Is It in You to Stop the Line for Safer Care?

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Stop!

That one word—stated with volume, clarity and purpose—can lead to care that is measurably and meaningfully safer than it has ever been. In fact, it might be the most important four-letter word in health care.

When health care workers are empowered to say "stop"—to halt a care process—because they know an error has been made or feel something isn't quite right, it provides the entire care team the opportunity to identify and correct mistakes that might otherwise compromise patient safety down the line.

Yet the term is not uttered as easily or as often as it should be. Barriers such as an unsupportive organizational culture or lack of leadership encouragement can prevent individuals from speaking up, particularly if they fear negative repercussions for interrupting time-sensitive health care processes or questioning a supervisor. They may also worry about the consequences of exposing their own mistakes.

The price of silence, however, takes a heavier toll. In a 2005 study, one in five physicians acknowledged that they had seen harm come to patients when they or their colleagues didn't speak up when they became aware of an instance of poor clinical judgment or shortcuts that could cause harm (Maxfield et al. 2005).

AT A GLANCE

- Health care leaders must nurture a culture in which all employees feel comfortable stopping processes when they spot a possible defect that could compromise patient safety down the line.
- All employees should bear responsibility for stopping the line when an error is suspected.
- Leaders must understand and educate caregivers and others about scenarios in which stopping a process is warranted, the methodology for doing so and the actions and conditions that are required before the care process can be resumed.

For this reason, "stop" should be embraced universally by health care providers as a necessary and valuable safety tool in the same way it has been integrated into defect-alert systems in manufacturing and other industries.

Stopping work immediately when a problem occurs is a central pillar of the Toyota Production System—which has been adopted across industries. The practice is based on a concept called "jidoka" that originated in Japan in the early 1900s. When a problem is detected, a process will automatically stop or be stopped by an empowered operator, thus preventing the problem from continuing downstream.

Empower and Encourage

At Toyota, jidoka is facilitated via an "andon system"—a signaling tool that workers use to call for help when they recognize an abnormal condition that requires some form of corrective action. The system empowers employees by putting the stop-work ability directly into their hands. Workers pull an andon cord, a light goes on, music plays as a signal for supervisors to come and help, and the entire assembly line either slows or stops (depending on the degree of the defect resolution time) while line workers and supervisors assess and fix the problem, often preventing an error from becoming embedded in the final product. This can happen many times a day.

The theory behind stopping the line is that mistakes are inevitable, but often more reversible early on. Defects are mistakes that were not fixed at the source, were passed on to another process, or were not detected soon enough and have become relatively permanent.

Importantly, every worker in the Toyota plant has the power and the obligation to stop the assembly line when a defect or error is identified or even suspected. Military aviation workers are similarly empowered, and lives have been saved because of it.

Over the course of my nearly three decades as a naval aviator and F/A-18 pilot, I have experienced several andon events, or "stand-downs," as they are called in naval aviation. They did not occur often, but when they did, all parties took notice and were intently focused on the "why" and "what's next" associated with them in order to prevent them from happening again.

This past summer, the Deputy Commandant for Aviation (DCA) for the U.S. Marine Corps ordered a stand-down in the wake of a fatal mishap involving a Marine Corps F/A-18 in California. It was the third mishap in just a month and a half involving Marine Corps F/A-18 pilots. While the outcome of that operational pause is not yet publicly known, my experience tells me that corrections necessary to mitigate the spate of accidents are well under way. I can also say I am confident that Marine Corps Aviation is spending considerable effort to identify both the individual and the systemic failures that led to these mishaps in order to alter the conditions that allowed the mishaps to occur. That is what High Reliability Organizations do, and it's what health care organizations must do in order to build a culture of Zero Harm.

"Stop" Comes from the Top

We in health care are becoming more and more familiar with the idea of andon systems, or "stopping the line." Increasingly, the language is being integrated into our policies and protocols. However, that doesn't mean the systems are actively being used or promoted. It is up to leaders and managers to support and encourage all employees to say "stop" when necessary, with the understanding that the short-term interruption will improve quality and safety over the long term.

As leaders, we must also develop a clear understanding of the situations that would lead us to stop a process and communicate that across the organization. Further, employees at all levels must be comfortable with the concept and should be educated about what to do and how to do it.

Toward this end, health care leaders and managers should ask themselves the following questions and discuss the answers with their teams.

1. Can we as health care professionals cite at least three scenarios that would lead us to "stop the line"? Some examples include beginning a procedure on the wrong site (laterally), noticing a colleague about to administer a high-risk medication without reconciliation or seeing a colleague begin to administer care to a patient without patient ID verification.

2. How do we stop the line? Is there a mechanism (or statement) that we can use that all would acknowledge? Many of our partners use the acronym CUS (stating I am "concerned," then I am "uncomfortable" if there is no resolution, and then asking a colleague to "stop" or "stop the line").

3. What actions and conditions are required to resume operations in the wake of such an event? In other words, what must transpire so that we are confident the issue has been resolved? This is simply a conversation among leaders and employees that achieves acknowledgment by all involved that they are no longer concerned, they understand why the stop was called, they are comfortable with the plan of care moving forward, including what will be done differently, and, most importantly, they are confident the patient is no longer in any danger of being harmed.

Although speaking up may not always be easy or comfortable, it is a necessary, powerful step forward on the road to High Reliability. In order to progress toward the goal of safe, error-proof health care, providers must be ready and willing to embark on a journey that is full of stops.