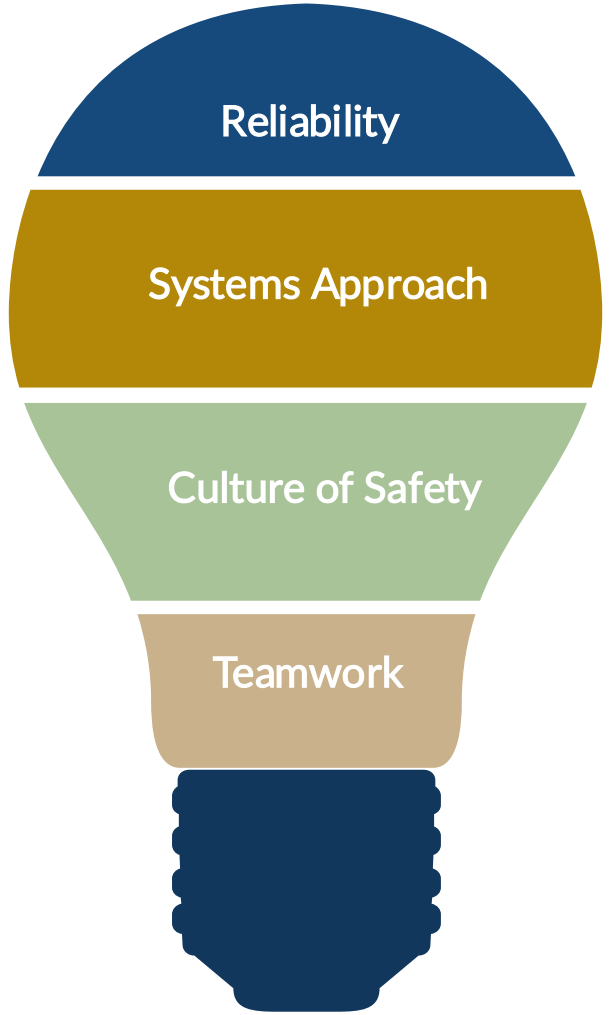
2026 Oregon Rural Health Conference Presentation Slides



PATIENT SAFETY SERIES

"From Reactive to Reliable: Building a Culture of Patient Safety in Rural Hospitals"

What does it take for rural healthcare organizations to achieve an environment in which reliable processes exist with a culture of continuous learning?
It takes more than just telling employees to try harder to be safe. It requires a systematic approach that addresses the fundamental ways in which providers interact and provide care. The purpose of this session is to provide critical steps involved in creating and sustaining a robust patient safety program.



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Learning Outcomes

By the end of this presentation, you should be able to:

- Recall the core principles of high reliability organizations (HROs)
- Identify and mitigate systemic risks before harm occurs
- Describe strategies to promote psychological safety, transparency, and accountability
- Identify practical tools for engaging frontline staff in safety initiatives
- Recall the role of Patient Safety Organizations

Learning Outcome Standard: This workshop is based upon program standards defined by the Agency for Healthcare Research and Quality, Institute for Healthcare Improvement, and other nationally recognized resources in the science of patient safety.

Introduction:
High Reliability in Rural Healthcare

A compelling vision with patient and workforce safety as a core value is essential to achieving safe care.

Zero harm is the aspirational "North Star."

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Why it matters in rural hospitals:

Building Safer, More Consistent Care in Resource-Limited Settings

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Workforce Challenges

Key Point: Resilience, collaboration, and communication among teams is entirely dependent on our workforce and structures.

Broad impacts on workforce resilience include:

- Burnout
- Workplace Violence
- Fatigue
- Stress
- Shortages
- Compassion fatigue
- Production pressure to do more with less

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How High Reliability Helps Small Teams

- ✓Standardized workflows reduce guesswork
- ✓Shared mental models improve coordination
- ✓Clear expectations lighten cognitive load
- ✓Reliability becomes a team habit, not an individual effort

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Limited Specialty Access ↠ Need for Strong Processes

Key Point: When specialists aren't on-site, processes must be strong.

- Frontline teams manage high-risk situations longer
- Protocols and checklists become essential safety nets
- Rapid escalation pathways ensure timely decisions
- Telehealth helps—but isn't always available or reliable

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How High Reliability Strengthens Clinical Reliability

- ✓Ensures readiness for rare, high-risk events
- ✓Builds system-level expertise when specialty depth is limited
- ✓Supports safe transfers and coordination with regional partners
- ✓Prepares teams for contingencies when technology or transport fails

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Community Trust and Continuity of Care

Key Point: Rural hospitals serve people they know personally.

- ✓Safety events affect community confidence
- ✓High reliability demonstrates commitment to safe, transparent care
- ✓Patients return for years—reliability improves long-term outcomes
- ✓Strong trust supports recruitment, retention, and sustainability

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Why High Reliability is a Strategic Advantage

Enhances patient safety

Improves staff confidence and teamwork

Strengthens community relationships

Supports financial stability through fewer adverse events

Positions the hospital as a trusted, high-quality care provider

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High Reliability: Mindful Organizing



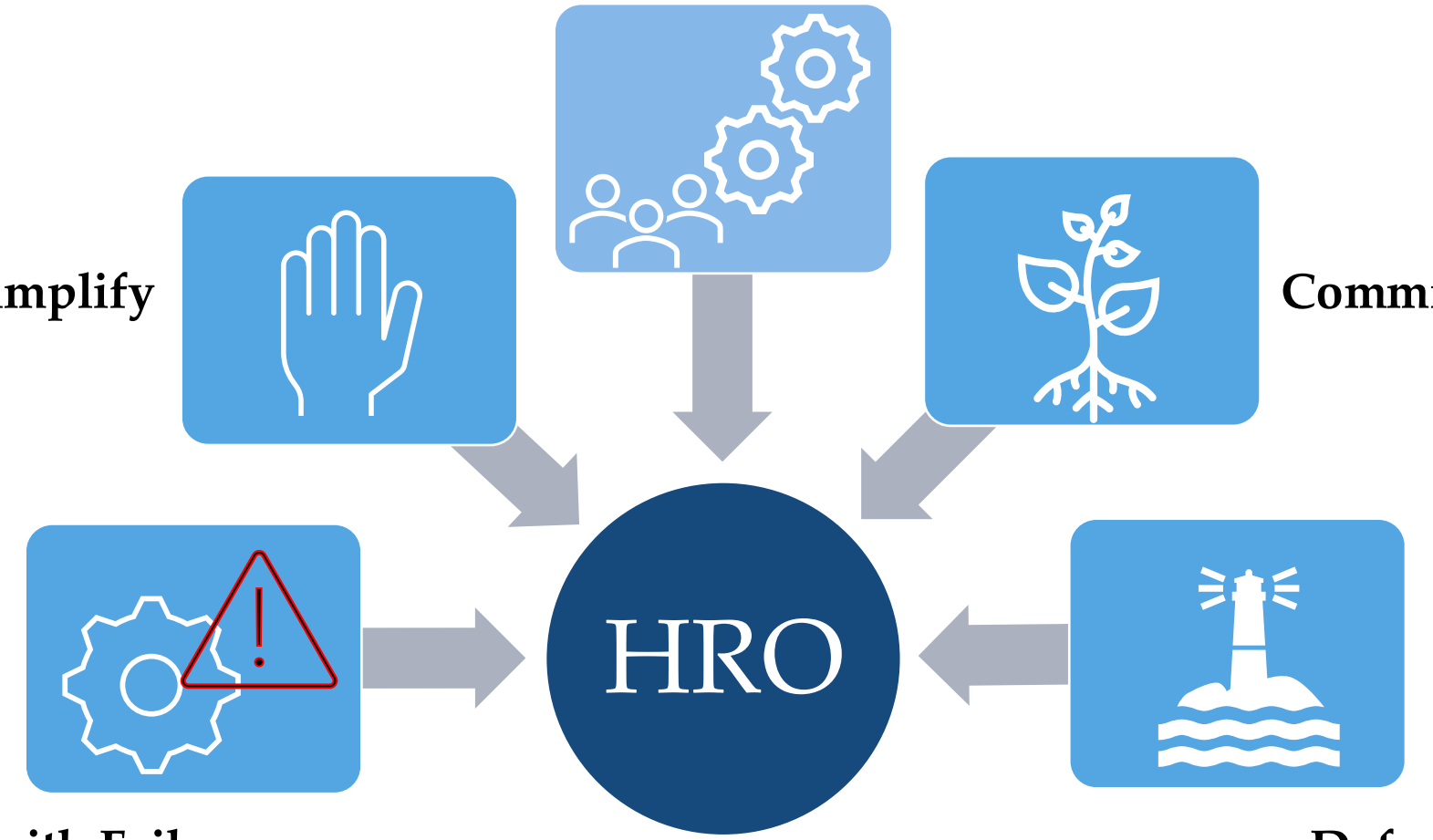
"mindful" organizations actively anticipate, detect, and adapt to unexpected events.

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Five Principles of High Reliability

Sensitivity to Operations

Reluctance to Simplify



Commitment to Resilience

Preoccupation with Failure

Deference to Expertise

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Preoccupation with Failure

- Recognizing early signs of risk
- Encouraging staff to speak up
- Using near-misses as learning opportunities
- Example: medication errors, ED triage delays, transport challenges

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Reluctance to Simplify

- Avoiding “that’s just how we do it” thinking
- Understanding root causes, not symptoms
- Using tools like 5 Whys and fishbone diagrams

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Sensitivity to Operations

- Real-time awareness of what's happening on the floor
- Daily huddles tailored for small teams
- Cross-department communication (ED, lab, radiology, inpatient)

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Commitment to Resilience

- Recovering quickly from unexpected events
- Simulation training for low-frequency/high-risk events
- Rural examples: obstetric emergencies, trauma stabilization, telehealth downtime

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Deference to Expertise

- Empowering the person with the most relevant knowledge
- Flattening hierarchy in critical moments
- Examples: EMTs advising on transport, lab techs flagging specimen issues

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5 Principles of Human Performance

People Make Mistakes (Error is normal)
Blame fixes nothing
Context drives behavior
Learning and improving is Vital
Leadership response matters



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The Principles Work Together

- If mistakes are normal → we must avoid blame.
- If blame doesn't help → we must understand context.
- If context drives behavior → we must learn from it.
- If learning is vital → leaders must respond constructively.

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Essence of High Reliability in Healthcare

Culture

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Safety Culture

"The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management."

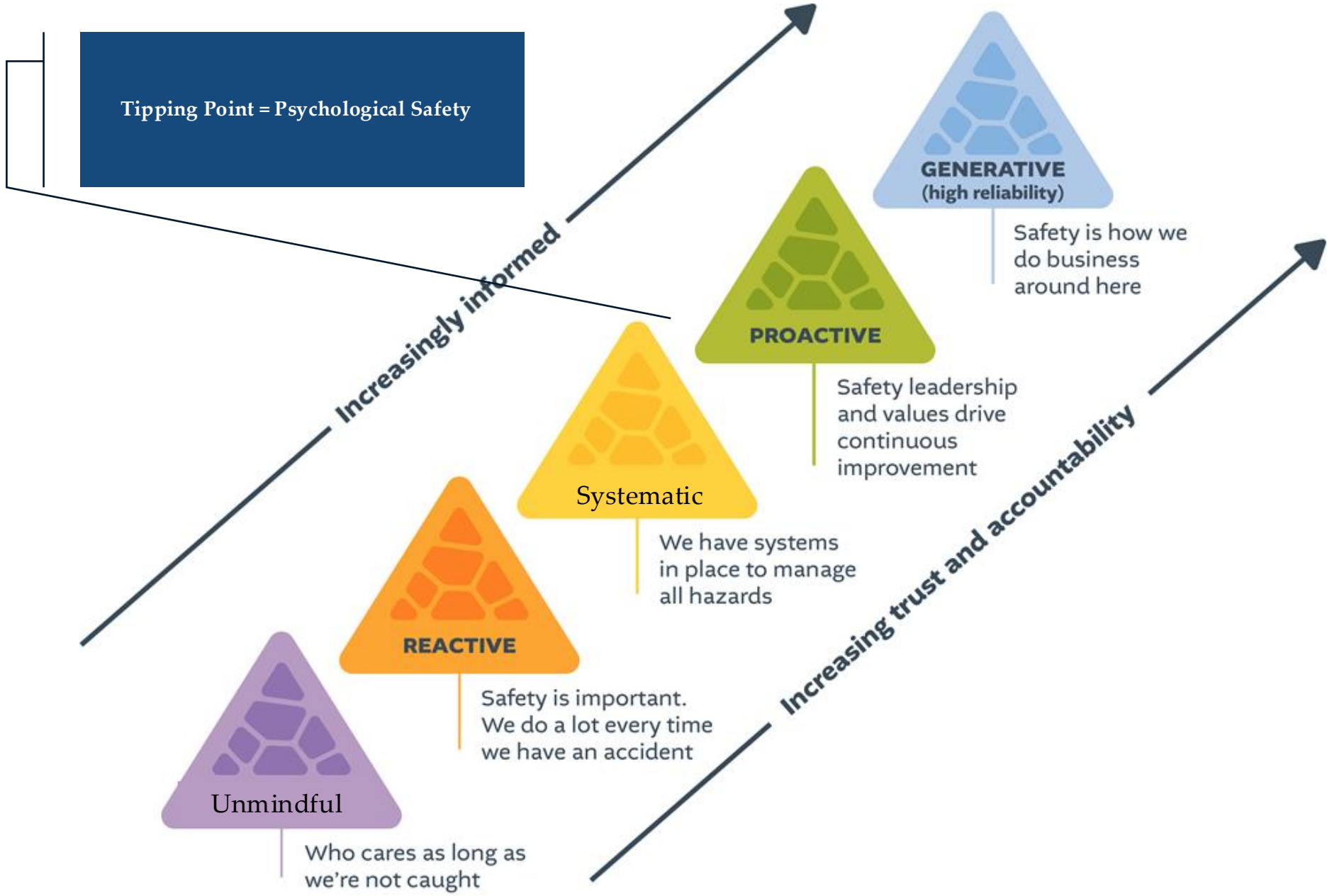
International Atomic Energy Agency (IAEA)

"An informed culture where people understand the hazards and risks involved in their work, and everyone accepts their role in maintaining safety."

Professor James Reason

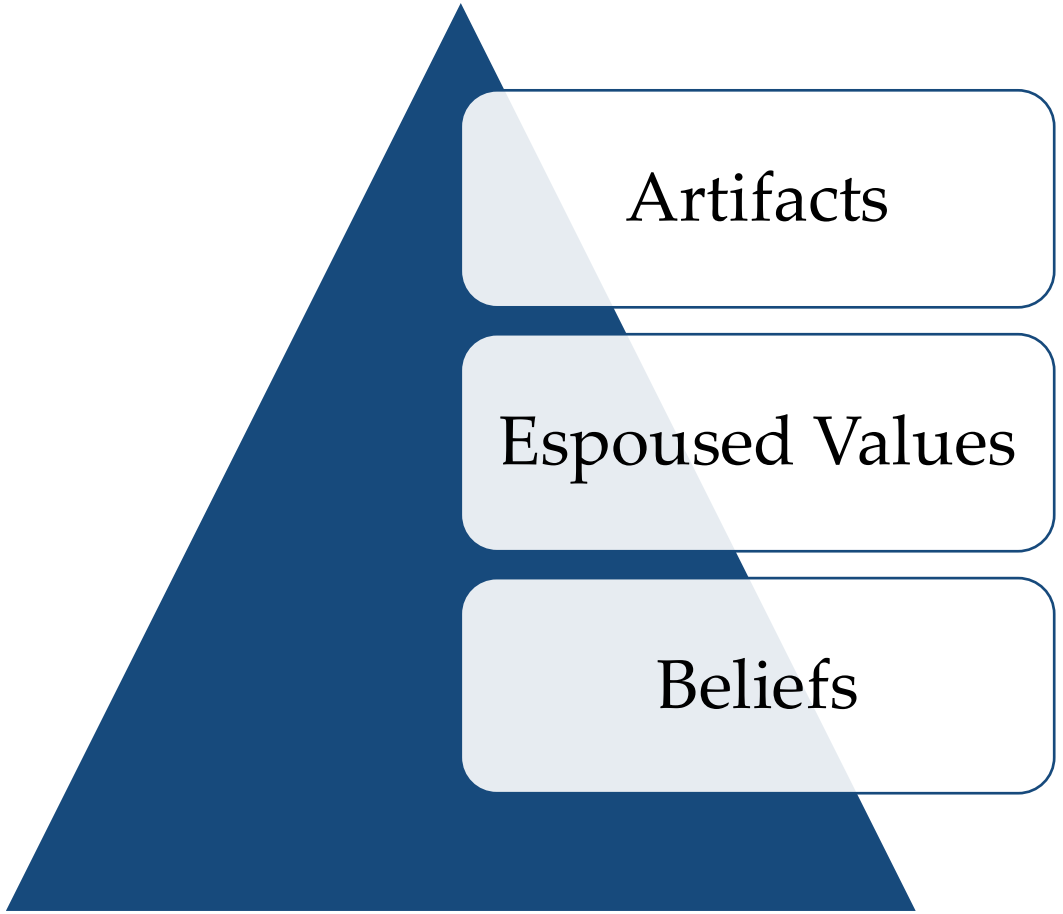
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Tipping Point = Psychological Safety



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Model of Organizational Culture



"Speak up for Safety" flyer on the wall

Error Reporting/Near Miss policy

"I can speak up about concerns without Judgement"

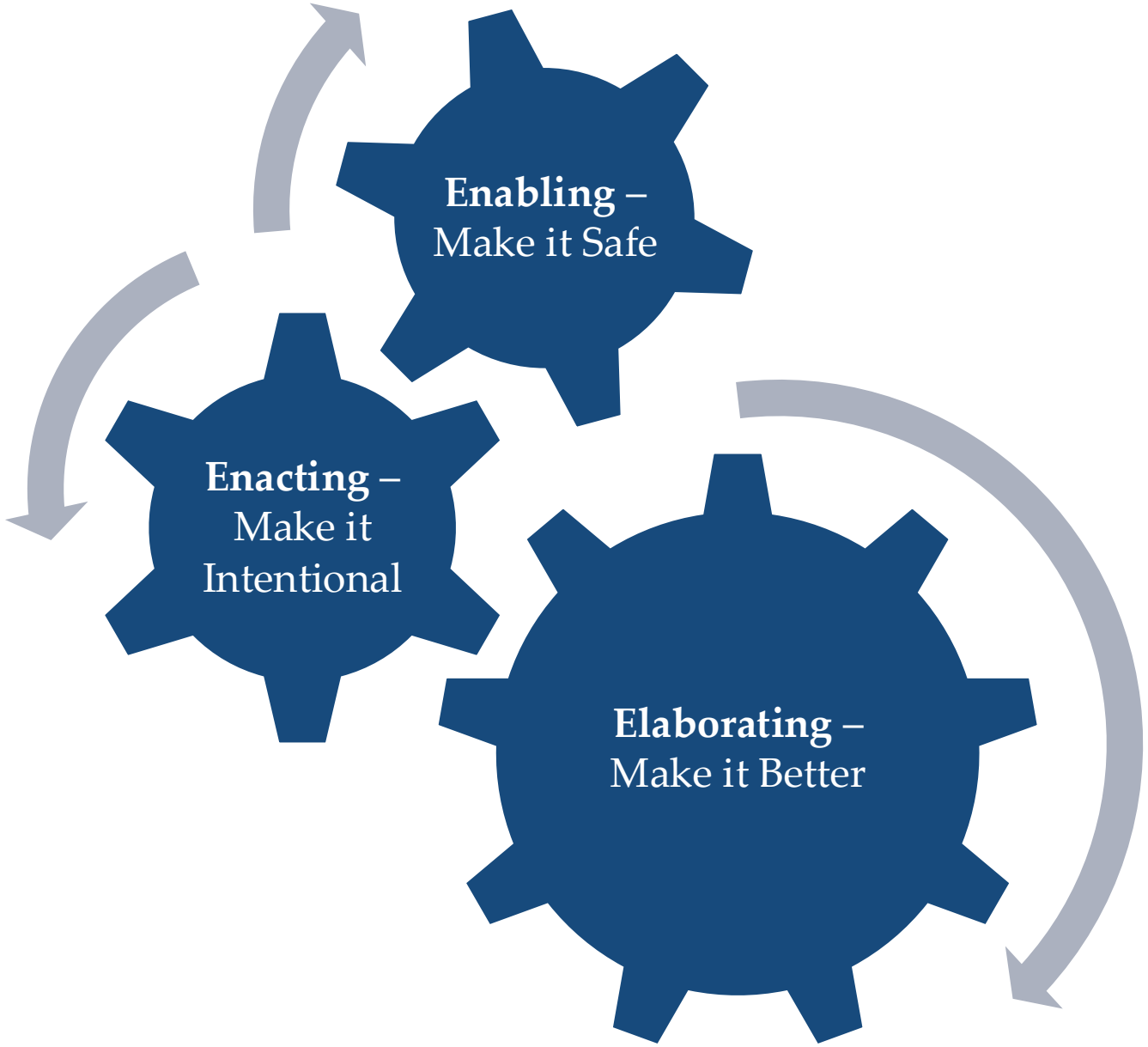
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Culture Drives High Reliability

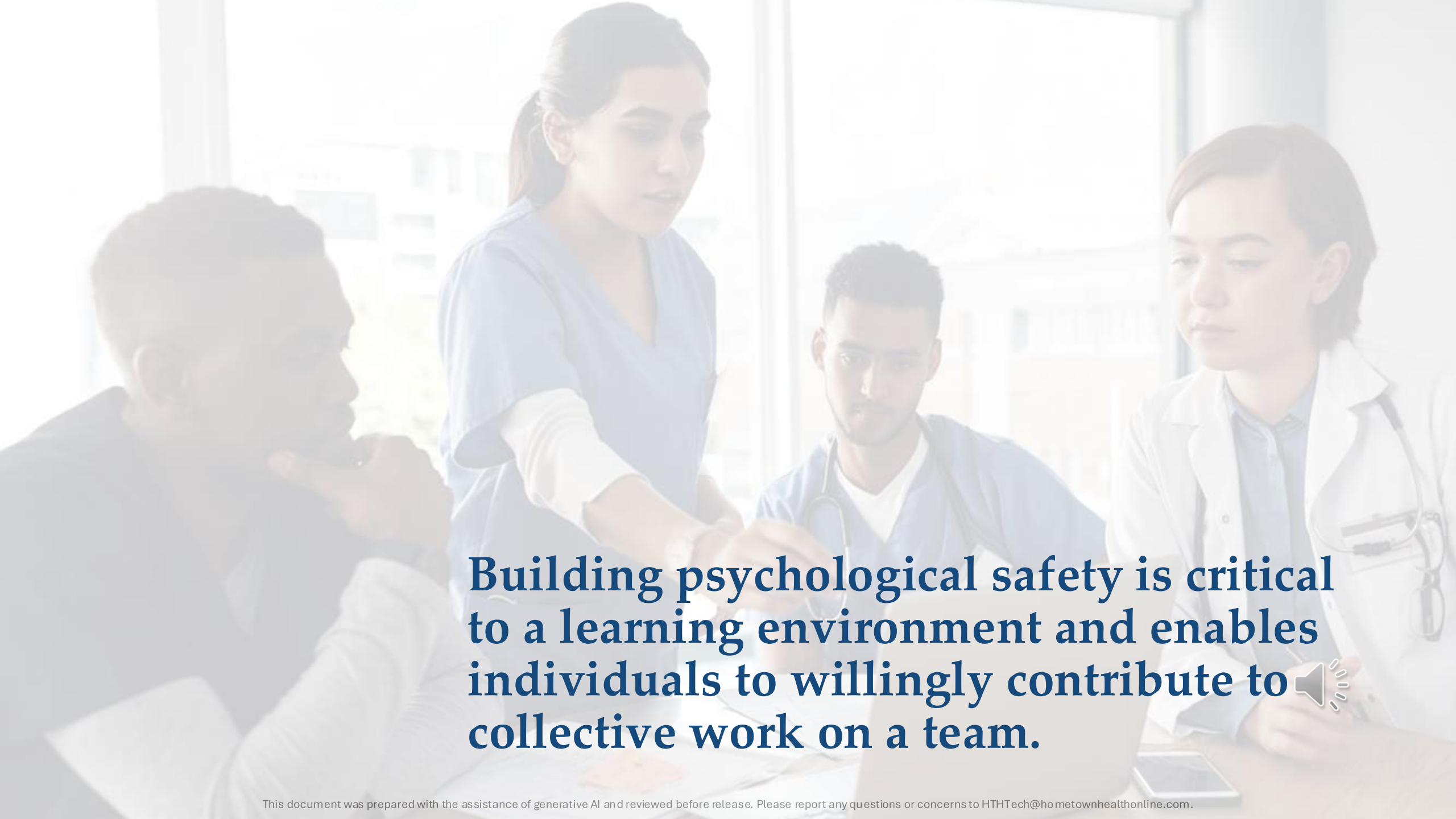
- High-reliability organizations (HROs) depend on consistent, safe behaviors every day—not just during audits.
- A strong culture reinforces shared values like vigilance, accountability, and teamwork, so staff act reliably even under pressure.

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The 3 Es



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Building psychological safety is critical to a learning environment and enables individuals to willingly contribute to collective work on a team.

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“Culture eats strategy for breakfast”

Peter Drucker

But Psychological Safety sets the table!

Dr Asif Sadiq MBE

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Workplace Characteristics

Psychologically Safe

- Minimized interpersonal fear
- Fully participating
- Speaking up
- Trust
- Climate of Openness
- Belongingness
- Consideration of diverse perspectives
- Challenging the status quo
- Admitting mistakes without fear
- Value learning
- Productively managing conflict

Non-Psychologically Safe

- Interpersonal fear
- Holding back participating
- Not speaking up/silence
- Limited/lack or trust
- Climate lacks openness
- A lack of belongingness
- Limited consideration of other perspectives
- Complacency
- Not admitting mistakes due to fear
- Not valuing learning
- Unproductive conflict management/artificial harmony

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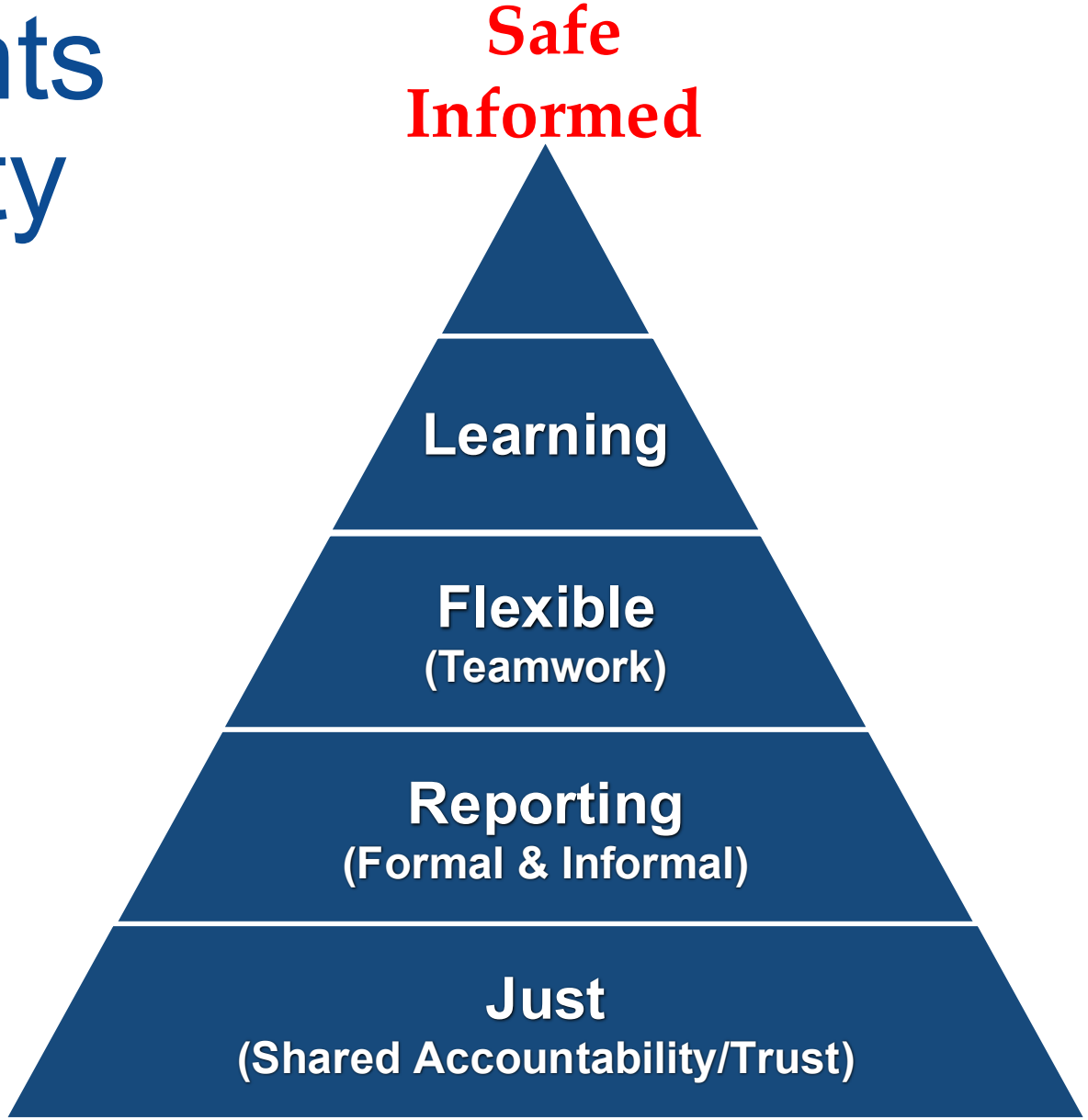
Application to Practice – Measuring Safety Culture



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Four Key Components in a Culture of Safety

- **Just** – reporting is rewarded in an atmosphere of trust; clear line between acceptable & unacceptable behavior; shared accountability between management and staff to address root causes of events
- **Reporting** – staff report their errors
- **Flexible (Teamwork)** – authority gradients relax when safety information is exchanged; there is psychological safety to speak up about safety related information
- **Learning** – action is taken based on safety information systems and sensemaking conversations



Reason, J. *Managing the Risks of Organizational Accidents.* Hampshire, England: Ashgate Publishing Limited; 1997.

Measuring Safety Culture - AHRQ

Measures Covered by the SOPS Hospital Survey 2.0

Composite Measures: A composite measure is a grouping of two or more survey items that assess the same area of culture. The 10 composite measures and 32 survey items assessed in the SOPS Hospital Survey 2.0 are:

- Teamwork (3 items)
- Staffing and Work Pace (4 items)
- Organizational Learning – Continuous Improvement (3 items)
- Response to Error (4 items)
- Supervisor, Manager, or Clinical Leader Support for Patient Safety (3 items)
- Communication About Error (3 items)
- Communication Openness (4 items)
- Reporting Patient Safety Events (2 items)
- Hospital Management Support for Patient Safety (3 items)
- Handoffs and Information Exchange (3 items)

Single Item Measures: In addition to the composite measures, single item measures included assess:

- Number of Events Reported (1 item)
- Patient Safety Rating (1 item)
- Background Questions (6 items)

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Systemic Risks and Harm

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Historical Perspective on the Patient Safety Movement

"First do no Harm"

Hippocrates

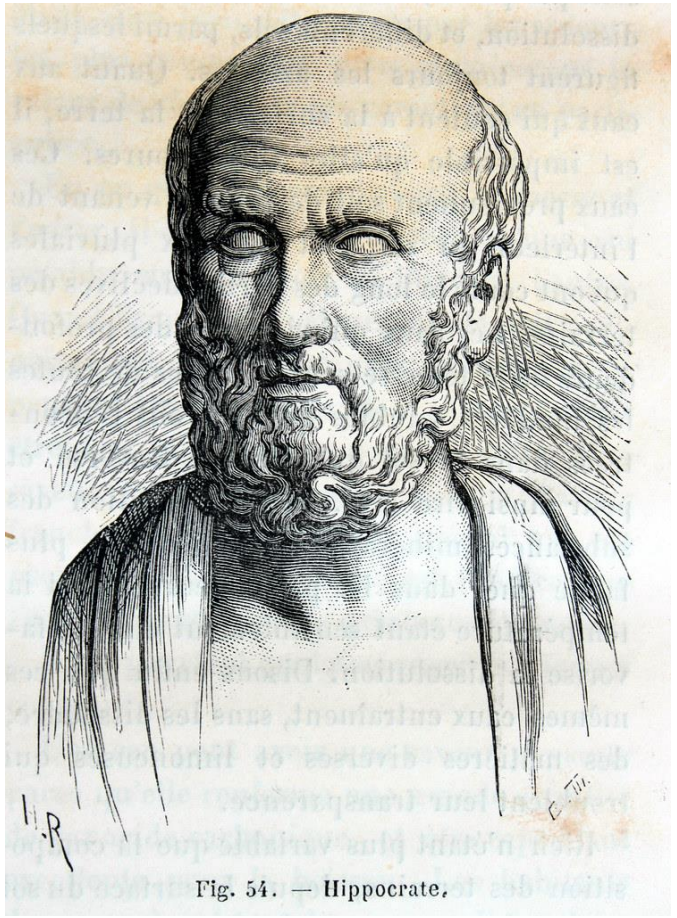


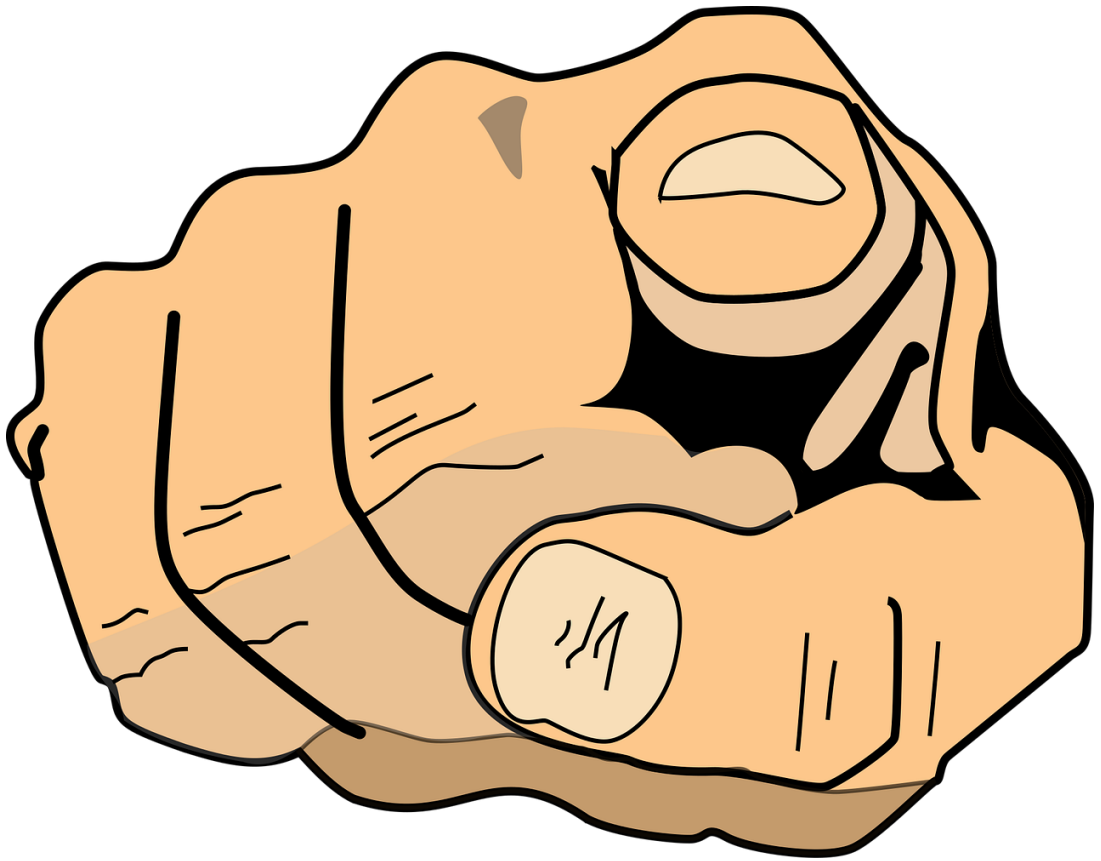
Fig. 54. — Hippocrate.

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Historical Perspective on the Patient Safety Movement

Before 1999

- Clinician focused approach - limited focus on systemic safety efforts



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Historical Perspective on the Patient Safety Movement



IOM: *To Err is Human*

Patient Safety & Quality Improvement Act of 2005



Journal of Patient Safety

JAMA The Journal of the American Medical Association

Journal of the American Medical Association

1999	2005	2013	2015

▪ Approximately **100,000** patients die each year from medical errors
▪ **72%** resulted from communication errors
	▪ Federal Law & regulation
	▪ Intent of the PSQIA
	  ▪ Share & Learn
	  ▪ Be proactive
	  ▪ Reduce cost
	  ▪ Reduce Harm
	  ▪ Created Patient Safety Organizations (PSO)
		▪ James, J.T., estimated **210,000 to 440,00 deaths** due to preventable medical errors	▪ Foreign objects left inside patient **96x per week**
			▪ Wrong procedures **10x a week**
			▪ Wrong body part/site operations **20x a week**

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Patient Safety and Quality Improvement
42 CFR Part 3

Purpose of the Legislation

- The **Patient Safety and Quality Improvement Act of 2005** was created to address a national problem: healthcare organizations were **not reporting safety events openly** because they feared lawsuits, regulatory penalties, and reputational harm.
- PSQIA establishes a **confidential, protected space** where providers can analyze errors, near misses, and system failures without fear of legal exposure.
- The goal is to **promote learning rather than blame**, so organizations can identify risks earlier and prevent harm before it reaches patients.
- At its core, PSQIA is about building a **culture of safety**, where transparency and improvement are valued over punishment.

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Patient Safety and Quality Improvement

42 CFR Part 3

National Strategy for Improving Patient Safety

- PSQIA supports a **nationwide learning system** by encouraging providers to share safety data with **Patient Safety Organizations** (PSOs).
- By aggregating data across many hospitals and clinics, PSOs can identify **patterns, trends, and systemic risks** that no single organization could see on its own.
- This creates a **feedback loop**: providers submit data → PSOs analyze it → PSOs return evidence-based recommendations → providers implement improvements.
- The legislation strengthens the national infrastructure for patient safety by promoting **standardized reporting, data-driven insights, and collaborative learning** across the healthcare system.

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Patient Safety Evaluation System (PSES)

Policies Defining What Enters the PSES

- Every organization must clearly define **what types of information are placed into the PSES**, because only information inside the PSES can become **Patient Safety Work Product**.
- Policies should specify **incident reports, near-miss reports, root cause analyses, committee reviews, and internal safety analyses** that will be handled within the PSES.
- The policy should also clarify **what does *not* enter the PSES**, such as mandatory state reporting data or original medical records.

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Patient Safety Evaluation System (PSES)

PSES is

- Sources of your patient safety and quality data and information
- An overarching umbrella of all your patient safety and quality improvement work
- Privileged and confidential under the PSQIA of 2005

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Patient Safety Evaluation System (PSES)

Processes for Collecting and Analyzing Safety Data

- The PSES must outline **how safety information is collected**, who collects it, and how it flows through the organization.
- This includes **reporting pathways**, intake forms, electronic reporting systems, and escalation procedures.
- The PSES should define how the organization conducts **analysis**, including root cause analysis, trend reviews, and multidisciplinary safety meetings.
- The goal is to ensure that safety data is **captured consistently, analyzed thoroughly, and used to drive improvement**.

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Role of Patient Safey Organizations (PSO)

- WHAT is a PSO?
  - An organization that collects data from participants, analyzes it, and develops and support recommendations for safer care
- WHO can participate with a PSO?
  - Any licensed provider
- WHAT is reported to a PSO?
  - Medical errors, near misses, unsafe conditions
- Why participate in a PSO?
  - Patient Safety Work Product Protections
  - Overcoming low sample sizes
  - Trend analysis



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Patient Safety Perspectives

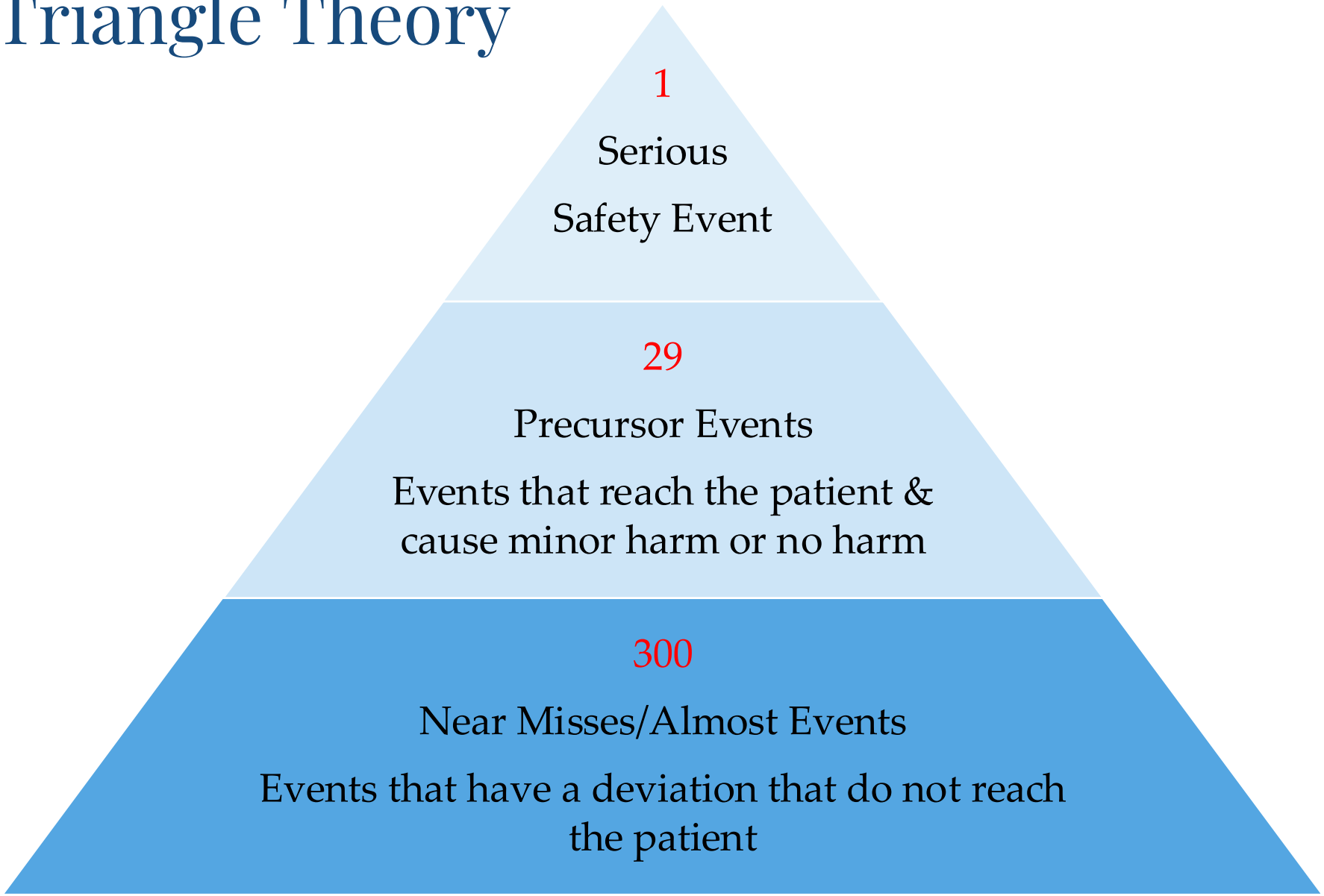
- **Safe Care** – *preventing harm to patients while administering care that is intended to help them*
- **Preventable Harm** – *describes errors that could have been avoided through reasonable actions and decisions*
- **An Adverse Event** – *when patients are harmed from care delivery or care management*
- **Sentinel Events** - *patient safety events resulting in death, permanent harm, or severe temporary harm*

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Application to Practice – Reporting and Analysis Practices

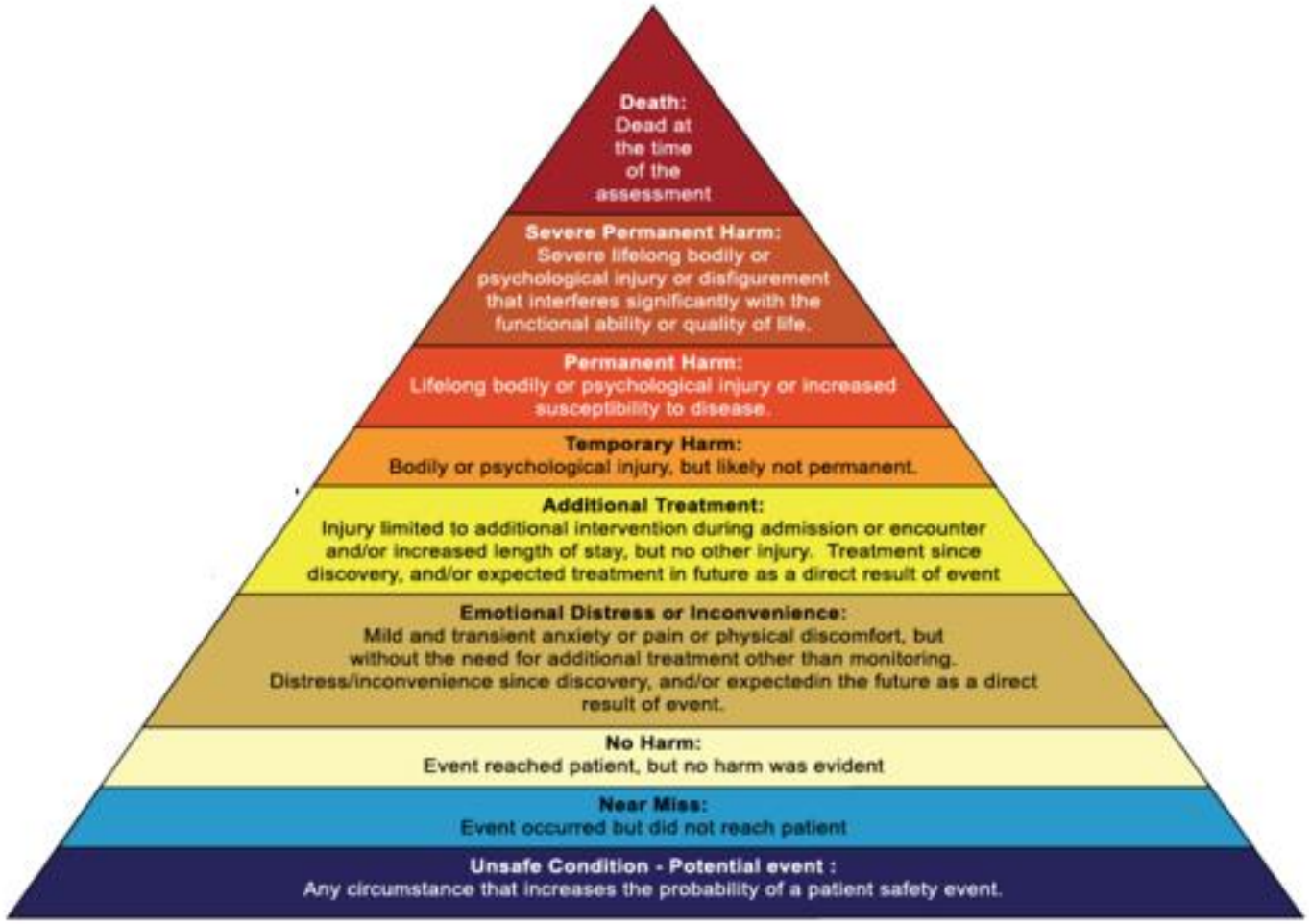
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Heinrich Triangle Theory



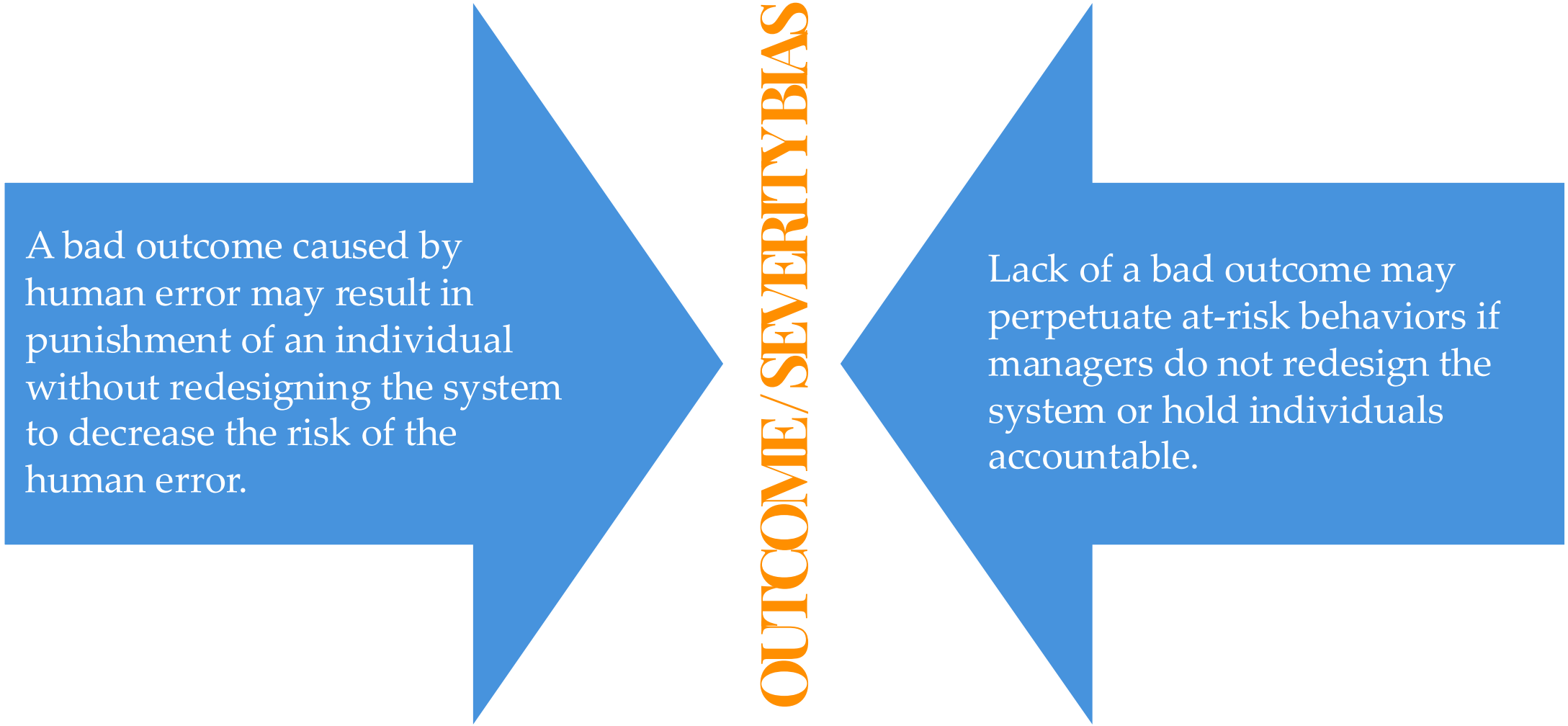
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Common Definition – Defining Harm



Safety Event Class	Level of Harm	Code	Patient Outcome	Suggested Follow-Up Analysis
Serious Safety Event (Reaches the patient)	**Death**	**SSE-1**	Unexpected death not related to the natural or expected course of the patient's illness or underlying condition . On balance of probabilities, was caused by or brought forward in the short term by the Incident.	RCA, including culpability / accountability review (CCA)
	Severe Permanent or Temporary Harm	**SSE-2**	Patient outcome is symptomatic, requiring life-saving intervention or major medical-surgical intervention, shortening life expectancy or causing major, permanent or temporary harm or loss of function.	RCA, including culpability / accountability review (CCA)
Safety Event (Reaches the patient)	**Moderate Permanent or Temporary Harm**	**SE-3**	Patient outcome is symptomatic, requiring intervention (e.g . additional operative procedure, additional therapeutic treatment), an Increased length of stay, or causing permanent or temporary harm, or loss of function.	**Options:** RCA, ACA, barrier analysis, including culpability/accountability review
	Mild Temporary Harm or None	**SE-4**	Patient outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate, but short-term, and minimal or no intervention (e.g., extra observation, investigation, review, or minor treatment), Is required.	**Options:** ACA, barrier analysis, trending analysis, including culpability / accountability review
	No Detectable Harm/No Harm	**SE-5**	Patient outcome is asymptomatic. No symptoms are detected and no treatment Is required. Not able to discover or ascertain the existence, presence, or fact of harm, but harm may exist; Insufficient information is available, or unable to determine any harm. Harm may appear later.	**Options:** ACA, barrier analysis, trending analysis, including culpability / accountability review
Pre-Patient Event (Does not reach the patient)	**Almost Happened**	**PPE-6**	Error or capacity to cause harm was caught by an error detection barrier prior to reaching the patient. ✓ The system worked	Review barrier detection, celebrate success

Tragic effects of Outcome /Severity Bias



Components of an Incident Reporting System

Event Collection

- The day, date, and time of the incident
- The type of incident that took place
- Where the incident happened
- Injuries obtained
- Names of the people involved
- Equipment involved
- Medical treatment that may be required
- Eyewitnesses who can tell their perspective
- Events leading up to the incident



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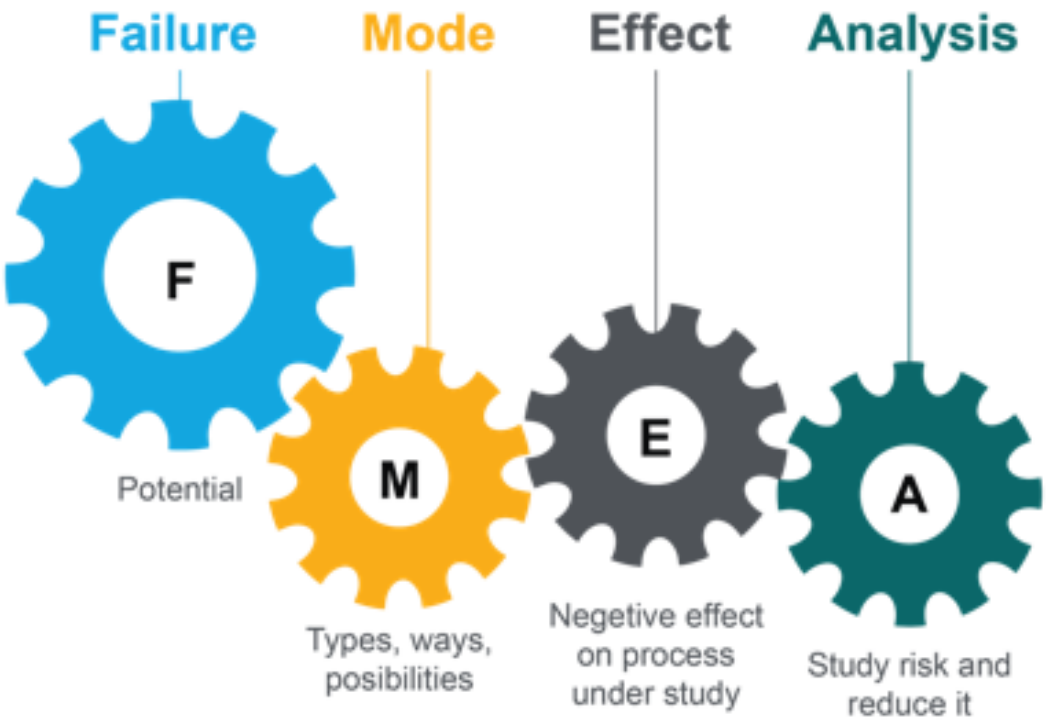


Sources of Data

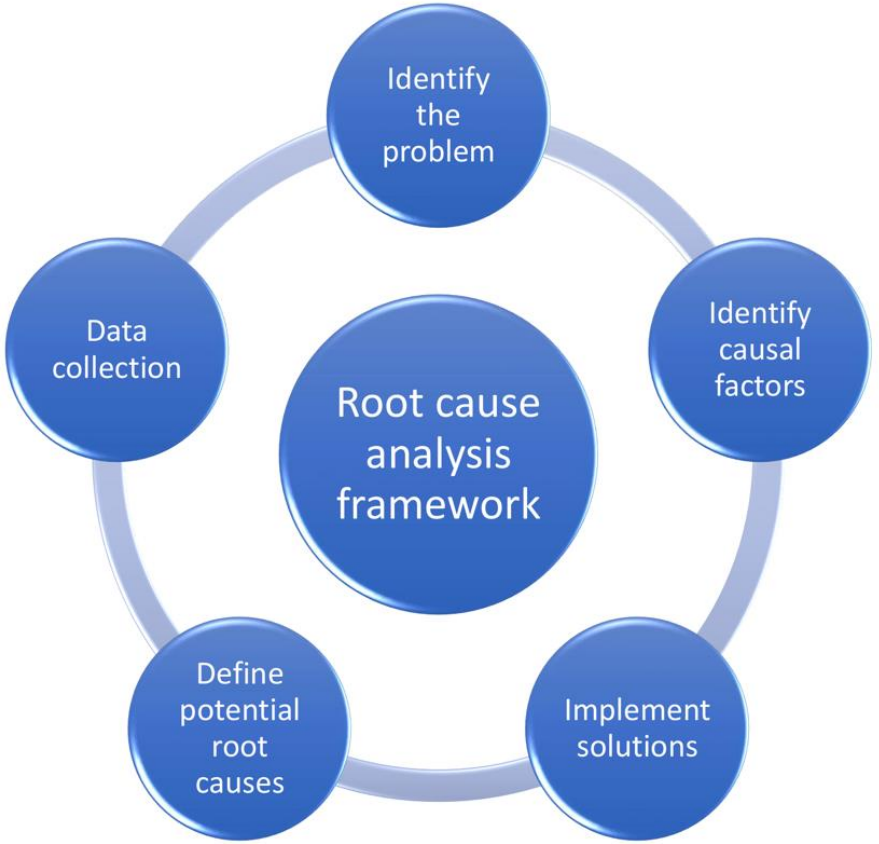
1. Incident Reports
2. Good Catch – Near miss events
3. Case Reviews – monthly morbidity and mortality reviews
4. Routine Audits of clinical records
5. Active surveillance of signals and alerts from electronic medical records
6. Prospective safety rounds
7. Patient Complaints
8. Multidisciplinary Rounds
9. Malpractice allegation abstracts

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FMEA



RCA



FMEA = Future (Preventable)
RCA = Retrospective (after the event or close call)

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Aggregate Root Cause Analysis (AggRCA) Common Cause Analysis (CCA)

Aggregate root cause analysis (AggRCA) and common cause analysis (CCA) in healthcare are systematic methods used to identify, analyze, and prevent recurring patient safety incidents by investigating trends across multiple, similar, or high-volume events (e.g., falls, medication errors) rather than single, isolated cases.

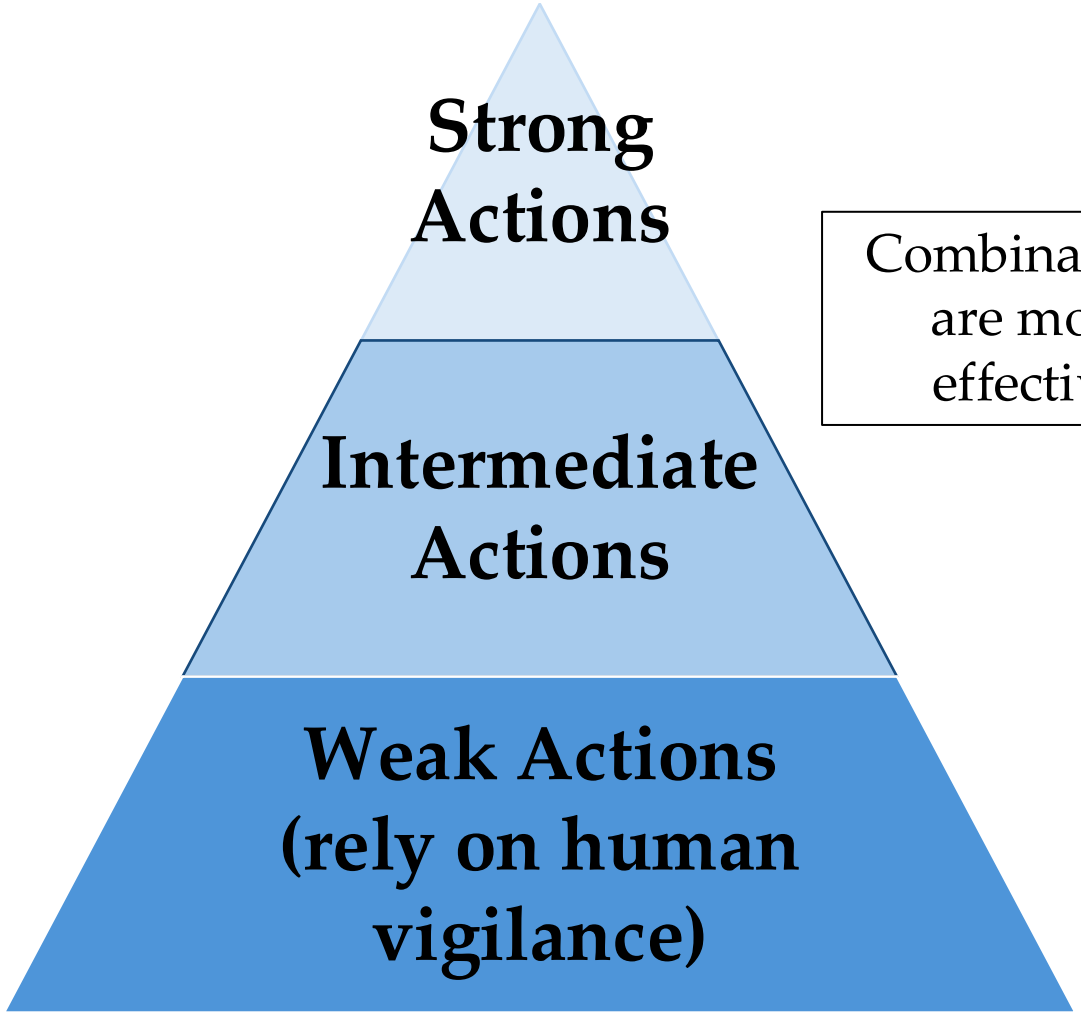
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ACTIONS: System Design Hierarchy

- ✓ Engineering/Environment
- ✓ Simplify processes
- ✓ Standardize equipment
- ✓ Support from leadership

- ✓ Build in redundancy (independent double-checks)
- ✓ Implement checklists
- ✓ Standardize communication
- ✓ Simulation-based training

- ✓ Alerts and Warnings
- ✓ New policy/procedure/memo
- ✓ Training and education



Combinations are most effective

National Patient Safety Foundation. RCA^2 Improving Root Causes Analyses and actions to Prevent Harm.



Application to Practice – Teamwork Leadership

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Team Strategies and Tools to Enhance Performance and Patient Safety

Knowledge
- Shared Mental Model

Sustainability
- Habits
- Enduring Culture of Safety
- Aligned Incentives



Attitudes
- ☐ Mutual Trust
- ☐ Team Orientation

Performance
- ☐ Adaptability
- ☐ Accuracy
- ☐ Productivity
- ☐ Efficiency
- ☐ Safety
- ☐ High Reliability

https://www.ahrq.gov/teamstepps-program/index.html

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Safety Coach/Champion Programs

- Develop a network of multidisciplinary safety experts that act as a “voice” and “face” of safety
- Model safe practices
- Mutual support
- STAR “Stop, think, Act, Review” modeling
- Great catch stories
- Create a ripple effect

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Application to Practice – Learning Practices

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Safety Briefings

- Safety Briefings or Huddles to maintain situational awareness of immediate problems impacting safety, reliability, and experience at the front line.
- We give direction about priority and responsibility for problem resolution.

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Safety Briefings – Sample Outline

- LOOK BACK - Significant safety, quality, or service concerns from the last 24 hours or last shift
- LOOK AHEAD - Anticipate predict and plan for safety quality service issues that may occur within the next 24 hours
- FOLLOW-UP – Resolution to prior day issues
- START-THE-CLOCK - Assign responsibility for Safety Critical Issues raised without using huddle to problem solve

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Encourage High-Reliability Thinking

- How do you know you had no problems?
- What immediate actions did you take?
- Is this happening in other places? or
- Could this happen in other places?
- What other areas does this impact?
- How are you preparing your team for that task?

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Preparing to Participate

- Do we have any high-risk patients or procedures?
- Do we anticipate any non-routine procedures or tasks?
- Are we dealing with any situations or conditions that distract our ability to focus or think critically about our patients?
- Are there any safety issues that I know about that may impact other departments?
- Do we have what we need to deliver safe quality care? Are there any deficiencies in information equipment supplies or staff that will make it hard to deliver safe high-quality care?
- What conditions outside our unit or outside our hospital could impact our ability to deliver safe quality care today?

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Preparing to Participate

- If any of the questions are an issue –
  - What actions am I taking to have a safe day?

- If there are no issues….
  - We have what it takes to **CREATE A SAFE DAY**.

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Executive Leadership Safety Walkrounds

Role of Leaders in Transformational Change

- Create a compelling positive vision
- Concretely define the goal as a performance problem…not "changing culture"
- Ensure new behaviors are formally taught
- Ensure new behaviors are reinforced
  - Provide opportunities for practice, coaching, feedback
  - Be a positive role model
- Create structures consistent with new way of thinking/working/behaving
  …policy/procedure, job descriptions, performance appraisals

Hospital Inpatient Quality Reporting (IQR) Program
Prospective Payment System-exempt Cancer Hospital Quality Reporting (PCHQR) Program
Patient Safety Structural Measure Quick Reference Guide

Patient Safety Structural Measure Attestation

- The measure is comprised of a set of complementary attestation statements that aim to capture actions that advance safety practices and outcomes. These attestations are organized into five priority domains:
  - Leadership Commitment to Eliminating Preventable Harm
  - Strategic Planning and Organizational Policy
  - Culture of Safety and Learning Health Systems
  - Accountability and Transparency
  - Patient and Family Engagement
- Each of the five domains include five attestation statements that a hospital must respond to.
- A hospital will evaluate and determine whether it engaged in all the statements that comprise a domain. If a facility can attest "Yes" at any time during the applicable reporting period (January 1 through December 31), it would satisfy the requirement for a domain. A hospital is not able to receive partial points for a domain.
- If a hospital is comprised of more than one acute care hospital facility under one CMS Certification Number (CCN), all facilities sharing the same CCN will need to satisfy domain criteria for a positive (i.e., "Yes") attestation.
  - If multiple Organization Identification Numbers (OrgIDs) under a shared CCN report different score values for the Patient Safety Structural measure, CMS will apply the lowest facility score of the OrgIDs to the CCN.
- For the full list of attestation statements and additional resources, please refer to the Patient Safety Structural Measure specifications and attestation guide documents on QualityNet.

Data Submission for the CY 2025 Reporting Period

- For the calendar year (CY) 2025 reporting period, the measurement period is from January 1, 2025, through December 31, 2025.
- Reporting compliance will impact the fiscal year (FY) 2027 payment determination for the Hospital IQR Program and the FY 2027 program year for the PCHQR Program.
- The data submission period for both programs will take place between April 1 through May 15, 2026.
- The attestation is completed once annually using the data submission and reporting standard procedures set forth by the Centers for Disease Control and Prevention through the National Healthcare Safety Network (NHSN).
- The NHSN website will provide more details closer to the initial data submission period.
- Hospitals are strongly encouraged to have at least two staff with access to the NHSN system to ensure the ability to submit data.

Public Reporting

- CMS will publicly display the hospital's measure performance score, which would range from 0 to 5 points, on an annual basis.
- CY 2025 performance scores will display on the Compare tool on Medicare.gov (for the Hospital IQR Program) and the Provider Data Catalog (for the PCHQR Program), beginning fall 2026.

Closing Thoughts

"The names of the patients whose lives we save can never be known. Our contribution will be what did not happen to them. And, though they are unknown, we will know that mothers and fathers are at graduations and weddings they would have missed, and that grandchildren will know grandparents they might never have known, and holidays will be taken, and work completed, and books read, and symphonies heard, and gardens tended that, without our work, would never have been."

Donald M. Berwick, MD, MPP

Former Administrator of the CMS and CEO IHI

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References & Resources

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