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Actions to Renew Focus on Safety Culture

Four steps leaders can take to improve patient and workforce safety.

How safe do you feel about receiving healthcare in your own organization? Do you know your patient and workforce safety data? If you're a leader in a top-performing health system, are you close to achieving zero harm? Is your health system truly safe, or just safe enough?

Listening to the voices of patients and families and acting according to their wishes increases trust, respect and dignity for all. Failure to do so risks moral distress or injury and can lead to missed opportunities for early intervention that prevent the need for rapid response or code events.

Delivering the healthcare that our patients expect—in every setting and under all conditions—demands that we urgently revisit safety culture as the fundamental driver of both patient and workforce safety. And it's vital that we unify these two goals. Workforce safety is a necessary precondition for patient safety and essential to sustaining reliability over time.

The healthcare workforce has faced previously unimagined challenges from the COVID-19 pandemic, which compounded and exacerbated existing issues such as moral distress and injury, deep inequities, and distrust of health systems, payers and the legal system. As these dynamics evolve—with the added stressors of reduced staffing levels, increased acuity of patients, and increased lengths of stay and ED boarding times—the voices of patients, families and caregivers are drowned out or dismissed as a distraction or a component of alarm fatigue.

This perfect storm of contributing factors and latent influences has culminated in the patient safety setbacks experienced during the pandemic. The healthcare workforce cannot be expected to outperform, or even perform at all, with a flawed system design, particularly with added post-pandemic stressors. Prominent among these flaws are a weakened culture of safety and the attendant loss of patient, family and caregiver voices, heralding a clarion call around the world for health systems, payers and legislative leaders to renew the focus on these foundational influences affecting patient and workforce safety. Below are four recommendations for how leaders can use powerful culture-enhancing tools to improve healthcare safety.

Listen to the voices of patients, families and caregivers, and act on their input. Listening to the voices of patients and families and acting according to their wishes increases trust, respect and dignity for all. Failure to do so risks moral distress or injury and can lead to missed opportunities for early intervention that prevent the need for rapid response or code events. Ways to amplify these voices and incentivize listening to them include huddle reporting on what the patient, family and caregiver has expressed, stories of good catches and earlier interventions, and escalating these stories as a regular safety-stories-moments agenda item at the beginning of meetings. Methods to learn from adverse events (e.g., root cause analysis) should also clearly acknowledge dismissal of the patient, family or caregiver voice as a contributing factor to the event, when identified. A profound way to incorporate these perspectives is to include them directly in post-event learning processes and action planning to inform system-level improvements.

Embody and lead a just culture of accountability for the healthcare workforce. Philip G. Boysen II, MD, in his article "Just Culture: A Foundation for Balanced Accountability and Patient Safety" in the *Ochsner Journal*, writes that "a just culture balances the need for an open and honest reporting

environment with the end of a quality learning environment and culture." A just culture recognizes and accepts human fallibility, while also acknowledging unjustified risk taking, or even harmful intent, and prescribes appropriate organizational responses to the identified behaviors. To foster a just culture in your organization, look beyond investing *only* in educational training for yourself, staff and leaders—begin addressing the additional need for coaching, practice and simulation to reinforce just culture methods and to ensure their implementation. Also, be an example and enabler of just culture by sharing your experience and practice with it via written communications with the workforce. Be candid about both your challenges and successes. Develop a reporting system for just culture, or adapt your current safety reporting system, to track and evaluate application and the organization's response. Share this data with the workforce. Be mindful to align with HR, risk management and legal departments to overcome barriers or resistance to full implementation and use of just culture as standard work.

Create an environment and expectation for disclosure of adverse events to patients, families and caregivers aligned with communication and resolution (reconciliation) programs, or CRPs. The healthcare workforce, patients, families and caregivers frequently report discomfort with standard approaches to adverse event management in the absence of CRPs. For the workforce, this contributes to moral distress or injury and can lead to disengagement. For patients, families and caregivers, this adds to the harm of an adverse event and falls short of meeting their well-known expectations in the aftermath. To remedy this discomfort and harm, align leadership with clinical and medical staff, safety, risk management, and legal departments to support education, training and implementation of CRPs to reduce barriers for uptake, promote a collaborative team approach to disclosure and reconciliation, and directly address patient, family and caregiver expectations. Visible use of CRPs to manage the response to adverse events contributes to sustainability and reinforces for the workforce its importance and the organization's commitment to effectively and appropriately responding. Reliable adverse event management processes can also have the added benefit of reducing moral distress and injury among staff, and reinforce a patient-centered approach to both care and communication.

Delivering the healthcare that our patients expect—in every setting and under all conditions—demands that we urgently revisit safety culture as the fundamental driver of both patient and workforce safety.

Build trust with those closest to delivering healthcare services. Create a virtuous cycle for safety and well-being by dedicating leadership time to rounding in clinical spaces for building rapport with the workforce, learning about what is working well or can be improved and acting on their ideas.

To help ensure that new ideas continue to be generated and given voice, leaders can complete the virtuous cycle by acting on ideas surfaced by the workforce during rounding and communicating across the organization about resulting improvements. It takes the entire leadership team to make this strategy successful, so empower and align local leaders (supervisors, managers, directors) to enable tests of change and improvements with their teams and staff based on staff inputs, and then communicate the successes and the learning to help spread the changes.

In communications, highlight staff members as stars in their own stories. Consistently celebrate the workforce for their ideas, ingenuity and improvements. Leaders today can do much more of this.

Building and sustaining a culture of safety by listening to patient, family and caregiver voices and supporting the healthcare workforce is a powerful way to improve both safety and care outcomes.

Clearly defining these goals, and the described methods to achieve them, and making them standard work everywhere, will establish a new trajectory to exceed past performance in patient and workforce safety. ▲

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