SPS Board Behaviors for Safety

Practical Guidance for Children's Hospital Board Members to Lead for Safety
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Board Behavior	Description	Examples
Support Strategic Safety Goals	Board supports and approves: • establishment of strategic safety goals, including leading and lagging indicators of frontline performance; • implementation of safety improvement actions; • development of a strong safety culture; • learning from the frontline to anticipate potential harm.	Board approves organizational safety improvement strategy Board reviews annual safety operational plans Board members discuss progress towards safety goals at least quarterly Board reviews annual safety program assessment including gap analysis Metrics demonstrating progress toward safety goals are prominent on board dashboard
	Board understands resources required to achieve safety goals and assures their availability	Board assures investment plan to optimize safety performance Board members encourage leaders to report resource gaps and opportunities Board supports executive team in removing barriers and securing resources for safety
	Board models and encourages active participation in SPS for collaborative learning and performance improvement	Board assures that organizational safety strategy and operational plans optimize participation in the SPS Network
Build Foundational Board Safety Knowledge and Core Competencies	Board members have access to the education and information necessary to understand and govern the hospital's safety portfolio	Board members receive foundational training in safety so they can understand opportunities, successes and the basics of improvement science Board members attend SPS Board Training Session
	Board understands and adopts a proactive safety approach to improvement	Board members appreciate the evolution from reactive to proactive safety Board understands hospital efforts to learn from frontline day-to-day performance, foster innovation internally and through SPS collaboration, and measure success through leading indicators Board members observe simulation of day-to-day performance of safety critical tasks
	Board participates in self-assessment of core competencies	Board completes IHI's Governance of Quality Assessment or similar review

Maintain Relentless Focus on Culture of Safety	Board supports the physical and psychological safety of employees/staff	Board ensures and supports efforts to improve employee/staff safety, including the reduction of workplace violence
		Board members receive periodic objective assessments of employee wellness and psychological safety
		Board seeks system enhancements to better support frontline performance so they can safely and effectively do their jobs
		Board supports the application of the "just culture" model for all clinical, non- clinical and executive employees
		Board reviews routine key metrics of organizational safety culture such as those found in AHRQ Culture of Safety survey and similar tools
	Board members are familiar with and supportive of SPS culture training	Board members are familiar with and model basic error prevention behaviors expected of all personnel
	Board actively encourages the perspectives of patients and families	Board includes one or more patient or family representatives
		Board members model safety for others, such as safe walking, safe driving and mitigating observed fall hazards
	Board encourages equity in health care and endorses the exploration and elimination of disparities in safety outcomes	Board values and includes diverse perspectives among their members and hospital leadership
		Board reviews critical safety data through the lens of race, ethnicity, and other important social determinants of health
Build Awareness and Assure Analysis of Potential and Actual Serious Harm Events	Board members receive regular updates on potential for harm and harm events Board assures that: • systems are in place to strengthen frontline performance; • actions to optimize frontline performance and prevent recurrence of events are implemented in a timely manner	Board members are apprised of serious harm events in a timely fashion
		Board expects maximal organizational learning from harm events and the efficient and timely implementation of actions to prevent recurrence
		Board supports disclosure and conflict resolution programs
		Board assures that systems and improvement plans are in place to optimize critical safety task performance in areas of potential harm
		Board understands what the critical tasks are and ensures that actions to strengthen day-to-day frontline performance of these tasks are taken
	Board appreciates impact of harm events on employees/staff	Board ensures that injured employees receive the care and support they need
		Board supports robust caring for the caregiver program

Board Behavior	Description	Examples
Maintain Visible and Vocal Engagement in Safety	Board interacts directly with clinical and non-clinical employees/staff, patients and families outside of the boardroom	Board members participate in leadership walk rounds and Gemba walks
		Board members attend staff celebrations
		Board members attend hospital safety training classes such as error prevention
		Board members make a short video endorsing error prevention and leadership methods that can be shown at the beginning of training classes
	Board celebrates safety milestones and successes	Board members join executives on leadership walk rounds
		Board members spend time with front line staff to appreciate the complexity of tasks in places like pharmacies, inpatient wards and emergency departments
		Board members observe simulations of the day-to-day performance of safety critical tasks

REFERENCES

Leading a Culture of Safety: A blueprint for Success (IHI/NPSF Lucian Leape Institute) http://safety.ache.org/blueprint/

SPS Change Package: Our All Cause Harm Reduction Change Package has strategies and tactics listed as well. https://www.solutionsforpatientsafety.org/wp-content/uploads/SPS_ACH_ChangePackage.pdf Lyren et.al. We Will Not Compete on Safety

Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human http://www.ihi.org/resources/Pages/Publications/Free-from-Harm-Accelerating-Patient-Safety-Improvement.aspx IHI Framework