NEBRASKA COALITION FOR PATIENT SAFETY

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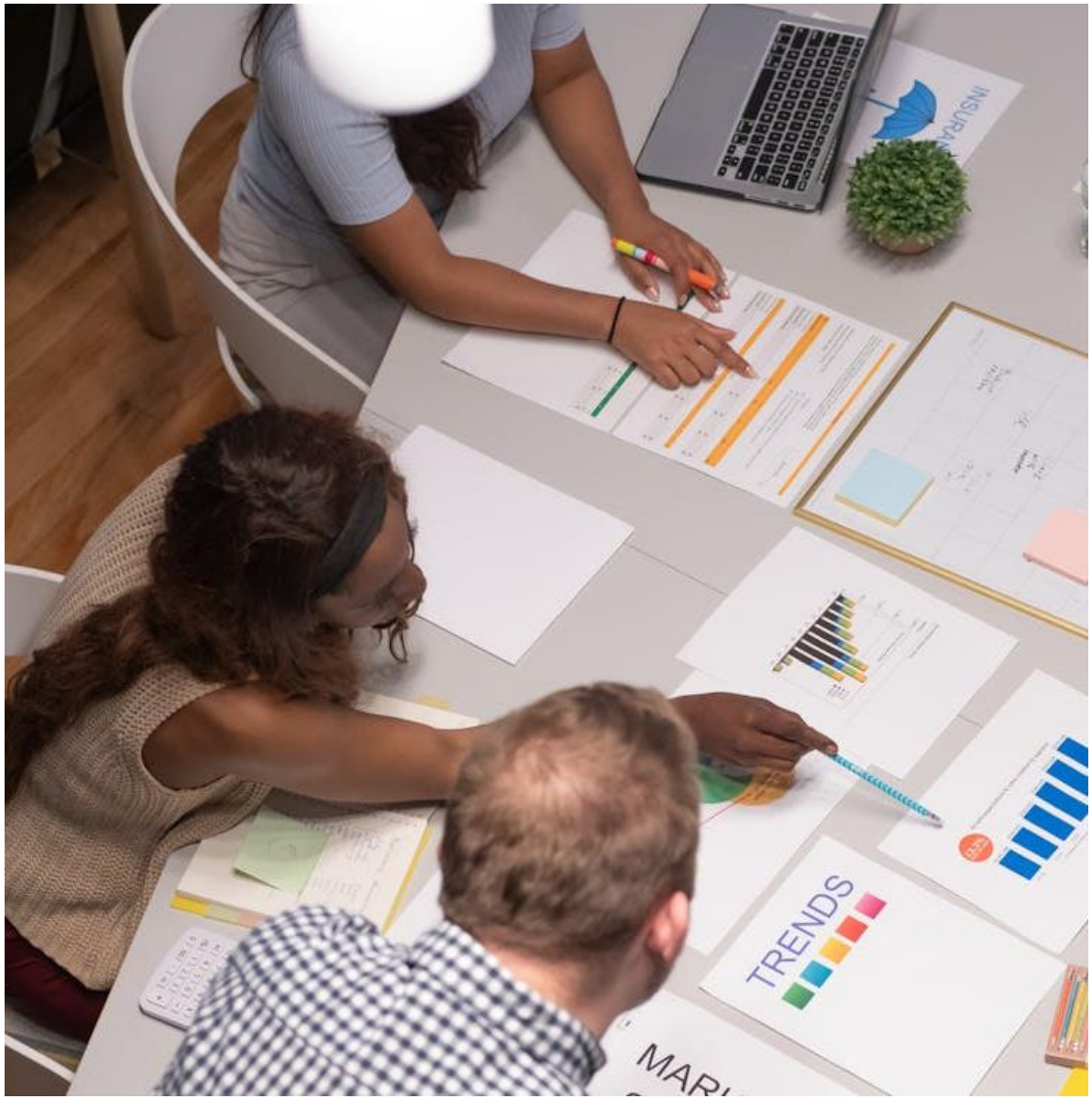
Objectives

1. Explain the imperative for creating a culture of safety to reduce harm to patients and the workforce.
2. Review the key components of the National Action Plan to Advance Patient Safety.
3. Discuss the recommendations and implementation tactics outlined for Culture, Leadership, and Governance in the action plan.
4. Describe the leadership domains found in the American College of Healthcare Executives 'Leading a Culture of Safety', which require CEO focus and dedication to develop and sustain a culture of safety in an organization.
5. Outline foundational and sustaining strategies that create and support a culture of safety.
6. Evaluate strategies a quality leader can use to engage and influence their organization's leaders for support of quality and patient safety initiatives.

INTRODUCTION AND A CALL TO ACTION

A TOTAL SYSTEMS APPROACH TO SAFETY

- Comprehensive method for improving patient care by integrating safety into all aspects of an organization
- Uses principles of system design, human-factors engineering, healthy equity, and advanced safety science (Davila & Giuffrida, n.d.) Total Systems Safety Focus on Reducing Harm (mplassociation.org)
- Areas of focus: culture, leadership and governance, patient and family engagement, workforce safety, and learning systems



A PATIENT SAFETY MOVEMENT TIMELINE

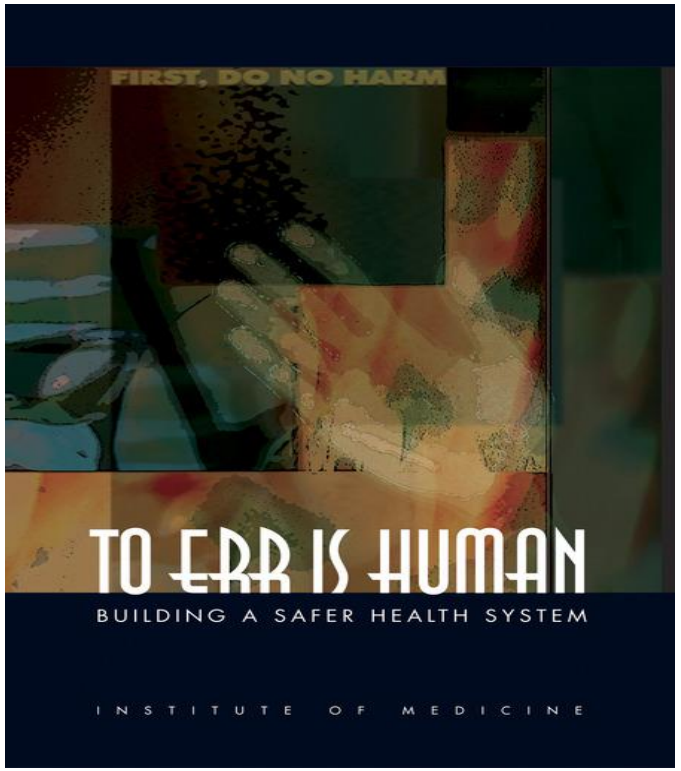
TO ERR IS HUMAN →

CROSSING THE QUALITY CHASM →

PCAST REPORT

TO ERR IS HUMAN

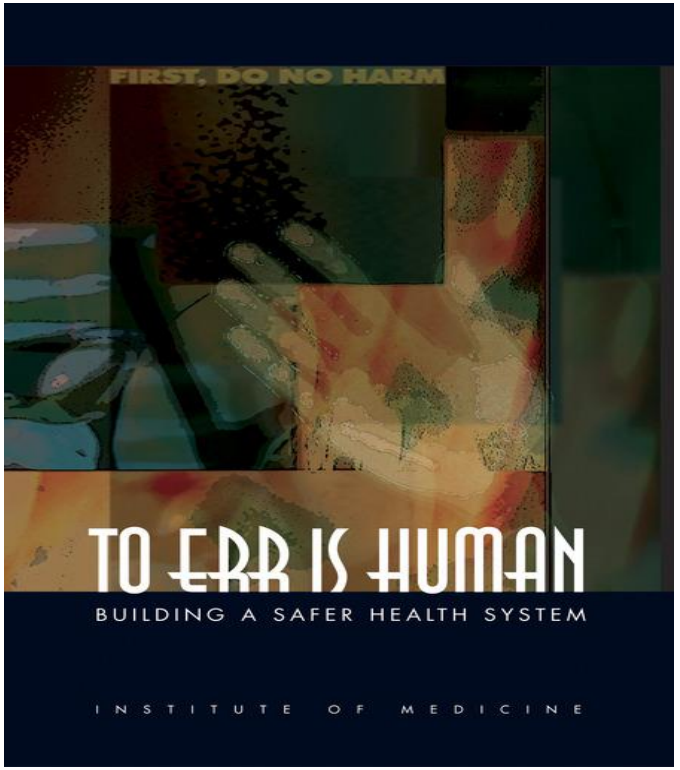
- At least 44,000 people die in hospitals each year as a result of medical errors that could have been prevented (1999).
- Medical error: "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim."
- $17-$29 billion estimated annual total costs nationwide
- Patients, healthcare professionals, and society bear the consequences
- "More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them."



TO ERR IS HUMAN

Strategies for Improvement

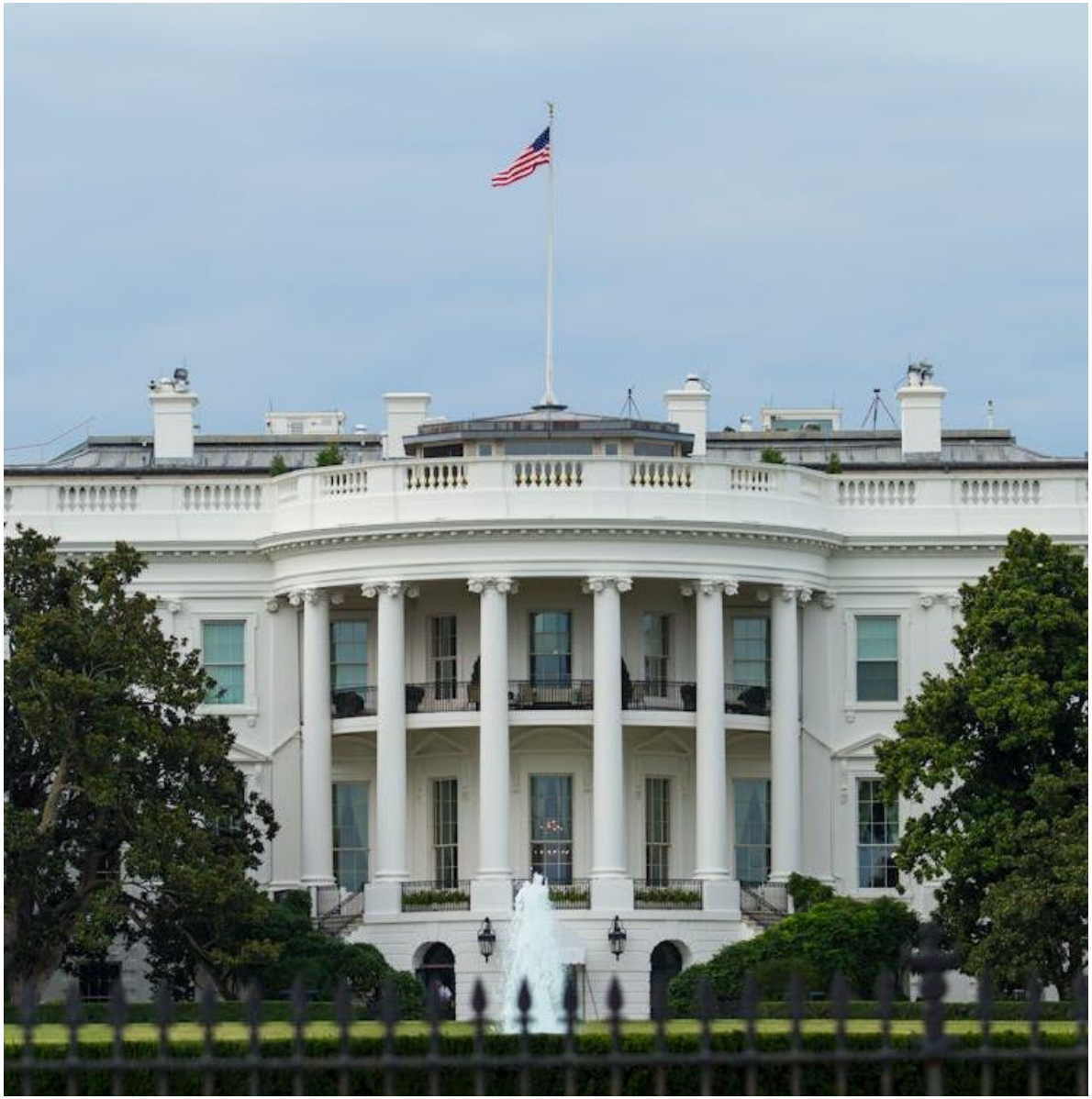
- Establishing a national focus to create leadership, research, tools, and protocols to enhance the knowledge base about safety
- Identifying and learning from errors by developing a nationwide public mandatory reporting system and by encouraging health care organizations and practitioners to develop and participate in voluntary reporting systems
- Raising performance standards and expectations for improvements in safety through the actions of oversight organizations, professional groups, and group purchasers of health care
- Implementing safety systems in health care organizations to ensure safe practices at the delivery level



CROSSING THE QUALITY CHASM

- Builds from the 1999 report on patient safety, referencing that there are more widespread issues that present as quality problems.
- To Err is Human: a call for action to make care safer
- Crossing the Quality Chasm: "a call for action to improve the American health care delivery system as a whole, in all its quality dimensions, for all Americans."

- Six aims for improvement:
  - Safe
  - Effective
  - Patient-centered
  - Timely
  - Efficient
  - Equitable



PCAST REPORT

PRESIDENT BIDEN'S ADMINISTRATION

PCAST REPORT

- Approximately 1 in 4 Medicare patients experience adverse events during their hospitalizations
- 40% are estimated to be due to preventable errors
- Despite commitments to quality care by practitioners and organizations, high rates of error still occur
- Progress toward understanding root causes of avoidable medical errors and implementation of evidence-based solutions
- Call to action for renewing nation's commitment to improving patient safety, and for the healthcare workforce

PCAST RECOMMENDATIONS

- Establish and Maintain Federal Leadership for the Improvement of Patient Safety as a National Priority
- Ensure That Patients Receive Evidence-Based Practices for Preventing Harm and Addressing Risks
- Partner with Patients and Reduce Disparities in Medical Errors and Adverse Outcomes
- Accelerate Research and Deployment of Practices, Technologies, and Exemplar Systems of Safe Care

PCAST UPDATES 2024

- Announced recommendations on World Patient Safety Day, September 17, 2024
  - Enhance federal leadership and prioritization of patient and workforce safety
  - Increase adoption of evidence-based practices for preventing harm and addressing risks
  - Partner with patients and other stakeholders to address disparities and increase transparency
  - Accelerate research and deployment of technologies to spur innovation and quality improvement

SEPTEMBER 17, 2024

Biden-Harris Administration Announces Progress and New Commitments to Improve Patient and Health Care Workforce Safety

OSTP › NEWS & UPDATES › PRESS RELEASES

PCAST UPDATES 2024

- The Agency for Healthcare Research and Quality (AHRQ)
- National Action Alliance for Patient and Workforce Safety
  - November 1: delivered first version of a National Healthcare Safety Dashboard

PCAST UPDATES 2024

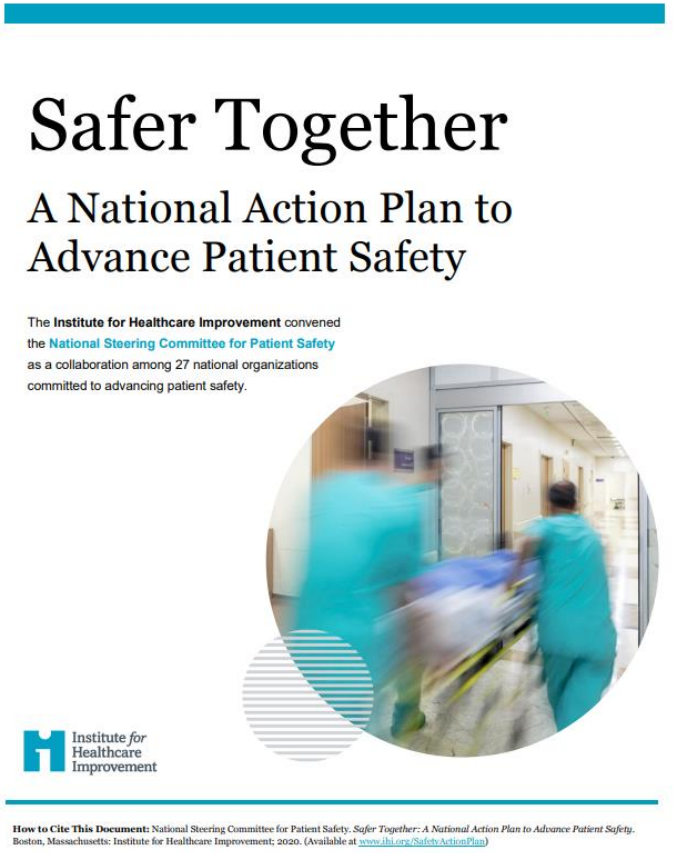
- Incorporate a patient safety element, such as the patient safety structural measure into its public reporting and quality programs
- Address health care disparities and empower patients' voices

NATIONAL STEERING COMMITTEE FOR PATIENT SAFETY

- Purpose of the National Steering Committee for Patient Safety
- Safer Together Plan

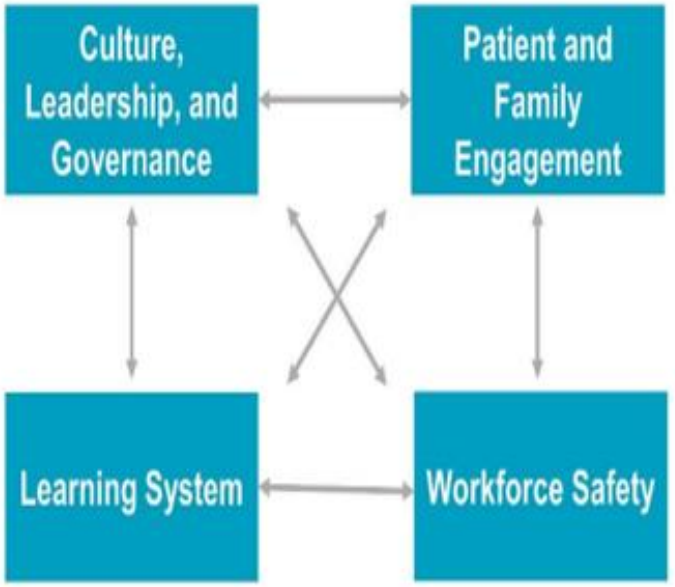
THE NATIONAL ACTION PLAN

- Provides clear direction and actions to advance total systems safety and advance safer care across the continuum of care
- 17 recommendations to advance patient safety



THE NATIONAL ACTION PLAN

- Aim: Health care is safe, reliable, and free from harm
- Primary Drivers
  - Culture, Leadership, and Governance
  - Patient and Family Engagement
  - Workforce Safety
  - Learning System



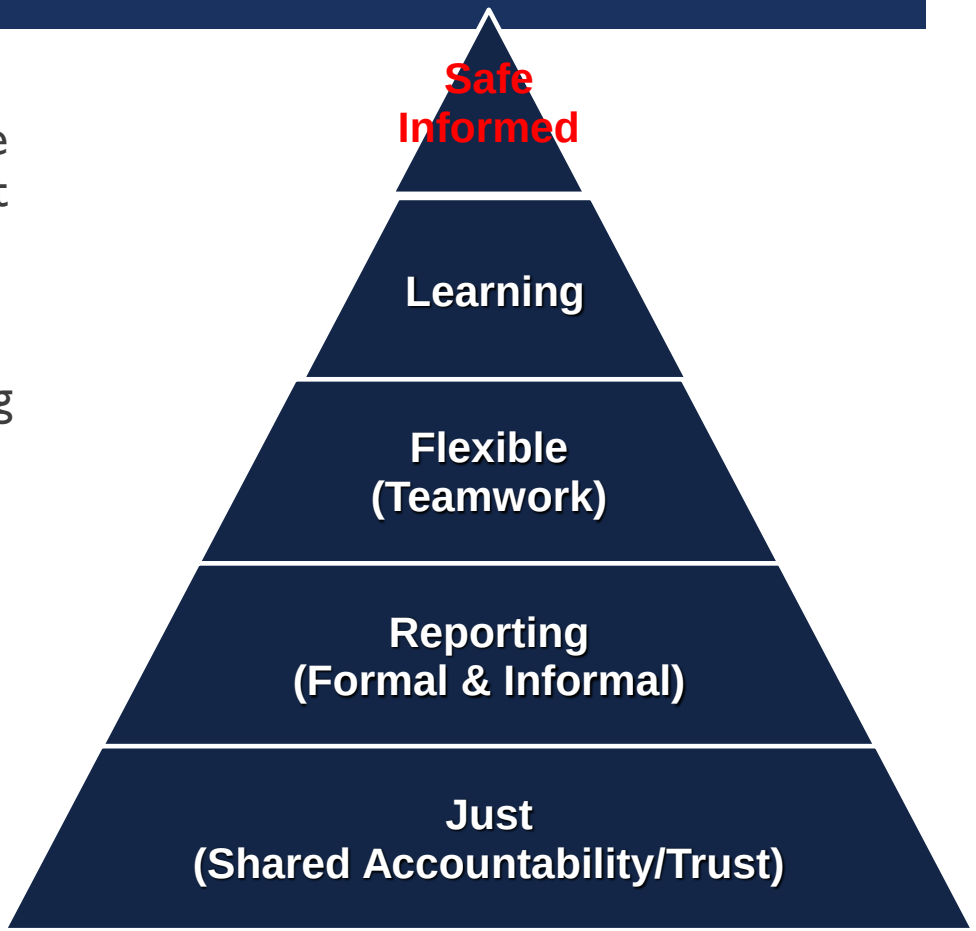
National Action Plan Four Foundational Areas: Interdependent Relationships

CULTURE, LEADERSHIP, AND GOVERNANCE

1. Ensure safety is a demonstrated core value.
2. Assess capabilities and commit resources to advance safety.
3. Widely share information about safety to promote transparency.
4. Implement competency-based governance and leadership.

IMPLEMENTATION TACTICS

- "Tactic 1a: Build a strong safety culture by implementing the practices of a just culture, ensuring that policies, procedures, and performance evaluations support a safety culture, regularly assessing culture, determining the root causes of culture issues, and continually taking steps to improve culture."
- "Tactic 2a: Identify, mitigate, and address system problems that contribute to physical, psychological, and emotional workforce harm, including burnout, and provide appropriate resources."



Four Key Components of a Culture of Safety

Reason, J. *Managing the Risks of Organizational Accidents.* Hampshire, England: Ashgate Publishing Limited; 1997.

IMPLEMENTATION TACTICS

- "Tactic 3b: Commit to sharing key safety information across the organization and with patients, families, care partners, and the public."
- "Tactic 4a: Use a standardized assessment to ensure that board members and senior leaders demonstrate competencies in safety, equity, and data literacy. Track progress over time in their oversight of these areas and in their use of data. Ensure that ongoing education provides coordinated guidance, curriculum, and assessment for board members and leaders across governance-support organizations."

PATIENT AND FAMILY ENGAGEMENT

1. Established competencies for all health care professionals for the engagement of patients, families, and care partners.
2. Engage patients, families, and care partners in the co-production of care.
3. Include patients, families, and care partners in leadership, governance, and safety and improvement efforts.
4. Ensure equitable engagements for all patients, families, and care partners.
5. Promote a culture of trust and respect for patients, families, and care partners.

IMPLEMENTATION TACTICS

- "Tactic 5a: Create competencies for health care professionals for the engagement of all patients, families, and care partners."
- "Tactic 6a: Seek to understand and address patient priorities by asking, 'What matters to you'."
- "Tactic 7c: Ensure that patient and family perspectives and experience data are systematically included in board discussions and planning work."
- "Tactic 8b: Establish systems to analyze safety data to identify and address gaps related to the social determinants of health, such as being at risk for housing or food insecurity, and to share community resources that can provide support."
- "Tactic 9a: Transparently provide information related to the organization's safety and quality performance with patients, families, and care partners during the informed consent process."

WORKFORCE SAFETY

1. Implement a systems approach to workforce safety.
2. Assume accountability for physical and psychological safety and a healthy work environment that fosters the joy of the health care workforce.
3. Develop, resource, and execute on priority programs that equitably foster workforce safety.

IMPLEMENTATION TACTICS

- "Tactic 10a: Educate leaders and governance bodies about the impact of workforce harm and the business case for prioritizing harm reduction."
- "Tactic 11a: Establish a safety system and ensure that key safety practices, including safe patient handling, ergonomics, falls, exposure, violence prevention, and safe sharps practices, are embedded into systems, workflows, practices, and care protocols."
- "Tactic 12b: Promote worksite wellness behaviors through established national programs."

LEARNING SYSTEM

1. Facilitate both intra- and inter-organizational learning.
2. Accelerate the development of the best possible safety learning networks.
3. Initiate and develop systems to facilitate interprofessional education and training on safety.
4. Develop shared goals for safety across the continuum of care.
5. Expedite industry-wide coordination, collaboration, and cooperation on safety.

IMPLEMENTATION TACTICS

- "Tactic 13a: Ensure that the elimination of risk and harm and sustained levels of safety over time are ultimate strategic goals of the learning system."
- "Tactic 14b: Spread greater awareness of federal and state legal protections to facilitate and accelerate sharing learning about patient safety that can be applied throughout the health care system."
- "Tactic 15b: Create standards for safety education for all types of health care professionals and for relevant job descriptions."
- "Tactic 16a: Establish a national expert group to accomplish the following work: a) identify data for measurement."
- "Tactic 17b: Seek out and include patient, family, care partner, and community perspectives to inform and guide all activities."

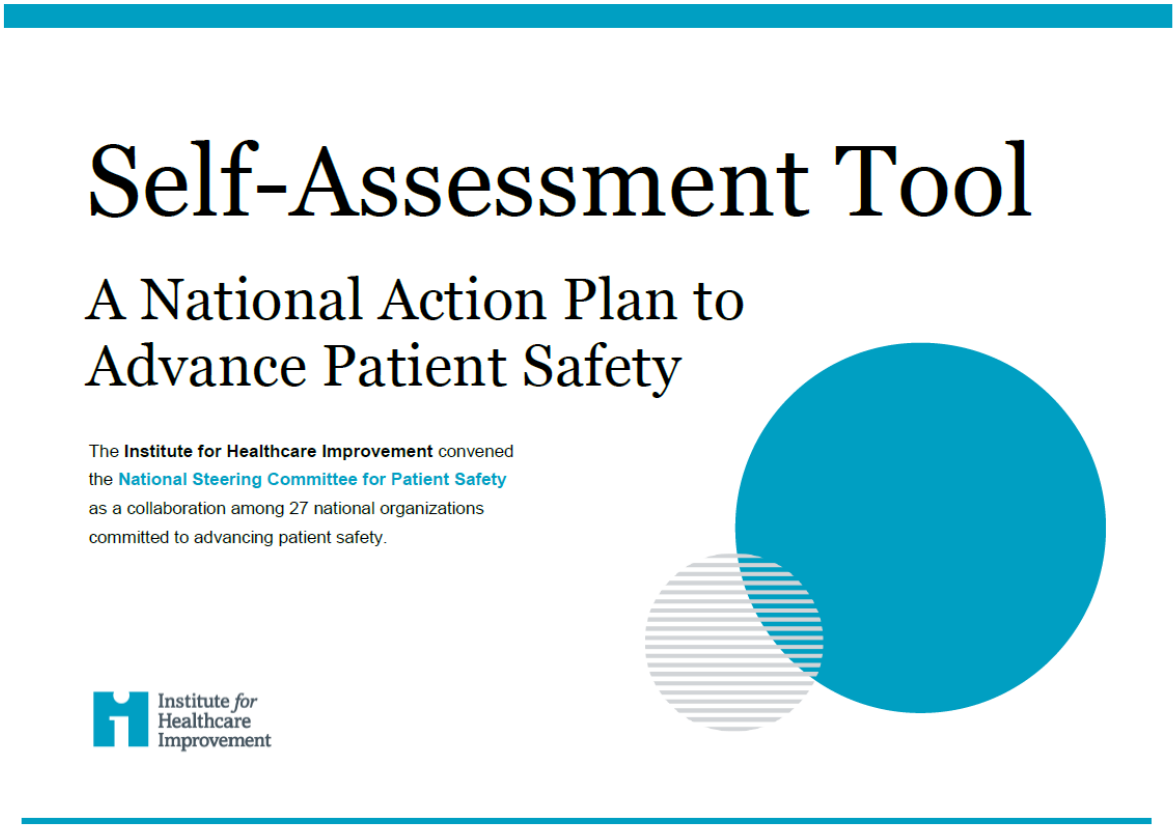
THE NATIONAL ACTION PLAN

- Secondary Drivers
  - Leverage the influence of leadership and governance to commit to safety as a core value of the organization and drive the creation of a strong organizational culture.
  - Commit to the goal of fully engaging patients, families, and care partners in all aspects of care at all levels.
  - Commit to workforce physical, psychological, and emotional safety and wellness, and full and equitable support of workers.
  - Commit to continuous learning within organizations by creating and strengthening internal processes that promote transparency and reliability, and through sharing as part of an integrated learning system and networks.

GUIDING PRINCIPLES FOR MEASURING PATIENT SAFETY

- Measure purposes
- Impact measures and harm indicators
- Measures of capability and competency
- Key indicators or proxy measures
- Future considerations

SELF-ASSESSMENT & ORGANIZATIONAL TOOL



Self-Assessment Tool

A National Action Plan to Advance Patient Safety

The **Institute for Healthcare Improvement** convened the **National Steering Committee for Patient Safety** as a collaboration among 27 national organizations committed to advancing patient safety.

Institute *for* Healthcare Improvement

How to Cite This Document: National Steering Committee for Patient Safety. *Self-Assessment Tool: A National Action Plan to Advance Patient Safety*. Boston, Massachusetts: Institute for Healthcare Improvement; 2020. (Available at www.ihi.org/SafetyActionPlan)

SELF-ASSESSMENT TOOL COMPLETION

- Instructions
- Assess and score
- Interpret score results

DISCUSSION ABOUT ASSESSMENT COMPLETION

- Culture, Leadership, and Governance
  - Safety goals, job descriptions, annual reviews, Just Culture, harm events, meeting agendas, safety culture surveys
- Patient and Family Engagement
  - PFAC, co-design care with patients, training & resources, patient portals, equity, CRP, escalation pathways for safety events
- Workforce Safety
  - Job descriptions, safety strategy, occupational safety, budgeting, safety reporting system, priority safety programs, safety events
- Learning System
  - Harm events, patient engagement, event review, education & competencies, learning networks, safety goals

10-MINUTE BREAK

ENGAGING WITH C-SUITE AND BOARD OF DIRECTORS ON PATIENT SAFETY

LEADING A CULTURE OF SAFETY: ACHE

THE SIX DOMAINS

- Establish a compelling vision for safety
- Build trust, respect, and inclusion
- Select, develop, and engage your Board
- Prioritize safety in the selection and development of leaders
- Lead and reward a Just Culture
- Establish organizational behavior expectations

ESTABLISHING A COMPELLING VISION FOR SAFETY

- *Goal: "Commit to develop, communicate, and execute on an organizational vision of zero harm to patients, families, and the workforce."*
- Strategies
  - Understanding, Communication, & Prioritization
- Tactics
  - Building awareness, training & education, ongoing communication
- Assessing execution
  - "Can all members of the organization articulate the vision for safety and how it relates to their individual work?"

FROM THE BEGINNING…WHAT IS SAFETY CULTURE?

Safety culture is the shared beliefs and behaviors **TAUGHT** by organizational leaders that define how to think and feel about patient safety. It reflects an organization's ability/willingness to learn from errors.

How leaders teach culture

What do leaders measure, reward, provide resources for, and role model?

Which is more important: Patient Safety or Productivity?

HSOPS MEASURES LEADERSHIP SUPPORT FOR PATIENT SAFETY

1. **For Hospital as a Whole:**
   Hospital Management Support for Patient Safety

2. **At Unit/Dept Level**:
   Supervisor/Manager/ Clinical Leader Support for Patient Safety

Agency for Healthcare Research and Quality. Survey On Patient Safety Surveys Available at: https://www.ahrq.gov/sops/surveys/index.html

CONDUCT HSOPS TO ATTEST TO HOSPITAL MANAGEMENT SUPPORT FOR PATIENT SAFETY

Attestation Statement: "Our hospital leaders, including C-suite executives, place patient safety as a core institutional value…"

HSOPS Hospital Management Support for Patient Safety	**10th %ile***	**90th %ile***
	% Strongly Agree/Agree	
The actions of hospital management show that patient safety is a top priority.	60%	89%
Hospital management provides adequate resources to improve patient safety.	53%	85%
	% Strongly Disagree/Disagree	
Hospital management seems interested in patient safety only after an adverse event happens.	36%	63%

*Results from 2022 HSOPS User Database Report

CONDUCT HSOPS TO ATTEST TO UNIT/DEPARTMENT SUPPORT FOR PATIENT SAFETY

Attestation Statement: "Our hospital leaders, including C-suite executives, place patient safety as a core institutional value…"

HSOPS Supervisor/Manager Support for Patient Safety	**10th %ile***	**90th %ile***
	% Strongly Agree/Agree	
My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety.	71%	88%
My supervisor, manager, or clinical leader takes action to address patient safety concerns that are brought to their attention.	76%	91%
	% Strongly Disagree/Disagree	
My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts.	68%	87%

*Results from 2022 HSOPS User Database Report

RESULTS FROM 2022 HSOPS USER DATABASE

Supervisor/Manager Support for Patient Safety	10th %ile	Avg.	90th %ile
	% Strongly Agree/Agree		
My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety.	71%	80%	88%
My supervisor, manager, or clinical leader takes action to address patient safety concerns that are brought to their attention.	76%	84%	91%
	% Strongly Disagree/Disagree		
My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts.	68%	78%	87%

NOTE: Results will vary across units/depts as each supervisor/manager teaches staff how to think and behave about patient safety in that unit/dept.

BUILD TRUST, RESPECT, AND INCLUSION

- *Goal: "Establish organizational behaviors that lead to trust in leadership and respect and inclusion throughout the organization regardless of rank, role, or discipline."*
- Strategies
  - Creating expectations, Accountability, Transparency
- Tactics
  - Promote discussions, psychological safety, sharing information
- Assessing execution
  - "Are measures of respect included in all performance assessment tools?"

SELECT, DEVELOP, AND ENGAGE YOUR BOARD

- *Goal: "Select and develop your board so that it has clear competencies, focus, and accountability regarding safety culture."*
- Strategies
  - Board education, Board metrics and oversight
- Tactics
  - Dashboards, Competencies, Participation
- Assessing execution
  - "Does the Board conduct regular self-assessments related to knowledge and understanding of culture of safety?"

PRIORITIZE SAFETY IN THE SELECTION AND DEVELOPMENT OF LEADERS

- *Goal: "Educate and develop leaders at all levels of the organization who embody organizational principles and values of safety culture."*
- Strategies
  - Identify, Expectations & Accountability
- Tactics
  - Leadership Competencies, Roles & Expectations, Ongoing Learning
- Assessing execution
  - "Do all leaders receive training in patient safety science and safety culture?"

LEAD AND REWARD A JUST CULTURE

- *Goal: "Build a culture in which all leaders and the workforce understand basic principles of patient safety science, and recognize one set of defined and enforced behavioral standards for all individuals in the organization."*
- Strategies
  - Committing to Just Culture, Setting Expectations
- Tactics
  - Implement a decision-making process, identify metrics, tool integration
- Assessing execution
  - "Do Board, leadership, and workforce development programs include training on Just Culture?"

ESTABLISH ORGANIZATIONAL BEHAVIOR EXPECTATIONS

- *Goal: "Create one set of behavior expectations that apply to every individual in the organization and encompass the mission, vision, and values of the organization."*
- Strategies
  - Behavior recognition, competencies
- Tactics
  - Culture of safety survey, team-based tool implementation
- Assessing execution
  - "Are specific tools to encourage teamwork and clear communication in place, used, and regularly evaluated?"

TABLE DISCUSSION

1. My organization's CEO and leadership team effectively build enthusiasm for and understanding of my organization's safety vision statement.
2. My organization transparently shares information and metrics around harm events and action plans for improvement across our organization.
3. Performance assessments and incentives for my organization's leadership are inclusive of safety culture metrics and performance.
4. My organization has defined roles, safety competencies, and development programs for leaders at all levels.
5. My organization regularly reviews metrics for Just Culture education and understanding and defines improvement opportunities.
6. Professional accountability standards, including processes to address disruptive behavior and disrespect, are implemented uniformly across my organization.

C-SUITE AND BOARD OF DIRECTORS' ENGAGEMENT

- Marty Fattig, CEO, Nemaha County Hospital
  - Organizational report on culture of safety from C-Suite and Board of Directors' perspective
  - Reflect on personal/organizational strategies/challenges when engaging C-Suite and BOD
  - Recommendations for approaches for patient safety leaders

OPEN DISCUSSION

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