Prevention for Positives:

Improving the Culture of Safety within the Moore Clinic

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1 Background

A culture of a safety encompasses the attitudes and beliefs held within a workplace [1]. This includes how;

•open health care workers (HCWs) are to discussing patient safety issues and concerns with their colleagues and leaders

• safe HCWs feel about speaking up when they feel their patient is in danger,

•serious they believe their leadership is about patient safety.

A culture of safety relies heavily on communication, openness, and a shared responsibility [2].

In 2013, A Safety Culture Survey was conducted JHH-wide and was completed by 100% of Moore Clinic staff/providers. From this survey, the Moore Clinic learned that 59% of their respondents agreed with the following statement: **"The culture in the work setting makes it easy to learn from the errors of others."** In an effort to improve on this score, a follow up questionnaire which aimed to identify areas where interventions could be made to improve the safety culture within the clinic was created.

2 Methods

The questions asked in the Culture of Safety Questionnaire were designed to understand the clinic's current knowledge and attitudes about patient safety, ability to identify reportable events, and understanding of who to contact when there are patient safety concerns.

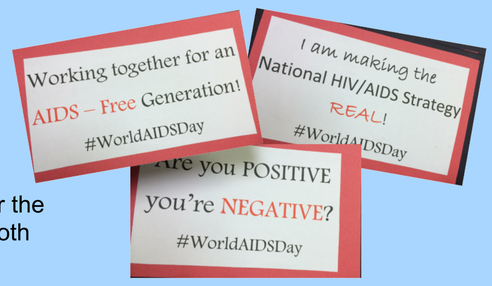
The overall goal was to collect and analyze the results to develop interventions geared at ***improving communication, reporting***, and ***sharing of errors*** within the Moore Clinic. A questionnaire to all Moore Clinic staff/providers via email was distributed.

3 Findings & Resulting Projects

As anticipated, the questionnaire findings provided valuable information for the development of a safety culture interventions within the Moore Clinic. The findings indicated a need for increased CUSP team awareness and transparency. Therefore, a decision was made to include all new interventions under the Comprehensive Unit-based Safety Program (CUSP) "Culture of Safety" clinic promotion plan. A brief description of these interventions are listed below.

- Summarized & presented questionnaire results to in-clinic staff
- Created an electronic messaging plan to introduce the Moore Clinic CUSP team and communicate results to offsite staff
- Incorporated a dedicated timeslot within Monthly staff meetings to discuss CUSP team initiatives and gather feedback from staff
- Created an in-clinic CUSP team bulletin board for ongoing in-clinic announcements and JHH training opportunities on patient safety
- Developed a standard electronic handoff note for reporting of Moore Clinic patient information between outpatient clinic nurse to inpatient nurse
- Created a revised World AIDS Day program at JHH which included 25% staff participation in the creation of a "Facing AIDS" photo booth activity, Creation & distribution of > 200 AIDS awareness ribbons, and the creation of unique program signage

Picture of tables in Herd Hall for the annual World AIDS Day Event



Picture of signs used for the "Facing AIDS" photo booth activity

4 Effects on Staff Attitudes & Beliefs

According to a recent Safety Attitudes Questionnaire, the Moore Clinic received strong scores in areas related to culture of safety. More specifically, an increase in knowledge about how to communicate safety concerns was also observed. We believe this improvement is due to initiatives implemented by the CUSP "Culture of Safety" clinic promotion plan. As such, patient safety discussions will continue to occur during monthly staff meetings and feedback collected from these meetings will be used to generate additional projects.

HIGHEST/LOWEST ITEMS — view all

[1] Negatively worded question. Lower scores are better.

Highest Scoring Items	% Positive	Change
1 I know the proper channels to direct questions regarding patient safety in this work setting.	96	+4
2 Practice management (e.g., practice administrators, office medical directors, managers) doesn't knowingly compromise the safety of patients.	96	0
3 In this work setting, it is difficult to speak up if I perceive a problem with patient care.[1]	10	--

5 Future Directions

Future directions for this project may include:

- Quarterly assessment of safety culture through online surveys
- Use of EPIC flowsheets to generate reports aimed at proactively identifying & monitoring areas for improvement (medication adherence, missed appointments, upcoming refills, etc)
- Continued use of monthly staff meetings to discuss patient safety concerns and identify areas that need attention

6 References

[1] Center for Innovation in Quality Patient Care (2015). Culture of Safety. Johns Hopkins Medicine. Retrieved from http://www.hopkinsmedicine.org/innovation_quality_patient_care/areas_expertise/improve_patient_safety/culture/

[2] Cosby, K. and Croskerry, P. (2004). Profiles in patient safety: Authority gradients in medical error. *Academic Emergency Medicine, 11,* 1341-1345.

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