

ZERO HARM

THE BLUEPRINT — GUIDE —

The high reliability framework to
help your organization build a
Zero Harm culture.





Dear SCHA Members,

Congratulations! We're proud of the work you've done over the last few years to embrace the journey to high reliability as you strive to improve the quality of care and eliminate harm at your hospitals. We know achieving zero harm in the healthcare setting is a challenging goal, and that delivering exceptionally safe and consistently high-quality results in such complex, high-risk environments takes time and requires true culture change.

Since 2013, we've recognized your efforts through our Certified Zero Harm Awards program. The goal of this program was to publicly recognize the progress South Carolina hospitals have made in targeting and eliminating some of the most common areas of harm, like bloodstream and post-surgery infections, through procedural improvement fostered by a culture of learning and accountability. Thanks to those improvements, hospitals across the state demonstrated 12, 24, 48 and even as many as 88 months of harm-free stretches, all of which are validated by the South Carolina Department of Health and Environmental Control. After six years, two-thirds of our members have now won at least one Zero Harm Award, and we've certified more than 700 awards during that period.

But while these awards have been a tremendous success, we've also recognized that reaching zero harm goals requires more than focusing on the results—that it's as much about process and culture as bottom-line metrics. With that in mind, SCHA is expanding our Zero Harm program to assess and acknowledge the foundational elements of a zero harm culture—the Zero Harm Blueprint. Based on American College of Healthcare Executives and the IHI/NPSF Lucian Leape Institute / Leading a Culture of Safety: A Blueprint for Success this new approach will celebrate the leadership-based benchmarks that are essential on the journey to high reliability but are often one step removed from the clinical practice. The Blueprint will be focused on six key domains detailed in the following pages: Vision for Safety, Trust & Respect, Board Engagement, Leadership Development, Just Culture, and Behavioral Expectations.

It is our hope that the Blueprint will aid our member hospitals in creating highly reliable organizations by providing a comprehensive framework for creating and sustaining a culture of safety. By working together, South Carolina hospitals can be the safest in the country.

Sincerely,



Thornton Kirby, CEO, South Carolina



ZERO HARM

THE BLUEPRINT



VISION: Commit to develop, communicate and execute an organizational vision of zero harm to patients, families and the workforce.



TRUST, RESPECT AND INCLUSION: Establish organizational behaviors that lead to trust in leadership and respect and inclusion throughout the organization regardless of rank, role or discipline.



BOARD ENGAGEMENT: Develop and engage your board so that it has clear competencies, focus and accountability regarding safety culture.



LEADERSHIP DEVELOPMENT: Educate and develop leaders at all levels of the organization who embody organizational principles and values of safety culture.



JUST CULTURE: Build a culture in which all leaders and the workforce understand basic principles of patient safety science, and encourage the reporting of errors, lapses, near misses and adverse events.



BEHAVIOR EXPECTATIONS: Create one set of behavior expectations that apply to every individual in the organization and encompass the mission, vision and values of the organization.



ZERO HARM

VISION

GOAL: An organization-wide vision of zero harm that extends to patients, families and the workforce.

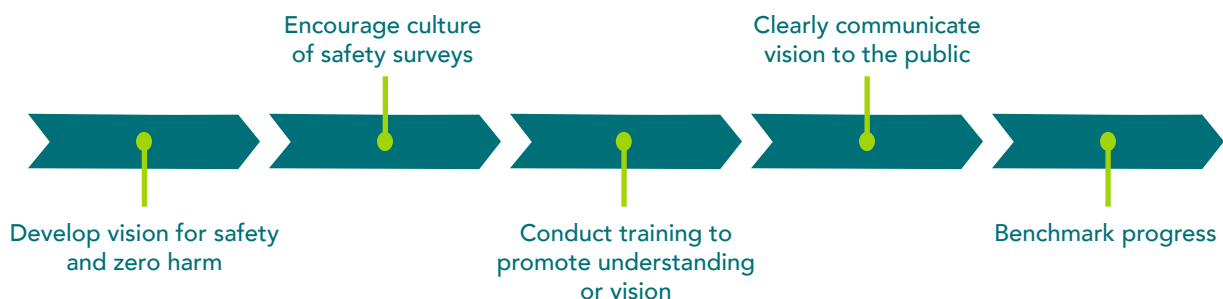
A compelling vision of safety clearly articulates that it is a top strategic priority for your organization that can enhance performance, promote change, motivate individuals and provide context for decision making. This is the foundation of what your organization does and should engage and inspire both the workforce and the public. Establishing a vision of safety is the CEO's responsibility and a critical first step in the Zero Harm Blueprint.

FOUNDATION STRATEGIES

- CEO assumes responsibility for educating themselves on how to develop and lead a culture of safety.
- CEO models a shared vision of zero harm to patients, families, the community and the workforce.
- CEO communicates genuine, clear messages about the vision of safety and its importance to the hospital's success.
- CEO participates in harm investigations, including disclosure, apology and root cause analysis.

SUSTAINING STRATEGIES

- CEO and leadership repeatedly provide messaging about the importance of safety and zero harm to internal and external audiences.
- CEO practices transparency and shared accountability between the Board and leadership team regarding the vision and the relevant measurements and reporting.





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TRUST, RESPECT & INCLUSION

GOAL: An organization-wide culture that values trust, respect and inclusion regardless of rank, role or discipline.

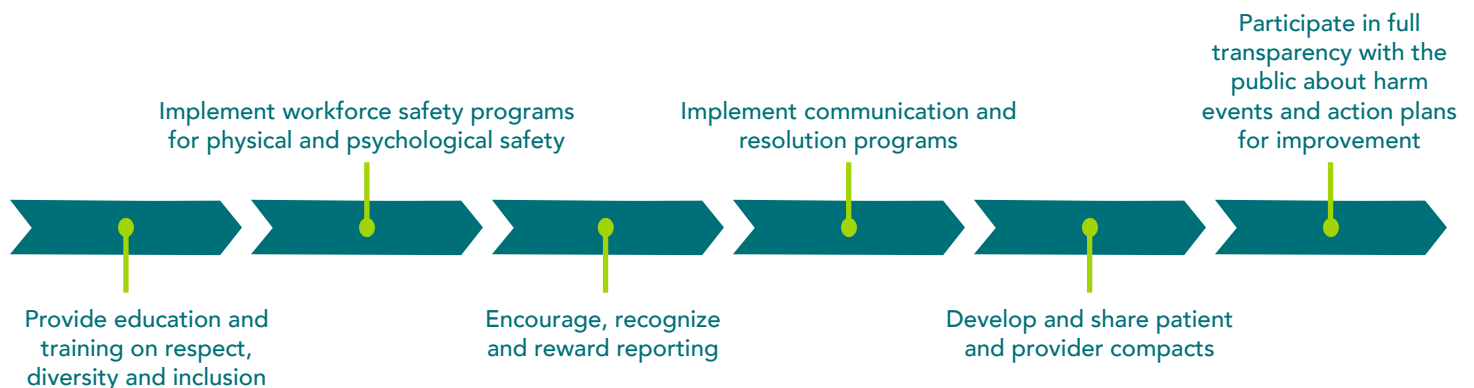
Trust, respect for others and inclusion are essential for physical and psychological safety. An organization dedicated to practicing honesty and transparency, where members of the workforce feel compelled and empowered to uphold mutual accountability, must develop trust and manage conflict with genuine concern and interest. The expectations are set and modeled by the CEO and should be implemented across the organization.

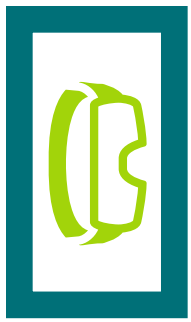
FOUNDATION STRATEGIES

- CEO creates expectation of trust, respect and inclusion, and models these through their interactions with every individual at every level of the organization.
- CEO holds leadership team accountable for modeling trust, respect and inclusion.
- CEO implements policies that empower the workforce to act within guidelines of trust, respect and inclusion when making decisions.
- CEO establishes expectation of learning from failures and improving systems as part of daily organizational activities.

SUSTAINING STRATEGIES

- CEO establishes formal expectations and accountability guidelines focused on trust, respect and inclusion across the organization.
- CEO establishes transparent practices with the Board, senior leadership, workforce and the community.
- CEO takes ownership of partnering with similar organizations through Patient Safety Organizations (PSOs) and other collaboratives to share learning and best practices.





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BOARD ENGAGEMENT

GOAL: Develop a Board of Trustees that is focused and accountable regarding safety culture.

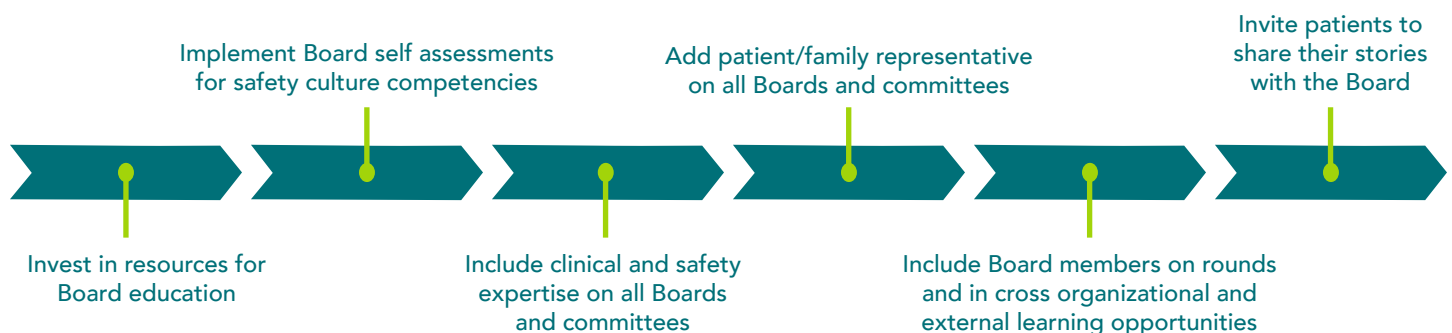
Healthcare organizations' Boards oversee fiduciary performance, reputation and key performance outcomes including those related to quality, safety and culture. The CEO is responsible for educating the Board on the importance of safety, ensuring the Board understands quality and safety metrics, and including sufficient safety expertise on the Board. Since the Board is responsible for making sure the correct oversight is in place and that quality and safety are systematically reviewed, it's imperative that safety is at the core of the Board's decision-making process.

FOUNDATION STRATEGIES

- CEO guarantees Board education on importance of quality and safety metrics and safety culture principles.
- CEO ensures Board membership includes clinical, safety and patient representation.
- CEO provides adequate agenda time to discuss safety culture metrics and issues.
- CEO creates quality and safety committee with Board representation.
- CEO designates time on each agenda for Chief Medical Officer or Chair of Quality and Safety Committee to present safety and quality data.

SUSTAINING STRATEGIES

- CEO works with the Board to set direction, goals, metrics and systems of mutual accountability for zero harm to both patients and the workforce.
- CEO oversees the credentialing and re-credentialing process, including elements of quality and safety.
- CEO works with the Board to align executive compensation with patient and workforce safety metrics.
- CEO leverages patient stories and presentations to educate the Board.
- CEO provides opportunities for Board member representation on appropriate safety committees.





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LEADERSHIP DEVELOPMENT

GOAL: Educate and develop leaders who embody the organizational principles and values of a safety culture.

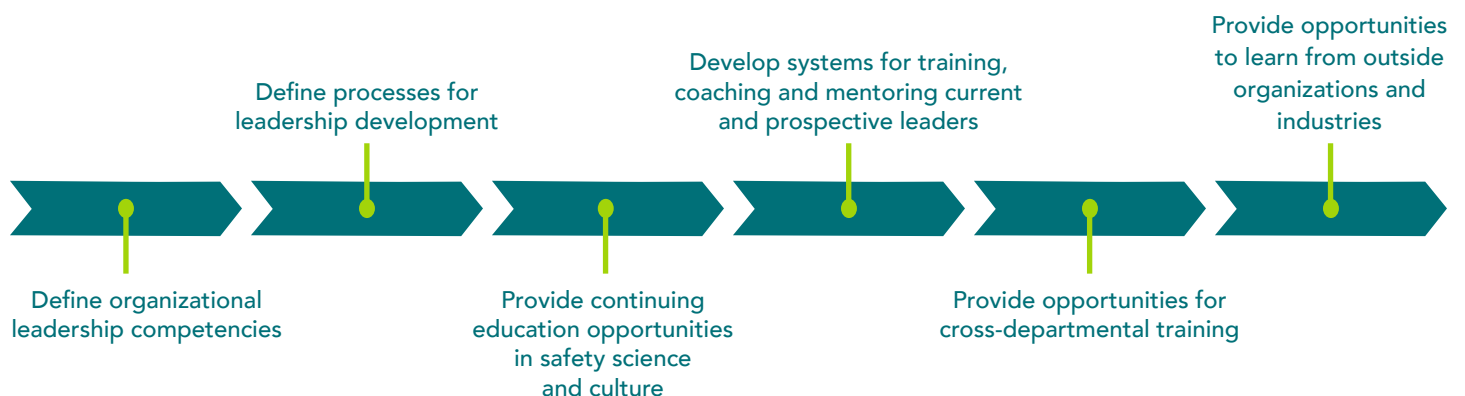
A key part of making a culture of safety a priority is the development of leaders who are champions for safety at all levels and in all departments of your organization. Numerous studies indicate the positive impact clinical leaders can have on culture and safety—they have a strong understanding of patient care and provide a valuable link between administration and the clinical workforce. CEOs should commit to developing effective physician, nursing and other clinical leaders by providing and encouraging leadership training.

FOUNDATION STRATEGIES

- CEO sets expectations and accountability for developing the organization's leadership strategy.
- CEO ensures leadership team receives necessary safety education.
- CEO identifies physicians, nurses and other clinical leaders as champions of safety.

SUSTAINING STRATEGIES

- CEO mentors other C-suite executives.
- CEO establishes quality and safety performance as required elements of evaluating current and potential leaders for promotion.
- CEO assigns accountability for measurable outcomes of safety education.
- CEO ensures patient and workforce safety are key parts of the organization's rewards and recognition system.





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JUST CULTURE

GOAL: Build a culture in which all leaders and staff understand the basic principles of patient safety and recognize consistent behavioral standards for all individuals in the organization.

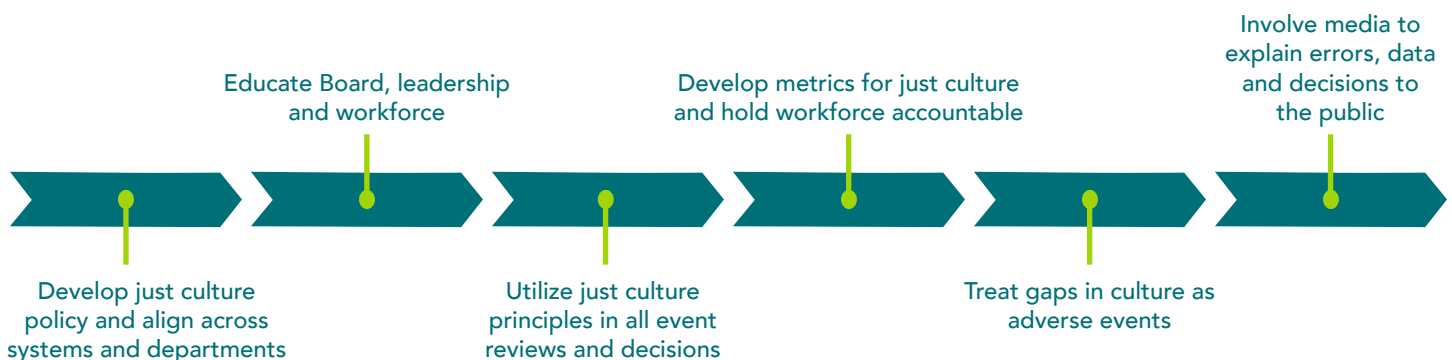
Successful safety improvement and harm elimination requires leaders to understand and commit to the principles of just culture. Just culture uses a system-oriented lens to investigate issues that lead individuals to engage in unsafe behaviors. Individual accountability is maintained by distinguishing between human error, at-risk behavior and reckless behavior. The focus in a just culture organization is on identifying and correcting imperfections in the system and pinpointing the most common causes of adverse events.

FOUNDATION STRATEGIES

- CEO encourages commitment to just culture framework as an essential organizational philosophy.
- CEO champions and models use of just culture principles in all decision and actions, including root cause analysis.
- CEO educates Board and leadership team on principles of just culture and models these principles.

SUSTAINING STRATEGIES

- CEO employs just culture principles throughout the organization regardless of rank, role or discipline.
- CEO sets expectations of accountability for utilizing just culture principles in every day practice and decisions.





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BEHAVIOR EXPECTATIONS

GOAL: Create a single set of behavior expectations for your entire organization that encompass its mission, vision and values.

Much of the work in establishing a culture of safety is linked to the everyday behaviors that characterize an organization. CEOs set the tone and have the responsibility to establish behaviors, set expectations and promote accountability for these norms for both employees and non-employees. It is essential for Board members, the CEO and leaders at every level to model the behaviors they aim to cultivate throughout the organization.

FOUNDATION STRATEGIES

- CEO creates, communicates and models an organizational climate of personal and professional accountability for behavior.
- CEO establishes systems to recognize and reward desirable behavior.
- CEO empowers organization to develop, implement and evaluate that address and improve personal, professional and organizational behavior and accountability.
- CEO engages Board by sharing metrics and dashboards related to organizational behavior.
- CEO engages and holds all leaders and workforce accountable for defined behaviors.

SUSTAINING STRATEGIES

- CEO prioritizes resources for professional accountability framework and programs to ensure sustained excellence.
- CEO ensures that succession planning and talent management programs prepare future leaders with competencies in organizational behavior and accountability.
- CEO works with licensing bodies and medical executive committees, where applicable, to ensure behavioral expectations and accountability practices are consistent.
- CEO and leaders at all levels of the organization encourage questions, increasing the likelihood that the right question is asked at the most critical of times.





THE HISTORY & FUTURE OF HIGH RELIABILITY

The story of high reliability in healthcare begins in 1999 when the Institute of Medicine published its landmark study *To Err is Human: Building a Safer Health System*. The report revealed the extent to which quality of care and patient safety were not as they should be, that complex hospital systems lead to numerous medical errors and poorer outcomes for patients.

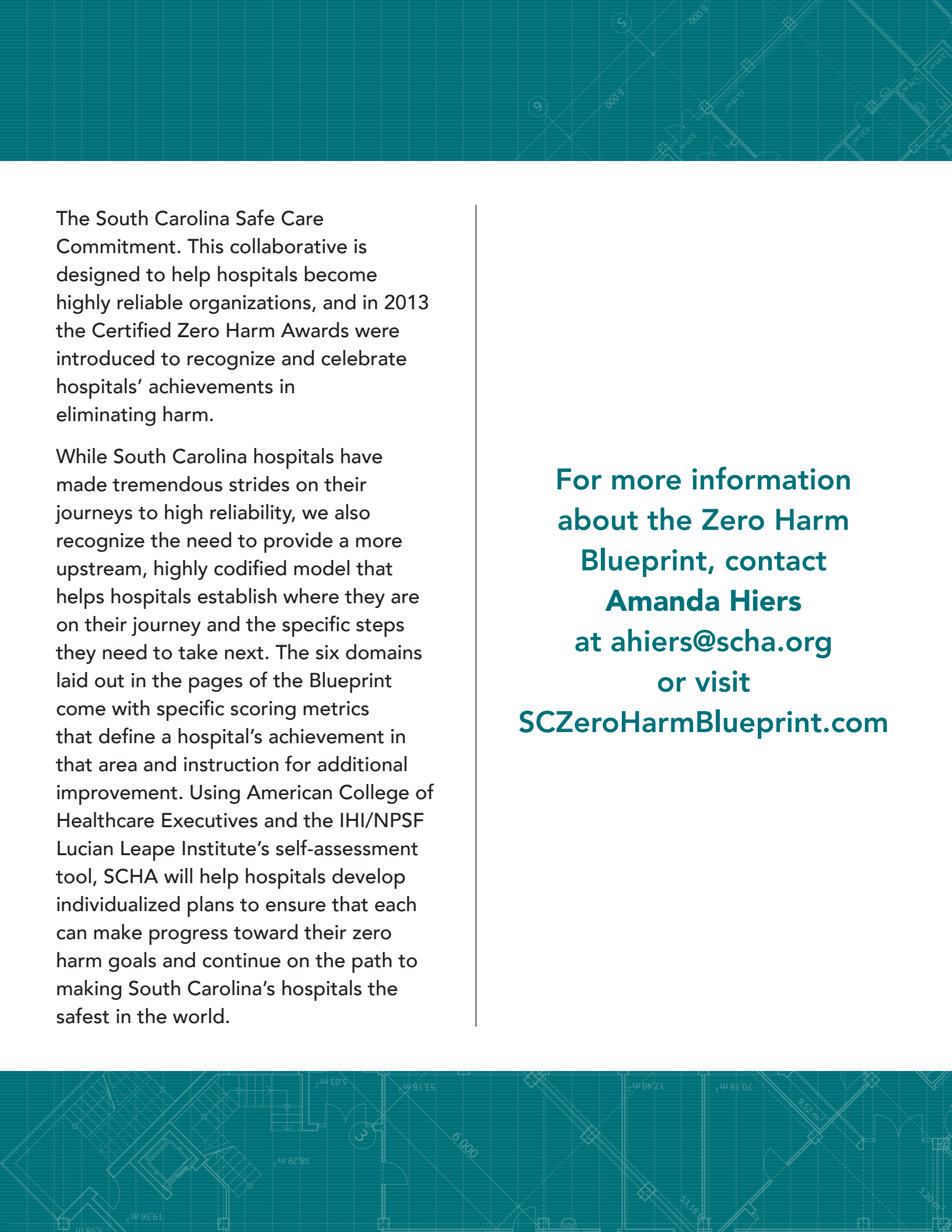
One of the key recommendations from *To Err Is Human* was that hospitals promote “cultures of safety” in their workforces and processes. This was a broad charge that required defining safety as an explicit organizational goal and leadership actively modeling safety principles. It also meant standardizing and simplifying equipment, supplies and processes and implementing continuous improvement policies to constantly monitor and refine patient safety practices.

Fortunately, the model of High Reliability Organizations (HROs) already existed in other industries such as aviation and nuclear power operations. Like hospitals,

these industries operate in challenging social and political environments with high risk and complex systems, but they have learned how to deliver exceptionally safe results over long periods of time.

Around the same time of the Institute of Medicine’s report, researchers began working to codify how HROs work. A systemic review revealed that the infrastructure of high reliability is permeated by a “collective mindfulness” rooted in five key principles: a preoccupation with failure, reluctance to simplify interpretations, sensitivity to operations, commitment to resilience, and deference to expertise. In short, HROs successfully heighten the quality of attention and awareness in organizations that constantly seek self-improvement and reinvention.

Based on this research, in 2012 SCHA formally teamed up with The Joint Commission Center for Healthcare Transformation, Health Sciences SC, PHTS Risk Management Services, and 31 hospitals and health centers to launch



The South Carolina Safe Care Commitment. This collaborative is designed to help hospitals become highly reliable organizations, and in 2013 the Certified Zero Harm Awards were introduced to recognize and celebrate hospitals' achievements in eliminating harm.

While South Carolina hospitals have made tremendous strides on their journeys to high reliability, we also recognize the need to provide a more upstream, highly codified model that helps hospitals establish where they are on their journey and the specific steps they need to take next. The six domains laid out in the pages of the Blueprint come with specific scoring metrics that define a hospital's achievement in that area and instruction for additional improvement. Using American College of Healthcare Executives and the IHI/NPSF Lucian Leape Institute's self-assessment tool, SCHA will help hospitals develop individualized plans to ensure that each can make progress toward their zero harm goals and continue on the path to making South Carolina's hospitals the safest in the world.

**For more information
about the Zero Harm
Blueprint, contact
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A Better State of Health