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Improving the Patient Experience

The Experience of Safety in Healthcare: A Call to Expand Perceptions and Solutions

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About The Beryl Institute

The Beryl Institute is the global community of practice committed to elevating the human experience in healthcare. We believe human experience is grounded in experiences of patients & families, those who work in healthcare and the communities they serve.

We define patient experience as the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care.

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Executive Summary

It has become apparent to those working in healthcare that the current models of separating safety, quality and experience into siloed strategies and workstreams are counterproductive to the outcomes these areas seek to achieve. Equally so, there is an increased awareness of the need for patient/family perspectives to guide operational priorities and move beyond traditional surveys and councils. In this paper, we will take a step-by-step approach to understand the opportunities created through the strategic integration of safety and experience efforts as well as identify ways to open the door to a new paradigm in which the experience of patients, families and clinicians becomes the guiding light in decisions around cost, safety strategies, technology and prioritization of action.

This paper offers a set of key recommendations generated from the concepts explored:

1. **Acknowledge safety as a primary driver for overall experience of both patients and clinicians**

   Whether or not patients frame their experiences in the context of harm, or lack of harm, their safety drives all that is perceived and remembered in the patient experience. Equally, the clinician experience is shaped by organizational culture, financial choices, attention to patient experience, technologies, safety systems and processes chosen.

2. **Approach safety and patient experience through a unified lens**

   Today, healthcare organizations often still perceive safety and experience as two separate areas of care. Only after approaching safety and experience through a unified lens will organizations create a healthcare experience which truly elevates the human experience in healthcare.

3. **Make financial choices that reflect a commitment to the experience of safety**

   Organizations must decide who they want to be in terms of cost and safety and then, through innovative methods, strive to become an organization that allows clinicians to focus on their role as carers and is known to patients and families as one that prioritizes their well-being over anything else.

4. **Make a conscious, accountable and strategic effort to build a culture of caring**

   Organizations cannot overlook the impact of culture on patient safety, because only in healthy environments can staff help patients feel safe and secure. Only in a culture with strong safety infrastructure and psychological safety can a clinician have and provide good experiences.

5. **Optimize technology to care for the carers**

   Organizations must pay close attention to choices made when evaluating and choosing technology, a broad and budding field of options that have the potential to improve or complicate the experience of clinicians as well as the clinical outcomes for patients.

6. **Engage patient and family voice to lead change and drive future solutions**

   Healthcare organizations must begin to align the patient's perception of safety and harm with how they design their safety efforts and how they build their ability to understand the lived experiences of those they serve.

A Paradigm Shift: Experience as Integrator

This paper in many ways expands upon ideas and beliefs we have long held at The Beryl Institute. For patients and families, quality, safety, service and issues such as cost, access and outcomes all collectively frame the experience of healthcare. This is a basic idea we cannot deny.

This has only been elevated by an acknowledgment in the last decade that consumer voice has arrived and is having and will continue to have significant influence on how healthcare organizations operate, the decisions they make and the priorities they set. This idea that all actions in healthcare impact experience is an essential starting point for a new paradigm in how we tackle quality in healthcare. It is also meant to elevate the very importance of and reinforce the needed focus on quality and safety in healthcare overall.

But when we look at this idea from the perspectives of those healthcare serves, they do not see quality or safety efforts as separate from the experience they have, rather they see them as essential TO the experience they have. While quality and safety are what consumers expect from healthcare, they assume it is our priority and that we are doing all we can to ensure quality and safety are the essence of what we do.

At the same time, we also need to recognize that for all To Err is Human called on us to tackle in 1999, we still see harm and error in healthcare. We are not "there" yet; in fact, from an experience perspective, there is no "there" at which to ultimately arrive, for the next patient deserves the very same as the one that comes before. Yet, we can and should aspire to critical opportunities and achievements with vigor. This may be no better exemplified than in striving for zero harm. This idea has been around for some time. In fact, the Joint Commission's Center for Transforming Healthcare, established in 2008, has a single, important mission: help health systems reach zero harm. We have been striving and must continue to strive for excellence here, but our opportunity is to think bigger.

To Err is Human called on us to create a culture of safety in our organizations. The recommendations called for us to put in place processes and protocols that have made significant improvements. But we still find ourselves with one reality in healthcare: we are an industry built on human beings caring for human beings and that will always leave variation and opportunities for error. If we do not address the broader systems and organizations in which people operate, then we leave room for mistakes to continue. That is why a shift to experience is so integral. For while addressing safety through safety organizations and checklists provides process, we need to ensure people and organizations act with unwavering focus on execution. That happens based on the types of organizations we build, support and sustain in healthcare.

At the heart of the definition of patient experience, we assert it is "based on an organization's culture." Experience is not something that just happens to others, it is how we show up in healthcare every day for those who deliver and support the delivery of care, as much as for those who are impacted by it.

To truly shift the paradigm to achieving and sustaining a safe, reliable, consistent and quality healthcare system, we need to build organizations that can deliver on this promise. We cannot expect quality results from uncertain or even unstable healthcare environments. That is why experience must be an essential focus for healthcare strategically. It is not the idea at the edge of the conversation on how we treat people kindly or ensure they are satisfied, but rather it is about a commitment to all who chose healthcare as a profession to ensure the best outcomes for all we serve.

This paper challenges us to look at safety and quality with fresh eyes, not simply as a tactical issue to rewire or run through improvement processes alone. Rather, our opportunity is to tackle these issues by seeing their roots in who we are and aspire to be in healthcare. It is grounded in how we act as healthcare organizations and realized through the people who engage in ensuring the consistent and safe delivery of care. That is the shift we are calling for.

In the 2018 paper from The Beryl Institute To Care is Human, I offered, "Perhaps the first step is in reframing the very ideas of what it takes to achieve the best in outcomes in healthcare. By operating healthcare as something that is done to others, a sense of the humanity in these interactions with people has been removed." When we reintroduce humanity to healthcare and the human perspective that it brings, we can no longer overlook the intricately interwoven reality of quality, safety and service. Together, they are the complete experience people have. They are the outcomes we provide, and our actions must not waver from this reality. This paper begins to lay out a case for and recommended actions to do just that.

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President & CEO
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An Integrated View and a Lasting Story

> Experience is something we have lived through. It is about something that happened and it is our lasting story. It is defined in all that is perceived, understood and remembered.

Patient safety is defined by the Institute of Medicine as "the prevention of harm to patients."[1] Thanks to efforts made by organizations such as The Institute for Healthcare Improvement (including the former National Patient Safety Foundation), it is commonly understood that delivering safe care requires organizations working to prevent errors, learning from the errors that do occur and building a "culture of safety." In a culture of safety, people are not merely encouraged to work toward change; they take action when it is needed.[2]

Over the last decade, great strides have been made to improve safety, quality and experience in healthcare. Unfortunately, those very strides have been impeded by the simple fact that our efforts have been designed in such a way that we have addressed these opportunities as three distinct areas. The root of this can be traced to many factors but, overall, it is simply a reflection of the transactional nature of healthcare.[3] Rather than seeing safety, quality and experience through the eyes of those receiving care from the outside in, most efforts for improvement have been created and driven by those looking at healthcare from the inside out. The time has come to look beyond the transactional nature of safety and experience in order to recognize that:

1. this perspective is not representative of how patients and families perceive their healthcare experiences.
2. it may create mistaken delineations between safety efforts and clinician experience.
3. it limits our ability to build relationships.

In short, to improve experience, we must shift our approach to operationalizing safety using a more relational model.

The Agency for Healthcare Research and Quality, a Federal agency in the United States charged with improving the safety and quality of the U.S. health care system, defines patient experience as "the range of interactions that patients have with the health care system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other health care facilities. As an integral component of health care quality, patient experience includes several aspects of health care delivery that patients value highly when they seek and receive care, such as getting timely appointments, easy access to information, and good communication with health care providers."[4] This definition presents a limited view of experience, as it does not acknowledge that consumers of care are perceiving quality, clinical outcomes and service as their healthcare experience. The fact that this definition is missing any mention of safety also reflects an oversight. A reference to experience without acknowledging safety as an integral part creates a distinction that made sense when efforts were first being developed but which have now evolved into new perspectives and solutions.

The success, failure and efficiency of all safety efforts is fundamental to the experience of patients and families. Consumer Perspectives on Patient Experience 2018,[5] a study from The Beryl Institute, supports this. The study verifies that patients and families do not differentiate between experience and safety. In fact, in many of the areas where healthcare tends to create delineations in order to operate more effectively, they are collectively perceived by patients and families as part of their overall experience (See Figure 1).

Figure 1: An Integrated Perspective The Beryl Institute

If a patient experiences an adverse event, for example, no matter how well it may have been handled by the staff and clinicians, the error remains an integral part of that patient's experience. Ultimately, a safety issue such as a medical error is part of the overall patient experience and will forever alter how that patient (and family) interacts with healthcare. It is a significant part of their "lasting story." Equally, if a patient utilizes services from a healthcare organization and things go as planned, that too, is their experience. The lack of an adverse safety event is as much a part of their lasting story as if there had been one, whether or not they know to name it as such. For the most part, patients and families enter into a healthcare experience with an expectation that they are safe from harm. Through this lens, safety and experience should not be seen as distinct from each other, but rather part of how people experience healthcare overall.

The safety systems in place in an organization directly shape and define the clinician's experience. An adverse event due to poor systems impacts morale and a professional's ability to trust themselves and their colleagues, two substantive contributors to the staff/clinician experience. In addition, when it is perceived by healthcare staff that the proper investments are not being made in focusing on safety, this too can create an extremely stressful and challenging work environment that significantly impacts the experience of those delivering care. In short, if an organization's focus is on safety, those efforts are impacting experience, and if an organization's focus is on experience, safety must be at the foundation of those efforts.

The Beryl Institute defines patient experience as: *The sum of all interactions, shaped by an organization's culture, that influences patient perceptions across the continuum of care.*[6] As we explore the nature of safety in the experience of patients and families, we must ask ourselves, if experience boils down to interactions, culture, perceptions and care across a continuum, how does that align with the efforts made to keep patients safe? If we were to flip this definition and look at it through the eyes of clinicians, don't these four components of experience—interactions, culture, patient perceptions and care across a continuum—also represent core components of the safety efforts they design and execute? Is it time to dismantle the safety and experience silos, both philosophically and operationally, in order to recognize the greater opportunities that lie with aligning these efforts as fundamentally driving the best experience and outcomes for all healthcare serves?

Based on how safety impacts both the clinician and patient/family experience, organizations must consider moving away from seeing these efforts as distinct and rather work to address them as an integrated whole. This white paper seeks to advance this idea that more accurately aligns with the perceptions and reality of patients, families, staff and clinicians; **safety is a primary driver for the overall experience of both patients and clinicians.**

As part of this integrated view, we have an opportunity to look at this topic through three essential and connected lenses:

1. The reality of cost in healthcare today and the financial impact of safety
2. The impact of experience and safety on those who work in healthcare
3. The perceptions of patients and family members who are impacted by experience overall

The Financial Reality of Safety

Before exploring these concepts more deeply, one must first wrestle with one of the greatest threats to safety and experience efforts: perceived and real cost. Despite increasing evidence that preventing a safety event is far less costly than the financial burdens that arise as a result of a safety event, organizations in healthcare who are often operating in a resource constrained environment still opt to save money in key areas known to keep patients safe. Equally, despite all the concrete ways that providing a good patient experience can positively impact an organization's bottom line, it is often still regarded as customer service "extras", such as nice artwork on the walls or greeters at the front door. If an organization is not willing to accept a broader and integrated view of experience and/or commit to advancing its perspective beyond a philosophical acceptance of safety's role in experience and then reexamine how this impacts its priorities and associated financial decisions, change will be slow, difficult and likely unsustainable. Without financial support and a strong organizational commitment to establish a culture as framed in the definition of experience above, improvement efforts and supporting tactics are built on a weak foundation and are likely to fade in time.

Every healthcare organization must be a good steward of their operating funds, and many today lack needed resources (financial, human or otherwise). Yet, we must also acknowledge that the cost of safety and ultimately experience efforts are not only realized in the investments needed to succeed. There are also significant cost implications when investments are not made. The global focus on patient safety has resulted in a large body of research dedicated to understanding how to implement safety programs as well as how safety efforts impact the bottom line. Some of the significant findings related to cost show[7]:

- In systems of a typical developed country, approximately **15% of total hospital activity and expenditure** is a direct result of adverse events.
- The flow-on and indirect costs of harm include loss of productivity and diminished trust in the healthcare system. In 2008, the economic cost of medical error in the US was estimated to be almost **USD 1 trillion.**
- As much as **one dollar in seven is spent treating the effects of patient harm** in acute care (Jackson, 2009). These estimates resonate with the findings in a study from New Zealand, which suggests that $ NZ 0.30 of every dollar spent in a public hospitals goes toward treating an adverse event.
- Many adverse events are preventable. Furthermore, the **costs of prevention are dwarfed by the cost of failure.** The Hospital Harm Data captured in 2016 by Canadian Hospitals estimates that patients having experienced an adverse event spent more than half a million additional days in hospital during 2014-2015. This equates to about four large hospitals or 1,600 hospital beds per day. The aggregate financial burden of patient harm in Canadian hospitals was CAD685 million in 2014-15.

The extensive evidence outlining how dedication to improving safety saves healthcare organizations money might make one wonder why the number of safety events has not greatly improved over the last decade. There are certainly multiple causes for this, but in many cases there appears to still be resistance to prioritizing safety over cost.

The Challenge of Putting Cost above Safety

As a means to explore this issue more practically, it is valuable to examine recent examples of what happens when cost is placed above all else. One powerful case that illustrated this point occurred in the National Health Service (NHS) in England and reset the standards for care around these very safety issues. Prompted by a series of serious safety-related events from 2005 – 2009 at Stafford Hospital, a small district general hospital in Staffordshire, England, the NHS has developed a model for radically changing a system's priorities. Their commitment as articulated now reads "to support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable."

The Francis Report,[8] the first of many reports released regarding the events at Stafford Hospital, cites a few of the primary reasons for the clinically unsafe environment. They include cutting staffing and asking staff/clinicians to practice outside of their professional scope. The reason given for these and other decisions was the desire of the Trusts' board to save ten-million pounds as part of its desire to gain

foundation trust status. The Francis Report describes it most clearly here:

> "A story of terrible and unnecessary suffering of hundreds of people who were failed by a system which ignored the warning signs of poor care and put corporate self-interest and cost control ahead of patients and their safety."

The events at Stafford Hospital serve as a sobering reminder that we must remain diligent in overseeing the relationship an organization has between being fiscally sound and providing safe patient care. For the purposes of this paper, the case of Stafford Hospital also serves to affirm a grim reality: humans are capable of putting cost over care, even to such an extreme that lives are lost. This is, most certainly, a dramatic example but, nonetheless, it should serve as a reminder that one must not be so naïve as to think that the welfare of patients, families, staff and clinicians are always the primary driver for decisions in healthcare. Before one can begin to operationalize safety efforts, one must first examine how organizations choose to prioritize and fund those efforts and understand the potential implications for those decisions.

The Cost of Ineffective Staffing

The Stafford Hospital case highlights one common approach to reducing organizational costs: reducing staff. The idea that more staff costs more money sounds like common sense. In reality, however, that is an assumption that needs to be questioned. One must examine how "cost" is defined in a case like this. Is the financial cost of fully staffing a ward, for example, more than the cost of an increased likelihood of a medical error, clinician burnout and ultimately a poor patient experience? Of all the cost saving measures, this one is perhaps the most commonly witnessed across all areas of healthcare and in all corners of the globe.

What is the impact of an understaffed unit, clinic, nursing home or emergency department? No matter the clinical environment, the impact of understaffing is felt quite the same: more pressure is placed on the staff who are working, causing them higher levels of stress, a greater chance they will make mistakes and less time for them to interact with patients. Often, this level of pressure causes a shift in attitude among staff and clinicians, creating a poor working environment and sub-par patient interactions. When an unexpected event happens, clinical or otherwise, this places a strain on the team and the systems. In some cases, this may even threaten the safety of the patients being served.

There is no other resource consideration in healthcare like staffing, because fundamentally healthcare is still delivered primarily by people. If there are not enough people to carry out what needs to be done, providing a good patient experience becomes exponentially more difficult and patients are at a higher risk of a safety event, to say nothing of how it radically impacts the experience of those delivering care. It's for these reasons that

"A story of terrible and unnecessary suffering of hundreds of people who were failed by a system which ignored the warning signs of poor care and put corporate self-interest and cost control ahead of patients and their safety."

the mindset around staffing must change. Moving dollars to increase staffing is one viable option. In some cases, a more innovative approach may be preferable. If one or both options reduce the potential for error, then in the end the investment will far outweigh any longer-term expense.

The Safety Link between Staffing and Clinician Experience

There is general agreement that professional experience is interwoven with safety, and safety is interwoven with professional experience. When we create environments where healthcare clinicians and staffs want to work and feel they can work effectively, we ensure greater engagement and reduced turnover. Additionally, if clinicians stay in their roles, they are likely to have:

- greater ease with an organization's systems and processes, enabling them to provide safer care.
- some level of satisfaction with their job, making it more likely they will provide a better patient/family experience.
- opportunities to participate in performance improvement cycles aimed at creating more efficient and safe care delivery.

There is no benefit to a revolving door of clinicians from any angle: safety, experience or cost. Healthcare organizations must dedicate effort and money to ensure a healthy culture, smooth systems and the opportunity for meaningful patient partnerships in order to avoid the cost of losing and recruiting clinicians and staff.

Financial Reality: A Call to Action

The push and pull between fiscal responsibility and a responsibility to provide the best possible care is a reality. Innovation and long-term thinking play a great role in finding balance between cost and quality. Stafford Hospital shows us what can happen if we make cost our only goal.

These examples have one thing in common: the courage to move beyond traditional thinking and aim for the larger goal that may be miles down the road to build a long-term plan in which cost and care are balanced. If we truly want to provide the safest care and ultimately the best experience, organizations must first determine "who they are" when it comes to cost and quality. Organizations that look to innovate will find a way to live within the cost constrained world healthcare often finds itself, while making plans that focus on the provision of quality care. This is a balancing act that requires awareness and intention to address. Ultimately, patients and families will choose organizations that find ways to prioritize their well-being, even in the face of complex financial choices. And it will be those healthcare organizations that will in the end see the greatest success.

The Clinician Experience is Driven By How Safety is Operationalized

In The State of Patient Experience 2019: A Call to Action for the Future of Human Experience from The Beryl Institute, healthcare organizations from 34 countries and six continents were asked to identify the top items in which the organization is expected to invest, either as a new effort or with additional resources, over the next three years to advance patient experience improvements. Of all the items named, reducing physician and caregiver burnout had the highest increase in investment, moving from 21% in 2017 to 29% in 2019.[9]

To Care is Human,[2] a 2018 white paper from The Beryl Institute, studies the approach and attitudes that top-rated high performing units adopt in operationalizing experience efforts. Among the top ten items that set apart the high performers from the rest of the respondents were teamwork among the care team, engagement level of employees, clinical team well-being and partnering with patients and families. This complements the 2019 State of Patient Experience data in that it represents an important shift in recognizing that staff/clinician experience cannot be seen as separate from patient experience.

If clinicians' experience at work is poor, that will most likely impact their relationship with co-workers, patients and their own self-perception of what they do every day. The experience of the clinician drives the experience of the patient. The experience of the patient drives how clinicians experience their role. Without the necessary systems, attitudes and resources for keeping patients safe, the ability for clinicians and/or patients to have a good experience becomes as difficult as attempting to drive a car with three wheels: it is possible but dangerous, stressful and incredibly difficult.

As data continues to show that burnout is an epidemic and national healthcare systems continue to ask healthcare professionals to do more with less (resources, funding, time, etc.), greater efforts can and must be made in seeking ways to improve staff/clinician experience. Losing staff and clinicians costs organizations money, and it disrupts workflows to orient new staff. Patients who are told certain clinicians and staff have left the organization are often upset by the loss of an established relationship and may struggle with trusting that organization, especially if there appears to be a pattern of employees leaving.

So, what creates a positive work experience for healthcare professionals? What aspects of a positive work experience are rooted in successful safety efforts? Before digging into these questions, it is of benefit to first understand why clinicians leave healthcare organizations and then begin analyzing and addressing these items proactively.

Countless articles and books have been written along with lectures given outlining the need for a healthy culture or, as often referred to in safety literature, a "culture of safety." According to a Work Institute 2018 study, an "undesirable atmosphere" is cause for clinicians to leave an organization.[10] The following explores culture, a primary driver of experience and central to its very definition and a key indicator of patient safety.

Culture and Co-Workers

As noted previously, the events surrounding Stafford Hospital demanded multiple investigations and a significant number of reports suggesting the necessary changes needed to ensure nothing like this would happen again. In this case, it is documented that staff and clinicians became desensitized to the patients' suffering, essentially enabling the conditions to continue. This desensitization, of course, is not something specific to Stafford Hospital. Clinicians who become desensitized to the experience of patients and families are not uncommon in any healthcare organization and can often be attributed to burnout.

Burnout is defined by the three primary symptoms[11]:

- Depersonalization
- Emotional exhaustion
- Lack of efficacy (not feeling effective in or needed)

The three primary root causes for burnout, and physician burnout more specifically, can be attributed in many ways to organizational culture[11]:

- Frustration from challenges using an Electronic Medical Record
- Mismatch of values between MD and organization/administration
- Social relationships at work

Organizational culture can be defined as "a set of shared mental assumptions that guide interpretation

and behavior."[12] The fact that some staff/clinicians at Stafford Hospital reported feeling bullied into silence speaks to how the power a co-worker may have over another can override keeping patients safe. To this end, the NHS has refocused efforts and placed a high value on establishing a culture of caring. One primary method for building this culture is through hiring, training and developing those who are not only technically skilled but have the proper values needed for caring for patients. This effort has the potential to impact the "shared mental model" so that it is one focused on values as much as outcomes, peer support as much as personal success and safety as indistinguishable from experience. Figure 2 includes some approaches mandated to build a culture built on values and measured by staff and clinician behavior.[13]

Alongside this effort to hire and retain healthcare professionals with personal values that align with supporting a culture of caring, the NHS has continued using the lessons of Stafford Hospital to advance their safety strategy. In addition to building a strategy aimed to keep patients safe, the NHS is leading the way to ensure that psychological safety for staff and clinicians is a cornerstone of operationalizing safety efforts:

> *The key ingredients for healthcare organisations that want to be safe are: staff who feel psychologically safe; valuing and respecting diversity; a compelling vision; good leadership at all levels; a sense of teamwork; openness and support for learning.*
>
> *To work at our best, adapting as the environment requires, we need to feel supported within a compassionate and inclusive environment. Psychological safety operates at the level of the group not the individual, with each individual knowing they will be treated fairly and compassionately by the group if things go wrong or they speak up to stop problems occurring. It means staff do not feel the need to behave defensively to protect themselves and instead opens the space in which they can learn.*[14]

The approach the NHS has taken to shift the mindset on safety is quite progressive. While the 2019 NHS Patient Safety Strategy sits on the foundation of effective harm prevention practices, the focus moves from one of process to people:

> *Patient safety is about maximising the things that go right and minimising the things that go wrong for people experiencing healthcare…To realise this vision the NHS will build on two foundations: a patient safety culture and patient safety system, across all settings of care… Blame is a natural and easy response to error. It allows the cause of mistakes to be boiled down to individual incompetence, carelessness or recklessness and asserts that the problem is the individual. Blame relies on two myths. First, the perfection myth: that if we try hard, we will not make any errors. Second, the punishment myth: if we punish people when they make errors, they will not make them again.*
>
> *Too often blame is disguised within otherwise valid approaches to improvement such as training and reflection. When these are recommended for one individual only, the underlying assumption is that they alone are the problem that needs fixing. But usually they are not the real problem, so this 'individual' approach does not prevent future errors.*[15]

Creating an environment where clinicians feel safe to express concerns and report errors begins with creating new and meaningful avenues for them to be heard. In so doing, before designing the updated 2019 Safety Strategy, the NHS displayed a keen dedication to listening to the "pain points" experienced by staff and clinicians via a variety of methods including online

NHS Values and Behaviours
Themes
Increased focus on delivering safe, dignified and compassionate care.
Short term deliverables
Ensure that selection into all new NHS funded training posts incorporates testing of value based recruitment.
Introduce and evaluate pilots of giving NHS-funded students hands-on care experience.
Increasing the proportion of entrants to healthcare professional education who have experience working providing care in a care setting before they start their course.
Longer Term Objectives
Continual improvement in scores from patient surveys on questions relating to staff behaviours and compassion in care.
Support efforts to deliver a continual improvement in proportion of both staff, patients and the public who recommend friends and family by ensuring an adequate supply of suitably qualified staff.

Figure 2: reprinted from NHS Mandate from the Government to Health Education England: April 2013 to March 2015[13]

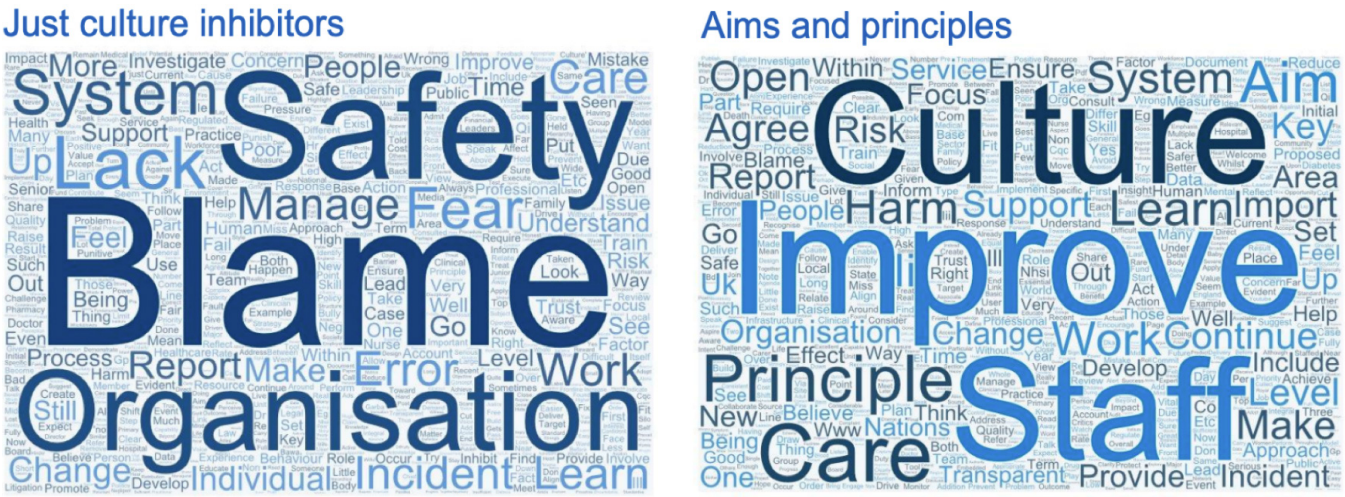

Figure 3: Reprinted from NHS Patient Safety Strategy consultation results[14]

surveys, focus groups, twitter chats, workshops and stakeholder meetings. The word clouds, pictured in Figure 3, provide a glimpse into the feedback provided by NHS staff and clinicians when asked what they perceive as barriers to a just culture and what they believe needs to be the primary aims for improving safety in the NHS. It was from this foundation of feedback that the NHS was able to create a safety strategy that was both relevant to the realities of NHS carers and sensitive to and shaped by the experiences of those delivering care.

So far, we have recognized that "culture and co-workers" is a primary factor when forging a good experience for clinicians and, by extension, patients and families. The NHS provides a model for taking this to the next level with a heightened dedication to assessing a clinician's skills and personal values and through realigning the safety mindset so that it is deeply grounded in understanding and protecting the experience of those delivering care.

Assuming clinicians with desirable values are in place (by design or just by good fortune), how does an organization ensure that clinicians with properly aligned values stay that way? What can an organization do to effectively support the experience of those providing the care? The answer lies in caring for the carers.

Caring for the Carers

> *Many studies have revealed that most employees leave their organization because of the relationship with their immediate supervisor or manager, or because the physical environment is no longer conducive.*
>
> *In addition to providing an acceptable and comfortable work environment where delivering outstanding care is possible, healthcare leaders "should ensure that staff have the right tools to do their jobs effectively, including solutions to improve productivity, efficiency, and accuracy."*[16]

The ways to keep staff and clinicians from moving to another organization or leaving the healthcare field altogether is quite logical: examine what they need and what they enjoy about their work and use that information to create the systems and processes that support them.

> *Health workers' performance can be influenced by salary increases and bonuses, but this is short lived and has a limited effect compared to the impact workplace environment has on the performance of the employee. It is the quality of the employee's workplace environment that most impacts their level of motivation and subsequent performance. How well they engage with the organization, especially with their immediate environment, influences to a great extent their error rate, level of innovation and collaboration with other employees, absenteeism and ultimately how long they stay in the job.*[17]

Many of the elements of "workplace environment" referenced in the study quoted here are directly or closely related to safety efforts. Examples include[17]:

- ***Defined processes:*** *The organization constrains the variability of how work is actually performed through documenting processes and communicating such expectations to employees.*
- ***Social factors:*** *Here, the relationship between the health worker, the employer and the*

patient is considered. Poor inter-personal skills and attitude among the colleagues can affect performance.

- ***Goal-setting:*** *When health workers are being involved in setting meaningful goals and key performance indicators (KPI) for their work. This can be done informally between the health worker and their immediate supervisor or as part of an organization's formal performance management process.*
- ***Support:*** *Training, development, management and access to support such as Mental Health first-aiders*
- ***Job aids:*** *Providing templates, guides, soft training, checklists, etc. to the health worker to assist in improving their performance. This is to make their work easier and minimize error rate and improve patients' satisfaction.*

The least commonly recognized of the above key factors that is an influence on the clinician experience is that of "job aids." The link to safety is both spelled out above and quite obvious, but what is the link to experience? As the market begins to flood with job aids parallel to the ones named above (such as templates, guides, checklists, etc.) but based more in technology, healthcare organizations now have more options—and, therefore, more responsibility—for providing tools that can either improve or complicate the clinician experience.

There are a variety of innovative technology solutions to support clinicians. Are we working to decrease medication error? Perhaps better utilization of closed loop medication management systems is what an organization needs. Are we looking to decrease charting time so that clinicians can spend more time face-to-face with patients? The technology we need might be new EMR software. Are we hoping to use technology to better comfort patients when pain management has been a challenge? In that case, it may be worth exploring the world of virtual reality. For this reason, knowing the problem that needs to be solved is key to finding the right technology for the right purpose at the right time.

Speaking in generalities, however, the world of technology solutions is another way to care for the carers. Currently, healthcare technology supports clinicians in a few significant ways:

- Information capture, coordination and management
- Virtual collaboration with specialists
- Automated systems to minimize manual tasks
- Clinical precision (i.e., robot-assisted surgery, etc.)
- Data from patients remotely self-monitoring vitals, blood sugar, etc.

The more technology is able to provide additional safety checks, the more time is available for human interactions and empowering patients to get care that matches their needs, the better the clinician experience will be. The technologies listed above are all built with the intention to support clinicians for these purposes. It is important to note that current technologies are in the early stages of providing meaningful support to clinicians. This is reflected in the following example of how technology must continue to advance in order to more comprehensively support clinicians:

> *Many patients suffer an overdose of narcotics through patient-controlled analgesia (PCA) pumps… Clinicians either fail to identify a patient receiving too much narcotic or mistakenly program the PCA to deliver a higher dose than the prescribed dose coded in the EMR. To defend against the latter error, most hospital policies require that two nurses manually check every PCA order change against the EMR order. In the ICU, we observed PCA orders changed, on average, four times per patient and it takes 8 to 10 minutes for one nurse to find another nurse to confirm the orders match. With 20 patients in this ICU, confirming orders relies on heroism and wastes 8 to 10 nursing hours a day, one full time equivalent of nursing time per unit.*
>
> *Ironically, the PCA pump and the EMR have an electronic order for the narcotic dose. If integrated, these devices could automatically, continuously, and reliably confirm matching orders, saving lives and improving productivity.*[18]

As we look at the future of technology, the road seems paved with scenes from sci-fi movies. While some of those technologies may make their way into clinical environments, the more urgent need is to build upon and streamline the primary technologies already being used today.

> *One major cause of low safety and productivity is the failure to integrate different medical technologies, especially electronic health records and alarms…Tragically, there are countless devastating examples of the failure to integrate technology. A 12-yr-old girl died from respiratory arrest as narcotics that were slowing her breathing continued to infuse into her…oxygen-deprived veins. She died in large part because the pump infusing the narcotics could*

not talk to the monitor counting her ever-slowing breaths. If these devices had communicated, the infusion pump would have shut off when her breathing slowed below a critical threshold.[18]

The technologies we need to improve care are already here, and the next step is interoperability. To truly support the clinician experience, technology must continue to advance to essentially perform as another clinician might: anticipating needs, changes in condition and warning signs ahead. In so doing, technology will transform from a task-ridden necessity to another set of eyes, ears and hands that can free time and reduce stress for clinicians so that they can attend to the relational components of healthcare, improving their own experience of work while improving the experience of those they care for as well. This will also require healthy and ongoing private/public sector and industry/healthcare partnership.

The two interoperability examples above also bring us back to this certainty: the key to improving clinician experience is to ensure the problem is identified before the technology is procured. Whether an organization is struggling with understaffing or working to solve physician burnout, technology is most certainly one key part of the solution. Choosing that technology wisely requires careful exploration of the most urgent need to be met, how that technology will be used in the actual setting and whether the technology itself will build or break down the relationship between patients and their clincians.

It has been established that if a technology can provide more time and an additional safety measure, it surely is one practical way an organization can care for the carer. Equally, better uptake of innovation and technology for repetitive tasks such as medication processes saves time that can then be given to more interactions between clinicians, patients and families. In countless ways, the experience of safety, more specifically, the future of our clinicians' experience, lies directly in the lap of technology.

The Impact of Emotional Support on the Clinician Experience

Another element of "workplace environment" is less intuitive but essential to safeguarding the clinician experience: supervisor support. *Immediate supervisors act as advocates for employees, gathering and distributing the resources needed by the employees for them to be able to do a good job and providing positive encouragement for a job well done.*[17]

Examining this aspect through the experience of safety, we must explore what this means in the context of error. Support for improvement programs and building a safety culture become almost nullified when a clinician must come to terms with a medical error without needed guidance and support.

The following study outlines what impact an adverse event (AE) has on the experience of clinicians:

Second victims have been defined by Susan Scott et al. as healthcare team members involved in an unanticipated patient event, in a medical error and/or a patient-related injury who become victimized in the sense that the team member is traumatized by the event…when there is an AE, health professionals change their way of interacting with patients, respond emotionally, become insecure and doubt their professional judgement; all this, in turn, affecting the quality of care they provide to other patients.

…the following are common among second victims after an AE: feelings of guilt, anxiety, and concern about the consequences and that, in line within the findings of other studies, the role of colleagues and the management is crucial, especially in the early stages after an AE.

The experience of second victims is related to post-traumatic stress disorder but with some extra factors[19]*:*

- *Doubts regarding informing patients, colleagues and managers about what has happened*
- *Fear of the legal consequences of AEs*
- *Concerns about a loss of standing (feeling that event will mark them forever, a scarlet letter*

As evidenced in this study and many other stories and studies, an adverse event becomes the clinician's experience. Without proper intervention, they are deeply impacted emotionally, ironically placing them at a higher risk for error. When describing their emotional reaction to an adverse event—anxious, worried, filled with self-doubt—it is not hard to see that this colors everything they do professionally, thus becoming their experience of themselves and the role itself.

Clinician Experience: A Call to Action

Certainly, not every aspect of what impacts and shapes a clinician's experience can be included in one white paper. The concepts explored in this section serve to illustrate that the clinician

experience—essential to the patient experience—has a broad variety of factors requiring consideration that are typically viewed as unrelated to how clinicians experience their role, their organization and themselves. While the aim of an organization's safety efforts is to keep patients safe, they also come with intended or unintended consequences on the overall clinician experience.

To separate safety from experience means an organization may be unaware of the acute burdens the by-products of these efforts are placing on the clinician. A lack of awareness, concern or priority about how safety efforts impact the clinician experience may actually create a less safe environment for patients, as well as an unstable culture in which retention becomes less likely. The only way to address this issue is to broaden the scope of how safety is viewed. It is not only a series of processes, technologies and protocols; it is how those processes, technologies and protocols impact the day to day experience of those delivering care.

What Patients See: Safety is the Experience

To this point, we have primarily explored the experience of safety through the eyes of those delivering care. Because this "expanding perspective" requires a shift in attitude from leaders, clinicians and other decision-makers in order to make changes inside an organization, this is a logical place to start. However, we cannot have a complete and informed conversation on safety without understanding the perception of patients, or we run the risk of perpetuating the very challenges we seek to address.

As noted above, patients and families do not separate a "healthcare experience" from a "safety effort." This is due, in part, to the fact that they are free from the restraints of considering regulation and internal silos. When looking through their eyes, one finds that the current perspective of safety is quite limited.

So, if patients and families do not/cannot distinguish the results of safety efforts from their overall experience, what does the lived experience reveal? As reinforced through this paper, culture is the bedrock on which safety and experience efforts are grounded. What we also must acknowledge is the role culture plays in the perception a patient has of an organization, as the definition above states. Patients may not always know what they are witnessing when receiving care within a particular culture, but the culture will reveal itself for better or for worse. For example, a culture may be described as a "that's not my job" culture which may leave a patient or family member feeling alone and without enough support. An example of a healthy culture might be a "the patients are why we get out of bed in the morning" culture and this may translate to the patient or family member as being in an environment where "everyone really cares about me as a person."

Often, the culture of an organization plays out in the interactions patients and families have with clinicians. These interactions are driven, in some ways, by the way in which clinicians see their role, the level of stress they are currently feeling and the processes in place enabling them to provide the highest quality care possible.

To this point, we have explored "harm" from the perspective of healthcare systems, clinicians and leaders. Safety has been described and defined primarily as the efforts, processes and commitment (financial and otherwise) to keep patients free from harm. Based on the body of extensive research and recommendations for preventing harm, we can see harm is defined by healthcare professionals as an event that results in, or had the potential to result in, unexpected medical complications, a delay in recovery, permanent physical deficits or death.

While the accepted understanding of "harm" is most often defined by clinicians, safety officers and organizational leaders, the question this raises is do patients define harm the same way? One might be surprised to see that patients and families define harm differently. This serves as a profound example for why it is imperative to put aside assumed ideas about common terms/concepts in healthcare and, instead, design ways to understand what patients and families perceive. Without understanding this, we are incapable of sharing a mental model with patients and families about when and how they are "safe", properly addressing adverse events, or acknowledging and addressing events that are not traditional "safety" events but are still perceived as harm.

The question now becomes, if we look at how patients and families define harm, how might that influence the ways in which we operationalize safety efforts? More so, if patients, families and consumers of care in general do not distinguish safety from their overall experience, how might that open the possibilities for how healthcare views and operationalizes the experience of safety?

Defining Harm from a Patient's View

When building organizational capacity for experience excellence, one factor that shines through an organization's culture is how well they are able to seek, capture and act upon the perceptions of those they serve. One of the greatest examples of this is examining how "harm" is defined and understood by patients and families. For example, what comes to the minds of patients when they hear the phrase "do no harm?"

We cannot assume patients and families define harm in the same way as healthcare organizations. To truly address harm effectively, it is essential for an organization to have consistent methods to capturing the lived experience of those they serve and, as an integral part of that, explore how harm is defined and what best helps in recovering from harm.

An example of this opportunity is seen in a comprehensive survey of pediatric inpatients and their loved ones. The study sought to understand

their perspectives on undesirable events, and it was discovered that patients and families named a "diverse array of undesirable events." The following are ways in which patients and families defined harm[20]:

> ***Communication:*** *Communication problems are manifested in different ways: between providers, in receiving or not receiving critical information, and in challenges in providing clear information.*
>
> ***Policy:*** *Patients and caregivers found themselves at odds with policies that seemed unreasonable or inconvenient.*
>
> ***Lack of Care Coordination:*** *This includes problems with scheduling, logistics, or coordination among providers, families, and patients.*
>
> ***Information Needs and Preferences:*** *This highlights the need to fully understand and act on the information preferences for patients and families.*

In addition to a deeper understanding that patients and families may define harm quite differently than most healthcare organizations and professionals do, this study provides a profound illustration of how limited the current view of what falls under safety currently is within most healthcare organizations. In the study above, harm was described as waking a baby multiple times in the night, separation of family members during a patient's health event and lack of communication about test results. While more traditional safety events were described, such as a medication error, the ways in which patients and families described safety and harm were much farther reaching and completely based on their experience.

As much as it has been said that the success, failure and efficiency of all safety efforts becomes the experience of patients and families, it could also be said that trust is the root of the patient/family experience. The degree to which patients and families trust their clinicians and the healthcare organization as a whole is the degree to which they can relax and focus on their own emotional well-being and physical recovery. Those who do not trust that they are being well cared for, both clinically and as a person, will be on guard, defensive and skeptical. This often creates an adversarial dynamic between the clinician and the patient/family which, in itself, is a threat to that patient's safety. It is for these reasons that healthcare has begun to recognize the need for creating meaningful partnerships with patients and families. But, again, it is imperative to inquire as to what "partnership" means to patients and families.

Partnership and Activation

The term "partnering with patients" is one heard regularly in healthcare today, yet it is often said without a clear understanding of what it means or how to bring it to life. The methods for "partnership" are far and wide. This may include anything from "teach-backs" to having a Patient and Family Advisory Council. Since the concept of partnership is relatively new, tactics to engage as partners can be awkward, empty or lack a clear direction. However, the momentum for finding ways to partner has not slowed and more and more strategies are being developed and implemented. As time goes on, these strategies become more effective and have evolved to include "co-design," "co-creation" and "co-production."

Another term taking hold within healthcare is "patient activation." Activation describes the knowledge, skills and confidence a person has in managing his/her own health and health care. The impact of a patient's activation level is far reaching:

- *People who have low levels of activation are less likely to play an active role in staying healthy. They are less good at seeking help when they need it, at following a doctor's advice and at managing their health when they are no longer being treated.*
- *Patient activation scores have been robustly demonstrated to predict a number of health behaviours. They are closely linked to clinical outcomes, the costs of health care and patients' ratings of their experience. Highly activated patients are more likely to adopt healthy behaviour, to have better clinical outcomes and lower rates of hospitalisation, and to report higher levels of satisfaction with services.*
- *Patients with low activation levels are more likely to attend accident and emergency departments, to be hospitalised or to be re-admitted to hospital after being discharged. This is likely to lead to higher health care costs.*[21]

Looking at the concept of partnership through the lens of the clinician experience, one can easily see that when a clinician and patient are able to find a way to engage as partners, the clinician will likely feel more effective in their role as a medical provider, become energized by the interaction, and view the patient more as a person than their disease or lab results. It is worth noting that these are the opposite of what a clinician experiences when burned out. This kind of partnership enables better communication and trust, potentially supporting the patient in increasing their activation level. As patients and

CASE STUDY: MAKING THE CASE FOR EVIDENCE-BASED PATIENT INFORMATION

If the first step to being activated is to be knowledgeable, organizations and individual clinicians must ask: "How do our patients and families gain knowledge?" The following case study demonstrates what it can look like when an organization chooses to partner with the patients and families to gain more knowledge and, therefore, become more activated.

> *On behalf of Health Education England and as part of a Senior Leadership Programme, a group of health library and knowledge specialists across England worked together on a shared project exploring how evidence is used in the creation and review of information for patients. The project titled, 'Making the case: evidence-based patient information,' explores the real need for patients and the public to have access to high quality, reliable health information. As individuals are being encouraged to self-manage and be partners in their care they need access to a range of resources tailored to their literacy level.*
>
> *The aim of the project was to influence and advocate the importance of evidence for health information for patients, carers and the public in healthcare settings, as well as identifying key learning to support others in influencing the evidence base of patient leaflets in their local NHS settings.*
>
> *As health librarians, we play a key role in providing evidence for patient care as part of our service to healthcare staff. We have skills in finding the evidence, appraising it and making it readily available in formats needed by our healthcare colleagues. The need for patient information to be evidence based is driven by a number of strategic priorities including patient experience, self-management, shared decision-making and health system sustainability.*
>
> *The project focused on the production of patient leaflets within NHS Trusts, usually written by local clinical staff for specific conditions or procedures. We were looking at the current level of involvement by NHS LKS in the production and review of leaflets and the key stakeholders who play a role in this process.*
>
> *Information was gathered from case studies of three NHS Trusts, through telephone interviews with NHS librarians delivering and supporting the production of patient information and a literature search on good quality patient information. The findings of the work are outlined in a report, along with other useful resources highlighting; the importance of LKS role in supporting evidence-based information, the key policy drivers, the emphasis on influencing key stakeholders and the challenges of clinical language.*
>
> *The report makes a number of recommendations; including, making patient information a part of our 'offer' as a service forming part of LKS existing role as champions of evidence-based practice within their organisations. Key themes from the case studies and learning from networks were the significance of influencing skills and the importance of demonstrating the impact of this work and sharing best practice.*[22]

While this case study focuses more on process than outcomes, the mere concept of developing a "health library" for patients and families demonstrates partnership. In addition to a deliberate effort to provide a way for patients and families to better understand their healthcare condition and treatments, this study exemplifies an approach to "partnership" that is reversed from a typical healthcare approach. Generally, patients and families are asked to partner with their clinicians to achieve a certain health outcome. In this case, the organization is partnering with the patient and family to achieve a broader reaching goal: activation. Activation, of course, leads to improved outcomes and reportedly better experiences of care.

families increase their level of activation, they will improve their own experience because they feel more effective in their role as a patient or loved one providing care, become energized by the interactions with their clinicians, and view their clinicians more as a person than an authority or adversary.

If partnership and activation are fundamental to how patients experience their care, so too, it is fundamental to how they perceive and participate in safety efforts. Just as activation has a scale one can advance through, patients can become competent in efforts to keep themselves safe in a healthcare setting. Over time, they can take more responsibility for their own safety and well-being by learning what to watch out for and finding their voice to speak up with their questions/concerns. This must always be fostered by the way in which organizations approach their work. In seeing safety as part of the larger experience patients have, healthcare organizations can look to invite, support not only partnership, but ownership. This intentional focus leads to safer patients with better outcomes and experiences.

In partnering with patients, a primary lesson to be learned is the need to listen to patients and families and view them as a resource that can contribute to the process, as much as a person in need of clinical care. This requires both a willingness and commitment from clinicians. It ultimately opens the door to the opportunity for co-designing an organization's systems/processes. The closer we come to this symbiotic relationship between clinician and patient, the safer and happier patients will be. So how might we continue to advance this partnership perspective and develop solutions in alignment with those healthcare serves?

In the Consumer Perspectives on Patient Experience 2018 study, "listen to me" was identified as the chief factor when shaping a patient's experience in healthcare.[5] While, for most people, this brings to mind a clinician listening to a patient's medical concerns or family history, it is important to consider all of the ways in which a patient is listened to when moving through a healthcare experience. One can conclude "listening" has a broad meaning and should be considered as both an individual behavior as well as an organizational commitment.

In support of humans listening to humans, healthcare currently has many strategic tactics to choose from including everything from simple techniques like "teach backs" to more involved methods such as Motivational Interviewing. The recent Journal of General Internal Medicine study suggests we may be best served to begin by *literally* listening; "On

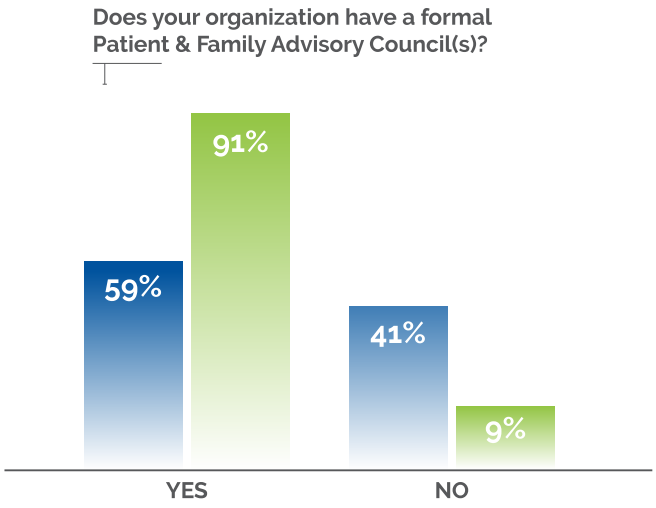

Figure 4: Reprinted from 2019 State of Patient Experience[9]

average, patients have 11 seconds to explain the reasons for their visit before physicians interrupt."[23]

Currently, within experience improvement, the emphasis is on individual interactions and methods for improving listening in that context. This is certainly as it should be. Too often, missing from the equation is a focused effort to ensure the *organization is listening*. How does an organization "listen" to patients and families? This is achieved through a commitment to utilizing multiple methods for capturing the lived patient/family experience throughout every corner of the system/organization.

Perhaps the most well-known model for an organization working to capture the lived experience of patients and families is a Patient and Family Advisory Council (PFAC). This is a group of patients and families who are brought together, often monthly, to provide feedback to staff, leaders and clinicians regarding new ideas, programs and written materials. The prevalence of PFACs continues to rise. In 2019 State of Patient Experience, we see that 91% of organizations reported having an official PFAC in 2019 vs. 59% in 2017.[9] See Figure 4.

If we hope to achieve true partnership, and if listening is the foundation of partnership, organizations must begin to include more methods for not only capturing lived experience but acting upon what is discovered. Feedback given in a PFAC is often not acted upon because of a lack of solid processes and needed hand-offs to operationalize good ideas. This may cause a breakdown in trust or a lack of enthusiasm for the patient and family advisors and could result

in the organization questioning the measurable contribution of the group to the organization overall. To have an effective PFAC, processes must be put in place to operationalize the feedback given, or it runs the risk of being a "box checked" in a partnership strategy rather than achieving the intended impact.

Using a PFAC is only one way for an organization to listen. New approaches such as design-thinking are beginning to flourish in healthcare, providing more and more tools for listening at the organizational level that include measurable results. Experience Based Co-Design (EBCD) is one such example of design thinking for healthcare that includes multiple robust approaches to capturing the lived experience, co-designing solutions with staff, clinicians, patients and families and measuring solutions through a standard PDSA (Plan-Do-Study-Act) cycle. When exploring the literature on specific outcomes of EBCD Cycles, it becomes apparent this approach increases buy-in, prioritizes the most urgent "pain point" and increases sustainability after solution implementation.

According to the Point of Care Foundation, "A 2013 global survey discovered that EBCD projects had either been implemented, or were being planned in more than 60 health care organisations, in countries including Australia, Canada, England, the Netherlands, New Zealand, Sweden, and the United States"[24] which indicates the growing global recognition of the value co-design brings to healthcare. In this approach, shown in Figure 5, strategies such as shadowing, observation, focus groups and interviews provide a non-bias perspective on the collective lived experience so that key patterns and priorities may be gleaned from those

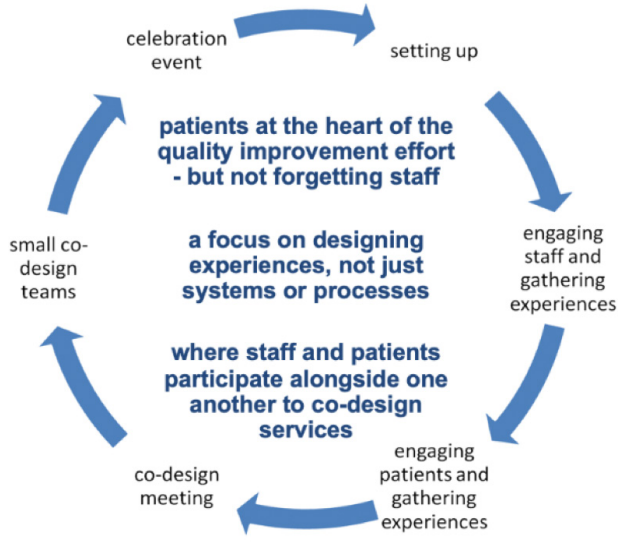

Figure 5: Reprinted from British Medical Journal[25]

in need of the improvements rather than assuming the priorities for them. This is just one of the things that differentiate this process form standard PFA feedback.

While getting feedback from patients and families via surveys and committees certainly provides insight into the lived experience, literature shows that using additional methods to understanding the lived experience enables us to find patterns and trends "on the ground" that would be difficult or impossible to discover through written questions and conversation alone. As a prime example, one acute mental health triage ward at Oxleas NHS Foundation Trust already had plenty of feedback in the form of formal service user and family complaints. The Trust used experience-based co-design to examine the issues and redesign procedures. After completing the cycle, one of the primary discoveries included the impact of the staff experience was having on the patient experience:

> *The pressures on ward staff and the quick turnover of patients meant many clinical procedures, particularly in admissions processes, had become overly routinised. Staff described this contributing to losing sight of the significance of their individual interactions with patients; the value that patients placed on this negatively affected morale. Service user feedback was central in restoring a more balanced sense of staff effectiveness, by reinforcing the importance of the relational aspects of their work. This created a virtuous cycle, where more effective interactions increased staff morale, which then further impacted on improving patient care. Prioritising communication and relational aspects of care as defined by users resulted in no complaints on an acute mental health ward for 23 consecutive months*[26]

The evidence shows us that listening to patients and families is at the root of improving their experience. If the success, failure and efficiency of all safety efforts is foundational to their experience, it follows that we must also listen to how patients define harm and prioritize improvements based in this perspective. The key question then becomes "how do we listen?" Listening is multi-directional and not limited to one-on-one interaction. There is need for individual clinicians to listen as partners and support patients in becoming more activated. Additionally, organizations must continue to ensure that methods to understand and act upon the lived experiences of patients and clinicians are built into improvement efforts at every touch point. If organizations and individual clinicians and organizations are able to put aside traditional and outdated attitudes towards the way in which patients are positioned within the healthcare team, the opportunities for the patient to add tremendous value increases.

The Role of Safety in the Patient Experience: Opportunities for Action

In this paper, we explored the experience of safety for clinicians with an eye on culture and the necessity for "people before process." We all also called on leaders to commit to being aware of the experience of clinicians within the organization's safety efforts and how that may influence financial, staffing and technology decisions. In addition to understanding the clinician's experience of safety, we must also take a step back and ask how patients define harm and if that answer may influence how we realign our efforts to mirror those perceptions. Perhaps most essential, in order to break down unnecessary walls between safety and experience, we must develop and employ methods for capturing and responding to the lived experience of those delivering and receiving care.

"Human error is roughly defined as the failure of an action to achieve its intended outcome."[28] In healthcare, great efforts are made every day to prevent human error so that the "intended outcome" can be achieved, most often to restore or improve the health of an individual. As time goes on and safety practices continue to advance, however, we see that these efforts are also foundational to the experience of clinicians and patients alike. In reflection, we must open up to a larger definition of "outcome" when applying a focus on safety to ensure we are not limiting the scope to clinical outcomes and, by extension, limiting our ability to provide safe and positive experiences.

The time has come to change the healthcare narrative about safety as separate from experience. Letting patients lead with their lived experience and resulting perceptions can aid in this transition. Assuring the clinician experience is acknowledged and addressed must also be an integral component of this endeavor. At its core, these changes begin with an understanding that the traditional silos that have separated experience and safety should be dismantled so that these areas can be operationalized from a perspective of "wholeness". It is time to take essential actions that will preserve safety in healthcare and ensure a positive experience for all. Below we offer actions that are foundational to integrating safety and experience efforts and ultimately elevating the human experience in healthcare overall.

1. **Acknowledge safety as a primary driver for overall experience of both patients and clinicians**

   It has been said "experience is everything," meaning, the patient and family experience encompasses everything they encountered during an engagement with healthcare. If a patient leaves a healthcare encounter feeling better and able to go back to their daily life, that is due to the success of safety efforts and will be remembered. If a patient experiences an adverse event, they will reflect on their experience and remember that the safety efforts failed them. Whether they understand to frame their experiences in the context of harm, or lack of harm, those working to keep patients safe must begin to better align safety efforts with the perceptions of those they serve.

   In the same light, the clinician experience, like the patient experience, must be observed, understood, captured and acted on in an effort to ensure their priorities for providing safe care are recognized, thus ensuring their experience with delivering care is optimized. A good clinician experience impacts culture, engagement and retention, quality, safety and ultimately patient experience. Bringing these ideas together helps to realize our opportunity to elevate the human experience in healthcare.

2. **Approach safety and patient experience through a unified lens**

   After the alarming data presented in *To Err is Human*[27] in 1999, there was an explosion of safety efforts made around the globe. These efforts primarily focused on processes and improving a culture of safety. In retrospect, it is easy to see that these efforts lacked attention to the actual experience of those carrying out and benefiting from these safety protocols.

   At this point in the safety journey, enough time has gone by that safety strategies are integrated into most healthcare organizations' daily operations. This now gives us the breathing room to recognize that not considering the experiential aspect of safety tactics may, indeed, be one of the reasons the explosion of safety efforts has not been as successful as the medical community would have hoped or expected it to be.

   Today, healthcare organizations often still perceive safety and experience as two separate areas of care. Without a systemic

approach to the patient and clinician experience, our silos will continue to impede progress and reinforce the limiting perspective that a "safety effort" is separate from an "experience effort."

As noted earlier, the success, failure and efficiency of all safety efforts is foundational to experience for patients and families. After an era when safety and quality have been words absent from most definitions of experience, it is time to remove what stands between these three distinct efforts. Doing so will require looking beyond the transactional nature of healthcare today, to one in which the system is built on relational concepts and practices. It is the connectedness between clinicians and patients and families that organizations must first address in order to begin to move beyond the "what we do to answer the question 'Who are we?'" The answers can be identified through three key lenses, that of cost, impact of safety efforts on the clinicians carrying them out, and capacity to deliver experiences based on patient and family perceptions of safety and harm. Only after approaching safety and experience through a unified lens will organizations be able create a healthcare experience which truly elevates the human experience in healthcare.

3. **Make financial choices that reflect a commitment to the experience of safety**

In our familiar world of cost constraints, it is a challenge for healthcare organizations to swiftly change mindset and strategy when it comes to financials. However, through the examples shared in this paper, not investing in safety can significantly impact the bottom line; resistance to prioritizing safety over cost can come with detrimental results.

How do organizations choose to prioritize? As noted earlier, it is not always the welfare of patients, families, staff and clinicians that drive sound fiscal decisions. In some cases, cost surpasses providing safe care, such as in the examples of cutting staff or asking clinicians to provide services outside their scope of expertise. Understaffing and stretching of one's professional skills strain the entire system and puts the safety of patients at risk. These examples are sad reminders that all in healthcare need to be unwavering in finding balance between these two elements and create environments where staff and clinicians prefer to work and where patients and families remain loyal.

It is time for organizations to commit to preventative safety measures; statistics confirm prevention is less costly than an adverse event. Organizations should decide who they want to be in terms of cost and safety, and then through innovative methods strive to become an organization that allows clinicians to focus on their role as carer and is known to patients and families as one that prioritizes their well-being over anything else. It is these organizations that will see the greatest success in the future.

4. **Make a conscious, accountable and strategic effort to build a culture of caring**

We cannot overlook the impact of an organization's culture on patient safety, because only in healthy environments can staff help patients feel safe and secure. Central to this point is that staff and clinician experience cannot be seen as separate from patient experience. High performing teams operationalize safety in everyday best practices to create a culture of safety exemplified through teamwork, employee engagement and partnering with patients and families. For staff and clinicians, such environments reduce self-doubt, increase joy in work and provide emotional and technological support, ultimately reducing the risk of medical errors.

At no other time has creating a culture of safety been so critical to organizational success, because an undesirable working atmosphere has been identified as a major cause for staff to leave. Depersonalization of care, emotional exhaustion and not feeling effective are further causes for unhealthy environments which often lead to high turnover. Patients who experience the loss of a familiar caregiver who has left the organization often find it difficult to restore the relationship with another staff member, which can lead to patient uncertainty, confusion, and mistrust.

As we learned from examples in this paper, a focus on personal values of all individuals in addition to professional skill when hiring

lie at the core of establishing a workforce grounded in a culture of safety. Without a positive environment that supports keeping patients safe, the probability of clinicians, staff, and patients of having a good experience becomes unlikely.

5. **Optimize technology to care for the carers**

   In addition to a good working environment, leaders need to ensure proper tools are accessible by staff so they can feel effective in their work and provide the highest quality of care to patients. Providing resources to staff impacts their levels of motivation and performance, collaboration, absenteeism and how long they stay on job. In this regard, often overlooked as an important resource for staff are job aids. A pertinent job aid in healthcare is technology, a broad and budding field of options that have the potential to improve or complicate the experience of clinicians as well as the clinical outcomes for patients.

   Optimizing technology has the opportunity to create efficiencies to replace burdensome, time-consuming tasks and free-up staff to better support each other in providing compassionate care and building relationships with patients and families.

   When choosing technology as a solution, careful attention is needed to ascertain how it will be used, where it will be used, and if it can resolve identified, unmet needs. Through careful exploration, organizations should optimize technology that does not obstruct the building of relationships between others, but rather, feeds partnerships that are at the heart of the experience today.

6. **Engage patient and family voice to lead change and drive future solutions**

   Patients and families already recognize, through their lived experience, that safety is one primary component of their overall experience. Because of this, the point does not need to be proven to the same degree. Rather, it is more important that healthcare organizations begin to align this perception with how they design their safety efforts and how they build their ability to understand the lived experiences of those that they serve.

   The more an organization understands the root of patient perceptions by capturing their actual experiences within healthcare, the more we will build capacity for better experiences through safety practices that have emphasis in the areas of patients' and families' highest priorities. In this way, patients and families provide a great opportunity for healthcare organizations to be led into a new era in which silos between experience and safety are dismantled and new methods to approach safety from the lens of experience can be operationalized.

In taking on these actions, we create an opportunity for alignment and focus, shaped by those delivering and receiving care. When we acknowledge that, at our roots, we are committed to the best in outcomes for patients and that those outcomes are all part of the experience they have, we can act to ensure safety is no longer a separate effort but integrated into all we hope to provide in a healthcare experience. Equally, we recognize the need for organizations to be cognizant that choices made in setting financial priorities, procuring technology and prioritizing safety efforts drive the clinician experience which has a broad impact on the organization as a whole. When we take these steps, we are truly ensuring an unwavering commitment to the human experience, and with it, the best in quality and safety, and ultimately the best in experience that all in healthcare deserve.

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