December 2004

VA PATIENT SAFETY PROGRAM

A Cultural Perspective at Four Medical Facilities

GAO Accountability·Integrity·Reliability

Highlights

Highlights of GAO-05-83, a report to Secretary of Veterans Affairs

Why GAO Did This Study

The Department of Veterans Affairs (VA) introduced its Patient Safety Program in 1999 in order to discover and fix system flaws that could harm patients. The Program process relies on staff reports of close calls and adverse events. GAO found that achieving success requires a cultural shift from fear of punishment for reporting close calls and adverse events to mutual trust and comfort in reporting them.

GAO used ethnographic techniques to study the Patient Safety Program from the perspective of direct care clinicians at four VA medical facilities. This approach recognizes that what people say, do, and believe reflects a shared culture. The focus included (1) the status of VA's efforts to implement the Program, (2) the extent to which a culture exists that supports the Program, and (3) practices that promote patient safety. GAO combined more traditional survey methods with those from ethnography, including in-depth interviews and observation.

What GAO Recommends

To better assess the adequacy of clinicians' familiarity with, participation in, and cultural support for the Program, VA should (1) set goals, (2) develop tools for measuring goals by facility, and (3) develop interventions when goals have not been met. VA concurred with our recommendations and will develop an action plan.

www.gao.gov/cgi-bin/getrpt?GAO-05-83.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Nancy Kingsbury at (202) 512-2700 or kingsburyn@gao.gov.

What GAO Found

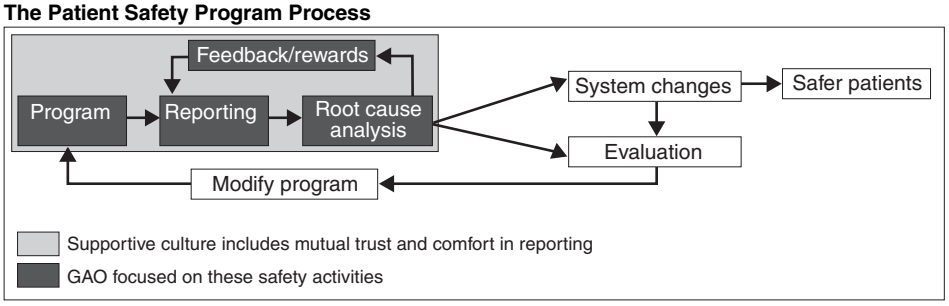
GAO found progress in staff familiarity with and participation in the VA Patient Safety Program's key initiatives, but these achievements varied substantially in the four facilities we visited. In our study conducted from November 2002 through August 2004, three-fourths of the clinicians across the facilities were familiar with the concepts of teams investigating root causes of unintentional adverse events and close calls. One-third of the staff had participated in such teams, and most who participated in these teams found it a positive learning experience.

The cultural support clinicians expressed for the Program also differed. At three of four facilities, GAO found a supportive culture, but at one facility the culture blocked participation for many clinicians. Clinicians articulated two themes that could stimulate culture change: leadership actions and open communication. For example, nurses need the confidence to disagree with physicians when they find an unsafe situation. Although VA has conducted a cultural survey, it has not set goals or explicitly measured, for example, staff familiarity and mutual trust.

Clinicians reported management practices at one facility that had helped them adopt the Program, including (1) story-telling techniques such as leaders telling about a case in which reporting an adverse event resulted in system change, (2) management efforts to coach staff, and (3) reward systems.

The Patient Safety Program Process in the figure shows how ideally (1) clinicians have cultural support for reporting adverse events and close calls, (2) teams investigate root causes, (3) systems are changed, (4) feedback and reward systems encourage reporting, and (5) patients are safer.

The Patient Safety Program Process



Source: GAO.