Managing Risk & Safety: A Priority for Today's Healthcare Facility

by Thomas W. Ross, MS, RPh

Risk management is just that: management of the risks inherent in any business. In healthcare, risk management typically involves risks incurred by patients, employees, staff and all other individuals accessing the facility. As healthcare facilities become more cognizant of the important role safety plays, active risk management programs have taken on a new importance to the oncology community.

For years, risk management has focused on two areas: insurance programs purchased by the healthcare organization and litigation. In the past, many risk management programs were more closely aligned with legal departments than clinical operations; however, an emphasis on safety is changing this scenario. Today, risk management programs are far more encompassing, involving both prevention and remediation of problems across the organization.

While insurance and litigation continue to drive risk management, today many other safety-related components affect healthcare organizations nationwide, including:

- Employee health and safety
- The environment of care
- Disaster preparedness
- Institutional safety and security
- Research safety.

Key areas that are closely linked to the perception of safety in a healthcare organization include patient satisfaction, patient complaints, and employee satisfaction.

The presence (or absence) of specific safety-related programmatic components can directly affect an organization's recruitment and retention efforts, public perception, compliance with regulatory and accreditation agencies, and the emerging area of pay-for-performance (P4P).

It is not surprising then that many of today's healthcare environments are employing system-wide safety initiatives. These initiatives draw together various components of what used to be freestanding, or at best loosely integrated efforts, into a comprehensive safety program—that builds on the cornerstone of risk management.

The Right Thing to Do

For the healthcare community, this issue is first and foremost an ethical one. Jim Conway, Senior Fellow at the Institute of Healthcare Improvement and Senior Fellow at the Dana-Farber Cancer Institute states it well, "*We are excellent, but not perfect. We must strive to close the gap.*" In addition to ethical considerations are the practical realities of initiating and achieving system-wide change. Change of this magnitude takes a huge commitment of staff and resources—in an environment in which facilities are already dealing with the pressure of increased litigation and insurance costs, reimbursement cutbacks, unfolding Medicare reform changes, and with the unknown price tag for P4P initiatives on the horizon.

Creation of a culture of safety is not only an ethical decision; it also makes good business sense. Consider the issue from the perspective of an organization's human resources (HR) department. With the changing demographics of our society and increased tendencies to litigate, a workable, employee-centered safety program can help mitigate workers' compensation insurance rates. (In some states, these rates have approached prohibitive status). A well thought out, well-designed employee safety program can reduce risk and potential liability, making the cost of insurance, including self-insurance, more cost-efficient and affordable. Furthermore, creating a safe environment—*for patients and employees*—can help employee recruitment and retention efforts. As we all know, the traditional "shame and blame" approach to error management can drive away talented staff and physicians—at a time when the shortages in the healthcare workforce are increasing.

As the insurance market continues to tighten its belt, healthcare facilities are placing new emphasis on risk management programs. Insurance rates are generally tied to claims, so it behooves organizations to have as clean a record as possible. Today, some insurance carriers are requiring safety programs and are inspecting compliance annually.

From the perspective of the institution as a whole, research has shown the high cost of preventable events in terms of increased utilization, cost, and litigation. For hospitals, adverse drug events (ADEs) can increase costs up to $5.6 million per year and increase length of stay (LOS) by 8 to 12 days.[1] One 10-year retrospective analysis of medication-related malpractice claims reported that ADEs accounted for 6.3 percent of claims, and that 73 percent of these ADEs were, in fact, preventable.[2] After a significant adverse event, a healthcare organization can spend considerable resources investigating and responding to regulatory and accrediting

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agencies. Furthermore, medical errors or accidents result in the loss of public confidence. An effective safety and/or risk management program can reduce (or perhaps even eliminate) these occurrences, improving both the healthcare organization's bottom line and its standing within the community.

Creating a "Culture of Safety"

Organizational "culture" is key to instilling a system-wide safety program. Culture can be defined as the predominating attitudes and behaviors that—as a whole—influence and create the activities of an organization. Healthcare facilities establishing a culture of safety must first be aware of the barriers to establishing such a culture. Lucian Leape, MD, a patient safety expert with the Institute of Healthcare Improvement, identified a number of these barriers, including:[3]

- A culture change involves changing attitudes, routines, and practice, which is always difficult.
- Reimbursement constraints and the resultant belt-tightening have already added stress to healthcare workers, so it is challenging to get staff to take on additional safety-related tasks.
- Staffing shortages, particularly in nursing, have many healthcare facilities in a survival or defensive posture. Talking about quality of care or safety when your program is concerned with survival can be challenging.
- Traditionally the focus has been on the failures of individuals. A culture of safety must focus instead on improving *systems.*

Taking these challenges into consideration, can a healthcare facility effectively implement a culture of safety? The crucial first step is to understand and accept that attainment of a culture of safety is a journey, not a destination. There is no turnkey program; however, a number of conceptual approaches have facilitated the successful implementation of such a culture.

Executive Leadership. The commitment to establish and foster a culture of safety must start at the top of the organization and cascade to all levels. This process begins with three realizations: 1) errors *do* occur in the organization, 2) healthcare—especially oncology—is a high-risk environment, and 3) the primary cause of error is not the people, but rather the systems. Senior leadership must ensure that adequate resources are devoted to creating a culture of safety. Even more important, these leaders must model the behavior and attitude that they expect in others. Finally, senior leadership must show unwavering attention and support for the safety initiative.

Reciprocal Accountability. This theory holds that frontline workers have the responsibility of being messengers who are accountable to keep management and leadership fully informed about errors, failures, risks, and hazards.[4] In response, management and leadership must listen and act on these findings—improving systems for the frontline workers. Open and honest communication, without fear of unjust consequences, is at the heart of this relationship.

A Fair and Just Culture. This concept is one of the most difficult—and most important—to define. Traditionally healthcare has tried to manage risk and decrease the potential for error by writing policies and procedures, and then hiring competent people. When an accident occurred, or a patient was harmed, the focus was on, "Who did it?" This punitive methodology often represses the reporting of actual or potential errors.

Advancing a culture of safety requires learning from our mistakes (and potential mistakes) so that systems can be redesigned to decrease the likelihood of an occurrence or recurrence. Therefore, reporting of all events, risks, circumstances, and good catches (errors that almost occurred

10 Tips for Improving Workplace Safety

1. Develop an Effective Reporting System
2. Conduct Root Cause Analysis
3. Conduct Failure Mode and Effect Analysis
4. Practice Full Disclosure
5. Provide Support for Affected Staff
6. Conduct Executive Safety Rounds
7. Develop and Communicate "Red Rules" to Staff
8. Assign Safety Officers
9. Use "Mock" Tracers to Identify Opportunities for Improvement
10. Support Family and Patient Involvement (Patient-centered Care)

but were caught) must be encouraged. While some have used this premise to advocate for a "blame free" culture in which individuals are guaranteed immunity from discipline if they report an event—society has not embraced this approach. In fact, when malicious intent, intentional rule violation, or repetitive error (despite prior corrective action) occurs, healthcare organizations *must* act to protect patients and staff.

As a balance between these extremes, the concept of a Fair and Just Culture was developed, with many significant contributions from the Dana-Farber Cancer Institute. The Fair and Just Culture values fair, objective, and explicit decision rules for determining accountability and culpability to an adverse event. Recognizing that human beings make mistakes, the healthcare organization encourages everyone to report adverse events, close calls, and any unsafe conditions—not to punish or discipline any individual, but to learn what happened. The fact that the vast majority of mistakes occur as a result of ineffective, improperly designed, or flawed systems is acknowledged. When events and close calls (or "good catches") are reported, they are tracked to find patterns and trends. In turn, this analysis allows the healthcare organization to improve systems to prevent future mistakes. The Fair and Just Culture focuses on, "*What happened*?" not, "*Who did it*?"

As stated above, the Fair and Just Culture does not tout "no blame" as its governing principle. A Fair and Just Culture must protect the safety of patients, families, and healthcare workers. Therefore, the Fair and Just Culture does not tolerate intentional or conscious disregard of clear risks to patients/co-workers or gross misconduct and repetitive rule or policy violation despite prior improvements in process, training, and education

Behavioral Expectations and Reward/Recognition. A culture is often defined in terms of the predominating attitudes and behaviors. Successful healthcare organizations clearly define behavioral expectations for their staff. Including behavioral expectations in job descriptions and developing a formal means of recognizing and/or rewarding adherence to these expectations benefits everyone—the healthcare organization, staff, and patients. For a look at how one community cancer center uses this method to develop a culture of safety, read "The H. Lee Moffitt Experience" in this article.

Scope and Prioritization. In addition to the traditional functions of risk management, a progressive risk/safety program should consider including:

- Employee health and safety
- Infection control
- Safety and security
- Patient and employee satisfaction
- Patient complaints
- Emergency preparedness
- Clinical and basic research.

Once the scope of the safety initiative has been established, the biggest challenge is defining the safety priorities. Thousands of possible safety-related improvements are available from a variety of sources, including accrediting bodies, professional organizations, organizations devoted to safety, and peer-reviewed literature. To succeed, healthcare organizations committed to creating a culture of safety must carefully select and limit the number of initiatives to avoid diluting already scarce resources.

Tools to Foster Safety

If you stand in front of your staff and tell them, "*Be safe*!" you will certainly raise their consciousness of safety. But these words do not give your staff the specific tools needed to make a difference. A successful risk management program uses a variety of tools to produce measurable improvement in safety—the ultimate goal of a culture of safety.

An Effective Reporting System. Incident or occurrence reports have long been the cornerstone of risk management. Oftentimes these systems are mandated by states as a way to track errors and incidents, identify opportunities for improvement, and ensure that potential reportable events are identified. While traditionally oriented towards documenting untoward occurrences and events, incident reporting systems can be adapted to provide invaluable event reporting and capturing for the entire safety initiative. The key to making this transition is to establish the Fair and Just Culture discussed above and to use the information reported to help staff and other professionals make improvements in the quality and safety of the care they deliver to their patients.

One challenge: establishing the perception that the occurrence process is a non-punitive tool to foster safety. Florida, for example, requires identification of the involved licensed professionals in all events that are reported to the state. This requirement can lead to investigation and possible fines and/or discipline for the involved parties. Furthermore, Florida has a "3 Strike Rule" where physicians who have been adjudicated guilty of at least three instances of medical malpractice may be banned from practicing in the state. While many legislative efforts foster the safety movement by focusing attention and identifying resourc-

What Can We *Really* Do for Safety?

Putting best practices to work in our community cancer centers

by E. Strode Weaver, FACHE, MBA, MHSA

Tom Ross has provided an excellent overview of what it takes to truly address safety improvement in our programs and institutions. The challenge for oncology leadership is to take these comprehensive suggestions, translate them for use into their own programs, and then decide what actions can and should be taken.

For example, a review of the article brought to mind several ways that my program—the University of Colorado Cancer Center—could improve the safety and care environment of its cancer patients.

First, we need to make patient safety a number one priority for our cancer service line. The issue should have a place in the cancer center's annual goals, regular departmental communications, and all reports going back to the leadership of our healthcare organization.

Second, whenever possible we should link the cancer center's safety efforts to the structures and activities that are already going on within our healthcare organizations. I am an active member of the University of Colorado Hospital's Quality and Safety Committee, which meets monthly. Twice a year, I report to the full committee on the quality and safety initiatives that we are pursuing within the cancer service line.

In addition to focusing inside, our healthcare organizations should also look outside at regional and national patient safety initiatives, participating in these efforts whenever appropriate. The University of Colorado Hospital, for example, is actively participating with the "100,000 Lives" campaign. Our institution has already implemented five out of the campaign's six high priority recommendations for improving patient safety. Like most hospitals, we also have an ongoing JCAHO preparedness effort. And this group regularly communicates with *all* hospital departments regarding the National Patient Safety Goals and our institution's efforts to meet those goals.

Third, we must ensure that *all* departments, including the cancer service line, participate in the institution's safety reporting and review system. We need to report all issues that arise within our departments and take the time to analyze trends that reveal areas of potential risk. The University of Colorado Hospital, for example, identified a safety issue in its radiation therapy department. As patients weakened from treatment moved through the department, they were experiencing a number of fall-related injuries. The solution: a fall risk-assessment process that called for increased monitoring and physical support for at-risk cancer patients.

To effect honest and open reporting, we must move away from the traditional—and often accusatory—reaction of "*Who* erred?" and ask instead, "*Why* did this error occur, and how can we prevent such errors from happening in the future?"

Finally, just as Ross discussed, each institution must develop and enforce its own "Red Rules," emphasizing staff training and feedback about these items. Currently, my cancer program is putting a high priority on chemotherapy, including ordering, preparation, and patient administration. We're implementing an electronic order entry system and educating physicians, nurses, and support staff in the use of this system and the increased safety that it can provide at various checkpoints in this very complex process.

Like so much of life, the pursuit of increased safety is truly a journey—as opposed to a destination. Our healthcare institutions will always need to review their actions, report their issues, analyze trends, and take action to enhance the safety built into their processes, procedures, and training. We must remain eternally vigilant in our efforts to provide a safe environment for both our patients *and* our staff.

E. Strode Weaver, FACHE, MBA, MHSA, is executive director at the University of Colorado Cancer Center in Aurora, Colo., and immediate past president of the Association of Community Cancer Centers.

es for improvement, examples such as this Florida law are antithetical to fostering an overall culture of safety.

In addition to establishing a Fair and Just Culture, while adapting an occurrence report system into an overall safety initiative healthcare organizations may also want to:

- Change the "occurrence report" name to something more positive or less-threatening such as "safety report."
- Keep reporting simple. Lengthy reports (and the time required to complete them) are barriers.
- Customize reports to the type of incident being reported. For example, the information needed to investigate an extravasation differs greatly from that required for a fall.
- Have the reports readily accessible to the staff, preferably in an online format.
- Ensure that management follows up on identified safety opportunities with the involved staff.

Root Cause Analysis. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) defines a root cause analysis (RCA) as "a process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event."[5] This type of analysis is usually performed in response to a significant event or incident. Such analysis is required by JCAHO for sentinel events and is also required for defined outcomes in some states. Keep in mind that RCAs are a structured process. Oftentimes analysis of an adverse event or other critical incident focuses on the "symptoms" rather than on the underlying causes; the structured approach ensures that no stone is left unturned.

To conduct a root cause analysis, a team is assembled as soon as possible after the event is identified—preferably within 24 hours. The team should consist of both front-line staff and management and leadership who can effect

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change. The process begins with a narrative description of the event and flowcharting the process(es) involved. Next, the team drills down into all of the possible contributing factors to the event, ranging from staffing to equipment to environmental factors. For each root cause identified, a risk reduction strategy is developed that includes the responsible party, milestones for success, and the measurement that will be used to assess the impact of the interventions. An excellent template for conducting an RCA can be found on JCAHO's website (*www.jointcommission.com*).

Failure Mode and Effect Analysis. A similar concept, Failure Mode and Effect Analysis (FMEA), is used in a prospective manner. FMEA starts by identifying a known or suspected high-risk process. Next, the likelihood of a particular process failure is combined with an estimate of the relative impact of that error to produce a "criticality index." Those steps in the process that are most likely to fail and/or have the highest risk associated with them in terms of outcome are then targeted for improvement. The purpose is to perform the analysis *before* a system failure results in harm. JCAHO-accredited organizations are required to perform at least one FMEA each year.

Patient Disclosure. Should a patient have an undesirable unanticipated outcome (e.g., an adverse event), JCAHO (and some states) require that this information be disclosed to the patient. Traditionally, many healthcare organizations have been hesitant about such reporting for fear of precipitating litigation. Organizations with a safety culture, however, should view themselves as healthcare partners to patients and their families. This "partnership" requires full disclosure. Patients want to hear three facts: 1) what actually happened, 2) what is being done to prevent it from occurring again, and 3) that the healthcare organization is sorry. Organizations that fully disclose to patients are not only fulfilling their moral duty, they also avoid certain risks related to non-disclosure. If patients find out in another fashion of unanticipated outcomes, the consequences to the healthcare organization can be much more severe.

Staff Support. Keep in mind that when a patient is harmed, others are hurt as well, including the providers involved in the incident. The organization must be prepared to provide the support, training, counseling and any other steps needed to help and restore its employee(s).

Executive Safety Rounds. This concept requires getting senior leadership together with front-line care providers to have open and honest conversations about safety. These safety rounds are not inspections or compliance rounds, but instead a non-threatening forum that fosters the culture of safety by:

- Demonstrating the organization's commitment to safety because senior leadership is taking the time to meet with staff
- Identifying safety-related concerns to address on an individual basis with the management team for a given area
- Aggregating data over time and across different areas allows for common safety-related themes to emerge
- Sharing of safety-related stories, as well as educational moments, with staff.

"Red Rules." These rules must be followed by 100 percent of the members of the healthcare organization, 100 percent of the time. Deviation is not allowed. To set them apart from the healthcare organization's other mandatory rules and policies, "Red Rules," should:

- Apply to all employees all the time.
- Be simple and easy to remember.
- Support the safety mission, addressing important and risky processes.
- Be supported by the *entire* organization. In other words, when someone at the frontline calls for work to cease on the basis of a Red Rule, top management will *always* support this decision.

Safety Officers. One of the significant differences between traditional risk management systems and a culture of safety is that risk management no longer drives the safety mission. Rather, risk management staff serves as coordinators and experts who support the safety movement that is now driven by administrators, physician leaders, and department directors. One method of facilitating this change is to assign safety officers who are decentralized throughout the healthcare organization. This move not only demonstrates the commitment to safety, but also has the advantage of creating more informal, open lanes of communication. Specific roles that safety officers may be equipped and trained to perform may include: 1) advocating for the safety mission; 2) identifying high-risk processes; 3) assisting management and staff to examine and improve processes; and 4) training other staff in safety and risk management improvements

In addition to identifying, training, and empowering these officers, healthcare organizations can benefit by bringing them together on a regular basis to communicate their experiences and to share information.

"Mock" Tracers. In recent years JCAHO has dramatically changed its approach to accreditation, moving to unannounced surveys. The reason for these changes is to create a state of "perpetual readiness," or being in compliance with 100 percent of the standards, 100 percent of the time. Other accrediting organizations are adopting this approach, changing their methodology from interviews and policy review to "tracer methodology." This methodology involves following the treatment course of individual

The H. Lee Moffitt Experience

The H. Lee Moffitt Cancer Center and Research Institute is developing and refining a safety and risk management program that includes behavioral expectations and reward and recognition. The cancer program includes safety-related behavioral-based expectations in every staff job description and performance appraisal.

Senior Staff

As part of their job performance evaluations, managers, directors, and other senior staff are expected to:

- Foster a culture that encourages continuous safety improvement and reporting
- Establish a culture that encourages error, event, and near miss reporting
- Involve staff in identification of system flaws and potential corrective actions required, with a focus on the "how" rather than the "who"
- Implement corrective measures and plans, and educate staff accordingly
- Reinforce safe practices of all individuals through appropriate evaluation processes
- Maintain compliance with all licensing/regulatory bodies by appropriate actions taken for violations.

All Staff

As part of their job performance evaluations, all staff are expected to:

- Promote safety and prevention of injury as the first consideration in actions
- Maintain awareness and follow safety policies and procedures applicable to assigned duties
- Use sound judgment, including reasonable awareness of potential hazards before acting
- Promptly report errors, events, and situations of actual or potential events or harm.

Other Rewards and Programs

In addition to these universal expectations, which are linked to merit increases, the H. Lee Moffitt Cancer Center and Research Institute employs other methods for rewarding and recognizing safety. For example, the cancer program renamed its employee suggestion program S.M.A.R.T. (Safety, Money and Resource Team). Every submission is acknowledged, and financial incentives are provided to individuals whose suggestions are implemented. The program incorporates various levels of reward and recognition ranging from a simple "thank-you" note to a nominal gift card ($25-$50) to an amount representing 10 percent of the first 12 months savings of additional revenue—up to a maximum payment of $5,000.

Another improvement the cancer program implemented was to alter its annual Team Award Program, which recognizes and rewards exceptional team performance, to include a safety category.

Lastly, the H. Lee Moffitt Cancer Center and Research Institute made the commitment to bring in outside experts in the field of safety to provide consultation, motivation, and education to its staff.

Defining Safety Priorities

Defining safety priorities can be challenging for any risk management program.

The H. Lee Moffitt Cancer Center and Research Institute adopted a process of selecting its safety initiatives on an annual basis, trying to limit the initiatives to 12 or fewer. As new external guidelines are established (e.g., National Patient Safety Goals) or internal issues are identified (e.g., serious events or new trends in data) priorities are modified accordingly.

For each safety initiative selected, the cancer program identifies:

- A leader
- A specific goal
- Measures of success
- Required resources
- Milestones.

Progress reports are shared with key safety committees and the Board of Directors. The H. Lee Moffitt Cancer Center and Research Institute found that the establishment of concrete measures of success—either internal and/or external benchmarks—is vital to this process. And management and leadership use these measurable targets in the cancer program's reward and recognition process.

Executive Safety Rounds

The H. Lee Moffitt Cancer Center and Research Institute schedules these rounds on a weekly basis. Management and staff are notified a few weeks prior as to the purpose of the rounds and to allow them to schedule staff participation.

These one-hour rounds are attended by a senior leader, the Patient Safety Officer, the Director of Safety/Quality, and from 3 to 40 staff members from the area. Safety leaders are provided with scripted questions to elicit staff feedback. During the rounds, notes are taken and emailed back to staff for correction and/or clarification.

Approximately two weeks after the actual rounds occur, safety leadership meets with the department management to validate staff perceptions and to develop corrective actions. The H. Lee Moffitt Cancer Center and Research Institute believes in the importance of communicating corrective actions to staff so that they realize their input is taken seriously. Lastly, the data is aggregated and used to identify trends to address throughout the entire organization.

patients throughout the healthcare system while assessing compliance with JCAHO standards.

Healthcare organizations can use this new JCAHO methodology as a template for risk reduction. To assess compliance, for example, the healthcare organization can perform their own "mock" tracers, following patients through their own systems. Mock tracers help prepare staff for JCAHO visits and help identify opportunities

The Quality Chasm—Driving the Safety Movement

In the 1970s and 1980s numerous articles were published, quantifying the effect that errors and adverse events had on patients. These studies were primarily driven by concerns over increasing costs in malpractice insurance. Unfortunately, much of this information remained contained within the healthcare industry while those outside of the field continued to perceive that overall healthcare provided "safe" care. In other words, the true potential for risk associated with healthcare was familiar only to those within the profession.

This scenario began to radically shift in the mid-1990s with the publication of a number of studies that quantified the incidence of harm being caused by healthcare. One National Public Radio reporter rephrased the number of deaths reported in one such publication as being equivalent to, "two 747s crashing every three days."[1] Media coverage of medical errors increased and was further fueled by a remarkable string of errors that became public knowledge in 1995. The most widely known of these errors was the death of the *Boston Globe* reporter Betsy Lehman due to a chemotherapy overdose. This specific case was significant in that it gave a face to the issue of medical errors.

This scrutiny led to the Institute of Medicine's (IOM) 1999 report, *To Err is Human: Building a Safer Health System.* Among the report's most-cited conclusions was the statement that 48,000 to 98,000 Americans die in hospitals annually due to *preventable* medical errors. Public outcry from this data led to further investigation, legislation, and other actions, among them:

- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) began a process to completely revamp its accreditation process and standards.
- States increasingly mandated that licensed healthcare providers develop an active risk management program, many with strict reporting guidelines.
- States with required reporting of "serious incidents" also brought medical staff into the risk management arena. As part of the care team, physicians were now involved in the reporting process of adverse occurrences.
- The Leapfrog Group was formed. This is a coalition of Fortune 500 companies whose intent is to recognize and reward improvements and innovations in safety.
- Public "report cards" have emerged. These list process and outcome data for healthcare institutions, allowing consumers to comparison shop among healthcare providers.

With the chasm between actual and ideal healthcare open to public scrutiny, with the erosion of the public's trust in the ability of healthcare industry to, at a minimum "do no harm," and with increased government, regulatory, and media scrutiny of healthcare facilities—the healthcare industry has experienced significant pressure to improve the safety and quality of its systems.

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to improve current processes and, subsequently, safety.

Patient and Family Involvement. Traditionally, patients and their families used to implicitly trust the healthcare system; however, the events of the past 10 or so years combined with increasingly informed patients have eroded this trust. Today, patients and families want more information and involvement in their care. As healthcare organizations, it is our responsibility to adapt to meet these changing needs.

And, after all, increased patient and family involvement in treatment is a positive change. Forward-thinking healthcare organizations have long been forming patient and family advisory councils to get these groups more involved in the design and delivery of care. The philosophical change is to move from delivering care to patients to partnering with them. This method is often referred to as Patient-Centered Care. Patients and their family members can offer tremendous insight into the design of facilities, in perceptions of care, education and teaching, and in their perspective of the safety of care they received. This movement has proven so beneficial that many healthcare organizations now require patient representation on their patient safety committees.

Going Forward

The once implicit trust the public had with the healthcare system and its care providers has been damaged—if not broken. To repair this fractured relationship, as well as to reap many other tangible and intangible benefits, healthcare organizations should strive to create a culture of safety. This culture should address both patient and staff safety, in addition to many other facets of safety relevant to healthcare. Traditional risk management programs alone cannot guarantee an effective safety program today. When incorporated as part of an institution-wide effort, however, risk management can help to create and foster an environment that truly embraces a culture of safety.

Thomas W. Ross, MS, RPh, is director of Quality and Safety at the H. Lee Moffitt Cancer Center and Research Institute in Tampa, Fla.

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