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Creating Safe Spaces in Organizations to Talk About Safety

Executive Summary

A presentation was delivered at the 6th Annual National Patient Safety Congress in Boston (2004), and participants were encouraged to focus on methods to create safe spaces in their organizations to talk about patient safety, a precursor for a safety culture and the mainstay for understanding and continually enhancing patient safety. Key messages from that presentation were:

- The foundation of a culture of safety is trust. Clinicians, leaders, and employees must trust that a blameless and just culture is part of the organization culture.
- Assuring psychologically safe spaces to talk about patient safety advances systems of trust and community.
- Safety is a transient and vulnerable state requiring continual vigilance and dialogue.
- Focusing solely on counting and control methods is insufficient to create safety and can be wasteful. Safety is created by keeping the stories of events and conditions alive through description and dialogue, which reveal how systems are actually operating.
- Internal and external strategies to create safe spaces to talk about safety, such as focus groups, executive rounds, mini courses, safety action teams, and dialogues are helpful architecture to build safer systems.
- Comparative focus group results (1999-2003) and workforce survey results demonstrate evidence of promising leadership interventions to advance an organization to higher levels of patient safety.

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"WE WILL BE THE SAFEST HOSPITAL *in the world, and then become even safer."* — Patient Safety Vision, Children's Hospitals and Clinics, Minneapolis-St. Paul, Minnesota.

Patient safety begins with fostering a blameless, yet accountable, culture devoted to vigilance, learning, improvement, and resilience. Such a culture is grounded in trust that errors can be reported and examined without the fear of ridicule, punishment, or shame. Creating psychologically safe spaces for this disclosure and management of information is vital to advancing a culture of safety which values and rewards open communication and transparency. Personal and organizational honesty are not only encouraged but expected for the purpose of learning, prediction, and prevention. Creating this trust and safety is the work of leadership.

In an environment of psychological safety, clinicians are able to discover, through self-examination and effective teamwork, attitudes, behaviors, and latent conditions in care delivery that are barriers to patient safety. A collective perspective (the outcome of diverse individuals with unique experiences talking together) produces a deeper understanding of organizational risk and sources of success or recovery, essential to creating safer and more resilient systems. The tools of reporting, analysis, inquiry, and continual sharing of information, without regard to hierarchy, are developed and tested in psychologically safe spaces while building the overall patient safety culture.

Children's Patient Safety

In 1999, Children's Hospitals and Clinics, Minneapolis/St. Paul, Minnesota (Children's) established a challenging agenda to improve patient safety, informed in large part by evidence from other high-risk, high-hazard industries. The organization committed to the vision of eliminating medical accidents or harm to patients through the design and operation of safer systems of care. Children's Hospitals and Clinics performed well when compared nationally on indicators of safety, such as medication errors within control limits. But rather than chasing rates, Children's realized that the safety performance of the health care industry as a whole was not good enough and the entire bar needed to be raised.

The publication of the 2000 Institute of Medicine Report, *To Err is Human*: *Building a Safer Health System*, confirmed this realization. This sobering report estimated that 44,000 to 98,000 people die each year in the United States due to medical errors in hospitals.

The national debate which followed the release of the Institute of Medicine report challenged the report's study methods, limitations, and conclusions. The debate over the numbers, however, is academic. The real issue is: Do you know your own experience of error and harm? Children's believed that if *one child* is harmed or put at risk, that is one too many. The oath, *To Do No Harm*, needed to extend from the individual clinician level to an organizational commitment to design and operate systems that do no harm.

Figure 1 depicts Children's organizational initiatives and milestones to achieve the vision of eliminating harm due to medical error/accident. The agenda was designed to:

- Shape culture through knowledge and trust.
- Develop infrastructure to support information and create safe, efficient systems.
- Build a medication administration system that is world class and error free.
- Openly and responsibly disclose and accept accountability in the event of a medical accident.

Creating Safe Spaces to Talk About Safety

When a medical accident causes harm, it is a defining moment for an organization. How such events are viewed and managed both *expresses* and *shapes* the culture of the organization. As highlighted in the publication *Redefining the Culture of Patient Safety* (Minnesota Hospital and Healthcare Partnership, 2000): "A common misconception is that patient safety is about reminding people to be more careful. But patient safety isn't about cautioning health care staff to be more careful. In fact, health care staff are some of the most careful people on earth. Improving patient safety is about changing the culture in health care from one of blame to one where we examine our systems from beginning to end to reduce the opportunities for mistakes."

How the organization (through its leaders and policymakers) responds can reinforce a culture of secrecy and blame or advance a culture of safety: open disclosure, analysis, learning, prevention, and face-to-face accountability. In a safety culture, executive leaders stand shoulder-to-shoulder with caregivers and affected families.

The Value and Creation of Trust

Harkins (1999) describes trust as the operating principle by which organizations foster openness and information sharing. This openness allows organizations to uncover problems, make good decisions, and convert ideas into action. Harkins (1999) describes trust as the "currency of leadership; an asset with unlimited return." Trust is not seen as merely the byproduct in relationships. It is viewed as the *goal* of a leader's relationships. It is the trusting relationship that produces the conditions for achieving goals through performance and results. In this context, trust is needed to develop safer systems of care, systems that do no harm.

How do leaders create trust? Harkins (1999) creates a helpful model describing four competencies that leaders, skilled in effecting trust, demonstrate in their relationships. Harkins titles these "The 4 C's of Trust," and they are necessary to create psychologically safe spaces: caring, commitment, clarity, and consistency.

In this model (see Figure 2), Harkins builds on comments made by DePree at Linkage's 1997 Global Institute for Leadership Development. The panel session, facilitated by Warren Bennis, was entitled "Lessons of Leadership."

Caring

Leaders build trust by respecting everyone and committing to taking everyone seriously. They care for and about others. This may appear an easy attribute that leaders exhibit as second nature. But, in fact, demonstrating authentic caring in the domain of leadership requires more than good will. It requires focused intention, time, and energy. Many dismiss caring as a "soft skill;" however, it is increasingly understood that "emotional intelligence" is a fundamental competency for effective leadership. Genuine caring on the part of leaders creates loyalty: loyalty to a vision, to an organization's mission, and to the leader. Genuine caring increases the probability that people will be willing to follow the direction of leaders.

Children's demonstrated caring leadership through focus groups on the topic of patient safety, initially conducted in 1999 (Edmondson, Roberto, & Tucker, 2001) with followup groups conducted in 2003. Seventeen focus groups were conducted utilizing the methodology developed by Nancy Wilson, MD, in the Veteran's Health Administration. Focus groups were conducted with nurses, pharmacists, physicians, family members of patients, managers/directors, residents/medical students, social workers, chaplains, interpreters, and union leaders. In these groups, members were asked for their concerns and assessment of the "state of safety" in the organization: What was working well? What barriers to safety existed? The inquiry of the focus groups was authentic; that is, the information sought was valued and needed to inform and prioritize action. The focus groups proved not only a source of information and the platform on which to build the safety agenda, but a deep cultural intervention to disclose and talk about patient safety in a respectful, psychologically safe space.

Another example of caring was a 4-year series of mini courses (Edmondson et al., 2001) sponsored by the organization on the science of patient safety. National content experts were faculty for half-day courses available to all members of the Children's

Figure 1.
Children's Patient Safety Timeline

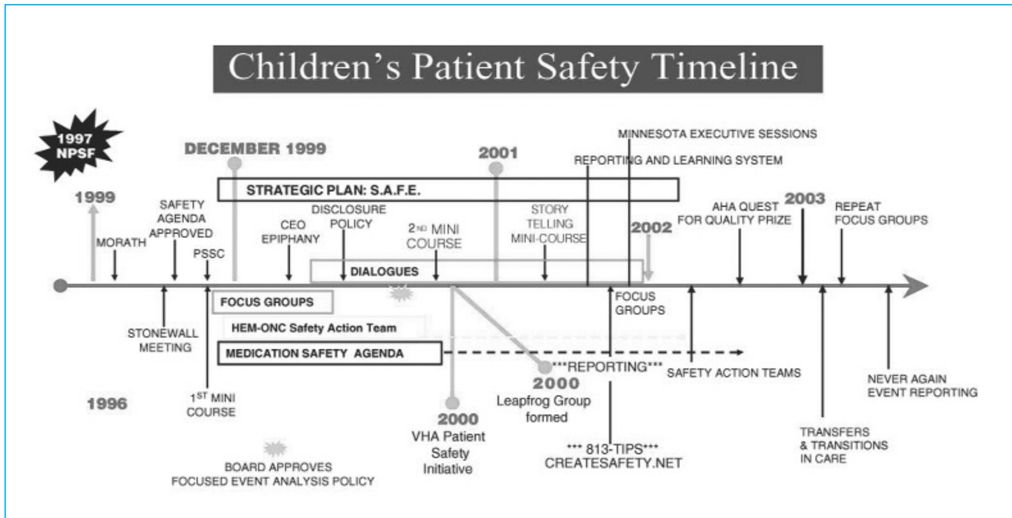
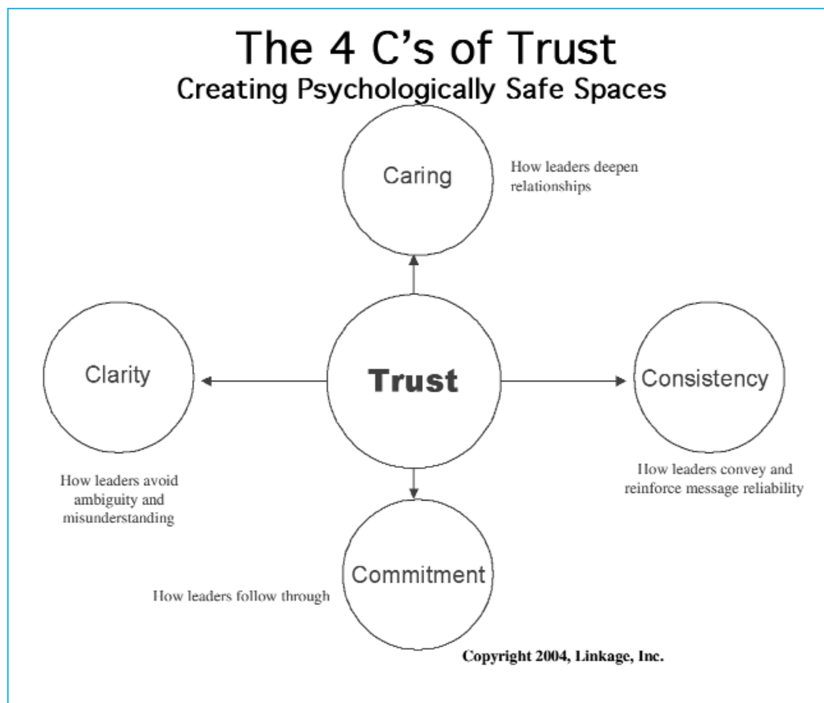


Figure 2.
The Three Cs of Trust



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community. The courses were designed to engage and empower individuals to enhance safety. Staff who attended were paid for their time in learning. This initiative was an investment with return of increased understanding and knowledge of safety science at all levels of the organization, communication and reinforcement of safety as a value and priority, and tangible proof that staff development is a priority and necessity to achieve harm-free care. The mini courses also provided face-to-face learning and thinking time with leadership on this important topic.

Commitment

Commitment on the part of leaders assures an organization that the leader's promises will be kept. Commitment shines a light on the integrity between what a leader says and what a leader does. Demonstrating commitment, through focused priorities and follow-through, increases the "believability" of both the leader and the leader's intentions. Harkins (1999) reminds us that leaders lay the foundation of trust through commitments and grow the trust by keeping those commitments.

At Children's, commitment to the importance of patient safety was emphasized through clear goals, actions, and monitoring and reporting performance against them. Commitment was manifest in a number of ways by hardwiring safety into the organization, but perhaps most importantly through leadership visibility, presence, executive rounds, and participation in the actual work of patient safety.

A safety steering committee was established, consisting of nurses, physicians, pharmacists, parents, board members, executive leadership, resident ethicist, and communications manager. The committee continually reviews the literature, searching for new ideas and better practices and exploring applications to Children's. The committee sets direction for organization-wide leverage points in improvement and monitors progress to plans.

Safety goals are measured, monitored, and reported at a governance level and throughout the organization. Performance in safety is a requirement in job descriptions, performance evaluations, and educational requirements. Management incentives are also aligned to safety goals in addition to financial, access, and satisfaction/experience goals. Safety action teams are interdisciplinary front-line teams, chartered to continually assess the state of safety in the patient care unit and develop locally relevant improvements. Safety action teams are the vehicle to bring safety alive closest to care. The office of patient safety was established to support the work of safety action teams and is the central repository for safety learning reports, analysis, and database management.

Key policies that serve as "culture carriers" guide the attention and behavior of the organization. They include *Disclosure of Medical Accident* and *Stop-the-Line to Restore Safety*. The Medical Accident policy outlines the commitment to transparency; support to patient, family, and caregivers in the event of harm; and pursuit of understanding and improving the system to reduce the probability of recurrence.

The Stop-the-Line policy provides the expectation and authority for any member of Children's community, including patient and family members, to stop any procedure, administration of a substance, or test that looks or feels wrong. Evoking this policy requires authentication that the act in question is, in fact, the correct action and that it is safe.

Other policies include correct-site markings for surgery or procedure, pause-for-cause prior to initiating surgery, two-identifiers for all patient identification, and crew-resource management training and simulations for high-risk low-volume procedures.

Clarity

The third competency of leadership to support organizational safe spaces is the focus on consistency between what leadership says and what is heard. The integrity of a leader is on the line when there is a disconnection between the intentions of their communication and the perceptions of its meaning by listeners. To assure accuracy of message and understanding, leaders must take the time to use active listening skills, such as reflection and clarification. Dialogue and focused conversations improve the clarity of message by surfacing assumptions, attributions, and mental models that may be operating at an unconscious level in both the speaker and the listeners. Making assumptions overt creates and contributes to achieving a shared vision between leaders and members of the organization.

The intentional use of language, with specific definitions, maximizes common understanding. Language creates reality, shapes culture, and strongly communicates values. At Children's, there was an intentional design and use of language to move from a traditional "blame and shame" health care culture to the blameless culture of patient safety. Current reality was contrasted with the intended future state. The following are examples of the use of new language, unencumbered by connotations of blame, to set new direction in patient safety. The examples (see Table 1), originally entitled *Words To Work By*, illustrate the power of words to communicate values and intentions.

For further understanding of a Just Culture, refer to the work of Marx (2001). He describes "blameworthy" acts that are barriers to safety and that must be dealt with fairly, consistently, and in a timely manner in order for an organization to believe that leadership is serious about safety. These acts are rare, but legendary if not addressed. They include intentional violations, malfeasance, impairment, disruptive and disrespectful behavior, and failure to learn over time.

Table 1.
Language Shapes Culture

Past Vocabulary	New Vocabulary
Human error as cause of an event	Accident, latent conditions and multi-causal variables of an event
Root cause	Multicausal variables
Judgment	Learning, awareness
Investigation leading to a culprit or single cause	Examination, study, or analysis to understand human factors, design, and conditions contributing to risk or events.
Isolated event	System interactions
Blame	Accountable, just
Punitive/Retaliatory	Blameless, just
Whose fault is it?	What happened?

Consistency

The fourth leadership competency emphasizes that trust must be continually and consistently nurtured. Arbitrary actions or comments can quickly defray the fabric of trust between a leader and staff. Behavioral manifestations of espoused cultural values of the organization must align: Is learning really valued in this organization? If I report an error or unintentional violation, will I be disciplined? Is the event analysis process an environment of investigation and accusation, or one of study to increase understanding and system improvements? Will I be supported personally and professionally for disclosure?

Finally, in creating psychological safety and trust, leaders must be willing to express their own vulnerabilities and challenges. Lencioni (2003) describes that vulnerability-based trust is essential in the creation of effective and functional teams. And it is the effective work of teams that creates safety through both accident/error prevention as well as resilience and recovery. Lencioni (2003) articulates the following which holds particular relevance for the independent professional environment in health care organizations.

"Members of a cohesive, functional team must learn to comfortably and quickly acknowledge, without provocation, their mistakes, weaknesses, failures, and needs for help. They must also readily recognize the strengths of others, even when those strengths exceed their own. In theory — or kindergarten — this does not seem terribly difficult. But when a leader is faced with a roomful of accomplished, proud, and talented staff members, getting them to let their guard down and risk loss of positional power is an extremely difficult challenge. And the only way to initiate it is for the leader to go first" (p. 2).

Punishment and Safety Systems

Traditional incident reporting in health care counts occurrences of specific types of events or injuries, through checking off fixed fields on a form. Focused on accounting for single types of errors, reports are aimed towards identifying a single cause or individual blame for breeches of safety in the environment. The actual story of the event, and the complexity of the system in which it occurred, is lost to the accounting system. This results in an impoverished view of the care delivery system.

Traditional reporting cultures are linked to formal discipline or informal reprimand (Edmondson et al., 2001). These reprimands are directed by hindsight bias that constructs the source of an event as human error. Confidentiality within such punitive systems is afforded to the individual who was blamed for the error. This creates a shroud of secrecy around an incident, which is further exacerbated by fears of risk and litigation. The organization then continues with an illusion of greater safety, because a scapegoat was identified, and individual sanctions were levied. However, all the conditions operating, including the human factors involved, were left

Figure 3.
Safety Learning Report

CHILDREN'S HOSPITALS AND CLINICS
OFFICE OF PATIENT SAFETY
SAFETY LEARNING
REPORT (revised 6/01)

ADDRESSOGRAPH OR NAME / MEDICAL RECORD # / DOB / ACCOUNT NUMBER

The information you report is generated and maintained f[or] quality improvement purposes under Minnesota Statute 145.61 et seq and is confidential under that statute.

ACCIDENT / NEAR MISS / SYSTEM BREAKDOWN /
GOOD CATCH / HOW SAFETY WAS CREATED /
HAZARDOUS SITUATION / ACCIDENT WAITING TO HAPPEN /
NORMALIZATION OF DEVIANCE

MINNEAPOLIS
RIDGES
ROSEVILLE
ST. PAUL
WEST
OTHER

INPATIENT
OUTPATIENT
STAFF
STUDENT
VISITOR
VOLUNTEER
OTHER

EVENT LOCATION
PATIENT DEPT
OTHER DEPT INVOLVED

WAS APPARENT TO THE PATIENT'S FAMILY
CAUSED HARM OR INJURY
ALTERED THE TREATMENT PL[AN]
HAS HAPPENED REPEATEDLY
CAUGHT AT THE LAST STEP
FAILURE OF A SAFETY DEFENSE

unmined for learning, prediction, and prevention. This leaves the set up for recurrence of future events, because nothing was changed.

Lucian Leape, MD, an adjunct professor in Harvard University's School of Public Health and patient safety expert, asserts that a punitive mindset is the single greatest obstacle to progress in patient safety in our health care institutions today (Robeznieks, 2003). He emphasizes that knowing what is going on in an organization is paramount for making the organization a safer place for patients. Dr. Leape is clear that you will not find out what is going on if you punish people for mistakes and unintentional violations. In a punitive environment, people

report only those errors that they cannot hide. He estimates that within these punitive systems, 95% of errors are not reported.

At Children's, errors are understood as a data source to learn about the system and the boundaries of safe practice. A narrative safety-learning system was implemented, based on the principal of *reciprocal accountability* (Runy, 2002). Reciprocal accountability defines that the system (represented by its leadership/management) must trust that staff will call out safety concerns; and that the staff must trust that the system will listen and take into account that which was reported. The safety-learning system is transparent and nonpunitive.

The safety learning report (see Figure 3) emphasizes the reporter's narrative experience of an accident, potential accident (also known as *near hits* or *good catches*), error, or risk-prone condition. In this format, the story of the safety risk is described.

Reporting can be anonymous and is entered through paper format, dedicated telephone dictation system, or the preferred Web-based reporting. Each report, in which the author provides her/his name, is acknowledged with a written or phoned response of thank you from the staff in the office of patient safety. The reports are analyzed for pattern detection, entered into the safety database, and then forwarded to the accountable manager. Managers use the information to work with the safety action teams to design improvements and reduce the probability of errors and system failure from reaching a patient to cause harm. Site-specific safety reports are also forwarded to unit-based safety action teams to look for patterns, identify barriers to creating safety, discover improvement opportunities, and gain insight about the environment of care. All reports are logged in to a Web-based search engine. Staff can access all reports that have been filed according to topics culled from the technique of content analysis. The electronic filing is stored in learning stacks by topic. These stacks provide information to staff inquiring about a topic of interest.

Increased reporting is actively sought, encouraged, and rewarded. Learning from the experiences of the Aviation Safety Reporting System, Children's believes that responding to the stories of those closest to patient care will yield intelligence for designing safety systems and reinforcing safety practices. Reporting increased 60% in the first year of the new reporting methods. Web-based reporting, as a percent of total reports, increased from 0 at the time of introducing the new reporting system to 68% of all reporting in the first 8 months of 2003. Leape stated well the findings of those organizations who have reformed their reporting systems: "When you make reporting safe and make it worthwhile, you get more than you can handle. Every report is a potential treasure" (Robeznieks, 2003).

Focused event reviews, as required by the Joint Commission of Accreditation, are conducted in response to a sentinel event through a disciplined process. However, the emphasis of event analysis surrounds "near misses" (sometimes called *near hits*, or *good catches*) to identify improvement opportunities prior to a sentinel event ever occurring. A rigorous problem-solving process is applied in a confidential forum of team members with information about the event or near miss. The forum is facilitated by trained leadership staff. The process documents the sequence of events and identifies underlying systemic failures that may have contributed to the event or near miss. The disclosure policy of the organization requires timely communication of information about the event, the analytic process, and the learnings from the analysis to affected parent(s). The philosophy of the organization is that as much information can be learned from the analysis of a near miss as from an actual event without the tragedy of harm.

Quality Conversations and Dialogues

Dr. Richard Cook, director of the Cognitive Technologies Laboratory at the University of Chicago and practicing anesthesiologist, guided thinking in creating the structure in which patient care is delivered. He consistently asserts that: "The work of building sustainable communities starts when we stop thinking about what we need and start thinking about how to contribute and help each other" (Cook, 2001).

This leads to the notion that units or environments in which care is delivered are not based on mere transactions, but rather built on shared contribution to achieve desired outcomes. Care is delivered in three care communities, designed around the principle of contribution and the orchestration of resources to populations with similar needs, supported by similar processes and expertise: critical care, surgery-perioperative care, and pediatrics. The underlying assumptions to building a community is to enhance psychological safety, set the expectation of team and quality conversations, recognize the interdependency of processes, and establish accountability. The basic principles of this organizational structure are:

- Learning and process are not localized, but shared.
- Complex tasks involve doing and understanding working with others.
- Conversation is the intellectual mainstay of safety.

Leadership Responsibilities: Vision, Structure, and Processes

The leadership role and actions in creating safe spaces to talk about patient safety through building the structure, process, reporting infrastructure, and resources of protected time to build community and

trust have been discussed. It is only in a culture of ambient trust and transparency that a culture of patient safety can fully emerge. This culture is led by a clear vision and aim that harm-free care is both possible and achievable. The structure, processes, and resources are strategically designed to continually strive to achieve the vision and aim.

This aim, however, will not provide shared beliefs or aligned actions unless the sense of purpose is shared from boardroom to frontline. This alignment is necessary for an organization to consistently experience trust and psychological safety. Trust and psychological safety must permeate the organization; including the ability to withstand the circumstance and constraints in the face of harm and failure. Building psychological safety in pursuit of a patient safety culture calls for courage, resolve, and informed strategy to advance the health care industry, each organization at a time, to demonstrate that this is a safe place to give and receive care (see Tables 2-4).

Evidence of Success

There is evidence that leadership interventions to create safe spaces in the organization were successful. Results of focus group findings 3 years post interventions were that the perceived barriers to patient safety had receded. There was an increased understanding of a safety culture, evidenced by more complex concepts and specifics by the participants. Participants identified the operations plan for the organization as a reference point of commitment and accountability for safety. Increased reporting and dialogue about safety, demonstrated leadership commitment, and improved pharmacy and medication use safety were also prominent findings.

Most interesting was that staffing issues, which were perceived in 1999 as the most significant barrier to safety, was replaced in 2003 by issues of staff training, communication, and teamwork. The numbers of available staff, although nursing hours per patient day were actually reduced, did not emerge as a barrier. The understanding of safety as a system property, created through communication, teamwork, and trust was a consistent theme. The following responses to the question of what influences free and open communication changed in the hierarchy of frequency, but remained stable in theme (see Table 5).

Ongoing employee pulse surveys continue to demonstrate improvement in the sense of trust and safety to disclose and talk about risk and safety concerns.

Concluding Thoughts on Trust

Creating safe places to talk about safety creates systems of trust and community versus systems of control. In systems of trust, people are free to create

continued on page 354

Table 2.
Leaders in Patient Safety Must Create Safe Spaces by Attending to:

- The value and creation of trust
- Effects of shame and punishment
- Effective change leadership
- Quality conversations and dialogue
- Personal presence: listening, understanding, and

Table 3.
Internal Safe Spaces to Talk About Safety

- Focus groups
- Patient safety steering committee
- Executive rounds
- Mini courses
- Dialogues
- Safety action teams
- Safety reporting learning systems

Table 4.
External Safe Places to Talk About Safety

- Community collaboratives
- Research pilots and studies
- Partnerships with consumers, business community, legislators, regulators, media

Table 5.
What Influences Open Communication About Safety?

1999 Results	2003 Results
The belief that something will be done.	A safe environment for reporting.
A safe environment for reporting.	Time to report.
Good venue to discuss with colleagues.	The belief that something will be done.
Time to report.	Good venue to discuss with colleagues and others.

Using a Balanced Scorecard to Improve the Performance of an Emergency Department, 140
Nursing Home Costs and Quality of Care Outcomes, 178
A Cost Comparison of Hand Hygiene Regimens, 196
Outcomes of a Career Planning and Development Program for Registered Nurses, 231
Comparing Variations in Labor Costs For Two vs. One Full-Time Nurse Manager, 254
A Review of the Effect of an Accommodation Program to Support Nurses with Functional Limitations, 320

Retention and Recruitment (Department)
Using a Blitz to Help Retention, 35
The Children's National Medical Center Story: Nursing Shortage to Employer of Choice, 91
'Grow Your Own': A Responsible Approach to Addressing the Nursing Shortage, 155

$uccess $tories
A New Approach in Psychiatric Care Delivery, 81

2004 AUTHOR INDEX

Acton, C., 307
Anderson, M.A., 94
Atherton, M.J., 6
Barkauskas, V., 124
Bower, F.L., 200
Boyle, S.M., 111
Brown, D., 36
Burge, P., 155
Carroll, C.A., 254
Chang, W., 140
Chen, P., 140
Chisholm, L., 58, 120, 193
Cimiotti, J.P., 196
Connor, M., 211
Cornell, B., 81
Cox, K.S., 254
Creighton, F.A., 245
Cronin, S.N., 155
Curran, C., 5, 57, 109, 177, 229
Currier, C.A., 14
Cusack, G., 58, 120, 193
Deese, D., 273, 336
DeMarco, R., 211
Dolan, L., 155
Donner, G., 231
El-Adham, A.F., 6
Esperat, M.C., 307
Feeg, V.D, 6
Forrest, K., 124
Futch, C., 280
Gaskamp, C.D., 135
Gelinas, L.S., 266
Goodman, G.R., 44, 100
Green, A., 307
Hall, L.M., 231
Harrison, J.P., 64
Hicks, L., 178
Hirth, R.A., 14
Honig, J., 239
Huang, S., 140
Johnson, A.P., 94
Jones, A., 58, 120, 193
Jones, A., 120
Karavattuveetil, G., 41
Keida, R., 258
Kerfoot, K., 33, 84, 157, 208, 282, 333
Kernich, C.A., 245
Killackey, J., 251
Kirkley, D., 36, 94, 147, 216
Klingensmith, K., 21
Koviack, P., 320
Kramer, J., 155
Lacey, S.R., 254
Lang, N.M., 325
Larson, E.L., 196
Leary, M., 344
Lee, H., 140
Lester, V., 36
Lo, L., 75
Loh, D.Y., 266
Luna, K., 27
Mackey, T.A., 21
Mackey, T.A., 124
Maguire, J.M., 71
Maxwell, M., 39, 86, 159, 214, 285
McCullough, C., 200
McGinley, A.M., 325
McNiel, N.O., 21
Morath, J., 344
Morris, J., 81
Morris, J., 81
Mukamel, D.B., 178
Mundinger, M.O., 239
Neville, S., 258
Nickitas, D.M., 258
Nokes, K.M., 258
Nolin, J., 251
Nolin, J., 64
Ober, J., 155
Petroski, G.F., 178
Pinkerton, S., 35, 91
Pohl, J., 124
Ponte, P.R., 211
Poole, M., 124
Price, C., 155
Price, J., 211
Rantz, M.J., 178
Robinson, N.C., 91
Schafer, P., 124
Schmidt, L., 295
Shirey, M., 313
Smith, D.G., 14
Smith, A.P., 41, 88, 161, 205, 264, 342
Smolowitz, J., 239
Sokol, P.E., 152
Spicer, J.G., 27
Stein, M., 216, 273, 336
Stone, P.W., 196
Suero, E., 64
Swan, B.A., 325
Thomas, E., 239
Tomallo-Bowman, R., 71
Vonderheid, S., 124
Waddell, J., 231
Wakefield, M.K., 47, 166
Walker, D.S., 14
Walrath, J.M., 71
Wheeler, J.R.C., 14
Wheeler, M.M., 231
Yang, M., 140
Yen, M., 75

Patient Safety

continued from page 351

the relationships they need to identify and improve patient safety. Trust enables the positive potential, capacity, and capabilities of organizations to open and expand. More conversations among teams become more inclusive; diverse and emerging views become important. People decide to work with those from whom they have been separate. Gaps in patient care are made visible, closed, or bridged, and patient safety improves.**$**

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