**Introduction**

- Vanderbilt University Medical Center (VUMC) is a large academic medical center, with over 900 beds, serving both pediatric and adult populations.
- Within Perioperative Services, we have over 82 operative suites and 200 HR/PACU beds, caring for more than 56,000 patients annually. We are also experiencing rapid growth and expansion.
- Our geographic footprint includes multiple facilities across an expansive territory. We also have multiple affiliation agreements with partner facilities.
- Our faculty consists of over 400 attending surgeons, residents and fellows.
- Our staff consists of multiple roles with over 1,100 respondents organizationally.
- Improving the culture of safety in healthcare is of paramount importance for numerous reasons, especially with Perioperative Services, including:
  - Never events
  - Sentinel events
  - Near misses
  - Retained surgical items
  - Medication errors
- Commonalities found within adverse events reporting nationally, with human factors and communication being leading concerns.

**Organization Wide Programs**

- Implementation of AHRQ Safety Culture Survey
  - Over 4,400 respondents organizationally
- Many units with significant response rates (~70%)
- Diverse, multi-disciplinary response pool.
- Used to assess perceptions of safety culture and track changes over time.
- Results track in a similar fashion to national data, with non-punitive response to error being the most significant finding.
- This finding was present across multiple disciplines, with some differences amongst roles.
- Those that responded with more positive perceptions of teamwork also had more positive perceptions of safety and response to error.

**Perioperative Services**

- Aggressive efforts undertaken in 2012 to increase survey participation across all disciplines in PeriOp Services.
- Implementation of AHRQ Safety Culture Survey
  - Over 1,000 respondents (~70%)
- Formation of validated baseline results.
- Findings of very similar results across nursing, allied health, surgeon & anesthesia faculty.
- Transparency of data with open sharing and discussion in multiple, repeated formats.
- Multiple ongoing sessions discussing safety and teamwork, ongoing for existing staff.
- New staff also obtain focused orientation.
- Additional focus groups including surgeon and anesthesia faculty for team training.
- Efforts were largely tied to an internal program to improve teamwork and quality called Pioneer programs.

**Interprofessional Collaborative Learning**

Five teams were selected as Pioneer Programs for FY12. Pioneer status provides programs with special resources for focused quality and safety improvement projects. Participants receive training and technical support from collaborative faculty to ensure successful design, implementation, and evaluation of their project goals.

**Pioneer Program Design/Curriculum**

Pioneer program teams committed to a one-year immersion in safety science and quality improvement that culminated in the supported implementation of 1-2 focused improvement projects.

- Comprehensive curriculum that encompasses both internal and external subject matter experts.
- A wraparound model of support and consultation.
- Customized onsite workshops on improvement tools and methods.

**Experiential Learning**

Pioneer Teams have developed and implemented improvement projects with the support of internal coaches and external sensei. Implemented improvement projects include; interdisciplinary rounding, huddles and debriefs, hand-over communications, and teamwork behaviors.

**Summary**

- Utilization of the AHRQ Safety Culture survey provides a nationally standardized tool with significant sample size for benchmarking comparisons.
- AHRQ also offers ample materials for training in this area which can be customized for your team.
- Collecting data is often a positive intervention for change via increased awareness.
- Process takes time and repeated interactions.
- The essential content to educate and improve upon teamwork and safety culture are not significantly difficult to comprehend.
- The human factors of communication and psychological safety are key elements to integrate.
- Working towards small iterative steps of change, small group implementations with very simple tools.
- Primary goal of changing culture rather than complex tools (i.e. 3 question debrief).

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