



# **Results from the AHRQ Hospital Survey on Patient Safety Culture 2009 Comparative Database**

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# Objectives



- Preview results from the AHRQ Hospital Survey on Patient Safety Culture 2009 Comparative Database (*to be released in early 2009*)
  - 2009 results very consistent with 2007 & 2008 results
  - More data & information about hospitals that administered the survey more than once
- Discuss future activities

# Background



- Hospital Survey on Patient Safety Culture (HSOPS)
- Developed by Westat, funded by AHRQ
- Survey development process:
  - Reviewed literature & existing surveys
  - Interviewed hospital staff
  - Identified key areas of safety culture
  - Developed survey items & pretested
  - Obtained input from researchers & stakeholders
  - Pilot tested in 21 hospitals with 1,437 respondents
- Final survey released November 2004
  - ◆ [www.ahrq.gov/qual/hospculture](http://www.ahrq.gov/qual/hospculture)

# ***HSOPS Patient Safety Culture Dimensions***



- 42 items assess 12 dimensions 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

# HSOPS Comparative Database



- AHRQ has funded an HSOPS comparative database
  - Annual reports (2007, 2008 --- 2009 *coming soon*)  
<http://www.ahrq.gov/qual/hospsurvey08/>
- Purposes:
  - *Comparison*
  - *Assessment and Learning*
  - *Supplemental Information*
  - *Trending*

# 2009 HSOPS Comparative Database



- 623 U.S. hospitals, 196,546 respondents
  - Average # respondents per hospital = 315 staff
  - Overall, database hospitals are similar to US AHA-registered hospitals
- Survey administration
  - Paper 44%
  - Web 33%
  - Both 23%
- Average hospital response rate = 52%
  - Paper 58%
  - Web 45%
  - Both 52%

# Work Areas



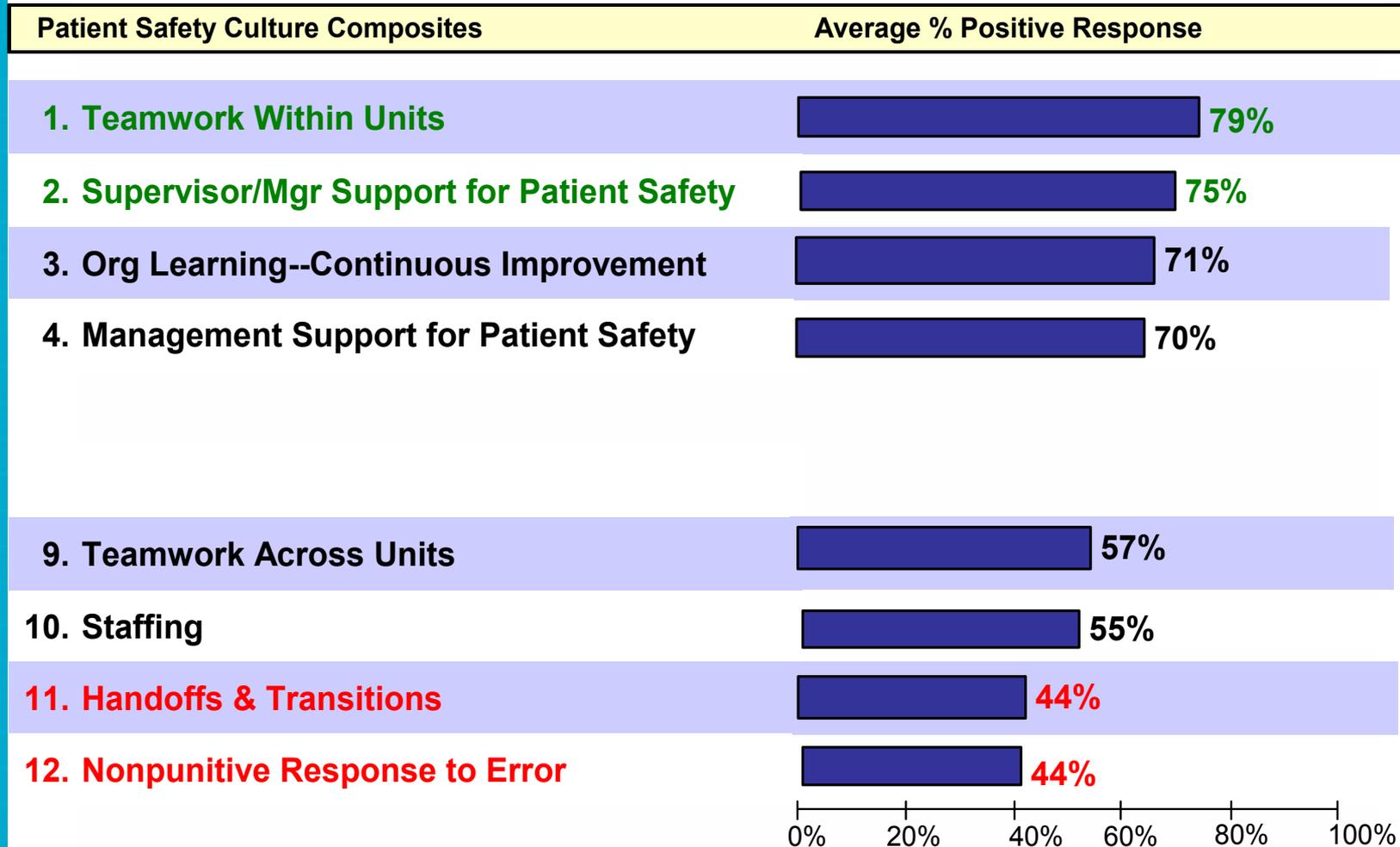
- Surgery 10% (17,403)
- Medicine 9%
- Many areas/no specific area 8%
- ICU 7%
- Radiology 6%
- Emergency 5%
- Lab 5%

# Staff Positions & Patient Contact

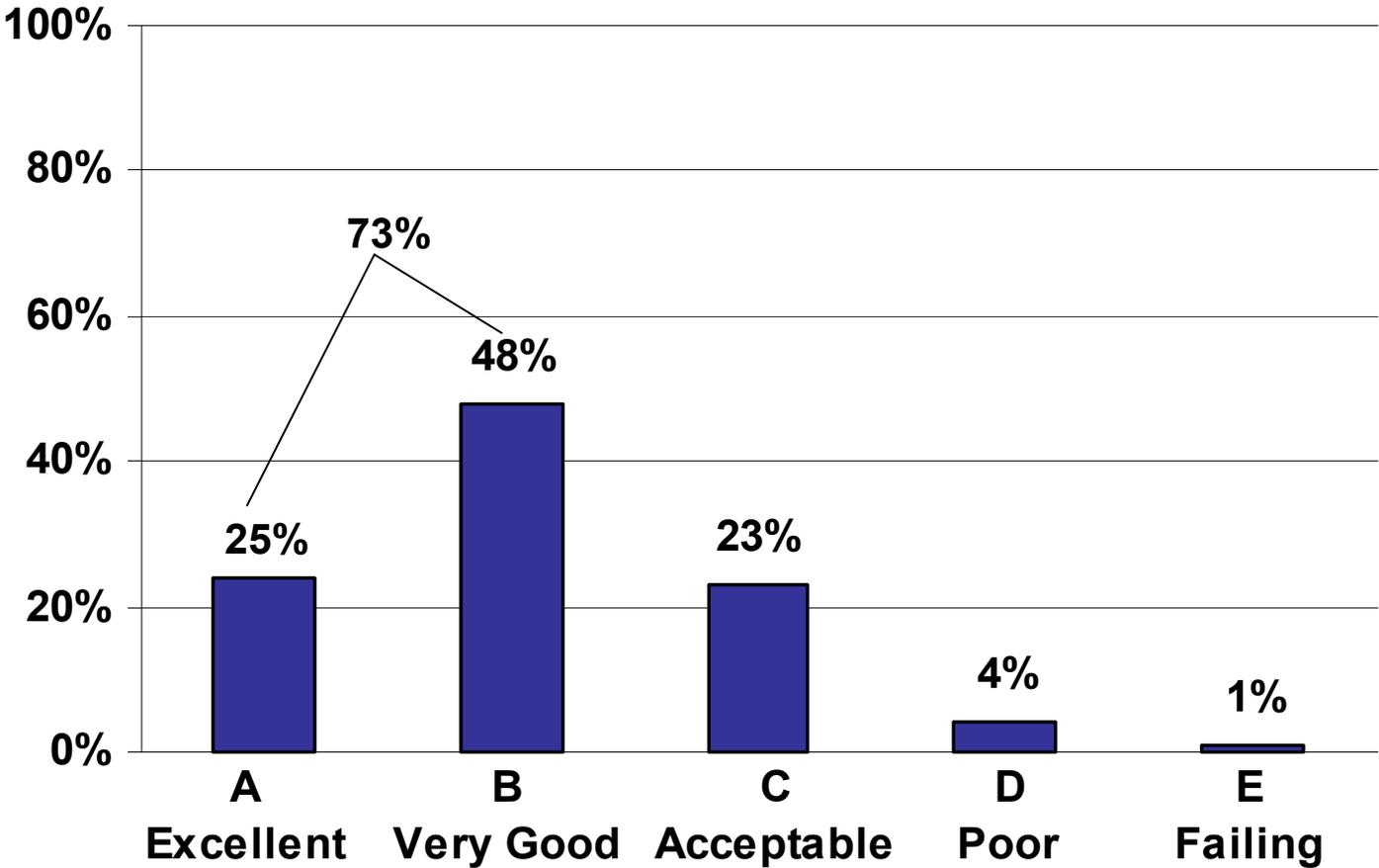


- Nursing 36% (66,298)
  - Technicians (EKG, Lab, Radiology, etc) 10%
  - Management, administration 7%
  - Unit Assistant/Clerk/Secretary 6%
  - Patient Care Asst/Hospital Aide 6%
  - Therapists 6%
  - Physicians, PAs, NPs 4%
  - Pharmacists 2%
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- 77% had direct interaction with patients

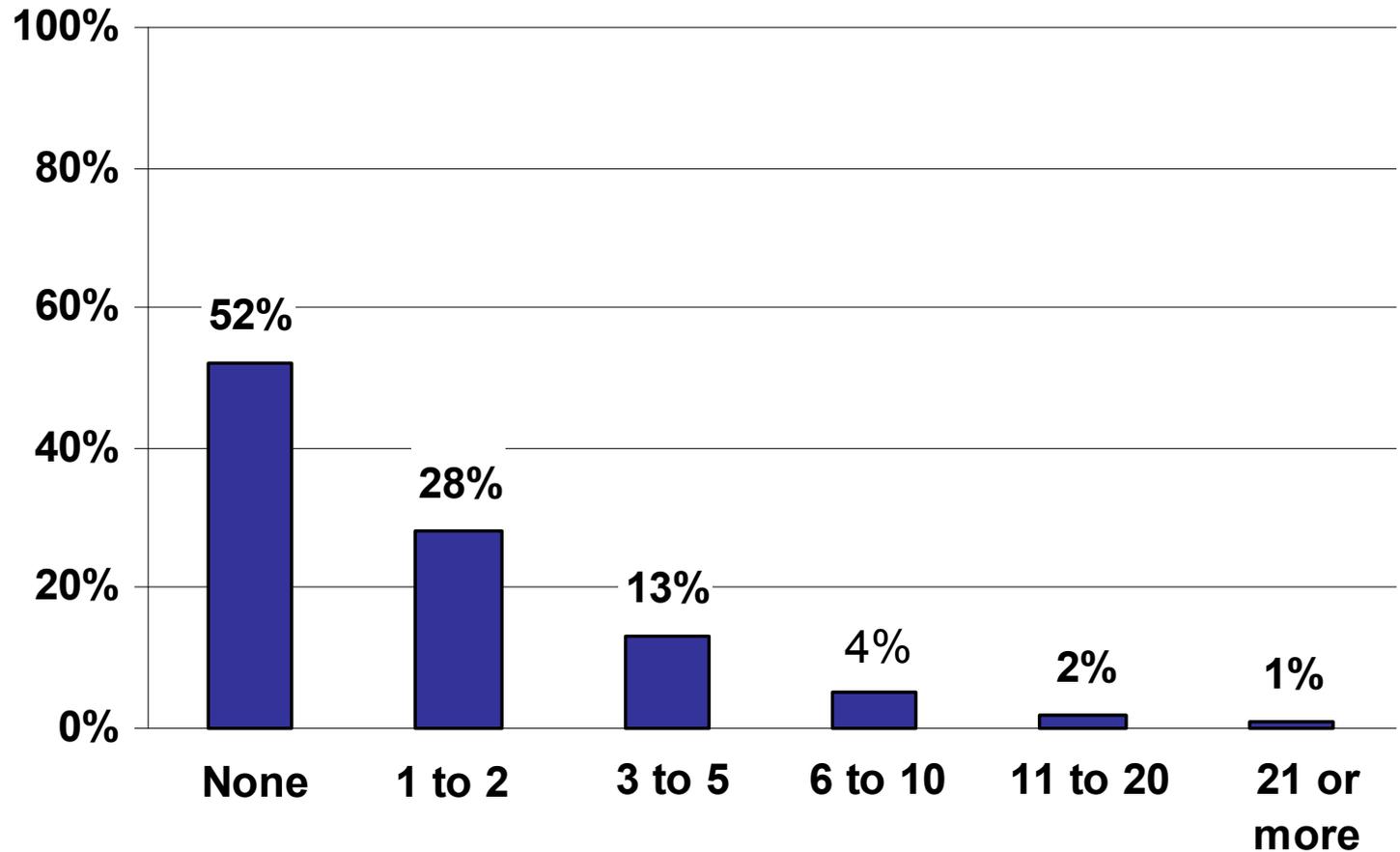
# Hospital Strengths & Areas for Improvement



# Patient Safety Grade



# Number of Events Reported



# Most Positive Survey Items



## Teamwork Within Units

When a lot of work needs to be done quickly, we work together as a team to get the work done.

% Strongly Agree or Agree

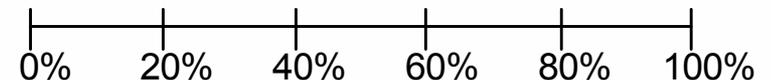


People support one another in this unit.



## Organizational Learning

We are actively doing things to improve patient safety.



# Least Positive Survey Items



## Nonpunitive Response to Error

% Strongly Disagree or Disagree

Staff worry that mistakes they make are kept in their personnel file.



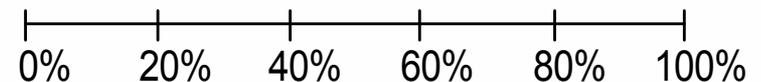
## Handoffs & Transitions

% Strongly Disagree or Disagree

Things “fall between the cracks” when transferring patients from one unit to another.



Problems often occur in the exchange of information across hospital units.



# *Drilling Down the Results*



- In addition to the overall results, we also provide results broken out by:
  - Hospital Characteristics (bed size, teaching status, ownership, region)
  - Respondent Characteristics (work area, staff position, direct interaction with patients)

# Results by Hospital Characteristics



- Smaller hospitals (49 beds or fewer) scored highest on all dimensions of safety culture and patient safety grade
  - Smallest hospitals (6-24 beds) 22% more positive on *Handoffs & Transitions* than large hospitals (400-499 beds)
- Non-teaching hospitals scored higher than teaching on
  - *Teamwork Across Units*
  - *Handoffs & Transitions*
- Government hospitals scored higher than non-govt on
  - *Handoffs & Transitions*
  - *Staffing*

# Results by Respondent Characteristics



- Work Area: Rehabilitation scored highest on 8 of 12 dimensions of safety culture



- *Staff Position: Administration/Mgmt* scored highest on 11 of 12 dimensions of safety culture



- No general pattern based on *Respondents with or without direct interaction with patients*



## ***204 Trending Hospitals***



- Characteristics varied across the 204 trending hospitals for
    - ◆ Bed size
    - ◆ Teaching status
    - ◆ Ownership
    - ◆ Region
  - Average time between survey administrations: 16 months
  - Average response rate: 52%
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# 204 Trending Hospitals



- Average change on dimensions was +2%
- Biggest increase
  - 38% of trending hospitals had increased +5% on Patient Safety Grade (“Excellent” or “Very good”)
- Biggest decrease
  - 23% of trending hospitals had decreased -5% on Number of events reported (those reporting at least 1 event)
- At least a third of trending hospitals had increased +5% on:
  - Overall perceptions of patient safety
  - Teamwork across units

# ***Actions Taken by Trending Hospitals***



- 162 hospitals responded to patient safety initiative form – 79% response rate
- % shared survey results with
  - 93% Hospital administrators
  - 90% Department managers
  - 75% Staff
  - 62% Board of directors
  - 60% Physicians
- 93% had implemented more than 1 patient safety initiative

# Patient Safety Initiatives



Type of Initiative Taken	Trending Hospitals	
	Number	Percent
Implemented SBAR communication (Situation-Background-Assessment-Recommendation)	93	57%
Made changes to policies/procedures	91	56%
Implemented patient safety walkarounds	81	50%
Conducted training	80	49%
Improved compliance with Joint Commission National Patient Safety Goals	65	40%
Improved fall prevention program	61	38%
Conducted chart audits	59	36%
Conducted root cause analysis	55	34%
Purchased new hospital equipment	53	33%
Improved error reporting system	51	31%

N=162

# *Interviews with HSOPS Resubmitters*

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- Purpose of Interviews
  - To help explain changes in patient safety culture and patient care practices over time
- Recruited Hospitals
  - 6 hospitals with notable increases in their HSOPS percent positive scores over time
  - 3 hospitals with notable decreases in their scores

# *Interview Method / Participants*

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- 1 hour telephone interviews, mostly with Directors of Quality/Risk Management; one CEO
- Hospital characteristics:
  - Stand-alone / part of a system
  - Different bed sizes
  - Teaching and non-teaching
  - Government-owned and non-government-owned
  - Various regional locations, both rural and urban

## ***General Interview Findings***



- Overall, HSOPS survey results were useful and helped lead to follow-up action plans
- Dissemination of HSOPS results varied across hospitals
- Physicians and board members were typically not strongly engaged in HSOPS survey or followup action planning
- Patient safety initiatives originated from a variety of sources

# Trending Hospitals with Score Increases



- Said HSOPS scores accurately reflected their patient safety culture at both survey administrations
- Four general themes explaining increases in scores over time

## *1) Hospitals improved their communication between management & staff on patient safety*

- Senior leaders' engaged with staff during walkabouts
- Continually focused staff meetings on the importance of patient safety
- Staff invited to participate in biweekly “huddles” to discuss patient safety issues, and other topics



# ***Patient Safety Initiatives Leading to Score Increases***



## ***2) Hospitals focused on improving error reporting systems and applying non-punitive/”Just Culture” principles***

- Educated hospital leaders on making error reporting anonymous, easy, and convenient
- Implemented electronic reporting system
- Set up a hotline for reporting errors and developed anonymous reporting forms for medical errors
- Trained staff to use the new reporting systems
- Provided training on “Just Culture”



# ***Patient Safety Initiatives Leading to Score Increases***



## ***3) Hospitals engaged staff in identifying solutions to patient safety problems***

- Allocated resources for safety needs identified by staff – for example, buying safer beds
- Directly involved staff in designing successful solutions to handoff problems
- Started an employee engagement committee that included senior leaders
- Instituted nursing peer review to promote open communication
- Assigned staff to a scheduling team to accommodate staff preferences



# ***Patient Safety Initiatives Leading to Score Increases***



## *4) Hospitals developed, implemented, and monitored action plans*

- Charged department managers with developing and implementing an annual action plan & held them accountable

## *5) Other explanations*

- Implemented SBAR communication tool for unit-to-unit transfers
- Hired a consultant group to work with department directors on specific patient safety problems
- Addressed staffing requirements – filled nursing vacancies and improved patient/staff ratios
- Used and displayed scorecards to monitor progress on hospital initiatives

## *Trending Hospitals With Score Decreases*



- Said HSOPS scores usually reflected their patient safety culture – some were surprised at lower-than-expected scores
- Explanations for decreases in scores due to variety of hospital-specific factors
  - Staff issues with specific managers – particularly with incident reports and lack of followup
  - Manager and staff turnover and vacancy rates
  - Drilled down and found scores lower for larger units due to less frequent and personal communications; weaker sense of accountability to coworkers
  - In union negotiations and staff were feeling hostile

# *Future Activities*



- New Medical Office and Nursing Home surveys on patient safety culture & comparative databases
  - ◆ [www.ahrq.gov/qual/hospculture](http://www.ahrq.gov/qual/hospculture)
- Annual HSOPS Comparative Database Reports for next 4 years
  - May 1 to June 30 for data submission
  - Participating hospitals receive customized reports comparing their data to the database
  - New reports released each February from AHRQ

# *Version 2.0 of HSOPS?*



- Need for an update of the HSOPS
  - Adding a “Don’t know/Not applicable” response option
  - Updating the wording and focus of some items
  - Expanding work areas & staff positions
- Obtain input from the SOPS technical expert panel
- Solicit input from HSOPS users at 9:15am session on Friday December 5<sup>th</sup> & via email to HSOPS users
- Plan for crosswalking back to Version 1.0 and for how to handle the HSOPS comparative database once Version 2.0 is released
  - No dates yet set for Version 2.0

# *International HSOPS Users*



- International Hospital SOPS comparative database
- Focus on countries participating in the World Health Organization's (WHO) High 5s Patient Safety Initiative

<http://www.who.int/patientsafety/solutions/high5s/en/index.html>

- Australia, Canada, France, Germany, Mexico, the Netherlands, New Zealand, Singapore, Saudi Arabia, Spain, the United Kingdom, and the U.S.

# *International HSOPS Users*



- 25 countries

- Australia
- Bahrain
- Belgium
- Brazil
- Canada
- Denmark
- El Salvador
- France
- Germany
- Greece
- Ireland
- Italy
- Malta
- Netherlands
- Norway
- Saudi Arabia
- Scotland
- Serbia
- Singapore
- Spain
- Sweden
- Switzerland
- Taiwan
- Turkey
- United Kingdom

# *Questions & Technical Assistance*

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