2018-08-09 Board Quality Committee Meeting

Thursday, August 9, 2018 at 9:00 a.m.

Eskridge Conference Room - Tahoe Forest Hospital

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2018-08-09 Board Quality Committee Meeting

08/09/18 Board Quality Committee

AGENDA

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ITEMS 1 - 4: See Agenda

5. APPROVAL OF MINUTES

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6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First
No related materials.

6.2. Patient & Family Centered Care (PFCC)

6.2.1. Follow up on previous Patient Experience presentation
No related materials.

6.2.2. PFAC Update.pdf Page 9

6.3. Quality Assurance Performance Improvement Initiatives 2018.pdf Page 10

6.4. Patient Safety

6.4.1. Beta HEART Program Update to BOD 072318.pdf Page 13

6.5. Hospital Compare Star Rating overview.pdf Page 14

6.6. Board Quality Education

6.6.1. SEA_57_Safety_Culture_Leadership_030117.pdf Page 18

6.6.2. High Reliability Organization Article.pdf Page 26

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QUALITY COMMITTEE
AGENDA

Thursday, August 9, 2018 at 9:00 a.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
Alyce Wong, RN, Chair; Charles Zipkin, M.D., Board Member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

4. INPUT – AUDIENCE
This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. APPROVAL OF MINUTES OF: 05/08/2018 .... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First

6.2. Patient & Family Centered Care (PFCC)

6.2.1. Follow up on previous Patient Experience presentation
Provide status report on mental health coordination and resources for patients in our community.

6.2.2. Patient & Family Advisory Council Update .... ATTACHMENT
An update will be provided related to the activities of the Patient and Family Advisory Council (PFAC).

6.3. Performance Improvement Initiatives .... ATTACHMENT
Provide status report on the Quality Assurance/Performance Improvement Plan (#AQPI-05) priorities for 2018.

6.4. Patient Safety

6.4.1. Beta HEART Program .... ATTACHMENT
Provide update regarding the Beta Healthcare Group culture of safety program.

6.5. Quality Star Rating .... ATTACHMENT
Review the Hospital Compare Quality star rating program.

6.6. Board Quality Education .... ATTACHMENT
The Committee will review and discuss topics for future board quality education. Identify best practice topics for review at future meetings.

6.6.1. The Joint Commission (2017). The essential role of leadership in developing a safety culture. *Sentinel Event Alert*, 57.

6.6.2. Patient Safety Network (2017). High Reliability. *Patient Safety Primer,* 31.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE

The date and time of the next committee meeting will be confirmed.

9. ADJOURN

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

QUALITY COMMITTEE
DRAFT MINUTES

Tuesday, May 8, 2018 at 12:00 p.m.
Pine Street Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER
Meeting was called to order at 12:01 p.m.

2. ROLL CALL
Board: Alyce Wong, RN, Chair; Charles Zipkin, M.D., Board Member

Staff in attendance: Harry Weis, Chief Executive Officer; Judy Newland, Chief Operating Officer; Karen Baffone, Chief Nursing Officer; Dr. Shawni Coll, Chief Medical Officer; Janet Van Gelder, Director of Quality and Regulations; Jean Steinberg, Director of Medical Staff Services; Lorna Tirman, Patient Experience Specialist; Martina Rochefort, Clerk of the Board

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA
No changes were made to the agenda.

4. INPUT – AUDIENCE
No public comment was received.

5. APPROVAL OF MINUTES OF: 02/01/2018
CNO noted the PRIME initiatives were set in year one. The number of items reported on increases every year.

Director Zipkin moved approval of the February 1, 2018 Board Quality Committee minutes, seconded by Director Wong.

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION
6.1. Patient & Family Centered Care (PFCC)
6.1.1. Patient Experience Presentation TIMED ITEM – 12:05 p.m.
Patient shared experience from when he sought treatment for depression.

Dr. Scholnick, Vice Chief of Staff and Dr. Peter Taylor joined the meeting at 12:08 p.m.

Committee discussed the Health System's care coordination program.

6.1.2. Patient & Family Advisory Council Update
Lorna Tirman, Patient Experience Specialist, provided an update on the activities of the Patient and Family Advisory Council (PFAC).

PFAC meets every month. In April, the council discussed improving outpatient and medical practices experiences using CARE (Connect, Ask, Respect and Respond, Empathy and Educate).

DRAFT

PFAC felt the following were behaviors that mattered:

-Welcome immediately with acknowledgement and eye contact.
-Make everyone feel welcome.
-Ask "How can I help you?"
-Pay attention to me and keep me informed.
-Remember that people are not at their best, they are scared, anxious and in general do not want to be here. They may be afraid of getting bad news from their tests. Communication is the key.
- Use volunteers for wayfinding.

These behaviors are not happening with every patient every time.

PFAC has two new members but is still recruiting for additional members.

Dr. Taylor spoke about the outpatient experience. There is a lot of parallel to the MSC clinics. Feedback coming in from training of MSC.

6.2. Performance Improvement Initiatives

Quality Committee received a status report on the Quality Assurance/Performance Improvement Plan (#AQPI-05) priorities for 2018.

To improve the top decile quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence, Quality shares the patient satisfaction metrics quarterly with the board. EPIC best practice alerts have helped a lot.

COO sends out updates on the Perfect Care Experience.

Director Zipkin asked if quality gets resistance from staff when scores drop a few percent for top box scores but switch to red. Patient Experience Specialist responded that is about how the conversation is had. The Health System never stops trying to be a better organization.

CMO emphasize the District is "striving" for the perfect care experience.

CNO noted that this how many organizations get paid.

To ensure Patient Safety across the entire Health System with a focus on High Reliability Organizational (HRO) thinking, Quality is putting together a plan to train 25 key staff members on HRO in July.

Another performance improvement initiative will be to roll out a user friendly incident reporting system. The cost is in the budget for next year. The daily admin huddle is reporting any Quantros reports received and there has been an uptick in reporting.

The initiative to identify best practice plan related to Co-Management of Hospitalized Patients was reviewed. Dr. Taylor does not feel that formal agreements with hospitalists are needed. The desire was to generate it based on a patient safety measure. CEO would want physicians to drive it. Director Wong noted it should be stated in the quarterly report.

6.3. Quality Metric for CEO Incentive Compensation

Committee discussed a quality metric for the CEO Incentive Compensation plan for fiscal year 2019.

Committee discussed the TFH IP Core Measure Rollup metric. This measure includes the following measure(s)/sets: Immunization (IMM), Perinatal Care of Mothers (PCM), Stroke (STK), Venous Thromboembolism (VTE), Sepsis (SEP) and Acute Myocardial Infarction (AMI). It is measured by noncompliant over compliant opportunities.

Committee also discussed a metric related to Emergency Department throughput.

CNO noted there are factors that can alter throughput such as the ICU being closed or how a hospitalist rounds discharging and admitting patients.

Committee recommended the CEO Incentive Compensation metric to be TFH IP Core Measure Rollup at 94.4% or better.

6.4. Annual Quality Assurance/Performance Improvement Report to Board of Directors
Item was deferred to the next meeting.

6.5. Patient Safety

6.5.1 Beta HEART Program Update
Seven TFHD staff, including two providers and CMO, attended Beta HEART Conference #1 in February. The focus was on Culture of Safety and initial discussion of Rapid Response to Events

SCORE (Safety, Communication, Operational Reliability, and Engagement) Culture of Safety Survey was completed in March. The response rate was 64% with 48 providers. Preliminary results have been received and Quality is in the process of reviewing and analyzing the results and will present to the leadership team. Leadership will be sharing department specific results with staff and developing action
Plans.

The next Beta HEART conference scheduled for May 9-10. Five TFHD staff and three providers (Wicks, Jowers, Semrad) will attend. The focus is on Rapid Event Response, Care for the Caregiver, and in depth Communication and Transparency training. A future conference will be held in early September.

Dr. Taylor spoke to BETA's program and how well developed it is.

6.6. Healthy People 2020 Recognition
No discussion was held. Acknowledgement was previously made at a board meeting.

6.7. Board Quality Education
Committee will discuss topics for future board quality education. The committee will also review the following articles:

6.7.1. The Joint Commission (2017). The essential role of leadership in developing a safety culture. *Sentinel Event Alert*, 57.

No discussion was held.

6.7.2. Patient Safety Network (2017). High Reliability. *Patient Safety Primer,* 31.

No discussion was held.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS
None.

8. NEXT MEETING DATE
Thursday, August 9, 2018 at 9:00 a.m. was confirmed for the next Board Quality Committee meeting.

9. ADJOURN
Meeting adjourned at 1:36 p.m.

Patient and Family Advisory Council Summary Report: January 2018 to June 2018

Submitted by: Lorna Tirman Patient Experience Specialist

The Tahoe Forest Hospital Advisory Council meets every month 9 months in the year. We do not meet July, August or December.

There are currently 8 active members.

Council agreed in January that their work will be aligned with hospital plan to assist leadership in creating the perfect care experience.
Meetings are focused on improving processes and behaviors to continue to provide the Perfect Care Experience to our community and visitors.

Plan for 2017-18 is to review patient feedback and comments from patient experience surveys.

Currently reviewing top performing service areas and focusing on service areas that are lowest performing.

Reviewed history of patient experience and evolution of Patient Advisory Councils. Discussion about how patient experience and quality of care are related.

Communication is a large part of a care experience.

Engaged council in how to improve Patient Experiences in our lowest scoring service areas, outpatient and multispecialty clinics.

Council defined behaviors would be ideal to create a perfect care experience. CARE= Connect, Ask, Respect and Respond, Educate with Empathy. Will take these ideas to CARE committee.

Advisory council recommended we encourage all patients to return surveys. Scripting sent to all leaders to share with staff to encourage patients and families to send back their feedback if they receive a survey.

Next Meeting September 18th, 2018

	Tahoe Forest Health System			
	Title: Quality Assurance / Performance Improvement (QA/PI) Plan		**Policy/Procedure #: AQPI-05**	
	Responsible Department: Quality & Regulations			

Type of policy		Original Date:	Reviewed Dates:	Revision Dates:
☒	Administrative	9/96		12/14; 2/16; 2/17; 1/18
☐	Medical Staff			
☐	Departmental			

Applies to: X System ☐ Tahoe Forest Hospital ☐ Incline Village Community Hospital

PURPOSE

The purpose of the Quality Assurance/Performance Improvement (QA/PI) plan is to provide a framework for promoting and sustaining performance improvement at Tahoe Forest Health System, in order to improve the quality of care and enhance organizational performance. The goals are to proactively reduce risk to our patients by eliminating or reducing factors that contribute to unanticipated adverse events and/or outcomes and provide high quality care and services to ensure a perfect care experience for our patients and customers. This will be accomplished through the support and involvement of the Board of Directors, Administration, Medical Staff, Management, and employees, in an environment that fosters collaboration and mutual respect. This collaborative approach supports innovation, data management, performance improvement, proactive risk assessment, commitment to customer satisfaction, and use of the Just Culture model to promote and improve awareness of patient safety. Tahoe Forest Health System has an established mission, vision, values statement, and utilizes a foundation of excellence model, which are used to guide all improvement activities.

POLICY:

MISSION STATEMENT

The mission of Tahoe Forest Health System is *"To serve our region by striving to be the best mountain health system in the nation."*

VISION STATEMENT

The vision of Tahoe Forest Health System is "*We exist to make a difference in the health of our communities through excellence and compassion in all we do."*

VALUES STATEMENT

Our vision and mission is supported by our values. These include:

- Quality – holding ourselves to the highest standards and having personal integrity in all we do
- Understanding – being aware of the concerns of others, caring for and respecting each other as we interact
- Excellence – doing things right the first time, on time, every time, and being accountable and responsible
- Stewardship – being a community steward in the care, handling and responsible management of resources while providing quality healthcare
- Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do

FOUNDATIONS OF EXCELLENCE

Our foundation of excellence includes: Quality, Service, People, Finance and Growth

- Quality – provide excellence in clinical outcomes
- Service – best place to be cared for
- People – best place to work, practice and volunteer
- Finance – provide superior financial performance
- Growth – meet the needs of the community

PERFORMANCE IMPROVEMENT INITIATIVES

The 2018 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations;
- Reducing the per capita cost of health care;
- Staff engagement and joy in work.

Priorities identified include:

- Top decile quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
    - Striving for the Perfect Care Experience
    - Reinforce performance excellence framework to improve organizational processes, capabilities, and results

- Sustain a Just Culture philosophy that promotes a culture of safety, transparency, and system improvement
    - Participate in Beta HEART (healing, empathy, accountability, resolution, trust) program

- Ensure Patient Safety across the entire Health System with a focus on High Reliability Organizational thinking
    - Preoccupation with failure
    - Reluctance to simplify

    - Sensitivity to operations
    - Deference to expertise
    - Commitment to resilience

- Implement user friendly incident reporting system with a goal to increase reporting of events

- Identify best practice plan related to Co-Management of Hospitalized Patients

- Support Patient and Family Centered Care and the Patient and Family Advisory Council
    - Dignity and Respect: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
    - Information Sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.
    - Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
    - Collaboration: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.

- Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies

- Identify gaps in the Epic electronic health record implementation and develop plans of correction

- Maximize Epic reporting functionality to improve data capture and identification of areas for improvement

- Achieve Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Project Initiatives

Tahoe Forest Health System's vision will be achieved through these strategic priorities. Each strategic priority is driven by leadership oversight and teams developed to ensure improvement and implementation (see Attachment A).

Beta HEART Program Update

HEART = Healing, Empathy, Accountability, Resolution, Trust

Dawn Lockwood, Patient Safety Specialist

- 7 TFHD staff, including 2 physicians and CMO, attended Beta HEART Conference #1 in February
    - Focus on Culture of Safety and initial discussion of Rapid Response to Events

- TFHD Staff, additionally 1 ED physician, attended Beta HEART conference #2 in May
    - Focus on Rapid Event Response, Care for the Caregiver, and in depth Communication and Transparency training

- SCORE (*Safety, Communication, Operational Reliability, and Engagement)* Culture of Safety Survey completed in March
    - 64% response rate, with 48 providers
    - Results have been shared with all department leaders and AC. Key areas for opportunity overall include
        - Teamwork (inter and intra- departmental)
        - Improving feedback and performance expectations to staff (by leadership)
        - Continuing to work on technology process improvement (EPIC)
    - Survey results and debriefing sessions with department staff are occurring throughout July and August
    - Department Leadership will receive feedback from staff debriefing sessions and develop goals for improving

- Disclosure and Care for the Caregiver policies have been reviewed and updated by team.
    - Education to Medical Staff and TFHD staff has begun and is ongoing.

- 3rd Beta HEART conference to be held in mid-October with same team attending

Medicare.gov | Hospital Compare
The Official U.S. Government Site for Medicare

Hospital Compare overall rating

Questions about the Hospital Compare overall rating can be submitted to: cmsstarratings@lantanagroup.com.

What is the Hospital Compare overall rating?

The overall rating summarizes up to 57 quality measures on Hospital Compare reflecting common conditions that hospitals treat, such as heart attacks or pneumonia. Hospitals may perform more complex services or procedures not reflected in the measures on Hospital Compare. The overall rating shows how well each hospital performed, on average, compared to other hospitals in the U.S.

The overall rating ranges from one to five stars. The more stars, the better a hospital performed on the available quality measures. The most common overall rating is 3 stars. Learn more about the overall rating calculations.

How can I use the Hospital Compare overall rating?

In an emergency, you should go to the nearest hospital. When you are able to plan ahead, the Hospital Compare overall rating can provide a starting point for comparing a hospital to others locally and nationwide. Along with the overall rating, Hospital Compare includes information on many important aspects of quality, such as rates of infection and complications and patients' experiences, based on survey results.

Choosing a hospital is a complex and personal decision that reflects individual needs and preferences. You should consider a variety of factors when choosing a hospital, such as physician guidance about your care plan and other sources of information about hospitals in your area.

Discuss the information you find on Hospital Compare with your physician or health care provider to decide which hospital best meets your health care needs.

Where does the Hospital Compare overall rating come from?

Hospitals report data to the Centers for Medicare & Medicaid Services, the federal agency that runs the Medicare program, through the Hospital Inpatient Quality Reporting (IQR) Program and the Hospital Outpatient Quality Reporting (OQR) Program. The Hospital Compare overall

rating includes up to 57 of these measures in the overall rating calculation. Learn more.

Do the overall rating and the measures on Hospital Compare include all patients treated at the hospital or just Medicare patients?

Some of the measures used to calculate the overall rating are based only on data from Medicare patients and some are based on data from all patients. The claims-based measures, which include the mortality, readmission, complications, PSI-90, imaging efficiency, and unplanned hospital visits measures, are calculated using Medicare fee-for-service (FFS) hospital claims data only. The process of care, healthcare-associated infection (HAI), and HCAHPS Survey measures include data from all payers.

Why is the Hospital Compare overall rating not displayed for some hospitals?

This website displays an overall rating for about 80% of hospitals on Hospital Compare. In order for Hospital Compare to display an overall rating for a hospital, the hospital must have enough data on the individual quality measures used to calculate the overall rating. Some hospitals, due to the number and type of patients they treat, may not report data on all measures, and therefore, are not eligible for an overall star rating. For example, hospitals that are new or small may not have enough patients for the measures used to calculate an overall rating.

Medicare.gov | Hospital Compare
The Official U.S. Government Site for Medicare

How the Hospital Compare overall rating is calculated

The Hospital Compare overall rating summarizes up to 57 quality measures across seven areas of quality into a single star rating for each hospital. Once reporting thresholds are met, a hospital's overall rating is calculated using only those measures for which data are available. This may include as few as 9 or as many as 57 measures. The average is about 39 measures. Hospitals report data to the Centers for Medicare & Medicaid Services through the Hospital Inpatient Quality Reporting (IQR) Program and the Hospital Outpatient Quality Reporting (OQR) Program. Star ratings are not calculated for Veterans Health Administration (VHA) hospitals.

The methodology uses a statistical model known as a *latent variable model*. Seven different latent variable models are used to calculate scores for seven groups of measures.

1. Mortality
2. Safety of Care
3. Readmission
4. Patient Experience
5. Effectiveness of Care
6. Timeliness of Care
7. Efficient Use of Medical Imaging

A hospital summary score is then calculated by taking the weighted average of these group scores. If a hospital is missing a measure category or group, the weights are redistributed amongst the qualifying measure categories or groups.

Finally, the overall rating is calculated using the hospital summary score.

Only hospitals that have at least three measures within at least three measure groups or categories, including one outcome group (mortality, safety, or readmission), are eligible for an overall rating. Not all hospitals report all measures. Therefore, some hospitals may not be eligible for an overall rating.

The comprehensive methodology report provides additional detail on the methodology used to calculate the Hospital Compare overall rating.

National distribution of overall star ratings

The following table shows the national distribution of the overall star rating based on December 2017 results.

Overall Rating	Number of Hospitals (N=4,579, %)
5 stars	337 (7.36%)
4 stars	1155 (25.22%)
3 stars	1187 (25.92%)
2 stars	753 (16.44%)
1 star	260 (5.68%)
N/A[2]	887 (19.37%)

Additional information

The methodology for calculating the overall ratings was developed with input from stakeholders and members of the public. Detailed information on the methodology is available on QualityNet.

Questions about the Hospital Compare overall rating may be submitted to: cmsstarratings@lantanagroup.com.

A complimentary publication of The Joint Commission
Issue 57, March 1, 2017

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]

In addition, through the results of its safety initiatives, The Joint Commission Center for Transforming Healthcare has found inadequate safety culture to be a significant contributing factor to adverse outcomes. 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 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."

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The Joint Commission introduced safety culture concepts in 2008 with the publication of a Sentinel Event Alert on behaviors that undermine a culture of safety.[14] Further emphasis was made the following year with a Sentinel Event Alert on leadership committed to safety (this Alert replaces and updates that one), and the establishment of a leadership standard requiring leaders to create and maintain a culture of safety. The Patient Safety Systems (PS) chapter of The Joint Commission's *Comprehensive Accreditation Manual for Hospitals* emphasizes the importance of safety culture. As of Jan. 1, 2017, the chapter expanded to critical access hospitals, and to ambulatory care and office-based surgery settings.

Safety culture foundation

Safety culture is the sum of what an organization ***is*** and ***does*** in the pursuit of safety.[15] The PS chapter defines safety culture as the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety. Organizations that have a robust safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.[16] The safety culture concept originated in the nuclear energy and aviation industries, which are known for their use of strategies and methodologies designed to consistently and systematically mitigate risk, thereby avoiding accidents.[17,18] The Institute of Nuclear Power Operations defined safety culture characteristics[19] that are adaptable to the health care environment:

1. Leaders demonstrate commitment to safety in their decisions and behaviors.
2. Decisions that support or affect safety are systematic, rigorous and thorough.
3. Trust and respect permeate the organization.
4. Opportunities to learn about ways to ensure safety are sought out and implemented.
5. Issues potentially impacting safety are promptly identified, fully evaluated, and promptly addressed and corrected commensurate with their significance.
6. A safety-conscious work environment is maintained where personnel feel free to raise safety concerns without intimidation, harassment, discrimination, or fear of retaliation.
7. The process of planning and controlling work activities is implemented so that safety is maintained.

Leaders can build safety cultures by readily and willingly participating with care team members in initiatives designed to develop and emulate safety culture characteristics.[13] Effective leaders who deliberately engage in strategies and tactics to strengthen their organization's safety culture see safety issues as problems with organizational systems, not their employees, and see adverse events and close calls ("near misses") as providing "information-rich" data for learning and systems improvement.[3-5] Individuals within the organization respect and are wary of operational hazards, have a collective mindfulness that people and equipment will sometimes fail, defer to expertise rather than hierarchy in decision making, and develop defenses and contingency plans to cope with failures. These concepts stem from the extensive research of James Reason on the psychology of human error. Among Reason's description of the main elements of a safety culture[20] are:

- **Just culture** – people are encouraged, even rewarded, for providing essential safety-related information, but clear lines are drawn between human error and at-risk or reckless behaviors.
- **Reporting culture** – people report their errors and near-misses.
- **Learning culture** – the willingness and the competence to draw the right conclusions from safety information systems, and the will to implement major reforms when their need is indicated.

In an organization with a strong safety culture, individuals within the organization treat each other and their patients with dignity and respect. The organization is characterized by staff who are productive, engaged, learning, and collaborative.[19] Having care team members who gain joy and meaning through their work has been found to have an important role in establishing and maintaining a safe culture. The Lucien Leape Institute's Joy & Meaning in Workforce Safety initiative addresses clinician burnout, which is at record highs.[11,21] Clinician burnout is associated with lower perceptions of patient safety culture and may directly or indirectly affect patient outcomes.[22]

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Joy and meaning will be created when the workforce feels valued, safe from harm, and part of the solutions for change. When team members know that their well-being is a priority, they are able to be meaningfully engaged in their work, to be more satisfied, less likely to experience burnout, and to deliver more effective and safer care.[11,21] Leaders who encourage transparency in response to reports of adverse events, close calls and unsafe conditions, and who have established processes that ensure follow-up to ensure reports are not lost or ignored (or perceived to be lost or ignored), help mitigate intimidating behaviors because transparency of action itself discourages such behavior. On the opposite end of the spectrum, intimidating and unsettling behaviors causing emotional harm, including the use of inappropriate words and actions or inactions, has a detrimental impact on patient safety[10] and should not occur in a safety culture. This includes terminating, punishing or failing to support a health care team member who makes an error (the "second victim").

Unfortunately, as attention to the need for a culture of safety in hospitals has increased, "so have concomitant reports of retaliation and intimidation targeting care team members who voice concern about safety and quality deficiencies," according to a National Association for Healthcare Quality report.[9] Intimidation has included overtly hostile actions, as well as subtle or passive-aggressive behaviors, such as failing to return phone calls or excluding individuals from team activities. Survey results released by the Institute for Safe Medication Practices (ISMP) show that disrespectful behavior remains a problem in the health care workplace. Most respondents reported experiences with negative comments about colleagues, reluctance or refusal to answer questions or return calls, condescending language or demeaning comments, impatience with questions or hanging up the phone, and a reluctance to follow safety practices or work collaboratively.[23]

Actions suggested by The Joint Commission

The Joint Commission recommends that leaders take actions to establish and continuously improve the five components of a safety culture defined by Chassin and Loeb: ***trust, accountability, identifying unsafe conditions, strengthening systems, and assessment.***[18] These actions are not intended to be implemented in a sequential manner. Leaders will need to address and apply various components to the workforce simultaneously, using tactics such as board engagement, leadership education, goalsetting, staff support, and dashboards and reports that routinely review safety data.[12]

1. Absolutely crucial is a transparent, non-punitive approach to reporting and learning from adverse events, close calls and unsafe conditions,[16,24] states the Patient Safety Systems (PS) chapter of The Joint Commission's *Comprehensive Accreditation Manual for Hospitals*. Develop ***trust and accountability*** through an organizational-wide and easy-to-use reporting system. This reporting system should be accessible to everyone within the organization. Having this system is essential for developing a culture in which unsafe conditions are identified and reported without fear of punishment or reprisal for unintentional mistakes, leading to proactive prevention of patient harm.[14,18,25,26] Leaders can augment voluntary reporting by using other methods, such as trigger tools and observational techniques, to proactively address risk and identify potential errors.[27]

2. Establish clear, just, and transparent risk-based processes for recognizing and separating human error and error arising from poorly designed systems from unsafe or reckless actions that are blameworthy.[18] Mistakes, lapses, omissions and other human errors are opportunities for improvement and lessons learned from them should be shared. Punishing, terminating or failing to support an employee who makes a mistake during the course of an adverse event can erode leadership's credibility and undermine organizational safety culture.[28] The Incident Decision Tree, from the United Kingdom's National Patient Safety Agency, is one example that supports the aim of creating an open, fair and accountable culture, where employees feel able to report patient safety incidents without undue fear of the consequences, and health care organizations know where to draw the accountability line.

3. To advance trust within the organization, CEOs and all leaders must adopt and model appropriate behaviors and champion efforts to eradicate intimidating behaviors.[18,25,26] These behaviors include demonstrating respect in all interactions, personally participating in activities and programs aimed at improving safety culture, and by making sure safety-related feedback from staff is acknowledged and, if appropriate,

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implemented. Leadership must maintain a fair and equitable measure of accountability to all.

4. Establish, enforce and communicate to all team members the policies that support safety culture and the reporting of adverse events, close calls and unsafe conditions.[19]

5. Recognize care team members who report adverse events and close calls, who identify unsafe conditions, or who have good suggestions for safety improvements. Leaders can recognize "good catches" – in which adverse events are avoided – and share these "free lessons" with all team members (i.e., feedback loop).[29] The Joint Commission Center for Transforming Healthcare's Safety Culture project found that two effective ways of reporting back to team members who raised safety issues were through 1) shift and unit huddles, and 2) visual management boards. They found that care team members stopped making suggestions when they received no feedback from team or hospital leaders.

Also useful toward recognizing safety initiatives and promoting safety culture are activities involving leaders, such as team safety briefings and planning sessions,[17,30] huddles[31,32] about safety threats or issues, debriefs to learn from identified errors or safety defects,[30,33] and safety rounds or walkarounds.[34-36]

6. Establish an organizational baseline measure on safety culture performance using the Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture (HSOPS) or another tool, such as the Safety Attitudes Questionnaire (SAQ).[37-39] A summary of these tools can be found in the Resources section of this alert.

7. Analyze safety culture survey results from across the organization to find opportunities for quality and safety improvement.[33,39-40] Analyzing data in this manner enables an organization to find improvement opportunities and solutions in line with organizational priorities and needs. This analysis must drill down to local unit levels so that unit-specific solutions can be developed and implemented.[41] Share the results with frontline staff throughout the organization and with governing bodies, including the board.

8. In response to information gained from safety assessments and/or surveys, develop and implement unit-based quality and safety improvement initiatives designed to improve the culture of safety.[33,39-40,42-46] Examples from Joint Commission-accredited organizations include:

- An obstetrics service line created a multidisciplinary code of professionalism as a mechanism to address unprofessional behavior. Physicians, nurses, and support staff underwent education that addressed why and how to report unprofessional behavior. Leadership followed up on all reports concerning unprofessional behavior with coaching. As a result of the education, reporting and coaching, statistically significant improvement was shown on the following AHRQ Hospital Survey on Patient Safety Culture dimensions: teamwork within units, management support, organizational learning, and frequency of events reported.[47]

- The Rhode Island Intensive Care Unit (ICU) Collaborative conducted a study to examine the impact of a Safety Attitudes Questionnaire Action Plan (SAQAP) on ICU central-line associated blood stream infections (CLABSIs) and ventilator-associated pneumonia (VAP) rates. Teams that developed SAQAPs improved their unit culture and clinical outcomes. Units that developed SAQAPs demonstrated higher improvement rates in all domains of the SAQ, except working conditions. Improvements were close to statistical significance for teamwork climate (+18.4 percent in SAQAP units versus -6.4 percent in other units, $p = .07$) and job satisfaction (+25.9 percent increase in SAQAP units versus +7.3 percent, $p = .07$). Units with SAQAPs decreased the CLABSI rates by 10.2 percent in 2008 compared with 2007, while those without SAQAP had a 2.2 percent decrease in rates ($p = .59$). Similarly, VAP rates decreased by 15.2 percent in SAQAP units, while VAP rates increased by 4.8 percent in units without SAQAP ($p = .39$).[48]

- An academic medical center developed a comprehensive unit-based safety program that included steps to identify hazards, partnered units with a senior executive to fix hazards, learned from defects, and implemented communication and teamwork tools. In 2006, 55 percent of units achieved the SAQ-measured safety climate goal of meeting or exceeding a 60 percent positive

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score or improving the score by 10 or more percentage points. In 2008, 82 percent of units achieved the goal. For teamwork climate, the two-year improvement was 61 to 83 percent. Scores improved in every SAQ domain except stress recognition.[39]

Many other examples of successful and measurable safety culture initiatives can be found in health care literature. Some of these initiatives[39,49] successfully used tactics such as walkarounds,[34-36] huddles,[31,32] employee engagement,[50,51] team safety briefings and planning sessions,[17,30] debriefs to learn from identified errors or safety defects,[30,33] and safety ambassadors[52] to improve various aspects of safety culture. Improvement on safety culture measures is associated with positive outcomes, such as reduced infection rates,[38,53] fewer readmissions,[38,53] decreased care team member turnover,[39] better surgical outcomes,[54] reduced adverse events,[55,56] and decreased mortality.[55] Health care organizations in which care team members have positive perceptions of safety culture tend to have positive assessments of care from patients as well.[57]

9. Embed safety culture team training into quality improvement projects[33,39-40,49] and organizational processes to strengthen safety systems.[17,18,30] Team training derived from evidence-based frameworks can be used to enhance the performance of teams in high-stress, high-risk areas of the organization – such as operating rooms, ICUs and emergency departments – and has been implemented at many health care facilities across the country.[17,30]

Safety Culture Key to High Reliability

The Joint Commission established a theoretical framework that emphasizes safety culture, leadership and robust process improvement as three domains that are critical to high reliability within a health care organization.[18] By promoting the core attributes of trust, report and improve,[15] high-reliability organizations create safety cultures in which team members trust peers and leadership; report vulnerabilities and hazards that require risk-based consideration; and communicate the benefits of these improvements back to involved staff. Leaders can self-assess performance and improvements relating to high reliability by using the Oro™ 2.0 High Reliability Organizational Assessment and Resources Tool. See this alert's Resources section for more information.

10. Proactively assess system (such as medication management and electronic health records) strengths and vulnerabilities and prioritize them for enhancement or improvement.[18,58]

11. Repeat organizational assessment of safety culture every 18 to 24 months to review progress and sustain improvement.[38] Ensure that the assessment drills down to unit levels,[41] and make these assessments part of strategic measures reported to the board.[18]

Related Joint Commission requirements
Many Joint Commission standards address issues related to the design and management of patient safety systems. These requirements and elements of performance, which include the following, can be found in the Patient Safety Systems (PS) chapter of The Joint Commission's accreditation manuals for hospitals and critical access hospitals, and for ambulatory care and office-based surgery settings:

LD.03.01.01: Leaders create and maintain a culture of safety and quality throughout the organization.

EP 1. Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.

EP 4. Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.

EP 5. Leaders create and implement a process for managing behaviors that undermine a culture of safety.

Resources
Hospital Survey on Patient Safety Culture (HSOPS) – Identifies 12 dimensions of safety culture (10 climate dimensions and two outcomes variables):[53]

- Communication openness
- Feedback and communication about error
- Frequency of events reported
- Handoffs and transitions
- Management support for patient safety
- Non-punitive response to error
- Organizational learning (continuous improvement)
- Overall perceptions of safety
- Staffing
- Supervisor/manager expectations and actions promoting safety

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- Teamwork across units
- Teamwork within units

United Kingdom's National Patient Safety Agency's Incident Decision Tree – Supports the aim of creating an open culture, where employees feel able to report patient safety incidents without undue fear of the consequences. The approach does not seek to diminish health care professionals' individual accountability, but encourages key decision makers to consider systems and organizational issues in the management of error.[28]

Institute for Healthcare Improvement's Joy in Work initiative – Addresses clinician burnout.

The Joint Commission Center for Transforming Healthcare's Oro™ 2.0 High Reliability Organizational Assessment and Resources application – High reliability organizations routinely self-assess. This self-assessment tool is intended for hospital leadership teams. It can be used in combination with tools (such as HSOPS and SAQ) that measure the perceptions of staff at all levels of the organization. The tool evaluates:

- Leadership commitment
- Safety culture
- Performance improvement

Patient Safety Systems (PS) chapter of The Joint Commission's *Comprehensive Accreditation Manual for Hospitals* (as of Jan. 1, 2017, also applicable to critical access hospitals, and to ambulatory care and office-based surgery settings)

Safety Attitudes Questionnaire (SAQ) – Measures six culture domains:

- Teamwork climate
- Safety climate
- Perceptions of management
- Job satisfaction
- Working conditions
- Stress recognition

Safety Culture Project, The Joint Commission Center for Transforming Healthcare – Seven participating organizations focused on identifying unsafe conditions before they reached the patient and finding reliable, sustainable solutions. The organizations found that reporting back to team members about how their suggestions improved care increased team member satisfaction, particularly if the feedback included praise, either public or private as appropriate, for those who spoke up.[29] The project utilized The Joint Commission's Robust Process Improvement® (RPI®), a blended approach to improve business and clinical processes and outcomes using Lean, Six Sigma and change management methodologies. RPI is intended for all staff, including leaders.

Strategies for Creating, Sustaining, and Improving a Culture of Safety in Health Care – Published by Joint Commission Resources, this second edition book expands the idea of "building" a culture of safety by spotlighting the best articles related to this topic from *The Joint Commission Journal on Quality and Patient Safety*. These articles provide unique perspectives of challenges inherent when establishing and maintaining a culture of safety.

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Patient Safety Advisory Group
The Patient Safety Advisory Group informs The Joint Commission on patient safety issues and, with other sources, advises on topics and content for *Sentinel Event Alert*.

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High Reliability

Background

High reliability organizations are organizations that operate in complex, high-hazard domains for extended periods without serious accidents or catastrophic failures. The concept of high reliability is attractive for health care, due to the complexity of operations and the risk of significant and even potentially catastrophic consequences when failures occur in health care. Sometimes people interpret high reliability as meaning effective standardization of health care processes. However, the principles of high reliability go beyond standardization; high reliability is better described as a condition of persistent mindfulness within an organization. High reliability organizations cultivate resilience by relentlessly prioritizing safety over other performance pressures. A classic example is that of the military aircraft carrier: despite significant production pressures (aircrafts take off and land every 48 –60 seconds), constantly changing conditions, and hierarchical organizational structure, all personnel consistently prioritize safety and have both the authority and the responsibility to make real-time operational adjustments to maintain safe operations as the top priority.

Characteristics of High Reliability Organizations

High reliability organizations use systems thinking to evaluate and design for safety, but they are keenly aware that safety is an emergent, rather than a static, property. New threats to safety continuously emerge, uncertainty is endemic, and no two accidents are exactly alike. Thus, high reliability organizations work to create an environment in which potential problems are anticipated, detected early, and virtually always responded to early enough to prevent catastrophic consequences. This mindset is supported by five characteristic ways of thinking: preoccupation with failure; reluctance to simplify explanations for operations, successes, and failures; sensitivity to operations (situation awareness); deference to frontline expertise; and commitment to resilience (Table).

Table. Characteristics of High Reliability.

Characteristic	Description
Preoccupation With Failure	Everyone is aware of and thinking about the potential for failure. People understand that new threats emerge regularly from situations that no one imagined could occur, so all personnel actively think about what could go wrong and are alert to small signs of potential problems. The absence of errors or accidents leads not to complacency but to a heightened sense of vigilance for the next possible failure. Near misses are viewed as opportunities to learn about systems issues and potential improvements, rather than as evidence of safety.
Reluctance to Simplify	People resist simplifying their understanding of work processes and how and why things succeed or fail in their environment. People in HROs* understand that the work is complex and dynamic. They seek underlying rather than surface explanations. While HROs recognize the value of standardization of workflows to reduce variation, they also appreciate the complexity inherent in the number of teams, processes, and relationships involved in conducting daily operations.
Sensitivity to Operations	Based on their understanding of operational complexity, people in HROs strive to maintain a high awareness of operational conditions. This sensitivity is often referred to as "big picture understanding" or "situation awareness." It means that people cultivate an understanding of the context of the current state of their work in relation to the unit or

	organizational state—i.e., what is going on around them—and how the current state might support or threaten safety.
Deference to Expertise	People in HROs appreciate that the people closest to the work are the most knowledgeable about the work. Thus, people in HROs know that in a crisis or emergency the person with greatest knowledge of the situation might not be the person with the highest status and seniority. Deference to local and situation expertise results in a spirit of inquiry and de-emphasis on hierarchy in favor of learning as much as possible about potential safety threats. In an HRO, everyone is expected to share concerns with others and the organizational climate is such that all staff members are comfortable speaking up about potential safety problems.
Commitment to Resilience	Commitment to resilience is rooted in the fundamental understanding of the frequently unpredictable nature of system failures. People in HROs assume the system is at risk for failure, and they practice performing rapid assessments of and responses to challenging situations. Teams cultivate situation assessment and cross monitoring so they may identify potential safety threats quickly and either respond before safety problems cause harm or mitigate the seriousness of the safety event.

*HROs: High reliability organizations

Sources: Weick et al 2007; Hines et al 2008; Chassin et al 2013; Rochlin 1999.

Current Context

It is important to recognize that standardization is necessary but not sufficient for achieving resilient and reliable health care systems. High reliability is an ongoing process or an organizational frame of mind, not a specific structure. AHRQ has outlined practical strategies for health care organizations aiming to become highly reliable in their report of practices employed by hospitals in the High Reliability Organization Learning Network. The Joint Commission suggests that hospitals and health care organizations work to create a strong foundation before they can begin to mature as high reliability organizations. Such foundational work includes developing a leadership commitment to zero-harm goals, establishing a positive safety culture, and instituting a robust process improvement culture. The Joint Commission also provides metrics for

assessing the maturity of an organization's leadership, safety culture, and process improvement culture as preconditions to high reliability.

Editor's Picks

CASE

Wrong-side Bedside Paravertebral Block: Preventing the Preventable

JOURNAL ARTICLE › STUDY

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PERSPECTIVE

Update on Safety Culture

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