



The Patient Safety
Education Program™
CANADA

Module 5: Organization and Culture: Essential to Patient Safety

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[Revised 2017]

PSEP – Canada Objectives	Related CPSI Safety Competencies
<p>The knowledge elements include an understanding of:</p> <ul style="list-style-type: none"> • Organizational culture <ul style="list-style-type: none"> ○ Elements of organizational culture ○ Features of a positive safety culture • Understanding how to assess culture at the organizational and unit level <ul style="list-style-type: none"> ○ Strategies to improve the culture <p>The performance elements include the ability to:</p> <ul style="list-style-type: none"> • Develop a strategic plan for safety culture measurement and improvement • Evaluate current culture <ul style="list-style-type: none"> ○ Measure, track, monitor culture • Design and implement culture improvement strategies • Identify barriers to improvement 	<p>Domain: Contribute to a Culture of Patient Safety</p> <p><i>1. Health care professionals who commit to patient and provider safety through safe, competent, high-quality daily practice:</i></p> <ul style="list-style-type: none"> 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 <p><i>2. Health care professionals who are able to describe the fundamental elements of patient safety, understand:</i></p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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

accountabilities

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

Domain: Optimize Human and Environmental Factors

1. Health care professionals who are able to describe the individual and environmental factors that can affect human performance understand:

1.5. How to evaluate the impact of organizational resource allocation, policies and procedures and culture

Abstract

Slide 1



Module 5

Organization and Culture:
Essential to Patient Safety

This module provides the audience with an understanding of organizational culture and how such a culture impacts patient safety. The material in this module presents information on how to measure and improve organizational culture to achieve a positive patient safety culture. Using change management principles an organization can create an open, diverse and transparent culture in which reporting and learning are celebrated.

Keywords

Organizational culture, safety culture, patient safety culture, systems perspective, measurement, improvement, readiness for change.

Teaching methods

Interactive lecture, role play

Learning objectives

Slide 2

Knowledge requirements

- Organizational culture:
 - Elements of organizational culture
 - Elements of patient safety culture
 - Dimensions of a positive safety culture
 - Assessment of culture at the organizational level
 - Strategies to improve culture

Slide 3

Performance requirements

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

The learning objectives of this module are to explain organizational safety culture and to describe how to foster an organizational culture in which patient safety is an essential dimension.

Knowledge requirements

The knowledge elements include an understanding of:

- Elements of organizational culture
- Elements of patient safety culture
- Dimensions of a positive safety culture
- Understanding how to assess culture at the organizational level
- Strategies to improve culture.

Performance requirements

The performance elements include the ability to:

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

Clinical case on trigger tape

Slide 4

Trigger tape

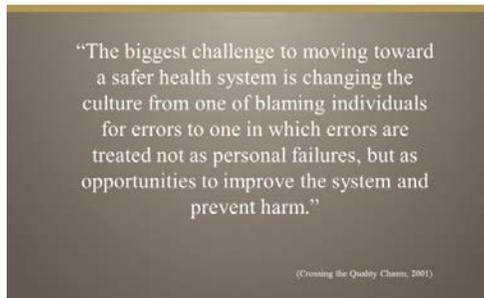


A clinician describes a patient safety incident following the administration of a nerve block, which result in the patient going into cardiac arrest. Fortunately, there was a fully staffed cardiac operating room close by and the patient was put on by-pass and survived. The physician explains how he wanted 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

Slide 5

Introduction



Since the release of *To Err is Human* in 1999 (IOM, 1999) and the Canadian Adverse Events Study in 2004 (Baker et al., 2004), there has been increased emphasis on identifying and mitigating potential sources of patient safety incidences. With increased knowledge that health care poses significant risks to patients, greater attention has been paid to other high reliability organizations, like the commercial aviation and the nuclear industry that operate with a high level of risk yet maintain high safety levels, to explore the impact of organizational culture on patient safety.

While it has been acknowledged that system failures contribute greatly to patient safety incidents, organizations still often blame individuals when bad things happen. This in turn can breed a culture of fear and mistrust where health care professionals are less likely to report incidents and near misses when they occur and organizations are unable to learn from mistakes. (Reason, 2000) (Weick KE, Sutcliffe KM, 2001)

Organizational culture

Slide 6

Organizational culture

“Shared values (what is important) and beliefs (how things work) that interact with an organization’s structures and control systems to produce behavioral norms (the way things are done)”
(Uital, 1983)

An exploration of patient safety culture first needs to begin with an appreciation for organizational culture as a whole. Every organization has a culture that speaks to how things are done. Patient safety culture requires that the organizational culture, staff, and workplace policies and procedures be aligned. While individual awareness of the potential for, and consequences of, patient safety incidents is important to ensuring the delivery of safe and effective care, taking a systems approach to patient safety is important to understand the underlying cultural context that may either enable or prevent incidents from occurring.

Organizational culture has also been described by Schein (2004) as encompassing three different levels: (1) artefacts and behaviours, (2) espoused values, and (3) underlying assumptions. These levels range from tangible elements (e.g., patient safety strategies, reporting systems) to those that are inherent and deeply embedded (e.g., how surgical teams always work together). Organizational culture is also reinforced through organizational strategic plans, mission and vision statements, and codes of conduct. It is imperative that all of these levels and supports reinforce one another if cultural change is to take place.

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Organizational culture in health care

- “Organizational culture” can often be made up of different cultures
- In health care, “unit” cultures can be seen as a subset of organizational culture

(Phipps & Ashcroft, 2012)

When one describes organizational culture it is often assumed that an organization has one culture. However, in larger organizations, and especially those that have many different departments and units working towards different goals, subcultures may develop. Phipps & Ashcroft (2012) identify these “subcultures” as those that exist within an organization’s overarching culture and may share common elements. However, subcultures may also compete with an organization’s overall culture. As such, cultural change may have to take place at the organizational level, or may only need to take place at the unit level. As well, health care organizations can be in the unique position to have different cultures based on employee type (e.g., nurses vs. physicians). This can be attributed to the degree of professional autonomy in health care. While this is important in ensuring patient safety, as it encompasses professional responsibility and codes of ethics, it can also create opportunities for variations in culture and practice. This is not necessarily a deterrent to measuring and changing organizational culture, but helps to explain the multitude of factors that need to be considered when understanding organizational culture in health care.

Slide 8

Importance of culture

“The biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm.”

(p. 79; Crossing the Quality Chasm. 2001)

The importance of culture has been widely recognized within the literature and by leading patient safety organizations as being critical to the advancement of safety within health care. As well, it is widely recognized that improvement in patient safety requires a change in healthcare culture. Health care culture plays a critical role in how well patient safety incidents are detected and handled. Health care organizations uphold many

important aspect of safety culture, including professional autonomy and acceptance of personal responsibility. However, there has been an overall failure to understand patient safety incidents from a systems perspective, which has led to the belief that incidents are the result of personal and professional failure (Leape et al., 1998). This culture encourages healthcare providers to hide mistakes, to resist attempts to measure safety performance and make learning from patient safety incidents difficult. Before attempting to change the culture, it is important to understand the culture and how it can facilitate or prevent patient safety improvement. The Canadian Adverse Events Study, released in 2004, found an adverse event incidence rate of 7.5% for hospitalized adults has been a target for reduction (Baker et al, 2004). Interestingly, 36.8% of all adverse events were judged to be preventable, indicating that there is a role for organizations and safety culture to play in ensuring that potential incidents are identified and mitigated.

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Importance of culture



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 also supported by 4 Accreditation Canada (2017) Required Organizational Practices (ROPs) to support the creation of a positive safety culture, including:

1. Accountability for quality
2. Patient safety incident disclosure
3. Patient safety incident management
4. Patient safety quarterly reports

Safety culture

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Safety culture

“the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine commitment to, and the style and proficiency of, an organization’s health and safety management”

(pg. 23, 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. Many other high hazard industries (e.g., aviation, nuclear power) also actively promote a positive safety culture. The Advisory Committee on the Safety of Nuclear Installations (ACSNI) definition is the most widely accepted definition of a positive safety culture.

There is currently no clear consensus as to how organizational safety culture is conceptualized. To date, it is being described as a type of organizational culture, a subset of organizational culture, as well as a product of organizational culture. However, given the use of organizational safety culture to describe organizations where safety is a priority and is inherent throughout all three levels of organizational culture, we will assume for the purposes of this learning that it is a result of organizational culture – e.g., it arises out of a culture that supports safety.

It is also important to clarify here two terms that are often used interchangeably, but refer to two different concepts: safety climate and safety culture. Safety climate refers to employee perceptions of safety culture, whereas safety culture refers to the underlying beliefs, assumptions and values of an organization as they relate to safety. As underlying assumptions and values are difficult to measure, safety culture measurements and surveys can usually only measure safety climate.

Patient safety culture

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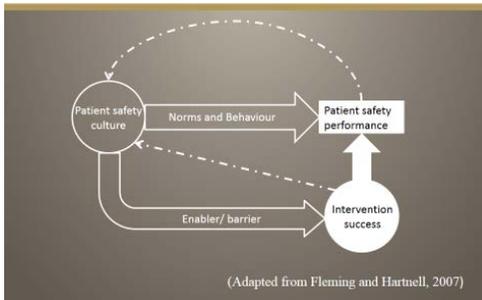
Patient safety culture



After the release of *To Err is Human* and similar reports internationally, there was a greater understanding and appreciation of the risks involved with providing and receiving health care. For the first time health care was seen as a high-risk industry and was tasked with adopting similar risk mitigation and safety promotion strategies. Health care is unique, however, in that organizational safety culture must ultimately translate not only to employee safety, but also to who employees provide care for: the patient (Kaufman & McCaughan, 2013). This adds an important dimension to patient safety culture, and thus requires its own definition. It is also apparent from this definition the importance that is placed on “continuous” improvement of the processes that support patient care, which is an important tenet of quality improvement.

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Culture and patient safety



As shown in the figure above, culture directly influences patient safety outcomes as culture determines the accepted norms and practises. For example, hand hygiene practices are determined by the accepted norms within the organization. The failure to practice good hand hygiene in turns directly affects patient safety. Culture can also indirectly influence patient safety by acting as a barrier or enabler to the adoption of interventions designed to promote patient safety. For example, the adoption of the Safety Surgical Checklist can 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 there is a problem, or assert that the problem is because of a few "bad apples," act as a barrier to system level interventions. (WHO, 2008)

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Dimensions of patient safety culture

- Leadership and commitment to safety
- Opening communication founded on trust
- Organizational learning
- Non-punitive approach to adverse event reporting and analysis
- Teamwork
- Shared belief in the importance of safety

(Halligan & Zecevic, 2011)

Patient safety is a multi-dimensional construct. While there has been no formal agreement on the dimension that make up patient safety culture, recent reviews of the literature have identified several dimensions that are commonly cited. This list is from a review conducted by Halligan & Zecevic (2011) in which they identified the six most frequently cited dimensions:

1. Leadership and commitment to safety
2. Open communication founded on trust
3. Organizational learning
4. Non-punitive approach to adverse event reporting and analysis
5. Teamwork
6. Shared belief in the importance of safety

The six common dimensions speak to the underlying supports and structures that must be in place to build and sustain a positive safety culture. Commitment by leadership to safety is often the keystone of a positive patient safety culture, and should be demonstrated by both frontline managers and senior managers within the organization (Agnew & Flin, 2014; Dixon-Woods et al, 2014). Employee perceptions of patient safety culture can be shaped significantly by ensuring consistent communication regarding safety and through open feedback when patient safety incidents occur. 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 health care organizations will vary across these dimensions, performing better on some and poorer on others.

Patient safety Maturity Model

Safety Maturity Level	Characteristics
1. Pathological	No systems or processes in place to promote a positive patient safety culture
2. Reactive	Systems and processes are in place but are only used in response to an error or as needed for regulatory requirements
3. Calculative	A systems approach to patient safety is evident but identification of possible risks is not performed
4. Proactive	Near misses and errors are resolved systematically and learning occurs to prevent recurrences
5. Generative	A positive patient safety culture is evident throughout all operations and formalized as a central mission of the organization

(Ashcroft et al., 2005; Fleming & Wentzell, 2008; Parker et al., 2008)

The dimensions of patient safety culture introduced above may also differ for health care organizations based on their cultural maturity. The organizational culture maturity model was first developed by Westrum (2004) and is used to assess an organization’s safety culture and help identify specific actions that can be taken to improve. There are five culture maturity levels:

1. Pathological
2. Reactive
3. Calculative
4. Proactive
5. Generative

This model has been adapted for use in patient safety by Parker et al. (2008) and Ashcroft et al. (2005). The goal of the maturity model is to move to a culture that is generative – one that is evident throughout all aspects of the organization. In a generative culture, organizations seek out information and data that will allow them to anticipate patient safety incidents and take proactive steps to mitigate them. However, many health care organizations exist within the reactive/calculative maturity levels.

As a general principle, when failures or mistakes occur it is common for individuals to be singled out. It is often easier to blame someone than undertake a complicated detailed analysis of the many factors surrounding a patient safety incident. We think someone must be accountable. The problem with this assumption is that it is predicated on a belief that the offender chose to make the error rather than adopt the correct path; that they voluntarily intended to do the wrong thing. However, this approach negates the ability for health care organizations to identify potential systems issues or mitigate potential recurrences.

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Patient safety culture barriers

- ❑ Fear of blame
 - ❑ Fear of reporting
 - ❑ Belief in the inevitability of error
 - ❑ Lack of systemic analysis of failures
 - ❑ Inadequate teamwork
 - ❑ Complexity of work
 - ❑ Provider desire for autonomy
 - ❑ Divergent occupational responsibilities
- (Kalisch & Aebbersold, 2006; Waring, 2005)

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. This fear of blame that comes from singling out individuals is one of the most powerful barriers to creating and sustaining a positive patient safety culture (IOM, 1999). When individuals are blamed, they are less likely to report patient safety incidents and near misses, which leads to an inability to learn from past mistakes and to identify future ones. As well, given the ever-increasing complexity of work that is involved in providing health care, many health care providers may see error as an inevitable part of providing care and become immune to near misses when they occur. The autonomy in which many health care providers work in, such as physicians and nurses, while allowing them to act independently to make the best decision for their patients, can also be a barrier as teamwork becomes more difficult and care becomes more compartmentalized.

A systems approach to patient safety

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A systems approach

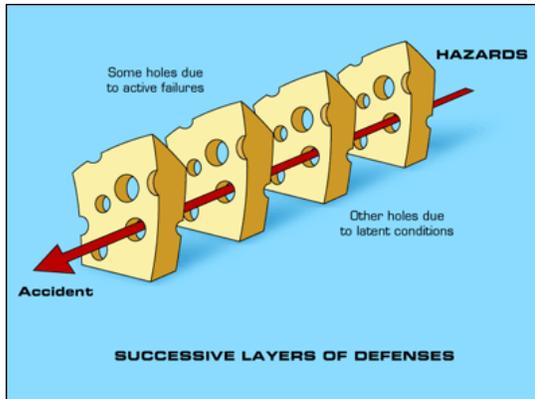
- ❑ Patient safety incidents can arise when organizational safeguards fail

- ❑ A systems approach allows us to identify potential safety issues before they occur

Because health care providers 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/ethics. 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.

However, taking a systems approach to patient safety culture is important in identifying how organizational systems, processes, and policies can be improved and strengthened to prevent patient safety incidents from occurring. This approach takes the “blame and shame” away from individuals and focuses on how health care organizations can support their staff in providing safe care to patients.



James Reason’s Swiss Cheese Model of Accident Causation (Reason, 2000) provides an excellent illustration of how a system can act either as a defence to a potential patient safety incident or can enable it through either active or latent failures. Patient safety culture influences whether or not these defences are in place and are monitored to identify potential events. Active failures refer to unsafe acts that can be directly linked to an error, whereas

latent failures are conditions that are present in the organization that make barriers and defences less effective at preventing the error from occurring.

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A systems approach

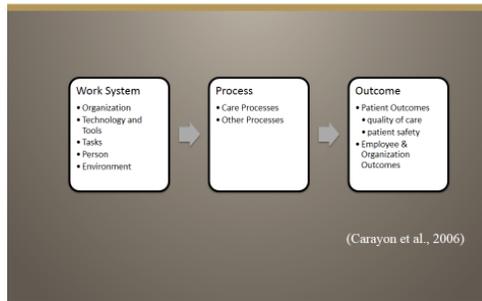
Three ways systems can help reduce error and harm:

1. Design the system to prevent errors
2. Design procedures to make errors visible when they occur
3. Design procedures to mitigate adverse effects

(Nolan, 2000)

Nolan (2000) expands on the systems approach identified by Reason and posits that organizational systems need to be actively designed for safety. Here, the importance is placed on designing systems that not only prevent incidents from occurring, but also make them visible when they do occur. The ability of an organization to see what led to an incident occurring is paramount to improving quality improvement and preventing recurrences from happening in the future.

Systems Engineering Approach



The Systems Engineering Initiative for Patient Safety (SEIPS) model provides a framework for health care organizations in trying to achieve the above goals (Carayon et al., 2006). The SEIPS model identifies how a system should be designed around individual health care providers and other staff members to facilitate the performance of safe care. There are three major elements:

1. The work system
2. Processes
3. Outcomes

The work system includes the organization, the technology and tools that are used to provide care, the tasks performed by health care providers, the providers themselves and the context in which they work (environment). This in turn influences the processes that provide patient care and ultimately the outcome of that care (e.g., patient safety, patient satisfaction). The patient is also an important part of the work system within this model as they interact with health care providers and the environment, and ultimately influence their care outcomes with their actions. By designing work systems with these elements in mind, organizations can ensure that systems can mitigate potential patient safety incidents, identify potential failures, and lessen their effects on patient outcomes. (Carayon et al., 2006).

For further information on a systems approach to patient safety culture please refer to PSEP – Canada Module 1: Systems Thinking: Moving Beyond Blame to Safety.

Measuring safety culture

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Measuring safety culture

- Organizational Level
 - Major system wide change process requires significant resources
- Unit Level
 - Focused intervention
 - Incremental improvement

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.

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.

Slide 20

Safety culture surveys

- Hospital Survey on Patient Safety Culture (Blegen et al., 2009)
- Safety Attitudes Questionnaire (Sexton et al., 2006)
- Stanford Instrument (Singer et al., 2003)
- Modified Stanford Instrument (Ginsburg et al., 2009)
- Canadian Patient Safety Climate Survey (Ginsburg et al., 2014)

Over the past decade, a number of research teams have developed various patient safety culture survey instruments. The five safety culture surveys presented above are a few of the most commonly used safety culture surveys by health care organizations around the world. A number of uses of safety culture measurement in health care have been identified, including:

1. Diagnosing safety culture to identify areas for improvement
2. Raising awareness of safety culture

3. Evaluating changes over time
4. Benchmarking
5. Fulfilling regulatory requirements

While administering patient safety culture surveys is an efficient way of measuring the perceptual indicators of the organization’s culture, it has been argued that the sole use of questionnaires may not be all that useful (Guldenmund, 2007). As such, a combination of surveys, focus groups and other audits may help to provide a more holistic picture of an organization’s safety culture. Nonetheless, surveys provide a good snapshot of staff perceptions of an organization’s safety culture at a particular point in time and have shown a positive relationship with patient outcomes (Haugen, 2010).

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Safety culture surveys

- Many to choose from, with one that has been specifically developed for Canadian context (Can-PSCS, 2014)
- Measurement of climate vs. culture
- Challenges:
 - Length of questionnaires
 - Limited number of dimensions
 - Limited reliability data

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 administering the survey.

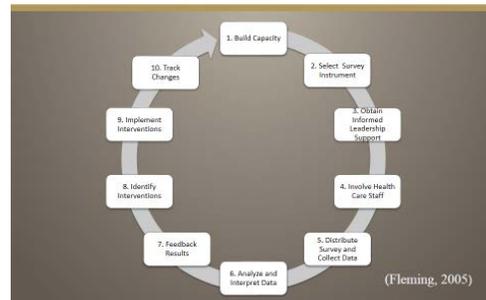
A validated patient safety culture survey with Canadian context has been available since 2008 and is used by Accreditation Canada as part of the accreditation process. (Gingsburg 2014)

There are several challenges with using safety culture surveys, including the length of some surveys to complete, the number of safety culture dimensions that they measure, and a lack of published reliability data. 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?

Improving patient safety culture

Slide 22

Patient safety culture improvement tool



One model which provides guidance on how to measure and improve patient safety culture is the 10-step process described by Fleming (2005). Creating organizational level change is challenging, however it can produce a significant change in patient safety performance. 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. Evaluate changes

Improving patient safety culture

- Investigate
 - Build capacity
 - Select appropriate measurement instrument
- Initiate
 - Obtain **informed** senior leadership support
 - Involve health care staff

Investigate

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

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.

Initiate

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. 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.

Health care staff should be directly involved in the culture measurement process by having a representative on a planning committee, by helping in the implementation of culture measurement initiatives (e.g., distributing patient safety culture surveys), and indirectly through being continuously informed of the progress of culture measurement process. Having employees involved in patient safety initiatives is a key aspect of a positive patient safety culture.

Improving patient safety culture

- Implement
 - Collect data
 - Interpret results
 - Feedback results to staff
- Improve
 - Implement, monitor and evaluate plan
 - Assess change in culture

Implement

Data collection can start once leadership support has been obtained and healthcare workers are engaged in the process. When analyzing culture survey results, it is better to concentrate 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 often grouped together to form an evaluation of the element or dimension of culture they are all measuring.

Once an audit of the patient safety culture is complete, examine the results and identify which organizational practices 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, this may be done through various communication mechanisms including unit meetings, town hall style forums, newsletters, etc. By informing everyone about the results of the measurement process they are more likely to continue to be interested and involved in the process.

Improve

Patient safety improvement strategies can be developed based on the results from the measurement process. 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 dimension. 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. If you wish to measure improvement over time, it is helpful to ask participants to create a unique code that can be used to match their responses on surveys over time.

Taking action

Slide 25

Taking action

- Culture change requires individuals to change their values, beliefs and behaviour
- Culture change can begin at the:
 - Organizational level
 - Unit level
 - Individual level

Fundamentally, patient safety culture is about people and it changes by the actions of people. By considering 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

Slide 26

Patient safety culture strategies

- Limited evidence on best strategies
- A number of strategies in the literature:
 - Leadership walk rounds **
 - Structured educational programs
 - Team-based strategies
 - Simulation-based training
 - Multi-faceted unit-based programs**
 - Multi-component organizational interventions

** strongest evidence

(Morello et al., 2013)

Patient safety culture improvement is a new and burgeoning field. As such, there is limited evidence available to guide organizations in their improvement efforts. A recently published systematic review of strategies aimed at improving patient safety culture (Morello et al., 2013) revealed two promising strategies: (1) leadership walk rounds and (2) unit-based programs.

Future research is needed to strengthen the evidence around best practices for patient safety culture to ensure that strategies are not being implemented without knowledge of

effectiveness. In the absence of clear guidelines, organizations should look to the best available evidence and assess compatibility with their improvement needs. Organizations should also consider publishing their implementation and evaluation results to improve the knowledge base in this area going forward.

Slide 27

Organizational readiness for change

- Understand the applicability and acceptability of patient safety strategies
- Understand motivations to change at the individual level
- Five domains play an important role

The introduction of patient safety strategies within health care has grown in the last decade, with many changes being spearheaded by national and international organizations. As such, understanding the applicability and acceptability of patient safety strategies within individual organizations is paramount to ensuring uptake by health care administrators and front line health care providers. Readiness for change is aimed at better understanding motivations to change through the lens of change recipients, in this case health care providers. While change management can involve both change leaders and change recipients, it is recommended that patient safety strategies be approached from the change recipient standpoint. Armenakis and Harris (2009) suggest that since organizational change occurs often at the hand of individual change recipients, it is important to understand and utilize their motivations in order for change to succeed. There are five key message domains to consider to improve organizational readiness (Armenakis et al., 2007):

1. Discrepancy – the belief that the change is necessary
2. Appropriateness – the belief that the change is needed and achievable
3. Efficacy – the belief that the change can be implemented
4. Principal support – the belief that management and peers will support change efforts
5. Valence – the belief that the change will be personally beneficial

It is recommended that the introduction of new patient safety strategies follow a thorough exploration of an organization’s readiness for change and safety culture. Safety culture can play an important role in helping to mitigate the challenges associated with adopting patient safety strategies, such as demands on time, appreciation of the importance of

safety, and integration of safety strategies into everyday workflow. Evaluation of strategies that have failed to attract widespread adoption are an ideal starting point to understand where bridges need to be made between change leaders and recipients.

For further information on spread and practical application of patient safety strategies in organizations refer to PSEP – Canada Module 15: Capacity Building: Transferring PSEP – Canada Knowledge to your Organization.

Slide 28

Patient involvement

- Patient involvement is an importance aspect of patient safety culture
- Patient narratives have been shown to provide organization's insight into their current culture

(Bishop & Cregan, 2015)



As previously discussed within the SEIPS model (slide 18), patients play an important role as not only end-users of the health care system, but also as active participants in their care. While many patients are involved in their care in varying ways, such as asking questions and helping to make treatment decisions, many barriers still exist for patients to become more involved in their health care (Bishop & Macdonald, 2014). One of the key outcomes of a positive patient safety culture should be the engagement of patients during all health care encounters; however, many patients are still wary to ask challenging questions of their health care providers and to speak up if they feel something is wrong (Bishop et al., 2015). Patients are also in a unique position as the end-user of care to help organizations measure how well their patient safety culture is being translated to the frontlines of care. While most patient safety culture surveys, as described in this chapter, focus mainly on provider (employee) perceptions of safety, patients also experience patient safety culture when they receive care in a health care organization. Recent research has demonstrated that patients are able to identify aspects of an organization's safety culture (Bishop & Cregan, 2015).

Please refer to PSEP – Canada Module 7a: Patients as Partners: Engaging Patients and Families: Patient and Family Centred Care for a more in-depth look on engaging patients in all aspects of the health care system.

Summary

Slide 29

Summary

- ❑ Creating a culture of patient safety is crucial
- ❑ Culture determines what behaviours are acceptable and unacceptable
- ❑ Patient safety culture consists of a number of dimensions
- ❑ It is important to measure the current culture and assess readiness for change before trying to change it
- ❑ Cultural change is iterative and can take place at different levels

An organization's culture in relation to patient safety is central to improving the quality and safety of healthcare and minimizing patient safety incidents. Organizations with a strong and generative 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 health care organizations demonstrate that priority is by continually assessing the vulnerabilities in the system, making improvements, and reassessing to make sure the improvements are maintained. It is also important to remember that when taking action and introducing changes, organizational readiness should be assessed and change should be evaluated at different levels.

Potential Pitfalls

Slide 30

Potential pitfalls

- ❑ Using a one-size-fits-all approach without understanding unique organizational context
- ❑ Not including all stakeholders in the measurement, evaluation and improvement of organizational patient safety culture
- ❑ Making changes at one level without an overall appreciation of the impact on other layers of the organization

1. Using a one-size-fits-all approach without understanding unique organizational context
2. Not including all stakeholders in the measurement, evaluation and improvement of organizational patient safety culture
3. Making changes at one level without an overall appreciation of the impact on other layers of the organization

Pearls

Slide 31

Pearls

- ❑ Creating a positive patient safety culture is critical to improving the quality and safety of care
- ❑ A blame culture that focuses on individual versus system causes of error results in hidden patient safety incidents
- ❑ An open, diverse and transparent culture is created when reporting is routine, feedback is provided, and people learn from errors

1. Creating a positive patient safety culture is critical to improving the quality and safety for patients
2. A blame culture that focuses on individual versus system causes of error results in hidden patient safety incidents
3. An open, diverse, and transparent culture is created when reporting is routine, and people learn from the errors.

Toolkits and outcome measures

- **Patient Safety Culture Improvement Tool:** Fleming, M, Wentzell, N (2008) “Patient Safety Culture Improvement Tool: Development and Guidelines for Use” *Healthcare Quarterly* 11 (Special Edition):10-15. <http://www.longwoods.com/content/19604> 
- **Patient Safety Culture Measurement and Improvement: A ‘How To’ Guide:** Fleming, M (2005) “Patient Safety Culture Measurement and Improvement: A ‘How To’ Guide” *Healthcare Quarterly* 8(Special Edition):14 - 19. <http://www.longwoods.com/content/17656#loopBack> 
- **30 safe practises for better health care:** The National Quality Forum with support from the Agency for Healthcare Research and Quality (AHRQ). <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-safety-resources/resources/advances-in-patient-safety/vol4/Kizer1.pdf>
- **Patient Safety Culture Surveys:** Agency for Healthcare Research and Quality <http://psnet.ahrq.gov/resource.aspx?resourceID=5333>
- **Checklist for Assessing Institutional Resilience:** Institute for Healthcare Improvement: Carthey J, Reason J. Institutional resilience in healthcare systems. *Quality and Safety in Healthcare*. 2001;10(1):29-32. <http://www.ihl.org/resources/Pages/Tools/ChecklistForAssessingInstitutionalResilience.aspx>

- **Maximizing the use of state adverse event data to improve patient safety:** Rosenthal J, Booth M. National Academy for State Health Policy. Funded by the Commonwealth Fund. 2005. <https://psnet.ahrq.gov/resources/resource/3055/maximizing-the-use-of-state-adverse-event-data-to-improve-patient-safety>
- **Tools for Hospitals and Health Care Systems:** AHRQ Publication No. 05-P016, March 2005. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.ahrq.gov/professionals/systems/index.html>
- **Incident Decision Tree:** National Patient Safety Agency National Health Service UK 2006 <http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59900>
- **Safety Attitudes Questionnaire and Safety Climate Survey:** Sexton JB, Helmreich RL, Neilands TB, et al. The Safety Attitudes Questionnaire: Psychometric Properties, Benchmarking Data, and Emerging Research. BMC Health Services Research 2006; 6:44.; Sexton JB, & Thomas EJ. The Safety Climate Survey: Psychometric and Benchmarking Properties. Technical Report 03-03. The University of Texas Center of Excellence for Patient Safety Research and Practise (AHRQ grant # 1P01HS1154401 and U18HS1116401). <https://med.uth.edu/chqs/surveys/safety-attitudes-and-safety-climate-questionnaire/>
- **VHA tool:** Strategies for Leadership: An Organizational Approach to Patient Safety www.aha.org/aha/content/2002/pdf/VHAtool.pdf
- **Walk-through (IHI Tool):** David Gustafson, PhD, University of Wisconsin, Madison; Institute for Healthcare Improvement <http://www.ihl.org/resources/Pages/Tools/Walkthrough.aspx>
- **Engaging Clinicians:** National Patient Safety Agency 2005 <http://www.nrls.npsa.nhs.uk/resources/?entryid45=59883>
- **Implementing Dana-Farber Cancer Institute Patient Safety Rounds in Your Organization - A Toolkit:** Dana-Farber Cancer Institute (DFCI) <https://www.dana-farber.org/uploadedFiles/Library/adult-care/care-quality-and-safety/patient-safety-resources/patient-safety-rounding-toolkit/toolkit-overview.pdf>
- **World Alliance For Patient Safety** <http://www.who.int/patientsafety/worldalliance/en/>

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/-/learning-from-adverse-events-fostering-a-just-culture-of-safety-in-canadian-hospitals-and-health-care-institutions>  <https://www.cmpa-acpm.ca/fr/-/learning-from-adverse-events-fostering-a-just-culture-of-safety-in-canadian-hospitals-and-health-care-institutions> 
- **Modified Stanford Instrument (MSI) Patient Safety Culture Survey:** Ginsburg, L. R. (n.d.). *Patient safety culture research at York University.* 
- **AHRQ Health Care Innovations Exchange:** Agency for Healthcare Research and Quality <http://www.innovations.ahrq.gov/index.aspx>
- **Managing the risks of organizational accidents:** Reason J. Ashgate Publishing Company; 1997.
- **Safety and Ethics in healthcare: A guide to getting it right:** Runciman B, Merry A, Walton M. Ashgate Publishing Company; 2007.

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Principal message

The single most important message your audience should come away with is that *creating a positive patient safety culture is critical to improving the quality and safety for patients*. Organizations with a strong and generative patient safety culture implement a range of processes and tools to ensure that everyone in the organization makes patient safety a top priority.

Module overview

This module provides the audience with an understanding of organizational culture and how such a culture impacts patient safety. The material in this module presents information on how to measure and improve organizational culture to achieve a positive patient safety culture. Using change management principles an organization can create an open, diverse and transparent culture in which reporting and learning are celebrated.

Some basic concepts such as definitions and relationships between organizational culture and patient safety are presented to help the audience understand the nature of patient safety culture. Common dimensions of patient safety culture, as well as how they are measured and used to improve, are outlined and allow scope for audience discussion. A systems approach to patient safety is outlined as a basis for understanding the importance of not blaming individuals when patient safety incidents occur. This includes how systems can be designed to ensure that incidents are actively mitigated and learned from.

The module also discusses steps that can be taken to improve patient safety culture using a systematic approach. This includes selecting appropriate instruments, obtaining senior leadership and staff commitment, collecting data, interpreting results and feeding them back to staff, and assessing and evaluating change.

The module concludes with steps to take to identify whether safety is valued in the organization and organizational readiness for change. The importance of understanding organizational and staff capacity for implementing change that arises from safety culture improvement is discussed as a necessary step to ensure adherence and sustainability. Finally, patient involvement is discussed not only as an important indicator of patient safety culture, but also as a potential data source when measuring culture at the frontlines of care.

Preparing for a presentation

1. Assess the needs of your audience

Choose from the material provided in the module 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

The suggested timing for each part of this module is:

Introduction	2-3 minutes
Trigger tape & discussion	5-7 minutes
Presentation	30 minutes
Summary	2-3 minutes
<u>Evaluation</u>	<u>5 minutes</u>
Total	44-48 minutes

3. Number of slides: 31

4. Preparing your presentation

The text in the module 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 module, 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 module text and slides 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 ensure to acknowledge the source of the

material, the PSEP – Canada Acknowledgment Page at the front of the module provides a formal citation.

6. Equipment needs

- Screen, computer and projector
- Flipchart and markers for recording discussion points

Test your equipment beforehand to ensure that it works.

Review your video to assess which 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 video fails, you can read the vignette of the trigger tape story;
- if the slides cannot be shown, you can refer to the hand out slides; and
- if flipcharts and markers are not available, you can 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 trigger tape

After reviewing the objectives for the session, show the trigger tape. It has been designed to engage the audience and provide an appropriate clinical context for the session. The trigger tape does not need 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 other appropriate trigger tape. 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 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 video or how “real” the players seemed. If the participants do not like something that was said or done in the video, 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 video 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 backup case from your own experience in case 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 an unjust organizational culture, and
- experience advocating for a just safety 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 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 lawsuit was brought.

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

Role – Dr. Sallaway, Chief of Emergency

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 believes that an error occurred and that the hospital is trying to hide it since communication was cut off. You want to talk to the family. You have been advised by Mr. Gefman that it is too late since the lawsuit has been brought. You are frustrated that someone not on the initial care 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 allowed for a partnership, rather than 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. This could then be used against your client in what you considered to be an inevitable lawsuit.

6. Key take-home points

1. Creating a positive patient safety culture is critical to improving the quality and safety for patients.
2. A blame culture that focuses on individual versus system causes of error results in hidden patient safety incidents.
3. An open, diverse, and transparent culture is created when reporting is routine, and people learn from the errors.

7. Summarize the discussion

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