Leading a Culture of Safety: A Blueprint for Success

AmericanCollege *of* HealthcareExecutives
for leaders who care®

THE NATIONAL PATIENT SAFETY FOUNDATION'S
LUCIAN LEAPE INSTITUTE

Contents

Leading a Culture of Safety: A Blueprint for Success

American College of Healthcare Executives

The American College of Healthcare Executives is an international professional society of 40,000 healthcare executives who lead hospitals, healthcare systems, and other healthcare organizations. Its mission is to advance its members and healthcare management excellence. ACHE offers its prestigious FACHE® credential, signifying board certification in healthcare management. Its established network of 78 chapters provides access to networking, education, and career development at the local level. In addition, ACHE is known for its magazine, *Healthcare Executive*, and its career development and public policy programs. Through such efforts, ACHE works toward its vision of being the preeminent professional society for healthcare executives dedicated to improving health. **The Foundation of the American College of Healthcare Executives** was established to further advance healthcare management excellence through education and research. The Foundation of ACHE is known for its educational programs — including the annual Congress on Healthcare Leadership, which draws more than 4,000 participants — and groundbreaking research. Its publishing division, Health Administration Press, is one of the largest publishers of books and journals on health services management, including textbooks for college and university courses.

For more information, visit www.ache.org.

The National Patient Safety Foundation's Lucian Leape Institute

Established in 2007, the NPSF Lucian Leape Institute is charged with defining strategic paths and calls to action for the field of patient safety, offering vision and context for the many efforts under way within healthcare, and providing the leverage necessary for system-level change. Its members are national thought leaders with a common interest in patient safety. Their expertise and influence are brought to bear as the Institute calls for the innovation necessary to create significant, sustainable improvements in culture, process, and outcomes that are critical to safer healthcare.

For more information, visit www.npsf.org/LLI.

The National Patient Safety Foundation at the Institute for Healthcare Improvement

The Institute for Healthcare Improvement (IHI) and the National Patient Safety Foundation (NPSF) began working together as one organization in May 2017. The newly formed entity is committed to using its combined knowledge and resources to focus and energize the patient safety agenda in order to build systems of safety across the continuum of care. To learn more about our trainings, resources, and practical applications, visit ihi.org/PatientSafety.

Letter from the Project Co-chairs

Dear Colleagues:

Healthcare is one of the most complex industries in our world. Amid all of the pressing priorities, we must remember that the elimination of harm to our patients and workforce is our foremost moral and ethical obligation. In our roles as healthcare leaders, we have numerous responsibilities for ensuring the quality of care provided within our organizations, including patient and family experience, improving the health status of our communities, and maintaining the financial sustainability of our organizations. However, one of the most critical roles we must fulfill is ensuring the safety of patients who entrust their lives to our care, as well as ensuring the safety of a workforce—both clinical and non-clinical—that entrusts their livelihoods to our organizations. It is the ultimate duty of leaders to ensure the safety and prevention of unnecessary harm to these individuals and their loved ones. Healthcare executives must address the need to create sustainable cultures of safety throughout a healthcare system full of daunting challenges.

As our organizations aim to continually improve the reliability and safety of care, we can look to resources and successful practices to assist us, our Boards, our executive colleagues, our healthcare professionals, and the entirety of our workforce. The American College of Healthcare Executives (ACHE) and the National Patient Safety Foundation's Lucian Leape Institute (NPSF LLI) have partnered to collaborate with some of the most progressive healthcare organizations and globally renowned experts in leadership, safety, and culture to develop *Leading a Culture of Safety: A Blueprint for Success*. This document is an evidence-based, practical resource with tools and proven strategies to assist you in creating a culture of safety—an essential foundation for achieving zero harm. It is our hope that this guide will inspire and motivate, while providing approaches and tactics leaders can implement in driving cultural change, with the goal of elevating healthcare into the realm of recognized industries that have succeeded in reducing error and harm.

ACHE and NPSF LLI stand ready to assist you on this journey. We invite you to use this guide in both a strategic and tactical manner to direct your efforts in creating and sustaining a culture of safety, and to evaluate your success along your journey to zero harm.

Sincerely,

Gary S. Kaplan, MD, FACMPE
Co-chair

Charles D. Stokes, RN, BSN, FACHE
Co-chair

Acknowledgments

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The Culture of Safety Imperative

Harm to Patients and the Workforce

In 1999, the Institute of Medicine (IOM) Committee on Quality of Health Care in America estimated that between 44,000 and 98,000 Americans die each year as a result of medical errors (IOM 1999). More recent estimates place this number closer to 200,000 deaths per year (James 2013). Though deaths due to medical error are notoriously difficult to measure, if this number is accurate within 100,000 deaths, medical error kills four times more Americans each year than motor vehicle accidents. It is important to note that these statistics, while disconcerting on their own, do not account for serious temporary or permanent physical and psychological harm caused by medical error, and they do not include harm to the healthcare workforce. Regardless of the measurement or estimation used, the rate of error and harm in healthcare is astounding, and sweeping, system-wide changes are imperative.

Moreover, when patients experience harm, clinicians find themselves negatively impacted as well. Being involved in an error that results in the harm or death of a patient is devastating for an individual who is committed to serving those who are sick. At its worst, this devastation can lead to self-harm, depression, isolation, and even suicide. The desolation that often results from causing harm is compounded for clinicians who work in organizations without supportive systems. Based on the 2016 Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture's hospital comparative database, only 64% of staff respondents felt that reported mistakes led to positive changes in their organization. Even fewer members of the workforce, only 45%, responded positively to questions related to their organization's non-punitive response to error (AHRQ 2016).

Considering the impact described above, every healthcare executive should prioritize enhancing the safety of patients and the workforce. As an industry, healthcare has taken steps in improving quality and patient safety. However, these small-scale, incremental improvements are not enough. Our immediate work requires a focus on safety not just as a key improvement initiative but as a core value that is fully embedded throughout our organizations and our industry.

In every healthcare organization, the ultimate responsibility for system-based errors and their resulting costs rests with the CEO and Board of Directors. CEOs and Boards will be held increasingly responsible for harm and death caused by error. In the long run, patient and workforce safety will not only be a moral imperative but will likely be critical to sustainability and essential to delivering on value.

Based on data from James and the American Hospital Association, an average, 100-bed hospital committed errors in care that caused the death of 23 patients in 2013. Such statistics indicate that each organization contributed to the preventable death of almost one patient every other week (AHA 2014, James 2013).

The Business Case for Safety

While the business case for patient safety continues to expand and to change with new regulatory and reimbursement requirements, the general consensus within the healthcare research community is that organizational costs for error and harm are high and will likely increase in the coming years. In addition to the increase in direct cost of care for the impacted patient and family following an error, organizations must also consider personnel costs, regulatory costs, and resource costs including investigation of errors, pursuit of legal defense, and payment of settlements. Perhaps most important to consider are the potentially immense costs related to repairing reputation after a catastrophic event has occurred and been publically reported (Weeks and Bagian 2003). When each of these costs is considered on top of the direct cost of patient care, the business case for improving safety becomes abundantly compelling.

A Case Study in Culture:

Mr. Jones is a previously healthy 55-year-old man, with a recent history of shortness of breath that is related to exercise. He has been referred by his primary care physician for a cardiology consultation, at which a stress test is ordered. The results of the stress test indicate a positive finding for potential heart disease. These results are not communicated back to his primary care provider, and although they are sent to the referring cardiologist, he is away at a conference. Mr. Jones receives no communications about the results of his test. One week later, Mr. Jones presents to the emergency department with chest pain and is diagnosed with an acute myocardial infarction. Upon further review of his medical records, the care team reviews his past test results and learns about the positive stress test. Mr. Jones requires placement of a stent to open his coronary artery, and requires rehabilitation prior to discharge to his home due to reduced cardiac function. One week after discharge from inpatient rehabilitation, Mr. Jones returns to his primary care physician, who realizes that Mr. Jones is not taking one of the new cardiac medications that was ordered by his inpatient team.

A Tale of Two Organizations: Which is more like yours?

ORGANIZATION A:

The inpatient team notifies the patient safety department about the missed test result, and a root cause analysis is performed to determine why Mr. Jones' critical test result was not communicated to either him or his cardiologist. Action steps from the root cause analysis focus on re-educating the stress test department about the policy for communication of abnormal test results.

The lessons from the root cause analysis are not shared beyond the safety team. The action plan is not presented to the leadership team or the Board for approval, and does not include metrics for sustainability. The CEO and Board hear about the event only as a statistic presented quickly at the end of a quarterly Board meeting.

Mr. Jones is not informed about either the missed stress test result or the root cause analysis.

The primary care provider writes a new prescription for the cardiac medication. Mr. Jones ultimately misses several weeks of work.

ORGANIZATION B:

The inpatient team notifies the patient safety department about the missed test result, and a root cause analysis is performed. Action steps include designing a new process for communication of test results that includes an escalation policy when it is not immediately possible to communicate critical test results to the ordering provider and/or the patient.

The primary care provider ensures that Mr. Jones begins taking the cardiac medication and also notifies the risk management/patient safety department about the delay in medication use. An additional root cause analysis is conducted, with a clear tracing of the breakdown during transition from hospital to rehabilitation and rehabilitation to home, and how and why it may have occurred.

The results of both RCAs, including strong action plans for improvement and metrics for sustainability, are presented to the organization's leadership team for review and approval. The CEO presents the case and action plan at the next quality and safety meeting.

Mr. Jones' care team informs him about these breakdowns in communication, and how they may have contributed to his myocardial infarction and could cause future health issues. His care team extends an apology, as well as an offer for early resolution and compensation that helps Mr. Jones pay for his medical bills, his time away from work, and the additional costs associated with the need for his family to care for him.

Six months later, an assigned member of the leadership team follows up with the frontline care team involved in the event to evaluate and reassess the action plan and review improvement metrics. These results are presented at the next Board meeting.

DEBRIEF

Many organizations report that their response to handling Mr. Jones' situation is more similar to Organization A than to Organization B. This example is but one of many that illustrate why healthcare must create and improve systems that are committed to zero harm to patients and our workforce.

Introduction

Dr. Lucian Leape, widely regarded as the father of the modern patient safety movement, has repeatedly stated that "the single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes." By prioritizing, developing, and sustaining an organizational culture focused on safety, we can drive the future of healthcare to a place where patients and those who care for them are free from harm. It is not only one of many priorities, but is the overriding ethical imperative for all leaders.

AHRQ defines a culture of safety as one "in which healthcare professionals are held accountable for unprofessional conduct, yet not punished for human mistakes; errors are identified and mitigated before harm occurs; and systems are in place to enable staff to learn from errors and near-misses and prevent recurrence" (AHRQ PSNet Safety Culture 2014). The leaders of organizations must set and, more importantly, demonstrate the behaviors and expectations essential to a safe and transparent culture.

To help healthcare leaders achieve their mission of total system safety, ACHE and LLI have partnered to develop this guide, which is intended to assist leaders in creating, shaping, and sustaining the type of culture needed to advance patient and workforce safety efforts. It is designed to inspire, motivate, and inform you as you lead your organization on its journey to zero harm.

The information in this guide comes from industry leaders and experts who have had success in transforming their organizations into system-wide cultures of safety. It is designed for you and your team members to adapt to your organization, wherever you may be on your journey.

Cultures of Safety Across the Continuum

Because error and harm happen across the continuum, it is imperative that all improvement initiatives also encompass all care settings. While some of the tactics and recommendations throughout this document will be more relevant in certain environments than others, the key principles developed throughout the six domains are applicable to all who oversee the delivery of care—not just hospital settings. This work is intended to be adapted as needed to enhance applicability for all organizations. However, the key concepts—building trust, respect, and enthusiasm for improvement through behaviors and principles that focus on ameliorating systems issues while requiring fair and inclusive practices—are critical to safe care in all settings.

This resource is organized into six leadership domains that require CEO focus and dedication to develop and sustain a culture of safety:

Establish a compelling vision for safety. An organization's vision reflects priorities that, when aligned with its mission, establish a strong foundation for the work of the organization. By embedding a vision for total patient and workforce safety within the organization, healthcare leaders demonstrate that safety is a core value.

Build trust, respect, and inclusion. Establishing trust, showing respect, and promoting inclusion — and demonstrating these principles throughout the organization and with patients and families — is essential to a leader's ability to create and sustain a culture of safety. In order to achieve zero harm, leaders must ensure that their actions are consistent at all times and across all levels of the organization. Trust, respect, and inclusion are non-negotiable standards that must encompass the Board room, the C-suite, clinical departments, and the entire workforce.

Select, develop, and engage your Board. Governing Boards play a vital role in creating and maintaining safety cultures. CEOs are responsible for ensuring the education of their Board members on foundational safety science, including the importance of and processes for keeping patients and the workforce safe. Boards must ensure that metrics that meaningfully assess organizational safety and a culture of safety are in place and systematically reviewed, analyzed, and the results acted upon.

Prioritize safety in the selection and development of leaders. It is the responsibility of the CEO, in collaboration with the Board, to include accountability for safety as part of the leadership development strategy for the organization. In addition, identifying physicians, nurses, and other clinical leaders as safety champions is key to closing the gap between administrative and clinical leadership development. Expectations for the design and delivery of relevant safety training for all executive and clinical leaders must be set by the CEO and subsequently spread throughout the organization.

Lead and reward a just culture. Leaders must possess a thorough understanding of the principles and behaviors of a just culture, and be committed to teaching and modeling them. Human error is and always will be a reality. In a just culture framework, the focus is on addressing systems issues that contribute to errors and harm. While clinicians and the workforce are held accountable for actively disregarding protocols and procedures, the reporting of errors, lapses, near-misses, and adverse events is encouraged. The workforce is supported when systems break down and errors occur. In a true just culture, all workforce members—both clinical and non-clinical—are empowered and unafraid to voice concerns about threats to patient and workforce safety.

Establish organizational behavior expectations. Senior leaders are responsible for establishing safety-mindfulness for all clinicians and the workforce and, perhaps even more importantly, modeling these behaviors and actions. These behaviors include, but are not limited to, transparency, effective teamwork, active communication, civility, and direct and timely feedback. These cultural commitments must be universally understood and apply equally to the entire workforce, regardless of rank, role, or department.

The journey toward patient and workforce safety requires vigilance and the highest level of dedication. Safety cannot be merely a strategic priority, but must be a core value that is woven into the fabric of our organizations. A culture of safety demands the involvement and commitment of the full healthcare team, from patients to clinicians to the rest of the workforce. However, an organization cannot be what its leader is not. It is both the obligation and the privilege of every healthcare CEO to create and represent a compelling vision for a culture of safety: a culture in which mistakes are acknowledged and lead to sustainable, positive change; respectful and inclusive behaviors are instinctive and serve as the behavioral norms for the organization; and the physical and psychological safety of patients and the workforce is both highly valued and ardently protected.

A Note about Disparities in Care

Across the United States, individuals experience great differences in life expectancy and other health outcomes based on social determinants that may include ethnicity, religion, socioeconomic status, geographic location, sexual orientation, and gender identity, among others. It is impossible to envision an organization driving toward zero harm that is not also consciously focused on addressing these disparities.

Professor Margaret Whitehead, head of the World Health Organization (WHO) Collaborating Centre for Policy Research on the Social Determinants of Health, defines equity in health this way: "Ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, no one should be disadvantaged from achieving this potential, if it can be avoided" (Whitehead and Dahlgren 2006). The reality of healthcare today is that quality and safety cannot be achieved without equity. Healthcare organizations have the power to address disparities at the point of care and to make an impact on many of the determinants that create these disparities (Institute for Healthcare Improvement 2016). Because equity in health is essential to quality and safety, mitigation of health disparities must be prioritized across the six domains for developing a culture of safety. Not only is creating health equity part of the safety imperative, but it requires many of the same mechanisms recommended throughout this document.

A Note about Learning Systems

The IOM describes a learning healthcare system as one in which "science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the care process, patients and families are active participants in all elements, and new knowledge captured as an integral by-product of the care experience" (IOM 2013).

While this guide focuses on developing and sustaining a culture that drives patient and workforce safety outcomes, a CEO's accountability for developing and supporting a learning system is equally important. Change implementation is a vast interdisciplinary undertaking that requires all aspects of a safety culture, from safety science knowledge, to trust, respect, and visionary leadership (Friedman 2015). The design of learning systems may vary—from high reliability to Six Sigma™ to the Toyota Production System and other Lean methodologies—but the key characteristics are the same. Zero harm to patients and the workforce is only possible with both a robust culture of safety and an embedded organizational learning system.

Recommendations for Use of This Guide

This guide was developed for CEOs and other executive leaders in order to provide a useful tool for assessing and advancing an organization's culture of safety. It can be used to help determine the current state of your organization's journey, inform dialogue with your Board and leadership team, and help you set priorities. The six domains are intended to be discussed with your Board, your leadership team, your workforce, and your community. These domains are interdependent, and each domain is an essential element that must be addressed along your journey. This guide contains recommendations for developing and evaluating plans to flourish in each of the six domains, and resources for helping you move forward and make measurable progress in your journey.

The high-level strategies and practical tactics in this guide are divided into two levels: foundational and sustaining. The foundational level provides basic tactics and strategies essential for the implementation of each domain. The sustaining level provides strategies for spreading and embedding a culture of safety throughout the organization. However, it is important to note that the journey to zero harm is more complex than this simple two-level structure. Each organization will be at a different place on the spectrum from developing the foundation of a culture of safety to embedding and sustaining these principles. An organization may work on strategies and tactics across the two levels, or may be at various levels of progress across each of the domains. In organizations that lack an empowering vision statement or trust and respect among leadership, clinicians, and the workforce, it may be most effective to begin improvement initiatives in these two domains. The keys to developing and sustaining a culture of safety are honest and transparent evaluation of your organization's current state, identification of gaps and goals, and an action plan that engages all members of the Board, leadership team, and workforce.

Whether an organization is just beginning the journey to a culture of safety or is working to sustain its safe culture, the following steps are recommended:

- Share this document with your Board Chair and leadership team.
- Complete the self-assessment with input from your Board, leadership team, clinicians and the frontline workforce, and patient and family representatives, as appropriate.
- Develop action plans based on an understanding of the current state of your organization. Use assessment results to frame discussions with your leadership team and the Board that focus on identifying ways to close gaps and aligning the direction of your organization with key safety and culture initiatives.
- Share the outcomes of the assessment, action plans, and progress with your senior leadership team, the Board, your workforce, and your patients and families, as appropriate and helpful.
- Ask for periodic feedback from your Board, your leadership team, and the workforce.
- Refer to this guide as a resource for systematic check-ins and adjustments, as needed.

A Culture of Safety: The Six Domains

Establish a Compelling Vision for Safety

GOAL: COMMIT TO DEVELOP, COMMUNICATE, AND EXECUTE ON AN ORGANIZATIONAL VISION OF ZERO HARM TO PATIENTS, FAMILIES, AND THE WORKFORCE.

To engage and inspire all clinical and non-clinical healthcare professionals and the public, an organization's vision should reflect long-term, aspirational goals. This vision must be clearly aligned with the organization's mission, which establishes the foundation of what an organization does.

A compelling vision enhances performance, promotes change, motivates individuals, and provides context for decision making (Lipman 1996). Clearly articulated, a strong vision addresses the why, the how, and the when of the aspirational goal (Lipman 2003). Many CEOs of healthcare organizations strive to include safety among their top strategic priorities, and this objective must be clearly reflected as a core value in the vision and mission statements. The CEO is responsible for launching the critical first step of establishing safety as the most important part of what everyone does, every day.

	Foundational	Sustaining
Strategies *Overarching strategies for implementation at the CEO level*	✓ CEO takes responsibility for educating himself/herself on how to develop vision and lead a culture of safety ✓ CEO communicates and models a shared vision of zero harm to patients, families, the community, and the workforce ✓ CEO communicates genuine, clear messages about vision, conveying purpose of safety culture to everyone, in all settings, repeatedly and for the long term ✓ CEO communicates how vision is critical to organizational success ✓ CEO prioritizes measurement, gap analysis, and improvement of culture of safety as foundational for vision ✓ CEO gains additional understanding of safety by participating in full harm investigation, including disclosure and apology and root cause analysis	✓ CEO and leadership team provide consistent, personalized messaging about the importance of safety and zero harm ✓ CEO relays importance and urgency of safety vision to both internal and external audiences ✓ CEO practices transparency and shared accountability between Board and leadership team regarding vision and relevant measurement and reporting

Establish a Compelling Vision for Safety

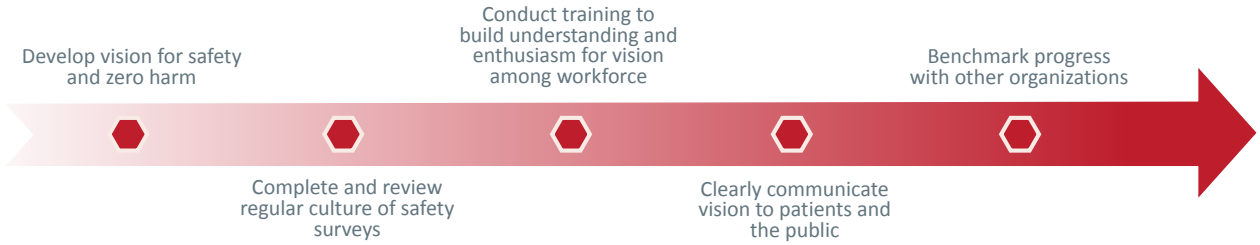
A compelling vision with patient and workforce safety as a core value is essential to achieving safe care. Zero harm is the aspirational "North Star." Healthcare CEOs demonstrate their belief that safety is a primary, non-negotiable goal by working with their Board, clinical leadership, and workforce to develop such a vision, to embed it in their organization, and to demonstrate their commitment and energize frontline workers through direct involvement in safety activities (NPSF 2015).

The first step for a CEO in creating this vision is to understand, acknowledge, and communicate the current state of their organization. A successful vision statement may be developed by top management and shared with the organization, or created in partnership with the workforce. The key is that the vision statement must encompass all organizational interests and engage the entire workforce. Visions that offer long-term perspective and include a degree of difficulty or stretch are often the most powerful. Finally, a vision statement should be clear and concise, allowing it to be easily remembered, repeated, and communicated (Kantabutra and Avery 2010).

Leaders must work with their teams, in direct partnership with physicians, nurses, and other clinical and non-clinical leaders, to assess the internal and external landscape of their organization. They must consider safety metrics, clinicians' attitudes and perceptions, patient and family experiences, and current practices, as well as trends and events that affect or might affect the healthcare industry. Landscape analysis is often accomplished through tactics including focus groups, safety culture surveys, safety rounds, analysis of safety metrics and reporting, and other diagnostic approaches. As one team of management researchers tell us, "The best way to lead people into the future is to connect with them deeply in the present" (Kouzes and Posner 2009). Understanding and communicating the current state enables leaders to connect and work with their teams and clinical experts to create a shared vision that can inspire everyone within the organization and the community.

While it is important to get input and buy-in from all levels when developing a vision, CEOs must be the ones to define and model the vision. Leaders at every level need to be visible in their commitment to patient and workforce safety and vocal about supporting actions that align with the organizational vision.

A clear and aspirational vision inspires the workforce and the public. The CEO works with the Board, leadership team, clinicians, and workforce to develop and embed this vision.



Establish a Compelling Vision for Safety

Organizational Readiness Level	Foundational	Sustaining
Tactics *Examples of tactics that may be implemented to create change at each of these levels*	**To engage your organization:** ✓ Work with select individuals throughout the organization to develop understanding of key organizational interests and goals ✓ Work with leadership team to develop aspirational end state (e.g., zero harm) that will be incorporated into vision ✓ Communicate the definition and importance of a culture of safety ✓ Build awareness of current state through culture surveys, observations, and focus groups, and communicate this throughout the organization ✓ Include zero harm vision in all communications from leaders at all levels, and keep this communication simple, consistent, and repetitive ✓ Include equity of care as part of vision statement and communicate the definition and importance of health equity ✓ Conduct training and information sessions for all employees to build understanding and enthusiasm for the vision ✓ Spend time on all floors and units communicating the connection of culture of safety and vision to the work of the frontline	**To engage your organization:** ✓ Clearly articulate your vision to the workforce and the public ✓ Benchmark culture progress and best practices with other similar organizations (e.g., participate in collaboratives) ✓ Develop and implement a recognition program for leaders, clinicians, and the workforce based on growth and adherence to vision ✓ Establish organizational goals that address safety and disparities in care **To engage clinical leaders:** ✓ Include physician, nursing and other clinical leaders in development of vision statement and strategic plan **To engage patients and families:** ✓ Clearly communicate the vision statement and values to patients ✓ Incorporate patient and family stories, along with statistics, when discussing vision at the Board level ✓ Include patient feedback in the development of vision statement
Assessing Execution *List of questions that should be asked to further assess and measure progress*	**YES / NO** ☐ ☐ Are the CEO and leadership team able to clearly communicate the vision to all parties, in both internal and external interactions? ☐ ☐ Can all members of the organization articulate the vision for safety and how it relates to their individual work? ☐ ☐ Is a patient safety and quality dashboard (which includes safety culture metrics) utilized and regularly reviewed in the context of organizational vision?	

Trust, Respect, and Inclusion

Value Trust, Respect, and Inclusion

GOAL: ESTABLISH ORGANIZATIONAL BEHAVIORS THAT LEAD TO TRUST IN LEADERSHIP AND RESPECT AND INCLUSION THROUGHOUT THE ORGANIZATION REGARDLESS OF RANK, ROLE, OR DISCIPLINE.

Trust, respect for others, and inclusion are essential to creating environments that are both physically and psychologically safe. Building trust involves managing conflict and making the environment safe for communicating bad news. It also involves practicing honesty, inclusion, transparency, and respect with everyone. Each member of the workforce must feel compelled and empowered to uphold mutual accountability and speak up for safety. Healthcare leaders develop trust within their organizations by having authentic relationships and conversations. For example, undertaking humble inquiry, asking questions to which you do not already know the answer, and building relationships based on genuine curiosity and interest all help leaders find information that might otherwise elude them (Schein 2013).

	Foundational	Sustaining
Strategies *Overarching strategies for implementation at the CEO level*	✓ CEO recognizes the critical importance of trust, respect, and inclusion in shaping organizational culture ✓ CEO creates expectation for trust, respect, and inclusion, and models these through his or her interactions with every individual at every level of the organization ✓ CEO holds the leadership team accountable for modeling trust, respect and inclusion ✓ CEO directs policies that empower the workforce to first and foremost act within the guidelines of trust, respect, and inclusion when making decisions ✓ CEO establishes the expectation that learning from failures and improving systems is a part of daily organizational activity	✓ CEO establishes expectations and accountability for formal program focusing on trust, respect, and inclusion that includes patients and is implemented across the organization ✓ CEO and organization have clear, visible expectations of acceptable behavior and consequences for behaviors that do not meet standards of trust, respect, and/or inclusion ✓ CEO establishes transparent practices with the Board, senior leadership, workforce and community, as appropriate ✓ CEO takes ownership of partnering with similar organizations, through Patent Safety Organizations (PSOs) or other collaboratives, to share learning and best practices

Trust, Respect, and Inclusion

Value Trust, Respect, and Inclusion

The actions of leaders must be consistent over time and throughout the organization. Behavioral standards and expectations should apply to everyone, without exception. Respect for others—be they patients, family members, peers, or subordinates—is essential for creating and sustaining trust. Developing and holding all leaders and the workforce accountable to codes of conduct or code of ethics can help to solidify the practices and behaviors that encourage trust and respect (Chassin and Loeb 2013).

Beyond modeling behaviors of respect themselves, leaders may need to institute ongoing education for volunteers, students, clinicians, and the workforce about appropriate behavior, and continue to actively encourage changes designed to increase fairness, transparency, collaboration, inclusion, and individual responsibility (Leape et al., 2012).

In pursuing safety as a core value, trust, respect, and inclusion are fostered by CEOs who make and keep commitments to the workforce, who communicate when a problem cannot be fixed immediately, who consistently display a sense of fairness, and who engage in and encourage reciprocal, helping behavior throughout the organization.

CEOs must also display their trust in others. Creating a strong team enables leaders to have confidence in delegating decisions and authority, though trust does not mean believing nothing will ever go wrong. Leaders can expect to continually work on building, sustaining, or repairing trust.

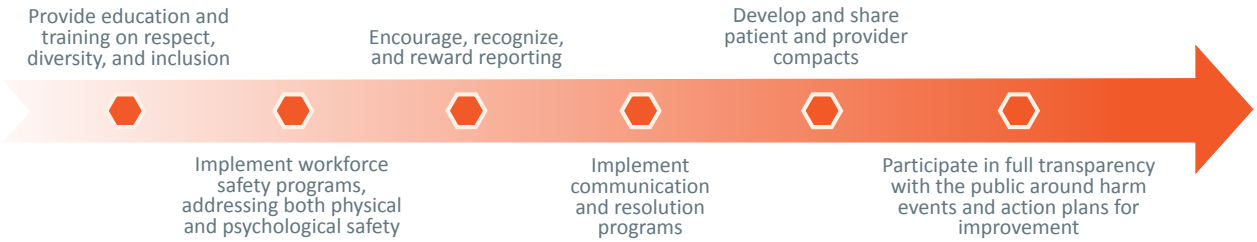
Cultural Diversity and Respect in the Workplace

It is imperative that CEOs understand the cultural makeup of both the community and the organization in which they serve. Implementing and modeling behaviors that reflect a respectful and inclusive environment is essential to a culture of safety. This should include placing a high value on the positive impact of greater diversity and inclusion among leadership as well as the workforce. It should also include efforts to evaluate and eliminate disparities in patient care. Unleashing the potential of workforce diversity depends on the establishment of inclusion, the building of trust and respect, and training in skills and behaviors that support an inclusive and respectful organization. With this approach, cultural diversity can be an effective resource for creative problem solving and organizational learning, and can help to identify and ameliorate disparities of care. (EU-OSHA 2013)

Trust, Respect, and Inclusion

Value Trust, Respect, and Inclusion

Trust, respect, and inclusion are the foundation of a culture of safety. The CEO develops trust and respect with individuals at all levels of the organization, and, with the Board, holds leaders, clinicians, and the workforce accountable for policies and behaviors that reflect these values.



Organizational Readiness Level	Foundational	Sustaining
Tactics *Examples of tactics that may be implemented to create change at each of these levels*	**To engage your organization:** ✓ Commit to implementing and holding all leaders and the work force accountable for processes and policies related to respect for people, just culture, and managing disruptive behavior ✓ Encourage and promote open discussion of safety issues via leadership rounds and reporting systems, and ensure follow-up and feedback ✓ Ensure that the workforce has dedicated time to devote to patient safety and safety culture work ✓ Implement workforce safety programs to reduce physical and psychological harm to the workforce ✓ Clearly define and encourage behaviors that show deference to expertise rather than hierarchy or title	**To engage your organization:** ✓ Aim for total transparency, but explain situations in which the organization is unable to be completely transparent ✓ Publicly share available information about events of harm, and plans for managing associated risks ✓ Ensure follow-up and feedback on identified safety issues, and be transparent if an issue cannot be resolved promptly ✓ Create compacts for leaders that clearly define expected behaviors in trust and transparency as they relate to other leaders, peers, and subordinates ✓ Build metrics for respect and trust (e.g., workforce psychological safety, error reporting) into the evaluation process for all leaders

Trust, Respect, and Inclusion

Value Trust, Respect, and Inclusion

Organizational Readiness Level	Foundational	Sustaining
Tactics *Examples of tactics that may be implemented to create change at each of these levels*	**To engage your organization (cont):** ✓ Recognize and reward reporting with the goal of reducing and eventually eliminating anonymous reporting ✓ Provide education and training on diversity and inclusion at every level of the organization ✓ Track employee engagement and turnover as a metric to evaluate trust, inclusion, and respect ✓ Include care disparity metrics on regularly reviewed patient safety dashboards ✓ Translate tools and resources for both patients and the workforce into a variety of languages, keeping in mind cultural context and linguistic idiosyncrasies ✓ Adopt communication and resolution/reconciliation programs for patients and families after events of preventable harm ✓ Establish patient and family advisory councils	**To engage clinical leaders:** ✓ Provide training for physicians, nurses, and other clinical leaders around patient engagement and communication ✓ Provide cultural competency training for all clinical leaders that is relevant to the patient populations they serve **To engage patients and families:** ✓ Encourage and enable patients and families to speak up if they notice a risk to safety ✓ Ensure that crisis plans address how to communicate with patients and families in the event of an error, regardless of degree of harm ✓ Commit to shared decision making and consider patient preferences in all treatment plans ✓ Engage patients and families in creating and disseminating patient compacts that include what patients can expect from the organization, their care providers, and the workforce
Assessing Execution *List of questions that should be asked to further assess and measure progress*	YES / NO ☐ ☐ Are all clinicians and workforce members provided with training in communicating with patients, including disclosure and apology? ☐ ☐ Are measures of respect included in all performance assessment tools? ☐ ☐ Is a formal program for respect and trust in place and evaluated regularly? ☐ ☐ Is there systematic training on diversity and inclusion for both the clinical and non-clinical workforce? ☐ ☐ Do the Board and leadership team regularly create and evaluate improvement plans for addressing disparities in patient care?	

Board Engagement

Select, Develop, and Engage Your Board

GOAL: SELECT AND DEVELOP YOUR BOARD SO THAT IT HAS CLEAR COMPETENCIES, FOCUS, AND ACCOUNTABILITY REGARDING SAFETY CULTURE.

Boards of healthcare organizations oversee the fiduciary performance, reputation, and key performance outcomes of an organization, including those related to quality, safety, and culture. The accountability for safety is shared between the CEO and the Board. The CEO is responsible for guaranteeing Board education on the importance of safety, ensuring that the Board understands quality and safety metrics, and recommending the appropriate representation of safety expertise on the Board, which could mean a safety expert from another field. In line with the CEO's responsibilities, the Board is responsible for making sure the correct oversight is in place, that quality and safety data are systematically reviewed, and that safety receives appropriate attention as a standing agenda item at all meetings. It is imperative that safety be a foundational factor in how healthcare Boards make decisions, so that patient and workforce safety culture is a sustainable focus for the organization.

	Foundational	Sustaining
Strategies *Overarching strategies for implementation at the CEO level*	✓ CEO guarantees Board education on importance of safety, the meaning of quality and safety metrics, and safety culture principles and behaviors ✓ CEO ensures Board membership includes clinical, safety, and patient/family representation ✓ CEO provides adequate agenda time for review and discussion of safety culture metrics and issues ✓ CEO sets up quality and safety committee(s) with Board representation ✓ CEO ensures each Board agenda includes time designated for Chief Medical Officer or Chair of Quality and Safety Committee to present safety and quality data ✓ CEO develops a robust Board-level patient and workforce safety dashboard that includes culture of safety metrics	✓ CEO works with the Board to set direction, goals, metrics, and systems of mutual accountability for zero harm to both patients and the workforce ✓ CEO provides for the appropriate level of oversight of the credentialing and re-credentialing process, including elements of quality and safety ✓ CEO works with the Board and/or compensation committee to align executive compensation with patient and workforce safety and culture metrics ✓ CEO leverages patient stories and presentations to educate the Board ✓ CEO provides opportunities for Board member representation on appropriate safety committees

Board Engagement

Select, Develop, and Engage Your Board

In recruiting new Board members, considerable thought should be given to the competencies, skills, experiences, and diversity needed to create and sustain a culture of safety. These skills may include specific competencies related to leading culture improvement efforts, as well as clinical and safety competencies. Ensuring that there is robust clinical expertise in the Board room is critical to incorporating frontline perspective into all conversations and initiatives, and allows for collaborative leadership in safety efforts throughout the organization (Goeshel et al. 2010). These decisions should also include measures of diversity that ensure the board is representative of the community and workforce it serves. Finally, leaders may encourage Boards or relevant committees to include a patient and family representative and safety experts from relevant industries. These recommendations should be made at the appropriate level based on each unique organization's needs.

A well-rounded and diverse Board empowers and supports the work of the CEO in creating and sustaining a culture of safety. The importance of Board education and training in safety science fundamentals, including just culture, human factors, and systems engineering cannot be overemphasized (NPSF 2015). There is real power in support for the CEO from the Board regarding issues of safety, allowing this focus to cascade to leadership and, ultimately, throughout all levels of the organization.

Effective Patient and Family Representation on Boards and Committees:

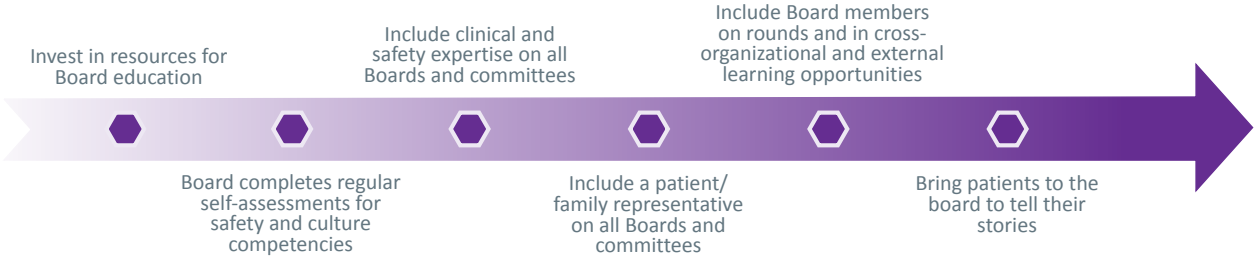
CEOs should consider the following characteristics of effective representation, while keeping in mind the appropriate voice and level of representation of patient/family member(s) to meet the needs of their organization and community:

1. Culture of the Board encourages total engagement and involvement of patient/family member(s)
2. Patient/family member(s) are representative of the community the organization serves
3. Patient/family member(s) have representation on quality and safety committee(s) and other committees, as appropriate
4. Patient/family representative is provided with ongoing learning opportunities in safety science and safety culture

Board Engagement

Select, Develop, and Engage Your Board

An engaged Board plays a key role in organizational culture and safety. The CEO encourages Board competencies and commitment regarding safety, while providing a transparent line of sight between the Board and the rest of the organization.



Organizational Readiness Level	Foundational	Sustaining
Tactics *Examples of tactics that may be implemented to create change at each of these levels*	**To engage your organization:** ✓ Establish Board Quality and Safety Committee with oversight responsibility for culture change, safety, and performance improvement ✓ Include an individual with safety and culture expertise on Board and appropriate committees, or ensure an advisor with these skills is available to the CEO and the Board ✓ Begin each Board meeting with a slide detailing the number and names of patients and staff who experienced harm since last meeting, and include a story about at least one of these individuals ✓ Regularly share and discuss a dashboard that includes patient and workforce safety and culture metrics ✓ Utilize a Board self-assessment that includes inquiry on safety culture knowledge to determine educational opportunities ✓ Identify a list of required Board competencies specific to leading culture improvement	**To engage your organization:** ✓ Encourage the Board to link executive compensation to safety outcomes, while ensuring metrics chosen do not discourage safety efforts ✓ Include Board members on guided leadership rounds ✓ Align Board dashboards to show safety and quality metrics as segmented by categories related to disparities in care ✓ Ask Board members to participate in events to show their support during Patient Safety Awareness Week and to be present at major quality, safety, and culture-related events ✓ Bring frontline teams to Board meetings to share their success stories and receive recognition ✓ Consider a rotating position on the Board or Quality and Safety Committee reserved for the frontline workforce ✓ Request that Board members spend time on all floors and units communicating and supporting the safety agenda

Board Engagement

Select, Develop, and Engage Your Board

Organizational Readiness Level	Foundational	Sustaining
Tactics *Examples of tactics that may be implemented to create change at each of these levels*	**To engage your organization (cont):** ✓ Discuss whether Board reflects the community your organization serves and implement action plan to address any gaps ✓ Invest in resources for Board education, including patient safety science and quality ✓ Create a matrix of Board competency needs and seek candidates with those skills in mind ✓ Regularly review accreditation survey results with the Board ✓ Encourage ample clinical expertise, including physicians and nurses on the Board and/or on Board committees ✓ Include a presentation on a current organizational safety culture issue by an expert in safety and quality at each Board meeting ✓ Educate Board members on issues of disparities in care	**To engage your organization (cont):** ✓ Provide Board members with opportunities to learn from Boards and leaders of outside organizations and industries ✓ Require Board approval on resolutions to all serious safety events **To engage clinical leaders:** ✓ Involve physicians, nurses, and other clinical leaders to present clinical and quality improvement efforts regularly to the Board ✓ Bring clinical leaders dedicated to culture to Board meetings to share their experience and receive recognition **To engage patients and families:** ✓ Create positions for patient/family representatives on your Board and on your quality/safety committee(s) ✓ Present patient stories at Board and appropriate committee meetings ✓ Invite patients to attend Board meetings and personally share their stories and experiences (both positive and negative)

Assessing Execution

List of questions that should be asked to further assess and measure progress

YES	NO	
☐	☐	Does the Board conduct regular self-assessments related to knowledge and understanding of culture of safety?
☐	☐	Are programs in place to build competencies in culture improvement for Board members?
☐	☐	Is the amount of time spent on quality and safety during each Board meeting tracked and at least comparable to time spent on finance and other items?
☐	☐	Do performance assessments for the CEO include the organization's safety activities and measures of culture?
☐	☐	Do patient safety and quality leaders participate in at least a portion of all Board meetings?
☐	☐	Is a patient and/or workforce story presented at each Board meeting?

Prioritize Safety in Selection and Development of Leaders

GOAL: EDUCATE AND DEVELOP LEADERS AT ALL LEVELS OF THE ORGANIZATION WHO EMBODY ORGANIZATIONAL PRINCIPLES AND VALUES OF SAFETY CULTURE.

Healthcare CEOs, in collaboration with the Board, are responsible for establishing the direction and accountability for the design and delivery of their organization-wide leadership development strategy. Within this strategy, it is imperative that safety is part of the education for both current and emerging leaders. It is the responsibility of the CEO to establish the priority for safety and culture in the development of leaders at all levels and in all departments across the organization.

Emphasis on safety education can also help close the gap between administrative and clinical leadership, providing all leaders with the shared goal of driving toward a culture of safety for the betterment of the organization and the patients they serve. Identifying and developing physician, nursing, and other clinical leaders as champions for safety is a key responsibility of the CEO. Numerous studies indicate the positive impact clinical leaders can have on culture and safety, particularly in an era when healthcare leaders are often in a position to make decisions that affect care at the frontlines. Clinical leaders have extensive understanding of healthcare's "core business" of patient care, and are therefore in a unique position to connect administration with the clinical workforce, and to garner support for safety and culture initiatives. In addition to safety education, CEOs can commit to developing effective physician, nursing, and other clinical leaders by providing and encouraging training in non-clinical skills, including professionalism, emotional intelligence, team building and communication, and basic business principles (Angood 2014).

	Foundational	Sustaining
Strategies *Overarching strategies for implementation at the CEO level*	✓ CEO sets expectations and accountability for the design and delivery of the organization's leadership development strategy ✓ CEO ensures he/she and the leadership team receive necessary safety education, and provides the appropriate level of safety education throughout the rest of the organization ✓ CEO identifies physicians, nurses, and other clinical leaders as champions for safety	✓ CEO serves as a mentor for other C-Suite executives ✓ CEO establishes expectation that quality and safety performance and competence are required elements for evaluating current and potential leaders for promotion and succession planning ✓ CEO assigns accountability for measurable outcomes of safety education as part of leadership development strategy ✓ CEO ensures patient and workforce safety are key parts of the organization's reward and recognition system

Prioritize Safety in Selection and Development of Leaders

The selection process for both current and emerging leaders should be predicated on their understanding of, dedication to, and alignment with the organization's vision for patient and workforce safety, communication skills, and modeling of expected safety behaviors. Safety can be a topic for individual professional development as well as organization-wide succession planning to ensure that the commitment to safety is sustainable throughout all levels and functional areas. Many organizations already have a process in place for identifying individuals with high potential to succeed as leaders, into which a safety and culture program can be integrated (Garman and Anderson 2014).

Finally, it is critically important to provide regular feedback to both current and developing leaders that is valuable to them, whether that is a 360-degree review model or another structured review (Garman and Anderson 2014). Feedback should clearly define, communicate, and embody required leadership competencies in safety culture, and safety development plans should be reviewed at regularly scheduled check-ins. CEOs are responsible for not only setting this direction, but also participating in these reviews from the perspective of gathering feedback about their own competence in safety culture and behaviors, and sharing input for members of their leadership team.

A well-developed leadership team that is dedicated to a culture of safety provides a catalyst for the evolution of the organization. The CEO, in collaboration with the Board, is responsible for establishing the direction and accountability for the design and delivery of an organization-wide leadership development strategy.

Prioritize Safety in Selection and Development of Leaders

Organizational Readiness Level	Foundational	Sustaining
Tactics *Examples of tactics that may be implemented to create change at each of these levels*	**To engage your organization:** ✓ Define and develop organizational leadership competencies in safety culture and safety behaviors and ensure that all current and future leaders and the frontline workforce receive education in selected competencies ✓ Define cultural roles and expectations for all leaders within the organization, including clinical leaders ✓ Create systems to support leaders in culture work at all levels of the organization through training, coaching, and mentoring ✓ Consider safety expertise and credentialing along with leadership potential when considering emerging leaders ✓ Discuss whether leadership team reflects the community the organization serves and develop plan to address any gaps ✓ Create systems that ensure regular reporting on leadership development measures ✓ Develop and employ a talent review process that is candid and transparent ✓ Conduct gap analysis of CEO and leadership for knowledge, skills, and attitudes around patient safety and culture	**To engage your organization:** ✓ Build an incentive program into leadership reviews that is focused on reporting performance on key culture of safety metrics ✓ Provide continuing learning opportunities in safety and culture, with a focus on experiential learning ✓ Tie measures and performance on safety and culture to leadership development priorities, talent management reviews, and succession planning ✓ Provide opportunities and expectations for leaders to learn outside of the organization, both with similar organizations and outside industries ✓ Build a guiding coalition of champions, including clinicians and frontline workforce members, that provides candid and honest feedback to the CEO ✓ Incorporate leadership development into organizational people strategy ✓ Define talent as an organizational resource and allow for interdepartmental training and mobility ✓ Ensure leaders are trained to teach and coach their employees ✓ Recommend that each senior executive participate in communication and apology to patients and families who have experienced harm

Prioritize Safety in Selection and Development of Leaders

Organizational Readiness Level	Foundational	Sustaining
Tactics *Examples of tactics that may be implemented to create change at each of these levels*	**To engage your organization (cont):** ✓ Ensure all executives can clearly articulate how a culture of safety applies in their department, and that all leaders can do the same ✓ Develop systems that encourage deference to expertise rather than hierarchy or title in issues of safety	**To engage clinical leadership:** ✓ In leadership development programs, incorporate opportunities for clinical leader advancement **To engage patients and families:** ✓ Ensure leaders have competencies in how to partner effectively with patients at all levels of care ✓ Include patient and family representatives in leadership recruitment and hiring process
Assessing Execution *List of questions that should be asked to further assess and measure progress*	**YES / NO** ☐ ☐ Do all leaders receive training in patient safety science and safety culture? ☐ ☐ Is at least one member of the executive leadership team a Certified Professional in Patient Safety or a safety expert? ☐ ☐ Are leadership development plans reviewed annually? Do they include measures of key safety culture competencies? ☐ ☐ Do leadership development programs include cultivation of a robust skill set in communication, engagement, listening, performance improvement, and emotional intelligence, as well as business acumen?	

Lead and Reward a Just Culture

GOAL: BUILD A CULTURE IN WHICH ALL LEADERS AND THE WORKFORCE UNDERSTAND BASIC PRINCIPLES OF PATIENT SAFETY SCIENCE, AND RECOGNIZE ONE SET OF DEFINED AND ENFORCED BEHAVIORAL STANDARDS FOR ALL INDIVIDUALS IN THE ORGANIZATION.

Healthcare organizations that are successful in improving safety and eliminating harm have leaders who understand and commit to the principles of just culture. A just culture "focuses on identifying and addressing systems issues that lead individuals to engage in unsafe behaviors, while maintaining individual accountability by establishing zero tolerance for reckless behavior. Just organizations focus on identifying and correcting system imperfections, and pinpoint these defects as the most common cause of adverse events. Just culture distinguishes between human error (e.g., slips), at-risk behavior (e.g., taking shortcuts), and reckless behavior (e.g., ignoring required safety steps), in contrast to an overarching 'no-blame' approach" (PSNet Safety Primer 2016).

	Foundational	Sustaining
Strategies *Overarching strategies for implementation at the CEO level*	✓ CEO encourages commitment to just culture framework as an essential business philosophy ✓ CEO communicates and models the use of just culture principles in all decisions and actions as part of daily responsibilities and interactions, including root cause analysis ✓ CEO educates Board and leadership team on principles of just culture and role models these principles	✓ CEO employs just culture principles throughout organization and communicates that rules apply to all, regardless of rank, role and discipline ✓ CEO sets expectations for accountability for anyone interacting with the healthcare organization to commit to utilizing just culture principles in every day practice and decisions ✓ CEO ensures just culture principles are implemented in all interactions

A just culture is not a blame-free environment; clinicians and the workforce are still held accountable for following protocols and procedures. The vast majority of errors are not a result of individual failures, but are the result of systems that are inherently flawed and create environments of risk. A just culture acknowledges that punishing people for mistakes discourages reporting, fails to correct problems in the system, and sets up the likelihood of recurrence. Just culture also emphasizes the importance of the affected workforce after events occur, and focuses on support and peer-to-peer counseling for affected clinicians and the workforce.

When clearly defined, articulated, and implemented by leadership, a just culture approach encourages the reporting of errors, lapses, near-misses, and adverse events. It is through reporting and event analysis that the organization learns what went wrong, or could have gone wrong, and how to prevent it from happening again.

Lead and Reward a Just Culture

The hard work of establishing a just culture, however, goes well beyond agreeing to the concept itself. It involves incorporation of expertise in human factors engineering and systems design, full support and resources from the CEO and all leadership, and full engagement of departments such as Human Resources and Organizational Development. It also requires robust reporting systems with mechanisms in place to provide timely feedback to the workforce about not only what went wrong, but why it went wrong. This feedback also includes strong action plans to prevent future occurrence. Developing a just culture policy is just the first step, and organization-wide, systemic implementation is key.

While training of leaders and the patient safety workforce on just culture is vital, everyone at all levels of the organization must consistently integrate just culture principles as an organizational norm. The CEO's role in ensuring that just culture principles are understood and implemented across the organization is fundamental to success. If one individual within the organization is punished for a system flaw, just culture efforts can be severely undermined. Leaders must be transparent with the Board, physicians, the workforce, and the public about the organization's approach, so that when something does go wrong, the response is expected, practiced, and applied uniformly throughout the organization.

Just Culture Principles

Human behaviors within a just culture can be described as follows:

- **HUMAN ERROR =** An inadvertent slip or lapse. Human error is expected, so systems should be designed to help people do the right thing and avoid doing the wrong thing.

  Response: Support the person who made the error. Investigate how the system can be altered to prevent the error from happening again.

- **AT-RISK BEHAVIOR =** Consciously choosing an action without realizing the level of risk of an unintended outcome.

  Response: Counsel the person as to why the behavior is risky; investigate the reasons they chose this behavior, and enact system improvements if necessary.

- **RECKLESS BEHAVIOR (NEGLIGENCE) =** Choosing an action with knowledge and conscious disregard of the risk of harm.

  Response: Disciplinary action.

(PSNet Safety Primer 2016)

Lead and Reward a Just Culture

A just culture that focuses on identification and resolution of systems issues supports clinicians and the workforce when these systems break down. CEOs ensure that the principles of a just culture are implemented organization-wide and that they inform every action and decision.

Organizational Readiness Level	Foundational	Sustaining
Tactics *Examples of tactics that may be implemented to create change at each of these levels*	**To engage your organization:** ✓ Educate Board, leadership, and workforce about just culture through integrated training programs ✓ Develop and implement a decision-making process and application of just culture that is behavior-based, rather than harm-based ✓ Ensure organization-wide leadership commitment to frameworks of just culture and accountability that are aligned across all departments ✓ Create an interdisciplinary just culture champion team to review organizational policies, provide training, and ensure policies are being followed at all levels ✓ Identify metrics to track performance on just culture implementation	**To engage your organization:** ✓ Educate organization to be responsive to and transparent about actions related to professional discipline ✓ Implement a peer support program ✓ Hold workforce accountable for implementing just culture principles in daily practice and decision-making ✓ Include actual and mock scenarios on meeting agendas that demonstrate application of just culture principles ✓ Involve the media as a way to explain errors, decisions, and data to the public ✓ Treat and respond to gaps in culture and expected safety behaviors as adverse events ✓ Expect that leaders utilize just culture tools in all situations, even those not significant or punishable, to ingrain principles and use into organizational norms

Lead and Reward a Just Culture

Organizational Readiness Level	Foundational	Sustaining
Tactics *Examples of tactics that may be implemented to create change at each of these levels*	**To engage your organization (cont):** ✓ Align systems and standards for just culture across all organizational departments, including Human Resources ✓ Ensure employees are well-trained in just culture algorithm and tools and utilize them in daily activities and decisions ✓ Publicly reward positive examples of just culture	**To engage clinical leadership:** ✓ Include clinical leaders in the development of just culture policies ✓ Provide training for physicians, nurses, and other clinical leaders in just culture to build understanding and enthusiasm **To engage patients and families:** ✓ Ensure that patients and family members who serve on Board and committees are educated on just culture principles ✓ Include patients and families in mediation committees/tribunals to assist in resolving conflicts between departments

Assessing Execution

List of questions that should be asked to further assess and measure progress

YES	NO	
☐	☐	Do Board, leadership, and workforce development programs include training on just culture?
☐	☐	Is there one set of defined behavioral standards for all individuals within the organization, including leadership, physicians, and the workforce?
☐	☐	Is compliance with the established just culture framework part of regularly reviewed performance reviews, including career development plans, for leaders and the workforce?
☐	☐	Does the organization use, evaluate, and define action plans related to measures of just culture on employee surveys?
☐	☐	Is there an existing measure that is regularly evaluated for assessing frontline knowledge of just culture algorithm?

Establish Organizational Behavior Expectations

GOAL: CREATE ONE SET OF BEHAVIOR EXPECTATIONS THAT APPLY TO EVERY INDIVIDUAL IN THE ORGANIZATION AND ENCOMPASS THE MISSION, VISION, AND VALUES OF THE ORGANIZATION.

Much of the work involved in creating a culture of safety in healthcare is intrinsically linked to the everyday behaviors that characterize an organization (PSNet Patient Safety Primer: Safety Culture 2016). In fact, culture is often defined as "the way we do things around here." CEOs set the tone and have the power and responsibility to establish behaviors, set expectations, and promote accountability for these behavioral norms for everyone, including both employed and non-employed individuals. It is essential for Board members, the CEO, and leaders at every level to model the behaviors they aim to cultivate throughout the organization.

	Foundational	Sustaining
Strategies *Overarching strategies for implementation at the CEO level*	✓ CEO creates, communicates, and models an organizational climate of personal and professional accountability for behavior ✓ CEO establishes systems to recognize and reward desirable behaviors ✓ CEO activates organization to develop, implement, and evaluate programs that address and improve personal, professional, and organizational behavior and accountability ✓ CEO engages Board by sharing metrics and dashboards related to organizational behavior ✓ CEO engages and holds all leaders and workforce accountable for defined behaviors	✓ CEO prioritizes resources for professional accountability framework and programs to ensure and sustain behavioral excellence ✓ CEO ensures that succession planning and talent management programs prepare future leaders with competencies in organizational behavior and accountability ✓ CEO works with licensing bodies and medical executive committees, where applicable, to ensure behavioral expectations and accountability practices are consistent ✓ CEO and leaders at all levels of the organization encourage questions, increasing the likelihood that the right question will be asked at a critical time

Establish Organizational Behavior Expectations

Chief among the behaviors that contribute to an environment of physical and psychological safety are transparency, effective teamwork, active communication, just culture, respect, and direct and timely feedback. Each of these can be learned, and the workforce should be educated about what is expected and why. For example, educating health professionals in effective communication with patients and families, whether disclosing an error, seeking informed consent, or practicing shared decision making, is a key part of cultivating teamwork, communication, and respect.

One of the first responsibilities of a CEO is to understand the current accepted behaviors within the organization. One way to achieve this understanding is through use of validated surveys of patient safety culture, which can help identify areas of strength as well as areas for improvement at organizational, departmental, and unit levels. Surveys can also reveal the strength or weaknesses of organizational culture and "subcultures," and provide leaders a better sense of where they may need to focus attention. In this manner, leaders are able to better connect with the frontline workforce on a regular basis, whether through leadership rounding, safety huddles, briefings/debriefings, or other tactics, so they can hear about challenges firsthand. A Board, leadership, physician and other clinical professional, and workforce "credo" or compact also helps to communicate behavioral expectations. Such a compact can frame discussions and maintain accountability when someone violates the standard behavioral code (Webb et al. 2016).

It is also important to have a mechanism for escalating concerns when behavioral codes are violated and for dealing with disruptive and unsafe behaviors. Everyone within the organization should understand what that procedure is, and that it will be applied consistently across the organization, regardless of rank, department, revenue, or other considerations. It is essential to remember that the process of changing behavioral norms across an organization or system can be a long and challenging one. That is why it is equally important to ensure that there is also a system to reward individuals who are identified as modeling desired behavior. True progress can be accomplished with the dedication of a highly engaged, unwavering, and courageous CEO.

Importance of Physical and Psychological Safety of the Workforce

An environment that protects the physical and psychological safety of the workforce is fundamental to a culture of safety. Yet many healthcare workers suffer from harm, including bullying, burnout, and physical injury and assault, during the course of providing care. Under these conditions, it is difficult for care providers to find joy and purpose in their work, and patient safety is jeopardized. The prioritization of safety behaviors including respect, transparency, and teamwork is at the foundation of safety for the workforce, and therefore for patients. The workforce needs to know that their safety is an enduring, non-negotiable priority for the CEO and Board. This commitment is demonstrated when action plans are developed and implemented to ensure the workforce feels valued, safe from harm, and part of the solution for change (NPSF LLI 2013).

Behavior Expectations

Establish Organizational Behavior Expectations

Organizational safety behavior expectations are the daily demonstration of a true culture of safety. CEOs work with leaders and the workforce to develop these expectations and to personally demonstrate expected behaviors, while holding the leadership team accountable for doing the same.

Organizational Readiness Level	Foundational	Sustaining
Tactics *Examples of tactics that may be implemented to create change at each of these levels*	**To engage your organization:** ✓ Complete culture of safety surveys every 12-18 months and review with Board, leadership team, and workforce; set targets for improvement and take deliberate action to achieve them ✓ Stratify and track culture and safety metrics by sociodemographic variables that are important to the organization's community and develop plans to address any gaps ✓ Develop required processes for teamwork, communication, and handoffs among the workforce and with patients, using tools like SBAR, read back, "stop the line," briefings, and de-briefings ✓ Require, participate in, and give context for existing safety processes, including safety huddles and operational briefings, and use these opportunities as forums to build better teamwork and safety culture	**To engage your organization:** ✓ Require annual signatures on compacts for Board members, leaders, and the workforce that clearly define expected professional accountability behaviors ✓ Educate and explain to your organization and the public what you will be transparent about, and what limits may exist on transparency ✓ Design and implement a crisis communications policy and plan for both internal and external audiences ✓ Align and integrate organizational safety and respectful behaviors with all departments across the organization ✓ Provide feedback to employees when they report a safety issue, closing the loop and demonstrating how frontline callouts improve safety ✓ Recognize and reward individuals and teams for demonstrating positive safety behaviors and reporting

Behavior Expectations

Establish Organizational Behavior Expectations

Organizational Readiness Level	Foundational	Sustaining
Tactics *Examples of tactics that may be implemented to create change at each of these levels*	**To engage your organization (cont):** ✓ Define organizational safety behavior expectations and respectful behaviors, as well as the organizational response to disrespectful behavior and conflict ✓ Proactively promote and encourage teamwork by implementing a formal team training program ✓ Break down hierarchical policies and systems for reporting, and encourage reporting without fear of punishment or retribution ✓ Break down power gradients by communicating and rewarding a policy that requires all staff to speak up for safety concerns ✓ Develop and abide by leadership behaviors, including appreciative or humble inquiry ✓ Celebrate and recognize individuals and teams who excel at key safety behaviors ✓ Work with key stakeholders to clearly communicate and enforce the same behavioral standards for both employed and non-employed practitioners and staff	**To engage your organization (cont):** ✓ Ensure the existence of measurement tools and/or report cards for individual performance ✓ CEO requires and accepts notification of any serious safety events within 24 hours, without exception ✓ SBAR for all serious safety events is shared with full administrative and clinical leadership teams and with the Board ✓ Leadership distributes awards for teams and organizations based on culture of safety metrics **To engage clinical leaders:** ✓ Recognize and reward physicians, nurses, and other clinical leaders who actively participate in teamwork and communication initiatives ✓ Create (and require signatures on) physician and leadership compacts that clearly define behavioral expectations ✓ Commit to and train the workforce on communication and resolution programs **To engage patients and families:** ✓ Include patients in the development of required processes for communication with patients, using tools like AskMe3® and shared decision making ✓ Encourage and enable patients and families to report safety concerns, and follow up with families who have reported ✓ Ensure that safety behavior expectations are centered around the patient, and involve patients in setting these expectations ✓ Create, supply, and use understandable tools for patient involvement and shared decision making ✓ Invite patients to utilize versions of communication and reporting tools (e.g., SBAR) and to participate in team processes ✓ Have a designated team available to provide support to patients, families, and the workforce when an error has occurred

Establish Organizational Behavior Expectations

Organizational Readiness Level	Foundational	Sustaining
Assessing Execution *List of questions that should be asked to further assess and measure progress*	YES / NO ☐ ☐ Does the organization have a clearly defined reporting system and measure utilization of this system (including follow-up and feedback processes)? ☐ ☐ Are organizational behavior expectations, such as use of huddles and briefings, with follow-up plans and identified owners of action items, implemented and reviewed regularly? ☐ ☐ Are professional accountability standards (e.g., a process to address disruptive behaviors) in place, used, and regularly evaluated? ☐ ☐ Are specific tools to encourage teamwork and clear communication in place, used, and regularly evaluated? ☐ ☐ Are communication and resolution/reconciliation programs in place, utilized, and regularly evaluated?	

Appendix

Key Terms Related to Patient Safety and a Culture of Safety

Based on AHRQ PSNet Glossary [nd], Runciman et al. 2009, and others as noted.

Adverse Event: Any injury caused by medical care. An undesirable clinical outcome that has resulted from some aspect of diagnosis or therapy, not an underlying disease process. Preventable adverse events are the subset that are caused by error.

Clinician: A health professional qualified in the clinical practice of medicine, such as a physician, nurse, pharmacist, or psychologist who is directly involved in patient care, as distinguished from one specializing in laboratory or research techniques or in theory.

Error: An act of commission (doing something wrong) or omission (failing to do the right thing) that leads to an undesirable outcome or significant potential for such an outcome.

Harm: An impairment of structure or function of the body and/or any deleterious effect arising therefrom, including disease, injury, suffering, disability, and death. Harm may be physical, social, or psychological, and either temporary or permanent.

Inclusion: Positively striving to meet the needs of different people and taking deliberate action to create environments where everyone feels respected and able to achieve their full potential (National Institute for Health Research 2012).

Just Culture: A culture that recognizes that individual practitioners should not be held accountable for system failings over which they have no control. A just culture also recognizes that many individual or "active" errors represent predictable interactions between human operators and the systems in which they work. However, in contrast to a culture that touts "no blame" as its governing principle, a just culture does not tolerate blameworthy behavior such as conscious disregard of clear risks to patients or gross misconduct (e.g., falsifying a record, performing professional duties while intoxicated).

Patient Safety: Patient safety refers to freedom from accidental or preventable injuries produced by medical care. Thus, practices or interventions that improve patient safety are those that reduce the occurrence of preventable adverse events.

Psychological Safety: Individuals' perceptions about the consequences of interpersonal risks in their work environment. These perceptions include taken-for-granted beliefs about acceptable interactions with co-workers, superiors, and subordinates, and how others will respond when one puts oneself on the line, such as by asking a question, seeking feedback, reporting a mistake, or proposing a new idea (Edmondson 2011).

Respect: The treatment of others with deference in daily interactions, weighing their values, views, opinions and preferences (Sergen's Medical Dictionary 2012).

Safety Culture/Culture of Safety: The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the characteristics of the organization's health and safety management. Organizations with a positive safety culture are characterized by communications based on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures (Health and Safety Commission 1993).

Total Systems Safety: Safety that is systematic and uniformly applied (across the total process) (Pronovost et al. 2013). A systems approach can help with the design and integration of people, processes, policies, and organizations to promote better health at lower cost.

Trust: The collective expectations by the public and other clinicians that health care providers will demonstrate knowledge, skill, and competence, and will act in the best interest of both patients and colleagues with beneficence, fairness, and integrity (Calnan 2008).

Workforce: Health professionals and all other workers employed in health service or other settings, including but not limited to clinicians, administrators, medical records personnel, and laboratory assistants.

Workforce Safety: Healthcare workforce safety refers to freedom from both physical and psychological harm for all those who work with patients as well as those who oversee or provide non-clinical support for those who work with patients.

Zero Harm/Free from Harm: The total absence of physical and psychological injury to patients and the workforce.

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Self-Assessment Tool

Culture of Safety Organizational Self-Assessment

Please Note: *The questions in this self-assessment represent a selection of elements from the report, "Leading a Culture of Safety: A Blueprint for Success." This brief assessment may not accurately represent the full environment or state of each organization. It is recommended that teams review all strategies, tactics, and information in the full document for additional clarity and guidance.*

Instructions:

1. **Select** a diverse team to lead the safety culture review and improvement process. It is recommended that this team include key C-Suite executives, clinical leadership, patient safety leadership, and a patient and family representative.

2. **Share** the guide, *Leading a Culture of Safety: A Blueprint for Success* with your team. Review the full document as a team or independently.

3. **Ask** each team member to complete this self-assessment independently. Conduct a series of meetings to:
   - **A)** Review self-assessment responses and scoring for each category as a team, and finalize your organizational score.
   - **B)** Develop action plans, metrics/dashboard, for assessment, and follow-up plans for low scoring domains (Refer back to *Leading a Culture of Safety: A Blueprint for Success* for assistance)

     Note: *if your team records low scores in Establish a Compelling Vision for Safety or Value Trust, Respect, and Inclusion, it is recommended that you begin with action plans for improvement in these domains.*
   - **C)** Review improvement metrics, revisit action plans, and make adjustments as necessary. You should include additional team members and/or consultants where applicable.

Notes on Scoring:

Each statement should be scored on a scale of 1-5 based on the following:

- **1 – Never** true for my organization
- **2 – Rarely** true for my organization
- **3 – Sometimes** true for my organization
- **4 – Almost always** true for my organization
- **5 – Always** true for my organization

If you are **unsure** of the response, please check the box titled unsure. When adding responses for a total score, this box should be recorded as a **0**. For any item where a member of the leadership team is unsure of the response, it is recommended that he or she spend time speaking with frontline staff and other appropriate individuals in the organization to determine the best answer.

Reviewing Responses:

The **total score** is the sum of the response for each of the three questions. The total score will correlate with one of the three ranges in the boxes below, 0 – 4, 5 – 9, or 10 – 15. Confirm that the **organizational state** box accurately describes the current state of your organization. If it does not, you may need to reevaluate your responses, or speak with additional individuals to better understand the current state of your organization.

Use the **recommended next steps** box in the column that correlates with your total score as a quick reference when developing action plans for improvement. For additional information and recommendations, refer to *Leading a Culture of Safety: A Blueprint for Success*.

Scoring:

1 – **Never** true for my organization
2 – **Rarely** true for my organization
3 – **Sometimes** true for my organization
4 – **Almost always** true for my organization
5 – **Always** true for my organization
0 – **Unsure** of the response

Establish a compelling vision for safety

MEASURABLE ELEMENTS	SCORE						OBSERVATIONS
Key questions to ask about your organization's capabilities and processes.	1	2	3	4	5	Unsure 0	***Please provide a brief description of why you chose this score, considering all parts of each question.***
1. My organization's safety vision statement and aspirational end state are clear and consistently communicated.							
2. My organization completes and reviews culture of safety surveys every 12 – 18 months with evidence of improvement.							
3. My organization's CEO and leadership team effectively build enthusiasm for and understanding of my organization's safety vision statement.							

Total Score = _____

	Score: 0 – 4	Score: 5 – 9	Score: 10 – 15
Organizational State *Brief description of current state of the organization*	Organization's vision statement does not reflect an end state of zero harm and is not regularly communicated to the workforce. Leaders and staff may have a difficult time understanding or communicating how their daily work contributes to advancement of the vision statement.	Organization has a defined vision with a clear, aspirational end state. Leaders communicate this vision consistently to the workforce, and understand how their work fits into the organizational vision statement. All members of the workforce are able to effectively communicate the vision statement.	Leaders and the workforce effectively communication the organization's vision to patients, families, and the public. The workforce is motivated by the vision statement and can clearly tie their daily work to the advancement of this vision. Metrics to benchmark progress toward vision are in place and regularly evaluated.
Recommended Next Steps *Recommended next steps for improvement and implementation are based on domain and included in Leading a Culture of Safety: A Blueprint for Success*	*Begin with review of* ***Foundational*** *tactics* Develop a vision statement with a clear end goal; Educate leaders and the workforce on the meaning of safety culture and zero harm; Host information sessions to build understanding and enthusiasm for the vision	*Review* ***Foundational*** *and* ***Sustaining*** *tactics* Encourage leader visibility on front lines and communication about how daily work advances vision; Hold leaders accountable for regularly and consistently communicating vision to all units and departments	*Review* ***Foundational*** *and* ***Sustaining*** *tactics* Share vision and action plans for change transparently with patients, families, and the public; Benchmark progress towards zero harm and share goals and strategies with similar organizations; Develop and support programs that recognize growth and adherence to vision

Scoring:

1 – Never true for my organization
2 – Rarely true for my organization
3 – Sometimes true for my organization
4 – Almost always true for my organization
5 – Always true for my organization
0 – Unsure of the response

Value trust, respect, and inclusion

MEASURABLE ELEMENTS	SCORE						OBSERVATIONS
Key questions to ask about your organization's capabilities and processes.	**1**	**2**	**3**	**4**	**5**	Unsure **0**	***Please provide a brief description of why you chose this score, considering all parts of each question.***
1. My organization uses and regularly evaluates formal respect programs that provide education and support to patients and the workforce.							
2. My organization implements workforce safety programs to reduce physical and psychological harm to the workforce.							
3. My organization transparently shares information and metrics around harm events and action plans for improvement across our organization.							

Total Score = _____

	Score: 0 – 4	Score: 5 – 9	Score: 10 – 15
Organizational State *Brief description of current state of the organization*	CEO and organizational leaders understand the criticality of trust, inclusion, and respect, but may not model these values in all situations. The workforce fears punishment from reporting and disclosing errors to patients. Hierarchies based on rank and role exist throughout the organization.	Formal respect and teamwork programs are in place across the organization, and all staff participate in regular trainings. The workforce reports errors and close calls anonymously and without fear of retribution. Leaders across the organization embody behaviors that focus on trust, respect, and inclusion in all interactions.	Open and honest reporting is standard across the organization and includes defined feedback cycles. Both patients and the workforce are empowered to speak up about safety concerns. Robust communication and support programs are in place for patients, families, and the workforce.
Recommended Next Steps *Recommended next steps for improvement and implementation are based on domain and included in Leading a Culture of Safety: A Blueprint for Success*	*Begin with review of* ***Foundational*** *tactics* Develop organization-wide respect for people programs; Train all leaders, staff, and clinicians on respect program; Develop, implement, and train on anonymous reporting systems; Establish a patient and family advisory council	*Review* ***Foundational*** *and* ***Sustaining*** *tactics* Educate leaders and workforce on inclusion, diversity, and communication with both patients and co-workers; Develop and implement disclosure and apology program; Include metrics for trust, respect, and inclusion as part of annual review process for all leaders	*Review* ***Foundational*** *and* ***Sustaining*** *tactics* Publically share information about harm events and plans to prevent recurrence; Enable and encourage patients and families to speak up for safety through available tools and education programs; Provide cultural competency training for leaders and workforce; Regularly evaluate metrics on disparities in patient care

Scoring:

1 – **Never** true for my organization
2 – **Rarely** true for my organization
3 – **Sometimes** true for my organization
4 – **Almost always** true for my organization
5 – **Always** true for my organization
0 – **Unsure** of the response

Select, develop and engage your Board

MEASURABLE ELEMENTS	SCORE						OBSERVATIONS
Key questions to ask about your organization's capabilities and processes.	**1**	**2**	**3**	**4**	**5**	Unsure **0**	***Please provide a brief description of why you chose this score, considering all parts of each question.***
1. At all Board meetings in my organization, the amount of time spent reviewing and discussing a transparent dashboard on safety and culture is equal to or greater than time spent reviewing financial performance.							
2. My organization's Board members are required to complete regular self-assessments and education related to safety culture and quality principles.							
3. Performance assessments and incentives for my organization's leadership are inclusive of safety culture metrics and performance.							

Total Score = _____

	Score: 0 – 4	Score: 5 – 9	Score: 10 – 15
Organizational State *Brief description of current state of the organization*	Organization's Board members have strong financial backgrounds, but lack quality and safety expertise. Safety metrics are presented briefly at each Board meeting, and few questions are asked. The majority of the meeting focuses on financial review.	Organization has a quality and safety committee that reviews all serious harm events, but these are rarely presented to the full Board. Time spent on safety during Board meetings includes a story of harm told by the safety/quality manager, and some questions are asked about the event. Board meetings prioritize financial review over safety review.	Organization's Board and committees include experts in safety, clinicians, and a patient and family representative. Patients are invited to meetings to present their experiences directly to the Board. Safety is a top priority and Board members understand how safety impacts the bottom line and feel empowered to ask questions.
Recommended Next Steps *Recommended next steps for improvement and implementation are based on domain and included in Leading a Culture of Safety: A Blueprint for Success*	*Begin with review of* ***Foundational*** *tactics* Provide educational opportunities in safety science and culture for all Board members; Include a safety expert on the Board; Develop a patient and workforce safety dashboard for regular review; Establish a quality and safety committee	*Review* ***Foundational*** *and* ***Sustaining*** *tactics* Consider including a patient/family representative on Board and all committees; Provide opportunities for all Board members to participate on guided leadership rounds; Share all serious safety events and action plans with the full Board	*Review* ***Foundational*** *and* ***Sustaining*** *tactics* Link CEO compensation and bonuses to performance on safety and culture metrics; Provide opportunities for Board members to learn from other organizations and industries; Bring frontline teams to Board meetings to tell their stories and be recognized for exemplary performance

Scoring:

1 – Never true for my organization
2 – Rarely true for my organization
3 – Sometimes true for my organization
4 – Almost always true for my organization
5 – Always true for my organization
0 – Unsure of the response

Prioritize safety in the selection and development of leaders

MEASURABLE ELEMENTS	SCORE						OBSERVATIONS
Key questions to ask about your organization's capabilities and processes.	**1**	**2**	**3**	**4**	**5**	**Unsure 0**	***Please provide a brief description of why you chose this score, considering all parts of each question.***
1. All leaders in my organization receive education and review opportunities in safety science and safety culture.							
2. My organization has defined roles, safety competencies, and development programs for leaders at all levels.							
3. My organization allows leaders opportunities for learning across departments and from outside organizations and industries.							

Total Score = _____

	Score: 0 – 4	Score: 5 – 9	Score: 10 – 15
Organizational State *Brief description of current state of the organization*	Organization's leaders are considered for development opportunities and promotion based on business and financial competencies. Leader development programs focus on executive leadership. All leaders have semi-regular reviews that focus on financial performance.	Organization's executive leaders are provided basic safety science and culture educational opportunities. Leadership development programs are in place at all levels and throughout the organization. Both current and emerging leaders have access to peer coaching and mentoring programs.	Leaders at all levels of the organization are required to complete safety culture training. Regular reviews for all leaders include safety and culture metrics. Leaders are provided opportunities to learn from outside organizations and industries and are able to transfer among departments and units based on interest and organizational needs.
Recommended Next Steps *Recommended next steps for improvement and implementation are based on domain and included in Leading a Culture of Safety: A Blueprint for Success*	*Begin with review of* ***Foundational*** *tactics* Define required leadership competencies in culture and safety; Conduct regular gap analyses for CEO and senior leader competencies in safety culture; Develop and implement an organization-wide leadership development program	*Review* ***Foundational*** *and* ***Sustaining*** *tactics* Provide continuing education opportunities in safety and culture for both new and emerging leaders; Develop systems that support leaders at all levels, including opportunities for cross-departmental training	*Review* ***Foundational*** *and* ***Sustaining*** *tactics* Provide leaders at all levels opportunities for learning outside the organization; Define talent as an organizational resource; Tie performance on safety culture to leadership development priorities and promotional opportunities

Scoring:

1 – **Never** true for my organization
2 – **Rarely** true for my organization
3 – **Sometimes** true for my organization
4 – **Almost always** true for my organization
5 – **Always** true for my organization
0 – **Unsure** of the response

Lead and reward a just culture

MEASURABLE ELEMENTS	SCORE						OBSERVATIONS
Key questions to ask about your organization's capabilities and processes.	1	2	3	4	5	Unsure 0	***Please provide a brief description of why you chose this score, considering all parts of each question.***
1. My organization uses a defined just culture policy during all review processes and decisions (e.g. not just harm event review).							
2. My organization regularly reviews metrics for just culture education and understanding and defines improvement opportunities.							
3. My organization has one set of defined and employed behavior standards and accountability guidelines in place for all individuals, regardless of department, rank, or role.							

Total Score = _____

	Score: 0 – 4	Score: 5 – 9	Score: 10 – 15
Organizational State *Brief description of current state of the organization*	Organization may have just culture policy but it is not robust or embedded in decisions and processes across the organization. Patient safety and risk management professionals are systematically trained in just culture principles.	Organization has a robust just culture policy that is well-communicated internally and utilized in processes and departments across the organization and/or system. All staff are trained on just culture principles and use of just culture algorithm.	Just culture algorithm is embedded in all reviews and decisions across all departments. The Board, leaders, and the workforce are held accountable for utilizing the just culture policy. Patients and the public are educated on just culture and transparency around events through their providers and use of the media.
Recommended Next Steps *Recommended next steps for improvement and implementation are based on domain and included in Leading a Culture of Safety: A Blueprint for Success*	*Begin with review of* ***Foundational*** *tactics* Develop a robust just culture policy; Educate the Board, leadership team, and workforce on just culture principles and the daily use of the just culture algorithm; Ensure utilization of just culture principles in all event reviews	*Review* ***Foundational*** *and* ***Sustaining*** *tactics* Work with the Board and organizational leaders to align just culture policies across all professions and departments; Develop and review metrics for just culture; Hold workforce accountable for the utilization of just culture algorithm	*Review* ***Foundational*** *and* ***Sustaining*** *tactics* Treat gaps in culture as adverse events requiring review with the just culture algorithm; Educate providers on transparent communication of errors; Work with the media to educate and inform the public about just culture and plans for improvement

Scoring:

1 – **Never** true for my organization
2 – **Rarely** true for my organization
3 – **Sometimes** true for my organization
4 – **Almost always** true for my organization
5 – **Always** true for my organization
0 – **Unsure** of the response

Establish organizational behavior expectations

MEASURABLE ELEMENTS	SCORE						OBSERVATIONS
Key questions to ask about your organization's capabilities and processes.	**1**	**2**	**3**	**4**	**5**	Unsure **0**	***Please provide a brief description of why you chose this score, considering all parts of each question.***
1. My organization uses and regularly reviews a formal training program and defined processes for teamwork and communication.							
2. Professional accountability standards, including processes to address disruptive behavior and disrespect, are implemented uniformly across my organization.							
3. My organization has a program for recognition and celebration when individuals or teams excel at key safety behaviors and culture metrics.							

Total Score = _____

	Score: 0 – 4	Score: 5 – 9	Score: 10 – 15
Organizational State *Brief description of current state of the organization*	Behavior expectations vary across the organization, often based on department, unit, or role. Leaders and the workforce are not aware of defined standards of respectful behavior or consequences for disrespectful behavior. Best practices and standard processes also vary.	Behavior expectations are consistent across care providers, but organizational response to disruptive behavior may vary. Non-clinical departments, including finance and human resources, may not utilize common behavioral standards. Leaders are held accountable for modeling expected behaviors.	All members of the organization are held accountable for the same behavior expectations and have the same consequences for disrespectful behavior. Organization provides transparency of these expectations through patient/provider compacts. Leaders and the workforce are rewarded for exceptional teamwork and communication.
Recommended Next Steps *Recommended next steps for improvement and implementation are based on domain and included in Leading a Culture of Safety: A Blueprint for Success*	*Begin with review of* ***Foundational*** *tactics* Implement a formal team training program; Develop and communicate organization-wide behavioral expectations; Develop and implement standard processes for teamwork and communication	*Review* ***Foundational*** *and* ***Sustaining*** *tactics* Measure implementation and compliance of teamwork and communication programs; Develop compacts detailing behavior expectations for signature by leaders and the workforce; Ensure measurement tools and report cards for individual performance exist and are utilized	*Review* ***Foundational*** *and* ***Sustaining*** *tactics* Work with key stakeholders to ensure identical processes for employed and non-employed clinicians and staff; Develop required processes for communication and teamwork with patients and families; Develop standard tools for patient and family involvement in teamwork and communication processes

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