The Partnership for Patients Campaign

Guide to Safety Across the Board

“This guide will help healthcare organizations develop systematic approaches to hardwiring safety into their organization’s culture. I applaud the PfP Campaign and the HEN leads for creating this Safety Across the Board Guide that can serve as a blueprint for promoting a culture that reduces all harm occurring in hospitals.”

—LaShannon Spencer, MPA, MHSA, Patient Advocate
Preface

The Hospital Safety Landscape in 2014

On December 2, 2014, at the 2014 QualityNet Conference, Secretary of Health and Human Services Sylvia Burwell announced a new report on hospital safety. This report outlined new hospital safety numbers that showed a 17% reduction in hospital safety events from 2010 to 2013, based on the Agency for Healthcare Research and Quality (AHRQ) National Scorecard measurement system designed and produced under the Partnership for Patients. This improvement in hospital patient safety corresponds to a reduction of harm events in US hospitals of 1.3 million events over the last three years. It corresponds to estimated savings of approximately $12B. Most importantly, it represents 50,000 lives saved. These results show that “Safety Across the Board (SAB)” in US hospitals is possible. This improvement happened at a time of great change in the US health care system. It corresponded to the time of the enactment of the Affordable Care Act, and the simultaneous implementation of many new features of health care system reform in our country, including payment reform and incentives for improvement, a new Quality Improvement Organization Program, many new State programs targeting health care quality improvement, initiatives and contributions by many federal and private partners, and the Partnership for Patients. All of these factors have contributed to these powerful and impressive results.

As encouraging as these results are, Secretary Burwell stated in her speech that this is “a start.” The 26 Hospital Engagement Networks (HENs) of the Partnership for Patients have put together this “Guide to Safety Across the Board” as a distillation of their experiences over this time period of great change and improvement in our health care system. Much more work remains to be done. It is the hope of the Hospital Engagement Networks that this short executive level guide be useful to hospital CEOs and hospital boards, who are entrusted with the responsibility for the safety of patients in their hospitals, to help to rapidly drive harm rates even lower over the next few years. As per the request of the Secretary on December 2, 2014, “I need your help in accelerating the pace of our progress.”

Secretary Burwell asked for a “call to action.” The 26 HENs that prepared this guide believe that by adopting the guiding principles outlined here, every hospital will be able to deliver on the Secretary’s important request.
A Hospital Guide to Safety Across the Board

Purpose of the Guide

Every hospital in the United States has as its mission to provide quality and safe patient care. Every patient and family member expects hospitals to meet or exceed this goal. At a very basic level, patients expect we will not harm them, and so “to do no harm” should be the top priority of every hospital in our nation. Proven and practical strategies for hospitals to achieve “Safety Across the Board” and an introduction to the origin of Safety Across the Board can be found on the PIP Community of Practice.

This guide was developed by the Hospital Engagement Networks (HENs) with support from the Partnership for Patients. It summarizes the collective experience of 26 HENs collaborating with more than 3,700 hospitals on achieving Safety Across the Board. This document describes a framework of fundamental concepts and ways every hospital executive can commit to providing safe care and achieving Safety Across the Board.

All 26 HENs Participating in the Partnership for Patients Campaign

Contributed to the Knowledge Base for This Guide:

- The Health Research & Educational Trust, an affiliate of the American Hospital Association
- Ascension Health
- Carolinas HealthCare System
- Dallas-Fort Worth Hospital Council Foundation
- Dignity Health (formerly Catholic Healthcare West)
- Essential Hospital Engagement Network
- Georgia Hospital Association Research and Education Foundation
- Healthcare Association of New York State
- Hospital & Healthsystem Association of Pennsylvania
- Intermountain Healthcare
- Iowa Healthcare Collaborative
- Joint Commission Resources, Inc.
- Lifepoint Hospitals, Inc.
- Michigan Health & Hospital Association
- Minnesota Hospital Association
- Nevada Hospital Association
- New Jersey Hospital Association
- North Carolina Hospital Association
- Ohio Children’s Hospital Solutions for Patient Safety
- Ohio Hospital Association
- Premier
- Tennessee Hospital Association
- Texas Center for Quality & Patient Safety
- UHC (formerly University Health System Consortium)
- VHA
- Washington State Hospital Association
## Safety Across the Board

**Table of Contents:**

Safety Across the Board: The New Normal ................................................................. 5

1. Establish a Culture of Safety .................................................................................. 6

2. Engage the Patient and Their Family .................................................................... 7
   *Include the Patient Voice* ...................................................................................... 7
   *Address Health Disparities* .................................................................................. 8

3. Create Safety Across the Board ............................................................................ 8
   *A Formal and Dynamic “Safety Across the Board” Agenda* .................................. 8
   *Organize for Action* .............................................................................................. 10
   *Sustain the Gains* ................................................................................................. 10
   *Collaborate* ........................................................................................................... 11
   *Push the Business Case for Safety* ...................................................................... 11

4. Count All Harms .................................................................................................... 11
   *Choose a Performance Improvement Measurement System to Reduce All-Cause Harm* 11
   *Be Transparent* ..................................................................................................... 12
   *Put a Face on the Data; Make It Personal* ............................................................. 13
   *Act on Measurement* ............................................................................................ 14

Conclusion: Hospitals in Action ............................................................................... 14
The hospital is a complex, adaptive system where people, process, and technology intersect in the work environment. The work environment supports providers who deliver care interventions for a wide spectrum of acute care conditions, by a variety of medical specialties, in various departments and nursing units, and as a result, each encounter has the potential for some risk of unintended patient harm. “Safety Across the Board” happens when the hospital has a culture of safety and a sensitivity to operations that makes it “difficult to do the wrong thing” and therefore easy “to do the right thing” to prevent patient harm and keep care providers safe.

In order to improve the system of care, all associates and providers must willingly report “near misses” and report serious safety events (with and without harm). As a result, learning from each occurrence will influence the continuous design of safer systems and processes that improve safety and the work environment. As one patient advisor put it, “Who wants to go to a hospital that only pays attention to 2 or 3 harm areas!” Having measurement systems that are capable of adding up all the harm events that occur and representing how many of their patients are harmed “puts a face” on the harm data.

Safety Across the Board occurs when hospitals take a systemic approach to measuring, monitoring and continually improving care. Rather than using a project-by-project or unit-by-unit approach, the focus shifts to systems thinking to reduce all harms occurring in the hospital. Leadership commitment and board of director’s engagement are two ways to promote “no harm.” Organizational infrastructure and a comprehensive reporting and measurement system that can analyze and respond to the data collected is another important component. A dynamic and responsive performance improvement measurement system assists those who deliver care and receive care. Continuous improvement, including addition of new topics for investigation and assessment, is suggested.

Safety Across the Board is something we all make happen. It is driven by four imperatives:

1. Establish a Culture of Safety
2. Engage the Patient and Their Family
3. Create Safety Across the Board
4. Count All Harms

“Care is being provided to a person, not a diagnosis or case. Personalizing the care helps to drive improvement with preventing harm. Personalizing the harm assists with preventing recurrence.”
—Lynda Martin, RN, BSN, MPA
Director, Pennsylvania Hospital Engagement Network, Hospital & Healthsystem Association of Pennsylvania

Safety Across the Board

Using the four imperatives outlined in this guide will set the course for Safety Across the Board. It is a professional as well as personal commitment to being a highly reliable organization that has patient and family centered safe care at its core.

There are six action steps that ensure Safety Across the Board:

1. Publicly commit to eliminate harm in your facilities
2. Use the Safety Across the Board Guide in a Board Executive Strategic Planning Exercise
3. Use the Safety Across the Board Guide as a self-assessment tool
4. Charter a Patient and Family Advisory Council to champion Safety Across the Board
5. Work to eliminate health disparities
6. Charter a Clinical Committee to certify that the data and measures are showing safety
Taken together, they enable us to make our hospitals safe today.

1. **Establish a Culture of Safety**

   A safety culture exists within an organization when each individual employee, regardless of position, assumes an active role in error prevention and that role is supported by the organization. A safety culture includes the values, beliefs, assumptions, and behaviors about safety defined by members of the organization.

   The organization supports a culture of patient and worker safety when leadership creates an open and non-punitive environment whereby any employee can speak up when they see an unsafe act or process of care. Key drivers are:

   - Leadership makes safety a top priority in the organization and allocates the necessary resources.
   - Leadership sets expectations for behavior and support and rewards staff for exhibiting a commitment to safety.
   - Leadership promotes and models teamwork behaviors.

   A just culture encourages open and full disclosure of events once they are investigated by subject matter experts to fully inform the person/patient. “Just culture” fosters the transparent response of the organization to unanticipated events. Punishing people for events or unanticipated events does not create a culture of safety; focusing on the common cause of events and how to improve the system does. However, accountability in the system is critical. There are three types of mistakes. The first is human error – a slip or lapse. These individuals should be consoled. The second is at-risk behavior. This is a behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified. These individuals should be coached. The last type of mistake is reckless behavior. This is a behavioral choice to consciously disregard a substantial and unjustifiable risk. These individuals should be sanctioned.

   In addition to a safe and just culture, an organizational commitment to high reliability concepts creates reliable safe performance in light of uncertainty and unpredictability. The hallmarks of a highly reliable organization include:

   - Sensitivity to operations
   - Reluctance to simplify
   - Healthy preoccupation with failure
   - Deference to expertise
   - Commitment to resilience

---

These identify essential elements of organizational traits and characteristics that build and reinforce a culture of quality, preparedness, and containment and instill a sense of collective mindfulness. They also foster an environment to support and spread improvement initiatives, which makes the organization’s performance more reliable.

Despite the commitment by a hospital to do no harm, errors do occur. When an unanticipated event occurs, communicate openly and honestly under a policy known as “full disclosure.” How the message is conveyed may require subtlety; however, the truth should be told. It can be difficult to admit a mistake. Communication with the patient and their family can be more difficult when a patient is harmed, seriously or otherwise; therefore, knowing how to disclose the information appropriately and address it forthrightly is important.

“Hospitals are a costly and sometimes dangerous place that can be transformed when leaders, care providers and associates work in harmony to design highly reliable environments of care. It is possible to keep patients at the center of all that we do and our providers safe by enabling them with voice and the ability to continually improve their work environment.”
—Ann Hendrich, RN, PhD, FAAN
Senior Vice President, Chief Quality/Safety/PSO and Nursing Officer, Ascension Health System

2. Engage the Patient and Their Family

Include the Patient Voice
Engaging patients and families is critical to achieving Safety Across the Board. Incorporating the patient voice into hospital operations actively facilitates quality improvement. Integrate the patient voice into care design and operations by:

- Involving patients and families at the point of care
  - Incorporate patients and their caregivers in the care rendered such as during bedside shift reporting and in the discharge planning process
  - Uphold shared decision-making
  - Use teach back
- Partnering with patients and families in developing policies and procedures, designing the environment and conducting walking rounds
  - Develop a Patient and Family Advisory Council (PFAC)
  - Include patients on quality improvement teams
  - Designate a staff person responsible for patient and family engagement
- Incorporating patient advisors on the decision-making level such as on the Board of Directors
- Working with patients and families to build a healthier community
  - Include patients and families in community health needs assessments to identify barriers and needed resources
  - Prepare patients and families in healthcare decisions prior to hospitalization

“As hospitals and health systems commit to collecting data and employing new strategies to improve safety, they need to incorporate patient and family engagement as it can transform an organization’s culture in important and profound ways. Patients bring a much needed voice and perspective to quality improvement efforts and can help identify additional methods to reduce harm.”
—Charisse Coulombe, MS, CPHQ, Vice President, Health Research & Educational Trust
In addition, Patient and Family Advisory Councils, or PFACs, support the Safety Across the Board efforts of the organization by empowering the advisors through training to call for the elimination of all harm and making them familiar with what is being measured.

**Address Health Disparities**

Health equity is a key tenet to achieving hospital Safety Across the Board. Research supports paying particular attention to vulnerable populations, as they are disproportionately impacted by adverse outcomes. By addressing disparities in safety performance, we create systems that are responsive to the unique needs of our patient populations. The driving characteristics of disparities in quality and safety are commonly associated with race, ethnicity, culture, language and demography. Operationalizing performance strategies to address health equity helps to identify targeted areas of focus that work to eliminate all harm for all patients. Health service delivery organizations focused on health equity create a systems approach to treating the whole person and safeguarding all patients from harm.

Deployment of equitable safety performance strategies include:

- **Look for the signal of disparities in safety**: Collect, integrate and utilize patient demographic data in clinical decision-making and safety outcomes performance tracking.
- **Get into action**: Issue a charter and develop a workgroup that will organize goals, objectives and activities.
- **Apply best practices**: Ensure diversity and inclusion of stakeholders. Consider activating patient voices in collaboration with clinical teams to improve patient and family engagement and diversity of perspectives.
- **Rapidly improve outcomes**: Instill best practice, discipline and methods.

3. Create Safety Across the Board

**A Formal and Dynamic “Safety Across the Board” Agenda**

Hospitals with SAB agendas can describe the universe of harms they are currently tracking and their method and plan for increasing that universe. Their agendas are transparent to the staff and public and are supported by the Hospital Board, Medical Staff and Administration. The SAB is a formal commitment of hospital intent and accountability.

Hospitals can benchmark their formal safety agenda against the set of topics and measures that the Agency for Healthcare Research and Quality (AHRQ) set for Partnership for Patients to capture all harm. The planning work group for the Partnership for Patients, which included AHRQ, CMS and others,
developed a list of nine adverse events that constitutes about 80% of measureable harmful events in hospitals:

- **Adverse Drug Events (ADEs)**
- **Catheter-Associated Urinary Tract Infection (CAUTI)**
- **Central Line-Associated Blood Stream Infection (CLABSI)**
- **Falls with Injury**
- **Obstetrical Adverse Events, including Early Elective Deliveries (EEDs)**
- **Pressure Ulcers**
- **Surgical Site Infection (SSI)**
- **Ventilator-Associated Pneumonia/ Ventilator-Associated Events (VAP/VAE)**
- **Venous Thromboembolism (VTE)**

*All drug-related adverse events should be measured. In particular, events involving anticoagulants, poor glycemic control and opioids should be tracked because they represent the majority of ADEs. Click [here](#) for The National Action Plan for Adverse Drug Event Prevention (ADE Action Plan).

> “It is important to use a systematic performance improvement process to address and resolve adverse events and to sustain gains. By doing so we build capacity to see and address new safety topics that offer more opportunities for improvement.”
> —Lynda Martin, RN, BSN, MPA
> Director, Pennsylvania Hospital Engagement Network, Hospital & Healthsystem Association of Pennsylvania

A 2010 baseline of 145 harms/1000 discharges was established. In addition, 30 day readmissions was added to the safety agenda, with a 2010 baseline of 144/1000 discharges. All nine conditions and 30 day readmissions had evidence based practice bundles that were known to work. For the 3,700 hospitals participating in PfP (2011 – 2014) this became the hospital safety agenda. The goal was, by 2014, to reduce harms by 40% and readmissions by 20% over baseline. Today, aggressive management of these events constitutes the baseline definition of having Safety Across the Board.

As the state of knowledge about harms increases, the SAB agendas will grow. Late in 2013 a second collaborative effort was introduced that advanced SAB. The original Partnership for Patients harm agenda did not include a number of serious safety topics because they were under defined and had limited evidence of improvement practice. CMS introduced a rapid cycle development process called Leading Edge Advanced Practice Topics (LEAPT). Six HENs and a subset of their hospitals took under defined serious harm topics to a state of “readiness” for spread in a matter of months. Nine additional areas of harm are now ready or are being made ready for national spread.

- **Clostridium difficile (C. diff)**
- **Hospital-Acquired Acute Renal Failure**
- **Culture of Safety including Worker Safety**
- **Iatrogenic Delirium**
- **Procedural Harm**
- **Severe Sepsis and Septic Shock**
- **Undue Exposure to Radiation**
- **Failure to Rescue**
- **Airway Safety**
A hospital’s Safety Across the Board agenda can encompass the original 10 adverse event topics and the 9 newly developed topics. A hospital’s safety improvement committee can assess how robust and complete its agenda is by comparing it to the Partnership for Patients goal structure.

**Organize for Action**

In order to achieve Safety Across the Board, frontline staff from all departments and unit/department managers are actively involved alongside engaged and active leadership. A frontline champion for each priority area drives change and is accountable for the results with metrics and outcomes. The champion, along with an interdisciplinary team of hospital staff such as Case Managers, Patient Safety Officers, Quality Improvement Specialists and Infection Preventionists, lead the improvement efforts as “key stakeholders and subject matter experts.” These experts drive improvement through resources and project support provided by the champion and organization. The interdisciplinary team convenes and acts to support the change process within the workforce. Culture and leadership is local and behavior change is adopted best when a respected peer convinces others to adopt and sustain the desired change in behavior.

Safety Across the Board requires a comprehensive, continuous model of improvement with an inherent ability to deploy small tests of change within an integrated safety system. Coordinated communication and centralized tracking of improvements maximizes adoption and spread that can be sustained over time while building more capacity for change. Key functional areas such as safety, quality, infection control, medical staff office and patient advisors partner and collaborate with each other in a formal way. Integrating these functions under one senior leader is an effective way to facilitate collaboration.

**Sustain the Gains**

Sustainability means making sure that the goals of projects continue to be met through activities that are consistent with the desired outcomes. This comes through building an infrastructure that facilitates care in a consistent, safe manner. Key components of a sustainable structure include:

- Strong leadership at all levels of the organization to “hardwire” the changes to “do it right, every time.”
- Systematic, multifaceted training approaches that continually reinforce the desired behaviors to current staff and introduce expectations to new staff.
- Monitoring and information sharing focuses the information learned from the data toward learning opportunities.
- Personal accountability can be achieved through emphasis on unit-based safety culture where the staff is empowered to speak up and recognized for putting safety first.

It is best that sustainability be considered at the onset of any initiative. Safety Across the Board means that when it comes to harm, you can never take your eye off the ball. Remain vigilant to maintain the gains that your hospital achieves through initiatives related to eliminating harm.

“Sustainability is harder than getting there in the first place. It requires one to maintain focus while multiple other priorities require your attention. Leadership must reinforce a new mindset – getting to zero and maintaining successes is not the ‘flavor of the month’ but a new norm to ensure patient centered care.”
—Rosalie Weakland, RN, MSN, CPHQ, FACHE, Ohio Hospital Association
Collaborate

Internal and external collaboration is critical to the provision of safe care. Strive for excellent teamwork internally. This includes an effective team structure, collaborative communication, aligned leaders, effective situation monitoring and mutual support. The Agency for Healthcare Research and Quality (AHRQ) has an outstanding program available on teamwork, free of charge, entitled TeamSTEPPS® 2.0.

Externally, hospital collaboration with other entities is fundamental to successful improvement. Collaboration with other healthcare settings across the care continuum is critical to effective “hand-offs and smooth care transitions.” Mutual goals help to drive improvement across settings. Benchmarking with organizations both inside and outside of healthcare generates best practices that can be adapted and adopted to suit the organization.

Collaborate with physicians and other providers such as nursing homes, home health agencies, rehabilitation settings, area agencies on aging and community organizations. Establish community partnerships to provide a holistic approach to providing safe care across the continuum. This consists of community partnerships; joining an established collaborative locally, regionally or nationally; or contacting an organization to mentor the team on a particular safety topic or Safety Across the Board.

“Safety Across the Board is everyone’s goal. Community wide partnerships are crucial in providing effective care coordination. Collaborating with both the internal care team and external healthcare providers and community resources lead to patient and family centered safe care. Hospitals can no longer do it alone.”
—Joyce Reid, Vice President, Community Health Connections, Georgia Hospital Association

Push the Business Case for Safety

As a hospital moves toward an idealized environment of safety, the outcomes affect productivity, operating costs, utilization and revenue and can facilitate achievement of the Triple Aim of the National Quality Strategy related to improvements in cost, quality and access. Assets become available for redeployment as new business opportunities arise and new efficiencies can be introduced. Safety should be a strategic initiative in the hospital’s financial plan.

4. Count All Harms

Choose a Performance Improvement Measurement System to Reduce All-Cause Harm

Choosing measures in order to track progress in eliminating harm is integral to achieving Safety Across the Board. The more transparent the system, the faster the improvement will occur.

National databases for standardized measures offer indicators for hospital-acquired conditions and readmissions. Using these standardized measures fosters the ability to benchmark against the best hospitals in the nation as well as evaluate your hospital’s progress over time.
Some organizations that offer reliable measures of harm include:

- Centers for Medicare & Medicaid Service (CMS)
- Centers for Disease Control and Prevention’s National Healthcare Safety Network (NHSN)
- Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSIs)
- National Quality Forum (NQF)
- National Database of Nursing Quality Indicators (NDNQI)
- The Joint Commission (TJC)

Once a measurement system is established, strive to expand the focus by adding other measures of harm to the metrics. If standardized measures are not available for some adverse event areas of interest, establish a baseline for comparison and seek input from clinical staff to determine process and outcome measures that can detect a change from that baseline. A key consideration is to start measuring and then expand (e.g., measuring CAUTI only in the ICU expanded to measuring CAUTI for all patients over time, unit by unit, utilizing electronic capture of this data from existing systems).

In addition to selecting measures, maximize a thoughtful and well-resourced data collection system and/or interfaces that unite disparate data and minimize burden for the Quality Department and others involved in data collection. Every attempt should be made to build the indicators into the electronic medical record (EMR), and resources should be allocated to support staff in collecting the data when this is not possible. Include frontline staff in data development to seek their expertise and validate findings while also instilling a sense of ownership. When adding indicators to the EMR, be mindful of how to retrieve the data. Having a clear picture of the essential data elements and aggregate reports to be generated will assist you in standardizing data collection at the point of care and assist in taking action.

**Be Transparent**

Hospitals are asked to commit to the public display of quality safety data to demonstrate Safety Across the Board.

There are two levels of data that will be a positive force for both celebration and progress. One is to measure and track progress on each topic in the SAB agenda. The other to measure and track total harms. The first guides improvement in specific areas. The other makes it more personal.

"Data transparency drives change – changes in behavior which lead to changes in patient outcomes and experience. No matter how good you are, you have opportunities to improve if you know where those opportunities are. You can't act on what you don't see."

—Mitzi Ressmann, RN, FACHE, President/CEO, Texas Hospital Association Foundation
One mechanism used to display this is a scorecard or dashboard. The following is an example of a Hospital System dashboard showing progress on each topic. This is very effective for Executive and Board review.

Put a Face on the Data; Make It Personal

Tracking total harm is compelling data with an emotional impact. To see how many patients are being harmed by quarter, sum the count of all harms and show it in graphic form. When the Board and staff realizes how many people are being harmed their commitment to safety is dramatically enhanced. Below is an example of such a data display from a Georgia HEN network hospital:

“When organizations stop looking at harm rates and denominators, and begin to focus on only the numerators or numbers of patients harmed, this changes the focus of the staff from data to people and it becomes a personal crusade to keep those numbers to a minimum.”
—Cathleen Krsek, MSN, MBA, RN, FAAN
Senior Director, UHC
In addition to the graphic results, patient stories at board and staff meetings are very powerful to make the issue personal. This will engage the heart as well as the mind and reinforce the desired behaviors with care providers.

**Act on Measurement**

In addition to graphical depictions, data should be translated into information that fuels action. Making data transparent is an effective way to foster a sense of accountability for hospital employees and medical staff toward improvement efforts and operational results in safety. Data should be available to all staff, the Board of Trustees, and the public through the hospital’s website and newsletters.

Relevant data should be displayed on the units. As leaders conduct rounds for safety, they should be engaging with staff as they review this data. In this way, the leaders can celebrate the positive outcomes with staff as well as explore and discover the barriers to success to help identify educational opportunities aimed at mitigating those barriers.

Today’s healthcare system demands a comprehensive and integrated quality management system that is designed to identify, analyze and act to eliminate harm and improve quality and the care experience with lower cost. Our patients deserve no less.

**Conclusion: Hospitals in Action**

This Partnership for Patients’ guide will enable hospital leadership to set the course for Safety Across the Board. It is a professional as well as personal commitment to being a highly reliable organization that has patient and family-centered safe care at its core.

Hospital leadership is asked to publicly and formally commit to Safety Across the Board. There are six action steps that hospital leadership would take to exercise that commitment.

1. Publicly commit to eliminate harm in your facilities
2. Use the *Guide to Safety Across the Board* in a Board Executive Strategic Planning Exercise
3. Use the *Guide to Safety Across the Board* and the experiences of the Partnership for Patients as a self-assessment tool
4. Charter a Patient and Family Advisory Council to champion Safety Across the Board
5. Work to eliminate health disparities
6. Charter a Clinical Committee to certify that the data and measures are showing safety

Wherever the hospital is on its quality journey, we hope that this guide will assist you in reducing harm within your hospital and creating Safety Across the Board as your new normal. The organizations that created this document (page 2) stand ready to assist you in this journey.