PSNet
PATIENT SAFETY NETWORK

Safety Across The Board

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Defining *Safety Across the Board*

Safety Across The Board (SAB) is a concept originating from the Centers for Medicare & Medicaid Services (CMS) Partnership for Patients (PfP) Hospital Improvement Innovation Network (HIIN).[1] The overarching goal of SAB is to make the prioritization of safety a primary mission within an organization. In SAB, the concept of safety extends beyond individual process improvement initiatives and the traditional clinical care team to the level of the organization, and is a core value regardless of staff position or workforce role. A SAB ethos recognizes that healthcare organizations have a moral responsibility to ensure safety, with the objective of zero harm to patients, family/caregivers, and the workforce.

There are three key components necessary for foster SAB in a healthcare organization: culture, strong safety processes, and engagement.[1,2] Operationalizing these three components will vary by organization, but effective SAB is characterized by successful incorporation of all three.[1]

Culture[1]

Culture in the context of SAB encompasses many of the core concepts of a strong culture of safety. SAB culture prioritizes patient safety, encouraging the measurement, reporting, and identification of both present and potential future harms. Harm identification is transparent among the public, frontline staff, and senior leadership, but is non-punitive. The emphasis is placed on the opportunity for continuous learning from success, near misses, and safety failures. However, all staff are accountable for harm and are committed to continuously identifying and mitigating current and future safety threats. To do this effectively, engaging patients and their families is critical, as well as considering how social demographic factors may contribute to a patient's experience with the healthcare system.

In addition to a focus on the safety of patients, a strong SAB culture also focuses on workforce safety and the reduction of workforce-related harms. There is an awareness and acknowledgement that there are challenges and stressors to working as a frontline provider. The organization needs to make resources available to support the workforce and to engage staff around issues that can lead to burnout, while at the same time also celebrating successes.

Strong Safety Processes[1]

An institution operating under the principles of SAB is always seeking the opportunity to implement evidence-based practices and continuous performance improvement concepts. The institution is not only seeking the latest information and evidence from outside organizations and thought leaders, it is conducting its own performance improvement activities. This includes training around performance improvement concepts and approaches, team building, and providing education around safety tools and resources. Successful approaches are systematically spread throughout the organization and a formal organizational performance improvement strategy should be in place that considers how technology can be used to both monitor and prevent harms.

Engagement[1]

Engagement in SAB primarily focuses on the steps an organization can take to ensure that patient safety is a shared mission and objective for everyone in the organization. To support this goal, there must be continuous communication of this expectation at all levels of the organization, including among leadership, physicians, and nurses. Patient and family engagement is a critical component of organizational culture, as previously mentioned, and Patient and Family Engagement Advisory Councils (PFACs) can play a critical role in the identification of areas for improvement and provide a venue to demonstrate and recognize the importance of the patient and family. The existence and engagement of a PFAC helps patients and families know that safety is a priority for the organization.

Resources to Support *Safety Across The Board*

CMS through its HIIN program developed a resource to support organizations interested in achieving SAB. In it, users will find the following:

- A Driver Diagram illustrating the primary and secondary drivers that support the aim of preventing all harm.
- Tactics to support the implementation of the three core components (culture, strong safety processes, and engagement).
- Case studies highlighting successful implementation of the concepts of SAB in a variety of hospitals and health systems across the country and results associated with implementation.
- Hyperlinks to related resources, models, and approaches.

Authors

Eleanor Fitall, MPH
Research Associate, IMPAQ Health
IMPAQ International
Washington, DC

Kendall K. Hall, MD, MS
Managing Director, IMPAQ Health

IMPAQ International
Columbia, MD

Bryan Gale, MA
Senior Research Analyst, IMPAQ Health
IMPAQ International
Columbia, MD

References

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2 Safety Across the Board. PFCCpartners. Published September 22, 2014. Accessed July 28, 2020.