Just Culture:
A 2020 Update and Case Studies

March 19, 2020
Webinar Month 137

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Welcome

Charles Denham, MD

Chairman, TMIT Global

TMIT High Performer Webinar
March 19, 2020

Webinar Month 137
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Surfing the Healthcare Tsunami
BRING YOUR BEST BOARD

Surfing the Healthcare Tsunami: Bring Your Best Board!™
TMIT presents our Discovery Channel documentary, Surfing the Healthcare Tsunami. The incoming healthcare tsunami threatens all but the best. Will you surf, swim, or sink?

Safe Use of Electronic Health Records and Health Information Technology Systems: Trust But Verify

Read about unrecognized hazards in HIT on a national scale, how to make EHR-CPOE systems safer, and the case for all stakeholders to leverage proven methods and teams in HIT performance verification. Download article here.
High Performer Webinar

March 19, 2020, 12:00 pm – 1:30 pm CT / 1:00 pm – 2:30 pm ET

Just Culture: A 2020 Update and Case Studies

Session Overview

David Marx, JD, is a true pioneer in the internationally recognized safety practice of Just Culture. Each time he speaks to our community of practice, he receives terrific reviews. Our March webinar will provide a 2020 update on the Just Culture movement and case studies will be presented that illustrate practical challenges we face at the frontline. David Marx draws on experience that spans more than two decades of examining laws, regulations, and industry practices to help lawmakers, regulatory authorities, and organizational leaders fulfill their responsibilities to produce safer outcomes. Our reactor panel will discuss the update and implications of the case studies.

We offer these online webinars at no cost to our participants.

Webinar Video, and Downloads

The webinar video will be available within five (5) business days after the webinar.
If you wish to follow us on Twitter, go to: http://twitter.com/TMIT1 or use #safetyleaders hashtag

Also, go to:
www.facebook.com/SafetyLeaders and related sites
TMIT Purpose Statement

Our Purpose:
We will measure our success by how we protect and enrich the lives of families...patients AND caregivers.

Our Mission:
To accelerate performance solutions that save lives, save money, and create value in the communities we serve and ventures we undertake.
Disclosure Statement

The following panelists certify that unless otherwise noted below, each presenter provided full disclosure information; does not intend to discuss an unapproved/investigative use of a commercial product/device; and has no significant financial relationship(s) to disclose. If unapproved uses of products are discussed, presenters are expected to disclose this to participants. None of the participants have any relationship medication or device companies discussed in their presentations.

David Marx, a pioneer of the Just Culture movement. The firm originally addressed safety issues and human factors in aviation and offered expertise in post-event investigation and analysis. With the unique combination of systems engineering, human factors, and the law, Marx adopted and expanded the concepts of ‘Just Culture’ to help improve the management of human error. He has nothing to disclose.

Heather Foster, RN, is a practicing nurse in Colorado who has championed the cause of patient and caregiver safety with great courage and faith after her patient died a preventable death. She receives the Pete Conrad Global Patient Safety Award for her steadfast support of speaking truth to power, for championing patient safety at great personal risk, and for representing the masses of frontline caregivers who feel at personal risk and powerless to stand up for their patients. She is one of expert advisors to The Healthcare Innocence Project, a program founded on the principles of the Innocence Project which 25 years ago pioneered using a “new technology” of DNA testing to help exonerate the wrongly convicted. The Healthcare Innovation Project uses the currently “new technology” of electronic medical and human resources records that can be used to protect patients, caregivers, and their families from error and administrative fraud. Heather Foster is developing educational resources to help caregivers deal with preventable adverse events, ethical human resources best practices relating to frontline caregivers, and case studies in healthcare ethics related to governance interactions with frontline caregivers. Working with global educators, she is helping develop programs to help other caregivers like her deal with some of healthcare’s most challenging problems in patient and caregiver safety. She has nothing to disclose.

Arlene Salamendra is a former Board member and Staff Coordinator of Families Advocating Injury Reduction (FAIR). A number of years ago, she was the subject of a preventable medical error. Since that time, she has devoted a portion of her time to giving support to other patients who have been injured or have lost a loved one, and rectifying the systems errors that lead to preventable medical errors. She is a member of the TMIT Patient Advocate Team. She has nothing to disclose.

Charles Denham, MD, is the Chairman of TMIT; a former TMIT education grantee of CareFusion and AORN with co-production by Discovery Channel for Chasing Zero documentary and Toolbox including models; and an education grantee of GE with co-production by Discovery Channel for Surfing the Healthcare Tsunami documentary and Toolbox, including models. HCC is a former contractor for GE and CareFusion, and a former contractor with Siemens and Nanosonics, which produces a sterilization device, Trophon. HCC is a former contractor with Senior Care Centers. HCC is a former contractor for ByoPlanet, a producer of sanitation devices for multiple industries. He does not currently work with any pharmaceutical or device company and has not done so for more than 5 years. His current area of research is in threat management to institutions including conflict of interest, healthcare fraud, and continuing professional education and consumer education including bystander care. Dr. Denham has been a collaborator with the late Professor Christensen at Harvard Business School.
Speakers and Reactors

Dr. David Marx
Heather Foster
Arlene Salamendra
Dr. Charles Denham
Voice of Patient and Family

Arlene Salamendra

Former Board Member and Staff Coordinator, Families Advocating Injury Reduction (FAIR)
TMIT Global Patient Advocate Team Member
Plano, IL

TMIT High Performer Webinar
February 20, 2020
In the News Update and February 2020 Webinar Recap

Charles Denham, MD
Chairman, TMIT Global

TMIT High Performer Webinar
March 18, 2020
Webinar 137
Flattening the Curve: Avoid the Surge

Our Healthcare Capacity
The Healthcare Threat Safety Spectrum

- **Academic Fraud**
- **Patient Safety Errors of Omission**
- **Workplace Employee Bullying**
- **Administrative Misconduct**
- **Cyber & I.T. Theft**

The private community of practice addresses a number of sensitive topics and subject matter that should not be made public for security reasons.

- **Workplace Violence** including physical, verbal, sexual, or emotional harassment, bullying or harm to caregivers, staff, students, or patients.
- **Active Shooter, Violent Intruder, and Deadly Force** incidents involving events causing physical harm to staff, caregivers, and patients.
- **Domestic Terrorism** such as organized attacks using chemical, biological, radiological, nuclear, and explosive weapons. Also, weaponization of transportation & vehicles (CBRNET).
- **Violent Acts Against Leadership** where administrative, clinical, or governance leaders are specifically targeted by insiders or outsiders.
- **Intentional Harm of Patients** by caregivers who commit harmful acts against patients with or without enablers who do not report such harm.
- **Unintentional Patient Harm** through errors of omission from systems failures identified by mortality reviews such as diagnostic errors.
- **Failure to Rescue** pre-hospital, hospital, and post-hospital continuity of care.
- **Hospital Optimization and Flow** leading to overcrowding, boarding, and transfer issues.
- **Readiness for Epemics** including preparedness for testing and volume surges.
- **Sexual Misconduct** including sexual harassment, abuse of power, and or harm to caregivers, staff, students, or patients.
- **Racial and/or Sexual Discrimination** against those we serve including patients and their families and or those who serve in the organization.

- **Cybersecurity Patient Records Issues** including breach, theft, and contamination of medical records leading to patient and caregiver harm.
- **Cybersecurity Operation Issues** including breach, theft, and contamination of operational records, invasion of data systems, and/or ransom crimes.
- **Theft of Intellectual Property** by insiders, outsiders, or nation-states.
- **Sabotage** of service, information systems, clinical care, and property.
- **Nation State Influence** through academic espionage, financial conflicts of interest, or other means.
- **Drug Diversion** by staff including caregivers and pharmacists who divert medications for themselves or others.
- **Conflict of Interest** of staff including physicians, researchers, and administrators including disclosed and undisclosed financial relationships.
- **Conflict of Interest of Governance** including undisclosed financial relationships and disclosed financial relationships.
- **Academic Fraud** including fabrication, falsification, plagiarism, or dishonest grant documentation including applications and reports.
- **Defamation or Unfair Press** by investigative reporting or whistleblowers.
- **Burn-out of caregivers, leadership, and staff.**
- **Critical Drug and Supply Shortages** such as I.V. fluids, medications, and supplies that may prevent proper care.
- **Regulatory Compliance Issues** including new risk for non-compliance.
Readiness for Epidemics including preparedness for testing and volume surges

The private community of practice addresses a number of sensitive topics and subject matter that should not be made public for security reasons.
A Medical-Tactical Approach undertaken by clinical and non-clinical people can have enormous impact on loss of life and harm from very common hazards:

- **High Impact Care Hazards** are frequent, severe, preventable, and measurable.
- **Lifeline Behaviors** undertaken by anyone can save lives.
Bystander Rescue Care for Failure to Rescue

www.MedTacGlobal.org
In response to the Coronavirus pandemic we have asked our panel of experts to produce a series of free webinars to help the public, professional first responders, security and medical volunteers, and families deal with the critical issues.

Coronavirus – Protecting You & Your Family: First Responder & Family Briefing

March 18, 2020 Webinar – See Protecting You and Your Family in Video Library below.

Video Library

WHO Coronavirus Story

- CDC Website Tour
- Dr. Sanjay Gupta Coronavirus Brief
- Why ICU Care & Respirators?
- Protecting You & Your Family Briefing
- Best Disinfectant & Soap

www.medtacglobal.org/coronavirus-response/.org
Speakers

Dr. Gregory Botz
Chief William Adcox
Dr. Charles Denham

Reactors

Dan Ford
Dr. Chris Fox
Randy Styner
Tom Renner
David Beshk
Jennifer Dingman
LETTER TO THOSE ORGANIZATIONS RECEIVING FEDERAL GRANTS

Unfortunately, threats to the integrity of U.S. biomedical research exist. NIH is aware that some foreign entities have mounted systematic programs to influence NIH researchers and peer reviewers and to take advantage of the long tradition of trust, fairness, and excellence of NIH supported research activities. This kind of inappropriate influence is not limited to biomedical research; it has been a significant issue for defense and energy research for some time. Three areas of concern have emerged:

1. **Diversion of intellectual property (IP) in grant applications or produced by NIH supported biomedical research to other entities, including other countries**;

2. **Sharing of confidential information on grant applications by NIH peer reviewers with others, including foreign entities, or otherwise attempting to influence funding decisions; and**

3. **Failure by some researchers working at NIH-funded institutions in the U.S. to disclose substantial resources from other organizations, including foreign governments, which threatens to distort decisions about the appropriate use of NIH funds**.

“We recently reminded the community that applicants and awardees must disclose all forms of other support and financial interests, including support coming from foreign governments or other foreign entities.”

“We also expect and encourage your institution to notify us immediately upon identifying new information that affects your institution's applications or awards. Lastly, we encourage you to reach out to an FBI field office to schedule a briefing on this matter.”
Many factors, including professional and personal relationships and activities, can influence the design, conduct, and reporting of the clinical science that informs health care decision. The potential for conflict of interest exists when these relationships and activities may bias judgement. Many stakeholders — editors, peer reviewers, clinicians, educators, policymakers, patients, and the public — rely on the disclosure of authors’ relationships and activities to inform their assessments. Trust in the transparency, consistency, and completeness of these disclosures is essential.
In The News ...

Patient Safety and COI Stories Being Followed

Tampa Bay Times Reports:
- Deaths of children in 1 in 10 undergoing CV Surgery at JH All Children’s
- Mutilation of children in burn unit in Maryland
- Cover up of harm
- Retaliation against whistleblower MD
- Patient Safety Issues in all Johns Hopkins hospitals
- Whistle blower law suit
- Multiple malpractice suits.
- Regulatory problems
- Oversight letting team of doctors make unannounced visits

NYT & Propublica Reports:
- Conflicts and large payments to Chief Med Officer – resigns
- CEO with conflicts, vote of non-confidence – resigns
- Board Members own equity in start up with special deals.
- Revision of conflict of interest policies.
- Top executives barred from serving on corporate boards or investing in start-ups

Propublica & Houston Chronicle Reports:
- Cardiac Complications
- Undeclared financial conflicts of interest
- Allegations of exaggerated quality program to lure patients.
- Transplant program shut down based on reporting.
- Leadership restructuring
- State and federal officials enforcing safety standards.
- 08-08-19 Feds Cease Greater Oversight Of Baylor St. Luke’s Medical Center Initiated After Patient Death

New York Times & Washington Post Reports:
- Falsification of research in cardiac stem care.
- Scientific misconduct
- 31 Articles Retracted
- Many patients treated
- Unknown impact of product used in patients treated.
- Hospital paid to settle allegations.
- Hospital pays $10M to settle

Tennessean & Beckers Hospital Review Reports:
- Nurse medication error during imaging with patient death
- Electronic medication dispensing cabinet safeguards overridden.
- Nurse indicted for reckless homicide for fatal error.
- State Health Officials decided no reason to discipline or take action against nurses license.
## Patient Safety and COI Stories Being Followed

### Duke University Hospital

**Medscape Reports:**
- Duke Settles Doctored Data Lawsuit for $112.5 Million
- Duke Whistleblower Gets More Than $33 Million In Research Fraud Settlement
- William Foster, who ran the lab where the data were faked, studied the effects of pollutants on the lungs of mouse models.
- Thomas alleged that Duke had won some 50 grants from the NIH

### University of Maryland Medical Center

**The Washington Post Reports:**
- UMMS Board Chairman announced the board’s unanimous decision March 21 to have CEO Robert Chrencik take a leave of absence.
- Resignations of three UMMS, including Baltimore Mayor Pugh.
- Hours before Mr. Burch notified the public of Mr. Chrencik’s leave of absence, the Maryland House of Delegates unanimously fast-tracked bill to overhaul UMMS’ 27-member board of directors.

### UNC Health Care

**Medscape Reports:**
- Between 2011 and 2019 William Roper, failed to disclose his seats on the boards of major corporations.
- At the same time, those corporations did business with the state, records show.
- Roper has served on the board of directors of DaVita, Inc.
- Roper also a member of the board of directors of three successor companies in the pharmacy benefits administration industry.
- None of his corporate board service was disclosed on state ethics forms.

### Massachusetts Institute of Technology

**New York Times Reports:**
- Director of M.I.T.’s Media Lab Resigns After Taking Money From Jeffrey Epstein.
- M.I.T. official, Joichi Ito, left the boards the MacArthur Foundation, the John S. and James L. Knight Foundation, and The New York Times.
- He “stepped down after the disclosure of his efforts to conceal his financial connections to Mr. Epstein, the disgraced financier who killed himself in a Manhattan jail cell last month while facing federal sex trafficking charges”. acknowledged last week that he had received $1.7 million from Mr. Epstein, including $1.2 million for his own outside investment funds.

### Johns Hopkins Medicine

**Tampa Bay Times Reports:**
- Johns Hopkins All Children’s faces record state fines.
- The planned $800,000 penalty is the latest fallout from problems in the hospital’s heart surgery department.
- State regulators intend to hit Johns Hopkins All Children’s Hospital with some of the largest fines levied against a Florida hospital in recent memory.
- The Times found that surgeons in the hospital’s Heart Institute made serious mistakes and their procedures went wrong in unusual ways. It also found that the hospital continued to perform heart surgeries for years after frontline workers raised safety concerns to their supervisors.
Patient Safety and COI Stories Being Followed

Beth Israel COI & Theft:
- Chinese cancer researcher, confessed that he had planned to take the stolen samples to Sun Yat-sen Memorial Hospital, and publish the results under his own name.
- Customs officers found what they were looking for: 21 vials of brown liquid — cancer cells.
- The researcher admitted he had taken the samples to publish the work under his own name.

The New York Times

Joshua and Beth Friedman
University Professor
Harvard University
Department of Chemistry and Chemical Biology

Harvard Chemistry Chairman Under Investigation Is a Giant of His Field
Charles Lieber is charged with lying to U.S. authorities about taking millions of dollars from the Chinese government.

January 29, 2020

The Harvard University professor arrested and charged with lying to U.S. authorities about taking millions of dollars from the Chinese government is considered one of the fathers of a specialized field in nanotechnology. Charles M. Lieber has led a research lab at Harvard for nearly 30 years and generated in excess of $15 million in grants from government agencies since 2008. He was rated the top chemist of the aughts by one analytics organization that rated academic productivity. Former research assistants in his lab said Wednesday they were shocked by his arrest and even surprised by his alleged association with the Chinese program that allegedly paid him $1.5 million that he didn’t report. Mr. Lieber was remanded to federal custody. He is charged with a single felony count for making false statements to U.S. government agencies.
A New Program

The Healthcare Innocence Project builds on the successful model of *The Innocence Project*. Where it used the new technology of DNA 25 years ago, we will use the new technology of electronic records and the digital DNA in the E.H.R. and administrative records to protect the medical identity of patients and the professional identity of caregivers. Both patients and caregivers may be unjustly treated through intentional or unintentional behaviors of insiders or outsiders of healthcare organizations. They include weaponization of HR, sham peer review, discrediting patients and families after healthcare accidents, or unjust harm through outsider cybersecurity issues.

www.HealthcareInnocenceProject.org
False Narratives & Weaponizing Information

- **Mis-information**: when false information is shared, but no harm is meant.
- **Dis-information**: when false information is knowingly shared to cause harm.
- **Mal-information**: when genuine information is shared to cause harm, often by moving information designed to stay private into the public sphere.

Source: Claire Wardle and Hossein Derakhshan “Information Disorder”
Pre-presentation Questions & Comments

Jeanne M. Huddleston, MD, FACP, FHM

Hospitalist
Former Chair Mortality Review Subcommittee
Mayo Clinic
Rochester, MN

TMIT Global High Performer Webinar
February 20, 2020

Webinar 135
Continuous Organizational Improvement and Learning: A Modified Delphi Approach Connecting Reviews to Meaningful Change

01 MultiLens Reviews
Multidisciplinary, multispecialty review findings and opinions

02 Group Consensus
Multidisciplinary, multispecialty case discussion meetings turning issues into OFIs

03 Cluster Analysis
Which patients fell through the same vulnerable crack in the system?

04 Common Thread Reviews
What do the patients in the cluster have in common?

05 Common Thread definition
Common threads become actionable requirements for SBAER & successful project charter.

MultiLens Reviews
MultiLens Group Consensus
Cluster Analysis
Common Thread Reviews
SBAER & QI project definition

Gather data
Finalize data
Detect patterns
Create requirements
Actionable information

Anonymous Survey Questions

I would like another webinar on MORTALITY REVIEWS by COLLABORATORS

94% Agreed and 76% Strongly or Very Strongly Agreed, and 64% Very Strongly Agreed

Source: TMIT High Performer Webinar Series; Mortality Reviews and Patient Safety: A 2020 Update – February 20, 2019
The topics I wish to have covered in another webinar on MORTALITY REVIEWS

- Action planning after opportunities are identified
- Admin support and lack of for culture change
- Administrative support
- Any topic, this was so insightful
- Anything
- Anything quality related to help take care of patients better.
- Benefits of risk and quality committee involvement for OFI and issues.
- Best team approach and phases as well as data for trend analysis
- Capturing SOI/ROM
- Changing culture to just culture and removing punitive mindset. Helping senior leaders understand the infrastructure that is required for a robust quality and safety program. One FTE where six are needed just doesn't cut it.
- Classifying and quantifying system level changes, identifying the rate of adverse events, learning to identify unanticipated deaths
- Common threads; focus areas
- Continue with the same educational line, I love how it addresses that if we don't fix the omissions, there will be more burn out and severe depression in medical staffs
- Creating a mortality review committee and examples of review format and training.
- Culture of safety

- Deep dive into the review methodology
- Deeper into risk adjusted mortality indexes
- Diagnostic errors
- Disease specific concerns
- Do you have a worksheet or allorhythmia that you recommend to initiate the mortality reviews?
- Ed mortalities
- Emergency dept mortality reviews
- End of life
- End of life - how can we increase awareness about palliative care vs. Hospice care among our communities (patients, families and even our internal professional healthcare staff). So few people have a good understanding or awareness of how beneficial both end of life specialties are and that they should get these specialties involved earlier in their care journey. The majority either don't consult palliative care nor refer to hospice OR they do, but it's a few days prior to the day that the patient dies.
- End of life care, advanced directives
- Expand on the actual process or data points reviewed during mortality reviews.
- Expand on the interdisciplinary reviews, how to begin
- Finding the common thread
- Further drill down into best key metrics and data points to capture

Source: TMIT High Performer Webinar Series; Mortality Reviews and Patient Safety: A 2020 Update – February 20, 2019
The topics I wish to have covered in another webinar on MORTALITY REVIEWS

• General
• Getting started
• Getting started with mortality review. More detail on how to start.
• Great information
• HACS/hai’s
• Hear from the staff that are doing the work, the process, tools overcoming barriers and staff that are disengaged
• How do you work with organizational barriers to have providers involved? Such as RN restrictions on spending additional time, MDS over scheduled, prioritization by management, dealing with independent MDS?
• How to achieve these robust reviews. Role of student monitoring in patient safety
• How to get leadership engaged in understanding bedside caregivers need to have the tools to provide the best care; free from errors
• How to moving from discovery to improvement
• How to perform a motility review
• I would like to hear more from this presenter.
• Implementing change
• Improved care for the prison population
• Incorporating safety into traditional M&M
• Interested in a series on what dr. Huddleston is learning

• Interested in hearing more about why we need to shift the focus beyond preventability. Would this change event classification?
• Intraoperative injuries and deaths
• Is there a mortality review template you could share? Also, how do you go about obtaining by-in from providers related to mortality review?
• Items to look for while doing mortality reviews, trends, high risk items.
• Learners vs doers
• Managing critical patients issues up to leaders
• Medication error
• MI mortality
• More about the review process
• More details of the safety learning system
• More info on SBAER, case studies utilizing clutter and common thread analysis
• More information about focusing on opportunities instead of preventability/causality. This is very interesting
• More inf
• More on how to address OFI
• More on lifting up the blind spots to leaders uncovered from mortality reviews using your framework.

Source: TMIT High Performer Webinar Series; Mortality Reviews and Patient Safety: A 2020 Update – February 20, 2019
The topics I wish to have covered in another webinar on MORTALITY REVIEWS

- More specifics on how to do these chart reviews, perhaps a form that prompts people to look for specifics? Also what types of findings and how those are put into practice.
- Mortality review data collection
- Mortality review data collection
- Mortality review process
- Moving from identified OFI to improvement
- Near misses
- Nurse quality outcomes specialist escalating cases for physician review.
- Nurses workplace violence
- Opioid events
- Palliative care
- Palliative care delay
- Pediatric mortality
- Peer review best practices
- Practical tips for implementation of review system; suggestions to help identify and elevate the “below the iceberg” problems to leadership; how did you structure your team & engage the disillusioned; practical ideas for systemic learned helplessness
- Preventable complications
- Process
- Quality measures in total cost of care environs
- Readmissions
- Recognizing medical problems in patients admitted for behavioral health event
- Recognizing physical aspects of burnout
- Report building, review process & escalation, inclusion of medical staff
- Review of the application of the CMS guidelines for mortality exclusion charts.
- Screening/review forms
- Sepsis
- Templates for mortality review & database
- The connection with earlier palliative intervention. What evidence is there that earlier palliative involvement will positively affect mortality rates or readmissions.
- Tips to improve mortality
- Tools for analysis
- What do the nurse reviewers look for when reviewing a mortality and is that shared with the MD or do they review individually then compare?
- What was done to improve several issues?
- When improvements are identified in your mortality reviews, how do those get handled or funneled through? Who’s responsible? Many times improvements are identified and then there’s the...Then what?
- When palliative care consult should be involved; aspiration pneumonia; sepsis

Source: TMIT High Performer Webinar Series; Mortality Reviews and Patient Safety: A 2020 Update – February 20, 2019
Anonymous Survey Questions

I am interested in a series of webinars on BURN OUT

72% Agreed and 44% Strongly or Very Strongly Agreed, and 35% Very Strongly Agreed

Source: TMIT High Performer Webinar Series; Mortality Reviews and Patient Safety: A 2020 Update – February 20, 2019
After involved in patient safety event
Bouncing back after burning out
Burn out resulting from staffing shortages
Burn out wouldn't be a topic that I'm extremely interested in at this point.
Clinician burnout and moral distress among nurses
Compassion fatigue and the impact
Difference between physicians versus other disciplines and the differences in approach
Finding a balance
Healthcare providers, I see much about physicians and nurses, what about the interdisciplinary team?
How burn out impacts patient safety and interaction with colleagues.
How to address staffing issues
How to measure burn out contributing to safety events-what questions to ask when investigating
How to not get los
How to prevent healthcare worker burn out to maintain long term employees
I believe burn out is a wonderful topic, that is very important to the global organizations, I am not in a place to focus on more than one topic at this time, so mortality is my focus.
I would like to see the topic expanded beyond physician burnout
Identification
Improving quality by avoiding burnout
Increasing education on additional staff
Increased staff demands amid decreased staffing
Lack of communication and emotional reasons for burnout
Lack of support
Never enough. It's never enough staff to comfortably perform gentle care. It's never enough of your dedication to administration. It just seems like it is never enough.
Not sure but would really like to see safety study repeated since technology added. Has it helped or added different issue?
Not sure, but an important topic in what we do.
Nurse burn out
Nurses, sleep deprivation and caffeine
Nursing shortage
Patient safety due to errors from burn out
Prevention of burnout, remedies
Provider engagement
Recognition, prevention, intervention and honestly, what can we really do about it when we have no budget. Thanks!
Recognizing burnout in advance
Recognizing signs. How to create more whitespace. How to recognize things that make someone feel burned out, when it may not exactly be burn out. Examples: person is in the wrong job. Toxic culture. Not enough resources to get the work done (might still stay in discipline, just need more resources.)
Recommended actions, not just a presentation how burn out exists and it’s impact, but more on ways to prevent and address.
Recommended supports for burn out (internal, local and on-line). Who should approach the person to have the discussion to ask if they are okay vs. Burnt out? How can we reduce the stigma of talking about mental or emotional health?
Signs and symptoms
Similar to above comment/ overcoming the learned helplessness barrier
Strategies to reduce nurses' burnout
Stress management
Type of errors that correlate to provider burnout

Source: TMIT High Performer Webinar Series; Mortality Reviews and Patient Safety: A 2020 Update – February 20, 2019
Just Culture: A 2020 Update

David Marx, JD

Just Culture Leader & Innovator
Principle, Outcome Engenuity Center
Eden Prairie, MN

TMIT Global High Performer Webinar
March 19, 2020
Just Culture
A 2020 Update and Case Studies

David Marx, BSE, JD
CEO, The Just Culture Company
www.outcome-eng.com

March 19, 2020
FYI - Two Companies
Do We Live in a Just Culture?

Grandfather Charged in Toddler’s Fatal Fall From Cruise Ship
Salvatore Anello, who dropped his granddaughter from a cruise ship window in July, was charged with negligent homicide in Puerto Rico.

Rep. Devin Nunes Contradicts Health Experts: “It’s a Great Time to Go Out”

Not everyone’s neurosurgeon, but everyone’s a judge
The Two Camps

Hospital A
If you make a mistake involving the safety of the patient, raise your hand so that we can together learn from your mistake.

Hospital B
If you make a mistake involving the safety of the patient, pack your things, because you are fired.
Just Culture

• How should we hold each other accountable?
  • For our outcomes?
  • For our errors?
  • For our choices?

• Accountability v. punitive sanction?
• Aspiration v. expectation?
• Perfection v. inescapably fallible?
• No harm, no foul?
• What is a “just” culture?
Just Culture

• When is Just Culture used?
  • Formally
  • Informally

• What’s the procedure?
  • HR involvement?
  • Peer review?
  • Who helps the manager?

• What are the actual actions to be taken?
  • Coaching
  • Counseling and disciplinary sanction
Duty and Breach
The Three Duties

1. The duty to avoid causing unjustifiable risk or harm
2. Duty to produce outcomes
3. Duty to follow procedural rules

DON’T

DO

WHAT

To Do

HOW

To Do It
Upon arrival on a med-surg unit after surgery, the husband of a patient sees that the hand hygiene rate of nurses entering his wife’s room is hovering around 10%.

The husband raises his concern to the unit manager, who says in response, “We saved your wife’s life. Can’t you just be grateful for what we’ve done?”

Procedure – Nurses’ duty to wash hands
Outcome – Manager’s duty to create safe rate of hygiene
Values – Manager’s tone with family member
Human Error
Unintended conduct: where the actor should have done other than what they did
Accept

At-Risk Behavior
A choice where risk is not recognized, or is mistakenly believed to be justified
Coach

Reckless Behavior
Conscious disregard of a substantial and unjustifiable risk of harm
Sanction

Knowledge
Knowingly causing harm (sometimes justified)
Sanction

Purpose
A purpose to cause harm (never justified)
Sanction

All Independent of the Actual Outcome
Where We’re At in 2020
Just Culture Implementation

1. Commit to explore the idea (scouts)
2. Learn the concepts and methods (certification)
3. Commit to implement (time, resources, resolve)
4. Benchmark (survey, audits, reporting, outcomes)
5. Scrub policies and procedures (alignment?)
6. Train managers (1 day)
7. Establish the covenant (a unilateral promise)
8. Train staff (2 hours)
9. Feed the change (continuous reinforcement)
10. Measure progress (survey, audits, reporting, outcomes)
We’re Still Seeing Many Hospitals take the Easy Path

- **Just Culture Light**
  - It’s about non-punitive reporting
  - It’s only about safety
  - It’s only post-event
  - It’s about rules
  - It’s somewhere in a policy
  - It’s an “optional” tool

- **Just Culture**
  - It’s about accountability
  - It’s all conduct
  - It’s duty and breach
  - It’s about values
  - It’s hardwired in
  - It’s a covenant
Putting You on the Hot Seat
In the nursery at 3:00 am, a highly experienced volunteer falls asleep while rocking a baby to sleep in a rocking chair. The baby falls to the floor, with only minor bruising. The volunteer quickly reported the event.

It is the first time this has occurred in this nursery, although some of the staff have heard of it happening elsewhere.
A scheduler receives a call from a “friend-of-a-friend” requesting her appointment be moved up to the next day, however the day is already completely booked.

Attempting to accommodate the request, the scheduler decides to cancel one of the appointments for the next day and substitutes the “friend.”
A manager who had lost a son in the Gulf War, was heard saying to a colleague that she would never hire anyone from a middle eastern country.

A subsequent review of job applications showed a number of qualified middle-eastern candidates that were not brought in for interviews.
A new nurse to the OR (watching and learning the processes and practices of her new employer) storms out of the safety timeout ahead of surgery and right in the Director of the OR’s office. He blurts out, “Are you kidding me? The anesthesiologist has her ears covered by headphones. She’s actually dancing a bit, you know, moving to the beat, nodding her head when people look her way. I looked at everyone else in the timeout, and no one seemed to notice. They look like Zombies. Is this how we’re going to treat patient’s here? Do anesthesiologists get a pass? Does anyone care?”
The chair of department allows a clinician to overbook morning clinic appointments. Average wait times for late morning appointments are over 90 minutes, as compared to 15 for other clinicians. This is in part because many appointments get pushed to after the doctor’s lunch period. The chair is aware of the wait time data, but takes no action to force a schedule revision.
Safety Culture

Reckless Homicide at Vanderbilt? A Just Culture Analysis
Still Much Work to Do

• Getting lawyers, HR professionals and safety professionals on the same page
• Understanding it's more about choice (not about error)
• Peer accountability (being my brother’s keeper)
• Leadership accountability and justice
• Precision: making it a covenant
• Understanding it’s CrossFit (very hard work)
National Survey Questions

I would like another webinar on JUST CULTURE

The topics I wish to have covered in another webinar on JUST CULTURE
National Survey Questions

I would like a WEBINAR on CORONAVIRUS CARE FOR CAREGIVERS

The topics I wish to have covered in WEBINAR on CORONAVIRUS CARE FOR CAREGIVERS
Protecting our Seniors

Charles Denham, MD

Chairman, TMIT Global
Founder Med Tac Bystander Rescue Care

Med Tac Bystander Rescue Care
March 18, 2020

CareUniversity Webinar #134
Care of the At Risk & Seniors at Home

Supplies Checklist:
- Prescription Medications: On hand, have at least 90 days of prescription medications and at least 30 days of over-the-counter medications in case of emergencies.
- First Aid Kit: Include essential items such as bandages, antiseptic wipes, and pain relievers.
- Personal Protective Equipment: Masks, gloves, and hand sanitizer.
- Food and Water: In case of isolation or evacuation, ensure a 2-week supply of non-perishable foods and water.
- Toilet Paper and Sanitizers:

Process Checklist:
- In Case of Emergencies: Call 911 for immediate assistance. Ensure all household members know how to call for help.
- Contact List: Include emergency contacts for family members and close friends.
- Medical Records: Make sure all medical records are up-to-date and easily accessible.
- Medication List: Keep a list of all medications and dosages.
- Communication Plan: Develop a plan for communication in case of emergencies.

Care of the At Risk & Seniors at Home

Coronavirus Response

CareUniversity Series

Med Tac Bystander Rescue Care
Care of the At Risk & Seniors at Home

**Supplies Checklist:**

- **Prescription Medications On Hand:** Have at least 90 days of prescription medications on hand. If insurance will allow it, get a 120-day supply. If not, keep track of when they can renew them and then have them filled so they have them on hand.
- **Over the Counter Medications:** Make sure they have over the counter medications for headache, colds, and other ailments they may have not needing prescriptions.
- **Thermometers:** Every home should have a thermometer on hand to so that inhabitants can monitor their temperature whether healthy or sick. Many will get colds or the flu and may be frightened they may have Coronavirus.
- **Food and Bottled Water:** It is important to have food on hand that will not spoil. If power goes out as it can in ordinary circumstances, it may take longer to repair if service personnel are sick. Food that does not require refrigeration or to be stored in freezers needs to be on-hand.
- **Flashlights and Batteries:** (better than candles for reasons of risk) and batteries incase power goes out.
- **Cleaning and Disinfectant Supplies:** Soap and water is very effective to kill the virus because it dissolves fats and the virus has a fat layer. Liquid Soap and water is even better than alcohol disinfectants for both hands and for contact surfaces for killing the Coronavirus.
  - If alcohol and soap runs out, bleach may be diluted to 1:10 Bleach to Water concentration for contaminated clothing.
  - Dilution of 1:50 Bleach to Water concentration for disinfecting contact surfaces.
  - Dilution of 1:100 Bleach to Water for skin cleaning.
  - Having plenty of liquid soap, buckets, and rags are important if caring for someone at home. Paper towels may be in short supply – rags and towels cleaned in washing machines are safe.
- **Kitchen Rubber Gloves:** Two to three pairs of rubber gloves will be good to have on hand if one has to take care of someone in the home. They should be used for disinfecting the surfaces. Some surfaces will sustain the virus for a few hours. Some, however, can sustain the virus for three to nine days. The virus lasts longer on-porous surfaces like door handles.
- **Full Tank of Gas:** If the supply chain is disrupted by illnesses of those transporting or operating gas stations, you may have a hard time getting fuel. We need to be as prepared as we would with a storm or during any natural disaster or emergency.
- **Reading Materials & Recordings:** In the extreme case cable systems and internet providers may go down and seniors should have access to reading materials and recordings to inspire them and maintain hope. Our faith-based communities can provide tremendous support of them here.

**Process Checklist:**

- **In Case of Emergency - ICE Contact List:** Phone numbers and email addresses of friends and family members who know they are going to be called if an individual experiences an emergency should be on an accessible list. The In Case of Emergency phone numbers should be generated. It should include those who have a Power of Attorney for healthcare and for business issues.
- **All Caregivers Contact Information:** A master list of the doctors, nurse practitioners, pharmacists, and caregiver’s office phone numbers, emergency numbers, and addresses should be on an easy to read list.
- **Local Support Individuals:** Names and mobile numbers of friends and family who can pick up supplies for them, transport them, care for them, and check on them.
- **“If I Get Sick Plan”:** A plan of “what if I get sick” directions. For instance – what signs and symptoms should prompt them to call for help. A certain temperature or other developments to drive action.
- **Hospital of Choice:** If an individual has been under the care of a hospital, their medical records are very important to future care. They may identify that hospital or a hospital as a first choice for care.
- **Medical Power of Attorney:** Everyone over the age of 18 will need to execute a medical power of attorney if they are to allow another person to make decisions regarding care if the victim is unable to do so. For instance, college students going to school in another state who are in another state get sick, parents will need one to get medical records.
- **Regular Expenses & Payment Mechanism:** Create a list of regular bills and how to pay them if a person is in the hospital and unable to take care of them.
- **Regular Home Chores:** A list of tasks that must be undertaken if residents become ill and are taken to the hospital should be created. They might include watering indoor and outdoor plants, pet care, and pet care.
- **Daily Check In Calls:** Seniors and those with underlying conditions such as heart, lung, or kidney disease as well as those with immune compromised conditions such as chemotherapy and transplant patients should have someone check in on them if they are alone.
- **Food Replenishment Process:** A process for regular replenishment of food and supplies should be set up.
- **Meals on Wheels & Support Programs:** If seniors and those who qualify can be added to such programs, they should consider such support.
- **Sick Care Room:** A room or section of the home should be identified where a family member can be treated in case, they become ill. This is whether they get the Coronavirus, a cold, or the flu.
Can We Still Have Fun Through the Curve?

Social Distance Means Distance and No Mutual Contact Surfaces
Speakers and Reactors

Dr. David Marx
Heather Foster
Arlene Salamendra
Dr. Charles Denham
Voice of Patient and Family

Arlene Salamendra

Former Board Member and Staff Coordinator, Families Advocating Injury Reduction (FAIR)
TMIT Global Patient Advocate Team Member
Plano, IL

TMIT Global High Performer Webinar
February 20, 2020
ADDITIONAL RESOURCES
Recent Safety Scandals Suggest Healthcare Leaders Haven’t Learned Lessons

The 1994 death of Boston Globe health reporter Betsy Lehman from a chemotherapy overdose at the Dana-Farber Cancer Institute prompted the Institute of Medicine’s investigation of medical errors, catalyzing a national movement to improve patient safety.

But the IOM’s To Err is Human report and 20 years of subsequent safety efforts hardly eliminated the problem. News investigations over the past year and a half have found that patients continue to die at prestigious hospitals from preventable errors, even after physicians and staff warned hospital leaders about chronic safety issues.

UNC Health Care System, Baylor St. Luke’s Medical Center, Johns Hopkins All Children’s Hospital, and University of Texas MD Anderson Cancer Center each have come under fire for medical errors and adverse events that led to the deaths and injuries of pediatric and adult patients.

The revelations of systematic problems at these major hospitals have disturbed safety experts, who wonder whether healthcare leaders have truly learned the painful lessons of how to reduce patient harm. These cases, they say, demonstrate holes in the culture of safety, transparency, and routine measurement of errors and adverse events.

“Once harm occurs, some leaders aren’t interested in hearing about it,” said Dr. Stephen Swensen, former director of leadership and organization development at Mayo Clinic. “They may be thinking, ‘If this got out, what would that do to our U.S. News rating, our brand, or our referrals?’”
In The News …

Shame, Scandal Plague Healthcare Providers In 2018

Dec 10, 2018

These were big stories with no small implications. If these scandals were the work of only a few selfish individuals, most HR departments could resolve them. Unfortunately, the problems are endemic and deeply embedded in medical culture. When it comes to the questionable ethics of accepting money and perks from drug and device companies, doctors and hospital administrators routinely look the other way.

In 2005, Dr. Sharon Levine designed and orchestrated the industry’s strictest conflict-of-interest policy, a program that defied the doomsday predictions of many doctors. Only two of the 5,000 physicians working in the medical group at the time left as a result of the new policy. (Kaiser conflict of interest policy)

Doctors, Defamation, and Damages: Medical Practitioners Fighting Back.

Author information
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2 Lecturer, Graduate School of Business and Law, RMIT University.

Abstract
In three judgments in favour of New South Wales medical practitioners between 2017 and 2019 the Supreme Court awarded ordinary and aggravated damages for harm done to professional reputations. The decisions in Al Muderis v Duncan (No 3) [2017] NSWSC 726, O’Neill v Fairfax Media Publications Pty Ltd (No 2) [2019] NSWSC 655 and Tavakoli v Imisides (No 4) [2019] NSWSC 7 are considered in the context of international decisions and analysis of doctors taking defamation action arising from online publications. Reflections are provided about the repercussions of the phenomenon, its commercial justification and the inhibitions that should be experienced before defamation and injurious falsehood actions are taken by medical practitioners.

KEYWORDS: damages; defamation; honestly held opinions; medical practitioners; tort of injurious falsehood
Conflict of Interest Code of Conduct

1. Prohibit doctors from accepting anything at all from drug or device companies.
2. Form an ethics committee to address any concerns doctors may have.
3. Direct all research funding, regardless of the source, to the institution and not to individuals.
4. Require all providers to disclose any past payments, prior to the policy’s implementation.

Source: Kaiser Conflict-of-Interest Policy, Forbes
Paying Attention To Complaints Can Protect Nurses From Violence

Complaints from patients and their family members could signal future violence against nurses and should not be ignored, suggests new research from the University of British Columbia.

“What we think happens is a spiral of aggression is created. Patients get frustrated by what they see as poor-quality performance—often caused by factors such as staff shortages and large workloads,”

“They respond initially with complaints, and if those complaints aren’t addressed in a timely manner, they can then escalate into more serious acts of aggression.”

“Health care workers are four times more likely to face physical and emotional abuse on the job as workers in other professions,” says study author Farinaz Havaei, an assistant professor of nursing at UBC. “Other studies have shown that addressing patient complaints contributes to positive patient outcomes. Now, for the first time, we have evidence that acting on these complaints can also protect nurses’ safety.” The B.C. Nurses’ Workload Impact Study, comparing workload factors (such as how many tasks nurses say they left unfinished during their last shift and how often they experienced heavy workloads) with patients’ complaints and reports of emotional and physical abuse towards nurses. Results showed a strong correlation between patients’ complaints and violence.

SOURCE: https://scienmag.com/paying-attention-to-complaints-can-protect-nurses-from-violence/
The article by Maria Castellucci opens with “Too few boards appreciate their responsibility to oversee quality, but safety issues at some high-profile organizations should motivate boards to do more”. The article cites Dr. Gary Kaplan of Virginia Mason and other leaders such as former CEOs including Nancy Schlichting Henry Ford in Detroit. The patient safety crisis at Johns Hopkins All Children’s Hospital was discussed in the context of board involvement.

Beth Daley Ullem, a leading governance board expert with IHI is cited: “When I talk with boards, a lot say they get hit with too much data”. She recommends boards ask leadership to dive into one or two areas in which the organization is facing challenges and then explain some approaches to address them. “That tends to help facilitate a confidence about management’s approach to identifying, understanding and coming up with a plan to tackle a problem”.

SOURCE: Modern Healthcare February 8, 2020
Meaningful Use is dead. Long live something better!

In the News: Med Tac Updates

Meaningful Use is dead. Long live something better!

Med Tac Slides and Articles in RESOURCES SECTION

Med Tac Articles: Campus Safety Magazine

YouTube TMIT Patient Safety Briefings

Opioid Overdose Crisis
https://www.youtube.com/watch?v=10OkH4aI5E&feature=youtube.be

Sudden Cardiac Arrest
https://www.youtube.com/watch?v=mp7XW5Vz7dF&feature=youtube.be

Active Shooter Events in Healthcare
https://www.youtube.com/watch?v=mytZ9S6Jz8A&feature=youtube.be

Med Tac Lifeguard Surf Program
https://www.youtube.com/watch?v=701V6mLqXk&M=feature=youtube.be

Med Tac Bystander Care Training
https://www.youtube.com/watch?v=7JYMKjQPQ&feature=youtube.be

Rapid Response Teams
https://www.youtube.com/watch?v=sXwK5s5Z9WQ&feature=youtube.be

Campus Safety

January/February 2019 Issue
Effectively Responding to Active Shooters in Healthcare Facilities
"Source, Protect, Fight" has been proposed as an alternative to respond to active shooters in healthcare settings where there, Fight is not possible.

Dr. Charles DeCarlo, F. Dr. Gregory A. Gadoury, Dr. Charles DeCarlo

Unique Characteristics of Healthcare Facilities
Active shooter events at healthcare facilities are different from schools, shopping malls and commercial businesses for several important reasons:

1. Active shooters motives usually are reach more personal, targeted and focused.
2. Necessary security measures are often hindered or undeterred.
3. Healthcare providers feel compelled to stay with their patients.
4. Certain patients will die without continued life support in ICUs and operating rooms.
5. Certain areas of hospitals are not easy to harden or evacuate.
6. Most hospitals are organized vertically, with only limited access to elevators.
7. Emergency departments may be located on top floors and not bottom floors.
8. The violence could end in less than 10 minutes, but the healthcare delivery disruption could outlast.
9. Many healthcare shootings occur at entrances or outside buildings.
10. Healthcare facilities cannot easily shut down or training.

The excellent NEAR action framework is used to detect factors to be taken for healthcare facilities by safety leaders in hospitals, schools, universities, and faith-based organizations.

Med Tac Publication in Campus Safety Magazine: January/February Issue

Campus Safety

November/December 2018 Issue

MEDICINE AND SOCIETY

By Charles DeCarlo and William Addis

Unique Characteristics of Healthcare Facilities

The unique characteristics of healthcare facilities are as follows:

1. The motive is usually more personal, targeted, and focused.
2. Security measures are often hindered.
3. Patients feel compelled to stay with their patients.
4. Patients may die without continued life support.
5. Certain areas are not easy to harden or evacuate.
6. Hospitals are organized vertically.
7. Emergency departments may be located on top floors.
8. Violence could end in less than 10 minutes.

The excellent NEAR action framework is used to detect factors to be taken for healthcare facilities by safety leaders.

Med Tac Publication in Campus Safety Magazine: In Publication

Battling Failure to Rescue With Rapid Response Teams

Applying what we have learned in hospitals to schools, higher education, and worship centers.

- Have you learned from 9/11 and the latest active shooter events?
- Can you define the current and specific risks to those you serve and who serve?
- Can you get care to any victim within three minutes?
- Are AEDs and care supplies positioned within three minutes of victims?
- Do players from your various departments regularly practice emergency response together?

After 3 minutes without bystander care...you are counting lives lost and long term harm to victims of significant health hazards and conditions.

NOTE: See June Issue of Campus Safety Magazine at www.CampusSafetyMagazine.com
Hospitals Fall Short of Patient Safety Goals 20 Years after 'To Err Is Human'

Total HACs: Preliminary 2017 data shows the total rate of hospital acquired conditions is still 6.9 per 1,000 higher than the 2019 goal.

2019 Goal: 79 per 1,000

Hospitals Fall Short of Patient Safety Goals 20 Years after 'To Err Is Human'

I’m especially disappointed that quality improvement hasn’t risen to the strategic center of healthcare.”

DR. DON BERWICK, PRESIDENT EMERITUS
INSTITUTE FOR HEALTHCARE IMPROVEMENT

“I’m happy that the problem is now recognized,” said Dr. Don Berwick, president emeritus of the Institute for Healthcare Improvement and one of the IOM report’s authors. “But I’m especially disappointed that quality improvement hasn’t risen to the strategic center of healthcare. It is what we should be about.”

He and other safety experts lament that too many healthcare organizations still have not built a culture in which physicians, nurses and other staff feel confident that they can raise quality of care concerns without suffering retribution and that their concerns will be addressed. Inseparable from that, organizations haven’t concentrated on enhancing the physical safety and emotional well-being of their staffs.

"Is the culture of an organization one that genuinely cares about the people who care for patients?" said Dr. Stephen Swenson, former medical director for leadership and organization development at the Mayo Clinic. “This is not widespread. But if we’re serious about creating safety, we have to change the culture of organizations, and that’s largely leadership actions.”
Nearly 200 investigations are underway at major academic centers. Critics fear that researchers of Chinese descent are being unfairly targeted.

The N.I.H. and the F.B.I. have begun a vast effort to root out scientists who they say are stealing biomedical research for other countries from institutions across the United States. Almost all of the incidents they uncovered and that are under investigation involve scientists of Chinese descent, including naturalized American citizens, allegedly stealing for China. Seventy-one institutions, including many of the most prestigious medical schools in the United States, are now investigating 180 individual cases involving potential theft of intellectual property. The cases began after the N.I.H., prompted by information provided by the F.B.I., sent 18,000 letters last year urging administrators who oversee government grants to be vigilant.
2019 National Drug Threat Assessment
DEA - US Justice Department

The 2019 National Drug Threat Assessment (NDTA) is a comprehensive strategic assessment of the threat posed to the United States by domestic and international drug trafficking and the abuse of both licit and illicit drugs. The report combines federal, state, local, and tribal law enforcement reporting; public health data; open source reporting; and intelligence from other government agencies to determine which substances and criminal organizations represent the greatest threat to the United States.

Meaningful Use is dead. Long live something better!

By Dr. Charles Denham II, William Adcox, Charles Denham III, and Dr. Gregory Botz

Published November 11, 2019


Inadequate Placement of AED and Bleeding Control Gear Could Cost You

AEDs and bleeding control kits can save lives, but only if they are always accessible and staff members know how to use them.

PROXIMITY:
- Existing fixed AEDs should be 1 minute away from any victim to enable 3 minutes from "drop to shock" allowing 30 seconds to put the AED into action.
- Bleeding Control Gear should be co-located with AEDs to enable 3 minutes from "shot to stop" of major bleeding for gunshot wounds.

ACCESS:
- All AEDs and Bleeding Control Gear supplies co-located so that they are available 24 hours a day, 7 days per week and never behind locked doors.

LOCATION:
- Identify high traffic and high risk areas. Place AEDs and Bleeding Control Gear in locations for surge.
- Portable AEDs and Bleeding Control Gear may need to be provided in backpacks or mobile on bicycles, golf carts, or patrol cars to pass 3 minutes to care test.

POSITIONING:
- The positioning of gear above the ground should match the local requirements. Students of small stature may have to retrieve the gear to support bystander care.
- AEDs and Bleeding Control Gear should be placed following local regulatory statutes that evolve.

VISIBILITY:
- Signage must be clearly visible and the addition of Bleeding Control Gear to AED locations will require new signage clearly communicating bleeding control gear.
- Signage must be visible from all directions to allow bystanders under stress to find the supplies.
Meaningful Use is dead. Long live something better!

YouTube Patient Safety Briefings

Opioid Overdose Crisis 2019 Update
https://www.youtube.com/watch?v=vyCxQWxaEqE

Sudden Cardiac Arrest
https://www.youtube.com/watch?v=qdXW5WxDY8&feature=youtu.be

Active Shooter Events in Healthcare
https://www.youtube.com/watch?v=qSsWAs5JJBw&feature=youtu.be

Med Tac Lifeguard-Surf Program
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Med Tac Bystander Care Training
https://www.youtube.com/watch?v=2IM0jh4CQU&feature=youtu.be

Rapid Response Teams
https://www.youtube.com/channel/UCCoR25LxSltrdRqyCQ7fA/