Creating a culture shift for safety

Less focus on checking off boxes, more focus on teamwork. That’s the shift experts say is needed to make lasting change to keep patients safer in surgery.

The new study from the Veterans Health Administration finds OR team training was associated with a reduction in patient mortality (related article). VA facilities closed their ORs and mandated 4 hours of teamwork instruction. They also began using briefings and debriefings.

Much of the focus in patient safety in the OR has been on specific tools—checklists, briefings, and debriefings.

But it’s more involved than that, stresses a patient safety expert from Johns Hopkins.

Just marking boxes on a checklist isn’t likely to bring a shift in culture. Nor are top-down efforts like mandating the time-out before surgery, says Sean Berenholtz, MD, MHS, FCCM. “It becomes a check-the-box exercise” without buy-in from front-line clinicians.

An associate professor in the Johns Hopkins School of Medicine and Bloomberg School of Public Health, Dr Berenholtz is working with over 100 hospitals in Michigan to improve OR safety through Keystone Surgery, a project of the Michigan Health & Hospital Association. Robert J. Welsh, MD, a surgeon at William Beaumont Hospital in Royal Oak, Michigan, is coleading the program.

What does make a difference?

Front-line nurses, physicians, and other staff have to be engaged in identifying and addressing what could harm patients at the unit level, he emphasizes.

This engagement, not checklists alone, he says, is what led to the dramatic and widely discussed reduction in central line-associated bloodstream infections (CLABSI) in Michigan ICUs (Pronovost P et al, N Engl J Med. 2006;355:2725-2732). The results have been sustained for 3 years. A new project is spreading these strategies to hospitals in all 50 states.

In the CLABSI project and in Keystone Surgery, clinicians are engaged using a model called CUSP, for Comprehensive Unit-Based Safety Program, developed at Johns Hopkins (sidebar). Keystone Surgery involves OR teams through presentations, conference calls, and sharing processes and stories. Projects include briefings and debriefings, the specimen process, and loaner instrumentation. Leaders have conducted focus groups and summits to learn from clinicians about challenges they face and effective methods to overcome them.

In just over a year, Keystone Surgery has found 60% of the teams reported better teamwork scores than when the project began, and 59% had better safety scores.
Engaging physicians, nurses

Dr Berenholtz and Mary Murphy, RN, BSN, CNOR, project manager for Keystone Surgery, shared a few strategies for engaging physicians and nurses.

• Secure senior leadership commitment. Senior leaders sign a letter of commitment agreeing to partner with front-line clinicians. They participate in meetings and conference calls and spend time on patient units. Because one of the barriers to participation is time, they also agree that CUSP teams will have 10% protected time to work on safety-related activities.

• Provide education. Teams are educated in the science of safety and learn to use practical tools like briefings and debriefings.

• Engage clinicians with a safety assessment that asks 2 questions:
  —How will the next patient in your clinical area be harmed?
  —What can we do to prevent or minimize this harm?

  Asking these questions typically generates an “overwhelming response,” Dr Berenholtz says. “Allowing providers to share what they think about patient safety hazards and how to prevent them sends a clear message—your opinion and ideas are essential to improving in this area; it’s what is meaningful to them.”

• Think about “what’s in it for me,” particularly for surgeons. How will participating in safety efforts benefit them?

  One way to gain buy-in from front-line staff is to use briefings and debriefings to identify defects and then take steps to fix them. Teams are urged to collect and log data on defects mentioned, such as faulty equipment, specimen issues, and process problems. Leaders then partner with front-line staff set to correct the defects.

  “This clearly requires resources,” Dr Berenholtz says.

  But it goes a long way toward demonstrating to clinicians that if they participate in briefings and debriefings, “their issues are going to be heard and addressed.”

  He adds that clinicians “need to see tangible organizational commitment to this work.

  “If they don’t, it’s unlikely they will commit to this work either.”

—Pat Patterson

References


What is CUSP?

CUSP, or the Comprehensive Unit-Based Safety Program, is a model developed at Johns Hopkins to empower front-line clinicians in improving patient safety.

CUSP teams, which involve all disciplines, identify safety concerns, learn about successful approaches and tools, initiate solutions, and perform regular safety assessments.
The 6-step CUSP process:
1. Evaluate a hospital’s culture of safety.
2. Educate staff on the science of safety.
3. Identify defects from safety surveys and incident reports.
4. Assign an executive to “adopt” a unit.
5. Learn from 1 identified defect each month.
6. Assess the culture of safety regularly.

Resources
Agency for Healthcare Research and Quality
www.innovations.ahrq.gov/content.aspx?id=1769

Johns Hopkins
www.hopkinsmedicine.org/innovation_quality_patient_care/services/consulting/patient_safety_cusp.html