THE UNIVERSITY OF KANSAS HEALTH SYSTEM

# Tips for Managing Your Culture of Safety Survey

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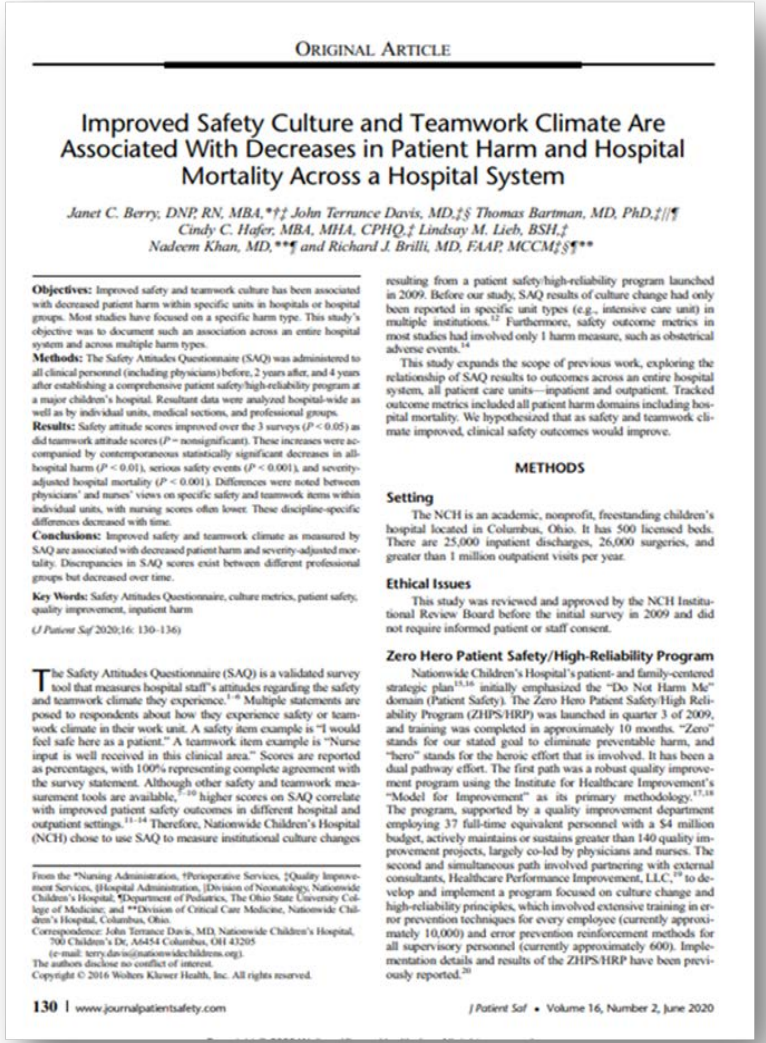
# Objectives

- Describe Why Participating in a Culture of Safety Survey is Important
- List 3 Strategies for a Successful Culture of Safety Survey

# Why is a Safety Culture Important?

- Develop a **culture of safety** & improve health care outcomes (Kohn et al., 2000)
- Positive correlation between hospital **patient safety culture** & patient care outcomes (DiCuccio,2015)
- Consistent and authentic engagement by leadership results in significant progress in patient safety (Moffatt-Bruce et al., 2018)
- Fewer healthcare worker injuries, including sharps-related and other injuries, better job satisfaction, improved staff retention, reporting of safety events, and reduced burnout (Hessels & Wurmser, 2020; McHugh et al., 2011).
- Reduced costs associated with decreased adverse events (Agency for Healthcare Research and Quality, 2019).
- Improved **Safety Culture** Linked with…
  - ✓ Decrease in Serious Safety Event Rate
  - ✓ Improved Mortality
  - ✓ Additional research needed to identify effective strategies for improving safety culture



ORIGINAL ARTICLE

Improved Safety Culture and Teamwork Climate Are Associated With Decreases in Patient Harm and Hospital Mortality Across a Hospital System

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**Objectives:** Improved safety and teamwork culture has been associated with decreased patient harm within specific units in hospitals or hospital groups. Most studies have focused on a specific harm type. This study's objective was to document such an association across an entire hospital system and across multiple harm types.

**Methods:** The Safety Attitudes Questionnaire (SAQ) was administered to all clinical personnel (including physicians) before, 2 years after, and 4 years after establishing a comprehensive patient safety/high-reliability program at a major children's hospital. Resultant data were analyzed hospital-wide as well as by individual units, medical sections, and professional groups.

**Results:** Safety attitude scores improved over the 3 surveys ($P < 0.05$) as did teamwork attitude scores ($P$ = nonsignificant). These increases were accompanied by contemporaneous statistically significant decreases in all-hospital harm ($P < 0.01$), serious safety events ($P < 0.001$), and severity-adjusted hospital mortality ($P < 0.001$). Differences were noted between physicians' and nurses' views on specific safety and teamwork items within individual units, with nursing scores often lower. These discipline-specific differences decreased with time.

**Conclusions:** Improved safety and teamwork climate as measured by SAQ are associated with decreased patient harm and severity-adjusted mortality. Discrepancies in SAQ scores exist between different professional groups but decreased over time.

**Key Words:** Safety Attitudes Questionnaire, culture metrics, patient safety, quality improvement, inpatient harm

(*J Patient Saf* 2020;16: 130–136)

The Safety Attitudes Questionnaire (SAQ) is a validated survey tool that measures hospital staff's attitudes regarding the safety and teamwork climate they experience.[1–6] Multiple statements are posed to respondents about how they experience safety or teamwork climate in their work unit. A safety item example is "I would feel safe here as a patient." A teamwork item example is "Nurse input is well received in this clinical area." Scores are reported as percentages, with 100% representing complete agreement with the survey statement. Although other safety and teamwork measurement tools are available,[7–10] higher scores on SAQ correlate with improved patient safety outcomes in different hospital and outpatient settings.[11–14] Therefore, Nationwide Children's Hospital (NCH) chose to use SAQ to measure institutional culture changes resulting from a patient safety/high-reliability program launched in 2009. Before our study, SAQ results of culture change had only been reported in specific unit types (e.g., intensive care unit) in multiple institutions.[15] Furthermore, safety outcome metrics in most studies had involved only 1 harm measure, such as obstetrical adverse events.[14]

This study expands the scope of previous work, exploring the relationship of SAQ results to outcomes across an entire hospital system, all patient care units—inpatient and outpatient. Tracked outcome metrics included all patient harm domains including hospital mortality. We hypothesized that as safety and teamwork climate improved, clinical safety outcomes would improve.

## METHODS

### Setting

The NCH is an academic, nonprofit, freestanding children's hospital located in Columbus, Ohio. It has 500 licensed beds. There are 25,000 inpatient discharges, 26,000 surgeries, and greater than 1 million outpatient visits per year.

### Ethical Issues

This study was reviewed and approved by the NCH Institutional Review Board before the initial survey in 2009 and did not require informed patient or staff consent.

### Zero Hero Patient Safety/High-Reliability Program

Nationwide Children's Hospital's patient- and family-centered strategic plan[15,16] initially emphasized the "Do Not Harm Me" domain (Patient Safety). The Zero Hero Patient Safety/High Reliability Program (ZHPS/HRP) was launched in quarter 3 of 2009, and training was completed in approximately 10 months. "Zero" stands for our stated goal to eliminate preventable harm, and "hero" stands for the heroic effort that is involved. It has been a dual pathway effort. The first path was a robust quality improvement program using the Institute for Healthcare Improvement's "Model for Improvement" as its primary methodology.[17,18] The program, supported by a quality improvement department employing 37 full-time equivalent personnel with a $4 million budget, actively maintains or sustains greater than 140 quality improvement projects, largely co-led by physicians and nurses. The second and simultaneous path involved partnering with external consultants, Healthcare Performance Improvement, LLC,[19] to develop and implement a program focused on culture change and high-reliability principles, which involved extensive training in error prevention techniques for every employee (currently approximately 10,000) and error prevention reinforcement methods for all supervisory personnel (currently approximately 600). Implementation details and results of the ZHPS/HRP have been previously reported.[20]

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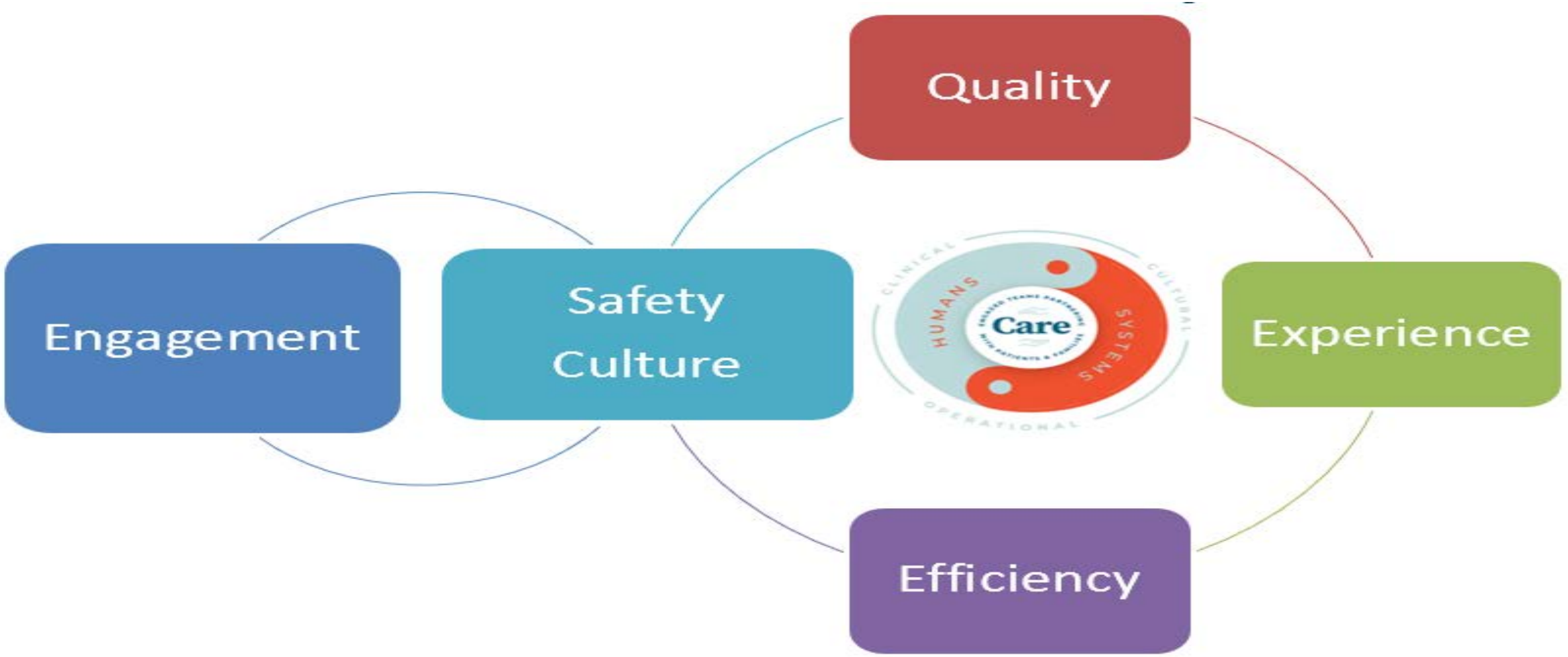
The authors disclose no conflict of interest.

# Engagement & Safety Drive Performance




- **Reference:** [Prioritizing safety as the foundation for staff engagement and retention in healthcare (pressganey.com)]

# Culture of Safety Surveys

## Evaluate & improve the culture of safety at an organization

## Survey Tools

- AHRQ Hospital and Medical Office Survey on Patient Safety Culture
- Press Ganey Safety Culture Survey
- Microsoft Viva Glint patient safety survey
- Gallup Patient Safety Culture Survey

## Regulatory & External Organization Reporting Standards

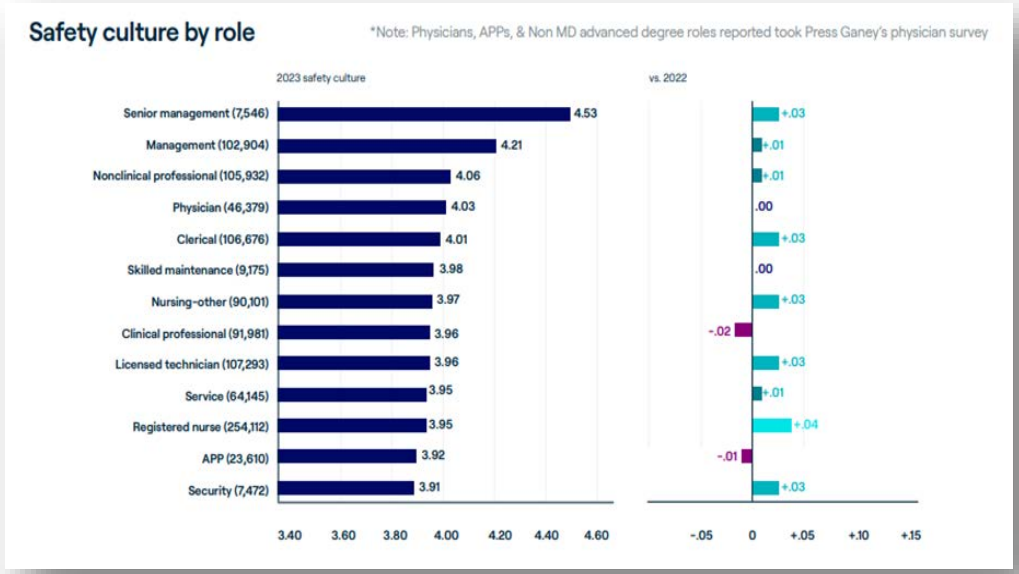
- CMS Patient Safety Structures FY2025 Hospital Inpatient Prospective Payment Structure – NEW
- Joint Commission Leadership Standards
  - LD.03.01.01, EP 1: Leaders regularly **evaluate** the culture of safety and quality using valid and reliable tools
  - LD.03.01.01, EP 2: Leaders **prioritize and implement changes** identified by the evaluation [of safety culture].
- Leapfrog Culture of Safety Guidelines

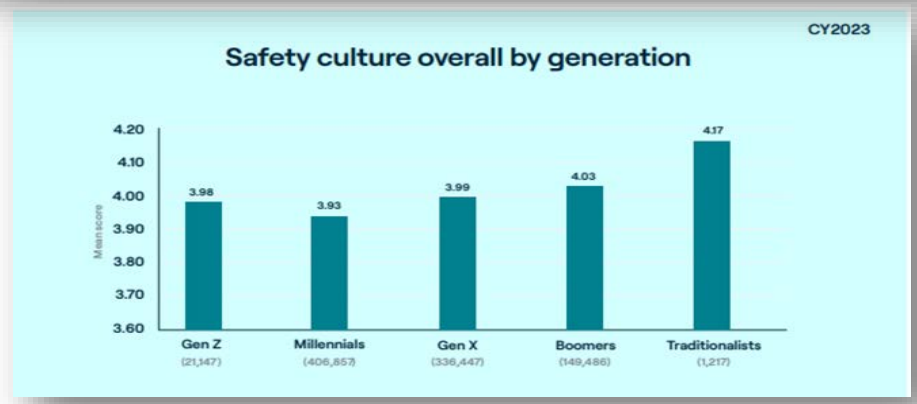
# Safety Culture

*The sum of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that impact the commitment and ability to provide a safe environment for patients.*

# Safety Culture in Healthcare

- **Safety in Healthcare 2024 - Press Ganey Report**
  - ✓ Staff safety cultures were at an all-time low in 2021
  - ✓ 2023 scores are on the rise
- **Perceptions of Safety Differ by Race, Ethnicity, Experience, Role**
  - ✓ Millennials report the lowest safety scores
  - ✓ Senior management report the highest perceptions of safety culture
  - ✓ Registered nurses and advanced practice providers report the 2nd and 3rd lowest
  - ✓ Security team members had the lowest perceptions of safety




https://info.pressganey.com/e-books-research/safety-2024

# Planning a Successful Survey: The Process

**PREPARATION:**
4 – 8 WEEKS

**SURVEY**
4 – 6 WEEKS

**FEEDBACK AND REPORTING**
4 – 12 WEEKS

**ACTION PLANNING**
ONGOING

# Additional Considerations

## Timing

- Survey Duration
- Survey Fatigue
- Competing Priorities
- Significant Changes

## Communication

- Safety Culture is Aligned with Hospital Strategy
- Survey Results Will Shape the Future
- Responses are Confidential
- Send Response Rates & Reminders
- The Link is Safe (Cybersecurity)

## Promote the Survey

- Raffle Prizes
- Divisional Team Competition
- Pie in the Face Contests
- Departmental Parties
- Rejuvenation Cart
- QR Codes in Break Rooms & Time Clocks
- Make it Easy to Complete

# After the Survey

- Thank Participants
- Share Preliminary Results
- Communicate Next Steps
- Present Final Results – Executive Summary, Departmental & Divisional Reports
- Prioritize & Implement Action Plan
- Intentionally Communicate Progress

# Action Planning

## The Most Important Stage of the Safety Culture Assessment

- Staff must have visibility to how their voice is leading to change
- Highlight resources that may already exist
- Tackle specific, low-hanging fruit
- Be Intentional with Communications - Connecting Feedback to Action

# Four High Reliability Practices to Transform a Safety Culture

## What Juice is Worth the Squeeze?

| | |
|---|---|
| Chase Zero | Adopt the goal of zero harm goal and message on safety |
| Measure | Measure harm and make harm visible |
| Just Culture | Foster a fair and just culture |
| Huddle | Practice daily check-ins for safety |

# Another Helpful Resource –
## Safer Together: A National Action Plan to Advance Patient Safety

### Culture, Leadership & Governance

1. Ensure safety is a demonstrated core value.
2. Assess capabilities and commit resources to advance safety.
3. Widely share information about safety to promote transparency.
4. Implement competency-based governance and leadership.

### Patient and Family Engagement

5. Establish competencies for all health care professionals for the engagement of patients, families, and care partners.
6. Engage patients, families, and care partners in the co-production of care.
7. Include patients, families, and care partners in leadership, governance, and safety and improvement efforts.
8. Ensure equitable engagement for all patients, families, and care partners.
9. Promote a culture of trust and respect for patients, families, and care partners.

### Workforce Safety

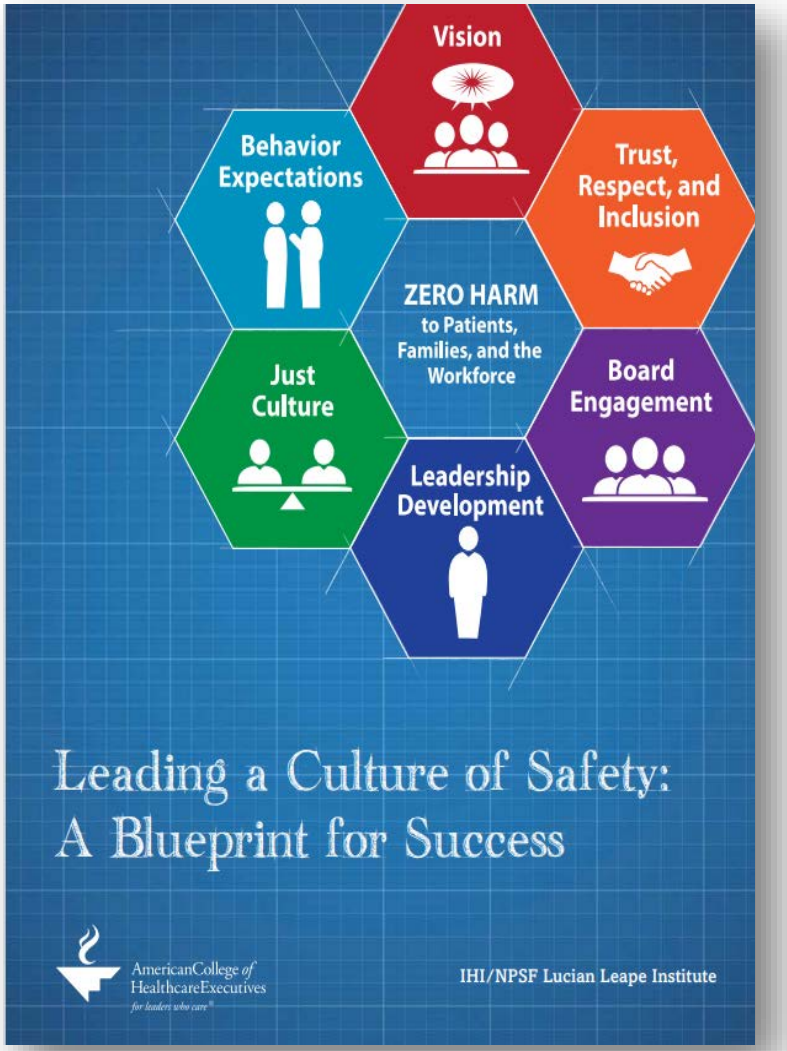
10. Implement a systems approach to workforce safety.
11. Assume accountability for physical and psychological safety and a healthy work environment that fosters the joy of the health care workforce.
12. Develop, resource, and execute on priority programs that equitably foster workforce safety.

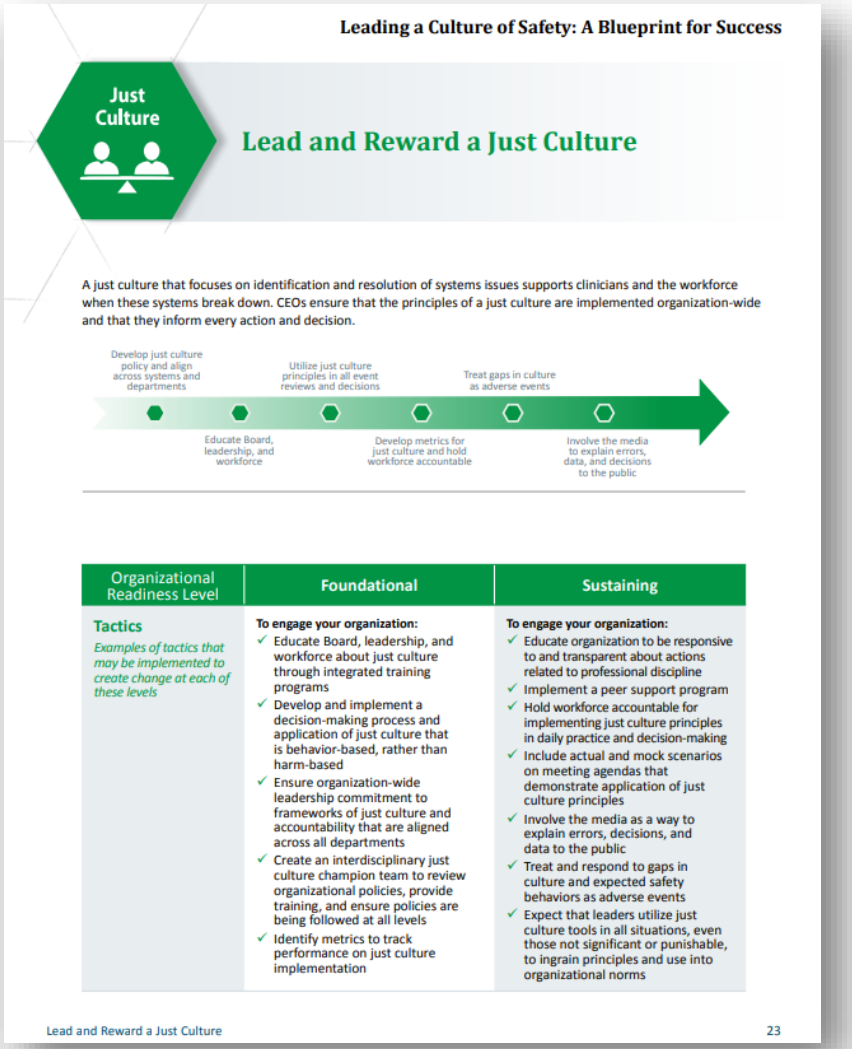
### Learning System

13. Facilitate both intra- and inter-organizational learning.
14. Accelerate the development of the best possible safety learning networks.
15. Initiate and develop systems to facilitate interprofessional education and training on safety.
16. Develop shared goals for safety across the continuum of care.
17. Expedite industry-wide coordination, collaboration, and cooperation on safety.

National Action Plan to Advance Patient Safety | Institute for Healthcare Improvement (ihi.org)

# Another Helpful Resource –
## Leading a Culture of Safety: A Blueprint for Success



Leading a Culture of Safety: A Blueprint for Success

Just Culture

### Lead and Reward a Just Culture

A just culture that focuses on identification and resolution of systems issues supports clinicians and the workforce when these systems break down. CEOs ensure that the principles of a just culture are implemented organization-wide and that they inform every action and decision.

Develop just culture policy and align across systems and departments
Educate Board, leadership, and workforce
Utilize just culture principles in all event reviews and decisions
Develop metrics for just culture and hold workforce accountable
Treat gaps in culture as adverse events
Involve the media to explain errors, data, and decisions to the public

| Organizational Readiness Level | Foundational | Sustaining |
|---|---|---|
| **Tactics**<br>*Examples of tactics that may be implemented to create change at each of these levels* | **To engage your organization:**<br>✓ Educate Board, leadership, and workforce about just culture through integrated training programs<br>✓ Develop and implement a decision-making process and application of just culture that is behavior-based, rather than harm-based<br>✓ Ensure organization-wide leadership commitment to frameworks of just culture and accountability that are aligned across all departments<br>✓ Create an interdisciplinary just culture champion team to review organizational policies, provide training, and ensure policies are being followed at all levels<br>✓ Identify metrics to track performance on just culture implementation | **To engage your organization:**<br>✓ Educate organization to be responsive to and transparent about actions related to professional discipline<br>✓ Implement a peer support program<br>✓ Hold workforce accountable for implementing just culture principles in daily practice and decision-making<br>✓ Include actual and mock scenarios on meeting agendas that demonstrate application of just culture principles<br>✓ Involve the media as a way to explain errors, decisions, and data to the public<br>✓ Treat and respond to gaps in culture and expected safety behaviors as adverse events<br>✓ Expect that leaders utilize just culture tools in all situations, even those not significant or punishable, to ingrain principles and use into organizational norms |

Lead and Reward a Just Culture 23

Leading a Culture of Safety: A Blueprint for Success

Just Culture

### Lead and Reward a Just Culture

| Organizational Readiness Level | Foundational | Sustaining |
|---|---|---|
| **Tactics**<br>*Examples of tactics that may be implemented to create change at each of these levels* | **To engage your organization (cont):**<br>✓ Align systems and standards for just culture across all organizational departments, including Human Resources<br>✓ Ensure employees are well-trained in just culture algorithm and tools and utilize them in daily activities and decisions<br>✓ Publicly reward positive examples of just culture | **To engage clinical leadership:**<br>✓ Include clinical leaders in the development of just culture policies<br>✓ Provide training for physicians, nurses, and other clinical leaders in just culture to build understanding and enthusiasm<br>**To engage patients and families:**<br>✓ Ensure that patients and family members who serve on Board and committees are educated on just culture principles<br>✓ Include patients and families in mediation committees/tribunals to assist in resolving conflicts between departments |
| **Assessing Execution**<br>*List of questions that should be asked to further assess and measure progress* | YES / NO<br>☐ ☐ Do Board, leadership, and workforce development programs include training on just culture?<br>☐ ☐ Is there one set of defined behavioral standards for all individuals within the organization, including leadership, physicians, and the workforce?<br>☐ ☐ Is compliance with the established just culture framework part of regularly reviewed performance reviews, including career development plans, for leaders and the workforce?<br>☐ ☐ Does the organization use, evaluate, and define action plans related to measures of just culture on employee surveys?<br>☐ ☐ Is there an existing measure that is regularly evaluated for assessing frontline knowledge of just culture algorithm? | |

Lead and Reward a Just Culture 24

Leading_a_Culture_of_Safety_Blueprint.pdf (ihi.org)

# One Health System's Experience

*An Example of Culture of Safety Survey Action Planning*

# Glint Metrics & Methodologies

- Survey ratings are converted on a 100-point scale to derive the mean score for the organization

- Glint's benchmarks reflect the mean of company scores for all healthcare customers in our database.
  - 50 Health Systems, 750+ Unique Hospitals
    - HCA, Kaiser Permanente, Henry Ford, Johns Hopkins, Atrium Health, Mercy Health, Advent Health, Yale New Haven Health
  - > 1.7 million healthcare professionals surveyed each year

- Guidelines for determining Meaningful Differences when Comparing Mean (Average) Scores

# Communicating Results

## Venues

- Health System & Hospital Leadership Venues
- Divisional & Departmental Meetings
- Tiered Distribution of Results to Leadership

## Format Template

- Overall Results vs. Healthcare Benchmark
- Participation
- Year over Year Comparison
- Theme Analysis
- Performance Improvement Ideas

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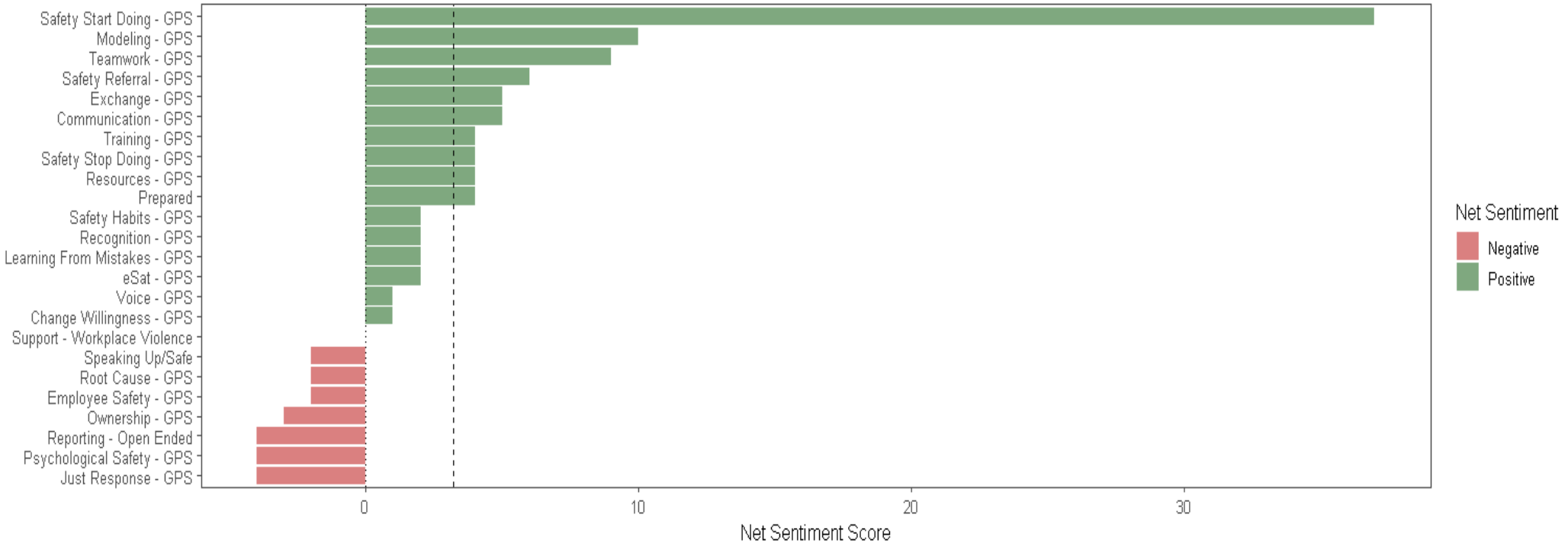
**Glint Culture of Safety Survey - 2024**

*Executive Summary*

Outperforming Benchmark
Equal to Benchmark
Underperforming Benchmark

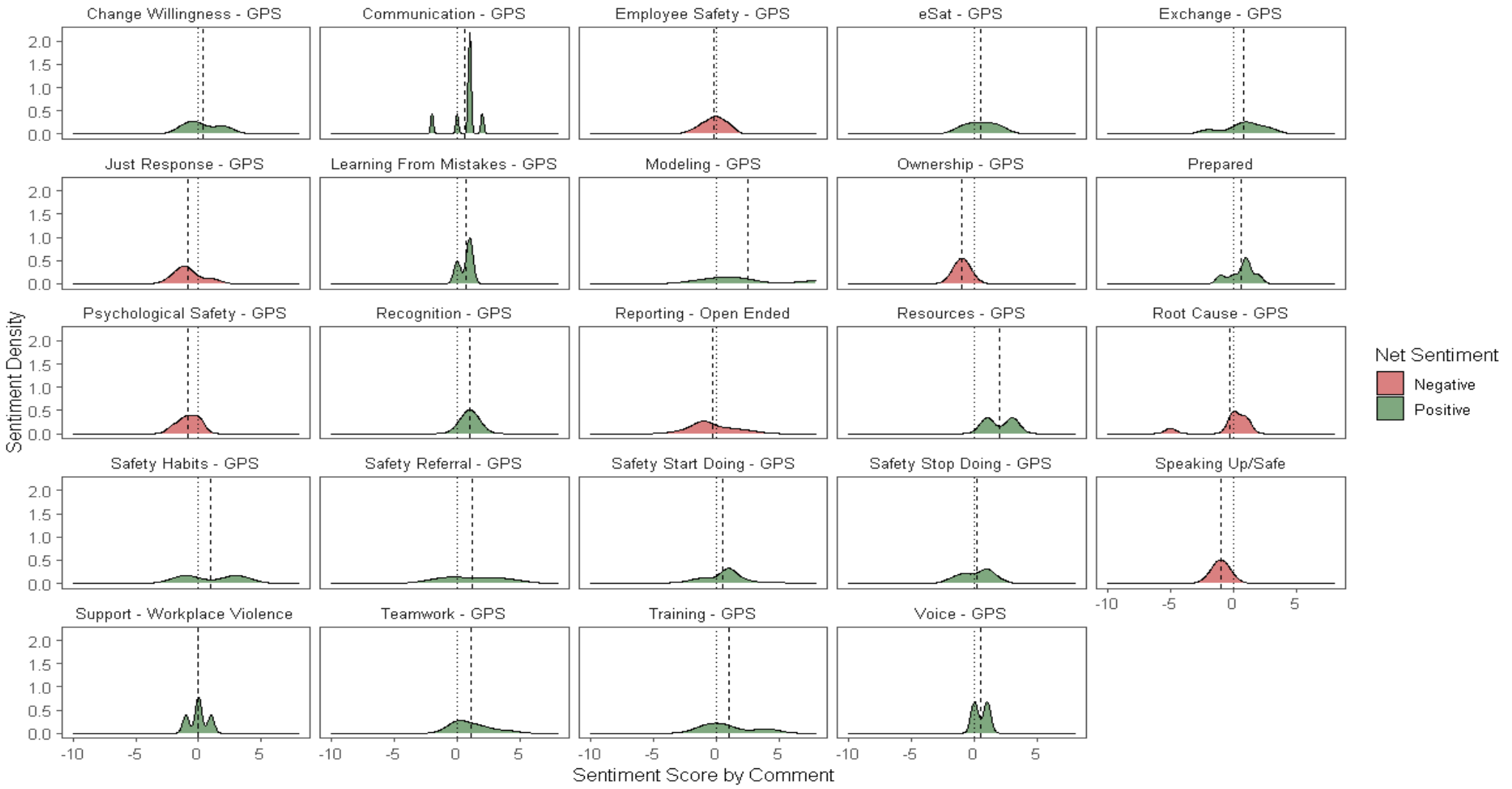
Note: 4 Additional Open-Ended Questions, Responses Available in Comments

| 20/24 Survey Questions - Question | Component | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| I would recommend this organization to family and friends as a safe place to receive care. (Benchmark = 80) | Safety Referral | 84 | 85 | 88 | 74 | 78 | 75 | **78** |
| I feel safe speaking up when seeing something that could cause harm to patients or employees. | Speaking Up/Safe | 83 | 83 | 85 | 77 | 81 | 75 | **No Benchmark, Internal Question** |
| Leadership's actions show that patient safety is a top priority. | Modeling | 83 | 84 | 82 | 80 | 79 | 74 | **74** |
| We discuss ways to prevent safety errors from happening again. | Learning from Mistakes | 82 | 83 | 83 | 77 | 78 | 72 | **78** |
| We support each other in caring for patients safely here. | Teamwork | 83 | 83 | 85 | 78 | 81 | 76 | **79** |
| Ensuring patient safety is part of the way we do things around here. | Safety Habits | 82 | 83 | 83 | 78 | 79 | 73 | **80** |
| I feel safe here as an employee. | Employee Safety | 82 | 83 | 85 | 76 | 80 | 71 | **77** |
| Employees who prioritize patient safety are appreciated here. | Recognition | 80 | 81 | 82 | 74 | 77 | 70 | **75** |
| I can speak up about patient safety without fear of retaliation. | Psychological Safety | 80 | 81 | 84 | 74 | 77 | 71 | **77** |
| Actions taken based on safety event reporting have led to positive changes here. | Change Willingness | 78 | 79 | 82 | 73 | 73 | 65 | **72** |
| I feel empowered to correct potential safety hazards. | Ownership | 80 | 80 | 80 | 76 | 76 | 73 | **76** |
| How happy are you working at The University of Kansas Health System ? | eSAT | 78 | 79 | 81 | 76 | 74 | 72 | **73** |
| There is a just process for handling safety-related errors here. | Just Response | 80 | 81 | 82 | 75 | 74 | 68 | **75** |
| There is good communication between leaders and employees here about patient safety. | Communication | 79 | 80 | 78 | 72 | 74 | 66 | **72** |
| We have the resources we need to keep patients safe. | Resources | 77 | 78 | 80 | 76 | 71 | 69 | **71** |
| The patient safety-related training I receive is effective. | Training | 79 | 79 | 79 | 76 | 74 | 72 | **75** |
| My input about patient safety is valued here. | Voice | 75 | 76 | 77 | 70 | 71 | 65 | **72** |
| At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.' | Root Cause | 72 | 73 | 76 | 67 | 69 | 65 | **69** |
| I feel well-prepared to manage aggressive or violent behavior from patients and visitors. | Prepared | 69 | 70 | 67 | 69 | 69 | 60 | **No Benchmark, Internal Question** |
| The exchange of information between departments occurs smoothly. | Exchange | 61 | 61 | 67 | 55 | 57 | 55 | **60** |




# Sentiment Analysis – MAY NOT Match Question Performance

- Above we have net sentiment by section: Comment volume differences drive most of the result we see above, but there are 7 sections that were net negative:
    1. Speaking Up/Safe,
    2. Root Cause
    3. Employee Safety
    4. Ownership
    5. Reporting,
    6. Psychological Safety, and
    7. Just Response




# Sentiment Analysis

**Most Questions Will See Positive & Negative Comments, May Not Represent the Whole Population**

# Comment Themes

## Employee Safety

- Worried about personal safety, lack of security measures (cameras, badge access doors, police/security personnel, locked doors, parking garages, too many entry points)
- Workplace violence from patients and families

## Learning From Mistakes

- There is a desire to have better follow up/loop closure after reporting incidents & what changes are being made
- Action plans should be visible, so people know work is being done when they escalate concerns

## Psychological Safety

- Many staff feel safe speaking up, but worry there is not any action resulting from the concerns
- There is a sense that psychological safety does not apply to non-patient facing employees

## Just Response

- Lack of consistency with accountability was referenced at multiple campuses
- Appreciation for the Just Culture training was highlighted

## Reporting

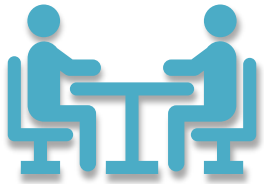
- Staff don't feel there is follow up or are unsure what the follow up is when events are reported
- Some participants feel concerned about retaliation when reporting safety events across all campuses

# Learning from Others – An Evolving Approach

## Listening Sessions

✓ **High Performing Departments:**
Learn & Share What is Going Well

✓ **Departments Needing Support:**
Clarify Opportunities for Improvement



## Leadership Pairing

Pair up High Performing Department Leaders with Departments Needing Support

Coach & Mentor Improvement

Share Lessons Learned

# Leadership Toolkit Development

## TRAINING

**Culture of safety survey question:** The patient safety-related training I receive is effective.

### Tips for leaders

- Include a patient safety topic in all staff meetings (NPSGs, HRO components, Culture of Safety, etc.)
- Invite a member of the Quality and Safety team to speak at a staff meeting. Email qualityteam@kumc.edu to coordinate.
- Encourage staff to consider Certified Professional in Patient Safety (CPPS) certification.
- Encourage employees who are also students to take courses from the Institute for Healthcare Improvement (IHI) Open School.
- Encourage attendance at the health system Patient Safety Symposium.
- Enroll staff in the following Helix courses:
  - Patient Safety Reminders
  - Defining Patient Safety
  - National Patient Safety Goals
  - The Safety Wheel: A Tool to Keep Patients Safe

**Resources**

Patient Safety | The Joint Commission

High Reliability | Joint Commission Resources (jcrinc.com)

National Patient Safety Goals | The Joint Commission

Patient Safety | IHI - Institute for Healthcare Improvement

Patient Safety Component (PSC) Training | NHSN | CDC

Education & Training for Health Professionals | Agency for Healthcare Research and Quality (ahrq.gov)

## VOICE

**Culture of safety survey question:** My input about patient safety is valued here.

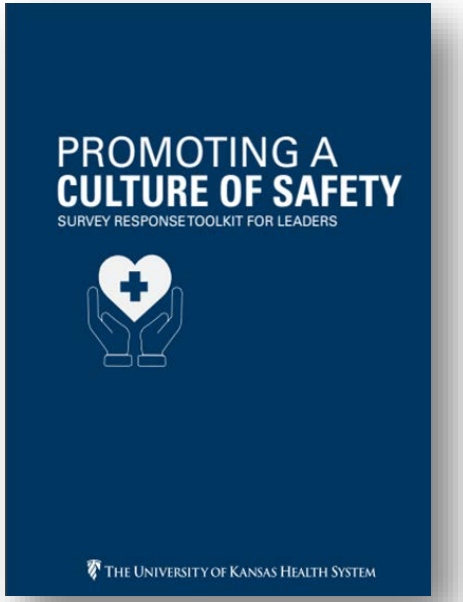
### Tips for leaders

- Highlight staff reporting safety risks and the impact of changes that have been made due to the reporting.
- Review Safety Intelligence event reports and leadership's response at staff meetings, etc.
- Follow up individually with staff who submit Safety Intelligence event reports. Thank them for reporting and provide a small token of appreciation (candy, snack, recognition in a staff meeting, etc.)
- Recognize employees for escalating "near miss" events through the Good Catch Program.
- Conduct a focus group with your staff to have them share safety concerns and ideas for resolution.
- Invite a member of the Quality and Safety team to speak at a staff meeting. Email qualityteam@kumc.edu to coordinate.

**Resources**

Safety Event Reporting Leadership Training in Helix

17




## PSYCHOLOGICAL SAFETY

**Culture of safety survey question:** I can speak up about patient safety without fear of retaliation.

### Tips for leaders:

- Orient new staff to the expectation that everyone is responsible for patient safety. Reinforce this message repeatedly with all employees. Use the organization's overall mission and value statements as the basis for establishing a unit-based mission/purpose statement about safe, high-quality care and service.
- Investigate and resolve conflicts between employees promptly. Keep performance expectations focused on the unit's shared purpose rather than on individual needs.
- Research all patient concerns brought to your attention through SI reports and follow-up with the employees to explain the resolutions. Be a role model for the accountability you wish to see among your employees. Focus on the process, not the people.
- Be visible and available for employees to speak privately with you if they are concerned about open discussion of a patient care situation.
- Seek to understand others' perspectives on what represents patient care concerns. Be open to listening and responding with encouragement. Be aware of your own bias and reactions, especially when repeated complaints or concerns are made. Employees will stop bringing concerns to your attention if they believe you are too busy to listen or will pass judgment before investigating.
- Educate staff on ways to raise concerns respectfully and appropriately, with the least amount of critical judgment, to create receptive listening.
- Foster an environment of inquiry, in which ideas are welcome and it is safe to question what goes on. Employees should feel free to question the effectiveness of practices affecting patient care and engage in problem-solving together to continuously improve outcomes.

**Resources**

**Helix:**
Psychological Safety Tip Sheets/e-learning

**Videos:**
Building a Psychologically Safe Workplace

AHA TeamSTEPPS Video Toolkit

**Articles:**
10 Tools to Develop Psychological Safety at Work

Setting the Stage for Psychological Safety: 6 Steps for Leaders

15 Ways To Promote Psychological Safety At Work (forbes.com)

Celebrate Good Catches More Often

Promote Huddles & Huddle Toolkit from Organizational Improvement

Offer More Active Shooter Training & Code Cart Training (Specific, Low-Hanging)

Continue Efforts on Workplace Violence Prevention, Highlight What Already Exists

Improve Lighting on Grounds/Parking Lots, Communicate When Additions Occur

When Supplies Change, Be Intentional About Asking for Frontline Participation & Feedback, Communicate It

Incorporate Review of Event Reports in Daily Huddles & Staff Meetings

Share Safety Stories More Often – Linking Action to Reporting of Events

# Safety Culture Performance Improvement Over Time

Establish Good Catch & HOPE (2nd Victim) Programs at New Campuses

Centralize or Align Safety Programs Across the Enterprise

Establish Consistent Safety Event Response Process

Establish Consistent Just Culture Principles Across the System

Help Connect Dots – What Already Exists & Relationship to Concepts Measured by Survey

Link New Initiatives to Culture of Safety Survey

Add Resources to the Toolkit

# Safety Culture Performance Improvement Over Time, Responding as a Health System

# References

National Steering Committee for Patient Safety. Declaration to Advance Patient Safety. Boston: Institute for Healthcare Improvement; May 2022. (Available at www.ihi.org)

Prioritizing safety as the foundation for staff engagement and retention in healthcare (pressganey.com)

Perception of safety culture in healthcare (pressganey.com)

Safety in healthcare 2024 (pressganey.com)

Leading_a_Culture_of_Safety_Blueprint.pdf (ihi.org)

# Questions?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