HOSPITAL SURVEY ON PATIENT SAFETY CULTURE

Interpreting Safety Culture Survey Results and Action Planning

Katherine Jones, PT, PhD

Anne Skinner, RHIA

Oregon Rural Health Quality Network

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PATIENT SAFETY
AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov
TRICARE

Why did you conduct the survey?

- Identify areas of culture in need of improvement
- Increase awareness of patient safety concepts
- Conduct external benchmarking
- Conduct internal benchmarking

Nieva VF, Sorra J. Safety culture assessment: A tool for improving patient safety in healthcare organizations. Qual Saf Health Care 2003; 12(Suppl II): ii17-ii23.

What does the survey measure?

- Culture of Patient Safety: Enduring, shared beliefs and behaviors that reflect an organization's willingness to learn from errors*
- Four beliefs present in a safe, informed culture**
  - Our processes are designed to prevent failure
  - We are committed to detect and learn from error
  - We have a just culture that disciplines based on risk
  - People who work in teams make fewer errors

*Wiegmann. A synthesis of safety culture and safety climate research; 2002. http://www.humanfactors.uiuc.edu/Reports&PapersPDFs/TechReport/02-03.pdf

**Institute of Medicine. Patient safety: Achieving a new standard of care. Washington, DC: The National Academies Press; 2004.

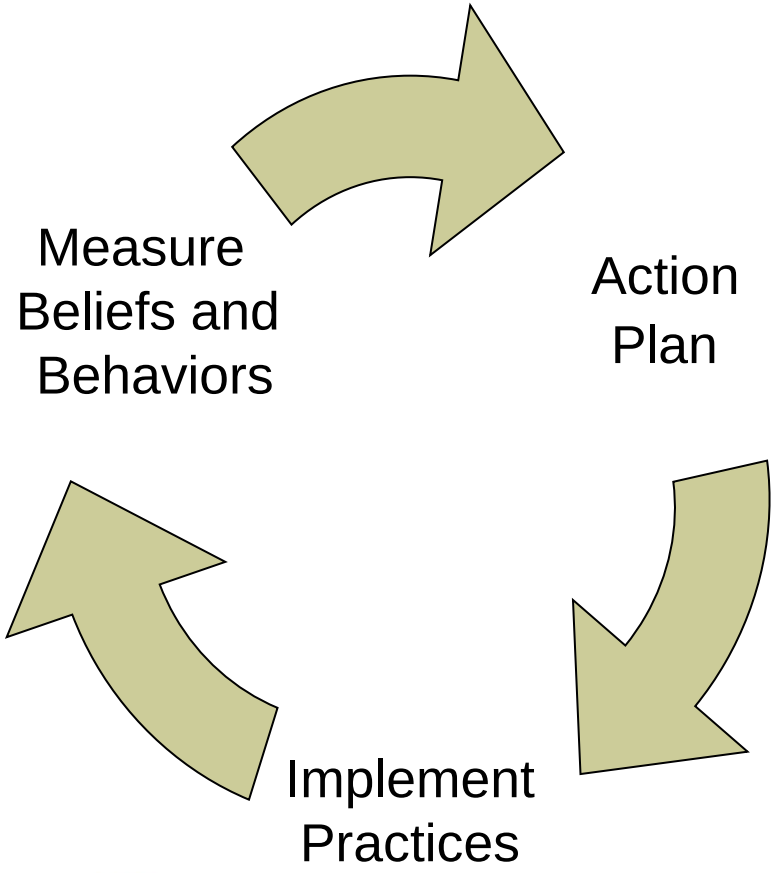
Components of Safety Culture

A culture of safety is informed. It never forgets to be afraid…

Reason, J. (1997). *Managing the Risks of Organizational Accidents.* Hampshire, England: Ashgate Publishing Limited.

Battles et al. (2006). Sensemaking of patient safety risks and hazards. HSR, 41(4 Pt 2), 1555-1575.

How to Become an HRO: Engage in Continuous Improvement



Measure Beliefs and Behaviors with HSOPS

- Developed by AHRQ to provide healthcare organizations with a valid tool to assess safety culture http://www.ahrq.gov/qual/hospculture/
- 42 items categorized in 12 dimensions
  - 2 dimensions are outcome measures at dept/unit level
  - 7 dimensions measure culture at dept/unit level
  - 3 dimensions measure culture at hospital level
- 2 additional items are outcome measures at dept/unit level

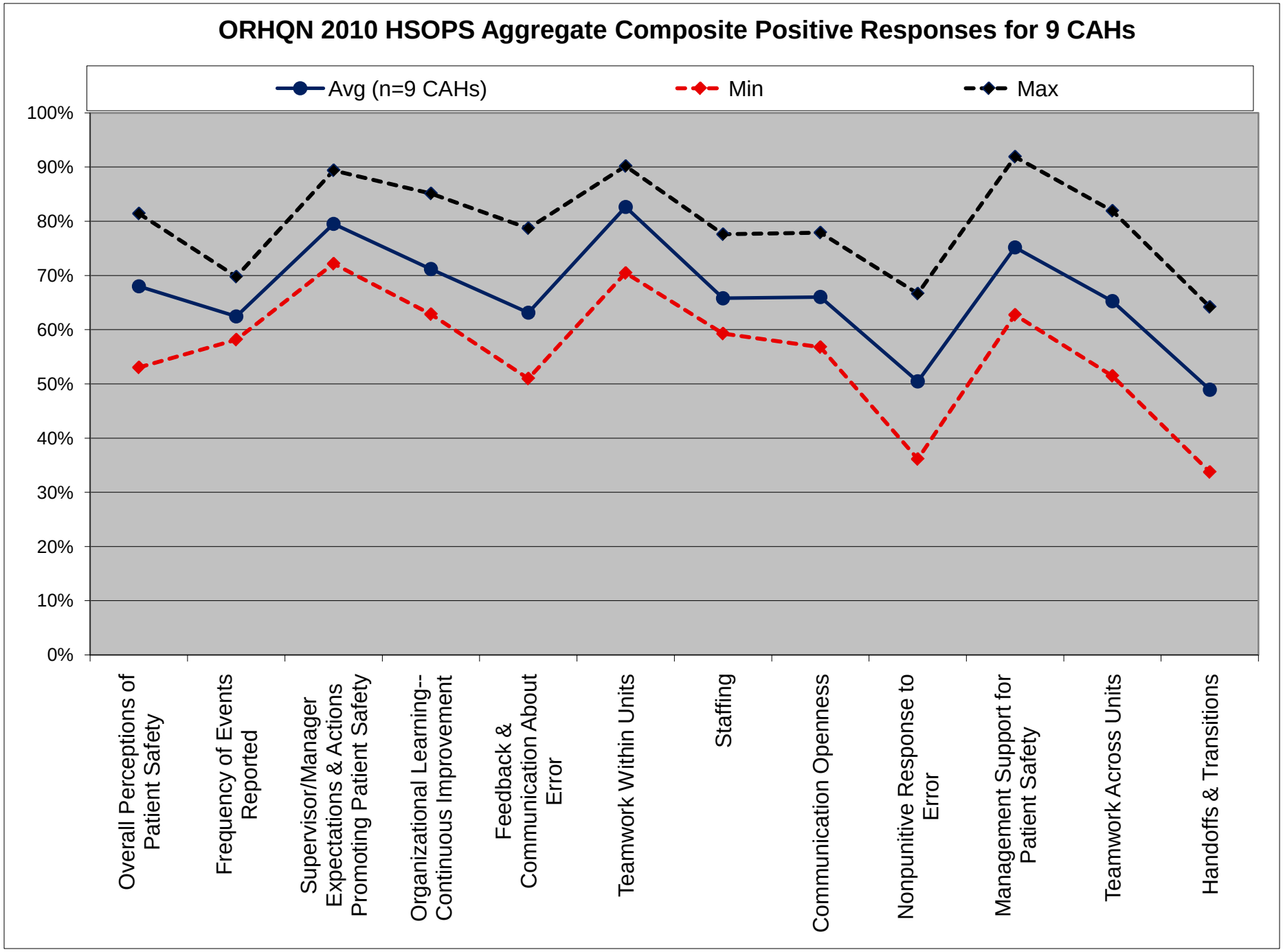
Reason's Components	HSOPS Dimensions or Outcome Measures
Reporting Culture - a safe organization is dependent on the willingness of front-line workers to report their errors and near-misses	• Frequency of Events Reported (O) • Number of Events Reported (O)
Just Culture - management will support and reward reporting; discipline occurs based on risk-taking	• Nonpunitive Response to Error (U)

O = Outcome measure
U = Measured at level of unit/department
H = Measured at level of hospital

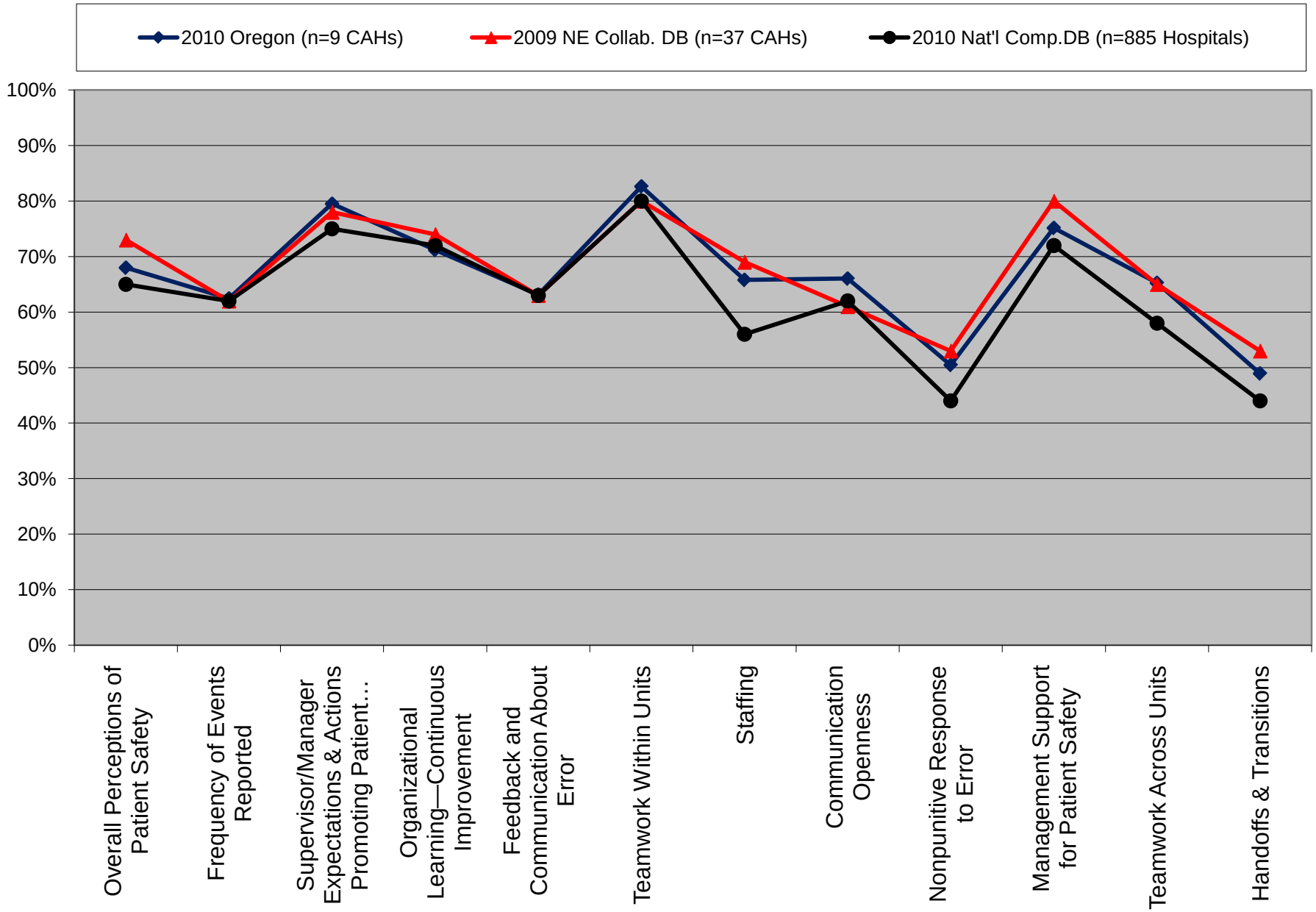
Reason's Components	HSOPS Dimensions or Outcome Measures
Flexible Culture - authority patterns relax when safety information is exchanged because those with authority respect the knowledge of front-line workers	• Teamwork w/in Units (U) • Staffing (U) • Communication Openness (U) • Teamwork ax Units (H) • Hospital Handoffs (H)
Learning Culture - organization will analyze reported information and then implement appropriate change	• Hospital Mgt Support (H) • Manager Actions (U) • Feedback & Communication (U) • Organizational Learning (U) • Overall Perceptions (O) • Patient Safety Grade (O)

External Benchmarking

- Peer Hospitals
  - 9 Oregon CAHs (2010, overall response 54% for 7 for whom we had data)
    - 718 respondents
  - 37 CAHs in Nebraska Collaborative (2009, overall response 75%)
    - 3,465 respondents
- National Comparative Database (2010, response rate 56%, 45% for web surveys)
  - 885 hospitals
  - 338,607 respondents


ORHQN 2010 HSOPS Aggregate Composite Positive Responses for 9 CAHs
Avg (n=9 CAHs)
Min
Max
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Overall Perceptions of Patient Safety
Frequency of Events Reported
Supervisor/Manager Expectations & Actions Promoting Patient Safety
Organizational Learning--Continuous Improvement
Feedback & Communication About Error
Teamwork Within Units
Staffing
Communication Openness
Nonpunitive Response to Error
Management Support for Patient Safety
Teamwork Across Units
Handoffs & Transitions

ORHQN 2010 HSOPS Average Composite Positive Responses Compared to 2009 NE Collaborative and 2010 National Database



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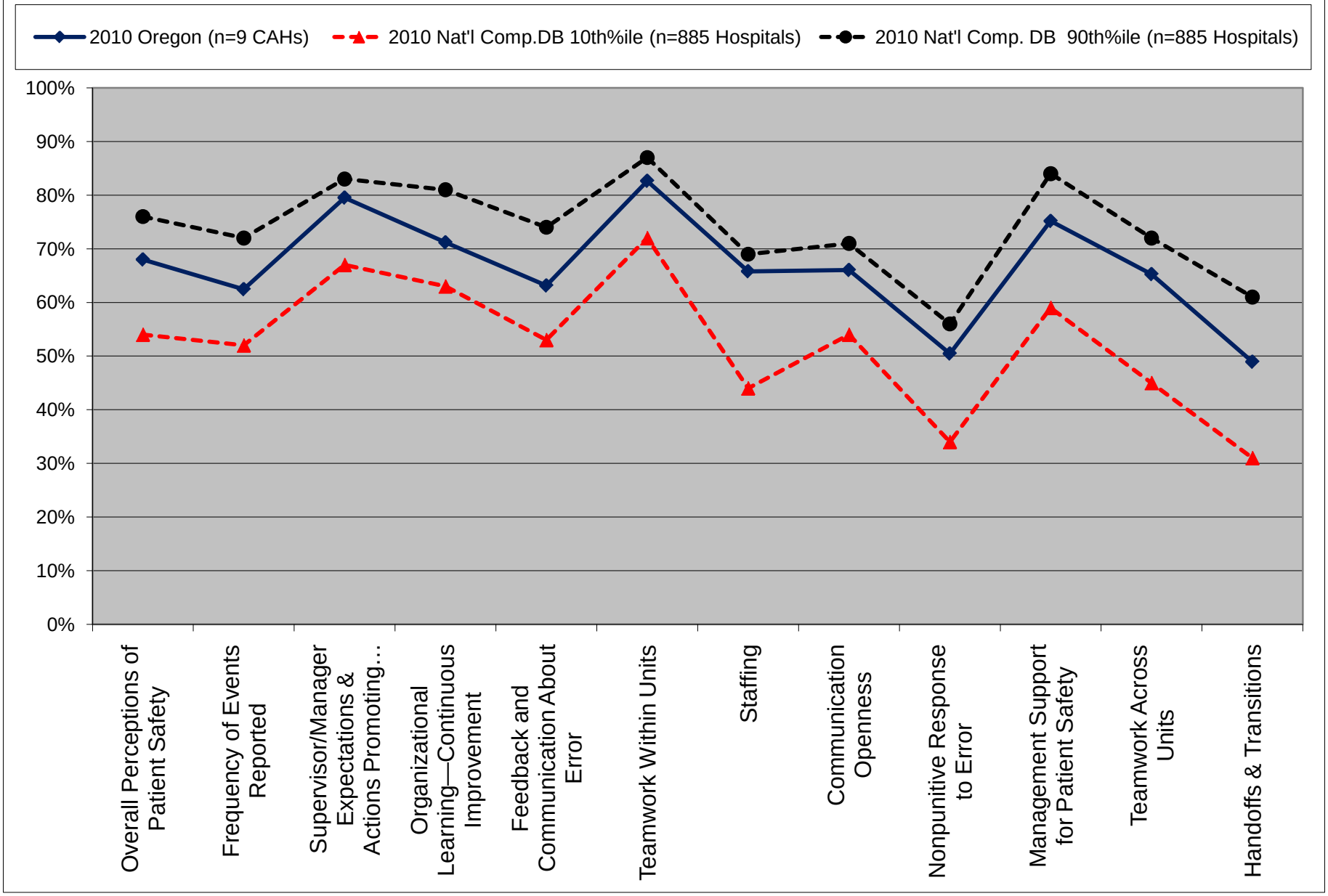

Identify Areas in Need of Improvement

Dimension	ORHQN Percent Positive	NE Collab. Percent Positive
Nonpunitive Response to Error (Just Culture)	50%	53%
Frequency of Events Reported (Reporting Culture)	62%	62%
Feedback & Communication About Error (Teamwork & Learning Cultures)	63%	63%
Teamwork Across Units (Teamwork Culture)	65%	65%
Staffing (Teamwork Culture)	66%	69%
Communication Openness (Teamwork Culture)	66%	61%
Overall Perceptions of Patient Safety	68%	73%
Organizational Learning--Continuous Improvement (Learning Culture)	71%	74%
Management Support for Patient Safety (Learning Culture)	75%	80%
Supervisor/Manager Expectations & Actions Promoting Patient Safety (Learning Culture)	80%	78%
Teamwork Within Units (Teamwork Culture)	83%	80%

Internal Benchmarking

- Compare aggregate results over time
- Compare results by work area and job title

Internal Benchmarking of Beliefs and Behaviors Over Time

Communication Openness (West Valley Data)	2010	2009	Change
1. Staff will freely speak up if they see something that may negatively affect patient care.	83%	87%	-4
2. Staff feel free to question the decisions or actions of those with more authority.	66%	52%	14
3. Staff are afraid to ask questions when something does not seem right.	84%	68%	16
Composite Score	78%	69%	

Internal Benchmarking of Beliefs and Behaviors Over Time

Overall Perceptions of Patient Safety (West Valley Data)	2010	2009	Change
1. It is just by chance that more serious mistakes don't happen around here.	85%	75%	10
2. Patient safety is never sacrificed to get more work done.	81%	78%	3
3. We have patient safety problems in this unit.	73%	83%	-10
4. Our procedures and systems are good at preventing errors from happening.	87%	79%	8
Composite Score	82%	80%	

Increase Awareness of Patient Safety Concepts

- High reliability organizations
- Preoccupied with failure
- Sensitive to how each team member affects a process
- Allow those who are most knowledgeable about a process to make decisions
- Resist temptation to blame individuals for errors within complex processes

Internal Benchmarking of Beliefs and Behaviors Across Work Areas/Units

Teamwork within Units (Baseline Sample from NE)	Acute/ Skilled (n=29)	ED (n=5)
1. People support one another in this unit.	86%	60%
2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	72%	100%
3. In this unit, people treat each other with respect.	76%	60%
4. When one area in this unit gets really busy, others help out.	55%	60%
Composite Score	72%	70%

Internal Benchmarking of Beliefs and Behaviors Across Job Titles

Nonpunitive Response to Error (Sample NE Data)	Admin/ Mgt (n=6)	Nurse (n=22)
1. Staff feel like their mistakes are held against them.	68%	59%
2. When an event is reported, it feels like the person is being written up, not the problem.	56%	49%
3. Staff worry that mistakes they make are kept in their personnel file.	53%	24%
Composite Score	59%	44%

Interpreting Results to Develop an Action Plan

- Anchor plan in history, mission, strategic goals
- Understand response rate (> 60% best)…are results generalizable?
- Wrap your mind around reverse worded questions
- Identify organization-wide areas in need of improvement
- Identify microcultures by work area/job title
  - Identify gaps between beliefs/behaviors within 4 components

Interpreting Results to Develop an Action Plan

- Identify practices in place that support 4 components within departments
- Relate open-ended comments to quantitative results
- Consider how management uses information
  - Close the loop with reporters
  - Reporting > Feedback > Learning > Reporting
- Explicit plan to strengthen 4 components within depts by implementing specific practices

Contact Information

Katherine Jones, PT, PhD

kjonesj@unmc.edu

Anne Skinner

askinner@unmc.edu

Toolkit to interpret HSOPS results

www.unmc.edu/rural/patient-safety