Interpreting Hospital SOPS Results and Action Planning

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Resident & Patient Safety Learning Collaborative #1
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Objectives

- Identify four components of a culture of patient safety
  - Develop a working definition of 'culture of patient safety'
- Explain the role of culture assessment in a program of patient safety
  - Recognize three types of organizational culture
- Use dimension level results to identify variation in safety culture by work area and job title
- Use item level results to compare beliefs and behaviors within HSOPS dimensions
  - Identify practices needed to support a culture of safety
- Use a structured action plan to describe your hospital's next steps in creating a culture of

The Problem and Challenge…

"The problem is not bad people; the problem is that the system needs to be made safer . . ."

IOM (2000). To Err is Human: Building a Safer Health System

"The biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm."

IOM (2001). Crossing the Quality Chasm: A New Health System for the 21st Century, p. 79

Definition of Safety Culture

- 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.

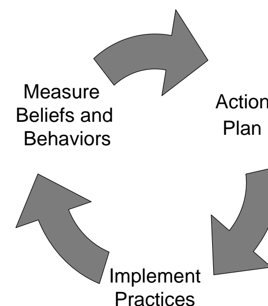
Components of Safety Culture

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 Safety Culture in Healthcare with SOPS Family of Surveys

- Patient Safety Culture Surveys funded by AHRQ and developed by Westat to support a culture of patient safety and quality improvement in the Nation's health care system http://www.ahrq.gov/qual/patientsafetyculture/
  - Hospital Survey on Patient Safety Culture (HSOPS) 11/04
  - Nursing Home Survey on Patient Safety Culture (NHSOPS) 12/08
  - Medical Office Survey on Patient Safety Culture (MOSOPS) 12/08

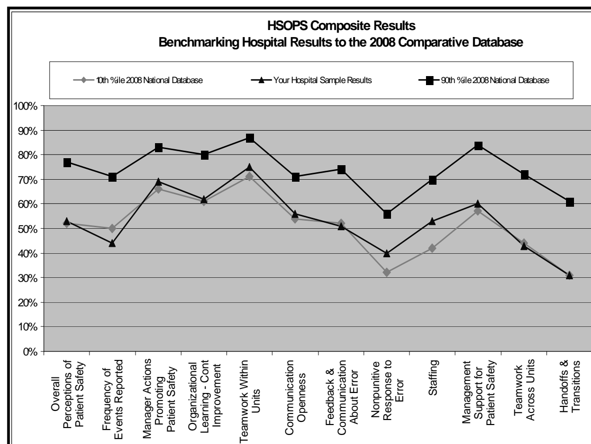
HSOPS

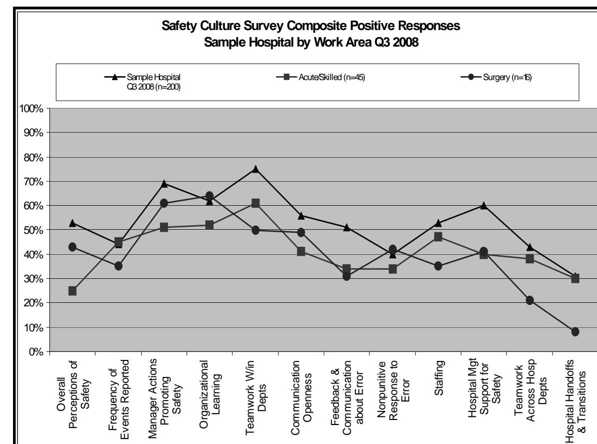
- Survey tool kit available http://www.ahrq.gov/qual/patientsafetyculture/
- 2008 Comparative Database for Benchmarking
  - 519 hospitals and 160,176 hospital staff respondents
- 42 items categorized in 12 dimensions
  - 2 dimensions outcome measures at dept/unit level
  - 7 dimensions measure culture at dept/unit level
  - 3 dimensions measure culture at hospital level
- 2 additional items are outcome measures at dept/unit level

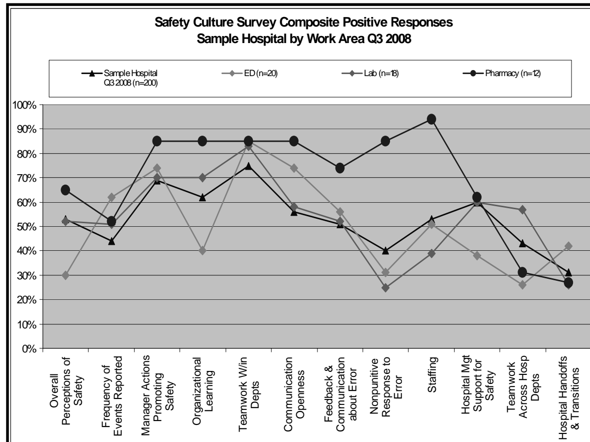
Reason's Components	HSOPS Dimensions or Outcome Measures
Reporting Culture - a safe organization is dependent on the willingness of front-line workers to report their errors and near-misses	•Frequency of Events Reported (O) •Number of Events Reported (O)
Just Culture - management will support and reward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

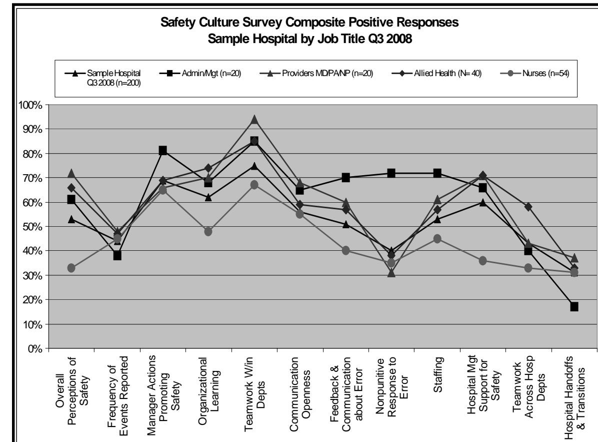
O = Outcome measure
U = Measured at level of unit/department
H = Measured at level of hospital

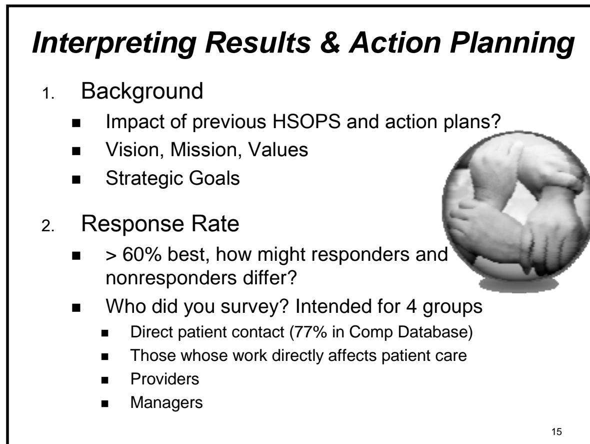
Reason's Components	HSOPS Dimensions or Outcome Measures
Flexible Culture - authority patterns relax when safety information is exchanged because those with authority respect the knowledge of front-line workers	•Teamwork w/in Units (U) •Staffing (U) •Communication Openness (U) •Teamwork ax Units (H) •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)











Interpreting Results & Action Planning

1. Background
   - Impact of previous HSOPS and action plans?
   - Vision, Mission, Values
   - Strategic Goals
2. Response Rate
   - > 60% best, how might responders and nonresponders differ?
   - Who did you survey? Intended for 4 groups
     - Direct patient contact (77% in Comp Database)
     - Those whose work directly affects patient care
     - Providers
     - Managers

Interpreting Results & Action Planning

3. Overall Strengths and Weaknesses guide organization-wide interventions
   - Strengths from National Database
     - Teamwork w/in units (79%)
     - Manager actions promoting safety (75%)
     - Management support for patient safety (70%)
   - Weaknesses from National Database
     - Staffing (55%)
     - Handoffs & Transitions (45%)
     - Nonpunitive Response to Error (44%)

Interpreting Results & Action Planning

4. Identify microcultures by work area…from benchmark graphs
   - Work areas above aggregate
   - Work areas below aggregate
   - Patterns of potential deviations
     - Frequency of events reported lower
     - Relationship between communication, feedback and learning
     - Nonupunitive response to error very low
     - High perceptions of teamwork within units, low perception of teamwork across units
     - Low Manager Actions

Interpreting Results & Action Planning

4. Identify microcultures by work area at the item level to target specific interventions by department (see Action Planning Work Sheet)

   - Reporting systems
   - Just Culture
   - Teamwork skills…huddles, mutual support
   - Communication openness…CUS
   - Feedback
   - Handoffs and Transitions…I PASS the BATON

Interpreting Results & Action Planning

5. Identify microcultures by job title at the item level (see Action Planning Work Sheet)

- Is management more or less positive than front-line workers?
- How do nursing and allied health compare?
- Intended to target specific interventions by position/job title
  - Leadership WalkRounds
  - Unsafe Act's Algorithm
  - Team work skills
  - Root Cause Analysis

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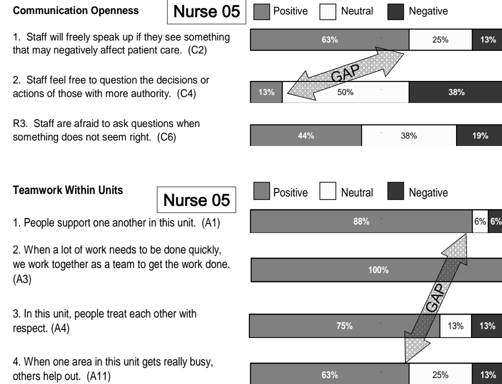
Gaps Between Beliefs & Behaviors



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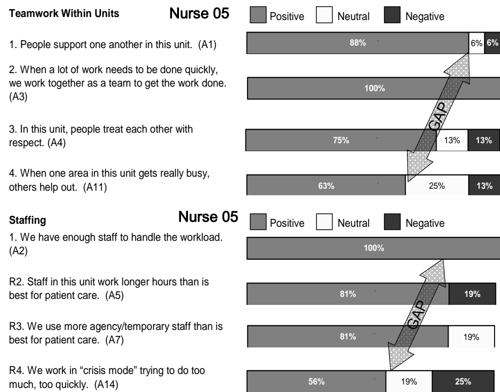
Gaps Between Beliefs & Behaviors



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Interpreting Results & Action Planning

7. Code Comments by Theme (See examples)

- On average 15% of respondents provide a comment
  - Themes reflect components of culture…reporting, just culture, teamwork, learning
  - Feedback about effectiveness of safety systems
  - Disruptive behavior
  - Safety Concerns
- Comments are gifts! Acknowledge and place in context

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6. Practices that Support a Reporting Culture

- Successful reporting systems (Leape, 2002)
  - Nonpunitive
  - Confidential
  - Independent
  - Expert analysis
  - Timely
  - Systems-oriented
  - Responsive
- Practices/Tools
  - Reporting Form
  - Standardized taxonomy
  - Near miss log
  - Chart audit
  - Secret Shopper
  - Safety Briefings
  - Leadership WalkRounds™
  - Bulletin board/ suggestion box/telephone hotline

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6. Practices that Support a Just Culture

Practices/Tools

- Understanding human error (Reason 2003, 2006)
  - Active errors (sharp end)
  - Latent errors
- Just Culture and behavior (Marx, 2001)
  - Conduct: human error, negligence, reckless, intentional rule violation
  - Disciplinary decision-making: outcome-based, rule-based, risk-based
- Unsafe Acts Algorithm
- Disruptive Behavior Policy/Standards

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6. Practices that Support a Just Culture

A "just culture" requires an understanding of the nature of human error.

Losses

Hazards

Human Error	Negligent Conduct
Missed exit XR not reg	Run stop sign Adult dose vs. flush
Reckless Conduct	**Knowing Violations**
Cell phone & drunk Refuse time out	U Turn No 5 Rights

Reason, J. (1997). *Managing the risks of organizational accidents.*

Marx, D. (1997). *Patient safety and the "just culture:" A primer for health care executives.*

Execute Just Culture . . . UNSAFE ACTS ALGORITHM

Were the actions as intended? — NO → Evidence of illness or substance use? — NO → Knowingly violated safe procedures? — NO → Pass substitution test? (Could someone else have done the same thing)? — YES → History of unsafe acts?

Were the actions as intended? — YES → Were the consequences as intended? — YES → Sabotage, malevolent damage

Were the consequences as intended? — NO → Evidence of illness or substance use?

Evidence of illness or substance use? — YES → Known medical condition? — NO → Substance abuse without mitigation; YES → Substance use with mitigation

Knowingly violated safe procedures? — YES → Were procedures available, workable, intelligible, correct and routinely used? — YES → Possible reckless violation; NO → System induced violation

Pass substitution test? — NO → Deficiencies in training, selection, or inexperienced? — YES → System induced error; NO → Possible negligent behavior

History of unsafe acts? — NO → Blameless error; YES → Blameless error, corrective training, counseling indicated

Culpable — Gray Area — Blameless

Adapted from James Reason. (1997). *Managing the Risks of Organizational Accidents.*

6. Practices that Support a Flexible Culture

TeamSTEPPS

Team Strategies & Tools to Enhance Performance & Patient Safety

PERFORMANCE

Leadership

Communication

Situation Monitoring

Mutual Support

SKILLS

KNOWLEDGE

ATTITUDES

PATIENT CARE TEAM

Individuals Operate within Teams

We must acknowledge the impact of disruptive behavior on individuals if they are to effectively use TeamSTEPPS skills.

Valuing individuals and treating them with respect is the foundation of effective communication and teamwork.

PERFORMANCE

SKILLS

KNOWLEDGE

ATTITUDES

INDIVIDUALS FEEL VALUED

INDIVIDUALS ARE TREATED WITH RESPECT

The Importance of Teams in Organizational Learning

"Teams are the fundamental learning units in modern organizations. Unless teams can learn, organizations cannot learn."

Peter Senge (1990). *The Fifth Discipline: The Art and Practice of the Learning Organization*. New York: Doubleday Currency, p. 10.

6. Reporting, Just, and Flexible practices support *Learning*

Ultimately, the willingness of workers to report depends on their belief that the organization will analyze reported information and then implement appropriate change—organizational practices support a *learning culture*.

Practices/Tools

- Individual RCA
- Aggregate RCA
- FMEA
- Safety Briefings
- Leadership WalkRoundsTM
- Close the loop with reporting…feedback

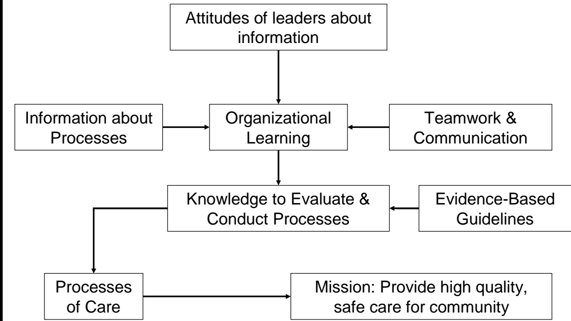
What is a learning culture?

- It observes and collects data
- It reflects and draws correct conclusions from information systems
- It creates and plans change based on information
- It has the will to act and implement change

"Learning disabilities are tragic in children, but they are fatal in organizations." -- Peter Senge

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

Determinants of Learning Culture



Adapted from Westrum (2004) & Firth-Cozens, J. Cultures for improving patient safety through learning: the role of teamwork. *Quality and Safety in Health Care* 2001;10:26-31.

Typology of Organizational Cultures

- Pathological—use of information to enhance personal power
  - Punitive environment
- Bureaucratic—use of information to adhere to rules, positions, and protect turf
  - Information collected but use of information for learning and change is limited
- Generative—use of information to achieve the mission
  - Practices interact to support 4 components

Westrum, R. A typology of organizational cultures. *Quality and Safety in Healthcare* 2004;13:22-27.

Typology of Organizational Cultures

Pathological	Bureaucratic	Generative
Low cooperation	Rule oriented	Performance oriented
Messengers shot	Messengers neglected	Messengers encouraged
Responsibilities shirked	Responsibilities are narrow	Responsibilities are shared

Westrum, R. A typology of organizational cultures. *Quality and Safety in Healthcare* 2004;13:2-27.

Typology of Organizational Cultures

Pathological	Bureaucratic	Generative
Sharing info across depts discouraged	Sharing info across depts tolerated	Sharing info across depts encouraged
Failure → scapegoating	Failure → Justice	Failure → Inquiry
Change → crushed	Change → problem	Change → implemented

Westrum, R. A typology of organizational cultures. *Quality and Safety in Healthcare* 2004;13:2-27.

10 Step Action Plan

1. Use Background Steps 4 – 7 to define the problem, challenge, opportunity
   - We need to strengthen our Just Culture because the majority of staff believe mistakes are kept in their personnel file, and there are significant numbers of comments that reflect disruptive behavior.
   - We will do this by training all managers to use the Unsafe Acts Algorithm and implementing a policy/procedure to manage disruptive behavior.

10 Step Action Plan

2. Create the change team
3. Define aims and goals…see examples
4. Design an intervention
   - Transformational…hospital as a whole e.g. Just Culture, Disruptive Behavior
   - Unit/dept specific
   - Identify tools and strategies
5. Decide on measures
6. Develop a plan

10 Step Action Plan

7. Sustain and spread the change
8. Communication plan…Elevator Speech

We have chosen to focus on managing disruptive behavior. It is important that we enable employees to recognize and report disruptive behavior because this behavior puts our patients at risk and impacts our performance. We need you to support our efforts by completing this survey of the frequency of disruptive behaviors in our organization and reporting these behaviors to our new interdisciplinary staff relations committee.

9. Write the final plan
10. Review plan by key personnel

Summary: Role of HSOPS

- Measure beliefs and behaviors needed to create an infrastructure for patient safety and QI
- Raise awareness about role of culture
- Identify impairments in organizational learning
- Evaluate effectiveness of patient safety interventions over time within an organization
- Conduct internal & external benchmarking
- Meet regulatory requirements

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

Jones, Skinner, Xu, Sun, Mueller. (2008). The AHRQ Hospital Survey on Patient Safety Culture: a tool to plan and evaluate patient safety programs. *Advances in Patient Safety: New Directions and Alternative Approaches*

Regulatory Requirement

- Conduct HSOPS to meet Joint Commission Leadership Standards (Standard LD.03.01.01)

  http://www.jointcommission.org/NR/rdonlyres/D53206E8-D42B-416B-B887-491B6D5AA163/0/HAP_LD.pdf
  - Leaders regularly evaluate the culture of safety and quality using valid and reliable tools
  - Leaders prioritize and implement changes identified by the evaluation

URLs for Surveys

- Toolkit to interpret HSOPS results

http://www.unmc.edu/rural/patient-safety

Rural adapted version of HSOPS

Click on

Hospital Survey on Patient Safety Culture Resources

- Original AHRQ version of HSOPS

http://www.ahrq.gov/qual/patientsafetyculture/hospsurvindex.htm

Contact Information

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Web site where tools are posted
www.unmc.edu/rural/patient-safety