Program Brief
Network of Patient Safety Databases

How PSOs Help Health Care Organizations Improve Patient Safety Culture

Developing a culture of safety is an essential task for health care organizations as they strive to eliminate the factors that contribute to medical errors, patient harm, and unsafe conditions (Singer, 2009; Mardon, 2010; Berry 2015). Moreover, improving patient safety culture can potentially lead to improvements not only in safety, but in patient health outcomes. According to the 2000 Institute of Medicine report, To Err is Human, "the biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm" (Kohn, 2000). However, efforts to improve patient safety culture face challenges such as a lack of teamwork, poor communication, and the conflicting priorities of health care executives and patient safety managers (American International Group, 2013). In this context, Patient Safety Organizations (PSOs) can play a key role in helping health care organizations overcome the challenges of optimizing patient safety culture.

Background

Patient safety culture involves the shared perceptions or attitudes about the norms, policies, and procedures that are related to patient safety within the organization. An organization's culture informs staff perceptions about what is praiseworthy and what is punishable (Weaver, 2013). More specifically, it includes staff attitudes, cognitions, and behaviors that can influence a person's motivation to engage in safe behaviors in daily practice.

One way to drive improved culture is to develop the norm of routine safety event reporting. Healthcare organizations that encourage and facilitate patient safety

event reporting are taking an active step to improve safety culture.

In addition, evidence suggests that bundled, multicomponent interventions can improve clinician and staff experience and perceptions of safety culture (Weaver, 2013). Consequently, some PSOs are implementing initiatives to improve patient safety culture in their member organizations by supporting changes in work processes, promoting collaboration, and providing staff education and training.

Interviews and Key Findings

To better understand how PSOs are working with providers to improve patient safety culture, the Network of Patient Safety Databases conducted interviews with

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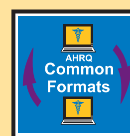

key staff from five PSOs that are actively involved in efforts to improve patient safety culture.

The interviews revealed three themes for understanding how PSOs can work with their member organizations to improve patient safety culture:

1. Patient safety culture improvement starts with assessment
2. PSO privacy and confidentiality protections promote trust
3. PSOs facilitate improved patient safety culture by offering collaborative initiatives, education, and training

Theme 1: Patient safety culture improvement starts with assessment

An initial assessment of patient safety culture is essential for identifying areas for improvement in a health care organization. By conducting a patient safety culture assessment, health care organizations can assess staff attitudes about patient safety issues, medical errors, and event reporting. Moreover, the assessment raises staff awareness about patient safety concerns in their facilities.

> "A positive culture for safety is the foundation for learning about the vulnerabilities in the system. Once you know the opportunities, you can take action."
>
> Alex Christgen
> Interim Executive Director
> Center for Patient Safety

The *AHRQ Surveys on Patient Safety Culture* are valuable tools for assessing patient safety culture in hospitals, medical offices, ambulatory surgery centers, nursing homes, and community pharmacies. The surveys ask about dimensions of safety culture such as teamwork, communication, and leadership. In addition, the surveys ask physician and staff respondents about the number of events that they reported in the past 12 months, and about respondent perceptions of the frequency of events reported.

> "Providing a debriefing of safety culture survey results and creating action plans is most important before another survey is administered."
>
> Sam R. Watson
> Senior Vice President
> Michigan Health & Hospital Association

After survey administration is complete, PSOs and their member organizations can use the results to drive change. Using the safety culture survey results, a PSO can compare each organization's scores to AHRQ comparative results or to those of similar PSO member organizations that administered the survey. Through the survey review process, the PSO can identify areas for improvement, explain the results to PSO members, and provide support to their members so they can create focused action plans. For example, one PSO provides action planning templates to their members that not only guides them through the action planning process but instructs their members on how to debrief staff on their safety culture results.

PSOs Interviewed

- California Hospital Patient Safety Organization
- Michigan Health & Hospital Association
- Missouri Center for Patient Safety
- North Carolina Quality Center
- The PSO Advisory

Health care organizations should plan to re-administer the AHRQ surveys after member organizations have implemented action plans, and after enough time has passed for the organizations to achieve measurable changes in patient safety culture. Health care facilities are encouraged to submit their data to one or more of the companion *AHRQ Surveys on Patient Safety Culture Comparative Databases*. Doing so allows facilities to compare their safety culture scores to those of similar organizations across the United States.

Theme 2: PSO privacy and confidentiality protections promote trust

Trust is an important element of patient safety culture. In an organization with a strong safety culture that fosters trust, clinicians are comfortable reporting safety problems in the spirit of collaborative improvement, without fear of retaliation and litigation. These organizations provide a safe space where people are not afraid to report. The resulting increase in reporting of safety events can then lead to improvement in patient safety culture and more opportunities for learning and practice improvement.

A key factor that helps PSOs build trust is the set of legal protections for patient safety work product that protects incident investigations and the identity of the providers involved in a patient safety event or its report. With these protections, a PSO offers a safe space for both reporting

of adverse events and discussion of ways to improve safety. Several PSOs provide members a confidential analysis of patient safety event data, and provide forums for sharing accounts of patient safety events at the local, regional, or national levels.

> "If you don't feel comfortable reporting, you don't have a safe culture."
>
> Nancy Schanz
> Director
> North Carolina Quality Center

PSOs encourage voluntary patient safety event reporting by offering technical assistance and the capability to report events directly to the PSO. For example, PSOs can make a series of calls to walk their members through procedures for efficiently and safely submitting event data. Greater reporting of safety events is one factor that leads to a positive safety culture, which in turn leads to improvements in safety.

One method that PSOs use to foster discussion of safety events is a forum known as "Safe Tables" that offers a way for PSO members to share accounts of patient safety events. Conducted in person or though virtual meetings, PSO Safe Tables promote a culture of trust that encourages open dialogue by PSO members about patient safety issues (Wagner, 2011).

Safe Tables can focus on a single setting or include a variety of settings; the latter approach is especially useful when discussing a topic such as transitions of care that is applicable across all relevant settings. PSOs may host Safe Table events regionally, or focus on specific target audiences such as children's hospitals, critical care and rural hospitals, or obstetric departments. The following are examples of topics that have been discussed during Safe Table events:

> "When you hear those Safe Table cases, even very simple ones, you find culture all through it."
>
> Rory Jaffe
> Executive Director
> California Hospital Patient Safety Organization (CHPSO)

- Failure to inform patients of abnormal test results
- Factors related to falls
- Prevention of health care-associated infections
- Responses to patient violence and aggression

After establishing trust and gathering information, PSO leadership share aggregated, comparative safety culture survey results with their member organizations as a way of identifying and acknowledging problems in trust or other aspects of safety culture. Such sharing supports learning, helps to identify areas for improvement, and contributes to the development of action plans. PSOs also build trust with health care organizations by sharing patient safety alerts with member organizations to promote insight into the underlying causes of patient safety events. One interviewed PSO sends patient safety alerts to its members on a monthly basis using an email distribution list that members can subscribe to. The alerts describe the reported events and provide information on how to prevent similar events.

Theme 3: PSOs offer collaborative initiatives, education, and training to improve patient safety culture

Health care organizations that are striving to improve patient safety culture invest in initiatives that promote change. To that end, PSOs inform their members about the importance of having the infrastructure and staffing that is required to implement patient safety culture initiatives and evaluate their effectiveness. Implementation of such initiatives has been linked to improvement of patient safety culture in areas such as increased teamwork and elimination of a punitive culture (Chera, 2014; Jones, 2013; Weaver, 2014). Many of these initiatives are shared in a collaborative format that allows members to discuss their experiences and supports implementation of best practices. In some cases, PSOs are collaborating with other PSOs and their members to expand the reach of patient safety culture initiatives.

Examples of patient safety culture initiatives that PSOs support include the following:

- Comprehensive Unit-based Safety Program (CUSP)
- Just Culture Training
- Patient and Family Engagement Training
- Second Victim Experience
- Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®)

PSOs make patient safety culture initiatives available to members in the form of learning collaboratives, coaching services, educational workshops, newsletters, PSO blogs, webinars, and in-person conferences. Some PSOs convene annual conferences as a means to further engage members, introduce national experts, and allow for further sharing. These conferences provide a place for providers to learn new content, participate in interactive learning, and engage in networking. The conferences provide specific safety information and intervention support, and they reinforce the importance of the culture of safety.

> "We work to have corporate workers involved, corporate safety workers in particular, field managers, and then obviously frontline folks."
>
> William Smith
> President
> The PSO Advisory

In order for an organization to advance and sustain patient safety culture, senior leadership must understand the relevance of attaining a strong culture of patient safety and must support continued improvement efforts and initiatives. For this reason, one interviewed PSO focuses their patient safety culture education on physicians and managers (Schwendimann, 2013). One PSO offers training on patient and family engagement and encourages CEOs and senior leaders to pledge to have a dedicated person responsible for patient and family engagement initiatives in their hospital.

PSO-led improvements in patient safety culture encourage physicians and staff to be more transparent about their mistakes so they can learn from them. For example, one PSO enrolls all new members in the Comprehensive Unit-based Safety Partnership (CUSP) program at the beginning of PSO membership, to help clinicians work better together. In another initiative aimed at promoting transparency, a member organization within a PSO evaluated the initiative of Second Victim Experience support for clinicians who have made medical errors by administering the AHRQ Hospital Survey on Patient Safety Culture before and after implementing the initiative. The results showed higher patient safety culture scores among the clinicians who received training compared to those who did not (Miller, Scott, & Hirschinger, 2015).

Conclusion

Clearly, PSOs offer a wide variety of resources, experts, and collaborative opportunities that can support health care organizations as they seek to achieve further improvements in patient safety culture. Health care organizations with strong patient safety culture learn from their mistakes and evaluate the effectiveness of continuous quality improvement. The mutual collaboration and support that PSOs offer to their members can lead to improvements in patient safety culture not only within a health care organization but across organizations.

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