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Research Brief

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1301 Pennsylvania Avenue, NW, Suite 950
Washington, DC 20004

202 585 0100 tel / 202 585 0101 fax
www.naph.org

Larry S. Gage / PRESIDENT
Bruce Siegel, MD, MPH / CHIEF EXECUTIVE OFFICER

The Patient Safety Initiative at America's Public Hospitals: The Year One Overview

Reflecting on the tenth anniversary of the Institute of Medicine's groundbreaking report, *To Err is Human: Building a Safer Health System*, researchers acknowledge that the hospital industry has made progress toward improving patient safety, yet emphasize that much remains to be done.[1] Some key milestones from the last decade include The Joint Commission's "National Patient Safety Goals" published in 2002, the creation of the National Quality Forum's "Safe Practices" in 2003, and Medicare's "no pay for errors" initiative in 2008. While these efforts illustrate the industry's sharpening focus on patient safety, their impact on improved outcomes has been difficult to establish.[2]

With this in mind, a key priority in the NAPH strategic plan for 2010-2013 is to support the work of safety net hospitals and health systems in providing high quality and safe health care. Collaboration with national quality and safety organizations enables NAPH to bring leading education and training initiatives to NAPH members. Through a generous grant from the Kaiser Permanente Community Benefit Fund, NAPH partnered with the National Patient Safety Foundation (NPSF) to offer *The Patient Safety Initiative at America's Public Hospitals*. This collaboration provides education, resources, and communication strategies that promote safer health care. Launched in October 2009, the *Initiative* is intended to engage all NAPH members over three years, beginning with the participation of 35 organizations in the first year's class. However, the high degree of interest from NAPH members in the initial year of the program prompted Kaiser Permanente to provide additional funding and expand the first year's class to 42 NAPH member hospitals. In October 2010, an additional 24 NAPH members joined the *Initiative*.

This Research Brief summarizes how NAPH members from the first year's class (referred to as "Phase One") used this training to improve patient safety in their organizations, and includes eight examples of projects and activities they implemented as part of the *Initiative*. It also offers detailed information about the program resources and how those resources helped members achieve various patient safety goals.

Program Goals

The *Initiative* goals include establishing public hospitals as national leaders in patient safety and quality care, building a consistent and shared pool of patient safety knowledge and techniques, and developing a community of public hospital leaders committed to patient safety (see Table 1 for the complete set of goals). To this end, the program offers

TABLE 1 | **Goals of *The Patient Safety Initiative at America's Public Hospitals***

Position public hospitals on the leading edge of patient safety and quality.
Establish a consistent and shared pool of patient safety knowledge, tool sets, and techniques.
Develop a community of public hospital clinicians, patient safety and quality leaders, and hospital executives committed to this initiative.
Deliver on the imperative to transition from patient safety awareness to results-driven programs.
Create patient and community programs fostering communication that engages, informs, and builds continued confidence in care within the public hospital system.

SOURCE NPSF-NAPH Patient Safety Initiative at America's Public Hospitals

curricula and shares best practices around patient safety culture and leadership, infrastructure and measurement development, and evidence in improving patient safety and outcomes.

The program also helps participants disseminate success stories to external audiences. Given the varying levels of readiness for patient safety improvement work, the *Initiative* allows participating NAPH members to tailor the program by selecting the tools and resources that will help them achieve their specific goals (see Table 2 for more information on program components).

Program Impact

Patient safety researchers note that measuring the impact of a broad-based patient safety initiative on safety outcomes can be difficult.[4] At the end of the *Initiative's* first year, NAPH and NPSF identified the new safety practices developed by program

PATIENT SAFETY FRIDAYS—STONY BROOK UNIVERSITY MEDICAL CENTER

In 2010, Stony Brook University Medical Center (SBUMC) in Stony Brook, New York, a Phase One *Initiative* participant, instituted a new program called "Patient Safety Fridays." Based on a process established by New York-Presbyterian Hospital, SBUMC's leadership team (including department heads, executives, and senior executive leaders) meets every Friday to examine safety and regulatory issues and make improvements. The team devotes Friday morning to a combination of educational activities (usually covering one or two topics per week), surveys of hospital units, debriefings on audit findings, and issue resolution. On Friday afternoons, leadership conducts unit-based education and safety and quality meetings. By standardizing these activities, SBUMC hopes to improve safety culture, comply with state and federal regulations, prepare for regulatory surveys, provide consistent education to all staff about policies and procedures, and better engage front-line staff. SBUMC held its first Patient Safety Friday during the last day of *Patient Safety Awareness Week* in March 2010.

TABLE 2 ***Initiative*** **Elements**

Enrollment in the NPSF Stand Up for Patient Safety ("Stand Up") program
The Stand Up program provides hospitals with a continuing curriculum supplemented by tools, resources, and complimentary subscriptions to publications and journals. Some of the topics covered over the past year included leadership engagement, organization-wide communication, fostering a safe and just culture, and adverse event reporting.
Scholarships to the AHA-NPSF Patient Safety Leadership Fellowship
The *Initiative* provides funding for participants in each phase to apply for scholarships to the Patient Safety Leadership Fellowship (PSLF), a cooperative fellowship program between the American Hospital Association and NPSF. The PSLF is designed to shape future leaders by providing education from current industry leaders and guidance on integrating innovative strategies into participating organizations. As these members participate in the Fellowship throughout the next year, they will complete action learning projects to address a specific improvement area, introduce new processes or training, or expand existing change initiatives within their organizations.
Patient Safety Awareness Week (PSAW)
PSAW is an educational and awareness-building campaign sponsored by the National Patient Safety Foundation, held annually in March. Phase One organizations received a complimentary PSAW Toolkit to assist in the 2010 celebration, which included themed materials, customizable templates, patient engagement tools, and best practice documents to support the development of successful provider and patient partnerships.
NPSF Annual Patient Safety Congress
The NPSF Patient Safety Congress is a key patient safety conference held each year. Funding for the *Initiative* allows each participating organization to receive one complimentary registration and discounted registration for additional staff.
Patient Safety Measurement Tools
The federal Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture (HSOPS) is a nationally recognized and reliable tool for measuring hospital progress in adopting a culture of patient safety that is founded on mutual trust, shared perceptions of the importance of safety, and confidence in the efficacy of preventative measures.[3] Through the HSOPS Comparative Database, *Initiative* participants have access to multi-year comparative reports detailing characteristics such as communication, event reporting, and medical errors from over 800 U.S. hospitals.

SOURCE NPSF-NAPH Patient Safety Initiative at America's Public Hospitals

PATIENT SAFETY AWARENESS WEEK—NEW YORK CITY HEALTH AND HOSPITALS CORPORATION (NYCHHC)

During the 2010 Patient Safety Awareness Week (PSAW), the NYCHHC system conducted massive outreach on patient safety issues both to its staff and the public. NYCHHC also recognized patient safety champions throughout the 11 acute-care hospitals, four long-term care facilities, six diagnostic treatment centers, and the certified home health agency that comprise the system. Moreover, NYCHHC held a Patient Safety Leadership Forum, which included both a keynote address from the Vice President for Safety Management at Kaiser Permanente and a formal recognition of both staff and units for specific performance improvement efforts.

In addition to the NYCHHC-wide activities, each hospital within the NYCHHC system also held its own PSAW events. For example, Lincoln Medical and Mental Health Center staged a health fair to educate patients and staff on infection prevention and surgical and medication safety. Lincoln also developed a video to educate providers and patients about surgical safety checklists and procedures.[5] Additionally, Lincoln staff participated in the "Patient Safety Knowledge Bowl," which tested their knowledge of patient safety principles. At the closing of PSAW, Lincoln held a ceremony recognizing patient safety champions and master trainers involved in the implementation of the TeamSTEPPS program, a free online resource provided through the NPSF/NAPH *Initiative* and created by AHRQ and the U.S. Department of Defense.[6]

Another NYCHHC hospital, Metropolitan Hospital Center, honored one of its nursing units on the first day of PSAW with an award for excellence in hand hygiene. Later in the week, hospital leadership held a trivia game for staff with questions pertaining to patient safety and the National Patient Safety Goals. Metropolitan also held an educational forum in its hospital lobby at which community members received information from the hospital's departments of infection control, pharmacy/medication safety, behavioral health, pediatrics, and police. One of the most "hands on" activities at the forum involved asking community members to complete a questionnaire on hand hygiene practices and then to demonstrate how they washed their hands; hospital staff coached participants, providing them with useful tips for improvement.

INTEGRATING PATIENT SAFETY AND GRADUATE MEDICAL EDUCATION—LINCOLN MEDICAL AND MENTAL HEALTH CENTER

Another NAPH member and Phase One *Initiative* participant, Lincoln Medical and Mental Health Center (of the New York City Health and Hospitals Corporation), secured a scholarship for the 2010-2011 AHA-NPSF Patient Safety Leadership Fellowship. This year's Fellow will develop curricula and integrate the concepts of patient safety, performance improvement, teamwork, and communication into Lincoln's annual teaching programs for its 220 residents. He will also create intern and resident teams to lead patient safety projects on priority topics identified in a preliminary needs assessment. By increasing resident and intern knowledge about patient safety and by involving them in patient safety projects and targeted interventions, Lincoln hopes to advance the overall culture of safety, improve patient care and outcomes, and support intern and resident professional development.

participants and are currently tracking their implementation. In addition, NPSF is assessing program participants' results on the federal Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture. Although still in its early stages, evidence suggests that the *Initiative* is bringing about positive changes, as outlined below.

FOCUS AREA ONE: PATIENT SAFETY CULTURE AND LEADERSHIP

The *Initiative* is designed to assist hospitals in integrating a patient safety focus into the organizational culture. Through multi-stakeholder engagement, education, and leadership development, the *Initiative* seeks to equip participating organizations in building and sustaining successful patient safety programs. As a result, three NAPH members established organization-wide patient safety educational initiatives to disseminate key information and accountability throughout their facilities. Stony Brook University Medical Center, for instance, implemented "Patient Safety Fridays" as a way to institutionalize their patient safety activities; Lincoln Medical and Mental Health Center is developing a patient safety program for residents and interns; and Metropolitan Hospital Center is instituting a "Patient Safety Deputy Program" to engage front-line staff in identifying and responding to patient safety issues. These activities, supported by resources and training from the *Initiative*, target hospital staff of all levels, thereby

PATIENT SAFETY DEPUTY PROGRAM—METROPOLITAN HOSPITAL CENTER

To instill patient safety practices throughout its organization, Metropolitan Hospital Center (of the New York City Health and Hospitals Corporation), an NAPH member and Phase One *Initiative* participant, is implementing a Patient Safety Deputy Program as part of its participation in the AHA-NPSF Patient Safety Leadership Fellowship. Metropolitan's program will transfer enforcement and accountability for patient safety from the management level to front-line staff. These clerks, housekeeping staff, medical assistants, and others will rotate every three months into a patient safety leadership position for their unit. These individuals will also receive education on patient safety practices, evaluate their own work environments for potential hazards, and make needed improvements. Rather than the traditional top-down approach to influencing corporate culture, this program allows staff at every level to lead the way to a safer organization.

PATIENT SAFETY AWARENESS WEEK—CAMBRIDGE HEALTH ALLIANCE

During Patient Safety Awareness Week, Cambridge Health Alliance (CHA) in Cambridge, Massachusetts, a Phase One *Initiative* participant, used the buttons and posters included in their program materials to help facilitate communication among staff about adverse event reporting. As part of this effort, CHA provided every inpatient unit with a 2009 year-end summary of the top adverse events reported in their unit. All inpatient unit managers wore "Let's Talk" buttons and displayed posters throughout their units, along with their adverse event report summary from 2009. The three CHA campuses now each conduct daily "huddles," giving the management staff a forum in which to discuss important events, daily census/patient flow issues, and patient safety concerns.

demonstrating commitment to an organization-wide patient safety culture.

FOCUS AREA TWO: INFRASTRUCTURE AND MEASUREMENT DEVELOPMENT

A robust and sustainable patient safety program requires the adoption of best practices, active participation in continuing education and training, reward and recognition programs, and a willingness to conduct regular evaluation and measurement activities. For example, throughout the year, LSU-University Medical Center implemented elements of the *Initiative* that helped them improve communication between departments, providers, caregivers, and patients. Memorial Healthcare System developed a medication management system to measure and prevent errors in patient medication, while Harborview Medical Center implemented a falls prevention and reduction program.

NAPH members also shared their best practices with other Phase One participants in audio-web conference calls and at the NPSF Annual Congress in May 2010. Fully 76 percent of the Phase One organizations attended the Annual Congress, and six members presented during breakout and poster sessions. Two NAPH members noted that they adopted several strategies from Memorial's medication management program, and a third NAPH member reported receiving helpful information on how to implement a patient safety champions program.

FOCUS AREA THREE: EVIDENCE IN IMPROVING PATIENT SAFETY AND OUTCOMES

An essential part of the *Initiative* is to help NAPH member facilities achieve the cultural and systemic changes needed to improve patient safety. A key program element related to this focus area is the use of measurement tools that allow hospitals to evaluate their progress in becoming safer and to benchmark themselves against other organizations. AHRQ's Hospital Survey on Patient Safety Culture (HSOPS), the major measurement and benchmarking tool facilitated through the *Initiative*, is a reliable instrument for measuring progress in culture shifts throughout the various layers of organizations. HSOPS measures hospitals on such dimensions as frequency of event reporting, teamwork within and across units, and handoffs/transfers.

Phase One participants who had administered the HSOPS survey prior to joining the *Initiative* previously submitted their survey results to the AHRQ comparative database, while the majority of the remaining participants did so by May 2010. Thus far, 62 percent of Phase One organizations administered the survey and submitted their findings to the AHRQ database.

In September 2010, participants received their "Individual Hospital Feedback Report," which included their survey results by work area/unit and staff position, as well as a comparison of their overall results with other hospitals. Participants have access to multi-year comparative reports detailing characteristics from over 800 U.S. hospitals through the database.

NAPH members in Phase One began to address issues identified by survey results even before receiving their detailed report from AHRQ. For example, one member chose to perform a "failure mode, effects, and criticality analysis" on handoff communication based upon data from its culture of safety survey.[8] Another member developed educational activities and policy changes in response to its scores. During the second year of the *Initiative*, NPSF will continue to work with participants to advance specific improvements to their safety culture.

NPSF and NAPH also queried Phase One participants near the

INTEGRATING PATIENT SAFETY EDUCATION—LSU HEALTH CARE SERVICES DIVISION, UNIVERSITY MEDICAL CENTER

At the start of the *Initiative*, the University Medical Center (UMC) in Lafayette, Louisiana, appointed a project leader to drive the implementation of the program. The project leader established a Patient Safety Initiative Team, consisting of a representative from each hospital department, including non-clinical departments like housekeeping and maintenance. The team members—each designated the "patient safety expert" for their department—take part in *Initiative* activities, are instrumental in implementing UMC patient safety projects, and participate in root cause analyses that affect their department or work area. Members of the team then use information learned through the *Initiative* to educate staff members in their respective departments. Each department adds an agenda item to its monthly meetings specifically reserved for *Initiative* topics. UMC's project leader noted that immersion into the *Initiative* has increased communication between departments and has given staff members the opportunity to become active leaders in the hospital's goal to provide safer care.

FALLS PREVENTION—HARBORVIEW MEDICAL CENTER

Harborview Medical Center in Seattle, Washington, a Phase One *Initiative* participant, received a scholarship from the *Initiative* to cover tuition for the 2010-2011 AHA-NPSF Patient Safety Leadership Fellowship. As part of its work with the Fellowship, Harborview is building a multidisciplinary approach to falls prevention that involves all members of the health care team, as well as patients and families. Using elements from the TeamSTEPPS program, a free online resource provided through the NPSF/NAPH Initiative and created by the AHRQ and the U.S. Department of Defense,[7] Harborview's goal is to decrease its 2010 overall fall rate by 20 percent, its repeat falls by 50 percent, and the frequency of falls leading to moderate to severe injury to less than one per month by the end of 2011.

NOVEL APPROACHES TO IMPROVING MEDICATION MANAGEMENT—MEMORIAL HEALTHCARE SYSTEM

During a breakout session at the 2010 NPSF Annual Patient Safety Congress, Memorial Healthcare System in Hollywood, Florida, presented their efforts in improving medication management. Key staff from the Memorial nursing and pharmacy units worked together to develop and test a patient-friendly daily medication schedule that allows patients to be included as partners in their hospital care. Memorial found that this tool helped patients better understand their medication and empowered them to spot potential critical errors.

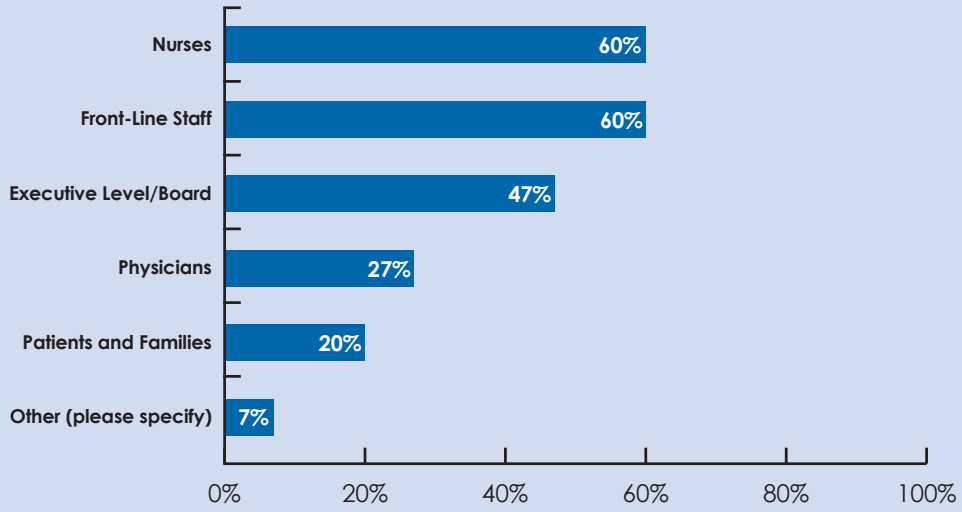
end of the *Initiative's* first year to ascertain lessons learned thus far. More than half of participants noted that the program increased patient safety awareness and practice among nurses and front-line staff; 47 percent indicated that participation increased awareness of patient safety issues within their executive suites (see Figure 1).

Conclusion

Diffusing patient safety practices throughout large and complex organizations can be challenging. Several members acknowledged that having a designated patient safety "driver" to implement *Initiative* components is fundamental to propelling change. Members reported that their greatest successes came from their ability both to identify areas of need and to specifically address those particular patient safety issues.

Despite the challenges inherent in improving patient safety, those NAPH members that participated in Phase One of the NPSF-NAPH *Patient Safety Initiative at America's Public Hospitals* adopted tools and strategies that are helping them create meaningful change in their organizations. The member stories included here illustrate how these hospitals used program resources in innovative ways to spread awareness and techniques to improve patient safety, instill and standardize safe practices, and improve outcomes. As the *Initiative* progresses, NPSF and NAPH will continue to aid members in implementing results-driven programs and achieving specific patient safety goals. For more information on the *Initiative* and to view additional member patient safety innovations, please visit the NAPH website at: www.naph.org and the National Patient Safety Foundation website at www.npsf.org. ■

FIGURE 1 **Percentage of Participants Indicating the Initiative Increased Patient Safety Awareness and Practice Among Key Groups**



SOURCE NPSF-NAPH Program Evaluation of Phase One Participants

Notes

1. Wachter, Robert, "Patient Safety at Ten: Unmistakable Progress, Troubling Gaps," *Health Affairs* 29:1 (2010): 165-173, accessed October 12, 2010, doi: 10.1377/hithaff.2009.0785.

2. Ibid.

3. The Agency for Healthcare Research and Quality, "Surveys on Patient Safety Culture," www.ahrq.gov/qual/patientsafetyculture/hospdim.htm (Last accessed October 15, 2010).

4. Greenberg, Michael et al., "Safety Outcomes in the United States: Trends and Challenges in Measurement," *Health Services Research* 44:2 (2009): 739-755, accessed October 12, 2010, doi: 10.1111/j.1475-6773.2008.00926.x

5. See "Surgical Safety Checklist" at: www.youtube.com/watch?v=LHbxF3P-DwY

6. The Agency for Healthcare Research and Quality, "TeamSTEPPS: National Implementation," http://teamstepps.ahrq.gov/abouttoolsmaterials.htm (Last accessed September 3, 2010).

7. Ibid.

8. Failure mode, effects, and criticality analysis is a step-by-step approach for identifying all possible failures in a process, product, or service.