Interpreting Safety Culture Survey Results and Action Planning

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Objectives…Measure to Understand

• What did you measure?
  – Define organizational culture, safety culture
  – Identify 3 types, 3 levels, and 4 universal components

• Why did you measure safety culture?

• When should you measure safety culture?

• How do you measure?

• How do you interpret results?
  – Frameworks/Concepts
  – Role of leadership in engineering culture

• Develop an action plan to implement specific behaviors
• Definitions
• Categories
• Types
• Levels
• Components

WHAT DID YOU MEASURE?
What is organizational culture?

The shared, learned beliefs and behaviors of stable group members

• Allow us to make sense of our environment
• Reflect common language (think TeamSTEPPS tools) and behavior….thus is heard and observed
• Leaders create/teach culture as they reward/provide feedback/hold accountable
• Can be measured with self-report tools

We can not change what we do not measure!

Categories of Culture

Macroculture

Organizational Culture

Subculture (Schein, 2010)

Microculture
Three Types of Organizational Culture

• Pathological—use of information to enhance personal power
  – Punitive environment

• Bureaucratic—use of information to adhere to rules, positions, and protect turf
  – Information collected but use of information for learning and change is limited

• Generative—use of information to achieve the mission
  – Practices interact to support 4 components

### Three Types of Organizational Culture

<table>
<thead>
<tr>
<th>Pathological</th>
<th>Bureaucratic</th>
<th>Generative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low cooperation</td>
<td>Rule oriented</td>
<td>Performance oriented</td>
</tr>
<tr>
<td>Messengers shot</td>
<td>Messengers neglected</td>
<td>Messengers encouraged</td>
</tr>
<tr>
<td>Responsibilities shirked</td>
<td>Responsibilities are narrow</td>
<td>Responsibilities are shared</td>
</tr>
<tr>
<td>Sharing info discouraged</td>
<td>Sharing info tolerated</td>
<td>Sharing info encouraged</td>
</tr>
<tr>
<td>Failure → scapegoat</td>
<td>Failure → Justice</td>
<td>Failure → Inquiry</td>
</tr>
<tr>
<td>Change → crushed</td>
<td>Change → problem</td>
<td>Change → implemented</td>
</tr>
</tbody>
</table>

“…in many organizations, values reflect desired behavior but are not reflected in observed behavior.”

What is a Culture of Safety?

• Enduring, shared, LEARNED⁠¹ beliefs and behaviors that reflect an organization’s *willingness to learn from errors*⁠²

• Four beliefs present in a safe, informed culture⁠³
  – Our processes are designed to prevent failure
  – We are committed to detect and learn from error
  – We have a just culture that disciplines based on risk
  – People who work in teams make fewer errors

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A culture of safety is informed. It never forgets to be afraid…


• Institute of Medicine Reports
• Role of Culture in Chain of Impact
• Joint Commission and National Quality Forum
• High Reliability Organizations engage in continuous improvement

WHY MEASURE SAFETY CULTURE?
“The problem is not bad people; the problem is that the system needs to be made safer . . .”

*IOM (2000). To Err is Human: Building a Safer Health System*

“The biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm.”

*IOM (2001). Crossing the Quality Chasm: A New Health System for the 21st Century, p. 79*
The quality, safety and value of care can be no better than the structures and processes used by providers in direct contact with the patient. Culture is a lens through which organizations must support providers at the point of care.

Adapted from:
• Joint Commission 2010 Leadership Standards for hospitals (Standard LD.03.01.01)
  – Leaders *create and maintain a culture of safety*
  – Leaders *evaluate the culture* on a regular basis
  – Leaders *encourage teamwork*; they create structures, processes, and programs to support it

• National Quality Forum Safe Practice 2: Culture Measurement, Feedback, and Intervention

HROs Engage in Continuous Improvement

Measure Beliefs and Behaviors

Implement Practices

Action Plan

We can not change what we do not measure!
Goals of Culture Assessment

• Identify areas of culture in need of improvement
  – Identify impairments in organizational learning
• Increase awareness of patient safety concepts
• Evaluate effectiveness of patient safety interventions over time
• Conduct internal and external benchmarking,
• Meet regulatory requirements
• Identify gaps between beliefs and observed behaviors within subcultures and microcultures
Goals of Culture Assessment

References


Baseline prior to patient safety intervention
18 – 24 month intervals

WHEN SHOULD YOU MEASURE SAFETY CULTURE?
HOW DO YOU MEASURE SAFETY CULTURE?

Qualitative
• Focus Groups
• Structured Interviews
• Observation

Quantitative
• Survey Tools...use best tool for your setting
Measure Beliefs and Behaviors with HSOPS

- Survey tool kit available
  http://www.ahrq.gov/qual/patientsafetyculture/hospsurvindex.htm

- Comparative Database for Benchmarking
  http://www.ahrq.gov/qual/hospsurvey12/
  567,703 respondents from 1,128 hospitals in 2012 database

- 42 items categorized in 12 dimensions
  - 2 dimensions outcome measures at dept/unit level
  - 7 dimensions measure culture at dept/unit level
  - 3 dimensions measure culture at hospital level

- 2 additional outcome measures at dept/unit level

Comments
UNMC Adapted HSOPS

- Available at [www.unmc.edu/rural/patient-safety](http://www.unmc.edu/rural/patient-safety)
- Developed by UNMC as part of AHRQ Partnerships in Implementing Patient Safety Grant 05 -07
- Collapses work areas and positions to reflect Critical Access Hospital (CAH, ≤ 25 beds) environment
- Allows sorting by Work Area/Position if ≥ 5 respondents
- Creates valid HSOPS benchmarks for CAHs
- Supports use of HSOPS to evaluate patient safety interventions over time in CAHs
- Evaluates impact of TeamSTEPPS by adding 10 items to assess training, knowledge, and adoption of behaviors
Original AHRQ HSOPS 2012 Comparative Database

SECTION A: Your Work Area/Unit
In this survey, think of your “unit” as the work area, department, or clinical area of the hospital where you spend most of your work time or provide most of your clinical services.

What is your primary work area or unit in this hospital? Mark ONE answer by filling in the circle.

- a. Many different hospital units/No specific unit
- b. Medicine (non-surgical)
- c. Surgery
- d. Obstetrics
- e. Pediatrics
- f. Emergency department
- g. Intensive care unit (any type)
- h. Psychiatry/mental health
- i. Rehabilitation
- j. Pharmacy
- k. Laboratory
- l. Radiology
- m. Anesthesiology
- n. Other, please specify.

UNMC Adapted HSOPS

SECTION A: Your Department
In this survey, think of your department, as the area of the hospital where you spend most of your work time or provide most of your clinical services.

What primary department do you work in at this hospital? Mark ONE answer.

- Many different hospital departments/No specific clinical department (e.g. HIM, Billing, Front Office)
- Acute/Skilled Care
- Long-term Care
- Home Health Care
- Surgery/Operating Room
- Emergency Department
- Therapies (PT, OT, ST, RT)
- Pharmacy
- Laboratory
- Radiology
- Housekeeping
- Physician Clinic
- Other, please specify
### Original AHRQ HSOPS 2011 Comparative Database

4. What is your staff position in this hospital? Mark ONE answer that best describes your staff position.

- a. Registered Nurse
- b. Physician Assistant/Nurse Practitioner
- c. LVN/LPN
- d. Patient Care Assistant/Hospital Aide/Care Partner
- e. Attending/Staff Physician
- f. Resident Physician/Physician in Training
- g. Pharmacist
- h. Dietician
- i. Unit Assistant/Clerk/Secretary
- j. Respiratory Therapist
- k. Physical, Occupational, or Speech Therapist
- l. Technician (e.g., EKG, Lab, Radiology)
- m. Administration/Management
- n. Other, please specify:

**UNMC Adapted HSOPS**

3. Check ONE answer that best describes your position.

- a. Administration/Management
- b. Physician/Physician Assistant/Nurse Practitioner
- c. Nurse (RN, LPN, LPN-C)
- d. Allied Health (Pharmacy, Lab-Tech, Radiology, EKG, Dietary, Therapy)
- e. Clinical Support Staff (Nurses Aide, Medication Aide)
- f. Nonclinical Support Staff (Unit Clerk, HIM, Billing)
- g. Other, please specify:

**21%**

**0.9%**
Extent of TeamSTEPPS Training

SECTION H: Teamwork Skills
Please answer the following questions about your knowledge and practice related to teamwork. For each question, mark the ONE best answer. If you are unsure of an answer, please mark "Don't Know".

1. Indicate your experience in teamwork training.
   ○ a. I have no formal team training experience
   ○ b. I have some experience in team skills but not with the TeamSTEPPS program
   ○ c. I have completed SOME training in the TeamSTEPPS modules
   ○ d. I have completed training in ALL of the TeamSTEPPS Fundamental modules
   ○ e. I am a TeamSTEPPS Master Trainer
UNMC Adapted HSOPS

Impact of TeamSTEPPS Training on Knowledge of Tools

2. Which one of the following tools allows team members to assign roles, establish expectations, and discuss contingency plans for unusual circumstances?
   - a. Don't Know
   - b. Check-back
   - c. Debrief
   - d. Huddle
   - e. Brief
   - f. Call-out

3. SBAR provides a structured framework for communication among team members and stands for...
   - a. Don't Know
   - b. Situation, Background, Action, Recommendation
   - c. Situation, Background, Assessment, Recommendation
   - d. Situation, Behavior, Assessment, Results
   - e. Setting, Background, Action, Results
   - f. Status, Background, Action, Recommendation

4. Which one of the following tools allow any team member to speak up to those with more authority without provoking a conflict or confrontation?
   - a. Don't Know
   - b. Call-Out
   - c. CUS
   - d. Check-Back
   - e. Handoff
   - f. I PASS THE BATON

5. STEP provides a structured framework for team members to monitor situations in the delivery of health care and stands for ...
   - a. Don't Know
   - b. Situation, Time, Event, Plan
   - c. Situation, Team members, Equipment, Plan
   - d. Status of the patient, Tests, Equipment, Plan
   - e. Status of the patient, Team members, Environment, Progress toward goal
   - f. Safety, Teamwork, Environment, Performance

alpha = 0.71
### Impact of TeamSTEPPS Knowledge on Implementation of Tools

#### Please indicate how often the following actions are taken in your department.

<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Most of the time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>When people in your department communicate information that requires immediate attention and action, how often do they use a structured communication tool like SBAR?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>When people in your department need to advocate for a patient or voice a concern, how often do they use a tool such as Two-Challenge Rule or CUS?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>When people in your department hand off information to a different department, how often do they use a structured communication tool such as SBAR or I PASS THE BATON?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>9.</td>
<td>When information or work loads change in your department, how often do team members call a huddle to adjust plans?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>10.</td>
<td>When things don't go according to plan in your department, how often does your team conduct a debrief afterwards to discuss what should be improved?</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

alpha = 0.79
• Reason’s Components of Safety Culture
• Your Results
• Reverse Worded Items
• Gap between values/beliefs and behavior
• Kirkpatrick’s Taxonomy of Training Criteria
• Response Shift Bias
• 9 Step Plan

HOW DO YOU INTERPRET HSOPS RESULTS?
<table>
<thead>
<tr>
<th>Reason’s Components</th>
<th>HSOPS Dimension or Outcome Measure</th>
</tr>
</thead>
</table>
| **Reporting Culture** - a safe organization is dependent on the willingness of front-line workers to report their errors and near-misses | • Frequency of Events Reported (O)  
• Number of Events Reported (O) |
| **Just Culture** - management will support and reward reporting; discipline occurs based on risk-taking | • Nonpunitive Response to Error (U) |

O = Outcome measure  
U = Measured at level of unit/department  
H = Measured at level of hospital
<table>
<thead>
<tr>
<th>Reason’s Components</th>
<th>HSOPS Dimension or Outcome Measure</th>
</tr>
</thead>
</table>
| **Flexible Culture** - authority patterns relax when safety information is exchanged because those with authority respect the knowledge of front-line workers | • Teamwork w/in Units (U)  
• Staffing (U)  
• Communication Openness (U)  
• Teamwork ax Units (H)  
• Hospital Handoffs (H)  |
| **Learning Culture** - organization will analyze reported information and then implement appropriate change | • Hospital Mgt Support (H)  
• Manager Actions (U)  
• Feedback & Communication (U)  
• Organizational Learning (U)  
• Overall Perceptions (O)  
• Patient Safety Grade (O) |
<table>
<thead>
<tr>
<th>Resource</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excel Tool</td>
<td>ANALYSIS - Contains raw data</td>
</tr>
<tr>
<td></td>
<td>Generates spreadsheet to upload for national database</td>
</tr>
<tr>
<td></td>
<td>Instructions for interpretation</td>
</tr>
<tr>
<td></td>
<td>Demographics of respondents</td>
</tr>
<tr>
<td></td>
<td>Contains dimension and item level results in the aggregate, by department, position, direct patient care, action planning sheet</td>
</tr>
<tr>
<td>Benchmark Graphs</td>
<td>COMMUNICATION</td>
</tr>
<tr>
<td></td>
<td>Compare aggregate results to peer group (external benchmark)</td>
</tr>
<tr>
<td></td>
<td>Compare aggregate results over time</td>
</tr>
<tr>
<td></td>
<td>Compare results by work area and job title to the aggregate</td>
</tr>
<tr>
<td>Item Level Over Time</td>
<td>COMPARISONS AND COMMUNICATION</td>
</tr>
<tr>
<td></td>
<td>Compare item level results over time</td>
</tr>
<tr>
<td></td>
<td>Includes responses to teamwork questions</td>
</tr>
<tr>
<td>Comments Coded by Theme</td>
<td>CONTEXT</td>
</tr>
<tr>
<td></td>
<td>Open ended comments coded by culture-related themes</td>
</tr>
<tr>
<td></td>
<td>Provides respondents’ direct feedback</td>
</tr>
<tr>
<td>Action Plan</td>
<td>PLAN – Exec Summary and work sheet to anchor plan in history, mission and strategic goals; identify practices needed to support safety culture</td>
</tr>
</tbody>
</table>
SAMPLE HOSPITAL FROM SUMMER 2012

EXEC SUMMARY
REVERSE-WORDED ITEMS
OPPORTUNITIES & RECOMMENDATIONS

DEFINE THE PROBLEM
STRENGTHS, WEAKNESSES, CHANGES
VARIATIONS — WORK AREA, JOB TITLE, TEAM SKILLS
GAPS BETWEEN BELIEFS & BEHAVIORS
COMMENTS
MATCH PROBLEMS WITH OPPORTUNITIES
12. Nonpunitive Response to Error

1. Staff feel like their mistakes are held against them. (A8R)
   - Positive: 56%
   - Neutral: 24%
   - Negative: 21%

2. When an event is reported, it feels like the person is being written up, not the problem. (A12R)
   - Positive: 49%
   - Neutral: 30%
   - Negative: 21%

3. Staff worry that mistakes they make are kept in their personnel file. (A16R)
   - Positive: 40%
   - Neutral: 31%
   - Negative: 29%

• If Item labeled with “R” then it is positive to DISAGREE
• Bigger numbers always better
• Positive is positive for patient safety

* Green Bar = % DISAGREE/STRONGLY DISAGREE for REVERSE-WORDED ITEMS
Define the Problem

• Benchmark Graphs
  – Overall strengths & areas in need of improvement from Peers & National Database
  – Changes over time
  – Variations by work area, job title, Team skills

• Action Planning Worksheet from Excel Tool
  – Values reflect the desired behavior within each of the four components
  – Are observed behaviors consistent with values?
<table>
<thead>
<tr>
<th>Component</th>
<th>Example Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Culture</td>
<td>People need to understand the importance of reporting so we can change the system, not think they will be punished if they do report.</td>
</tr>
<tr>
<td>Just Culture</td>
<td>Management does not care for your suggestions. ...If you write them up they find a way to get you in trouble for reporting it. A few people in the hospital have abrasive personalities and this makes them hard to approach. ..patient care would be smoother and safer if not for their attitudes. Also if an employee is not demonstrating the skills expected of their profession that person should be remediated and or let go.</td>
</tr>
<tr>
<td>Teamwork Culture</td>
<td>We help each other well within our department and we are responsive to requests from other departments when they ask help of us. I have not been trained in the two challenge rule, SBAR, or CUS. I feel that communication and cooperation between departments could be improved.</td>
</tr>
<tr>
<td>Learning Culture</td>
<td>When a problem is reported in another department, I never get a report or comment back about what is going to be done to prevent the problem or a resolution to the current problem.</td>
</tr>
<tr>
<td>Safety Concern</td>
<td>Computerized charting has made Emergency nursing much less efficient and less safe.</td>
</tr>
<tr>
<td>Patient Safety Systems</td>
<td>We have lots of policies and procedures in the hospital .... It's okay to know where to find them but if you don't have time to sit and read them how are we supposed to know what they contain?</td>
</tr>
<tr>
<td>Feedback</td>
<td>I have worked here for many years and have seen many changes and I do have to say we have always had the patient's safety and care front and foremost.</td>
</tr>
</tbody>
</table>
### IV. Inventory of Safe Practices

Rate the extent to which practices that support the four components of safety culture are in place. Indicate if the inventory is for: **Hospital as a whole** or **Work Area**. 

**Scoring:**
- 0 = Not in place
- 1 = ineffective
- 2 = moderately effective
- 3 = very effective
- NA = not applicable

<table>
<thead>
<tr>
<th>Reporting Practices</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal reporting of adverse events with standardized taxonomies (e.g. National Coordinating Council for Medication Error Reporting and Prevention A – I Error Severity Taxonomy)</td>
<td></td>
</tr>
<tr>
<td>Near misses are frequently reported, valued, and learned from</td>
<td></td>
</tr>
<tr>
<td>Non-harmful errors that reach the patient are frequently reported, valued, and learned from</td>
<td></td>
</tr>
<tr>
<td>Safety Briefings (also considered a Learning Practice)</td>
<td></td>
</tr>
<tr>
<td>Leadership WalkRounds (also considered a Learning Practice)</td>
<td></td>
</tr>
<tr>
<td>Other (Describe):</td>
<td></td>
</tr>
</tbody>
</table>

**Just Culture Practices**

- Training provided on role of human factors in error and active vs. latent sources of error
- The principles of Just Culture are understood and used by management
- Discipline is based on risk-taking and not on outcomes
- Managers use Algorithms to balance individual and system accountability
- Policy/procedures in place to manage disruptive behaviors
- Other (Describe):

**Flexible Culture Practices: Teamwork and Communication Skills**

- Briefs are used to assign roles, establish expectations, and establish contingency plans
- Huddles are used to assess the need to change a plan
- Debriefs are used to learn by reviewing team performance and conducting after action reviews
- Monitoring actions of other team members (e.g. Cross Monitoring to “watch each other’s back”)
- Front-line providers use a structured approach to monitor patient care situations (e.g. STEP: Status of the patient, Team members, Environment, Progress toward goals)
- Task assistance is sought by individuals when their work load increases
- Task assistance is offered to others when their work load increases
- Structured communication is used to resolve information conflicts and enable all employees to advocate for the patient (e.g. CUS: “I'm Concerned! I need Clarity, I’m Uncomfortable, Stop…this is a patient safety concern”)
- Structured communication is used to resolve personal conflicts
- Structured communication is used to communicate information that requires immediate attention (e.g. SBAR: Situation Background Assessment Recommendation)
- Structured communication is used to communicate critical information during emergent situations (e.g. Call-Out: Information directed at a responsible individual and conveyed to all to anticipate next steps)
- Structured communication is used to ensure that information conveyed by a sender is understood by the receiver (e.g. Check Back)
- Structured handoff communication is used to transfer information, responsibility and accountability when patients transition from department to department or from one hospital to another (e.g. I PASS the BATON)
- Other (Describe):

**Learning Practices**

- Process Mapping
- Individual Root Cause Analysis
- Aggregate Root Cause Analysis of Non-Harmful Events
- Failure Mode and Effects Analysis
- Safety Briefings (also considered an informal Reporting Practice)
- Leadership WalkRounds (also considered an informal Reporting Practice)
- Other (Describe):
Kirkpatrick’s Taxonomy

Definition: a four-level framework to evaluate the impact of training programs. The four levels are: (1) learner reactions to the training, (2) changes in learner knowledge as a result of the training, (3) transfer of new knowledge/skill to behavior in work environment, and (4) changes in desired outcomes at the level of the organization, practitioner, and/or patient.


See Item Level Over Time to understand relationship between training, knowledge, and behavior change relative to TeamSTEPPS training.

See Benchmark Graph for variation by Adoption of Team Behaviors.
Kirkpatrick’s Taxonomy

2012

- No formal team training: 41%
- TeamSTEPPS Master Trainer: 0%
- Completed all TeamSTEPPS modules: 1%
- Completed some training in TeamSTEPPS: 4%
- Correctly defined Brief: 9%
- Correctly defined SBAR: 39%
- Correctly defined CUS: 2%
- Correctly defined STEP: 4%
- Use SBAR within dept Most of time/Always: 26%
- Use CUS to advocate Most of time/Always: 12%
- Use SBAR or I PASS the BATON across depts Most...: 24%
- Used huddle to adjust plans Most of time/Always: 29%
- Use debrief for improvement Most of time/Always: 23%
Kirkpatrick’s Taxonomy

No formal team training
TeamSTEPPS Master Trainer
Completed all TeamSTEPPS modules
Completed some training in TeamSTEPPS
Correctly defined Brief
Correctly defined SBAR
Correctly defined CUS
Correctly defined STEP
Use SBAR within dept Most of time/Always
Use CUS to advocate Most of time/Always
Use SBAR or I PASS the BATON across depts Most...
Used huddle to adjust plans Most of time/Always
Use debrief for improvement Most of time/Always

<table>
<thead>
<tr>
<th>2012</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>0%</td>
<td>10%</td>
</tr>
</tbody>
</table>

% of Respondents

Behavior
Knowledge
Kirkpatrick’s Taxonomy

Why care about Kirkpatrick’s Taxonomy?

• Training and changes in knowledge account for just 20% of impact from an intervention

• Greatest impact is from what leaders do, change in p/p, performance appraisals, what is measured, what is role-modeled, rewarded---hard-wired

• Bottom line: Implementing change must include
  – Training
  – Explicit plan to sustain desired behavior changes
Response Shift Bias

Definition: tendency for an individual to overestimate their knowledge, skills, and behaviors in a pretest because their understanding of a concept is limited prior to the program intervention.


<table>
<thead>
<tr>
<th>Teamwork Within Departments</th>
<th>2007</th>
<th>2009</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. People support one another in this department. (A1)</td>
<td>87%</td>
<td>84%</td>
<td>79%</td>
</tr>
<tr>
<td>2. When a lot of work needs to be done quickly, we work together as a team to get the work done. (A3)</td>
<td>89%</td>
<td>90%</td>
<td>81%</td>
</tr>
<tr>
<td>3. In this department, people treat each other with respect. (A4)</td>
<td>76%</td>
<td>83%</td>
<td>65%</td>
</tr>
<tr>
<td>4. When one area in this department gets really busy, others help out. (A11)</td>
<td>76%</td>
<td>77%</td>
<td>66%</td>
</tr>
<tr>
<td>COMPOSITE Teamwork Within Departments</td>
<td>82%</td>
<td>84%</td>
<td>73%</td>
</tr>
</tbody>
</table>
• Define the problem
• Match problems to interventions (use Inventory of Safe Practices)
• *Create SMART Goals: Specific, Measurable, Achievable, Relevant, and Time bound.*
Interpreting Results to Develop an Action Plan

Executive Summary

Background

Define the problem

A. Identify overall strengths, weaknesses, and changes in your HSOPS scores over time

B. Identify variations within four key components of safety
   1) Work area, job title, team skills
   2) Gaps between beliefs and behaviors

C. Relate themes in open-ended comments to survey results

D. Summarize problems and opportunities for improvement

2. Create the appropriate change team

3. Define your aims and goals

4. Choose measures to monitor implementation
5. Review your overall plan (who is doing what, when?)
6. Determine how you will sustain and spread changes embedded in your intervention(s)
7. Develop a strategy to communicate your survey results and action plan to key stakeholders
8. Write the final action plan
9. Obtain a review and approval of final action plan by key stakeholders
Action Planning: A Reporting culture is engineered...

- Practices/Tools
  - Reporting Systems that use standardized taxonomies
  - Near miss log
  - Chart audit
  - Secret Shopper
  - Safety Briefings
  - Leadership WalkRounds™
  - Bulletin board/suggestion box/telephone hotline

- Successful reporting systems
  - Nonpunitive
  - Confidential
  - Independent
  - Expert analysis
  - Timely
  - Systems-oriented
  - Responsive
1. Staff will value reporting of near misses as a way to learn about system risks without harming patients.
   a. Goal: Greater than 50% of all respondents will indicate that near misses are reported “Always / Most of the Time” at the next HSOPS reassessment
   b. We will do this by implementing the following interventions:
      i. Conducting quarterly aggregate root cause analyses of “near miss” and non-harmful event reports
      ii. Discussing near misses during departmental Safety Briefs (including shift change), huddles, and debriefs
      iii. Discussing near misses during regular Leadership WalkRounds
   c. Identify where this change will occur…hospital-wide or a specific work area?
   d. Identify when this change will occur
Practices/Tools

- **Understanding human error** *(Reason 2003, 2006)*
  - Active errors (sharp end)
  - Latent errors

- **Just Culture principles and behavior** *(Marx, 2001)*
  - Conduct: human error, negligence, reckless, intentional rule violation
  - Shared accountability: managers & individuals/systems & individual behavior
  - Disciplinary decision-making: outcome-based, rule-based, risk-based

- **Unsafe Acts Algorithm**

- **Disruptive Behavior Policy/Standards**
1. A consistent approach to operationalizing a just and fair culture across the hospital regardless of profession or hierarchy.
   a. Goal: Improve aggregate perceptions of Nonpunitive Response to Error by 5% or more at the next HSOPS reassessment
   b. We will do this by implementing the following interventions:
      i. Providing training about human factors and active vs. latent causes of errors
      ii. Training managers to use Algorithms to balance individual and systems accountability
      iii. Training managers to collaborate with human resources and discipline individuals based on at-risk and reckless behavior and not on outcomes
      iv. Implement a policy/procedure to manage disruptive behavior.
   c. Identify where this change will occur…hospital-wide or a specific work area?
   d. Identify when this change will occur
Action Planning: A Flexible culture is engineered...

TeamSTEPPS
Team Strategies & Tools to Enhance Performance & Patient Safety
http://teamstepp.sahrq.gov

- Essential component of safety culture
- KSAs of teamwork create flexibility and adaptability
  - Manage complexity
  - Learn from experience
- Developed by Dept of Defense and AHRQ
- Four key categories of skills
- 18 specific tools
- Effective adoption improves all components of safety culture
- Focus on hard-wiring behaviors
  - Training/Sustainment = 20/80
3. Use team skills to manage changing work loads.
   a. Goal: 75% of all respondents will agree that they help each other out when it gets busy
   b. We will do this by teaching staff to use briefs, huddles, debriefs, situation monitoring, and seeking/offering task assistance to manage changing work loads.
   c. Identify where this change will occur...hospital-wide or a specific work area?
   d. Identify when this change will occur
4. Use team skills to make it psychologically safe for staff to advocate for patients to those with more authority.
   a. Goal: 60% of all respondents will agree that they feel free to question the decisions and actions of those with more authority.
   b. We will do this by teaching staff to use the Two Challenge Rule and CUS from the TeamSTEPPS mutual support skills.
   c. Identify where this change will occur...hospital-wide or a specific work area?
   d. Identify when this change will occur
5. Use team skills to standardize handoffs within and across hospital departments.
   a. Goal: Improve Hospital Handoffs & Transitions by 5% or more
   b. We will do this by implementing the following interventions:
      i. Teaching staff to use SBAR when communicating critical information that needs immediate attention
      ii. Teaching staff to use I PASS the BATON when handing off responsibility and accountability for patients across hospital departments
   c. Identify where this change will occur...hospital-wide or a specific work area?
   d. Identify when this change will occur
Practices/Tools

- Process Mapping
- Individual RCA
- Aggregate RCA
- FMEA
- Safety Briefings
- Leadership WalkRoundsTM
- Close the loop with reporting...feedback

Ultimately, the willingness of workers to report depends on their belief that the organization will analyze reported information and then implement appropriate change—organizational practices support a learning culture.
6. Close the loop with front-line workers about reported events and actions taken as a result of those events.
   a. Goals: Improve Organizational Learning and Feedback and Communication about Error by greater than 5%
   b. We will do this by implementing the following interventions:
      I. Providing feedback to front-line staff about the results of individual and aggregate RCAs
      II. Ensuring relevant front-line staff are involved in conducting individual and aggregate RCA at the unit and department level
      III. Implementing Safety Briefings within units
      IV. Implementing patient safety-focused Leadership WalkRounds
      V. Creating a "high reliability academy" for managers; a regular meeting to learn patient safety principles, human factors, and high reliability concepts using AHRQ Patient Safety Primers available at http://psnet.ahrq.gov/primerHome.aspx.
   c. Identify where this change will occur...hospital-wide or a specific work area?
   d. Identify when this change will occur
Role of Leaders in Transformational Change

- Create a compelling positive vision
- Concretely define the goal as a performance problem...not “changing culture”
- Ensure new behaviors are formally taught in groups
- Ensure new behaviors are reinforced
  - Provide opportunities for practice, coaching, feedback
  - Be a positive role model
- Create structures consistent with new way of thinking/working/behaving

“...it is the unique function of leadership to perceive the functional and dysfunctional elements and to manage cultural evolution and change.”

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