NATIONAL ASSOCIATION FOR HEALTHCARE QUALITY

Call to Action

Safeguarding the Integrity of Healthcare Quality and Safety Systems

The National Association for Healthcare Quality, an organization dedicated to improve healthcare quality and safety, recognizes an urgent need to protect professional integrity and assure that all healthcare professionals can express concerns about quality and safety without fear of retaliation. A strong and just safety culture is imperative to achieve our shared aim of providing patients with the best and safest healthcare possible.

We commit to implementing the actions outlined in this report and call on fellow organizations and professionals to do the same. We ask you to support our national effort to ensure effective quality and patient safety systems function optimally to fulfill our collective goal of keeping patients safe from injury and substandard care.

NAHQ thanks the following organizations for the significant contributions made by its leadership and staff in the development of this paper:

American College of Physician Executives (ACPE)
American Health Information Management Association (AHIMA)
American Medical Association (AMA)
American Nurses Association (ANA)
American Organization of Nurse Executives (AONE)
American Society for Healthcare Risk Management (ASHRM)
National Association for Healthcare Quality (NAHQ), convener
National Association Medical Staff Services (NAMSS)
National Association of Public Hospitals and Health Systems (NAPH)
National Patient Safety Foundation (NPSF)
The Joint Commission

Table of Contents

Executive Summary

In spite of significant efforts over the past two decades to improve healthcare quality and safety, it is widely recognized that there is more work needed to eliminate preventable harm in the U.S. healthcare system. While a strong and just safety culture has been recognized as a key element for improvement, a critical deficit that has not yet been fully addressed is the lack of protective infrastructure to safeguard responsible, accurate reporting of quality and patient safety outcomes and concerns. In fact, as attention to creating a culture of safety in healthcare organizations has increased, so have concomitant reports of retaliation and intimidation targeting staff who voice concern about safety and quality deficiencies.

Some healthcare providers acknowledge that they fear reporting events or conditions that could endanger quality and patient safety. Some professionals whose direct responsibilities include the monitoring and reporting of quality and patient safety outcomes have experienced pressure, outright harassment, or even experienced serious legal and licensure challenges when they recognize and report events of concern. Only with integrity in reporting can healthcare organizations identify and eliminate the root causes of systemic problems that threaten patient safety.

The accelerating implementation of new financial models that tie quality outcomes to payment will raise the stakes associated with quality results. The need will be even greater for a protective infrastructure to safeguard accurate reporting of quality data and patient safety concerns.

Our organizations share goals that are widely endorsed by leading healthcare and patient advocacy groups: meaningful and measurable improvement in patient outcomes, safety, and quality of care; improvement in the patient experience; and transparency of quality and safety data. These goals can be attained only with impeccable accuracy and trustworthy reporting.

In any given situation where quality or patient safety is called into question, the process by which an issue is reported is as important as the query itself. Not every question of concern about patient safety or quality of patient care will ultimately be deemed valid; but every reported concern deserves consideration. A culture that encourages such disclosures is critical to improved patient care. So is the process by which concerns are examined, investigated and ultimately determined to be valid or not.

We call upon leaders of healthcare organizations to **implement protective structures to assure accountability for integrity in quality and safety evaluation and comprehensive, transparent, accurate data collection, and reporting to internal and external oversight bodies.**

This call has four actionable components:

- Establish accountability for the integrity of quality and safety systems.
- Protect those who report quality and safety findings.
- Report quality and safety data accurately.
- Respond to quality and safety concerns with robust improvement.

We also call upon other agents of change such as professional membership associations, accrediting agencies, and legislative and regulatory bodies to provide guidance, specific tools, and formal supports to ensure integrity in the reporting of quality and patient safety concerns, adverse events, and outcomes.

Framework for Action:
Integrity in Healthcare Quality and Safety

Background

Since the 1999 publication of the landmark Institute of Medicine report, *To Err is Human: Building a Safer Health System*, patient safety experts, leaders of healthcare organizations, and frontline providers have worked to implement best practices and organized systems to improve the reliability, safety, and quality of the care that patients receive.

> ***"On a regular monthly basis, the medical peer review committees…allow medical staff to continue to practice despite bullying and intimidation. Probably on a daily basis, staff fails to report serious adverse outcomes for fear of retaliation."***
>
> ***NAHQ Member Survey***

A strong safety culture is one in which safety of operations is a primary goal, reporting of concerns is welcomed, the approach to errors is free of blame, collaboration across the hierarchy is encouraged, and organizational resources are committed for addressing safety concerns.[1] A strong safety culture has been associated with improved patient outcomes, such as reduced avoidable readmission rates for acute myocardial infarction and heart failure.[2] The concept of a just culture has been proposed to balance the need for a nonpunitive environment with appropriate accountability of the individual. In a just culture, systemic issues are identified and corrected, but reckless behavior is not tolerated.[3]

Work in the aviation, aerospace, nuclear power, construction, and other high-risk, high-reliability industries has demonstrated that a strong safety culture is essential to recognize and mitigate sources of potential error and harm.[1] Early work confirmed that these insights are relevant to healthcare quality and safety as well, and yet a safety culture has been particularly difficult to build in healthcare. According to data published by the Agency for Healthcare Research and Quality (AHRQ) in February 2012, only 44% of surveyed healthcare providers described the response to error at their organization as nonpunitive.[4] Characterized by powerful and long-established hierarchies and the apprentice culture of medicine and made more complex by the medical staff privileging process in hospitals, healthcare has been especially resistant to cultural transformation.

A solid understanding of systems and their potential for error is fundamental to improving reliability.[5] In the healthcare context, two kinds of information are critical to this understanding:

- Details of past potential harm situations, identified by examining adverse events and close-call situations
- Patterns of performance over time, gleaned from accurate, reliable data regarding variation in care processes.

If individuals fail to report near misses and significant events, underlying systemic issues will remain unseen and unaddressed. Without a strong and just safety culture, frontline providers and management may fail to identify an event as reportable or may hesitate to report such an event. Moreover, it's important to report patient and caregiver identified safety problems. The patient-centered culture is integrally connected to a just safety culture and achievement of high levels of quality, including patient safety. Patient safety officers, risk managers, infection preventionists, quality managers, department chiefs, and other professionals whose direct responsibilities include the monitoring and reporting of quality and patient safety have reported that they experience pressure—up to and including outright harassment—when they recognize and report unfavorable trends, data, or events.

The Joint Commission recognizes a spectrum of intimidating behaviors that threaten a culture of safety, including verbal outbursts, physical threats, uncooperative attitudes, reluctance to answer questions, condescending tone of voice, and impatience with questions.[6] Recent reports suggest that healthcare providers, managers, and performance improvement professionals have experienced pressure or perceived a lack of protection when reporting quality and safety concerns.

In a 2010 survey, some NAHQ members reported experiencing outright harassment or intimidation at least once or twice a year.[7] A straw poll of NAHQ members in leadership positions found that almost 3/4 had personally experienced an incident of ethical and professional concern related to reporting quality or safety concerns and outcomes.[8] A 2010 study found that 1/3 of physicians with direct knowledge of an impaired or incompetent colleague failed to report the colleague to the appropriate authorities; a commonly cited reason for failing to report was fear of retribution.[9]

Some NAHQ members stated that they face concerns from leaders in their organizations that there is 'over reporting' of adverse events, such as a retained foreign object, when in the opinion of these leaders, it is not truly reportable.

NAHQ Member Survey

As a testament to the importance of quality and safety measures, many payers are beginning to tie quality outcomes to payment, such as pay-for-performance programs, value-based purchasing, and the withholding of reimbursement for hospital-acquired conditions. The hope is that this change will eliminate perverse incentives that impede efforts to improve quality and patient safety. However, the shift will raise the stakes associated with reporting less-than-optimal outcomes. With the emergence of healthcare financing models that tie reimbursement to quality outcomes, a just culture is imperative.

An expectation of professionalism and integrity inherent in a just culture is fundamental to protect against the heightened emphasis on compliance mandates, which may encourage documentation inaccuracies intended to satisfy quality measures, omissions of reporting, or inaccurate reporting of quality performance data. Examples include the following:

- A quality manager learns that a surgical procedure was performed to remove a foreign body unintentionally retained in a previous surgery. She begins preparing a report to inform quality supervisors in the hospital and external authorities about the incident. However, she is approached by the chairman of the surgery department who pressures her to withhold the reports, arguing that that the foreign body was identified quickly and removed without long-term harm to the patient.
- A nurse notices that an intravenous medication was given to the wrong patient by a nurse on the prior shift. The nurse manager attempts to persuade him not to submit an event report to the risk management department, rationalizing that the patient experienced no harm and that there could be significant consequences for the manager and the nurse who committed the error if the error was reported.
- A social worker believes that the transfer of a patient from the emergency department to another hospital may have involved a violation of the Emergency Medical Treatment and Active Labor Act (EMTALA). However, his manager forbids him to pursue further evaluation of the incident.
- The physician chair of a peer review committee develops serious concerns about the possible impairment of a colleague, one of the most popular and high-volume physicians at the medical center, after identifying several examples of failure to provide what is considered the standard of care in the community. The medical staff president informs the chair that her own privileges will be at risk if she challenges the qualifications of this colleague.
- The electronic health record documentation standards committee of a medical center is strongly urged to approve the addition of a statement to all discharge summaries that the patient received smoking cessation counseling. The committee is told this will enhance the medical center's results with a Centers for Medicare & Medicaid Services (CMS) core measure. The statement will appear in each patient's record regardless of whether the patient is or was a smoker and regardless of whether the counseling was actually provided.

> ***"The hospital's most profitable surgeon had complication and mortality rates two to three times the national average. I was asked to resign after repeated attempts to get administration to address the issue."***
>
> ***NAHQ Member Survey***

We share the goals widely endorsed by leading healthcare and patient advocacy groups: meaningful and measurable improvement in patient outcomes, healthcare quality, and patient safety; improvement in the experience of care; and transparency of trustworthy quality and safety data. We can achieve these goals only if clear, protective policies are in place to support impeccable accuracy in quality evaluation, supported by an infrastructure that includes a strong and just safety culture. We believe that the present environment often fails to protect and ensure integrity in the reporting of quality and safety outcomes, adverse events, and concerns.

> ***"Disclosure is sometimes an issue. The policy calls for full disclosure of patient-related incidents; in reality, it is often downplayed or glossed over, sometimes absent altogether."***
>
> ***NAHQ Member Survey***

We believe a few key action steps taken by the leaders of every healthcare organization in the country—as well as changes made at the national level—will substantially improve protective supports for the reporting of quality and safety concerns and the collection of comprehensive, accurate data. Only in this way can we learn from past mistakes, craft new systems that prevent or reduce the chance of recurrences, and move ahead to true improvement in health outcomes.

Detailed Recommendations and Actions

Framework for Action:
Integrity in Healthcare Quality and Safety

We call upon leaders of healthcare organizations to **implement protective structures to assure accountability for integrity in quality and safety evaluation, and comprehensive, transparent, accurate data collection, and reporting to internal and external oversight bodies.**

This call has four actionable components:

- Establish accountability
- Protect those who report quality and safety findings
- Report quality and safety data accurately
- Respond to quality and safety concerns with robust improvement.

We also call upon other agents of change such as professional membership associations, accrediting agencies, and legislative and regulatory bodies to provide guidance, specific tools, and formal supports to ensure integrity in the reporting of quality and patient safety concerns, adverse events, and outcomes.

Recommended Actions for Leaders of Healthcare Organizations

1. Create a **focus on accountability** for quality and safety as part of a strong and just culture. *Help **clinicians recognize their** responsibility for quality and safety*.
   - **Educate** every employee and healthcare provider at hiring, upon promotion, and during credentialing about your organization's expectations for timely reporting of quality and safety concerns.
   - **Publicize** ethical responses to error and "good catches" through management praise, peer recognition, and other techniques. Communicate the appropriateness of identifying, investigating, and reporting errors. Highlight stories of ethics in action to demonstrate desired actions.
   - **Benchmark** regularly. Compare your organization's performance in reporting and responding to quality and safety concerns with that of peer organizations.
   - **Engage patients and families** to report their concerns and ideas, participate on committees and councils to drive the quality and safety agenda, and maintain a focus on integrity and patient outcomes.

2. Ensure that **protective structures** are in place to encourage reporting of quality and safety concerns.

   - Set clear **expectations** for identifying and reporting errors. Establish explicit **policies** that support error reporting and penalize subtle retribution, intimidation, and harassment in response to reporting of quality and safety concerns.
   - **Educate** every employee and healthcare provider at hiring, upon promotion, and during credentialing about your organization's policies regarding the reporting of quality and safety concerns and the penalties for behaviors that restrict unfettered reporting.
   - **Respond, counsel, and discipline as needed** to ensure that egregious violators of the policies regarding error reporting will not be permitted to work or practice at your organization. Appropriately penalize any individual who violates the established policies on error reporting, whether he or she is a healthcare provider or professional in whom the quality and safety of patients are entrusted.
   - **Engage general counsel or corporate compliance officers** to provide the necessary guidance for addressing situations of conflicting interests or intimidation.

3. Ensure **comprehensive, transparent, accurate data collection and reporting** to internal and external oversight bodies.

   - Establish **quality improvement plans** to ensure that the primary goal of data collection is true improvement in patient outcomes, not the attainment of performance metrics or compliance with external mandates.
   - Establish **policies that protect data integrity.**
   - Model internal **transparency of performance data**, ensuring that data and associated improvement opportunities are openly discussed.

- **Communicate to clinicians** any identified gaps in the patient care process. Reinforce the message that your organization's goal is collaborating with providers to improve performance.

4. Ensure an **effective response** to quality and safety concerns.

- **Demonstrate a just response** to quality and safety concerns
  - Immediately investigate and respond to any adverse event, complaint, or concern.
  - Adopt an attitude of appreciative inquiry when examining quality and safety concerns. Communicate and model that the primary aim of an error investigation is identifying system issues rather than criticizing individuals.
  - Ensure that individuals involved in an error—staff, managers, patients, and patient families—are supported through the emotional distress that such an event can cause.
- **Establish and enforce policies** for responding to a quality or safety concern, including adverse events, errors, never events, and incidents that result in patient harm.
  - As appropriate, escalate the response to the issue along the organizational chain of responsibility.
- **Implement effective action plans** at the systems level to address vulnerabilities and gaps in quality and safety processes. Measure for a sufficient period of time to assure robust implementation and sustained performance.

In addition, we endorse the work of other leaders as fundamental to improvement:

Foster teamwork and open communication.
We endorse the actions recommended by many leaders in quality and safety to develop and nurture a just culture:[10]

- Work to **minimize organizational hierarchy** and encourage open interprofessional communication among all members of the organization, especially those working in the areas of quality improvement, root cause analysis, and action planning.
- Foster a **healthy and productive relationship** between administration and all staff, encouraging active engagement of medical staff members in interdisciplinary team-based training and other initiatives.
- Work to **recruit** individuals who will support and work effectively within a strong and just safety culture.

Ensure effective oversight.
We endorse the actions recommended by many leaders in quality and safety to assure effective governance of the improvement agenda:[11]

- **Evaluate your organizational structure.** Position individuals responsible for quality and patient safety programs at a high level of the organization, with the

decision-making autonomy, budgetary discretion, available avenues of communication, and accountability for report integrity and accuracy equivalent to those of other executive leaders or board members.
- **Prioritize** quality and patient safety by including these topics as regular agenda items in executive and board meetings. Work toward a culture at the board and senior management levels that welcomes reports of potential quality problems (e.g., commends increases in incident reporting).
- **Demonstrate accountability** to the board via regular, detailed reports about all aspects of quality and patient safety, including adverse events, root cause analyses, action plans, and peer review investigations.
- **Set clear expectations** for the board, including oversight of accreditation and licensure requirements, careful monitoring of organizational performance relating to quality and safety, approval of necessary resources, and holding leaders accountable for quality and safety outcomes.

Contributing Roles for National Change Agents

1. Professional membership associations

   - Provide strong **guidance** regarding the ethical response to errors and the importance of a strong and just safety culture.
   - Publish a written **code of ethics** regarding the identification and reporting of quality and safety concerns. Include a description of the protective supports necessary to encourage reporting.
   - Create **tools** such as communication templates for dealing with conflicting interests or intimidation relating to the reporting of quality and safety concerns.

2. Accrediting bodies

   - **Facilitate education of healthcare organizations regarding the importance of the integrity** of error reporting to internal sources and external agencies and promotion of a safety culture.

3. Legislative and regulatory bodies

   - Further develop and enforce effective **legislative protections** for individuals investigating or reporting quality and patient safety concerns.
   - Ensure that **state regulations provide special protection** for individuals with responsibility for reporting data on quality and patient safety performance.

Conclusion

Every patient deserves patient-centered high-quality, safe, reliable healthcare.

Every person working in healthcare deserves a professional environment that values integrity, dignity, accuracy, and a commitment to quality.

We believe that we must safeguard the integrity of healthcare quality and safety systems by cultivating a strong and just safety culture and developing a protective infrastructure to ensure the truthful and reliable reporting of quality and safety concerns. Without such protection, healthcare providers and professionals with direct responsibility for quality and safety reporting may fail to address all concerning events, leaving patients at risk for recurrent errors.

The need to address these gaps will only increase as new reimbursement models raise the incentive to improve performance metrics. We call on organizational and national leaders to take immediate action to transform our healthcare system into one that consistently provides high-quality, safe, reliable care—the kind of care we all want for ourselves and our loved ones.

Appendix 1. Organizations Contributing to the Call to Action

American College of Physician Executives (ACPE)
ACPE is the nation's largest healthcare organization for physician executives—doctors who hold leadership and management positions—who want to boost their leadership skills while adding weight to their Curriculum Vitae (CVs). Since its founding in 1975, ACPE's primary focus is to provide superior leadership and management skills to physicians and encouraging them to assume more active roles in the leadership and management of their organizations. (www.acpe.org)

American Health Information Management Association (AHIMA)
AHIMA is the premier association of health information management (HIM) professionals. AHIMA's more than 61,000 members are dedicated to the effective management of personal health information required to deliver quality healthcare to the public. Founded in 1928 to improve the quality of medical records, AHIMA is committed to advancing the HIM profession in an increasingly electronic and global environment through leadership in advocacy, education, certification, and lifelong learning. (www.ahima.org)

American Medical Association (AMA)
Since 1847, AMA has had one mission: to promote the art and science of medicine and the betterment of public health. Today, AMA's core strategy used to carry out this mission is its concerted effort to help doctors help patients. The association does this by uniting physicians nationwide to collaborate on the most important professional and public health issues. (www.ama-assn.org)

American Nurses Association (ANA)
ANA is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses through its constituent member nurses associations and its organizational affiliates. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and lobbying the Congress and regulatory agencies regarding healthcare issues affecting nurses and the public. (http://nursingworld.org)

American Organization of Nurse Executives (AONE)
AONE is the national organization of nurses who design, facilitate, and manage care. Since 1967, the organization has provided leadership, professional development, advocacy, and research to advance nursing practice and patient care, promote nursing leadership excellence, and shape public policy for healthcare. AONE's 48 affiliated state and metropolitan chapters and its alliances with state hospital associations give the organization's initiatives a regional and local presence. AONE is a subsidiary of the American Hospital Association. (www.aone.org)

American Society for Healthcare Risk Management (ASHRM)
Established in 1980, AHSRM is a personal membership group of AHA, with more than 5,400 members representing healthcare, insurance, law, and other related professions. ASHRM promotes effective and innovative risk management strategies and professional leadership through education, recognition, advocacy, publications, networking, and interactions with leading healthcare organizations and government agencies. (www.ashrm.org)

The Joint Commission
An independent, not-for-profit organization, The Joint Commission accredits and certifies more than 19,000 healthcare organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. (www.jointcommission.org)

The National Association for Healthcare Quality (NAHQ)
NAHQ is a professional association dedicated to the advancement of the profession of healthcare quality and patient safety and the individual professionals working in the field. Founded in 1976, NAHQ has a membership of more than 10,000 quality and patient safety professionals working in healthcare settings both nationally and internationally. These professionals drive the delivery of vital data for effective decision making in healthcare systems by combining technology with their unique expertise in quality management. (www.nahq.org)

National Association Medical Staff Services (NAMSS)
NAMSS is the preeminent organization for the development of individuals responsible for managing credentialing, privileging, practitioner/provider organizations, and regulatory compliance in the diverse healthcare industry. (www.namss.org)

National Association of Public Hospitals and Health Systems (NAPH)
NAPH represents America's safety net hospitals and health systems. These facilities provide high-quality health services for all patients, including the uninsured and underinsured, regardless of ability to pay. They provide many essential community-wide services, such as primary care, trauma care, and neonatal intensive care, and train many of America's doctors, nurses, and other healthcare providers. NAPH has cultivated a strong presence on Capitol Hill and is the only national organization representing the interests of safety net hospitals and health systems before Congress and the Administration. (www.naph.org)

National Patient Safety Foundation (NPSF)
NPSF has been pursuing one mission since its founding in 1997: to improve the safety of care provided to patients. As a central voice for patient safety, NPSF is committed to a collaborative, inclusive, multi-stakeholder approach in all that it does. From transformative strategic initiatives to tactics, tools, and vital information resources, from the front lines of care to the leadership level, NPSF defines and develops

groundbreaking programs designed to accelerate positive change and drive forward the patient safety mission. (www.npsf.org)

Appendix 2. Tools for Organizational Self-Assessment

Organizations that provide healthcare services should have methods in place to assess safety culture and help staff identify potential threats to patient safety or quality of care. Many self-assessment resources are available to help organizations accomplish this goal. These resources provide leaders with answers to these questions:

- Is there underreporting or fear of reporting in my organization?
- Is there a culture of safety or fear of retaliation in my organization?

The aim is to develop sustained focus on a robust culture of safety through the use of reliable evaluation instruments and systems. Some widely used resources include these:

- AHA's *Strategies for Leadership: Hospital Executives and Their Role in Patient Safety*[12]
- Agency for Healthcare Research and Quality's (AHRQ) Survey on Patient Safety Culture (now available for several settings)13 and other culture survey approaches[14]
- AHRQ TeamSTEPPS[15]
- AONE's *Role of the Nurse Executive in Patient Safety: Guiding Principles Toolkit*[16]
- Clinical Microsystems (Dartmouth)[17]
- AMA's Communication Climate Assessment Toolkit (C-CAT), which allows hospitals to incorporate patient and staff feedback to generate validated scores in nine key domains of communication[18]
- Crucial Conversations toolkits by VitalSmarts[19]
- Dana-Farber Cancer Institute's *Principles of a Fair and Just Culture*[20]
- Dana-Farber Cancer Institute's Patient Safety Rounding Toolkit: Toolkit Overview and Rationale for a Patient Safety Rounds Program[21]
- Ethical Force Program (developed by the AMA in collaboration with the ANA Center for Ethics and Human Rights and other organizations)[22]
- Governance Institute[23]
- Joint Commission resources on leadership, disruptive behavior, conflict resolution[24]
- *Leadership Leverage Points Self-Assessment Tool for System-Level Aims* (Institute for Healthcare Improvement [IHI])[25]

These resources are generally focused on healthcare provider organizations, where most of the literature, innovations, and evidence have been developed.

Appendix 3. Resources for Promoting Professionalism

Concepts such as *quality improvement*, *interprofessional teamwork*, and *patient safety systems* should be introduced in the training of healthcare professionals and a growing body of resources designed to train practicing professionals in the fundamentals of quality improvement is available. Helpful resources include

- AHRQ's *Mistake-Proofing the Design of Healthcare Processes*[26]
- AMA's extensive resources on professionalism: Declaration of Professional Responsibility,[27] Code of Medical Ethics,[28] Ethical Force Program,[29]Communication Climate Assessment Toolkit (C-CAT)[30]
- AONE's *AONE Guiding Principles for Excellence in Nurse/Physician Relationships*[31] and *Guiding Principles to Protect Patients from Reckless Behavior by Registered Nurses*[32]
- IHI's *Going Lean in Health Care*[33]
- IHI's Open School for Health Professions (www.ihi.org/IHIOpenSchool). This online curriculum for undergraduate and graduate healthcare professions students and professionals includes concepts in quality improvement, patient safety, teamwork, communication, and leadership.
- Intermountain Healthcare, Salt Lake City, UT. Brent James, MD, leads an advanced training program for practicing professionals.
- Interprofessional Education Collaborative. The collaborative—which comprises, among others, representatives of the American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Medicine, Association of Schools of Public Health, American Association of Colleges of Pharmacy, and American Dental Education Association—helps health professions students develop teamwork competencies during their training.[34]
- Joint Commission Center for Transforming Healthcare
- Joint Commission Standards on Patient Rights and Standards on Leadership
- Liaison Committee on Medical Education's *Functions and Structure of a Medical School*[35] and Accreditation Council for Graduate Medical Education's *ACGME Institutional Requirements*[36] and *Common Program Requirements: General Competencies*[37]
- National Association Medical Staff Services[38,39]
- Quality and Safety Education for Nurses curriculum[40]
- University of Texas System Clinical Safety and Effectiveness Course[41]

Appendix 4. Further Reading

Fowler, M. D. M. (Ed.) (2008). *Guide to the Code of Ethics for Nurses: Interpretation and Application*. Washington, DC: American Nurses Association.

Kathleen, L., McFadden, K. L., Henagan, S.C., & Gowen, C. R. (2009). The patient safety chain: Transformational leadership's effect on patient safety culture, initiatives, and outcomes. *Journal of Operations Management 27*, 390–404.

Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds.) (1999). *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press.

Leape, L., Berwick, D., Clancy, C., Conway, J., Gluck, P., Guest, J.,…Isaac, T. (2009). Transforming healthcare: A safety imperative. *Quality & Safety in Healthcare, 18*(6):424–428. doi:10.1136/qshc.2009.036954

Marx, D. (April 17, 2001). Patient safety and the "just culture": A primer for health care executives. Retrieved from www.mers-tm.org/support/Marx_Primer.pdf

Rich, V. (2008). Creation of a Patient Safety Culture: A Nurse Executive Leadership Imperative. In Hughes, R.G., (Ed.). *Patient Safety and Quality: An Evidence-Based Handbook for Nurses.* AHRQ Publication No. 08-0043. Agency for Healthcare Research and Quality, Rockville, MD. Retrieved from www.ncbi.nlm.nih.gov/books/NBK2642

Schyve, P. M. (2009). Leadership in healthcare organizations: a guide to Joint Commission leadership standards. Retrieved from The Governance Institute website: Retrieved from www.governanceinstitute.com/ResearchPublications/ResourceLibrary/tabid/185/CategoryID/4/List/1/Level/a/ProductID/827/Default.aspx?SortField=DateCreated+DESC%2CDateCreated+DESC

Singer, S. J., Falwell, A., Gaba, D. M., Meterki, M., Rosen, A., Hartmann, C. W., & Baker, L. (2009). Identifying organizational cultures that promote patient safety. *Health Care Management Review, 34*(4):300–311.

Appendix 5. Acknowledgments

NAHQ extends special thanks to its call to action partners:

Ann Scott Blouin, The Joint Commission
Michael Callahan, AHLA
Kara Clark, ASHRM
Megan Cohen, NAMSS
Kate Conklin, NAMSS
Maureen Dailey, ANA
Sandy Fuller, AHIMA
Gerald Glandon, NAHQ External Advisory Council
Michelle Hoppes, ASHRM
Charles MacKay, NAHQ member
Grace Martos, AONE
Vivian Miller, ASHRM
Jan Patterson, ACPE
Burdett Porter, ACPE
Angelique Ramirez, NAPH
Pamela Rudisill, AONE
Bill Rudman, AHIMA
Manishah Shah, NPSF
Patricia Sokol, AMA
Susan White, NAHQ
Modena Wilson, AMA
Matthew Wynia. AMA

NAHQ also gratefully acknowledges the contributions of the task team who worked on the project:

Cynthia Barnard, *team leader*
Claire M. Davis
Colleen M. Gallagher
Susan T. Goodwin
Lee Hamilton
Sandra Jones
Roya Nassirpour
Ruth Nayko
Grena Porto
Diane Shannon, *writer*

References

1 Nance, J. J. (2008). *Why Hospitals Should Fly: The Ultimate Flight Plan to Patient Safety and Quality Care.* Bozeman, Montana: River Healthcare Press.

2 Hansen, L.O., Williams, M. V., Singer, S. J. (2011). Perceptions of hospital safety climate and incidence of readmission. *Health Services Research, 46*(2):596–626.

3 Agency for Healthcare Research and Quality (AHRQ). Safety culture. Retrieved from http://psnet.ahrq.gov/primer.aspx?primerID=5.

4 Sorra, J., Famolaro, T., Dyer, N., Nelson, D., & Smith, S. A. (2012). Hospital Survey on Patient Safety Culture: 2012 user comparative database report. Rockville, MD: AHRQ. Retrieved from www.ahrq.gov/qual/hospsurvey12/index.html.

5 Deming, W. E. (1986). *Out of the Crisis.* Cambridge, MA: MIT Press.

6 The Joint Commission. (July 9, 2008). Sentinel event alert: behaviors that undermine a culture of safety. Retrieved from www.jointcommission.org/assets/1/18/SEA_40.PDF.

7 National Association for Healthcare Quality (NAHQ). (September 2010). Healthcare quality professional ethical challenges [electronic survey]. Glenview, IL: NAHQ.

8 NAHQ. (November 2010). [Straw poll internal data]. Unpublished raw data.

9 DesRoches, C. M., Rao, S. R., Fromson, J. A., Birnbaum, R. J., Iezzoni, L., Vogeli, C., & Campbell, E. G. (2010). Physicians' perceptions, preparedness for reporting, and experiences related to impaired and incompetent colleagues. *JAMA. 304*(2):187–193.

10 AHRQ. (August 2010). *Improving Patient Safety in Hospitals: A Resource List for Users of the AHRQ Hospital Survey on Patient Safety Culture*. Rockville, MD: AHRQ. Retrieved from www.ahrq.gov/qual/patientsafetyculture/hospimpptsaf.htm.

11 5 Million Lives Campaign. (2008). *Getting Started Kit: Governance Leadership "Boards on Board" How-to Guide.* Cambridge, MA: Institute for Healthcare Improvement (IHI). Retrieved from www.ihi.org/knowledge/Pages/Tools/HowtoGuideGovernanceLeadership.aspx.

12 Conway, J. B. (2001). Strategies for leadership: hospital executives and their role in patient safety. Chicago, IL: American Hospital Association (AHA). Retrieved from www.aha.org/aha/content/2002/pdf/conwaytool.pdf.

13 AHRQ. (2004). Hospital survey on patient safety culture. Retrieved from www.ahrq.gov/qual/patientsafetyculture/hospsurvindex.htm.

14 Sexton, J. B., Paine, L. A., Manfuso, J., Holzmueller, C. G, Martinez, E. A., Moore, D.,…Pronovost, P. J. (2007). A check-up for safety culture in "my patient care area." *Joint Commission Journal on Quality and Patient Safety, 33*(11):699–703, 645.

15 AHRQ. TeamSTEPPS®: National Implementation. Rockville, MD: AHRQ. Retrieved from http://teamstepps.ahrq.gov.

16 The American Organization of Nurse Executives (AONE). (2007). AONE Guiding Principles: For the role of the nurse executive in patient safety. Chicago: AONE.

Retrieved from www.aone.org/resources/PDFs/AONE_GP_Role_Nurse_Exec_Patient_Safety.pdf.
17 Clinical Microsystems Website. (2011). Retrieved from www.clinicalmicrosystem.org.
18 American Medical Association (AMA). (2012). C-CAT patient centered communication. Chicago: AMA. Retrieved from www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources.page.
19 VitalSmarts Website. Retrieved from www.vitalsmarts.com.
20 Dana-Farber Cancer Institute. (2012). Dana-Farber Cancer Institute principles of a fair and just culture. Boston: Dana-Farber Cancer Institute. Retrieved from www.dana-farber.org/uploadedFiles/Library/adult-care/care-quality-and-safety/patient-safety-resources/patient-safety-rounding-toolkit/principles-of-a-fair-and-just-culture.pdf.
21 Dana-Farber Cancer Institute. (2012). Patient safety rounding toolkit. Boston: Dana-Farber Cancer Institute. Retrieved from www.dana-farber.org/uploadedFiles/Library/adult-care/care-quality-and-safety/patient-safety-resources/patient-safety-rounding-toolkit/toolkit-overview.pdf.
22 AMA. The Ethical Force Program. (2012). Chicago: AMA. Retrieved from www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program.page. Accessed July 28, 2011.
23 The Governance Institute Website. (2012). Retrieved from www.governanceinstitute.com.
24 Joint Commission Resources Website. (2012). Retrieved from www.jcrinc.com.
25 IHI. (2012). Leadership leverage points self-assessment tool for system-level aims. Cambridge, MA: IHI. Retrieved from www.ihi.org/knowledge/Pages/Tools/LeadershipLeveragePointsSelfAssessmentToolforSystemLevelAims.aspx.
26 Grout, J. (2007). *Mistake-Proofing the Design of Health Care Processes*. Rockville, MD: AHRQ. Retrieved from www.ahrq.gov/qual/mistakeproof/mistakeproofing.pdf.
27 AMA. (2012). Declaration of professional responsibility. Chicago: AMA. Retrieved from www.ama-assn.org/ama/pub/physician-resources/medical-ethics/declaration-professional-responsibility.page.
28 AMA. (2012). AMA's code of medical ethics. Chicago: AMA. Retrieved from www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page.
29 AMA. (2012). Ethical force program. Chicago: AMA. Retrieved from www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program.page.
30 AMA. (2012). Communication climate assessment toolkit. Chicago: AMA. Retrieved from www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources.page?.

31 AONE. (2005). AONE guiding principles: For excellence in nurse/physician relationships. Chicago: AONE. Retrieved from www.aone.org/resources/PDFs/AONE_GP_Excellence_Nurse_Physician.pdf.
32 AONE, American Society for Healthcare Risk Management, & American Society for Healthcare Human Resources Administration. (2011). Guiding principles to protect patients from reckless behavior by registered nurses. Chicago: AONE. Retrieved from www.aone.org/resources/PDFs/AONEGuidingPrinciplesMaliciousPractitioners.pdf.
33 IHI. (2005). *Going Lean in Health Care*. Cambridge, MA: IHI. www.ihi.org/knowledge/Pages/IHIWhitePapers/GoingLeaninHealthCare.aspx.
34 Health Resources and Services Administration, Josiah Macy Jr. Foundation, Robert Wood Johnson Foundation, & ABIM Foundation. (2011). Team-based competencies: Building a shared foundation for education and clinical practice. Conference report. Retrieved from www.aamc.org/download/186752/data/team-based_competencies.pdf.
35 Liaison Committee on Medical Education (LCME). (May 2011). Functions and structure of a medical school: standards for accreditation of medical education programs leading to the M.D. degree. Chicago: LCME. Retrieved from www.lcme.org/functions2011may.pdf.
36 Accreditation Council for Graduate Medical Education (ACGME). (July 1, 2007). ACGME institutional requirements. Chicago: ACGME. Retrieved from www.acgme.org/acWebsite/irc/irc_IRCpr07012007.pdf.
37 ACGME. (February 13, 2007). Common program requirements: general competencies. Chicago: ACGME. Retrieved from www.acgme.org/outcome/comp/GeneralCompetenciesStandards21307.pdf.
38 Gutierrez, B. (Jan/Feb 2011). National Association of Medical Staff Services (NAMSS) raises the bar on professionalism. *Synergy*.
39 NAMSS. (2012). NAMSS code of professional conduct. Washington, DC: NAMSS. Retrieved from www.namss.org/AboutUs/CodeofProfessionalConduct/tabid/317/Default.aspx.
40 Quality and Safety Education for Nurses Website. (2012). Retrieved from www.qsen.org.
41 Thomas, E. J., Patterson, J., Martin, S., Quinn, D., Reed, G., & Shine, K. (February 2011). The University of Texas System clinical safety and effectiveness course. In *Perspectives on Safety*. Retrieved from www.webmm.ahrq.gov/perspective.aspx?perspectiveID=98.