ORGANIZATIONAL ARTICLES

Organizational Leadership

265 Knowing, and Doing: Closing the Gaps in Board Leadership for Improvement of Quality and Safety

J.L. Reinertsen

Although the gap between what boards (and CEOs) know and what they should know is substantial, the gap between what they do and what they should do is even greater.

267 Closing the Gap and Raising the Bar: Assessing Board Competency in Quality and Safety

P.A. McGaffigan, B.D. Ullem, T.K. Gandhi

In a survey on quality and safety practices, knowledge, and understanding, 80% and 84% of health care organization board members and CEOs, respectively, ranked patient safety and/or quality as their “number one” strategic priority. In contrast, a smaller percentage of each group reported that patient safety events or dashboard measures were discussed at all board meetings. Further research and consensus would be beneficial to identify best practices for board education and governance activities to drive quality and safety.

Performance Improvement

275 Using Lean to Rapidly and Sustainably Transform a Behavioral Health Crisis Program: Impact on Throughput and Safety

M.E. Balfour, K. Tanner, P.J. Jurica, D. Llewellyn, R.G. Williamson, C.A. Carson

Lean principles were used to rapidly and sustainably transform clinical operations in a freestanding behavioral health facility providing crisis services and emergency psychiatric care to adults and children. Organizational changes such as the development of shift leads and daily huddles were implemented to sustain change and create an environment supportive of future improvements. Interventions led to significant and sustained decreases in median door-to-door dwell time, security calls for behavioral emergencies, and staff injuries.

284 Introductions During Time-outs: Do Surgical Team Members Know One Another’s Names?


Introductions are the first item of the time-out in the World Health Organization Surgical Safety Checklist (SSC). All operating room (OR) personnel at the three teaching hospitals of a large academic medical center were individually interviewed at the end of 25 surgical cases in which the SSC was used. For example, 147 (98%) of the 150 OR personnel named the surgery attending correctly, while the surgery attending named only 44% of other OR staff ($p < 0.001$). The results suggest that OR personnel may consider introductions to be another bureaucratic hurdle instead of the safety check they were designed to be.

RAPID RESPONSE SYSTEMS

289 Organizational Perspectives of Nurse Executives in 15 Hospitals on the Impact and Effectiveness of Rapid Response Teams

P.L. Smith, J. McSweeney

To help determine how organizations monitor rapid response teams (RRTs), interviews were conducted with 27 nurse executives and key informants at 15 300-to-500-bed hospitals in the southeastern United States. All of the hospitals monitored patient outcomes in the context of the RRT, such as code and mortality rates or patient disposition. They also perceived positive influences of the RRT on the health care team, such as education, relationships, and promotion of a culture of safety, including providing consistency of care and evidence-based care.

ADVERSE EVENTS

299 Root Cause Analysis of Adverse Events in an Outpatient Anticoagulation Management Consortium

C.M. Graves, B. Haymart, E. Kline-Rogers, G.D. Barnes, L.K. Perry, D. Pluhatsch, N. Gearhart, H. Gikas, N. Ryan, B. Kurtz

The Michigan Anticoagulation Quality Improvement Initiative (MAQI²), a consortium of six anticoagulation management services, performs root cause analyses (RCAs) for patients with major bleeds or thromboembolic events. Most (55 [80%]) of the 69 RCA cases were due to patient-related issues, suggesting the need for more effective patient education. Many of the events analyzed in the RCA process led to significant changes in the delivery of care among the consortium members.

COMMENTARY

308 An Organizational Framework to Reduce Professional Burnout and Bring Back Joy in Practice

S.J. Swensen, T. Shanafelt

Reducing professional burnout represents an important opportunity to create value for patients because of its deleterious effects on safety, quality, access and patient experience. To reduce professional burnout and bring back joy in Practice, the authors explain how leaders can take six evidence-based actions, such as Design Organizational Systems to Address Human Needs, Build Social Community, and Bolster Individual Wellness.

INFORMATION FOR AUTHORS