patient
safety
learning

Feedback on the CMS list of Measures Under Consideration: Patient Safety Structural Measure (#MUC2023-188)

This submission to relates to our organization's support of the Patient Safety Structural Measure (#MUC2023-188) on the Centers for Medicare & Medicaid Services (CMS) list of Measures Under Consideration.

Patient Safety Learning

Patient Safety Learning is a charity and independent voice for improving patient safety. We harness the knowledge, enthusiasm and commitment of healthcare organisations, professionals and patients for system-wide change and the reduction of harm. We believe patient safety is not just another priority; it is a core purpose of health and social care. Patient safety should not be negotiable.

Through our work we support safety improvement through policy, influencing and campaigning and the development of 'how to' resources such as *the hub*, our free award-winning global platform to share learning for patient safety, and our unique Patient Safety Standards and support tools.

Patient Safety Structural Measure

Modern healthcare is increasingly complex and there are many ways that avoidable harm can occur during care and treatment – it is estimated that one in every ten patients is harmed while receive hospital care.[1] This harm can be caused by a range of patient safety incidents, and more than 40% of these incidents are preventable.[2]

At Patient Safety Learning we believe that reducing avoidable harm should be a top priority for governments, organizations and individuals. Every avoidable death and disability is an unnecessary tragedy for patients, families and healthcare professionals. In addition, patient harm comes at a huge financial cost, with the Organization for Economic Co-operation and Development (OECD) estimating that in high-income countries the direct cost of treating patients who have been harmed during their care approaches 13% of health spending.[3] Excluding safety lapses that may not be preventable, this figure is 8.7% of health expenditure.[4]

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[1] WHO, Patient Safety, 13 September 2019. https://www.who.int/news-room/fact-sheets/detail/patient-safety

[2] de Vries EN, Ramrattan MA, Smorenburg SM, Gouma DJ, Boermeester MA., The incidence and nature of in-hospital adverse events: a systematic review. Qual Saf Health Care. 2008;17(3):216–23. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2569153/

[3] OECD and Saudi Patient Safety Center, The Economics of Patient Safety. From analysis to action, 21 October 2020. https://www.oecd-ilibrary.org/social-issues-migration-health/the-economics-of-patient-safety_761f2da8-en

[4] Helen Hughes, Improving patient safety: a financial imperative, Healthcare Financial Management Association, 17 May 2023. https://www.hfma.org.uk/articles/improving-patient-safety-financial-imperative

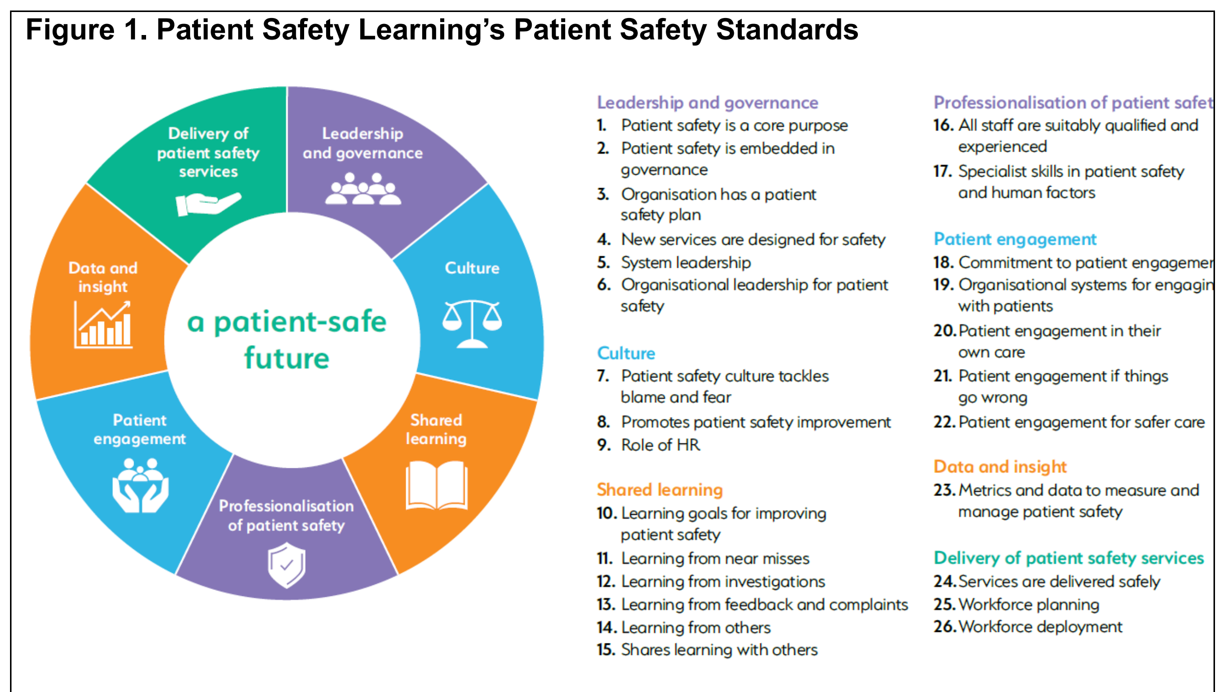
In our report, *A Blueprint for Action*, we set out the need for a transformation in the healthcare systems approach to patient safety.[5] We explain how too often, patient safety is typically seen as a strategic priority, which in practice will be weighed (and inevitably traded-off) against other priorities. To transform our approach to this, we believe it is important that patient safety is not just seen as another priority, but as a core purpose of health and care.

We therefore strongly support the Patient Safety Structural Measure's statement that, given the persistence of patient harm at significant rates, a 'systems-based approach to reducing patient harm is necessary within the complex healthcare ecosystem'. We are supportive of the model proposed in the Measure to work towards this, an attestation-based measure which assesses whether hospitals demonstrate having a structure and culture that prioritizes patient safety. The proposed new quality measure aligns with our organizational view that it is essential that we apply standards of good practice for patient safety in the way that we do for other issues.

Alignment with our Patient Safety Standards

At Patient Safety Learning, initially looking at the healthcare system in the United Kingdom, we have developed a unique set of unique patient safety standards centred around seven key foundations for patient safety which share much in common with the Patient Safety Structural Measure.[6]

Figure 1. Patient Safety Learning's Patient Safety Standards



Underpinning each Foundation and Aim in our Patient Safety Standards there are a series of clearly defined Standards that explain what an organization must do to deliver against their specific requirements. For each Standard, there are details of evidence-based outputs, outcomes and behaviours required to enable an organisation to demonstrate achievement against those Standards.

[5] Patient Safety Learning, The Patient-Safe Future: A Blueprint For Action, 2019. https://s3-eu-west-1.amazonaws.com/ddme-psl/content/A-Blueprint-for-Action-240619.pdf?mtime=20190701143409
[6] Patient Safety Learning, Why Standards?, Last accessed 19 December 2023. https://www.patientsafetylearning.org/standards

In total, there are 144 identified Standards. These represent the core for any organisational safety improvement strategy and delivery plan.

Each of the Standards is identified against our three-level Accreditation Framework ranking of: Essential; Enhanced; Exemplary. A core resource for using our Standards is our online self-assessment toolkit designed to capture self-assessment scores, as well as record the basis of assessments, identify goals for improvement and enable relevant documentation to be uploaded. It serves as an action-planning tool, supporting the development of improvement plans, as well as outcome and measurement frameworks.

The attestation-based model proposed in the Patient Safety Structural Measure has a similar basis to our Patient Safety Standards, enabling organisations to self-assess their current patient safety performance, identifying both strengths and weaknesses. The outputs can form the basis for a comprehensive patient safety strategy, as well as the foundations for evidence-based improvement programmes.

Likewise, organizations are assessed in our Patient Safety Standards against each of the seven foundations, which significantly align and overlap with the five domains set out in the Patient Safety Structural Measure. In the remainder of our feedback, we will set out our views on each of the five domains included in the Measure.

Domain 1: Leadership Commitment to Eliminating Preventable Harm

To reduce patient harm, we need a model for leadership and governance for patient safety in healthcare that sets and requires high and consistent standards and behaviours of our leaders. At Patient Safety Learning we identify this as one of the six foundations of safer care in our report, *A Blueprint for Action*.[7]

We therefore strongly support the Patient Safety Structural Measure identifying senior leadership and governing board commitment as key to improving patient safety. We concur with the view that patient safety 'should be central to all strategic, financial, and operational decisions'.

Considering the activities listed for attestation statements, we in particular support:

- Ensuring that relevant patient safety metrics and information on the execution of initiatives are shared with the hospitals and governing boards.
- Enshrining measures to ensure reporting on serious safety incidents to governing boards.

We also think it may be valuable to consider as part of this having named organizational leaders at Board level (executive and non-executive) for patient safety and patient engagement.

Domain 2: Strategic Planning & Organizational Policy

We support the Patient Safety Structural Measure's emphasis on ensuring that hospitals leverage strategic planning and organization policies to demonstrate a commitment to safety as a core value. As mentioned earlier in our submission, we also believe that patient safety should be at the core of every healthcare organization's work, not simply another priority weighed against others.

[7] Patient Safety Learning, The Patient-Safe Future: A Blueprint For Action, 2019. https://s3-eu-west-1.amazonaws.com/ddme-psl/content/A-Blueprint-for-Action-240619.pdf?mtime=20190701143409

Considering the activities listed for attestation statements, we in particular support:

- Hospitals publicly sharing in their strategic plans their commitment to patient safety.
- Implementing written policies and protocols to cultivate a just culture that balances no-blame and appropriate accountability. We believe that organizational leadership behaviours need to also evidence practical commitment of an open and fair culture.
- Implementation of a patient safety curriculum and competencies for all clinical and non-clinical hospital staff. This aligns with our Patient Safety Standards, in which we set out the importance of all staff being suitably qualified and experienced as part of this.[8]

Further to the above points, we believe it may be valuable to consider:

- The role of effective multi-disciplinary (MDT) working, which we believe is core to patient safety. This could include having formal requirements for effective MDT training.
- Capacity for patient safety and human factors specialists and having competency frameworks that inform training needs analysis and education programmes.
- Decision frameworks for patient safety including business cases, cost benefit analysis and other impact assessment tools.
- Considering how patient safety should be integral to care pathway design and delivery.
- Workforce planning, skills and capacity for patient safety.
- Reliable clinical systems and processes including safe patient handovers and discharges.
- Medication and medical device safety system management.

Domain 3: Culture of Safety & Learning Health System

An organisational culture that seeks to assign blame when things go wrong makes patient harm more likely to happen again. A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution. The latter also forms a key part of the *Strategic Objective 2 – High-reliability systems*, set out in the World Health Organization (WHO) Global Patient Safety Action Plan.[9]

In our report, *A Blueprint for Action*, we identify a Just Culture as one of the six foundations of safer care to improve patient safety, and this is also one of the key foundations in our Patient Safety Standards.[10] [11] To meet our Standards an organisation needs to demonstrate that:

- Its leadership fosters a patient safety culture and tackles blame and fear.
- The working environment actively supports and promotes a culture of patient safety improvement.

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[8] Patient Safety Learning, Why Standards?, Last accessed 19 December 2023. https://www.patientsafetylearning.org/standards

[9] World Health Organization, Global Patient Safety Action Plan 2021-2030: Towards eliminating avoidable harm in healthcare, 3 August 2021. https://iris.who.int/bitstream/handle/10665/343477/9789240032705-eng.pdf?sequence=1

[10] Patient Safety Learning, The Patient-Safe Future: A Blueprint For Action, 2019. https://s3-eu-west-1.amazonaws.com/ddme-psl/content/A-Blueprint-for-Action-240619.pdf?mtime=20190701143409

[11] Patient Safety Learning, Why Standards?, Last accessed 19 December 2023. https://www.patientsafetylearning.org/standards

We therefore strongly support the Patient Safety Structural Measure stating the importance of hospitals integrating 'a suite of evidence-based practices and protocols that are fundamental to cultivating a hospital culture that prioritizes safety and establishes a learning system both within and across hospitals'.

Considering the activities listed for attestation statements, we in particular support:

- Regularly measuring patient safety culture through staff surveys.
- Participating in large-scale learning networks for patient safety improvement. This is something we support as an organization through our patient safety platform *the hub*. This hosts a number of growing information peer support networks for people involved in patient safety, providing forums to meet, discussing and sharing ideas and initiatives, and learn from others.[12]

Further to the above points, we believe it may be valuable to consider:

- Organisational leadership behaviours to evidence practical commitment of an open and fair culture.
- Emphasis on risk management in governance; risk registers and risk management action plans.
- How organisations tackle blame and fear.

Domain 4: Accountability & Transparency

We strongly support the Patient Safety Structural Measure's statement that 'accountability for outcomes, as well as transparency around safety events and performance, represent the cornerstones of a culture of safety'.

Considering the activities listed for attestation statements, we in particular support:

- Organizations having 'a confidential safety reporting system that allows staff to report patient safety events, near misses, precursor events, unsafe conditions, and other concerns, and prompts a feedback loop to those who report'.
- Organizations sharing serious safety events, near misses and precursor events with a Patient Safety Organization listed by the Agency for Healthcare Research and Quality.

Further to the above points, we believe it may be valuable to consider:

- Beyond individual organizations, how learning from incident investigations is shared between organizations, whether this relates to when patients are harmed or near misses.
- We recognize that the above point may require work that is separate to this Measure, potentially considering how the Patient Safety Organizations listed by the Agency for Healthcare Research and Quality disseminate and share information that is reported to them by healthcare providers.
- How regulatory alerts and good practice are disseminated and implemented.

[12] Patient Safety Learning's *the hub*, Join a private community, 19 December 2023. https://www.pslhub.org/join-a-private-community/

Domain 5: Patient & Family Engagement

Patient engagement is increasingly recognised as being crucial to improving health outcomes and the overall quality of life of patients and their families. If successfully implemented, patient engagement can significantly contribute to a reduction in adverse events, which place a significant burden on patients, health systems and economies. This is identified as *Strategic Objective 4 – Patient and family engagement* in the in the WHO Global Patient Safety Action Plan and the WHO has also recently published a new Advocacy Brief on the importance of this.[13]

At Patient Safety Learning, we believe that patients should be engaged for safety at the point of care, if things go wrong, in improving services, in advocating for changes and in holding the system to account. We identify patient engagement as one of our six foundations of safer care in our report *A Blueprint for Action*, and it also forms one of the key foundations in our Patient Safety Standards.[14] [15] To meet our Standards an organisation needs to demonstrate that:

- It is committed to patient engagement for patient safety.
- It has established organizational systems for engaging patents for patient safety.
- Patients are engaged in promoting, designing and supporting safer care.

We therefore strongly support the Patient Safety Structural Measure's statement that hospitals 'must embed patients, families, and caregivers as co-producers of safety and health through meaningful involvement in safety activities, quality improvement, and oversight'.

Considering the activities listed for attestation statements, we in particular support:

- Patients having comprehensive access to and are encouraged to view their own medical records and clinician notes via patient portals and other options.
- Incorporating patient and caregiver input about patient safety events or issues.
- Supporting the presence of family and other designated persons (as defined by the patient) as essential members of a safe care team.

Concluding comments

We strongly support the intention and content of the Patient Safety Structural Measure (#MUC2023-188). As we have noted in our submission, there are a number of areas where these proposals overlap with the Patient Safety Standards we have developed, and we would welcome an opportunity to discuss how we could support this further if the Measure is adopted.

Thank you for this opportunity to make this public comment.

Patient Safety Learning, 21 December 2023
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[13] WHO, Engaging Patients for Patient Safety: Advocacy Brief, December 2023. https://iris.who.int/bitstream/handle/10665/375011/9789240081987-eng.pdf
[14] Patient Safety Learning, The Patient-Safe Future: A Blueprint For Action, 2019. https://s3-eu-west-1.amazonaws.com/ddme-psl/content/A-Blueprint-for-Action-240619.pdf?mtime=20190701143409
[15] Patient Safety Learning, Why Standards?, Last accessed 19 December 2023. https://www.patientsafetylearning.org/standards