

## Acting on Safety Culture Survey Results

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Resident and Patient Safety Learning Collaborative  
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## Overview

- What do we mean by “Safety Culture” and why is it important?
- You have results – what next?
  - Understanding and communicating results
  - Prioritizing areas for action
  - Strategies/interventions
  - Change is hard!
- Learn from your colleagues



## Institute of Medicine: To Err is Human

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

Institute of Medicine. (2000). *To Err is Human: Building a Safer Health System*.



## Institute of Medicine: Crossing the Quality Chasm

“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.”

Institute of Medicine. (2001). *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*



## Culture of Safety

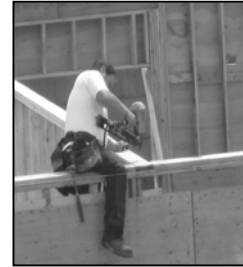
“An integrated pattern of individual and organizational behavior, based upon shared beliefs and values, that continuously seeks to minimize patient harm that may result from the processes of care delivery.”



Institute Of Medicine (2004). *Patient Safety: A New Standard for Care*



Culture is ...  
“The way we do things around here and why we do them.”



Carroll & Quijada (2004). *Quality and Safety in Health Care*.

<http://www.safetycenter.navy.mil/photo/archive/>



Culture of Safety??

<http://www.safetycenter.navy.mil/photo/archive/>



## Culture of Safety

- 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 responds based on behavioral choices not outcome
  - People who work in teams make fewer errors

*In a culture of safety, people are not merely encouraged to work toward change; **they take action** when it is needed.*

\*Institute Of Medicine (2004). *Patient Safety: A New Standard for Care*



## Components of a culture of safety



## Uses of Safety Culture Surveys

- Raise staff awareness about patient/resident safety
- Assess the current status of patient/resident safety culture
- Identify strengths and areas for safety culture improvement
- Evaluate the cultural impact of safety culture initiatives and interventions
- Fulfill directives or regulatory requirements

Nieva & Sorra (2003). *Quality and Safety in Healthcare*.

## Survey Instruments

Common safety culture survey tools:

AHRQ Surveys on Patient Safety Culture

<http://www.ahrq.gov/qual/patientsafetyculture/>

Teamwork and Safety Attitude Questionnaire

<http://www.biomedcentral.com/1472-6963/6/44>

## AHRQ Safety Culture Survey Dimensions

### Nursing Home Survey

- Communication openness.
- Compliance with procedures
- Feedback and communication about incidents.
- Handoffs
- Management support for resident safety.
- Nonpunitive response to mistakes.
- Organizational learning
- Overall perceptions of resident safety.
- Staffing.
- Supervisor expectations and actions promoting resident safety
- Teamwork
- Training and skills

### Hospital Survey

- Communication openness
- Feedback & communication about error
- Frequency of events reported
- Hospital handoffs & transitions
- Hospital management support for patient safety
- Nonpunitive response to error
- Organizational learning-continuous improvement
- Overall perceptions of safety
- Staffing
- Supervisor/manager expectations & actions promoting patient safety
- Teamwork across hospital units
- Teamwork within units

## Common Areas for Improvement

### Nursing Homes

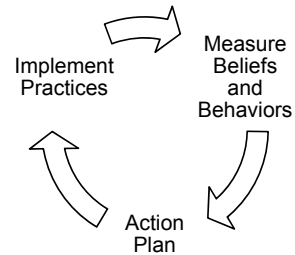
- Nonpunitive Response to Mistakes
- Communication Openness
- Staffing
- Management Support for Resident Safety

### Hospitals

- Nonpunitive Response to Error
- Hospital Handoffs and Transitions
- Communication Openness
- Staffing



## Engage in Continuous Improvement



## Communicate Results!

- Leadership/Management
- Staff: If they took the survey, let them know the results!
- Messages may be different for different audiences



## Standards of Effective Communication

- Complete
- Clear
- Brief
- Timely
- Continuous



### SBAR – a tool for communication

- **S**ituation—What is going on?
- **B**ackground—What is the context?
- **A**ssessment - What do I think the challenge is?
- **R**ecommendation—What do I recommend?



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### Elevator Speech (SBAR)

We have chosen to focus on \_(S)\_ .  
\_(B)\_ puts our patients at risk and impacts our performance, so it is important that we improve \_(A)\_ .  
We need you to support our efforts by \_(R)\_ .



### Use safety culture survey results to START conversation

- **Example:**  
“The survey results show XXX. Can you tell me more about what that may mean to you?”
- Consider comparisons between staff types or work areas
- Look at individual questions and compare gaps between beliefs and behaviors



### Appreciative Inquiry: One approach to learning from staff

#### Three Questions:

1. What is working well?
2. What could be better?  
–What would ‘better’ look like?
3. How do we get to “better”?  
–What ideas do you have?



### Prioritizing for Action

- Consider how challenges align with other initiatives/needs
- Focus on strategies that may address more than one area
- A couple of approaches...



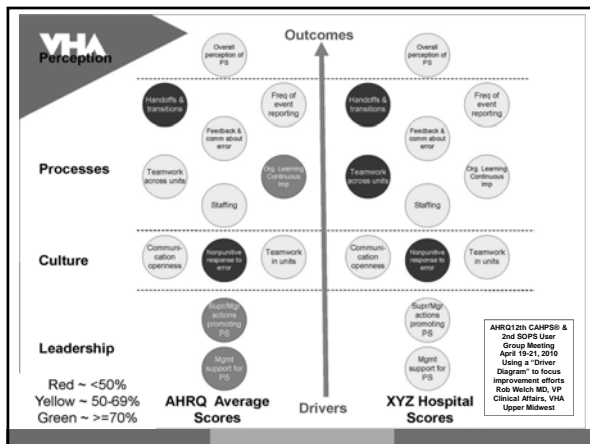
### Four Components of Safety Culture

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

Reason, J. (1997). *Managing the Risks of Organizational Accidents.*

Battles et al. (2006). Sensemaking of patient safety risks and hazards.

Jones and Skinner (2009). Building Infrastructure for Safety and Quality. Interpreting SOPS Results



### Strategies and Interventions

What is your organization doing?



## Strategies and Interventions

Interventions that are considered influential:

- Teamwork training (Team STEPPS)
- Structured communications
- Executive/Management walk rounds
- Just Culture
- Person Centered Care Principles



## Change is Hard!

Kotter's Model for Change:

- Create a sense of urgency
- Pull together a 'guiding coalition'
- Develop a vision and strategy
- Communicate the vision
- Empower action
- Generate short-term wins
- Consolidate gains and produce more wins
- Anchor new approaches in the culture

John P. Kotter. *Leading Change*. Harvard Business Press (1996)



The daydreams of cat herders

<http://www.code-muse.com/blog/?p=27>



## Questions?

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Resource:

Engineering a Culture of Safety – Nebraska Center for Rural Health Research, UNMC

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



## Stratis Health – Advancing health care quality and patient safety

Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.



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