CULTURE OF SAFETY IMPROVEMENT PROJECT REQUIRES SUSTAINED ORGANIZATIONAL COMMITMENT

by

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Hospital leaders have been directed to focus on assuring patient safety and improving outcomes through the development of a strong safety culture. The Safety Attitude Questionnaire (SAQ) at a small rural hospital showed a decline, over three years, in the perceived safety climate of the organization, by clinical staff. The purpose of this quality improvement project was the implementation of a structured debriefing program, promoting teamwork and collaboration between leadership and front-line staff, to improve the safety culture of the organization, exhibited by an improvement in SAQ scores within one year. Leading safety researchers suggest that developing a culture of safety has not been a priority due to the required time and resource allocation. Shifting organizational priorities eliminated the focus on this project’s development and eliminated the opportunity to reassess staff perceptions of the safety climate by discontinuation of the SAQ. A project wrap up meeting revealed the benefits of the debriefing sessions and reinforced the opportunity for continued promotion of a culture of safety. There was consensus amongst the leadership that education, at all levels, was needed to define a culture of safety and create awareness of the importance of teamwork and collaboration.

*Keywords*: culture of safety, teamwork, collaboration, patient safety
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A culture of safety promotes behaviors throughout an organization that result in an effective, reliable, repeatable and productive performance. Reinforcing the characteristics of teamwork and collaboration become essential for cultural transformation, and require the entire organization to participate. Creating a culture of safety requires a continuous strategic focus, a comprehensive assessment of past performance, systematic implementation of improvement initiatives and an obligation to maintaining a strong safety culture (Drenkard, 2011).

Health care organizations have access to multiple tools to evaluate the culture of safety and utilize the results to target opportunities for development and education. Pascal Metrics Inc. provides software and services supported by scientifically-validated patient safety culture surveys, to provide metrics and analytics in improving the culture of safety and quality in high-risk areas of healthcare. This survey instrument is considered valid and reliable. The Safety Attitude Questionnaire (SAQ), scores seven domains with a goal of 75% to identify a healthy culture. Responses are tabulated and analyzed in useful format at the department/unit level, by domain and by question. Additionally, data is compared to a standard to identify “danger zone” opportunities for improvement. This standard was developed from more than 900 hospitals and 20,000 clinical units.

The results of a Safety Attitude Questionnaire (SAQ), at a small rural hospital, over three years indicated a decline in the perceived safety and teamwork climate by nursing staff. Perceptions of safety and teamwork, assessed annually by the SAQ, presented a decrease to below 65%, indicating a decline in the organizations safety culture. The 2012 SAQ score for teamwork in nursing units declined 10% in the past two years, dropping from 74% in 2010, to
70% in 2011 and 64% in 2012. The hospitals with teamwork climate scores over 70% consistently exhibit improved clinical outcomes. The SAQ equates teamwork and safety climate as the perceived quality of collaboration and level of commitment to patient safety.

Analyzing the results of the annual survey, the hospital had the opportunity to implement a structured debriefing plan and a just culture disciplinary system model. Acceptance and engagement of senior and local leadership was paramount to the success of safety promotion and teamwork improvement through collaboration. Development of a culture of safety began with senior leadership engagement of the organization to make patient safety and improved outcomes a priority. Improving the culture, over time, embeds teamwork and communication as the vision for establishing priorities.

The organization defined a culture of safety as a shared value and belief among employees, managers, and leaders regarding the primary importance of ensuring that the organization’s processes cause no physical harm to employees or customers. The quality improvement project was structured to answer the study question: Will the implementation of a structured debriefing program and a just culture disciplinary system model, for senior and local leadership, improve the safety culture of the organization, to promote teamwork, as exhibited by annual improvement in SAQ scores related to Teamwork and Safety Climate, within one year?

**Method**

In 2010, the American Nurses Association (ANA) published a new position statement to address the application of a just culture model to create an open, fair, learning culture that will support designing safe systems and manage behavioral choices. This model empowers staff to work with leadership, in the development of safer processes by identifying near miss events and making choices that align with policy. Development of a strong safety culture promotes an open
and trusting environment, resulting in increased reporting of near misses, facilitating comprehensive understanding of opportunities for process improvement. Literature suggests, this type of collaboration facilitates teamwork to improve patient outcomes (Goh et al., 2013).

**Theory**

Reason’s attribution theory supports a culture, in which, poorly designed systems, not the actions of individual staff members, are responsible for adverse events (Reason, 2000). Employee engagement, through the application of a just culture, will positively influence performance, making clinical staff feel engaged, empowered, and satisfied with their working environment. Implementation and facilitation of just culture principles, addresses the culture of attributing events to personal intent and facilitates the assessment of situations for system failure.

In order to identify latent failures at the managerial level, before the possibility of human error, Reason (1990), developed the Swiss cheese model, to describe the dynamics of accident causation. This model begins with the failure and identifies the precursors, triggers and failures, making the holes that allow error to occur at the system level. Frequently, hospital leaders fail to engage the most expert individuals to solve safety and quality problems, allowing nursing and physician hierarchies to dominate the authority structure of the organization (Chassin & Loeb, 2013).

**Project Development**

The project was structured to ensure quality and promote a culture of safety, and address the problem of behaviors that threaten the performance of the health care team. To improve teamwork, collaboration and culture, the survey results were utilized to develop debriefing session agendas, individualized for each unit based on the results of the SAQ. Engagement of the front line staff in the debriefing sessions was viewed as a way to share their values about
what is important. A study by the Institute of Medicine, in 2001, showed that the safety culture of an organization is viewed as the values shared among organization member (Singer et al., 2009). The Institutional Review Board (IRB) at Capella University reviewed the project and determined that it did not meet the federal regulations definition of Human Subjects Research, therefore IRB oversight was not needed.

The organization trained senior leaders and department directors in a non-punitive approach to errors, focused on manageable behaviors, event investigation, and systems design. This training was intended to create a focus on the culture of safety to support an open reporting environment, promoting teamwork and communication. Reason (1990), supports the notion of focusing on intent when considering the nature of error. A non-punitive culture investigates incidents and categorizes them into human error, at-risk behavior, or reckless behavior. Individuals involved then participate in process re-design, corrective action or coaching to improve the system (Boysen, 2013).

Department leaders were provided education monthly regarding topics related to promoting just culture, teamwork and collaboration. Error investigation was reviewed with scenarios, provided by participants, to work through a non-punitive investigation and determine the appropriate response to behavior. Town hall meetings were scheduled to increase communication and promote reporting of patient safety concerns. Online education tools were released to hospital staff to present the just culture principles and promote the engagement of all employees the safety improvement project.

**Project Implementation**

Initially, a high-impact presentation, addressing system and hospital overall scores, outlining the current safety climate, identifying the high-risk area scores, review of evidence
based practice strategies and the debriefing session agendas for all departments was completed. An overview of a structured debriefing program for leadership was developed and presented to promote a culture of safety and teamwork. The outcome of the debriefing sessions, based on the just culture model, was to enable leadership to develop and generate an individual sense of responsibility and accountability for departmental development, enhance the ability to advance patient care delivery process, and create a workplace culture that inspires quality and safety (ANA, 2010).

Coordination of department debriefing sessions were designed to create an accepting environment to develop teams to coordinate clinical care and drive improvement efforts. Senior leadership and department directors were provided with interactive debriefing agendas to review and evaluate their individual SAQ results. The purpose of the debriefing sessions were to identify specific areas of concern, gain insight and recommendations, leading to the selection of targeted areas for improvement. Working through this process, department directors would have an increased understanding of the unit’s culture and form intentional actions and interventions to improve working environments.

The debriefing sessions for management were outlined in a structured and standardized approach, to engage frontline staff for grass roots improvement. Staff engagement, in all surveyed departments, had a common theme requesting senior leadership engagement with frontline staff. Cultural transformation of safety and teamwork to improve patient outcomes starts with leadership understanding the need for change and the development of a long term plan to integrate and maintain the established improvement. This type of organizational structure that supports teamwork and collaboration through non-hierarchical organization design, have a positive impact on development of a culture of safety (Goh et al., 2013).
In May 2014, Leadership Rounding was implemented in a structured format to facilitate documentation of opportunities, hot topics, action items and follow-up. Members of the senior leadership team were sent monthly reminders and documentation of continuing topics and action items at the end of each month. The input from staff members, during increased leadership engagement, led to multiple opportunities for improving teamwork, increased patient-centered care and inspired a culture of safety and reliability.

Organizational changes, accomplished from front-line staff input, were presented in the hospital newsletter. The following list are examples of some of the implemented changes.

- Additional certified nurse aides hired
- Improved staffing by acuity
- Volunteer orientation to assist with patient needs
- Purchase of new equipment
- Use of Spirit Board
- Patient room furniture to maximize space
- Hover Mat on site
- Safe Patient Handling education
- Initiated strategy for single patient rooms
- Updated triage area and improved staffing plan in Emergency Department
- Increased number of Workstations On Wheels
- Updated break room furniture
- Improvements in cleanliness and communication with Environmental Services
- Increased Director presence on units
- Patient Care Coordinator role development
- Increased departmental communication
- Improved electronic medical record downtime communication
- Increased electronic medical record physician liaison presence
Project Limitations

Six months after the project implementation began, a series of organizational decisions severely disrupted progression towards sustaining and measuring the culture of safety. Conflicting priorities brought on by a new fiscal year and low HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) scores focused attention away from leadership rounding. Leadership rounding was consistent for three months and then tapered off. Just culture education for front-line staff was not completed due to mandatory education focused on meeting regulatory requirements and a new corporate campaign. Continued requests for education from department directors on a non-punitive approach to disciplinary action were not addressed.

In September 2014, it was announced the SAQ, applied over the past five years, would no longer be utilized. The corporate office terminated the agreement with Pascal Metric Inc. to discontinue participation in the SAQ survey. A limited number of similar questions would be included in an upcoming Employee Engagement Survey (EES) related to the employee’s feelings on safety and teamwork. Clinical areas previously providing input were excluded from the EES, including, the Intensive Care Unit, Physical Therapy, Respiratory Therapy, and Laboratory. Documented improvement in the safety culture of the hospital would be measured through the applicable questions available in the new survey.

The results of the EES, from November 2014, showed a decrease in the overall safety climate of the organization by 2.5%, while the overall teamwork climate increased by 1.5%. The definitions of safety and teamwork climates, within the survey, leads to the conclusion that the employees perception of leaderships commitment to safety had declined, while their perceived
quality of teamwork and collaboration within their units had improved. However, improvements or declines in the culture could not be assessed from the outcomes of different surveys.

A project wrap up meeting was held to review the benefits of the debriefing sessions and the opportunity for continued promotion of a culture of safety and teamwork. Senior leadership acknowledged that an action plan was necessary to reach the 70% threshold on safety and teamwork survey scores. There was consensus that education was needed to define a culture of safety and create awareness of the importance of teamwork, prior to the next survey. Directors and management requested training on coaching on performance and communication regarding the strategic direction of the organization.

**Discussion**

Sustaining a culture of safety requires consistently promoting involvement, delegating responsibility, providing necessary resources, and listening, acknowledging, and acting upon concerns was necessary for creating an environment in which front line workers felt motivated to engage (Singer, et al, 2009). Perceptions of executive leadership form front-line staffs’ beliefs about organizational dedication to patient safety and the safety climate that develops their response to situations that may negatively affect patient care. Interprofessional collaboration must foster mutual respect, emphasize teamwork, promote communication and align the quality improvement philosophy.

Patient safety is an increasingly important issue in the healthcare industry as outcomes become tied to reimbursement, and medical errors are publically reportable. Evidence reports that communication improves with the implementation of a just culture. In a just culture, individuals are encouraged to voluntarily report any incident that occurs, that would otherwise have gone unnoticed, possibly introducing unnecessary risk into the system. Teamwork is
evident in the development of a just culture, when visible leadership involvement is initiated
with tools and education, to improve collaboration. Teamwork develops from collaboration in
interdisciplinary teams that organize their thoughts and communications to reach an agreed upon
resolution. Communication failures inhibit organizational growth and the limit a workers ability
to learn from events that could be viewed as learning opportunities (Goh et al., 2013).

Employee engagement, through the application of a just culture, will positively influence
performance, making clinical staff feel engaged, empowered, and satisfied with their working
environment. Senior leadership, at this small rural hospital, should implement a formal rounding
program to increase their presence in clinical departments. Findings and improvements would be
reported monthly in the hospital newsletter. Staff need the continued assurance that senior
leadership engagement is the culture of the organization and not a trend.
References


APPENDIX A. STATEMENT OF ORIGINAL WORK

Academic Honesty Policy

Capella University's Academic Honesty Policy (3.01.01) holds learners accountable for the integrity of work they submit, which includes but is not limited to discussion postings, assignments, comprehensive exams, and the dissertation or capstone project.

Established in the Policy are the expectations for original work, rationale for the policy, definition of terms that pertain to academic honesty and original work, and disciplinary consequences of academic dishonesty. Also stated in the Policy is the expectation that learners will follow APA rules for citing another person's ideas or works.

The following standards for original work and definition of plagiarism are discussed in the Policy:

Learners are expected to be the sole authors of their work and to acknowledge the authorship of others' work through proper citation and reference. Use of another person's ideas, including another learner's, without proper reference or citation constitutes plagiarism and academic dishonesty and is prohibited conduct. (p. 1)

Plagiarism is one example of academic dishonesty. Plagiarism is presenting someone else's ideas or work as your own. Plagiarism also includes copying verbatim or rephrasing ideas without properly acknowledging the source by author, date, and publication medium. (p. 2)

Capella University’s Research Misconduct Policy (3.03.06) holds learners accountable for research integrity. What constitutes research misconduct is discussed in the Policy:

Research misconduct includes but is not limited to falsification, fabrication, plagiarism, misappropriation, or other practices that seriously deviate from those that are commonly accepted within the academic community for proposing, conducting, or reviewing research, or in reporting research results. (p. 1)

Learners failing to abide by these policies are subject to consequences, including but not limited to dismissal or revocation of the degree.

Statement of Original Work and Signature

I have read, understood, and abided by Capella University’s Academic Honesty Policy (3.01.01) and Research Misconduct Policy (3.03.06), including the Policy Statements, Rationale, and Definitions.

I attest that this dissertation or capstone project is my own work. Where I have used the ideas or words of others, I have paraphrased, summarized, or used direct quotes following the guidelines set forth in the APA Publication Manual.

Learner name and date

Mentor name and school