Healthcare Organization Commitment

Contact Details

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Commitment Details

Commitment Name
Culture of Safety

Participants
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What Patient Safety Challenge does your Commitment address?
Challenge 1 - Culture of safety

How Many Hospitals Will This Commitment Represent

Patient Safety Movement Foundation | patientsafetymovement.org
**Action Plan**

The University of Vermont employs a multi-pronged approach to improving and maintaining a highly positive safety culture. Elements of this approach include the following:

- **Leadership/Governance:**
  - Patient safety and quality is a strategic priority for the organization and is the foundation for all we do.
  - Safety culture is recognized throughout the organization as a critical element of a high performing team and advances the quality of care.
  - Provide and support infrastructure focused on patient safety and quality.

- **Infrastructure:**
  - Centralized patient safety and quality programs, with content expert leadership specific to each team.
  - Online electronic event reporting system available throughout the organization, with the ability to report anonymously.

- **Procedures:**
  - Implementation of patient safety plans/policies that stress a blame free but accountable culture.
  - Implement a non-retaliation policy.
  - Regular planned and structured communication between risk management, quality, patient safety, nursing, regulatory, patient and family advocacy, and medical staff quality leadership to identify issues, complaints, and/or event reports that indicate systems and process failures, and initiate improvements.
  - Use of an objective structured event review and analysis process, such as root cause analysis, to identify process and systems issues, and avoid blame and focus on individual performance issues.
  - Event review/analysis facilitated by trained experts in process failure, human factor analysis, and systems design.
  - Ensure performance improvement plans are systems focused, with individuals assigned to each action item, and timelines for implementation.
  - Use data to analyze the effectiveness of the performance improvement plans at regular intervals.
  - Ensure analysis and improvement data is reported through structured committees up to and including the Board of Directors in the organization.
  - Educate hospital staff, including Residents and Medical staff on the importance of identification and reporting events and on the use of the reporting tool.
  - Provide a feedback mechanism for front line reporters.
  - Educate management on the non-punitive nature of the event reporting and how to recognize performance issues as opposed to systems failures.
  - Conduct FMEAs to proactively evaluate the risk potential in our systems and use redesign principles to optimize performance.

- **Assess the Culture of Safety:**
  - Regularly measure the culture of safety.
  - Share safety culture results throughout the organization.
  - Focus on areas of concern to affect change in those areas.
  - Celebrate the positive culture throughout the organization.

**Commitment Timeline**

Ongoing

**Impact Details**

**Lives Lost in Last Calendar Year**

0

How many lives do you expect to spare from harm in the next calendar year?
How many lives do you expect to save in the next calendar year?
0

Methodology for Determining Lives Saved
Unavailable at this time