

Safety culture: What is it and how do we monitor and measure it?

A summary of learning from a Health Foundation roundtable

Event report

March 2013

1. Introduction

Background

Large-scale failings, such as those at Mid Staffordshire, suggest that the behaviour of an organisation can often be explained by focusing on cultural problems, rather than simply on the particular processes, people or equipment that failed.¹

A safety culture in healthcare can be thought of as one where staff have positive perceptions of psychological safety, teamwork, and leadership, and feel comfortable discussing errors.² In addition, there is a 'collective mindfulness' about safety issues, where leadership and frontline staff take a shared responsibility for ensuring care is delivered safely. A positive safety culture has been found to be a common characteristic of high reliability organisations, where a lack of complacency and a constant concern about safety is built into the organisational fabric.³

In 2011 we published a scan of empirical evidence, exploring whether there was a relationship between safety culture and outcomes for patients.⁴ The scan concluded that 'it is now increasingly recognised that the culture of an organisation and staff attitudes can have a tangible impact on safety processes and ultimately patient outcomes'. However, rather than a one-way causal relationship, with culture influencing behaviours and clinical outcomes, there may be a circular relationship, with changes in behaviours and outcomes also improving safety culture.

Towards an active approach to safety

In 2013, the Health Foundation is focusing on leading a step-change in thinking about patient safety. We want to enhance a culture that has historically focused on measuring harms, moving towards an active approach that also establishes the presence of safety. This means not waiting for things to go wrong before they are identified as risks, and addressing potential failures as rigorously as actual failures.

An important element of this active approach is to recognise how the culture of an organisation – 'the way things are done around here' – can both explain the way people behave, and be the vehicle for improving patient safety and outcomes.

This approach builds on the successes achieved over the past 10 years by targeting and reporting specific healthcare associated harms. We believe that in order to deliver continuous improvement in patient safety, a broader approach is now needed that can identify and monitor the elements of a safety culture.

2. About the event

On 20 February 2013, the Health Foundation hosted a roundtable event to discuss what is understood as 'safety culture', why it is important and how it can be measured and monitored.

Patient safety experts from academia, public policy, quality improvement and frontline care came together to share their knowledge and learning in order to build understanding in this area, and to recommend some practical next steps. A list of attendees is provided on page 5.

The event is the first in a series of roundtable discussions hosted by the Health Foundation in 2013 to lead a debate about how to approach the measurement of safety in healthcare.

¹ Health Foundation Newsletter, September 2012. *The importance of culture in patient safety*. www.health.org.uk/safetyculturenews

² Health Foundation, May 2012. *How can leaders influence a safety culture?* www.health.org.uk/influenceculture

³ A High Reliability Organisation can be described as a consistently reliable organisation that operates in a complex environment where accidents might be expected to occur frequently, but which manages to avoid or seeks to minimise catastrophes. Health Foundation, November 2011. *High reliability organisations* www.health.org.uk/reliabilityscan

⁴ Health Foundation, November 2011. *Does improving safety culture affect patient outcomes?* www.health.org.uk/safetyculturescan

Key messages

- In the absence of a strong evidence base that describes the mechanism by which culture directly affects outcomes, safety culture is best understood to be a precondition for change rather than an agent of change.
- Safety culture is more than just a subset of organisational culture. It is made up of the different sub-cultures that exist within healthcare organisations at the frontline, management and executive level or ‘layer’.
- Understanding of the prevailing safety culture can differ between these three layers. There can also be a disconnect between the morals and values of individuals and what can happen operationally.
- An array of different beliefs, values and input factors (such as leadership) provide a more practical understanding of what is meant by a safety culture. Using a construct which describes how the culture of a unit or organisation can be manifested might be a useful starting point.
- Safety culture and climate assessment tools provide a practical device for stimulating conversations amongst staff - the creation of ‘safe spaces’ can help to surface safety issues. However, the temptation to impose the use of these tools for performance measurement or compliance purposes must be avoided.

3. Discussion

What is a safety culture?

It is possible to distinguish between organisational climate and culture, though the definitions of both vary markedly in the published research.

- Climate emerges through a social process, where staff attach meaning to the policy and practice they experience and the behaviours they observe.
- Culture concerns the values, beliefs and assumptions that staff infer through story, myth and socialisation, and the behaviours they observe that promote success. In other words, culture is more interpretative.

Much of the existing research on safety culture has focused less on developing technical metrics to measure it, and more on how it is conceptualised. For many, the notion of culture has become a vague and even mysterious concept, with too little insight into how it is constituted.

One definition of culture that resonated with participants was, ‘it’s what you do when nobody’s looking’.

In research to be published by the Health Foundation in 2013, the measurement and monitoring of safety is broken down into five dimensions: past harms, reliability, sensitivity to operations, anticipation and preparedness, and integration and learning. Safety culture bears on all of these dimensions; but it is best understood as a precondition to change rather than an agent of change. In this sense, whilst it is not possible to anticipate every potential problem, it is possible to prepare for the potential for problems to arise.

Current attempts to define and understand organisational safety culture are limited by how safety is viewed, as a subset of the wider culture. The work of Edgar Schein defines organisational culture as a pattern of shared basic assumptions and describes three sub-cultures – the operator, engineer and executive. Within a healthcare organisation, these sub-cultures – which could be compared to frontline professionals, managers and executives – are further influenced by external factors, such as the professional bodies and communities that health professionals often defer to.

What can be measured?

There is little in the published research that aids understanding of the mechanism by which culture directly influences safety. It is impossible to say with any certainty that enhancing the culture of an organisation will directly lead to improved patient outcomes. However, there was a general consensus in the group that culture is a **contributor** to safety in healthcare.

One suggested approach was to begin with a construct, to describe (rather than measure) how culture can be manifested. For example, take this hypothetical, but probably typical, scenario of an acute medical admissions unit in a busy hospital.

The telephone constantly rings but is never answered to avoid further patients being admitted. Nurses are busy completing paperwork to avoid being chastised by management. Diagnostic tests are repeated because staff lack confidence that the tests were undertaken properly in A&E. Doctors constantly interrupt nurses during their rounds because of a persistent hierarchical structure. Poor performance is tolerated because people know it will not be dealt with effectively.

This scenario can be mapped to illustrate the different beliefs and values that are being described as culture, and elements such as leadership which can be described as the input factors. Given all of the different elements which may constitute a poor or unsafe culture, it would be difficult to have a single measure of it. Some of these elements might be precise enough to measure, whilst for others it would be more appropriate to describe them. For instance, it would be possible to ask the nurses whether they feel valued by the doctors.

Regardless of whether the above example is considered as a description or a measure, or whether the elements could be said to directly lead to poor patient outcomes, a conclusion that it would not be a pleasant environment to work or be treated in seems certain.

How are measurements made?

A national survey found that one third of NHS trusts in England are currently using safety culture/climate assessment tools.⁵ Our evidence scan, *Measuring safety culture*,⁶ found that most tools focused on safety climate rather than culture. It concluded that tools that are 'short, easily repeatable over time and adaptable to various contexts may be most practical'.

Whilst the group was keen to avoid imposing another tool on the health service for performance measurement or compliance purposes, there was recognition of the role tools can play in surfacing safety issues, particularly by engaging frontline staff. Tools are a useful way to get people thinking and talking about safety and can help to provide the baseline for where a unit or organisation is starting from.

Safety culture tools provide an opportunity for staff to reflect on the things that are working well, that should be renewed or strengthened, as well as identifying areas for action. Arguably, the greatest value in using these tools comes from the process of bringing issues related to safety culture to the forefront of people's minds, rather than the score or assessment that can come from applying the tool.

Where are measurements made?

It was suggested that the concept of a 'safe space' was important in order to create the right environment for a positive safety culture to be fostered. The example of Jönköping was provided, where priority is given as much to sharing staff stories as patient stories, which has improved job satisfaction and reporting rates. It also acts as a 'laboratory' where staff groups come together to share improvement methodologies. Another example provided was Schwartz Center Rounds, which are a multidisciplinary forum for staff to come together once a month to discuss the emotional and social challenges associated with their jobs.⁷

⁵ Sujan MA. 'A Novel Tool for Organisational Learning and its Impact on Safety Culture in a Hospital Dispensary', *Reliability engineering and system safety* 101 (2012) 21-34

⁶ Health Foundation, February 2011. *Evidence scan: Measuring safety culture*. www.health.org.uk/safetyculture

⁷ www.kingsfund.org.uk/publications/articles/contribution-schwartz-center-rounds-hospital-culture-2012

But how realistic is it to build this into the system, given the day-to-day pressures on staff? The phrase ‘perversion points’ was used to illustrate how the environment can interfere with the best of intentions of frontline staff, how executives can be unduly influenced by the financial pressures they are placed under, and how middle managers can be ‘compressed’ with pressure from either side. There appears to be a ‘chasm’ between the values or ‘moral enterprise’ of individuals and what happens operationally.

There can also exist a disconnect between what the ‘sharp end’ or frontline of the organisation experiences and what the board and executives understand to be the prevailing culture. Such a disconnect is often not due to a lack of knowledge, but rather to do with differing priorities as a result of the pressure being placed upon them from both internal and external factors.

4. Next steps

The group agreed that there were two emerging themes that the Health Foundation should explore further:

- Drawing on the idea of a disconnect between the different layers of an organisation, we should explore how understanding of the prevailing safety culture varies from the ward to the board, and potentially extending up to the level of Government.
- Using the idea of a map, we should take some example elements that make up a positive safety culture, such as openness when something goes wrong, and identify the various input factors that influence it and the outputs that are the manifestation of it.

5. Attendees

Attendees at the event included:

Mr Ajit Abraham	Consultant HPB Surgeon, Barts Health NHS Trust
Murray Anderson-Wallace	Facilitator
Jonathan Bamber	Research and Evaluation Manager, Health Foundation
Dr Jo Bibby	Director of Strategy, Health Foundation
Professor Mary Dixon-Woods	Professor of Medical Sociology, University of Leicester
Dr Mike Durkin	Director of Patient Safety, NHS Commissioning Board
Professor Aneez Esmail	Professor of General Practice, Associate Vice-President – Social Responsibility & Equality and Diversity, University of Manchester
Tim Heywood	Programme Manager, 1000 Lives Plus Wales
John Illingworth	Policy Manager, Health Foundation
Lesley Massey	Director of Quality Improvement and Development, Advancing Quality Alliance
Dr Elaine Maxwell	Assistant Director – Patient Safety, Health Foundation
Sir Stephen Moss	Former Chair of Mid Staffordshire NHS Foundation Trust
Professor Anne Marie Rafferty CBE	Chair of Nursing Policy, King’s College London
Dr Kevin Stewart	Director of the Clinical Effectiveness and Evaluation Unit, Royal College of Physicians of London
Professor Charles Vincent	Professor of Clinical Safety Research, Imperial College London
Dr Simon Watson	Consultant Nephrologist, Lothian NHS Board, National Clinical Lead – Patient Safety Fellowship Programme for Scotland

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