FROM THE FIELD

How Swiss Cheese is Helping Banfield Help Pets

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From the Field shares insights from Banfield Pet Hospital veterinary team members. Drawing from the nationwide practice's extensive research, as well as findings from its electronic veterinary medical records database and more than 8 million annual pet visits, this column is intended to explore topics and spark conversations relevant to veterinary practices that ultimately help create a better world for pets.

At Banfield Pet Hospital, we've long had processes in place to help ensure our hospitals have the tools to practice high-quality medicine. In 2014, we embarked on a new phase in our continuous quality journey with the goal of strengthening our hospital systems to help our veterinarians provide great care for every pet, even on chaotic days. We knew embracing a culture focused on quality and safety was imperative, as was creating systems and processes that made the right thing to do the easy thing to do.

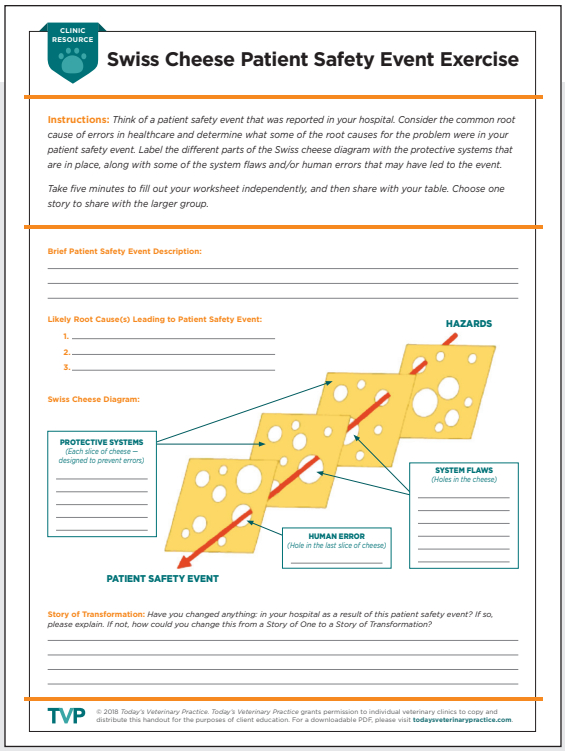
We gathered learnings from human healthcare, including insights from high-profile cases involving system failures, and adopted the "Swiss Cheese Model" to analyze safety incidents. The model illustrates how a particular hazard penetrates multiple barriers and safeguards to result in a safety event. Each slice of cheese represents a system or process that acts as a safeguard to prevent an event from occurring. The holes in the cheese represent areas for improvement in the process. If the slices are organized a certain way, and the holes line up, a safety event may occur. In this way, the Swiss Cheese Model analysis helps to identify risk factors for safety events. This information can then be used to improve systems to prevent harm.

We began to actively foster an environment of openness and transparency without blame across our practice, a step essential to creating a Culture of Safety.

Culture of Safety

The collective product of facilities, equipment, standards and training, as well as individual and group attitudes, values, competencies and patterns of behavior that supports and promotes associate, client and patient safety in the work environment.

To learn more, visit https://psnet.ahrq.gov/primers/primer/5/safety-culture.



CLINIC RESOURCE

Swiss Cheese Patient Safety Event Exercise

Instructions: *Think of a patient safety event that was reported in your hospital. Consider the common root cause of errors in healthcare and determine what some of the root causes for the problem were in your patient safety event. Label the different parts of the Swiss cheese diagram with the protective systems that are in place, along with some of the system flaws and/or human errors that may have led to the event.*

Take five minutes to fill out your worksheet independently, and then share with your table. Choose one story to share with the larger group.

Brief Patient Safety Event Description:

Likely Root Cause(s) Leading to Patient Safety Event:

1. _____
2. _____
3. _____

Swiss Cheese Diagram:

Story of Transformation: *Have you changed anything: in your hospital as a result of this patient safety event? If so, please explain. If not, how could you change this from a Story of One to a Story of Transformation?*

TVP

CLINIC RESOURCE. Download a copy of the Swiss Cheese Patient Safety Event Exercise at **tvpjournal.com**.

In January 2016, Banfield rolled out a Patient Safety Event reporting system to enable associates to report quality and safety concerns without fear of reprisal. We encouraged reporting on near misses as well as cases where harm occurred, given both offer insights on how to continually enhance safeguards.

Developing a Culture of Safety is important and achievable for all types of practices, big and small. As we develop strategies to reduce risk, we continue to use the Swiss Cheese Model as a tool to develop changes that minimize risk and improve outcomes. We encourage you to share experiences and use the activity below to work through events in your own practice. TVP

Additional Resources

- *Swiss Cheese Model*
  Agency for Healthcare Research and Quality (2000)
  https://psnet.ahrq.gov/resources/resource/1104
- *Patient Safety Primer Systems Approach*
  Agency for Healthcare Research and Quality (2017)
  https://psnet.ahrq.gov/primers/primer/21/systems-approach
- *Terrible Tragedy — and Powerful Legacy — of Preventable Death*
  Virginia Mason Institute (2014)
  https://virginiamasoninstitute.org/2014/03/terrible-tragedy-and-powerful-legacy-of-preventable-death/