Improving The Patient Experience by Adopting a Culture of Safety

January 30, 2024

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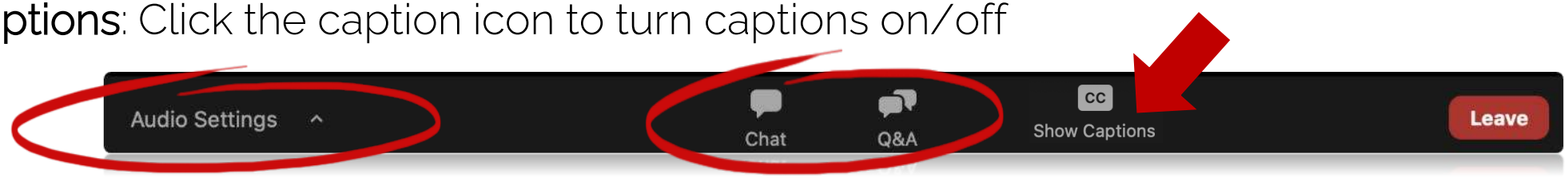

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Our Speakers

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President
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System Director,
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CommonSpirit

Improving The Patient Experience By Adopting A Culture of Safety

Our Speakers

Chris Dube

President, Sentact

15+ years in healthcare

Beth Miller

System Director of Patient Safety Performance Improvement,

CommonSpirit Health

Reflection

"Tell me and I forget.
Teach me and I remember.
Involve me and I Learn."

- Benjamin Franklin

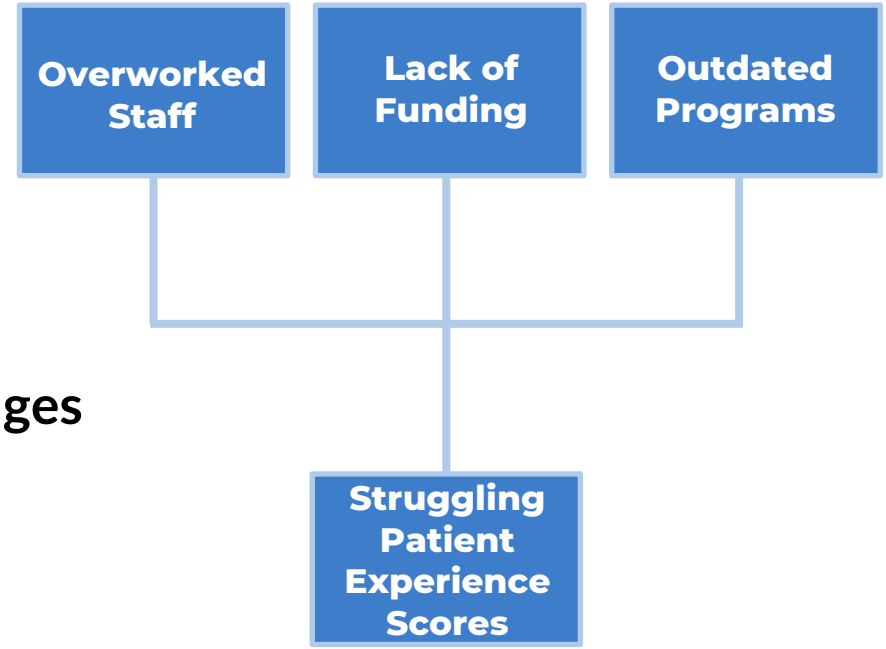
Culture of Safety & How it Impacts PX

- **What is a Culture of Safety?**
  - How does it look in different facilities?
  - Nurturing it within hospitals

- **Correlation between a Culture of Safety & Patient Experience**
  - A symbiotic relationship
  - Observed within hospitals

Challenges Maintaining a Culture of Safety

- **Identifying the Challenges**
  - Staffing shortages
  - Limited Resources
  - Insufficient Technology
- **Outcomes Resulting From Challenges**
  - Higher frequency of PSEs & HAIs
  - Low PX Scores



Solutions to Mitigate Challenges

- **Improving Staff Communication**
  - Establishing Lines of Communication Across Departments
- **Introducing Leadership Models**
  - Demonstrating commitment to safety
- **Implementing Reporting Systems/Technology**
  - Leveraging technology to increase reporting efficiency

Safety Culture & High Reliability

High-reliability organizations (HROs) are organizations that apply mindfulness, failure anticipation, and containment (using the five principles) to improve outcomes

HROs achieve better-than-expected outcomes despite challenges within complex systems

Establish a safety culture – achieved using high-reliability methods and expectations – resulting in fewer events of preventable harm

High-Reliability Organizations (HROs)

Principle of HRO's

"Operate under very trying conditions all the time and yet manage to have fewer than their fair share of accidents."

Karl E. Weick &
Kathleen M. Sutcliffe

High-Reliability Organizations

- Stay alert for the possibility of the unexpected
- Pay attention to what's happening on the front line
- Take deliberate steps to question assumptions
- Develop capabilities steps to question assumptions
- Develop capabilities to detect, contain, and bounce back from errors
- Push decision-making authority to the person or people with the most expertise, regardless of rank

High-Reliability Organizations (HROs)

- High Reliability connection to Leadership and Employee behavior = link to Culture of Safety
- Leadership Methods are a series of skills taught to leaders to help support decision-making, communication, and interactions with staff that emphasize safety.
- One of our favorite leadership methods is Rounding to Influence (RTI)

Leapfrog

Culture of Safety Leadership – Structures and Systems 1.4a

Leapfrog Requirement 1.4a

1.4 Within the last 12 months, structures and systems for ensuring that senior administrative leadership is taking direct action have been in place, as evidenced by:

a. CEO and senior administrative leadership are personally engaged in reinforcing patient safety improvements, e.g., "walk-arounds", and reporting to the board (governance). Calendars reflect the allocated time

To Say "Yes" Requires The Following:

- ☐ CEO and leader schedules showing "walk-arounds" or other ways of reinforcing patient safety improvements in various departments in real-time, and board meeting minutes reflect the results of the implementation of patient safety performance improvement reinforcement.

  - ☐ Example: Tracking the number of walk-arounds performed per unit or clinical area for designated time periods as shown in the calendars of the CEO and senior administrative leadership.

Rounding to Influence

- Maintain focus on employee-empowered improvement
- Builds team strengths and competencies
- Gather Feedback on operational issues
- Operationalize improvement and sustainment in practice
- Establish a personal connection to the reason we do work

Patient Safety

Patient Experience

Leader Experience

Effective Connections With Staff & Providers

Why The 4C Method Rounding On Staff and Providers

One Voice, One Message
- An intentional tool for leaders
- Assist leaders when dealing with an unfamiliar or difficult subject
- Keep conversation focused and on track

Culture Shaping – Quality, Experience, and Safety
- Connect staff and providers to purpose
- Provides facts and stories
- Promotes an environment of consistency and agility

Outcome Driven
- Promotes a culture of shared ownership and accountability
- Reduced “never events”
- Improves communication and handoff
- Empower staff to share safety concerns ideas earlier

Rounding to Influence – It's Really A Conversation…

Greeting – *Hello! Do you have a few minutes for a brief conversation about…*

Rounding to Influence 4C Method

Rounding to Influence Component	Script
Core Value	I'm rounding today to talk about our High Reliability Behavior Expectation to _____
Can You…	**Can you** tell me about how and when you use _____
Concerns	Are there any **problems or barriers** you or your coworkers are having using _____? Or… have there been any near misses or safety events where this tool would have been helpful?
Commitment	Can I **count on you** to use _____? Will you cross-check and coach others in using _____?

Optimizing RTI with Technology

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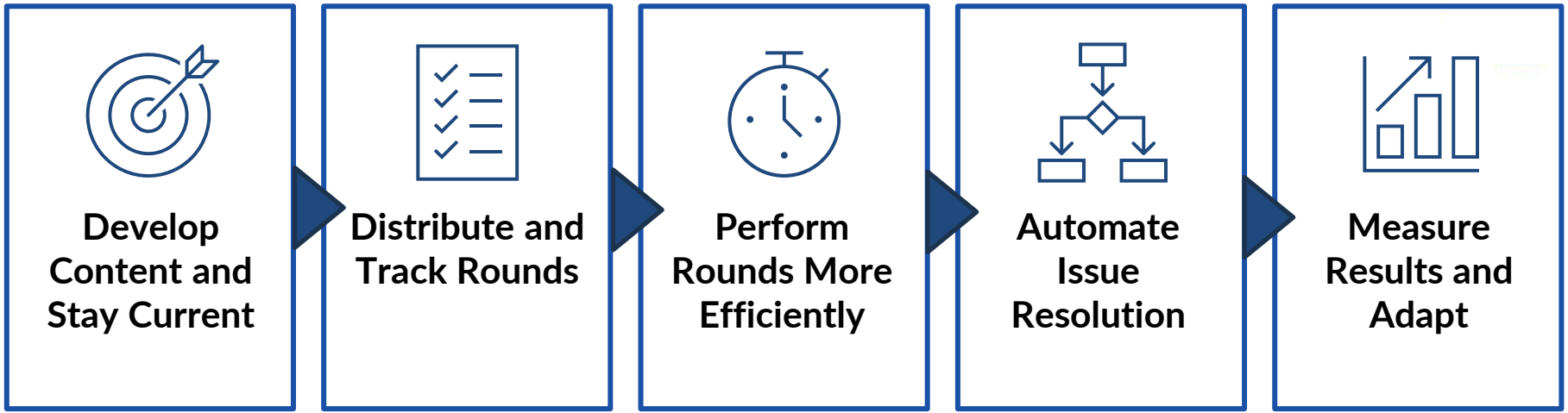

Key Takeaway

- Requires practice to keep the process conversational
- “We measure what we treasure”
- Rounding to Influence is effective in clinical and nonclinical areas
- Quality, Safety, and Patient Experience practices continue to enhance and support one another

Q&A

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February 14 | Lost Belongings Workgroup

PROGRAMS

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Photographer & Founder, POSITIVE EXPOSURE

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Breast Cancer Survivor, Emmy-Winning TV Host

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