Hennepin County Medical Center faced a disconnect between the perceptions of its administrators and those of its frontline staff regarding the hospital’s safety culture. The hospital partnered with Press Ganey with the goal of closing the gap and ensuring that all of its employees and physicians understand and embrace its organization-wide commitment to safe patient care.

Vital Statistics
The Facility: Hennepin County Medical Center is Minnesota’s largest safety-net hospital, providing care for many low-income and uninsured patients. A comprehensive academic medical center and the state’s fourth largest hospital by operating revenue, it is also Minnesota’s premier Level 1 trauma center and operates several clinics in and around Minneapolis.
Location: Downtown Minneapolis
Beds: 471
Type: Publicly owned, operated by the Hennepin Healthcare System, a public subsidiary corporation owned by Hennepin County, Minn.

Overview
Hennepin County Medical Center faced a challenge common among health care providers: a disconnect between the perceptions of its administrators and those of its front-line staff regarding the hospital’s safety culture. The hospital has partnered with Press Ganey for safety since 2007 with the goal of closing the gap and ensuring that all of its employees and physicians understand and embrace its organization-wide commitment to safe patient care.

Since Hennepin began working with Press Ganey, the hospital has taken several significant steps to enhance its safety culture and communicate it more effectively to employees. Patient safety has been added to new-employee orientation, and administrators have incorporated safety behavior into employee performance reviews. Weekly, unit-based “Safety Chats” and management huddles to discuss safety issues have created an environment in which employees feel more comfortable discussing and reporting safety concerns. Paper event reporting has been replaced by an online reporting system, and event reporting has risen dramatically as a result.

The actions Hennepin has taken to promote a culture of safety have been reflected in improved scores on Press Ganey’s Safety Culture Assessment. Hennepin’s overall mean score rose 2.5 points from its initial assessment in 2007 to its second assessment in 2008. This represented a statistically significant change in the hospital’s overall mean score. As a result of this mean-score change, Hennepin’s percentile rank within the national database increased. Its percentage of most positive responses — those that received the highest rating possible — increased to 14.1%. This was a significant increase from 11.4% in its initial survey. Moreover, improved scores show that surveyed employees believe the hospital’s actions now demonstrate that patient safety is a top priority and that management is working to promote safety.
Organization
Hennepin County Medical Center, which occupies a five-block campus near the Metrodome in downtown Minneapolis, is a 471-bed teaching hospital that balances its responsibilities as the state’s premier Level 1 Trauma Center with those of an essential teaching hospital and safety-net provider within a diverse community.

In addition to its busy acute care hospital, Hennepin operates four primary care clinics in the Twin Cities and is overseen by a 13-member board of community leaders. Hennepin Healthcare System, a public subsidiary corporation owned by Hennepin County, operates the hospital. Hennepin’s chief executive officer, Arthur Gonzalez, PhD, joined the system in mid-2009.

Despite a difficult economic environment exacerbated by recent losses in state funding, Gonzalez has continued the safety culture commitment that began under the leadership of Lynn Abrahamson, who had been at Hennepin County since 2001 and retired in June 2009. Lori Johnson, RN, MA, the hospital’s senior director of performance improvement services and patient safety officer, says that while executive pay has been frozen and capital projects have been delayed due to budgetary constraints, administrators continue to support and fund patient safety initiatives because of their critical importance.

Safety Culture Strategies
The first year Hennepin used Press Ganey’s safety culture assessment tool, the organization was undergoing tremendous change; it had recently implemented an electronic medical record, and the hospital had changed its governance model, creating a new human resources system.

Given this backdrop of significant change, Hennepin’s early actions to strengthen its safety culture focused on organizational and infrastructure changes that would not put too much of a strain on managers who were already under pressure. One of the most significant initial efforts was to add more than an hour of patient safety and quality training to new-employee orientation. Previously, safety had not been on the agenda.

The training, given to all new employees, examines broad questions such as why health care as an industry needs to focus on patient safety and what human factors can lead to medical errors. It also covers more specific topics, such as Minnesota’s mandated adverse-event reporting law and Hennepin’s expectations of its staff. Videos are shown that underscore these themes and provide poignant examples of the potential for human error in the health care setting, and employees are encouraged to participate in an open-ended discussion afterwards. “The evaluations have been very positive,” Johnson says. In addition, new managers at the hospital are mentored on when and how to carry out an investigation once an event has been reported.

As part of the new-employee orientation, employees are asked for feedback. The following comments are examples of the feedback specific to the patient safety/quality section:

- “Showed the importance of attitude/culture on safety. It’s so much more than just trying not to make mistakes.”
- “Provides a lot of info on what to expect as an employee, and (shows) that HCMC will be supportive.”
- “Video about blame was an eye-opening video.”

Highlighting safety and opening the lines of communication from the moment an employee steps through the door signals Hennepin’s commitment to continuous quality improvement at all levels of the organization.

Safety behaviors are also reinforced at Hennepin through performance-based employee evaluations. The success factors that are used to judge an employee’s performance are behaviors that support a culture of safety. Employees who champion change, use resources wisely, demonstrate accountability and trustworthiness and deliver customer service are rewarded. This provides an ongoing incentive for employees to strive to avert errors and to feel comfortable communicating safety concerns in a way that maximizes accountability but downplays blame.

Safety Chats
Early on, Hennepin’s Press Ganey safety culture consultant suggested that, when an error did occur, hospital leaders should provide relevant information to all those involved. Anyone who might be able to help prevent similar errors in the future should be included in follow-up discussions about how to fix the problem.

Responding to this suggestion, Hennepin implemented “Safety Chats.” These hour-long discussions take place several times a month on both inpatient and outpatient units. The hospital’s top leaders, including the CEO, the executive leadership team, chief of staff, patient safety officer and associate medical director of performance measurement and improvement meet informally with front-line staff. Anyone on the unit may participate in these open-ended talks, and hospital leaders respond to staff suggestions about what can be done to improve safety at both the system and unit level. Hospital leaders create a safety to-do list and expect to hear back from those responsible for implementing any changes on the unit. Any improvement projects that emerge following the safety chats are published in the hospital’s newsletter to keep hospital employees in the loop about the status of safety initiatives.
As the concept has evolved, the hospital has made more of a concerted effort to follow up by communicating to employees about successes that have come out of the safety chats. Some examples of staff-identified concerns that were addressed include:

- Exam-room doors that had been closing too fast were adjusted.
- Inadequate hot water for one unit was mitigated with a special boosting valve.
- Unit-specific infection rates were posted for a unit that had requested it.
- Hallway safety mirrors were installed.

This extra communication serves as both an acknowledgment to employees who have spoken out and a signal that leadership is committed to acting on employees’ identified concerns. The safety chats also increase the visibility of the hospital’s leaders among hospital staff, which helps to close the communication gap.

Hennepin’s executive leaders are also involved in replicating the Joint Commission’s tracer methodology, in which they select a different area of the hospital twice a week and evaluate whether it is complying with safety and other standards. Hospital leaders observe and speak with staff to determine whether they are using appropriate safety measures and infection control practices and whether their work environment meets safety requirements.

The Payoff

Since Hennepin has begun focusing on its safety culture, near-miss and overall event reporting has risen at least 25% and continues to rise, Johnson says. The hospital implemented an online event-reporting tool called Morrisey Concurrent Care Manager in October 2008. The program is simple and direct, guiding employees through the areas they need to complete. Unlike the hospital’s previous paper reporting format, the electronic tool is more streamlined, allowing staff to respond only to questions that are relevant to the event they are reporting. Once submitted electronically, the report goes immediately to the unit manager and to the hospital’s central management. This addresses a perception among staff, reflected in the hospital’s initial safety culture assessment scores, that reports had not previously gone to the people who had the power to do something about the problem.

Overall, Hennepin has made statistically significant improvements in 11 of 13 safety culture dimensions on its Press Ganey Safety Culture Assessment, with non-punitive response to error ranked the highest. Furthermore, two of the three questions reflecting the hospital management support dimension have improved and are no longer ranked as one of the hospital’s top 10 priorities. These results show the hospital has made strides in improving communication and closing the gap in perceptions about safety between management and front-line employees.

Striving to create organizational transparency remains a prominent fixture of Hennepin’s effort to create a culture of safety. Since 2007, the organization has realized an improvement in both hospital-acquired infection rates and the Centers for Medicare & Medicaid Services’ core measures data, including a 40% reduction in central-line blood stream infections and improvements for all core measures ranging from 10% to 49%.

Accountability Within Units

Once Hennepin began to make strides incorporating aspects of a safety culture into its broader infrastructure, it began to shift the focus to improving accountability at the department level. Unit managers were asked to focus on two areas they could improve and to create their own action plans with their staffs. Unit managers have also been encouraged to share their safety successes with their department members. The hospital’s safety leaders have also stepped up one-on-one coaching where necessary. Still, Hennepin continues to refine and augment its safety culture, recognizing that its improvement effort is an ongoing process.

Looking Ahead

Johnson regards creating a safety culture as a work-in-progress. In the future, she says, the concept may even be useful in improving Hennepin’s hiring practices. Not only can new hires be educated in the importance of safety behaviors at orientation meetings, but potential employees can also be interviewed with safety culture considerations in mind. Would this person be supportive of safety goals? Would he or she be more likely to hide problems and be punitive or work collaboratively with colleagues to confront safety concerns? Approaching job candidates with behavioral interviewing techniques may help Hennepin, and other hospitals, weed out individuals who might put up roadblocks to safety improvements.

In the uncertain legislative, regulatory and financial environment health care providers face today, those that are willing to invest time and resources in creating a safety culture will be ahead of the game. Federal health care reform proposals and other initiatives reward facilities that consistently produce quality outcomes, and reimbursement is increasingly tied to quality measures. Getting all members of a hospital community to unite around safety goals is a first step toward achieving continuous quality improvement in the health care setting.
As safety becomes more of a financial concern for hospitals, financial officers and board members can no longer afford to ignore the issue. “Organizations should be linking quality outcomes and financial outcomes as they are highly correlated and make a strong business case to do the right thing,” explains Hennepin Chief Financial Officer Larry Kryzaniak.

Hennepin County Medical Center’s ongoing actions to rally its employees around a culture of safety appear to be paying off in a greater willingness among staff to report events and a keener appreciation of management’s commitment to safety. Establishing this kind of organizational trust and support is likely to produce an environment in which patients feel secure that they are getting the best care possible.