Interpreting Safety Culture Survey Results and Action Planning

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Oregon Rural Health Quality Network
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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

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


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


How to Become an HRO: Engage in Continuous Improvement

Measure Beliefs and Behaviors

Implement Practices

Action Plan
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
<table>
<thead>
<tr>
<th>Reason’s Components</th>
<th>HSOPS Dimensions or Outcome Measures</th>
</tr>
</thead>
</table>
| **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
<table>
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<th>Reason’s Components</th>
<th>HSOPS Dimensions or Outcome Measures</th>
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| **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

- 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

Avg (n=9 CAHs)
## Identify Areas in Need of Improvement

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

- Compare aggregate results over time
- Compare results by work area and job title
## Internal Benchmarking of Beliefs and Behaviors Over Time

<table>
<thead>
<tr>
<th>Communication Openness (West Valley Data)</th>
<th>2010</th>
<th>2009</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff will freely speak up if they see something that may negatively affect patient care.</td>
<td>83%</td>
<td>87%</td>
<td>-4</td>
</tr>
<tr>
<td>2. Staff feel free to question the decisions or actions of those with more authority.</td>
<td>66%</td>
<td>52%</td>
<td>14</td>
</tr>
<tr>
<td>3. Staff are afraid to ask questions when something does not seem right.</td>
<td>84%</td>
<td>68%</td>
<td>16</td>
</tr>
<tr>
<td><strong>Composite Score</strong></td>
<td>78%</td>
<td>69%</td>
<td></td>
</tr>
</tbody>
</table>
### Internal Benchmarking of Beliefs and Behaviors Over Time

#### Overall Perceptions of Patient Safety (West Valley Data)

<table>
<thead>
<tr>
<th>Statement</th>
<th>2010</th>
<th>2009</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. It is just by chance that more serious mistakes don’t happen around here.</td>
<td>85%</td>
<td>75%</td>
<td>10</td>
</tr>
<tr>
<td>2. Patient safety is never sacrificed to get more work done.</td>
<td>81%</td>
<td>78%</td>
<td>3</td>
</tr>
<tr>
<td>3. We have patient safety problems in this unit.</td>
<td>73%</td>
<td>83%</td>
<td>-10</td>
</tr>
<tr>
<td>4. Our procedures and systems are good at preventing errors from happening.</td>
<td>87%</td>
<td>79%</td>
<td>8</td>
</tr>
</tbody>
</table>

#### Composite Score

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score</td>
<td>82%</td>
<td>80%</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Teamwork within Units (Baseline Sample from NE)</th>
<th>Acute/Skilled (n=29)</th>
<th>ED (n=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. People support one another in this unit.</td>
<td>86%</td>
<td>60%</td>
</tr>
<tr>
<td>2. When a lot of work needs to be done quickly, we work together as a team to get the work done.</td>
<td>72%</td>
<td>100%</td>
</tr>
<tr>
<td>3. In this unit, people treat each other with respect.</td>
<td>76%</td>
<td>60%</td>
</tr>
<tr>
<td>4. When one area in this unit gets really busy, others help out.</td>
<td>55%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Composite Score</strong></td>
<td><strong>72%</strong></td>
<td><strong>70%</strong></td>
</tr>
</tbody>
</table>
# Internal Benchmarking of Beliefs and Behaviors Across Job Titles

## Nonpunitive Response to Error (Sample NE Data)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Admin/ Mgt (n=6)</th>
<th>Nurse (n=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff feel like their mistakes are held against them.</td>
<td>68%</td>
<td>59%</td>
</tr>
<tr>
<td>2. When an event is reported, it feels like the person is being written up, not the problem.</td>
<td>56%</td>
<td>49%</td>
</tr>
<tr>
<td>3. Staff worry that mistakes they make are kept in their personnel file.</td>
<td>53%</td>
<td>24%</td>
</tr>
</tbody>
</table>

### Composite Score

Admin/ Mgt: 59%
Nurse: 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
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Toolkit to interpret HSOPS results
www.unmc.edu/rural/patient-safety