When it comes to achieving zero harm in healthcare, there is no silver bullet solution. *Leading a Culture of Safety: A Blueprint for Success* does, however, outline six leadership domains that can help ensure safety remains a focus from the top down in hospitals and other healthcare settings.

**Safety 101 Syllabus: Prioritize Safety in Selection and Development of Leaders**

Welcome back, class. Since posting our last lesson, the COVID-19 pandemic has spread across the globe and presented the healthcare field with new, never before seen obstacles. Between the high contagiousness and rapid spread of the virus, patient surges, shortages of personal protective equipment and ventilators, and limited testing supplies, keeping staff and patients safe has become particularly challenging and especially important.

Continue Reading.
Redefining Criticism

(Members Only) Healthcare organizations are quick to laud, with good reason, employees who fix problems on the fly and make things work, all too often in the face of seemingly impossible situations and systemic barriers. Organizational leaders are sometimes less exuberant about employees who point out defects or potential sources of failure in our systems. Employees who repeatedly identify opportunities for failure are often viewed as chronic complainers. Managers may dismiss them as disgruntled persons who are not team players; colleagues may regard them as disruptors to a comfortable status quo. Worse, they may be labeled “whistleblowers.”

Five to Zero: How High Reliability Happens

(Members Only) In the mid-1980s, following a scathing attack on anesthesia safety by ABC television’s 20/20 program, Ellison “Jeep” Pierce Jr., MD, then president of the American Society of Anesthesiologists, conceived the idea of the Anesthesia Patient Safety Foundation, and the ubiquitous term “patient safety” was born out of this effort. Pierce’s vision was a simple one: “that no patient shall be harmed by anesthesia.”
Engaging the Board in Patient Safety Goals

Over the past few decades, many hospitals and health systems have invested significant time and resources in building and reinforcing quality improvement and patient safety programs. This has led to declines in some medical error rates. For instance, central line-associated blood stream infections dropped by 50 percent between 2008 and 2016, and have continued to fall.

The Promise and Practice of a Just Culture

Leaders whose organizations have made big safety gains will tell you that a high-reliability safety culture is one of shared learning characterized by an atmosphere of trust. Members of the workforce feel safe speaking up when they make an error or encounter circumstances that could lead to harm. And, since these high-performing organizations recognize that most errors are due to flawed systems, not individual negligence, they’re listened to and supported.
Walk the Walk

What does it take to truly establish a culture of safety in your hospital? According to Mark P. Jarrett, MD, senior vice president and chief quality officer at Northwell Health in New York, the secret to success is none other than leadership. And, he claims, good leadership is ensuring that the culture will sustain itself beyond your tenure. “Simply budgeting dollars will not fix the issue,” he says; “a thoughtful patient safety strategy requires leaders to engage on a personal level.” Jarrett points out that, in commercial aviation and nuclear—two industries widely hailed as highly reliable—analysis following accidents nearly always reveals the problem to stem from failure of leadership to promote a safety culture.

In an article written for the Journal of Healthcare Management, Dr Jarrett encourages leaders to “walk the walk” in their efforts to establish a lasting culture of safety. By “walk the walk,” Jarrett is talking both figuratively and literally: he encourages healthcare executives to do weekly patient safety rounds in which they engage with and listen to staff and drive home the importance of and commitment to safety. Jarrett also recommends a brief, daily telephone discussion to “engage all leaders in a rapid situational safety review of the organization.”

According to Jarrett, there are several factors that are essential to a safety culture—and these can only be
fostered by effective leadership. These are:

- Commitment
- Nonpunitive response to errors and “near misses”
- Shared belief in the importance of safety
- Teamwork
- Widespread trust

Measurement

How do leaders achieve these foundational elements? To begin with, says Jarrett, measure. The only way to gauge success in performance improvement efforts is through measurement. At Northwell—a metropolitan system with 21 acute-care and 450 ambulatory locations—Jarrett’s team employs the Agency for Healthcare Research and Quality’s Hospital Survey on Patient Safety Culture, administered every 18 months.

Human Error

The results of the survey must be analyzed with a keen understanding of human psychology, cautions Jarrett. He reminds healthcare leaders to question the outcomes and never assume the causes behind the data. Rather than celebrate results indicating 100% compliance, first determine if the numbers stem from complacency in reporting rather than conformity.
“Improvement will only occur if leadership establishes a safety culture as a foundation to build on—and only then will we know that every patient, including our own family members, can receive the best possible care.”

Teamwork

A “team approach is necessary to drive lasting cultural change throughout the organization,” Jarrett maintains. At Northwell, they have adopted TeamSTEPPS, developed by the Department of Defense to heighten patient outcomes through multidisciplinary team training and common terminology to improve communication.

Just Culture

Finally, a successful safety culture must be founded on a “model of shared accountability” that is based in nonpunitive reporting of errors, staff accountability and willingness by care providers to speak up.

Jarrett concludes, “Improvement will only occur if leadership establishes a safety culture as a foundation to build on—and only then will we know that every patient, including our own family members, can receive the best possible care.”
Be sure to read “Patient Safety and Leadership: Do You Walk the Walk?” to see Jarrett’s checklist of elements required for the promotion of patient safety. ACHE Members: Visit ache.org/Journals and select Journal of Healthcare Management to log-in and access for free.

The Story as Catalyst for Change

As healthcare leaders we gather data and use the numbers to guide our decisions and make strategic plans for our organization’s future. Sometimes, however, we come across a patient story so revealing and so humbling that it compels us to act now. The all-to-real human experience as relayed to us by a distraught mother, by the trustee-turned-patient, or by a trusted staff member becomes so palpable that it is clear what change is urgently needed. The story becomes the catalyst for change.

That is the premise behind “Inspired to Change: Improving Patient Care One Story at a Time,” a compilation edited by Linda Larin. Her book contains perspectives written by patients, family members and healthcare providers that illustrate patient care at its shining best and shameful
worst. Larin’s hope in preparing this volume is that the stories will influence healthcare leaders and providers to discover better methods for delivering care that is more patient- and family-centered, safer and more efficient.

“It’s time to consider healthcare with a new lens and ask ourselves: What are we doing today that will be obsolete tomorrow? What will compel us to challenge the status quo?”

Her book challenges us to envision a future far from today’s status quo. In one chapter, Larin reminds us that hospitals only adopted smoking bans beginning in the 1980s. Prior to that time, the right of staff and patients to smoke was practically unquestioned. “It’s time to consider healthcare with a new lens and ask ourselves: What are we doing today that will be obsolete tomorrow? What will compel us to challenge the status quo?” she asks.

In chapters with titles such as “Going Above and Beyond Expectations,” “Looking Back with Regret,” “A Little Caring Goes a Long Way,” “The Stress of Illness,” and “A Day in the Life of a Hospital,” Larin’s collection of stories challenges the reader to see opportunities for improvement. Each chapter concludes with lessons learned, resources for more information, and recommended readings.

“Some [stories]...are a tribute to humankind, but others are dramatically sad and insensitive and show us that we could and should have performed better. From these, we attempt to gain a better understanding and improve for the future.”
The editor and healthcare executive encourages her colleagues to listen to their patients, draw out their stories and learn from the lessons hidden within. Patients with chronic illnesses, she says, often have so much experience of the healthcare system that they know our organizations’ strengths and weaknesses better than we do. “We need only ask for their input,” she suggests.

“The reality of healthcare, as any experienced leader or clinician knows, is that it is full of stories about patient–staff interactions. Some are incredibly poignant and are a tribute to humankind, but others are dramatically sad and insensitive and show us that we could and should have performed better. From these, we attempt to gain a better understanding and improve for the future,” she writes.

This book will live up to its title: it will inspire you to make lasting changes at your hospital or health system to provide the kind of quality care that you would want for yourself and for your loved ones.
The Role of Racism as a Core Patient Safety Issue

(Members Only) In February 2019, the Johns Hopkins Bloomberg School of Public Health hosted a special symposium titled, “The Fierce Urgency of Now,” in honor of Shalon Irving, PhD, a JHBSPH alumna, who passed away unexpectedly in 2017 just weeks after giving birth to her first daughter, Soleil. Irving was black, and the circumstances of her death were, tragically, far too common. The symposium was both a way to shine a brighter light on health inequities and a tribute to Irving’s lifelong work to eradicate unjust health disparities.

Safety: The Importance of Culture

(Members Only) November 2019 marks the 20-year anniversary of To Err Is Human: Building a Safer Health System. Since then, we have invested a great deal of resources to reduce errors, and we have made progress. As examples, infection rates are lower, fewer falls have occurred, and, it is reported, the number of patient deaths has declined. This is evidence we are moving in the right direction. It is, however, both difficult and premature to celebrate. With preventable errors still evident, we must remain vigilant in our quest for zero harm.