

Solution: Embracing a Non-Punitive Culture for Patient Safety**Organization:** St. Mary's Hospital**Type:** Acute Care**Primary Contact:** Joan Gelrud, Vice President**E-mail:** Joan_Gelrud@smhwecare.com**Phone:** 301.475.6428

IDENTIFICATION:

To improve the culture of safety at St. Mary's Hospital by creating a non-punitive response to error as evidenced by results of the Agency for Healthcare Research and Quality's Hospital Survey on Patient Safety Culture for that question.

The AHRQ Survey was implemented in 2006 with 124 surveys returned out of 993 employees, representing 12% of St. Mary's Hospital's total staff. The non-punitive response to error score was 36% well below a goal of 49%, which was the AHRQ 75th percentile. The low response rate was interpreted as apathy. The low score was interpreted as a low probability that reporting would occur because of a low overall perception of a non-punitive culture.

The results from the first AHRQ Patient Safety Survey conducted in 2006 served as the baseline. The survey has been repeated annually thereafter.

PROCESS:

The Patient Safety Council was restructured, changing its membership to mostly front-line staff. The desired effect was to empower staff to identify and resolve a wide range of patient safety concerns within the organization. The tools used to achieve their success include:

- Conducting FMEAs (Failure Modes and Effects Analysis)
- Conducting RCAs (Root Cause Analysis)
- Removing anonymity in reporting into the automated variance system
- Including Patient Safety (which is part of the Organization's Strategic Initiatives) in individual Department Leader Goals
- Conducting bimonthly Patient Safety Rounds by the Patient Safety Council members
- Participating in collaboratives with other hospitals to identify, track and develop solutions to shared patient safety issues
- Providing an annual Patient Safety Survey to all staff to identify key areas in need of improvement

SOLUTION:

Examples of solutions to improve the culture of patient safety via a non-punitive response to errors and their implementation include:

- Development and implementation of an Electronic Medical Record.
- Use of "Speak Up" brochures for all patients on admission, encouraging them to come forward with any concerns that develop.
- Implementation of patient safety rounds by all frontline Council members to elicit errors and unsafe processes. All patient safety opportunities identified by Patient Safety

Rounds are forwarded to the appropriate Department Leader for investigation and resolution.

- Formation of departmental Patient Safety sub-committees to encourage staff accountability
- Presentation of Patient Safety Dashboard of indicators at Patient Safety Council meetings and the Continuous Quality Improvement Council.

These measures resulted in:

- A re-survey of St. Mary's Hospital employees using the AHRQ annual patient safety tool resulted in 419 surveys out of 1,124 employees, representing 37% of St. Mary's Hospital's total staff. This was more than three times the response rate of the first survey.
- The results of the AHRQ annual patient safety survey revealed an improvement in the culture for patient safety within the hospital. The non-punitive response to error score improved from 36% to 51% which was greater than the AHRQ 75th percentile.
- Extremely well attended monthly Patient Safety Council meetings with an average 71% attendance rate.
- Correction of 245 patient safety issues identified via rounding..
- Quarterly recognition of Patient Safety Heroes for their contributions toward patient safety.
- Development of Clinical Ladders.
- Introduction of physician's perception of improved culture for reporting as evidenced by 14 Physicians reporting safety opportunities.

These results will be sustained over time by taking the following measures:

- Staff meeting monthly agendas were altered to include the Patient Safety Council's representatives report to encourage dialogue.
- A patient safety article is published in every issue of the hospital's monthly publication for employees – *The Pulse*.
- Safety reminders are posted on computer login screens.
- Each year all staff members will continue to receive the AHRQ Patient Safety Survey and results will be analyzed to provide insight into problem areas and to celebrate successes.
- The Patient Safety Council will continue to meet monthly to evaluate our current processes and brainstorm new ways to improve the culture of safety within the hospital.
- The Patient Safety Council will continue to round for purpose, but with differing questions to staff to creatively elicit patient safety concerns.
- Department Leadership is now asked to report quarterly on their strategies to meet the organization's patient safety goals.