Improving Patient Safety
Using AHRQ Safety Culture Survey Results and Just Culture Theories

Linda Oman, BS, CPHRM
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Learning Objectives

• Describe a Just Culture Organization
• Describe Just Culture in relationship to patient safety
• Identify ways to implement Just Culture training
• Discuss ways to utilize AHRQ Safety Culture Survey data with performance improvement teams
How Did We Know We Needed a Culture Change

Overall Perception of Safety

- Composite Score
- Patient safety is never sacrificed to get more work done
- Our procedures and systems are good at preventing errors from happening
- It is just by chance that more serious mistakes don't happen around here
- We have patient safety problems in this unit

Safety Culture Composites

<table>
<thead>
<tr>
<th>Composite Score</th>
<th>Overall Perceptions of Safety (4 items -- % Agree/Strongly Agree)</th>
<th>66%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency of Events Reported (3 items -- % Most of the time/Always)</td>
<td>63%</td>
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<tr>
<td></td>
<td>Supervisor/Manager Expectations &amp; Actions Promoting Patient Safety (4 items -- % Agree/Strongly Agree)</td>
<td>67%</td>
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<td></td>
<td>Organizational Learning--Continuous Improvement (3 items -- % Agree/Strongly Agree)</td>
<td>64%</td>
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<td></td>
<td>Teamwork Within Units (4 items -- % Agree/Strongly Agree)</td>
<td>81%</td>
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<td></td>
<td>Communication Openness (3 items -- % Most of the time/Always)</td>
<td>47%</td>
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<tr>
<td></td>
<td>Feedback &amp; Communication About Error (3 items -- % Most of the time/Always)</td>
<td>49%</td>
</tr>
<tr>
<td></td>
<td>Nonpunitive Response to Error (3 items -- % Agree/Strongly Agree)</td>
<td>36%</td>
</tr>
<tr>
<td></td>
<td>Staffing (4 survey items -- % Agree/Strongly Agree)</td>
<td>63%</td>
</tr>
<tr>
<td></td>
<td>Hospital Management Support for Patient Safety (3 items -- % Agree/Strongly Agree)</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Teamwork Across Hospital Units (4 survey items -- % Agree/Strongly Agree)</td>
<td>56%</td>
</tr>
<tr>
<td></td>
<td>Hospital Handoffs &amp; Transitions (4 survey items -- % Agree/Strongly Agree)</td>
<td>41%</td>
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</tbody>
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H B Magruder

Our procedures and systems are good at preventing errors from happening.
How Can We Improve Response Rates?

- Offer the survey during National Patient Safety Week
- Talk about the importance of the survey during February Employee meetings
- Provide fun things to do throughout Patient Safety Week that promote the survey (word search, department posters, giveaways)
- Offer survey online or on paper
- Have computer lab open for those who don’t have a work computer
What Is a ‘Just Culture’ Organization?

Accountable → High employee morale → Learns from mistakes and near misses → Clear expectations → Always learning → Risks proactively managed

Accountable
High employee morale
Learns from mistakes and near misses
Clear expectations
Always learning
Risks proactively managed

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What Is a ‘Just Culture’ Organization? (cont.)

Just Culture Organization manages:

• Three Types of Behaviors
• Three Types of Duties
• Framework of Five Skills
• Upheld by leadership and staff
Three Behavioral Choices

- **Human Error (Console)**: Inadvertently doing other than what was intended: a slip, lapse, or mistake.

- **At-Risk Behavior (Coach)**: Behavior choice that increases risk where risk is not recognized, or is mistakenly believed to be justified.

- **Reckless Behavior (Punish)**: Behavioral choice to consciously disregard a substantial and unjustifiable risk.
Three Duties or Expectations

- Duty to avoid causing unjustified risk or harm
- Duty to produce an outcome
- Duty to follow procedural rule
Five Skills

• Mission, Values & Expectations
• Systems Design
• Behavioral Choices
• Learning System
• Accountability & Justice
Tool to aid in determining the right course of action when an employee has made an error, drifted into at-risk behavior, or not met obligations to the organization.

Designed to evaluate behaviors.

Just Culture Algorithm™

Identifies if more than one behavior was associated with a single event.

Helps identify repetitive behaviors.
Just Culture in Relationship to Patient Safety?

• Blaming individuals
  – Punitive action

• “No Blame” approach
  – Doesn’t hold people accountable

• Just Culture
  – Doesn’t punish someone for simple human errors
  – Re-engineers processes with barriers, redundancies
Implementing Just Culture

- Start at the top
- Revise policies and procedures
- Train middle management
- Revise evaluation tools
- Take training offsite
- Share what you are learning front-line staff
Using Safety Culture Survey Results With PI Teams

- Director Expectations/Actions Promoting Patient Safety
- Communication Openness
- Feedback/Communication about Errors
- Non-punitive Response to Errors
- Teamwork Across Hospital Units
- Hospital Handoffs & Transitions
2014 Survey Results

Improvement Teams Composite Scores

Director Expectations, Communication Openness, Feedback & Communication about Errors, Nonpunitive Response to Errors, Teamwork Across Hosp Depts, Handoffs & Transitionis

2014 Survey Results, (cont.)

Director Expectations & Actions Promoting Patient Safety
(2013 Improvement Team)

- Composite Score
- My supervisor/manager says a good word when sees a job done according to established patient safety procedures
- My supervisor/manager seriously considers staff suggestions for improving patient safety
- Whenever pressure builds up, my supervisor/manager wants us to work faster even if it means taking shortcuts
- My supervisor/manager overlooks patient safety problems that happen over and over

Legend:
- 2008
- 2010
- 2012
- 2014
- National
- 6-24 Beds
2014 Survey Results, (cont.)

Communication Openness
(2013 Improvement Team)

- Staff will freely speak up if they see something that may negatively affect patient care
- Staff feel free to question the decisions or actions of those with more authority
- Staff are afraid to ask questions when something does not seem right

Graph showing Composite Score, Staff will freely speak up, Staff feel free to question, and Staff are afraid to ask questions for years 2008 to 2014.
Feedback and Communication About Errors
(2013 Improvement Team)

- Composite Score
- We are given feedback about changes put into place based on event errors
- We are informed about errors that happen in this unit
- In this unit, we discuss ways to prevent errors from happening again

- 2008
- 2010
- 2012
- 2014
- National
- 6-24 Beds
2014 Survey Results, (cont.)

Nonpunitive Response to Errors
(2013 Improvement Team)

- Staff feel like their mistakes are held against them
- When an event is reported, it feels like the person is being written up, not the problem
- Staff worry that mistakes they make are kept in their personnel file

Graph showing Composite Score, Staff feel like their mistakes are held against them, When an event is reported, it feels like the person is being written up, not the problem, and Staff worry that mistakes they make are kept in their personnel file, comparing 2008, 2010, 2012, 2014, National, and 6-24 Beds.
2014 Survey Results, (cont.)

Teamwork Across Hospital Departments
(2013 Improvement Team)

- There is good cooperation among hospital units that need to work together.
- Hospital units work well together to provide the best care for patients.
- Hospital units do not coordinate well with each other.
- It is often unpleasant to work with staff from other hospital units.

2014 Survey Results, (cont.)

Handoffs and Transitions
(2013 Improvement Team)

- Things fall between the cracks when transferring patients from one unit to another
- Important patient care information is often lost during shift change
- Problems often occur in the exchange of information across hospital units
- Shift changes are problematic for patients in this hospital

- Composite Score
- 2008
- 2010
- 2012
- 2014
- National
- 6-24 Beds
Back to the Drawing Board

Five improvement teams

Add to “wish list”

Look at 2013 “wish list” outstanding items

Front-line staff

Add to “wish list”
2016 Survey Results

Safety Culture Survey Composite Comparison

Percent Positive Responses

- Overall Perception of Care
- Frequency of Reporting
- Director Promoting Patient Safety
- Org Learning & Continuous Improvement
- Teamwork within Departments
- Communication Openness
- Feedback & Communication about Errors
- Nonpunitive Response to Errors
- Hospital Mgmt. Support for Patient Safety
- Teamwork Across Departments
- Hospital Handoffs & Transitions

2016
2014
National
6-24 beds

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When a mistake is made, but is caught and corrected before affecting the patient, it is frequently reported.

When a mistake is made but has no potential to harm the patient, it is frequently reported.

When a mistake is made that could harm the patient but does not, it is frequently reported.

FREQUENCY OF REPORTING

2016 Survey Results, (cont.)

COMMUNICATION OPENNESS

- Staff will freely speak up if they see something that may negatively affect patient care
- Staff feel free to question the decisions or actions of those with more authority
- Staff are afraid to ask questions when something does not seem right

Graph showing the composite score and communication openness from 2008 to 2016, with data for national and 6-24 beds.
2016 Survey Results, (cont.)

NONPUNITIVE RESPONSE TO ERRORS

Composite Score
- Staff feel like their mistakes are held against them
- When an event is reported, it feels like the person is being written up, not the problem
- Staff worry that mistakes they make are kept in their personnel file

2016 Survey Results, (cont.)

HOSPITAL HANDOFFS AND TRANSITIONS

Composite Score
Things fall between the cracks when transferring patients from one unit to another
Important patient care information is often lost during shift change
Problems often occur in the exchange of information across hospital units
Shift changes are problematic for patients in this hospital

Back to the Drawing Board (again)

- Frequency of Event Reporting
- Non-punitive Response to Errors
- Communication Openness
Extra Benefit from Our Efforts

$50,000
Additional Outcomes

Total Events Reported
Jan 2012 - April 2017

- Began improvement projects using Safety Culture
- Began anonymous reporting 5/13
- VPs of Nursing & Ancillary Services attended week
- Began LDIs on Just Culture
- HR Director & HR Manager attend
- Safety Culture
- Safety Culture Survey Results
- Safety Culture
- Quantros conversion
- Employee focus groups based on last Safety

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Total Number of Event Per Year
January 2012 - April 2017

- 2012: 321
- 2013: 357
- 2014: 405
- 2015: 388
- 2016: 645
- 2017: 198

Percent of Reported Events that were Near Miss Events
(14.7% increase between 2012 and 2016)

- 2012: 5.3
- 2013: 13.7
- 2014: 16.6
- 2015: 19.4
- 2016: 20
- 2017 thru April: 17
In Summary

• An accountable *Just* organization is a safer organization
• Safety Culture survey results provide valuable info on current hospital culture
• Culture change starts from the top (but remember to spread the knowledge throughout the organization)
• Involve front-line staff in improvement efforts
• Measure your success!
• *Every One Can Do This!*
Questions?
References

*Patient Safety and the “Just Culture.”* David Marx, JD. President, Outcomes Engineering, LLC. 
