Everyday HeRO
Getting ahead of harm

Jodi Ploquin, Roxanne Stelmaschuk
AHS Provincial Patient Safety

Everyday HeRO

Everyday HeRO <noun>

eve • ry • day he • ro | evrē dā hirō

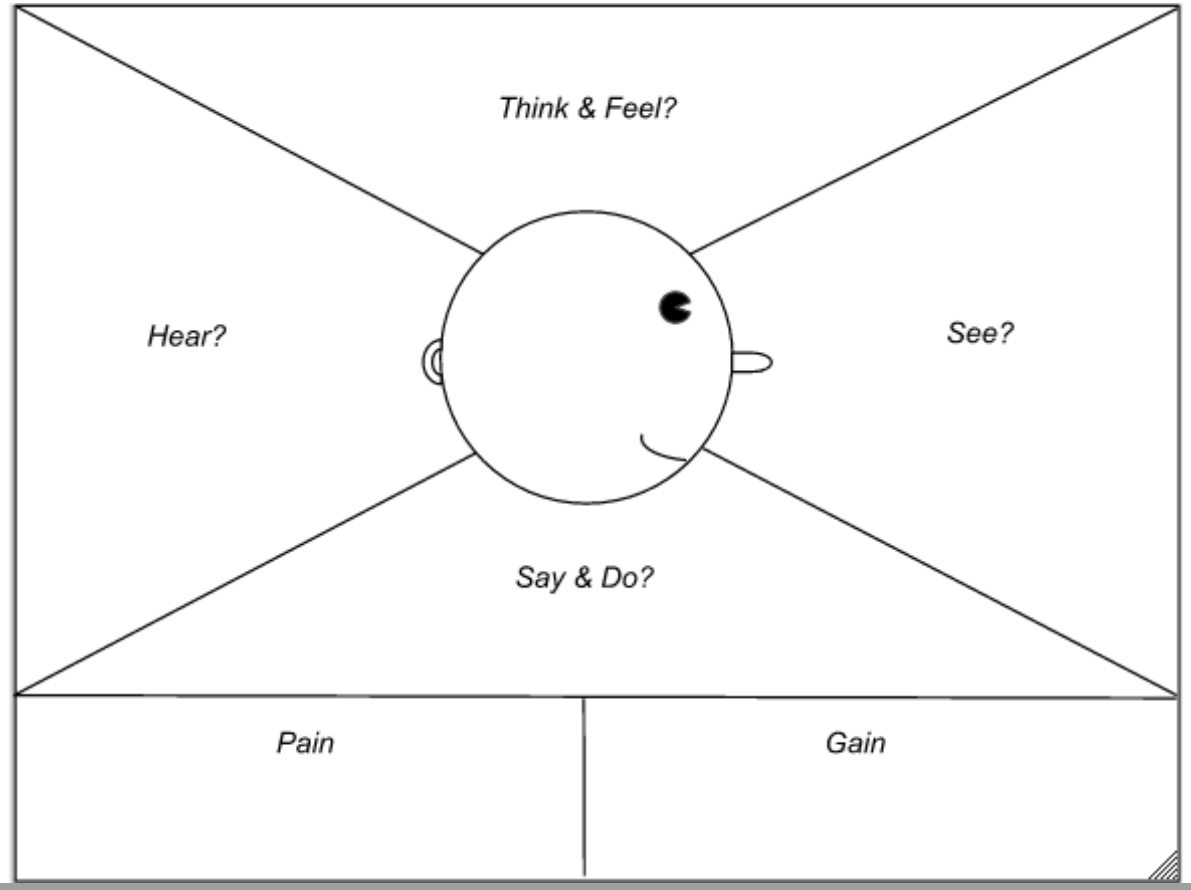
1. A person who exhibits high reliability behaviors enhancing patient safety in their everyday work

What the heck is a High Reliability Organization?

Why *wouldn't* we want this for healthcare?

How do you keep patient's safe?

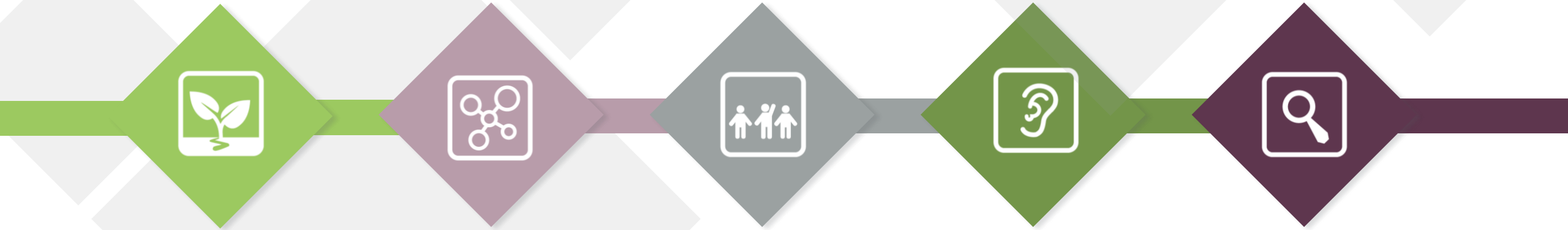
Is high reliability currently being practiced in AHS?



What do you feel, hear, see that makes you feel safe?

Is high reliability currently being practiced in AHS?

Five principles of high reliability



The World Health Organization defines 5 characteristics that support high reliability

Is high reliability currently being practiced in AHS?

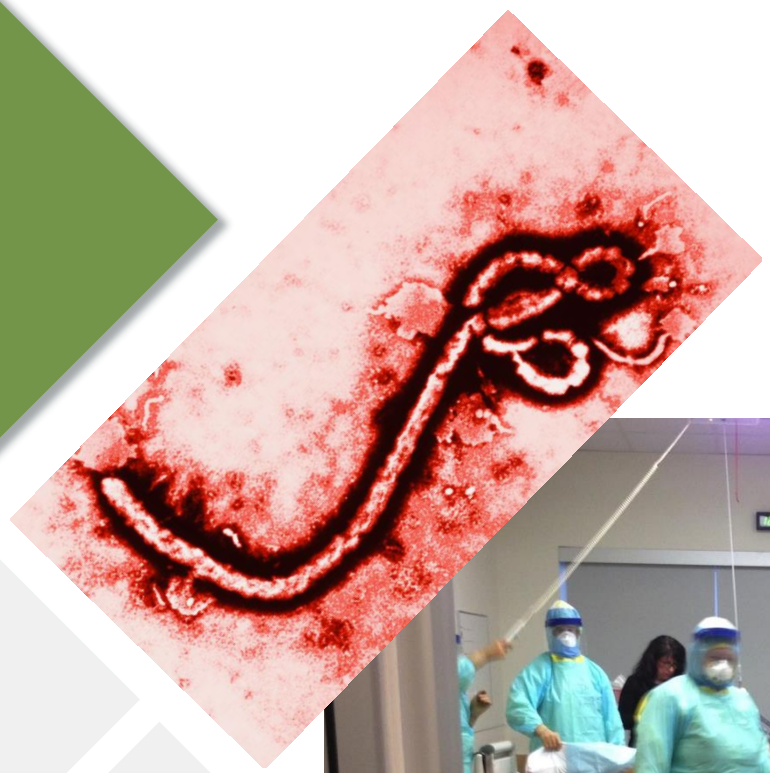
Commitment to resilience

Deference to Expertise

Pre-occupation with Failure

Reluctance to accept simplification

Sensitivity to operations



How can patients be proactive in their own care?

1 – 2 – 4 ALL STORYTELLING ACTIVITY

1 - Think of a high reliability behavior story (1 min)
2 – Share with someone at your table (2 min)
4 – Share the stories at your table (5 min)
ALL – Share one story with the larger group (8 min)

Ever heard of a BLACK BOX being used in the OR?

SafeOr Program

Alberta Health Services Quality and Patient Safety summit
October 17th

Dr Tom Lloyd, Director Saegis Safety Institute

Objectives

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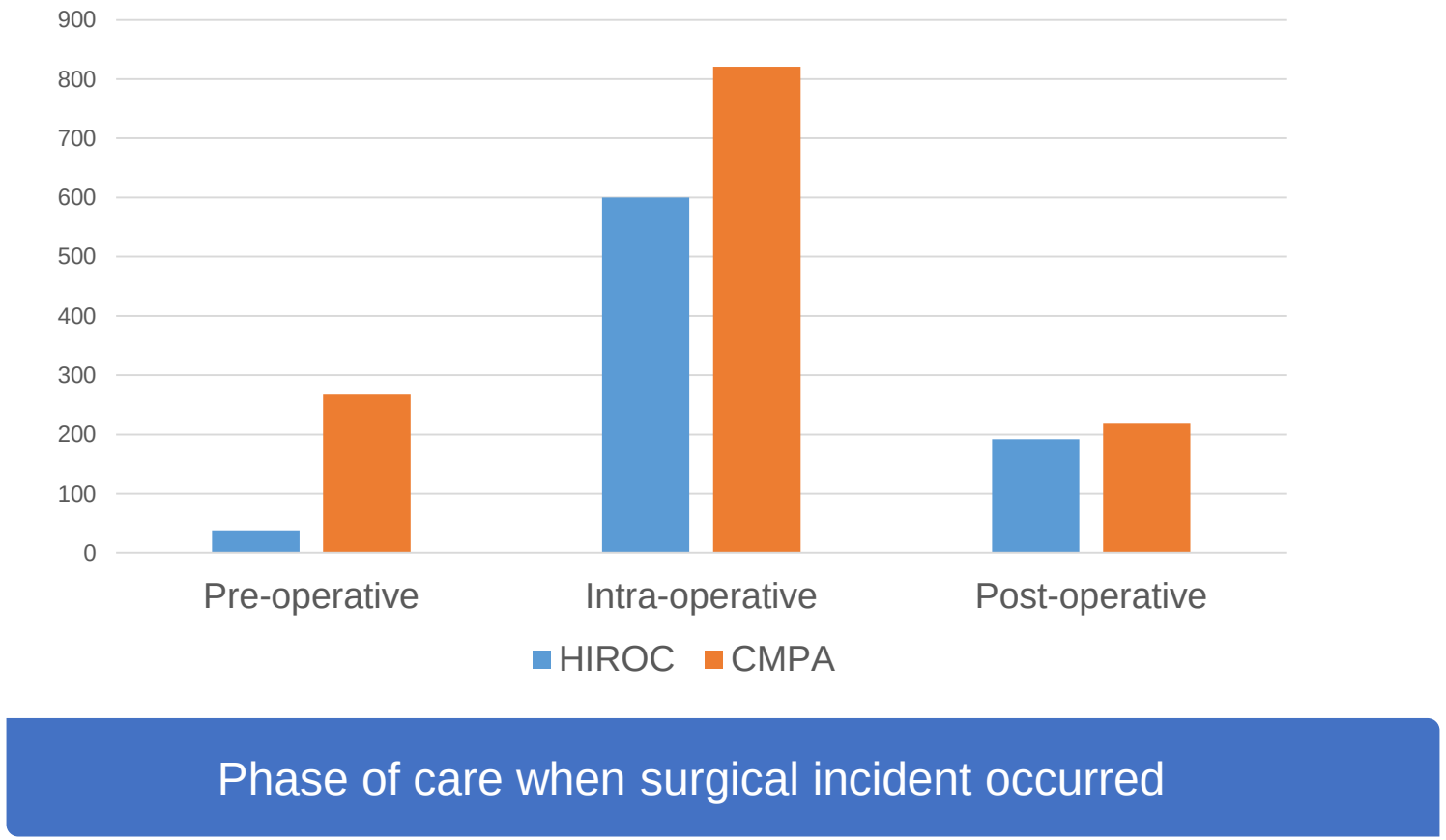
Show how technology and different thinking could lead to OR and patient safety

To introduce you to a transformative new program in OR safety

Most incidents occur during the intra-operative phase



Phase of care when surgical incident occurred

Data from *Surgical Safety in Canada: A 10-year review of CMPA and HIROC medico-legal data*

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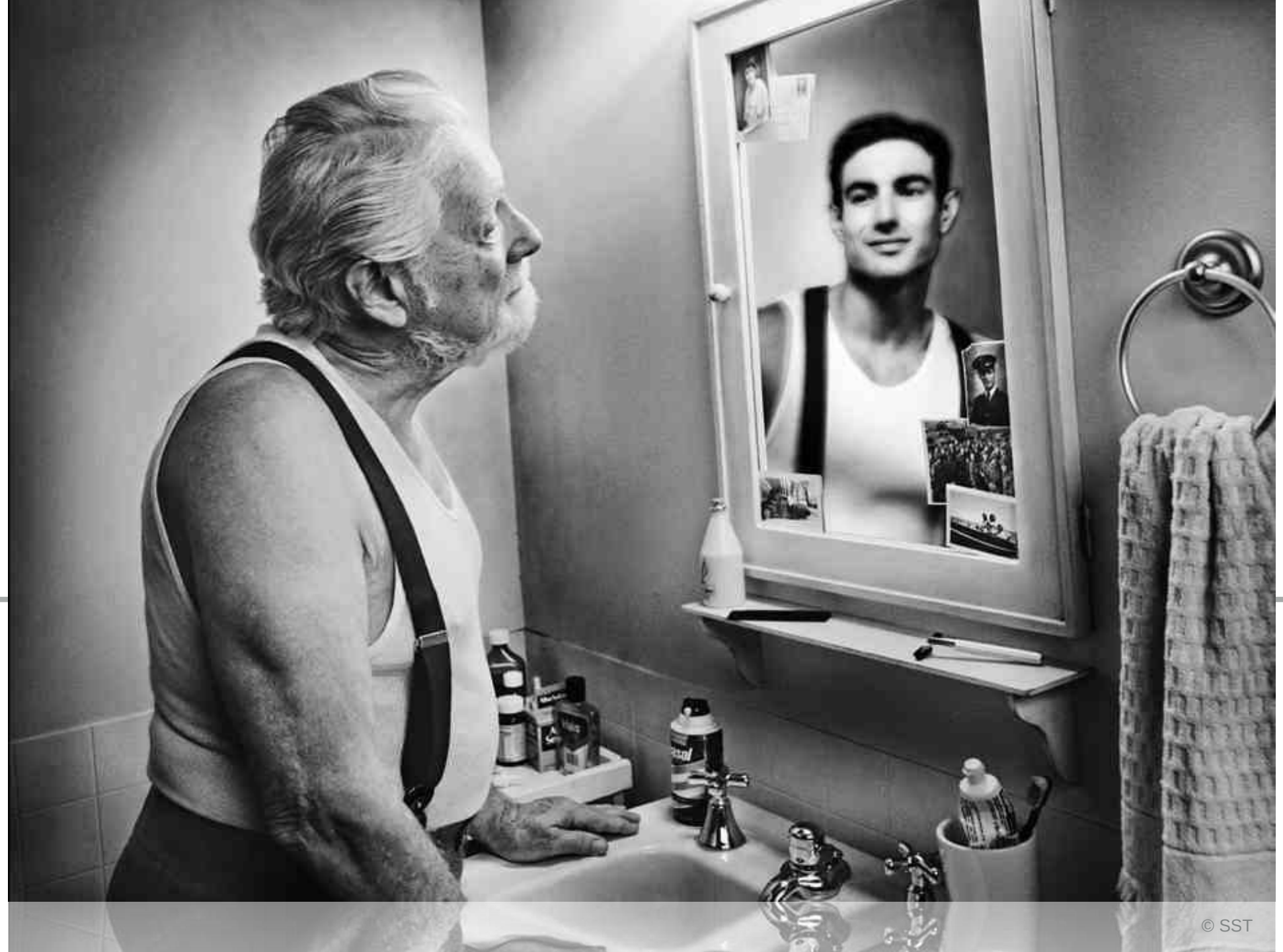
WHAT
HAPPENS
HERE
IN THE OPERATING ROOM
STAYS
HERE



© SST

The operating room is a critical area of opportunity.

To advance patient safety

To improve team culture

The Saegis SafeOR Program

Leading edge technology

Data and insights

Customized coaching & education

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Surgical Safety Technologies

BRINGING EXPERTS FROM HEALTH SCIENCES, ENGINEERING, DATA SCIENCE, MATHEMATICS, DESIGN, AND TECH INDUSTRY

DESIGN	ENGINEERING	DATA SCIENCE	HEALTHCARE	INDUSTRY
• Human Factors • Arts and Design • Industrial Design	• Signal Analysis • Comp Science • Biomedical Engineering	• Math & Statistics • Deep Learning • A.I.	• Education • Quality & Safety • ClinEpi • Nursing	• Medical Device • Insurance • Technology

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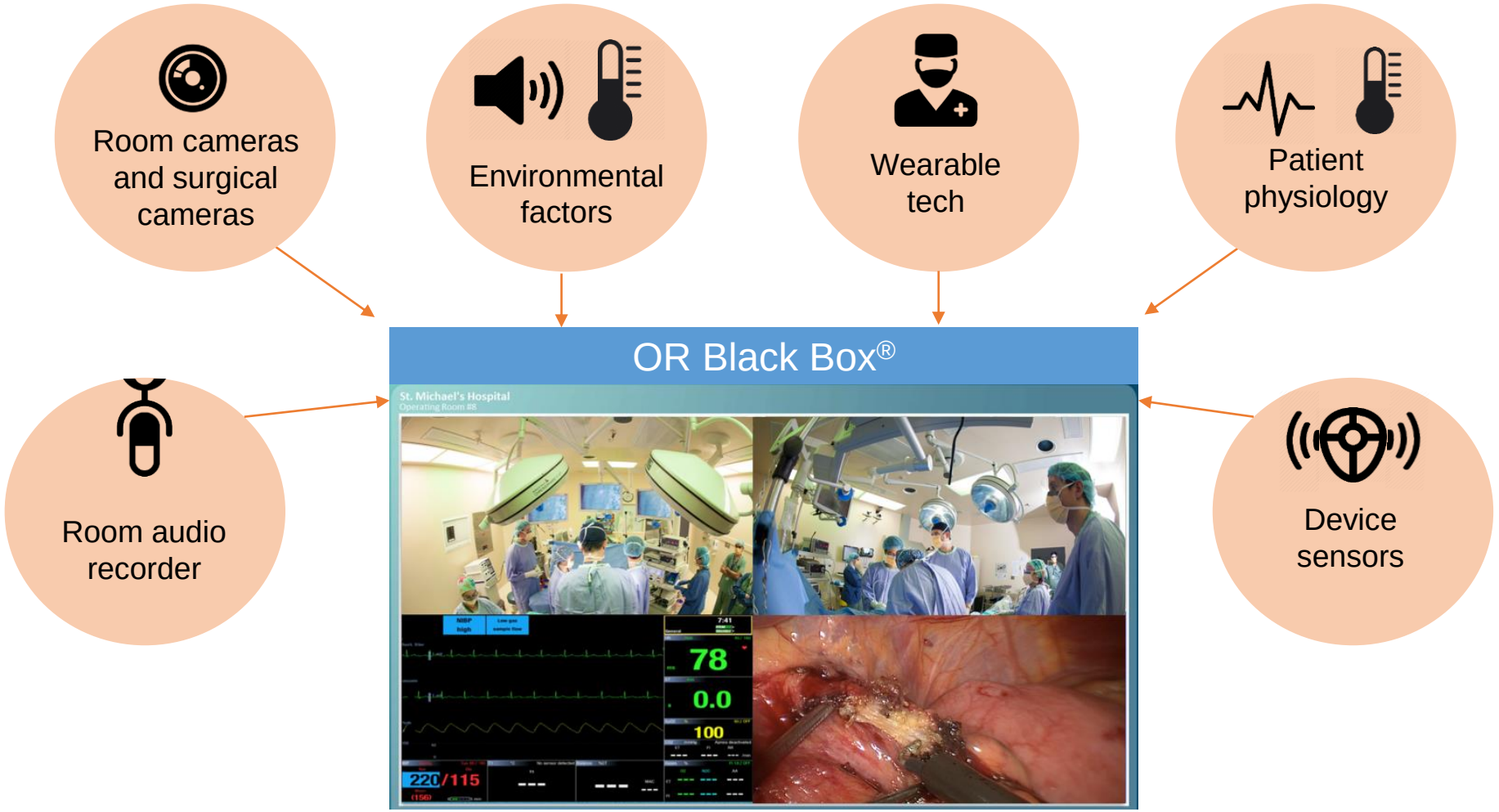
OR Black Box: The OR Quantified™



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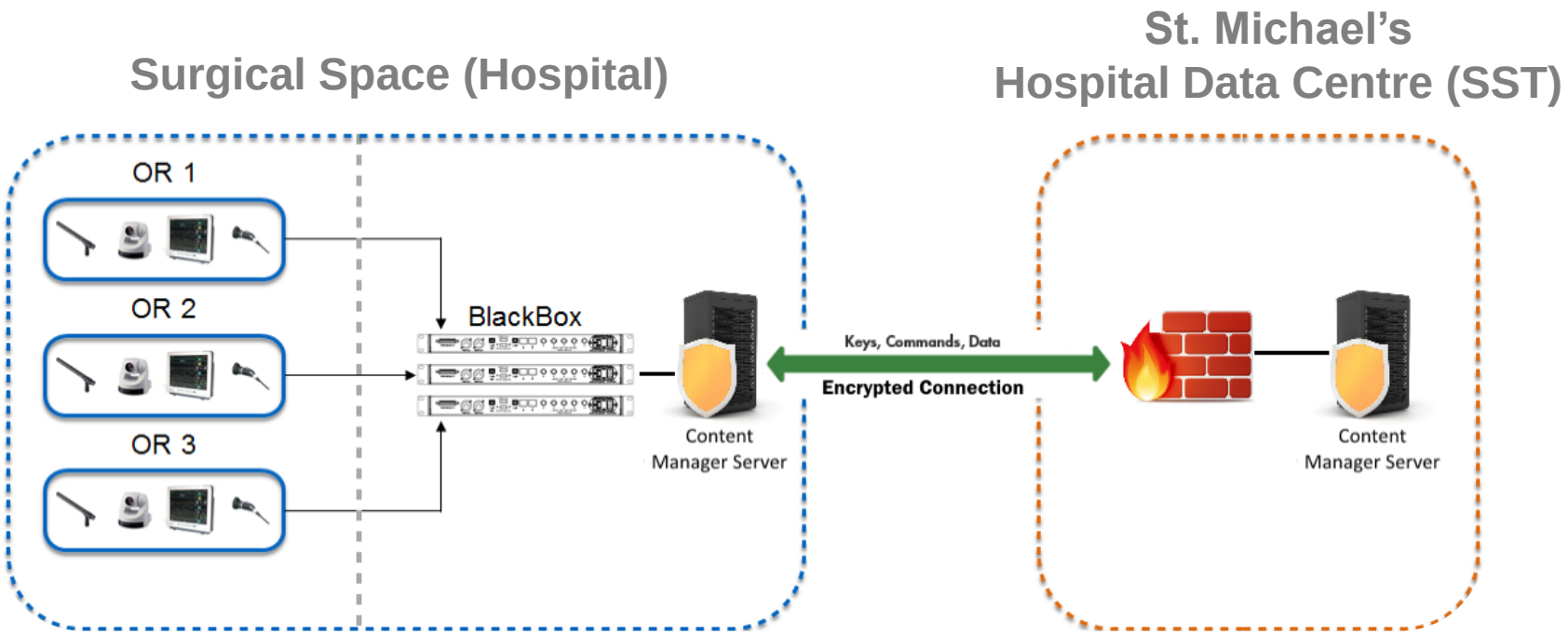
Secure Data Transmission



- Minimal intrusion in the surgical space
- Encrypted files are transmitted over a secure socket connection to Surgical Safety Technologies Servers, co-located at the St. Michael's Hospital Data Center in Toronto.

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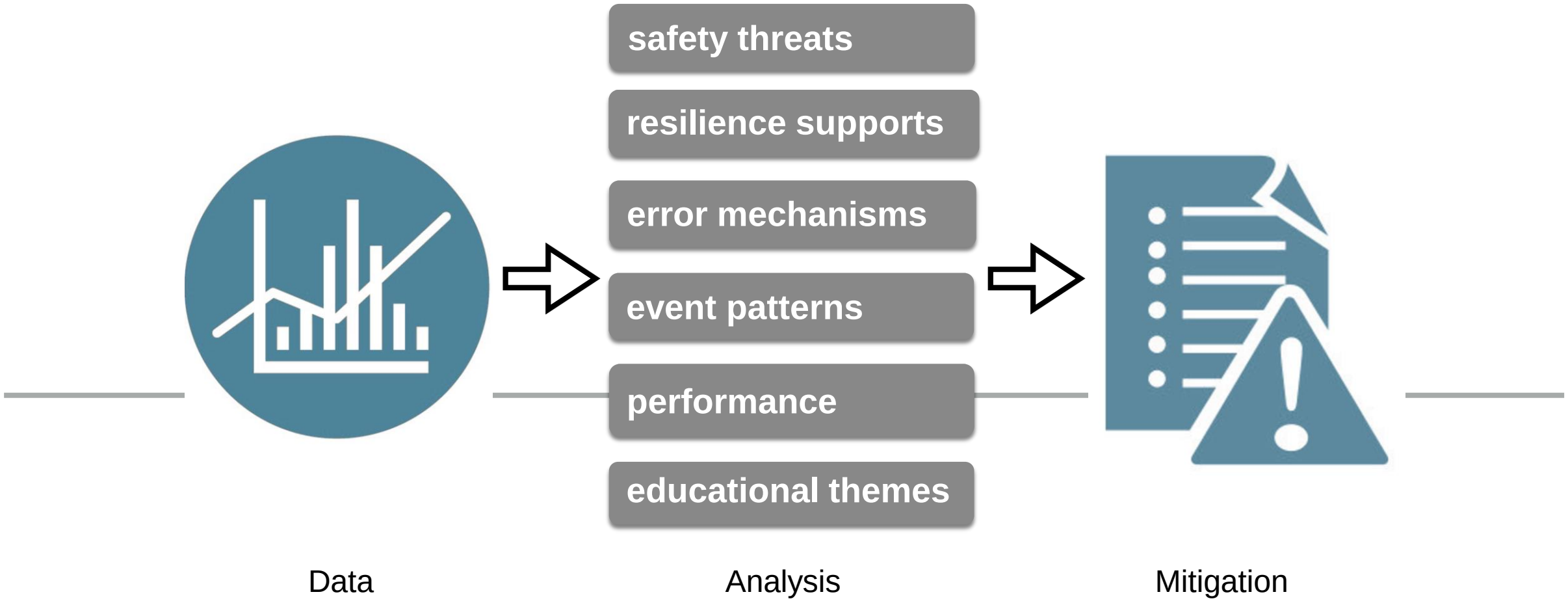
OR BlackBox


safety threats
resilience supports
error mechanisms
event patterns
performance
educational themes
Data
Analysis
Mitigation

Early insights from research sites

Patient Safety

- 8+ individuals in OR = double the adverse events
- OR doors opened every 2 minutes
- Pilot study: of 66 adverse events, 75% were unnoticed

Team Culture

- Unnecessary conversation is a prevalent threat
- Surgical coaching results in significant reduction in errors

Efficiencies

- 30% of cases have technology malfunctions
- Team member late (13%) or absent (7%)
- Multidiscipline team can improve inefficiencies

Source: SST

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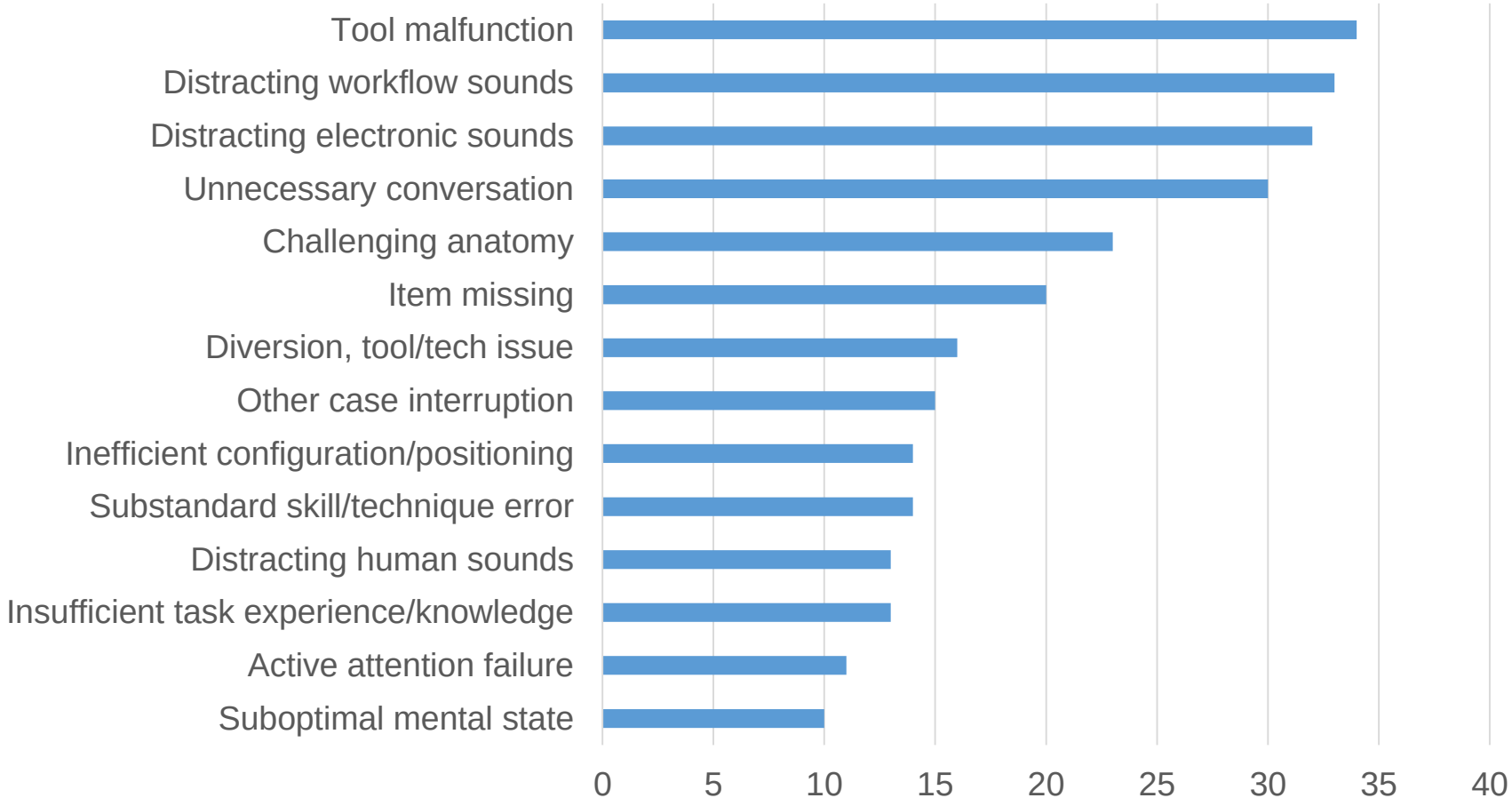
Prevalent Safety Threats



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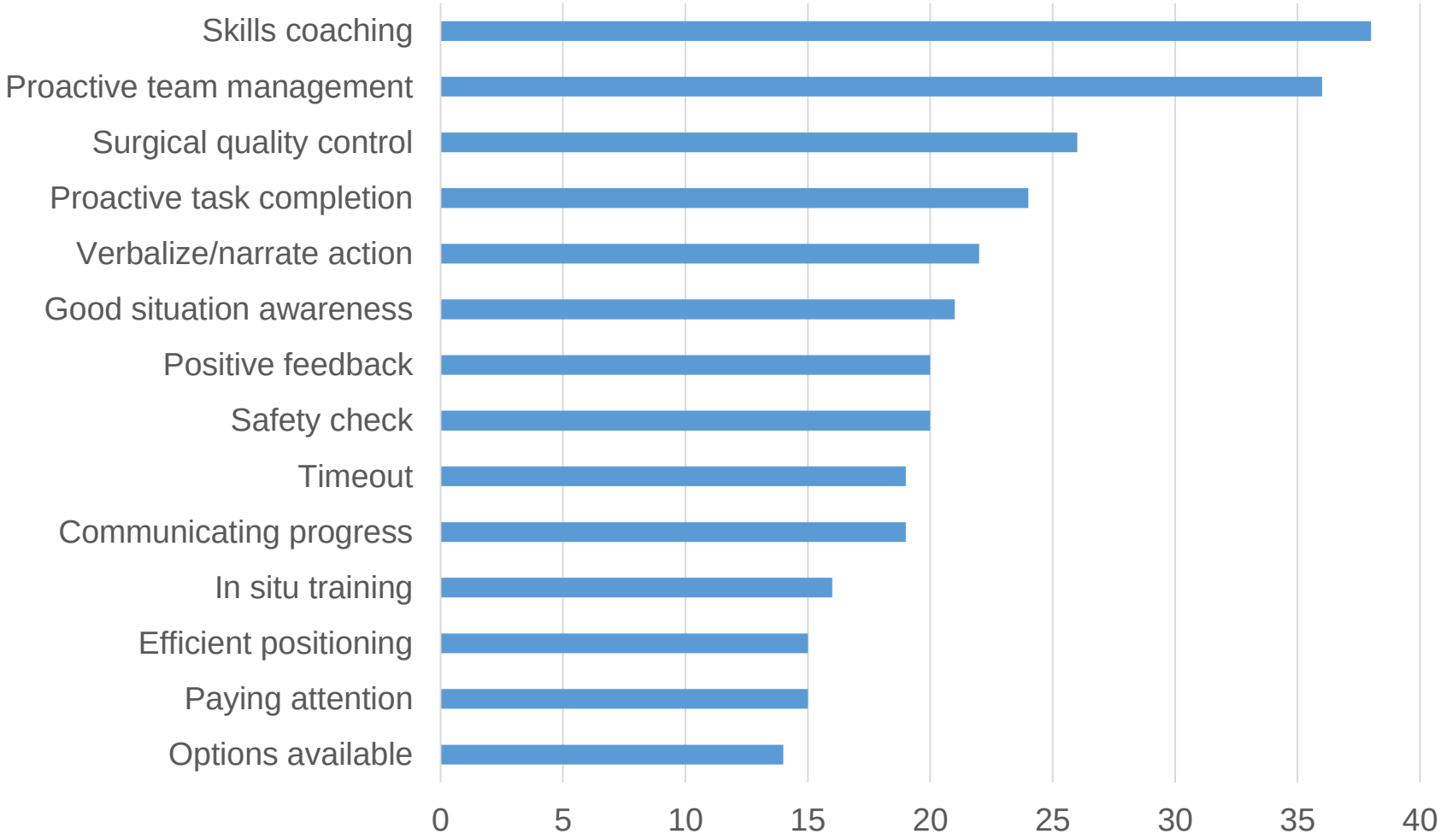
Prevalent Resilience Supports



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SafeOR supports problem identification & prioritization; facilitates QI.

OR Black Box

Lets find trouble before it finds us

Black Box does not equal disaster

Need to learn from what we did, not by whom

Aggregated data not individual cases

Confidential and non punitive


Greenland
Iceland
Finland
Sweden
Canada
United States
Mexico
North Pacific Ocean
North Atlantic Ocean
France
Spain
Italy
Ukraine
Kazakhstan
Turkey
Iraq
Iran
Afghanistan
Pakistan
India
Saudi Arabia
Egypt
Libya
Algeria
Mali
Niger
Chad
Sudan
Nigeria
Ethiopia
Kenya
DR Congo
Tanzania
Angola
Namibia
Botswana
Madagascar
South Africa
Indian Ocean
South Atlantic Ocean
South Pacific Ocean
Venezuela
Colombia
Peru
Brazil
Bolivia
Argentina

OR Black Box

- Transparency and accountability
- Perfection is not the goal
- Assessment and reflection
- Recognize, tolerate and learn from error
- Improving safety is impossible without improving team culture

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How do we continue to grow high reliability behaviors?

Modified Open Space Exercise

3 areas for discussion

CREATE NEW CARD CAPTIONS

Cards with pictures, you create the captions to support high reliability behaviors!

NEW CARD IDEAS

Do you see the need for a new card concept/ design?

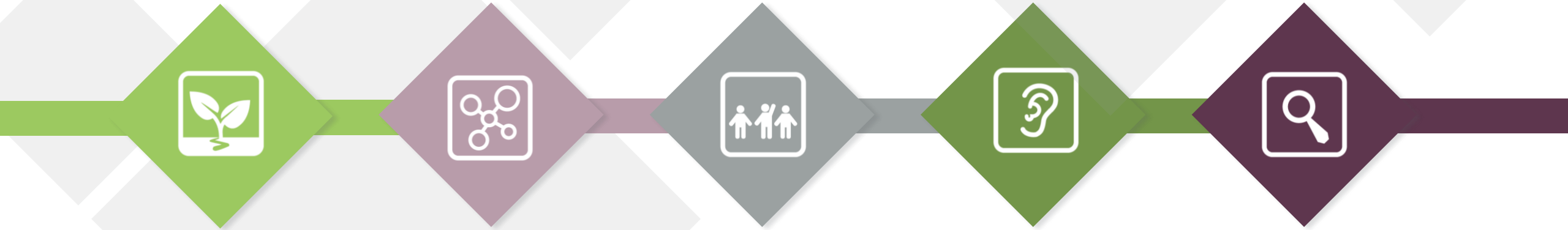
OTHER RESOURCES

What resources have you found helpful in your areas?

What else can we create to support HR activities in your area?

How else can we celebrate HR behaviors?

A shift in mindset to get ahead of harm…



Oct.29-Nov.2

Join us in celebrating our Everyday HeROs by sending an AHS Spirit card!

Thank you

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Provincial Patient Safety, AHS

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