Digging into the National Action Plan to Advance Patient Safety

Amanda Cackler, DNP, RN, CIC, CPHQ
Senior Director Quality & Safety
The University of Kansas Health System

Session Objectives

1. LIST AT LEAST 3 OF THE 17 RECOMMENDATIONS TO ADVANCE PATIENT SAFETY
2. UNDERSTAND THE LINK BETWEEN THE NATIONAL ACTION PLAN AND NEW CMS PATIENT SAFETY STRUCTURE STANDARDS
3. IDENTIFY 3 RESOURCES FOR IMPLEMENTING THE RECOMMENDED ACTION PLAN TO IMPROVE PATIENT SAFETY AT YOUR HOSPITAL

The Complexity of Healthcare Systems

People: This includes healthcare professionals with diverse knowledge, skills, and responsibilities. Each person, from nurses to pharmacists, is essential to the system's functionality.

Physical Environment: The spaces where care is delivered—such as patient rooms, operating theaters, and laboratories—must be designed for efficiency and safety.

Organization: This includes the mission, vision, policies, and management structure of healthcare facilities, which directly influence how care is provided.

Tools and Technologies: The equipment and technology used in healthcare—infusion pumps, MRI machines, and electronic health records—must be user-friendly and effective to support patient care.

Tasks and Processes: The millions of daily tasks performed, from administering medication to cleaning patient rooms, are the backbone of healthcare operations.

Acknowledging Numerous Risks in Healthcare

- *As long as healthcare involves humans, there will be mistakes.*

- *However, error-likely situations are predictable, manageable, and preventable if we focus on why mistakes happen and apply lessons learned to prevent them from happening again*

Figure 5: Sample Risk List

Hazard	• Natural Disaster • Failure to Plan • Failure to Act Timely	• Inability to Manage a Crisis • No Backup Systems or Appropriate Duplicate systems
Technology	• Multiple Vendors • Social Networking • Information Breach • Bar Coding • Hybrid EMR	• IT Infrastructure & Security • Paucity of IT Professionals • Failure to Act in a Timely Manner • Incompatible Programs
Legal & Compliance	• Conflicts of Interest • Fraud, Theft and Embezzlement • Governance, Compliance and Oversight	• ACO • HIPAA Privacy & Security • Health Reform • Employment Practices
Financial	• Credit/Collections • Financial Performance • Billing Accuracy/Compliance • Payer Mix/Reimbursements • Pension/Retirement Obligations • Philanthropy/Fundraising /Capital	Campaign • Failure to Meet Margin • Uncompensated Care • Access to Capital • Contract Management • Revenue Enhancement
Human Capital	• Hiring & Retention • Organizational Structure, Alignment & Direction • Succession Planning • Unionization •Turnover	• Recruitment • Aging Workforce • Disruptive Behavior • Flex Staffing •Workers' Compensation • Physician Shortage
Operational	• Business Management Discipline/ Cost Management • Equipment Maintenance	• Facility Maintenance •Timely Access to Care
Strategic/External	• Competition • Affiliation, Mergers & Acquisitions •Variability in Patient-Related Volume • Research Grant/Funding Availability • Diminished Market	• Regulatory Change /Healthcare Reform • Conflict of Interest • Decreased Capital Spending • Hospital/ Physician Relationship • Availability of Public Data (HAI/HAC)
Clinical/Patient Safety	• New Models for Care Delivery • Failure to Refer • Failure to Diagnosis • Clinical Continuity	• Insufficient Discharge Planning • Inconsistent Clinical Competency • Failure to Identify & Follow Evidence Based Medicine

Patient Safety Today

Between 2010 – 2019 rates of adverse events for heart failure, pneumonia, and major surgical procedures significantly decreased (JAMA, 2022)

Since 2020, and the COVID-19 pandemic, healthcare-acquired infections, falls, and pressure ulcers **increased** (AHRQ, 2023)

Performance on a range of other key safety metrics from 2019 – 2021 also showed **significant worsening** (CMS, 2024)

When a patient is admitted to hospital, **harm occurs 24% of the time;** more than 40% determined to be preventable (HHS, 2018)

“Now more than ever, we must all work together to create the safest health care possible. Health care organizations are in different places on their respective paths, but we all have further to go and more to learn and share”

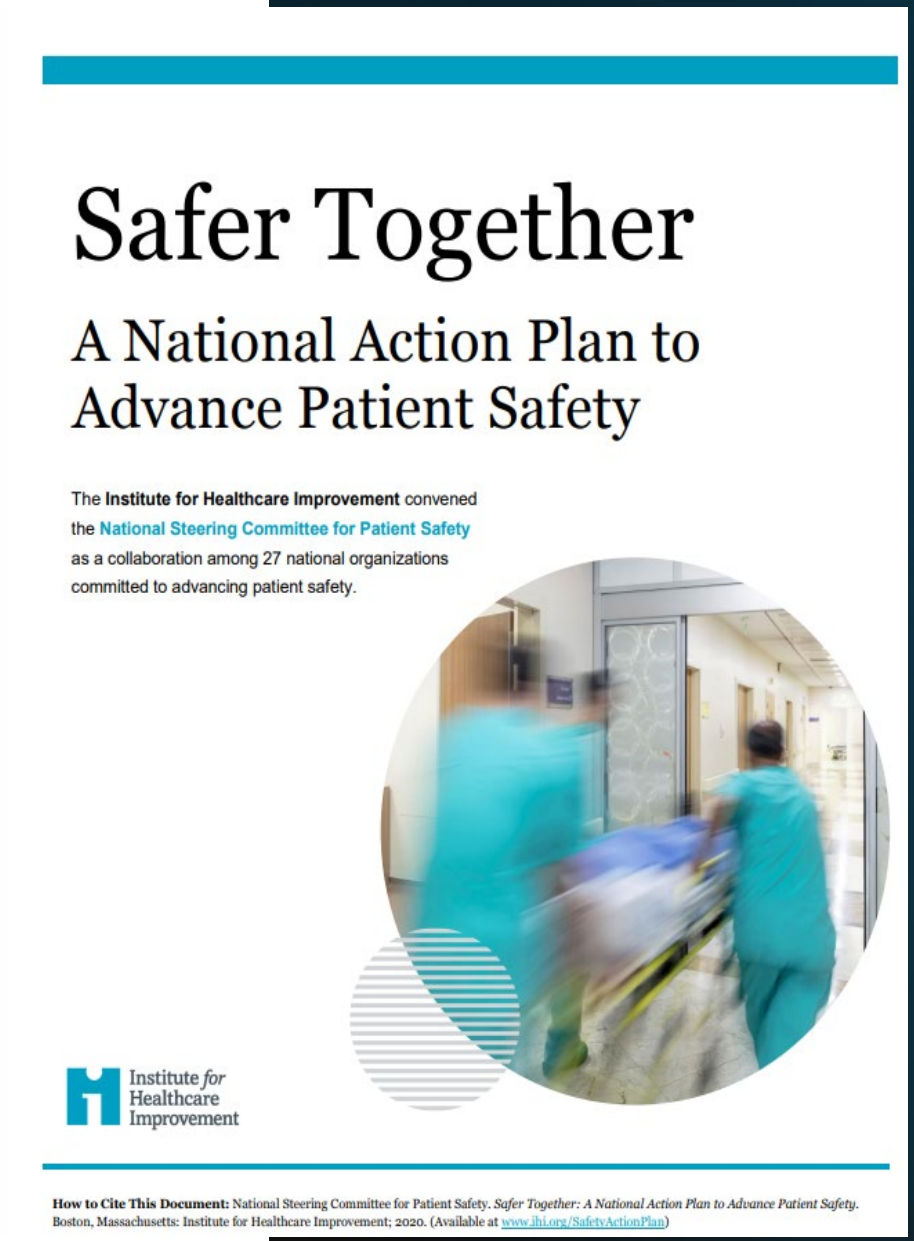
National Steering Committee for Patient Safety

Safer Together

- IHI published in 2020
- 17 recommendations, 4 foundational areas

Culture, Leadership, and Governance	Patient and Family Engagement
Workforce Safety	Learning System

- Serves as the foundation for the CMS Patient Safety Structural Measures – October 1, 2024



CMS Patient Safety Structural Measures

Attestation-based measures that assess whether hospitals demonstrate having a structure and culture that prioritizes patient safety

25 Statements Across Five Domains
Informed by Safer Together: The National Action Plan to Advance Patient Safety:

1. Leadership commitment to eliminating preventable harm
2. Strategic planning and organizational policy
3. Culture of safety and learning health system
4. Accountability and transparency
5. Patient and Family Engagement

Attestation Timelines:

- Attestation reflects activities completed January – December 2025
- Attestation is due May 2026
- Hospitals will not be penalized for low scores, but Medicare payments will be reduced starting on Oct. 1, 2027, for hospitals that do not submit their data

Because the measure looks at structure and policy (not outcomes), compliance is entirely under the organization's control.

The measure applies to hospitals that participate in CMS's Hospital Inpatient Quality Reporting Program and the PPS-Exempt Cancer Hospital Quality Reporting Program.

Children's hospitals, inpatient psychiatric hospitals, long-term care hospitals, and rehabilitation hospitals are excluded.

CMS will publicly report each hospital's overall score (0-5) annually on its consumer-friendly Care Compare website and its Provider Data Catalog.

Culture, Leadership, & Governance

National Action Plan to Advance Patient Safety Domain Recommendations

1. Ensure safety is demonstrated as a core value
2. Assess capabilities and commit resources to advance safety
3. Widely share information about safety to promote transparency
4. Implement competency-based governance & leadership

https://www.ihi.org/national-action-plan-advance-patient-safety

Culture, Leadership, & Governance

Example Tactics, Implementation Resource Guide

Implement Just Culture	Ensure policies, procedures, and performance evaluations support a culture of safety	Ensure physical and psychological safety of the workforce	Dedicate the necessary resources to develop quality and safety data analytics	Allocate resources to translate data into practice improvements
Allocate time in leadership meetings and board meetings to address quality and safety	Share patient and family experiences with staff, leaders, and board members	Align leaders' performance reviews and compensation with safety goals	Prioritize safety in strategic, financial, and operational plans	Participate in learning networks to encourage internal and shared learning
	Commit to sharing key safety information internally & externally	Assess board members and senior leader competencies in safety, equity, and data literacy.	Require board member competency in safety and completion of a minimal annual assessment	

https://www.ihi.org/national-action-plan-advance-patient-safety

Patient & Family Engagement

National Action Plan to Advance Patient Safety Domain Recommendations

5. Establish competencies for all health care professionals for the engagement of patients, families, and care partners.

6. Engage patients, families, and care partners in the co-production of care.

7. Include patients, families, and care partners in leadership, governance, and safety and improvement efforts.

8. Ensure equitable engagement for all patients, families, and care partners.

9. Promote a culture of trust and respect for patients, families, and care partners.

https://www.ihi.org/national-action-plan-advance-patient-safety

Patient & Family Engagement

Example Tactics, Implementation Resource Guide

Create competencies for health care professionals for the engagement of all patients, families, and care partners

Ensure that patient/family educational materials use plain language and are designed and validated for varying literacy levels and languages

Launch a public education campaign to advise the public about what they can do to improve safety and reduce the risk of harm in their care

Seek to understand and address patient priorities by asking, “What matters to you?”

Recognize patients, families, and care partners as full partners on the health care team

Ensure that patient and family perspectives and experience data are systematically included in board discussions and planning work

Engage patients and families on health care organization governing boards, Patient and Family Advisory Councils, and quality and safety committees

Analyze safety data to identify and address gaps related to the social determinants of health

Apply practices of equity and trauma-informed care that are contextually appropriate for the unique needs of patients and families

Transparently provide information related to the organization’s safety and quality performance with patients and families during the informed consent process

https://www.ihi.org/national-action-plan-advance-patient-safety

Workforce Safety

National Action Plan to Advance Patient Safety Domain Recommendations

10. Implement a systems approach to workforce safety.

11. Assume accountability for physical and psychological safety and a healthy work environment that fosters the joy of the health care workforce.

12. Develop, resource, and execute on priority programs that equitably foster workforce safety

Workforce Safety

Example Tactics, Implementation Resource Guide

Educate leaders and governance bodies about the impact of workforce harm

Develop a workforce safety strategy that aligns with the organizational mission, patient safety goals, responsiveness to workforce safety data, and resource allocation

Systematically assess the hazard risks of all job tasks (ergonomic, chemical, infectious pathogens, assaults, slippery surfaces)

Establish systems to identify, assess, and mitigate hazards, including modified shift schedules, fatigue management, staffing levels, and human factors.

Adopt healthy work environment standards to promote physical and psychological safety as well as joy in work

Ensure that communication and accountability about the workforce safety plan, process and outcomes measures, is transparent across the entire organization

Role model and practice safety with huddles, rewards and recognition, storytelling, and rounding.

Support workplace safety through zero tolerance expectations and clear shared values (e.g., joy, respect, trust

Promote worksite wellness behaviors through established programs.

Establish processes for reporting and assessing workforce safety hazards and the overall impact on staff retention, satisfaction, and engagement

https://www.ihi.org/national-action-plan-advance-patient-safety

Learning System

National Action Plan to Advance Patient Safety Domain Recommendations

13. Facilitate both intra- and inter-organizational learning.

14. Accelerate the development of the best possible safety learning networks.

15. Initiate and develop systems to facilitate interprofessional education and training on safety.

16. Develop shared goals for safety across the continuum of care.

17. Expedite industry-wide coordination, collaboration, and cooperation on safety

Learning System

Example Tactics, Implementation Resource Guide

Ensure the elimination of risk and harm and sustained levels of safety over time are ultimate strategic goals of the learning system

Develop and implement processes to systematically learn from safety events, including input from patients, families, and health care professionals

Integrate lessons learned into the process of setting goals and priorities for interventions to improve patient safety

Develop systems to engage all staff in continuous learning and use of data

Use a systematic and systems-based approach to process improvement

Solicit feedback from patients, families, including people in higher risk communities and underserved populations, about what works and what needs improvement

Work to align incentives (e.g., payment, regulatory, recognition) to enable participation in learning networks

Create standards for safety education for all types of health care professionals and for relevant job descriptions

Evaluate competencies for patient safety

Seek out and include patient, family, care partner, and community perspectives to inform and guide all activities.

https://www.ihi.org/national-action-plan-advance-patient-safety

Domain 1: Leadership Commitment to Eliminating Preventable Harm

Our hospital senior governing board **prioritizes safety as a core value**, holds hospital leadership **accountable for patient safety,** and includes patient safety metrics to inform annual **leadership performance reviews and compensation**.

Our hospital leaders, including C-suite executives, place patient **safety as a core institutional value.** One or more C-suite leaders oversee a system-wide assessment on safety and the execution of patient safety initiatives and operations, **with specific improvement plans and metrics**. These plans and metrics are widely shared across the hospital and governing board.

Our hospital governing board, in collaboration with leadership, **ensures adequate resources to support patient safety (**such as equipment, training, systems, personnel, and technology).

Reporting on patient and workforce safety events and initiatives (such as safety outcomes, improvement work, risk assessments, event cause analysis, infection outbreak, culture of safety, or other patient safety topics) accounts for **at least 20% of the regular board agenda** and discussion time for senior governing board meetings.

C-suite executives and individuals on the governing board are notified **within 3 business days** of any confirmed **serious safety events resulting in significant morbidity, mortality, or other harm**

Domain 2: Strategic Planning & Organizational Policy

Our hospital has a **strategic plan that publicly shares its commitment to patient safety** as a core value and outlines specific safety goals and associated metrics, including the goal of “zero preventable harm.”

Our hospital safety goals include the use of metrics to identify and **address disparities in safety outcomes** based on the patient characteristics determined by the hospital to be most important to health care outcomes for the specific populations served

Our hospital has implemented written policies and protocols to cultivate **a just culture that balances no-blame and appropriate accountability** and reflects the distinction between human error, at-risk behavior, and reckless behavior.

Our hospital requires implementation of a **patient safety curriculum and competencies for all clinical and non-clinical hospital staff, including C-suite executives and individuals on the governing board**, regular assessments of these competencies for all roles, and action plans for advancing safety skills and behaviors.

Our hospital has an action plan for **workforce safety** with improvement activities, metrics and trends that address issues such as slips/trips/falls prevention, safe patient handling, exposures, sharps injuries, violence prevention, fire/electrical safety, and psychological safety.

Domain 3: Culture of Safety & Learning

Our hospital conducts a hospital-wide **culture of safety survey** using a validated instrument annually, or every two years with pulse surveys on target units during non-survey years. Results are shared with the governing board and hospital staff, and used to inform unit-based interventions to reduce harm

Our hospital has a dedicated team that conducts **event analysis of serious safety events** using an evidence-based approach, such as the National Patient Safety Foundation's Root Cause Analysis and Action (RCA2).

Our hospital has a **patient safety metrics dashboard** and uses external benchmarks (such as CMS Star Ratings or other national databases) to monitor performance and inform improvement activities on safety events (such as: medication errors, surgical/procedural harm, falls, pressure injuries, diagnostic errors, and healthcare-associated infections

Domain 3: Culture of Safety & Learning, Continued

Our hospital implements a minimum of 4 of the following **high reliability practices:**

- Tiered and escalating (e.g., unit, department, facility, system) safety huddles at least 5 days a week, with one day being a weekend, that include key clinical and non-clinical (e.g., lab, housekeeping, security) units and leaders, with a method in place for follow-up on issues identified.
- Hospital leaders participate in monthly rounding for safety on all units, with C-suite executives rounding at least quarterly, with a method in place for follow-up on issues identified
- A data infrastructure to measure safety, based on patient safety evidence (e.g., systematic reviews, national guidelines) and data from the electronic medical record that enables identification and tracking of serious safety events and precursor events. These data are shared with C-suite executives at least monthly, and the governing board at every regularly scheduled meeting.
- Technologies, including a computerized physician order entry system and a barcode medication administration system, that promote safety and standardization of care using evidence-based practices.
- The use of a defined improvement method (or hybrid of proven methods), such as Lean, Six Sigma, Plan-Do-Study-Act, and/or high reliability frameworks.
- Team communication and collaboration training of all staff.
- The use of human factors engineering principles in selection and design of devices, equipment, and processes

Our hospital participates in **large-scale learning network(s)** for patient safety improvement (such as national or state safety improvement collaboratives), shares data on safety events and outcomes with these network(s), and has implemented at least one best practice from the network or collaborative.

Domain 4: Accountability & Transparency

Our hospital has a **confidential safety reporting system** that allows staff to report patient safety events, near misses, precursor events, unsafe conditions, and other concerns, and **prompts a feedback loop** to those who report.

Our hospital voluntarily works with a **Patient Safety Organization** listed by the Agency for Healthcare Research and Quality (AHRQ) to carry out patient safety activities as described in 42 CFR 3.20, such as, but not limited to, the collection and analysis of patient safety work product, dissemination of information such as best practices, encouraging a culture of safety, or activities related to the operation of a patient safety evaluation system.

Patient safety metrics are tracked and reported to **all clinical and non-clinical staff and made public** in hospital units (e.g., displayed on units so that staff, patients, families, and visitors can see).

Our hospital has a defined, evidence-based **communication and resolution program** reliably implemented after harm events, such as AHRQ's Communication and Optimal Resolution (CANDOR) toolkit, that contains the following elements:

- Harm event identification
- Open and ongoing communication with patients and families about the harm event
- Event investigation, prevention, and learning
- Care-for-the-caregiver
- Financial and non-financial reconciliation
- Patient-family engagement and on-going support

Our hospital uses standard measures to **track the performance** of our communication and resolution program and reports these measures to the governing board **at least quarterly**.

Domain 5: Patient & Family Engagement

Our hospital has a **Patient and Family Advisory Council** that ensures patient, family, caregiver, and community input to safety-related activities, including representation at board meetings, consultation on safety goal-setting and metrics, and participation in safety improvement initiatives.

Our hospital's Patient and Family Advisory Council includes patients and caregivers of patients who are **diverse and representative of the patient population**.

Patients have **comprehensive access to** and are encouraged to view their own medical records and clinician notes via patient portals and other options, and the hospital provides support to help patients interpret information that is culturally- and linguistically-appropriate as well as submit comments for potential correction to their record.

Our hospital **incorporates patient and caregiver input** about patient safety events or issues (such as patient submission of safety events, safety signals from patient complaints or other patient safety experience data, patient reports of discrimination).

Our hospital supports the **presence of family** and other designated persons (as defined by the patient) as essential members of a safe care team and encourages engagement in activities such as bedside rounding and shift reporting, discharge planning, and visitation 24 hours a day, as feasible

This all sounds easy, right?

- This is all a bit overwhelming
- There is still time, 8 months in fact!
- There are loads of resources available to help

Next Steps to Consider

- Form a Work Group
- Conduct a Gap Analysis
- Review One Domain at a Time
- Review Resources As a Team
- Progress Over Perfection

STATUS	PROJECT + TASK	KC	Olathe	Paola	GB	Liberty	COMMENTS
Completed	**Establish** ownership per facility KC, GB, OMC, MMC						
Completed	Review project task list and ppt resource						
1. Leadership Commitment to Eliminating Preventable Harm - The senior leadership and governing board at hospitals set the tone for commitment to patient safety. They must be accountable for patient safety outcomes and ensure that patient safety is the highest priority for the hospital. while the hospital leadership and the governing board may convene a board committee dedicated to patient safety, the most senior governing board must oversee all safety activities and hold the organizational leadership accountable for outcomes. Patient safety should be central to all strategic, financial, and operational decisions.							
Ongoing	(A) Our hospital senior governing board prioritizes safety as a core value, holds hospital leadership accountable for patient safety, and includes patient safety metrics to inform annual leadership performance reviews and compensation.	Yes	Yes	Yes	Yes		Documentation: example of Incentive Program requirements for 5 star performance
In Progress	(B) Our hospital leaders, including C-suite executives, place patient safety as a core institutional value. One or more C-suite leaders oversee a system-wide assessment on safety (examples provided in the Attestation Guide), and the execution of patient safety initiatives and operations, with specific improvement plans and metrics. These plans and metrics are widely shared across the hospital and governing board.	Yes	Yes	Yes	Yes		Zero harm scorecard, meeting minutes, emails weekly, etc.
In Progress	(C) Our hospital governing board, in collaboration with leadership, ensures adequate resources to support patient safety (such as equipment, training, systems, personnel, and technology).	Yes	Yes	Yes	Yes		team, PSRT, annual training, safety pillar training, NEO, Just culture training, IT Safety initiatives and prioritization process
In Progress	(D) Reporting on patient and workforce safety events and initiatives (such as safety outcomes, improvement work, risk assessments, event cause analysis, infection outbreak, culture of safety, or other patient safety topics) accounts for at least 20% of the regular board agenda and discussion time for senior governing board meetings.	Yes	Yes	Yes	Yes		Meeting minutes from board meetings from each hospital board

Additional CMS PSSM Resources

Attestation Guide for the Patient Safety Structural Measure in CMS Quality Reporting

I. Preface

The purpose of the Patient Safety Structural Measure is to drive action and improvement in patient safety across key domains. The development of the measure is anchored in best practices and evidence for improving patient safety and reducing harm using a total systems framework that views patient safety events as a result of system failure rather than individual error.[1,2,3]

The Patient Safety Structural Measure consists of five domains, each with statements to which the hospital must respond. Affirmative attestation to all statements within a domain will be required for the hospital to receive a point for that domain; partial credit will not be awarded. At one point per domain, hospitals affirmatively attesting to all statements will receive the maximum five points. Hospitals participating in the Hospital Inpatient Quality Reporting (IQR) Program and the Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program would complete attestation during the CMS-specified time period.

This Attestation Guide for the Patient Safety Structural Measure provides information and examples for illustrative purposes to support hospital response to the statements included in the measure. Guidance is provided on select measure domains and statements, as needed; a glossary of key terms and concepts is also provided. For each "Statement-specific guidance" provided below within each domain, the statement is identified as it appears in the Patient Safety Structural Measure specifications, identified by the domain number and statement letter as it appears in the measure specifications; the guidance for that statement immediately follows. [As guidance is provided for select, but not all, measure statements, the statements identified in this guide will not appear sequentially (e.g., Statement A, then Statement B, then Statement C, etc.). Statements for which guidance was not deemed necessary have not been included.]

II. Domain-Specific Guidance

Domain 1: Leadership Commitment to Eliminating Preventable Harm

Overarching guidance:

- There are varying governance structures at hospitals. For this measure:
  - Hospital leadership is identified as the "senior governing board" and C-suite "leaders" or "executives." Hospital leadership works directly with, and may include, medical staff responsible for quality delivery of care within the hospital.
  - Senior governing board is intended to be the body with fiduciary responsibility for the hospital, in charge of resource management, with ultimate authority. The senior governing board may or may not oversee other, subordinate hospital boards and committees. While hospital quality and/or safety committees and subcommittees have an important role in improving patient safety, for this

1

https://qualitynet.cms.gov/inpatient/iqr/measures#tab2

Quick Start Guide: Patient Safety Structural Measure

As part of the FY2025 final rule, CMS is requiring hospitals participating in the Hospital Inpatient Quality Reporting (IQR) program to report on the Patient Safety Structural Measure (PSSM).

Why? Structural measures provide a way for hospitals to address a topic for which no outcome measure exists. CMS expects that by attesting to these measures, hospitals will develop evidence-based programs and processes to support improvements in high impact areas.

What? The Patient Safety Structural Measure is an attestation-based measure that assesses whether hospitals have a structure and culture that prioritizes safety as demonstrated by the following five domains: (1) leadership commitment to eliminating preventable harm; (2) strategic planning and organizational policy; (3) culture of safety and learning health system; (4) accountability and transparency; and (5) patient and family engagement. Hospitals will attest to whether they engage in specific evidence-based best practices in each domain. Each domain is worth one point, for a total of five (5) points. The hospital must meet the required number of elements within a domain to receive a point. CMS will not give partial credit within the domain.

How? The attestation-based Patient Safety Structural measure will be reported through the National Healthcare Safety Network (NHSN) platform. NHSN will be releasing additional details at a later date. This Quick Start Guide outlines the five domains and provides resources to assist hospitals as they evaluate activities and processes against each domain.

Domain 1: Leadership Commitment to Eliminating Preventable Harm

The senior leadership and governing board at hospitals sets the tone for commitment to patient safety. They must be accountable for patient safety outcomes and ensure that patient safety is the highest priority for the hospital. While the hospital leadership and the governing board may convene a board committee dedicated to patient safety, the most senior governing board must oversee all safety activities and hold the organizational leadership accountable for outcomes. Patient safety should be central to all strategic, financial, and operational decisions.

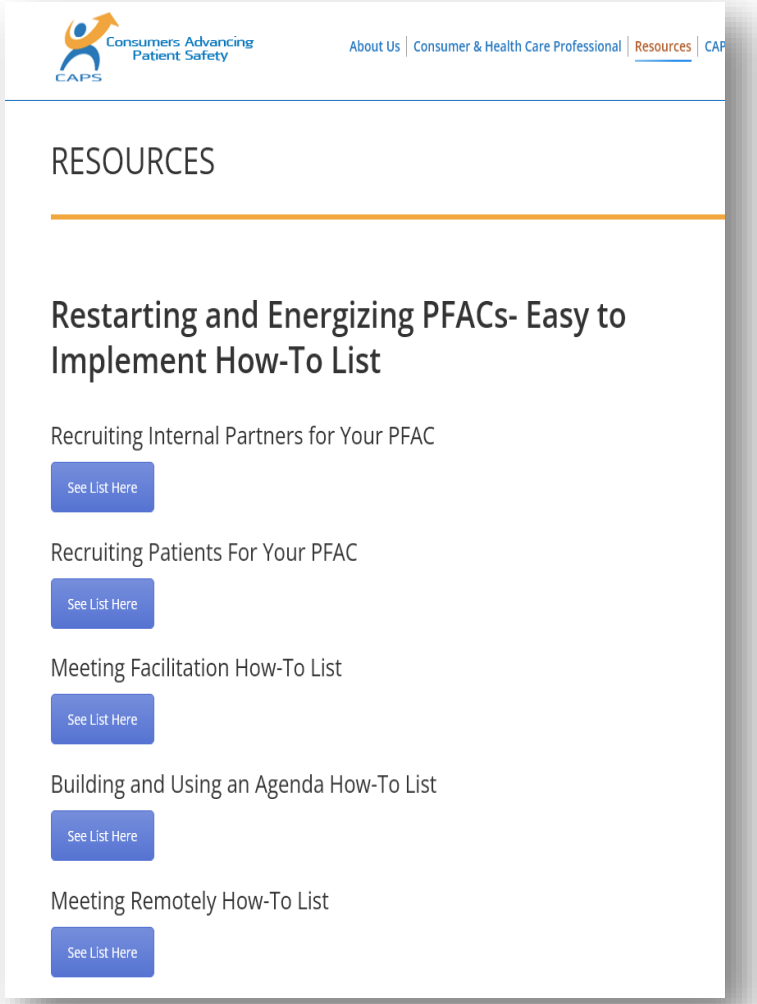
Attestation Statements
A. Our hospital senior governing board prioritizes safety as a core value, holds hospital leadership accountable for patient safety, and includes patient safety metrics to inform annual leadership performance reviews and compensation.
B. Our hospital leaders, including C-suite executives, place patient safety as a core institutional value. One or more C-suite leaders oversee a system-wide assessment on safety and the execution of patient safety initiatives and operations, with specific improvement plans and metrics. These plans and metrics are widely shared across the hospital and governing board.
C. Our hospital governing board, in collaboration with leadership, ensures adequate resources to support patient safety (such as equipment, training, systems, personnel, and technology).
D. Reporting on patient safety and workforce safety events and initiatives (such as safety outcomes, improvement work, risk assessments, event cause analysis, infection outbreak, culture of safety, or other patient safety topics) accounts for at least 20% of the regular board agenda and discussion time for senior governing board meetings.
E. C-suite executives and individuals on the governing board are notified within 3 business days of any confirmed serious safety events resulting in significant morbidity, mortality, or other harm.

1

HQIN Health Quality Innovation Network

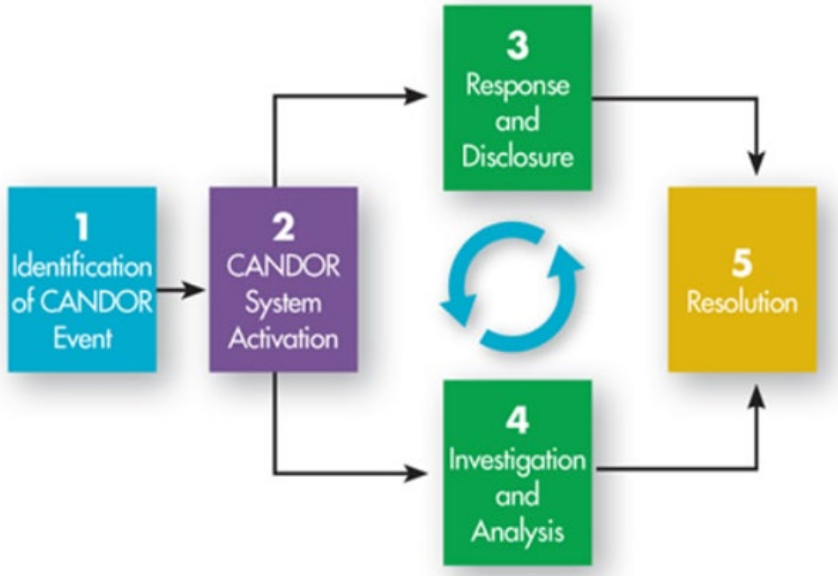
https://hqin.org/wp-content/uploads/2024/07/Quick-Start-Guide-Patient-Safety-Structural-Measure.pdf

Additional Resources



https://www.patientsafety.org/resources/

https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_60_reporting_culture_final.pdf



https://www.ahrq.gov/patient-safety/settings/hospital/candor/modules.html

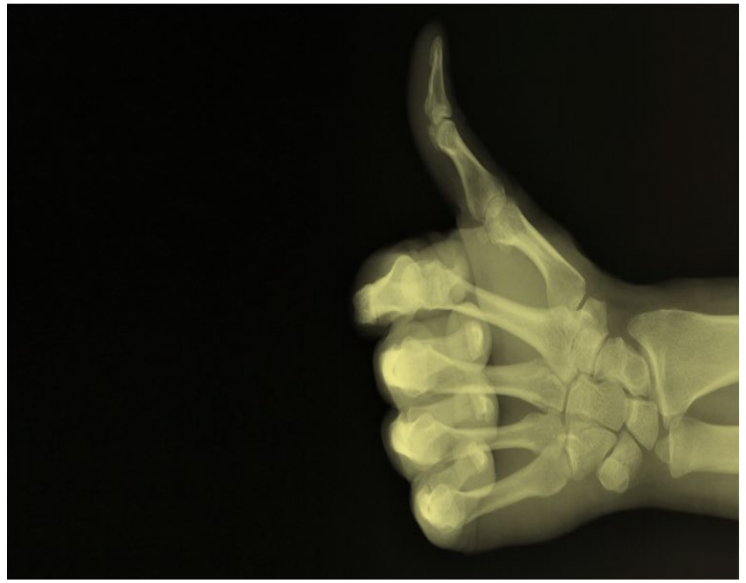
Additional Resources

Transparency

Building a Culture of Transparency in Health Care

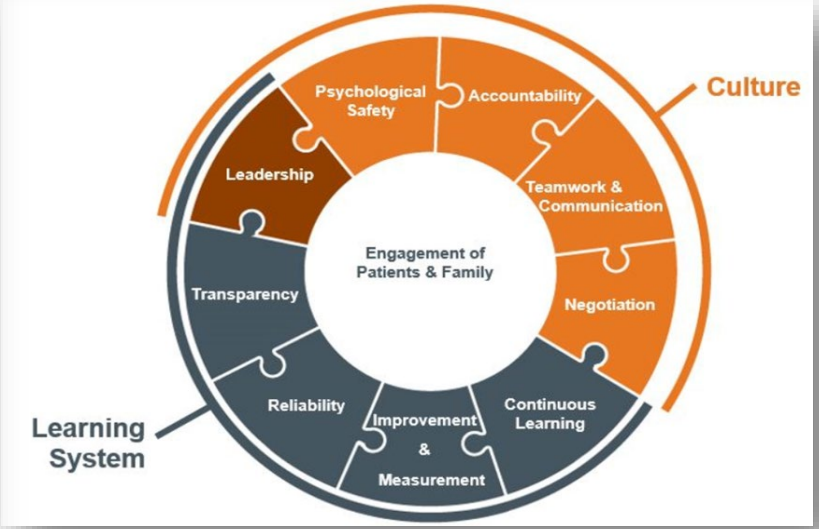
by Gary S. Kaplan

November 9, 2018

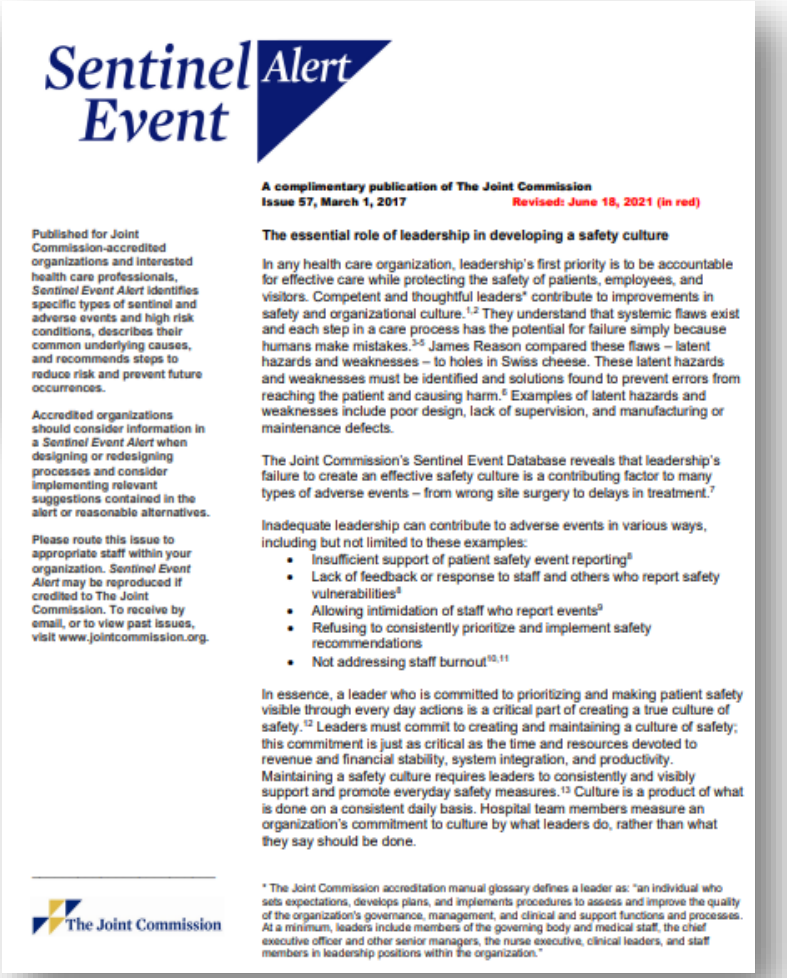


[Building a Culture of Transparency in Health Care]

https://www.ihi.org/resources/publications/leading-culture-safety-blueprint-success



[A Framework for Safe, Reliable, and Effective Care | Institute for Healthcare Improvement]



Sentinel Event Alert

A complimentary publication of The Joint Commission
Issue 57, March 1, 2017 Revised: June 18, 2021 (in red)

Published for Joint Commission-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

Please route this issue to appropriate staff within your organization. *Sentinel Event Alert* may be reproduced if credited to The Joint Commission. To receive by email, or to view past issues, visit www.jointcommission.org.

The essential role of leadership in developing a safety culture

In any health care organization, leadership's first priority is to be accountable for effective care while protecting the safety of patients, employees, and visitors. Competent and thoughtful leaders* contribute to improvements in safety and organizational culture.[1,2] They understand that systemic flaws exist and each step in a care process has the potential for failure simply because humans make mistakes.[3-5] James Reason compared these flaws – latent hazards and weaknesses – to holes in Swiss cheese. These latent hazards and weaknesses must be identified and solutions found to prevent errors from reaching the patient and causing harm.[6] Examples of latent hazards and weaknesses include poor design, lack of supervision, and manufacturing or maintenance defects.

The Joint Commission's Sentinel Event Database reveals that leadership's failure to create an effective safety culture is a contributing factor to many types of adverse events – from wrong site surgery to delays in treatment.[7]

Inadequate leadership can contribute to adverse events in various ways, including but not limited to these examples:

- Insufficient support of patient safety event reporting[8]
- Lack of feedback or response to staff and others who report safety vulnerabilities[8]
- Allowing intimidation of staff who report events[9]
- Refusing to consistently prioritize and implement safety recommendations
- Not addressing staff burnout[10,11]

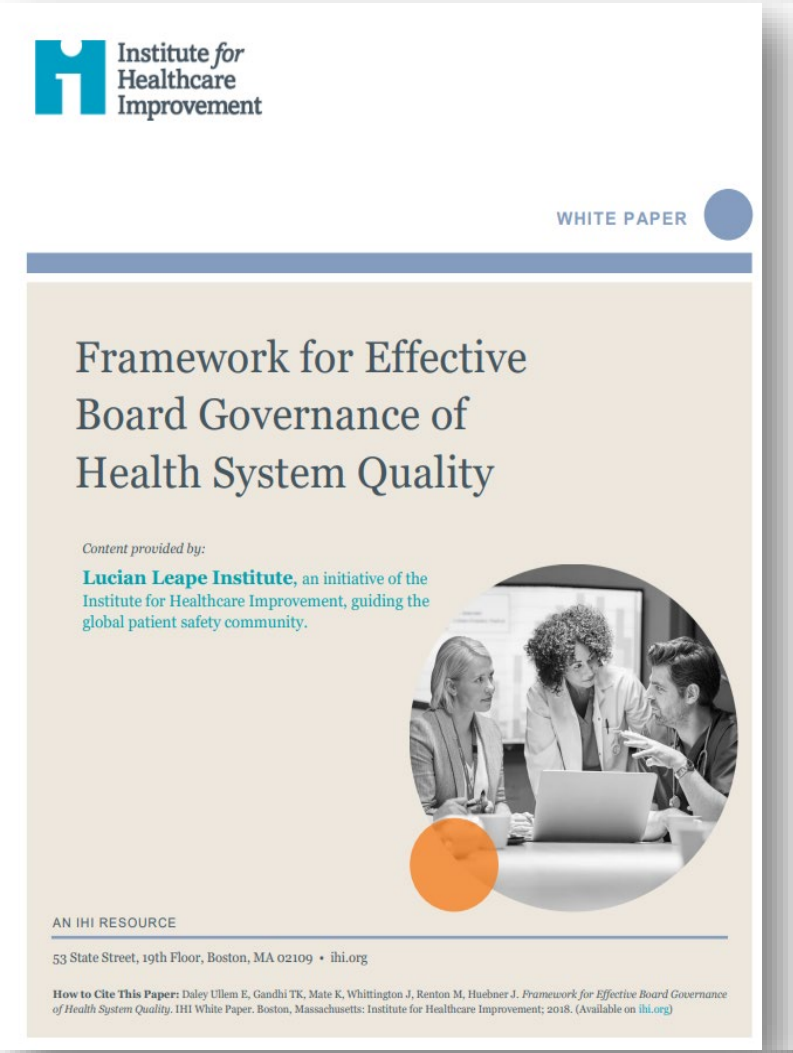
In essence, a leader who is committed to prioritizing and making patient safety visible through every day actions is a critical part of creating a true culture of safety.[12] Leaders must commit to creating and maintaining a culture of safety; this commitment is just as critical as the time and resources devoted to revenue and financial stability, system integration, and productivity. Maintaining a safety culture requires leaders to consistently and visibly support and promote everyday safety measures.[13] Culture is a product of what is done on a consistent daily basis. Hospital team members measure an organization's commitment to culture by what leaders do, rather than what they say should be done.

The Joint Commission

* The Joint Commission accreditation manual glossary defines a leader as: "an individual who sets expectations, develops plans, and implements procedures to assess and improve the quality of the organization's governance, management, and clinical and support functions and processes. At a minimum, leaders include members of the governing body and medical staff, the chief executive officer and other senior managers, the nurse executive, clinical leaders, and staff members in leadership positions within the organization."

https://www.jointcommission.org/-/media/tjc/newsletters/sea-57-safety-culture-and-leadership-final3.pdf

Additional Resources



Institute for Healthcare Improvement

WHITE PAPER

Framework for Effective Board Governance of Health System Quality

Content provided by:

Lucian Leape Institute, an initiative of the Institute for Healthcare Improvement, guiding the global patient safety community.

AN IHI RESOURCE

53 State Street, 19th Floor, Boston, MA 02109 • ihi.org

How to Cite This Paper: Daley Ullem E, Gandhi TK, Mate K, Whittington J, Renton M, Huebner J. *Framework for Effective Board Governance of Health System Quality.* IHI White Paper. Boston, Massachusetts: Institute for Healthcare Improvement; 2018. (Available on ihi.org)

Quality Concept	Key Questions	Suggested Educational Concepts
Basic Quality Overview	• What is quality in health care? • What are the benefits of quality? • What are the costs of poor quality? • Who oversees the elements of quality in our organization?	• Brief overview of quality in health care • STEEEP dimensions of quality presented through a patient lens • IHI Triple Aim • Benefits of quality • "Cost" of poor quality: Financial, patients, staff • Quality strategy, quality management • Overview of risk-/value-based care • Structures for quality reporting, assessment, and improvement • Structure for CEO/leadership evaluation
Keep Me Safe *Safe*	• What is safety? • What is a culture of safety? • What are surveys of patient safety culture? • What is "harm"? • What are the types of harm? • How do you decide if an adverse outcome is preventable harm? • How do we learn about harm in a timely manner? • What is our response to harm (i.e., what actions do we take when harm occurs)? • What are the financial and reputational costs of harm? • How do we reduce, learn from, and prevent harm? • How do we track harm in our system and in the industry?	• Preventable harm vs. adverse outcome • Just Culture and culture of safety • Science of error prevention and high reliability • Classification of the types of harm • Knowing about harm: Incident reporting, claims, grievances • Response to harm: Root cause analysis/adverse event review, patient apology and disclosure, legal, learning systems • Costs of harm: Claims/lawsuits, penalties, ratings, reputational, human emotional impact • Harm terminology: HAC, SSI, falls, ADE, employee safety, etc. • Regulatory oversight of safety

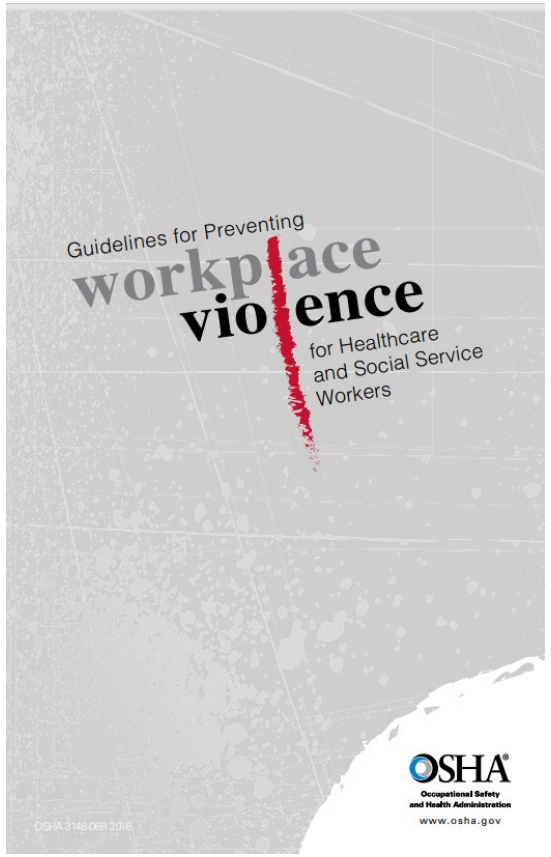
Quality Concept	Key Questions	Suggested Educational Concepts
Provide Me with the Right Care *Effective*	• How do we ensure that our health system properly diagnoses and cares for patients to the best evidence-based standards in medicine? • How does leadership oversee whether approaches to care vary within our system? • How do we identify the areas where care is not to our standards? • How do we identify the areas where care is meeting or exceeding our standards? • How do we attract and retain talent to care for patients?	• Evidence-based medicine • Overview of staff and physician recruitment, credentials/privileges, training, retention (burnout, turnover, violence) • Overview of standard of care concept and issues/processes that lead to variation • Trends in care utilization and clinical outcomes • Key care outcomes to be evaluated through an equity lens: race, ethnicity, gender, language, and socioeconomic status
Treat Me with Respect *Equitable and Patient centered*	• How do we evaluate patients' satisfaction and feedback? • What is "equitable care" and how do we evaluate it? • Do some patient groups have worse outcomes? Why? • What is our staff diversity and how may it impact patient care? • How do we ensure that patients are partners in their care? • How do we reduce cost of care? • How do we track medical debt for patient groups?	• Patient satisfaction and patient grievances (e.g., HCAHPS[22]) • Patient-centered care • Care affordability, debt burden • Social determinants of health • Pricing and affordability of care bundles • Total costs of care for conditions • Medical debt concerns/trends • Value-based payment models
Help Me Navigate My Care *Timely and Efficient*	• What do care navigation and care access mean? • What issues result from waiting for care or disconnected care (care that is not timely or efficient)? • Which populations have more complex care needs? What do we do to help them navigate care? • What is the role of a portable medical record and health IT in supporting care navigation?	• Care access, efficiency, and drivers of care navigation • Define "continuum of care" • Focus on key areas that are "roadblocks" in care navigation and their drivers • Define electronic health record, health IT, and the systems to support and secure patient information and patient access

https://www.ihi.org/resources/white-papers/framework-effective-board-governance-health-system-quality#downloads

Additional Resources

https://patientcarelink.org/wp-content/uploads/2018/03/2017-safety_culture_change_package.pdf

IHI Framework for Improving Joy in Work | Institute for Healthcare Improvement

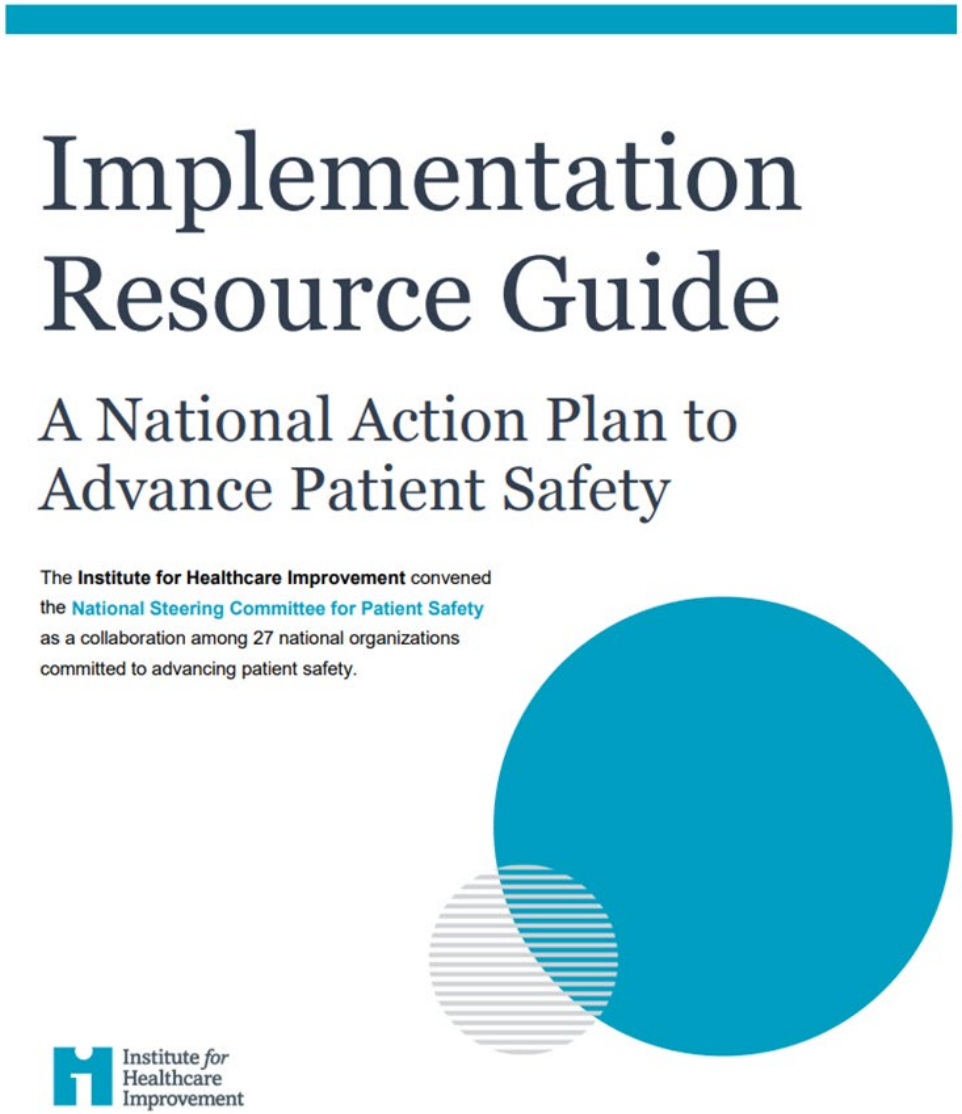


https://www.osha.gov/sites/default/files/publications/osha3148.pdf

SCORE:	Unsure	0	1 – Beginning Must meet all Score 1 criteria	2 – Making Progress Must meet all Score 2 criteria	3 – Significant Impact Must meet all Score 2 and 3 criteria	4 – Exemplary Must meet all Score 2, 3, and 4 criteria	ROW SCORE	Optional Comment
4. Patient Safety Culture Surveys	Do not know or not aware of	Does not meet Score 1	☐ **Some Surveys:** Some departments or units conduct patient safety culture surveys, but surveys are not conducted consistently across the organization on a routine schedule of, at a minimum, every two years.	☐ **Organization-Wide:** An organization-wide patient safety culture survey occurs at least every 2 years using a validated survey instrument, with pulse surveys conducted during interim years. ☐ **Results Shared:** Results from patient safety surveys are reported to senior and department leaders and the governing body. Leaders review survey results with department teams to discuss opportunities for recognition and/or improvement.	☐ **Action Plans:** Action plans based on patient safety survey results are consistently developed with input from staff, and progress is monitored and evaluated by accountable leaders, both at the organization and department levels.	☐ **Trends and Stratification:** Patient safety culture survey results are consistently tracked and trended over survey periods, with stratification of results by department, job type/role, and length of service to identify and share best practices and opportunities for improvement.		

Resources Available at

[National Action Plan to Advance Patient Safety (NAP) | Institute for Healthcare Improvement]



References

- A Framework for Safe, Reliable, and Effective Care | Institute for Healthcare Improvement
- CMS Patient Safety Structural Measure Specs & Attestation Guide: https://qualitynet.cms.gov/files/66ac085486c07e0c5ec5e930?filename=PSSM_Specs_073124.pdf
- Communication and Optimal Resolution (CANDOR) Toolkit | Agency for Healthcare Research and Quality
- https://www.ihi.org/resources/white-papers/framework-effective-board-governance-health-system-quality#downloads
- https://www.jointcommission.org/-/media/tjc/newsletters/sea-57-safety-culture-and-leadership-final3.pdf
- https://patientcarelink.org/wp-content/uploads/2018/03/2017-safety_culture_change_package.pdf
- Leading a Culture of Safety: A Blueprint for Success | Institute for Healthcare Improvement
- National Steering Committee for Patient Safety. Safer Together: A National Action Plan to Advance Patient Safety. Boston, Massachusetts: Institute for Healthcare Improvement; 2020. (Available at www.ihi.org/SafetyActionPlan
- Resources by the CMS Patient Safety Structural Measure Domains | Agency for Healthcare Research and Quality