Mission Zero in Action

1. Untitled Scene

1.1 Untitled Slide
Instructions

Please read the following instructions before proceeding.

- Read the content on each slide carefully.
- Follow the steps as listed on the slide.
- Some slides are interactive and will not allow you to proceed unless you have clicked on all the buttons/images.
Objectives

- Provide an overview of Mission Zero and the current state of preventable patient harm at Packard Children’s
- Provide an understanding of how human error contributes to safety events
- Introduce proven safety behaviors to promote a safe environment
- Explain how safety behaviors and actions will be a part of your everyday work
- Demonstrate the link between various Packard Children’s initiatives and Mission Zero
Definition

What is Mission Zero?

↑

CLICK
HERE
Definition

Tell me more...

Mission Zero means keeping our patients, visitors, and staff safe so we have no errors, no accidents and no safety events.

Click here to continue.
**Definition**

We will eliminate preventable harm by:

- Introducing and sustaining evidence-based practice into standard work
- Supporting a personal and organizational commitment to transform our culture of safety through
  - Integration of standardized communication
  - Issue escalation
  - Non-punitive response to errors
  - Rounding by all leaders
  - Culture of continuous improvement
Definition

Harm to patients that can be prevented.

But what is preventable harm?

For example:
Poor hand hygiene and hub scrubbing/drying results in a patient getting a central line associated bloodstream infection (CLABSI)

Inadequate room cleaning between patients results in a patient getting a hospital acquired infection
At Packard Children's, we are working to reduce two types of preventable harm:

**Hospital Acquired Conditions (HAC)**
HACs are undesirable situations or conditions that affect patients, arising during a hospital stay.
Examples: Pressure ulcers, CLABSI

**Serious Safety Events (SSE)**
SSEs are deviations from our performance standards that reach the patient and result in moderate to severe harm or death.
Definitions

CLICK HERE

Two providers do not verify correct patient before giving blood

Hmmm... SSE. Example please!
Definitions

Two providers do not verify correct patient before giving blood

Severe transfusion reaction and death

SERIOUS SAFETY EVENT

Hmmmm... SSE Example please!

CLICK HERE

CLICK HERE → Continue
Definitions

Two providers do not verify correct patient before giving blood

Hmmm... SSE. Example please!
It is a common mindset and commitment to embrace safety as a core value in daily work. This means:

- **Everyone** Makes a Personal Commitment to Safety
- **Everyone** is Accountable for Clear & Complete Communication
- **Everyone** Supports a Questioning Attitude
Safety is our number one concern at Packard Children’s.
We know this can be done - more than 100 other health systems have integrated the same culture of safety interventions resulting in profound and sustained reduction in preventable harm to patients and culture of safety improvement.

Ohio Children Hospitals' Solutions for Patient Safety
Implement Cultural Change

Decrease Serious Safety Events

CLICK HERE ➔ Next
Safety is Important to Patients and Families

Patients expect us to:

- Keep them safe
- AND
- Heal them
- AND
- Be compassionate

Many of us have had a personal experience with patient safety. Have you, a family member or friend ever been harmed by medical error? Have you ever been involved in a medical error?
So how safe are our patients?

So far in 2013

Patients experienced a Serious Safety Event every ....... days at Packard Children’s. Click the button to select the right answer. Select Close to choose any other option.

- 10 days
- 50 days
- 100 days

Close
So how safe are our patients?

So far in 2013
Patients experienced a Serious Safety Event every ... days at Packard Children’s. Click the button to select the right answer. Select Close to choose any other option.

- 10 days
- 50 days
- 100 days

A patient preventable death occurred every ... days at Packard Children’s. Click the button to select the right answer.

- 180 days
- 91 days
- 365 days
So far in 2013

Patients experienced a Serious Safety Event every ....... days at Packard Children’s. Click the button to select the right answer. Select Close to choose any other option.

- 10 days
- 50 days
- 100 days

Close
Patients experienced a Serious Safety Event every .... days at Packard Children’s. Click the button to select the right answer. Select Close to choose any other option.

- 10 days
- 50 days

91 days

That’s right! A preventable death occurred every 91 days. Click the right answer.

Next
Are you concerned by how often our patients are seriously harmed?

What is getting in our way of eliminating preventable harm?

1.15 Drag and Drop

(Drag and Drop, 0 points, unlimited attempts permitted)
### How do Serious Safety Events Occur?

Identify the correct situation, behavior, and Serious Safety Event by dragging and dropping the examples into the appropriate circles.

#### Drag Item
- Tailgating
- Abrupt lane changes
- Not turning on headlights
- Rush hour traffic
- Poor visibility
- Driver fatigue

#### Drop Target
- Car crash
- Whiplash
- Potential for serious injury

#### Table

<table>
<thead>
<tr>
<th>Drag Item</th>
<th>Drop Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tailgating</td>
<td>High Risk Behavior</td>
</tr>
<tr>
<td>Abrupt lane changes</td>
<td></td>
</tr>
<tr>
<td>Not turning on headlights</td>
<td></td>
</tr>
<tr>
<td>Rush hour traffic</td>
<td>High Risk Situation</td>
</tr>
<tr>
<td>Poor visibility</td>
<td></td>
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<tr>
<td>Driver fatigue</td>
<td></td>
</tr>
<tr>
<td>Car crash</td>
<td>Serious Safety Event</td>
</tr>
<tr>
<td>Whiplash</td>
<td></td>
</tr>
</tbody>
</table>

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www.articulate.com
### Potential for serious injury

<table>
<thead>
<tr>
<th>Drag and drop properties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Return item to start point if dropped outside any drop target</td>
</tr>
<tr>
<td>Snap dropped items to drop target (Stack random)</td>
</tr>
<tr>
<td>Delay item drop states until interaction is submitted</td>
</tr>
</tbody>
</table>

**Feedback when correct:**

That's right! You selected the correct response.

**Feedback when incorrect:**

You did not select the correct response.
How do Serious Safety Events Occur?

Identify the correct situation, behavior, and Serious Safety Event by dragging and dropping the examples into the appropriate circles.

Correct
That's right! You selected the correct response.

High Risk Situation + High Risk Behavior = Serious Safety Event
How do Serious Safety Events Occur?

Identify the correct situation, behavior, and Serious Safety Event by dragging and dropping the examples into the appropriate circles.

Incorrect

You did not select the correct response.

Continue

High Risk Situation + High Risk Behavior = Serious Safety Event
How do Serious Safety Events Occur?

Identify the correct situation, behavior, and Serious Safety Event by dragging and dropping the examples into the appropriate circles.

Incorrect

Oops! Please try again.

High Risk Situation + High Risk Behavior = Serious Safety Event
Existing Safety Systems

Click on the button on your left to learn more about what a good safety systems can include. Please click from top to bottom.

- Technology
- Processes
- People
- Employee Safety
Existing Safety Systems

Click on the button on your left to learn more about what a good safety systems can include. Please click from top to bottom.

Example: Pharmacy order entry system that warns the Pharmacist of potential drug interactions.
Existing Safety Systems

Click on the button on your left to learn more about what a good safety systems can include. Please click from top to bottom.

- **Technology**
- **Processes**
- **People**
- **Employee Safety**

Example: Verification process which requires the team to pause before starting a procedure in order to confirm the correct procedure for the correct patient on the correct body site.
Existing Safety Systems

Click on the button on your left to learn more about what a good safety systems can include. Please click from top to bottom.

- Technology
  Example: Staff member sees a coworker about to touch a patient without washing his hands and stops to remind him.
- Processes
- People
- Employee Safety
Existing Safety Systems

Click on the button on your left to learn more about what a good safety systems can include. Please click from top to bottom.

- Technology
- Processes
- People
- Employee Safety
Existing Safety Systems

Click on the button on your left to learn more about what a good safety systems can include. Please click from top to bottom.

- **Technology**
  
  Example: Needles have safety mechanisms to prevent staff from accidentally sticking themselves.

- **Processes**

- **People**

- **Employee Safety**

  We are introducing a new safety system called Error Prevention strategies to reduce the human error rate.
As Humans, We work in 3 Modes

Click on the question marks to learn more about the three modes. You must click, and not hover on all three question marks to proceed.

- **Skill-Based Performance “Auto-Pilot Mode”**
- **Rule-Based Performance “If-Then Response Mode”**
- **Knowledge-Based Performance “Figuring It Out Mode”**
As Humans, We work in 3 Modes

Click on the question marks to learn more about the three modes. You must click, and not hover on all three question marks to proceed.

- Skill-Based Performance
  “Auto-Pilot Mode”

- Rule-Based Performance
  “If-Then Response Mode”

- Knowledge-Based Performance
  “Figuring It Out Mode”
As Humans, We work in 3 Modes

Click on the question marks to learn more about the three modes. You must click, and not hover on all three question marks to proceed.

- ? Skill-Based Performance “Auto-Pilot Mode”
- ? Rule-Based Performance “If-Then Response Mode”
- ? Knowledge-Based Performance “Figuring It Out Mode”

CLICK HERE → Next
Hmm... What do these modes have to do with Patient Safety? Are you saying breakdowns in each of these modes can result in serious patient harm?
Patient Safety Example and 3 Modes of Performance

Earlier in the day, the ordering resident did not close the loop of communication and ordered what he thought he heard - 50mg, when actually the attending physician had communicated 15mg.

Next

Resident

Pharmacist

Nurse

CLICK HERE
Patient Safety Example and 3 Modes of Performance

Earlier in the day, the ordering resident did not close the loop of communication and ordered what he thought he heard - 50mg, when actually the attending physician had communicated 15mg.

A pharmacist was functioning on auto pilot mode. He remembered approving a similar order earlier in the day and did not closely critique this new order.
Patient Safety Example and 3 Modes of Performance

Earlier in the day, the ordering resident did not close the loop of communication and ordered what he thought he heard: 50mg, when actually the attending physician had communicated 15mg.

A pharmacist was functioning on auto pilot mode. He remembered approving a similar order earlier in the day and did not closely critique this new order.

The nurse administering a medication was unfamiliar with this type of order and tried to clarify with both the resident and pharmacist. Although her concerns were not answered to her satisfaction, she proceeded with administering the medication despite her doubt.

Resident

Pharmacist

Nurse

Click here to continue.
Click on the images to identify Errors related to 3 Modes of Performance. You must click on all three images to proceed.

Earlier in the day, the ordering resident did not close the loop of communication and ordered what he thought he heard: 50mg, when actually the attending physician had communicated 15mg.

A pharmacist was functioning on auto pilot mode. He remembered approving a similar order earlier in the day and did not closely critique this new order.

The nurse administering a medication was unfamiliar with this type of order and tried to clarify with both the resident and pharmacist. Although her concerns were not answered to her satisfaction, she proceeded with administering the medication despite her doubt.
Click on the images to identify Errors related to 3 Modes of Performance. You must click on all three images to proceed.

Earlier in the day, the ordering resident did not close the loop of communication and ordered what he thought he heard, 50mg, when actually the attending physician had communicated 15mg.

A pharmacist was functioning on auto pilot mode. He remembered approving a similar order earlier in the day and did not closely critique this new order.

The nurse administering a medication was unfamiliar with this type of order and tried to clarify with both the resident and pharmacist. Although her concerns were not answered to her satisfaction, she proceeded with administering the medication despite her doubt.
Skill-based errors (Slide Layer)

Click on the images to identify Errors related to 3 Modes of Performance. You must click on all three images to proceed.

Earlier in the day, the ordering resident did not close the loop of communication and ordered what he thought he heard—50 mg, when actually the attending physician had communicated 15 mg.

Pharmacist on autopilot, verifies med order. Sounds just like med ordered the day before.

The nurse administering a medication was unfamiliar with this type of order and tried to clarify with both the resident and pharmacist. Although her concerns were not answered to her satisfaction, she proceeded with administering the medication despite her doubt.

Skill based errors occur when:
We are doing tasks so routine and familiar that we don’t even have to think about what we are doing.
Rule Based errors (Slide Layer)

Click on the images to identify Errors related to 3 Modes of Performance. You must click on all three images to proceed.

Resident misheard attending's order over the phone (15mg as 50 mg) and didn't repeat back.

A pharmacist was functioning on auto pilot mode. He remembered approving a similar order earlier in the day and did not closely critique this new order.

The nurse administering a medication was unfamiliar with this type of order and tried to clarify with both the resident and pharmacist. Although her concerns were not answered to her satisfaction, she proceeded with administering the medication despite her doubt.

Rule based errors occur when:
We choose how to respond to a situation that has a rule, but
- We use the wrong rule
- We misapplied the rule
- We choose not to follow the rule

Two-Thirds of healthcare human errors are rule based (Wow that’s a lot!)
Knowledge-based errors (Slide Layer)

Click on the images to identify Errors related to 3 Modes of Performance. You must click on all three images to proceed.

Earlier in the day, the ordering resident did not close the loop of communication and ordered what he thought he heard—50mg, when actually the attending physician had communicated 15mg.

A pharmacist was functioning on auto pilot mode. He remembered approving a similar order earlier in the day and did not closely critique this new order.

The nurse, after trying several sources for clarification, reluctantly gives the medication.

Knowledge based errors occur when we are problem solving in a new, unfamiliar situation. We don't have a skill or no rules, we come up with the answer by:

- Using what we do know (fundamentals)
- Taking a guess
- Figuring it out by trial-and-error

If you guess, you have a 50-50 chance of getting it wrong.
Take a minute to reflect on knowledge based, skill based and rule based errors that might happen in your work area.

- Rushing to a meeting and forgetting to log off of your computer.
- Due to unfamiliarity with construction changes, misdirecting someone to Emergency Department.
- Not including “SECURE” in your email headers when sending PHI, even though you know it keeps patient information safe and secure.
Think of a series of errors like Swiss cheese

Poorly designed processes or active errors within a well designed process

When the "holes line up, significant adverse events can occur!

Human error can start a cascade of events if there are no barriers to catch the error
Combination of Errors

Click here

Medication
Overdose:
Unfamiliar medication ordered in an unusual dose
Combination of Errors

Click here

Rule

Skill

Knowledge

Medication

Overdose:
Unfamiliar medication ordered in an unusual dose

Resident misheard attending’s order over the phone (15mg as 50 mg) and didn’t repeat back.
Combination of Errors

Medication
Overdose:
Unfamiliar medication ordered in an unusual dose

Resident misheard attending’s order over the phone (15mg as 50 mg) and didn’t repeat back.

Pharmacist on autopilot, verifies med order. Sounds just like med ordered the day before.
Knowledge (Slide Layer)

Combination of Errors

Rule

Knowledge

Skill

The nurse, after trying several sources for clarification, reluctantly gives the medication.

Medication

Overdose:

Unfamiliar medication ordered in an unusual dose

Resident misheard attending's order over the phone (15mg as 50 mg) and didn't repeat back.

Pharmacist on autopilot, verifies med order. Sounds just like med ordered the day before.
Safety Doesn't Just Happen,
We Have To Work to Make it Happen
Mission Zero is the evolution of our current work to reduce preventable harm through

- Identifying and fixing system problems (the holes in the Swiss cheese)
- Reducing the human error rate

How do we reduce preventable harm?
Mission Zero is the evolution of our current work to reduce preventable harm through:

- Implement standard processes (HAC reduction, PQMS principle)
- Making it easier to identify and communicate safety concerns (PQMS, tiered huddles, PCARES, incident reporting system)
- Analyze safety events to reduce recurrence (Root Cause Analysis-RCA)
Mission Zero is the evolution of our current work to reduce preventable harm through

- Implement **safety behaviors** using error prevention strategies
- **These safety behaviors are critical to the success of Mission Zero**
How do we reduce preventable harm?

Mission Zero is the evolution of our current work to reduce preventable harm through:

- Identifying and fixing system problems (the holes in the Swiss cheese)
- Reducing the human error rate
How can you help improve our Culture of Safety?

Click each of the boxes below to continue.

- Everyone Makes a Personal Commitment to Safety
- Everyone is Accountable for Clear & Complete Communication
- Everyone Supports a Questioning Attitude
How can you help improve our Culture of Safety?

Click each of the boxes below to continue.

- **Everyone** Makes a Personal Commitment to Safety
  
  "I will demonstrate a personal and a team commitment to safety."

- **Everyone** is Accountable for Clear & Complete Communication

- **Everyone** Supports a Questioning Attitude
How can you help improve our Culture of Safety?

Click each of the boxes below to continue.

- **Everyone** Makes a Personal Commitment to Safety
  
  “I will demonstrate a personal and a team commitment to safety.”

- **Everyone** is Accountable for Clear & Complete Communication
  
  “I am personally responsible for concise, accurate, clear, and timely verbal and written communications.”

- **Everyone** Supports a Questioning Attitude
How can you help improve our Culture of Safety?

Click each of the boxes below to continue.

- **Everyone** Makes a Personal Commitment to Safety
  
  “I will demonstrate a personal and a team commitment to safety.”

- **Everyone** is Accountable for Clear & Complete Communication
  
  “I am personally responsible for concise, accurate, clear, and timely verbal and written communications.”

- **Everyone** Supports a Questioning Attitude
  
  “I will question. I will welcome being questioned.”

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Over 100 hospitals have found that comprehensive training on error prevention strategies can reduce serious safety events BY 80% OR MORE!
Over 100 hospitals have found that comprehensive training on error prevention strategies can reduce serious safety events by 80% or more!

These strategies help everyone to:
- Apply behaviors that promote safety
- Minimize their chance of making a mistake
- Communicate concerns effectively
- Increase awareness in high risk situations
- Enhance our culture of safety
Over 100 hospitals have found that comprehensive training on error prevention strategies can reduce serious safety events by 80% or more!

By using these strategies you will be 10 times more likely to prevent a human error.
Each month, Packard:
- Focuses on 1-2 Error Prevention strategies that prevent skill, rule or knowledge based errors
- Includes Error Prevention education at meetings, huddles & rounds
Error Prevention strategies are supported by:
- Leaders rounding in gemba, seeking feedback and providing recognition
- Visual process management boards
- Using scenarios and exercises to facilitate conversation
- Integration of Error Prevention strategies into current processes

Annual HealthStream refresher
- Expected safety behaviors
- Error Prevention strategies
Error Prevention Strategies - Please click as instructed.

Name Game
Know the name and role of those you work with.

STAR
(Stop, Think, Act, Review) Taking a thoughtful pause in high risk situations before acting.

Click Here
**Error Prevention Strategies**

- **Name Game**
  - Know the name and role of those you work with
  - **STAR** (Stop, Think, Act, Review) Taking a thoughtful pause in high risk situations before acting

- **ARCC**
  - (Ask a question, Request a change, voice a Concern, Chain of command) - Assert a concern in a non-threatening way

Please click as instructed.
Closed loop communication (Slide Layer)

Error Prevention Strategies - Please click as instructed.

Name Game
Know the name and role of those you work with

STAR
(Stop, Think, Act, Review) Taking a thoughtful pause in high risk situations before acting

ARCC
(Assess a question, Request a change, voice a Concern, Chain of command) - Assert a concern in a non-threatening way

Closed Loop Communication
Validate what you think you heard
Numeric/phonetic clarification
Clarifying questions

CLICK HERE
Error Prevention Strategies- Please click as instructed.

- **Name Game**
  - Know the name and role of those you work with.

- **STAR**
  - (Stop, Think, Act, Review) Taking a thoughtful pause in high-risk situations before acting.

- **ARCC**
  - (Ask a question, Request a change, voice a Concern, Chain of command) - Assert a concern in a non-threatening way.

- **Closed Loop Communication**
  - Validate what you think you heard.
  - Numeric/phonetic clarification.
  - Clarifying questions.

- **SBAR**
  - Situation, Background, Assessment, Recommendation, Standardized Handoff.
  - Communicate standardized information to ensure safe transition of care.
Error Prevention Strategies - Please click as instructed.

Name Game
Know the name and role of those you work with
(Stop, Think, Act, Review) Taking a thoughtful pause in high-risk situations before acting

ARCC
(Ask a question, Request a change, voice a Concern, Chain of command) - Assert a concern in a non-threatening way

Question and Confirm
Use good judgment to detect when things are not right
Stop and Resolve
Don't proceed in the face of uncertainty

SBIAR
Situation, Background, Assessment, Recommendation
Standardized Handoff
Communicate standard information to ensure safe transition of care

Closed Loop Communication
Validate what you think you heard
Numeric/phonetic clarification
Clarifying questions
Error Prevention Strategies - Please click as instructed.

**Name Game**
Know the name and role of those you work with.
**STAR** (Stop, Think, Act, Review) Taking a thoughtful pause in high risk situations before acting.

**ARCC**
(Ask a question, Request a change, voice a Concern, Chain of command) - Assert a concern in a non-threatening way.

**Click Here**

This is our cycle of continuous improvement. Each group represents a monthly focus on one or more Error Prevention Strategies. This is our continuous cycle for improving our Culture of Safety.

**Question and Confirm**
Use good judgment to detect when things are not right.
Stop and Resolve.
Don’t proceed in the face of uncertainty.

**SBAR**
Situation, Background, Assessment, Recommendation
Standardized Handoff.
Communicate standard information to ensure safe transition of care.

**Closed Loop Communication**
Validate what you think you heard.
Numeric/phonetic clarification.
Clarifying questions.

Click Next to continue.
Thinking back to the Swiss cheese model, how can Error Prevention strategies help? Click on the boxes from left to right. You must click on all three boxes to proceed.

- Resident misheard attending’s order over the phone (15mg as 50 mg) and didn’t repeat back.
- Pharmacist on autopilot, verifies med order. Sounds just like med ordered the day before.
- The nurse, after trying several sources for clarification, reluctantly gives the medication.
Thinking back to the Swiss cheese model, how can Error Prevention strategies help? Click on the boxes from left to right. You must click on all three boxes to proceed.

- The resident performs closed-loop communication using numeric clarification.
- Order is clarified as 15mg, "one-five," and the medication is ordered correctly.
Pharmacist (Slide Layer)

Thinking back to the Swiss cheese model, how can Error Prevention strategies help? Click on the boxes from left to right. You must click on all three boxes to proceed.

Resident misheard attending’s order over the phone (15mg as 50 mg) and didn’t repeat back.

The resident performs **closed-loop communication** using numeric clarification.

Order is clarified as 15mg, “one-five,” and the medication is ordered correctly.

Pharmacist on autopilot, verifies med order. Sounds just like med ordered the day before.

The pharmacist **Stops**
**Thinks**
**Acts**
**Reviews**

The pharmacist questions the order and phones the ordering physician.

The nurse, after trying several sources for clarification, reluctantly gives the medication.
Thinking back to the Swiss cheese model, how can Error Prevention strategies help? Click on the boxes from left to right. You must click on all three boxes to proceed.

**Resident** misheard attending’s order over the phone (15mg as 50 mg) and didn’t repeat back.

The resident
Performs **dosed-loop communication** using numeric clarification.

Order is clarified as 15mg, "one-five," and the medication is ordered correctly.

**Pharmacist** on auto-pilot, verifies med order. Sounds just like med ordered the day before.

The pharmacist
**Stops**
**Thinks**
**Acts**
**Reviews**

The pharmacist questions the order and phones the ordering physician

**The nurse**, after trying several sources for clarification, reluctantly gives the medication.

The nurse
**Questions and Confirms**

The nurse continues to question until she confirms the correct dose with the attending
What is my role in Error Prevention?

- **Advocate** for safety - speak up
  - Think - “What if this was my child?”
- **Incorporate the strategies** into your daily practice
- **Encourage others** to use the strategies to keep patient, staff, and visitors safe
- **Apply the strategies** to discuss potential and actual safety events in your area
  - How do they help stop safety events from happening?
  - How could they be applied to prevent reoccurrence?
How do Error Prevention, PCARES, PQMS and Epic work together to improve our culture of safety? Click inside the circles to learn more. You must click inside all four circles to proceed.
pqms (Slide Layer)

How do Error Prevention, PCARES, PQMS and Epic work together to improve our culture of safety? Click inside the circles to learn more. You must click inside all four circles to proceed.

As Packard’s management and improvement system, PQMS supports and enables a culture of safety by emphasizing a patient-centric mindset, empowering individual accountability, & demanding the relentless elimination of defects.
How do Error Prevention, PCARES, PQMS and Epic work together to improve our culture of safety? Click inside the circles to learn more. You must click inside all four circles to proceed.

**CULTURE OF SAFETY**

As Packard’s management and improvement system, PQMS supports and enables a culture of safety by emphasizing a patient-centric mindset, empowering individual accountability, & demanding the relentless elimination of defects.

PCARES is our communication framework which promotes a culture of safety by ensuring a consistent message of concern, appreciation, and safety to our patients and families, and to one another, thus strengthening our foundation for exemplary care.
ePIC (Slide Layer)

How do Error Prevention, PCARES, PQMS and Epic work together to improve our culture of safety? Click inside the circles to learn more. You must click inside all four circles to proceed.

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PCARES is our communication framework which promotes a culture of safety by ensuring a consistent message of concern, appreciation, and safety to our patients and families, and to one another, thus strengthening our foundation for exemplary care.

Epic supports patient safety through a single patient record across the continuum of care, decision support alerts, and reports to manage key performance indicators in patient safety.
Error Prevention (Slide Layer)

How do Error Prevention, PCARES, PQMS and Epic work together to improve our culture of safety? Click inside the circles to learn more. You must click inside all four circles to proceed.

CULTURE OF SAFETY

As Packard’s management and improvement system, PQMS supports and enables a culture of safety by emphasizing a patient-centric mindset, empowering individual accountability, & demanding the relentless elimination of defects.

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Epic supports patient safety through a single patient record across the continuum of care, decision support alerts, and reports to manage key performance indicators in patient safety.

Error Prevention methods provide the common language and strategies to improve our culture of safety.
Safety starts with **YOU**, and together, **WE** can achieve Mission Zero!
1.35 **Untitled Slide**

Quiz

Instructions

There are five questions in the quiz. You are required to answer all five questions. Please select Submit to register your answer. The pass mark is set to 100%.

If you wish to review any content, please select Review or click Continue to take the quiz.

1.36 **Patient safety is the priority for Packard Children's.**

(True/False, 10 points, 1 attempt permitted)
Patient safety is the priority for Packard Children's.

- True
- False

Feedback when correct:
That's right! You selected the correct response.

Feedback when incorrect:
You did not select the correct response.
Correct (Slide Layer)

Patient safety is the priority for Packard Children's.

- True

Correct

That's right! You selected the correct response.

- False

Continue
1.37 If I practice the Error Prevention strategies, I am 10 times more likely to prevent a human error.

(True/False, 10 points, 1 attempt permitted)
If I practice the Error Prevention strategies, I am 10 times more likely to prevent a human error.

- True
- False

**Feedback when correct:**
That's right! You selected the correct response.

**Feedback when incorrect:**
You did not select the correct response.
If I practice the Error Prevention strategies, I am 10 times more likely to prevent a human error.

Correct

That's right! You selected the correct response.

Continue
1.38 We will focus on 1-2 Error Prevention strategies a month.

(True/False, 10 points, 1 attempt permitted)
We will focus on 1-2 Error Prevention strategies a month.

- True
- False

<table>
<thead>
<tr>
<th>Correct</th>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>True</td>
</tr>
<tr>
<td></td>
<td>False</td>
</tr>
</tbody>
</table>

**Feedback when correct:**
That's right! You selected the correct response.

**Feedback when incorrect:**
You did not select the correct response.
We will focus on 1-2 Error Prevention strategies a month.

Correct

That's right! You selected the correct response.

Continue
1.39 I don’t work in the hospital; Error Prevention strategies do not apply to me

(True/False, 10 points, 1 attempt permitted)
I don’t work in the hospital; Error Prevention strategies do not apply to me

☐ True
☐ False

Feedback when correct:
That's right! You selected the correct response.

Feedback when incorrect:
You did not select the correct response.
I don’t work in the hospital; Error Prevention strategies do not apply to me

Correct
That’s right! You selected the correct response.

Continue
1.40 Cultural change and improved communication are not integral to improving patient safety.

(True/False, 10 points, 1 attempt permitted)
Cultural change and improved communication are not integral to improving patient safety.

- [ ] True
- [x] False

Feedback when correct:
That's right! You selected the correct response.

Feedback when incorrect:
You did not select the correct response.
Cultural change and improved communication are not integral to improving patient safety.

- True
- False

Correct

That's right! You selected the correct response.

Continue
Cultural change and improved communication are not integral to improving patient safety.

Incorrect

You did not select the correct response.

Continue

1.41 Results Slide

(Results Slide, 0 points, 1 attempt permitted)
Results

Your Score: % Results.ScorePercent% (% Results.ScorePoints% points)

Passing Score: % Results.PassPercent% (% Results.PassPoints% points)

Result:

Results for

<table>
<thead>
<tr>
<th>1.15 Drag and Drop</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.36 Patient safety is the priority for Packard Children's.</td>
</tr>
<tr>
<td>1.37 If I practice the Error Prevention strategies, I am 10 times more likely to prevent a human error.</td>
</tr>
<tr>
<td>1.38 We will focus on 1-2 Error Prevention strategies a month.</td>
</tr>
<tr>
<td>1.39 I don't work in the hospital; Error Prevention strategies do not apply to me</td>
</tr>
<tr>
<td>1.40 Cultural change and improved communication are not integral to improving patient safety.</td>
</tr>
</tbody>
</table>

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Result slide properties

Passing Score 100%

Success (Slide Layer)

Results

Your Score: % Results.ScorePercent % (% Results.ScorePoints % points)

Passing Score: % Results.PassPercent % (% Results.PassPoints % points)

Result:

Congratulations, you passed.

Exit
Failure (Slide Layer)

Results

Your Score:

Passing Score:

Result:

You did not pass.

Retry Quiz