Montana Quality & Patient Safety Fellowship 2021

Session 4



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Performance Improvement Project

Complete your project plan prior to April webinar

•Set up coaching calls between April and May with Kim and Barb

Present project during July webinar



Montana Quality and Patient Safety Fellowship Name / Organization: (Enter here)

Project AIM: (What, Who, Where, How much, By when?) (Enter here – example: *The 4 West Unit at ABC Hospital will reduce falls with injury by 40% by the end of 4th quarter 2020*)

Process changes we are exploring/have tried: (Enter here) (example: 1. Hourly rounding, 2. Early progressive mobility, 3. Standardizing up for meals for certain patient populations)

How will we measure success?

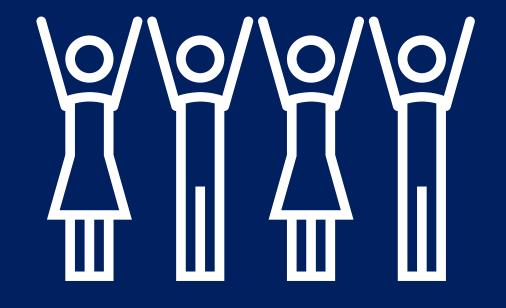
Outcome Measure: (Enter here) (Example: rate of falls with injury in the 4 West unit. Remember, this will be met in the future not within a short period of time.)

Process Measure(s): (Enter here) (Example: 1. Compliance rate for hourly rounding as evidenced by documentation, patient feedback during charge RN interviews, etc., 2. Rate of patients observed sitting up in chair for meals, 3. Rate of eligible patients with documentation of assisted mobility once per shift)

Next Steps for our project: (Enter here)

Let's Talk About Your Quality Improvement Projects

- What's working?
- What's the biggest challenge?
- How have you decided to change your original plan?
- What would you like to accomplish by July?







Human Factors and the Connection to Safety



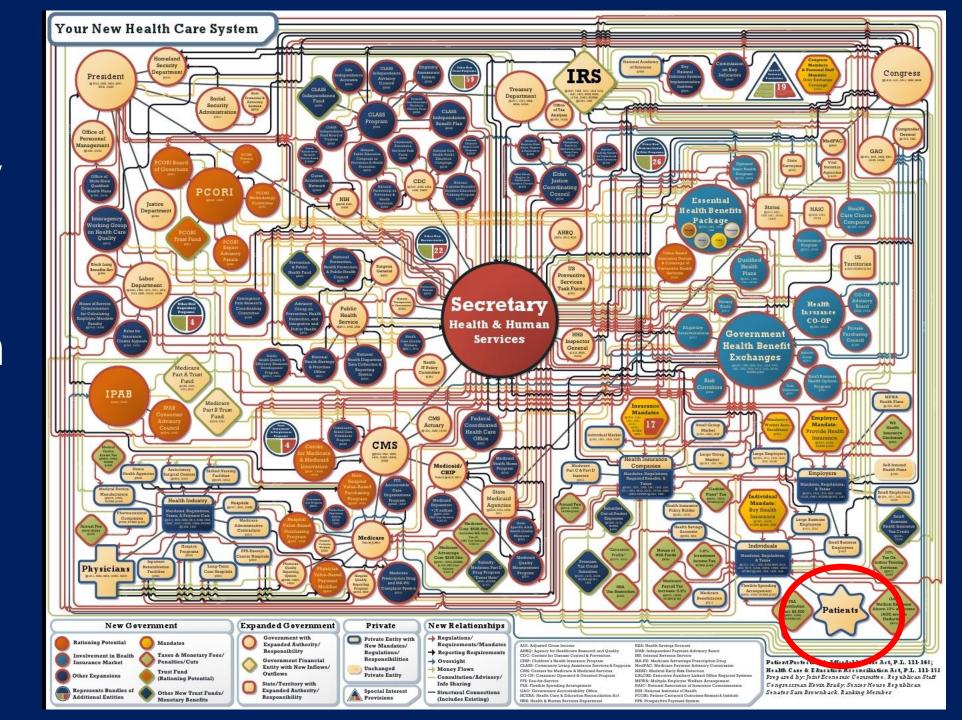
Key Concept

- Human behavior must be understood when designing systems
- Highly reliable organizations understand this and take human factors into account when designing systems



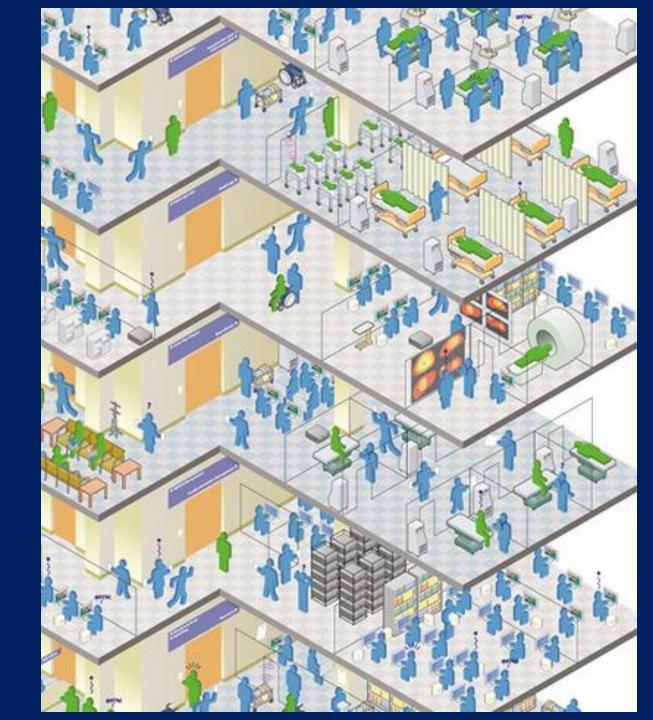


Complexity in Healthcare and Human Factors



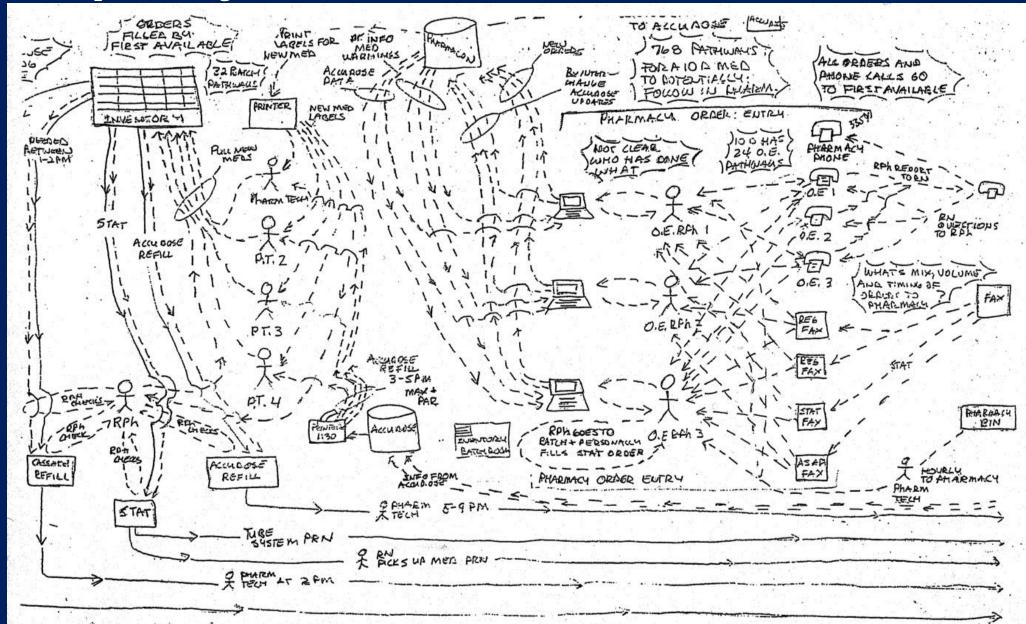


Complexity in Healthcare and Human Factors





Complexity in Healthcare and Human Factors





Complexity and Human Factors in Other High Consequence Industries





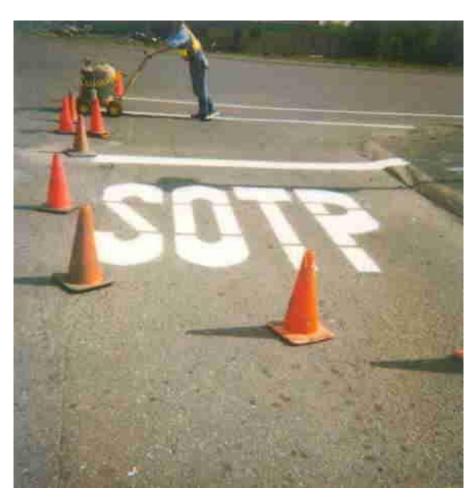
Hospitals Aren't Airplanes, but...

The design principles for human factors both include:

- Simplify
- Standardize
- Use forcing functions and constraints
- Use redundancies
- Avoid reliance on memory
- Take advantage of habits and patterns
- Promote effective team functioning
- Automate carefully



The bottom line is human beings make mistakes





Constraints, Forcing Functions and Redundancies

• **Constraints** make it difficult to complete a task. A constraint can be defined as the state of being checked, restricted, or compelled to avoid or perform some action.





Constraints, Forcing Functions and Redundancies

• Forcing functions make it impossible to do a task incorrectly. They create a hard stop that you cannot pass unless you change your actions.









A forcing function does not have to involve device design

Constraints, Forcing Functions and Redundancies

• A **redundancy** is a system design that includes a duplicate, but not necessary to complete, step or component.







Technology Can Reduce Errors, BUT...

• The interface between humans and machines can also lead to errors.

 Technology also provides us with new forms of error







Safety Culture and the Connection to Teamwork and Communication

Culture "How we do things here"

Safety Culture

"How can we change HOW we do things to make care safer?"

Contributions to the Development of a Safety Culture (Or Not)







What's similar?

- Custody of many lives
- Can kill or maim you
- Complex
- Many things have to go right and in sequence
- You have little if any personal control



What's different?

Commercial Aviation

- Multiple redundant systems
- Safe means to report error
- Not expected to be perfect
- Very few commercial airline mortalities in last decade, but MAJOR response when they do occur

Hospitals

- Occasional redundant systems (often short-cut or ignore)
- Fear of reporting error
- Error is cost of doing business
- Expected to be perfect
- Last unexpected death in US will occur while we are meeting today



The Key

Communication





How might a focus on team communication improve the culture of safety in your organization?





Critical Language Among Teams

Structured communication among teams is one way to improve the culture of safety

as long as the organizational culture values the voices of all team members





Structured Communication

Structured communication helps us to communicate more efficiently and effectively with our teammates. These techniques help the team to plan for care, respond to changes in care plans or patient conditions, and build situational awareness among all team members.





Critical Language

Critical language is a set of agreed-upon terms that members of the team use when clarity is needed.

I am C oncerned
I am U ncomfortable
This is a S afety issue
Please, I N eed...



Briefings and Debriefs

A way for teams to quickly plan for a complex procedure, plan the day with a quick safety update, or identify any issues that need to be addressed.





SBAR

SBAR is a common form of structured communication used most frequently in health care to communicate about a patient between one provider and another.

SBAR is a technique designed to communicate critical information succinctly and briefly.



5 itu

ituation

What's going on with the patient right now? (Identify yourself, Identify the patient, State the problem concisely.)



ackground

What's the background on this patient? How did we get to this point? (Review the chart. Anticipate questions.)
State the relevant medical issues.)



ssessment

What do I think the issue is? Why am I concerned? (Provide your observations and evaluations of the patient's current state.)



ecommendation

What should we do to respond to the situation? (Suggest what should be done to meet the patient's immediate needs.)



esponse

Collaboration resulting in a plan of action, (Listen for/seek feedback to ensure responder understands the lister.)





Sepsis SBAR

Situation

```
has screened + for sepsis at __(time)_____
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- Background
 - 1. ____has the following + criteria for SIRS
 - a. Temp > 38C or <36C
 - b. BP <90 or >40mmHg from baseline
 - c. Respiratory rate >20/min
 - d. HR >90/min
 - e. Change in mental status, ALOC
 - 2. I suspect infection; the most recent WBC is_____

Part 2 of Sepsis SBAR

Assessment

- 1. Vital signs are _____
- 2. SA0₂ is _____, compared to _____
- 3. Mental status is now
- 4. Urine output is ____cc/hr or ___over last 8 hours
- 5. Most recent creatinine is_____; on adm was____

Recommendations

- 1. I need you to evaluate the patient to confirm if he has severe sepsis
- 2. In addition to a stat lactate, what other labs?
- 3. Should I start an IV and give a fluid bolus?



	Primary Pianasia	
S	Primary Diagnosis: Secondary Diagnosis:	
3	Secondary Diagnosis.	
Situation		
D	PMH: DM / CHF / HTN / CAD / PCI / HLD	
В	Asthma /Smoker / Drug Abuse / Psych / Dementia / Hypothyroid	
Background	Tests: MRI / X-ray / CT / CBC / CMP / UA / CARD PANEL / PT-PTT / D-Dimer / CRP	
	IV # R/L SL	IVF: NS / ½ NS / D5 ½ NS / LR / Abx
Α	Site: AC / FA / Hand / Wrist / Other	IV rate:ml/hr
Assessment	Central: PICC / Port	Drips: Heparin / Blood / TPN / Card
Assessment	Neuro:	Pain:
Precaution:	A&O x / Confused / GCS	Level:
	Activity: Ind / x1 / x2 / Bedrest	Location:
MRSA	Walker / Cane	Medication:
C-Diff	Neuro Checks / Restraints / Bed alarm	Frequency:
ESBL	Respiratory:	Cough: Productive / Nonproductive
Influenza	O2@L NC / NRB / CPAP / BiPAP	Treatments: Nebs / IS / RT
Droplet	Breath Sounds: Clear / Diminished / Wheezing / Crackles/Chest tube Out:	
Neutropenic	Cardiovascular: Brady / NSR / A-Fib / A-Fib / A-Flutter / Paced / PACs / PVCs / Murmur / Block	
Need:	Edema: None/Gen/Trace/1+/2+/3+/Pitting/Non-Pitting/R/L/Bilat/Upper/Lower	
Urine Cu	VTE Pophylaxis: SCDs/Heparin/Lovenox/Coumadin/Xarelto/Eliquis/NA/Needs	
Resp Cu	GI/GU: Last BM:	
COVID Swab	Diet: Reg/Clear/Full/ADA/soft/dysphagia/NPO/Renal/AHA	
Flu Swab	Bowel Sounds: Active/Hypo/Hyper/Absent/Nausea/Vomiting/Diarrhea	
MRSA Swab	Urine Output: Voiding/Foley/Inc/Anuria/Bathroom/Urinal/Bedpan/Commode	
	Character: Clear/Cloudy/Yellow/Amber/Bloody Output:	
Wound Swab	Tubes: Ostomy/J-tube/G-tube/NG Output:	
	Blood Sugar: AC/HS/QLast BS Reading:	
Extras:	Musculoskeletal:	Skin:
Daily Weight	Weakness: RUE/LUE/RLE/LLE	Wounds:
Strict I&Os	Numbness: RUE/LUE/RLE/LLE	Dressing: /Wound Vac
Fall Risk	Surgical:	
1:1	Procedure:Surgeon:	
NPO @ Midnight	Position: Supine/Prone/L Lateral/R Lateral/Beach Chair/Lithotomy	
	Anesthesia: General/Spinal/Epidural/Regional Block/Local/Mac/Other	
	Tourniquet Time:/NA	
	Spinal Level: T2/T4/T6/T8/T10/Below umbilical	
	Medications due:	
	Discharge needs:	
_	Schedule procedures: US/Stress/Echo/M	RI
R	Consults: CM/PT/OT/GI/Card/Neuro/Nephro/Wound/Ortho/Psych/Pulm/Surg	
	Date/time Consult:	
Recommendation		

Repeat Back

Repeating back is a way to confirm that communication from another has been heard and understood.





Discussion

What kind of structured communication is in use in your department? Your organization? How has it helped to improve safety? What are the biggest barriers to structured team communication in your organization?

How might human factors play a role in the process design you have chosen for your QI project?



Thank you!

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