January 2024

CommonSpirit

FY2024
Care Giver Well-Being Goal

Culture of Safety Toolkit

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Introduction

The Leadership of CommonSpirit Health has identified the Culture of Safety as a direct influencer of caregiver wellbeing and safer patient care. The Culture of Safety is defined as the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior determining the organization's commitment to safety. Favorable employee scores on safety culture surveys are associated with shorter lengths of stay, fewer medication errors, lower ventilator associated pneumonia rates, lower bloodstream infection rates and a decrease in the frequency and severity of patient harm events.[1] Health care errors resulting in patient harm are a leading cause of morbidity and mortality in the United States, although there is no national reporting of such.[2] Leaders must employ the modern methods of high reliability to engage staff and overcome the challenges faced by deficits in the safety culture.[3] A culture of safety describes behaviors that come about when there is a collective and continuous commitment by organizational leadership, managers and health care workers to emphasize safety over competing goals.[4]

Background

Healthcare is a high-risk industry. Other high-risk industries such as aviation and nuclear energy pay considerable attention to assessing safety while having fewer events of harm. Historically, safety determinations have been based on a retrospective review of data from harm and injury; high-risk industries have only a few to review. Driven by the awareness that organizational, managerial, and human factors rather than simply technical or individual failures produce harm, high-risk industries have converted to predictive measurements of safety. A predictive focus is the evaluation of the "safety climate," a term that generally refers to the measurable components of a "safety culture" that are experienced by individuals within work units and teams, such as management behaviors, safety systems, and employee perceptions of safety. Studies have shown safety climate effects staff well-being, job satisfaction, and burnout, all of which can impact patient safety. Embracing a safety culture in which all providers feel valued and successes are emphasized is a way to mitigate these negative, unintentional effects.[5,6]

Measure Definition

Culture of Safety

Objective
Improve results on the Safety Climate Survey which is associated with better patient outcomes, including lower mortality rates.

Rationale
Favorable results on safety climate surveys are associated with shorter lengths of stays, fewer medication errors, lower ventilator associated pneumonia rates, and lower bloodstream infection rates. They are also associated with lower risk-adjusted patient mortality rates.

Metric
Composite Score of the following three questions from the annual employee engagement survey and FY2024 pulse checks:

1) I would feel safe being treated here as a patient.
2) I have the support that I need from others in this work setting to care for patients.
3) Disagreements in this work setting are resolved appropriately (i.e. not who is right, but what is best for the patient).

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Data Source: Annual Employee Engagement Survey and FY2024 Pulse Checks conducted by Press Ganey

How to Use Culture of Safety Toolkit

Multiple strategies have been identified to improve the culture of safety. However, there are three core proven strategies that must be put into place to achieve a culture of safety. These strategies include:

1. Having leaders conduct a Unit Safety Huddle once per shift in addition to the Leadership Safety Huddle that coincides with Patient Experience
2. Training all staff, including providers, on how to use ARCC/C.U.S.S. when speaking up for safety
3. Conducting effective leadership rounds on staff members using the Rounding to Influence 4C method to connect to staff and reinforce their commitment to quality and safety

CSH Culture of Safety Resources

Key Strategies for Success

1 Conduct Unit Safety Huddles

Unit Safety Huddles are brief, regularly scheduled meetings held for sharing information about potential or existing safety problems facing patients or workers. Unit Safety Huddles increase individual and collective accountability for patient safety, designate a fixed time during the workday and/or shift to focus on care coordination, facilitate immediate face-to-face clarification of safety issues, result in fewer interruptions during the rest of the workday, and foster a culture of safety empowerment, engagement, and collaboration.

Highlight Safety Issues and Concerns during Unit Safety Huddles and Leadership Safety Huddles

The purpose of a huddle is to engage frontline staff in problem identification and build a culture of collaboration and quality. By sharing information and highlighting concerns in the daily huddle, we can enhance our ability to deliver safer care. Concerns raised during huddles are then directed to an appropriate person or group for resolution such as peers, supervisors, or patient safety committees.

Unresolved concerns should also be escalated during the Leadership Safety Huddle debrief that coincides with patient experience. This platform allows multiple leaders to be aware of the concerns, which could be effecting numerous other departments and sets a precedence for the priority issue(s) to be resolved.

Assign Leader Responsibility for Department/Unit Safety Huddles

- The Unit Safety huddle is typically led by a member of the unit or department leadership team (e.g., nurse shift managers, supervisors, managers, directors, etc.).
- The huddle leader gives every team member the opportunity to contribute to the discussion by going around the group and inviting everyone to share a positive observation or a concern about patient safety from the previous day. The team leader encourages others to listen and avoid interrupting the person speaking.
- Potential and actual events of patient harm and issues with non-functional or defective equipment or concerns about patient rooms are included in these discussions.

Frequency of Unit Safety Huddles

The Unit Safety Huddles occur each shift. Typically at the beginning of the workday in an outpatient setting, at the start of each major shift in ambulatory surgery, and every shift in the inpatient and ancillary units. Administrative staff should have a huddle that coincides with normal working hours.

Apply a Standard Structure to Unit Safety Huddles

The huddle process is most efficient if team members gather in front of a visual management board (huddle board) that provides information on the agenda for the huddle, highlights regarding current safety issues, and performance on safety metrics.

- The following should be covered in the Unit Safety Huddle:
  - Days since last Serious Safety Event
  - Concerns from the previous 24 hours
  - Concerns for the upcoming 24 hours
  - Barriers to the work day
  - Metrics: Board Goals, falls, pressure ulcers, or other key area of focus
  - Recognition for Good Catches
- It is important to ensure that the location of huddles and visual management boards comply with patient privacy standards.

- A designated team member notes issues that need follow up as well as the individual(s) responsible for this follow-up on the visual management/huddle board. The advantage of tracking follow-up items on the board is that team members can indicate and share, in real time, how and when safety issues have been followed up and resolved. If a safety critical issue is raised, the facilitator assigns an accountable person and establishes a date and time for an update on its resolution. If the issue is of a greater concern for the organization, the huddle leader will share it at the leadership huddle for follow-up and/ or resolution.
- Lastly, it is helpful if participants stand during the huddle as it increases the likelihood of the meeting being engaging and concise.

2 Adopt ARCC/C.U.S.S. to Speak-Up for Safety

***Note – this is the final year ARCC will be promoted as acceptable to use. Starting in FY25, C.U.S.S. will be the only tool recognized with speaking-up for safety.** ARCC/C.U.S.S. to Speak-Up for safety are key components to providing safe and effective care by providing staff the tools and resources to speak-up and resolve issues when a safety concern arises. As humans are fallible, despite their best intentions, mistakes occur that could have been prevented by another individual "speaking-up." Staff who are vigilant, situationally aware and trained in techniques for raising a concern, can improve others' awareness and raise concerns in a scripted manner. Many safety concerns can be resolved simply by asking the individual to rethink their actions and bringing in a supervisor or activating the chain of command.

ARCC and C.U.S.S. are both acronyms within the High Reliability skillset that support speaking up. Facilities only need to use one and it is best if the whole facility/division uses the same language to promote consistency and reduce confusion.

- ARCC stands for: **A**sking a question; making a **R**equest f**o**r a behavioral change or re- evaluating the situation; and voicing a **C**oncern. If there is not a resolution, the last step is to activate the **C**hain of command for supervisor assistance.
- C.U.S.S. stand for: "I have a **C**oncern about…"; "I am **U**ncomfortable about…"; "**S**top this is a safety issue because…"; and, if no resolution, contact a **S**upervisor to escalate the concern.

Train All Staff and Physicians

For ARCC/C.U.S.S. to be successful, it is important to remove the power gradient inhibiting staff from speaking-up when there is a concern. Establish the expectation that everyone will stop and resolve before proceeding when a safety concern is raised.

- Initial training can be provided in various settings, but the key is to ensure that staff can practice (and leaders can reinforce) this universal skill.
- Including physicians and other Independent Licensed Professionals is key to removing power gradients and making it safer for individuals to speak up.
    - Educate physicians on the importance of listening for cues that a concern has been raised.
- A review of the chain of command policy and processes will be necessary for ARCC/C.U.S.S. to be successful and should be included in the training.
    - Also include the importance of reporting when chain of command is invoked to help determine attributions of the event that can be prevented in the future.

Say Thank You to Staff who Raise Concerns

Remind all staff that it takes a lot of courage for someone to speak-up when they see a potential safety issue or event. Some concerns arise out of a knowledge deficit and allowing peers to speak up could be turned in to a learning opportunity.

- Thanking employees for their questions reinforces that it is okay to speak-up.

Report Safety Concerns

It is important for leadership to known when a safety concern arises (whether a near miss or a harm event) and that staff have used ARCC/C.U.S.S., as it can prompt an analysis to determine system issues that allowed the conflict or confusion to occur. Reporting events in the iVOS or IRIS event reporting system lets leaders know that staff are using the skill and speaking-up for safety.

3 Rounding to Influence: 4C Method

Fundamental leadership skills, grounded in evidence-based best practice, are required to improve the Culture of Safety Index score and support a High Reliability approach in the organization. Round to Influence (RTI) is one of these fundamental leadership skills because it connects leaders with staff and reinforces their commitment to safety and quality through a discussion that addresses barriers to performance excellence (in safety, quality, patient experience and beyond). RTI improves leaders' awareness of problems and improves employee engagement in resolving safety issues. RTI is most effective at shaping behaviors when you use the 4C format to guide the conversation: First you create a **"Connection"** to what you want to discuss by relating it to a core value or expectation. Next, assess for knowledge by asking about the **"Can-do"** actions. This is followed by asking the employee if they have any **"Concerns"** about applying the skill; and, lastly, asking for a **"Commitment"** to use the skill. Please see below for the model and an example. *Refer to the appendix for a template and example of 4C rounding.*

Practice Frequent and Consistent Rounding to Influence

Leaders should round frequently, delivering the same message and using the 4C method.

- Follow a monthly topic schedule so that all leaders deliver the same message at the same time.
  - These topic schedules should focus on the application of universal skills to other daily work.
  - Ex: RTI on STAR (Stop, Think, Act, Review) to assess how STAR can support fall precautions/reductions or eliminating CAUTIs.

Use 5:1 Feedback when Engaging with Staff

Providing 5:1 feedback includes recognizing, encouraging, and reinforcing the desired behaviors when observed.

- This approach focuses on a ratio of providing 5 positive/praise encounters to every 1 coaching/corrective encounter when giving feedback.
  - Not all at once, but instead across all interactions with employees—focus on recognizing the great work that happens every day 5 times as often as you correct behaviors.
- You can give praise in subtle ways such as saying "thank you" or "nice job," or using nonverbal mechanisms such as smiling and nodding your head or giving a thumbs up.
- Leaders sometimes feel that they don't need to give feedback when an employee is doing their assigned job, but it lets them know that you appreciate the work that they are doing.
  - This type of feedback makes individuals more likely to repeat the desired behavior.

Report-out and Recognize

Leadership daily huddle should cover the findings from RTI. Rounding to Influence efforts should be documented in the digital rounding tracking tool Sentact.

- Departmental leaders should report-out findings from RTI along with patient/employee concerns and praise.
  - To help reinforce desired behaviors it is important to recognize staff when they do something right.
  - The implementation and delivery of a Good Catch Award can also be used to recognize those who caught a near-miss.
- All leaders should follow-up on concerns verbalized by employees during RTI to close the loop for safety.

Culture of Safety Gap Analysis Tool

What is this tool?

The purpose of the gap analysis is to provide goal improvement teams with a mechanism to:

- Compare the evidence-based "must have" improvement strategies with the processes currently in place within the facility/entity
- Determine the "gaps" between current practices and identified best practices
- Provide a structured approach to documenting action plans to address identified "gaps"
- Provide a reference of available resources to support improvement efforts

Who should use this tool?

The HRO Lead will facilitate completion of the gap analysis with participation from providers and other team members. Facilities/entities should establish improvement teams or workgroups to develop action plans to address identified gaps and successfully deploy improvement strategies.

How can the tool help you?

Upon completion of the gap analysis, goal improvement team members will have:

- An understanding of the differences between current practices and evidence-based, best practices related to optimal goal performance
- An assessment of the barriers that need to be addressed before successful implementation of best practices
- An awareness of available resources to support improvement efforts

Instructions

Please use the online FY24 Clinical Scorecard to complete the GAP analysis.

1. Please review each of the improvement strategy elements in Column 2. Answer Yes or No questions in Column 3 by checking the appropriate box.
2. If the improvement strategy is currently not in place, or associated elements are not addressed by current processes within your setting, use the Action Planning document to detail your action items, responsible individuals and estimated implementation date.

Gap analysis and Action Planning document should be completed as soon as possible but no later than August 31, 2023. Measure Leads are available to answer questions and/or offer assistance with this evaluation.

THANK YOU!

Culture of Safety Gap Analysis

Division _____ Facility _____ Date of Completion _____

Key Concept	Improvement Strategy	Assessment	Comments	Available Resources
Strategy 1: **Safety Huddles**	**A brief, regularly scheduled meeting for sharing information about potential or existing safety problems facing patients or workers.** • Department daily huddle or check-in is led by the unit / department leader (e.g. manager, director, supervisor etc.). • Occurs at least once per day; ideally, once per shift every day. • Administration holds a daily huddle once per normal working hours. • Daily Leadership Huddle/ Check-in directives and safety or quality issues from the previous 24 hours and upcoming 24 hours are discussed. • If a safety critical issue is raised, the facilitator assigns an accountable person and establishes a date and time for an update on its resolution. • Good catches are celebrated and near misses are reviewed. • A unit specific Huddle Board is used to track the information shared. • The number of days since the last patient serious safety event (SSE) in the department is reported each day.	☐YES ☐NO ☐YES ☐NO ☐YES ☐NO ☐YES ☐NO ☐YES ☐NO ☐YES ☐NO ☐YES ☐NO		Shaikh, U., MD. (2020, January). Improving Patient Safety and Team Communication through Daily Huddles. Retrieved 2020, from https://psnet.ahrq.gov/primer/improving-patient-safetyand-team-communication-through-daily-huddles Stockmeier, Carole, MHA and Clapper, Craig, PE. Daily Check-in: From Best Practice to Common Practice Retrieved 2020, from https://www.psqh.com/analysis/daily-check-in-for-safety-from-best-practice-to-common-practice/ Di Vincenzo, Priscilla BSN. Team huddles: A winning strategy for safety. Retrieved 2020, from https://journals.lww.com/nursing/Full-text/2017/07000/Team_huddles__A_winning_strategy_for_safety.17.aspx CSH Culture of Safety Resources CSH Huddle Board

Key Concept	Improvement Strategy	Assessment	Comments	Available Resources
Strategy 2: **Speaking up for Safety: ARCC/C.U.S.S. & Report**	**C.U.S.S. (Concern, Uncomfortable, Stop, Supervisor) is a scripted reliability tool for anyone to speak up for safety or raise a safety concern ARCC: Ask, Request Change, VoiceConcern, use Chain of Command** • At least 80% of staff, including physicians, are trained on how to ARCC/C.U.S.S. • All events that resulted in the use of ARCC/C.U.S.S. are reported and investigated for common causes. • ARCC/C.U.S.S. is used as leadership rounding topic at least once a year using the 4C method in Rounding to Influence. • All new employees are trained and encouraged to use ARCC/C.U.S.S. as part of their on-boarding orientation. • Facility has a policy on the use of Chain of Command	☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO		John Day and John T. Paige, MD. *Good Catch in the Operating Room.* Retrieved 2020, from https://psnet.ahrq.gov/web-mm/good-catch-operating-room CSH Culture of Safety Resources

Strategy 3:
 	
Rounding to Influence (4C Method)
	A scripted message using the 4Cs (Connection, Can Dos, Concerns & Commitment) that leaders use to reinforce a safety/reliability behavior or tactic.
	• Directors / managers round to influence at least four times per month.
	• Senior leaders (VP and above) round at least once per month.
	• All leaders round on the same topic during the defined period.
	• Every department / unit in the facility is rounded on at least once per month.
	• Rounding is tracked and includes the following elements:
	  • The safety topic of the month
	  • The number of encounters per rounding session
	  • The leader's title
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
				Reinertsen JL, Johnson KM. Healthcare Executive. 2010; 25:72-5. Rounding to Influence. Retrieved 2020, from https://psnet.ahrq.gov/issue/rounding-influence
				
				CSH Culture of Safety Resources

Key Concept	Improvement Strategy	Assessment	Comments	Available Resources
	• The rounding location(s) • Associates' comprehension of the topic • Associates' ability to apply the topic / technique • Safety concerns raised by the associate	☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO		

Culture of Safety Gap Analysis Action Plan

Facility/Entity Name: _____

Completed By: _____ Date Initiated _____

Key Concept/ Process	Action Plan	Responsible Person	Estimated Completion Date	Monitoring/ Validation Process (How do you know it's happening?)

Additional Comments:

Culture of Safety Champion Role Description

Recommended Role for HRO Lead:
HRO/SafetyFirst facility lead (if already in place), Safety Team Member, Quality Team Member

Recommended Role for MD Champion:
Chief Medical Officer, Chief of Quality, Vice President of Medical Affairs

Recommended Role for Nursing Champion:
Chief Nurse Executive Officer, Assistant Chief Nurse Executive Officer

Role Summary
The HRO champions are the facility-level leaders who promote, implement, and sustain culture changes designed to support our High Reliability skills. They will promote participation in education and provide communication to enhance engagement and interaction with the other team members.

Successful improvement in the Culture of Safety Index is best achieved with a complimentary dyad leadership from Nursing (CNO) and Physician (CMO) in partnership with the HRO Lead. The CNO and/or CMO may also serve as the HRO Lead.

Functions and Duties of HRO Champions
- Oversee yet collaborate with local leaders for the development and sustainment of the strategies listed in this goal
- Serve as local experts for the practice and reinforcement of the universal skills / error prevention tools
- Serve as local experts for the practice and reinforcement of the leadership methods / skills for high reliability
- Attend daily safety huddle and lead when assigned
  - Ensure Unit Safety Huddles are occurring using a high reliability huddle board
- Round to Influence for safety using the 4C method at least monthly and report the RTI practice of all local leaders (e.g., by supplying the talking points and monthly topic)
- Serve as a conduit between the leadership team and the medical staff on high reliability efforts
  - Ensure the medical staff are trained in universal skills or error prevention tolls within 90 days of credentialing date

Frequently Asked Questions

Q Who should review and complete the gap analysis?

A The HRO lead should partner and collaborate with physician and nursing leadership to complete the gap analysis. Anyone else who has been or wants to be involved is more than welcome to participate.

Q When the gap analysis is complete, who should own the action plan?

A The action plan should be managed by the HRO Lead but any leaders can participate and own a specific section if it works for your facility.

Q Is all CommonSpirit Health using the same gap analysis?

A Yes, all CommonSpirit facilities are adopting or focusing on the use of the three primary high reliability tactics to improve the Safety Culture Index Score in fiscal year 2024.

Q Why were these high reliability tactics chosen over others?

A These chosen tactics are the result of collaboration amongst members of Press Ganey, hospital leaders and HRO Leads to determine which strategies would drive the strongest change.

Q If I've just started my high reliability journey, how will this affect the work?

A Implementing each of the three strategies is an initial step in the high reliability journey and should correspond to the work that you are planning to do.

Q If I've been on the high reliability journey for some time, do I need to adopt the same principles, terms and timetables for these tactics if mine are similar, but not the same?

A In fiscal year 2024 this Quality Goal offers CommonSpirit Health facilities an opportunity to standardize practices and terminology for high reliability. Those who have been on the high reliability journey for some time will benefit from revisiting basic strategies and adding in the new terms and practices offered by our high reliability partners. For example, the standard use of the high reliability huddle board for unit-based huddles is a best practice, but not frequently used by organizations currently on the high reliability journey. Adding in the additional best practice components will optimize the use of the high reliability methods.

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Appendix

1. 4C Format Template

Rounding to Influence Component	Script
Core Value	I'm rounding today to talk about our High Reliability Behavior Expectation to _____
Can You…	**Can you tell me about how and when you use _____?**
Concerns	**Are there any problems or barriers you or your coworkers are having in using _____?** Or…have there been any near misses or safety events in your area where this tool would have been helpful?
Commitment	**Can I count on you to use _____?** Will you crosscheck and coach others in using _____?

2. 4C Format example

Rounding to Influence Component	Script
Core Value	I'm rounding today to talk about our SafetyFirst Expectation to Communicate Clearly. As a reminder, it is our duty to ensure we hear and understand information correctly to reduce errors. One tool that we can use is SBAR (Situation, Background, Assessment, Recommendation / Request).
Can You…	**Can you tell me about how and when you use SBAR?** Correct answers for when to use: • Any time I need to provide a clear and concise communication for the purpose of requesting an action. • Example: calling about a change in patient condition to a provider. • Correct answers for how to use SBAR: *I say, "The situation is…"; "The background is…"; "The assessment is…"; "My recommendation / request is…"*
Concerns	**Are there any problems or barriers you or your coworkers are having in using SBAR?** Or…have there been any near misses or safety events in your area where this tool would have been helpful?
Commitment	**Can I count on you to use SBAR?** Will you crosscheck and coach others in using SBAR?

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