

**University of Michigan Hospitals and Health Centers
Patient Safety Program
Presentation Script**

VISUAL	COMMENTARY
Slide #1 University of Michigan Hospitals and Health Centers (UMHHC) Patient Safety Program	It is my pleasure to introduce you to the University of Michigan Hospitals and Health Centers Patient Safety Program. (Remind participants to sign in)
Slide #2 Goals of Presentation	This presentation is designed to acquaint you with a very important initiative at UMHHC. The goals of this presentation are: <ul style="list-style-type: none"> • Recognize that health care errors occur • Understand the system vs. individual approach to error reduction • Identify our safety initiatives • Realize <u>your</u> role in the importance of reporting incidents, hazards and near-misses • State the process for reporting and immediate steps if an event occurs
Slide #3 “To Err is Human”	Approximately three years ago, The Institute of Medicine released the report, “To Err Is Human”. This report highlighted many issues surrounding medical errors and patient safety.
Slide #4 Headline from The Detroit News and Free Press, February 6, 2000	As a result of this report, both national and local media responded. You may recall seeing articles such as this, which appeared in <i>The Detroit News</i> and <i>Free Press</i> in February 2000.
Slide #5 Errors Do Cause Death	Some individuals debate the estimate of deaths due to medical errors. Despite the debate over the exact number of deaths over a period of time, we know that medical errors are a serious problem.
Slide #6 Beyond Blame Video	<ul style="list-style-type: none"> • This video was prepared by a healthcare organization after an error occurred so that others would learn from their experience. • The video can evoke an emotional response.
Slide #7 “Beyond Blame” Take-Aways	As you can see from the video: <ul style="list-style-type: none"> • The impact of errors is devastating, often personally and professionally • Even “good people” make errors <ul style="list-style-type: none"> – Most often due to systems problems – Usually no single person or cause is responsible

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	<ul style="list-style-type: none"> • It is necessary to move from culture of blame to identification of systems problems • Working harder for safe care is not the answer • Organizations, such as ours, have a responsibility in creating safer systems. <p>(Offer an opportunity for discussion or for participants to share comments)</p>
<p>Slide #8 Systems Failures (Swiss Cheese)</p>	<p>This slide shows that complex systems fail because of the combination of multiple small failures, each individually insufficient to cause an error.</p> <p>In order for a system to fail many small failures need to occur, either concurrently or sequentially, which can then result in an error involving patient harm.</p> <p>Here are examples of “holes” in the system that all could line up and result in the patient falling:</p> <ol style="list-style-type: none"> 1. Light bulb burned out 2. Floor wet 3. Patient on new medication causing dizziness 4. Walker placed out of reach
<p>Slide #9 Error Defense Strategies</p>	<p>Error Defense Strategies (preventing the holes from “lining up” therefore, reducing errors)</p> <ul style="list-style-type: none"> • Communication • Training/Competency/Testing • Licensing/Credentialing/Privileging • Information technology, i.e. Computerized Physician Order Entry (CPOE) • Protocols, pathways, policies • Redundancy • Human Factors Considerations (Improving human performance at the point of interface between humans and the environment and/or technology) <p><u>Non-clinical example:</u> Not being able to place your car into gear until your foot is on the brake.</p>

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	<p><u>Clinical example:</u> You cannot hook oxygen flow meters into a nitrous oxide wall outlet (this is an OR example).</p> <ul style="list-style-type: none"> - Design jobs for safety - Avoid reliance on memory - Standardize work processes • Including patients on the care team
<p>Slide #10 UMHHC 2002 Patient Safety Committee</p>	<p>UMHHC has recently formalized its commitment to patient safety through the development of the Patient Safety Committee. Dr. Darrell Campbell, the Chief of Staff, chairs the Committee and serves as the Patient Safety Officer.</p>
<p>Slide #11 2002 Patient Safety Committee Members</p>	<p>The Patient Safety Committee is comprised of internal, multi-disciplinary staff and external, nationally renowned experts in patient safety, organizational behavior and behavioral sciences.</p>
<p>Slide #12 2002 Patient Safety Committee Initiatives</p>	<ul style="list-style-type: none"> • The Patient Safety Plan was completed in July 2002 and is available on the web. This Plan describes the institutional framework, structure and approach to patient safety. <p>(Briefly highlight the multiple 2002 Patient Safety Committee initiatives. Due to time constraints you may prioritize your discussion based on the bullet points on the slide and the participants knowledge)</p> <ul style="list-style-type: none"> • Patient safety is now part of initial orientation. • “Commitment to Safety” has been approved and signage is coming in clinical areas. • Installing of web/based incident-reporting system is in process. • “Patient Safety Rounds” are conducted to encourage discussion regarding patient safety • One high-risk process has been selected for prospective evaluation. This process is the review of arrest data & mechanisms by which staff call for emergency assistance in an arrest. • A Patient Safety Culture Survey was completed by approximately 500 nurses

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	<p>in 2001. The Patient Safety Committee will be surveying all clinical staff in the near future to assess our patient safety culture.</p>
<p>Slide #13 Creating a Culture of Safety</p>	<p>The next series of slides focus on what is necessary to create a culture of safety in our environment.</p>
<p>Slide #14 Safety – Comprised of Many Pieces</p>	<p>To build a culture of safety, we must successfully bring together many pieces of the safety puzzle.</p> <ul style="list-style-type: none"> • Educate • Trust • Analyze • Report • Inform
<p>Slide #15 Trust (1)-Fostered by Effective Communication</p>	<p>Effective communication was mentioned earlier as a defense strategy to error. Poor communication is often seen in our serious adverse events.</p> <ul style="list-style-type: none"> • It is important to know that communication skills are acquired • How you say something is important • Developing effective communication skills is a progressive process moving from: <ul style="list-style-type: none"> – Uncomfortable to – Unskilled to – Learning through practice to – Integration into practice • Two questions to ask yourself to determine if you need to do work in this area: <ul style="list-style-type: none"> – Do you behave in a way that makes you more approachable if someone sees an error about to occur? – Are you comfortable telling someone that an error is about to occur?
<p>Slide #16 Trust (2) – Fostered by Effective Communication</p>	<p>Effective Communication – Messages given and received as intended</p> <p>Consider this acronym: TEACH – To give feedback LEARN – To receive feedback</p>

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<p>Slide #17 Trust – Fostered by Effective Communication</p>	<p><u>Resources</u> Trust your intuition. When something doesn't look or seem right seek advice from peers, supervisors, on-call staff to problem solve issues.</p> <p>DO NOT hesitate to move up the "Chain of Command" to resolve patient safety issues.</p>
<p>Slide #18 Report (1) – One Piece of the Puzzle</p>	<p>Reporting an error does not result in blame or disciplinary action</p> <p>Incident reports provide an information base from which educational, preventative and corrective action can be taken</p> <p>Anyone can report. Online reporting will make it easier to report and to follow-up</p>
<p>Slide #19 Report (2) – One Piece of the Puzzle</p>	<p>What to report?</p> <ul style="list-style-type: none"> – Medication near-misses and errors – Falls – Treatment near-misses and errors – Complications – Equipment near-misses and errors – Behavioral issues <ul style="list-style-type: none"> • If unsure, call Risk Management • Incident reporting sets analysis and improvement process in motion
<p>Slide #20 Report (3) – One Piece of the Puzzle</p>	<p>If an error occurs</p> <ul style="list-style-type: none"> • Think first aid and comfort for the patient, family and staff • Inform you supervisor • Call Risk Management immediately if injury occurs • Document facts surrounding event • Fill out an Incident Report
<p>Slide #21 Report (4) – One Piece of the Puzzle</p>	<p>For equipment related events</p> <ul style="list-style-type: none"> • If equipment/device is involved: <ul style="list-style-type: none"> – Do not turn off or unplug until data is saved, unless further injury would result – Save packaging and product if disposable – Page Biomedical Engineering 24 hours/day • Call Risk Management immediately if injury occurs

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	<ul style="list-style-type: none"> • Fill out an Incident Report <ul style="list-style-type: none"> – Include lot/serial numbers as applicable • Safe Medical Device Act requires reporting: Committee reports to FDA based on your incident reporting
<p>Slide #22 Inform – One Piece of the Puzzle</p>	<p>Poor communication has been identified as a variable in some of our error events that have led to patient harm. Clinical staff have suggested that they felt intimidated or unwilling to communicate concerns due to the behaviors of other clinical staff in a setting. The communication of these concerns might have prompted a course of action that ultimately avoided patient harm.</p>
<p>Slide #23 Analyze (1)– One Piece of the Puzzle</p>	<p>Incident reports are classified in a variety of ways to drive analysis</p> <p><u>Severity</u></p> <ul style="list-style-type: none"> – Near Miss: An event or situation that could have resulted in patient harm, but was avoided by a non-systematic intervention – Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof <p><u>Frequency</u></p>
<p>Slide #24 Analyze (2) – One Piece of the Puzzle</p>	<p>Goal of incident reporting and analysis is learning and improvement</p> <p><u>Medication Safety Committee</u></p> <ul style="list-style-type: none"> – Reviews medication incident reports to prioritize medication safety improvement initiatives <p><u>Sentinel Events</u></p> <ul style="list-style-type: none"> – Action plans are developed after the root cause analysis is complete – Implementation and monitoring of action plans
<p>Slide #25 Educate – One Piece of the Puzzle</p>	<ul style="list-style-type: none"> • All errors provide learning opportunities to prevent future occurrences • Share potential problems and solutions, and new information or changes in process with all staff • Use technology to improve safety and prevent errors

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<p>Slide #26 Trust – One Piece of the Puzzle</p>	<ul style="list-style-type: none"> • Use evidence-based practice guidelines <p>Trust is built when:</p> <ul style="list-style-type: none"> • Everyone believes patient safety is an institutional priority • Everyone speaks up and intervenes when they see an error about to occur • Everyone reports • Reports are analyzed with a system focus • Learning occurs from the analysis • Improvements are made • Care is safer
<p>Slide #27 Safety – Putting it All Together</p>	<p>Safety is more than a program.....Safety is a way of life</p> <p>Individual reporting here at UMHC has helped focus attention on systems in need of improvement.</p> <p>Some of the significant changes we have made here include revisions in our education and orientation for nurses, physicians and medical students, renovations to our environment, improvement in medical equipment selection, improved emergency support, standardized physicians orders and many more positive improvements.</p>
<p>Slide #28 Patient Safety Scenarios</p>	<p>Presenter to select one of the three options: Share one of the following actual scenarios with the group:</p> <ol style="list-style-type: none"> 1. <u>Patient fall</u> – an elderly patient is hospitalized and put on several new medications that can cause dizziness, fatigue, or confusion. For infection control, the patient’s condition requires the door to her room to be shut. The patient’s family has stayed with her around the clock but on this night, they indicate that they are going home. The patient falls during the night. <u>System interventions as a result:</u> Established pharmacy computer alerts for medications and dose levels with higher risk for elderly patients. Implemented consistent, thorough fall assessment on all patients with action steps identified

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	<p>if risk determined. Designed mechanism to enlarge patient attendant pool and integrate family participation.</p> <p><u>Fire in patient's room</u> – a patient with a long history of smoking is admitted for surgery. The patient received numerous warnings not to smoke and his cigarettes were taken away on several occasions. One afternoon, a house officer enters his room to find the patient's electrically operated bed on fire and attempts to put out the fire with a Class A fire extinguisher (water).</p> <p><u>System Interventions as a result:</u> Increase rate of patient referrals to TCS (Tobacco Consultation Service). Add Fire Safety education to House Officer's orientation. Update the oxygen shut-off valve policy (establishing the authority to make the decision), Purchase water mist fire extinguishers (safe with electrical beds).</p> <ol style="list-style-type: none">2. Choose a specific safety issue in your department that represents an opportunity to improve patient safety through system and process changes.3. Ask your staff to identify a patient safety concern that they have observed and discuss suggestions for how the department may address the issue.
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