CLARITY PSO
A Patient Safety Organization

White Paper

Journey to an Effective Safety Culture

Part I of III Exploring the Role of Culture in Safety Outcomes

Embracing Patient Safety Culture

What is the Purpose of this Series?

The purpose of this three-part white paper series is to bring awareness and understanding of safety culture from a healthcare perspective. Furthermore, we hope to provide you with a pathway in which to navigate the current programs and tools available for patient safety. The knowledge gained from this process can facilitate improvement processes, such as Plan-Do-Study-Act (PDSA)/Standardize-Do-Study-Act (SDSA), which impact patient outcomes and organizational safety culture.

- Part I, *Embracing Patient Safety Culture*, will start by defining patient safety and safety culture to better understand what makes an effective culture of safety. It will then introduce the history that prompted global awareness of patient safety issues and a call for action. We will also discuss the current state of patient safety from the Agency for Healthcare Research & Quality's (AHRQ) hospital survey on patient safety (HSOPS) culture results and identify the top strengths and weaknesses at the national level.

- Part II, *Awareness & Assessment of Safety Culture*, will focus on how errors occur as well as the role of complexity and chaos in an ever-changing healthcare environment. We will explore theories from complexity/chaos, systems thinking and human factors. Part II will also provide an introduction to proven safety programs and assessment tools available to support safety culture.

- Part III, *Effective Change for Quality Improvement*, will discuss principles of change and microsystems thinking, which go hand-in-hand with culture to create evidence-based, quality improvement processes that can be successfully sustained within an organization. We will also provide information on one of a variety of improvement processes, such as Plan-Do-Study-Act (PDSA). Essential to any change initiative is sustainment; the Standardize-Do-Study-Act (SDSA) process along with reinforcement throughout all levels of an organization would be required to assist in meeting this goal.

Introduction

>>What is Safety Culture?

We've all heard the term "safety culture," but what does it really mean and how do we know we are achieving it? These are very simple questions critical to positive patient safety, but they are often difficult to answer. A culture represents the values, beliefs and behaviors of a group or group(s) that are influenced by leaders and carry an intangible strength in driving actions within a group (Galanes & Adams, 2010). An effective safety culture uses a proactive versus a reactive approach to preventable harm and is the very glue connecting care processes within a healthcare delivery system, especially at the patient care unit level. The quality of this culture can make or break an organization's ability to provide patients with safe, effective, efficient, timely, equitable, patient-centered care leading to best outcomes.

To start the discussion and identify the keys pieces to an effective patient safety culture, we must first look at how healthcare defines patient safety and safety culture.

Patient Safety

The Institute of Medicine (IOM) (1999) defined patient safety as "*freedom from accidental injury.*" AHRQ expanded this definition to include *"freedom from accidental or preventable injuries produced by medical care*" and also provided the following extended definition in its text (Emanuel et al., 2008):

> *"Patient safety is a discipline in the healthcare sector that applies safety science methods towards the goal of achieving a trustworthy system of health care delivery. Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of and maximizes recovery from, adverse events."*

Activities performed to improve patient safety have also been defined as "*those that reduce the risk of adverse events related to exposure to medical care across a range of diagnoses or conditions*" (Mitchell, 2008). Safety science, then, is the method of gaining and acquiring knowledge of safety followed by practical application to create safe, reliable work designs in an organization (Emanuel, 2008).

Safety Culture

AHRQ (2004) defines safety culture as:

> *"The product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures."*

>>Why are Patient Safety and Safety Culture a Concern?

A burning question that has been raised recently is why, despite over 20 years of patient safety improvement efforts, are there still concerns about the number of medical errors and preventable harm? A recent hospital safety report card by the Leapfrog Group (HealthLeaders Media, October 23, 2013) states, "There has been very little improvement in how well providers are preventing patient harm." In his literature review, *A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care*, John James (2013) states that the number of preventable harm resulting in death exceed the original estimates of 44,000 - 98,000 and are closer to 210,000 - 440,000 deaths. While these are only estimates, the issue remains – patients continue to die from preventable harm. The real questions, then, are why and how do we improve these numbers? To answer these questions, we must first start by determining how effective an organization's culture really is. In fact, a new report from the National Patient Safety Foundation (2014), *Safety is Personal: Partnering with Patients and Families for the Safest Care*, lists "a dysfunctional professional culture" and "organizational leadership deficits" as two of the top five health system barriers to patient safety as it relates to patient engagement.

The issues of patient safety have become so alarming that in 2005, Congress passed the Patient Safety and Quality Improvement Act (PSQIA). This law led to the creation of Patient Safety Organizations (PSO), which gives healthcare providers a secure and protected environment to dig deep into matters of patient safety and share their knowledge with others without the fear of discovery. Healthcare professionals want to improve patient safety, but there is always the fear of blame and potential negative consequences, such as those affecting licensure or professional reputation. PSOs encourage candid learning and collaboration among healthcare providers making them valuable resources for the improvement of patient safety. The mission of PSOs is to foster a culture of safety by giving healthcare professionals voices and the resources they need to make positive changes.

>>How are Safety Cultures Created and Why are they Important?

From the recent explosion of knowledge and the advances in technology, we now have oceans of guidelines, toolkits and other how-to guides that have given us roadmaps of evidence-based best practices. Having the knowledge and skill to implement best practices simply isn't enough, though. Our attitudes are also important. Attitudes are reflected in what we do every day both as an individual and as a group. They directly impact a culture, including the safety culture of an organization or unit. According to AHRQ (2012), the following are the key features to safety improvement initiatives and a strong culture of safety, many of which tie directly to attitudes and accountability:

- Realizing the high-risk nature of an organization's activities and the determination to achieve consistently safe operations
- A blame-free environment where individuals are able to report errors or near misses without fear of punishment
- Encouraging collaboration among all healthcare providers to find solutions to patient safety problems
- Resources and commitment by an organization to address safety concerns

Ultimately, an effective safety culture must be woven into the very fabric of a unit's culture not only to drive safety practices, but to sustain them. To do this, you need the knowledge, the tools and the attitude. This does not always happen, though. The brunt of the problem can be described with the following adage: You can lead a horse to water, but you can't make him drink it. This is why bringing awareness and understanding of a safety culture to healthcare organizations is so important.

Historical Perspective

Since the IOM's landmark report on preventable harm, *To Err is Human*, agencies and hospitals have put considerable effort into improving patient safety outcomes. These activities have included advancements in technology, evidence-based best practices and quality improvement initiatives. The impact of these activities, however, has been unclear. Everyone seems to understand that changes need to be made, but there are barriers, and the current way of doing things appears to be part of the problem.

Medical traditions have not typically supported multidisciplinary team approaches or open communication regarding errors. Linda Emanuel (2008) provides an interesting background history in *Advances in Patient Safety: New Directions and Alternative Approaches* and concepts from the book are presented in this section. In earlier years, knowledge and skills were passed between providers in secrecy rather than shared out in the open. Error was seen as individual incompetency that had to be hunted down and "rooted out" (Emanual, 2008). A punitive response to error became the norm driving errors further down and hidden.

As time has passed, the credibility of both medical practices and practitioners evolved into reliable, evidence-based medicine leading to an increase in accountability for practice, continuing education and safe outcomes (Emanuel, 2008). However, we still see the same problem as before, a lack of accountability for the outcomes of patient care practices. In a world of individual blame and punitive responses to error, the transparency to share and to learn from each other has been either non-existent or limited to confidential hallway conversations. Improvement opportunities have been missed and patient harm has continued with an overreliance on individual human efforts of error prevention. What has been missing is the consideration of external factors and system processes that may have contributed to error and harm.

Production/service industries have long recognized the importance of system processes on successful outcomes in their areas, but systems thinking has been missing from healthcare. The recent focus on safety in healthcare prompted leaders to look to other industries such as aviation and production services to better understand systems thinking and see how these ideas can be adapted to the health industry. Systems thinking looks at external factors as the driving force of a system environment and includes culture (Porter-O'Grady & Malloch, 2011).

Safety Culture: A Call to Action

Today's healthcare delivery systems, patient acuity and group cultures, together form a complex web that often times results in gaps/fragmentation of care that can lead to harmful patient safety events. As we continue to explore how patient care can benefit from improvements in care, we must also be vigilant to culture and its effect on safety improvement outcomes and sustainability. John James' (2013) literature review sought answers to the question, "Where are we now?" with respect to patient safety and preventable harm and it appears the answer is not far from the start.

A little improvement is not enough to ensure the safety of our patients. We must amend our answer to James' question and do more in terms of preventable harm. To begin this quest, we must first start with improving safety cultures. Safety and quality strategies and initiatives will not work if you do not have the support and commitment from your both your leadership and staff.

Safety cultures can be very different from organization to organization, even unit to unit. While each unit has a safety culture that is uniquely its own (positive or otherwise), all the cultures must work well together. It is important, then, to evaluate each culture to see how each works, and ultimately, how they work together. Culture can be directly measured by surveys, such as AHRQ's Patient Safety Culture Survey or other assessment tools, and indirectly through a variety of organizational metrics.

Equally important is a Just Culture where individual accountability is considered, such as reckless behavior, in addition to system failures. While "no blame" is typically the case for most errors, with each event, we must consider an individual's role in terms of human error (e.g., slips), at-risk behavior (e.g., shortcuts) and reckless behavior (e.g., refusal to perform safety action such as a time out). Behaviors sabotaging a culture of safety play a role in the success of the culture and must be factored in.

Less formal assessments of safety culture include elements that can indicate a true patient safety culture. A discussion between health leaders, which included representatives from the Joint Commission's Center for Transforming Healthcare (Oh, 2012), brought forward the following notions to maintaining a patient safety culture:

1. Patient safety culture comes from the top; leadership makes safety a priority
    a. Visibility to staff; access to leadership, regular executive walk rounds, executive champion on initiatives/units
    b. Commitment among other leaders
    c. Resources are provided to support safety and improvement processes
    d. Psychological safety in discussing concerns is noted between frontline staff and leadership
2. Patient safety culture is driven by a vision
    a. The vision must support driving culture
    b. Analysis is done to understand where the organization currently is in terms of culture of safety and what the goal will be
    c. The vision is communicated to a shared mental model
3. Patient safety culture involves all healthcare team members and support staff at every level
    a. All members contribute to suggestions/action planning from their perspectives
    b. Providers/staff are comfortable speaking up or discussing safety issues or concerns

    c. There are methods to provide feedback, give suggestions, update progress, share results, etc.; all voices are heard
4. Patient safety culture requires some evolution; a culture evolves based on the unique needs of a healthcare system/unit and is an ongoing journey versus a one-time fix
5. Patient safety culture needs consistency
    a. In leadership commitment/support
    b. Among frontline providers, both senior staff and incoming staff
    c. Shared ideas and effective teamwork on the unit
6. Patient safety culture transcends leadership
    a. Effectiveness is not dependent on one leader or group
    b. Positive safety culture is internally driven, interwoven into the organization
    c. Sustained, improved patient safety outcomes

>>Current Status of Safety Culture: National Results of the AHRQ Hospital Survey on Patient Safety

Areas of strength are important to identify so organizations may use them to their advantage to improve safety cultures. On the other hand, areas for improvement are of great concern since each area effects safety culture in its own way.

Since 2007, in the AHRQ Hospital Survey on Patient Safety Culture (based on percent positive response), the top strengths and weaknesses related to safety culture have remained the same. As data matured, the top two in each category have remained unchanged. Below are the 2012 comparative database report results.

Areas of Strength
• Teamwork within units (80%) • Supervisor/manager expectations and actions promoting patient safety (75%) • Organizational learning – continuous improvement/management support for patient safety (tied at 72%)

Areas of Weakness
• Non-punitive response to error (44%) • Handoffs and transitions (45%) • Staffing (56%)

Why might these be the weakest areas in terms of safety culture? Non-punitive response to error speaks to issues of trust that may be blocking the psychological safety needed to report and learn from errors. Communication, particularly related to handoffs and transitions, is a critical, error-prone process in patient care that has been associated in over 80% of errors (the Joint Commission, 2002). Finally, staffing concerns/workflow issues can cause work overloads that result in frustration and dissatisfaction both for providers and patients.

Conclusion

Approaches to an effective safety culture need to become a part of an organization's everyday routine in order to sustain and avoid "flavor of the month" pitfalls. While there is no one-size-fits-all recipe that will magically build an effective culture of safety, there are enough best practice resources available to help create an organization's own unique recipe; one that supports national priorities, organizational mission/values, department goals, and above all, the needs of frontline providers and patients. The secret ingredient is your safety culture.

On your journey to an effective safety culture, the scope and intent have been presented to give you a basic understanding of the importance of culture in trying to prevent harm and improve patient safety. Part II of this white paper series will look at the role of complexity/chaos, systems thinking and human factors within a healthcare setting. Theories and safety program frameworks will be reviewed and safety culture assessment tools will be presented. Part III will conclude with an overview of change management along with processes for unit (microsystem) assessment and improvement to use within an organization and/or unit toward the ultimate goal: an effective culture supporting patient safety.

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