

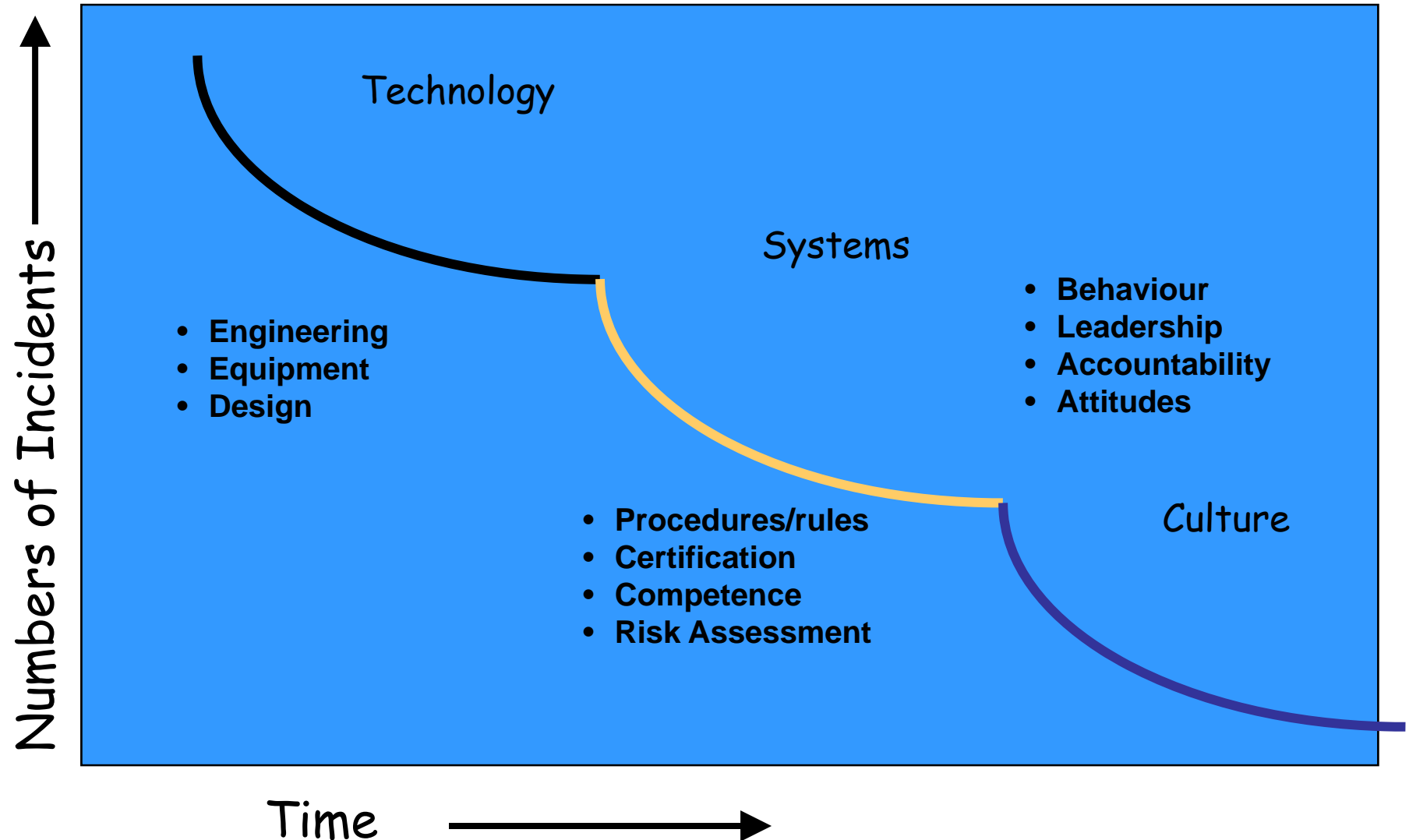
What is a safe environment/safety culture?

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How do other industries approach safety?



The 3 approaches in healthcare

- Technology and design:
 - Electronic prescribing
 - Barcoding of medicines
 - Single use syringes
 - Panic buttons for staff
- Management systems
 - Lone working policy
 - Reporting systems
 - Incident investigations
 - Clinical guidelines
- Culture
 - Not so much!
 - IHI tools to help develop a culture of safety
 - UK Health Foundation Safer Patients Initiative

What is safety culture?

- a culture where staff have a constant and active awareness of the potential for things to go wrong
- a culture that is open and fair, and one that encourages people to speak up about mistakes

UK National Patient Safety Agency

- a commitment to safety that permeates all levels of an organization, from frontline personnel to executive management

US AHRQ

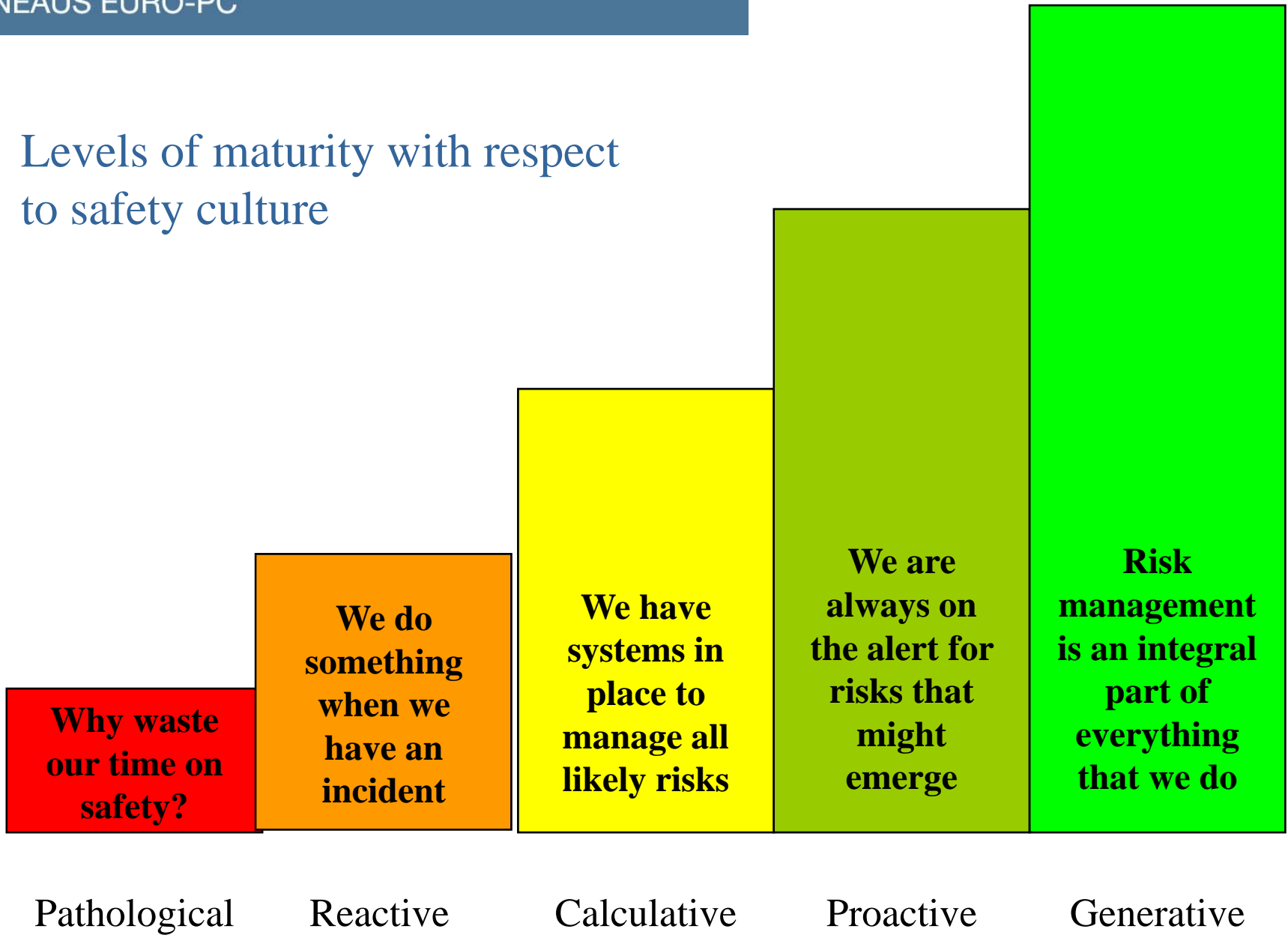
A culture of safety

- Safety culture is not something you do or do not have: it is multi-dimensional
- It emerges from, and is manifested in, all aspects of the way safety is handled in an organisation
- A slippery concept – difficult to measure! (Two ways of measuring will be described today)
- Qualitative: Manchester Patient Safety Framework (MaPSaF)
- Quantitative: AHRQ safety culture survey

Multidimensional: MaPSaF workshop dimensions

- Overall commitment to quality
- Priority given to patient safety
- Perceptions of the causes of patient safety incidents
- Investigating patient safety incidents
- Learning following a patient safety incident
- Communication about safety issues
- Staff management and safety issues
- Staff education and training about safety issues
- Team working around safety issues

Levels of maturity with respect to safety culture



Pathological

Reactive

Calculative

Proactive

Generative



Characteristics of a pathological organisation

- Information is hidden
- Messengers are “shot”
- Responsibilities are shirked
- Bridging is discouraged
- Failure is covered up
- New ideas are actively crushed

Characteristics of a bureaucratic organisation

- Information may be ignored
- Messengers are tolerated
- Responsibility is compartmentalised
- Bridging is allowed but neglected
- Organisation is just and merciful
- New ideas create problems

Characteristics of a generative organisation

- Information is actively sought
- Messengers are trained
- Responsibilities are shared
- Bridging is rewarded
- Failure causes inquiry
- New ideas are welcomed

Multidimensional: AHRQ survey dimensions

- communication openness
- feedback & communication about error
- frequency of events reported
- hospital handoffs & transitions
- hospital management support for patient safety
- nonpunitive response to error
- organizational learning-continuous improvement
- overall perceptions of safety
- staffing
- supervisor/manager expectations & actions promoting patient safety
- teamwork across hospital units
- teamwork within units

Comparison points

MaPSaF workshop	AHRQ survey
facilitates self-reflection	raises awareness
stimulates discussion of strengths weaknesses in safety culture	identifies strengths and areas for patient safety culture improvement
helps evaluate any specific ps intervention	evaluates the cultural impact of ps intervention
shows what an organisation with a more mature safety culture might look	allows examination of trends in patient safety culture over time

Linneaus WP5 objectives

- Both safety culture measures adapted for use in primary care in Europe
- Field testing to enable development of practical tips for users, and FAQs
- Translations into German, Polish, Danish, Dutch (so far)
- Which one to use, when and how

