High Reliability Transformation at Boston Children’s Hospital: Building a Safety Culture through Patience and Persistence

By Diana Mahoney

The road to High Reliability at Boston Children’s Hospital is paved with patience and persistence, as well as a deeply ingrained understanding that there is no finish line. “We don’t stop. We can’t. The journey is the destination,” Kevin Churchwell, president and chief operating officer of the internationally recognized comprehensive pediatric health care center, told leaders of some of the nation’s top children’s health systems participating in Press Ganey’s 5th Annual Pediatrics Executive Summit.

Boston Children’s High Reliability journey began four years ago as a way to accelerate progress on a mandate to improve safety across the enterprise that had been issued 10 years earlier. At that time, a series of serious safety events provided a “wake-up call” to health system leaders, Churchwell explained. “It galvanized us to develop programs in quality and safety and create new policies, procedures, and practices where safety became a top priority for us.”

While the work led to improvements, the gains were not where they needed to be. “Our [safety and quality leadership] team would meet every week, and we would be presented with incidents that occurred, but there would always be an explanation or an excuse,” said Churchwell. “We thought we had made great strides, but when we looked at what was going on over time, we saw a lot of serious safety events. Patients were still being harmed and employees were still getting hurt.”

Realizing the need for a paradigm shift in how they addressed patient and workforce safety, BCH leaders explored solutions that could “put us at the next level,” Churchwell said. “There were issues that we felt we had to tackle, and the question that we asked ourselves was whether there was a transformational opportunity in safety.”

After examining various options, including Lean management principles, the team chose High Reliability. “High Reliability is a way of thinking as much as anything else. It’s a willingness to embrace failure—the idea that if something bad happens, you don’t move it to the side or explain it away. You accept that a failure has happened and you examine it to learn why it happened, then you create a plan of action to prevent it from happening again,” Churchwell explained.

High Reliability centers on the concept of zero preventable harm. Although some leaders pushed back on the Zero Harm goal, claiming it’s impossible to achieve, “High Reliability is about creating an environment where Zero Harm is where you’re headed,” Churchwell said.

At BCH, the High Reliability efforts focus on two key areas:

1. A preoccupation with failure, which requires a commitment to learning why errors occur in order to prevent them from recurring, and
2. A sensitivity to operations that includes paying close attention to activity on the front lines of care that is inconsistent with a safety culture, and helping teams change.

AT A GLANCE

- Since embarking on a High Reliability journey four years ago to accelerate transformation of its safety culture, Boston Children’s Hospital has seen steady declines in its rate of serious safety events.
- Error prevention training of clinical and nonclinical leaders, all employees, and, most recently, patients and families has made the vocabulary of High Reliability familiar to the entire enterprise.
- Area-specific safety huddles, daily operations briefs, and rounding to influence are additional cornerstone initiatives that have increased safety awareness, enhanced attention to detail, improved accountability, and empowered every individual to be a safety advocate.
“Everything we do, all of our High Reliability work, applies to everyone in the organization in both clinical and nonclinical areas, and it extends across the enterprise, including research, administration, government relations, and other areas,” Churchwell said.

Although it sounded like a reasonable goal, “getting 16,000 individuals on the same page was not easy,” said Churchwell. “We had to create an environment where everyone could see there was a pressing need for this work.”

To create such an atmosphere, the team heeded the advice of their Press Ganey HPI safety consultants: Use data. “They recommended we create a slide showing how many serious safety events had occurred over a given period of time—specifically, how many patients were harmed because of something that we didn’t do, a process we didn’t follow, a communication that didn’t occur,” said Churchwell. Rather than populate the slide with numbers, the team used names to represent each patient who had been harmed. The names filled the screen. “We showed this slide to all of our leadership and said, ‘This is what is going on in our institution. This is the number of children in our care who were harmed over a year and a half.’”

The powerful visual was a turning point. “It galvanized us, and we found commitment from across the hospital and enterprise to implement High Reliability as our safety transformation,” Churchwell said. Because the “High Reliability” label held little meaning for people, the team created a tagline to better reflect the overarching goal of the effort: “Every moment matters.”

“It’s an elevation of how to think about everything we do, that every interaction, every touchpoint, makes a difference,” Churchwell stated.

To adapt and apply High Reliability principles to the organization’s operations, BCH leaders worked with consultants to develop an implementation framework that consisted of three cornerstone initiatives: error prevention training, a daily operational brief, and rounding to influence.

The rollout of the first initiative, High Reliability error prevention training, began with senior leaders. “We started at that level so acceptance could flow downward. The faculty will accept something as valuable if they see that it’s important to the department chair. The nursing staff will perceive its importance if the nurse managers do, and the nurse managers will value it if the nursing director does, and so forth,” Churchwell said.

Over the course of one year, 100% of BCH clinical and nonclinical leaders were trained in High Reliability safety behaviors and error prevention techniques, Churchwell said. Next, training was (and continues to be) disseminated to the rest of the workforce. “Every employee who comes through our building is educated on High Reliability on their first or second day. So far, the training has touched more than 16,000 individuals.”

The second initiative, the daily operations brief, has had the most impact on the BCH safety culture, according to Churchwell. Led by executive leaders, the focused, 15-minute gathering of clinical and administrative leaders across 40 disciplines provides a forum to address safety issues, share updates, identify concerns, and assign ownership. “We go around the room and ask each representative if there are any safety concerns in their unit or area,” he explained. “When we started it four years ago, a lot of people thought it would be another flavor-of-the-month initiative, but it continues to this day, seven days per week, including holidays, and most people feel it’s one of the most important events of the day.”

Not everyone has a safety concern every day, but one day per week—“all-talk Wednesdays”—every person has to come prepared with a safety issue or story, Churchwell said.

Many of the issues brought to the table during the daily operations brief emerge from area-specific huddles. “Once we started having the daily operations brief, every area decided to have their own huddle prior to it so they could identify safety issues that couldn’t be solved within the unit or area,” said Churchwell. “This process has brought incredibly important issues related to clinical safety and employee safety to our attention, and we have a tracking mechanism to ensure that once an issue has been identified, it doesn’t go off the board until it’s fixed.”

The third key initiative, rounding to influence, serves as a tool for supporting High Reliability principles and reinforcing accountability. “Our senior leaders round regularly in different areas of the hospital and ask individuals and groups how things are going with specific components of High Reliability, such as speaking up for safety, cross-checking, structured handoffs, or honoring distraction-free zones,” Churchwell said. “We try to identify any implementation barriers, and we ask what we can do to support the team.”

In addition to the workforce-focused High Reliability initiatives, BCH also created a patient and family High Reliability partnership through which patients and families are involved in identifying and preventing harm. The partnership extends the error prevention training—focusing on speaking up for safety, communicating clearly, and paying attention to detail—through various media, including posters, brochures, and video programming. The partnership debuted in February of this year, and to date, more than 1,000 patients and families have received High Reliability training, according to Churchwell.
The impact that High Reliability has had at BCH can be appreciated through the many instances in which the enhanced alertness, attention to detail, and empowerment of clinicians, staff, and families have prevented harm. Some examples shared by Churchwell include a food service worker who flagged and investigated a write-in order of a granola bar from a patient with a peanut allergy; MRI technicians whose questioning attitude about the MRI compatibility of a patient’s EEG leads led them to stop the line and not go forward with the procedure despite the disruption to the busy MRI schedule; a mom who spoke up when she sensed her child’s problem was more serious than the stomach bug for which she was receiving treatment; and an employee who felt empowered enough by the safety culture of the organization to call out the president and COO (Churchwell) for walking while looking at his phone.

The trajectory of the organization’s Serious Safety Event Rate® (SSER®) has mirrored these advances. Following an initial, expected rise in 2015 at the beginning of the journey resulting from an increased focus on identifying and reporting harm events and near misses, “the rate has steadily come down,” Churchwell said. “In our daily operations brief, we report out the number of days between SSERs. When we started, we’d say, ‘It’s been three days since our last event.’ Soon after, the number could be expressed in weeks, then months.”

Two years ago, there was a nearly five-month SSER-free duration, “but then we had one, because that’s what happens, and that’s why the journey doesn’t end. We have to stay vigilant. We have to pay attention,” Churchwell stressed.

At the time of his presentation, the system’s SSER-free duration was nearing the four-month mark, and the galvanizing slide of patients who had been harmed had just a handful of names on it. “We are pleased, but that’s still too many,” he said. “Our goal is to present a blank slide, and that’s what we continue to work on every day.”