Rural Organizational Safety Culture Change (ROSC)

Senior Leadership —*Toolkit*—

A Centers for Medicare & Medicaid Services (CMS) Project

Leaders establish quality and safety as preconditions of serving people and protecting the workforce. They accept responsibility for everything. They ask themselves whether they are getting all the information they need on what has gone wrong every day, and they ensure that the frontline troops have the permission and tools they need to solve each problem. Finally, leaders ask ceaselessly: How far are we from the ideal and what is the next improvement to move us closer to that ideal?

—Paul O'Neill, et al. 2004.
Commentary on Hospital Quality: Ingredients for Success.
New York: The Commonwealth Fund.

HSAG HEALTH SERVICES ADVISORY GROUP

www.hsag.com

Description and Purpose of the

Rural Organizational Safety Culture Change (ROSC)

Senior Leadership —Toolkit—

A Centers for Medicare & Medicaid Services (CMS) Project

The ***ROSC Senior Leadership Toolkit*** is a compilation of tools and information gathered from a variety of sources to assist hospitals that are participating in the Rural Organizational Safety Culture Change (ROSC) Identified Participant Group (IPG), a project of the Centers for Medicare & Medicaid Services (CMS).

The ***ROSC Senior Leadership Toolkit*** complements the ***ROSC Survey Toolkit*** and the ***ROSC Intervention Toolkit***. Those earlier toolkits were designed to help hospital quality improvement staff coordinate and follow up on the AHRQ Hospital Survey on Patient Safety Culture. The current toolkit contains information that we hope will help hospital senior leadership implement successful patient safety culture plans in their organizations. The toolkit focuses on six primary change ideas:

- Establishing Patent Safety Leadership WalkRounds
- Encouraging staff to actively participate in Safety Briefings
- Establishing a nonpunitive event-reporting policy
- Assisting staff in developing and using communication skills that will help them to effectively discuss their patient safety concerns
- Involving patients and their families in patient safety education and improvement activities
- Involving hospital governing boards in patient safety culture change activities and ongoing monitoring of hospital patient safety status

About the included ***ROSC Senior Leadership Toolkit CD-ROM***: The self-launching CD has been designed to work in an MS Windows environment. After placing it in your computer's CD drive, the disk will automatically open using MS Internet Explorer. Use the menu to select any of the files you would like to open or view. Save a file to your computer's hard drive before attempting to modify it.

This material was prepared by Health Services Advisory Group, the Medicare Quality Improvement Organization for Arizona, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. **Publication No. AZ-8SOW-1C-110606-01**

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System Change Overview

- Institute for Healthcare Improvement (IHI): *Leadership Guide to Patient Safety*

WalkRounds

- IHI: *Patient Safety Leadership WalkRounds*

Safety Briefings

- IHI: *Safety Briefings*

Event Reporting

- Columbia University: *Patient Safety and the "Just Culture": A Primer for Health Care Executives*

Staff Communication

- HSAG PowerPoint: *Crucial Conversations Overview*
- VitalSmarts Press Release: *New Study Finds U.S. Hospitals Must Improve Workplace Communication to Reduce Medical Errors, Enhance Quality of Care*
- VitalSmarts: *Silence Kills—The Seven Crucial Conversations for Healthcare*
- VitalSmarts: *Dialogue Heals: The Seven Crucial Conversations for the Healthcare Professional*
- Joseph Grenny*: Knowing No Boundaries—Five Crucial Conversations for Influencing Administration*
- Crucial Conversations Case Studies: MaineGeneral Health, Cook Children's Health Care System, Nursing, and Patient
- HSAG Poster (small version): *Patient Safety—Our First Thought*
- HSAG Poster (small version): *Patient Safety—"Stop: I Have a Concern!"*

Patient & Family Education

- AHRQ: *20 Tips to Help Prevent Medical Errors*
- HSAG Poster (small version): *Patient Safety—Help Us Keep You Safe in Our Hospital*
- HSAG Brochure: *Patient Safety—Help Us Keep You Safe in Our Hospital*

Governing Boards

- Bader & Associates: *7 Things Your Board Can Do to Improve Quality and Patient Safety*
- Healthcare Executive: *Quality and Patient Safety—Engaging Your Board to Take the Lead*
- National Quality Forum (NQF): *Hospital Governing Boards and Quality of Care—A Call to Responsibility*

References

- NQF: *Safe Practices for Better Healthcare—A Consensus Report* (2006 Draft)
- Institute of Medicine (IoM): *To Err is Human—Building a Safer Health System* (Executive Summary)
- IoM: *Keeping Patients Safe—Transforming the Work Environment of Nurses* (Executive Summary)
- The Commonwealth Fund: *Committed to Safety—Ten Case Studies on Reducing Harm to Patients*
- O'Neill, et al.: *Commentary on "Hospital Quality: Ingredients for Success"*

Rural Organizational Safety Culture Change (ROSC)
Identified Participant Group (IPG)
Senior Leadership Meeting

Thursday, November 16, 2006
10 a.m. to 2 p.m.

Mt. Graham Regional Medical Center
Safford, Arizona

OBJECTIVES

The purpose of the meeting is for each ROSC-participating hospital senior leader to:

- Understand the purpose of ROSC and the importance of the senior leadership role in promoting the development of a hospital culture of patient safety.
- Obtain tools that will be useful in improving the hospital's patient safety culture.
- Promote group networking to exchange ideas for interventions.
- Identify next steps.

AGENDA

Welcome .... Pat O'Brien
CEO, Mt. Graham Regional Medical Center

Introduction .... Herb Rigberg, MD
CEO, HSAG

What is ROSC? .... Judith Richard, RN, MS, CPHQ
ROSC Lead, HSAG

Patient Safety Organizational Checklist:
Ten Easy Steps .... Herb Rigberg and All Attendees

Lunch (Short Video)

Patient Safety Organizational Checklist:
Ten Easy Steps (Continued) .... Herb Rigberg and All Attendees

Crucial Conversations .... Judith Richard

Next Steps .... All Attendees

Additional ROSC information is available at http://acute.hsag.com/rosc_ipg.asp.

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Rural Organizational Safety Culture Change (ROSC)

Identified Participant Group (IPG)

Judith Richard, RN, MS, CPHQ
November 16, 2006

What is ROSC?

- National initiative of the CMS 8th Scope of Work: 2005–2008
- Specific for CAHs and rural hospitals
- Focus: Organizational change to create a culture of patient safety
- Measurable results

What are the basic components of ROSC?

- Assessment of the current patient safety culture via the *Hospital Survey On Patient Safety Culture* (*HSOPSC*)—May 1–31, 2006
- Baseline Results to share with staff and determine area of focus—Summer 2006
- Determine/initiate/implement interventions—Autumn 2006 onward
- Remeasure to determine improvement—late Summer 2007

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What is an IPG?

- An IPG is a group of hospitals that have agreed to work with the CMS-contracted Quality Improvement Organization (QIO) to accelerate quality improvement.
- To participate, each hospital's CEO must have signed the participation agreement that recognized the strong role of hospital leadership.

Information for Health Care Improvement HSAG

Why did CMS include IPGs in its 8th SoW?

- Prior pace of quality improvement was too slow
- Need to accelerate improvement
- CMS believes that IPGs will lead by example
- Need to achieve transformational change
- Need for organizational culture change

Information for Health Care Improvement HSAG

What is meant by transformational change?

Transformation:

1. Alters the culture of the institution by changing select underlying assumptions and institutional behaviors, processes, and products.
2. Is deep and pervasive, affecting the whole institution.
3. Is intentional.
4. Occurs over time.

Information for Health Care Improvement HSAG

What is culture?

Culture has been called "the way of life for an entire society." As such, it include codes of manners, dress, language, religion, rituals, norms of behaviour, and systems of belief.

—Jary, D. and Jary J. 1991.
The HarperCollins Dictionary of Sociology, p.101.

What is meant by organizational culture change?

- Senior leadership orients the organization to quality, e.g., Leadership WalkRounds and Staff Safety Briefings
- Staff empowerment and teamwork, e.g., dialogue tools such as Crucial Conversations

Nationally, how many hospitals are participating in ROSC?

364 hospitals

CAHs—245

Rural—119

Information for Health Care Improvement HSAG

Why were six hospitals selected in Arizona?

- CMS indicated a minimum and maximum number of hospitals to be included in each IPG, except ROSC.
- ROSC had a minimum of six hospitals to be included, no maximum.
- HSAG chose the minimum number of hospitals in order to focus its resources.

Information for Health Care Improvement HSAG

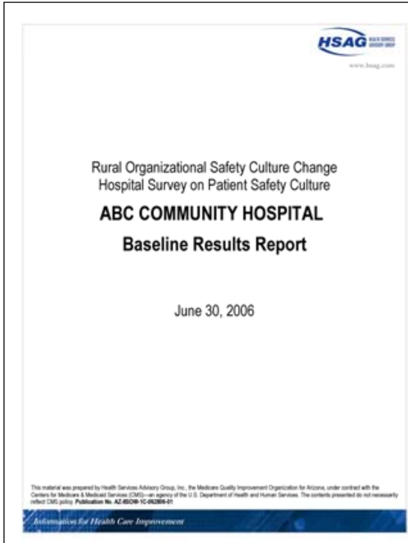
Which are the six Arizona ROSC Hospitals?

- Benson Hospital
- Copper Queen Community Hospital
- Mt. Graham Regional Medical Center
- Northern Cochise Community Hospital
- Southeast Arizona Medical Center
- Wickenburg Community Hospital

Information for Health Care Improvement HSAG

Information for Health Care Improvement HSAG

Baseline Results Report



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Rural Organizational Safety Culture Change
Hospital Survey on Patient Safety Culture

ABC COMMUNITY HOSPITAL

Baseline Results Report

June 30, 2006

Information for Health Care Improvement

Information for Health Care Improvement HSAG

CMS Survey Questions for Evaluation

AHRQ Hospital Survey on Patient Safety Culture

— Section F —

- F1 – Hospital management provides a work climate that promotes patient safety
- F8 – The actions of hospital management show that patient safety is a top priority
- F9 – Hospital management seems interested in patient safety only after an adverse event happens (reverse worded)

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Update of Activities

June 2006: Intervention Toolkit

- Silence Kills, Dialogue Heals, discussion questions
- Crucial Conversations Overview (four one-hour Webinars)
- National Teleconference: *Improving Patient Safety Culture: What Works in Rural Hospitals*? www.medqic.org

August 2006

- HSAG WebEx: *A Sense of Urgency: Patient Safety* http://acute.hsag.com
- ROSC teleconference to network and share ideas, barriers, and successes.

September/October 2006

- Individual hospital calls for updates, resources sent via Listserv

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Update of Activities

November 16, 2006

- ROSC Senior Leadership meeting

December 2006–January 2007

- HSAG on-site visits to assist as needed, e.g., WalkRounds, Safety Briefings, Crucial Conversations, Just Culture

February–July 2007

- System change(s) implemented and monitored

August–September 2007

- Resurvey

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Information for Health Care Improvement

HOSPITAL SURVEY ON PATIENT SAFETY CULTURE

INSTRUCTIONS

This survey asks for your opinions about patient safety issues, medical error, and event reporting in your hospital and will take about 10 to 15 minutes to complete.

- *An "event" is defined as any type of error, mistake, incident, accident, or deviation, regardless of whether or not it results in patient harm.*
- *"Patient safety" is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery.*

SECTION A: Your Work Area/Unit

In this survey, think of your "unit" as the work area, department, or clinical area of the hospital where you spend *most* of your work time or provide *most* of your clinical services.

What is your primary work area or unit in this hospital? Mark ONE answer by filling in the circle.

○ a. Many different hospital units/No specific unit

○ b. Medicine (non-surgical)
○ c. Surgery
○ d. Obstetrics
○ e. Pediatrics
○ f. Emergency department
○ g. Intensive care unit (any type)
○ h. Psychiatry/mental health
○ i. Rehabilitation
○ j. Pharmacy
○ k. Laboratory
○ l. Radiology
○ m. Anesthesiology
○ n. Other, please specify:

Please indicate your agreement or disagreement with the following statements about your work area/unit. Mark your answer by filling in the circle.

Think about your hospital work area/unit…	Strongly Disagree ▼	Disagree ▼	Neither ▼	Agree ▼	Strongly Agree ▼
1. People support one another in this unit	①	②	③	④	⑤
2. We have enough staff to handle the workload	①	②	③	④	⑤
3. When a lot of work needs to be done quickly, we work together as a team to get the work done	①	②	③	④	⑤
4. In this unit, people treat each other with respect	①	②	③	④	⑤
5. Staff in this unit work longer hours than is best for patient care	①	②	③	④	⑤
6. We are actively doing things to improve patient safety	①	②	③	④	⑤
7. We use more agency/temporary staff than is best for patient care	①	②	③	④	⑤
8. Staff feel like their mistakes are held against them	①	②	③	④	⑤
9. Mistakes have led to positive changes here	①	②	③	④	⑤
10. It is just by chance that more serious mistakes don't happen around here	①	②	③	④	⑤
11. When one area in this unit gets really busy, others help out	①	②	③	④	⑤
12. When an event is reported, it feels like the person is being written up, not the problem	①	②	③	④	⑤

SECTION A: Your Work Area/Unit (continued)

Think about your hospital work area/unit…	Strongly Disagree ▼	Disagree ▼	Neither ▼	Agree ▼	Strongly Agree ▼
13. After we make changes to improve patient safety, we evaluate their effectiveness	①	②	③	④	⑤
14. We work in "crisis mode" trying to do too much, too quickly	①	②	③	④	⑤
15. Patient safety is never sacrificed to get more work done	①	②	③	④	⑤
16. Staff worry that mistakes they make are kept in their personnel file	①	②	③	④	⑤
17. We have patient safety problems in this unit	①	②	③	④	⑤
18. Our procedures and systems are good at preventing errors from happening	①	②	③	④	⑤

SECTION B: Your Supervisor/Manager

Please indicate your agreement or disagreement with the following statements about your immediate supervisor/manager or person to whom you directly report. Mark your answer by filling in the circle.

	Strongly Disagree ▼	Disagree ▼	Neither ▼	Agree ▼	Strongly Agree ▼
1. My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	①	②	③	④	⑤
2. My supervisor/manager seriously considers staff suggestions for improving patient safety	①	②	③	④	⑤
3. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	①	②	③	④	⑤
4. My supervisor/manager overlooks patient safety problems that happen over and over	①	②	③	④	⑤

SECTION C: Communications

How often do the following things happen in your work area/unit? Mark your answer by filling in the circle.

Think about your hospital work area/unit…	Never ▼	Rarely ▼	Some-times ▼	Most of the time ▼	Always ▼
1. We are given feedback about changes put into place based on event reports	①	②	③	④	⑤
2. Staff will freely speak up if they see something that may negatively affect patient care	①	②	③	④	⑤
3. We are informed about errors that happen in this unit	①	②	③	④	⑤
4. Staff feel free to question the decisions or actions of those with more authority	①	②	③	④	⑤
5. In this unit, we discuss ways to prevent errors from happening again	①	②	③	④	⑤
6. Staff are afraid to ask questions when something does not seem right	①	②	③	④	⑤

SECTION D: Frequency of Events Reported

In your hospital work area/unit, when the following mistakes happen, *how often are they reported?* Mark your answer by filling in the circle.

	Never	Rarely	Some-times	Most of the time	Always
1. When a mistake is made, but is *caught and corrected before affecting the patient*, how often is this reported?	①	②	③	④	⑤
2. When a mistake is made, but has *no potential to harm the patient*, how often is this reported?	①	②	③	④	⑤
3. When a mistake is made that *could harm the patient*, but does not, how often is this reported?	①	②	③	④	⑤

SECTION E: Patient Safety Grade

Please give your work area/unit in this hospital an overall grade on patient safety. Mark ONE answer.

○	○	○	○	○
A	**B**	**C**	**D**	**E**
Excellent	Very Good	Acceptable	Poor	Failing

SECTION F: Your Hospital

Please indicate your agreement or disagreement with the following statements about your hospital. Mark your answer by filling in the circle.

Think about your hospital…	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
1. Hospital management provides a work climate that promotes patient safety	①	②	③	④	⑤
2. Hospital units do not coordinate well with each other..................	①	②	③	④	⑤
3. Things “fall between the cracks” when transferring patients from one unit to another	①	②	③	④	⑤
4. There is good cooperation among hospital units that need to work together	①	②	③	④	⑤
5. Important patient care information is often lost during shift changes	①	②	③	④	⑤
6. It is often unpleasant to work with staff from other hospital units .	①	②	③	④	⑤
7. Problems often occur in the exchange of information across hospital units	①	②	③	④	⑤
8. The actions of hospital management show that patient safety is a top priority...	①	②	③	④	⑤
9. Hospital management seems interested in patient safety only after an adverse event happens	①	②	③	④	⑤
10. Hospital units work well together to provide the best care for patients..	①	②	③	④	⑤
11. Shift changes are problematic for patients in this hospital...........	①	②	③	④	⑤

SECTION G: Number of Events Reported

<u>In the past 12 months</u>, how many event reports have you filled out and submitted? Mark ONE answer.

- ○ a. No event reports
- ○ b. 1 to 2 event reports
- ○ c. 3 to 5 event reports
- ○ d. 6 to 10 event reports
- ○ e. 11 to 20 event reports
- ○ f. 21 event reports or more

SECTION H: Background Information

This information will help in the analysis of the survey results. Mark ONE answer by filling in the circle.

1. How long have you worked in this hospital?
   - ○ a. Less than 1 year
   - ○ b. 1 to 5 years
   - ○ c. 6 to 10 years
   - ○ d. 11 to 15 years
   - ○ e. 16 to 20 years
   - ○ f. 21 years or more

2. How long have you worked in your current hospital work area/unit?
   - ○ a. Less than 1 year
   - ○ b. 1 to 5 years
   - ○ c. 6 to 10 years
   - ○ d. 11 to 15 years
   - ○ e. 16 to 20 years
   - ○ f. 21 years or more

3. Typically, how many hours per week do you work in this hospital?
   - ○ a. Less than 20 hours per week
   - ○ b. 20 to 39 hours per week
   - ○ c. 40 to 59 hours per week
   - ○ d. 60 to 79 hours per week
   - ○ e. 80 to 99 hours per week
   - ○ f. 100 hours per week or more

4. What is your staff position in this hospital? Mark ONE answer that best describes your staff position.
   - ○ a. Registered Nurse
   - ○ b. Physician Assistant/Nurse Practitioner
   - ○ c. LVN/LPN
   - ○ d. Patient Care Assistant/Hospital Aide/Care Partner
   - ○ e. Attending/Staff Physician
   - ○ f. Resident Physician/Physician in Training
   - ○ g. Pharmacist
   - ○ h. Dietician
   - ○ i. Unit Assistant/Clerk/Secretary
   - ○ j. Respiratory Therapist
   - ○ k. Physical, Occupational, or Speech Therapist
   - ○ l. Technician (e.g., EKG, Lab, Radiology)
   - ○ m. Administration/Management
   - ○ n. Other, please specify:

5. In your staff position, do you typically have direct interaction or contact with patients?
   - ○ a. YES, I typically have direct interaction or contact with patients.
   - ○ b. NO, I typically do NOT have direct interaction or contact with patients.

6. How long have you worked in your current specialty or profession?
   - ○ a. Less than 1 year
   - ○ b. 1 to 5 years
   - ○ c. 6 to 10 years
   - ○ d. 11 to 15 years
   - ○ e. 16 to 20 years
   - ○ f. 21 years or more

SECTION I: Your Comments

Please feel free to write any comments about patient safety, error, or event reporting in your hospital.

THANK YOU FOR COMPLETING THIS SURVEY.

Sample Staff Newsletter Article Announcing Survey Results

On behalf of [HOSPITAL NAME], thank you for participating in the patient safety culture survey that we conducted in May. We believe that our overall survey completion rate of [INSERT NUMBER] percent provides us with an accurate picture of staff perceptions of our current patient safety culture.

Health Services Advisory Group has provided us with a report of our survey results. Please be assured that confidentiality and anonymity of staff responses were maintained. Because the surveys were processed by HSAG, [HOSPITAL NAME] does not have access to the raw data, and response summaries for units or positions with fewer than 11 people were not reported to us.

The survey results report will be made available to all staff [INSERT MANNER AND TIME FRAME]. Our patient safety team is currently reviewing the report to determine areas in which to best focus our patient safety improvement activities. If you would like to have input into this process, please place your comments and suggestions in the boxes labeled “Patient Safety—Your Opinion Matters,” located at [INSERT LOCATIONS].

I will keep you informed of our patient safety improvement activities as they are developed and implemented. Thank you for helping [HOSPITAL NAME] continue to improve its culture of patient safety.

Sample Article for Community Newspaper

FOR IMMEDIATE RELEASE:
[DATE]

Contact:
[CONTACT NAME]
[CONTACT PHONE, E-MAIL]

[HOSPITAL NAME] Participates in National Patient Safety Project

[INSERT CITY], ARIZONA—[Hospital Name] is one of six Arizona hospitals selected to participate in a national hospital patient safety project sponsored by the Centers for Medicare & Medicaid Services (CMS). [HOSPITAL NAME] joins over three hundred other rural and critical access hospitals from across the United States that have volunteered to participate in this project to create systems of care that reduce medical errors.

CMS has identified patient safety as a priority in its current quality improvement efforts. The Institute of Medicine has estimated that medical errors resulting in injury cost $17 billion to $29 billion each year, over half of which reflects health care costs.

"Reducing the incidence of these errors leads to better health outcomes, reduced length of hospital stays, reduced costs to Medicare and other health care payers, and reduced turnover rates among hospital personnel," says Herb Rigberg, MD, CEO of Health Services Advisory Group (HSAG)—the Medicare-contracted Quality Improvement Organization leading the project in Arizona.

Contrary to the notion that most medical errors occur as the result of isolated mistakes made by individual doctors and nurses, research indicates that about 80 percent of these errors are system-derived—a byproduct of the increasingly complex medical technologies and care processes utilized in modern health care.

"We're very pleased to be participating in this important project," said [INSERT NAME], chief executive officer of [INSERT HOSPITAL NAME]. "It provides us with a unique opportunity to analyze our systems and develop processes that will ensure the safety of our patients, while giving our frontline staff the tools and support they need to deliver high quality care."

The Rural Organizational Safety Culture Change (ROSC) project focuses on redesigning and improving hospital care systems. The project utilizes a staff survey developed by the Agency for Healthcare Research and Quality (AHRQ) to track the progress each participating hospital makes in improving its patient safety processes. The baseline survey occurred this past spring; the remeasurement survey will occur in August 2007.

In between the surveys, each hospital is working to implement interventions that have been shown to be effective at reducing adverse medical events. In Arizona, the interventions include implementing weekly senior leadership safety rounds on the units, involving all staff in routine safety briefings, creating safety monitoring activities for the hospitals' governing boards, and developing an overall culture that rewards staff for reporting and learning from errors and "near misses."

According to HSAG's Rigberg, "By helping hospitals address patient safety and quality as the basic preconditions of the care they provide, we will ensure that Arizona patients receive the care they expect and deserve."

# # #

About [HOSPITAL NAME]
[INSERT SHORT OVERVIEW OF HOSPITAL]

About Health Services Advisory Group (HSAG)

HSAG is the Medicare-contracted Quality Improvement Organization (QIO) for the state of Arizona. For over 25 years, HSAG has provided innovative leadership on health care quality improvement projects for federal, state, and private sector clients. Founded by a group of medical professionals in 1979, HSAG is one of most experienced QIOs in the nation. HSAG is recognized as an agent of change in the health care industry because of the company's successful collaboration with providers across the continuum of care. For more information about HSAG, go to www.hsag.com.

Publication No. AZ-8SOW-1C-111306-01

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Patient Safety

Organizational Checklist

- ❑ ***Conduct a survey*** *of staff perceptions of the hospital's patient safety culture.*
- ❑ ***Share survey results*** *with staff.*
- ❑ *Develop a* ***patient safety culture plan****.*
- ❑ *Establish* ***Patient Safety Leadership Rounds****.*
- ❑ *Encourage staff to communicate patient safety concerns and participate in* ***Safety Briefings****.*
- ❑ *Establish a* ***nonpunitive event-reporting*** *policy that also rewards staff for reporting near misses.*
- ❑ *Assist staff in developing and using* ***communication skills*** *that help them to be 100% candid and 100% respectful when discussing patient safety concerns.*
- ❑ *Involve* ***patients and their families*** *in patient safety education and improvement activities.*
- ❑ *Involve the hospital* ***Governing Board*** *in patient safety culture change activities and ongoing monitoring of hospital patient safety status.*
- ❑ ***Resurvey*** *staff perceptions of patient safety culture.*

This hospital voluntarily participates in the CMS Rural Organizational Safety Culture Change Project.

This material was prepared by Health Services Advisory Group, the Medicare Quality Improvement Organization for Arizona, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy.
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Rural Organizational Safety Culture Change (ROSC)
— Senior Leadership Plan —

☐ 1. Participate in ROSC team meetings.

- Meet with ROSC Team to discuss and develop a patient safety culture plan. Meet weekly or biweekly for updates on progress, feedback, and guidance.
  Meeting Schedule:____

☐ 2. Share baseline results with the entire staff.

- Share the survey results report or executive summary with each department head.
  Completion Date: ____
- Place an announcement (in the hospital newsletter, on staff bulletin boards, and/or in the staff communication book) that staff members should contact their department head to view hospital survey results (see template). Method and Completion Date: ____________
  ____

☐ 3. Establish Senior Leadership Patient Safety Rounds.

- Decide on the method of implementing senior leadership patient safety rounds.
  - Who (e.g., CEO, COO, CNO, CFO) ______________________________
  - Frequency (e.g., weekly or other specified):______________________________
  - Location (e.g., in a meeting room, on each unit, ad hoc hallway conversations, luncheons):______________________________
  - Time (day/evening/night shifts): ______________________________
  - Announced or unannounced: ______________________________
- Announce the intervention to staff (e.g., an announcement by the CEO, staff newsletter, bulletin board, staff communication book, in-service to staff):
  Date: ______________________ Method: ______________________
  ____
- Follow up on staff members' safety concerns (e.g., newsletter, bulletin board, communication book, individual thank-you-for-sharing notes, other).
  Method: ____
  Consider writing a procedure/policy for this (☐ Yes ☐ No). Keep an ongoing list of all the changes that occurred due to staff members' input.

☐ 4. Establish Staff Safety Briefings

- Implementation method (e.g., start with one unit weekly, then gradually spread to other units, each shift, several times per week) ______________________________
  ____
- Announce the intervention to staff (e.g., an announcement by the CEO, staff newsletter, bulletin board, staff communication book, in-service to staff). Make sure staff members are aware of the purpose and method of implementation. Consider writing a procedure/policy for this (☐ Yes ☐ No). Date: ______________________
  Method: ____
  ____

☐ 5. Establish nonpunitive event reporting.

- Review your hospital's policy on event reporting, encourage managers to read *Just Culture*, revise your policy as needed to support a nonpunitive environment that encourages reporting of near misses.
  Method: ____
  ____

☐ 6. Present the baseline results and patient safety culture plan to the hospital governing board.

Date:________________ Results/Comments: ______________________________________
____
____

☐ 7. Contact community newspaper regarding project article.

Date:________________ Results/Comments: ______________________________________
____
____

☐ 8. Develop a means to provide patients with a patient-safety brochure.

Date:________________ Brochure Selected: ______________________________________
Distribution Method: ____
____

☐ 9. Display posters.

Date:________________ Posters Displayed and Locations: __________________________
____
____

☐ 10. General Suggestions

- Lead by example.
- Hold a staff in-service on the video, *Beyond Blame: America's Other Drug Problem*.
- Show the video to all new employees—demonstrating your hospital's commitment to a culture of patient safety.
- Implement a suggestion box for staff input and feedback on interventions.
- Join and encourage the use of the ROSC4AZ Listserv (rosc4az@listserv.hsag.com).
- Invite HSAG to in-service staff on the dialogue skills of Crucial Conversations.

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