ZERO HARM GUIDE

STARTS WITH YOU

BECAUSE OF YOU

MOUNT CARMEL

A GUIDE FOR CLINICAL
AND NON-CLINICAL STAFF

ZERØHARM
STARTS WITH YOU

About this guide

This guide provides an overview about how becoming a high-reliability organization (HRO) will support our goal to eliminate preventable harm throughout Mount Carmel. You will find information about types of safety events, why all people make errors and why errors occur (especially in healthcare) as well as the STARTS with YOU toolkit—specific behaviors and actions that each of us are responsible for meeting.

Use this guide to:

- Take notes and keep it handy for future reference
- Memorize and begin practicing START
- Talk about why high-reliability is important
- Encourage others around you to use START

Remember these tools are to be used throughout our system in clinical and non-clinical departments.

Additional information and materials are being finalized and will be posted on InSight in the coming weeks. If you have questions or thoughts you would like to share, don't hesitate to reach out to a senior leader or email ZeroHarm@mchs.com.

Table of Contents

BECAUSE OF YOU
MOUNT CARMEL

More than 500 people die each day in the U.S. from preventable medical errors – it's the third leading cause of death in the U.S.

At Trinity Health and Mount Carmel, Safety is a core value. We embrace a culture that prevents harm and nurtures a healing, safe environment for all.

Everyone makes mistakes, but in healthcare mistakes can lead to harm. At Mount Carmel, a patient was seriously harmed or died due to a preventable medical error **every 6 days**.

We have the power to stop errors before they happen – to do better – to save lives. Human error is predictable, and when we understand how mistakes are made, we can prevent errors from happening.

When it comes to preventing harm, there is only one acceptable goal: Zero.

That's what ZeroHarm is all about. ZeroHarm is an outcome of high-reliability, a science-based approach that hardwires reliable behaviors and principles into our culture.

Building a high-reliability organization (HRO) requires us to change how we do things, how we act and interact. It's about putting systems into place to make us exceptionally consistent and reliable. It will happen– just not overnight.

It starts with support, action and unwavering commitment from every single person.

It starts with each of us speaking up and taking ownership for safety. Asking questions when something doesn't seem right, and most importantly, not giving up when our questions aren't answered.

It starts with us talking about safety events throughout the system even when it is difficult. It starts with a no-blame culture and having each other's backs. It starts with finding and celebrating great catches and learning from them to prevent future errors.

It starts with YOU.

On behalf of the entire leadership team, thank you.

ZERØHARM STARTS WITH YOU

GOAL: Eliminate preventable harm throughout our system for patients and colleagues.

Lorraine Lutton
President & CEO

Nicholas Kreatsoulas, DO
Executive VP & Regional Chief Clinical Officer

BECAUSE OF YOU
MOUNT CARMEL

Building a High-Reliability Organization (HRO)

The high-reliability concept is successfully used by other complex, high-risk and high-error organizations from industries such as commercial airline and nuclear power. HROs focus on improving reliability by designing better systems, building a culture of reliability and using "human factors" to create intuitive tools and processes that help people do the right thing.

High-Reliability Organizations (HROs) "operate under very trying conditions all the time and yet manage to have fewer than their fair share of accidents."

— *Managing the Unexpected* (WEICK & SUTCLIFFE)

HROs focus on PREVENTING human errors and DETECTING and CORRECTING safety errors before they occur.

5 Principles of HROs

1. **Preoccupation with Failure**
   Regard small, inconsequential errors as a symptom that something is wrong.
2. **Sensitivity to Operations**
   Pay attention to what's happening on the front line.
3. **Reluctance to Simplify**
   Encourage diversity in experience, perspective and opinion.
4. **Commitment to Resilience**
   Develop capabilities to detect, contain and bounce back from events that do occur.
5. **Deference to Expertise**
   Push decision making down to the person with the most related knowledge and expertise.

   — *Managing the Unexpected* (WEICK & SUTCLIFFE)

This means HROs:

← 1. Don't ignore any failure, no matter how small—they think about how things can fail.

← 2. Focus on the actual situation and rely on their frontline for the best picture of the situation.

← 3. Don't explain away problems—they ask questions and dig deep to find answers.

← 4. Never give up even when it's hard—they adapt and bounce back.

← 5. Recognize that expertise is not based on authority.

While ZeroHarm is leading the way towards becoming an HRO, the work we are doing will improve performance across every layer of organization.

SAFETY[1] + QUALITY[2] + PATIENT EXPERIENCE[3] = THE CARE EXPERIENCE

Mount Carmel's care experience plus our staff's engagement are how we deliver on our promise—to put people at the center of everything we do.

From our patients' perspective, reliability means three things:

1. **Don't harm me**
2. **Heal me**
3. **Be nice to me**

About safety events

Why do safety events happen?

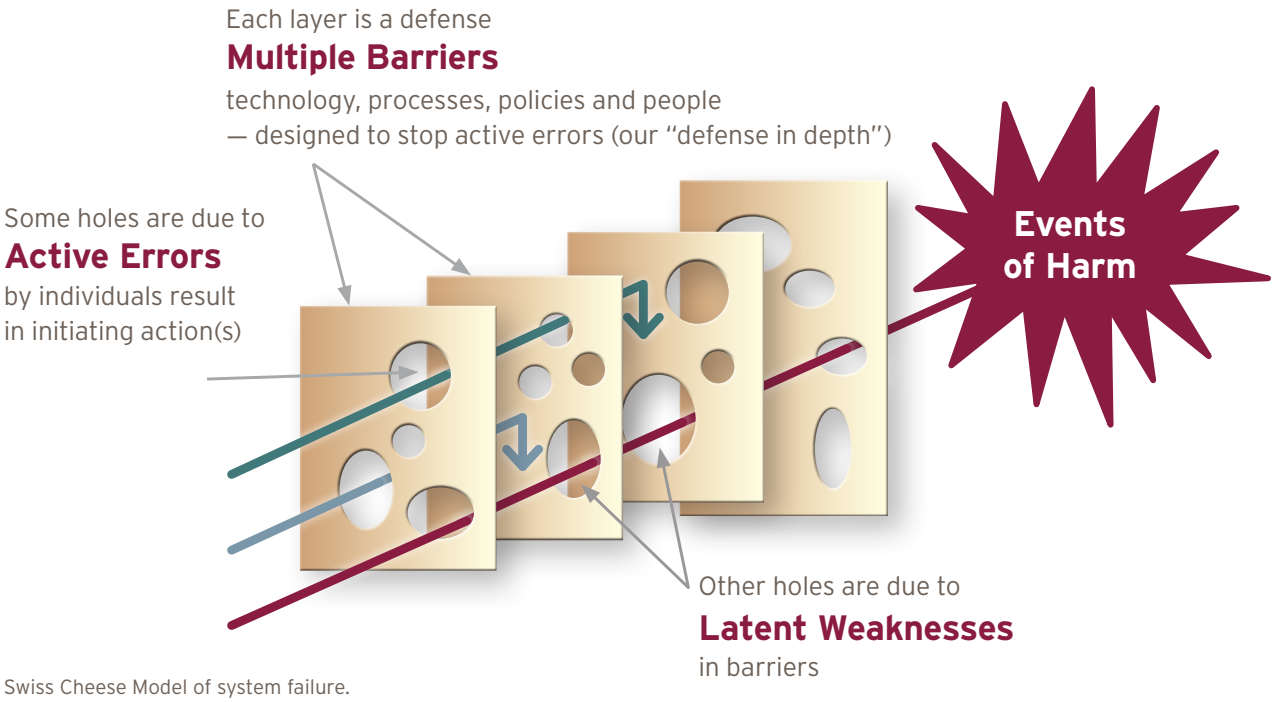
Within our system, there are defensive layers of checks and barriers designed to catch errors and prevent them from resulting in events. The Swiss Cheese Model shows that events of harm are a combination of active errors that trigger the system and latent system weakness (the holes) that allow the error to reach the patient and cause harm.

Safety is the absence of events—zero events of harm. This model shows two basic approaches to achieving zero:

1. **Prevent active errors that trigger events.** ← *Arm our workers with reliable skills and behaviors.*
2. **Find and fix the latent system weaknesses.** ← *Fill the holes.*

This way, if an active error does occur, there will be reliable people, processes, technologies, etc., to catch the error from reaching the patient and causing harm.

Smaller and fewer holes mean that we are more likely to catch/stop errors before they occur.



Swiss Cheese Model of system failure.
Adapted from James Reason, *Managing the Risks of Organizational Accidents* (1997)

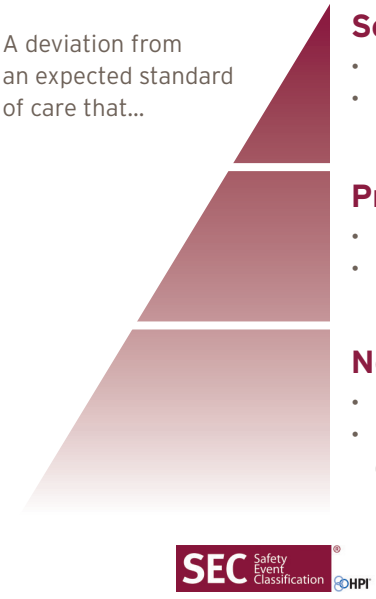
Healthcare systems that use focused efforts can reduce their serious event rate by 80% in two years.

What is a safety event?

There are dozens, maybe hundreds of Precursor Safety Events and hundreds, maybe thousands of Near Miss Events that take place for every Serious Safety Event that occurs in our system.

From a human performance standpoint, the causes of these Events are the same—it's just that on one fateful day, in the case of a Serious Safety Event, the holes of the Swiss Cheese all lined up, resulting in an event of harm to a patient.

Types of Safety Events



Examples of Mount Carmel's Serious Safety Events (SSE)

- A suture needle being left in operative site requiring a patient to undergo a second surgery for removal.
- Patient requiring intubation and admittance to the ICU due to being overly sedated and not well monitored.
- Patient sustaining a subdural hematoma following a fall in the bathroom due to not being assisted by staff.

Report and Celebrate Great Catches

Reporting a near miss (Great Catch) is incredibly important to learning how to prevent future safety events. A culture of safety also means that we celebrate colleagues who speak up or take action to prevent harm.

Have a Great Catch story to share?
Send an email to **ZeroHarm@mchs.com**.

Human Error 101

Human error is predictable and when we understand how mistakes are made, we can act to prevent and reduce the probability of human error.

Humans perform work in three ways	1 **Skill-Based** Auto-pilot	2 **Rule-Based** If I see this, then I do that	3 **Knowledge-Based** Figuring it out
What you're doing at the time	Routine, frequent tasks in a familiar environment that you can do without even thinking about it – like you're on auto-pilot	Responding to situations by recalling and using rules learned either through education or experience	Problem solving in a new, unfamiliar situation by using what you know (parts of different rules); taking a guess; figuring it out by trial-and-error
Errors you experience	• Slip • Lapse • Fumble	• Used the wrong rule • Misapplied rule • Non-compliance	Wrong answer/action (mistake)
Error-prevention strategy	Stop and think before acting	• Educate • Think a second time • Reduce burden, increase awareness, improve coaching	Stop and find an expert who knows the correct answer
Error probability	1 in 1,000 (0.1%)	1 in 100 (1%)	30 - 60 in 100 (30-60%)

Facts about Errors

- Everyone makes errors—even experienced healthcare workers.
- Healthcare is a high-risk, complex environment, which increases the chance you will make an error.
- You can avoid most errors by practicing low-risk behaviors.
- Culture affects how we behave, and our behaviors determine outcomes.
- Most safety errors are due to system or process problems—not due to an individual.

BECAUSE OF YOU MOUNT CARMEL

Starts with YOU Toolkit

WHY? People are at the center of everything we do and that means safety is our first responsibility

GOAL: Eliminate preventable harm throughout our system for patients and colleagues

The **Starts with YOU Toolkit** includes safety behaviors and tools that have been created specifically for Mount Carmel.

Safety Behaviors: Behavior-based expectations that clarify the performance expected to avoid human error.

Error Prevention Tools: Each safety behavior uses one or more error prevention tools. These are specific actions or methods that are proven to prevent human error when consistently practiced by all members of an organization.

ZERO HARM STARTS WITH YOU

TOOLKIT

BEHAVIOR EXPECTATIONS	ERROR PREVENTION TOOLS
I am accountable for...	*I will use...*
S SPEAK UP I'm not afraid to speak up if I have a safety concern.	▶ **Clarifying Questions** ▶ **ARCC It Up** • **A**sk a question • **R**equest a change • Voice a **C**oncern • **C**hain of Command
T TEAMWORK I'm accountable to myself, my team, the Mount Carmel system and our patients.	▶ **Cross Check** ▶ **5:1 Feedback**
A ATTENTION TO DETAIL I take time and pay attention to important details to avoid unintended errors.	▶ **STAR** • **S**top one second • **T**hink about your action • **A**ct out your task • **R**eview your result
R RELIABLE COMMUNICATIONS I'm responsible for professional, clear and complete verbal and written communications to ensure understanding and ownership.	▶ **Standard Handoffs** ▶ **SBAR** • **S**ituation—*What is the bottom line?* • **B**ackground—*What do you know?* • **A**ssessment—*What is happening now?* • **R**ecommendation/**R**equest—*What is next?* ▶ **3-Way Repeat & Read-Backs with Clarifications** • Sender initiates using receiver's name • Receiver acknowledges, "I understand..." • Sender acknowledges, "That's correct" or "That's not correct"
T THINK IT THROUGH I think critically about things seen and heard during our workday.	▶ **Questioning Attitude using Validate & Verify** • Validate concern • Verify any difference ▶ **Stop the Line**

BECAUSE OF YOU MOUNT CARMEL

NOTES

▶ Clarifying Questions

WHAT it is and WHY we use it

Clarifying Questions are used to make sure you really understand what's being communicated. This understanding is called ***situational awareness***.

Complete and clear information provides better understanding so that you don't make choices based on wrong assumptions. Safety is our first and most important responsibility and you should always encourage questions and feel it is okay to speak up and ask questions.

HOW to use it

If you are unsure, or you just want to be sure you understand, speak up and ask 1-2 clarifying questions.

Always ask Clarifying Questions:

- In **all high-risk** situations
- When information is **incomplete**
- When information is **not clear**

SAFETY PHRASE

> *Let me ask a clarifying question.*

TIP Ask questions in a polite and helpful way. People are much more receptive to questions when you start with, "Let me ask a clarifying question."

TIP Clarifying Questions may be asked by a sender of receiver of information. Examples include:
- *What criteria did you use to...?*
- *Did I hear you say...?*
- *Will you help me understand...?*

TIP Ask Clarifying Questions with Repeat-Backs & Read-Backs

PLEASE NOTE

Asking Clarifying Questions can reduce the risk of making an error by 2 1/2 times.

A Safety Culture means having the courage to speak up for safety, even when it is difficult to do.

Remember, what you permit is what you promote.

NOTES

SPEAK UP

I'm not afraid to speak up if I have a safety concern.

ERROR PREVENTION TOOL

ARCC it Up

WHAT it is and WHY we use it

ARCC can help you raise a concern in a respectful, non-threatening way and escalate the concern if it's not addressed. Every healthcare system should have a safe word and at Mount Carmel that word is—concerned. When you hear somebody say they're concerned—you should stop to talk about why this person has a genuine worry about safety.

HOW to use it

*If you see or hear something that you think is a safety concern, speak up using **ARCC**.*

Ask a question

Still no response? **R**equest a change—offer another alternative & explain why

Voice a **C**oncern—*use "I have a concern"*

If no success,

Escalate up **Chain of C**ommand

SAFETY PHRASE

"I have a concern."

TIP Start with the lightest touch. Ask a non-judgmental question.

TIP Respond with "thank you" when someone draws your attention to a potential safety concern.

TIP ARCC is especially helpful if you feel hesitant or uncomfortable raising a concern to someone with high power distance.

Ask a Question: Dr. Jones, aren't we supposed to put on a gown and gloves when entering an isolation room?

Dr. Jones: *I won't touch anything.*

Request a Change: Dr. Jones, please put on a gown and gloves as per isolation precautions.

Dr. Jones: *I don't have time.*

Voice a Concern: Dr. Jones, I am CONCERNED about the safety of our patient and staff — we use barriers to prevent the spread of infections.

Dr. Jones: *Enters the patient's room.*

Escalate Chain of Command: Dr. Jones, I am not comfortable with this; I need to speak with my supervisor.

PLEASE NOTE

Power distance is the degree of people accepting and expecting others to have more power due to a higher rank or status.

NOTES

TEAMWORK

I'm accountable to myself, my team, the Mount Carmel system and our patients.

ERROR PREVENTION TOOL

▶ Cross Check

WHAT it is and WHY we use it

Cross Checking means that we look out for each other in order to catch each other's mistakes, while at the same time building a greater sense of accountability for our own actions. Cross Checking helps you perform at your individual best and supports the team in reaching higher levels of performance.

Cross Checking increases our reliability. Together, our chances of making an error are 1 out of a million.

HOW to use it

Use Cross Checking at all times and make it a daily habit.

- Offer to check the work of others—check a calculation, proofread a memo or assist with a complicated task.
- Point out work conditions or hazards that your team member might not have noticed—a floor that recently was mopped or a trip hazard in the lobby.
  - It can be as simple as, *"Stop, you are about to back into a wet floor sign."*
- Point out unintended slips and lapses—a supply room key left on the counter, an order placed in the wrong chart or practicing good hand hygiene.
  - *"You forgot to wash your hands."*
- Demonstrate a willingness to be checked by saying, *"Thanks for the Cross Check."*

SAFETY PHRASE

> *Thanks for the Cross Check.*

TIP The key to successful checking is not only to be willing to check others—but to be willing to have others check your work.

TIP Take advantage of working as a team and ask others for a Cross Check.

PLEASE NOTE

Cross Checking

I'll look out for you and you look out for me.
This is called being mutually supportive.

NOTES

TEAMWORK

I'm accountable to myself, my team, the Mount Carmel system and our patients.

▶ 5:1 Feedback

WHAT it is and WHY we use it

5:1 Feedback is the optimal ratio of positive to negative feedback—5 positives for every 1 negative.

There are two types of feedback:

Reinforcement	Means	Does NOT Mean	Example
Positive **+**	**Encouraging** or reinforcing so a person is more likely to perform a behavior again.	Nice or pleasant.	*Great job washing your hands and thanks for double-checking the high-risk med with me.*
Negative **–**	**Correcting** or discouraging so a person is less likely to perform the behavior again.	Rude or unkind.	*Don't forget your seatbelt.*

As a team, we have a lot of influence in either promoting good behaviors or discouraging bad behavior within our team. In fact, about 50% of effective feedback should come from our peers.

HOW to use it

We are most helpful to our team when we average 5 Encouraging reinforcements for every 1 Corrective reinforcement.

5 Encourage safe and productive behaviors

- Find opportunities to catch someone in the act of "doing it right" and build it into your everyday routine.

1 Correct unsafe and unproductive behavior

- Try asking, *"May I point out something to you?"* Be sure to explain the correct behavior and why it's important.

TIP Be willing to give feedback and receive feedback.

TIP Base your feedback on what you observed and not what you've heard. Be specific and explain how the behavior either met or did not meet expectations.

TIP Provide timely feedback or as close in time as possible.

Non-verbal feedback

- When encouraging, use a head nod, smile, thank-you or just a thumbs up.
- When correcting, use the lightest touch possible—which means keep it simple—look a little put-off or shake your head.

PLEASE NOTE

5:1 Feedback improves accountability.

Improving accountability is one of the few system changes that reduces all types of human error.

NOTES

ATTENTION TO DETAIL

I take time and pay attention to important details to avoid unintended errors.

ZERO HARM STARTS WITH YOU

ERROR PREVENTION TOOL

STAR

WHAT it is and WHY we use it

STAR is a self-checking tool to help us pay attention and prevent us from making skill-based errors—those unintended errors that occur when we perform familiar, routine acts as if we're on auto-pilot.

In healthcare, we work under time pressure and distractive environments. Sometimes, we are stressed or fatigued. All of these conditions increase our risk of making an error. **STAR reduces unintended errors by more than 10 times.**

HOW to use it

Always use STAR to self-check when doing critical tasks.

Make STAR a daily habit when going from thought to action, identifying a patient, entering data, documenting, connecting a device, selecting meds, etc.

STOP for 1 to 2 seconds to focus your attention on the patient or task.

THINK about your action.

ACT out the task.

REVIEW your 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.

TIP

STAR is especially helpful to use when you are distracted or tired, when you are running behind or feeling pressured to work fast, and especially when you're about to do a high-risk or complex action.

PLEASE NOTE

STAR— a 1–2 second pause is most helpful in skill-based (auto-pilot) mode.

NOTES

RELIABLE COMMUNICATIONS

I'm responsible for professional, clear and complete verbal and written communications to ensure understanding and ownership.

Standard Handoffs

WHAT it is and WHY we use it

A Standard Handoff is designed to provide a clear transfer of responsibility and information for patient care or project by using SBAR.

Handoffs in patient care are a high-risk activity because of the opportunities for critical information to be lost or misunderstood. By using a Standard Handoff, we ensure understanding and ownership using structured and interactive communication in an environment that limits outside interruptions.

HOW to use it

Use Standard Handoffs at shift change, during in-house patient transfers between departments or external transfers. Use SBAR and other START tools to ensure complete reliability.

- Use SBAR
- Handoffs should occur in protected time and space
- Minimize interruptions or distractions
- Include family and patient participation
- Include up-to-date, accurate, relevant information
  - Cover contingency plans and precautions
- Follow a standardized format
  - Agreed-upon specific order or checklist

TIP Use phonetic/ numeric clarifications and ask for 3-way Repeat & Read-backs on critical info

TIP As the sender, prompt for clarifying questions

Did you answer these questions?

- Why is this important?
- What don't you know that could be a problem?
- How could not knowing this potentially cause harm to you or someone else?

PLEASE NOTE

You are the owner until you handoff to another person.

If you accept a handoff for someone else, you are the owner until you hand it off to someone else.

NOTES

SBAR To be used in both clinical and non-clinical situations, verbally, by phone or in writing. Always use an SBAR format **when communicating problems**, to handoff information and to communicate patient condition information.

Today's date:

Completed by:

1. Identify yourself and those involved
2. Use the words (SBAR) when doing a verbal SBAR

S **Situation** The bottom line *(overview, immediate concern)* **Clinical:** Patient name and status.	*The situation is:*
B **Background** What do you know? *(relevant history, important info)* **Clinical:** Explain relevant history, procedures, treatments/clinical course, and pertinent changes. Include resuscitation status and other risk factors.	*The background is:*
A **Assessment** What is happening now? *(your view)* **Clinical:** Describe abnormal assessment findings or trends of concern.	*The assessment is:*
R **Recommendation (or Request)** What is next? *(action or request)* **Clinical:** Explain what needs to be done, identify pending lab results and who needs to be notified.	*The recommendation/request is:*

ZERØHARM STARTS WITH YOU!

BECAUSE YOU CARE MOUNT CARMEL

See page 34 for full-size SBAR form.

RELIABLE COMMUNICATIONS

I'm responsible for professional, clear and complete verbal and written communications to ensure understanding and ownership.

ERROR PREVENTION TOOL

SBAR

WHAT it is and WHY we use it

SBAR structures your communication to help you remember the types of information that should be communicated. It supports reliable communications so that we have complete and accurate information to understand what we are being asked to do.

Because patient safety is our first priority, we should all be communicating using SBAR to ensure a complete and accurate understanding.

HOW to use it

SBAR should be used in both clinical and non-clinical situations, verbally, by phone or in writing, such as in an email. ***Always use an SBAR format when communicating problems****, to handoff information and to communicate patient information.*

1. Identify yourself and those involved
2. Provide SBAR information and specifically state the words if it is a verbal SBAR

Situation: The bottom line *(overview, immediate concern)* **Clinical:** Patient name and status.

Background: What do you know? *(relevant history, important info)* **Clinical:** Explain relevant history, procedures, treatments/clinical course, and pertinent changes. Include resuscitation status and other risk factors.

Assessment: What is happening now? *(your view)* **Clinical:** Describe abnormal assessment findings or trends of concern.

Recommendation (or Request): What is next? *(action or request)* **Clinical:** Explain what needs to be done. Identify pending lab results and who needs to be notified.

TIP When communicating, specifically use the words — **Situation, Background, Assessment, and Recommendation** — so that the listener knows the nature of the information you're giving.

TIP Situational Awareness is a critical thinking skill that gives us the ability to anticipate future problems and notice existing ones.

PLEASE NOTE

SBAR can be used throughout your day.

Always use SBAR when communicating problems and as part of Standard Handoffs.

NOTES

RELIABLE COMMUNICATIONS

I'm responsible for professional, clear and complete verbal and written communications to ensure understanding and ownership.

ERROR PREVENTION TOOL

▶ 3-Way Repeat & Read-Backs with Clarifications

WHAT it is and WHY we use it

3-way Repeat-Backs and Read-Backs support reliable communication. Repeating or reading back information ensures the authenticity of the communication—you heard it the way I said it. The tools are nearly identical and can be used in a wide range of our daily communications.

Repeat-Back—the receiver listens and reads back the information

Read-Back—the receiver writes down the information and reads it back

Complete and clear information provides better understanding so that you don't make choices based on wrong assumptions.

HOW to use it

Use 3-Way Repeat-Back and Read-Back when you communicate routine, but important, specific information

1 ▶ **Sender initiates** communication using receiver's name.
- Sender provides a request/info to receiver in a clear and concise format.

2 ◀ **Receiver acknowledges** with I understand and repeats back the request/info.
- Safety Phrase: ***"I understand..."***

3 ▶ **Sender acknowledges** with that's correct.
- Safety Phrase: ***"That's correct."***
- If not correct, sender repeats the communication.

SAFETY PHRASES

"I understand."

"That's correct."

Sender | Nurse: *Dr. Irons, I'm calling because Mrs. Reardon's blood pressure has dropped to 78 over 50.*

Receiver | Physician: ***I understand.*** *Mrs. Reardon's blood pressure is now 78 over 50.*

Sender | Nurse: ***That's correct.***

TIP Read-Back—make sure you read back what you have just written—not what you heard. This confirms you documented correctly.

TIP When acknowledging, always use the phrase, *"that's correct."* Don't say, *"that's right"* because right goes with left and could cause confusion.

PLEASE NOTE

Read-Back is required by Joint Commission for communication of critical test results, verbal orders and all telephone orders.

With Read-Back: the receiver writes down the information and reads back what is written.

NOTES

RELIABLE COMMUNICATIONS

I'm responsible for professional, clear and complete verbal and written communications to ensure understanding and ownership.

ERROR PREVENTION TOOL

▶ 3-Way Repeat & Read-Backs with Clarifications

WHAT it is and WHY we use it

Use phonetic (letter) clarifications and numeric clarification for sound-alike words and letters.

HOW to use it

Phonetic (letter) Clarifications

Use as needed but always use when communicating important information such as:

- Patient names
- Procedure or test names
- Medication names

- Say the word
- Spell the word by saying the letter and the phonetic clarification for that letter
  - ▶ "Neurology consult to room 405 — ***that's*** neurology with an N as in November"
  - ▶ "I'm calling about Mr. Danes — ***that's*** with a D as in Delta"
  - ▶ "Code Blue in room 330 B — ***that's*** B as in Bravo"

Numeric Clarifications

Use as needed but always use when communicating important information such as:

- Medication doses
- Critical lab values
- Equipment set points
- Patient identification numbers

Letter Clarifications

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

Numeric Clarifications

Say the number . . . Say 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

SAFETY PHRASE

"That's..."

Use "that's" as a separating word to avoid confusion between the information you are communicating and its clarification.

NOTES

Questioning Attitude using Validate & Verify

WHAT it is and WHY we use it

Validate & Verify is a two-step, critical thinking tool that supports a questioning attitude.

Its purpose is to detect information and incorrect assumptions that can lead to bad decisions or actions.

Having a questioning attitude helps ensure you correctly perceive the conditions around you so that you choose the correct response for the situation.

HOW to use it

Use a Questioning Attitude every time you interpret information. Take the time to validate every situation and information you come across—it takes only a few seconds.

Think of it like your internal smoke detector →

1. Validate ← internal check

Always think:
Does it make sense to me?

- Is it right, based on what I know?
- Is this what I expected?
- Does this information "fit in" with my past experience or other information I may have at this time?

When your internal detector goes off →

When should you verify?

1. When it doesn't make sense to you
2. In all high-risk situations
3. When the plan of action changes

2. Verify ← external check

If it doesn't make sense, stop and check it out with an independent, expert source

Qualified, expert sources:

- Policies & procedures
- Clinical protocols & guidelines of care
- Reference manuals
- Experts (supervisors, specialists, pharmacists)
- Chain of command (charge nurses, supervisors, managers)

SAFETY PHRASE

> *Does it make sense to me?*

TIP Practicing with a questioning attitude means ***accepting*** a questioning attitude.

TIP It may feel uncomfortable to ask about something you think you should know...but think about how you will feel if you don't ask and you make a mistake or error that causes harm.

PLEASE NOTE

Questioning Attitude is not about asking questions—
it's about questioning the answers.

NOTES

THINK IT THROUGH

I think critically about things I see and hear during our workday.

▶ Stop the Line

WHAT it is and WHY we use it

Stop the Line means **you have the power to stop all work activities when you feel there is a potential risk of harm (real or perceived)** for a patient or colleague.

At Mount Carmel, safety is the priority—Stop the Line is based on our belief that every person at Mount Carmel is responsible for safety. Stop the Line provides the time to think it through when you find yourself in the "figure it out" or "take a guess" mode.

HOW to use it

You have the power to STOP the Line and get further clarification or assistance if you have a concern about patient or colleague harm.

STOP the Line

- If you are unsure about what you are about to do
- If you have questions
- If someone else raises a concern or question

STOP
Get the correct people involve and be committed to using error prevention tools.

REVIEW your plan

RESOLVE the concern

REASSESS your actions

SAFETY PHRASE

"*Stop the Line.*"

TIP Be firm but respectful until you are certain there is no risk of harm.

You are 10 times more likely to make an error when you proceed with uncertainty.

PLEASE NOTE

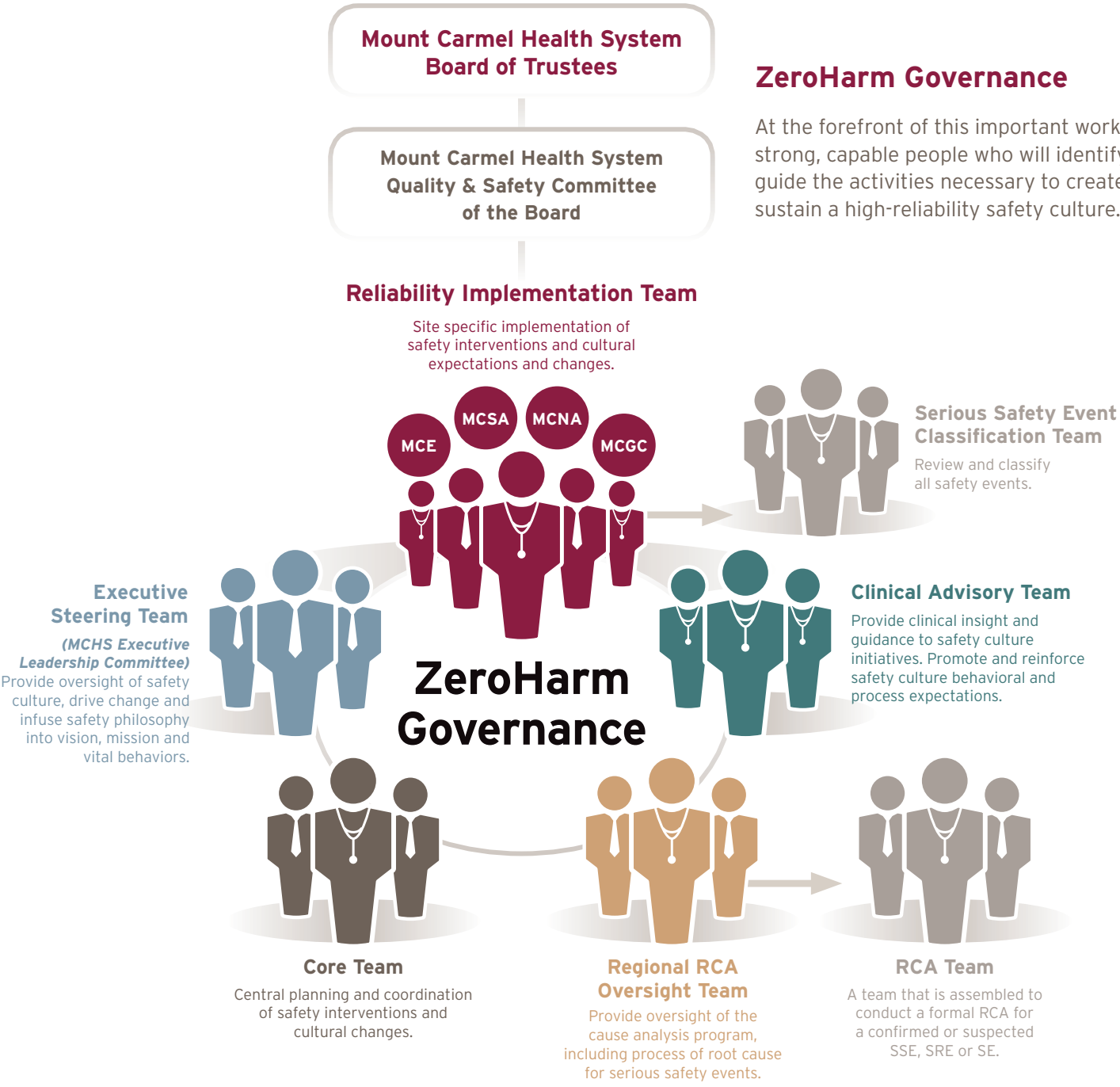
Mount Carmel is committed to thanking (and protecting) those who have the courage to do the right thing.

NOTES

Contacts and Resources

ZeroHarm Governance

At the forefront of this important work are strong, capable people who will identify and guide the activities necessary to create and sustain a high-reliability safety culture.



BECAUSE OF YOU
MOUNT CARMEL

Holly Reardon
Regional VP, Clinical Quality Management
614.546.4784
holly.reardon@mchs.com

Questions or comments?

Send an email to **ZeroHarm@mchs.com.**

SBAR

To be used in both clinical and non-clinical situations, verbally, by phone or in writing. Always use an SBAR format **when communicating problems**, to handoff information and to communicate patient condition information.

Today's date: _____

Completed by: _____

1. Identify yourself and those involved
2. Use the words (SBAR) when doing a verbal SBAR

S **Situation** The bottom line *(overview, immediate concern)* **Clinical:** Patient name and status.	*The situation is:*
B **Background** What do you know? *(relevant history, important info)* **Clinical:** Explain relevant history, procedures, treatments/clinical course, and pertinent changes. Include resuscitation status and other risk factors.	*The background is:*
A **Assessment** What is happening now? *(your view)* **Clinical:** Describe abnormal assessment findings or trends of concern.	*The assessment is:*
R **Recommendation (or Request)** What is next? *(action or request)* **Clinical:** Explain what needs to be done. Identify pending lab results and who needs to be notified.	*The recommendation/request is:*

ZERO HARM STARTS WITH YOU

BECAUSE OF YOU MOUNT CARMEL

BECAUSE OF YOU
MOUNT CARMEL

MOUNT CARMEL
6150 East Broad Street
Columbus, OH 43213

(614) 546-4000
mountcarmelhealth.com

A Member of Trinity Health