

Safety culture and team climate in Post Anaesthetic Care Units (PACU): impact on handover safety

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Australian health system

Public Hospitals	Private Hospitals
<ul style="list-style-type: none"> • 2.5 beds per 1,000 • 60% separations • Growth 1.8% (07/08) • 50% same day • LOS 6.2-6.5 days • 1.7m elective surgery 	<ul style="list-style-type: none"> • 1.3 beds per 1,000 • 40% separations • Growth 6.4% (07/08) • 66% same day • LOS 5.4 days • 1.2m elective surgery

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Team Climate & Safety Culture

- Characteristic of successful teams
- Positive safety culture
 - increased incident reporting
 - better risk management
 - team functioning
 - organisational readiness for change
 - job satisfaction
 - patient care outcomes
 - patient evaluations of their care

(Hutchinson et al., 2009; Sharma et al., 2006; Hamilton et al., 2007; Gosling et al., 2003; Harris et al., 2007; Bower et al., 2003)

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Objective

To investigate team climate and safety culture in the PACU with a particular focus on its influence on clinical handover and the incidence and impact of preventable errors

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Methodological Framework

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The Project

- 3 hospital sites
 - 1 public, 2 private
- 3 Stages
 1. Explore existing practice
 2. Develop tools
 3. Evaluate feasibility




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Stage 1. Explore practice

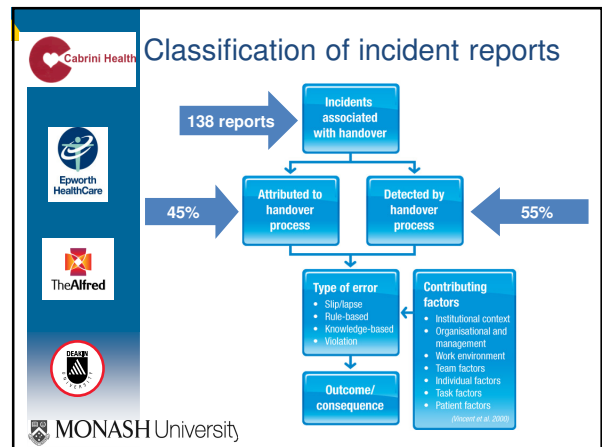
- Explore existing practice in PACU
 - **138** reported critical incidents related to handover
 - **314** observed handover events
 - focus groups with **62** multidisciplinary clinicians
 - team climate and safety culture surveys by **166** clinicians

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PACU handover related critical incidents

Incidents	Site 1	Site 2	Site 3
TOTAL (patient related & clinical area only)	2699	2973	791
Related to PACU handover	46 (1.6%)	81 (2.7%)	14 (1.8%)
Nurse	45 (97%)	80 (98.8%)	14 (100%)
Anaesthetist	16 (35%)	32 (39.5%)	9 (64.3%)
Surgeon	10 (22%)	13 (16%)	1 (7.1%)

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Team culture surveys

Safety Attitudes Questionnaire (sub-scales)

- Teamwork climate
- Perceptions of management
- Safety climate
- Stress recognition
- Job satisfaction
- Work environment

Team Climate Inventory (sub-scales)

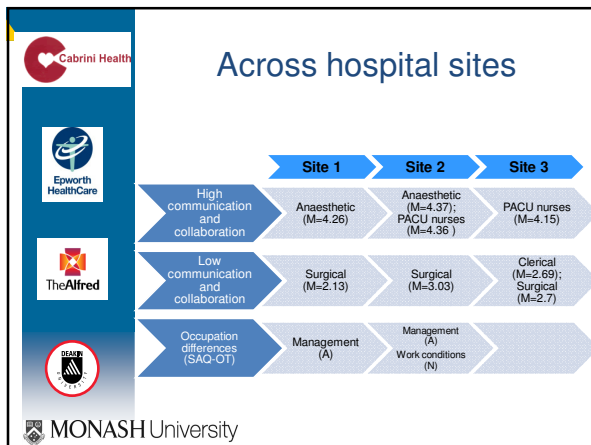
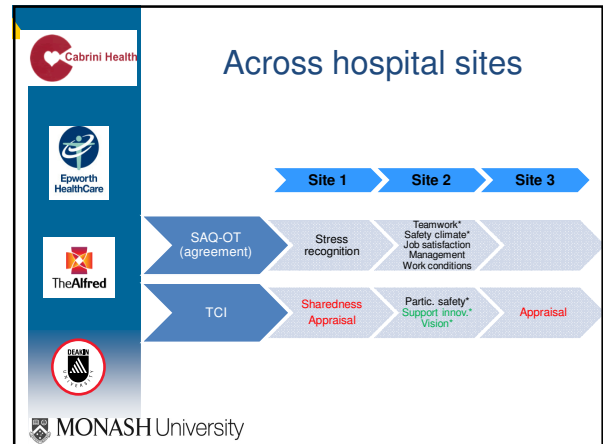
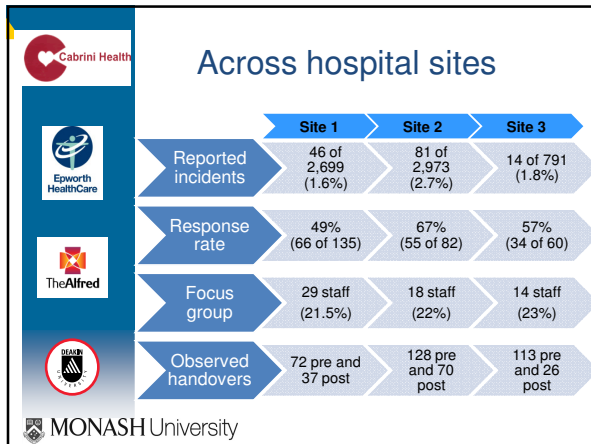
- Vision
- Participative safety
- Task orientation
- Support for innovation
- Social desirability

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Findings

- Responses lower than benchmark
- Across sites
 - communication and collaboration similar
 - SAQ & TCI differed between sites
- Between professions
 - Communication and collaboration higher with anaesthetic and nurses

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- ### Conclusions
- Communication impacts preventable errors in PACU
 - Organisational perspectives of team climate and safety culture influence improvement
 - More attention to the local context needed
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Further information

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MJA Handover supplement 2009
 Botti, M., et al. (2009). Examining communication and team performance during clinical handover in a complex environment: the private sector PACU. *Medical Journal of Australia*, 190, 1 June, S157-160.