

Mission Zero in Action

1. Untitled Scene

1.1 Untitled Slide

Lucile Packard
Children's Hospital
at Stanford

mission zero
Eliminating Preventable Harm

Mission Zero in Action:
Error Prevention At Packard Children's

Ohio Children's Hospitals'
Solutions for
Patient Safety
Every patient. Every day.

1.2 Untitled Slide

Instructions

Please read the following instructions before proceeding.

- *Read the content on each slide carefully.*
- *Follow the steps as listed on the slide.*
- *Some slides are interactive and will not allow you to proceed unless you have clicked on all the buttons/images.*

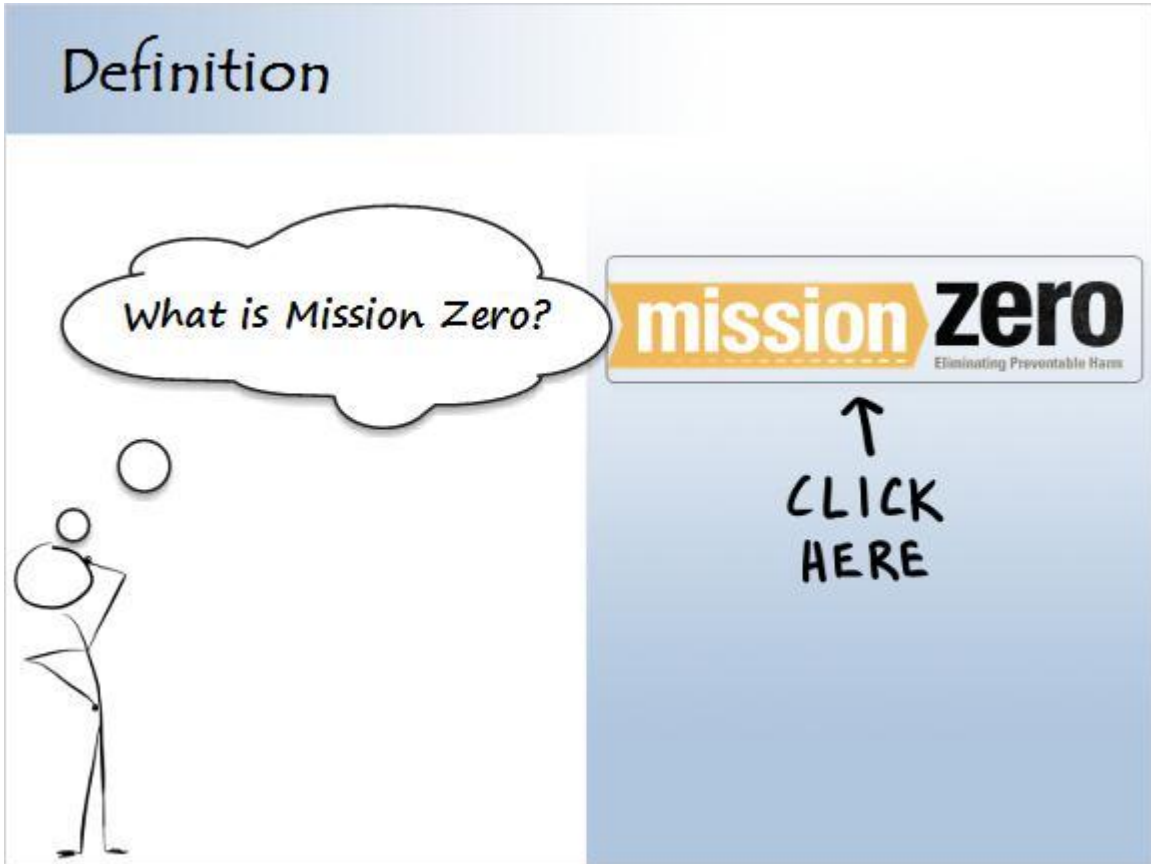
1.3 Untitled Slide

Objectives

- Provide an overview of Mission Zero and the current state of preventable patient harm at Packard Children's
- Provide an understanding of how human error contributes to safety events
- Introduce proven safety behaviors to promote a safe environment
- Explain how safety behaviors and actions will be a part of your everyday work
- Demonstrate the link between various Packard Children's initiatives and Mission Zero

1.4 Untitled Slide

Definition




What is Mission Zero?

mission zero
Eliminating Preventable Harm


↑
CLICK
HERE

Layer 1 (Slide Layer)

Definition



Tell me more..



mission zero
Eliminating Preventable Harm

↑

Mission Zero means keeping our patients, visitors, and staff safe so we have no errors, no accidents and no safety events

Click [here](#) to continue.


1.5 Untitled Slide

Definition

- *We will eliminate preventable harm by:*
 - ▶ *Introducing and sustaining evidence-based practice into standard work*
 - ▶ *Supporting a personal and organizational commitment to transform our culture of safety through*
 - *Integration of standardized communication*
 - *Issue escalation*
 - *Non-punitive response to errors*
 - *Rounding by all leaders*
 - *Culture of continuous improvement*

1.6 Untitled Slide

Definition



But what is preventable harm?

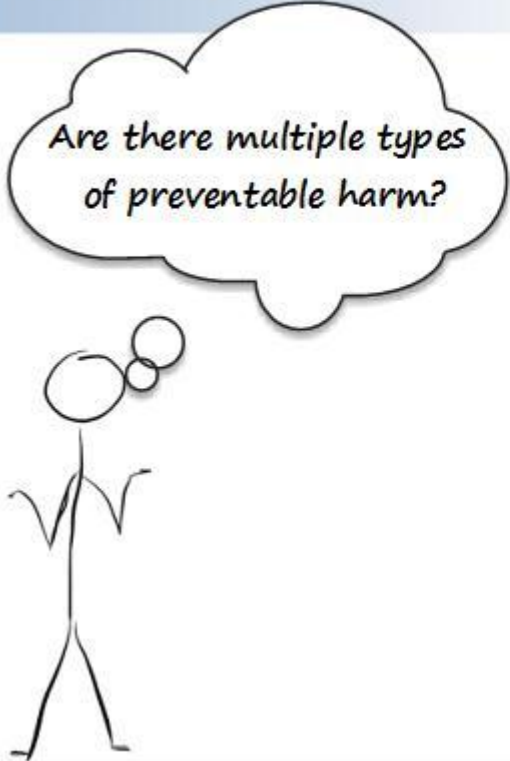
Harm to patients that can be prevented.

For example:
Poor hand hygiene and hub scrubbing/drying results in a patient getting a central line associated bloodstream infection (CLABSI)

Inadequate room cleaning between patients results in a patient getting a hospital acquired infection

1.7 Untitled Slide

Definitions



Are there multiple types of preventable harm?


At Packard Children's, we are working to reduce two types of preventable harm

Hospital Acquired Conditions (HAC)
HACs are undesirable situations or conditions that affect patients, arising during a hospital stay
Examples: Pressure ulcers, CLABSI

Serious Safety Events (SSE)
SSEs are deviations from our performance standards that reach the patient and result in moderate to severe harm or death


1.8 Untitled Slide

Definitions



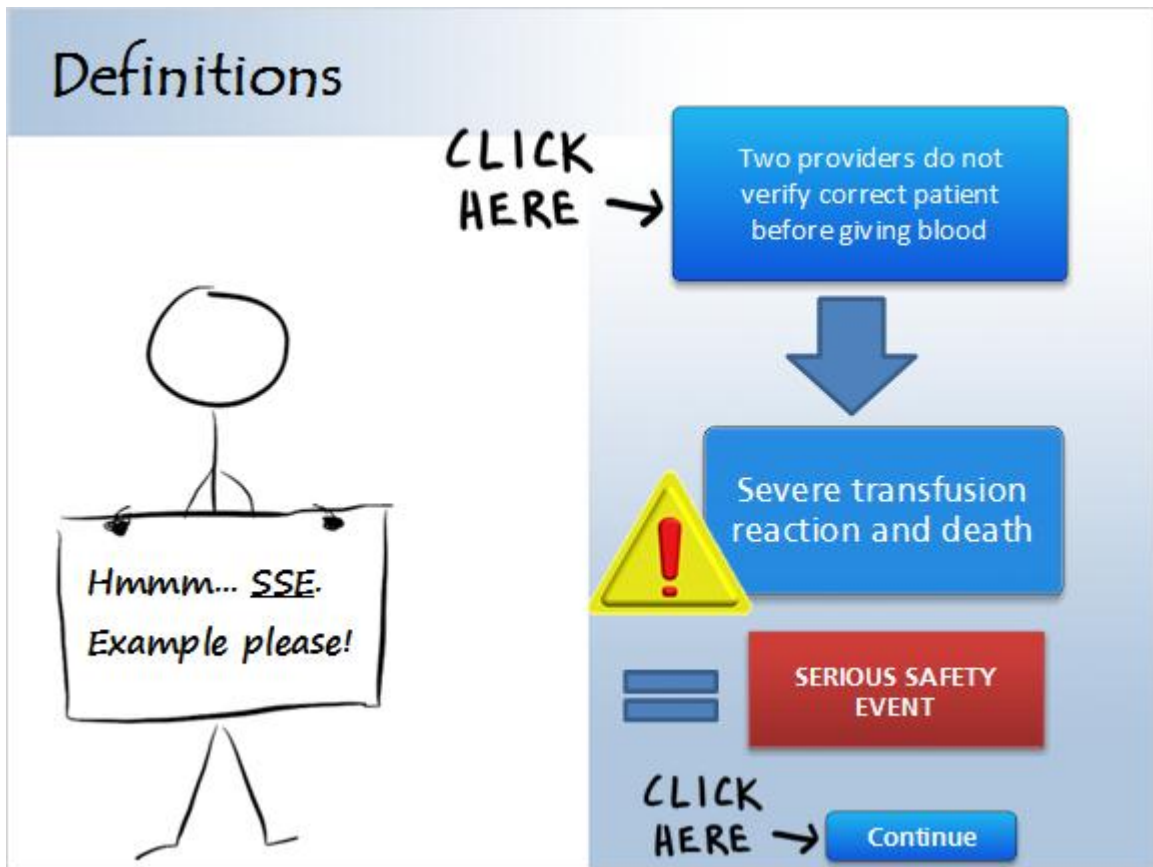
CLICK HERE →

Two providers do not verify correct patient before giving blood



The slide features a light blue header with the word "Definitions" in a dark font. Below the header, on the left, is a simple black stick figure holding a rectangular sign. The sign contains the text "Hmmm... SSE. Example please!". To the right of the figure, the words "CLICK HERE" are written in a bold, black, sans-serif font, with a black arrow pointing to the right. This arrow points towards a blue rectangular button with rounded corners. The button contains the text "Two providers do not verify correct patient before giving blood" in white. Below the button is a large, solid blue arrow pointing downwards.

SSE Example (Slide Layer)



Untitled Layer 2 (Slide Layer)

Definitions

CLICK HERE →

Two providers do not verify correct patient before giving blood

Hmmm... SSE.
Example please!

1.9 Untitled Slide

Definition

Then what is a Culture of Safety?

It is a common mindset and commitment to embrace safety as a core value in daily work
This means:

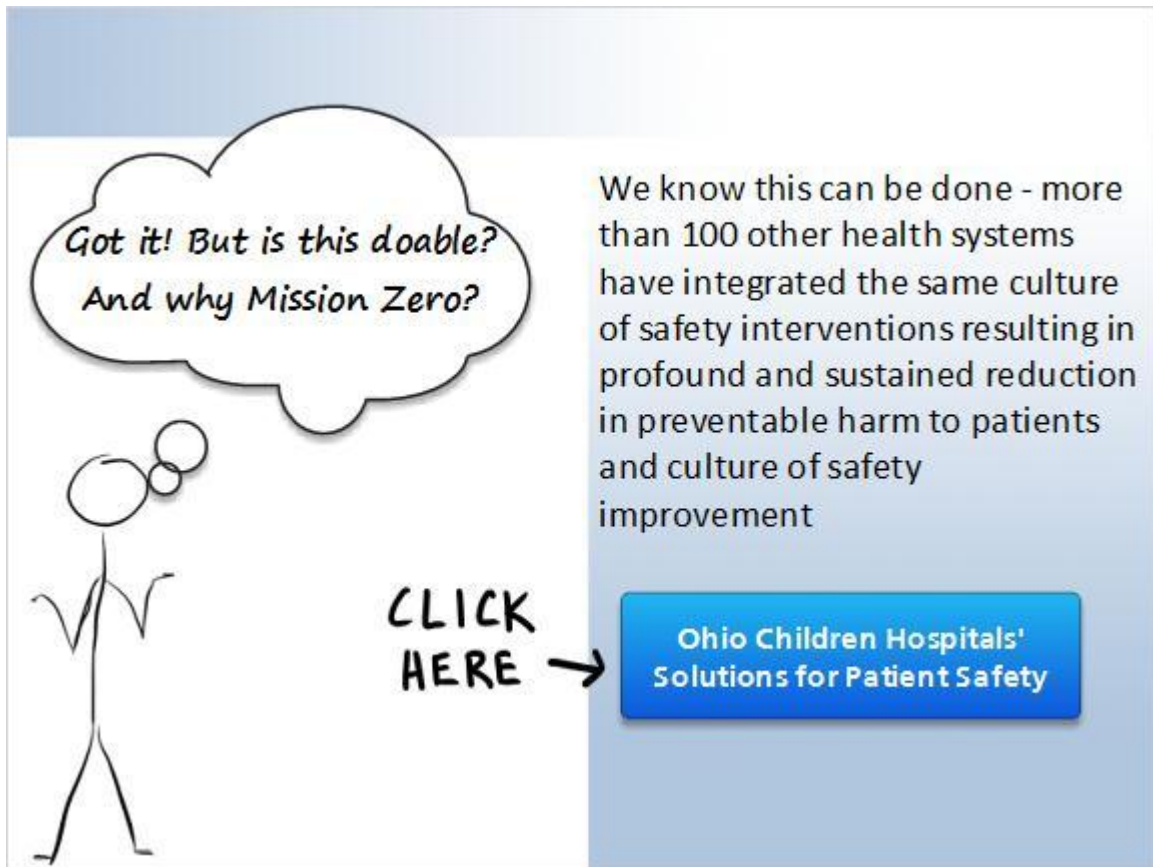
- Everyone** Makes a Personal Commitment to Safety
- Everyone** is Accountable for Clear & Complete Communication
- Everyone** Supports a Questioning Attitude



1.10 Untitled Slide



1.11 Untitled Slide



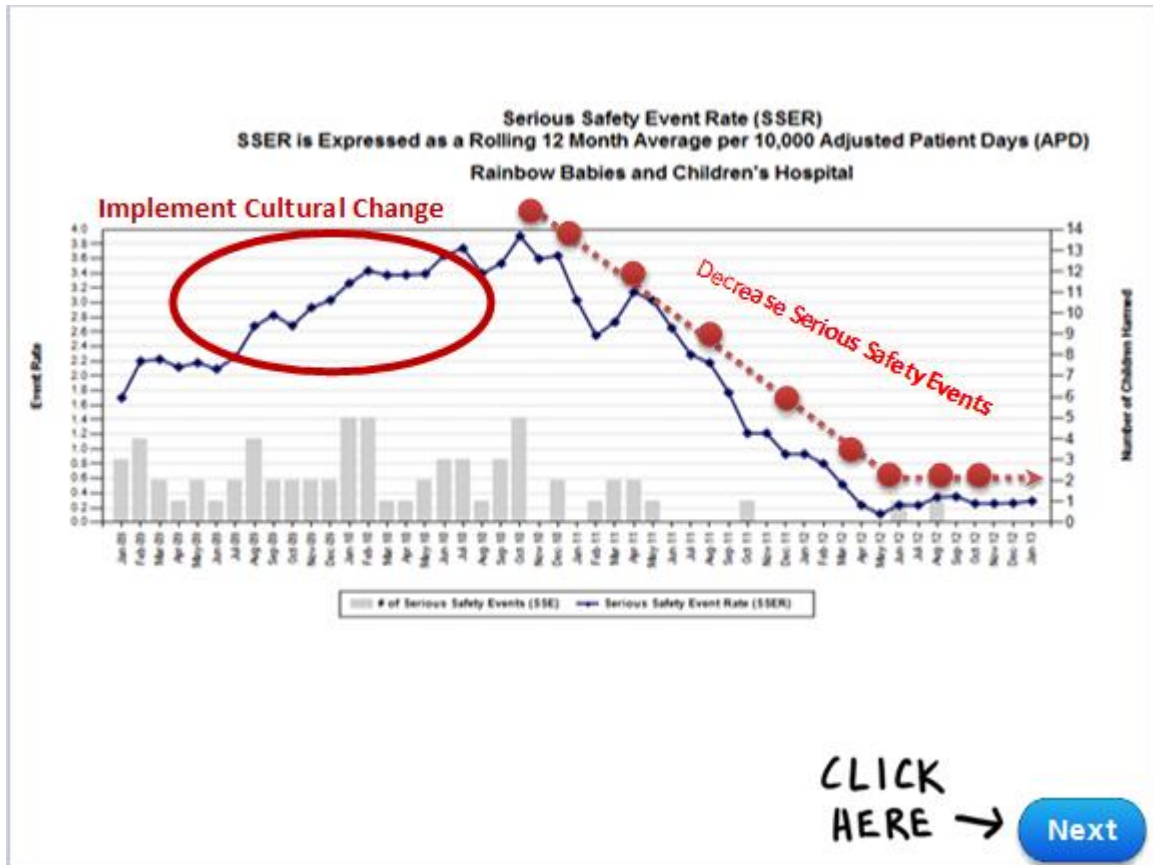
*Got it! But is this doable?
And why Mission Zero?*

We know this can be done - more than 100 other health systems have integrated the same culture of safety interventions resulting in profound and sustained reduction in preventable harm to patients and culture of safety improvement

**CLICK
HERE** →

**Ohio Children Hospitals'
Solutions for Patient Safety**

Graph (Slide Layer)



1.12 Untitled Slide

Safety is Important to Patients and Families

Patients expect us to:

Keep them safe

AND

Heal them

AND

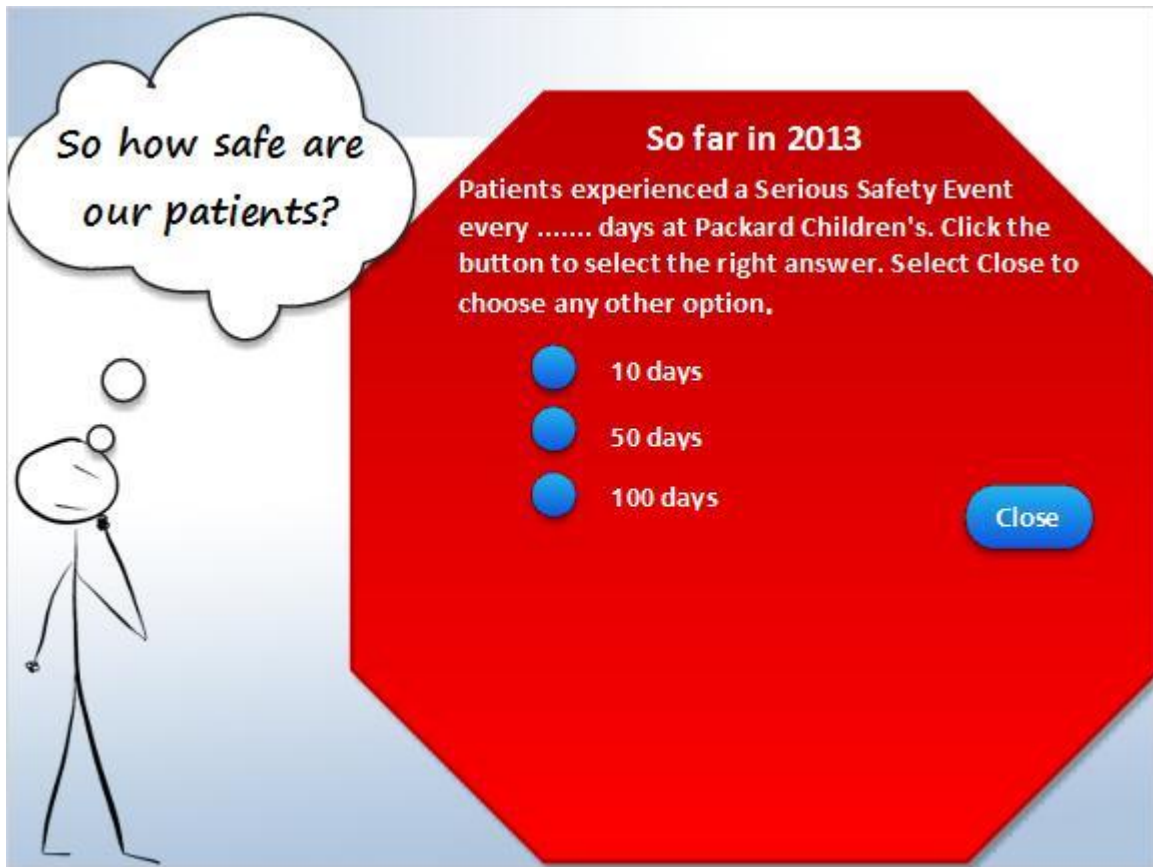
Be compassionate



Many of us have had a personal experience with patient safety
Have you, a family member or friend ever been harmed by medical error?

Have you ever been involved in a medical error?

1.13 Main Slide



So how safe are our patients?


So far in 2013

Patients experienced a Serious Safety Event every days at Packard Children's. Click the button to select the right answer. Select Close to choose any other option.

- 10 days
- 50 days
- 100 days

Close

Second question (Slide Layer)



So how safe are our patients?

So far in 2013

Patients experienced a Serious Safety Event every days at Packard Children's. Click the button to select the right answer. Select Close to choose any other option.

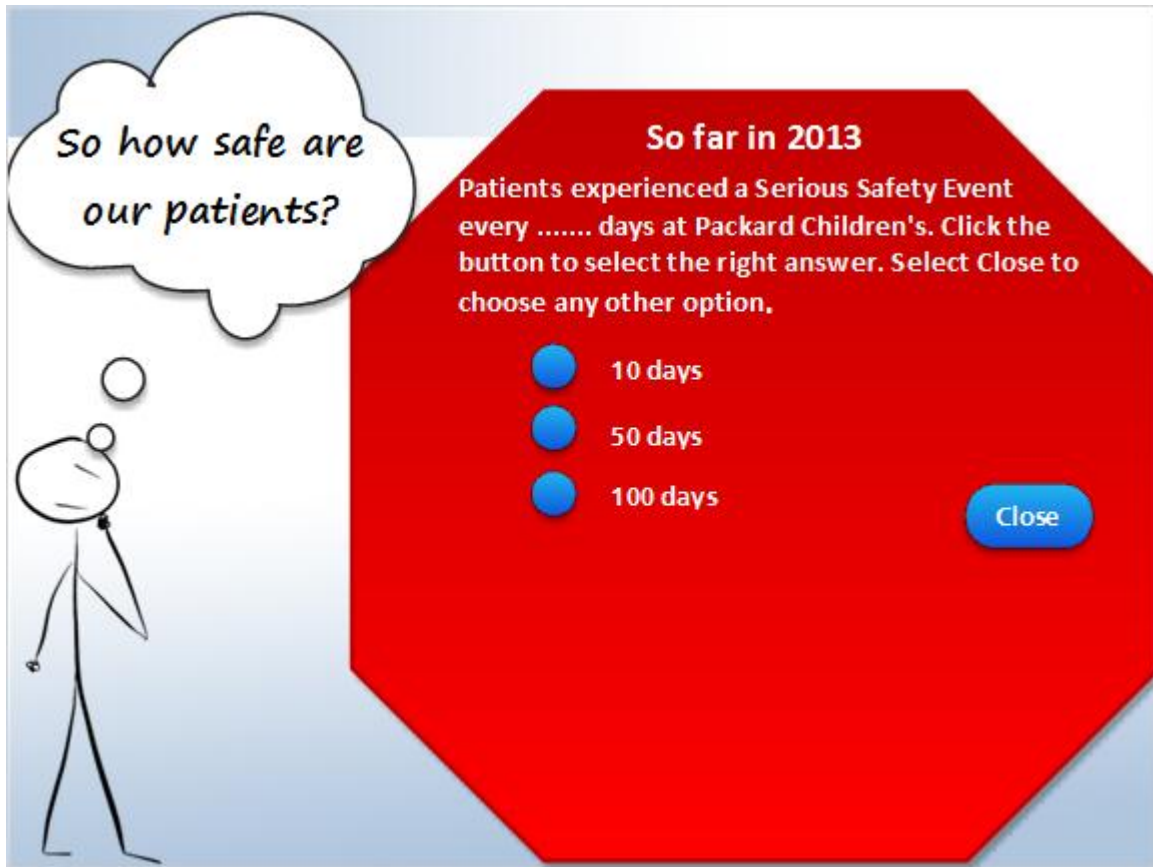
- 10 days
- 50 days
- 100 days

[Close](#)

A patient preventable death occurred every days at Packard Children's. Click the button to select the right answer.

- 180 days
- 91 days
- 365 days

Close button (Slide Layer)



Next button (Slide Layer)

The slide features a stick figure on the left with a thought bubble containing the text "So how safe are our patients?". To the right is a large red octagonal area containing a quiz. The quiz title is "So far in 2013". The text reads: "Patients experienced a Serious Safety Event every days at Packard Children's. Click the button to select the right answer. Select Close to choose any other option." There are three radio button options: "10 days", "50 days", and "91 days". The "91 days" option is selected. A feedback box says: "That's right! A patient preventable death occurred every 91 days." A "Close" button is in the top right of the red area. A "Next" button is in the bottom right of the red area, with the text "CLICK HERE" and an arrow pointing to it.

So how safe are our patients?

So far in 2013

Patients experienced a Serious Safety Event every days at Packard Children's. Click the button to select the right answer. Select Close to choose any other option.

10 days

50 days

91 days

That's right! A patient preventable death occurred every 91 days.

Close

CLICK HERE → Next

1.14 Untitled Slide

Are you concerned by how often our patients are seriously harmed?

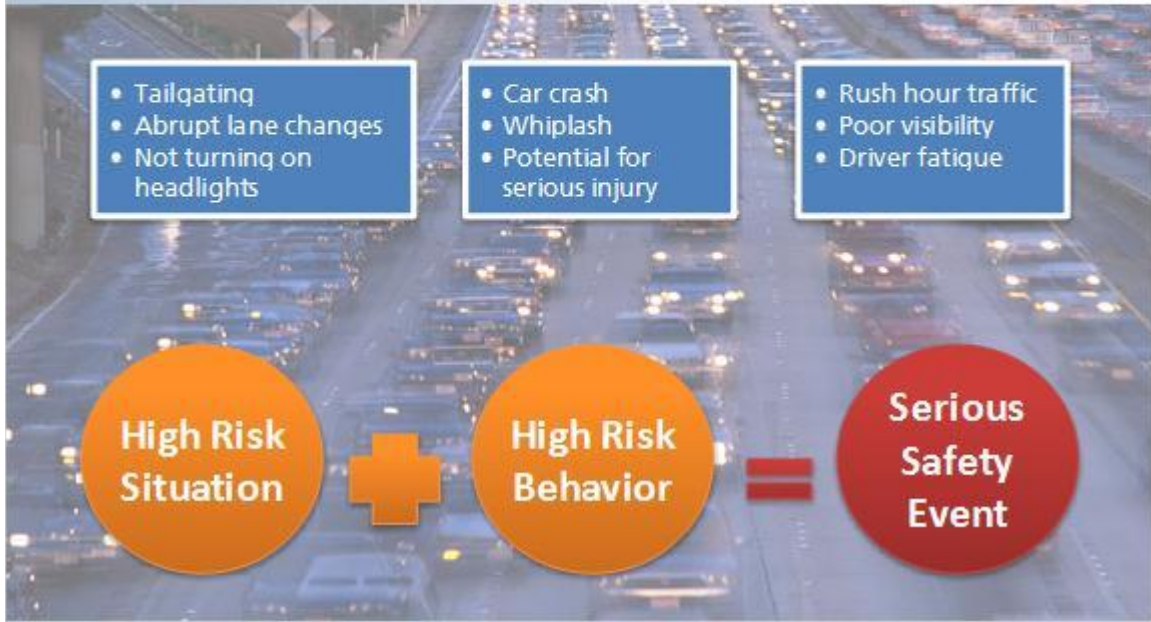


1.15 Drag and Drop

(Drag and Drop, 0 points, unlimited attempts permitted)

How do Serious Safety Events Occur?

Identify the correct situation, behavior, and Serious Safety Event by dragging and dropping the examples into the appropriate circles.



Drag Item	Drop Target
Tailgating	High Risk Behavior
Abrupt lane changes	
Not turning on headlights	
Rush hour traffic	High Risk Situation
Poor visibility	
Driver fatigue	
Car crash	Serious Safety Event
Whiplash	

Potential for serious injury

Drag and drop properties

Return item to start point if dropped outside any drop target

Snap dropped items to drop target (Stack random)

Delay item drop states until interaction is submitted

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response.

Correct (Slide Layer)

How do Serious Safety Events Occur?

Identify the correct situation, behavior, and Serious Safety Event by dragging and dropping the examples into the appropriate circles.

Correct

That's right! You selected the correct response.

Continue

High Risk Situation + High Risk Behavior = Serious Safety Event

- Tailgating
- Abrupt
- Not turning on headlights

our traffic
bility
atique

Incorrect (Slide Layer)

How do Serious Safety Events Occur?

Identify the correct situation, behavior, and Serious Safety Event by dragging and dropping the examples into the appropriate circles.

Incorrect

You did not select the correct response.

Continue

High Risk Situation + High Risk Behavior = Serious Safety Event

- Tailgating
- Abrupt
- Not turn on headlights

Your traffic Fatigue

Try Again (Slide Layer)

How do Serious Safety Events Occur?

Identify the correct situation, behavior, and Serious Safety Event by dragging and dropping the examples into the appropriate circles.

The slide features a background image of a multi-lane highway at night with heavy traffic. A central grey dialog box displays the text "Incorrect" and "Ooops! Please try again." with a "Try Again" button below it. To the left of the dialog, a blue box lists: "• Tailgating", "• Abrupt", "• Not turning on headlights". To the right, another blue box lists: "• Poor traffic", "• Visibility", "• Fatigue". Below the dialog, a diagram consists of three circles: an orange circle on the left containing "High Risk Situation", a plus sign, another orange circle in the middle containing "High Risk Behavior", an equals sign, and a red circle on the right containing "Serious Safety Event".

1.16 Main slide

Existing Safety Systems

Click on the button on your left to learn more about what a good safety systems can include. Please click from top to bottom.

Technology

Processes

People

Employee Safety

Technology (Slide Layer)

Existing Safety Systems

Click on the button on your left to learn more about what a good safety systems can include. Please click from top to bottom.

Technology

Processes

People

Employee Safety

Example: Pharmacy order entry system that warns the Pharmacist of potential drug interactions

Existing Safety Systems

Click on the button on your left to learn more about what a good safety systems can include. Please click from top to bottom.

Technology

Processes

People

Employee Safety

Example: Verification process which requires the team to pause before starting a procedure in order to confirm the correct procedure for the correct patient on the correct body site.

Other People (Slide Layer)

Existing Safety Systems

Click on the button on your left to learn more about what a good safety systems can include. Please click from top to bottom.

Technology

Processes

People

Employee Safety

Example: Staff member sees a coworker about to touch a patient without washing his hands and stops to remind him.

New Safety system (Slide Layer)

Existing Safety Systems

Click on the button on your left to learn more about what a good safety systems can include. Please click from top to bottom.

Technology

Processes

People

Employee Safety

Existing Safety Systems

Click on the button on your left to learn more about what a good safety systems can include. Please click from top to bottom.

Technology

Processes

People

Employee Safety

Example: Needles have safety mechanisms to prevent staff from accidentally sticking themselves.

We are introducing a new safety system called Error Prevention strategies to reduce the human error rate.

1.17 Untitled Slide

As Humans, We work in 3 Modes

Click on the question marks to learn more about the three modes. **You must click, and not hover on all three question marks to proceed.**



Skill-Based Performance
"Auto-Pilot Mode"



Rule-Based Performance
"If-Then Response Mode"



Knowledge-Based Performance
"Figuring It Out Mode"

As Humans, We work in 3 Modes

Click on the question marks to learn more about the three modes. **You must click, and not hover on all three question marks to proceed.**



Skill-Based Performance
"Auto-Pilot Mode"



Rule-Based Performance
"If-Then Response Mode"




Knowledge-Based Performance
"Figuring It Out Mode"

Next button (Slide Layer)

As Humans, We work in 3 Modes

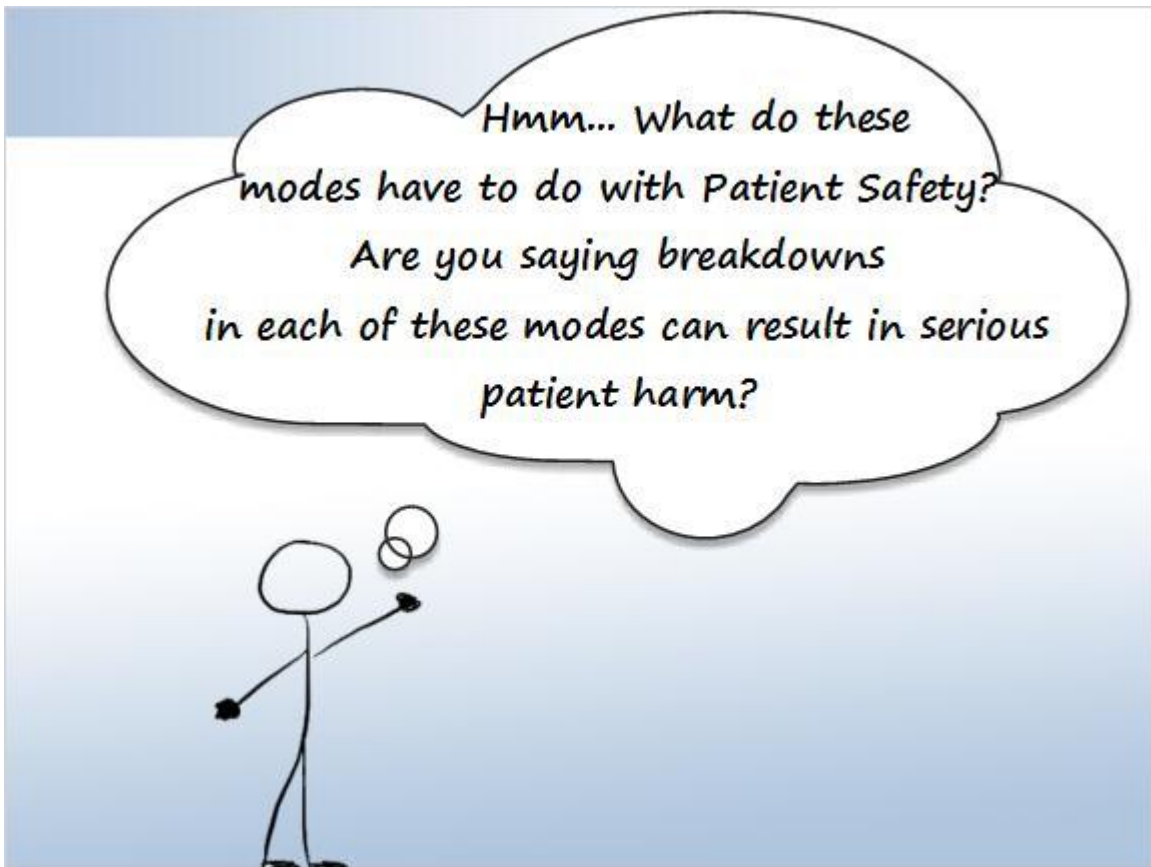
Click on the question marks to learn more about the three modes. **You must click, and not hover on all three question marks to proceed.**



- ? Skill-Based Performance
"Auto-Pilot Mode"
- ? Rule-Based Performance
"If-Then Response Mode"
- ? Knowledge-Based Performance
"Figuring It Out Mode"

CLICK HERE → [Next](#)

1.18 Untitled Slide



1.19 Untitled Slide

Patient Safety Example and 3 Modes of Performance

Earlier in the day, the ordering resident did not close the loop of communication and ordered what he thought he heard- 50mg, when actually the attending physician had communicated 15mg.

Next

Resident

Pharmacist

Nurse

CLICK HERE


Resident (Slide Layer)

Patient Safety Example and 3 Modes of Performance

Earlier in the day, the ordering resident did not close the loop of communication and ordered what he thought he heard- 50mg, when actually the attending physician had communicated 15mg.

Next

Resident




CLICK HERE

A pharmacist was functioning on auto pilot mode. He remembered approving a similar order earlier in the day and did not closely critique this new order.


Next

Pharmacist



CLICK HERE

Nurse



Nurse (Slide Layer)

Patient Safety Example and 3 Modes of Performance

Earlier in the day, the ordering resident did not close the loop of communication and ordered what he thought he heard- 50mg, when actually the attending physician had communicated 15mg.

Next

Resident

CLICK HERE

Pharmacist

A pharmacist was functioning on auto pilot mode. He remembered approving a similar order earlier in the day and did not closely critique this new order.

Nurse

The nurse administering a medication was unfamiliar with this type of order and tried to clarify with both the resident and pharmacist. Although her concerns were not answered to her satisfaction, she proceeded with administering the medication despite her doubt.

Click here to continue.

Next



1.20 Untitled Slide

Click on the images to identify Errors related to 3 Modes of Performance. You must click on all three images to proceed.

Earlier in the day, the ordering resident did not close the loop of communication and ordered what he thought he heard - 50mg, when actually the attending physician had communicated 15mg.

Resident



← CLICK
HERE

A pharmacist was functioning on auto pilot mode. He remembered approving a similar order earlier in the day and did not closely critique this new order.

Pharmacist



The nurse administering a medication was unfamiliar with this type of order and tried to clarify with both the resident and pharmacist. Although her concerns were not answered to her satisfaction, she proceeded with administering the medication despite her doubt.

Nurse



Nurse (Slide Layer)

Click on the images to identify Errors related to 3 Modes of Performance. You must click on all three images to proceed.

Earlier in the day, the ordering resident did not close the loop of communication and ordered what he thought he heard- 50mg, when actually the attending physician had communicated 15mg.

Resident



← CLICK
HERE

A pharmacist was functioning on auto pilot mode. He remembered approving a similar order earlier in the day and did not closely critique this new order.

Pharmacist



The nurse administering a medication was unfamiliar with this type of order and tried to clarify with both the resident and pharmacist. Although her concerns were not answered to her satisfaction, she proceeded with administering the medication despite her doubt.

Nurse




Skill-based errors (Slide Layer)

Click on the images to identify Errors related to 3 Modes of Performance. You must click on all three images to proceed.

Earlier in the day, the ordering resident did not close the loop of communication and ordered what he thought he heard- 50mg, when actually the attending physician had communicated 15mg.

Resident




← CLICK HERE

Pharmacist on auto-pilot, verifies med order. Sounds just like med ordered the day before.

Skill based errors occur when:
We are doing tasks so routine and familiar that we don't even have to think about what we are doing

The nurse administering a medication was unfamiliar with this type of order and tried to clarify with both the resident and pharmacist. Although her concerns were not answered to her satisfaction, she proceeded with administering the medication despite her doubt.

Nurse



CLICK HERE →

Rule Based errors (Slide Layer)

Click on the images to identify Errors related to 3 Modes of Performance. You must click on all three images to proceed.

Resident misheard attending's order over the phone (15mg as 50 mg) and didn't repeat back.

A pharmacist was functioning on auto pilot mode. He remembered approving a similar order earlier in the day and did not closely critique this new order.

The nurse administering a medication was unfamiliar with this type of order and tried to clarify with both the resident and pharmacist. Although her concerns were not answered to her satisfaction, she proceeded with administering the medication despite her doubt.

Rule based errors

occur when:

We choose how to respond to a situation that has a rule, but

- We use the wrong Rule
- We misapplied the rule
- We choose not to follow the rule

Two-Thirds of healthcare human errors are rule based (Wow that's a lot!)

Pharmacist



← CLICK
HERE

Nurse



Knowledge-based errors (Slide Layer)

Click on the images to identify Errors related to 3 Modes of Performance. You must click on all three images to proceed.

Earlier in the day, the ordering resident did not close the loop of communication and ordered what he thought he heard- 50mg, when actually the attending physician had communicated 15mg.

Resident



← CLICK
HERE

A pharmacist was functioning on auto pilot mode. He remembered approving a similar order earlier in the day and did not closely critique this new order.

Pharmacist



The nurse, after trying several sources for clarification, reluctantly gives the medication.

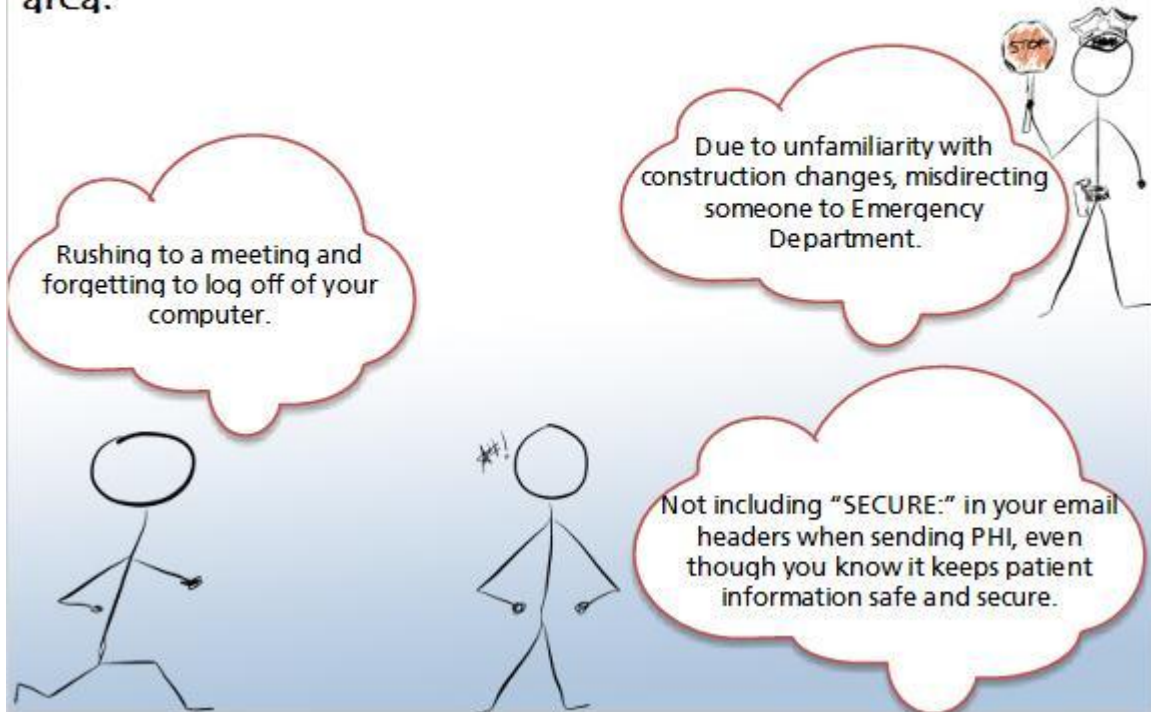
Knowledge based errors occur when we are problem solving in a new, unfamiliar situation. We don't have a skill or no rules, we come up with the answer by:

- Using what we do know (fundamentals)
- Taking a guess
- Figuring it out by trial-and-error

If you guess, you have a 50-50 chance of getting it wrong.

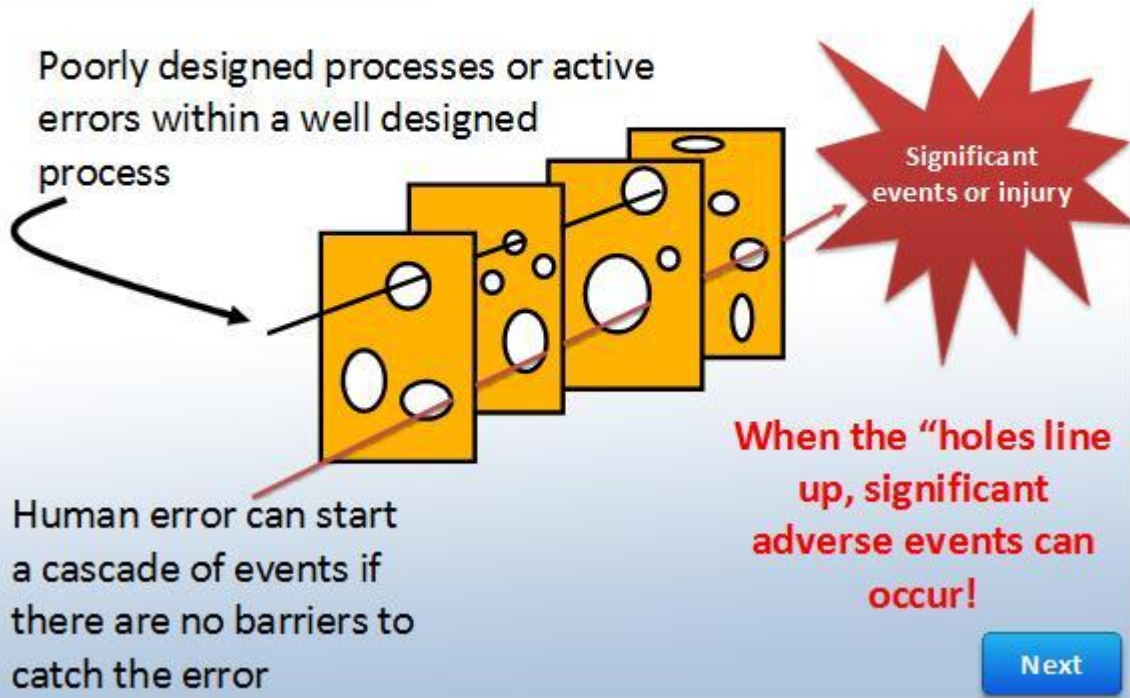
1.21 Untitled Slide

Take a minute to reflect on knowledge based, skill based and rule based errors that might happen in your work area.

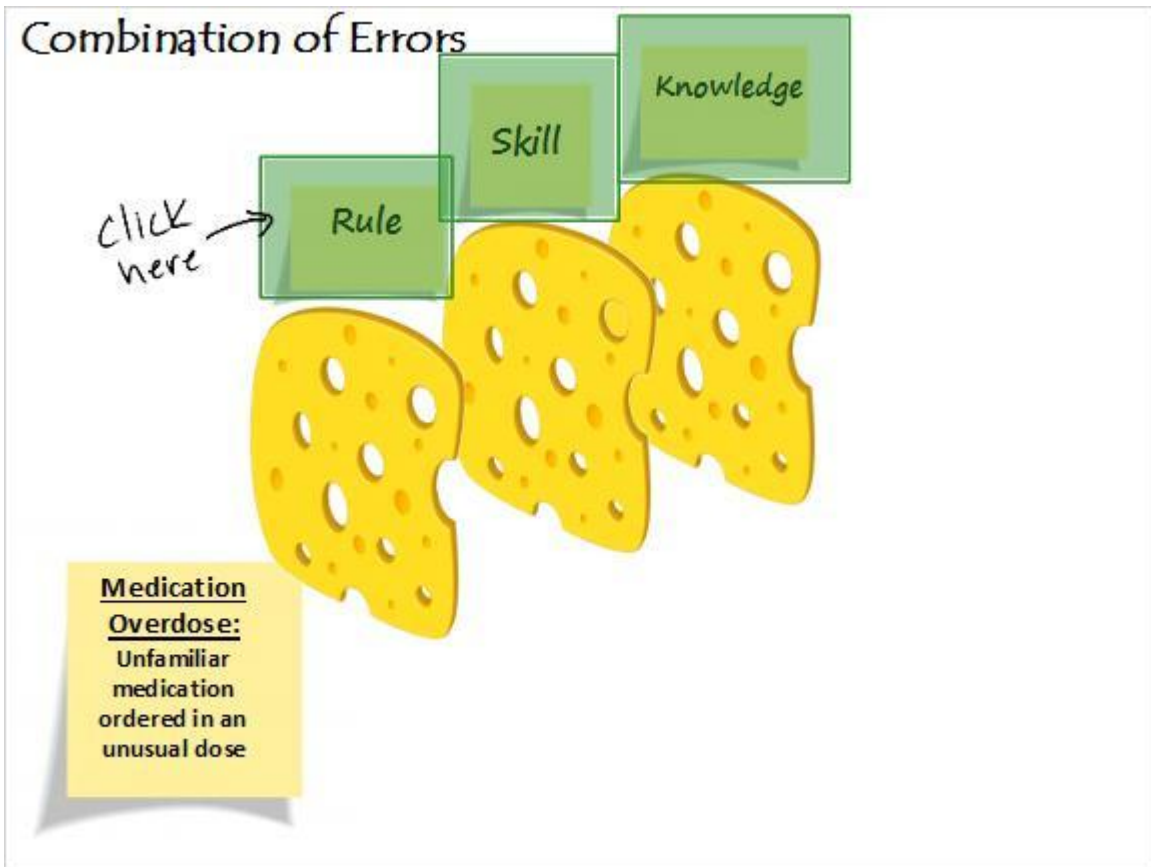


1.22 Untitled Slide

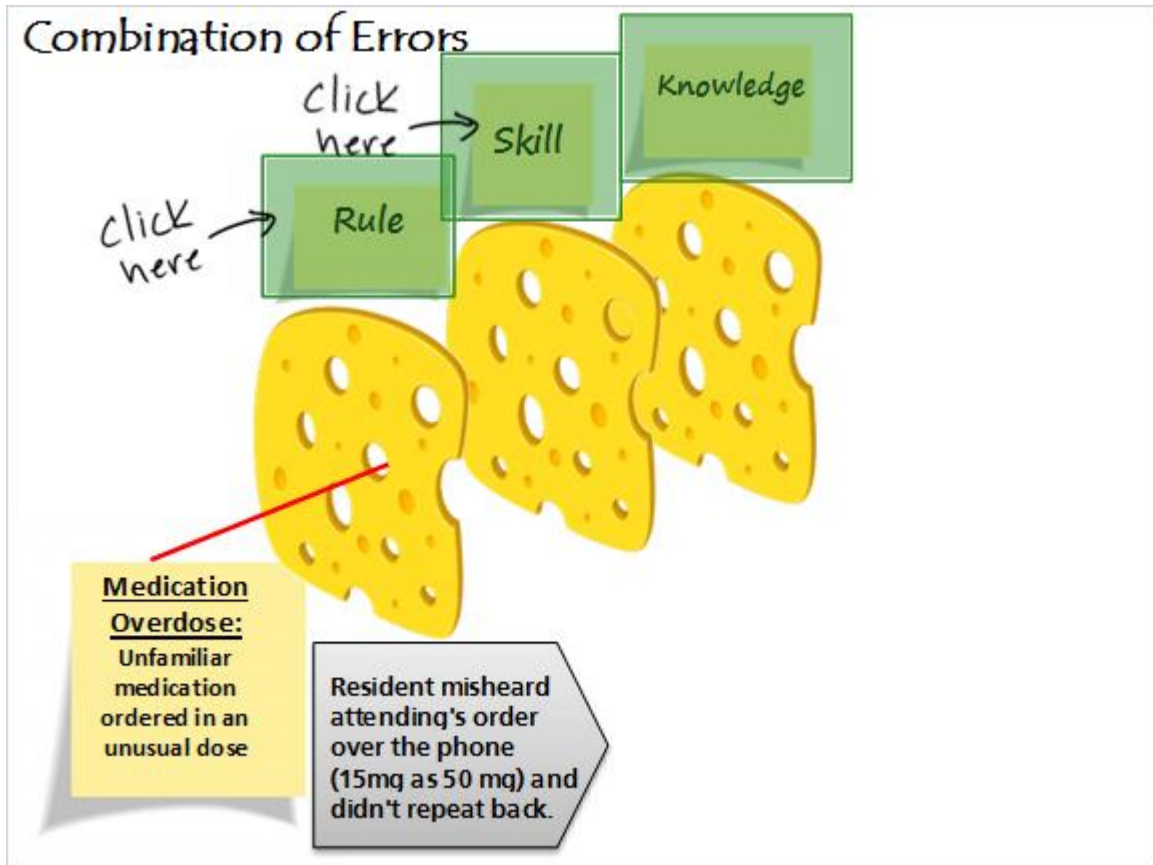
Think of a series of errors like Swiss cheese



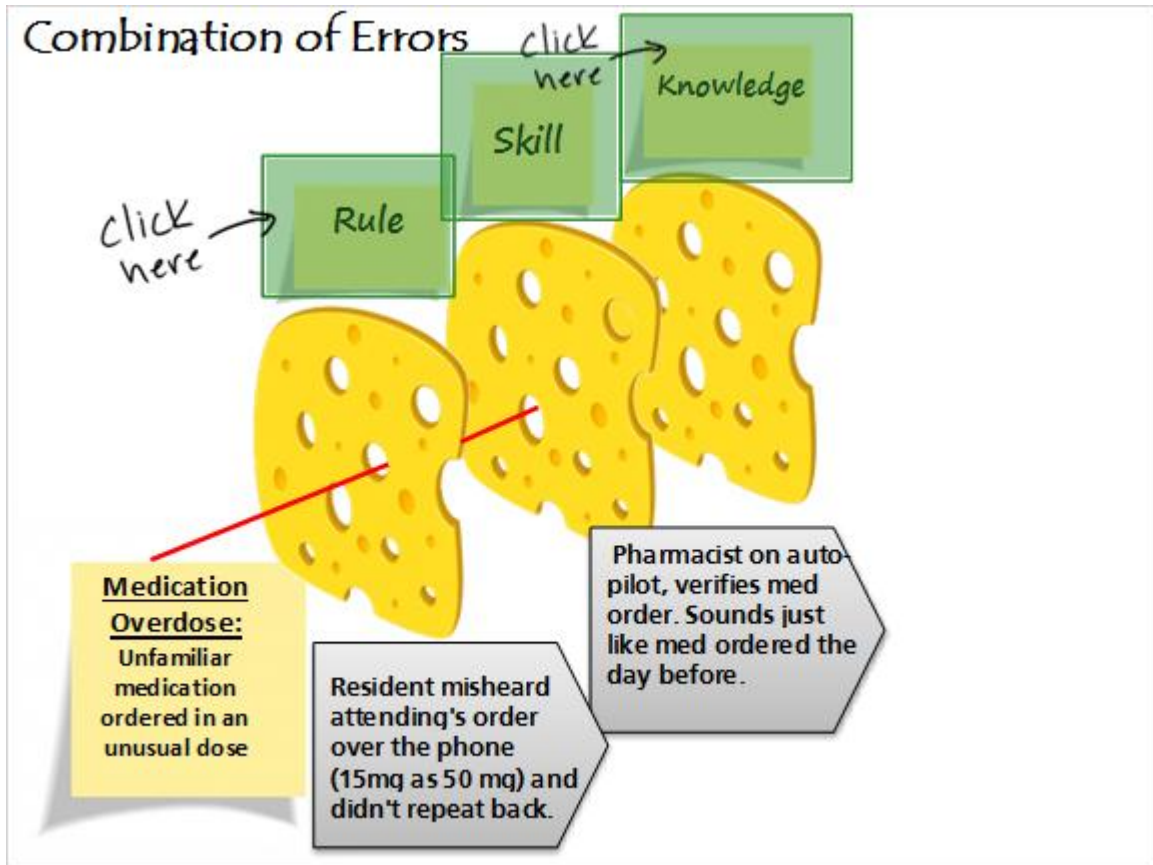
1.23 Untitled Slide



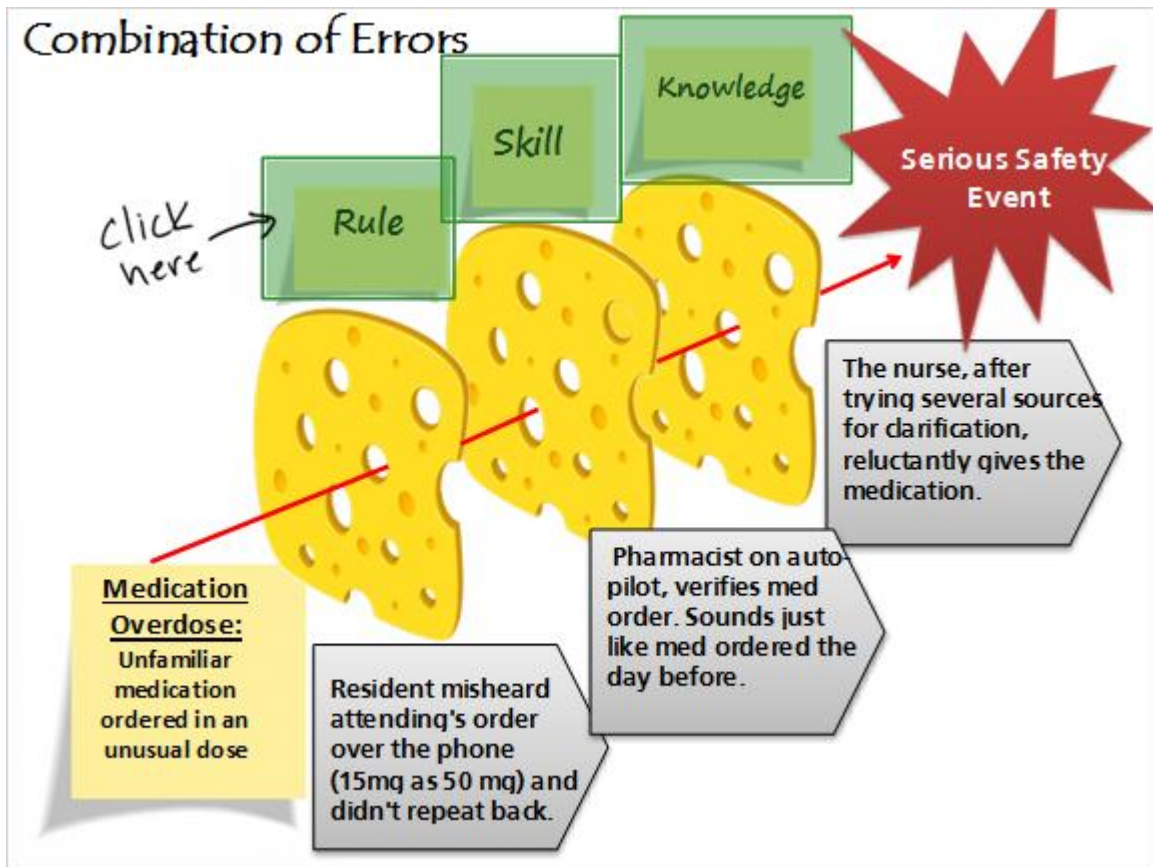
Rule (Slide Layer)



Skill (Slide Layer)



Knowledge (Slide Layer)



1.24 Untitled Slide



1.25 Title Layer

How do we reduce preventable harm?

click here →

Mission Zero is the evolution of our current work to reduce preventable harm through

- Identifying and fixing system problems (the holes in the Swiss cheese)
- Reducing the human error rate

Identify and fix issues (Slide Layer)

The slide features a stick figure on the left with a thought bubble above it containing the text "How do we reduce preventable harm?". A hand-drawn arrow points from the text "click here" to a blue-bordered box on the right. This box contains a list of three bullet points and a "Back" button at the bottom.

How do we reduce preventable harm?

click here

Mission Zero is the evolution of our current work to reduce preventable harm through

- Implement standard processes (HAC reduction, PQMS principle)
- Making it easier to identify and communicate safety concerns (PQMS, tiered huddles, PCARES, incident reporting system)
- Analyze safety events to reduce recurrence (Root Cause Analysis-RCA)

Back

Reducing human error (Slide Layer)

The slide features a stick figure on the left with a thought bubble above it containing the text "How do we reduce preventable harm?". A hand-drawn arrow points from the text "click here" to the top-left corner of a large rounded rectangular box on the right. This box contains the text "Mission Zero is the evolution of our current work to reduce preventable harm through" followed by two bullet points. At the bottom right of this box is a blue button labeled "Back".

How do we reduce preventable harm?

click here

Mission Zero is the evolution of our current work to reduce preventable harm through

- Implement **safety behaviors** using error prevention strategies
- *These safety behaviors are critical to the success of Mission Zero*

Back

Click here (Slide Layer)

How do we reduce preventable harm?

Mission Zero is the evolution of our current work to reduce preventable harm through

Identifying and fixing system problems (the holes in the Swiss cheese)

Reducing the human error rate

1.26 Untitled Slide

How can you help improve our Culture of Safety?

Click each of the boxes below to continue.

Everyone Makes a Personal Commitment to Safety

Everyone is Accountable for Clear & Complete Communication

Everyone Supports a Questioning Attitude

Personal Commitment (Slide Layer)

How can you help improve our Culture of Safety?

Click each of the boxes below to continue.



Everyone Makes a Personal Commitment to Safety

"I will demonstrate a personal and a team commitment to safety."



Everyone is Accountable for Clear & Complete Communication



Everyone Supports a Questioning Attitude

Accountable (Slide Layer)

How can you help improve our Culture of Safety?

Click each of the boxes below to continue.

Everyone Makes a Personal Commitment to Safety

"I will demonstrate a personal and a team commitment to safety."

Everyone is Accountable for Clear & Complete Communication

"I am personally responsible for concise, accurate, clear, and timely verbal and written communications."

Everyone Supports a Questioning Attitude

Questioning Attitude (Slide Layer)

How can you help improve our Culture of Safety?

Click each of the boxes below to continue.

Everyone Makes a Personal Commitment to Safety

"I will demonstrate a personal and a team commitment to safety."

Everyone is Accountable for Clear & Complete Communication

"I am personally responsible for concise, accurate, clear, and timely verbal and written communications."

Everyone Supports a Questioning Attitude

"I will question. I will welcome being questioned."

1.27 Slide 26

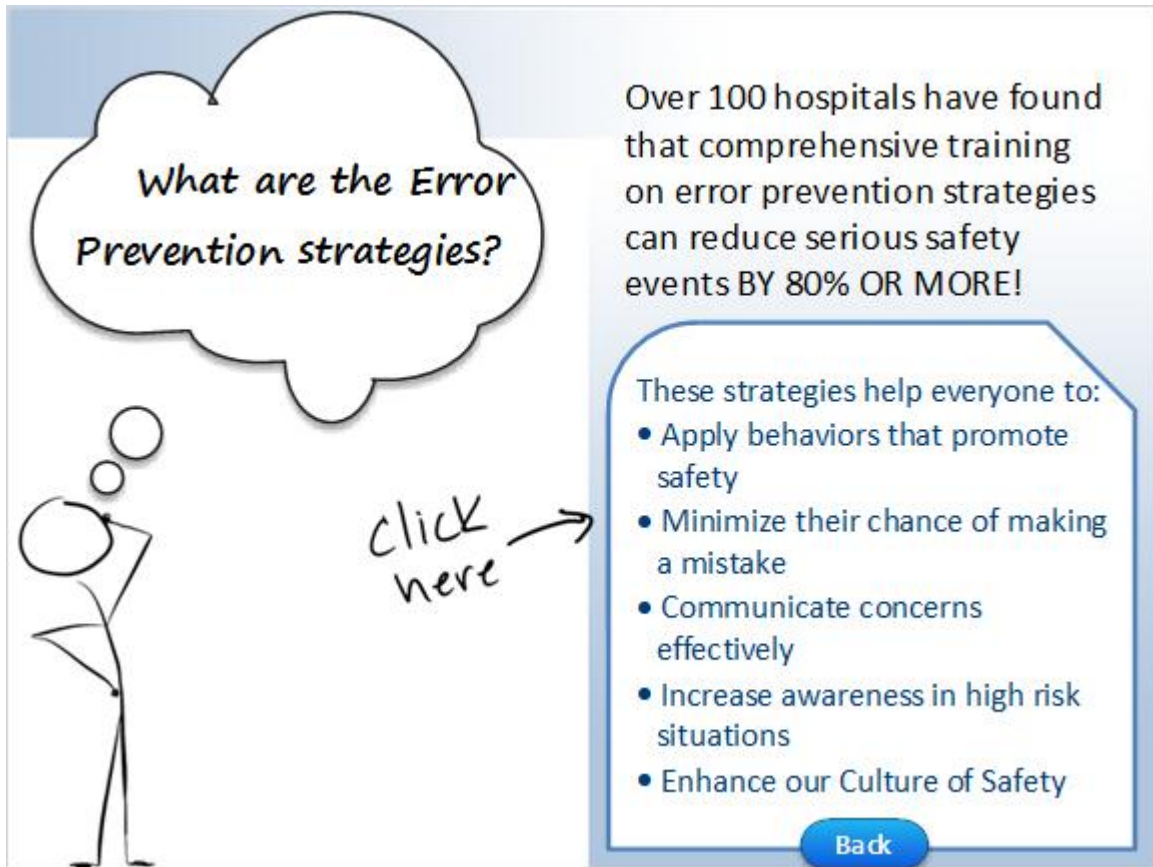
What are the Error Prevention strategies?

click here →

Error Prevention Strategies

Over 100 hospitals have found that comprehensive training on error prevention strategies can reduce serious safety events BY 80% OR MORE!

Strategies (Slide Layer)



What are the Error Prevention strategies?

Over 100 hospitals have found that comprehensive training on error prevention strategies can reduce serious safety events BY 80% OR MORE!

These strategies help everyone to:

- Apply behaviors that promote safety
- Minimize their chance of making a mistake
- Communicate concerns effectively
- Increase awareness in high risk situations
- Enhance our Culture of Safety

Back

10 times more likely (Slide Layer)

What are the Error Prevention strategies?

click here →

Error Prevention Strategies

By using these strategies you will be **10 times MORE likely** to prevent a human error.

1.28 Untitled Slide



How are these strategies supported by PQMS and PCARES principles?

Each month, Packard:

- Focuses on 1-2 Error Prevention strategies that prevent skill, rule or knowledge based errors
- Includes Error Prevention education at meetings, huddles & rounds

MORE INFO → [Continue](#)

1.29 Untitled Slide

Error Prevention strategies are supported by:

- Leaders rounding in gemba, seeking feedback and providing recognition
- Visual process management boards
- Using scenarios and exercises to facilitate conversation
- Integration of Error Prevention strategies into current processes

Annual HealthStream refresher

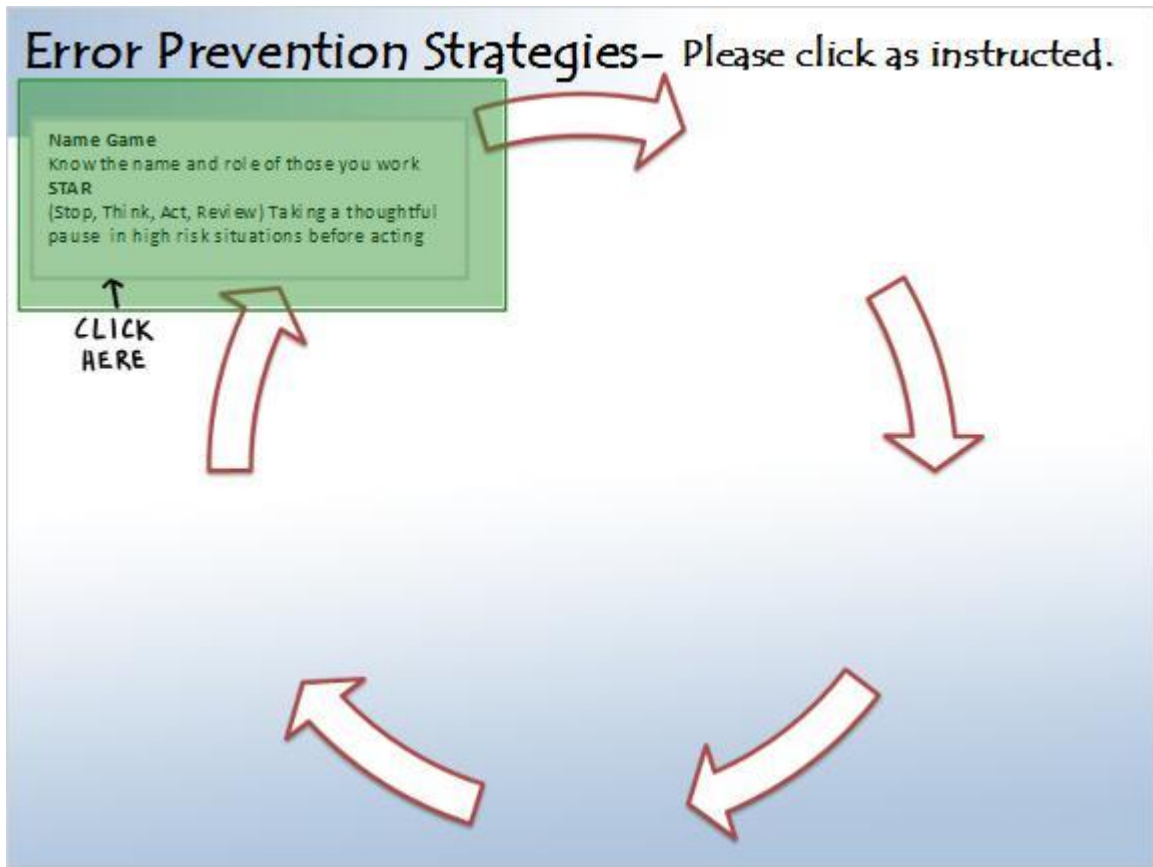
- Expected safety behaviors
- Error Prevention strategies

1.30 Untitled Slide

Error Prevention Strategies- Please click as instructed.

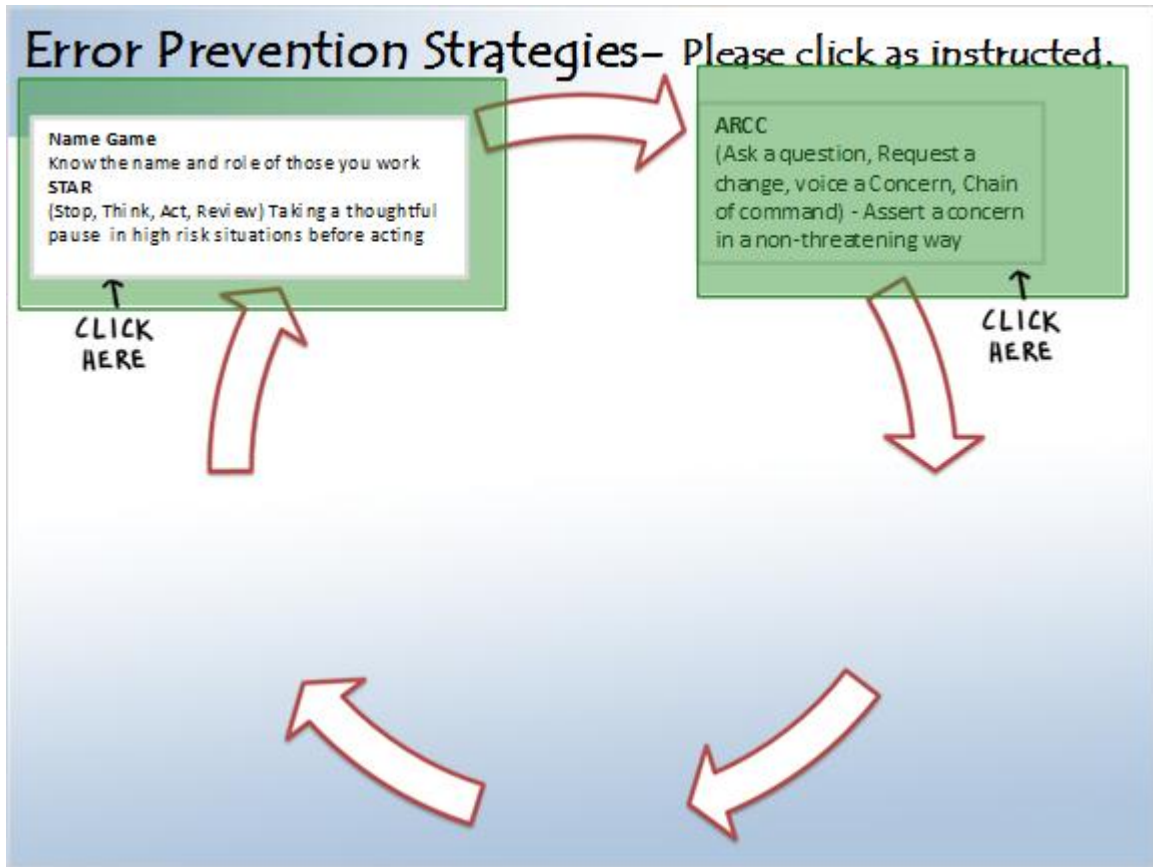
Name Game
Know the name and role of those you work
STAR
(Stop, Think, Act, Review) Taking a thoughtful
pause in high risk situations before acting.

CLICK
HERE

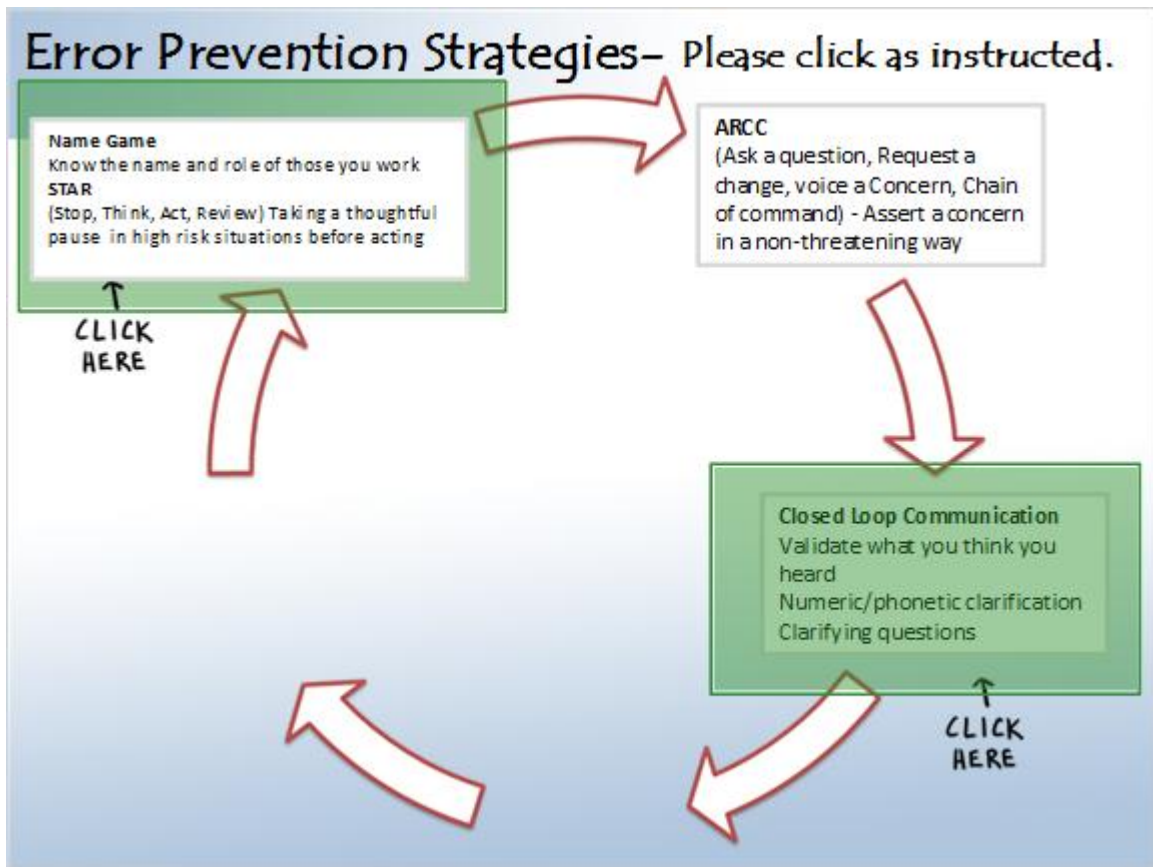


The diagram features a central green rectangular box containing text. To the left of the box, the text 'CLICK HERE' is written in black, with a small black arrow pointing upwards towards the bottom-left corner of the box. Five large, red-outlined arrows are positioned around the box: one at the top-right, one at the top, one at the bottom-right, one at the bottom, and one at the bottom-left. The background of the slide is a light blue gradient.

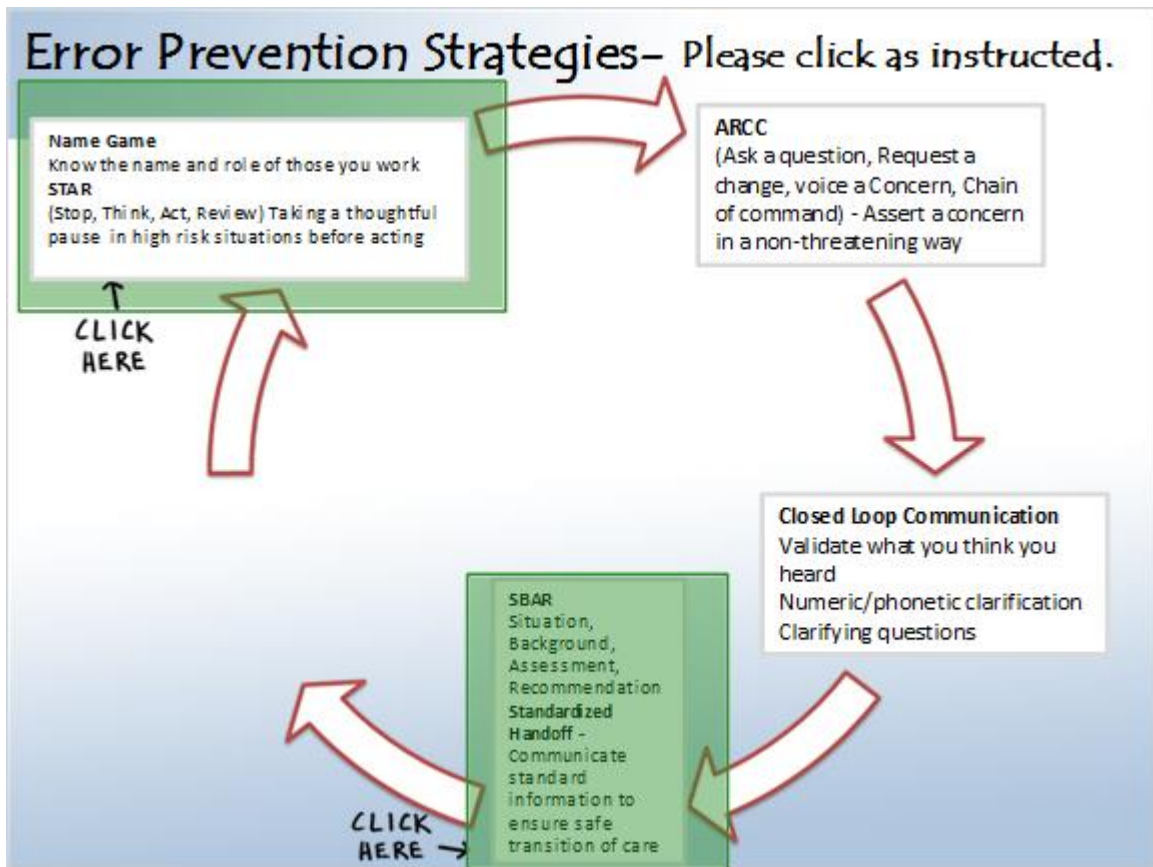
ARCC (Slide Layer)



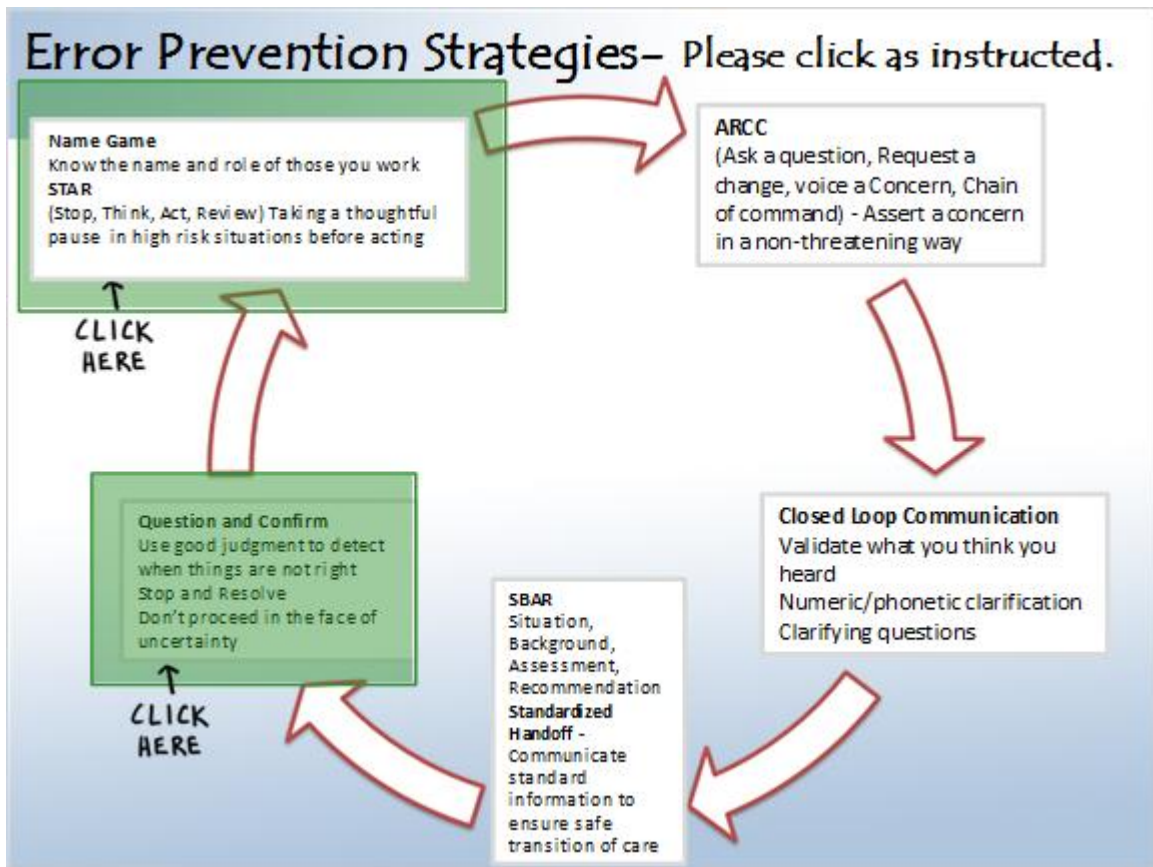
Closed loop communication (Slide Layer)



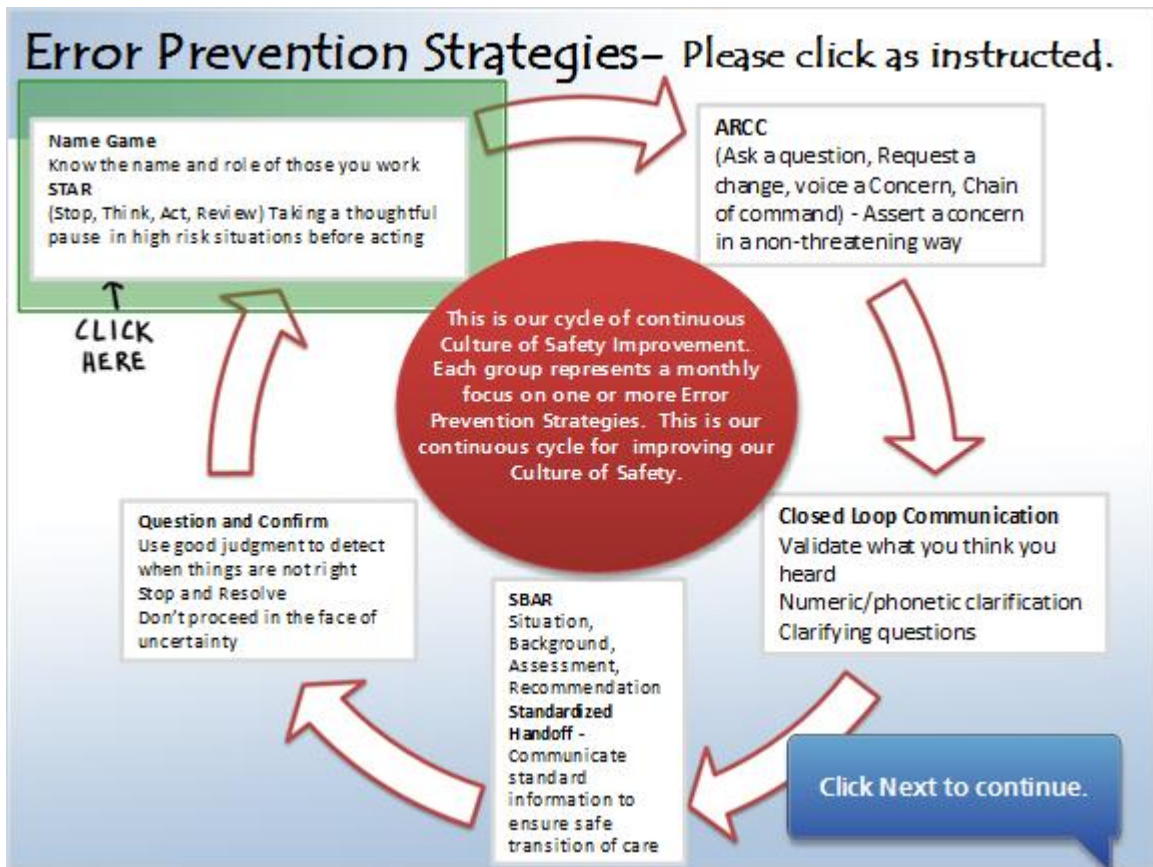
SBAR (Slide Layer)



Question n confirm (Slide Layer)



Circle (Slide Layer)



1.31 Untitled Slide

Thinking back to the Swiss cheese model, how can Error Prevention strategies help? Click on the boxes from left to right. You must click on all three boxes to proceed.

Resident misheard attending's order over the phone (15mg as 50 mg) and didn't repeat back.

Pharmacist on autopilot, verifies med order. Sounds just like med ordered the day before.

The nurse, after trying several sources for clarification, reluctantly gives the medication.

Resident (Slide Layer)

Thinking back to the Swiss cheese model, how can Error Prevention strategies help? Click on the boxes from left to right. You must click on all three boxes to proceed.

Resident misheard attending's order over the phone (15mg as 50 mg) and didn't repeat back.

Pharmacist on autopilot, verifies med order. Sounds just like med ordered the day before.

The nurse, after trying several sources for clarification, reluctantly gives the medication.

The resident Performs ***closed-loop communication*** using numeric clarification.

Order is clarified as 15mg, "one-five," and the medication is ordered correctly.

Pharmacist (Slide Layer)

Thinking back to the Swiss cheese model, how can Error Prevention strategies help? Click on the boxes from left to right. You must click on all three boxes to proceed.

Resident misheard attending's order over the phone (15mg as 50 mg) and didn't repeat back.

The resident Performs ***closed-loop communication*** using numeric clarification.

Order is clarified as 15mg, "one-five," and the medication is ordered correctly.

Pharmacist on autopilot, verifies med order. Sounds just like med ordered the day before.

The pharmacist ***Stops***
Thinks
Acts
Reviews

The pharmacist questions the order and phones the ordering physician

The nurse, after trying several sources for clarification, reluctantly gives the medication.

Nurse (Slide Layer)

Thinking back to the Swiss cheese model, how can Error Prevention strategies help? Click on the boxes from left to right. You must click on all three boxes to proceed.

Resident misheard attending's order over the phone (15mg as 50 mg) and didn't repeat back.

The resident Performs **dosed-loop communication** using numeric clarification.

Order is clarified as 15mg, "one-five," and the medication is ordered correctly.

Pharmacist on auto-pilot, verifies med order. Sounds just like med ordered the day before.

The pharmacist **Stops Thinks Acts Reviews**


The pharmacist questions the order and phones the ordering physician

The nurse, after trying several sources for clarification, reluctantly gives the medication.

The nurse **Questions and Confirms**

The nurse continues to question until she confirms the correct dose with the attending

1.32 Untitled Slide



What is my role in Error Prevention?

- **Advocate** for safety - speak up
 - Think - "What if this was my child?"
- **Incorporate the strategies** into your daily practice
- **Encourage others** to use the strategies to keep patient, staff, and visitors safe
- **Apply the strategies** to discuss potential and actual safety events in your area
 - How do they help stop safety events from happening?
 - How could they be applied to prevent reoccurrence?

1.33 Untitled Slide

How do Error Prevention, PCARES, PQMS and Epic work together to improve our culture of safety? Click inside the circles to learn more. You must click inside all four circles to proceed.

The diagram features four green circles arranged horizontally. From left to right, they contain the following content:

- PQMS:** A circular graphic with a bar chart and the text "Florida Comprehensive Family-Centered Care" at the top, "Improvement and Evaluation" in the middle, and "Measure for People" at the bottom.
- PCARES:** The text "PCARES" in a stylized font.
- Epic:** The "Epic" logo in its characteristic red and black font.
- Error Prevention:** The text "Epic Children's Hospital Solutions for Patient Safety" with the tagline "Extra patient. Extra safe." below it.

Below each circle is a blue rectangular button with the same name as the circle: "PQMS", "PCARES", "Epic", and "Error Prevention". A large, light blue arrow with a white outline points from left to right across the bottom of the four circles, with the text "CULTURE OF SAFETY" centered inside it.

pqms (Slide Layer)

How do Error Prevention, PCARES, PQMS and Epic work together to improve our culture of safety? Click inside the circles to learn more. You must click inside all four circles to proceed.

The diagram features four green circles arranged horizontally. From left to right, they are: 1. PQMS, which contains a bar chart and the text 'Florida Education Quality Improvement System' and 'Measuring and Improving Performance'. 2. PCARES. 3. Epic. 4. Error Prevention, which contains the text 'St. Joe Children's Hospital Solutions for Patient Safety Every patient. Every day.' Below each circle is a blue rectangular label with the same name: 'PQMS', 'PCARES', 'Epic', and 'Error Prevention'. A large, light blue arrow points from left to right across the bottom of the circles, with the text 'CULTURE OF SAFETY' centered on it.

As Packard's management and improvement system, PQMS supports and enables a culture of safety by emphasizing a patient-centric mindset, empowering individual accountability, & demanding the relentless elimination of defects.

pcares (Slide Layer)

How do Error Prevention, PCARES, PQMS and Epic work together to improve our culture of safety? Click inside the circles to learn more. You must click inside all four circles to proceed.

The diagram features four green circular icons arranged horizontally. From left to right: 1. PQMS: A circular icon containing a bar chart with three bars of increasing height, labeled 'PQMS'. 2. PCARES: A circular icon with the word 'PCARES' in a stylized font. 3. Epic: A circular icon with the 'Epic' logo in red. 4. Error Prevention: A circular icon with the text 'Solutions for Patient Safety' and 'Every patient. Every day.' Below each icon is a blue rectangular button with the same name: 'PQMS', 'PCARES', 'Epic', and 'Error Prevention'. A large, light blue arrow points from left to right across the bottom of the icons, with the text 'CULTURE OF SAFETY' centered inside it.

PQMS

PCARES

Epic

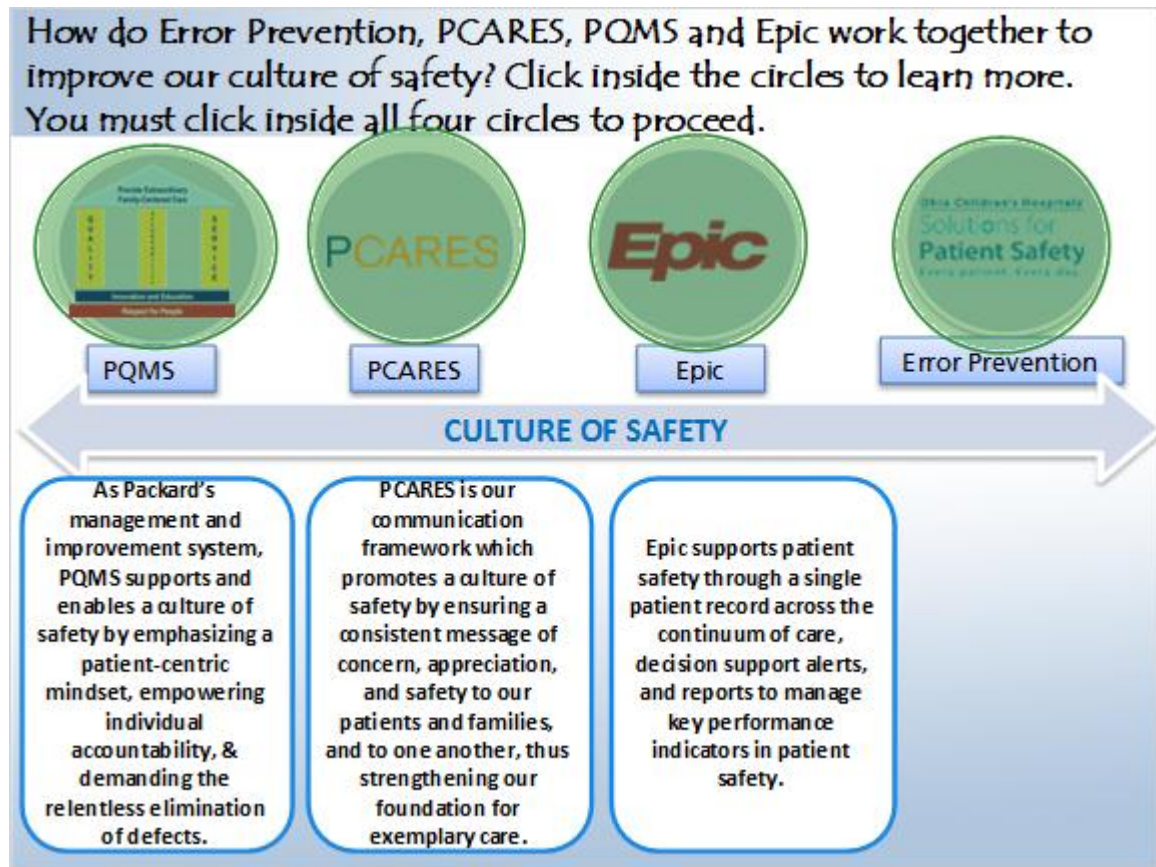
Error Prevention

CULTURE OF SAFETY

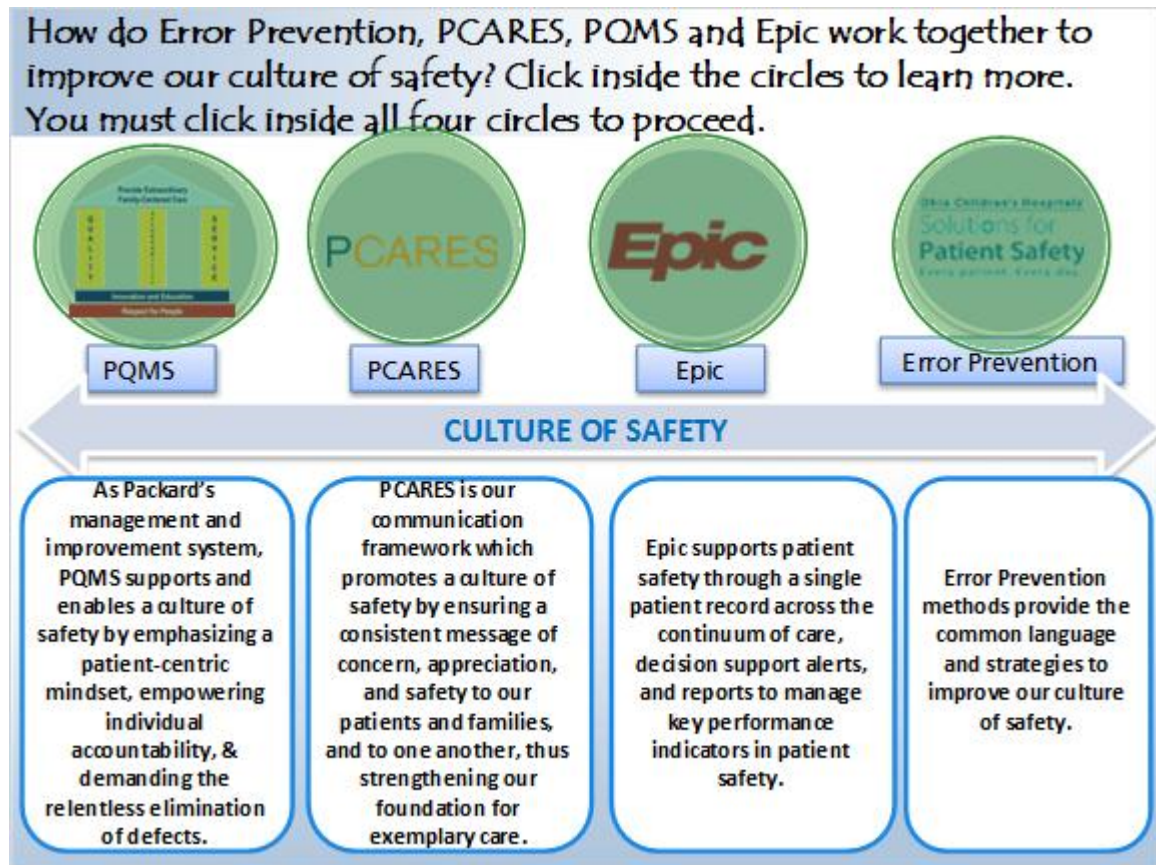
As Packard's management and improvement system, PQMS supports and enables a culture of safety by emphasizing a patient-centric mindset, empowering individual accountability, & demanding the relentless elimination of defects.

PCARES is our communication framework which promotes a culture of safety by ensuring a consistent message of concern, appreciation, and safety to our patients and families, and to one another, thus strengthening our foundation for exemplary care.

ePIC (Slide Layer)



Error Prevention (Slide Layer)



1.34 Untitled Slide



Lucile Packard
Children's Hospital
at Stanford



mission zero
Eliminating Preventable Harm

**Safety starts with YOU,
and together,
WE can achieve Mission Zero!**

Continue

1.35 Untitled Slide

Quiz

Instructions

There are five questions in the quiz. You are required to answer all five questions. Please select **Submit** to register your answer. The pass mark is set to 100%.

If you wish to review any content, please select [Review](#) or click [Continue](#) to take the quiz.

[Review](#) [Continue](#)

1.36 Patient safety is the priority for Packard Children's.

(True/False, 10 points, 1 attempt permitted)

Patient safety is the priority for Packard Children's.

True

False

Correct	Choice
X	True
	False

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response.

Correct (Slide Layer)

Patient safety is the priority for Packard Children's.

True

False

Correct

That's right! You selected the correct response.

Continue

Incorrect (Slide Layer)



1.37 If I practice the Error Prevention strategies, I am 10 times more likely to prevent a human error.

(True/False, 10 points, 1 attempt permitted)

If I practice the Error Prevention strategies, I am 10 times more likely to prevent a human error.

True

False

Correct	Choice
X	True
	False

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response.

Correct (Slide Layer)

If I practice the Error Prevention strategies, I am 10 times more likely to prevent a human error.

- True
- False

Correct

That's right! You selected the correct response.

Continue

Incorrect (Slide Layer)

If I practice the Error Prevention strategies, I am 10 times more likely to prevent a human error.

True

False

Incorrect

You did not select the correct response.

Continue

1.38 We will focus on 1-2 Error Prevention strategies a month.

(True/False, 10 points, 1 attempt permitted)

We will focus on 1-2 Error Prevention strategies a month.

True

False

Correct	Choice
X	True
	False

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response.

Correct (Slide Layer)

We will focus on 1-2 Error Prevention strategies a month.

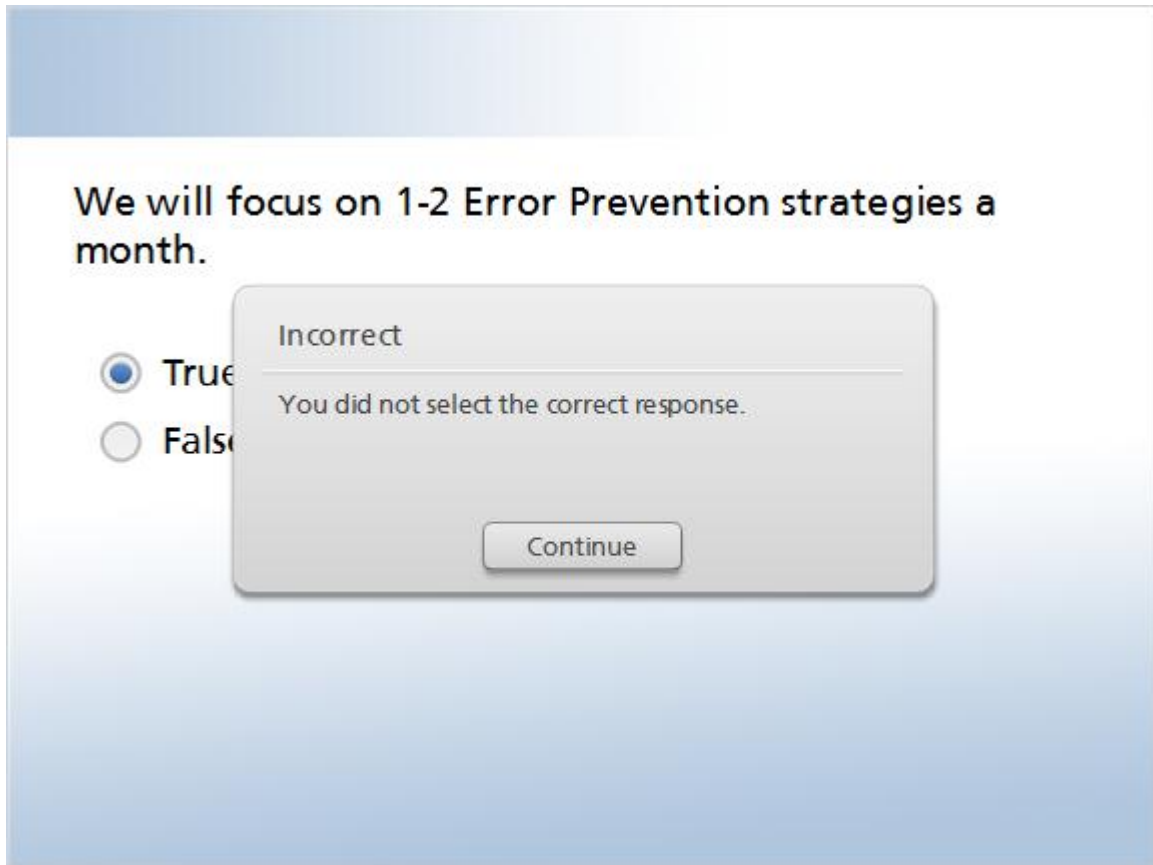
- True
- False

Correct

That's right! You selected the correct response.

Continue

Incorrect (Slide Layer)



1.39 I don't work in the hospital; Error Prevention strategies do not apply to me

(True/False, 10 points, 1 attempt permitted)

I don't work in the hospital; Error Prevention strategies do not apply to me

True

False

Correct	Choice
	True
X	False

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response.

Correct (Slide Layer)

I don't work in the hospital; Error Prevention strategies do not apply to me

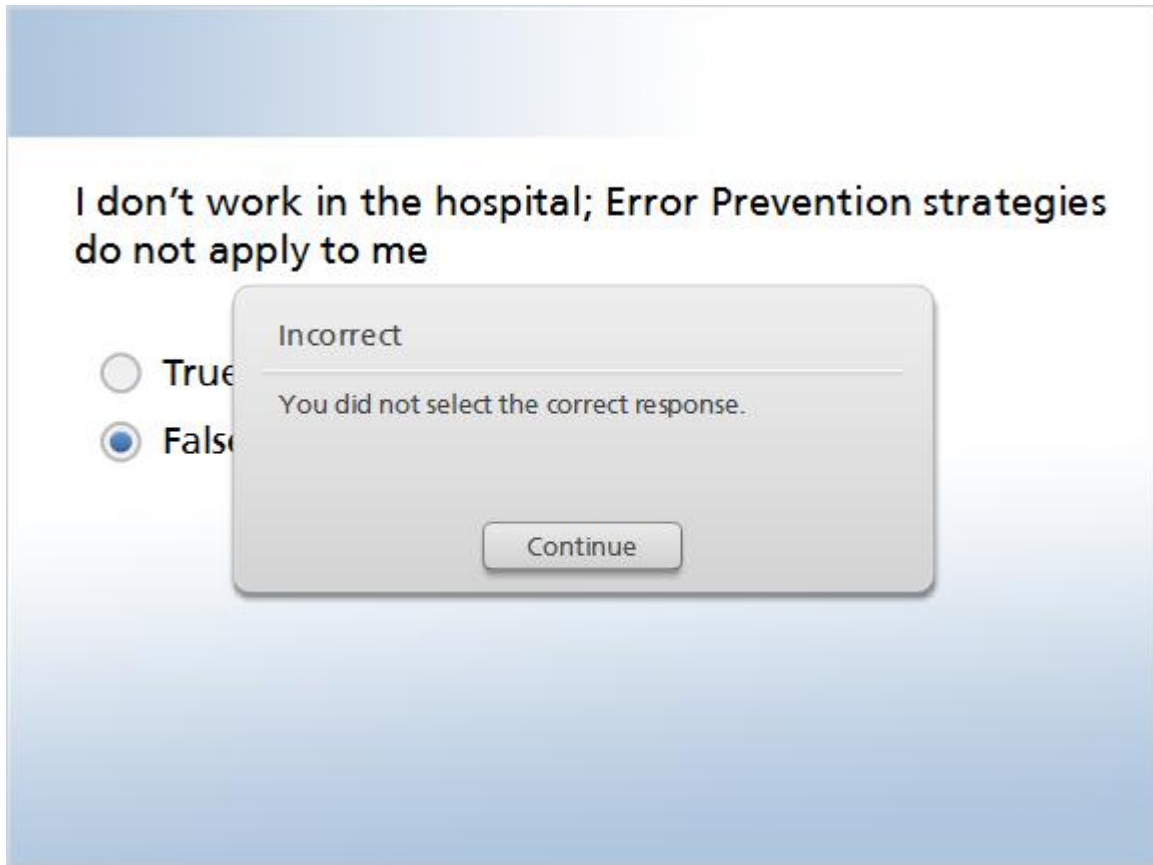
- True
- False

Correct

That's right! You selected the correct response.

Continue

Incorrect (Slide Layer)



1.40 Cultural change and improved communication are not integral to improving patient safety.

(True/False, 10 points, 1 attempt permitted)

Cultural change and improved communication are not integral to improving patient safety.

True

False

Correct	Choice
	True
X	False

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response.

Correct (Slide Layer)

Cultural change and improved communication are not integral to improving patient safety.

- True
- False

Correct

That's right! You selected the correct response.

Continue

Incorrect (Slide Layer)

Cultural change and improved communication are not integral to improving patient safety.

True

False

Incorrect

You did not select the correct response.

Continue

1.41 Results Slide

(Results Slide, 0 points, 1 attempt permitted)

Results

Your Score:

%Results.ScorePercent%% (%
Results.ScorePoints% points)

Passing Score:

%Results.PassPercent%% (%Results.PassPoints%
points)

Result:

Results for

1.15 Drag and Drop

1.36 Patient safety is the priority for Packard Children's.

1.37 If I practice the Error Prevention strategies, I am 10 times more likely to prevent a human error.

1.38 We will focus on 1-2 Error Prevention strategies a month.

1.39 I don't work in the hospital; Error Prevention strategies do not apply to me

1.40 Cultural change and improved communication are not integral to improving patient safety.

Result slide properties

Passing Score


100%

Success (Slide Layer)

Results

Your Score:	%Results.ScorePercent%% (% Results.ScorePoints% points)
Passing Score:	%Results.PassPercent%% (% Results.PassPoints% points)

Result:

 Congratulations, you passed.

[Exit](#)


Failure (Slide Layer)

Results

Your Score: %Results.ScorePercent%% (%Results.ScorePoints% points)

Passing Score: %Results.PassPercent%% (%Results.PassPoints% points)

Result:

 **You did not pass.**

[Retry Quiz](#)