BETA*rm Consulting Services

BETA HEART®

Healing • Empathy • Accountability • Resolution • Trust

BETA HEART® Guideline

Program Year 2026

BETA HEART®

Healing • Empathy • Accountability • Resolution • Trust

On behalf of all of us at BETA Healthcare Group, welcome to *BETA HEART*®. BETA HEART is BETA Healthcare Group's comprehensive and coordinated effort to guide participating organizations in implementing a reliable and sustainable culture of safety that is grounded in a philosophy of HEART: **H**ealing, **E**mpathy, **A**ccountability, **R**esolution and **T**rust. We applaud you for partnering with us in this endeavor to reduce harm in healthcare.

As we take this journey together, know that we are here as your partners in the development and implementation of each of the five domains of BETA HEART, which include:

1. *Culture of Safety*: Administering a scientifically validated, psychometrically sound culture-of-safety survey to measure staff perceptions of safety and engagement, as well as sharing and debriefing results.
2. *Rapid Event Response and Analysis*: A formalized process for early identification of, and rapid response to, adverse events. Includes cognitive interviewing techniques to collect information. Event analysis integrates human factors science, systems analysis, and the principles of Just Culture.
3. *Communication and Transparency*: A commitment to early and ongoing, honest and transparent communication with patients and family members after an adverse event.
4. *Care for the Caregiver*: A proactive organizational program that ensures emotional support for members of the healthcare team involved in, or impacted by, an adverse event.
5. *Early Resolution*: A process for achieving resolution absent litigation when harm is deemed a result of inappropriate care or medical error.

We look forward to your participation in the domain-specific workshops and regional training each year. After each workshop, our team will work with your organization to develop a plan and provide you with customized support as you progress through domain implementation.

This Guideline provides the criteria that need to be met for each domain to be considered fully implemented. Domains build upon one another and serve as mileposts on the journey to patient safety. As of 2025, we have updated validation criteria to ensure alignment with meeting the Patient Safety Structural Measure, in particular, Domain 4: Accountability and Transparency. Achieving full validation in all five domains of BETA HEART will serve to meet the requirements set forth in several additional domains of the PSSM. Completion of each domain is evaluated and validated in a joint meeting between your organization's leaders and the BETA HEART team. Your hospital will receive formal recognition after completing each domain. The guideline also provides a list of documents that will need to be made available at the time of validation assessment, and key personnel whom we will look to interview to understand organizational processes.

Please review the following materials carefully. When your hospital is ready for a validation assessment in a particular domain, documents listed for review may be forwarded to the undersigned prior to the visit. All other documents will be reviewed onsite.

Thank you for your ongoing commitment to patient safety and the reduction of harm. We look forward to working with you and celebrating your team's success!

For questions regarding BETA HEART, contact Heather Gocke, Vice President, Risk Management and Safety, BETA Healthcare Group, at heather.gocke@betahg.com.

Culture of Safety

Requirement	Validated By
The organization has designated a Culture team lead and team members responsible for overseeing organizational culture measurement and strategies to develop a culture of safety.	Interviews with Culture team and leader
Within the past year, the organization has administered a culture of safety survey to all staff and providers using a psychometrically sound, scientifically validated instrument. A 60% response rate is required to ensure statistical significance.	Review survey instrument utilized (SCOR-E, SAQ, Press-Ganey or AHRQ) Culture survey results/report to include overall response rate and provided at the time of validation
Evidence that the culture survey results have been analyzed and shared using a debrief methodology Debriefs are facilitated and held in focus group settings. • Debrief records include the number of attendees • Debriefs are led by staff who have been educated about the debriefing process	Medical staff committee minutes and unit/department staff meeting minutes reveal that culture of safety survey results are reviewed and shared Review evidence of unit-level debriefing (schedule, session notes, themes) Staff interviews (debrief facilitator, scribe, frontline, manager/director and provider)
Show evidence of performance improvement at the unit-level, based on survey and debrief findings annually.	Review selection of culture survey items and the performance improvement strategies developed Document review and/or meeting minutes (medical staff, quality, staff) demonstrate the organization's structure and process for oversight, tracking and accountability of PI projects
Lessons learned are shared: • Department/unit-specific trends from event reports (incident reports/QRRs) are shared and discussed, at a minimum, quarterly with medical staff and nursing staff • To raise staff awareness of safety concerns, a process for disseminating lessons learned from individual case studies has been developed and implemented. Dissemination may be accomplished through case study presentations, M&M rounds or patient safety newsletters/written communications discussing errors and/or near-miss events.	Medical Staff and Nursing Department/Unit minutes reflect discussion Evidence of participation through sign-in sheets Documentation of lessons learned, presentations and/or newsletters Staff interviews (frontline, providers)
Policies are in place that support the reporting of adverse clinical events.	Policy review
The organization adopts a Just Culture philosophy and approach to adverse event investigation and response. • HR policies and adverse event policies contain language consistent with a fair and just approach to investigation of adverse events and determining employee culpability • Adverse event investigations focus on evaluation of systems factors for determining causative and contributing factors that led to the event • Where an adverse event or error is determined to be due to individual behavior, the organization utilizes a consistent algorithm to evaluate such behavior	Human resources policies and adverse event policies Adverse event investigation records and related documents Evidence of application of Just Culture algorithm Staff interviews (frontline, managers/directors, HR, and providers)

Culture of Safety

Requirement	Validated By
Measurement: The organization completes a scientifically validated, psychometrically sound culture of safety survey and staff/physician engagement survey annually. • Specific culture survey items are selected and studied year over year • The organization communicates survey items and results to BETA At a minimum, choose at least one additional evaluation criterion to be measured: • Staff turnover/retention rates • Number of reported adverse events • Number of reported near-miss events	Review of culture survey domain/question selected by the organization to be studied over time Review of organizational data on staff retention/turnover rates, number of reported adverse events and/or reported near misses Review/verify selected survey meets HEART requirements
The organization has adopted a HEART dashboard and communicates selected data broadly to medical staff and workforce members.	Dashboard review (on units) and in minutes Interviews with staff
Patient safety metrics are tracked and reported to all clinical and non-clinical staff and made public in hospital units (displayed so staff, patients, families and visitors can see).	

Culture of Safety

Subsequent Year Validation Requirements

Has the organization previously achieved validation in this domain? _____Yes _____No _____Validation Year(s)

If yes, in addition to the requirements listed above, organizations must also meet the following criteria:

Requirement	Validated By
Updates to your culture team and lead have been submitted to BETA.	Review of Participation Agreement
HEART Culture of Safety leads have provided prior approval of any targeted vs. house-wide survey administration proposals.	BETA pre-approval obtained
Policy revisions/changes from the previous year are provided to BETA.	Review of updated policies
Develop and show evidence of a process for overseeing/reviewing the Just Culture/accountability algorithm's use in practice to ensure consistency. Develop and show evidence of a process for ongoing coaching/education of Just Culture. Suggestions include: • Presentation of cases where the Just Culture algorithm was used appropriately in management and/or staff meetings • Simulate case reviews using the algorithm at management meetings	Medical staff committee and/or staff meeting minutes reflect a process for oversight, education, and coaching of Just Culture in practice.
Demonstrate improvement in at least one of the culture measures selected previously.	Review of data to demonstrate improvement

Rapid Event Response and Analysis

Requirement	Validated By
An Executive Leader and Event Analysis team are identified and actively involved in program development.	• HEART Opt-In Agreement (on file at BETA) • List of HEART team participants • Interview with Executive and Team Lead
The organization defines HEART Events and includes a process for timely identification and reporting. • There is a formalized process for communicating/educating frontline physicians and staff as to the HEART event definition and response process	Organizational documents that include a definition of HEART event. (May be noted in Adverse event, Sentinel Event, or HEART event policy) Evidence of communication/education method and materials
• Serious or sentinel events HEART events are reliably reported within the timeframe defined by organizational policy, i.e., the goal of within one (1) hour of event detection or recognition • Serious or sentinel events are reported to Executive Leaders and the board within 3 business days • Other adverse events are reliably reported as defined by organizational policy, i.e., a goal of within 24 hours of the event detection or recognition • A tracking process is in place to verify the timeliness of reporting according to the goals outlined in organizational policy	Review the organization's Adverse Event/Sentinel Event reporting policy Adverse event data reflecting category, severity, and length of time from event occurrence to receipt of the event report Evidence of improvement toward a one-hour goal in the timeliness of serious event reporting over time
The organization has an event reporting system that provides easy access for physicians and staff and a process that supports timely activation of the event response team. Some examples might include: • Online reporting system • Risk/Patient Safety Hotline • HEART Event activation	Adverse/sentinel/HEART event reporting policies and process
The organization has a consistent process to objectively determine which events warrant an RCA.	Event Review/RCA policy Review process for determination, i.e., SAC score (Safety Assessment Code) or similar process
Key investigative interviews are conducted by individuals trained in cognitive interviewing methods and utilize CI methods. • CI interviews are conducted in a timely manner when possible • It is preferable that CI interviews are conducted by a neutral party/interviewer	Evidence of participation in a cognitive interviewing workshop Documentation of the interview process reflects use of proven methods to elicit memory retrieval; please provide notes from the investigative Cognitive Interview
Patients, families, or both are routinely interviewed during the investigation of adverse events (when relevant). • The organization incorporates patients' and families' input about patient safety events.	Event Review/RCA policy Review documentation/notes of interviews with patients/ families
Event analyses/RCAs demonstrate the following: • RCAs are inter-professional and multidisciplinary and, whenever appropriate, include physician engagement • The organization applies principles of human factors/safety science to the analysis of adverse events • Event investigation/RCA identifies causal and contributing factors • Causal and contributing factors address upstream (distal) human performance-shaping system issues	• Review of Event/RCA policy/protocol • Event/RCA case review • List of event analysis/RCA participants and their professional disciplines for the relevant policy year • Interviews of current and recent event analysis/RCA team members reflect broad participation • Evidence of the application of just culture principles in event analyses/RCAs completed in the relevant policy year • Provide the Just Culture outcome obtained

Rapid Event Response and Analysis

Requirement	Validated By
• Event analyses accord, at minimum, with IHI RCA2 Five Rules of Causation • When individual behaviors are determined to have contributed to harm, a consistent and fair process is utilized to determine their culpability (i.e., application of Just Culture) • RCA team presents findings to the stakeholder consensus committee to support the organization in determining whether any harm suffered by the affected patient or family was caused by inappropriate care	• Adverse event policy reflective of just culture principles
RCA/Event Review Action Plans include at least one strong or intermediate action item. The organization applies human factors/safety science principles to process improvement strategies. Process improvement/RCA action items address upstream (distal) human performance-shaping system issues.	Event/RCA case review with action plans included Review of internal publications, such as newsletters and meeting minutes
Evidence that the organization has a process to consistently distribute lessons learned from the event review/RCA completed. Lessons learned are distributed broadly (organization-wide) when applicable.	Review of internal publications, such as newsletters and meeting minutes or other methods of sharing lessons learned.
The organization reports the outcomes of the event review to the board, including lessons learned, action items, progress in implementing action items, and progress toward resolution.	Review board minutes
The number of RCAs the organization shall provide to BETA for review to make a validation decision: • For hospitals with ≤100 licensed beds, critical access hospitals, and non-hospital facilities: ≥3 harmevents • For hospitals with >100 licensed beds: ≥5 harm events *RCAs provided shall be from events that occurred during the current policy year. BETA reserves the right to request additional RCAs to make validation decisions if necessary.	
For each **HEART event**, the organization tracks the following data: • Length of time (in hours) from event occurrence to notification of Risk Management or another organizational representative • Length of time (in hours or days) between notification of Risk Management or another organizational representative and the *beginning* of the investigation or fact-finding • Length of time (days) between notification of Risk Management or another organizational representative and the *completion* of the investigation/event review	Dashboard or HEART Event tracking reflecting specified data Evidence of improvement toward a one-hour goal in the timeliness of serious event reporting over time
Aggregated data: • Number of adverse events reported, including number of near misses • Number of serious events reported to Risk Management >24 hours after an event • Patient demographics data, including race, ethnicity, and preferred language of patients who experience serious adverse events • Dashboard is reported to the board at least quarterly	Dashboard or HEART Event tracking reflecting specified data

Rapid Event Response and Analysis

Subsequent Year Validation Requirements

Has the organization previously achieved validation in this domain? ___Yes ___No _____Validation Year(s)

If yes, in addition to the requirements listed above, organizations must also meet the following criteria:

Requirement	Validated By
Updates to your rapid event response and analysis team and lead have been submitted to BETA.	Review of Participation Agreement
Events brought to the organization's attention by patients or families through grievances, claims, notices of intent to sue, or state licensing board complaints are handled in a manner comparable to those detected and reported by employees or contractors of the organization.	Comparison of incident reports, grievances, claims, and reports of HEART events made to BETA Event/RCA case review
Claims or lawsuits trigger an organizational review to determine whether the HEART process was followed. If it was not, specific opportunities for improvement are identified and implemented.	Event/RCA case review Review event/RCA case review of any claims/lawsuits
Strategies to improve patient safety following adverse events are developed with input from patient and family representatives (such as a Patient and Family Advisory Council or inclusion of Patient Safety Advocates on organizational Performance Improvement or Patient Safety committees).	Event/RCA case review PFAC Meeting Minutes Review of Event/RCA policy/protocol
Demonstrate improvement in at least one of the HEART or aggregated data measures.	Review of data to demonstrate improvement
Suggested policy revisions/changes from the previous year are provided to BETA.	Demonstrate improvement in at least one of the measures selected previously
The organization provides specific evidence of applying BETA's recommendations from previous validations to its policies and processes.	Updated policy review Evidence of recommendation application

Communication and Transparency

Requirement	Validated By
The organization has designated a Communication Consult Team and team leader responsible for implementing specific strategies.	Interview with team leader and team
Building a Communication Consult Team: All potential Communication Consult Team members complete a communication assessment. The organization has considered the communication assessment results in determining Communication Consult Team development. Additional sources of information to be considered in selecting Communication Consult Team members include: Professional experience within the organization, position within the organization, performance reviews, patient satisfaction scores, and personal experience recommendations.	Names of physicians and staff who have completed the communication assessment (evidence of multidisciplinary composition of the organization's Communication Consult Team members) Interviews with Communication Consult Team members and staff Correlate the list of Communication Consult Team members with the communication assessment data findings
Key leaders and staff, including Communication Consult Team members, are provided additional training and development in empathic communication skills.	Documented evidence of (at a minimum) participation in HEART communication workshop and/or BETA-offered Empathic Communication Regional Training or other training that develops Empathic Communication skills A copy of the training agenda and program content will be provided to BETA if training was not provided by BETA BETA reserves the right to determine if program content meets requirements for validation
A Communication Consult Team consists of multidisciplinary members	Review of team roster or other documentation that reflects the multidisciplinary membership Medical records or other organizational documents reflect individual Communication Consult Team members responding to a communication consult request Communication Consult Team member has completed empathic communication training or has a plan to complete the training if they joined the team within the past six months
The organization has a formal and approved Communication After Harm policy that is aligned with BETA HEART's template policy. The policy, at a minimum, shall include the following:	Communication After Harm policy
1. The organization sets a goal of sixty (60) minutes for a timeline from the adverse event until initial communication to the patient/family by healthcare providers or organizational leaders.	Adverse Event Policy review Communication After Harm Policy
2. The Communication Consult Team proactively prepares for the initial conversation with the patient or family by using the HEART Huddle and the Communication Checklist.	Discussion with Communication Consult Team members and obtaining a narrative as to how the HEART Huddle and the Communication Checklist are utilized
3. The initial communication includes the following: • Acknowledging the adverse event that occurred while the patient was under the care of the organization (this is not an admission of fault; rather, it acknowledges that an adverse event occurred while the patient was under the organization's care) • Showing empathy, such as offering an apology	Organizational policy review Medical record documentation reflects initial communication and ongoing follow-up and interactions with patient/family as agreed upon Discussion with Communication Consult Team members

Communication and Transparency

Requirement	Validated By
• Affirming the first priority is to take care of the patient and meet their healthcare, social and emotional needs • Informing the patient/family that an investigation and analysis will be completed to understand what occurred and that results will be shared • Designation of an organizational contact person the patient/family can reach with questions/concerns, and who will reach out to the patient/family within an agreed-upon time period	Ongoing HEART Event case reviews with BETA HEART Director
4. Communication Consult Team reviews event analysis findings in preparation for follow-up communication.	Discussion with Communication Consult Team members to confirm a consistent process is in place for the team members to learn and review event analysis findings prior to meeting with the patient/family in subsequent conversations Communication After Harm policy references checklist (included as an addendum or other method of verifying a principled approach to preparing for conversation)
The organization conducts follow-up communication with the patient/family to discuss the findings obtained through the event review process, as applicable.	Discussion with Communication Consult Team members to confirm a consistent process in place for follow-up communication with patient/family to discuss event review findings Organizational policy review Ongoing HEART Event case review with BETA HEART Director
Review evidence of the post-harm communication process application as part of the HEART event submission	Review HEART events submitted since the last validation meeting for evidence of post-harm communication process application
The organization evaluates the effectiveness of its communication process: • Debriefings are held with Communication Consult team members who participated in the meeting with the patient/ family HEART metrics are tracked and reported to the governing board quarterly. • Time from event to time of initial communication with patient/family • # of communications/# of adverse events where communication is indicated • # HEART events that are converted into claims with documented communication with the patient/family	A standardized debriefing model is utilized to evaluate what worked and identify opportunities for improvement Review of debriefing tool utilized by communication team members Review communication timeliness data Board meeting agenda and minutes HEART Event and Claims data

Communication and Transparency

Subsequent Year Validation Requirements

Has the organization previously achieved validation in this domain? ___Yes ___No _____Validation Year(s)

If yes, in addition to the requirements listed above, organizations must also meet the following criteria:

Requirement	Validated By
The Communication Consult Team is consistently accessed and utilized when communicating with patients and families who experience a HEART event.	Documentation reflects consistent engagement and support of Communication Team members HEART Dashboard reflects that the Communication Consult Team is activated in 100% of events at all subsequent validations Debrief process incorporates feedback to members who participate in communication interactions with patients/ families
The Communication Consult Team further engages providers in the organization's communication after harm effort.	Provider attendance at empathic communication training (BETA offered or external) List of Communication Consult Team members reflecting expanded medical staff engagement
There is evidence of early and ongoing communication with patients and families in at least 90% of the HEART events that cannot be resolved at the bedside at the time of the event, and 100% of events that meet sentinel events or HSC 1279.1 events.	Review of HEART Event medical records and/or event case files Adverse event/HEART Event log
Process improvement activities evaluate the effectiveness of the organization's communication process and data reporting to the BETA HEART dashboard. Key measurements may include: • Time from event to time of communication with patient/ family is tracked and reported • # of communications/# of adverse events where communication is indicated • # of claims with documented communication with patient/family	Evidence of process improvement activities (including data) within the organization to evaluate the effectiveness of the organization's communication process Review of organizational data submitted to HEART Dashboard Evidence of sharing communication metrics across the organization
A quarterly communication team meeting or other regularly scheduled meeting/strategy will be held for subsequent years to review communication the after harm process, evaluate effectiveness, analyze relevant data, and refine the process.	Communication team quarterly meeting or other patient safety meeting minutes that reflect review and improvement actions
The organization considers the impact of trauma on patient/family and maintains a list of resources to provide when needed.	The list of resources to address potential impact of trauma experienced by the patient/family related to the harm event

Care for the Caregiver

Requirement	Validated By
The organization has designated a Care for the Caregiver team lead and team members responsible for overseeing organizational Care for the Caregiver program.	Designation of Care for Caregiver Executive Champion and Team Lead
A Care for the Caregiver Steering Committee has been created to drive the program's development forward. *Recommended members include Executive sponsors such as VP Patient Safety, VP Human Resources; Champions representing physicians, nurses and residents; Department Directors; and representatives from Employee Health, Pastoral Care, Risk Management and Marketing.*	Review of the roster for Care for the Caregiver Steering Committee members
The organization has assessed its current infrastructure and resources to support the development of a Care for the Caregiver program.	The organization has completed a personnel resource assessment to determine what resources are currently available **See:** HEART Care for the Caregiver toolkit: Peer Support Implementation Guide/worksheet
A Care for the Caregiver policy includes the following elements: • Criteria to determine the need for a total team emotionally focused debrief* (make-up of the team may consist of both clinical and non-clinical staff) • A mechanism for connecting individual staff involved in an event with a peer supporter of a similar role immediately after the event (including night shift and weekends) • The process allows for the routine responsibilities of peer supporters to be managed when peer support is needed. • The process for activating Tier 3 Resources (Chaplain Services, Social Workers, Clinical Psychologists, Employee Assistance Program, etc.) **Note: This debrief is different from and does not include case debrief elements like 'what could we have done differently', as these discussions can disrupt the investigation if they happen pre-interview (See RERA for more details). The debrief also does not take the place of deploying individual peer supporters to members of the team.*	Review of Care for the Caregiver policy and procedure Interviews with Peer Supporters regarding the process Review of Peer Support user feedback questionnaires for effectiveness of plan for immediate availability
A process is in place for the identification and training of peer supporters. • The multidisciplinary peer support team includes clinical and non-clinical staff and providers (See toolkit for Peer definition) • Potential Peer Supporters will complete a communication assessment as one component of the team selection process • Peer Supporters sign a formal agreement defining their role and indicating their commitment to complete required training, be available to staff, and maintain confidentiality of discussions Peer Supporters participate in formal training that includes responding to healthcare team members involved in an unanticipated patient event, effective empathic communication strategies, active listening, situational awareness, and recognizing signs and symptoms that a colleague may benefit from peer support.	Review of Peer Support Activation log for role concurrence of Peer Supporters Review of Peer Supporter Communication Assessment roster Review of signed Peer Supporter agreements Review of Peer Supporter training materials and sessions (not needed if BETA-led training)

Care for the Caregiver

Requirement	Validated By
Development of a formal, proactive Peer Support program will include: • A process by which a peer proactively contacts the affected healthcare team member immediately after the event and initiates Peer Support • The number of Peer Supporters should be commensurate with the size of the organization and the number of employees and physicians • Marketing and promotion of the program should be ongoing and regularly promoted by the organization	Review of program structure and activation process Review of Peer Supporter team roster Review of marketing materials
The organization designates a "Safe Space" where caregivers can go after a harm event to begin to recover. • If selected spaces have multiple uses, there must be the ability to shift purpose immediately when needed • Staff members are aware of locations	Review of Care for the Caregiver Policy Evidence of communication of Safe Space locations to frontline staff Interview Peer Supporters regarding the locations and availability of Safe Spaces
Team meetings (for trained peer supporters) occur at least quarterly, and ongoing training occurs at least annually.	Review of Peer Supporter team meeting agenda, minutes and educational curriculum Review of Peer Supporter sign-in sheet or other attestation as to participation
Peer supporters use a Peer Support Encounter/Activation Log to document peer supporter activities after events (see toolkit for criteria to include). A process is in place to evaluate the effectiveness and/or staff satisfaction with the Care for the Caregiver program. • Surveys to recipients of peer support • Surveys to Peer Supporters The HEART dashboard identifies and includes a measurement strategy. Examples: • # of Peer Support calls activated (peer-to-peer interactions) per month • # of Peer Support interactions by unit/department • Types of referrals made (clinician self-referral/ supervisor/RM/other) • Effectiveness and timeliness of response (User survey) • Timely access to a higher level of support (User survey) • Staff retention rates Data is shared with the Steering Committee and Peer Supporter team. Data is shared with the organizational Performance and Quality Improvement structure (Patient Safety Program, QI Committee, Board, and Medical Staff committees).	Review of Care for the Caregiver activation logs Review of Culture of Safety Survey results Review of HEART Dashboard Review of Steering Committee and Peer Supporter Team meeting agenda and minutes Review of Care for the Caregiver reports to the organization (as defined in the requirement)

Subsequent Year Validation Requirements

Has the organization previously achieved validation in this domain? ___Yes ___No _____Validation Year(s)

If yes, in addition to the requirements listed above, organizations must also meet the following criteria:

Requirement	Validated By
Subsequent Year Validation Requirements (in addition to all above-listed requirements): The organization demonstrates program growth through: 1. Expansion of peer supporter team size (as appropriate) 2. Inclusion of multidisciplinary team - medical staff, ancillary support departments, and non-clinical personnel The organization demonstrates ongoing engagement efforts through: 1. Continued marketing 2. Orientation/onboarding of new employees and medical staff 3. Steering Committee activities The organization demonstrates ongoing improvement efforts through: 1. Communication between the Peer Supporter Team and Steering Committee 2. Feedback from Peer Support surveys and interaction logs by the Steering Committee should be utilized to identify, assess, and address resource needs. The Steering Committee evaluates recommendations from the previous validation and takes appropriate action to improve the program.	Review of Peer Supporter team roster and activation logs Review of Steering Committee meeting minutes and Peer Supporter Team meeting minutes

Validation Requirements for Organizations That Have Been Through the Train the Trainer Model

Has the member participated in a Train the Trainer session of this domain?____Yes ___No _____TTT Dates

If yes, in addition to the requirements listed above, organizations must also meet the following criteria:

Requirement	Validated By
The organization utilizes internal experts to train new peer supporters, holding at least one full training session a year. The organization is evaluating the quality of its training sessions and gathering attendee feedback for improvement. Trainers may additionally provide refresher content to existing Peer Support team members.	Roster of new Peer Support team members trained since the previous year Review of Training Session feedback surveys Review of Training Session Times/Dates and Sign-in Sheets

Early Resolution

Requirement	Validated By
All criteria of the following domains have been met: • Culture of Safety • Rapid Event Response and Analysis (RERA) • Communication and Transparency • Care for the Caregiver	Validation of the domains results reflects successful completion
An executive Early Resolution champion, team lead, and team are identified and actively involved in program development.	Interview with executive champion and Early Resolution Team
A sincere and timely apology is made when a patient is harmed by inappropriate care or medical error.	Review the organizational communication after harm policy Review medical records or case files for evidence of documentation of apology Interview with Communication Consult Team member
When the event analysis indicates that medical care was appropriate, the patient and family are provided with a thorough and empathic explanation.	Review of organizational Communication after Harm Policy Review of medical records or case file for evidence of documentation with patient and family Interview with Communication Consult Team member or others engaged in resolution conversations
Leaders seek to learn from HEART events and implement process changes to prevent similar harm to patients.	Review of committee minutes reflecting performance improvement activities Review process changes resulting from event review findings Review evidence that performance improvement actions have been fully implemented
The organization broadly disseminates lessons learned and process improvement actions resulting from event analysis. Lessons learned and improvement actions are shared with the patient and family.	Documentation or interviews show evidence of the implementation of process improvement Evidence reflects method and completion of dissemination of lessons learned
The organization informs the Governing Board of ongoing HEART Event activities and resolutions in a timely manner.	Review case files and Governing Board minutes
The organization actively engages and collaborates with BETA HEART team to ensure HEART-centric responses to reported HEART events.	Review HEART Event reporting data and documentation Contemporaneous observation
The organization has a Stakeholder Consensus Team that collaboratively evaluates events and determines (when appropriate) a fair and equitable resolution for patients and families. A Stakeholder Consensus Team is a multidisciplinary team that may include representatives from administration, risk management, medical staff, hospital clinical departments, finance, and patient/family advisors. BETA representatives should be included when appropriate. The organization has an approved Early Resolution Policy that reflects the BETA HEART Early Resolution process.	Review the organizational Early Resolution Policy Review Stakeholder Consensus Team membership and meeting minutes
The organization's Early Resolution Team works with the BETA HEART team to utilize external resources and consultants as needed.	Review the organizational Early Resolution Policy Interview Early Resolution Team members

Early Resolution

Requirement	Validated By
• Resources may include external experts, attorneys, and consultants.	
The Early Resolution process addresses both financial compensation (when indicated) and other opportunities to assist patients and families in finding closure. Examples of non-monetary resolutions include involving patients and family members in performance improvement processes, families sharing their stories with clinical staff, and memorializing loss suffered (such as a plaque or bench).	Review the organizational Early Resolution Policy Review of Early Resolution case files or documentation for evidence of process to determine financial resolution efforts, if indicated Review of Early Resolution case files or documentation for evidence of engagement with patients and families to facilitate non-monetary resolution, if indicated
Measurement: The organization has identified and implemented measurements to evaluate the effectiveness of the Early Resolution process. • Timeliness of reporting: length of time from event to receipt of internal report • Timeliness of communication: length of time from event to communication • Number of harm events that the organization first became aware of through a claim, Notice of Intent to Sue, or plaintiff attorney communication • Number of events in which organization proactively responded to patient and family • Number of events resolved through Early Resolution (absent claim or suit) • Time from event to settlement (if applicable) • Financial resources expended in resolving events • Claims frequency and severity	Review organizational data

Early Resolution

Subsequent Year Validation Requirements

Has the organization previously achieved validation in this domain?____Yes _____No _____Validation Year(s)

If yes, in addition to the requirements listed above, organizations must also meet the following criteria:

Requirement	Validated By
There is evidence of patient/family advisors in organizational patient safety activities.	Performance Improvement Committee minutes PFAC committee minutes Interviews with patient/family advisors (please arrange for a 30-minute interview with advisors or inclusion of PFAC in gap analysis focus group sessions noted below)
The Stakeholder team is consistently convened prior to offering resolution. "Consistently" is defined as being convened in at least 80% of cases.	Stakeholder consensus meeting minutes Evidence of Stakeholder consensus meetings in at least 80% of cases resolved HEART Event analysis and files reflecting activities of Stakeholder consensus team and inclusion of appropriate representation
Subsequent year validation criteria are met in all domains of HEART.	Review current year validation assessment findings
The principles of HEART are understood and adopted broadly throughout the organization, as evidenced by findings from repeat Gap Analysis. Repeat Gap Analysis includes reviewing organizational documents, findings from the validation process and interviews conducted via focus group sessions. *(BETA will provide a Gap Analysis process and structure upon member request.)*	Completion of repeat Gap Analysis by the BETA team (conducted prior to subsequent year validation and every three years thereafter, provided continued validation is achieved)
Evidence that BETA HEART dashboard metrics are communicated broadly throughout the organization, and improvement actions are taken where opportunities are identified.	Observation of HEART dashboard metrics displayed at the unit level, as evidenced during a unit tour Patient Safety Committee, Board Quality and/or Executive Leader meeting minutes reflect a review of HEART dashboard metrics at least biannually