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Building a Culture of Safety: 7 Lessons From a Hospital CEO

by Molly Gamble | July 18, 2011

Across the United States every day, hospitals experience patient safety events both large and small. Several years ago, a number of hospitals in Rhode Island experienced an unusually high number of wrong-site procedures and other serious patient safety events, prompting a mandate from the State Department of Health to implement several initiatives to improve patient safety.

Sandra Coletta, president and CEO of Kent Hospital in Warwick, R.I., was tasked with leading the hospital and its providers through these initiatives and, today, she believes that true change in patient safety can happen with a strategic, top-down approach. As part of these continued efforts, Kent Hospital is part of a major patient safety initiative in Rhode Island — all 13 private acute care hospitals in the state, including Kent, are part of GE Healthcare's Patient Safety Organization. The GE PSO allows providers to share knowledge, insights and findings through the PSO Community. Here, Ms. Coletta and Pat Daughenbaugh, Senior Manager, leading the Patient Safety team for GE Healthcare Performance Solutions' Clinical Operations, discuss the how hospital leaders should develop a culture of safety — not silence.

1. Collaborate with other providers. Sharing information helps hospitals identify risks that may not be on their radar, but should be. "For instance, placing a catheter line in a wrong arm brings more attention to that risk, and the idea that wrong sites can be involved in more than surgery," says Ms. Coletta. Through the common event reporting platform, GE Healthcare Performance Solutions' Medical Event Reporting System (MERS), the entire state of Rhode Island reports errors in the same format. The PSO de-identifies data so it cannot be traced to individual hospitals or patients, creating a safe harbor environment for providers to share data on adverse events and near-misses across specialties.

2. Design new interventions. Along with the reporting platform, Kent now has a full-time patient safety officer, whose entire focus is on boosting safety and identifying risks within the hospital. "She has implemented safety rounds and asks staff where they consider the next risks to be," says Ms. Coletta. The hospital also established the Michael J. Woods Institute in late 2009, which examines systems within the hospital and designs them to be safer.

3. Refuse to believe any risk is "too small." Some providers may deem a risk as too small to report, and others may fear punitive measures for reporting the shortcomings of their peers or themselves. CEOs should quell this idea and encourage vigilant reporting. As Kent nears its one-year anniversary of using MERS to report medical events, Ms. Coletta says the hospital has reported 3,860 events. "This is not because there are more errors, but because more people understand the value of reporting these events," says Ms. Daughenbaugh.

4. Delineate categories of problematic behaviors. A common cause for cultures of silence is the fear of punishment. Hospitals can reduce this hesitation to report by creating consensus over what makes up a "medical error" and replacing overly-punitive approaches to error management with a system of positive reinforcements for safe behaviors. For instance, dividing patient safety events into four categories — human error, reckless conduct and negligence — can help staff recognize and report events accurately, according to a white paper co-authored by Ms. Daughenbaugh. A systematic and organized approach to patient safety improvements can help hospitals find middle ground between a blame-free and overly punitive hospital culture.

5. Understand the concept of human drift. In healthcare, identifying a patient is like tying a pair of shoes — it's a universally-known policy that would seem low-risk to most hospital CEOs. However, when Ms. Coletta and Kent began to examine reported risks, they found a large number of issues had to do with identifying patients. "By human nature, we tend to drift from policies, and that drift in patient identification was picked up by the system." Kent went back and provided reminders, education and adopted a systematic approach to prevent further identification errors.

6. Adopt a proactive mindset. CEOs should not be content in receiving instructions on how to fix errors that have already happened — they should be fixing where the next error will occur. The patient safety culture has to be built from top down, says Ms. Coletta. Rather than reacting to an event, leaders should maintain a sense of urgency around patient safety and consistently be alert to any potential risks. By collaborating with other providers, hospital leaders can learn of risks before they occur at their institution and work diligently to prevent them.

7. Remember why you're sitting at the CEO desk. "The first order of business is to remember that this is not about a billboard or a bond rating," says Ms. Coletta. "It's about high-quality care and delivering it without harm." Ms. Coletta also suggests that CEOs be prepared to take some risks in rolling out new initiatives to improve patient safety and accept the fact that everything may not go exactly as planned. "We don’t have the luxury of waiting for a perfect solution — there isn’t one. We do what we can, learn from what doesn’t work and keep getting better," says Ms. Coletta. "Our patients deserve nothing less."