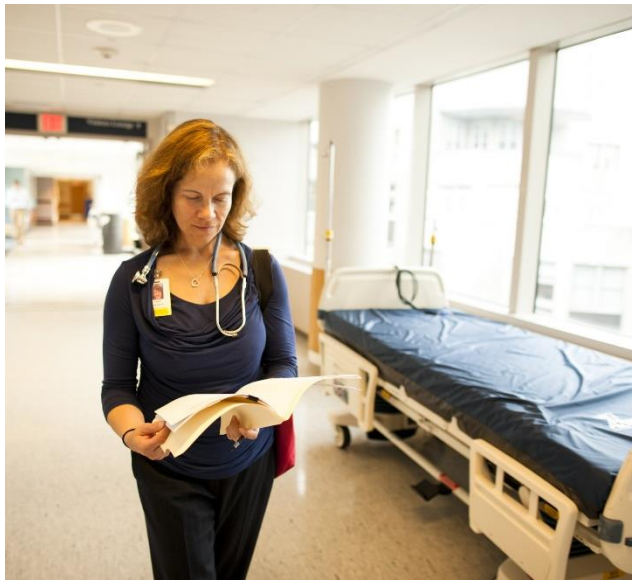

Walk This Way

Key Steps to an Effective Patient Safety Culture

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RAP: Risk Appraisal and Planning Process

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CRICO

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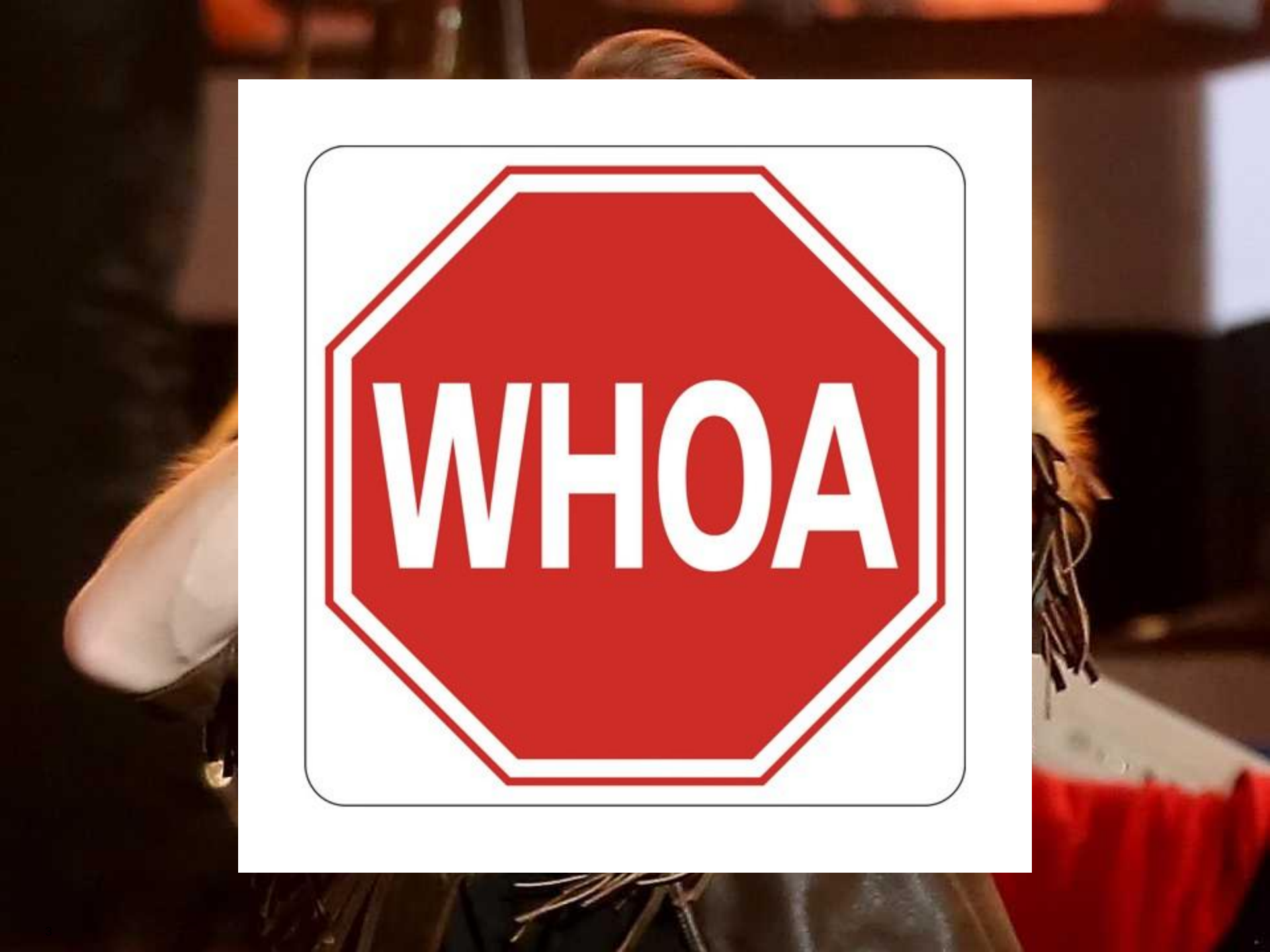
The Other Kind of RAP

Assessment of an organization's ability to recognize and respond to signals/vulnerabilities that put their patients and providers at risk


WHOA

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Maximizing the impact of patient safety efforts

Are your key initiatives having maximum impact on error management and patient safety outcomes?

Many organizations, despite significant focus and effort, are not achieving maximum impact from their risk management and patient safety programs

Consistent adoption of key risk and patient safety initiatives often varies from practice to practice, and across shifts, units, and departments

Many well-planned initiatives, once implemented, struggle for a consistent and/or long-term foothold in the day-to-day processes of staff and providers

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Maximizing the impact of patient safety efforts

Are your key initiatives having maximum impact on error management and patient safety outcomes?

A RAP is designed to identify the organizational barriers to consistent implementation
—and maximum impact—
of your patient safety programs and initiatives.

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A Model Patient Safety Profile

Organizational Readiness in Risk Detection and Response

An organization *best poised* to recognize and respond to risk has a well-developed **Patient Safety Profile.**

Potential data sources include:

- adverse events
- near misses / hazards
- RCAs, FMEAs
- patient complaints / satisfaction
- staff / safety surveys
- walk rounds
- quality indicators
- office assessments (OPE)
- malpractice claims
- outside assessment/ external review (RAP)

prioritize and resource patient safety initiatives

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The RAP identifies potential “gaps” between the current & desired state of a Patient Safety Profile

Potential gaps in...

- **Goals and progress**
  - Where the organization is and where it would like to be (relevant to patient safety)
  - Initiatives implemented and initiatives sustained
- **Intent and perception**
  - The message being sent (by leadership) and the message being heard (by providers/staff)
  - The statements and expectations “documented” and accountability to same
- **Data intelligence**
  - Data available and data analyzed
  - The indicators seen in the data and the (visible) focus and prioritization of interventions

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RAP Methods and Operational Details

Method	Operational Details
1. Conduct interviews with leadership and front line providers to: ○ Validate/correlate/ gain insight into practice and perspectives ○ Systematically investigate key themes	• 45 minute time slots • 1-3 days of consecutive interviews at each site • Interviewees benefit from invitation with information from leadership

2. Review available relevant data for correlation to:
○ Key areas of concern
○ Existing initiatives in quality, risk and patient safety
	• Will request from Org:
	  • Culture of Safety Data
	  • Adverse event, patient complaint data etc...

3. Synthesize findings, development of recommendations ○ Validation between interviewers	• May result in request for additional interviews
4. Prepare summary of findings and recommendations ○ Deliverables: Written report and presentation	• 2-hour onsite presentation to key stakeholders, interviewees

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Structure

Defines clear processes and forums for unfettered communication of risk / patient safety information across departments / the organization

- **Integrates Quality, Risk, & Patient Safety leaders and initiatives**
- **Provides means for consistent, bi-directional communication of safety events / signals**
- **Designs committee / meeting structure for consistent sharing of concerns / solutions**

Interviewers look for the following:

- Are risk and safety leaders structurally aligned for collaboration?
- Are there structural barriers to information sharing across departments that limit the ability to view the full scope of safety/risk data signals?
- Does organizational accountability adequately extend into the ambulatory and office practice environments?
- Is there an expectation – and a means for – bi-directional communication, i.e., is there recognition and follow-up to reporters?
- Is there a forum for consistent sharing of critical information (e.g. aggregated adverse event data, generalized RCA findings) across clinical services, for both shared learning and shared interventions?

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Culture

Integrates a “fear free” patient safety mindset across the organization and into the daily practice of all services

- **Patient safety is an integrated / visible component of the everyday business**
- **Values / rewards event/hazard reporting and learning via feedback and sharing**
- **Experienced consistently at all levels by all providers / employees**

Interviewers look for the following:

- Is there active evidence of an open and just culture focused on patient safety?
- Are there concerns about discussing or reporting errors or near misses? If so, how does this concern “play out”? What are the barriers to speaking up?
- Is the vision of patient safety evident in the day-to-day activates of the clinical departments? (I.e., Is patient safety as a “mindset” promoted in everyday activity?)
- Is there ready translation of daily challenges as “SIGNALS” of vulnerability?
- Is there recognition of the value in reporting risk-related information / data?
- Is there clear role delineation and a process for escalation of issues when needed? Are teamwork behaviors evident?

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Leadership

Promotes the organization's commitment to patient safety and provides visible support of and resources to drive action

- **Ensures the focus on patient safety is actively evident at all levels**
- **Provides support / resources to ensure consistent focus on safety goals**
- **Drives the use of data as resource for intervention and decision-making**

Interviewers look for the following:

- Is there a consistent focus on patient safety from the top down?
- Does leadership drive mission and tone of organization's commitment to patient safety at ALL LEVELS?
- Is it visible across the organization? (E.g. Walkrounds, focus groups)
- Does leadership ensure the culture is promoted/supported by all levels of management?
- Is there accountability for supporting initiatives borne out of reporting?

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Data-driven Patient Safety Agenda

Proactively uses data to identify, trend, prioritize and resource patient safety initiatives

- **Data drives safety initiatives**
- **Integrates all available data sources in to decision making / action plans**
- **Aligns patient safety initiatives with signals and information found the data**

Interviewers look for the following:

- Is there a process to receive and analyze relevant data for continuous identification hazards or vulnerabilities in the delivery of patient care?
- Is there an organizational ability to disseminate and act on that knowledge?
- How organized and effective is the use of data (multiple data sources) for prioritizing actions across the organization?
- How well does the organization leverage its captive insurer for guidance /perspective on prioritizing key risks? Is the relationship as healthy as it could be?
- What short-term metrics can be identified that can help the organization know—in a more predictive fashion -- whether its overall malpractice profile is starting to improve?