Health System Risk Management - Guidance

Culture of Safety: An Overview

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EXECUTIVE SUMMARY

Numerous studies show a link between a positive safety culture (where safety is a shared priority) and improved patient safety within a healthcare organization. The evidence is so convincing that the National Patient Safety Foundation (NPSF) lists leadership support for a safety culture as the most important of eight recommendations for achieving patient safety.

An organization whose leaders embrace a safety culture makes safety its number one priority. Leaders demonstrate their commitment by supporting the organization to learn about errors and near misses, investigate errors to understand their causes, develop strategies to prevent error recurrence, and share the lessons learned with staff so they recognize the value of reporting their concerns.

Risk managers are essential in helping the organization achieve a safety culture. A culture of safety brings a focus on error analysis and mitigation that is fundamental to the functions of risk management.

The term "safety culture" has been defined by various organizations. Generally, a safety culture is viewed as an organization's shared perceptions, beliefs, values, and attitudes that combine to create a commitment to safety and an effort to minimize harm (Weaver et al.). In the simplest of terms, a safety culture is the combination of attitudes and behaviors toward patient safety that are conveyed when walking into a health facility.

A safety culture is not limited to healthcare. The concept is used in other high-risk industries, such as nuclear power and aviation, that seek to understand safety incidents to prevent future disasters.

Indeed, the concept of a safety culture has been around for more than two decades. In its sentinel event alert on the role of leadership in developing a safety culture, the Joint Commission references James Reason's concepts about safety culture in his 1997 book on human error, *Managing the risks of organizational accidents*. Still applicable today, the three key elements of a safety culture are the following (Joint Commission "The Essential Role of Leadership"):

- Fair and just culture
- Reporting culture

- Learning culture

This guidance article describes each of the three elements of a safety culture and provides recommendations on how an organization can approach each element.

Action Recommendations

- Communicate leadership support for a culture of safety.
- Model expected behavior within a safety culture.
- Develop and enforce a code of conduct that defines appropriate behavior to support a culture of safety and unacceptable behavior that can undermine it.
- Create an environment in which people can speak up about errors without fear of punishment; use the information to identify the system flaws that contribute to mistakes.
- Apply a fair and consistent approach to evaluate the actions of staff involved in patient safety incidents.
- Support event reporting of near misses, unsafe conditions, and adverse events.
- Identify and address organizational barriers to event reporting.
- Cultivate an organization-wide willingness to examine system weaknesses and use the findings to improve care delivery.
- Promote collaboration across ranks and disciplines to seek solutions to identified safety problems.
- Periodically assess the safety culture of an organization to track changes and improvements over time.

WHO SHOULD READ THIS

Administration, Chief medical officer, Human resources, Legal counsel, Nursing, Patient safety officer, Quality improvement, Risk manager

SHARE WITH LEADERSHIP

Ready, Set, Go: Culture of Safety: An Overview

SHARE WITH RISK MANAGEMENT

Make a Plan: Culture of Safety

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THE ISSUE IN FOCUS

Numerous studies show a link between a positive safety culture and improved patient safety within a healthcare organization (Berry et al.; Brilli et al.; Fan et al.; Huang et al.; Mardon et al.; Weaver et al.). The evidence is so convincing that the National Patient Safety Foundation (NPSF) lists leadership support for a safety culture as the most important of eight recommendations for achieving patient safety.

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Risk Manager's Toolbox

- Ready, Set, Go: Culture of Safety
- Make a Plan: Culture of Safety
- Accountability Decision Tree
- Sample of Code of Conduct
- Safety First for Staff: Culture of Safety
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- Learning culture

This guidance article describes each of the three elements of a safety culture and provides recommendations on how an organization can approach each element.

Defining Safety Culture

What is a safety culture? In the simplest of terms, a safety culture is the combination of attitudes and behaviors toward patient safety that are conveyed when entering a health facility.

Consider the following definitions from the Agency for Healthcare Research and Quality (AHRQ) and the Joint Commission.

Ask ECRI

A ECRI member asked us for assistance identifying a tool to survey hospital staff about the organization's culture of safety. See our response.

AHRQ. Patient safety culture is the extent to which the beliefs, values, and norms of an organization support and promote patient safety. These beliefs extend to all levels of an organization (e.g., system, department, unit) and influence the actions and behaviors of staff throughout the organization. (Famolaro et al.)

Joint Commission. The safety culture of an organization "is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety." (Joint Commission "Patient Safety Systems")

More relevant than any definition, however, are the attributes of an organization that contribute to a safety culture, which shape clinician and staff behavior on a daily basis. The Joint Commission lists the following traits of a safety culture (Joint Commission "Patient Safety Systems"):

- Staff and leaders value transparency, accountability, and mutual respect.
- Safety is everyone's first priority.
- Behaviors that undermine a culture of safety are unacceptable.
- Staff recognize that systems have the potential to fail and are, therefore, mindful of identifying hazardous conditions and close calls before a patient is harmed.
- Staff report errors because they know the information can be used to address system flaws that contribute to patient safety events.
- Staff create a learning organization by learning from patient safety events to continuously improve.

For these behaviors to thrive in an organization, leaders must model the behavior they want others to follow, as described in the discussion Secure Leadership Commitment. To do otherwise undermines the safety culture. In the narratives of patient safety events reported to ECRI Institute PSO[1], staff at reporting organizations have commented on the negative effects of the attitudes of leaders who are disengaged from a safety culture, as in the following event reports:

- "It would be great if someone in upper management would sit down with the doctor and let him know his behavior is unacceptable."
- "Anesthesia's behavior puts patient safety at risk. When will this hospital decide enough is enough and patient safety comes first?"
- "I hope that more staff feel compelled to report these types of issues that get swept under the rug by our management far too often."

[1] ECRI Institute PSO is a federally certified patient safety organization (PSO). It collects and analyzes patient safety information and shares lessons learned and best practices with participating facilities.

Patient Safety

ECRI identified failure to embrace a culture of safety as one of its top 10 patient safety concerns in 2016. An increasing number of studies show an association between a positive safety culture, in which safety is a shared priority, and good patient care. Examples listed in the Joint Commission's sentinel event alert on a safety culture indicate that a positive safety culture has been associated with the following (Joint Commission "The Essential Role

of Leadership"):

- Reduced infection rates (Fan et al.)
- Fewer readmissions (Fan et al.)
- Better surgical outcomes (Sacks et al.)
- Reduced adverse events (Berry et al.; Birk)
- Decreased mortality (Berry et al.)

Additionally, studies have shown a safety culture's effect on staff well-being, job satisfaction, and burnout, all of which can impact patient safety. Burnout, for example, has been shown to negatively impact safety and quality and the organization's safety culture. (Profit et al.; Tawfik et al.) Embracing a safety culture in which all providers feel valued and successes are emphasized is one way to mitigate the effects of burnout. Higher scores for teamwork, one area assessed by safety culture surveys, are generally associated with higher employee satisfaction and fewer employee injuries, lower absenteeism rates, and fewer nurse vacancies (Leonard).

Regulations and Standards

Many of the provisions for a safety culture have long been requirements for accreditation by the Joint Commission. The accreditation standards for performance improvement and medication management, for example, describe processes for event reporting and investigation, which are key elements of a safety culture. The accrediting organization formally introduced safety culture concepts in 2008 with publication of its sentinel event alert on behaviors that undermine a safety culture (Joint Commission "Behaviors That Undermine"). In 2015, the Joint Commission codified the elements of a safety culture in the "Patient safety system" chapter of its hospital accreditation manual. In 2017, the chapter was expanded to cover critical access hospitals, ambulatory care, and office-based surgery settings.

Additionally, specific provisions for creating and maintaining a culture of safety and quality are listed in the leadership standards of the Joint Commission's accreditation manual (LD.03.01.01). To establish a culture of safety, leaders are expected to (Joint Commission "CAMH"):

- Evaluate the organization's culture of safety using valid and reliable tools
- Prioritize and implement changes identified by the evaluation
- Develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety
- Create and implement a process to manage behaviors that undermine a culture of safety

Other accrediting organizations also describe the importance of a positive safety culture for safe healthcare delivery. DNV GL Healthcare, which accredits U.S. hospitals, incorporates the ISO 9001 standard for a quality management system into its accreditation program, National Integrated Accreditation for Healthcare Organizations. The accreditation requirements do not specifically address a safety culture, but DNV GL says that a positive safety culture is "foundational" to a quality management system.

Although Medicare conditions of participation (CoPs) for hospitals do not refer to a safety culture, many of a safety culture's elements are a component of the CoPs for a quality assessment and performance improvement program

(42 CFR § 482.21). Specifically, hospital governing boards, administrative leaders, and medical staff are required to establish clear expectations for a patient safety program intended to identify and reduce medical errors.

ACTION PLAN

Make a Plan: Culture of Safety: An Overview

Download this customizable document to track your implementation of these action recommendations.

Secure Leadership Commitment

Action Recommendation: Communicate leadership support for a culture of safety.

Action Recommendation: Model expected behavior within a safety culture.

Action Recommendation: Develop and enforce a code of conduct that defines appropriate behavior to support a culture of safety and unacceptable behavior that can undermine it.

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Safety First for Staff: Culture of Safety

As with any organization-wide initiative, leadership support is essential for a safety culture's success, an issue described by ECRI as a top patient safety concern in 2018. Leadership—consisting of the governing body, senior management, and nurse and physician leaders—should communicate a single vision of the organization's approach and expectations (Chassin and Loeb). The staff handout Safety First for Staff: Culture of Safety can be used by organizations to concisely summarize a safety culture.

Without sustained leadership support for a safety culture, where is the impetus for staff in an organization to embrace it? By some estimates, up to 80% of initiatives that require people to change behaviors fail in the absence of effective leadership to manage the changes (Leape et al.).

Lack of leadership support for a culture of safety could jeopardize patient safety. Experts say that a culture of safety is necessary before other patient safety practices can be successfully introduced. Indeed, failure to create an effective safety culture is a contributing factor to many types of adverse events. Why? Without a safety culture, staff may be insufficiently motivated to report events that could be used to identify and address the causes of patient safety breakdowns. Additionally, staff may be unconvinced of the value of event reporting if there is no feedback about how the reports are used. (Joint Commission "The Essential Role of Leadership").

Refer to Table 1. Leadership Attributes and Strategies for an Effective Safety Culture for strategies addressed in more detail in the discussions Model Expected Behavior and Support and Enforce a Code of Conduct.

Table 1. Leadership Attributes and Strategies for an Effective Safety Culture

Attributes	Sample Strategies
Promote continuous learning from patient safety events	Encourage reporting of patient safety events and near misses
	Remove barriers to event reporting; make reporting easy for staff
	Highlight "good catches" of unsafe conditions identified from

	event reporting Identify and address systems issues that contribute to adverse events
Motivate staff to uphold a fair and just culture	Protect staff from unfair targeting for patient safety incidents that are the result of system failures Adopt and practice a fair approach to evaluating accountability for patient safety incidents for which there are concerns about an individual action; ensure the approach is consistently applied Provide support for team members involved in adverse patient events
Provide a transparent environment in which quality measures and patient harms are freely shared with staff	Conduct leadership walkrounds on units to ask staff about barriers they encounter to delivering safe patient care Hold daily leadership patient safety huddles with managers to discuss patient safety issues and mitigating strategies Disseminate lessons learned from event reports Share organization- and unit/department-level safety data
Model professional behavior	Set a positive tone Think out loud to encourage a shared mental model with colleagues and staff Invite staff into patient safety discussions to hear their suggestions and concerns Use noncritical language to question people by saying, for example, "I just need a little clarity." Use people's names
Eliminate intimidating behaviors that interfere with safe behavior	Adopt a zero tolerance approach for intimidating behavior Implement a policy that addresses disruptive behavior Adopt mechanisms for staff to report disruptive behavior (including an anonymous reporting hotline) Enforce processes to promptly address disruptive and disrespectful behavior
Provide resources and training for improvement	Offer simulation training to promote effective team behaviors

initiatives	and communication Allow time for staff to participate in performance improvement meetings

Source: Health Research & Educational Trust. Culture of safety change package: 2018 update. 2018 [cited 2019 Apr 17]; The Joint Commission. Patient safety systems (PS). In: Comprehensive accreditation manual for hospitals. 2018 Jan [cited 2019 Mar 8]; Leonard MW. A systematic approach to safe and high reliability care. Remarks at: Health Care Improvement Foundation and Philadelphia Area Society for Healthcare Risk Management spring Conference; 2019 Apr 4; ECRI, Plymouth Meeting (PA).

When leaders set the right tone for a safety culture, staff trust their leaders to listen to their concerns; staff members are unafraid to speak up about unsafe conditions and hazards. They understand the importance of event reporting because they are told how the information is used to improve patient safety. And they know that event reporting can make a positive difference in the quality of care provided at their organization.

An important offshoot from a strong safety culture is the effect it can have on staff morale. If staff feel engaged and productive at their workplace, they are also more likely to find meaning in their work. (Joint Commission "The Essential Role of Leadership")

Model Expected Behavior

Leadership backing of a safety culture requires more than just lip service. Leaders are role models and must demonstrate the type of behavior they expect from staff to support a safety culture.

One strategy used to demonstrate a commitment to safety and to engage both senior managers and staff is patient safety rounds, often referred to as leadership walkrounds (Frankel et al.). The concept involves key leaders, such as the chief executive officer and other senior executives, board members, vice presidents, and key clinical managers, visiting various areas of the hospital and asking providers and frontline staff specific questions about patient safety on a regular basis. Examples of questions to ask on walkrounds include the following (Frankel et al.):

- Were you able to safely care for your patients this week? If not, why not?
- What could your unit do on a regular basis to improve safety?
- What action could the leadership team take to make the work you do safer for patients?
- When you make a mistake or intercept a mistake, do you report it? If not, why not?
- Do you know what happens to the information that you report?

Often conducted weekly, walkrounds afford leaders the opportunity to solicit staff input on errors, near misses, and other safety issues to discuss the causes of these events and situations. Walkrounds provide leaders with insights into barriers that prevent staff from delivering safe patient care. These insights help leaders identify improvement priorities.

Another way leaders can show their commitment to safety is to recognize staff members who report errors or recognize unsafe conditions. As an example of a "good-catch" program, one hospital issues a daily email highlighting a near-miss error or unsafe condition identified through event reporting. Each month, it also recognizes employees who are "safety stars" through their reporting efforts. (Joint Commission "Developing a Reporting Culture")

Additionally, leaders demonstrate their commitment to the organization's safety culture by their willingness to set aside funds to support the effort, such as by offering team training programs to promote communication, cooperation, and collaboration and by investing in resources to strengthen system safety.

Support and Enforce a Code of Conduct

An effective culture of safety depends on leadership support and enforcement of an organization-wide code of conduct that defines acceptable behavior as well as behaviors that undermine a culture of safety and negatively affect patient safety. For more information about establishing a code of conduct, refer to the guidance article Disruptive Practitioner Behavior and the Sample of Code of Conduct.

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Disruptive Practitioner Behavior

Sample of Code of Conduct

The code of conduct defines the expectations of staff on a day-to-day basis and reflects the organization's core values. The Joint Commission's leadership standard (LD.03.01.01) requires leaders at accredited organizations to adopt and promote a code of conduct that defines acceptable behavior as well as behaviors that undermine a culture of safety, such as the following (Joint Commission "Patient Safety Systems"):

- Shaming others for negative outcomes
- Refusal to comply with known and generally accepted standards of care
- Failure to work collaboratively or cooperatively with other members of an interdisciplinary team
- Not returning pages or calls promptly

All staff, regardless of seniority or discipline, are expected to uphold an organization's code of a conduct in a positive manner. Likewise, the organization is expected to hold all staff accountable for adhering to the code. As described in the discussion Adopt Accountability Assessment Method, leaders must ensure that the organization applies its expectations for staff conduct in a consistent manner. Allowing exceptions and unequal treatment creates mistrust and undermines the organization's ability to achieve a safety culture.

If an organization is unwilling to address unacceptable behavior, patient safety could be jeopardized. For example, staff members may be reluctant to clarify a medication order if the ordering provider is known to act impatiently when questioned about an order. The intimidating behavior could lead to a medication error if the order is filled incorrectly. Likewise, intimidating behavior can suppress staff willingness to report errors and unsafe conditions if staff are afraid of retaliation for reporting. (Chassin and Loeb)

Adopt Accountability Assessment Method

> **Action Recommendation: Create an environment in which people can speak up about errors without fear of punishment; use the information to identify the system flaws that contribute to mistakes.**
>
> **Action Recommendation: Apply a fair and consistent approach to evaluate the actions of staff involved in patient safety incidents.**

A culture of safety supports an environment in which people feel free to speak up to voice their concerns about

issues that could jeopardize patient safety. In such an environment, people are comfortable raising their hand to say, "I made a mistake," because they trust that the organization's response will be, "How was this possible?" instead of "Who did it?" (Leonard and Frankel)

Over the last several decades, healthcare organizations have been encouraged to shift from a punitive culture to a "just culture," a term first coined in 2001 (Marx). A fair and just culture recognizes that individuals are human, fallible, and capable of making mistakes, especially when the systems that they work in are flawed. These individuals should not be held responsible for errors that are symptomatic of an imperfect system that needs fixing. By contrast, a "shame and blame" environment drives error reporting underground because people feel singled out for safety issues that may have deeper causes. Without the information provided by event reporting, organizations cannot learn from mistakes.

For example, say a nurse incorrectly programs an infusion pump to deliver too high a dose of medication. Many factors, or a combination of factors, could have contributed to the error, such as distractions, staffing shortages, heavy workload, fatigue, pump programming difficulties, and unclear labeling of the medication. A fair approach to evaluate the mistake recognizes that, under the same circumstances, other individuals could have made the same error because of problems within the system that are setting them up to fail. Instead of singling out the nurse for the mistake, the organization supports the nurse for reporting the error in order to understand the systems issues contributing to the errors and to prevent similar mistakes from recurring.

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Disclosure of Unanticipated Outcomes

Additionally, the organization helps the nurse cope with the trauma of the event, particularly if the mistake caused patient harm. For more information, refer to the guidance article Disclosure of Unanticipated Outcomes.

Nevertheless, a fair approach to patient safety incidents holds problematic individuals accountable for unacceptable behavior. It draws a line between acceptable and unacceptable behavior by differentiating the problematic individuals from the good, skilled people who were set up to fail from system errors they could not foresee (Leonard and Frankel).

A staff member who repeatedly fails to follow an organization's procedures—for example, by skipping, without justification, the organization's requirement to check for two patient identifiers with every patient encounter—takes unacceptable risks with the unfounded belief that skipping patient identification procedures will not cause patient harm. The staff member may need coaching to be reeducated about the expected behavior or practice and its importance for patient safety. If the behavior continues, the organization may need to intervene with more serious corrective actions, ultimately ending with dismissal if the behavior does not change.

In rare cases, either malicious actions or impaired judgment from drug or alcohol use could contribute to a patient safety event. A healthcare professional who deliberately intended to cause harm to a patient exhibits behavior that is punishable regardless of the outcome of the behavior.

To help organizations adopt a consistent and fair approach to evaluate the actions of people involved in an incident, James Reason, in his 1997 book on human error, developed an "unsafe acts" algorithm that asks a series of short

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Accountability Decision Tree

questions to help distinguish incidents caused by human error from those caused by risky, malicious, or impaired behavior (Reason).

ECRI's Accountability Decision Tree, adapted from Reason's algorithm and others, applies four tests to evaluate caregiver actions and determine an organization's response:

- Deliberate harm: Were the actions intended?
- Incapacity: Does there appear to be evidence of ill health or substance abuse?
- Foresight: Did the individual depart from agreed protocols or safe procedures?
- Substitution: Would another individual coming from the same professional group, possessing comparable qualifications and experience, behave in the same way in similar consequences?

The decision tree guides the user through a series of structured questions to understand the reasons for an individual's actions and possible consequences. For example, when the deliberate harm test is met, the decision tree suggests suspension and referral to a disciplinary body. By contrast, when the substitution test is met, the decision tree points to system failures, not individual fault, as the cause for the error.

Many healthcare organizations have developed similar decision trees, or accountability assessment tools, for their use (Leonard and Frankel). Brigham and Women's Hospital, Boston, describes its approach in a video on its website. "We don't punish for errors or decisions we all could make," the hospital says.

The University of North Carolina (UNC) Health Care (Chapel Hill), described its just culture algorithm and accompanying policy and procedure during an AHRQ webcast, Using Just Culture to Improve Hospital Survey of Patient Safety Culture Results. The system's just culture algorithm and corrective action policy took two years to develop, requiring multiple levels of review and revision before organizational approval was obtained (Mayer). UNC Health Care's just culture algorithm, corrective action policy, and related materials are available from the Massachusetts Society of Health-System Pharmacists. A similar approach, developed by the United Kingdom's National Health Service (NHS), is called the Just Culture Guide and is publicly available.

Risk managers can also use ECRI's Accountability Decision Tree to tailor a policy for their organizations. The policy should clearly define how the decision tree is used—when? by whom? and with whom?—and underscore consistent application of the decision tree so that no staff member feels unfairly treated.

To successfully implement a policy to assess accountability for patient safety incidents, organizations should consider the following (ECRI Institute PSO; Mayer):

- Involve a multidisciplinary team from various departments (e.g., risk management, patient safety, human resources, legal, medical staff, nursing) in developing the organization's approach
- Establish clear expectations, and ensure that human resource policies are consistent with the approach
- Seek visible support from high-profile leaders
- Roll out the policy to everyone in the organization, from housekeeping to leadership, and include the medical staff
- Provide ongoing training to managers in using an accountability assessment tool and applying the accompanying policy

- Encourage leaders and managers to regularly practice applying the organization's accountability assessment tool using actual scenarios from past patient safety incidents
- Consistently apply the tool to establish accountability for patient safety incidents; do not allow exceptions
- Support the medical staff in practicing and using the tool with their peers
- Require managers to document use of an accountability assessment tool in any counseling or corrective action with an employee; ensure that the employee also sees and signs the document

By ensuring that everyone within the organization is familiar with its approach to assessing accountability and by encouraging those who use the tool to regularly practice its application, the organization can embed its approach to accountability within its safety culture.

Support a Reporting Culture

Action Recommendation: Support event reporting of near misses, unsafe conditions, and adverse events.

Action Recommendation: Identify and address organizational barriers to event reporting.

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Event Reporting

A safety culture depends on an organization's willingness to learn from failure. How can an organization improve patient safety if it cannot learn from its mistakes? To do so, a safety culture requires a robust event reporting program. Organizations' event reporting programs depend on staff members voluntarily completing an event report about a near miss, unsafe condition, or patient injury. The reports often are submitted by frontline staff directly involved with patient care.

Unfortunately, many events are not reported for a variety of reasons. The barriers to event reporting are well documented. If the organization suspects underreporting of events, it should find out why staff are hesitant to report and help them overcome the obstacles. Do staff have a clear understanding of the types of events the organization expects to see reported? Does the organization encourage staff to report near misses and close calls so it can take steps to address the unsafe conditions? Do staff trust that the organization views patient safety incidents as system failures? Does the organization provide feedback about event reports so staff are aware that the information they report is taken seriously?

Table 2. Event Reporting Barriers and Strategies lists commonly identified barriers and suggestions for overcoming them. The guidance article Event Reporting provides comprehensive information about a reporting program.

Table 2. Event Reporting Barriers and Strategies

Barriers	Strategies
Belief that someone else reported the event	Implement reporting systems that are able to identify duplications.
Lack of time to complete event report form	Design event report forms for ease of completion (e.g., explore ways to autopopulate some fields with data from other

	sources, such as the admission, discharge, and transfer system).
Lack of understanding of importance of reporting	Provide education about event reporting at orientation and annually thereafter; establish reporting as a performance expectation in job descriptions.
Unclear policies and procedures for reporting; lack of availability of event report forms (or computer access for electronic systems)	Develop clear, specific policies and procedures for event reporting; provide easy access to forms and systems to support reporting.
Belief that reporting does not contribute to improvement; lack of feedback on action taken as a result of event report	Communicate back to staff information about changes and improvements made as a result of reported events; explicitly recognize positive effect reporting has on patient safety.
Reluctance to "tell on" another healthcare worker; fear of punishments and lawsuits	Explain that individuals are not punished for errors that result from system failures; establish a just and fair approach to evaluate accountability for patient safety incidents.
Lack of involvement by physicians and other providers in the event reporting system	Include physicians and other providers in event reporting system development and educational programs; create the expectation that physicians and other providers will participate in event reporting.

Sources: Evans SM, Berry JG, Smith BJ, Esterman A, Selim P, O'Shaughnessy J, DeWit M. Attitudes and barriers to incident reporting: a collaborative hospital study. Qual Saf Health Care 2006 Feb;15(1):39-43. PubMed. doi:10.1136/qshc.2004.012559; Uribe CL, Schweikhart SB, Pathak DS, Dow M, Marsh GB. Perceived barriers to medical-error reporting: an exploratory investigation. J Healthc Manage 2002 Jul-Aug;47(4):263-79. PubMed.

In addition to a robust event reporting system, organizations should augment their information gathering with other techniques to identify potential problem areas that can jeopardize patient safety. These techniques include use of trigger tools for medical record review, observation of existing processes, and proactive risk assessment of high-risk processes to identify vulnerabilities and prioritize them for improvements. The guidance article Failure Mode and Effects Analysis describes how to conduct a proactive risk assessment.

Foster a Learning Culture

Action Recommendation: Cultivate an organization-wide willingness to examine system weaknesses and use the findings to improve care delivery.

Action Recommendation: Promote collaboration across ranks and disciplines to seek solutions to identified safety problems.

Fundamental to a safety culture is an organization's willingness to examine its own weaknesses and to use the findings to improve care delivery. The term

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"high-reliability organization" has been used to describe organizations from high-risk industries, such as healthcare, that attain and maintain a high level of safety by demonstrating a willingness to learn and change before accidents occur. They approach safety systematically, even at the expense of production or efficiency. Using event reporting programs and other means, they look for, identify, and fix problems before harm can occur. When accidents do occur, high-reliability organizations investigate them to identify and address the underlying system faults that contributed to the problem. (Chassin and Loeb)

Failure Mode and Effects Analysis

Event Reporting

Getting the Most out of Root-Cause Analyses

The Role of the Healthcare Risk Manager: A Primer

Developing a Risk Management Program

Also characteristic of a learning organization is a shared mindset by all—from senior leaders to frontline workers—to function as a high-reliability organization and to deliver and sustain safe, dependable care. A learning organization's success in mantaining a safety culture depends on encouraging collaboration across ranks and disciplines to seek solutions to identified safety problems.

Given that a learning culture is intertwined with a reporting culture and a fair and just culture to support a safety culture, many attributes of a learning culture are already described elsewhere in this guidance article and others, such as Event Reporting and Getting the Most out of Root-Cause Analyses. The attributes are also at the core of many risk management activities, as described in the guidance articles The Role of the Healthcare Risk Manager: A Primer and Developing a Risk Management Program, and include the following:

- Acknowledging the importance of reporting all patient safety events, from near misses to events that cause serious harm
- Using retrospective analysis to investigate event reports to define the problem and identify solutions
- Using proactive analysis to identify and address vulnerabilities in care delivery before patient harm occurs
- Disseminating feedback to the rest of the organization about lessons learned from event investigations and any changes put in place
- Sharing data from event reports to illustrate reporting's effect on improved patient care (e.g., reduction in the number of event reports of falls with injuries)
- Using every opportunity possible (e.g., leadership walkrounds, unit safety huddles and debriefings) to ask about patient safety concerns and to share feedback

Measure the Safety Culture

> **Action Recommendation: Periodically assess the safety culture of an organization to track changes and improvements over time.**

Transformation to a safety culture does not occur simply because policies and procedures to support it are in place. Culture change takes time to become ingrained within an organization. The attitudes and beliefs that support the three elements of a safety culture must permeate the organization and be adopted by everyone—including those who may have been initially reluctant to embrace change.

Fortunately, organizations can track their progress. The extent of a safety culture within an organization can be measured with surveys that evaluate the organization's willingness to embrace the characteristics of a safety

culture. Several tools are available to assess a safety culture. For example, AHRQ released the Hospital Survey on Patient Safety Culture in 2004 (and an updated version in 2019) for hospitals to assess staff perceptions of an organization's safety culture and to pinpoint areas of concern. The survey also helps identify differences in perception about the organization's safety culture among staff and among care units. AHRQ has also released safety culture surveys for ambulatory surgery centers, for community pharmacies, for medical offices, and for nursing homes.

ECRI's INsight® survey tool simplifies the survey process with a confidential, web-based approach using the questions from AHRQ's surveys on patient safety culture. Facilities can customize the survey with additional questions. The results are available electronically for facilities to dig deeper into the data and compare the findings to aggregate results of other facilities by size and by region. The results also display aggregate responses from AHRQ's survey database of responses from 382,834 providers and staff at 630 hospitals (Famolaro et al.).

Safety culture surveys can be conducted periodically—preferably, every two years—to track changes and improvements over time. Of course, organizations may want to include other sources of information (e.g., findings from executive walkrounds, patient surveys, general employee surveys) to obtain a complete picture of the safety culture.

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RESOURCE LIST

Risk Manager's Toolbox

- Ready, Set, Go: Culture of Safety
- Make a Plan: Culture of Safety
- Accountability Decision Tree
- Sample of Code of Conduct
- Safety First for Staff: Culture of Safety
- Essentials: Event Management

Guidance, Assessments, and Training

- Disclosure of Unanticipated Outcomes
- Disruptive Practitioner Behavior
- Developing a Risk Management Program
- Event Reporting
- Failure Mode and Effects Analysis
- Getting the Most out of Root-Cause Analyses
- The Role of the Healthcare Risk Manager: A Primer

TOPICS AND METADATA

Topics

Accreditation
Culture of Safety
Incident Reporting and Management
Quality Assurance/Risk Management

Caresetting

Hospital Inpatient
Hospital Outpatient

Roles

Clinical Practitioner

Corporate Compliance Officer
Healthcare Executive
Human Resources
Legal Affairs
Nurse
Patient Safety Officer
Quality Assurance Manager
Risk Manager

Information Type

Guidance

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