Patient Safety & Rights
https://youtu.be/VolJBldOczk
This Happened in a CHI Saint Joseph Health Facility....
#1 Cause of Harm is MISCOMMUNICATION

- Lack of, or unclear/inadequate communication
- Increases:
  - Times of high stress
  - When rushed or time-pressured
  - As the number of individuals/providers (handoff) increases
Patient Safety

- Active pre-procedure Time Outs
  - Verify correct patient,
  - side/site, procedure, documentation
  - (consent) and necessary equipment.
  - Activity stops until all present
  - confirm/agree

- MRI Safety (anyone entering suite)
  - Magnetic/Metal
  - Don’t enter scanner room unless cleared by tech!
Safe Medical Devices Act

• Hospitals are **Federally** required to report incidents where a medical device/ implant has caused or contributed to a patient death, serious illness or injury.

• We voluntarily log and report failures in equipment, instruments, or implants which helps the FDA track patterns as a proactive means of stopping serious injuries **BEFORE** they occur.
When Incidents happen they NEED to be Reported

When to complete an incident report:

- Patient Event
- Team Member Injury
- Faulty Equipment
- Non-Patient Event
- Security Violation
IRIS Report

Incident Reporting Information System (IRIS)

Click the appropriate button below to report a new Incident. Hover over each button for additional help in deciding the appropriate TYPE of incident to report:

- PATIENT
- SECURITY or WORKPLACE VIOLENCE
- VISITOR
- MOTOR VEHICLE
- EMPLOYEE/STAFF work related incidents, injuries or exposures

REMINDER: Please report potential privacy events or concerns to your designated Privacy Officer

Things to know before you get started...
CHI supports anonymous reporting - however, entering your name and department can be beneficial if incident follow-up is necessary.
IRIS will time out after 15 minutes of inactivity - Data entered into an incident report is confidential. After 15 minutes of inactivity, IRIS will time out and all unsaved data will be lost.
For quick Overview or Reporting an Incident in IRIS 2.0 please click here - http://learn.healthstreamvideo.com/media/mo757vrdru

Submitting an incident report will assist CHI and your organization enhance the culture of safety for our patients, residents, staff and visitors. The information you provide will be utilized by a variety of professionals for quality improvement, risk management, performance excellence, peer review and patient/resident satisfaction, with a goal of providing highly reliable quality care. Every incident, regardless of the outcome, is read and investigated. This confidential report and its attachments, which may or may not contain protected health information, is not a public record and shall be used only for purposes provided by law. Do not print, copy or otherwise distribute this report other than as provided for in your facility's policies and procedures.

Practice Reporting - Please use the following link to the IRIS Training environment in order to practice reporting an Incident. Click here for Training Environment

NOTE: Once you enter the Training Environment, via the link above, you will not be able to return to this Reporter. You will need to close out of the training reporter browser and re-enter, via the weblink on your Intranet Home Page.
What is Considered a Reportable Patient Incident?

• Any event not consistent with routine care of the patient, including near misses, or any event that causes or MAY cause patient harm or a reduction in the quality of care that we provide.

• Anything that happens to a patient that you would consider to be a deviation from Generally Accepted Performance Standards. (GAPs)

• Anything that occurs to a patient that makes you question whether or not to report it.
How to Complete a Patient or Security Incident- IRIS

• IRIS= Incident Reporting Information System
  - Accessed through the intranet site, 24/7
  - Can be anonymous
  - Takes 3-7 minutes to complete
  - Top events= Falls, Medication errors, Lab Errors (Mislabeled specimen).

• We want to know:
  - Not a punitive process
  - We all make mistakes
  - Cannot change what happened but MAY be able to keep it from happening to someone else.
  - Every IRIS report reviewed by Risk Management and forwarded to the appropriate leader for F/U.
The organization encourages respect for the personal preferences and values of each individual. We consider patients as partners in their health care. When patients are well informed, participate in treatment decisions and communicate openly with their doctor and other health professionals, they help make their care as effective as possible.

_PolicyStat ID:2683256_
Pain Management Policy

- Patients have the right to receive appropriate assessment and management of pain.
- Pain is managed using an individualized approach considering cultural and personal beliefs and values.
The patient has a right to:

A safe environment free from abuse and harassment
What is Abuse?

**Abuse:**
The infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury.

**Neglect:**
Deprivation of services by a caretaker that are necessary to maintain health or self-neglect.
Abuse of Adults and Children

Kentucky state law provides protection of adults and children who may be suffering from abuse, neglect, or exploitation.

Perpetrator could be family, care providers, agency staff or team members.

If you suspect: Report it immediately
ANY suspected cases of abuse must be reported to your manager or charge person immediately.

Licensed health care professionals may be fined for failure to report.
The patient has a right to:

- Be free from restraints and seclusion of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
Restraints

- Restraints should be used as a last resort!
- Minimal level of restraints should be used!
- Minimal duration!
- Read your policy! Know monitoring procedures!
Concerns?

Patients, team members, or other individuals may communicate concerns about quality of care or safety within CHI Saint Joseph Health to:

- The Kentucky Cabinet for Health and Family Services by contacting the Office of Inspector General at **502-595-4079**
- The Joint Commission on the Accreditation of Healthcare Organizations at **800-944-6610** or email at **complaint@jcaho.org**

*CHI Saint Joseph Health will take NO disciplinary or punitive action against care providers for communicating/reporting concerns*
Safety Behaviors for Safe Care

Safety First Error Prevention Training
Objectives

• Create awareness of behavior-based expectations and human error prevention techniques.

• Develop an understanding of the SafetyFirst Error Prevention Techniques to be practiced
Safety is the Keystone
Our Core Values Require Safety

Cultural Characteristics of CHI’s Core Values

- Reverence
- Integrity
- Compassion
- Excellence

Safety:
- Teamwork and participation, shared wisdom and knowledge
- High ethical standards in all our decisions
- Commitment to quality care that is safe, personalized, comprehensive and collaborative
- Accountability for performance and behaviors
From the Patient’s & Family’s Perspective

1. Keep me safe
2. Heal me
3. Be nice to me

...in this order...

creates and defines an Exceptional Experience
Putting a Face on Error Prevention

Josie King – Died February 22nd, 2001
https://youtu.be/ho6XdEmBv0Q
Culture and Safety

Culture:
the shared values and beliefs of the individuals in the organization

(\textit{the way we act when no one is looking})

\begin{itemize}
  \item Behaviors
  \item Outcomes
\end{itemize}
Shaping Behavior

Blunt End Influencer
- Protocols, procedures, technology,

Sharp End Provider
- Physicians, nurses, technologists, etc.
Human Error is Normal

- Everyone makes errors – even experienced, professional people.
- Healthcare workers work in high-risk situations; high-risk situations increase the chance we will make an error.
- We can avoid most errors by practicing low-risk behaviors.
- Culture affects how we behave, and our behaviors determine outcomes.
- Most near-misses and significant events are due to system or process problems.
- Do you know how many mistakes you made in the past hour?
Do you know how many mistakes you made in the past hour?

- **Everyone makes errors** – even experience professional people.
- We work in **high-risk situations** that increase the chance we will make an error.
- We can avoid most error by practicing **low-risk behaviors**.
- **Culture** affects how we behave, and our behaviors determine outcomes.
- Most near-misses and significant events are due to **system or process problems**.
How do Serious Safety Events occur?

High Risk Situation + High Risk Behavior = Safety Event
How Do Events Happen?

Barriers to failure

Team Member A initiates an action

Patient suffers an unexpected outcome and/or harm.

Team Member B breaches a barrier

Team Member C breaches a barrier

Team Member D breaches a barrier

Team Member E breaches the final barrier
In November 2004, Elevator maintenance employees drained fluid from elevators into containers used for surgical detergent.

Containers not re-labeled/securely stored. Cardinal Health restocked/shipped as detergent back to Durham Regional Hospital and Duke Health Raleigh Hospital.

For two months, hydraulic fluid was used as detergent in one step of a multi-step cleaning and sterilization process of surgical tools.
A deviation from generally accepted performance standards (GAPS) that...

**Serious Safety Event**
- Reaches the patient *and*
- Results in moderate harm to severe harm or death

**Precursor Safety Event**
- Reaches the patient *and*
- Results in minimal harm or no detectable harm

**Near Miss Safety Event**
- Does not reach the patient
- Error is caught by a detection barrier or by chance
Human Error 101
Understanding why we make errors
Modes of Human Performance

- **Skill-Based**
  - “Auto-Pilot”

- **Rule-Based**
  - “If-Then Response”

- **Knowledge-Based**
  - “Figuring It Out”

*Based on Generic Error Modeling Systems developed by G. Rasmussen and J Reason*
Skill-Based Performance

What You’re Doing at the Time: Auto-pilot

Being on auto-pilot means preforming routine, frequent tasks in a familiar environment that you can do without even thinking about it.

<table>
<thead>
<tr>
<th>ERRORS WE EXPERIENCE</th>
<th>ERROR-PREVENTION STRATEGY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Slip</strong> – <em>Without intending to</em>, you do the wrong thing</td>
<td><strong>Stop and think before acting</strong></td>
</tr>
<tr>
<td><strong>Lapse</strong> – <em>Without intending to</em>, you fail to do what we meant to do</td>
<td></td>
</tr>
<tr>
<td><strong>Fumble</strong> – <em>Without intending to</em>, you mishandle or blunder an action or word</td>
<td></td>
</tr>
</tbody>
</table>

1-3 in 1,000 (0.3%) acts performed in error
*(this is a normal human error rate)*
Rule-Based Performance

What You’re Doing at the Time: **Rule-based performance** means responding to situations by recalling and using rules learned either through education or experience; **are aware that you are making a choice**

<table>
<thead>
<tr>
<th>ERRORS WE EXPERIENCE</th>
<th>ERROR-PREVENTION STRATEGY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Used the wrong rule</strong> – You were taught or learned the wrong response for the situation</td>
<td>Educate about the right rule</td>
</tr>
<tr>
<td><strong>Misapplied a rule</strong> – You knew the right response but picked another response instead</td>
<td>Think a <em>second</em> time</td>
</tr>
<tr>
<td><strong>Non-compliance</strong> – Chose not to follow the rule (usually, thinking that not following the rule was the better option at the time)</td>
<td>Reduce burden, increase risk awareness, improve coaching</td>
</tr>
</tbody>
</table>

1 in 100 (1%) of choices made in error
Knowledge-Based Performance

What You’re Doing at the Time:

**Problem solving in a new, unfamiliar situation.** You come up with the answer by:

- Using what you know (parts of different rules)
- Taking a guess
- Figuring it out by trial-and-error

<table>
<thead>
<tr>
<th>ERRORS WE EXPERIENCE</th>
<th>ERROR-PREVENTION STRATEGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Came up with the wrong answer (a mistake)</td>
<td>Stop and find an expert who knows the correct answer</td>
</tr>
</tbody>
</table>

30-60 of 100 decisions – that’s 30% to 60% – made in error!
Practicing Low Risk Behaviors
Expectations and Techniques

**Expectation: Clear & Complete Communications**
I am responsible for professional, accurate, clear and timely verbal, written, and electronic communication.

**Techniques:**
- Include the “5Ps” as part of standardized structured hand-off process when transferring & sharing patient care or other work responsibilities (Patient/Project, Plan, Purpose, Problems, Precautions)
- Use **SBAR** to communicate issues or concerns requiring action (Situation, Background, Assessment, Recommendation)
- Use **Repeat-Backs and Read-Backs** with 1 or 2 Clarifying Questions
- Document legibly and accurately, When in doubt, go to source

**Expectation: Personal, Patient & Team Safety**
I will demonstrate an open, personal and team (200%) commitment to safety.

**Technique: Practice Team Member Checking and Team Member Coaching using ARCC (Ask a question, Request a change, voice a Concern, invoke Chain of Command)**

**Techniques: Practice Safe Patient Handling and Mobility (SPHM) when positioning, ambulating, transferring and assisting patients**

**Expectation: Have A Questioning Attitude**
I will “think it through,” and ensure that my actions are the best.

**Technique: Stop and resolve** when questions arise (Validate & Verify)

**Expectation: Pay Attention To Detail**
I focus on the details at hand to avoid unintended errors.

**Technique: Practice Self-Checking with STAR (Stop, Think, Act, Review)**
How to Communicate Clearly

• **What should we do?**
  
  Communicate complete and accurate information in a timely and appropriate manner

• **Why should we do this?**
  
  • Ensure that we *hear* things correctly
  • Ensure that we *understand* things correctly
  • Prevent wrong assumptions and misunderstandings that could cause us to make wrong decisions

  **SBAR**
  
  **Structured Hand-offs**
  
  Use 3-Way Repeat Backs & Read-Backs
**Situation:** What is the patient’s or project’s situation?

**Background:** What background information should be known?

**Assessment:** What is your assessment of the situation?

**Recommendation:** How do you recommend solving the problem? Your request or plan?

SBAR is not designed as a handoff tool, but a communication tool when a decision is needed.
Effective Communication?

What happened in this scenario?
What was the situation with the patient?
What was the resolution after this communication?
https://youtu.be/wc8jA_sqln0
Effective Communication?

What happened in this scenario?
What was the situation with the patient?
What was the resolution after this communication?
Use “Handoff” Process When Transferring Any Responsibility

- **Safe Handoffs…**
  - Interactive, direct communications between “care providers or team members
  - Standardized process specified by the department/service
  - Occur prior to a change in a care provider or service and
  - May be for an entire shift or portion of a shift
The 5Ps for Patient Handoffs

Responsibility/Shift Change Checklist:
• **P**atient or **P**roject - What is to be handed off
• **P**lan - What is to happen next
• **P**urpose (of the plan) - The desired end state
• **P**roblems - What is different, unusual, or complicated about this patient or project
• **P**recautions - What could be expected to be different, unusual or complicated about this patient or project

*I own it until I hand it off to an appropriate person.*
Repeat-backs

Use when communicating routine but important information:

• Sender communicates an order, request, or information to a receiver
• Receiver repeats back the order, request, or information to the sender
• Sender acknowledges *the accuracy* of the repeat-back. If not correct, repeats/clarifies the communication

“That’s correct.”
Read-backs

- Sender communicates an order, request, or information to a Receiver.
- Receiver writes down the order or result and *reads it back* as written to the sender.
- Sender acknowledges *the accuracy* of the read-back. If not correct, repeats/clarifies the communication.

“That’s correct.”
Getting it Right

- Legible handwriting
- Sufficient, factual detail
- Timely notes

GETTING IT RIGHT THE FIRST TIME AND EVERY TIME

- Never try to “figure it out”
- Go back to the original author, not to another coworker
Read Vitamin E Order

Sotalol 120 mg PO twice daily
Vitamin E 200 IU PO daily
Ambien 5 mg PO HS
What looks like IV is actually IU
Read Versed Order

Yet urs. permit he for
Versed 12.5 mg 25 on
What looks like 12.5 mg is actually 2.5 mg
Read Flomax Order

Flomax 0.4 mg PO QD
What looks like QID is actually QD
Expectations and Techniques

**Expectation: Clear & Complete Communications**
I am responsible for professional, accurate, clear and timely verbal, written, and electronic communication.

**Techniques:**
- Include the “5Ps” as part of standardized structured hand-off process when transferring & sharing patient care or other work responsibilities (Patient/Project, Plan, Purpose, Problems, Precautions)
- Use SBAR to communicate issues or concerns requiring action (Situation, Background, Assessment, Recommendation)
- Use Repeat-Backs and Read-Backs with 1 or 2 Clarifying Questions
- Document legibly and accurately When in doubt, go to source

**Expectation: Personal, Patient & Team Safety**
I will demonstrate an open, personal and team (200%) commitment to safety.

**Technique: Practice Team Member Checking and Team Member Coaching using ARCC** (Ask a question, Request a change, voice a Concern, invoke Chain of Command)

**Techniques: Practice Safe Patient Handling and Mobility (SPHM) when positioning, ambulating, transferring and assisting patients**

**Expectation: Have A Questioning Attitude**
I will “think it through,” and ensure that my actions are the best.

**Technique: Stop and resolve** when questions arise (Validate & Verify)

**Expectation: Pay Attention To Detail**
I focus on the details at hand to avoid unintended errors.

**Technique: Practice Self-Checking with STAR** (Stop, Think, Act, Review)
Team Member Checking

• Something I do to help myself.
• Take advantage of working together – “two heads are better than one”.
• Identify potential problems; seek advice from a team member.
• Check your own work and thinking
• Request a “check”.

Ask a coworker to review your plan
Team Member Coaching

**Encourage** safe and productive behaviors.

**Correct** unsafe and unproductive behaviors.

- Point out the good things!
- Provide feedback based on observations.
- Use the “lightest touch” possible.

*Remember: “What you permit, you promote.”*

Kathleen M. Vollman, Nurse, Scientist, & Educator
Helping a **team member** prevent a safety event. Use the lightest touch possible..

- **Ask** – first ask a question
- **Request** – If they don’t modify their plan - ask for a change
- **Concern** – If they still don’t modify their plan – express your concern about the situation (A safety phrase: "I have a concern...”)

If no success...

- If this doesn't’ t work, follow the **Chain of command** and inform your leader immediately to prevent an event

**Safety Phrase** – “I have a **Concern**...”
**Expectation: Clear & Complete Communications**  
I am responsible for professional, accurate, clear and timely verbal, written, and electronic communication.

**Techniques:**

- **Include the “5Ps”** as part of standardized structured hand-off process when transferring & sharing patient care or other work responsibilities (Patient/Project, Plan, Purpose, Problems, Precautions)

- **Use SBAR** to communicate issues or concerns requiring action (Situation, Background, Assessment, Recommendation)

- **Use Repeat-Backs and Read-Backs** with 1 or 2 Clarifying Questions

- **Document legibly and accurately**  
When in doubt, go to source

**Expectation: Personal, Patient & Team Safety**  
I will demonstrate an open, personal and team (200%) commitment to safety.

**Technique: Practice Team Member Checking and Team Member Coaching using ARCC** (Ask a question, Request a change, voice a Concern, invoke Chain of Command)

**Techniques: Practice Safe Patient Handling and Mobility (SPHM)** when positioning, ambulating, transferring and assisting patients

**Expectation: Have A Questioning Attitude**  
I will think it through, and ensure that my actions are the best.

**Technique: Stop and resolve** when questions arise (Validate & Verify)

**Expectation: Pay Attention To Detail**  
I focus on the details at hand to avoid unintended errors.

**Technique: Practice Self-Checking with STAR**  
(Stop, Think, Act, Review)
A **Questioning Attitude** is not about asking questions – it’s about **questioning the answers** - using our **critical thinking skills** to make sure that our actions are the best ones for the situation.

Helps reduce the chance of decision-making errors in a high risk situation or when we receive information that is different than expected.

If something doesn't seem right, or unsafe conditions are identified, we should **STOP** until we are sure that we can proceed safely.
Ask and encourage clarifying questions

Asking **one or two clarifying questions** reduces the chance of making an error by **2½ times**

Clarifying questions should be **phrased in a positive way** and in a manner that improves understanding
https://youtu.be/hX3z8iXOLVw
### Types of Clarifying Questions

<table>
<thead>
<tr>
<th>Phonetic</th>
<th>Numeric</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Hotel Alpha Papa Papa Yankee Bravo India Romeo Tango Hotel Delta Alpha Yankee”</td>
<td>“15....that’s one - five” “50...that’s five-zero”</td>
<td>“When do you want the lab work performed ....before or after Mrs Jones’ diagnostic study?”</td>
</tr>
</tbody>
</table>
Qualify, Validate and Verify

Qualify (the source):  Do I trust this source?

Validate:  Does it make sense to me?

Verify:  Check it with an independent, expert source
Stop & Resolve

• If you are uncertain about what you are about to do...
• If you have questions...
• If someone raises a concern or question...

**STOP**

• **Review** your plan
• **Resolve** the concern
• **Reassess**

Get the right people involved and be diligent in the use of error prevention techniques

© 2006 Healthcare Performance Improvement, LLC. ALL RIGHTS RESERVED.
Expectations and Techniques

**Expectation: Clear & Complete Communications**
I am responsible for professional, accurate, clear and timely verbal, written, and electronic communication.

**Techniques:**
- Include the “5Ps” as part of standardized structured hand-off process when transferring & sharing patient care or other work responsibilities (Patient/Project, Plan, Purpose, Problems, Precautions)
- Use SBAR to communicate issues or concerns requiring action (Situation, Background, Assessment, Recommendation)
- Use Repeat-Backs and Read-Backs with 1 or 2 Clarifying Questions
- Document legibly and accurately When in doubt, go to source

**Expectation: Personal, Patient & Team Safety**
I will demonstrate an open, personal and team (200%) commitment to safety.

**Technique: Practice Team Member Checking and Team Member Coaching using ARCC (Ask a question, Request a change, voice a Concern, invoke Chain of Command)**

**Techniques: Practice Safe Patient Handling and Mobility (SPHM) when positioning, ambulating, transferring and assisting patients**

**Expectation: Have A Questioning Attitude**
I will “think it through,” and ensure that my actions are the best.

**Technique: Stop and resolve when questions arise (Validate & Verify)**

**Expectation: Pay Attention To Detail**
I focus on the details at hand to avoid unintended errors.

**Technique: Practice Self-Checking with STAR (Stop, Think, Act, Review)**
Take two seconds to...

Stop–Think–Act–Review

• **Stop**
  • Pause to focus attention on task at hand
• **Think**
  • Understand WHAT is to be done
  • Plan your actions
  • Decide what to do if unexpected occurs
• **Act**
  • Carry out planned task
• **Review**
  • Verify you get expected/desired results
The Power of the Pause

Say the color...not the word....

<table>
<thead>
<tr>
<th>YELLOW</th>
<th>GREEN</th>
<th>RED</th>
<th>ORANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLACK</td>
<td>RED</td>
<td>YELLOW</td>
<td>PURPLE</td>
</tr>
<tr>
<td>RED</td>
<td>RED</td>
<td>GREEN</td>
<td>ORANGE</td>
</tr>
<tr>
<td>GREEN</td>
<td>BLUE</td>
<td>BLACK</td>
<td>YELLOW</td>
</tr>
</tbody>
</table>
What can Stop-Think-Act-Review do for you?
Expectations and Techniques

**Expectation: Clear & Complete Communications**
I am responsible for professional, accurate, clear and timely verbal, written, and electronic communication.

**Techniques:**

- Include the “5Ps” as part of standardized structured hand-off process when transferring & sharing patient care or other work responsibilities (Patient/Project, Plan, Purpose, Problems, Precautions)

- Use SBAR to communicate issues or concerns requiring action (Situation, Background, Assessment, Recommendation)

- Use Repeat-Backs and Read-Backs with 1 or 2 Clarifying Questions

- Document legibly and accurately
  When in doubt, go to source

**Expectation: Personal, Patient & Team Safety**
I will demonstrate an open, personal and team (200%) commitment to safety.

**Technique:** Practice Team Member Checking and Team Member Coaching using ARCC (Ask a question, Request a change, voice a Concern, invoke Chain of Command)

**Techniques:** Practice Safe Patient Handling and Mobility (SPHM) when positioning, ambulating, transferring and assisting patients

**Expectation: Have A Questioning Attitude**
I will “think it through,” and ensure that my actions are the best.

**Technique:** Stop and resolve when questions arise (Validate & Verify)

**Expectation: Pay Attention To Detail**
I focus on the details at hand to avoid unintended errors.

**Technique:** Practice Self-Checking with STAR (Stop, Think, Act, Review)
Safe Patient Handling and Mobility (SPHM)

Safe Patient Handling includes:

- Moving and positioning the body and limbs of partially dependent, dependent and non-weight bearing care recipients
- Preserving care recipients’ joint flexibility and mobility function by moving care recipients’ limbs through their full range of motion during care, treatments and services
- Safely assisting care recipients with mobility during personal-care activities, repositioning, sitting, standing, transferring and ambulating using the appropriate assistive tools or devices and observing a safe weight lifting limit
- Ambulating, transporting, positioning and caring for care recipients throughout the facility during care treatment and services using the appropriate assistive tools or devices and observing a safe weight lifting limit
Practice SPHM

- Speak-up and elevate a concern through the Chain of Command when unsafe conditions are identified
- Stop when faced with uncertainty
- Practice SPHM when positioning, ambulating, transferring and assisting patients
- Be able to identify the appropriate transfer devices / sling selections
- Confirm SPHM equipment is available, clean and functional
- Integrate SPHM information into handoffs
- Educate and engage patients and families regarding SPHM practices
- Maintain competency for SPHM practices
  - Equipment maximum weight
  - Cleaning and disinfection process
  - Number of staff required to operate the equipment safely
  - Space available to use the equipment
Expectations and Techniques

**Expectation: Clear & Complete Communications**
I am responsible for professional, accurate, clear and timely verbal, written, and electronic communication.

**Techniques:**
- Include the “5Ps” as part of standardized structured hand-off process when transferring & sharing patient care or other work responsibilities (Patient/Project, Plan, Purpose, Problems, Precautions)
- Use SBAR to communicate issues or concerns requiring action (Situation, Background, Assessment, Recommendation)
- Use Repeat-Backs and Read-Backs with 1 or 2 Clarifying Questions
- Document legibly and accurately
  When in doubt, go to source

**Expectation: Personal, Patient & Team Safety**
I will demonstrate an open, personal and team (200%) commitment to safety.

**Technique: Practice Team Member Checking and Team Member Coaching using ARCC** (Ask a question, Request a change, voice a Concern, invoke Chain of Command)

**Techniques: Practice Safe Patient Handling and Mobility (SPHM)** when positioning, ambulating, transferring and assisting patients

**Expectation: Have A Questioning Attitude**
I will “think it through,” and ensure that my actions are the best.

**Technique: Stop and resolve** when questions arise (Validate & Verify)

**Expectation: Pay Attention To Detail**
I focus on the details at hand to avoid unintended errors.

**Technique: Practice Self-Checking with STAR** (Stop, Think, Act, Review)
• We will **commit** to practice the error prevention techniques we have just learned and try to incorporate them into our daily work habit

• We will **stop** and contact our supervisor for help when something doesn't seem right

• We will **help** our coworkers practice using these low-risk safety behaviors

• We will try to coach our coworkers and provide **immediate feedback** before they make a mistake

• We will say “**thank you**” to someone when they coach us

*Error Prevention & High Reliability start with you....*