

Nursing Home Survey on Patient Safety Culture (NH SOPSC) Results and Communication Tools

March 10, 2011

Joe Bestic, NHA, BA
Elaine Nelson, RAC-CT
Deb Stirnaman, RAC-CT
Health Services Advisory Group, Inc.

1

Background on the Nursing Home Survey

- An expansion of the Agency for Healthcare Research and Quality (AHRQ) *Hospital Survey on Patient Safety Culture*
www.ahrq.gov/qual/hospculture
- Specifically designed to measure the culture of resident safety in nursing homes from a staff perspective
 - Assesses staff attitudes and beliefs about resident safety
 - Assesses many areas similar to the hospital survey, but items are different
- Pilot-tested in 2007 in 40 U.S. nursing homes, with 3,698 respondents; final survey released on AHRQ Web site in 2008

2

Arizona Aggregate Baseline and Remeasurement Factoids

Baseline NH SOPSC

- Conducted in 2009 in 19 Arizona nursing homes, with 809 respondents
- Average number of returned surveys per facility = 45

Remeasurement NH SOPSC

- Conducted in 2010 in 18 Arizona nursing homes, with 880 respondents.
- Average number of returned surveys per facility = 49

3

Assesses 12 Areas of Resident Safety

Survey Areas:

1. Overall Perceptions of Resident Safety
2. Feedback and Communication About Incidents
3. Supervisor/Manager Expectations and Actions Promoting Patient Safety
4. Organizational Learning
5. Management Support for Resident Safety
6. Training and Skills
7. Compliance With Procedures
8. Teamwork
9. Handoffs
10. Communication Openness
11. Nonpunitive Response to Mistakes
12. Staffing

Two overall rating questions:

- Whether staff would tell friends this is a safe nursing home for their family
- Overall rating on resident safety

4

Nursing Home Survey on Patient Safety Culture (NH SOPSC)
Results and Communication Tools

Comparison Data

Patient Safety Culture Area	AZ Aggregate Baseline % Positive	AZ Aggregate Remeasurement % Positive	NH Pilot Study Comparison: Average % Positive
1. Overall Perceptions of Resident Safety	83	82	87
2. Feedback and Communication About Incidents	81	79	85
3. Supervisor/Manager Expectations and Actions Promoting Patient Safety	76	76	81
4. Organizational Learning	68	67	76
5. Management Support for Resident Safety	68	67	72
6. Training and Skills	63	62	72
7. Compliance With Procedures	58	57	67
8. Teamwork	64	62	67
9. Handoffs	56	56	63
10. Communication Openness	51	50	58
11. Nonpunitive Response to Mistakes	43	42	55
12. Staffing	48	47	48

5

Information for Health Care Improvement

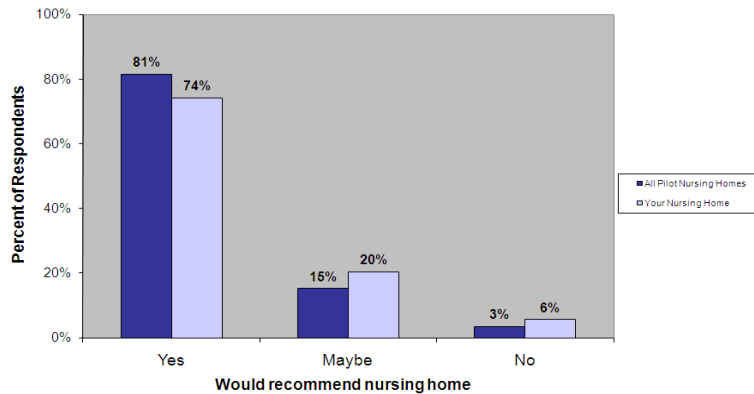
HSAG

Baseline: Nursing Home Recommendation

Recommendation to Friends Comparative Results

AZ Baseline AHRQ NH SOPSC Aggregate Results

Would tell friends that this is a safe nursing home for their family.
(Survey Item E1)



6

Information for Health Care Improvement

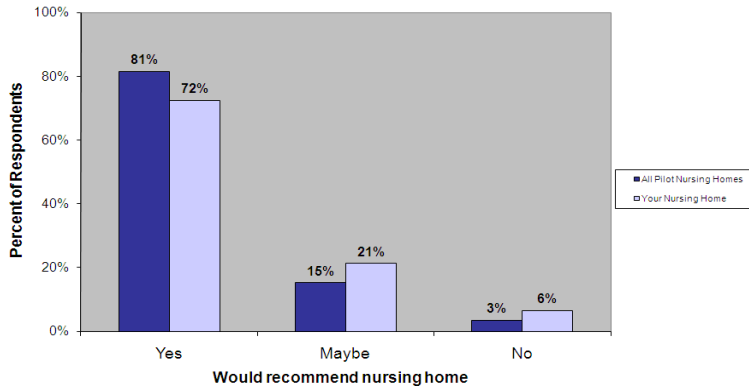
HSAG

Nursing Home Survey on Patient Safety Culture (NH SOPSC)
Results and Communication Tools

Remeasurement: Nursing Home Recommendation

Recommendation to Friends Comparative Results

AZ Remeasurement AHRQ NH SOPSC Aggregate Results
I would tell friends that this is a safe nursing home for their family.
(Survey Item E1)



7

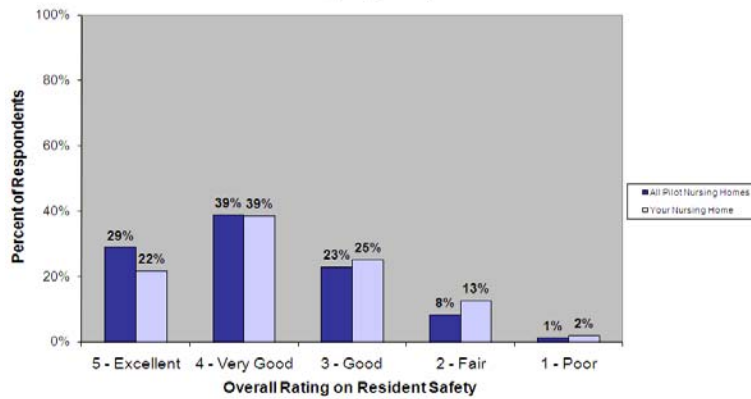
Information for Health Care Improvement

HSAG

Baseline: Overall Rating on Resident Safety

Overall Rating on Resident Safety Comparative Results

AZ Baseline AHRQ NH SOPSC Aggregate Results
Please give this nursing home an overall rating on resident safety.
(Survey Item E2)



8

Information for Health Care Improvement

HSAG

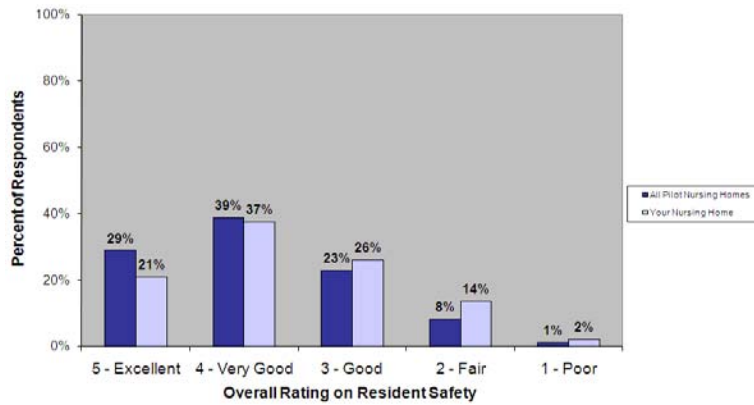
Nursing Home Survey on Patient Safety Culture (NH SOPSC)
Results and Communication Tools

Remeasurement: Overall Rating on Resident Safety

Overall Rating on Resident Safety Comparative Results

AZ Remeasurement AHRQ NH SOPSC Aggregate Results

Please give this nursing home an overall rating on resident safety.
(Survey item E2)



9

Information for Health Care Improvement

HSAG

Addressing Communication In Long-Term Care

10

Information for Health Care Improvement

HSAG

Incidents Surrounding Communication

Ineffective communication is a root cause for nearly 66 percent of all sentinel events reported.

*JCAHO Root Causes and Percentages for Sentinel Events (All Categories)
January 1995–December 2005*

11

Communication Tools



12

Silence Kills: The Seven Crucial Conversations for Health Care

www.silencekills.com

- American Association of Critical-Care Nurses (AACN)
- VitalSmarts: A company specializing in organizational performance that provides research and consulting services
- www.vitalsmarts.com

13

Silence Kills: The Seven Crucial Conversations for Health Care (cont'd)

- This national study initially involved focus groups, interviews, and workplace observations.
- This was followed by the collection of survey data of more than 1,700 physicians, nurses, clinical-care staff, and administrators during 2004.
- Research sites included 13 urban, suburban, and rural hospitals.
- The study identified categories of conversations that are difficult, yet essential to address in health care.

14

Silence Kills: The Seven Crucial Conversations for Health Care *(cont'd)*

- Broken rules
- Disrespect
- Incompetence
- Lack of support
- Mistakes
- Micromanagement
- Poor teamwork

15

The Seven Crucial Conversations for Health Care *(cont'd)*

- > 50 percent of the health care workers saw the occurrence of at least one of these categories.
- < 10 percent fully discussed their concerns with the coworker.
- About 50 percent said their concerns persisted for a year or more.
- 20 percent of physicians said they had seen harm come to a patient as a result of these concerns.

16

The Seven Crucial Conversations for Health Care *(cont'd)*

- 23 percent of nurses said they were considering leaving their units because of these concerns.
- The 10 percent who were confident in their ability to raise concerns observed better patient outcomes, were more satisfied, and were more committed to stay with their jobs.
- Implications: If more health care workers learned to do what the 10 percent do, there would be significantly fewer errors, higher productivity, and lower turnover.
- www.silencekills.com

17

***A crucial conversation is a
problem that needs to be worked
out through dialogue.***

***If you don't talk it out,
you will act it out.***

18

What is Crucial Conversations?

- Tools for talking when the stakes are high
- Everyday conversations when the stakes are high, opinions vary, and emotions are strong

19

The Three Elements That Make Up a Crucial Conversation



20

What Is Crucial Conversations About?

Crucial Conversations is about a set of dialogue skills that helps you to be 100 percent candid and 100 percent respectful while obtaining positive outcomes, solving problems, and enhancing relationships.

21

What Crucial Conversations Is Not About

- Debating
- Word games
- Deception
- Compromise
- Manipulation
- Winning

22

The Sucker's Choice: Two Bad Options "Either/Or" Thinking

- We create false dilemmas
 - Either we tell people the truth and offend or we water down the truth and keep the peace

23

Start With Heart: Avoiding The Sucker's Choice

- Go from “either/or” thinking to “and” thinking:
 - Clarify what you want to achieve.
 - Clarify what you want to avoid.
 - Combine the two into an “and” question by asking, “**I wonder how** I can tell Dr. Jones about not using wet-to-dry dressings **and avoid** making him angry?”

24

Start With Heart *(cont'd)*

- Work on “me” first.
- Focus on what we really want.
- Refuse the Sucker’s Choice by moving from “either/or” to “and” thinking by asking “I wonder how...”

25

Learn to Look

How to notice when safety is at risk

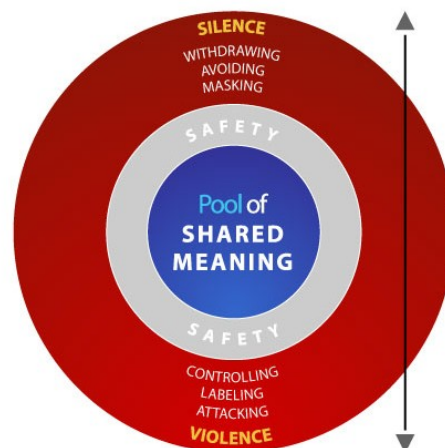
26

Learn To Look Skills

- Learn to look when a conversation becomes crucial.
 - When a conversation becomes crucial, we either miss or misinterpret the early warning signs.
- Learn to look for silence or violence.
- Learn to look for your own style under stress.

27

Silence or Violence Model



28

Learn to Look—When Conversations Turn Crucial

- **Silence:** Purposely withholding information from the pool of shared meaning
- **Examples:**
 - Masking
 - Avoiding
 - Withdrawing

29

Learn to Look (cont'd)

- **Violence:** Forcing one's point of view into the pool of shared meaning
- **Examples:**
 - Controlling
 - Labeling
 - Attacking

30

Make It Safe

*How to make it safe to talk about
almost anything.*

*When it comes to safety, it's all
about **intent, not content.***

31

Make It Safe (cont'd)

- Establish Mutual Purpose: The entrance condition of dialogue
 - Do others believe I care about them?
 - Do others believe I care about their interests?
 - Do others trust my motives?

32

Make It Safe (cont'd)

- Establish Mutual Respect: The continuance condition of dialogue
 - You are worthy of being treated civilly and vice versa.
 - Do others believe I respect them?

33

Make It Safe—CRIB

- Commit to seek mutual purpose.
- Recognize the purpose behind the strategy.
- Involve a mutual purpose.
- Brainstorm new strategies.

34

Make It Safe (cont'd)

- **Apologize when appropriate initially.**

“A stiff apology is a second insult . . . The injured party does not want to be compensated because he has been wronged; he wants to be healed because he has been hurt.”

—G. K. Chesterton

- **Contrasting**—State what you **don't** intend and what you **do** intend to avoid misunderstandings.

35

Master My Stories

How to stay in dialogue when you're angry, scared, or hurt.

How to master emotions and return to dialogue.

36

Master My Stories Skills

- Separate facts from stories.
- Watch for three clever stories.
- Tell the rest of the story.

37

Master My Stories (cont'd)

- Separate facts from stories.
 - Facts are visible and audible. Facts are scientifically verifiable.
 - Stories are judgments, conclusions, and attributions that we make from facts.

38

Master My Stories (cont'd)

- Watch for three clever stories we tell ourselves:
 - Victims—“It’s not my fault.”
 - Villains—“It’s all your fault.”
 - Helpless—“There’s nothing else I can do.”

39

Master My Stories (cont'd)

Our stories create our emotions, we create our stories. First you control your story. Then your story controls you. If you want to change your results, change your story.

40

Master My Stories *(cont'd)*

- Tell the rest of the story.
 - You've retraced your path to action
 - Separated facts from stories
 - Recognized Victim, Villain, Helpless stories
 - Ask, "Why would a reasonable, rational and decent person do this?"
 - New more accurate and complete stories create new feelings, which support new and healthier actions
 - New stories encourage you to return to dialogue 41

Just Culture

- Console
- Coach
- Punish

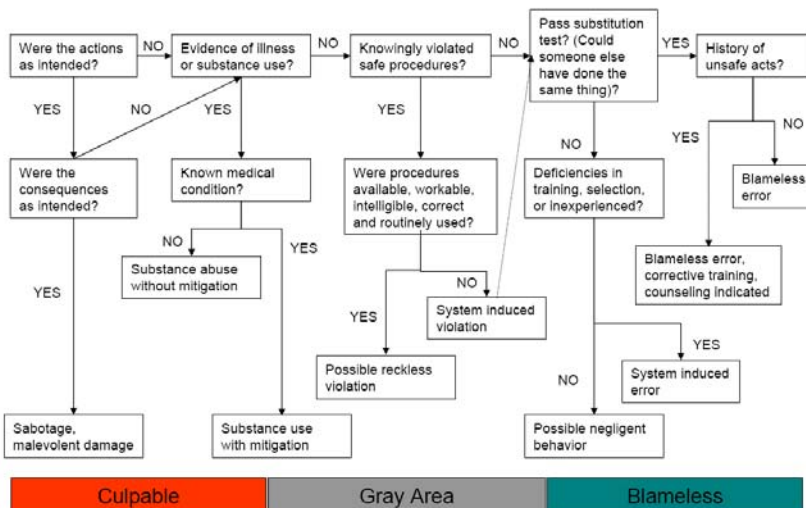
Event Accountability

“To promote a culture in which we learn from our mistakes, organizations must re-evaluate just how their disciplinary system fits into the equation. Disciplining employees in response to honest mistakes does little to improve overall system safety. Yet, mishaps accompanied by intoxication or malicious behavior presents an obvious and valid objection to today’s call for blame-free error reporting systems.”

43

David Marx, 2001

UNSAFE ACTS ALGORITHM



Adapted from James Reason. (1997). Managing the Risks of Organizational Accidents.

44

Remedial Actions

- Strong
 - Create leadership involvement and action
 - Simplify the process
 - Standardize process and equipment
- Intermediate
 - Create checklist or other cognitive aid
 - Reduce distractions
- Weak
 - Training
 - New procedure
 - Additional study

45

Accountability: Human Error

Human error is a social label.

It may be characterized as follows: When there is general agreement that the individual should have done other than what they did, and in the course of that conduct inadvertently causes or could cause an undesirable outcome, the individual is labeled as having committed an error.

Human error is a term that we use to describe our everyday behavior.

46

David Marx, 2001

Getting Inside the Tunnel

47

Search for Information for Health Care Improvement

<u>Outside the Tunnel</u>	<u>Inside the Tunnel</u>
<ul style="list-style-type: none">▪ Outcome determines culpability.▪ “Look at this! It should have been so clear!”▪ We judge people for what they did.	<ul style="list-style-type: none">▪ Quality of decisions not determined by outcome.▪ Realize evidence does not arrive as revelations▪ Refrain from judging people for errors

48

Information for Health Care Improvement

Questions?

49

Contact Information

Joe Bestic, NHA, BA
HSAG Director, Nursing Home
jbestic@hsag.com
Phone: 602.801.6930
Fax: 602.241.0757

Elaine Nelson, RN, RAC-CT
HSAG Clinical Quality Specialist
enelson@hsag.com
Phone: 602.801.6933

Deb Stirnaman, LPN, RAC-CT
HSAG Clinical Quality Specialist
dstirnaman@hsag.com
Phone: 602.801.6932



50

Nursing Home Survey on Patient Safety Culture (NH SOPSC)
Results and Communication Tools

Over 1 million drug-related injuries occur every year in health care settings. The Institute of Medicine estimates that at least a quarter of these injuries are preventable.

To find out how to prevent medication errors, go to
<http://www.hsag.com/drugsafety/>.



www.hsag.com

This material was prepared by Health Services Advisory Group, the Medicare Quality Improvement Organization for Arizona, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.
Publication No. AZ-9SOW-6.2.2-030911-01

51