An Overview of the AHRQ Hospital Survey on Patient Safety Culture™ (SOPS™) and Value and Efficiency Supplemental Item Set

Using the SOPS Toolkit for Patient Safety Improvement

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Objectives

• Provide overview of the following:
  • SOPS Hospital Survey
  • SOPS Databases
    • Results from the 2016 Hospital Database
  • Hospital Value and Efficiency Results
  • SOPS Updates and Products
What is patient safety culture?

Patient Safety Culture
The beliefs, values, norms, shared by health care staff

Rewarded
Supported
Expected
Accepted

It exists at multiple levels:
System
Hospital
Department
Unit
Why should you do a culture survey?

- Raise staff awareness about patient safety
- Assess patient safety culture in hospital units/work areas
- Identify strengths and areas for improvement
- Examine change over time
- Evaluate the impact of patient safety initiatives
- Conduct internal and external comparisons
Background

- Hospital Survey
  - Developed by Westat, funded by AHRQ
  - Final survey released November 2004
Hospital SOPS Survey Development Process

1. Reviewed literature and existing surveys
2. Interviewed experts, providers & staff
3. Identified key thematic areas
4. Developed & cognitively tested draft items
5. Obtained input from Technical Expert Panel (TEP)
6. Pilot tested in 21 hospitals
7. Conducted psychometric analyses
8. Consulted with TEP to finalize items
HSOPS Patient Safety Culture Dimensions

• 42 items assess 12 composites of patient safety culture

1. Communication openness
2. Feedback & communication about error
3. Frequency of event reporting
4. Handoffs & transitions
5. Management support for patient safety
6. Nonpunitive response to error
7. Organizational learning--continuous improvement
8. Overall perceptions of patient safety
9. Staffing
10. Supv/mgr expectations & actions promoting patient safety
11. Teamwork across units
12. Teamwork within units

• Patient safety “grade” (Excellent to Poor)

• Number of events reported in past 12 months
SOPS Databases
SOPS Databases

- Repositories for data from SOPS surveys

<table>
<thead>
<tr>
<th></th>
<th>Hospital</th>
<th>Medical Office</th>
<th>Nursing Home</th>
<th>Community Pharmacy</th>
</tr>
</thead>
</table>
Benefits of All SOPS Databases

- Individual facility feedback reports comparing results to the database
- Database Report of aggregate facility-level statistics
- Additional results by facility characteristics and respondent characteristics
- Facilities de-identified in the database
SOPS Hospital Database

• 2016 Report
  • 680 U.S. hospitals, 447,584 respondents
    • Average # respondents per hospital = 658 staff
    • 326 trending hospitals

• Survey modes
  • Paper 7%
  • Web 78%, In 2007 was 25%
  • Both 16%

• Average hospital response rate = 55%
  • Paper 71%
  • Web 54%
  • Both 55%
<table>
<thead>
<tr>
<th>Hospital Work Areas</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>12%</td>
</tr>
<tr>
<td>Surgery</td>
<td>10%</td>
</tr>
<tr>
<td>Many areas/no specific areas</td>
<td>8%</td>
</tr>
<tr>
<td>ICU</td>
<td>7%</td>
</tr>
<tr>
<td>Emergency</td>
<td>6%</td>
</tr>
<tr>
<td>Radiology</td>
<td>5%</td>
</tr>
<tr>
<td>Lab</td>
<td>5%</td>
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</tbody>
</table>
### Staff Positions & Patient Contact

#### Hospital Work Areas

<table>
<thead>
<tr>
<th>Hospital Work Areas</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>36%</td>
</tr>
<tr>
<td>Technicians</td>
<td>11%</td>
</tr>
<tr>
<td>Management, administration</td>
<td>7%</td>
</tr>
<tr>
<td>Pt. care asst/aide/care partner</td>
<td>6%</td>
</tr>
<tr>
<td>Physicians, PAs, NPs</td>
<td>6%</td>
</tr>
</tbody>
</table>

- 77% had direct interaction with patients
Hospital Strengths

1. Teamwork Within Units  82%
2. Supv/Mgr Expectations & Actions Promoting Patient Safety  78%
3. Organizational Learning - Continuous Improvement  73%
Hospital Areas for Improvement

10. Staffing 54%
11. Handoffs & Transitions 48%
12. Nonpunitive Response to Error 45%
Patient Safety Grade

Overall Patient Safety Grade:

- A = Excellent: 34%
- B = Very Good: 42%
- C = Acceptable: 19%
- D = Poor: 4%
- E = Failing: 1%

76% Positive
Number of Events Reported

- None: 55%
- 1 to 2: 27%
- 3 to 5: 12%
- 6 to 10: 4%
- 11 to 20: 2%
- 21 or more: 1%

45% Positive
How Do I Compare My Results?

- Compare Percent Positive Results

  Nonpunitve Response to Error

  - Database
  - Your Hospital

- Compare Results by Hospital and Respondent Characteristics
Hospital Value and Efficiency Pilot Study
Value and Efficiency Supplemental Item Set

13 items that measure four composites

1. Empowerment to Improve Efficiency (3 items)
2. Efficiency and Waste Reduction (3 items)
3. Patient Centeredness and Efficiency (3 items)
4. Management Support for Improving
   Efficiency and Reducing Waste (4 items)

Four overall rating items related to hospital performance
Pilot Test

February – August 2014

47 Hospitals

% of Hospitals Provided Training on Value and Efficiency

42% Response Rate

45%
## Hospital Respondents

<table>
<thead>
<tr>
<th>Hospital Staff Positions</th>
<th>N</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Staff</td>
<td>1,272</td>
<td>(34%)</td>
</tr>
<tr>
<td>Other Clinical Staff</td>
<td>959</td>
<td>(26%)</td>
</tr>
<tr>
<td>Other Support Staff</td>
<td>797</td>
<td>(21%)</td>
</tr>
<tr>
<td>Department Managers, Senior Leaders</td>
<td>348</td>
<td>(9%)</td>
</tr>
<tr>
<td>Medical Staff</td>
<td>197</td>
<td>(5%)</td>
</tr>
</tbody>
</table>
## Results

<table>
<thead>
<tr>
<th>Value and Efficiency Composites</th>
<th>% Positive Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor, Manager, or Clinical Leader Support for Improving Efficiency and Reducing Waste</td>
<td>78%</td>
</tr>
<tr>
<td>Patient Centeredness and Efficiency</td>
<td>73%</td>
</tr>
<tr>
<td>Efficiency and Waste Reduction</td>
<td>69%</td>
</tr>
<tr>
<td>Empowerment To Improve Efficiency</td>
<td>64%</td>
</tr>
</tbody>
</table>
Results: Overall Quality Ratings

1. Patient Centered
   Is responsive to individual patient preferences, needs, and values.

2. Effective
   Provides services based on scientific knowledge to all who could benefit.

3. Timely
   Minimizes waits and potentially harmful delays.

4. Efficient
   Ensures cost-effective care (avoids waste, overuse, and misuse of services).

% Positive Response

- Patient Centered: 67%
- Effective: 65%
- Timely: 58%
- Efficient: 52%
SOPS Updates and Products
SOPSTM Trademark

• Surveys on Patient Safety Culture™ (SOPS™) Hospital Survey

• Database participants cannot:
  • Change the wording of the items or response options.
  • Change the order of the items or response options.
  • Delete one or more items.
  • Add supplemental or custom questions within the core survey.
SOPS Database Schedule

• Upcoming Database Submissions
  • 2018
    • Nursing Home June 1-21, 2018
    • Community Pharmacy October 1-21, 2019
  • 2019
    • Hospital
    • Medical Office
Action Planning Tool

Resource List

Composite 12. Nonpunitive Response to Error

1. Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems

   The National Association for Healthcare Quality Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems provides best practices to enhance quality, improve ongoing safety reporting, and protect staff. It addresses accountability, protection of those who report quality and safety concerns, and accurate reporting and response.

2. Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management
   http://www.ihi.org/resources/Pages/Tools/LeadershipResponseSentinelEventEffectiveCrisisMgmt.aspx

   This page of resources was developed by the Institute for Healthcare Improvement. IHI periodically receives urgent requests from organizations seeking help in the aftermath of a serious organizational event, most often a significant medical error. In responding to such requests, IHI has drawn on learning and examples assembled from many courageous organizations over the last 15 years who have respectfully and effectively managed these crises.

3. Living a Culture of Patient Safety Policy and Brochure
   http://www.ihi.org/resources/Pages/Tools/LivingACultureOfPatientSafety.aspx

   St. John’s Mercy Medical Center created an institution-wide policy regarding non-punitive reporting, as well as a brochure entitled Living a Culture of Patient Safety that was developed by its Culture of Safety Subcommittee, signed by the president, and mailed to all co-worker homes. The brochure reinforces the non-punitive reporting policy and encourages all co-workers to report errors.

4. Patient Safety and the “Just Culture”

   This presentation by David Marx defines just culture, the safety task, the just culture model, and statewide initiatives in New York.

Thank you!

Additional questions or comments?

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