Clinical Pearls

&

Take Home Messages
Follow the Policy

- Do No More
- Do No Less
Do NOT ‘Reinvent the WHEEL’
Remember

• System
• System
• System
KISS Principle

Keep It Simple Standardized
From: “**WHO**
did it?”

To: “**HOW**
did it happen?”
“The most detrimental error is failing to learn from an error.”

*James Reason*
Some people watch things happen!

Some people wonder what happened?!

Some people make things happen!
INDEPENDENT Double-Check
Therapeutic Classes that Cause the Greatest Harm:

- Opioids (all)
- Anticoagulants (all)
- Insulins (all)
- Chemotherapy
One Stop Resource
JUST Culture
Communication

**ISBAR**

- Identification
- Situation
- Background
- Assessment
- Recommendation
PATIENT education
Acute Anaphylaxis Management

1. EPINEPHrine
2. EPINEPHrine
3. EPINEPHrine
4. EPINEPHrine
5. EPINEPHrine
6. EPINEPHrine
7. EPINEPHrine
8. EPINEPHrine
9. EPINEPHrine
10. EPINEPHrine
11. EPINEPHrine
12. EPINEPHrine
13. EPINEPHrine
14. EPINEPHrine
15. EPINEPHrine
16. EPINEPHrine
USING ABBREVIATIONS MAY SAVE MINUTES,

PROHIBITING ABBREVIATIONS MAY SAVE LIVES
IF in Doubt, CHECK it OUT
• Eliminate the denominator
• Put a face on the data
  • Start every meeting with a *story*
  • Convert data to *names, dates, & events*
• Harness the power of **TRANSPARENCY**
Embrace the Power of Storytelling

There is no better way to inspire and sustain cultural change than through the simple craft of telling factual stories that move listeners into action.

The Institute for Healthcare Improvement & ISMP
Mini-RCA

1. Why?
2. Why?
3. Why?
4. Why?
5. Why?
If you require more than three (3) dosage forms to prepare / administer a dose, CHECK IT OUT!
Don’t ASSUME

Always CONFIRM
It’s NOT Rocket Science

Be comfortable with what you do, and feel safe reporting.
Safe Patient Care Is Our Goal