NYSPFP
AHRQ Culture of Safety Survey
Debrief & Action Planning Tool

Hospital: Unit

2019

Objectives

- Review and discuss the 2019 Safety Culture Survey results with hospital and unit specific data
- Understand what drives improvement in safety culture
- Identify our hospital and/or unit strengths and weaknesses
- Continuously improve or adopt new practices where indicated

Safety Culture

"Safety culture provides valuable insights as to what it feels like to be a unit secretary, nurse, physician, or other caregiver at the clinical unit level or those supporting direct caregivers. Feeling valued and having the psychological safety to speak up and voice concerns and learn from errors, all have a tremendous impact on the quality of care and the social dynamic among caregivers. Safety culture is measurable and can be deployed as a powerful mechanism to engage caregivers in positive behavioral change."

From: *Creating a Road Map for Patient Safety* in The Essential Guide for Patient Safety Officers, 2nd Ed. (2013); Joint Commission Resources

What is Safety Culture?

Elevator Speech:

Safety culture is the attitudes, beliefs and behaviors that characterize an organization, group or unit's level of commitment to preventing harm to its patients and staff

Three Fundamental Questions

- **What are we trying to accomplish?**
  - Our aim is to improve safety culture so that we can become a high reliability organization where we can anticipate patient harm and prevent it before it occurs

- **How will we know if a change is an improvement?**
  - Our measures of improvement are the scores from the AHRQ Hospital Survey of Patient Safety Culture (HSOPS)

- **What changes can we make that will result in improvement?**
  - There are specific interventions that have been identified through learning from best practices and we can develop actionable plans

http://www.nichq.org/how_we_work/model_for_improvement.html

Debriefing and Action Planning

- Team input helps get to the root cause of concern through meetings and conversation
- Share ideas and recommendations for improvements
- Focus on a few key action areas for follow up; do a few things well, not several poorly

Hospital & Unit-Level Debrief

Participation Rate

The overall participation rate was XX% for Hospital Name.

- XX% of Unit Name colleagues contributed to the overall results.
  - The participation rate is an important metric for safety culture and engagement.
  - Higher participation rates determine the confidence with which we believe the survey results truly reflect the opinions of the staff
  - XX% of staff want to engage in a conversation about the factors which drive safety.

Survey Dimensions

Surveys on Patient Safety Culture

1. Overall Perception of Safety
2. Teamwork within Units
3. Organizational Learning
4. Staffing
5. Non-punitive Response to Error
6. Supervisor/Manager Expectations & Actions Promoting Patient Safety
7. Communication Openness
8. Feedback and Communication about Errors
9. Frequency of Events Reported
11. Management Support for Patient Safety
12. Teamwork Across Units
13. Handoffs and Transitions

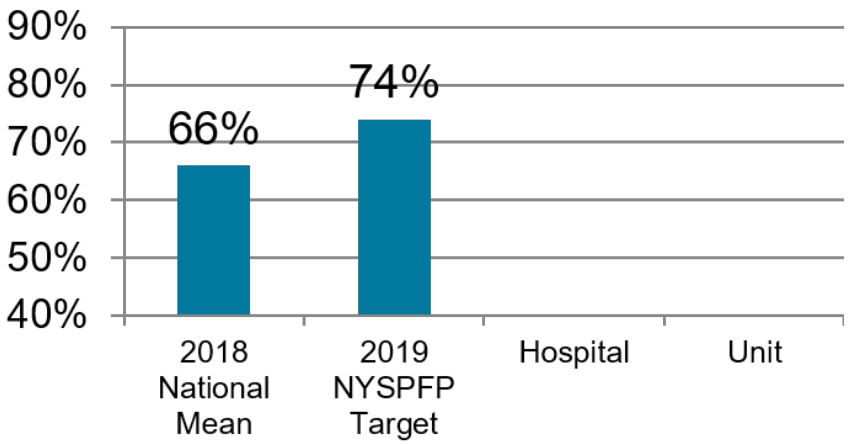
Supplemental Items

14. Empowerment to Improve Efficiency
15. Efficiency and Waste Reduction
16. Patient Centeredness and Efficiency
17. Supervisor, Manager, or Clinical Leader Support for Improving Efficiency and Reducing Waste
18. Experience With Activities to Improve Efficiency
19. Overall Efficiency Ratings

Overall Perception of Safety

Survey Questions

- 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.



Conversation Tips

- What have we accomplished to improve patient safety on our unit?
- What can we do now, or put into place to improve patient safety on our unit?

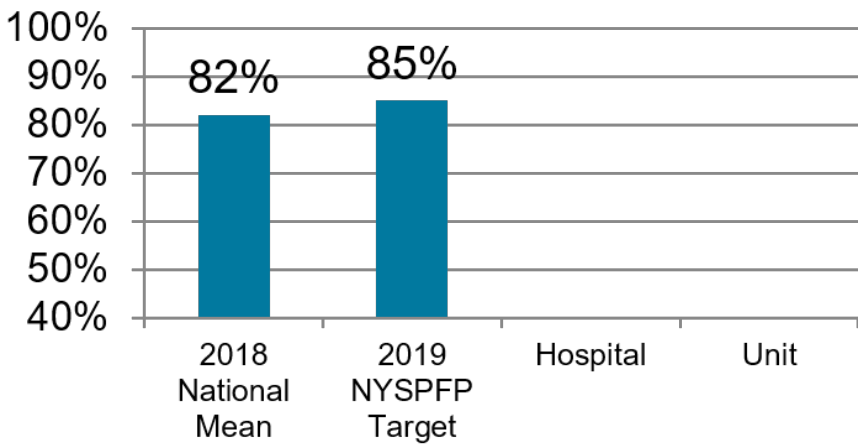
Practices That Improve Overall Perceptions of Safety

- Hand Hygiene Training
- Patient Safety Checklists
- Patient Safety Assessments

Teamwork within Units

Survey Questions

- People support one another in this unit.
- When a lot of work needs to be done quickly, we work together as a team to get the work done.
- In this unit, people treat each other with respect.
- When one area in this unit gets really busy, others help out.



Conversation Tips

- What are our strengths as a team? When and how do we work well together to improve patient care?
- What can we do now, or put into place to improve teamwork on our unit?
- What standardized set of communication practices do we have on our unit?

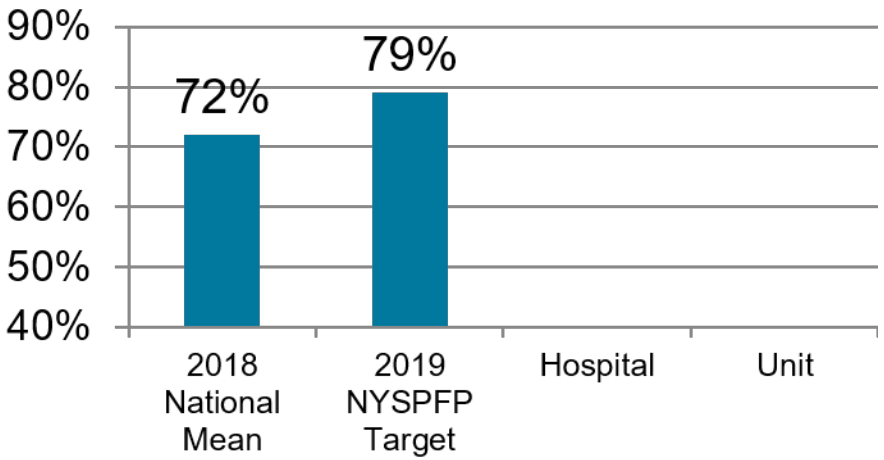
Practices That Improve Teamwork

- CUSP
- Patient Safety Primer Teamwork Training
- Team STEPPS

Organizational Learning - Continuous Improvement

Survey Questions

- We are actively doing things to improve patient safety.
- Mistakes have led to positive changes here.
- After we make changes to improve patient safety, we evaluate their effectiveness.



Conversation Tips

- What have we accomplished to improve Organizational Learning?
- In what ways do we continue to learn and improve as a team?
- What can we do now, or put into place to improve Organizational Learning on our unit?

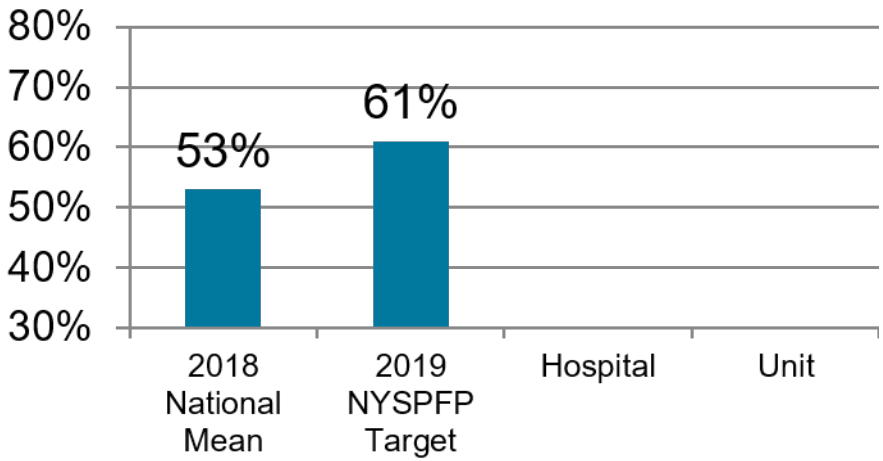
Practices That promote Continuous Improvement

- Root Cause Analysis
- Patient-Family Centered Care Self Assessment Tool
- Plan-Do-Study-Act (PDSA)

Staffing

Survey Questions

- We have enough staff to handle the workload.
- Staff in this unit work longer hours than is best for patient care. (negatively worded)
- We use more agency/temporary staff than is best for patient care. (negatively worded)
- We work in "crisis mode" trying to do too much, too quickly. (negatively worded)



Conversation Tips

- What do we do to work together to maximize staffing and resources available?
- What education, training or skills do we have to better care for patients on our unit?

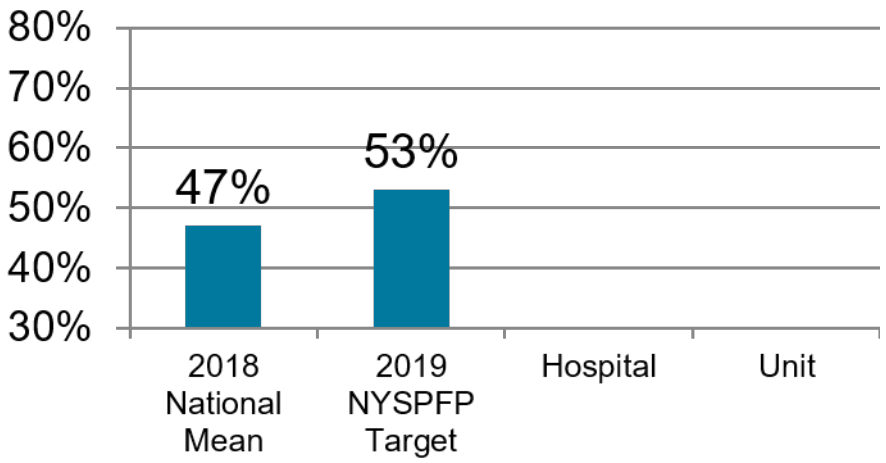
Practices That Improve Staffing

- Nurse-Led, Unit-Based Quality Improvement Increases Amount of Time Spent With Patients, Reduces Falls and Nurse Turnover
- Patient Safety Primer: Missed Nursing Care

Non-punitive Response to Error

Survey Questions

- 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.



Conversation Tips

- What have we accomplished to improve error reporting on our unit?
- What can we do to be even more effective?
- When do you worry about mistakes being held against you?

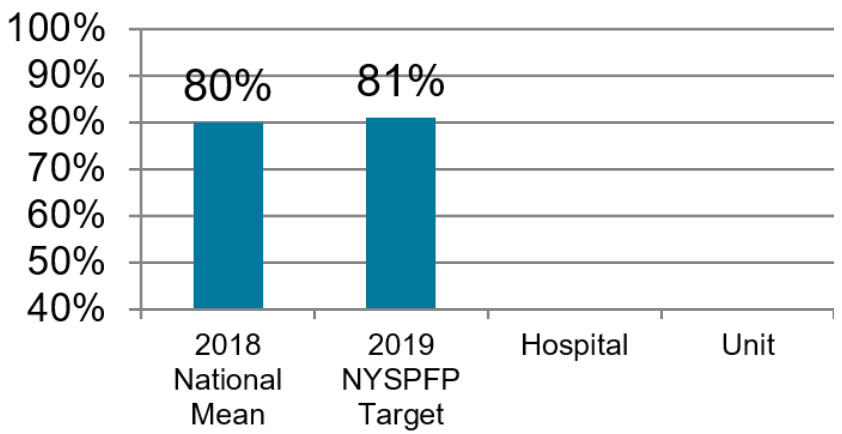
Practices That Improve Non-punitive Response to Error

- Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems
- Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management
- Patient Safety and the “Just Culture”

Supervisor Expectations and Actions Promoting Safety

Survey Questions

- My supervisor/manager says a good word when he/she 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.



Conversation Tips

- In what ways do supervisor expectations and actions help promote a culture of safety on our unit?
- What can we do now, or put into place to improve supervisor expectations and actions promoting safety on our unit?

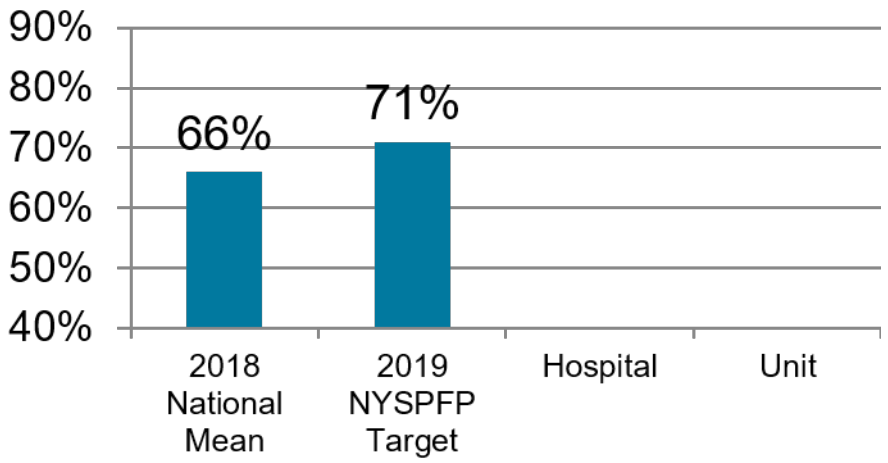
Practices That Improve Supervisor Expectations and Actions

- Unit Champions
- Leadership Rounds
- Patient-Family Centered Care

Communication Openness

Survey Questions

- 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.



Conversation Tips

- What have we done on our unit to make sure that we communicate openly and honestly?
- What can we do to be even more effective?

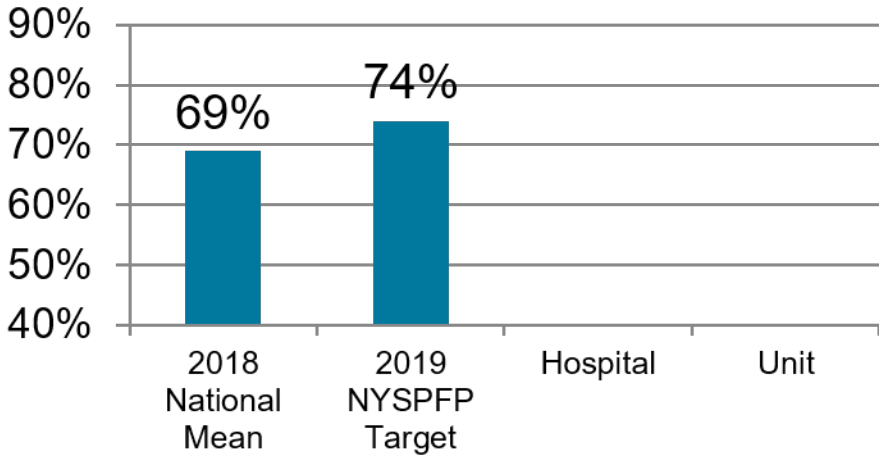
Practices That Improve Communication Openness

- **Rapid Response Team Record with SBAR**
- Team STEPPS
- NYSPFP Culture of Safety Resources

Feedback and Communication About Error

Survey Questions

- We are given feedback about changes
- We are informed about errors that happen in this unit.
- In this unit, we discuss ways to prevent errors from happening again.



Conversation Tips

- In what ways do you prefer to receive feedback and communication about errors?
- How can you effectively communicate about errors to your teammates?
- How do we learn from our errors to prevent them from happening again?

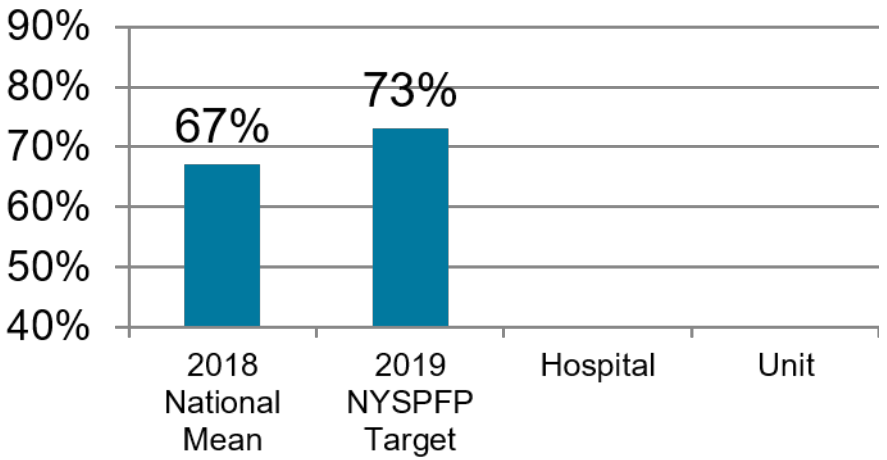
Practices That Improve Feedback and Communication About Error

- Learning From Error
- Safety Huddle Results
- Frontline Feedback Tools

Frequency of Events Reported

Survey Questions

- When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?
- When a mistake is made, but has no potential to harm the patient, how often is this reported?
- When a mistake is made that could harm the patient, but does not, how often is this reported?



Conversation Tips

- Do you know how to report events?
- Do you feel comfortable reporting events?
- What have we accomplished to improve the frequency of events reported?
- What can we do now, or put into place to improve event reporting on our unit?

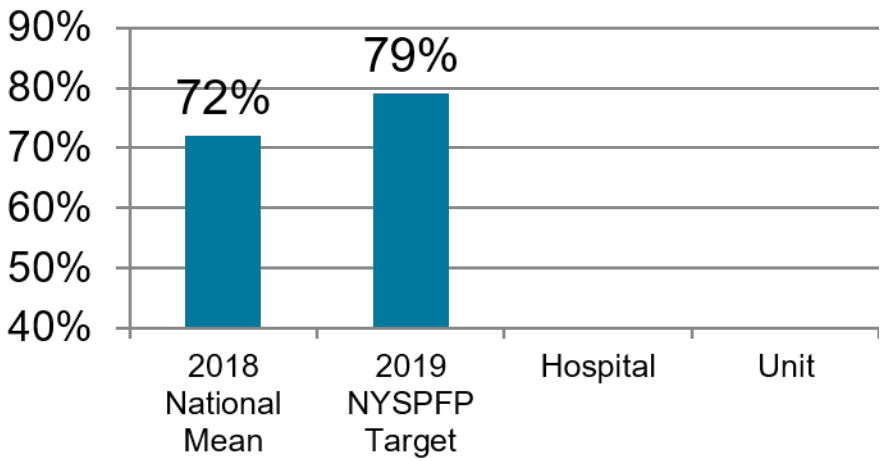
Practices That Improve Frequency of Events Reported

- Incident Reporting
- Multifaceted Program Increases Reporting of Potential Errors, Leads to Action Plans to Enhance Safety
- Patient Safety Toolbox for States

Hospital Management Support for Patient Safety

Survey Questions

- Hospital management provides a work climate that promotes patient safety.
- The actions of hospital management show that patient safety is a top priority.
- Hospital management seems interested in patient safety only after an adverse event happens.



Conversation Tips

- When do you feel most supported by hospital management?
- What can we do now, or put into place to improve hospital management support for patient safety on our unit?

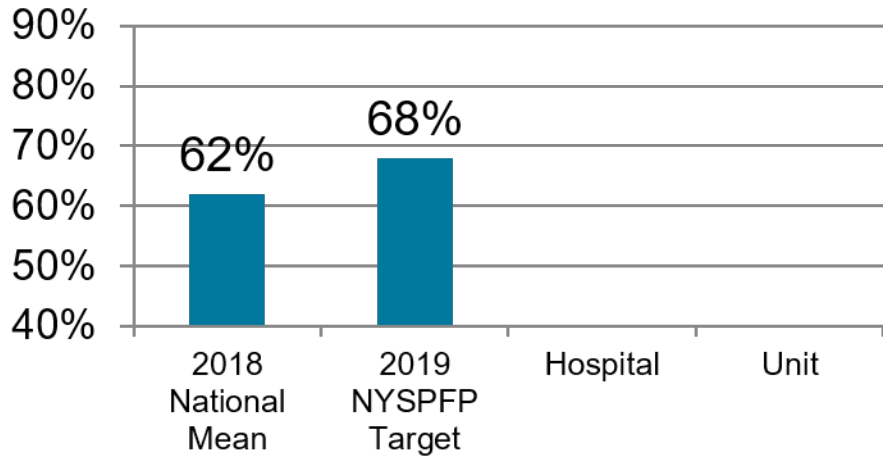
Practices That Improve Hospital Management Support for Patient Safety

- Unit Champions
- Leadership Rounds
- Patient-Family Centered Care

Teamwork Across Units

Survey Questions

- 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.



Conversation Tips

- When is it difficult to work as a team across units?
- What have we accomplished to improve Teamwork Across Units?
- What can we do now, or put into place to improve our Teamwork Across Units?
- How standardized is the EHR, the evidence based practice, the communication system?

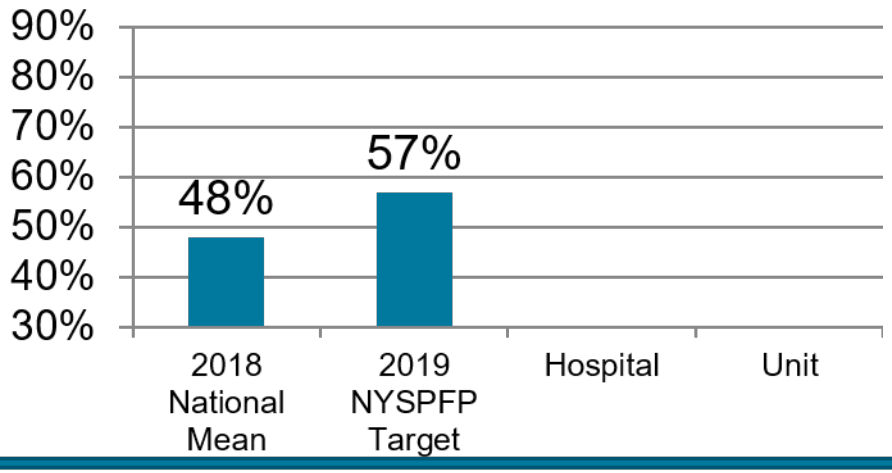
Practices That Improve Teamwork Across Units

- Improving Patient Flow and Reducing Emergency Department Crowding: A Guide for Hospitals
- TeamSTEPPS® — Team Strategies and Tools to Enhance Performance and Patient Safety
- Patient Safety Primer: Teamwork Training

Hospital Handoff and Transitions

Survey Questions

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



Conversation Tips

- Do you feel comfortable during handoffs and transitions?
- What have we accomplished to improve Handoffs and Transitions on our unit?
- What can we do now, or put into place to improve Handoffs and Transitions?

Practices That Improve Hospital Handoff and Transitions

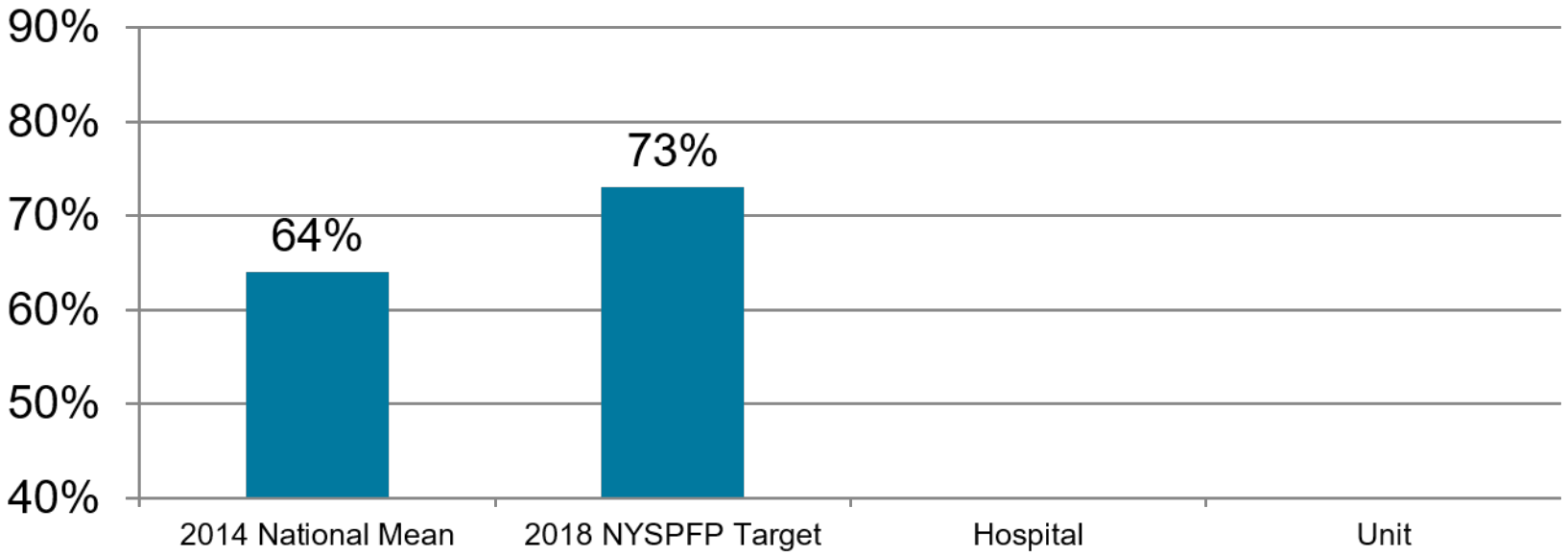
- Coordinated-Transitional Care Toolkit
- SBAR
- Door-to-Doc Patient Safety Toolkit

Supplemental Items Debrief

Empowerment to Improve Efficiency

Survey Questions

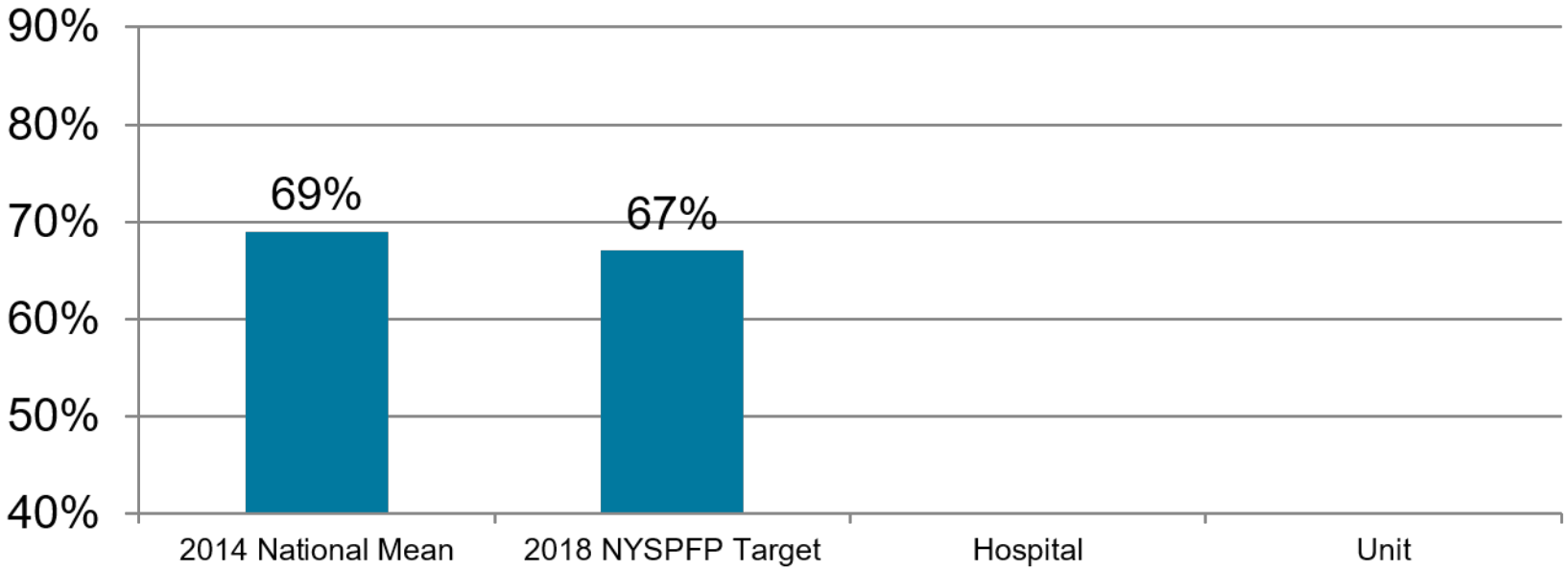
- We are encouraged to come up with ideas for more efficient ways to do our work
- We are involved in making decisions about changes to our work processes
- We are given opportunities to try out solutions to workflow problems



Efficiency and Waste Reduction

Survey Questions

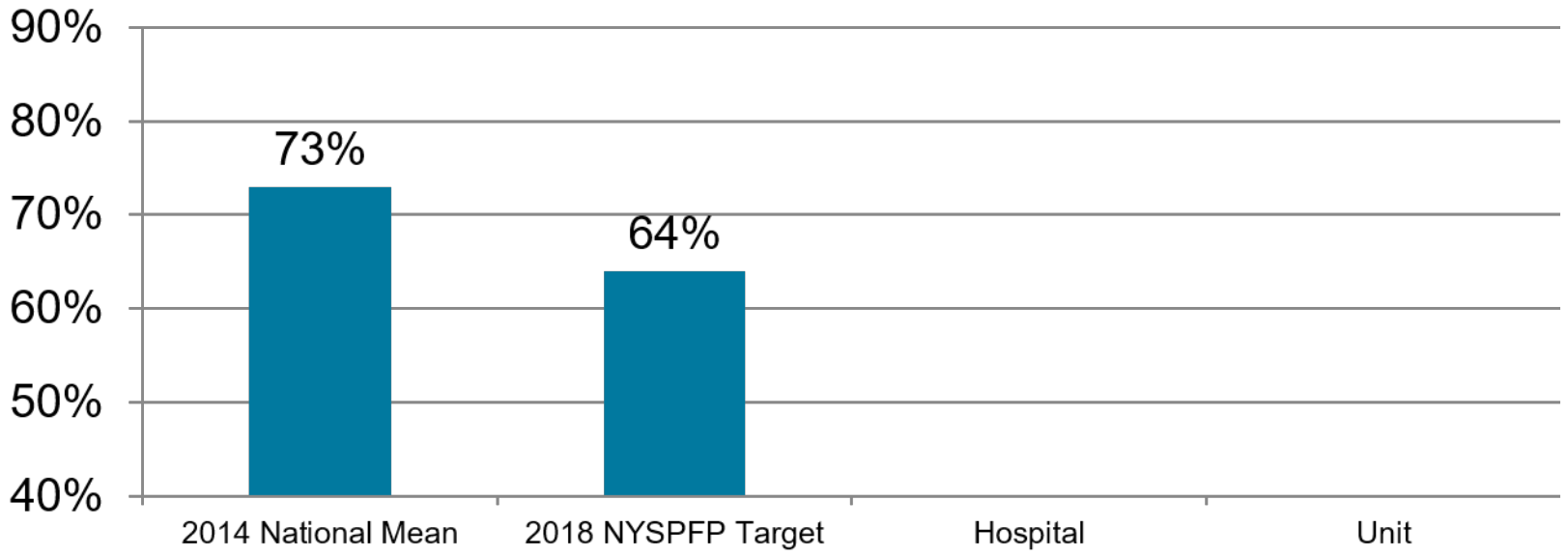
- We try to find ways to reduce waste (such as wasted time, materials, steps, etc.) in how we do our work
- In our unit, we are working to improve patient flow
- We focus on eliminating unnecessary tests and procedures for patients



Patient Centeredness and Efficiency

Survey Questions

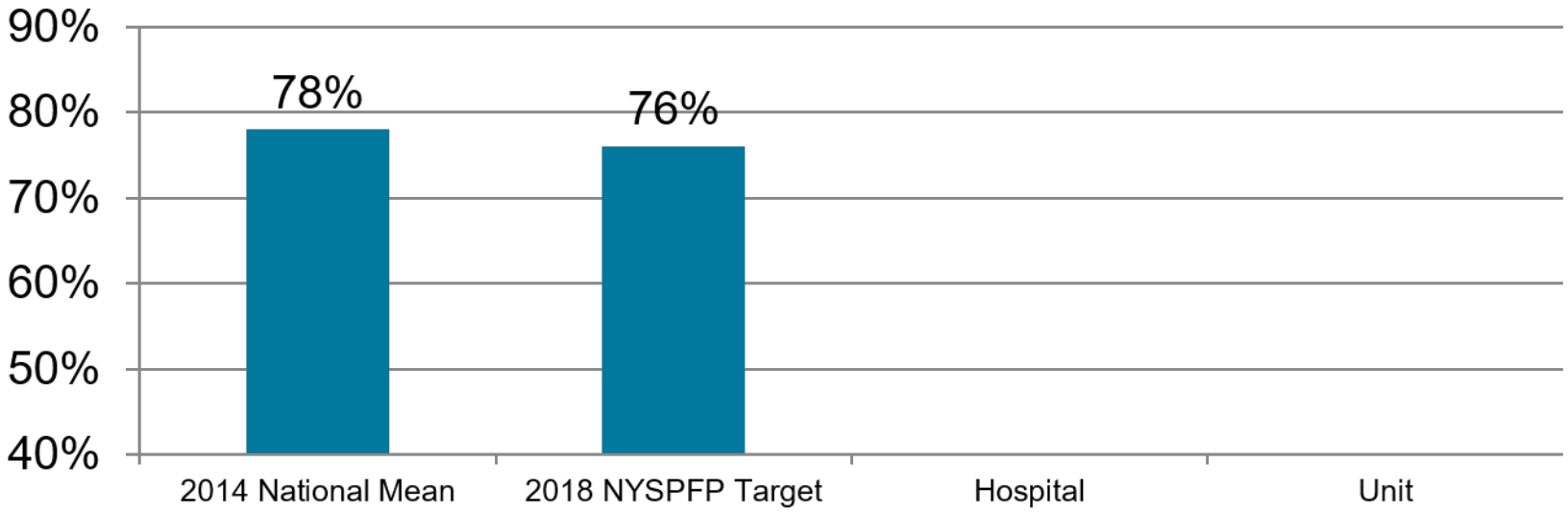
- In our unit, we take steps to reduce patient wait time
- We ask for patient or family member input on ways to make patient visits more efficient
- Patient and family member preferences have led to changes in our workflow



Supervisor, Manager, or Clinical Leader Support for Improving Efficiency and Waste Reduction

Survey Questions

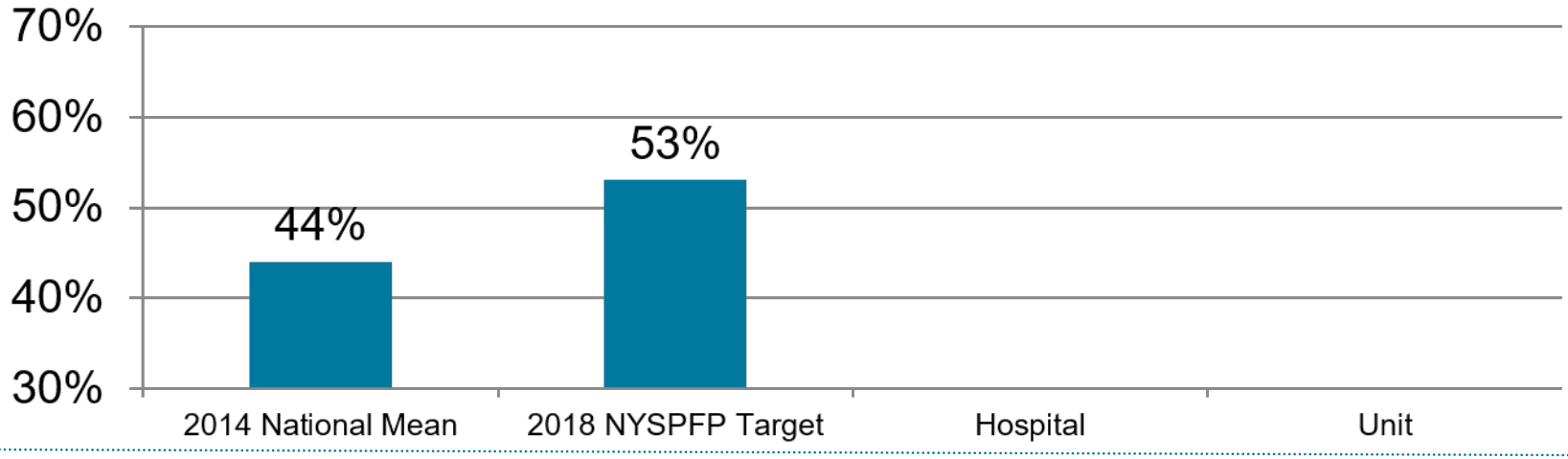
- Recognizes us for our ideas to improve efficiency
- Provides us with reports on our unit performance
- Takes action to address workflow problems that are brought to his or her attention
- Places a high priority on doing work efficiently without compromising patient care



Experience With Activities To Improve Efficiency

Survey Questions

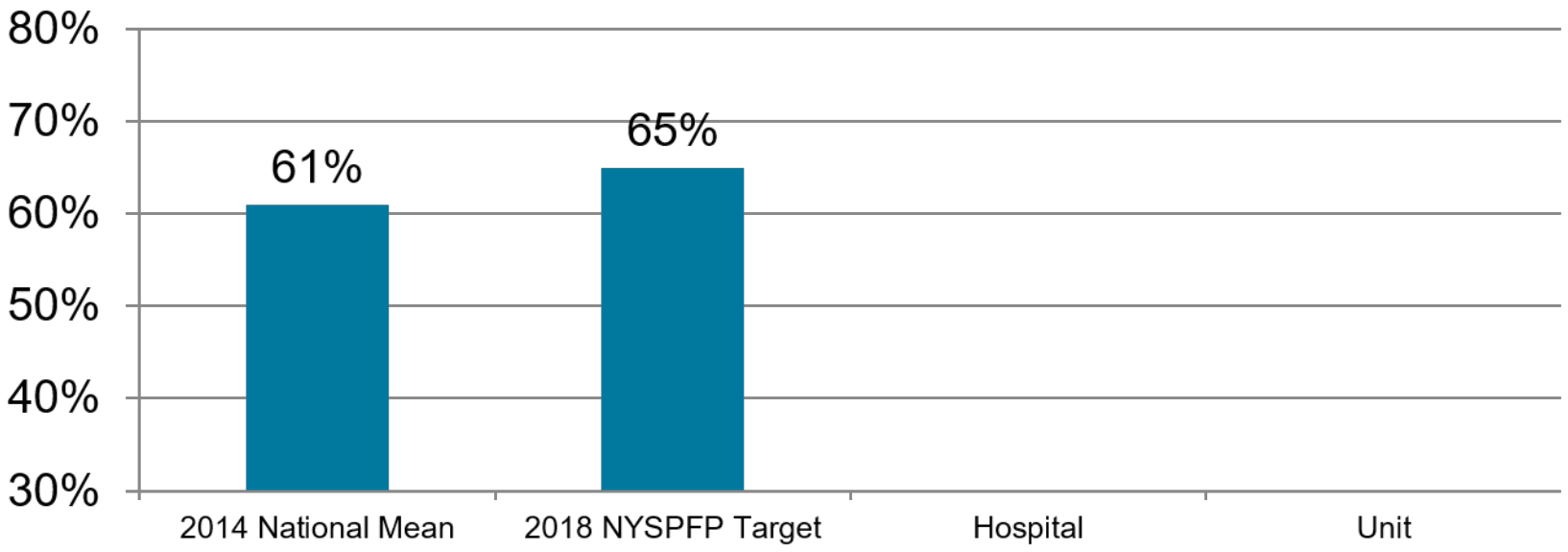
- I received training on how to identify waste and inefficiencies in my work
- I helped to map a workflow process to identify wasted time, materials, steps in a process, etc.
- I shadowed/followed patients in this hospital to identify ways to improve their care experience
- I looked at visual displays or graphs to see how well my unit was performing
- I made a suggestion to management about improving an inefficient work process
- I made a suggestion to management about improving patients' care experiences
- I served on a team or committee to make a work process more efficient
- I monitored data to figure out how well an activity to improve efficiency was working



Overall Efficiency Ratings

Survey Questions

- Is responsive to individual patient preferences, needs, and values
- Provides services based on scientific knowledge to all who could benefit
- Minimizes waits and potentially harmful delays
- Ensures cost-effective care (avoids waste, overuse, and misuse of services)



Action Planning

Documenting Your Plan

- There are several action planning tools available
  - AHRQ, NYSPFP website, your organization
- Choose a few (one or two) domains
- Develop the plan with your teams input
- Share and post your plan for reference
- Keep it alive
  - Update it regularly, change it if it isn't working

Action Planning

- Next Steps:
  - Complete Action Plan
    - NYSPFP Action Planning Template
    - AHRQ Action Planning Template

- Resource Guide:
  - AHRQ Resources by Composite

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