SAFE PRACTICE 2: CULTURE MEASUREMENT, FEEDBACK, AND INTERVENTION

The Objective

Ensure that organizations are measuring their patient safety culture, providing feedback to all levels of the organization, and, most importantly, undertaking interventions that generate improvements that reduce patient harm.

The Problem

Since achieving its own high-risk designation from the Institute of Medicine (IOM) a decade ago, healthcare has intensified its activities to measure safety culture and to develop interventions to improve it. [Kohn, 2000] While a universal definition or model of safety culture has not emerged, several definitions have gained popularity. One such definition of safety culture is “the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to and style and proficiency of an organization’s health and safety management.” [Health and Safety Commission, 1993] Another definition more succinctly describes safety culture as “the way we do things around here.” [Helmreich, 1998] Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures. [Health and Safety Commission, 1993; Denham, 2007] There are no estimates on the frequency of medical errors or adverse events resulting from deficient or suboptimal safety culture, but it is known to be a contributing factor to their occurrences. [Pizzi, 2001] An organization’s safety culture determines the degree of personal risk an individual provider will take to protect the safety of his or her patients, thereby maximizing the safety of the unit and hospital. Its contribution to medical errors and adverse outcomes becomes elevated in relation to other factors when the perceived risk of being blamed or punished for mistakes is high. [Denham, 2007]

The severity of harm resulting directly from the effects of poor safety culture is unknown and possibly immeasurable. [Pizzi, 2001] However, history shows us that the consequences of poor safety culture can range from no harm (i.e., safe operations) to death. Safety improvements in aviation and steel production illustrate the positive effects of a strong safety culture on organizational performance. [Clark 1991; Spears, 1999; Helmreich, 1999]

Safety culture and the preventability of medical errors or adverse events are difficult to measure because they change continually over time. Survey instruments may be used to measure safety climate, which has been described as a “snapshot” of an organization’s safety culture. Safety climate is the measurement of the workforces’ attitudes and perceptions of the current environment or prevailing conditions at a point in time. [Flin, 2000] There are numerous surveys that measure patient safety climate. [Colla, 2007] While many hospitals are actively using or implementing safety improvement strategies based on culture measurement, the effectiveness of such strategies has not been proven. [Ginsburg, 2005; Nakajima, 2005; Thomas, 2005; Fleming, 2008; McKeon, 2008; Pronovost, 2008; Zimmerman, 2008] The need persists for systematic quantitative and qualitative analyses of interventions to create a safe culture. [Pizzi, 2001]

Currently, there is no standard to estimate the cost of poor safety culture to a clinical unit, a hospital, or a hospital system. However,
IOM firmly established that the safety culture of the U.S. healthcare system is deeply flawed and is the root cause of substandard care delivery.

**Safe Practice Statement**

Healthcare organizations must measure their culture, provide feedback to the leadership and staff, and undertake interventions that will reduce patient safety risk. [AHRQ, 2009; AHRQ, N.D.; JCR, 2010]

**Additional Specifications**

- At least annually, leaders should assess the organization’s safety and quality culture using a survey tool that is selected with consideration of validity, consistency, and reliability in the setting in which it will be applied and that is conceptualized around domains that are applicable to performance improvement (PI) initiatives/efforts such as teamwork, leadership, communication, and openness to reporting. [Deilkås, 2008; IHI, 2009; Relihan, 2009]
  - Survey a census of units or service areas that in aggregate deliver care to more than 50 percent of the patients receiving care.
  - Measure service lines or units where there is a high patient safety risk.
  - Identify and prioritize culture PI targets; provide adequate resources to address performance gaps over a specified period of time.
  - Survey a valid sample to allow unit-level analysis and facilitate improvement.
- Critical care areas and services and high-volume and high-risk areas should be surveyed (e.g., emergency department, outpatient surgical services, diagnostic centers) and should include, in the aggregate, ambulatory totals to determine which of these areas should be targeted initially. [Donnelly, 2009; Kaafarani, 2009; Pater, 2009]
- The results of the culture survey process should be documented and disseminated widely across the enterprise in a systematic and frequent manner. [Audet, 2008; Chadwick, 2009; Hutchinson, 2009] The interventions component of this safe practice will be satisfied if the survey findings are documented and have been used to monitor and guide performance improvement interventions. [Pronovost, 2005a; Sexton, 2006; Sexton, 2007; Pringle, 2009]
- The organization should document that the results of the survey process, as defined in the Leadership Structures and Systems safe practice and by the activities defined in the Teamwork Training and Skill Building and the Identification and Mitigation of Risks and Hazards safe practices, have been provided to governance and senior medical leaders. [IHI, N.D.]

**Applicable Clinical Care Settings**

This practice is applicable to Centers for Medicare & Medicaid Services care settings, to include ambulatory, ambulatory surgical center, emergency room, dialysis facility, home care, home health services/agency, hospice, inpatient service/hospital, outpatient hospital, and skilled nursing facility.

**Example Implementation Approaches**

- Organizations measure culture by using proprietary surveys and/or those found in the public domain. What is important is that the leadership and those implementing
these surveys understand their aims and their limits, and ensure that they are building feedback processes and interventions into their designs.

Some organizations are undertaking cultural measurement in certain subsets of the workforce against performance improvement goals to reduce specific adverse events. Although not enterprise wide, such subset assessments of culture tied to safety outcomes are valuable, and due to the narrower scope may be more easily done on a quarterly basis to inform performance improvement activities.

Using validated surveys to assess culture should be done at the unit or care area level across the entire organization. The unit level needs assessment, then guides leadership for resource needs and quality improvement. [Pronovost, 2005b; Sexton, 2005; Rose, 2006; Huang, 2007]

Strategies of Progressive Organizations

Some organizations have embraced culture measurement, feedback, and interventions with vigor. They are measuring culture in an organization-wide fashion, linking broad performance improvement programs to patient safety performance gaps, and correlating the outcomes to culture measurement. Staff turnover, retention, and other operational metrics are also being tracked. Many are exploring new survey instruments and customizing them to suit their strategic objectives.

Opportunities for Patient and Family Involvement

Include patient and family members in culture of safety survey measurement. [NPP, N.D.]

Encourage patients to share their stories/experiences with staff at staff meetings or grand rounds.

Outcome, Process, Structure, and Patient-Centered Measures

These performance measures are suggested for consideration to support internal healthcare organization quality improvement efforts, and may not necessarily address all external reporting needs.

Outcome Measures should be correlated with other patient safety measures that are related to clinical care. Staff turnover, staff retention, job satisfaction, and teamwork can be correlated with operations and financial impact.

Process Measures include survey response rates, the percentage of total staff surveyed, reliability, consistency, representation, and other measures pertinent to the survey tools used. These metrics relate to the domains assessed and other considerations pertinent to the survey groups.

Structure Measures pertain to the structural elements put into place to ensure that the information gained from the survey is used to reduce patient harm.

Patient-Centered Measures are in their infancy and would not be used directly in the measurement of culture through surveying staff; however, any correlations that can be made between an organization’s culture and patient-centered care should be made with a consideration of the following dimensions drawn from IOM’s report Crossing the Quality Chasm: A New Health System for the 21st Century.
1. respect for patients’ values, preferences, and expressed needs;
2. continuous collaboration, coordination, and integration of care among providers and across conditions and settings;
3. accessible and customized information;
4. communication, education (including self-efficacy and self-management skills for patients and families), and easy access to decision support tools;
5. the provision of physical comfort to patients;
6. the offering to patients of emotional support and relief from fear and anxiety;
7. the involvement of family and friends in care; and
8. access to care.

Settings of Care Considerations

- **Rural Healthcare Settings**: All rural healthcare settings should comply with the relevant specifications of this safe practice. Although small and rural organizations may have more resource constraints than larger urban or suburban organizations, great efficiencies can be realized by participating in the national safety and quality collaborative initiatives of similar organizations. Alliances with these organizations in noncompetitive service areas provide significant opportunities for sharing information and identifying resources.

- **Children’s Healthcare Settings**: All children’s healthcare settings should comply with the relevant specifications of this safe practice. National alliances and collaborative initiatives provide rich opportunities for efficiencies in information and resource-sharing about culture measurement and transformation.

- **Specialty Healthcare Settings**: All specialty healthcare settings should comply with the relevant specifications of this safe practice. National alliances and collaborative initiatives with similar specialty facilities offer special opportunities to compare performance in culture measurement and improvement.

**New Horizons and Areas for Research**

One of the most important new horizons in culture measurement and improvement is the dimension of leadership. Although a growing number of studies tie systems failures in healthcare organizations to an overemphasis on financial performance, many administrative leaders are uncomfortable managing a highly clinical business and continue to neglect opportunities for performance improvement. As culture measurement continues to be refined and correlated with workforce performance—and, in turn, safety and quality—new dimensions and opportunities for improvement will be identified. Researchers are investigating direct correlations between an organization’s unit- or area-specific teamwork climate and overall nurse retention, for example.

**Other Relevant Safe Practices**

Safe Practice 1: Leadership Structures and Systems; Safe Practice 3: Teamwork Training and Skill Building; and Safe Practice 4: Identification and Mitigation of Risks and Hazards, are directly relevant. All practices involving performance improvement projects, and those projects in which teamwork is important, are also relevant.
Notes


June 1, 2010

Dear Healthcare Leader:

We are delighted to announce that the National Quality Forum has graciously given us permission to distribute copies of the *NQF Safe Practices for Better Healthcare – 2010 Update*. This section has been provided to you in the interest of helping you implement, and/or educate others to adopt the suggestions and implementation examples into your safe practices.

The National Quality Forum is dedicated to providing evidence-based practices as ready-to-use tools to improve safety. The practices in the *NQF Safe Practices for Better Healthcare – 2010 Update* have been evaluated, assessed and endorsed to guide large and small healthcare systems in providing the safest care in every area of patient safety. We give our highest recommendation for them as a valuable resource toward patient safety from hospital bedside to boardroom. It is in the fulfillment of this mission that NQF makes the gift of this to you in your pursuit of your quality journey.

We hope that you will recommend that others purchase the report from NQF. The homepage of the National Quality Forum can be accessed at the following link: [http://www.qualityforum.org/](http://www.qualityforum.org/) and an abridged report of the *NQF Safe Practices for Better Healthcare—2010 Update* can be downloaded free online at: [http://www.qualityforum.org/Publications/2010/04/Safe_Practices_for_Better_Healthcare__2010_Update.aspx](http://www.qualityforum.org/Publications/2010/04/Safe_Practices_for_Better_Healthcare__2010_Update.aspx). To obtain the full report for a cost of $29.99, please contact NQF by phone during business hours at 202-783-1300 or via e-mail at info@qualityforum.org and their staff will contact you for payment details.

If you want to have a free copy of the entire set of practices, you may receive one if you fill out a web-based survey that may be filled out at [http://www.safetyleaders.org/2010nqfResearchStudy/index.jsp](http://www.safetyleaders.org/2010nqfResearchStudy/index.jsp).

We want to acknowledge you and your institution for your current efforts in patient safety. We hope you enjoy this important information and find it useful in your future work.

Sincerely,

Charles R. Denham, M.D.
Chairman