

# **Advancing a Culture of Safety in Surgical Services**

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**Track:** SOPS Survey Administration & Interpretation of Results

**Session:** Unit-Based Hospital SOPS Administration and Improvement Priorities

**Date & Time:** April 20, 2010, 9:30 am

**Track Number:** SOPS T1 – S2

# Hillcrest Hospital

- **424-bed, Cleveland Clinic Community Hospital in suburban Cleveland**
- **2300 Employees**
- **Full service facility**
  - **20 Operating Rooms**
  - **Level II Trauma Center**
  - **Level III NICU**

# Hillcrest Hospital

- 11 – time Thomson Reuters 100 Top Hospital Recipient
- U.S. News & World Report Top 50 Hospital for digestive disease and pulmonary services
- **VISION:**  
To be the best place to receive care, the best place to work, and the best place to practice medicine

# **Culture of Safety Survey**

- **Raises Awareness about Patient Safety Issues**
- **Evaluates the current status of Safety Culture**
- **Required by Joint Commission and Leapfrog**
- **Utilized shortened version for 2009 survey**
- **Added two questions re: disruptive behavior**

# Culture of Safety Survey

- In **2008**
  - March 3<sup>rd</sup> - April 4<sup>th</sup>
  - 11 (eleven) Participants
  
- In **2009**
  - March 8<sup>th</sup> - April 3<sup>rd</sup>
  - 154 Total Participants (“Surgical Services”)

# Culture of Safety Survey

- What Changed from **2008** to **2009** ?
  - Safety was prioritized
    - More discussions with staff about safety prior to the survey and throughout the year
    - Genuine need to know about patient and staff safety issues by unit/clinical area
  - Leadership changes
  - Added on-line option vs. paper survey

# Sample Data

## 2009 Culture of Safety Survey Summary Hillcrest -- Surgical Services

				HILLCREST							"Surgery" DEPT.		SURGICAL SERVICES
Safety Culture Scores	National Average	75th %-ile	25th %-ile	2008	2009	CPD	DHC	PACU	PAT	SC	2008	2009	2009
A1: People support one another in this unit	85%	89%	82%	97.5%	93.7%	88.0%	100.0%	100.0%	80.0%	87.3%	98.2%	81.8%	88.8%
A4: In this unit, people treat each other with respect	78%	83%	73%	86.4%	85.7%	72.0%	96.0%	100.0%	80.0%	87.3%	87.3%	56.7%	71.7%
A6: We are actively doing things to improve patient safe	82%	87%	77%	86.1%	94.2%	96.0%	100.0%	100.0%	100.0%	100.0%	98.2%	88.4%	97.4%
A8R: Staff feel like their mistakes are held against them	51%	58%	45%	47.0%	45.7%	40.0%	72.0%	91.4%	0.0%	54.5%	10.9%	27.7%	41.3%
A9: Mistakes have led to positive changes here	63%	68%	57%	57.2%	69.4%	64.0%	100.0%	91.4%	20.0%	65.5%	21.8%	62.0%	68.6%
A18: Our procedures and systems are good at preventing errors from happening	70%	76%	64%	65.1%	80.3%	88.0%	100.0%	97.1%	60.0%	65.5%	10.9%	75.2%	81.0%
NEW: Intimidating and disruptive behaviors by medical staff and employees affecting patient safety are not tolerated				0.0%	85.5%	96.0%	108.0%	120.0%	80.0%	87.3%		76.5%	87.3%
B1: My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	72%	78%	67%	83.5%	85.1%	80.0%	100.0%	91.4%	60.0%	65.5%	87.3%	76.5%	79.5%
NEW: I can report intimidating and disruptive behaviors without fear of retaliation				0.0%	83.2%	88.0%	108.0%	102.9%	80.0%	54.5%		72.5%	79.5%
C4: .Staff feel free to question the decisions or actions of those with more authority	47%	52%	42%	54.9%	52.6%	48.0%	84.0%	85.7%	20.0%	43.6%	43.6%	31.6%	44.4%
D3: When a mistake is made that could harm the patient, but does not, how often is this reported?	73%	78%	68%	79.7%	80.6%	96.0%	100.0%	97.1%	80.0%	65.5%	98.2%	72.5%	81.0%
F3R: Things "fall between the cracks" when transferring patients from one unit to another	41%	49%	30%	24.8%	38.8%	40.0%	60.0%	62.9%	40.0%	76.4%	0.0%	38.2%	46.0%
F8: The actions of hospital management show that patient safety is a top priority	72%	79%	65%	65.1%	78.6%	96.0%	96.0%	85.7%	20.0%	76.4%	32.7%	73.8%	77.1%

# What the Survey Told Us...

- **The definition of safety has multiple levels:**
  - **Environmental**
  - **Patient Care**
  - **Quality**

# What the Survey Told Us...

The Staff's definition of safety has multiple levels:

- **Process**
  - **Equipment**
  - **Resources / Orientation / Education**
  - **Problem Solving**
- **Communication**
  - **Accountability**
  - **Individual Responsibility**

# How We Shared the Results

- **Unit specific presentations**
  - **Interactive process**
  - **Safety exercises**
  - **Task assignments (where appropriate)**
- **Surgical Council presentation**
- **Reaffirmed our department culture**
- **Introduced new Culture of Safety Model**

# **Safety**

## **Exercise #1**

***What does safety mean to you?***

***What does safety look like to you  
in your work setting?***

# **Safety**

## **Exercise #2**

***What would make surgical care safer in this work environment?***

# **Safety Exercise #2**

## **Work Group Feedback**

- **Adequate staff and resources**
- **More equipment available**
- **Reduce clutter**
- **Team support – Helping each other out**
- **Reduce distractions (pagers, cell phones)**
- **Time management**

# Culture

- **Surgical Services - Guiding Principles**
  - **Patient Focused Quality Service**
  - ***Safe* Surgical Care**
  - **Evidence Based Practice**
  - **Value Added Continuous Improvement**
  - **Integrity and Mutual Respect**

# Traditional Culture vs. New Culture of Safety

<b>Who did it?</b>	→	<i>What happened?</i>
<b>Focus on individual failures</b>	→	<i>Focus on system failures</i>
<b>React to harm</b>	→	<i>Proactive: identify risk and act to prevent harm</i>
<b>Punitive</b>	→	<i>Just culture: fix bad processes</i>
<b>Top down communication</b>	→	<i>Bi-directional communication</i>
<b>Silence about harmful events</b>	→	<i>Open, honest disclosure</i>

# Follow-up

- Reviewed all suggestions
- Added Safety Updates to all Staff Meetings
  - Identified opportunities for improved communication and collaboration across Surgical Services
  - Identified learning moments
- Shared results and feedback with the medical and administrative staff

# In Summary

- **SAFETY** is an everyday priority

*“Even if you are on the right track, you’ll get run over if you just sit there”*

- Ongoing education is key
- Post outcomes and update monthly
  - Core measures
  - Patient experience scores

# In Summary

- **Expect staff involvement**

*“To improve is to change; to be perfect is to change often”*

- **Celebrated Impact of Safe Patient Care**

# CULTURE OF SAFETY

CULTURE OF SAFETY "CHECK LIST"

1.	_____
2.	_____
3.	_____
4.	_____
5.	_____
6.	_____
7.	_____
8.	_____
9.	_____
10.	_____

