Improving the Culture of Safety in an Ambulatory Care Center: Implementing an Outcome Based Communication Process

PURPOSE
An evaluation of existing safety event reporting and communication processes was performed and new strategies implemented in an ambulatory care center.

BACKGROUND
Reporting of this type can assist organizations in identifying errors, enhancing their culture of safety. The frequency of safety events reported varies. During a 2018 Culture of Safety survey administered by the Agency for Healthcare Research and Quality (AHRQ), this center’s respondents noted an average of four safety events were reported in a twelve-month period. This is approximately 22% lower than the AHRQ benchmark.

METHODOLOGY
The DNP student formed a workgroup to identify barriers to event reporting. The group met monthly, to review safety events submitted, implement communication and workflow process changes, then analyze the impact of these changes. The review process allowed the team to identify safety education needs and process gaps.

RESULTS
A pre- and post-project implementation survey was distributed to 29 employees, with a response rate >80%.

Findings of interest included:

Safety investigation process knowledge increased 57.9%
Satisfaction with the center’s process for managing safety events was rated at the highest level, extremely satisfied, for 61.6% of employees
This top level of satisfaction with communication of safety events reported increased 50.9% during the project
The rating of the center’s ability to encourage a positive culture of safety increased by 21.3%, compared to baseline

IMPLICATIONS
1. The improvement in survey results reflect an increased awareness of safety in the center.
2. Employees were more knowledgeable about the process of submitting and investigating safety events.