



Facts about the Safety Culture Project

In October 2011, the Center for Transforming Healthcare launched its sixth project which aims to optimize behaviors and practices resulting in an improved safety culture that reinforces and supports the prevention of patient harm. A safety culture enables trust, empowers staff to speak up about risks to patients, and to report errors and near misses, all of which drive improvement. The confluence of growing public vigilance, patient dissatisfaction, continued unsafe events, and payment systems that penalize bad outcomes serves as the burning platform for dramatic transformation of how hospitals focus on quality and safety. It has been estimated that the average cost of a medical error is \$11,366 resulting in approximately \$17.1 billion in costs in 2008.¹

Organizations that achieve high reliability (those which manage serious hazards extremely well) have long emphasized safety culture as a key factor necessary to performance that is consistently excellent. Despite widespread attention to the importance of safety culture in performance improvement, many – if not most – health care organizations struggle to achieve it. In fact, lack of safety culture was a prominent underlying factor of the issues addressed by the first four Center projects.

A strong safety culture allows for the identification and elimination of risk and harm. The lack of a safety culture results in concealment of failure and errors and, therefore, a failure to learn from them. According to the Institute of Medicine, “the biggest challenge to moving toward a safer health system is *changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm.*” The Agency for Healthcare Research and Quality’s (AHRQ) 2013 Hospital Survey on Patient Safety Culture revealed that of 405,281 hospital staff respondents from 653 hospitals³:

- 76 percent rated patient safety in their work area either as excellent or very good
- 50 percent felt that mistakes would be held against them
- 56 percent had not reported any events in the previous 12 months

These numbers indicate the difficulty involved in strengthening the safety culture within health care organizations: while most staff give their work areas high grades on patient safety, more than half feel that mistakes would be held against them and more than half don’t report anything. This high ranking for patient safety combined with low rates for reporting would seem to indicate that adverse and sentinel events are infrequent occurrences; in fact, the opposite may be true. This is supported by recent literature that indicates adverse events occur in one third of hospital admissions.¹ In addition, evidence suggests that the risk of harmful error in health care may be increasing.²

The Joint Commission Center for Transforming Healthcare uses Robust Process Improvement® (RPI®) methods and tools in the development of its solutions. RPI® is a fact-based, systematic, and data-driven problem-solving methodology. It incorporates specific tools and methods from Lean, Six Sigma and change management methodologies. Using RPI®, the project teams will develop solutions that create and sustain a strong safety culture by addressing the complex factors that perpetuate safety failures. The team will work to develop measures of the behaviors that underlie a culture of safety at organizations and of the factors that strengthen or weaken the culture. Understanding these drivers will lead to the development of solutions that are specific to the individual organization’s culture.

The results for this project are targeted for publication in 2015.

Project team

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For more information about this project or its participants, visit the [project detail](#) page or the Center [website](#).

¹ Classen D.C., et al: "Global Trigger Tool' Shows That Adverse Events in Hospitals May be Ten Times Greater Than Previously Measured," *Health Affairs*, 30(4):581-589, 2011

² Chassin M.R., Loeb J.M.: "The Ongoing Quality Improvement Journey: Next Stop, High Reliability," *Health Affairs*, 30(4):559-568, 2011

³ 2014 User Comparative Database Report: Hospital Survey on Patient Safety Culture. March 2014. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/2014/index.html> (Accessed November 12, 2014)