Improving Patient Safety by Changing the Culture

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Oaklawn Hospital

- Located in Marshall, Michigan
- 94-bed hospital, independently owned, non-profit organization
- 150 physicians representing 30 specialties
- Received ANCC Magnet Recognition in September 2009
Patient Safety Committee

Revamped Patient Safety Committee in May 2008

- Created separate Patient Safety Committee that “owned” patient safety culture
- Revised Patient Safety Plan
- Set measurable goals
- Membership requirements / commitment
Patient Safety Committee Membership

Membership Qualifications:
- Have a passion for patient safety and high quality care.
- Willing to attend monthly meetings
- Willing to work as a collaborative team member.
- Willing to work outside the committee to accomplish the committee’s goals.
- Willing to trial change suggestions **AND** have the authority to do so in their area/unit/dept and monitor results.
- Willing to network with colleagues to identify best practices so Oaklawn does not reinvent the wheel.

Rewards:
- Knowledge that the committee’s accomplishments will improve health outcomes and provide a safer environment for our patients.
- Trial new and leading edge patient safety change packages – become early adopters of important patient safety techniques.
- Learn and apply Rapid Improvement techniques when trialing change concepts.
- Have some fun along the way!

I am interested in participating on the Patient Safety Committee.

_________________________________________  __________________________
Signature                                      Department
Culture Survey

Conducted AHRQ Survey on Patient Safety Culture June 2008

- Clinical staff
- Ancillary staff impacting patient safety
- Return rate of 74% (371/489)
## 2008 SOPS RESULTS

<table>
<thead>
<tr>
<th>Composite Score</th>
<th>Oaklawn % positive</th>
<th>AHRQ average % positive</th>
<th>Oaklawn percentile</th>
<th>Goal ≥75&lt;sup&gt;th&lt;/sup&gt; percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Perception of Safety</td>
<td>67%</td>
<td>64%</td>
<td>61&lt;sup&gt;st&lt;/sup&gt;</td>
<td><img src="image" alt="Stop Icon" /></td>
</tr>
<tr>
<td>Frequency of events reported</td>
<td>60%</td>
<td>60%</td>
<td>50&lt;sup&gt;th&lt;/sup&gt;</td>
<td><img src="image" alt="Stop Icon" /></td>
</tr>
<tr>
<td>Teamwork Across Hospital Units</td>
<td>57%</td>
<td>57%</td>
<td>50&lt;sup&gt;th&lt;/sup&gt;</td>
<td><img src="image" alt="Stop Icon" /></td>
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<tr>
<td>Nonpunitive Response to Error</td>
<td>42%</td>
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<td>45&lt;sup&gt;th&lt;/sup&gt;</td>
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<td>Teamwork Within Units</td>
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What Do We Do With This Information?

- Drill down to identify reasons why questions are answered the way they were
- Communicate SOPS outcomes to Management – place outcomes on Executive Staff’s dashboard
- Identify actions that will impact staff perceptions of selected items
- Develop a process for communicating results and celebrating improvements
Action Plan – Event Reporting

- Convert paper-base reporting system into electronic event reporting
  - Education / training included non-punitive culture for mistakes and errors
  - Ability to report anonymously
- Provide immediate feedback to staff
- Initiate “Good Catch” Award – Celebrate
Good Catch Party
2009 Event Reporting Outcomes

- Increased reporting occurrence reporting from 267 in 2008 to 630 in 2009.

- Increased medication “good catches” by from 30 in 2008 to 73 in 2009.
Relationship Based Care Nursing Model (RBC)*

Interdisciplinary communication and teamwork are vital as they promote mutual respect and role clarity.

Each and every member of an organization, in all disciplines and departments, has a valuable contribution to make.

Healthy relationships among members of the health care team lead to the delivery of quality care and result in high patient, physician, and staff satisfaction.

Transformational change happens one relationship at a time.

* Authors: Mary Koloroutis; Marie Manthey; Jayne Felgen; Colleen Person; Leah Kinnaird; Donna Wright; Sharon Dingman
Action Plan – Teamwork

Identified patient safety improvement opportunities and approved multiple Quality Work Groups (QWG)

- Fall Prevention
- Pressure Ulcer Prevention
- Handoff Communication between OR to Med/Surg/CCU, ED to Med/Surg/CCU, and physician and nursing staff
- Standardize patient wristbands
Action Plan – MHA Keystone

Surgery and OB Projects

Implemented *Comprehensive Unit-Based Safety Program (CUSP)

- Evaluate culture of safety
- Educate staff on science of safety
- Identify defects
- Senior Executive Partnership
- Implement teamwork tools; Learn from one defect per month
- Evaluate culture of safety

*The Johns Hopkins University, School of Medicine
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2009 SOPS Actions

- Drilled down into individual department results – shared with managers and appropriate executives
- Ask departments to identify two actions they will take to improve patient safety culture
  - Unit Based Councils identified improvement opportunities
  - PI Department facilitated focus groups
- Continue with RBC, QWGs
- Implement “Red Rules”
- Celebrate successes
Key Learning's

- No magic bullet – takes multiple initiatives through multiple mediums.
- Connect the dots on why changes are occurring and what to expect as an outcome.
- Need to define when an event would be considered punitive vs. non-punitive.
Key Learning's

Culture is department specific: Some things can be addressed house-wide, but many are department issues.

The survey results are symptoms – must drill down to identify “root cause”.
2010 SOPS Improvements

- Improve staff education on survey tool and its questions
- Improve turn-around-time of information back to department managers
Questions??

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