Developing Patient Safety Culture

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Patient Safety Culture - Outline

- Why is it important?
- What is it?
- Barriers in implementing patient safety system
- Key components required to create patient safety culture
- How is it measured?
- An example of patient safety culture survey result
- Conclusion

Importance of culture

An organization's patient safety culture must not be ignored. The patient safety culture significantly impacts the individual, the organization, as well as society as a whole. – WHO WAPS meeting Nov 2007, Japan

Importance of culture

- There is a ***need for a cultural change***, the status quo is no longer acceptable (IOM, 1999)
- The Change foundation recommends ***Creating a culture of safety*** to improve patient safety (February 2004)
- The Canadian Patient Safety Institute will:
  - influence ***change in culture*** … to improve patient safety;

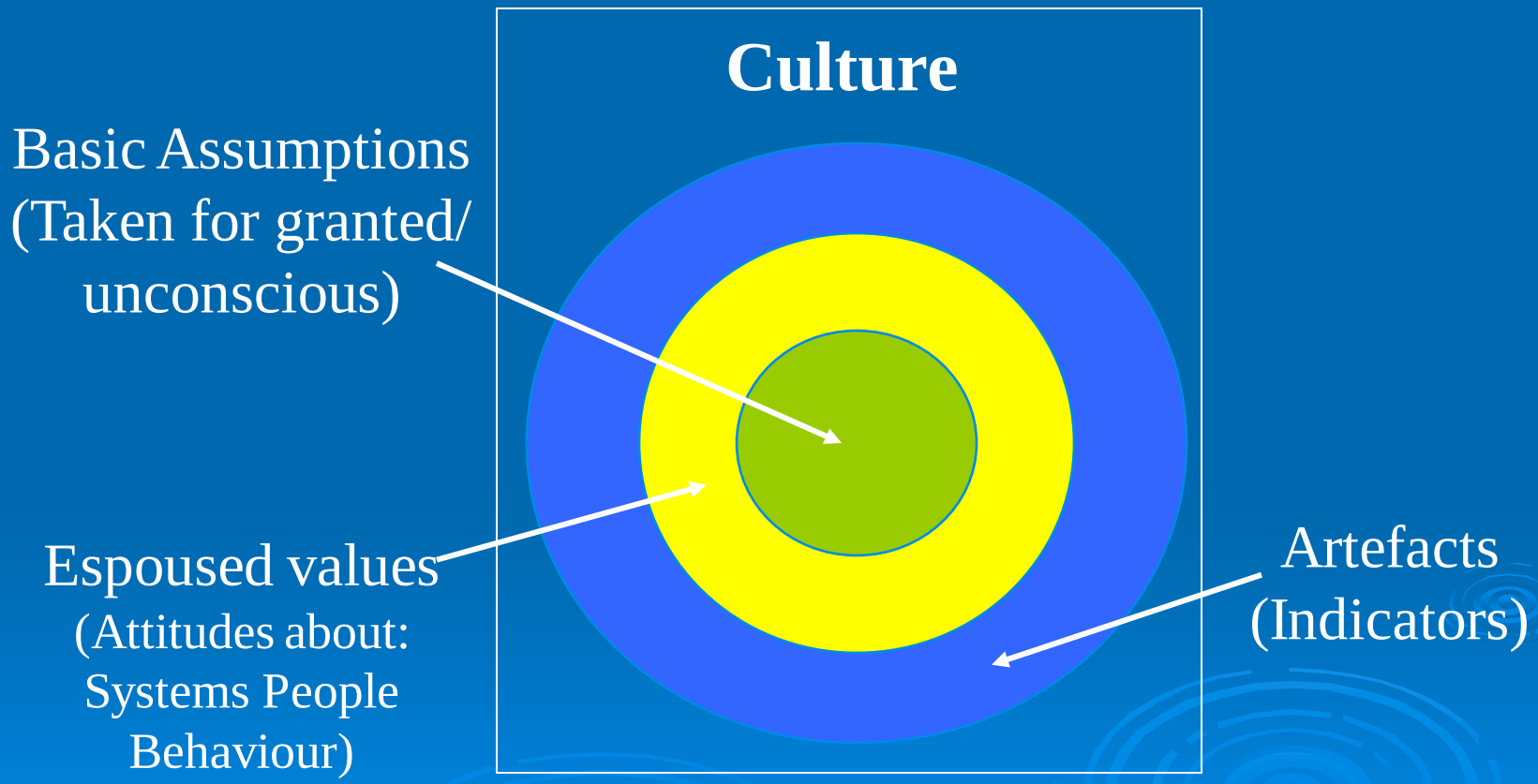
Organizational Culture

Culture has been defined as:

- A pattern of basic assumptions
- Invented, discovered or developed by a given group
- Learnt from coping with problems of external adaptation and internal integration
- That has worked well enough to be considered valid
- Is taught to new members (as the)
- Correct way to perceive, think and feel in relation to problems

Schein 1990 p110

Culture model



Barriers to implement a patient safety system

The "culture of blame" is one of the top seven barriers to implementing a patient safety system. The others are:

- Competition for scarce resources in a system where patient safety is not considered to be a top priority.
- Lack of resources: inadequate staffing and work overloads.
- Availability and cost of patient safety.
- Resistance to change.
- Lack of commitment at the executive level.
- Culture of health care workforce perceptions, attitudes and behaviors of error "cover up."

Even the best plans and strategies developed by experts are no more than academic exercises without the support of everyone in the organisation.

Consequently, culture change is also our biggest challenge

Key components required to create a patient safety culture

- **Leadership commitment**
- **Assessing and monitoring safety culture**
- **Patient engagement**

…Why the interest in Safety Culture?

- It is thought to be related to actual levels of patient safety; it is used as a proxy for safety as it is more easily quantifiable
- *Coercive and normative mechanisms

How do we Measure Safety Culture?

- Quantitative approaches
  - Just learning about their sensitivity to differences between units / organizations and to change over time
  - Is it a org or unit-level phenomenon? This has really practical implications for who and how many to survey and how to report the data for an organization
- Qualitative approaches
  - Provide a kind of depth and richness that is quite different

Areas Measured

AHRQ Dimensions

- Overall perceptions of safety
- Frequency of events reported
- Supervisory Leadership
- Organizational learning—continuous improvement
- Teamwork within units
- Communication openness
- Feedback & communication about error
- Nonpunitive response to error
- Staffing
- Hospital management support for patient safety
- Teamwork across hospital units
- Hospital handoffs & transitions

PLUS:

- Patient safety “grade”
- # of events individuals reported in last 12 months

Areas Measured

MaPSaF

Focuses on

- measuring progress towards making patient safety a central focus within their organization
- Identifying areas of particular strengthen or weakness
- Channeling resources in the most appropriate fashion

Dimensions

- Overall commitment to quality
- Priority given to patient safety
- Perception of causes of patient safety incidents and their identification
- Investigating patient safety incidents
- Organizational learning following a patient safety incident
- Communication about safety issues
- Personnel management and safety issues
- Staff education and training
- Team working around safety issues

How it's done Quantitatively

Tools available that organizations can implement on their own

- AHRQ (Agency for Healthcare Research and Quality) tool

  (www.ahrq.gov/qual/hospculture/)

- Manchester Patient Safety Framework (MsPSaF) tool

  (www.npsa.nhs.uk/nrls/improvingpatientsafety/humanfactors/mapsaf/)

How it's done Qualitatively

- Interviews and focus groups can be used to:
  - Help assess how well surveys are detecting real differences in safety culture (done more in a research)
  - As a proactive or reactive mechanism to promote learning and improvement and move safety forward:
    - unit specific dialogue to diagnose problems, bring discussion of the culture of safety to the surface, monitor progress in improving culture
    - may be a valuable, yet underutilized tool for enhancing safety
    - requires a certain level of immediate supervisory commitment
    - would also fit with more senior level commitment and leadership walkarounds

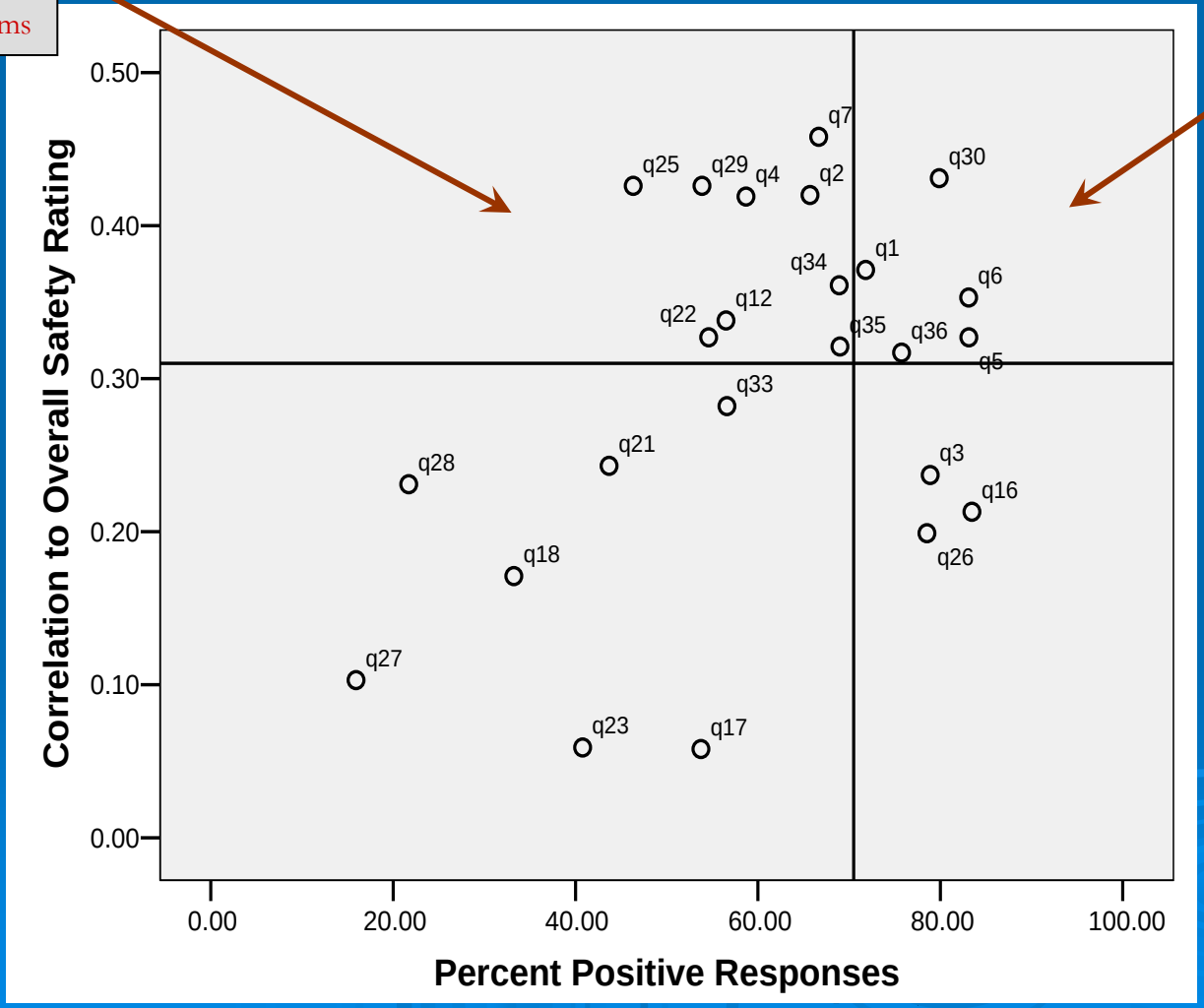
How to Use the Data

- Identification of learning opportunities:
  - Areas with low scores relative to other areas
  - Units or organizations with low scores relative to other units / orgs
    - Learning from best practice places seems to be terribly under-utilized as a strategy for implementing change
  - Some areas easier to address than others: valuing safety, reporting practices, state of safety, supervisory leadership

Performance / Improvement Learning Tool

High importance, weaker performance items

High importance, high performance items



Patient Safety Culture Survey Result: An Example

- Five general hospitals (private and public) in Belgium
- Questionnaire
- Hospital staff members: nurses and assistants, physicians, physiotherapist and lab technicians, pharmacist and pharmacy assistants, social workers
- Evaluated ten patient safety culture dimension and two outcomes

Dimensions with lowest scores

- Hospital management support for patient safety
- Non-punitive response to error
- Hospital transfers and transitions
- Staffing
- Teamwork across hospital units

Items with lowest positive scores

- “Hospital units do not coordinate well with each other” (overall 17%, range: 12-24%)
- “Things fall between the cracks when transferring patients from one unit to another” (24%, range: 20-27%)
- “Staff worry that mistakes they make are kept in their personnel file” (26%, range: 21-35%).
- “We work in crisis mode, trying to do too much, too quickly” (28%, range: 22-31%).
- “Hospital managers seem interested in patient safety only after an adverse event happens” (28%, range: 20-39%).

Highest positive score

When much work need to be done quickly, we work together as a team to get the work done (Teamwork within hospital units)

Areas identified for urgent attention

- more supportive management towards patient safety;
- developing a non-punitive culture;
- stimulating organisational learning; and
- focusing on hospital transfers and transitions through the different units in the hospital.

Conclusion: Highlights on Key positive safety culture aspects

- Communication based on mutual trust and openness
- Shared perceptions of the importance of safety
- Confidence in the efficacy of preventive safety measures
- Organizational learning
- Committed leadership and executive responsibility
- A “no blame”, non-punitive approach to incident reporting and analysis

Thank You

10 Dimensions

- Teamwork within hospital units
- Communication openness
- Feedback and communication about error
- Non-punitive response to error
- Staffing
- Hospital management support for patient safety
- Teamwork across hospital units
- Hospital transfers and transitions
- Frequency of event reporting
- Overall perceptions of safety