Washington State Hospital Association

Patient Safety Transforming Culture

Effective Leadership for the Delivery of Health Services

Patient Safety: Transforming Culture

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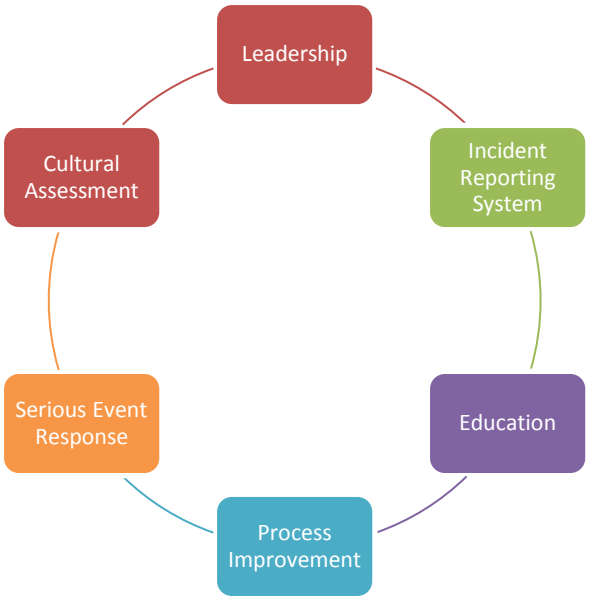
"Between the healthcare that we now have, and the health care we could have, lies not just a gap, but a chasm." - ***Crossing the Quality Chasm, 2001***

Overview

Great leaders regardless of their position or role understand the need to create an environment where there is capacity for themselves and those around them to learn, grow and change; in essence not just to survive but to thrive. Along with this, the current demands for the reduction in the fragmentation of health care require that hospitals, physicians and health systems develop environments that support safety and protect patients from harm.[1]

Culture is an important aspect of social environments. It is the shared assumptions, beliefs and norms that determine the way people perceive, think and feel.[2] There is considerable research demonstrating the relationship between organizational culture and the ability to consistently deliver services which provide value and good outcomes.[3] A safe culture is an environment in which there is shared responsibility, role clarity and open and frequent communication related to safety. Key values and activities are nurtured and rewarded including employee awareness, vigilance, a process for formally identifying hazards and action steps for resolving safety concerns and problems.[4]

Core Strategies



This toolkit was developed to support health systems, hospitals and physician offices strengthen their culture to achieve safe, timely, effective, efficient, equitable and patient-centered care. The focus is on high-impact approaches that are effective in an organization's journey towards a safe culture.

The toolkit is organized into five main sections:

- C***ore strategies*** are the basic building blocks for developing a safe culture.
- ***Leading practices*** refers to practices which are believed to be more effective at delivering a particular outcome than others, for the time being, recognizing that practices are continuously being developed and improved.
- ***Hardwire*** refers to the activities that support the sustainment of a safe culture.
- ***Implementation*** describes the steps to take to move forward.
- ***Appendix section*** includes a glossary of terms, sample tools, and other documents.

Leading Practices

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Core Strategies

The core strategies are the basic building blocks needed to develop a safe culture. They provide a strong foundation from which to advance your patient safety programs.

Leadership:

"Leadership has never been more important to show how quality improvement and patient safety at full scale is within reach and how this improvement is key to health care affordability."
- Don Berwick, MD, MPP, 2012

Creating and sustaining a culture that promotes patient safety usually requires significant organizational change within a hospital. Patient safety is everyone's job, including front-line clinicians and staff, managers, administrators, and senior leaders and board members. To tap into the capabilities of all members of the hospital, formal and informal leadership is needed at all of these levels to spread information and to address identified safety concerns.

The literature specifically points to the critical role of senior leadership in culture change since they are the only ones who can direct the efforts and the commitment needed to address the underlying system causes of medical errors and harm to patients. What separates organizations that get results from those that don't is that the boards and senior leaders of successful systems are actively engaged in patient safety and take responsibility for the culture. They not only make changes in the organization's structures, processes and practices but they also make changes in the patterns of behavior of the organization.[5] Leadership that is committed to establishing a safe culture:

- Positions patient safety at the highest level in the organization's mission, values and strategic plan.
- Acknowledges the high-risk nature of the activities the organization conducts and is committed to carrying out consistently safe operations.
- Recognizes that to achieve safe, compassionate, and respectful care to patients these same qualities must be demonstrated in how their personnel are treated.
- Creates an environment of psychological safety where individuals are encouraged to report errors or near misses without fear of negative repercussions.
- Encourages improvement among all levels of staff to identify opportunities to improve patient safety standards.
- Models and articulates the attitudinal and behavioral norms that create a safe culture.
- Provides the necessary resources and infrastructure so staff can function efficiently and effectively and can address any safety concerns that may arise.

Article on leadership[5]

Education on Patient Safety:

A safe culture recognizes that safety is not an accident. It requires an understanding of the basic principles of safety improvement on the part of leadership and staff and how they can use these principles in their daily jobs.

The Institute for Healthcare Improvement (IHI) Open School provides a variety of courses on patient safety. These courses are available to personnel in health systems and hospitals that have an IHI subscription and are free for students, medical residents and university faculty who teach courses. Subscription information can be found here.

Patient Safety Courses: ***Click on the course name to link to information***

PS 100: Introduction to Patient Safety

PS 101: Fundamentals of Patient Safety

PS 102: Human Factors and Safety

PS 103: Teamwork and Communication

PS 104: Root Cause and Systems Analysis

PS 105: Communicating with Patients after Adverse Events

PS 106: Introduction to the Culture of Safety

Cultural Assessment:

An early step in developing a safe culture is to assess your hospital's safety climate with a safe culture survey. Safety climate is a subset of the broader culture and refers to personnel's attitudes and perceptions about patient safety within the hospital or clinic. This is important because the culture of an organization and the perceptions and attitudes of personnel have been found to affect patient safety outcomes.[6]

Administering a safe culture survey requires a thoughtful process to reap its full benefits. Appropriate resources should be dedicated to planning the project, establishing data collection procedures and timelines, analyzing responses and communicating results. Initial survey results provide a baseline from which to gauge the effectiveness of interventions designed to improve your hospital's culture by comparing them with repeated surveys.

Survey results can be leveraged to drive improvements by engaging staff in a dialogue about what it means to have a safe culture:

Sample questions:

- Why do you think our unit scored this way?
- How accurately do the scores reflect your experience on this unit?
- What gets in the way of achieving a better score on this question?
- What behaviors would we see if the answer to this question was rated high?

The following safe culture assessment tools are among the most common tools used by hospitals and outpatient facilities.

***Hospital Survey on Patient Safety Culture*:** This 42-item questionnaire measures 12 dimensions for both clinical and non-clinical staff at unit and management levels in hospitals. Available at: http://www.ahrq.gov/legacy/qual/patientsafetyculture/hospscanform.pdf

Safety Attitudes Questionnaire: This 60-item questionnaire measures dimensions including teamwork, management, and working conditions. There are different versions for specialty areas: ambulatory, ICU, labor and delivery, operating room, and pharmacy. Available at: https://med.uth.edu/chqs/surveys/safety-attitudes-and-safety-climate-questionnaire/

Incident Reporting System:

An environment in which healthcare workers can report actual or potential errors without fear of reprisal is a hallmark of a safe culture. Currently in hospitals across the country errors and near misses are severely under reported.[7] An essential part of developing a safe culture is creating an environment where reporting is expected, encouraged and rewarded.

An effective event reporting system has four key attributes:[8]

- ✓ The hospital must have a supportive environment for event reporting that protects the privacy of staff who report occurrences.
- ✓ Reports should be received from a broad range of personnel.
- ✓ Summaries of reported events must be disseminated in a timely fashion.
- ✓ A structured mechanism must be in place for reviewing reports and developing action plans.

While trends from incident reports are critical sources of information for improving safety and organizational strategic planning, they also have their limitations. First, it can be difficult to determine incidence rates based on reported data because of variability in the rate and consistency of reporting. Second, incident reporting systems capture only a small percentage of adverse events and some categories of events are underrepresented. Because of this, incident reporting reports should be combined with other surveillance methods, such as direct observation, trigger tools, or chart audit, to get a more complete picture of patient safety threats.

Example policies and tools can be found in the appendix section of this tool kit.

Serious Event Reporting:

Every day, serious clinical adverse events occur in hospitals as a result of systems failures, human error, and other causes. In some cases they are tragic, leading to serious physical and psychological harm, or even death to patients, as well as related harm to their families, staff members, medical providers, the community and the organization. No hospital is exempt from these events; however, what differentiates organizations positively or negatively is how they respond to them and what they learn from them.[9]

The tools below provide hospital leaders with:

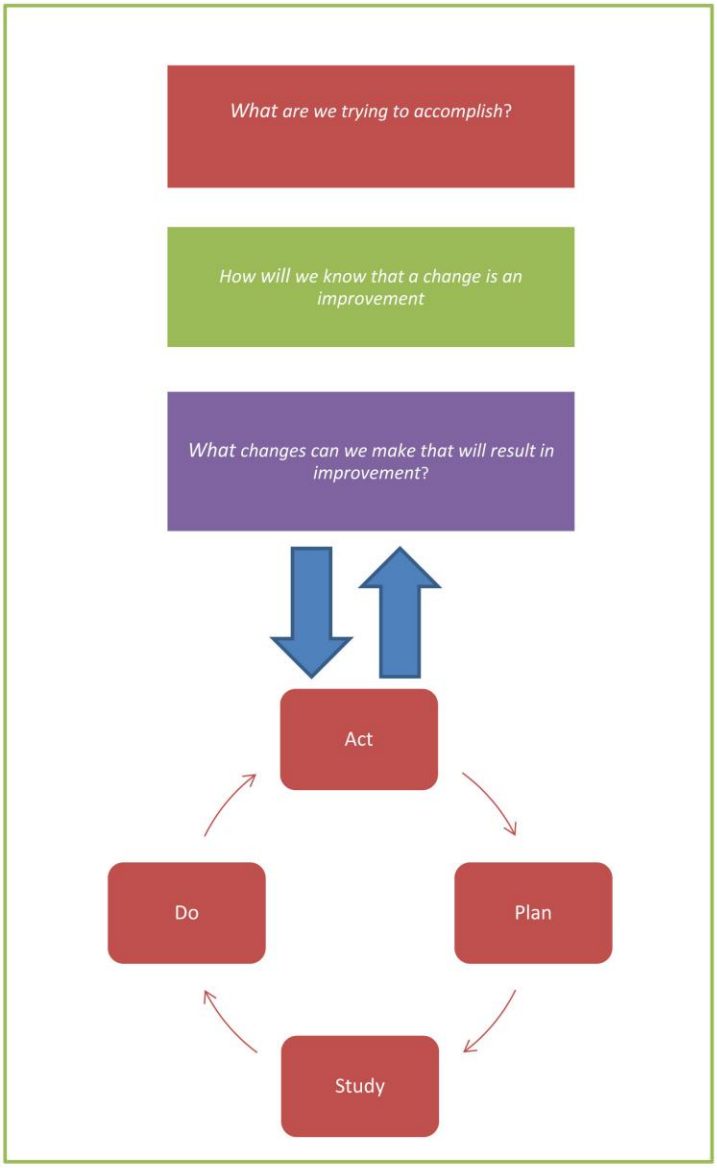
- A process to develop a crisis management plan before they need to use it.
- An approach to integrate the plan into the organizational culture of quality and safety with a special focus on patient and family centered care and fair and just treatment for staff.
- A resource to inform their efforts when a serious adverse event occurs in the absence of a crisis management plan.

- Respectful management of serious clinical adverse events toolkit[9]
- Respectful management of serious clinical adverse events Checklist[9]
- Respectful management of serious clinical adverse events Workplan[9]
- Respectful management of serious clinical adverse events Disclosure checklist[9]

Process Improvement:

Unnecessary harm is caused in the process of providing healthcare. Process improvement approaches are ways to improve patient safety by addressing system failings. A key focus of process improvement is to improve the reliability of a system and its clinical processes. Reliability mitigates against waste and defects in the system and reduces error and harm.[10]

A High Reliability Organization (HRO) is an organization that maintains consistent excellence during an extended period of time.[11] In healthcare, achieving a HRO level of performance is viewed as the next step in the pursuit of quality and safety improvement. One of the critical changes health care needs to make in order to start down this road and to make rapid progress towards High Reliability is to adopt the approaches of robust process improvement.[12]



Three of the most common process improvement approaches are listed below. They can be used on their own or in combination.

Plan, Do Study, Act (PDSA):

The PDSA cycle is the most commonly used approach for rapid cycle improvement in health care. This method has four repeated steps; Plan, Do, Study, and Act. The PDSA steps support organizational learning through experimentation to make improvements. In this model, suggested solutions are tested on a small scale before changes are made to the whole system.[13]

Lean:

The Lean methodology was developed by the Toyota Motor Company. It is driven by the needs of the customer and determines what the customer would consider of value. In healthcare, customers can be patients and their families, regulatory bodies, payors, and providers. If a process does not provide value, it is considered waste and should be a target for improvement.[10, 14]

Lean outlines five basic principles:

- Specify value from the standpoint of the customer.
- Identify waste in the value stream
- Make the value-creating steps occur in tight sequence so the product will flow smoothly toward the customer.
- Let customers pull value from the next upstream activity.
- As value is specified, value streams are identified, wasted steps are removed, and flow and pull are introduced, begin the process again and continue it until a state of perfection is reached in which perfect value is created.

Seven categories of waste are identified:

- Overproduction or underproduction
- Wasted inventory
- Rework or rejects
- Wasted motion
- Waste associated with waiting
- Waste associated with processing
- Waste from transport or handling

A key component of the Lean methodology is its emphasis on empowering employees to improve quality. In a Lean organization employees are expected to identify and address poor quality and waste. *Kaizens* are rapid change employee engagements where employee's improvement ideas are quickly tested and implemented.

A commonly used tool in *Kaizen* engagements is *value stream mapping* (VSM). This tool graphically displays the process of services using inputs, throughputs, and outputs. Typically, a current state VSM is done at the beginning of a project to identify the waste which is followed by designing a future state VSM to represent the suggested improvements. AHRQ LEAN tools

Six Sigma:

Six Sigma is a rigorous statistical measurement methodology that grew out of quality control efforts at Motorola in the mid-1980s. Its focus is to identify sources of variation in a process that are potential sources of error in order to reduce variation so it can be performed nearly error free. Sigma comes from a statistical unit reflecting the number of standard deviations a given process is from perfection. Six Sigma represents the goal of creating a process that performs with such low variability that it is error free to six standard deviations of a normal distribution, resulting in only 3.4 errors per million attempts. [10]

Six-sigma is achieved through a five step process known as **DMAIC**:

- **Define**: this step defines who the customers are, what the customers want, the process capabilities, and provides objectives for project-based improvement efforts.
- **Measure:** this step measures the quality characteristics that reflects improvement in customer satisfaction and product performance and provides the metrics of data on which the improvement efforts will be based..
- **Analyze**: in this step, data collected in previous steps are analyzed using analytical tools such as Pareto analysis, process flow diagram, fish-bone diagram, statistical process control charts, for identifying necessary design and process modifications for achieving customer satisfaction and performance objectives.
- **Improve:** in this step resources are allocated so that design and process modifications needed for improvement can be implemented.
- **Control:** in this step the process is monitored using quality management tools such as Pareto charts, and statistical process control charts to ensure that the performance improvements are maintained. AHRQ Six Sigma tools

LEADING PRACTICES

Leading practices are practices which are believed to be more effective at delivering a particular outcome than others, for the time being, since practices are continuously being developed and improved. Recognizing that developing a safe culture is not a one-time project but instead a journey, the following rating system provides a guide to help hospitals decide which practices to select and build on the core strategies based on the developmental stage of the organization and the resources available.

Leading Practices Rating System

	Least Complex ◆	Moderately Complex ■	Most Complex ▲
Developmental stage	Beginner	Intermediate	Advanced
Resource need	Minimal resources needed	Moderate resources needed	Extensive resources needed
Level of integration	Can be implemented in a single department	Should be implemented in more than one department	Needs to be implemented throughout organization

Safety Huddles: ◆

A safe culture is built on high awareness of real and potential safety issues at all times and at all levels of organizational operations.

Why?
Safety huddles help organizations create a safe culture because they provide a quick and easy format for personnel to share safety concerns, develop plans and celebrate successes.

What?
An informal forum to share information about potential safety problems and increase safety awareness among personnel at all levels of the organization.

Who?
Safety huddles can occur in a variety of settings. They work well for groups of people who work together in a unit, department, or clinic and they also work well at the administrative level to raise awareness and share safety concerns in real time across the organization.

When?
Safety huddles can be incorporated into existing systems and timed to accommodate the unique characteristics of the environment. They should occur often enough to maintain on-going safety awareness and vigilance but not so frequent they become a burden and interfere with the team's work. In hospital units a common safety huddle schedule is twice a day. Information learned at the safety huddles can cascade from the administrative level to the front line huddles and vice versa when timing among the safety huddles is coordinated.

How?
- ✓ Keep briefings brief, approximately 5 – 15 minutes.
- ✓ Start briefing with a reminder that the purpose is to increase awareness of patient safety issues.
- ✓ Reinforce the intent to not place blame but to improve care.
- ✓ Use a tool to standardize safety huddle questions and discussions on safety risks and to track identified safety concerns.
- ✓ Encourage everyone to speak up.
- ✓ Develop a process to follow up on safety concerns.

In addition to identifying real time safety concerns, safety huddles are an ideal place to report back actions taken on identified concerns from past safety huddles. They are also opportunities to educate, reinforce and motivate teams on current and future safety initiatives.

- **Safety Huddle Tool**

Executive Rounds for Safety:

Executive rounds for safety demonstrate the leaderships' on-going commitment to developing a safe culture. The focus of the rounds is to obtain information from staff on system vulnerabilities and threats to patient safety and to identify opportunities for improvements.

- **Executive Rounding toolkit**

Just Culture Principles:

"It is through a Just Culture that we will begin to see, understand, and mitigate the risks within the healthcare system" - *David Marx*

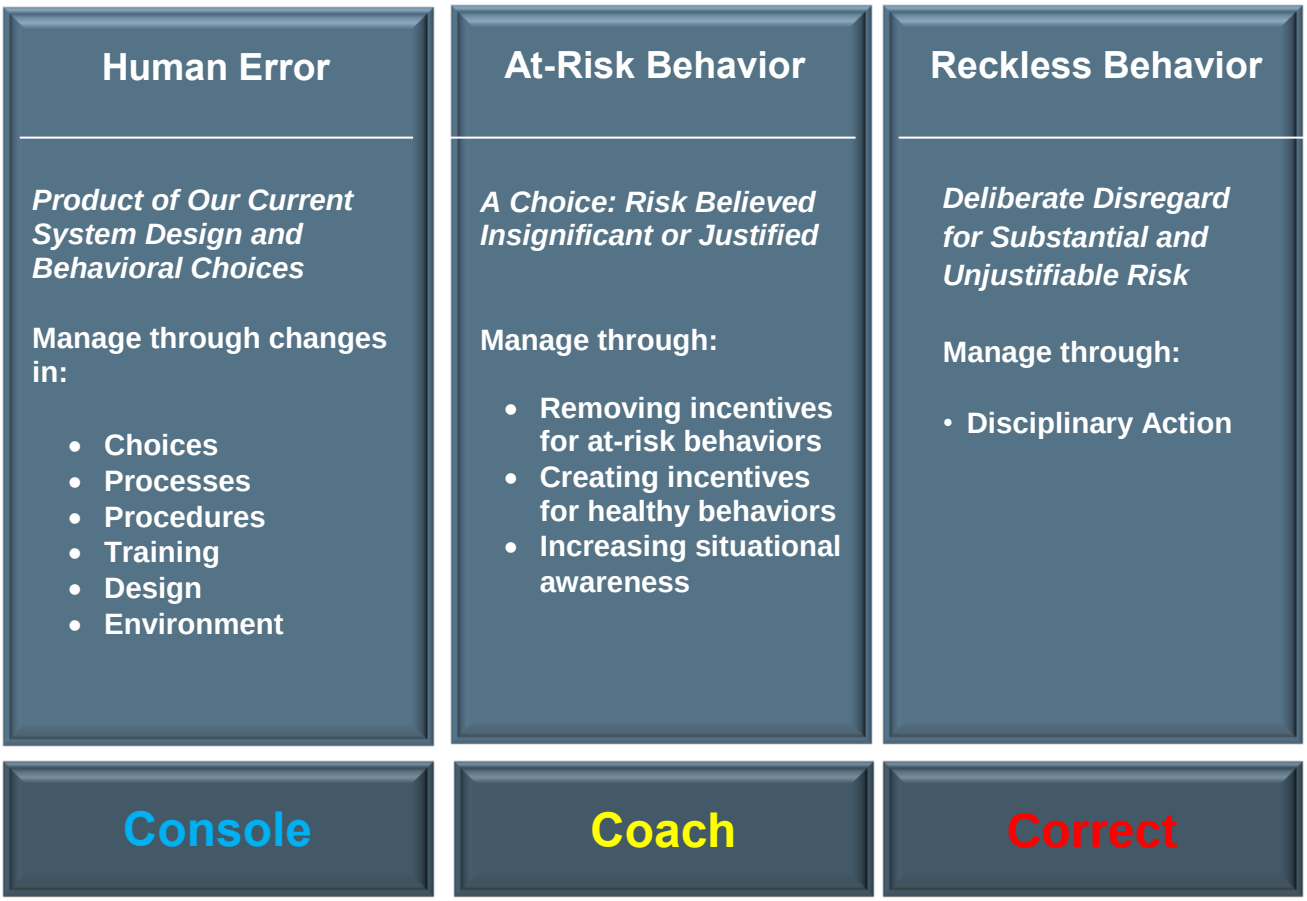
Just Culture recognizes that mistakes will be made. It helps health systems, hospitals and physician offices learn from those mistakes to improve the safety of the healthcare system. In the absence of this information healthcare organizations do not learn from their mistakes and cannot prevent similar mistakes from happening in the future. The literature shows that the majority of errors go unreported.[7, 15] People fear the consequences of their mistakes and they reluctantly stay silent rather than doing what is best for patient safety .[16, 17] A culture that supports a fair and just approach to managing errors can create an environment of psychological safety that encourages health care workers to report and share mistakes.

A Just Culture includes the following.[18, 19]

- **Balance** between non-punitive treatment with accountability. Just Culture focuses on determining whether an error occurred as a result of a system process break down while providing care or was a result of negligent behavior on the part of an individual.
- **Open communication** refers to an individual's willingness to disclose information about adverse events and near misses. For a Just Culture to be effective, it requires that health care workers trust the process. Without trust, people withhold information about events for fear of retribution
- **Feedback** by hospital leaders to share information about adverse events and the improvements made as a result of the error disclosure. It is especially important that the information is shared with staff members who have reported the event.
- **Organizational learning** is the process of using what is learned from the adverse events to prevent future harm.

> **"The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes."**
>
> *Dr. Lucean Leape Professor, Harvard School of Public Health…Testimony before congress on Health Care Quality Improvement*

James Reason, Sidney Dekker, and David Marx, are leading experts in safe culture and have contributed to the advancement of the just culture concept, each with his own perspective, model or algorithm.[20,21,22] The following framework was adapted from David Marx and is used as an example of how the Just Culture concept can be applied in healthcare organizations. This model makes the point that because errors are going to occur, leaders have the most influence with the systems they design around their employees and the behavioral choices their employees make within those systems. In this model there are three classes of human fallibility and each of these require a different organizational response [22].



Steps to implement Just Culture principles:

- ✓ Clearly define the change and desired behavior
- ✓ Ensure support from the board, management and medical staff
- ✓ Enlist champions to overcome barriers
- ✓ Ensure the change is an organizational priority
- ✓ Provide resources to train managers
- ✓ Hardwire the change through:
  - Human Resources policies and procedures
  - Job descriptions and performance evaluations
  - On-going evaluation of the effectiveness of the change

Just Culture Web site

TeamSTEPPS:

"There are ten doctors, twenty nurses and thirty tests; please talk to each other…" - *Patient*

TeamSTEPPS is a training method that builds teamwork and communication to improve the safety and quality of patient care. It was created by the Department of Defense to improve communications in their complex environment. Like healthcare, the military struggled with poor communications between people of different power levels and ranks, which led to errors. Feelings of intimidation create fears about speaking up regarding a safety concern even though it is known there could be a serious error and harm as a result of not speaking up. TeamSTEPPS provides a structure for safe communications where all team members feel respected.

One of the strengths of TeamSTEPPS is that it can be implemented in total or in part depending on what is most valuable. Below is an outline of the approach to implement TeamSTEPPS and links to some of the most valuable tools. A link to the entire program is included in the reference section of this toolkit.[23]

Three steps are recommended for successful TeamSTEPPs implementation:

1. **Assess the need and readiness** – assessing organizational need and readiness is an important step in implementing a successful teamwork initiative.
   Resources:
   - **Organizational assessment checklist**
   - **Organizational readiness tool**

2. **Planning, training, and implementation** – TeamSTEPPS is designed to be tailored to the organization. The materials are designed to be adaptable to all organizational needs and capabilities.

Resources:

- **Implementation checklist**
- **Quick guide to TeamSTEPPS strategies**
- **Training materials**

3. **Sustainment** - The goal of this step is to sustain and spread the improvements in teamwork performance, clinical processes and outcomes resulting from the TeamSTEPPS program. The key objective is to ensure on-going opportunities to implement the tools and strategies taught, practice and receive feedback on the skills, and provide continual reinforcement of the TeamSTEPPS principles on the unit or within the department.

    - **Click here for sustainment checklist**

University of Washington TeamSTEPPS training center.

Comprehensive Unit-Based Safety Program (CUSP):

The comprehensive unit-based safety program (CUSP) is an intervention to help healthcare teams learn from mistakes and improve their safety culture. It focuses on important aspects of a safe culture such as teamwork, management involvement, and reporting and learning from errors, by engaging clinicians and staff from all levels in a continuous quality improvement process.

The critical role culture plays in the degree to which safety checklists are utilized has been demonstrated. [24] The CUSP program is designed to integrate multiple culture building strategies that include the technical, such as checklists, and the relational elements so all aspects of system performance are addressed. This framework can be applied to any quality improvement initiative.

The Agency for Healthcare Research and Quality provides a CUSP toolkit that includes step by step training modules and tools.

CUSP modules:

- ✓ *Learn about CUSP*
- ✓ *Assemble the team*
- ✓ *Engage the senior executive*
- ✓ *Understand the science of safety*

- ✓ *Identify defects through sense making*
- ✓ *Implement teamwork and communication*
- ✓ *Apply CUSP*

CUSP toolkit

Compacts: ▲

Compacts are change management tools that engage and connect leaders, providers and staff to the healthcare organization's mission and strategy. Ultimately, compacts transform culture by fostering a new kind of relationship that is grounded in mutual trust, responsibility, commitment, respect and collaboration.

Compacts align the interests of the healthcare organization with those of its providers and personnel, to share in both the risks and rewards of working together. They spell out in explicit terms what each can expect from the other. For example, the hospital provides the environment, leadership, and support that allows providers and personnel to develop and exceed their career expectations. In return, providers and personnel give the hospital their full engagement, their best ideas, and as much motivation and patient and family focus as they possibly can every day.

The compact's impact on culture is experienced in multiple ways. During the adoption process, the discussions that take place to identify and develop agreements that are most important to all parties become the foundation for the relationship building that is essential for trusting partnerships and satisfying collaborations. Once developed, the compacts are used throughout the employment/engagement cycle; in recruitment, during the on-boarding process, and at regular meetings. They serve as real time reminders of the agreements made and the promise of the partnership.

Compact examples: see next page

VIRGINIA MASON MEDICAL CENTER LEADERSHIP COMPACT

Organization's Responsibilities

Foster Excellence
- Recruit and retain the best people
- Acknowledge and reward contributions to patient care and the organization
- Provide opportunities for growth of leaders
- Continuously strive to be the quality leader in health care
- Create an environment of innovation and learning

Lead and Align
- Create alignment with clear and focused goals and strategies
- Continuously measure and improve our patient care, service and efficiency
- Manage and lead organization with integrity and accountability
- Resolve conflict with openness and empathy
- Ensure safe and healthy environment and systems for patients and staff

Listen and Communicate
- Share information regarding strategic intent, organizational priorities, business decisions and business outcomes
- Clarify expectations to each individual
- Offer opportunities for constructive open dialogue
- Ensure regular feedback and written evaluations are provided
- Encourage balance between work life and life outside of work

Educate
- Support and facilitate leadership training
- Provide information and tools necessary to improve individual and staff performance

Recognize and Reward
- Provide clear and equitable compensation aligned with organizational goals and performance
- Create an environment that recognizes teams and individuals

Leader's Responsibilities

Focus on Patients
- Promote a culture where the patient comes first in everything we do
- Continuously improve quality, safety and compliance

Promote Team Medicine
- Develop exceptional working-together relationships that achieve results
- Demonstrate the highest levels of ethical and professional conduct.
- Promote trust and accountability within the team

Listen and Communicate
- Communicate VM values
- Courageously give and receive feedback
- Actively request information and resources to support strategic intent, organizational priorities, business decisions and business outcomes

Take ownership
- Implement and monitor VM approved standard work
- Foster understanding of individual/team impact on VM economics
- Continuously develop one's ability to lead and implement the VM Production System
- Participate in and actively support organization/group decisions
- Maintain an organizational perspective when making decisions
- Continually develop oneself as a VM leader

Foster Change and Develop Others
- Promote innovation and continuous improvement
- Coach individuals and teams to effectively manage transitions
- Demonstrate flexibility in accepting assignments and opportunities
- Evaluate, develop and reward performance daily
- Accept mistakes as part of learning
- Be enthusiastic and energize others

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VIRGINIA MASON MEDICAL CENTER PHYSICIAN COMPACT

Organization's Responsibilities

Foster Excellence
- Recruit and retain superior physicians and staff
- Support career development and professional satisfaction
- Acknowledge contributions to patient care and the organization
- Create opportunities to participate in or support research

Listen and Communicate
- Share information regarding strategic intent, organizational priorities and business decisions
- Offer opportunities for constructive dialogue
- Provide regular, written evaluation and feedback

Educate
- Support and facilitate teaching, GME and CME
- Provide information and tools necessary to improve practice

Reward
- Provide clear compensation with internal and market consistency, aligned with organizational goals
- Create an environment that supports teams and individuals

Lead
- Manage and lead organization with integrity and accountability

Physician's Responsibilities

Focus on Patients
- Practice state of the art, quality medicine
- Encourage patient involvement in care and treatment decisions
- Achieve and maintain optimal patient access
- Insist on seamless service

Collaborate on Care Delivery
- Include staff, physicians, and management on team
- Treat all members with respect
- Demonstrate the highest levels of ethical and professional conduct
- Behave in a manner consistent with group goals
- Participate in or support teaching

Listen and Communicate
- Communicate clinical information in clear, timely manner
- Request information, resources needed to provide care consistent with VM goals
- Provide and accept feedback

Take Ownership
- Implement VM-accepted clinical standards of care
- Participate in and support group decisions
- Focus on the economic aspects of our practice

Change
- Embrace innovation and continuous improvement
- Participate in necessary organizational change

TEAM MEDICINE VIRGINIA MASON

Tracking progress:

Effective measurement and data collection play an important role in improving culture. Health systems, hospitals and physician offices can learn how successful their efforts are at cultural transformation by tracking the following measures:

- ✓ Monitor progress through on-going culture assessment results.
- ✓ Share trends (from board to staff level) related to selected leading practices, e.g. number of executive rounds, number of errors and near miss reports, safety huddle actions, SBAR use, harm events.
- ✓ Track operational impacts such as staff- turnover, staff injury rates, number of liability cases.

Reward and Recognition:

Reward and recognition is a valuable way to engage staff and providers in fostering and sustaining an atmosphere of patient safety. The following are some examples of ways to reward and recognize:

- Publicly acknowledging personnel who exhibit specific safety behaviors the organization is promoting through newsletters, memos, announcements, etc. for how they made an impact on a patient, family member or another employee.
- Providing an opportunity for personnel who exhibit safety behaviors to share their story in front of the management team.
- Employee of the month programs, "on-the-spot" and peer-to-peer programs. These programs are popular and they encourage recognition from colleagues and patients as well as management.
- Small note cards describing how an employee made a contribution toward patient safety can be publicly posted and possibly redeemed for pins or stickers to put on an employee's identification badge.
- Team awards for most improvement in a safety focus area.

IMPLEMENTATION

Implementation Steps

Step 1: Starting out:

- Measure safety culture
- Share baseline culture assessment results and ask key questions
- Determine a plan based on assessment results
- Communicate a compelling vision for patient safety

Step 2: Implement core strategies:

- Leadership
- Education
- Incident reporting system
- Serious event reporting
- Process improvement

Step 3: Select leading practices based on hospital developmental level and available resources:

- Safety huddles
- Executive rounds for safety
- Just Culture
- TeamSTEPPS
- Comprehensive Unit-Based Safety Program (CUSP)
- Compacts

Step 4: Evaluate Success:

- Monitor progress through on-going culture assessment results
- Monitor and share trends (from board to staff level) related to selected leading practices, e.g. number of executive rounds, number of errors and near miss reports, safety huddle actions, SBAR use, harm events.
- Track operational impacts such as staff turn-over, staff injury rates and number of liability cases.

Step 5: Hardwire

- Celebrate successes
- Develop standard processes and measures to support on-going patient safety culture activities
- Reward and recognize personnel for patient safety culture behaviors

APPENDIX

Glossary of Terms:

Culture Terms

Culture: How we do things around here.

Just Culture: Just culture is about building organizational trust by creating an open and fair culture. The goal is to develop a learning culture and design safe systems. Just Culture acknowledges that humans will make mistakes and responds differently based on the underlying cause of the error and the intent:

- Human error - inadvertently doing something other than what should have been done; slip, lapse, mistake. The response that should be taken is to console.
- At-risk behavior – a behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified. The response that should be taken is to coach.
- Reckless behavior – a behavioral choice to consciously disregard a safety step. The action taken should be to correct. (David Marx)

Safe Culture: A safe culture is an atmosphere of mutual trust in which all staff members can talk freely about safety problems and how to solve them without fear of reprisal.

Error Terms:

Adverse Event: An injury caused by medical care, or lack of appropriate care, and not due to the patient's illness.

Error: An incorrect delivery of care whether it is evident or harmful to the patient.

Harm: Unintended physical injury resulting from the medical care which requires additional monitoring, treatment or hospitalization; or that results in death (IHI).

Near Miss: A near miss is an error that was stopped before it reached the patient or did not produce patient injury, but only because of chance.

Overuse: Overuse is providing care to patients that is not clinically indicated, that the patient did not want, or when there was a less invasive or less costly alternative, which could reasonably be expected to produce the same results.

Methodologies:

High Reliability Organizations (HROs): Operating in a way that results in very few adverse events. (AHRQ)

Human Factors: Takes into account the human aspect of a social environment and builds in systems that will prevent mistakes upfront instead of waiting until they happen.

Systems Approach: When looking for the sources of error, the focus is on how the system could have been designed to prevent them.

Tools:

Compact: a formal agreement between parties. They spell out in explicit terms what each can expect from the other.

Failure Modes and Effects Analysis (FMEA): A systematic, proactive method for evaluating a process and identifying where and how it might fail, and to assess the impact of different failures in order to find parts of the process that are most in need of change.

Lean: A process to maximize value and eliminate waste using tools developed by Dr. Deming. These processes were first utilized on a wide scale in Japan following World War II.

PDSA: A process for making improvements which includes: developing a plan to test the change (**P**lan), carrying out the test (**D**o), observing and learning from the results (**S**tudy), and determining what modifications should be made based on what was learned (**A**ct).

Root Cause Analysis: An investigation that seeks to understand the underlying causes in which the incident happened.

Six Sigma: A disciplined, data-driven approach that strives to eliminate defects in processes. It was first developed by Motorola in 1985.

Virginia Mason Health and Services Patient Safety Alert (PSA) Documents:

PSA article
PSA policy

PSA Management Checklist:

PSA Management Checklist

Goal of the PSA System: Objective incident reporting system to identify safety events for investigation and allow for sorting to appropriate area. Encourage culture of safety for staff to report incidents as they occur and follow through with actions for staff to understand their impact on change.

When event occurs:

1) Debrief with all involved (team safety huddle) on genba in real time when possible.
2) Consider stopping the line for this process
3) Enter PSA for tracking, trending and follow up.

PSA Analysis: Track/trend common issues via RiskPro Monitor using at least three months of data (Patient Safety, John Campos). Consider Kaizen Event (VMPS for Leaders) to address issues.

	Yellow PSA (Limited resources needed, low harm/low risk, not a trend)	Orange PSA (Multiple resources needed, minor-moderate injury/liability, frequent process, critical safety policy)	Red PSA (Mod-major injury, hospital-wide resolution needed, major liability/mandatory reportable event, critical safety event)
Manager Action	☐ Review weekly report ☐ Follow up with staff involved ☐ Ask "Why" five times ☐ Establish root cause Is this a performance issue (individual behavior) → HR Business Partner Is this a systems issue→ Patient Safety; Who else needs to be involved? Thank Reporter & notify of actions taken ○ Email template ○ Applause system Make event transparent to staff ○ People Link ○ Episode of Care (template)& Tool ○ Quality Board (Std Work for Leaders)	☐ All of Yellow PSA Actions + ☐ Prepare for Meeting ○ Chart Review ○ Staff interviews ○ Develop timeline (template) ○ Immediate action taken ○ Recommendations from staff to prevent incident ○ Complete CAPs template ○ Relevant policies? ☐ Complete resulting tasks ☐ Expect six month follow up (random audit)	☐ All of Orange PSA Actions + ☐ Review evidence with VP and Patient Safety Specialist (prior to QOC) ☐ Expect six month follow up (all red PSAs)
Trouble-Shooting	Not your area→ reply to Patient Safety Scope to large→ reply to Patient Safety ☐ Consider increasing level of PSA	Need support with timeline, staff interviews, case review → contact Patient Safety Disclosure to family → refer to policy Second Victim Support for staff	
Accountability	Manager/Director	Administrative Director	Vice President; Quality Oversight Committee (Gary Kaplan chair)

Resources: Patient Relations (link), Claims (link), HR Business Partner (link)

PSA Sorting Tool:

USE THIS SORTING TOOL TO AID IN YOUR CODING PSA RISK PRIORITIES

Risk	Description	Scores			Top Score
Harm	**Reportable events are always 3** *What is the greatest amount of injury that could result if this incident were to harm (or did harm) the patient?*	No risk of injury possible **0**	Minor to moderate injury possible **1-2**	Major injury or death possible **3**	
Care Process Rate	*How often does the care process involved in the incident occur?*	Infrequently (not standard) **1**	Weekly or Monthly **2**	Hourly or Daily **3**	
Resource	**Reportable events are 2 or 3** *How many resources would be needed to resolve the issue?*	Single manager only required **1**	Multiple departments **2**	Hospital-wide **3**	
Liability	**Reportable events are always 3** *What is VM's risk of liability from this incident? Media exposure is a liability.*	No liability foreseen **0**	Moderate liability **1-2**	Major liability **3**	

Add the top score from each row.	Yellow PSA 2 to 4	Orange PSA 5 to 7	Red PSA 8 to 12

WHAT IS A POSSIBLE REPORTABLE EVENT REGARDLESS OF PHYSICAL INJURY, ANY OF THESE:

- Abduction
- Air embolism in hospital or clinic
- Death (any)
- Foreign object retained after surgery
- Gas delivered to patient was toxic
- Impersonation of a practitioner
- Infant discharge to the wrong person
- Infection involving vascular or urinary catheter
- Infection of surgical site after bariatric, CABG, mediastinitis or orthopedic surgeries
- Sexual assault or misconduct
- Transfused wrong blood type
- Wrong patient surgery
- Wrong site surgery

Critical Safety Policies:

- Patient Identification
- Hand Hygiene
- Isolation Precautions
- Medication & Solution Identification and Labeling
- Evidence Based Protocols (central line, ventilator associated pneumonia
- Pre-procedure verification
- Response to calls
- Drug Free Workplace
- High Risk Medication Check

Where major injury or death occurred with:

- Assault in hospital or clinic
- Burn in hospital or clinic
- Contaminated drugs or supplies
- Elopement (patient disappearance)
- Equipment misuse
- Glycemic control poorly managed by hospital
- Labor and delivery in low-risk pregnancy
- Medication misuse
- Restraints or bed-rails in hospital or clinic
- Radiation therapy
- Spine manipulative therapy
- Suicide attempt in hospital or clinic
- Trauma (physical) in hospital or clinic
- Ulcers, pressure (Stage 3-4) in hospital or clinic

CODING A POSSIBLE REPORTABLE EVENT

1. In the Sorting Tool, possible reportable events are always ***Harm = 3, Resource = 2 or 3 & Liability = 3***
2. In Risk Monitor Pro, code the PSA's ***Organization Outcome = Reportable event possible***

RMPro will automatically notify the Patient Safety Director of this PSA via pager and e-mail.

[The Joint Commission Root Cause Analysis tool]

[The Joint Commission FMEA toolkit]

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