





## Issue:

A multi-hospital health system, committed to eliminating causes of harm, set improvement targets to reduce patient and employee harm while increasing reporting of harm events and risks of harm through increased capability to see harm, solve to root, and share learnings across the system.



## Approach:

Engage everyone daily in Seeing harm, Solving to root and Sharing learnings:

- Built structure and employee skills to see and solve problems in real time
- Coached leaders to support employees through standard work and PDSA to continuously improve
- Deployed management and improvement systems to address work system problems, e.g., tiered huddles to understand problems & responses, and to close gaps



## Results:

Realized desired outcomes of increased reporting with decreased harm events, and continues to improve toward zero harm events.

- 20% increase in reporting of risk and harm events
- 38% reduction in patient safety events
- 46% reduction in employee safety events



## **Next Steps:**

- Building deeper capability to see, solve, share and coach within care delivery teams and the support teams
- Addressing problems when present as a risk, before they affect people or processes
- Solving problems, with a coach, as close to the work as possible

