Healthcare Organization Commitment

Contact Details

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Commitment Details

Commitment Name
APSS #1: Creating a Culture of Safety

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

Commitment Start Date
01/07/2011

How Many Hospitals Will This Commitment Represent

Patient Safety Movement Foundation | patientsafetymovement.org
Commitment Summary
Since at least 2000, CHOC Children’s Hospital has been steadfastly working to improve the
culture of safety within our organization. While this is a continuous journey, not a destination
(James Reason, "Managing the Risks of Organizational Accidents;" Ashgate Publishing Ltd;
Hants, England, 1997), one measurable output is the Serious Harm Rate, which objectively
measures the most severe types of preventable patient harm. In the mid 2000s, CHOC
adopted a quality goal, subsequently an organizational goal in 2011, to Reduce the Serious
Harm Rate. It is the highest level measure of the effectiveness of our safety systems and
culture to improve the patient safety domain of our organization quality program.
Simultaneously, CHOC has been regularly measuring, learning from and responding with
action to the validated and widely used Agency for Healthcare Research and Quality (AHRQ)
Patient Safety Culture Survey. Patient Safety simply cannot sustain improvement and
performance without a relentless approach to recognizing and modifying organizational
safety culture. While discrete safety events can often be prevented through best practice
adherence and other campaigns, the fundamental imperatives of just culture, error
prevention techniques, human factors engineering and high-reliability can neither be
effectively introduced nor maintained without cultural buy in. While this is a journey
measured in years, not days, it is one in which patients and their families cannot afford the
hesitation of a single step.

Commitment Description & Detail
CHOC Children’s uses the Healthcare Performance Improvement (HPI) Inc. Safety Event
Classification (SEC) event classification system to label harm and potential harm events. The
CHOC Serious Harm Rate uses the denominator of 1000 inpatient days. Potentially
preventable patient harm events are identified from multiple sources, including Daily Safety
Briefing, the online Safety Reporting System, morbidity and mortality conferences, and peer
review. There are three broad categories within the SEC: Serious Harm, Precursor Safety
Event, and Near Miss Event (in order of increasing frequency). The five types of serious harm
are: Death, Permanent Severe, Temporary Severe, Permanent Moderate and Temporary
Moderate (in order of increasing frequency). All serious safety events undergo detailed
analysis, typically root cause level. Analytic efforts then lead to answering the fundamental
question of how to improve our systems and culture to prevent recurrence and advance
reliability. Since inception a decade ago, CHOC Children’s has reduced its Serious Harm
Rate 97.9% to the current 0.05/1000 patient days. While this is a notable improvement,
rates alone can be impersonal. For this reason, we also track and discuss the actual number
of such children harmed, which can be very impactful, particularly at leadership and lay
levels. In alignment with the Patient Safety Movement Foundation’s Actionable Patient
Safety Solutions (APSS) checklist, CHOC Children’s Hospital is very close to reaching our
goal for all of the below checklist items. As the items contain references to “create culture,”
it is doubtful that such a checklist can - or should - ever be signed off as truly completed.
Action Plan
Achieving a culture of safety in a healthcare organization requires transformational change which is owned and led by the executive leaders of the organization, including the board, encouraging accountability and transparency. Leadership’s primary goal must be to make their hospital a safe haven for patients. • Address unexpected outcomes with open disclosure and prompt resolution. • If patient harm results from a preventable medical error, adopt the CANDOR (Communication and Optimal Resolution) or similar approach: apologize as soon as possible, pay for all care related to the preventable harm, seek a just resolution, and provide ongoing support for patients and families. Clinicians (the “second victims” of patient harm events) may also require attention and support (Lambert et al., 2016). • Create an open and transparent culture that encourages staff to speak up and self-report • Apologize within 60 minutes of discovery • No charge for care related to event • Incentivize lawyers to settle fast • Do event reviews to avoid reoccurrence • Within 30 days of any event review disseminate learning out to the patient, family, hospital system and externally • Create a standard of care to ensure that clinicians speak with family members to explain what will be changed so this event won’t happen again. Offer family members an opportunity to be involved and witness the change in procedure, etc. • Create a reliable means to capture and analyze good catches/near-misses. Set a goal that includes aspirations that all errors and incidents are preventable and that zero is the most important goal. • Implement an electronic adverse event reporting system that allows for both authored and anonymous reporting, tracking, trending and response to aggregate safety data. • Implement thoughtful and memorable internal branding to keep safety expectations and aligned behaviors top of mind throughout an organization.

Commitment Timeline
These patient safety culture checklists items are currently in place at CHOC Children’s. Our commitment to this APSS will be ongoing and reported yearly.

Impact Details
Lives Saved

Predicted Lives Spared Harm
0.399999999999985

For reporting purposes, the number has been rounded up to the nearest whole number. Predicted Lives Spared Harm = 1