NQF Safe Practice #2: Culture Measurement, Feedback, and Intervention

NQF# N/A

Developer: The Leapfrog Group

Data Source: Leapfrog Hospital Survey

Practice Statement: Hospitals must ensure patient safety culture is measured, the feedback is provided to all levels of the organization, and interventions are undertaken that reduce patient harm.

Rationale: Since achieving its own high-risk designation from the Institute of Medicine (IOM) a decade ago, health care has intensified its activities to measure safety culture and to develop interventions to improve it. There are no estimates on the frequency of medical errors or adverse events resulting from deficient or suboptimal safety culture, but it is known to be a contributing factor to their occurrences. The severity of harm resulting directly from the effects of poor safety culture is unknown and possibly immeasurable.

However, the consequences of poor safety culture can range from no harm (i.e., safe operations) to death. While many hospitals are actively using or implementing safety improvement strategies based on culture measurement, the effectiveness of such strategies has not been proven. The need persists for systematic quantitative and qualitative analyses of interventions to create a safe culture. Currently, there is no standard to estimate the cost of poor safety culture to a clinical unit, a hospital, or a hospital system. However, IOM firmly established that the safety culture of the U.S. health care system is deeply flawed and is the root cause of substandard care delivery.

Citations for Rationale:

- Fleming M, Wentzell N. Patient safety culture improvement tool: Development and guidelines for use. Health Q 2008;11(3 Spec No,):10-5.
- Kohn LT, Corrigan JM, Donaldson MS, eds.; Committee on Quality of Health Care in America, Institute of Medicine. To Err is Human: Building a Safer Health System. Washington, DC: The National Academies Press; 2000.
- McKeon LM, Cunningham PD, Detty Oswaks JS. Improving patient safety: patient-focused, high-reliability team training. J Nurs Care Qual 2008 Aug 25.
- Pizzi LT, Goldfarb NI, Nash DB. Promoting a culture of safety. IN: Making Health Care Safer: A Critical Analysis of Patient Safety Practices: Evidence Report/Technology Assessment, No. 43. AHRQ Publication No. 01-E058. Rockville (MD): Agency for Healthcare Research and Quality [AHRQ]; 2001 Jul: Chapter 40.
- Pronovost PJ, Rosenstein BJ, Paine L, et al. Paying the piper: investing in infrastructure for patient safety. Jt Comm J Qual Patient Saf 2008 Jun;24(6):33-40.
- Zimmerman R, Ip I, Daniesl C, et al. An evaluation of patient safety leadership walkarounds. Healthc Q 2008;11(3 Spec No.):16-20.

Impact:

- Potential to affect most hospitalized patients.
- Clear documentation of harm reduction.

Citations for Impact:

- National Quality Forum (NQF). Safe practices for better healthcare—2010 update: A consensus report. Washington (DC): National Quality Forum (NQF); 2010.
- Pizzi LT, Goldfarb NI, Nash DB. Promoting a culture of safety. IN: Making Health Care Safer: A Critical Analysis of Patient Safety Practices: Evidence Report/Technology Assessment, No. 43. AHRQ Publication No. 01-E058. Rockville (MD): Agency for Healthcare Research and Quality [AHRQ]; 2001 Jul: Chapter 40.

Opportunity:

- Opportunity for improvement exists, based on the coefficient of variation for the measure.

Evidence:

- Supported by theoretical rationale.

Citations for Evidence:

- National Quality Forum (NQF). Safe practices for better healthcare—2010 update: A consensus report. Washington (DC): National Quality Forum (NQF); 2010. NQF Safe practices for better healthcare-2010 update: A consensus report
- Pizzi LT, Goldfarb NI, Nash DB. Promoting a culture of safety. IN: Making Health Care Safer: A Critical Analysis of Patient Safety Practices: Evidence Report/Technology Assessment, No. 43. AHRQ Publication No. 01-E058. Rockville (MD): Agency for Healthcare Research and Quality [AHRQ]; 2001 Jul: Chapter 40.