Healthcare Organization Commitment

Contact Details

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Commitment Details

Commitment Name
The Blue Angel Standard

What Patient Safety Challenge does your Commitment address?
Challenge 1 - Culture of safety

Commitment Start Date
20/11/2013

How Many Hospitals Will This Commitment Represent

Patient Safety Movement Foundation | patientsafetymovement.org
**Action Plan**
The use of systematic personal and group strategies to ensure the proper configuration and functioning software equipment, processes and care teams has lagged far behind the explosion of high-consequence devices, procedures, and complexity at the bedside. Despite the increasing use of time-outs, checklists, briefing and debriefing to achieve reliability, as they did in the aviation industry, we just don’t see the same results in medicine, not even close. As a former officer and Flight Surgeon for the US Navy Blue Angels, my life and the lives of others on the team and on the ground depended on using personal strategies, structured communication tools and teamwork strategies to achieve the highest degree of reliability and safety in one of the most hazardous and unforgiving environments in the world: low-level, near supersonic formation aerobatics over and in front of hundreds of thousands of spectators. Now, as a private pilot and a neuroanesthesiologist at Mayo Clinic in Florida, I use these same strategies to keep my family safe and my personal flying and my patients safe during high-consequence and highly complex neurological procedures, respectively. My commitment is to use this unique experience to produce media and print, specifically meant for front-line healthcare workers of all disciplines and levels, that describes the essential individual behaviors, essential team members, and the variety of communication tools that can be employed by anyone interested in achieving "Blue Angel" levels of habitual individual excellence and team member trust. Both of these factors: habitual individual excellence and team member trust are critical in achieving safety and reliability. Proper configuration and functioning of software, equipment, processes and care teams is merely a byproduct of these two behaviors when combined with an understanding and consistent use of communication tools such as time-outs, checklists, briefing, debriefing, and Standard Operating Procedures. My action plan: 1. Produce the manuscript outline and manuscript 2. Select great examples from medicine that concretely illustrate the above concepts 3. Produce the interviews and media for the target audience of front line workers (I already have an in-house audio and video media production capability) 4. Post-production work including exploring partnerships to ensure widespread availability to frontline healthcare workers

**Commitment Timeline**
Completion of Manuscript by May 2014 Media production complete by August 2014 Post-production complete by November 2014 Roll-out December 2014

**Impact Details**

**Lives Lost in Last Calendar Year**
0

**How many lives do you expect to spare from harm in the next calendar year?**
0
How many lives do you expect to save in the next calendar year?
0

Methodology for Determining Lives Saved