Patient engagement is essential to the provision of safe, quality healthcare. Evidence shows that patients who are involved in their health care incur lower costs and have improved health outcomes. Although some organizations are incorporating patient perspectives to improve and redesign services, there are challenges in determining how to meaningfully integrate the perspective of the patient to improve patient safety.

In a June 2016 issue of the *British Medical Journal, Quality and Safety* article (“At a Crossroads? Key Challenges and Future Opportunities for Patient Involvement in Patient Safety”), the authors identify several challenges of including patients in safety improvement:

- Research has not included some of the most vulnerable patients, thereby limiting the generalizability of research results;
- Patients’ perspectives are sought in a variety of ways (surveys, patient websites and social media) resulting in an immense amount of data that makes it difficult to prioritize and implement actionable improvements;
- The feedback provided by patients may not fit within the narrowly defined confines of quality and safety, so may be dismissed;
- Feedback may not be considered relevant because it does not fit within the distinct structures of health services (since patients often do not recognize those structures); and
- The lack of understanding of the relevance of safety concerns across various healthcare settings.

The article suggests that patient involvement as partners to ensure quality and safety in care will vary, so different opportunities for engagement should be offered and utilized. Some patients may only want to complete a quick survey while others may want to tell their stories in detail; qualitative and quantitative data can both be beneficial for an organization.

Additional suggestions for health care organizations include:

- Providing resources and support for patients to be involved in design, measurement and improvement of healthcare services;
- Recognizing and embracing a wider view of risk and safety. Silos of organizational and professional boundaries should not limit the way data is gathered or acted upon;
- Encouraging specialties to be open to assessing the complexities of services, performance measures and opportunities to improve; and
- Streamlining the measurement of quality and safety data to create more meaningful indicators that could be used for service and safety improvements.

Many health care organizations are employing strategies such as education and shared decision making to better engage with patients. Shared decision making involves patients and providers working together when considering the patient’s condition; options, risk and benefits of treatment; patient preferences; and development of treatment plans. The primary responsibility of the physician is identifying the medical problem and providing reasonable options; patients have the primary responsibility for identifying and conveying their concerns and goals relevant to the decisions they must make (“Shared Decision-Making in the Medical Encounter: What Does it Mean?”, *Social Science and Medicine*, 1997).

Providing information to patients about diseases and treatments is valuable. However, patients must be provided the opportunity and encouraged to be active participants in their healthcare. In order to have meaningful
input into their treatment options patients need unbiased, objective information and options; they must be allowed time to consider and process the information; and have their concerns and goals should guide the decision-making process (“Informing and Involving Patients to Improve the Quality of Medical Decisions”, *Health Affairs*, 2011).

Although the practice of shared decision making is on the rise, when an adverse event occurs, meaningful communication with the patient often does not happen. Safety literature has shown that after an adverse event has occurred, patients (and families) want a provider to candidly discuss the incident with them, and that this is usually beneficial for both the patient and provider.

The Agency for Healthcare Research and Quality (AHRQ) recently updated the Communication and Optimal Resolution (CANDOR) Toolkit. The CANDOR process is an approach that providers can use to respond to an unanticipated incident that caused harm to a patient. The CANDOR process can be initiated even when the cause of the event is still being discovered. The process involves open engagement with patients and families. The CANDOR toolkit offers a framework to enhance short-term improvements such as the development of processes and systems to improve monitoring and reporting of adverse events. The long-term improvements include: better patient safety outcomes, a decrease in medical liability claims, and increased patient satisfaction scores. The CANDOR toolkit may be accessed at: [http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/index.html](http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/index.html).

Resources are also available to assist facilities in being proactive with patient engagement to prevent adverse events. In June 2016 the Institute for Healthcare Improvement (IHI) released the Always Event toolkit. Always Events are parts of the patient experience that are so essential for patient care that they should be performed consistently for every patient, every time by all health care providers. The Always Events Toolkit is designed to support leaders and care teams in partnering with patients and family members to co-design, reliably implement, and sustain and spread Always Events to improve the care experience. The link to the toolkit is: [http://www.ihi.org/resources/Pages/Tools/Always-Events-Toolkit.aspx](http://www.ihi.org/resources/Pages/Tools/Always-Events-Toolkit.aspx).

High Reliability Organizations (HROs) are entities that function in complex and high-hazard areas for extended time periods without disastrous failures or serious accidents. The industries first to embrace HRO concepts were those in which past failures had led to catastrophic consequences, such as airline crashes and nuclear reactor meltdowns. These industries found it essential to identify danger signals and respond to them immediately so that system functioning could be maintained and disasters avoided.

High reliability has been described as a “condition of persistent mindfulness within an organization” (Agency for Healthcare Research and Quality, Patient Safety Network, July 2016). HROs focus on systems when designing and evaluating for safety, yet remain aware that threats to safety are continuously emerging and vary from incident to incident. Therefore HROs create environments where potential problems are managed proactively; they are anticipated, detected early, and usually responded to before significant adverse consequences occur.

The five organizational characteristics that foster high reliability are as follows:

- **Preoccupation with failure** - understanding that threats to safety occur in areas no one suspects, so everyone is vigilant to what could go wrong and aware of small signs of potential problems;
- **Commitment to resilience** - the acknowledgement that system failures are unpredictable and there is a risk for failure. Potential safety threats are identified quickly and response occurs either before harm happens or seriousness is mitigated by the quick response;
- **Deference to expertise** - acknowledges that the people closest to the work are the work-experts; status and hierarchy are de-emphasized and expertise is valued. Everyone feels comfortable speaking up about potential safety concerns;
- **Reluctance to simplify** - acknowledges that the work is complex. Processes, successes, or failures are not simplified and underlying explanations are sought; and
- **Sensitivity to operations** - involves “big picture” thinking; people understand that they are part of a bigger system and maintain significant awareness of operational conditions.
The concept of high reliability in health care has received considerable attention, although health care leaders may be hesitant to commit to the concept because it seems unattainable, unrealistic, or is a distraction from regulatory and fiscal pressures (“High Reliability Health Care: Getting There from Here”, The Millbank Quarterly, 2013). This article assessed hospitals’ current performance against the principles of HROs and found that the average hospital is very far from being a HRO; rarely are the five characterizes of HROs guiding the actions of organizations. Health care organizations seemingly function with an expectation that failure and error are inevitable and a daily occurrence. The inability or unwillingness of organizations to scan for and identify adverse events creates misplaced confidence in their systems and complacency.

Additionally, a truly just culture is absent from many organizations; health care workers at multiple levels do not speak up about unsafe conditions, behaviors, and practices; poor communication is common; and there is an excessive amount of intimidating behavior that inhibits the reporting of safety problems. Furthermore, health care organizations are found to be tolerant of poorly designed and uncoordinated mechanical systems despite the fact they are not safe; for example, alarm fatigue is tolerated and accepted. Finally, hospitals do not value and allow the most expert individuals to contribute to and implement safety and quality solutions; instead there is a hierarchical approach within disciplines and throughout the organization.

The article concludes that there is no easy method for elevating a low-reliability organization to a HRO. However, three major changes were identified that would make a substantial difference toward progressing to a HRO. These include:

- Leadership’s commitment to a goal of ‘zero harm’ to patients – HROs are not tolerant of the current safety level and are always looking to improve it;
- Integrating all practices and principles of a safety culture throughout the organization. A culture of safety has three essential qualities: trust, reporting, and improvement. Trust involves eliminating intimidation, quickly responding to and fixing reported problems, and communicating improvements to those that reported concerns.
- The widespread implementation of the most effective process improvement methods and tools. The tools must be understood and used throughout the organization for them to be effective; training and accountability for all employees are essential.

One HRO resource for facilities is the Checklist for Assessing Institutional Resilience (CAIR). It was designed by James Reason & John Wreathall to help health care organizations assess the culture of patient safety in their workplaces. (http://www.ihi.org/resources/Pages/Tools/ChecklistForAssessingInstitutionalResilience.aspx)

AHRQ DATA IDENTIFY STATES THAT RANK HIGHEST IN HEALTH CARE QUALITY

Maine, Massachusetts, Wisconsin, New Hampshire and Minnesota were the nation’s top performing States when it comes to health care quality, according to AHRQ’s updated State Snapshots. The online tool is an interactive resource that provides State-level data showing how all 50 States and the District of Columbia performed on more than 250 measures related to health care quality and access. Drawn from AHRQ’s 2015 National Healthcare Quality and Disparities Report (QDR), the State Snapshots show how each State fared according to National Quality Strategy priorities; prevalence of diseases and conditions; health status of priority populations; insurance status; access to care; type of care; and setting of care. The link to the Maine information is: https://nhqrnet.ahrq.gov/inhqrdr/Maine/snapshot/summary/All_Measures/All_Topics

### Performance of All States Across All Measures

<table>
<thead>
<tr>
<th>State</th>
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UPDATES FROM THE SENTINEL EVENT TEAM

On-site reviews – The SET continues to conduct on-site reviews to determine if facilities are in compliance with the SE Rules and Statute.

Patient Safety Academy Conference - was held September 8th. Dr. Bryan Sexton was the keynote speaker. He spoke of the importance of resiliency and psychological safety, as well as the significant importance of healthcare workers maintaining a healthy work life balance and the impact of that on patient safety. Break-out sessions offered information on a variety of patient safety related topics such as: medications, patient advocacy, high reliability, telehealth, and superbugs.

Falls Collaborative- Scheduled for September 30th in Augusta. Falls are the second highest category of reported sentinel events in Maine for 2016. The SET has organized a Falls Collaborative scheduled for September 30th in Augusta at the Armory. This is an opportunity for several facilities to present their falls programs, sharing challenges and successes, and collaboration among participants. Additional details will be emailed to those enrolled.