Creating a Culture of Quality and Patient Safety

EXECUTIVE BRIEFING
A Thought Leader Discussion
A Letter from Amerinet’s President and CEO

Faced with a future of new regulations and healthcare reform, it is becoming even more apparent that for healthcare organizations to be truly successful in the future, increased productivity and revenues need to be matched by a measurable level of quality and patient safety.

Amerinet is committed to understanding our customers’ needs relative to their direction regarding quality and patient safety initiatives. Accordingly, we created a 30-question survey and asked our C-suite members to respond. Results from this survey were later discussed during an executive roundtable session with healthcare leaders throughout Amerinet. This report summarizes the findings from both the survey and conversations with our thought leaders on issues related to creating a culture of quality and patient safety.

I would like to thank Dr. Charles W. Sorenson, president and CEO of Intermountain Healthcare, Dr. Maulik S. Joshi, president of Health Research and Educational Trust, and senior vice president, research, of the American Hospital Association, Dr. Jerome J. Roche and the Six Sigma team members at Fairfield Medical Center for helping to lead and contribute to the dialogue at the executive roundtable.

The survey and roundtable discussion is just one example of Amerinet’s quality and patient safety leadership role within the industry. Likewise, we offer Amerinet Quality SolutionsSM to meet the unique needs of all healthcare facilities. Through on-site assessments, contract access, information and education, Amerinet is helping members achieve improvements in clinical outcomes, patient safety, operational quality and regulatory compliance.

In the coming years it will be critical for all healthcare organizations to establish a relationship between being a quality organization and being cost effective and efficient. We thank you for your support as we focus on continued improvements in quality of care delivery and patient safety.

Todd C. Ebert, President and CEO, Amerinet

ROUNDTABLE ATTENDEES

* Edward Andersen, president and CEO, CGH Medical Center
  Tim Barnett, president and CEO, Yavapai Regional Medical Center
* Douglas Black, board of directors, Intermountain Healthcare
* Mark Christopher Coons, CEO and regional vice president, Intermountain Healthcare’s Southwest Region, and CEO, Intermountain Healthcare’s Home Health Services
* Michael J. Farrell, CEO, Somerset Hospital
  Rohitha J. Fike, CEO, Loma Linda University Medical Center
  David H. Freed, president and CEO, Nyack Hospital
  John E. Horns, president of regionalization, ProMedica Health System
  Bradley D. LeBaron, president and CEO, Uintah Basin Healthcare
  Robert Miller, CFO, Coshocton Hospital
  James Moore, CEO, OSF Healthcare System
* Robert Mulcahey, vice president and COO, Stratum Med, Inc.
  Larry A. Mullins, president and CEO, Samaritan Health Services
  Paul Norris, executive director of pharmacy and materials management, Loma Linda University Medical Center
  James Pappas, vice president, quality and patient safety, Loma Linda University Medical Center
  Scott Parker, president emeritus, Intermountain Healthcare
  Theodore Pasinski, president, St. Joseph’s Hospital Health Center
  Mark Peters, president and CEO, East Jefferson General Hospital
  Kevin Schoepfle, executive vice president, OSF Healthcare System
  Mina Ubbing, president and CEO, Fairfield Medical Center
  Gerald R. Winslow, vice president, mission and culture, Loma Linda University Medical Center
  Bert R. Zimmerli, senior vice president and CFO, Intermountain Healthcare

Guest speakers

Maulik S. Joshi, president of Health Research and Educational Trust, and senior vice president, research, of the American Hospital Association

Jerome J. Roche, Jr., chief medical officer, Fairfield Medical Center
Robert J. Rothwell, IV, decision support manager, Fairfield Medical Center
Celesta A. Schmelzer, six sigma black belt, Fairfield Medical Center
Charles W. Sorenson, MD, president and CEO, Intermountain Healthcare

Amerinet attendees

Todd C. Ebert, president and CEO
Holly Hampe, director, quality and patient safety
RU McNaughton, executive vice president, sales
Randall Walter, executive vice president, enterprise solutions

* Member, Amerinet board of directors
Creating a Culture of

QUALITY AND PATIENT SAFETY

The patient safety movement began to accelerate its progress in the United States in 1999 when the Institute of Medicine (IOM) reported that 44,000 to 98,000 individuals die each year from medical errors in hospitals, making it the fifth leading cause of death in the country. IOM researchers discovered that many of the healthcare errors were commonly caused by faulty systems, processes and conditions that lead people to make mistakes or fail to prevent them, and were not directly caused by individuals' errors or recklessness.

According to many researchers and industry experts, the best way to prevent these errors from occurring was to focus on organizational systems and the culture within these systems. More than a decade later, the same solutions still hold true. There is a strong link between culture and results. Great organizations with great cultures produce great results.

Accordingly, more and more healthcare facilities are analyzing corporate culture as a means of increasing safety performance. There are many definitions of culture, but in its simplest form it is the shared beliefs, perceptions and expectations of individuals in an organization. When there is congruence between management’s values and those of the employees, employees feel that they “fit” in the organization and safety performance improves. Safety performance is directly associated with employee morale and commitment.

For safety efforts to be effective, an organization needs to reach a dedicated culture of patient safety. In the end, culture is driven by leadership. Dr. Maulik S. Joshi, president of Health Research and Educational Trust, and senior vice president, research, of the American Hospital Association, states, “Healthcare transformation will occur in organizations whose DNA includes a culture of improvement and leadership’s ability to execute.”

In conjunction with Amerinet’s Executive Roundtable in February 2010, nearly 170 executives at Amerinet member facilities responded to a 30-question, online survey regarding patient safety and quality. From asking respondents who is primarily responsible for the patient safety program within their organization to questions about incentive programs for executing patient safety initiatives, the survey sought to open a discussion of concerns and issues which would lead to sharing best practices in creating a culture of quality and patient safety.

Three common themes emerged from the survey results. In order to execute a culture of improvement and patient safety, healthcare executives and boards of directors need to ensure the following:

**Commitment**
The everyday mission, vision and strategic plan needs to be clear. These elements must include quality and patient safety and be aligned with quality and patient safety initiatives. Patient care and safety must always come first and include all individuals in the organization.

**Transparency**
An organization’s patient and employee safety and satisfaction, quality information and ethics policies all need to be transparent both internally and externally. Through this open sharing, accountability and trust increases, leading to a safer organization.

**Patient Safety Initiatives**
When an organization reengineers for safety (i.e. medication and lab barcoding), the organization is hardwired for successful outcomes. This is accomplished through the development, implementation and evaluation of these patient safety initiatives.
Commitment

To promote a culture of patient safety, the leaders of the organization need to set clear goals and establish the values and practices necessary to keep all employees on target. This commitment is an important foundation at any healthcare facility and realizing that patient safety and quality is an ever-evolving commitment is key.

To be successful, an organization needs to be willing to make changes when it is necessary. Intermountain Healthcare – a nonprofit system of hospitals, surgery centers, doctors, clinics, and homecare and hospice providers that serves the medical needs of Utah and southeastern Idaho – has a 15 year history of clinical process improvement through a focus on being a learning organization.

“As a learning organization, we identify key processes that are the most important to us and measure how we are currently doing,” said Dr. Charles W. Sorenson, president and CEO of Intermountain Healthcare. “We have to be willing to confront the brutal facts that objective data may show us that we are not as good as we thought we were. But you can't get better unless you have established accurate measurement systems and implement a clearly understood plan for process improvement.”

When confronting the stark realities, an organization needs to be consistent in its approach to carefully implement change. It is never easy, but in order to engage clinicians the primary objective needs to be quality and patient outcomes. Working together as a team and being genuinely receptive to physician and staff ideas is critical. If that commitment is there and realized by the entire organization, then overcoming obstacles, even including the difficult task of finding savings in the purchasing of physician-sensitive supplies, can be achieved.

“We created five physician committees to look objectively at the evidence and how much we were paying for different orthopedic implants from different vendors,” said Sorenson. “We provided the physicians with objective comparison data and asked them to help us work with vendors to provide devices that would be competitively priced. Five years ago I never would have predicted that independent surgeons would come together, objectively evaluate the evidence and agree we needed to work together to reduce costs. But the physicians recognized that Intermountain's primary objective is to provide excellent outcomes for our patients and that we have a responsibility of working together to make healthcare more affordable for the communities we serve.”
With respondents representing acute and alternate care
Amerinet member facilities, 49 percent indicated the C-suite
is fully committed to patient safety while only 10 percent
indicated it was not fully committed (Graph A). A total of
41 percent did not respond to the question. Because nearly
half did not respond, it is difficult to gauge some organizations’
level of commitment. The results from this question
certainly reveal there is a need to further educate healthcare
executives on the value of being committed to patient safety
and quality.

Building the foundation of commitment starts with leaders
preparing themselves and earning trust with physicians
and staff by emphasizing quality at all company meetings,
having incentives for quality improvement and holding
management accountable for helping to implement change.
“Aligning your major quality goals, strategies and projects is
essential to your organization’s performance,” said Joshi.

As shown in Graph B, respondents indicated 67 percent of
the medical staff was fully committed to quality and patient
safety. Nine percent was not committed and 24 percent
did not respond. While results reveal a little over half of
the medical staff is fully committed, there is still room for
improvement.

If the medical staff is not on board and not committed, then
the organizational culture cannot advance. Everyone within
the organization needs to share the perception of safety and
how it results in positive patient outcomes.

**Amerinet QualityScore**

Amerinet is committed to assisting members in the development of an infrastructure
that fosters patient safety. Amerinet QualityScore™ is a customized on-site quality
assessment that will help healthcare executives reaffirm their commitment to quality
and patient safety.

Focused on areas including document review, policy and procedure review, and
patient safety and quality assessment in clinical areas, Amerinet QualityScore
helps all areas of the organization — administration, medical staff, patient safety,
quality, risk management and materials management professionals — to establish
the relationship between quality and cost efficiency. Facilities are provided with a
customized on-site quality report and regulatory compliance assessment report, as
well as an action plan identifying opportunities for improvement.
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Commitment

What initiatives have helped to enhance the level of commitment to quality and patient safety within your organization?

Mina Ubbing: “Our board of directors and senior leadership all read the book, ‘Why Hospitals Should Fly?’ by John Nance to kick start the patient safety program. We are also involved in our state hospital association. Last November, the association had a meeting involving CEOs, CMOs and board members to focus on the ‘big dots’ of quality. We are moving away from rates and focusing on the patients. One sentinel event is too many, so our scorecard has changed to reflect this. And we’ve developed a harm index that involves infections, falls, unexpected mortality and serious medication errors.”

David H. Freed: “Safety is the first of Nyack Hospital’s five values. Our value states, ‘Safety means doing no harm to any person or property under our care. Safety is the absolute highest priority at Nyack Hospital.’ In this context, three select initiatives have especially raised the level of commitment and transparency surrounding quality and patient safety.

“First, the board of trustees, medical staff and hospital leaders are active and visible participants in Nyack Hospital’s Performance Improvement Committee, a board committee which routinely reports its results at every level of the organization. Second, we conduct ‘Safety and Quality Fridays’ which are weekly, three-hour sessions involving all managers in topical education about a select Joint Commission standard followed by tracers throughout defined patient care areas of the hospital. Third, Nyack Hospital conducts root cause analyses of troublesome incidents and shares the results with the board of trustees, medical staff and hospital leadership.”

Tim Barnett: “Yavapai Regional Medical Center (YRMC) has sent two groups of department directors to the Intermountain Institute Mini-Advanced Training Program in Health Care Delivery Improvement. We have been able to utilize the understanding and tools provided in this outstanding program to conduct clinical quality improvement projects at our Medical Center. These leaders are now assisting others in our organization in a train-the-trainer model to grasp the FOCUS-PDCA (Find, Organize, Clarify, Understand, Select – Plan Do Check Act) methodology and statistical process control techniques. We have completed a process improvement project to improve patient understanding and compliance with discharge instructions for congestive heart failure (CHF), and another to decrease the time from receipt of an order for discharge to room availability.

“We plan to use the experience we have gained from this program to apply the process to other patient safety initiatives supported by the Institute for Health Care Improvement (IHI). Our first two projects will be to reduce catheter-associated urinary tract infections (CA-UTIs) and to decrease the incidence of central venous catheter bloodstream infections (CVC-BSIs).”

John E. Horns: “The goals of the hospital and the goals of the medical staff are both tied to patient safety and quality. Compensation is dependent upon the patient safety goals – if someone does well and exceeds the goals, they should be rewarded/compensated. Fortunately, the majority of the physicians at ProMedica are employed by the health system so we have great compliance with this group and great adherence to core measures and low defect rates.”
Another key element for the infrastructure and culture of an organization is transparency. If staff members do not feel they can communicate with management on patient safety then executive leadership should recognize this as a red flag. Internal transparency, or open book management, has shown to improve employee satisfaction, reduce turnover and improve performance.

The Agency for Healthcare Research and Quality (AHRQ) developed the “Hospital Survey on Patient Safety Culture,” which is used by thousands of hospitals nationally to measure the culture of safety in their organizations and to identify opportunities for improvement. AHRQ has a database in which more than 600 hospitals submitted data from almost 200,000 hospital staff respondents. An interesting finding from the national data is that administration/management positions tend to have the highest positive scores compared to their counterparts in the same organizations – and on the same questions. When asked whether “staff feel free to question the decisions or actions of those with more authority,” 68 percent of administration agreed, while only 45 percent of nurses agreed, and 41 percent of patient care assistants agreed. For the question, “Mistakes have led to positive changes,” 80 percent of management/administration positively agreed, while 68 percent of physicians/NPs/PAs agreed and 62 percent of unit clerks/secretaries agreed. Therefore, although there is a lot of discussion and education about culture and Just Cultures – those that report, learn, inform are flexible and create an atmosphere of trust, encouraging and rewarding – this survey reveals that the healthcare industry still is not quite there yet in terms of alignment between staff.

Along with the need for internal transparency, it is equally important for an organization to have external transparency. “Although transparency is only slowly getting to engaging consumers, we do know it dramatically impacts provider improvement,” said Joshi. When hospital report cards are disclosed to the public, it provides another perspective for healthcare organizations to address issues of healthcare quality. And it begins to enable consumers to make informed decisions.

In Joshi’s book, “Healthcare Transformation: A Guide for the Hospital Board Member,” written with Bernard J. Horak, he lists transparency as one of his top ten healthcare transformers. Joshi and Horak encourage healthcare leadership to embrace transparency and place data on patient satisfaction and quality outcomes on their organizations’ public websites.

Several organizations are providing data regarding the performance of hospitals such as Thomson Reuters, HealthGrades, Leapfrog Group, The Joint Commission (TJC), UCompare and Consumer Reports Health. Healthcare providers should use this data both internally and externally to clearly communicate their objective of improving patient health and safety. This is an opportunity to further promote the organization’s commitment and progress on achieving quality goals.

Amerinet survey participants were asked, “How transparent is the communication within your organization?” As shown in Graph C, results revealed that 27 percent of the organizations were very transparent, 39 percent had evolving transparency and 9 percent had minimal transparency. A total of 24 percent did not respond to the question, which could infer the organization does not have transparency or the organization does not understand the meaning of transparency.

About 31 percent of survey participants are required to publicly report patient occurrences and incidents (Graph D). In many states, public reporting has been a government requirement for some time. A total of 39 percent are not required to report and 5 percent are not required, but choose to report.

Healthcare organizations in the state of Pennsylvania have been required to report on patient safety since the enactment of the Medical Care Availability Reduction of Error (MCare) Act in 2002. In the beginning, it was believed that medical malpractice would increase, but the opposite actually occurred. Pennsylvania has seen less medical malpractice cases because organizations were being forthright with patients.

Amerinet QualityTouch
To help healthcare executives find resources that will support their efforts to be more transparent, Amerinet QualityTouch℠, a section of the Amerinet Member Resources website, offers CMS Never Events and Hospital Acquired Conditions (HAC) toolkits, a monthly newsletter, educational information and much more.

Amerinet QualityShare
Amerinet organized the formation of regional collaboratives to provide a forum for learning, sharing knowledge and building consensus. Participants in QualityShare – nursing executives, patient safety officers, quality/risk management, infection prevention practitioners and wound ostomy continence nurses – improve quality and patient safety at their healthcare facilities by sharing experiences and resources.
What measures have you implemented to increase the level of transparency within your organization in order to move to a more dedicated patient safety culture?

Mina Ubbing: “Fairfield Medical Center improves awareness of near misses through the ‘Good Catch’ program, implemented in November 2009. Our staff is encouraged to report any near misses. These near misses include equipment not programmed correctly, problems with egress or life safety issues or problems with fall alarms. By publicly recognizing the staff through meetings and newsletters, we have seen an increase in reporting of these good catches. This helps to raise staff awareness and let them know it is okay to report.

“In addition, there is a contest on the nursing units regarding falls. A traveling football helmet for each nursing unit tracks the number of days since the last patient fall. Then a debriefing is done after the football season and the nursing unit with the least number of falls is declared the winner.”

Michael Farrell: “I believe our most important initiative at Somerset Hospital was developing a culture of quality and patient safety as our highest priority. Some of the steps were simple, but important and proved successful. For example, our chief operating officer presents the quality and patient safety report from the Quality Committee and the Patient Safety Committee as the first agenda item at every board of directors meeting. The Quality Committee is chaired by our director of emergency medicine and a board member. As the chief executive officer, I chair the Patient Safety Committee.

“Each committee is dedicated to not just hearing reports on such things as patient falls and medical errors, but to initiate corrective action. We recommend to the fiscal department the purchase of equipment to improve patient safety. We have initiated the wearing of red slippers by patients at risk for falls allowing all hospital personnel to be aware of and to assist the patient. And our organization developed a procedure and process to meet with the family and report any adverse patient event. Utilizing the information from The Sorry Works! Coalition, we believe that disclosure and apologies enhance transparency with patients and families. In summary, it is imperative to develop the culture and continue to build on the culture in every way possible.”

David H. Freed: “Nyack Hospital recently installed risk management software that is accessible from any computer and enables simple, real-time reporting of safety, quality or customer service issues. This enables our organization to not only respond right away, but also benchmark improvement progress over time.

“In addition, senior management routinely invites former patients who experienced a safety or quality issue to discuss it in person in order to ascertain areas of concern and ways to improve the care going forward.”

John E. Horns: “ProMedica developed its own reporting format, superimposing the core measures from all the hospitals to compare results on a quarterly basis. Our board of directors is very heavily involved in the quality initiatives. As a health system, we focus on mistakes and errors in the OR and we’re preparing to meet the government’s reform initiatives such as readmissions.”

Mark Christopher Coons: “First, you need to be specific about what you mean by transparency and who will be the end user. This involves working with the board of directors to define what transparency means to them and the communities they represent. Our system chief nursing officer, chief medical officer and chief financial officer work closely with the board, so we can try to link together timely, accurate measures with quality, service and finances. Our organization has a balanced score card – including both clinical and financial measures with specific system board goals in areas of clinical excellence, service excellence and operational efficiency/effectiveness.”
Patient Safety Initiatives

Many facilities are vulnerable to poor care and quality service simply as a result of the increasing number of complexities in our healthcare system. However, when the Centers for Medicare & Medicaid Services (CMS) ruled that it was not going to pay for certain conditions, never events or hospital-acquired conditions (HACs), the leadership teams at many organizations started to pay attention to quality. They realized that since this was something that was going to affect them financially, patient safety initiatives needed to be made a priority and implemented.

At the Executive Roundtable, Dr. Joshi spoke about implementing the basics to achieve improvements – making sure pneumonia patients are given the most appropriate antibiotic, heart failure patients are given discharge instructions, the care of pressure ulcers and open access scheduling. “It’s amazing that we have the evidence and know how to do it, yet we’re just not executing it all the way,” said Joshi.

Facilities need to be hardwired for consistency in their processes and leadership should continually review the nationally emerging best practices and consider implementation at their facility. Keep in mind there is not a one size fits all solution. Processes and best practices cannot be adopted blindly. Organizations need to apply evidence-based practices and make the initiative their own. “If healthcare leaders can solidify some of these initiatives of execution and establishing processes, it starts changing the culture in terms of patient-oriented, family-activated commitment, and really drives an organization toward a safety culture,” said Joshi.

There are several common practices within organizations that have successfully improved quality of care:

**Present-on-admission conditions.** Any diagnosis present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter – including emergency department, observation or outpatient surgery – are considered present-on-admission. Documenting a patient for pressure ulcers or bed sores or any other ailments before being brought under the facility’s care is an easy patient safety initiative to implement at any facility.

**Electronic medical record (EMR).** The struggle in achieving EMR is the fact that many organizations have hybrids of different medical records that all need to be pulled together and put into place. Although it might not be a perfect system, the presence of a system can help providers deliver better care and help patients and families be more involved in the management of their own care.

**Staff cell phones.** Not only do cell phones improve transparency, but they create a link of communication between physicians, nurses and other hospital staff to ensure important information transfers among staff, settings or providers.

**Barcode technology.** While finding the right application is a component of success, many facilities struggle with implementation and integration. Leadership must realize that barcode technology needs to be implemented now. Purposeful design, patience and backing from executive management can make this initiative a success.
When asked about their organization-wide patient safety efforts, documentation regarding present-on-admission conditions, electronic medical records and staff cell phones were the most widely adopted initiatives (Graph E). This was followed by patient safety dashboard, medical staff practice profile and smart IV pumps.

Barcoded methodology for lab work and medications fell to the bottom, according to survey results. Electronics and interfaces have definitely caused a concern in implementing barcode technology. There is one system used for lab and another used for pharmacy. For this reason, it can become difficult for an organization to understand and implement different measures.

**Amerinet Quality Solutions**

To emphasize the importance of our members being committed to patient safety and quality, Amerinet developed Amerinet Quality Solutions™ to meet the unique needs of all healthcare facilities, acute and alternate care sites alike. From healthcare leadership and facility administrators to patient safety officers and nursing professionals, Amerinet Quality Solutions offers the tools necessary to implement quality and safety initiatives and establish a relationship between being a quality organization and being cost efficient. Amerinet Quality Solutions focuses on nine pillars of quality:

1. Patient Safety Infrastructure
2. Clinical Challenges
3. Clinical/Benchmarking Guidelines
4. Regulatory Compliance
5. Quality Improvement Tools
6. Safety/Environmental Issues
7. Legislative Issues
8. Key Industry Issues
9. Education/Toolkits

Toolkits regarding CMS Never Events/HACs, regulatory readiness and education are available to provide members with all available information regarding each topic including contracts, policies, procedures and protocols. These toolkits help to foster transparency between members, suppliers and Amerinet.
What role should Amerinet take to enhance or encourage its membership to embrace and implement available patient safety initiatives (i.e. Barcoded methodology for lab and medications)?

David H. Freed: “Amerinet should continue to be an essential information resource for patient safety and quality initiatives. Certainly it is impossible to catalogue all the initiatives that translate in either theory or practice to improved safety and quality. However, Amerinet can continue to facilitate information sharing, benchmarking and ready access to the equipment and supply systems that support safety and quality improvement efforts.”

Mark Christopher Coons: “Amerinet can provide leverage, expertise and networking. It’s important for Amerinet to maintain the working relationship with medical device suppliers to make healthcare a safer environment.”

Michael Farrell: “Amerinet should team with The Sorry Works! Coalition in some manner that would aid Amerinet, SorryWorks and our members.”

Mina Ubbing: “Share best practices and benchmarking.”

CONCLUSION

Significant advancement has been made in healthcare regarding patient safety, but much remains to be accomplished. The benefits of an organization committing to a culture of patient safety and quality will be instrumental in the next few years of healthcare reform. Healthcare organizations must set clear goals, have aligned strategic and operating plans, and consistently communicate this commitment throughout the organization. Being transparent by sharing the facilities’ quality and patient safety with internal and external stakeholders is an enabler for creating a culture focused on improvement and accountability. Finally, facilities must follow-up on the data by implementing patient safety initiatives that lead to positive quality and financial outcomes.

The healthcare industry needs to have pathways, protocols and accurate measurement systems – and be willing to make changes when necessary – to achieve a collective vision of patient safety. “An organizational culture of performance excellence and accountability for results, along with a focus on leadership execution are the keys to achieving high performance,” said Joshi.
A Best Practice

The following is a synopsis of a presentation by Fairfield Medical Center titled “A Journey to a Culture of Quality and Patient Safety.”

Assessment

In 2009, Fairfield Medical Center – a 222-bed, nonprofit hospital located in Lancaster, Ohio – focused its efforts on improving the culture of safety within the organization. In examining where Fairfield Medical was headed, leaders researched the success of other industries. It is an unfortunate fact that healthcare is a decade or more behind other high-risk industries, such as commercial aviation or nuclear power generation, in its attention to ensuring basic safety. In Wyke and Sutcliffe’s book titled “Managing the Unexpected,” they found five key characteristics of HROs (High Reliable Organizations):

Sensitivity to operations. Manuals and policies constantly change, but HROs work quickly to identify anomalies or problems in their systems to eliminate potential errors. Maintaining “situational awareness” is important for staff at all levels because it is the only way anomalies, potential errors and actual errors can be quickly identified and addressed.

Preoccupation with failure. HROs are focused on predicting and eliminating catastrophes rather than reacting to them. A preoccupation with failure means “near misses” are viewed as opportunities to improve current systems by examining strengths, determining weaknesses and devoting resources to improve and address them.

Reluctance to simplify interpretations. HROs refuse to simplify or ignore explanations for difficulties and problems they face. Instead, these organizations accept that their work is complex and do not accept simplistic solutions for challenges confronting complex and adaptive systems. All staff members are encouraged to recognize the range of things that might go wrong and not assume that failures and potential failures are the result of a single, simple cause.

Deference to expertise. HROs cultivate a culture in which team members and organizational leaders defer to the person with the most knowledge relevant to the issue they are confronting – realizing the most experienced person or the highest person on the organizational hierarchy does not necessarily have the information most critical to responding to a crisis. A high-reliability culture requires staff at every level to be comfortable sharing information and concerns with others.

Resilience. HROs pay close attention to their ability to quickly contain errors and improvise when difficulties occur. An HRO assumes that despite considerable safeguards, the system may fail in unanticipated ways. They plan for these failures by training staff to perform quick situational assessments, working effectively as a team that defers to expertise and practicing responses to system failures.
A Best Practice

What many healthcare executives may not realize is that a safe culture is not only the group or organizational values, attitudes and perceptions, but it is also at the individual level. Disruptive behavior undermines the culture of safety. This behavior can cause adverse patient outcomes and increased healthcare costs – both to the patient and the organization.

Understanding that safety and quality thrive in an environment that promotes teamwork and respect, Fairfield Medical Center realized this journey required creating new behaviors within the organization. Building a quality and patient safety culture does take a lot of time, effort, resilience and dedication on the part of the administration and the board of trustees in the organization. The leaders at Fairfield Medical Center accepted the responsibility for not only creating this new culture, but maintaining the culture within the organization.

Below is a list of five attributes of a safety culture that Fairfield Medical Center aspired to achieve:

- **Informed culture.** An informed culture involves transparency and the sharing of information across all areas and levels of the organization.

- **Reporting culture.** A reporting culture is one in which everyone in the organization, from those at the bedside to those in the board room, all need to value the importance of reporting safety concerns.

- **Flexible culture.** A flexible culture is where everyone in the organization understands the value of change. There needs to be an openness to change to help prevent and decrease errors.

- **Learning culture.** A learning culture has to do with learning about errors and working to improve processes, and the importance of everyone – the organization and the individual.

- **Just Culture.** The key component of a Just Culture is personal accountability. It has to do with each individual accepting their own personal responsibility to understand what at-risk behaviors are.

**Measurement**

Fairfield Medical Center utilized the Agency for Healthcare Research and Quality (AHRQ) hospital survey on patient safety culture to help measure its progress. Executives selected this survey for its emphasis on patient safety issues, medical errors and event reporting. Plus, the survey enabled the organization to submit its data not only to AHRQ, but to compare its data with other organizations, as well as trend the data over time.

**Action**

The AHRQ survey revealed positive results in the area of teamwork within departments for Fairfield Medical Center. However, there were five areas identified as needing improvement – communication openness, frequency of events reports, teamwork across hospital departments, non-punitive response to error, and hospital handoffs and transitions.

With these five areas now identified, Fairfield Medical Center developed key projects to change the results.

**Event reporting.** Needing to improve communication openness, frequency of reporting events and non-punitive response to error, Fairfield Medical Center planned an awareness campaign to educate staff on the importance of reporting near-misses. The facility also improved its process to make it easier to report incidents. These simple actions helped to dispel the assumption that it was not okay to report errors.

**Multi-disciplinary teams.** Bringing departments together can be a challenge. One major change to encourage teamwork across hospital departments was the creation of multi-disciplinary case reviews. Scheduled twice a month and organized by the chief medical officer and safety office at Fairfield Medical Center, the case reviews joined people from across all areas of the facility – dietary, respiratory, facility maintenance, environmental services, etc. – to examine unexpected events. These multi-disciplinary team meetings present Fairfield Medical Center with an opportunity to improve current systems by examining strengths, determining weaknesses and devoting resources to improve and address them.

**Hand-offs and transitions.** A fundamental change that needed to occur at Fairfield Medical Center was to review and update the transfer process of patients across departments. The organization created a pilot project to analyze its system, identify areas for improvement and standardize a new system. It was discovered that Fairfield Medical Center utilized more than 30 forms across departments for hand-offs and transitions of patients. By collaborating and identifying the important things that each department needed to know about a patient, Fairfield Medical Center was able to use just three forms.

**Technology.** When proper care is not given, oftentimes it is because rules are not being followed. In order to achieve a culture of patient safety, Fairfield Medical Center needed the ability to get real-time feedback on the core measures of a patient. The organization built a technology system to deal with the inter-relatedness of all variables of executing patient care. Then, by providing physicians and staff with a mobile device to access this system, it enabled getting the right information to the right people at the right time so that staff can make the decisions that they need.

**Conclusion**

Research shows it take about 20 years for an organization to develop culture. In its ongoing commitment to achieve a patient safety culture, Fairfield Medical Center is building a foundation of mutual trust throughout all levels of the organization. Change does not happen overnight, but continually adopting new ideas and processes, then testing them to see what works and what does not work, is helping Fairfield Medical Center become successful.

