PATIENT SAFETY CHAMPIONS: THEIR ROLES IN DEVELOPING AND SUPPORTING PARTNERSHIPS WITH PATIENTS AND FAMILIES

In their roles to build awareness for and enhance patient safety in an organization, Patient Safety Champions are uniquely positioned to develop and support partnerships with patients and families at the care level and in a myriad of patient safety and quality improvement initiatives at the organizational level.

Key attributes and qualities of a Patient Safety Champions that contribute to his/her effectiveness:

♦ **Avoids Tokenism** – Patients and families are engaged in patient safety initiatives throughout all phases of an initiative: conception of the idea; planning; implementation; evaluation; and sustaining the effort over time.

♦ **Easily Accessible** – Engages staff, clinicians, patients, and families in meaningful conversations and offers a means to contact their patient care team.

♦ **Empathy** – Offers empathy to a patient or family impacted by an adverse event, and gives them the opportunity to participate in a Focused Event Review to bring about meaningful change.

♦ **Feedback** – Actively solicits the ideas and perspectives of patients, families, clinicians, and staff, encouraging everyone to share their safety stories and work to create mechanisms for real time reporting.

♦ **Physically Visible** – Constantly circulating and talking with staff, clinicians, patients, and families.

♦ **Resolve** – Understands that a solution may create a “new way of doing things” that is not how it has always been done, but is the right thing to do.

♦ **Transparent** – Takes ownership of a patient safety related issue, and openly acknowledges an ongoing problem requiring attention.

Patient Safety Champions work to develop the organizational commitment, structure, and processes to foster a patient- and family-centered approach to patient safety, and enhance clinician’s and staff’s ability to collaborate with patients and families.

♦ **Patient and Family Involvement in Patient Safety Initiatives** – Sees the value of establishing a collaborative working relationship with the Patient and Family Advisory Council, the Youth Advisory Council; and other collaborative endeavors.
♦ **Patients and Families on Key Organizational Committees** – Affirms that decisions made that will impact families and direct patient care requires patient and family representation as part of the multi-disciplinary team approach — Patient Safety Committee, Ethics, Institutional Review Board, Ad Hoc Committees driven by events, and Policy and Program Development Committees and Improvement Processes).

♦ **Just Culture** – Just culture should prevail, and errors viewed as a systems breakdown vs. an individual mistake. Many things went wrong prior to the event – define and change.