



Improvement Rounds: Team Problem Solving to Support a Culture of Safety

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Background

In 1999, the Institute of Medicine released a report “To Err is Human” that highlighted how impaired patient safety standards and medical errors resulted in significant injury to patients. Today, medical errors still account for the 3rd leading cause of death in the United States.

A **Culture of Safety** is founded on the idea that all healthcare workers are committed to continuously improving systems to support patient safety. It is comprised of four key concepts:

- *Reporting Culture*: Actual & Potential Errors
- *Learning Culture*: Reflection on Action
- *Engaged and Informed Culture*: Relationships & Transparency
- *Just Culture*: Adverse Events

Purpose

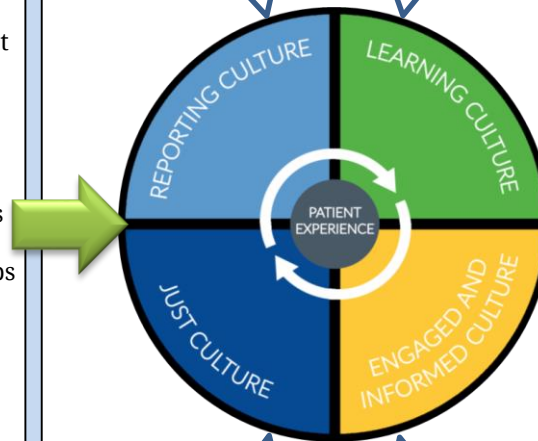
In 2014, the AHRQ Culture of Safety Survey was conducted with all staff. The Cardiovascular Intermediate Care Unit had below-benchmark data throughout the survey. The goals of this initiative:

- improve patient safety by increasing reporting
- engage staff in problem solving
- develop communication standards

Methods

Structured Closed Loop Communication for all reports

Interdisciplinary Huddles weekly that discuss recent safety events

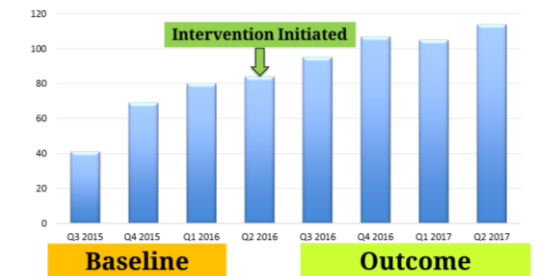


Collaborative, systems based approach to evaluating incident reports and debriefing with staff

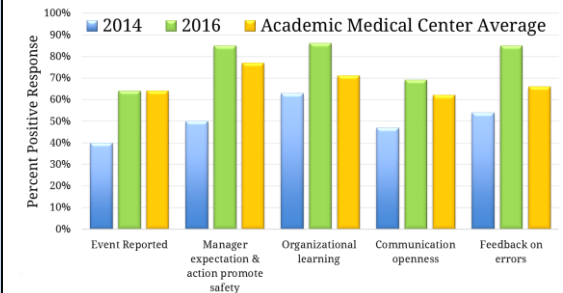
Multi-faceted approach to sharing of learnings that is communicated to all team members

Results

Total Incident Reports by Quarter



AHRQ Pre/Post Survey Results



Conclusion

Structures that support closed loop communication, team problem solving, and transparent communication about safety are effective, efficient, cost-neutral tactics that work to foster a Culture of Safety.