Developing a Culture of Safety
Tejal Gandhi, MD MPH
President
National Patient Safety Foundation
Associate Professor of Medicine
Harvard Medical School
Carol Haraden, PhD
Vice President
Institute for Healthcare Improvement

Disclosures
- None
What is Culture?

- “The way we do things around here.”
- Shared perceptions about what is good, right, important, valued, rewarded, supported, and expected
- Culture is shaped by:
  - Policies, practices, and procedures
  - The values and personalities of people in the organization
  - Leadership
- We can talk about specific pieces of culture, for example:
  - Safety climate: To what extent is safety of patients a priority?
  - Teamwork climate: To what extent is collaboration valued and supported?

Safety Culture

Safety Culture Definition

The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.

Culture is predictive

1. Medication errors
2. Back injuries
3. Patient satisfaction
4. Nurse turnover & absenteeism
5. AHRQ Patient Safety Indicators
6. Nurse satisfaction
7. Urinary tract infections
8. Malpractice claims
...and more.

Useful References for Culture-to-Outcomes Linkage:
- Hofmann & Mark (2006)
- Katz-Navon et al. (2005)
- Mark et al. (2007)
- Naveh et al. (2005)
- Singer et al. (2008)
- Vogus & Sutcliffe (2007)

Culture is measurable

- A survey instrument can most effectively distinguish between a “healthy” culture and an “unhealthy” culture when:
  - a valid instrument is used
    - The Safety Attitudes Questionnaire (SAQ) is one validated and widely-used instrument in healthcare
  - all members of a unit are invited to complete the survey
    - Including people of different roles ensures that each role’s piece of the patient care stream is taken into account
  - the survey response rate is high (at least 60%)
    - A high response rate usually indicates that data are representative of everyone’s perceptions
Culture is Local

Teamwork Climate

What Can We Do about Adverse Events?

Simple strategy to follow:
1. Identify events, near misses, and errors
2. Analyze the errors to determine systems improvements
3. Perform these improvements

Unfortunately, it's not so simple….
Culture of Blame vs Safety

- Medicine and society have tended to fault the person, not the system
- Health care providers have concern for personal consequences for reporting errors
- Also tedious to report
  - Providers are busy
  - Not a priority
- Need to create a culture of safety, similar to the aviation industry
  - Move beyond blaming and punishing and towards improving the system
  - Reduce fear of reporting
  - Make people feel reporting makes a positive impact

A balanced accountability

- Support of system safety and other values
- Blame-free culture
- Punitive culture
- What system of accountability best supports our values?

As applied to:
- Providers
- Managers
- Institutions
- Regulators
Creating a Culture of Safety

- Walkrounds
- Reporting and feedback
- M&M
- Debriefings
- Educational efforts

Patient Safety Executive Walkrounds

- Senior leadership (CEO, CMO, CNO) do rounds with different office practices and ambulatory sites each week
- Ask standard set of questions to elicit staff concerns
  - Were you able to care for your patients this week as safely as possible?
  - When was the last time a patient was harmed or nearly harmed?
- Conducted in a visible place
- Multidisciplinary
Walkrounds (cont.)

Goals:
- Increase executive awareness of issues
- Show leadership involvement to staff
- Educate staff about safety
- Identify real issues that need addressing
- Bring action items to the attention and ownership of the VP’s
- Feedback to staff about actions taken
- All leading to continued leadership commitment and culture change

Information analysis and Feedback

- Patient Safety Team
  - Creates list of possible actions
  - Works with appropriate leadership and administrators to identify actual action steps
  - Maintains database to keep track of action item status

- Frontline staff informed when actions taken as a result of their comments
  - Email from Patient Safety Officers
  - Letter from Executive (when possible)
- Formal method of feedback is essential
Key Learnings

- Surprisingly, it is not difficult to elicit comments from staff
- Important to have multi-disciplinary representation
- Managing the large amount of information is the challenge
  - Prioritization
  - Understanding limitations (pick 2-3)

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Does your clinical area use Patient Safety Leadership WalkRounds?

- Blue: Average score of clinical areas where more than 60% responded Yes to this WalkRounds item
- Orange: Average score of clinical areas where less than 60% responded Yes to this WalkRounds item

* Statistically significant difference at $p < .05$, two-tailed
Other Strategies to Engage Staff

- Walkrounds may not be frequent enough
- Other options include:
  - M&M conferences
  - Weekly huddles and debriefings
  - Safety reporting mechanisms
- Key to perform follow-up and provide feedback to staff
- This in turn will lead to culture change and increased reporting
Primary Care M&M

- Monthly or bimonthly
- At a convenient time and location
- Solicit cases from providers
- Systems based discussion
- Good opportunity to bring in specialists to facilitate cross-discipline discussions
- Action items
- Well received; being spread across Harvard-insured institutions

Conclusions

- Creating a culture of safety is a critical foundation to improving safety
- Many strategies exist to make culture change
  - Not a fast process though
- Good tools to measure where your culture is
- Identifying/assessing areas of risk in your practice is also paramount
How do you assess the safety culture of your ambulatory setting?

### Medical Office Survey on Patient Safety

**Survey Instructions**

Think about the ways things are done in your medical office and make your opinion or answer that reflects your safety culture. Your input will provide valuable information to improve patient safety in your office.

1. The practice does not emphasize patient safety in the office.
2. The practice does not use reports from the professional staff or patient complaints.
3. The practice does not emphasize staff education and training.
4. The practice does not have policies and procedures for patient safety.
5. The practice does not have policies and procedures for staff education and training.
6. The practice does not have policies and procedures for patient safety.

**Sections**

- AHRQ Medical Office Survey on Patient Safety
SECTION A: List of Patient Safety and Quality Issues

- **Access to Care**
  A patient was unable to get an appointment within 48 hours for an acute/serious problem.

- **Patient Identification**
  The wrong chart/medical record was used for a patient.

- **Charts/Medical Records**
  A patient's chart/medical record was not available when needed.
  Medical information was filed, scanned, or entered into the wrong patient's chart/medical record.

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- **Medical Equipment**
  Medical equipment was not working properly or was in need of repair or replacement.

- **Medication**
  A pharmacy contacted our office to clarify or correct a prescription.
  A patient's medication list was not updated during his or her visit.

- **Diagnostics & Tests**
  The results from a lab or imaging test were not available when needed.
  A critical abnormal result from a lab or imaging test was not followed up within 1 business day.
Other Sections

SECTION B: Information Exchange With Other Settings
Over the past 12 months, how often has your medical office had problems exchanging accurate, complete, and timely information with:

SECTION C: Working in Your Medical Office
- When someone in this office gets really busy, others help out
- In this office, there is a good working relationship between staff and providers
- In this office, we often feel rushed when taking care of patients
- This office trains staff when new processes are put into place
- In this office, we treat each other with respect

SECTION D: Communication and Follow-up
- Staff are afraid to ask questions when something does not seem right
- This office documents how well our chronic-care patients follow their treatment plans
- Our office follows up when we do not receive a report we are expecting from an outside provider
- Staff feel like their mistakes are held against them.
- Providers and staff talk openly about office problems.

SECTION E: Owner/Managing Partner/Leadership Support
- They overlook patient care mistakes that happen over and over
- They place a high priority on improving patient care processes.

SECTION F: Your Medical Office
- Our office processes are good at preventing mistakes that could affect patients
- Mistakes happen more than they should in this office
Interpreting culture data

- **Step 1**: Identify areas that seem to be struggling
  - Extreme ends of the distribution
  - High scores on “difficult to speak up” or “difficult to discuss errors”
  - Other tools / views: Scatterplots, heat maps, benchmarking

- **Step 2**: Drill into specific areas to understand culture at a deep level
  - Breakouts of different roles
  - Examine specific survey items

Debriefing culture data locally

- Local debrief sessions target improvement at the clinical area level
- Sessions empower caregivers to “own the data”
## Identifying Harm

### Outpatient Adverse Event Trigger Tool

Developed in Association with
Kaiser Permanente and Baylor Health Care System

Institute for Healthcare Improvement
Roger Rorrer, MD
October 2005
Version 4

[www.ihi.org](http://www.ihi.org)

<table>
<thead>
<tr>
<th>Trigger</th>
<th>Trigger Positive (Yes/No)</th>
<th>Brief Description of Adverse Event (if identified)</th>
<th>Severity of Event (Category 5-1)</th>
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Meeting the Challenge of Patient Safety in the Ambulatory Care Setting

Medical Group Management Association
Patient Safety and Quality Advisory Committee
White Paper

Patient Safety Tools for Physician Practices

In 2009, the Health Research and Educational Trust (HRET), the Institute for Safe Medication Practices (ISMP), and the Medical Group Management Association (MGMA) launched the Physician Practice Patient Safety Assessment® (PPPSA), a self-assessment tool that helps physician practices evaluate their patient-safety processes and identify areas for improvement.

In 2010, the partners released Pathways for Patient Safety™, a series of web-based modules aimed at increasing awareness, knowledge and implementation of best practices to reduce the risk of patient harm in physician practices.

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<tr>
<th>Physician Practice Patient Safety Assessment</th>
<th>Pathways for Patient Safety</th>
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<tr>
<td>PPPSA is designed to:</td>
<td>The free tools will include:</td>
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<td>• enhance physician awareness of patient</td>
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<td>• Assessing Where You Stand</td>
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<td>• highlight provider knowledge of</td>
<td>• Creating Medication Safety</td>
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<td>• create baseline comparisons for practices</td>
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<td>to use to enhance and support patient</td>
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Use this tool to provide safer and better care, reduce liability and facilitate conversation among staff and physicians to identify opportunities for increasing patient safety.

Pathways for Patient Safety are a series of Web tools you can use to increase awareness, knowledge and implementation of best practices for reducing the risk of patient harm in physician practices.

The free tools will include:

- Working as a Team
- Assessing Where You Stand
- Creating Medication Safety

http://www.mgma.com/pppsahome/
Office Patient Safety Assessment (ACOG)

Advances in surgical techniques, technology, and anesthetics have made all kinds of procedures, formerly restricted to hospital facilities, now possible in the office setting. Therefore, the office setting creates a unique set of challenges for healthcare providers, including less legal and regulatory oversight and more fragmented patient care. But it also presents an opportunity for Fellows to evaluate the quality and safety of the care they are providing for their patients.

For this purpose, ACOG has set up a voluntary, self-assessment survey for practitioners to complete regarding patient safety in their own practice. This Office Patient Safety Assessment (OPSA) survey aims to gather data, raise awareness about patient safety concerns in the office practice, and give office practices some benchmarking data based on size, type, and location of practice.

To access this self-assessment, please click here.

For more information about the Office Patient Safety Assessment program, please contact Ramona Rie at (202) 893-2482 or by email at rrie@acog.org.
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