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 (AHRQ) 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.

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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 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.
High Reliability Healthcare

The ultimate goal for healthcare providers is zero harm to patients, families and the workforce. In order to achieve and maintain this in the long-run, you have to learn how to walk before you can run.

Patient safety expert, Dr. Michael Shabot, offers healthcare leaders the foundational tools to measure, build and sustain a culture of safety in the workplace.