Eliminating Preventable Harm Through Building a Reliable Culture of Safety
Denise Murphy, Main Line Health
A Webber Training Teleclass

Eliminating preventable harm through building a reliable culture of safety
Denise Murphy, RN, BSN, MPH, CIC, FAAN
Vice President, Quality & Patient Safety

www.webbertraining.com February 13, 2014

Objectives

• Discuss importance of establishing a culture of safety
• Define a reliable culture of safety and three strategies for organizing cultural transformation
• Identify at least three leader methods for enhancing and sustaining reliability
• List five error prevention tools used by healthcare teams to eliminate human errors that lead to harm
• Review innovative strategies for engaging physicians in the work of building and sustaining a reliable safety culture
• Discuss the results of establishing a reliable culture of safety
• Identify barriers to sustaining cultural transformation

Safety is our Main Line

What do patients expect from us?

• Don’t hurt me (patient safety)
• Help me (quality patient care)
• Be nice to me (patient satisfaction)

Safety is our Main Line

What do employees expect from us?

- Leaders create a safe, high quality work environment (culture of safety + good process design + behavioral accountability = reliability)
- Support when things go wrong (“just culture” - where human error is not punished, system errors are found and fixed, and unsafe behaviors result in appropriate action)

What is Organizational Culture?

• Culture is that set of beliefs, values and principles that shape the way individuals and groups within an organization act. It’s the often unspoken “way we do things around here.”
• Culture can be best felt by new individuals in an organization when they “push against” the existing norms.
• And although the culture is generally set by leaders, it involves every one…and takes a long time to change.
• A culture of safety is embedded when we know that people are doing the safest thing when no one is watching!

What is Reliability Science?

• The knowledge and understanding of human error and human performance in complex systems.
• Building reliability into systems intentionally to make it easier for humans to do the right thing and harder for them to make mistakes.
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Event of Harm = High Risk Situation × High Risk Behavior

Reliability Synergy

Behavior Accountability
Knowledge & Skills
Reinforce & Build Accountability
Integrated With
Optimized Outcomes

Process Design
Evidence-Based Best Practices
Technology Enablers
Intuitive Work Environment
Resource Allocation
Continuous Quality Improvement

Complementary Strategies

Central Line Infections
Hand Hygiene
Surgical Site Infections
Codes Outside the ICU
...and on, and on, and on...

Three Strategies to Transform Culture

Set Expectations
Educate & Build Skill
Reinforce & Build Accountability

All three...in this order!

MLHS Diagnostic Assessment

Case analysis documentation from 73 patient safety events occurring January 2008 thru October 2009

Interviews with ~ 563 staff, physicians, and leaders
- Bryn Mawr ~ 145
- Bryn Mawr Rehab ~ 75
- Lankenau ~ 135
- Paoli ~ 82
- Riddle ~ 115
- System Execs ~ 10

Review of documents and outcomes. Tour of facilities.

Review of data from the 2009 AHRQ Safety Culture and Gallup Employee Engagement Surveys

Building a RELIABLE Culture of Safety:
The Journey at MLH and Making the Case for Change

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Skill-Based Errors
Errors made when performing acts or tasks that require limited or no thought attention.

Rule-Based Errors
Errors made when performing acts or tasks that require application of rules - accumulated through experience and training - to familiar situations.

Knowledge-Based Errors
Errors made when performing acts related to new or unfamiliar situations that requires problem solving and for which a rule does not exist or is not known.

Skill-Based Errors 21%
Rule-Based Errors 69%
Knowledge-Based Errors 21%

PRIVILEDGED & CONFIDENTIAL CLIENT INFORMATION protected from discovery as pursuant to state statutes of the client organization

AHRQ Safety Culture Surveys
Main Line Health 2010 and 2012, National, and Regional % Positive

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Main Line Health, 2010</th>
<th>Main Line Health, 2012</th>
<th>National Average</th>
<th>Regional Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication openness</td>
<td>80%</td>
<td>80%</td>
<td>59%</td>
<td>61%</td>
</tr>
<tr>
<td>Feedback and communication</td>
<td>63%</td>
<td>60%</td>
<td>62%</td>
<td>61%</td>
</tr>
<tr>
<td>Frequency of events reported</td>
<td>62%</td>
<td>60%</td>
<td>60%</td>
<td>61%</td>
</tr>
<tr>
<td>Handoffs and transitions</td>
<td>45%</td>
<td>40%</td>
<td>40%</td>
<td>41%</td>
</tr>
<tr>
<td>Management support for patient safety</td>
<td>72%</td>
<td>72%</td>
<td>59%</td>
<td>72%</td>
</tr>
<tr>
<td>Non-punitive response to error</td>
<td>38%</td>
<td>36%</td>
<td>39%</td>
<td>44%</td>
</tr>
<tr>
<td>Organizational learning</td>
<td>72%</td>
<td>71%</td>
<td>71%</td>
<td>69%</td>
</tr>
<tr>
<td>Overall perception of patient safety</td>
<td>62%</td>
<td>62%</td>
<td>61%</td>
<td>63%</td>
</tr>
<tr>
<td>Staffing (adequacy)</td>
<td>55%</td>
<td>54%</td>
<td>53%</td>
<td>54%</td>
</tr>
<tr>
<td>Supervisor expectations &amp; actions</td>
<td>72%</td>
<td>72%</td>
<td>72%</td>
<td>72%</td>
</tr>
<tr>
<td>Teamwork across units</td>
<td>59%</td>
<td>59%</td>
<td>59%</td>
<td>53%</td>
</tr>
<tr>
<td>Mean Composite Score</td>
<td>82%</td>
<td>80%</td>
<td>78%</td>
<td>72%</td>
</tr>
</tbody>
</table>

Main Line Health 2010 and 2012: 90% 80%
National Average: 59% 61%
Regional Average: 61% 69%

MLHS Crucial Conversation Surveys

Willing to Speak up when someone at MLHS:

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breaks Rules, takes dangerous shortcuts</td>
<td>48%</td>
<td>59%</td>
</tr>
<tr>
<td>Shows Poor Initiative</td>
<td>39%</td>
<td>38%</td>
</tr>
<tr>
<td>Demonstrates incompetence</td>
<td>37%</td>
<td>52%</td>
</tr>
<tr>
<td>Demonstrates Poor Teamwork</td>
<td>34%</td>
<td>35%</td>
</tr>
<tr>
<td>Acts Disrespectful</td>
<td>29%</td>
<td>44%</td>
</tr>
</tbody>
</table>

- Makes a mistake 25% 38%
- Micromanages / Abuses Authority 16% 20%

Cultural Assessment Conclusions

- Strong commitment on the part of leaders, staff, and medical staff leaders to improve patient safety.
- Culture accounts for >70% of system causes that led to patient harm or death. Specifically,
  - lack of critical thinking
  - and compliance with documented safe practices.
- A foundation exists for evidence-based MLHS leadership behaviors consistent with high-reliability organizations.
- Power Distance (Authority Gradient) exists in most practice areas - surely a problem in some.

Cultural Assessment Conclusions

- Medical staff must support and actively participate in the safety culture change.
- Implementation plan should include high-leverage leadership expectations and tools.
- Safety behaviors for preventing error should focus on:
  - Questioning attitude and critical thinking through effective handoffs
  - clear team communication
  - Intelligent compliance to behavioral expectations and rules that protect patients
  - Peer checking and peer coaching
  - Self-checking before routine acts
  - Communication in an authority gradient - empower staff.

Source: Main Line Health, Syosset, January 2011

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Making the Case for Change...Personalize Harm

<table>
<thead>
<tr>
<th>Year</th>
<th>SSE Categories 1-4</th>
<th>SSE Categories 5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>188</td>
<td>33</td>
<td>221</td>
</tr>
<tr>
<td>2012</td>
<td>185</td>
<td>33</td>
<td>218</td>
</tr>
</tbody>
</table>

This is a SAMPLE REPORT....names and dates are fictional and not related to real events

Organizing for Culture Change: Strategies, Tools and Infrastructure

Safety is our Main Line

*2013 Goal: Reduce preventable harm serious safety events by 50%: ACHIEVED – 81% reduction!

2016 Goal – another 50% reduction (until we reach zero events of harm)

Leadership – An Evolution in Perspective

From... To...
- Externally driven safety focus (e.g. Joint Commission, CMS)
- Safety is a priority
- We are creating a safety culture
- The board and senior leader support culture change
- Medical staff support culture change
- Internally driven safety focus (first, do no harm – it's the right thing to do)
- Safety is a core value that cannot be compromised
- We are shaping a reliability culture that creates safety first (then quality, satisfaction and financial health)
- The board and senior leader own and manage the culture
- Medical staff own and promote safety culture

Power Distance & Authority Gradient

Power Distance is the extent to which the less powerful expect and accept that power is distributed unequally.

Power Distance is a measure of interpersonal power or influence superior-to-subordinate as perceived by the subordinate.

High Reliability Actions
1. Use organizational culture to reduce PD of professional & national cultures.
2. Use organizational culture to flatten the authority gradient.

Source: In High-Reliability Organizations: Attribute of "Deference to Expertise" (Weick & Sutcliffe)
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Safety Culture Transformation - Infrastructure and Alignment

Senior Leadership Team
- Develop safety culture vision, strategy, and goals.
- Establish alignment and accountability.

Physician Leadership Team
- Develop safety culture vision, strategy, and goals.
- Establish alignment and accountability.

Safety Culture Leadership Teams
- Establish and support actions to improve safety culture

Safety Coach Team
- All Sites

Curriculum Development and Training

- Design sessions (2) with hundreds of employees and medical staff to review, vet, select error prevention tools and leader methods for reliability
- Developed and revised curriculum with HPI
- Selected and trained about 150 trainers
- Spent 12 months training all senior and medical staff leaders, board, directors and managers, then staff and physicians

Facts About Human Errors

1. Everyone makes errors – even experienced, professional people
2. We work in high-risk situations that increase the chance we will make an error
3. We can avoid most errors by practicing low-risk behaviors
4. Culture affects how we behave, and our behaviors determine outcomes
5. Most near-misses and significant events are due to system or process problems

Source: Adapted from: www.hanfordtraining.com/learning/2015/04/07/human-error-consequences-and-patterns/

Three Ways Humans Perform

Knowledge Based Performance
(Figuring-It-Out Mode)

Rule Based Performance
(If-Then-Response Mode)

Skill Based Performance
(Auto Pilot Mode)

The Main Line Health Reliability Culture Toolkit for Leaders

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Make Safety a Core Value</td>
<td>1. Start every meeting with a safety topic or story</td>
</tr>
<tr>
<td>2. Recognize &amp; support people who ask the safety question or “stop the line for safety”</td>
<td></td>
</tr>
<tr>
<td>3. Transparency in sharing safety events</td>
<td></td>
</tr>
<tr>
<td>4. Ended safety in hiring and performance reviews</td>
<td></td>
</tr>
<tr>
<td>5. Encourage and reward reporting of safety events – eliminate fear of reporting</td>
<td></td>
</tr>
</tbody>
</table>

| II. Find & Fix System Problems | 1. Daily Check-in |
| 2. Start the Clock for Safety |
| 3. Brief / Executives / Delivery |
| 4. Encourage and reward reporting of safety events – eliminate fear of reporting |

| III. Build and Sustain Accountability | 1. 5S feedback |
| 2. Rounding To Influence |
| 3. Just Culture |
| 4. Red Rules |

Source: Excellence in Human Performance, The Institute of Nuclear Power Operations, 1997
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Leadership for Performance Reliability

1. Define and demonstrate safety as a core value.

2. Find problems and fix causes in systems and processes
   A. Daily Check-In
   B. Start the Clock Safety Issues
   C. Brief/Execute/Debrief

3. Reinforce and build accountability for behavior expectations at the sharp end

The Daily Safety Huddle, Typical Agenda

- Number of days since last Preventable Harm Serious Safety Event (includes any new healthcare associated infections or falls w harm)
- Follow-up reports on previous days action items
- Updates from previous day and night activities — identify any actionable items requiring immediate (start the clock) intervention
- Anything going on today that would impact our patients’ safety? Anything we predict could happen in next 24 hours to impact our patients’ safety?
- Share great catches and great experience stories.
- Any employee/physician safety concerns that need to be discussed

Start the Clock for Safety

- Start the Clock sense of urgency — a “ticking time bomb”
- Mobilize those with the expertise to solve the problem and authority to empower action
- Actions:
  - Assign Responsibility
  - Set time frame for resolution
  - Schedule follow up report with senior leader and at next day’s Safety Huddle

Cause Exposure Time

Window of potential for harm

The Main Line Health Error Prevention Toolkit

<table>
<thead>
<tr>
<th>I commit to the following...</th>
<th>By practicing the following...</th>
<th>Error Prevention Toolkit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Behavior Expectations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Error Prevention Tool</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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</table>

Stop
Pause for 1 to 2 seconds to focus attention on the task at hand

Think
Visualize the act and think about what is to be done

Act
Concentrate and perform the task

Review
Check for the desired result

Self Checking
The most effective way to avoid slips and lapses. It takes only seconds to do and reduces the probability of making an error by a factor of 10 or MORE!

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Clear Communication
3 – Way Repeat Backs

When information is transformed... Use 3-Way Communication!

Sender initiates communication using Receivers Name. Sender provides an order, request, or information to Receiver in a clear and concise format.

Receiver acknowledges receipt by a repeat-back of the order, request, or information.

Sender acknowledges the accuracy of the repeat-back by saying, That's correct! If not correct, Sender repeats the communication.

Train our ears to listen for "That's Correct!" — it’s a codeword for "we understand each other".

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

Error Prevention Tools:
* 3-Way Repeat Backs & Read Backs
* Clarifying Questions
* Phonetic & Numeric Clarifications

What should we do?
Ensure that we hear things correctly and understand things accurately

Why should we do this?
To prevent wrong assumptions and misunderstandings that could cause us to make wrong decisions

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

3-way Communication
Sender initiates communication using Receivers Name. Sender provides an order, request, or information to Receiver in a clear and concise format.

Receiver acknowledges receipt by a repeat-back of the order, request, or information.

Sender acknowledges the accuracy of the repeat-back by saying, That's correct! If not correct, Sender repeats the communication.

Clear Communication
Ask Clarifying Questions

Ask one to two clarifying questions:
• In all high risk situations
• When information is incomplete
• When Information is not clear

Why
To make sure that you really understand what’s being communicated so that you don’t make a decision based on a wrong assumption.

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

Safety Culture 101 created by a physician leader/believer
Focused on Physicians as leaders in culture change
Promoted conversation and role playing where they could be "non-physicians" and evaluate common scenarios

Safety Culture 102 is about embedding tools AND reducing the power gradient. It expands individuals’ commitment ... and provides safety CMEs!

One of the most effective tools in changing culture
Projects staff feel empowered, often works if used respectfully without going beyond the "Ask or Request" steps
Specifically used to reduce the "power gradient" and to promote peer checking or peer coaching. Fear of using these tools remain the two biggest barriers to full culture change.

Good tool to use for lack of compliance with isolation precautions or hand hygiene. Remember, you usually don’t have to go beyond the "ask/request".

"Stop the Line" is a good tool for use with clinicians not following all of the steps for line insertion. Must be done calmly and respectfully: "Please stop the line, I need clarity."

If imminent danger to a patient or staff exists, use the MLH Safety Phrase: "I need clarity."

Using ARCC to Escalate Safety Concerns

Use the lightest touch possible...

Ask a question
Make a Request
Voice a Concern

If no success...

Use Chain of Command

Engaging Physicians – Innovative strategies

• Safety Culture 101 created by a physician leader/believer
• Focused on Physicians as leaders in culture change
• Focused on "what was in it for them"
• Promoted conversation and role playing where they could be "non-physicians" and evaluate common scenarios
• Safety Culture 102 is about embedding tools AND reducing the power gradient. It expands individuals’ commitment ... and provides safety CMEs!
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Embedding a RELIABLE Culture of Safety:
Making It Stick!

Primary Embedding Mechanisms
- What leaders pay attention to, measure, and control routinely
- How leaders react to critical incidents and organizational crises
- Observed criteria by which leaders allocate scarce resources
- Deliberate role modeling, teaching, and coaching
- Observed criteria by which leaders allocate rewards and status
- Observed criteria by which leaders recruit, select, promote, retire, and excommunicate organizational members

Secondary Articulation & Reinforcement Mechanisms
- Organizational design and structure
- Organizational systems and procedures
- Organizational rites and rituals
- Design of physical space, facades, and buildings
- Stories, legends, and myths about people and events
- Formal statements of organizational philosophy, values, and creed

Peer Coach, Role Model, Leadership Liaison
Safety Coach Duties
- Training & education:
  - Monthly meetings - 1 hour per month
  - Plan monthly targets, program focus, & coaching methods
  - Receive ongoing education and coaching materials – becoming the expert
- Duties include:
  - Monthly tracking of behavior observation and interview
  - Environment of care monitoring
  - Facilitate habit formation
  - Feedback & reinforcement
  - Collect concerns from staff
  - Collect Safety Success Stories

Bridges gap across the “power gradient”

Physician Safety Champions
DUTIES:
- Study, design and implement improvements to processes already identified as challenges
- Model patient safety behaviors and coach colleagues
- Report observed adverse events, near misses and good catches
- Select and develop new patient safety leaders

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Patient Safety Success Story

Thanks to Deb, RN
Lankenau Medical Center

P: What potential harm was avoided? CLASS:
S: What was the situation? A resident in the ICU was about to begin a central line insertion without assistance. The Unit Secretary was bedside, and saw the resident struggling with the full drape, becoming frustrated and throwing the drape to the floor. Since the drape is the line insertion are critical, the secretaries knew that the full drape was a critical infection prevention step.

She asked the question, “Dr. Jones, can I get a nurse in here to assist you?” When no response, the Secretary requested, “Dr. Jones, man you please hold on just 30 seconds while I clear my hands and pop my head next door to get a Nancy [RN] that you need help?” Dr. Jones stopped, agreed to wait for assistance and use a new drape to fully comply with the CLASS bundle steps.

S: What safety behavior did the employee use to intervene? How?
The Unit Secretary used ARCC to get Dr. Jones attention. She then asked a question, then escalated to make a request (please stop while I find assistance). She helped Dr. Jones do the next best thing related to safety.

SI: Was the story shared with others?
Yes, it was shared with Lankenau’s Safety Committee, Leadership Assembly and was selected the Great Catch for September.

We’re using our Safety Behavior Tools to Prevent Harm to patients!

Safety Behavior Success Stories

Speak Up For Safety 808
Attention To Detail 773
Got Your Back 304
Communicate Clearly 237
Handoff Effectively 73

Main Line Health Red Rule

Patient Identification

Verify & Match? patient identification using name and date of birth (or MR #) before any patient encounter where patient identification is a safety imperative for the procedure or task to be completed.

1. Verify by having patient verbalize their name and date of birth
   OR visualize it on their wristband.

2. Match patient to a source document (for example – order, prescription)

Results and Summary

MLH Preventable Harm Serious Safety Events

January 2011 – December 2013
Includes events at all MLH Hospitals and MLHC Practices

Safety Culture Effectiveness = Plan Effectiveness x Implementation Effectiveness

Task Implementation

For Building & Sustaining Safety Culture Change

MLH Safety Culture Roadmap

Mission, Vision, & Values

Leadership Method for Performance Excellence

Systemic Change Strategies

SSE 1: Death
SSE 2: Critical, life-changing harm with no expected change in clinical status including permanent loss of organ, limb, or function
SSE 3: Significant harm with no expected change in condition yet not sufficiently severe to impact activities of daily living (ADL) or business function. Includes permanent reduction in physiologic reserve, disfigurement, or impaired or aided sense or function
SSE 4: Critical, life-threatening harm yet lasting for a limited time and no permanent residual; requires prolonged transfer to a higher level of care or monitoring, transfer to a higher level of care for a life-threatening condition, or additional surgery/procedure/treatment

*Includes events at all MLH Hospitals and MLHC Practices

Safety Culture Roadmap

Task Implementation

For Building & Sustaining Safety Culture Change

HPI: Hospital Patient Initiative

Safety Culture Effectiveness = Plan Effectiveness x Implementation Effectiveness

Results and Summary

MLH Preventable Harm Serious Safety Events

January 2011 – December 2013
Includes events at all MLH Hospitals and MLHC Practices
Eliminating Preventable Harm Through Building a Reliable Culture of Safety
Denise Murphy, Main Line Health
A Webber Training Teleclass
Hosted by Paul Webber   paul@webbertraining.com
www.webbertraining.com

Challenges in Sustaining Cultural Improvement

- Safety Culture: we’ve made safety our core value, reducing patient harm significantly. How do we sustain this culture?
- How do we improve staff perceptions that an accountable and a “just” culture align?
- We must recognize complacency and “drift” from culture of safety - respond to underlying causes...
  - poorly designed processes and systems
  - reluctance to adopt simple but proven safety behaviors (e.g., STAR... takes seconds but can reduce risk for error)
  - compliance, but inhibited by power gradient
  - distraction due to competing priorities; manager, staff and physician burnout
  - Leader practices don’t change – leaders don’t lead for high reliability
  - Medical staff “support” safety rather than “own” safety

Summary – A Just and Reliable Culture of Safety

- Creation of a culture of safety must be intentional: safety is the core value... it trumps everything else.
- Reliability results from the intersection of good process design and behavioral accountability.
- Leaders lead for reliability... using tools that make a just culture of safety visible to everyone, every day.
- In a just culture, mistakes are not punished. At the same time, leaders hold everyone accountable for safety and everyone accepts accountability for safety (reciprocal accountability).
- Staff also commit to speaking up for safety, even in the presence of a power distance/authority gradient, when they see unsafe practices.

“The world is not a dangerous place because of those who do harm, but because of those who look on and do nothing.”

» Albert Einstein

“error Causation:

1. Error Causation: Descriptions for Individual v. System Failures

<table>
<thead>
<tr>
<th>Common Cause</th>
<th>Individual Failures (individual at fault)</th>
<th>Most Likely caused by (system at fault)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Thinking</td>
<td>Tendency to focus on details of task</td>
<td>Skill weakness in judgment/failure</td>
</tr>
<tr>
<td></td>
<td>rather than big picture</td>
<td>decision-making</td>
</tr>
<tr>
<td></td>
<td>Lack of awareness of situation &amp; that it</td>
<td>Lack of guidance/ tools to support</td>
</tr>
<tr>
<td></td>
<td>could deviate from desired path</td>
<td>standard action or collaborative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>decision-making</td>
</tr>
<tr>
<td>Compliance</td>
<td>Cultural weakness in reinforcing</td>
<td>Cultural weakness in reinforcing</td>
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<tr>
<td></td>
<td>expectations of safety &amp; team</td>
<td>expectations of safety &amp; team</td>
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<tr>
<td></td>
<td>accountability for performance</td>
<td>accountability for performance</td>
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<tr>
<td></td>
<td></td>
<td>(reciprocal accountability)</td>
</tr>
<tr>
<td>Knowledge &amp; Skill</td>
<td>Lacking sufficient experience in specific</td>
<td>Cultural weakness in reinforcing</td>
</tr>
<tr>
<td></td>
<td>tasks to assure performance reliability</td>
<td>expectations of safety &amp; team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>accountability for performance</td>
</tr>
<tr>
<td>Attention to Detail</td>
<td>Premature, weekly, format, and</td>
<td>Cultural weakness in reinforcing</td>
</tr>
<tr>
<td></td>
<td>changes in procedure leading to skill</td>
<td>expectations of safety &amp; team</td>
</tr>
<tr>
<td></td>
<td>based errors</td>
<td>accountability for performance</td>
</tr>
<tr>
<td>Normalized Deviance</td>
<td>Behavioral deficiency, different from</td>
<td>Cultural weakness in reinforcing</td>
</tr>
<tr>
<td></td>
<td>primarily involved activities, as a</td>
<td>expectations of safety &amp; team</td>
</tr>
<tr>
<td></td>
<td>variety of actions</td>
<td>accountability for performance</td>
</tr>
<tr>
<td>Communication</td>
<td>Ineffective use of clear communication</td>
<td>Cultural weakness in reinforcing</td>
</tr>
<tr>
<td></td>
<td>tools to avoid miscommunication errors</td>
<td>communication tools with wrong</td>
</tr>
</tbody>
</table>

QUESTIONS?
murphyd@mlhs.org

See videos at http://webbertraining.com/denise-murphy-videos.php


February 27  RAPID BACTERIAL DIAGNOSTICS – IMPACT ON PATIENT AND INFECTION CONTROL
Dr. Stephen M. Brecher, VA Boston Health Care System
March 6  HEALTHCARE LAUNDRY: EPIDEMIOLOGY AND MICROBIOLOGY ISSUES
Dr. Lynne Sehulster, Centers for Disease Control
March 7 (Free WHO Teleclass... Europe)
HOW TO PREVENT THE SPREAD OF MULTRESISTANT BACTERIA
Dr. Stephan Harbarth, University of Geneva Hospitals, Switzerland
March 20  FRIDAY OUTBREAKS – FACT OR FICTION?
Chingiz Amirov, Baycrest Centre for Geriatric Care, Toronto
March 27 (Free Teleclass)
INTEGRATING HUMAN FACTORS WITH INFECTION PREVENTION AND CONTROL

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