QWEST (Quality of Work Environment Study) SYMPOSIUM

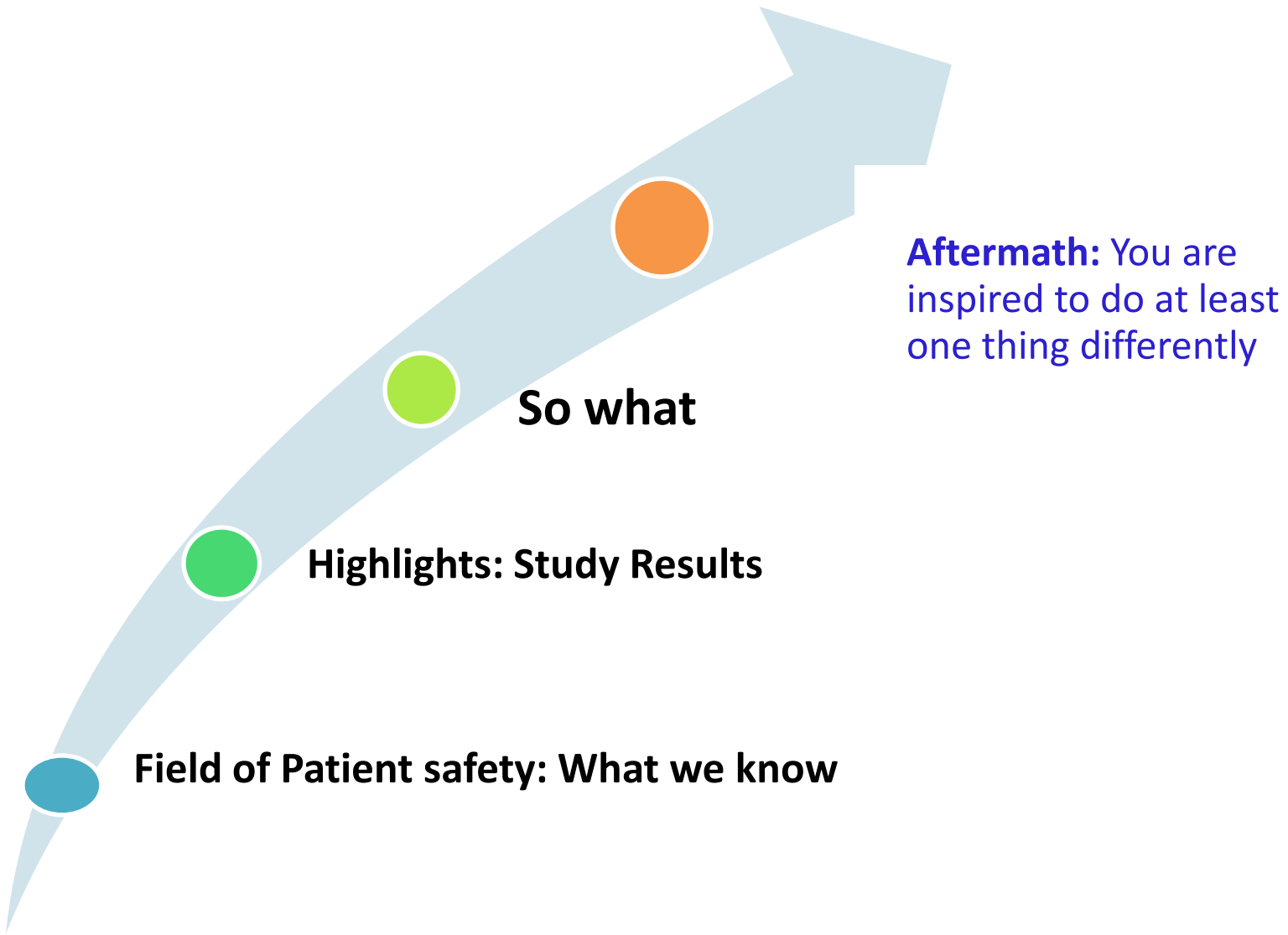
Panel D: Patient Safety Culture

Debbie Barnard, MSc, CPHQ

December 1 2010 – 1:15 to 1:45pm

Lister Conference Centre, University of Alberta

Presentation Roadmap



Concept of Safety Culture

- Originated outside health care, in studies of high reliability organizations, organizations that consistently minimize adverse events despite carrying out intrinsically complex and hazardous work. High reliability organizations maintain a commitment to safety at all levels, from frontline providers to managers and executives.

Source: http://psnet.ahrq.gov/primer.aspx?primerID=5

High Reliability Organizations

Key Features

- Acknowledgment of the high-risk nature of an organization's activities and the determination to achieve consistently safe operations
- A blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment
- Encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems
- Organizational commitment of resources to address safety concerns

Source: http://psnet.ahrq.gov/primer.aspx?primerID=5

What we know

- Safety culture has been defined and can be measured
  - Organizational vs. Unit Measurement
- Poor perceived safety culture has been linked to increased error rates.
- Specific measures, such as teamwork training, executive walk rounds, and establishing unit-based safety teams, have been associated with improvements in safety culture measurements.
- Other methods, such as rapid response teams and structured communication methods such as SBAR, are being widely implemented to help address cultural issues such as rigid hierarchies and communication problems.

Source: http://psnet.ahrq.gov/primer.aspx?primerID=5

What We Know *cont'd*

- Improving Quality: You should know your culture to be effective stewards of limited quality resources

- Culture is local – work unit culture trumps organizational/facility culture, and is related to clinical and operational outcomes

- Culture Critters that introduce new Chaos:
  - New Manager, New Location, New Technology

- Patient Safety is defined as the **reduction** and **mitigation of unsafe acts** within the health-care system, as well as through the use of **best practices** shown to lead to **optimal patient outcomes.**

- Royal College of Physicians and Surgeons of Canada.Jan M. Davies, Philip Charles Hébert and Carolyn Hoff man. Canadian Patient Safety Dictionary. Ottawa, ON: The Royal College of Physicians and Surgeons of Canada, 2003.

Competencies to transform systems are not linear but are broad and overlapping

Results *(A Teaser)*

Research Question:

How are nursing unit characteristics and nurse manager transformational leadership practices related to nurse perceptions of workplace empowerment, worklife and culture of patient safety

Patient Safety Related items	Correlation with Manager's Leadership Style	n
My unit takes the time to identify and asses risks to patients	.496**	470
Senior Management provides a climate that promotes patient safety	.583**	472
I have enough time to complete patient care tasks safely	.257**	470
I work in an environment where patients safety is a high priority	.415**	470
My supervisor says a good word when he/she sees a job well done according to established patient safety procedures	.710**	474
Things that are learned from major events are communicated to staff on our unit using more than one method (e.g., communication book, in-services, unit rounds, e-mails) and/or at several times so all staff hear about them	.525**	473
Compared to a year ago, the quality of patient care on my unit has improved	.459**	465

Research Question:

Is workplace empowerment positively related to unit culture of patient safety, staff nurse perceptions of quality work life and negatively related to staff absenteeism

Nurses' Perceptions of Patient Safety

Questions *Scale 1 Strongly Disagree to 5: Strongly Disagree*	**Teaching (n=237)**	**General (n=178)**	**LTC (n=87)**	**F Test**
Staff suffer negative consequences if they report a patient safety problem	2.53	2.44	2.24	.04*
My unit takes the time to indentify and asses risks to patients	3.36	3.55	3.7	.01**
I have enough time to complete patient care tasks safely	3.16	3.24	2.89	.02*
I work in an environment where patients safety is a high priority	3.57	3.84	4.11	.00**
My supervisor says a good word when he/she sees a job well done according to established patient safety procedures	2.94	2.76	3.38	.00**
Things that are learned from major events are communicated to staff on our unit using more than one method (e.g., communication book, in-services, unit rounds, e-mails) and/or at several times so all staff hear about them	3.31	3.03	3.63	.00**
In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	3.12	2.92	3.3	.04*

So What, Now What?

Patient Safety Activities

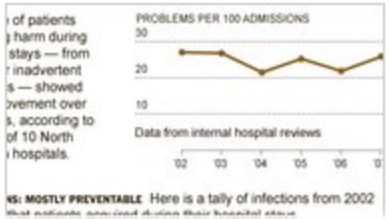
- Institute of Medicine (IOM) Report – 1999
- Canadian Patient Safety Institute established 2003
- CAES (Canadian Adverse Events Study) 2004
- Safer Healthcare Now 2005
- Accreditation Canada – RoPs (31+)

Study Finds No Progress in Safety at Hospitals

By DENISE GRADY
Published: November 24, 2010

Efforts to make hospitals safer for patients are falling short, researchers report in the first large study in a decade to analyze harm from medical care and to track it over time.

Multimedia



Little Change in Patient Safety

The study, conducted from 2002 to 2007 in 10 North Carolina hospitals, found that harm to patients was common and that the number of incidents did not decrease over time. The most common problems were complications from procedures or drugs and hospital-acquired infections.

"It is unlikely that other regions of the country have fared

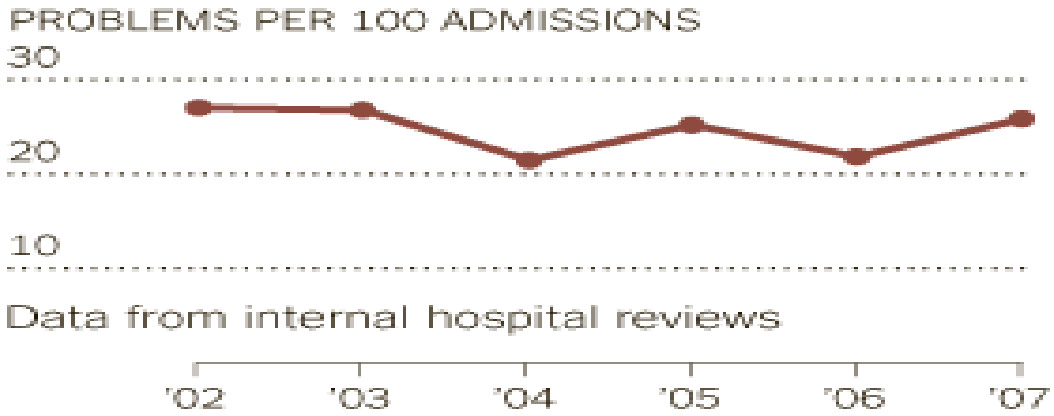
Well
Tara Parker-Pope on Health

Phys Ed: Why Wii Fit Is Best for Grandparents
December 1, 2010, 12:01 AM

Beauty Discrimination During a Job Search
November 30, 2010

Little Change in Patient Safety

The rate of patients suffering harm during hospital stays — from errors or inadvertent problems — showed no improvement over six years, according to a study of 10 North Carolina hospitals.



INFECTIONS: MOSTLY PREVENTABLE Here is a tally of infections from 2002 to 2007 that patients acquired during their hospital stays. About 75 percent of all infections were preventable (■).

	PREVENTABLE/TOTAL:
Urinary tract infections	**24** out of 31
Surgical site infections	**10** out of 17
Pneumonia not related to ventilator	**9** out of 11
Sepsis or bacteremia unrelated to catheter	**8** out of 10
Catheters in arteries/veins	**8** out of 9
Ventilator-associated pneumonia	**6** out of 8

Source: The New England Journal of Medicine

THE NEW YORK TIMES

It’s Really About Action

Example: "Safe Design "Tools for Learning from Mistakes and Improving Safety Culture

CUSP Teamwork Tools	CUSP Safety Tools
▪ Morning/Shift Briefings ▪ Daily Goals ▪ Shadowing Exercise ▪ SBAR ▪ Use Critical Language ("I need some clarity") ▪ Culture Debrief/Checkup Tool	▪ Executive Partnership ▪ Identify Defects ▪ Learning from Defects Tool ▪ Science of Safety Training • 45 Minute online course; free registration is required • http://distance.jhsph.edu/trams/index.cfm?event=training.launch&trainingID=72 ▪ Culture Debrief/Checkup Tool

Source: Comprehensive Unit-based Safety Program (*CUSP*)Peter Pronovost, MD, PhD, and other faculty from the Johns Hopkins Quality & Safety Research Group

Actionable Resources

- **Patient Safety Primers**
  - Adverse Events after Hospital Discharge
  - Diagnostic Errors
  - Disruptive and Unprofessional Behaviour
  - Handoffs and Signouts
  - Health Care-Associated Infections
  - Wrong-Site, Wrong-Procedure, and Wrong-Patient Surgery
  - Adverse Events after Hospital Discharge
  - Never Events

Source: http://psnet.ahrq.gov/primerHome.aspx

Actionable Resources

- **Patient Safety Primers** - Approach to Improving Safety
  - Checklists
  - Computerized Provider Order Entry
  - Error Disclosure
  - Handoffs and Signouts
  - Medication Reconciliation
  - Never Events
  - Physician Work Hours and Patient Safety
  - Rapid Response Systems
  - Root Cause Analysis
  - Safety Culture
  - Teamwork Training
  - The Role of the Patient in Safety

Source: http://psnet.ahrq.gov/primerHome.aspx

Thank You
Questions