Transforming the Culture Of Patient Safety in Organizations

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During the past decade, those most involved in the patient safety movement have come to realize that preventing catastrophic events—or any avoidable harm to patients, for that matter—requires more than simply changing systems and implementing best practices. Also required are changes in our mindset about patient safety and adjustments in the underlying “culture” in which health care is provided, assessed, and improved.

One of the most significant predictors of success in keeping patients safe is the state of an organization’s culture.1 For instance, we might ask the following questions:

- How open are employees to reporting risk, near misses, and errors?
- Do they regard near misses as system failures that reveal potential danger or as evidence of success because potential harm was avoided?
- How receptive is an organization’s leaders and executives to hearing about problems that affect patient safety?
- Is it just by chance that more serious mistakes don’t happen?

The answers to these questions about an institution’s culture do not rest within a single individual. The entire organization, from board members to first-line workers, should be surveyed to establish a baseline that describes the current culture upon which strategies for improvement can be determined and upon which repeated measurements can show change.1

An institution’s culture can be found in the pattern of shared basic assumptions about the values, beliefs, and behaviors that have been transmitted to the workforce in both explicit and implicit ways.2 Thus, the culture encompasses the observable customs, behavioral norms, stories, and rituals that take place as well as the unobservable assumptions, values, beliefs, and ideas shared by groups.

The most common means of measuring an organization’s culture is to survey an adequate sample of employees. Two examples of validated survey tools can be found on the Web sites of the Agency for Healthcare Research and Quality (www.ahrq.gov/qual/patientsafetyculture) and the Health Research and Education Trust (www.hret.org/hret/programs/saq.htm). In addition to staff surveys, other ways to add to the pool of knowledge consist of the following steps:

1. **Patient surveys.** Surveys can be used to determine the perceptions that patients and the community have about an organization’s culture.

2. **New-hire interviews.** During the first few months, supervisors might ask new employees these questions:
   a. Are we doing things differently from what we mentioned in your earlier interview?
   b. When you first joined the organization, what details struck you?
   c. Is there anything that might make you want to leave your position?

A new worker’s answers to these questions can help pinpoint underlying problems in the organization’s culture, particularly those that might conflict with the organization’s espoused values.

3. **Rounding.** Rounds that cover patient safety can be used as a forum to learn more about an organization’s culture, particularly if standard queries are included in the script used for interacting with staff and patients.

4. **Focus groups.** Small groups can meet to discuss the organization’s progress in improving patient safety. The organization’s leaders can gather clues about domains that should be targeted by asking employees this question: What would you tell new colleagues about what they need to know to get their job done?

5. **Exit interviews.** Knowing rates of staff turnover and accessing information gleaned during employees’ exit interviews can help uncover undesirable elements that exist in an organization’s culture.

6. **Performance evaluations.** Aggregate data can be gathered about domains used to measure the performance of all personnel, such as teamwork, communication, respect, and transparency.

The combined information obtained should be used to perform a gap analysis. This type of study could be conducted to compare the current culture with the ideal culture to identify opportunities for improvement. Comparing data from various large groups can also provide important information. Comparisons can be made, for example, between the perceptions of (1) board members and the executive team, (2) the executive team and management, (3) management and staff, (4) new staff members and experienced staff, (5) nurses and pharmacists, and (6) patients and health care practitioners. Differences in perceptions among specific groups can illuminate problems that might not be detected by an analysis of the aggregate data alone.

Findings should be shared with all employees, and the meaning of the results should be clearly explained, either in a meeting or in writing. Feedback about how to best support patient safety should be sought throughout the organization. The more feedback that is requested and acted upon, the faster change can occur.1

As an added bonus, the surveying process itself can help an organization articulate the most important aspects of the desired culture, and the actions taken **continued on page 316**
in response to the survey can help to establish the organization’s commitment to a culture of safety. Data should also be used to demonstrate improvements in key patient safety domains over time. However, the same tools should be used to measure the same groups so that internal comparisons are valid. New measures can be introduced as desired, but a core group of key measures should remain unchanged.

Laying a foundation for a culture of safety takes time and commitment, but simply performing a survey is no indication of an organization’s progress toward improving safety. The organization may have an event-reporting program, a reasonably just culture, and a fair amount of assessment activity and teamwork, and it may have succeeded in implementing some important safety measures. However, as James Reason notes, “assembling the parts of a machine is not the same thing as making it work.”3

It is not enough to possess some of the elements of a culture of safety; we need to totally transform the way we perceive and react to risks that threaten the safety of patients. Measuring the culture in an organization builds the groundwork for this transformation.4

REFERENCES

The reports described in this column were received through the ISMP Medication Errors Reporting Program (MERP). Errors, close calls, or hazardous conditions may be reported on the ISMP Web site (www.ismp.org) or communicated directly to ISMP by calling 1-800-FAILSAFE or via e-mail at ismpinfo@ismp.org.