# *Strategies for* LEADERSHIP

## *Hospital Executives and Their Role in Patient Safety*

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Dear Colleague:

In 1995, two tragic medication errors – one resulting in a patient's death and another triggering a significant medical intervention – changed the Dana-Farber Cancer Institute in Boston forever. Not only was the attention of the public and the media riveted on the events, so were the eyes of the entire health care field. What happened? How? Why? What can be done to be certain it doesn't happen again? As chief operations officer at Dana-Farber, I was one of many asking these questions. Our search for the answers was a journey of change for our leadership and staff.

Later on, we received many invitations to speak about our experience and what we had learned. Our presentations focused on leadership; designing safe medication systems; interdisciplinary practice; and making patients and families true partners in care design and delivery. And we heard the same questions over and over from our colleagues across America:

- Why aren't executives more visible in patient safety?
- In the absence of a tragic, high-profile error, how do you create the catalyst for change?
- What does effective executive leadership that promotes the importance of patient safety look like? What strategies promote dramatic success?

It is clear from our work and the work of others that executives must be visible and active in leading patient safety improvements. We have seen how, through effective leadership, more and more organizations are able to make significant safety improvements without waiting until a highly public sentinel event forced their hand. At the same time, there are many organizations and leaders struggling to create awareness and make dramatic change.

*Hospital Executives and Their Role in Patient Safety* is our effort to pull together leadership strategies that grew from our own experiences, those that we have learned from others, and share them with our colleagues across America. Strategies that we have learned from others come from many sources:

- Responses from quality improvement and patient safety listservs.
- Literature on patient safety leadership.
- Patient safety experts.

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- Leaders associated with the Massachusetts Coalition for the Prevention of Medical Errors and Massachusetts Hospital Association.
- National Patient Safety Foundation stakeholders' meeting on leadership.

These leadership strategies have been combined into a self-assessment tool that can be used by all executives within your organization. It is not intended to seek a "pass/fail" grade, but rather to give individuals and groups of leaders a range of choices to consider, periodically revisit, and use to trigger action. To be sure, having a number of checks in the "yes" column of the self-assessment is far more significant than having none. But identifying a plan to move some checks from "no" to "yes" could be equally significant. Completing the self-assessment with others could actually be powerful, not only for setting priorities, but also for reinforcing the rewards of honest appraisal.

While I wish this tool could be extensively annotated, externally validated, and backed by a 100 percent guarantee that it will drive massive improvement, that is not the case. However, I do believe the tool reflects much of the best learning to date.

It is a privilege to share this tool with you. Many thanks to the Massachusetts Coalition for the Prevention of Medical Errors, Massachusetts Hospital Association and AHA for their efforts in getting this tool to you. Your questions and observations, as well as recommended enhancements, would be most welcome in the spirit of continuous improvement. They can be submitted to james_conway@dfci.harvard.edu.

By sharing everything we learn and experience in patient safety, all of us in the field can make this important journey together and make a real difference for patients, families, and the dedicated professionals who care for them.

Jim Conway

| *complete?* Y | N | |
|---|---|---|
| | | Read *To Err Is Human: Building a Safer Health System* Kohn LT, ed, Corrigan JM, ed, Donaldson MS, ed. Washington, DC: National Academy Press; 1999. |
| | | Read other primers on patient safety: |
| | | ○ *Human Error,* Reason, JT, Cambridge University Press, 1990. |
| | | ○ *The Psychology of Everyday Things*, Norman, D, Basic Books, 1988. |
| | | ○ *Managing the Risks of Organizational Accidents*, Reason, JT, Ashgate Pub. Co., 1997. |
| | | ○ *Normal Accidents: Living with High Risk Technology*, Perrow, C, Basic Books, 1984. |
| | | ○ Lucian Leape's seminal articles.[1] |
| | | ○ *Human Factors in Aviation*, Wiener, EL, Nagel, DC (eds), Academic Pr, (1989). |
| | | Participate in external safety education programs, CME, conferences, etc. |
| | | Hold detailed conversations with in-house experts on our realities of practice. |
| | | Walk my hospital with a human factors expert. |
| | | Walk my hospital as a patient. |
| | | Familiarize myself with enhanced JCAHO Patient Safety Standards.[2] |
| | | View Bridge Medical video “Beyond Blame”[3] and Partnership for Patient Safety video “First Do No Harm.”[4] |

| *complete?* Y | N | |
|---|---|---|
| | | Speak publicly to various audiences on the unacceptability of the current state of and my commitment to patient safety as a personal and corporate priority. Include safety focus in hospital publications, strategic plans, etc. |
| | | ○ Board and hospital leaders |
| | | ○ Medical and hospital staff |
| | | ○ Patients/consumers |
| | | ○ Media |
| | | Implement a proactive effort on patient safety design, measurement, assessment, and improvement. Include direct care, administrative and clerical staff, and patients and family members in all aspects. |
| | | Set the goal of establishing an environment of trust with a non-blaming, responsibility-based approach to the causation of incidents and errors; establish policy in this area. |
| | | Set the expectation for timely and interdisciplinary error and near-miss investigations with an emphasis on: patient/family impacted by the error; the broader institutional implications of and learning from the error; and the support of staff at the sharp end [closest to care]. |
| | | Build quality improvement and patient safety policies into staff orientation and continuing education offerings. |
| | | Set the expectation for executive involvement in significant incident investigations. |
| | | Establish a policy to ensure patients/families are notified ASAP when an error reaches a patient. |
| | | Establish effective grievance systems for patients/families who see themselves as "victims of error." |
| | | Establish mechanisms to train leadership and other experts in patient safety. |

| *complete?* Y | N | |
|---|---|---|
| | | Openly engage with medical staff, nursing, and other leaders in patient safety planning. |
| | | Continuously articulate the business case for safety improvement. |
| | | Personally participate in a significant incident investigation/root cause analysis. |
| | | Tell "my story" around incidents/errors that I have been involved with and the systems improvements that could have prevented them. |
| | | Routinely involve myself, all levels of our staff, and our patients and family members in direct and ongoing communications around the patient safety work of our institution and areas for improvement. |
| | | Routinely bring patient safety matters, trending data, and specific cases to the board and other hospital leadership committees. |
| | | Routinely probe staff perceptions of risk areas from existing or proposed systems and take immediate actions wherever possible. |
| | | Openly support staff involved in incidents and their root-cause analysis. |
| | | Ensure that there is ongoing prioritization and achievement of safety improvement objectives. |
| | | Ensure that articles on patient safety matters regularly appear in my organization's communications vehicles. |
| | | As part of annual budget preparation, ensure resources are funded for priority safety areas. |

| *complete?* | | |
|---|---|---|
| Y | N | |
| | | Request and routinely receive reports on facility utilization of and comparison with best-practice information from the AHA[5], NPSF[6] and ISMP[7]. |
| | | Ensure self-assessments from the AHA and others are completed and used internally for quality improvement activities. |
| | | Cultivate media understanding of patient safety and my organization's efforts to improve safety. |
| | | Ensure effective systems are in place to assess individual accountability and competence. |

## ADVANCING THE FIELD

| *complete?* | | |
|---|---|---|
| Y | N | |
| | | Share my personal and the institution's patient safety learning outside of the organization. |
| | | Participate in local, regional, and national conferences, coalitions and other efforts to improve patient safety. |
| | | Engage in initiatives to drive enhancements in regulatory, facility/professional licensing, and accreditation agencies that support safety improvement and cultural change in consort with the specific goals of the agency. |
| | | Advocate for my professional association to make/keep patient safety a high priority. |

## *Short-term Goals*

## *Long-term Goals*


## ACKNOWLEDGEMENT

*This assessment tool is based significantly on the learning of board members, leadership, staff, and patients and their family members of the Dana-Farber Cancer Institute. It also draws heavily from members of the Massachusetts Coalition for the Prevention of Medical Errors, the Massachusetts Hospital Association, the National Patient Safety Foundation, the Institute for Healthcare Improvement, the Institute for Safe Medication Practices, the American Hospital Association, the Joint Commission on Accreditation of Healthcare Organizations, and the countless others in health care organizations across the nation that are working to improve patient safety.*



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## NOTES

[1] Publications of Lucien L. Leape and colleagues:

> "The nature of adverse events in hospitalized patients: Results from the Harvard Medical Practice Study II," Leape, L. L., Brennan, T. A., Laird, et al. New Engl J. Med, 1991, 324:377-384.
>
> "Error in medicine," Leape, L. L. JAMA, 1994, 272:1851-1857.
>
> "Systems analysis of adverse drug events," Leape, L. L., Bates, D. W., Cullen, D. J., et al. JAMA, 1995, 274:35-43.
>
> "Out of the darkness," Leape, L.L., Hlth Sys Rev, 1996, Nov/Dec:21-24.
>
> "Promoting patient safety by preventing medical error," Leape, L.L., Woods, D., Hatlie, M., et al.,. JAMA, 1998, 280:1444-1447.
>
> "Why should we report adverse incidents?," Leape, L.L., J Eval Clin Pract, 1999, 5:1-4.
>
> "Safe health care: Are we up to it?," Leape, L.L. and Berwick, D.M., BMJ 2000;320:725-726.
>
> "Reducing adverse drug events: lessons from a breakthrough series collaborative," Leape, L.L., Kabcenell, A.I., Gandhi, T.K., et al., Jt Comm J Qual Improv, 2000, 26:321-331.

[2] The revised standards are available at the JCAHO web site at http://www.jcaho.org/ptsafety_frm.html

[3] Order through Bridge Medical at http://www.mederrors.com

[4] Order through the Partnership for Patient Safety at http://www.p4ps.org

[5] Reference American Hospital Association safety site at http://www.aha.org/medicationsafety/medsafety.asp

[6] Reference National Patient Safety Foundation site at http://www.npsf.org

[7] Reference Institute for Safe Medication Practices site at http://www.ismp.org


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