

Improving Hospital Patient Safety Culture Through Teamwork

Muskie School of Public Service

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Track: SOPS Patient Safety Improvement Initiatives
Session: Improving Patient Safety Culture Through Teamwork
Date & Time: April 20, 2010, 9:30 am
Track Number: SOPS T2 – S1

Goodall Hospital Sanford, Maine



Background

- Goodall Hospital, Sanford, Maine
 - Strategic plan, quality plan
 - Hospital Survey on Patient Safety Culture
- Donaghue Foundation RFP
- Muskie School of Public Service Academic Partner
- Proposal, Topic Selection, Funded Project



Grant Specifics

- Leadership involvement
- Project goals
- Academic partnership
- Teamwork training (Crew Resource Management)
- Formative evaluation
- Dissemination



Interventions

- Engagement of hospital leadership
- Training in teamwork
 - ED, Surgical Services primary sites
- Institutionalization of teamwork concepts and behavior



Goodall Hospital ED Team



Teamwork Training

- MedTeams – vendor
- Crew Resource Management
- Project structure
 - Train the trainer
 - Emergency Department training 1st group
 - Inclusion of Sanford Fire Dept. paramedics
 - Engagement of management



Project Evaluation Components

- Qualitative interviews with staff
- Patient satisfaction surveys
- Quality of Care surveys (MedTeams tool)
- AHRQ H-SOPS
- Process evaluation
- “Lessons learned” Dissemination



Opportunities

- Leadership support
- Tie-in with patient safety culture improvement goals
- H-SOPS provides framework
 - Completed annually
 - Useful tool for both administrative and unit discussions, drill-downs
 - Benchmarks, areas for improvement
 - Coaching sharing result process at department head level



Comparison of Composite Scores for 12 H-SOPS Dimensions, Goodall Hospital

Goodall Hospital

Hospital Survey on Patient Safety Culture

Comparison of Composite Scores	MARCH 2007	MARCH 2009	AHRQ 2009 [‡] Benchmark
Overall Perceptions of Safety	53%	67%▲	64%
Frequency of Events Reported	58%	65%▲	60%
Supervisor/Manager Expectations & Actions Promoting Patient Safety	66%	71%▲	75%
Organizational Learning, Continuous Improvement	63%	68%	71%
Teamwork within Areas	76%	83%▲	79%
Communication Openness	66%	64%	62%
Feedback & Communication about Error	54%	60%▲	63%
Non-punitive Response to Error	47%	47%	44%
Staffing	41%	57%▲	55%
Hospital Management Support for Patient Safety	63%	74%▲	70%
Teamwork Across Hospital Areas	45%	53%▲	57%
Hospital Handoffs and Transitions	29%	38%▲	44%

▲ Significantly different from March 2007 survey

‡ Hospital Survey on Patient Safety Culture: 2009 Comparative Database Report. AHRQ Publication No. 09-0030, April 2009. Agency for Healthcare Research and Quality, Rockville, MD.

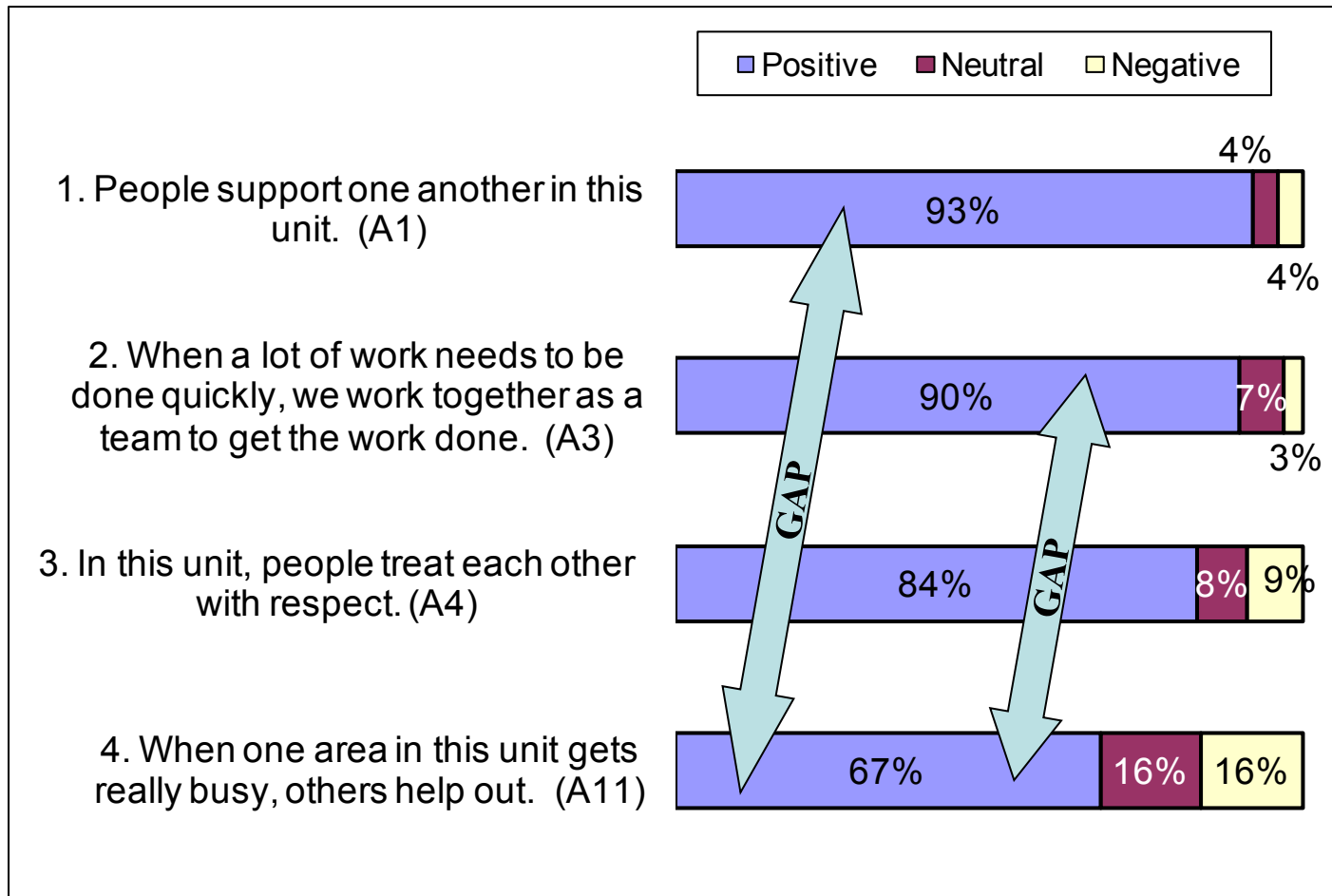


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Example of Drill-down

Gap Between Belief and Behavior

Teamwork Within Hospital Units



Opportunities

- Skill building
 - Increased communication at both management and unit level about teamwork behaviors
 - Common language/lexicon
- Engagement with paramedics
- Adoption in secondary site (Surgical Services) somewhat easier



Hard-wiring Teamwork Behavior

- Seems to fit well in partnership with Human Resources
 - Code of Conduct
 - Employee handbook
 - Job Descriptions
 - HR performance evaluations (peer and supervisor)
 - Orientation – expectations and training
 - Ongoing staff education
 - Availability of learning aids for employees
 - Assessing staff turnover issues for teamwork components



Hard-wiring, cont.

- Patient safety activities
 - Skills Fair, Safety Fair
 - Teamwork and safety culture standing agenda item
 - Attention to H-SOPS results feedback
 - Review of patient satisfaction surveys for evidence of teamwork
 - Including language in patient admission handouts that supports, expects, and encourages teamwork behavior
 - Intranet screensavers defining and encouraging teamwork behavior



Hard-wiring, cont.

- Patient safety activities
 - Root cause analysis (check for teamwork)
 - M & M retrospective review (check for teamwork)
 - Physician case conferencing (check for teamwork)
 - Engaging Fire Dept. involvement through supportive communication with Chief and highlighting successful teamwork
 - Naming behaviors whenever possible to reinforce skills and challenge concerns about boundaries



Challenges

- Roll-out issues
 - Choice of trainers
 - Sustainability for training (staff turnover, \$\$\$)
- Physician role in training, uptake
- Leadership turnover (ED nursing leadership primary site)
- Cross-department interactions
- Need tools to continue ongoing teamwork coaching



Challenges, cont.

- Financial pressures
 - Lay-offs
 - Economic downturn led to increase in ED utilization and unreimbursed care
- Convincing staff that this is not a fad
 - Change fatigue



Results

- Engagement of leadership, staff and academic partner
- Significant percentage of staff trained
- Sustainable train-the-trainer model
- Significant improvement in 9 (of 12) dimensions of patient safety culture



Questions?

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