



Using Just Culture to Improve Hospital Survey on Patient Safety Culture Results

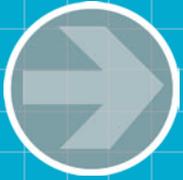
Webcast

November 9, 2016

1:00-2:00 ET

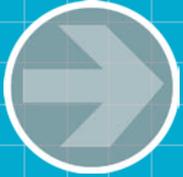
Presented by Westat under contract to the Agency
for Healthcare Research and Quality





Need Help?

- No sound from computer speakers?
 - Join us by phone: 855-442-5743
 - Conference ID #: 99643066
- Trouble with your connection or slides not moving?
 - Select F5 to refresh your screen
 - Log out and log back in
- Other problems?
 - Use Q&A feature to ask for help



Today's Speakers



Celeste Mayer, PhD

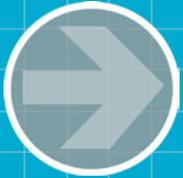
University of North Carolina Health
Care System, Chapel Hill, NC



Theresa Famolaro, MPS, MS, MBA

Westat, Rockville, MD

Using the Webcast Console and Submitting Questions



Surveys on Patient Safety Culture™

Side Area

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AHRQ

Westat

Speaker Bios

Celeste Mayer, PhD
Patient Safety Officer
University of North Carolina Health Care System, Chapel Hill, NC

Theresa Famolaro, MPH, MS, MBA
Database Manager: AHRQ Surveys on Patient Safety Culture
Westat, Rockville, MD (Moderator)

Q&A

Refresh Now

Please enter a question

Submit

To submit a question, type question here and hit submit

Click on the "Q&A" icon to get the Q & A window to appear

Navigation bar icons: Home, Profile, Question, Document, Q&A, Link, CC



Accessing Presentation

Surveys on Patient Safety Culture™

Slide Area

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Q&A

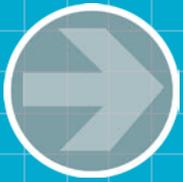
Refresh Now

Please enter a question

Submit

Click on the "Download Slides" icon for a PDF of the slides

Navigation icons: Chat, Profile, Help, Slides, Q&A, Download Slides, CC



Accessing Resources

The screenshot shows a webcast player interface. At the top, a blue banner reads "Surveys on Patient Safety Culture™". Below this, a "Side Area" panel displays the title "Using Just Culture to Improve Hospital Survey on Patient Safety Culture Results", the format "Webcast", and the date and time "November 9, 2016 1:00-2:00 ET". Logos for AHRQ and Westat are visible. To the right, a "Speaker Bios" panel lists Celeste Mayer, PhD (Patient Safety Officer, University of North Carolina Health Care System, Chapel Hill, NC) and Theresa Famolare, MPH, MS, MDA (Database Manager, AHRQ Surveys on Patient Safety Culture, Westat, Rockville, MD (Moderator)). Below the bios is a "Q&A" section with a "Refresh Now" link, a text input field, and a "Submit" button. At the bottom of the interface is a navigation bar with icons for chat, user profile, a yellow question mark icon, a document icon, "Q&A", a red link icon, and "CC". A red arrow points from the text below to the yellow question mark icon.

Side Area

Surveys on Patient Safety Culture™

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Q&A

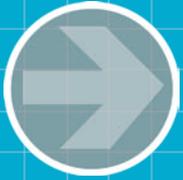
Refresh Now

Please enter a question

Submit

To access the event materials and resources, click on the "Resources" icon

Chat User ? Document Q&A Link CC



What is Patient Safety Culture?

The way we do things around here.

Exists at multiple levels:

System



Organization



Department



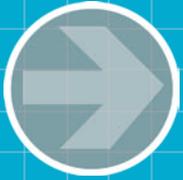
Unit

Beliefs, values & norms

Shared by staff

What is:

- Rewarded
- Supported
- Expected
- Accepted

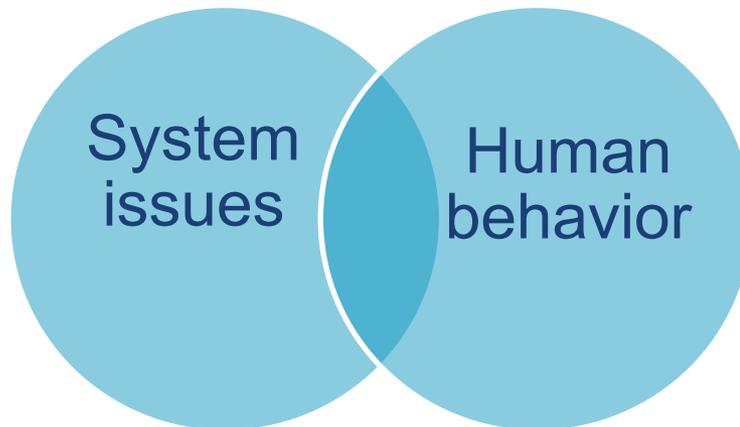


What is Just Culture?

“An atmosphere of trust in which those who provide essential safety-related information are encouraged and even rewarded, but in which people are clear about where the line is drawn between acceptable and unacceptable behavior” (Reason, 1997)

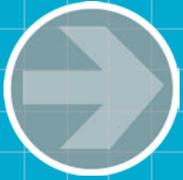
Just Culture is an Accountable Culture

(Outcome Engenuity)



Levels of accountability

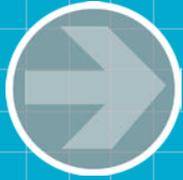
- System
- Management
- Staff
- Providers



Hospital Survey on Patient Safety Culture

- 42 items assess 12 dimensions of patient safety culture
 - 1. Communication openness
 - 2. Feedback & communication about error
 - 3. Frequency of event reporting
 - 4. Handoffs & transitions
 - 5. Management support for patient safety
 - 6. Nonpunitive response to error
 - 7. Organizational learning--continuous improvement
 - 8. Overall perceptions of patient safety
 - 9. Staffing
 - 10. Supv/mgr expectations & actions promoting patient safety
 - 11. Teamwork across units
 - 12. Teamwork within units

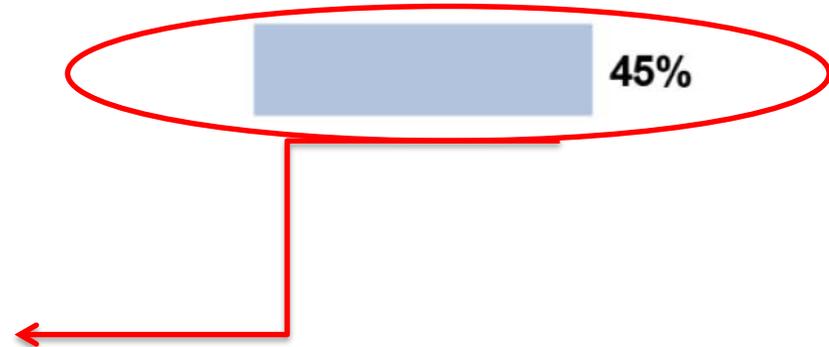
 - Patient safety “grade” (Excellent to Poor)
 - Number of events reported in past 12 months
-



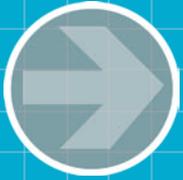
Lowest Performing Composite Results – 2016 AHRQ Comparative Database

Patient Safety Culture Composites	% Positive Response
10. Staffing	54%
11. Handoffs & Transitions	48%
12. Nonpunitive Response to Error	45%

Opportunity for improvement – lowest scoring composite

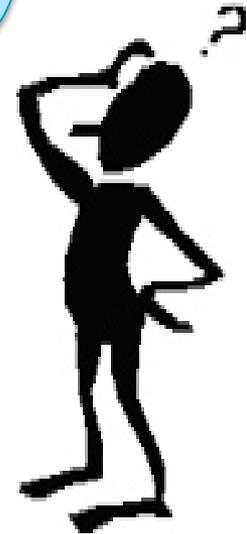


<http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/hosp-reports.html>

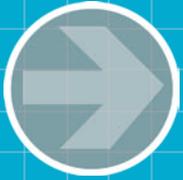


Defining Nonpunitive Response to Error

The extent to which staff feel that their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file.



Nonpunitive Response to Error Survey Items



- Staff feel like their mistakes are held against them.
- When an event is reported, it feels like the person is being written up, not the problem.
- Staff worry that mistakes they make are kept in their personnel file.