

CRITERIA ONE

The American Hospital Quest for Quality Prize™ criteria (2004) are partially adapted from “Strategies for Leadership: An Organizational Approach to Patient Safety,” developed by VHA, Inc. (may be downloaded from www.aha.org/questforquality). Abridged here for length

I. Leadership**

The way your organization demonstrates patient safety as a top leadership priority and the degree to which, for example:

- Patient safety is adopted as an organizational strategic goal or a top leadership priority.
- Senior leadership allocates sufficient resources to accomplish patient safety initiatives.
- Governance is actively engaged in organizational strategic planning efforts, in defining patient safety as a strategic goal, and in providing demonstrable support for safety that is recognized throughout all levels of the organization.
- All departments, services and standing teams/committees apply safety principles to work processes and analysis of outcomes.

How you promote a non-punitive culture for sharing information and lessons learned and the degree to which, for example:

- The organization has clearly defined expectations and accountabilities related to job performance.
- Patient safety is approached in an interdisciplinary way. All individuals within the organization, including leadership, the medical staff, and organization employees (i.e., anyone who directly or indirectly affects the way care is rendered in the facility) address patient adverse events and close calls with courage and honesty
- All individuals within the organization, including leadership as well as organizational employees, role-model non-punitive attitudes that emphasize system failure rather than individual error in all meetings, conferences, and other activities directed at improving patient safety.

II. Strategic Planning

Your methods for routinely conducting an organization-wide assessment of the risk of harm to patients in the care delivery processes and the degree to which, for example:

- An organization-wide patient safety assessment occurs at regular intervals.
- The organization uses the safety assessment results to develop a Patient Safety Plan that defines the scope of the programs and mechanisms/systems for carrying out patient safety activities.
- The Patient Safety Plan is reviewed and approved by leadership annually. This effort is multidisciplinary, involving opinions and experiences from anyone who directly or indirectly renders care in the facility, including volunteers, students, and contract staff.

Whether and how your organization actively evaluates the competitive/ collaborative environment and identifies partners with whom to learn and share best practices in clinical care and the degree to which, for example:

- Lessons learned from health care and from other industries are incorporated into the Patient Safety Plan.
- The organization routinely engages the consumer/patient community in a proactive dialogue about safety and how it can be improved.

**Includes governance, clinical-nursing, physician, pharmacy, and non-clinical leaders and management

III. Information and Analysis

Your commitment to analyzing adverse events and identifying themes across events, and the degree to which, for example:

- The organization engages all staff in an ongoing process to identify opportunities for patient safety improvement.
- The organization offers all employees and medical staff a user-friendly, easily accessible, confidential, narrative reporting system for reporting recognized risks, close calls and adverse events.
- An evaluation is performed following an adverse event or close call.
- Event analysis is systematic and conducted in a manner that takes into account human factor design principles.
- Appropriate evidence-based measures are continually sought, accessed in a timely fashion, and properly used to monitor and improve performance for high-risk and high-volume conditions and diseases that are relevant to the organization.

IV. Human Resources

Your ability to establish rewards and recognition for reporting errors and safety-driven decision-making and the degree to which, for example:

- The organization explicitly defines employee and medical staff roles in advancing patient safety in all job descriptions, orientation materials and activities, and required continuing education.
- Patient safety efforts are multidisciplinary and continuous.
- Safety-driven decision-making is an essential and well-recognized element of the reward/promotion system.

Your ability to foster effective teamwork regardless of a team member's position of authority and the degree to which, for example:

- Leadership empowers employees, regardless of rank, to act to avoid adverse events.
- The organization maintains safe staffing through such activities as cross-training, adequate volume ratios, appropriate skill mix, and appropriate work hours.

V. Process Management

Your ongoing commitment to implement care delivery process improvements that employ human factors concepts such as, for example:

- The organization uses checklists, protocols, reminders, decision support, and standardizes equipment, forms, times and locations to avoid reliance on memory
- The organization uses system constraints, forcing functions, and effective alarms to avoid reliance on vigilance (e.g., IV Luer lock and indwelling lines match before fluid can be infused; when a device fails, it defaults to the safest mode).
- Patient care processes use a minimum number of steps and handoffs.
- Where appropriate and where resources are available, thoughtful application of technological support is utilized to improve patient safety but only after thorough engineering and human factors analysis has been conducted.

VI. Patient and Family Incident Communication

Your organization assists patients and their families in understanding what may have occurred, communicating with them the facts, as they are uncovered and assuring effective communication through the course of management of the event and the degree to which, for example:

- Patients and family members are informed and engaged in an ongoing communication process when an adverse event occurs.
- Employees are educated about appropriate and effective ways to communicate with patients in such a situation.

- Support mechanisms (patient advocacy, chaplain, etc.) are informed and made available to patients as incidents unfold.
- Mechanisms are in place for immediate response to patient/family-reported safety concerns.

VII. Patient and Family Involvement

Your organization engages patients and families in care delivery workflow process design and feedback and the degree to which, for example:

- Efforts are in place to work toward involving patients and their families in planning services, work/process design, problem solving and safety/quality improvement efforts.
- Based upon their stated preferences, patients and/or their families (or designated significant others), where appropriate, receive the information and education they need to be full partners in their care (e.g., evidence-based guidelines, personal medical data, self-management instructions, etc.).
- Patient information and education is designed and delivered in useful formats and matched to literacy and cultural needs.

CRITERIA TWO: **James Reason's Approach to the Development of a Culture of Safety**

From: *Managing the Risks of Organizational Accidents*. Ashgate Publishing, 1997.

- **Reporting culture** – people actively report errors and near-misses
- **Just culture** – atmosphere of trust in which people are encouraged to report and a clear line between acceptable and unacceptable behavior
- **Flexible culture** – ability to adapt to high risk conditions, e.g. shift of decision-making to those with expertise
- **Learning culture** – willingness and ability to learn from safety information system and the will to change when needed

CRITERIA THREE: "Mindfulness" in high reliability organizations

Weick KE and Sutcliffe KM. *Managing the Unexpected. Assuring Performance in an Age of Complexity*. Jossey Bass, 2001.

- **Preoccupation with failure** – avoid denying failure and don't focus on success or how good we are
- **Reluctance to simply interpretations** – understand that work is complex, unstable, unpredictable
- **Sensitivity to operations** – attentive to the front line where the real work gets done
- **Commitment to resilience** – capability to detect, contain and bounce back from inevitable errors
- **Deference to expertise** – when needed, decision-making migrates to those with the most expertise, regardless of rank

CRITERIA FOUR – JCAHO Culture of Safety Environmental Characteristics

From: pg 10 Patient Safety – Essentials for health Care: 3d edition. JCR; 2005

- Routine reporting and uninhibited discussion of sentinel events and near misses
- Analysis of each of these occurrences
- Feedback to those who report, as a demonstration of the value of reporting
- Support for staff involved in a sentinel event
- Communication with patients about their care outcomes, including unanticipated outcomes
- Engagement of patients as active members of the care team
- Teamwork
- Proactive risk assessment and error prevention