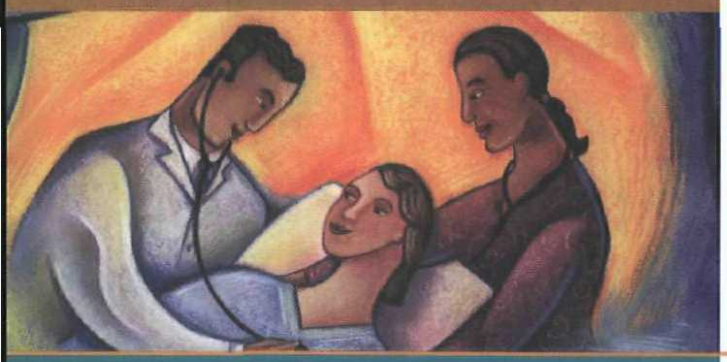

Putting Safety at the Core

A St. Louis–Based System Launches a Campaign to Transform Its Culture

BY LYNETTE BALLARD
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Patient safety is a much-discussed topic in today's health care. *To Err Is Human: Building a Safer Health System,* the groundbreaking 2000 report from the Institute of Medicine (IOM) threw a spotlight on the issue as nothing had done before.[1] The IOM reported that from 44,000 to 98,000 Americans die each year as a result of medical errors.

Since publication of the IOM report, there has been little room for denial of the problem but much room for excuses. Adverse events and "near misses" events occur every single day at hospitals throughout the country. "American health care operates with levels of unreliability, injury, waste and just plain poor service that long ago became absolutely unacceptable in many other industries," says Donald Berwick, MD, a Harvard pediatrician and president/CEO of the Institute for Healthcare Improvement (IHI), a leader in the patient safety movement.[2] On any given day, the public can read newspaper stories about catastrophic errors in health care.

It is time to regain the trust of patients and families. Sisters of Mercy Health System (Mercy), St. Louis, is stepping forward to do precisely that with an initiative to put patient safety at the forefront of concerns and to connect patient safety to every facet of Mercy operations.

"Do No Harm"

Americans have become increasingly fearful of the risky environments they encounter when they seek care. In 2004, Robert M. Wachter, MD, and Kaveh G. Shojania, MD, published *Internal Bleeding: The Truth Behind America's Terrifying Epidemic of Medical Mistakes.*[3] Their book recounts and analyzes numerous tragic medical mistakes and calls upon everyone in health care to attack the epidemic of medical mistakes with better systems, more training, and more resources. In an appendix, the authors urge patients to protect themselves by becoming well-informed health care consumers.

For Catholic health care, patient safety is both a systems issue and a theological issue.

From ancient times, a physician's oath has been to "first, do no harm." The *Ethical and Religious Directives for Catholic Health Care Services* remind those of us who serve Catholic health care that "health care professionals pursue a special vocation to share in carrying forth God's life-giving and healing work."[4] There is a sacred trust between health care providers and those they serve. "The person in need of health care depends on the skill of the health care provider to assist in preserving life and promoting health of body, mind and spirit."[5] Br. Daniel P. Sulmasy, OFM, MD, PhD, paraphrasing Gabriel Marcel, writes, "A patient is not a problem to be solved, but a mystery in whose presence the clinician is privileged to dwell."[6] Patients are not objects to be manipulated and processed through a health care system; they are human beings containing the spark of the divine.

For Catholic health care, patient safety is both a systems issue and a theological issue. We say that our health care ministries are based on "our Savior's concern for the sick" and on Gospel accounts of Jesus' compassionate acts of healing. Ultimately, our ministry is a sign of the reign of God—compassionate, holistic, and inclusive. In our work, we are meant to touch the human spirit and to give hope and healing and maintain a high awareness of the sacredness and dignity of human life. However, we don't always remember that. And our failure to remember sometimes shows itself in small ways. For example, the language we use in referring to patients may lead us to be less conscious of their dignity, as when they are referred to by diagnosis (rather than by name) or as units of production. Careless terminology about patients is a step toward conditions in which harm can occur.

Toward a Culture of Safety

As part of its effort to improve the quality of patient care, Mercy has joined a number of national efforts, including the Hospital Quality Alliance (which focuses on data collection and reporting), the National Quality Forum (which focuses on the development of quality and safety measures), and the 100,000 Lives Campaign sponsored by the IHI.

Mercy has sponsored several programs, each of them highly complex and requiring intensive dedicated resources, to improve patient safety. All have shown promising results.

- "Mercy Meds," for example, is an effort aimed at preventing medication errors by bar-coding medications and involving pharmacists more fully in the delivery of patient care.
- "Mercy Alerts" are internal information bulletins aimed at sharing errors and near misses, the goal being to track high-risk processes and pursue improvements in these processes.
- The "Genesis Project" is a commitment to improve and simplify work processes, both clinical and nonclinical, through information technology. "Genesis" includes computerized physician order entry (CPOE) for ordering medications from the pharmacy.

These efforts are not merely a matter of numbers. Mercy has committed itself to the creation of a deeper *culture of safety*—an environment in which safety is the first priority of every person in the system, both clinical and nonclinical: staff members, physicians, volunteers, and boards. Judy E. Borland, MD, medical director, medical information, St. Joseph's Mercy Health Center, Hot Springs, AR, has made the case for culture change:

SUMMARY

To create a deeper culture of safety—an environment in which safety is the first priority of every person in the system—Mercy Health System, St. Louis, has launched a variety of safety and quality initiatives.

In September 2005, Mercy began an effort to develop blame-free environments in which the reporting and gathering of data can lead to improvements in patient safety. Mercy's top executives attended Mercy's annual Pathways Leadership Development event in October and November 2005 to discuss the moral and theological imperatives for building a culture of safety.

Mercy's leaders addressed six stumbling blocks that have impeded progress toward a culture of safety: production demands and time pressures, absent or inadequate processes, failure to focus on process problems, poor teamwork, inadequate communication, and fear and pride. They have identified five key elements that should enhance patient safety: improved leadership, reporting systems, measurement, best practices, and a supporting structure. For Mercy, the safety initiative is not just about policy change; it's about cultural transformation.

In health care, we often see people at their worst. A patient (or a loved one) is ill or injured, and both the patient and family members are worried, frightened, and in an unfamiliar environment. Mercy's goal is to help our patients and keep them safe—do no harm. The organization's challenge is that we work in a complex, constantly changing, and often hectic environment. Keeping our patients safe requires constant attention to our work processes with double-checks, good communication, teamwork, critical thinking, and some information technology solutions. To keep our patients safe, we need the help of all our co-workers.

Ronald B. Ashworth, Sisters of Mercy Health System's president/CEO, noted that the system has taken a number of steps to identify areas of risk, change work processes, and implement technology to provide a safer environment for patients. But more work remains to be done, he said.

Ashworth inaugurated the system's latest safety initiative September 9, 2005, by convening a patient safety conference that was attended by 200 Mercy leaders. The featured speaker was James P. Bagian, MD, director of the U.S. Department of Veterans Affairs's (VA's) National Center for Patient Safety. A former astronaut and investigator for the National Aeronautics and Space Administration, Bagian now applies his expertise to the creation of safe health care systems. He argues for the establishment of blame-free environments in which the reporting and gathering of data can lead to improvements in patient safety. Testifying before a Senate subcommittee several years ago, he noted that "the health care system punishes providers without giving them the tools to improve patient safety. . . . An overreliance on punitive accountability systems is a major stumbling block to improvement because it does not encourage identification of potential problems and provides disincentives for reporting."[7] A blame-free culture, in which confidentiality of reporting enables a safety system to be effective, is a major Mercy goal.

The "Pathways" Session

Safety was the focus of the October and November 2005 sessions of Mercy's annual Pathways Leadership Development event (Pathways is the system's leadership-development program). The two-day sessions, which were attended by all top Mercy executives, emphasized the moral imperative for building a culture of safety in which the overriding priority is to prevent harm to the patient.

Sr. Mary Roch Rocklage, RSM, chair of Mercy's Sponsor Council, and Brian O'Toole, PhD, Mercy's vice president of mission and ethics, addressed the meeting, discussing the moral and theological case for building a culture of safety. That case, they noted, is built on Mercy's core values of dignity, justice, service, excellence, and stewardship, supported by Scripture and Catholic social teaching.

O'Toole asked participants to think about professional and cultural mind-sets—which he called the "shadow side of professionalism"—that can sometimes interfere with safe practices of care. O'Toole noted that professionals tend to be set apart from other people by virtue of their specialized knowledge and expertise and the social good that results from their work. For centuries, he said, physicians have been selected and trained to perform independently, to make judgments and to exert their authority with little or no room for questions, except by peers. Hospital employees know that medical authority is traditionally hierarchical, flowing from physicians to nurses and other trained professionals and finally to workers with the least formal training.

Teamwork is impaired, O'Toole said, when each level of the hierarchy automatically defers to the level above it, never calling it into question. He noted that workers with little authority tend to be addressed by their first names, while those

Brian O'Toole, PhD, talked about what he called the "shadow side of professionalism."

MERCY'S PRAYER FOR PATIENT SAFETY

O God,
we believe that we abide
in the shelter of your wings,
and that you hold us
in the palm of your hand.
Our patients, who come to us sick and injured,
entrust themselves to our care.
May we be to our patients, O God,
as you are to us.
May they abide safely
in the shelter of our wings,
may we hold them carefully
in the palms of our hands.
Amen.

with more authority are addressed by title. In such an environment, mistakes are perceived as *personal* failures, O'Toole said. Depending on the severity of the mistake, the individual experiences shame and even ostracism.

The "shadow side of professionalism" negatively affects communication, teamwork, and accountability, O'Toole said. Is it any wonder, then, that patient safety is compromised? If health care is to have a culture of safety, people who work in health care must be transformed, O'Toole said. They must come to see themselves in a new light, in relationship to one another. They must communicate differently and hold each other accountable in different ways for different things, O'Toole said. Health care must drop blaming and, instead, emphasize shared responsibility for secure and safe processes and procedures that are respected and followed.

Care is "the active, effective concern for the well-being of another or others," said Sr. Roch (as she is affectionately known), referring to a recent journal article on patient safety.[8] The essence of patient safety, its very core, "is about dignity and respect," she said. Caregivers must be in right relationship with one another and with patients and families if they are to care for others safely. Genuine care requires respect for the dignity of the patient. Caregivers must never violate the dignity of the person or the trust that the person has in the caregiver. Safety in health care, Sr. Roch said, "is a system of right relationships that facilitate and sustain the commitment to being and doing what is right between and among individuals, departments, and institutions." Justice sustains the culture of safety.

The first of the Ten Commandments admonishes people to love God and to reject all false gods. O'Toole said that patient safety in U.S. health care has been compromised by the near-worship of the "false gods" inherent in its hierarchical systems and by outmoded, fixed mind-sets about "the way we do things in hospitals." Caregivers should have a covenant relationship with patients patterned on the Hebrew Scripture story of God's love for people and the inherent dignity he bestowed on humankind. In ancient times, "covenant" was a relationship, exemplified by Abraham and his descendents, between a powerful entity and weaker or more vulnerable one, O'Toole noted. The prophets insisted that, to be in right relationship with God, people had to be in right relationship with one another—the strong taking care of the weak, the widowed, and the orphaned. Caregivers are to treat vulnerable people the same way that God has promised to care for all humankind.

In a recent article, Sr. Juliana M. Casey, IHM, STD, PhD, and Richard F. Afable, MD, noted that a distinction exists between a *contract* (a transaction with finite boundaries and responsibilities) and a *covenant* (an agreement, a promise, and a gift that have deeper meaning).[9] The covenant is the proper model for health care—"the healing work of Jesus taught to us in the Gospels," Sr. Juliana and Afable maintain. Jesus personified the ancient covenant, saying that whatever people do to the least of our brothers and sisters, they do to him. In health care, we carry out the healing ministry of Jesus and live out our covenant with God.

All who attended the Pathways sessions said they felt they were a great success. At the end of the two days, Mercy's leaders returned home to launch patient-safety campaigns at their own facilities. Octavio R. Chirino, MD, physician executive for OB/GYN, St. John's Mercy Medical Center, St. Louis, said, "Until the IOM report, we were aware of safety problems, but we didn't appreciate the magnitude of the problem. Then we felt powerless in the face of the problem. Now we are seeking to find the right tools for change."

Ronald B. Ashworth, the system's CEO, identified six "stumbling blocks."

Stumbling Blocks to Progress

Ashworth recently identified six stumbling blocks in health care that in the past have impeded progress toward a culture of safety.

Production Demands and Time Pressures Such pressures are common in chaotic and complex environments in which shortages of space, equipment, and skilled professionals are realities; and interruptions and distractions can lead to inattention and errors. Time pressures and demands for productivity and efficiency can result in "things slipping through the crack."

Absent or Inadequate Processes Because of various pressures, processes that should be improved are instead ignored or "worked around." This increases the chances that mistakes will occur. In a high-pressure environment, processes can be undermined by hierarchical thinking and lack of accountability.

A Failure to Focus on Process Problems When process problems are overlooked, people tend to indulge in fault-finding and blaming—which are detrimental to a culture of safety. In most cases, medical errors are the result of flawed processes in which several factors contribute to a breakdown of safety.

People who work in health care *want* to do the

right thing for patients. Unfortunately, some health care processes are susceptible to mistakes. Add to this susceptibility a tendency to find fault and place blame (which is part of American culture), and we can see why errors and near misses are reported at low rates. To improve flawed processes, one must have accurate data and an analysis of events. Mercy intends to focus on what happened, why it happened, and what is needed to prevent the error or near miss from reoccurring.

Poor Teamwork A lack of teamwork can only contribute to a chaotic environment. Seasoned health care professionals are highly aware of the forces that prevent teams from working together safely. Caregivers are often overwhelmed by hierarchical thinking and fearful of challenging the actions of physicians and others in authority. The environment lends itself to autonomous decision making, rather than collaborative problem solving. Divisions of care operate like silos, encouraging people to protect their "turf" and refuse to share accountability for errors that arise out of the complex reality of shared patient care.

Inadequate Communication Weak listening skills and fear of reprisal lead to underreporting of errors and near misses. In a health care organization that has not developed good communication and a reporting process that generates action for improvement, patients will continue to suffer from the same mistakes.

Fear and Pride Fear and pride tend to combine in a way that can obscure one's view of reality. In particular, pride of accomplishment and fear of blame and exposure inhibit professionals from asking for help and questioning judgments. When professionals fail to depend on—and work trustingly with—one another, communication breaks down, leading to mistakes and harm for patients.

Five Key Elements

According to Ashworth, five key elements will distinguish the Mercy safety initiative: leadership, reporting systems, measurement, best practices, and a supporting structure.

Leadership To create a culture of safety, a strong and accountable leadership will be absolutely indispensable, for safety is the foundation for quality. Leaders will work together to create an environment that is conducive to safety, that clearly and relentlessly communicates the message "Do no harm." Leaders need to be actively and visibly involved in the culture of safety. They must:

- Focus on creating new and better processes to ensure patient safety
- Develop goals that are meaningful and measurable
- Seek out "best practices" to implement
- Empower physicians and other staff members to create and support change and take risks
- Celebrate successes

Through the safety initiative, leaders will create a *just culture*, a blame-free environment in which it is understood that most errors are the result of inadequate processes. In such a culture, it is recognized that all people make mistakes and that processes cannot be improved by blaming individuals. In seeking to create a just culture, in which fear of punishment does not suppress the reporting of adverse events and near misses, the VA has defined truly blameworthy actions and set policy accordingly. Blameworthy occurrences are acts involving alcohol or substance abuse on the part of the care provider, acts committed intentionally by a person who is conscious of acting unsafely, or criminal acts.[10] For other adverse events, in which these conditions do not apply, the VA holds processes responsible.

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Reporting Systems A just culture puts people in right relationship with one another, so that they function better as teams and communicate in a way that protects patients from harm. Mercy is creating a culture that encourages and supports the reporting of all adverse events and near misses, in order for analysis and process correction to occur. Data will be collected through a single reporting process for the entire system. In addition to the reporting tools already available, new resources will be dedicated to the monitoring of adverse events. A prioritization system will determine which, and in what order, adverse events and near misses warrant further analysis and action. To address near misses as well as actual adverse events, Mercy will increase the practice of as "root cause analysis" (RCA) to determine the factors that allowed the occurrence. Mercy CEOs will personally sign off on RCA recommendations. RCA data will be monitored at the system level, enabling the system's top leaders to set priorities.

Measure "What Matters" Measurement is crucial because it shows where Mercy is making progress and where further improvements can be made. In the Pathways meeting, participants were charged with measuring "what matters" in order to improve the culture of safety. "Often we think of things in regard to how they affect the budget, when we really should be asking ourselves how they affect safety," said Bernard Duco, Jr., JD,

the system's senior vice president/general counsel. "We need to deliberately set expectations about safety and measure our performance on a regular basis."

Having researched advances being made by, among others, the Johns Hopkins Center for Innovation in Quality Patient Care, the VA, and the 100,000 Lives Campaign, Mercy is determined to identify effective actions and adopt them for its own use. The system will implement both near-term and long-term measures, beginning with national evidence-based quality measures, safety outcome measures, and responses to recommendations made as a result of RCA and systemwide prioritization. In the future, Mercy will make use of evidence-based order sets (treatment order sets, categorized by diagnosis and based on reviews of current medical literature) and will be able to respond to alerts and reminders from software systems now being developed as a part of the Genesis Project. By building automatic alerts and reminders into technology and developing CPOE, Mercy will make processes safer and reduce human error.

In addition, Mercy will measure employees' perceptions of the system's culture of safety, through surveys similar to those being used by Johns Hopkins and the VA. In October 2005, St. Joseph's Mercy Health Center piloted a patient safety survey of staff members.

"Best Practices" Mercy intends to employ a wealth of "best practices" at both the local and system level. For instance, models developed for the aviation industry for teamwork training and communications will be applied. Mercy's leaders realize that, although the tools are available, it will take time and a strong sense of purpose to "hard wire" their practice in the day-to-day delivery of care.

Structure Service is an important Mercy value, and safety is at the core of service. Safety, service, and quality are bound together in this strategic initiative. The importance of safety will be reflected in organizational structure and agendas.

Pathways participants acknowledged the many challenges to patient safety improvement. Some noted that employees must be involved in solutions to safety problems. Martin J. Bell, MD, chief of staff, St. John's Mercy Medical Center, St. Louis, observed that the system must improve teamwork. "Teamwork is related to staff stability and turnover," he said. "Constant turnover is to be avoided. We need to enhance work life on areas where there is high turnover."

"We need to listen better [to the patient], no matter how many time pressures we are under," said Ashworth. Borland observed that the airline industry has not compromised in applying safety standards consistently. "In health care, we must stop compromising and succumbing to pressure," he said. "We cannot be satisfied as things now stand in health care. Our attitudes must change and our blinders must come off."

"It's not about writing new policies," said Mark Stauder, executive vice president/chief operating officer, St. John's Mercy Medical Center, St. Louis. "It's a cultural transformation." ■

NOTES

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