Hartford Hospital
A Hartford HealthCare Partner

High Reliability

Bob Spillane MD
Interventional Radiology
Department of Radiology
Medical Director of Quality
Hartford Hospital

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High Reliability Organizations (HROs)

Bob Spillane MD
Interventional Radiology
Department of Radiology
Medical Director of Quality
Hartford Hospital

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USS *Ronald Reagan* in the Straits of Magellan in 2004.

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USS *Ronald Reagan* in the Straits of Magellan in 2004.

The control room at an American nuclear power plant.

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USS *Ronald Reagan* in the Straits of Magellan in 2004.

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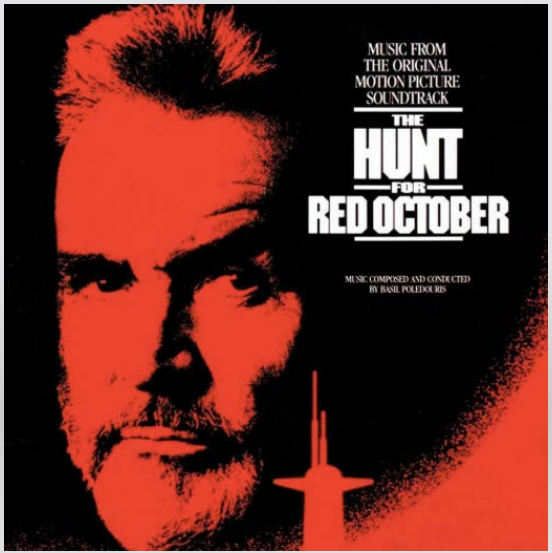
HROs



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We're all in this together…

Bob Spillane MD
Interventional Radiology
Department of Radiology
Medical Director of Quality
Hartford Hospital

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ARIN Vision

G. Laukhuf, ND RN, CRN, RN-BC, NE-BC ARIN Update: *Teamwork is Innovation*
IR Quarterly Winter 2015

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High Reliability—We're all in this together

"With current health care and reimbursement pressures, the next innovation in IR is team performance in the IR suite."

"Team success occurs when the team achieves tasks and works more effectually than a group of individuals working alone. The Team realizes a collective synergy from the members."

G. Laukhuf, ND RN, CRN, RN-BC, NE-BC ARIN Update: *Teamwork is Innovation* IR Quarterly Winter 2015

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High Reliability– Financial Disclosures

1. I have no financial disclosures.

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High Reliability- Agenda

Introduction
Acknowledgements
Disclosures
Hartford Hospital and Why Me?
Medical Errors
    The Swiss Cheese Model
The Complex IR Environment
High **R**eliability **O**rganizations
    Characteristics of **HROs**
High Reliability in IR
    Crew **R**esource **M**anagement (**CRM**)
Take Aways
    Hartford Hospital implementation

High Reliability—Hartford Hospital

Hartford, CT

-800 beds

Established 1854

Acute, tertiary care hospital

4500 transfers per year

Level 1 Trauma Center

LifeStar Helicopter program

Transplant

Celebrated #3000 in 2014

1600 doctors

7000 employees

Hartford Hospital

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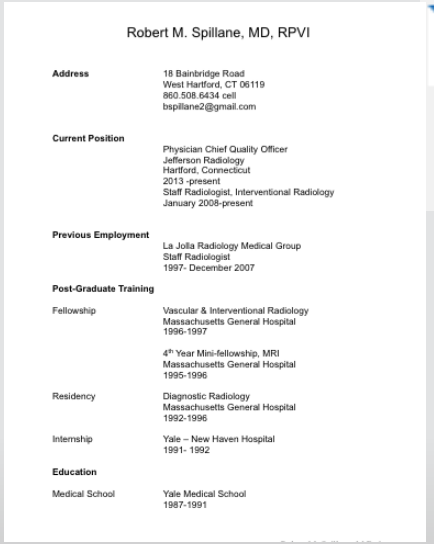
Scripps

MASSACHUSETTS GENERAL HOSPITAL



Robert M. Spillane, MD, RPVI

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West Hartford, CT 06119
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bspillane2@gmail.com

Current Position
Physician Chief Quality Officer
Jefferson Radiology
Hartford, Connecticut
2013 -present
Staff Radiologist, Interventional Radiology
January 2008-present

Previous Employment
La Jolla Radiology Medical Group
Staff Radiologist
1997- December 2007

Post-Graduate Training

Fellowship
Vascular & Interventional Radiology
Massachusetts General Hospital
1996-1997

4th Year Mini-fellowship, MRI
Massachusetts General Hospital
1995-1996

Residency
Diagnostic Radiology
Massachusetts General Hospital
1992-1996

Internship
Yale – New Haven Hospital
1991- 1992

Education

Medical School
Yale Medical School
1987-1991

YALE-NEW HAVEN HOSPITAL

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Scripps

YALE-NEW HAVEN HOSPITAL

MASSACHUSETTS GENERAL HOSPITAL

artford ospital

High Reliability—Acknowledgements

CT High Reliability

Dr. Mary Cooper

Initiated 2012

25 of 28 hospitals

10, 000 staff trained

“CHAMP” Card

Hartford Hospital

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Institute of Medicine
1999

44, 000 – 98, 000 each year

"A 727 each day"

November 1999

INSTITUTE OF MEDICINE

Shaping the Future for Health

TO ERR IS HUMAN:
BUILDING A SAFER HEALTH SYSTEM

Health care in the United States is not as safe as it should be--and can be. At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented, according to estimates from two major studies. Even using the lower estimate, preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS.

High Reliability– Medical Disclosures

1. I have been involved with, or present for, medical errors.

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High Reliability– Medical Disclosures

1. I have been involved with, or present for, medical errors.

Allow me an exercise……

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If you have been the victim of a medical error,

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If you have been the victim of a medical error,

If a loved one, or someone you know, has been the victim of a medical error,

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High Reliability—We're all in this together

If you have been the victim of a medical error,

If a loved one, or someone you know, has been the victim of a medical error,

If, through work, you've been party to, or present for, a medical error,

High Reliability—We're all in this together

If you have been the victim of a medical error,

If a loved one, or someone you know, has been the victim of a medical error,

If, through work, you've been party to, or present for a medical error,

Raise your hand, please

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EXCLUSIVE! DID FATAL MEDICAL BLUNDERS KILL JOAN RIVERS?!

Published on: September 10, 2014
by GIA PORTFOLIO, DOUGLAS MONTERO & LEELA DE KRETSER, NATIONAL ENQUIRER

Photography by: Getty

JOAN RIVERS died as the result of "a horrific medical mistake," The National ENQUIRER has learned exclusively from experts.

After the 81-year-old comedy icon lost her life Sept. 4 – exactly one week after undergoing a routine procedure on her vocal cords at an outpatient clinic in Manhattan – a source claims: "She could have been saved."

An ENQUIRER investigation reveals that the minor procedure Joan underwent on Aug. 28 carried only a tiny 0.5% mortality rate – and we uncovered shocking evidence shedding new light on the tragedy.

"Investigators suspect a fatal drug cocktail" could have been administered to the 5-foot-2, 102-pound star after she entered Yorkville Endoscopy, according to a source.

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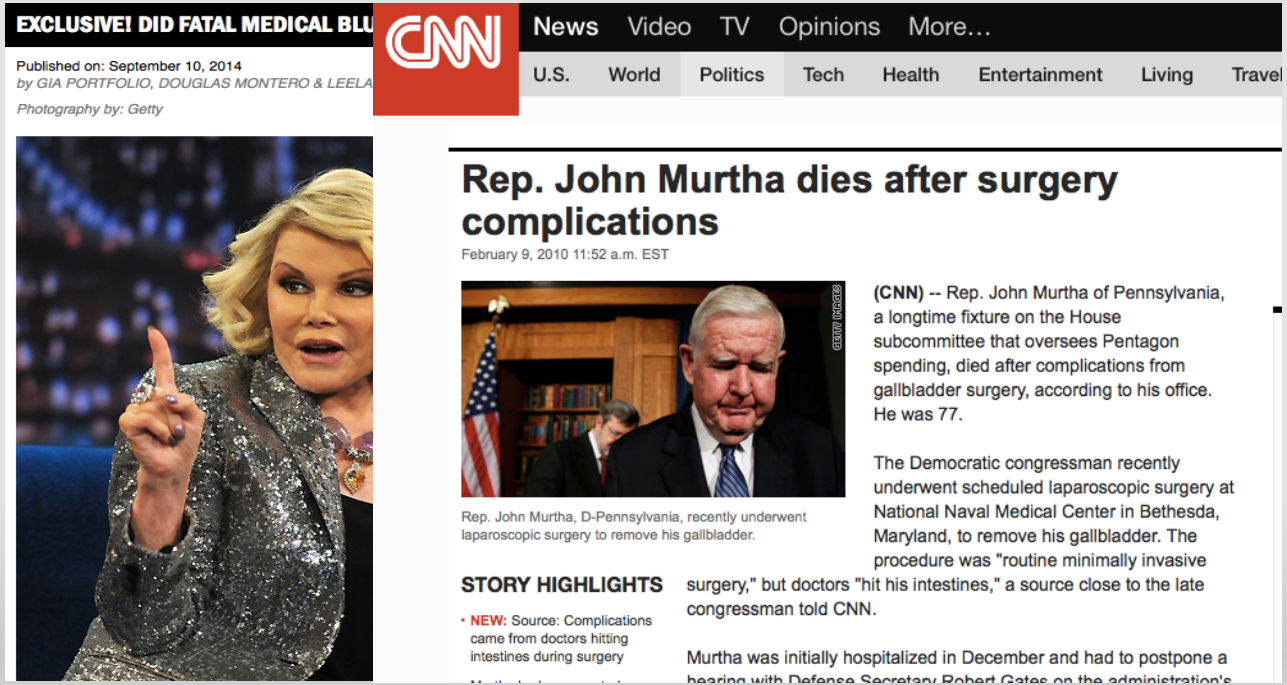

EXCLUSIVE! DID FATAL MEDICAL BLU

Published on: September 10, 2014
by GIA PORTFOLIO, DOUGLAS MONTERO & LEELA

Photography by: Getty

CNN

News Video TV Opinions More...

U.S. World Politics Tech Health Entertainment Living Travel

Rep. John Murtha dies after surgery complications

February 9, 2010 11:52 a.m. EST

Rep. John Murtha, D-Pennsylvania, recently underwent laparoscopic surgery to remove his gallbladder.

(CNN) -- Rep. John Murtha of Pennsylvania, a longtime fixture on the House subcommittee that oversees Pentagon spending, died after complications from gallbladder surgery, according to his office. He was 77.

The Democratic congressman recently underwent scheduled laparoscopic surgery at National Naval Medical Center in Bethesda, Maryland, to remove his gallbladder. The procedure was "routine minimally invasive surgery," but doctors "hit his intestines," a source close to the late congressman told CNN.

Murtha was initially hospitalized in December and had to postpone a hearing with Defense Secretary Robert Gates on the administration's

STORY HIGHLIGHTS

- **NEW:** Source: Complications came from doctors hitting intestines during surgery

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EXCLUSIVE! DID FATAL MEDICAL BLU

Published on: September 10, 2014
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Photography by: Getty

CNN News Video TV
U.S. World Politics

Rep. John Murtha complications

February 9, 2010 11:52 a.m. EST

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STORY HIGHLIGHTS

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Murtha was i
hearing with

Dennis Quaid takes aim at health care mistakes

Updated 4/12/2010 8:20 PM | Comment | Recommend

Enlarge By Joe Brier, for USA TODAY

After his newborn twins nearly died because they'd received an overdose of a drug in a hospital, actor Dennis Quaid became a patient safety advocate. Quaid spoke about his efforts with members of the National Press Club April 12 in Washington, D.C.

HEALTH REPORTER TWEETS

By Rita Rubin, USA TODAY

WASHINGTON — As a private pilot, actor Dennis Quaid was struck by the differences between how aviation errors and medical errors are handled.

The airline industry doesn't have much choice, Quaid noted in an interview Monday after speaking at a National Press Club luncheon. "When a crash happens, it's so public," he said. "No one is going to fly on their airplanes unless they have that trust."

DOCTORS: 'Soul' tormented by medical errors

But when a mistake occurs in a hospital, the pu
hear about it. Although an estimated 100,000 A
each year because of medical errors, their dea
over thousands of hospitals, "where people die
said. "It doesn't get the same type of attention.

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Doctors 'Shocked' by Radiation Overexposure at Cedars-Sinai

Oct. 13, 2009

By RADHA CHITALE

ABC News Medical Unit via **WORLD NEWS**

Hospital officials say a computer-resetting error caused radiation overdoses for 206 patients who underwent CT scans at Cedars-Sinai Medical Center in Los Angeles.

ABC News Photo Illustration

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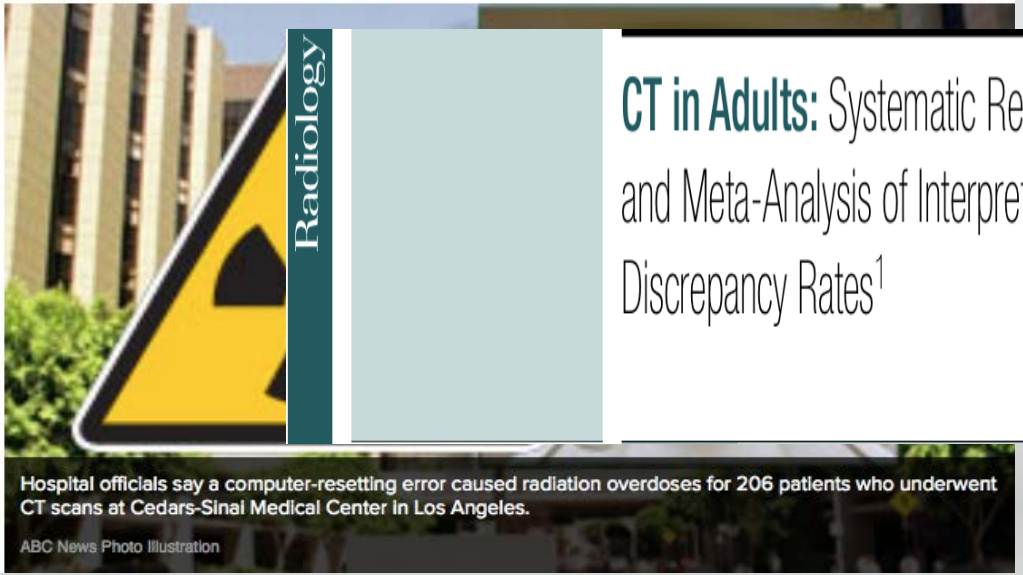

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ABC News Photo Illustration

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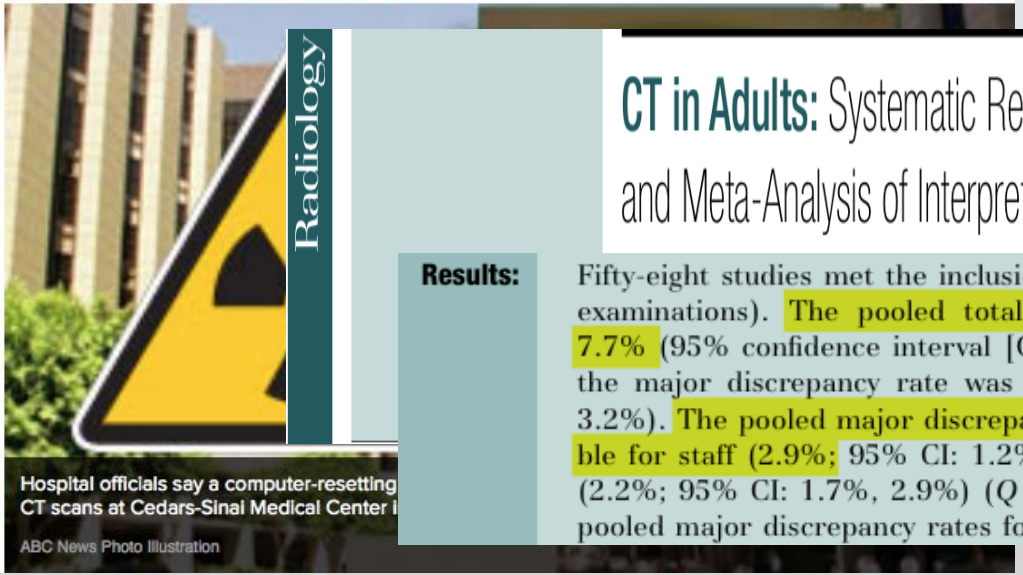

CT in Adults: Systematic Review and Meta-Analysis of Interpretation

Results: Fifty-eight studies met the inclusion criteria (388123 CT examinations). The pooled total discrepancy rate was 7.7% (95% confidence interval [CI]: 5.6%, 10.3%), and the major discrepancy rate was 2.4% (95% CI: 1.7%, 3.2%). The pooled major discrepancy rate was comparable for staff (2.9%; 95% CI: 1.2%, 6.7%) and residents (2.2%; 95% CI: 1.7%, 2.9%) ($Q = 0.92$, $P = .633$). The pooled major discrepancy rates for head CT (0.8%; 95%

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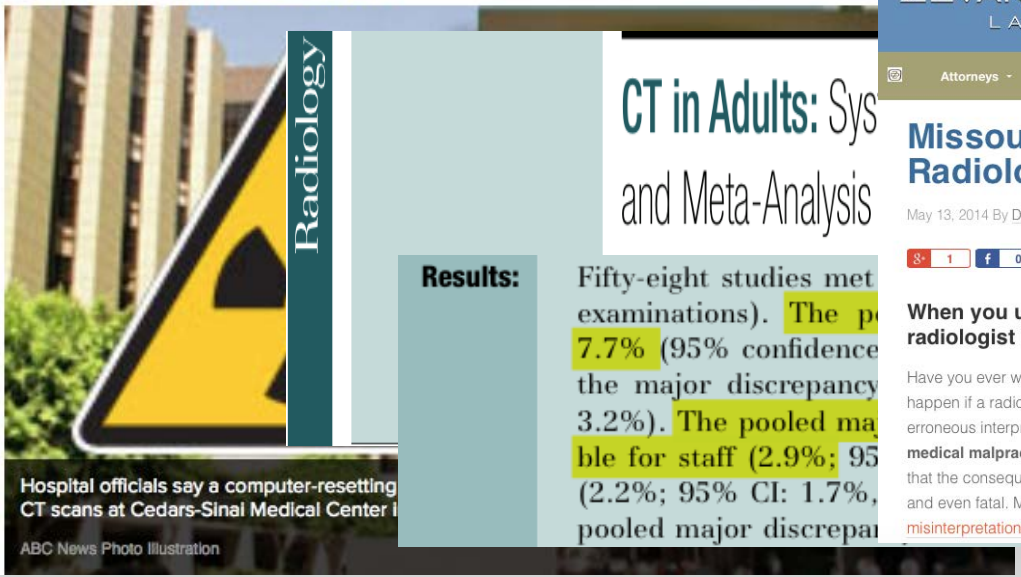

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LAW FIRM, LLC

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Missouri Medical Malpractice and Radiology Errors

May 13, 2014 By David Zevan — Leave a Comment

When you undergo an x-ray, CT scan, or MRI scan, a radiologist is responsible for making interpretations.

Have you ever wondered what would happen if a radiologist made an erroneous interpretation? **Missouri medical malpractice lawyers** answer that the consequences can be serious and even fatal. Many cases of misinterpretations are reported every

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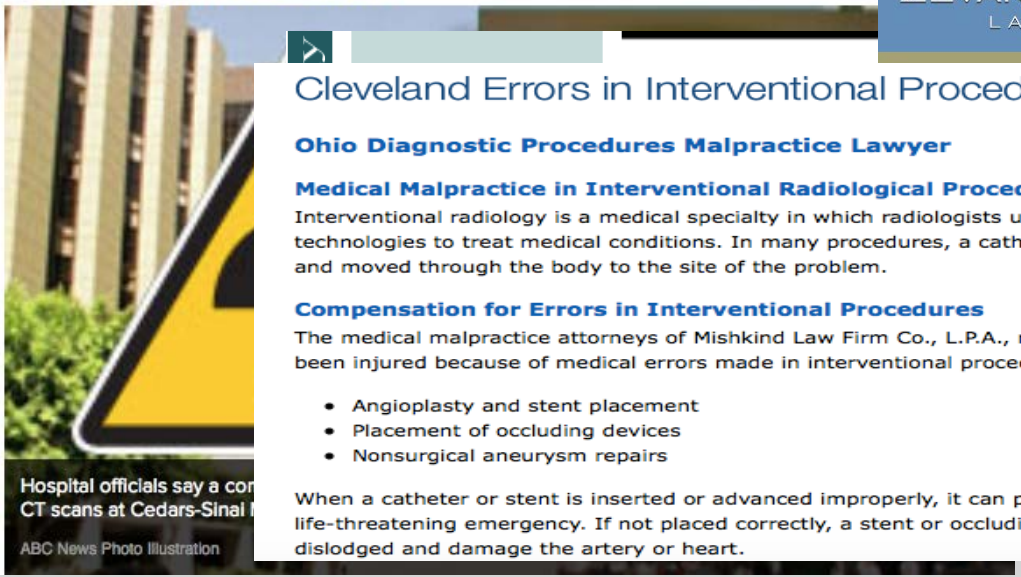
Doctors 'Shocked' by Radiation Overexposure at Cedars-Sinai

Oct. 13, 2009

By RADHA CHITALE

ABC News Medical Unit via **WORLD NEWS**



ZEVAN & DAVIDSON
LAW FIRM, LLC

Cleveland Errors in Interventional Procedures Attorney

Ohio Diagnostic Procedures Malpractice Lawyer

Medical Malpractice in Interventional Radiological Procedures

Interventional radiology is a medical specialty in which radiologists use X-rays, MRIs and other technologies to treat medical conditions. In many procedures, a catheter is inserted into an artery and moved through the body to the site of the problem.

Compensation for Errors in Interventional Procedures

The medical malpractice attorneys of Mishkind Law Firm Co., L.P.A., represent patients who have been injured because of medical errors made in interventional procedures, such as:

- Angioplasty and stent placement
- Placement of occluding devices
- Nonsurgical aneurysm repairs

When a catheter or stent is inserted or advanced improperly, it can perforate the artery, causing a life-threatening emergency. If not placed correctly, a stent or occluding device may become dislodged and damage the artery or heart.

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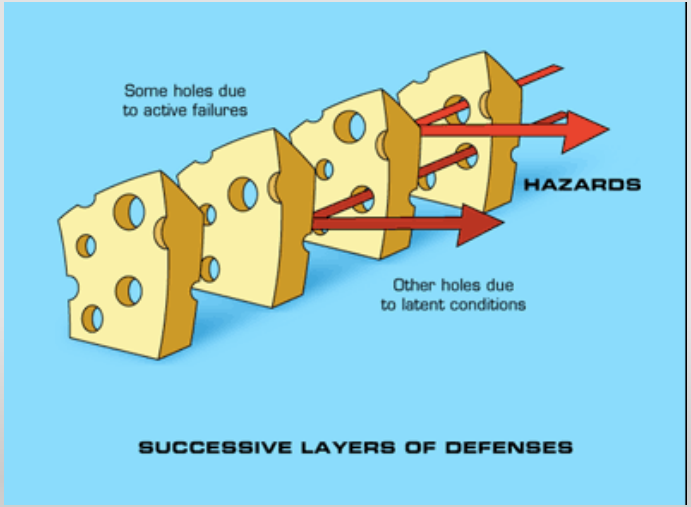
Swiss Cheese Model

Layered protections for failure prevention



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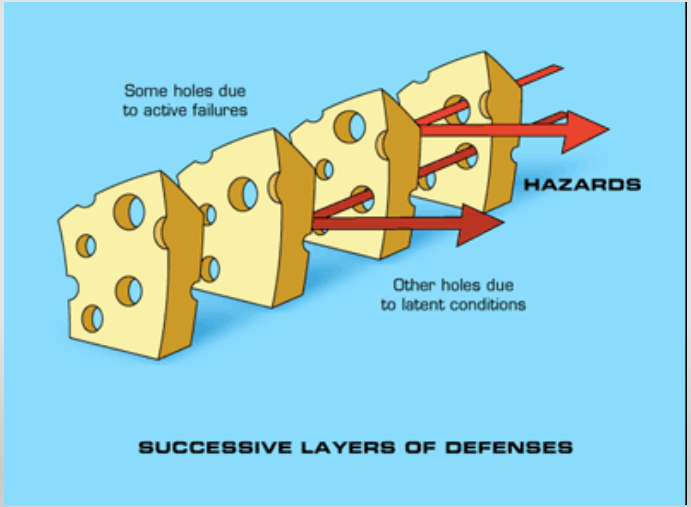
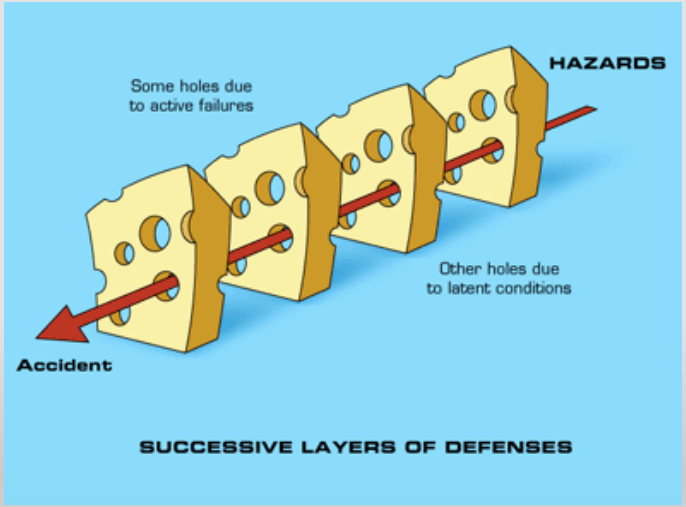
Swiss Cheese Model

Layered protections for failure prevention

J. Reason
Human Error
Cambridge University Press
1990





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Institute of Medicine

1999

44, 000 – 98, 000 each year

"A 727 each day"

November 1999

INSTITUTE OF MEDICINE

Shaping the Future for Health

TO ERR IS HUMAN:
BUILDING A SAFER HEALTH SYSTEM

Health care in the United States is not as safe as it should be--and can be. At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented, according to estimates from two major studies. Even using the lower estimate, preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS.

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REVIEW ARTICLE

A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care

John T. James, PhD

JOURNAL OF PATIENT SAFETY

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- James
  - **J Patient Safety 2013;9:122-128**
- Estimate based on data extrapolated from 4 data mining studies
  - Contemporary data
  - IOM *To Err is Human* ca. 1984
- Estimates error rate (*Preventable Adverse Event*, PAE)
- Extrapolates a LETHAL error rate

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Types of PAEs

The cause of PAEs in hospitals may be separated into these categories:

- Errors of commission,
- Errors of omission,
- Errors of communication,
- Errors of context, and
- Diagnostic errors

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- James
  - **J Patient Safety 2013;9:122-128**
- Estimate based on data extrapolated from 4 data mining studies
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- 200 000 -400 000 per year

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- James
- Estimate based on data extrapolated from 4 data mining studies
  - Contemporary data
  - IOM *To Err is Human* ca. 1984
- Estimates error rate (*Preventable Adverse Event*, PAE)
- Extrapolates a LETHAL error rate
- 200 000 -400 000 per year
- Serious Harm is 10X-20X more common than LETHAL Harm

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High Reliability- Were all in this together

- James
- Estimate ba studies
  - Contemp
  - IOM *To*
- Estimates e
- Extrapolate
- 200 000 -4
- Serious Ha rm

CONCLUSIONS

There was much debate after the IOM report about the accuracy of its estimates. In a sense, it does not matter whether the deaths of 100,000, 200,000 or 400,000 Americans each year are associated with PAEs in hospitals. Any of the estimates demands assertive action on the part of providers, legislators, and people who will one day become patients. Yet, the action and progress on patient safety is frustratingly slow; however, one must hope that the present, evidence-based estimate of 400,000+ deaths per year will foster an outcry for overdue changes and increased vigilance in medical care to address the problem of harm to patients who come to a hospital seeking only to be healed.

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Google maps

TomTom

Hartford Hospital

High Reliability—We're all in this together

Google maps

NPSG.01.01.01

TOMTOM

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The Joint Commission

National Patient Safety Goals Effective January 1, 2015

Hospital Accreditation Program

Goal 1

Improve the accuracy of patient identification.

NPSG.01.01.01

Use at least two patient identifiers when providing care, treatment, and services.

--Rationale for NPSG.01.01.01--

Wrong-patient errors occur in virtually all stages of diagnosis and treatment. The intent for this goal is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual. Acceptable identifiers may be the individual's name, an assigned identification number, telephone number, or other person-specific identifier.

www.jointcommission.org

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Google maps

TOMTOM

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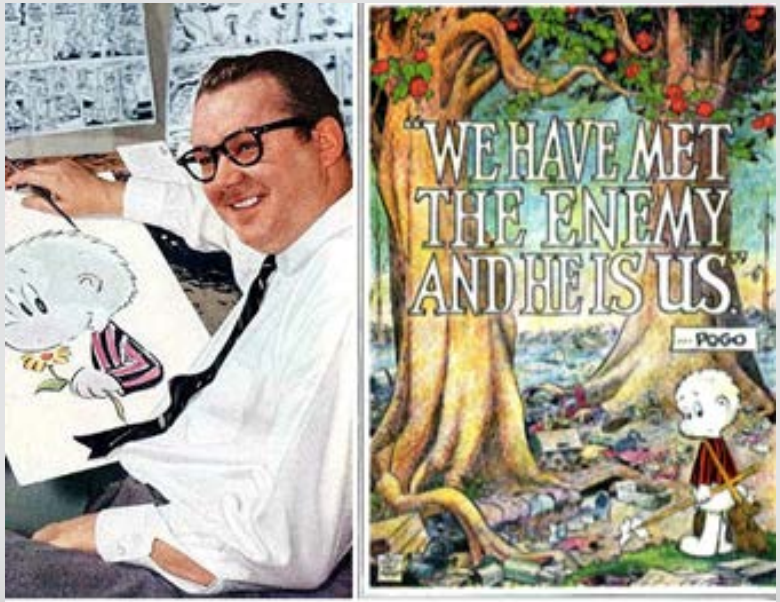

Walt Kelly (1913-1973) and his famous poster for the first Earth Day on April 22, 1970

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Why does this happen?

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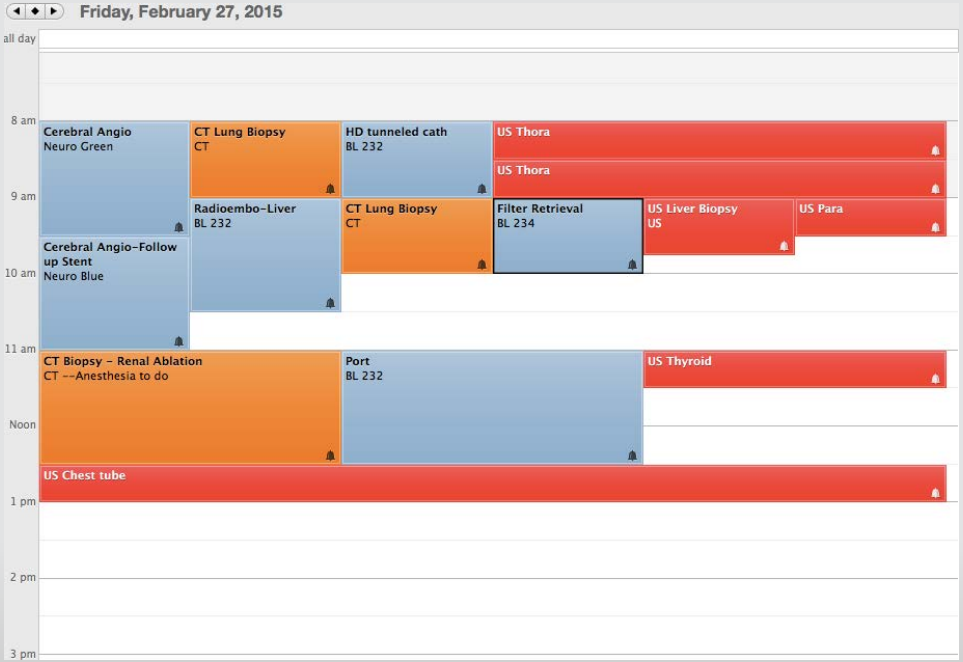
We work in a COMPLEX environment



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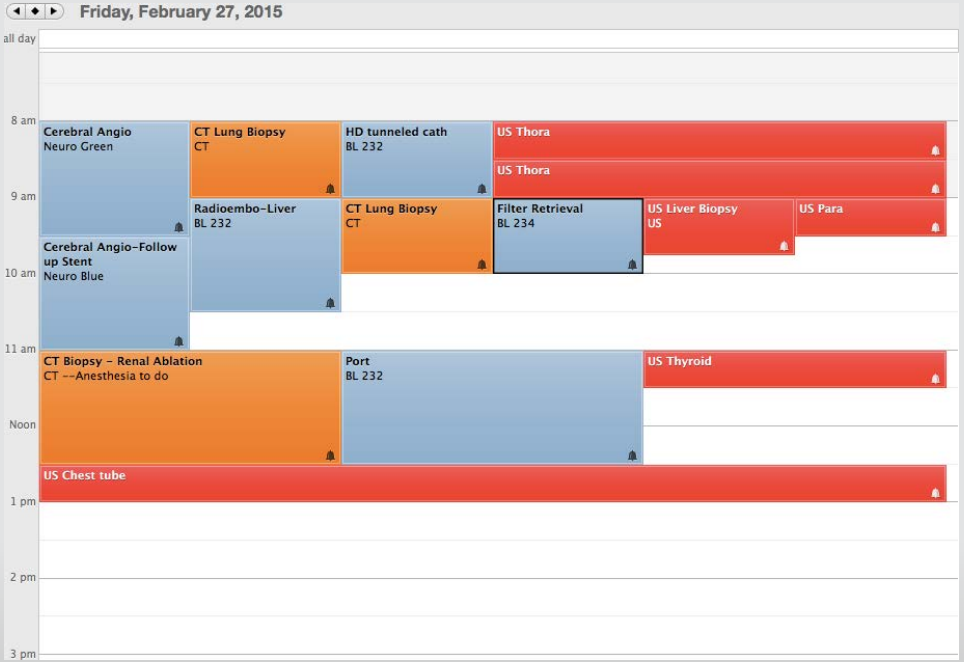
High Reliability—We're all in this together

We work in a COMPLEX environment

Various resources
- IR Suites
- Staff needs
- Patient needs
- Transport
- Equipment needs
- IT issues "downtime"



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We work in a COMPLEX environment

Various resources
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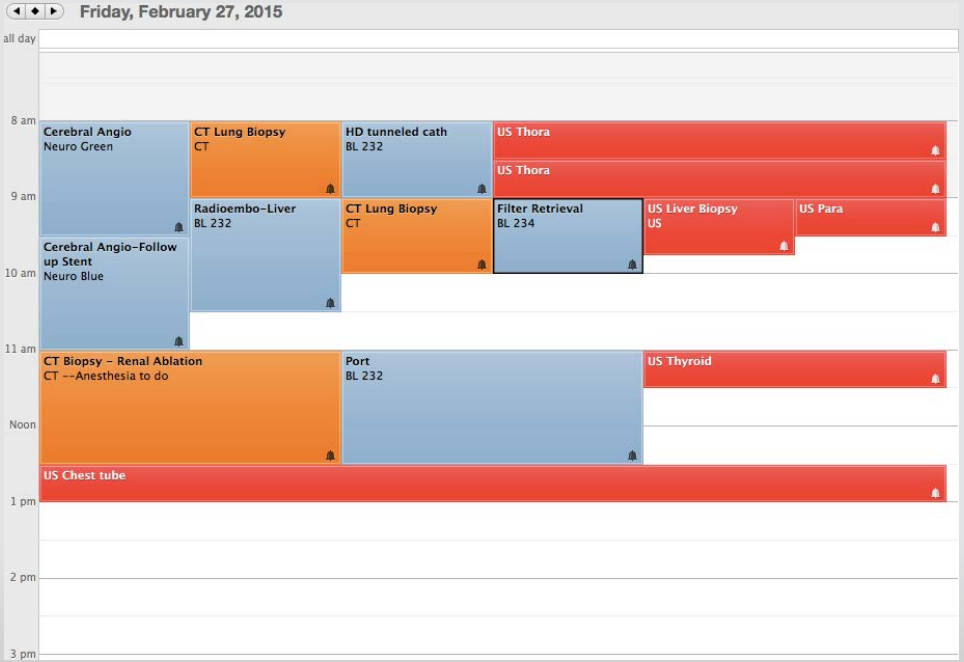
Variable acuity



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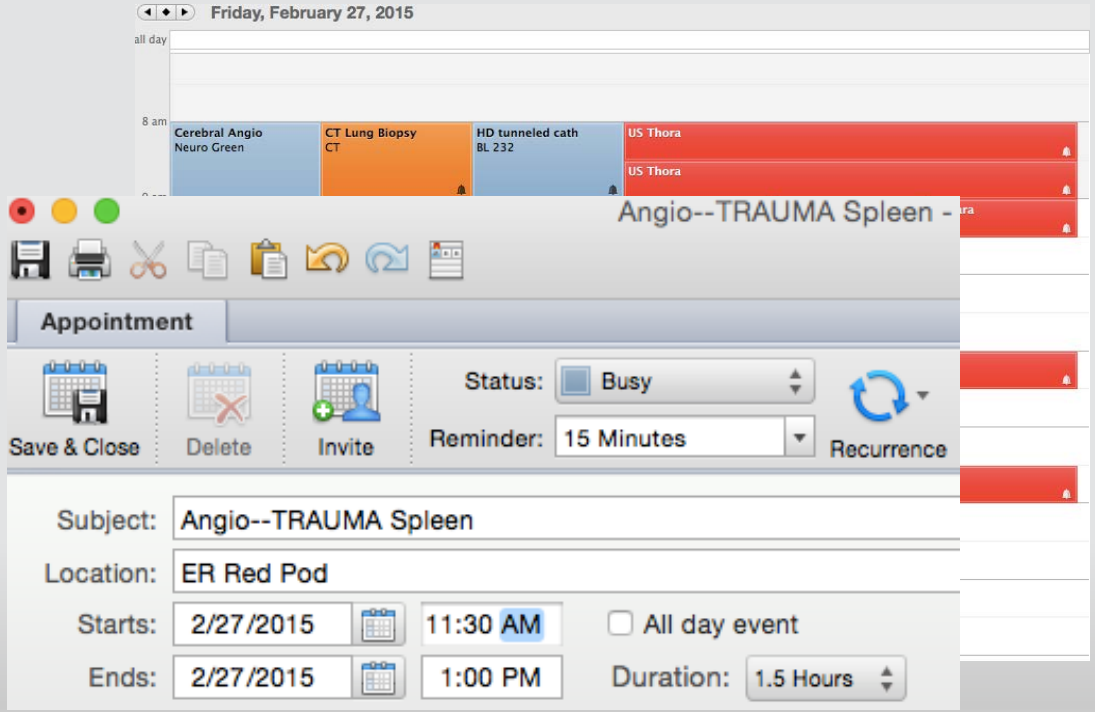

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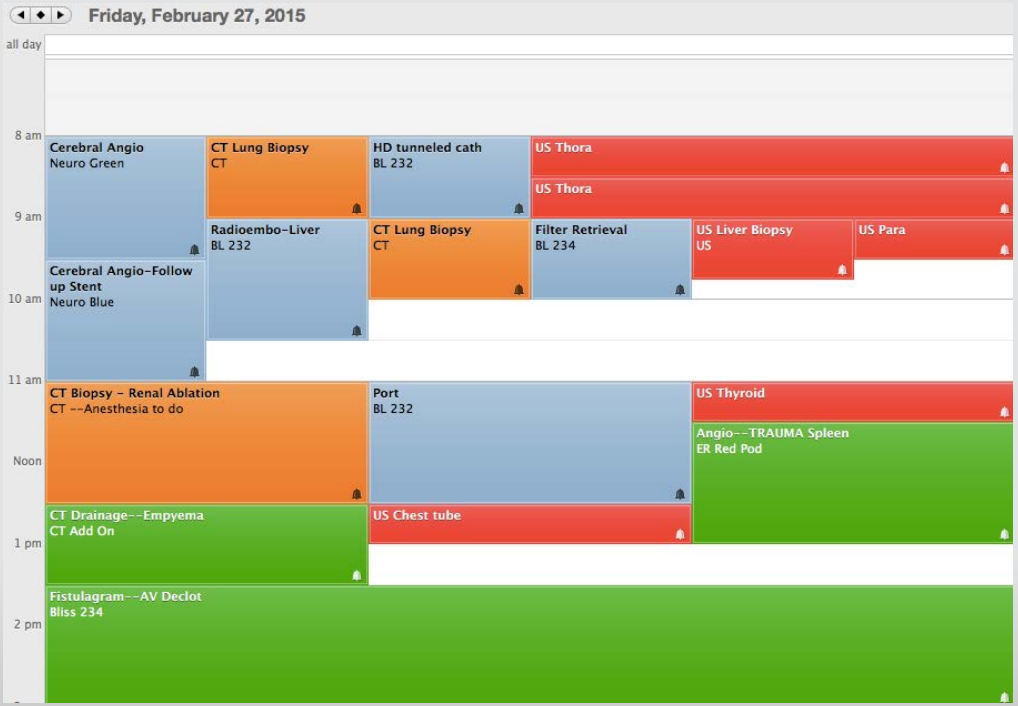
High Reliability—We're all in this together

We work in a COMPLEX environment

Various resources
- IR Suites
- Staff needs

Variable acuity
- Emergent add-ons

Equipment issues, phone calls



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High Reliability—We're all in this together

We work in a COMPLE

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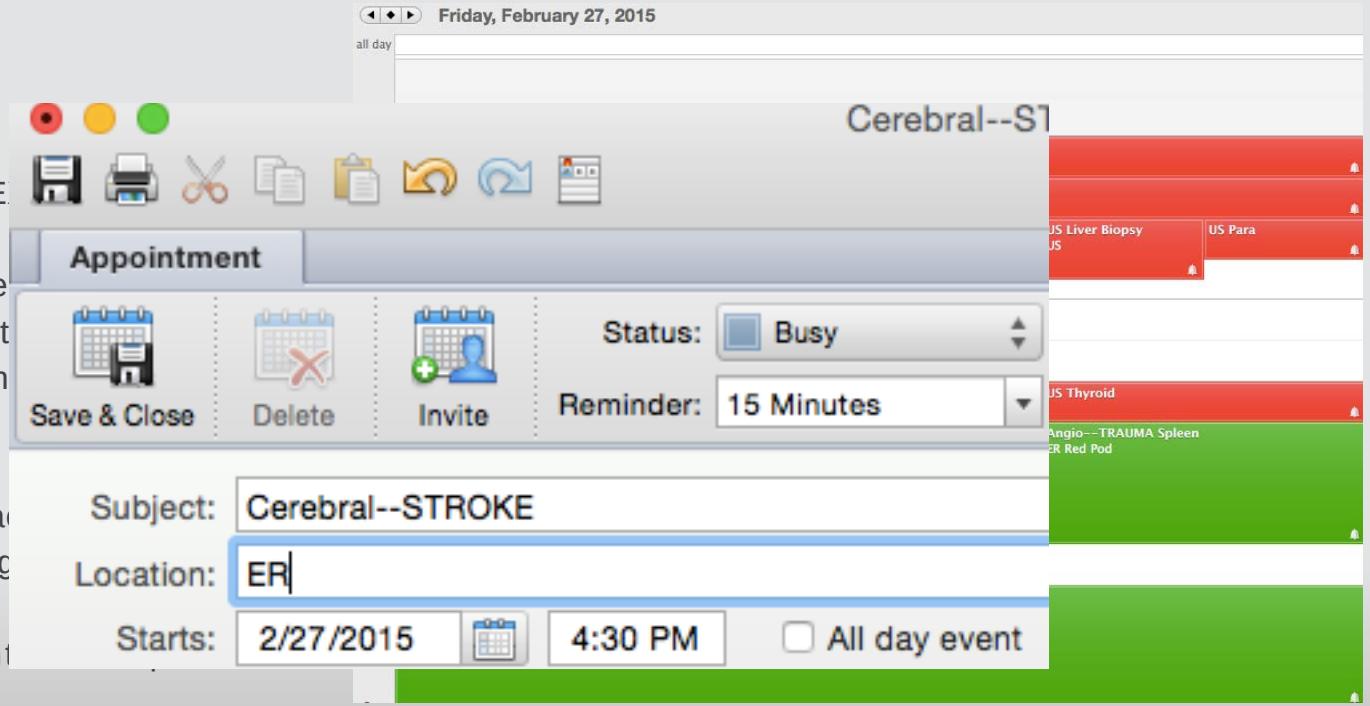

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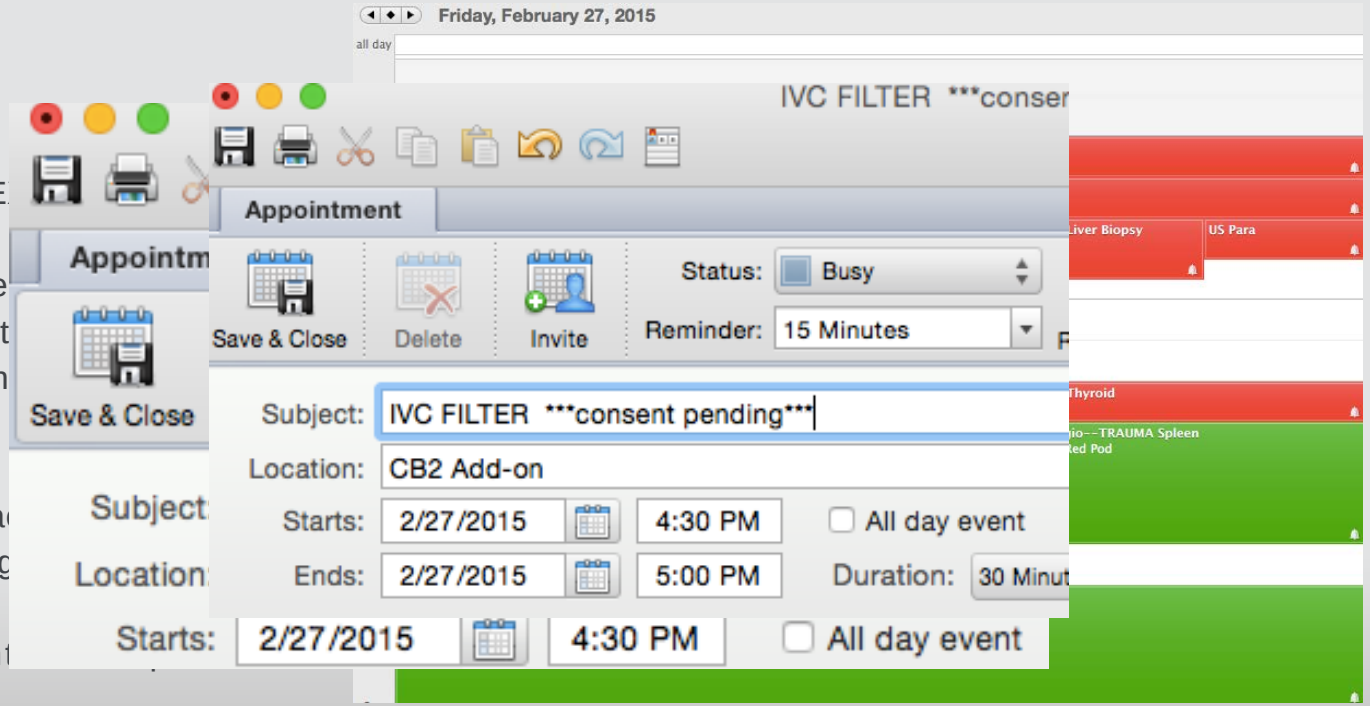

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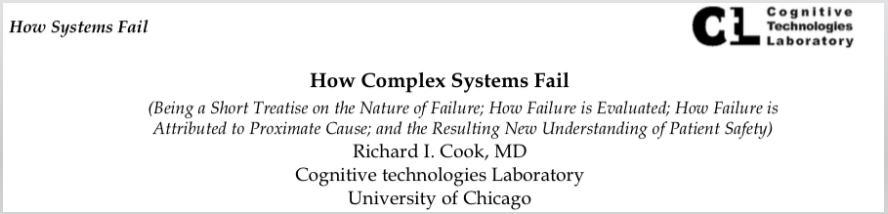
Why does this happen?

Complex Systems are intrinsically hazardous systems



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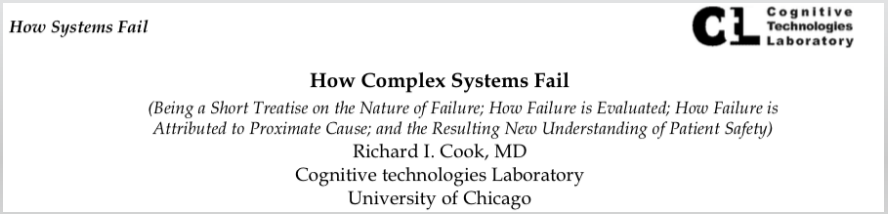
Why does this happen?

Complex Systems are intrinsically hazardous systems

Complex Systems contain changing mixtures of latent failures within them


How Systems Fail

Cognitive Technologies Laboratory

How Complex Systems Fail

(Being a Short Treatise on the Nature of Failure; How Failure is Evaluated; How Failure is Attributed to Proximate Cause; and the Resulting New Understanding of Patient Safety)

Richard I. Cook, MD
Cognitive technologies Laboratory
University of Chicago

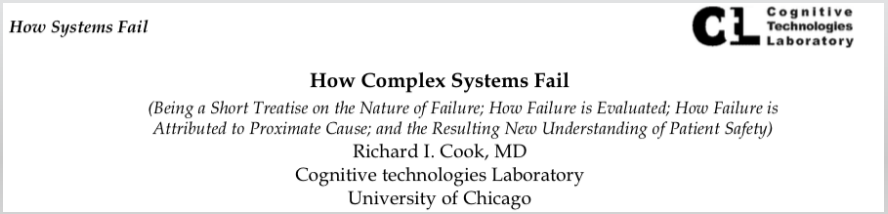
High Reliability—We're all in this together

Why does this happen?

Complex Systems are intrinsically hazardous systems

Complex Systems contain changing mixtures of latent failures within them

Complex Systems run in degraded mode



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High Reliability—We're all in this together

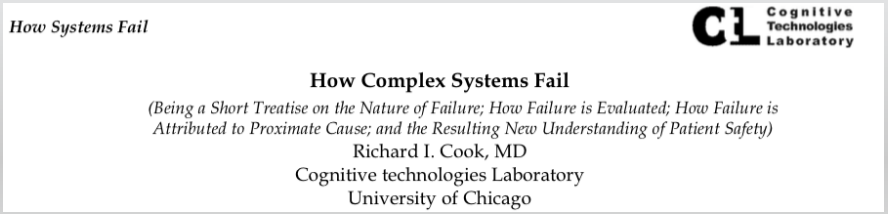
Why does this happen?

Complex Systems are intrinsically hazardous systems

Complex Systems contain changing mixtures of latent failures within them

Complex Systems run in degraded mode

Catastrophe is always just around the corner



How Systems Fail

Cognitive Technologies Laboratory

How Complex Systems Fail

(Being a Short Treatise on the Nature of Failure; How Failure is Evaluated; How Failure is Attributed to Proximate Cause; and the Resulting New Understanding of Patient Safety)

Richard I. Cook, MD
Cognitive technologies Laboratory
University of Chicago

High Reliability—We're all in this together

Why does this happen?

Why don't these things happen more often?

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High Reliability—We're all in this together

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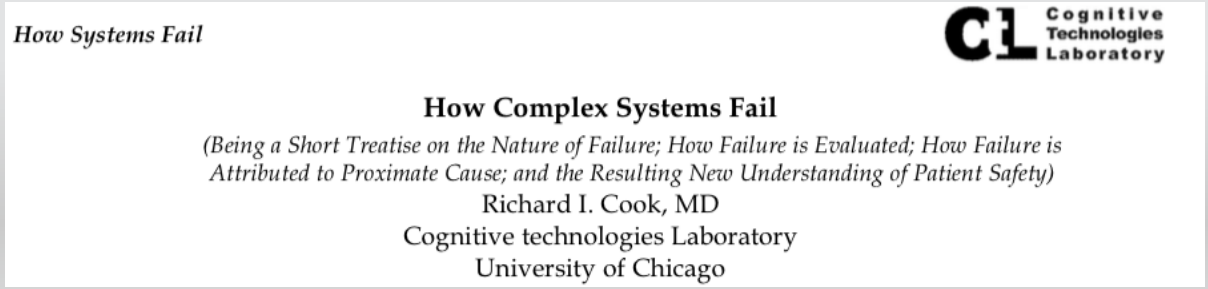

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Why does this happen?

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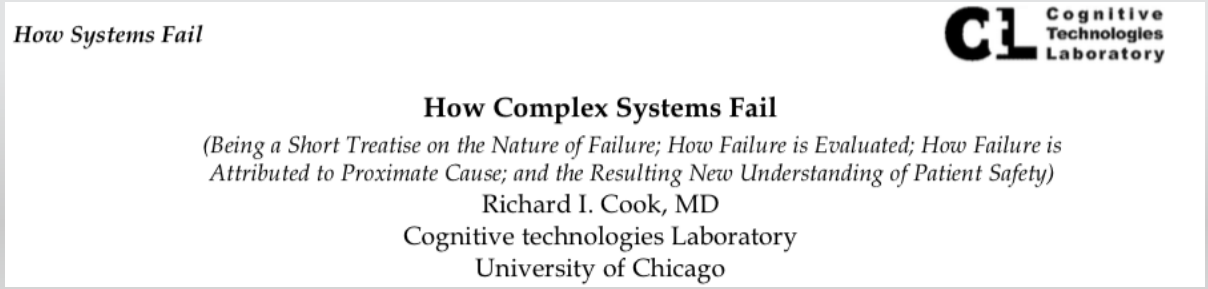
Complex Systems are heavily and successfully defended against failure



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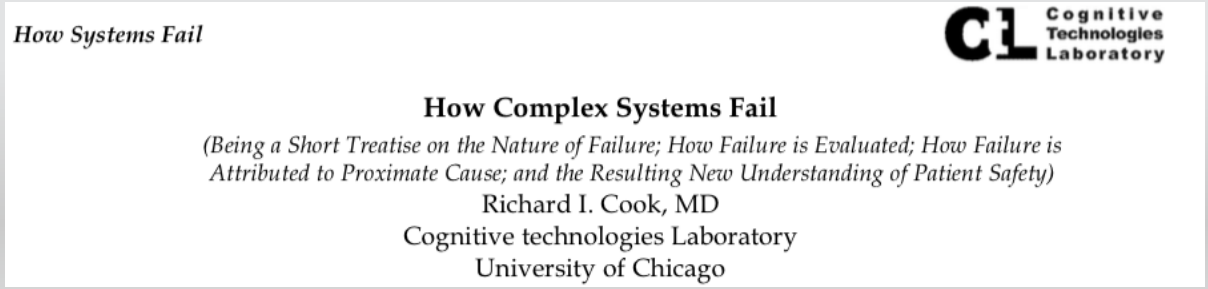

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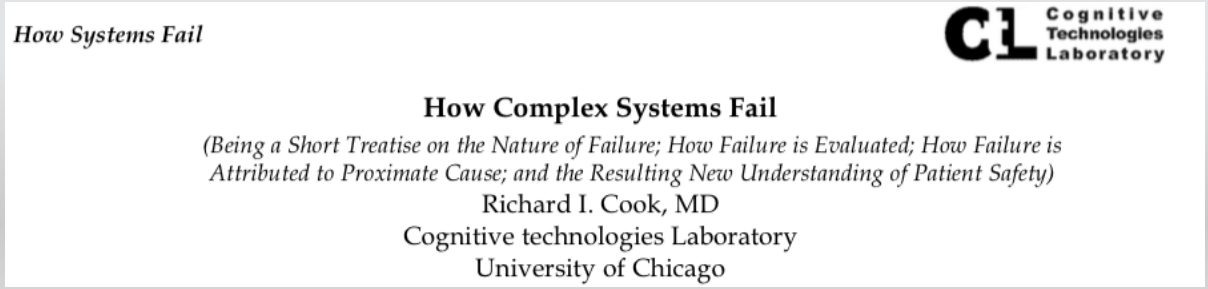
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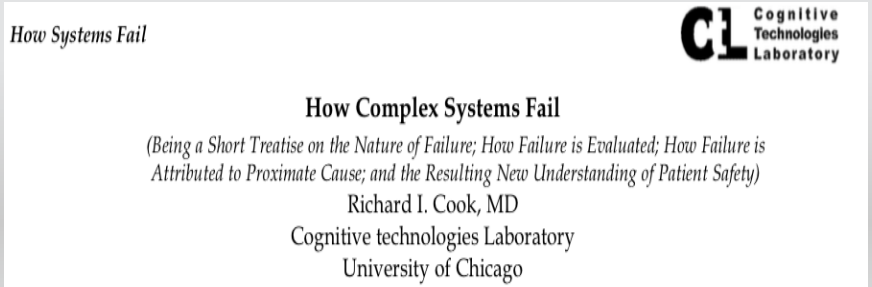
Human practitioners are the adaptable element of complex systems



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High Reliability—We're all in this together

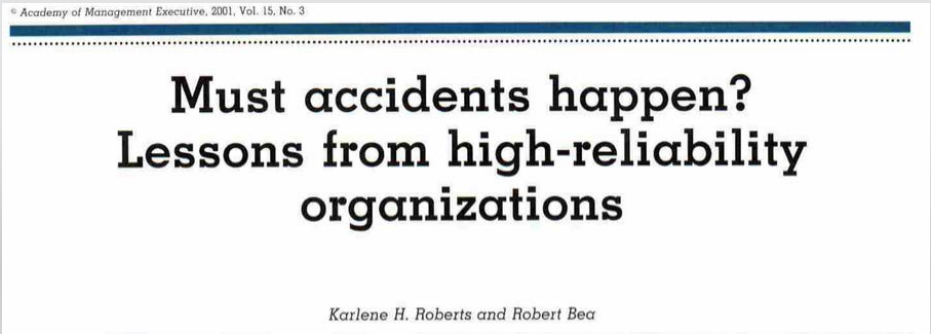
High Reliability Organizations (HROs)

Concept developed based on complex systems that successfully avoid accidents and catastrophic failures

Examples studied: Aircraft Carrier operations

Nuclear Power generation

Commercial aviation



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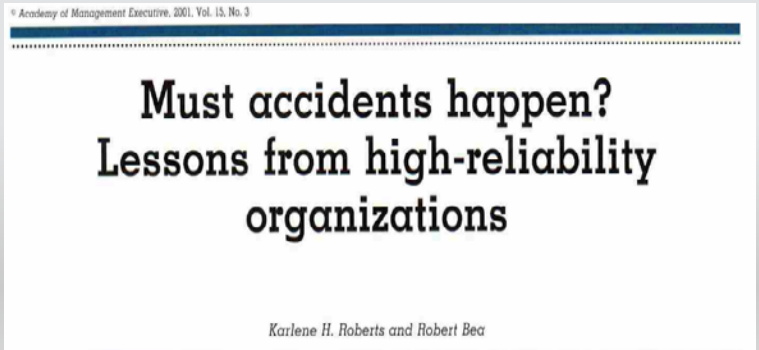

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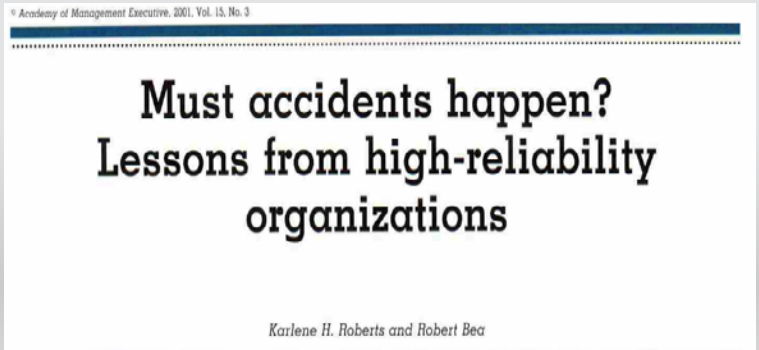
2. Recognize the cost of failure and the benefits of reliability



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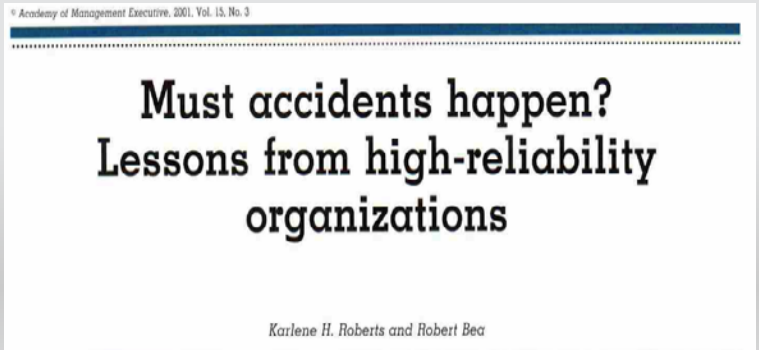
1. Seek to know what you don't know
2. Recognize the cost of failure and the benefits of reliability
3. Keep everybody in the loop



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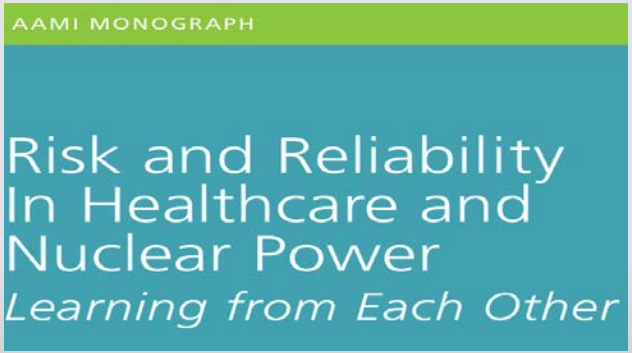
High Reliability—We're all in this together

1. High Consequence Industries
    1. Healthcare
    2. Nuclear Power
    3. Military Command and Control
    4. Commercial aviation
    5. Space Exploration
    6. Wildfire firefighting
    7. Chemical process control
    8. Deep Sea Oil/Gas exploration
    9. Deep ground mining
    10. Mass transit systems
    11. "Big Science" projects



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"The healthcare industry may be the largest and most expensive endeavor in the developed world, with the United States at the top of the list of per capita expenditure."

" A decentralized and massive undertaking"

4000-6000 hospitals (Same number of surgicenters)
Owned by 1000-2000 firms
200 000 physician offices
20 million surgical procedures with Anesthesia
1 billion prescriptions written per year

Risk and Reliability in HealthCare and Nuclear Power: Learning from Each Other. AAMI Monograph 2013. Eds: Weinger MB Halbert BD Logan MK

High Reliability—We're all in this together

In contrast, Nuclear Power….

About 100 Nuclear power plants in the United States
Owned by 30-40 firms
Regulated and scrutinized by the NRC
Highly-trained individuals
Extensive use of simulation and team work

High Reliability—We're all in this together

High Consequence events: Health Care v. Nuclear Power

Scale of catastrophe
Publicity
Operator risk
Facility Risk

PERSPECTIVES—WHAT ARE THE ISSUES

Thorniest Issues in Healthcare

I cynically suggest that if the aftermath of medical errors or preventably suboptimal care events in an OR, ICU room, or emergency department bay would be to take that room out of service for days or months, that would generate a much more aggressive response for improvement by the healthcare institution than we currently see.

D Gaba MD. AAMI Monograph. Page 22

High Reliability—We're all in this together

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"If you've seen one hospital….
you've seen *one* hospital"

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Innovation Series 2004

Improving the Reliability of Health Care

Authors:

Thomas Nolan, PhD: *Senior Fellow, IHI; Statistician, Associates in Process Improvement*
Roger Resar, MD: *Senior Fellow, IHI; Assistant Professor of Medicine, Mayo Clinic College of Medicine; Change Agent, Luther Midelfort Mayo Health System, Eau Claire, Wisconsin, USA*
Carol Haraden, PhD: *Vice President, IHI*
Frances A. Griffin, RRT, MPA: *Director, IHI*

Editor: Ann B. Gordon

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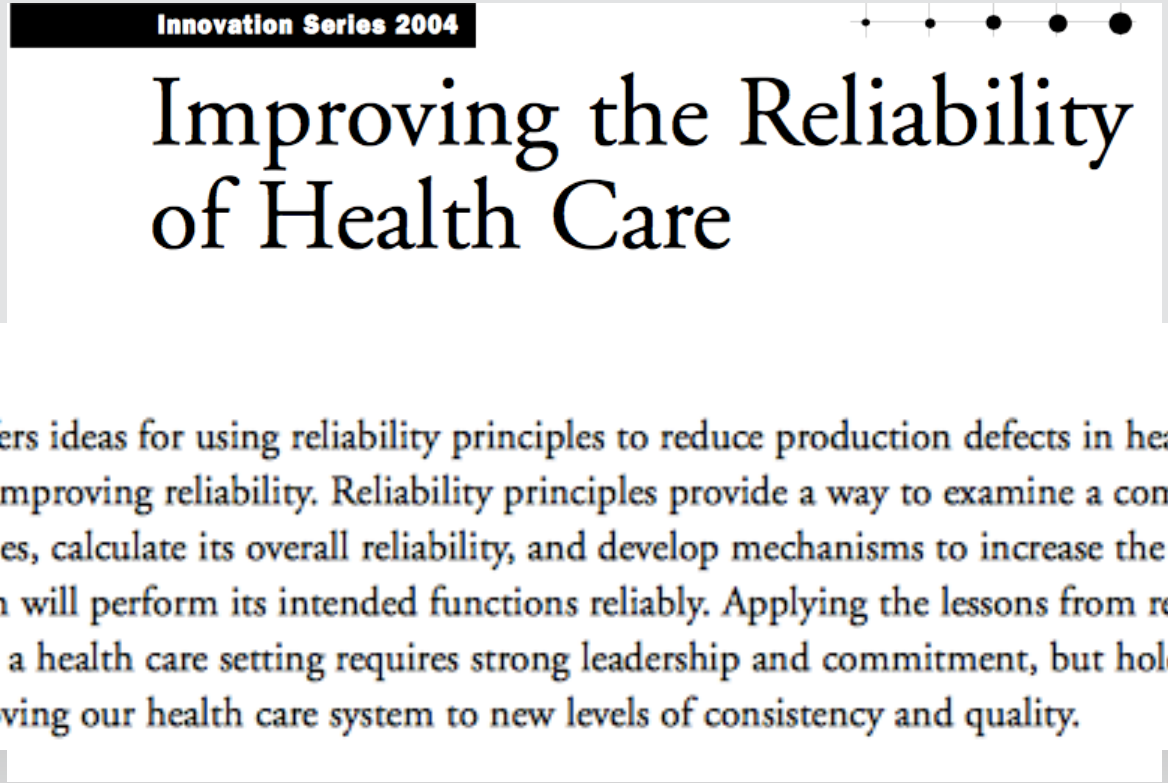

Innovation Series 2004

Improving the Reliability of Health Care

Conclusion

This paper offers ideas for using reliability principles to reduce production defects in health care, one aspect of improving reliability. Reliability principles provide a way to examine a complex system and its processes, calculate its overall reliability, and develop mechanisms to increase the likelihood that the system will perform its intended functions reliably. Applying the lessons from reliability engineering to a health care setting requires strong leadership and commitment, but holds the promise of moving our health care system to new levels of consistency and quality.

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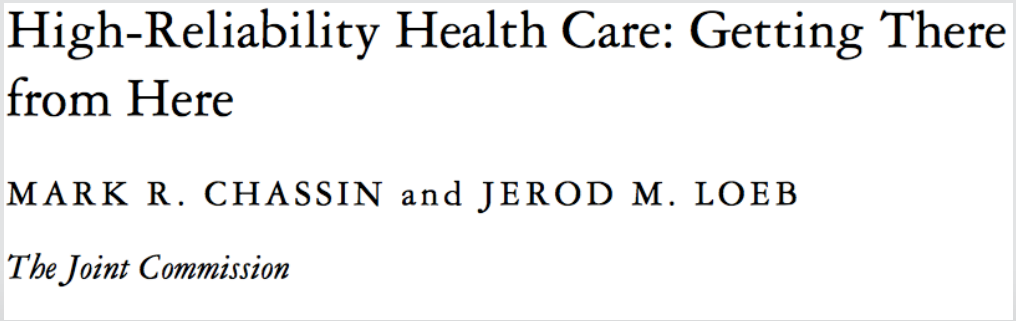
Medical Errors—

OR Fires happen maybe 600 times per year

Wrong patient or wrong side surgery happen maybe 50 times per week in the U.S.



Chasen MR Loeb JB Milbank Quarterly 2013;91(3):459-490.

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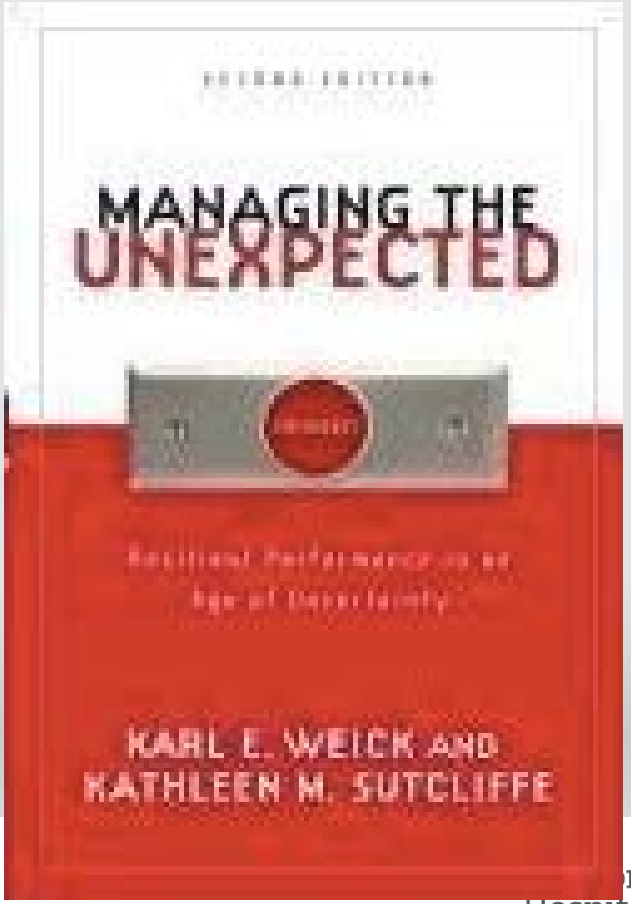
Managing the Unexpected



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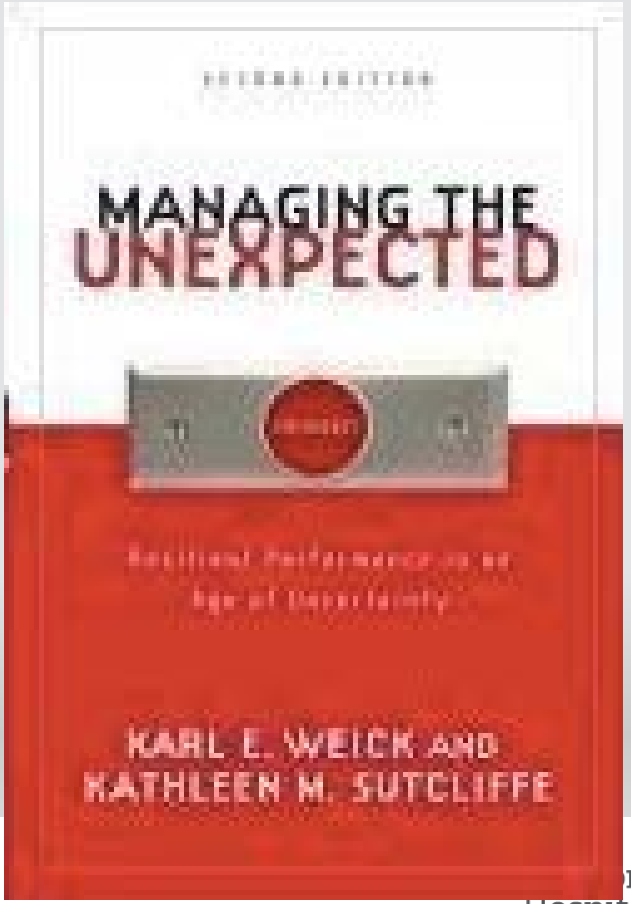
Managing the Unexpected

<u>Characteristics of HROs</u>

1. Preoccupation with failure.
2. Reluctance to simplify.
3. Sensitivity to Operations
4. Commitment to Resilience
5. Deference to Expertise



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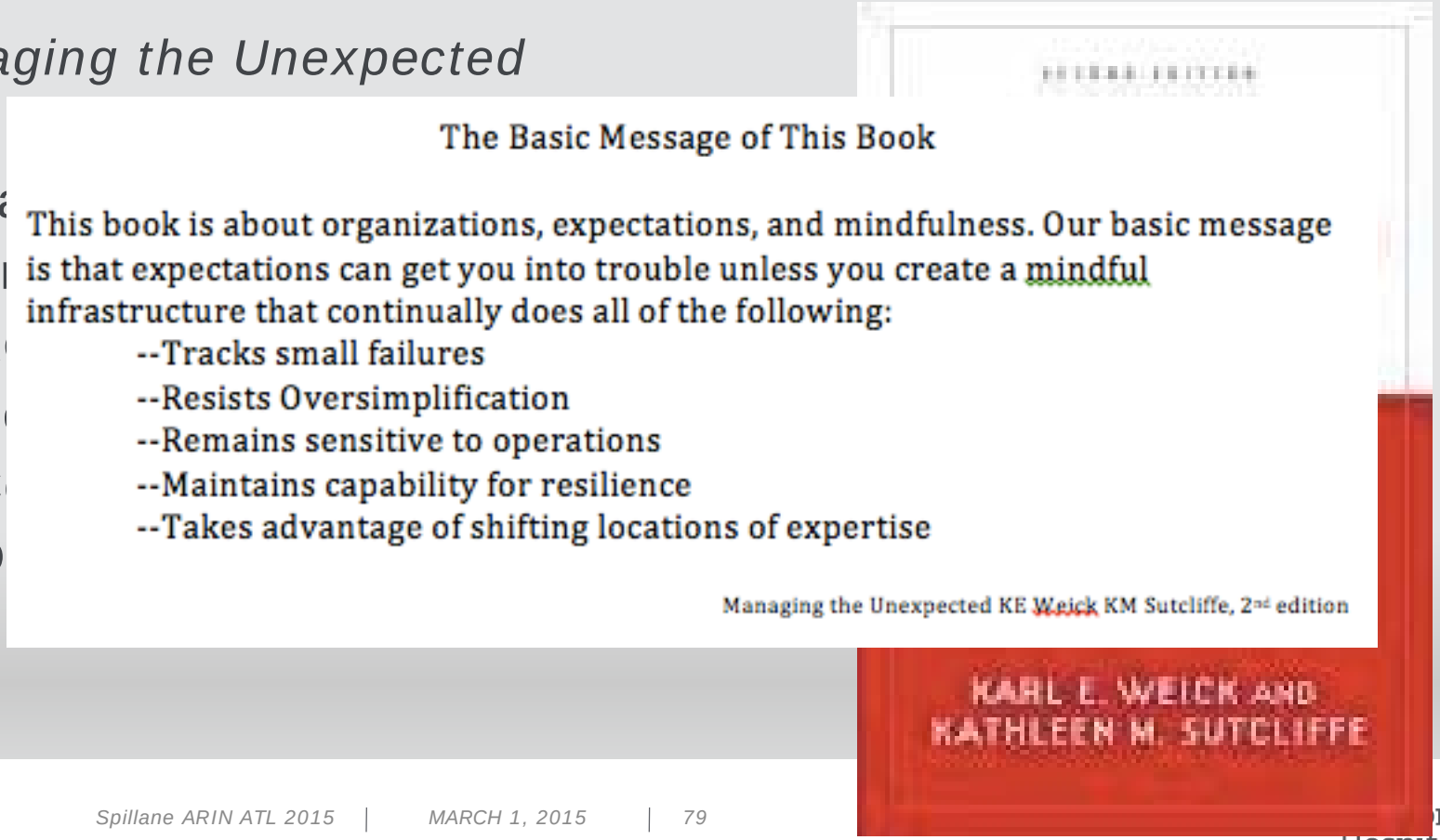
Managing the Unexpected

Chara

1. P
2. R
3. S
4. C
5. D



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Mindfulness

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Mindfulness

History: *L elbow pain*

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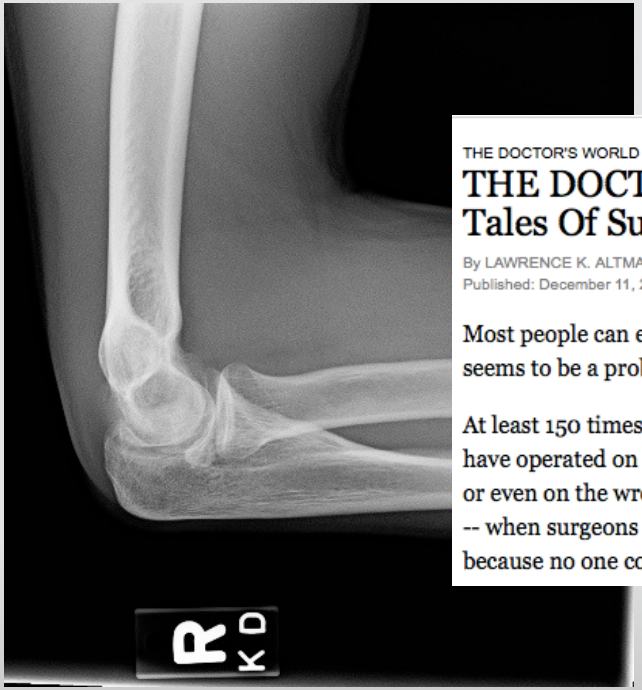
Mindfulness



THE DOCTOR'S WORLD

THE DOCTOR'S WORLD; The Wrong Foot, And Other Tales Of Surgical Error

By LAWRENCE K. ALTMAN, M.D.
Published: December 11, 2001

Most people can easily tell right from left, but for some surgeons it seems to be a problem.

At least 150 times since 1996, surgeons in hospitals in this country have operated on the wrong arm, leg, eye, kidney or other body part, or even on the wrong patient. The figure does not include near misses -- when surgeons started to operate on the wrong site or patient -- because no one collects such information.

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Highly Reliable Organizations (HROs)

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Highly Reliable Organizations (HROs)—**Teamwork is Innovation**

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Highly Reliable Organizations (HROs)—**Teamwork is Innovation**

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High Reliability—We're all in this together

1. **Crew Resource Management (CRM)**
    1. ***Cockpit Resource Management***
        1. ***IR SUITE RESOURCE MANAGEMENT***

2. Coined by John Lauber
    1. NASA
3. NTSB analysis of United Airlines flight 173 in 1979
    1. Crew was focused on a landing gear problem and the plane ran out of fuel

Wikipedia, "Crew Resource Management"

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"…a set of training procedures for use in environments where human error can have devastating effect."

"focuses on interpersonal communication, leadership, and decision making in the cockpit."

"communication barriers are reduced and problems can be solved more efficiently, leading to increased safety."

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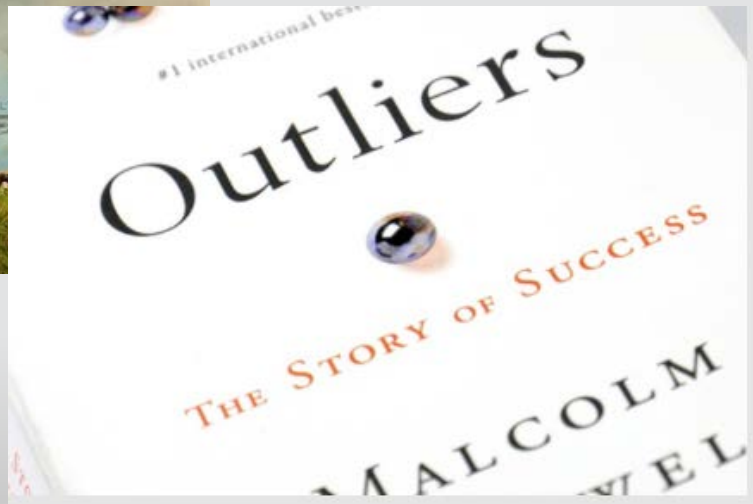
Assertiveness



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Crew Resource Management

The need to speak up: HIERARCHY and the POWER DISTANCE INDEX (PDI)

IBM HR researcher Geert Hofstede, 1960s-1970s

-Cross cultural psychology and its workplace impact

-Questions about **how people worked together**,

how they solved problems, **how they felt about authority**

Hofstede's cultural dimensions theory

From Wikipedia, the free encyclopedia

(Redirected from Power distance)

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Crew Resource Management

The need to speak up: HIERARCHY and the POWER DISTANCE INDEX (PDI)

Cultures have different POWER DISTANCE INDICES or POWER GRADIENTS

Moderate to Low in the United States

Industries and Teams have different POWER GRADIENTS

Anesthesiologists and Surgeons view it as **LOW**
Nurses tend to view it as **HIGH**

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Crew Resource Management

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PERCEIVED POWER GRADIENTS LEAD TO AUTHORITY GRADIENTS

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Crew Resource Management is about

Communication !

Expertise, training, equipment, and procedures appeared to be adequate protection, yet the presence of multiple defences obscured their faulty functioning, just as they often do in medical settings. A number of other problems occurred aboard *Greeneville* which we also see in health care. The problem was the total breakdown of communication. The *Greeneville* team also failed to move from a rigid hierarchical structure to a more flexible adaptive structure. Communication often breaks down in healthcare settings, which are organized to maximize status and hierarchical differences, thus often impeding information flow

LEARNING FROM OTHER INDUSTRIES

Lessons learned from non-medical industries: the tragedy of the USS Greeneville*

K H Roberts, C T Tadmor

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Crew Resource Management is about

Communication !

Box 1 Problems aboard *Greeneville*

- Video monitor that tracks the courses of other ships failed
- Response to monitor breakdown was "business as usual" instead of hypervigilance
- Lunch ran late
- The Captain took the controls and failed to use the crew as "back up"
- Communication broke down among crew members
- Initial periscope depth observation gave cause for concern that wasn't noted
- The fire control technician did not update contacts
- The sonar data collection and analysis was ab
- Fire control and sonar failed to notice disc position of *Ehime Maru*
- The final briefing was not held
- The final periscope search was abbreviated

Key messages

To maintain safety healthcare organizations must:

- Routinely make observations of situational cues and indicators of poor safety and report them to accountable sources.
- Ensure equipment failure back ups exist and are used.
- Ensure that everyone openly discusses errors, near misses, and adverse events.
- Value and teach teamwork in the running of the organization.
- Develop a leadership team that can recognize possible time and resource constraints and reduced redundancy, and will take extra steps to compensate for increased risks.

Qual Saf Hlth Care 2002;11:355-357

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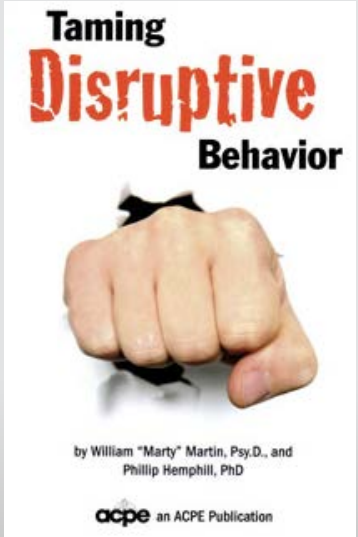
Intimidating behavior

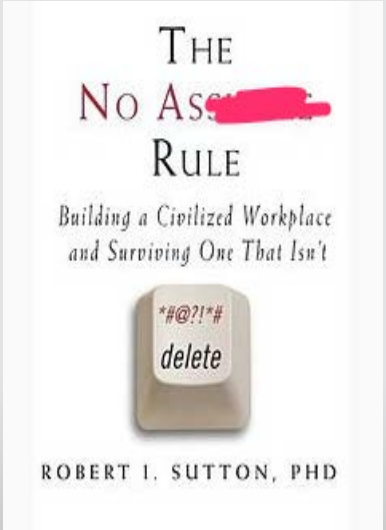
Often ascribed to MDs, but it's not just the MDs

Occurs with MDs, RNs, Techs, Pharmacists

Includes loud or profane language, but also things like,

-condescending language
-not returning phone calls or pages
-intimidating or belittling body language
-impatient behaviors or language





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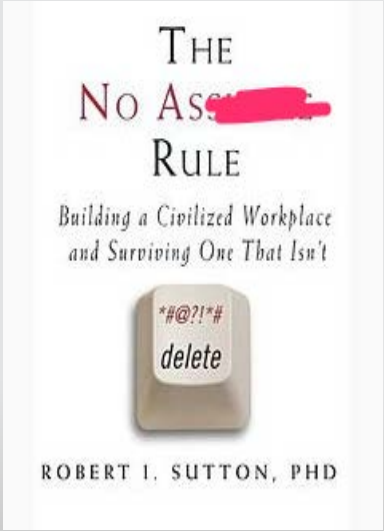
Intimidating behavior

Not tolerated by HROs

Why?

Because they suppress reporting of safety concerns



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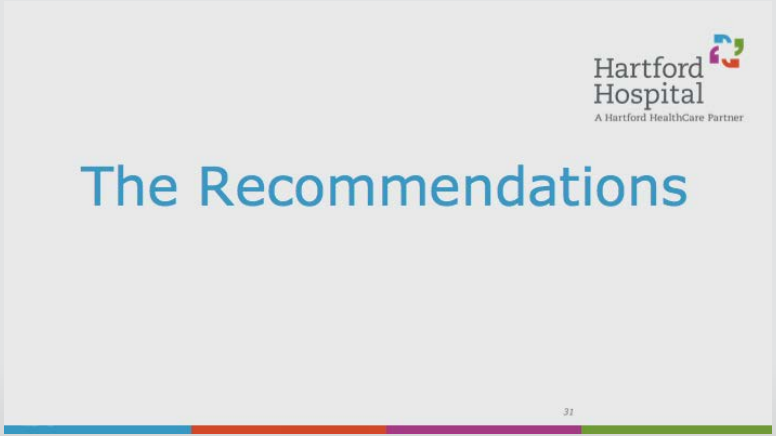
What are we doing with this at Hartford Hospital?



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The Recommendat

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Crew Resource Management

Improved Communication

Structured interaction

3-Way Repeat Back

When information is transferred...

1. **Sender initiates** communication using Receiver's Name. Sender provides a request or information to Receiver in a clear and concise format.
2. **Receiver acknowledges** receipt by a repeat-back of the request or information.
3. **Sender acknowledges the accuracy** of the repeat-back by saying, **That's correct!** If not correct, Sender repeats the communication.

A Safety Phrase:
"Let me **repeat that back...**"

Train our ears to listen for **"That's Correct!"** – it's a codeword for "we understand each other"

Safety Starts with Me | | 33

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Crew Resource Management

Phonetic Clarifications

For *sound alike words and letters*, say the letter followed by a word that begins with the letter...

A	Alpha	**J**	Juliet	**S**	Sierra
B	Bravo	**K**	Kilo	**T**	Tango
C	Charlie	**L**	Lima	**U**	Uniform
D	Delta	**M**	Mike	**V**	Victor
E	Echo	**N**	November	**W**	Whiskey
F	Foxtrot	**O**	Oscar	**X**	X-Ray
G	Golf	**P**	Papa	**Y**	Yankee
H	Hotel	**Q**	Quebec	**Z**	Zulu
I	India	**R**	Romeo		

Adopted by NATO, International Civil Aviation Organization, Federal Aviation Administration, International Telecommunication Union, and US Nuclear Power Industry

Numeric Clarifications

For ***sound alike*** numbers,
say the number and then the digits

15...that's one-five
50...that's five-zero

45...that's four-five
425...that's four-two-five
4 to 5...that's the range four dash five

...and **always** use leading zeros – as in 0.9

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Expectations for interactions

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Multi-tasking is bad

Be in the Moment

Safety Starts with Me | | 42

Self-Check Using STAR

Stop	Pause for *1 to 2 seconds* to focus our attention on the task at hand
Think	Consider the action you're about to take
Act	Concentrate and carry out the task
Review	Check to make sure that the task was done correctly and that you got the correct result

STOP is the most important step. It gives your brain a chance to catch up with what your hands are getting ready to do.

Safety Starts with Me | | 43 Hartford Hospital

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Safety Starts with Me | | 42

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Safety Starts with Me | | 43

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Focusing on the human interaction and the transfer of information

Pay Attention Moments

Conditions that increase the chance you will experience an unintended error when performing a familiar, routine task:

- Working under time pressure
- Doing multiple things at the same time
- Distractions
- Interruptions
- Boredom
- Mental or physical exhaustion
- *Just not paying attention*

Any sound familiar???

STAR reduces your chances of making an unintended mental slip or lapse by **more than 10 times**...

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Focusing on the human interaction and the trans of information

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The expectation to speak up

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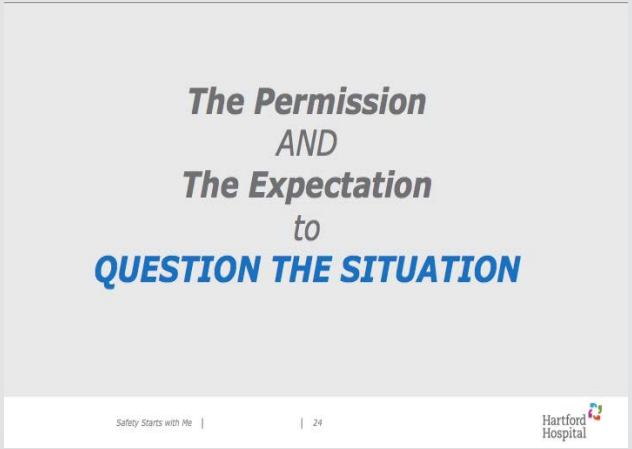
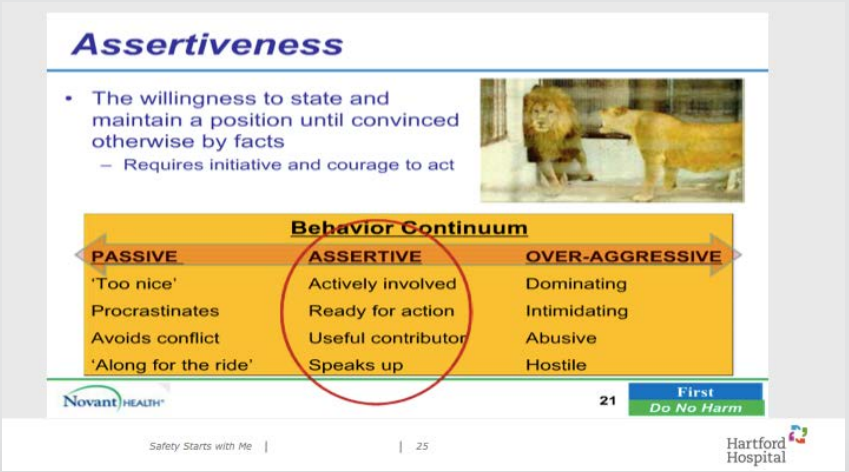
Staff training at Hartford HealthCare





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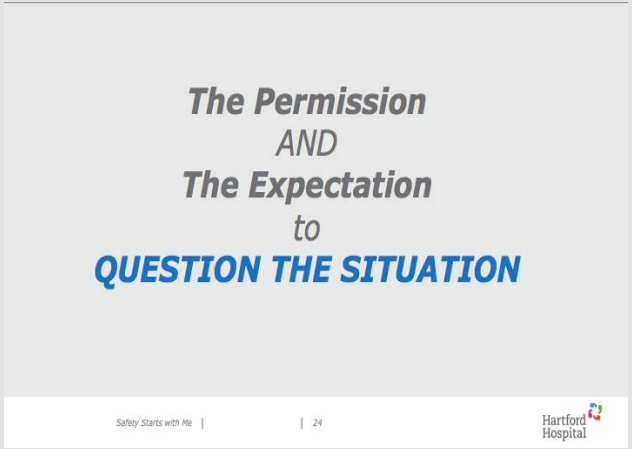
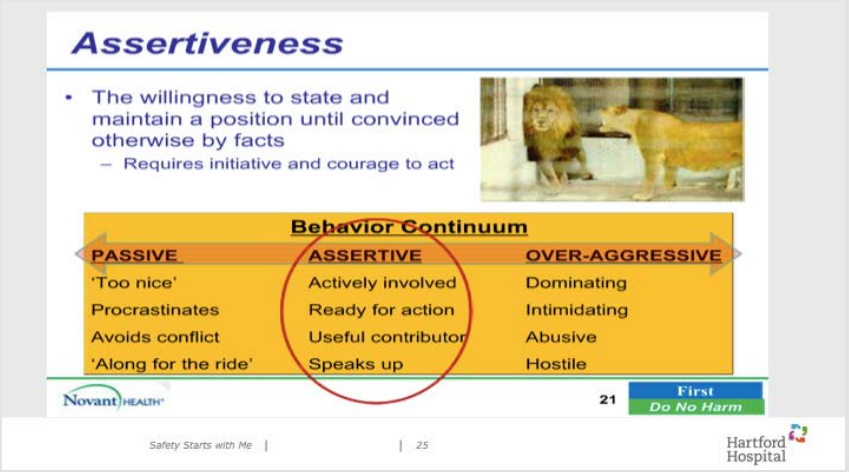


POLITE PERSISTENCE



GRACIOUSNESS

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Human practitioners are the adaptable element of Complex Systems– *Richard I Cook MD*

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Thank you for having me.