Autumn 2022

# First Do No Harm

Quality & Patient Safety Division  Massachusetts Board of Registration in Medicine

In This Issue



## Message from QPSD Leadership

Booker T. Bush, MD
Chair, Quality & Patient Safety Committee

Daniela Brown, MSN, RN, CIC
Director, Quality & Patient Safety Division

Dear Colleagues,

The poet, Maya Angelou said: "Do the best you can until you know better. Then when you know better, do better." Most clinicians and leaders in healthcare are continually seeking knowledge and opportunities to "do better" for our patients and their families. The concept of ongoing organizational improvement is at the core of quality assurance programs in healthcare. Using a systematic approach to quality improvement aids in standardizing processes and structure to improve outcomes for patients and healthcare organizations.

The mission of the Board's Quality and Patient Safety Division (QPSD) (Quality and Safety Program | Mass.gov) is to assist Massachusetts healthcare facilities in maintaining and improving systems for patient care that are evidence and team-based, sustainable, safe, and inclusive. We achieve this by reviewing data, listening, collaborating, and educating teams in healthcare facilities throughout the state. The QPSD is a very distinct division of the Board which operates behind a firewall. Information and reports that are necessary to comply with the Patient Care Assessment (PCA) regulations (243 CMR 3.00: The establishment of and participation in qualified patient care assessment programs, pursuant to M.G.L. c. 112, § 5, and M.G.L. c. 111, § 203. | Mass.gov) and reported to the QPSD are afforded statuary protection and not shared with other divisions of the Board. The intention is to be collaborative, non-punitive, and to proceed utilizing the principles of Just Culture (Introduction to Just Culture | Just Culture in Health Care). Our goal is to assist hospitals and ambulatory clinics with continuous organizational and systemic learning and improvement.

This newsletter focuses on learning and performance improvement. Several hospitals provided information regarding their efforts to promote a culture of safety and ongoing improvement. We thank them for sharing their progress with our readers.

To assist with the process of quality improvement, the QPSD offered three sessions of a PCA Boot Camp over the summer for sixty-seven of our quality and risk management colleagues that had been reporting to our division for two years or less. The QPSD noted that many individuals reporting to our division were newly in their role and felt that this support would be beneficial. There are plans to repeat a session of our PCA Boot Camp during the winter. The next virtual, educational sessions will occur in December. Anyone reporting to the QPSD is encouraged to participate. Information regarding the program and how to register may be found on page seven.

Finally, on behalf of the QPSD and the QPS Committee, we would like to extend our sincere appreciation to Dr. Julian N. Robinson who recently stepped down from his position as the Chair of the QPS Committee for the past four years. Dr. Robinson has been instrumental in creating an active, knowledgeable, and diverse committee which supports the work of the QPSD. We are fortunate that Dr. Robinson will remain a member of the committee. We thank him for his dedication and commitment to furthering the mission of BORIM and the QPSD.

Best Regards,

Booker T. Bush, MD, Chair, QPSC and Daniela Brown, RN, Director, QPSD

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## Berkshire Health System

### Creating a Just Culture and Psychological Safety at Berkshire Health Systems

Lisa Khanna RN, BSN, CPHQ
Vice President of Quality

Three years ago, Berkshire Health Systems (BHS) embarked on journey to improve our patient safety program. We made a system wide commitment to a just culture and psychological safety. A just culture is an environment that promotes the reporting of safety events, uses events as learning opportunities and proactively seeks to improve processes to prevent future events. Psychological safety is the staff's belief that they won't be punished or humiliated for speaking up with safety concerns or reporting mistakes.

Leadership commitment to just culture and psychological safety is vital to a successful patient safety program. Our leadership team receives all safety event reports from the previous 24 hours every morning. At morning safety huddle, leaders review the previous 24-hour safety events as well as follow up on all unresolved safety issues. No meetings are scheduled between 10am and 11am to allow leaders and the patient safety team to round on the patient care units and speak to staff and patients about their safety concerns. If a serious safety event occurs, a Critical Event Response Team of senior leaders is available 24/7 to support staff, address the immediate issue and prevent reoccurrence. Psychological first aid is offered immediately to all staff involved in serious safety events.

Staff engagement is crucial for maintaining a just culture and psychological safety. Staff are encouraged to speak up and point out process failures and make suggestions for improvement. We reinforce this daily by rewarding "good catch" reporting at safety huddle. Our Patient Safety Hero award was instituted to reward staff who go above and beyond their duties to prevent a patient safety event. Our latest recipient of this award is an Environmental Service staff member who noticed a patient in distress, driving erratically in the parking lot, and brought her safely into the Cancer Center for care. Our safety event reporting system has been moved to our electronic medical record with additional access through our employee portal and a confidential hotline. This allows ease of access to 100% of our staff and providers.

To promote team centered psychological safety, we are instituting Structured Interdisciplinary Bedside Rounds (SIBR) in inpatient care areas. This is a brief, bedside patient huddle involving a patient specific report out by all disciplines, including a safety checklist. All team members are expected to both share and listen with mutual respect. Psychological safety means that the staff is comfortable expressing concerns up the power gradient and escalating their concerns if they do not feel the situation has been properly addressed. We have a clear policy on how to escalate patient safety concerns.

Because a just culture is a learning culture, all near misses and safety events are used as learning opportunities. To promote this, we involve the frontline staff in debriefing all safety events and conducting RCAs. To reinforce psychological safety for all participants we use ground rules stating that we are looking for "what, when and why" in order to create system improvements, not "who" for blame. We use the just culture algorithm to review the actions of staff involved in the event. Staff are then involved in the process improvements to prevent reoccurrence.

Transparency about safety events is essential for maintaining a just culture and psychological safety. Department specific safety dashboards are provided to each unit to inform their performance improvement efforts. All departments present their performance improvement projects at monthly Quality Council. All safety events are reviewed for broader trends at monthly interdisciplinary Safety Committee meetings. This information is shared with senior leadership and the board of trustees. This transparency gives us an institutional knowledge of our safety culture and helps us use all events for process improvement.

These efforts have resulted in many positive outcomes. Frontline staff have increased safety event reporting by 800 per quarter, demonstrating individual ownership and trust in leadership to listen and create change. Our PSI 90 score has decreased from 1.125 in 2021 to 0.76 in 2022 showing an actual decrease in safety events. Finally, we have attained both a Leapfrog A and Best Teaching Hospital designation for the past two years. We feel these outcomes show that culture change and psychological safety are powerful tools for improving patient safety.

## Lowell General Hospital

### Building Trust & Accountability Through a Just Culture Environment

Erin M. Donovan, MHA, Vice President
Quality & Regulatory Compliance
Tatiana Schultz, JD, Sr. Risk Manager

In 2018, as part of our ongoing journey to High Reliability, Lowell General Hospital leadership committed to advancing a Just Culture environment. This evidence-based operational model resonated with leaders and staff. Just Culture recognizes human error as universal, holds employees accountable for their behavioral choices, holds the organizational leadership accountable for designing and implementing systems and processes that promote patient and staff safety, and ensures workplace justice for all regardless of the patient outcome or level of harm.

We began this work by driving home the point that every staff member has accountability in ensuring a safe environment for our consumers and fellow colleagues regardless of one's job title, position, or scope. We introduced a Zero Harm pledge that all staff was asked to take, and new staff sign upon hire. This pledge is reinforced throughout the course of the year through newsletters, patient stories, and ongoing education.

*Zero Harm Pledge:*

*I acknowledge my responsibility in providing a safe environment for our patients to receive healthcare services and agree to the following:*

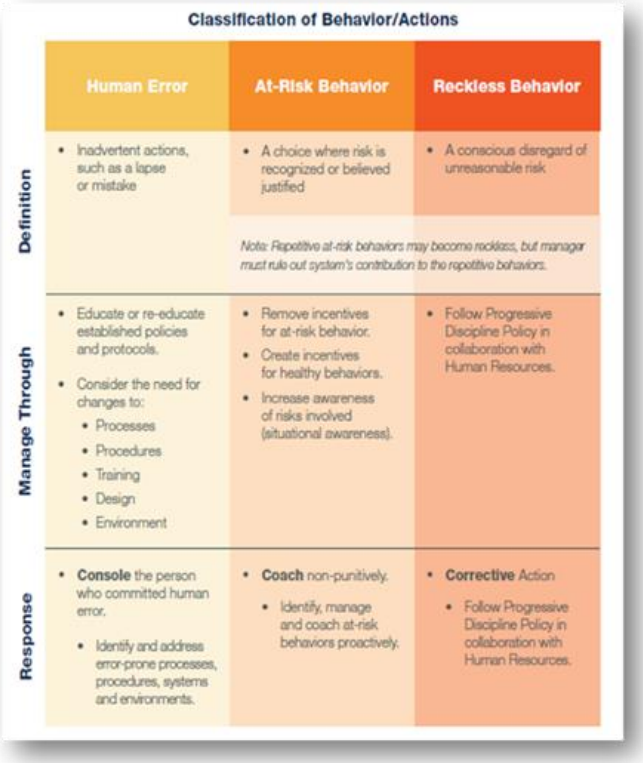
- ✓ *I will maintain ongoing knowledge and awareness of hospital and department-specific policies, procedures and protocols that affect the manner in which I perform my job responsibilities.*
- ✓ *I will utilize the hospital's electronic safety reporting system to report any events resulting in unexpected injury/harm to a patient or visitor, any events suggesting a lapse from customary operations that have the potential to cause unexpected injury/harm to other ("Near Miss") and*
- ✓ *I will maintain ongoing safety awareness while on hospital premises and proactively address or report safety issues that I may observe that have the potential to cause injury/harm to others.*


As a next step, we began training for Just Culture. A mandatory on-line training module was developed for all staff outlining what Just Culture is; why it is important to adopt at Lowell General; exposure to the types of behavior that contribute to error (Human Error, At-Risk Behavior, Reckless Behavior), and the appropriate responses. Staff were taken through scenarios (clinical and non-clinical) to reinforce the behaviors and follow-through expected.

In addition to the on-line training, all leaders were required to participate in workshop training. The objectives of this training were to have each leader identify actual or potential risks that existed in their department, recognize barriers that prevent employees from speaking up, understand their role as a leader in supporting a Just Culture environment, identify the components necessary to effectively investigate the source of errors and at-risk behaviors, recognize how to facilitate safe choices focused on managing behavior and systems, demonstrate understanding of using the Just Culture Model guidelines through practice, and develop a communication plan for their department to reinforce the initial on-line training and next steps in developing this culture.

Leaders were asked to evaluate more sample scenarios so they could identify the behavior in play and apply the best corrective response. They practiced having conversations with employees following the analysis of the event. They were instructed on questions to consider helping uncover underlying system issues, and they left training with a plan for advancing this model in their departments. Toolkits were also created for our leaders to reference in the weeks following training.

*Example tools:*



**Safety Action Guidelines**

These steps guide you through the necessary actions to take after an event has been identified using a Just Culture structure. *It is not intended to take the place of a Safety Report.*

**Step 1: Initial incident investigation / Ensure factual understanding of event**

- How did steps leading to event differ from what should have occurred?
- Interview involved staff members individually to understand their perspective of event
- Review relevant data sources (i.e., medical record, safety report)
- Helpful Tip: Creating a timeline of event may help identify process lapses or barriers

**Step 2: Analysis of staff behavior/motivation in choosing how to act**

- Did staff member act contrary to established policy/protocol?
- Was staff member aware of established policy/protocol? If not, should they have been?
- Did the staff member believe their actions were justified? If so, why?
- Did the staff member appreciate that their actions might cause harm and if not, should they have?
- Did the staff member consciously disregard the risk of potential harm?
- Did the staff member consult with any resources prior to acting?
- What is the staff member's usual and customary practice?
- Has this been a repetitive behavior with this staff member?

**Step 3: Analysis of Systems Issues**

- Is this an issue addressed at new dept orientation, dept meetings or performance evaluations?
- Has this been a recurring issue? If so, have adequate efforts been taken to address it?
- Are the involved staff members' competencies/education/licensure up to date?
- Are staffing issues at play? Was there adequate staffing? The right combination of roles?
- Were there IT or EMR issues that contributed to event?
- Were there equipment or supply issues that prevented the staff member from acting appropriately?
- Where there any ineffective communication practices that contributed to the event?
- Do policy and procedure conform to current national standards?
- What is the culture on the unit --- how would other staff have acted?
- Were there adequate resources available to the staff for guidance?

**Step 4: Analyze behavior to determine if HUMAN ERROR, AT-RISK, OR RECKLESS**

**Step 5: Console, Coach or Correct staff behavior as appropriate**

**Step 6: Consider measures that might be implemented to improve safety**

- Involve front-line staff in development of corrective actions
- Share safety improvement suggestions with department for enhanced awareness

**Step 7: Monitor corrective actions for effectiveness and sustainability**

- Ensure staff enculturation and alignment with operations

This training approach positioned our leaders with the didactic knowledge, practical applications, and resources they would need to be successful.

Just Culture and Zero harm is reinforced on a monthly basis by our President and CEO's Executive Insight column in the hospital's monthly staff newsletter. The column highlights a process, policy or procedure reflecting our unwavering commitment to a Zero Harm environment. These might include review of critical hospital policies, lessons learned from case reviews or unit-based performance improvement initiatives. Examples of potential harm scenarios are highlighted in each issue arising from both clinical and non-clinical hospital service lines. Staff are further educated on how the specific Zero Harm topic at hand is tied back to larger initiatives associated with our hospital's overall Strategic Plan. These efforts promote enculturation of our hospital commitment to Zero Harm and Just Culture among all clinicians and staff members on an ongoing basis.

We measure the success of this work and our ongoing safety culture through annual Employee Engagement surveys. Scores for elements such as *"I can report patient safety mistakes without fear of punishment"*, *"In my work areas, we discuss ways to prevent errors from happening again"* and *"Employees will freely speak up if they see something that may negatively affect patient care"* demonstrate high positive response levels. Variations in these scores and department level analyses allow us to target areas that may require additional support or improvement efforts.

## Steward Health Care System

### Building Psychological Safety through Trust: A Vital Component for Sustainable, High-Performing Teams

Kenneth Lawson, MD, FACEP
Chief Medical Officer
Good Samaritan Medical Center (Brockton)
Saint Anne's Hospital (Fall River)
New England Sinai Hospital (Stoughton)

It is clear that the healthcare environment has changed dramatically over the last few years. We routinely ask our teams to perform at higher levels, achieving more all the while equipping them with less and less resources. Regardless of setting, whether it be a single provider practice or a fully integrated health system, this cycle repeats itself daily challenging our ability to execute. Seminal to circumnavigating these challenges is the ability to hire and retain execution and mission oriented staff and leaders. However, it is becoming harder and harder to find talent. It is becoming nearly impossible to retain talent. We all recognize the many external factors that add to this, however, the impact of the "Great Resignation" over the past two years have thoroughly exacerbated this crisis. With all of these external forces afoot, it is incumbent upon leadership to maintain focus on what is within their control to impact, continuously moving the ship forward despite the uncertainty of what lies ahead.

I find Trust to be the most important bi-directional ingredient for a successful team. Trust is the fulcrum that the rest of the team is stabilized upon. I have found and experienced that trust includes most components of psychological safety, empathy, and workplace confidence. Trust is easy to describe but all too challenging to achieve. But once harnessed, it must be nurtured to keep the equilibrium of the team alive. Having trust in your leadership team has been shown to:

- Reduce stress/burnout
- Improve productivity
- Reduce sick days
- Improve satisfaction
- Improve engagement

Failure to build trust becomes an imminent threat to success and can often actually lead to a systematic dismantling of the team.

The onus for building a culture of trust resides at the top, seemingly cliché but true. Senior Leadership Teams must

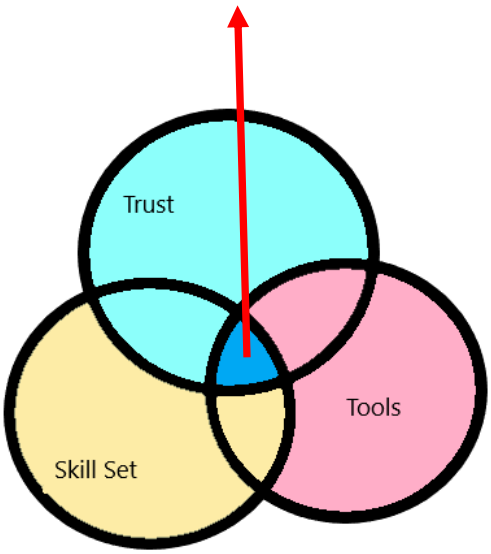
be able to live and demonstrate trust in each other and their team members, empowering all to fully buy in to the mission. Leaders must communicate in a logical and authentic way while also embracing and celebrating the interpersonal skills that have become lost in our world today. This focus must cascade down the organizational chart in a way that is visible to all employees. Leaders must look for and celebrate those trust bearing behaviors in action, ingratiating them further and further into the desired culture. Within the flux of today's job market, partnering with our team members to understand their career goals and curating a path for them to be successful is incredibly important. Not only does this simple act further encourage trust building, but it also markedly improves job satisfaction and empowers our team members to think big. Regularly scheduled sessions to catch up with your team members brings structure and helps them stay on track to achieve their goals. It also gives leaders the opportunity to provide constructive feedback, doing so in a way that harnesses the trust and destigmatizes the idea of continuous improvement.

At Steward Health Care, we are constantly working to improve employee experience by nurturing a culture that caters to the needs to our team members. We have a clear and focused plan to help us achieve our goals of employee recruitment and retention. To help us achieve these goals across a national organization, many of the action plan's component parts have been hardwired and revolve around a standardized tool bundle and reporting system. Managers at all levels complete education through an in-house program. Leading this initiative is a compilation of tools and programs that have been designed to assist our leaders in recruiting, recognizing, and retaining top talent. This educational program works through training, tools, and practice resulting in stronger leaders, more engaged team members, and excellent patient experience. This program, which includes an employee referral program, new team member checklists, Steward University education, a buddy program, performance appraisals, career development, leader rounding, and resignation recovery, has rolled out over the past 18 months and has shown positive results during challenging times.

These are a few steps to bring stability to our review and evaluation process. Continued dialogue with managers helps to build the tools needed for success and help build ties in frontline leadership.

An overly simple way to categorize required elements for high performance people/teams:

## High Performing Team




| Skill Set | Tools | Trust |
|---|---|---|
| Ability to grow | supplies | empathy |
| Training | staff | communication |
| Attitude | space | confidence |
| License | time | common goal |

Skill set is owned by and adjustable by the individual.

Tools and Trust are owned and delivered by leadership.

Ensuring that these elements are built into the fabric of a developing team is absolutely essential to ensure high performance. They serve as an incubator for creativity and growth. Building your team in that way, will lead to new levels of efficiency, retention, and success. An inability to support and balance these required ingredients can lead to repetitive failures despite pockets of excellence. I have found that highly effective leadership teams continuously evaluate themselves, are intellectually curious, and have the trust in one another to throw out novel ideas and think big. These things are infectious and will permeate an organization and culture. This is what drives performance beyond expectations.

## Tufts Medical Center

### Creating a Safer Hospital Environment Through a Proactive Psychiatric Consultation Model

Cristina Montalvo, MD, MBS
Chief, Consultation-Liaison Psychiatry and Emergency Services
Kathryne Adams, MD
Tufts Medical Center Psychiatry Residency Program

Healthcare providers are at elevated risk of suffering physical or emotional abuse from patients, family members, and visitors.[1] In a survey by the American Nurses Association (ANA) in 2015 it was found that 43% of nurses or nursing students experience verbal or physical threats from either patients or family members.[2] This level of verbal abuse and threat of physical abuse creates a direct impact on patient quality and safety. An analysis of associations between verbal abuse and quality and safety outcomes demonstrated that nurses who experience regular verbal abuse, at least monthly, from patients or families were 45% less likely to report high-quality care.[3]

Fortunately, there is the potential to identify patients more likely to be physically and/or verbally assaultive in an appropriate and timely manner. The most common characteristic exhibited by patients prior to an assault is altered mental status with the etiology often being dementia, delirium, substance use, or decompensated mental illness.[4] In addition, further research has elucidated that there are racial disparities in the use of physical restraints in various healthcare settings with Black and Asian patients more likely than White patients to be physically restrained to hospital beds.[5,6] Screening tools and team-based approaches can lead to effective intervention, leading to improvement in patient safety as well as satisfaction among healthcare workers.[7] At Tufts Medical Center (TMC), we are working to combine the Brøset Violence Checklist (BVC) and a Behavioral Emergency Response Team (BERT) to create a safer hospital environment for both patients, families, and staff.

These interventions are being rolled out in two phases. The first phase, currently ongoing, includes short de-escalation training and utilization of the BVC, a pro-active screening measure. The de-escalation training is an abbreviated one-hour version of the longer Crisis Prevention Institute (CPI) training. The BCV is a validated, predictive, nurse-administered screening tool to identify patients displaying agitated or aggressive behavior. The BVC assesses the presence or absence of confusion, irritability, boisterousness, verbal threats, physical threats, and attacking objects. Patients can receive a score of 0-6 with scores of 3 or greater being a predictor of violence towards staff within the next 24 hours.[8,9] This pro-active screening tool aims to reduce behavioral health emergencies, pharmacologic and physical interventions, including the use of restraints and also aims to enhance staff psychological safety.

The second phase will be the creation and implementation of a BERT. The team would be comprised of a psychiatrist, public safety officer, nursing supervisor, a registered nurse with mental health training and members of a patient's care team.[10] At TMC, the BERT would be a tool similar to a medical code blue that could be called by any concerned team member to address acute agitation and would lead to activation of a team response.

Currently, the first phase has been rolled out successful to one of our surgical units with the highest assault rates in the hospital. Since the utilization of the BVC, both the amount of physical restraints for patients and assaults against nursing staff were reduced over the course of 21 weeks. Teams were able to anticipate escalating behaviors prior to an event which lead to proactive plans and consults to the Consultation-Liaison Psychiatry team. We are in the process of rolling out the utilization of the BVC to several more of our medical-surgical units. We anticipate with the utilization of the BVC we will be able to proactively identify patients who will require more intervention and benefit from proactive plan during hospitalization. We anticipate with both these interventions (BVC and BERTs) we will see an improvement in workplace safety as well as patient, family, and staff satisfaction. Our overall goal is to create a healthier and safer hospital community.

[1]Vincent-Höper S, Stein M, Nienhaus A, Schablon A. Workplace aggression and burnout in nursing— the moderating role of follow-up counseling. *Int J Environ Res Public Health*. 2020;17(9). doi:10.3390/ijerph17093152

[2]Simpson KR. Incivility, bullying, and workplace violence: New recommendations for nurses and their employers from the American nurses association. *MCN Am J Matern Nurs*. 2016;41(1):68. doi:10.1097/NMC.0000000000000206

[3]Cho H, Pavek K, Steege L. Workplace verbal abuse, nurse-reported quality of care and patient safety outcomes among early-career hospital nurses. *J Nurs Manag*. 2020;28(6):1250-1258. doi:10.1111/jonm.13071

[4]Joint Commission Sentinel Event Report Issue 59, April 2018

[5]Cassie KM, Cassie W. Racial disparities in the use of physical restraints in U.S. Nursing homes. *Heal Soc Work*. 2013;38(4):207-213. doi:10.1093/hsw/hlt020

[6]Price TB, David B, Otis D. The use of restraint and seclusion in different racial groups in an inpatient forensic setting. *J Am Acad Psychiatry Law*. 2004;32(2):163-168.

[7]Zicko CJM, Schroeder LRA, Byers CWS, Taylor LAM, Spence CDL. Behavioral Emergency Response Team: Implementation Improves Patient Safety, Staff Safety, and Staff Collaboration. *Worldviews Evidence-Based Nurs*. 2017;14(5):377-384. doi:10.1111/wvn.12225

[8]Woods P, Almvik R. The brøset violence checklist (BVC). *Acta Psychiatr Scand*. 2002;106(SUPPL.S412):103-105. doi:10.1034/j.1600-0447.106.s412.22.x

[9]Stinson K, Dunn T. Utilization of the Broset Violence Checklist to Proactively Engage Consultation-Liaison Phsyciatry. 2020. https://www.eventscribe.com/2020/CLP/fsPopup.asp?Mode=posterinfo&PosterID=307460.

[10]Loucks J, Rutledge DN, Hatch B, Morrison V. Rapid response team for behavioral emergencies. *J Am Psychiatr Nurses Assoc*. 2010;16(2):93-100. doi:10.1177/1078390310363023

## QPSD Outreach

The QPSD is pleased to offer virtual, educational sessions in December which will assist hospitals and ambulatory clinics in the submission of Safety and Quality Review (SQR) reports.

If you are new to reporting, or if you have been reporting to the QPSD for some time, these sessions may be helpful. We will break down the elements of the SQR report and provide examples of two events.

The process by which the QPSD reviews and processes SQR reports will also be discussed. Data regarding report submissions will be provided including the frequency of the QPSD's requests for more information and the most common reasons why the QPSD requests additional information.

### Deconstructing Safety & Quality Review (SQR) Reports

- Audience: Anyone who is responsible for or contributes to the submission of SQR reports to the QPSD
- 90-minute webinar via Webex
- SQR review process and data presented
- Will break down two (fictitious) event reports
  - Option A : December 2, 2022 @ 12 pm
    - Obstetrical event
    - Procedure-related event
  - Option B: December 8, 2022 @ 2 pm
    - Obstetrical event
    - Procedure-related event
  - ~~Option C: December 16, 2022 @ 12 pm~~
    - Procedure-related event (ambulatory setting)
    - Medication-related event

Full

- Note: Option A and B are the same.

**Please register for only one option.**

Registration is limited to individuals that currently report to the QPSD. Others wishing to register must obtain the permission of their organization's PCA Coordinator and the QPSD Director.

All sessions will be virtual via Webex.

**Please note that registration is not guaranteed until you receive a confirmation email.**

To register, please send an email to

qpsd.conference@mass.gov

Please include your name, credentials, title, and organization.

Space is limited.

Additional sessions may be scheduled if needed.

Questions and comments may be directed to
Mali Gunaratne
QPSD Administrative Coordinator
Quality & Patient Safety Division
Massachusetts Board of Registration in Medicine

mali.gunaratne@mass.gov