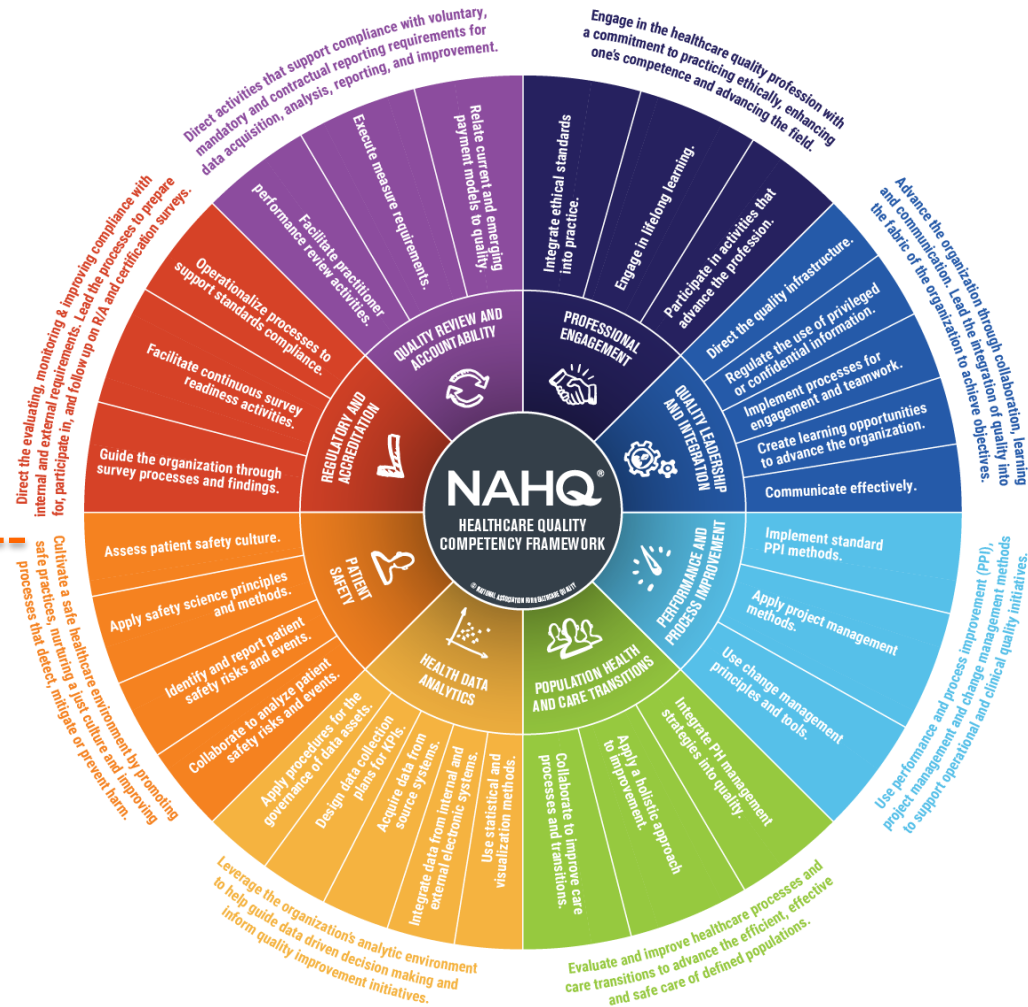


# **Patient Safety Stories as a Tool for HRO Staff Engagement**

Susan V. White, RN, PhD, CPHQ, FNAHQ, NEA-BC

**I have no Conflict of Interest to disclose.**

# NAHQ Healthcare Quality Competency Framework



## Patient Safety

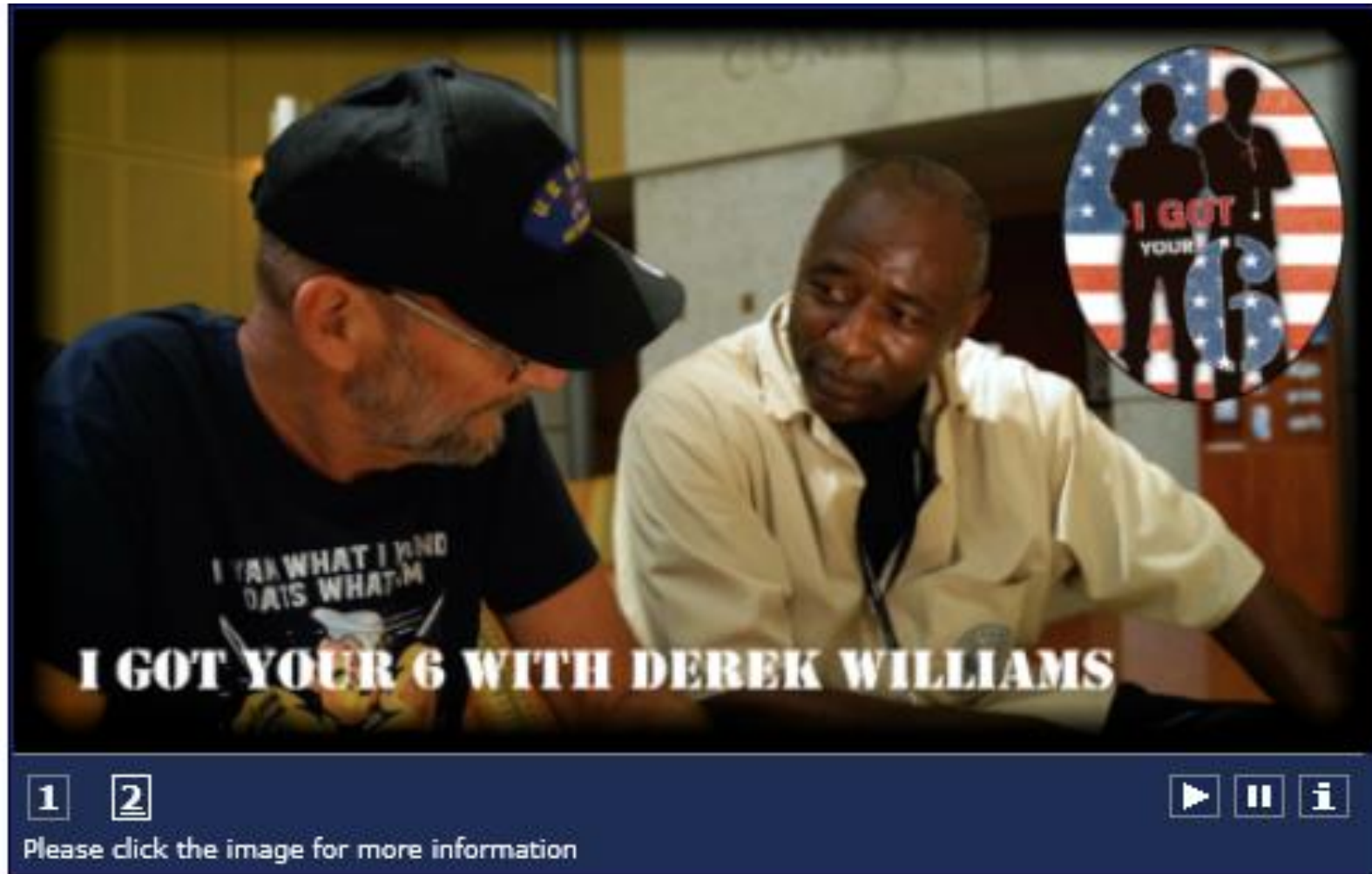
- Assess patient safety culture
- Apply safety science principles and methods
- Identify and report patient safety risks and events
- Collaborate to analyze patient safety risks and events



High Reliability Organization

# Story 1

---



[Patient Safety Story \(1:50\)](#)

<https://www.youtube.com/watch?v=M53gOVrTUUw&feature=youtu.be>

Engagement with the Employee (12:58)

[https://www.youtube.com/watch?v=FHwki\\_6WmH4&feature=youtu.be](https://www.youtube.com/watch?v=FHwki_6WmH4&feature=youtu.be)

## Example

[Patient Safety Story \(1:50\)](https://www.youtube.com/watch?v=M53gOVrTUUw&feature=youtu.be)

<https://www.youtube.com/watch?v=M53gOVrTUUw&feature=youtu.be>

Engagement with the Employee (12:58)

[https://www.youtube.com/watch?v=FHwki\\_6WmH4&feature=youtu.be](https://www.youtube.com/watch?v=FHwki_6WmH4&feature=youtu.be)

Objectives: The participant will be able to:

- Describe (at least 3) benefits of Patient Safety Stories
- Apply the concepts of Patient Safety Stories into current practice (clinical or non-clinical) to engage front line staff
- Apply a standard story telling template for use in practice as a tool for High Reliability Organizations (HRO)

# High Reliability Organization (HRO)

---

- Definition
  - Development from Other Industries
  - Three (3) Pillars
    - Leadership Commitment
    - Safety Culture
    - Continuous Process Improvement
  - Five (5) Principles
    - Sensitivity to Operations
    - Preoccupation with Failure
    - Deference to Expertise
    - Reluctance to Simplify
    - Commitment to Resilience
- Goal-Zero Harm
  - Why Patient Safety Stories
  - Engagement of Staff
  - How do we Measure Engagement-Data

**Definition**-An organization that experiences fewer than anticipated accidents or events of harm, despite operating in complex, high-risk environments.

Adapted from Weick, Karl E., and Kathleen M. Sutcliffe. *Managing the Unexpected*. Jossey-Bass 2nd ed. 2017





What is a High  
Reliability Organization?

---

583



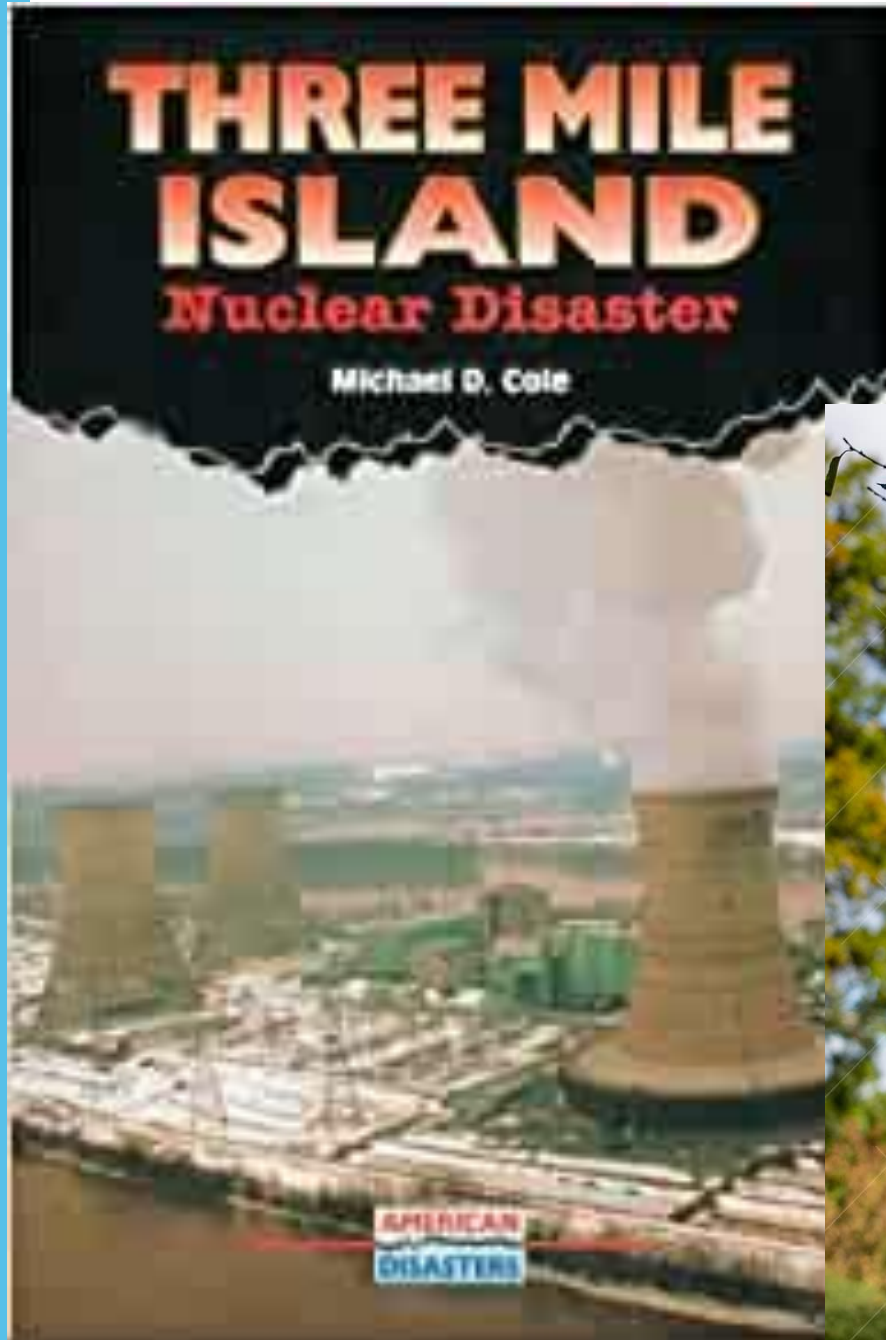


**Tenerife  
Crash  
Worst  
Disaster  
in  
Aviation**





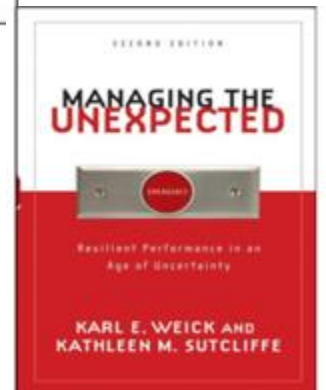
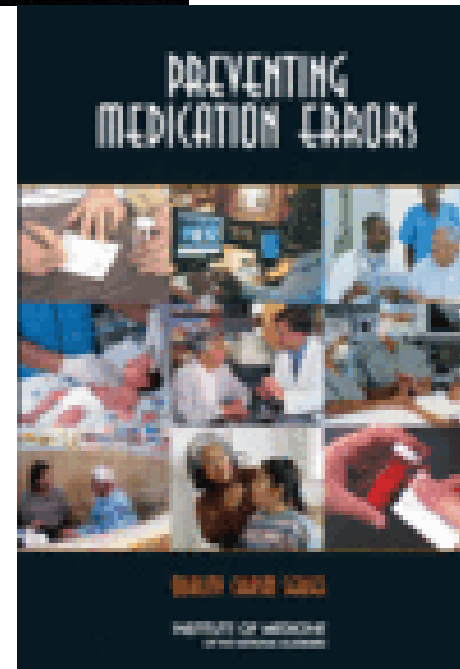
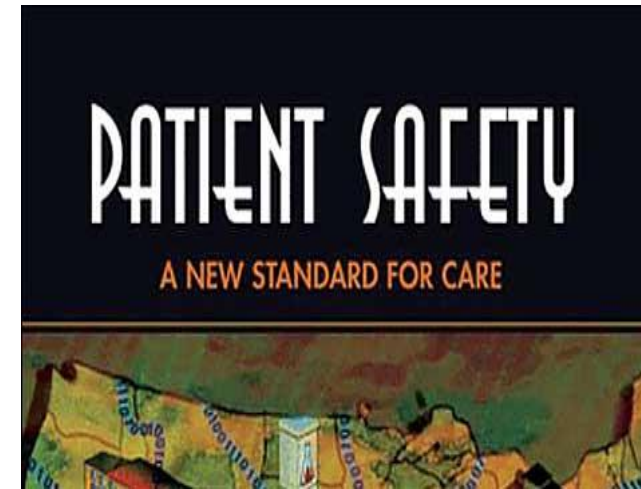
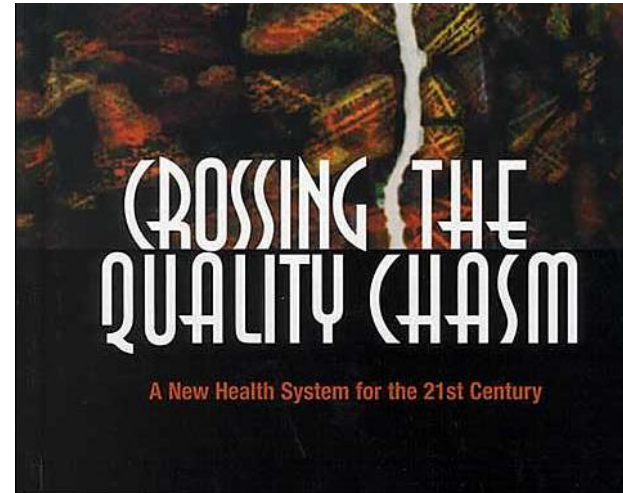
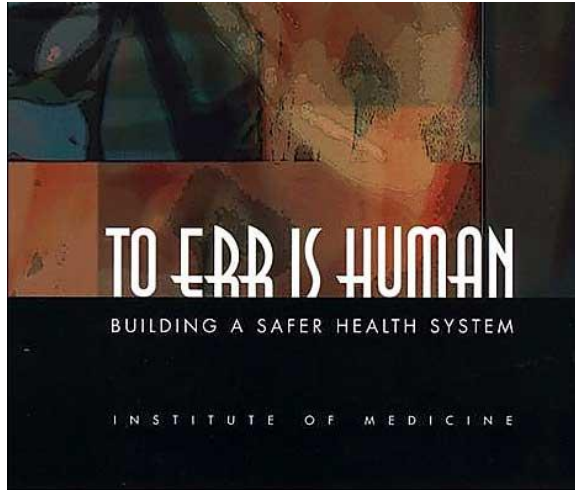
It's personal- Focus on Preventable Harm



## Nation's Worst Commercial Nuclear Accident



# How did we respond



# Benefits of Patient Safety Stories

## Benefits/Value of Stories

- Activates the Brain
- Creates Emotional Impact
- Transmit the History & Legends
- Embodies the Culture

## Benefits/Value of Patient Safety Stories

- Creates Focus on Organizational Values
- Engages All Levels of Staff
- Increases Communication Flow
- Cements the Culture

# THE SCIENCE OF STORYTELLING

As more brands make the move towards content marketing, cutting through the noise is more vital than ever before. But our brains are built to connect with compelling stories.

## Neural Coupling

Part of the brain is activated to allow listeners to turn the story into their own ideas and experience.

## Mirroring

Listeners not only experience the similar brain activity to each other, but also to the speaker.



## Dopamine

The brain releases dopamine, making it easier to remember with greater accuracy.

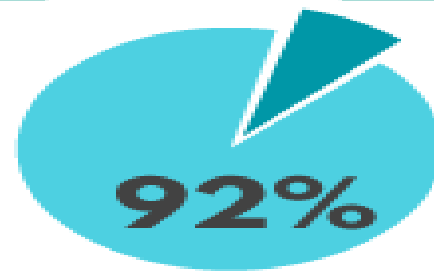
## Cortex Activity

A well-told story can engage many additional areas, including the motor cortex, sensory cortex and frontal cortex.

**F**

100,500

digital words are consumed by the average US citizen everyday



of consumers want brands to make ads that feel like a story



rate at which the brain processes images in comparison to words

**N**

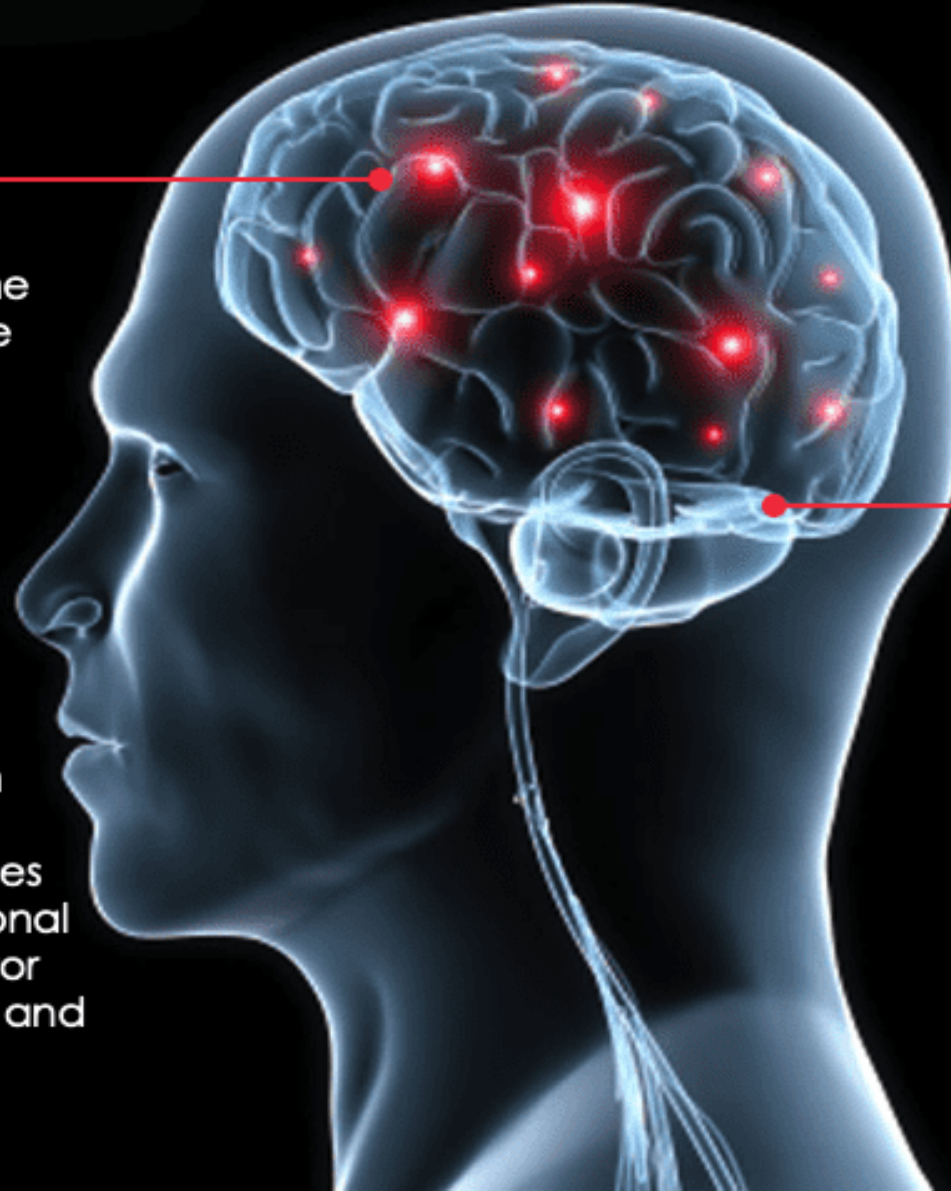
Deliver content

Keep it short (and

Show, don't tell.



# HOW STORYTELLING AFFECTS THE BRAIN



## NEURAL COUPLING

A story synchronizes the listener's brain with the teller's brain.

## MIRRORING

Mirror neurons enable listeners to mirror experience

## CORTICAL ACTIVITY

Two areas of the brain are activated when processing facts. Stories activate many additional areas such as the motor cortex, sensory cortex and frontal cortex.

## DOPAMINE

The brain releases dopamine in response to an emotionally-charged event, resolution of conflict, or even recognition of a pattern, creating a pleasurable response and ease of memory and recall

## CORTISOL

The brain releases cortisol when it experiences conflict which increases attention and memory

## OXYTOCIN

The brain releases oxytocin in response to characters that increases empathy and connection as well as compassion and trust

# Why Tell a Story?

Distinctly human— hard-wired into DNA

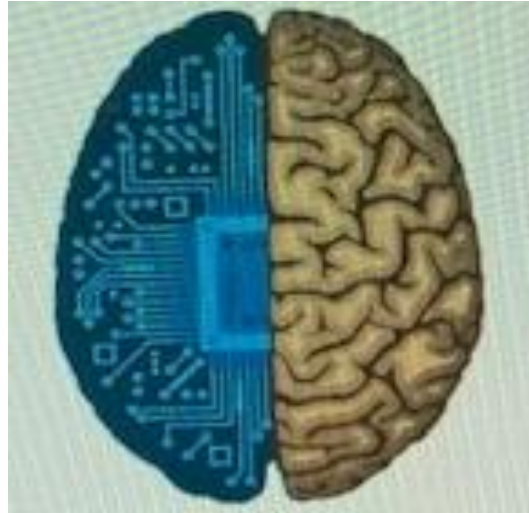
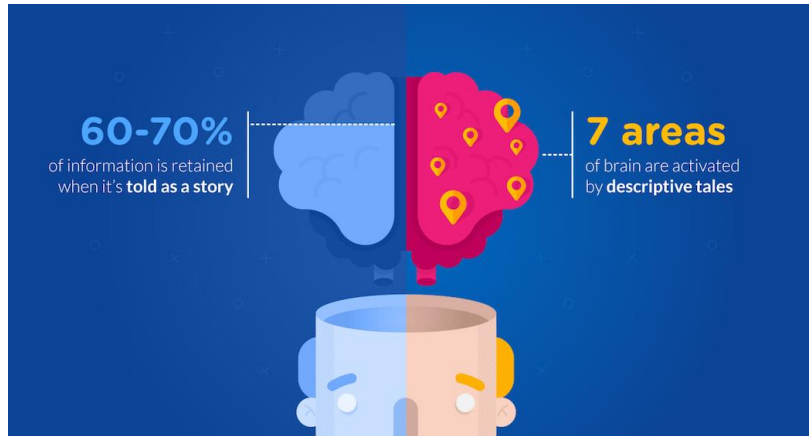
Activates the emotional part of brain

Aids memory



# Emotion

## Q. Why use emotion in a story?

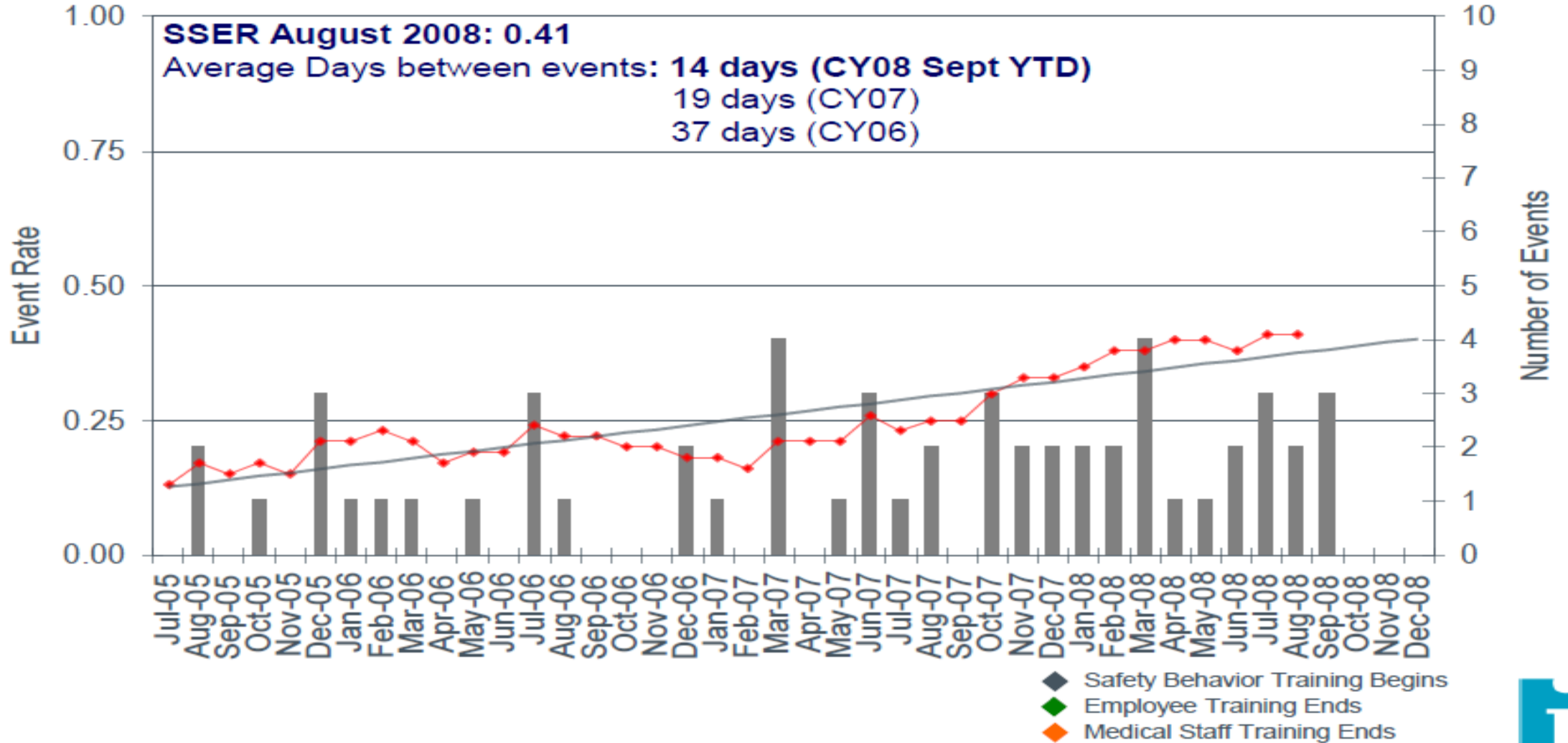


Humans make **emotional** decisions

Messages in stories can be **22X** more memorable than facts

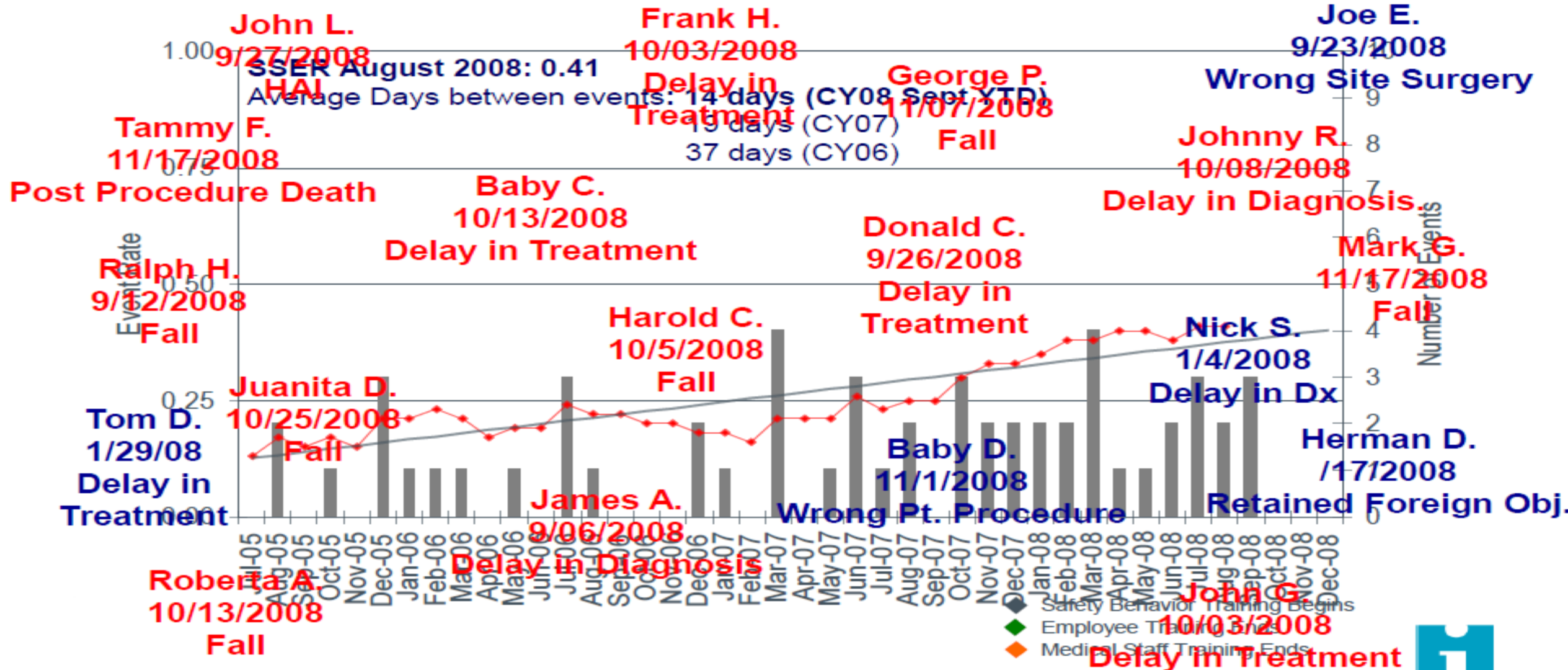
Personal stories make up **65%** of our conversation

Rolling 12-month Serious Safety Events expressed per 10,000 adjusted patient days



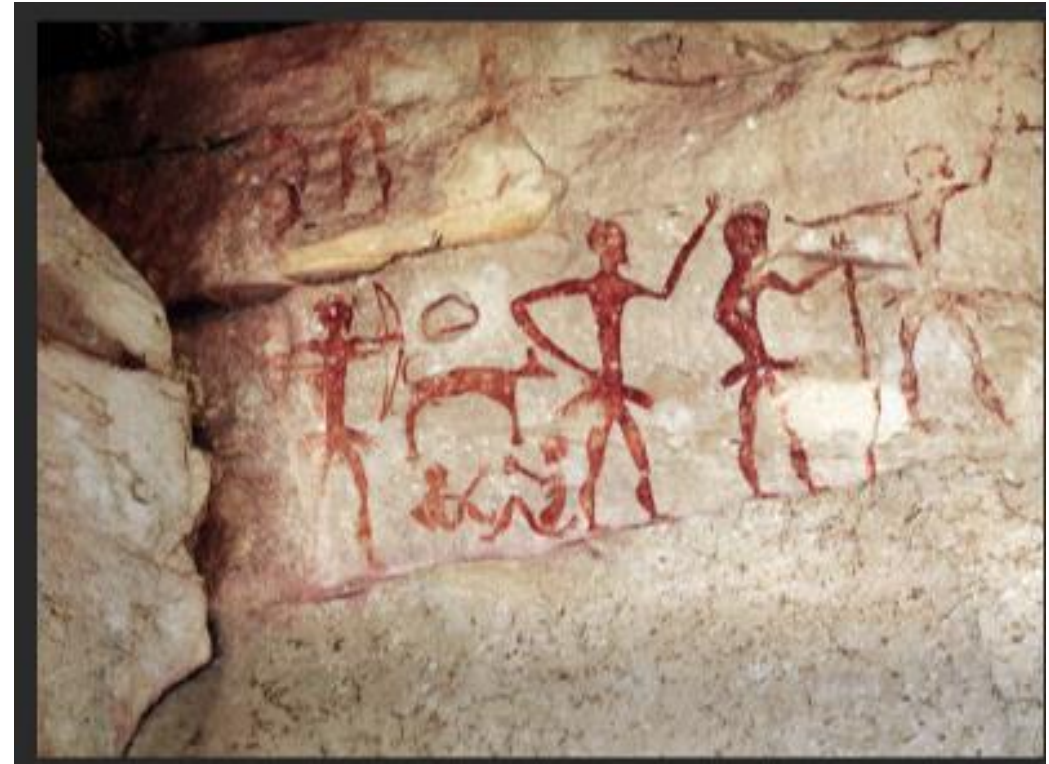
# A Different View of the Data

Rolling 12-month Serious Safety Events expressed per 10,000 adjusted patient days



# Top 10 Reasons To Tell Stories

1. Simple
2. Timeless
3. Demographic-proof
4. Contagious
5. Easy to remember
6. Inspire
7. Appeal to all learners
8. Work here learning happens
9. Put the listener in “learning mode”
10. Shows respect for the audience



# What makes a great story a great story?



- A hero we care about
- A villain we're afraid of
- Epic struggle between them



- A relatable hero
- A relevant obstacle
- An honest struggle
- A worthy lesson

# THE POWER OF STORYTELLING

**01** MRI scans reveal that when we read words like "perfume" and "coffee", our primary olfactory cortex activates.

**04** Our brain will ignore clichéd words and phrases – a phenomenon that scientists theorize is caused by loss of storytelling power.







## DESIGNING YOUR STORY

Think about an innovation you are proud of or a challenge that your team has overcome. It could be something that would be of interest to other teams at your organization and beyond. Is there something that you or your team have done around Quality & Outcomes? Team Performance? Well-Being? Education and Facilitation?

Use this template to explore the key plot points, narrative flow, compelling imagery, and data that will contribute to a great story. Start by really understanding your audience - this will help you build something that is custom designed for them and increase your story's chance of resonating. Then move through the 'chapters' to architect a journey that will appeal to the 'head, heart, and eyes'.

	THE PROBLEM	THE BIG IDEA	IMPACT	KEY TAKEAWAYS & ADVICE	PAINS
HEAD (Brain icon)					
HEART (Heart icon)					
EYES (Eyes icon)					
					GAINS

TITLE:

WHO IS YOUR AUDIENCE?

WHAT IS THE THEME OF YOUR STORY?

- Team Performance
- Quality and Outcomes
- Other: \_\_\_\_\_
- Well-Being
- Education and Facilitation



Designed by: **do tank**

# Story

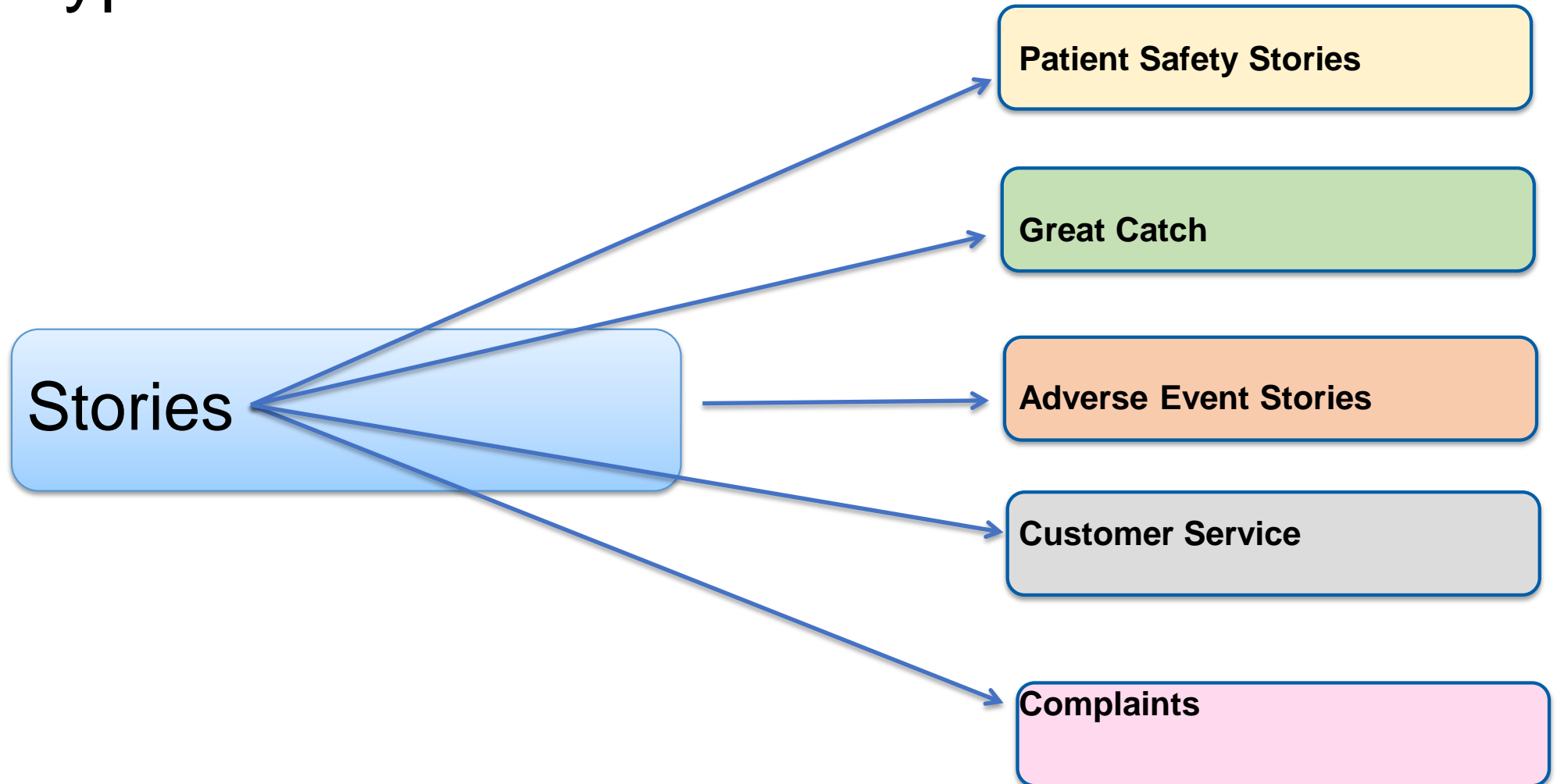






[October 4, 2018](#)<sup>SEP</sup> N Engl J Med 2018; 379:1299-1301<sup>SEP</sup> DOI: 10.1056/NEJMp1806388

# Types of Stories



# **Patient Safety Stories**

# Great Catch

# **Adverse Event Stories**



# Story- Support a cause for reporting tests Advancing safety with closed-loop communication of test results



When a critical result of breast cancer is missed and discovered a year later... it is too late Joint Commission

Was care delivered reliably?



Betsy Lehman  
*Boston Globe* Health Reporter  
Died December, 1994 after receiving an  
accidental four-fold overdose of chemotherapy  
at Dana Farber.



## *Josie King*

18 month old who died as  
a result of medical error at  
John Hopkins. She had  
suffered burns from a hot  
bath and died of severe  
dehydration and misused  
narcotics

## *Jesica Santillan*

17 year old who received organ  
transplant with incompatible blood  
type at Duke.



Dennis Quaid twins receive heparin overdose

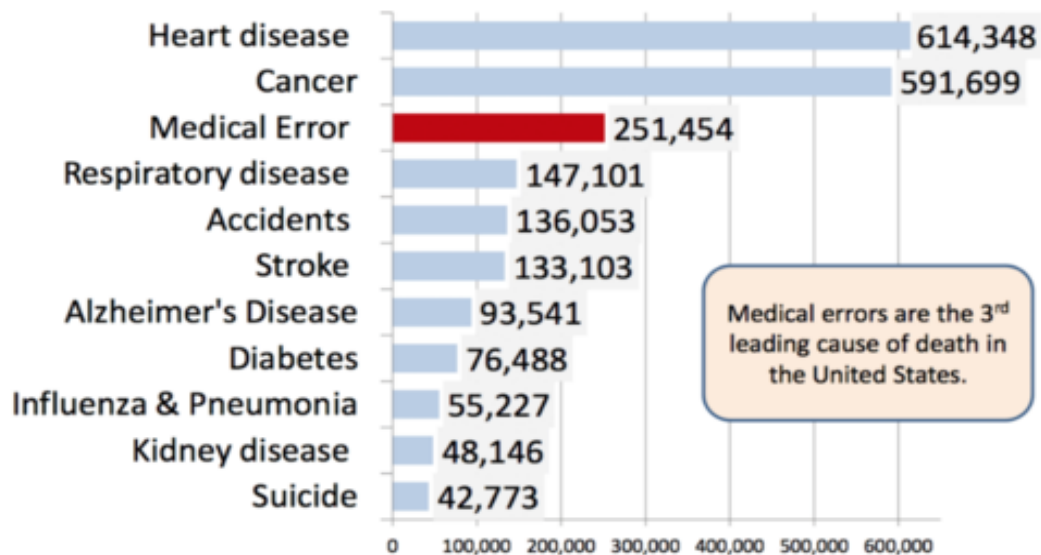


# The Joint Commission Sentinel Event Alert on Kernicterus

IMPROVING  
DIAGNOSIS IN  
HEALTH CARE

QUALITY CHASM SERIES  
The National Academies of  
SCIENCES • ENGINEERING • MEDICINE

## Number of Deaths in the United States



Sources: CDC. National Center for Health Statistics. Number of deaths for leading causes of death, 2014.



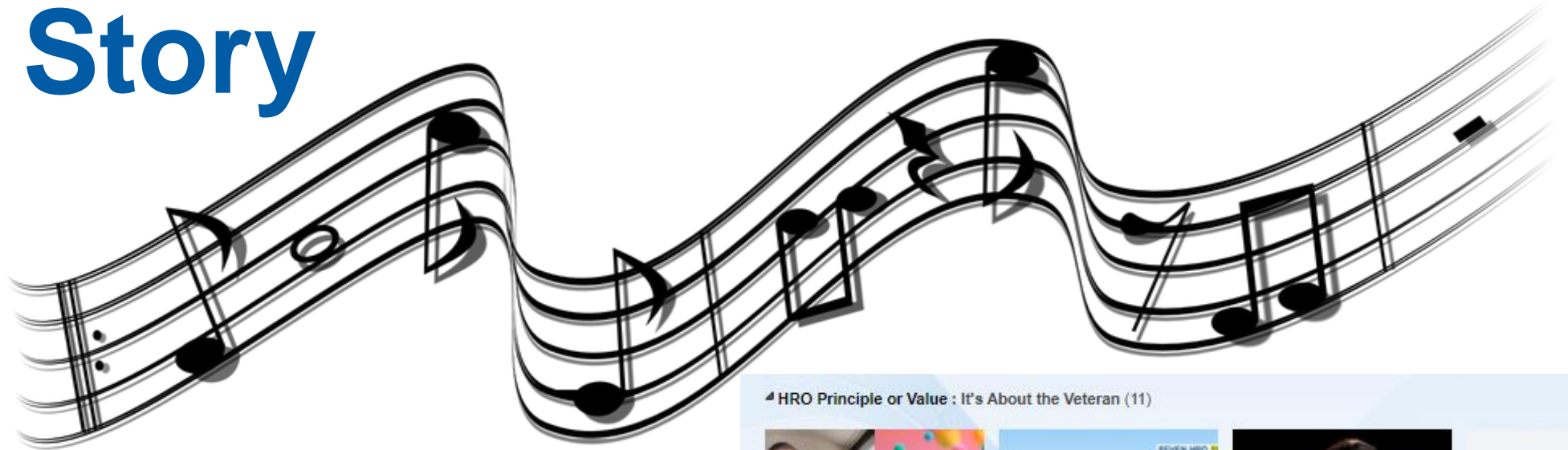
Patrick Sheridan and son Cal

**Customer Service**

**Complaints**



# Story



4 HRO Principle or Value : It's About the Veteran (11)

HRO Safety Story  
✓ 30

HRO Safety  
✓ ry\_Cliff

HRO Surgery  
✓ ient Safety

HRO The Seizure  
✓

U for all who continue  
our Veterans and staff  
this Pandemic.  
Hudson Valley  
✓ ety Story

SSVC\_Craig  
✓ j\_VISN20

SSVC\_Felicia  
✓ ggs\_VISN17

SSVC\_Leticia  
✓ bos\_VISN17

SSVC\_Rosy  
✓ ites\_VISN8

SSVC\_Ruth  
✓ nora\_VISN17

VA Northern  
✓ ifornia Home

# Journey to High Reliability

## 2021 Safety Story Video Challenge Submissions

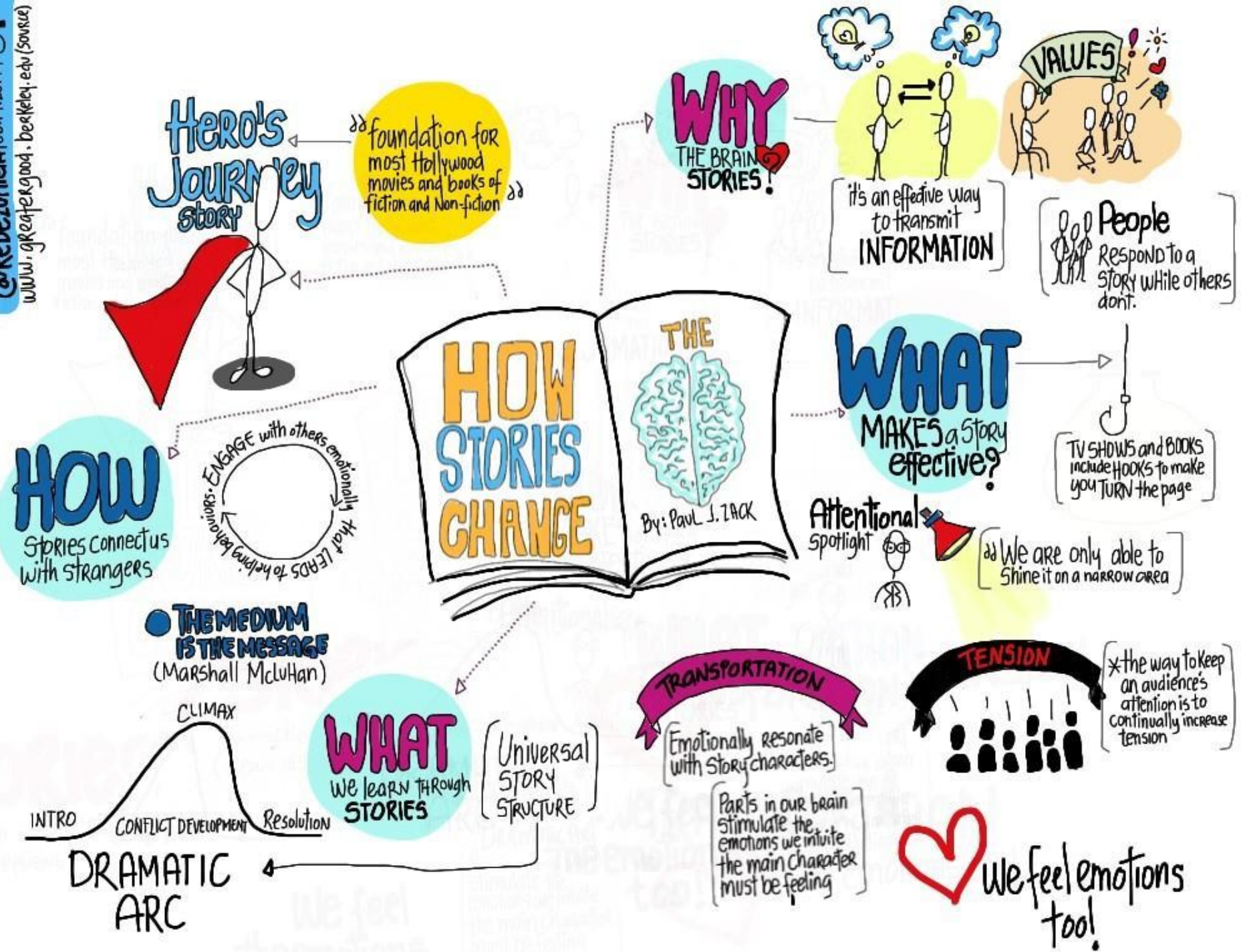
Name

- ▷ HRO Principle or Value : Clear Communications (4)
- ▷ HRO Principle or Value : Commit to Zero Harm (3)
- ▷ HRO Principle or Value : Commitment to Resilience (7)
- ▷ HRO Principle or Value : Deference to Expertise (8)
- ▷ HRO Principle or Value : Duty to Speak Up (9)
- ▷ HRO Principle or Value : It's About the Veteran (11)
- ▷ HRO Principle or Value : Learn, Inspire, and Improve (3)
- ▷ HRO Principle or Value : Preoccupation with Failure (11)
- ▷ HRO Principle or Value : Reluctance to Simplify (4)
- ▷ HRO Principle or Value : Respect for People (1)
- ▷ HRO Principle or Value : Sensitivity to Operations (14)
- ▷ HRO Principle or Value : Support a Safety Culture (10)

Slide Title

Enter Text  
Enter text

Visual Notes by:  
@Rebezmiga | 08.17.2014 | ©:  
www.greatagood.com, berkeley.edu (source)



## Engaging Staff with Patient Safety Stories

- Implementation of Patient Safety Stories into Practice Using a Formalized Method and Template
- Sharing Patient Safety Stories





VHA'S JOURNEY TO  
**HIGH**  
RELIABILITY  
ORGANIZATION

**COMMITTING TO ZERO HARM**

An organization that has succeeded in avoiding catastrophes in an environment where normal accidents can be expected due to risk factors and complexity.



# THREE PILLARS OF HRO



### LEADERSHIP COMMITMENT

A commitment that safety and reliability is reflected in leadership's vision, decisions and actions.



### SAFETY CULTURE

Throughout our organization, safety values and practices are used to prevent harm and learn from mistakes.



### CONTINUOUS PROCESS IMPROVEMENT

Across the VA, teams use effective tools for continuous learning and improvement.

# FIVE PRINCIPLES

These tools will lead us on a journey to high reliability

- **SENSITIVITY TO OPERATIONS**  
Focus on Front Line Staff and Care Processes.
- **PREOCCUPATION WITH FAILURE**  
Anticipate Risk - Every Staff Member is a Problem Solver.
- **RELUCTANT TO SIMPLIFY**  
Get to the Root Causes.
- **COMMITMENT TO RESILIENCE**  
Bounce Back from Mistakes.
- **DEFERENCE TO EXPERTISE**  
Empower and Value Expertise and Diversity.

# SEVEN VALUES

These values unite us. They should guide our decisions every day.

- **It's about the Veteran**
- **Support a Safety Culture**
- **Commit to Zero Harm**
- **Learn, Inquire & Improve**
- **Embrace a Duty to Speak Up**
- **Have Respect for People**
- **Ensure Clear Communications**



U.S. Department of Veterans Affairs  
Veterans Health Administration  
Orlando VA Medical Center

*Your Care is Our Mission.*

For more information, visit our SharePoint site:  
[http://bit.ly/HighReliability\\_sp](http://bit.ly/HighReliability_sp)

# Patient Safety Stories

Daily Morning Huddle-

Committee Agenda

Digital Signage

Newsletter

Great Catch Poster



Orlando VA Health Care System  
Orlando, FL

Department of Veterans Affairs  
**AGENDA**  
Orlando VA Medical Center  
High Reliability Organization Committee

I. Agenda Items

1. STORY- Orlando story (Great Catch Content Example)
2. Read Ethical Decision-Making Questions
3. Minutes
4. Action Plan
  - a. Pillar: Leadership
  - b. Pillar: Safety Culture
  - c. Pillar: Process Improvement

**LEADERSHIP**

- Be the JET! Walk: One Health Care System
- Be the Leader in Trust of our Veterans
- Be the Leader in Satisfaction of our Team
- Be the Leader in Wellness and Education
- Be the Leader in Research and Innovation

**Secretary's Priorities for VA**

1. Customer Service
2. Implementing the HRO/VA Act
3. Enhance Health Research
4. Transforming our Business System

**Five of Seven Morning Questions**

1. Do we have all the information relevant facts to make the decision?
2. Have we looked? Have that should be part of the decision?
3. Does the decision reflect our organizational, professional, social, and safety values?
4. Do the likely benefits of the decision outweigh any potential harm?
5. How would this decision look outside the organization?
6. Do you have any real or potential external conflicts of interest that may enter the course of decision or agenda item?

**IMPROVEMENT MODEL (DMAIC)**

- Define
- Measure
- Analyze
- Improve
- Control

**Patient Safety**

Chasing Zero Harms  
High Reliability Organization

Digital HRO Stories

High Reliability Organization  
**PRINCIPLES & VALUES**

**CONTENT:**  
A Veteran-employee stopped by Radiology to inform the team of an imaging order that was incorrectly placed under his name.

**ACTION:**  
Radiology was able to correct the issue and ensure the orders were appropriately placed.

**RESULT:**  
Radiology conducted a service-level root-cause analysis, isolated the issue, identified similar errors and created a plan to reduce the likelihood of recurrence.

**HRO PRINCIPLE:**  
Reluctant to Simplify - the service not only corrected initial problem but took the extra step to analyze and correct the root cause.

*It's All About The Veteran!*

VA Department of Veterans Affairs  
For more information visit <http://bit.ly/HighReliability>

**HIGH RELIABILITY**

A circular inset image showing two women in a meeting, one pointing at a document.

675 Newsletter  
(Online)

## Apply a Standard Story Telling Template

---

- National Template
  - Context
  - Action
  - Results
  - Principle (HRO)
- Getting Staff to Use the Template
  - Initial Approach
  - Barriers/Fears
  - Time
  - Repository
  - Integration into Great Catch Award

# High Reliability Safety Story Telling

## How to Craft Your Message

These three steps can help you craft your message, to ensure your objectives are met while telling a story that last from 2-5 minutes:

1. Picture the world **after** your story.

- ✓ What do you want people to remember?
- ✓ What do you want people to do (or not do)?
- ✓ What do you want people to learn?

2. Write your message in a **conversational tone** using plain language.

3. Make the **connection** for your audience between the story and the HRO concept(s) you are highlighting.

## Story Framework Template

A Three-Part Structure for Effective Leadership Storytelling	
<b>Context</b>	<input type="checkbox"/> Where and when? <input type="checkbox"/> Who is the main character? <input type="checkbox"/> What does the main character want? <input type="checkbox"/> Who or what is getting in the way?
<b>Action</b>	<input type="checkbox"/> What happened?
<b>Result</b>	<input type="checkbox"/> What's the message? <input type="checkbox"/> What did you learn from this story? <input type="checkbox"/> What connection does your story have to HRO concepts? <input type="checkbox"/> What commitment do you want from your audience?
<b>Alignment to HRO</b>	<input type="checkbox"/> Which HRO pillar, principle or value does your story align to?

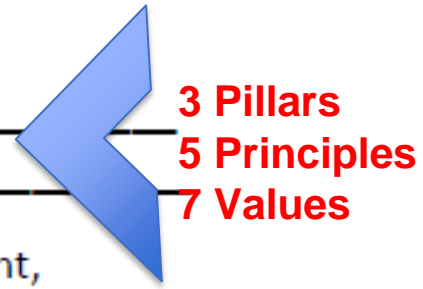
**Write Your Safety Story Here:**

**Context:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Action:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Result:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Alignment to HRO:** \_\_\_\_\_  
\_\_\_\_\_



**Use of your name or anonymous?** Can we use your name and/or facility name in print, speeches or video when we share your story? \_\_\_\_\_

# Lab Patient Safety Story

## Chemistry Lab- Story

- A lactic acid ordered STAT was erroneously collected in a white top tube (6.0 mL) instead of the correct gray top tube. Technologist realized that a particular location was sending the larger 6.0 ml gray top tubes instead of the smaller 4.0 ml tubes and that staff was confusing the color tops since they were so similar in color and size (light gray vs. white).

### Context



- Technologist suggested we reach out to Logistics to see if they could resume ordering the smaller 4.0 ml gray top tubes to help avoid this confusion and prevent recollects.
- Communication with service and Logistics staff resulted in removal of larger tubes to smaller tubes.

### Action



- It takes a team to achieve our mission: *Honor America's Veterans by providing excellent health care that improves their health and well-being*

### Results



- *Sensitivity to Operations and It's about the Veteran!*

### HRO Principle



# Definition: Safety Story vs. Good Catch Story

**Safety Story:** Safety Stories are brief, plain language stories used to explain HRO principles and values. They are most effective when they do the following:

- ✓ Appeal to emotions and bring humanity into work
- ✓ Represent different staff roles
- ✓ Motivate and spark action
- ✓ Compel people to change
- ✓ Educate

GREAT  
↓

~~Good Catch Story:~~ A sub-set of Safety Stories, a Good Catch story recognizes VA staff members who, by following safe practices in their everyday work, noticed an event that could have, but did not, cause harm due to corrective action or timely intervention.

- ✓ Good Catch stories should describe why this was a "good catch," and how the individual or team's action avoided potential harm to a patient, including organizational or process improvements made to prevent patient safety events.

# Repository

---

- Local Data Base of Stories (National has one too)
- Tracker by Service, by Date
- Useful for Quarterly/Annual Great Catch Recognition-\$
- Useful for Quarterly “On The Spot” Award- \$
- May Identify Trends/Patterns in Patient Safety
- Opportunities for Improvement



# Great Catch Award Program

## HRO PRINCIPLES & VALUES

2021 | Patient Safety Awareness Week

### THREE PILLARS OF HRO

- Leadership Commitment**  
Establish a vision and strategy for HRO, and ensure resources are available to support it.
- Culture & Safety**  
Promote a culture of safety and high reliability, and ensure that all staff are trained and empowered to speak up.
- Customer Process Improvement**  
Engage patients, families, and staff in the design and delivery of care, and ensure that the process is continuously improved.

#### HRO Principles and Values

- Accountability to Operations**  
Focus on Front-Line Staff and Care Processes
- Preoccupation with Failure**  
Assess Risk - Every Staff Member is Trained to Stop
- Reluctance to Simplify**  
Get to the Root Cause
- Commitment to Resilience**  
Bounce Back from Adversity
- Defiance to Expertise**  
Empower and Trust Front-Line Professionals
- It's About the Patient**
- Support a Safety Culture**
- Commit to Zero Harm**
- Learn, Improve and Monitor**
- Duty to Speak Up**
- Respect for People**
- Clear Communications**

Poster Title: \_\_\_\_\_ Members: \_\_\_\_\_

**CONTEXT:** \_\_\_\_\_

**ACTION:** \_\_\_\_\_

**RESULTS:** \_\_\_\_\_

#### PILLARS

Safety Culture  
Customer Process Improvement

#### PRINCIPLES

Accountability to Operations  
Defiance to Expertise

#### VALUES

It's About the Patient  
Support a Safety Culture  
Commit to Zero Harm  
Learn, Improve and Monitor

OUR JOURNEY TO  
**HIGH RELIABILITY**  
Your Care is Our Mission.

VA  U.S. Department of Veterans Affairs

For more information, visit: <http://2016.va.gov/ohrt/relia16/>

# HRO PRINCIPLES & VALUES

2021 | Patient Safety Awareness Week

## THREE PILLARS OF HRO



Leadership  
Commitment

Reliability is  
linked to effective risk  
management.



Culture of Safety

Trust in operations  
only established as  
management and  
team members



Continuous Process  
Improvement

Reverse operations, remove  
errors and prevent future  
occurrences

## HRO Principles and Values



Sensitivity to Operations  
Focus on Front-Line Staff and  
Care Processes



Preoccupation with Failure  
Anticipate Risk - Every Staff  
Member is a Problem Solver



Reliance to Simplify  
Get to the Root Causes



Commitment to Resilience  
Source: *Back from the Front*



Deference to Expertise  
Empower and Value Expertise  
and Diversity

- It's About the Veteran

- Support a Safety  
Culture

- Commit to Zero Harm

- Learn, Inquire, and  
Improve

- Duty to Speak Up

- Respect for People

- Clear  
Communications

2021 Annual Patient Safety Great Catch Poster Contest  
Congratulations to all of those who participated

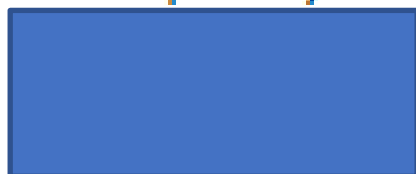
Special Congratulations to our top 3!



1<sup>st</sup>: Promoting Continuity  
of Care-



2<sup>nd</sup>: Team up for Safety-



3<sup>rd</sup>: Procrit or Retacrit- A Real  
Crit Storm-



PILLARS

PRINCIPLES

VALUES

WHAT'S JOURNEY TO  
**HIGH  
RELIABILITY**

Your Care is Our Mission.

VA



U.S. Department  
of Veterans Affairs

For more information, visit: [http://bit.ly/HighReliability\\_us](http://bit.ly/HighReliability_us)

# High Reliability Organization (HRO) Great Catch of the Week

- HRO Principle:
  - Facility
  - Context/Scenario:
  - Action:
  - Result:
-



Veterans Health Administration (VHA) presents the  
**National HeRO Award**

Recognizing employees who advance VHA's Journey to High Reliability through demonstration of VHA's High Reliability Organization (HRO) Principles in action

#### Award Criteria

Nominations must demonstrate one or more of the five VHA HRO Principles in action.

#### Award Frequency: Quarterly

Quarter	Submissions Open	Submissions Close
CY21 Q1	January 4, 2021	March 12, 2021
CY21 Q2	April 1, 2021	June 11, 2021
CY21 Q3	July 1, 2021	September 10, 2021
CY21 Q4	October 1, 2021	December 3, 2021

#### Award Recognition

Awardees will be highlighted in HRO communications and recognized by VHA Leadership for their commitment to the goal of Zero Harm.

#### Award Categories

- (1) Clinical Individual from a VISN or Facility
- (1) Clinical Team from a VISN or Facility
- (1) Individual or Team from VHACO
- (1) Non-Clinical Individual from a VISN or Facility
- (1) Non-Clinical Team from a VISN or Facility

#### Nomination Instructions

1. Visit the HRO SharePoint ([http://bit.ly/HighReliability\\_sp](http://bit.ly/HighReliability_sp)) to access the Nomination Form.
2. Submit completed Nomination Forms to **[Insert Facility HRO Champion/Lead or VHACO Supervisor Contact Info prior to distribution]**.



High Reliability Hero

*This certificate confirms that*

*[Insert Name]*

*demonstrates exemplary behaviors in High Reliability Organization (HRO) Principles and has been nominated for a*

*National HeRO Award*

*[Insert Date]*

**[INSERT MCD NAME]**

Medical Center Director, Veterans Health Administration

Date

*Your Care is Our Mission.*

VA



U.S. Department  
of Veterans Affairs

## Other Actions

\*Safety Forums- share adverse event and RCA actions for open discussion & learning

\*Committees- share stories

\*HRO Theme of the Month- based on pillars, principles & values-poster & video

\*Safety Story Video Challenge (National)

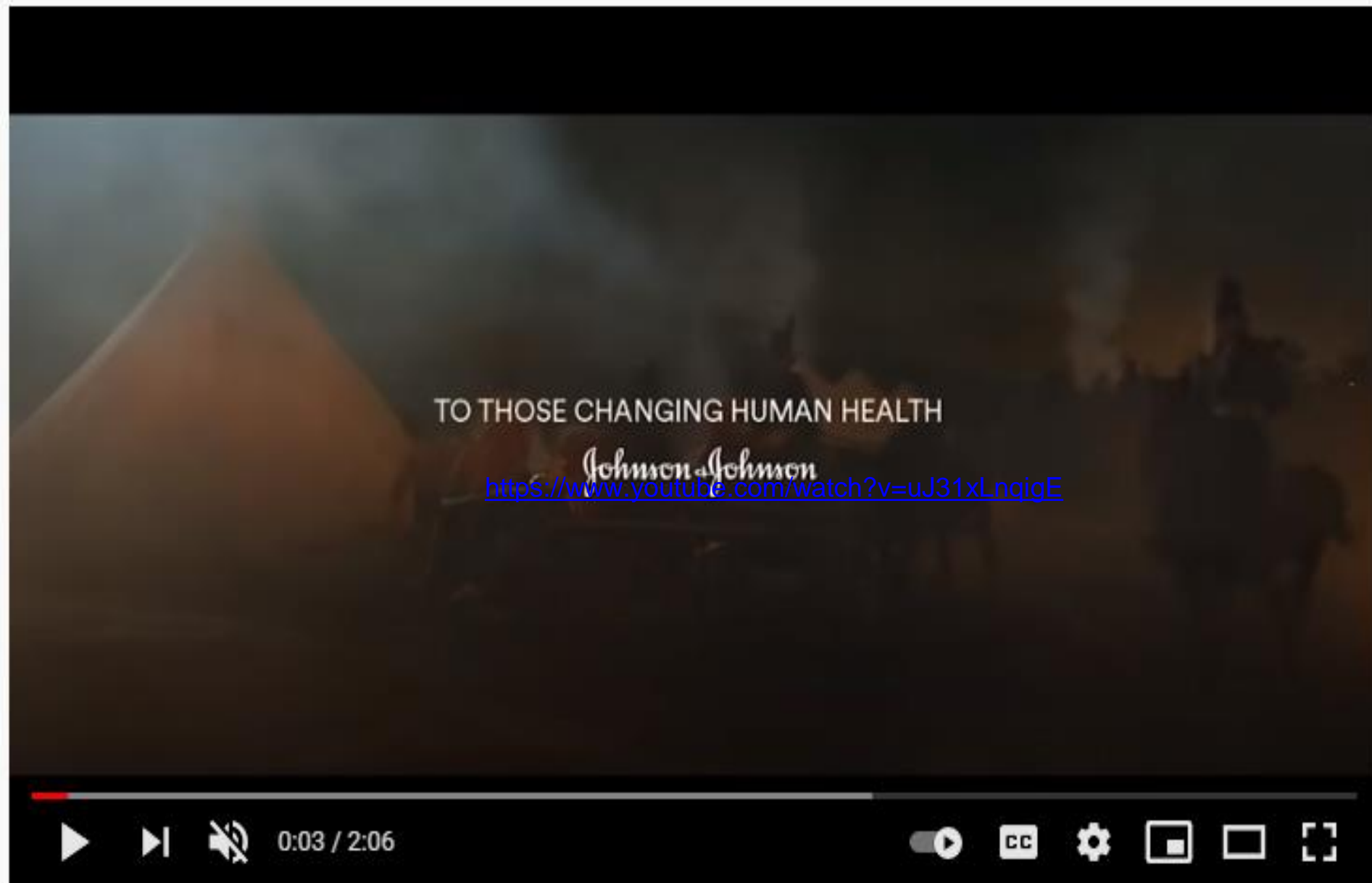
\*HRO Training

\*Clinical Team Training

\*Veteran to Share Story

Story- Spread the Love





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<https://www.youtube.com/watch?v=uJ31xLnqigE>



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https://www.youtube.com/102a5a5f-73a0-4c49-8d28-773a9db0f947

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## Key Takeaways

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- HRO Map Showing Where Patient Safety Stories Align
- Sample Tool to Collect Patient Safety Stories
- Patient Story Telling Template
- Sample Digital Signage Format for Patient Safety Stories

# Questions?

**How are you using stories?**

**What have you learned?**

**What changes or improvements have you made?**

**What else to support HRO?**



## Contact Information

Susan V. White  
Chief, Quality Management  
Orlando VA Health Care System  
[Susan.White4@va.gov](mailto:Susan.White4@va.gov)

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