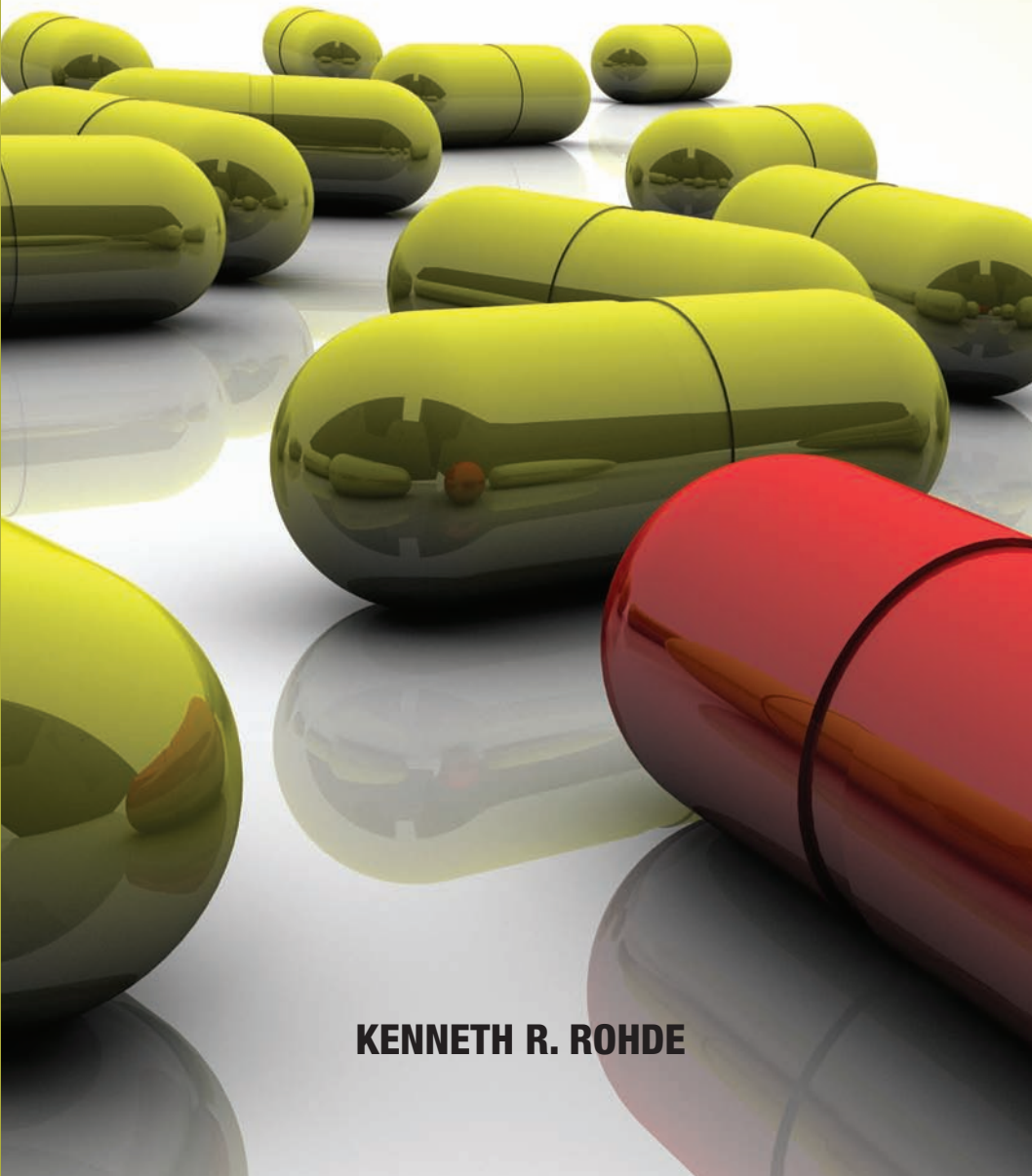
BUILDING YOUR CULTURE OF SAFETY

Six Keys to Preventing Medical Errors



KENNETH R. ROHDE

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HCPro

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About the Author

Kenneth R. Rohde

Kenneth R. Rohde is a senior consultant for The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. He brings more than 27 years of experience in quality management to his work with hospitals and medical centers across the country.

Rohde instructs, speaks, and consults in the areas of error reduction strategies, root-cause analysis, improving performance through process simplification, error reduction through effective procedure writing, apparent-cause analysis, engineering effectiveness and error reduction, Failure Modes and Effects Analysis, effective data collection, analysis and trending, patient safety evaluation and improvement, change management, corrective action program evaluation and redesign, human performance evaluations, and procedure error reduction. Rohde also specializes in technology-based approaches to preventing human errors and analyzing performance data.

Prior to joining The Greeley Company, Rohde served as director for Performance Improvement International and director of corrective actions process at Westinghouse Electric Company. He has also participated in

or managed projects to improve business effectiveness and business development for healthcare, nuclear power, and manufacturing facilities around the globe.

Rohde is also the author of *Failure Modes and Effect Analysis: Templates and Tools to Improve Patient Safety*, and *Making Your Data Work: Tools and Templates for Effective Analysis*, published by HCPro.

Rohde holds a bachelor's degree in mechanical engineering from the University of Hawaii.

Introduction: Building Our Culture of Safety

Healthcare is a complex business, and preventing errors is vitally important because every day real people—mothers, fathers, children, our friends and associates—can get hurt. None of us want to be involved in a medical error and we all want to do everything we can to keep our patients and residents safe. It takes an organizationwide effort to instill a commitment to maximizing patient safety by minimizing the harm from errors. Safety is not something we can add on at the last minute just before our patient or resident leaves the facility: Safety has to be included in everything we do. It must be an integral, precious part of our culture. In short, we need a *culture of safety*.

So, what is culture?

Culture is really our shared values and beliefs. If we believe in safe driving, we will wear our seat belts, and we will share that value with everyone who rides in our cars. "Buckle up, or the car doesn't move!" is our way of letting people know that our culture of safety will not let us put passengers at risk.

In healthcare, the decisions and actions you take every day directly influence the health, the comfort, and even the very life of your patients and residents. This is why working in healthcare can be so rewarding, but it is

also why we must be constantly vigilant to prevent errors that can affect patients, residents, coworkers, and ourselves.

So, what are the shared values and beliefs in healthcare that will keep us from making errors? In this booklet, we will introduce six safe behaviors that are expected of all of us to make sure our patients and coworkers are safe. Variations of these six safe behaviors are used in many hospitals and even in other high-risk businesses, such as aviation and nuclear power plant operation.

WE EXPECT EVERYONE TO:

Key Behavior 1: Pay attention to details

Key Behavior 2: Keep a clear line of communication open

Key Behavior 3: Have a questioning attitude

Key Behavior 4: Use a clear and effective handoff process

Key Behavior 5: Look out for each other as a team

Key Behavior 6: Follow the rules

This handbook also offers some easy-to-use error reduction tools that will help you demonstrate your commitment to safety. But no system is perfect—what if something happens? In the section "Oh No! It Just Happened to Me!" you'll find straightforward, don't-panic steps describing what you should do if you are involved in an error with a patient.

All of this information might seem obvious, but a look through recent newspaper headlines or television news reports show that hospital and medication errors are still occurring all too frequently.

Before we begin with the six key behaviors, it's important to understand why medication errors occur.