

After the Culture Survey: Moving Patient Safety From the Executive Suite to the Bedside



SOPS PATIENT SAFETY IMPROVEMENT INITIATIVES

**INITIATIVES TO IMPROVE EVENT REPORTING AND
NONPUNITIVE RESPONSE TO ERROR**

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Track:	SOPS Patient Safety Improvement Initiatives
Session:	Initiatives to Improve Event Reporting and Nonpunitive Response to Error
Date & Time:	April 20, 2010, 11:00 am
Track Number:	SOPS T2 – S2

DoD Tri-Service Culture Survey

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- The DoD prepared a Patient Safety Culture Survey for employees
 - All Military Treatment Facilities (MTF) participated
 - ✦ Air Force, Navy, and Army
 - ✦ Inpatient Hospitals and Ambulatory Facilities
- Originally given in 2006 and repeated in 2008
 - The DoD provided each MTF with an analysis of the surveys
 - ✦ The analysis of change from 2006 to 2008 was especially important

Source of this Project

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- DoD requested interviews with 9 MTFs who made significant progress in a culture of safety from 2006 to 2008
 - Interview preparation required an in-depth analysis of survey findings related to the Patient Safety Program (PSP)
 - ✦ Analysis highlighted PSP strengths
 - ✦ And revealed PSP weaknesses
- Project: use survey results to guide PSP enhancements
 - Survey is research-based
 - ✦ Survey provided tools to collect valid metrics

Survey Results: Patient Safety Program Strengths

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- Improvements in all areas between 2006-2008
 - Improvements ranged from 3-9%

Patient Safety Culture Area	% Positives		Difference	Change
	2006	2008		
1. Overall Perceptions of Patient Safety	63	69	+6	↑
2. Frequency of Events Reported	60	63	+3	↑
3. Supervisor Expectations & Actions Promoting Pt Safety	73	77	+4	↑
4. Organizational Learning – Continuous Improvement	68	73	+5	↑
5. Teamwork Within Work Area	72	77	+5	↑
6. Communication Openness	58	62	+4	↑
7. Feedback and Communication About Error	65	70	+5	↑
8. Nonpunitive Response to Error	43	47	+4	↑
9. Staffing	41	50	+9	↑
10. Management Support for Patient Safety	72	75	+3	↑
11. Teamwork Across Work Areas	52	55	+3	↑
12. Handoffs and Transitions	41	46	+5	↑
13. Work Area/Unit Patient Safety Grade	75	84	+9	↑
14. Reported Events in Past 12 Months (<i>Converted from negative to positive</i>)	30	35	+5	↑



Low scores that became focus of project

Survey Results: PSP Weaknesses

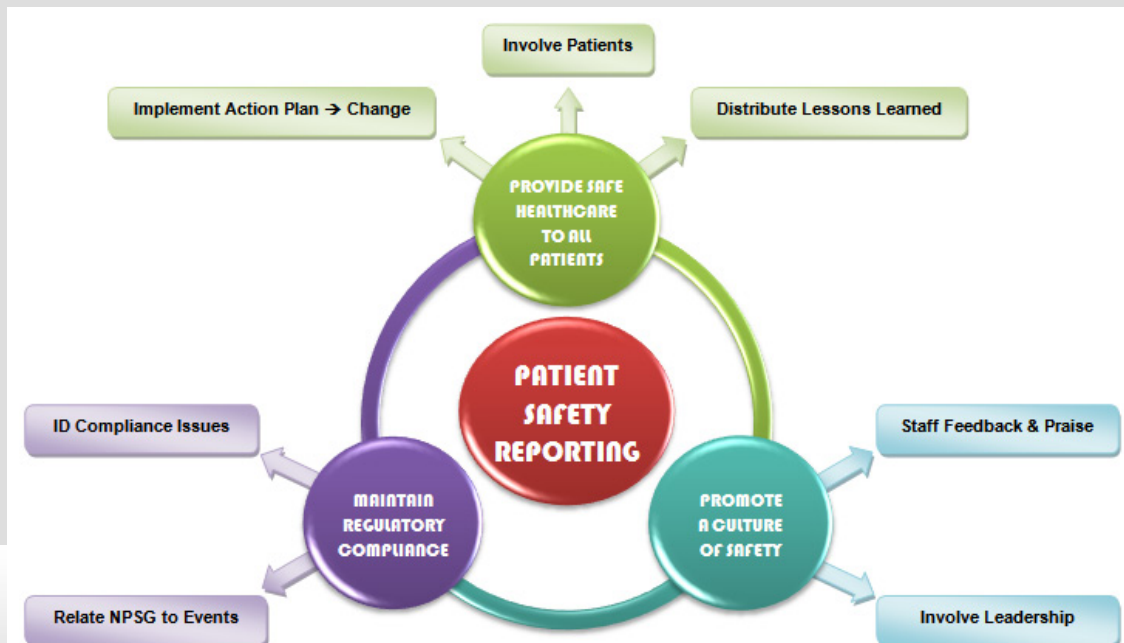
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- **Low survey scores occurred in two areas:**
 - Staff's belief in a non-punitive Patient Safety Program
 - Number of staff who participate in Patient Safety Program by reporting Patient Safety events
- **These metrics fit with our theoretical PSP model**
 - They provided the hypothesis for this project

PSP Theory in Brief

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- Reporting is at the center of our PSP
 - It quantifies our *Culture of Safety*
 - ✦ As reporting goes up, harm events decline
 - ✦ It measures National Patient Safety Goal compliance
 - ✦ It involves our patients



Project Hypothesis

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- Increasing the number of staff who report Patient Safety events will enhance the nonpunitive culture of our hospital
 - Is the fear of reprisal a hold-over from the healthcare culture before Patient Safety?
 - Unless staff report, how can they know if reprisal occurs?
 - ✦ Only 47% of staff believe error reporting is nonpunitive
 - ✦ Even less – 35% of staff – do any reporting

The Plan

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- Increase Patient Safety event reporting
- Market a nonpunitive Patient Safety Program
 - Provide substantive, positive feedback to reporters
 - Leadership assumes active role
 - Share “lessons learned” with all staff
- Conduct a follow-up mini survey to prove hypothesis

Increasing Patient Safety Event Reporting

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- Increased PS Work Group (PSWG) Reps from 12 - 30 (they represented every clinical area)
 - Created customized National Patient Safety Goal (NPSG) Compliance Trackers for each clinical area/representative
 - ✦ Non-compliance equals a reportable near miss
- Utilized patient point-of-care surveys to collect data on NPSG compliance
 - Non-compliance equals a reportable near miss
- Monthly Patient Safety Reports reflected near misses and events identified by staff and patients

Selling Patient Safety

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- Answer this question for staff: “What’s in it for me?”
 - Feedback to reporters includes thanks and actions taken, never blame
 - Participants are recognized by leadership
 - Participation is reflected in evaluations and awards
 - ✦ These are important to military promotion and advancement
 - Elimination of crazy-makers
 - ✦ Many PS events interfere with providing uninterrupted, safe patient care; these are not only risky, but frustrating
 - Real change occurs and safe care becomes easier to give
 - ✦ Takes involved leadership
 - ✦ Requires long term carry-through

Follow-up Survey



- Used questions from original Tri-Service Survey
 - Given to 50 clinical staff at 8 months into project
 - ✦ **Only change: Event** was further defined from DoD survey

Choose the appropriate response for the following statements:			Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Staff feel like their mistakes are held against them.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When an event is reported, it feels like the person is being written up, not the problem.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff worry that mistakes they make are kept in their personnel file.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How many near misses, errors, or harm events did you report during the past twelve months? <i>(The only change in Survey questions)</i> Please note that reports may take many forms, e.g., laboratory check-sheets, medication errors entered into JAMRS, RCA actions not completed accurately, etc.							
None	1 to 2	3 to 5	6 to 10	11 to 20	21 or more		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Results of Project: Reporting

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- **Patient Safety average monthly reporting increased 56% while harm events fell 73%**
 - Discreet items observed and audited by PSWG Reps each month increased 430% over the 8 months of the project (Jan thru Aug 2009)
 - ✦ Less than 3% of the observations/audits in Aug 09, were near misses; National Patient Safety Goal compliance was 97%
 - Project made the connection between National Patient Safety Goal non-compliance and Patient Safety reporting
 - The NPSG are not just items to memorize; they impact patient care
 - The Joint Commission Survey in Oct 2009 found, “Zero NPSG Findings.”
 - Patients submitted an average of 585 surveys per month

Results of Project: Nonpunitive PS

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- Relied on repeat survey to measure
- Staff who claim they report PS events increased from 35% on the 2008 survey to 51% post-project
 - A 16% improvement versus only 5% from 2006 to 2008
- Positive answers to “belief in a nonpunitive response to error” increased from 47% on the 2008 survey to 59% post-project
 - A 12% improvement versus only 4% from 2006 to 2008

Project Conclusions

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- Reporting Increased
- Nonpunitive Culture Enhanced
- **MOST IMPORTANT RESULT:**
 - Safer patient care as evidenced by decreased patient harm

Recommendations

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- Every inpatient and ambulatory health care facility will benefit from a Patient Safety Culture Survey that is accompanied by a complete analysis of survey findings . . . *if* . . .

the findings are used to guide and measure change!

Questions?

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- **Our National Patient Safety Goal Compliance Tracker is available from:**
 - Shelley Drake
 - 99 Medical Group
 - Nellis AFB, NV
 - Email: shelley.drake.ctr@nellis.af.mil