Commitment to Quality and Safety Is Part of Catholic Health Care's Mission

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Health care has long espoused a commitment to quality. Evidence of the pursuit of quality has been framed across a continuum involving the implicit to the explicit — from a historical and presumed obligation within professions to an understanding of it as an emerging science requiring new and specific skills.

Although there are multiple definitions of what quality actually looks like, from both patient and provider perspectives, there is general consensus that it incorporates dimensions that include acceptability, accessibility, appropriateness, effectiveness, efficiency, equity, and perhaps most important, safety.[1]

Patient safety — and elimination of preventable harm — has become its own area of emphasis, and for good reason, based on an abundance of evidence. The word *iatrogenesis* comes from the Greek and means "brought forth from a healer"; iatrogenic illness therefore encompasses the suffering patients endure in adverse events such as hospital-acquired infections, pressure injuries, incorrect medications or doses, wrong site surgeries and other incidences. These circumstances profoundly impact those we serve and those who serve. And so for the Catholic health care ministry — steeped in a mission of service — the language of quality and patient safety must also be part of our vocabulary and accountability.

Fulfilling this accountability requires an honest and critical examination of the performance of mission and the expectations of quality and patient safety to understand the relationship between them. We need to make courageous and intentional efforts to identify and address blind spots — those places where we may tell ourselves that we are a mission-inspired culture or excelling in quality and patient safety, when this may not always be true. Embracing the intentionality and discipline required to continuously improve should be part of our mission.

Culture is fragile and is affected by many things, including significant stress. Crises, such as the current COVID-19 pandemic, can reveal the gaps between espoused values and values that seem more expedient for the situation at hand. For example, the challenge of living our mission when we had to restrict visitors to our facilities had undeniable impact on patients and families. We knew the standard of care was strained in cancelling elective surgeries and other ambulatory procedures to free up critical bed space. On the other hand, those crises served as opportunities for learning and improvement and can often show the best of who we are.

While such morally difficult decisions arise from necessity, crises should not serve as a shield to excuse our response in navigating the many issues we routinely face. Our commitment to mission, quality and patient safety will be influenced by economic and political drivers, regulatory pressure, disruptive behavior, social justice and other population health needs. How we navigate such issues reveals an organization's true colors.

By aligning mission and quality in an organi-

zation's consciousness, we are more apt to communicate a compelling message that mutually reinforces our commitments. Initiatives targeted to improve quality and patient safety should draw on the moral and ethical imperatives of our mission, which call us to take risks and be vulnerable for the sake of another; mission, too, benefits from the critical thinking, rigor and methodology of quality standards — particularly patient safety science — that improve performance and engagement.

We have inspirational messaging that speaks to our mission, but it's ultimately when we translate these as calls to action for improved quality and safety that real change occurs. And as we process the things that are revealed to us, our mission imperative will compel us to confront our quality and patient safety data, even when it is not expedient. There are no shortcuts.

We make the same connection in selecting candidates for all teams and departments, and in particular with new staff. For example, every two weeks, the authors present back-to-back, one-hour blocks of time in our orientation program. The first session introduces new staff to our mission, values, vision and ethical tradition, including the legacy of our founding congregations. The second session leads participants into a fulsome understanding of our commitment to patient safety and quality. We reference each other's key messages, underscoring the inherent relationship between mission, quality and patient safety that is foundational to our identity as a Catholic organization.

Other mechanisms are used to reinforce this message: patient safety reviews, mission formation programs, and throughout our COVID-19 response, in which being successful in one domain is contingent upon success in the other.

Consider for a moment the experience of suffering. As a ministry of the Catholic Church, our mission calls us to respond to those who are marginalized and vulnerable. The example of the Good Samaritan was used to frame the *Health Ethics Guide* in Canada precisely because Jesus' directive to "go and do likewise" was not optional.[2] It is an ethical and moral imperative that defines our very identity and sets Catholic health care apart from other service providers whose found-

BUILDING A CULTURE THAT SUPPORTS MISSION, QUALITY AND PATIENT SAFETY

To better understand the challenges inherent in shaping a culture that supports mission, quality and patient safety, it is worth exploring what they have in common. Three things come to the fore:

- **"We Already Do This":** Health care is populated by people who care about the welfare of others and who want to do their best. This is something to recognize and be proud of. But it can lead to the assumption that quality and patient safety are therefore inherently assured and need no further exploration. Mission can suffer from this as well; we are a Catholic organization and therefore "everything is mission." The truth is that mission, quality and patient safety (and many other domains) cannot be evaluated simply on how we feel about our care; they require deliberate technique, good data, action and study.
- **Disbelief in Suboptimal Performance:** Tied to the first point, mission, quality and patient safety can suffer from a love/hate relationship with the concepts of compliance and commitment, and specifically with evaluation. When standards are met or exceeded, people are likely to think it is automatic verification — proof of what they knew all along, without knowing why. Likewise, when data shows that performance is less optimal, people are prone to believe the methodology was wrong, or worse yet, look for bad actors, rather than consider the system as the reason.
- **Overemphasis on Symbolism:** Symbolism is important, but don't mistake the symbols of things for the things themselves. Mission is not merely a masthead on corporate documents; it must be present in our actions, choices and decisions. In the highly accountable realm of health care, swift but reactionary issues of management can be taken as a proxy for quality. Mission, quality and patient safety each contain subjective as well as objective elements. Unless those definitions and elements are clear and agreed upon, symbols can be confused with more substantive content, analysis and investment.

ing stories differ from ours. Like other health service organizations, we are committed to fiscal stewardship and savvy business acumen, but ultimately ours is a ministry that sees suffering as something to which we must respond, even if it is not convenient, lucrative or beneficial.

As we know from the world we live in, suffering takes many forms. There are many poverties evident to us as we care for those in need. One form of suffering is that of suboptimal care, in which adverse events can cause harm.

Responding to this awareness calls upon the philosophical and practical or technical acumens of mission, quality and patient safety. Mission is a response to the recognition of unmet need, and calls us not only morally, but also practically, because compassion felt in the heart and acted upon with the hands is powerful healing.

Quality and patient safety also have moral components, and the actions of care play a technical role in analyzing, ameliorating and ultimately reducing incidents of suffering that result from incomplete and failed attempts to care for those in need. Near misses, adverse events and deviations from standards of practice all can result in harm to our patients and residents. We have no business remaining in health care if we cannot provide care equal to, or greater than, the local governmental health care authority.[3]

The Japanese have a term "Kaizen," which is often referenced in literature when discussing continuous improvement in quality.[4] There are many translations, but perhaps one of the more poetic is "repent and enhance." We believe that the pursuit of mission, quality and patient safety are aligned to this concept. Repentance requires more than acknowledging the harm done and apologizing for the wrongdoing or error. It also demands intentional effort to identify the contributing factors that led to the damage and being accountable for mitigating preventable harm in the future.

In mission terms, we might describe repent and enhance as *metanoia*, a turning around. Like St. Paul falling off his horse, this honest examination of our behavior and earnest commitment to see ourselves for who we really are in relation to another is ultimately a moral enterprise. Quality and patient safety data, along with regular systems review, inform such examination of conscience. Mission responds to the learning and insight that emerge to send us forth.

For example, in 2018 we discovered a potential patient safety issue regarding operating room air exchanges at one of our hospitals. Questions and discussion crossed the spectrum: Are there building system issues? Are there equipment and building system calibration issues? Who is accountable? Was monitoring not done? How widespread is this type of concern in the industry? Are the standards themselves based on the most current infection control and other data? And, importantly, disclosure: How will we talk to patients about this?

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The investigation and disclosure process to patients and families was complex, inviting significant legal, financial and public exposure. In principle, everyone understands the necessity to disclose and take corrective action to prevent harm in the future. Most organizations have a policy for disclosing issues to the public. But the very process at arriving at that decision point can involve tension and differences of opinion regarding acceptable levels of risk.

This type of tension regarding disclosure was known and named several years earlier when the authors wrote Covenant's original disclosure policy. We didn't rely solely on the literature support and evidence from the quality and patient safety world. As important as this is, our departure point was the interpretive lens of mission and the sound methodology of our mission discernment process. This integrative approach between mis-

sion and quality reinforced the commitment to transparency and clearly identified the distribution of ethical obligations within the complexity of multiple competing priorities.

The work of quality and patient safety is messy, complex and multifactorial. Earlier forays into quality in health care tended to focus on 'soft' skills or explored more philosophical concepts, but patient safety has since become a *bona fide* discipline, based in engineering, psychology and medicine. Reviews require detailed environmental and human factor analysis, understanding of cognitive biases, organizational and individual behavior, process mapping and proper contextualization of statistical data. Findings need to be shared internally, and often externally, to mitigate future occurrence in our organization or the broader world of health care. This cannot be biased by pressure from board, senior teams, risk managers, politicians or funders who are nervous about what the evidence will show.

We also recognize that there will be some interpretation of data that could lessen or heighten the sense of culpability. System issues rightly require a systems approach that does not place the entire burden of accountability on individuals alone. Our mission that upholds a holistic view in health care of body, mind and soul reinforces that we equally need to bring a thorough systems review, too.

How do we improve the broader world of health care with our learning? In addition to the insights we gain from our specific reviews, Dr. Donald Berwick of the Institute for Healthcare Improvement maintains there are moral determinants of health that must factor in our quality reviews.[5] Often this is manifest in stories. Berwick uses the language of solidarity, which is language familiar to, but not monopolized by, Catholic health care. Quality and patient safety, understood as a moral enterprise driven to reduce suffering, certainly requires compassion, but it also requires rigor, science and demonstrated willingness to shift long-standing practices to prevent future harm. This requires change management, strong leadership and board and senior team expectations to drive organizational performance.

Our COVID-19 response illustrates this integrated and mutually reinforcing approach to mission and quality. Covenant, like most health care organizations faced with unprecedented impact by the pandemic, constantly needed to adjust its practices in keeping with both the latest scientific evidence of viral spread and exposure. It also had to use detailed review and continuous improvement techniques to understand outbreaks. And it has been critical that our mission and values shape the overall narrative in the face of real and perceived public and staff health risks, and that our organizational voice and our responsibility

What can leaders do in order to ensure the areas of mission and quality are not only kept front and center, but also lived, in a Catholic health care organization?

- **Realize Purpose:** The ultimate aim of Jesus' healing ministry is to bring hope and healing and to reduce suffering. The mission of Catholic health care is intimately tied to this core purpose. The pursuit of patient safety, which is a key element of quality, is a lived example of this purpose. Eliminating harm that is preventable not only optimizes care, it is a demonstration of the care and concern we have for those we serve. To continuously improve our practice based on data, learning and engagement is an important part of the ministry.
- **Dedicate Resources and Acknowledge Risk:** A positive attitude, belief in values and the desire to provide the best care goes a long way. But bringing the mission alive and achieving increased performance in quality and safety does not happen simply through faith. Leaders must dedicate resources (including time for honest reflection and evaluation) to this pursuit. Examination involves risk; you must have courage to move forward in areas that are controversial, and you must build and support your teams to do the same.
- **Apply Critical Thinking and Technique:** Mission, quality and patient safety are not just about how we feel, nor are they convenient shields to protect us from uncomfortable truth. They need to be viewed with both ideology and methodology in mind. Believing in them is important, but the practice of actual technique and implementation of change are necessary for an organization to flourish.

We must remember that being a witness to suffering requires utmost attention and respect. Suffering haunts the caring heart, but it is also the catalyst that restores brokenness.

were maintained. Under federal and provincial health legislation in Canada (e.g., Public Health Act), although the Chief Medical Officer of Health has the authority to direct public health emergencies, organizations cannot shift away their responsibilities.[6]

Covenant Health's responsibilities have been to follow the legally binding orders, which included sensitive topics like visitor restrictions, but also to ensure that we keep front and center the moral and mission-based calling to care. And to reduce the suffering caused through the burdens of isolation that many patients and residents have experienced. Further still, to help families understand why this was required and what we could do to support communication through other creative, virtual means. Our mission of service and compassion compelled us to find ways to respond despite the restrictions and ever-changing dynamic.

Likewise, our mission compelled us to mitigate and reduce suffering given the risk of occupational exposure we faced, whether actually or potentially. The long hours and trying conditions in which our clinicians worked only elevated the risk of an adverse event. Solidarity, understood as an expression of both our mission and our quality and safety commitments, required us to respond to the suffering our staff experienced, as well as to what they feared might happen.

Our commitments required us to provide staff with timely, accurate information, with safe personal protective equipment, sleep rooms and food. It was also important for leaders to have the courage to support teams when things went wrong. Outbreaks can be exacerbated through errors, as we have all learned in the pandemic, and there have been multiple quality improvement efforts in reviewing these.

The act of living our mission and giving the highest quality of care is ultimately an act of love. But genuine love involves compassion and kindness. It also involves risks – the risks of seeing suffering, the risks of error, the risks of courage and authenticity, and the risk of forgiveness given and grace received from those we care for and with each other. We must remember that being a witness to suffering requires utmost attention and respect. Suffering haunts the caring heart, but it is also the catalyst that restores brokenness. We live our mission and improve quality and patient safety when we serve, when we continuously learn, and when we transform ourselves, our organizations and our systems.

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NOTES

1. See, for example, https://www.ahrq.gov/talkingquality/measures/six-domains.html or https://www.hqca.ca/about/how-we-work/the-alberta-quality-matrix-for-health-1/.
2. The *Health Ethics Guide* is the Canadian equivalent of the *Ethical and Religious Directives for Catholic Health Care Services. Health Ethics Guide*, Catholic Health Alliance of Canada, 3rd edition. Ottawa, 2012. See, for example, the introductory reflection on the Good Samaritan at http://chac.ca/ethics/Health%20Ethics%20Guide_2013.pdf.
3. Francis G. Morrisey, "What Does Canon Law Say About the Quality of Sponsored Works," *Health Progress* 88, no. 2, March-April, 2007, 10-11.
4. Lean production and kaizen, https://www.leanproduction.com/kaizen.html.
5. Donald M. Berwick, "The Moral Determinants of Health," *JAMA*, published online June 12, 2020, https://jamanetwork.com/journals/jama/fullarticle/2767353.
6. See https://www.alberta.ca/office-of-the-chief-medical-officer-of-health.aspx.

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