Development of an educational presentation that describes a comprehensive program for the hospital board is the first step.

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Introduction

Most hospitals in the nation have been involved in patient safety efforts for years, under the umbrella of quality improvement. Thus, patient safety in many cases is a new name for ongoing activities such as process improvement, incident reporting, analysis of errors for trends, improvement initiatives based on incident report data, risk reduction, and adverse drug event and medication error reduction. The development of a comprehensive patient safety program therefore involves, to a large extent, coordination of activities that have been ongoing under various committee structures in the facility, a renewed commitment to safety initiatives and ensuring communication of activities to the facility board.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has incorporated patient safety into its accreditation standards, with a focus on leadership support and participation in patient safety efforts within the organization(1). At the same time, health care facilities are being bombarded with other new regulatory requirements (e.g., Health Insurance Portability and Accountability Act/ HIPAA, federal needle safety laws, etc.) that also require time and resources to achieve compliance. Additional pressures include installation of new information systems, rising costs of health plans and pharmaceuticals and a tight labor market that is boosting health care wages.

Concurrently, many health care facilities are in financial crisis due to changes in reimbursement and vulnerability of their investment income.

In this climate, how can patient safety efforts gain the resources and attention they need to be successful? The key is repeated and frequent communication with senior leadership.

Development of an educational presentation that describes a comprehensive program for the hospital board is the first step. Each organization has its own mission, vision and goals set within its unique culture. Within this framework, there are still important common elements that all organizations need to include in such a presentation. These elements, as well as who should be involved in patient safety efforts and how it is planned, will be described in this article.

Elements of a board presentation

This presentation should include, at a minimum, the following elements:

- background information/rationale for a program (the Institute of Medicine report, JCAHO, National Quality Forum)
- history of error reporting in the facility
- types of incidents and populations to be included
- assessment of committees/task forces/groups in the facility that may already be working on elements of patient safety
- proposed committee members (i.e., infection control staff, safety officers, quality improvement staff, physicians and patient care services leaders, among others)
- committee information flow and feedback timelines
- reporting schedule to the board as well as a sample board report
- identification of a patient safety leader (a physician leader has the advantage of being easily able to enlist colleague physicians from other specialties to participate) and last, but not least,
- a non-punitive approach to error reporting.

These issues raise myriad questions that can only be resolved by means of an assessment of the organization’s current structure.

Committee issues

Considerations should be given to which aspects/elements of safety will be reported, how frequently reports will be made and whether there is an existing committee structure that can support patient...
safety efforts or whether a patient safety committee should be formed. Many facilities already have safety committees, quality committees and/or infection control committees with broad membership, including physician leaders.

Safety committees typically deal with environmental safety aspects, quality committees with patient safety aspects and infection control committees with a combination of patient (nosocomial infections, communicable disease exposures) and employee (blood and body fluid exposures, immunizations, etc.) safety aspects. The scope of these entities can be broadened to include all issues relating to patient and employee safety.

A second approach is to assign individual aspects of patient and employee safety responsibilities to a variety of existing committees. Thirdly, a patient safety committee could be formed, with liaisons to existing committees.

Whichever strategy is decided upon, it is important to designate a single committee or coordinator who can coordinate/integrate safety activities flowing from a variety of sources within the organization into a comprehensive report that can be shared with top leaders as the overall program. For this reason, the third approach is favored.

It is important to identify how a new committee would fit with current quality/risk committees and how it might be linked to other environmental safety committees. Utilizing pre-existing committee structures will reduce committee time commitments and take advantage of communication structures that may already be in place.

Other questions include whether the patient safety team will focus only on patients or also encompass employee and visitor safety, and whether additional staff will be required.

Regardless of which of the three approaches to committee structure is chosen, a clear delineation of responsibilities (including directed action plans) and communication plans are essential to success. The board needs to have all the information in a coordinated fashion, including results and recommendations, especially as some initiatives will require additional funding.

**Error reporting issues**

Questions that need deliberation:

- Is there currently a system to report errors and/or is it limited to specific types of error?
- Is the current system effective/utilized?
- Should anonymous reporting be utilized?
- Are near misses being reported?
- Do health care workers and/or patients have a mechanism for suggesting improvements in patient safety?
- Do health care workers feel their concerns are acted upon?
- Is the system truly non-punitive (from the health care worker perspective)?

**Program completion, approval and education**

Once the assessment yields a completed educational module with input from the organization’s leaders (chief medical officer, chief nursing officer), it should be presented for approval to key committees: the quality improvement committees, medical executive committees and patient care committees. Finally, it can be presented to the hospital board.

Part of the process will be approaching leaders of all disciplines and educating them about their roles and responsibilities in the patient safety program. The board’s role includes oversight, prioritization and deployment of adequate resources.

**Tips for staff ‘buy in’**

Emphasis should be on optimizing patient safety efforts that are already in place, and how they can be improved. Effectiveness depends upon identifying problems as well as proposing solutions. Often, front line health care workers can identify problems as well as solutions — their opinions should be sought.

Another strategy for achieving “buy in” is to provide feedback in a timely manner to those reporting errors. An effective method for gaining health care worker support is to include in the program issues pertaining to employee safety. This sets an organizational tone that improving safety is a priority for all.

Practical success in implementation of a program requires providing clear timelines for proposed performance improvement initiatives with scheduled reports back to senior leadership. Staff interest and buy in to this focus require engaging hospital leaders in discussions of how patient safety can be improved. Physicians and patient care services leaders are often still practicing patient care; asking their opinions engages them in the process and allows them to feel ownership of patient safety efforts.

Another method to achieve buy in by senior leadership is to actively present errors and resultant root cause analyses to the quality committees and then to the hospital board. These presentations should be ongoing and scheduled, and include both reactive as well as proactive process improvements.

**Naming a leader demonstrates the organization’s commitment to improving safety.**
Identification of a patient safety champion

One of the first goals of an organization developing a patient safety program should be the identification of a patient safety leader. In a health care organization, this can be effectively accomplished by naming an interested, committed, knowledgeable individual. This leader should have the ability to engage physicians and non-physicians, as well as administrators.

A physician leader has the advantage of being able to enroll other physicians in the effort. In addition, physician leaders can mobilize colleagues when crucial issues involving physician buy-in, such as disclosure of errors to patients, are discussed. The patient safety champion can meet one-on-one with board members and other key leaders to advance sensitive issues and serve as the spokesperson for patient safety efforts throughout the organization – and to the population served – as well. Naming a leader demonstrates the organization’s commitment to improving safety.

Pilot projects – key to early successes

Pilot projects that are readily built on current programs might start with increasing medication error reporting, fall reduction or allergy alerts. For example, start with a small project, organize a multidisciplinary team and report results back to senior leadership within three months. An early success will encourage team members and convince leadership that you are on the right track.

Do not attempt to start the initial program with multiple complicated, comprehensive projects; this will compromise team energy. Instead, pick two to three major projects for completion within six months to one year. Utilize existing data to prioritize efforts. For major projects, schedule leadership progress reports at least quarterly. Report on failures as well as successes, but include information on where the fail points can be modified to improve chances of success in the next project.

Development of a non-punitive culture

The natural human tendency after an error occurs is to attempt to place blame.

Development of a non-punitive culture for error reporting does not happen overnight. A strong safety leader can refocus health care teams on the system processes that need improvement, rather than on individual retribution(3). Health care workers must see a non-punitive approach in action in order to believe that they will not be fired for the commission of a medical error. Top leaders in human resources need to be involved in discussions regarding divorcing medical error reporting from disciplinary action and necessary policy development.

In addition, a system needs to be in place whereby individuals providing care during episodes of system breakdown and resultant patient harm are offered counseling and assistance when necessary. Guilt and self-blame almost inevitably occur when a health care professional’s actions result in patient harm.

Present the business case for patient safety

Whenever possible, include a cost-benefit or cost-effectiveness evaluation with reports to senior leadership and the board. For example, if medication errors were reduced by 25 percent, report on the cost savings of those errors to the hospital. Costs can be estimated via case-control comparisons, estimations of length-of-stay reductions, calculations of the attributable cost of the error or using estimates published in the medical literature. Including cost data with results can result in increased funding for patient safety efforts.

Conclusions

Patient safety concerns have been the focus of increasing attention from the media, regulatory and accrediting bodies, payers and the public. A comprehensive patient safety program is a necessity for any health care organization. Success depends upon strong organizational leadership and support from the hospital board. This can be accomplished through ongoing, proactive process improvement methodologies coupled with a patient safety champion who can keep safety foremost in the minds of all.

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REFERENCES

