The Patient Safety Team: Healthcare Executives Embrace Their Role

By Susan Birk

The notion of the healthcare executive as a critical patient safety change agent was a rare concept not long ago. It was primarily the clinical staff who worked to ensure safety in patient care. Administrative-clinical alignment was strengthened, however, with the realization that the C-suite carries as much accountability for patient safety as the clinical staff does. If you are a healthcare executive, you know that patient safety has become an integral part of your job.

Transparency as a Catalyst for Executive Accountability

Accountability breeds transparency—quality and safety data now appear with regularity on hospital and health system websites, for example—and that transparency has put a lot of safety issues on CEOs’ front burners that were never there before.

“It’s been a big change in the years since I was a hospital CEO,” says Maureen Bisognano, president and CEO of the Institute for Healthcare Improvement, Cambridge, Mass. “We’re now seeing whole C-suites and boards focused on their responsibilities for identifying safety problems and closing the gap between the administrative side and the clinical side [of care delivery].”

Healthcare’s past tendency to rationalize serious mistakes as unfortunate but sometimes unavoidable occupational hazards has evolved into acceptance of responsibility for
adverse events and a commitment to keeping them from happening.

Doug Doris, FACHE, CEO of Central Carolina Hospital, a 137-bed acute-care facility in Sanford, N.C., and a part of Tenet Healthcare Corporation, says, "I've been a CEO since 1990, and my involvement in safety when I began consisted of attending quality improvement meetings with other directors at the hospital. Today, 30 percent of my annual incentive is based on safety and quality metrics, and I chair the quality council." Not that it's about the compensation for Doris. The council meets monthly to review every department's goals and performance in depth and to discuss strategies for improvement. A few years ago, "I would not have made attending these meetings the highest priority as I do now," he says.

"The hospital's commitment to quality and safety improvement, including a focus on all aspects of emergency department throughput, has yielded a reduction in the average time it takes patients to see a physician—"door to doc" time—to 25 minutes from 83 minutes, even as volume grew by more than 10 percent in each of the past two years. In 2010, Central Carolina Hospital was recognized by the Leapfrog Group as one of the top rural hospitals in the country. The hospital was one of only five in the nation recognized in all three categories of patient safety, quality care and resource use standards."

Michael D. Connelly, FACHE, president and CEO of Catholic Health Partners, Cincinnati, a nonprofit system of 31 hospitals, 15 long-term care facilities and other healthcare organizations, also attests to the change. "Safety has permeated literally everything we do," he says. "Half of our senior team's annual objectives deal with issues of quality and safety. And we've developed dozens of different initiatives to promote quality and safety throughout the organization, led primarily by senior executives."

They include Catholic Health Partners' Marcia Messer, RN, vice president of clinical transformation and nursing, who leads a team of improvement engineers and patient safety officers in redesigning the delivery system and reframing the culture by integrating tools from Lean, Six Sigma, TeamSTEPPS and other methodologies across the healthcare delivery continuum.

At Catholic Health Partners, the board of each hospital has a quality committee that spends half of each meeting dissecting the facts of a sentinel event and discussing how to prevent it from happening again. The member hospitals' CEOs share all serious reportable events and results of root cause analyses in monthly teleconferences.

The system spends more money now on safety initiatives than on medical malpractice, reports Connelly. The organization's early
adoption of evidence-based standards in obstetrics and other areas has drastically reduced malpractice claims. “And we’ve reinvested the savings in safety,” he says. Facility leaders attend a leadership academy each year devoted to safety issues. As an outgrowth of these learning opportunities, it has become policy for the CEOs to speak directly with the families of patients involved in a serious incident or death. “That cultural expectation puts a human face on all of the statistics,” Connelly says.

When the mother of a Catholic Health Partners executive died because she was mistakenly given an IV bag containing a powerful narcotic rather than fluid for hydration, the executive took a leadership role in sharing the story. “The ability to use these stories . . . in a variety of settings is a very compelling way to get people to overcome their biases and see the profound human cost of a single mistake,” Connelly says.

The Cultural Context of Patient Safety
Senior executives’ responsibility continues to grow in sophistication and complexity as new knowledge emerges about safety culture and science. It includes the realization that safety is a systems issue. “It’s not the kind of work you can do by tackling one particular type of error or discipline and solving that problem in a vacuum,” says Diane C. Pinakiewicz, president of the National Patient Safety Foundation (NPSF), Boston. “You have to pay attention to the cultural context in which the work gets done. If you don’t have the cultural context in place to embrace best practice interventions that need to be pursued on a continuing basis, you will have problems with sustainability and improvement.”

And it’s the healthcare leader’s responsibility to foster that cultural context, although providers still have a way to go in this regard, Pinakiewicz says. “We see a lot of focused improvements in a variety of areas, such as ventilator-associated pneumonias. What we’re not seeing is a comprehensive, massive, forward movement of measurable proportions.”

Still, hospitals and health systems are making strides. They now know, for example, that an effective safety culture neither points fingers at individuals nor sweeps problems under the rug. Rather, the most successful approaches blend openness with accountability. “What’s needed is a respectful learning culture that exhibits all the tenets that we now know are necessary for safety, including transparency, collaboration and the ability for people to speak up so that reporting an error becomes a genuine opportunity to learn and improve,” Pinakiewicz says. “There can’t be an immediate assumption that people are to blame for things that go wrong, because now we know the system plays into this.”

A blaming culture is a fearful and joyless one, Bisognano notes. The

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16 Healthcare Executive
SEPT/OCT 2011

anxiety that results produces communication gaps between caregivers and patients and among caregivers on the same team, which lead to errors.

But that doesn’t mean individuals should not be held accountable for their performance, says Pinakiewicz.
Responsibility has not gone away; instead, its definition has evolved and expanded. Accountability encompasses behavior as well as clinical outcomes. Providers are beginning to focus on disruptive staff behavior because they understand that unprofessional attitudes compromise safety.

“We’ve known for a long time that our culture of medicine has tolerated some disruptive behavior,” says Pinkiewicz. “People in high-risk industries from whom we’re learning valuable lessons will tell you that those kinds of behaviors are just not safe. We hesitate to deal with behavioral challenges in our hierarchies, including the ‘star performers’ who bring in significant revenue. But we’re beginning to understand the serious consequences of tolerating disrespectful behavior and now holding individuals accountable for their behavior in the same way that we hold them accountable for outcomes. What’s needed is a new definition of ‘star performer’ as someone who has exceptional clinical skills but also models and encourages the professionalism and teamwork that we now know need to be present in a safe culture.”

According to Bisognano, such redefinition requires a shift from an acceptance of the physician as a solo practitioner focused on caring for his or her patient panel, whose sometimes idiosyncratic needs must be accommodated, to the expectation of team player devoted to reducing variation, apportioning resources effectively and listening to the voice of experience from other disciplines, such as pharmacy and physical therapy, because their knowledge adds to the team’s IQ. “I don’t think we see enough of that in healthcare yet,” Bisognano says. “The important questions are, ‘How do we work together to ensure safety?’ and ‘How do we work together to create joy in what we do?’ That’s still a work in progress.”

Pinkiewicz encourages hospitals to develop a credo with physicians based on a commitment to safety and to behavior that is professional, respectful, cooperative and team focused. It should articulate behavioral expectations and the consequences of not adhering to them. And healthcare leaders must have the organizational strength to follow through on any lapses in that commitment. “It’s no longer just about performing the best medicine based on best evidence,” she says. “It’s about the impact the person has on the rest of the team and the safety of the processes associated with the delivery of care. If somebody says, ‘I have to stop the process right now,’ you don’t turn around and scream at them. You stop the process. It’s a matter of embedding a mind-set based on all the things we know to be necessary to practice safe care.”

Catholic Health Partners administers the Agency for Healthcare Research and Quality’s culture survey every two years to measure safety perceptions and attitudes among staff. Posing such questions as, “Do you feel comfortable reporting errors?” and “Do you have support when you report a safety problem?” the survey gives organizations the data they need to pinpoint problems, target specific areas and confirm that problems exist.

Connelly says, “It’s interesting that when you ask professionals about disruptive behavior, you’ll often find that few say it is a problem. But when they’re asked on a survey whether they’ve seen an example of disruptive behavior within the past 30 days, the incidence might show something like 75 percent.”

**Engaging Staff Starts at the Top**

Pinkiewicz points out that awareness is growing in the C-suite that creating a workforce capable of delivering safe care requires attention to the workforce itself and skill in translating broad strategic commitments to the language of day-to-day expectations. “In this age, where resources are tight and challenges are steady, it’s difficult to expect a workforce that isn’t inspired, motivated and enjoying what it’s doing to do this hard work,” she says. NPSF calls this ingredient of a safe culture "the joy and meaning of work." It can be found only in an environment that invigorates and empowers staff and reconnects them with why they went into healthcare in the first place.
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“As we work toward creating a delivery system that is efficient and safe, we are also facilitating a culture of empowerment and engagement for those who know the work best—our frontline associates,” says Messer. During the past five years, Catholic Health Partners has tackled a multitude of problems, such as improving patient throughput, enhancing timely access to procedures, optimizing labor resources and decreasing handoffs, improving surgical services and redesigning its emergency departments. “Our hospital staff are now working in tandem in a way they thought was impossible a few years ago,” Messer says. For example, in some facilities, patients awaiting an inpatient bed are retrieved by the admitting unit staff, not taken to the unit by staff in the emergency department.

Most healthcare workers want to do their jobs well, but the environment must allow them to do so. Support for creating such an environment must come from the top. “You can’t expect your workforce to do what needs to be done if people feel beaten down every day and disconnected from the meaning of their work,” Pinkiewicz says. It is the C-suite’s responsibility to create this environment by setting the cultural tone; deploying the appropriate resources; and making sure that people feel free to report errors, ask for support and participate in solutions. “You have to make it very clear to people what a commitment to safety means for them on a day-to-day basis, and how they are part of the solution set,” she says. “And you have to recognize, celebrate and [motivate] people as they move in these new directions.”

Bisognano recalls seeing an outstanding example of staff empowerment when she accompanied the CEO of an academic medical center on his regular safety rounds. “I’ve made safety rounds with CEOs who say ‘How is everything?’ and everyone lines up and says ‘Fine.’” What was profoundly different about these rounds, says Bisognano, was the ease with which a nurse manager was able to express her concern to the CEO about two specific safety-related problems that had been occurring in her area, and then to have those problems listened to. “He demonstrated incredible leadership because he was showing that he really understood the

ACHE Joins the Partnership for Patients

This spring ACHE joined the Partnership for Patients: Better Care, Lower Costs, a new public-private partnership launched by the Obama administration. The partnership aims to bring together leaders of major hospitals, employers, physicians, nurses and patient advocates with state and federal governments in a combined effort to make hospital care safer, more reliable and less costly.

The partnership’s two goals are:

**To keep patients from getting injured or sicker.** By the end of 2013, decrease preventable hospital-acquired conditions by 40 percent compared to 2010. Achieving this goal would mean 60,000 lives saved during the course of three years.

**To help patients heal without complication.** By the end of 2013, decrease preventable complications during a transition from one care setting to another so all hospital readmissions are reduced by 20 percent compared to 2010.

To learn more about the Partnership for Patients, including how to join, visit www.healthcare.gov/center/programs/partnership.
problems this nurse manager was facing,” she says. “And though she was dealing with some really tough issues, she was joyous because she knew she wasn’t alone. It was wonderful to see this CEO and this nurse having a conversation about the real battles she faced and the support that he could bring.”

Patient and Family Involvement
Healthcare providers are also discovering the value—and the necessity—of involving patients and families as part of the solution. “The engagement of patients and families is an untapped lever for improving patient safety,” says Pinkiewicz. “It’s the responsibility of leadership to find ways to include that voice, not just by having a patient/family advisory council, which everyone should have anyway, but also by involving patients in solutions design.

“There are roles for patients, families and patient advocates in the solutions that aren’t always considered in the redesign process,” she says.

“Sometimes you have your provider hat on so tightly that it’s hard to see that other perspective. It’s remarkable how the patient always comes up with something that other people didn’t think of. The focus is no longer how we optimize the limited provider resources that we have—it’s how we optimize the patient experience.”

The focus is also on breaking down traditional boundaries between functions in favor of collaboration. Bisognano cites ThedaCare Inc., Appleton, Wis., a community-owned, four-hospital health system, as an innovator in this area. When patients are admitted to the hospital, a team composed of a doctor, a nurse and a pharmacist admits them. The team visits the room together to review the medical history, medications and drug interactions and to map out care. “They’re finding that when everybody’s on the same page, not only do harm and errors decrease but also patient satisfaction increases and the length of stay decreases by 25 percent,” she says.

Catholic Health Partners has focused on collaboration as a safety improvement strategy as well, using a program originally developed by the aviation industry called Crew Resource Management to break down the traditional barriers between functions. This process allows staff to see how their work influences that of their colleagues in other departments and disciplines.

“We’ve gone so far as to simulate catastrophes and let the team watch videos of each other to see how they manage the event as a team and how they really all depend on each other even though they may be in different locations,” Connelly says. “It’s been revealing.”

Healthcare leaders are tuning in to the undeniable interconnectedness between management and the culture and science of delivering safe care, says Bisognano. As part of that discovery, they are talking directly with patients who have been harmed. “It’s a whole new leadership style and knowledge base for executive teams to absorb. But it’s helping them see the whole system, and that’s a good thing. Ten years ago, it was rare that I would sit in a meeting and hear about the real impact of harm. I don’t think leaders understood that the harm we were producing was causing death. Now they do, and they’re becoming more proactive in talking about it and establishing a patient safety culture.”

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