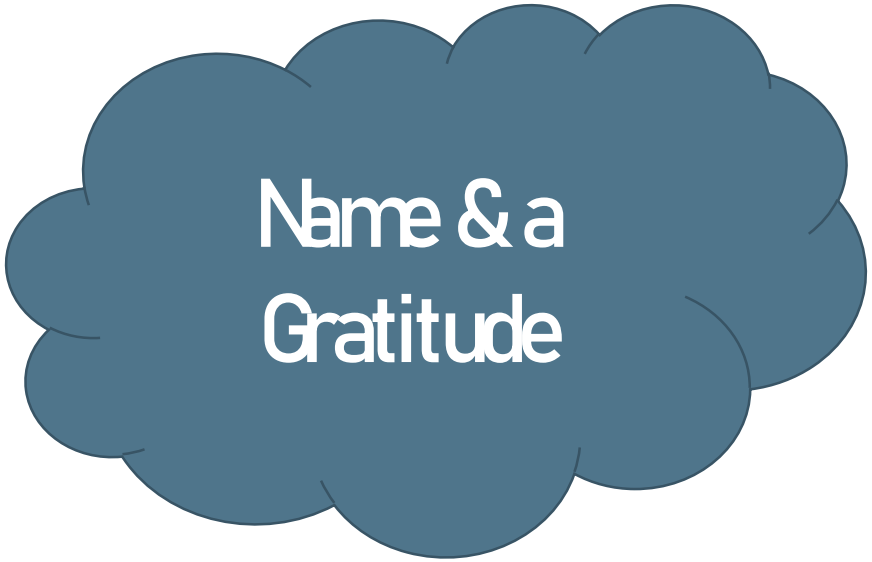
Champions of Quality Improvement Cohort

June 21, 2022

Welcome! We will begin shortly while everyone gets logged in!

Virtual Roll Call



Follow Up

What is the most important question you hope to have answered by the end of today?

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How do you hold others accountable?

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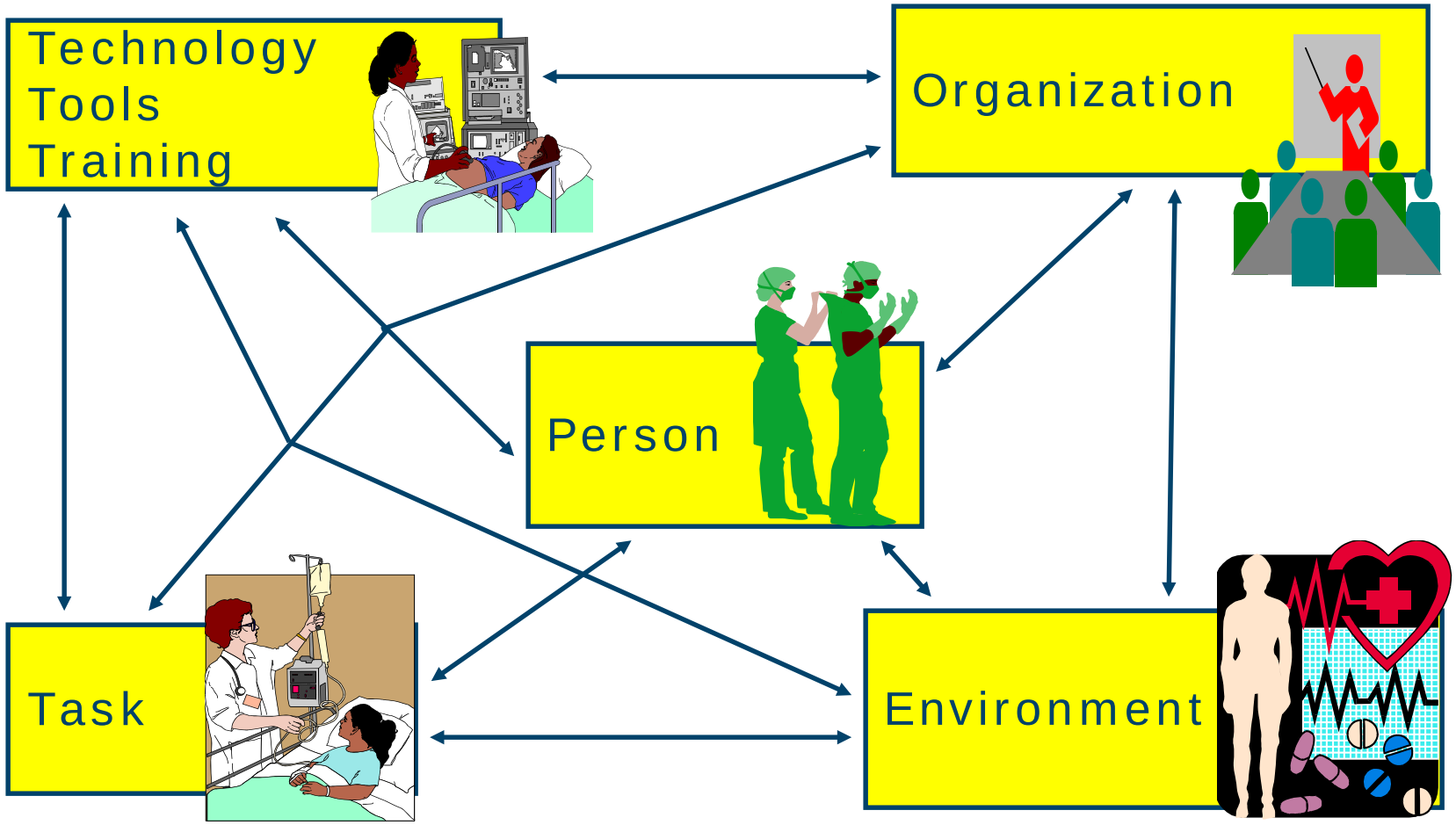
Systems Approach to Harm Reduction

Human Factors Work System Model



Carayon, P., Hundt, A., Karsh, B-T., Gurses, A., Alvarado, C., Smith, M., and Brennan, P.(2006) Work system design for patient safety: the SEIPS model. Qual and Safety in Health Care;15(supp 1):50-58.

Why do mistakes happen?

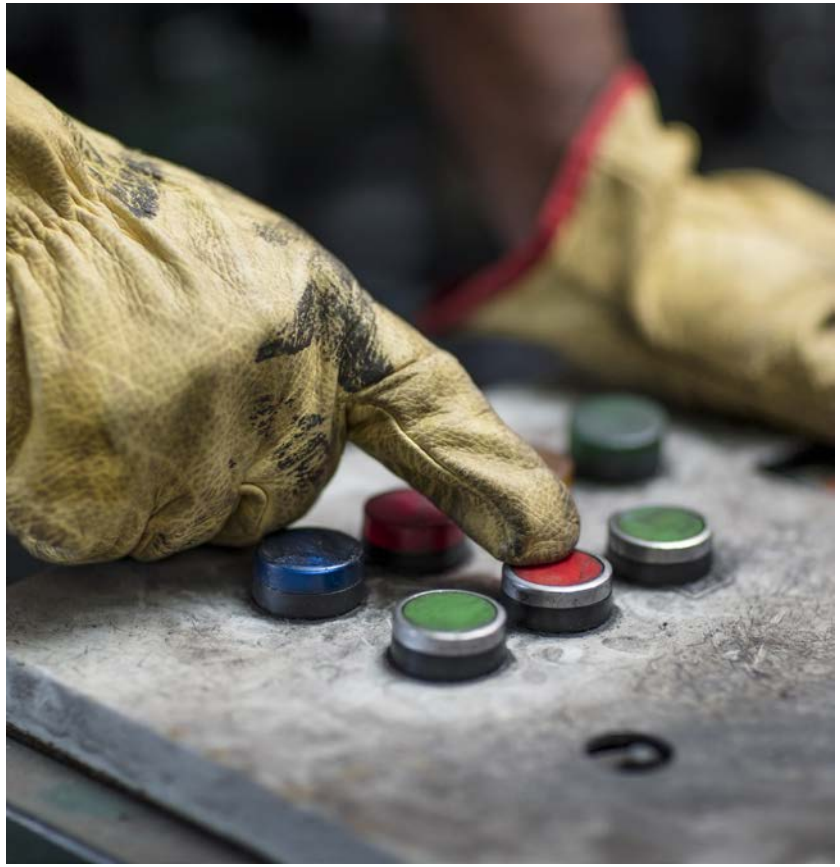
- Human error
- System error
- Negligence

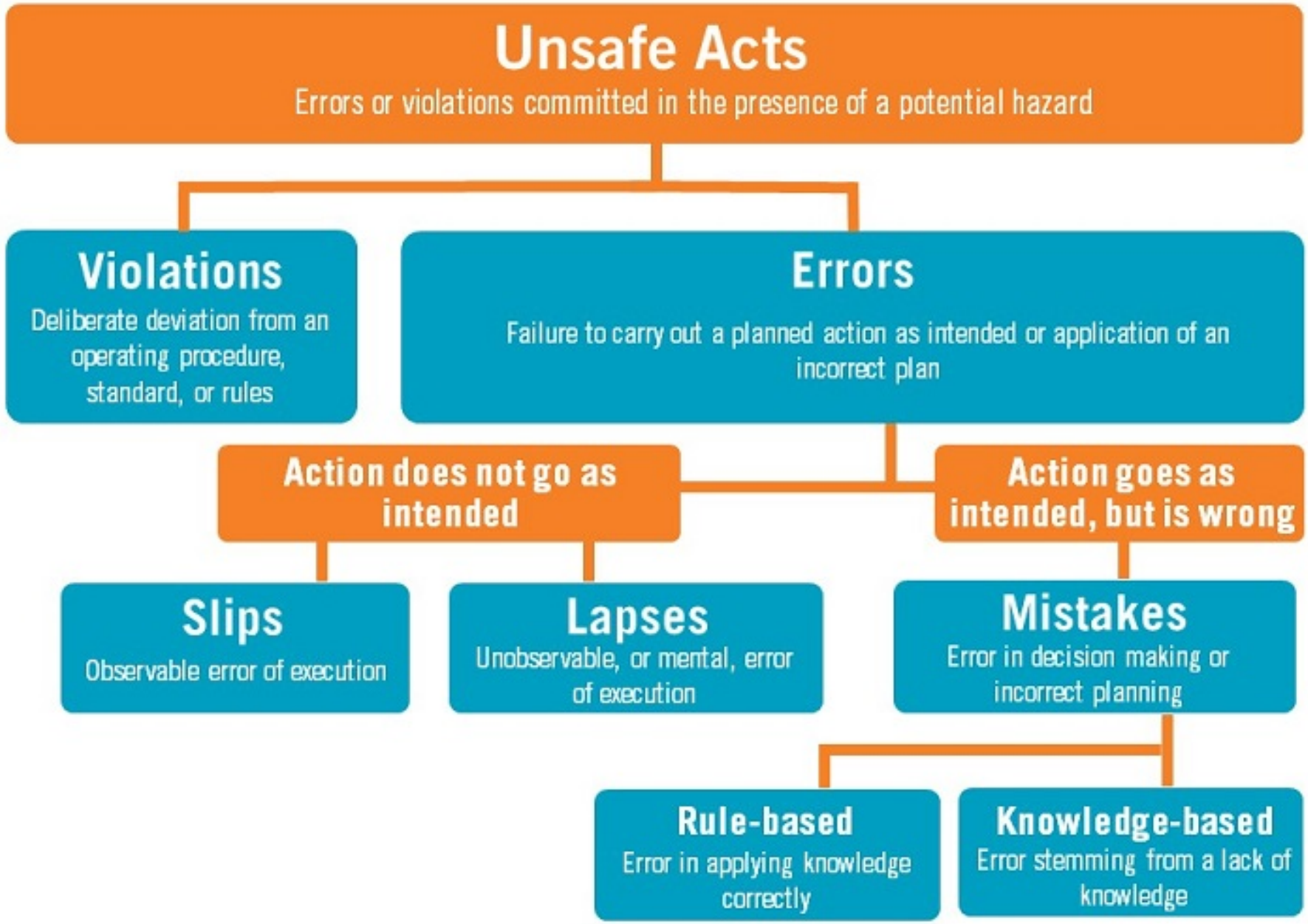
A Closer Look at Error

Unsafe acts are categorized as either *errors* or *violations*.

- An **error** is a *lapse*, *slip,* or a *mistake*.
  - When an action fails to go as intended, the error is called either a ***slip*** (if it is observable – like pushing the wrong button on a piece of equipment) or a ***lapse*** (if it is unobservable – like forgetting to give a medication).
  - When an action goes as intended but is the wrong one, it is called a ***mistake*** (such as a diagnostic error).

A **violation** is a deliberate deviation from an operating procedure, standard, or rules.




Unsafe Acts
Errors or violations committed in the presence of a potential hazard
Violations
Deliberate deviation from an operating procedure, standard, or rules
Errors
Failure to carry out a planned action as intended or application of an incorrect plan
Action does not go as intended
Action goes as intended, but is wrong
Slips
Observable error of execution
Lapses
Unobservable, or mental, error of execution
Mistakes
Error in decision making or incorrect planning
Rule-based
Error in applying knowledge correctly
Knowledge-based
Error stemming from a lack of knowledge

Just Culture

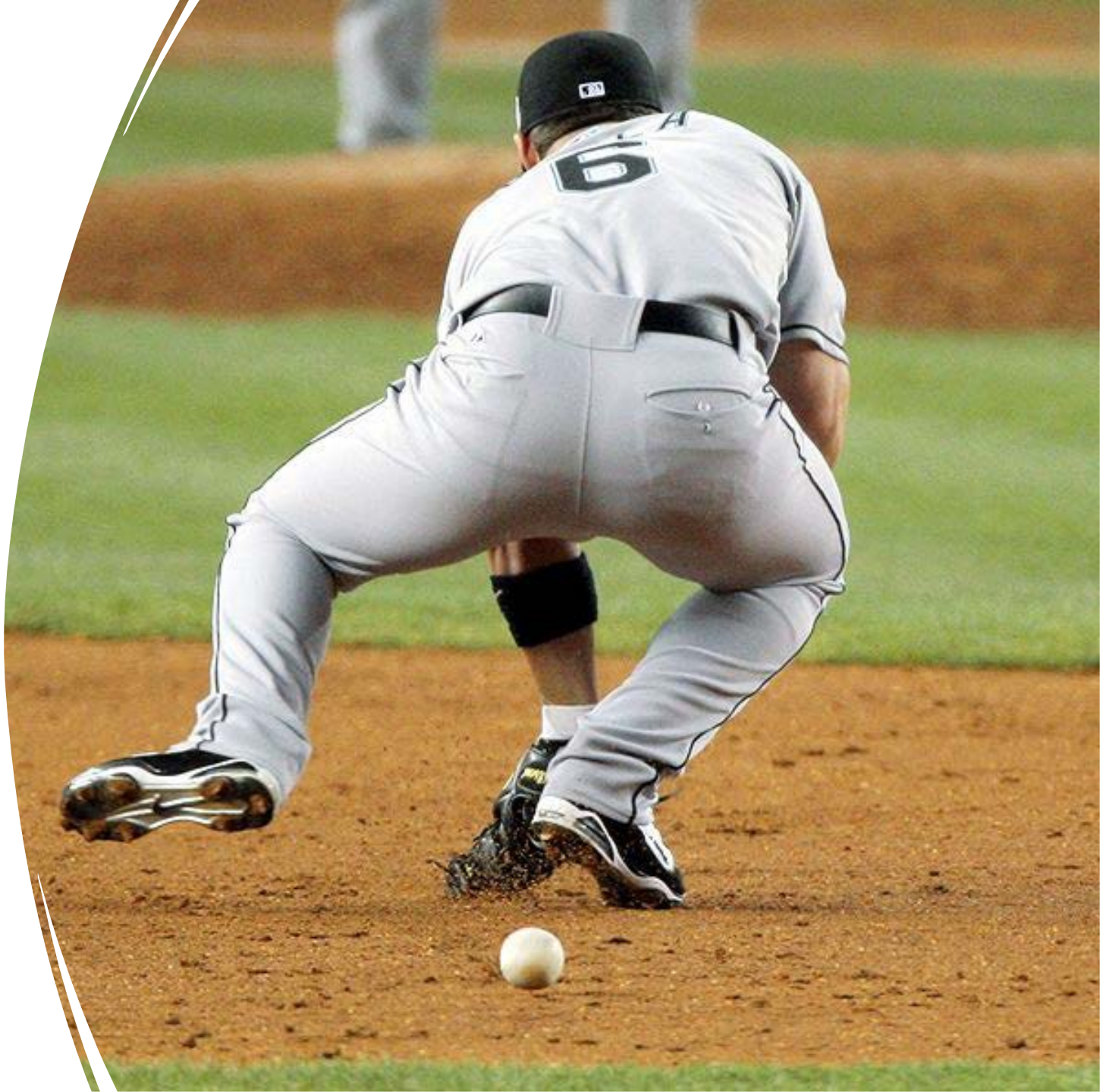
- An atmosphere of trust
- People are encouraged to provide essential safety-related information
  - –Include self reporting of errors
- Clarity about the line between acceptable and reckless behavior

From Error to Harm

- Human error
- Behavioral choice
  - –At risk behavior
  - –Reckless behavior

Human Error

- ***Inadvertently*** doing other than what should have been done:
  - a mental slip, lapse, or mistake
  - not a choice



Whoops….

Behavioral Choice

Intentional acts undertaken by the free exercise of one's judgment.

Purposeful behavior intentionally employed while engaging in our day-to-day activities.

At-Risk Behavior

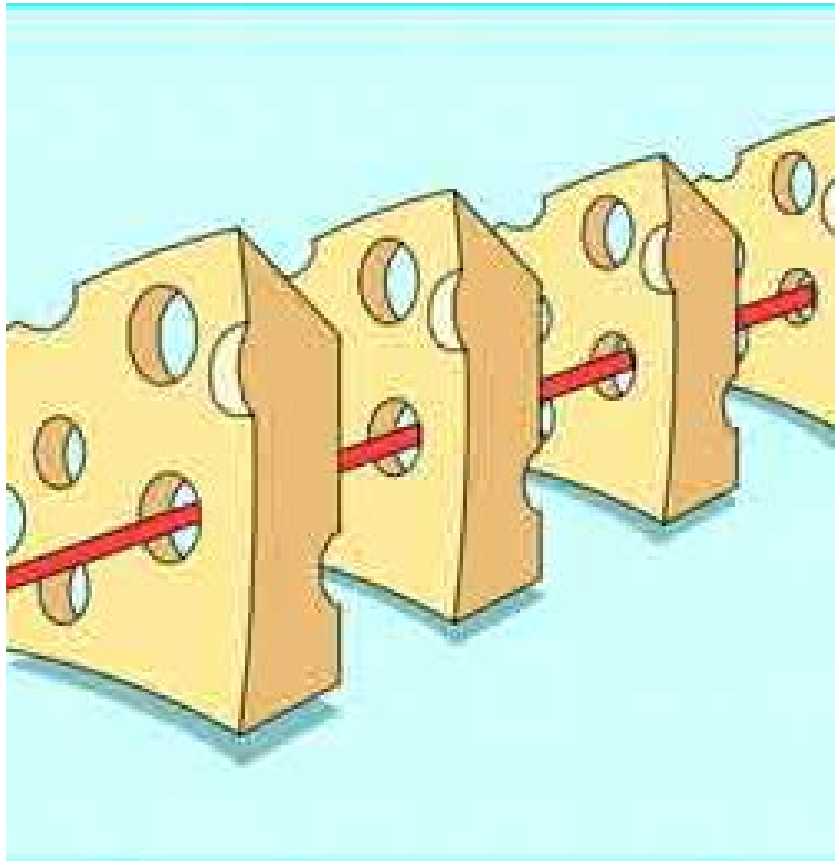
- Behavior that increases risk *where risk is not recognized or is mistakenly believed to be justified*

Reckless Behavior

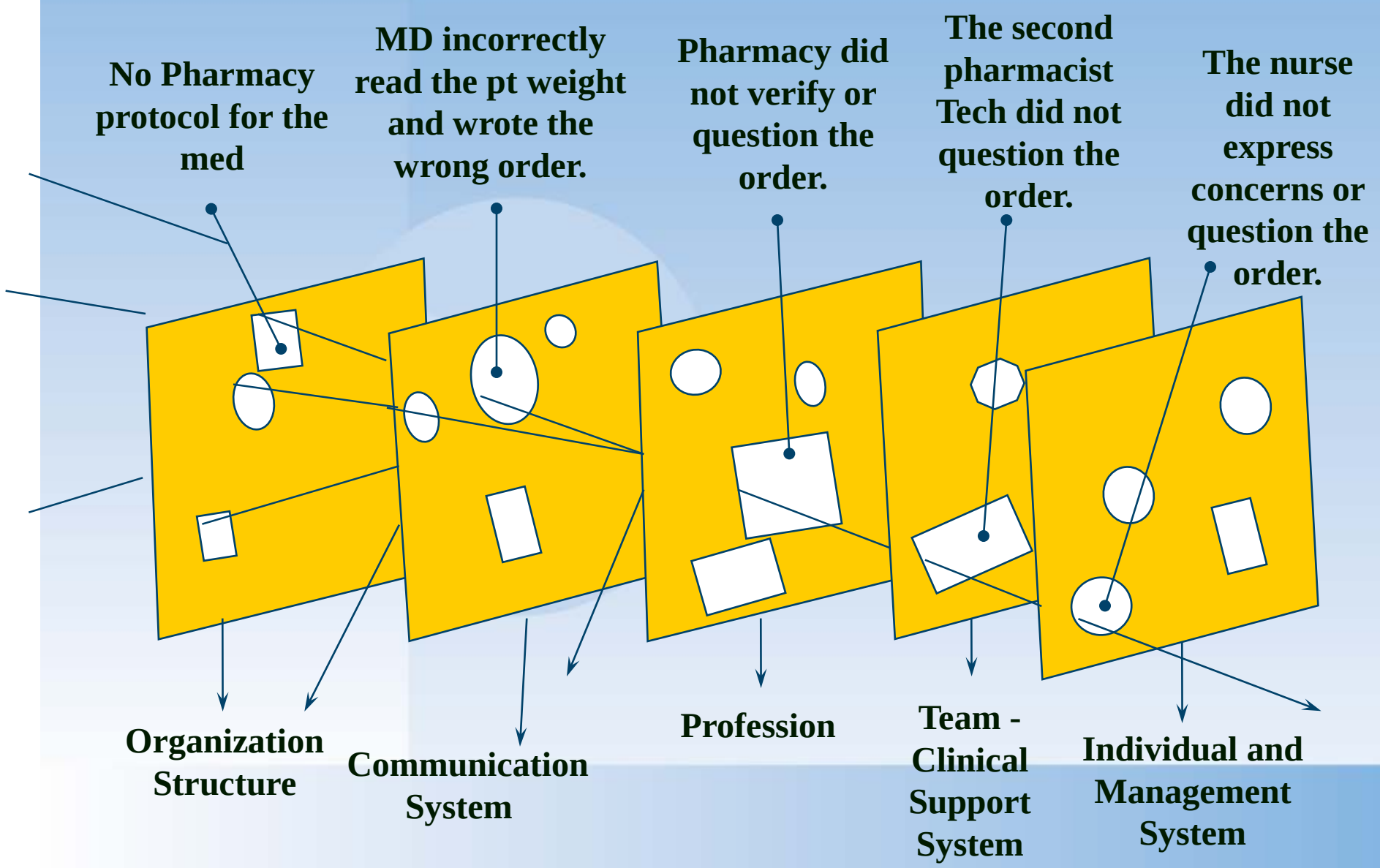
- A **BEHAVIORAL CHOICE to consciously disregard a substantial** and unjustifiable risk.
  - The risk is perceived
  - The risk is substantial
  - The action is intentional
  - Awareness others are not engaging in the same behavior

Defining the Problem

- Most errors are made by good (but fallible) people working in often dysfunctional systems
- Swiss cheese model when the holes align . . . errors occur
- Need to fix our systems to catch “the inevitable lapses of mortals”



Preparation of the Medication



The latent failure model of complex system failure - modified from James Reason, 1991

Discussion

- Are you concerned that Radonda Vaught being found guilty of criminally negligent homicide will impact reporting of errors or near misses?

Top Three Reasons for Human Error

PERCEPTION

ASSUMPTION

COMMUNICATION

Perception

- We perceive things incorrectly at critical times
- We hear what we expect to hear, and we see what we expect to see

Pregnant

positive

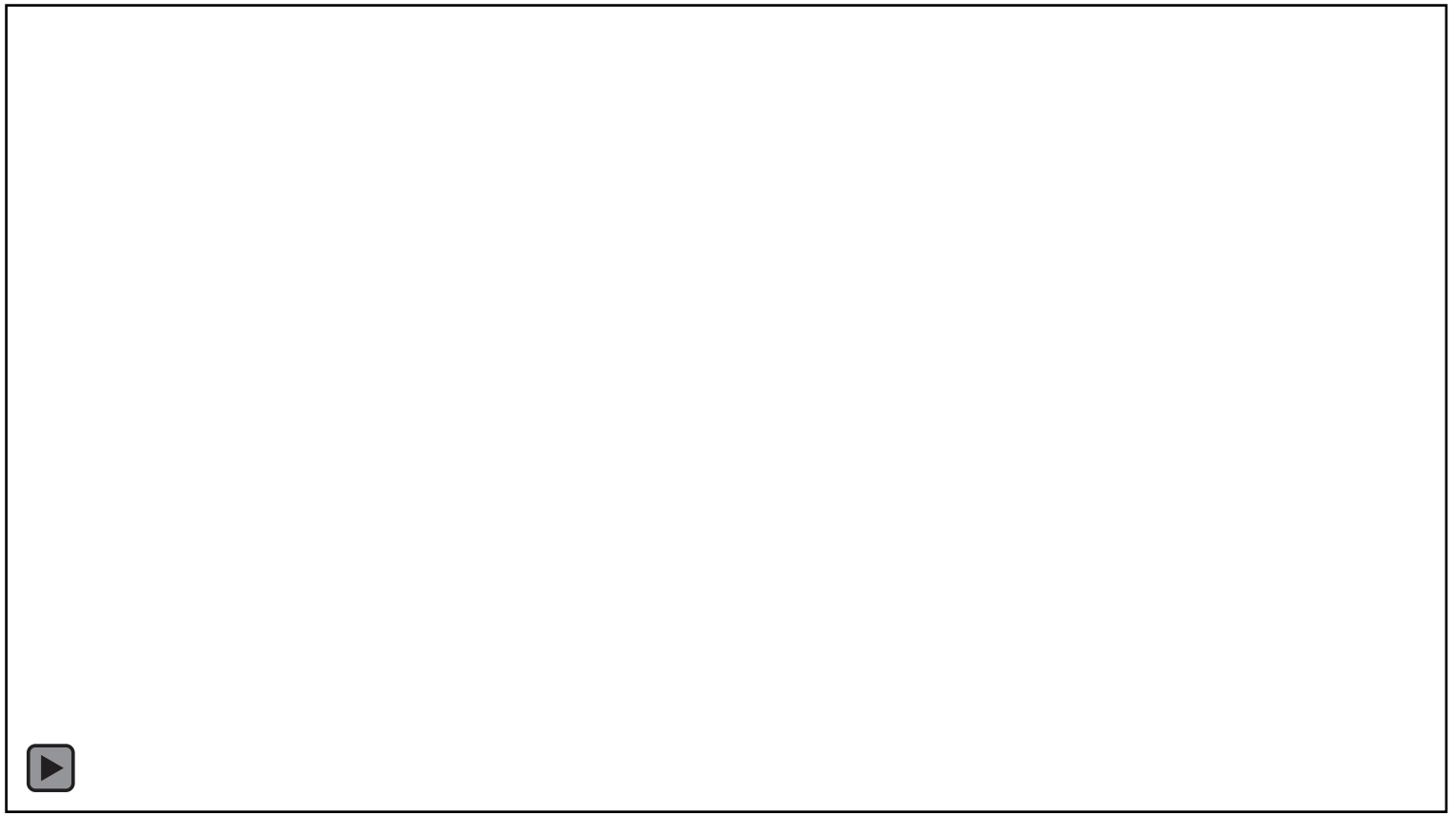
Heparin 10000 U.

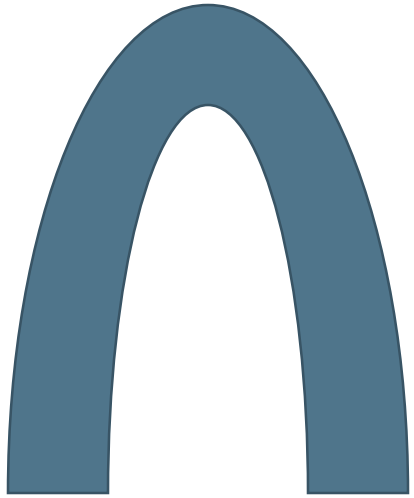
Hypertension.

Negative

What do you see when it’s an emergency?

Group Exercise

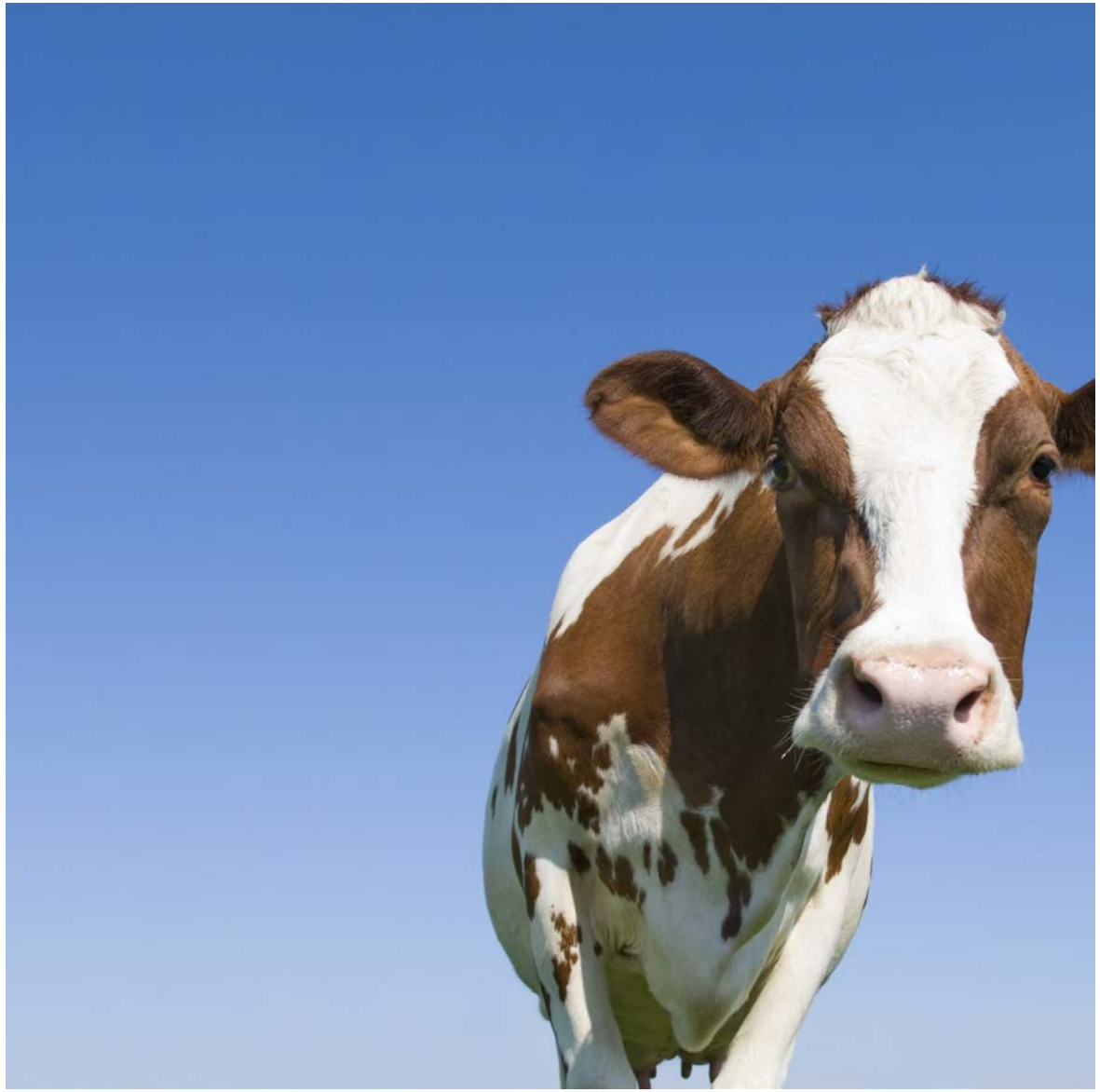




Paris
in the
the Spring

Spell ‘Silk’

What do cows drink?




RED GREEN BLUE YELLOW PINK
ORANGE BLUE GREEN BLUE WHITE
GREEN YELLOW ORANGE BLUE WHITE
BROWN RED BLUE YELLOW GREEN
PINK YELLOW GREEN BLUE RED


RED GREEN BLUE YELLOW PINK
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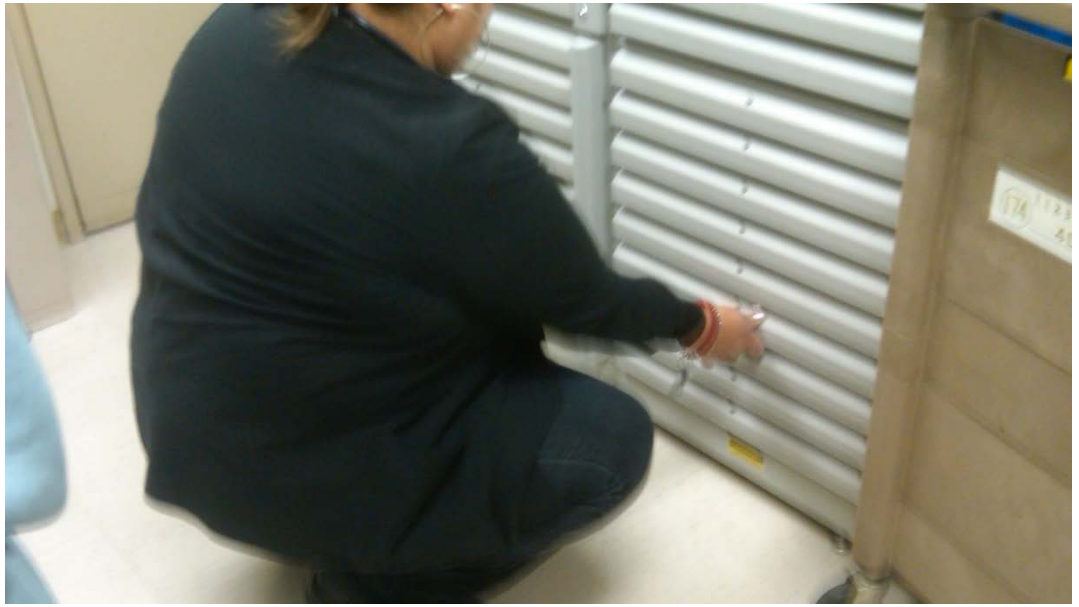
BROWN RED BLUE YELLOW GREEN
PINK YELLOW GREEN BLUE RED

Perception: we see what we expect to see and hear what we expect to hear

Assumption

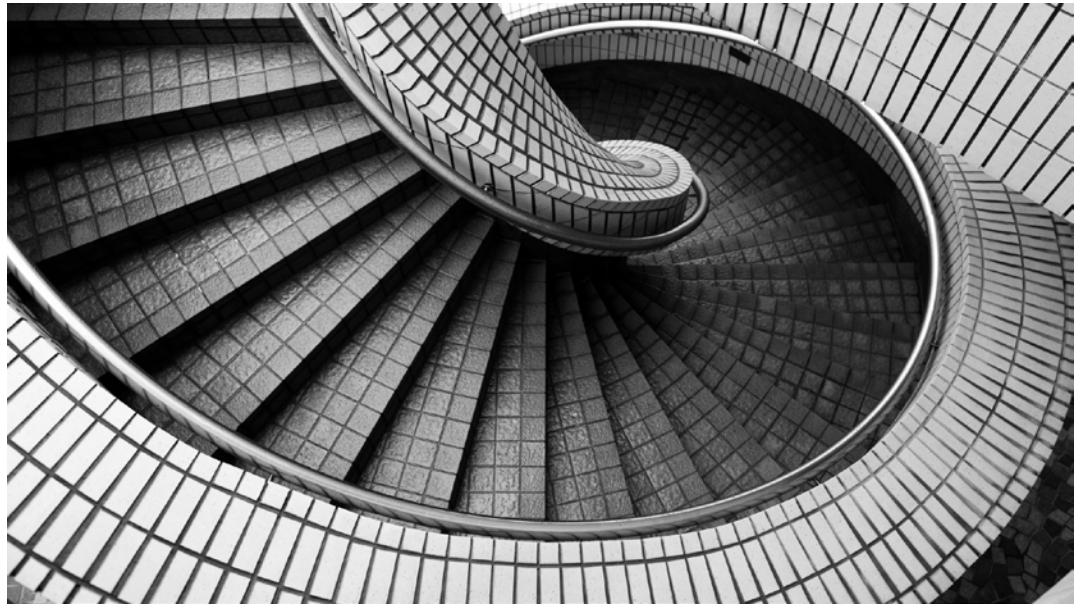
Cedars-Sinai 2007

Is the ‘right’ drawer one of the 5 rights?



Assumption: we jump to conclusions

Breakdown in communication



Question

- In the past month, I have experienced a breakdown in communication with either a family member, a friend, or a colleague at work:
  - Yes, of course
  - No, I communicate with perfection

So, why is communication such a problem?

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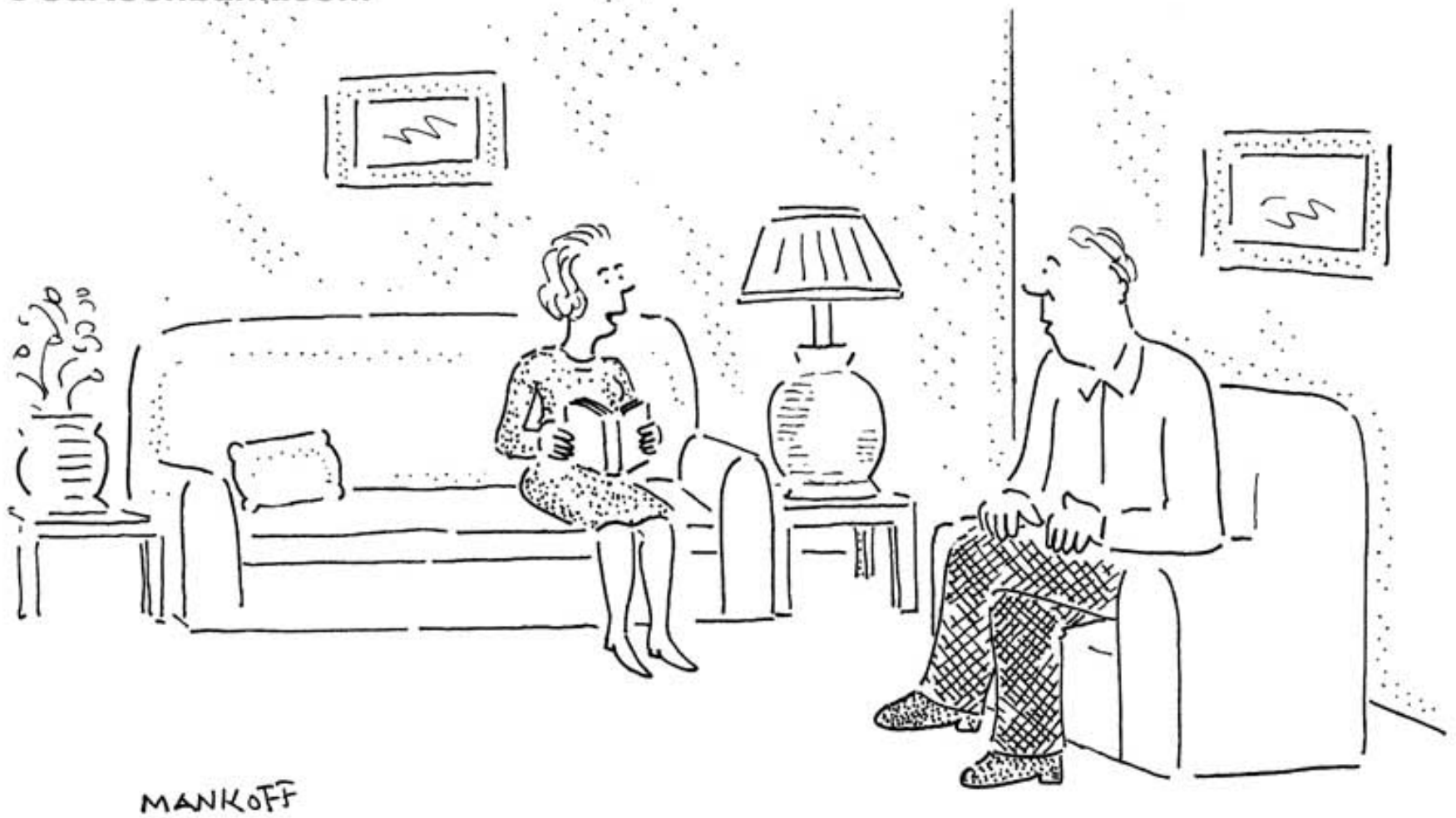
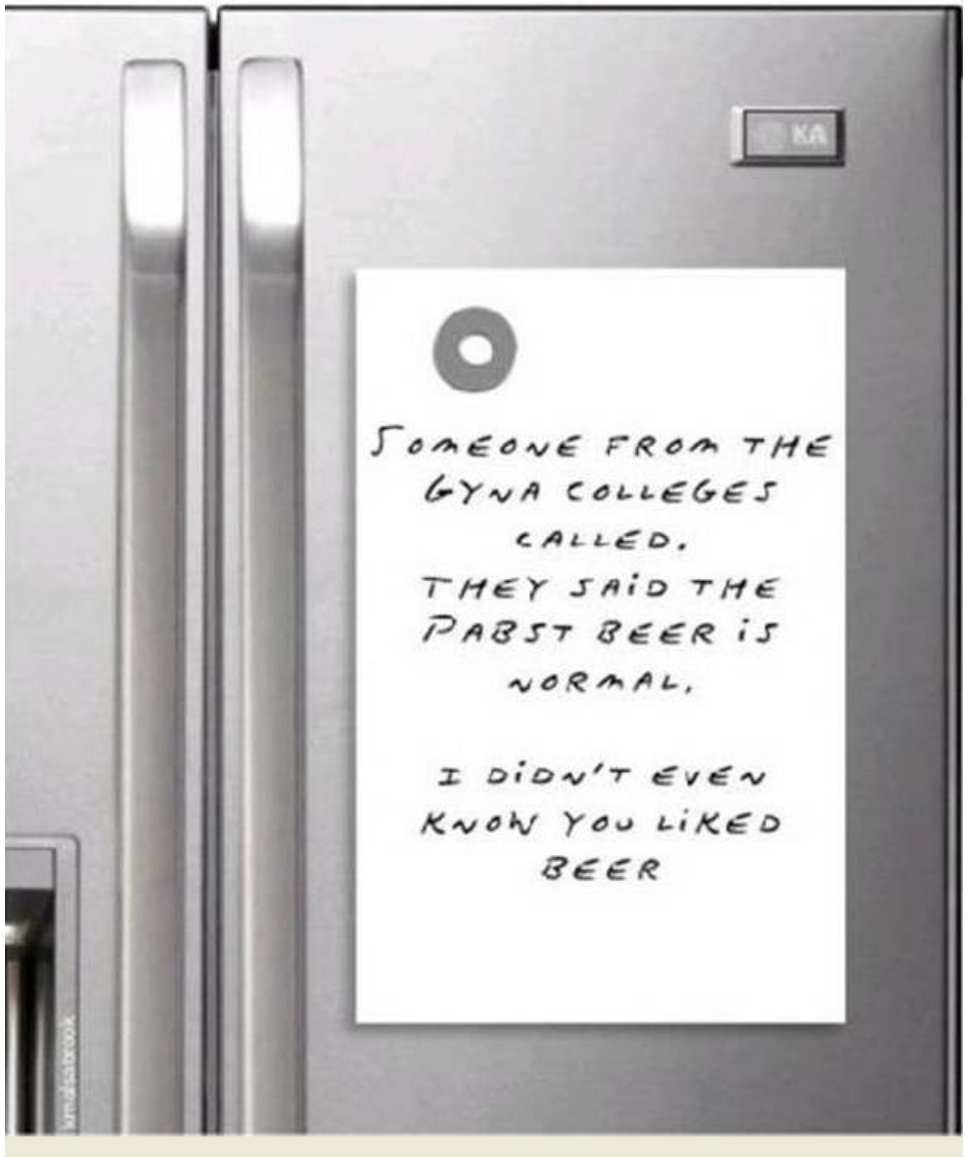


"I'm sorry, dear. I wasn't listening. Could you repeat what you've said since we've been married?"


SOMEONE FROM THE GYNA COLLEGES CALLED.
THEY SAID THE PABST BEER IS NORMAL.
I DIDN'T EVEN KNOW YOU LIKED BEER


STORE CLOSING
NOW HIRING


Kalfurd
CLEANERS
DROP YOUR PANTS HERE
AND YOU WILL RECEIVE
PROMPT ATTENTION


35,000 per day


NEWS


dish
Tuesday June 7
3:35pm
starz
sundance
Service
News
Shop
Sports
Games
Entertainment
Exit

Discussion

- When I am at work, most of my communication with colleagues is:
  - Face to face
  - On the phone
  - Text or email

How are these barriers?

Next Up

Date	Activity	Notes
~~July 20~~	~~Flex/HQIC Office Hours~~	*Canceled*
August 16	August ‘Book Club’	Share your favorite books, blogs, podcasts, videos, or articles and gems you have learned!
August 17	Flex/HQIC Office Hours	*Kristy Heller*

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Don’t have one? Try these!

Podcasts	Books	Videos	Blogs/Articles
Dare to Lead *Brene’ Brown*	Atomic Habits - *James Clear*	Upstream Public Health Model	3-2-1 Newsletter (habit building)
WorkLife *Adam Grant*	Think Again - *Adam Grant*		
A Bit of Optimism *Simon Sinek*	Upstream – *Dan Heath*		
Quality Time: Sharing PIE *Stratis Health*	Made to Stick – *Dan & Chip Heath*		
	Influencer – *Grenny et al*		
	Internal Bleeding – *Kaveh Sojania & Robert Wachter*		

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Contact

Jennifer Wagner, CPHQ	Barb DeBaun, MSN, RN, CIC
MT Flex Program/MHA	Cynosure Health
Rural Hospital Improvement Coor.	Improvement Advisor
Jennifer.wagner@mtha.org	bdebaun@cynosurehealth.org
406-457-8000	
Group Email	qichampions21@googlegroups.com
Project Website	https://mtpin.org/qichampions21/

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