Module 5: Organization and Culture
### PSEP – Canada Objectives

The knowledge elements include an understanding of:

- Organizational culture
  - Elements of organizational culture
  - Features of a positive safety culture
- Understanding how to assess culture at the organizational and unit level
  - Strategies to improve the culture

The performance elements include the ability to:

- Develop a strategic plan for safety culture measurement and improvement
- Evaluate current culture
  - Measure, track, monitor culture
- Design and implement culture improvement strategies
- Identify barriers to improvement

### Related CPSI Safety Competencies

#### Domain: Contribute to a Culture of Patient Safety

1. *Health care professionals who commit to patient and provider safety through safe, competent, high-quality daily practice:*

1.1. Are able to articulate their role as individuals, as professionals, and as health care system employees in providing safe patient care

1.2. Act as role models and champion patient-safety behaviours

1.10. Demonstrate a commitment to a just culture, promoting fair approaches to dealing with adverse events

1.11. Advocate for improvements in system processes to support professional practice standards and the best patient care

2. *Health care professionals who are able to describe the fundamental elements of patient safety, understand:*

2.1. Core theories and terminology of patient safety and the epidemiology of unsafe practices

2.2. The characteristics and capacities of organizations with respect to patient safety, namely:

  2.2.1. A commitment to patient safety as a major organizational or institutional goal demonstrated at the most senior levels

  2.2.2. The establishment and maintenance of a just culture

  2.2.3. The implementation of patient safety best practices

  2.2.4. The conduct of adverse event and incident (e.g., close call) analysis

  2.2.5. The involvement of patients and their families as key players in patient safety

  2.2.6. The provision of an environment of support and safety for health care professionals

2.3. The use of evaluative strategies to promote safety

2.9. The elements of a just culture for patient safety, and the role of professional and organizational
<table>
<thead>
<tr>
<th>Domain: Optimize Human and Environmental Factors</th>
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<tr>
<td>1. Health care professionals who are able to describe the individual and environmental factors that can affect human performance understand:</td>
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<td>1.5. How to evaluate the impact of organizational resource allocation, policies and procedures and culture</td>
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3. Health care professionals who maintain and enhance patient safety practices through ongoing learning:

3.1. Identify opportunities for continuous learning and improvement for patient safety

3.2. Reflect on actions and decisions continuously, with self-awareness and using self-evaluation, to improve knowledge and skills in patient safety

3.7. Participate in self- and peer assessments reflecting on practice and patient outcomes

4. Health care professionals who demonstrate a questioning attitude as a fundamental aspect of safe professional practice and patient care:

4.1. Recognize that continuous improvement in patient care may require them to challenge existing methods

4.2. Identify existing procedures or policies that may be unsafe or are inconsistent with best practices and take action to address those concerns

4.3. Re-examine simplistic explanations for adverse events to facilitate optimal changes to care

4.4. Demonstrate openness to change
Leadership Standards

- A healthy and safe work environment is identified as a strategic priority.
- Support is provided for quality worklife and healthy and safe work environment improvement activities.
- Workplace health and safety policies that comply with relevant legislation are developed and implemented.
- Team members' fatigue and stress levels are monitored and work is done to reduce safety risks associated with fatigue and stress.
- REQUIRED ORGANIZATIONAL PRACTICE: A documented and coordinated approach to prevent workplace violence is implemented.
- Quality improvement is identified as a strategic priority.
- Roles and responsibilities for patient safety are defined in writing.
- REQUIRED ORGANIZATIONAL PRACTICE: Patient safety training and education that addresses specific patient safety focus areas are provided at least annually to leaders, team members, and volunteers.
- REQUIRED ORGANIZATIONAL PRACTICE: A patient safety plan is developed and implemented for the organization.
- Responsibility for implementing and monitoring the patient safety plan and for leading patient safety improvement activities is assigned to a council, committee, group, or individual.
- REQUIRED ORGANIZATIONAL PRACTICE: A patient safety incident management system that supports reporting and learning is implemented.
- The organization's leaders support a just culture and provide opportunities for team members to learn from patient safety incidents.
• REQUIRED ORGANIZATIONAL PRACTICE: A documented and coordinated approach to disclosing patient safety incidents to clients and families, that promotes communication and a supportive response, is implemented.

• REQUIRED ORGANIZATIONAL PRACTICE: At least one patient safety related prospective analysis is carried out and appropriate improvements are implemented as a result.

• ACCREDITATION CANADA REQUIRED INSTRUMENT: The organization's client safety culture is monitored by using the Canadian Patient Safety Culture Survey Tool.

• REQUIRED ORGANIZATIONAL PRACTICE: The governing body is provided with quarterly reports on patient safety that include recommended actions arising out of patient safety incident analysis, as well as improvements that were made.

• Opportunities for quality improvement are identified based on trends in patient safety incidents, performance data, patient experience data, feedback from Client and Family advisory councils and other sources, and plans are developed to prioritize and address those opportunities.

Governance Standards

• The governing body fosters and supports a culture of client safety throughout the organization.

• The governing body adopts client safety as a written strategic priority for the organization.

• REQUIRED ORGANIZATIONAL PRACTICE: The governing body demonstrates accountability for the quality of care provided by the organization.

Service Excellence Standards

• Safety improvement strategies are evaluated with input from clients and families. *

• Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families. *
Abstract

This module defines organizational culture, including patient safety culture and the distinction between a ‘blame’ culture and a ‘just’ culture. An open and transparent culture requires honest reporting and rewards for those who implement patient safety principles into their workplace. Strategies to assess the culture are presented including the strengths and weaknesses of each method. The module concludes with information on how to create a positive safety culture.

Keywords

Organizational culture, safety culture, just culture, double loop learning, values, beliefs, norms, violations, hindsight bias, reporting

Teaching methods

Interactive lecture, role play

Learning objectives

Knowledge requirements

- Be able to understand:
  - organizational culture
  - elements of organizational culture
  - features of a positive safety culture
  - assessment of culture at the organizational and unit level
  - strategies to improve the culture
The learning objectives of this module are to understand organizational culture of safety and to know how to create an organization in which patient safety is an essential component.

**Knowledge requirements**

The knowledge elements include an understanding of:

- organizational culture:
  - elements of organizational culture, and
  - features of a positive safety culture; and
- understanding how to assess culture at the organizational and unit level:
  - strategies to improve the culture.

**Performance requirements**

The performance elements include the ability to:

- develop a strategic plan for safety culture measurement and improvement;
- evaluate current culture:
  - measure, track, monitor culture;
- design and implement culture improvement strategies; and
- identify barriers to improvement.
Clinical case on trigger tape

A clinician describes an adverse event following the administration of a nerve block, which resulted in the patient going into cardiac arrest. Fortunately there was a fully staffed cardiac operating room close by and the patient was put on by-pass and survived. The physician explains how he wanted to go and speak to the patient and say that he was sorry for what he had done, but was advised to stay away from the patient. The physician describes the lack of support for his colleagues and that the culture made it difficult for him to discuss the issue. Eventually he wrote a letter to the patient and met with her and she forgave him for the event. He now works to change the culture to make it acceptable to discuss adverse events and to support healthcare workers involved in adverse events.

Introduction

Despite overwhelming agreement among health leaders that one of our biggest problems is a lack of a patient safety culture, we have yet to replace the old ways with policies and programs that support safety cultures. We acknowledge the role of systems in adverse events yet we still blame individuals when bad things happen. Mistrust is still prevalent - mistrust of managers, of bureaucracy, of government, of the media and of other health professions. Organizations are made up of individuals who collectively reflect the culture.
In the diagram above, the attributes of an individual healthcare provider (top left) and of an organization (top right), are each depicted as three sides of a safety triangle. The culture of an organization reflects the collective behavioural attributes of the individuals within it (the large triangle).

Individual awareness of the potential for and consequences of error is an important first step in understanding the multiple factors associated with adverse events, but in order to improve the safety and quality of healthcare we need to also understand the organization and the cultural milieu in which care is delivered.

Providing safe care that is patient-centered requires two conditions:

1. all healthcare professionals understand the need for delivering healthcare from the perspective of their unique patient; meeting their needs and expectations, and
2. the design of the system of healthcare needs to facilitate all those in need of healthcare to be able to access it and have care delivered in an environment that openly acknowledges the inherent risks in healthcare and designs services and prepares the workforce with that knowledge.

Importance of culture

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It is widely recognized that improvement in patient safety requires a change in healthcare culture. The healthcare culture plays a critical role in how well adverse events are detected and handled. The current healthcare culture has many strengths including the
autonomy of action and acceptance of personal responsibility, but it has the weakness of promoting the belief that adverse events are the result of personal and professional failure. (Leape, LL, Woods, DD, Hatlie, MJ, et al, 1998) This culture encourages healthcare providers to hide mistakes, to resist attempts to measure safety performance and make learning from adverse events difficult. Before attempting to change the culture it is important to understand the culture and how it can facilitate or prevent patient safety improvement.

**Culture and patient safety**

In Canada the importance of culture is clearly recognized. The Canadian Patient Safety Institute aims to create culture change within and across the healthcare system. Accreditation Canada has selected creating a patient safety culture as one of its important patient safety goals. This goal is supported by 5 required organizational practises to support the creation of a positive safety culture.

**Figure 1: Culture’s Influence on Patient Safety Outcomes**

*Adapted from Fleming and Hartnell Measurement*
Culture influences patient safety outcomes directly as the culture determines the accepted norms and practices. For example, hand hygiene practices are determined by the accepted norms within the organization. The acceptability of a nurse challenging a physician's practice (e.g., breaking the sterile field in theatre) is also determined by the culture. The behaviour of healthcare providers influences the safety of patients.

Culture indirectly influences patient safety by acting as a barrier or enabler to the adoption of interventions designed to promote patient safety. For example, the safe surgery checklist will only improve patient outcomes if implemented correctly, which requires healthcare professionals' acceptance. The adoption of the checklist requires a culture to recognize the need to improve patient safety, the possibility for improvement, and a willingness to change practice. Cultures that deny that there is a problem or assert that the problem is down to a few incompetent people, act as a barrier to system level interventions.

The culture of the organization changes in response to actions or interventions. A culture that is skeptical about the possibility of improving patient safety can be improved by the successful implementation of patient safety interventions. Although such cultures are a barrier to interventions, by persisting with the intervention culture change will occur. It is important to understand the cultural barriers and address them directly as part of the intervention. If the culture is likely to act as a barrier to success, then additional resources are required and initial failure should be anticipated.

**Organizational culture**

Safety culture is a particular type of organizational culture where safety is the dominant feature of the culture. Organizational culture emerged in response to the realization that simplistic management models (e.g., Taylorism) were not effective as they did not consider human nature (Reiman T, Oedewald P, Rollenhagen C, 2005). Culture became part of management vocabulary in the 1980's following the publication of a number of influential books (e.g., in search of excellence). Culture influences what we value and what we believe is important and is stable over time. Culture develops when individuals share a common experience in dealing with challenges. Culture is greater than the people...
that share the culture, as it is passed on to new group members. New members of the organization informally ‘learn’ the culture, through observation, social feedback and trial and error. Culture can be likened to an invisible guiding hand that directs behaviour. It influences group member’s choice to adopt safe or unsafe behaviours, e.g. to comply with rules and procedures.

**Common cultural terms**

A wide range of terms are used when discussing the culture of patient safety. Although these terms are often used interchangeably it is important to understand the distinct meaning of each term.

**Healthcare Culture:** Norms and accepted practises in healthcare

**Culture of safety:** Desired culture to support patient safety improvement

**Safety culture:** The relative priority placed on safety

**Blame culture:** A negative culture where people are reluctant to report adverse events

**Fair and just culture:** Desired culture where people do not fear unfair treatment for errors, but are held accountable for their actions.

**Safety culture**

“Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety and by the efficiency of preventive measures.”

- ACSNI
The term safety culture was first used by the International Atomic Energy Association (IAEA) in examining causal factors in the Chernobyl nuclear disaster in 1986. A poor safety culture has been identified as a causal factor in many other disasters such as the BP Texas city refinery explosion and the Deepwater Horizon in the Gulf of Mexico. The IAEA standards require nuclear facilities to develop and maintain a positive safety culture. Nuclear facilities regularly conduct safety culture self-assessment and have implemented many programs to promote a positive culture. Many other high hazard industries (e.g. offshore oil exploration) also actively promote a positive safety culture.

Outside of healthcare the Advisory Committee on the Safety of Nuclear Installations (ACSN) quote is the most widely accepted definition of a positive safety culture.

**Patient safety culture**

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Patient safety culture

A culture of safety can be defined as an integrated pattern of individual and organizational behaviour, based upon shared beliefs and values, that continuously seeks to minimize patient harm that may result from the processes of care delivery.

The Institute of Medicine (IOM) adopts Kenneth Kizer’s definition of a culture of safety in their new book *Patient Safety - Achieving a New Standard of Care*. This definition is consistent with the broader literature on safety culture but applies specifically to healthcare. The culture of safety is reflected by the behaviour of healthcare workers, which is shaped by their shared beliefs and values. A positive culture supports continuous improvement aimed at reducing patient harm. This definition does not explicitly mention the importance of trust which influences healthcare workers’ willingness to report mistakes and adverse events.
Patient safety culture elements

Patient safety culture is a multi-dimensional construct, consisting of a number of components or elements. There is no one accepted list of dimensions, as different research teams focus on different aspects of culture. The list produced by Singer et al. (2003) is comprehensive. Others provided more elements but these can be subsumed under the headings above. For example, Ginsburg et al. (2010) separate leadership commitment into unit and organizational leadership. Sexton included teamwork, which could be captured under effectiveness and openness of communication. The important point is that patient safety culture is a broad construct that contains many aspects rather than one unitary dimension. It is likely that healthcare organizations will vary across these dimensions, performing better on some and poorer on others.

Culture Recommended Organizational Practises

The multi-dimensional nature of patient safety culture is recognized in Accreditation Canada’s five Recommended Organizational Practises (ROPs) to support a positive safety culture.

Reporting system: This ROP supports organizational learning and the creation of fair and just culture.

Adverse event disclosure policy/process: This ROP supports openness about problems and errors and a fair and just culture
**Patient safety as a strategic priority:** This supports prioritizing safety over production and resources for patient safety

**Patient safety quarterly reports:** This supports leadership commitment and resources for patient safety

**Patient safety-related prospective analysis:** Supports organizational learning and resources for patient safety.

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**Understanding the blame culture**

As a general principle, when failures or mistakes occur it is common for individuals to be singled out. In healthcare, attributing or apportioning blame for adverse events to individuals is also common. Mistakes do not happen in a void; the social and political context inevitably impacts on our understanding and subsequent demands for answers as to why the event occurred. It’s easier to blame someone than undertake complicated detailed analysis of the many factors surrounding an adverse event. We think someone has to be accountable.

Underpinning the blame sentiment is the belief that:

- punitive action sends a strong message to others, and
- errors are unacceptable and that those who make them will be punished.

The problem with this assumption is that it is predicated on a belief that the offender actually chose to make the error rather than adopt the correct path; that they voluntarily intended to do the wrong thing.

Because individuals are trained and/or have professional/organizational status we think that they ‘should have known better’. Western notions of personal responsibility play a role in the search for the guilty party. Expressions such as ‘the buck stops with me’ are widely used. Professionals accept and assume responsibility for their actions as part of their training and code of practice. It is also easier to attribute legal responsibility for an accident to the mistakes and misconduct of those in direct control of the operation than on those at the managerial level.
Today most complex industrial/high technological organizations realize that a blame culture will not bring safety issues to the forefront. Finger pointing and cover-ups have no place in safe organizations which depend on open communication to identify breaks in the ‘defenses’. Accident analysis in these organizations routinely examines equipment design, procedures, training and other organizational features. But in non-industrial fields such as healthcare, the blame-and-punish management philosophy is still dominant.

Figure 2: Incident Decision Tree (National Patient Safety Agency, 2006)

The flowchart above is based on James Reason’s Culpability model. It details a series of questions regarding an individual’s motives and behaviours during an incident. These questions are grouped into four categories:

1. deliberate harm;
2. physical/mental health;
3. foresight; and
4. substitution.

When an incident occurs, using a decision-making process such as this example will help establish a fair and just culture.

**Trust**

One of the main aspects of a safety culture is the ability of healthcare workers to report mistakes, learn from them and measure the improvements. The lack of trust in existing processes for these activities has been a major factor behind the reluctance of staff to report mistakes.

**Common problems**

Many industries have had to overcome similar problems in their efforts to create safety cultures:

- fear by staff of consequences for reporting incidents:
  - don’t shoot the messenger, and
  - incentives and threats of disciplinary actions can encourage non-reporting or false reporting;
- safety requirements and statements are not related to behaviour on the job:
  - safety requirements do not reinforce safe behaviour because measurement is on outcomes rather than process measures, and
  - this approach encourages short-cuts;
- management usually makes plans and decisions regarding safety:
  - management usually takes charge of safety which serves to develop a them and us regime, and
  - staff rely on managers to look after safety; and
- over reliance on punishment to reduce unsafe acts:
  - punishment based safety programs are reactive rather than preventative, and
  - often teaches the wrong lesson.
Safety culture measurement and improvement can be conducted at either an organization-wide level or unit level. Organization-level measurement is a complex process requiring support from senior management and significant resources to undertake. The 10 step process described by Fleming (2005) provides guidance on how to measure and improve patient safety culture. Although creating organizational level change is challenging, it can produce a significant change in patient safety performance.

Within healthcare organizations, the culture of individual units or departments varies significantly. Individuals can take action to improve the culture at a local level. Unit level measurement and improvement mirrors the organizational-level process except it is more straightforward as there are fewer players. It is possible for a unit to assess their culture and develop an improvement plan that can be implemented at the unit level.

**Ten steps to culture measurement and improvement**
Irrespective of the measurement option selected, success can be enhanced by following best practise in safety culture measurement. The improvement process can be broken down into four main phases, namely Investigate, Initiate, Implement and Improve. These four phases incorporate the ten step process proposed by Fleming (2005).

I. Investigate
   1. Build capacity
   2. Select appropriate measurement instrument

II. Initiate
   3. Obtain informed leadership support
   4. Involve healthcare staff

III. Implement
   5. Conduct survey
   6. Analyse and interpret results
   7. Feedback results

IV. Improve
   8. Agree on interventions via consultation
   9. Implement interventions
   10. Track changes
Assessing and measuring the culture of an organization is a major undertaking. Organizations and the individuals charged with the culture measurement and improvement initiative should have some expertise in safety culture measurement and improvement.

Having expertise in safety culture measurement and improvement will assist with making decisions regarding:

- if culture measurement is appropriate;
- selection of the most appropriate measurement approach for the organization; and
- selection of external culture measurement provider (if necessary).

Expertise in safety culture measurement will also ensure that the culture measurement and improvement process is sustained.

Ideally, a small group comprising of individuals with diverse backgrounds and with different roles in the healthcare system such as quality, risk management, and clinical is created and charged with the task of measuring safety culture and developing an improvement strategy.

There are a number of different cultural measurement techniques currently available. These techniques can be categorized into two groups:

1. **Assessment of perceptual indicators of the culture:** These include patient safety surveys, conducting one-on-one interviews, and conducting focus groups or workshops. All three measurement techniques require a high degree of involvement from all levels of healthcare staff.

2. **Assessment of organizational level indicators of the culture:** Measurement of organizational level indicators requires a high degree of involvement from senior administrators as they are typically the ones responsible for completing the assessment.

Patient safety culture audit tools are designed to be completed by a team comprised of senior management and direct care providers. Audit tools identify what practises the
organization is currently doing well, which practises need improvement, and if there are any important practises the organization is currently not doing.

The VHA tool is one example of a patient safety culture audit tool, which assesses organizational practises in six areas.

**Patient safety surveys**

Over the past decade, a number of research teams have developed various patient safety culture survey instruments. These four culture surveys are just a few of the surveys now available to healthcare organizations.

With so many different versions of culture surveys now readily available, the question becomes which one is the best? This is not a question that can be easily answered. Each survey has its strength and weaknesses.

It is important to consider your specific organizational context in which the survey would be administered and the purpose for administrating the survey.

The Modified Stanford Instrument (MSI) patient safety culture survey has been used by Accreditation Canada as part of the accreditation process since January 2008.

Administering patient safety culture surveys is an efficient way of measuring the perceptual indicators of the organization’s culture. They can allow for benchmarking and comparison between sites or units within one site. However, the accuracy of patient safety culture survey responses in terms of representing staff perceptions of the culture is often called into question when there is a low response rate for these surveys. In addition, these surveys can be difficult to interpret. For example, what does it really tell you about the culture of the organization when 65% of staff agree with a question or when the organization scores a means score of 3.5 (rated on a 5-point scale) on a particular dimension of culture assessed with the survey? It is not surprising that the other criticism of patient safety culture surveys is that staff regardless of whether they completed the survey or not often have difficulty seeing the link between the survey and what they are
being asked to do as part of an improvement strategy that resulted from the results of the survey.

**Initiate**

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Senior leadership support for any initiative is crucial for its success. Senior leadership should fully understand the process that is being conducted to measure the culture of the organization, including what resources will be required to implement this process. The senior leadership should also be aware of the likely barriers encountered during this process, and most importantly what the expected outcomes are likely going to be, including what information will be gained by measuring the culture, how will this be disseminated, and who will have access to the results. Senior leaders need to be aware and be willing to accept that the process of measuring the culture may result in some negative findings, which depending on how the information is disseminated, may become public.

Healthcare staff can become involved in the culture measurement process directly by having a representative on a planning committee, by helping in the implementation of culture measurement initiative (e.g., distributing patient safety culture surveys), and indirectly through being continuously informed of the progress of culture measurement process. The idea here is that employees feel like they have a vested interest in the process. Having employees involved in patient safety initiatives is a key aspect of a positive patient safety culture.

At this stage in the process the information about the culture is collected using one of the techniques discussed (i.e., culture surveys, interviews/workshops, audits).
Data collection can start once the leadership support has been obtained and healthcare workers are engaged in the process.

When analyzing culture survey results concentrate more on patterns of responses, than on responses to individual questions (e.g., 70% of individuals agree with this statement). Similar questions in a culture survey are grouped together to form an evaluation of the element or dimension of culture they are all measuring (e.g., senior leadership support for safety is an element of culture measured with the MSI using 7 questions). Averaging responses for each element of culture measured provides an overall assessment of each element.

Once an audit of the patient safety culture is complete, examine the results and identify which organizational practises described in the audit that are not currently done in the organization or that should be improved.

The results of the patient safety culture measurement process should be communicated to all healthcare providers and staff. By informing everyone about the results of the measurement process they are more likely to continue to be interested and involved in the process. Communicating the results of an audit can also help demonstrate senior leaders commitment to patient safety.

It is not enough to simply provide a summary of the results from your measurement process, a timeline for the next steps taken and a plan to identify actions that result from measuring the culture should also be outlined at this time.
Patient safety improvement strategies can be developed based on the results from the measurement process. Perceptual indicators of the culture (e.g., culture surveys) are a reflection of the organizational practices and systems, therefore, improvement strategies should be targeted at changing organizational practices and systems. For example, if the results of a patient safety culture survey indicate that staff do not perceive management to be committed to patient safety, then improvement strategies should be aimed at improving employee interactions with management through, for example, training and evaluating safety leadership practices.

It is important to know if the improvement strategies that resulted from the initial assessment of the culture worked. One way to evaluate if the improvement strategy was effective is to reassess the cultural indicators. For example, if a culture survey was conducted in the initial assessment of culture, the organization can resurvey staff members to see if their perceptions have improved. In this particular case, it is helpful to ask staff members to create a unique code that can be used to match their responses on surveys over time.

**Unit level assessment and improvement**

The “Culture Check-up” was developed by Sexton and colleagues in 2006. The purpose of this tool is to provide structure and direction for patient safety culture discussions and
action planning sessions. The culture check-up is meant to be completed as a group exercise with a representative sample of frontline caregivers. The exercise is broken down into three tasks:

1. using the results from the Safety Attitudes Questionnaire (SAQ) (or another validated patient safety culture survey) the group selects one item which less than 60% of respondents agreed upon (there is also an option to choose upon a list of diagnostic items provided);
2. discuss what that item chosen means to them, if the item score is reflective of their experiences, and what 100% agreement for this item would look like; and
3. identify one actionable idea to improve the results related to this item.

The culture check-up can be a useful tool when trying to make sense of culture survey results and make decisions on the next actions to take to improve the culture of the organization. The tool can be used immediately after the organization receives its culture survey results or periodically through the year as a way of keeping a finger on the pulse of the culture. The more often the culture check-up tool is completed, the more it will help in normalizing conversations about patient safety culture.

Models of change

Organizational development theory and change theories can be applied to quality improvements in healthcare.

What is the shared ‘vision’ to be accomplished?

Everyone needs to understand why the way they currently work is not viable and what changes they need to make and how. The case for fundamental change needs to be made to everyone so they are aware of the reasons for change and the driving forces supporting them.

Leadership at the ward, unit and organizational levels is essential. Without leadership those who do not support the changes will remain a strong group. Many good programs have failed because of weak and wavering support of those in leadership positions. PSEP
Canada Module 8: Leadership: Everybody's Job develops this theme and further explores the role of leadership in culture change.

**How receptive is the organizational culture to change?**

Ignoring those who are doubtful of the proposed changes is not viable if change is to occur. It is important that staff remaining uncertain of the value of the changes have formal opportunities (meetings, forums) to voice their concerns. Everyone needs to be engaged and permitted to participate in the change process. Rewarding those who embrace change is important. But there may be times when those who do not embrace a change and continue, for example, to violate a protocol may have to be held accountable.

An effective approach is to assume a culture of learning and not focus on the individuals who transgress. Take the time to identify those individuals who can assist the process. Train them and develop their knowledge and skills so they can become change agents for the organization. Only with repeated expression of the desired changes and follow-through on the changes will organizations actually change.

The policies of an organization must reflect what is being communicated. This will require effective communication. A common factor in organization failure is the suboptimal quality of the communication between the managers and staff. The use of managers rather than front line supervisors and staff to communicate change was another problem that met resistance. Face to face communications are best, particularly in healthcare where so many variables underpin how information is received and considered.

**What must be done during implementation of the changes?**

The vision alone will not lead to change. Key people must continually talk about the vision and engage others around them so that they become part of the implementation process. This creates an environment in which others become receptive to change.

Many projects begin with enthusiasm and energy but fail because of inadequate planning for the middle stage of implementation. Sometimes people are worn down by resistance. The lack of incentives, champions and basic planning for each stage of the process are common oversights.

All change processes need a champion or dedicated person or persons to be responsible for the process and manage those who will not or cannot adapt to change. In their role as mediators, they can help resisters move on or adapt through some other processes (retraining opportunities). The project team will be able to put out brush fires and keep up the momentum. Successes should be known and widely publicized.
Double loop learning

The process of changing the values, beliefs and delivery in an organization is called ‘double loop learning’. Adverse events are identified and reported and then corrected at a system and organizational level. This will usually involve changes to the organization’s rules, policies and objectives. Argyris and Schon (1978) were the first to describe single-loop and double-loop learning.

Figure 3 – Double loop learning (Argyris C, Schön D, 1978)

Single loop learning occurs when individuals, groups or organizations modify their actions according to the difference between expected and obtained outcomes. This learning focuses on the identification and correction of adverse events within a given set of explicit variables, usually linked to incremental change in organizations. Double loop learning occurs when the entities (individuals, groups or organization) question the values, assumptions and policies that led to the actions in the first place; if they are able to view and modify those, then second-order or double-loop learning has taken place. Double loop learning is the learning about single-loop learning. This learning interrogates the explicit variables themselves and can lead to major changes such as a total restructure or revision of the methods used in the system, alterations in strategy and so on.
Taking action

Fundamentally patient safety culture is about people and it changes by the actions of people. By consider the current culture within the organization and department/unit, providers can brainstorm about what can be done differently. Some examples of activities include:

- identifying aspects of the culture that could be improved;
- identifying one action that would improve the culture within the organization;
- identifying one action that would improve the culture within the department or unit; and
- listing one thing that could be done to promote a positive safety culture.

Summary

An organization’s culture in relation to patient safety is central to improving the quality and safety of healthcare and minimizing adverse events. Organizations with a strong patient safety culture implement a range of processes and tools to ensure that everyone in the organization makes patient safety a top priority. One of the key ways that healthcare organizations demonstrate that priority is by continually assessing the vulnerabilities in the system, making improvements and re-measuring to make sure the improvements are maintained.
Potential pitfalls

1. Try to ensure that the same rules apply to everyone in the organization equally
2. Avoid saying that a just culture exists when the staff do not trust the organizational processes for reporting.
3. Making changes at one level without an overall appreciation of the impact on other layers of the organization.

Pearls

1. Creating a positive patient safety culture is critical to improving the quality and safety for patients
2. A blame culture results in adverse events being hidden
3. A just culture describes a system where there is a balance between system and individual accountability.
4. An open, diverse, and transparent culture is created when reporting is routine and people learn from errors.
Toolkits and outcome measures

Refer to the Toolkit and Resource Compendium (PSEP – Canada Appendix 1c) for more details on the following toolkits.

- **Incident Decision Tree**: National Patient Safety Agency National Health Service UK 2006 [http://www.msnpsa.nhs.uk/idt2/(10cvn1fo5fssc4ell4fhtp45)/index.aspx](http://www.msnpsa.nhs.uk/idt2/(10cvn1fo5fssc4ell4fhtp45)/index.aspx)
03-03. The University of Texas Center of Excellence for Patient Safety Research and Practice (AHRQ grant # 1PO1HS1154401 and U18HS1116401). http://www.uth.tmc.edu/schools/med/imed/patient_safety/survey&tools.htm

- **Walk-through (IHI Tool)**: David Gustafson, PhD, University of Wisconsin, Madison; Institute for Healthcare Improvement http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Tools/Walk-through.htm

## Resources

Refer to the Toolkit and Resource Compendium (PSEP – Canada Appendix 1c) for more details on the following resources.

- **Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions**: Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions. Canadian Medical Protective Association; 2009. https://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/com_learning_from_adverse_events-e.cfm https://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/com_learning_from_adverse_events-f.cfm

References


Canadian Medical Protective Association. *Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions*. Ottawa, ON: Canadian Medical Protective Association; 2009. [http://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/com_learning_from_adverse_events-e.cfm](http://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/com_learning_from_adverse_events-e.cfm)


Principal message

The single most important message your audience should come away with is that *when individuals are blamed for mistakes and failures, others hide mistakes for fear of punishment.* As part of this insight, participants should understand that *individuals need to be rewarded not punished* for implementing patient safety principles into their workplace.

Module overview

This module provides the audience with an understanding of the blame culture and how such a culture impacts on organizational culture. The material in this module presents information on how to achieve the desired culture – one of fairness and transparency, also called a just culture. Using change management principles an organization can create an open, diverse and transparent culture in which reporting and double loop learning are instilled.

Some basic concepts such as beliefs, norms and practices are defined to help the audience understand the nature of organizations and how they are composed. The ways people think about culture is also covered. Common problems for safety cultures are outlined and allow scope for audience discussion.

The components of a safety culture are described and defined in the context of healthcare (individual and group values, attitudes, competencies and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization’s health and safety programs).

The module also discusses the main two types of changes that occur: reform (first order change) and transformational (second order change). Single loop learning and double loop learning concepts introduced by Argyris and Schon in 1978 are explained so that the audience can understand how to effect change.

The module concludes with steps to take to identify whether safety is valued in the organization. At a system level seven characteristics of organizations with a culture of safety are described. The module concludes with the personal steps that can be taken by each person knowing that their actions collectively can change the system.

Preparing for a presentation

1. Assess the needs of your audience

Choose from the material provided in the syllabus according to the needs of your expected participants. It is better for participants to come away with a few new pieces of
information, well learned, than to come away with a deluge of information from which they can remember little or nothing.

2. Presentation timing

Allow sufficient time to collect participants’ demographic data and complete the pre-test.

The suggested timing for each part of this module is:

- Introduction: 2-3 minutes
- DVD trigger tape & discussion: 5-7 minutes
- Presentation: 30 minutes
- Debrief about teaching methods: 5 minutes
- Summary: 2-3 minutes
- Post-test & Evaluation: 5 minutes
- Total: 49-53 minutes

3. Number of slides: 31

4. Preparing your presentation

The text in the syllabus was not designed to be used as a prepared speech. Instead, the text provides material you may want to use. The slides have been designed to trigger your presentation. Although the slides closely follow the text of the syllabus, they do not contain all of the content. Their use presumes that you have mastered the content.

You may want to make notes on the slide summary pages to help you prepare your talk in more detail and provide you with notes to follow during your presentation.

Remember that you can adjust the slides to suit your presentation content, your style, and to make it feel fully familiar and your own.

Practice your presentation using the slides you have chosen, and speaking to yourself in the kind of language you expect to use, until it is smooth and interesting and takes the right amount of time. The most accomplished presenters and teachers still practice prior to a presentation; don’t miss this step.

5. Preparing a handout for participants

The syllabus text and slides in the Participant’s Handbook were designed to be reproduced and provided to participants as a handout. Take the portion you need; they can be used in their entirety, module by module, or for just one specific topic. Please include the following in each set of handouts:

- PSEP - Canada Front Cover Page;
6. Equipment needs

- Slide projector and screen
- DVD player and monitor or projector
- Flipchart, or overhead projector with acetates, and markers for recording discussion points

Test your equipment beforehand to ensure that it works.

Review your DVD segments to assess which trigger videos or portions you would like to use.

Have a back-up plan so that if there is any equipment failure you can move without panic to your back-up plan. For instance, have in mind that:

- if the DVD fails, you can read the vignette of the trigger tape story;
- if the slides cannot be shown, refer to the hand out slides; and
- if the markers or overhead projector do not work, have participants list items on their hand outs that you would have written up for all to see.

Making the presentation

1. Introduce yourself

If you have not already done so, introduce yourself. Include your name, title, and the organization(s) you work for. Briefly describe your professional experience related to the information you will be presenting.

2. Introduce the topic

Show the title slide for the module. To establish the context for the session, make a few broad statements about the importance of topic as a patient safety matter. Tell participants the format and time you will take to present the session. Identify the teaching styles that you intend to use.
3. Review the session objectives
Show the slide with the session objectives listed. Read each objective and indicate those that you are planning to emphasize.

4. Show the DVD trigger tape
After reviewing the objectives for the session, show the DVD trigger tape. It has been designed to engage the audience and provide an appropriate clinical context for the session. It was not designed to demonstrate an ideal interaction, but to “trigger” discussion.

Trigger tape content
Dr. van Pelt administered anesthesia to patient Linda Kenney who was undergoing ankle replacement surgery. Soon after, Mrs. Kenney suffered cardiac arrest as a result of his nerve block placement. Dr. van Pelt recounts his anguish over the harm to his patient, the frustration and isolation he experienced because of the medical culture’s lack of support for patients and clinicians, and his commitment to work to improve the system.

Keep in mind that the facilitator may choose to use any one of the trigger tapes. Since the vignettes are rich and overlap in their teaching points, it may make sense to do this, for instance if an audience has seen the trigger tape already or if a trigger tape from another module is easier for the audience to identify with.

A teachable moment: discussion after the trigger tape
After the trigger tape, ask the participants for their comments about the issues and the interaction they have just seen. To affirm what they contribute, consider recording the important points on a flipchart or overhead projector.

If the discussion is slow to start, you may want to ask more direct questions, like:

- What is challenging regarding organization and culture?
- Has a something like this happened in your institution? How did your institution react?
- Do you think your institution has a culture of safety?

Use the discussion to set the stage for the material to follow. Do not let the discussion focus on a critique of the technical quality of the DVD or how “real” the players seemed. If the participants do not like something that was said or done in the DVD, acknowledge that there is always room for improvement and ask them how they would do it themselves.
Setting limits to discussion time

It is usually best to limit discussion of the DVD to no more than five minutes, then move on to the presentation. To help move on if the discussion is very engaged, try saying something like:

- let’s hear two last points before we move on, and
- now that you have raised many of the tough questions, let’s see how many practical answers we can find.

For the more advanced facilitator who is very confident of both the patient safety material and his or her pedagogic skills, it is possible to use the trigger tape as a form of case-based teaching and to facilitate the discussion to draw out the teaching points of the module. The hazard of this approach is that the discussion will not yield the desired teaching points. Feel free to return to the slides if this happens. If this approach is used, it is essential to write up the points on a flip chart as they arise, to fill in any gaps and to summarize at the end. Again, use this method with caution and only if you are really ready.

5. Present the material

Recommended style: interactive lecture

An interactive lecture will permit you to engage your audience, yet cover your chosen material within the time.

Ask the participants about their major concerns regarding organization and culture and to give you a case from their institution or experience. Once you find a case that resonates with the group, you may choose a focus. Have a back up case from your own experience in case you there are reasons to not go into the ones from the audience. Choose the focus so that you can deliver specific content you have prepared.

Alternative style: role play

Conduct a role play using the case description below. The goal is to:

- experience the challenges presented by a closed organizational culture, and
- experience advocating for an open culture.

The role play can be conducted as a fishbowl, where three participants perform the role play in front of everyone, or within small groups. After completing the role play, facilitate discussion among the group. Possible questions include:

- To actors: What did you find difficult about your role?
- To group: What aspects went well and what didn’t? How would you have handled a similar situation?
Case description

A 57 year old patient drove himself from home one evening to the Emergency Department (ED) with new abdominal pain. He was examined by the resident and presented to the attending physician; after full and appropriate assessment no clear diagnosis could be made, so he was placed in the Observation Area. The patient went into cardiac arrest. Full resuscitation attempts failed. The family could not be found for two days, at which point the information was communicated by a different resident who was on call at the time. The family asked for access to the patient’s medical records, which was denied. The Risk Management Office advised no further communication with the family. Several months later, a suit was brought.

The attending physician, Dr. Gray is meeting with the chairman of the ED, Dr. Sallaway, and the Risk Management Office director, Mr. Gefman, to consider how this situation could have been handled differently.

Role – Dr. Sallaway, chairman of the ED

You have been sued before, as have many of your colleagues. You view emergency medicine as a high-risk activity and you are anxious to make sure Dr. Gray is not too devastated by this. You offer assurance and encouragement to keep on going.

Role – Dr. Gray, attending physician

You are concerned that the family must believe that something was done wrong that the hospital is trying to hide since they were unable to get information. You want to talk to the family. You have been advised by Mr. Gefman that it is too late since suit has been brought. You are frustrated that someone not on the team talked with the family to tell them of the death and you are also frustrated that you were counseled to avoid contact with the family right after that time. You ask Dr. Sallaway and Mr. Gefman to let you explain how you would have spoken with the family and how you feel it would have provided for a partnership with instead of an antagonistic relationship with the family.

Role – Mr. Gefman, risk management director

You are aware that the family seemed to be highly upset when the meeting was held to tell them the news. The wife was away from the house when the patient became ill and seemed to have ‘issues.’ You counseled against further communication at the time as you were concerned that expressions of empathy would be construed as admission of fault and used against your client in what you considered to be a virtually inevitable law suit.

6. Key take-home points

1. The organization’s patient safety culture is critical to improving quality and safety for patients.
2. The blame culture is responsible for keeping errors hidden.
3. A just culture describes a system where there is a balance between system and individual accountability.

4. An open, diverse and transparent culture is created when reporting is routine and people learn from the errors.

5. Try to ensure that the same rules apply to everyone in the organization equally.

6. Avoid saying that a just culture exists when the staff do not trust the organization processes for reporting.

7. **Summarize the discussion**
   
   Briefly, review each part of the presentation. Recap two or three of the most important points that were discussed.

8. **Debrief about the teaching method**
   
   Tell the group that it is time to consider the teaching method used, how it worked and what its limitations were. Ask them what other methods might work, and what methods would work best *for the topic* in their home institutions. Ask them to consider what method would work best *for themselves as facilitators* and for their *target audience*.

9. **Post-test/evaluation**
   
   Ask the participants to complete the post-test questions for this module and evaluate the session.