Facilitating Change in the Patient Safety Culture of the Clinical Learning Environment

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• Welcome

• Background

• Small Group Work
  – Debriefing
  – Coaching
  – Facilitating
The Bottom Line Up Front (BLUF)
Patient Safety Culture can be **Measured**, and this information can be used to **Coach** program directors, hospitals, and trainees to **Improve**
Session Objectives

• Describe ways to **assess patient safety culture**

• Demonstrate the **interpretation of results** from a survey of patient safety culture

• Summarize ways that data can be used to **facilitate patient safety culture change**
UPMC Medical Education

~1800 residents and fellows
120 ACGME-accredited programs

10 teaching hospitals
  Tertiary care
  Community
  Specialty - Women’s, Children’s, Psychiatric

More than 62,000 UPMC employees
Our patient safety and quality improvement mission

✓ Engaging graduate medical trainees in patient safety and quality improvement

✓ Increasing safety event and medical error reporting by graduate medical trainees

✓ Integrating graduate medical trainees into hospital/institutional safety and quality structures
Where do Graduate Medical trainees fit in?

Residents and fellows **are our frontline physicians**

- In the trenches of patient care day in and day out
- Recognition of shortcomings in our systems of care is a given – they need to be empowered to share

They are **ideally positioned** to identify potential solutions
Are Graduate Medical Trainees EMPOWERED?

• Do they know *what* to do when medical errors or near misses happen?

• Do they know *how* to access the patient safety and QI infrastructure of the hospital?

*How do we provide them with the knowledge to recognize errors and near misses, the invitation to report them, and the power to fix them?*
Strategy

Building relationships...

Breaking down silos

GME

PSQI

Institutional Leadership

Residents and Fellows

Hospital Leadership

GME Programs

UPMC LIFE CHANGING MEDICINE
Strategy – Setting the wheels in motion

- Event analysis
- Error and event reporting
- QI work
Where is the Data?

- When people discuss changing things, often faculty members, administrators, staff will ask...

  “Where is the data? Is this really a problem?”

  “Isn’t this just a solution in search of a problem?”

  “I don’t think this is a real issue…”
Where is the Data?

Surveys on Patient Safety Culture

As part of its goal to support a culture of patient safety and quality improvement in the Nation's health care system, the Agency for Healthcare Research and Quality (AHRQ) sponsored the development of patient safety culture assessment tools for hospitals, nursing homes, ambulatory outpatient medical offices, community pharmacies, and ambulatory surgery centers.

Five surveys on patient safety culture are available:

- Hospital Survey on Patient Safety Culture.
- Community Pharmacy Survey on Patient Safety Culture.
SECTION E: Patient Safety Grade

Please give your work area/unit in this hospital an overall grade on patient safety.

☐ A
Excellent

☐ B
Very Good

☐ C
Acceptable

☐ D
Poor

☐ E
Failing

SECTION F: Your Hospital

Please indicate your agreement or disagreement with the following statements about your hospital.

Think about your hospital...

1. Hospital management provides a work climate that promotes patient safety

2. Hospital units do not coordinate well with each other

3. Things “fall between the cracks” when transferring patients from one unit to another

4. There is good cooperation among hospital units that need to work together
## Teamwork Within Units
People support one another in this hospital
When a lot of work needs to be done quickly, we work together as a team to get the work done
In this hospital, people treat each other with respect
When one area in this hospital gets really busy, others help out

## Feedback & Communication About Error
We are given feedback about changes put into place based on event reports
We are informed about errors that happen
In this hospital, we discuss ways to prevent errors from happening again

## Organizational Learning—Continuous Improvement
We are actively doing things to improve patient safety
Mistakes have led to positive changes here
After changes are made to improve patient safety, their effectiveness is evaluated

## Handoffs & Transitions
Things “fall between the cracks” when transferring patients from one unit to another
Important patient care information is often lost during shift changes
Problems often occur in the exchange of information across hospital units
Shift changes are problematic for patients in this hospital

## Management Support for Patient Safety
Hospital management provides a work climate that promotes patient safety
The actions of hospital management show that patient safety is a top priority
Hospital management seems interested in patient safety only after an adverse event happens

## Supv./Mgr. Expectations & Actions Promoting Patient Safety
My program director says a good word when he/she sees a job done according to established patient safety procedures
My program director seriously considers resident/fellow suggestions for improving patient safety
Whenever pressure builds up, my program director wants us to work faster, even if it means taking shortcuts
My program director overlooks patient safety problems that happen over and over

## Frequency of Events Reported
Near Miss: When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?
Medical Error: When a mistake is made that could harm the patient, but does not, how often is this reported?
Adverse Event: When a mistake is made that causes patient harm, how often is this reported?

## Teamwork Across Units
Hospital units do not coordinate well with each other
There is good cooperation among hospital units that need to work together
It is often unpleasant to work with residents/fellows from other hospital units
Hospital units work well together to provide the best care for patients

## Nonpunitive Response to Error
Residents/fellows feel like their mistakes are held against them
When an event is reported, it feels like the person is being written up, not the problem
Residents/fellows worry that mistakes will affect their rotation evaluations

## Communication Openness
Residents/Fellows will freely speak up if they see something that may negatively affect patient care
Residents/Fellows feel free to question the decisions or actions of those with more authority
Residents/Fellows are afraid to ask questions when something does not seem right

## Management Support for Patient Safety
Hospital management provides a work climate that promotes patient safety
The actions of hospital management show that patient safety is a top priority
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## Staffing
We have enough residents/fellows to handle the workload
Residents/fellows in this hospital work longer hours than is best for patient care
We use more “temporary” residents/fellows than is best for patient care
We work in “crisis mode” trying to do too much, too quickly

## Overall Perceptions of Patient Safety
It is just by chance that more serious mistakes don’t happen around here
Our procedures and systems are good at preventing errors from happening
Patient safety is never sacrificed to get more work done
We have patient safety problems in this hospital
2014 Culture of Safety Survey Respondent Profile

- 71% Response Rate
  - 1,456 Trainees Surveyed
  - 1,027 Total Respondents
- 76 Programs
  - 73 Primarily Inpatient
  - 3 Primarily Outpatient

Respondent PGY Level

- % PGY6: 13%
- % PGY5: 14%
- % PGY4: 14%
- % PGY3: 19%
- % PGY2: 20%
- % PGY1: 22%

Resident vs. Fellow

- 72% Residents
- 28% Fellows
National Benchmarks vs. UPMC GME

% Positive Response by Domain – National vs. UPMC GME

- National
- UPMC GME Aggregate
All Facilities by Patient Safety Culture Domain
2013 vs. 2014 Comparison

% Positive by Domain

- Teamwork Within Units: +3%
- Supervisor Expectations/Actions: -1%
- Management Support for Patient Safety: +4%
- Overall Perceptions of Patient Safety: +3%
- Feedback/Communication about Errors: +2%
- Frequency of Events Reported: +5%
- Communication Openness: +0%
- Teamwork Across Units: +3%
- Staffing: +3%
- Handoffs & Transitions: +1%
- Non-Punitive Response to Error: +2%
2014 Culture of Safety Survey Results UPMC vs. UPMC ME
Program Report Card Example

% Positive Response by Domain

- National
- UPMC Aggregate
- Program 2014
Trainee Report Cards

[Graph showing Culture of Patient Safety Resident/Fellow Survey Results]

- The percentage of positive responses indicates better patient safety culture across domains: Communication Openness, Staffing, Supervision/Manager Expectations, and Actions Supporting Patient Safety, Teamwork Across Units, Teamwork Within Units, Frequency of Events Reported, Overall Perceptions of Patient Safety, Organizational Learning, Continuous Improvement, Handoffs & Transitions, Non-Punitive Response to Error, and Management Support for Patient Safety.

- Program: Site

- 56% of respondents disagree

- UPMC Residents & Fellows Survey Overall: 60%

- [Bar chart showing Domain Scores]

- [Table: Teamwork Within Units]

- [Table: Teamwork Across Units]

- [Table: Organizational Learning and Continuous Improvement]

- [Table: Handoffs & Transitions]

- [Table: Non-Punitive Response to Error]

- [Table: Management Support for Patient Safety]

- If you have safety and quality concerns, feel free to contact us: 1-800-822-3633 or report it online.

- [Contact information for UPMC Patient Safety and Quality Improvement Committee]
Providing Data Helps Open Doors

• By presenting data to leadership, many began to recognize a missed opportunity.
  
  – All hospitals engage in quality improvement.
  – We don’t label QI work well. Residents and fellows do not recognize the ways that hospitals are working to make things better.
  – Residents and fellows miss the opportunity to make QI an integral part of their training and their careers.

• Based on results many committees now have resident and fellow participation:
  
Culture is a consensus view of “the way we do things around here.” Research has shown that asking frontline caregivers to assess patient safety in their work setting is a valid and effective way to identify strengths and weaknesses. Survey results provide a snapshot of the various facets of culture that exist in your work setting.

The purpose of this meeting is to review the results in a small group of frontline caregivers (not managers) to identify a specific area of concern, and provide your insights and recommendations for how to address it. Selecting one or two items to discuss helps target the discussion to specific areas for improvement. This exercise will help to better understand your culture and consider actions and interventions for improving your work environment.

To aid in selecting a relevant item, the table below provides a selection of the most positive and least positive items from your cultural assessment.

### MOST POSITIVE COMPOSITE SCORES IN YOUR AREA

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Item 1</td>
<td>Most positive item 1 description</td>
</tr>
<tr>
<td>Item 2</td>
<td>Most positive item 2 description</td>
</tr>
<tr>
<td>Item 3</td>
<td>Most positive item 3 description</td>
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</tbody>
</table>

### LEAST POSITIVE COMPOSITE SCORES IN YOUR AREA

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</tr>
<tr>
<td>Item 3</td>
<td>Least positive item 3 description</td>
</tr>
</tbody>
</table>

After reviewing your item-level results, which item is of particular concern or relevance to this work setting right now due to recent or ongoing events or activities?

Why was this item important to your program?

What are some specific examples that illustrate how this item reflects your experience in this work setting?

Envision an ideal residency. What would it look like if 100% of the respondents in this residency program felt positively about this survey item (provide specific behaviors, processes, norms, policies, etc.)?

Agree on one or two actionable steps to move your program closer to the ideal program (agree on specific task(s); (persons responsible). Consider actionable items that the hospital could do, the program could do, and the trainee could do.
Getting Residents Involved - PM&R Example

- Culture of Safety Retreat with faculty and residents hosted by department
  - Established the following committees chaired by a faculty member with resident representation
    - M & M/Case Review – now scheduled as part of didactics
    - Feedback and Follow-up Friday – small groups of attendings and residents working on a service review events that occurred over the past week to provide more real-time feedback to everybody on the team
    - D/C Transitions – the residents are working on a number of projects in this area. One specific project is a pilot with Neurology that assures physician-to-physician direct communication with transfers of stroke patients to rehabilitation.

- Additional efforts to improve safety for all inpatient rehab units
  - Standardization of order sets across all inpatient units,
  - Standardization of processes across all inpatient units.
Our multifaceted approach at Children’s Hospital

• Didactics to provide the foundation
  – Orientation, Intern Boot Camp, Noon Conference, Leadership Workshop
• Innovative Morning Report Sessions
  – To Err is Human, Senior Safety Rounds
• Integration of PSQI into daily activities
  – i.e. “setting the tone”
    • Chief Resident for Patient Safety and QI, start morning sign-in and rounds with patient safety
• Involvement in institutionally-supported QI work
  – Hand hygiene, Pediatric Septic Shock Collaborative, Solutions for Patient Safety
  – Joint projects with industrial engineering students and health care policy and management graduate students
• Opportunities to present QI work
Success with PSQI Curriculum at CHP

Academic Year

Number of Events Reported

2010 2011 2012 2013 2014 2015

2 4 43 211 386 334*

*through 12/31/14
Total Number of Patient Safety Reports
Number of Patient Safety Reports

Children's Hospital of Pittsburgh of UPMC
Patient Safety Reports filed by Graduate Medical Residents

Children's Hospital of Pittsburgh of UPMC
Patient Safety Reports by All Positions except Graduate Medical Residents

UPMC
LIFE CHANGING MEDICINE
Percentage of Reports filed by Residents
Trainee Patient Safety Leadership Committee

- Invite 1-3 residents from Internal Medicine, Radiology, Emergency Medicine, Neurosurgery, Orthopedics, Urology, General Surgery, Psychiatry, Ophthalmology, ENT, Anesthesia, CCM, Family Medicine, Neurology, PMR
  - 30 trainees
- Opportunity for hospital leadership to capitalize on fresh ideas and perspectives from the front line.
- Opportunity for residents to shape practice.
- Residents disseminate practice changes to their colleagues. Work with residency programs to disseminate solutions.
Safety and Quality are Active Processes
The Minimum

- Residents and fellows should know how to **Recognize** medical errors and unsafe conditions.

- Residents and fellows should know that medical errors and unsafe conditions should be **Reported** to someone who can make changes and improve the circumstances contributing to error.

- Doctors should be **Empowered** to contribute to making change.
Questions?