Enhancing Culture Of Safety with “Learning From Defects” Tool

Team Membership:
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Background – The Problem

• Results from 2012 Culture Of Safety Survey at LUMC indicated opportunity for improvement within the Respiratory Care Department.

• Assessment of scores and voluntary feedback revealed staff hesitance to report safety issues and potential recommendations for improvement for fear of corrective action.
Project Aim Statement

• The RC Management Team collaborated with LUMC’s Center for Clinical Effectiveness (CCE) and Trinity Health to initiate process improvements to change and enhance the culture of safety within the department.

• Success would be measured by comparison of scores between the 2012 and 2013 Culture Of Safety Surveys.
Project Goals

• To change the general staff perception that reporting errors is addressed with corrective action only in a punitive manner.
• To educate the staff regarding tools that enhance and improve culture of safety.
• To experience an increase in score and a positive trend in results for the RC Department from the last two Culture of Safety surveys.
Solutions Implemented

• All RC Staff Members watched required Culture of Safety video, “Safety as a System” provided by Trinity Health.

• Three Safety Ambassadors were identified to participate in Trinity’s Culture Of Safety Ambassador Program.

• RC Management provided 25 sessions of “Learning From Defects” Tool to all staff, on all shifts, achieving 100 % attendance.
Respiratory Care
Percentage Change 2012 to 2013 "Culture of Safety Survey"

10.2
13.7
19.9
14.6
11.4
15
12.6
12.3
14.4
0
5
10
15
20
25
30

Teamwork Within Units
Actions Promoting Patient Safety
Mgmt Support for Patient Safety
Organizational Learning—Continuous Improvement
Overall Perceptions of Patient Safety
Feedback and Communication About Error
Communication Openness
Frequency of Events Reported
Teamwork Across Units
Staffing
Handoffs & Transitions
Nonpunitive Response to Error
Patient Safety Grade

Trinity monitors MO performance based on the Composite Average Score...
Analysis of Results

• The “Learning From Defects” tool had a tremendous positive impact on RC staff members and was successful in contributing to significant improvement in Culture Of Safety survey results.

• The majority of major category scores improved between 10% and 20% with a Patient Safety Grade increase of 14.4%.
Lessons Learned

• Implementing tools to improve the culture of safety, such as the “Safety as a System” video, the Safety Ambassador Program, and Learning From Defects sessions, promotes buy-in and participation from all levels of department personnel.

• “Learning From Defects” is a powerful and effective tool in promoting positive change in staff perception. Overwhelming staff feedback indicated that the Learning From Defects presentations were very well received and very effective in improving patient safety.
RCP Feedback

• “In the five years I have been working here, that was the best one hour presentation that I have attended from all Respiratory Care meetings. It was very informative and interesting, and everyone will learn something from it. Very good. I’ am looking forward to more like this.” R.M.

• “This was a great presentation. I think it's great strategy to share this type of information with the team. Medical errors happen all the time it's nice to have an eye opener, as this was.” H.M.

• “The presentation on Culture of Safety was very beneficial and productive. We'll definitely learn from it. Thanks.” S.S.
Next Steps

• Select new errors and continue with “Learning From Defects” presentations for all department staff.

• Train RC safety ambassadors to present Learning From Defects sessions.

• Solicit topics and suggestions from staff for future sessions.
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A review by Manager/AD/Medical Director/VP is recommended prior to submission.

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