

Ideas and Incentives for Promoting Safety Culture



“... Improving the usefulness of [incident reporting] systems is critical to hospital efforts to improve patient safety.”

Department of Health and Human Services Office of the Inspector General

The Joint Commission renewed focus on patient safety in 2017 when it issued a Sentinel Alert¹ stating failure by leadership to create an effective safety culture contributes to adverse events.

The Joint Commission’s findings followed evidence released in 2016 by the Agency for Healthcare Research and Quality (AHRQ) that showed positive correlation between the strength of a hospital’s safety culture and its patient safety improvement,² and came after the National Patient Safety Foundation (NPSF) presented new recommendations³ for hospital incident reporting systems. Common bonds among these and

other studies are that leadership drives culture, and culture is key to improving quality and safety.

No one will say they are against safety culture, but is your organization doing enough for it? Safety culture needs to be nurtured. It also needs processes that promote it, and systems that support the processes.

What Is Needed?

Culture, processes and systems have all been identified as key components for improving patient safety. The Joint Commission stated *“The Joint Commission’s Sentinel Event Database reveals that leadership’s failure to create an effective safety culture is a contributing factor to many types of adverse events – from wrong site surgery to delays in treatment.”*⁴ It specifically cited shortcomings in reporting processes and systems as contributing factors. These shortcomings include:

- Maintaining a non-punitive culture
- Not providing positive support for patient event reporting
- Insufficient feedback to staff who report safety vulnerabilities and events

How Does Incident Reporting Help?

Modern incident reporting systems can mitigate these shortcomings. *“Because hospitals rely on incident reporting systems to track and analyze events, improving the usefulness of these systems is critical to hospital efforts to improve patient safety”* is one of the conclusions of a Department of Health and Human Services Office of the Inspector General (OIG) report.⁵

AHRQ data seem to validate the link between improving reporting and improving safety. Among hospitals that completed its Hospital Survey on Patient Safety Culture in both 2014 and 2016, the average hospital that had an increase in the number of staff members who had reported at least one incident improved its safety culture score five times more than the average hospital that had not increased its number of staff members reporting incidents.⁶ The two groups average 5 percent improvement and 1 percent improvement, respectively, indicating that on average, hospitals that improved reporting had five times more improvement in their safety culture than those that did not.

Putting Innovation Into Practice

Anecdotes also support the belief that improving reporting, and establishing a culture to encourage it, improves safety and quality. Here are some results that hospitals achieved after updating their reporting systems:

- **Arkansas Children’s Hospital** averaged a **500 percent** monthly increase in reported incidents
- **Ochsner Health System** achieved a **49 percent** reduction in wrong patient/procedure/site/test errors
- **Brigham & Women’s** was already recognized as a leader in patient safety, yet attained a **25 percent** increase in reported patient safety events
- **Bridgepoint Health** increased its good catch reporting by **400 percent**
- **North Shore Medical Center** improved morale and employee satisfaction – **77 percent** of employees said feedback about actions being taken from reported incidents reassured them that improvements are being made

Results from the field and recommendations from researchers and practitioners make a compelling case for aligning culture, processes and systems to improve safety event reporting. Here are some effective and creative ways hospitals are achieving positive results.

- **Bassett Medical Center** began conducting daily, 15-minute blame-free safety huddles to reinvigorate an incident reporting program that had lost momentum. Bassett credits the huddles with contributing to a **51 percent** increase in incident reporting and for identifying 20 to 30 system and process improvements to pursue each quarter; **88 percent** of huddle participants believe safety issues are corrected more quickly.⁷
- The Joint Commission has endorsed the practice of patient safety walks (a.k.a., WalkRounds) in which senior leaders regularly visit patient care departments to observe and have informal

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The Joint Commission

discussions about safety issues. **Maine Medical Center** implemented the practice to show its commitment to its patient safety culture. Unit directors receive questions to consider before each scheduled Patient Safety Executive WalkRound. Maine Medical Center enters information from WalkRounds into the organization’s safety reporting system, which helps staff analyze and prioritize any identified issues. Reports on the priority issues are shared monthly with the board of directors.

- Many facilities have successfully implemented “good catch” programs to encourage and reward near miss reporting. Such programs put reporting in a positive light and help reinforce the safety culture. The Joint Commission recommended the use of good catch programs in its Sentinel Event Alert on patient safety culture.⁸ **Partners Continuing Care** is a good example of a successful program. Partners created its Good Catch of the Month program to honor the employees who made the best submissions to its incident reporting system where no harm reached the patient.⁹ **Memorial Health Systems** took an interesting approach to encouraging incident reporting by making submitting an incident report a requirement for its residents.

Why Systems Matter

Incident reporting systems are an essential enabler for safety culture and reporting programs to deliver positive results. The Joint Commission, AHRQ and others have cited the importance of incident reporting systems and provided guidance on what capabilities are valuable or necessary to drive improvements. A follow-up to the Institute of Medicine *To Err Is Human* report made the following conclusion:

“The future of incident reporting lies in targeted incident reporting, effective triaging and robust analysis of the incident reports and meaningful engagement of doctors. Incident reporting must be coupled with visible, sustainable action and linkage of incident reports to the electronic health record. If the healthcare industry wants to learn from its mistakes, miss or near miss events, it will need to take incident reporting as seriously as the health budget.”¹⁰

The Joint Commission emphasizes that incident reporting capabilities should be widely available throughout the organization:

“This reporting system should be accessible to everyone within the organization. Having this system is essential for developing a culture in which unsafe conditions are identified and reported without fear of punishment or reprisal for unintentional mistakes, leading to proactive prevention of patient harm.”

What Can You Do Next?

There are several steps hospitals can take to determine if their incident reporting programs align with current guidance and promote a safety culture.

- Consider adding proven, low-risk, low-cost practices like safety huddles and rewarding good catches while you conduct a more thorough review of your culture, processes and systems
- Secure a senior-level champion to support incident reporting; the Joint Commission emphasized the importance of doing so, and its accreditation manuals for hospitals and critical care systems include this [Patient Safety Systems](#) chapter that lists specific leadership requirements
- Take an [AHRQ Survey on Patient Safety Culture™ Survey](#) to benchmark your operations against others
- Review the citations in this brief and other literature
- Contact [RL Solutions](#) for more information about incident reporting systems, including the free Patient Safety Awareness Toolkit to promote incident reporting

Culture is essential for protecting and improving patient safety, but it is not enough. Culture, processes and systems all need to be part of the solution; consider all three elements when planning quality and safety improvements. As the examples and findings in this brief show, innovative processes and incident reporting systems can nurture the safety culture throughout an organization and enhance specific initiatives to improve safety as quality.

- 1 Joint Commission Sentinel Event Alert “The essential role of leadership in developing a safety culture” Issue 57, March 1, 2017.
- 2 Agency for Healthcare Research and Quality “Hospital Survey on Patient Safety Culture: 2016 User Comparative Database Report” March 2016. AHRQ Publication No. 16-0021-EF.
- 3 National Patient Safety Foundation “Free From Harm: Accelerating Patient Safety Improvement Fifteen Years After To Err is Human” 2015.
- 4 Smetzer J, et al. Shaping systems for better behavioral choices: lessons learned from a fatal medication error. Joint Commission Journal on Quality and Patient Safety. 2010;36:152-163.
- 5 Department of Health and Human Services Office of the Inspector General Hospital Incident Reporting Systems Do Not Capture Most Patient Harm. January 2012 OEI-06-09-00091.
- 6 Agency for Healthcare Research and Quality “Hospital Survey on Patient Safety Culture: 2016 User Comparative Database Report” March 2016. AHRQ Publication No. 16-0021-EF.
- 7 Hospitals in Pursuit of Excellence “Bassett Medical Center – Improving Patient Safety in 15 Minutes a Day” online case study accessed May 18, 2017, from <http://www.hpoe.org/resources/case-studies/2817>.
- 8 Joint Commission Sentinel Event Alert “The essential role of leadership in developing a safety culture” Issue 57, March 1, 2017.
- 9 RL Solutions “Made to Measure” case study on Partners Community Care. Accessed May 18, 2017, from <http://www.rlsolutions.com/RLSolutions/media/pdf/caseStudies/Made-to-Measure.pdf?ext=.pdf>.
- 10 Mitchell I, Schuster A, Smith K, Pronovost P, Wu A. Patient safety incident reporting: a qualitative study of thoughts and perceptions of experts 15 years after ‘To Err is Human.’ BMJ Quality & Safety. Published Online First: July 27, 2015. doi:10.1136/bmjqs-2015-004405B.



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