2009 Culture of Safety Survey

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Background and Method

- Downstate personnel were administered a five-page questionnaire via secure website
- 518 responses - approximately 19% response rate
- 72% have direct contact with patients
- 31% in nursing, 8% periop/OR services
- Chief areas covered:
  - Work/area unit
  - Supervisor/manager
  - Communications
  - The hospital as a whole
  - Frequency/circumstances of reportage
  - Graded assessment of “Culture of safety”
My Work Area/Unit

Opportunity areas: Staffing, and perception that improvement is construed as criticism
Strengths: Active, improvement-oriented culture focusing on evaluation
Opportunity: Communicating when a good job is done.
Strength: We do not overlook patient safety problems that recur
In this unit, error prevention is discussed. We are informed re: errors that happen in this unit. Staff feel free to question decisions/actions of authorities. Staff are afraid to ask questions when something seems wrong.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Percent Who Strongly</th>
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<tr>
<td>We are informed re: errors that happen in this unit</td>
<td>50.0%</td>
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<td>In this unit, error prevention is discussed</td>
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<tr>
<td>Staff are afraid to ask questions when something seems wrong</td>
<td>10.0%</td>
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<td>Staff feel free to question decisions/actions of authorities</td>
<td>20.0%</td>
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Opportunity: Questioning is always essential toward maintaining a “culture of safety”.
Strength: Communication of errors and discussion of their prevention.
How Frequently are Events Reported When A Mistake is Made?

- **Mistake has no pt. harm potential**
  - Never: 10.0%
  - Always: 30.0%

- **Mistake is caught/corrected before affecting pt.**
  - Never: 5.0%
  - Always: 45.0%

- **Mistake has pt. harm potential, but does not harm the patient**
  - Never: 5.0%
  - Always: 60.0%

**Opportunity:** Non-harmful errors require reportage, lest they become harmful.

**Strength:** Potentially harmful errors are reported, even if they do not harm the patient.
The actions of hospital mgmt. show that pt. safety is a top priority. Mgmt. provides a work environment that promotes pt. safety. Hospital units work together to provide best care. Problems often occur in cross-unit communication. Things “fall between cracks” when transferring pts. across units. Shift changes are problematic for pts. in this hospital.

**Opportunity:** Cross-unit communication and shift-change communication are easily fixable problems.  
**Strength:** Patient Safety is a top priority of management, which also ensures a “climate of safety”
Almost two thirds of respondents give UHB a “very good” or “excellent” culture of safety grade.
The average tenure at UHB was 10.8 years (median, 8.2)
The average time spent in the work unit – 8.6 years (median, 6.6)
Conclusions

- The “Culture of Safety” is alive and well at Downstate.
- We do well in possessing a proactive, evaluation-oriented culture, where we discuss how to prevent errors from occurring.
- Improvement can be made in communication across units, at tour-change time, and in emphasizing that proposed improvements are NOT meant as personal critiques.