

Welcome

Welcome to the second issue of ***Patient Safety Tools***, IPRO's electronic newsletter designed to provide information and resources on patient safety to health care providers across New York State.

We have adopted this format to increase the reach and effectiveness of our efforts to communicate a range of useful, current information regarding patient safety initiatives sponsored by IPRO and others. We hope that by bringing key findings, lessons learned, workable strategies, and practical tools to your attention, these newsletters will highlight proven ways to apply quality improvement processes to achieve "transformational" advances in patient safety.

Introduction and Purpose

In each newsletter, we present information focused around each of the twelve safety dimensions for hospitals defined by the Agency for Healthcare Research and Quality (AHRQ) as implemented in their Patient Safety Climate Survey. This valuable survey is currently being used by IPRO in a CMS-directed rural hospital initiative to promote an improved hospital patient safety environment and may be used by any hospital. The survey identifies specific patient safety strengths and vulnerabilities associated with each of the twelve measured dimensions and can facilitate a data-driven plan to engage senior leadership to promote safety improvement activities using specific evidence-based, proven interventions.

The patient safety dimensions that reflect various hospital processes are the following:

- Overall perceptions of safety.
- Event reporting.
- Supervisor/manager expectations and actions promoting patient safety.
- Organizational learning/ continuous improvement.
- Teamwork within units.
- Communication.
- Feedback and communication about error.
- Nonpunitive response to error.
- Staffing.
- Hospital management support for patient safety.
- Teamwork across hospital units.
- Hospital handoffs and transitions.

The first issue focused on using the Situation, Background, Assessment and Recommendation (SBAR) technique to improve communication during the many handoffs and transitions that occur during any hospital stay. This issue will deal with the absolute need for active and visible participation by hospital senior leadership, especially the CEO, in driving safety culture change efforts and the tools that will permit busy executives to do so. Senior leadership does not refer to a single person or specific entity but includes individuals on the Hospital Board of Directors, executive and nursing management, and medical staff leaders.

The Case for Leadership

Leaders make choices among competing priorities-selecting those goals, objectives, and strategies that give their organizations shape, meaning, and direction.

"Quality is never an accident, it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives." William A. Foster

The same can be said for patient safety. Management support in any organization simply means providing thoughtful leadership.

Leadership can be active or passive, ongoing or intermittent, heartfelt or shallow. When you need to get something done safely and well in a complex and risky environment (like a hospital of any size), there is no substitute for active, ongoing, heartfelt leadership. Somebody has to get everybody's attention, focus that attention on what needs to get done, obtain agreement on how to proceed, and provide feedback and encouragement along the way.

The safest and most reliable hospitals in the country today are being led by senior management teams on a mission - on a mission to insure that the care delivered in their facility, and that bears their imprint, is of the highest quality and unfailingly safe. Senior executives, medical staff leaders, and board members working together to prevent harm to the patients who come to them for care characterize highly reliable hospitals. They understand that safety and quality are system properties that reside in the way things are done; that all complex systems are vulnerable to something going awry at any time; that human factors for good and ill are inextricably interplexed with the technologies of 21st century medicine; and that no part of any care delivery process should ever remain unexamined or be taken for granted.

The importance of senior leadership activities in determining the actual safety and quality of care in hospitals should not be underestimated and cannot be pushed aside. Senior leadership makes choices. Any effort to move the big dots of patient-safety and care-quality to another level will not work without the active and committed participation of senior leaders. Period!

Engaging Senior Leadership

Why do we need to engage senior leadership? Isn't everybody who works in a hospital interested in safety and making sure no harm comes to patients? The answer to this question is obviously "yes". But, being interested in safety and actively doing something about assuring and improving it with evidence-based tools are two vastly different things. Hospital leaders have long been rightly concerned about patient safety issues and have done what they believe is the right thing. Traditionally, senior leadership in hospitals (i.e. executives, medical staff, and Board members) have focused most of their time and efforts on making sure the hospital is viable - financially and operationally - with the latest technology and appropriately trained staff. In the rooms and corridors of care, patient safety was assumed to exist - a given, along with cleanliness and high-quality, expert care. We all now know that the assumption of safety in hospitals has proven false. The need for large-scale change is abundantly clear. The adverse impact of medical errors has been documented several times since the 1999 IOM report, *Crossing the Quality Chasm*ⁱ -

- Total national cost is estimated to be between \$8.5 billion and \$29 billion
- 44,000-98,000 US annual deaths as result of errors
- Medical errors are the leading cause of death, followed by surgical mistakes and complications
- More Americans die from medical errors than from breast cancer, AIDS or car accidents
- Two percent (2%) of admissions to the hospital experience an adverse drug event that results in an increased stay and nearly \$4,700 added cost per event

- Seven percent of hospital patients experience a serious medication error
- Large (3-5 fold) variation in care by geography exists

The list goes on. McGlynn's seminal 2003 studyⁱⁱ on the quality of care delivered to Medicare beneficiaries nationwide found that participants received only 55% of recommended care under the best of circumstances. A more recent studyⁱⁱⁱ published in March 2006, by the same researchers in a large, community-based sample of patients who had made at least one visit to a health care provider in the previous two years confirmed this finding. Shouldn't we all receive 100% of the recommended care all the time? Change of the magnitude required to achieve highly reliable care requires active leadership at all levels. Do senior leaders need to be actively engaged to make hospitals safer? Yes.

Leadership Tools

Two key leadership concepts adopted from reliability science (a science that focuses on reducing error rates to protect the public) apply to safety culture change efforts in health care. First, safety culture change must lead to a deeper understanding of how **professional autonomy** among caregivers can support, or work against, the development of standards to insure that all patients receive the appropriate care. This does not mean giving up independent practice, but simply means incorporating professional skills into a team-based work environment. Second, **standardization** of care processes is essential. This does not mean "cookbook" medicine, but simply means creating an evidence-based infrastructure to provide appropriate care to all patients all the time. Applying these concepts in hospitals requires the concerted effort of board, executive, and medical staff leadership.

There are several, well-established processes for hospital executives to become visible and active in leading patient safety improvements in their organizations. These include:

- Involve the hospital's board with safety and quality
- Incorporate safety and quality goals into organizational strategic plans
- Implement a safety culture survey process
- Educate everyone on safety and quality improvement science
 - Root Cause Analysis (RCA)
 - Failure Modes and Effects Analysis (FMEA)
 - Plan-Do-Study-Act (PDSA)
- Senior leadership WalkRounds™
- Formal support in establishing safety briefings
- Establishment of a "just culture" hospital policy
- Formal support for improving communication and teamwork
 - Situation, Background, Assessment and Recommendation (SBAR)
 - Crew Resource Management
- Introduce lean thinking into the organization

How do you get started on this list?

Dr. Peter Pronovost from Johns Hopkins recommends starting small. He has developed an 8-step Comprehensive Unit-Based Safety Program (CUSP)^v that can serve as a model for how to get senior leadership actively involved in transforming a hospital's safety culture. He focuses on educating everyone about safety science, with four key learning objectives:

- Understand the safety problem is large
- Understand that workers are not to blame
- Focus on systems
- Understand that staff members are responsible for the systems within which they work

Here are four evidence-based leadership tools to help jump-start leadership involvement:
Patient Safety Leadership WalkRounds: By using Patient Safety Leadership WalkRounds™, an IHI tool, weekly, senior leaders of health care organizations can demonstrate to the staff the organization's commitment to building a culture of safety. ^{vi vii}

Safety Briefing: This is another simple, easy-to-use, IHI tool that frontline staff can implement to share information about potential safety problems and concerns on a daily basis. Support for implementation of regular safety briefings by hospital leadership can foster a culture of safety, reduce the risk of errors, and improve the quality of patient care. ^{viii}

Just Culture Primer: To create a culture of safety, leadership must foster and develop an open learning culture where it is possible to learn from mistakes. To create this type of open learning culture, it is important to reevaluate how we hold health care practitioners accountable for mistakes and behaviors. This 28-page primer, developed by David Marx, JD, for Columbia University under a grant provided by the National Heart, Lung and Blood Institute, explores this concept, its impact on event reporting systems, and application of the concepts in creating a culture of safety in healthcare.

Sensemaking Guidelines: Sensemaking conversations can provide an opportunity for hospital leadership and staff to explore and understand unexpected, ambiguous, or novel events within an organization. Nancy Dixon of Common Knowledge Associates developed the Sensemaking Guidelines as part of a CMS Patient Safety Learning Pilot. The Guidelines explain the concept of sensemaking, outline clear steps to creating sensemaking conversations, and provide practical examples of how this powerful tool can be used as part of creating a culture of safety. [Click here](#) to access the guide on MedQIC.org.

Here are some additional evidence-based leadership tools:

- [Leadership Guide to Patient Safety: Tools for Establishing & Maintaining Patient Safety](#)
- [Strategies for Leadership](#)
- [Seven Leadership Leverage Points](#)
- [Going Lean in Health Care](#)
- [Transform Organizational Culture](#)

Finally, here's an executive reading list derived from patient safety experts that provides clarity and support for a culture of patient safety in hospitals –

Managing the Unexpected: Assuring High Performance in an Age of Complexity

Karl E. Weick, Kathleen M. Sutcliffe
 ISBN: 0-7879-5627-9
 2001, Jossey-Bass

The Design of Everyday Things

Donald Norman
 ISBN: 100-262-64037-6
 1998, Bantam Doubleday Dell

Clinical Risk Management

Charles Vincent
ISBN: 0727913921
2001, BMJ Books

Complications: A Surgeon's Notes on an Imperfect Science

Atul Gawande
ISBN 0-312-42170-2
2002, Henry Holt & Company

Managing the Risks of Organizational Accidents

James T. Reason
ISBN 1840141042
1997, Ashgate Publishing Company

Human Error

James T. Reason
ISBN 05214131944
1990, Cambridge University Press

Human Error in Medicine

Marilyn Sue Bogner
1994, Lawrence Erlbaum Associates

The Field Guide to Human Error Investigations

Sidney Dekker
ISBN 0754619176
2002, Ashgate Publishing Ltd.

Difficult Conversations: How to Discuss what Matters

Douglas Stone, et al
ISBN 0670883395
1999, Penguin Books

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The WalkRounds trademark is owned by Allan Frankel, MD, Director of Patient Safety, Partners HealthCare System, Boston, and the Health Research and Educational Trust (HRET), a subsidiary of the American Hospital Association. Partners HealthCare System and HRET are involved in a study in Massachusetts to evaluate the rounds and then disseminate the findings through HRET.

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ⁱ Committee on Quality Health Care in America /Institute of Medicine Crossing the quality chasm: a new health system for the 21st century, National Academy Press, 1999.

ⁱⁱ McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA. The quality of

healthcare delivered to adults in the United States. *N Engl J Med.* 2003;348:2635-2645.

ⁱⁱⁱ Asch SM, Kerr EA, Keeseey J, Adams JL, Setodji CM, Malik S, McGlynn EA. Who is at greatest risk for receiving poor-quality health care? *N Engl J Med*

^{iv} Nolan T, Resar R., Midelfort L., Haraden C., Griffin F. IHI White Paper *Improving the Reliability of Healthcare*

^v Pronovost, P. MD, Weast, Rosenstein, B. MD, Sexton J. Holzmueller, Paine, L Davis, Rubin H. Implementing and Validating a Comprehensive Unit-Based Safety Program *Volume 1, Number 1, March 2005*

^{vi} Frankel A, Graydon-Baker E, Neppi C, Simmonds T, Gustafson M, Gandhi TK. Patient Safety Leadership WalkRounds *Jt Comm J Qual Saf*2003 Jan;29(1):16-26.

^{vii} Thomas E, Sexton, J, Bryan, Neilands, Torsten, Frankel, A, Helmreich, Robert. The effect of executive walk rounds on nurse safety climate attitudes: A randomized trial of clinical units. *BMC Health Services Research* 2005, **5**:28

^{viii} DeFontes, J MD, Surbida, S MPH, Preoperative Safety Briefing Project. *The Permanente Journal* Spring 2004/ Volume 8 No. 2

^{ix} Astion, M MD, PhD; Chou, D MD. **Just Culture and Strong Interventions at the Point of Care.** *Point of Care: The Journal of Near-Patient Testing & Technology.* 4(4):154-157, December 2005

^x Zboril-Benson, L. and Magee, B. How Quality Improvement Projects Influence Organizational Culture. *Health Care Quarterly* Vol 8, Special Issue, October, 2005

Other useful references:

Elgert, S, MD. Reliability Science: Reducing the Error Rate in Your Practice. *Fam Pract Manag.* 2005;12(9):59-63.

Leonard M, Graham S, Bonacum D. The human factor: the critical importance of effective teamwork and communication in providing safe care. *Qual Saf Health Care.*2004 Oct;13 Suppl 1:i85-90.

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