Safety
Solutions Starter®

This Solutions Starter provides best practices, research and tools to help you improve the engagement of your workforce. These solutions are linked to standard survey sections and questions, making it easy to find the information you need. Many of these solutions can also be used to help you improve performance on your custom, or nonstandard, questions.

PRESS GANEY®

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I can report patient safety mistakes without fear of punishment

QUESTION DEFINITION

This item measures the extent to which staff members feel that their organization supports and encourages the reporting of safety events through a non-punitive culture. Such organizations recognize that consistent reporting is the key to error prevention. Staff members pay attention to how organizations respond to reported errors and use this information to determine whether they would report in the future. When reported errors are analyzed without blame and result in process improvement, staff members are more likely to report. Conversely, reported errors that lead to blame, reprimand or unfair sanctions will discourage future reporting.

VOICE OF THE EMPLOYEE

Management is on our side. I really feel like they value nurses and that they are dedicated to making our organization safe. As a result, I'm not scared that I'm going to be fired for small mistakes.

We have an environment of fear and high anxiety in my unit. The tension is high, and most team members are fearful that they will be fired if they make a mistake. We are all human, and sometimes, mistakes happen. Team members need to feel comfortable to report mistakes so that a proper analysis can be conducted.

IMPROVEMENT SOLUTIONS

- Many employees avoid reporting patient safety errors because they are afraid of retaliation. Helping your staff feel safe and comfortable can increase the number of errors that are reported. As a result, patterns can be established, systems can be improved upon, and staff can be re-educated, if necessary. Consider creating a "just culture." According to AHRQ, a just culture focuses on identifying and addressing system issues that lead individuals to engage in unsafe behaviors while maintaining individual accountability by establishing zero tolerance for reckless behavior. It distinguishes between human error (e.g., slips), at-risk behavior (e.g., taking shortcuts) and reckless behavior (e.g., ignoring required safety steps).
    - As with any process change effort, the first step involves increasing awareness and obtaining support from leadership. It starts with conversations and presentations about the characteristics and benefits of a just culture and an evaluation of how existing practices compare to, or fall short of, just culture principles. With executive leadership on board, steps can be taken to determine a starting point by evaluating staff perceptions of the safety culture and to initiate a campaign for safety.
        - Engage leadership.
            - Educate clinical and operational leaders on the concepts of a just culture and the advantages of using lessons learned through error and near-miss events to improve systems and avoid future harm.

- Survey everyone about their perceptions of a just culture and the organizational safety culture.
  - Gain an understanding of the current state of the safety climate to better target weaknesses.
- Create a culture of learning.
  - Talk openly about safety as an organizational goal at every opportunity.
  - Promote learning from mistakes at all levels of employment and leadership.
  - Train management to recognize the difference between risky behavior that requires individual coaching along with process evaluations and reckless behavior that merits remedial action.
- Promote safety event reporting as an organizational tool for learning and improvement.
  - Encourage reporting constantly.
  - Educate everyone about who should report, what to report and how to report.
  - Reward employees who report near miss safety events. When a potential mistake or near miss is reported, place the name of the staff member who reported the potential problem into a drawing. Every two months, select winners from the drawing, and provide each winner with a "Good Catch" certificate and pin (as well as other prizes, such as cafeteria gift cards, prime parking spaces, lunch with the CEO, etc.).
    - Announce the winner during team or department meetings. Invite the staff member to speak about the specific mistake he or she identified and what he or she did to ensure that the patient remained safe.
  - Protect individuals who report errors by drafting policies that shield against liability and retaliatory or adverse reactions from peers.
- Use safety event data to improve safety and prevent harm.
  - Organize processes for cause analysis, action planning and process change.
  - Be transparent about errors, and provide feedback about actions taken to improve systems.
  - Track the effectiveness of process improvement efforts related to error, and demonstrate a commitment to designing high-reliability processes.

- Exhibit behaviors that make staff members feel safe, welcome and comfortable when approaching you about concerns.
  - Pay attention to your body language – it matters. Facial expressions can convey a powerful message. Smile, make eye contact with your employee and nod when appropriate to show you are listening.
  - Be present; listen to what the employee has to say. Focus on the employee, and repeat back what you heard to ensure your understanding and to demonstrate that you are being attentive.

- Don’t be defensive. Communicate with an open mind; your goal should be to understand what’s on the minds of your employees – even in tough situations.
- To the farthest extent possible, visualize the error or situation as something separate from the staff member. In other words, give staff members a “clean slate” after they’ve made a mistake. Avoid holding grudges against staff members who make mistakes (which are often not the staff member’s fault).
- Emotional competence in tough situations is a critical skill. Managers who easily fall into tirades or who become upset when an error is made do not invite staff openness or foster trust. Publicly praise managers who possess emotional competence and a calm demeanor in tough situations; educate managers who do not.
- Communicate with empathy and care. Ensure that your message is authentic and transparent. When an employee comes to you with a safety concern, don’t be dismissive. Use phrases that clearly demonstrate your concern for the staff member; for example, "That must have been hard for you to see. What happened next?” Asking open-ended questions can often make it easier for the staff member to share additional information.
- Read between the lines: Hone your ability to understand what is not said, witnessed or heard.

- Create a culture of transparency.
  - Invite open dialogue on the subject of errors. If there is one thing you can do today, it’s simply to start talking. Use time in staff meetings and one-on-one sessions to gather staff feedback on the subject. Do staff members feel they have to hide errors? Do they feel that their future performance will be prejudged when they make a mistake? Sharing information will help staff members feel that they can be open while providing managers with valuable insight into staff culture.
    - Share stories about successes and events that did not go as planned. Stories help listeners remember facts and details that otherwise might be forgotten. Detailed stories of how a particular situation placed a patient in harm’s way or actually evolved into an adverse event can be helpful when teaching safety concepts. Remember to discuss what worked and what could have been done differently.
  - All leaders should demonstrate commitment to patient safety and serve as role models for the organization.
    - Individuals in leadership or management roles should always admit to staff when they make a mistake. Management’s honesty encourages staff members to follow suit when things go wrong for them.
    - Managers must ensure that staff members are aware of both the organization's policies and how errors are handled.
  - Consider adopting an "open door" policy regarding all staff personnel files. Staff members should know exactly what is in their personnel file and be able to view their own file. Develop an amnesty policy for reporting of all errors. This allows staff to report errors, mistakes or close calls without the worry that they will be punished or blamed for the incident.

Prevention and Reporting

In my work unit/department, we discuss ways to prevent errors from happening again

QUESTION DEFINITION

This item assesses staff perception of unit-level communication aimed at the prevention of reoccurring errors. Patient safety is a team responsibility. Awareness of potential safety issues will help the team successfully implement changes in practice or work routine. An open discussion of safety concerns reinforces a just environment and encourages staff members to consider personal habits or practices that could compromise patient safety.

VOICE OF THE EMPLOYEE

I love working here. I can help heal our patients and keep them safe by training my team to prevent the spread of bacteria and other microorganisms.

My prior employer offered classes beyond nurse training. We learned communication skills and professionalism that helped us do the right thing in the right way. I feel that this hospital has no teamwork, and when errors occur, you are the one to get blamed even though you were doing all you could to prevent errors.

IMPROVEMENT SOLUTIONS

- Ask employees to brainstorm ways to prevent errors that have happened in the past.
  - Establish a block of time during regular team meetings dedicated to this topic. Review any serious, precursor and near miss safety events that may have taken place prior to the meeting. If nothing has been reported in your work unit, discuss common events, such as patient falls, or use an example from another department. The goal is to consistently use this time to brainstorm. For example, prior to your meeting, a patient was almost administered the wrong drug. Discuss what went wrong, and ask the group to brainstorm ways to prevent medication mistakes in the future.
    - Ask each staff member to identify something that works well in this area of concern. For example, “Medication is clearly labeled.” Then, ask what’s not working well. For example, “Medications with similar names are stored close together.” Identify opportunities for improvement and specific actions to drive change. For example, “We could reorganize the medication to prevent this error from occurring.”
      - Record employee ideas. Consider using a flip chart or Excel spreadsheet.
      - Consider creating a rewards program for ideas or solutions that are chosen and successful. Be creative; you might set up a quarterly contest. Award the best ideas with a gift card, a special lunch, etc.

- Don't forget the introverts on your team. They are less likely to speak up unless they've had time to process the information beforehand. Consider adopting a pre-communication strategy. Email staff members an agenda before a meeting. Ask them to come prepared to discuss.
- Set clear expectations. Let staff members, especially those who have a tendency to be "non-participants," know that you expect their full participation. Make participation in team problem solving a performance requirement. Give employees feedback periodically.

- Consider using a tool, such as Survey Monkey, to gather staff input. Here's one approach:
  - Ask staff to think about the most recent serious, precursor or near miss safety event.
  - Next, ask them to list three things that work well in this area of concern.
  - Then, ask them to list three things that are not working well.
  - Finally, ask each staff member to identify at least one idea that, if implemented, can drive change.

- Set aside time for a "Safety Share." Ask staff members to share success stories about what they've personally done to keep patients safe. Stories help listeners remember facts and details that otherwise might be forgotten. Keep this activity focused on positive achievements. This allows all staff members to hear how peers are contributing, and it may inspire others to be more aware of how their actions can impact patient safety.
- Conduct an Apparent Cause Analysis (ACA) for near misses or less serious safety events. An ACA is a limited investigation, void of in-depth fact finding, which focuses on the immediate causes of a safety event. This highly regarded process allows staff (not limited to those in Patient Safety) to identify the root causes of incidents more quickly and with fewer resources than the more time-intensive Root Cause Analysis (RCA). As a result, more events can be assessed. You can conduct an ACA onsite – in a room, during a staff meeting or during a team huddle. Serious safety events require a more in-depth RCA.
  - In short, investigate the event.
  - Identify what went wrong (e.g., the human errors and equipment or process failures). In other words,
  - begin asking "why." Implement the "five whys" approach developed by Taiichi Ohno, the pioneer of the Toyota Production System. For example:
    - Why did the patient fall even though he or she was identified as at risk for fall?
      The patient was left alone in a wheelchair.
    - Why was the patient left alone?
      The transport personnel went to get the chart and didn't know the patient was a fall risk.
    - Why didn't the transport personnel know the patient was a fall risk?
      The transport person was in a hurry and did not notice the fall risk sticker on the door.
    - Why didn't the transport personnel notice the fall risk sticker on the door?
      It is small and is one of many color-coded notices posted on the door.
    - Why are the visible indicators of fall risk so hard to notice?
      When the process was initiated, it was the only color-coded indicator on the door, and the process has not been assessed for effectiveness.

- Develop an apparent cause statement.
- Describe the significance of the occurrence.

Prevention and Reporting

Employees freely speak up if they see something that may negatively affect patient care

QUESTION DEFINITION

This item focuses on the degree to which staff members feel comfortable speaking up when they see something that may adversely impact care. Healthcare workers may feel reluctant to voice concerns due to a punitive environment or peer pressure. This reluctance is not limited to situations in which one staff member has greater authority. An employee may be reluctant to question the actions of a colleague.

VOICE OF THE EMPLOYEE

When mistakes are identified, our unit sees this as an opportunity for future improvement. When mistakes have been corrected and improvements have been made, we are acknowledged. This makes us feel appreciated.

Some staff members take shortcuts and deviate from our standard protocol. Oftentimes, people are afraid to speak up about this. I've also noticed that managers don't like to confront staff.

IMPROVEMENT SOLUTIONS

- Encourage staff members to voice concerns. Asking employees to discuss and report errors is a significant culture change. Barriers to reporting events include reluctance to assume an additional task, worry about punitive action, skepticism that positive change will occur as a result of the effort and fear of admitting an error.
  - Share thoughts in safety-focused discussions, such as safety rounds, team meetings or open staff forums. If an open and honest environment has not yet been achieved, allow staff members to submit concerns prior to meetings.
  - Implement a user-friendly error reporting system. The system must be easily accessible and should support the full range of error reporting functions. Ensure that each staff member has access to it and is properly trained to use the system effectively.
    - Anonymous reporting systems are best received by staff members; however, anonymity may result in the lack of detail about a situation.
- Emphasize a just culture. According to AHRQ, a just culture focuses on identifying and addressing system issues that lead individuals to engage in unsafe behaviors while maintaining individual accountability by establishing zero tolerance for reckless behavior. It distinguishes between human error (e.g., slips), at-risk behavior (e.g., taking shortcuts) and reckless behavior (e.g., ignoring required safety steps). Remind staff that care is patient-centered, and safety is about the patient. The purpose of reporting errors and concerns is to improve safety.
  - As a leader, always openly admit when you have made a mistake. Safety-oriented behaviors, including acknowledging one's own fallibility, provide an example for

others to follow. Such positive safety culture behaviors encourage staff members to work actively to foster patient safety.

  - Train management on how to create and support a no-blame environment. Managers need to feel comfortable with staff members reporting concerns and admitting mistakes. If managers cannot foster a comfortable culture, staff members will hesitate to speak up when necessary.

- Give staff members examples of safety issues and situations. The better understanding they have of safety, the more likely that staff members would speak up about incidents.
  - Engage staff through role play. Ask volunteers to act out a scenario that would result in multiple safety errors (the instructor should provide the scenario). Ask the audience to identify all mistakes. Follow up by asking them what could have been done to prevent the error from happening.
  - Share examples during safety discussions in all types of meetings. Specifically, include situations in which staff members spoke up about safety concerns. Knowing that others have spoken up makes staff members feel safe about sharing.
- Encourage reporting behavior through positive reinforcement.
  - Recognize those who report errors and near misses.
  - Tell stories about how improvements were made or harm was prevented through error or near miss reporting.
  - Acknowledge and reward staff members who follow patient safety procedures.
  - Praise staff members when a job is done according to established patient safety procedures.

Prevention and Reporting

This organization is actively doing things to improve patient safety

QUESTION DEFINITION

This item is designed to assess staff members' perception of the organization's engagement in patient safety improvement initiatives. Using the term "actively" in the item is intentional so that staff members focus on proactive or preventative improvement projects rather than those initiated as a response to known problems. Unit-specific plans typically include measurable and objective goals for major patient safety measures or leading indicators. The actions and timelines tied to these goals should be well-known to everyone on the unit. This improves staff members' awareness that patient safety improvement activities remain active while promoting staff participation and commitment to patient safety.

VOICE OF THE EMPLOYEE

Senior leaders of the hospital are excellent to work with and are always willing to improve the work environment for employees while providing safe, genuine patient care.

We've never experienced leader rounding, and we don't have department meetings or daily huddles even though we asked for them. We have no input or collaboration on decisions. I don't know what our unit plans are, let alone what is happening in the hospital. Most of my information comes from gossip in the breakroom.

IMPROVEMENT SOLUTIONS

- Staff members throughout the organization should be aware of each patient safety improvement activity and effort. To facilitate buy-in, you must communicate the purpose of the activity and the staff members' role in the activity, as well as provide feedback about the success of the process. Critical success factors include:
  - Involving staff in the evaluation of processes for potential problems and in finding solutions to those issues
  - Encouraging reporting in a blame-free environment
  - Providing leadership that is actively involved in creating a fair and just culture

  The following tip about executive safety rounds allows for the opportunity to create awareness as described above.
- Conduct rounds as an effective means of involving staff and leadership in ongoing efforts to improve patient safety. Different rounds are conducted by different staff members and have various purposes, as described below:
  - Executive safety rounds: These rounds involve leaders aligned with specific safety efforts (e.g., VP of Quality, VP of Risk Management, Safety Officer), a senior executive (e.g., CEO, CMO) and staff on the unit. The purpose is to show that leadership is invested and committed to resolving staff concerns about patient safety, as well as to educate executives about concerns.

  - Consider holding these rounds monthly.
  - Encourage open and honest discussion, and create a relaxed, informal environment.
  - Use standard questions and prompts, such as:
    - "Tell me about near misses that almost caused patient harm."
    - "What can we do to prevent the next adverse event?"
  - Share investigation findings to reinforce the importance of reporting and how learning from event reporting can be used to prevent future errors.
- Hourly rounds: These rounds increase patient safety by ensuring regular check-in with patients. Such rounds may involve nursing assistants, in addition to frontline nurses.
  - Round every hour during the day and less frequently at night, such as every two hours.
  - Use talking points or standards, such as the 3 P's – Pain, Potty and Position – for each round. Press Ganey's CNO, Christy Dempsey, also includes 4 R's – Rx, Reach, Respond and Reassure – to ensure that providers are delivering compassionate and connected care.

  Purposeful hourly rounds have been proven to facilitate a reduction in patient falls in various organizations.
- Safety briefings can be another effective tool in ongoing efforts to improve patient safety. One example is a five- to ten-minute meeting in which staff members are asked to discuss what was seen that caused harm, what might have caused harm or what was done to prevent harm. From there, the situation is addressed by a Patient Safety Officer, and ultimately, the outcome is shared with staff.
- Empower staff members to be proactive participants in ongoing patient safety efforts. The ways to empower staff members include:
  - Tell staff members that they can "stop the line" if they see a potential mistake.
  - Incentivize staff members for watching for potential mistakes. When a potential mistake or near miss is reported, place the name of the staff member who reported the potential problem into a drawing. Every quarter, select winners from the drawing, and provide each winner with a "Good Catch" certificate and pin (as well as other prizes, such as cafeteria gift cards, prime parking spaces, lunch with the CEO, etc.).
  - Encourage physicians to ask staff members to speak up if they have any concerns. Unwillingness of staff members to speak up is common if they feel that their input about something unusual or dangerous is not welcomed by the physician.
- Use preoperative briefings to discuss the background of a case, assess threats and risks and offer relevant information. Arm operating room personnel with a short document that can be used as a checklist or discussion guide prior to every surgery. This document should remind participants of the relevant questions regarding patient safety prior to performing any surgery.

Prevention and Reporting

Mistakes have led to positive changes here

QUESTION DEFINITION

This item measures staff perceptions of the organization's reaction to errors. Mistakes can be traumatic to staff members, especially if they are due to human error and result in a serious adverse outcome. It is important for staff members to understand how the organization will address the safety event and prevent the error from reoccurring. When the organization communicates progress and informs staff members of improvement efforts, staff members can readily see the positive changes that occur.

VOICE OF THE EMPLOYEE

Our organization places great emphasis on resources and team work to improve the safety culture. We've seen too many mistakes. Now, everyone is expected to model safe working behaviors. We have the goal of becoming a highly reliable organization that, for example, does not promote or tolerate shortcuts.

We need more opportunities to learn from difficult patient situations, safety events or other incidents that have happened. Sometimes, something happens, and we never find out how an issue was resolved or what was learned.

IMPROVEMENT SOLUTIONS

- Gather as much safety data as possible, and make the data more meaningful by acting on it. In other words, make improvements and report progress or feedback in a positive way so that people can see the change you are making. Ensure that you communicate such change often in department meetings, team huddles, town halls, etc. When busy staff members and clinicians see the positive impact you are making with the data they submit, they would be more likely to continue contributing. A larger amount of gathered data allows you to address many of the safety issues in your organization, thereby making your facility a safer place for patients (i.e., you can't fix what you don't know).
- Establish a multidisciplinary patient safety committee. This committee should include representatives from various departments in the hospital. The representatives from these departments will serve as role models, promoting an open safety culture.
    - The committee should be responsible for training on the aspects of a safety culture, including:
        - Reporting serious safety events, precursor safety events and near miss safety events.
        - Using behavioral standards that are objective, measureable and uniformly applied.
        - Communicating openly.
        - Training on and rewarding for the characteristics of a just environment (an environment in which system improvements are promoted over individual punishment).

  - Leading by example.
    - Take reports from safety briefings, and assign the appropriate people to investigate and correct the situation or process.
    - Share outcomes from Root Cause Analysis, Failure Mode and Effects Analysis and safety briefings. Allow members to participate in the implementation of the agreed-upon new practices and procedures.
    - Always follow up with all staff members who voiced concerns about particular safety issues or mistakes. Take these matters seriously, and include a thorough explanation of what will be changed or implemented to prevent the issue or mistake from happening again. The more rapid and thorough the follow-up, the more likely staff members will be to perceive that mistakes lead to positive change. This encourages staff members to continue bringing legitimate concerns to management's attention.
- Senior leadership should communicate important messages directly to employees and physicians rather than filtering the information through mid-level leaders and managers. Communication direct from senior leadership sends the message that employees and physicians are valued and trusted and that they should know about important events and changes within the organization. This can be done by hosting town hall meetings in which senior leaders can communicate with large groups of people at one time. Alternatively, senior leaders can send emails directly to their associates. When employees and physicians feel that they are aware of all the goings on within the organization, as well as the reasons why these things are happening, they will be more likely to notice how past mistakes have created a change for the better.
- Hold monthly safety forums for all staff members and management. Allow staff members to talk about their concerns and the common mistakes or near misses that they have uncovered or experienced. Use part of the forum for leadership to provide follow-up on issues that were brought to light in past meetings and to communicate what changes have been made to prevent future mistakes. Communicate success to employees. Highlight:
    - Safety achievements.
    - Above average comparisons to other organizations.
    - Quality standards and how your organization excels.
    - Any awards your facility has recently received.
    - Stories of patient experience accomplishments.
    - Examples of reduced patient suffering.
- Learn from mistakes. When a safety event takes place:
    - Investigate what happened on the unit.
    - Investigate why it happened.
    - Set up staff quality improvement teams. Involve staff members from teams that have made mistakes. The manager should act as a coach and facilitator for the team.
    - Share investigation findings and plans of action with other units that may be encountering similar mistakes.
    - Use mistakes as an opportunity to educate or re-educate employees.
    - Coach or remove low-performing employees and physicians. Failing to do so will hurt morale, patient care and certainly patient safety.

Prevention and Reporting

When a mistake is reported, it feels like the focus is on solving the problem, not writing up the person

QUESTION DEFINITION

This item measures the degree to which staff members feel confident that when errors are reported, the focus is on investigating faulty systems instead of assigning blame. Higher levels of error reporting are commonplace in organizations that promote a non-punitive culture. Such organizations strive to understand, analyze and improve systems and processes in order to prevent future errors. On the contrary, staff members who are subjected to a punitive culture learn that it is not safe to report safety events.

VOICE OF THE EMPLOYEE

When a safety event occurs, we have a process in place to determine the cause. This wasn't the case at my previous job. At this hospital, I feel like we work to find out what went wrong instead of punishing one person.

Management in our unit needs to focus on helping nurses improve instead of disciplining staff members for minor errors. There is no free exchange of opinions and ideas. The stress level in our unit is so high because keeping your job has become more important than standing up for what is right.

IMPROVEMENT SOLUTIONS

- When working to understand what went wrong, foster an environment of respect and trust. When interacting with employees:
  - Be polite and considerate.
  - Ensure that all corrections/instructions regarding staff errors are given in private. Do not correct or counsel staff members for errors in front of peers or patients
  - To the farthest extent possible, managers should visualize the error or situation as something separate from the staff member. In other words, give staff members a "clean slate" after they've made a mistake. Do not hold grudges against staff members who make mistakes (which are often not the staff member's fault).
  - Be supportive of staff members who may be uncomfortable raising a safety concern with someone with more authority. Use phrases that clearly demonstrate your concern for the staff member; for example, "That must have been hard for you to see. What happened next?" Asking open-ended questions can often make it easier for the staff member to share additional information.
  - Emotional competence in tough situations is a critical skill for successful managers. Managers who easily fall into tirades or who become upset when an error is made do not invite staff openness or foster trust. Publicly praise managers who possess

emotional competence and a calm demeanor in tough situations; educate those that do not.

- Create an open, fair and just culture. A just culture avoids blaming individuals when errors occur and focuses its energy on identifying and correcting system-level causes of error. Open communication about error is supported in a non-punitive environment, but it is not a “blame-free” environment. Gross misconduct with reckless disregard for patient and coworker safety is not tolerated. Just culture is fair – it holds individuals accountable for reckless behavior but also withholds blame and shame approaches to dealing with error. Mistakes are tolerated in that the organization intends to learn from them.
  - A just culture operates around a system of accountability:
    - Institutions and leadership are accountable for the systems they design.
    - Staff, patients and visitors are accountable for the choices they make.
- Staff members should feel empowered to call attention to patient safety hazards whenever they are identified. Acknowledge and publicly reward staff members who follow patient safety procedures and who report mistakes and near misses. Examples of rewards could be: announcing staff names at regular staff meetings, naming a "Safety Staff Member of the Month," giving out gift certificates to local restaurants or shops, etc. Encourage reporting behavior through positive reinforcement.
  - Recognize those who report errors and near misses.
  - Tell stories about how improvements were made or harm was prevented through error or near miss reporting.
  - Acknowledge and reward staff members who follow patient safety procedures, as well as identify potential near misses.
  - Praise staff members when a job is done according to established patient safety procedures.
- Help staff and clinicians feel safe to speak up. Protect them against liability.
  - Write and implement a policy that protects clinicians and staff members from legal and peer retribution.
- Complete a Root Cause Analysis (RCA) after a serious safety event, and use the “five whys” approach to drill down and identify preceding causes. An RCA focuses on what went wrong with the system rather than the people.
  - Form a committee to conduct the investigation. Select a team lead and team members.
  - Outline the sequence of events that led up to the safety event.
  - Identify factors that contributed to or caused the event.
    - Examine all documentation.
    - Interview those involved.
    - Interview SMEs not directly involved.
    - Keep in mind that you might ask “why” more than five times in the RCA. In some cases, you can ask a single question, but you might get two different answers. Explore all answers with additional questions. Review the following example, and notice where the same scenario diverges:

      Scenario 1:

      - Why did the patient go to the operating room without his or her pre-op antibiotic?

The transport person did not tell the nurse that he or she was taking the patient.

- Why didn't the transport person inform the nurse?
  The transport person thought the OR had called ahead to notify the nurse.
- **Why did the transport person assume** that **the OR nurse called ahead**?
  Some transport staff members check with unit nurses, but some don't.
- Why don't all transport staff members check at the nurses' station?
  There is no policy requiring them to do so.
- Why is there no policy requiring transport personnel to check in at the nurses' station?
  Transport services are not included in process planning and policy making.

Scenario 2:

- Why did the patient go to the operating room without his or her pre-op antibiotic?
  The transport person did not tell the nurse that he or she was taking the patient.
- Why didn't the transport personnel inform the nurse?
  The transport person thought the OR had called ahead to notify the nurse.
- **Why didn't the OR nurse call ahead**?
  The OR staff members rely on the OR administrative assistant to call ahead to the inpatient units.
- Why didn't the OR admin notify the nursing unit that transport personnel would be picking up the patient?
  An emergent case was rolling in, and the OR staff members were distracted.
- Why does one emergent case disrupt normal protocol?
  There is only one administrative assistant, and no back-up process is in place to support her in times of high volume.

  - Redesign the process to make it less prone to error by developing action plans for each root cause identified in the process above. This will decrease the likelihood of error occurrence.
  - Measure success using patient safety data.

- Institutions with a healthy patient safety culture do not wait for a serious/adverse patient outcome before they take corrective action. In other words, be proactive. By preventing an error from ever occurring, you eliminate any potential blame. Address issues with processes and systems before they contribute to a safety event.
  - Learn from precursor and near miss events. What events took place that caused the almost-error to occur? Look at these events from a systems perspective rather than placing individual blame.
  - Carefully review and monitor hospital systems to ensure they function as intended and that they do not inadvertently place patients at risk.

- Conduct regular organization-wide surveys to assess the organization's safety strengths and vulnerabilities. Clearly communicate findings to all staff members through such means as leadership rounds, town hall forums or staff meetings.
- Educate staff members about the process and benefits of serious, precursor and near miss safety event reporting. Identify the particular drivers of change present in the organization. Realize that it may not be possible to get full buy-in from every staff member right away. Help change adoption stragglers by reviewing not only the mandates for change but also the organizational benefits of a culture of safety for both patients and staff.

Prevention and Reporting

Where I work, employees and management work together to ensure the safest possible working conditions

QUESTION DEFINITION

This item measures the extent to which staff members feel they can work together with management to create a safe environment. Not only can staff members help to identify safety concerns, but they can also provide solutions. Establishing regular communication between staff and management allows both parties to discuss potential safety errors and ways they can collaborate to improve working conditions. Management will also be better able to partner with staff to develop solutions and advocate for resources, support and process/policy change.

VOICE OF THE EMPLOYEE

We have a great team that focuses on patient safety. Older and more experienced nurses mentor the younger nurses, which is great teaching experience for both parties. Our manager often asks us to participate in team-building activities to promote cohesiveness and teamwork.

Managers need to hold people accountable. They often let things go and do not address poor behavior, lack of teamwork or poor performance because they are fearful that they will not be supported by their leadership. Often, we talk about our commitment to patient safety and practice excellence, but our actions do not align.

IMPROVEMENT SOLUTIONS

- Empower staff members to be proactive participants in ongoing patient safety efforts. Ways to empower staff include:
  - Tell staff members that they can "stop the line" if they see a potential mistake.
  - Incentivize staff for watching for potential mistakes. When a potential mistake or near miss is reported, place the name of the staff member who reported the potential problem into a drawing. Every two months, select winners from the drawing, and provide each winner with a “Good Catch” certificate and pin (as well as other prizes, such as cafeteria gift cards, prime parking spaces, lunch with the CEO, etc.).
  - Provide the necessary education, training and resources to employees. When employees feel invested in and supported, they feel empowered.
    - Communicate safety standards and policy during leadership rounding, town hall meetings, team meetings, etc.
    - Conduct formal in-service trainings. You might consider such topics as hand hygiene, wrong-site surgery, patient identifiers and infection control. Regardless of the topic, make sure your in-service is fun and engaging.
      - Cover multiple categories (i.e., topics) by playing a Jeopardy-style game.

- Engage staff members through role play. Ask volunteers to act out a scenario that would result in multiple safety errors (the instructor should provide the scenario). Ask the audience to identify all mistakes. Follow up by asking them what could have been done to prevent the error from happening.
- When conducting a hand-washing in-service, use a black light to show how a proper technique results in cleaner hands. Consider looking at the hand under black light before and after handwashing. Ask staff members what they notice. Explore what happens if you use anti-bacterial gel vs. soap and water.
- Accurate communication is essential to patient safety. Reinforce this important point by asking two volunteers to participate in a live demonstration. Ask one volunteer to dictate the instructions for making a peanut butter and jelly sandwich. Ask the other volunteer to follow the directions exactly as stated. Relate this activity to a patient safety example to demonstrate the importance of accurate communication.

- Provide resources, such as posters, that educate on or reinforce organizational safety initiatives. For example, if your organization is focused on decreasing contamination or cross contamination on hospital surfaces and medical equipment, you might create a poster that displays the top five most contaminated surfaces and what you can do to prevent contamination from happening.
- Develop a brown-bag lunch series. Ask staff members to lead a 30-minute lunch session about a safety topic of their choice.

- Get workers involved in making decisions about safety. Ask each staff member to identify something that works well in this area of concern. For example, “Medication is clearly labeled.” Then ask what’s not working well. For example, “Medications with similar names are stored close together.” Identify opportunities for improvement and specific actions to drive change. For example, “We could reorganize the medication to prevent this error from occurring.”
  - Record employee ideas. Consider using a flip chart or Excel spreadsheet.
  - Consider creating a rewards program for ideas or solutions that are chosen and successful. Be creative; you might set up a quarterly contest. Award the best ideas with a gift card, a special lunch, etc.
  - Don’t forget the introverts on your team. They are less likely to speak up unless they’ve had time to process the information beforehand. Consider adopting a pre-communication strategy. Email staff members an agenda before a meeting. Ask them to come prepared to discuss.
  - Set clear expectations. Let staff members, especially those who have a tendency to be “non-participants,” know that you expect their full participation. Make participation in team problem solving a performance requirement.
- Demonstrate that safety initiatives are working by sharing results.
  - Post safety data publicly on the organization’s website, intranet, bulletin boards, newsletters, etc. For example, by posting the number of days since a serious patient safety event occurred, employees will see how positive changes can impact safety.
    - Always remove old updates and clutter. Individuals will begin to ignore these areas if they are not clean and up-to-date.

  - Share updates on the progress of improvement efforts with employees during leadership rounds, one-on-one meetings, town hall and team meetings.
  - During team meetings, ask employees to share the improvement they've seen. Ask staff members to answer open-ended questions, such as, "How have you seen an impact on patient safety?"

- Implement and support leader rounding. Studies show that when leadership rounding occurs, caregivers are more likely to experience a higher safety climate and a risk reduction in patient safety. Just by being present and asking questions, leaders can demonstrate their commitment to patient safety, increase awareness of safety issues, educate staff and reinforce safety standards and policy, such as non-punitive reporting, obtain crucial information that can lead to positive change and follow-up on the progress of that change.
  - During leader rounding, consider asking open-ended questions such as these:
    - What are we doing well?
    - What keeps you up at night?
    - What conditions in your environment might contribute to the next safety event?
    - What is the next thing that could hurt a patient?
    - What can we do to improve patient safety?
  - Duration and length of rounds will vary by area but should be scheduled on a consistent basis according to predetermined guidelines. It is important to establish a calendar for leader rounding as a means to ensure consistent practice on a regular basis. Schedule leader rounds so as not to surprise staff members and physicians.
  - It is critical to follow up on issues identified during leader rounds.
    - Document identified issues during every round.
    - Track and review trends recognized through rounding.
    - Keep staff members informed of the progress on issues of interest to develop the trust that makes leader rounds effective.
- Together, develop an action plan that outlines how your department is going to reduce serious, precursor and near miss safety events within your organization.
  - Define your goals. Use survey data to help you identify your improvement opportunities. Align your efforts with your organization's goals and initiatives. For example, if your organization is currently conducting an "identify the right patient" campaign, make sure your goals and objectives do not contrast with what your organization is doing.
  - Set aside dedicated time to discuss safety events and brainstorm solutions. Ask members of your team to offer as many improvement ideas as possible. Remember to encourage any and all ideas during a brainstorm. Refrain from analysis or criticism at this point. Simply record all ideas.
  - As a team, select the improvement idea you wish to implement. Consider using SurveyMonkey, and ask team members to vote for the top five ideas.
  - Form a committee to lead the initiative. The committee should contain a mix of employees, from seasoned workers with plenty of patient safety experience to new employees who might have a fresh perspective.
  - Conduct a GAP analysis. Take a look at the current state (i.e., how things are done now) vs. the desired state (i.e., how you want things to be done). Determine the gap in practice. For example, transport currently does not follow up with nursing staff to ensure patients have received pre-op antibiotics. There is no policy requiring them to

do so. The desired process would be that transport would follow up with the nursing staff to ensure that patients have received pre-op antibiotics before they are taken to the OR. The gap is that no policy exists. To ensure patient safety, formulate a policy that requires transport to follow up with nursing.

  - Identify the resources you will need.
  - Identify barriers.
  - Determine how you will measure success.
  - Plan a timeline.
  - Implement your initiative.
  - After your plan is implemented, make sure to follow up and communicate progress on a regular basis. Consistent communication provides reassurance that safety is taken seriously and that efforts to improve it are actually happening as a result of working together. Updates will also keep the team enthusiastic about the organization's commitment to safety.

- As your focus on safety improves, your safety reporting may very well increase. As a result, it may appear that more safety events occur. The rise in the number of events should not be attributed to a true increase. Instead, recognize that there is likely more reporting. Accurate reporting now provides you with a more complete picture of the organization's true safety performance.
  - Set expectations that this may occur, and reassure staff by fully explaining what the new numbers indicate.
  - Make a plan to address the impact on meeting annual goals, which may affect staff bonuses.

Prevention and Reporting

I feel free to raise workplace safety concerns

QUESTION DEFINITION

This item assesses the degree to which staff members are encouraged to raise safety concerns. The workplace must be open and welcoming to multiple viewpoints, particularly as they relate to safety. An employee's level of comfort in raising workplace safety concerns is determined by how the organization responds, follows up and addresses those concerns. Organizations must ensure that staff members are not criticized or demeaned for voicing concerns, even if the assessment of the situation should prove to be incorrect.

VOICE OF THE EMPLOYEE

I trust that the managers and senior management are going to have my back when I raise concerns. I feel that the culture here is to put patient safety first.

I wish that our unit manager was someone we could trust, approach and depend on – someone who would respect and value us, and above all, someone who understands that as humans, we all make mistakes.

IMPROVEMENT SOLUTIONS

- Foster trust among all employees.
  - Trust is an essential component of an effective safety culture. If employees trust that they will not be punished for honest mistakes and if they have a sense of camaraderie and are encouraged to participate in open dialogue and improvement processes, they will feel more comfortable reporting errors. Create a safe environment in which staff members can openly discuss safety errors.
    - Consider holding a quarterly team-building session where ideas and processes that can improve patient safety are shared.
      - Prior to the session, have employees confidentially vote (once a quarter) for a teammate who demonstrated excellence in ensuring patient safety.
      - Announce the name of the winner during this meeting. Budget permitting, give the employee a reward that is meaningful to him/her, or provide some tangible form of recognition.
      - Ask this employee and other staff members to share stories about improving patient safety. Share patient stories as well. Demonstrate how improving safety affects patients.
      - Encourage open dialogue and discussion regarding new ideas, but beware of naysayers. Don't let naysayers derail team building.

- Identify successful behaviors and processes that the team would like to implement as a department standard. Make this a performance metric, and hold staff members accountable.
- Provide the team with skills training opportunities. These include negotiating skills, dialogue and conflict management, collaborative problem solving, meeting facilitation and creative ways of using differences in opinion.
- Seek out the best teamwork practices from other departments, share them with your employees and use them in your work group.
- Engage an organizational development specialist to conduct team-building exercises, or take time off to perform team-building activities outside work.

- Discourage toxic behavior.
  - Help staff members avoid the blame game when problems arise. It is counterproductive and unprofessional to blame physicians, administrators, organizations or other staff members for safety events. Instead, encourage all staff members to accept responsibility for patient outcomes. This will foster trust and respect. When blaming occurs:
    - Set aside time to discuss the issue privately. This sends the message that the issue is important and that managers want to work collaboratively with staff to solve the issue.
      - Don't focus on who did what (i.e., eliminate the blame) but instead focus on what happened (e.g., were there system issues, issues with equipment or technology, a gap in policy, etc.).
      - Contribute to the solution. Support the staff in the resolution of the problem. This sends the message that patient safety outcomes are a joint responsibility.
- In May of 2002, the Joint Commission launched a successful Speak Up™ patient safety program designed to empower patients to participate in their care. Consider creating a similar campaign that empowers employees to speak up. Support your Speak Up™ campaign by implementing programs that promote good communication in a strong safety culture.
  - Implement TeamSTEPPS®. According to AHRQ, TeamSTEPPS is an evidence-based set of teamwork tools aimed at optimizing patient outcomes by improving communication and teamwork skills among health care professionals.
  - Use SBAR (Situation, Background, Assessment, Recommendation) to facilitate prompt and appropriate communication. SBAR promotes quality and patient safety, primarily because it helps individuals communicate with one another and with a shared set of expectations.
  - The CUS tool is used when a care provider clearly needs to get the attention of a supervisor or physician about a matter that is causing a rising level of concern. Using this tool, care providers emphasize three specific words – **c**oncerned, **u**ncomfortable and **s**afety. For example, "I am **c**oncerned about my patient's condition. I am **u**ncomfortable with my patient's condition. I believe that the **s**afety of my patient is at risk."
- Celebrate Patient Safety Awareness Week. This week-long campaign is designed to bring patient safety to the forefront. Ultimately, participation can serve as a reminder that the entire organization is dedicated to improving patient safety. Develop a plan to celebrate in your

organization. Visit the National Patient Safety Foundation website for ideas on how you might get involved. Past suggestions have included:

- Wear a patient gown to work. Demonstrate that we are all patients.
- Social media is a powerful tool; use it. The website offers sample posts.
- Download campaign materials, such as posters, Post-it notes, notepads, etc.
- Engage in discussions with other organizations, and learn how they celebrate Patient Safety Awareness Week.

Resources and Teamwork

Resources and Teamwork

My work unit/department works well together

QUESTION DEFINITION

This item measures the extent to which employees perceive the effective coordination of effort within their team, unit or department. Departments create their own unique social cultures over time based on shared assumptions of how to operate, solve problems and resolve conflicts. These assumptions are reflected in the day-to-day rituals, values and behaviors exhibited by the leadership, the team as a whole and the individual team members.

VOICE OF THE EMPLOYEE

I believe this organization gives excellent patient care. I very much enjoy working in the emergency room. The team I am in works great together, and I love my job!

We need to strengthen communication and teamwork among physicians, nurses, lab and other units to minimize communication and labeling errors for patients and patient specimens. It is important for us to work together as an organizational team and help one another achieve the best possible outcomes.

IMPROVEMENT SOLUTIONS

- Encourage respectful dialogue and the sharing of different opinions during meetings.
  - Lead by listening, and ask open-ended questions. A question such as, “What can we do as a team to improvement patient safety?” will foster more collaboration and buy-in than a statement such as, “We need to improve patient safety, and I think we should do X.”
  - Do not rush to obtain consensus or follow a natural tendency to avoid disagreements. Allow healthy dialogue and the sharing of different perspectives.
  - Encourage open exchanges of information for the betterment of the team.
  - Discourage politics, secrets, cliques and information hoarding.
  - Set up a shared network drive or SharePoint site; doing so can facilitate coordination and information exchange within and across teams.
- Immediately address any concerns about bullying, rudeness or unprofessional behavior that may undermine how well employees work together.
  - Model good behavior by muting your phone during meetings, paying attention to questions and following up on promises.
  - Create a culture of respect and appreciation.
  - Speak up when colleagues are rude. It puts staff members on alert that somebody is watching and cares about how everyone is treated.
- Look for opportunities to celebrate positive interactions. Begin or end team meetings with “kudos” so staff can point out the behaviors of other team members who helped them out.

- Managers must model teamwork within and across departments. As a manager, share what you have done to foster such teamwork. For example, you can say, “Team, I worked with the radiology, EVS and lab managers to create this new process. We agree that it will make things safer for our patients!”
- Model behaviors you want your team to emulate.
  - Speak with purpose.
  - Employ active listening techniques when others are speaking. For example, put down whatever else you are working on, make eye contact and use phrases such as, “I see,” to show you are listening.
  - Make sure your body language matches your message and your intent.
- Evaluate your influence on the relationship dynamics among your employees. Think about a recent interaction with one of your direct reports. Ask yourself the following questions, and check them off as you do so:
  - Do I treat employees equitably? Am I impartial, reasonable, fair and just?
  - Am I misled by just a few instances of poor/great performance?
  - Do I keep appropriate confidences and refrain from talking about employees when they are not present?
  - Do I encourage teamwork in a clear, compelling, open and consistent manner?
  - Have I appropriately invested in training the team to be effective and productive?
  - Have I provided the team with a set of clear expectations as it relates to teamwork, and am I holding all team members consistently accountable for meeting these expectations?
  - Does the team have goals? Are the concepts of coordination of effort, communication, planning and other important behaviors included in department goal statements?
  - Do I overemphasize winning and competition at the expense of collaboration and teamwork?
  - Do I enable unhealthy triangles in communication? When employees have issues with one another, do they come to me first to vent their frustrations, or do they seek to work out issues with one another first?
- Coach, counsel and consistently provide feedback to all employees, with a focus on those who have the greatest room for improvement. Clarify expectations for teamwork and performance, and if necessary, initiate your organization’s performance management process. When performance standards are clear and consistent, marginal employees are likely to either improve performance or leave the unit or organization.
- Evaluate processes in which there are handoffs among team members. How well a team works together is influenced by the effectiveness of processes and the clarity of expectations. Identify process gaps by asking questions like, “How do you know who does what?” and “How do you know this will be addressed?” Create or clarify processes that would address areas of confusion or lack of information among team members.
- Create opportunities for staff members to shadow personnel in other areas. This learning opportunity is a positive way to promote teamwork and enhance cooperation. By observing work practices, demands and processes that differ from their own unit, staff members can gain a better sense of how things work in other areas and, ultimately, work more effectively with staff members from other units or departments.
  - Create such opportunities on a semi-annual basis in two-hour shadowing sessions.

- Leverage interdisciplinary teams to foster unit-to-unit or department-to-department communication. For example, invite nurses on coronary artery bypass surgery teams and those on coronary care units to participate in an interdisciplinary team designed to reduce post-surgical infections. Interdisciplinary teams can build trust and help staff members learn to think from an organization- or system-wide perspective.
    - Take extra steps to invite staff members from units or departments that struggle to work well with others to serve on such teams.

Resources and Teamwork

Different work units/departments work well together in this organization

QUESTION DEFINITION

This statement measures the extent to which employees perceive that there exists effective cross-functional, cross-departmental teamwork. As health care organizations move toward flattened or matrix structures the need to work effectively across functional lines increases. It will be important to engage other departments to resolve the issues measured within this survey item. Given that employees often look to their leaders to model behaviors that should be used when working across functional lines, you should evaluate how well leaders resolve/have resolved problems or conflicts across boundaries. The better you can understand what employees had in mind when responding to this item, the more effective your improvement efforts will be.

VOICE OF THE EMPLOYEE

Using a standard for our unit-to-unit reporting has increased the trust between units immensely.

It is difficult for us to work with certain units because they don't communicate with us at all. We have no idea what's been going on with their patients when they send them to us.

IMPROVEMENT SOLUTIONS

- Leaders should model the behaviors of good unit-to-unit or department-to-department teamwork by demonstrating the qualities that make up good teamwork. For example, leaders can:
  - Use effective and timely communication techniques by responding to staff members' and physicians' questions quickly and thoroughly.
  - Demonstrate a non-punitive approach to error by thanking staff members and physicians for bringing errors to the attention of leadership.
  - Listen effectively by minimizing distractions like personal smart phones.
- Incorporate the knowledge, skills and abilities that are crucial to effective teamwork into position descriptions, recruiting/hiring strategies and performance evaluations.
  - When writing position descriptions, describe the traits of someone who works well with others. For example, "The person in this role should exhibit excellent communication skills so that he or she can work effectively with others. For example, he or she should be a good listener, use appropriate nonverbal communication (e.g., maintain eye contact during a conversation), speak clearly and concisely, use courtesy, demonstrate confidence and express empathy and respect when talking to others."
  - When designing recruiting/hiring strategies, list the knowledge, skills and abilities you'd like to see in potential candidates. For example, "Candidates who will be

considered must be able to explain why effective teamwork is important, communicate effectively with peers (and give examples of having done so in the past) and present information about patients in an organized manner (e.g., use SBAR when providing information about a patient to the nurse on the incoming shift). When interviewing, ask interviewees to explain a time when they have demonstrated effective inter-unit teamwork and the positive outcomes of this collaboration.

  - When conducting performance evaluations, leaders should describe instances in which employees demonstrated effective teamwork and then use these examples when determining overall performance. For example, "When our census was at maximum capacity, Laura stepped in and helped her co-worker care for a patient who was declining rapidly. This was an example of effective teamwork, as Laura took it upon herself to help out when a patient was in need."

- Handle errors in a non-punitive fashion – especially when errors occur in other units/departments. Without a non-punitive culture, teamwork will be adversely impacted when staff members look to assign blame for failure to effectively cooperate with another unit or department. An example of a just culture approach would be investigating the system failures that led to a patient receiving the wrong dose of medication from another department, such as the pharmacy, rather than immediately blaming the pharmacy staff members. Create opportunities for staff members to shadow personnel in other areas. This learning opportunity is a positive way of promoting teamwork and improving cooperation. By observing work practices, demands and processes that differ from those of their own unit, staff members can gain a better sense of how things work in other areas and ultimately work more effectively with personnel from other units or departments.
  - Create such opportunities on a semi-annual basis in two-hour shadowing sessions.
- Leverage interdisciplinary teams to foster unit-to-unit or department-to-department communication. For example, invite nurses on coronary artery bypass surgery teams and those on coronary care units to participate in an interdisciplinary team designed to reduce post-surgical infections. Interdisciplinary teams can build trust and help staff members learn to think from an organization- or system-wide perspective.
  - Take extra steps to invite staff members from units or departments that struggle to work well with others to serve on such teams.
- Develop a standard format for giving a report about a patient for both shift-to-shift and unit-to-unit reporting. If each staff member reports in his or her own way, important information may not be communicated. Use a communication model, such as SBAR, within and across units and/or shifts to help staff adhere to the standard reporting format.
  - Institute regular reviews of inter-unit reporting. Include both clinical leadership and front-line caregivers in the evaluation of the quality and appropriateness of interactions. Task the group with making recommendations for changes that would improve their inter-unit dynamic.
- Use patient interdisciplinary safety rounds to break down barriers between staff. These rounds should involve leaders, managers and staff members from each unit. The focus should be to provide an informal means to identify risks and to gather staff input on errors and near misses. Use safety rounds to gather information that will be useful for making changes to improve patient safety, as well as for demonstrating an engaged leadership that promotes open, blameless communication. Reinforce the notion that units can learn from one another. Learning in this way fosters teamwork and enables staff members to share best practices.
- Offer formalized team training, such as Crew Resource Management (CRM), to improve teamwork in a variety of medical settings. CRM training aims to foster a culture where authority may be respectfully questioned. It recognizes that a discrepancy between what is

happening and what should be happening is often the first indicator that an error is occurring. This is a delicate subject, especially in health care organizations with traditional hierarchies. Appropriate communication techniques must be taught to supervisors/physicians and their subordinates, so that supervisors/physicians understand that the questioning of authority need not be threatening, and subordinates understand the appropriate way to question orders. CRM training should include members from a variety of units/departments and focus on the following aspects of care in order to promote a culture in which authority can be questioned for the sake of patient safety:

- Human errors and non-punitive responses
- Communication
- Giving and receiving performance feedback
- Managing workload, stress and fatigue
- Risk management
- Decision-making
- Recognition of adverse events

Resources and Teamwork

There is effective teamwork between physicians and nurses at this hospital

QUESTION DEFINITION

This question addresses the dynamic between the nurses and physicians. Good patient care requires that nurses work collaboratively with the medical staff. Interactions between nurses and physicians should always be respectful. Nurses must be empowered to address a physician when they have concerns about safety. Physicians must be willing to discuss concerns raised by nurses, even when there isn't empirical evidence of risk.

VOICE OF THE EMPLOYEE

There is mutual respect between nurses and physicians here. We work well together by communicating effectively so that patients' needs come first.

The physicians here have no idea what "teamwork" means. It's their way or no way.

IMPROVEMENT SOLUTIONS

- Require the use of communication models or tools to improve communication between physicians and nurses. The following are examples of communication models/tools that can be used:
  - SBAR, which stands for Situation, Background, Assessment, Recommendation, is a communication model used to address communication problems arising from the differences in communication styles between health care professionals. By consistently using a standard model, people on the care team transfer information to one another using the same format. This helps avoid confusion or misunderstanding. SBAR promotes quality and patient safety, primarily because it helps individuals communicate with one another and with a shared set of expectations.
  - Closed-loop communication. This style of communication is used to avoid misunderstandings. In closed-loop communication, when a sender gives a message, the receiver repeats it back. The sender then confirms that the receiver understands the message by saying "yes". If the receiver incorrectly repeats the message, the sender says "negative" and repeats the correct message. This process is repeated until both parties are on the same page, essentially "closing the loop." This communication process is very similar to the "teach-back" model that many health care providers use with patients to verify understanding of information.
  - CUS: The CUS tool is used when a care provider clearly needs to get the attention of a supervisor or physician about a matter that is causing a rising level of concern. Using this tool, care providers emphasize three specific words – **c**oncerned, **u**ncomfortable and **s**afety. For example, "I am **c**oncerned about my patient's condition. I am **u**ncomfortable with my patient's condition. I believe that the **s**afety of my patient is at risk."

- Designate certain physicians to care for patients admitted to specific units. Localization of physicians results in improved efficiency when caring for patients and better communication between nurses and physicians. Further, by assigning physicians to specific units, teamwork training and interdisciplinary rounds are easier to coordinate and will likely be more successful, as the individuals participating will be used to working with one another.
- Develop behavioral standards for both nursing and medical staff. Educate nurses and physicians about acceptable behaviors, and hold everyone accountable, regardless of position. A behavioral standard might sound like, “All nurses and physicians must demonstrate respect when speaking with a fellow care provider of any discipline.”
    - Examples of behavioral standards include:
        - Treating all physicians and employees within the organization with respect by communicating with courtesy and clarity.
        - Expressing gratitude and appreciation to others by praising them for their achievements.
        - Openly receiving messages of different opinions and acknowledging differences respectfully.
        - Resolving conflict promptly and directly with those involved.
        - Writing legibly for safe and effective communication.
    - Outline the disciplinary process for inappropriate or unprofessional behavior that does not meet behavior standards.
    - Put mechanisms in place to protect staff who report inappropriate or unprofessional behavior from retribution. Administration should intervene early and in a non-confrontational manner with the accused staff member or physician.
- Implement nurse-physician collaborative rounding, during which the nurse and physician jointly assess patients, discuss goals for the day, and answer questions that patients or families might have. This is an ideal opportunity to review the overall plan of care, as well as discuss upcoming tests and treatments and a potential discharge date.
- Help staff improve emotional intelligence to instill confidence and enhance positive behavior when interacting with others. Emotional intelligence is the ability to understand, manage and effectively express one’s own feelings. Planned and strategically sequenced educational experiences can shape attitudes and build communication skills. Experiences that can develop emotional intelligence in nurses and physicians include:
    - Pairing new residents with registered nurses for eight-hour orientation shifts. While working together on the nurses’ terms, physicians directly encounter the unique functions, perspectives and contributions of nursing.
    - Holding simulations in which staff members and physicians are required to demonstrate emotional intelligence. An example is giving trainees the opportunity to interact with someone demonstrating extremely negative behavior, such as someone pretending to be a very angry patient who blames a care provider for a delayed discharge. Train staff members and physicians to avoid jumping to negative conclusions right away, and coach them to come up with multiple ways of viewing the situation before reacting.
    - Offering team-building activities in which nurses and physicians are required to work together to accomplish a goal. For example, present information on the concepts and qualities of good leadership, communication and teamwork to a group of physicians and nurses who need to improve teamwork. Next, place the nurses and physicians into two teams (include a mix of nurses and physicians on each team.) Ask teams to

compete with one another in a communication improvement activity similar to the Family Feud game.

- Prepare a list of questions about teamwork in the workplace.
- Ask each team to send one person to a podium to serve as the representative for the team.
- Ask the two competitors (one person from each team) to answer questions about teamwork in the workplace, such as:
  - Name the top five reasons leaders fail (1 – poor communication, 2 – perception that leaders are more important/have more skills/abilities, 3 – directive vs. inclusive leadership, 4 – lack of self-awareness, 5 – reactive leadership)
  - Name the top four ways that communication can break down among caregivers (1 – speak at people instead of with them), 2 – failure to share information/knowledge, 3 – previous experience of disrespect/lack of support, 4 – poor listening skills)
  - Name the top three signs of a collaborative team (1 – good communication, 2 – follow-through, 3 – respect for one another's ideas and opinions)
- Give each competitor a chance to answer one question on behalf of his or her team so that everyone has a chance to participate.
- After the game, debrief on the key concepts and qualities of good leadership, communication and teamwork that were highlighted through the questions in the game.
- Discuss, as a group, how these key concepts and qualities can be applied among the participants.

- To pursue a just culture, help staff and physicians avoid blaming others when problems arise. According to AHRQ, a just culture focuses on identifying and addressing system issues that cause individuals to engage in unsafe behaviors (rather than immediately blaming the individuals themselves) while maintaining individual accountability by establishing zero tolerance for reckless behavior. It distinguishes between human error (e.g., slips), at-risk behavior (e.g., taking shortcuts) and reckless behavior (e.g., ignoring required safety steps). Staff and physicians must avoid blaming others for problems that manifest in the care environment. It is counterproductive and unprofessional to blame physicians, nurses, administrators, organizations or other staff members for the unexpected and/or disappointing aspects of health care. Willingness and courage to share the load of responsibility for patient outcomes can foster greater trust and respect within the team.
  - When people begin to blame others, managers or leaders of medical staff should set up time to discuss the issue privately. This allotted time sends the message that the issue is important and that the manager/leader wants to work with the team to resolve the issue. During the meeting, instead of focusing on blaming others, discuss the role that everyone and everything (e.g., system issues, equipment/technology issues, etc.) played in the issue. Talk about how the manager/leader can assist to provide a solution as well. By offering to support the person placing blame in the resolution of the problem, managers/leaders can send the message that they are taking joint responsibility for its solution.
- Manage conflict wisely. Cohesiveness and joint problem solving are the desired results of collaborative teamwork. However, nurses and physicians will not always agree. There must be freedom to disagree. In fact, when managed correctly, conflict is actually a desirable

element. Without it, the trap of groupthink can occur, in which case creative but contradictory solutions are suppressed in the interest of maintaining consensus and peaceful relationships.

- Quickly identify when achieving consensus has become unrealistic. When this occurs, communication difficulties must be analyzed, openness fostered and inclusive language incorporated. Focusing on the facts versus opinions helps preserve unity. Encouraging productive conflict without destroying group cohesiveness requires mature team members and humble, practiced leadership.

Resources and Teamwork

My work unit is adequately staffed

QUESTION DEFINITION

This item measures the extent to which employees perceive that there is adequate level of staffing within their team, unit or department in order for care to be provided effectively. Staffing adequacy includes both the actual number of staff members on the unit as well as the nature and volume of work that must be accomplished. If there is difficulty completing tasks despite time and effort, or the perceived quality of patient care is diminishing, employees tend to assume there is a need for additional staff. Poor performance on this question suggests that staff members lack the confidence in their ability to meet unit or department work demands. This conclusion may be attributed to staff perceptions about what is an appropriate staffing mix and level, or it may relate to other factors, such as the presence of under-skilled employees, ineffective organizational processes or poor unit systems.

VOICE OF THE EMPLOYEE

We have a lot of work to do here, but the team is highly skilled and works hard.

It is impossible to get our work done given the number of people we have working on this unit. Hiring more qualified nurses is critical.

IMPROVEMENT SOLUTIONS

- Establish a special committee that includes senior leaders to review staffing levels, staff mix and staff assignments. Make certain that the committee is representative of the organization. Seek input from each unit. Use the committee's findings as the basis for change.
  - Benchmark staffing against units of similar size and service line both within and outside of the organization. If staffing adjustments are justified but not budgeted, conduct a return-on-investment study.
  - Communicate clearly and often.
    - When initiating this committee, share its goals organization-wide.
    - After determining findings, clearly communicate them along with how the organization intends to address them.
- Train unit leaders to delicately manage the needs of both the organization and their employees. Specifically, set expectations showing that unit leaders must avoid throwing the organization "under the bus." When an employee expresses concern that there is not enough staff to support workload, a common tendency for unit leaders is to say things like, "You're right. We are understaffed, and this organization knows it." Instead, train unit leaders to have more productive conversations with staff members. For example, a unit leader might say, "Thanks for sharing that with me. I can hear the frustration in your voice. Let's talk about what we can do to make things better using the resources we have." This can lead to the identification of resources that don't include additional staffing, such as training or coaching.

- To demonstrate listening and to connect with staff, use an empathy statement. Empathy statements are made up of three parts:
  - Empathize: Expressing empathy for a staff member who feels that a unit is understaffed sounds like, “I can see how frustrating this is for you.”
  - Pause: After making your empathy statement, pause. Pausing gives the person with concerns time to say more. It can be challenging to pause, but all it takes is some practice.
  - Probe: The last step is to probe. Probing allows leaders to explore the deeper meaning of what the staff member is saying – for example, “What are the things that need to be done that make you feel that we need more staff?”
    - Altogether, it sounds like this: “I can see how frustrating this is for you. (*Pause)* What are the things that need to be done that make you feel that we need more staff?”

- Train leaders on effective listening skills. If leaders are not inclined to listen to concerns and complaints, they won’t be prepared to handle situations in which staff members express that there is not enough staff on a unit. Furthermore, if leaders fail to listen, staff members won’t feel that they’ve had the opportunity to express their needs. To be effective listeners, leaders must:
  - Manage distractions, such as phones, other people and competing priorities, when speaking with employees.
  - Avoid interrupting employees when they are speaking, i.e., jumping in with a solution before allowing the person to finish expressing his or her thoughts or concerns.
  - Set aside the time to listen. For instance, if an employee would like to discuss staffing, set up a meeting at a specific time to discuss. This way, interruptions are less likely to occur.
- Work to win the loyalty of nursing staff, especially in times of nursing shortages. Training and educational opportunities to enhance each employee's existing strengths are good strategies for gaining loyalty, as they will support the growth and development of your staff. Work with staff members to create individual development plans. When doing so:
  - Provide candid feedback to each employee about his or her relative strengths and development opportunities. Ask each employee to define career goals and the skills they are working to develop.
  - Provide suggestions for development activities. For example, invite a nurse who struggles with confidence to join an interdisciplinary team where his or her opinions will be valued.
  - Help them set realistic timeframes. For example, if a novice nurse explains that he or she wants to become a life flight nurse within one year, listen to his or her goals, and talk about how you can work together to achieve those goals while explaining that achieving such a role will likely take several years.
  - Schedule periodic (quarterly or semi-annual) meetings to monitor an employee’s progress toward goals.
  - Make revisions to employee plans, as appropriate.
  - Acknowledge the accomplishment of employee goals. For instance, if an employee receives a certification that he or she has been working toward, him or praise for this accomplishment in your next team huddle.
  - Create flexible work options to ensure that each employee is given the time and resources for the training and development opportunities listed on his or her plan.

- Discuss training needs, and assess costs before budget deadlines. This will ensure that the appropriate funds are set aside for the upcoming year. This helps you avoid such conversations as, “I wish I could support that training, but we just don’t have the funding.” If budgets are already set and funding is not possible, be honest. Tell employees that you support ongoing training, but training/education will have to wait until funding is available. Furthermore, find budget-friendly development opportunities, such as mentoring programs or shadowing.

- When staffing shortages exist, care providers need motivation to come to work and do their best each day. Frederick Herzberg’s Motivation-Hygiene Theory explains that the following motivational factors lead to the greatest motivation and job satisfaction:
  - Achievement
  - Recognition
  - Responsibility
  - Advancement
  - The Work Itself

  Fortunately, leaders can play an integral role in motivating employees by focusing on these five factors. See the examples below for strategies to improve employee motivation:
  - Achievement: Give employees the opportunity to own a project from start to finish or to join a high-profile improvement team.
  - Recognition: Recognize staff with verbal praise, awards, recognition with leadership, handwritten notes, special treats, etc., when performance is exceptional.
  - Responsibility: Give staff opportunities to take on more responsibility by mentoring a new nurse or taking on especially difficult clinical cases.
  - Advancement: Provide employees the opportunity to advance within the organization by taking note of specific instances in which they’ve demonstrated leadership qualities or outstanding performance. When a new position is available, use these records to help make the case for the employee’s advancement within the organization.
  - The Work Itself: Incorporate the importance of the work that is health care into each day. For example, speak about the significance of caring for patients and reducing their suffering at the beginning of every huddle, or incorporate goals related to your organization’s mission into employee evaluations.

Resources and Teamwork

Communication between work units/departments is effective in this organization

QUESTION DEFINITION

This item gauges how effectively employees feel work units/departments communicate with one another on a daily basis. High-quality and safe patient care is dependent on the coordination of many different individuals and departments, all of which need to communicate different aspects of patient information. Gaps in interdepartmental communication can cause serious breakdowns in the continuity of care and potentially lead to patient harm. Poor communication between units often manifests itself in inefficiencies, re-work, deficits in patient care and increased risk of errors. Separate budgets, separate staff and separate work locations set the stage for an "us" versus "them" mentality. Managers must work collaboratively to resolve any issues between departments satisfactorily and to enhance communication among all caregivers.

VOICE OF THE EMPLOYEE

We have standardized communication between units in this hospital. It has greatly improved our ability to work together for the greater good of the patient.

The right hand has no idea what the left hand is doing here. Patients are required to connect all of the dots themselves.

IMPROVEMENT SOLUTIONS

- Work with supervisors or other leaders to enable staff members to shadow other caregivers. Doing so will allow staff members to observe care practices and safety protocols that differ from those of their own unit. These sessions need only last from two to four hours on a semi-annual basis. Have the shadow staff share observations and suggest possible changes to improve safety. Managers tend to overestimate their units' safety attitudes. Make sure to provide an in-house comparison from unit to unit, in addition to national benchmarks for all unit managers.
- Provide opportunities for all staff members to serve on inter-unit teams to foster unit-to-unit communication. Inter-unit teams can help staff learn to think from an organizational or system-wide perspective. While some may be quicker to volunteer than others, work to involve all staff members to serve on inter-unit teams or projects.
- Use standard communication models/tools to improve communication between units/departments. A consistent approach makes interactions between units more objective and less likely to omit essential information. Try to maintain as much consistency as possible with such models/tools, but allow some customization to accommodate special needs. The following are examples of communication models/tools that can be used:
    - SBAR, which stands for Situation, Background, Assessment, Recommendation, is a communication model used to address communication problems arising from the

differences in communication styles between health care professionals. By consistently using a standard model, people on the care team transfer information to one another using the same format. This helps avoid confusion or misunderstanding. SBAR promotes quality and patient safety, primarily because it helps individuals communicate with one another and with a shared set of expectations.

- Closed-loop communication. This style of communication is used to avoid misunderstandings. In closed-loop communication, when a sender gives a message, the receiver repeats it back. The sender then confirms that the receiver understands the message by saying "yes". If the receiver incorrectly repeats the message, the sender says "negative" and repeats the correct message. This process is repeated until both parties are on the same page, essentially "closing the loop." This communication process is very similar to the "teach-back" model that many health care providers use with patients to verify understanding of information.
- SOAP: SOAP is an acronym/communication tool used to standardize the documentation and/or transfer of information from one health care provider to another. Use it when writing notes on a patient's chart, admission notes, etc. SOAP stands for **s**ubjective, **o**bjective, **a**ssessment and **p**lan.
  - The subjective component is the patient's chief complaint or a brief statement describing the reason for the office visit, hospitalization, etc.
  - The objective component creates an opportunity for the health care provider to incorporate his or her observations of the patient. This would also include measures from the patient's current presentation, including vital signs, findings from physical exams, results from lab and other diagnostic tests, etc.
  - Assessment will include the medical diagnosis, including the possible and likely causes of the patient's problems.
  - Finally, the plan component includes what the health care provider will do to address the patient's concerns and reduce his or her suffering, such as order further labs, perform procedures, give medications, etc.

- Identify unit mentors who can help new staff members develop skills in effectively exchanging information with other units or departments. Include this training in the new hire orientation. The mentor should continue to work with the staff member until it is clear that he or she can effectively exchange information with staff members in another unit or department.
- Avoid assigning blame to other units. Placing blame engenders ill will and can perpetuate feelings of distrust. Managers must carefully examine their response to inter-unit issues and ensure that such issues are handled in a blame-free, non-judgmental manner. This is called a just culture. According to AHRQ, a just culture focuses on identifying and addressing system issues that cause individuals to engage in unsafe behaviors (instead of immediately blaming the individuals themselves) while maintaining individual accountability by establishing zero tolerance for reckless behavior. It distinguishes between human error (e.g., slips), at-risk behavior (e.g., taking shortcuts) and reckless behavior (e.g., ignoring required safety steps). When we avoid assigning blame to other individuals or units, it demonstrates how to deal with these situations constructively. Staff members who continue to assign blame for safety failures should be privately coached by the concerned manager.
- Conduct interdisciplinary rounds to advocate for collaboration across the care continuum and to prevent adverse events. Integrated care delivery through these rounds provides a unified plan to meet the complex needs of patients and prevent harm while ensuring the best possible outcomes. These rounds eliminate the silos that can often manifest in individual units/departments.
  - In a hospital, interdisciplinary rounds should take place daily.

- The rounds should include a core team of attendees, including a nursing representative, social worker, discharge planner, utilization review nurse, financial counselor and pharmacist. Other members should be invited depending on the unit and the patients being discussed. For example, in some cases, a representative from clinical documentation should be present to discuss the working DRG and geometric length of stay to help the team assign a discharge date. In other instances, however, members of the quality team attend to check on whether core measures are in place.
- Rounds are most effective when physicians attend, but this may not always be possible due to office hours and surgery times. If physicians cannot attend, ask the nurses who are caring for each patient to come in and speak about the plan for the patient. Physicians, especially hospitalists, who attend the rounds would realize that their presence saves time in the long run, as they can share their plan and instructions to the entire team instead of getting calls from the individual team members.

- Incorporate the knowledge, skills and abilities that are crucial to effective teamwork into position descriptions, recruiting/hiring strategies and performance evaluations.
  - When writing position descriptions, describe the traits of someone who works well with others. For example, “The person in this role should exhibit excellent communication skills so that he or she can work effectively with others. For example, he or she should be a good listener, use appropriate nonverbal communication (e.g., maintain eye contact during a conversation), speak clearly and concisely, use courtesy, demonstrate confidence and express empathy and respect when talking to others.”
  - When designing recruiting/hiring strategies, list the knowledge, skills and abilities you’d like to see in potential candidates. For example, “Candidates who will be considered must be able to explain why effective teamwork is important, communicate effectively with peers (and give examples of having done so in the past) and present information about patients in an organized manner (e.g., use SBAR when providing information about a patient to the nurse on the incoming shift). When interviewing, ask interviewees to explain a time when they have demonstrated effective inter-unit teamwork and the positive outcomes of this collaboration.
  - When conducting performance evaluations, leaders should describe instances in which employees demonstrated effective teamwork and then use these examples when determining overall performance. For example, “When our census was at maximum capacity, Laura stepped in and helped her co-worker care for a patient who was declining rapidly. This was an example of effective teamwork, as Laura took it upon herself to help out when a patient was in need.”
- Create incentives or rewards to encourage inter-unit or inter-department cooperation. Such incentives or rewards are designed to highlight the demonstration of behaviors that are supportive of effective teamwork. For example, create a monthly award for two people who show inter-unit or inter-department collaboration, naming them the month’s “Powerful Partners.”
  - Present awards like “Powerful Partners” to the recipients during unit or department meetings, describing the steps that were taken and the behaviors demonstrated that led to inter-unit or inter-department collaboration. Describe how such collaboration led to better patient care. Providing rewards and recognition during such a meeting sends a powerful message to other staff members that collaboration across units and departments is valued.
  - Consider including the names of the winners of awards like “Powerful Partners” in your monthly newsletter. Include a brief description of the steps taken and behaviors

demonstrated by the recipients that led to the award being given. Describe how such collaboration led to better patient care.

- Invite guests from other units/departments to speak about their work on your next unit/department meeting with the goal of improving communication. Recommend that the speaker talk about a process that involves two units or departments and that requires effective teamwork, along with the things that meeting attendees can do to work effectively with the speaker's unit or department. The exposure will improve your team's understanding of the challenges faced by those in other work groups.

Resources and Teamwork

The amount of job stress I feel is reasonable

QUESTION DEFINITION

This statement measures the extent to which employees feel their level of job stress is reasonable. In today's health care environment, many employees feel stressed because of workloads, process and technology changes and conflicting priorities between work and family. Job stress is a known antecedent of job burnout and lowered resilience, and it can impact the critical thinking needed to deliver safe care and prevent medical errors successfully. Additionally, workplace stress can lead to absenteeism and staff turnover, thus impacting quality and productivity.

It is important to remember that responses to this survey item are about "feelings." The employees responding "own" that feeling. In other words, while management may think an employee's stress should be manageable, or the workload isn't too heavy, no one can argue with someone else's feelings. Feelings, regardless of what they are, must be respected as being very real for that employee and should thus be addressed appropriately. Management can provide information to help employees see the workplace environment differently and to help them support one another. Transparent communications, management's willingness to listen empathetically, wellness initiatives and supportive peers can ease employee stress levels significantly.

VOICE OF THE EMPLOYEE

This is a tough job, no doubt about it, but my colleagues are so supportive. Caring for patients makes it all worth it.

The stress of this job is debilitating. I am so overwhelmed with paperwork, training, etc., that I feel like I have little time left to do what I'm here for – to care for my patients!

IMPROVEMENT SOLUTIONS

- Discuss with employees how resilience affects the safety of patients. Evidence supports the relationship between nurse engagement and the safety and quality of patient care. Engaged nurses feel a sense of ownership, loyalty and dedication to creating a safe environment for patients.
    - Dedicate time to talking about resilience – the ability of employees to recover and remain engaged even in challenging work environments, interpreted as the opposite of burnout. Taking care of oneself naturally results in better patient care. Organizations with highly engaged employees score higher on patient experience results (HCAHPS), according to Press Ganey data. Hospitals with highly engaged employees also perform better on core measures and earn more Value-Based Purchasing points than hospitals with less engaged employees.
    - Inspire employees to engage in practices that help them manage stress. Coping with stress in healthy ways contributes to resilience.

  - Exercise
  - Meditate
  - Journal
  - Pray
  - Spend time in nature
- Help employees focus on what they can do versus what they should do. Empower employees to say “no.” Saying “no” is often regarded as negative – not being a team player, being judged later on in a review or having an inability to handle workload. Instead, regard “no” as realistic self-preservation.
- Recognize that employees in direct care positions score lower in employee engagement results than non-direct care employees. Understanding resilience and a focus on building resilience are vital to the health and well-being of your nurses, which ultimately affects the experiences and safety of patients and the well-being of the entire organization.

- Establish processes to share positive patient feedback. Caregivers may not directly receive gratitude or praise from patients and families, and sharing and celebrating this information highlights the difference they are making in people's lives. In health care, the work itself (i.e., reducing the suffering and ensuring the safety of patients and their families) can be motivational in and of itself.
  - Collect feedback from:
    - Patient experience surveys. Review survey comments regularly, and establish a process for sharing positive responses, as well as learning from negative ones.
    - Nurse leader rounds. During rounds, ask patients if they would like to recognize anyone for the care he or she provided or for something meaningful done.
  - Share the feedback:
    - Share each positive comment with the caregiver to whom it is attributed, either verbally or through a handwritten note.
    - Share comments related to the entire unit or teamwork with the unit staff during a staff meeting or huddle.
- Consider creating a “What Patients Say About Us” board, where you could post positive comments about patient care, visible to visitors and family members. This helps promote a favorable image of your unit or area.

Resources and Teamwork

Communication between physicians, nurses, and other medical personnel is good in this organization

QUESTION DEFINITION

This question addresses the dynamic between nurses, physicians and other medical personnel and their ability to communicate effectively as a cohesive care team. Good patient care requires the medical team to be in constant communication with one another in the midst of continuous interruptions and multiple patient handoffs. Breakdowns in communication can lead to delays, costly errors and subpar patient experience. Low scores on this item can indicate a lack of respect and trust between caregivers, in addition to communication inefficiencies.

Interactions between physicians, nurses and other medical personnel should always be respectful, and everyone should feel comfortable and empowered to share patient concerns, ask questions and speak up about something unusual or dangerous without feeling inferior. Managers, administration and physician leaders should work together to understand existing barriers and develop strategies to enhance communication and collegiality between medical staff members and physicians.

VOICE OF THE EMPLOYEE

There is great mutual respect between all who work for this organization. People avoid gossip and are honest with one another. It makes for a great work environment.

The physicians are rude and condescending toward the nurses on my unit. This leads to poor care for our patients.

IMPROVEMENT SOLUTIONS

- Partner with peer managers who are “upstream” and “downstream” from your department to jointly round on one another’s departments.
  - Determine whether a “joint task force” comprising employees from the appropriate “upstream” and/or “downstream” departments can be assembled to discuss common communication concerns and identify potential solutions.
  - Invite managers or frontline staff from other departments that you work closely with to your staff meetings to discuss how you can work and communicate better together. This type of meeting often results in important insights into how each department’s work is impacted by others.
- Develop behavioral standards for physicians, nurses and other staff members. Educate all about acceptable behaviors, regardless of position. Hold everyone accountable for demonstrating acceptable behaviors by incorporating behavioral standards into both rewards and performance evaluations.
  - Examples of behavioral standards include:

  - Treating all physicians and employees within the organization with respect by communicating with courtesy and clarity.
  - Expressing gratitude and appreciation to others by praising them for their achievements.
  - Openly receiving messages of different opinions and acknowledging differences respectfully.
  - Resolving conflict promptly and directly with those involved.
  - Writing legibly for safe and effective communication.
- Outline the disciplinary process for inappropriate or unprofessional behavior that does not meet behavior standards.
- Put mechanisms in place to protect staff who report inappropriate or unprofessional behavior from retribution. Administration should intervene early and in a non-confrontational manner with the accused staff member or physician.

- Create a safety nurse position. This nurse would serve as the liaison between nursing and medical staff. He or she would be responsible for improving communication between these groups, identifying adverse event cases and systemic weaknesses, overseeing the hospital's event reporting system, reviewing daily logs, analyzing mistakes or near misses and communicating investigation findings to staff.
- Conduct interdisciplinary rounds to advocate for collaboration and improve communication across the care continuum. Integrated care delivery through these rounds provides a unified plan to meet the complex needs of patients and prevent harm while ensuring the best possible outcomes. These rounds eliminate the silos that can often manifest in individual units/departments.
  - In a hospital, interdisciplinary rounds should take place daily.
  - The rounds should include a core team of attendees, including a nursing representative, social worker, discharge planner, utilization review nurse, financial counselor and pharmacist. Other members should be invited, depending on the unit and the patients being discussed. For example, in some cases a representative from clinical documentation should be present to discuss the working DRG and geometric length of stay to help the team assign a discharge date. In other instances, however, members of the quality team attend to check on whether core measures are in place.
  - Rounds are most effective when physicians attend, but this may not always be possible due to office hours and surgery times. If physicians cannot attend, ask the nurses who are caring for each patient to come in and speak about the plan for the patient. Physicians, especially hospitalists, who attend the rounds would realize that their presence saves time in the long run, as they can share their plan and instructions to the entire team instead of getting calls from the individual team members.
- Help staff improve emotional intelligence to instill confidence and enhance positive behavior when working with others. Emotional intelligence refers to the ability to understand, manage and effectively express one's own feelings. Planned and strategically sequenced educational experiences can shape attitudes and build communication skills. Experiences that can develop emotional intelligence in nurses and physicians include:
  - Pairing new residents with registered nurses for eight-hour orientation shifts. While working together on the nurses' terms, physicians directly encounter the unique functions, perspectives and contributions of nursing.
  - Holding simulations in which staff members and physicians are required to demonstrate emotional intelligence. An example is giving trainees the opportunity to

interact with someone demonstrating extremely negative behavior, such as someone pretending to be a very angry patient who blames a care provider for a delayed discharge. Train staff members and physicians to avoid jumping to negative conclusions right away, and coach them to come up with multiple ways of viewing the situation before reacting.

- Offering team-building activities in which nurses and physicians are required to work together to accomplish a goal. For example, present information on the concepts and qualities of good leadership, communication and teamwork to a group of physicians and nurses who need to improve teamwork. Next, place the group of nurses and physicians into two teams (include a mix of nurses and physicians on each team), Ask teams to compete with one another in a communication improvement activity similar to the Family Feud game.
  - Prepare a list of questions about teamwork in the workplace (see examples below).
  - Ask each team to send one person to a podium to serve as the representative for the team.
  - Ask the two competitors (one person from each team) to answer questions about teamwork in the workplace, such as:
    - Name the top five reasons leaders fail (1 – poor communication, 2 – perception that leaders are more important/have more skills/abilities, 3 – directive vs. inclusive leadership, 4 – lack of self-awareness, 5 – reactive leadership)
    - Name the top four ways that communication can break down among caregivers (1 – speak at people instead of with them), 2 – failure to share information/knowledge, 3 – previous experience of disrespect/lack of support, 4 – poor listening skills)
    - Name the top three signs of a collaborative team (1 – good communication, 2 – follow-through, 3 – respect for one another's ideas and opinions)
  - Give each competitor a chance to answer one question on behalf of his or her team so that everyone has a chance to participate.
  - After the game, debrief on the key concepts and qualities of good leadership, communication and teamwork that were highlighted through the questions in the game.
  - Discuss, as a group, how these key concepts and qualities can be applied among the participants.

- Highlight instances in which others have communicated exceptionally well. Use powerful communication stories to teach others about the kind of communication you seek as an organization. Place stories of powerful communication (and the outcomes) in newsletters, on intranets, in company-wide emails, etc. Putting a microscope on such stories sends the message that good communication is valued by the organization.

Pride and Reputation

Pride and Reputation

This organization provides high-quality care and service

QUESTION DEFINITION

This statement measures employees' perceptions of quality care at the organization level. It is a foundational item, as employees see all aspects of care and have long memories. A care deficiency would be noticed. A near miss will be remembered. Often, when work units provide unfavorable responses on this item, it is caused by the perception of the quality of care and service provided by other work units within the organization. If someone asks employees, "Do you provide high-quality care?" they will say, "Of course we do." If someone asks them if others within the organization provide the same high-quality care and service, they are more likely to share negative stories they have witnessed or heard from other employees or patients.

VOICE OF THE EMPLOYEE

I am proud of the high-quality care here. Because of the tremendous effort to improve patient safety, very few serious safety events take place. I truly believe that patients are safe when they come to this organization.

I feel that the majority of the associates I work with are not dedicated to providing quality care.

IMPROVEMENT SOLUTIONS

- Collaborate with your employees to define what safe, high-quality care and service look like. Point out examples, not only from your department, but across the organization as well.
- Invite team members to share details about the things they love about your organization. Such details can be shared in team huddles, unit meetings, department meetings or informally over lunch with staff.
    - Managers must remember that employees come to them first with complaints. It is important for managers to avoid taking such complaints personally. Managers should resist the urge to feed the cycle of negative talk by choosing responses carefully. A clear commitment to eradicating negative talk will help set a tone that will positively influence the entire team.
- Act quickly when negative talk turns toxic.
    - Everybody complains, but if a team member consistently does so, it is best to intervene before the destructive attitude begins to impact others. When an employee complains chronically, stage a matter-of-fact, nonjudgmental intervention in a one-on-one setting. Frame the meeting as an opportunity to reopen the lines of communication and ask for the employee's input.
    - Reframe the employee's negative perspective. Focus on improvement efforts and actions taken; help the employee see the organization's strengths instead of its shortfalls.
    - Specifically talk about what your organization is doing well. Highlight examples of work units or areas in your organization where perceptions of safety, quality care and

service are positive. Stories of high-quality care and service can be shared in team huddles, unit meetings or department meetings.

- Introduce a forum for constructive criticism. If you've noticed an outpouring of negative talk, it may be an indication that there is a genuine need for more discourse and discussion within the team.
  - Develop multiple channels to allow employees to get their voices heard. These include suggestion boxes (where staff can confidentially submit ideas for improvement), town hall forums with leadership, brainstorming lunch-and-learn meetings, weekly "sound-off sessions," etc.
  - Emphasize your open-door policy. Circle back with employees after constructive criticism has been expressed to demonstrate that something is being done about it. Publicize an "if you tell us, we'll listen" policy.
  - Try to harness the truth behind the criticism, and use this information to help improve the safety, quality and patient experiences within organization.
- In collaboration with your colleagues, create an action plan outlining how your department is going to achieve specific goals.
  - Review the organization's goals and the reasons behind them with the team. If they know about the goals, employees will be more likely to buy in (when employees are unaware of goals and the reasons behind them, they are much less likely to buy in).
  - Brainstorm ways the team can help meet these high standards. For example, if the organization is committed to reducing falls, make this a priority for the department. Help employees by discussing the importance of reducing falls, and obtain input about how the team can effectively work together to reduce falls.
  - Follow through on any solutions the work unit agrees on. If the solution lies in another area, provide a progress report to the unit. Do not let solutions fail because they were not implemented. Periodic updates will help keep the team enthusiastic about the organization's commitment to safety and quality.
  - Look for previous solutions that were never implemented. In the past, issues regarding quality of care may have been acknowledged and solutions identified but not implemented. Often, when employees give unfavorable responses to quality items, they are frustrated that there has been no follow through with implementing high-quality care and service improvements.
    - Sometimes, implementation can fail if there are too many initiatives. Beware of the crowded closet. Before successfully implementing a new initiative, evaluate the tactical closet. How crowded is it? Is it already full of methods, procedures, policies and approaches? If so, evaluate what works, and get rid of the processes and operations that don't.
    - Establish inter-departmental service standards that focus on patient care, as well as safety and quality issues. Set up routine monitoring systems to track and evaluate when and why standards are not met.
- Encourage employees to identify and report policy breaches that would detract from safety, quality and service outcomes. For example, if employees notice that an individual is failing to wash his or her hands when entering patient rooms (standard policy), they should be encouraged to report it.
  - Follow up promptly on any concerns, resolve them and close the communication loop by reporting to those who raised the concern.
  - Work with the appropriate managers to investigate and resolve reported issues that occur outside of your own work unit.

- Be sure to approach your peers with a spirit of inquiry rather than criticism, so that the opportunities to both strengthen cross-organization relations and resolve problems in a collegial way are accomplished.

Pride and Reputation

I would recommend this organization to family and friends who need care

QUESTION DEFINITION

Employees' confidence in the quality of care at their organization is a key indicator of their engagement. Their willingness to recommend the organization to their family and friends reveals that confidence.

Please Note: Commitment/Engagement items measure the employees' emotional attachment to, identification with and involvement in the organization. Although the score is an indication of how engaged your employees are to the organization, the item is not easy to address directly. Often, the best way to act on a Commitment/Engagement item is to focus on low-scoring items in the three primary domains: Organization, Manager and Employee. The items in these domains represent the key drivers of individual employee engagement – the workforce issues that influence employee engagement. Items in these domains are more directly actionable, and improving performance on them will improve the performance of Commitment/Engagement items as well. For this reason, ideas for the improvement of Commitment/Engagement items are often tied to other survey item topics.

VOICE OF THE EMPLOYEE

I see instances of staff members coming together to help a patient time and time again. I would recommend this organization to my closest friends and family without hesitation.

Because of communication breakdowns that happen frequently here, I could not, in good conscience, recommend this organization to family and friends. It's just not safe here.

IMPROVEMENT SOLUTIONS

- Institute leader rounding. Executive teams round on staff members and patients to connect the work to outcomes and to improve the patient experience. Rounding provides a time to not only build relationships but also to be a role model, assess employee morale, recognize wins and identify and remove barriers that prevent staff members from doing their jobs. In addition, it provides real-time feedback on how the organization is meeting patients' and families' needs and identifies opportunities for improvement. Effective leaders know that organizations can get better only if they listen to the patients, as well as the caregivers on the front line.
  - Leaders should ask the following questions during leader rounds:
    - What are we doing well?
    - What are we not doing well?
    - What can we do to improve staff and patient experiences?
    - What can we do to improve patient safety?
  - Duration and length of rounds will vary by area, but should be scheduled on a consistent basis according to predetermined guidelines. It is important to establish a

calendar for leader rounding as a means to ensure consistent practice on a regular basis. Schedule leader rounds so as not to surprise staff members and physicians.

- It is critical to follow up on issues identified during leader rounds.
  - Document identified issues during every round.
  - Track and review trends recognized through rounding.
  - Keep staff members informed of the progress on issues of interest to develop the trust that makes leader rounds effective.

- Take care of your employees so that they can take care of patients with clear heads and plenty of energy. Many health care providers spend their days taking care of others while failing to take care of themselves. Organizations can play a big role in the caretaking of their employees by reducing their stress and working to eliminate burn out and instill resilience among staff members and physicians.
  - Offer on-site and virtual stress management classes. Make sure these classes are offered at a variety of times, are relatively short and make sense for busy staff members and physicians. Tailor strategies and techniques that are applicable to the healthcare environment, such as deep breathing, that can be performed during a quick meal break. Encourage staff to participate by raffling off gift certificates for massages, spa treatments, etc.
  - Provide a place for staff members to come together. Break rooms and staff lounges can be more than just a place in which to eat a quick lunch. Social interaction can help reduce stress, so encourage staff to take breaks together, when possible, to build a sense of community.
  - Develop a mentor program. Pairing staff members together boosts engagement and helps in long-term retention and professional development.
  - Minimize job stress by offering continuing education programs and frequent training. Staff members who feel competent in their jobs are less likely to feel anxious.
  - Offer fitness facilities and/or gym memberships to physicians and staff members. This sends the message that the organization values the health and well-being of the individuals who work there.
- Have an open discussion with your employees about why they would or would not recommend your organization to their family and friends. If you do not feel comfortable leading this discussion, consider utilizing an outside facilitator provided by your Human Resources department. The objective is to identify the set of issues influencing employee engagement.
- Communicate success to employees. Highlight:
  - Safety achievements
  - Above-average comparisons to other organizations
  - Quality standards and how your organization excels
  - Any awards your facility has recently received
  - Stories of patient experience accomplishments
  - Examples of reduced patient suffering
- Listen to and discuss safety concerns and suggestions with your team. Make this a standing agenda item during unit/department meetings.
- Coach or remove low-performing employees and physicians. Failing to do so will hurt morale, patient care and certainly patient safety. In order to create an environment where staff

members and physicians will recommend the health care facility to their friends and family, avoid leaving low performers or disruptive physicians in place.

- Senior leadership should communicate important messages directly to employees and physicians rather than filtering the information through mid-level leaders and managers. Communication direct from senior leadership sends the message that employees and physicians are valued and trusted and that they should know about important events and changes within the organization. This can be done by hosting town hall meetings in which senior leaders can communicate with large groups of people at one time. Alternatively, senior leaders can send emails directly to associates. When employees and physicians feel they are aware of all the goings on within the organization, as well as the reasons why these things are happening, they will be more likely to recommend the organization to friends and family.
- Post safety data publicly on the organization's website, intranet, bulletin boards, newsletters, etc. For example, by posting the number of days since a serious patient safety event occurred, employees and physicians alike will have greater confidence in the quality of care provided by the organization and will therefore be more likely to recommend it to friends and family in need of health care.

Pride and Reputation

This organization makes every effort to deliver safe, error-free care

QUESTION DEFINITION

This statement measures employees' perceptions of safe, error-free care at the organization level. It is a foundational item, as employees see all aspects of safety and care and have long memories. A care or safety deficiency will be noticed. A near miss will be remembered. Often, when work units provide unfavorable responses on this item, it is caused by the perception of the quality of care and service provided by other work units within the organization. If someone asks employees, "Do you provide safe, error free care?" they will say, "Of course we do." If someone asks them if others within the organization provide the same high-quality care and service, they are more likely to share negative stories they have witnessed or heard from other employees or patients.

VOICE OF THE EMPLOYEE

I've seen so many changes to improve patient safety here. I feel like leadership and staff members are truly committed to making this a safe environment for our patients and families.

When errors are reported, people are blamed for them. Hence, errors are reported less and less. The culture here is a breeding ground for patient safety disasters.

IMPROVEMENT SOLUTIONS

- Discuss problems that could be contributing to errors and the recurrence of errors.
  - Ensure that discussions are constructive and non-judgmental by purposefully avoiding the placement of blame on others. Instead, look at errors from a systems perspective. Ask questions like, "What factors in this environment led to this mistake?" or, "What role did technology play in this event?"
  - Share stories across the organization about events that did not go as planned. Stories help listeners remember facts and details that otherwise might be forgotten. Detailed stories of how a particular situation placed a patient in harm's way or actually evolved into an adverse event can be helpful when teaching safety concepts.
    - Consider creating a structured process or acronym for discussions about safety events, similar to using SBAR for communication. You can use something like SRAN:
      - Situation: the general situation.
      - Risk: the safety risk to the patient; consequences.
      - Assessment: how the issue was handled, missed, etc.
      - Next time: what was done appropriately or what should be done differently.

- Inform leadership of patient safety issues. Establish a regular meeting during which safety is the main topic of discussion – for example, the first meeting of each month.
- Learn from mistakes. When a safety event takes place:
  - Investigate what happened in the unit.
  - Investigate why it happened.
  - Share investigation findings and plans of action with other units that may be experiencing similar mistakes.
- Implement unit-level processes and procedures to reduce the likelihood that the event will occur again (as opposed to generalized, organization-wide processes and procedures).

- Establish a multidisciplinary patient safety committee. This committee should include representatives from various departments in the hospital. The representatives from these departments will serve as role models, promoting an open safety culture.
  - The committee should be responsible for training on the aspects of a safety culture, including:
    - Reporting serious safety events, precursor safety events and near-miss safety events.
    - Using behavioral standards that are objective and measureable, as well as uniformly applied.
    - Communicating openly.
    - Training on and rewarding for the characteristics of a just environment (an environment in which system improvements are promoted over individual punishment).
    - Leading by example.
  - Take reports from safety briefings, and assign the appropriate people to investigate and correct the situation or process.
  - Share outcomes from Root Cause Analysis, Failure Mode Effects Analysis and safety briefings. Allow members to participate in the implementation of the agreed-upon new practices and procedures.
- Standardize hand-off communication through the use of communication models, such as SBAR (Situation, Background, Assessment and Recommendation). The SBAR technique is an easy and focused way of communicating. Describe the *situation* at hand (relay level of urgency), provide *background* information that is pertinent, state your *assessment* of the situation concisely and provide a *recommendation* for further follow-up.
- Empower staff to be proactive participants in ongoing patient safety efforts. Ways to empower staff include:
  - Tell staff members and physicians that anyone can "stop the line" if they see a potential mistake. For example, if an OR nurse notices a surgeon creating an incision on a patient's left arm and knows that the operation should be taking place on the right arm, the nurse can "stop the line" and notify the surgeon of the mistake without fear of retribution.
  - Incentivize staff members for watching for potential mistakes. When a potential mistake or near miss is reported, place the name of the staff member who reported the potential problem into a drawing. Every two months, select winners from the drawing, and provide each winner with a "Good Catch" certificate and pin (as well as other prizes, such as cafeteria gift cards, prime parking spaces, lunch with the CEO, etc.).

- Share stories about successes and events that did not go as planned during huddles or staff meetings.

Pride and Reputation

Senior management provides a work climate that promotes patient safety

QUESTION DEFINITION

This item measures employees' opinions of whether senior management's actions promote an environment that is supportive of patient safety. Transforming or maintaining a culture of safety cannot occur without the direct engagement of all levels of leadership. The actions of management are distinct barometers of a safety culture, as it is the leadership that sets the tone. Employees observe and draw conclusions about how management reacts to mistakes or safety incidents. Does senior management engage in a constructive review of how safety management may have failed, or do they seek someone to blame? Do they foster a positive work environment that promotes transparency and encourages the reporting of safety events?

Health care organizations are subject to a multitude of safety and quality mandates from such organizations as the CMS, The Joint Commission and other state and federal agencies. Given that the staff members are aware of the requirements, they invariably notice any inconsistency between the requirements and what they see in practice in the facility. Rather than being reactive to safety problems, those in senior leadership roles must become proactive and implement approaches to prevent harm. Staff will judge leadership primarily by what they do rather than by what they say.

VOICE OF THE EMPLOYEE

I truly feel that our senior leaders are committed to keeping our patients safe. In passing, I once mentioned to our Chief Nurse that I had some safety concerns. By the time I returned to my unit, I had an email waiting for me from her. She wanted to set up time to talk! Safety is a major priority for this organization and for everyone who works here.

Leaders talk the talk, but they don't walk the walk. Our Chief Experience Officer often tells us that patient safety is a priority and stresses the impact safety has on the patient experience, but she never follows up with any actions. We aren't given the staff, equipment, technology or time to keep our patients safe!

IMPROVEMENT SOLUTIONS

- Conduct patient safety leader rounds. This is an effective way to involve staff and leadership in ongoing efforts to improve patient safety. Patient safety leader rounds can be conducted by managers, facility leaders, executives and/or the patient safety team. The focus should be an informal means of gathering staff input on errors and near misses, as well as any identified risks.
    - Patient safety leader rounds indicate to staff members that leadership is pursuing a just culture. When leaders round, they should thank staff members for bringing errors to the attention of others so that the organization can learn from them. Furthermore, leaders should talk about their goal of creating a just culture. According to AHRQ, a just culture focuses on identifying and addressing system issues that cause

individuals to engage in unsafe behaviors (rather than immediately blaming the individuals themselves) while maintaining individual accountability by establishing zero tolerance for reckless behavior. It distinguishes between human error (e.g., slips), at-risk behavior (e.g., taking shortcuts) and reckless behavior (e.g., ignoring required safety steps). Through these rounds, leaders can promote blameless communication regarding event reports and information about patient safety as learning opportunities.

- Leaders should designate patient safety coaches on each unit to provide a work climate that promotes patient safety. Safety coaches should:
  - Be passionate about safety and service.
  - Be the go-to person who is called upon when others need assistance or a second opinion when a matter of patient safety arises.
  - Be able to recognize safety and service concerns and situations, taking appropriate action to reduce or eliminate risks of patient harm and to promote service excellence.
  - Observe and interview staff members in the unit to learn about error prevention tools (what's working, what's not) and patient safety stories.
  - Relay unit-level patient safety information to unit managers, department directors, leadership, etc. It is important for safety coaches to meet regularly with leadership to discuss safety observations, successes and barriers to patient safety.
  - Lead or get involved in patient safety improvement projects.
  - Serve as a role model for patient safety improvement, error reporting, safety improvement behaviors, etc.
  - Raise awareness and gather buy-in regarding patient safety improvement efforts.
  - Collaborate with other disciplines and departments to achieve effective issue resolution.
  - Be able to communicate clearly.
- Do not wait for serious safety events to occur. Institutions with a healthy patient safety culture do not wait for a serious/adverse patient outcome before they take corrective action.
  - Learn from precursor and near miss events. What events took place that caused the almost-error to occur? Look at these events from a systems perspective rather than placing individual blame.
  - Carefully review and monitor hospital systems to ensure they function as intended and that they do not inadvertently place patients at risk.
  - Conduct regular organization-wide surveys to assess the organization's safety strengths and vulnerabilities. Clearly communicate findings to all staff members through such means as leadership rounds, town hall forums or staff meetings.
  - Educate staff members about the process and benefits of serious, precursor and near miss safety event reporting. Identify the particular drivers of change present in the organization. Realize that it may not be possible to get full buy-in from every staff member right away. Help change adoption stragglers by reviewing not only the mandates for change but also the organizational benefits of a culture of safety for both patients and staff.
- Ensure adequate funding and appropriate resource allocations to support a culture of safety. Leadership must evaluate working hours, workload, scheduling practices, turnover, use of temporary staff and other items that directly influence the organization's ability to provide a safe environment for care delivery.

- Safety meetings should include time focused on the workforce and their needs to support a safe environment.
- Educate employees about the importance of resilience and how to maintain it. Transition from a focus on burnout to a focus on resilience to introduce positive psychology to employees.
  - Inspire employees to engage in practices that help them manage stress, such as journaling, exercise and mediation. Coping with stress in healthy ways contributes to resilience.
  - Emphasize the importance of sleep. Severe sleep deprivation mirrors alcohol impairment, creating risk in the health care environment.

- Understand that when an organization begins pursuing a culture of safety, error reporting will likely increase initially. The increase in error reports and drop in scores are most likely the result of raised awareness about the reporting of patient safety events and near misses, as well as more accurate event reporting. With heightened awareness and more accurate reporting, organizations can see a more complete picture of its true safety performance.
  - Set expectations that this may occur, and reassure staff by fully explaining what the increase in error reports indicates.
- Create behavior-based expectations linked to techniques for preventing commonly occurring errors.
  - Gather a grassroots group of employees to develop the hospital staff and leadership (i.e., supervisors/managers) in terms of behavior-based expectations.
  - Ask a separate group of physicians and nurses to create behavior-based expectations for physicians.
  - To help make behavior-based expectation habits, supervisors should regularly offer feedback on them.
  - Behavior-based expectations can serve as core competencies for staff performance reviews.
  - Managers should informally observe progress in terms of behavior-based expectations when they make walk rounds in hospital units.
  - Trained observers from the hospital's clinical effectiveness department should determine whether opportunities for applying behaviors are handled appropriately at critical safety junctures, such as during shift change reports.

  The following are examples of behavior-based expectations that can be implemented to improve patient safety:
  - Nurses and physicians should use teach-back when explaining medications to patients to ensure that patients understand a medication's purpose, dosage, administration, etc.
  - All staff members and physicians should speak up when they feel that a patient is going to be harmed.
  - Staff members and physicians should report all events through the organization's event reporting system. These include near-miss events (does not reach the patient; error is caught by a detection barrier or by chance), precursor safety events (reaches the patient and results in minimal harm or no detectable harm) and serious safety events (reaches the patient and results in moderate to severe harm or death).
  - Leaders should thank staff members and physicians for bringing medical errors to their attention. This promotes a just culture by identifying and addressing system

issues that cause individuals to engage in unsafe behaviors (rather than blaming individuals for mistakes).