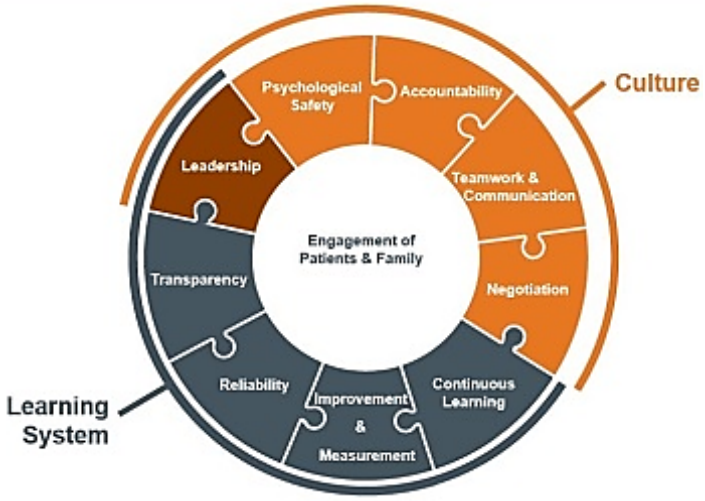
Are You a GEM?

As BETA Healthcare Group (BETA) continues to partner with member organizations and healthcare providers to manage risk, we celebrate this opportunity to share the success of our members in the areas of patient safety, employee safety and risk management. BETA GEMS (Guiding Excellence Through Member Sharing) is a collegial resource that highlights both patient and employee safety best practices that have transformed BETA facilities and medical groups. The BETA GEMS newsletter, which will feature member spotlight articles, is included in the program along with an opportunity for a poster presentation and staff award at our annual risk management symposium. Sharing these "gems" to further progress safety, reliability and effectiveness of care speaks to BETA's vision of assisting members with improving healthcare quality and safety for patients, families and employees.

At the Institute of Healthcare Improvement (IHI) National Forum in December 2016, a resolution was passed that focused on creating systems of safety. From that, a white paper was published (A Framework for Safe, Reliable and Effective Care) which laid out a practical framework for how any health care organization or system can continuously, and reliably, improve patient safety. The core domains discussed were 1) creating a culture of safety and 2) becoming an active learning system.

BETA GEMS projects are those which speak to any of the nine components of these domains, as listed in the white paper. For your convenience, they are outlined in this document, along with applicable project examples. After reviewing the information, contact your BETA representative or a BETA GEMS lead, if you believe your project is a good fit for the BETA GEMS program: Joann Wortham, joann.wortham@betahg.com or Paul D'Aquila, paul.daquila@betahg.com. You may also submit questions to betaGEMS@betahg.com.



Institute of Health (IHI, 2016): Framework for Safe, Reliable and Effective Care

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Framework for Safe, Reliable and Effective Care: Culture

Culture of Safety	Descriptive Detail	Type of Projects
Leadership	Facilitating and mentoring teamwork, improvement, respect and psychological safety	Leadership Walk Rounds Scheduled Leadership Visibility Scheduled Leadership Engagement with Frontline Staff Establishing Learning Boards
Psychological Safety	Creating an environment where people feel comfortable and have opportunities to raise concerns or ask questions	Safety Huddles Debriefings Call Outs Coaching/Mentoring Programs Employee Health Programs
Accountability	Being held to act in a safe and respectful manner, given the training and support to do so	Use of Just Culture tenets Procedure Simulations Adverse Response Team Safety Champions Call Light Team Response Pledge
Team Work & Communications	Developing a shared understanding, anticipation of needs and problems, and agreed-upon methods to manage these as well as conflict situations	Debriefs Call Outs CUS Words Huddles Team STEPPS
Negotiation	Gaining genuine agreement on matters of importance to team members, patients, and families	Adverse Event Response Team Family/Patient Experience Committee

Institute of Health (IHI, 2016): Framework for Safe, Reliable and Effective Care

Note: The projects listed are only to provide an idea of what type of projects might fit in the given category. Feel free to discuss your project with your BETA representative, if you believe it exemplifies the components of a culture of safety.

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Framework for Safe, Reliable and Effective Care: The Learning System

Learning System	Descriptive Detail	Type of Projects
Leadership	Facilitating and mentoring teamwork, improvement, respect and psychological safety	Leadership Walk Rounds Scheduled Leadership Visibility Scheduled Leadership Engagement with Frontline Staff Establishing Learning Boards
Transparency	Openly sharing data and other information concerning safe, respectful and reliable care with staff, partners and families	Learning Boards Family/Patient Experience Committee Adverse Response Team Family/Patient Rounds
Reliability	Applying best evidence and minimizing non-patient specific variation, with the goal of failure-free operation over time	Standardizing Processes Simplifying Processes HFMEA Safe Patient Handling
Improvement & Measurement	Improving work processes and patient outcomes using standard improvement tools, including measurements over time	Falls Program CLABSI Prevention Wrong-Site Surgery Prevention Safe Patient Handling Employee Health Programs Use of PDSA Use of LEAN/Six Sigma Measuring Process, Outcome and Balancing Measures
Continuous Learning	Regularly collecting and learning from defects and successes	Huddles Debriefs Learning Boards Feedback Loops Patient/Family Rounds

Institute of Health (IHI, 2016): Framework for Safe, Reliable and Effective Care

Note: The projects listed are only to provide an idea of what type of projects might fit in the given category. Feel free to discuss your project with your BETA representative, if you believe it exemplifies the components of a progressive learning system.