



### VA NCPS Topics in Patient Safety

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### Good News About Access From Las Cruces, New Mexico

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An interdisciplinary team effort at the El Paso VA Health Care System's Las Cruces Community Based Outpatient Clinic (CBOC) has increased Veteran walk-in access, satisfaction and completeness of screenings for alcohol use, depression, PTSD, and tobacco use. This was accomplished by utilizing a coordinated, multidisciplinary approach with top leadership engagement and support. The effort was part of the clinic's involvement in the VA National Center for Patient Safety's (NCPS) Clinical Team Training program (CTT),<sup>1</sup> a year-long initiative comprised of didactic training and the implementation of a project aimed at improving teamwork, communication, team decision-making, and patient safety.

Clinical Team Training was initiated on-site at the Las Cruces CBOC in May 2015 where clinic staff of all disciplines participated in classroom sessions facilitated by NCPS faculty. Immediately following the sessions, a project Implementation Team (IT) was formed with clinic staff to tackle identified challenges in managing unscheduled or "walk-in" patients. The team wanted to improve patient flow and access – specifically situations requiring prompt evaluation by clinic staff. A baseline evaluation by team members identified wide variations in the walk-in patient process. For example, vital information was sometimes not communicated between staff during handoffs. Workload distribution between Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), and Medical Support Assistants (MSAs)

was inefficient leading to back-ups in the flow of patients through the clinic. The team also found that clinic walk-in patients were often in need of more immediate attention, as many Veterans were coming into the clinic as a substitute for visiting the Emergency Department (ED). This was an important issue to address to ensure that Veterans with potentially life-threatening conditions could be quickly identified, assessed by a nurse, and referred to a local ED if warranted.

Over the next year, the Las Cruces CTT project IT and staff worked diligently to increase access for Veterans by standardizing the process for those patients who walk-in to the clinic for care. The team rolled up their sleeves and began to work on devising improvements which are identified below:

### Process Improvements

Initial process improvements were made by updating and disseminating Veteran education pamphlets containing general patient information, VA phone numbers, and a description of patient and staff responsibilities. This set the expectation for wait-times for unscheduled visits, and identified key phone numbers for departments such as pharmacy, behavioral health and prosthetics. Next, staff roles were reviewed, standardized and clarified. For example, LVNs assumed the task of checking in all unscheduled Veteran walk-in patients, while the RN completed a comprehensive assessment. This change divided the workload and

provided redundancy by assuring that two licensed personnel would lay eyes on the Veteran during the walk-in process. Staff lunch break periods were rearranged utilizing a “buddy system” so that nurses and MSAs were readily available should a Veteran walk into the clinic. The next step for the team was to simplify and revise the multi-use, “catch all” nurse evaluation form which includes items such as current medications, medical equipment, supplies, and recent test results. Prior to the revision, Veterans were unclear on how to use the form. For example, rather than focus on the immediate need for the visit, they would list a multitude of requests from medication refills to requesting referrals to other specialties. The new form included an area which prompted the Veteran to explain in his/her own words the goal for their visit. Also, the back of the form was updated to include clinical reminder screenings; a section that is completed by the patient and evaluated by the nurse at check in. A clinical reminder screening is a series of questions that assesses the Veteran for risk factors such as post traumatic stress, thoughts of suicide and alcohol and tobacco use. Since March 2015 when the change occurred, there has been a marked increase in the number of completed clinical reminders.

### When to Get a Nurse

Increasing access and efficiency were important goals, but it was also paramount to ensure that all Veterans were kept safe through the process. A cornerstone achievement included implementing “When to Get a Nurse” training for MSAs. This training served to emphasize the Patient Aligned Care Team (PACT) approach to providing safe care and emphasized the requirement for prompt and open communication between the MSA and RN staff to manage patient flow. The training highlighted an assessment for universal signs of distress often seen with life-threatening conditions such as a heart

attack and stroke. In addition, other signs and symptoms of conditions warranting immediate assessment by a RN were covered. The course ensured that the MSAs, often the first contact for walk-in patients, had the requisite knowledge to thoroughly perform a physical assessment, along with an ongoing invitation by team leaders to speak up if there were concerns about a Veteran. This was a vital part of the overall project as prior to the intervention instances occurred where Veterans needing prompt care arrived at the clinic, but experienced extended delays while waiting among regularly scheduled appointments. The project’s emphasis on the MSA is strategic. The IT recognized the critical role that MSAs play in a Veterans experience in the clinic. Whether it involves sending an instant message to a team member about a patient, or taking a wheel chair out to a Veteran who is having difficulty standing, the MSAs were the first point of contact for the Veteran with the care delivery system.

### Daily Team Huddles

The team recognized that project implementation would require small corrections along the way. Therefore, daily huddles (briefings) were conducted to review the previous day’s events, to plan for the current day, review clinic staffing, and to strategize for the efficient flow and safety of walk-in patients. In addition to serving as a monitor for reviewing what worked well and what needed to be changed, the huddles served to reinforce team roles, improve situational awareness, and reinforce expectations to speak up with suggestions and/or patient safety concerns.

### Results

In the first two months after implementation, the amount of time the clinic manager spent handling patient complaints decreased markedly from a reported 50 percent to approximately 10 percent of the work day. The “When to Get a Nurse” training had an empowering effect on the MSA staff. There have been

specific cases where MSAs have drawn upon their training to identify and then speak up to “Stop the Line” when encountering patients with chest pain, symptoms of stroke, and other urgent problems. In each case the situation was promptly identified and a nurse notified. In one particular case a Veteran with chest pain presented to the clinic. He was promptly assessed, received supportive care, handed off to paramedics, and transported to a cardiac catheterization lab within one hour.

An anonymous survey was given to staff to gauge their perceptions about the management of walk-in patients both before and after the process changes in the clinic. Prior to the change 36 percent of the staff were either satisfied or very satisfied with the management of walk-in patients. That number increased to 90 percent one-year post implementation of the CTT improvement project. Moreover, the percent of completed reminder screenings by clinic staff for major risk factors increased across all categories. Results are outlined below:

- Alcohol use screening increased from 78 to 92 percent
- Depression screening increased from 72 to 85 percent
- PTSD screening increased from 95 to 98 percent
- Tobacco use screening increased from 73 to 90 percent

### Teamwork and Safety Climate Questionnaire (TSCQ)

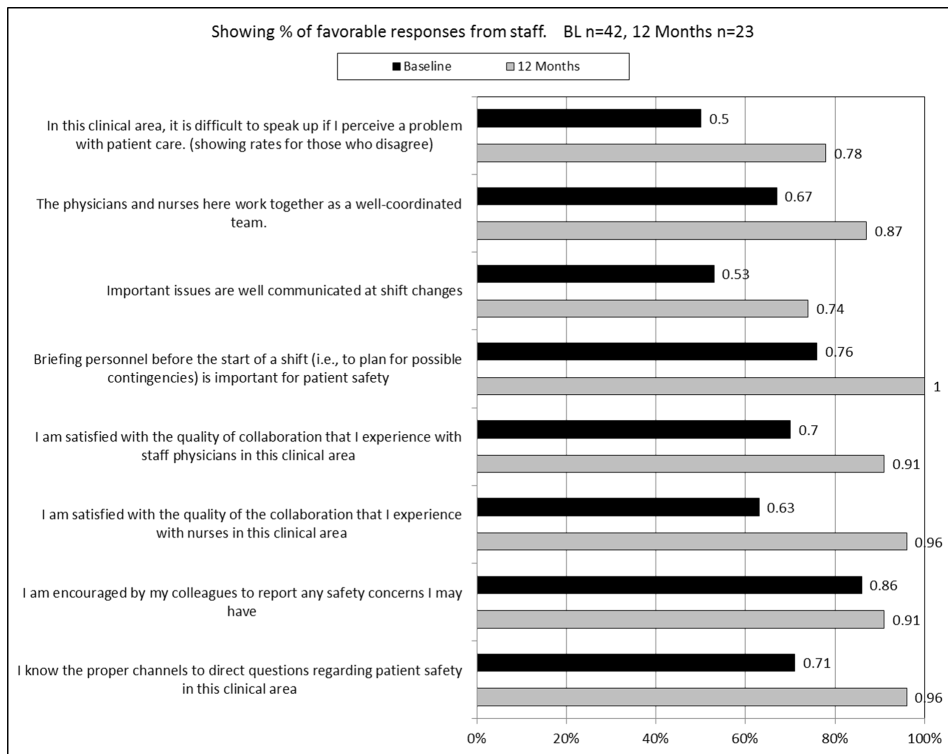
The TSCQ is a tool that allows health care organizations to measure staff attitudes about the existing safety culture within a particular patient care area. The TSCQ, adapted from Sexton’s Safety Attitudes Questionnaire,<sup>2</sup> was administered to the Las Cruces CBOC staff at baseline, six and 12 months post CTT to assess patient safety culture within the clinic. All 27 questions on the survey demonstrated improvement at one year from baseline. Table 1 depicts the percentage of staff that responded favorably (agree or agree strongly)

for each question. Eight of the 27 questions are shown.

The Las Cruces CBOC team, through the use of briefings, an

emphasis on prompt team communication, and the redesign of work processes and patient screening tools, successfully built a triage process for improving access to care for walk-in Veterans, while adding to the body of work that the Veterans Health Administration has been implementing since the late 1990s. Gail Graham, facility director, captured it best when she said, "The Las Cruces Community Based Outpatient Team exemplified the benefit of Clinical Team Training. The project to improve same-day access supports the MyVA access initiative and is a wonderful example of the benefit of team collaboration and diversity of input."

**Table 1**



**References:**

1. CTT: <http://www.patientsafety.va.gov/professionals/training/team.asp>
2. TSCQ: <https://psnet.ahrq.gov/resources/resource/3601>

**Use of the Mental Health Environment of Care Checklist to Reduce the Rate of Inpatient Suicide in VHA**

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In 2013, suicide was the tenth leading cause of death in the United States.<sup>1</sup> In 2013, 41,149 people killed themselves and over 494,169 people with self-inflicted injuries were treated in U.S. emergency departments.<sup>1</sup> Among Veterans we see approximately 22 deaths from suicide per day in the U.S. and five deaths from suicide per day among Veterans receiving care in VHA. There is a 42 percent increased risk of suicide among users of VHA services compared to rates of suicide in the U.S. general population.<sup>2</sup> In 2003, the American Psychiatric Association reported that approximately 1,500 completed suicides take place in inpatient hospital units in the United States each year and, despite focused efforts, one-third of these take place while the patient is on 15-minute checks;<sup>3</sup> in a recent review Sakinofsky found the rate of inpatient suicide

internationally to be between 1 and 4.5 per 1,000 inpatient discharges.<sup>4</sup> This article describes the development and implementation of the Mental Health Environment of Care Checklist (MHEOCC)<sup>5</sup> designed to review the environment of care in mental health units and identify environmental hazards associated with increased suicide risk. We chose to institute the use of a checklist so that those approaches and techniques that we identified to possess value could be standardized across all VA facilities. This was a conscious decision to depart from the traditional health care approach of inconsistently disseminating mitigation strategies by means that often involve oral communication or peer reviewed publications, and then hoping that staff would employ them. The use of a checklist is an explicit effort to reduce ambiguity of communication

and implementation to mitigate patient risk and improve care. In the summer of 2006, a confluence of two events occurred: The VA National Center for Patient Safety completed a review of all root cause analysis reports of inpatient suicides and serious suicide attempts<sup>6</sup> and senior leadership recognized the need for greater national standardization in inpatient psychiatric units. A multidisciplinary committee was formed, charged with the task of developing a checklist to be used to identify environmental hazards on acute mental health units treating suicidal patients. The committee developed both general guidelines to be applied to all areas of the psychiatric unit, and detailed guidelines for specific rooms, such as bathrooms, bedrooms and seclusion rooms. The criteria for the checklist were based on both the data collected from Root Cause



Analysis reports<sup>6</sup> and the extensive experience of the committee members. In addition, a second system was developed to rate each identified hazard for the level of risk on a scale of 1 to 5: “1” represented minimal risk and “5” represented critical risk requiring immediate abatement. Drafts of the checklist were extensively pilot tested in VA hospitals during the spring and early summer of 2007.

In August 2007, as a result of actions taken by VA leadership, use of the checklist became mandatory in all VA mental health units treating suicidal patients. Every mental health unit in the VA system was required to form a Multidisciplinary Safety Inspection Team (MSIT) consisting of a suicide prevention coordinator, patient safety manager, facility occupational safety manager or specialist, psychiatric unit nurse manager, a non-psychiatric unit nurse manager, psychiatrist, mental health worker (e.g., an out-patient case manager, therapist, or psychology tech.), representative from engineering, and a representative from environmental services to review the unit on a quarterly basis. The teams were required to submit a list of all identified hazards – along with their plans for abatement to their facility directors and to a national database maintained by the Center for Excellence in Suicide Prevention located at the Canandaigua VA Medical Center in N.Y. Since that time patient safety

and mental health staff have worked together to use the checklist to identify and abate suicide hazards on mental health unit every six months – over 15,000 individual hazards that could have resulted in a Veteran suicide have been fixed! We have also moved to a web-based, data-collection system using the Patient Safety Assessment Tool (PSAT). The PSAT is a web-based tool that can be accessed by anyone in VHA. Every six months we load an updated MHEOCC onto the PSAT where staff can use it to conduct their bi-yearly safety inspections.

VA NCPS continues to monitor RCA reports of suicide attempts and completions on inpatient mental health units in VHA and have found that hanging continues to be the most commonly reported method for inpatient suicide, and doors, especially interior doors, are the most common anchor points. In addition, sheets and bedding continue to be the most common type of lanyard for hanging. In a systematic review of suicide by hanging, Gunnell et al<sup>7</sup> report that 50 percent of all hanging suicides have a ligature point below the head so it is important to identify anchor points both above and below the head and even those relatively close to the floor. Nevertheless, since the MHEOCC was deployed we have seen a significant decrease in the number of suicides on mental health units; and we have also realized a significant decrease in the rate of

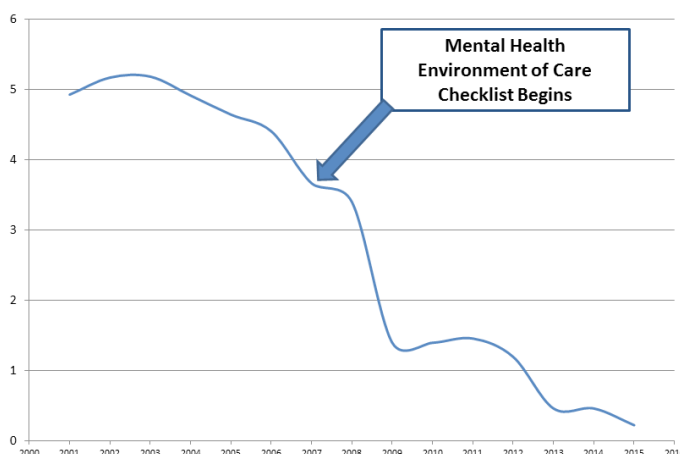
inpatient suicides on mental health units (see Figure 1).<sup>8</sup> Thanks to the hard work of patient safety and mental health staff in VA, inpatient suicide on psychiatry units in VA continues to be extremely rare. As we move into the future, we will continue to look at the results of the MHEOCC and make recommendations

for improvements in mental health units nationally. NCPS continues to modify and add questions to the MHEOCC based on reports from the field of hazards or adverse events encountered at the local level. In this way we can use local reports to inform the VHA system nationally and make care safer for all Veterans using our system.

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**Figure 1: Suicides per 100,000 admissions to acute mental health units in VA**



## Calling All Leaders: Paradigms for Embarking on the Just Culture Journey

Gary Sculli, MSN, ATP, NCPS director, clinical training programs and patient safety program manager

As an industry, health care has traditionally been characterized by a quick-fix mentality when adverse events and patient harm occurs.<sup>1</sup> Often leaders will want to know “who” made an error, or focus on the fact that policies and rules were not followed. As leaders, zeroing in on what are considered to be unsafe acts, and exacting discipline on those involved, is an approach that serves to alleviate immediate pressures to show critics that we are responding, but does little to remedy the dangerous cause and effect relationships lurking within the organization.<sup>2</sup> Once front-line staff believe they will be punished for errors and rule violations that occurred either inadvertently or with good intent, they will stop communicating with organizational leaders and safety personnel altogether. Unsafe conditions, broken processes, minor errors, or close calls that can signal the evolution of bigger problems later on, are concealed. Over time, sensitivity to the true state of risk in the operational environment is muted, and when patient harms and adverse events occur, you will perpetually feel blindsided. The temptation to respond punitively is strong and the cycle continues.<sup>3</sup> Put very simply – you cannot fix things you know nothing about. Your greatest and most valuable resource is an engaged front-line staff that surveys the patient care system for risks, openly communicates those risks, and takes part in devising workable solutions to improve the system. The methodology to achieve this desired state can be found in an organization-wide implementation of a just culture. The following definition of a just culture has been widely discussed:

*An atmosphere of trust in which people are encouraged (even rewarded) for providing essential safety-related information. Individuals trust that they will not be held accountable for system failures; but, are also clear about where the line must*

*be drawn between acceptable and unacceptable behavior.*<sup>4</sup>

While this definition seems straight forward, it is important to expand the discussion a bit. Health care leaders are responsible for the systems within which individuals work. If that system is flawed, creating conditions that facilitate mistakes, then accountability rests with those that have the authority and decision-making power to change it.<sup>5,6</sup> It is inherently unfair to hold staff accountable for things that are beyond their control. For example, we can exonerate a nurse who is repeatedly interrupted by visitors while trying to administer medications on an inpatient unit, and then commits a medication error. The system creates conditions where the nurse is subject to distractions and interruptions while attempting to carry out a safety sensitive task. Stewards of the system decide when visiting hours will be, not staff. Thus we get the part of the definition that talks about individuals not being held accountable for system failures. But let's go a step further. It is a fact that even in the most robust of systems, well-meaning individuals can still commit cognitive slips and mistakes that lead to adverse events and harm. It is also a reality that individuals in a system will at times purposefully, and with good intent, practice deviations from prescribed protocols to meet workload demands. In a just culture, neither case calls for formal discipline. Let's examine two pre-requisite paradigms that form the basis of a just response to errors and adverse events.

### **Paradigms About Human Error and Drift**

“People should just know what to do.” This was the statement that came from an executive health care leader in the wake of an adverse event where a patient was seriously harmed. This statement would be

true in a perfect world. But, the world is full of imperfect people working in flawed systems designed by these very same imperfect people. People often know what to do, but things simply don't go as they intended. Fatigue, high-task load, high-mental load, distractions, interruptions, poor equipment design, poor process design, clumsy technology, communication breakdowns, poor lighting – the list goes on.<sup>7</sup> All of these things can strain the limited attention and working memory of the average human. In the blink of an eye a well-intended act can morph into an error.

In 2003, the United States Air Force Thunderbirds experienced the crash of an F-16 fighter jet during an airshow at Mountain Home Airforce Base, Idaho.<sup>8</sup> The pilot took off and climbed aggressively to an altitude at which his maneuver would begin. As he rolled the jet inverted at the apex of his climb, he began the descent toward the runway – so far so good. However, the pilot soon realized there would not be enough altitude to arrest his descent and level off as he had done so many times before. He ejected fractions of a second before the jet crashed and exploded in plain view of spectators. An investigation revealed that the pilot experienced a cognitive slip, entering the maneuver at the wrong altitude. Mixing up the altitude for the maneuver as it is carried out in Nevada where the Thunderbirds practice, with the required altitude at Mountain Home in Idaho, resulted in a maneuver initiated about one-thousand feet too low. This is a statement about the human condition. Whether it is an emergency room physician's misdiagnosing chest pain as a myocardial infarction when it is really a pulmonary embolus, an ICU nurse programming an infusion pump incorrectly, or a USAF Thunderbird executing a maneuver at the wrong altitude, the thread that binds each is simply *the state of being human*. No matter how

good we are, or how good we think we are, errors will happen - period. Even technical elites and the most experienced experts can have an intimate role in the most unthinkable errors. In the words of James Reason, "The best people can make the worst errors."<sup>9</sup> As a prerequisite to moving forward with a just culture implementation, the following paradigm must be accepted:

*"Human error is ubiquitous and inevitable. Human error is not a choice. No one is immune."*<sup>6,10</sup>

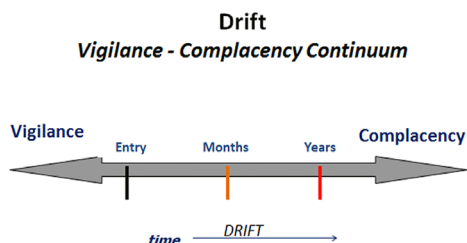
You might think that this is self-evident, but if you cannot fully embrace this paradigm, it will be difficult to find success in your just culture endeavor. You will continue to see those who make errors as wrongdoers - flawed and careless - rather than simply human. The focus will inevitably remain on seeking retribution for individual acts rather than a thorough analysis of the quality of the human-system interface. For leaders, accepting the non-discriminatory and inevitable nature of human error appropriately leads us to focus energies on creating systems that anticipate, manage and mitigate the effects of errors and unsafe conditions before they cause harm.

The next paradigm is a bit more controversial - but also a trademark of human behavior and central to just culture methodologies. The Vigilance- Complacency continuum (see Figure 1) depicts human professional behavior.<sup>11</sup> As we enter a profession or start a new job, we exist at the vigilance side of the continuum. For example, book and technical knowledge is fresh in our minds. Processes and standard operating procedures are well known and adhered to. We think about risks and how to avoid danger, we double check and verify; we are vigilant. However as time passes, things begin to change. The technical knowledge that forms the basis of the procedures and practices we follow gets stale and harder to recall. Thoughts about risks might be usurped by feelings of comfort, predictability and routine. The need to verify and double check may wane.

Production pressures and high-task loads that define the day-to-day "real-world" operational environment find us practicing short cuts and minor procedural violations to get the job done. When you couple these things with the protracted absence of significant errors and/or failures we, by degrees, migrate to the right on the continuum. We are now complacent. This movement toward complacency can be referred to as "drift." Drifting toward complacency is a natural human evolution. Knowledge gets stale and comfort sets in; shortcuts and workarounds become habits. These procedural deviations, the behavioral product associated with drift, are called "at-risk" behaviors. This brings us to the second paradigm which must also be accepted if you are to move successfully forward with just culture implementation:

*"Drift is ubiquitous and inevitable. The behaviors associated with drift such as short cuts and minor procedural violations are choices. No one is immune."*<sup>2,3,6</sup>

**Figure 1**



**What to Do About Staff Behaviors**

The implementation of a just culture is built upon the paradigms previously discussed. This aids organizational leaders in formulating a plan to deal with employees involved in mishaps and adverse events. In cases where an individual makes or participates in an error while working appropriately and in the patient's best interest, the system is analyzed via the Root Cause Analysis (RCA) process and the staff member(s) involved is consoled.<sup>2,6,12</sup> On the other hand, in a just culture, when employees purposefully make dangerous choices with little regard for the risks they create, formal discipline of that

employee is appropriate. But what about at-risk behaviors resulting from drift? As a general rule in a just culture, at-risk behaviors do not rise to the level of formal discipline as they are not a product of malintent. In such cases staff members make potentially unsafe choices via short cuts or routine rule violations, but believe their actions still reside within a "safe place." In their minds they are doing what is right for the patient while meeting day-to-day operational demands.<sup>2,6</sup> Investigations in the wake of an adverse event often find that drift behaviors are habitually practiced by several individuals in a department or unit. The unit culture as a whole has slowly drifted into the place where mildly deviant actions are normalized and the associated risks are not seen. It is also important to consider that leaders may inadvertently reinforce at-risk behavior through a visible and audible focus on budgetary or performance thresholds while de-emphasizing the science of patient safety.<sup>13</sup> Whether correct or not, tacit messages are sent to staff that imply "productivity trumps safety." The just culture response to at-risk behavior is:

1. Coach the employee involved - meaning to teach and supervise, to act as a trainer, to give instruction. The coaching should center on behavioral modifications to manage and reduce risk.
2. Remove incentives for staff to engage in at-risk behavior or make unsafe choices.
3. Analyze and improve the system via the RCA process to truly understand "why" at-risk behaviors are occurring.

Punitive reprisals are replaced with a thoughtful response that considers both intent and the inevitability of humans to drift. Energies are directed at correcting employee behavior in a supportive manner outside of the disciplinary process, while fixing system elements that create preconditions for at-risk behavior to flourish.<sup>2,6</sup>



To be successful in managing risks, health care organizations require engaged employees willing to be transparent about burdensome processes and the existence of work-arounds in the operational environment. They also require a culture that freely reports errors, close calls and unsafe conditions.<sup>9</sup> This necessitates trust between leadership at all levels and front-line staff. In building that trust, leadership must make it clear that no one will be held to a standard of perfection; subject to discipline and censure for simple human error and drift.<sup>4</sup> As Lucian Leape points out, “people will report only the things that they cannot hide.”<sup>14</sup> By accepting the prerequisite paradigms discussed here, along with a sustained just culture initiative, health care leaders can migrate their organizations toward the desired state; where people report the things they can hide, choosing not to, so the system can be augmented in the patient’s best interest.

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**Putting a Face to a Name: Your Patient Safety Team**



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**NCPS Offers a Just Culture Program**

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NCPS is pleased to offer a program entitled “My Voice Matters” (MVM). The program is comprehensive and aims to partner with VA facilities interested in creating, and sustaining a just culture. The subtitle for MVM is: “Creating high reliability through a fair and just culture.” This statement was chosen carefully. Ultimately, the journey toward high reliability requires a culture that is deeply committed to patient safety and risk mitigation at all levels in the organization. Put simply, an antecedent for high reliability is a safety culture, and one key component of that safety culture is the presence of a just culture. In this climate staff are actively engaged in identifying and reporting potential hazards to leadership. Staff willingly report errors, deviations from policy, mishaps, and close

calls for the sake of transparency and organizational learning. They understand that the preconditions leading to failure in the care delivery system must be exposed and thoughtfully corrected; otherwise such failures will perpetually reappear, putting patients in harm's way. For this to occur, staff must feel safe in speaking up. They must trust that leadership will not default to discipline and that they will not be held to an unattainable standard of perfection. My Voice Matters exists to assist VA leaders in creating the climate for that trust to take hold and flourish. The program's mission statement is:

*To engage all VHA leadership in the creation and sustainment of a safety culture; one in which employees actively report safety concerns, even their own errors, without fear of a default to reprisals or punitive action, so the organization can learn about its failures and improve its care delivery system. To clearly define the boundaries used to determine individual and organizational accountability.*

My Voice Matters has eight elements. Implementation of the first three elements is required. The remaining five are optional adjuncts that will help to strengthen and sustain the initiative. Facilities can choose to implement all or none of the adjunct elements. All program elements are listed and described in the table below:

Workbooks with information on all elements will be provided for each member of the facility-based just culture implementation team. NCPS plans to follow up with all of those enrolled in the program to help facilities stay on track and to assist with measuring program effectiveness.

Interested in "My Voice Matters"? Contact NCPS via the following email address: [VHANCPSMYVOICE@va.gov](mailto:VHANCPSMYVOICE@va.gov)



Required MVM Element	Description
Patient Safety Culture Analysis	A review of the latest patient safety culture survey is conducted with facility leadership and patient safety personnel. The purpose is two-fold: To compare the results with previous surveys and to establish a baseline prior to implementation of MVM.
Just Culture Seminar for Leadership	On-site NCPS faculty deliver a 3-hour seminar covering key concepts and tools required for a theoretical understanding and practical application of a just culture program. The seminar is designed for all top, mid-level and front-line leaders and supervisors in the organization.
Just Culture Seminar for Front-Line Staff	Just culture concepts are imparted to all front-line staff in all areas (both clinical and non-clinical) by a cadre of facility-based champions. The champions are selected by facility top leadership.

Optional Adjunct MVM Element	Description
Leadership Walk Rounds	On a perpetual basis, top leaders engage in prescheduled scripted conversations with front-line staff to determine what risks and safety vulnerabilities are of concern to them. The information is collected, corrective actions are taken, and those actions are communicated back to the front line to close the loop.
Monthly Safety Forums	A series of short (45 minute) meetings are conducted by facility personnel on a monthly basis to review a summary of select adverse event and/or close call cases; the forum is open to all staff. The review covers the events from the reporting phase through to the corrective system actions put in place via the RCA process. Just culture concepts are also reinforced and reporting behaviors are openly commended. Top leadership is present to engage in conversation with staff if needed. The forum aims to reinforce reporting behaviors and communicate openly about failure and system improvements.
Clinical Team Training (CTT) in Key Areas of the Facility	Leadership selects clinical areas to receive team training from NCPS. This on-site training by NCPS faculty is multidisciplinary and can be administered in any clinical area. Units such as the emergency department, intensive care, and the operating room are common high-risk and/or high-turnover areas that receive CTT. Clinical Team Training is also effective on medical-surgical, community living center, and behavioral health units. Curriculum covers topics such as team leadership, assertive communication, standardized communication, situational awareness and team decision-making. Teams learn how to practice safety behaviors and implement countermeasures to manage threats and risks in the operational environment. The training includes the use of interactive classroom-based learning sessions and patient simulation.
Root Cause Analysis (RCA) Training for Front-Line Staff With Dedicated Time Sanctioned by Leadership for Staff to Serve on RCA Teams.	NCPS faculty conduct on-site training for front-line staff. The course is designed to give staff the necessary tools and information to serve on RCA teams chartered by the facility director. Upon completion of the training a roster is developed which assigns participants to upcoming RCA teams. Staff gain a greater understanding about what happens <i>after</i> a patient safety report is submitted, a greater appreciation for the importance of reporting, and how systems based improvements are developed. Staff also witness the importance placed on patient safety activities through the experience of training and dedicated time to participate fully in the RCA process.
Lean Fundamentals	Facility personnel develop with assistance from NCPS a plan to disseminate the principles and tools used in "lean". An emphasis is placed on empowering front-line staff to actively survey the patient care delivery system and devise improvements that serve to make processes more efficient. Staff will learn to see processes through a lens that helps to identify and eliminate unnecessary steps while also balancing the need for redundancies that enhance safety.