Development of the AHRQ Ambulatory Surgery Center Survey on Patient Safety Culture

Scott Smith, PhD
Senior Study Director
What is Patient Safety Culture?

“The way we do things around here”

Beliefs, values & norms

Shared by staff

What is:
- Rewarded
- Supported
- Expected
- Accepted

Exists at multiple levels:
- System
- Organization
- Department
- Unit
## Technical Expert Panel

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bill Berry, MD</td>
<td>Ariadne Labs/Harvard School of Public Health</td>
</tr>
<tr>
<td>Jan Davidson, MSN, RN, CNOR, CASC</td>
<td>Association of periOperative Registered Nurses</td>
</tr>
<tr>
<td>Atul Gawande, MD</td>
<td>Ariadne Labs/Harvard School of Public Health</td>
</tr>
<tr>
<td>Caren Ginsberg, PhD, MA</td>
<td>Centers for Medicare &amp; Medicaid Services*</td>
</tr>
<tr>
<td>Elizabeth Goldstein, PhD</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>Janice Izlar, CRNA, DNAP</td>
<td>American Association of Nurse Anesthetists</td>
</tr>
<tr>
<td>Marcia Patrick, MSN, RN, CIC</td>
<td>Association for Professionals in Infection Control and Epidemiology</td>
</tr>
<tr>
<td>Bill Prentice, JD</td>
<td>Ambulatory Surgery Center Association</td>
</tr>
<tr>
<td>Michael Rose, MD</td>
<td>McLeod Regional Medical Center</td>
</tr>
<tr>
<td>Daniel Schwartz, MD, MBA</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>David Shapiro, MD, CHC, CHCQM, CHPRM, LHRM, CASC</td>
<td>Ambulatory Surgery Center Association</td>
</tr>
<tr>
<td>Ann Shimek, MSN, RN, CASC</td>
<td>United Surgical Partners, Intl</td>
</tr>
<tr>
<td>Diann Simms</td>
<td>Patient</td>
</tr>
<tr>
<td>Donna Slosburg, BSN, LHRM, CASC</td>
<td>Executive Director, ASC Quality Collaboration</td>
</tr>
<tr>
<td>AHRQ Staff</td>
<td></td>
</tr>
</tbody>
</table>

* Dr. Ginsberg is now at the Agency for Healthcare Research & Quality (AHRQ)
Survey Development Process

1. Reviewed literature & existing surveys
2. Interviewed experts and ASC staff
3. Identified key areas of patient safety culture
4. Developed survey items & pretested them
5. Obtained input from Technical Expert Panel (TEP)
6. Piloted the survey in 59 ASCs with 1,821 staff
7. Conducted psychometric analyses
8. Consulted with AHRQ and TEP to finalize survey
9. Developed toolkit materials
ASC Survey
Patient Safety Culture Composites

27 items assess 8 composites of patient safety culture

1. Communication About Patient Information
2. Communication Openness
3. Staffing, Work Pressure, and Pace
4. Teamwork
5. Staff Training
6. Organizational Learning—Continuous Improvement
7. Response to Mistakes
8. Management Support for Patient Safety

Near-Miss Documentation

Overall Rating on Patient Safety (Excellent to Poor)

Communication in the Procedure/Surgery Room
ASC Ownership

- Hospital Affiliated: 25%
- Not Hospital Affiliated: 75%
ASC Survey Pilot Test

ASC Type

- Mixed (Surgical and Non-surgical) 69%
- Single Specialty - Surgical 7%
- Single Specialty - Non-Surgical 17%
- Gastrointestinal Procedures Only 7%
ASC Survey Pilot Test

- Average ASC response rate: 77% (479 out of 635)
  - Range: 50% to 100%

- Average number of completed surveys per ASC: 31
  - Range: 5 to 90
ASC Size

<table>
<thead>
<tr>
<th>Size</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 2 rooms</td>
<td>14</td>
<td>24%</td>
</tr>
<tr>
<td>3 rooms</td>
<td>11</td>
<td>19%</td>
</tr>
<tr>
<td>4 rooms</td>
<td>13</td>
<td>22%</td>
</tr>
<tr>
<td>5 rooms</td>
<td>5</td>
<td>9%</td>
</tr>
<tr>
<td>6 rooms</td>
<td>7</td>
<td>12%</td>
</tr>
<tr>
<td>7 or more rooms</td>
<td>9</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>59</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

- ASCs represented 20 states across the United States
- Largest proportions were from the Pacific (29%) and the West Central regions (15%)
### Staff Position

<table>
<thead>
<tr>
<th>Staff Position</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor/Physician (excluding anesthesiologist) or Surgeon</td>
<td>389</td>
<td>21%</td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td>138</td>
<td>8%</td>
</tr>
<tr>
<td>Certified Registered Nurse Anesthetist (CRNA)</td>
<td>62</td>
<td>3%</td>
</tr>
<tr>
<td>Physician Assistant or Nurse Practitioner</td>
<td>42</td>
<td>2%</td>
</tr>
<tr>
<td>Management</td>
<td>134</td>
<td>7%</td>
</tr>
<tr>
<td>Nurse</td>
<td>592</td>
<td>33%</td>
</tr>
<tr>
<td>Other</td>
<td>458</td>
<td>26%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1815</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note: 6 staff positions were not identified.
ASC Composite Results

- Organizational Learning–Continuous Improvement: 92%
- Communication About Patient Information: 91%
- Management Support for Patient Safety: 89%
- Teamwork: 86%
ASC Composite Results

- % Positive Response

- Communication Openness: 85%
- Response to Mistakes: 82%
- Staff Training: 78%
- Staffing, Work Pressure, & Pace: 76%
Top Performing Items

% Positive Response

Communication About Patient Information

- Important patient care information is clearly communicated across areas in this facility 96%

- Within this facility, we do a good job communicating information that affects patient care 95%
**Bottom Performing Items**

- **Staff Training**
  - Staff feel pressured to do tasks they haven't been trained to do: 72%

- **Staffing, Work Pressure, & Pace**
  - We feel rushed when taking care of patients: 58%
Open-Ended Comments

Communication About Patient Information

Hand off report between RNs has improved with face to face report given.

Staffing, Work Pressure, and Pace

Sometimes I feel some of the doctors are all about how fast you can turn over the OR and I feel pressured if I am not going as fast as they want me to.
Overall Rating on Patient Safety

87% positive

52% Excellent
35% Very good
10% Good
2% Fair
0% Poor
Frequency of Near-Miss Documentation

When something happens that could harm the patient, but does not, how often is it documented in an incident or occurrence report?

- 59% Always
- 29% Most of the time
- 8% Sometimes
- 3% Rarely
- 1% Never
Communication About Patient Information

% Positive Response

Just before the start of procedures, all team members stopped to discuss the overall plan of what was to be done 92%

Just before the start of procedures, the doctor encouraged all team members to speak up at any time if they had any concerns 65%

Immediately after procedures, team members discussed any concerns for patient recovery 73%
Results by ASC Characteristics

- No differences between Multispecialty vs. Single Specialty ASCs

- Hospital affiliated ASCs were more positive (86%) than Not hospital affiliated ASCs (80%) on Response to Mistakes
  - Staff are told about patient safety problems, learning rather than blame is emphasized, and staff are treated fairly when they make mistakes

- Smaller ASCs (1 or 2 Rooms) were more positive than larger ASCs (6 Rooms or More) on Response to Mistakes and Staffing, Work Pressure and Pace
  - Staff do not feel rushed, they have enough time to properly prepare for procedures, and there are enough staff to handle the workload
Results by Staff Position

- Doctors/Physicians (excluding anesthesiologists) or Surgeons were more positive than other staff positions on all composites

- Largest differences:
  - **Staffing, Work Pressure, & Pace**
    Doctors/Physicians (excluding anesthesiologists) or Surgeons (94%) vs. Nurses (64%)
  - **Staff Training**
    Doctors/Physicians (excluding anesthesiologists) or Surgeons (93%) vs. Nurses (73%)
Relationship with Overall Rating

- All composites are significantly related to the Overall Rating on Patient Safety

  - The strongest correlation is with Organizational Learning – Continuous Improvement ($r = 0.80$)
AHRQ Support

• Toolkit materials
   Survey
   Data Entry and Analysis Tool
   Pilot study preliminary comparative results
   Technical assistance

• There is no comparative database for the ASC survey at this time.