Blog Post

Is A Safer Healthcare System Within Reach?

November 3, 2020

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COVID-19 has made healthcare organizations acutely aware of the need to fine-tune their internal safety systems. The National Steering Committee for Patient Safety (NSC), comprised of 27 organizations, has come to the rescue. NSC recently released guidance entitled, "Safer Together: A National Action Plan to Advance Patient Safety" (the Plan). The Plan provides a methodology for improving safety and reducing harm by outlining 17 recommendations within four foundational areas throughout healthcare.

Individuals at the pinnacle of the healthcare organization must establish a strong culture of safety. Buy-in and engagement is then obtained from patients, their families, and healthcare workers. To put it colloquially, the Plan dictates a proactive approach – the right hand must know what the left hand is doing. "Total systems safety requires a shift from reactive, piecemeal interventions to a proactive strategy in which risks are anticipated and system-wide safety processes are established and applied across the entire healthcare continuum."

Reducing patient harm benefits everyone. Such benefits of an improved quality of care include increased patient and staff well-being, reduced liability actions, fewer patient complaints, and fewer governmental investigations. States are also doing

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what they can to enforce quality improvement. For example, Florida's Agency for Healthcare Administration <u>announced</u> on October 23, 2020, that it plans to develop a new rule for patient safety culture surveys. This action is in response to <u>Florida House Bill No. 763</u>, recent legislation requiring each hospital and ambulatory surgical center to conduct a patient safety culture survey at least biennially. For all these reasons, healthcare organizations should follow the Plan's recommendations.

Area #1: Culture, Leadership, and Governance

It starts at the top, with senior leadership promoting a culture of safety. "[A]ll leaders have an obligation to substantially advance patient and workforce safety by committing to safety and the elimination of harm." The first foundational area therefore encourages leaders to prioritize safety in the mission and values of the organization by following these recommendations:

- Make safety a core value.
- Focus on current capabilities and allocate resources for safety.
- Share information throughout the organization.
- Assess the safety competencies of senior leaders and board members.

Area #2: Patient and Family Engagement

Patients and their families have responsibilities, too. As an example, see the <u>Florida Patient's Bill of Rights and Responsibilities</u>. Patient outcomes improve when family members are also involved in patient care. For this reason, the second foundational area is to ensure that patients, families, and healthcare partners are fully engaged in all aspects of patient care by:

- Training healthcare professionals on how to engage patients and families.

- Encouraging patients and their families to speak up with questions.

- Ensuring patients and their families are involved in safety assessments.

- Applying safety measures equitably for all patients and families.

- Treating patients and their families with respect and being transparent in sharing safety issues.

Area #3: Workforce Safety

Protect the workforce. "The well-being and physical and psychological safety of the workforce are essential for patient safety. Healthcare workers who are safe are more likely to think, act, and practice in a safe way." To promote workforce safety, healthcare providers should:

- Educate leaders on the development of safety strategies.

- Encourage leaders to feel accountable for everyone's safety.

- Promote programs which monitor safety through metrics and performance dashboards.

Area #4: Learning System

Leaders must learn to work together inside and across all organizations. Successful implementation of the Plan's recommendations will be achieved by working together. Accordingly, healthcare providers should:

- Ensure staff throughout the organization is educated on safety protocols.

- Create networks on a national level to share safety best practices.

- Set high standards for education and training.

- Develop shared goals across organizations.

- Expedite collaboration through interactive methods, such as data sharing.

<u>Getting Started</u>

Improving patient safety cannot take a back seat during the COVID-19 pandemic. Senior leaders should implement the Plan's recommendations as soon as possible. As COVID-19 cases may surge, getting a handle on reducing preventable harm is key.

NSC created two companion guides to assist in this process: (1) an <u>Implementation Resource Guide</u>, and (2) a <u>Self-Assessment Tool</u>. The Implementation Resource Guide provides further support for the Plan by outlining tactics and resources to guide next steps. The Self-Assessment Tool allows leaders to assess progress in the four foundational areas, before and throughout implementation. Recommended actions are outlined, based on the assessment.

Risk Departments and/or Quality Departments may choose to use the Self-Assessment Tool as part of their yearly Work Plans. These departments are ideally positioned to work with leaders and staff to ensure successful implementation of the Plan.

After all, we are all "safer together."