



A Framework for Local Accountability for Patient Safety

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Abstract

Despite numerous publications outlining the magnitude of patient safety issues, the literature provides limited strategies for organizations to develop comprehensive, effective patient safety programs. Hamilton Health Sciences (HHS) has created a framework to foster local accountability called Patient Safety Triads and Networks. The Networks operationalize patient safety initiatives, develop knowledge and improve patient safety culture in a collaborative interdisciplinary team model. They have proven to be an effective way to support patient safety at the local level and to integrate organizational and local work on patient safety.

Background

Many organizations are committed to patient safety; however, translating organizational commitment to local accountability for patient safety can be a challenge. In 2004, Hamilton Health Sciences (HHS) created and unveiled our patient safety model: Cornerstones, Connections and Caring (Figure 1). This model is based on the need for a balanced approach to the creation of an effective patient safety program. Four “cornerstones” need to be addressed to achieve this balance: Culture of Patient Safety and Accountability, Measurement and Improvement, Education and Professional Development, and Information and Communication. To translate these cornerstones into action, there are underlying infrastructures called connections. The

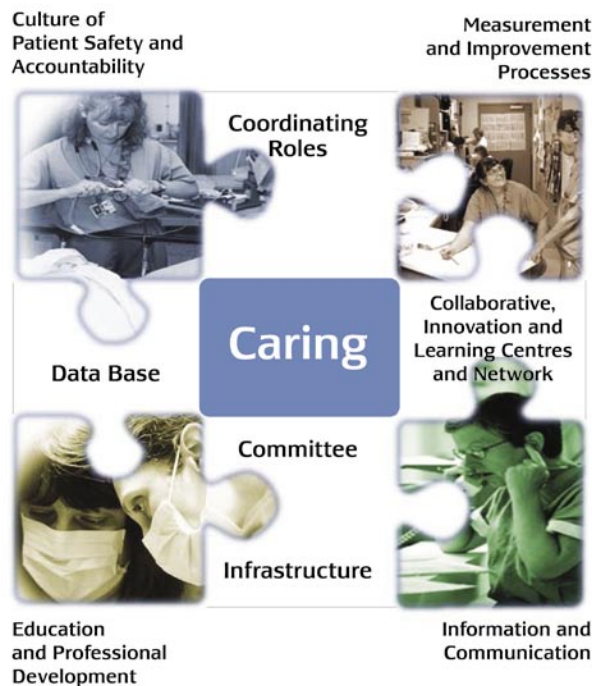
integration of the cornerstones and the connections ensures a strong patient safety program and optimal care for our patients.

The connections of the model include: coordinating roles for safety (Patient Safety Specialists); databases to track and trend adverse events, near misses and identified safety issues; committee infrastructure (a Patient Safety Steering Team); and Collaboratives, Innovation and Learning Centres and Patient Safety Networks. The Collaboratives represent the collaborative quality work that occurs within the organization. The Innovation and Learning Centres are areas where teams are supported by Quality Improvement Specialists in their ongoing improvement work.

HHS is a large, four-site tertiary care centre, which includes five hospitals and a cancer centre. We believe that patient safety is the responsibility of the 10,000 people who work at HHS in more than 100 units/areas. “A critical task of any executive is to build accountability into the systems they manage or lead; part of this task is to encourage individual employees to share that responsibility” (DiBella 2001). HHS has developed a framework to foster local accountability called Patient Safety Triads and Networks. Accountability for patient safety must exist at organizational and local levels to effect the needed changes in practice and culture. Delegation leads everyone to share accountability (DiBella 2001). This framework has enabled us to create consistent and sustainable improvements in patient safety.

Figure 1. HHS Patient Safety Model

Cornerstones, Connections and Caring



Intervention

Patient Safety Triads

Patient Safety Triads (PST) are unit- or area-based champions for patient safety. In clinical areas Triad members most often include a manager, a frontline staff member and a third member from the multidisciplinary team who is most often a physician. In service areas, membership includes a manager, a supervisor/leader and a frontline staff member. The configuration of the Triad membership ensures that the staff who provide care and work within the system, and those who have decision-making authority, are able to identify and address patient safety issues together.

When the Triads were developed, there was recognition that the diversity of areas represented might require customization of the structure. In this regard, two key considerations were suggested: (1) to ensure that a frontline staff member, who directly provided care to patients or service to support patient care, was part of the Triad and (2) to select opinion leaders who would enhance the strength of their team. At the time of this publication, there existed 91 Triads with more than 320 members.

In both clinical and service areas, PST members are identi-

fied as the “local point people” for patient safety, whose role is to develop an expertise in safety concepts, identify and manage local safety issues, assist with the spread of organizational safety initiatives, provide a connection between the frontline and the senior team and be a role model for patient safety culture.

The Patient Safety Networks were developed to support the Triad members in meeting these goals.

Patient Safety Networks

The Patient Safety Networks are comprised of multidisciplinary members from all hospital sites with a diverse mix of clinical and service area Triads. This type of interdisciplinary team development and communication has been shown to positively influence patient safety (Leonard, Frankel and Simmonds 2004). Due to the large number of Triad members, three Patient Safety Networks were developed to keep meetings to a manageable size and facilitate networking and group work. The Networks are coordinated and supported by the two Patient Safety Specialists.

The Networks meet once every two months for two hours, to communicate and share, develop patient safety expertise and obtain and provide support to further empower the members. “Change from learning is not an accidental event; there must be preparation, persistence and follow-up” (DiBella 2001).

Each Network meeting starts with an update of organizational patient safety initiatives and activities. There are opportunities for Triads to share successful initiatives and obtain ideas and support for challenges and barriers. Case studies of adverse events are presented, either by Triad members who have demonstrated the courage to share their own events, or as anonymous HHS case studies. Each case study is discussed to assess the system and human factor issues that led to the adverse event. This exercise assists in developing an open culture in which contributing factors and possible preventive measures are identified.

There is also a 30-minute “teaching moment” in which a specific principle of patient safety is presented, followed by group work applying the principles. Teaching moments include topics such as standardization, rapid tests of change, teamwork, change strategies and application of human factors principles in product acquisition and implementation.

At the end of each Network meeting, Risk Management, Pharmacy and Infection Control each present a five-minute synopsis of a key issue in their area.

Three additional strategies are used to enhance the effectiveness of the Triads and Networks. Every Network meeting is evaluated, and the feedback is used to develop future meetings. Also, the members are periodically asked to complete, before the next meeting, specific tasks related to patient safety. These simple tasks, which achieve easy wins, assist Triads that may be finding the work challenging. The third strategy is to provide, at each meeting, literature related to the teaching moment, which the Triads can use to create their own libraries of resources.

Discussion

The development of the Triads and Networks has created a framework of local accountability for patient safety with an infrastructure to support and continuously develop safety expertise throughout the organization. All four cornerstones of the patient safety model are supported within this framework.

Cornerstone: Culture of Patient Safety and Accountability

The formation of the Networks has further developed the culture of patient safety and local accountability within the organization. There are more than 320 individuals working together to lead patient safety improvement. Each area or unit has support and a clear process to address local patient safety issues. These areas and units are supported in their local work through the Networks. The Networks also identify trends in patient safety issues, which are then reported to the Patient Safety Steering Team.

Patient safety is hard work. The Networks provide an opportunity to share successes and struggles with colleagues within a comfortable safe environment and generate solutions for patient safety issues. The collaboration of disciplines, sites and clinical and service teams has created an awareness of and respect for the contribution that everyone within the organization makes to patient safety. The greatest accomplishment of the Networks has been the enhanced teamwork within and between disciplines, clinical and service areas and sites. "The strength of an integrated system is that its leaders can develop a framework for constant collaboration to occur. Safety requires collaboration amongst clinical groups and should be a goal of all those responsible for patient safety" (Frankel, Gandhi and Bates 2003: i33). The opportunity to develop relationships between areas and to understand the challenges faced by all parts of the team has been especially powerful.

Cornerstone: Measurement and Improvement

The open sharing and networking allows the Triads to share project work. For example, recently a project to improve the process for labelling of liquids on a sterile field was completed by diagnostic imaging in collaboration with perioperative services. Their work was presented to the Networks and has now engaged other areas faced with the same issue to adopt and learn from their project. A database of all Triad projects is maintained and made available to members, not only allowing them to learn from the experiences of others, but also to ensure that areas working on similar projects are able to connect and integrate their work.

Cornerstone: Education and Professional Development

The ongoing education and support within the Triads has created many experts in patient safety, who then share knowledge on their units and areas to further develop other staff.

The Networks offer a framework to access both internal and external resources. In addition, once a year the organization holds a day-long patient safety symposium for all the leaders at HHS. As recognized leaders in patient safety, all Triad members are included.

Cornerstone: Information and Communication

The Networks offer an opportunity to ensure access to information and sharing of organizational initiatives. Communication is often a big challenge in large organizations. To support this further, a bimonthly patient safety newsletter is disseminated to members, in a medium that readily lends itself to sharing within the units/areas.

Finally, the Networks provide a communication channel between frontline staff and leadership. Triad members attend "Patient Safety Leadership Walkarounds" with the senior leaders in their areas. This allows the leaders to be part of the dialogues with staff about patient safety. The Triads bring their concerns and challenges to the Networks, which are also communicated back to the Patient Safety Steering Team.

The Challenges

Three key challenges have been faced since the inception of the Triads and Networks in January 2005. The first is creating Network meetings that meet the needs of both clinical and service areas. This requires planning and reflection of the issues from multiple viewpoints. Often, due to the nature of the healthcare work, case studies are clinical in nature. Time must be taken to extrapolate their key principles and offer examples of how they apply to service areas.

The second challenge has been to engage physicians. Physician attendance at the Networks is limited, due to the time of the Network meetings and conflicting clinical commitments. While many physicians are engaged at the local level, their opportunity to network is limited. To address this, Triads have used different strategies: to tackle the key issues as seen by physicians, to integrate Triad meetings into existing meeting frameworks, and to collaborate with physicians in a consultative model whereby they provide input into initiatives and assist with creating support for these initiatives among their colleagues.

The third challenge has been to recognize the need for support and development of frontline leaders. Skills such as project management, quality improvement and change management require further support and education. These have been built into the planning of future Network meetings.

Lessons Learned

In November 2005, one year after the inception of the Networks, a "pulse check" was conducted with them to assess satisfaction with the current framework and determine opportunities for improvement. Members were asked to respond in small groups

to questions related to the Triads, the Networks and the organizational support for their roles.

Overall, the message was that the Triad members felt valued, excited and committed to their work. They also valued their Network meetings and felt the multidisciplinary, multisite model had created a more cohesive and collaborative approach across disciplines, programs/services and sites. The monthly evaluations of sessions were consistently rated as very good to excellent, and the areas most useful to the Triads were identified as the networking opportunities, the “teaching moments,” the tools learned, and the sharing of projects, challenges and adverse events.

To further develop the Networks five areas of opportunity were identified.

First was the need to revise the team structure of some Triads. For some unit and service areas, the three-person model was working extremely well. For some of the larger areas, members expressed the need to increase the size of the Triad to accomplish the work. Some unit/area Triads have now developed into groups of four to seven. As well, some Triads have identified the need to add the educator, recognizing his or her important role in implementation of initiatives in their unit/area. Other Triads have decided to remain as a core group of three and have ad hoc members for projects as appropriate.

The second area of opportunity developed as the number of Triads increased across the organization. The members of the initial 45 Triads had received training on the basic principles of patient safety and human factors. When Triads doubled to 91 within one year, the new members identified the need for education. Repeat education sessions have now been provided to all members to review or acquire core knowledge.

The third opportunity relates to variation in the expectations for Triads, and the level of support for time and resources. This issue is currently being addressed.

The fourth area was clarification of the Triads’ role as both “doer and communicator,” and this message has now been clearly discussed with the Triad groups, and suggestions of how to fill that role have been offered.

The final issue, raised during the “pulse check,” came as a surprise. The lack of support the Triads felt from their colleagues was almost universal. The Triads struggled daily with engaging their unit and area staff in their work. Multiple strategies and tools are presently planned to address this concern.

Conclusion

“For the healthcare industry as a whole to become highly reliable, organizations must move to a culture focused on safety” (Leonard, Frankel and Simmonds 2004: 32). The Patient Safety Triads and Networks have been a successful framework to enhance patient safety culture and to build local accountability for patient safety. Patient Safety Triad members identify

themselves as leaders in patient safety, and the growing number of improvement projects in progress has been impressive. Most importantly, ongoing collaboration in safety projects between and within programs has been evident. The commitment and excitement of the Triad members has been very inspiring, and it continues to gain momentum. The Networks continue to increase in membership, demonstrating an enhanced ownership, leadership and accountability for patient safety at HHS.

About the Authors

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