Safety Across the Board: An Idea Whose Time Has Come

Terms:

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Patients expect hospitals to be safe places; places of healing, not harm. But those of us in health care know that’s not always the case. Patients experience harm in the course of their care from hospital-acquired conditions (HACs), such as central-line blood stream infections or ventilator-associated pneumonia. The rate of patient harm has been quantified by the Agency for Healthcare Research and Quality as 115 HACs per 1,000 discharges, according to the 2015 Annual Hospital-Acquired Condition Rate [7], down from 145 HACs per 1,000 discharges in 2010. This harm measure is used as part of the Partnership for Patients (PfP), a public-private partnership led by the Centers for Medicare & Medicaid Services (CMS). The goal of the PfP is to reduce this number to 97 per 1,000 discharges by 2019.

To meet this goal, the PfP has been advancing the concept of Safety Across the Board (SAB), which is the ability to use broad, systematic approaches toward building a patient-centered organizational strategy to reduce and ultimately prevent all patient harm. It’s also been called Eliminating Harm Across the Board (prior to patient advisors suggesting the more simple message of SAB), but no matter what you call it, it’s time has come. This concept challenges the traditional notion that hospitals and health systems only have capacity to work on one or two improvement projects at a time. “This year we’re focused on ABC, next year we’ll work on addressing XYZ.”

Addressing all forms of harm simultaneously is certainly not easy and requires strong, committed leadership. We recognize how complex the health care system is, in fact Peter Drucker calls hospitals “the most complex human organizations ever devised” in his book, Managing the Next Society. However, there are hospitals and health care systems achieving SAB and there are many tools and resources available to help those who need it.

The PfP has formed an affinity group for SAB to help the more than 4,000 participating hospitals understand the concept and design resources to help them take action. Vizient actively participates in and proudly supports the SAB Affinity Group. This group has created a SAB guidance document [8] that provides a framework with three key imperatives: Culture, Strong Safety Processes and Engagement. This document also includes five hospital case studies, one from Vizient member Parrish Medical Center, recent recipient of the Patient Safety Movement’s First 5-Star Hospital Ranking [9]. Parrish Medical Center has achieved some remarkable results including zero ventilator-related pneumonia in 12 years, one catheter-related UTI in 10 years, and one CLABSI in the past 10 years.

Successful organizations such as those highlighted in the SAB guidance document create the capacity for continuous quality improvement. Leaders of these organizations set bold goals and believe they can achieve them. These organizations are resilient. They build bench depth. They train all staff in quality improvement and high reliability, not just relying on a single department or staff member. They use systematic, hands-on approaches to spread learnings about potential harms—from one unit to another, from one facility to another. They create continuous learning environments where events are seen as opportunities from which they can learn, strengthening their organization. They make patient safety a shared vision and goal for everyone in the organization. They engage patients and families in their work through Patient and Family Advisory Councils or placing patients or family members on improvement committees with staff or on the board of directors to help govern the organization. Many of these common qualities have also been identified as part of a study conducted by Vizient [10] focused on high-performing academic medical centers.

Patients expect hospitals to be safe places; places of healing, not harm. This can become reality. There are many things hospitals can do to begin the journey to SAB. One simple step is to heighten the attention of patient harm in your organization by reframing the rate of harms as a percentage to the actual number of people harmed. Putting a number, or better yet a face to patient harm is an extremely impactful message to hospital leadership and board of directors.

To quote Don Berwick, “Some is not a number. Soon is not a time.” The time for SAB is now and, for the PfP, the number is 97 HACs per 1,000 discharges by 2019.

About the author. In her current role as director of HIIN and TCPI Delivery, Kellie Goodson leads transformation networks on the topics of culture/leadership/high reliability, patient and family engagement, and health equity that provide cross-cutting strategies to reduce patient harm in member health care organizations, in partnership with patient safety experts and advocates.

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