

On the Journey to a Culture of Patient Safety

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Abstract

In 2005, our hospital participated in a Canadian Council on Health Services Accreditation (CCHSA) Patient Safety Cultural Assessment project. Online survey results collected and analyzed by CCHSA demonstrated numerous opportunities for our organization to improve its patient safety culture. An eight-point Patient Safety Plan was created, and over the following two years, numerous patient safety initiatives were implemented. In 2007, the Patient Safety Cultural Assessment was repeated using the same survey instrument and an online survey response method. Results showed only very minor positive improvements in our culture.

Leamington District Memorial Hospital (LDMH) is an 88-bed acute care, rural community hospital in Ontario's Erie St. Clair Local Health Integration Network. In 2005, the Canadian Council on Health Services Accreditation (CCHSA) solicited participation from volunteer hospitals in an online pilot project to assist hospitals in assessing their individual patient safety culture. LDMH was one of 30 healthcare agencies nationwide that joined the project (CCHSA 2005b). Over the course of one month, 61% of hospital staff completed the online

Patient Safety Climate in Healthcare Organizations survey tool through CCHSA's web portal. Data were collected, analyzed and reported back to us by CCHSA. The summary themes suggested (1) that LDMH had a culture of blame and shame, (2) that the senior management team did not care or know about patient safety and (3) that the senior team did not "walk the talk" of patient safety.

These results, coupled with CCHSA's new Patient Safety Required Organizational Practices (ROPs) and our upcoming 2006 accreditation survey, created a sense of urgency for change. An eight-point Patient Safety Action Plan was developed by the senior management team and adopted by the hospital's board of directors. The board made patient safety a written strategic priority for the hospital, and work began immediately on implementing the Patient Safety Action Plan. The end goal was to improve the patient safety culture at LDMH. The final point in the action plan required that we repeat the patient safety cultural assessment after two years. The board expected to see measurable improvement in our culture by 2007.

LDMH's Eight-Point Patient Safety Action Plan

Point One: Evaluate Patient Safety Culture

The themes identified in the results of the survey helped focus the Patient Safety Action Plan. A review of the patient safety literature, including CCHSA's Achieving Improved Measurement

(AIM) standards and ROPs (CCHSA 2005a), provided input to the plan. Numerous education sessions, poster displays and internal newsletters were used to inform LDMH staff of the survey results. We made no attempt to soften the report's findings and included the board's Patient Safety Action Plan in our communications to staff. We emphasized to our staff that we were committed to improving the hospital's culture.

Point Two: Encourage Patient Safety Learning across LDMH

The senior team adopted a three-part patient safety philosophy for LDMH: (1) we will make mistakes, (2) we will promote the reporting/identification of mistakes and (3) we will focus on systems, not people. The agenda for general orientation of new staff was revised to include the introduction of this philosophy, education about a no-blame culture and encouragement for all employees to report errors and near misses. They were promised that no repercussions would result from such reporting. A video titled *Beyond Blame (1997)* was shown, and a copy was placed in each area of the hospital for staff to view. Managers were counselled on a just culture approach, a balance of accountability and responsibility, in responding to staff errors. All care teams were informed at their monthly meetings about the patient safety activities under way within the hospital. Internal patient safety newsletters were distributed on a bi-monthly basis throughout the following 18 months as we prepared for our accreditation survey. These newsletters conveyed information about the hospital's patient safety philosophy, care teams' objectives and activities related to patient safety improvements and progress toward meeting CCHSA's ROPs.

Point Three: Identify Staff Safety Concerns

A number of initiatives were developed to encourage staff to identify and raise patient safety concerns with each other and with members of the senior management team. Volunteer patient safety champions were recruited from each clinical area to be the *eyes and ears* of patient safety for their units. The champions met with the chief nursing executive (CNE) monthly in the *Patient Safety Champions Council*. The council was a forum for front-line staff to freely exchange *patient safety* concerns with the CNE, a representative of the senior management team.

The role of the patient safety champion was to advocate for patient safety; to influence front-line colleagues to focus on patient safety; to take staff's safety concerns to the council meetings; and to take recommendations, action plans and feedback from the council back to the front line. The CNE listened to concerns, encouraged open dialogue and facilitated timely resolutions to identified issues. At each consecutive council meeting, she reported back to the champions specific resolutions to their concerns. The champions were delighted

at their influence, and word spread very quickly throughout the organization that patient safety was important and that champions' concerns would be addressed. Patient safety champion and patient safety were terms that quickly became a part of LDMH's daily language.

Point Four: Conduct Weekly Executive Patient Safety Walkabouts

The senior management team began conducting weekly walkabouts to each clinical and non-clinical area of the hospital. The senior manager stopped to talk to front-line staff, asking them if they had concerns about patient safety and what those concerns were. The senior manager publicly acknowledged and praised staff who reported concerns. An online template was created in which the executive logged the reported issues of concern and identified the manager(s) responsible for addressing the concern and a target date for resolution. This template was reported to the board of directors through Quality Council, a standing committee of the board, every quarter. It was also posted for staff reference to a newly created Patient Safety link on the hospital's intranet.

Point Five: Prioritize Improvement Efforts

Both clinical and non-clinical improvement initiatives were identified and promoted throughout the organization. Clinical initiatives included (1) improving communication at points of patient hand off, (2) a Back to Basics of patient care campaign, (3) the Seamless Discharge Prescription Form, (4) participation in the Ontario Hospital Association (OHA 2005) Your Healthcare – Be Involved campaign and (5) a patient falls management program.

Non-clinical, organizational improvement efforts included (1) promoting an Employee Wellness Program to ensure optimal levels of staff physical and emotional health, (2) the development of a Quality of Care Committee and a Disclosure of Harm Policy and (3) regular, formal training of all staff regarding patient safety.

Point Six: Implement Improvements

An admission/transfer checklist was created by the Emergency/Ambulatory Care Team and was completed at every point of patient hand-off. The Acute Care Team created a Back to Basics campaign that featured removing all patient restraints from chairs, beds, table tops and so on. Our medication reconciliation initiative, the Seamless Discharge Prescription Form, was created by a team of nurses, internal medicine physicians and a pharmacist. The Complex Continuing Care/Rehabilitation Team led the patient falls management program, and all areas of the hospital participated in OHA's Your Healthcare – Be Involved (OHA 2005). A copy of that campaign's "Five Patient

Safety Tips” was included in every patient’s discharge package.

Our organizational improvement efforts were driven by the senior management team, whose members were delighted to accept the 2007 platinum award from the local Health Action/Health Unit Windsor-Essex for LDMH’s Employee Wellness Program. The Quality of Care Committee, established under the auspices of the Quality of Care Information Protection Act, allowed us to include staff and physicians in internal patient care case reviews without fear of revelation. The Disclosure of Harm policy, approved by our Medical Advisory Committee and board of directors, created some discomfort among the professional staff. However, the chief of staff was a proponent and was able to alleviate their concerns. The most significant organizational improvement related to patient safety was the hospital’s commitment to direct one third of its annual capital equipment budget to purchases that would improve patient safety.

Point Seven: Share Stories and Disseminate Results

To share information with our staff about these patient safety improvement strategies, we created a Patient Safety site on our intranet. The executive walkabout templates, Patient Safety Champions Council meeting minutes and action plans, all patient safety newsletters and patient safety educational resources were posted on this site. Patient safety champions wore large metallic buttons identifying them, and they became well known throughout the organization.

We also wanted to share our stories externally. Our hospital pharmacist made an oral presentation at the 2005 International Society for Quality’s annual convention about the Seamless Discharge Prescription Form. Subsequently, she wrote an article about the process we undertook to create and implement that medication reconciliation process (Namespetra 2008). Through our partnership with the University of Windsor, we are pleased to host nursing graduate students’ clinical placements annually. We offered them exposure to, and involvement in, the research component of our falls management program. Finally, our restraint-free falls management program was presented at the Nursing Leadership Network of Ontario’s 2007 annual conference (Tiessen and Deter 2007, October). Each of these public presentations was celebrated in our internal newsletter so that all staff could share in the progress toward creating a patient safety culture at LDMH.

Point Eight: Re-evaluate Patient Safety Culture

In June 2007, after two years of concerted efforts to improve our patient safety culture, we asked our staff to complete the survey tool again. We were convinced we had made great strides in improving our culture. We used the same online survey methodology using the Survey Monkey website but achieved only a 35% response rate. Data analysis showed significant change

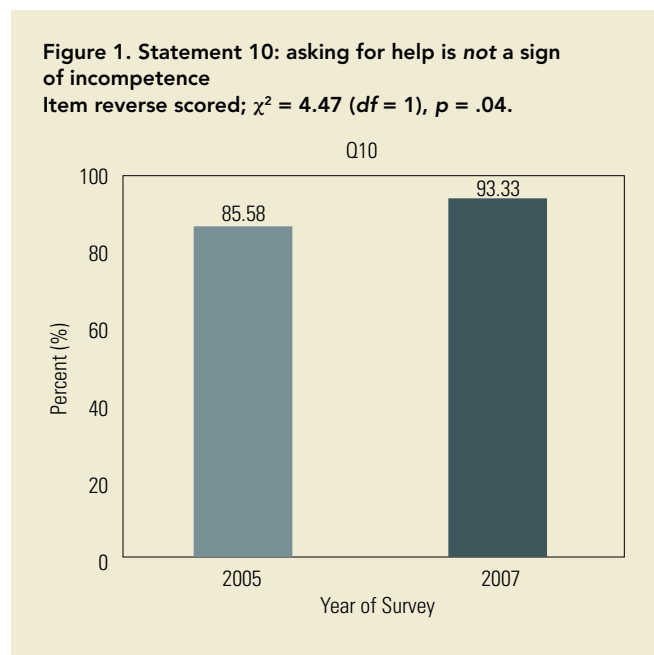
since 2005 on only three statements, and marginally significant change on three others. Not all the changes were positive.

Results

Statements Showing a Significant Difference across Time

Statement 10: Asking for Help is Not a Sign of Incompetence

Figure 1 shows that in 2005, 85.6% ($n = 178$) of respondents either agreed or strongly agreed that asking for help is not a sign of incompetence. In 2007, 93.3% ($n = 112$) of respondents agreed or strongly agreed with this statement, revealing a significant increase across time, $\chi^2(1) = 4.47, p = .04$. Furthermore, in the 2007 data, no respondents thought that asking for help was a sign of incompetence.



Statement 13: If I Make a Mistake That Has a Significant Consequence and Nobody Notices, I Do Tell Someone about It

In 2005, 88.41% of respondents either agreed or strongly agreed that they would tell someone if they made a mistake that had a significant consequence (Figure 2). The proportion of respondents agreeing with this statement further increased in 2007, with 94.1% ($n = 112$) of respondents either agreeing or strongly agreeing, $\chi^2(1) = 5.28, p = .02$.

Statement 24: My Unit Follows a Specific Process to Review Performance against Defined Training Goals

Figure 3 shows that, in 2005, 46.3% ($n = 34$) of respondents either agreed or strongly agreed that their unit follows a specific process to review performance against defined training goals. However, the proportion of respondents agreeing with this statement significantly decreased over time, with only 29.3% ($n = 34$) of respondents agreeing or strongly agreeing in 2007, $\chi^2(1) = 7.52, p = .01$. These results suggest that employees do not perceive that their unit's processes to review performance and training goals are linked. In 2005, a large proportion of respondents were essentially split on this statement. Responses were spread across the neutral, disagree and agree categories. In 2007, there appears to have been a shift in responses, such that employees were either neutral or disagreed with the statement.

that employees did not necessarily disagree or strongly disagree that senior management promotes a patient safety climate.

Figure 3. Statement 24: my unit follows a specific process to review performance against defined training goals
 $\chi^2 = 7.52 (df = 1), p = .01$.

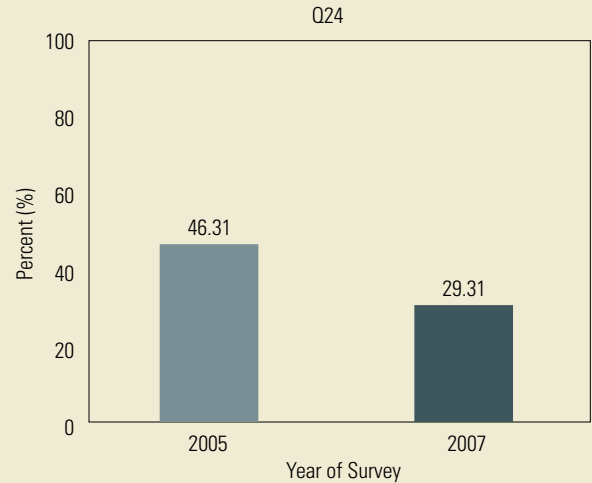


Figure 2. Statement 13: if I make a mistake that has a significant consequence and nobody notices, I do tell someone

Item reverse scored; $\chi^2 = 5.28 (df = 1), p = .02$.

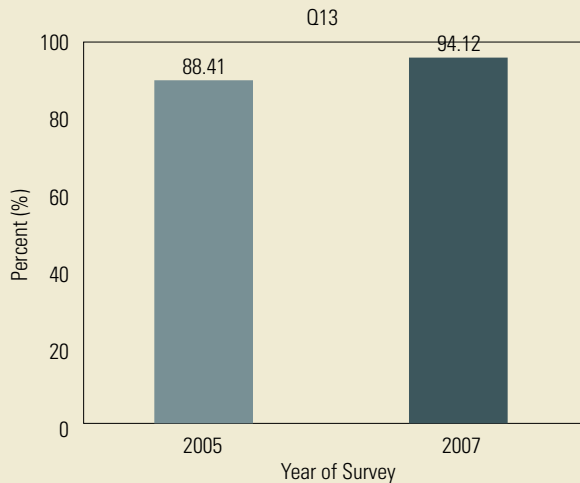
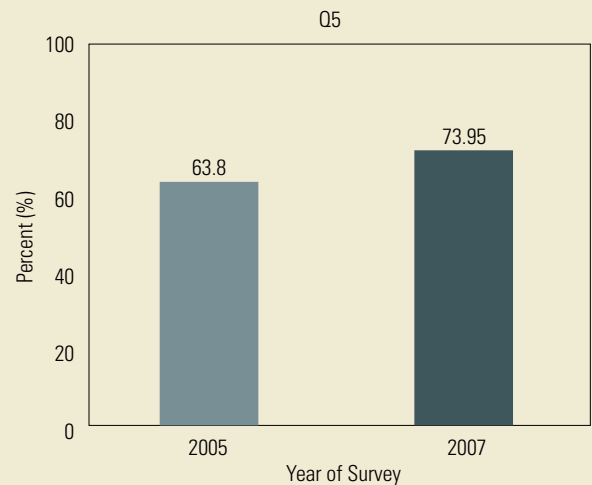


Figure 4. Statement 5: senior management provides a climate that promotes patient safety
 $\chi^2 = 3.58 (df = 1), p = .06$.



Statements Showing a Marginally Significant Difference across Time

Statement 5: Senior Management Provides a Climate That Promotes Patient Safety

Figure 4 depicts that, in 2005, 63.8% ($n = 132$) of respondents either agreed or strongly agreed that senior management provides a patient safety climate. In 2007, 73.9% ($n = 88$) of respondents agreed that senior management provides a patient safety climate, showing a marginally significant increase, $\chi^2(1) = 3.58, p = .06$. Of note is that in both survey years, a large proportion of respondents were neutral on this statement, suggesting

Statement 14: My Unit Recognizes Individual Safety Achievement through Rewards and Incentives

In 2005, 16.4% ($n = 34$) of respondents either agreed or strongly agreed that their unit recognized safety achievement through rewards and incentives (Figure 5). The 2007 data

showed a marginally significant increase, with 23.5% ($n = 28$) of respondents agreeing or strongly agreeing, $\chi^2(1) = 3.32, p = .07$. Even though there was a marginal increase in the percentage of employees agreeing with this statement, the vast majority of respondents disagreed in both the 2005 and 2007 surveys. This suggests that hospital units may not be recognizing safety achievements and linking them to rewards and incentives.

Figure 5. Statement 14: my unit recognizes individual safety achievement through awards and incentives
 $\chi^2 = 3.32 (df = 1), p = .07$.

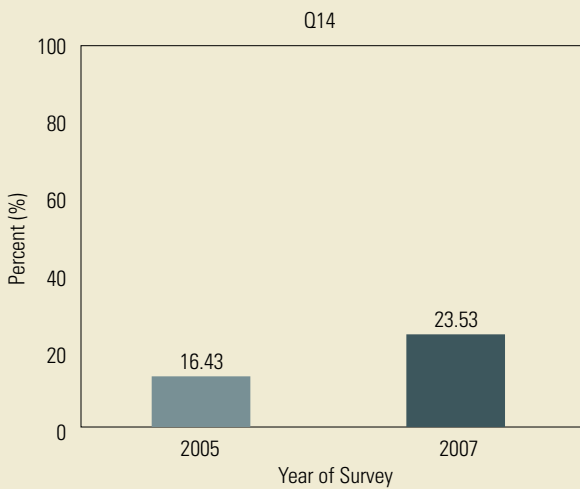
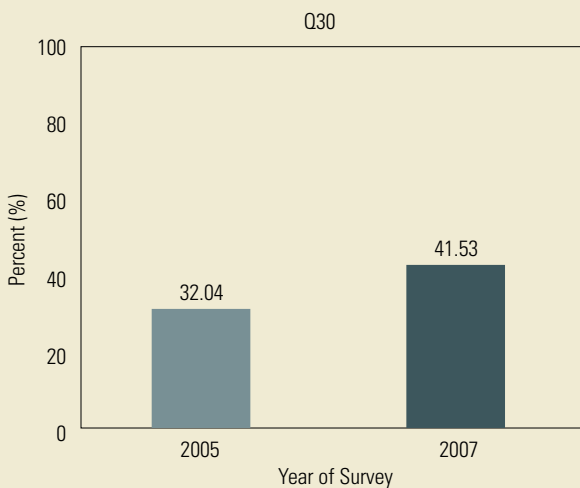


Figure 6. Statement 30: I have enough time to complete patient care tasks safely
 $\chi^2 = 3.18 (df = 1), p = .07$.



Statement 30: I Have Enough Time to Complete Patient Care Tasks Safely

In 2005, 32% ($n = 66$) of respondents either agreed or strongly agreed that they had adequate time to complete patient care tasks safely (Figure 6). In 2007, the results showed that a larger proportion of respondents, 41.5% ($n = 49$), agreed or strongly agreed with this statement, although the difference was only marginally significant, $\chi^2(1) = 3.18, p = .07$.

Discussion

Based on the survey responses, there is some evidence to suggest that between 2005 and 2007, LDMH made some modest improvements in promoting a patient safety culture. Some of the improvements reported in 2007 included employees more likely to feel comfortable asking for help and to report if they made a mistake that had a significant consequence. However, they also reported that their units did not recognize individual safety achievements through rewards and incentives.

Unfortunately, from survey responses to statements about senior management’s involvement in patient safety issues, the data suggested that employees might not be fully aware of the steps senior management had been taking to improve the patient safety culture. Given the numerous avenues identified above through which information had been disseminated, the hospital board and senior management were bewildered by employees’ apparent lack of awareness.

Upon reflection on hospital activities over the past two years, an analysis emerged that might explain the negative results of the 2007 survey. Many changes had occurred in our organization between 2005 and 2007. For the first time in a decade, the hospital’s financial situation was precarious. Projecting deficits for each upcoming fiscal year, senior management had introduced cost-cutting measures that included staffing changes, staff reductions in some areas and reassignment/scheduling adjustments in other areas. A large number of nursing staff were affected, and their discord was felt across the entire organization. Staff morale was dramatically, and negatively, impacted and may account for the less-than-optimal response rate in the 2007 survey. Survey responses indicating that rewards and incentives were not used and that staff did not know about steps senior management members were taking to improve the patient safety culture may have been directly related to employee discontent. Finally, it may be that our expectation for a dramatic improvement in patient safety culture in a matter of only two years was unrealistic.

Conclusion and Lessons Learned

Once again, we used the results of the 2007 survey to help us enhance our Patient Safety Action Plan. Many of our original initiatives remain in place and (1) strategies to improve commu-

nication, (2) additional clinical process improvements and (3) a Board of Directors Leadership Plan for Patient Safety have been added. Our next accreditation survey, scheduled for 2009, using CCHSA's Qmentum program (CCHSA 2008), requires us to conduct a Patient Safety Cultural Survey within the next 18 months and then once in every three-year accreditation cycle. We have embarked on a journey toward a patient safety culture, and it seems we have a long way to go. The Qmentum program will help guide us in that journey and will afford us opportunities to regularly reassess our hospital's progress along the way. We have learned that a patient safety culture cannot be built in two years. **HQ**

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