Preventable, life-threatening medical errors are a high-profile issue in hospitals around the country. The Joint Commission’s National Patient Safety Goals have made medication management an important focus in recent years, and CMS has announced it will not pay for preventable medical errors going forward. Good communication, effective tools, and a well-documented process for handling medical errors are critical in improving patient safety.

This handy pocket-sized guide:
- Provides tips and tools that caregivers can refer to throughout the day
- Explains how to meet accreditation standards in clear, concise language
- Contains easy-to-read information covering the basics of prevention
- Features simple illustrations to help emphasize key issues

*Building Your Culture of Safety: Six Keys to Preventing Medical Errors* is an effective and easy-to-use training tool and reference guide for caregivers on all levels.

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BUILDING YOUR CULTURE OF SAFETY

Six Keys to Preventing Medical Errors

Kenneth R. Rohde
## Contents

About the Author ................................................................................................. v

Introduction: Building Our Culture of Safety ................................................. 1

Medication Errors: One of the Most Common Kinds of Error ............... 5

Six Keys to Error Prevention ......................................................................... 15

Simple Tools to Help Prevent Errors ......................................................... 21

Oh No! It Just Happened to Me! ................................................................. 31

Additional Resources ................................................................................. 33

References .................................................................................................. 34
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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.

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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.