Safer Together: A national action plan to advance patient safety

Received (in revised form): 15th July, 2021

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Abstract Healthcare leaders have a duty to ensure that their organisations are safe for those receiving care and for those providing it. Despite the efforts of many organisations across the United States, progress in patient safety improvement remains limited. Lack of a unifying strategy and challenges with coordination have limited substantial improvements in patient safety. In response, the Institute for Healthcare Improvement convened a group of national organisations that formed the National Steering Committee (NSC) for Patient Safety. The NSC's charter was to develop 'Safer Together: A National Action Plan to Advance Patient Safety' (Safer Together). Guided by core principles, Safer Together focuses on four foundational and interdependent areas: culture, leadership and governance; patient and family engagement; workforce safety and the learning system. Safer Together provided 17 recommendations and related tactics across each of the four foundational areas. The recommendations are supported by an organisational Self-Assessment Tool and an Implementation Resource Guide. The Safer Together action plan highlights important interdependencies among the foundational areas and the coordination and collaboration that are necessary to drive safety improvement, as well as the importance of ensuring equity in all four foundational areas. Patient and healthcare worker safety should garner more attention as the US healthcare system continues to shift from fee-for-service to value-based payment. As a result, organisations that maintain safety as a core value will be better situated to respond to the changing reimbursement landscape. Leadership must establish safety as a core value of the organisation, then leverage their influence to foster and sustain the implementation of the foundational areas and the recommendations. Organisations that devote resources towards ensuring safety are better positioned to improve value because of less harm to both patients and staff. The following sections of this paper describe in more detail the foundational areas outlined in Safer Together, provide practical examples of what success looks like and underscore the role of the healthcare leader as a structural linchpin.

KEYTERMS: patient safety, leadership, culture, workforce safety, learning systems, patient and family engagement

INTRODUCTION

Although some progress has been achieved in patient safety in specific areas such as the prevention of healthcare-associated infections or medication errors, many experts have observed a sense of complacency in the field, stating that other priorities have moved safety to the back burner. In the United States, many organisations work on patient safety, including federal agencies, hospitals and health systems, accreditation groups, healthcare provider associations, foundations and patient advocacy groups; however, often these efforts are not well coordinated. This disconnected approach often results in recommendations and advice coming to the front line from many different directions.

The seminal report 'To Err Is Human: Building a Safer Health System',[1] from 1999, and more recently, 'Free from Harm',[2] from 2015, called for more centralised, coordinated and collaborative approaches at the national level to improve patient safety. In 2017, the National Patient Safety Foundation (NPSF) released a Call to Action[3] that stated that preventable healthcare harm is a public health crisis requiring a concerted response, again emphasising the need for national-level goals, collaboration and actions. These reports, as well as the sense of complacency, prompted an urgent need to re-energise and better coordinate the work in safety to build upon existing accomplishments.

To take on the challenge of fulfilling the long-standing recommendations from the 'To Err Is Human' and other reports, the Institute for Healthcare Improvement (IHI) invited many of the organisations engaged in patient safety to join a national steering committee. This group would work together to advance safety, not by competition, but through collaboration. On the basis of an enthusiastic response, IHI convened the National Steering Committee (NSC) for Patient Safety with the goal of creating an action plan to reduce harm, eventually published under the title 'Safer Together: A National Action Plan to Advance Patient Safety' (Safer Together). The steering committee members represent a diverse group of organisations and individuals, including federal agencies, associations, accreditors and patient advocates (Table 1). The steering committee created a vision and core principles for its work, with the intent that these would also apply to the way organisations work together to improve patient safety.

Table 1: National Steering Committee members

1. AARP Public Policy Institute, Center to Champion Nursing in America
2. Agency for Healthcare Research and Quality
3. America's Essential Hospitals
4. American Board of Medical Specialties
5. American College of Healthcare Executives
6. American College of Physicians
7. American Hospital Association
8. American Nurses Association/Nurse Alliance for Quality Care
9. American Organisation for Nursing Leadership
10. American Society of Health-System Pharmacists
11. Centers for Disease Control and Prevention
12. Centers for Medicare & Medicaid Services
13. Children's Hospitals' Solutions for Patient Safety
14. DNV GL Healthcare
15. ECRI
16. Healthcare Information and Management Systems Society
17. Institute for Healthcare Improvement
18. Institute for Safe Medication Practices
19. Mothers Against Medical Error
20. National Association for Healthcare Quality
21. National Center for Patient Safety, Veterans Health Administration
22. Occupational Safety and Health Administration
23. Project Patient Care
24. Society to Improve Diagnosis in Medicine
25. The Joint Commission
26. U.S. Food and Drug Administration

Safer Together, released in September 2020, captures the collective perspectives and insights of members of the NSC, who are united in their efforts to reduce harm to patients and those who care for them. The plan focuses on four foundational areas in patient safety that serve as the fertile soil in which specific projects will thrive. The focus on foundational areas is what makes this plan so unique. Large-scale collaborative initiatives, such as the Centers for Medicare & Medicaid Services (CMS) Partnership for Patients[4] and the 100,000 Lives Campaign,[5] have addressed certain safety issues like hospital-acquired conditions and preventable readmissions. Patients, front-line clinicians, patient safety experts and other stakeholders remain focused on the types of problems and harm that these efforts targeted; however, as we have come to understand more about the wide range of threats to patient safety, we also realise the need for a different approach. Free from Harm emphasised the need for a total systems perspective, and outlined a shift from a piecemeal, project-by-project approach for ensuring safety to an approach that also emphasises the common foundations on which all successful safety initiatives are built. Therefore, in Safer Together, the NSC specified the following four foundational areas of focus: culture, leadership and governance; patient and family engagement; workforce safety and the learning system.

Over the past 20 years, the modern patient safety movement has generated a vast array of experience, and the purpose of Safer Together was to capture and organise this collective wisdom. The plan provides clear direction for fundamental changes that are needed to improve care and reduce harm. There are recommendations in each of the four foundational areas for all stakeholders to engage in advancing the shared work and the goal of safer care. Ultimately, this goal can only be accomplished through actionable programmes and stalwart leadership support.

Interconnections between the four areas are also important to note. For example, both workforce safety and patient and family engagement depend on informed and committed leadership and governance. Similarly, learning systems establish the necessary capabilities to understand problems and drive improvement in the other areas. In addition, Safer Together highlights the importance of embedding equity into safety efforts, both in its guiding principles and in each of the four foundational areas. Inequities lead to harm, and thus, a focus on equity in safety strategies and tactics is paramount.

Safer Together is accompanied by a Self-Assessment Tool to assist leaders and organisations in deciding where to start, and an Implementation Resource Guide with supporting information for executing the plan's recommendations. NSC member organisations have committed to work together to move these recommendations forward. Our vision is that all stakeholders, including associations, hospitals and health systems and policy makers, will review the recommendations and use them to drive progress across all healthcare settings.

The plan translates the knowledge and insights of many into a set of actionable recommendations that provide a clearer path to safer care. By sharpening the focus on the foundational areas outlined in the plan, keeping patients safe in the face of multiple complex threats will be more feasible and efficient. Systems theory[6] underscores the critical need to understand all parts of a complex system and their interaction. People and organisations throughout the healthcare system represent the critical parts that must work in harmony to keep patients safe. We truly believe that we can save more lives by coordinating efforts in a collaborative way. By working together we can create a world where patients and those who care for them are free from harm. If healthcare organisations nationwide can use Safer Together to make significant advances towards safer care and reduce harm across the continuum of care, we will consider it successful. The following sections of this paper describe in more detail the foundational areas outlined in Safer Together, provide practical examples of what success looks like and underscore the role of the healthcare leader as a structural linchpin.

SAFER TOGETHER FOUNDATIONAL AREAS AND LEADERSHIP LEVERAGE

Safety initiatives have traditionally focused on implementing specific clinical and technical interventions to address circumscribed harms such as healthcare-associated infections; however, interventions often may fail to result in sustainable progress. As the NSC was finalising Safer Together, the world was in the early days of the COVID-19 pandemic. The experiences and learning that occurred during that time served to validate Safer Together and exhibited the heightened need for leadership leverage to effectively deploy strategies that could create positive change in healthcare safety.

Safer Together reinforces the call to action for all leaders and organisations to commit to and address the four foundational, interdependent areas that are essential for achieving total systems safety (Figure 1). One area cannot be successfully implemented without the other three, as they each serve a key role in advancing patient safety. While specific tactics will be addressed here, it is important to establish capable leadership in all four foundational areas. The plan provides concrete actions within, and across, each of these areas for a comprehensive scaffolding for healthcare safety. It is also imperative that activities within each of the four areas be designed and implemented through the lens of health equity to ensure that current inequities are being successfully identified and addressed, and that new inequities are not inadvertently introduced. In Safer Together, strategies and tactics are outlined in all four foundational areas (Table 2). For example, when considering an approach for

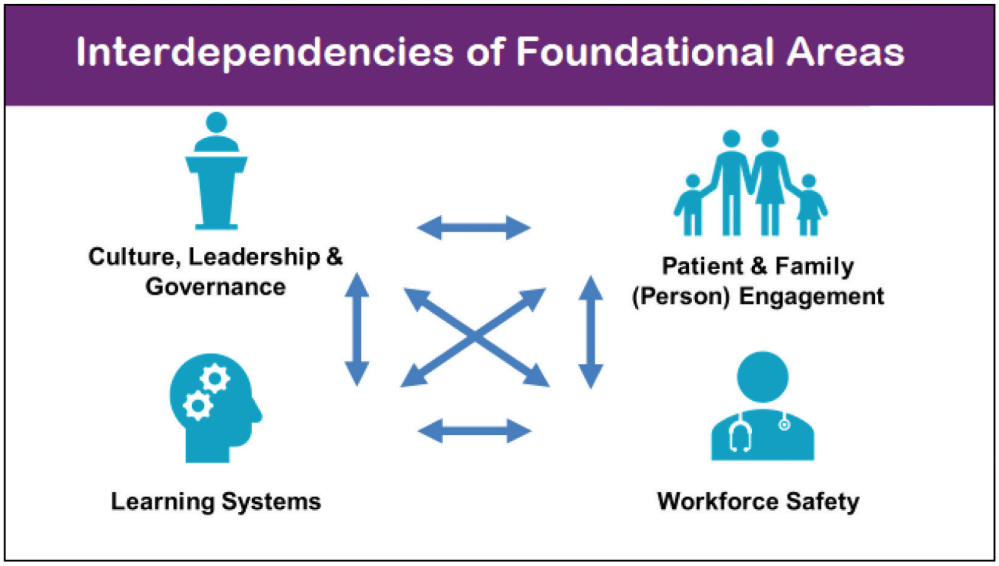

Figure 1: Interdependencies of foundational areas

Table 2: From concepts to actions: Examples from Safer Together—A national action plan to advance patient safety

Concept	Safer Together recommendation	Organisational status (highest levels from the self-assessment tool)	Implementation resources	Actions and tactics
Equitable Patient and Family Engagement	**Recommendation 5. Establish competencies for all health care professionals for the engagement of patients, families and care partners.** Healthcare leaders in all care settings must ensure that healthcare professionals are prepared to form equitable and effective partnerships with patients, families and care partners.	The organisation provides safety and patient–provider communication training and resources to all patients, clinicians and staff. These educational materials are available in the preferred language and appropriate literacy level for each patient.	Examples of effective communication and training tools include the following: • AHRQ Questions Are the Answer • Ask Me 3® • Choosing Wisely® • PREPARE™ for Your Care • ©The Conversation Project	Tactic 5c. In partnership with patients and literacy experts, select and implement effective communication and training tools and materials in all care settings, including home and community settings, to assist patients, families and care partners in understanding and identifying risks, potential hazards, urgent or additional care needs and problems. Ensure that materials use plain language and are designed and validated for varying literacy levels and languages.

(*continued*)

Concept	Safer Together recommendation	Organisational status (highest levels from the self-assessment tool)	Implementation resources	Actions and tactics
Leadership and Governance Competencies	**Recommendation 4. Implement competency-based governance and leadership.** Senior leaders must ensure that quality and patient safety competencies are identified and assessed during onboarding and throughout the tenure of governance bodies and leaders. Competencies must include the knowledge, skills and attributes needed to champion patient safety practices that lead to measurable improvement in safety.	The organisation clearly identifies the role of the board and senior executives in reviewing and overseeing patient outcomes.	American College of Healthcare Executives and Institute for Healthcare Improvement. (2017) 'Leading a culture of safety: A blueprint for success', Institute for Healthcare Improvement, Boston, MA. Institute for Healthcare Improvement. (2018) 'Framework for effective board governance of health system quality', IHI White Paper, Institute for Healthcare Improvement, Boston, MA.	Tactic 4a. Use a standardised assessment to ensure that board members and senior leaders demonstrate competencies in safety, equity and data literacy. Track progress over time in their oversight of these areas and in their use of data. Ensure that ongoing education provides coordinated guidance, curriculum and assessment for board members and leaders across governance-support organisations.
Learning Systems Supporting Improvement	**Recommendation 13. Facilitate both intra- and inter-organisational learning.** All healthcare organisations must take steps to become collaborative learning organisations by using high-reliability principles, ensuring robust learning feedback loops and engaging with established local, regional, state or national learning systems.	Clinical leaders are involved in event investigations. Information is shared in the involved department/service and learnings are regularly communicated to all staff. All team members can share examples of improvements spurred by reported events.	The Joint Commission. (2018, December) 'Sentinel Event Alert 60: Developing reporting culture: Learning from close calls and hazardous conditions'. ECRI Institute. (2018, March 16) 'Getting the most out of root-cause analyses', *Healthcare Risk Control*.	Tactic 13d. Use a systematic and systems-based approach to process improvement. This includes the following: • Developing robust, timely mechanisms for data collection and analytics • Developing and refining systems to report and analyse both risks and errors • Creating the necessary infrastructure to support continuous learning • Supporting and encouraging healthcare professional engagement with patients and peers • Supporting professional development of risk-reducing competencies

(*continued*)

Concept	Safer Together recommendation	Organisational status (highest levels from the self-assessment tool)	Implementation resources	Actions and tactics
Workforce Safety Strategy	**Recommendation 10. Implement a systems approach to workforce safety.** Ensure that every healthcare organisation across the care continuum has comprehensive workforce safety programmes in place. Senior leaders must develop and implement governance and oversight structures to support a systems approach to workforce safety, which includes leadership and engagement, safety management systems, risk reduction and performance analytics and management.	The organisation has an explicit workforce safety strategy that is aligned with the mission and patient safety strategy. This strategy includes a multi-year work plan, metrics and a well-understood reporting protocol.	Lucian Leape Institute. (2013) 'Through the eyes of the workforce: Creating joy, meaning, and safer health care', National Patient Safety Foundation, Boston, MA, available at: http://www.ihi.org/resources/Pages/Publications/Through-the-Eyes-of-the-Workforce-Creating-Joy-Meaning-and-Safer-Health-Care.aspx.	Tactic 10b. Develop a workforce safety strategy that aligns with the organisational mission, patient safety goals, responsiveness to workforce safety data and resource allocation.

patient engagement, issues with language, health literacy or cultural competency must be addressed.

Culture, leadership and governance are clearly dependent on leadership influence. The role of leaders in setting culture is a long-known aspect of organisational behaviour. Creating a culture of safety must be an essential competency for leaders.[7,8] The four foundational areas all require leadership to ensure that values are clearly established and shared across the organisation and reinforced by how resources are deployed. The organisation's culture and aspirational goals, such as Zero Harm,[9] are set by the CEO and reinforced by its senior team. Through strategic priorities, budgets and individual actions, safety can become a regular and uncompromising component of organisational processes, taking the front seat in all activities and being inclusive of all stakeholders from a diverse demographic make-up. There is evidence that when senior leadership is visible and transparent with staff, safety culture improves.[10]

As critical as it is for the CEO and senior team to articulate the core value of safety, it is equally important that the deployment of resources, competencies and transparency is supported at the middle management level. The middle manager is often the individual positioned to reinforce the need for bedside staff to be stewards of safety. How they respond to reports of near misses and harm influences staff confidence and demonstrates whether safety is a priority.[11]

To this end, leaders should allocate resources to ensure that culture is being continuously measured and addressed, and information on the safety of staff, patients and family members is transparently and widely shared. Furthermore, new leaders should be prepared with the necessary skills to fully champion current and future safety efforts.

Similarly, boards also have a duty to establish safety as a core value, adopt strategic safety priorities and hold management accountable for safety results. Each member should have proven competencies in safety and quality principles and serve as an exemplar. For instance, board rounds provide the opportunity to show a commitment to bedside staff, while also identifying ways to better enhance safety. Taking these necessary actions will solidify safety as a core value within any healthcare setting and across varying governance structures, whether it be primary care practices, home care organisations or acute care hospitals.

Patient and family engagement is an integral part of understanding the perspectives of those receiving care and their care partners. Care partners include family, friends or others in the patient's circle of influence who assist in making decisions about care. This level of insight helps with designing person-centred health care and can nurture further engagement downstream. The authentic and meaningful inclusion of patients and care partners at every juncture of the care continuum and in the design of every process will ensure that the safest and most equitable care is provided, while simultaneously strengthening the organisation's cultural fabric.[12] Unfortunately, this partnership has been strained during the pandemic because organisations dramatically limited, and often prohibited, visitors. While these actions protected patients, staff and visitors from the risk of exposure to COVID-19 and preserved personal protective equipment, there is a growing understanding of the impact on the experience, and arguably the safety, of patients, although it is too early for a thorough analysis. Successfully integrating patient and family engagement into system operations is reliant on the support of leadership, especially in how the recommendations of these stakeholders are woven into the operations of the organisation.

Another consideration of critical importance is that healthcare leaders activate and reinforce the urgency for actionable steps and meaningful measurement to improve engagement with this group of stakeholders. This includes ensuring and improving staff competencies in purposeful engagement of patients and families, which not only elevates the aptitude of the staff but also clearly conveys the importance that patient and family engagement plays in safety. By extension, adopting competency training as an iterative process promotes further trust and respect for patients, families and their care partners. Furthermore, engaging patient representatives on governing boards, committees and councils encourages participation in decision-making processes and allows organisations to develop meaningful ongoing safety initiatives built by, and for, the communities they serve. This includes seeking input from this stakeholder group on virtual care and their experiences with telehealth applications. Leaders who understand the value of bringing the patients' voice into how the organisation operates gain insights that may otherwise not be realised. An example highlighting the importance of this concept is cited by one of the authors, who participated in a Lean event for orthopaedic surgeries where patients were included as part of the full care delivery team. The patient had the vantage of the entire experience and was able to point to issues that the clinical members would not have seen. The distinction is that the clinicians' perspectives had been concentrated on only one part of the process flow, so engaging the patient allowed for better information and a complete picture of the situation. Again, it is paramount to ensure equitable engagement from advocates

representing all patient demographics. This enables organisations to assimilate contextually appropriate information into various aspects of their operation.

Workforce safety, as was already alluded to, is a precondition to patient safety. If organisational leadership cannot confidently assure that staff will be protected from physical and psychological harm while doing their jobs, then staff in turn cannot ensure that patients will receive the safest care possible. This has been an emerging concern during the pandemic. The accounts of physical violence and psychological distress, in addition to the ongoing injuries staff encounter in their daily work routines, such as falls and needle-stick injuries, have increased.[13–15]

The recommendations in Safer Together are focused on the organisational level, requiring that workforce and patient safety be addressed as a unified safety strategy. Leaders at all levels of the organisation should participate in reviewing patient and workforce harm events and establish patient and workforce safety goals, together. Leaders have a fundamental duty to address workforce safety by prioritising and investing in reporting systems that provide stratification of sociodemographic data. This will bolster workforce harm-reduction programmes that focus on performance measurement, incident transparency, resource allocation and best practice adoption. These programmes must use an equitable approach, meaning an emphasis should be placed on robust efforts to address high frequency, highly impactful types of physical and emotional staff harm that may affect various segments of the workforce differently. Executive leaders and governing boards serve pivotal roles in advancing this work and should incorporate regular updates on staff harm rates, along with risk-mitigation activities, during standing board meetings, safety rounds and huddles.

There are many examples of large-scale workforce safety improvement efforts spearheaded by leaders from which we can learn. For example, while operational aspects of aerospace travel and aluminium production are quite different from healthcare delivery, lessons learned from the Apollo 1 and Challenger disasters, as well as during Paul O'Neill's time as CEO of Alcoa, demonstrate how the values of leadership accountability and culture can prioritise the safety of the workforce.[16] In the case of the Apollo 1 and Challenger disasters, leadership placed time pressures ahead of crew safety. In both examples, substantial decreases in harm were achieved with other positive impacts throughout the organisations.[17,18] Under O'Neill's leadership, his organisation experienced a measurable and sustainable reduction in harm to employees, as well as improved organisational financial performance.

By sharing data regarding worker injuries within the organisation, such as the recordable incident rates (RIR) and days away, restricted or transferred (DART), leaders allow for more transparency and greater opportunity to learn from adverse events and prevent them in the future. Healthcare leaders and others can use data to target high-priority areas for improvement, as well as necessary resources. For example, if there is a patient care unit with high numbers of musculoskeletal injuries due to improper patient lifting, appropriate equipment and training in how to safely handle patients may be deployed. Segmentation of the data is also critical to understand which groups are at most risk, such as by job type or by race and ethnicity. If measures are taken to fully support the physical, psychological and emotional safety and wellness of all healthcare staff, they will be better equipped to identify, prevent and learn from breakdowns in care processes.

Learning systems, when implemented well, beget widespread and often profound improvements. Their absence can, on the other hand, have detrimental effects on an organisation's ability to learn from and improve with historical information. George Santayana highlighted this caution when he wrote, 'Those who cannot remember

the past are condemned to repeat it'.[19(p. 284)] Unfortunately, as stated earlier, while there has been progress in safety, events continue to occur, even where there is evidence on how to prevent them. Healthcare continues to have the opportunity to be more transparent in this area. Where there is opportunity to share learning within an organisation, there is also great potential to improve.

A functional learning system effectively integrates information from internal and external sources to inform the design and implementation of evidence-based programmes to advance safety. Leaders of learning systems encourage active collaboration with key stakeholders at the local, regional, state or national levels to establish a larger learning network. This collaboration is instrumental in rapid cycle process improvement, where continual programme evaluation and adjustments may be needed, and can thus be quickly shared throughout the learning network. The onus is on healthcare leaders to foster a coordinated, cooperative approach to addressing safety across the healthcare continuum and at all levels of education and professional development. This responsibility can be achieved by championing the development of strategic partnerships representing all stakeholders in both public and private sectors.

As is true within the other foundational areas, transparency supported by leadership is essential for sharing lessons learned throughout the health system as well as across the healthcare industry. Among the mechanisms that allow sharing of serious safety events and near misses are patient safety organisations (PSOs), established by the Patient Safety and Quality Improvement Act. PSOs allow for a level of protection from legal discovery with the intention of fostering the identification of common adverse events, recognizing potential patterns and sharing effective interventions. This process also provides a considerable lift to an organisation's safety culture. By showing staff their voluntarily reported adverse events are actionable and can lead to systemic changes, leaders can cultivate a learning system from the ground up. Thus, the PSO concept provides a framework for the creation of a learning system across healthcare providers and systems. Healthcare leaders are then uniquely poised to emulate other industries, such as in civil aviation, where widespread, systematic learning systems have been expertly utilised for safety improvement (see Figure 2).

It evident that each of the four foundational areas will not stand without the other. There must be clear leadership to establish a culture that makes safety a core value, provides effective deployment of resources to engage patients and their care givers in the provision of care, ensures that there is physical and psychological safety for the workforce and supports effective mechanisms with which to learn. Since the recommendations in Safer Together address these interdependent factors together, they can offer leaders a strategic approach for strengthening their organisation's infrastructure against patient safety threats.

BUSINESS CASE AND THE VISION

CEOs seeking to lead their organisation in making safety a core value, especially those working in resource-constrained environments, must consider the business case for patient safety and the implications of considering it among organisational priorities. Healthcare continues shifting from volume-based reimbursement to value-based payments. The most common mathematical formula for defining the value of care is the cost of care divided by quality, where quality is significantly influenced by the safety of patients and staff. Centers for Medicare & Medicaid Services and many commercial payers have implemented value-based metrics for the delivery of safe care as either incentives or penalties.

There are also significant costs to be avoided as a result of decreasing workplace injuries. The average cost of a worker injury is US$1,100 per injury and US$42,000 for injuries where medical intervention is necessary.[20] Additionally,

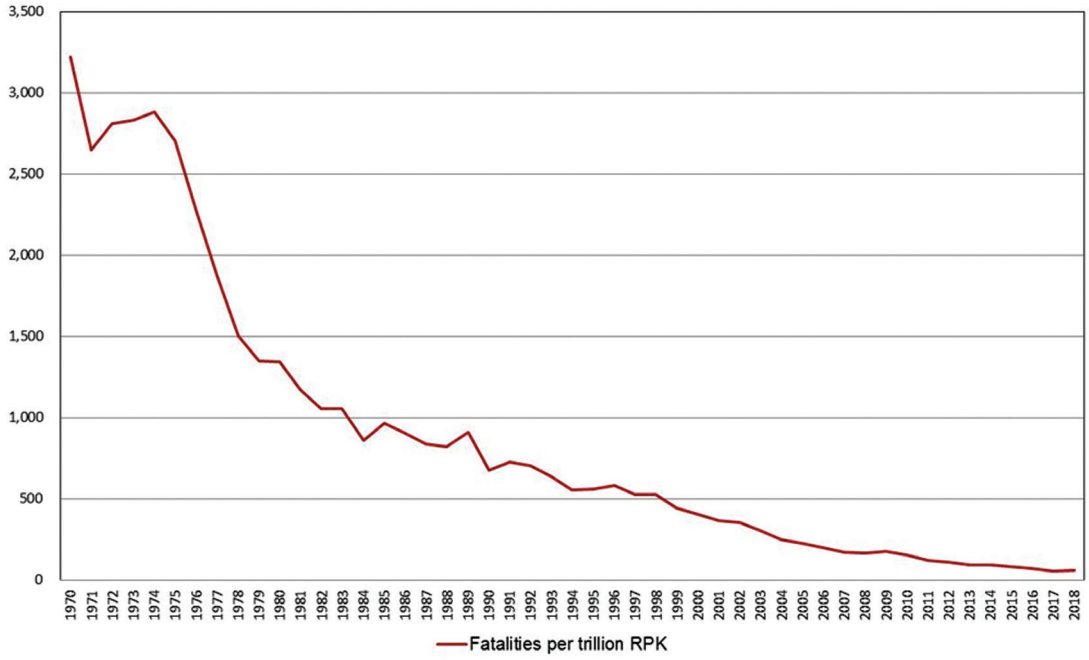

Figure 2: Aviation Safety: Fatalities per trillion RPK

an incident may take the staff member out of the workforce for a period of time, resulting in compounded expenses. This adds credence to the argument that investing in staff training and competencies at all levels of the organisation will pay dividends. Furthermore, cultural change, which is the bedrock of safety, may take five years or more to realise. Holding safety as a core value and instilling the culture to support it requires a long-term, progressive view. In a world in which CEO tenure is 5.5 years,[21] this requires the board to understand the need to sustain the work of culture improvement, even through leadership changes.

IHI and NPSF published a guide that leaders may use to develop the business case for patient safety.[22] Ultimately, safety as a core value must be grounded in the vision set by the leader and embraced by the board, senior leadership team and middle-level managers. It must be practiced using the foundational areas as a routine part of the operations of the organisation. Success requires incorporating its principles into strategies and planning, as well as instituting processes for staff evaluation, promotion and recognition. Once engagement and support have been established using the business case, organisations can move to formally launch and sustain Safer Together through various assessment and deployment tactics.

ASSESSMENT AND DEPLOYMENT TACTICS

As has been the clear theme throughout this paper, the safety of health care delivered by organisations is dependent on the role of leaders and their actions. Safer Together can help guide and support these actions as healthcare leaders take the necessary steps to keep patients safe. A leader is responsible for setting the vision and core values for their organisation, and this must include safe, high-quality care as a central focus. Without a unified vision that prioritises both patient and workforce safety, other members of the organisation may develop well-intentioned but uncoordinated approaches for ensuring safety. This disorder is antithetical to the systems-based perspective and high-reliability principles that are necessary for safe care. (see Figure 3)

Effective leaders are committed to ongoing assessment and evaluation of their organisation's

Figure 3: High Reliability Model

status and performance in safety, and consistently refresh priorities for improvement. The Safer Together Self-Assessment Tool was developed to help organisations take account of the strengths and weaknesses that ultimately determine the safety of care that is delivered. This also provides a baseline with which to inform the selection of specific tactics, tools and resources from the Safer Together Implementation Resource Guide. Collectively, the Self-Assessment Tool and the Implementation Resource Guide set the stage for Safer Together to truly serve as a 'Plan for Action'.

CONCLUSION

The accelerated pace and large-scale improvement that are envisioned in Safer Together will only be possible if leaders work to share and learn within and between organisations. The complexity of health care can overwhelm even the most capable organisations, and inter-organisational collaboration and learning can help overcome some of the challenges to identify solutions that address the full set of safety threats. Safer Together summarises features of highly functional learning systems that are effective at supporting and driving improvement. Leaders have a responsibility to demonstrate their commitment to patient safety by ensuring these capabilities have sufficient resources and generate information that is critical for providing safe care.

Safer Together was designed to be used by a wide variety of organisations with varied experience and capabilities that support safety improvement. Since the Self-Assessment Tool and Implementation Resource Guide are aligned with the Safer Together recommendations, leaders can maintain consistent framing as they move from familiarity with the recommendations, through an assessment of their own organisational status, to the point of implementing actions that will improve care. Recommendations from Safer Together, along with corresponding parts of the Self-Assessment Tool and the Implementation Resource Guide, illustrate this logical flow from concept to actions that improve patient safety. Table 2 highlights concrete examples and potential solutions from Safer Together that organisations can use to create momentum in the foundational areas through a complementary, fully integrated approach.

The level of success organisations will experience when implementing the four foundational areas of Safer Together is largely dependent, although not exclusively, upon their leadership. As leaders we must set the culture through actions and inclusion, dictating its trajectory while empowering patients, care partners, workforce and our greater communities to have active, meaningful roles. Only then can we truly address patient safety from a multidimensional perspective and continue advancing into the future.

AUTHOR'S NOTE

The authors are solely responsible for this paper's contents, findings and conclusions, which do not necessarily represent the views of AHRQ. Readers should not interpret any statement in this paper as an official position of AHRQ or of the U.S. Department of Health and Human Services.

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