American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

June 29, 2006

Janet Corrigan, Ph.D.
President and CEO
National Quality Forum
ATTN: Safe Practices Project
601 13th Street, N.W.
Suite 500 North
Washington, DC 20005

Dear Dr. Corrigan:

On behalf of the American Hospital Association (AHA) and our 4,800 member hospitals, health care systems and other health care organizations, and our 35,000 individual members, we are pleased to provide comments to the National Quality Forum (NQF) and its steering committee charged with updating the agency's report on safe practices. The original list of safe practices has been helpful to many health care organizations striving to improve the safety of patient care. Nothing is more important to hospital leaders, health care professionals and the patients we serve than the safety and quality of care that hospitals provide.

The following comments may provide additional ideas to the steering committee and NQF about how the information contained in the draft report, which seeks to update the list of safe practices, can become even more useful in furthering safety improvement practices in America's health care settings. It is clear that the steering committee has done significant work and used their substantial technical expertise to draft the document. We congratulate the NQF for involving such a broad array of experts in reviewing the existing science and identifying additional safe practices. In many ways, the work process used to create this draft report could be a model for other NQF projects. By setting a broad and important goal – the identification of a parsimonious list of important practices that will effectively improve safety – and bringing together diverse groups of technical experts under the guidance of a small and highly knowledgeable steering committee, the NQF has created a draft document that is rich in ideas and information, and provides scientific foundation for its recommendations.

Comments on the Substance of the Practices

Usefulness of the Report. As the AHA previously commented in its letter about the Serious Reportable Events draft report, we believe that any steering committee charged with updating an existing report should first address whether the product continues to be useful. We strongly believe that the safe practices report is both important and useful, and would like to have a statement reaffirming its usefulness. It also may be important, in setting the framework for how the rest of the report is to be understood, to define the intended audience and the expectations as to how the report should be used. Important lessons learned from the previous NQF safe practices list also could be noted here, if the users provided feedback that was helpful in updating the list. We urge the NQF to include a recommendation from the steering committee that this list continue to be updated and identify additional safe practices which health care providers then should strongly consider adopting.

First Safe Practice. The first practice, "Create and Sustain a Healthcare Culture Of Safety," is critical, as reflected by the depth and breadth of the materials included in this section. Since responsibility for this particular safe practice lies with the boards of trustees and organizational leaders, the AHA sought specific input on this practice from hospital and health system CEOs and from our Committee on Governance. The AHA concurs with the steering committee's assessment that a health care culture of safety is "…arguably the most important safe practice..." The leaders and trustees with whom we spoke are keenly aware that they are expected to create the right environment and set safety as a top priority of the organization. They also yearn for good advice on what they can do to foster a vibrant culture of safety in their own organizations; yet, they struggled to find relevant ideas in the plethora of information provided in the "Safe Practice 1." They felt much of the information would assist those supporting leaders and governing boards in the work of creating and sustaining the right culture, but the responsibilities of leaders and boards in accomplishing the task should be more clearly defined.

Clearly, the practice elements that are listed in the current document – setting up systems to identify gaps in performance, measuring organizational culture, building capacity for teamwork and identifying and addressing existing risks – are important to organizational progress on safety, but it is not clear that simply engaging in these four tasks will lead to the creation of a culture of safety in the organization. The AHA suggests that the steering committee more explicitly describe the expectations of the board, the management team and the staff who support the board and management.

For example, the AHA Committee on Governance suggested that the document clearly state that it is the responsibility of the board to set safety goals (including organizational culture), ensure resources are provided and hold management accountable for achieving the goals. Similarly, there should be a statement on management's responsibility to take the critical actions necessary and identify key opportunities for changing operations to achieve the goals and bring about necessary changes. The management team needs to differentiate between behaviors that impose unacceptable risk to patients and errors in

care. Errors need to be investigated and opportunities to reduce risk identified, but individuals who make mistakes because they work in imperfect care processes should not be punished. Alternately, individuals engaging in behaviors that impose unacceptable risks, such as refusing to mark the site of impending surgeries in accordance with practice guidance, should be held accountable for their actions.

These roles and responsibilities for the board and management need to be clearly articulated, so that updates to management and trustees about how well the organization is doing in addressing any gaps in safety (Element 1) and surveys to measure culture (Element 2) will be well understood. However, extending the length of the current description of "Safe Practice 1" is not desirable. In reviewing the document, several hospital leaders said that the message of the first safe practice is lost in the existing details. Instead, we suggest that clearer definitions of the roles and responsibilities of the board and management replace much of what currently exists in the first safe practice, and that the material currently under this practice be captured in an appendix to further assist implementing this practice. The AHA believes that this first practice is of such significance that all materials currently listed in Table 1 continue to be part of the report, so that they can assist health care organizations in implementing these practices. We also believe that a simple and compelling explanation of board and management responsibilities would have greater impact, with more appropriate supplementary guidance.

If you have questions, please contact the AHA's Nancy Foster, vice president for quality and patient safety policy, at (202) 626-2337.

Sincerely,

Carmela Coyle
Senior Vice President, Policy