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Clinical Excellence

A Leadership Framework for Culture Change in Health Care

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This article is the second of a series that charts the journey of one health care system, Ascension Health, toward the clinical transformation of inpatient care—and no preventable injuries or deaths.

In 2002 Ascension Health, the largest Catholic and largest nonprofit health care system in the United States, articulated a call to action to a commitment to "provide 100% access to safe, effective care in ways that satisfy patients, associates, and physicians." In 2005, Ascension Health's strategic direction sharpened the focus of the *Call to Action* to provide "Healthcare That Works, Healthcare That Is Safe, and Healthcare That Leaves No One Behind, for Life," as described in the first article in the Clinical Excellence series.[1] This article further introduces the series by describing the process by which Ascension Health changed its culture to enable it to successfully address its call to action—and effect transformational (rather than incremental) change.[1]

Ascension Health operates with a small system leadership group that works through "distributed influence," which involves promoting the desired behavior without command and control capability. Figure 1 (page 434) demonstrates pathways through which the elements of culture change flow in general from the system services office to and from the ministries—that is, hospitals or regional groupings of hospitals and health providers[1]—and their leadership, where accountability for results ultimately rests. In addition to formal in-person meetings, members of these groups communicate via e-mail, postings and listserves, and the Ascension Health intranet.

At Ascension Health we approach challenges in our care environments with the Five Cs of Culture Change, as follows:

Article-at-a-Glance

Background: In 2005, Ascension Health's strategic direction sharpened the focus of its 2002 *Call to Action* to provide "Healthcare That Works, Healthcare That Is Safe, and Healthcare That Leaves No One Behind, for Life," Ascension Health has used a framework, the Five Cs of Culture Change, to address the call to action—comprehension (understanding the problem), compassion (spirituality and commitment), collaboration (teaming between subcultures and providers), coordination (system processes, infrastructure, and ideation), and convergence (leadership of local culture with spread and dissemination of new norms in a rapid way).

The Five Cs of Culture Change and Culture Surveys: Climate (or culture) of safety results are provided from a baseline systemwide survey of front-line caregivers' assessments of teamwork and patient safety. The findings are aggregated at the hospital level, clinical area level, and caregiver role level, and fed back to executives, managers, and front-line caregivers. The final major element of culture change, and arguably the most important, involves the leadership and fortitude necessary to stimulate convergence of the culture on a new way of doing things.

Conclusion: Ascension Health will continue to use a systemwide culture survey for front-line assessments' of safety and teamwork across all clinical areas and to discover best practices and track progress in improving performance.

Action and Information Flow for Clinical Excellence

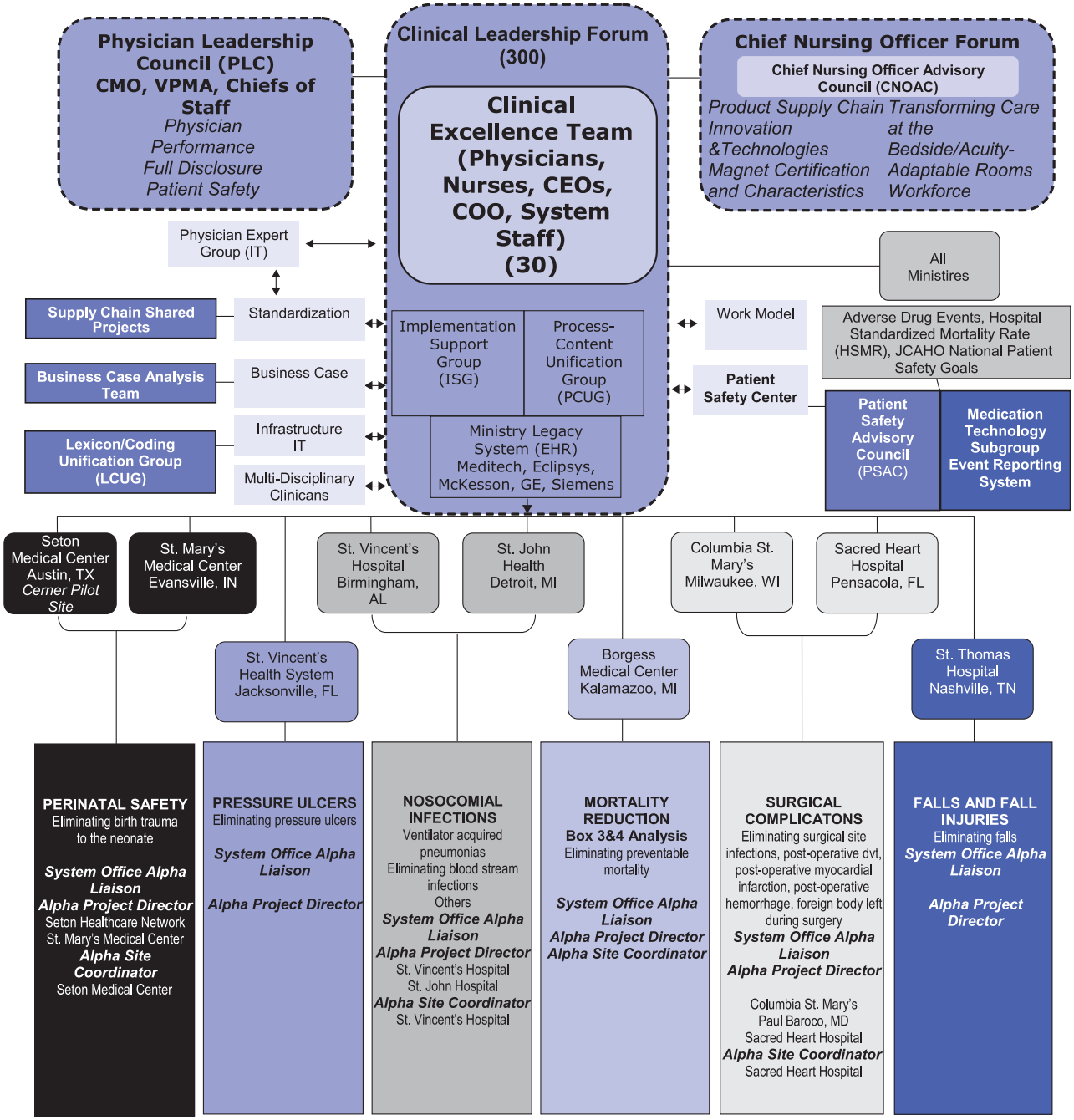

Figure 1. *Clinical leaders provide input and guidance through various councils and through the Clinical Leadership Forum, a group of more than 300 [it grows in number every year]clinical leaders that meets twice a year. It is represented by the Clinical Excellence Team, which is empowered to act on behalf of the clinical leaders to provide overall clinical direction. The Physician Leadership Council and the Chief Nursing Officer Forum and subgroups (affinity groups or task forces) each meet regularly (often weekly) through phone conferences. This diagram provides a general idea for all individual leaders of who is engaged or responsible for what areas so that appropriate contacts, communications, policies, questions, and feedback can be efficiently accomplished.*

- Comprehension: Understanding the problem
- Compassion: Spirituality and commitment
- Collaboration: Teaming between subcultures and providers
- Coordination: System processes, infrastructure, and ideation
- Convergence: Leadership of local culture with spread and dissemination of new norms in a rapid way

We and a subgroup of the clinical excellence team (Figure 1) charged with culture analysis and development conceived these principles to describe our conceptual approach to changing the organizational culture. We have used them in disseminating innovative practices, creating permeability between organizational barriers, facilitating the design and implementation of a systemwide information infrastructure, and fostering a culture of trust and respect.

The Five Cs of Culture Change

To paraphrase cognitive psychologist Steven Pinker, culture is a pool of technological and social innovations that people accumulate to help them with their lives, not a collection of arbitrary things that happen to befall them.[2] In the interest of simplicity, we define culture as "the way we do things around here." Given our unique set of shared beliefs and customs, we approach challenges in our care environments with the Five Cs of Culture Change in mind and plan for interventions and communications that acknowledge each of them. Excluding any of these principles halts progress toward an organizationwide goal.

For each of the Five Cs, results are provided from a number of databases as described earlier.[1] However, crucial to culture are the baseline results from a systemwide survey of front-line caregivers' assessments of teamwork and patient safety. The intensive care unit (ICU) and the operating room (OR) areas were surveyed with the respective, tailored full versions of the Safety Attitudes Questionnaire (SAQ).[3-5]* (The full version of the SAQ covers the domains of teamwork and safety climate but also elicits caregiver perceptions along four additional domains—job satisfaction, perceptions of management, stress recognition, and working conditions.) For all other patient care areas, we used the housewide version of the SAQ Teamwork and Safety Climate survey.

We tracked teamwork climate and safety climate systemwide at the patient care area level:

- Teamwork climate is defined as the shared perceptions of the quality of collaboration between caregivers in this clinical area.
- Safety climate is defined as a strong and proactive commitment to patient safety in this clinical area.[6]

These are the areas for which managers and executives are held accountable.

Administered in more than 700 hospitals worldwide, the SAQ is a valid[7] and practical tool[6,8] for the diagnosis of context of care strengths and weaknesses. At Ascension Health, the findings are aggregated at the hospital level, clinical area level, and caregiver role level, and fed back to executives, managers, and frontline caregivers. The SAQ was administered to employees across 60 Ascension Health hospitals in Fall 2004. Surveys, which require less than 10 minutes to explain and complete, were distributed during departmental and staff meetings. Twenty-seven (45%) of the sites returned their surveys within a month, while 49 (82%) did so within two months. The overall response rate was 80%, with 16 of 60 sites achieving a $\geq$ 90% response rate (four sites had a 100% response rate). There were 3,831 OR responses, 2,688 ICU responses, and 23,274 responses from all other care areas.

Comprehension: Understanding the Problem

During clinical education, physicians and caregivers develop methods of problem solving that help us understand the world in which we live. Some of these methods of thinking are ingrained in the course of training, and once learned, may be very difficult to supplant. In our view, physicians and caregivers believe that their thinking is "correct" and have an enormous desire to be right; being wrong equates to culpability in their minds for problems that can ultimately cause a good deal of damage.

Health care professionals generally are very good at problem solving when intellect and rationale are engaged at the start of the process. Most clinicians pride themselves on their logic as well as their grasp of the subtleties of making patients well. Thus, one would

* Results from a repeat survey 18 months later will be provided later in the series.

think that simply presenting good information would be enough to stimulate change. Yet this is not the case. In health care, we believe that a very specific kind of culture-dependent diplomacy is needed to reach "mutual comprehension."

In the case of clinicians, we believe that the best approach to gain mutual comprehension of troublesome situations is to minimize the emotional components of the shared facts until they can integrate those facts. Some of what clinicians must ultimately understand *is* emotionally unpleasant, and there are many problems for which we are blameworthy; this problem is not new.

Presenting the evidence of a problem in a nonthreatening manner is the crucial first step to the comprehension that presages behavior changes. To be effective stewards of change, leaders need to understand the front-line workers' perspective—not filtered through hierarchies and levels of management. Shared understanding is equally important in the other direction, whereby clinicians understand and promote the vision expressed by the organization's leadership.

In 1867 Ignaz Semmelweiz identified a significant factor in the cause of childbirth fever—doctors failing to wash their hands between the morgue and the delivery ward.[9] However, the emotional consequences of comprehending this theory required practitioners to acknowledge that they had killed thousands of women. Labeling colleagues as "murderers" (which Semmelweiz did), did not work to advance his cause. Blame hasn't worked as a change agent in many other areas in which we could have advanced much more quickly without the implied culpability.[9,10]

Despite decades of alarming reports and studies, true comprehension of the magnitude of the safety problem in the health care community remained elusive until the 2000 publication of the Institute of Medicine (IOM) report[11] and its subsequent widespread public attention. Numerous leaders in health care set about questioning the data, as if a few thousand deaths one way or the other eliminated cause for concern.[12] The safety challenges inside health care organizations have been well documented.[13]

By far the report's most positive element was the clear indication that the safety problems were due not to bad clinicians but rather to failings in a complex system without the safeguards and balances and infrastructure to support proper practices. Because none of us was guilty individually, but all of us were responsible collectively, things began to change.

At Ascension Health, we communicate the known safety issues with every caregiver, from the board to the ward, so improving care and eliminating error can begin. Communications, which emphasize data, occur along the channels and programs noted in Figure 1. For example, internally monitored safety performance data such as Joint Commission National Patient Safety Goals and core measures, events reported through the voluntary event reporting system, and report cards on the priorities for action,[1] are reported unblinded to medical and facility leaders. This data reporting transparency has been well received. Performance reports are posted for review by authorized individuals on the intranet (called Ascension Health Exchange).

At Ascension Health, we believe that the methods used to explain safety issues make the difference as to whether or not clinicians make the changes necessary to create safer environments. Although clinical education and training are often, perhaps even *usually*, out of alignment with the tenets of teamwork,[14] we believe that clinicians can and do embrace organizational change. We have seen the paradigm shift from "clinicians won't change" to "clinicians will change, particularly given the conditions necessary to allow for a full comprehension of a problem." Nurses have adopted systemwide standards, for example, for pressure ulcer prevention, fall prevention, and birth trauma mitigation. Physicians are creating and adopting tighter hyperglycemia control methods, rapid response team functions, and heightened clinical communication through multidisciplinary rounds and Situation, Background, Assessment, and Recommendations (SBAR) reports among intensivist and hospitalist teams. Clinicians from all ministries are collaborating on the development and deployment of shared order sets, care plans, and decision support rules to be delivered in manual and advancing electronic health record systems (see section on collaboration, page 438).

Comprehension and the Survey. The surveys provide an idea of the depth and breadth of the data from the survey across hospitals (for example, Figure 2 [page 437]), and across departments (for example, Figure 3 [page 437])

Safety Climate Across Ascension Health Hospitals

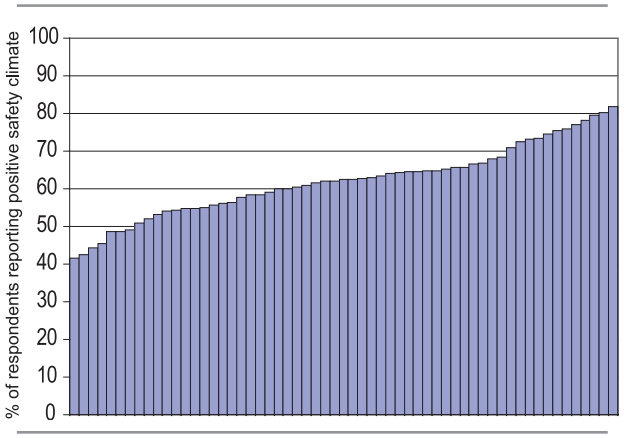

Figure 2. *The figure provides an idea of the depth and breadth of the data from the survey across 60 hospitals.*

Safety Climate Across 890 Ascension Health Clinical Areas

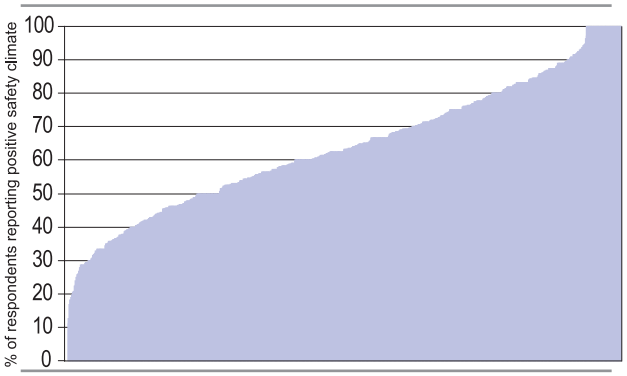

Figure 3. *The figure provides an idea of the depth and breadth of the data from 890 clinical areas in those hospitals.*

and job positions in those hospitals. Other data can be used to evaluate front-line perceptions in each of the SAQ areas, allowing correlation of job satisfaction with safety climate. Using the data to intervene and assess low performers and to discover what high performers are doing differently is very valuable.

The surveys showed the following results:

- Safety climate at the hospital level ranged from 42% to 82% of caregivers (Figure 2) reporting a positive safety climate (median, 62%; mean, 62%, standard deviation [SD], 9.6). The percentage reporting a positive safety climate is the percentage of caregivers who agreed slightly or agreed strongly (on the five-point Likert scale) with the safety climate domain items (it is safe here, errors are handled appropriately, and colleagues encourage reporting patient safety concerns).
- Safety climate across 890 clinical areas ranged from 0% to 100% of caregivers reporting a positive safety climate (median, 64%; mean, 63%; SD, 19.7). Note that these 890 do not include the OR or ICU specialty data (Figure 3).
- Safety climate across caregiver roles ranged from 51% (respiratory therapists) to 84% (medical administrator) reporting a positive safety climate.
- In one hospital, 24% of radiology caregivers agreed with the statement, "I would feel safe being treated here as a patient," as compared with 86% of diabetes educators. This example is typical of the variability we found within hospitals, between caregiver roles.

All Ascension Health executive and clinical leadership received the results of the survey unblinded and in the context of appropriate methods for interpreting and communicating the data. The survey directed our attention to areas of particularly low performance, while allowing us to use areas of high achievement as potential models for modifying the overall climate. The systematic collection of data from frontline caregivers allows us to suggest specific interventions in specific clinical areas or with specific professions and, coupled with true outcomes and quality measures, makes a compelling and easily comprehended case for change. In the context of minimizing negativity in communicating the results, the results stimulated systemwide thinking about how everyone might positively contribute to address the identified problems.

Compassion: Spirituality and Commitment

The second of the Five C's of Culture Change addresses how we feel about the work we do. We might well comprehend a problem, but our ability to deal with it is vitally connected to our beliefs, which go beyond simple intellect.

Spirituality and religion are distinct, although many people experience them as related. Spirituality comprises relationships, meaning, and purpose. In our experience, spirituality in health care builds a calm, centered, compassionate sense of caring—for patients and for one another. We deliver our services and

engage our logic as a community seeking common experience, understanding, judgments, and actions.[15] To attain this commonality of values, we use techniques that often are foreign to the strict logician—reflection, retreats and pilgrimages, storytelling, formative readings, evaluation, study, celebration, balance, metaphors, and "prayers of communication and organizational learning."[10]

In our faith-based organization, we begin our rounds, committee work, or meetings with reflections that emphasize the meaning of our work and our respect for one another. These reflections provide staff the opportunity to express thanks and concerns with one another, and to spend time in prayer, meditation, or silence depending on their individual beliefs. This time communicates to employees the importance that Ascension Health places on spiritual life, and provides employees with the opportunity to integrate this into their work life. This kind of observance and reflection connects us with our set of values and goals. It leads us to see things "whole," to experience that what we do is inseparable from the mission for which we do it.

We believe that the capacity of a group of people to change their ways is irrevocably tied to compassion and commitment. Just as negative feelings like guilt or blame can stall comprehension, a compassionate culture can enhance our understanding and move us toward change.

Compassion also helps us to create a nonpunitive culture by encouraging people to acknowledge that being human inherently entails imperfection—making errors. The organization acts with compassion by emphasizing what may need attention in "the system" rather than isolated blame.

Compassion and the Survey. Staff from the departments of mission integration (at the system-office level and at each ministry) added questions on spirituality to the SAQ. Results indicated considerable variability. For example, OR personnel's agreement with the statement, "I am encouraged to express spirituality in the workplace" ranged across hospitals from 0% to 100% (median, 44%; mean, 43%; SD, 18.8). Moreover, when caregivers reported feeling encouraged to express spirituality, they also generally reported a better teamwork climate. (High scores for teamwork climate indicate that physicians and nurses collaborate well, that it is easy to speak up if there is a problem, and that conflicts are appropriately resolved—not *who* is right, but *what* is best for the patient).

Our sense is that the integration of spirituality in our care delivery serves to somewhat flatten traditional hierarchies, and fosters a sense of community and commonality among team members.

Collaboration: Between Subcultures and Care Providers

Collaboration among individuals or groups in a culture means working together at a significantly higher level than cooperation. Collaboration results from "shared understanding of issues, open communication, mutual trust, and tolerance of differing points of view."[16] We believe that it is an essential part of any high-reliability organization or process.

Physicians and nurses often differ in their perceptions of cooperation and collaboration with each other.[4,17] Communicating information among physicians and nurses is often less than optimal. Reporting or discussion of potential or actual errors has historically been infrequent at a rate of 5–20%.[18] Our routine monitoring and voluntary event reporting system, now deployed throughout the ministries, has resulted in an ongoing upsurge in data for root cause analysis and risk management and has further reinforced collaboration necessary for optimizing performance to yield a safer, more effective culture.[19]

As reported in the "Collaboration in the Survey" section (page 439), considerable variability was evident within hospitals at the clinical area level in the extent to which caregivers reported good teamwork across ministries. This tells us that cookie-cutter teamwork solutions that disregard the context and reality of front-line care delivery will likely be a waste of resources. Rather, to address the need to focus on specific clinical areas where caregivers reported poor teamwork, we promoted learning from the clinical areas that reported excellent teamwork. (We have found initial work with SBAR communications in our ICUs and multidisciplinary rounds particularly useful in this regard.)

We also found significant variability across caregiver roles in the same hospital. Only through multidisciplinary collaboration can organizations become "*mindful.*"[20]

When we are mindful, we consistently watch out for one another and remain open to input from our collaborators, readily adapting our behavior in the interest of the goal—optimizing care for our patients.

To change culture, we believe that we are obligated to help our associates change the way they *feel* as well as the way they *think* about their team members and the system. Caregivers are encouraged through the leadership and management levels to absorb the lessons of mindfulness at the emotional level so that they will express approval when others hold certain beliefs and act in certain ways.[20] One has to really feel rather than just intellectualize change.

We are using the survey data and subsequent interventions in culture management in an effort to create an informed, just culture—an atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety-related information—but also one in which they clearly identify the line between acceptable and unacceptable behavior.[21] On the basis of the transparency of survey and other outcomes data, we work with the physician leadership council (Figure 1) to reach out to troubled relationships and provider situations. We offer suggestions for change and develop standards of acceptable credentialing and peer review through our physician relations central function. A variety of issues, ranging from full disclosure of mistakes to isolated incidences of unacceptable risk, are examined in partnership with our risk department and the clinical nursing leaders.

We work to consistently harness individual strengths and forge productive collaborative teams in each quality or safety endeavor. We focus on communication, behavior, and flexibility in the work place, and we expect our clinicians to be healers, leaders, and partners,[22] not just good diagnosticians or treaters of disease. We are moving toward the ideal in which clinicians, like pilots, will be selected and recredentialed for not only technical skills but also their ability to coordinate activities, learn from error, and recognize that others can contribute to problem solving.[17]

At Ascension Health we present our leaders and middle managers with organizational challenges rather than autocratic solutions. We acknowledge the stress of change and cite the inherent value of each team member in their combined successes. By working through influence and in teams, rather than by control and command, we model the behavior we seek to engender.

We also applaud and reward innovation. We bestow an award for advances in care quality at our annual Clinical Leadership Forum event; the winner and competing projects are publicized in posters, presentations, and demonstration forums for clinical and administrative leaders. We continually emphasize the importance of maintaining an environment of psychological safety in which input, critiques and innovations are accepted, and ownership of errors is the norm for all team members.

Collaboration in the Survey. Teamwork climate assesses how health care providers from the same work unit perceive the quality or collaboration between personnel. Using front-line caregiver assessments of teamwork is warranted because collaboration is associated with error-reduction behaviors in aviation,[17,23] with patient outcomes in ICUs,[24,25] and with nurse turnover in the OR.[26] Good teamwork is associated with better job satisfaction[27] and less time missed from work due to illness[28] and may counteract some of the detrimental effects of fatigue on performance.[29] Research also suggests that discrepant attitudes about teamwork may be a significant source of nurse dissatisfaction with the profession, exacerbating the ongoing nursing shortage in hospitals.[30]

As stated, results indicated considerable variability in perceptions of teamwork within Ascension Health:

- Teamwork climate at the hospital level ranged from 50% to 83% of caregivers across the 60 hospitals reporting a positive teamwork climate (median, 66%; mean, 66%; SD, 7.7) Positive teamwork climate is the percentage of caregivers who agreed slightly or agreed strongly with the teamwork climate domain items (for example, ability to speak up, resolve conflicts, ask questions during uncertainty, and collaborate).
- Teamwork climate across 890 clinical areas ranged from 0% to 100% of caregivers reporting a positive teamwork climate in their clinical areas (median, 68%; mean, 67%; SD, 16.6).
- Teamwork climate across caregiver roles ranged from 58% (respiratory therapists) to 83% (medical administrator) reporting a positive teamwork climate.

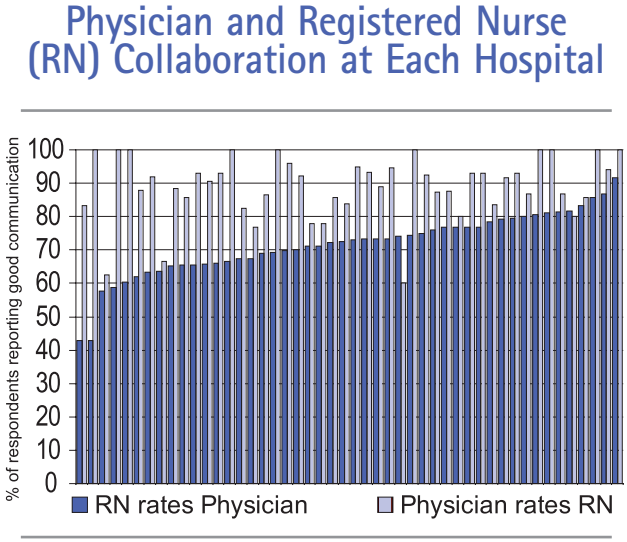

Figure 4. *Each bar represents the percentage of caregivers who agree (slightly or strongly) that they experience good collaboration with the other discipline.*

■ Physicians and nurses rated each other on the quality of communication, and their ratings often varied widely within the same hospital. Across the 60 hospitals, fewer registered nurses tended to report good communication with physicians than the reverse (Figure 4, above)

Coordination: System/Systemic Processes and Ideation

Health care is an enormously information-intensive industry. The complex and variable processes of care, along with the fragmentation of services, make information accessibility a huge problem. Indeed, the major causes of incidents that lead to malpractice claims are most often related to information documentation, communication, and follow-up errors.[31] Health care organizations generally lack the standardization and unification of data and work flows that typify high-reliability organizations.

Clinicians have traditionally functioned as independent, autonomous practitioners in an environment of incomplete information, rapidly changing practices, and an explosion of relatively inaccessible discoveries in clinical science. As they have moved into the information age, the biggest obstacles to improving processes have not been technical, but rather, practitioners' fundamental belief that if they continue to do the best they can as individuals, things will probably be all right. Yet without simplifying, normalizing, and standardizing these processes, practitioners have great difficulty taking advantage of information system tools. Such tools can facilitate communication and bring knowledge to their fingertips as they have for most other industries.

The culture of safety demands that in decisions about processes, quality trump autonomy, communication trump authority, and learning trump tradition.

Standardization in data, terminology, and process allows us to measure aberrations, positive or negative, and to discover the true outcomes. Coordination of more standardized processes decreases reliance on memory in critical processes; minimizes errors of omission during handoffs; leverages the aggregate knowledge and capabilities of the whole rather than the idiosyncratic, unpredictable actions of the few; enhances professional satisfaction across the care team; and provides a sense of belonging that improves chances of organization improvement.

As we move Ascension Health facilities toward electronic health records, we have allowed significant room for choice, provided the critical set of functions and unified relevant processes are addressed. We use influence pathways to maximize convergence to the following:

■ Interoperability of these systems
■ Standards of clinical terminology and coding
■ Unification and normalization of data from their sources
■ Collaborative agreement on pathways, order sets, protocols, and interdisciplinary care plans.

Coordination in the Survey: Some results of the survey reflecting perceptions of coordination at Ascension Health are as follows:

■ For the 32 clinical areas in one hospital, from 33% (neurophysiology) to 100% of respondents in another clinical area (diabetes education) agreed with the statement, "Important issues are well communicated at shift changes" (median, 67%, mean 64%, SD, 15.3). Such data allow for more thoughtful interventions and focused investigations of areas where walkarounds, SBAR communication, adopt-a-unit, and a host of other practices can enhance communication, staffing planning, and the acceleration of the development of the information system infrastructure.

■ 24% to 87% of caregivers across the 60 hospitals agree that "Levels of staffing in this clinical area are sufficient to handle the number of patients" (median, 52%; mean, 51%; SD, 13.1).

Convergence: Migration of Culture Toward Best Safe Practice

The final major element of culture change, and arguably the most important, involves the leadership and fortitude necessary to stimulate convergence of the culture on a new way of doing things. We use the term *convergence* because it conveys both dedication to the vision and recognition of the patience required to transform the attitudes and beliefs of our associates. We do not believe that leaders can mandate culture change.

A leader sets the purpose or direction for one or more others and gets them to move along in that direction with competence and full commitment.[32] The creation of transformational change, as opposed to incremental change, requires leaders to share emotional attachment with the people they lead. The techniques that leaders may use to induce or reward followers to join them are just that—techniques. True and effective leaders manifest compassion in their relationships with their followers.[10] Successful change requires vision, persistence, courage, an ability to thrive on ambiguity, and a willingness to engage those who have a stake in the outcome.[33]

Ascension Health leaders came together to determine the vision and outline the goals needed to meet that vision.[1] Those leaders subsequently determine, in the context of their facility cultures, how to best push and pull their colleagues toward the vision. In many cases, best practices spread almost in a viral fashion by leadership's willful adoption as transparent results were reported.

From the boards of directors through line managers, leaders speak and communicate openly about the commitment to patient safety as a personal and organizational priority, using every communication pathway and medium at their disposal (Figure 1). They determine (1) how best to converge on the goals without sacrificing innovation and how best to address cultural barriers to change and disruption in their environments in the process, (2) the degree to which they will protect autonomy or enforce standardization, (3) the techniques they will apply to encourage and reward new behaviors, and (4) the practices they wish to incorporate to enhance safety.

Incentives and accountability among top leaders are critical to reaching the goals of our clinical excellence vision, and therefore, executives have compensation targets pegged to performance in key care quality indicators (scorecards) as well as financial targets for their operations. At meetings of CEOs, the safety measures are gaining parallel prominence to financial metrics. It is as important for these leaders to know the trend in case-adjusted mortality and other indicators of quality across their facilities as it is for them to manage their bottom lines. The leaders are also accountable for elevating scores on key areas of climate of safety and culture of teamwork each year. The goal by 2008 is a score of 80% in safety and teamwork in at least 80% of all clinical areas in each facility.

It is important that various actions toward standardization show efficacy. At some point, there are a sufficient number of such actions that clinicians realize that convergence and standards are working and that to not be "on board" may not be appropriate. For example, standardizing diabetic care in the ICU or using a single protocol for the delivery of preoperative antibiotics should prove compelling to most clinicians.

Each ministry's leadership also contributes resources for collaboration in developing "foundation knowledge"—agreed-on knowledge (for example, order sets, practice clinical decision support, protocols, plans of care) across the system. They contribute personally to leadership forums on culture change and clinical excellence, demonstrating the kind of collaboration that they expect from their associates. The leaders model their willingness to change and set the tone for the just culture and trusting environments they desire.

Convergence in the Survey. The survey revealed an unusual interest in the drive to safety, as expressed by leaders' day-to-day influence on respondents. Thirty-six percent to 97% of caregivers across the 60 hospitals agreed that "Leadership is driving us to be a safety-centered institution" (median, 67%; mean, 68%; SD, 9.6).

Conclusion

Ascension Health uses its framework for culture change to advance patient safety. It will continue to use a systemwide culture survey for front-line assessments of safety and teamwork across all clinical areas and to discover best practices and track progress in improving performance. J

This article was written on behalf of the Clinical Excellence Team of Ascension Health (St. Louis) and the leaders of the local health ministries, as cited at the conclusion of the first article in the series.

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