Safety culture: A journey to zero

Interprofessional collaboration drives culture change.

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In 2014, Advocate Good Shepherd Hospital, a Magnet®-recognized, 176-bed, community-based hospital in Barrington, IL, embarked on a journey to reach a goal of zero events of serious patient harm by the year 2020. Many factors contributed to this ambitious venture, but the primary reason was that it was the right thing do for patients, their families, and our team members.

When examining the effects of hospital-acquired conditions and medical errors, we discovered delays in recovery, disability, loss of income, and even loss of life. We also recognized that medical mistakes impact our healthcare teams. Nurses may experience physical and emotional symptoms such as depression, flashbacks or repetitive memories of the event, difficulty concentrating and sleeping, and reluctance to care for patients in similar situations. Some nurses even leave their jobs.

Culture change

Every team member, beginning with our hospital system's executive leadership, made a commitment to be the safest healthcare organization we could be. Part of that effort included working toward becoming a high-reliability organization (HRO). HROs, including those in aviation and nuclear energy, work under difficult conditions all the time but are successful at minimizing errors by adhering to the five HRO principles. (See *HRO principles*.)

Our journey started by gaining a better understanding of what defines safety events and how they occur. The Swiss cheese model of safety acknowledges that despite all best efforts, humans, processes, policies, technology, and environmental factors all have gaps that can allow errors to slip through and reach the patient.

Healthcare performance improvement (HPI) defines *safety events* as any variation in practice or expected outcome that reaches the patient; *serious safety events* are those in which the patient incurs moderate to severe harm or death. A *near-miss event* is one that might have caused harm but was identified by a team member before the error reached the patient.

To think like an HRO, we needed to encourage our staff to report safety events, especially near-miss events, which when analyzed and then corrected, can mitigate similar events from occurring. Simply put: To fix it, we must know about it.

But first, we needed to overcome a significant barrier: Staff felt that by reporting an event, they were reporting a person, which carried a negative connotation. To tackle this challenge, we needed to make a culture change. We now apply the principle of a just culture, which states that no punishment will occur as a result of unintentional human error or mistakes caused by system problems. Fair consequences do exist for those who intentionally choose to not follow the rules. In addition to maintaining a just culture, we recognize staff for great catches and self-reporting. When reported events lead to causal analyses, we invite team members to share not only the events, but also their recommendations for how to prevent them from happening again.

Leadership support

One of the HRO must-haves is executive leadership support and commitment. Our leadership team guided us in weaving safety into our organizational fabric and making safety efforts real. As a result, we begin every meeting with a safety story or a quick win, using specific safety language, and safety huddles. Leadership-led safety huddles occur every morning (including holidays and weekends) in every department and focus on 24-hour reflection and next 24-hour anticipation. Safety coaches from

HRO principles

High-reliability organizations (HROs) adhere to five principles to reduce risk.

1. **Preoccupation with failure.** Always think that something is wrong, then validate that it's right.
2. **Sensitivity to operations.** Be aware of internal and external factors in the team, technology, and environment.
3. **Reluctance to simplify.** Have a questioning attitude and challenge assumptions.
4. **Commitment to resilience.** Bounce back from mistakes before they cause more damage.
5. **Deference to expertise.** Identify who is the expert or has the most experience in the situation.

each department hold monthly unit-based high-reliability meetings. In addition, safety efforts are recognized at department and manager meetings and at celebratory events such as during National Nurses Week. Our frontline staff became enthusiastic partners on this safety journey and began to take the lead on many initiatives.

Leaders also invested in safety and HRO education. Initially, we focused on standardized safety education for our leaders, but we eventually provided every nurse with training on HRO principles and incorporated this training when onboarding new nurses. In addition to this baseline training, we implemented a frontline safety coach program to continue to infuse safety into daily practice. Safety coach training includes nursing units and interprofessional partners (pharmacy, respiratory therapy, labs, social work, imaging, ancillary services, and physical, occupational, and speech therapy).

Interprofessional partnerships

As a result of these efforts, we began to see improvements in safety and reporting, but not enough to reach our goal of zero events of serious harm. To drive greater improvement, we realized we needed to move beyond departmental silos and individual nursing unit teams to unite nursing and create partnerships with our interprofessional colleagues. These partnerships drove us from unit-based to house-wide high-reliability safety coach meetings.

Knowing that hospitals function 24/7, we tried several methods to encourage maximum meeting participation. Our hospital's chief nurse executive initiated the inclusive interprofessional process, which she later transitioned to be co-facilitated by the emergency department and patient safety managers. These managers led the monthly meetings, both in person and through a virtual platform, to accommodate anyone who needed to participate from home.

The high-reliability meetings nurtured dialogue that created mutual understanding across the service lines, encouraging people to share best practices and providing a great venue for learning about safety reporting, just culture, and safety tools and behaviors. Through these monthly interprofessional meetings, we learned that staff wanted to work on building confidence and skill with peer coaching and to have a safety summit.

Safety summit

Our first safety summit, a day-long event held off-campus, included 87 safety coaches and leaders. Participant seating was prearranged to promote interprofessional teamwork, broaden perspectives, and build relationships.

We used appreciative inquiry—a process that focuses on the positive and highlights successes so that innovative thinking can occur—to build on our safety strengths. We started the day with an appreciative inquiry exercise: Think about a time when you intervened or prevented an unsafe event from occurring.

All participants received a copy of the book *Why Hospitals Should Fly* by John J. Nance. This book launched us into visioning activities about what we could achieve. We included peer-coaching exercises to help address confidence levels and skills. In addition, we reinforced and used common safety language, behaviors, and tools to continue to support an interprofessional safety culture. We concluded the day with innovative brainstorming activities, which provided a springboard for future projects.

The safety summit inspired many frontline ideas. Coaches created a "Spin the wheel of safety" game that uses predetermined safety-based questions to reinforce safety principles. This game is shared with all

Simulating safety

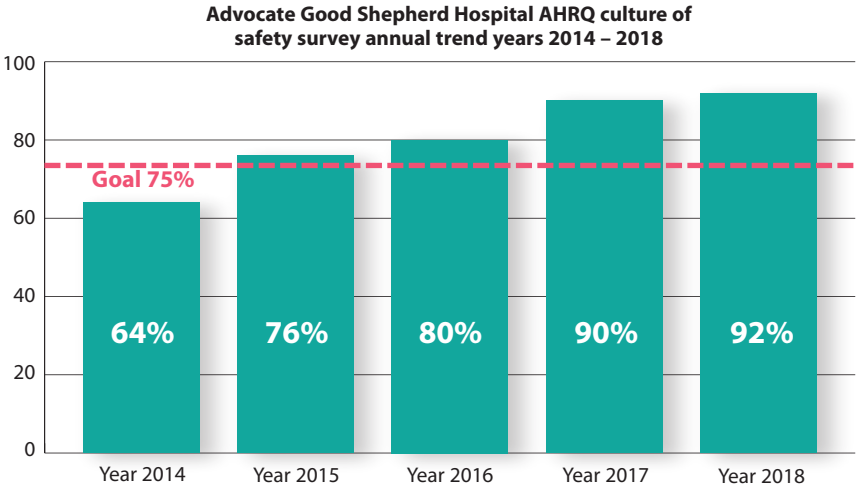
The Advocate Good Shepherd Hospital Safety Summit inspired several initiatives to reinforce a culture of safety, including safety simulations. Eight interprofessional safety coaches took advantage of the hospital's new high-fidelity simulation lab to create safety simulations that allowed participants to:

- be preoccupied with failure
- anticipate what could go wrong
- identify potential safety situations
- practice peer coaching.

Initially, the 144 safety coaches used the safety simulations, but then all the clinical frontline staff used them and they were adopted for implementation at other sites.

Safety outcomes

The Advocate Good Shepherd Hospital's efforts at implementing a safety culture to reduce hospital-acquired conditions and medical errors resulted in improved Agency for Healthcare Research and Quality (AHRQ) Culture of Safety Survey scores.



disciplines to use at their department meetings and also is used to engage associates across the hospital during monthly safety rounds. Another group created "Safety starts at the door," which teaches that before we enter or exit a door, we must ask ourselves, "Am I complete? I am always safe no matter what doorway I pass through." Another safety coach created a great tag line—To prevail we pre-fail—that's posted in key areas in all departments. It reinforces the preoccupation with failure concept to always think of what could go wrong. One of the most exciting projects generated by our safety summit was a series of safety simulations. (See *Simulating safety*.)

To continue the momentum and excitement through the year, we celebrated Patient Safety Awareness Week in March, which included daily safety story contests and games to support safety behaviors and tools into our everyday language. Seven interprofessional safety coaches, representing the house-wide high-reliability team, presented the safety work and outcomes to our organization's chief executive officer during one of his routine site visits.

In November 2018, we held our second safety summit. More than 100 people participated, and based on feedback for the previous year's summit we included more physician engagement and partnership. Physician safety leaders joined us for an interprofessional panel discussion focused on the power gradient and each of our safety roles. The panel shared ways to promote a barrier-less culture of communication to empower all staff to speak up, and physicians participated in visioning activities to develop innovative ideas to combat safety challenges. This latest summit also explored human factors engineering, which focuses on modifying technology and processes to meet humans' needs rather than humans accommodating technology. We explored the principles of emotional intelligence (EI) and discovered that the interplay between EI and safety is powerful. We learned to recognize how our own feelings and biases can directly impact safety outcomes, both positively and negatively.

> Since 2014, we decreased our serious safety events by 60%.

Safety outcomes

Since becoming an HRO in 2014, we decreased our serious safety events by 60%, increased our hospital safety event reporting rate from 3.7 to 6.6, and improved our Agency for Healthcare Research and Quality Culture of Safety Survey scores from 64% to 92%. (See *Safety outcomes*.)

A new synergy

Widening our safety partnerships throughout the hospital created a synergy we hadn't experienced before. Together we learned that we all have the same desires to provide safe, high-quality care to our patients. By sharing our values and beliefs, our safety behaviors changed. Once that happened, we started to see the outcomes we had hoped to achieve. This is the essence of culture change, and we know that we have created a culture of safety. The journey to zero drives us; interprofessional collaboration will get us there.

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