Improving Safety Culture through Simulation: Influencing Policy and Practice Changes

12th National Doctors of Nursing Practice Conference

August 7-9, 2019

Washington, DC Georgetown

Improving Partnerships with Patients and Families Through Simulation to Create a Culture of Safety

Courtnay E. Caufield, DNP, RN, MSN, CENP, NE-BC, RN-BC, CPN

Simulation was done at Cedars-Sinai Medical Center in Los Angeles, CA

Objectives

Objective 1

Identify three scenarios that would benefit from the use of simulation and involve standardized actors to improve and change organizational policy.

Objective 2

Recognize the value of the patient voice when changing policy and or institutional processes that impact their care.

Objective 3

Identify one policy at their organization or institution that would be altered if the patient and or family voice was heard, recognized and understood.

Purpose

This presentation will discuss how the DNP leader utilized best practices to change policy and perception around the use of parents as standardized patients in simulation in order to reduce harm and to improve healthcare outcomes.

By creating a culture of innovation and safety, DNP leaders think differently about using evidence to implement change, alter and update policy and collaborate with the clinical team as well as patients to improve safety.

The importance of communication between nurses, patients, and their family members with respect to treating each other as partners in safety cannot be overstated.

The Issue to Be Addressed

The Institute of Medicine's (IOM) landmark report;

To Err is Human: Building a Safer Health System, released in November 1999, notoriously reported that 44,000 to 98,000 Americans died each year due to preventable mistakes in hospitals.

Simple systemic flaws, minor medical errors, or "near-misses" that could lead to improved patient safety are rarely addressed or reported
(AHRQ, 2017).

Why is this important?

According to the Joint Commission

Sentinel Event Alert

Released in 2007, Leaders can help create the personal responsibility establishing trust and clear performance expectations among employees within a psychologically safe environment.

This includes policy change and guidelines of expectations and promoted behaviors.

When staff report close calls and hazardous conditions, leaders can act by addressing concerns, resulting in improvement in safety.

Background Problem Statement

Why Is This Important

Studies suggest the ability of the bedside nurse to effectively communicate, speak up about concerns to improve the care with patients and families, has a major impact on harm reduction, improves safety, promotes the ability of patients and families to report mistakes, and improves their perceptions of effective communication (Rosen, Stenger, Bochkoris, and Kwoh, 2009).

- This project aimed to translate existing evidence into practice to explore nurses' ability to promote safety partnerships with patients and families.
- The impact to policy change in the organization will be discussed as well as future global policy change goals.

- ***The use of simulation training was identified as a way to improve caregiver confidence and ability to report concerns.***

What Was Done?

A systematic search of the evidence was completed.

:

The quality of each study was assessed and evaluated. Multiple studies returned examples of the benefit of family centered care rounds, family voice and implementing tactics to increase a safety culture and reduce potential for harm.

A review of current internal policies that may be impacted was completed, reviewed and ranked for urgency.

Summary of the Literature Review

- November, 1999 brought about a release of a report prepared by the prestigious National Academy of Science's **Institute of Medicine** (IOM) making medical mistakes and their magnitude of the risks to patients receiving hospital care to common **public knowledge**.

History and Relevance of this study:

- Safety Rounds Implementation (Connor, DeMarco and Price, 2004)

- At Dana Farber Cancer institute, a fatal medication error in a child, sparked an initiative around implementing "Safety Rounds" with a proactive approach to increase reporting of safety concerns to prevent harm.

Relevance:
Pediatric Heparin error in 2008 at Cedars-Sinai

The Quaid Foundation was formed as health activists/ parents.

thequaidfoundation.org -- dedicated to helping minimize the kind of medical mistakes in hospitals that befell his newborn twins.

History and Relevance of this study:

- In another study, family-centered multidisciplinary rounds were used to present the patient and their diagnosis to the care team (Rosen, et al., 2009).

Unique feature:
Clinical information was presented by the patient or family

Outcomes: promotes teamwork and family–patient empowerment.

- Communication is often a point of weakness in clinical settings.

- May cause: safety risks, poor outcomes, readmissions, and contribute to patient and family confusion (Institute of Medicine, 2013).
  - *Relation to Project: Communication Barriers were Reported by Nurses.*

Barriers To Communication		
Physical Barriers	Language Barriers	Emotional Barriers
Emotional Barriers- Not Ready	Expectations	Prejudices
Hearing barrier	Visual Barrier	Resistant
Devices	“Communication Ability	Importance/ Policy Support

Started with a SWOT Analysis

Desired State

- Caregiver Confidence in Communication
- Standards Changed and Organizational Stance

Gap in Current State

- Training “Focused on Communication” did not exist
- No Guidelines/ Policy To Support Changes Needed
- Lack of Consistency in Communication
- Nurses Reported Low Confidence

Outcome Goal

- Implement Simulation-Based Training
- Include PFCC Families in Training
- Improve Nurse Confidence
- Implement New Standard (*Organization/ Policy Support*)

Patient and Family Council Goal

- Participate in simulation training
- Provide feedback
- Train as standardized actors
- Pay it forward

Connection to purpose

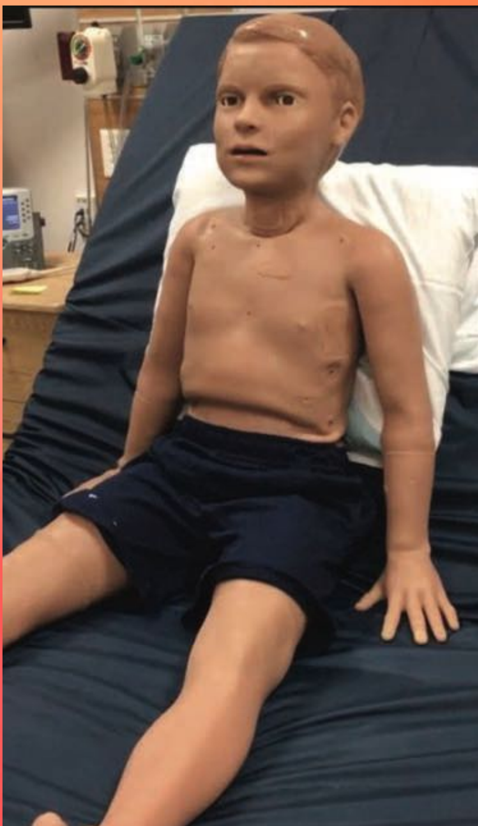
- Simulation
  - With Simulation equipment or humans/ Standardized Actors?
- In Simulation Center or In-Situ?
  - Both areas valuable, was able to purcase equpiptment to tape the sim for debriefing in-situ in the unit.

We did simulation with both.

- If participants have buy in, both valuable.
- Parents gave real feedback and examples of scenarios where a policy or procedure limited ability to care for their child in the way that they wanted.

Connection to purpose

- Through simulation and debriefings, care teams can improve safety and move towards improved care planning by showing participants how to avoid events by exposing gaps in processes during usual routines (Duffy et al., 2004).



Simulation with PFCC Parents using **technology** to communicate with child.

Discussed Safety and Psychological Safety with parents.

POLICY Change Supported use of this Standard.
Participant Idea and Debriefing outcome- More ability to talk to patients in isolation, ability to electronically share concerns.

What Tools Were Used?

Four Prong Approach

Impact Organization Policy and Practice

- Increase "near miss" reports in MIDAS

Increase nurse confidence in conversations around safety and mistakes

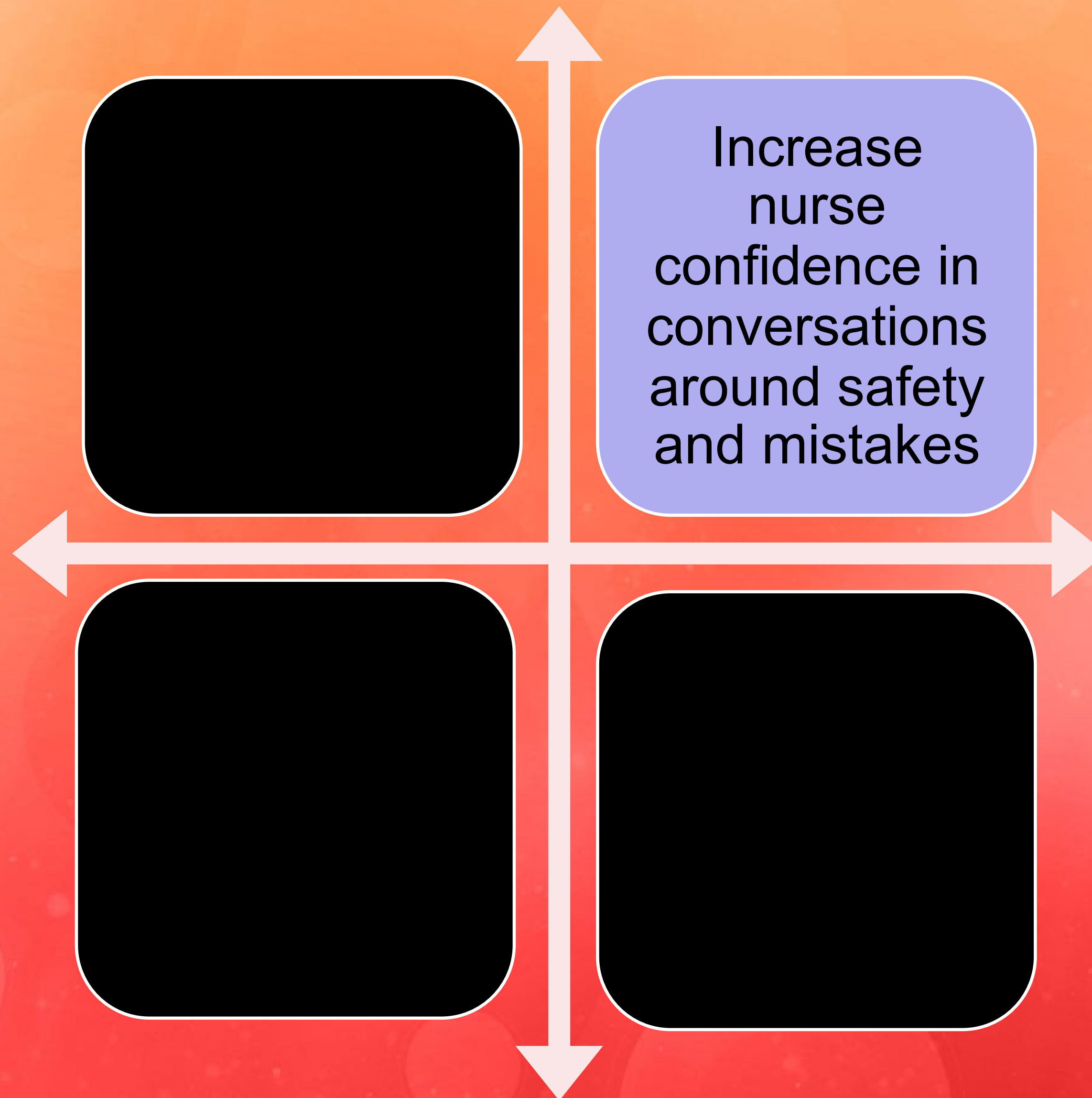
Improve HCAHPS Measure "reporting mistakes"

Establish family participation in simulation

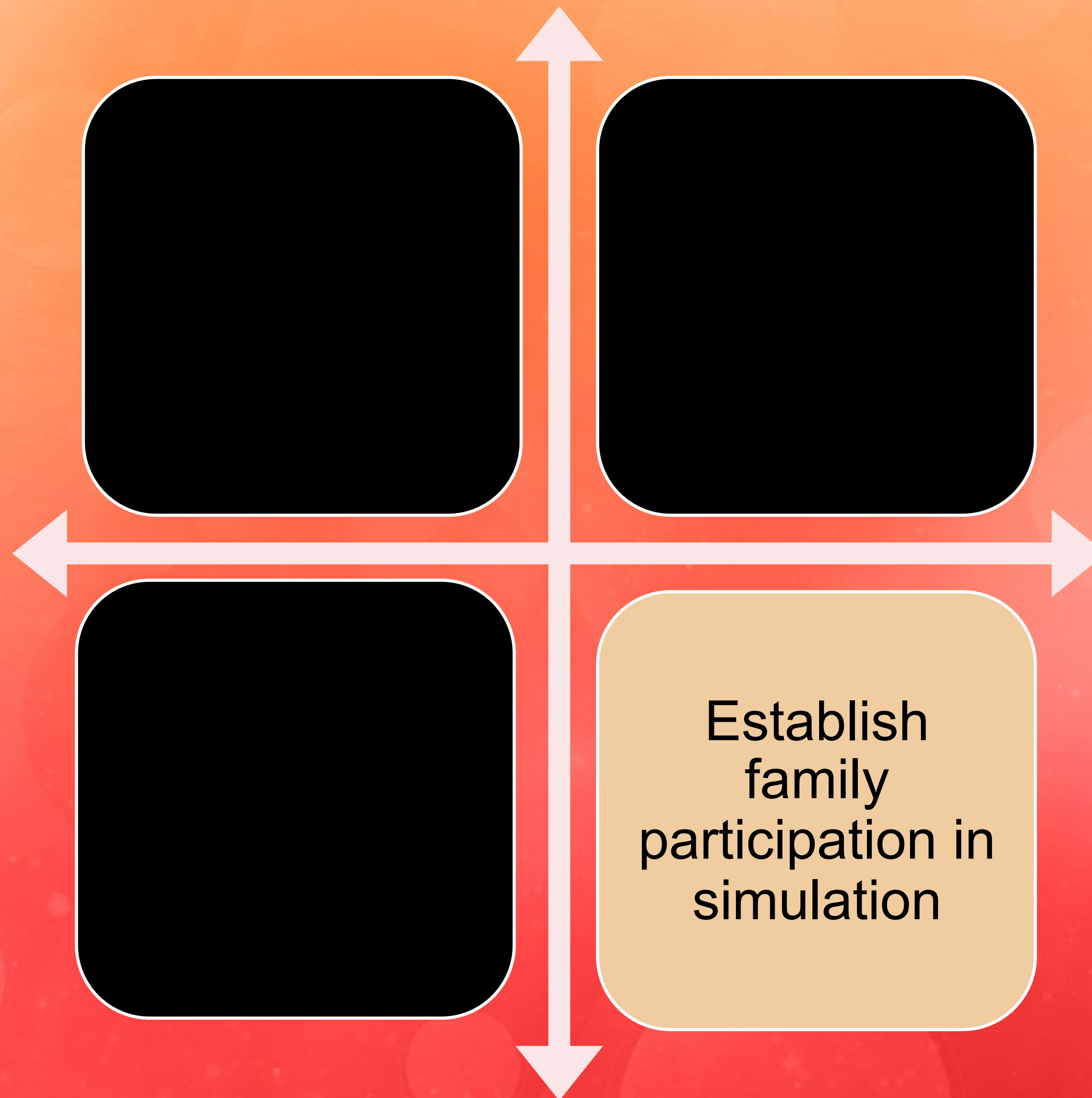
Four Prong Approach

- Increase "near miss" reports in MIDAS

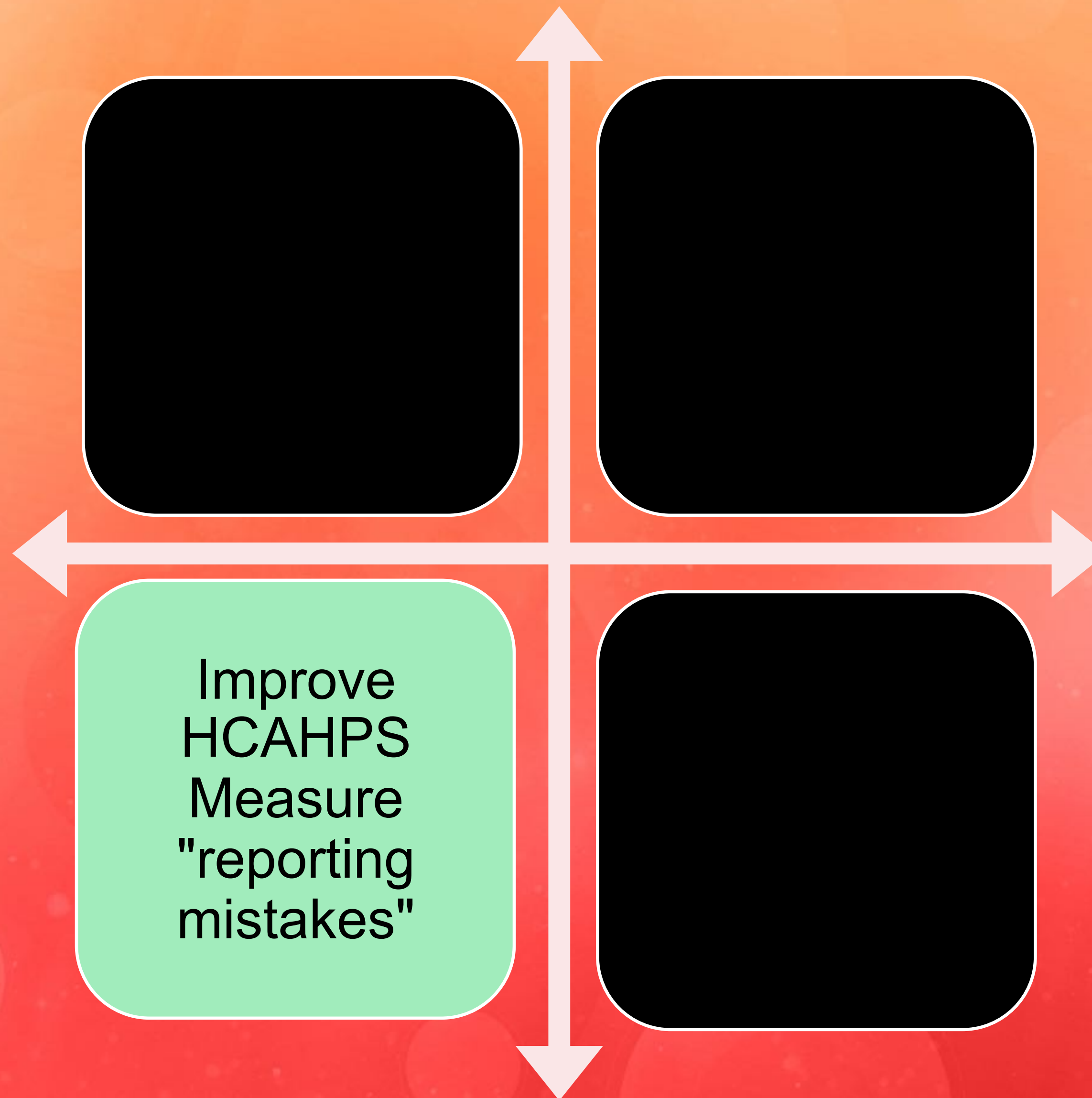
Four Prong Approach



Four Prong Approach



Four Prong Approach



Approach Intervention

- MIDAS- Education and discussions
  - Ongoing events review and recognition with Multidisciplinary team
  - Public sharing, normalize reporting safety

- HCAHPS Measure
  - PFCCC Partnership
  - Partner with Safety Team & Initiate Tools

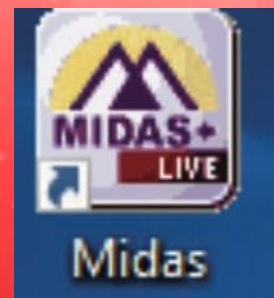
Approach Intervention

- Confidence and Communication- Simulation Center Training
  - Pre-Survey & Post-Survey on Nurse Confidence
  - Education & Role Modeling
  - Debriefing
  - Repeat

- PFCCC Family Participation in Simulation
  - Broke ground!
  - Established Value
  - Offered Ongoing tools
  - Valuable input

MIDAS REPORTING

Goal- Increase Reporting of Near Misses and Decrease the Reporting of Actual Events

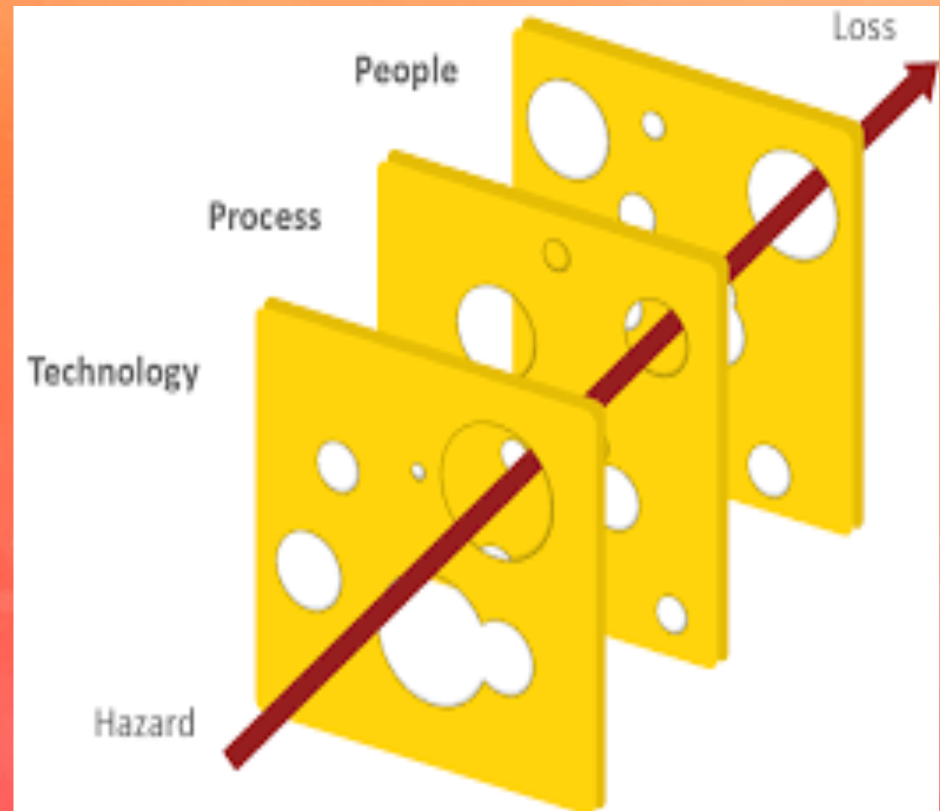


MIDAS Reports Were Considered a "Disciplinary Tool"

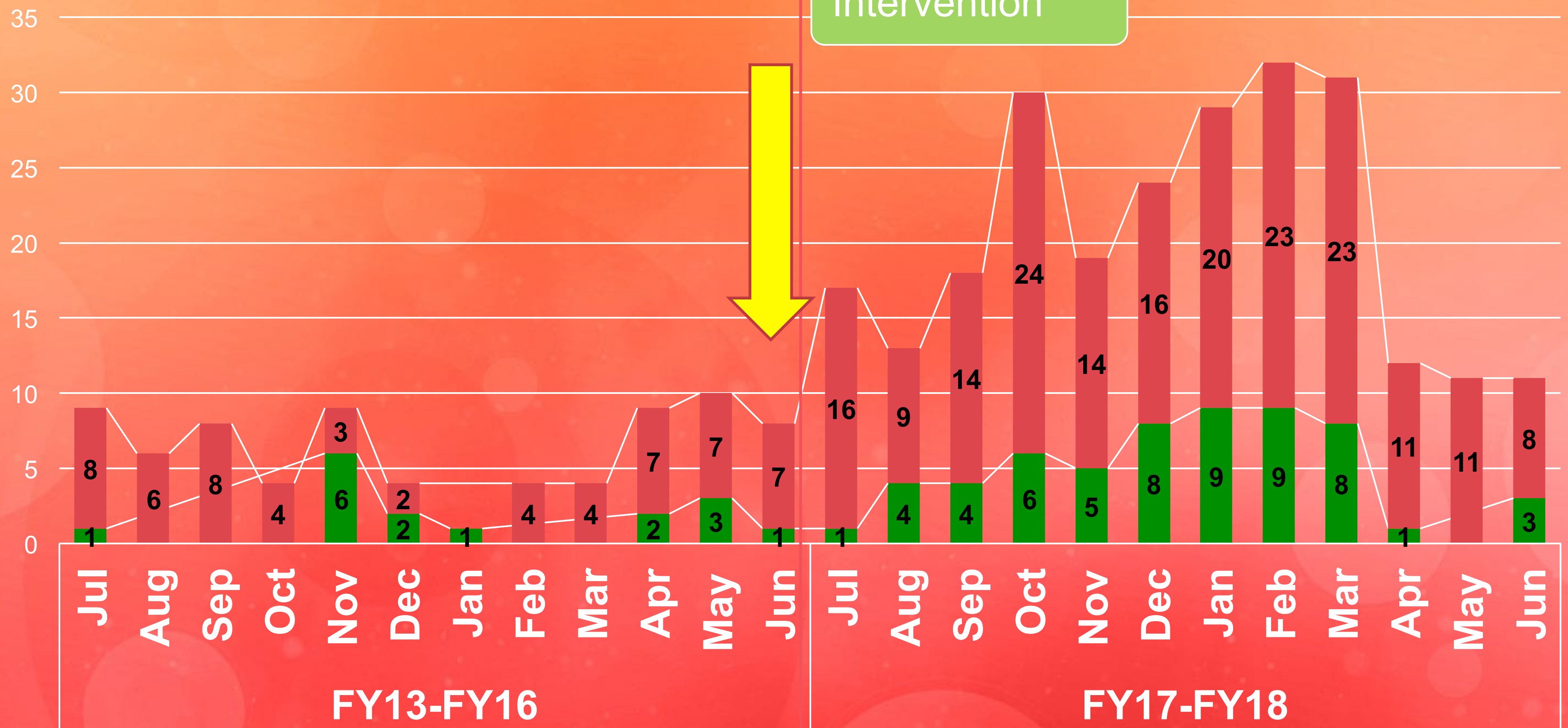
MIDAS

Nurses surveyed stated it was a system to:

- "Write up"
- Enter details about a "poor outcome"
- "Tell management about an event"
- "Report an error"
- "Its annoying and busy work"
- Who reads or reviews them anyway?
- "Don't let patients or families know any of this!"



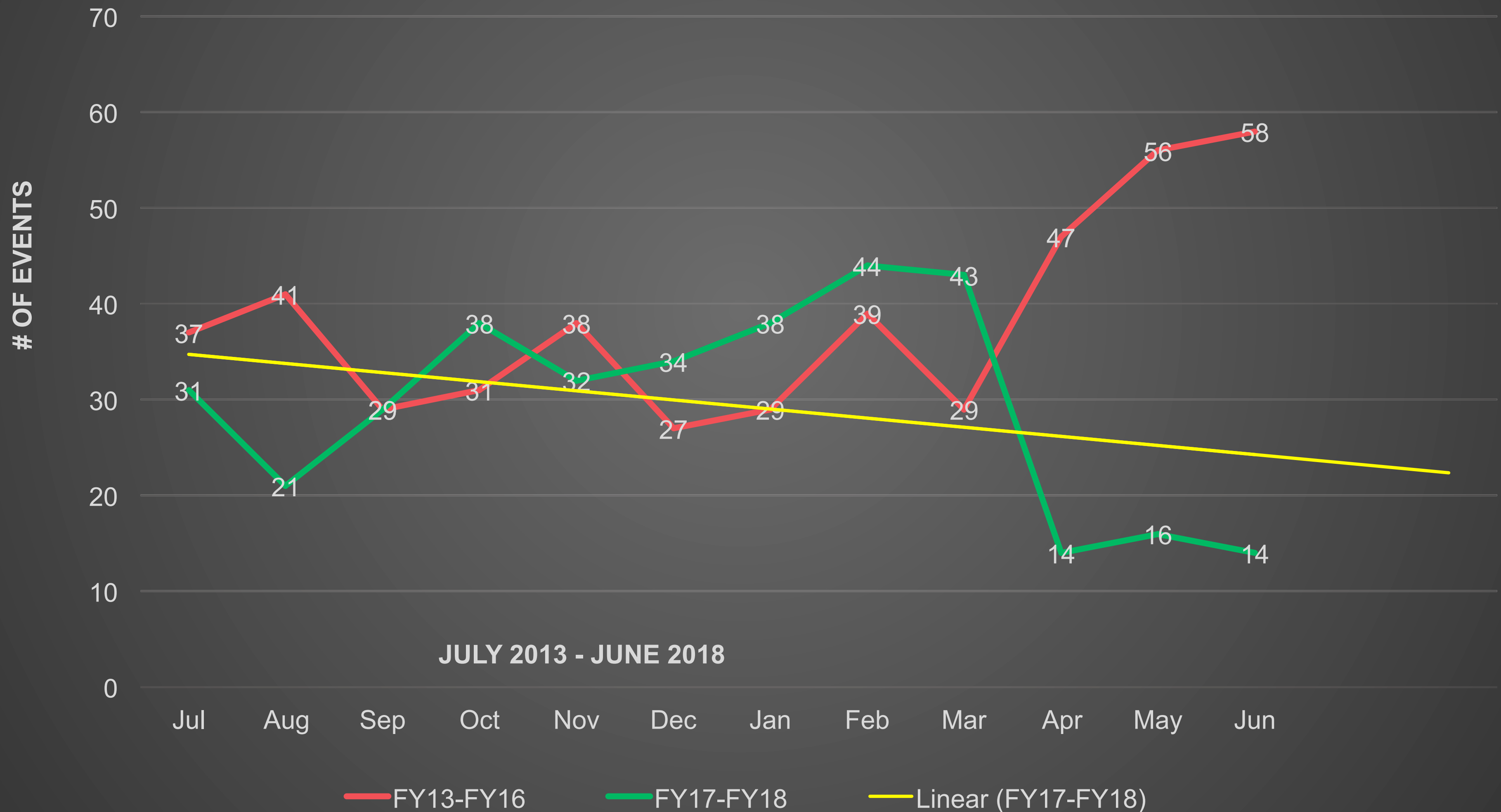
This perception needed to be changed:



Midas Events- Pediatric Unit 4 NE
Good Catch vs Near Miss Reporting
FY13-FY16 vs FY17-FY18 (Jul-March)
Good Catch
Near Miss
Intervention
35
30
25
20
15
10
5
0
8
1
6
8
4
3
6
2
2
1
4
4
7
2
7
3
7
1
16
1
9
4
14
4
24
6
14
5
16
8
20
9
23
9
23
8
11
1
11
8
3
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY13-FY16
FY17-FY18

After the intervention, the number of entries in the organization's error reporting system that identified "near misses" or "close call events" increased from a total reported of three percent (3%) to thirty seven percent (37%) of total events.
67 out of a total of 125 reports.

This increase displays a recognition by the nursing staff to report potential harm and near misses, not only actual mistakes; and speak up to prevent actual harm in future cases.


ACTUAL EVENTS:
Midas Events- Pediatric Unit 4NE
FY13-FY16 vs FY17-FY18 (Jul-Mar)
OF EVENTS
70
60
50
40
30
20
10
0
JULY 2013 - JUNE 2018
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
37
41
29
31
38
27
29
39
29
47
56
58
31
21
29
38
32
34
38
44
43
14
16
14
FY13-FY16
FY17-FY18
Linear (FY17-FY18)

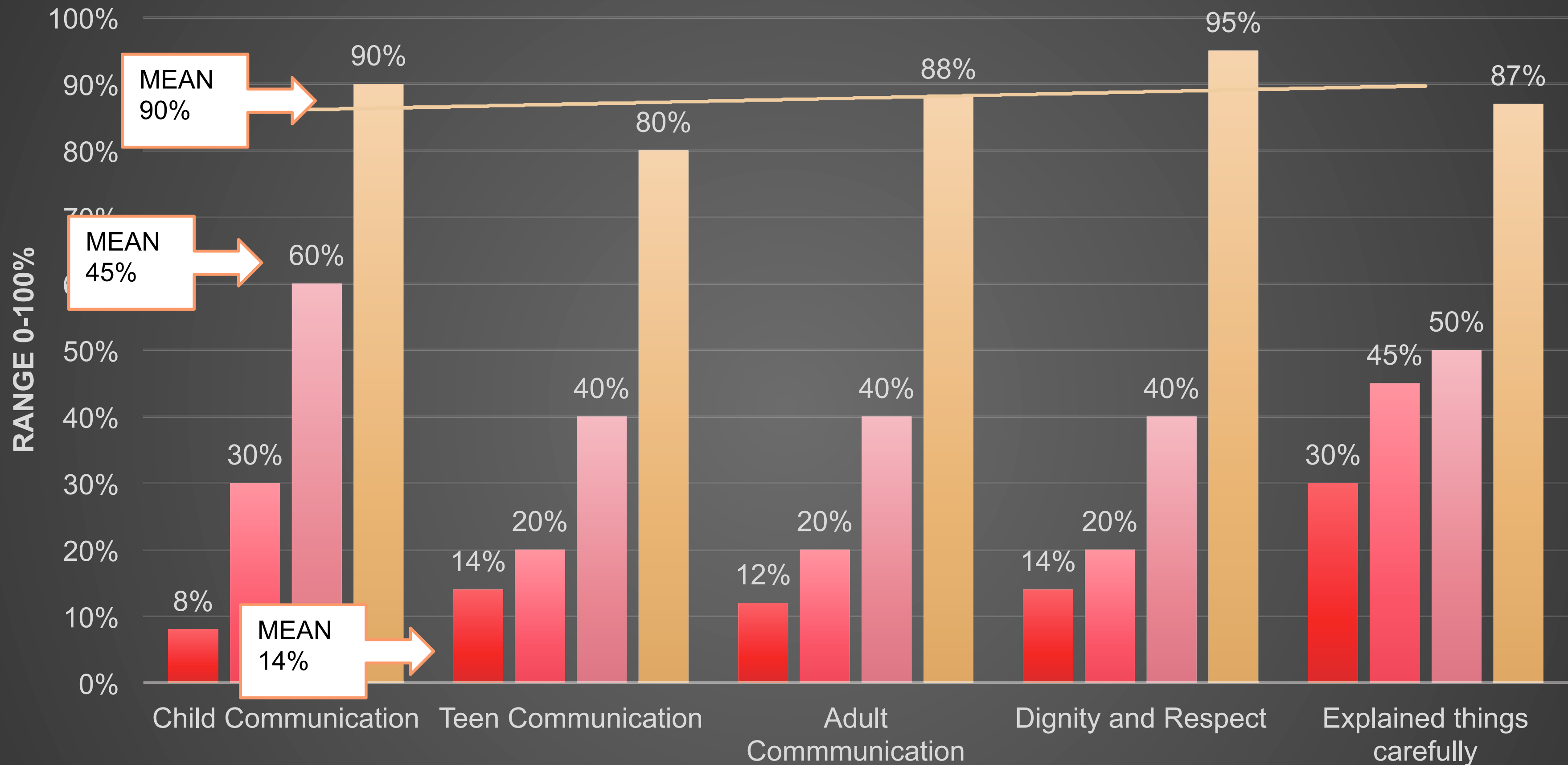
Child HCAHPS

Hospital Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version (Child HCAHPS)

Child HCAHPS Question

- ***Actual HCAHPS Question:***
  - Mistakes in your child's health care can include things like giving the wrong medicine or doing the wrong surgery.
  - During this hospital stay, did providers or other hospital staff tell you how to report if you had any concerns about mistakes in your child's health care?

Child HCAHPS Question



Nurse Comfort and Communication

Intervention: NURSE COMMUNICAITON

- **What did we do:**
- **GOAL: INCRESE CONFIDENCE AND COMMUNICAITON**
  - Simulation Center Training
    - Pre and Post Survey on Confidence and Importance of this Problem
    - Education
    - PFCCC Parents and Family Feedback
  - Ongoing Leader Role Modeling Shadowing and Mentoring
  - Rolled Similar Scenario with Parents in EBOLA Training In-Situ Simulation
  - *Storytelling*

NURSE COMFORT

- **How Important Do You Feel It Is to Partner with Patients, Parents, and Families?**

Pre-Simulation		
Question		Total
Extremely important	86.67%	24
Very important	13.33%	9
Moderately important	0.00%	0
Slightly important	0.00%	0
Not at all important	0.00%	0

Post Simulation		
Question		Total
Extremely important	95.00%	31
Very important	5.00%	2
Moderately important	0.00%	0
Slightly important	0.00%	0
Not at all important	0.00%	0

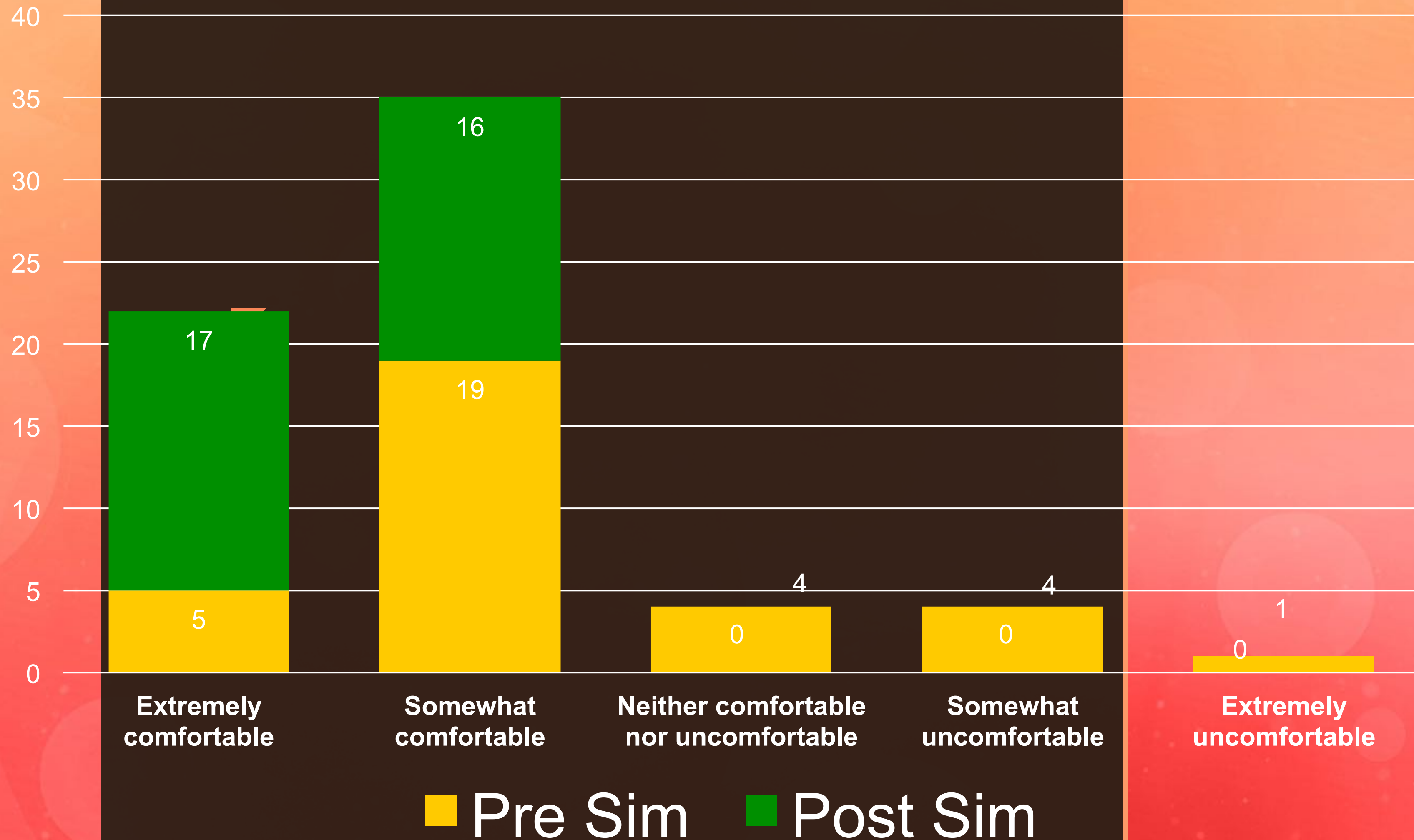
NURSE COMFORT

- **How Comfortable are you with speaking to parents or family members about reporting a mistake and or concern?**

#	Answer	%	Count
PRE SIMULAITON			
1	Extremely comfortable	15.15%	5
2	Somewhat comfortable	57.58%	19
3	Neither comfortable nor uncomfortable	12.12%	4
4	Somewhat uncomfortable	12.12%	4
5	Extremely uncomfortable	3.03%	1
	Total	100%	33

#	Answer	%	Count
POST SIMUAITON			
1	Extremely comfortable	51.93%	17
2	Somewhat comfortable	48.07%	16
3	Neither comfortable nor uncomfortable	0.00%	0
4	Somewhat uncomfortable	0.00%	0
5	Extremely uncomfortable	0.00%	0
	Total	100%	33

How comfortable are you with speaking to Parents or Family members about a reporting mistake and or concern?

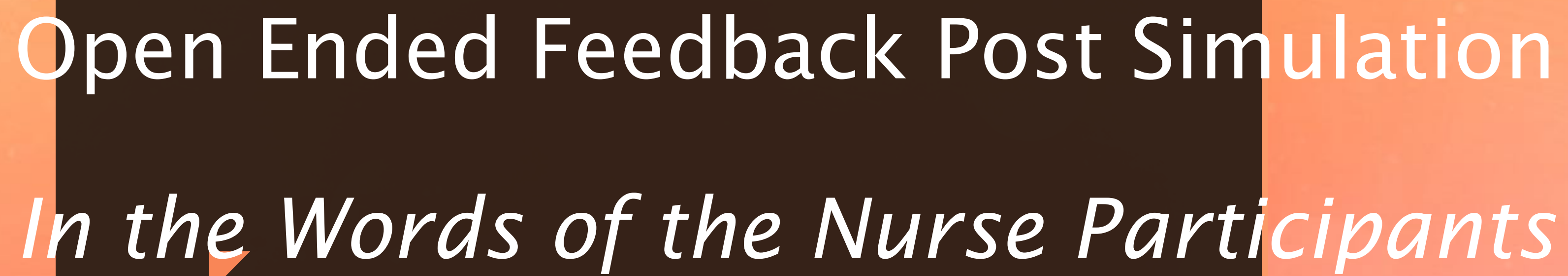


Approach Intervention

- Reviewed Unit Culture of Safety Scores
- 2015 to 2017 Favorable Improvements, continue to aim to improve.
- 2018 in progress- New department created.
- The unit reported that it is a “Safety Culture” However the opportunities were with reporting mistakes.
- This Survey was timely as the Simulation center training had just started when results were received.

Approach Intervention

Survey Item	2015 % Favorable	2017 % Favorable	Change
Nonpunitive Response to Errors			
Staff feel like their mistakes are held against them.	20.7	37.9	17.2
When an event is reported, it feels like the person is being written up, not the problem.	31.0	37.9	6.9
Staff worry that mistakes that they make are kept in their personnel file.	13.8	24.1	10.3
Communication Openness			
Staff will freely speak up if they see something that may negatively affect patient care.	86.2	86.2	0.0
Staff feel free to question the decisions or actions of those with more authority.	58.6	65.5	6.9
Staff are afraid to ask questions when something does not seem right.	66.7	69.0	2.3


Open Ended Feedback Post Simulation
In the Words of the Nurse Participants

Q - What is something that you learned, or gained knowledge in that would you add to EVERY Simulation for future participants?

What is something that you learned, or gained knowledge in that would you add to EVERY Simulation for future participants?
Verbiage, remember how to talk to families.
Our families hear something completely different than what I say often and I need to *ensure* they understood what I mean.
How to communicate better, US guided IV training was great- Skills and words…….
How to properly prepare parents and patients on procedures, explaining
Assess interactions with patient and family and ***consider more involvement with patient and family members as to their comfort and encourage involvement***
Made me think "how to word or describe things differently" i.e. *Social Work*
some different ways to communicate and explain things
I learned better ways to explain things to patients/parents
explain in detail, **I will wait to make sure they understand and ask to teach back what they know**
eye contact, presence, sit down and talk with them.

Q - Do you feel that this training will improve your communication and or clinical practice?

Do you feel that this training will improve your communication and or clinical practice?	
I didn’t know I needed it until I needed it. I feel like I wish there was a place to "Ask a parent".	Yes, in terms of finding different ways to communicate ideas and procedures
Yes, please have the residents and the phlebotomy come to this class.	**Yes makes me think, what would the parents think about this when we implement new processes**
Watching the video gives the opportunity to evaluate your communication techniques.	Debriefing is great, need to debrief a lot more.
Yes, I learn better with practice. I can adapt many of these skills to clinical practice.	Yes, can we focus on what else we can say to better communicate?
Thank you guys yes this helps a lot	Yes, thank you for good tools
Yes, When can we do it again?	Yes, have other people come too, have the MD’s

Simulation Impact

Simulation

- **Created a <u>Template for Simulation</u> based on California Simulation Alliance (CSA) Templates**

- Updated internal template for simulation and added a line for PFCC/ Parent Council volunteer role, patient advocate role.
- Trained Parents (And Teen Volunteers) as Standardized Actors
- Simulation Process- Prompts for Patient volunteer. Simulation center staff and PFCCC volunteers can speak to the "Why would we need that" if asked.
- Updated Organizational Policy on Including Non-Employees in training and Simulation.

Created situation that was likely and created need for communication about a *mistake*.

Simulation

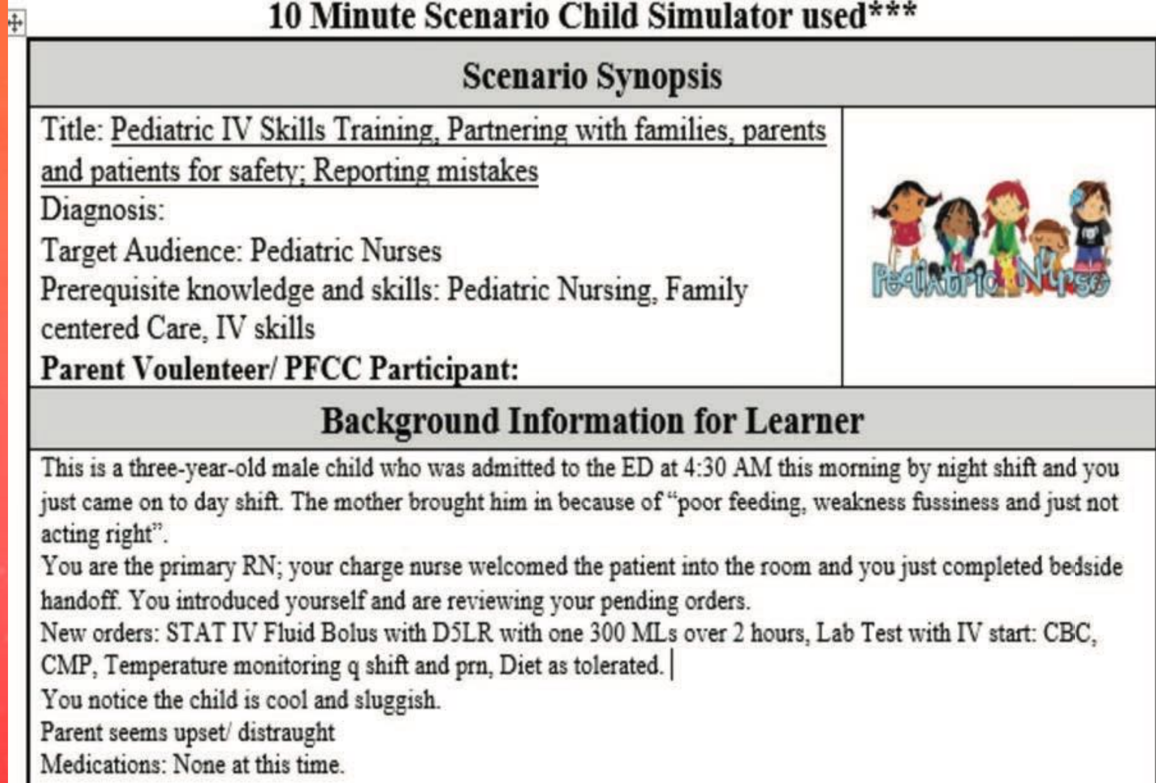
- **Many Policy Changes:**

- Change to the House wide IV policy, bedside procedures, initiation of anesthesia and discharge planning policies.
- Technology for Communication- ***Babyface*****time**- Isolation Communication
- TV's Installed with ability to ensure family Safety Rounds Participation.
- Initiated **POKE plan** and adult version is in the works.
- House wide visitation policy
- MIDAS system being replaced and part of RL Soluitons build will include Near Miss Reporting call out and recognition.
- Policy on transparent mistake reporting training and process change.
- Initiated new Partnership with the Institute of Patient and Family centered care.

PFCCC Participation

- "Will you be involving a Family Centered Care Council member or *volunteer* in your simulation?"
- "If yes, do they need standardized actor training?"
- "Are they an official Hospital Volunteer?"

Added Additional Information to Standard Template at Simulation Center:



*****FOR INSTRUCTORS & SIM OPERATORS ONLY**
10 Minute Scenario Child Simulator used***

Scenario Synopsis	
Title: Pediatric IV Skills Training, Partnering with families, parents and patients for safety; Reporting mistakes Diagnosis: Target Audience: Pediatric Nurses Prerequisite knowledge and skills: Pediatric Nursing, Family centered Care, IV skills **Parent Voulenteer/ PFCC Participant:**	Pediatric Nurse
Background Information for Learner	
This is a three-year-old male child who was admitted to the ED at 4:30 AM this morning by night shift and you just came on to day shift. The mother brought him in because of "poor feeding, weakness fussiness and just not acting right". You are the primary RN; your charge nurse welcomed the patient into the room and you just completed bedside handoff. You introduced yourself and are reviewing your pending orders. New orders: STAT IV Fluid Bolus with D5LR with one 300 MLs over 2 hours, Lab Test with IV start: CBC, CMP, Temperature monitoring q shift and prn, Diet as tolerated. You notice the child is cool and sluggish. Parent seems upset/ distraught Medications: None at this time.	

Return on Investment

Issue	Average cost per episode	Sustainable?
One Medical Error	Current cost of medical errors can be estimated at **$20.8 billion** **$75,000- $100,000/** year	• Preventable Harm • May have impact hours to years to indefinite time. • Underreported
Online Training Course	**$10,000** 90-240 hours to produce	• Yes however inflation costs unaccounted.
One day or online hour program	**$8,880-$28,640** **100-160** hours to produce	• Yes Per person Purchase.
Facility Led Simulation training (Project utilized Here)	**$5478** $206/ per person 195 hours to produce	• Yes and Replicable • Content utilized repeatedly.
Cost for this Project with Staff costs	**$14,978.00** ($453 per Nurse)	• Yes.

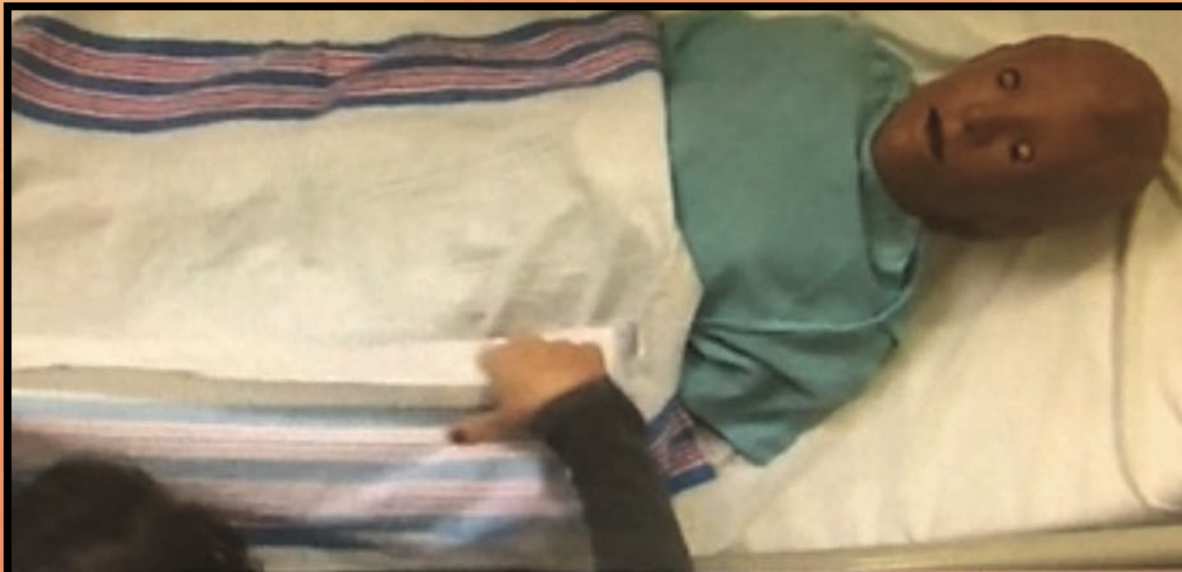
Return on Investment

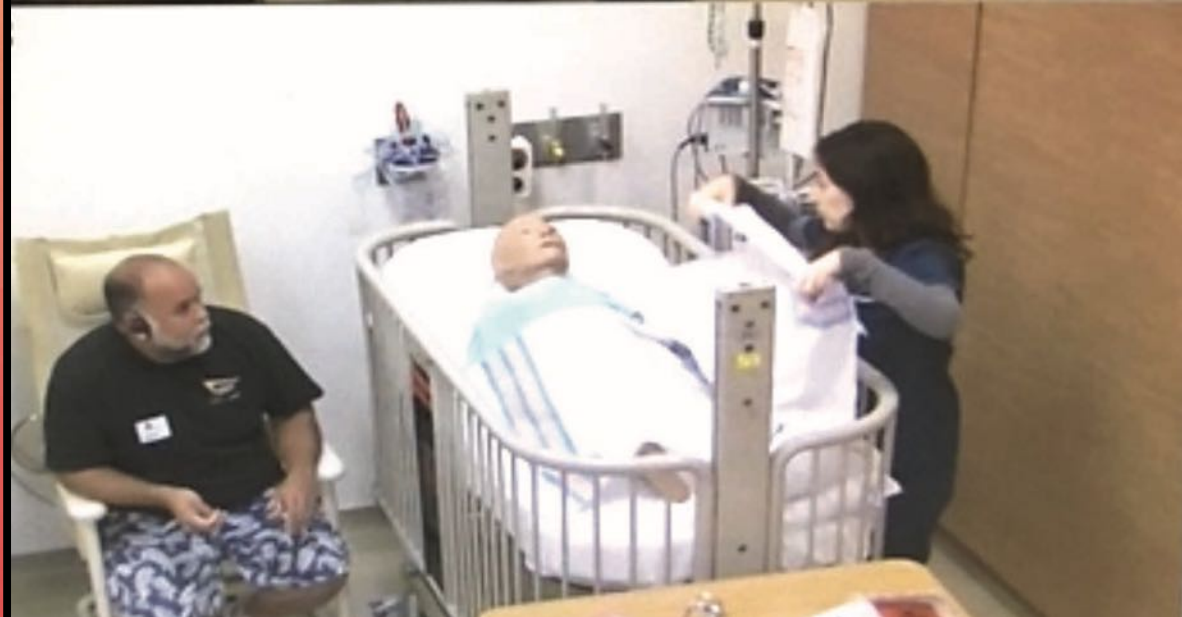
Studies have suggested that the economic impact is actually much greater than once thought.

If one applies quality-adjusted life years **(QALYs)** to the 250,000 people who die each year from medical errors—and assumes an average of 10 lost years of life at $75,000 to $100,000 per year, the loss in QALYs for those deaths is **$187.5 billion to $250 billion**.

(Andel, et al., 2012).

SIMULATION Training WITH PARENTS!

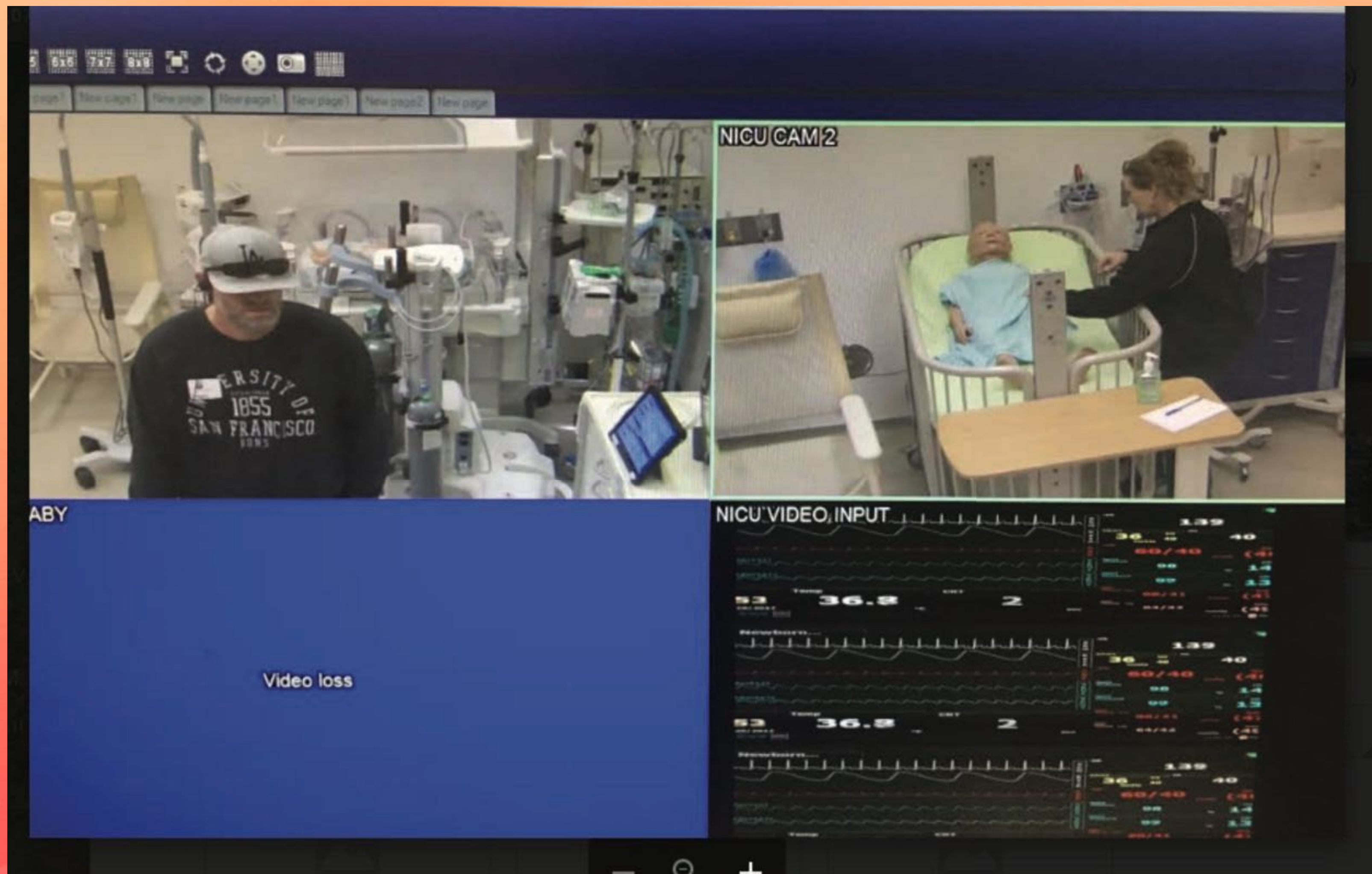




Conversations around reporting mistakes. Improved Communication

With our PFCC Parent Council Members!

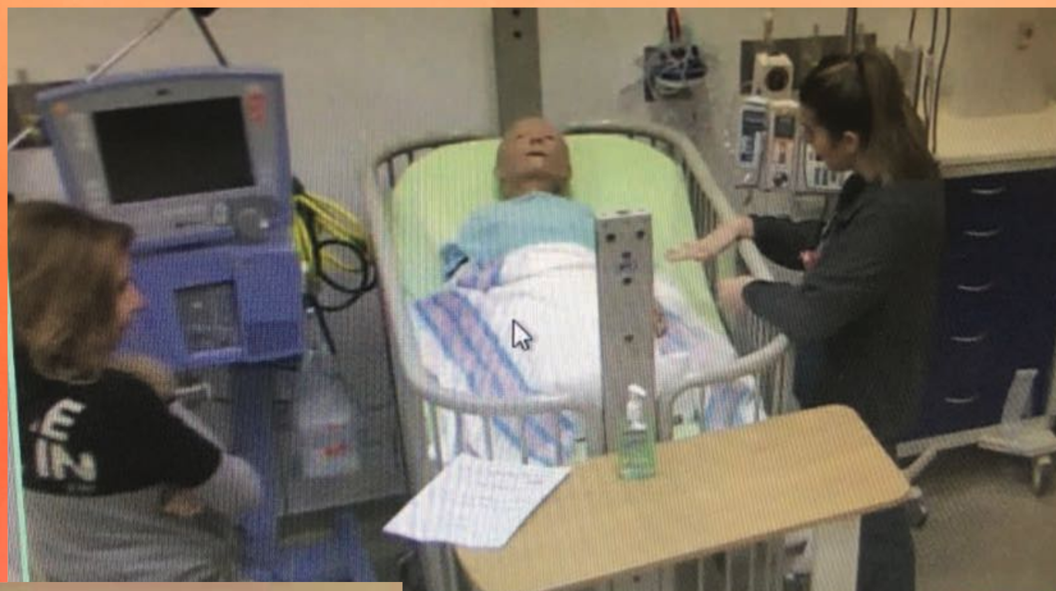
SIMULATION Training WITH PARENTS!



Parent Feedback in Debriefing opened the eyes of the Nursing Staff. Brought to light more change was needed!

SIMULATION Training WITH PARENTS!

Leadership Support demonstrated Value.



Confidence increased in a safe place.

Debriefing and listening the team assisted each other.

Outcome Review

What did I not anticipate, *mistakes were made!*

- **Support:** Initial buy-in that faded over time with changes in financial models, tools changed, stay to course, fall back to roots.

- **Replication:** Needs Organizational support and structure, have replicated in various areas but not set as an organizational standard.

- **Leadership Changes:** Executive leadership changes, organizational focus changes, expectations and focus of the Project manager changes, Safety office support and new programs with Patient Advocates

- **New Position:** Offering and new perspective

Impact to the
Profession of Nursing

Impact to Nursing

- **What does this mean to the nursing profession?**
  - *As a profession moving forward, how will this impact our profession.*

- Creating a **Safety Culture** is more than surveying staff.
- *Safety rounds and staff reporting with issues. The other side of the coin is partnering with patients, parents and families to take a team event towards safety. Importance of the Parent and patient voice, policy changes receive IFPCC input. Celebration and tracking of near misses.*
- Simulation is an innovative approach
- *Opportunity to train staff and PFCC families together. Debriefing very valuable for all, utilized in Actual Events outside of a formal RCA.*

What are the next steps

- Moving forward:
  - Evident demonstration of the importance of the family voice in safety.
  - Increased and Consistent Training Standard for all Nurses, and Clinical Staff through Simulation
  - GOAL- PFCC Councils in all units, Institute of Patient and Family Centered Care (IPFCC) Simulation team support volunteer patient debriefing and participation.
  - Recognition and Celebration of Safety Concerns and Catches
  - Establishment of an Easy Way for Parents Patients and Families to Speak up about Concerns, Staff comfort with reporting and share the knowledge publicly!

The Organization took Note!

The organization recognized the win and made policy changes to implement more process changes.

Future of Safety Culture

- **Issue 60, Dec. 11, 2018 the Joint Commission issues a Sentinel Event Alert as a publication titled:**
- **Developing a reporting culture: Learning from close calls and hazardous conditions**
- Recommendations to improve a Safety Culture by reviewing Near Misses and Reporting Mistakes.
- **4 E Tool Published.**

Future of Safety Culture

- ✓4 E's of a Reporting Culture

- ✓ Establish Trust
- ✓ Encourage Reporting
- ✓ Eliminate the Fear of Punishment
- ✓ Examine Close Calls or Near Misses

Conclusions and
Summary

Conclusions

- This project produced both **quantitative** and **qualitative** results supporting the project goal at a **minimal cost**.

- Results demonstrated an **improvement in HCAHPS** scores reported by parents about their confidence in reporting mistakes or errors.

- Nurses reported an **increase in confidence** post-simulation in communication around talking with families around reporting mistakes.

- PFCC Families **participated** and demonstrated value- Included now with organizational changes and debreifing.

- **MIDAS "Near Miss"** events **increased-** Actual Events **Decreased**.

Tools Created

Learning and Tools Created:

ADDED: PFCC Volunteer/ Patient Actor Role in Simulation Scenarios.

ADDED: Electronic Messaging in Bedside "MyChart" Created By Family Council.

POLICY:

Policies to Support Technology and involve Families ISOLATION/ ROUNDS/ DISTANCE

SAFETY: Safety Rounds and Safety Star Recognition of Near Miss Reporting

What did I learn: Create Tools

Today's Date: _____ /_____ / ______ (mm/dd/yyyy)

Poke Plan for (child's name): ____________________

How would you describe **your/your child's** experience(s) with previous needlesticks/procedures?

☐ no problems ☐ cries ☐ worries ☐ very fearful ☐ no previous experience

Comments: ____________________

Information:

During a procedure, would you/your child like (check all that apply):

☐ verbal cues

☐ curtain pulled/privacy ☐ count out loud "1, 2, 3" then poke

People: Who would you/your child like to be present?

☐ parent ☐ nurse(s) only ☐ Child Life staff member (if available)

Position: Would you/your child prefer to: ☐ lie flat ☐ sit up ☐ sit with adult caregiver/be held

Watching: Would you/your child prefer to: ☐ watch ☐ not watch

Distraction: Would you/your child like (check all that apply):

☐ bubbles ☐ book ☐ glitter wand ☐ pin wheel ☐ TV/video ☐ none

☐ other (specify) ____________________

Comfort Measures: Would you/your child like any of these comfort measures? (check all that apply)

For infants: ☐ swaddle ☐ caress ☐ pacifier ☐ sucrose/Sweet-Ease

Children of all ages:

☐ imagery (e.g. my favorite place) ☐ deep breathing ☐ squeezing someone's hand

☐ playing a game (if possible) ☐ my personal comfort item (blanket, stuffed animal)

Would you/your child like any of these comfort measures?

☐ LMX (numbing cream) ☐ Buzzy ☐ Pain-Ease cold spray ☐

Additional comments and notes: ____________________

____

____

If the poke plan does not result in a successful needlestick with minima

options to complete the proc

Adapted with permission from University of Michigan C.S. Mott Children's Hospital poke program.

The "POKE PLAN" was initiated and adopted.

Communication

Expectations

How to share concerns

Adult Version in the works!

Today's Date: _____ /_____ / ______ (mm/dd/yyyy)

Poke Plan for (child's name): ____________________

How would you describe **your/your child's** experience(s) with previous needlesticks/procedures?

☐ no problems ☐ cries ☐ worries ☐ very fearful ☐ no previous experience

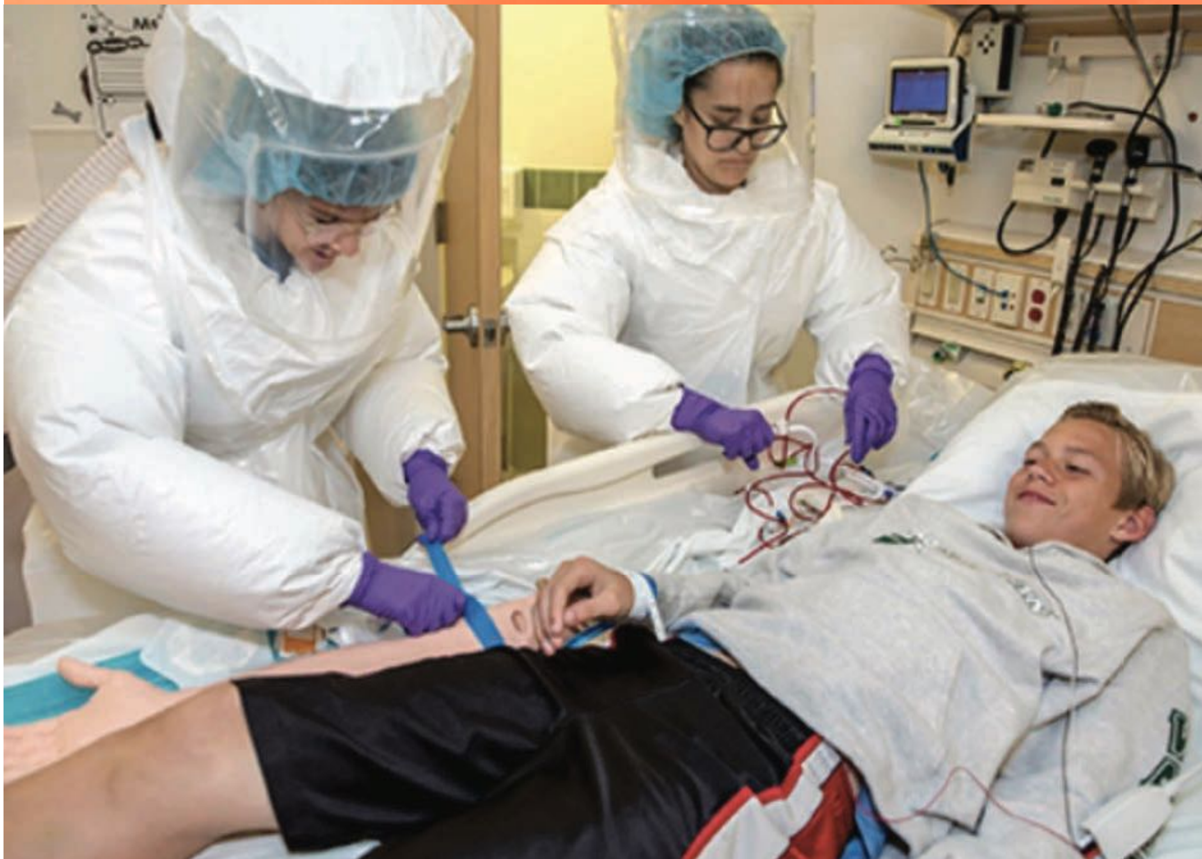
Partnerships

Implementing <u>Better Together</u> The <u>Institute of Patient and Family Centered Care</u> program to partner with families.

Institute of Healthcare Improvement education series around patient safety:

Training With PFCC Families Continues!

Repeat Ebola Drill Training!



Partnering with Parents and Families for safety

You and your family are valuable partners in your care. Cedars Sinai Medical Center Pediatrics, Pediatric Intensive Care Unit (PICU), and Congenital Cardiac Unit (CCICU) encourage you to participate in medical and care and decisions.

Simulation Photos

More Change After Each Simulation with Families.

Simulation Photos

PFCC Family and Teen Quotes

- Thank you for asking my opinion
- I want to help
- I just don’t want anyone to go through what I did (or other kids)
- How can we change the minds of the organization?
- The nurses can ASK me anything, we are “off the clock”
- Please talk to me
- I see things you may not
- Why haven’t you done this before?
- What else can we work on?
- I am so glad I’m here

- ***“I think this would have prevented my daughters death if we had felt more comfortable to speak up and the team asked me more questions”.***

Did we meet our objectives

Objective 1

Identify three scenarios that would benefit from the use of simulation and involve standardized actors to improve and change organizational policy- **(Ideas?)**

Objective 2

Recognize the value of the patient voice when changing policy and or institutional processes that impact their care- **(Thoughts)?**

Objective 3

Identify one policy at their organization or institution that would be altered if the patient and or family voice was heard, recognized and understood. **(Ideas?)**

Review of Purpose

I hope that the information that we discussed in this presentation shared how the DNP leader can use the evidence and best practices to change policy and perception around the use of patients and parents as standardized actors in simulation in order to reduce harm and to improve healthcare outcomes.

Remember, by creating a culture of innovation and safety, DNP leaders think differently about using evidence to implement change, I look forward to see what scenarios or new processes develop as a result from this presentation!

THANK YOU

I want to thank my support system and my committee with my work in Simulation, Parent and Patient Councils and in Safety over the last few years.

Parent Mentors and patient volunteers: Your voice and feedback is invaluable;

Jojo Smith, Caitlyn Meenaey and Jessica Meenaey, Bryce Caufield, Steve Guerrero, Veronique Massey.

Mary Lynne Knighten, DNP, RN, NEA-BC

Adjunct Faculty University of San Francisco and Azusa Pacific University

Healthcare Consultant ; My DNP committee, friend safety co-advocate and partner in leadership.

Pooja Nawathe, MD, FACHE, CHSE-A PICU Intensivist, Director PICU

Tessie Guerrero, CHSE and Pediatric Education Program Coordinator

Cedars-Sinai Medical Center Team and Simulation Advocates

K.T Waxman, DNP, MBA, RN, CNL, CHSE CENP, FSSH FAAN

Faculty- University Of San Francisco- Inspiration & President Society for Simulation in Healthcare

References

- HFMA, Health Care Finance, 2016,*The Human and Economic Costs of Medical Errors. Retrieved December 10, 2018 from:* https://www.hfma.org/Content.aspx?id=48695

- Institute of Medicine (IOM) (2000). To Err Is Human: Building a Safer Health System. Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/9728

- James Reason Swiss Cheese Model. Source: BMJ,.(2000) 18:320(7237): 768-770

- Johnson, B.H. & Abraham, M.R. (2012). Partnering with patients, residents, and families: A resource for leaders of hospitals, ambulatory care settings, and long-term care communities. Bethesda, MD: Institute for Patient- and Family-Centered Care

- Joint Commission (2018) Sentinel Event Alert; *Developing a reporting culture: Learning from close calls and hazardous conditions.*

- Retrieved December 11, 2018; https://www.jointcommission.org/assets/1/18/SEA_60_Reporting_culture.pdf

- NRC Health Picker Catalyst Web page (2017). Retrieved November 1, 2017, from: https://catalyst.nrcpicker.com/CatalystHome/SitePages/white-papers.aspx

References

- OSHA: Better Safety Conversations (n.d) *Safe and Sound Safety Conversations*. Retrieved October 28, 2018: https://www.osha.gov/safeandsound/docs/SHP_Better-Safety-Conversations.pdf
- Palokas, J.M., Northington, L., Wilkerson, R.R., & Boss, B.J., (2015). An interactive evaluation of patient/family centered rounds on pediatric inpatient units. Journal of Pediatric Nursing: Nursing Care of Children and Families. 30(4): e9 – e15.
- Ponte, P., Connor, M., DeMarco, R., and Price, J. (2004). Linking patient- and family-centered care and patient safety: the next leap. Nursing economics. July-August;22(4):211-3, 215. PubMed PMID: 15382399.
- Rosen, P., Stenger, E., Bochkoris, M., Kwoh, C.K., (2009). Family-centered multidisciplinary rounds enhance the team approach in pediatrics. Pediatrics. Apr;123(4): e603-8. doi: 10.1542/peds.2008-2238
- Society for Simulation in Healthcare (2016). Retrieved October 31, 2018 from http://www.ssih.org/
- van Schaik, S. M., Plant, J., Diane, S., Tsang, L., & O'Sullivan, P. (2011). Interprofessional Team Training in Pediatric Resuscitation: A Low-Cost, In Situ Simulation Program That Enhances Self-Efficacy Among Participants. Clinical Pediatrics, 50(9), 807–815.
- Zhang C, Thompson S, Miller C. A review of simulation-based interprofessional education. Clinical simulation in nursing. 2011;7(4):e117-e26.
- Garbee DD, Paige JT, Bonanno LS, Rusnak VV, Barrier KM, Kozmenko LS, et al. Effectiveness of teamwork and communication education using an interprofessional high-fidelity human patient simulation critical care code. Journal of Nursing Education and Practice. 2013;3(3):1.

References

- OSHA: Better Safety Conversations (n.d) *Safe and Sound Safety Conversations*. Retrieved October 28, 2018: https://www.osha.gov/safeandsound/docs/SHP_Better-Safety-Conversations.pdf
- Palokas, J.M., Northington, L., Wilkerson, R.R., & Boss, B.J., (2015). An interactive evaluation of patient/ family centered rounds on pediatric inpatient units. Journal of Pediatric Nursing: Nursing Care of Children and Families. 30(4): e9 – e15.
- Ponte, P., Connor, M., DeMarco, R., and Price, J. (2004). Linking patient- and family-centered care and patient safety: the next leap. Nursing economics. July-August;22(4):211-3, 215. PubMed PMID: 15382399.
- Rosen, P., Stenger, E., Bochkoris, M., Kwoh, C.K., (2009). Family-centered multidisciplinary rounds enhance the team approach in pediatrics. Pediatrics. Apr;123(4): e603-8. doi: 10.1542/peds.2008-2238
- Society for Simulation in Healthcare (2016). Retrieved October 31, 2018 from http://www.ssih.org/
- van Schaik, S. M., Plant, J., Diane, S., Tsang, L., & O'Sullivan, P. (2011). Interprofessional Team Training in Pediatric Resuscitation: A Low-Cost, In Situ Simulation Program That Enhances Self-Efficacy Among Participants. Clinical Pediatrics, 50(9), 807–815.
- Zhang C, Thompson S, Miller C. A review of simulation-based interprofessional education. Clinical simulation in nursing. 2011;7(4):e117-e26.
- Garbee DD, Paige JT, Bonanno LS, Rusnak VV, Barrier KM, Kozmenko LS, et al. Effectiveness of teamwork and communication education using an interprofessional high-fidelity human patient simulation critical care code. Journal of Nursing Education and Practice. 2013;3(3):1.