Aligning Baldrige and the Agency for Healthcare Research and Quality Criteria for Creating a Culture of Patient Safety: A Convergence to Create a Winning Culture

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The *Wall of Silence* (Gibson, 2003) presents, in its early pages, the visceral phrase, "So much harm, so little done."

In spite of careful clinical practices, adverse events occur. At best we try to determine what occurred and why; none of us wants to relive a mistake. At worst, we have short-term memories: we forget why we implement safe systems of care.

Though healthcare facilities may protest, the Joint Commission has implemented challenging patient safety initiatives which help achieve consensus on patient safety issues. Some hospitals have implemented *AHRQ's Culture of Patient Safety Survey*-in 2009 there will be a major emphasis on the use of this tool.

An Introduction to the Culture of Patient Safety and Why this is important:

AHRQ includes the following expectations for a healthcare system to gain insight into its level of commitment to patient safety:
Governance/Leadership must own the accountability for organizational performance, the actual *culture* that defines the organizations approach and response to safety issues must be defined, the *Patient Safety Progr*am to support strategic focus has to be complete and well communicated, process *design and re-engineering* will have to be continuous, *measurement and monitoring* of performance must take precedence, and a *safe, learning environment* for staff has to be created.

The actual survey to assess patient safety from the Agency for Healthcare Research and Quality (www.ahrq.gov) assesses work area/environment, management, communications, systems for error reporting, and perceptions of outcomes relative to patient safety overall.

As if on queue, these words produce a familiar imprint in our minds as we read them and note their similarity to the Baldrige Criteria.

Tools, established by The Malcolm Baldrige National Quality Improvement Act of 1987, include a structured self-assessment framework that advocates performance excellence through continuous improvement. Highlighting role model performers in various industries ensures credible criteria for evaluating improvement and sharing of best practices. Since 1999, when the criteria were expanded to include healthcare, eight healthcare systems have earned this award. *www.nist.gov/baldrige*

Hammering home the pursuit of excellence, both of these lighthouse organizations require honest self assessment; both position leadership as a major driver in this quest. Stakeholder and market voices drive strategic plans. Attention to the creation and maintenance of a positive workforce environment are foundational. Finally, a goal of systemic transformation through process review and improvement and the data to document that journey are by-products of these challenging criteria.

The Agency has determined that medical error often occurs because of human factors and teamwork /communications breakdown. Cultural barriers emerge as a major contributor to this alarming and disarming medical reality.

(Denney, et al, 2009) states that it is no surprise that Baldrige award recipients often demonstrate "stronger patient safety outcomes compared with their peers." Use of the Baldrige criteria to strengthen an organization will strengthen patient safety efforts.

Malcolm Baldrige National Quality Association (MBNQA) brings a focused approach to AHRQ's survey responses and provides a more proactive path to organizational effectiveness.

The *Wall of Silence* speaks again and questions if "So much good, (is) good enough?" When it comes to patient safety, our mantra must be, "good enough is never good enough" even one error is one too many.

Leading an MBNQA Award winning Team, Sister Mary Jean Ryan says "Baldrige is the best way to get better faster."

Focused on "So little harm, and so much done," these combined improvement tools challenge us to do the hard but worthy work of keeping our patients safe. Maintaining a, "laser like" focus on excellence is our only choice for the sake of our patients, our organizations and ourselves.

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