

**JUST CULTURE COLLABORATIVE
PATIENT SAFETY CULTURE
SURVEY REPORT**

**Strategies for Improving
Organizational Patient Safety**

**“Survey on Patient Safety Culture”
Post-Intervention Aggregate Report**

February, 2009



USING THE POST-INTERVENTION FEEDBACK REPORT

This report provides you with aggregate results of the survey component of the Missouri Just Culture Collaborative, a project funded by the National Council of State Boards of Nursing. As you will recall, the survey is a modified version of the national Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture. This report includes the aggregate results of all survey responses from provider participants in the collaborative.

As indicated in the cover memo to this report, although we were unable to provide your organization with facility-level feedback, we hope the enclosed report will be of use in continuing your discussion about a Just Culture in your organization.

An interesting finding from the analysis of the pre-intervention and post-intervention survey results is that viewpoints of participants from facilities that fully engaged in the education, training, and consultation available through the collaborative are more closely aligned with the national norms for the measured culture of safety indicators.

To the extent possible, you may want to assess how your organization compares because this finding suggests that the more leadership was engaged in the interventions, the more they may have become aware of the real issues from the staff and patient perspective, possibly suggesting a more realist and open approach to the change necessary to create a true just culture.

AGGREGATE OVERVIEW OF SURVEY RESPONSES

During the 20-month time frame of the Missouri Just Culture Collaborative, fifty-two organizations participated in the survey process and other aspects of the collaborative. The aggregate results of such activity are provided in this report. Twenty organizations that had a sufficient number of respondents to the survey received facility-specific reports. Twenty-seven organizations did not receive a facility-specific report because the number of respondents was insufficient to allow for reporting to ensure anonymity of respondents. The remaining five organizations did not receive a facility-specific report because the organizational number entered into the survey did not match an assigned organizational code.

Table 1 provides an overview of demographic characteristics of the 52 facilities that participated in the survey process.

Table 1. Selected Characteristics of Collaborating Facilities

Intervention Group	Percentage by Bed Size			Percentage Not for Profit	Percentage Urban
	Less than 100 Beds	101-300 Beds	Greater Than 300 Beds		
4 (n=17)	29.4%	35.3%	35.3%	76.4%	41.1%
3 (n=15)	66.6%	13.3%	20%	86.6%	26.6%
2 (n=16)	60.0%	20.0%	20.0%	86.6%	53.3%
1 (n=4)	50.0%	25.0%	25.0%	100.0%	25%

Table 2 describes the intervention provided through the collaborative that was offered to each participating facility.

Table 2. Levels of Collaborative Education, Training and Consultative Intervention

Level of Intervention	Description of Intervention
Level 1 (n=4)	Champion’s Training held December 2007 - an all day workshop focused on Just Culture principles for a “champion” leader from each participating organization.
Level 2 (n=16)	Regional Team Training - an all day workshop on Just Culture principles held at four regional sites across the state between January and March 2008 to train teams of up to six individuals from each collaborating organization. Attendees included Chief Executive Officers, Chief Nursing Officers, Patient Safety/Quality/Risk Managers, Medical Directors and other Executive and Management staff.
Level 3 (n=15)	Participation in three intervention activities: Champion’s Training, Regional Team Training, and at least 50% of the nine audio-conferences held between January 2008 and October 2008 <i>OR</i> additional intervention. Audio-conferences were on the following topics: Networking and sharing of collaborative activities, “Implementing a Just Culture”, “Event Investigations”, “Managing Human Resources”, “Managerial Accountabilities”.
Level 4 (n=17)	Champion’s Training, Regional Training, participation in at least 50% of the audio conference calls, and successful application for additional on-site intervention. Twenty provider organizations were awarded additional intervention and chose among training options including an executive briefing (3 participants), training for managers (17), and/or Safe Choices™ staff training (8). Note: Some providers received more than one training option.

Table 3 provides a comparison of "peers" within the intervention groups for consideration in comparing your organization's results with those of other organizations participating at the same level of intervention.

Review of these results reveals that the more engaged a facility was with the intervention (Level 4), the more they approximated the perceptions of hospital staff across the country (last column) with very few exceptions.

Table 3. Comparison by Intervention Level of Selected Item Level Responses and AHRQ 2008 Benchmark

Dimension/Selected Items	Level 1	Level 2	Level 3	Level 4	AHRQ 2008* Administration/ Management	AHRQ 2008** All
<i>Number of total respondents</i>	(6)	(16)	(58)	(279)	10,955	152,473
Communication Openness	70.9	79.1	76.8	66.1	74.0	62.0
<i>Staff will freely speak up if they see something that may negatively affect patient care.</i>	100.0	76.7	92.2	77.4	80.0	76.0
<i>Staff feel free to question the decision or actions of those with more authority.</i>	100.0	90.0	71.9	56.6	67.0	47.0
Feedback & Communication about Error	70.9	77.2	82.6	70.9	73.0	62.0
<i>In this unit, we discuss ways to prevent errors from happening again.</i>	100.0	83.3	90.8	83.1	87.0	70.0
<i>We are given feedback about changes put into place based on event reports.</i>	75.0	60.0	76.3	61.0	61.0	52.0
Frequency of Events Reported	66.7	73.1	73.2	49.8	65.0	60.0
<i>When a mistake is made that could harm the patient, but does not, how often is this reported?</i>	100.0	88.9	84.9	61.3	78.0	73.0
<i>When a mistake is made, but is caught and corrected before affecting the patient, how often is it reported?</i>	75.0	54.4	62.5	40.8	58.0	51.0
Handoffs and Transitions	43.8	54.6	65.1	37.1	51.0	45.0
<i>Important patient care information is [not] often lost during shift changes.</i>	25.0	56.7	65.0	38.9	53.0	49.0
<i>Things [don't] fall between the cracks when transferring patients from one unit to another.</i>	25.0	61.1	71.2	39.9	47.0	41.0
Management Support for Patient Safety	66.7	95.3	92.2	79.7	85.0	70.0
<i>Hospital management provides a work climate that promotes patient safety.</i>	100.0	100.0	91.5	90.1	91.0	80.0
<i>Hospital management [does not] seem interested in patient safety only after an adverse event.</i>	75.0	86.7	88.1	68.5	76.0	59.0

Dimension/Selected Items	Level 1	Level 2	Level 3	Level 4	AHRQ 2008* Administration/ Management	AHRQ 2008** All
Manager Expectations/Actions Promoting Patient Safety	82.3	95.6	92.5	82.6	85.0	75.0
<i>My supervisor/manager [does not] overlook patient safety problems that happen over and over.</i>	100.0	93.3	89.5	83.8	85.0	76.0
<i>My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.</i>	50.0	93.3	81.8	80.3	82.0	71.0
Non-punitive Response to Error	58.4	69.5	68.7	50.6	65.0	44.0
<i>Staff [do not] feel like their mistakes are held against them.</i>	75.0	63.3	70.3	58.8	70.0	51.0
<i>Staff [do not] worry that mistakes are kept in their personal files.</i>	50.0	43.4	63.7	30.0	55.0	36.0
Organizational Learning-Continuous Improvement	91.7	95.8	92.2	84.0	85.0	70.0
<i>We are actively doing things to improve patient safety.</i>	100.0	100.0	98.7	93.6	90.0	81.0
<i>Mistakes have lead to positive changes here.</i>	100.0	100.0	87.4	81.7	83.0	62.0
Overall Perceptions of Patient Safety	68.8	86.8	72.0	59.3	74.0	64.0
<i>Our procedures and systems are good at preventing error from happening.</i>	100.0	88.9	74.2	70.3	77.0	69.0
<i>It is [not] just by chance that more serious mistakes don't happen around here.</i>	75.0	65.6	70.6	66.1	75.0	60.0
Staffing	50.0	80.8	78.6	56.2	65.0	55.0
<i>We [do not] use more agency/temporary staff than is best for patient care.</i>	25.0	63.3	83.5	64.8	68.0	64.0
<i>We [do not] work in "crisis mode" trying to do too much, too quickly.</i>	25.0	65.6	76.6	41.3	62.0	49.0
Teamwork Across Units	93.8	88.1	81.2	65.8	63.0	57.0
<i>Hospital units work well together to provide the best care for patients.</i>	100.0	88.9	96.1	73.4	78.0	67.0
<i>Hospital units [do] coordinate well with each other.</i>	100.0	83.3	74.7	66.2	54.0	45.0
Teamwork Within Units	87.5	96.5	93.8	85.0	86.0	79.0
<i>When a lot of work needs to be done quickly, we together as a team to get the work done.</i>	100.0	100.0	98.1	91.9	93.0	85.0
<i>When one area of the unit gets busy, others help out.</i>	100.0	88.9	85.1	70.0	79.0	68.8

* Sorra, J, Famolaro, T, Dyer, N, Khanna K. Hospital Survey on Patient Safety Culture 2008 Comparative Database Report. Appendixes, Part II and III (Appendixes for Publication No. 08-0039). (Prepared by Westat, Rockville, MD, under contract No. 233-02-0087, Take Order 18). AHRQ, Rockville, MD: Agency for Healthcare Research and Quality. March 2008.

** Sorra, J, Famolaro, T, Dyer, N, Khanna K. Hospital Survey on Patient Safety Culture 2008 Comparative Database Report (Prepared by Westat, Rockville, MD, under contract No. 233-02-0087, Take Order 18). AHRQ (Publication No. 08-0039), Rockville, MD: Agency for Healthcare Research and Quality. March 2008.

Table 4 provides an overview of responses provided by all organizations that completed the survey by question and safety dimension that was included in the survey.

Table 4. Aggregated Responses for All Participating Organization by Question and Safety Dimension

**Italicized text reflects reframing of the question to a positive frame*

Survey Dimension and Individual Items	Prior to Intervention (n=485)		After Intervention (n=441)	
	Percentage of Agree/Strongly Agree	Comparison to National AHRQ Findings	Percentage of Agree/Strongly Agree	2008 Comparison to National AHRQ Findings
Teamwork within Units	81.5%	Higher	86.4%	Higher
People support one another in their work unit.	90.9%		95.6%	
When a lot of work needs to be done quickly, staff works together as a team to get the work done.	92%		93.1%	
Within their work unit, people treat each other with respect.	77.2%		84.2%	
When one area is busy, others help out.	65.7%		72.6%	
Supervisor/Manager Expectations & Actions Promoting Patient Safety	80.1%	Higher	83.4%	Higher
Supervisory staff say a good word when patient safety procedures are followed.	74.8%		79.1%	
Supervisory staff seriously consider staff suggestions for improving patient safety.	86.8%		89.4%	
Whenever pressure builds up, management <i>does not</i> encourage taking short-cuts.	75%		79.3%	
Supervisory staff <i>do not</i> overlook patient safety problems that happen over and over.	83.8%		85.6%	
Management Support for Patient Safety	79%	Higher	79.8%	Higher
Management provides a work climate that promotes patient safety.	86%		89.3%	
Management shows by its actions that patient safety is a top priority.	78.9%		81.4%	
Management seems interested in patient safety even when an adverse event <i>does not</i> happen.	72.1%		68.8%	

Survey Dimension and Individual Items	Prior to Intervention (n=485)		After Intervention (n=441)	
	Percentage of Agree/Strongly Agree	Comparison to National AHRQ Findings	Percentage of Agree/Strongly Agree	2008 Comparison to National AHRQ Findings
Organizational Learning-Continuous Improvement	82.6%	Higher	83.8%	Higher
Staff actively do things to improve patient safety.	94.1%		93.2%	
Mistakes have led to positive change.	83.5%		82.6%	
After changes are made to improve patient safety, an evaluation of effectiveness occurs.	70.3%		75.5%	
Overall Perceptions of Patient Safety	54.2%	Lower	61%	Lower
It is <i>more than just chance</i> that serious mistakes do not happen in this organization.	64.3%		66.7%	
Patient safety is never sacrificed to get more work done.	52.8%		56.9%	
We <i>do not</i> have patient safety problems.	38.4%		50.2%	
Procedures and systems are good at preventing errors from happening.	61.1%		70.3%	
Feedback & Communication about Error	63.8%	Higher	68.9%	Higher
We are often given feedback about changes put into place based on event reports.	51.7%		56.7%	
We are often informed about errors that happen in our setting.	60.2%		66.7%	
We discuss ways to prevent errors from happening again.	79.6%		83.2%	
Communication Openness	58.2%	Lower	65.2%	Higher
Staff will speak up if they see something that may negatively affect patient care.	69.5%		77.9%	
Staff feel free to question the decisions or actions of those with more authority.	48.1%		55.1%	
Staff <i>are not</i> afraid to ask questions when something does not seem right.	57.1%		62.7%	
Frequency of Events Reported	45.9%	Lower	52.5%	Lower
Events that are caught and corrected before affecting the patient are often reported.	35.8%		42.6%	

Survey Dimension and Individual Items	Prior to Intervention (n=485)		After Intervention (n=441)	
	Percentage of Agree/Strongly Agree	Comparison to National AHRQ Findings	Percentage of Agree/Strongly Agree	2008 Comparison to National AHRQ Findings
Events that have no potential to harm the patients are often reported.	42.4%		49.8%	
Events that could harm the patient, but do not, are often reported.	59.6%		65.1%	
Teamwork Across Units	58.8%	Higher	67%	Higher
Units <i>coordinate well</i> with each other.	56.6%		63.2%	
There is good cooperation among units that need to work together.	58.2%		67.8%	
It is <i>often pleasant</i> to work with staff from other units.	56.5%		61.4%	
Units work well together to provide the best care for patients.	64%		75.6%	
Staffing	57.7%	Higher	58.1%	Higher
We have enough staff to handle our workload.	67.9%		67.6%	
Staff <i>do not</i> have to work longer hours than is best for patient care.	56.9%		54.7%	
The volume of temporary/agency staff use <i>does not</i> impact patient care.	64.8%		66.4%	
<i>We do not</i> work in “crisis mode,” <i>do not</i> try to do too much too quickly.	41.2%		43.6%	
Handoffs and Transitions	37.1%	Lower	38%	Lower
Things <i>do not</i> often “fall between the cracks” when transferring patients from one unit to another.	39.6%		37.3%	
Important patient care information is <i>not often lost</i> during shift change.	39.9%		39.9%	
Problems <i>do not often</i> occur in the exchange of patient information across units.	35.2%		38.1%	
Shift changes <i>are not</i> problematic.	33.5%		36.7%	

Survey Dimension and Individual Items	Prior to Intervention (n=485)		After Intervention (n=441)	
	Percentage of Agree/Strongly Agree	Comparison to National AHRQ Findings	Percentage of Agree/Strongly Agree	2008 Comparison to National AHRQ Findings
Non-punitive Response to Error	48.1%	Higher	49.3%	Higher
Staff <i>do not</i> feel like their mistakes are held against them.	49.6%		54%	
The <i>problem rather than the person</i> is being written up.	60.3%		61.3%	
Staff <i>do not</i> worry that mistakes are kept in their personnel file.	34.3%		32.6%	

Table 5 provides an overview of comments by level of intervention.

Again, substantive differences between responses are noted based on the level of intervention undertaken as part of the collaborative. While the majority of leadership participants across all organizations maintain staff is comfortable reporting errors, only leaders from organizations that participating at Level 4 of the intervention made comments suggesting staff is actually mindful of errors, specifically near misses and potential for harm. Such comments included, “staff report problems they have seen that *could be problematic*”, and “I receive reports that have *no harm*.”

Additionally, leaders from organizations receiving Level 4 intervention commented that there are still barriers to error reporting, including many who believe “pockets of employees” still fear blame. Such an acknowledgement of barriers may reflect a clearer understanding of their staff’s perception, suggesting leadership perceptions are now more aligned with those of their staff.

Other findings suggest the initial response to error is now more often centered around event investigation and resolution for organizations that participated in Level 3 and 4 intervention, whereas the majority of leaders from organizations at Level 1 and 2 intervention appear to be primarily focused on the individual when initially responding to error.

Table 5. Comparison of Summarized Comments by Level of Intervention

Pre-Survey Responses for all participants	Intervention Level 4 (N=279 from 17 Organizations)	Intervention Level 3 (N=58 from 9 Organizations)	Intervention Level 2 (N=16 from 5 Organizations)	Intervention Level 1 (N=6 from 2 Organizations)
Most leaders believe that staff is comfortable reporting errors.	Most leaders believe staff is comfortable reporting errors; many indicated reporting was due to open communication and relationships among staff and leaders.	Most leaders believe staff is comfortable reporting errors.	Most leaders believe staff is comfortable reporting errors.	A few leaders believe staff is comfortable reporting errors.
Many leaders believe that staff is mindful of the errors or opportunities for error around them.	Most leaders believe staff is mindful of the errors or opportunities for error around them.	Some leaders believe staff is mindful of errors or opportunities for error around them.	Some leaders believe staff is mindful of the errors or opportunities for error around them.	Leaders did not speak to staff mindfulness of error.
Many leaders believe that they focus upon the system issues when responding to errors.	Most leaders believe they focus on systems issues when responding to errors.	Most leaders believe they focus on systems issues when responding to errors.	Most leaders believe they focus on systems issues when responding to errors.	Some leaders believe they focus on systems issues when responding to errors.
Many believe their organizations are becoming more focused on patient safety.	Most believe their organizations are becoming more focused on patient safety.	Many believe their organizations are becoming more focused on patient safety.	Some organizations believe they are becoming more focused on patient safety.	Some leaders believe their organizations are becoming focused on patient safety; others spoke of the need for culture change.
New reporting systems and strategies are being implemented.	Some leaders talked of implementing improved reporting strategies.	Not mentioned	Not mentioned	Not mentioned
Some leaders did acknowledge staff's fear of retribution.	Many leaders acknowledge "pockets of employees" that fear retribution; however, few leaders cited fear of reporting as a reason staff do not report.	Some leaders acknowledge staff fears retribution.	Some leaders acknowledge staff fear of retribution.	Some leaders acknowledge staff fear retribution

Pre-Survey Responses for all participants	Intervention Level 4 (N=279 from 17 Organizations)	Intervention Level 3 (N=58 from 9 Organizations)	Intervention Level 2 (N=16 from 5 Organizations)	Intervention Level 1 (N=6 from 2 Organizations)
<p>Many barriers to error reporting were identified:</p> <ul style="list-style-type: none"> Limited time Lack of knowledge about how to report errors Cumbersome reporting systems Interdisciplinary tension, leading to reluctance to report 	<p>Few leaders cited barriers to reporting, these included:</p> <ul style="list-style-type: none"> Limited time Cumbersome reporting systems Lack of leadership follow up Interdisciplinary tension, leading to reluctance to report 	<p>Few leaders cited barriers to reporting, these included:</p> <ul style="list-style-type: none"> Time Cumbersome reporting systems 	<p>Few leaders cited barriers to reporting, these included:</p> <ul style="list-style-type: none"> Time 	<p>Barriers to error reporting, these included:</p> <ul style="list-style-type: none"> Time
<p>Many talked of mindful staff but did not believe staff is aware of near misses and/or potential errors.</p>	<p>Many leaders talked of mindful staff AND believe staff is aware of near misses and potential errors.</p>	<p>Few leaders talked of mindful staff; there was NO mention of staff reporting near misses and/or potential errors.</p>	<p>Some talked of staff being less likely to report near misses.</p>	<p>Not mentioned</p>
<p>Many indicated that staff only reported on errors that resulted in harm and/or significant adverse events.</p>	<p>Many talked of staff now reporting errors and near misses even when “no harm occurred.”</p>	<p>Not mentioned</p>	<p>Not mentioned</p>	<p>Not mentioned</p>
<p>While leaders said they looked at the underlying system issues</p> <ul style="list-style-type: none"> Many still indicated they looked at the individual. Many indicated their response depended upon the scope and severity of the error. Most feedback strategies were focused upon individuals’ education and/or counseling. 	<p>The majority said they looked at the underlying systems issues, however,</p> <ul style="list-style-type: none"> Some indicated they looked at the individual. Very few indicated their response depended upon the scope and severity of the error. Several indicated feedback focused on individuals’ education and/or counseling. 	<p>The majority said they looked at the underlying systems issues, however,</p> <ul style="list-style-type: none"> Some indicated they looked at the individual. A few indicated feedback depended on severity of error. Several indicated feedback focused on individuals’ education and/or counseling. 	<p>While some feedback strategies focus on error resolution,</p> <ul style="list-style-type: none"> Most talked of feedback being focused on individuals’ education and/or counseling. 	<p>While some feedback strategies focus on error resolution,</p> <ul style="list-style-type: none"> Some still indicated they looked at the individual. A few indicated their response depended upon the scope and severity of the error. Most remain focused on individuals’ education and/or counseling.

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