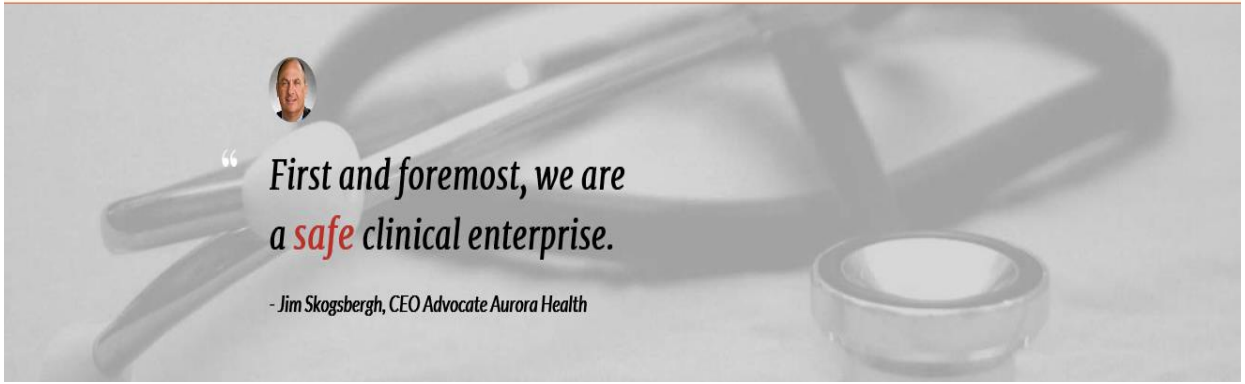
AdvocateAuroraHealth

Advocate Health Care Aurora Health Care®



AdvocateAuroraHealth®

1

We aim to be a High Reliability Organization (HRO)

High Reliability Organizations (HRO) use failures and near-misses as learning experiences to improve systems, processes, and service to its consumers.

We operate under difficult conditions all the time, yet manage to have fewer than our fair share of errors

We strive to make our systems ultra safe and use high reliability principles to decrease the chance of errors

Our Goal

Advocate Aurora's goal is to have zero events of serious patient harm by 2025. This is Advocate Aurora's "true north goal". We also call this our "moonshot goal" since its just like putting a man on the moon. It won't be easy. To reach it, we need the support of everyone in our organization.

Who We Are

*At **Advocate Aurora Health**, the work that we do is defined by...*

1

OUR PURPOSE

We help people live well.

OUR VALUES

EXCELLENCE – We are a top performer in all that we do.

COMPASSION – We unselfishly care for others.

RESPECT – We value the unique needs and preferences of all people.

3

OUR BEHAVIORS

Collaborates
Communicates Effectively

Values Differences
Fosters Resilience

Ensures Accountability

Exhibits Courage

Our High Reliability Tools and Tactics

Align...

...to our purpose, values and behaviors

Transforms...

...care delivery to eliminate harm and avoidable suffering

Integrates...

...safety, quality and service
tools and tactics for our team members

Leverages...

...High Reliability for a consistent experience

Creates and Sustains...

...a **mindset** of continuous improvement and resiliency

Enables...

...desired **safety, health outcomes and experience**

Establishes...

...life long **relationships and loyalty**

AdvocateAuroraHealth

1

OUR BEHAVIORS

Collaborates
Communicates Effectively

Values Differences
Fosters Resilience

Ensures Accountability

Exhibits Courage

All team members are accountable for demonstrating the above six behaviors in their work. Our unified set of behaviors are an important part of developing, evaluating and recognizing our people.

2

Our behaviors are organized into the above four categories – key concepts that contribute to our culture and mindset.

Collaborates

Builds partnerships, shares information, and involves others to accomplish group goals. Solicits inputs from others, acknowledging their efforts and contributions. Volunteers to help when needed, making positive contributions to the group.

Communicates Effectively

Keeps others informed, providing timely and helpful information. Listens attentively to others, considering others' perspectives and asking clarifying questions. Shares information in a clear, concise, and professional manner.

Values Differences

Engages with people with a variety of backgrounds and perspectives with openness and respect. Seeks out opportunities to draw upon and learn from diverse backgrounds, perspectives, and styles.

Fosters Resilience

Demonstrates professionalism under difficult circumstances, reaching out to others for support when needed. Recovers from setbacks, leveraging resources to move forward. Maintains productivity under stress and stays focused despite disruptions or obstacles. Navigates change and adapts to new or unexpected challenges.

Ensures Accountability

Demonstrates personal ownership, taking responsibility for own successes and learning from failures. Follows-through on commitments, communicating the status and completion of assignments. Holds self accountable for complying with policies, procedures and work requirements. Acts in the best interest of Advocate Aurora Health, protecting confidentiality and demonstrating integrity.

Exhibits Courage

Readily tackles tough assignments, showing readiness to learn and resolve issues even when the path forward is unclear. Addresses difficult issues, expressing what needs to be said in a respectful and direct manner. Shares ideas or opinions despite potential criticism or risk.

High Reliability Tools and Tactics - Defined

Our High Reliability Tools and Tactics are aligned to our team member behaviors.

Definition

Tools – Through our transformation and integration efforts as a *High Reliability Organization* (HRO), we have determined that these are the tools to utilize in everything we do to consistently achieve our desired outcomes. They are applicable to everyone and are to be used as situations require.

Tactics – Integrated practices that are currently in place or being implemented as part of our *High Reliability Organization* (HRO) journey to consistently achieve desired outcomes for safety, quality and service.

Collaborates

High Reliability Tools and Tactics

There are various high reliability tools and tactics to help our team members achieve our desired outcomes.

CROSSCHECK AND COACH (TOOL)	HUDDLE (TACTIC)	ASSUME POSITIVE INTENT (TACTI...	MANAGE UP (TACTIC)
SBAR (TOOL)	SBAR (TOOL) (CONT.)	LISTEN AND EXPLAIN (TACTIC)	HANDOVER (TACTIC)

Crosscheck and Coach (Tool)

The power of two; take advantage of working together by verifying each other's work in high risk tasks. Coach to provide reinforcement to colleagues for critical behaviors. We look out for one another and are not afraid to ask questions if we think someone has made an error. Be aware, not just of what you are doing, but of the status of the working environment and what others around us are doing.

- Watch out for each other
- Offer to cross check the work of others (peers check each other's work)
- ***Be willing to be crosschecked by others*** (it's OK to have someone point out our errors)
- Point out work conditions/hazards your team member might not have noticed
- Point out unintended slips and lapses
- Say "Thanks for the crosscheck!" when someone provides you with a check

Huddle (Tactic)

Come together, share information, and collaborate on what you are facing as a team.

- Quick (but not short-sighted)
- Fast-paced
- Organized
- To-the-point

Daily Huddles/Unit-Dept. Huddles - A huddle of the leader and direct reports at the start of the day to maintain awareness of operations, and to give direction about priority and responsibility for problem resolution.

- **Look back** (Significant safety, quality or service issues that occurred in the past 24 hours, or from the weekend)
- **Look ahead** (Anticipate and plan for safety, quality or service issues that may occur within the next 24 hours.)
- **Follow up** (Report on issues identified on previous days and what we are doing to resolve them.)

Assume Positive Intent (Tactic)

Consciously choose to believe that patients, loved ones, and the people you work with have good intentions, that they are operating to the best of their ability and are trying.

Offer the benefit of the doubt to help:

- Reduce defenses
- Build relationships
- Create resilience

Manage Up (Tactic)

Positively position the organization, yourself, and others to reassure patients, loved ones, and colleagues that they are in good hands, making them feel comfortable and safe.

By doing so:

- Patients feel better about their clinical teams
- Are more at ease about the coordination of their care
- We gain patient confidence

Manage Up:

- Team Members
- Physicians
- Other Departments
- Yourself

Communicates Effectively

High Reliability Tools and Tactics

There are various high reliability tools and tactics to help our team members achieve our desired outcomes.

ASK CLARIFYING QUESTONS (TOOL)	READ/REPEAT BACK (TOOL)	LETTER AND NUMBER CLARIFICATI...	SBAR (TOOL)	SE

Ask Clarifying Questions (Tool)

Asking one to two clarifying questions can reduce the risk of making an error by 2 1/2 times:

- In all high risk situations
- When information is incomplete
- When information is not clear by using the Reliability Phrase: "I have a clarifying question"

3-Way Repeat Back/Read Back

When information is transferred...

1. **Sender initiates** communication using Receiver's Name. Sender provides a request or information to Receiver in a clear and concise format.
2. **Receiver acknowledges** receipt by a repeat-back or read-back of the request or information.
3. **Sender acknowledges the accuracy** of the repeat-back by saying, That's correct! If not correct, Sender repeats the communication.

A reliable Phrase:
"Let me **repeat that back…**"

Train our ears to listen for **"That's Correct!"** – it's a codeword for "we understand each other"

Letter and Number Clarification

For **sound alike letters or words,** say the letter followed by a word that begins with the letter. For example:

A	Alpha	J	Juliet	S	Sierra
B	Bravo	K	Kilo	T	Tango
C	Charlie	L	Lima	U	Uniform
D	Delta	M	Mike	V	Victor
E	Echo	N	November	W	Whiskey
F	Foxtrot	O	Oscar	X	X-Ray
G	Golf	P	Papa	Y	Yankee
H	Hotel	Q	Quebec	Z	Zulu
I	India	R	Romeo		

For **sound alike numbers,** say the number and then the digits

15…that's one-five

50…that's five-zero

…and **always** use leading zeros – as in 0.5 (zero point five)

SBAR (Tool)

A framework for team members to effectively communicate critical information to one another so information can be formatted for sharing and clarity.

- **S**ituation
- **B**ackground
- **A**ssessment
- **R**ecommendation

Standardized communication develops teamwork and fosters a culture of safety.

Clinical		Non-Clinical	
S	What is happening with the patient?	S	What is happening?
B	What is the clinical background?	B	What is the background?
A	What do I think the problem is?	A	What do I think the problem is?
R	What would I recommend?	R	What would I recommend?

SBAR Situation Background Assessment Recommendation

	Clinical Example
S	Dr. Jones, this is Sharon Smith calling from the CCU. I have Mr. Holloway in Room 217, a 55-year-old man who looks pale and sweaty, feels confused and weak, and is complaining of chest pressure
B	▪ He has a history of HTN. ▪ He was admitted for a GI bleed, received 2 units of blood. ▪ His last hematocrit two hours ago was 31.
A	I just took his vital signs. His BP 90/50, pulse 120. I think he's got an active bleed and we can't rule out an MI, but we don't have a troponin or a recent H&H
R	I'd like to get an EKG and labs, and I need for you to evaluate him right away.

	NON-Clinical Example
S	This is Manny from Public Safety. A patient walked in upset stating there is a large patch of ice in the garage that he almost fell on. I came out to check it out.
B	We had heavy rain last night and the temperature dipped below freezing level overnight.
A	There is a 5 foot by 5 foot patch of ice about 15 feet east of the 3rd floor garage elevator. It's hard to see until you get close to it.
R	Please send over facilities along with the wet floor safety signs. I'll stay here to ensure no one accidentally falls. We also need to check throughout the garage to see if there is more ice.

Listen and Explain (Tactic)

A way of listening that improves understanding and trust.

Use this tactic to:

- Build trust and respect
- Enable the release of emotions
- Demonstrate caring
- Encourage the sharing of information
- Create a **safe**, collaborative environment

Apply this tactic by:

- Establishing and maintaining eye contact
- Fully concentrating on others' words, emotional tones, and non-verbal cues to best meet their needs
- Actively listening and explaining by resisting the temptation to multi-task and divert attention, especially by technology such as cell phones, computers, etc.
- Providing clear information, appropriate language and by using paraphrasing so that situation can be easily and thoroughly understood

Handover (Tactic)

Communicate the right information to create a seamless transition in responsibility for a patient, or work to decrease medical error through the effective sharing of information.

Effective Hand-Overs Include:

- Optimized information
- Responsibility / Accountability
- Uncertainty (clear up all ambiguity of responsibilities)
- Verbal Communications
- Acknowledgement (until handoff is acknowledged/understood/accepted you cannot relinquish responsibility)
- Opportunity (handoffs are an ideal time to review and have a new pair of eyes evaluate the situation for both safety and quality)

The handover technique can decrease medical errors through the effective sharing of information

Values Differences

High Reliability Tools and Tactics

There are various high reliability tools and tactics to help our team members achieve our desired outcomes.

CONNECT MEANINGFULLY (TACTIC)	THROUGH THEIR EYES (TACTIC)	APPRECIATE DIFFERENCES/RESPEC...

Connect Meaningfully (Tactic)

Express genuine interest and relate to patients, loved ones, and team members as an individual rather than a diagnosis or role.

Build trust and reduce suffering by:

- Appropriately using unspoken communication
- Appropriately using touch to demonstrate empathy and connection
- Bringing the patient / person into conversation
- Demonstrating active listening
- Using key words and plain language throughout encounters
- Narrating care/tasks to explain what is done and why
- Demonstrating respect for patients and others in words and actions

Through Their Eyes (Tactic)

Recognize and value the perspective of the patient, loved one, and/or other team member, so as to create mutual understanding and respect. By considering situations 'through the eyes of others', you can begin to view how the services you are providing are viewed from the points of view of others, so as, to ensure we are creating an inclusive setting for all those we serve.

By doing so, it:

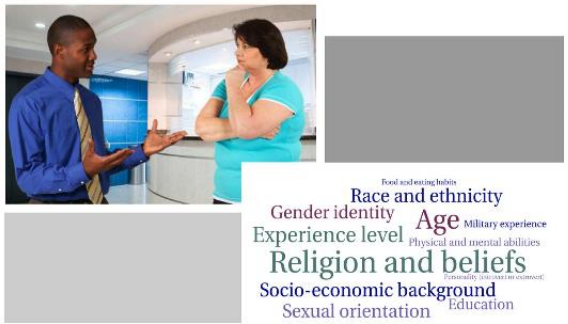
- Provides perspective
- Demonstrates empathy
- Creates a sense of mutual understanding
- Leads to trust and opens lines of communication

Appreciate Differences/Respect Preferences (Tactic)

Value different cultures and perspectives to strengthen our experience. Always ask and attempt to meet patients', loved ones', and team member preferences, values, cultural and spiritual needs.

By:

- Providing a safe, excellent, compassionate and respectful experience which begins with involving people in decision making
- Recognizing that individuals have their own unique values and preferences
- Seeking out and nurturing differences
- Empowering diverse perspectives to inspire creativity
- Understanding the differences that make us unique



Fosters Resilience

High Reliability Tools and Tactics

There are various high reliability tools and tactics to help our team members achieve our desired outcomes.

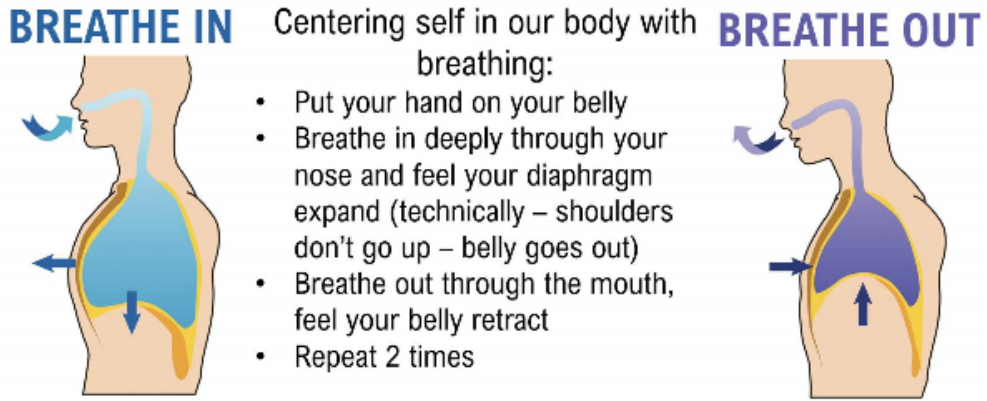
BREATHE (TACTIC)	SAVOR WHAT WENT WELL (TACTIC)	RECONNECT TO YOUR PURPOSE (TA...

Breathe (Tactic)

Pause and intentionally take a deep breath to calm yourself and refocus when feeling stressed, frustrated or anxious.

To avoid:

- Poor emotional reaction to situations
- Compromised decision making and under performance
- Increased risk for patient safety events and errors



Savor What Went Well (Tactic)

Identify and enjoy the positives, especially in difficult situations.

So that you can:

- Focus on Details
- Focus on Sensations
- Focus on the Positive
- Express Gratitude
- Do What You Enjoy

Reconnect To Your Purpose (Tactic)

Periodically reflect on why you find joy and meaning in what you do and reconnect to your purpose by identifying:

By doing so, it:

- Provides perspective
- Demonstrates empathy
- Creates a sense of mutual understanding
- Leads to trust and opens lines of communication

Ensures Accountability

High Reliability Tools and Tactics

There are various high reliability tools and tactics to help our team members achieve our desired outcomes.

STAR (TOOL)	TAKE A 'TIME-OUT' (TOOL)	TAKE A 'TIME-OUT' (TOOL) (CON...	PURPOSEFUL ROUNDING (TACTIC)

Self-Check Using STAR

Stop — Pause for *1 to 2 seconds* to focus our attention on the task at hand

Think — Consider the action you're about to take

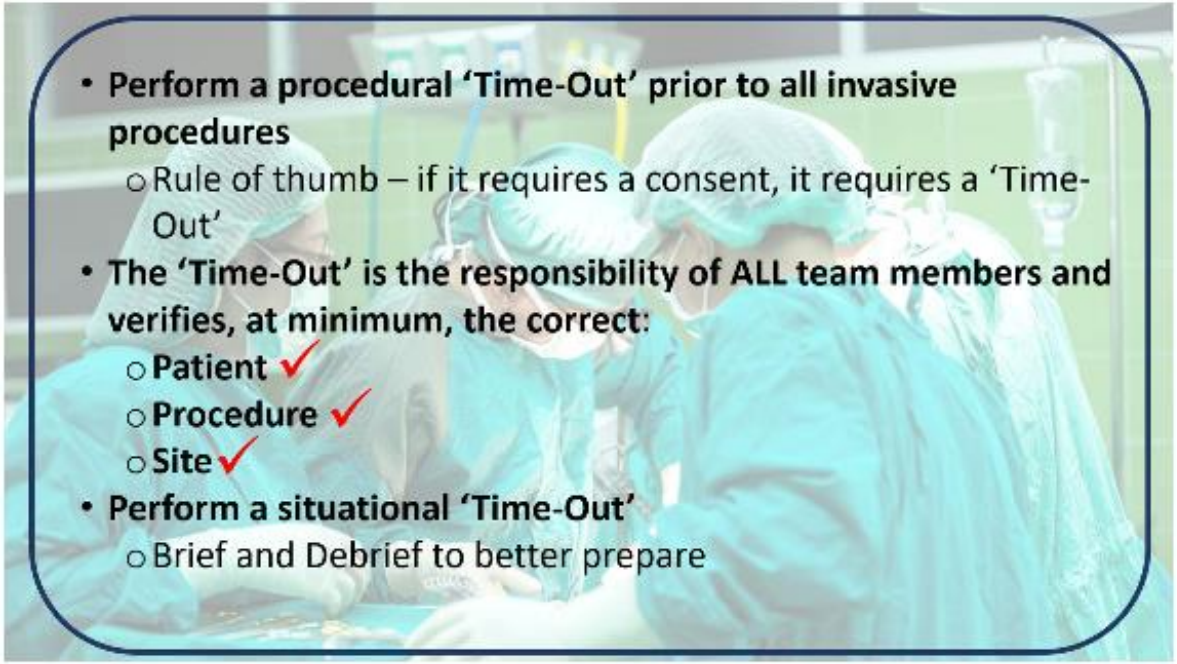
Act — Concentrate and carry out the task

Review — Check to make sure that the task was done correctly and that you got the correct result

STOP is the most important step. It gives your brain a chance to catch up with what your hands are getting ready to do.

Take a 'Time-Out' (Tool)

Formally take a moment to touch base with colleagues before and after critical activities. This brief moment sets the tone for the event, the debrief reviews performance and outcomes that foster continual improvement.



Procedural vs Situational Time-Out

PROCEDURAL TIME-OUT	SITUATIONAL TIME-OUT
• Optimize patient safety and prevent wrong-person, wrong-procedure, and wrong site procedures • Follow your current **Time-Out** policy • During the **time-out**, the team members agree, at a minimum, on the following: – correct patient identity – correct site – procedure to be done	• Formally Call a '**Time-Out**' and take a moment to touch base with colleagues before and after critical activities or when it is necessary to level set and ensure we are all on the same page. • Example: You realize three of your peers had a different perspective on what your manager requested your team to do. **Call a time-out**. This gives you, your team, and your leader the opportunity to ensure we all under the same understanding.

Purposeful Rounding (Tactic)

Anticipate and address the needs of your patients, loved ones, and coworkers through direct and meaningful dialogue to ensure desired outcomes are achieved.

Exhibits Courage

High Reliability Tools and Tactics

There are various high reliability tools and tactics to help our team members achieve our desired outcomes.

CUE (TOOL)	QUESTION AND VERIFY (TOOL)	EVENT REPORTING (TACTIC)

CUE (Tool)

You have permission to speak up and make your voice heard, especially when communicating with someone perceived to be in authority. Use **C**oncern, **U**ncomfortable, **E**scalate.

Our Responsibilities

- Protect our patients and team members from harm
- If you see or hear something that you think is a safety issue, escalate your concern in a **mutually respectful manner**
- **Assert** yourself, but <u>don't be</u> aggressive or rude

First, just ask a question – in other words, offer a cross-check

If that doesn't work, voice a **CONCERN** – use the following safety phase:

"I have a Concern…"

No response? Let your colleague know you are **UNCOMFORTABLE**:

"I am Uncomfortable with this course of action…"

If no success, **ESCALATE** up your of chain of command by saying:

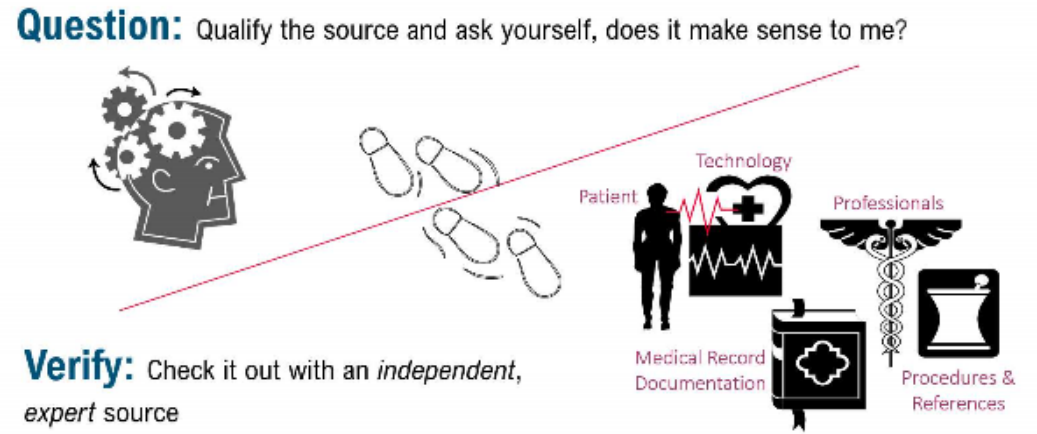
"STOP the Line – I need to Escalate this to my manager…"

Question and Verify (Tool)

Question and Verify is a top critical thinking tool that originated from the nuclear power industry. It's a two-step technique for processing raw information into fact.

Process Steps

1. Have a questioning attitude so you can recognize situations or raw information that doesn't seem quite right.
2. Think about whether or not the information that has been given to you makes sense with what you know to be true/right.
3. Then **Verify**. Verify an external check of the information with an independent/credible source to corroborate the thinking.



Event Reporting (Tactic)

Report safety, quality or service errors, near misses, and unsafe conditions.

Typical reasons for low reporting are:

- Fear of retribution (because we haven't established a fair culture)
- Burden (because the reporting system is too time consuming or difficult to use)

According to the Department of Health & Human Services (DHHS), additional reasons for failure to report are:

- Hospital associates do not recognize "what constitutes patient harm" or do not realize that particular events harmed patients and should be reported
- Team members thought that the harm or event was so common that it did not need to be reported

DO:

- Report safety, quality or service errors, near misses and unsafe acts
- Document only the facts of the situation, keep it as brief as possible, and do not include statements of fault, blame or judgment
- Report on team member behavior/performance if it is pertinent to patient safety or impacts a patient outcome.
- Know that your leaders are here to support you.

If You See Something, Say Something and Report it!

Summary - High Reliability Tools and Tactics

Now that you know what the ***High Reliability Tools and Tactics*** are capable of, feel free to begin sharing these with other team members so that everyone can begin making great strides in safety, quality, service and so that we are positively impacting the consumer experience.

AAH TEAM MEMBER BEHAVIORS

Collaborates	Values Differences	Ensures Accountability
Communicates Effectively	Fosters Resilience	Exhibits Courage

HIGH RELIABILITY TOOLS AND TACTICS

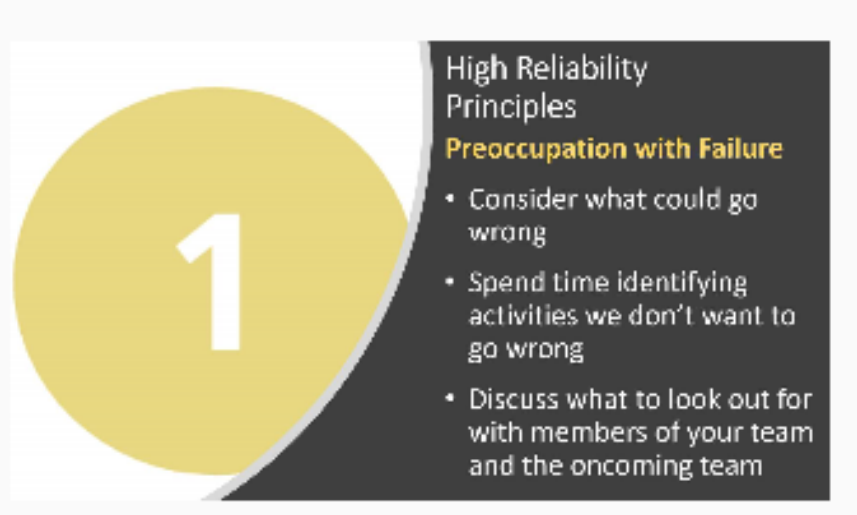
Values Differences	Ensures Accountability	Collaborates	Communicates Effectively	Fosters Resilience	Exhibits Courage
- Connect meaningfully - Through their eyes - Appreciate differences and respect preferences	- Stop Think Act Review (STAR) - Purposeful rounding - Take a 'time-out'	- Crosscheck and Coach - Huddle - Assume positive intent - Manage up	- Ask clarifying questions - Read / Repeat back - Letter and number clarification - SBAR - Listen and Explain - Handover	- Breathe - Savor what went well - Reconnect to your purpose	- Concern, Uncomfortable, Escalate (CUE) - Question and Verify - Event Reporting

High Reliability

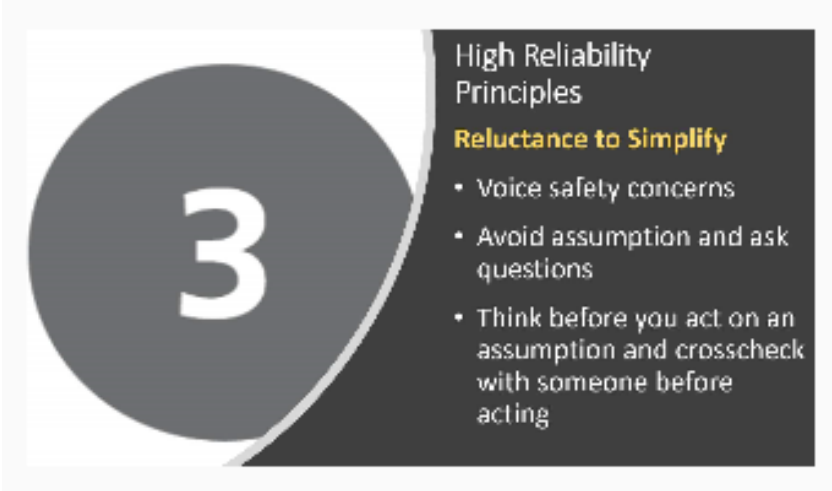
Our purpose, values and behaviors are instrumental in driving our culture. We live out our culture by being a *High Reliability Organization* (HRO) that has the capability to perform to the highest standard, consistently over time.

Five High Reliability Principles

There are five principles that guide us toward being a *High Reliability Organization* (HRO) and which help to make us safer and perform at a higher standard all of the time.


1
High Reliability Principles
Preoccupation with Failure
• Consider what could go wrong
• Spend time identifying activities we don't want to go wrong
• Discuss what to look out for with members of your team and the oncoming team


2
High Reliability Principles
Sensitivity to Operations
• Know what's going on around you
• Look for the holes in the "Swiss cheese" or process breakdowns
• Make an effort to know the stressors your team is facing


3
High Reliability Principles
Reluctance to Simplify
• Voice safety concerns
• Avoid assumption and ask questions
• Think before you act on an assumption and crosscheck with someone before acting


4
High Reliability Principles
Commitment to Resilience
• Bounce back from the unexpected
• Talk about mistakes, learn from them and discuss how they could have been prevented


5
High Reliability Principles
Deference to Expertise
• Engage your experts – don't just figure it out
• Don't hesitate to share your thoughts
• Pool collective expertise when problem solving

Five High Reliability Principles - Summary

1. Preoccupation with Failure
2. Sensitivity to Operations
3. Reluctance to Simplify
4. Commitment to Resilience
5. Deference to Expertise

High Reliability Tools and Tactics

1

As a *High Reliability Organization (HRO)*, we help people live well by providing a safe, excellent, compassionate, and respectful experience for patients, loved ones and each other through our **High Reliability Tools and Tactics**. Which are...

2

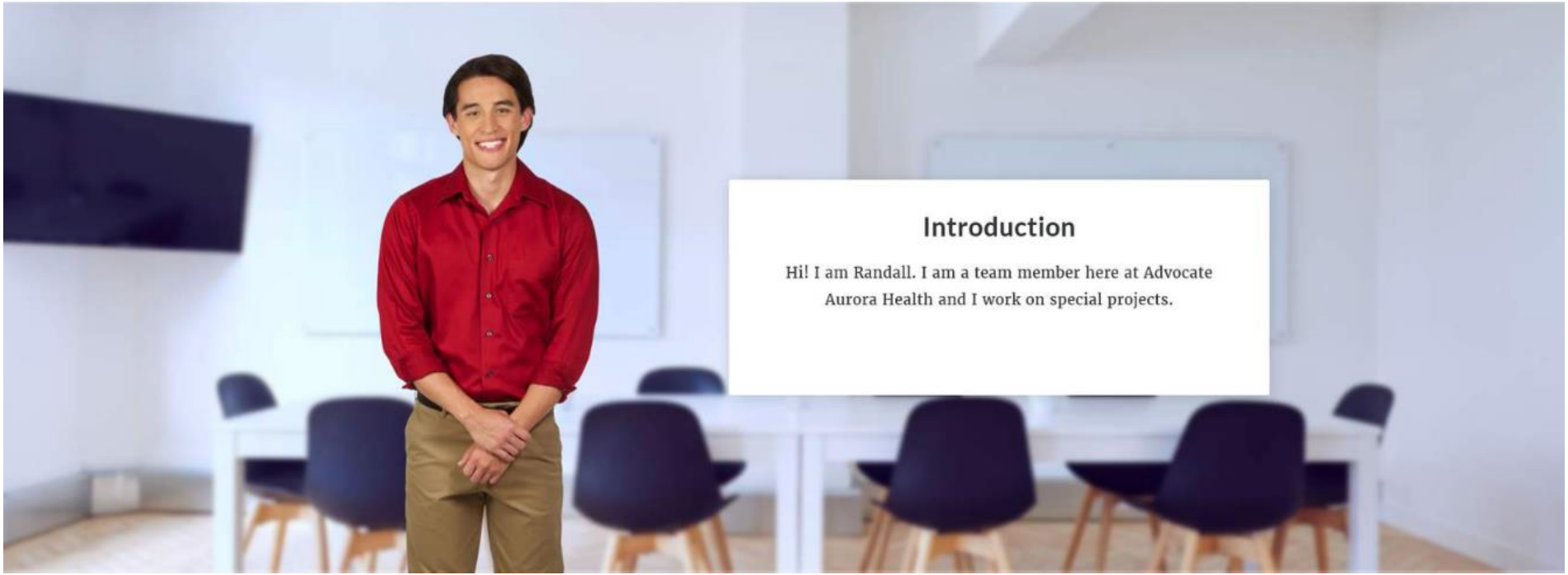
...aligned to our purpose, values and behaviors. So that we can...

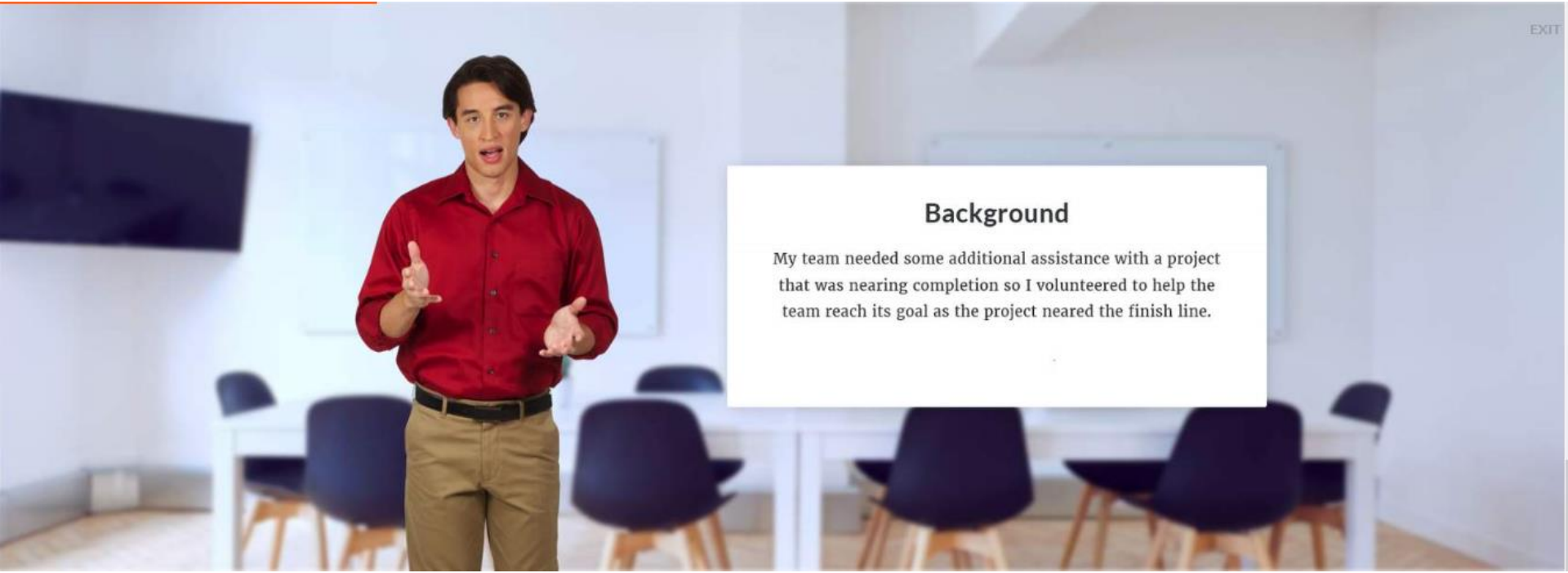
...transform care delivery to eliminate preventable harm and avoidable suffering caused by failures in safety, quality and service through an integrated approach. The following ***High Reliability Tools and Tactics*** are to be utilized in everything we do, to consistently achieve our desired outcomes.

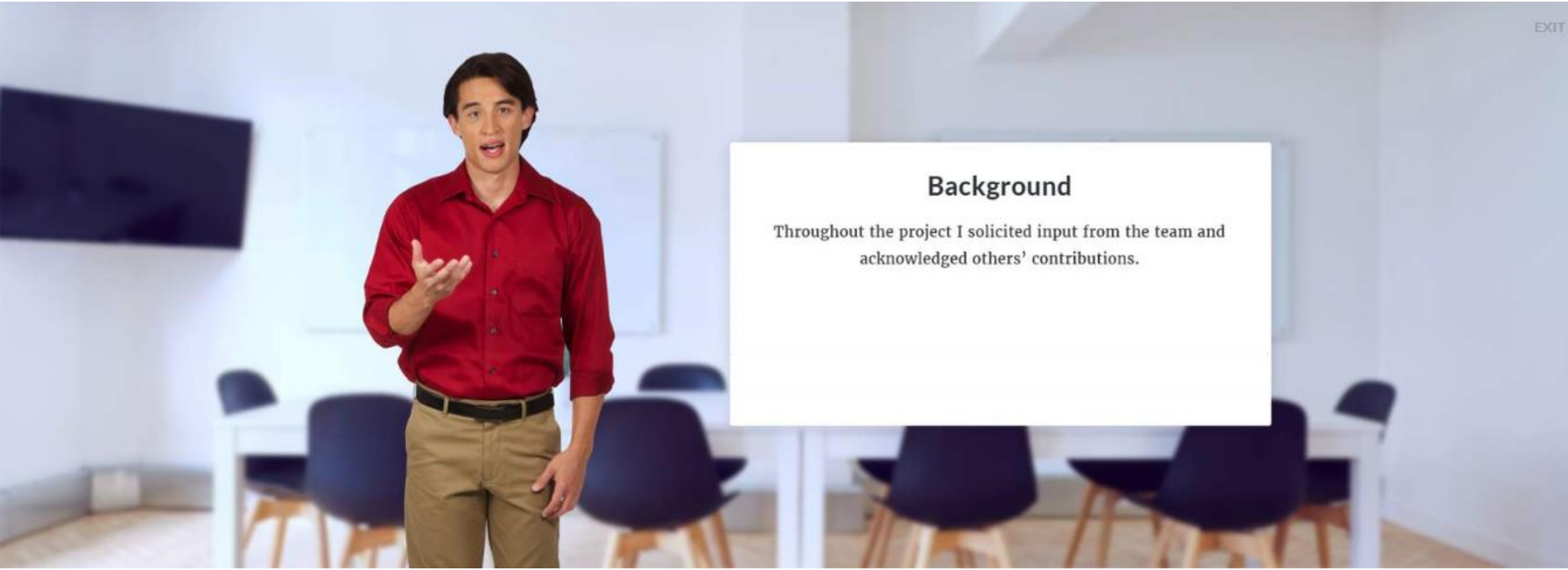
A Story For All

Congratulations, you are to the halfway point of this education. In the final section of this education, you will have an opportunity to immerse yourself in real-world examples so you can see how the Advocate Aurora behaviors and ***High Reliability Tools and Tactics*** are the keys to helping you perform the work that you do.

As you encounter a story, place yourself in the role of both the consumer as well as that of the team member. Reflect upon the behaviors and *High Reliability Tools and Tactics* being presented in the stories to determine how successful outcomes can then be


Introduction
Hi! I am Randall. I am a team member here at Advocate Aurora Health and I work on special projects.


EXIT
Background
My team needed some additional assistance with a project that was nearing completion so I volunteered to help the team reach its goal as the project neared the finish line.

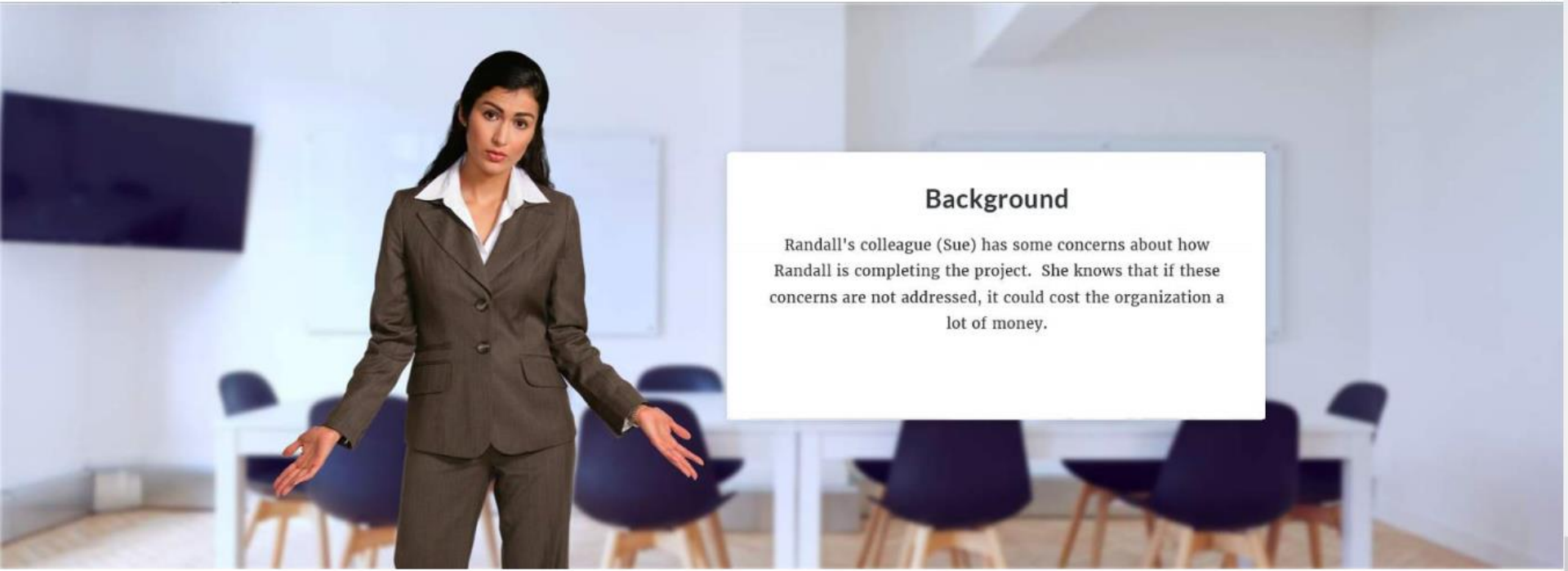

EXIT
Background
Throughout the project I solicited input from the team and acknowledged others' contributions.

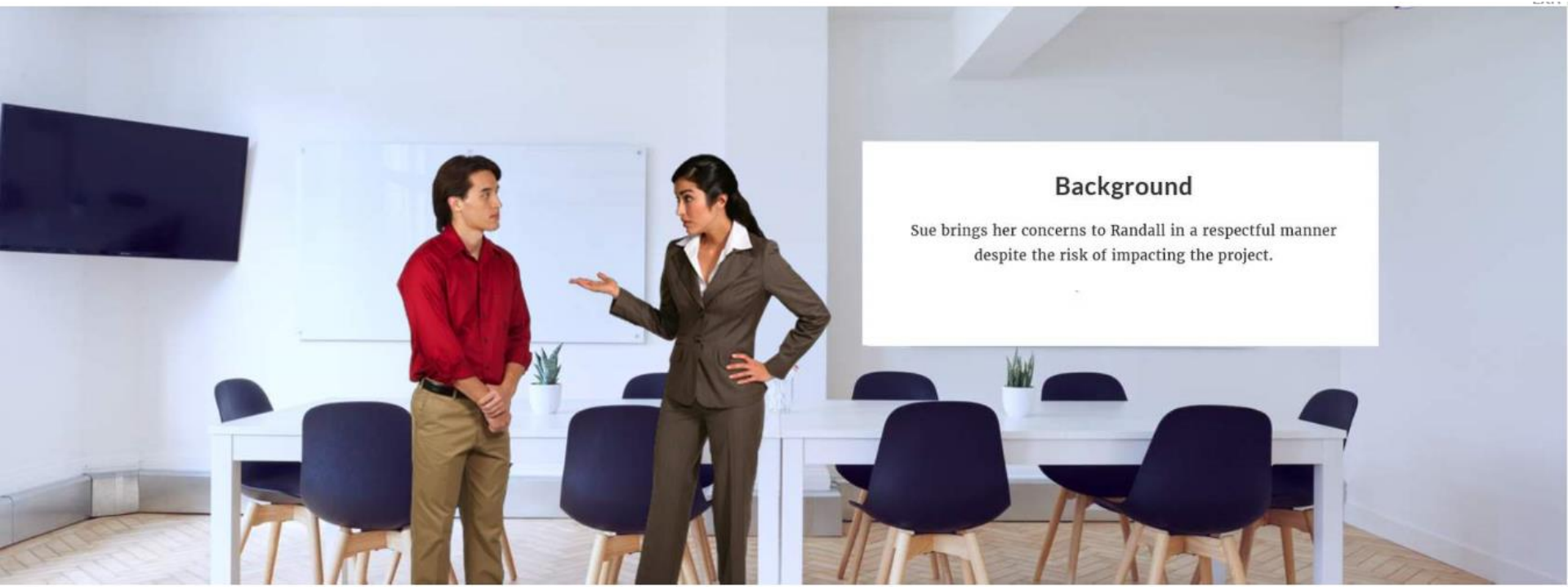
Which behavior did I use in the above scenario?

- ○ Collaborates
- ○ Communicates Effectively
- ○ Values Differences
- ○ Fosters Resilience
- ○ Ensures Accountability
- ○ Exhibits Courage

Which behavior did I use in the above scenario?

- ✓ Collaborates
- ✗ Communicates Effectively
- ✗ Values Differences
- ✗ Fosters Resilience
- ✗ Ensures Accountability
- ✗ Exhibits Courage


Background
Randall's colleague (Sue) has some concerns about how Randall is completing the project. She knows that if these concerns are not addressed, it could cost the organization a lot of money.

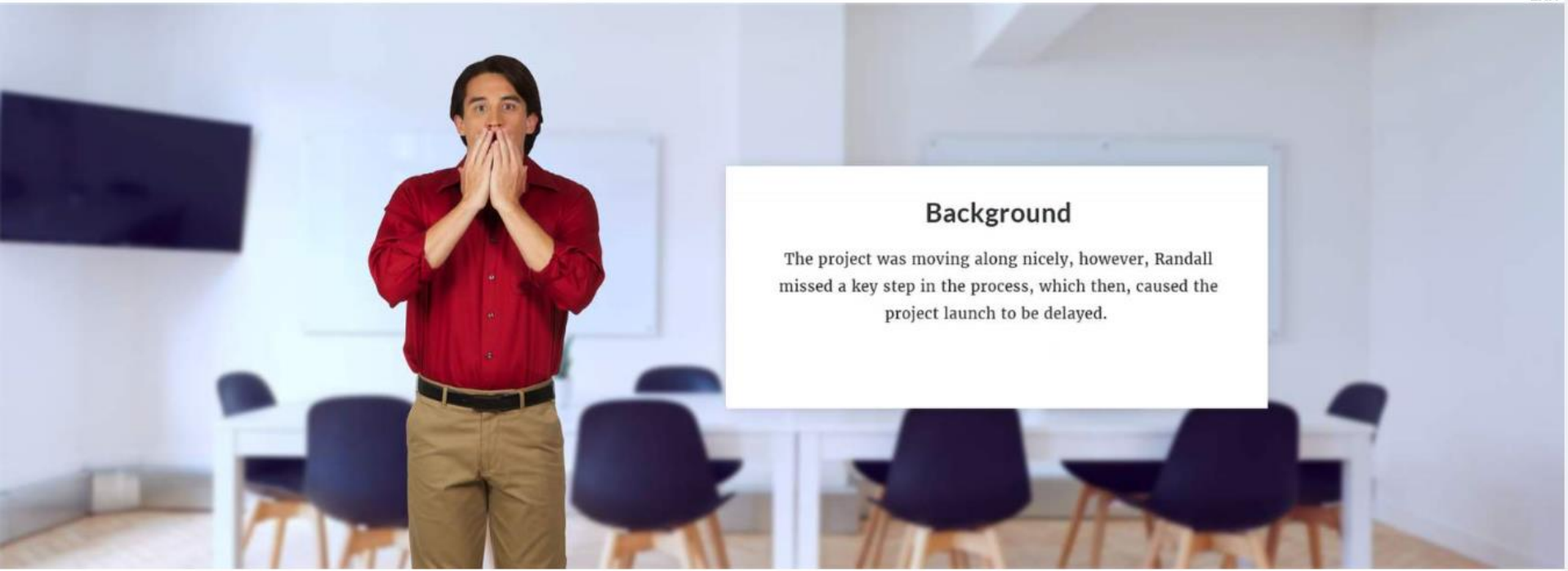

Background
Sue brings her concerns to Randall in a respectful manner despite the risk of impacting the project.

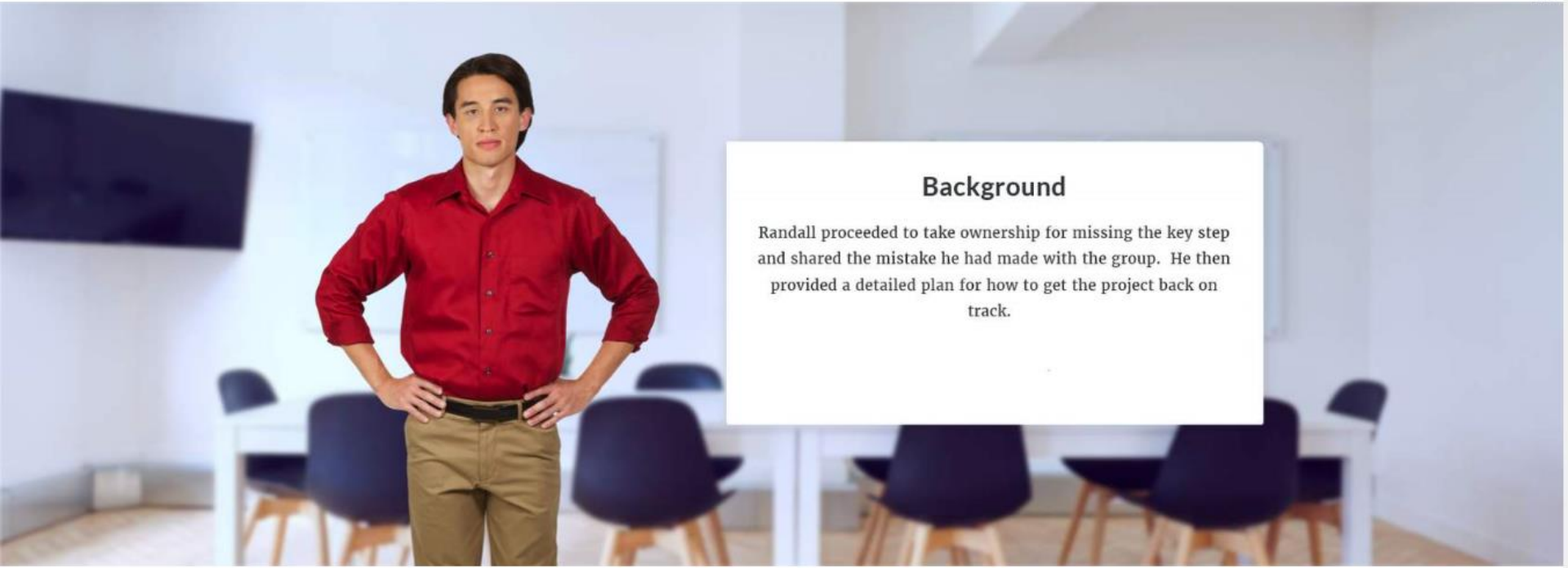
Which behavior did Sue demonstrate in the above scenario?

- ○ Collaborates
- ○ Communicates Effectively
- ○ Values Differences
- ○ Fosters Resilience
- ○ Ensures Accountability
- ○ Exhibits Courage

Which behavior did Sue demonstrate in the above scenario?

- ⊗ Collaborates
- ⊗ Communicates Effectively
- ⊗ Values Differences
- ⊗ Fosters Resilience
- ⊗ Ensures Accountability
- ✓ Exhibits Courage


Background
The project was moving along nicely, however, Randall missed a key step in the process, which then, caused the project launch to be delayed.

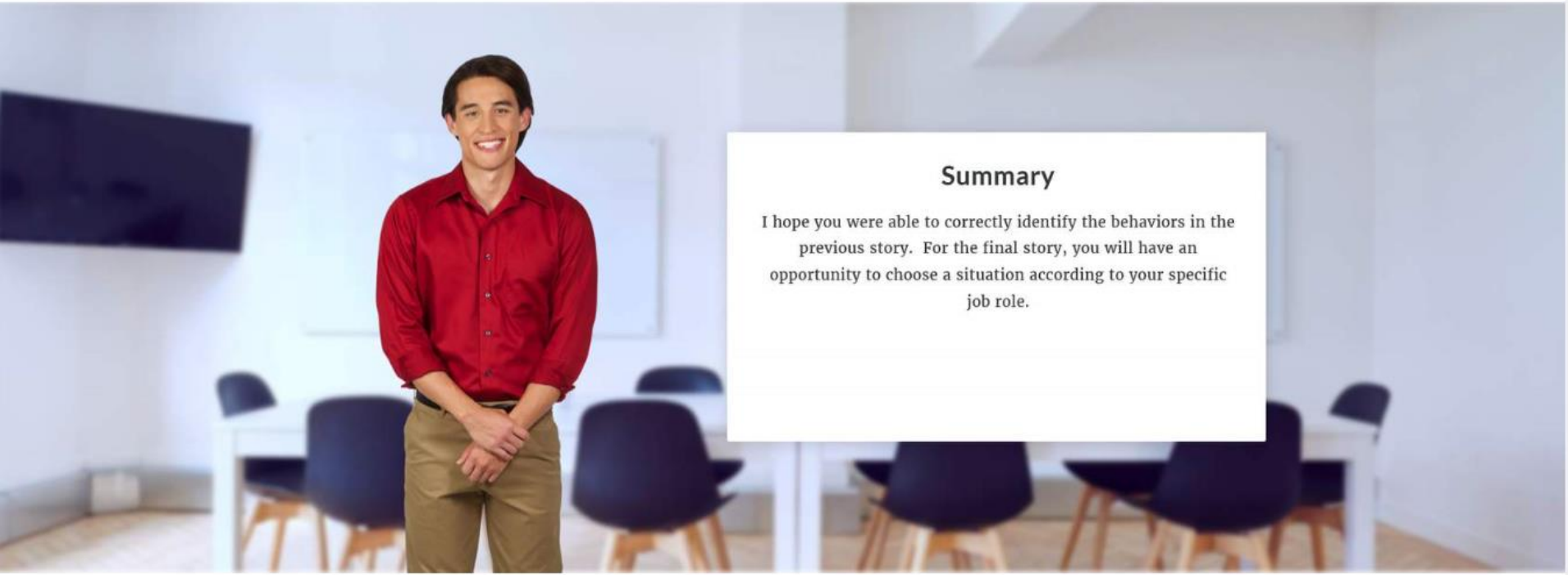

Background
Randall proceeded to take ownership for missing the key step and shared the mistake he had made with the group. He then provided a detailed plan for how to get the project back on track.

Which behavior did Randall demonstrate in the above scenario?

- Collaborates
- Communicates Effectively
- Values Differences
- Fosters Resilience
- Ensures Accountability
- Exhibits Courage

Which behavior did Randall demonstrate in the above scenario?

- ⊗ Collaborates
- ⊗ Communicates Effectively
- ⊗ Values Differences
- ⊗ Fosters Resilience
- ✓ Ensures Accountability
- ⊗ Exhibits Courage


Summary
I hope you were able to correctly identify the behaviors in the previous story. For the final story, you will have an opportunity to choose a situation according to your specific job role.

Mary's Story

Handover challenges
from acute to post-acute

Introduction

Mary, a 79 y/o with aortic stenosis was discharged from the hospital following a Trans-catheter Aortic Valve Replacement (TAVR) procedure.

1

Mary planned to stay with her daughter during her recovery.

Follow-up care included:

- Medication management
- PT/INR tests (blood work) to measure clotting factors
- Physical therapy for strengthening

2

Mary received two sets of discharge instructions from the hospital unit containing conflicting information on how to get her blood work done after discharge:

- She was instructed to see her primary care physician (PCP) on Monday for bloodwork.
- It was also planned that home health would perform the bloodwork.

3

Home Care Admission

Mary was first visited for an assessment by Ginny RN four days post-hospitalization. (The standard is to visit the patient within the first 48 hours of discharge from a facility. The delay was due to an error in address.)

4

Mary told Ginny RN she was supposed to have had her bloodwork at the clinic. (Ginny RN did not obtain the bloodwork nor did she clarify with the physician's office as to whom should be performing the test.)

5

Ginny RN did not check on the test results and did not verify with the physician that Mary's testing had been done at the clinic.

6

Ginny RN never visited Mary at home again because she was unable to reach Mary by phone. There was no emergency contact information available for Mary and Ginny RN did not notify her supervisor of the outstanding items.

Primary Care Physician (PCP) Follow Up

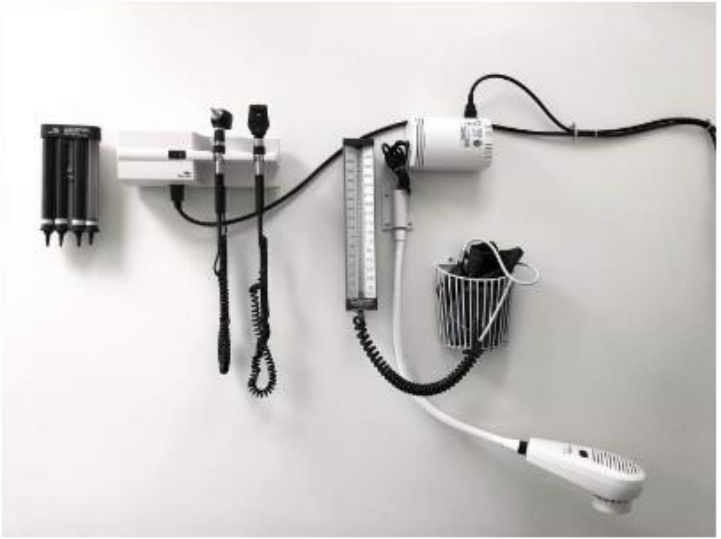
Mary was unable to keep her scheduled post hospital follow up appointment with her primary care physician (PCP) due to transportation issues.

When Mary called her PCP office to reschedule, she was told the provider's next appointment wasn't for another two weeks. Mary booked the first available appointment. She also left a voice message inquiring if she could be seen sooner.

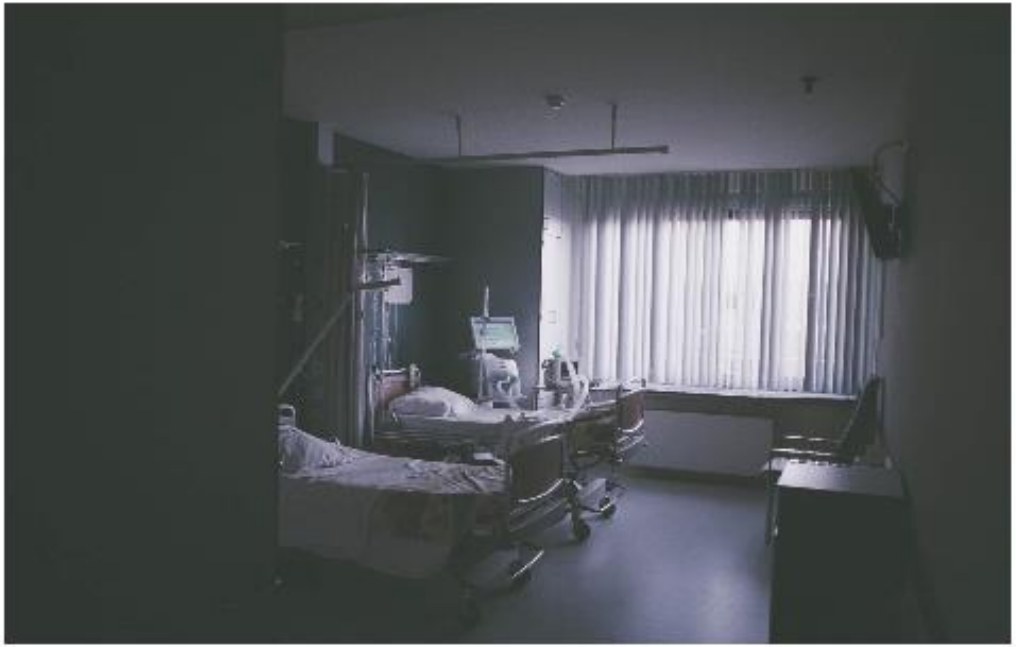
9

When the PCP received Mary's message, the he saw that Mary was already on the schedule and thought the message had already been taken care of so he did not return Mary's phone call.

The Discovery



When Mary finally made it to the office two weeks later, she was very sick with nausea/vomiting and was very weak. This is when the PCP discovered that the Mary was not getting any regularly scheduled bloodwork and medication adjustments.



Mary now requires a higher level of care in the hospital and is admitted.

Summary

As you can see, there were many facets where Mary did not receive the care she required. Reflect on Mary's story as you answer the next set of questions.


Reflecting on Mary's Story
Do your best to answer the questions correctly regarding the tools/tactics that could have been used so that Mary's care could have been more inline with Advocate Aurora's high reliability culture.
Post Acute Care


What tool/tactic would could have assisted the discharging nurse or physician with relation to the 2 different sets of discharge instructions?
1 STAR (Stop, Think, Act, Review)
2 Ask Clarifying Questions
3 Read and Repeat Back

AdvocateAuroraHealth


What is the best tool(s)/tactic(s) that should have been used when giving home health the patient's address?
1 Question and Verify and Ask Clarifying Questions
2 Letter/Number clarification and Repeat Back
3 Event Reporting and Handover

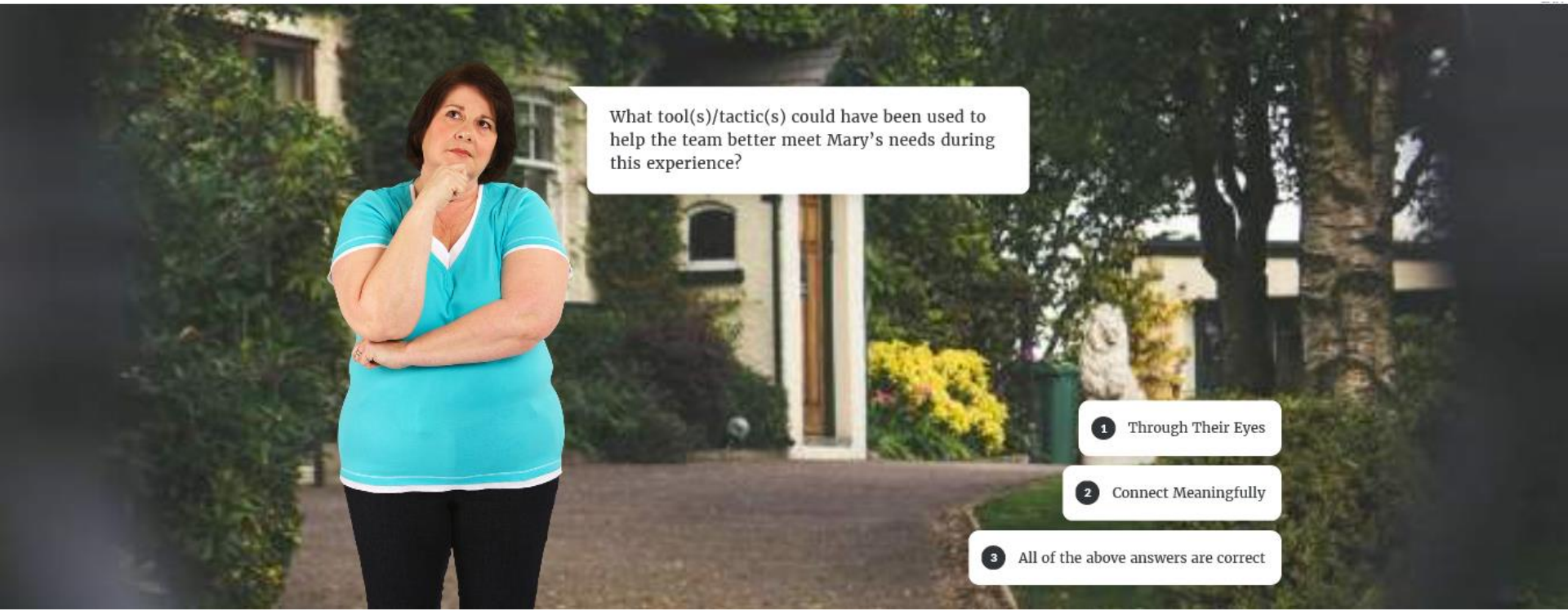

Letter/Number clarification and Repeat Back
Correct!

AdvocateAuroraHealth


Correct!
Question and verify


What is the best tool(s)/tactic(s) that the home health nurse should have used when she was unable to visit the patient for her next visit?
1 CUE (Concern, Understand, Escalate) and Event Reporting
2 Huddle and Appreciate Differences and Value Preferences
3 SBAR (Situation, Background, Assessment, Recommendations) and Manage Up

AdvocateAuroraHealth


What tool(s)/tactic(s) could have been used to help the team better meet Mary's needs during this experience?
1 Through Their Eyes
2 Connect Meaningfully
3 All of the above answers are correct


All of the above answers are correct
Correct!

A Mother's Story

Acute Care

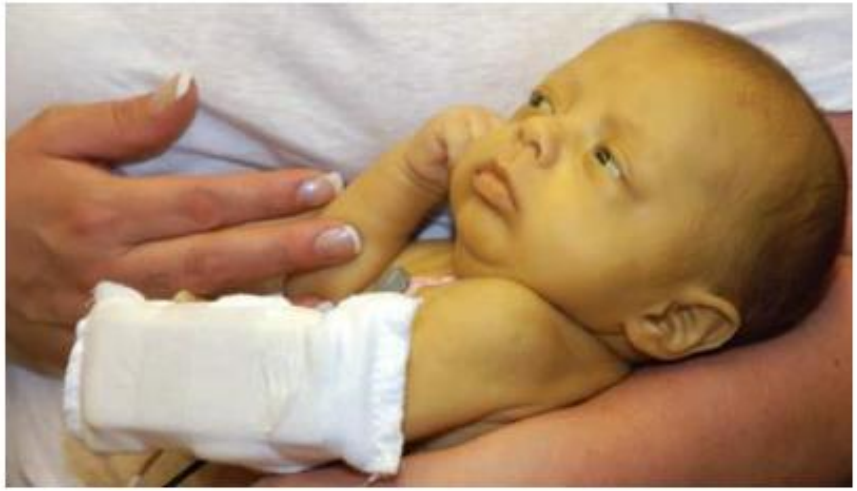
First Time Mom

Sue was in the Labor and Delivery unit after having delivered her first baby, Cal. All seemed to be going well.

The RN

At the time, baby Cal's nurse, Lisa RN, was caring for 2 other moms and their newborns in addition to Cal. One of the mom's she was treating was diabetic and a second mom she was treating required blood transfusions.

Concern



At the 15 hour mark post-delivery, Sue expressed to Lisa RN her concern about baby Cal, because he seemed to have a yellow appearance. (NOTE : Yellowing of skin and eyes occurs when newborns have a treatable liver condition called neonatal jaundice.)

Not What Happened

That's NOT what really happened...

What REALLY Happened

In actuality, Lisa RN brushed off the mother's concern and instead responded to the mother by saying: "This is your first baby, right? All new moms get nervous."

Lisa RN did not call anyone for a consult and the tests for jaundice had NOT been ordered or performed. The result was that both Sue and baby Cal were discharged.

Complications

Soon after, Baby Cal experienced seizures and developed Kernicterus. (Kernicterus is a rare kind of preventable brain damage that can happen in newborns with jaundice.)

The Result

Which ultimately resulted in a lifetime of severe physical disabilities for Cal.

What if..

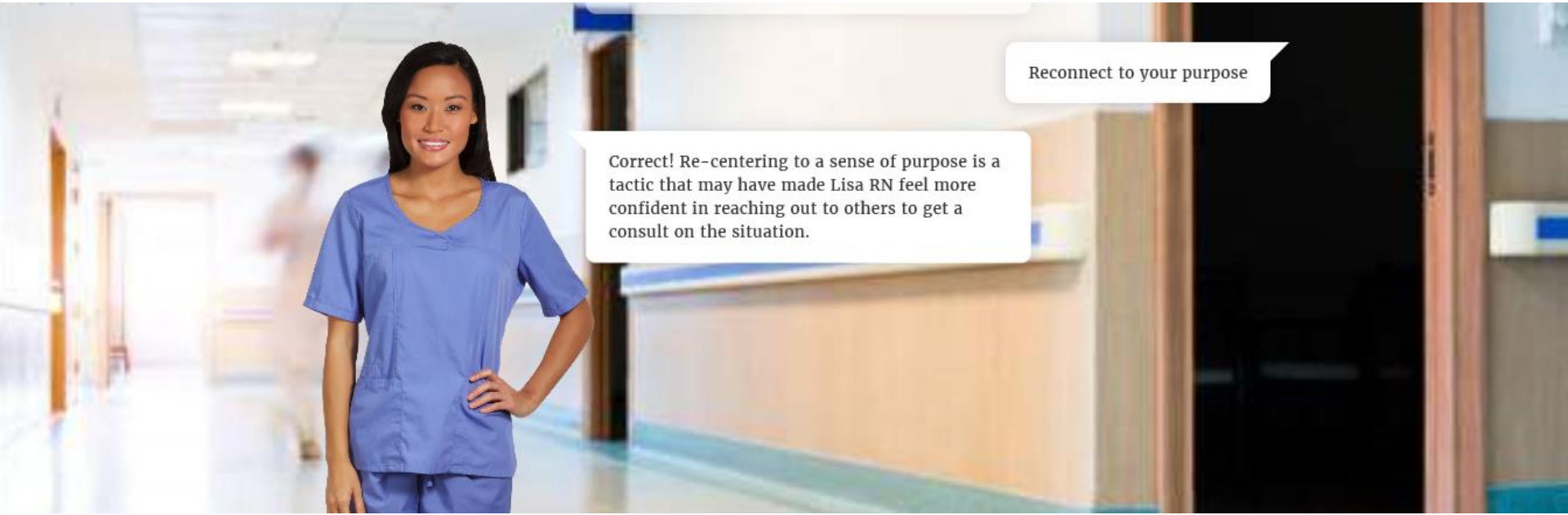
What if Lisa RN, had instead, looked at the situation through a different lens and leveraged the ***High Reliability Tools and Tactics***? We will explore this possibility further next.

What if...

A Mother's Story - Reflection

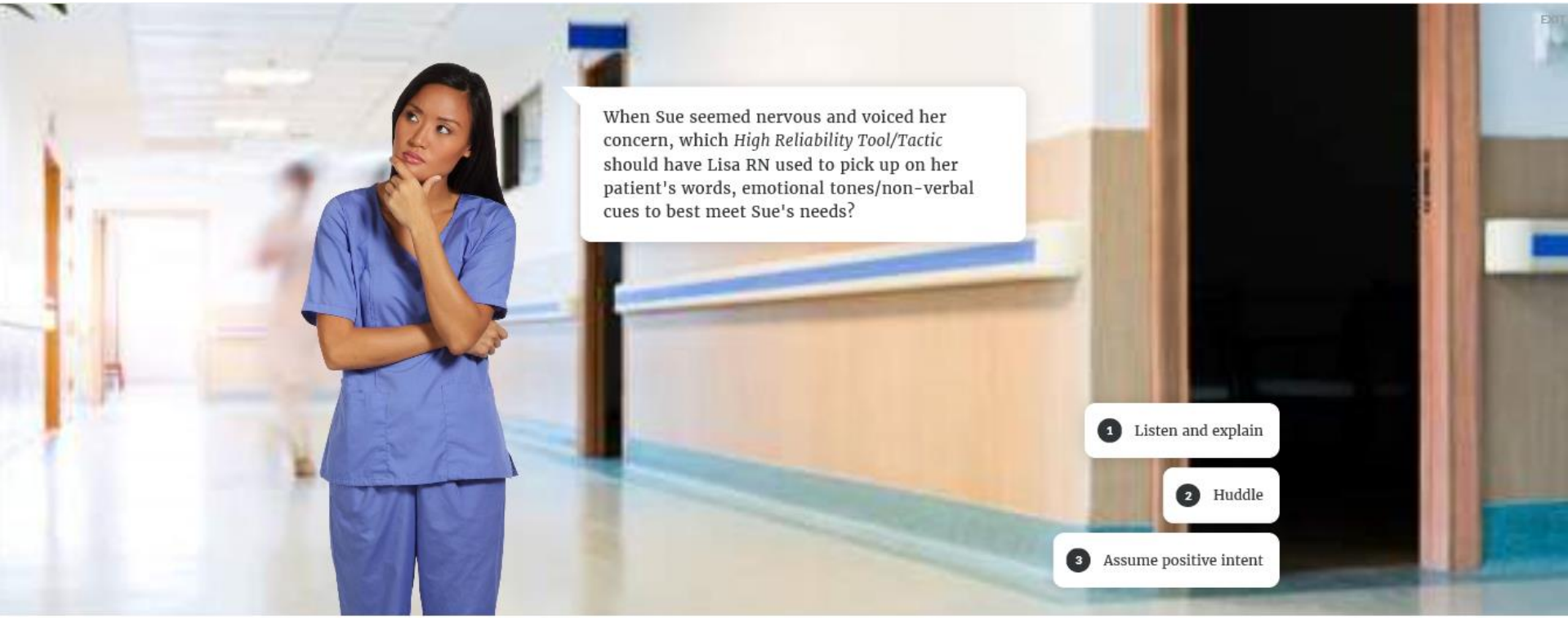
In the previous story, how might the situation and outcomes been different had Lisa RN instead used the *High Reliability Tools and Tactics*? Let's take a look...


What *High Reliability Tool/Tactic* should have Lisa RN used to help her find joy and meaning in her work so that she then might feel more confident to engage others in baby Cal's care?
1 Purposeful Rounding
2 Through their eyes
3 Reconnect to your purpose

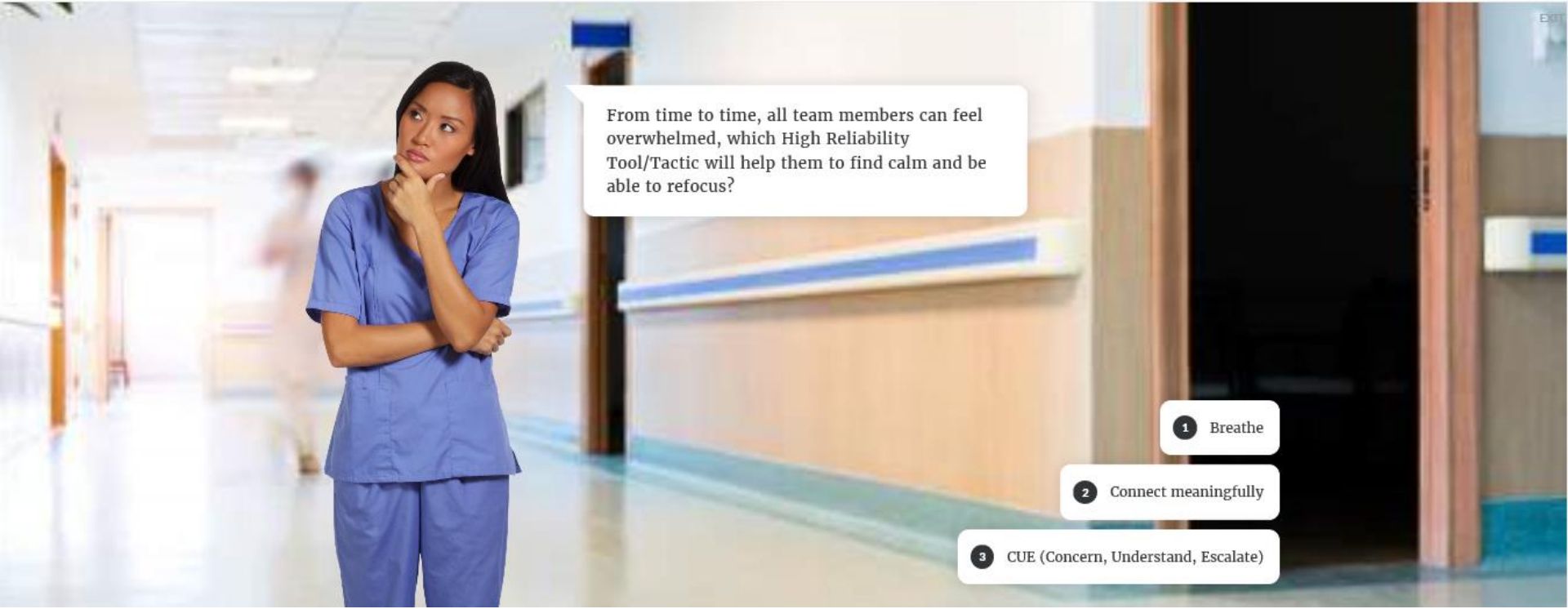

Reconnect to your purpose
Correct! Re-centering to a sense of purpose is a tactic that may have made Lisa RN feel more confident in reaching out to others to get a consult on the situation.


With baby Cal's mom, Sue, being a first-time mom, which High Reliability Tool/Tactic should have Lisa RN used to recognize and value the perspective of the patient so that Sue had felt heard?
1 SBAR (Situation, Background, Assessment, Recommendations)
2 Through their eyes
3 Take a Time-Out


Through their eyes
Correct! If Lisa RN had placed herself in a position to see the situation from Sue's perspective she may have been in a better position to address Sue's needs.


When Sue seemed nervous and voiced her concern, which *High Reliability Tool/Tactic* should have Lisa RN used to pick up on her patient's words, emotional tones/non-verbal cues to best meet Sue's needs?
1 Listen and explain
2 Huddle
3 Assume positive intent


Listen and explain
Correct! Listening first before explaining allows us to focus on the situation at hand, empathize and read verbal and non-verbal clues.


From time to time, all team members can feel overwhelmed, which High Reliability Tool/Tactic will help them to find calm and be able to refocus?
1 Breathe
2 Connect meaningfully
3 CUE (Concern, Understand, Escalate)


Breathe
Correct! When we step back and take deep breath by breathing in through our nose and out through our mouths we can slow things down and alleviate feelings of being overwhelmed.

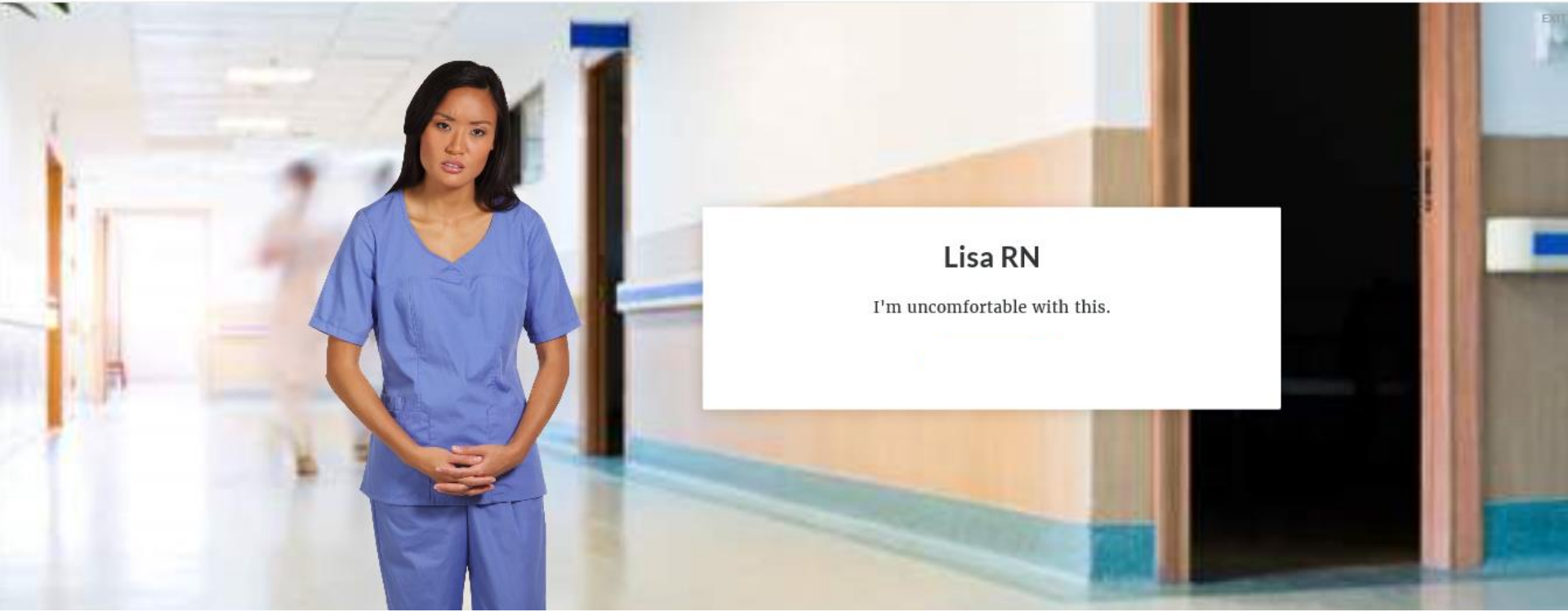

Lisa RN
Lisa RN has reviewed the *High Reliability Tools and Tactics* and now feels she is better prepared to reach out to others and make the call in baby Cal's case. Let's now see how this might progress...

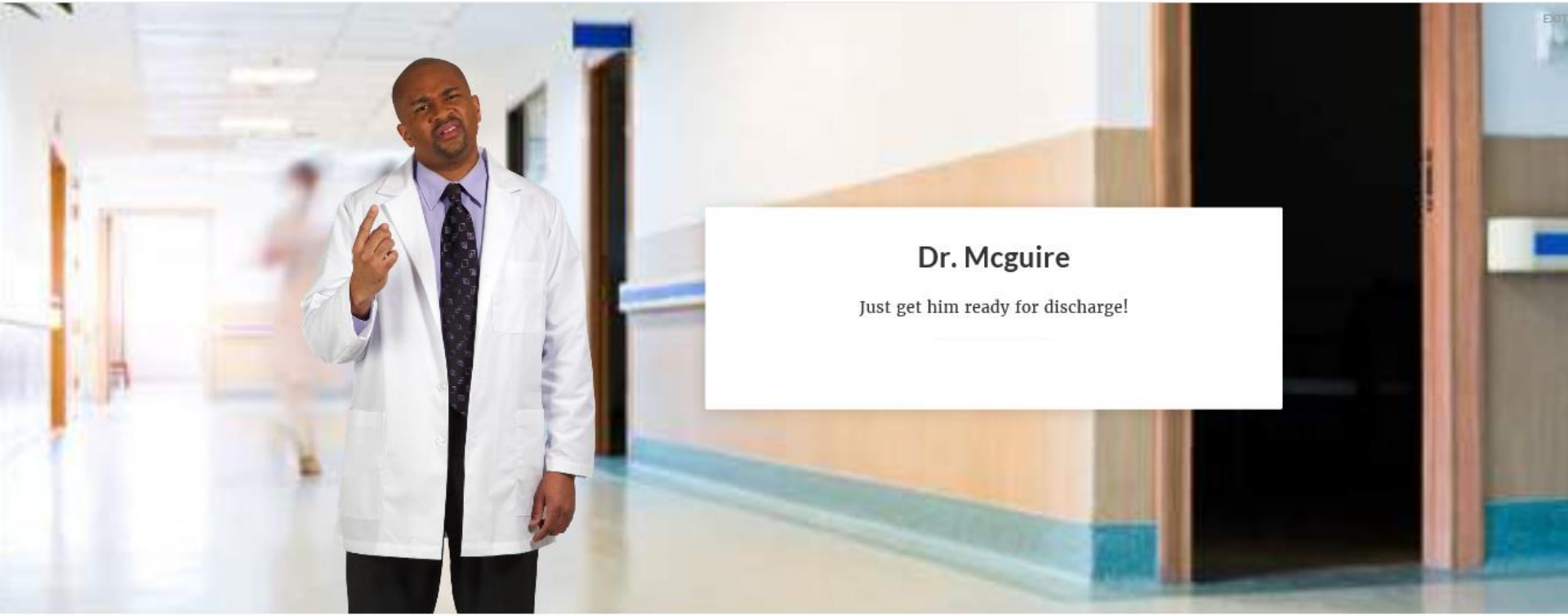

Lisa RN
I am going to let the Resident know about my concerns.


Dr. McGuire
Nah, I saw him this morning. He's fine.


Lisa RN
I'm still concerned. I think we need to work him up for jaundice.


Dr. Mcguire
I checked him already. He's not jaundiced.


Lisa RN
I'm uncomfortable with this.


Dr. Mcguire
Just get him ready for discharge!


Lisa RN
I am going to escalate my concern to the Attending.


What High Reliability Tool/Tactic did Lisa RN demonstrate when speaking with the Resident to help so her voice be heard?
1 Through their eyes
2 STAR (Stop, Think, Act, Review)
3 CUE (Concern, Understand, Escalate)


CUE (Concern, Understand, Escalate)
Correct! You have permission to speak up and make your voice heard, especially when communicating with someone perceived to be in authority. (Exhibits Courage)


Conclusion
Great job! You are well on your way to helping to create a High Reliability organization.

Conclusion

OUR PURPOSE

We help people live well.

We all play a key role in our High Reliability journey to help us achieve our purpose.

We hope you found this educational content both meaningful and useful so that you can begin to better understand and practice within the High Reliability journey Advocate Aurora is on.

Now it is time for you to purposefully practice the behaviors and utilize the *High Reliability Tools and Tactics* in your everyday work!

Together we help people live well.