“No unit is an island” might be the theme of a new Sentinel Event Alert from The Joint Commission (TJC).

“Health care leaders can . . . break down the barriers between clinical, operational and financial ‘silos’ by developing and recruiting leaders who understand the importance of all three areas working closely together in order to create safety,” says TJC in its Alert. (For more excerpts from the Alert, see p. 2. To access the complete Alert, go to www.jointcommission.org. Under “Sentinel Event,” click on “Sentinel Event Alert,” then “Issue 43: Leadership committed to safety.”)

ED managers agree that such silos, whether between different areas of the hospital or different disciplines within the department, are barriers to the successful creation of a safety culture. “You have to have representatives [from every unit] at each other’s meetings, as well as a [hospitalwide] quality meeting that focuses on safety every month,” says Kevin Klauer, DO, FACEP, director of quality and clinical education for Emergency Medicine Physicians, Canton, OH, and a staff emergency physician at Barberton Citizens Hospital and Lodi Community Hospital, both in the Akron/Canton area. “You’ve got to make sure safety is institutionalized into one system design — not 30 different ideas of what it is and what it means.” (This ability to share information is a vital ingredient in a successful safety culture. See the story on p. 2.)

India Owens, RN, director of emergency services at Clarian West Hospital in Indianapolis, says, “I think that most of the things we do, most of the processes we use, cross every one of our disciplines. This central approach is important because more often than not what you have difficulty with, I have difficulty with.” (The multidiscipline approach is reinforced at Clarian West by its Safe Passage Committee. See the story on p. 2. For additional information on creating a safety culture, see the story on p. 3.)

Accordingly, while there are corporate goals around safety, each department keeps a “scorecard” of its performance, and every department has its own goals to feed into the overall corporate goals, Owens says. The system is totally transparent, so the ED can view the scorecards of all the other departments in the hospital. “If I have a goal to reduce labeling errors and I wonder what kind of approaches should be used, I can go and look at what other units have done,” she explains. “If

Executive Summary

The Joint Commission has made it clear in a new Sentinel Event Alert that one of the keys to successfully creating a safety culture in any facility is the establishment of effective teamwork across clinical and managerial lines, or “silos.” Here are some of the successful strategies for teamwork cited by ED managers:

• Hold regular meetings involving representatives from all units and departments.
• Ensure adequate input from frontline staff; avoid a “top-down” approach.
• Within your department, hold joint meetings between physicians and nurses on an ongoing basis.

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another unit has a higher score in this area, I can review and discuss their tactics with them.”

Methodist Hospital in Sacramento, CA, held collaborative meetings between the physician staff and nursing. “You need the support of both to be effective,” says Cindy Myas, RN, MSN, director of emergency services. At Methodist, the triage process recently was overhauled to enhance patient safety. The triage nurse was put in the waiting room to serve as the “greeter.” She quickly determines if a patient should go home; requires further diagnostics and should be placed in the waiting room; or if they require an ED bed.

“If we were not all working in the same direction, this would not have worked,” Myas says.

During a series of meetings, both groups voiced their concerns, and everyone had to agree on the new processes, she says. “Our motto was, ‘If you come to the meetings, you get to make the decisions,’” Myas shares.

Administration also was a critical element, she says. “They had to be supportive,” Myas says. “They actually needed to sign on to what the leadership in the ED recommended because this hit our bottom line.” More staff were required to make the new process work, she explains. Administration approved the addition of two RNs to each shift, a midlevel physician’s assistant, and another physician for the busiest times in the ED. ■

**Multidisciplined group provides ‘safe passage’**

At Clarian West Hospital in Indianapolis, the ED participates in a multidisciplinary group that processes all safety issues. Called the Safe Passage Committee, it is led by the vice president of quality and safety.

“Frontline staff [members] attend the meetings and report back to leadership,” notes India Owens, RN, director of emergency services. Issues can be brought forward by staff or leadership. They are discussed, and an approach is decided upon. Meeting minutes are distributed throughout the hospital and also are available to any staff member online.

Many times, she notes, the decisions involve changing or creating a policy. At Clarian West, however, processes are part of the safety policies. “For example, in the ED, we have a policy for determining if a pregnant patient who presents should be sent to OB or stay in the ED,” Owens explains. “We have an algorithm embedded in the policy that outlines the steps a staff member goes through to make that determination — the key decision points.” The advantage to this approach is that ED staff members don’t have to go to two places (policies and processes) to find out what to do, she says.

Having all safety issues go through the committee ensures that safety practices unfold the same way in the ED as they do in other departments, Owens notes. Consider a hypothetical example in which there are three needlesticks in the ED related to a new product, she says. “It would go to that committee, and the vice president of quality and safety could make the decision to pull the product and communicate it to the entire hospital,” Owens says. “The product would be pulled, and we’d revert to a prior product.”

However, she adds, the process doesn’t stop there. At the next committee meeting the group would discuss whether this was truly a product failure or whether there was another factor involved. “Even if the product was pulled, we’d try to figure out the root cause,” Owens explains. “Maybe we did not educate the nurses well enough, or maybe the nurses were not used to the way the product was designed. We never just pull a product.” ■

**A safety culture key to reducing errors**

ED leaders agree that creating a safety culture that reaches across all hospital departments is the key to improving safety in any department. Kevin Klauer, DO,