

## Executive Summary

In the fall of 2005 four Health Regions in Manitoba participated in an initiative organized by the Manitoba Institute for Patient Safety (MIPS) to help examine patient safety culture in these regions. A survey of Patient Safety Culture in Healthcare Organizations was sent to all direct care providers, clinical care managers, direct and non-direct care support staff and non-direct care managers in all sectors including pre-hospital care, acute care, long term (personal) care, community care, mental health in the four regions. Only administrative staff in administrative departments were excluded. Exclusion was based on the fact that the survey instrument is not relevant to this group.

The survey included items in four areas: (1) Valuing safety at the organization and department level, (2) Fear of repercussions, (3) Perceived State of safety, and (4) Supervisory leadership. Of 5993 surveys that were sent out, 1790 were returned for a response rate of 30%. Response rate ranged from 26% to 36% across the four regions.

Data gathered through this initiative can be used to drive change initiatives in several ways: (1) Looking at high and low performance on individual survey items, (2) Focusing on questions that reflect areas that are the most important to staff, (3) Benchmarking - Looking for high performing groups.

## Results

There were no differences in safety culture scores across the four Regions. Regions tend to score between 3.5 and 4 on a 5 point score on three of the four dimensions, with lower scores (averaging closer to 3.0) on the state of safety dimension. Results differed by staff group. On the Valuing Safety dimension, nurses and physicians score significantly lower than healthcare aides, clinical care managers, and support staff. On the fear of repercussions dimension, clinical care managers score more positively than all other groups and EMS staff score lower than nurses and health care aides on this dimension. On the state of safety dimension clinical care managers score *lower* than health care aides, allied and technicians, and support staff—health care aides and support staff feel more positively about the state of safety than most clinicians.

There are few differences between the sectors on these 4 safety culture dimensions. The pre-hospital care sector provides lower scores on the fear of repercussions dimension than acute, LTC and community sectors. The Mental Health sector also provides lower scores than acute care on this dimension. Finally on the state of safety dimension, the acute care sector provided lower scores than the community sector.

For each of the four regions and for the 15 sites in the dataset that had more than 30 respondents, data are also presented that focus on the proportion of positive responses to individual questions in the 4 dimension of patient safety culture. It is often these more detailed data that can best help drive specific change and improvement efforts. Although some of the 15 sites scored significantly higher than other on most or all questions, suggesting some clear high performers, the same groups of questions seem to receive higher and lower proportions of positive responses across all sites. Three areas where the regions and sites tended to achieve the highest proportion of positive responses:

Q16. I will suffer negative consequences if I report a safety problem	83.5% disagree
Q6. My unit does a good job managing risks to ensure patient safety	83.1% agree
Q5. My unit takes the time to identify and assess risks to patients	83.1% agree

Five areas where sites and regions tended to achieve fewer positive responses:

Q24. In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time (%disagree)	49.3% disagree
Q21. Loss of experienced personnel has negatively affected my ability to provide high quality patient care (% disagree)	43.7% disagree
Q23. Clinicians who make serious mistakes are usually punished (%disagree)	40.8% disagree
Q18. I am rewarded for taking quick action to identify a serious mistake	33.2% agree
Q28. I believe health care errors often go unreported (%disagree)	21.7% disagree
Q27. I believe that health care error constitutes a real and significant risk to the patients that we treat (%disagree)	15.9% disagree

Organizations tend to receive a higher proportion of positive response to questions about how safety is valued and handled in the unit/organization and fewer positive responses to questions about the actual state of safety. These data are consistent with the idea that positive leadership support and cultural change around safety must precede real improvements in the state of safety.

Prioritizing areas for change and improvement can also be achieved by considering an items performance (percentage of positive responses) along with an item's importance (measured using an item's correlation with the overall patient safety rating). This approach helps organizations focus attention on areas where performance is lowest among those that are felt by staff to be the most critical for overall safety. Nine items were identified using this approach:

- Q2. Good communication flow exists up the chain of command regarding patient safety issues
- Q4. Senior management has a clear picture of the risk associated with patient care
- Q7. Senior management provides a climate that promotes patient safety
- Q12. Senior management considers patient safety when program changes are discussed
- Q22. I have enough time to complete patient care tasks safely
- Q25. I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care
- Q29. My organization effectively balances the need for patient safety and the need for productivity
- Q34. My supervisor/manager seriously considers staff suggestions for improving patient safety
- Q35. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts