Elements of a Culture of Safety

Patient Safety is Our Top Priority
Patient Safety—it is a concept that seems so simple that it’s one of the basic tenets of medical practice. When the prestigious Institute of Medicine (IOM) in November 1999 released the landmark report, *To Err is Human, Building a Safer Health System*, and followed in March 2001 with its report *Crossing the Quality Chasm: A New Health System for the 21st Century*, both reports documented the issue of patient safety and called for “a bold overhaul of the U.S. health care system—and a strategy to address serious shortcomings in the quality of health care available to all Americans.”

As the health care industry continues to evolve, one of the most significant changes that need to be made is to commit to continually improving the culture of safety.

This guide offers your organization some ideas of openness in addressing the issue of patient safety and recommends new approaches that you can incorporate in your organizations’ daily applications.

The Pennsylvania Patient Safety Collaborative is a tremendous example of how health care organizations can work together by committing themselves to creating a safer environment for patients.

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“Management must ‘manage’ for patient safety just as they manage for efficiency and profit maximization. And safety must become part of what a hospital or health care organization prides itself on.”

—Lucian L. Leape, M.D., adjunct professor of health policy, Harvard School of Public Health
What is the Pennsylvania Patient Safety Collaborative?

The collaborative is a network of 24 organizations representing health care providers, insurers, organized labor, private industry, and consumers whose goal is to address the systematic issues that lead to medical errors and to work to reduce patient injury from errors through identification and correction of the causes of medical errors.

**Vision**

Patient Safety must be identified as a top priority across the commonwealth by all stakeholders who influence patient care delivery.

**Mission**

To foster the sharing of knowledge and information about optimal patient safety practices and models; to identify causes and influence change in systems to prevent these; and to convene stakeholders for ongoing dialogue in support of patient safety improvements.

The Case for Making Patient Safety a Top Corporate Priority

Creating a safe environment for individuals within health care settings is basic to the values of care providers and organizations. Attention to individual well-being is inherent in a commitment to the relief of suffering and improvement in quality of life.

In committing ourselves to safeguarding individuals, we are required to fully understand the processes of delivery systems.

From this deeper understanding, we will be able to analyze, evaluate, and develop changes to continuously improve our design. The results of these efforts will produce a more efficient model of care, delivered by a more knowledgeable workforce who recognize the significance of their roles in protecting individuals and reducing the risks of care delivery. As processes are redesigned, there is further opportunity to control costs in the reduction of rework and by removing the embedded latent errors that plague our systems.

Organizations have an obligation to communicate the seriousness of their endeavors to patients, staff, and the community. Seeing organizational leadership’s commitment to the patient will allow each group to realize that the values of these leaders are in concurrence with their own. This will lead to improved relationships, greater employee and patient satisfaction, and enhanced employee recruitment/retention efforts which will assist in addressing workforce shortages.

**Pervasive Commitment to Patient Safety**

Improvement in safety does not occur unless there is a commitment by the organization’s governing body and senior management and an overt, clearly defined, and ongoing effort on the part of hospital leaders, physicians, managers, and employees to sustain the organization’s interest and focus on patient safety.

Characteristics of an organization with a pervasive commitment to patient safety:

- The organization articulates patient safety as a specific aim and then determines how to translate that goal into its processes and procedures that support the delivery of patient care.

- The organization establishes patient safety programs with defined executive responsibility that supports strong, clear, visible organizational commitment and attention to safety. Meaningful safety programs should include senior-level leadership; defined program objectives and plans; dedicated personnel resources; a budget; collection and analysis of data; and monitoring of progress to key board committees and the board of directors.
“Medical errors most often result from a complex interplay of multiple factors. Only rarely are they due to the carelessness or misconduct of single individuals.”

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Open Communication

Communication about the importance of patient safety must be well conceived, repeated, and consistent across the entire organization. In its communication with physicians, managers, employees, and patients, the organization should stress that safety problems are quality problems and that all persons must be involved in identifying deficiencies in current care delivery processes and in designing and executing solutions needed to create safer systems. Communicated messages must be supported by organizational behavior that reinforces the priority the organization places on patient safety to ensure that the communication is believable and, in turn, promotes the desired behavior of those practicing, working, and being cared for within the organization.

Characteristics of an organization with open communication about patient safety:

- The organization openly discusses patient safety at all levels of the organization and seeks mechanisms to foster such communication to reinforce patient safety as an organizational priority and to demonstrate that all persons’ contributions and concerns about patient safety are valued and respected.

“Reducing the risk of error in health care will require substantial and sustained effort at all levels of the health care system.” —Lucian L. Leape, M.D., adjunct professor of health policy, Harvard School of Public Health

- The organization discloses information about errors that reach a patient to the patient and his/her family in fulfilling its ethical responsibility to that patient and as a means to cultivate and demonstrate the organization’s commitment to patient safety to the community that it serves.

- The organization keeps the governing board informed of errors, safety problems, and efforts directed at maintaining and improving patient safety. Both the good news and bad news about patient safety is shared on a regular basis with the organization’s board of trustees.

- The organization fosters a management style in dealing with error that ensures that there are no reprisals and no impediments to information flowing freely against a power gradient.

Blame-free Environment

Punishing people for making mistakes emanates from the misconception that the individual is entirely to blame for his or her mistakes and that punishment will lead both to improved performance in that individual and as a deterrent to error in others. Abundant evidence in human factors and cognitive psychology literature recognize that most human errors are symptoms of underlying systems failures, not personal failures.

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- The organization strives to include patients as active participants in their care and promotes patient and family questioning of organizational routine, procedures, and processes whenever something does not look or seem “right.”
“It can't be just the hospital or just the doctor or just the nurse. It’s (medication errors) a societal problem and all of us have a role to play—some of us bigger than others.”

—Ian Jones, senior vice president, Crozer-Keystone Health System
Many organizations need to break out of the “blame and train” mentality that punishes individuals for errors and rarely looks beyond to underlying job designs or system malfunctions. In these environments, personnel tend not to report errors they can hide, and are hesitant to discuss them. As a result, voluntary reporting (such as the standard event report) typically identifies fewer than 5 percent of the errors that actually occur. Until this culture changes, voluntary reporting is of limited value in assessing the extent of errors and in an organization’s ability to make systemic changes that will improve patient safety.

Characteristics of an organization with a blame-free environment:

- The organization embraces the concept that those under its employ or who practice in their facility do not purposely seek to create errors, that most errors occur as a result of ineffective, improperly designed, or flawed systems.
- The organization seeks to develop human resource and medical staff policies and procedures that support the realization that most errors are not the result of individual failure, but system failure.
- The organization develops ways to reward rather than discourage reporting of errors or patient safety concerns.
- The organization celebrates success at improving the reporting of patient safety concerns and errors as well as how such disclosure has been used to make improvements in systems to prevent the future possibility of error.
- The organization purposely works to alter its mindset about errors and its behavior with respect to errors, possibly by changing the language it uses to talk about patient safety and errors.
- The organization seeks to engender an environment where reporting about medical errors and patient safety is the norm by actively creating an environment where practitioners and employees do not fear retribution for raising concerns or reporting errors.
- The organization implements methods of feedback to learn from error.

**Safety Design**

When human failures do occur, they are most often consequences of inevitable, “built-in” limitations of human cognition or endurance, such as limits on short-term memory capacity, sustained vigilance over long periods of time, judgment impacted by lack of sleep, and problem solving under stress. Prevention of future errors requires changing systems, not attempting to change individuals.

Characteristics of an organization with a focus on safety design:

- The organization recognizes the weaker aspects of human performance and purposely and tirelessly works to design error out and safety into workplace processes in a proactive manner by addressing such issues as work hours, workloads, rotation schedules, sources of distraction, staff turnover, unit reassignment, and use of temporary staff.

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—IAN V. JONES, SENIOR VICE PRESIDENT, CROZER-KEYSTONE HEALTH SYSTEM

- The organization seeks to reduce variation in how patients are cared for in their organizations and devises strategies to avoid reliance on memory through the use of protocols, checklists, and standardization of work processes.
- The organization evaluates how the number of steps, hand-offs, and persons involved in carrying out specific processes can be simplified and/or endanger those under their care and that reduced to lessen the possibility of error.
The organization reviews research and the experiences of others in and outside of health care in developing alternatives to reduce the possibility of error and improve patient safety.

The organization methodically evaluates the vulnerabilities of its current patient care technology and care delivery systems and also critically evaluates all new technology or changes in care delivery for threats to patient safety and potential for error. The organization uses such analyses to build in constraints and forcing functions or design for more immediate recovery if an error should occur.

“The issue of patient safety is a very complex one. Everyone involved in the delivery of health care—including our citizens—can and should play an active role in preventing errors and ensuring patient safety.”

—Dr. Robert S. Muscalus, Pennsylvania’s Physician General

Employee & Physician Involvement & Accountability

As noted above, success in creating a culture of patient safety starts with organizational leadership. However, involvement of employees and physicians is crucial in actually succeeding in implementing safer health care systems. It is also critical that organizations seek ways to actualize accountability for patient safety on the part of physicians and employees.

Characteristics of an organization with physician and employee involvement and accountability:

1. The organization incorporates accountability for patient safety into employee position descriptions and establishes a comparable mechanism that does the same with members of the organization’s medical staff.
2. The organization discusses the importance of patient safety, the importance of surveillance, and the expectations for reporting patient safety concerns and errors with all employees, beginning with their orientation to the organization.
3. The organization evaluates employees on the contributions that they made in the area of patient safety.
4. The organization rewards employees and physicians for disclosing errors, near errors, and patient safety concerns.
5. The organization institutes team training and simulation for physicians and employees who are expected to work in teams so that each member of the team knows his or her responsibilities as well as those of teammates, and members of the team “look out” for one another, noticing errors before they cause an accident.
COLLABORATIVE PARTNERS

AARP
BlueCross of Northeastern Pennsylvania
Capital Blue Cross
Highmark Inc.
Hospital Council of Western Pennsylvania
The Hospital & Healthsystem Association of Pennsylvania
Independence Blue Cross
Insurance Federation of Pennsylvania
Keystone Peer Review Organization
Managed Care Association of Pennsylvania
National Patient Safety Foundation
Pennsylvania AFL-CIO
Pennsylvania Association of Health Care Risk Management
Pennsylvania Chamber of Business & Industry
Pennsylvania Department of Health
Pennsylvania Healthcare Technology Network
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