Strategies to Improve the Culture of Safety

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Purpose

1. Define elements of a safety culture.

2. Identify strategies that address the multiple domains included in a hospital safety culture survey.
Background

- Agency for Healthcare Research and Quality (AHRQ) supported *Hospital Survey on Patient Safety Culture*

- 7 East unit staff completed survey in March 2013

- Results in the bottom quartile compared to the organization
What is a culture of safety?

- Individual or group values, attitudes and perceptions related to an organization’s health/safety management (AHRQ, 2014)

- Multifactorial framework with intent to build a system that prevents and reduces patient harm (Ammouri et al., 2015)

- MUSC definition:
Methods

• Survey results shared in staff meetings and electronically (email, unit blog)

• Top areas of concern included event reporting, staffing, non-punitive response to error and communication

• Smaller groups discussed key areas of concern, identified root causes, brainstormed remedies from current evidence

• Staff and manager made shared decision on strategies to implement
“If I had only one hour to save the world, I would spend fifty-five minutes defining the problem, and only five minutes finding the solution.”

Albert Einstein
### Culture Item Discussion Form:

**Statement to be discussed:**

| Role Specific score variation:  
| e.g. MD vs RN, RN vs Techs, Clinical vs. Admin |

| Unit Safety Assessment Score (percent agreement): |

| 1. What does this statement mean to you? |

| 2. How accurately does the unit score reflect your experience on this unit? Share examples |

| 3. How would it look (i.e., what behaviors/processes would we see) on this unit if 100% of caregivers responded agree strongly with this item? |

| 4. Identify at least one actionable idea to improve unit results in this area: |

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(Quality and Safety Research Group, 2010)
Strategy 1

• Weekly Safety Huddles
  1. Review current events & trends
  2. Plan topics for Hospital Safety Rounds
  3. Open forum

• Huddles occurred each Friday at change of shift, generally 15 minutes or less

• Provost et al. (2015) found huddles create time for conversation, enhance relationships, and improve communication efficiency
Strategy 2

- Hospital Safety Rounds

- Planning during Safety Huddles led to more meaningful use of time during Hospital Safety Rounds

- Singer and Tucker (2014) share that safety rounds or walkrounds must be authentic with engaged leadership to improve safety culture
Strategy 3

• Just Culture

• Reviewed scenarios every month at hospital leadership meeting and cascaded information to employees during staff meetings

• Used Just Culture algorithms with errors and events on the unit
Strategy 4

• Paging Protocol

• Included response codes

  **URGENT**: 10 minute response needed  
  **FYI**: Response within one hour needed  
  **NRR**: No response required

• ISBAR format
Strategy 5

• Reassessment of staffing patterns

• Reviewed ADT impact (admissions, discharges, transfers)

• Re-instituted a “Chaos Nurse” shift during the busiest hours

• Adjusted secretary schedule to cover evenings and weekends
Results

Percent Positive Responses

Domains

- Mar-13
- Oct-13
Results

Improvement in 12 of 13 domains

<table>
<thead>
<tr>
<th>Safety Grade</th>
<th>March 2013</th>
<th>October 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>Very Good</td>
<td>40%</td>
<td>32%</td>
</tr>
<tr>
<td>Acceptable</td>
<td>40%</td>
<td>18%</td>
</tr>
<tr>
<td>Poor</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Failing</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
What happened next?

- Persistence!!

- Continued with our action plan for the following 6 months
Why should we care?

• Organizations with positive safety cultures have:
  
  • Better patient satisfaction (Sorra et al., 2012)
  • Better nursing sensitive indicator outcomes
  • Lower mortality rates
  • Lower readmission rates (DiCuccio, 2014)

• Organizations with negative perceptions regarding patient safety culture are associated with higher rates of nursing burnout (Halbesleben et al., 2008)
Tip: Recognize Your Safety Stars!
Conclusion

• Be transparent when sharing results

• Listen to the stories

• Use the magic of persistence and perseverance
Contact Information

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Contact if you have questions!
References


