

PATIENT SAFETY INITIATIVE: Hospital Executive and Physician Leadership Strategies



Bedside Communication



Unit-Based Huddles



Harm Reduction Checklist



Hospital Board Engagement



Teamwork Training



Daily Safety Briefing

PATIENT SAFETY INITIATIVE: Hospital Executive and Physician Leadership Strategies

Preface

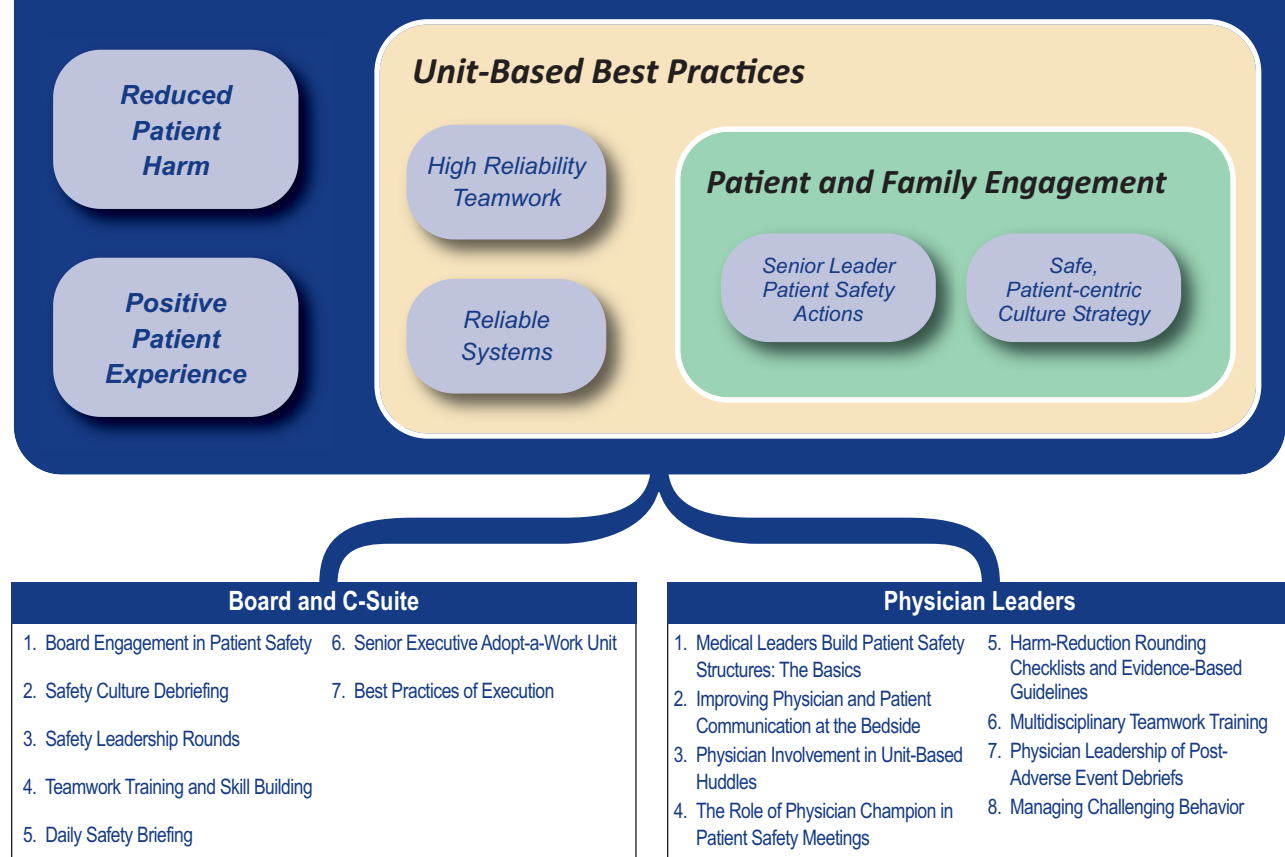
The Partnership for Patients (P.f.P.) initiative, a public-private partnership and its more-than 3,700 participating hospitals are focused on using effective improvement and change strategies to make hospital care safer, more reliable, and less costly.* Joint Commission Resources, Inc., one of 26 Hospital Engagement Networks in the P.f.P. campaign, has been assisting network hospitals in implementing evidence-based solutions aimed at eliminating the most common

preventable adverse events in the hospital setting. Based on a patient-centered and scientific foundation of performance improvement, JCR's Hospital Engagement Network program is individualized for the hospitals, evidence-based, data-driven, and aimed at sustained improvement.

We have now moved out of the education phase in Year 1 (2012), during which the improvement effort was focused on identifying best practice care and treatment methods for the prevention of infection (catheter-associated urinary infection, central

* Centers for Medicare & Medicaid Services. Partnership for Patients. Accessed May 30, 2013. <http://innovation.cms.gov/initiatives/Partnership-for-Patients/>.

Leadership and Physician Best Practices



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line-associated bloodstream infection, ventilator-associated pneumonia, and surgical site infection), adverse drug events, injury from falls and immobility, pressure ulcers, venous thromboembolism, maternal and neonatal harm, and unplanned readmission to the hospital within 30 days of discharge.

In the current execution and activation phase in Year 2 (2013), we are promoting and enhancing organizational patient safety culture, multidisciplinary team-based decision-making, leadership and physician effectiveness, and patient and family engagement.

The effectiveness of executive and physician leadership is essential to hospitals' successful implementation and sustainment of safe practices. Achievement of a safety culture at all levels of the organization is a fundamental requirement for safe practices and improved patient outcomes. It is understood that physicians in leadership positions will guide all members of the medical staff to

identify and act on opportunities to reduce harm in the organization.

There are real and urgent financial ramifications (the "margin") related to an organization's patient care services (the "mission"). When leaders set a course to achieve a culture of safety, margin and mission no longer compete but instead become inextricably linked. In this change package, Patient Safety Initiative: Hospital Executive and Physician Leadership Strategies, we present best practices in Hospital Executive Leadership Strategies (Part 1) and Physician Leadership Strategies (Part 2). Part 2 includes strategies for physician leaders to use in engaging all physicians in patient safety. This change package is intended to help motivate and energize health care leaders to assess gaps in their organizational safety culture, engage key influencers for change, set goals for targeted improvement, implement proven safe practices, and reinforce key behaviors to ensure high-reliability performance improvement.

Acknowledgements

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Part 1. Hospital Executive Leadership Strategies

Introduction

Congratulations on choosing to be a participant in the Partnership for Patients Program (P4P), and the outstanding results you and all the other hospitals in the Program have produced to date. The Partnership is aimed at helping to improve the quality, safety, and affordability of health care for all Americans. The P4P Program brings together federal partners and the leaders of major hospitals, employers, physicians, nurses, patient advocates, and state-level stakeholders in a collaborative effort to make hospital care safer, more reliable, and less costly.

The Partnership is intended by the end of 2013 to achieve the following two goals, which would save lives and prevent injuries to millions of Americans, helping to put our nation on the path toward a more sustainable health care system:

1. Decreases in preventable hospital-acquired conditions by 40% compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients and more than 60,000 lives saved in a three-year period.
2. Decreases in preventable complications during transitions from one care setting to another so that all hospital readmissions would be reduced by 20% compared to 2010. Achieving this goal would mean that more than 1.6 million patients would recover from illness without suffering a preventable complication that would require rehospitalization within 30 days of discharge.

Notwithstanding the Program's progress so far, taking the reductions in harm to the next level will require even better teamwork among all parties involved: The Board, the executive team, physicians and physician leadership, nursing and other clinical leaders in all areas, as well as frontline staff and patients and their families.

This two-part "toolkit" has been created for use by hospital executives (and Board members) on one hand, and physicians/physician leaders on the other. It advocates for the direct, hands-on involvement in patient safety programs by all executives, the Board, and all physicians and their physician leaders (who may also be part of the executive team). It constitutes a set of evidence-based tools that have been used successfully in hospitals across the nation. If you are a clinical leader or frontline staff member who would like your executives or physicians/physician leaders to be more directly involved in patient safety efforts, this toolkit can help you in those efforts. J.C.R. network leaders will be sharing a Clinical Best Practice Toolkit for the Reduction of Adverse Events in the near future as well. These tips for success will be helpful for clinical leaders and providers at the bedside.

While no hospital will or should adopt all the tools in each of the toolkits, please consider each tool in terms of its possible contribution to your organization's ability to achieve excellent and safe patient care. Also, leaders cannot solely rely on adopting these best practices alone but can apply them to the individual needs of their organization.

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Implementing the best practices in the toolkit, which entails training, information technology, and time and effort, requires investment of resources. Yet there is increasing evidence that patient safety programs pay for themselves in a very short period of time in direct cost savings, increases in patient and family satisfaction, the avoidance of costly legal problems, and the staff satisfaction that comes from knowing you are doing everything possible to provide safe care to your patients.

Changing Expectations of Leadership Team

The changing expectations for patient safety have important implications for the expectations of hospital leadership teams, as follows:

1. The Board and corporate (“C-suite”) teams are personally involved—they fully participate, individually and collectively in patient safety initiatives and stay informed of initiatives’ progress. As is now conventional wisdom, patient safety cannot be delegated—it can’t be left to a committee, function, or individuals, with results reported up the chain of command. Although organizational infrastructure is necessary for accountability, the current best practice demands participation at all levels—including not only the Board and C-suite but all leadership team(s), clinical practitioners, and all employees and contract service-providers—in a committed partnership with patients and their families.
2. The leadership teams learn from the best practices of organizations outside health care—including the nuclear power industry, the commercial air travel system, and the flight decks of aircraft carriers³—that achieved high reliability, as well as health care organizations that are approaching it. Critical to high reliability is a commitment to achieving zero patient harm, an organizationwide safety culture, and improvement work using effective process improvement tools. Even though health care, in the

words of John Nance, a frequent contributor to the practices of both aviation and health care safety, is “an order of magnitude more complex than any other enterprise,”⁴ the lessons learned can help health care make rapid progress. For example, almost all sentinel events in health care have poor communications and teamwork as their root cause or at least as a strongly contributing cause. The lessons about teamwork from other industries can make an enormous difference to the quality and accuracy of communications if the leadership team personally endorses, sponsors, participates in, and, most importantly, uses the techniques and strategies in applying those lessons.

3. The hospital leadership teams learn and adopt the best evidence-based practices in patient safety. The good news is that an enormous amount of research, experimentation, learning, and documentation of best practices in patient safety is going on, and is easily accessible, usually on the Internet, in webinars, workshops, academic journals, and trade publications. If there is “bad news,” it’s that the sheer volume of such information can be overwhelming.

Safety Leadership Best Practices

These Safety Leadership Best Practices represent proven and reliable best practices for creating a culture of patient safety for leadership and Board-level teams. The practices are specific, actionable initiatives that have been shown to reliably produce results associated with safe patient care. They emphasize the establishment and use of cross-functional, nonhierarchical, and collegial teams working together with patients and their family members to provide the safest care possible for each and every patient.

While a hospital’s leadership team is unlikely to adopt all these best practices, we encourage the team to carefully consider each practice in terms of its possible contribution to the team’s ability to meet the hospital’s

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safety goals. The team should ask, How does a given practice fit into existing patient safety structures, strategies, and programs? How might it heighten the visibility, use, and sponsorship of existing efforts as indicative of the entire organization's commitment to patient safety?

The best practices are based on recommendations from the National Quality Forum; the Institute for Healthcare Improvement; the Health Research and Education Trust (H.R.E.T.) of the American Hospital Association; Joint Commission Resources; the Research Division of The Joint Commission; and other notable practitioners, researchers, and institutional leaders in the field of patient safety, such as Paul Batalden, MD (Geisel School of Medicine, Dartmouth Medical School); Allan Frankel, MD (Pascal Metrics); and Peter Pronovost, MD, and colleagues at Johns Hopkins University.

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The Hospital Executive Activation Toolkit

The Hospital Executive Activation Toolkit is intended to help hospital leaders improve executive engagement.

Each best practice should be considered an integral part of the larger effort and be enacted with the overall goal of creating sustainable change.

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Board Engagement in Patient Safety

One of the most important interventions for hospital leadership in developing a hospital safety program is to get the hospital's Board involved with safety and quality.¹



What Is the Practice?

Establish a standing Board-level committee on patient safety and quality improvement, with goals, metrics, and regular reviews with hospital executives.

Why Use the Practice?

- Board's commitment to safety reinforces its value as an essential ingredient of the organization's culture.
- Board can reinforce safety behavior at all levels.
- Aligns the Board and the leadership team around the strategic goals for patient safety.

Instructions for Conducting the Practice

Increase the Board's Quality Literacy

- ✓ Educate the Board on salient quality issues.
- ✓ Consider adding quality experts to the Board.
- ✓ Use retreats for having in-depth dialogue on quality and safety improvement projects.
- ✓ Have Board members attend quality conferences.
- ✓ Consider adding a Board member who comes from a high reliability organization who has executive responsibility for quality in their organization.

Frame an Agenda for Quality

- ✓ Initiate discussion between the Board chair and Chief Executive Officer (C.E.O.) on the status of quality.
- ✓ Ensure that quality and safety on the Board agenda gets equal billing with other agenda items.

Engage in Quality Planning and Focus and Provide Incentives

- ✓ Create a vision for quality for the hospital with long-term outcome measures and goals.
- ✓ Review the hospital's quality plan and ensure it is aligned with the overall strategic plan.
- ✓ Ensure the quality measures the Board reviews are assessed regularly and are presented in a manner that the non-clinical trustee can understand.
- ✓ Integrate the quality measures into the overall Board performance.
- ✓ Link incentive compensation of leadership to quality metrics.

Patient-Centeredness

- ✓ Share patient stories at Board meetings to further increase focus on patient-centeredness.
- ✓ Ensure that patients are involved in improvement by having patients participate on improvement committees and projects.
- ✓ Ensure the appointment of at least one patient member to the Board.

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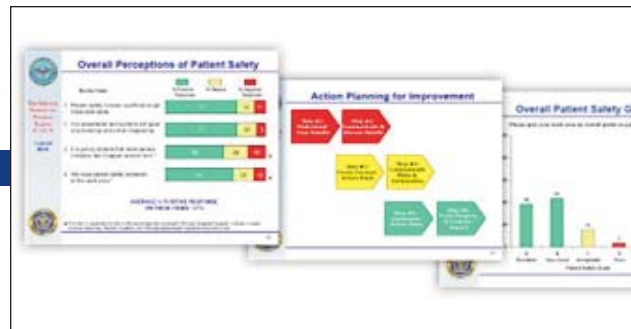
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Safety Culture Debriefing

The CEO and senior administrative leaders should be directly involved in the application of the knowledge that has been generated through the measurement of culture.¹



What Is the Practice?

At least annually, leaders should assess the organization's safety and quality culture using a survey tool that is selected with consideration of validity, consistency, and reliability in the setting in which it will be applied and that is conceptualized around domains that are applicable to performance improvement initiatives/efforts such as teamwork, leadership, communication, and openness to reporting. The results of the culture survey process should be documented and disseminated widely across the enterprise in a systematic and frequent manner. The interventions component of this safe practice will be satisfied if the survey findings are documented and have been used to monitor and guide performance improvement interventions.

Why Use the Practice?

Studies show positive correlations between a high culture of safety score with (1) improved clinical outcomes such as lower hospital-acquired infection rates and (2) higher staff retention because of higher morale, lower burnout, and less absenteeism.

Instructions for Conducting the Practice

Measurement of the culture of safety by itself is not enough. The results must be fed back to the organization to stimulate discussions about areas of weakness and solutions for improvement. Because culture resides at the local level, it's important to discuss

the results by departments, units, and roles. Focusing on group-level data depersonalizes the discussion and fosters actionable ideas for improvement in the context of the local realities of care delivery. More than simply a measuring stick, feedback to respondents at the work-unit level can actually be the first step in improving culture. Leadership needs to provide a structure for reviewing the results with frontline caregivers and managers to identify specific areas of concern and obtain insights and recommendations on how to address the issues.

Teach front line leaders how to use the data from the survey including) seeking staff interpretation of findings, 2) seeking staff solutions to identified issues and problems and 3) facilitating the creation of staff-built unit level workplans based on their ideas for improvement to improve the safety culture.

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Safety Leadership Rounds

(also known as WalkRounds)

Organizations across the world are . . . using the WalkRounds program as a mechanism to engage senior leaders in efforts to improve the reliability of care in their organizations.^{1(p. 46)}



What Is the Practice?

Safety Leadership Rounds are conducted in patient care departments such as the emergency department, medical surgical floors, and the operating room, as well as in ancillary departments such as the imaging and laboratory areas. Senior leaders go to the department weekly and conduct informal conversations with staff members about safety issues. Safety Leadership Rounds provide a method for leaders to talk with frontline staff about safety issues in the organization and show their support for safety practices.

Why Use the Practice?

- Demonstrates commitment to safety
- Fuels culture for change pertaining to patient safety
- Provides opportunities for senior executives to learn about patient safety
- Identifies opportunities for improving safety
- Establishes trusting relationships and lines of communication about patient safety among employees, executives, and managers

Instructions for Conducting the Practice

Ground Rules

- ✓ Organizations should decide whether or not to announce the time and place of Safety Leadership Rounds, and the decision should be agreed to by senior leaders and managers.
- ✓ Organizations should reassure employees that all information discussed in Safety Leadership Rounds is strictly confidential.

Who Should Conduct Safety Leadership Rounds?

- ✓ All “C-suite” leaders, usually including the C.E.O., chief operating officer (C.O.O.), chief medical officer (C.M.O.), and chief nursing officer (C.N.O.).
- ✓ Senior leaders should commit to conducting Safety Leadership Rounds at a minimum of once per week, for a minimum of one year, with no cancellations.
- ✓ Members of the senior executive team can rotate for easier scheduling, but every senior leader should perform a Safety Leadership Round every week.

Sample Questions

- ✓ “Have there been any near misses that almost caused patient harm but didn’t?”
- ✓ “Is there anything we could do to prevent the next adverse event?”
- ✓ “What specific intervention from leadership would make the work you do safer for patients?”
- ✓ “How are you engaging patients and families in their care?”

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Teamwork Training and Skill Building

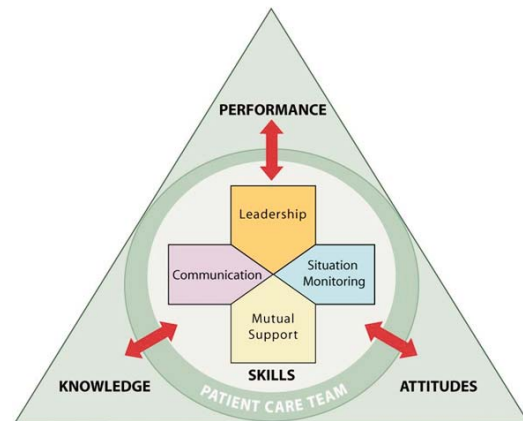
The CEO and senior administrative leaders should be directly involved in ensuring that the organization implements the activities detailed in the specifications of the Teamwork Training and Skill Building safe practice. This includes participating in the defined basic training program.¹

What Is the Practice?

Provide both basic and detailed teamwork training.

Basic Teamwork Training. Basic teamwork training should be provided annually to governance Board members, senior administrative leaders, medical staff (whether independent or employed by the organization), midlevel management, and frontline staff. The subject matter should include sources of communication failures, handoffs, and team failures that lead to patient harm. The length and modality of training should be established by the organization. Participation should be documented to verify compliance.

Detailed Teamwork Training. All clinical staff and licensed independent practitioners should receive detailed training consisting of the best available teamwork knowledge; however, staff of clinical areas, such as labor and delivery and critical care units, that are deemed to be at high risk for patient safety issues, should receive such training first. The clinical areas that are prioritized should focus on specific patient safety risks. The subject matter should include the principles of high reliability, human factors applied to real-world care processes, interpersonal team dynamics, handoffs, and specific communication methods. Focus should be placed on the development and application of structured tools.



Why Use the Practice?

- Care has become fragmented, necessitating successful team communication to prevent system failures.
- Organizations are treating sicker patients at ever faster rates with treatments that are becoming increasingly complex.

Failure of teamwork and communication has been consistently cited as a primary root cause of sentinel events reported to The Joint Commission.² In a systematic review of emergency department closed claims, fundamental teamwork behaviors would have prevented or mitigated the adverse event in 43% of reviewed cases.³

Instructions for Conducting the Practice

Most health care organizations either contract with an external firm to provide the initial teamwork training or send employees of the organization to be trained as trainers. After those employees are trained, they then in turn conduct the relevant trainings. Sometimes, a combination of both approaches is used. The TeamSTEPPS® program, developed jointly by the US Department of Defense Patient Safety Program and the Agency for Healthcare Research and Quality (A.H.R.Q.), is freely available for download from the AHRQ website, and AHRQ has provided funding for the national implementation of TeamSTEPPS®.⁴ Commercial programs are readily available.

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Daily Safety Briefing

Attention is the currency of leadership.¹

**—Lee Carter, Chairman of the Board,
Cincinnati Children's Hospital Medical Center**



What Is the Practice?

The Daily Safety Briefing is a 15-minute meeting of the senior leaders with all department leaders of the organization, and a three-point agenda is used:

1. **Look back:** Significant safety or quality issues from the last 24 hours
2. **Look ahead:** Anticipated safety or quality issues in next 24 hours
3. **Follow-up:** Status reports on issues identified today or days before

Why Use the Practice?

- Shared situational awareness
- Heightened risk awareness
- Early identification and resolution of problems
- Demonstrated staff follow up on issues, assuming that their resolution is well communicated

Instructions for Conducting the Practice

A senior leader facilitates the meeting, typically via conference call. All other senior leaders and all operational leaders participate. The meeting occurs in the morning with an “everyone checks-in” expectation. When safety-critical issues are identified, all organizations have a mechanism for tracking issues and their resolution.

The following are examples of questions that the leader can ask during the Daily Safety Briefing to promote a risk-averse mindset and risk-averse actions in others:

- ✓ How do you know you had no problems in the past 24 hours?
- ✓ What immediate, remedial actions did you take?
- ✓ Is this happening in other places? Could this happen in other places?
- ✓ What other areas does this issue impact?
- ✓ How are you preparing your team for that high-risk task?
- ✓ What error prevention behaviors should be used?
- ✓ How was the patient/family involved in the event, or how could their involvement prevent another such occurrence?
- ✓ How will we communicate our decisions that we have made today?

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Senior Executive Adopt-a-Work Unit

(Also known as Comprehensive
Unit-Based Safety Program [C.U.S.P.]

The keys to program success are the active role of an executive advocate and staff's willingness to openly discuss safety issues on the units.^{1(p. 56)}



What Is the Practice?

Adopt-a-Work Unit is a five-step program that pairs a hospital executive with a care unit to change the unit's workplace culture—and in so doing brings about significant safety improvements—by empowering staff to assume responsibility for safety in their environment. This is achieved through education, awareness, access to organizational resources and a toolkit of interventions. Adopt-a-Work Unit works because it recognizes the central importance of culture in sustainable patient safety improvements. Because culture is local, it must be targeted at the unit level, with support at the organizational level.

Why Use the Practice?

- Educates and improves awareness about patient safety and quality of care.
- Empowers staff to take charge and improve safety in their workplace.
- Creates high-trust partnerships between units and executives to improve organizational culture.
- Provides resources for unit improvement efforts.
- Provides tools to investigate and learn from defects.

Instructions for Conducting the Practice

- ✓ **Train staff in the science of safety.** Provide this training to all members of a unit—anyone who

spends more than 60% of his or her time working on the unit.

- ✓ **Engage staff to identify defects.** Ask each staff member to answer a simple, two-question survey: How is the next patient going to be harmed on this unit? How can we prevent this harm from occurring? Also find potential areas of improvement based on review of incident reports, claims, and sentinel events.
- ✓ **Senior executive partnership/safety rounds.** Perform monthly safety rounds in which the executive interacts with staff on the unit and discusses safety issues with them. All staff should be invited to attend.
- ✓ **Continue to learn from defects.** Use the Learning from Defects tool to address the top risks identified by the team.
- ✓ **Implement tools for improvement.** The safety team members highlight several priority areas needing improvement and use the many tools in the public domain to address them.

Reference

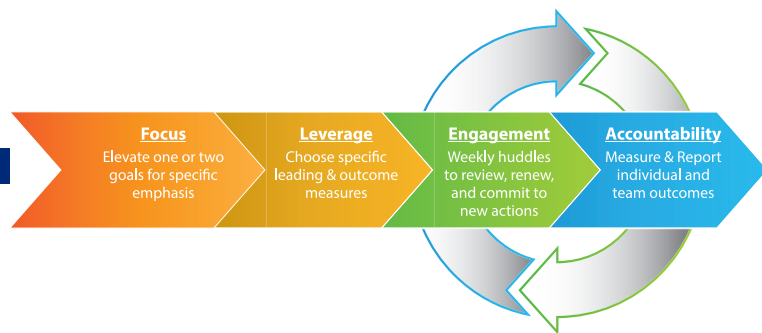
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Best Practices of Execution

The first discipline of execution is to focus your finest effort on one or two goals instead of giving mediocre effort to dozens of goals.¹



What Is the Practice?

Use a disciplined, structured approach for implementing and executing patient safety strategies, including

- Focus
- Leverage
- Engagement
- Accountability

Why Use the Practice?^{2*}

- 75%–80% of all initiatives that require people to change behavior fail.
- Implementing complex changes requires extraordinary discipline.
- Enables focused improvement efforts at the unit level to maintain the highest priority and not get lost in the “whirlwind” of the daily work flow.
- Enables leaders to assess organizational resources and capabilities to advance performance improvement

Instructions for Conducting the Practice

- ✓ Elevate one or two goals for specific emphasis.
- ✓ Decide on a measureable result and a time by when it is to be achieved.
- ✓ Investigate all best practice literature and solutions to

understand the scope of the issue and gap analysis (For example, if studying S.S.I., investigate the national solutions available on the Joint Commission’s Targeted Solutions Tool (T.S.T.)

- ✓ Select the leverage points that will move results toward the goal.
- ✓ Create leading measures of action on the leverage points—a scoreboard
- ✓ Ask team members to commit to actions that will move the levers.
- ✓ Hold weekly meetings/huddles with the team to review, renew, and commit to new actions.

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* The practices in this section are based on the book, *The 4 Disciplines of Execution: Achieving Your Wildly Important Goals*. Although we do not recommend or endorse any particular product or service from the authors or their company, the principles and disciplines of execution contained in the book have proven their effectiveness in health care settings and deserve careful consideration.

Part 2. Physician Leadership Strategies

Physician engagement and participation are critical elements to any health care delivery organization's efforts to improve the safety of care. However, as Taitz, Lee, and Sequist suggested, "most physicians are ill equipped to lead patient safety initiatives, and many physicians struggle to optimally contribute to patient and quality improvement efforts that lead to safer, high quality care for their patients."^{1(p. 722)} Physicians represent leadership in health care and help set the norms for an organization.

As frontline providers, physicians' patterns of behavior and level of engagement influence the views and expectations of nurses and other clinical care providers. Thus, it becomes very important to have them connected to any effort designed to improve clinical care. Without engagement and alignment, variation in care provision cannot be addressed and substantive, lasting improvement cannot be guaranteed.

Physician engagement is one of the more difficult aspects of safety culture to address because of the inherent complexities of the physicians' interactions within a health care organization. Because of the historically autonomous nature of physician practice, it can easily become disassociated from the organization's operational and strategic goals. With this in mind, we often find that the lack of physician involvement in quality endeavors reflects such factors as competing demands, wariness of loss of autonomy to corporate structures, an absence of compensation for participation, and lack of formal training and knowledge in quality improvement work. Our goal is to provide organizations with a framework to guide current and

future efforts to increase physician engagement, in which they are working "to reduce unjustifiable variation in care."^{1(p. 724)} We take "working" to refer to the larger picture of physicians as an integral part of the multidisciplinary health care institution. Physicians play an integral role in serving as a de facto source of leadership and guidance within the clinical environment. To this end, physicians must (1) play a key and active role in contributing to the establishment of organizational goals and objectives; (2) assume "ownership" of the health care delivery process to ensure favorable outcomes, and (3) demonstrate through behaviors their commitment to unit-based and organizational quality and safety objectives.

The Two Elements of Creating Change: Organizational and Systemic Components

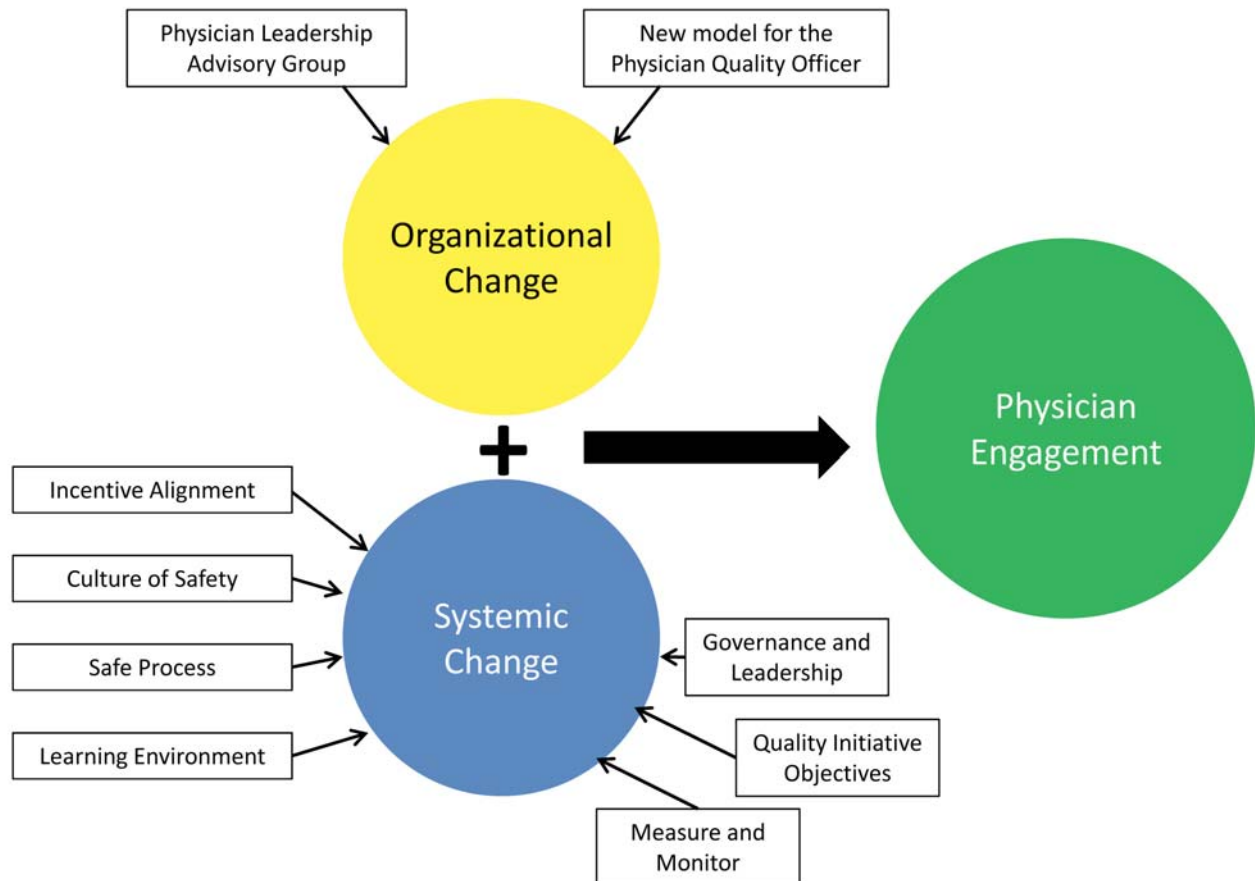
As illustrated in the figure on page 16, creating change in the realm of physician engagement for a health care system requires that we focus our efforts not just on organizational change but on reshaping and developing the systemic elements that can help or hinder physician engagement in quality and safety efforts.

The organizational changes that can be made include the following:

- *Creating* a Physician Leadership Advisory Group (*see figure*)
- *Developing* a New model for the Physician Quality Officer (*see figure*)
- Creating the Physician Compact (a commitment made with each physician) to formalize expectations

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Organizational and Systemic Components in Physician Engagement



The systemic changes that can be made include the following (*see figure*):

- *Establishing* a Culture of Safety
- *Redefining* the Learning Environment
- *Promoting* Governance and Leadership
- *Establishing* Quality Initiative Objectives
- *Ensuring* Safe Processes
- *Maintaining efforts* to Measure and Monitor
- *Revamping* Incentive Alignment

The Physician Activation Toolkit, which consists of eight listed strategies, is included for use by hospital medical/clinical staff.

The Expected Benefits of Increasing Physician Engagement

Through improved physician engagement in quality and safety, we aim to achieve the following four objectives:

1. Improve clinical outcomes.
2. Reduce malpractice risk.
3. Improve patient satisfaction.
4. Improve physician satisfaction and decrease physician burnout.

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The Physician Activation Toolkit

The Physician Activation Toolkit is intended to help physician leaders improve medical staff members' engagement.

Each best practice should be considered an integral part of the larger effort and be enacted with the overall goal of creating sustainable change.

Medical Leaders Build Patient Safety Structures: The Basics | page 19

Improving Physician and Patient Communications
at the Bedside | page 21

Physician Involvement in Unit-Based Huddles | page 22

The Role of Physician Champion in Patient Safety Meetings | page 23

Harm-Reduction Rounding Checklists and
Evidence-Based Guidelines | page 24

Multidisciplinary Teamwork Training | page 28

Physician Leadership of Post-Adverse Event Debriefs | page 29

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Medical Leaders Build Patient Safety Structures: The Basics

“While advances in biomedicine are awesome, progress in patient safety and quality of care has proven slow and arduous. One factor contributing to the labored progress is the paucity of physician-leaders who can help advance the science and practice of quality and safety.”¹¹(p. 1651)



What Are the Practices?

Leadership, including medical staff leaders, ensure the engagement of the physician body as partners with hospital executives and staff in building patient safety structures. These efforts are concurrent with the ongoing development of a safety culture that is designed to identify opportunities for reducing harm. Physicians and licensed providers experience various challenges in working within complex systems, given the many error-prone processes, regardless of the size and type of hospital. In order to advance the science and practice of quality and safety in hospitals, medical staff leaders' engagement and activation in systematic process improvement is critical to success.

Why Use the Practice?

- To reduce harm across the Board
- To eliminate errors that are preventable
- To create a system of high reliability and patient safety
- To create an infrastructure of multispecialty leaders, who are responsible and accountable for providing high-quality patient care.

Instructions for Conducting the Practice

- ✓ Appoint a Patient Safety Officer (P.S.O.)
- ✓ Appoint a Chief Medical Officer (may be the same as the PSO)
 - Establish budgets for the C.M.O. and PSO offices
 - Establish clear lines of accountability
- ✓ Establish qualifications and criteria for physician leaders, including personal commitment to harm reduction; professional credibility; quality improvement knowledge and skills; problem-solving prowess; and emotional intelligence and communication skills, as evidenced in positive relationships established with physician and nonphysician colleagues. Identify lead physician champions for large-volume or high-risk patient populations (surgery, anesthesia, orthopedics, cardiovascular, pediatrics, obstetrics, emergency services, general medicine, oncology)
- ✓ Create a Physician Leadership Advisory Group composed of lead physician champions, to be facilitated by the CMO
 - Review of annual patient safety goals
 - Review of quarterly initiatives/objectives, with alignment of strategic goals and dashboard metrics

(continued on page 20)

PATIENT SAFETY INITIATIVE: Hospital Executive and Physician Leadership Strategies

- Evaluation and assessment of clinical performance
- Oversight and facilitation of the organization's agreement with the physician body
- Maintenance of organizational rules of engagement and mutual expectations with hospital executives regarding a safety culture and quality improvement initiatives. The engagement compact will include a Code of Conduct emphasizing the promotion of a positive and supportive safety culture, signed by both hospital leadership and physician leaders.
- Creation of a safe venue for reporting concerns
- Provision of a structured approach to patient safety education for new physicians, residents, fellows, hospitalists, and medical students.
- Facilitation of transparent reporting and disclosure of data among physician staff
- Evaluation of physician satisfaction with quality initiatives and the monitoring of outcome data
- ✓ Educate physicians across the organization in the principles of the science and practice of quality and safety and cost- efficient care, value- versus volume-based reimbursement methods, and unit-based team building methods to ensure a changing mindset for multidisciplinary care providers.
- ✓ Consider re-naming the M&M (Mortality and Morbidity) Conference to the Patient Safety and Quality Improvement Conference, reflecting shift in focus from "shame and blame" to "what worked, what didn't work, and what will we do differently next time."
- ✓ Invite multidisciplinary teams to the Patient Safety and Quality Improvement Conference, to be held at least quarterly, for discussion and resolution of issues that are system and communication related.
- ✓ Maintain efforts to measure and monitor clinical performance and the prevention of adverse events.
- ✓ Align data to departments and teams to enable tangible connections between their systematic processes and the defined patient safety concerns.

- ✓ Create and/or revamp incentive alignment
 - Create an aligned financial incentive structure shifting from volume to performance (value) based
 - Consider performance-based bonus or compensation structure
 - Facilitate recognition of successful performance initiatives
 - Identify leadership opportunities for successful performance
 - Establish a planning process for succession of safety and quality physician champions

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Improving Physician and Patient Communications at the Bedside

Common to all such interactions is the desire for trustworthy information (often from an individual clinician) that is attentive, responsive, and tailored to an individual's needs.¹ (p. 50)



What Is the Practice?

Patients experience many caregivers communicating and providing clinical care throughout their inpatient stay. The benefit of having the multidisciplinary team, including the physician, discuss the care plan for each specific patient at the bedside provides coordinated information for all. This encourages discussion and patient questions for clarity and understanding, representing a tailored approach to meet the individual patient needs. In addition, it improves teamwork and engages both the patient and the family.

Why Use the Practice?

- Reinforce a patient's care plan in front of the entire team.
 - Provides mechanism for other physicians, nurses, pharmacists, and social workers to confirm and understand plan and provide input.
 - Provides direct mechanism for patient engagement.
 - Link to patient satisfaction survey scores to demonstrate effectiveness.
- Include patients and family members in rounding process
 - Increase communications.
 - Patient/family-centered approach.
 - Teach-back technique implemented after rounding to ensure communication understanding.

Instructions for Conducting the Practice

- ✓ A designated person caring for the patient assesses the physician rounding patterns and establishes the time for the team communication.
- ✓ A designated person is recording the key actions for the care plan documentation.
- ✓ Language uses easily understandable terms; non-English-speaking patients have the appropriate interpretation resources present.
- ✓ Pictures and teaching materials are used as appropriate to the topic and needs of the patient.
- ✓ Patients and families are encouraged to ask questions and participate in the discussion.
- ✓ Using teach-back, patients are asked to summarize (if they are capable) what they heard.
- ✓ SBAR (Situation, Background, Assessment, Recommendation) is a technique used for prompt and appropriate communication in the health care organizations.²

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Physician Involvement in Unit-Based Huddles

Patients want to be treated like responsible adults capable of assimilating information, asking informed questions, and having reasonable expectations.¹



What Is the Practice?

A team huddle is a short, quick, energetic stand-up meeting that is held one or more times per week in the work area of each team and is facilitated by a team leader. The huddle provides a brief time for quick questions and information sharing within each team. In 15 to 20 minutes, each team member is given the opportunity to receive and share information that is vital to the performance of the team. The patient can be an active participant. Unit-based huddles traditionally focus on the top priorities for a group of patients with each interdisciplinary staff member sharing their updates.

Why Use the Practice?

- The multidisciplinary team provides the collective wisdom of all the providers focused simultaneously on the needs of the patient.
- The huddle team may choose to invite the patient to participate in their care.
- This approach provides a unified approach and assures the patient that the “team” is providing care for them.

Instructions for Conducting the Practice

- ✓ Ask for the presence of all care team members (for example, physicians, nurses, social worker, pharmacy) at a set regular time
 - Communicate each member’s role for the patient to understand.
- ✓ Emphasize specific goal(s) and measureable result(s) that are *highly relevant* to provider work flow and patient care.
 - Communicate each member’s responsibilities.
- ✓ Create a scorecard or evaluation tool to assess progress.
 - Compare performance between units (or with specific patient populations) to foster teamwork.
- ✓ Use evidence-based best practices to guide the care and treatment plans.
- ✓ Discuss team disagreements privately and not in the presence of the patient as appropriate to the situation.

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The Role of Physician Champion in Patient Safety Meetings

The role of leaders is to define and communicate the purpose of the organization clearly and establish the work of practice teams as being of highest strategic importance. Leaders must be responsible for creating and articulating the organization's vision and goals, listening to the needs and aspirations of those working on the front lines, providing direction, creating incentives for change, aligning and integrating improvement efforts and creating a supportive environment and culture of continuous improvement that encourage and enable success.^{1(p. 137)}

What Is the Practice?

Physician leaders have a number of different roles in the patient safety meetings. They help identify and prioritize needs. They can help obtain resources, referrals, and respond to changes in the patient and the environment. Physicians also help to optimize the performance of teams that provide various services with a shared aim to improve the safety and quality of care. In the leadership role, they support and recognize the coordination of work across all services to sustain the improvement.

Why Use the Practice?

- The changes in health care are rapid and unrelenting. The leadership of the physician can bring harmony and cohesion to the continuous quality improvement efforts.
- There is an interdependence of multiple roles that physician leadership can influence to achieve measureable results.
- Physicians support accountability to individual patients while also assuming responsibility for leading the team.

Instructions for Conducting the Practice

- ✓ Select physician leaders who are positive role models.
 - Specifically seek out local opinion leaders (practitioners identified as influential by other practitioners).
- ✓ Multidisciplinary approach
 - Encourage physician involvement early.
 - Respect all members of the team.
 - Create a standardized agenda.
 - End each meeting with a 3W Action Plan (What, Who, When).
- ✓ Discourage “shame and blame” and encourage participation and openness.
- ✓ Focus meetings (M&M, QI, etc.) on system issues and opportunities.
- ✓ Emphasize specific goals and measureable results that are highly relevant and actionable.
 - Incorporate mini-PDSA (Plan, Do, Study, Act) cycles to rapidly assess progress and address pitfalls.

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Harm-Reduction Rounding Checklists and Evidence-Based Guidelines



A checklist is a type of informational job aid used to reduce failure by compensating for potential limits of human memory and attention. It helps to ensure consistency and completeness in carrying out a task. Evidence-based guidelines use the best available evidence regarding the effectiveness, risks, and cost of a medical procedure before implementing the procedure in clinical practice.^{1(p.688)}

What Is the Practice?

A harm reduction checklist is a tool to aid caregivers in the review of all important aspects of care. Benjamin Taylor, MD, MPH (University of Alabama, Birmingham) has provided the medical ICU (MICU) rounding checklist (See Figure 1, page 26), which he and his colleagues created to address the prevention of patient harm across the board. J.C.R. H.E.N. adapted this ICU checklist to create a non-ICU checklist (Figure 2, page 27) to enable physicians to address the reduction of all-cause harm in other care settings.

Evidence-based guidelines are designed from an examination of current evidence within the paradigm of evidence-based medicine. Clinical guidelines identify, summarize, and evaluate the highest-quality evidence and most current data about prevention, diagnosis, prognosis, therapy including dosage of medications, risk/benefit, and cost-effectiveness.

Why Use the Practice?

- Checklists are built off of risk awareness intelligence. They provide a systematic approach to check the predictable root causes that risk patient safety in order for those risks to reduce harm to the patient.
- Guidelines are designed to standardize medical care, increase quality of care, and reduce several kinds of

risk (to the patient and health care provider), and to achieve the best balance between cost and medical parameters.

Instructions for Conducting the Practice

- ✓ Checklists can be very helpful in the promotion of safety culture but should be developed carefully with constant feedback from the clinical environment:
 - Consider physicians' daily professional practice requirements and demands for time in balancing other duties.
 - There must be a predefined problem for which the checklist is the right tool and is perceived as being the right tool for solving the problem.
 - Ask: Are preventable adverse events, such as The Partnership for Patients's list of readmissions and nine hospital-acquired conditions—surgical site infections, ventilator-associated pneumonias, central line-associated bloodstream infections, catheter-associated urinary infections, pressure ulcers, injury due to falls and immobility, adverse drug events, obstetrical adverse events, and venous thromboembolisms²—being prevented in your organization or are they are a consistent issue? If you continue to see harm in each of these areas, this checklist tool might work well for your multidisciplinary teams.

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- Stakeholders must have input in the process, particularly revision, but quality assurance of the checklist is the responsibility of administration
- Checklist must be short, easy to use, with a clear, easy-to-read font.
- It must be made (or adapted) by the physicians within the organization who will use it.
- An influential person within the organization should lead the implementation effort.
- ✓ Guidelines that are evidence-based enable physicians to have the best available evidence regarding the effectiveness, risks, and cost of a medical procedure before implementing the procedure in clinical practice. Components are:
 - Policies based on clinical evidence
 - Estimate of the magnitude of treatment options
 - Analysis of recommendations and potential outcomes for treatment
- ✓ Provide concise, evidence-based best practices pocket guides/reminders to common hospital-acquired conditions.

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Figure 1. Harm Across the Board Reduction: ICU Rounding Checklist

Rounding Physician: _____

Date: _____

Purpose: To eliminate patient harm that is preventable. This tool will be designed by physicians within hospitals to reflect their priorities for harm reduction during daily rounds with the multidisciplinary team within their service specific area.

Category	Checklist Options	Notes: Action
Infection Prevention	<ul style="list-style-type: none"> Antimicrobials—day number, stop date, bug and sensitivities Central venous lines (C.V.L.s): <ul style="list-style-type: none"> –Central venous line #1 Proper insertion? Can it be removed? –Central venous line #2 Proper insertion? Can it be removed? Foley catheter? Can it be removed? (Do not leave in just to monitor urine output in a patient who can void) 	
Medication Safety	<ul style="list-style-type: none"> Review medication list—needs? Steroids—taper or stop? D.V.T. prophylaxis for everyone; ulcer—for patients with mechanical ventilation, sepsis, burns, and head injury/stroke Vaccines – Flu or Pneumococcal? Sedation Needs – Discontinue? 	
Bedside Safety	<ul style="list-style-type: none"> Pressure Ulcer Assessment and status? Fall prevention measures in place Physical Therapy, Ambulation? 	
Physiologic Safety	<ul style="list-style-type: none"> Vital Sign Stability – Shock Work up? Ventilated patient—H.O.B. elevated 30 degrees? Awaken today? Spontaneous breathing trial today? If A.R.D.S. patient, is V.T. 6 mL/kg ideal wt (5 ft tall 50 kg, 6 ft tall 75 kg scaling linearly) and is Ppl 30 cm H2O or less. Day number of intubation? Have we started nutrition and are we at tube feeding goal? Glucose control less than 180 mg/dl? Code Status Addressed? 	
Preparation for Hand-Off to Next Care Setting	<ul style="list-style-type: none"> Transfer Plan? Care team in place for handoff? L.T.A.C. candidate? 	

Provided courtesy of Benjamin Taylor, MD, MPH, Assistant Professor, and Chief Quality and Patient Safety Officer, University Hospital, University of Alabama at Birmingham School of Medicine. The checklist may be adapted for use with acknowledgement.

PATIENT SAFETY INITIATIVE: Hospital Executive and Physician Leadership Strategies

Figure 2. Harm Across the Board Reduction: Non-ICU Rounding Checklist

Rounding Physician: _____ Date: _____

Purpose: To eliminate patient harm that is preventable. This tool will be designed by physicians within hospitals to reflect their priorities for harm reduction during daily rounds with the multidisciplinary team within their service specific area.

Category	Checklist Options	Notes: Action
Infection Prevention	<ul style="list-style-type: none"> Antimicrobials—day number, stop date, bug and sensitivities Central lines: <ul style="list-style-type: none"> Central venous line #1 Proper insertion? Peripheral I.V.? Can it be removed? Hemodialysis shunt care? Foley catheter? Can it be removed? (Do not leave in just to monitor urine output in a patient who can void) 	
Medication Safety	<ul style="list-style-type: none"> Review prophylaxis list—needs? Antibiotics: Check ID/susceptibilities, Day number? Stop date? Steroids—taper or stop? Prophylaxis—V.T.E. risk assessment for everyone Mechanical versus pharmaceutical prophylaxis? Ulcer—for patients with mechanical ventilation, sepsis, burns, and head injury/stroke Vaccines—Flu or Pneumococcal? Sedation Needs—Discontinue? 	
Bedside Safety	<ul style="list-style-type: none"> Pressure Ulcer Assessment and status? Fall prevention measures in place Physical Therapy, Ambulation? 	
Physiologic Safety	<ul style="list-style-type: none"> Vital Sign Stability past 24 hours: If S.B.P. < 90, M.A.P. < 65, or H.R. > 130, shock workup been considered? Have we started nutrition and are we at tube feeding goal? Glucose control less than 180 mg/dl? Code Status Addressed? 	
Preparation for Hand-Off to Next Care Setting	<ul style="list-style-type: none"> Transfer Plan? Family Updates? Discharge Date? Readmission Risk? Patient and Family Education? Care team in place for hand off? Primary Care Provider? Follow up appointment? Special Equipment Needs? Home Health, Skilled Nursing or L.T.A.C. candidate? 	

Adapted by Joint Commission Resources from "ICU Rounding Checklist" (Figure 1, page 26) .

Multidisciplinary Teamwork Training

Teams perform better than collections of individuals. In any situation requiring a real-time combination of multiple skills, experiences, and judgment, teams—as opposed to individuals—create superior performance.^{1(p.381)}



What Is the Practice?

Successful organizations in a wide variety of industries recognize multidisciplinary teams as the unifying principle for operational excellence. Team interaction is collegial rather than hierarchical. Each team member has an obligation to speak up if a question of safety is apparent. Communication is highly valued. Team decision making is focused on patient safety as the priority.

Why Use the Practice?

- The primary purpose of the multidisciplinary team is to achieve consensus with patient safety in the inclusion of expertise from various professionals.
- Teams are to function as a unit, not individuals, to attain complex patient safety needs.
- A high degree of involvement and communication among the team members positively influences patient outcomes.

Instructions for Conducting the Practice

- ✓ Institute team-building activities to encourage care providers to work together, improve communication, and reduce errors as a united force rather than group of individuals.
- ✓ Consider use of existing teamwork training tools (for example, TeamSTEPPS®)
 - Evidence-based
 - Optimize use of resources
 - Resolves conflicts and barriers

- ✓ Communicate goals and message in multiple ways to multiple groups of providers; all are encouraged to participate.
- ✓ Effective teams operate in informal, comfortable and a relaxed atmosphere.
- ✓ Team members feel free to express their opinions.
- ✓ Leadership functions shift depending on the circumstances and needs of the group and skills of the members.
- ✓ TeamSTEPPS® provides higher-quality, safer patient care by:
 - Producing highly effective medical teams that optimize the use of information, people, and resources to achieve the best clinical outcomes for patients.
 - Increasing team awareness and clarifying team roles and responsibilities.
- ✓ Resolving conflicts and improving information sharing.
 - Eliminating barriers to quality and safety.

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Physician Leadership of Post-Adverse Event Debriefs

An adverse event is defined as an injury caused by medical management rather than by the underlying disease or condition of the patient.

A potential adverse event carries the potential for injury. Many, but not all, adverse events are preventable. Those that are preventable, or those that are preventable and result only in the potential for harm, are considered errors. Thus, errors may or may not result in adverse events, and adverse events may or may not be the result of errors.^{1 (p. 2)}



What Is the Practice?

Most errors arise not from the aberrant behaviors of an individual but rather from systemic and often predictable organizational factors. Physician leaders, along with other members of the multidisciplinary team, are almost always in the best position to assess what went wrong with internal systems and processes following an adverse event. These internal investigations are designed to ask the question, “Why? Why? Why?” in a sequence of complex processes that are examined.

Why Use the Practice?

- Adverse events require a multidisciplinary approach when being addressed. Physicians, who represent leadership in the clinical realm, are integral to future efforts to improve the system.
- Identifying lessons learned from the review of adverse events will create safer environments by limiting the potential for errors within the system.
- Creating a culture of safety enables staff to feel safe in reporting errors and confident that action will be taken to address the errors and system improvements.

Instructions for Conducting the Practice

- ✓ Discourage “shame and blame” and encourage reporting of adverse events and errors.
- ✓ Focus goals on needs of the patient with system improvements.
- ✓ Gather information surrounding the adverse event from multidisciplinary sources using a structured agenda.
- ✓ Identify gaps in performance and patient safety.
- ✓ Describe steps that will be taken to prevent recurrence of adverse event.
- ✓ Address “second victim” effects on involved health care providers.²

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Managing Resistance

A major challenge in transitioning to the health care system of the 21st century . . . is preparing the workforce to acquire new skills and adopt new ways of relating to patients and each other.^{1(p. 19)}



What Is the Practice?

In today's health care setting with advanced technology and expanding knowledge, physicians have less direct control over many of the decisions that affect their patients; they often work in collaboration with scores of staff in support of the clinical effort. This dynamic can cause stress and resistance, which inhibit teamwork and the collective, interdisciplinary efforts necessary to reduce harm and improvement of patient safety. Education, physician role models, and policies help to build a positive approach.

Why Use the Practice?

- Physician contributions toward safe, effective delivery of care can be substantial if effective roles are realized.
- The priority is for the providers to make the right clinical decisions and then execute the diagnostic and treatment plans without delay or error in collaboration with others.
- The guarantee of safe care involves the quality of the providers involved, the information available to them, and the redesign of systems that support the effort and the ability of the organization to evolve rapidly along with medical knowledge and technology.
- Creating buy-in for organizational change is difficult, especially for high-level care providers such as physicians, who are used to well-established and autonomous practice patterns.

Instructions for Conducting the Practice

- ✓ Investigate their reluctance to change or be engaged in patient safety initiative.
- ✓ Clarify their perception of facts/reality.
- ✓ Focus on evidence-based practices.
- ✓ Provide dedicated support to make it easier for them to participate.
- ✓ Highlight/create incentives.
- ✓ Focus on relationship with peers and team members.
- ✓ Review physician roles and responsibilities at the senior level:
 - What are the expectations at the senior level?
 - What are the goals for physician engagement?
 - What are the measurement data for hospital acquired conditions?

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