In the race to keep pace with efforts to improve quality of care, researchers are using increasingly sophisticated methods and measurements to make the case for quality. In measuring and assessing the impact of culture, a lesson we have learned is that hospital-level norms, behaviors, and values require less focus than the uniqueness, complexity, and importance of safety culture in a local patient care area. The Safety Attitudes Questionnaire (SAQ) is a formally validated and widely used tool to assess safety culture within every patient care area hospitalwide. Hospitals use the SAQ every 12 to 18 months to generate a thorough multidimensional profile of strengths and weaknesses within a given care area (for example, poor teamwork climate or excellent working conditions) by capturing assessments from frontline caregivers who are the eyes and ears of local care delivery processes. Metaphorically, an SAQ assessment is a thorough annual physical, but there is often a need for targeted or specialty consults or check-ups.

Local safety culture can have a powerful influence on the daily work of frontline caregivers—which can thwart the efforts of well-intended improvement efforts. For example, methodologically sound interventions can be derailed by distrust of management, poor communication, caregiver conflicts, feelings of intimidation about sharing patient concerns, or being overburdened from too many safety interventions.

Thus, local champions often want more frequent discussions and better insights into opportunities to improve local safety culture by targeting SAQ responses. We developed the Culture Check-Up Tool to address these needs and to help local champions take the next step toward improvement after an SAQ assessment.

Tool Description

The Culture Check-Up is a two-page tool that takes approximately 30–60 minutes to complete as a group exercise. Its purpose is to structure group discussions and actions that will ultimately improve safety culture in that clinical area. A culture check-up is meant to augment methodologically rigorous SAQ culture assessments; we do not recommend replacing the SAQ with this tool. This tool can be used in one of three ways:

1. It can provide a framework to review and discuss culture results immediately following a full-scale SAQ cultural assessment.

2. It can be used frequently to structure group discussions with staff relative to an SAQ item with a low score or an event in the unit that needs to be discussed and for which a related SAQ item exists.

3. It can be used longitudinally to track and compare actions taken and results achieved within a patient care area from one year to the next.

This tool includes an instruction page (Table 1, page 1).
Tool Application to Quality and/or Safety

There are six dimensions to the SAQ that a culture check-up could focus on: perceptions of management, teamwork climate, stress recognition, safety climate, job satisfaction, and working conditions. Teamwork and safety climate have been associated with clinical and operational outcomes, such as patient length of stay and error rates, burnout, delays, and wrong-site surgeries. The Culture Check-up facilitates a discussion of care area norms and practices that influence local safety culture and ultimately clinical and operational outcomes. In the example from Table 2, the group acknowledged that rounding with a Daily Goals sheet was helpful but that patient goals were not always clearly understood. Thus, a verbal summary of the goals for each patient was added during rounds to ensure comprehension. In addition to facilitating a structured culture conversation about SAQ results, the tool can serve as a culture barometer between SAQ assessments to periodically gauge progress, surface problems, and take action. For example, using the tool in an ad hoc meeting, the cardiac surgical intensive care unit (CSICU) staff at The Johns Hopkins Hospital suggested that kits be created with the appropriate equipment required to perform transvenous pacing to avoid another error with a mismatched wire and sheath.

In busy and resource-restrained patient care areas, culture and feedback sink to the bottom of the list of budget, staffing, leadership, and other important issues that are continuously monitored and reported. The Culture Check-up requires few resources, is easy to administer, and easily moves culture up on the list of critical items to monitor and report in perpetuity.

Tool Application Settings

This tool can help clinicians monitor culture in any clinical area that previously administered the SAQ (or another validated culture assessment survey) with a representative response rate of at least 60%. It can be used in multiple settings, such as in staff and faculty meetings, during executive WalkRounds on the unit, or in any interdisciplinary meeting to structure a discussion around safety culture in the unit. Because culture varies widely among patient care areas within a hospital, it is best to use
this tool at the care-area level rather than department- or hospitalwide.

**Best Application**
The tool helps caregivers review their SAQ scores, explore ways to improve culture, and gauge progress of their efforts relative to teamwork, working conditions, job satisfaction, stress recognition, management, and patient safety norms within their care area. The Culture Check-up can be applied in several ways:

- Immediately after an SAQ assessment to discuss results
- Periodically between rigorous culture assessments to focus on and improve low culture scores longitudinally to see trends in annual SAQ assessments

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**Guiding the Discussion**

Low scores and significant changes: Review your item-level results and consider discussing any item for which your unit had less than 60% agreement. If you have trend data across years, you could choose an item that changed significantly (up or down by 10 points or more). Additionally, below is a set of diagnostic SAQ items highly representative of overall unit climate that are frequently used for discussion. Choose an item from your results as the primary discussion starter during your culture check up.

- **Disagreements in this clinical area are resolved appropriately (i.e., not who is right, but what is best for the patient).**
- **The physicians and nurses here work together as a well-coordinated team.**
- **Medical errors are handled appropriately in this clinical area.**
- **My suggestions about safety would be acted upon if I expressed them to management.**
- **I am provided with adequate, timely information about events in the hospital that might affect my work.**

**Culture Item Discussion Section with Example**

<table>
<thead>
<tr>
<th>Statement to be discussed:</th>
<th>Unit SAQ Score: 54% Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagreements in this clinical area are resolved appropriately (i.e., not who is right, but what is best for the patient).</td>
<td></td>
</tr>
</tbody>
</table>

Role-Specific score variation (e.g., M.D. vs. R.N., R.N. vs. Technicians, Clinical vs. Administrative):

| MD (62%), RN (43%), Nurse Manager/Charge Nurse (71%) |

1. What does this statement mean to you?
   *This is a very important item because collaboration and conflict resolution underlies so much of what we do for patients. If we do not agree on what needs to take place, and coordinate our efforts to ensure it gets done as planned, mistakes will occur and our patients will suffer.*

2. How accurately does the unit score reflect your experience on this unit? Share examples.
   *Physicians and nurses felt their score accurately reflected their reality. The physicians tended to be more positive than the nurses but all agreed that we can do a better job of working together and resolving conflicts when they do occur.*

3. How would it look (i.e., what behaviors would we see) on this unit if 100% of staff strongly agreed with this item?
   *Overall, patients would be the focus of our efforts, morale would be very high, and specific efforts would be made to be transparent to reduce surprises and uncertainty. In particular, the charge nurse and ICU attending would have a clear plan in the morning regarding who was to be admitted and discharged, and surface any potential hazards each day. The interdisciplinary care team would be present on rounds, the team would create specific goals that all would understand, and the team would monitor progress toward those goals. When nurses express concerns about a patient, physicians will listen to them, and when physicians say that an intervention needs to be urgently implemented, nurses and other staff would respond quickly. When defects occur, the team would discuss them and reorganize the system to reduce the probability of the defect happening again. The focus would be on making information more transparent and reducing uncertainty rather than pointing fingers at people or personalities.*

4. Identify at least one actionable idea to improve unit results in this area:
   *Use the morning briefing tool to set expectations and reduce uncertainties for the day. This will help to prioritize, improve teamwork, and strategize for the coming daily.*
   *Modify the use of daily goals on the unit, such that nurses now summarize (i.e., read back) the goals after rounding on a specific patient. This improvement clarifies misunderstandings and ensures that the entire care team understands the goals.*

* SAQ, Safety Attitudes Questionnaire; ICU, intensive care unit.
This tool helps clinical areas recognize and fix problems (for example, resolving conflicts) that specifically affect their safety culture.

The Culture Check-up fits well into the Comprehensive Unit-based Safety Program (CUSP), which integrates unit-specific objectives, safety practices, and empirical evidence into the Culture Check-up process. CUSP follows a six-step process, which is continuous once the program begins. Briefly, safety culture is measured using the SAQ in step 1 (baseline) and remeasured in step 6 to evaluate improvements in patient safety and culture. Step 2 explains the science of safety and why safety hazards are mostly found in the systems in which care is organized; step 3 enlists staff to identify hazards and suggest ways to fix these hazards. In step 4, clinical areas form a partnership with a senior executive to jointly build safer systems of care delivery (WalkRounds). Step 5 involves staff in investigating errors and implementing actions to prevent or mitigate a future event, in implementing tools (for example, daily goals checklist, catheter-related bloodstream infection intervention) known to improve care, and in evaluating their actions to see if care is safer.

**How-to**

Table 1 provides instructions for tool application.

**Output**

For a given patient care area, the Culture Check-up results in a group discussion that addresses a weakness in the current culture, envisions a more perfect culture in the care area, and generates a tangible action to move the care area closer to that ideal future. The relative novelty of safety culture and its complexity makes it unlikely that spontaneous discussions would lead to meaningful improvements in culture without a tool like this, which structures discussion and enhances the ownership for making local improvements.

We used this tool in the CSICU and provide an example of its use (Table 2). The statement targeted was “Disagreements in this clinical area are resolved appropriately (i.e., not who is right, but what is best for the patient),” with a unit SAQ score of 54% agreement. This item was chosen because unresolved conflicts lead to poor collaboration in which the patient suffers. A disconnect between physician and nurse scores was recognized, and everyone perceived that a 100% positive score meant transparency of information to reduce uncertainty (keep everyone on the same page). One suggestion to improve physician and nurse collaboration was to change the daily goals process during rounds to ensure nurse comprehension. Another proposal was to use the morning briefing tool, in which the ICU attending physician and nurses meet prior to morning rounds to clarify ambiguities, discuss hazards, and formulate an operational plan for the unit that day.

**Results and Lessons to Date**

The Culture Check-Up tool was developed in early 2006 and was applied in the CSICU as part of CUSP. The tool has been given to ICUs in several patient safety collaboratives, statewide in Michigan, and to hospitals and health systems that administer the SAQ across their organizations, totalling more than 3,000 patient care areas in the past 18 months. It has been used by care team members, unit management, and by hospital executives who have partnered with a specific unit as part of CUSP. This tool has facilitated regular dialogue and discussions in patient care areas and engaged staff to create solutions to problems typically seen as the responsibility of administrators and other hospital leaders. Moreover, this tool has helped to depersonalize conversations. Instead of pointing fingers at colleagues, participants focused on their aggregate SAQ results and specific weaknesses found through item response scores.

These structured group discussions have already led to patient safety advances. Most importantly, the Culture Check-up tool provides a structured method to develop local strategies to improve context of care issues such as teamwork and patient safety norms. For example, changing the daily goals format in the CSICU reduced the uncertainty that exacerbated staff conflicts, improved team collaboration, and clarified care goals for patients in the CSICU—all factors known to improve patient safety.

In clinical areas that are truly safe, where over 80% agree that good teamwork and safety exists, the Culture Check-up tool is not needed as often. In these areas, a consensus of excellence in which caregivers surface defects and take responsibility for addressing problems on their own already exists. For the rest of us, this tool makes it easier to get the process started.
Other Applications
We offer the Culture Check-up tool to all patient care areas at The Johns Hopkins Hospital as part of our annual culture measurement and feedback, starting in care areas with less than 60% agreement in teamwork or safety climate. This tool can also be applied to patient and employee satisfaction assessments.

Contact Us
Please contact Bryan Sexton at jsexton2@jhmi.edu.

References