At Novant Health, Safety Is Woven into the Fabric of Its Culture

Fidelity to the core principles of High Reliability has led to a dramatic and sustained reduction in serious safety events across the North Carolina-based health care system.

By Diana Mahoney

Safety is not an option for the employees and medical staff of Novant Health, it’s a requirement.

In 2009, the North Carolina-based integrated health care system embarked on a journey to High Reliability in partnership with HPI, now part of Press Ganey. The first leg of the journey involved establishing a robust patient safety culture across the organization. This was achieved through an intense internal strategic initiative called “First, Do No Harm” (FDNH), which continues to be a fundamental component of the system’s safety improvement strategy, according to Sandy Cox, RN, patient safety program director for Novant Health.

All Novant Health team members, including physicians and nonclinical staff, participate in FDNH training, which includes an approach to safety that addresses the human behaviors behind safety events, called “Know Five. Save Lives.” The program directs staff to focus on five key behaviors that can significantly reduce the organization's serious-safety-event rate.

1. Practice with a Questioning Attitude.
   - Watch for safety red flags.
   - Stop, reflect and resolve in the face of uncertainty.

2. Communicate Clearly.
   - Use the SBAR-Q (situation, background, assessment, recommendation & questions) structure of communication to share information about patients.
   - Communicate using three-way repeat-backs and read-backs.
   - Use phonetic and numeric clarifications.

   - A “Red Rule” refers to the guidance around acts that have the highest level of risk or consequence to patient or employee safety if not performed exactly, each and every time.
   - Red Rules require 100% compliance.
   - If compliance is not possible, the action must be stopped.
   - Examples of Novant Red Rules: “I will always verify patient identity using two identifiers prior to any treatment, therapy, transport, procedure or specimen draw” and “I will always perform ‘double checks’ as specified by my department.”

4. Self-Check.
   - Focus on the task at hand.
   - Use the STAR technique when transitioning from thought to action, such as medication administration.
     - Stop: Pause for one to two seconds to focus attention on the task at hand.
     - Think: Visualize the act and think about what is to be done.
     - Act: Concentrate and perform the task.
     - Review: Check for the desired result.

AT A GLANCE

- Through its “First, Do No Harm” strategic initiative, Novant Health has embedded High Reliability operating principles into its organizational culture.
- Since the launch of its safety effort, the integrated health care system has reduced its serious-safety-event rate by 91.9%.
5. Support Each Other.
   - Cross-check and assist.
   - Use a 5:1 ratio of positive to negative feedback.
   - Speak up using ARCC (Ask a question to gently prompt the other person of a potential safety issue; Request a change to make the person fully aware of the risk; Voice a concern if the person is resistant; Use the chain of command if the concern is disregarded).

“Each of the Novant Health safety behaviors is considered critical to our culture of patient safety,” Cox stressed. “The literature suggests that, on average, a serious safety event is the result of 8.3 human errors—the ‘Swiss cheese’ model. This emphasizes the importance of knowing and utilizing all of the patient safety behaviors and error prevention tools.”

In addition to the safety training that is embedded into annual mandatory education for all of Novant Health’s team members as well as new-employee orientation and new-leader orientation, Novant Health engages patient safety coaches to provide mentoring and just-in-time training and education for the FDNH patient safety behaviors and error prevention tools, Cox explained. “Additionally, we have had team-member and leader refreshers along with ‘Back-to-Basics’ training” to keep safety front and center in the minds of all our team members, she said.

FDNH is fully embedded into Novant Health’s organizational culture, Cox noted. “Our physician team members are provided FDNH training with a three-part computer-based learning module during the initial credentialing and recredentialing process. It is part of our patient safety culture,” she said, adding that the FDNH behaviors are the paving stones to reaching zero events of harm—the goal championed by Novant Health CEO, Carl Armato.

“Carl challenges the Novant Health team to strive to make zero events of harm an attainable goal,” Cox said. “He frequently incorporates the patient safety behaviors and error prevention tools into his weekly blog.” And performance indicators suggest the team has taken on the challenge in earnest, having surpassed the original goal of an 80% reduction in serious safety events.

“The continued efforts of the FDNH ‘Know 5ive. Save Lives’ approach have led us to achieve a current 91.9% reduction from our initial baseline,” Cox reported, noting that the system has seen significant downward trending with falls, injuries and medication events.

The dramatic improvement in safety outcomes at Novant Health mirrors that seen by other organizations that have similarly adopted focused, comprehensive, system-level strategies to build and sustain a culture of safety and reliability. Some examples include Children’s National Medical Center, which saw a 70% reduction in serious harm events with its adoption of High Reliability principles and workforce engagement; Nationwide Children’s Hospital, which reduced its serious-harm-event rate by 83%; Vidant Health, which received the John M. Eisenberg Patient Safety and Quality Award for its safety transformation that led to an 83% overall reduction in serious harm events; and WellStar Health System, which reduced serious safety events by 88% systemwide with its Safety First cultural transformation.

“The efforts to establish, achieve and surpass safety improvement goals across these organizations reflect their leaders’ commitment to the goal of High Reliability and the development of a culture that places safety above any other competing priorities,” said Dr. Gary Yates, managing partner of Strategic Consulting at Press Ganey. They also reflect a growing understanding that improving the safety of care is integral to improving the quality and experience of care. “There is a synergistic effect among safety, clinical quality and experience,” Dr. Yates explained. “The High Reliability operating principles that organizations apply to prevent events of harm can also be used to improve their clinical outcomes and patients’ perceptions about their care experience.”