

In an era when patient safety has become front-page news and the health care industry is striving to incorporate safer patient-care practices, one of the most difficult barriers to overcome is the disconnect between staff on the perceptions of patient safety within organizations.

New technologies and procedural implementation have emerged to address and reduce errors, but these efforts require support from the top down to be successful. When staff have differing views of patient safety, consensus on how to combat errors cannot be reached, and improvement efforts cannot be fully implemented.

In order to improve patient safety, staff within health care organizations must be on the same page. Establishing a culture of safety is the best way to unify staff and ultimately create a safer environment for patients.

The Costs of Medical Errors

With the financial and human costs of errors rising, the pressure to improve patient safety is growing. Hospital-acquired infections (HAIs) cost the health care industry an estimated \$5 billion annually, and medical errors are estimated to cost between \$17 and \$29 billion a year.ⁱ

The Centers for Medicare and Medicaid Services (CMS) responded by expanding a program that ties Medicare payments for health care services to quality of care: the Hospital-Acquired Conditions Initiative.ⁱⁱ As of October 1, 2008, CMS is no longer reimbursing the costs associated with the following preventable “Serious Reportable Adverse Events”:

- Catheter associated urinary tract infections
- Certain falls and trauma (e.g., fractures, dislocations, intracranial injuries, crushing injuries, burns)
- Foreign object inadvertently left in patient after surgery
- Incompatible blood/blood products
- Intravascular air embolism
- Pressure (decubitus) ulcers
- Surgical site infection—mediastinitis (after coronary artery bypass graft surgery)
- Vascular catheter associated infectionⁱⁱ
- Certain manifestations of poor blood sugar level control
- Deep vein thrombosis/pulmonary embolism following post-total knee replacement and hip replacement surgeries
- Surgical site infection post certain elective surgeries (e.g., certain orthopedic surgeries and bariatric surgery for obesity)ⁱⁱⁱ

Errors and HAIs cost more than money; they cost lives. Unfortunately, the industry has not seen a reduction in the 44,000 – 98,000 lives affected each year, as reported in the report by the Institute of Medicine (IOM), *To Err is Human*.^{iv} One of the most important points the IOM makes in the report is that errors and HAIs are preventable.^{iv}

The Challenge to Adopting a Culture of Safety

In order to eliminate preventable errors and infections, many organizations, including the IOM, the National Quality Forum, the Agency for Healthcare Research and Quality, the Joint Commission, and the Leapfrog Group support the principle that the health care industry must work to create and uphold a culture of safety. However, one of the challenges facing facilities that set out to create a culture of safety is the struggle to create cohesiveness among staff. Front-line staff, physicians, managers, and administrators have been found to hold very different views of safety, even within the same unit or department.^v

Graph 1



Based on the responses of 39,281 staff at 64 Press Ganey Safety Culture client sites as of August, 2008.

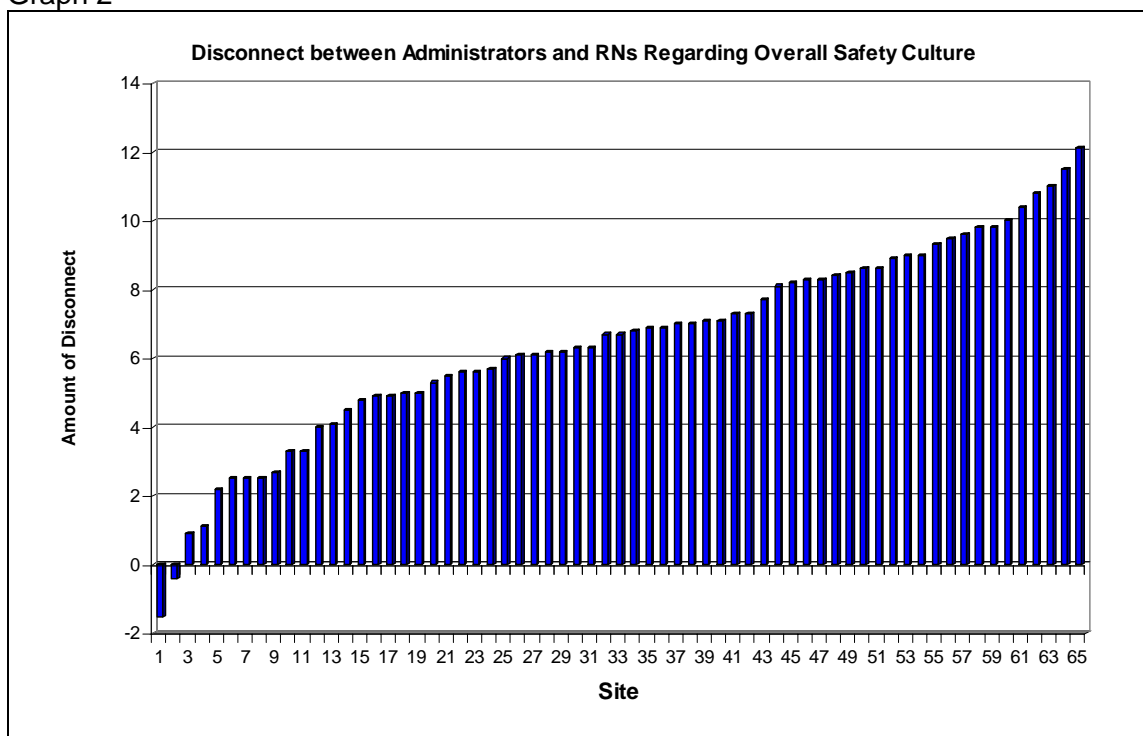
At the national level, as illustrated in Graph 1, managers have, by a wide margin, the highest regard for their organizations' safety culture. Conversely, respiratory therapists and physician assistants/nurse practitioners report the lowest overall perception of safety.

Disconnects Between Management and the Front Line

Graph 1 shows that, at the national level, administrators and registered nurses (RNs) have dramatically different perceptions of safety. As this disconnect may be the source of miscommunications and a lack of understanding, or transparency, between these important groups, we chose to examine this discrepancy more closely.

Graph 2 illustrates the enormous disconnect between a single organization's RNs and administrators when it comes to safety culture. Differences in mean scores for RNs and administrators/managers were computed hospital-by-hospital and subjected to paired-comparison t-tests. Each bar illustrates the difference between the safety perceptions of RNs and administrators from the same hospital. Bars above zero indicate that administrators rated their hospital's safety culture more positively than RNs at the same hospital.

Graph 2



Based on the responses of 12,411 RNs and 3,210 administrators/managers at 64 Press Ganey Safety Culture client sites as of August, 2008.

These differences not only affect the development of a culture but also undermine the implementation of safety efforts. If RNs feel safety culture is far worse than what managers believe, managers may not understand why RNs think budgetary or procedural changes are unnecessary, or why managers disagree with RNs' recommendations.

For instance, front-line staff may be aware that patient safety is at risk due to inconsistent patient identification protocols. If leadership is unaware of this threat, changes to processes that increase safety (e.g., training staff to ask the patient's date of birth and match it to their bands and charts, or ordering scannable ID bands) may not be implemented. As a result of this cultural disconnect, where leadership and nurses are not aligned, the promotion of procedures and systems to advance a culture of safety cannot be successfully implemented or sustained.

Cultural Reasons for the Disconnect

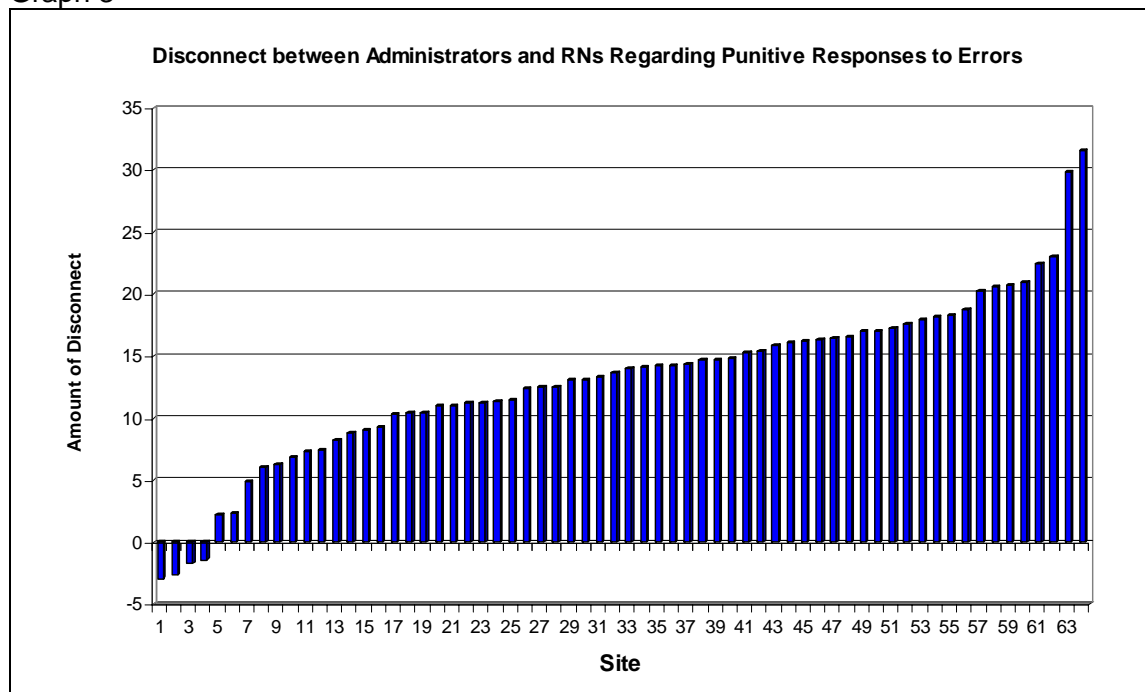
To help explain the disconnect between RNs and administrators, we examined the way facilities are perceived to respond to errors by looking at the average score from the "Nonpunitive Response to Error" section of the Press Ganey Safety Culture Survey. The questions comprising this section include:

- Staff feel like their mistakes are held against them
- When an event is reported, it feels like the person is being written up, not the problem
- Staff worry that mistakes they make are kept in their personnel file

Higher scores reflect the perception that the facility is not seen as punitive.

Following the same process used for overall perception of culture (Graph 1), a large disconnect between the perceptions of hospital administrators/managers and RNs was again observed. Graph 3 illustrates that administrators rated hospital's responses to errors more positively (less punitively) than RNs at the same hospital.

Graph 3



Based on the responses of 12,411 RNs and 3,210 administrators/managers at 64 Press Ganey Safety Culture client sites as of August, 2008.

These results show there are significant, and serious, differences in perception between the two groups. Administrators/Managers tend to view their cultures as safer and less punitive, whereas RNs tend to perceive cultures as less safe and more punitive.

Closing the Gap

These research results show that staff who provide direct care to patients view the culture of their facilities far differently than leadership. Also underscored is the need for facilities to improve communication between nurses and administration. A disconnect can create a culture where caregivers see problems but are less inclined to report them because of fear of punishment, rather than correction of a systemic issue.

Leaders must focus on their safety culture. Unfortunately, too often change that is initiated from front-line staff is slow or fails to be adopted organization-wide. Leadership buy-in is necessary to ensure a connected cultural momentum toward a culture of safety as well as consistent and total adoption of improvement efforts across an organization.

Open communication about errors without fear of punishment is essential. This can be done in a way that still affords accountability while not laying blame.^{vi} Rewarding, rather than punishing, those who report near-misses, errors, injuries, and poor care will promote a more safe and open culture which will lead to fewer errors. Hold open dialogues between nurses and administrators. Allow nurses to recommend how they think error reporting should occur. Train managers on how to encourage open discussion about errors and change the tone of reporting

from one of “tattling” to one of true collaboration. Encouraging front-line involvement and connection will also encourage front-line buy-in of changes initiated by leadership.

One step toward a change in safety culture is to determine the current perceptions of all employees. Allow staff the opportunity to provide feedback in a confidential manner that will help the organization pinpoint exact areas of improvement opportunity. Measurement also enables the organization to make the cultural disconnect quantifiable. Having data that shows where disconnects exist will enable organizations to implement targeted changes. This process is critical not only for improving quality care but also for reducing the financial and human costs of medical errors.

Conclusion

Reducing errors in health care is no longer a goal; it is a necessary mission. A multitude of reasons for the differing perceptions between staff shown in this research may exist (e.g., differential access to information, motivational biases, cognitive distortions, communication breakdowns). Before real progress in creating a safer health care organization can be achieved, these differences must be identified, acknowledged, addressed, and reconciled. And there is no time to wait. In the wake of Medicare’s never event policy, safety culture will be at the forefront of every hospital in the nation. By examining staff perceptions and identifying differences, organizations can begin to repair systemic cultural discrepancies and lay the solid foundation to achieve a true culture of safety. Lives depend on it.

References

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- ii CMS Proposes to Expand Quality Program for Hospital Inpatient Services in FY 2009. Released April 14, 2008. Available at: <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3041&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=365&pYear=&year=0&desc=false&cboOrder=date>; Department of Health and Human Resources, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates, 73 Fed. Reg. 84,23547 through 23562 (2008). (to be codified at 42 C.F.R. § 411, 412, 413 et al.). Available at: <http://edocket.access.gpo.gov/2008/pdf/08-1135.pdf>
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