Enhancing a Culture of Safety with Red Rules

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Objectives

Describe elements of Patient Safety initiatives at Novant Health

Discuss the challenges identified in defining the system Red Rules

Identify challenges associated with training and hardwiring the Red Rules

Discuss challenges with monitoring and measuring compliance
Novant Vital Statistics

Integrated healthcare system servicing four states

- $3.3 billion in revenue
- 26,000 employees
- 12 acute care hospitals, 2 hospitals under construction
- 159 ambulatory centers
- 3,015 licensed beds
- 118,000 discharges
- 119,000 surgeries
- 19,000 births
- 467,000 ED Visits
- 726,000 outpatient cases
- 3,892,000 physician encounters
- Approximately 5,000 medical staff

Note: Statistics reflect Novant Health 2009 Audit (reflects partial year data for HMA facilities)
Novant Health

Mission
Novant Health exists to improve the health of communities, one person at a time.

Vision
We, the employees of Novant and our physician partners, will deliver the most Remarkable Patient Experience, in every dimension, every time.

Values
- Compassion
- Personal Excellence
- Diversity
- Teamwork
What If ...

We could significantly reduce our errors?

There were "more tools and less rules" - fewer policies to fumble through?

We came to work knowing exactly what is expected of us?

We felt empowered to fix a problem or voice a concern related to safety?

We could leave work feeling absolutely confident that we delivered the best of care or services to our patients as possible?
Facts About Errors

1. Everyone makes errors – even experienced, professional people
2. We work in high-risk situations that increase the chance we will make an error
3. We can avoid most errors by practicing low-risk behaviors
4. Culture affects how we behave, and our behaviors determine outcomes
5. Most near-misses and significant events are due to system or process problems
Timeline of First Do No Harm Initiative

2007
- Corporate FDNH Leader Kickoff – created Safety Behaviors and Error Prevention Tools including Red Rule
- Adopted Serious Safety Event scoring methodology
- Created Education and Marketing Plans

2008
- Mandatory FDNH education for Leaders, Staff and Medical Staff
- Daily Safety Calls initiated in acute care
- FDNH Structure of Corporate and Market Workgroups
- Marketing Plan expanded

2009
- Red Rule Review
- Education roll-out to MGP Practices
- Safety Coach Pilot
- Marketing Plan expanded

2010
- Education roll-out to Imaging Center and expanded education to Medical Staff
- Safety Coach Program implemented and expanded to medical group practices (MGP)
- Safety Calls expanded to MGP
- Marketing Plan expanded

2011
- Goal “Getting to Zero” Serious Safety Events
- Focused system-wide efforts on top SSE categories
- Safety Calls and Safety Coach Program expanded to Imaging Centers
- FDNH education refresher planned
Red Rules for Safety

An act that has the highest level of risk or consequence to patient or employee safety if not performed exactly, each and every time

“Red” designates the highest priority for exact compliance – STOP action if you can’t comply
Red Rule

Always verify patient identity using two identifiers before any treatment, therapy, transport, procedure or specimen collection.

What are the two identifiers?

Name & Date of Birth
Safety Behaviors & Error-Prevention Tools

1. Practice with a Questioning Attitude
   A. Stop, Reflect & Resolve in the face of uncertainty

2. Communicate Clearly
   A. Use SBAR-Q to share information
   B. Communicate using three-way repeat backs & read backs
   C. Use phonetic and numeric clarifications

3. Know & Comply with Red Rules
   A. Practice 100% compliance with Red Rules
   B. Expect Red Rule compliance from all team members
   C. If compliance with a Red Rule is not possible, stop action until any uncertainty can be resolved

4. Self-Check: Focus on Task
   A. Use the STAR technique

5. Support Each Other
   A. Cross-check and Assist
   B. Use 5:1 Feedback to encourage safe behavior
   C. Speak up using ARCC – “I have a concern”
Power of Silence

Without saying a word...

“What you permit, you promote.”

Kathleen M. Vollman
Nurse, scientist & educator

“The world is not a dangerous place because of those who do harm, but because of those who look on and do nothing.”

Albert Einstein
Leaders put Safety F.I.R.S.T.

**Red Rules for Safety**

- Find and fix system problems that make Red Rules compliance challenging
- Implement intuitive design to support Red Rules compliance
- Stand behind individuals who stop the line when they cannot comply with a Red Rule
- Recognize Red Rule compliance and follow-through with fair consequence for non-compliance
## Know and Comply with Red Rules

100 percent compliance. 100 percent participation. 100 percent of the time.

<table>
<thead>
<tr>
<th>Why It’s Important</th>
<th>Red Rules are acts having the highest level of risk or consequence if not performed exactly every time. They are safety-critical actions.</th>
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<tbody>
<tr>
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<td>Individuals must expect exact compliance from themselves and their teammates.</td>
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<td>If compliance is not possible, action must be stopped until any uncertainty is resolved.</td>
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<td>Barriers to compliance must be reported to leaders, who are responsible for finding and fixing system problems (in the Swiss Cheese Model).</td>
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<td>Leaders express the importance of actions through Red Rules, leading staff to have clear understanding of their critical nature to patient safety.</td>
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### Red Rule

Always verify patient identity using two identifiers (name and date of birth) before any treatment, therapy, transport, procedure or specimen collection.

### Consequences for Non-Compliance

Everyone makes mistakes, so unintended human error will be treated differently than choices not to comply with expectations.

- **Non-compliance:** Fair consequences will be applied consistently with the progressive-discipline policy.
- **Honest mistakes:** Not automatic termination.

### Expected Results

- Consistent patient identification
- Elimination of errors related to patient identification
- Reporting of barriers to leaders
- Improvements in systems and processes
From Best Practice...

**Step 1: Set Expectations**
Define Safety Behaviors & Error Prevention Tools proven to help reduce human error.

**Step 2: Educate**
Educate our staff and medical staff about the Safety Behaviors and Error Prevention Tools.

**Step 3: Reinforce & Build Accountability**
Practice the Safety Behaviors and make them our personal work habits.

...to **Common Practice**

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NOVANT HEALTH
Red Rule Challenges

HR identified discrepancies in how the Red Rule was being applied – noting differing applications of consequences to a Red Rule violation

Operational Leaders identified confusion over what constituted a Red Rule violation

No clear data report to identify Red Rule violation trends, thus potentially missing opportunities for improvement
Response to the Red Rule Challenges

Leadership Tool Kit

Employee review of correct process(es) to ensure compliance with proper patient identification

Policy revisions to ensure consistent language

Tied event reports of identified Red Rule violations with HR data

Focus on identified top opportunity with Red Rule
Performance Management Decision Guide

Adapted from James Reason’s Decision Tree for Determining the Culpability of Unsafe Acts and the Incident Decision Tree of the National Patient Safety Agency (United Kingdom National Health Service)

Start

Deliberate Act Test
- D1: Did the individual intend the act?
  - Yes
  - No

Incapacity Test
- D2: Did the individual act with malicious intent (i.e. to cause individual harm or other damage)?
  - Yes
  - No
- I1: Is there evidence of ill health, a medical condition, or substance abuse? [See Fitness for Duty, HR Policy 3060]
  - Yes
  - No

Compliance Test
- C1: Did the individual depart from policies, procedures, protocols, or generally accepted performance expectations?
  - Yes
  - No

Substitution Test
- C2: Were the policies, procedures, protocols, or performance expectations available, understandable, workable, and in routine use?
  - Yes
  - No
- C3: Is there evidence that the individual chose to take an unacceptable risk OR has a trend in poor performance or decision making?
  - Yes
  - No
  - S2: Were there deficiencies in related training, experience, or supervision?
    - Yes
    - No

- C4: Were there significant mitigating circumstances that justify the act in this case?
  - Yes
  - No

Malevolent or Willful Misconduct
- Consult HR/Employee Relations
  - Actions to Consider
    - Disciplinary action (immediate suspension, progressive discipline up to and including termination)
    - Report to professional group or regulatory body through HR
    - Law enforcement referral through VP
- Identify Contributing System Factors

Possible System Induced Error
- Consult HR/Employee Relations
  - Actions to Consider
    - Console
    - Coaching
    - Mentor assignment
    - Increased supervision
    - Performance improvement plan
    - Adjustment of duties
- Identify Contributing System Factors

Medical Condition and/or Substance Abuse
- Consult HR/Employee Relations
  - Actions to Consider
    - Immediate call to EE/Occupational Health
    - Follow HR direction
- Identify Contributing System Factors

Possible Unintended Human Error
- Consult HR/Employee Relations
  - Actions to Consider
    - Console
    - Coaching
    - Mentor assignment
    - Increased supervision
    - Performance improvement plan
    - Adjustment of duties
- Identify Contributing System Factors

Possible Reckless or Negligent Behavior
- Consult HR/Employee Relations
  - Actions to Consider
    - Disciplinary action (immediate suspension, progressive discipline up to and including termination)
    - Job-fit consideration
- Identify Contributing System Factors

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Focus: Mislabeled/Unlabeled Specimens

Goal to decrease mislabeled / unlabeled events to zero:

- Monthly reports generated indicating number of reported mislabeled/unlabeled events by facility by unit
- Identify opportunities or trends and implement process improvement activities to improve process
Focus: Mislabeled/Unlabeled Specimens

Nursing

- Met with Lab Leaders to ensure consistent:
  - labeling definition requirements
  - response to mislabeled / unlabeled specimens
  - reporting of mislabeled/unlabeled specimen events

- Identified trends and shared with nursing leaders (and PDSA teams where applicable)
  - Implemented Rapid cycle (PDSA) process improvement activities; i.e. in GWM focus on specimens received from the ED
Focus: Mislabeled/Unlabeled Specimens

- Shared Lab defined specimen labeling requirements with Nursing Leaders and NPNC representing staff members from each facility
- NPNC delivers consistent messages and sets expectations on successful implementation and compliance with the Patient Identification Policy and provides Red Rule in Skills Fairs
This represents a 57% reduction in reported Mislabeled/Unlabeled Events since Jan-Feb 2012.
Lessons Learned

Do not assume a “known” rule is consistently understood (in this case, 2 patient identifiers)

Focus on trends and corresponding improvement activities around your Red Rule(s)
Change is a process, not a destination.