

CULTURE OF SAFETY

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Patient Safety Defined

Approach to Adverse Events

Psychological Safety

Root Cause Analysis & Action

TeamSTEPPS

Agenda

Patient Safety & Human Safety

PATIENT SAFETY

“Patient safety is defined as “the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum .”

Within the broader health system context, it is “a **framework of organized activities** that creates cultures, processes, procedures, behaviours, technologies and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make error less likely and reduce impact of harm when it does occur.”

To err is human , and expecting flawless performance from human beings working in complex, high-stress environments is unrealistic.

-WHO



Why Does It Matter?

We all have had adverse events – and will continue to have them.



MEDICAL ERRORS

3rd leading cause of death

> 200,000 deaths/year due to
preventable medical errors

Vet med is capturing this currently in
MVH, but misses private practice



HEALTH CARE PROFESSIONALS

Safety & Retention

Second Victim

Mental Health: anger, guilt, inadequacy,
depression, and suicidal ideation



FINANCIAL LOSS

> 20 Billion Annually

35-45 Billion Annually for Hospital
Acquired Infections Alone

Social media impacts, veterinary board pressure, client satisfaction & retention, etc.



Our Approach Makes All The Difference

Blame & Shame

Blame is normal - but it is detrimental to maintaining a culture of safety

Human Error is Common

To err is human
Errors are often environmental/systems-based
Most of the time we are inheriting the errors rather than causing them

If we do not confront these errors with curiosity, we will make them again

Person vs Systems Approach

Person approach:

Focused on individuals (inattention/recklessness, etc.)

“Just World Hypothesis” – assumes bad things happen to bad people.

Perpetuates a culture of blame.



Recognizes human errors and hopes to rethink conditions to mitigate risk of errors



Does not eliminate or lessen responsibility, but broadens it.

We have an obligation to prevent errors systemically.



Think error vs misconduct

Coaching vs discipline – a place for both

Common Examples

Systems errors & solutions



MEDICATION MISHAPS

Pharmacy Reorg



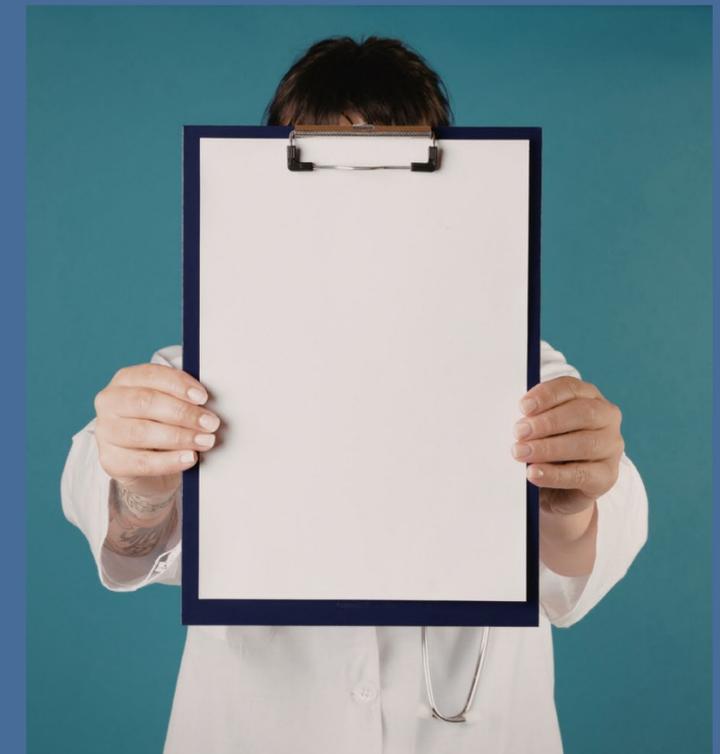
BAROTRAUMA

Safety Valves



DISTRACTING ENVIRONMENT

2 Minutes of Quiet



MISSING STEPS

Checklists



Psychological Safety

The term psychological safety is defined as an individual's "sense of being able to show and employ oneself without fear of negative consequences to self - image, status or career" and at the group level as "a shared belief that the team is safe for interpersonal risk taking." ¹

The term embodies individual confidence in the belief that speaking up will not result in embarrassment, rejection, criticism, or punishment from others.

Leaders must demonstrate this early, often, and as loudly as possible



The Ability to Speak Up:

Can your team say something? What will it cost them?



Medication Errors

"I gave this patient 0.4mL of acepromazine instead of 0.04mL"



Asking . . . again?

"I know you said this 4kg cat needs 900mL of LRS SQ, but can I ask you to check this again?"



Patient Advocacy

"I think that's hurting him"



Approachability

Emotional Wake

Body Positioning

Responses (verbal & non-verbal)

Active Listening

Encourage Reporting

HALO? Non-MVH Reporting?

Demonstrate Empathy (victims first, systems next)

Take Action (Root Cause Analysis & Action)

Normalize Feedback

Make "let's talk" feel normal

Encourage peer-to-peer feedback

Lead By Example

If your team doesn't see/hear about the mistakes that are made and the action that follows, no amount of talking about it will be enough

"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel". - Maya Angelou

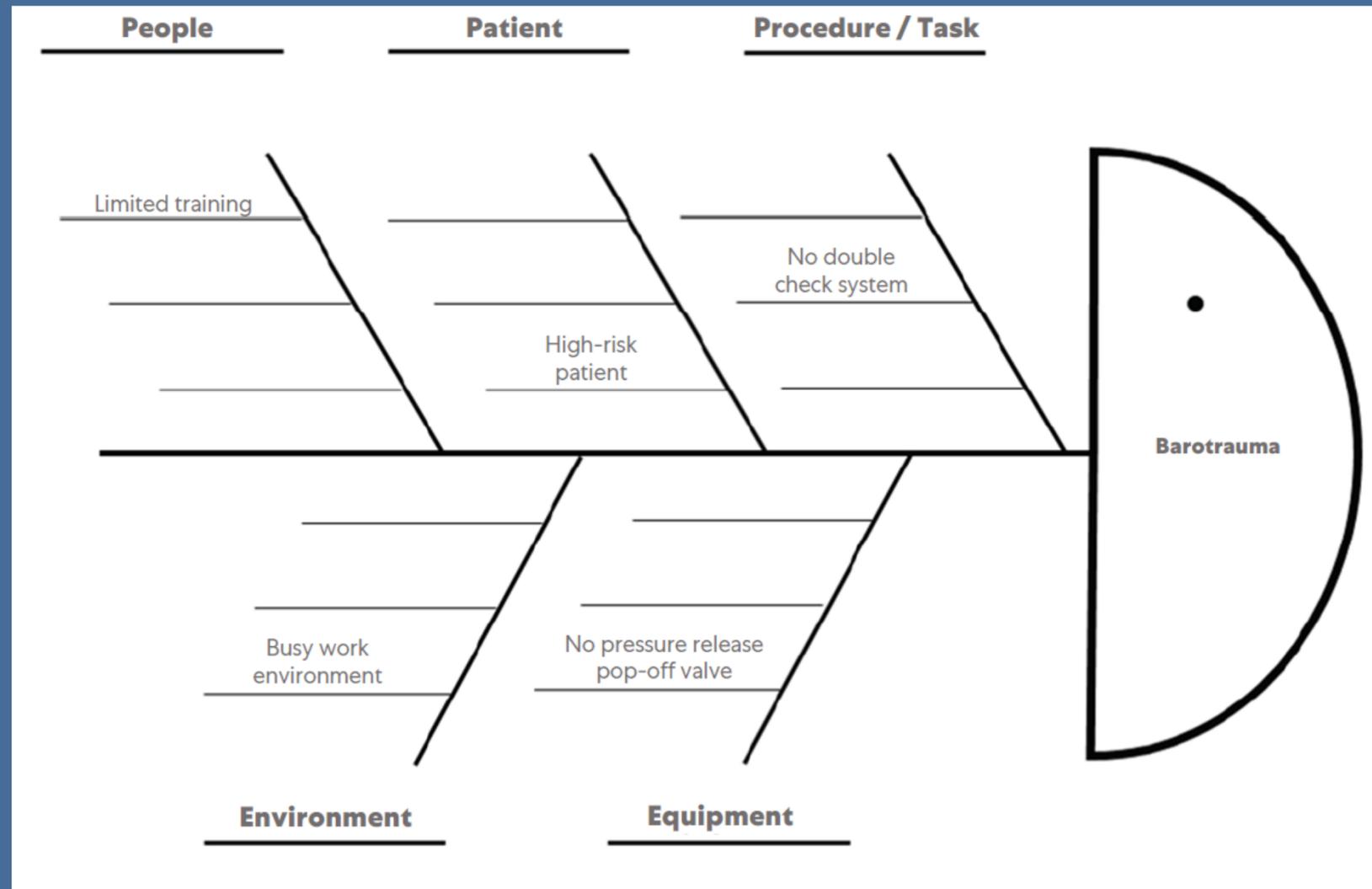
Root Cause Analysis & Action

“an RCA2 can credibly and effectively use to prioritize the events, hazards, and vulnerabilities in their systems of care to accomplish the real objective, which is to understand what happened, why it happened, and then take positive action to prevent it from happening again .

It cannot be over - emphasized that if actions resulting from an RCA2 are not implemented and measured to demonstrate their success in preventing or reducing the risk of patient harm in an effective and sustainable way, then the entire RCA2 activity will have been a waste of time and resources.”



Fishbone Diagram



Swiss Cheese Model

Case Example:

A 6-year-old French bulldog experienced barotrauma while under anesthesia for dental procedure.

Swiss Cheese Diagram

Protective System

(slice of cheese – design to prevent errors)

1. All veterinary team members trained in testing of anesthetic machine
2. Pressure release pop-off valve installed on all machines
3. Double check system in place with associate prior to introduction

Sentinel event or safety event

Human Error

(hole in the last slide of cheese)

1. After testing the machine, pop-off valve left accidentally closed
2. Veterinary team members equipment double-check did not occur

Hazards

System Flaw

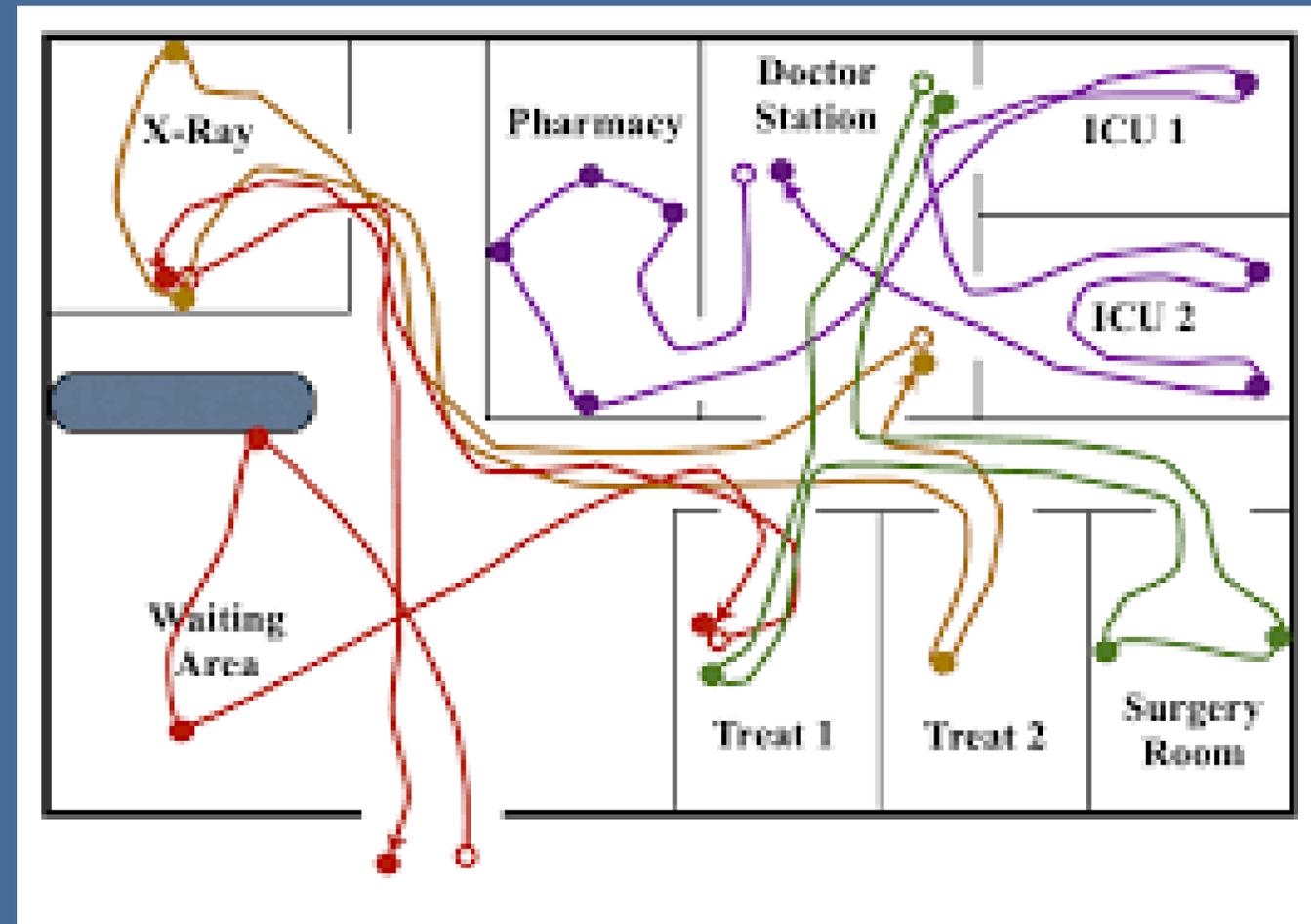
(hole in the cheese)

1. Very busy surgery day with 2 unexpected emergency cases
2. Team fatigue after multiple busy days
3. No pressure release pop-off valve in place on this machine

Case Outcome:

Barotrauma and system defect was diagnosed quickly. Patient recovered from Barotrauma after monitoring in the ICU overnight.

Spaghetti Diagram



TEAMSTEPPS Tools

Adapted by Johns Hopkins

Check Back



Closed loop communication.

"Fluffy needs 0.4mL of Cerenia SQ"

"Thank you, Fluffy needs 0.4mL of Cerenia SQ, correct?"

Two Challenge Rule



"I know you said this 4kg cat needs 900mL of LRS SQ, but can I ask you to check this again?"

Empowers teams to "stop the line" and encourages respectful challenge.

CUS



I am concerned, I am uncomfortable, this is a safety issue

"I think that's hurting him"



TEAMSTEPPS Tools

Adapted by Johns Hopkins

Call Out

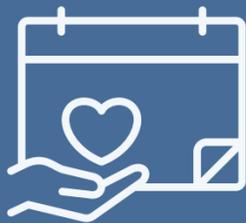


Specific communication

“Can someone get me a 3-0 PDS”

“Ashley, can you get me a 3-0 PDS”

Handoff



Appropriate transfer of patient care

Verbal & written, clear, able to ask questions, transfers responsibility and accountability

Brief/Debrief/Huddles



Prior to starting the day

After an event

Addresses patients, team, equipment, roles & responsibilities



The background is a light blue color with various medical icons in a darker blue. The icons include pill bottles, a first aid kit, a calendar with a cross, a syringe, a heart rate monitor, a microscope, a stethoscope, a medical bag, and a calendar with a cross. The icons are arranged in a grid-like pattern.

THANK YOU!

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<https://www.who.int/news-room/fact-sheets/detail/patient-safety>

<https://www.ncbi.nlm.nih.gov/books/NBK499956/>

<https://psnet.ahrq.gov/perspective/annual-perspective-psychological-safety-healthcare-staff>

<https://www.ashp.org/-/media/assets/policy-guidelines/docs/endorsed-documents/endorsed-documents-improving-root-cause-analyses-actions-prevent-harm.ashx>