ADDRESSING THE CHALLENGE

> Healthcare is full of passionate people here to make a difference in other people’s lives. If other industries are able to decrease their probability of having an event occur, why would healthcare turn their back on something so important to our values?

> Patient safety is a non-dynamic event; however it should be talked about everyday even when nothing has happened

> Preoccupation with failure should always be top of mind.

INTERVENTIONS AND RESULTS

> 100% of the organization attends HRO orientation were they learning about the science of safety and how the use of non-technical tools can reduce error.

> Every department/clinic has a defined safety coach that attends a monthly meeting to participate in simulation activities for the defined “Tool of the Month”. This simulation is then shared at department meetings and huddles.

> Standing morning huddle seven days a week. Information from department/clinic huddles is brought to the leadership huddle and then after information is disseminated back to the departments/clinics. Closed loop communication is key.

> Use our occurrence reporting system to recognized processes that could use improvement and encourage near misses to be entered by celebrating good catches from tools entered into the report.

> Each department/clinic is given a quarterly recognition box full of goodies to recognize employees in real time. In addition, we have many other rewarding activities that the employees are engaged in. (See image below.)

> Our main goal is decrease harm from reaching out patients by 2022. We are continually measuring our data through error prevention tool recall and harm classification. I am proud of the work that everyone in are our organization participates in to make safety and reliability our number one priority.