Gould Center for Interprofessional Education

Elephants, Cheese, and Using Your Voice

Maine Sonographers Association Conference

April 2023

Danielle M. Brown MEd, RDMS (AB, BR, FE, OB/GYN), RT(R)
Medical Imaging Clinical Coordinator
Danielle.Brown@mchp.edu

Ann Curtis DNP, RN
Director of Interprofessional Education
Ann.Curtis@mchp.edu

By the Numbers

3rd	
70-80	
1 in 20	
12	
9.3	

Small Group Activity

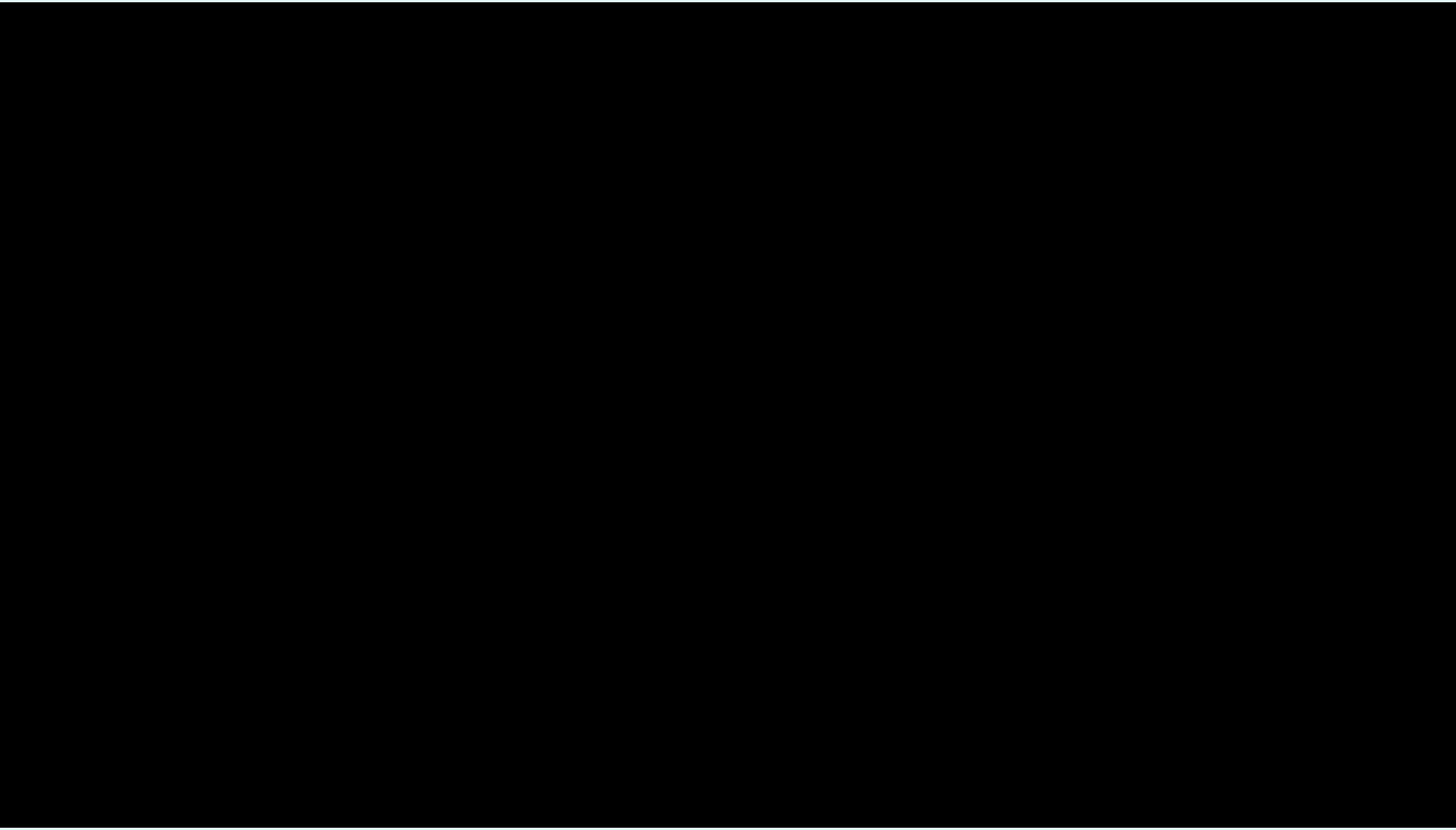
- One envelope per pair/group
  - Keep it secret, keep it safe!
  - Describe what's in the envelope

Small Groups Gather

- Gather according to COLOR
- 1 envelope per color group
- Follow instructions in envelope
- Reflect on the questions in the envelope.

Ponder

- What did you make?
- How would you describe it now?
- Did directions help?
- What if you were missing 1 piece?



Here’s what we know….

Healthcare professionals often educated in silos.

What did you say?

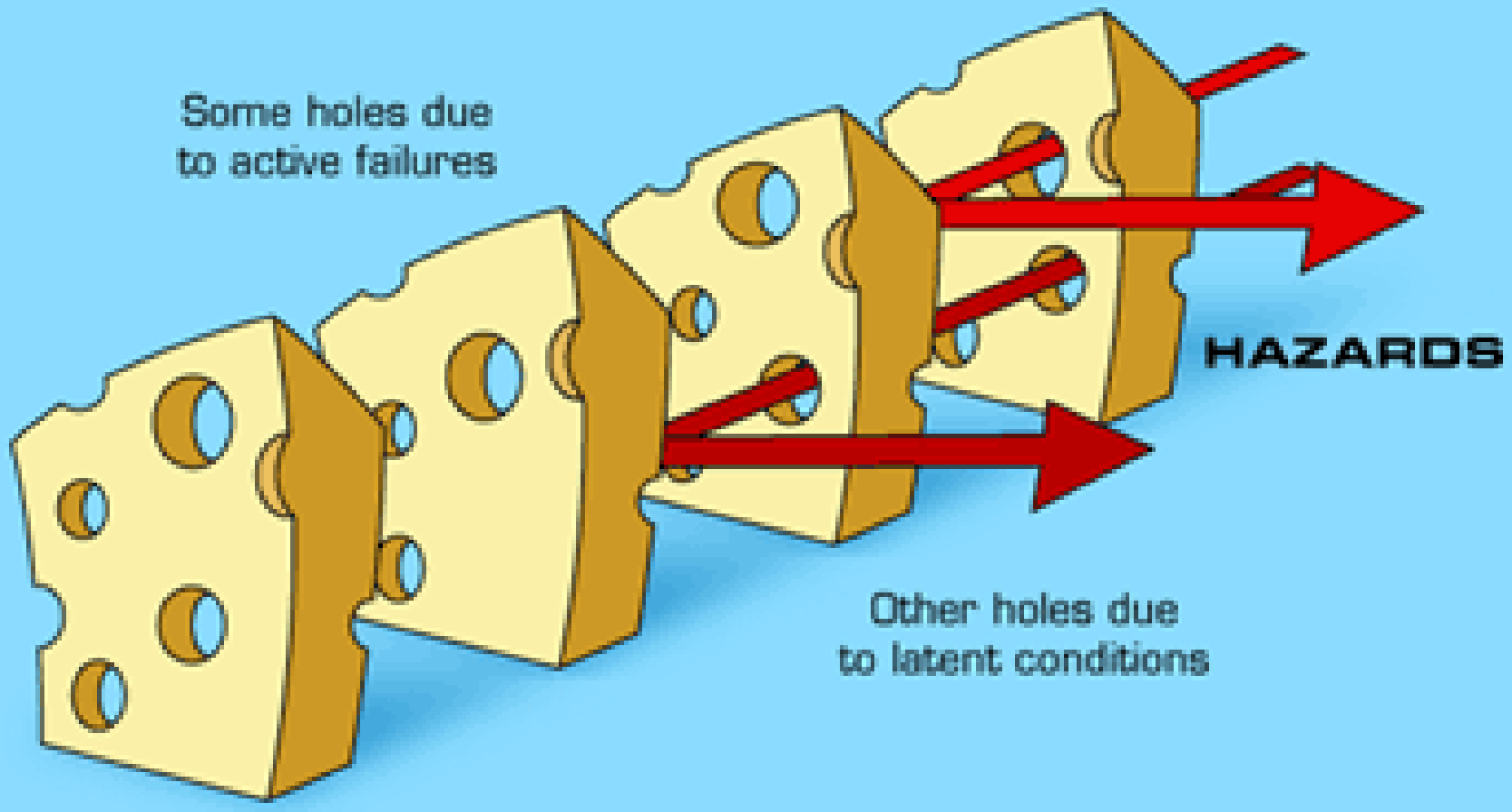
Commonly Used in US	Other Meaning(s)
CM: cisterna magna	Centimeter Cardiac murmur Casrimegaly Chronic migraine
CCA: common carotid artery	Cholagiocarcinoma Cervical cancer
NT: nuchal translucency	Non-tender
PV: portal vein	Peripheral vascular/vessel/vein Plasma volume Postvoid Pulmonary vein

Errors & Near Misses in Emergency Sonography

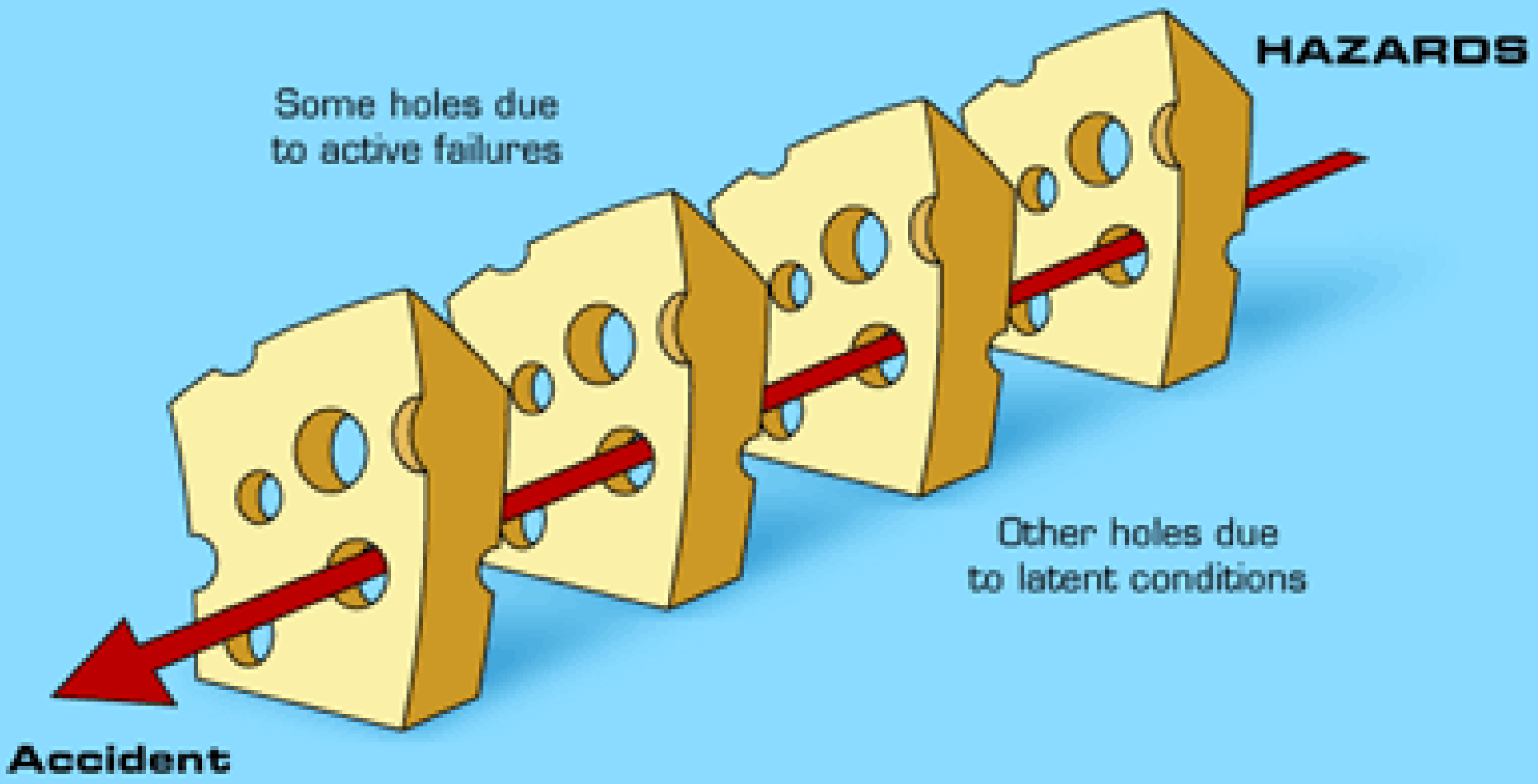
- Communication
- Lack of attention to clinical history
- Inadequate image optimization
- Lack of knowledge of technical equipment
- Similarities in the appearances of various physiological and pathological processes

(Pinto et al., 2013)

Reason's Swiss Cheese Model of Accident Causation



http://www.anesthesiaworld.net/swiss-cheese/



SUCCESSIVE LAYERS OF DEFENSES

http://www.anesthesiaworld.net/swiss-cheese/

Wounded Healers

Evidence-based strategies

- Minimize disruptions/distractions
- Be vigilant about confirmation bias
- Collaborate with team members
- Offer your perspective
- Ask questions
- Involve the patient
- Report near misses
- Support wounded healers

Your perspective is
unique.
It's important and it
counts.

GLENN CLOSE

“We need to quit blaming and punishing people when they make mistakes and recognize that errors are symptoms of a system that’s not working right and go figure out and change the system so no one will make that error again, hopefully. We have to change the culture, so everyone feels safety is his or her responsibility, and identifies hazards before someone gets hurt.” Dr. Lucian Leape , The National Patient Safety Foundation

References