Clarity PSO Learning Series

Topic #4: Culture of Patient Safety

CLARITY PSO
A Patient Safety Organization

Introduction

The World Health Organization (WHO) estimates that one in ten patients in developed countries is harmed during a hospital stay from an error or adverse event (1). We have also seen in recent literature that earlier estimates of patient deaths from medical errors may have been significantly underestimated, and the actual number in the United States is estimated to range from 210,000 to 440,000 (2). What this and other information tells us is that while we have seen consistent improvements in hospital care over the last several years, there are still gaps that need to be addressed.

Each healthcare work environment has its own uniquely defining inherent culture and potential threats to patient safety. There is great variability from state-to-state and within local service areas with some showing improvements and others struggling. In this edition of the Clarity PSO Learning Series, we will explore the current state of patient safety culture across healthcare organizations and offer options that may help improve the "health" of your organization's environment.

What We Learned

As a PSO, we are tasked with building and using the knowledge we receive from providers to help develop patient safety activities that drive discovery, learning and recommendations. Through our work and information provided by the healthcare industry, we have learned the following about the culture of patient safety:

- Errors can occur at any stage in any process and are most often due to failures within a system
- We continue to see similar patterns of events, harm and contributing factors in our reporting system. Despite knowledge and recommended best practice strategies, the numbers remain. The good news is that reporting does not indicate increasing negative trends in patient care delivery or harm
- Patient safety culture is often times over-shadowed by competing priorities within an organization. Culture must be seen as the foundational element that drives the priorities toward safer patient care
- Patient and insurance costs due to increased lengths of stay, litigation costs, lost income, disability, and medical expenses run upward of 6-29 billion dollars per year (3)
- Culture refers to not only unit specific safety culture, but also organizational safety culture (leadership, resources, system processes and patterns)
- The highest scoring data elements in AHRQ's 2012 Hospital Survey on Patient Safety Culture were teamwork within units and supervisor/manager expectations and actions promoting patient safety (4)
- The lowest scoring data elements in AHRQ's 2012 Hospital Survey on Patient Safety Culture were non-punitive response to error and handoffs/transitions (5)
- The importance of defining oneself as a "learning organization" cannot be underestimated

- Overall, patient safety culture promotion appears to be more of a combination of intangibles such as leadership, teamwork, and attitudes that includes multiple strategies versus a specific process or single intervention (6)
- There is encouragement for Congress to take action to enable strong, effective cultures of safety to exist while creating legislation to extend peer review protections to data related to patient safety and quality collected and analyzed for the purpose of patient safety (7). The Patient Safety Act of 2005 and subsequently the establishment of PSOs answered this call to action

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Recommendations

The development of a culture of patient safety should not be viewed as a priority on its own. Alignment of culture with organizational mission, values, and strategic planning is critical to change and eventual sustainability.

Based on our experience and knowledge, we suggest you consider the following recommendations during your journey toward a culture of patient safety:

Organizational & Leadership Support

- Promote leadership that is visible, approachable and supportive (leadership rounds, participation in patient safety activities)
- Clearly communicate to staff that leadership supports safety first to create trust and transparency among healthcare providers and staff
- Foster a fair, blame free, and just culture that encourages transparency; 46% of staff felt that when an event was reported, it was a write-up of the person, not the problem, while 50% felt their mistakes were held against them (8)
- Promote horizontal leadership creating shared mental models of care
- Consider systems, complexity, human factors and change theories in decision making and change processes within the organization
- Support effective improvement and change processes with ongoing evaluation for sustainability
- Gather patient and point of care feedback/input in operational decisions regarding workflow processes
- Celebrate the wins, reward workers for safety

Infrastructure to Support Patient Safety

- Create high-reliability designs including lean processes, error traps, a multi-layered system for the prevention of error, and resiliency to mitigate errors when they do happen
- Use safety science concepts derived from several disciplines including root cause analysis (retrospective) and failure mode and effects analysis (prospective) processes
- Establish a dedicated patient safety committee representing all stakeholders, a patient safety leader within the organization and unit-based patient safety champions
- Employ an effective patient safety event reporting system to aggregate, analyze and understand errors/near misses leading to potential change
- Consider options to gain patient and front line insight on incidents/near misses and what the staff felt could have prevented the actual/potential event (anonymous surveys, locked feedback suggestion boxes, optional item in an event reporting system)
- Organize formal education and training programs including interdisciplinary team training to enhance shared mental models of care, mutual understanding of roles and respectful communication
- Conduct annual culture of patient safety surveys

Position as a Learning Organization

- Transform physical and cultural environments of an organization into a "learning organization" that provides a psychologically safe, blame free, transparent, just culture
- Engage in learning opportunities from root cause analysis, failure modes and effects analysis, case studies, debriefing sessions at the unit and organization level...bridging the two
- Explore concepts from available safety program frameworks to determine which will be the best fit for your organization such as comprehensive unit-based safety program (CUSP)
- Establish interdisciplinary rounding and team training (TEAMSTEPPS)
- Encourage strong involvement from front line providers (Transforming Care at the Bedside/TCAB)

Effective Quality Improvement Processes & Sustainability

- Conduct a thorough microsystem assessment, analysis, and readiness including patients and front line providers
- Use an effective improvement process such as Plan-Do-Study-Act or Lean principles
- Align with regulatory agencies and organizational mission, values, and strategic plans
- Evaluate the effectiveness of strategy implementation with meaningful outcome measures
- Use comparative/benchmarking reports to create awareness around the understanding of internal data use and external data use
- Trend data over time; support sharing of best practices, which is a significant goal of the PSO program
- Implement small cycles of change for improvement processes prior to organizational change

In order to achieve a safe environment for your staff and patients, you need to infuse a combination of practices like those recommended here into your organization and its core strategies. A culture of safety cannot be achieved by just one tactic or one person, but it is a whole process that has to consider the various needs and differences of each work environment. In this case, the performance improvement processes you undertake are supported by the culture of safety you have developed.

Reference List

To learn more about Clarity PSO, contact us or visit our website

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