



**Baxter**



Advancing Safety in SPHM:  
The road to High Reliability

***Safe Patient Handling & Mobility  
Summit, October 29 2024***

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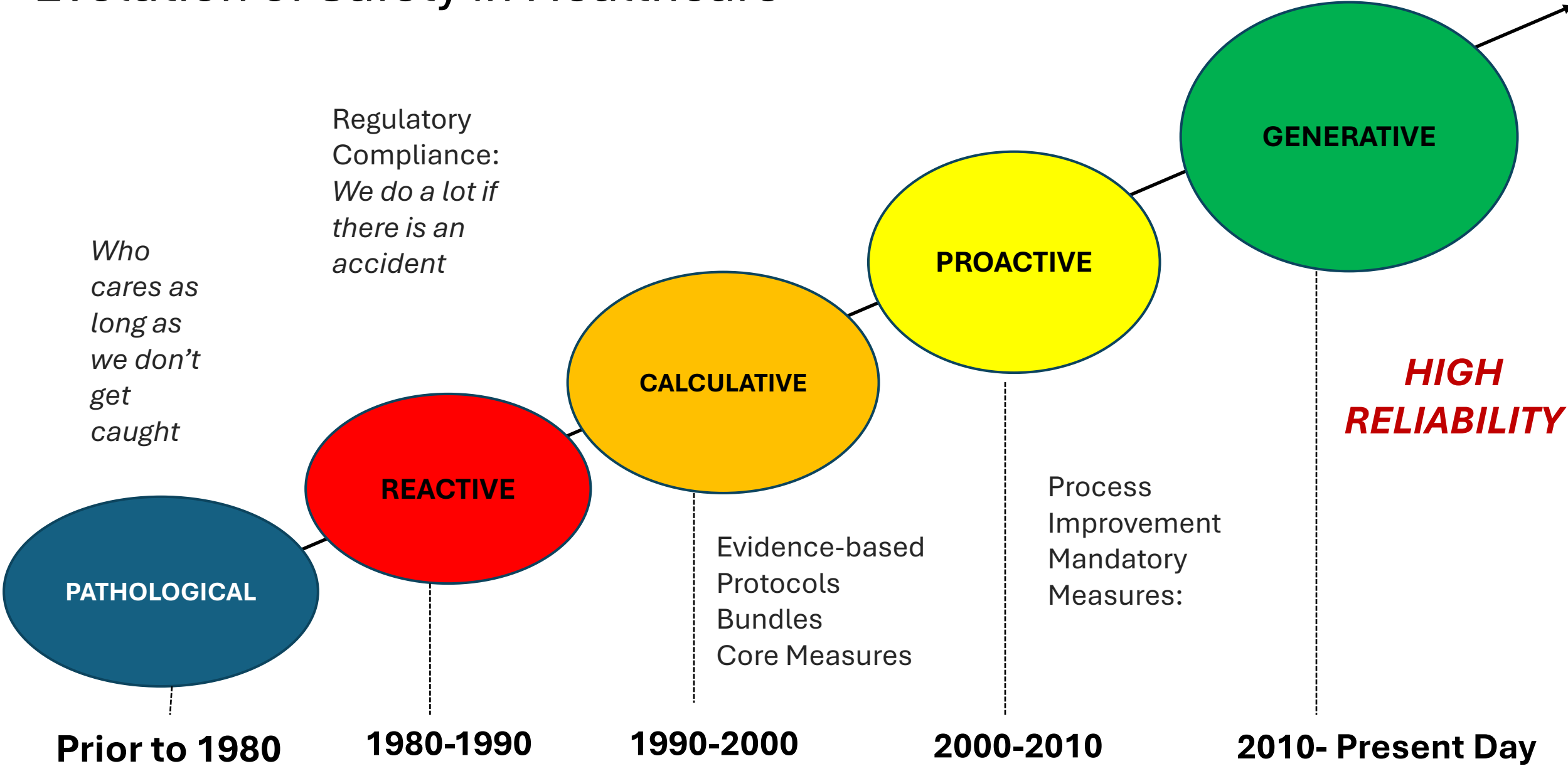
# Objectives

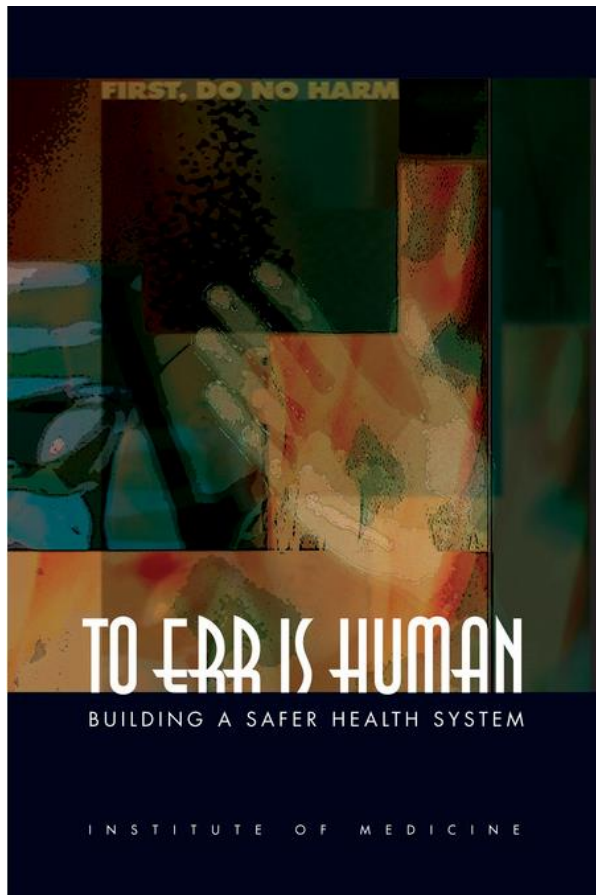
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- State the five principles of highly reliable organizations
- Know the error prevention techniques most frequently used
- Demonstrate how the principles of high reliability can be applied in clinical settings



# Evolution of Safety in Healthcare





# Safety in Healthcare

## Death by Numbers

250,000 deaths per year due to medical errors and mistakes

[National Institute of Health](#)

## Preventable Harm

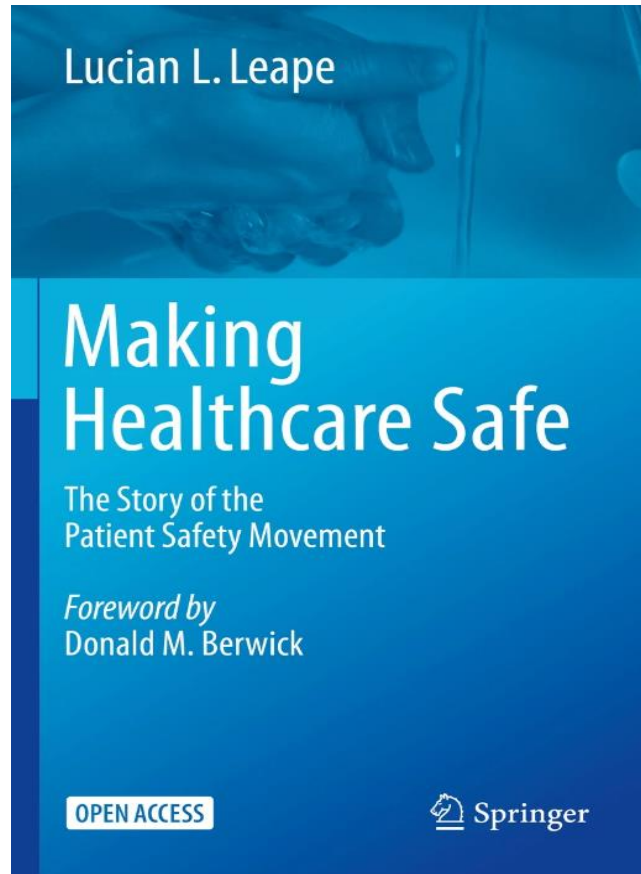
400,000 patients, each year, suffer from preventable harm

[Medical Error Reduction & Prevention](#) , Rodziewicz, Houseman, Vaqur, Hopskind, 2024

## Caregivers too

Musculoskeletal injuries most common injury in healthcare workers

[www.bls.gov/dsg/hospitals/documents.2018](http://www.bls.gov/dsg/hospitals/documents.2018)



For decades,  
we've known  
its  
importance;  
however ...

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# Common Challenges in SPHM programs

Staff are trained in use of equipment but do not use it

Equipment availability yet par levels are not maintained, resulting in low utilization

The program starts off strong but then enthusiasm subsides as new initiatives are rolled out

There is a lack of leadership awareness and follow through with SPHM processes



*“Every system is perfectly designed to get the results it gets”*

*Edward Deming*

# What is Reliability?

**Definition:** *The Probability that a system, structure, component, process, person will successfully provide the intended function(s).*

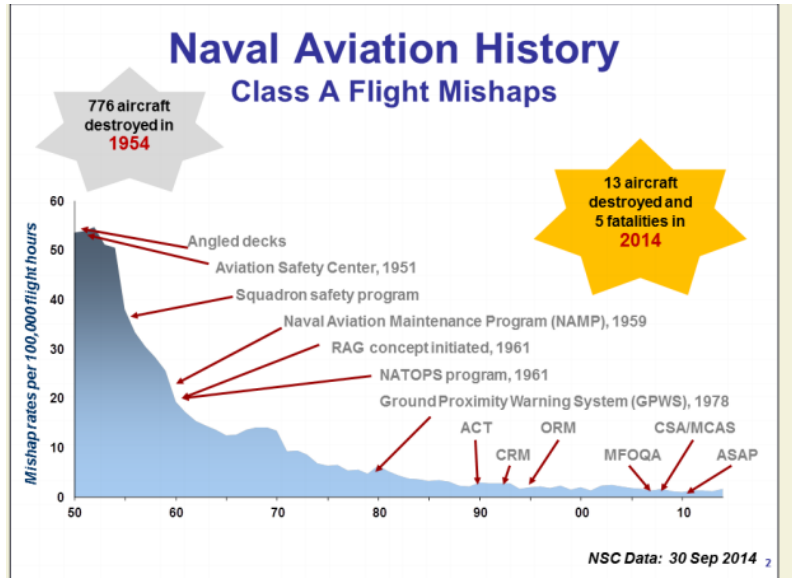
# What is an HRO?

High reliability organizations (HROs)

“operate under very trying conditions all the time

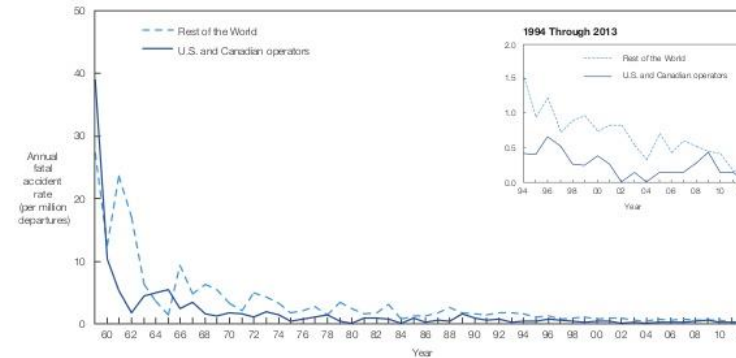
and yet manage to have fewer than their fair share of accidents.”

Managing the Unexpected (Weick & Sutcliffe)



### U.S. and Canadian Operators Accident Rates by Year

Fatal Accidents | Worldwide Commercial Jet Fleet | 1959 through 2013



# Five Principles of HROs

- Aware of potential failure & ready to respond
- Addressed immediately
- May or may not reach the patient

Preoccupation  
with Failure

Reluctance to  
Simplify  
Interpretation

- HRO's are complex by definition
- Reluctant to accept simple explanations
- Explore root causes

- Understand their systems and processes
- Use data to make decisions and track outcomes

Sensitivity to  
Operations

Commitment to  
Resilience

- Adaptable, learning organizations
- Do not let failures deter them
- Rapidly disseminate learning

Deference to  
Expertise

- Use experts when implementing a new strategy
- Expertise, rather than authority, takes precedence

# Understanding Human Error

Human error is not the cause of failure,  
but a ***symptom of failure***.

Human error – by any other name or by any other human – should be the ***starting point*** of our investigations, not the conclusion.

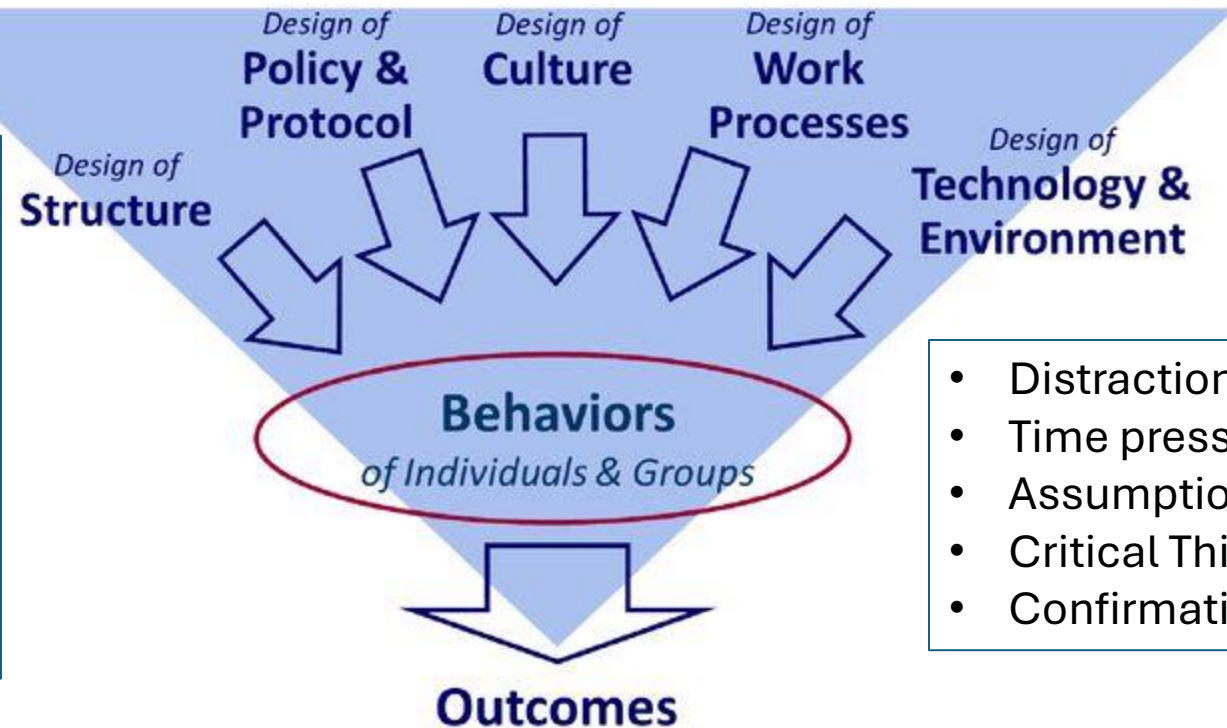


# The Sharp End Model

## HOW BEHAVIORS INFLUENCE OUTCOMES

### Blunt End

- SPHM Committee
- Champion
- Policy
- Leadership Support
- Sling workflows
- Right Equipment, right amounts



- Distraction
- Time pressure
- Assumptions
- Critical Thinking
- Confirmation Bias

# Proven Error Prevention Techniques

**Self-check using S-T-A-R (Stop, think, act, review)**

**Speak up using A-R-C-C (Ask a question, Make a request, voice a Concern, Use Chain-of-Command)**

**SBAR (Situation, Background, Assessment, Recommendation)**

**Peer Coaching – 200% Accountability**

# STAR – Stop, Think, Act, Review

## Purpose

- A simple, mental “time-out” you do for yourself that is designed to focus your attention on the critical aspects of a task
- It is the most effective self-checking technique for avoiding mistakes and lapses and only takes seconds.

## Implementation

### **STOP**

Pause 1-2 seconds to focus your attention on the task at hand

### **THINK**

Consider the action you’re about to take

### **ACT**

Concentrate and carry out task

### **REVIEW**

Check to make sure the task was done right and you got the correct result

# ARCC – I have a concern

A responsibility to protect in a manner of mutual respect – an assertion and escalation technique

Use the lightest touch possible....

**A**sk a Question

Make a **R**equest

Voice a **C**oncern

If no success...

Use **C**hain of Command

A Safety Phrase – **“I have a Concern”**

# Peer Coaching & Checking 200% Accountability



## What does that mean?

- I am not only 100% accountable for myself, but I am also 100% accountable for you.
- We look out for each other while building a great sense of accountability for our actions.
- We are ALL safety officers
- What you permit, you promote!

## Why should we do this?

- To capture honest errors before they reach our patients
- To hold each other accountable for meeting practice expectations.

$$\begin{aligned} & 1/1000 \text{ (my error probability)} \\ & \times 1/1000 \text{ (your error probability)} \\ & \underline{\hspace{1.5cm}} \\ & = 1/1,000,000 \text{ (our combined reliability!!)} \end{aligned}$$

# Peer Coaching & Checking in the SPHM World

- **Encourage** safe and productive behaviors
- **Correct** an unsafe behavior
- **Be willing** to give feedback...and BE WILLING TO HAVE OTHERS GIVE FEEDBACK OF YOU!
- **Provide** positive and corrective feedback in a 5:1 ratio



1. American Nurses Association (ANA). Safe Patient Handling and Mobility: Interprofessional National Standards Across the Care Continuum, 2013: 43,49.

2. OSHA Worker Safety in Hospitals.. [https://www.osha.gov/dsg/hospitals/education\\_training.html](https://www.osha.gov/dsg/hospitals/education_training.html). Accessed September 24, 2019.

3. Peer to Peer Coaching. Content last reviewed June 2018. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.ahrq.gov/hai/cusp/videos/07d-peer-2-peer-coach/index.html>

# SBAR for Notification

## Purpose

- A communication tool for planning and structuring information about an issue, which can be used in both clinical and non-clinical situations
- Address each SBAR element when communication important information

## Implementation

### **SITUATION**

Who you are and who, what, and where is the immediate problem

### **BACKGROUND**

Brief description of relevant history related to the current situation or condition

### **ASSESSMENT**

Your view of the situation and your perception of the urgent action

### **RECOMMENDATION**

Your suggestion about the action that should be taken to solve the problem or the request for guidance on what action to take

# HRO Leader Skills

Use Safety & Reliability science to foster **trust** that builds **psychological safety**



## Message on mission

Start every meeting with a safety message

Thank and support those who speak up

Put safety first in decision making



## Anticipate to avoid events

Daily Safety Check-IN

Tiered Huddles

Start the Clock on Safety-Critical Issues

Daily Management Systems



## Lead local learning

Learning Boards with Visual Management

Daily Problem & Cause Solving

Real Time Simulation



## Reinforce & build accountability

Collaborative Coaching & 5:1 Feedback

High Reliability Rounding

Fair & Just Culture

# In Summary...

*"Good ideas are not adopted automatically. They must be driven into practice with **courageous impatience**. Once implemented they can be easily **overturned or subverted** through **apathy or lack of follow-up**, so a continuous effort is required."*

Admiral Hyman G. Rickover  
1900-1986



# Let HRO & Safety be your core value

- HRO is a mindset that creates the framework for all safety initiatives
- HRO practices drives the culture change that is required for a successful SPHM program
- Alignment between initiatives drive adoption and sustainability
- HRO provides a proven strategy and language that can advance SPHM programs to the next level
- HRO provides tools to mitigate many of the barriers common in changing SPHM practice





The Association of  
Safe Patient  
Handling Professionals™

elevating safety. inspiring care.

## OUR MISSION

To advance the science and practice of safe patient handling and mobility by empowering caregivers and their patients to maximize their well-being and quality of life.

## OUR CORE VALUES

A reflection of who we are and why we are here.



### Advocacy

Advancing ASPHP's mission with integrity and collaboration across the continuum of care.



### Diversity

Promoting the fair and respectful treatment of all individuals so that they may have equitable access to opportunities and resources.



### Growth

Fulfilling our commitment to all stakeholders, by providing opportunities to learn and improve through ongoing education and professional development predicated on evidence-based research.



### Innovation

Supporting and promoting cutting-edge technological innovations and evidence-based research that seek to advance the science and practice of safe patient handling and mobility.



### Safety

Improving the health and safety of caregivers and their patients through interdisciplinary efforts to maximize overall quality of life.

**QUESTIONS**