MyVoice Back to Basics Education Front Line Teams

Quality and Safety January 2024



MyVoice Main "Buckets" of Reporting







Safety events and	d
near misses	

Any concerns regarding patient, staff member, or visitor involved in a situation that caused harm or had the potential to cause harm

HIPPA Grievances Complaints

Any breach in patient confidentiality
Any patient compliant or grievance

Employee Injury

Any employee injury while on duty including exposure to potential infectious diseases



MyMichigan Health Safety Behaviors and Tools

Prepare for the Day

- Daily Excellence Huddles
- Daily Safety Briefings
- Timeouts

Questioning Attitude

- Verify & Validate
- Stop the Line
- 2 challenge rule (ask & request)
- Speaking up with CUS

Clear Communication

- Three Way Repeat Back (i.e. critical values)
- SBAR/Handoffs
- Close Loop

Support the Team

- Briefing/Debriefing
- Peer Checking
- Peer Coaching

Attention to Detail

• STAR: Stop. Think. Act. Review.



Support the Team: Peer Checking

Why?

Peers support and watch out for each other.

Peers share situational awareness and provide on-the-spot second opinions. We need to watch out for others and share situational awareness with our team.

EXAMPLE

A team member notices a new team member struggling to program an intravenous medication to run through the pump. Offer to assist and teach the new member the process.



How to Use the Tool

Offer to check the work of others (second check a calculation, proofread a memo)

Point out unintended slips and lapses (a supply room key left on counter; an order placed in the wrong chart)

Point out work conditions that your team member might not have noticed.



Support the Team: Peer Coaching

Why?

Used to address unsafe or unproductive behavior. Coaching requires 1st observing behaviors and performance of our team members then offering coaching, where appropriate.

EXAMPLE

RN prepping patients encounters a provider who declines to see patients prior to procedure as required per policy and for safety. RN respectfully approaches provider, discusses policy requirements and importance of safety and communication. Provider acknowledges concerns and proceeds to see patient as required.



How to Use the Tool

Shared feedback to peers should provide a 5:1 ratio of positive to negative feedback to reinforce:

- good habits
- extinguish poor habits
- · build better practice habits

Encourage, praise others when safe, productive behaviors are used Discourage, give advice when unsafe, unproductive behaviors are used



Speaking up to Prevent Harm

Speaking up for patient safety among health care professionals is important because it can contribute to the prevention of adverse patient events, such as medication errors, infections, wrong-site surgical procedures, and other sentinel events.

ALL
team members have an EQUAL
VOICE
regardless of role





Barriers to Speaking Up

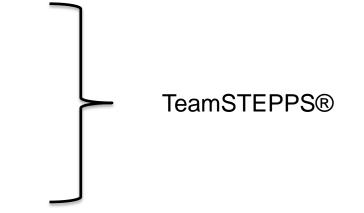
- Hierarchy
- Assumptions
- Fear of being wrong
- Inexperience

- Conflict
- Defensiveness
- Conventional thinking
- Fear of repercussions



Speaking Up Tools Advocacy & Patient Safety

- Advocacy and Assertion
- 2 Challenge Rule
- CUS



 MyMichigan Health Chain of Command Policy and Process



Advocacy and Assertion

- Advocate for the patient
 - Invoked when team members' viewpoints don't coincide with that of a decision maker
- Assert a corrective action in a firm and respectful manner







The Assertive Statement

- Respectful and supportive of authority
- Clearly asserts concerns and suggestions
- Is nonthreatening and ensures that critical information is addressed
- Five-Step Process:
 - 1. Make an opening
 - 2. State the concern
 - 3. State the problem (real or perceived)
 - 4. Offer a solution
 - 5. Reach an agreement on next steps



Two-Challenge Rule

Invoked when an initial assertion is ignored...

- It is your responsibility to assertively voice your concern at least two times to ensure that it has been heard
- The member being challenged must acknowledge
- If the outcome is still not acceptable
 - Take a stronger course of action, CUS then...
 - Use supervisor or chain of command





Please Use CUS Words

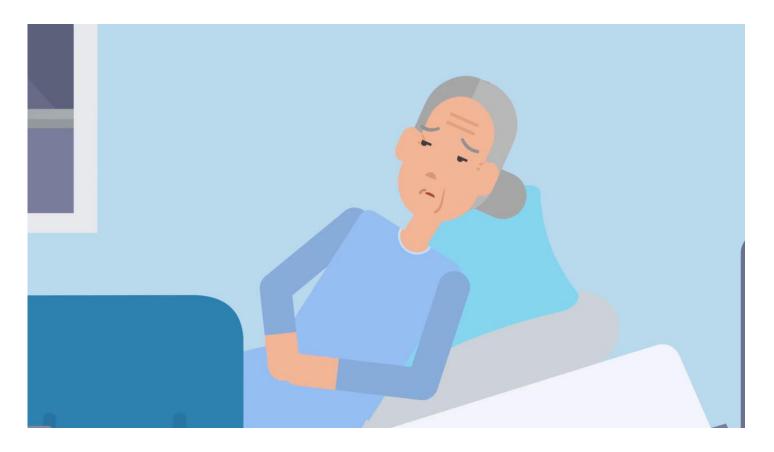
but only when appropriate!

I amCONCERNED!I amUNCOMFORTABLE!This is aSAFETY ISSUE!





CUS Video





CUS Coaching Tips

- Use the language consistently
- Use briefs and debriefs to encourage everyone to speak up and ask if others have concerns
- It's possible the recipient may act dismissive, deny any possibility of wrongdoing or be demeaning
 - Continue to escalate your CUS and focus on patient safety
 - Use your team members to back you up or go up the chain of command



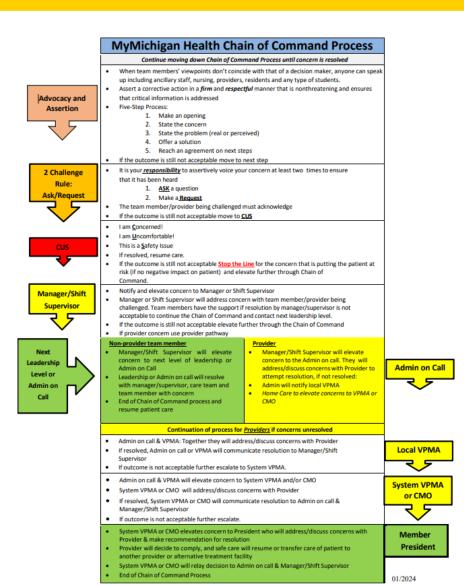
MyMichigan Chain of Command

Provides guidelines to be followed when an individual seeks to express a concern, a difference of opinion, or seeks to raise a question or resolve a conflict regarding clinical and/or patient safety or employee safety issue.

It is the responsibility of the staff involved to <u>Stop the Line</u> and not move forward with care until concerns are communicated through the appropriate chain of command and resolution is achieved.

Leaders in the escalation process have the duty to listen to the concern of staff and assist in helping to resolve the issue.





MyMichigan Health Chain of Command Policy and Process

Viewing Chain of Command Policy(policystat.com)



Why is Reporting Important?



Can help identify:

- Processes that need improvement
- Gaps in educational needs
- Trends of risk factors to help facilitate proactive harm prevention

Assists in:

- Preventing occurrences from happening again
- Promoting <u>Good Catch/Near miss</u> reporting before harm
- Building a culture of Zero Harm



Safe and Just Culture at MyMichigan

- In a safe and just culture;
 - Event reporting is not punished, we support zero tolerance for retaliation
 - Human error is not punished. We focus on systems and process improvements
 - All employees are encouraged and responsible to report events when they encounter them
 - Individual culpability is considered after full event investigation and analysis
 - Lessons learned are shared across system with appropriate teams to prevent future events



Events that can be entered as a variance...

- Adverse Drug Reactions
- Airway Management Events
- Blood Product Events
- Catheter/Tube/Drain Events
- Diagnosis/Treatment Events
- Employee Injuries
- Epic/IT Events
- Equipment Supply Events
- Facility Concerns
- •Falls
- Good Catches
- Grievances/Complaints
- HIPAA Privacy Concerns

- Infections
- IV/Vascular Access
- Lab/Specimen Events
- Maternal/Childbirth Events
- Medication/Fluid Events
- Patient Identification Events
- Professional Conduct
- Restraints Events
- Safety/Security Concerns
- Skin Tissue Events
- Surgery/Procedure Events



MyVoice is not the tool to use for...

- Requests to change the cafeteria menu
- Maintenance issues that require a work order
- Personal grievances, strained work relationships
- Accusations, speculations, or assumptions or hearsay not witnessed
- Workplace Harassment/Hostile Work Environment, Sexual Harassment events follow policy:
 - Viewing Anti-Harassment Policy (policystat.com)
 - Employees who believe they have been harassed, discriminated against, or believe they have witnessed other employees being harassed or discriminated against should report this activity to their immediate supervisor as soon as possible. If the immediate supervisor is involved, then the employee should report the activity to his/her supervisor's manager or designee, or report via the Corporate Compliance Hotline at 989.837.5471, or report the situation to the Vice President of Human Resources or designee



Test Your Knowledge



Event Example	Resolution Pathway	MyVoice
Patient's bed alarm is not functioning	Take out of service, place work order.	Not needed
Tissue specimen obtained during a procedure was placed in a specimen container with the incorrect solution resulting in the incorrect preservation of tissue	This is a patient safety event.	File a MyVoice
Communication messages to provider regarding change in patient condition are not being read or responded to timely and patient continues to decline	Advocate for the patient in a timely manner. Use chain of command to resolve until patient needs are met, and situation is resolved.	Not needed
Medication labeled with wrong patient, caught before administered	Medication labeled with wrong patient, caught before administered	File a MyVoice, this is a Good Catch!
Work environment perceived as hostile and discriminatory	Report to supervisor or their leader. Follow Anti-Harassment Policy. Can report to Corporate Compliance or MyHR.	Not needed



Test Your Knowledge



Event Example	Resolution Pathway	MyVoice
Patient family member is verbally aggressive caregivers every visit.	Attempt to set boundaries, contact security if needed. This is a Safety/Security event.	File a MyVoice
Housekeeper notices nurse entering an Isolation room without proper PPE.	Use the 2 Challenge Rule. Ask nurse if they Have the right PPE on for the isolation type. Request nurse use proper PPE. Nurse agrees and dons proper PPE	Not needed as situation addressed and resolved at the time of the concern.
During a bedside procedure provider is agitated and frustrated with current situation and is aggressive with language towards staff including swearing and disrespecting staff.	Respectfully ask provider to refrain from using the language. Escalate to manager or supervisor. Request an immediate debriefing of event with all involved to de-escalate and resolve issues.	Not needed as situation addressed and resolved at the time of the concern.
Patient not assessed for deep vein thrombosis prevention with no preventive measures in place and developed a blood clot	This is a patient safety event	File a MyVoice
Co-worker is taking extended lunch breaks daily which puts the team and patients at risk when trying to cover and is against policy. Team members have requested peer to stop.	Report behavior to supervisor/manager for resolution.	Not needed



MyVoice Event Follow-up



It is the responsibility of the manager of the department where the event occurred to complete a thorough investigation and follow-up on the variance entered



Please reach out to your manager/supervisor for communication of variance event resolution



Outcome and learning from event will be shared as appropriate





- Engage with your team to practice safety behaviors:
 - Support the Team use Peer Checking & Peer Coaching
 - Speak up with a <u>Questioning Attitude</u> use Advocacy & Assertion, 2 Challenge Rule, CUS, STOP the Line, Chain of Command...practice these with your peers, role play
- Report Good Catches, near misses, work a rounds, etc.
- Remember and respect that:
 - ALL team members have an <u>EQUAL VOICE</u> regardless of the role they have on the team!

