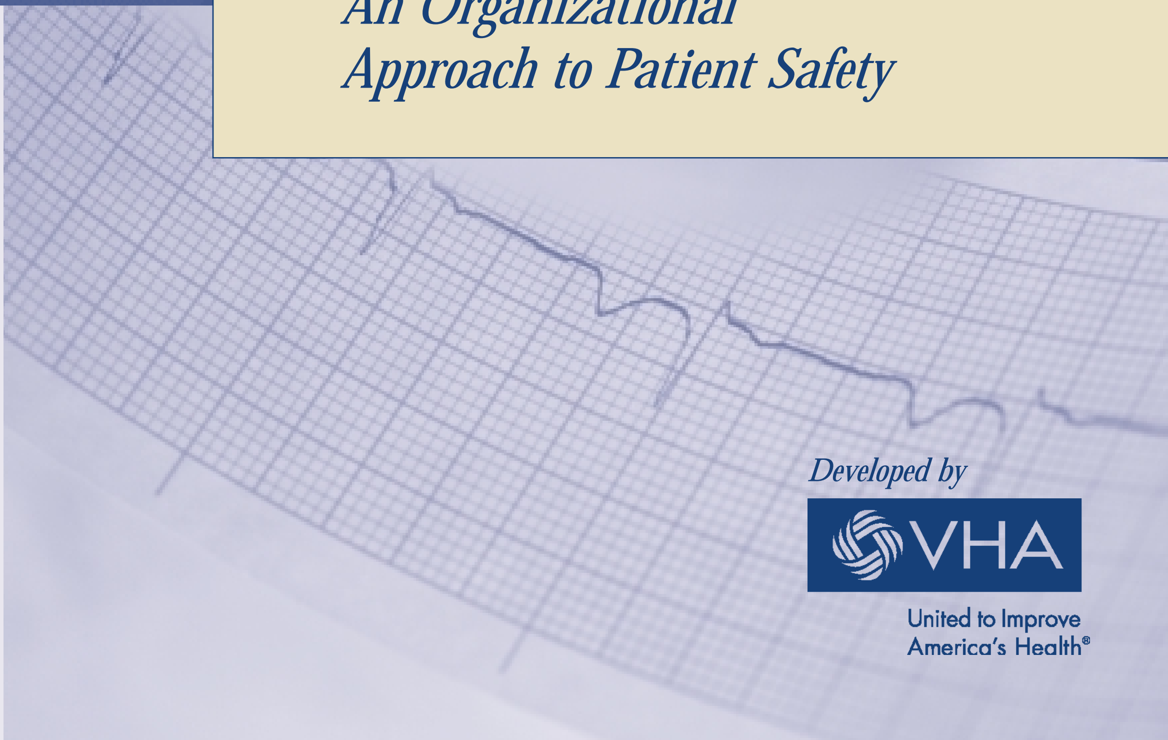
Strategies for LEADERSHIP

An Organizational Approach to Patient Safety



Developed by

United to Improve America's Health®

INTRODUCTION

Patient safety is a cornerstone of high quality care. Ensuring patient safety requires more than good intentions, diligence, and vigilance on the part of caregivers. It requires a "culture of safety," where we avoid assigning blame to individuals and instead foster a non-punitive environment that supports candid discussion of adverse events, their causes and ways to prevent them.

Creating a "culture of safety" begins by building awareness. One important step is to describe behavioral changes needed to achieve this culture. *An Organizational Approach to Patient Safety* attempts to describe the most critical organizational tactics and strategies needed to create a "culture of safety." The Malcolm Baldrige National Quality Program categories were used as the framework for this assessment tool to encourage cooperation and sharing of best practices among all segments of the health care community. Critical safety functions, called "Key Aspects of Safety" in the tool, are backed by research or expert analysis demonstrating their impact on patient safety. Each Key Aspect is supported by tactical and strategic actions that when implemented together, characterize a comprehensive organizational approach to safety. The tool is not perfect. It is offered as an initial roadmap to safer care, and can be used to assess the gap between an organization's present state and the defined "ideal."

With the belief that patient safety transcends business competition, it is a privilege to share this tool with you. Many thanks to the AHA and its state partners for distributing this tool with the nation's hospitals and health systems, as well as to the supporting organizations which have included their logos on the back cover.

By sharing everything we learn and experience in patient safety, we can put that knowledge into action and make a real difference for patients, families and the dedicated professionals who care for them.

Nancy J. Wilson, MD, MPH
Vice President, Clinical Affairs
VHA Inc.

INSTRUCTIONS

STEP 1

Because patient safety is a complex multidisciplinary topic, it is recommended that each health care organization establish a multidisciplinary team to complete a single organizational assessment. The team should consist of a minimum of six individuals drawn from a sufficiently broad pool of key decision makers. A team should include at least two representatives from each of the following categories:

- Direct care providers *(physicians, nurses, pharmacists, respiratory therapists, etc.)*
- Middle management *(service chiefs, head nurses, supervisors)*
- Top management *(senior executives, chiefs of staff)*

STEP 2

Have each team member completely review the organizational assessment before beginning the self-assessment process. Then as a team, evaluate your current status in implementing the associated activities. Choose responses that apply to your specific facility even if your facility belongs to a larger health care system. If necessary, discuss the status of the activities with other members of your organization who may be in a better position to assess the degree of implementation. When a consensus on the level of implementation has been reached, place an "X" in the appropriate box using the scoring key at the top of each page.

Note: For questions that include multiple components, full implementation (scores of 4 or 5) should be recorded only if all components have been fully implemented. If only partial implementation of all components has occurred or if only one of several components has been fully implemented, record your score as a 3.

STEP 3

Have each team member complete the overall summary questionnaire on page 8. Next, sum your total scores and compare with the results of the overall summary. (Maximum score is 270 [54 items x 5].) The team should identify three to five low scoring activities and develop an action plan to move them closer to full implementation in all areas of the organization. Use this organizational assessment tool annually to monitor your improvement.

STEP 4

Complete the accompanying demographics if you plan to compare your results to other facilities or health care systems.

Note: Questions regarding this tool can be directed to VHA's Keith Kosel at (972) 830-0684 between 8:30 AM – 5:30 PM (CST).

VHA gratefully acknowledges the methodology and content contributions of The Institute for Safe Medication Practices that were used in producing *An Organizational Approach to Patient Safety* tool.

© 2000 VHA Inc. All rights reserved. Duplication or distribution of this document without expressed permission from VHA is prohibited.

I. Leadership

A	*There has been no discussion around this activity.*
B	*This activity is under discussion, but there is no implementation.*
C	*This activity is partially implemented in some or all areas of the organization.*
D	*This activity is fully implemented in some areas of the organization.*
E	*This activity is fully implemented throughout the organization.*

Key Aspect of Safety: *Demonstrate patient safety as a top leadership priority.*	A (none)	B	C (partial)	D	E (full)
Patient safety is adopted as a strategic goal by the organization and the governing body.					
Senior leadership allocates resources to accomplish patient safety initiatives.					
Risk management, quality management and patient advocacy are functionally integrated around advancing patient safety.					
One committee or senior leader oversees patient safety within the organization.					
Leadership regularly monitors progress in implementing the patient safety agenda.					
Leadership promotes patient safety in the larger health care community through new and established associations.					
All departments, services and standing teams/committees apply safety principles to work deliverables.					

Key Aspect of Safety: *Promote a non-punitive culture for sharing information and lessons learned.*	A (none)	B	C (partial)	D	E (full)
The organization has a non-punitive policy to address patient adverse events involving medical staff and organization employees.					
Leadership encourages and rewards recognition and reporting of adverse events and near misses.					
Senior leadership, the medical staff and organization employees address patient adverse events with courage and honesty, looking for system issues to improve and lessons to share across the organization.					
The activity of legal counsel is aligned with the patient safety agenda to ensure consumer, public and legal accountability, while concurrently protecting the organization.					
Senior leadership directly communicates with medical staff and employees using case studies that illustrate a non-punitive approach to adverse events.					
Senior leadership, medical staff and organizational employees role-model non-punitive attitudes that emphasize system failure rather than individual error in clinical teaching and quality review conferences, such as morbidity and mortality conferences.					

© 2000 VHA Inc. All rights reserved. Duplication or distribution of this document without expressed permission from VHA is prohibited. Version 2.2

II. Strategic Planning

A	***There has been <u>no discussion</u> around this activity.***
B	***This activity is <u>under discussion, but there is no implementation.</u>***
C	***This activity is <u>partially implemented in some or all areas</u> of the organization.***
D	***This activity is <u>fully implemented in some areas</u> of the organization.***
E	***This activity is <u>fully implemented throughout the organization.</u>***

Key Aspect of Safety:	*Routinely conduct an organization-wide assessment of the risk of error and adverse events in the care delivery processes.*	*none*		*partial*		*full*
		A	B	C	D	E
	An organization-wide patient safety assessment occurs at regular intervals.					
	The organization uses the safety assessment results to develop a written Patient Safety Plan.					
	The Patient Safety Plan is reviewed and approved by the governing body, medical staff, legal counsel and senior leaders annually.					
	The Patient Safety Plan includes tactics to build a safety awareness campaign.					
	There is a contract management process that evaluates the capabilities of suppliers to meet patient safety requirements.					

Key Aspect of Safety:	*The organization actively evaluates the competitive/ collaborative environment and identifies partners with whom to learn and share best practices in clinical care.*	*none*		*partial*		*full*
		A	B	C	D	E
	Lessons learned from health care and from other industries are incorporated into the Patient Safety Plan.					
	The organization routinely engages the consumer community in a proactive dialogue about safety.					

III. Information & Analysis

A	*There has been no discussion around this activity.*
B	*This activity is under discussion, but there is no implementation.*
C	*This activity is partially implemented in some or all areas of the organization.*
D	*This activity is fully implemented in some areas of the organization.*
E	*This activity is fully implemented throughout the organization.*

Key Aspect of Safety: *Analyze adverse events and identify trends across events.*	A (none)	B	C (partial)	D	E (full)
The organization offers all employees and medical staff a user-friendly, easily accessible, confidential, narrative reporting system for recognized risks, near misses and adverse events.					
Following an adverse event, quality improvements are identified, implemented and monitored for effectiveness.					
Trends across events are regularly identified and used to drive quality improvement priorities.					
Patient safety intelligence from sources such as compliments; complaints; patient, employee and medical staff satisfaction data; and claims is integrated in quality improvement planning.					
Adverse event analysis is conducted by those knowledgeable in human factor design principles (e.g., hindsight bias).					
Evidence-based measures are used to monitor and improve performance toward zero-defect care for high-risk and high-volume conditions and diseases.					
Employees and medical staff report issues or occurrences impacting patient safety.					
There is a safety alert communication and dissemination system that gets information to the right people in a timely fashion.					

© 2000 VHA Inc. All rights reserved. Duplication or distribution of this document without expressed permission from VHA is prohibited. Version 2.2

IV. Human Resources

A	*There has been no discussion around this activity.*
B	*This activity is under discussion, but there is no implementation.*
C	*This activity is partially implemented in some or all areas of the organization.*
D	*This activity is fully implemented in some areas of the organization.*
E	*This activity is fully implemented throughout the organization.*

Key Aspect of Safety: *Establish rewards and recognition for reporting errors and safety driven decision-making.*	*none* A	B	*partial* C	D	*full* E
The organization explicitly defines employee and medical staff roles in advancing patient safety in job descriptions, orientation and required continuing education.					
All employees complete continuing education in patient safety and quality improvement.					
Following a patient safety adverse event or near miss, stress debriefing is provided using peer counselors or other means.					
Following a patient safety adverse event or near miss, the person involved is provided non-punitive management support.					
Making safety driven decisions is an essential element of the reward and promotion system.					

Key Aspect of Safety: *Foster effective teamwork regardless of a team member's position of authority.*	*none* A	B	*partial* C	D	*full* E
Training and practice is provided to support employee competencies in required new and existing clinical and interactive team skills.					
Simulation is used to improve interpersonal communication and team interactions in high-risk settings.					
Medical staff bylaws and regulations require continuing education and practice to maintain competencies in required new and existing clinical and interactive team skills.					
Leadership empowers employees, regardless of rank, to act to avoid adverse events.					
The organization maintains safe staffing through such activities as cross-training, adequate volume ratios, appropriate skill mix and limited work hours.					
Education and career development plans foster core competencies of continuous performance improvement, direct and open communication, innovation and problem solving.					

V. Process Management

A	*There has been no discussion around this activity.*
B	*This activity is under discussion, but there is no implementation.*
C	*This activity is partially implemented in some or all areas of the organization.*
D	*This activity is fully implemented in some areas of the organization.*
E	*This activity is fully implemented throughout the organization.*

Key Aspect of Safety:	*Implement care delivery process improvements that avoid reliance on memory and vigilance.*	*none*		*partial*		*full*
		A	B	C	D	E
	The organization uses checklists, protocols, reminders, decision support, and standardizes equipment, forms, times and locations to avoid reliance on memory in achieving zero-defect care.					
	The organization uses system constraints, forcing functions, natural mapping and effective alarms to avoid reliance on vigilance in achieving zero-defect care (e.g., IV luer lock and indwelling lines match before fluid can be infused; when a device fails, it defaults to the safest mode).					
	Patient care processes use a minimum number of steps and handoffs.					
	Patient care processes are designed with built-in opportunities to recover from critical error (e.g., reversing agent for overdosing of medication).					
	Patient care processes are designed such that safe, zero-defect care requires minimum effort to deliver.					
	Process redesign is piloted prior to widespread implementation to identify new sources of process failure and/or adverse events resulting from the change.					
	Process redesigns are monitored for effectiveness.					
	The organization invests in information technology to support patient safety (e.g., computer order entry, decision support).					
	The organization seeks active input from end users of technologies, supplies and products prior to purchase.					
	Technologies, supplies and products are piloted by end users prior to widespread implementation.					

© 2000 VHA Inc. All rights reserved. Duplication or distribution of this document without expressed permission from VHA is prohibited. Version 2.2

VI. Patient & Family Involvement

A	*There has been no discussion around this activity.*
B	*This activity is under discussion, but there is no implementation.*
C	*This activity is partially implemented in some or all areas of the organization.*
D	*This activity is fully implemented in some areas of the organization.*
E	*This activity is fully implemented throughout the organization.*

Key Aspect of Safety:	*Engage patients and families in care delivery workflow process design and feedback.*	*none*		*partial*		*full*
		A	B	C	D	E
	Mechanisms are in place for immediate response to patient and family-reported safety concerns.					
	Patients and families are actively involved in planning services, work/process design, problem solving and quality improvement efforts.					
	Patients and families receive information and education they need to be full partners in their care (e.g., evidence-based guidelines, personal medical data, self-management instructions, etc.).					
	Patient information and education is designed and delivered in useful formats and matched to literacy and cultural needs.					
	The organization informs and apologizes to patients and their families when an adverse event occurs.					

VII. Overall Summary

Each team member should complete this overall summary questionnaire. Upon finishing the organizational assessment, team members should discuss how their perceptions of the organization's approach to patient safety compares to its level of activities around the Key Aspects of Safety discussed in this assessment.

1 Does your health care facility enjoy a good reputation for patient safety within your community?

- ☐ Yes, completely
- ☐ Yes, pretty much
- ☐ Yes, somewhat
- ☐ Yes, a little bit
- ☐ No, not at all

2 Does your health care facility stress patient safety when it comes to patient care?

- ☐ Yes, completely
- ☐ Yes, pretty much
- ☐ Yes, somewhat
- ☐ Yes, a little bit
- ☐ No, not at all

3 Overall, how would you rate your health care facility on ensuring patient safety?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

4 Would you recommend your health care facility to a family member who needed care?

- ☐ Yes, definitely
- ☐ Yes, probably
- ☐ No, probably not
- ☐ No, definitely not

© 2000 VHA Inc. All rights reserved. Duplication or distribution of this document without expressed permission from VHA is prohibited. Version 2.2

VIII. DEMOGRAPHICS

(Please check the one response that best applies.)

1. **Number of beds currently set up and staffed for use in your hospital:**
   - ☐ Fewer than 100 beds
   - ☐ 100 to 299 beds
   - ☐ 300 to 499 beds
   - ☐ 500 beds and over

2. **Type of hospital:**
   - ☐ State or local government
   - ☐ Non-government, not-for-profit
   - ☐ Investor-owned, for-profit
   - ☐ Military
   - ☐ Veterans' Affairs
   - ☐ US Public Health Service
   - ☐ Other: ______________________________

3. **Type of service that your hospital provides to the majority of its admissions:**
   - ☐ General medical and surgical
   - ☐ Psychiatric
   - ☐ Rehabilitation
   - ☐ Specialty: Pediatric
   - ☐ Specialty: Oncology
   - ☐ Other: ______________________________

4. **Does your hospital have a PHYSICIAN residency training program that has been approved by the Accreditation Council for Graduate Medical Education?**
   - ☐ Yes
   - ☐ No

5. **Is your hospital part of a larger health care system?**
   - ☐ Yes
   - ☐ No

6. **Location of your hospital:**
   - ☐ Urban
   - ☐ Rural

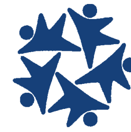
www.aha.org

United to Improve
America's Health®

www.vha.com

www.chausa.org

N•A•C•H



National Association of
Children's Hospitals

www.childrenshospitals.net

www.americashospitals.com

Additional copies of *An Organizational Approach to Patient Safety* may be purchased from AHA's Order Services at (800)242-2626, Item #166925.