



New York State  
Partnership  
for Patients



# Hospital Survey on Patient Safety Culture: Debrief and Action Planning

---

July 17, 2019

*A partnership of the Healthcare Association of New York State and  
the Greater New York Hospital Association*



# Three Fundamental Questions

---

- **What are we trying to accomplish?**
  - Our aim is to improve safety culture so that we can become a high reliability organization where we can anticipate patient harm and prevent it before it occurs
- **How will we know if a change is an improvement?**
  - Our measures of improvement are the scores from the AHRQ Hospital Survey of Patient Safety Culture
- **What changes can we make that will result in improvement?**
  - There are specific interventions that have been identified through learning from best practices and we can develop actionable plans



# Debriefing and Action Planning

---

**Survey Results  
indicate what  
employees are  
thinking**

**Feedback  
meetings  
clarify why  
they feel the  
way they do**

**Both are  
necessary to  
determine how  
we should  
respond**

- Team input helps get to the root cause of concern through meetings and conversation
  - Share ideas and recommendations for improvements
  - Focus on a few key action areas for follow up; do a few things well, not several poorly
-



New York State  
Partnership  
for Patients



# Sample Unit-Level Debrief

---



## Objectives

---

- Review and discuss the 2019 Safety Culture Survey results with hospital and unit specific data
  - Understand what drives improvement in safety culture
  - Identify our hospital and/or unit strengths
  - Continuously improve or adopt new practices where indicated
-



# Safety Culture

---

“Safety culture provides valuable insights as to what it feels like to be a unit secretary, nurse, physician, or other caregiver at the clinical unit level or those supporting direct caregivers. Feeling valued and having the psychological safety to speak up and voice concerns and learn from errors, all have a tremendous impact on the quality of care and the social dynamic among caregivers. Safety culture is measurable and can be deployed as a powerful mechanism to engage caregivers in positive behavioral change.”

From: *Creating a Road Map for Patient Safety* in The Essential Guide for Patient Safety Officers, 2<sup>nd</sup> Ed. (2013); Joint Commission Resources

---



# Participation Rate

---

The overall participation rate was **XX%** for **Hospital**.

On **unit** the overall participation rate was **XX/XX**.

- The participation rate is an important metric for safety culture and engagement.
  - Higher participation rates determine the confidence with which we believe the survey results truly reflect the opinions of the staff
  - **XX** % of staff want to engage in a conversation about the factors which drive safety.
-



# Core Survey Dimensions

---

1. Overall Perception of Safety
  2. Teamwork within Units
  3. Organizational Learning
  4. Staffing
  5. Nonpunitive Response to Error
  6. Supervisor/Manager Expectations & Actions Promoting Patient Safety
  7. Communication Openness
  8. Feedback and Communication about Errors
  9. Frequency of Events Reported
  10. Management Support for Patient Safety
  11. Teamwork Across Units
  12. Handoffs and Transitions
-





# Supplemental Survey Dimensions

---

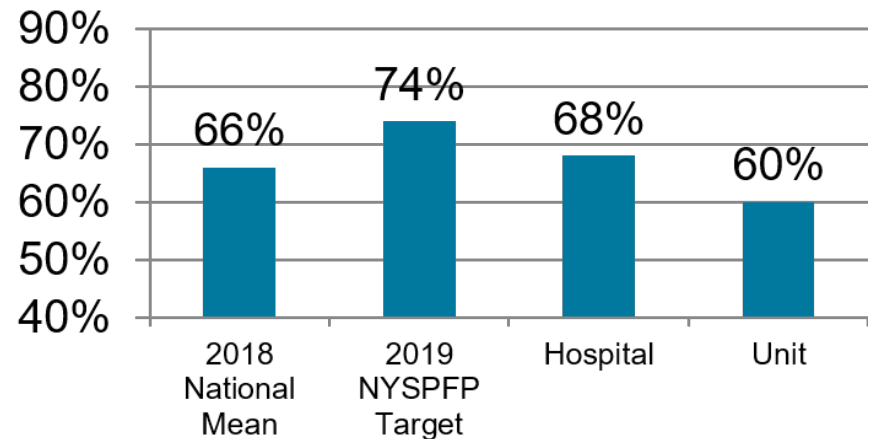
1. Empowerment to Improve Efficiency
2. Efficiency and Waste Reduction
3. Patient Centeredness and Efficiency
4. Supervisor, Manager, or Clinical Leader Support for Improving Efficiency and Reducing Waste
5. Experience With Activities to Improve Efficiency
6. Overall Efficiency Ratings



# Overall Perception of Safety

## Survey Questions

- Patient safety is never sacrificed to get more work done.
- Our procedures and systems are good at preventing errors from happening.
- It is just by chance that more serious mistakes don't happen around here.
- We have patient safety problems in this unit.



## Conversation Tips

- What have we accomplished to improve patient safety on our unit?
- What can we do now, or put into place to improve patient safety on our unit?

## Practices That Improve Overall Perceptions of Safety

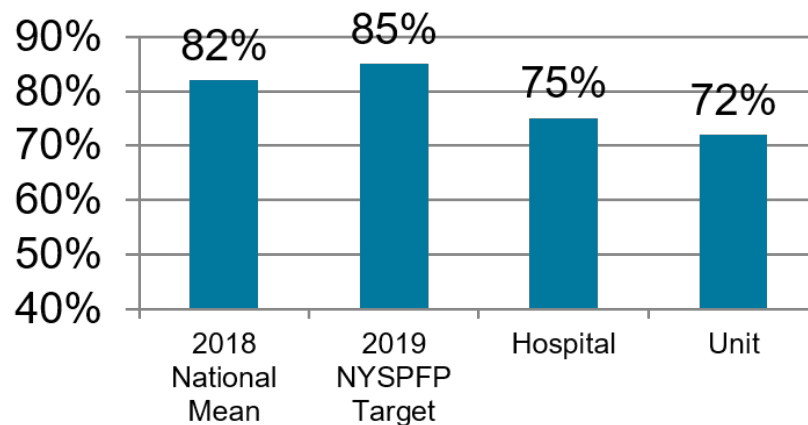
- [Hand Hygiene Training](#)
- [Patient Safety Checklists](#)
- [Patient Safety Assessments](#)



# Teamwork within Units

## Survey Questions

- People support one another in this unit.
- When a lot of work needs to be done quickly, we work together as a team to get the work done.
- In this unit, people treat each other with respect.
- When one area in this unit gets really busy, others help out.



## Conversation Tips

- What are our strengths as a team? When and how do we work well together to improve patient care?
- What standardized set of communication practices do we have on our unit?
- What can we do now, or put into place to improve teamwork on our unit?

## Practices That Improve Teamwork

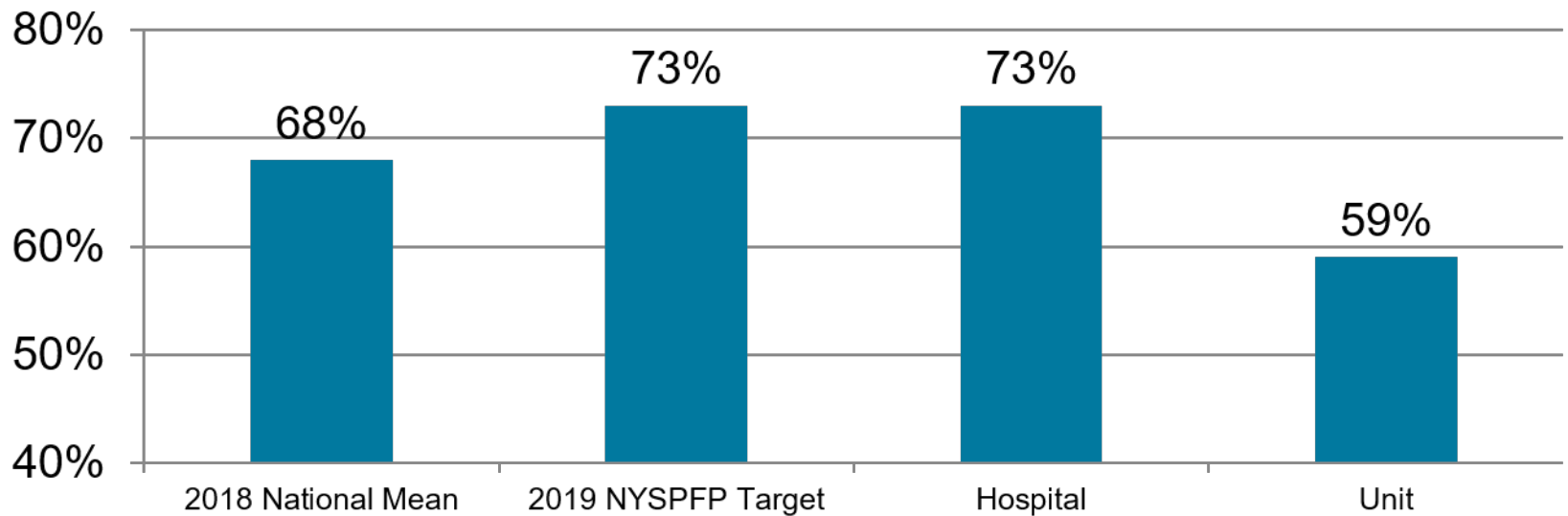
- [CUSP](#)
- [Patient Safety Primer Teamwork Training](#)
- [Team STEPPS](#)



# Empowerment to Improve Efficiency

## Survey Questions

- We are encouraged to come up with ideas for more efficient ways to do our work
- We are involved in making decisions about changes to our work processes
- We are given opportunities to try out solutions to workflow problems





New York State  
Partnership  
for Patients



# Action Planning

---



## Where to Begin

---

- Debrief with your team on your survey data
- Prioritize several potential improvement areas
- Consider selecting areas that align with:
  - Priorities that staff and leadership would support
  - Past or current initiatives to improve patient safety
  - The expected positive impact that improvement in an area would have on patient safety culture and patient outcomes
- Focus on survey areas that are furthest from benchmarks, not necessarily the lowest scores overall
- Develop Action Plans



# Documenting Your Plan

---

- There are several action planning tools available
    - AHRQ, NYSPFP website, your organization
  - Choose a few (one or two) domains
  - Develop the plan with your teams input
  - Share and post your plan for reference
  - Keep it alive
    - Update it regularly, change it if it isn't working
-



# Tools

---

- Action Plans:
    - [NYSPFP Action Planning Template](#)
    - [AHRQ Action Planning Template](#)
  
  - Resource Guide:
    - [AHRQ Resources by Composite](#)
-