

Interventions to Improve Safety Culture
The Emory Center on Health Outcomes and Quality in collaboration with
The Georgia Hospital Association's Partnership for Health and Accountability (PHA)

Why should your hospital care about safety culture?

Georgia's Partnership for Health and Accountability (PHA) recognizes patient safety as its top priority and describes the elements that support a culture of safety in healthcare organizations.¹ Among these are a pervasive commitment to patient safety, open communication, a blame-free environment, and the importance of safety design in preventing future errors. Acknowledging that success in creating a culture of safety requires the commitment of both organizational leadership and frontline health care workers, PHA stresses the critical role of physicians and employees in the process.

What is "safety culture?"

Safety culture can be defined as the set of values, beliefs, and norms about what's important, how to behave, and what attitudes are appropriate when it comes to patient safety in a work group. Organizations with effective safety cultures have a constant commitment to safety as a top-level priority, and these actions and attitudes are evident throughout the organization.² Experts delineate a number of safety culture dimensions, which a hospital can measure using a culture assessment tool developed by Westat for the Agency for Healthcare Research and Quality.³ The dimensions measured by this tool are:

1. Supervisor/manager expectations & actions promoting patient safety
2. Organizational learning—continuous improvement
3. Openness of communication
4. Feedback & communication about errors
5. Hospital management support for patient safety
6. Non-punitive response to error (blame-free environment or a "just" culture)
7. Staffing
8. Teamwork within units
9. Teamwork across hospital units
10. Hospital handoffs & transitions

Evidence from the literature

With improved measurement tools available, hospital systems are beginning to assess and describe their cultures related to patient safety. The healthcare industry is drawing from organizational theory, long used by other industries for which safety is critical, to learn how a culture is formed and what is required to change a culture.⁴

Although there is much interest in effecting culture change in our hospitals, the literature contains few examples of proven intervention strategies. Hoff, et al, examined 42 articles related to organizational factors, medical errors, and patient safety and found that fewer than 10 of the

articles addressed culture. Even then, most of these were limited to case studies and anecdotal evidence rather than employing statistical testing or systematic qualitative analysis.⁵ Hospital culture is a relatively new area of study, but thankfully more robust research studies are in the pipeline.

Despite the lack of proven best practices, hospitals can learn from the experiences of health care systems that have had some success with a number of strategies. Once a hospital has assessed its culture of patient safety, the leadership can decide which dimensions provide the best opportunity for intervention in that organization.

The Blame-Free Environment or “Just” Culture

Results from a survey of patient safety culture conducted among ICU, general medicine, surgery, and ancillary services staff in ten Georgia hospitals of varying sizes in fall 2003 revealed that the dimension of non-punitive environment (also called a “blame-free” environment or a “just” culture) has potential for improvement in many of our healthcare organizations. When compared to results from the PHA leadership surveys conducted in these same hospitals, in most cases, the hospital leadership felt that their organization had achieved a non-punitive environment, while the staff (nurses, pharmacists, and ancillary health care providers) felt otherwise.

Results varied among the four departments surveyed, which is not surprising, since most organizations tend to have mini-cultures within the larger culture of the organization. Issues regarding non-punitive environment were reported more often by staff in general medicine and ICU than surgery and ancillary medicine, while ICU employees were more likely than the other departments’ employees to say that mistakes go unreported.

In healthcare organizations, the challenge is to change the environment from one of crisis and blame to that of learning and improvement.⁶ In the past, organizations thought that if they rebuked those who made errors and provided enough training, it would address the problem. Instead, in this environment, error-reporting rates are typically low, and, as a result, it is difficult to determine the cause of the errors and prevent future occurrences.

In contrast, a major goal of the blame-free environment is to create a reporting culture, where people come forward when an error occurs, and everyone works together to improve patient safety. Prizzi, et al, in their chapter on promoting a culture of safety describes an effective culture as one that shares “...a constant commitment to safety as a top-level priority, which permeates the entire organization.”²

The concept of the non-punitive environment is embodied in the first two statements of the non-punitive reporting policy of Luther Midelfort, a hospital in the Mayo Health System.⁷

- *We recognize that competent and caring professionals will make mistakes and we don’t intend to instill fear or punishment for reporting them.*
- *Many errors result from an inadequate or complex system.*

As with patient safety culture in general, there is a scarcity of proven interventions designed to create a non-punitive environment. Obviously, the transformation to a non-blaming culture does not occur overnight, or because of one intervention. However, several authors have described shifts that must occur, barriers to change, and the success that some healthcare organizations have experienced with applying improvement models from other industries. A list of some of these resources is below.

TOOLS AND RESOURCES

General Resources

- PHA *Elements of a Culture of Safety* brochure
 - Access <http://www.gha.org/pha/publications/PHAREports/Elements/Elements%20of%20Culture.pdf>
- PHA website links to resources (Helpful links listed under *Patient Safety*)
 - Access <http://www.gha.org/pha/resources/topics/index.asp>

Tools for Assessing Your Safety Culture

- Westat Toolkit
 - A Quality and Safety in Healthcare article that discusses the characteristics and uses of safety culture assessment tools.
 - The Hospital Survey on Patient Safety, along with a document showing the safety culture dimensions being measured and the reliability of the items in the dimensions. The survey is provided electronically as a Word document, so hospitals can do some customization and add their own questions at the end;
 - A Survey Guide which provides hospitals with useful information about how to select a sample, administer the survey, and prepare the data for analysis;
 - A Survey Feedback Report Template which is provided electronically as a PowerPoint document so hospitals can simply add their own data in the embedded charts to prepare a simple, customized feedback report;
 - A Technical Report that presents the reliability and validity data obtained from a pilot administration of the survey.

Background Information on Building a Just Culture

- Dana-Farber Cancer Institute, Principles of a fair and just culture, <http://www.dana-farber.org/abo/news/tools/justculture.asp>
Describes the commitment of Dana-Farber to a fair and just culture. Could serve as a benchmarking tool.

- Hemman EA, Creating healthcare cultures of patient safety, *JONA* 32(7/8):419-427. An excellent overview of the influence of culture on hospital patient safety with strategies for shifting values, behavior, and process (see Tables 1 and 2). Outlines four perspectives for changing culture: Structural, human resources, political, and symbolic. Lists patient safety website resources.
- Marx D, Patient safety and the “just culture”: A primer for health care executives, 2001. A “must read” for those designing a new reporting and investigation system. Examines the problems posed by current disciplinary approaches and how to balance “blame-free” with the need to address malicious or negligent behavior.
- Ruchlin HS, The role of leadership in instilling a culture of safety: Lessons from the literature, *J Healthcare Mgmt* 49(1):47-58. Discusses normal accident theory and high-reliability organization theory and cites case examples from other industries that may have application in the health care organization.

Case Studies and Interventions

- Institute for Healthcare Improvement website <http://www.ihl.org>
 - This site is a great resource, where hospitals share tools that they have found helpful. You must register (click on Login/Register) to access the tools, but it’s easy to do and well worth it. Included is a link to extensive materials from the Pittsburgh Regional Healthcare Initiative (PRHI).
- Larson L, Ending the culture of blame: A look at why medical errors happen—and what needs to change. *Trustee*, February 2000.
 - A helpful article that includes barriers to change and several case studies.

¹ Partnership for Health and Accountability, *Elements of a Culture of Safety*, 2001.

² Prizzi LT, Goldfarb NI, Nash DB, Promoting a culture of safety, Agency for Healthcare Research and Quality (AHRQ), <http://www.ahrq.gov/clinic/ptsafety/chap40.htm>. Accessed June 2004.

³ Nieva VF, Sorra J, Safety culture assessment: a tool for improving patient safety in healthcare organizations. *Qual Saf Health Care* 2003;12(Supple II):ii17-ii23.

⁴ Ruchlin HS, Subbs NL, Callahan MA. 2004. The role of leadership in instilling a culture of safety: lessons from the literature. *Journal of Healthcare Management* 19(1):47-58.

⁵ Hoff T, et al. 2004. A review of the literature examining linkages between organizational factors, medical errors, and patient safety. *Medical Care Research and Review* 61(1):3-37.

⁶ Hemman EA, Creating healthcare cultures of patient safety, *JONA* 32(7/8):419-427.

⁷ Luther Midelfort, Administrative policies & procedures: non-punitive reporting. www.prhi.org/ Accessed June 2004.