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Zero Harm:
First-Focus Fundamentals for Safety Culture Transformation

Introduction

As we reflect on the millions of engagement surveys completed each year, one message consistently rises to the top – individuals who choose to work in healthcare are committed to providing safe, quality care. Virtually every year, items dealing with patient-centric care and enjoying the work score highest in the Press Ganey database, and messages involving safety and quality of care show up as key engagement drivers across the nation. Not only is patient safety the foundation of the patient experience, it also is important to the culture of the healthcare organization and the engagement of the caregivers themselves. Simply put, safety is a good producer of engagement, engagement is a good producer of safety, and both are needed to consistently deliver the optimal patient experience.

When an organization commits to Zero Harm, several first-focus fundamentals that should be considered as the starting point in establishing the tone and setting the stage for safety culture transformation:

1. **Adopt a Zero Harm Goal & Message on Safety**
2. **Measure Harm & Make Harm Visible**
3. **Foster a Fair & Just Culture**
4. **Practice Daily Check-Ins for Safety**

This workbook includes brief descriptions of each fundamental as well as questions to help organizational leaders consider current practices relative to each fundamental.

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Adopt a Zero Harm Goal & Message on Safety

When errors and mistakes result in harm in healthcare, we fail in our mission, and we fail those we serve. Harm turns *health* to *hurt*. Our patients take it for granted that we will heal without harm. We cannot take it for granted. The only acceptable goal is **Zero Events of Harm**. We need to deliver healing without harm *reliably* – each time, every time.

A goal of Zero Harm sounds like an aspiration that should exist in healthcare naturally. Yet treating Zero Harm as an assumed, or *unstated*, goal does not create the power or focus needed to achieve a highly reliable culture of safety. Hundreds of thousands of avoidable safety events resulting in harm or death occur each year in our healthcare systems. Harmful events are the result of human errors and mistakes that are shaped by and combine with weaknesses in organizational systems, processes, protocol, technology, and environment. To reduce events of harm, we must move beyond a passive assumption of safety to an active statement and sustained adoption of the pursuit of Zero Harm, starting at the highest levels of leadership and echoed through the entire organization. To this end, leaders must message on safety in word and in deed. What leaders declare about safety is important, yet what leaders do about safety influences the thinking and acting of others in the organization.

Questions to Consider

<u>Adopting a Zero Harm Goal</u>

- Has your organization declared a Zero Harm goal for *patient safety*? Have you declared a Zero Harm goal for *workforce safety*?
- Do leaders at all levels champion the stance that Zero Harm is the only acceptable goal?
- Is safety mentioned in your vision/mission statement?
- Is safety positioned as your core value or listed first among your stated values?

<u>Messaging on Safety</u>

- Do executive leaders personally and passionately believe in and speak to the Zero Harm goal?
- Do all meetings start with a safety message to reinforce the commitment to Zero Harm?
- Do you encourage, support, and recognize individuals who speak up for safety when they see an unsafe condition and/or suggest a safety improvement?
- When decisions or changes are considered and made, do you call the question, *"What impact does this have on safety?"*
- Is the commitment to Zero Harm expressed in organizational job descriptions and performance review criteria?

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Measure Harm & Make Harm Visible

While healthcare holds healing without harm as its core value, the industry has lacked a consistent nationally accepted method by which to measure performance against this promise. Several patient safety event taxonomies exist, yet these category-based classifications do not provide a means of consistently measuring harm resulting from safety events. In addition, harm as a healthcare-induced patient outcome has not been well-defined in healthcare. The lack of a standard definition of patient harm leads organizations to use disparate, subjective determination that requires significant interpretation. To sustain efforts toward achieving Zero Harm, an organization must know the frequency and severity of harm that occurs and be able to measure improvement over time.

Making an accounting of harm transparent to internal and external stakeholders reinforces your commitment to Zero Harm and informs your teams and communities that your commitment to safety is absolute. An important element of making harm visible is to consider how to make the numbers accessible, understandable, and relatable in terms of human impact. It is important not only to share percentages, rates, and incidents, but to put a face on the suffering in terms of lives, families, and loved ones.

Questions to Consider

<u>Measuring Harm</u>

- Does your organization have a consistent, repeatable method for assessing and measuring patient harm (such as the HPI SEC & SSER Measurement System for Healthcare)?
- Do you value and encourage reporting and learning from all types of events, regardless of degree of harm?
- Do you have a consistent group of individuals who review events and provide expertise, consistency, and integrity in event classification?
- Do you have a mechanism for reporting and reviewing patient harm measures at executive leadership meetings, operational leadership meetings, and board meetings?
- Do you assess and continuously work to strengthen the health of incident reporting to ensure that you are learning about all events?

Make Harm Visible

- While encouraging reporting of events, do you also have a means of communicating “days since last Serious Safety Event” to employees?
- Are stories of patient harm shared with employees in a manner that allows lessons learned to be discussed and applied across departments?
- When reporting patient harm events, do you have a means of personalizing the counts so that harm is seen not just in numbers but as the lives represented by the number?

Foster a Fair & Just Culture

As defined by James Reason in *Managing the Risks of Organizational Accidents* (1997), “Just Culture creates an atmosphere of trust in which people are encouraged to provide, and even rewarded for providing, essential safety-related information but in which they are clear about where the line must be drawn between acceptable and unacceptable behavior.” Just culture emerges when:

- Leaders encourage and recognize individuals who speak up for safety and who report safety events, errors, and mistakes, regardless of consequence.
- Leaders espouse a proactive, forward-looking method for reinforcing and building accountability for compliance with performance expectations.
- Leaders have a predictable method for assessing the causes of performance violations and responding in a manner where there is no punishment for unintended error or mistakes driven by system problems yet fair consequence for intended decisions to act against the rule.

In contrast, when caregivers experience a negative reaction when speaking up or inconsistency when leaders respond to performance violations, they are less likely to perceive that safety is important to the organization, less likely to view leaders as interested in solving issues impacting safety, and less likely to report safety events or share safety information – conditions all adverse to safety.

Questions to Consider

- Does your organization assess the perceptions of associates regarding comfort level in reporting events and non-punitive response to errors and mistakes?
- Are individuals encouraged and recognized when they raise concerns about safety?
- Do you work to minimize the perceived power distance across professional and authority gradients within your organization? Do you have zero tolerance for unprofessional and bullying behaviors?
- Do your organization’s leaders know and apply the Skill-Rule-Knowledge (SRK) human error classification system of Jens Rasmussen when assessing performance violations?

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Practice Daily Check-Ins for Safety

In the nuclear power industry, knowing the status of plant operations and early identification of potential problems is safety critical. At nuclear generating stations across the country, each day begins with a Plan of the Day meeting of plant leaders. A typical agenda includes a review of emergent safety issues, status of the plant Top 10 problem list, routine reports, and priorities for the day. The meeting is a leadership method for providing awareness of front line operations, identifying problems, assigning ownership for issue resolution, and ensuring common understanding of focus and priorities for the day.

The Plan of the Day equivalent in healthcare is the Daily Check-In (DCI) for safety. DCI is a deliberate, focused report and conversation among leaders about safety events and safety risks. In this real-time risk assessment, the leaders in charge must concern themselves with the details. If they do not consider them important, neither will their subordinates. And, leaders in the field must face the facts and make the necessary changes to prevent harm to patients, families, and workers.

Commonly, DCI is a 15-minute meeting of the senior leader with all department leaders of the organization, and a three-point agenda is used:

1. LOOK BACK – Significant safety or quality issues from the last 24 hours
2. LOOK AHEAD – Anticipated safety or quality issues in next 24 hours
3. FOLLOW-UP – Status reports on issues identified today or days before

Healthcare organizations across the country employ DCI as a high-reliability leadership method that drives shared situational awareness, heightened risk awareness, early identification and resolution of problems, and accountability for safety. DCI is a high-leverage leadership practice that requires little time and, when practiced well, has high impact on influencing organizational performance. In fact, DCI doesn't take time, it saves time for leaders.

Questions to Consider

- As the CEO, are you aware of the safety threats facing your organization today?
- Do you have an all-inclusive forum for department leaders to share situational awareness of safety issues that have occurred and perceived safety risks that need to be addressed?
- Do you have a method for tracking safety issues and ensuring ownership and resolution of safety issues?
- Share safety success stories (good catches, courageous reporting/action, etc.).

Final Thoughts

As you evaluate your current organizational goals for safety, engagement, and the patient experience, reflect on the first-focus fundamentals outlined here and take an inventory of what you're doing well and where you might improve. While these fundamentals are foundation steps for driving a culture of safety, implementing effective change requires commitment from leadership to champion and model their personal expectations for execution.

Often, organizations benefit from not only having insight into the basic concepts, but from working directly with experienced teams who can help guide them in the right paths. For additional guidance, and deeper interventions, Press Ganey can partner with you to identify options that fit your needs.