**Leadership Forum: Promoting a Culture of Safety**

**Dates:** 5/10, 5/13 and 5/14 (Note: All sessions at the InterContinental Hotel)

**Times:** 4-hour sessions (Note: Participants only attend 1 session)
- Morning session: 8:00 a.m. to noon
- Afternoon session: 1:00 p.m. to 5:00 p.m.

**FORUM SUMMARY**

What is a “safe culture” — and how does it fit into our culture at Cleveland Clinic? As a leader, you can help make safety “business as usual” for our patients and caregivers. But you must first understand how to support caregivers who speak up when they see opportunities for us to improve. No matter what setting you work in, you serve our patients — and can be a safety leader. Please join our next Leadership Forum to explore the elements of a safe culture and learn how you can lead the charge.

**FORUM OBJECTIVES**

- Define a safe culture and explain the impact of a safe culture on patient care and employee engagement.
- Gain confidence in your ability as a leader to create and promote a safe culture.
- Understand the 3 types of human behaviors that adversely impact reliability and appropriate leadership responses to each one.
- Network with leaders from across the enterprise.

**DETAILED FORUM AGENDA**

Registration

8:00 (1:00) Executive Welcome

Opening Video

Agenda & Introductions
- Agenda
- Table Introduction

Journey Toward High Reliability
- Presentation: “Journey Toward High Reliability”
- Mini-Case Study Discussions
- Individual Exercise: Systems Approach to Errors
- Table Discussion: Barriers to Speaking Up
- Video Scenarios: Speaking Up

10:00 (3:00) Break

Journey Toward a Just Culture
- Presentation: “Journey Toward a Just Culture”
- Video Scenarios: Responses to Errors
- Role Play

Connecting the Dots … Safety, Serving Leader and Continuous Improvement

11:30 (4:30) Close
- Closing Video
- Closing Comments
- Call to Action

**Sustaining and Building our Culture**

[Image: Engagement, Emotional Intelligence, Culture of Safety, Culture of Improvement]
Culture of Safety: Mini Scenarios (Errors)

Instructions
Read the case studies below. Most of the case studies highlight an error that could potentially impact a patient’s safety. Choose one case study and answer the following discussion questions. Share your responses with a partner.

- What is our desired outcome?
- What factors might have contributed to this error?
- How might this error be prevented in the future?

Scenario #1 – Wrong Blood Type
Bill Simmons was in a serious auto accident. He was rushed to the hospital for emergency surgery. After the surgery was complete, Bill was moved into a step-down unit. Shortly afterward, he developed a high fever. The clinical staff realized that he received the wrong blood type for his blood transfusion.

Scenario #2 – Duplicative Tests
A cancer patient was transferred from the ER at one Cleveland Clinic hospital to another hospital in the system. He was admitted to the second hospital and scheduled for emergency surgery. The surgery was delayed in order to run a series of blood tests and perform an invasive radiology test. The patient’s record did not reflect that the majority of these tests had been performed at the prior hospital.

Scenario #3 – Equipment Hazard
Jim B, an EVS Floor Technician, was diligently buffing the floor of an empty patient room to prepare for the next patient, who was expected within a half hour. The buffer was plugged into an outlet in the hallway. Jim was unexpectedly paged by his Supervisor to assist with a stat clean-up. Nurse Maggie entered the patient room. She tripped on the buffer cord, crashed to the floor and broke her arm.

Scenario #4 – Medication Error
A newborn baby born prematurely required an IV to provide nutrients. During routine line care, the nurse flushed the line with high dose heparin instead of a dilute solution. The infant did not develop symptoms but a nurse working at the next bed noticed the vial was not the usual flush.

Scenario #5 – Missing Paycheck
Christina Jones transferred from a part-time position at Main Campus to a full-time position at Hillcrest Hospital. On her first scheduled payday in her new role, she did not receive a paycheck.

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Culture of Safety: Mini Scenarios (Near Misses)

Instructions
Read the case studies below. Most of the case studies highlight an error that could potentially impact a patient’s safety. Choose a case study and answer the following discussion questions. Share your responses with a partner.

- What is our desired outcome?
- How might we respond to this “near miss”?
- What could be the potential impact if an error did happen?
- What steps can we take to prevent an error from happening in the future?

Scenario #1 – Wrong Site Surgery
Edna Wilson has had problems with her knees for several years. She was scheduled for knee replacement surgery on her right knee. As the surgery team prepared for the operation, they prepared for a left knee replacement. When the surgeon met with her to mark the knee, Edna indicated that the knee replacement was for her right knee. After a delayed start, the surgery proceeded on the right knee.

Scenario #2 – Medication Allergy
Penicillin was ordered for a patient with a documented allergy to this medication. When entering the order into the computer system, the pharmacist was alerted to the allergy. The prescriber was called and the penicillin was not dispensed or administered to the patient.

Scenario #3 – Wrong Patient
Transporter John arrived at the Radiology waiting area to transport Mrs. Jane Smith to Vascular Medicine for Doppler testing. John called out “Mrs. Smith” and Mrs. Smith responded by raising her hand. John took Mrs. Smith in her wheelchair to the second testing destination. Upon arrival at the Vascular department, the Technician receiving the patient told John that he brought Mrs. Jodi Smith…not Mrs. Jane Smith.

Scenario #4 – Falsified Credentials
Jerry Brown accepted a position at Cleveland Clinic in January 2013 as a Respiratory Therapist. During the pre-boarding process, Jerry’s unusual number of questions “raised a red flag” for his boss. After meeting with his HR Business Partner, they discovered that Jerry falsified his credentials on the application. Jerry was terminated prior to his official start date.

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(3 Types of Factors)
Systems Approach to Errors

Organizational Factors
(Includes culture, policies, procedures, regulations)

Environmental Factors
(Includes equipment, staffing, resources, constraints)

Human Factors
(Includes technical/functional skills, communication skills, problem solving skills)

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Journey Toward a Just Culture – Coaching Template

Step 1: Start positively: Approach the caregiver with an empathetic statement.

- Begin the conversation in a positive manner.
- Avoid confrontation.
- Be honest, friendly, and approachable.

E.g., “Thanks for meeting with me today, Deanna. “I know how pressured we are to get things done, and I know you’ve been feeling that a lot lately. I do appreciate you stepping up to fill in the gap.”

Your verbiage:

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Step 2: Understand the situation: What happened (or almost happened) and why.

- Ask open-ended, probing questions to gain an accurate understanding of the situation (i.e. What happened? What factors contributed to the situation?).
- Encourage full transparency.
  - Focus on facts.
  - Focus on learning – not blame.
- Listen to the other person without interrupting.
- Be cognizant of your tone of voice and body language.

E.g., “Deanna, something happened last week that I just learned about. I was hoping to learn more from you about what may have occurred regarding a patient last week. It appears that the wrong knee was indicated on the surgical schedule. It showed right when it was supposed to be left. Did anything seem not quite right to you?”

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Journey Toward a Just Culture – Coaching Template

Step 3: Make recommendations: Identify action steps to prevent this situation (i.e., error, near miss) from happening again in the future.

- Be proactive.
  - Identify mutual purpose.
  - Focus on solutions → people (i.e. behaviors), systems or processes.
- Solicit the caregiver’s ideas.
- Gain commitment from the caregiver to follow the agreed-upon action steps.

E.g., “So based on what you are saying, it seems like there was a time pressure, we were short-staffed, and there was difficulty in reading the handwriting on the paperwork, is that about right?” “Let’s think about what could be done in the future. Going forward, what ideas might you have to ensure this doesn't happen again?”

Your verbiage:

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Step 4: End Positively: Thank the caregiver for taking the time to talk with you and affirm their value.

- Thank the caregiver for meeting with you.
- Share appreciation for their contribution to the team.
- Affirm your confidence in the caregiver’s ability to follow the recommendations outlined in step 3.
- Establish a check-in point.

E.g., “Thank you Deanna for clarifying. I appreciate your candor and input. I know you will continue doing a great job. Everyone appreciates your smile every day, including me. You are a great team member. Even though you don’t treat patients directly, you are a caregiver and play an important role in a patient’s overall experience.”

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