Institute *for* Healthcare Improvement

# Declaration to Advance Patient Safety

## National Steering Committee for Patient Safety

May 2022

The Institute for Healthcare Improvement convened the National Steering Committee for Patient Safety as a collaboration among 27 national organizations committed to advancing patient safety.

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This **Declaration to Advance Patient Safety** is issued on behalf of the National Steering Committee for Patient Safety (NSC) and is a subsequent publication to the 2020 report, *Safer Together: A National Action Plan to Advance Patient Safety,* and its accompanying resources. The Institute for Healthcare Improvement convened the NSC as a collaboration among 27 national organizations committed to advancing patient safety.

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# Executive Summary

The safety of patients and the health care workforce is a public health emergency, exacerbated by the worsening national outcome trends during the COVID-19 pandemic. The impacts of this crisis on persons who receive and provide care and on our heavily stressed systems persist. The return to a pre-pandemic, status quo state of safety is insufficient for ensuring safe, reliable, and equitable care for every person. Rather, our recovery trajectory requires long-term, intensive focus to create, rebuild, and sustain the foundations for safe care.

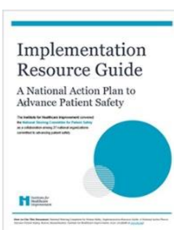
*Safer Together: A National Action Plan to Advance Patient Safety* provides concrete guidance for leaders to assess and fortify their total systems approach to safety by addressing specific needs and capabilities that enable safe care. These "prerequisites for patient safety" are organized in four foundational areas: culture, leadership and governance; patient and family engagement; workforce safety; and learning system.[1]

**The National Steering Committee for Patient Safety calls upon every health care leader across the continuum of care to recommit to advance patient and workforce safety by deploying the National Action Plan in their organizations.**

To achieve the vision of health care that is safe, reliable, and free from harm, collective and coordinated action is necessary. In commitment to this shared purpose, each health care leader committed to safety must:

1. **Review the 17 recommendations and tactics to advance patient safety** presented in *Safer Together: A National Action Plan to Advance Patient Safety*, a report that harnesses the knowledge and insights of the National Steering Committee for Patient Safety members.

2. **Identify a senior sponsor and core team** charged with deploying the Self-Assessment Tool, a companion resource to the National Action Plan, to evaluate your organization's current state across each of the four foundational areas, prioritized as essential to create total systems safety.




3. **Establish and enact strategies, tactics, and measurement and improvement plans** to meaningfully fortify and sustain your organization's performance in each of the four foundational areas by leveraging the Implementation Resource Guide, a companion resource to the National Action Plan.

# A Total Systems Approach to Safety

The Institute for Healthcare Improvement convened the National Steering Committee for Patient Safety (NSC) and charged the NSC with the creation of the first US national action plan for patient safety.

**Safer Together: A National Action Plan to Advance Patient Safety**

The National Action Plan presents a total systems approach to safety, with 17 specific recommendations for advancing safe and highly reliable care by driving improvement in four foundational areas:

- Culture, leadership, and governance;
- Patient and family engagement;
- Workforce safety; and
- Learning system.

The foundational areas are prioritized as essential to create total systems safety and establish the necessary conditions for delivering safe care and preventing harm.

Based on stakeholder consensus and grounded in principles that intentionally bring a health equity lens to patient and workforce safety, the National Action Plan is accompanied by an organizational Self-Assessment Tool and Implementation Resource Guide that translate important safety concepts and principles into purposeful actions that are important for every organization.

# What Every Health Care Leader Must Know about Safety

Throughout the patient safety field, many have contributed to an extensive collection of safety science, knowledge, and experience that has accumulated over the past two decades. Together, the persistence of longstanding challenges to patient safety and worrisome setbacks in patient and workforce safety performance during the COVID-19 pandemic have amplified the critical need for all health care leaders to take urgent action.[2-27]

**It is the responsibility of every executive and governance leader in health care to commit to the moral, non-negotiable core value of safety for all and to foster collective action to uphold this value**.

These actions should establish safe, equitable, and reliable care as a central theme in the organization's mission, the core competencies of leaders, and standard ways of working. When combined with actions described in the recommendations set forth in the National Action Plan, this commitment to safety fosters improved outcomes and experience for patients and the health care workforce and provides collateral benefits that increase the overall value of care.

To date, attention on health care safety has often focused on addressing specific safety projects, such as eliminating healthcare-acquired conditions or implementing specific clinical bundles or practices. While progress to improve safety has been demonstrated over time, this progress is often not consistent or sustained since attention to these specific issues may be fleeting. The number of threats to safety also exceeds the capacity needed for this problem-by-problem approach.

Far less attention has been placed on addressing safety from a total systems approach, in which safety foundations are reliably and uniformly applied throughout the organization or health system, targeting desired improvements in multiple aspects of care.[28] While specialized attention is still needed to prevent specific types of harm, this focused work on total systems safety is more efficient and seamless in organizations that invest in building strong foundations and competencies for improving safety.

Hence, the need for leaders to focus on the "total systems safety bundle" presented in the National Action Plan — four foundational elements that are essential to safe care: culture, leadership, and governance; patient and family engagement; workforce safety; and learning system.[1] Leaders must communicate their commitment to total systems safety across the organization, to mid-level leaders and point-of-care staff, creating alignment and engagement for system-level change across the workforce.

# The COVID-19 Pandemic: Impact on Safety

In response to COVID-19, health care leaders and systems needed to shift their focus to address immediate pandemic priorities. The response to the urgent situation diverted resources from other existing efforts. Some organizations that had reliably hardwired safety into their systems through consistent focus on the foundational areas reaped the benefits of these investments during the pandemic. The foundational values and practices put in place proved essential to preventing many different types of threats to patient and workforce safety and well-being that emerged or worsened during the pandemic. By contrast, many other organizations experienced drifts from their attention to safety during the pandemic, and as a result faced setbacks in safety events and other critical indicators such as clinician burnout across the care continuum.[3]

**The COVID-19 pandemic substantially magnified patient and workforce safety risks and harms and introduced new threats to an already fragile system.**

| Workforce Safety |
|---|
| • In a 2022 survey of more than 13,000 physicians in 29 specialties, 47% reported feeling burned out and 21% reported suffering from clinical depression.[4-5]<br>• Studies and surveys of health care workers across the United States report burnout rates of up to 76%.[6-9]<br>• A 2021 survey identified that nurses remain stressed almost 2 years into the pandemic, with 75% of nurses reporting feeling stressed and 62% reporting feeling overwhelmed.[10]<br>• When comparing 2021 data with 2019 data, Press Ganey noted performance declines across all health care culture of safety metrics, with particularly poor performance in adequate department staffing and reasonable job stress.[10-12]<br>• In a national study of more than 20,000 health care workers, the highest stress scores during COVID-19 were observed in those who identified as female and racial minorities.[13] |
| **Patient and Family Engagement** |
| • Racial and ethnic subgroups experienced a disproportionately higher percentage increase in deaths compared to their white counterparts.[14]<br>• Restricted access to care and fear of seeking care during the pandemic has led to missed and delayed preventive care, treatments, and diagnostic procedures.<br>    ○ In an online survey early during the pandemic, 41% of US adults reported delaying or avoiding medical care because of concerns about the pandemic and this avoidance of care was significantly higher among Black and Hispanic populations, unpaid caregivers, and persons with disabilities or two or more underlying medical conditions.[15]<br>    ○ Studies have noted the negative health impact of delayed diagnosis and treatment due to COVID-19 across emergent and chronic conditions.[16-18] |

| Learning System |
| --- |
| • Hospital-acquired infections increased, including an estimated 47% increase in central line bloodstream infections, 45% increase in ventilator-associated events, and 19% increase in catheter-associated urinary tract infections.[19]<br>• Skilled nursing facilities saw a 17.4% increase in falls causing major injury and a 41.8% increase in rates of pressure ulcers.[20]<br>• An increase in preventable 30-day revisits to hospitals were reported during COVID-19.[21]<br>• New approaches to caring for patients, including telehealth and changes to standard procedures, coupled with supply chain interruptions and increased demand for medication and supplies have resulted in unintended safety consequences.[29] |
| **Culture, Leadership, and Governance** |
| • Between February 2020 and September 2021, the health care industry lost half a million workers.[21]<br>• In an assessment of 160 hospitals, the Agency for Healthcare Research and Quality found an alarming 40% reduction in staff perceptions that management made safety a priority between 2018 to 2020.[23-25] |

# Why the National Action Plan and Leadership Action Matter Even More

Leadership commitment and action is critical to achieving the goal of zero harm in health care. Reliable implementation of the National Action Plan's four foundational areas — the "total systems safety bundle" — is essential for organizations to meaningfully reset and advance safe, reliable, and equitable care and to strengthen the resilience of systems. The National Action Plan provides leaders with an opportunity to candidly assess the current state of their organization's foundational safety practices and offers actionable solutions for a clear path forward to both address setbacks that have occurred during the pandemic and to advance and sustain the positive gains that have been achieved.

The current and future safety consequences for our patients and our health care workforce require the time and full attention of health care leaders. Whether the future holds stability or, more likely, new crises, for leaders the implications of safety are undeniable. Strengthening the foundation for safety is no longer a choice — it is a leadership imperative. The National Action Plan is our path forward.

Health care leaders must commit to safety as a core value and reliable implementation of these foundational areas through the following actions:

1. **Review the 17 recommendations and tactics to advance patient safety** presented in *Safer Together: A National Action Plan to Advance Patient Safety*.
2. **Identify a senior sponsor and core team** charged with deploying the Self-Assessment Tool in your organization to evaluate your organization's current state across each of the foundational areas presented in the National Action Plan.
3. **Establish and enact strategies, tactics, and measurement and improvement plans** to meaningfully fortify and sustain your organization's performance in each of the four foundational areas by leveraging the Implementation Resource Guide, a companion resource to the National Action Plan.

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