Create a Safety Culture not a Safety Programme

Culture is Shared Beliefs, Behaviors & Characteristics

Forced

Threats used as force for employees to comply

Punitive Culture

Protective

Believes that a written rule to anticipate and manage issues

Result in hundreds of pages of procedures and processes.

Involved

Strong commitment Safety training for employees.

Managers beyond first-level supervisors are unaware of safety expectations

Integral

Firm commitment from all levels of management,

Demonstrate publicly all components of the safety program

What ??

A Good Safety Culture

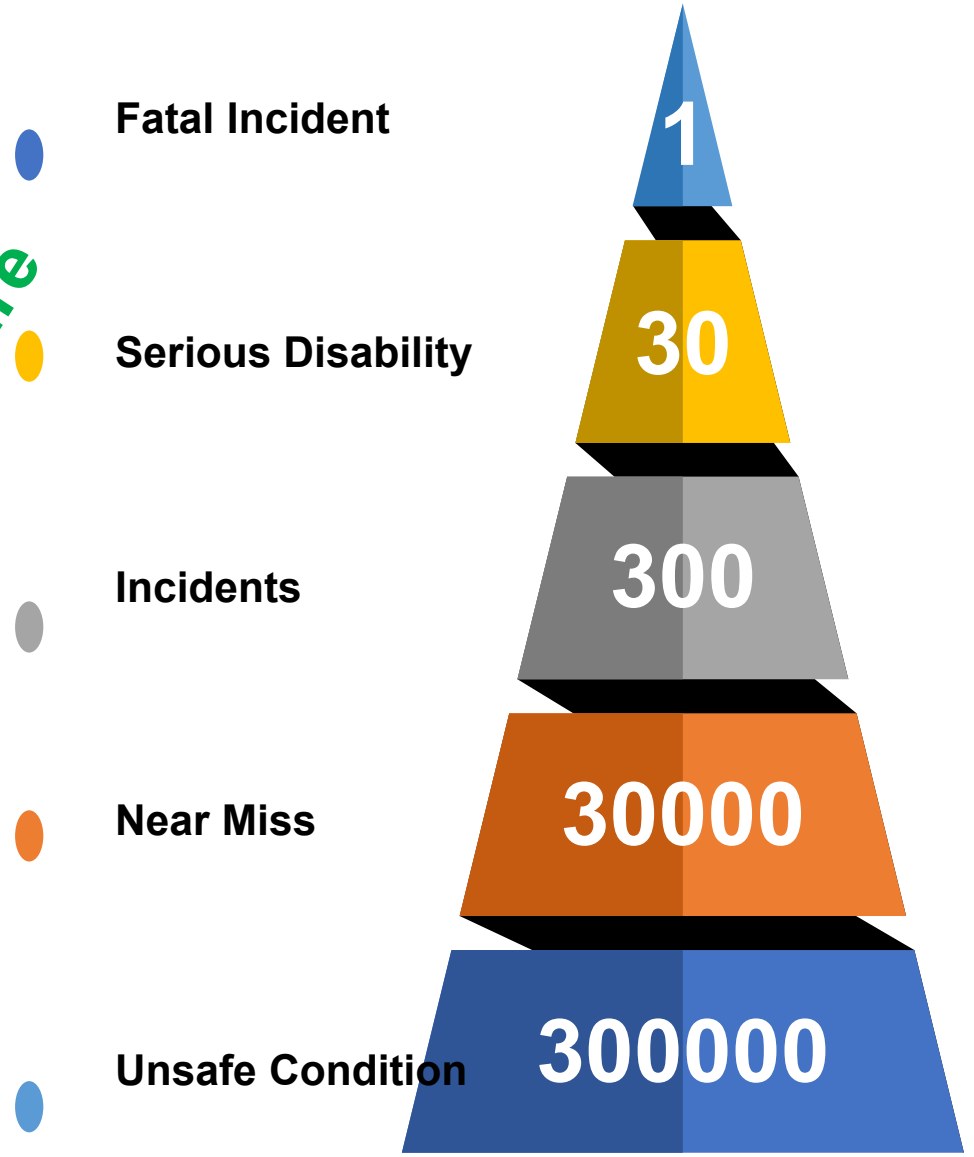
- **Alert** in Identifying existing or potential hazards
- **Promote** safe behaviors where individuals can report errors or near misses without fear of reprimand or punishment
- **Proactive** in establishing mitigation measures
- **Zero tolerance** for reckless behavior Omissions and inattention that compromise safety appropriate action

Safety Culture Pervasive

- All staff adopt safety as the prime concern
- By management and operating layers
  - ⑩Managers embed safety in decision making,
  - ⑩Management include in their vision and goals
- Attentive to lessons learned

Before the Incident Cultivate Safe and Just Culture

Why do we Need ?



How do we build safety Culture in Organization

- Induction of all Employee
- Ongoing Training
- Continuous awareness
- Safety Infrastructure Availability
- Lead by Example
- Blame free Reporting culture

Accreditation Standard

NABH Standard : PSQ.6.

The patient safety and quality improvement programme are supported by the management.

Objective Elements : Achievement : The management creates a culture of safety.

Joint Commission International

APR.9 Any individual hospital staff member (clinical or administrative) can report concerns about patient safety and quality of care to JCI without retaliatory action from the hospital.

To support this culture of safety, the hospital must communicate to staff that such reporting is permitted.

In addition, the hospital must make it clear to staff that no formal disciplinary actions (**for example**, demotions, reassignments, or change in working conditions or hours) or informal punitive actions (**for example**, harassment, isolation, or abuse) will be threatened or carried out in retaliation for reporting concerns to JCI.

GLD.13 Hospital leadership creates and supports a culture of safety program throughout the hospital.

GLD.13.1 Hospital leadership implements, monitors, and takes action to improve the program for a culture of safety throughout the hospital.

How to Measure - Tools

- Safety Attitudes Questionnaire from the University of Texas / Johns Hopkins University in the USA
- Hospital Survey on Patient Safety Culture 2.0 from the Agency for Healthcare Research and Quality (AHRQ) in the USA
- Manchester Patient Safety Assessment Framework from the University of Manchester in the UK

Safety Attitude Questionnaire

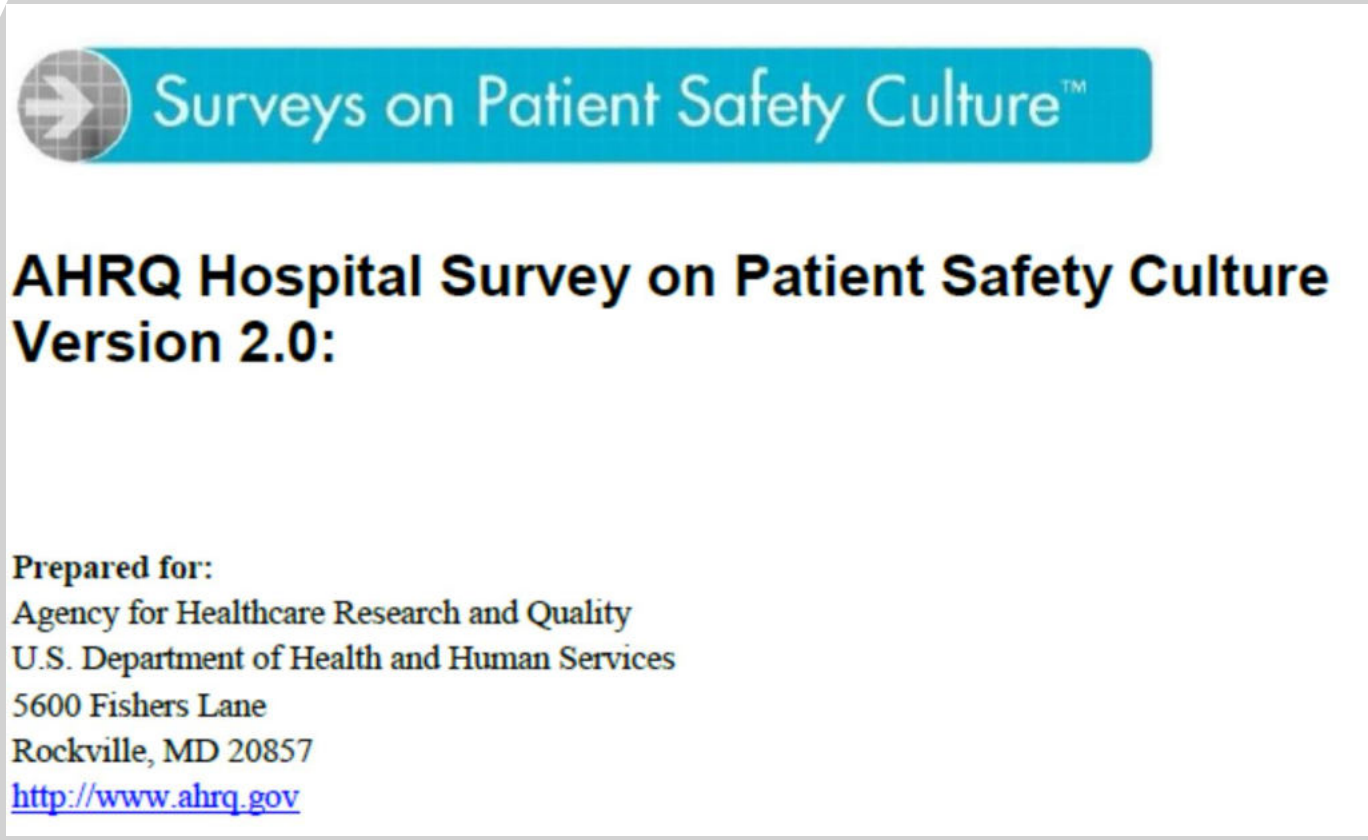
- Teamwork Climate
- Job Satisfaction
- Perception of Management
- Safety Climate
- Working Condition
- Stress Recognition

Scale: Definition
Teamwork climate: perceived quality of collaboration between personnel
Job satisfaction: positivity about the work experience
Perceptions of management: approval of managerial action
Safety climate: perceptions of a strong and proactive organizational commitment to safety
Working conditions: perceived quality of the work environment and logistical support (staffing, equipment etc.)
Stress recognition: acknowledgement of how performance is influenced by stressors

Safety Culture Measurement Tool AHRQ 2.0

- This survey is an update of the original SOPS Hospital Survey (1.0) that AHRQ released in 2004.
- The Surveys on Patient Safety Culture (SOPS) Hospital Survey Version 2.0
- SOPS Hospital Survey 2.0 is intended to help hospitals assess

  patient safety culture.



Survey Items and Composite Measures

The SOPS Hospital Survey 2.0 has a total of 40 survey items

- 8- Eight single-item measures:
  - One survey item asking how many patient safety events the respondent has reported
  - One survey item asking respondents to provide an overall rating on patient safety for their unit/work area
  - Six survey items on respondent background characteristics (staff position, unit/work area, hospital tenure, unit/work area tenure, work hours, interaction with patients)

- 32- Thirty-two survey items grouped into 10 composite measures that are groupings of two or more survey items that assess the same areas of patient safety culture.

COMPOSITE MEASURE

- ❑ Communication About Error
- ❑ Communication Openness
- ❑ Handoffs and Information Exchange
- ❑ Support for Patient Safety
- ❑ Organizational Learning
- ❑ Reporting Patient Safety Events
- ❑ Response to Error
- ❑ Staffing and Work Pace
- ❑ Supervisor, Manager, or Clinical Leader Support for Patient
- ❑ Teamwork

Modification

Change Background item

Additional or Supplemental Data

Patient safety culture composite measures	Definition: The extent to which…	Number of items
Communication About Error	Staff are informed when errors occur, discuss ways to prevent errors, and are informed when changes are made.	3
Communication Openness	Staff speak up if they see something unsafe and feel comfortable asking questions.	4
Handoffs and Information Exchange	Important patient care information is transferred across hospital units and during shift changes.	3
Hospital Management Support for Patient Safety	Hospital management shows that patient safety is a top priority and provides adequate resources for patient safety.	3
Organizational Learning—Continuous Improvement	Work processes are regularly reviewed, changes are made to keep mistakes from happening again, and changes are evaluated.	3
Reporting Patient Safety Events	Mistakes of the following types are reported: (1) mistakes caught and corrected before reaching the patient and (2) mistakes that could have harmed the patient but did not.	2
Response to Error	Staff are treated fairly when they make mistakes and there is a focus on learning from mistakes and supporting staff involved in errors.	4
Staffing and Work Pace	There are enough staff to handle the workload, staff work appropriate hours and do not feel rushed, and there is appropriate reliance on temporary, float, or PRN staff.	4
Supervisor, Manager, or Clinical Leader Support for Patient Safety	Supervisors, managers, or clinical leaders consider staff suggestions for improving patient safety, do not encourage taking shortcuts, and take action to address patient safety concerns.	3
Teamwork	Staff work together as an effective team, help each other during busy times, and are respectful.	3

Survey items / Question and Positive and Negative worded

Option Used :
Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree, Does Not Apply or Don’t Know)

AHRQ Survey 2.0

https://www.ahrq.gov/sites/default/files/wysiwyg/sops/surveys/hospital/hospitalsurvey2-items.pdf

How to Administer Survey ?

- Determine Resources and Scope
- Decide Data Collection Method
  - Web – Google or Microsoft office Form etc
  - Paper Based
  - Outside Vendor
- Confidential – Identifier available but assurance of not to be released
- Anonymous- No identifier
- Project Schedule
- Timeline for Survey
- Survey population and Sampling
- Communication – Intent , Question and weekly response rate
- Use AHRQ trademark

Minimum Sample Sizes by Total Number of Providers and Staff

Number of Providers and Staff	Minimum Sample Size*	Expected Number of Responses (Assuming a 50% Response Rate)
500 (or fewer)	500 – a census of all providers and staff	250 (or fewer)
501-699	500	250
700--1,299	600	300
1,300–3,999	700	350
4,000 or more	750	375

* The sample size is based on three assumptions: simple random or systematic random sampling, a response rate of 50 percent, and a confidence interval of +/– 5 percent.

Data Analysis

- Clean and Validate the Data
- Code the response for Positive worded and Negatively Worded
- Calculate Item Percent Positive Scores usually Score reported is “percent positive”
    - for positively-worded items - Percentage of responses rated 4 or 5 (Agree/Strongly agree or Most of the Time/Always),
    - for reverse-worded items- or 1 or 2 (Disagree/Strongly Disagree or Rarely/Never)
    - 8 of 12 composites have at least 1 reverse-worded item
    - 2 Composites all items reverse-worded
        - Handoffs & Transitions
        - Nonpunitive Response to Error
- Positive is positive for patient safety, higher score better
- Calculate Frequencies of Response
- Calculate Composite Measure Percent Positive Scores

Interpret Result

- Understand Reverse-worded Items
- Identify Gaps between beliefs & behaviors in composites
- Reason's Components of Safety Culture - (12 composites – 4 components)
- Variation by subculture (profession), microculture (unit)
- Conduct external benchmarking
- Conduct internal benchmarking - Nurse vs. Non-nurse (professional subcultures)
- Identify unit-wide areas in need of improvement

Culture of Safety Survey Report

Action Plan

- Identify areas in need of Improvement
- Prioritize area of Improvement
- Discuss with the stakeholder
- Presentation to Leadership
- Discuss on Action Tracker
  - Detailed action
  - Responsibility
  - Timeline
- Review and Track Action

Effectiveness of Action Plan

LINK AND ALIGN TO STRATEGIC PLAN

KEEP IT SIMPLE

IDENTIFY KPI FOR THE ACTION PLAN

MAINTAIN DATA

CREATE DASHBOARDS.

COMPARE SURVEY

Thank you

Safety Culture