# 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.

*“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."

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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.

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# 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.

# Lean Toward Zero Patient Harm

"The Toyota Way," "Lean"—we've all heard the terms and been exposed to the buzz. We know that the Toyota Production System model is admired and emulated the world over by management experts and gurus. But it's not news—it's not the latest-and-greatest—so, why should we care now? Here's why: The Toyota Way, or Lean, *works.* Its effect in helping healthcare organizations and entire health systems improve patient care, reduce errors, increase patient and staff satisfaction and more is well-documented—indeed, proven. Why, then, wouldn't we want to know all about it?

> *Lean has emerged as a potent tool to help healthcare leaders provide smoothly operating, patient-centered care free from errors.*

Derived from the waste-reduction, just-in-time management philosophy implemented in Japanese car manufacturing in the 1930s and 1940s, Lean has since emerged as a potent tool to help healthcare leaders provide smoothly operating, patient-centered care free from errors. In healthcare, waste is conceived as anything that doesn't add value. In *patient-centered* healthcare, value is regarded as only those items and services a patient would willingly pay for out of pocket. The waste to be eliminated, then, comprises unnecessary wait times, lengthy travel between service centers, redundant forms to complete and staff to inform, all manner of inefficiencies and, most particularly, errors and injuries in patient care.

At ACHE, through the Leading a Culture of Safety Blueprint jointly developed by ACHE and the IHI Lucian Leape Institute, we're extremely focused on helping our members transform their institutions and agencies into high-reliability organizations founded on a culture of safety. Implementation of Lean is one surefire way to move your hospital or health system closer to

the goal of zero patient harm.

ACHE members have access to the second edition of *The Toyota Way to Healthcare Excellence: Increase Efficiency and Improve Quality with Lean,* by John Black (with David Miller and Joni Sensel). This new edition provides detailed information regarding the implementation of Lean in the massive Saskatchewan provincial healthcare system as well as reports and historical perspectives from three leaders who have implemented Lean in U.S. health organizations for a decade or more.

What do these leaders want us to know? Dr. Gary Kaplan, CEO of Virginia Mason Medical Center in Seattle and chair of IHI Lucian Leape Institute, is one of the earliest Lean healthcare pioneers. In his foreword to the second edition, Kaplan is effusive. He professes that at Virginia Mason, Lean has led to: "…significant improvements—contributing to at least a 50 percent reduction in time, space, or the need for other resources. In areas of major focus, we've seen defects go to nearly zero. We've experienced improvements in the hospital length of stay, patient wait times to see a doctor, face-to-face time for patients with their physicians, time to get lab results, and even time to get the bill sent out.…Lean works!"

> *"In areas of major focus, we've seen defects go to nearly zero. We've experienced improvements in the hospital length of stay, patient wait times to see a doctor, face-to-face time for patients with their physicians, time to get lab results, and even time to get the bill sent out."*

Kaplan promises that healthcare executives can "create a better, safer, more efficient, and higher quality healthcare system if we are willing to embrace these new methods and are truly willing to lead."

# Partnering for Safety

As healthcare executives, we are all aware of and striving toward the broad and common goal of reducing preventable harm to patients. But did you know that the Centers for Medicare & Medicaid Services (CMS) have your back? Yes, lest we think we are doing it alone, the team at CMS would like us to be aware of the strides they are making to innovate for patient safety.

Using a systems approach, the Partnership for Patients (PfP) is a CMS initiative that focuses on education and advocacy to make advances in quality improvements, spread best practices, and promote reduction in preventable injury and subsequent readmissions.

> *"Aligning toward a common goal fosters synchronized communications, leverages broader perspectives, and promotes a higher likelihood of success."*

Why a systems approach? "Explicit effort to think about systems is necessary for organizational learning and innovation because humans tend to concentrate their efforts and understanding on those parts of the system for which they are directly accountable," explain the authors of Partnership for Patients: Innovation and Leadership for Safer Healthcare (Journal of Healthcare Management: May/June 2017 – Volume 62 – Issue 3 – p 166–170). The authors–Patrick Conway, Shelly Coyle and Nancy Sonnenfeld–are members of the CMS Quality Improvement and Innovation Group (QIIG). This team believes that systems thinking can help eliminate harmful events and lead to efficient innovations in healthcare.

PfP employs a multipronged strategy to reach toward successful innovation. The program consists of partnership among the QIIG

and its contractors, as well as collaborators from the federal, state, and local levels and private entities. To achieve change, the PfP has introduced incentives and penalties in reimbursement that are aligned with its goals as well as creating programs that focus on reducing hospital-acquired illnesses and injuries and subsequent readmissions.

The authors recognize the essential role of hospital executives in collaboration with the PfP. Considering the many demands on healthcare leaders, they propose that a systems approach is required to achieve real and sustainable improvement. Some methods they support are described below.

> *"Declare bold aims; make strong, public commitments; and expect the same from your partners."*

## Patient and Community Engagement

The PfP encourages healthcare executives to listen to and share openly with their patients and community. Opportunities for exchange and honest communication improve trust between parties and foster the development of a more patient-centered culture.

## Making the Rounds

Leaders who make daily or weekly rounds, visiting patients and frontline staff, will learn more about the workings of their organizations while communicating a commitment to those in their care. PfP recognizes that a workforce who feels heard and valued will produce better results for their patients.

## Partner Power

True to its name and mission, PfP values and promotes the power of partnerships. PfP welcomes collaboration with organizations aligned to the mission of improved patient safety and believes in the old adage "strength in numbers." For instance, the authors suggest that an initiative

incorporating diverse hospital departments like Nursing, IT and Environmental Services together might achieve more than one could accomplish alone. “Aligning toward a common goal fosters synchronized communications, leverages broader perspectives, and promotes a higher likelihood of success,” they write. “Declare bold aims; make strong, public commitments; and expect the same from your partners.”

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# A Marathon to Patient Safety

We’ve said it here before: leading for safety is a marathon, not a sprint!

Like all good marathoners, we’re prepared for the long haul and are determined to go the distance. With that in mind, it may not surprise you that it has been a full year since the ACHE, in partnership with the National Patient Safety Foundation’s Lucian Leape Institute (NPSF LLI), released Leading a Culture of Safety: A Blueprint for Success.

Perhaps in that time you have reached the first milestones in your marathon, or maybe you’re just now tying on your shoes and adjusting your bib—either way, there is still a long way to go in your organization’s journey to zero patient harm. It might be the right time now for a little inspiration: read “Partnering to Lead a Culture of Safety,” by Gary Kaplan, Tejal Gandhi, Deborah Bowen, and Charles Stokes, for a refresher on why the ACHE has teamed up with the NPSF LLI to help you and your executive-team colleagues learn to lead a culture of safety in your organization. You may wish to think of the ACHE and NPSF LLI as your distance-running coaches for this long journey.

According to the authors, these coaches have determined that

the essential first step in your marathon toward safe, high-quality healthcare is to build a safety culture in your organization. And, they say, the only way to transform a culture is to start with strong, committed leaders who convey urgency. “Without urgency, there can be no change, because the status quo is a powerful inhibitor,” they caution.

“Absent a true culture of safety, improvements…are difficult to sustain. Absent strong leadership, a culture of safety is difficult to develop and nurture,” write the authors.

Leaders must also commit to transparency in all organizational transactions and communications, and create a workable, reliable process for addressing safety concerns. To assure these priorities can be achieved, it is essential to engage all leaders: from the CEO to the trustees to the front-line clinical and administrative managers. “Strong leadership is…shared leadership,” Kaplan and his co-authors write.

Our coaches have adopted the belief of the LLI that “Safety needs to be much more than just another priority; it must be embraced as a core value of an entire organization—in fact, as a moral and ethical imperative in healthcare.”

If you haven’t done it yet, it’s time: tie on those running shoes and get moving. The authors agree, “…there is no better time to begin than now. It is the duty of healthcare leaders to protect their patients and their workforce and to aim for zero preventable harm.”

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# Lead for Safety

What can you, as a healthcare executive, do to aid your organization’s transformation into a high-reliability

organization that delivers safer care and saves lives? Whether you're a middle manager or a member of the C-suite, there is a role for you in building a culture of safety that leads toward error-free care.

In *The Safety Playbook: A Healthcare Leader's Guide to Building a High-Reliability Organization*, John Byrnes, MD, and Susan Teman, RN, use a straightforward, no-jargon approach to show leaders how to embrace, communicate, model and reward safety as they guide the transformation into a high-reliability organization. Published by ACHE, *The Safety Playbook* dovetails perfectly with the partnership effort of ACHE and the IHI/NPSF Lucian Leape Institute to increase the focus on and commitment to safety by today's healthcare executives.

## Commit to Safety

According to Byrnes and Teman, "every level of a high-reliability organization needs to be aligned with safety as a core value." From the board to physicians, to staff on the front-lines, each person is responsible for achieving zero patient harm. It starts at the top: with unwavering commitment by the trustees and executive leadership. This commitment is reflected in the inclusion of safety at the core of the strategic plan and in the dollars invested to train and motivate the entire organization.

## Build a Just Culture

One of the foundations of a high-reliability organization is the establishment of a just culture—one that distinguishes between system and individual failures. A just culture is a culture of transparency and respect, where errors are reported and the first question asked is, "Why did this happen?" rather than, "Who did this?"

Byrnes and Teman promote the flattening of hierarchy as an

essential step in the progress to a just culture, and they provide the “Call Me Bob” campaign as a case study. Taking a cue from the airline industry where the cockpit crew refer to each other by first names to encourage candid communication, Dr. Robert (Bob) Connors, president of Helen DeVos Children’s Hospital in Grand Rapids, Michigan, launched the “Call Me Bob” campaign to encourage a first-name-only approach among staff members and physicians. The goal of such initiatives is to eradicate the perception that speaking up to a senior staff member is equivalent to challenging authority. In a high reliability organization, it is essential that a nurse feels empowered to question a decision by a physician, and a junior staff member feels safe reporting an error.

## Flatten your hierarchy

Some leadership techniques suggested by Byrnes and Teman to achieve a flattened hierarchy and build a just culture include:

- Practice executive rounds. Make a habit of regular visits to patient care units, initiating two-way communication and building approachability and trust with staff. During these visits share your commitment to the organization’s mission and values, in particular to safety, and gather important information from the front lines in patient care
- Sponsor and champion cause-analysis capabilities (find-and-fix exercises) and the resulting system improvements. Believe in the organization as a system of continual learning and improvement, and share that conviction with all members of the staff
- Communicate. Share safety data in a relatable manner; make the data transparent and tell stories to personalize it; share safety metrics within individual units

Learn more in *The Safety Playbook: A Healthcare Leader’s Guide*

*to Building a High-Reliability Organization, available on the ACHE's Publication page.*

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# Imagine Your Hospital with Zero Errors

As healthcare leaders, we all want to create and sustain a culture of safety in our organizations. This goal is so crucial and timely that ACHE and the Institute for Healthcare Improvement/National Patient Safety Foundation Lucian Leape Institute are partnering to increase the focus on and commitment to safety.

Transforming vision into reality can seem a task so enormous and expensive, however, that we put it off, or we nibble around the edges—instead of jumping in with the full commitment required to ensure success.

Enter the team of John Byrnes, MD, and Susan Teman, RN. These experts in healthcare safety have given us a playbook of common sense strategies and real-world tactics that hospitals and health systems can employ now to begin or continue making the transition to error-free care.

In *The Safety Playbook: A Healthcare Leader's Guide to Building a High-Reliability Organization*, Byrnes and Teman draw from their experience in helping hospitals and health systems transform into high-reliability organizations that deliver safer care and save lives. Throughout the book, they scatter examples and case studies from their successes, including one children's hospital that cut serious safety events by 90%. They write, "No more children have died because of medical errors at that hospital (p. xxii)."

> *Medical errors are the third leading cause of death in the United States, accounting for approximately 250,000 deaths per year.*

That is quite the testimony in a healthcare environment that is suffering, quite frankly, a patient safety crisis. Medical errors are the third leading cause of death in the United States, accounting for approximately 250,000 deaths per year (Cha 2016; James 2013).

In the preface, Byrnes implores us to "imagine your hospital with zero errors," and then he, together with co-author Teman, proceeds to provide a practical guide to building a safety program that will eradicate preventable errors in your hospital, for your community and even for your own family.

Learn more in *The Safety Playbook: A Healthcare Leader's Guide to Building a High-Reliability Organization*, available on the ACHE's Publication page.

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# Why Safety and Quality Depend on Equity—and Vice Versa

How can safety and quality care in our healthcare institutions depend upon equity?

It has long been true that every patient deserves safe and high-quality care, but today's diverse population demands that we focus now on eliminating healthcare disparities in our institutions, according to Jack Lynch, FACHE, president and CEO of Main Line Health (MLH), Bryn Mawr, PA, in a recent article in the *Journal of Healthcare Management* (*J Healthc*

*Manag.* 2017 Sep/Oct;62(5):298-301).

What is the connection between equity and the delivery of safe and quality care? Past research has demonstrated a simple fact accepted by healthcare leaders today: patients identifying as racial minorities or LGBQT face increased risk for adverse safety events in our healthcare system. With our population rapidly diversifying—according to the US Census Bureau (2017), minorities will make up 54% of the American population by 2050—we must commit now to an unequivocal pledge of safety and quality care for every patient. Falling short of this, we will risk providing suboptimal care for fully one of every two patients who seek our assistance.

According to Lynch, the pledge to achieve equity at MLH is built on three mandates:

- Commitment to the STEEEP principles (to deliver care that is Safe, Timely, Efficient, Effective, Equitable and Patient centered)
- Education for cultural competence
- Organizational culture that rewards employees who take a stand for safety

"As healthcare leaders, we must address disparities in care with the same intensity and passion with which we have unequivocally embraced patient safety and quality," Lynch says.

**Unmistakably STEEP**

One patient at a time—that's how they meet the challenge at MLH, according to Lynch. While inequities in the country's healthcare system lead to disparities in patient care, healthcare leaders cannot and should not consider this problem insurmountable, in Lynch's view. By adopting the National Academy of Medicine's STEEEP principles and holding all employees accountable for ensuring that each patient receives care that is safe, timely, efficient, effective, equitable and

patient centered, MLH is committing to achieve their vision of equitable care for all by 2020.

**Culturally correct**

When ethnic disparities in patient safety occur, often they can be traced to a lack of cultural competence—a blend of cultural knowledge, attitudes, skills and resources—on the part of the healthcare providers (Suurmond, Uiters, de Bruijne, Stronks, & Essink-Bot, 2010, p.S116). Healthcare leaders today have a moral and financial imperative to invest in cultural competence education for their staff.

AT MLH, managers participate in a Diversity, Respect and Inclusion workshop over 2 days; the hospital intends to roll out similar training to all staff in 2019. In his article, Lynch mentions several national organizations that can help healthcare organizations improve their teams' cultural competency. One such resource is the ACHE's *Leading a Culture of Safety: A Blueprint for Success*, which helps leaders build a safety culture grounded in trust, respect and inclusion.

**Speaking up for safety**

"At MLH, we have worked diligently to create a culture in which everyone feels empowered and encouraged to speak up for safety and 'have each other's back,'" says Lynch, though he shares that the organization, like others, has much work to do. Such an environment is an essential precondition for patient safety. Human error is unavoidable in healthcare, as everywhere. For this reason, healthcare leaders must cultivate a culture of respect and trust, where staff members feel empowered and emboldened to admit to, to report, and to stand up to impending error.

"If we can establish trust and respect in our organizations, we can then be sure every healthcare worker will be that much more committed and sensitive to providing compassion, respect, and an equitable experience to every individual who gives us

the privilege to serve and care for them," promises Lynch.

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**Jack Lynch was a key speaker at the 2018 Congress on Healthcare Leadership, which just wrapped up in Chicago. Join us as we lead with intent, lead for safety and lead toward zero harm.**

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# How To Lead For Safety

There is nothing more important for healthcare providers than ensuring the safety of their patients and workforce. And, ACHE is committed to catalyzing healthcare leaders around safety.

We contacted three of our nation's leading safety experts, Tejal K. Gandhi, MD, CPPS, Chief Clinical and Safety Officer at Institute for Healthcare Improvement and President of its NPSF Lucian Leape Institute; John "Jack" Lynch III, FACHE, President/CEO of Main Line Health; and Doug Salvador, MD, Vice President of Medical Affairs at Baystate Health. Each of them emphasized that the journey to a zero-harm environment begins with creating a safety culture.

"A culture of safety is the foundation for all work, from day-to-day operations and care to improvement initiatives in safety and beyond," offers Gandhi.

But, culture often remains unchallenged because it's seen as the way things have always been. According to Salvador, there is a mountain of evidence linking disrespectful and dismissive behavior by healthcare providers to the harm of patients. For this to change, Lynch stresses that there can be no compromise on quality of care and patient safety. It must be "embedded as

a non-negotiable," a core value for all healthcare organizations.

## How To Get Started

"The most important first step is to measure the safety culture in your organization using a validated safety culture survey instrument," says Salvador. This includes leadership, communication and interactions right at the front lines. Often, this is where cultural issues exist but are never talked about.

Gandhi points out that it is nearly impossible to sustain improvement without a clear vision for the future. Leaders should set the vision and model aligning behaviors to demonstrate an expectation of trust and respect across all levels of an organization. Lynch agrees. For an organization to lead for a culture of safety, it must also "ensure a supportive, inclusive and respectful environment so that each member speaks up for safety … and feels empowered to do so."

ACHE, in partnership with the IHI/NPSF Lucian Leape Institute, launched *Leading a Culture of Safety: A Blueprint for Success*, including an organizational self-assessment and best practices to help healthcare leaders build a sustainable culture of safety. "Though creating a culture of safety is not easy, our new tool, provides a framework for leading an organization toward the ultimate goal of zero harm," says Gandhi.

## Common Obstacles Faced By Organizations

Lynch reminds healthcare leaders to expect challenges—and embrace them. These are essential to discovering an organization's strengths and weaknesses, and how to make necessary improvements. He suggests, "Leaders must be relied

upon by all levels of staff … to address changes when they need to be made," especially when focused on error prevention and safety.

It's also important to remember changing organizational culture is an "ongoing journey," indicates Gandhi. Salvador suggests leading these shifts in culture can be "extremely hard and often lonely." He emphasizes that support for creating a culture of safety has to come from the top because "setting new expectations for safe behaviors will be met with push-back from powerful places."

## Learn More About How To Lead For Safety

ACHE is committed to supporting the Leading for Safety journey for all healthcare leaders. As a result, it is offering a variety of learning opportunities, including:

- ***Creating and Sustaining A Culture of Safety***, a Hot Topic Session at the 2018 Congress on Healthcare Leadership providing practical strategies for driving change at every level of the organization. Led by Tejal K. Gandhi, MD, CPPS; John "Jack" Lynch III, FACHE: and Doug Salvador, MD.
- Leading for Safety: A FREE Three Part Webinar Series, which provides a deeper dive into the principles and practices of the *Blueprint*.
- High Reliability Boot Camp, pre-Congress one-day program that provides an in-depth look at the organizational requirements and tools needed to launch a high-reliability journey, with the ultimate goal of zero harm. Led by Michael Shabot, MD, President of the Joint Commission; Mark R. Chassin, MD, EVP and System Chief Clinical Officer, Memorial Hermann Health System; and Gary R. Yates, MD, Partner at Press Ganey Associates.
- Additional events at the Congress (March 26-29),

including a luncheon keynote by renowned leader Peter J. Pronovost, MD, PhD, FCCM, SVP, Johns Hopkins Medicine, and Director of its Armstrong Institute for Patient Safety and Quality.

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# How Leaders Can Engage & Make Organizations Safer Across the Care Continuum

Recently, the National Patient Safety Foundation released its report, "Free from Harm: Accelerating Patient Safety Improvement Fifteen Years After To Err is Human" which offers eight recommendations to lead to patient safety. A decade-and-a-half after the Institute of Medicine initially brought to the public's attention the issue of medical errors, the NPSF is partnering with ACHE to urge healthcare executives to take a pledge to commit to creating a culture of safety for patients and providers.

Following this recent report, Tejal Gandhi, MD, NPSF's president and CEO, breaks down how "there's a variety of ways that executives can make their organizations safe for patients and providers… our report really highlights different strategies that organizations can take to drive towards that goal of safety."

## Leaders drive the culture in healthcare organizations

“One of the biggest messages from our report is really that leaders in organizations drive the culture in organizations,” explains Gandhi, “And we need to create a culture of safety in organizations where safety is a top priority.” For her, some indications of a healthy culture of safety mean creating a workplace environment where both clinicians and patients “feel comfortable” being vocal about any issues or concerns. But beyond being able to speak up, it’s crucial that they “feel that those concerns are being listened to and lead to actual improvements.”

“There are lots of ways for executives to measure this culture,” says Ghandi. In partnership with NPSF, the ACHE’s Patient Safety Self-Assessment allows executives to honestly analyze their current safety measures then prioritize targeted areas of improvement to implement a culture of safety, building from the six fundamental domains outlined in “*Leading a Culture of Safety: A Blueprint for Success.”*

By identifying and developing “interventions,” Ghandi says leaders can then “try to create that culture, but it really has to come from the Board to the C-suites all through the organization. Our expert panel felt that creating this culture change was critical.”

## Safety extends across the care continuum

The patient experience extends beyond an intake center or an imaging lab. It can involve follow-up appointments, outpatient treatment, testing and so on, and Ghandi says healthcare leaders need to be thinking about delivering “safety across the entire care continuum.” She says, “as organizations are now becoming much more widespread and have facilities outside of hospitals, safety needs to be part of the conversation

regardless of the setting.” In order to implement change across the board, having an up-to-date and clear understanding of current safety practices in every setting is a must in order to create a cultural shift in a proud, meaningful way that the patient and clinician can feel regardless of the site.

**Why implementing workforce safety matters too**

“We think workforce safety is actually a pre-condition of patient safety,” Ghandi explains. In working towards zero medical errors, healthcare leaders should not forget the importance of the safety of their own workforce too. This sets the tone, impacts clinicians’ mood, productivity and comfort levels, and has a residual effect on the ability to deliver the best care.

“Executives need to really focus on the safety of their workforce from a physical standpoint and a psychological standpoint,” says Ghandi, who adds that this can include mindfulness of issues like “burnout, stress, disruptive and bullying behavior…as well as the physical harms, workplace violence, etcetera, [they] need to be at the top of the attention of boards and senior leadership.”

## To create a culture of safety, start by engaging patients at all levels

One of the report’s most significant takeaways is the essential need for leadership to value patient’s opinions, needs and concerns, and to engage with and learn from the real “users” of healthcare systems.

Ghandi says this means “really ensuring that patients are truly partners in their care, and having patients and the patient voice throughout the organization.”

This involvement can take different shapes and forms including

most basically, shared decision-making between providers and patients.

“At the organizational level,” Ghandi stresses the significance of “having patients on boards, on quality committees, on quality improvement projects and even on things like root-cause analysis.” Overall, she believes that in order to create a culture of safety, “it’s really critical to have that patient partnership in all activities of your organization.”

*ACHE’s John Buell interviewed Tejal Gandhi, MD, president and CEO, National Patient Safety Foundation, to learn healthcare executives can make organizations a safer place for clinicians to practice and patients to receive care.*