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Culture of Safety

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Culture of Safety Definition

The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of an organization's health and safety management.

Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.

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Who should complete the survey?

The *Hospital Survey on Patient Safety Culture* examines patient safety culture from a hospital staff perspective. The survey can be completed by all types of hospital staff from housekeeping and security, to nurses and physicians.

<u>The survey is best suited for the following:</u>

- **Hospital staff who have direct contact or interaction with patients (clinical staff such as nurses, or nonclinical staff such as unit clerks)**
- **Hospital staff who may not have direct contact or interaction with patients but whose work directly affects patient care (staff in units such as pharmacy, laboratory/pathology)**
- **Hospital employed physicians who spend most of their work hours in the hospital (ED physicians, hospitalists, pathologists); and**
- **Hospital supervisors, managers, and administrators**

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AHRQ Hospital Survey on Patient Safety Culture

- **The *Hospital Survey on Patient Safety Culture* was sponsored by the Quality Interagency Coordination Task Force (QuIC), a group established to ensure that all Federal agencies involved in purchasing, providing, studying, or regulating health care services are working together and toward a common goal of improving quality care.**

- **The survey was funded by the Agency for Healthcare Research and Quality (AHRQ).**

- **The development of this safety culture assessment tool included a review of published and unpublished safety culture assessment tools and the scientific literature pertaining to safety, error and accidents, as well as error reporting.**

- **Hospital employees and managers were interviewed to identify key patient safety and error reporting issues.**

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Value to Hospitals of Participating in the TCPS Survey

You can't fix what you don't measure

•Survey results provide:

- Demographic characteristics of responders

- Four overall patient safety outcomes:
  1) Overall perceptions of safety
  2) Frequency of events reported
  3) Number of events reported
  4) Overall patient safety grade

- Scores on ten dimensions of culture pertaining to patient safety

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Demographic Data for Respondents, Tennessee Hospital, 2008

1. Primary hospital work area, department or clinical area where respondents spend most of their work time:

6%	Many different units / No specific unit	9%	Intensive care unit (any type)
12%	Medicine (non-surgical)	0%	Psychiatry / mental health
10%	Surgery	4%	Rehabilitation
5%	Obstetrics	6%	Pharmacy
4%	Pediatrics	12%	Laboratory
1%	Emergency department	5%	Radiology
26%	Other	1%	Anesthesiology

2. Staff position in the hospital:

41%	Registered nurse	2%	Pharmacist
0%	Physician assistant / Nurse practition	1%	Dietician
5%	LVN / LPN	7%	Unit assistant / Clerk / Secretary
2%	Patient care asst / Aide / Care partne	1%	Respiratory therapist
0%	Attending / Staff physician	3%	Physical, occupational, or speech therapist
0%	Resident physician / Physician in trai	15%	Technician (e.g., EKG, Lab, Radiology)
18%	Other	6%	Administration / Management

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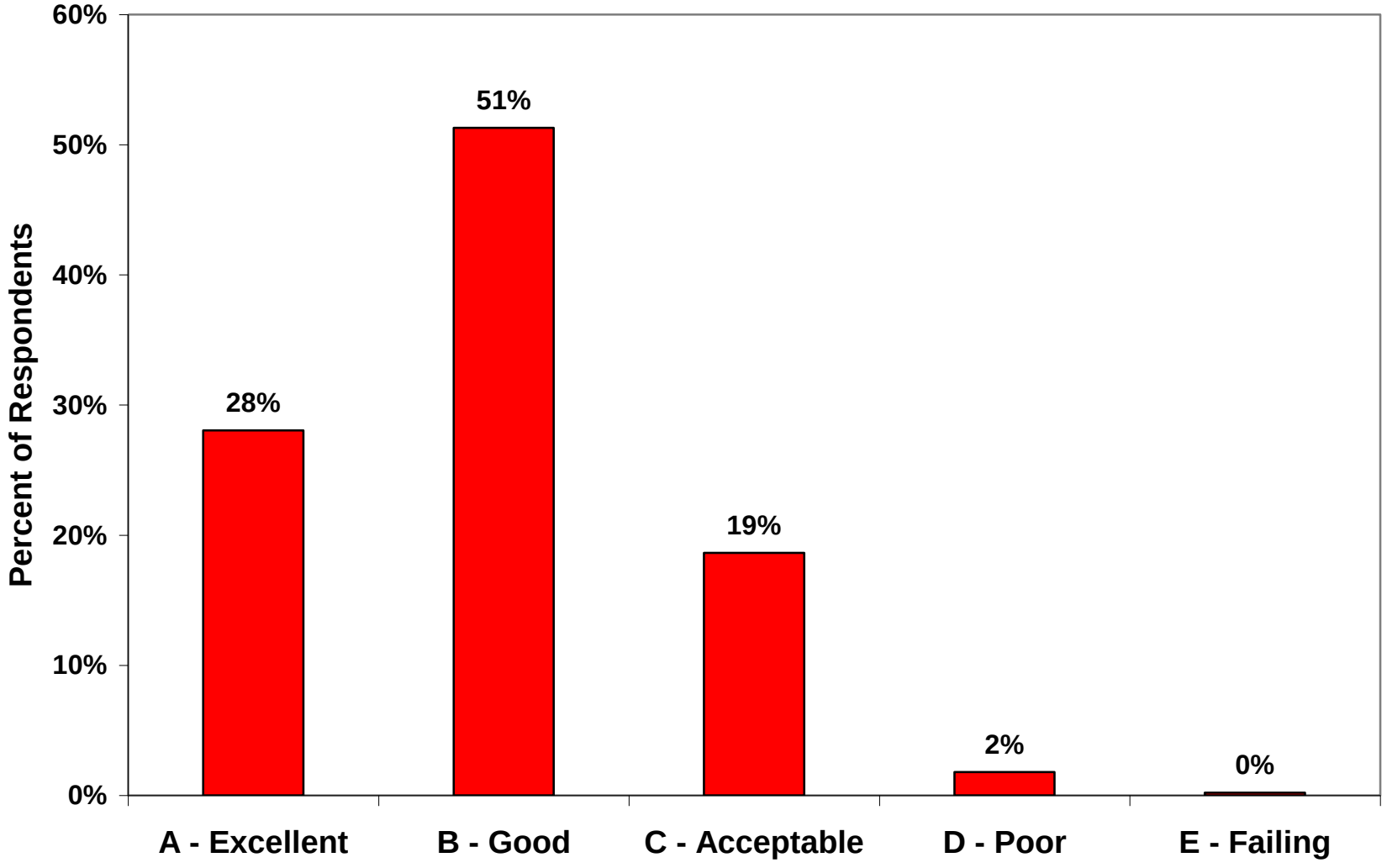
Overall Patient Safety Grade

Tennessee Hospital, 2008

Please give your work area/unit in this hospital an overall grade on patient safety.



Note: 0% of respondents did not answer

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Safety Culture Dimensions Measured in the Survey

The survey places an emphasis on patient safety issues and on error and event reporting. The survey measures seven unit-level aspects of safety culture:

- Supervisor/Manager Expectations & Actions Promoting Safety (4 items),
- Organizational Learning—Continuous Improvement (3 items),
- Teamwork Within Units (4 items),
- Communication Openness (3 items),
- Feedback and Communication About Error (3 items),
- Nonpunitive Response to Error (3 items), and
- Staffing (4 items).

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In addition, the survey measures three hospital-level aspects of safety culture:

1) Hospital Management Support for Patient Safety (3 items)
2) Teamwork Across Hospital Units (4 items)
3) Hospital Handoffs and Transitions (4 items)

Finally, four outcome variables are included:

1) Overall perceptions of Safety (4 items)
2) Frequency of Event Reporting (3 items)
3) Patient Safety Grade (of hospital unit) (1 item)
4) Number of Events Reported (1 item)

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Tennessee Hospital Safety Culture Composite Scores, 2008

Safety Culture Composites	Tennessee Hospital's Composite Score Average % of positive responses	2008 National Comparative Data from AHRQ Average % of positive responses
Overall Perceptions of Safety (4 items--% Agree/Strongly Agree)	68%	64%
Frequency of Events Reported (3 items--% Most of the time/Always)	71%	60%
Supervisor/Manager Expectations & Actions Promoting Patient Safety (4 items--% Agree/Strongly	83%	75%
Organizational Learning--Continuous Improvement (3 items--% Agree/Strongly Agree)	79%	70%
Teamwork Within Units (4 items--% Agree/Strongly Agree)	80%	79%
Communication Openness (3 items--% Most of the time/Always)	67%	62%
Feedback & Communication About Error (3 items--% Most of the time/Always)	68%	62%
Nonpunitive Response to Error (3 items--% Agree/Strongly Agree)	42%	44%
Staffing survey items (4 Items --% Agree/Strongly Agree)	56%	55%
Hospital Management Support for Patient Safety (3 items--% Agree/Strongly Agree)	74%	70%
Teamwork Across Hospital Units (4 survey items--% Agree/Strongly Agree)	57%	57%
Hospital Handoffs & Transitions (4 survey items--% Agree/Strongly Agree)	43%	45%

519 hospitals and 160,176 hospital staff respondents are included in the AHRQ national comparative data.

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Tennessee Hospital 2008 Overall Facility Score

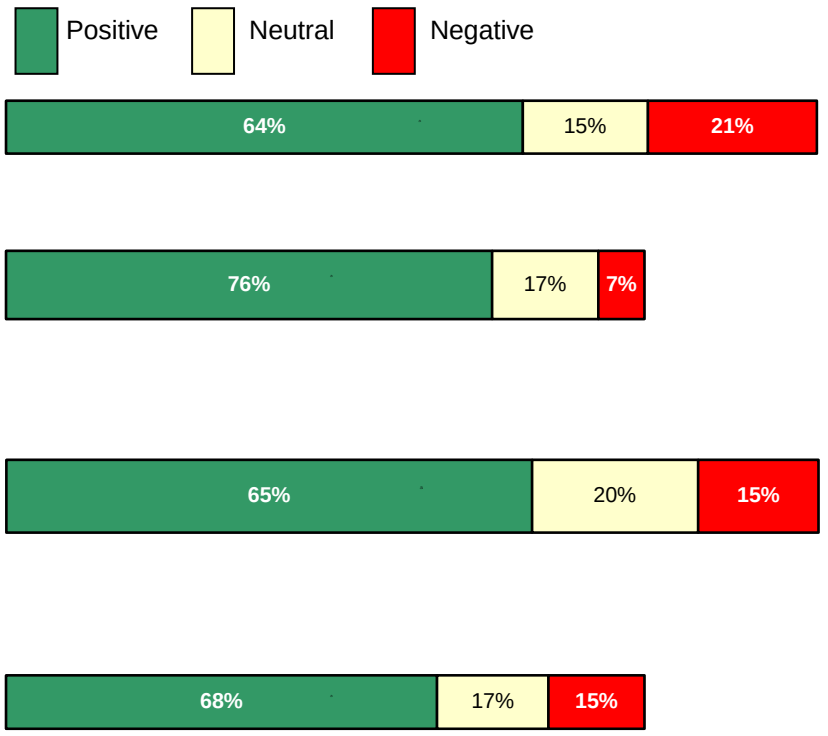
Overall Perceptions of Safety

1. Patient safety is never sacrificed to get more work done.

2. Our procedures and systems are good at preventing errors from happening.

R3. It is just by chance that more serious mistakes don't happen around here.

R4. We have patient safety problems in this unit.



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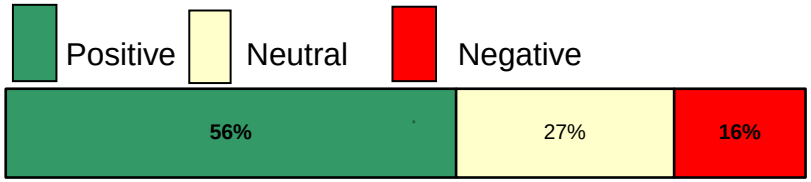
Tennessee Hospital 2008 Overall Facility Score

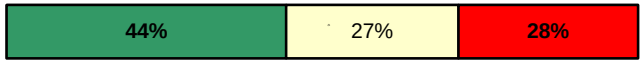
Teamwork Across Hospital Units

1. There is good cooperation among hospital units that need to work together. (F4)



2. Hospital units work well together to provide the best care for patients. (F10)

R3. Hospital units do not coordinate well with each other. (F2)



R4. It is often unpleasant to work with staff from other hospital units. (F6)

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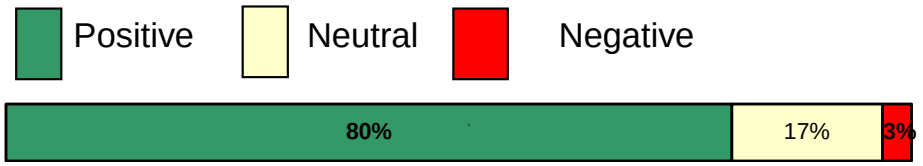
Tennessee Hospital 2008 Overall Facility Score

Communication Openness

1. Staff will freely speak up if they see something that may negatively affect patient care. (C2)



2. Staff feel free to question the decisions or actions of those with more authority. (C4)

R3. Staff are afraid to ask questions when something does not seem right. (C6)

Graphs also are available by specific job titles (RN, PT, dietician…) work areas (ICU, medicine, pharmacy…) and whether or not the employee has direct contact with patients (yes or no)

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Survey Respondent Comments from Tennessee Hospital 2008

- With our current staff level and the expectations of some departments, we often feel that we are living on the edge as far as committing serious errors.
- I am not certain the management team is on the same page in regards to patient safety.
- I think the hospital strives daily to maintain a safe and error free environment. I feel that if there are errors made they are addressed immediately.
- Staffing is my main concern, not enough staff or some staff (same people) do not work together well thus making pt. safety issues a real concern. Poor staffing is not healthy for anyone.
- I can only speak for my own department. There is so much equipment we use on patients there should be more biomed techs to check equipment monthly, not after there is a breakdown.
- Event reporting is loose in my area, not enough guidelines taught to us about what does and does not need to be reported.
- I feel we are making progress with patient safety, however, shift reports and dissemination of patient information to staff is lacking.
- I think our hospital should be more proactive in giving feedback about errors and make the data available to everyone. Often times it seems as though quality data is kept a secret here.

HOSPITAL SURVEY ON PATIENT SAFETY CULTURE

Action Planning

Hospital _____ Date _____

1. Background Information

1.a Date of most recent HSOPS mo _____ Year _____

1.b Has the HSOPS been conducted previously in your organization? YES _____ NO _____

1.c If Yes, what were the previous dates? mo _____ Year _____

_____ _____

_____ _____

1.d If yes, what was the previous impact and are action plans and change teams still functional?

1.e Describe your organization's overall vision, which may include your mission, vision and values:

1.f List your organization's strategic goals.

2. Response Rate [ ]. A response rate of 50% or greater ensures that survey results are likely to be representative of those surveyed. If your rate is less than 50%, consider how responders and non-responders might differ. A response rate of 60% or greater is ideal.

3. Identify overall strengths and weaknesses. For your aggregate hospital results, identify the three dimensions with the highest and the three dimensions with the lowest percent positive scores.

Top Three Dimensions (Strengths)	% +	Bottom Three Dimensions (Weakness)	% +

4. Identify how the four components of safety culture vary across your organization by work area. Use the Demographics Tab in the Excel Tool to identify the work areas by which you can sort your data. Enter the percent positive for each survey item by work area in the table below. The table categorizes survey items by the four components of safety culture. Paste additional copies of the table to accommodate the number of work areas by which you can sort your HSOPS data.

Survey Dimension and Items for Work Areas	% Work Area 1 Respond Positively	% Work Area 2 Respond Positively	% Work Area 3 Respond Positively
REPORTING CULTURE			
Frequency of Events Reported: (Behavior) When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?			
JUST CULTURE			
Nonpunitive Response to Error: (Belief) When an event is reported, it feels like the person is being written up, not the problem.[R]			
Nonpunitive Response to Error: (Belief) Staff worry that mistakes they make are kept in their personnel file.			
FLEXIBLE (TEAMWORK-ORIENTED) CULTURE			
Teamwork Within Departments: (Belief) People support one another in this department.			
Teamwork Within Departments: (Behavior) When one area in this department gets really busy, others help out.			
Staffing: (Belief) We have enough staff to handle the workload.			
Communication Openness: (Belief) Staff will freely speak up if they see something that may negatively affect patient care.			
Communication Openness: (Behavior) Staff feel free to question the decisions or actions of those with more authority.			
Hospital Handoffs & Transitions: (Behavior) Problems often occur in the exchange of information across hospital departments.[R]			

LEARNING CULTURE			
Feedback and Communication About Error: (Behavior) We are informed about errors that happen in this department.			
Feedback and Communication About Error: (Behavior) We are given feedback about changes put into place based on event reports.			
Supervisor/Manager Expectations & Actions Promoting Patient Safety: (Behavior) My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.			
Hospital Management Support for Patient Safety: (Belief) Hospital management seems interested in patient safety only after an adverse event happens. [R]			
Organizational Learning—Continuous Improvement: (Behavior) After we make changes to improve patient safety, we evaluate their effectiveness.			
Organizational Learning—Continuous Improvement: (Belief) Mistakes have led to positive changes here.			
HIGH RELIABILITY ORGANIZATION			
Overall Perceptions of Safety: (Belief) Our procedures and systems are good at preventing errors from happening.			

R = Reverse worded question for which "Strongly Disagree" and "Disagree" are positive responses.

5. Identify how the four components of safety culture vary across your organization by job title. Use the Demographics Tab in the Excel Tool to identify the staff positions (job titles) by which you can sort your data. Be sure to include Administration/ Management. Enter the percent positive for each survey item by staff position/job title in the table below. The table categorizes survey items by the four components of safety culture. Paste additional copies of the table to accommodate the number of staff position/job titles by which you can sort your HSOPS data.

Survey Dimension and Items for Job Titles	% Admin/Mgt Respond Positively	% Job Title 2 Respond Positively	% Job Title 3 Respond Positively
REPORTING CULTURE			
Frequency of Events Reported: (Behavior) When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?			
JUST CULTURE			
Nonpunitive Response to Error: (Belief) When an event is reported, it feels like the person is being written up, not the problem.[R]			
Nonpunitive Response to Error: (Belief) Staff worry that mistakes they make are kept in their personnel file.			
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Staffing: (Belief) We have enough staff to handle the workload.			
Communication Openness: (Belief) Staff will freely speak up if they see something that may negatively affect patient care.			
Communication Openness: (Behavior) Staff feel free to question the decisions or actions of those with more authority.			

6. Rate the extent to which the practices that support the four components of safety culture are in place within work areas. Use the following scale:

0 = Not in place 1 = ineffective 2 = moderately effective 3 = very effective NA = not applicable

	Work Areas					
Reporting Practices	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Formal Reporting of adverse events with standardized taxonomies						
Near misses reported, valued, and learned from						
Informal Reporting – Safety Briefings						
Informal Reporting – Leadership WalkRounds						
Just Culture Practices						
Training provided on role of human factors in error						
Training provided on active vs. latent sources of error						
Managers use Unsafe Acts Algorithm to determine accountability						
Policy/procedures in place to manage disruptive behaviors						
Teamwork Leadership						
Huddles, Briefs, Debriefs to manage workload						
Teamwork Situation Monitoring						
Cross Monitoring						
STEP						

Based upon your knowledge of how safety culture varies within your organization and your ratings of the extent to which safety culture practices are in place, complete the following 10 step action plan.

Step 1: Define the problem, challenge, opportunity

We need to strengthen our REPORTING CULTURE because (be specific by identifying low percent positive scores across the organization and within work areas/job titles):

We can do this by (be specific about the practices needed across the hospital and within work areas/job titles):

We need to strengthen our JUST CULTURE because (be specific by identifying low percent positive scores across the organization and within work areas/job titles):

We can do this by (be specific about the practices needed across the hospital and within work areas/job titles):

Step 2: Create the change team (choose members based on influence/willingness, relevance to problem, challenge, opportunity)

NAME	ROLE

Step 3: Define your aim(s)/goals

What will be achieved?

What departments will be involved?

Step 5: Design an intervention

Hospital as a whole:

Units/departments of focus:

Which tools/strategies:

Step 5: Decide Measures for your intervention (consider integrating into Balanced Scorecard)

- Observations
- Counts (e.g. # Briefs, # Reports, #RCAs, # WalkRounds)
- Outcome measures: Fall rate; rate of appropriate pre-op antibiotic usage

Step 6: Develop a plan

What	When
Obtain support from Management, Medical Staff, and Board by sharing results of Benchmark Graphs	
Provide Feedback to Department Heads by sharing aggregate and department specific graphs and results	
Departments engage in action planning reflecting aggregate hospital weaknesses or specific department weaknesses	
Communicate aims, goals of plan at hospital and department levels	
Conduct necessary training	
Ensure policies/procedures support action plans	

Step 7: How will you sustain and spread changes embedded in the action plans?

Role modeling

Step 8: Communication Plan

Stakeholder analysis (who needs to provide support, who needs to be brought over to your side)

Elevator Speech:

We have chosen to focus on _____.

It is important that we improve _____ because

_____ puts our patients at risk and

impacts our performance. We need you to support our efforts by _____

_____.

Step 9: Write your final action plan covering steps 1 – 8.

Step 10: Review of plan by key personnel