

Accelerating the Adoption of a Safety Culture

by Susan Birk

Although recent strides in improving patient safety in hospitals are a testament to healthcare's capacity for large-scale change, providers continue to face important hurdles. Much of the work that still needs to be done revolves around developing a robust safety culture in hospitals.

"There has been a lot of focus on improvement processes and technology in healthcare, and those are all well and good, but culture is the No. 1 system contributor to safety," says Steve Kreiser, a former U.S. Navy fighter pilot and a senior consultant with Healthcare Performance Improvement, Virginia Beach, Va., which specializes in performance improvement using methods from high-risk industries.

Creation of a high-reliability safety culture "is probably the most challenging work that a healthcare organization has to do," says Ana Pujols McKee, MD, executive vice president and CMO for The Joint Commission. And as with any other fundamental change in healthcare, the hard work of accelerating development of a safety culture begins with senior leadership: "Without concerted and ongoing efforts by senior leaders to exemplify and cultivate that culture, the organization cannot change," McKee says.

To accelerate adoption of a safety culture in hospitals, senior leaders must exemplify and cultivate such a culture in their organizations and then own

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that culture. Research shows that 75 to 80 percent of initiatives requiring behavior change fail because leaders are not engaged and actively involved, according to McKee.

Kreiser likens the effort to his experience flying F/A 18 fighter jets. Navy leaders wouldn't pursue a mission if it couldn't be done safely, he says. "That mindset motivates you to figure out how to fly safely. You do a lot of 'what-iffing' and contingency planning that sets you up for success."

How a Safety Culture Gains Traction

The intense work hospitals and health systems conduct to reduce medical errors and improve patient safety has yielded encouraging results, the most recent national data shows—but there is still much work to be done.

For example, hospital-acquired conditions declined 17 percent from 2010 to 2013, according to a report released by the U.S. Department of Health and Human Services in December 2014. During the three-year period, hospital patients experienced 1.3 million

fewer HACs; the decline in infection rates led to 50,000 fewer HAC-related deaths and an estimated \$12 billion in savings.

However, competing pressures, such as a focus on volume and production or concerns about patient satisfaction, can prevent a safety culture from taking hold—and these pressures can complicate efforts to move toward zero harm, Kreiser says.

When senior leaders, physicians and managers do not "own" the culture of safety in their organizations, staff will begin to view safety as "the flavor of the month," Krieser says—and that leads to complacency. "The question senior leaders should ask is: Are we merely paying lip service to safety, or are we living and supporting it each and every day in word and deed?" he says.

Efforts by senior leaders to drive the adoption of a safety culture should include making safety rounds,

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initiating daily safety huddles, participating in continuous quality improvement meetings, speaking directly with patients and staff members and developing recognition programs for individuals who have performed well, according to The Joint Commission's McKee.

Leaders also should seek to model the work of top-performing high-risk organizations. These organizations put safety first, without fail, whether a task or procedure is being done the first time or the thousandth.

The healthcare industry's recent gains in improving patient safety can be traced in part to the burgeoning use of the strategies and methodologies of high-performing, high-reliability organizations and industries outside of healthcare, including aerospace, nuclear energy and aviation.

Five years ago, The Joint Commission began championing the use of these robust methodologies and providing a forum for best practices and lessons learned through the creation of The Joint Commission Center for Transforming Healthcare. Since then, the center has involved hospitals in collaborative projects using rigorous improvement methods to address hand hygiene, hand-off communications, insulin use, sepsis mortality and several other areas.

"Evidence-based methodologies of performance improvement and change management must be well established

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in an organization that is committing to zero harm,” McKee says.

To make the move toward a patient-safety culture, Kreiser advocates the use of “light touch” mechanisms for peer-to-peer accountability in which co-workers look out for each other—a concept known in aviation as being a good “wingman.” The idea is to approach the person who may be at risk of jeopardizing safety in a non-threatening, respectful way. When this approach does not work, staff should then follow chain-of-command protocols to elevate the concern, Kreiser says.

Both McKee and Kreiser also stress the value of using data to pinpoint opportunities to improve patient safety within the organization. Surveys, such as those offered by the Agency for Healthcare Research and Quality, can help providers identify “safety hot spots” within the organization, as can a common-cause analysis of safety events over a two-year period, broken down into specific individual and system failure modes. In addition, look for themes in the data that is

received, Kreiser says: “You might find you’ve done some great work in the areas of technology or process improvement, but your organization is still experiencing issues related to safety.”

Once the data is reviewed, “It is important to develop local strategies and solutions specific to the areas in question rather than a single improvement strategy for the entire organization,” McKee says.

Setting the Pace for Sustained Improvement

One of the toughest hurdles senior healthcare leaders face in maintaining momentum once a safety culture takes hold is ensuring employees can report and openly discuss safety breaches without fear of subtle or overt retaliation or intimidation, McKee says.

In a 2012 report, *Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems*, the National Association for

Healthcare Quality called on healthcare organizations to prioritize development of an infrastructure for the responsible reporting of safety concerns. But developing a fair and just culture is trickier and more multilayered than many believe, according to McKee.

For example, the NAHQ report states that as attention to the need for a culture of safety in hospitals has increased, “so have concomitant reports of retaliation and intimidation targeting staff who voice concern about safety and quality deficiencies.” Such intimidation can include a host of subtle but pervasive behaviors, such as body language and failure to return phone calls related to safety concerns, McKee says. And, according to the AHRQ’s 2014 Hospital Survey on Patient Safety Culture, only 44 percent of respondents described their organization’s response to an error as nonpunitive.

Individuals who choose to disregard policies and procedures or act recklessly must be held accountable. But individuals must also be allowed to share openly and learn from mistakes in a collaborative environment that enables them to improve. “If you can establish clarity between the two, you will eliminate many errors,” Kreiser says.

Getting There From Here

The following health systems exemplify organizations in which senior

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AnMed Health

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leaders have propelled the adoption of a culture of safety.

Memorial Hermann Health System, Houston. Eight years ago, Memorial Hermann committed to a high-reliability patient safety culture when members of the organization's board of directors—many of whom come from high-reliability industries—decided to make patient safety the 12-hospital system's single core value.

“A patient safety movement cannot gain traction as a grassroots effort,” says M. Michael Shabot, MD, system CMO. “Our board originated the effort, and every one of our board members supports it. We have goals and initiatives in many areas, but patient safety—and, as a corollary, employee safety—governs everything we do.”

Beginning in 2007, the system's entire 20,000-member workforce, including nurses, pharmacists, therapists and staff members in areas such as environmental services and food and nutrition, underwent high-reliability training led by experts from nonhealthcare industries known for safety excellence. Most of Memorial Hermann's 6,000 physicians also have undergone such training.

This expensive and complex undertaking was a good start toward developing a culture of safety at Memorial Hermann, but it was only a start. According to Shabot, health system leaders view the creation of a high-reliability safety culture as a

long-term endeavor. “We're years down the road, but we're not there yet,” he says.

Still, the system's numerous major safety accomplishments during the past eight years demonstrate that the high-reliability ethos has taken hold. These achievements include the elimination of mismatched blood transfusion reactions in more than 1 million units transfused since the creation of a high-reliability system for blood transfusions in 2007. The system essentially precludes failure and exceeds Six Sigma reliability.

In 2011, Memorial Hermann launched the High-Reliability Certified Zero Award to recognize hospitals in its 12-hospital system that have gone a year or more without adverse events in federally defined categories. The results are formally certified in monthly reports to the Centers for Medicare & Medicaid Services. To date, Memorial Hermann hospitals have received 135 Certified Zero awards for superior performance in the prevention of hospital-acquired infections, retained foreign bodies, hospital injuries and many other adverse events and conditions.

Based on its efforts, in 2012, Memorial Hermann became the first health system in Texas to receive the John M. Eisenberg Award for Patient Safety and Quality from the National Quality Forum and The Joint Commission.

The system's safety gains were realized during a period of tremendous growth, Shabot says. “We have more than 500,000 patients going through our emergency departments each year, and yet we routinely meet zero targets for adverse events. We don't do unsafe things just because there is pressure to meet a schedule.”

Safety checklists are used without fail, regardless of the situation. “When a patient needs a blood transfusion, our process—which takes a few extra seconds—ensures that no one gets hurt with a transfusion,” Shabot says. “That's what high-reliability organizations do.”

Memorial Hermann's brand of high reliability also includes data transparency. The system shows outcomes per physician by name within specialties, shares quality and safety data transparently across hospitals and reviews the data in systemwide groups.

The system balances the requirement to deliver safe care and the desire to achieve patient satisfaction with such strategies as routine hourly rounding by nurses. In addition to making sure each patient's basic needs are being met, “We view these visits as a safety check,” Shabot says. “Taking a little extra time to make sure things are being done safely also involves extra time spent with the patient. What patients don't like is waiting in uncertainty. But showering patients with extra attention, which makes them

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happier, also helps to make sure they're safe."

Swedish Health Services, Seattle.

Swedish Health Services, the largest nonprofit provider in Greater Seattle, has designated patient safety as its No. 1 priority. Like Memorial Hermann, the five-hospital system has committed to a cultural transformation grounded in comprehensive high-reliability training for physicians and staff.

The system's accomplishments earned recognition in 2014 in The Joint Commission's Top Performer on Key Quality Measures program for heart failure, pneumonia and surgical care accountability measures. Swedish Health Services was one of 17 providers to earn Top Performer status among the 55 providers in Washington state that report data to The Joint Commission. Since embarking on its safety journey in 2012, the system also has seen its rate of adverse events decrease by more than one-third, according to CEO Anthony A. Armada, FACHE.

Swedish Health Services' high-reliability safety culture takes its inspiration from the concept of shared leadership. Every member of the health system's workforce—from housekeepers and technicians to physicians and nurses—is viewed as a caregiver, with shared responsibility for providing a patient experience that is safe, healing, quiet and clean. Toward this end, like the good

wingman concept described by Healthcare Performance Improvement's Kreiser, everyone is encouraged to work together as a team and support each other at all times.

That spirit of teamwork and supportiveness at Swedish Health Services revolves around the consistent use of a broad range of evidence-based safety techniques, including STAR (Stop, Think, Act, Review), the ISBAR (Introduce self, Situation, Background, Assessment, Recommendation) approach to patient hand-offs, and the ARCC (Ask a question, make a Request, voice a Concern, use Chain of Command) technique to express safety concerns in a nonthreatening way.

Swedish Health Services also employs consistent use of an open and nonpunitive approach to addressing errors known as "Mess up/Fess up," a system involving the electronic reporting of quality variances. The system encourages all caregivers to openly share when they have made a mistake, without fear of repercussion. "When an error occurs, we don't hide behind it," Armada says. "We share it proactively so that we can learn from it, fix something if it needs fixing, and most important, keep it from happening again."

At Swedish Health Services, every staff meeting begins with a safety story—a real-life example from the units of how the various high-reliability safety techniques have been

put into practice, "so that the use of these techniques becomes second nature and we are actually transforming the culture, not just saying that we care about safety," Armada says. "We reflect on these stories in meetings and safety huddles so we can apply what we've learned."

Additionally, leaders at all five campuses round daily to share ideas and keep each other informed about safety-related problems, priorities and new findings. Armada participates in these rounds and talks with patients "to live and breathe the culture and stay grounded in the 'why' and meaningfulness of what we do," he says. "It's a gift to be able to go on those rounds."

Swedish Health Services views patient safety and patient engagement as symbiotic aspects of care, Armada says. The health system is careful to differentiate between patient satisfaction and patient engagement. "If patients are engaged, then they will understand and appreciate that their procedure has been delayed for safety reasons," he says.

The system's work to create a high-reliability safety culture is closely connected with its ongoing efforts to involve patients in their care, Armada says. "We are partners with the patients and families we serve," he says. "The environment and the experience we create are important contributors to the cultural transformation. Our efforts to engage patients in their care

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enhance our efforts to ensure quality and safety.”

AnMed Health, Anderson, S.C.

AnMed Health already had a long history of patient safety accomplishments under its belt when it joined the South Carolina Safe Care Commitment in 2013. Through the collaborative, executives from 20 hospitals in seven systems meet regularly to learn the principles of high reliability, identify the causes of safety problems within their organizations, collaborate on the implementation of targeted, evidence-based solutions, measure results through survey assessments and a Web-based tool, and share lessons learned with each other and other South Carolina providers. The opportunity for high-reliability training through the Safe Care Commitment provided a cohesive platform for safety-related activities already in progress at the health system, says John A. Miller Jr., FACHE, CEO emeritus, and interim executive director, AnMed Health Foundation.

AnMed Health Medical Center is the only star-status

facility in the OSHA Voluntary Protection Program in South Carolina and one of only 13 in the United States. AnMed Health was also recognized by The Joint Commission's Top Performer on Key Quality Measures for 2013 program for its exemplary clinical performance in the areas of heart attack, heart failure, pneumonia and surgical care. The five-hospital system was among 20 providers in South Carolina to earn Top Performer status from the 56 organizations in the state that report data to The Joint Commission.

An initial safety culture survey undertaken by the health system revealed opportunities for improvement in such areas as the reporting of errors. In response, AnMed Health is building a culture of reporting and learning, focusing on the fine-tuning of systems and processes rather than individuals. “Now, if there is a bad outcome, we talk about why it happened,” Miller says. “The goal is not to punish someone but to learn.”

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The system also has implemented new processes for patient handoffs and transitions as a result of participation in the initiative. The safety culture survey identified opportunities for improvement in the exchange of information during transfers and shift changes. These findings led to the development and implementation of bedside shift reports to ensure accurate and thorough communication of patient information during handoffs. Since implementing the strategy across the continuum of care, the system's performance on the “hospital handoffs and transitions” dimension of the safety culture survey has risen from the 50th percentile to the 75th percentile in the survey's comparative database.

Miller views the shift to a high-reliability culture as “a matter of creating an environment that encourages staff to think about the details. A lot of little things can make a big difference.”

“Our position is that patient safety is the foundation of quality care and, from the patient's perspective, one of the key drivers of value,” says William T. Manson III, FACHE, president and CEO, AnMed Health. “As an industry, as we work to improve the patient experience and quality of care and reduce costs, what better way to do this than by moving toward high reliability?”

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