Vice President of Quality; Patient Safety and Risk Management - Cherye Morgan LLC is most interested in serving Chief Quality and Risk Management executives that are looking for an executive consultancy that can help them prepare for a well-planned systems approach to quality improvement and patient safety. Utilizing our knowledge gained from W. Edwards Deming, and the Improvement Model from the institute for Healthcare Improvement our team will design and help you implement an approach to excellence that will empower your organization to reach its goals, improve results, and become more competitive.

Engaging health care professionals and staff around reporting errors to reduce risk and improving the safety culture is a crucial but difficult task for many organizations. Unless staff members are engaged, feel safe to speak up, and are enabled to learn from the occurrence of preventable medical errors, poor patient outcomes will likely occur. How organizational leaders respond to safety events and communicate to staff, patients, and family members following such events is key to building high reliability organizations and enhancing safety cultures. Our team has over 30 years of experience in the following:

- Developing processes to encourage reporting and a culture of safety;
- Producing a rapid and standardized response to identified concerns;
- Empowering managers to address issues close to the source; and
- Promoting greater transparency.

There are 3 key strategies that we recommend for how patient safety work is leveraged to reduce risk:

1. *Culture of safety that encourages reporting of events*
2. *Leadership training and engagement*
3. *Early notification and collaboration with risk management (disclosure, support, etc.)*

Our team will help yours achieve improvement in patient safety initiatives and reduce liability exposure. To evaluate the impact of the safety initiatives, we often help our client evaluate the number of patient safety events reported monthly and establish a baseline. We then help them develop an approach to increasing incident reporting. An increase in reporting is not an indication that there is less safety, but that teams feel safer to report—which is the goal. In addition to incident reports, culture metrics are measured. Safety culture surveys are given to employees annually with questions that assess the degree to which staff feel they are informed about errors on their unit, receive feedback about changes put into place based on incident reports, and participate in discussions to prevent errors from happening.

The implementation of these processes has demonstrated a reduction in reported malpractice claims and overall reductions in hospital professional liability premiums. Our client's results show that the investment in a culture of safety and process improvement related to staff-identified safety concerns, coupled with robust communication and leadership training, can really impact the bottom line—which is good for patients and for the organization.