Pertama, Tidak Membahayakan

第一，不傷害

Primum non nocere

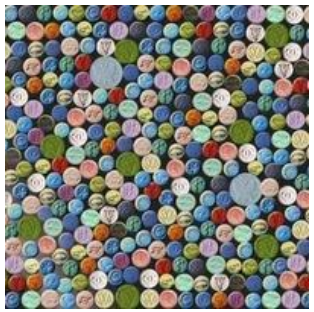
First, Do No Harm

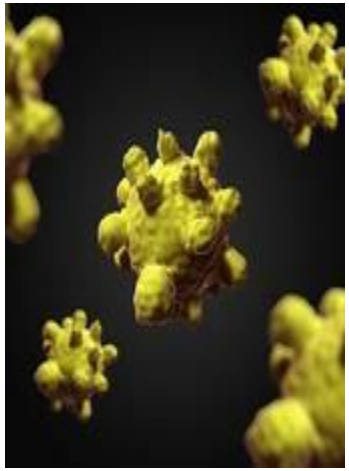
Conference 2014

SingHealth

Defining Tomorrow's Medicine

Zero Harm – Zero Defects





"First, Do No Harm"

Patient *Safety*
Starts WITH ME

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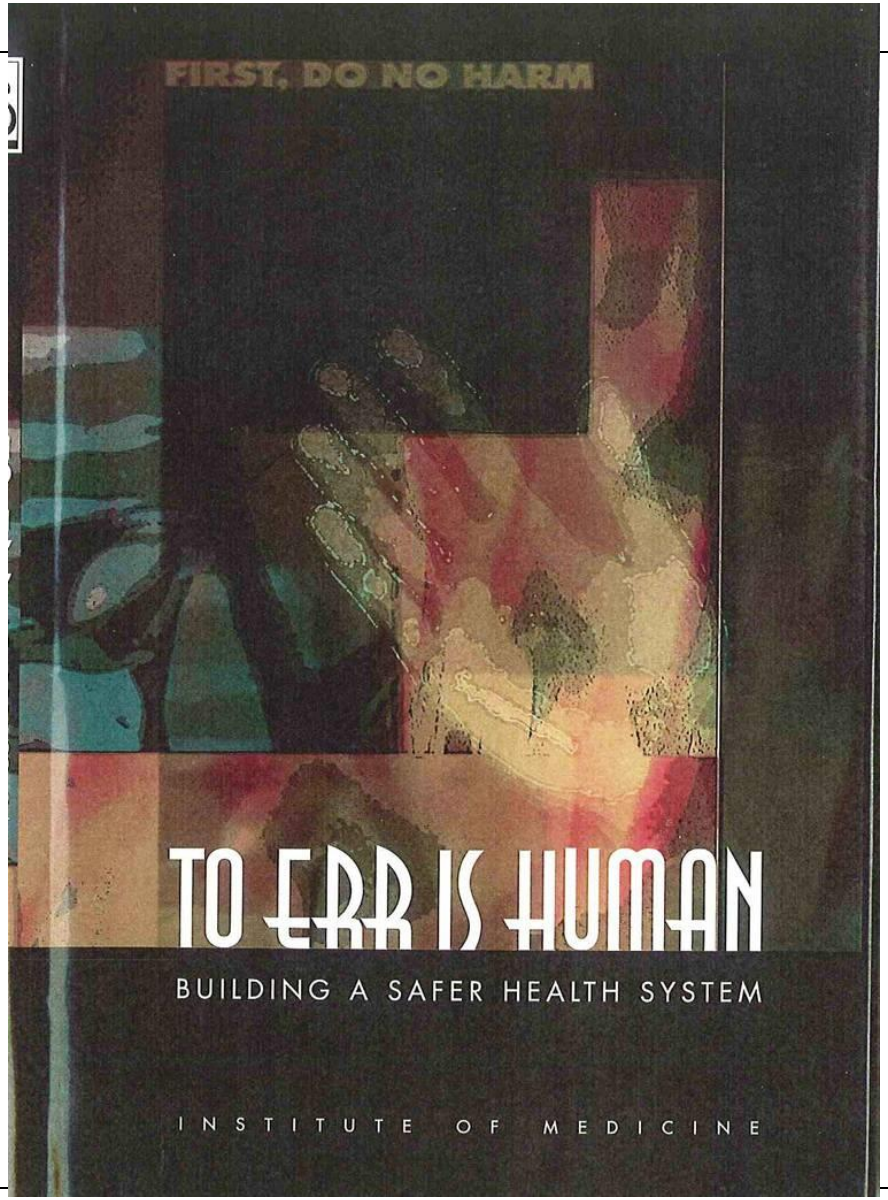
Patient *Safety*
Starts WITH ME


527953
LEVOTHYROXINE
SODIUM FOR INJECTION
FOR IM OR IV USE ONLY
500 mcg
LYOPHILIZED
LEVOTHYROXINE
SODIUM FOR INJECTION
FOR IM OR IV USE ONLY
200 mcg
LYOPHILIZED

"First, Do No Harm"

Patient *Safety*
Starts WITH ME

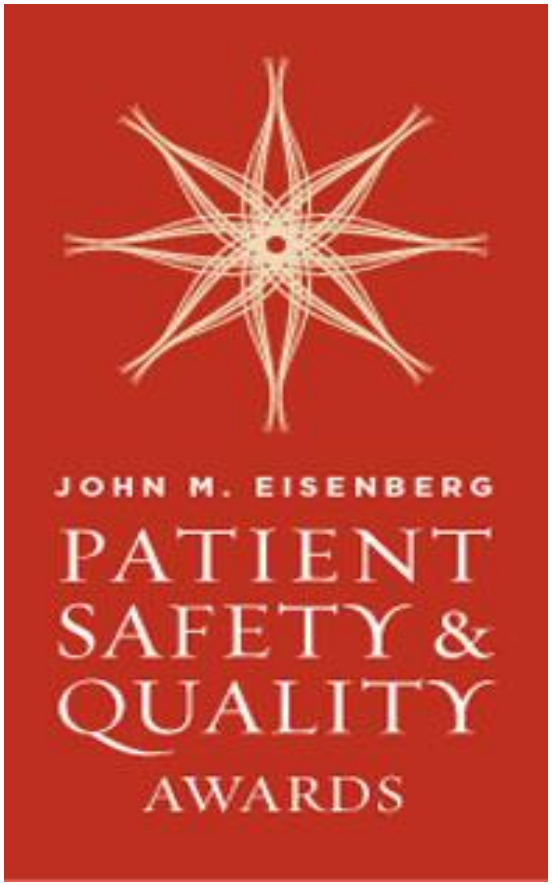
Speak up!



"*First, Do No Harm*"

Patient *Safety*
Starts WITH ME

Are we on the right path?



American Hospital Association – McKesson

Quest for Quality Prize®

Hospitals in Pursuit of Excellence

Complex System Success factors

- Three of them:
  - The People
  - The People
  - The People

My nickel assessment…

- SingHealth has the potential to perform at higher levels
- Your mission and values point to a solid foundation on which to build a stronger safety culture
- All of us need to improve the capabilities of leaders to prevent, detect and correct systems challenges related to safety and human performance challenges

My dime assessment…

- Based on safety events occurring at all hospitals, we know that beyond systems thinking, our human performance challenges (errors) are tied to:
  - Inadequate attention to detail
  - Less than adequate communications
  - Compliance to policies and procedures
  - Failure to recognize error-likely or high-risk situations

Background Theories

- All people make errors
- Error-likely or high-risk situations are predictable, manageable and preventable
- Individual behavior can be strongly influenced
- High-risk behaviors result in human errors
- Significant events can be avoided by understanding near-misses and applying lessons learned

Agenda

- Rambling Complete
- Accountability & Just Culture
- BBE's
- Red Rules
- Video
- Close

What is Accountability?

- Accountability is an attribute of the people, organization and culture

- Accountability is intrinsic motivation to meet performance standards

Just Culture!

- Dilemma:
  - How do we maintain a blame-free environment for problem reporting

WE MUST START WITH ACCOUNTABILITY!!!

If we get accountability?

- Increases attention to detail
- Increases compliance to policy and process
- Results in more conservative judgment and decisions
- Reduces human error rate by 50%

Be Aggressive in limiting excuse making

- Time & resources are both a serious management problem and the #1 excuse.
- Healthcare hurries in all the wrong places!
- Truly caring means taking time for the small things that make the care delivery system work.

Just Action

- Human Error – Slips and Lapses. Clearly no punishment is justified.
- Negligent conduct – More culpable than human error. A case both for and against punishment.
- Reckless conduct – Gross negligence. Clear punishment is justified.
- Knowing violations – person knew of or intended to violate a rule, procedure or duty. Clearly punishment is justified.

Practical Accountability

- Discipline improves performance
- Focus on the behavior (not the individual or the result)
- No adverse consequences for an honest mistake
- Errors send performers to the bottom of the list; they can work their way back up or not.

Errors are not free!

- Blame free or just culture does not mean errors are free
- A just culture balances the needs of the individual and the organization
- Accountability systems:
  - Performance appraisals
  - Instant feedback and constant reinforcement
  - Progressive discipline

So let's start with…

BBE's

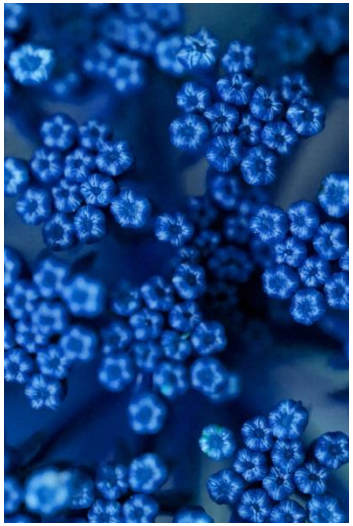
BBE's

- BBE's for leaders, physicians and staff
- Today, only focus on staff BBE's
- BBE's are part of prevention strategy and drive us towards error free performance – What would our patient care environment look like if everyone used these routinely?

BBE's

- ATTENTION TO DETAIL
- CLEAR COMMUNICATIONS
- QUESTIONING ATTITUDE
- EFFECTIVE HANDOFFS
- NEVER LEAVE YOUR WINGMAN

ATTENTION TO DETAIL



- WE FOCUS OUR ATTENTION TO **THINK** BEFORE WE **ACT**

<u>Tool: SAFE</u>

Stop:	pause 1-2 seconds to focus on task
Analyze:	think about what is to be done
Focus:	concentrate and perform the task
Evaluate:	check for desired result

CLEAR COMMUNICATION

- We respectfully communicate the correct information in a timely and appropriate manner.

<u>Tools:</u>

Read backs, repeat backs and common use of clarifying questions

QUESTIONING ATTITUDE

- We must use critical thinking skills to perceive correctly our actions are the best

<u>Tool: Validate and Verify</u>

Validate:	does this make sense to me
Verify:	check it with a second source

EFFECTIVE HANDOFFS

- We provide effective handoffs by taking time to give appropriate information and ensuring understanding and ownership

Tool: The 5 P's

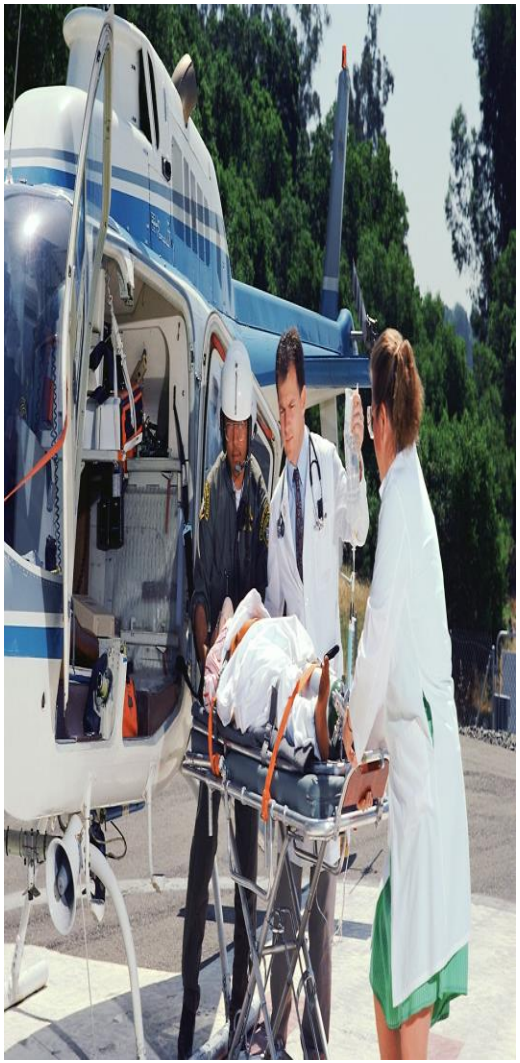
Patient –	What is to be handed off
Plan –	What happens next
Purpose –	The desired end state
Problem –	What is known to be different, unusual or complicating about this patient
Precaution –	what could be expected to be different, unusual or complicating about this patient

NEVER LEAVE YOUR WINGMAN

- We always help others and always expect them to help us.

<u>Tool:</u>

- Peer Checking - Help point out problems and check others when working together
- Peer Coaching - Provide positive reinforcement of safe behaviors and negative reinforcement on unsafe behaviors

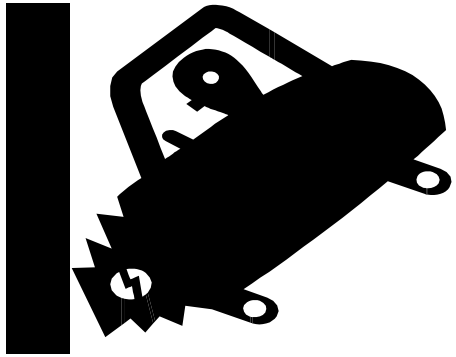


Questions of leaders????

- Do these BBE's make sense?
- Can we begin to educate staff and implement these behaviors?

- Yes, it will take time
- Yes, it will take your commitment
- Yes, it is the right thing to do
- Yes, it will help

Red Rules



What is a Rule?

- Defines how someone should act or behave
- Helps ensure consistent outcomes…if followed
- Examples of rules:
  - Policies & procedures
  - Regulatory requirements
  - Job aids such as checklists or decision trees
  - Clinical guidelines such as order sets or clinical pathways
  - Signs or postings that give direction
  - Alerts or requirements built into information system programs
  - Specific “rules” communicated within your department

What is a “Red Rule”?

RR Signifies

A higher level of *consequence or risk*
if the rule is not followed.

Failure to Comply

With a RR can result in:

- Injury, poor quality or unnecessary expense
- Significant impact on people, our hospital, our company or the community

Characteristics of RR

•*Significant in meaning*. Related to actions that have high consequence or risk if not performed or performed correctly

•*Brief*. Written as a few key words that remind employees of the rule and significance of actions – Something they can remember and holds meaning!

A RR Does NOT…

- Take the place of a policy or procedure

- Imply that RRs have to be followed and other rules do not. We develop ALL rules with the intent that they should be followed

Guidelines for Developing RR

1. Identify action for which non-compliance may result in a critical impact on safety, quality or cost.

2. Define the RE rule – a few key words that trigger an employee to remember the action or behavior.

3. Submit RR document to your administrator for final approval and vetting

4. Educate associates about department RR, why rules are RR's and consequences of non-compliance.

5. Remove or add RRs, as needed.

Consequence of Non-Compliance

*L*eaders are expected to define and communicate department rules AND set expectation for compliance. Use your *Code of Conduct Policy* to manage non-compliance with department rules:

Critical Violation (RR)

"Failure to maintain acceptable standards of work performance creating the potential for or resulting in *significant damage to the organization* and/or harm to patients or others."

Roll Out Plan for *Red Rules*

1. Present to hospital leadership.

2. Develop and finalize hospital wide red rules

3. Roll out Red Rules

. Directors/Managers facilitate department Red Rule Development

. Department Red Rules "challenged" at Executive workgroups.

. ET reviews and approves Red Rules

4. Implement Red Rules

Okay, so now what?

- **Human performance** is critical in transforming SingHealth to the safest place for care in the world
  - Accountability
  - BBEs
  - Red Rules

Disclosures

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