



The American Organization of Nurse Executives

Role of the Nurse Executive in Patient Safety

Guiding Principles TOOLKIT

The role of the nurse executive in patient safety is to help lead best practices and establish the right culture across multiple disciplines within the organization. The nurse leader must have the competencies necessary to design, coordinate and move forward patient safety principles and practices across the domains of governance, practice/patient care, education and research. This can only be accomplished in collaboration with the interdisciplinary team of health care academia, solution providers, policy makers and the community.

These guiding principles will assist the nurse executive in leading safety initiatives.

- [Lead Cultural Change](#)
- [Provide Shared Leadership](#)
- [Build External Partnerships](#)
- [Develop Leadership Competencies](#)

● LEAD CULTURAL CHANGE

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- Develop a safe culture that assures accountability and respects and values individual contributions and perspectives.
 - Incorporate safety as a visible design element in the system as a shared leadership accountability at the most senior level.
 - Provide the knowledge, tools and resources to prepare nurses to lead the safety agenda.
 - Value and promote nurse managers and frontline nurses' leadership in creating the safety culture.
 - Provide patient centric care by partnering with the patient and family to share, understand and align perceptions and reality of the care process.

Definition

Transforming culture change from that of a silent, hierarchical structure of blame to an open, team-oriented culture will improve patient safety. Human factors researcher and author, James Reason (1998) contends that a safe culture is an informed culture. An informed culture is “one in which those who manage and operate the system have current knowledge about the human, technical, organizational, and environmental factors that determine the safety of a system as a whole.”

Reason also contends that an informed culture requires four subcultures—a reporting culture, just culture, flexible culture and learning culture. Together these subcultures form a blameless culture that encourages and rewards reporting, one that is laterally structured and has processes in place so that members can study and grow from lessons learned.

Objectives

A safe, open, team-oriented culture improves patient care by providing a framework for identifying safety issues while holding people accountable for following the evidence based protocols and standards that have been shown to improve quality of care. According to Reason, a safe culture creates an atmosphere of trust by clearly defining safe and unsafe behaviors. When employees know what is expected of them and that they will be treated fairly, they will be more likely to communicate about events and risks and participate in safety improvement efforts.

Methods

A safety culture assessment will provide a baseline and raise awareness throughout the organization. The Agency for Healthcare Research and Quality has designed a “Survey on Patient Safety” that will identify areas in need of improvement. A copy may be found at: <http://www.ahrq.gov/qual/hospculture/hospcult.pdf>

Specific methods include:

- Recognize and reward reporting of errors and near misses. (just culture response to reporting)
- Increase executive leadership interactions with staff on patient safety issues.
- Enhance workforce knowledge about zero defects.
- Enhance skill set in communication of unanticipated outcomes.

- Increase the amount and quality of feedback to staff regarding changes made after incidents are reported.
- Ensure communication about and understanding of organization's critical policies and implications for failure to comply.
- Implement processes that are convenient for broad staff participation.
- Engage patients and families by creating a patient safety brochure that encourages them to be more involved with their care process by speaking up if something doesn't seem right or they don't understand what is happening.
- Identify a validated culture of safety survey instrument; monitor progress.
- Provide tools to assist managers and staff with the expectations for improvement.
- Report results throughout the organization with the goal of transparency.
- Create an audit/monitoring plan; report progress to the board, executive leadership team and throughout the organization.
- Create an annual patient safety award to recognize outstanding teamwork in making patient care safer.

Specific Exemplars

Specific practical examples that support building a culture of safety include:

- Virginia Mason Medical Center, Seattle, has developed a Patient Safety Alert System™, where staff members are expected to be "safety inspectors." A safety inspector is empowered to identify a mistake and correct it immediately before it adversely affects the process.
<https://www.virginiamason.org/home/body.cfm?id=156&action=detail&ref=2>
- Kaiser Permanente of California and Johns Hopkins Hospital in Baltimore trained surgical and critical care personnel to speak up about safety concerns and to cross-check each other's work. This empowered staff to make changes and flattened hierarchies that traditionally existed among physicians and other clinical care staff. http://www.cmwf.org/publications/publications_show.htm?doc_id=362681
- OSF St. Joseph Medical Center, in Bloomington, Ill., enabled informal reporting of errors and near-misses among nursing staff by holding safety briefings at shift changes and through "walking rounds"—routine visits on nursing units—by the hospital's executives. To reduce medication errors, the hospital also instituted a telephone hotline to simplify the reporting of adverse drug events and allow pharmacists to analyze potential problems each day.
Stories from the Sharp End: Case Studies in Safety Improvement (Milbank Quarterly, March 2006)

● PROVIDE SHARED LEADERSHIP

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- Move from hierarchical leadership models to one of shared interdependence.
 - Understand best practices and research tools used to create shared governance models.
 - Define the role of the nurse at the leadership table for patient safety.
 - Gain the perspective of other senior leaders, such as the CFO and CEO, to effectively communicate a business case for safety initiatives. Integrate the business requirements of the organization with patient safety requirements.
 - Actively participate in pay-for-performance initiatives to create a bridge between financial/business organizational issues and patient safety.

Definition

Shared leadership is when members of a group accept responsibility for the work and life of the group. The group functions more effectively when there is shared responsibility, rather than a hierarchical leadership model. Shared governance is the system that facilitates shared leadership. It creates a forum for collective wisdom by creating standards of practice, measuring the effectiveness of the decision, and fostering an environment that empowers the group to continually improve its processes and practice.

Tim Porter-O'Grady's (1984) milestone work on the concept of shared governance provides a practical blueprint that empowers individuals to make solid decisions at the point of care or service.

Nursing has a unique and systemic perspective in process design. The traditional health care culture is structured to allow physicians to work as autonomous professionals. However, this culture is unsupportable in the 21st Century. Physicians cannot and do not act alone. Nurses do not act alone. The nurse leader is the agent of change. The nurse leader must create and drive the patient safety strategy.

Objectives

As leaders, nurses are challenged to move away from hierarchical leadership models to one of shared interdependence. Nurses should engage teams to share responsibilities and accountability for continuous, ongoing system assessment, evaluation and improvements. Since health workers are trained to be independent workers, it is critical that all care providers are trained in an interdependent model and have opportunities to practice as a team. Nurse leaders must use an interdisciplinary approach in their executive roles. Engaging the entire executive team in establishing outcomes and objectives relative to patient safety is vital so that a bridge exists between the business and the science of patient care.

The literature and research continues to confirm that the greater the number of variables contained within a system the greater the chance of error. The more complex the care process becomes, the more critical teams become. Care must be provided using an interdisciplinary approach. The intellectual discipline around team building, team creation, team management, team measurement and team communication is only just beginning in healthcare.

Ralph M. Stogdill (1982) wrote what may be the most comprehensive treatise on leadership in *Stogdill's Handbook of Leadership: A Survey of Theory and Research*. In the book, Stogdill argues that leadership assumes many roles. By applying this definition, the traits of the nurse leader for patient safety include: a focus on the team, its personality and how that affects the process, and the exercise of influence and the art of inducing compliance, getting others to respond in a shared direction. It includes persuasion, an instrument of goal achievement.

In essence, care paths become a way of dealing with scientific evidence and are instrumental in creating the kind of scientific boundaries around permissible or supportable variation. As a nurse leader engaging the entire executive team in establishing outcomes and objectives relative to patient safety is vital so that a bridge exists between the business and the science of patient care. (See also [Patient Safety Leadership Competencies](#) page 9)

Methods

Specific methods include:

- Integrate patient safety into every activity of the organization.
- Pay strict attention to detail.
- Keep the patient as the focus.
- Develop systems and processes that recognize the variation that exist and the potential for error.
- Surround yourself with like-minded professionals to move the cause forward.
- Create a design/model that fits your organization and one that embeds integrity and sustainability.
- Leverage the voice of the bedside nurse and continue to enhance competencies.
- Provide acknowledgement that each member of the shared leadership team may have their own mix of needs and wants, these needs and wants are essential to groups' healthy functioning. They provide some of the motivation, energy and glue for group life.

Specific Exemplars

- St Alexius Medical Center used a shared leadership model to incorporate latex-free and latex-safe environments. See complete article [An Evidence-Based Project for Developing a Latex-Safe Environment](#), (page 16) By: Deb Walters, RN.
- Rochester (NY) General Hospital developed an "Early Nurse Intervention Team" (ENIT). The ENIT program is proactive and was created to provide nurse to nurse consultation for difficult patient situations. The ENIT nurse, an experienced ICU nurse rounds on the general units twice daily, assisting in patient assessment, intervention, and communication with providers. The ENIT nurse is available to the floor nurse for consultation. In 2006, ENIT was expanded hospital-wide and reduced the incidence of failure to rescue on general care units. Submitted by: Michele Unger MS, RN, CCRN, CNAA, BC, Director of Nursing Practice.

● **BUILD EXTERNAL PARTNERSHIPS**

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- Drive the patient safety agenda through collaboration and partnerships.
 - Reach out to academia, technology solution providers, communities, policy makers, regulatory agencies, state and federal agencies, and professional organizations to advocate for nursing and patient safety.
 - Proactively develop partnerships with academic institutions to drive effective curriculums that reflect working realities and include principles of safety.
 - Create visible partnerships with the public around patient safety initiatives.
 - Leverage the bedside nurse in the provider/technology partnership to enable ownership and effective implementations.
 - Shape the external environment to support patient safety.

Definition

External partnerships are essential for driving patient safety agendas. The nurse executives and the external partners stand to gain great benefits through collaboration. The collaboration involves the nurse leaders learning the latest best practices around managing people, developing processes and implementing solutions from various organizations; and the partnering organizations develop a greater appreciation and understanding of the problems a nurse executive is trying to overcome to improve patient safety.

Objectives

Grow patient safety knowledge and programs by leveraging existing and developing new relationships with academia, technology solution providers, communities, policy makers, regulatory agencies, state and federal agencies, professional organizations, and patients and families.

Methods

Improve external partnerships by defining the current relationship and identifying the gaps. Set goals for each type of relationship. Keep in mind that each relationship will add unique value to your knowledge portfolio. Therefore, it is helpful to map out what information you would like to gain from each relationship. This helps ensure your time is spent wisely and your relationship portfolio is well diversified. Furthermore, these objectives will enable you to better understand how to use the information gained, leverage any synergies between the groups and determine if there are any additional types of relationships that you would like to form. Once your objectives are set, select an organization and contact for each relationship type.

Sample Objectives by Organization

PARTNER	METHOD
Academia	<ul style="list-style-type: none"> ▪ Develop best practices. ▪ Drive effective curriculums that reflect working realities and include principles of safety ▪ Appoint joint faculty to train nurses. ▪ Align graduating nurses and workforce needs to mitigate shortages.
Technology solution provider	<ul style="list-style-type: none"> ▪ Sponsor seminars and users groups to share new and innovated practices. ▪ Work together to understand the people, processes and technology changes required for designing safe systems. ▪ Work with the bedside nurse to promote ownership and effective implementation of new technologies.
Communities	<ul style="list-style-type: none"> ▪ Create visible partnerships with the public around patient safety initiative.
Policy makers in health care	<ul style="list-style-type: none"> ▪ Define the issues and solutions to shape public policy.
Regulatory agencies	<ul style="list-style-type: none"> ▪ Monitor issues from standard-setting committees, comment when regulations are published, participate when possible.
State and federal agencies	<ul style="list-style-type: none"> ▪ Monitor issues and trends on patient safety topics. ▪ Offer written comment on proposals and key legislation. ▪ Provide written comment and testimony during public comment periods.
Professional organizations	<ul style="list-style-type: none"> ▪ Join committees that help shape positions on key issues. ▪ Participate in annual and local meetings to share your organization's best practices.
Patient and family	<ul style="list-style-type: none"> ▪ Involve patient and family in process redesign and policy formation.

Specific exemplars

- **Vanderbilt Medical Center** and their technology corporate partner, McKesson Corp., formed a strategic relationship focused on equipping providers with a clinical decision support system. With VUMC's self-developed product as the core, McKesson developed a commercial version and broadened its applicability for a variety of health care organizations, including other academic medical centers and community hospitals.
http://www.mckesson.com/en_us/McKesson.com/About+Us/Newsroom/Press+Releases/2006/Vanderbilt+University+Medical+Center+Implements+McKesson%2527s+Horizon+Clinicals.html

- The **TIGER** (Technology Informatics Guiding Educational Reform) enables practicing nurses and nursing students to engage in the unfolding digital electronic era. The purpose of the initiative is, to identify information/knowledge management best practices and effective technology capabilities for nurses. TIGER's goal is to create and disseminate local and global action plans that can be duplicated within nursing and other multidisciplinary healthcare training and workplace settings. <http://www.umbc.edu/tiger/index.html>
- [Additional Exemplars](#) (page 17)

Additional stories about the nurse leader's pivotal role in patient safety can be viewed on the **AONE** web site. <http://www.aone.org/aone/resource/patientsafety.html>

• DEVELOP LEADERSHIP COMPETENCIES

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- Enhance and focus the patient safety skills of future nurse leaders.
 - Identify the skill sets that are relevant to nursing leadership in patient safety.
 - Leverage established skills and existing resources and tools such as
 - AONE Nurse Executive Competencies
 - American Nurses Credentialing Center (ANCC) 14 Forces of Magnetism
 - AONE Nurse Manager Skills Inventory ©
 - National Patient Safety Foundation’s (NPSF) agenda for patient involvement, *Nothing About Me Without Me*
 - Develop, implement and evaluate additional tools through industry collaboration.
 - Create unrelenting champions of patient safety.

Definition

Leadership competencies around patient safety are intended to identify and establish skills common to nurses in executive practice. In order to assure that nurse leaders have the skills and knowledge to create a culture of safety, a [Patient Safety Competency Model](#) (page 12) specifically designed for the nurse leader was developed.

Objectives

The AONE Nurse Leader–Patient Safety Competency Model is designed to assure that the practice environments support exemplary, safe, high quality care of patients and families through effective nurse leadership. A knowledge base and skill set in the science of patient safety is a key competency for nurse leaders in today’s health care environment. This model pulls together a comprehensive set of elements that nurse leaders must be knowledgeable in to assure cultures of safety in their practice environments and the ability to influence nursing school curriculum. A basic assumption is that the leader is able to maintain a competent workforce.

Methods

Very specific knowledge areas have grown demonstrably in the past decade in the areas of human factors, error reporting, fair and just cultures, Lean, Six Sigma, High Reliability Organizations and many more. Three competency domains, patient safety leadership, core patient safety technology and culture of safety, were identified as essential to the development and implementation of a practice environment of safety. The elements of each competency are described below.

Patient Safety Leadership Competencies

- Active and Disciplined Listening
 - Use of active and effective listening behaviors, such as questioning and summarizing. Encourage participation, discussion, and engagement.
- Engagement and Inclusiveness
- Vigilance for Error Identification
 - Continuously scan organization for patient safety risk trends and identify areas of opportunity and create plans to intervene and improve. Develop a system to track events and patient safety concerns so that data can be assessed and trended.

- **Integrator of People and Tasks**
Encourage participation, discussion and engagement from a variety of team members. Connect people together that are working on similar objectives.
- **Interdisciplinary Co-leadership and Collaboration**
Collaborate with leadership at the top of the organization and members of the interdisciplinary team to create a partnership to support patient safety as a priority within the organization. Work collaboratively with physicians and other members of the interdisciplinary team to lead a commitment to patient safety.
- **Action Orientation**
Define a plan for patient safety with a timeline. Assign responsible parties, objectives, and a timeline to complete specific action plan toward improving patient safety.
- **The Art of Championing**
Communicate vision of safety to all staff throughout the organization. Serve as a positive and encouraging role model for a safe patient care environment.
- **Collaborative Practice Agreements**
Define a vision, mission, goals, and objectives for patient safety within the organization. Work collaboratively with leaders in the organization to meet the defined goals and objectives including adequate and appropriate resources, human as well as material/supply.
- **Team Leading and Participation**
Form partnerships with individuals with expertise and competence in the realm of patient safety. Foster a single team of engaged staff with mutually agreed upon goals and expectations.
- **Importance of Top Down Leadership Culture of Safety**
Senior leaders must embrace patient safety as a priority, determine a plan, align resources, motivate and encourage others throughout the organization.

Core Patient Safety Technology Competencies

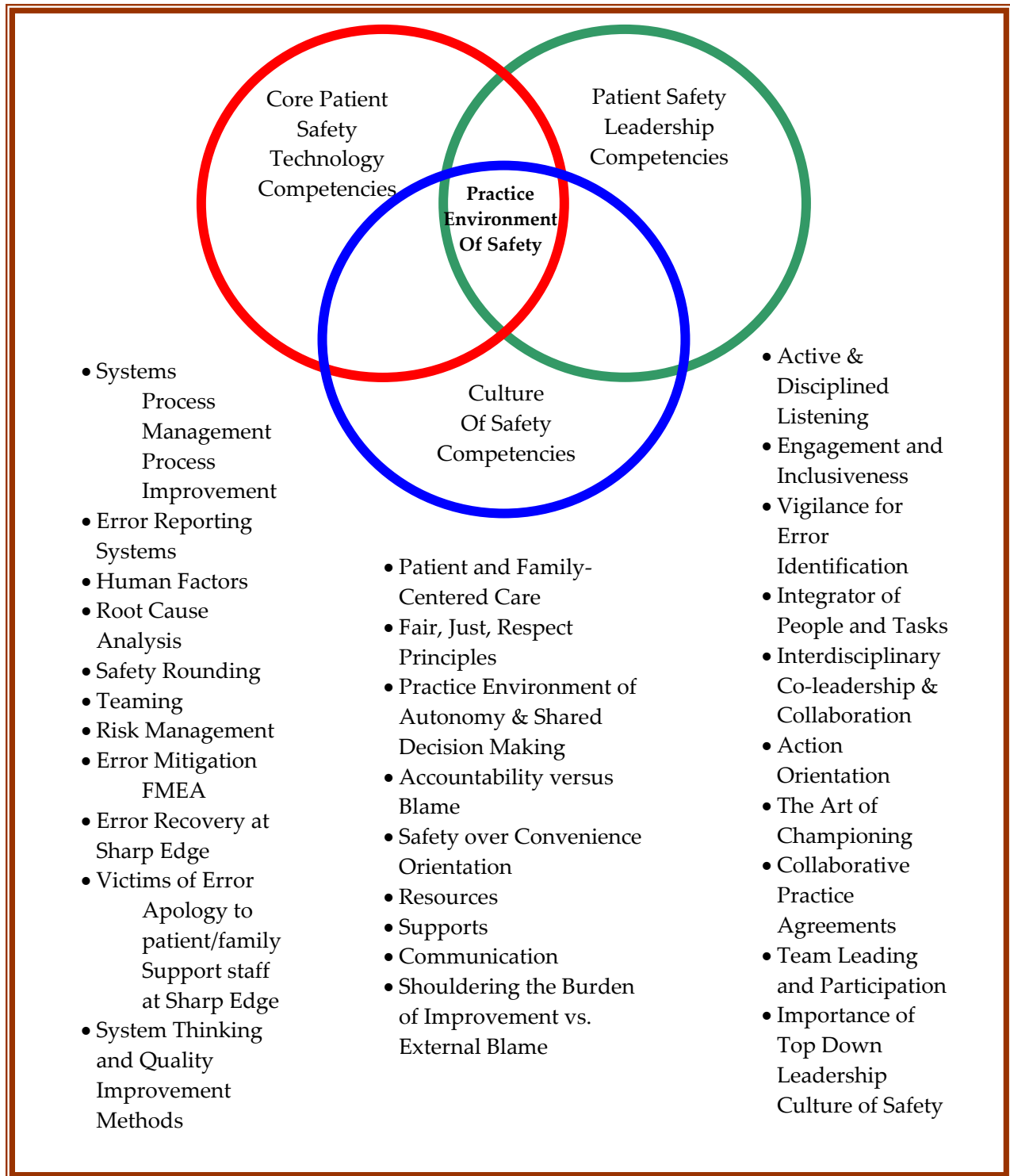
- **Systems—Process Management and Process Improvement**
Determine critical indicators and system to measure performance and opportunities for improvement. This requires a defined process.
- **Human Factors**
Focus on systems, but understand characteristics of human behaviors to understand errors.
- **Root Cause Analysis**
Review variations in process with involved staff to determine cause of error. Continue to ask why to find potential cause of error.
- **Safety Rounding**
Conduct patient safety rounds by senior leadership to identify safety risk trends; assure follow-up. Making Safety Systematic: Dana-Farber's Patient Safety Rounds Toolkit
- **Teaming**
Work collaboratively with key leaders and staff members it allows for communication and information sharing. Requires accountability. Need to develop outcome-based solutions.
- **Risk Management**
Intention is to create and maintain a safe and effective environment for patients, visitors, and staff to prevent or reduce loss.

- **Error Mitigation**
Explore patient care scenarios, identify potential sources of error, and recommend specific solutions knowledge and practice in FMEA
- **Error Recovery at the Sharp Edge**
Establish processes to make it easier to recover or back out if a wrong action is taken by practitioners at the point that is closest to the process breakdown.
- **Victims of Error**
Apology to patient/family, support staff at sharp edge
Need to have timely, full disclosure with a sincere apology. It is the provider's moral obligation to do this. Acknowledge stress of error to patient, family, staff- everyone will need support and intervention
- **System Thinking and Quality Improvement Methods**
Method to improve processes, safety and care delivery through assessing systems, and how individuals function within the system (not focused solely on the individual)

Culture of Safety Competencies

- **Patient and Family Centered Care**
Care that is focused on the patient's and family's needs and expectations.
- **Fair and Just Principles**
Timely, fair, appropriate actions that are carried out equitably when blameworthy behaviors have occurred. <http://www.justculture.org>
- **Practice Environment of Autonomy and Shared Decision Making**
Respect for individual's ability and right to determine what happens. A team-oriented structure that gives everyone the authority to make decisions for themselves.
- **Accountability vs. Blame**
Assign accountability. Determine goals. Avoid blame. Thank those that share concerns and perceived patient safety risks.
- **Safety Over Convenience Orientation**
Resources—Acquire resources needed for patient safety (personnel, systems, finances)
Supports--Patient safety will require significant commitment, resource and support
Communication--Patient safety requires excellent, intense communication among care providers (SBAR) and leaders
- **Shouldering the Burden of Improvement vs. External Blame**
Start somewhere and always seek process improvement. Avoid finding excuses/hindrances. Determine and manage a timeline. Set goals and priorities.

Nurse Leader Patient Safety Competency Model



Specific Exemplars

Web Resources

American Organization of Nurse Executives www.aone.org

The Agency for Healthcare Research and Quality, part of the U.S. Department of Health and Human Services, supports research to improve the quality of health care, reduce its cost, improve patient safety, decrease medical errors, and broaden access to essential services. www.ahrq.gov

The American Health Quality Association represents quality improvement organizations and professionals sharing best practices towards improving the quality of health care. www.ahqa.org

The AHA Quality Center is a resource of the American Hospital Association that helps hospitals to accelerate their quality and performance improvement processes in order to achieve performance excellence. www.ahaqualitycenter.org

Consumers Advancing Patient Safety is a consumer-led non-profit organization formed to be a collective voice for individuals, families and healers who wish to prevent harm in health care encounters through partnership and collaboration. <http://www.patientsafety.org/>

The Institute for Healthcare Improvement cultivates concepts for improving patient care and turning those ideas into action. www.ihl.org

The Institute for Safe Medication Practices provides education about adverse drug events and prevention. www.ismp.org

The Joint Commission has an online resource for best patient safety practices. <http://www.jointcommission.org/PatientSafety/>

Just Culture www.justculture.org

The Massachusetts Coalition for the Prevention of Medical Errors provides information for consumers and professionals on improving patient safety and minimizing medical errors. www.macoalition.org

The National Patient Safety Foundation Identifies and creates a core body of knowledge; Identifies pathways to apply the knowledge; develops and enhances the culture of receptivity to patient safety; raises public awareness and foster communications about patient safety; and improves the status of the Foundation and its ability to meet its goals. www.npsf.org

The National Quality Forum endorsed a standardized taxonomy for patient safety to facilitate management of patient safety data across reporting systems. <http://216.122.138.39/projects/completed/taxonomy.asp>

The Nursing Leadership Congress provides nurse executives and thought leaders an opportunity to share practical experience and creatively brainstorm

to develop interdisciplinary solutions to problems.

www.nursingleadershipcongress.com/

A partnership for Patient Safety is a collaborative group of people and organizations dedicated to reducing the harm. www.p4ps.org

The list of state patient safety organizations can be found at:

<http://www.vipcs.org/resources/stateps.htm>

OTHER RESOURCES:

Callahan, M.A., & Ruchlin, H. (2003). The role of nursing leadership in establishing a safety culture. *Nursing Economics*, November/December, 21 (6) 296-297.

Frankel, L.M., Simmons, T., Vega, K. (2004). *Achieving safe and reliable healthcare: Strategies and solutions*. Chicago, IL: Health Administration Press.

Kohn, L. T., Donaldson, M. S., & Corrigan, J. M. (2000). *To err is human: building a safer health system*. Washington D.C.: National Academy Press.

Raths, D. (July, 2006) *Vendor-provider partnerships can yield tremendous results. But, just like any relationship, success depends on effort from both sides*, Healthcare Informatics Online.

Nursing Leadership Congress, Building Bridges: Medication Safety. (2005). McKesson Corporation.

Porter-O'Grady, T. & Finnigan, S. (1984) *Shared governance for nursing a creative approach to professional accountability*. Aspen.

Reason, J. T., (1998): Achieving a safe culture: Theory and practice. *Work and Stress* 12 (July) 293-306.

Reason, J. T. (1997) *Managing the Risks of Organizational Accidents* Brookfield, VT: Ashgate.

Skiba, D. Barton, A., Norton, M., McCasky, T. & Kimmel, K. Sharing Intellectual and asocial capital: A partnership to advance informatics. Proceedings from the 9th Annual International Congress on Nursing Informatics June. 2006

Sutcliffe, Kathleen M., & Weick, Karl E. (2001). *Managing the Unexpected*, San Francisco, CA: Jossey-Bass.

Stogdill, Ralph M. (1982) *Stogdill's Handbook of Leadership: A Survey of Theory and Research*. 2ed. Macmillan.

Turner, B. A. & Pidgeon, N. F. (1997). *Man-made disasters*. 2nd ed. Boston Butterworth.

Turney, S. (2005, Nov-Dec). Quality patient care is a team effort. *MGMA Connexion*, p. 5-6.

Exemplars

PROVIDE SHARED LEADERSHIP

- **An Evidence-Based Project for Developing a Latex-Safe Environment**
By: Deb Walters, RN

At **St Alexius Medical Center**, the previous practice recommended latex-allergic patients be the first case of the day, with no previous cases performed in the preceding 12 hours. This practice resulted in scheduling conflicts. If the case was not identified prior to patient arrival, there was the risk of "breaking practice", or holding a room until the case was performed. Sometimes the patient's surgery had to be switched to a different day, very inconvenient for them.

I started doing evidence-based searches to see what was being done "out there". There are volumes of articles and information. My focus has been more in learning how to provide a safe environment to those patients who are; and to those who may present to our unit, but are not yet identified.

There is not an exact definition of what latex-safe environment means. The most complete definition I could find is one "in which every reasonable effort has been made to remove high- allergen and airborne latex sourced from coming into the direct contact with affected individuals" (AORN March 2204 Clinical Issues)

One of the most consistent things I found was the used of powdered latex gloves as the most frequent mentioned cause of increased latex allergens in the air. The American College of Allergy, Asthma and Immunology and the ANA both came out with position statements in the late 1990's stating only low allergen latex gloves or powder free latex gloves should be used.

Our medical center had already been very pro-active in reducing latex items whenever possible, including changing all nonsterile exam gloves used to powder-less latex gloves or vinyl. But in the OR we were still using powdered latex gloves.

I visited with the "end users" surgeons, of sterile gloves and explained the problems and the plan to become a latex-safe environment. A select group of surgeons trialed several different types of gloves and chose their favorite. A letter was then sent to all other surgeons notifying them of the change in the unit. We have not had any objections to the change.

We also provided education to staff and the surgeons about the difference between latex safe and latex free. Latex Free means absolutely NO latex. Moving to a latex free environment no longer requires the OR to adjust the schedule to accommodate latex sensitive patients. This increases OR flexibility and improves the safety of those latex allergic patients who arrive unexpectedly to the unit. It also reduces risk to our employees of future allergic reaction.

Several important things made this transition easier. First was finding evidenced-based practices. Second, the hospital had already been very proactive, whenever possible; a substitution to a latex-free item was made. Third, management strongly supported the effort. Finally, because of advanced education, the physicians were accepting of the change.

Exemplars

BUILD EXTERNAL PARTNERSHIPS

- By adapting strategies from aviation, including crew resource management training, pre-flight checklists, and crisis simulation, operating room staff at **Kaiser** became more willing to share their safety concerns and discuss mistakes within six months.
http://www.cmwf.org/publications/publications_show.htm?doc_id=362681
- **Missouri Baptist Medical Center**, St. Louis, developed multidisciplinary rapid response teams to improve the flow of information across traditional boundaries. Floor nurses began to call for them any time a patient exhibited early warning signs of a problem. As a result, the hospital reported decreases in acute medical crises of as much as 60 percent in two months time.
http://www.cmwf.org/publications/publications_show.htm?doc_id=362681
- The **Veterans Health Administration's** saw a 30-fold increase in the reporting of events within 10 months of implementing a reporting system.
http://www.cmwf.org/publications/publications_show.htm?doc_id=362681
- **Sentara Norfolk (Va.) General Hospital** implemented strategies including repeating back instructions or asking clarifying questions, and establishing high-priority "red rules"—such as verification of surgical sites—to emphasize the critical nature of certain safety steps. Adherence to these behavioral standards became part of staff performance reviews and overall organizational performance monitoring.
http://www.cmwf.org/publications/publications_show.htm?doc_id=362681