

BoardBrief

Knowledge Resources for Health Care Governing Effectiveness

Governance Accountabilities and Opportunities in the Quest for Quality

Boards of trustees are responsible for ensuring the quality and patient safety of their organization, and must take strong, organized action to establish and nurture an organizational culture that continually seeks to improve quality and patient safety at every turn.

While there has recently been a much-heightened awareness about quality and patient safety in health care, errors still occur in hospitals every day. These errors are not always large and egregious; they may instead be small or unnoticed acts of commission or omission. Regardless of the nature or scope of the problem, medical errors have great consequences on an organization's quality of care, patient satisfaction, medical staff and employee morale, and future reimbursement.

The Problem: Inadequate Systems

The health care system is fragmented, with patients seeing several different providers for any number of health issues. Each provider has only limited access to patient information, and care is often poorly coordinated amongst the providers. This has resulted in no clear lines of accountability, and oftentimes poor communication between all levels of care providers.

Understanding the nature of this fragmented system, boards must ask: "What can our hospital do to remove these system barriers?" According to the Institute of Medicine, there are many behavior choices that health care organizations make that can lead to patient injury or death, including:

- Not adhering to protocols/requirements;
- Inadequate investment in systems;
- Inadequate staffing;
- Lack of, or poor provider qualifications;
- Communication inefficiencies and ineffectiveness; and
- Failure to learn and change.

Boards must commit to changing these behavior issues by setting the tone or "culture" for the hospital, including setting patient safety guidelines and priorities and dedicating the resources necessary to provide appropriate, effective, safe care.

Quality and Patient Safety are Job One

Too often boards of trustees assume that quality and safety problems are not an issue in their hospital unless they hear otherwise. Instead, boards should ask specific questions to identify the hospital's current performance and pinpoint areas with the greatest need for improvement. Questions boards should be asking include:

- How good is our quality? How safe is our hospital? How do we know?
- What is our "culture" of quality and safety? Does everyone in the hospital family understand and embrace it?
- How can we improve?
- What should we be measuring?
- What does the public expect from us?
- How ready are we to publicly disclose our quality and safety performance?

Boards of trustees should be concerned about patient safety for moral, ethical, legal and financial reasons. Board members

"Board seats in American hospitals have traditionally been relatively honorific positions...it is time for hospital boards of directors – along with executives and physicians – to rise from slumber and view safety as an urgent matter"
-Donald M. Berwick,
Chief Executive,
Institute for Health Care Improvement

must understand that they are liable for the care provided at the hospital; that medical errors significantly impact health care costs; and that patient safety is a key component of “staying on top” in a highly competitive environment.

Board Liability. It is ultimately the board’s responsibility to ensure that the hospital is taking clear, appropriate measures to provide the safest health care in the most efficient and effective manner. As a result, trustees need to be aware of and proactive in addressing patient safety in their hospital, and seek continuing education about current trends and implications. Boards should regularly review key quality indicators, and take corrective action when necessary.

While it may be resource-intensive to implement and regularly monitor and measure quality improvement and safety protocols, consider the following:

- Medical liability costs rise as the number and scope of lawsuits increase;
- Fear of liability may cause providers to stop delivering services altogether;
- Doctors that don’t stop delivering services may practice “defensive medicine,” ordering extra tests and procedures out of fear of liability; and
- The cost of lost business, employee morale and a negative reputation from one or two serious patient safety breaches can be very damaging.

Cost. The cost of medical errors to the health care system and individual organizations is significant. Half of the cost of medical errors come from direct health care expenses, such as increased hospitalization; the other half includes such indirect expenses as lost productivity and disability. More specifically, medication errors are estimated to account for a significant portion of preventable medical errors. According to the National Committee for Quality Assurance’s 2004 State of Health Care Quality, more than \$9 billion in lost productivity and \$2 billion in hospital costs could be averted through more consistent use of proven best practices.

In addition, studies demonstrate that more people die annually from medication errors than motor vehicle accidents, breast cancer or AIDS – three causes that receive far more public attention. Adverse drug effects cause approximately 777,000 deaths per year and can cost hospitals between \$1.56 - \$5.6 million annually, depending on the size of the institution.

Competition. High quality providers are magnets for patient self-referral, physician referrals and managed care contracts, says Russell C. Coile in “Quality Pays: A Case for Improving Clinical Care and Reducing Medical Errors.” And although

Questions Trustees Should be Asking About Quality and Patient Safety	
1	What quality and patient safety measures should we be collecting and closely monitoring?
2	What are the top five safety issues at our facility?
3	What is our organization’s plan for safety improvements?
4	What should I hold the executive team responsible for this year to improve our patients’ safety?
5	Is it easy and safe to report errors at our hospital? What is the process?
6	How much do medical errors cost our hospital annually?
7	What steps have we specifically taken to address the IOM’s Six Aims?
8	If we were paid today on the basis of quality, not procedures, how would we do?

quality has traditionally been a matter of perception on the part of patients, many organizations routinely publish reports on the top-rated hospitals for quality. Hospitals that do not put protocols in place to reduce medical errors risk losing consumer confidence and market share.

Quality Leaders and Standard-Setters

Media scrutiny is increasingly shaping the public’s opinions about health care quality and patient safety. As the press continues to report anecdotal examples of poor health care quality and safety slip-ups, public skepticism and concern will continue to mount. People’s opinions will be shaped by the stories they read and hear, but more importantly, by the “word of mouth” outcomes of those stories.

Hospitals and lawmakers are increasingly looking to national leaders such as the Institute of Medicine (IOM) and National Quality Forum (NQF) for quality measurements and benchmarks and suggested action steps. The Joint Commission patient safety standards are aligned with these recommendations, and underscore the importance of organizational leadership in building a culture of safety.

Institute of Medicine. In 1996 the Institute of Medicine launched its effort focused on assessing and improving the nation’s quality of care. The first phase included research and documentation of the nation’s overall quality problem, resulting in the now well-known report, *To Err is Human*. The study brought national attention to the seriousness and frequency of health care errors, reporting that:

IOM: Simple Rules for the 21st Century Health Care System

The Institute of Medicine's 2001 *Crossing the Quality Chasm* report included specific recommendations for ways health care organizations can improve quality, including the ten rules for care delivery redesign outlined below.

Current Approach:

- Care is based primarily on visits
- Professional autonomy drives variability
- Professionals control care
- Information is a record
- Decision-making is based on training and experience
- Do no harm is an individual responsibility
- Secrecy is necessary
- The system reacts to needs
- Cost reduction is sought
- Preference is given to professional roles over the system

New Rules:

- Care is based on continuous healing relationships
- Care is customized according to patient needs and values
- The patient is the source of control
- Knowledge is shared and information flows freely
- Decision-making is evidence-based
- Safety is a system property
- Transparency is necessary
- Needs are anticipated
- Waste is continuously decreased
- Cooperation among clinicians is a priority

Source: *Crossing the Quality Chasm: A New Health System for the*

- 44,000—98,000 Americans die each year due to medical errors;
- Medical errors are the 8th leading cause of death in the U.S.;
- The annual cost of medical errors is as much as \$29 billion;
- The majority of problems are systematic;
- Many Americans are injured by the health care that is supposed to help them;
- Less than five percent of these injuries are due to individual errors; and
- Errors can be reduced, but not eliminated.

To Err is Human was followed by a second phase of research and the publication of *Crossing the Quality Chasm*, a report describing broader quality issues and defining the “six aims” of care, stating that care should be:

- **Safe**, avoiding injuries to patients from the care that is intended to help them;
- **Effective**, providing services based on scientific knowledge to all who could benefit, and refrain from providing services to those not likely to benefit;
- **Patient-centered**, providing care that is respectful of and responsive to individual patient preferences, needs values and ensuring that patient values guide all clinical decisions;
- **Timely**, reducing waits and sometimes harmful delays for both those who receive and those who give care;
- **Efficient**, avoiding waste, including waste of equipment, supplies, ideas and energy; and
- **Equitable**, providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.

Crossing the Quality Chasm included specific ideas of ways to make health care safer, including: 1) health care organizations' purpose should be to continually reduce the burden of illness, injury and disability; 2) purchasers and health care organizations should work together to redesign health care processes; and 3) purchasers should examine current payment methods and remove barriers that impede quality improvement.

The recommendations made in this document, and continuing research and recommendations by the IOM, have become the new standard for health care safety. It is critical that trustees understand the key components of this research and develop strategies to address these issues in their hospitals.

The Joint Commission. Aligning with the IOM's reports on improving patient safety in health care, the Joint Commission patient safety standards underscore the importance of strong organizational leadership in building a culture of safety. Such a culture should strongly encourage the internal reporting of medical errors, and actively engage clinicians and other staff in

The IOM Definition of Quality: “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

IHI: Characteristics of High-Achieving, Rapidly Improving Hospitals

Through review of literature, research evidence and best practices, the Institute for Healthcare Improvement identified 15 specific governance behaviors that increase the odds of rapid quality improvement throughout hospitals. The IHI recommends that observing these fifteen actions is the best place for boards to start in their quest to improve quality and patient safety. Best practice characteristics of high-achieving boards include:

1	They set a clear direction for the organization and regularly monitor performance
2	They take ownership of quality problems and make quality an agenda item at every board meeting
3	They invest time in board meetings to understand the gap between current performance and the best in class
4	They aggressively embrace transparency and publicly display performance data
5	They partner closely with executives, physicians, nurses, and other clinical leadership in order to initiate and support changes in care
6	They drive the organization to seek the regular input of patients, families, and staff, and they do the same themselves
7	They review survey results on culture, satisfaction, experience of care, outcomes, and gaps at least annually
8	They establish accountability for quality-of-care results at the CEO level, with a meaningful portion of compensation linked to it
9	They establish sound oversight processes, relying appropriately on quality measurement reports and dashboards (“Are we achieving our aims/system-level goals?”)
10	They require a commitment to safety in the job description of every employee and require an orientation to quality improvement aims, methods, and skills for all new employees and physicians
11	They establish an interdisciplinary Board Quality Committee, meeting at least four times a year
12	They bring knowledgeable quality leaders onto the board from both health care and other industries
13	They set goals for the education of board member about quality and safety, and they ensure compliance with these goals
14	They hold crucial conversations about system failures that resulted in patient harm
15	They allocate adequate resources to ongoing improvement projects and invest in building quality improvement capacity across the organization

Source: 5 Million Lives Campaign. *How-to Guide: Governance Leadership*. Institute for Healthcare Improvement. www.ihl.org.

the design of remedial steps to prevent future occurrences of these errors. The additional emphasis on effective communication, appropriate training and teamwork found in the standards draw heavily upon lessons learned in both the aviation and health care industries.

A second major focus of the new standards is on the prevention of medical errors through the prospective analysis and re-design of vulnerable patient care systems (for example, the ordering, preparation and dispensing of medications). Potentially vulnerable systems can readily be identified through relevant national databases such as the Joint Commission’s Sentinel Event Database or through the hospital’s own risk management experience.

Finally, the standards make clear the hospital’s responsibility to tell a patient if he or she has been harmed by the care provider. The Joint Commission now requires organizations to develop a policy for informing patients when they have received substandard care or their outcome varies from anticipated results. Those organizations that fear that this will increase litigation may be surprised to learn that the Association of Trial Lawyers of America have stated that this could reduce litigation because “people appreciate honesty and being told what is happening to them or what might happen to them. The more people know about their condition, the more favorably they view their doctor.”

The Centers for Medicare and Medicaid Services. Medicare recently completed a three-year experiment that paid 266 participating hospitals additional reimbursement for following specific medical recommendations. Participating hospitals had the opportunity to earn a payment “bonus” if they ranked among the top 20 percent in at least one of the five areas measured for the experiment: joint replacement, coronary artery bypass graft, heart attack, heart failure or pneumonia. While there is debate about whether the experiment used the best approach or measured the most appropriate indicators, the study did find that participants steadily improved the quality of care in the areas measured.

The experiment is a sign of things to come: the federal government is concerned about the quality of care provided in America’s hospitals, and will use its funding power to reward the best care, and perhaps punish for poorly provided care. According to a story in *The New York Times*, the experiment is “an effort by Medicare to address a fundamental concern about the current payment system.” Currently hospital reimbursement is the same regardless of patient outcomes, a situation that is unlikely to continue in the future.

National Quality Forum. The National Quality Forum (NQF) is a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting. It was developed through a combination of public and private leaders committed to bringing about national change in health care quality on patient outcomes, workforce productivity, and health care costs.

In response to the IOM report, the NQF identified 27 “never events,” or events that should never happen in a hospital and that can always be prevented. Examples of “never events” include:

- Operating on the wrong body part or the wrong patient;
- Performing the wrong procedure;
- Leaving foreign objects in a patient;
- Contamination, misuse or malfunction of products and devices;
- Wrong discharge of an infant;
- Patient disappearance or suicide;
- Death or disability due to a medication error;
- Death or disability associated with a fall, burn or use of restraints;
- Care ordered by someone impersonating a doctor or nurse; and
- Abduction or assault.

The NQF works to promote a common approach to measuring health care quality, and is known as the “gold standard” for the measurement of health care quality. In 2006 the NQF endorsed more than 300 measures, indicators, events and practices for measuring and improving health care quality across the spectrum of care.

The Institute for Healthcare Improvement. The Institute for Healthcare Improvement (IHI) was established in 1991 to lead the improvement of health care across the world. The IHI estimates that nearly 15 million instances of medical harm occur in the U.S. alone every year – a rate of over 40,000 instances per day. The IHI is striving to achieve health care for all patients with:

- No needless deaths;
- No needless pain or suffering;

- No helplessness in those served or serving;
- No unwanted waiting; and
- No waste.

In an effort to accomplish these aims, the IHI launched its “100,000 Lives Campaign”, with the goal of reducing 100,000 preventable deaths in the U.S. Over 3,000 hospitals participated in the campaign, and in 18 months an estimated 122,000 lives were saved. The combination of the campaign’s success and the desire to address medical errors that may harm patients in addition to preventing avoidable deaths led to the IHI’s recent launch of its “Five Million Lives Campaign.” The new campaign expands the focus of the 100,000 Lives Campaign, with the goal of dramatically accelerating efforts to reduce non-fatal harm, while continuing to fight needless deaths. The Five Million Lives goal is to protect patients from five million incidents of medical harm over a two-year period, from December 2006 – December 2008.

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To achieve the goals of the Five Million Lives Campaign, the IHI is enlisting at least 4,000 U.S. hospitals in a renewed national commitment to improve patient safety faster than ever before. The campaign challenges American hospitals to adopt 12 changes in care that save lives and reduce patient injuries:

- Six interventions are from the original 100,000 Lives Campaign that target preventable patient deaths, such as adverse drug events, surgical site infections and ventilator-associated pneumonia; and
- Six new interventions were added, with the goal of reducing unnecessary patient harm, such as reducing surgical complications and preventing pressure ulcers. One of these six interventions asks for hospitals to “get boards on board...by defining and spreading the best-known leveraged processes for hospital boards of directors, so that they can become far more effective in accelerating organizational progress toward safe care.”

Quality Reporting and Measurement

The increasing push for improved quality and patient safety has resulted in a number of publicly available quality reporting websites. The challenge of reporting hospital quality performance is daunting: hospitals perform a wide variety of services and procedures, and each patient case is unique due to the patient’s individual circumstances and co-morbidities.

Nonetheless, these sites are the first attempt to capture and compare hospital quality performance.

As the health care reimbursement and delivery landscape changes and patients are increasingly responsible for paying a greater portion of their health care costs and making their own health care decisions, the availability of easily understandable hospital quality data will increasingly influence patient care decisions. In addition, public and private payers are moving toward “pay for performance,” utilizing standardized hospital quality performance measures to influence hospital reimbursement.

One of the IHI’s twelve interventions is to “get boards on board...by defining and spreading the best-known leveraged processes for hospital boards of directors, so that they can become far more effective in accelerating organizational progress toward safe care.”

located in; and 3) The U.S. average for a variety of indicators in four condition areas: heart attack, heart failure, pneumonia, and surgical care improvement/surgical infection prevention.

Leapfrog Group. The Leapfrog Group is a voluntary organization that exists to mobilize employer purchasing power to “alert America’s health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded.” The Leapfrog Group asks hospitals to adhere to four quality and safety practices, endorsed by the National Quality Forum. The four “leaps in hospital quality, safety and affordability” are:

- **Computer Physician Order Entry (CPOE):** With CPOE systems, hospital staff enter medication orders via computer linked to prescribing error prevention software. CPOE has been shown to reduce serious prescribing errors in hospitals by more than 50%.

Hospital Compare. The Hospital Compare website was created through the combined efforts of CMS, the U.S. Department of Health and Human Services, and the Hospital Quality Alliance (HQA), a public-private collaboration established to promote reporting on hospital quality of care. The Hospital Compare website provides quality measures for hospitals across the country, indicating how often hospitals provide some of the recommended care to get the best results back for most patients. Currently the site lists: 1) Individual hospital performance; 2) The average for the state the hospital is

- **Evidence-Based Hospital Referral (EHR):** Consumers and health care purchasers should choose hospitals with extensive experience and the best results with certain high-risk surgeries and conditions. By referring patients needing certain complex medical procedures to hospitals offering the best survival odds based on scientifically valid criteria — such as the number of times a hospital performs these procedures each year or other process or outcomes data — research indicates that a patient’s risk of dying could be reduced by 40%.
- **ICU Physician Staffing (IPS):** Staffing intensive care units (ICUs) with doctors who have special training in critical care medicine, called “intensivists,” has been shown to reduce the risk of patients dying in the ICU by 40%.
- **Leapfrog Safe Practices Score:** The National Quality Forum-endorsed 30 Safe Practices cover a range of practices that, if utilized, would reduce the risk of harm in certain processes, systems or environments of care. Included in the 30 practices are the three leaps above. This fourth leap assesses hospitals’ progress on the remaining 27 NQF safe practices.

According to the Leapfrog website, research has shown that if the first three leaps were implemented in every non-rural hospital in the country, America could save up to 65,341 lives and prevent up to 907,600 medication errors annually. Implementation could also save up to \$41.5 billion annually.

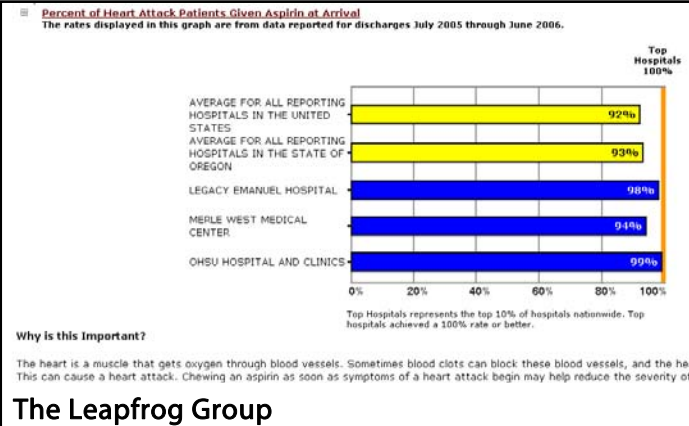
The Leapfrog website provides updates on hospitals’ progress in implementing the Leapfrog-recommended quality and patient safety practices using a chart system that indicates how close an individual hospital is to completing implementation of each Leapfrog recommended practice.

HealthGrades. HealthGrades provides provider ratings for over 5,000 hospitals and over 600,000 physicians, as well as nursing homes and home health agencies. Ratings are provided by category such as stroke, maternity care, and heart attack. Each hospital is given a “grade” for its performance, with five stars representing “best,” three stars indicating “as expected” and one star indicating “poor.”

Quality Check. The Joint Commission’s Quality Check website provides information about nearly 15,000 Joint Commission-accredited health care organizations throughout the country, listing each organization’s overall accreditation status as well as detailed performance information. The quality reports are displayed with checks, pluses and minuses to help the general public compare health care organization performance in a variety of key areas. Each hospital’s “Quality Report” provides

Sample Pages: Quality Reporting and Measurement

Hospital Compare



Health Grades

Hospital's Name	★★★★ Best		★★★ As Expected		★ Poor	
	Current Ratings	Previous Ratings	America's 50 Best Hospitals	Clinical Excellence-DHA	Patient Safety-DHA	Specialty Excellence
2007 Ratings Stroke						
High Volume Hospitals						
Providence Milwaukie Hospital	★★★	★★★★★	★★★	★★★★★	★★★	★★★★★
Providence Seaside Hospital	★★★	★★★	★★★	★★★	★★★	★★★
Samaritan North Lincoln Hospital	★★★	★★★	★★★	★★★	★★★	★★★
Willamette Valley Medical Center	★★★	★★★	★★★	★★★	★★★	★★★
Legacy Meridian Park Hospital	★★★	★★★	★★★	★★★	★★★	★★★
Legacy Mt. H...	★★★	★★★	★★★	★★★	★★★	★★★

The Leapfrog Group

Leapfrog Hospital Ratings

Search Results: Zip: 97006 Radius: 10 Miles

Below are the results of your search. Click on the "leaps" and the circles for more details.

Click to Compare	Hospital Name	City	Leap				Safe Practices Score	Results Submitted
			Leap1	Leap2	Leap3	Leap4		
<input type="checkbox"/>	LEGACY EMANUEL HOSPITAL & HEALTH CTR	Portland, OR	●	●	●	●	●	11/27/2006
<input type="checkbox"/>	LEGACY GOOD SAMARITAN HOSP & MED CTR	Portland, OR	●	●	●	●	NA	6/28/2006
<input type="checkbox"/>	OREGON HEALTH & SCIENCE UNIVERSITY HOSPITALS AND CLINICS	Portland, OR	●	●	●	●	●	6/29/2006
<input type="checkbox"/>	PROVIDENCE ST VINCENT MEDICAL CENTER	Portland, OR	●	●	●	●	●	6/29/2006
<input type="checkbox"/>	TUALITY HEALTHCARE	Hillsboro, OR	●	●	●	●	●	

Joint Commission Quality Check

Behavioral Health Care	Hospital	National Patient Safety Goals and National Quality Improvement Goals	
		Nationwide	Statewide
2006 National Patient Safety Goals (see details)	2006 National Patient Safety Goals (see details)	✓	N/A*
National Quality Improvement Goals:			
Heart Attack Care † (see details)	Heart Failure Care † (see details)	⊕	✓
Pneumonia Care (see details)		✓	✓
2006 National Patient Safety Goals (see details)		✓	N/A*

The Joint Commission only reports measures endorsed by the National Quality Forum.

information about the organization's Joint Commission accreditation, compliance with the Joint Commission's National Patient Safety Goals, and performance on National Quality Improvement Goals (currently including heart attack, heart failure, community acquired pneumonia, pregnancy and related conditions, and surgical infection prevention). The performance measures included on the Joint Commission page are approved and endorsed by the National Quality Forum.

Hospitals and Physicians Can't Do It Alone

Quality improvement requires an understanding and acceptance of mutual responsibilities between all key stakeholders, including employers, clinicians and staff, and

patients. Implementing quality and patient safety improvements is an opportunity for board members to be leaders in the community, coalescing all the key stakeholders together around a common purpose.

Employer Involvement. Employers have the opportunity to be champions for patient safety, promoting the need for safety reform and providing leadership in action toward the definition, measurement and improvement of quality and patient safety.

Clinician and Staff Involvement. Accountability for quality and safety should be incorporated into every employee's job description. Regardless if employees have direct contact with a patient, every employee has a role in patient safety, from keeping the facility clean, to arranging the room in the safest

manner possible, to ensuring the patient is checked in and registered correctly. Employees should be educated about the quality and safety expectations they are required to meet, as well as how to report safety concerns and errors. These concepts should be ingrained in the workplace culture, and effectiveness and success in meeting specific goals should be recognized and rewarded.

To ensure accountability, employees should work in teams that share responsibility and check one another to ensure protocols are followed. Individuals and groups should be recognized for disclosing errors, near misses and safety concerns, rather than punished.

Key elements of employee and medical staff commitment to safety include:

- **Accountability:** medical staff and other employee job descriptions should incorporate accountability for safety;
- **Education/Knowledge:** educate employees on the importance of safety, surveillance and expectations for reporting safety concerns and errors, beginning with their orientation as new hires;
- **Evaluation:** employee evaluations should take into account contributions to safety;
- **Disclosure:** reward employees and physicians for disclosing errors, near-misses and safety concerns; and
- **Teamwork:** employees and physicians should work in teams so each member knows his or her responsibilities and those of teammates, and members of the team look out for one another, noticing errors before they cause injury.

Patient Involvement. Patients play a critical role in quality and patient safety as well. Without patient honesty and clear communication, health care providers may misunderstand a patient’s needs, desires or abilities. That patient’s role in patient safety includes:

- Informing doctors about medication they are taking;
- Asking for written information about possible medication side effects;
- Choosing hospitals with experience treating their condition;
- Learning about their condition;
- Being a personal advocate or finding an advocate;

Changing Public Perceptions About Quality of Care

Recent public and private efforts to promote awareness of medical errors and improve quality of care is impacting the general public. A 2006 study conducted by the Kaiser Family Foundation and the U.S. Agency for Healthcare Research and Quality found that:

- 36% of Americans have seen information comparing the quality of care provided by health plans, doctors and hospitals; 20% have used the information to make decisions about their care
- 55% of Americans understand the term “medical error,” up from 31% in 2002
- When given a common definition for “medical error,” 43% of Americans believe that preventable medical errors occur “very often” or “somewhat often”
- Many Americans are taking their care into their own hands:
 - 70% report checking the medication given by their pharmacist against the doctor’s prescription
 - 54% bring a list of all their medications to a doctor’s appointment
 - 45% bring a friend or relative to doctor appointments to help as questions

Source: New Survey Captures Public’s Views of Medical Errors and Quality of Care. Kaiser Family Foundation. September 27, 2006. www.kff.org.

- Ensuring prescriptions are legible; and
- Demanding an understandable, written discharge treatment plan.

The Board Role. Too often quality is on the board agenda as a discrete item, such as finance. Boards must recognize that quality and patient safety is the backbone for everything the board does. Meeting agendas should include regular review of reports on quality and patient safety. The board should set performance goals for quality and safety improvement, and hold managers accountable for achieving those goals. Quality and safety expectations should be a major factor in board discussions about services, facilities, medical staff development and workforce development.

A Call to Responsibility: Improving Patient Safety at Your Organization

While no board or individual trustee sets out to govern low performance, boards can be “unsafe” or perform “governance malpractice” simply through lack of knowledge or understanding about key issues, not talking about quality and patient safety measures and their implications, lack of involvement, or focusing in the wrong areas. A “culture of

Nine Potential Causes of Medical Errors	
1	Fundamental difficulties in medical care <ul style="list-style-type: none"> Balancing act of over-testing and under-testing Too much information – impossible to stay up-to-date Lack of time
2	Medical industry system problems <ul style="list-style-type: none"> Under-funded care Inefficiency of use of funds Over-worked physicians Slow adoption of technology Failure to report medical errors for fear of lawsuits Unnecessary medical tests for fear of lawsuits
3	Physician mistakes <ul style="list-style-type: none"> Human mistakes Alcohol or drug abuse Poor handwriting Poor dosage instructions
4	Patient mistakes <ul style="list-style-type: none"> Failure to report symptoms Delay in reporting symptoms Failure to report medications Non-compliance with treatment plans Dishonesty: Fraud, hypochondria Fear: Legal, social Patient pressure on physicians
5	Pharmacist mistakes <ul style="list-style-type: none"> Wrong medication Similar labels and packaging Similar medication names Wrong dosage Failure to communicate instructions
6	Pathology laboratory mistakes <ul style="list-style-type: none"> Errors in sample labeling Cross-contamination during testing Inherent risks in tests – false positives and negatives Limitations of tests for certain patients Human error in examining slides
7	Pharmaceutical industry mistakes <ul style="list-style-type: none"> Naming similarities Inadequate safety testing
8	Hospital mistakes <ul style="list-style-type: none"> Nosocomial infections Surgical mistakes Errors in transferring and re-labeling of medications Medication errors: Wrong medication, wrong dosage, wrong patient, wrong time
9	Surgical mistakes <ul style="list-style-type: none"> Wrong surgery Right surgery, wrong site Medication error before, during or after surgery

Source: *Causes of Medical Mistakes*. www.wrongdiagnosis.com/mistakes/causes.

safety” should be ingrained in the hospital, beginning with the board. The board is responsible for setting the tone for the hospital, providing the tools necessary for employees to carry out the quality and patient safety vision, and encouraging a safe environment by regularly measuring and monitoring quality measures.

Creating a Culture of Safety. The term “culture of safety” is used often, but the definition can be ambiguous. Boards must define what a culture of safety means to their hospital, including the following critical components:

- **Commitment of Leadership:** Active involvement by the hospital’s governing body, clinical and non-clinical leadership, with continual improvement in patient safety and medical error reduction as an explicit hospital priority;
- **Open Communication:** Patient involvement in decisions about their care, informing patients of the consequences of the care they receive, and ensuring language that supports the patient safety effort;
- **Reporting:** Create an environment of trust to address accountability in a fair and just manner so blame is not automatically placed when an error occurs; encourage employees to view patient safety as an integral part of their jobs, and to internally report errors, “near misses” and other opportunities to improve safety;
- **Informed Action:** Understanding of systems thinking and human factors is critical to the effective evaluation of gathered data; data and information about errors and “near misses” collected and analyzed internally on an ongoing basis; regular evaluations of care processes conducted to seek opportunities for improving patient safety; and
- **Teamwork:** Continual training in both team skills and job specific competencies, encouraging caregivers to consistently work in a collaborative manner in which each individual has a responsibility to identify and/or act to prevent potential medical errors.

Steps the Board Should Undertake. Boards are responsible for ensuring that high quality care is consistently and effectively delivered to patients, and providing leadership that results in effective systems, measurement and improvement. In fulfilling this responsibility, boards should take action to ensure that health care quality is a paramount priority in every decision and action made on behalf of the hospital. The National Quality Forum issued a “Call to Responsibility” for hospital governing boards, outlining four key principles with actionable policies and practices that boards should follow to fulfill their role in quality improvement:

- Hospital governing boards play a vital role in monitoring and improving hospital care to ensure that it is safe, beneficial, patient-centered, timely, efficient and equitable. To fulfill their role in ensuring quality, hospital governing boards should:
 - Ensure that health care quality is a paramount priority and a primary focus of board activities
 - Prominently place patient safety and quality issues on board agendas
 - Proactively oversee and evaluate patient safety and health care outcomes and the creation of a culture of safety by engaging in patient safety and quality improvement projects, establishing governance practices that support performance measurement and quality improvement, and holding management accountable for performance
 - Ensure that a system of performance measurement and quality improvement is in place
 - Recognize physicians’ roles, and the role of the medical staff within the hospital, and the roles of nursing executives and other clinical leaders in achieving quality
 - Assure that the hospital leadership adopts human resources policies and physician staff bylaws that articulate specific expectations for quality improvement
 - Ensure that the hospital management is capable of and focused on the analysis and improvement of organizational design that supports patient safety and quality of care
 - Align budget development and financial resources with quality and patient safety goals
 - Actively support management’s negotiation of payment contracts that do not penalize the organization for its investment in quality and safety
- To enable effective evaluation of their own role in enhancing quality, hospital governing board should:
 - Advocate for diverse board composition with specific expertise in quality and patient safety
 - Review board performance (individually and collectively) in improving hospital care

- Hospital governing boards should develop a “quality literacy” regarding patient safety, clinical care, and health care outcomes. This literacy should:
 - Include education in the infrastructure of patient safety, healthcare quality and performance measurement
 - Recognize the role of the board in representing consumers and the community it serves

Stumbling Blocks to Implementing a Patient Safety Program	
Health care organizations may experience stumbling blocks as they begin to implement new or improved quality and patient safety initiatives. While none of these threats is great enough to prevent the implementation and continual enhancement of quality and patient safety programs, hospital boards must be prepared to deal with these kinds of problems.	
1	Board apathy
2	A board that insists on starting a program before obtaining CEO buy-in
3	Public opinion and suspicion fueled by a press story on medical errors
4	Chronic history of denial by hospital administration, board and physicians that errors occur
5	A traditional medical culture of individual responsibility and blame
6	Notion that the problems can be fixed as they happen (non-proactive approach)
7	Inadequate knowledge by the board and administration about the frequency, cause and impact of errors, as well as about effective methods for error prevention
8	A CEO who doesn't support a program
9	Lack of awareness by the board and/or administration that a problem exists
10	The threat of litigation from discovery in an open, communicative environment
11	Complexity of restructuring the reporting mechanism in order to channel patient safety data to the safety officer
12	Inadequate allocation of resources for quality improvement and error prevention
13	Belief that the current error rate is acceptable
14	The idea that patient safety is “a phase” that will pass if ignored long enough

Source: Mycek, Shari. Patient Safety: It Starts with the Board. Trustee Magazine. May 2001.

Key Questions for Trustees When Implementing a Quality and Patient Safety Program

The board's responsibility in patient safety is simply to monitor performance and demand accountability. Governing bodies should hold themselves accountable for patient safety just as they are accountable for financial performance. According to the American Hospital Association, boards should begin by:

- Asking to see regular reports on patient safety from the facility or organizational managers;
- Requiring root-cause analysis of all errors that lead to injury;
- Setting performance goals for safety improvement; and
- Holding managers accountable for achievable patient safety improvement goals.

- Be comparable and akin to the knowledge and understanding of the organization's financial health and well-being vis-à-vis the Sarbanes-Oxley Act
- Utilize existing organizations and their resources to provide courses, training and information (the Joint Commission, Quality Improvement Organizations, etc.)
- Hospital governing boards should oversee and be accountable for their institution's participation and performance in national quality measurement efforts and subsequent quality improvement activities:
 - Ensure that participation in national quality improvement activities focus on nationally agreed-upon priorities
 - Participate in one or more existing efforts, such as the Hospital Quality Alliance, Joint Commission National Patient Safety Goals, NQF-endorsed national voluntary consensus standards, the Leapfrog Group, and others
 - Consistently review performance data from participation in national quality improvement efforts
 - Calculate the determination of cost implications of adverse events and poor performance
 - Evaluate performance based on the context of the six NQF aims: safe, beneficial, patient-centered, timely, efficient and equitable
 - Hold management accountable and require full and complete explanations when safety and quality performance levels differ from national benchmarks or fall below expectations

- Facilitate the adoption of incentive programs for executives based on quality improvements

Building Physician Partnerships for Quality and Patient Safety. The medical staff is responsible for delivering the best possible quality to patients in the safest manner, working collaboratively with the board to identify clinical issues that prevent quality and patient safety improvement. Despite this shared quality goal, an eroded sense of shared vision can occur due to competing agendas, economic stress, regulatory pressures and leadership problems.

But working with the medical staff and medical executive team is essential in ensuring a patient safety plan is successful. For many boards this may be uncharted territory: in the past the board focused on building positive stakeholder relationships,

Leading the Quality and Patient Safety Movement: Steps for Boards

The American Hospital Association's Quality Center recommends that boards undertake the following seven steps as they begin their quest for improving quality and patient safety:

- | | |
|----------|--|
| 1 | Understand the issues. Attend educational retreats and national conferences, read relevant literature, and recruit trustees with backgrounds in the science of quality (such as engineering, aerospace or manufacturing). |
| 2 | Together with other senior leaders, learn about methods to monitor quality. Seize the opportunity to bring the board, medical staff and administration together to learn from experts and one another. Attend national meetings as a group and/or bring in guest speakers. Success is dependent on the entire leadership team rallying behind the cause. |
| 3 | Don't be intimidated by technical jargon. The board should be focused on ensuring peer review is conducted rigorously, understanding metrics related to outcomes, and asking common-sense questions, not overlooking the details of physicians work. Boards should focus on big-picture questions, such as "how do our results compare with our competitors?" |
| 4 | Challenge your CEO. Link senior staff compensation to quality outcomes data. |
| 5 | Join national and regional collaboratives. Participate in opportunities to share knowledge with and learn from other organizations, such as the IHI's 5 Million Lives Campaign. |
| 6 | Collaborate with physicians. Hold the medical staff accountable for their delegated quality assurance functions, and keep quality in the forefront of all recruitment and credentialing decisions. |
| 7 | Believe in quality. Recognize that board leadership can result in profound improvements in quality and patient safety; don't become passive or defer too much to the medical staff and administration. |

Source: Lister, Eric D. *Leading the Drive for Quality: Is Your Board Ready?* Trustee Magazine. November/December 2006.

philanthropy and setting the hospital's strategic direction, while the medical staff was responsible for quality of care. Physicians don't want to be micromanaged by the board, and trustees don't want to overstep their bounds. But the quality of care provided at the facility is ultimately the board's responsibility, and increasing involvement will help the board better understand the issues and recognize the resources and technology necessary to achieve greater patient safety.

Some trustees may be uncertain about voicing their opinions around members of the medical staff. A recent article in *Quality Management in Health Care* reported that trustees who lack medical expertise tend to be hesitant to challenge members of the medical staff, or to second-guess how the medical staff disciplines providers for violating procedures. But to successfully improve quality of care, the board and medical staff must work as a team. That requires the medical staff to translate complex medical issues into "plain English" that trustees can understand, and requires trustees to ask questions and stand up for what they believe is right.

The contrasting cultures of physician independence and autonomy and board shared-decision making may be difficult to overcome, but can be achieved through board-medical staff communication, relationship-building and mutual respect. The board sets the tone for the hospital by creating a culture that is acceptable to both the board and physicians, creating a "practice friendly environment" through strategic understanding of the issues, ensuring adequate staffing, quality employees, efficient and effective processes, and providing adequate resources.

Board/medical staff relationships can also be enhanced through additional efforts, such as retreats and workshops, one-on-one meetings or focus groups that allow both groups to understand one another's viewpoints. Conducting a medical staff needs assessment can also help the board to understand physician needs, and physician involvement in strategic planning allows mutual understanding of long-term issues and a shared long-term vision.

If boards struggle to get physicians onboard with a quality and patient safety plan, explaining how implementing the plan will provide their patients with better care will build physician support. Make sure providers know that the changes will result in fewer errors and less harm to their patients, itemizing the specific desired outcomes as a result of the changes. And clearly explain to the medical staff that they will play an integral role in the decision-making and implementation process, and that they will be instrumental in developing and implementing the patient safety plan. The reward will come for the physicians when they see that the care provided at the

organization has improved and that their patients are receiving the very best care possible.

Maximizing Employees' Quality Improvement

Commitment. The workforce is responsible for riveting its attention on improving quality and safety within the scope of their jobs, and employees are an integral part of the quality and patient safety improvement team. According to an article in *Hospitals & Health Networks*, to ensure that employees understand their critical role and maximize employees' quality improvement commitment, boards should:

- Demonstrate patient safety as a top leadership priority;
- Actively promote a non-punitive environment for sharing information and lessons learned;
- Routinely assess risk to positive patient outcomes;
- Determine ways employees can learn from one another and share information;
- Involve staff in analyzing causes and solutions to errors and near misses;
- Reward and recognize safety-driven decisions and reporting;
- Foster effective teamwork, regardless of authority, through team training and simulation;
- Implement care delivery processes that avoid reliance on memory;
- Implement care delivery processes that avoid reliance on vigilance; and
- Engage patients and caregivers in the design of care delivery processes.

Implementing a Quality Dashboard

According to the Massachusetts Hospital Association, one effective method for monitoring the hospital's quality performance is to implement a quality dashboard. The dashboard should be reviewed regularly at board meetings, ensuring that trustees are aware of the hospital's actual quality performance, and are empowered to make decisions based on hard facts and evidence rather than anecdotal opinions.

What is a Dashboard? Dashboard reports are useful tools that help hospitals convey large amounts of information in a concise manner. A concise display of clinical performance information is an ideal way for board members to monitor clinical aspects of care – similar to how a board scrutinizes

Quality Dashboard Board Checklist

Publicly Reported Measures: Track what the public is seeing...

1. Hospital Quality Alliance Measures posted on the Hospital Compare website (heart attack, heart failure, pneumonia, surgical infection)
2. Joint Commission Data (maternity measures, accreditation, patient safety goals)
3. Patient Satisfaction Measures (HCAHPS)
4. State-specific reported measures
5. Nurse Staffing Plans (yearly)
6. Leapfrog Profile

Other Internal Measures...

1. IHI Campaign Interventions
2. Emergency Department (diversion, boarders, waiting time)
3. Mandated Reports (DPH, BoRM, CMS, Joint Commission Sentinel Events)
4. Incident Reports
5. Medical Malpractice Claims (open, closed)
6. Community Public Health Measures (Preventable hospitalizations, e.g., asthma care studies)

Source: Massachusetts Hospital Association

financial information. Dashboard reports are easy-to-read updates of progress on those indicators important to the community and to hospital administrators, caregivers and boards.

Quality dashboards help hospitals accomplish the goal of regular trustee review and assessment of patient quality and safety measures. Dashboards are presented in the same easy-to-read format at every board meeting, ensuring that all trustees understand the reports and can make informed decisions about whether the hospital is “on track” with its quality and patient safety goals.

Because each hospital has its own unique goals and progress indicators to track, every organization’s quality dashboard will look slightly different. The key is that boards of trustees determine the type of reporting that works best for them to quickly review and interpret their organization’s quality performance.

General Implementation Principles. Quality dashboards should be simple and concise. The information should be presented in a language easily understood by everyone, avoiding and/or defining acronyms and technical terminology when possible. The best model provides a quick way to report the status of hospital measures. Dashboards should lead with

problems identified, followed by areas of progress. Dashboards should end with success stories.

In addition, dashboards should include a place for trustees to note next steps and/or solutions when problems are identified. And the reports should leave room for flexibility. Dashboards are not a one-size-fits-all approach, but rather should be adaptable to the unique and emerging needs of each organization. Be prepared to modify or tweak the dashboard as organizational goals and challenges evolve.

Choosing Dashboard Measures. When deciding on measures to present, consider the list of potential measures as a “menu” for board selection. Keep in mind that not all measures are appropriate for all dashboards. Some measures may be appropriate for some hospitals to follow and others may be appropriate to track only occasionally. Work with the quality and safety committee to determine which measures to report.

In addition, when selecting measures to include, align them with the hospital's strategic priorities. Consider measures that reflect issues determined to be most critical for review by hospital board members. Start with high risk, problem-prone areas. Also, include the hospital's publicly reportable measures, such as the indicators provided on the Hospital Compare website. This ensures that the board sees the same information that the general public sees.

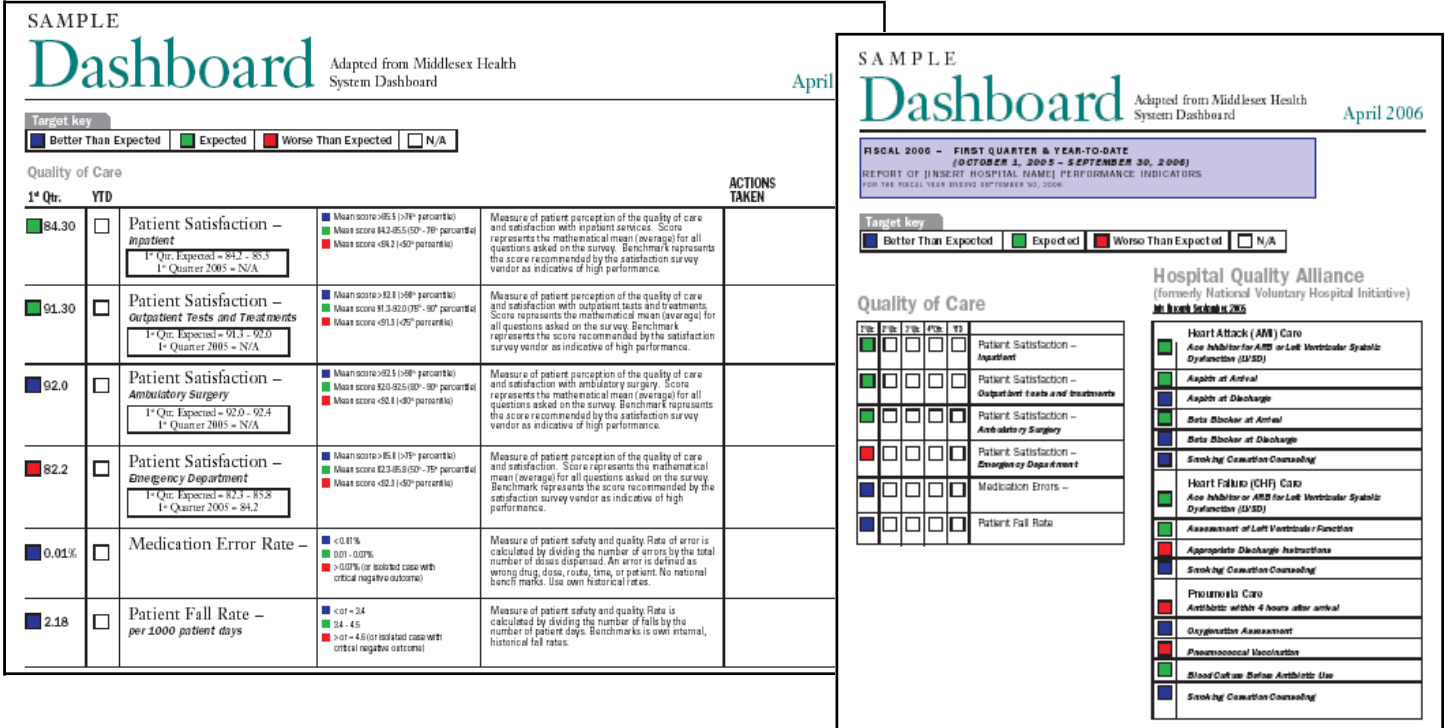
Presenting Performance Data. Presenting performance data in a format that everyone understands is critical. The following three steps can help ensure that the dashboard is understood equally by all trustees:

- First, bring attention to the status of the indicators selected. For example, color-coded metrics allow trustees to see the status of quality and safety measures at a quick glance.
- Second, select the “lightning rods,” or major areas of concern, for discussion at board meetings. In addition, follow-up on progress from previous meetings. Celebrating quality improvement successes are equally important to addressing current and emerging quality challenges.
- Finally, consider a “layered” approach. Board members wanting more detail about specific indicators can turn pages to review additional information, definitions used, explanations for how the targets are set, and information about any benchmarks used.

Framework, Benchmarks, and Targets. It is important to have a common framework across the organization for understanding and communicating information in your quality

Sample Quality Dashboards

The sample dashboards below visually show the status of priority indicators, and are easily adaptable to whatever key measures the hospital is tracking. The color coding quickly directs trustees' attention to the areas with the greatest need for improvement, with blue representing "better than expected," green representing "expected," and red indicating that the hospital's performance is "worse than expected." (Source: Massachusetts Hospital Association)



and safety dashboard (for example, a balanced score card based on the Institute of Medicine's Six Dimensions of Care: Safe, Effective, Patient-Centered, Timely, Efficient, and Equitable). The measures should be reported to the board at the same time as they are reported at the department/service and practitioner levels. Although the metrics may be provided in much greater level of detail at the department and committee level, reporting the same indicators to all stakeholders at the same time ensures that the key players are "on the same page," operating with consistent information and working toward the same shared goals.

Reports should also include benchmarks and/or targets for each measure where feasible. Measures should be compared to past performance, benchmarks at state and national levels, or data from published literature.

Strategies for Success

Hospital boards often begin their quest for quality and patient safety with a lack of knowledge about the issues. As they gain

knowledge and awareness, they develop a sense of direction and consensus about what needs to be done. Once a consensus is developed, meaningful change can occur, followed by continual re-evaluation and improvement to the hospital's quality initiatives.

The Evolution of Organizational Approaches to Patient Safety. Organizations evolve as their leadership gains a greater understanding and dedication to quality and patient safety issues. Hospitals generally move through four stages, although the speed at which hospitals transition between stages is dependent upon where they currently are:

- **Stage 1: Awareness:** Patient safety is one of many priorities, and the structure and accountability for patient safety is not clearly defined. Safety reporting primarily involves individual incidents, and standard definitions, metrics and regular reporting mechanisms for patient safety are lacking.
- **Stage 2: Learning:** Patient safety is recognized as a strategic priority with executive ownership, and a culture

of safety begins to be created with a focus on a non-punitive environment. The roles of the patient and family in safety is clearly defined, and all stakeholders are becoming involved in safety. Patient safety metrics are routinely measured and monitored, although technology does not yet play a fundamental role in improving patient safety.

- **Stage 3: Risk Reduction:** Patient safety is a strategic and tactical priority with increased use of tools and technologies to create an effective surveillance system and to reduce the risk of an event. There is movement toward proactive responses, including redesign of high-risk clinical processes. Technologies such as adverse drug event surveillance, computer physician order entry and bar code medication administration have been implemented.
- **Stage 4: High-Reliability:** Patient safety is everyone's priority, with a focus on organizational learning and incorporating "lessons learned" into training. Sophisticated tools and learning technologies, such as simulation, are frequently employed. Proactive risk assessment at the individual patient and organizational levels are routinely implemented and monitored.

Ensuring High Quality and Patient Safety. The board can help ensure high quality and patient safety by first ensuring that appropriate resources are dedicated for quality and patient safety initiatives. Boards must remember that quality is embedded in everything the hospital does, and ask themselves: "what is an appropriate amount of money to invest to achieve our quality and patient safety aims?"

Once sufficient resources are allocated, the board and hospital's commitment to quality and safety must be widely communicated to employees, physicians and the public. That commitment should be followed-up with regular reports and discussion about quality measurements, comparison of the hospital's measurements to benchmarks, and investigation and root-cause analysis of poor performance or events.

Organizational quality and safety initiatives should also be reviewed regularly to look for improved processes or best practices the hospital can implement. Finally, to ensure long-term commitment to these initiatives, new board members must be recruited who are dedicated to the quality and patient safety efforts.

Strategies for Leadership in Quality and Patient Safety. Each board can individually take actions that advance the hospital's progress toward its quality and patient safety goals. According to a recent article in Trustee magazine, specific steps boards can take include:

- Putting patient safety on every board agenda;
- Participating in external safety education programs and conferences;
- Asking how patient safety is addressed in the hospital;
- Discussing how the hospital ensures that everyone understands their role in quality and patient safety;
- Familiarizing board members with Joint Commission requirements and additional patient safety materials;
- Speaking publicly about the unacceptability of the current state of patient safety;
- Implementing a proactive patient safety approach;
- Developing a culture of trust, rather than blame;
- Setting an expectation for interdisciplinary error and near-miss investigations;
- Including quality improvement and patient safety in orientation and education;
- Ensuring patients/families are notified as soon as possible if an error occurs;
- Supporting investment in quality and safety;
- Openly engaging employees in patient safety planning, probing for perceptions of risk areas;
- Continuously articulating the business case for safety improvement;
- Personally promoting patient safety;
- Ensuring that resources are appropriate for safety improvement;
- Conducting self-assessments;
- Cultivating media and staff understanding of the issues;
- Ensuring systems are in place for assess individual accountability and competence;
- Sharing personal and institutional patient safety learning;
- Participating in conferences, coalitions and other efforts to improve patient safety; and
- Engaging in initiatives to drive enhancements in regulations, licensing and accreditation agencies that support safety improvement.

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Glossary of Quality and Patient Safety Terms

Accident – An event that involves damage to a defined system that disrupts the ongoing or future output of the future

Active Error – An error that occurs at the level of the frontline operator and whose effects are felt almost immediately

Active Failure – An error that is precipitated by the commission of errors and violations. These are difficult to anticipate and have an immediate adverse impact on safety by breaching, bypassing or disabling existing defenses

Adverse Drug Event (ADE) – An injury resulting from the use of a drug; any incident in which the use of a medication at any dose, a medical device, or a special nutritional product may have resulted in an adverse outcome in a patient

Adverse Drug Reaction (ADR) – A response to a drug which is noxious and unintended, and which occurs at doses normally used or tested in man for the prophylaxis, diagnosis, or therapy of disease, or for the modification of physiological function; an undesirable response associated with use of a drug that either compromises therapeutic efficacy, enhances toxicity, or both

Adverse Event – An incident in which unintended harm resulted to a person receiving health care; an injury caused by medical management rather than the underlying condition of the patient

Close Call – A potential adverse event, or a situation that could have resulted in an accident, injury or illness, but did not either by chance or through timely intervention

Competence – A range of abilities including clinical skills, knowledge and judgment together with communication skills, personal behavior and professional ethics

Compliance Error – Inappropriate resident behavior regarding adherence to a prescribed medication regimen

Deteriorated Drug Error – Administration of a medication when the physical or chemical integrity of the dosage form has been compromised, such as expired medications, medications not properly stored, or medications requiring refrigeration that are left out at room temperature

Dispensing Error – The failure to dispense a medication upon physician order (omission error) or within a specified period of time from receipt of the medication order to reorder (time error); dispensing the incorrect drug, dose, dosage form; failure to dispense correct amount of medication; inappropriate, incorrect or inadequate labeling of medication; incorrect or inappropriate preparation, packaging, or storage of medication

prior to dispensing; dispensing of expired, improperly stored, or physically or chemically compromised medications

Dimensions of Quality – Measures of health system performance, including measures of effectiveness, appropriateness, efficiency, responsiveness, accessibility, safety, continuity, capability and sustainability

Effective – Care, intervention or action achieves its desired outcome

Error – Encompasses all those occasions in which a planned sequence of mental or physical activities fails to achieve its intended outcome. The failure of a planned action to be completed as intended (i.e. error of execution) or the use of a wrong plan to achieve an aim (i.e. error of planning). Errors can include problems in practice, products, procedures and systems

Error of Commission – An error which occurs as a result of an action taken. Examples include when a drug is administered at the wrong time, in the wrong dosage, or using the wrong route; surgeries performed on the wrong side of the body; and transfusion errors involving blood cross-matched for another patient

Error of Omission – An error which occurs as a result of an action not taken. Examples include when a delay in performing an indicated cesarean section results in a fetal death, when a nurse omits a dose of a medication that should be administered, or when a patient suicide is associated with a lapse in carrying out frequent patient checks in a psychiatric unit. Errors of omission may or may not lead to adverse outcomes

Extra Dose Error – The administration of duplicate doses to a resident or administration of one or more dosage units in addition to those that were ordered. May include administration of a medication dose after the order was discontinued (could also be considered an “Unauthorized Drug Error”)

Fault Tree Analysis – A systematic way of prospectively examining a design for possible ways in which failure can occur. The analysis considers the possible direct proximate causes that could lead to the event and seeks their origins. Once this is accomplished, ways to avoid these origins and causes must be identified

Harm – Death, disease, injury, suffer, and/or disability experienced by a person

Hazard – A source of potential harm or a situation with a potential to cause loss

Iatrogenic – Arising from or associated with health care rather than an underlying disease or injury. Consequences of omission (failing to do the right thing) as well as commission (doing the wrong thing) are included; resulting from the professional activities of physicians, or more broadly, from the activities of health professionals. Originally applied to disorders induced in the patient by autosuggestion based on a physician's examination, manner or discussion, the term is currently applied to any undesirable condition in a patient occurring as the result of treatment by a health professional, especially to infections acquired by the patient during the course of treatment

Incident – An event or circumstance which could have, or did lead to unintended and/or unnecessary harm to a person, and/or a complaint, loss or damage

Injury – Damage to tissues caused by an agent or circumstance; untoward harm occurring to a patient

Latent Errors – Errors in the design, organization, training or maintenance that lead to operator errors and whose effects typically lie dormant in the system for lengthy periods of time

Liability – Being answerable, chargeable, or responsible; under legal obligation

Loss – Any negative consequence, financial or otherwise

Malpractice – Improper or unethical conduct or unreasonable lack of skill by a holder of a professional or official position; often applied to physicians, dentists, lawyers and other public officers to denote negligent or unskillful performance of duties when professional skills are obligatory, malpractice is a cause of action for which damages are allowed

Medical Error – Failure of a planned action to be completed as intended (i.e. error of execution) or the use of a wrong plan to achieve an aim (i.e. error of planning)

Medication Error – Any preventable event that may cause or lead to inappropriate medication use or patient harm, while the medication is in the control of the health care professional, patient or consumer

Mortality – Death from disease or injury

Morbidity – The negative consequences (symptoms, disabilities or impaired physiological state) resulting from disease, injury or its treatment

Near Miss – An incident that had the potential to, but did not cause harm (also a “close call” or “potential adverse event”)

Negligence – An action in tort law, the elements of which are: the existence of a duty of care; breach of that duty; and material damage as a consequence of the breach of duty. The existence of a duty of care is a legal obligation to avoid causing harm, and arises where harm is foreseeable if due care is not taken; failure to use such care as a reasonably prudent and careful person would use under similar circumstances

Nosocomial – Pertaining to or originating in a health care facility

Omission Error – The failure to administer an ordered dose to a resident by the time the next dose is due, assuming there has been no prescribing error. Exceptions would include a person's refusal to take the medication and failure to administer the dose because of recognized contraindications

Plan-Do-Study-Act (PDSA) – A four-part method for discovering and correcting assignable causes to improve the quality of processes

Preventable – Potentially avoidable in the relevant circumstances

Potential Adverse Event – An error of medical management that does not result in injury (“near misses”); an event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or through timely intervention

Preventable Adverse Event – An adverse event attributable to an error; an injury due to medical care that results from errors or other system breakdowns, such as failure of an infusion pump

Proximate Cause – An act or omission that naturally and directly produces a consequence. It is the superficial or obvious cause for an occurrence. Treating only the “symptoms,” or the proximate special cause, may lead to some short-term improvements, but will not prevent the variation from recurring

Quality – The extent to which the properties of a service or product produces a desired outcome

Risk – The chance of something happening that will have an impact upon objectives. It is measured in terms of consequences and likelihood

Risk Management – The culture, processes and structures that are directed toward the effective management of potential opportunities and adverse effects

Root Cause Analysis – A systematic process whereby the factors which contributed to an incident are identified; the most fundamental reason for the failure or inefficiency of a process

Safety – The degree to which the potential risk and unintended results are avoided or minimized; freedom from accidental injury

Sentinel Event – Events in which death or serious harm to a patient has occurred; an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof; an incident with actual or potential serious harm, or death; an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called “sentinel” because they signal the need for immediate investigation and response

System – A set of interdependent elements interacting to achieve a common aim. These elements may be both human and non-human (equipment, technologies, etc.)

Underlying Cause – The systems or process cause that allow for the proximate cause of an event to occur. Underlying causes may involve special-cause variation, common-cause variation, or both

Unpreventable Adverse Event – An adverse event that is not attributable to an error

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- PerformanceWORKS, a solution for conducting an accountable CEO compensation and performance evaluation process

RetreatWORKS™

Leadership workshops and retreats are a valuable tool to build understanding and teamwork, develop collaboration and consensus, and forge solutions and new directions. We custom-tailor our retreat planning and facilitation approach to achieve your critical objectives: Participation, interaction, creative thinking and results. Our services include:

- Pre-planning and preparation, including objectives and logistics
- Meeting materials, including agendas, name tents, case studies, background materials, retreat evaluations and other meeting support documents
- Meeting facilitation and management
- Development of a comprehensive, action-oriented summary retreat report
- Follow-up consultation on next steps

OpinionWORKS™

We plan, design and carry out a wide range of research solutions that improve organizational intelligence, build knowledge, and result in new success-building initiatives. We employ online surveys, printed surveys, focus groups and key informant interviews designed to meet your unique needs.

- Employee opinion surveys
- Medical staff surveys and needs assessments
- Community attitudes and needs assessments
- Key issues surveys
- Marketing effectiveness assessments

Leadership. Trust. Performance. Results.