

Road Map to a Safety Culture

For Patients, Residents, and Clients



Getting Started

Specific Action(s)	Audit Questions
<p>1. Secure endorsements and resources for the culture effort.</p>	<p>1a. The organization's governing body endorses the organization's involvement in the MAPS Safety Culture Campaign.</p> <p>1b. The governing body approves an interdisciplinary steering committee to oversee the strategic plan for assessing and improving the organization's patient safety culture. (may utilize existing quality/safety committees)</p> <p>1c. The steering committee reports to leadership/administration.</p> <p>1d. The patient safety culture plan has a designated senior leadership sponsor.</p> <p>1e. The patient safety culture plan has a designated coordinator.</p> <p>1f. The coordinator has designated time to serve in this coordination role.</p>
<p>2. Develop a safe culture steering committee.</p>	<p>The steering committee includes at a minimum:</p> <p>2a. Leadership/administration</p> <p>2b. Physicians</p> <p>2c. Nursing</p> <p>2d. Direct care staff</p> <p>2e. Human resources</p> <p>2f. Safety/quality lead</p> <p>2g. Patient/family member</p> <p>2h. Other steering committee members are added as appropriate (e.g. board member, risk management).</p> <p>The committee has a structured process in place to:</p> <p>2i. Regularly review patient safety data/information</p> <p>2j. Identify patient safety gaps</p> <p>2k. Prioritize areas to address</p> <p>2l. The oversight committee commissions interdisciplinary work groups to address priority issues, including work on the roadmap domains.</p>
<p>3. Identify patient safety culture champions.</p>	<p>Patient safety culture champions are identified for the organization and include the following disciplines:</p> <p>3a. Governing body</p> <p>3b. Non-nursing health professionals</p> <p>3c. Direct care nursing</p> <p>3d. Human resources</p> <p>3e. Legal counsel/risk management</p> <p>3f. Physicians</p> <p>3g. The roles of the culture champions are well-defined.</p>
<p>4. Provide education on patient safety principles and practices during orientation.</p>	<p>Patient safety practices and principles (e.g. safe system design, a just environment, patient safety definitions) are included in orientation for:</p> <p>4a. Senior leaders</p> <p>4b. Governing body</p> <p>4c. Physicians</p> <p>4d. Managers/Supervisors</p> <p>4e. Staff</p>

Continued

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5. Conduct an organizational safety culture assessment.	<ul style="list-style-type: none">5a. The organization conducts a patient safety culture survey.5b. Senior leaders set clear expectations for staff and physician participation in patient safety culture assessment.5c. The organization reviews and selects additional culture data from collection tools appropriate to the organization, (e.g. employee engagement assessment, patient/resident satisfaction, physician engagement assessments.)5d. Additional related data sources (e.g. claims data, mortality reviews, near miss and event reports, global trigger tool data) are reviewed as appropriate5e. A process is in place to perform initial assessment on the current status of key quality measures such as CMS Compare Data, MN Statewide Quality Measures, falls and pressure ulcer rates as appropriate to the setting.
6. Analyze assessment results and develop action plans.	<ul style="list-style-type: none">6a. A process is in place to analyze the patient safety culture assessment and other related data to identify safety culture trends and gaps.6b. The steering committee reviews data results and identifies strengths and opportunities.6c. The steering committee develops a plan to prioritize and address improvement opportunities.6d. The organization prioritizes and selects the culture roadmap domains for focused work based on culture survey and other culture data results. <p>The following key stakeholders are engaged in a dialogue to provide feedback and help finalize action plans for each domain (Communication, Justice, Teamwork, Learning, Engagement):</p> <ul style="list-style-type: none">6e. Direct care staff6f. Department leaders6g. Physician/clinician leaders6h. Staff members6i. Medical staff members6j. Governing body6k. Executive administration

Road Map to a Safety Culture

For Patients, Residents, and Clients



Leadership

Specific Action(s)	Audit Questions
<p>1. Set clear expectations for patient safety — <i>governing body/board</i></p>	<p>The governing body/board is engaged in, and sets clear expectations for the organization's patient safety culture through:</p> <ol style="list-style-type: none"> 1a. Including patient safety in the organization's mission and goals. 1b. Setting clear expectations for the physician role in patient safety culture. 1c. Patient safety is a standing board agenda item at every board meeting (e.g. patient safety data, sharing of adverse event findings, OHFC reports). 1d. Patient stories are shared at board meetings on a regular basis. 1e. CEO/executive leader(s) incentives (e.g. compensation/recognition/tenure) are tied to performance measures, such as audited patient safety best practices, rather than number of adverse outcomes.
<p>2. Set clear expectations for patient safety — <i>executive administration</i></p>	<p>The facility's CEO/administration sets clear expectations for the organization's patient safety culture through:</p> <ol style="list-style-type: none"> 2a. Engaging senior leaders in supporting the implementation of the facility's patient safety plan. 2b. Prioritizing and incorporating the goals identified by the steering committee in measures and goals for the organization. 2c. Assigning the resources required to achieve the patient safety goals for the organization. 2d. Regularly communicating the organizational vision and key strategies/goals for improving patient safety culture. 2e. Including stories of individuals affected by an adverse event occurring at the facility, in addition to patient safety data, at senior leadership and middle-management meetings. 2f. Communicating information about patient safety events and near misses (e.g. types and number of events and learnings) that occur within the facility to all staff on a regular basis. 2g. Tying clinical and department leader incentives (e.g. compensation/recognition/tenure) to performance measures, such as audited patient safety best practices, rather than number of adverse outcomes. 2h. Providing resources for clinician leaders to receive training and education on how to provide support and leadership to other clinicians.
<p>3. Set clear expectations for patient safety — <i>clinical and department leaders (e.g. medical executive committee, nursing leadership committees)</i></p>	<p>The facility's clinical and department leaders set clear expectations for the organization's patient safety culture through:</p> <ol style="list-style-type: none"> 3a. Regularly discussing safety updates and asking for safety ideas and concerns during performance reviews with direct reports. 3b. Regularly discussing safety updates and asking for safety ideas and concerns during departmental meetings. 3c. Providing resources for direct care staff members to help develop the actions plans to respond to safety ideas and concerns identified for their unit. 3d. Establishing clear policies and procedures for patient safety processes. 3e. Establishing a feedback mechanism for staff to convey barriers to following established policies and procedures. 3f. Establishing a standard process for addressing identified barriers. 3g. Regularly communicating the organizational vision and key strategies/goals for improving patient safety culture. 3h. Including stories of individuals affected by an adverse event occurring at the facility, in addition to patient safety data, at clinical staff/department meetings. 3i. Communicating patient safety events and near misses (e.g. types and number of events and learnings) that occur within the facility to clinical/department staff on a regular basis. 3j. Supervisor/manager incentives (e.g. compensation/recognition) are tied to performance measures, such as audited unit-level patient safety best practices, rather than number adverse outcomes.

Continued

Road Map to a Safety Culture

For Patients, Residents, and Clients



Leadership

Specific Action(s)	Audit Questions
4. Set clear expectations for patient safety — <i>physician leaders</i>	<p>Physician leaders set clear expectations that physicians will foster a patient safety culture through having processes in place to:</p> <ul style="list-style-type: none">4a. Provide physicians with on-going organizational clinical performance data on quality and safety indicators.4b. Engage physicians early on in establishing the key quality and safety initiatives for the organization.4c. Select physicians to lead and or participate in key performance improvements and participate in key safety and quality committees.4d. Provide time allowance and compensation for physician leadership and participation as appropriate.4e. Establish key responsibilities for physicians in promoting a safety culture.4f. Report to administration on a regular basis the progress on safety culture and safety work, including barriers to success.4g. Establish key physician behaviors that denote those of a safety culture.4h. Establish a code of conduct policy that clearly defines acceptable behavior, unacceptable behavior, and consequences for policy violations.4i. Establish clear processes that assure accountability in following organizational safety protocols and practices. <p>The facility has a process in place to engage physicians in patient safety through:</p> <ul style="list-style-type: none">4j. Performing initial and on-going assessment of physician engagement utilizing assessment tools (e.g. Physician Engagement Degree of Difficulty Factors).4k. Recruitment of a core group of medical staff leaders to work on identified engagement issues/barriers.4l. Creating avenues to listen to and address physician concerns on an on-going basis.4m. For settings with medical students and residents, providing ongoing support and coaching related to safety practices.4n. Engaging physicians in the development of metrics that will be used to drive improvements.4o. Identifying, when applicable, the evidence-based support for improvement projects and process changes.4p. Having a structured process in place for coaching physicians in understanding the system approach to safety practices.4q. Recognizing physicians for successes.

Continued

Road Map to a Safety Culture

For Patients, Residents, and Clients



Leadership

Specific Action(s)	Audit Questions
<p>5. Set clear expectations for patient safety — <i>supervisors/managers</i></p>	<p>The facility's supervisors/managers set clear expectations for the organization's patient safety culture through:</p> <ul style="list-style-type: none">5a. Regularly discussing safety updates and asking for safety ideas and concerns during performance reviews with direct reports.5b. Regularly discussing safety updates and asking for safety ideas and concerns during department/unit meetings.5c. Engaging direct care staff in developing and prioritizing the actions plans to respond to safety ideas and concerns identified for their unit.5d. Establishing clear strategies for implementing policies and procedures for patient safety processes at the unit-level.5e. Establishing a feedback mechanism for staff to convey barriers to following established policies and procedures.5f. Establishing a standard process for addressing identified barriers.5g. Establishing a standard process for updating staff on policy/process changes.5h. Establishing an auditing process (both documentation and observational) to identify "drift" of established policies and processes5i. Regularly communicating the organizational vision and key strategies/goals for improving patient safety culture.5j. Including stories of individuals affected by an adverse event occurring at the facility, in addition to patient safety data, at staff meetings.5k. Communicating patient safety events and near misses (e.g. type, number of events, learning) that occur within the facility to staff on a regular basis.
<p>6. Assess Safety Competencies</p>	<ul style="list-style-type: none">6a. The facility includes specific safety competencies in job descriptions across the organization6b. Leaders partner with human resources in the development of job position descriptions6c. Safety competencies are relevant to the job duties of the individual.6d. Written safety competencies are objective, measureable and updated as needed.6e. A process is in place to utilize an interdisciplinary team of healthcare providers to assess the safety competencies needed in the organization.6f. The team utilizes findings from safety culture data to identify and prioritize the core safety competencies.6g. A process is in place to identify and address gaps between expected and existing levels of competency.

Road Map to a Safety Culture

For Patients, Residents, and Clients



Communication

Specific Action(s)	Audit Questions
<p><i>Effective Process Improvement (EPI) Work Plan</i></p>	<ol style="list-style-type: none"> 1. The steps for identifying a specific action plan and measure of success for Communication are completed. 2. The work group has devised a structured implementation plan for Communication. 3. Structured roll-out strategies for Communication are in place. 4. A plan is in place to sustain implementation progress and spread of Communication.
<ol style="list-style-type: none"> 1. Establish structured communication tools. 	<ol style="list-style-type: none"> 1a. The facility has structured communication tools, (e.g. Situation, Background, Assessment, Recommendation [SBAR]), for communication at all levels of the organization. 1b. The facility has tools to assist staff/physicians in conversations involving differing opinions, intense emotions, and when the stakes are high. 1c. Staff and physicians are educated in the use of the communication tools. 1d. The facility provides simulation/role play training for clinicians working within high-risk processes, (e.g. OR, medication, transitions across settings, involving use of critical language and conflict resolution.) 1e. Periodic audits are conducted to assess implementation of the communication tools.
<ol style="list-style-type: none"> 2. Develop a structured hand-off process. 	<p>A structured hand-off process is in place throughout the organization with specific elements outlined that must be included for hand-offs:</p> <ol style="list-style-type: none"> 2a. During shift-change 2b. Between departments/units 2c. To other facilities
<ol style="list-style-type: none"> 3. Establish a “stop the line” policy. 	<p>The facility has established a clear process for speaking up and “stopping the line” which includes:</p> <ol style="list-style-type: none"> 3a. Clearly communicated expectation to speak up if staff suspects that a patient may be at-risk for harm. 3b. Clear language indicating that staff will be supported by administration in stopping the line and speaking up – even if they are wrong. 3c. Sample language for stopping the line. 3d. A clear process for stopping the line and chain of command to follow if staff are not supported in stopping the line at each level.

Road Map to a Safety Culture

For Patients, Residents, and Clients



Justice

Specific Action(s)	Audit Questions
<p><i>Effective Process Improvement (EPI) Work Plan</i></p>	<ol style="list-style-type: none"> 1. The steps for identifying a specific action plan and measure of success for Justice are completed. 2. The work group has devised a structured implementation plan for Justice. 3. Structured roll-out strategies for Justice are in place. 4. A plan is in place to sustain implementation progress and spread of Justice.
<ol style="list-style-type: none"> 1. Support a culture that is Just. 	<ol style="list-style-type: none"> 1. The organization's senior leadership formally supports a culture that is Just by adopting the MAPS statement of support.
<ol style="list-style-type: none"> 2. Engage key stakeholder groups in a Just process. 	<ol style="list-style-type: none"> 2a. Education is provided on the key Just principles, such as system design and recognition of at-risk and reckless behavior, for senior leaders, managers, human resources, all health care providers and students. 2b. Managers/supervisor/leaders with direct report responsibility are educated and trained on the application of the established process to evaluate and respond to staff behavioral choices. 2c. The organization identifies and engages key external stakeholder groups, such as unions, through early discussions for key projects and process changes to promote collaborative efforts/common expectations/understanding.
<ol style="list-style-type: none"> 3. Incorporate Just principles in policies and processes for human resources. 	<ol style="list-style-type: none"> 3a. A structured process is in place to assist managers in evaluating staff behavioral choices. 3b. A structured process is in place outlining responses to at-risk or reckless staff behaviors (e.g. coaching/mentoring vs. disciplinary action). 3c. The process to evaluate staff behavioral choices focuses on the behavior rather than the outcome of the behavior. 3d. The process to evaluate staff behavioral choices includes a balanced focus on system design and individual behavioral choices. 3e. Job descriptions incorporate Just principles in outlining behavior expectations and the organization's response to behavior issues. 3f. Just principles are incorporated in employment/practice agreements (e.g. physician code of ethics/behaviors, labor agreements). 3g. Human Resources is involved in incorporating Just principles in human resources processes.
<ol style="list-style-type: none"> 4. Just principles are incorporated into the Root Cause Analysis and Peer Review Process. 	<ol style="list-style-type: none"> 4a. A process is in place to communicate to staff involved in a root cause analysis that the RCA session will focus on systems vs. individual behavior. 4b. A system is in place to support physicians and employees that have been involved in an adverse event, (e.g. facility provides opportunities for peer-to-peer counseling.) <p>Just principles are incorporated into the peer review process including, at a minimum:</p> <ol style="list-style-type: none"> 4c. A process is in place to communicate to individuals involved in peer review that the organization follows a Just approach, (e.g. focus includes evaluation of error related to system issues as well as individual accountability.) 4d. System issues versus individual disregard for following protocol or policy are identified. 4e. Decisions are based on Just principles. 4f. There is a process to develop actions to address identified system issues and address individual behaviors that may denote reckless behavior.

Continued

Road Map to a Safety Culture

For Patients, Residents, and Clients



Justice

Specific Action(s)	Audit Questions
5. Just principles are incorporated into clinical practices.	5a. A process is in place to identify and communicate at-risk and reckless behavioral choices, as appropriate, for clinical practices, (e.g. not conducting a Time-out prior to a non-emergent invasive procedure would be considered reckless behavior.) 5b. Policies and procedures outline clear expectations for staff behavioral choices. 5c. Each situation is reviewed to determine at-risk or reckless behavioral choices vs. human error.
6. Just principles are hardwired throughout the organization.	6a. Management/front-line supervisor meeting agendas routinely include actual and mock case studies that demonstrate application of Just principles to respond to employee issues. 6b. A standard process is in place to identify and report instances of reckless and at-risk behavior including disruptive behavior. 6c. A standard process is in place to review and respond to reckless/at-risk/disruptive behavior reports. 6d. Individuals are acknowledged and celebrated for “speaking up” about possible patient safety issues or disruptive behavior. 6e. Case studies involving application of Just principles are routinely reviewed at medical staff executive committee meetings and at department/service line meetings.

Road Map to a Safety Culture

For Patients, Residents, and Clients



Learning

Specific Action(s)	Audit Questions
<p><i>Effective Process Improvement (EPI) Work Plan</i></p>	<ol style="list-style-type: none"> 1. The steps for identifying a specific action plan and measure of success for Learning are completed. 2. The work group has devised a structured implementation plan for Learning. 3. Structured roll-out strategies for Learning are in place. 4. A plan is in place to sustain implementation progress and spread of Learning.
<ol style="list-style-type: none"> 1. Develop a robust system of data-gathering that can improve patient safety and quality. 	<ol style="list-style-type: none"> 1a. The facility has a system in place for reporting safety events that do reach the patient/resident. 1b. The facility has a system in place for reporting near misses and other patient safety concerns. 1c. Processes are in place to encourage and reward staff/physicians for reporting (e.g. include mention in performance evaluations, acknowledgement from senior leadership). 1d. Processes are in place to assess barriers to safety event data-gathering (e.g. system difficult to access, reporting format too time consuming to complete). 1e. A process is in place to capture and utilize patient safety data from sources beyond reports (e.g. global trigger tool, claims, mortality reviews). 1f. CEOs gather data by conducting rounds that involve seeking input from staff and physicians. 1g. Physicians are an integral part of rounding (e.g. leading rounds, contributing safety concerns). 1h. Leaders frequently round within their departments. 1i. A process is in place to ensure patients/residents/clients/families members contribute input during rounding. 1j. A process is in place to ensure multidisciplinary staff members contribute input during rounding. 1k. A process is in place to prioritize and act upon input gathered during rounding.
<ol style="list-style-type: none"> 2. Use evidence-based <i>prospective</i> analysis methods to identify potential failures in care. 	<ol style="list-style-type: none"> 2a. Evidence-based, standard analysis methods are in place (e.g. failure mode and effects analysis — FMEA) to proactively analyze at least one potentially high-risk area/topic annually. 2b. Team members conducting proactive analyses have received training. 2c. The facility has set clear expectations that staff and physicians are required to participate in analysis sessions when needed. 2d. The facility has a process in place to communicate to staff that an analysis session is: <ul style="list-style-type: none"> • A safe, confidential process • Designed to identify process breakdown; not assign blame. 2e. A process is in place to prioritize and act upon issues identified during the analysis.

Continued

Road Map to a Safety Culture

For Patients, Residents, and Clients



Learning

Specific Action(s)	Audit Questions
3. Use evidence-based <i>retrospective</i> methods of analysis to identify root causes of problems or events.	<p>3a. Evidence-based, standard analysis methods are in place (e.g. root cause analysis) to retrospectively analyze problems.</p> <p>3b. The facility has established criteria for when an analysis needs to be conducted.</p> <p>3c. At a minimum, an analysis is conducted for adverse events that result in death or serious injury to a patient/resident and for any other event where an analysis is required by law.</p> <p>3d. The analysis requires explanation for each human error and at-risk behavior.</p> <p>3e. Team members facilitating analyses have received training.</p> <p>3f. The facility has set clear expectations that staff and physicians are required to attend analysis sessions when needed.</p> <p>3g. The facility has a process in place to communicate to staff that an analysis is:</p> <ul style="list-style-type: none">• A safe, confidential process• Designed to identify process breakdown; not assign blame. <p>3h. A process is in place to prioritize and act upon issues identified during the analysis.</p>
4. Develop solutions/action plans and monitor progress.	<p>4a. A designated person (role) has the authority and resources to require and support the implementation of action plans.</p> <p>4b. The facility has a standard process in place for tracking progress on action plans put in place.</p>
5. Share what is learned.	<p>5a. A process is in place to provide feedback to staff on actions taken in response to their reports.</p> <p>5b. A process is in place to regularly share patient safety success stories throughout the organization.</p> <p>5c. A process is in place to share lessons learned from events and alerts about potential patient safety threats with appropriate entities inside and outside of the organization (e.g. within units, across units, with similar departments outside the facility).</p>
6. Spread solutions/action plans.	<p>6a. A process is in place to identify other units and departments that may benefit from implementing action plans/solutions.</p> <p>6b. Department staff members/physicians have access to de-identified data, analyses, and action plans/solutions in order to customize action plans/solutions to their own environments</p>

Road Map to a Safety Culture

For Patients, Residents, and Clients



Teamwork

Specific Action(s)	Audit Questions
<i>Effective Process Improvement (EPI) Work Plan</i>	<ol style="list-style-type: none"> 1. The steps for identifying a specific action plan and measure of success for Teamwork are completed. 2. The work group has devised a structured implementation plan for Teamwork. 3. Structured roll-out strategies for Teamwork are in place. 4. A plan is in place to sustain implementation progress and spread of Teamwork.
1. Determine readiness to engage in teamwork efforts.	1a. The facility has completed an internal site assessment to determine organization readiness to move forward with their teamwork efforts.
2. Recruit and train teamwork facilitators.	<ol style="list-style-type: none"> 2a. The facility has recruited unit-based clinicians as teamwork instructors. 2b. Training is provided for teamwork instructors.
3. Train team members.	3a. Training is provided for all team members.
4. Assess gaps in teamwork.	<p>4a. Teams/units/departments use a structured assessment to assess their teamwork gaps.</p> <p>Teamwork areas assessed include, at a minimum:</p> <ol style="list-style-type: none"> 4b. Psychological safety 4c. Mutual respect 4d. Constructive conflict resolution 4e. Responses to disruptive behaviors 4f. Communication practices 4g. Individual and shared accountability 4h. Team role definition, including leader roles
5. Establish site/specific teamwork/communication work plans.	<ol style="list-style-type: none"> 5a. Teams/departments develop site-specific work plans to address identified gaps. 5b. The work plan is implemented. 5c. Dedicated coaching time is provided to teamwork instructors, team members, providers and the team as a whole.
6. Re-assess gaps to ensure training has successfully addressed them.	<ol style="list-style-type: none"> 6a. Teams/departments use a structured assessment to reassess their teamwork environment after training. 6b. Results are utilized to adjust plan as needed and celebrate positive outcomes.
7. Align hiring, training, and performance standards with teamwork goals.	<ol style="list-style-type: none"> 7a. Teamwork is included in orientation and ongoing unit training. 7b. Clear statements are included in the medical staff rules and regulations and in the code of conduct that identify teamwork as a critical, required behavior.

Road Map to a Safety Culture

For Patients, Residents, and Clients



Patient/Resident/Client and Family Engagement

Specific Action(s)	Audit Questions
<p><i>Effective Process Improvement (EPI) Work Plan</i></p>	<ol style="list-style-type: none"> 1. The steps for identifying a specific action plan and measure of success Engagement are completed. 2. The work group has devised a structured implementation plan for Engagement. 3. Structured roll-out strategies for Engagement are in place. 4. A plan is in place to sustain implementation progress and spread of Engagement.
<ol style="list-style-type: none"> 1. Solicit patient/resident/client & family input. 	<ol style="list-style-type: none"> 1a. A process is in place to evaluate how to involve patient/resident/client /families in key committees performing safety & quality work.
<ol style="list-style-type: none"> 2. Empower patient, resident, client & families to be informed and voice their concerns. 	<p>Processes are in place to:</p> <ol style="list-style-type: none"> 2a. Ensure easy access for patient/resident/client and families to paper and electronic medical records. 2b. Encourage and enable patient/resident/client /families to “Stop the Line” (e.g. halt a procedure/care process, such as a medication administration), if they believe that an error is about to occur. 2c. Regularly encourage and enable patient/resident/client /families to speak up in all decisions about their health care (e.g. a Speak Up campaign). 2d. Ensure patient/resident/client /family ability to participate in relevant team discussions (e.g. rounds, care conferences, etc.) 2e. Guide staff in how to empower patient/resident/client /families in reporting safety concerns. 2f. Report back to families who have shared safety concerns. 2g. Provide written materials that help families provide feedback on their experiences (e.g. patient/resident/client experience surveys) in the primary languages spoken by families.
<ol style="list-style-type: none"> 3. Effectively disclose unanticipated outcomes. 	<p>A policy is in place to promptly inform families when something unanticipated occurs and includes, at a minimum:</p> <ol style="list-style-type: none"> 3a. Direction on who should apologize to patient/resident/client /families and how that apology should occur. 3b. A process for disclosing to, and updating, patient/resident/client /families as the error is reviewed and analyzed. 3c. Direction on how to involve families in the event investigation when their involvement can help identify causes of the error. 3d. Staff members receive training on when and how to disclose. 3e. A designated person is available to provide support and just-in-time training to staff members who are about to disclose an error to a patient/resident/client/family.

Continued

Road Map to a Safety Culture

For Patients, Residents, and Clients



Patient/Resident/Client and Family Engagement

Specific Action(s)	Audit Questions
4. Supports patient/resident/client understanding of health care information.	<ul style="list-style-type: none">4a. A comprehensive, regularly updated plan is in place to improve patient/resident/client understanding of health care information.4b. The plan includes goals for clarifying spoken and written communications.4c. Patient/resident/client /family education, forms, and documents are regularly assessed for clarity, readability, accuracy, and availability.4d. A process is in place to assess patient/resident/client /families' understanding and deliver messages in a way that best responds to their needs.4e. A comprehensive, regularly updated plan is in place to improve staff members' cultural and linguistic competency.4f. A process is in place to regularly analyze cultures and populations in the organization's demographic area.4g. Staff members receive education on the cultures/populations they care for and cultural resources that can help them provide culturally competent care.4h. Processes are in place to ensure patient/resident/client /families easy access to interpretive services.
5. Define expectations around service standards.	<ul style="list-style-type: none">5a. Service standards (e.g. a set of desired behaviors occurring during interactions with patients, residents, clients, and families) are defined.5b. Service standards are communicated to all staff members/physicians.5c. A policy is in place to help guide leaders on appropriate responses to employees/physicians who are not meeting service standards.5d. Leaders are trained and supported in evaluating staff members for their performance of service standards.

Road Map to a Safety Culture

For Patients, Residents, and Clients



Sustaining the Overall Initiative

Specific Action(s)	Audit Questions
<p>1. Measure progress by collecting data on an on-going basis</p>	<p>The facility collects and analyzes data on an on-going basis including:</p> <ul style="list-style-type: none"> 1a. Patient safety culture surveys at least every two years. (e.g. AHRQ HSOPS, Safety Attitudes Questionnaire). 1b. Additional engagement and satisfaction survey data (e.g. employee engagement assessment, patient/resident satisfaction, physician engagement assessment). 1c. Culture Roadmap best practice implementation progress and gap identification. 1d. Performance data (e.g. staff turnover rates, mortality rates, complication rates, safety events). 1e. Additional related data sources (e.g. claims data, mortality reviews, global trigger tool data and event/near-miss data, safety rounding data) as appropriate. 1f. A process is in place to perform ongoing assessment on current status of key quality measures such as CMS Compare Data, MN Statewide Quality Measures, falls and pressure ulcer rates as appropriate to the setting.
<p>2. Review data and update patient safety plan on an on-going basis.</p>	<p>At least annually, the steering committee has a structured process in place to:</p> <ul style="list-style-type: none"> 2a. Review patient safety data/information. 2b. Identify patient safety gaps and barriers. 2c. Analyze quality and safety metrics that are not meeting the organization's goals to determine cultural principles that may impact the outcome (e.g. workloads, inadequate knowledge or experience, inadequate supervision, stressful environment, rapid change within an organization.) 2d. Prioritize and select culture roadmap domain/s for focused work based on survey and other data results. 2e. Prioritize additional patient safety areas to address based on patient safety data/information. 2f. Commission interdisciplinary work groups to address priority issues, including work on the roadmap domains. 2g. Provides opportunities for direct care staff to be engaged in the development of actions to address identified areas for improvement. 2h. Review and update the organization's patient safety plan.
<p>3. Communicate results and actions on an on-going basis.</p>	<p>Culture assessment results and action plans are communicated on a regular and on-going basis to:</p> <ul style="list-style-type: none"> 3a. Unit/department leaders 3b. Physician/clinical leaders 3c. Staff members 3d. Medical staff members 3e. Governing body 3f. Executive administration
<p>4. Gather on-going feedback and share learnings.</p>	<ul style="list-style-type: none"> 4a. A process is in place for gathering and incorporating feedback on the assessment results and identified actions from key stakeholders, (e.g. 3a – 3f above.) 4b. A process is in place to analyze culture improvement learnings on a unit by unit basis (e.g. learnings about tools, leadership, strategies). 4c. A process is in place to evaluate the transferability of learnings from individual units. 4d. A process is in place to share learnings across units/departments, where appropriate.

Continued

Road Map to a Safety Culture

For Patients, Residents, and Clients



Sustaining the Overall Initiative

Specific Action(s)	Audit Questions
5. Assess and provide on-going learning and feedback.	<p>A process is in place to assess on-going patient safety learning needs for:</p> <ul style="list-style-type: none">5a. Senior leaders5b. Governing body5c. Physicians5d. Managers/Supervisors5e. Staff <p>Based on learning needs assessment, formal patient safety education is provided at least annually for:</p> <ul style="list-style-type: none">5f. Senior leaders5g. Governing body5h. Physicians5i. Managers/Supervisors5j. Staff <p>5k. A process is in place to identify top patient safety practice areas and provide specific patient safety updates for those areas. (e.g. areas with high incident or near miss rates).</p> <p>5l. A process is in place to provide on-going education and coaching as appropriate for implementation and sustainment of specific patient safety practices.</p> <p>5m. A process is in place for review and feedback to staff members on their patient safety performance at least annually.</p> <p>5n. Safety expectations are clearly communicated to staff members (e.g. via job descriptions, employee goals, mentoring/learning opportunities).</p> <p>5o. A process is in place for review and feedback to leaders on their patient safety performance at least annually.</p> <p>5p. Safety expectations are clearly communicated to leaders (e.g. via job descriptions, goals, mentoring/learning opportunities).</p>
6. Celebrate success!	6a. The facility has a formal process in place to celebrate successes (e.g. improvements in quality and safety outcomes, good catches, improved audit scores) on a regular basis.