PATIENT SAFETY

Five Things You Can Do This Week to Make Your Patients Safer

It's been 20 years since the watershed *To Err Is Human* report was issued by the Institute of Medicine, which galvanized national concern about patient safety with its claim that as many as 98,000 people die in U.S. hospitals each year as a result of preventable medical errors (Kohn et al., 2000).

So how are we doing, 20 years on? Well, it's a good news/bad news situation. On the one hand, there have been some sobering studies in recent years that indicate that To Err Is Human may have underestimated the number of deaths caused by preventable medical errors. These studies suggest that this number may top 200,000 per year in the U.S. (James, 2013; Makary & Daniel, 2016). On the other hand, a national scorecard issued by the Agency for Healthcare Research and Quality reported that, from 2011 through 2017, public and private efforts to reduce hospital-acquired conditions (HACs) have prevented more than 100,000 inpatient deaths and saved more than $27 billion in healthcare costs (AHRQ, 2019).

One thing we've learned over the last two decades of research and practice is that improving patient safety is a complex, multifaceted problem, which won't be solved by piecemeal, ad hoc initiatives. Instead, moving the needle on patient safety requires a total systems approach and, first and foremost, the creation of a strong culture of safety within an organization.[1] The safety culture of an organization encompasses both shared values and the behaviors and structures that flow from these values (National Patient Safety Foundation [NPSF], 2015).

The idea of creating a culture of safety can seem both a little daunting and a little abstract. So let's break it down into five, concrete things you can do right now, this week, to advance essential aspects of a culture of safety in your organization.

1 The development of ideas about patient safety over the past two decades can be charted through a number of seminal reports issued since *To Err Is Human*; see, for example, *Crossing the Quality Chasm* (Committee on Quality of Health Care in American, 2001), *Free From Harm* (National Patient Safety Foundation, 2015), and "Transforming Concepts in Patient Safety" (Gandhi et al., 2018).

1

Build your reputation as a champion of patient safety

WHY IT MATTERS

If someone asked your team members to describe you, would “passionate about patient safety” be the first thing they say?

One consistent lesson learned from efforts to improve patient safety is that leadership commitment is an essential component of safety culture (NPSF, 2015; Gandhi et al., 2018). As a leader, whether you lead a single team or an entire organization, you set the tone for the local culture, influencing values and defining goals. It’s an understatement to say that leaders in healthcare are juggling many competing priorities, but the goal of providing safe, high quality care to patients should always be the focus that puts everything else—finances, staff retention, regulatory compliance, etc.—into perspective.

As a patient safety leader, one of your most important responsibilities is to foster an environment that supports transparency and mutual respect, where caregivers and other staff feel as if they can raise concerns about patient safety and report safety events without facing retribution.

This is an integral part of a "just culture," a central tenet of patient safety science that emphasizes that most errors "represent predictable interactions between human operators and the systems in which they work" (NPSF, 2015, p. xii); thus, to prevent future errors, you need to change the system rather than blame the person, except in the case of gross negligence or misconduct.

Demonstrate to your team that safety concerns are taken seriously and engage them in discovering the root causes of these concerns and in creating and implementing processes to address them. Recognize that "near misses" represent rich opportunities for learning, since they offer clues as to where and how processes break down and potentially endanger patients. Offer praise to team members who report near misses so that the team can learn from them.

ONE ACTION YOU CAN TAKE THIS WEEK

At your next huddle or staff meeting, whether it's a daily huddle with your team or a weekly leadership huddle, make a point of speaking up about the importance of patient safety. Once you've set this precedent, look for opportunities to encourage discussion of safety at future meetings and to link all pressing initiatives to the core mission of keeping patients safe.

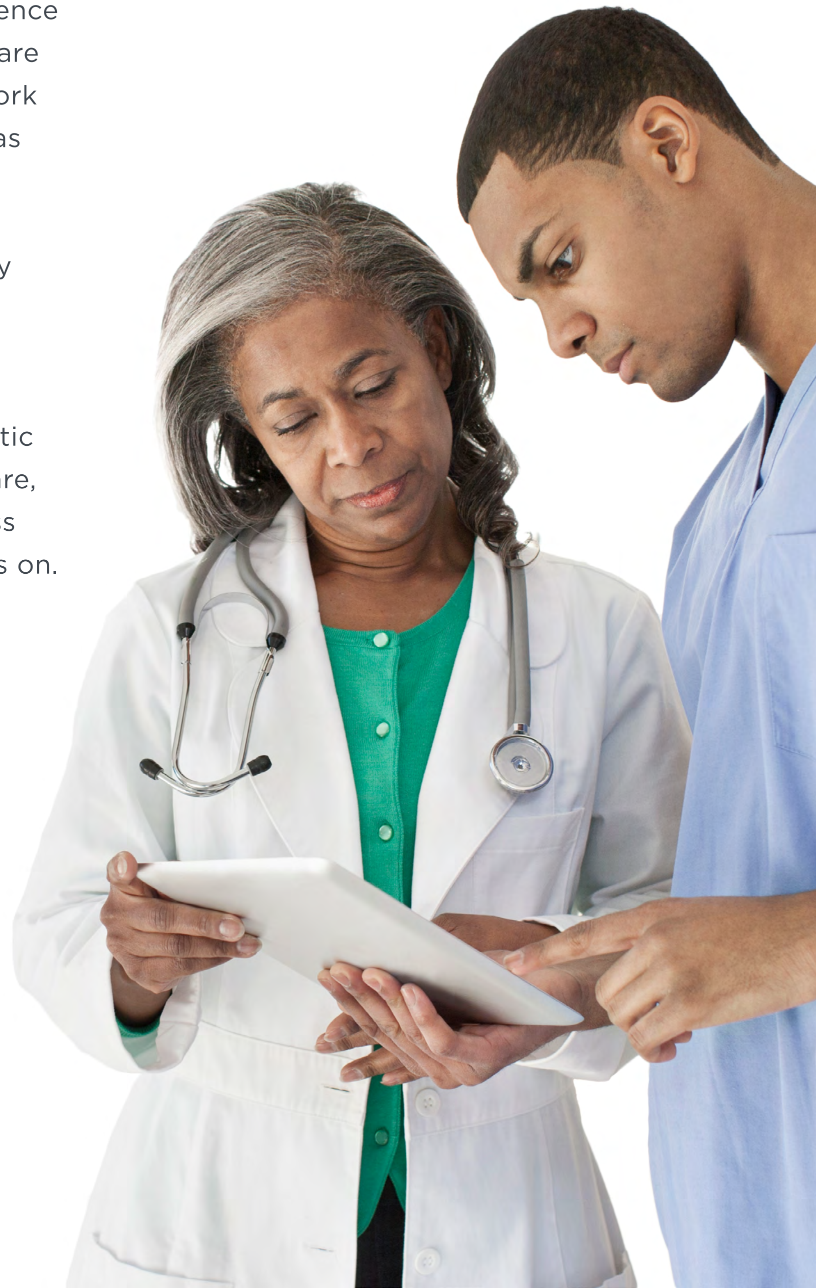
2

Listen to your people

WHY IT MATTERS

In an important article published in 2014, “From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider,” Bodenheimer and Sinsky make a compelling case that improving the work life of healthcare providers and staff should take its place alongside the three components of the Triple Aim—improving the health of populations, enhancing the patient experience of care, and reducing the per capita cost of healthcare (Berwick et al., 2008)—as part of a guiding framework to improve the U.S. healthcare system. This article, as well as recent reports such “Transforming Concepts in Patient Safety” (Gandhi et al., 2018) and Taking Action Against Clinician Burnout (National Academy of Medicine, 2019), map out the evidence trail that demonstrates the negative effects that burnout and dissatisfaction among healthcare professionals can have on patient care, including increases in diagnostic and patient safety errors, omissions of necessary care, reduced teamwork, dissatisfied patients who are less likely to adhere to treatment plans, and the list goes on.

The statistics on clinician burnout are troubling, with research indicating that 35–54% of U.S. nurses and physicians manifest substantial symptoms of burnout—emotional exhaustion, depersonalization (i.e., cynicism), and loss of a sense of personal accomplishment (National Academy of Medicine, 2019). Given these numbers, it’s possible, even likely, that members of your team could be experiencing or could be at risk for burnout, affecting their own well-being as well as that of their patients.



The place to start in understanding the realities of the work life of your team members is simply to ask them. Of course, this requires an opening of the lines of communication and the building of trusting relationships. In addition to the team communication that happens during huddles and staff meetings, a regular cadence of one-on-one conversations between leaders and team members can enable a more candid level of conversation than is often possible in a group setting. Leaders who round with their teams with the sincere intent to listen and learn about each individual's experiences and insights can assess and address the local drivers of frustration as well as hear about what is working well and how to build on it. An added bonus: You might also discover some great ideas for improving processes and patient safety from those who are doing the work every day.

ONE ACTION YOU CAN TAKE THIS WEEK

Begin a regular, manageable cadence of 10-minute, one-on-one leader rounds with team members. Identify team members to include on your schedule and communicate to them the purpose and importance of what you're doing. Make sure there is adequate coverage for those who are actively caring for patients.

3

Mind the gaps in team communication

WHY IT MATTERS

Even in the best of times, communication can be a sketchy endeavor: We think we're being clear in what we say only to find out later that our meaning was misconstrued, or a detail we thought was important was overlooked, or information was garbled as it was passed from person to person, like in the game of telephone.

In healthcare, communication is critical, gaps can lead to serious harm to patients, and there are multiple points in the process where gaps can emerge: A nurse handing off a patient to the nurse on the next shift; team members from different disciplines communicating across distinct and specialized professional languages; a healthcare professional explaining a treatment plan to a patient with low health literacy; a discharge planning nurse conveying vital patient information over the phone to a post-discharge facility, with distractions on both ends. Information is conveyed via the spoken word, handwritten notes on paper, handwritten notes on white boards, on templates and free form in electronic health records.

A patient safety leader can look to the high reliability toolbox for some practices to remedy potential gaps in communications processes. High reliability organizations “operate in complex, high-hazard domains for extended periods without serious accidents or catastrophic failures” (AHRQ, 2019, September). One feature of a safety culture that flows from high reliability is “collective mindfulness,” which means that all members of the team are always in a state of vigilance to detect small problems or unsafe conditions and to report them so that they can be fixed before they lead to harm. This “preoccupation with failure” means that teams view near misses as opportunities for learning and process improvement (Weick & Sutcliffe, 2015; Chassin & Loeb, 2011).

ONE ACTION YOU CAN TAKE THIS WEEK

During a huddle or other meeting, encourage your team to identify a recent near miss that involved a gap in communication. With your supportive facilitation, this exercise can build team trust and reinforce the value of collective mindfulness, while also providing a practical opportunity for your team to use process improvement tools to develop a solution to the problem identified (Institute for Healthcare Improvement, 2017).

4

Partner with your patients and their families

WHY IT MATTERS

Partnering with patients is an integral part of creating a culture of safety, improving both the patient experience of care and clinical outcomes (Anhang et al., 2014). Patients and their families should be considered as an integral part of the healthcare team, at every level of the organization, from the bedside to the boardroom.

The bedside, however, is a place to start. Shared decision-making is a value and approach that is intrinsic to person-centered care. With this approach, clinicians and patients work together to make treatment decisions, taking into account the best available clinical evidence, the balance between risks and benefits, and the patient's preferences and values (Elwyn et al., 2012). This approach relies on the development of trusting communication between the patient, family, and care team.

A critical component of shared decision-making is learning about the patient's preferences and values. Age-Friendly Health Systems, an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement in partnership with the American Hospital Association and the Catholic Health Association of the United States, has made the question, "What matters to you?" the foundation of its evidence-based approach to improving the care of older adults (Laderman et al., 2019).

And, indeed, the power of this question has been embraced by advocates of person and family engagement worldwide as a lever to start conversations with all patients that are crucial to making sure that the values of the patient guide clinical decision-making (Healthcare Improvement Scotland, n.d.).

Another bedside communication skill vital to patient safety and clinical outcomes is the ability to speak in plain language, avoiding the jargon of healthcare professionals, such as abbreviations and acronyms, and clearly explaining medical terms when they are necessary to communicate the patient's options. Two-way "teach back" is a high-reliability communication technique that helps to prevent gaps in communication, where the clinician repeats back what they hear the patient saying to make sure they are understanding questions and concerns and where the patient repeats back the treatment plan so that the clinician can check that they've communicated the plan effectively.

ONE ACTION YOU CAN TAKE THIS WEEK

Launch a project with your team to integrate the question, "What matters most to you?," into the workflow of caring for patients. When is the question asked, and how is the answer made part of the medical record and shared with other members of the interprofessional team?

5

Assess staff education

WHY IT MATTERS

The healthcare landscape is evolving rapidly—how we practice, how we are paid, what patients expect, what we expect of each other. The evidence base that informs best practices also continues to grow in scope and nuance, at a time when healthcare professionals are stretched very thin as they work to advance competing priorities that all feel urgent, leaving only limited pockets of time for continuing education and professional development.

Evidence-based practice is the gold standard for providing safe, high-quality care for our patients, yet we know that there is a great deal of variability in practice, even in clinical areas with a strong evidence base and expert consensus about best practices (Committee on Quality of Health Care in America, 2001). The Dartmouth Atlas Project (n.d.) documents significant, unwarranted variations in care, which are not consistent with evidence-based medicine, across the nation.

One path for improving knowledge of and adherence to evidence-based practice is effective, efficient and dynamic education for healthcare professionals that prepares them with the skills and knowledge needed for today's practice; fosters a shared vision of high-quality, highly reliable care; and fits their individual needs and schedule.

ONE ACTION YOU CAN TAKE THIS WEEK

Set up a one-hour calendar appointment for yourself this week to review your strategy for assessing the skills of your staff and for training, retraining, and providing professional development opportunities. Consider a consultation with an expert in analytics, assessments, and learning tools for healthcare professionals, such as Relias.

How Relias can help you cultivate your culture of safety

Relias has developed a personalized learning approach, measured by performance metrics, that helps you identify specific gaps in your staff's knowledge and close those gaps with targeted education that help them learn and apply evidence-based best practices. Relias tools can help you reduce variation in care, as clinicians are trained to share an evidence-based approach to clinical problems; advance high reliability, as you assess both knowledge and judgment for a true understanding of what each clinician needs; and support clinician satisfaction and fulfillment with customized learning paths and a roadmap for continuous improvement over time.

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RESOURCES

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