

Safety, Quality, Experience

Adventist Health Mendocino Coast

CMS National Quality Strategy

Promote Transparency

Provide individuals, families, and caregivers with more safety information, in a format they can understand, to make informed decisions about where they seek care. Give providers the necessary feedback and data to eliminate preventable harm

Updated Publicly Reported Quality Measures

Advance Safety Culture Through Partnership

Collaborate and actively engage patients, providers, health care organizations, federal partners, states, and other partners to empower patient voices, implement systemic changes, and eliminate disparities in patient safety

Health Disparities: Measures and Requirements

Incentivize Zero Harm

Drive health care leadership and governing bodies to make safety a priority and eliminate preventable harm.

Patient Safety Structural Measure

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
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Regular culture of safety survey • Dedicated team to conduct event analysis • Patient safety dashboard • High-reliability practices • Large-scale learning network participation 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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.

High Reliability Organization

CONTAINMENT

Deference to Expertise

People in HROs appreciate that the people closest to the work are the most knowledgeable about the work. Thus, people in HROs know that in a crisis or emergency the person with greatest knowledge of the situation might not be the person with the highest status and seniority. Deference to local and situation expertise results in a spirit of inquiry and de-emphasis on hierarchy in favor of learning as much as possible about potential safety threats. In an HRO, everyone is expected to share concerns with others and the organizational climate is such that all staff members are comfortable speaking up about potential safety problems.

High Reliability Organization

ANTICIPATION

Preoccupation With Failure

Everyone is aware of and thinking about the potential for failure. People understand that new threats emerge regularly from situations that no one imagined could occur, so all personnel actively think about what could go wrong and are alert to small signs of potential problems. The absence of errors or accidents leads not to complacency but to a heightened sense of vigilance for the next possible failure. Near misses are viewed as opportunities to learn about systems issues and potential improvements, rather than as evidence of safety.

High Reliability Organization

CONTAINMENT

Commitment to Resilience

Commitment to resilience is rooted in the fundamental understanding of the frequently unpredictable nature of system failures. People in HROs assume the system is at risk for failure, and they practice performing rapid assessments of and responses to challenging situations. Teams cultivate situation assessment and cross monitoring so they may identify potential safety threats quickly and either respond before safety problems cause harm or mitigate the seriousness of the safety event.

High Reliability Organization

ANTICIPATION

Reluctance to Simplify

People resist simplifying their understanding of work processes and how and why things succeed or fail in their environment. People in HROs* understand that the work is complex and dynamic. They seek underlying rather than surface explanations. While HROs recognize the value of standardization of workflows to reduce variation, they also appreciate the complexity inherent in the number of teams, processes, and relationships involved in conducting daily operations.

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

