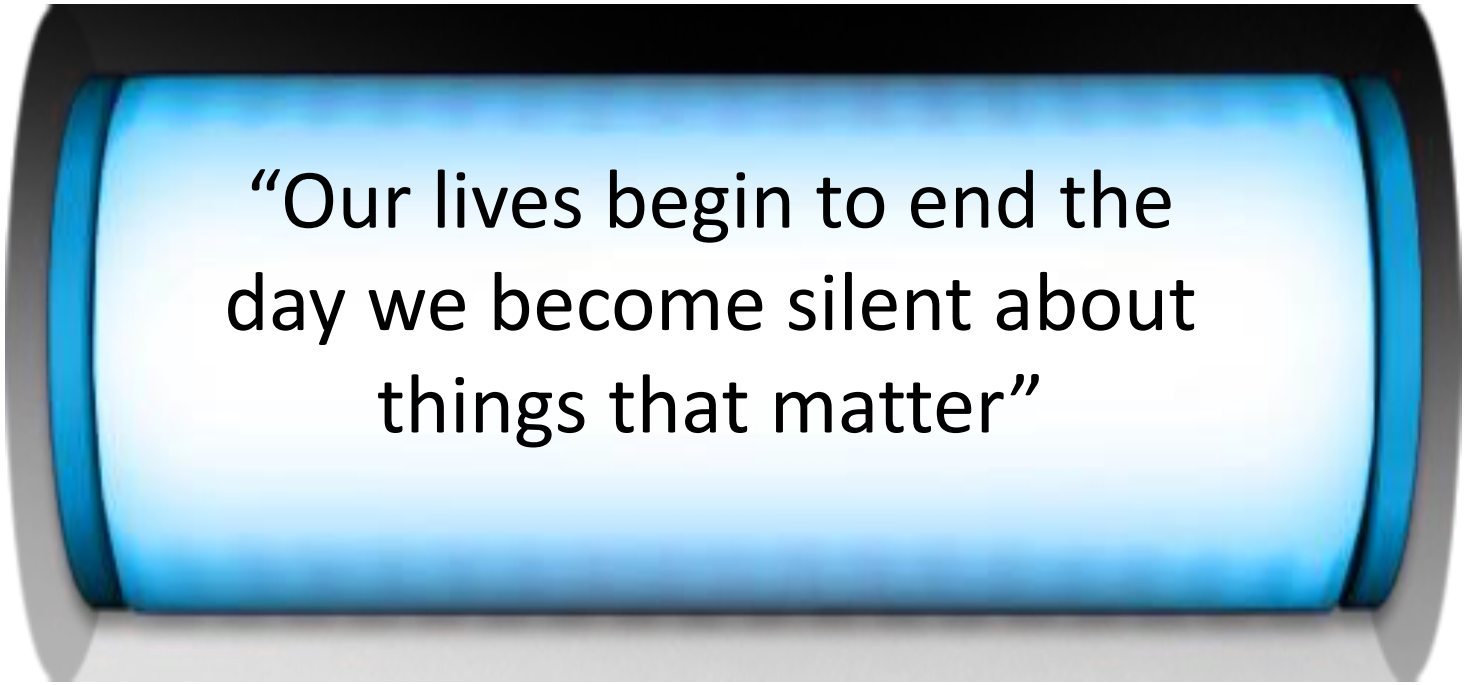
- 85% of workers- safety tool warned them
- Safety tools include: handoff protocols, checklists, COPE, automated medication dispensing machines.
- 58% said they got the warning but didn't speak up

Why:

- 1/2 say shortcuts lead to near misses
- 1/3 say incompetence leads to near misses
- 1/2 say disrespect prevented them from getting others to listen or respect their opinion

Only 16% confronted the disrespectful behavior

http://www.silenttreatmentstudy.com



Martin Luther King Jr.

What to Do?

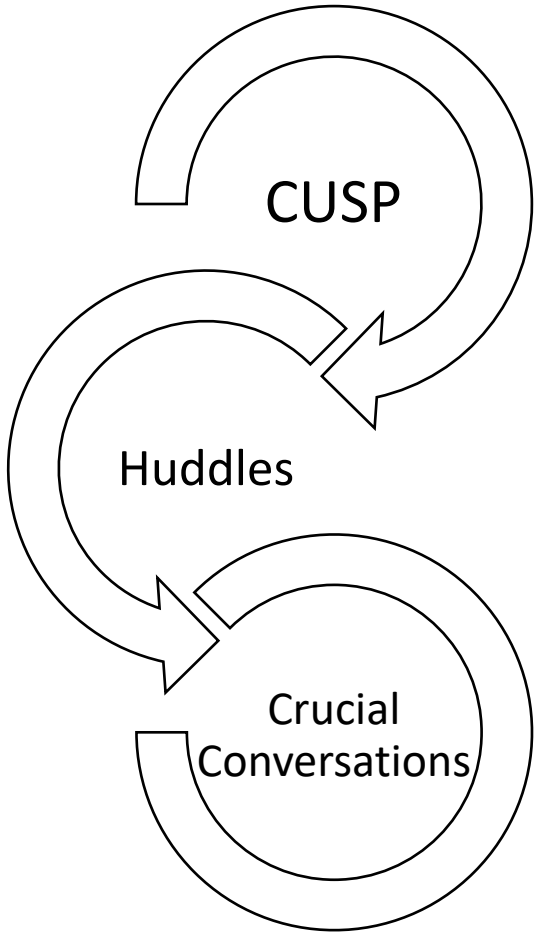
- Prevent from occurring through training on effective communication
- Deal in real time to prevent staff or patient harm
- Initiate post event reviews, action and follow-up
- Make it as transparent as possible
- Zero-tolerance policy and procedure
- Intervention strategy: code white

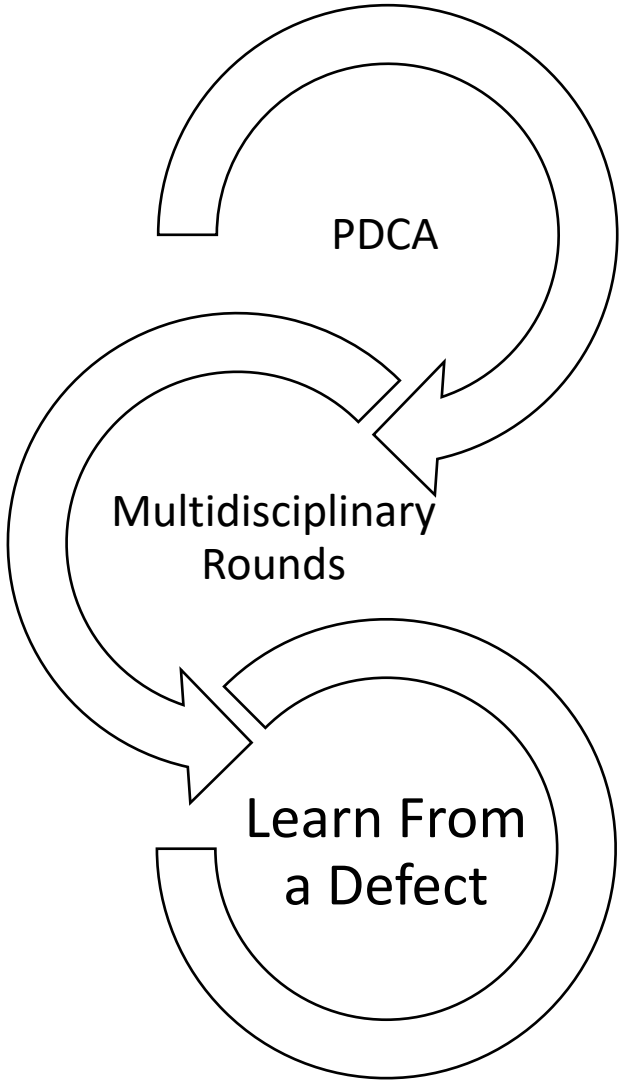
Leadership Communication Critical to Engagement

- Establish strategic clinical plan and goals with unit governance council
- Listening, sharing and follow up
- Be visible and available for staff to ask questions, express concerns
- Solicit opinions
- Multimodal communication
  - Huddles
  - Bulletin boards
  - Emails
  - Suggestion boxes
  - Newsletters
  - Generational communications

Tang JHC, et al. Journal of Gerontological Nursing, 2019;45:11-19

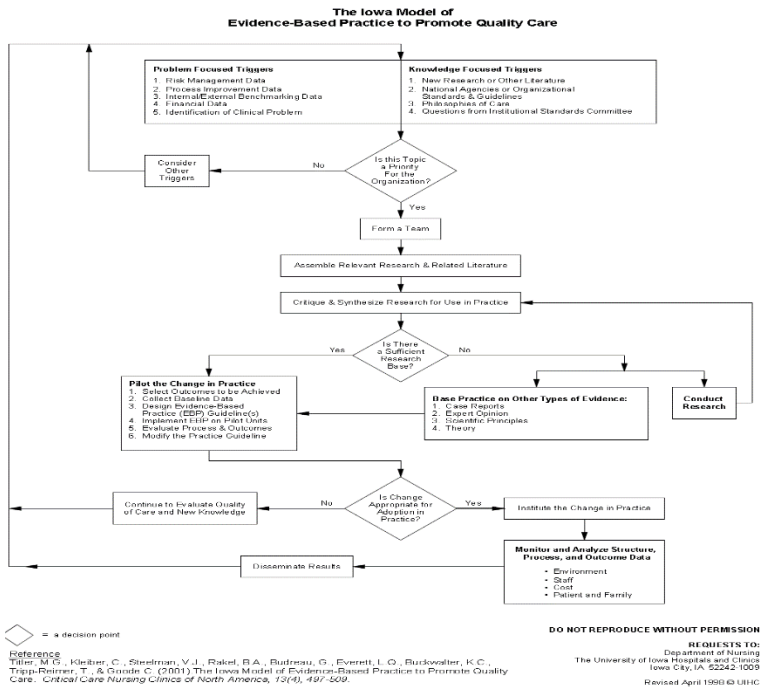
Process = Strategies for Creating a Safety Culture





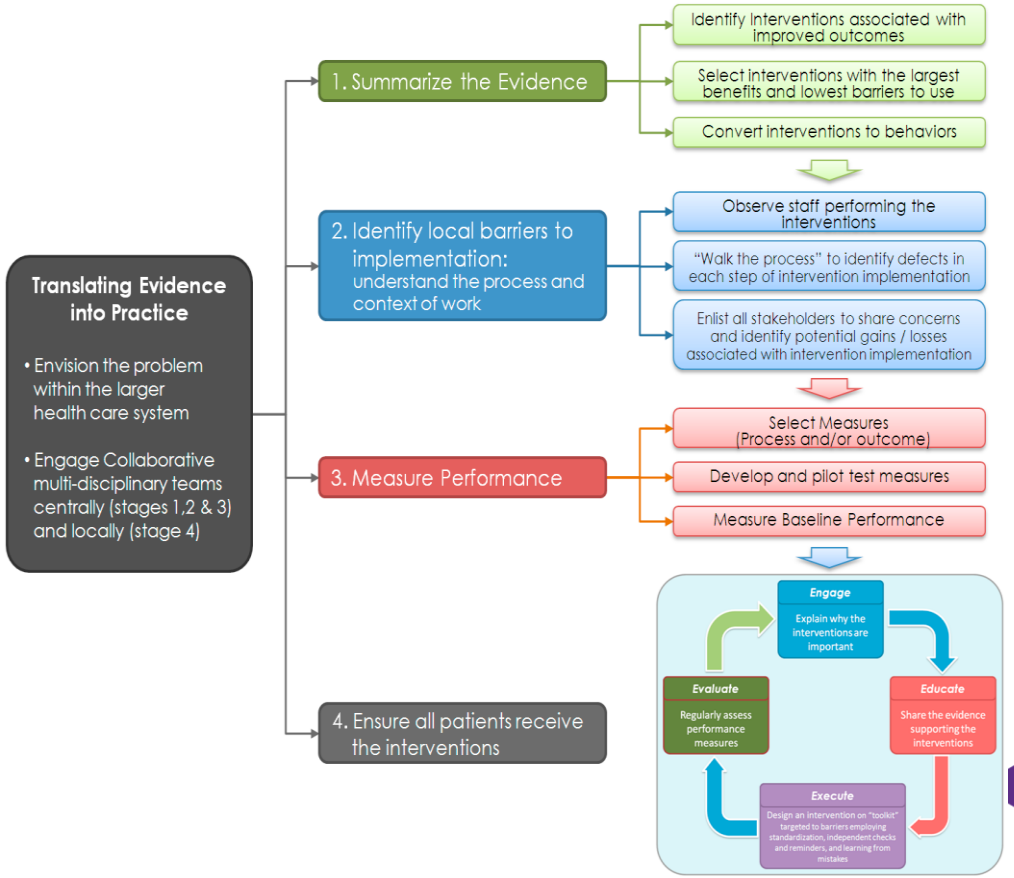
Models/Frameworks Used to Guide Change

Iowa Model



Donabedian Model

John Hopkins Translating Evidence into Practice Model

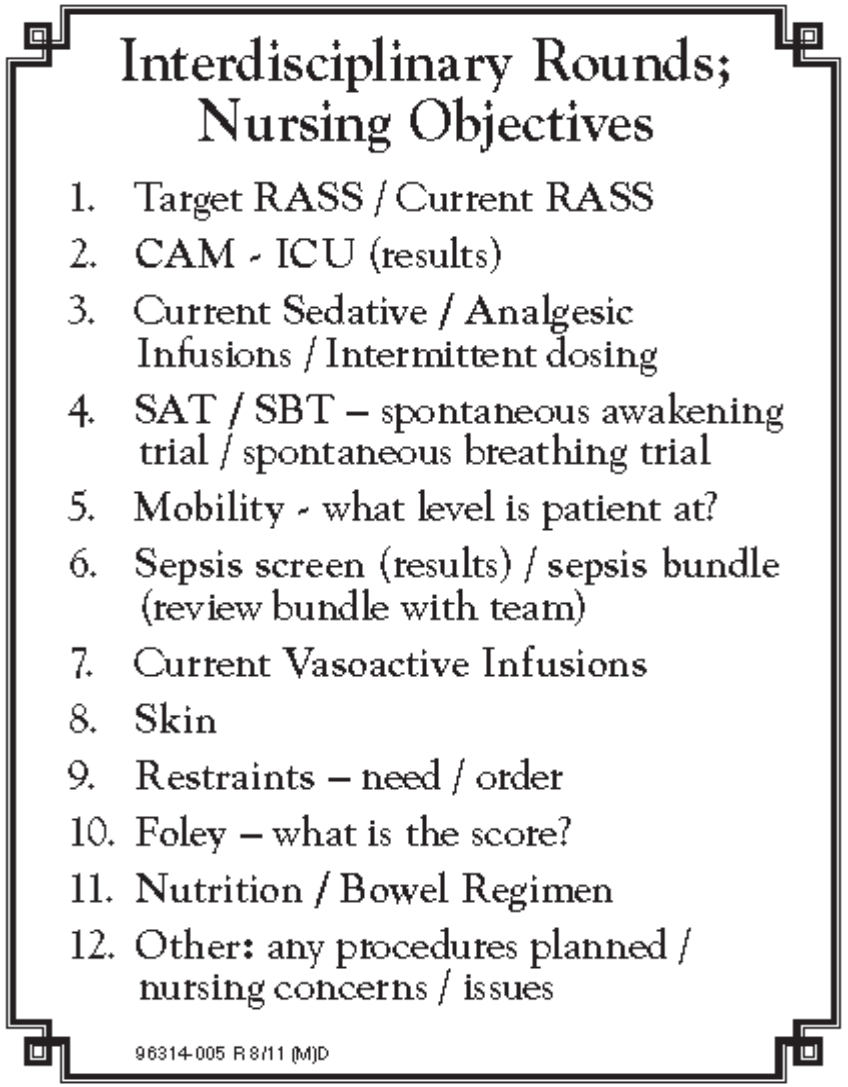


Tools and Strategies to Improve Communication and Teamwork

- Structured Handoff
- Huddles
- Daily rounds/goals
- Pre-procedure briefing
- Checklists


T
Together
E
Everyone
A
Achieves
M
More

RN Starts Round with Vital Signs Then Integrates The Checklist



Interdisciplinary Rounds; Nursing Objectives

1. Target RASS / Current RASS
2. CAM - ICU (results)
3. Current Sedative / Analgesic Infusions / Intermittent dosing
4. SAT / SBT – spontaneous awakening trial / spontaneous breathing trial
5. Mobility - what level is patient at?
6. Sepsis screen (results) / sepsis bundle (review bundle with team)
7. Current Vasoactive Infusions
8. Skin
9. Restraints – need / order
10. Foley – what is the score?
11. Nutrition / Bowel Regimen
12. Other: any procedures planned / nursing concerns / issues

96314-005 R 8/11 (M)D

Interdisciplinary Rounds; Nursing Objectives

1. Target **RASS** / Current **RASS**
2. **CAM - ICU** (results)
3. Current **Sedative / Analgesic** Infusions / Intermittent dosing
4. **SAT / SBT –** spontaneous awakening trial / spontaneous breathing trial
5. **Mobility –** what level is patient at?
6. **Sepsis screen** (results) / **sepsis bundle** (review bundle with team)
7. Current **Vasoactive Infusions**
8. **Skin**
9. **Restraints –** need / order
10. **Foley –** what is the score?
11. **Nutrition / Bowel Regimen**
12. **Other:** any procedures planned /nursing concerns / issues

Huddles

- Enable teams to have frequent but short briefings so that they can stay informed, review work, make plans, and move ahead rapidly.
- Allow fuller participation of front-line staff and bedside caregivers, who often find it impossible to get away for the conventional hour-long improvement team meetings.
- They keep momentum going, as teams can meet more frequently.

Immediate Huddle Learn from a Defect

Learning from Defect: Pressure Injury Facility Acquired

Date:_____

Attendees:_____

sticker

Instructions:

When HAPI is identified, staff nurse to notify unit manager. Manager will notify team of super huddle time. Super huddle to include any staff nurses and PSTs available, wound care nurse, CNS, CL, and NEC if available, and respiratory if applicable. If this occurs on nights, huddle can be done at night with any staff available, and then info passed on to manager to follow up with wound care, CL, CNS, NEC.

Manager to complete the form AT the BEDSIDE with input from everyone present. Once Section I has been completed, clinical leader (or manager designee) will complete Section II. Return completed form to Quality Department. Manager to keep a copy and have available for review at Pressure Injury Task force.

*if manager is off, contact whomever is covering, i.e. other manager or clinical leader.

Section I:

Location of the Pressure Injury: Unit_____ Date of Pressure Injury:_____

What happened? (brief description from RN caring for patient)

1. Anatomical location of the HAPI:_____
2. LOS when discovered: _____
3. Stage when discovered: _____
4. Was the patient transferred prior to discovery? ☐ yes ☐ no
5. Was there an OR procedure within 72 hours of discovery? ☐ yes ☐ no
6. Time in ED from admit order to admission to floor > 8 hours? ☐ yes ☐ no

Why did it happen?

Wound Nurse Comments:

Risk:

7. What risks were identified? ☐ Immobility ☐ Shear ☐ Medical device ☐ HD patient ☐ Moisture/incontinence ☐ hemodynamic instability with turning ☐ nutrition risk

Skin Assessment:

8. Redness was recognized before the skin broke down. ☐ Yes ☐ no ☐ N/A

Pressure/Shear and Patient Movement: complete on how patient is currently positioned

9. If the patient is in bed, what position are they currently in? ☐ back ☐ Rt side lying ☐ Lt side lying ☐ prone ☐ N/A
10. Immobile patients are moved using lifting equipment to minimize sheer and caregiver injury? ☐ Yes ☐ no ☐ N/A -not immobile
11. Heels are floated with pillows if temporary (<8hrs)? ☐ Yes ☐ no ☐ N/A
12. Heel floated with a device if >8 hrs of immobility? ☐ Yes ☐ no ☐ N/A
13. Sacral foam dressing in place? ☐ Yes ☐ no
14. HOB greater than 30
15. Urine and fecal containment per policy if patient is incontinent? ☐ Yes ☐ no ☐ N/A
16. Was barrier cream in room if patient is incontinent? ☐ Yes ☐ no ☐ N/A

Support Surface:

17. At risk patient is on appropriate surface? ☐ Yes ☐ no ☐ N/A

Medical Devices (check all that apply) (If none check proceed to the questions in a box)

☐ Trach ☐ noninvasive mask ☐ oxygen N/C ☐ cervical collar ☐ arterial line
☐ Endotracheal tube ☐ Endo Tube Holder ☐ orthotics ☐ cooling blanket ☐ SCD/Stocking
☐ Immobilizer/splint/arm board

18. Were protective measures taken to prevent injury? (Foam padding, protective dressing, repositioning? ☐ Yes ☐ No ☐ N/A

What happened to cause the defect?	What prevented it from being worse?

What can we do to prevent this from happening to someone else?

Action Plan	Responsible person	Targeted date	Evaluation Plan: How will we know risk is reduced?

With whom shall we share our learning? (communication plan)

Who	When	How	Follow up

Section II:

Additional Data to be completed when able:

1. Was Braden risk identified? yes ☐ no ☐
2. 4 eyes head to toe assessment performed on admission? ☐ Yes ☐ no
3. 4 eyes head to toe assessment performed per shift (last 24hrs)? ☐ Yes ☐ no
4. 4 eyes assessment of skin underneath device done q 12 hrs by RT.? ☐ Yes ☐ no ☐ N/A
5. Patient pressures redistributed and documented q 2? ☐ Yes ☐ no

Incontinence/Moisture

Rev. 7.11.2019 LMC

Huddle Issues Requiring In-Depth Review Gets the Full Drill Down—Consider a Good Catch Program

Implement Communication and Teamwork Tools

Tools Don’t Create Safety

People Do!!!

The Silent Treatment, April 2011

The Most Powerful Force of Human Behavior is Social Influence

Track Prevention Practices and Harness the Power of Local Data

- Continue to collect process and outcome data
- Set targets for process and outcome data
- Gather information from defects
- Use data to identify opportunities and hardwire practices
- Share data with:
  - Improvement team
  - Frontline staff
  - Leadership

A Safe Culture is a Just Culture

- A system that:
  - Holds itself accountable
  - Holds staff members accountable
  - Has staff members who hold themselves accountable

How Will You Know Your Culture is Safe?

Initially

- Increase number of incident reports
- Data is being shared (MDR/Huddles/Shared Governance Meetings)
- Staff initiated learn from a defect
- Staff participation in shared governance
- Staff participation in rounds
- Staff participation in practice changes
- Asking the question—how is the next patient likely to be harmed

As You Reach Full Safety Culture

- Less near misses/reduced reporting because harm is reduced
- Culture of survey should reflect easy to speak up
- Overall culture of safety data improving
- Zero harm

One of the reasons people don’t achieve their dreams is that they desire to change their results without changing their thinking

John C. Maxwell