HOSPITAL CULTURE OF PATIENT SAFETY

Internal Tool for Hospital Planning and Action Steps

This document is provided to hospitals as a guide for assessing opportunities for improvement related to findings from the AHRQ Hospital Culture of Patient Safety survey. It is intended as a voluntary internal tool. Documents and data will not be collected by NYSPFP.

Action Planning

1. Background Information

1.a Has the COS been conducted previously in your organization? YES ______ NO ______

1.b If Yes, what were the previous dates? Mo ______ Year ______
______ ______
______ ______

1.c If yes, what was the previous impact and are action plans and change teams still functional?

1.e Describe your organization's mission, vision and values:

1.f List your organization's strategic goals, related to organizational culture and safety.

2. Analysis of current COS

2.a Response Rate ______. A response rate of 40% or greater ensures that survey results are likely to be representative of those surveyed. If your rate is less than 40%, note how responders and non-responders might differ.

2.b Utilizing the COS Survey results Worksheet, identify overall strengths and opportunities for improvement. You may choose to start with opportunities that are more readily achievable, rather than the dimensions with lowest score. Available comparators include national and statewide means as well as 75th or 90th percentiles.

Top Three Dimensions (Strengths)	% +	Bottom Three Dimensions (Weakness)	% +

2.c Utilizing the COS – RFC Alignment and Integration Tool, review the readiness assessment practices for those dimensions where you have the greatest opportunity for improvement (bottom 2-3). On that tool, rate the effectiveness of your current related practices.

3. Complete the following 10 step action plan.

Step 1: Define the problem, challenge, opportunity
(be specific by identifying low percent positive COS scores and low effectiveness ratings in the COS-RFC Tool):

We need to strengthen our Overall Perception of Safety because:

We can do this by (be specific about the practices needed across the hospital and within work areas/job titles):

We need to strengthen Teamwork, Hand-Offs, Transitions because:

We can do this by (be specific about the practices needed across the hospital and within work areas/job titles):

We need to strengthen Organizational Learning – Continuous Improvement because:

We can do this by (be specific about the practices needed across the hospital and within work areas/job titles):

We need to strengthen Feedback and Communication About Error because:

We can do this by (be specific about the practices needed across the hospital and within work areas/job titles):

We need to strengthen Management Actions promoting Safety because:

We can do this by (be specific about the practices needed across the hospital and within work areas/job titles):

We need to strengthen Communication Openness/Event Reporting/Non-Punitive Response because:

We can do this by (be specific about the practices needed across the hospital and within work areas/job titles):

Step 2: Create the change team (choose members based on influence/willingness, relevance to problem, challenge, opportunity) (duplicate this form for each change process/team)

NAME	ROLE

Step 3: Define your aim(s)/goals

What will be achieved?

What departments will be involved?

When and where the change will occur?

EXAMPLES:

(1) We will strengthen our communication skills and make it psychologically safe for all to advocate for patients. We will do this by using SBAR for communication between all who exchange patient information, and teaching all staff to use CUS. We will start with acute care; Nurses and support staff will effectively use SBAR and CUS by October 1, 2012.

(2) We will improve reporting and learning in the ED by debriefing on a weekly basis, documenting the results and sharing them with all ED staff and management. We will begin by Sept 15, 2012.

(3) We will improve our nonpunitive response to error by focusing review of occurrences on process improvement and being transparent with all staff about how decisions are made regarding accountability. Leadership will communicate related process improvements emphasizing the importance of reporting to identify opportunities to improve the safety of the environment and services provided to our patients. Related procedures to be revised effective 11/1/12. Leadership communications and staff/physician training to occur during the month of October 2012.

Step 4: Design an intervention

Hospital as a whole:

Units/departments of focus:

Which tools/strategies:

Step 5: Determine Measures for your intervention (consider integrating into Balanced Scorecard)

- Observations
- Counts (e.g. # Briefs, # Reports, #RCAs, # WalkRounds)
- Outcome measures: Fall rate; rate of appropriate pre-op antibiotic usage
- Repeat Safety Culture Survey 2013-14
- Patient/Staff satisfaction

Step 6: Develop a plan (example)

What	When
Obtain support from Management, Medical Staff, and Board by sharing current results and benchmarks	
Provide Feedback to Department Heads by sharing aggregate and department specific graphs and results	
Engage departments in action planning based on both aggregate hospital and specific department opportunities	
Communicate aims, goals of plan at hospital and department levels	
Conduct necessary training	
Ensure policies/procedures support action plans	

Step 7: How will you sustain and spread changes embedded in the action plans? (example)

- Role modeling
- Monitoring
- Integrate into new employee orientation, competency testing
- Improved feedback at hospital and department level

Step 8: Communication Plan

Stakeholder analysis (who needs to provide support, who needs to be brought over to your side)

Talking Points:

We have chosen to focus on ____.
It is important that we improve ____
because ____ puts our patients at risk and impacts our performance. We need you to support our efforts by __________________
____.

Step 9: Write your final action plan covering steps 1 – 8.

Step 10: Review of plan by key personnel