Safety, Quality, Experience
Adventist Health Mendocino Coast

Adventist Health

CMS National Quality Strategy

CMS Patient Safety Structural Measures

Domain 1: **Leadership Commitment to Eliminating Preventable Harm**	Domain 2: **Strategic Planning & Organizational Policy**	Domain 3: **Culture of Safety & Learning Health Systems**	Domain 4: **Accountability & Transparency**	Domain 5: **Patient & Family Engagement**
• Prioritization of safety starting at the top • Safety as a core value, with timely and regular communication/review of events to leadership • Adequate resource allocation to patient safety	• Strategic plan, public commitment to safety • Metric-based equity initiatives • Just culture, with dedicated patient safety curriculum and competencies • Workplace violence action and improvement plan	• Regular culture of safety survey • Dedicated team to conduct event analysis • Patient safety dashboard • High-reliability practices • Large-scale learning network participation	• Confidential safety reporting system • Events, near misses and precursors reported to PSOs • Safety metrics tracked and reported to all staff • Defined communication and resolution program following harm (e.g., CANDOR) with performance monitoring measures	• Patient and family advisory council with diverse, representative participation • Comprehensive, patient access to medical records, clinician notes (with accommodation as needed) • Incorporation of patient and caregiver input on safety events, issues • Support for family/caregiver engagement as part of the care team

High Reliability Organization

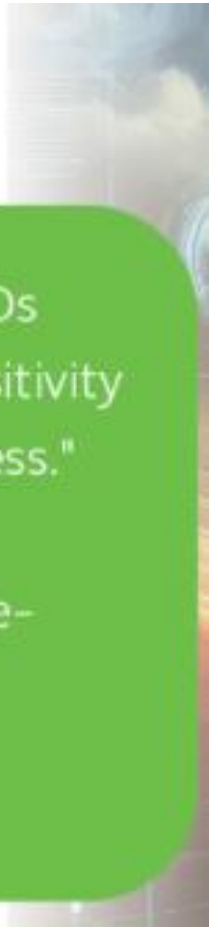
A High Reliability Organization is defined as ‘organizations that operate under very trying conditions all the time yet manage to have fewer than their fair share of accidents’. *Managing the Unexpected: Sustained Performance in a Complex World; Weick, K., Sutcliffe, K. 2015.*

High Reliability Organization

ANTICIPATION

Sensitivity to Operations

Based on their understanding of operational complexity, people in HROs strive to maintain a high awareness of operational conditions. This sensitivity is often referred to as "big picture understanding" or "situation awareness." It means that people cultivate an understanding of the context of the current state of their work in relation to the unit or organizational state- (ie., what is going on around them) and how the current state might support or threaten safety.



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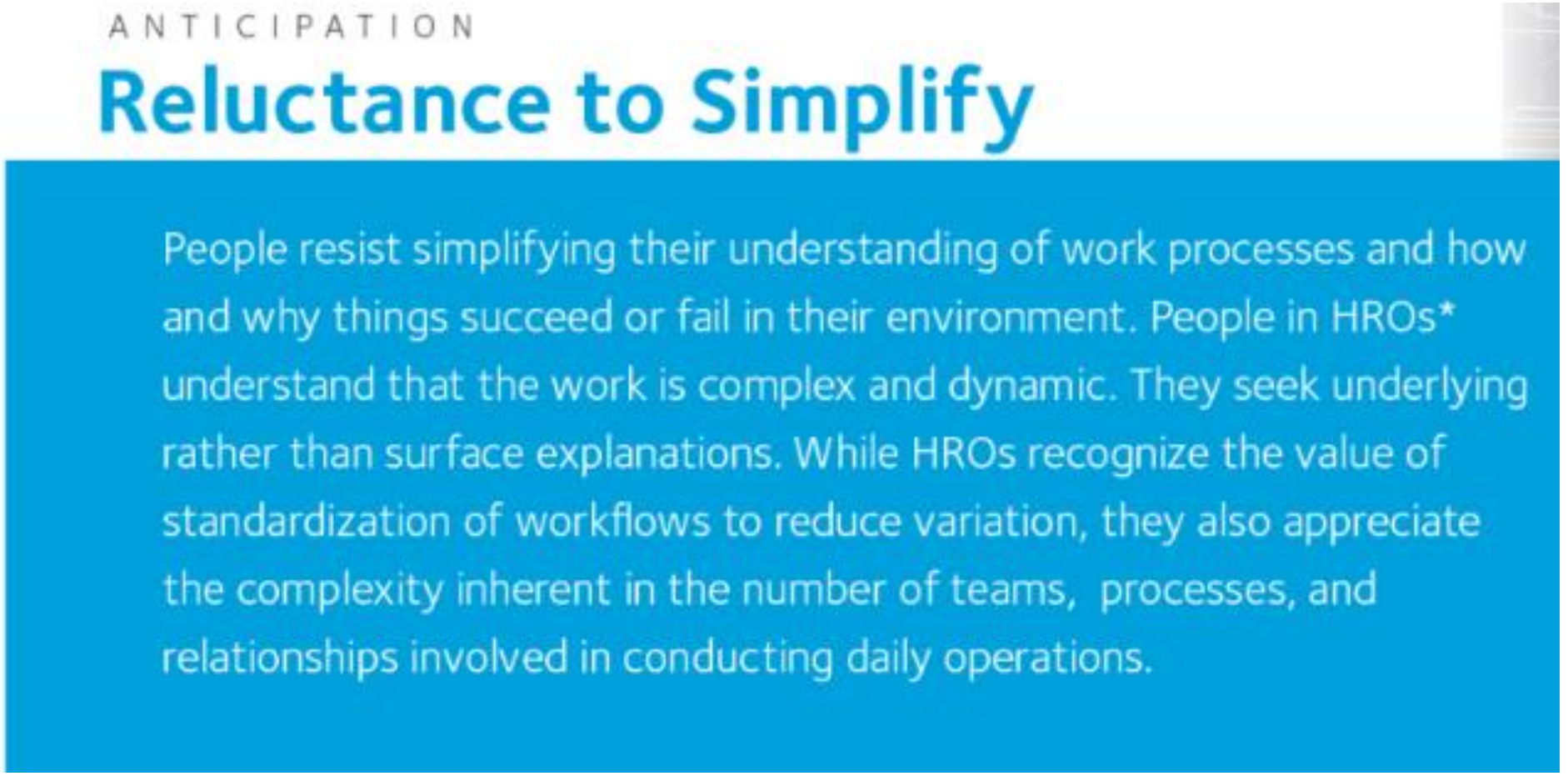

Just Culture

Creating a safe environment

- Recognition that many errors are caused by a breakdown in systems not individuals.
- When error does occur, we carefully consider potential system causes and intentions of those involved.
- Shared accountability where individuals are accountable for their choices, team members are accountable for supporting each other and leaders are accountable for designing more reliable systems.
- A Just and Accountable Culture is one where we trust each other, set clear expectations, improve our systems, hold ourselves accountable, **and feel safe to raise concerns**.

Daily Safety & Quality Improvement Work

- Daily Safety Huddles
- Fall prevention program
- Daily tactics to avoid infection, and other complications of being in hospital
- Safe patient mobility- training on equipment and promotion of activity
- Workplace Violence Prevention Program
- Medication safety – technology
- Faster diagnosis with virtual health and diagnostic software
- Medication Education Cards for Patients
- Nurse Leader Rounding on patients daily
- Bedside Safety Report
- Patient/Family Advisory Council