

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

Building Resilience: Evaluating Cultural Issues That Drive Reliability

BY THE ANESTHESIA PATIENT SAFETY FOUNDATION/SOCIETY FOR CRITICAL CARE MEDICINE
HIGH-RELIABILITY ORGANIZATION TASK FORCE

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Improving patient safety remains a healthcare organizational challenge.^{1,2} Compared to other industries with highly reliable processes, healthcare baseline process reliability is low and patient safety solutions continue to be in high demand.^{3,4} While studies have examined implementation of individual patient safety interventions, such as medication safety or improving the safety of infusion pumps, little has been studied or published on the theoretical framework of patient safety systems implementation in healthcare institutions.⁵ High-Reliability Organization Theory, or HROT, is one such framework.

One way to approach high reliability is to use a model that identifies characteristics of organizations with fewer accidents than might be expected given their hazards.⁶ This and other frameworks have yet to be widely accepted as models for patient safety in healthcare institutions.

It is easier to describe what a high-reliability organization (HRO) should look like than to describe the process of transforming an organization into one.^{7,8} A recent Agency for Healthcare Research and Quality (AHRQ) report gives examples of hospitals using HRO principles at the organizational level, but offers no explicit measure of how to confirm adoption of HRO characteristics at the microsystem level.⁹ To address this gap, the authors created an HRO task force consisting of a collaborative representing several hospitals. The group's mission: to develop and evaluate a tool to assess whether an organization meets the characteristics of high reliability at the unit or service line level.

Building a tool to assess patient safety systems

The collaborative brought together a team with experience from a variety of professional groups studying HROT. The task force first examined a "straw man" model of an HRO in a cardiac surgical service line.^{10,11} (A straw man model is a brainstormed proposal intended to generate discussion of its disadvantages and to provoke development of new and better models.) Other HROT models were examined and coalesced into a set of features encompassing all perspectives. These

HROT elements were then mapped onto the framework of the Baldrige National Quality Program.¹² The resultant assessment spreadsheet tool was piloted in one service line and found to be cumbersome and time-intensive. It was modified substantially and is now being applied in one hospital's labor and delivery unit. A second hospital in the collaborative is applying it in its pediatric service line.

"One way to approach high reliability is to use a framework that identifies characteristics of organizations with fewer accidents than might be expected given their hazards."

Studying Abington Memorial Hospital's labor and delivery unit

Striving for high reliability requires knowledge of processes, policies, practices and culture, and the degree of alignment among all members of a microsystem. Following many improvement efforts on the labor and delivery unit at Abington Memorial Hospital, a 580-bed regional teaching hospital in Abington, Pa, the team opted to assess the unit with the high-reliability instrument in development.

The closure of several area hospital obstetrical units has resulted in a surge in Abington's labor and delivery unit's volume. Abington now handles more at-risk and complicated births, making the environment increasingly complex. Staff members are stressed, faced with an increasing array of technology and complex multidisciplinary processes. With team training, perinatal bundles (a structured way of improving the processes of care and patient outcomes), and an engaged patient safety officer in place, the time was right to do a deeper "dig" into high reliability.

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This project is conducted under the aegis of the Anesthesia Patient Safety Foundation and the Society for Critical Care Medicine.

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The initial spreadsheet evaluation tool was modified to capture the processes, policies, and practices of the labor and delivery unit, and to incorporate existing relevant clinical care guidelines. Again, the team merged concepts from the Baldrige Program into the HROT framework to assess the degree of approach, deployment, learning, and integration of these key questions. This resulted in a user-friendly tool to initiate the investigation from the staff perspective.

Using an Internet-based survey tool, the team crafted a series of 155 questions framed in the Baldrige criteria: leadership, strategic planning and deployment, staff focus, measurement, analysis and knowledge management, patient focus, and process management.¹³ To avoid duplication of a traditional culture survey, the team solicited feedback (in mandatory fields) from survey respondents as to the “evidence” in each question. These free-text areas were designed to elicit information to help the team understand the degree of reliability in departmental processes and practices. This evidence will be used to audit the alignment between staff and microsystem policies, procedures, and processes at the end of the survey.

After an introductory meeting with the labor and delivery unit, the team deployed the tool to a 60-member multidisciplinary focus group composed of a diagonal slice of all disciplines in the unit that “touch” the patient. The tool assured respondents anonymity by de-linking their responses from demographic information—essential in eliciting an honest appraisal of the unit by the focus group.

Studying pediatric safety at Thomason Hospital

While national leaders face challenges in implementing patient safety initiatives, the challenge is even greater for small and geographically isolated hospitals. Thomason Hospital, the second organization testing the tool, is a 350-bed nonprofit community hospital in far-west Texas, with about 30% Medicaid/Medicare patients and up to 30% charity patients.

To implement high-reliability patient safety systems at Thomason, the team took a systematic approach starting with a Baldrige-type review of the system’s readiness for patient safety. The team used the checklist for implementation of patient safety systems in healthcare institutions, as shown on page 3.¹¹

Results show that most critical processes were in place and data were available on the performance measures—a very positive finding at the institutional level. Next, the team adapted the high-reliability service line tool for Thomason’s

pediatric service line as well as the hospital’s patient safety council. Repeated use of the tool assisted in identifying missing links and helped the team pay attention to multiple processes at the same time.

Initially, the tool’s scoring system referred to whether or not participants agreed with patient safety-related statements. The team then realized that it already understood the importance of patient safety and agreed on a more meaningful scoring system, helping determine whether Thomason was at the level of approach, deployment, learning, or integration for each process.

The approach was based on the assumption that different parts of the organization may use various venues in implementing patient safety measures, and that patient safety initiatives may originate at multiple levels of the same system.⁵ A multi-layered approach, with origins of change in both the microsystem of a service line and the macrosystem of the organization, might provide better momentum for culture change.

This strategy “decentralized” part of the patient safety problem, allowing the pediatric service line to take initiative in creating a high-reliability environment, while maintaining a degree of centralization by having the hospital’s patient safety council explore the possibility of shifting the organization’s orientation toward high reliability. One year into the process, small steps in patient safety high-reliability system implementation are still being taken.

Next: Developing a new tool

High reliability requires an environment of employee empowerment, appropriate reward systems, openness to creativity, and free communication flow.⁵ The team is in an early stage of assessing a new tool to identify how well organizations adhere to principles of high reliability, driven from the microsystem level and using a Baldrige framework. The initial response from 2 participating organizations, each carrying out the process in ways suitable to its environment, have been very positive. **NPSF**

For more information on the HRO Task Force initiative ...

HRO Task Force members conducted presentations at the 2008 NPSF Patient Safety Congress. To view copies of their slides and get background information and an update on HRO course initiatives, visit <http://apsf.org/initiatives/hro.msp>.

Patient Safety Organizational Checklist

Patient safety category	Critical process	Implemented (Yes/No)	Comments
Institutional Leadership	How senior leaders communicate the priority of patient safety to all stakeholders.		
Social Responsibility	How the institution ensures ethical communication with stakeholders regarding patient safety issues.		
Strategy Deployment	How the institution develops, monitors, and improves action plans to ensure patient safety.		
Patient, Other Customer and Healthcare Market Knowledge	How the healthcare institution determines patients' expectations and appropriate knowledge regarding patient safety.		
Patient and Other Customer Relationships and Satisfaction	How the institution obtains information and feedback from patients on patient safety issues to improve the delivery of health care.		
Measurement and Analysis of Institutional Performance	How the institution collects, tracks, and analyzes patient safety data.		
Information and Knowledge Management	How the institution ensures that its clinical information technology (Computerized Physician Order Entry or CPOE, infusion pumps, alarm systems, etc) is reliable, secure, and user-friendly.		
Work Systems	How the institution supports high clinical performance standards and alignment with national clinical performance measures and best case-management practices.		
Staff Learning and Motivation	How the institution structures and promotes effective education and training of professionals in developing and improving patient safety systems.		
Staff Well-being and Satisfaction	How the institution maintains an environment conducive to patient safety.		
Patient Safety System	How the institution ensures that patient safety requirements are met at the "sharp end" of the healthcare delivery system.		
Support Processes	How the institution coordinates departmental and interdepartmental patient safety infrastructure to reduce variability in healthcare delivery and improve performance.		
Patient Safety Institutional Performance	How the institution ensures patient safety.		

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Involving Patients, Families, and Caregivers: Strategies to Improve Ambulatory Care

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Dr. Stock led a session titled "Engaging Patients, Families, and Caregivers in Ambulatory Care: Collaborative Strategies to Improve Quality and Safety" at the 2008 NPSF Annual Patient Safety Congress, May 14-16, at the Gaylord Opryland Resort & Convention Center, Nashville, Tenn.

In the Pacific Northwest, one moderate-sized, nonprofit healthcare system has initiated projects to improve safety and quality by actively engaging patients and families. PeaceHealth, a system of hospitals, clinics, specialty institutes, and ancillary programs that serves 5 regions in Oregon, Washington, and Alaska, has experienced a leadership-driven cultural change focused on quality improvement and patient safety. During the past decade, PeaceHealth has begun recruiting patients and their family members to help develop new initiatives for improving quality and safety in its health system.

"In many, if not most, instances, the best source of information about the care that just occurred or the future care plan resides with the patient and/or family members."

PeaceHealth Oregon Region in Eugene, Ore, has led an effort to orient ambulatory care toward a collaborative team approach that involves patients and family members working with interdisciplinary provider teams. The initiatives undertaken through this team process have yielded strong evidence of a link between increased patient and family member involvement and improved patient safety.

Recognizing the importance of patient engagement

The care received in the current healthcare system is often poorly coordinated, particularly for those with multiple medical conditions, more-vulnerable patients, and those transitioning between care settings.¹ In many, if not most, instances, the best source of information about the care that just occurred or the future care plan resides with the patient and/or family members. Thus, any care system that aims to improve quality and safety requires the active involvement of this most critical source of information: the patient and family.²

But meaningful patient interaction with the health system to improve quality is new for both patients and healthcare

providers. Both exist in their own world. Instead of requiring patients to enter the health providers' world to receive care, health providers must better understand the world in which patients live—and must ask patients to participate in building a world in which both parties can thrive and patients can experience safe, high-quality care.

Creating a better care system

PeaceHealth has been involved in a number of quality improvement projects that have engaged patients. In 2003, an Agency for Healthcare Research and Quality (AHRQ) Patient Safety Implementation grant supported an aim to improve medication safety. This study created a single, updated, and accurate medication list electronically accessible to patients, caregivers, and all healthcare providers who participate in their care.

The project, using patient user-centered web development, involved the technical development of an electronic personal health record (available at www.sharedcareplan.org) where patients could record and learn about their medications. This list could be viewed alongside the medication list found in their physicians' electronic medical record. In one look, both patient and provider could see whether they both had the same list of medications. If not, they could have a conversation about agreeing on a common, accurate list.

The electronic personal health record was designed by and for patients and families. As with any new product or electronic tool, the effectiveness of the record depends on the people using it, so this project also focused on how the office practice asked for, recorded, and updated patients' medication lists. For the past 3 years, all PeaceHealth ambulatory practices have agreed to a process that reliably manages accurate medication lists at every ambulatory office visit. Patients were actively involved in all aspects of the medication management workflow process improvement.

Project evaluation revealed that the accuracy of medication lists improved significantly, and that patients are reliably being asked about their medications and offered an updated paper medication list to carry with them in more than 90% of visits. In the AHRQ study, the culture of medication safety was also measured in the pilot ambulatory clinics and showed significant improvement, creating an office environ-

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NPSF Proposes Universal Patient Compact

The NPSF recently proposed development of a Universal Patient Compact to complement the Consumer Bill of Rights and Responsibilities. The Universal Patient Compact will build on principles in the Consumer Bill of Rights to establish a covenant between healthcare providers and patients.

Focusing on the patient-caregiver relationship

While the Bill of Rights focuses on the patient perspective, the Compact will address the relationship between the patient and the caregiver by creating an understanding about how they should work together. The Compact will describe the agreed-upon commitments each party must make to provide a care process that is truly patient- and family-centered and respects the rights of patients.

For example, the Compact will spell out the patient's right to information as well as the caregiver's commitment to being honest and transparent in support of that right.

The genesis of the Compact was an idea proposed during an NPSF-led Roundtable at the 2007 Nursing Leadership Congress led by McKesson Corporation. The Congress drew approximately 150 nurse executives from across the US for lectures and roundtable discussions on best-practice approaches to medication safety and other key quality issues in healthcare.

The Nursing Leadership Congress was sponsored by Intel and McKesson along with NPSF, Joint Commission Resources, the American Organization of Nurse Executives and the Institute for Safe Medication Practices.

An open discussion of the proposed Compact was held during the 2008 NPSF Annual Patient Safety Congress, May 14–16 in Nashville, Tenn. [NPSF](#)

Involving Patients, Families, and Caregivers

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ment where staff is more fully engaged in ensuring that medications are dispensed and evaluated safely. More importantly, in the pilot study, patients reported that an electronic med list was beneficial and desirable, that they felt safer and confident that fewer errors would be made, and that having the medication list improved communication with their healthcare provider.

Patient and family involvement continues to be a high priority for PeaceHealth in many aspects of care delivery. Through its patient and family advisor program, quality improvement and work process redesign teams have secured patient participation. Meetings preceded by reflections on patient care stories have helped to change the health system's culture to be more patient- and family-centered. In one clinic, new patients are given a tour and oriented to the clinic by a patient volunteer.

The interdisciplinary teams have found, however, that merely inviting a patient to participate in meetings is not enough to take full advantage of what patients have to offer. Patients and family advisors need to be recruited, and a selection process is necessary to get the right patient "fit"

for the task. An example of such a process was documented by Wisconsin's Aurora Health Care.³ Once recruited and selected, patients need some orientation to the team and the task to be addressed, as well as ongoing coaching so their story and expertise can be adequately heard by the healthcare team.

What has been learned by engaging patients and families?

Through this process, PeaceHealth learned that many patients are surprised by the complexity of the healthcare system. Yet most want to help healthcare providers and practices improve their effectiveness and efficiency by becoming involved. The healthcare system needs to view patients as partners in both the personal provider-patient relationship and in working together to improve the system of care.

Healthcare providers should recognize that while patients are consumers of health care, the real value comes when they can be partners as clinicians perform the role of coaches and teachers. Patients and families are a valuable resource that is too precious to be ignored as the healthcare system of the future is being designed. [NPSF](#)

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Engaging CEOs and CNOs to Improve Patient Safety

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The landmark 1999 Institute of Medicine report, *To Err is Human: Building a Safer Health System*, focused public attention on the fact that 44,000 to 98,000 hospital patients die each year due to preventable medical errors.¹ Healthcare consumers are demanding to know the root cause for this error rate and many organizations and agencies are looking for answers. The notion of a "weak" culture of safety has emerged as a common theme in explaining this phenomenon.²

A foundation of medical and nursing practice is to "first, do no harm."³ The IOM report moved this concept to the center of public attention, creating momentum for the current patient safety movement. Large-scale national initiatives are underway and patient safety is a critical component of the national quality agenda.⁴ Several research studies have been conducted on creating a culture of safety. A good working definition of a culture of safety is "an environment in which patients, their families, and organization staff and leaders can identify and manage actual and potential risks to patient safety."^{5(p82)}

Still, the "culture of safety" concept remains poorly defined, and current definitions have largely failed to include input from nurses—specifically those involved in direct patient care. There are significant gaps in the research on a culture of safety and the lack of a clearly articulated definition of safety makes summary difficult.

Organizational culture has been shown to influence quality and patient safety. When this phenomenon was studied at one large academic medical center, results showed a discrepancy between how nurses and physicians perceive the culture of safety. Nurses perceived safety more positively than did physicians, and management perceived the culture of safety to be further developed than did hospital safety committee members.⁶ The researchers used 2 separate surveys to measure the climate of safety and strategies for leadership.

The dearth of empiric research on patient safety culture conducted by nurses or with nursing input results in an "apples to oranges" comparison. An informal author review of the medical and nursing literature found that most findings relate to select aspects of a culture of safety, but there is no comprehensive model for defining a culture of safety. Most published research on patient safety is physician-generated and anecdotal. A nursing voice in the literature is limited and most often found in editorials. Physician-

generated research tends to focus on therapeutic interventions and evidence-based practice rather than the culture of safety.

Despite the national attention physicians have given to patient safety, many organizations still fail to acknowledge the published "evidence" to support safer practices.⁷ The culture of safety concept also needs to be defined from a nursing perspective and incorporated into a definition that encompasses the voices of all clinicians, administrators, payers, and consumers of health care.

Hospital leaders are responsible for establishing and supporting a culture where consumers will consistently experience care with the quality and safety they deserve. This concept is being reinforced not only by accrediting agencies such as the Joint Commission, but by payors as well.

Hospitals are required by the Centers for Medicare and Medicaid Services (CMS) to have effective governing bodies legally responsible for the conduct of the hospital. CMS mandates that hospitals hold the medical staff accountable to the governing body for the quality of care provided, including patient safety.⁸ Other government and professional bodies have encouraged hospital leaders to initiate measures to ensure patient safety is central to their operations.

CEOs and CNOs must work together for patient safety

The case for cultural change has to be clearly articulated, and those who lead and govern healthcare organizations must rethink how health care can be delivered in a manner that is safe, effective, patient-centered, equitable, timely, and efficient.⁹ Chief executive officers (CEOs) and chief nursing officers (CNOs) are crucial to this transformation and must partner with leaders at all levels to effect change. This includes active participation with the hospital board of trustees.

As the CEO guides an organization in developing strategic and operating plans, he or she can make an important statement by including patient safety in the strategic plan and prioritizing patient safety among the hospital's values and core practices. This requires a commitment to allocate the necessary resources.¹⁰ Historically, the CEO or board chair has set the agenda for board meetings. CNOs have often been absent from board meetings and have rarely contributed to the agenda. While there has been a recent trend to include CNOs in board meetings, hospitals have been slow to adopt inclusive leadership practices.

Strengthening the CNO's role in patient safety

As CNOs gain visibility to the governing boards, they are uniquely positioned to influence the board's understanding and perception of quality and safety. The CNO can be most effective when partnering with the CEO and the entire leadership team to educate the board about quality and patient safety initiatives. The CNO must first establish credibility as an expert source of data about quality and safety.

“Boards need to understand the value of nurses in improving patient safety and how nursing quality and patient safety are tied to financial and operational performance.”

Boards need to understand the value of nurses in improving patient safety and how nursing quality and patient safety are tied to financial and operational performance. One tool to help the CNO educate the board is the National Database of Nursing Quality Indicators (NDNQI). The NDNQI collects data from participating hospitals on structure, process, and outcome measures directly related to nursing care. These “nursing-sensitive” outcomes can be used to benchmark a hospital's performance, enabling governing boards to understand and actively engage in quality improvement and patient safety initiatives.¹¹

Developing leadership strategies for change

There are several successful strategies and guiding principles for achieving and sustaining a culture of safety. An organization must commit to change and emphasize developing systems to minimize errors and prevent harm. Forcing functions can reduce the possibility of human error—particularly at the person-machine interface. One example is computerized prescriber order entry systems that alert prescribers to potential errors. The importance of communication and teamwork must not be underestimated in establishing a culture of safety. Programs such as crew resource management (CRM) help staff learn to communicate more openly and flatten hierarchies. Staff members now use

standardized language and utilize checklists, debriefs, and other systematic approaches that streamline communication and encourage input from staff members at all levels. CRM's impact on patient safety is not well documented but is widely supported as a strategy in improving a culture of safety.

Another resource in achieving a strong culture of safety is a well-trained, well-rested, well-staffed workforce. There is increasing evidence to support better patient outcomes with low nurse-to-patient ratios, decreased resident work hours, and increased numbers of board-certified staff.¹⁰

How else can senior leaders engage staff at all levels? One strategy widely employed and endorsed by the Institute for Healthcare Improvement is executive WalkRounds™. By interacting with staff at all levels, senior leaders can see what is really happening on the clinical units where patient care is delivered. This also demonstrates the organization's commitment to building a culture of safety. By conducting regularly scheduled rounds, leaders can learn about problems or issues on the unit and brainstorm with staff to develop solutions.

Walk rounds can be informal or formalized with a script. Specific questions can help identify issues that may have led to harm, delays in care resulting in prolonged length of stay, and environmental concerns that pose a safety threat and need to be addressed. Senior leaders also should ask for feedback on improving the effectiveness of quality walk rounds and how management can make the work safer for patients and staff.¹²

As public awareness of patient safety increases and consumers develop higher expectations of healthcare organizations, senior leaders and governing boards must meet a higher standard in maintaining patient safety and providing reliable tools to support patient care. The national safety movement has placed the responsibility for patient safety not only on the hospital leaders, but on governing boards as well.

Establishing a patient safety agenda and holding senior leadership accountable is crucial. Increasing the governing board's understanding of and engagement in quality and safety initiatives will have a positive influence on how resources are allocated. This, in turn, will support the organization's strategic goals of achieving and sustaining a culture of safety. **NPSF**

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Focus on Patient Safety
(ISSN 1097-0673) is the official
quarterly publication of the
not-for-profit National Patient
Safety Foundation (NPSF), in North
Adams, Mass. The opinions
expressed in this publication are
not necessarily those of the
National Patient Safety Foundation
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Virginia Mason Stroke Center Team Wins Stand Up for Patient Safety Management Award

The annual NPSF Stand Up for Patient Safety Management Award recognizes a Stand Up member organization for outstanding achievement in patient safety led by mid-level management. NPSF has issued the 2008 award to the Stroke Center Advisory Group and Operations Team at Virginia Mason (VM) Medical Center in Seattle, Washington.



This team comprises a multidisciplinary group of leaders including physicians, data and management support personnel, and staff nurse champions from each unit of the hospital. The group's comprehen-

sive team-based approach to its work, positive and enthusiastic attitude, patient-centered focus, scope of influence, and the demonstrated, measurable improvements in patient care resulting from its efforts were cited as factors in bestowing this year's award.

Patient-focused care

Each day, this team demonstrates incremental improvement by using Virginia Mason Production System's adaptation of the LEAN methodology to measure activity, innovate better processes, pilot new work tools, and evaluate results. The Stroke Center Advisory Group and Operations Team has successfully launched and maintained the Stroke Support

Group, which has a direct impact on community members affected by strokes. Their work has illustrated that a patient-centered care approach not only improves safety, but engages patients and family members during physical assessments and care-planning conferences.

Evidence-based interventions produce measurable improvement

Using national best-practice guidelines, the team developed and implemented a stroke-treatment "bundle" comprising a set of evidence-based practices to optimize stroke care and patient outcomes. Between June 2005 and December 2007, VM measured compliance with the stroke bundle and employed diverse strategies, including technological upgrades, staff training, enhancement of patient education materials, chart review, and leadership team meetings to promote continued progress. These efforts resulted in achieving and sustaining 100% compliance with the bundle throughout the last 4 months of 2007.

VM Stroke Center wins other honors

The VM Stroke Center has also earned a Gold Performance Achievement Award from the American Heart Association, and received the 2008 Virginia Mason Medical Center's Mary L. McClinton Patient Safety Award.

To find out more about the Stand Up for Patient Safety program, please visit www.npsf.org or e-mail standup@npsf.org. **NPSF**

Join NPSF's New Ambulatory Stand Up for Patient Safety Program

The new Ambulatory Stand Up for Patient Safety program helps improve patient safety in the ambulatory care or office practice setting. Find out more at www.npsf.org or e-mail ambulatory@npsf.org.

