BETA HEART®
for HQI Members

HQI Cares

Implementing BETA HEART®
to Build a Culture of Safety

BETA HEART® Guideline

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Implementing BETA HEART® to Build a Culture of Safety

On behalf of all of us at HQI and BETA Healthcare Group, welcome to *HQI Cares: Implementing BETA HEART®*. BETA HEART is BETA Healthcare Group's comprehensive and coordinated effort to guide participating organizations in implementing a reliable and sustainable culture of patient safety that is grounded in a philosophy of HEART: **H**ealing, **E**mpathy, **A**ccountability, **R**esolution and **T**rust. We applaud you for partnering with us in this endeavor to reduce harm in healthcare.

As we begin this journey together know that we are here as your partners in development and implementation of each of the five domains of BETA HEART, which include:

1. *Culture of Safety*: Administering a scientifically validated, psychometrically sound culture-of-safety survey to measure staff perceptions of safety and engagement, as well as sharing and debriefing results.
2. *Rapid Event Response and Analysis*: A formalized process for early identification of, and rapid response to, adverse events. Includes cognitive interviewing techniques to collect information. Event analysis integrates human factors science, systems analysis, and the principles of Just Culture.
3. *Communication and Transparency*: A commitment to honest and transparent communication with patients and family members after an adverse event.
4. *Care for the Caregiver*: An organizational program that ensures emotional support for members of the healthcare team involved in, or impacted by, an adverse event.
5. *Early Resolution*: A process for early resolution when harm is deemed a result of inappropriate care or medical error.

We look forward to your participation in the domain-specific workshops in 2022. After each workshop, our team will work with your organization to develop a plan and provide you with customized support as you progress through domain implementation.

This Guideline provides the criteria which need to be met for each domain to be considered fully implemented. Domains build upon one another and serve as mileposts on the journey to patient safety. Completion of each domain is evaluated and validated in a joint meeting between your organization's leaders and the HQI Cares/BETA HEART team. Your hospital will receive formal recognition after completing each domain, and an HQI Cares/BETA HEART Trophy after completing all five domains - signifying the highest distinction in building the culture of patient safety. The guideline also provides a list of documents that will need to be made available at the time of validation assessment and key personnel who we will look to interview to understand organizational processes.

Please review the following materials carefully. When your hospital is ready for a validation assessment in a particular domain, documents listed for review may be forwarded to the undersigned prior to the visit. All other documents will be reviewed onsite.

Thank you for your ongoing commitment to patient safety and the reduction of harm. We look forward to working with you and celebrating your team's success!

For questions regarding *HQI Cares: Implementing BETA HEART*, contact Boris Kalanj, Director of Programs, HQI, at bkalanj@hqinstitute.org or Deanna Tarnow, Senior Director, Risk Management and Patient Safety, BETA Healthcare Group at deanna.tarnow@betahg.com.

Demographics

Facility Name: _____

Designated HQI Cares/BETA HEART Lead/Contact: _____

Facility Leadership

Chief Executive Officer: _____

Chief Nursing Officer: _____

Chief Financial Officer: _____

Chief of Staff: _____

Chief Medical Officer: _____

Human Resources Director: _____

Risk Manager/Director: _____

Patient Safety Officer: _____

Physician Lead for Patient Safety: _____

Culture Survey Champion: _____

Quality Management/PI Lead: _____

Licensed Beds

Acute:_____ SNF:_____ Swing: _____ Average Daily Census: _____

Facility Locations: _____

Staff

Staff: _____ # Employed Medical Staff:_____ # Independent Medical Staff: _____

Names of Insurance Carrier Companies Representing Medical Staff: _____

_____

Has the Board of Directors been informed of and are they in support of the organization's participation in HQI Cares/BETA HEART? ☐ **Y** ☐ **N**

BETA HEART Assessments and Activities

Current Year in HQI Cares/BETA HEART: _____

	Yes	No	
Participation Agreement executed and submitted	☐	☐	Date: _____
Readiness Assessment completed	☐	☐	Date: _____
Gap Analysis completed	☐	☐	Date: _____
Gap Analysis Report presented to Leadership	☐	☐	Date: _____
Workshop One (Date and # of participants)	☐	☐	Date: _____ # Participants: ____
SCORE/Culture Safety Survey administered	☐	☐	Date: _____
Debriefings completed	☐	☐	Date: _____
Event process map submitted	☐	☐	Date: _____
Rapid Event Analysis RPIW	☐	☐	Date: _____
Event Analysis Onsite Workshop	☐	☐	Date:_____# Trained: _____
Cognitive Interviewing Workshop	☐	☐	Date:_____# Trained: _____
Just Culture implemented	☐	☐	Date:_____# Trained: _____
Workshop Two (Date and # of participants)	☐	☐	Date: _____ # Participants: _____
Communication Assessments completed	☐	☐	# completed: _____
Communication & Transparency Training	☐	☐	Date:_____# Trained: _____
Care for the Caregiver Training	☐	☐	Date:_____# Trained: _____
Workshop Three (Date and # of participants)	☐	☐	Date: _____ # Participants: _____
HEART Event submitted for validation	☐	☐	Date: _____
Quarterly Collaborative Call participation	☐	☐	_____Q1 _____Q2 _____Q3 _____Q4

Culture of Safety

Requirement	Validated By
The organization has designated a Culture team lead and team members responsible for overseeing organizational culture measurement and strategies to develop a culture of safety.	Interviews with Culture team and leader
The organization has administered an organization-wide culture of safety survey using a psychometrically sound, scientifically validated instrument. A 60% response rate is required to ensure statistical significance.	Culture survey results are provided at time of validation Survey participants include physicians and staff across all departments within the organization
A baseline survey may be completed within the six months prior to beginning the HEART journey, and going forward, a culture survey must be completed annually.	As above
There is evidence of the culture survey results having been analyzed. Debriefs are facilitated and have been held in focus group settings. • Debrief records include the number of attendees • Debriefs are led by staff that have been educated to the debriefing process	Unit/department and Medical Staff Debrief notes and identified action plans
Lessons learned are shared • Department/unit specific trends from event reports (incident reports/QRRs) are shared and discussed, at a minimum on a quarterly basis with medical staff and nursing staff. • To raise staff awareness of safety concerns, a process for disseminating lessons learned from individual case studies is developed and implemented. Dissemination may be accomplished through case study presentations, M&M rounds or patient safety newsletters/written communications discussing errors and/or near miss events.	Medical Staff and Nursing Department/Unit minutes reflect discussion Evidence of participation through sign-in sheets Documentation of lessons learned presentations and/or newsletters
Policies are in place that support reporting of adverse clinical events.	Policy review

Culture of Safety

Requirement	Validated By
The organization adopts a Just Culture philosophy and approach to adverse event investigation and response. • HR policies and adverse event policies contain language consistent with a fair and just approach to investigation of adverse events and determining employee culpability. • Adverse event investigations focus on evaluation of systems factors for determining causative and contributing factors that led to the event. • Where an adverse event or error is determined to be due to individual behavior, the organization utilizes a consistent algorithm to evaluate such behavior.	Human resources policies and adverse event policies Adverse event investigation records and related documents Evidence of application of Just Culture algorithm Staff interviews
Measurement: The organization completes a scientifically validated, psychometrically sound culture of safety survey and staff/physician engagement survey annually. • Specific culture survey items are selected and studied over time. At a minimum, at least one additional evaluation criteria is measured: • Staff turnover/retention rates • Number of reported adverse events • Number of reported near miss events	Review survey instrument utilized (Must be SCOR-E, SAQ, AHRQ or other survey that meets specified criteria) Review of survey results and evidence of debriefing Organizational data Review selection of culture survey items and performance improvement strategies Review baseline measures
The organization has adopted a HEART dashboard and communicates selected data broadly to medical staff and workforce members.	Dashboard review (on units) Interviews with staff

Rapid Event Response and Analysis

Requirement	Validated By
An Executive Leader and Event Analysis team are identified and actively involved in program development.	• HEART Participation Agreement • List of Event Analysis team participants • Interview with Executive and Team Lead
Adverse events are reported to Risk Management in a timely manner. • Serious or sentinel events, as defined by organizational policy, are reliably reported within one (1) hour of event detection or recognition. • Other adverse events are reliably reported within 24 clock hours of the event.	Adverse event data, including severity and timing of event reporting
The organization provides varying methods of submitting adverse event reports in order to support easy access for physicians and staff. • Online reporting system • Risk/Patient Safety Hotline	Adverse/sentinel event reporting policies and process
Patients, families, or both, are routinely interviewed during investigations of adverse events.	Closed event investigation or RCA files from the preceding 12 months
Event investigation utilizes cognitive interviewing skills. • Interviews are held in person with involved staff • Interviewers are trained in cognitive interviewing methods	• Evidence of participation in cognitive interviewing workshop • Documentation of interview process reflects use of proven methods to elicit memory retrieval
The organization applies the science of human factors/ergonomics to the analysis of adverse events and to process improvement planning.	Closed event analysis/RCA files, with action plans, from the preceding 12 months
At least one participant in event analyses/RCAs has received formal training in applied human factors/ergonomics.	Human factors training program agenda or syllabus with dates and names of participants
Event reviews are inter-professional, multidisciplinary and whenever appropriate, include physician engagement.	• List of event analysis/RCA participants and their professional disciplines for the preceding 12 months • Interviews of current and recent event analysis/RCA team members reflect broad participation
Strategies to improve patient safety following adverse events are developed with input from patient and family advisors.	Committee minutes with names of participating patient/family advisors
When individual behaviors are determined to have contributed to harm, a consistent and fair process is utilized to determine their culpability.	• Evidence of the application of just culture principles in event analyses/RCAs completed in the preceding 12 months • Adverse event policy reflective of just culture principles

Rapid Event Response and Analysis

Requirement	Validated By
For each serious adverse event, the organization tracks the following data: • Length of time (in hours) from event occurrence to notification of Risk Management or another organizational representative. • Length of time (in hours) between notification of Risk Management or another organizational representative and the beginning of the investigation or fact-finding. • Severity trends of reported adverse events over time. • Reporting trends of near miss events.	Dashboard reflecting specified data
Aggregated data: • Number of adverse events reported (denominator). • Number of events reported to Risk Management >24 hours after event. • Range and mean length of time (in days) between the organization becoming aware of serious events and completion of the RCA/event analysis • Patient demographics data including race, ethnicity, preferred language of patients/family members who experience serious adverse events.	Dashboard reflecting specified data

Communication and Transparency

Requirement	Validated By
The organization has designated a Communication Team and team leader responsible for implementation of specific strategies.	Interview with team leader
The organization has administered a communication assessment for all potential Communication Team members. Those assessed have received individualized feedback.	Evidence of communication assessments completed by team members List of those who took the assessment
Final Communication Team selection is done in part, based on communication assessment findings. The organization has considered the communication assessment results in its determination of Communication Team development. Additional sources of information to be considered in selecting Communication Team members include: • Professional experience within the organization, position within the organization, performance reviews, patient satisfaction scores, personal experience recommendations.	Interviews with Communication Team members and staff Communication assessment data findings and organizational graph
Key leaders and staff, including Communication Team members are provided additional training in empathic communication.	Documented evidence of (at a minimum) participation in a HEART communication workshop
The organization sets a goal of sixty (60) minutes for timeline from adverse event until initial communication to patient/family by healthcare providers or organizational leaders. Time from event to response is tracked and communicated across the organization.	Adverse Event Policy review Communication after Harm Policy Response time data/event response data
The Communication Team prepares for the initial and ongoing conversations. The HEART Huddle is used as a guide in preparing for initial communication.	Communication policy includes reference to HEART huddle Interviews with Communication team members reveals understanding and application of HEART Huddle questions

Communication and Transparency

Requirement	Validated By
The initial communication includes the following: • Acknowledging the event (this is not an admission of guilt, rather it acknowledges that an adverse event occurred while the patient was under the organization's care). • Showing empathy • Affirming first priority is to take care of the patient and meet their healthcare, social and emotional needs. • Informing the patient/family that an investigation and analysis will be completed to understand what occurred and that results will be shared. • Designation of an organizational contact person the patient/family can reach with questions/ concerns and who will reach out to the patient/family within an agreed upon time period.	Organizational policy review Medical record documentation reflects initial communication and ongoing follow-up and interactions with patient/family as agreed upon
Communication Team reviews event analysis findings in preparation for follow up communication. A communication checklist is utilized as a guide in preparing to hold the communication.	Interview with team members reflects use of communication checklist Communication policy references checklist (included as an addendum or other method of verifying principled approach to preparing for conversation)
The organization evaluates the effectiveness of their communication process: • Debriefings are held with Communication Team members who participated in meeting with patient/family. Measurement: • Time from event to time of communication with patient/family are tracked and reported • # of communications/# of adverse events where communication is indicated • # of claims with documented communication with patient/family	Standardized debriefing model is utilized as a method of evaluating what worked and opportunities for improvement. Evidence of debriefing tool utilized by each communication team members is retained, and components of the tool completed. Review timeliness data

Care for the Caregiver

Requirement	Validated By
A Care for the Caregiver Executive Champion and Team Lead are identified and roles are defined: • The Executive Champion will have oversight of the program development and ongoing identifications and provision of resource needs. • The Team Lead will have oversight of the program operations and serve as or designate a coordinator.	Designation of Care for Caregiver Executive Champion and Team Lead
The organization has assessed its current infrastructure and resources to support development of a Care for the Caregiver program.	Organization has completed a personnel resource assessment • HEART Care for the Caregiver toolkit: Peer Support Implementation Guide/ worksheet
A Care for the Caregiver Steering Committee is created to drive the program development forward. *Recommended members include: Department Directors, Champions representing physicians, nursing and residents; Executive sponsors such as VP Patient Safety, VP Human Resources, Behavioral Health Liaison; and representatives from Employee Health, Pastoral Care, Risk Management and Marketing.*	Review of roster for Care for the Caregiver Steering Committee members
Staff is surveyed as to their perceptions of safety through an evidence-based culture of safety survey and the results are shared with staff.	Review of Culture Survey results and evidence of mechanism used to share results with staff.
Policies consistent with the principles of Just Culture are in place to encourage and support staff to feel safe in reporting adverse events. • Staff is aware of organizational philosophy and policy	Review of organizational adverse event reporting and investigation policies Review of HR disciplinary policies Interviews with staff

Care for the Caregiver

Requirement	Validated By
A process is in place for identification, training and ongoing support of peer supporters. • As one component of the team selection process, potential Peer Supporters will complete a communication assessment. • Peer Supporters sign a formal agreement defining their role, and indicating their commitment to complete required training, be available to staff and maintain confidentiality of discussions. • Peer Supporters participate in formalized training that includes: responding to healthcare team members who are involved in an unanticipated patient event, communications, crisis intervention, active listening, situational awareness, recognition of signs and symptoms that a colleague may benefit from peer support, and indications for a peer support program. • Formalized training will be ongoing. • Team meetings to occur at least quarterly and ongoing training at least annually.	Review of Peer Supporter training materials and sessions Review of Peer Supporter sign-in sheet or other attestation as to participation Review of Peer Supporter team meeting minutes and educational curriculum
A policy is in place specifying team deployment 24/7, intervention, follow-up, and support from time of event through the investigation and litigation process. • Policy includes criteria to determine the need for total team debrief (make up of team may include both clinical and non-clinical staff).	Review of organizational Care for the Caregiver policy and procedure Interviews with staff regarding debrief process
Organization will designate a “Safe Space” (Recommended: in close proximity to each high-risk department) where caregivers can go after a harm event to begin to recover. • If selected spaces have multiple uses, must be able to shift purpose immediately when needed • Staff is aware of locations	Review of evidence of communication of Safe Space locations to frontline staff Interview staff regarding the locations and availability of Safe Spaces
Development of a formal, proactive Peer Support program will include: • A “reach in” process by which a peer proactively contacts the affected member of the healthcare team. • The program includes all disciplines: clinical and non-clinical, medical staff and organization employees. • The program is designed to be distinct and apart from other employee wellness activities.	Review of program structure and policy Peer Support deployment data

Care for the Caregiver

Requirement	Validated By
Care for the Caregiver policy contains a mechanism for connecting staff involved in an event with a peer supporter within the department immediately after the event. • A department peer supporter is available for each shift and day of week. • Process allows for peer supporter's routine responsibilities to be managed when assistance is needed for staff support.	Review Care for the Caregiver policy Review Peer Supporter Agreement Forms Review Peer Support user feedback questionnaires for effectiveness of plan for immediate availability
• A Peer Support Encounter form is used by peer supporters to document peer supporter activities after events. • Encounter forms are used by the Steering Committee to determine the need for additional resources or training.	Review of Steering Committee meeting minutes
A process for referring clinicians needing a higher level of support is in place and includes guideline criteria and mechanism for obtaining expedited access. • Referral Network includes resources available both locally as well as separate from the organization such as: Chaplain Services, Social Workers, Clinical Psychologist, and Employee Assistance Program.	Review of process and user feedback surveys of recipients of peer support and peer supporters
Using BETA's HEART Toolkit, an individualized organizational Care for the Caregiver program and related peer supporter tools are developed and implemented.	Review organizational policies, forms and tools Interviews with staff
A process is in place to evaluate the effectiveness and/or staff satisfaction with the Care for the Caregiver program. • Care for the Caregiver survey • Peer Supporter Program Evaluation	Review evaluation tools and results
A measurement strategy is identified, implemented and included in the HEART dashboard. Examples: • # of Peer Support calls activated (peer to peer interactions) per month • # of Peer Support interactions by unit/department • Types of referrals made (clinician self-referral/supervisor/RM/other) • Effectiveness and timeliness of response (User survey) • Timely access to higher level of support (User survey) • Staff retention rates	Review of HEART Dashboard

Early Resolution

Requirement	Validated By
A Resolution Executive Champion/team lead and team are identified and actively involved in program development.	Interview with Executive Champion and team
All criteria of the Culture of Safety domain have been met.	Validation of Culture of Safety domain results reflect successful completion
The organization has implemented a process for timely, honest and transparent communication that meets HEART communication domain criteria. The communication includes the following: • Taking responsibility for the event (this is not an admission of guilt, rather it acknowledges that an adverse event occurred while the patient was under the organization's care) • Expressing empathy • Designation of an organizational contact who will oversee ongoing, empathic and transparent communication with the patient/family • Making restitution	Review organization's adverse event and communication policies Validation of Communication & Transparency domain results reflect successful completion
All criteria for Rapid Event Response and Analysis are met.	Review of event analysis criteria Review event specific investigations and analysis Validation of Rapid Event Response and Analysis domain results reflect successful completion
A Care for the Caregiver program is implemented and in place. Peer supporters are deployed to assist physicians and staff who have been involved in or impacted by adverse events.	Validation of Care for the Caregiver domain results reflect successful completion Data reflecting peer support deployments
When patient harm is determined to be the result of inappropriate care or medical error, the patient/family is informed, and a sincere apology is made. The organization takes proactive steps to reach resolution.	• Review organizational communication policy • Review medical record for evidence of documentation of apology • Interview with communication champions
When harm is identified but event analysis indicates care was appropriate, a thorough and empathic explanation as to why care is believed to have been appropriate is provided to patient and family.	• Communication policy • Medical record documentation of conversation with patient/family • Interview with communication champions

Early Resolution

Requirement	Validated By
Leaders seek to learn from HEART events and implement process changes to prevent similar harm to patients.	Minutes reflecting performance improvement activities including committee membership and process changes as a result of event review findings Evidence performance improvement actions have been fully implemented
A process is in place to engage patient and family members in performance improvement activities.	Documentation reflecting patient/family advisor/advocates engagement in performance improvement activities
There is evidence of broad dissemination of lessons learned and process improvements as a result of event analysis.	Documentation and/or observation reflects evidence of implementation of process improvement efforts Documentation reflecting method and completion of dissemination of lessons learned, including to which departments/ areas communication is provided Interviews with frontline staff reveals understanding of lessons learned
The organization adopts an early resolution process that has at its core the goal of re-establishing patient trust and includes at a minimum, the following: • Apology • Taking responsibility; Reparation • Commitment to improvement	Review organizational policies: • Responding to Adverse Events • Communication and Apology • Early Resolution • Performance Improvement/Patient Safety Plan
The organization has identified a multidisciplinary early resolution team (stakeholder consensus team) that collaboratively evaluates events and determines, when appropriate, fair and reasonable reparation for patients and/or families. • The team consists of representatives from administration, risk management, medical staff, hospital clinical staff, finance and claims.	Early Resolution policy Event review team structure
The early resolution team works with claims partners to access external resources/consultants and experts on an ad hoc basis. Resources may include: • Life care planners • Actuaries • Economists • Financial planners • Patient/family advisor	Early Resolution policy/process Interview with Early Resolution team

Early Resolution

Requirement	Validated By
The early resolution process addresses both financial compensation (where indicated) as well as non-financial opportunities to help patients and families to find resolve. (Examples of non-financial resolution may include involving patient and family members in performance improvement processes, family presenting their story to Medical Staff or other clinical forum, memorialization of loss suffered via memory garden plaque, bench, etc.).	Review early resolution policy, PI plan Previous early resolution case files address financial resolution efforts Early resolution case files address non-financial resolution strategies to bring about resolution
Measurement: The organization has identified and implemented measurement strategies to evaluate the effectiveness of the early resolution process. Examples include: • Timeliness of reporting: Length of time from event to receipt of report • Timeliness of communication: Timeline from event to communication • # of harm events that organization first becomes aware of through notice of intent or by plaintiff's counsel • # of events to which organization proactively responds to patient/family • Time from event to settlement agreement • Dollars involved in settlements versus dollars involved in actual suits • Median and average payment to claimants • Claims frequency • Defense costs	Review organizational data