



HOSPITAL SURVEY ON PATIENT SAFETY CULTURE

Action Planning

Hospital

Date

1. Background Information

1.a Date of most recent HSOPS mo _____ Year _____

1.b Has the HSOPS been conducted previously in your organization? YES _____ NO _____

1.c If Yes, what were the previous dates? mo _____ Year _____

1.d If yes, what was the previous impact and are action plans and change teams still functional?

1.e Describe your organization's overall vision, which may include your mission, vision and values:

1.f List your organization's strategic goals.

2. Response Rate . A response rate of 50% or greater ensures that survey results are likely to be representative of those surveyed. If your rate is less than 50%, consider how responders and non-responders might differ. A response rate of 60% or greater is ideal.

3. Identify overall strengths and weaknesses. For your aggregate hospital results, identify the three dimensions with the highest and the three dimensions with the lowest percent positive scores.

Top Three Dimensions (Strengths)	% +	Bottom Three Dimensions (Weakness)	% +

4. Identify how the four components of safety culture vary across your organization by work area. Use the Demographics Tab in the Excel Tool to identify the work areas by which you can sort your data. Enter the percent positive for each survey item by work area in the table below. The table categorizes survey items by the four components of safety culture. Paste additional copies of the table to accommodate the number of work areas by which you can sort your HSOPS data.

Survey Dimension and Items for Work Areas	% Work Area 1 Respond Positively	% Work Area 2 Respond Positively	% Work Area 3 Respond Positively
REPORTING CULTURE			
Frequency of Events Reported: (Behavior) When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?			
JUST CULTURE			
Nonpunitive Response to Error: (Belief) When an event is reported, it feels like the person is being written up, not the problem. ^R			
Nonpunitive Response to Error: (Belief) Staff worry that mistakes they make are kept in their personnel file.			
FLEXIBLE (TEAMWORK-ORIENTED) CULTURE			
Teamwork Within Departments: (Belief) People support one another in this department.			
Teamwork Within Departments: (Behavior) When one area in this department gets really busy, others help out.			
Staffing: (Belief) We have enough staff to handle the workload.			
Communication Openness: (Belief) Staff will freely speak up if they see something that may negatively affect patient care.			
Communication Openness: (Behavior) Staff feel free to question the decisions or actions of those with more authority.			
Hospital Handoffs & Transitions: (Behavior) Problems often occur in the exchange of information across hospital departments. ^R			
Hospital Handoffs & Transitions: (Behavior) Shift changes are problematic for patients in this hospital. ^R			
LEARNING CULTURE			
Feedback and Communication About Error: (Behavior) We are informed about errors that happen in this department.			
Feedback and Communication About Error: (Behavior) We are given feedback about changes put into place based on event reports.			
Supervisor/Manager Expectations & Actions Promoting Patient Safety: (Behavior) My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.			
Hospital Management Support for Patient Safety: (Belief) Hospital management seems interested in patient safety only after an adverse event happens. ^R			
Organizational Learning—Continuous Improvement: (Behavior) After we make changes to improve patient safety, we evaluate their effectiveness.			
Organizational Learning—Continuous Improvement: (Belief) Mistakes have led to positive changes here.			
HIGH RELIABILITY ORGANIZATION			
Overall Perceptions of Safety: (Belief) Our procedures and systems are good at preventing errors from happening.			

R = Reverse worded question for which “Strongly Disagree” and “Disagree” are positive responses.

5. Identify how the four components of safety culture vary across your organization by job title. Use the Demographics Tab in the Excel Tool to identify the staff positions (job titles) by which you can sort your data. Be sure to include Administration/ Management. Enter the percent positive for each survey item by staff position/job title in the table below. The table categorizes survey items by the four components of safety culture. Paste additional copies of the table to accommodate the number of staff position/job titles by which you can sort your HSOPS data.

Survey Dimension and Items for Job Titles	% Admin/Mgt Respond Positively	% Job Title 2 Respond Positively	% Job Title 3 Respond Positively
REPORTING CULTURE			
Frequency of Events Reported: (Behavior) When a mistake is made, but is <u>caught and corrected before affecting the patient</u> , how often is this reported?			
JUST CULTURE			
Nonpunitive Response to Error: (Belief) When an event is reported, it feels like the person is being written up, not the problem. ^R			
Nonpunitive Response to Error: (Belief) Staff worry that mistakes they make are kept in their personnel file.			
FLEXIBLE (TEAMWORK-ORIENTED) CULTURE			
Teamwork Within Departments: (Belief) People support one another in this department.			
Teamwork Within Departments: (Behavior) When one area in this department gets really busy, others help out.			
Staffing: (Belief) We have enough staff to handle the workload.			
Communication Openness: (Belief) Staff will freely speak up if they see something that may negatively affect patient care.			
Communication Openness: (Behavior) Staff feel free to question the decisions or actions of those with more authority.			
Hospital Handoffs & Transitions: (Behavior) Problems often occur in the exchange of information across hospital departments. ^R			
Hospital Handoffs & Transitions: (Behavior) Shift changes are problematic for patients in this hospital. ^R			
LEARNING CULTURE			
Feedback and Communication About Error: (Behavior) We are informed about errors that happen in this department.			
Feedback and Communication About Error: (Behavior) We are given feedback about changes put into place based on event reports.			
Supervisor/Manager Expectations & Actions Promoting Patient Safety: (Behavior) My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.			
Hospital Management Support for Patient Safety: (Belief) Hospital management seems interested in patient safety only after an adverse event happens. ^R			
Organizational Learning—Continuous Improvement: (Behavior) After we make changes to improve patient safety, we evaluate their effectiveness.			
Organizational Learning—Continuous Improvement: (Belief) Mistakes have led to positive changes here.			
HIGH RELIABILITY ORGANIZATION			
Overall Perceptions of Safety: (Belief) Our procedures and systems are <u>good at preventing errors from happening</u> .			

R = Reverse worded question for which "Strongly Disagree" and "Disagree" are positive responses.

6. Rate the extent to which the practices that support the four components of safety culture are in place within work areas. Use the following scale:

0 = Not in place 1 = ineffective 2 = moderately effective 3 = very effective NA = not applicable

Reporting Practices	Work Areas					
	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Formal Reporting of adverse events with standardized taxonomies						
Near misses reported, valued, and learned from						
Informal Reporting – Safety Briefings						
Informal Reporting – Leadership WalkRounds						
Just Culture Practices						
Training provided on role of human factors in error						
Training provided on active vs. latent sources of error						
Managers use Unsafe Acts Algorithm to determine accountability						
Policy/procedures in place to manage disruptive behaviors						
Teamwork Leadership						
Huddles, Briefs, Debriefs to manage workload						
Teamwork Situation Monitoring						
Cross Monitoring						
STEP						
Teamwork Mutual Support						
Task Assistance Sought						
Task Assistance Offered						
CUS						
DESC						
Teamwork Communication						
SBAR						
Call-Out						
Check Back						
Structured Hand Off						
Learning Practices						
Process Mapping/FMEA						
Individual Root Cause Analysis						
Aggregate Root Cause Analysis						
Leadership WalkRounds						
Safety Briefings						
Additional Practices not listed above						

Go to www.unmc.edu/rural/patient-safety to download information about the above practices.

Based upon your knowledge of how safety culture varies within your organization and your ratings of the extent to which safety culture practices are in place, complete the following 10 step action plan.

Step 1: Define the problem, challenge, opportunity

We need to strengthen our REPORTING CULTURE because (be specific by identifying low percent positive scores across the organization and within work areas/job titles):

We can do this by (be specific about the practices needed across the hospital and within work areas/job titles):

We need to strengthen our JUST CULTURE because (be specific by identifying low percent positive scores across the organization and within work areas/job titles):

We can do this by (be specific about the practices needed across the hospital and within work areas/job titles):

We need to strengthen our FLEXIBLE (Teamwork-Oriented) CULTURE because (be specific by identifying low percent positive scores across the organization and within work areas/job titles):

We can do this by (be specific about the practices needed across the hospital and within work areas/job titles):

We need to strengthen our LEARNING CULTURE because (be specific by identifying low survey percent positive scores across the organization and within work areas/job titles):

We can do this by (be specific about the practices needed across the hospital and within work areas/job titles):

Step 2: Create the change team (choose members based on influence/willingness, relevance to problem, challenge, opportunity)

NAME	ROLE

Step 3: Define your aim(s)/goals

What will be achieved?

What departments will be involved?

When and where the change will occur?

EXAMPLES:

- (1) We will strengthen our communication skills and make it psychologically safe for all to advocate for patients. We will do this by using SBAR for communication between all who exchange patient information, and teaching all staff to use CUS. We will start with acute care; Nurses and support staff will effectively use SBAR and CUS by March 1, 2009.
- (2) We will improve reporting and learning in the ED by debriefing on a weekly basis, documenting the results and sharing them with all ED staff and management. We will begin by Dec. 1, 2008.
- (3) We will improve our nonpunitive response to error and perception of a just culture by being transparent with all staff about how the decision is made whether or not to hold an individual accountable. We will teach all managers to use the Unsafe Acts Algorithm in an interdisciplinary committee as part of this process.

Step 5: Design an intervention

Hospital as a whole:

Units/departments of focus:

Which tools/strategies:

Step 5: Decide Measures for your intervention (consider integrating into Balanced Scorecard)

- Observations
- Counts (e.g. # Briefs, # Reports, #RCAs, # WalkRounds)
- Outcome measures: Fall rate; rate of appropriate pre-op antibiotic usage
- Repeat Safety Culture Survey 2010
- Patient/Staff satisfaction

Step 6: Develop a plan

What	When
Obtain support from Management, Medical Staff, and Board by sharing results of Benchmark Graphs	
Provide Feedback to Department Heads by sharing aggregate and department specific graphs and results	
Departments engage in action planning reflecting aggregate hospital weaknesses or specific department weaknesses	
Communicate aims, goals of plan at hospital and department levels	
Conduct necessary training	
Ensure policies/procedures support action plans	

Step 7: How will you sustain and spread changes embedded in the action plans?

Role modeling

Monitoring

Integrate into new employee orientation, competency testing

Improved feedback at hospital and department level

Step 8: Communication Plan

Stakeholder analysis (who needs to provide support, who needs to be brought over to your side)

Elevator Speech:

We have chosen to focus on _____.

It is important that we improve _____ because

_____ puts our patients at risk and

impacts our performance. We need you to support our efforts by _____

_____.

Step 9: Write your final action plan covering steps 1 – 8.

Step 10: Review of plan by key personnel