



**CHRISTIANA CARE  
HEALTH SYSTEM**

# Building a Patient Safety Mentor Program

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**Track:** SOPS Patient Safety Improvement Initiatives  
**Session:** Patient Safety Mentors, Rounds, and Innovations  
**Date & Time:** April 20, 2010, 2:15 pm  
**Track Number:** SOPS T2 – S3

# Impetus for Safety Mentor Program

Landmark Report

- To Err is Human (IOM, 1999)

Culture Survey

- Nonpunitive response to error
- Improvements made as a result of reporting

Focus Groups/  
Culture Debriefing  
Sessions

- Reluctance to report errors

Safety First Learning  
Report Data

- Volume and severity of events and near misses

# Goals: Safety Mentor Program

- Empower front line staff to serve as ambassadors.
- Encourage peer-to-peer feedback and communication.
- Enhance and promote error reporting, including near misses.
- Facilitate learning.

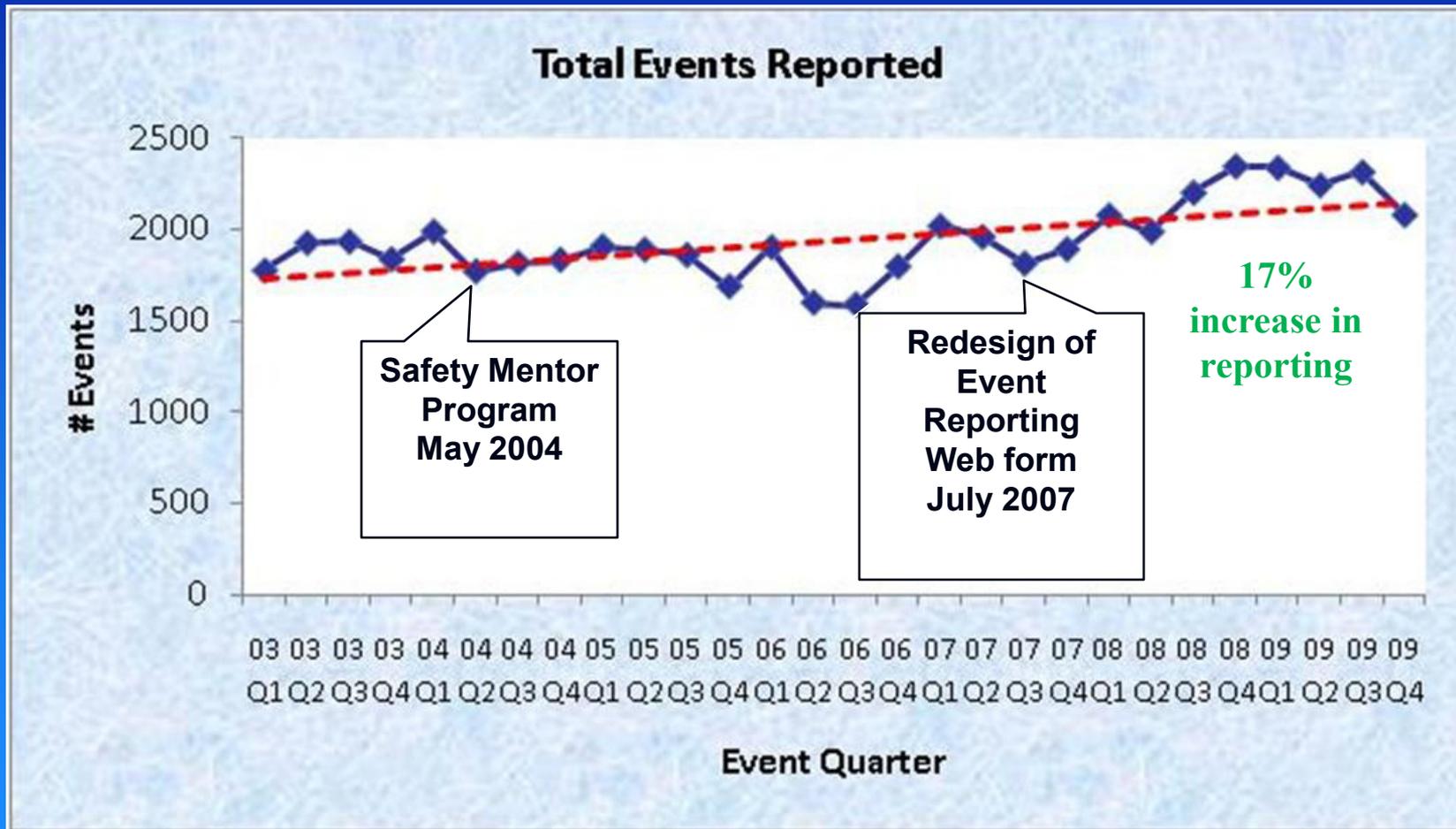
# Design of the Safety Mentor Program

- Formulate goals.
- Gain organizational buy-in.
- Define safety mentor role.
- Identify educational and training needs.
- Determine frequency and content of meetings.
- Develop and implement data collection plan/tools.
- Plan how to evaluate innovation.

# Considerations for Adopters

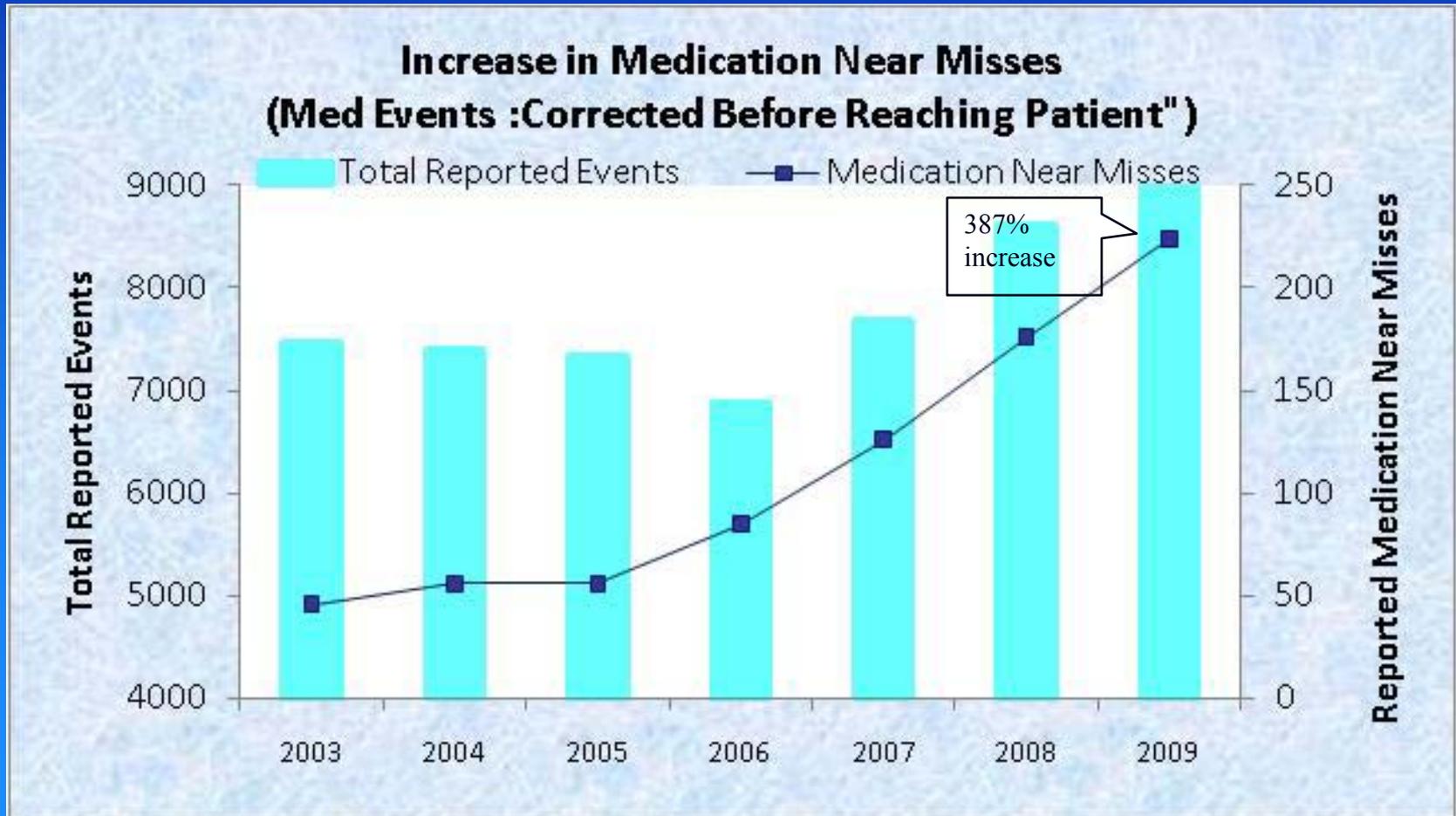
- Select mentors carefully.
- Consider protected time for data collection.
- Act on front-line input.
- **Will it Work Here? A Decisionmaker's Guide to Adopting Innovations**  
<http://www.innovations.ahrq.gov/resources/resources.aspx>

# Validation Of Our Success



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- Improved reporting of medication-related near misses:



# Validation Of Our Success

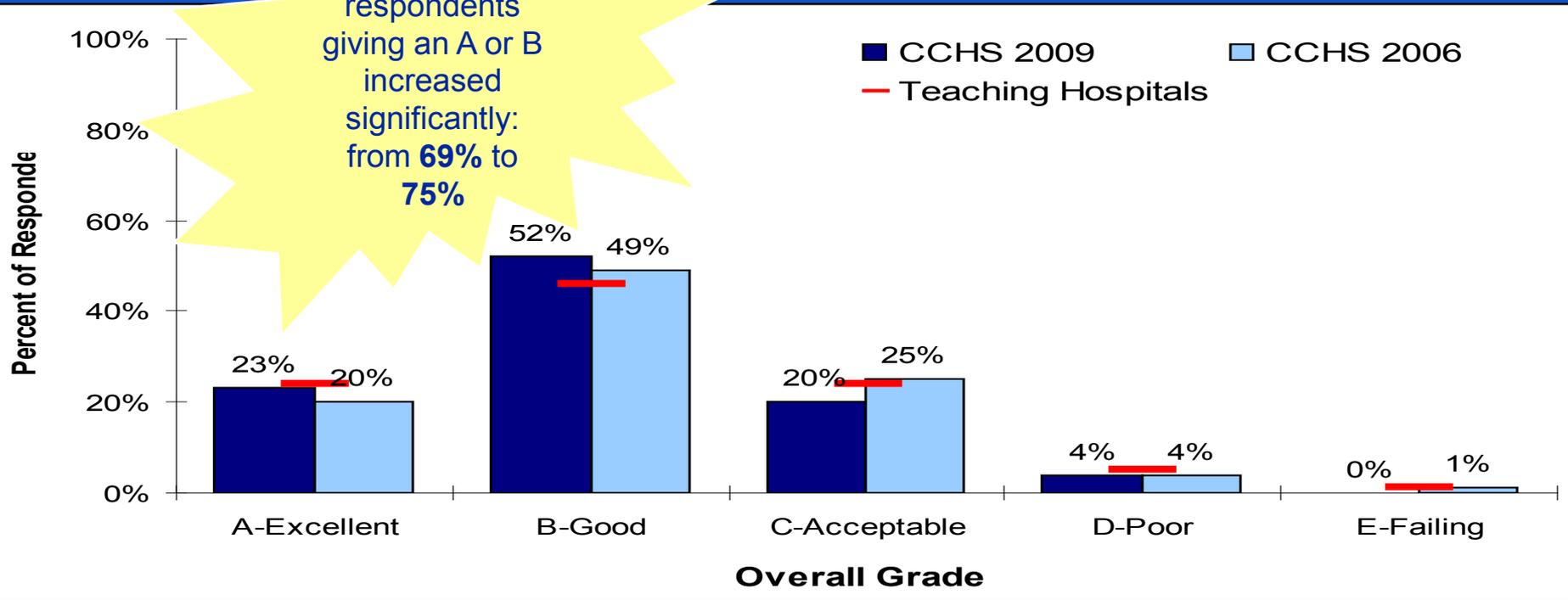
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- Fewer serious adverse events
- 37% decrease in events with major outcomes or harm to our patients
- Improvements in Safety Culture
  - Dramatic decline in fear of disciplinary action
  - Perception of improved patient safety and learning

# Overall Patient Safety Grade

Please give your work area/ unit in this hospital an overall grade on patient safety

Percent of respondents giving an A or B increased significantly: from **69%** to **75%**



Benchmark = Average score for Teaching Hospitals (N=190)

# Composite Scores with Comparison

Patient Safety Culture Composites		CCHS 2009	CCHS 2006	Change	Teaching Hospitals Average %
Strengths	Teamwork within units	80%	77%	3 ↑	78%
	Supervisor/manager expectations & actions promoting patient safety	77%	75%	2 ↑	73%
	Organizational learning-continuous improvement	76%	71%	5 ↑	70%
	Management support for patient safety	74%	67%	7 ↑	61%
	Overall perceptions of patient safety	64%	60%	4 ↑	62%
	Feedback & communication about error	64%	59%	5 ↑	61%
Opportunities	Staffing	62%	57%	5 ↑	53%
	Frequency of events reported	60%	54%	6 ↑	51%
	Communication openness	59%	60%	-1 ↓	60%
	<i>Teamwork across units</i>	54%	50%	4 ↑	54%
	<i>Handoffs &amp; transitions</i>	44%	38%	6 ↑	46%
	<i>Nonpunitive response to error</i>	40%	41%	-1 ↓	42%
Average Across Composites		63%	59%	4 ↑	60%

Italicized measures were Opportunities in 2006 and are including in the FY09 Annual Operating Plan

# Other Uses Of Quantitative and Qualitative Data

Safe Practice  
Behavior Monitoring

- Observations
- Documentation
- Interview questions

Safety First Learning  
Report

- Ease of completion and navigation

Effectiveness of Safety  
Mentor meetings

- Agenda items
- Improvements and suggestions

Focus Groups

- Qualitative feedback on safety project design and strategies

# Lessons Learned

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- Assess baseline data to evaluate success.
- Select culture survey instrument strategically.
- Resources impact selection of measures.
- Safety mentors' insights and perceptions promote learning.
- Recognize that safety culture is local, multidimensional, and still evolving.
- Sharing data at local and organizational levels can drive improvements.

# Lessons Learned

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- Use systematic approach to build data collection into busy clinical settings to answer critical questions
- Consider using cascading metrics to promote alignment of work at different levels of the organization & to link strategy with execution, improvement & innovation.

# Limitations

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- Variety of culture survey instruments utilized.
- Paper surveys utilized.
- Skills and understanding of staff affected data integrity.
- Real time peer-to-peer feedback depended on comfort level of staff.
- Pace of progress affected by turnover of front line staff who were safety mentors.

# Next Steps in Our Journey

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- Enhance “On Boarding” and formalize recognition.
- Provide education on communication and coaching
- Implement Just Culture concepts to further enhance our culture of safety and promote accountability
- Integrate “Just Culture” concepts in Management response to errors and Risk Master upgrade.

# Next Steps in Our Journey

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- Enhance Quality and Patient Safety education into Leadership Competency Curriculum .
- Implemented Team Training and Surgical Safety Checklist in Perioperative Services.
- Improve Post Event Management.
- Perform focus survey of select questions from the AHRQ Culture survey in 2010.
- Administer Patient Safety Culture Survey in 2011 to assess and evaluate our progress.

# On Behalf of our Patients Thank You !

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■ Questions ?