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Leadership Practices to Advance Patient Safety

Leaders define the culture, and culture determines the safety of an organization.

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Historically, the medical community has accepted that a certain amount of unintended injury and error will occur because of the complex nature of medicine and variation in patients. The executive team of a large multi-state health system knew it had to change that mindset among leaders and healthcare providers in its 32 hospitals.

The system had successfully implemented an extensive array of patient safety practices. To take safety to the next level — creating and sustaining a patient safety culture — the executive team was committed to establishing a system-wide preoccupation with failure. Doing so would drive hospital leaders and practitioners to proactively find ways to prevent error by improving processes, resulting in ever-safer environments.

Taking Inventory

To begin a journey, you need to know your starting point. In 2002, the system conducted the Dana-Farber Leadership Assessment Tool to determine the organization's readiness for moving to a safety culture. Representatives from all of the system's nine regions completed the assessment, which was accessible via the system's intranet. Over 2 years, more than 500 leaders used the tool to chart patient safety progress.

Also in 2002, James Conway, then executive vice president and COO of Dana-Farber Cancer Institute (DFCI), shared with system leaders how, 8 years earlier, complications from drug overdoses resulted in the death of one patient and in heart damage for another. Under intense public and regulatory scrutiny, DFCI established a proactive safety culture.

Armed with the assessment's results and key learnings from DFCI, the system's governance and leadership teams established safety-specific goals and integrated them into the system's strategic plan. Funds were dedicated to technology improvement, training, performance improvement, and staff additions to move the effort forward. Jane Durney Crowley, executive vice president and chief administrative officer, was assigned responsibility for assuring that a safety culture developed across the system.

Mapping a Route

Immediately, the organization faced tension and disagreement as to whether patient safety belonged to risk management or to quality. The ownership question was left for later, and a multidisciplinary patient safety task force was established. After four meetings, the task force identified activities on which to focus immediately:

- Communicate system-wide executive support of the patient safety effort.
- Conduct a staff-level patient safety survey.
- Select an electronic error reporting system.
- Begin reporting and managing "never" events.

System-wide executive support. To demonstrate the importance of the patient safety effort, the organization's executive management team transitioned the task force to committee status. It was formally chartered, and the executive team served as the committee's champion. Team members were selected from the system's home office and its four divisions.

Conduct surveys. In 2005, the AHRQ Patient Safety Culture Assessment was conducted among all caregivers. Although the paper-and-pencil survey was taken concurrently with the organization's annual employee survey, 13,000 responses were received. Based on the results, the committee knew where to begin its efforts: two of the most common areas of concern identified were leadership commitment and handoffs in care.

Select an electronic error-reporting system. The organization had been using a three-part risk management paper form for error reporting. A system was needed that could quickly aggregate data, thus enabling care givers to immediately identify adverse events and trends. The committee selected the Quantros Occurrence Report Management electronic reporting system. It was implemented across the system's hospitals in 2005 and in its 14 long-term care facilities in 2006. In its first year of use, more than 25,000 events were recorded.

Begin reporting and managing "never" events. Based on the National Quality Forum's (NQF) definitions, caregivers at the system's hospitals and long-term care facilities began reporting and addressing serious reportable events, the most frequent being falls and medication errors. Because Quantros had not been implemented when the process began, information was pulled from claims data. Events were reported internally and to hospital, regional, and system boards. Leaders began using the information to establish process and cultural improvements and managing to assure that those changes were adopted and sustained.

Creating a Safety Function

Almost 2 years after James Conway's visit, the patient safety committee reported its progress to the executive management team. It was determined that more help was needed to manage the initiatives under way, and the committee was given the freedom to design the structure of the safety function.

The patient safety committee determined that a system safety officer and one in each of its four divisions were needed. Each would provide expertise in a specific area of patient safety. Joining the safety team was the leader responsible for pharmacy quality. These six members of the patient safety team were responsible for creating the tools and training materials necessary for rapid implementation of the system's patient safety efforts. During this time, the question, "Where does patient safety belong in the organization's structure?" was answered. The system safety officer reports to the chief quality officer and has dotted-line reporting to the system's chief executive officer. Quality and risk management work collaboratively to proactively prevent and manage harm.

Grief and Guilt Strengthens the Organization's Commitment

In December of 2005, a medication error at one of the system's hospitals killed Barbara Hobbie, a retired nurse and hospital volunteer who was admitted for an exploratory laparotomy. Instead of receiving an antibiotic via IV, she was given 250 mg of morphine administered in a 30-minute time period. The similarly marked bags were stored in the same drawer; the nurse had picked up and administered the wrong one. Hobbie stopped breathing, coded, and was put on a ventilator.

In addition to being a volunteer and retired



employee, Mrs. Hobbie was also the mother of the system's senior vice president and chief information officer, Becky Sykes. Becky and her sister and brother grieved deeply as their mother was taken off the ventilator and died. In a time of great grief, Becky also experienced anger and frustration because the family was not informed of what had occurred to cause their mother's death.



Barbara Hobbie and her husband, Roy.

As the system's executives learned what their colleague was going through, they felt enormous guilt over this death caused by one of their hospitals. They also experienced guilt because this case affected them like none had before. They experienced the anguish that a medical error can cause. For the system's leaders, establishing a patient safety culture became a passion. Creating a culture that demanded transparency, that utilized new technologies to reduce errors, and that required continuous improvement became an even higher priority.

Hospital CEOs Learn to Lead the Way

One of the key concerns identified in Mrs. Hobbie's case and in the AHRQ Patient Safety Culture Assessment was leadership commitment. As the patient safety team evaluated the role of hospital CEOs in the patient safety culture under development, it realized that these leaders were not adequately equipped and supported to lead patient safety efforts. Furthermore, the CEOs didn't know if their day-to-day decisions were helping or hurting patient safety on the floor.

"The key to creating a safety culture is ensuring that hospital CEOs are actively engaged and take responsibility for patient safety," said Wayne Bohenek, vice president, patient safety and pharmacy excellence. "When a hospital faces a financial crisis, the CEO is at the table, working with his or her team to identify and implement strategies to address the problem. That has not always been the case when patient safety issues arise. Because many CEOs are not clinicians, they often have delegated responsibility for addressing adverse events. This reinforces across the hospital that patient safety is not a priority."

In 2006, the system conducted its first Patient Safety Academy, an educational session for hospital CEOs. "Our game plan was to start high level — what is a safety culture and why is it important — and with each subsequent academy, move to more specific tactics that are necessary in a safety culture," said Bohenek.

Patient Safety Academy I

Tom Krause, CEO of Behavior Science Technology, was the guest speaker at the first Patient Safety Academy. In the session, CEOs were introduced to the relationship between leadership, organizational culture, and behavior in a safety culture.

Patient Safety Academy II

The second academy, conducted 6 months later, focused on the structures and processes needed to create a safety culture. Allan Frankel, MD, of the Center for Patient Safety and Research, talked about the need for system and hospital transparency, how to overcome the fear inherent among caregivers in reporting errors or near misses, and how to enhance communications among all stakeholders.

Patient Safety Academy III

Chief Medical Officers were invited to join their hospital CEOs at the third Patient Safety Academy. The focus was on disruptive behavior and how it

Patient Safety Academy. The focus was on disruptive behavior and how it leads to unsafe environments. (For discussion of the system's response to disruptive behavior, see "[Drawing the Line: Effective Management Strategies for Disruptive Behavior](#)" by G. Porto and J. Deen in the November/December 2008 issue of *Patient Safety & Quality Healthcare*.)

Patient Safety Academy IV

The next academy provided stories to help leaders see just how critical it is to continuously work to reduce medical errors. A nurse who lost her license due to administering an incorrect drug shared her story. The husband of a patient permanently harmed by a medical procedure detailed his family's experience. Introduced at the session was an algorithm that helps leaders identify if punitive action is called for due to an adverse event, and, if so, the appropriate level of action that should be taken.

Patient Safety Academy V

The fifth academy focused on the national agenda related to safety and the business case for a safety culture. Leaders learned how Lean/Six Sigma can help caregivers and leaders continuously improve safety processes.

The academies have proven to be a highly effective method of building awareness and understanding among hospital CEOs as to their role in a safety culture. The system plans to continue offering the academies on a regular basis.

Adverse-Event Discussions

As Crowley discussed with CEOs the adverse events that occurred at their hospitals, she identified great variability in their involvement. She realized that in addition to educational sessions, coaching and mentoring were needed.

Crowley set up regular conference call meetings in which a CEO would discuss an adverse event that had occurred at his or her hospital. As safety culture leaders, when adverse events occur, they apologize to families and provide support to them and staff who are traumatized by the event. Their role can be challenging and painful. Through these sessions, CEOs honed their communication skills and continued to build their understanding of what it takes to create and maintain a patient safety culture.

Crowley led the CEO coaching sessions for 2 years. Today, hospital CEOs conduct their own calls, perpetuating coaching with their peers.

"By virtue of those calls, we have collectively been able to reduce adverse events," said Thomas S. Urban, president and CEO of one of the system's hospitals. "We take the information back to our team and determine if there are steps we need to take to avoid such an event. No one intends to make mistakes; often they are a system or process problem. We must continually check to see if we have the right systems."

Data and Storytelling

As the hospital CEOs assumed leadership over patient safety, they learned the power of storytelling. Because medical and drug errors are infrequent, from a statistical standpoint they may appear almost non-existent. During Patient Safety Academy sessions and their regular discussions on adverse events, hospital CEOs saw first-hand how sharing patients' and their families' stories elevated the importance of safety. They began using this technique when discussing patient safety with their boards and staffs.

By including a patient's story when reporting patient safety data, hospital CEOs are able to illustrate the tragedies represented by seemingly insignificant data points. This is a key step in assuring that patient safety remains a priority among boards, leaders, and staff.

Patient Safety Training

Patient Safety Tactics

With patient safety officers in place and hospital CEOs learning about their role as safety leaders, the organization further accelerated its efforts, identifying specific practices and behavioral changes necessary for creating and sustaining a safety culture. Specific activities were grouped into key areas established by NQF. Below is a partial list of some of the tactics initiated to enhance patient safety throughout the system:

Teamwork Training and Skill Building

- **Crucial Conversations** — training designed to help caregivers understand how to think about and prepare for difficult, necessary interactions.
- **SBAR** — a communication technique that enables caregivers to share information in exactly the same way with each situation by communicating: Situation, Background, Assessment, and Recommendation. The process enables caregivers to share information in a to-the-point manner, ending with a clear recommendation or request.
- **TeamSTEPPS** — developed by the Department of Defense and AHRQ, the program builds teamwork and communications specifically to enhance patient safety throughout an organization.
- **Guidelines for Professional Behavior** — a nationally recognized program the system developed that establishes clear expectations around professional behavior and standard processes for interventions when inappropriate behaviors are encountered (discussed in Porto & Deen, 2008).
- **Surgery Time-Outs and WHO Surgery Checklist** — before each procedure, a time-out is taken for members of the team to introduce themselves. Next, they confirm each point on a surgery checklist, which includes basic steps such as confirming the patient's identity and the procedure to be undertaken.

Leadership Structures and Systems

- Patient Safety Academy (see page 20 — 21)
- Adverse-Event Discussions (see page 21)

Culture Measurement, Feedback and Intervention

- **Patient Safety WalkRounds™** — developed by Health Research & Educational Trust and AHA. On a regular basis, leaders visit with frontline providers, hearing their concerns, identifying where additional resources are required, and promoting by their presence the importance of patient safety. Leaders gain knowledge about various aspects of safety issues and processes, which, in turn, enhances their ability to identify strategies for improving patient safety in their facilities.

Identification and Mitigation of Risks and Hazards

- **Quantros Safety and Risk Management Solution** — a data management reporting system that allows for quick identification of adverse events and trends.
- **Bedside Barcode Scanning** — helps assure the right medication is provided to the right patient.
- **Smart Pumps** — help assure appropriate dosages are provided to patients.
- **Lean/Six Sigma** — a process that is used to identify and remove the causes of defects and errors. Leaders and staff are trained in the Lean/Six Sigma process. Safety officers and others who have received

additional training and are credentialed. Six-Sigma Black Belts lead teams in process redesign of work to reduce errors and adverse events.

The Journey Continues

This large health system has made great progress in changing its culture. Many proven patient safety practices are in place. Expectations around professional conduct, clear communications, and teamwork are a daily focus. Technology enhancements support caregivers in their commitment to providing safe, quality care while enabling leaders to quickly identify necessary changes to head off adverse events.

The journey is not without its challenges, however. According to Herbert Schumm, MD, regional chief medical officer, there is only so much "change capital" available at any given time. "As we introduce safety initiatives, we're competing with other change efforts in the organization," he said. "Keeping safety top-of-mind requires daily maintenance."

Leaders know that to sustain a patient safety culture, they must make it a personal commitment, a passion. In 2008, the system CEO conducted WalkRounds at 17 hospitals, reinforcing with caregivers the organization's commitment to patient safety. This practice enabled him to also understand the safety issues caregivers face at hospitals throughout the system. He continues conducting WalkRounds in 2009.

Some CEOs in the system's hospitals carry patients' obituaries in their wallets. By keeping close the guilt and pain caused by an inadvertent unnecessary death, they assure that patient safety is always a personal priority. Each day, administrators, nurses, physicians, and other caregivers evaluate how care is provided and how it can be improved.

The journey has begun, and it will never end.

Catholic Healthcare Partners

The health system described in this article is Catholic Healthcare Partners (CHP). CHP is the largest health system in Ohio and one of the largest nonprofit health systems in the United States. CHP is on a continuous quest for quality. As evidence, in 2008, CHP was ranked 5th in a national study reported by the Joint Commission that compared quality of care among 73 of the nation's largest health care systems. With \$4.7 billion in assets, CHP employs 36,500 associates in more than 100 organizations, including 32 hospitals, which serve the healthcare needs of people in Ohio, Tennessee, Kentucky, Pennsylvania, and contiguous states. True to its mission, in 2008, CHP provided more than \$335 million, or 8.2% of total expenses, in targeted community benefit. Community benefit includes charity care, unpaid costs of public programs, community and subsidized health services, financial contributions, professional education and research, and other initiatives. CHP is a faith-based system sponsored by five Catholic religious sponsors.



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