Organisational Culture and Patient Safety

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The **World Health Organization** recently published the ***Global Patient Safety Action Plan 2021-2030****: Towards eliminating avoidable harm in health care*.[1] The need for improvement in patient safety is widely acknowledged. When things go wrong the traditional approach is to seek someone to blame, but there is increasing recognition that patient safety issues are usually systemic, and cultural.

What is organisational culture?

The culture of the organization comprises ***the mix of shared values, attitudes and patterns of behaviour that give the organization its particular character****.*
Put simply, it is 'the way we do things round here'.[4] **INSAG** (International Nuclear Safety Group)[5]

IAEA definition of safety culture

The assembly of characteristics and attitudes in organizations and individuals which establishes that, ***as an overriding priority, protection and safety issues receive the attention warranted by their significance****.*[6]

High reliability organisations

Healthcare has much to learn in respect of safety from high reliability organisations (HROs) operating in industries such as nuclear power, aviation and rail. HROs are characterised by their mindfulness, reached through five processes: (***Preoccupation with failure***; ***Reluctance to simplify***; ***Sensitivity to operations***; ***Commitment to resilience***; ***Deference to expertise***).[7]

Learning not blaming[8] (Extracts from UK govt response (2015) to 3 reports[9,10,11] on aspects of NHS culture relating to patient safety)

'…. widespread recognition that the NHS needed to radically improve the way it responded to concerns from staff and the public. A defensive culture more concerned with reputation than with either the truth, or with treating those raising concerns well and fairly, had grown up over several years.'

(The NHS): ***'must embrace a culture of learning rooted in the truth, a culture that listens to patients, families and staff and which takes responsibility for problems rather than seeking to avoid blame.'***

Organisational culture - the way forward (especially in response to patient safety incidents)

Organisations should avoid clichés, such as *'patient safety is our number one priority'* and *'lessons will be learned'*, unless their actions are consistent with them. If there is to be true learning from incidents they **must** acknowledge when something has gone wrong, and seek to understand how this occurred. They **must not** engage in cover-ups or scapegoat blaming.

Investigations need to be thorough and transparent, involving patients, family members and staff. It is important that the voices of all stakeholders are heard, and that issues related to complex systems and human factors are properly understood.

Those who have raised valid concerns should be thanked, not regarded as troublemakers. **Managers shoul**d practice *active listening*[12] and follow up concerns which have been raised. **Organisations should**, without fear of litigation, **apologise** to patients who have suffered iatrogenic harm, and to staff who have suffered reprisals after speaking up.

Healthcare systems and organisations should abandon adversarial legalistic mindsets. Instead their actions should **be guided by their values**, and those of the *NHS Constitution*.[13] They should **embrace safety culture principles, traits and attributes** developed by IAEA.[14] **Leaders should strive to instil ethical** behaviour,[15,16] **just** culture,[17,18] **generative** culture,[19,20] and a **culture of learning** throughout the organisation.[21,22]

Safety culture traits and outline principles developed by IAEA[2,3]

Individual Responsibility
All individuals are personally accountable for safety

Questioning Attitude
Individuals remain vigilant for assumptions, anomalies, conditions, behaviours or activities that can adversely impact safety and then appropriately voice those concerns

Effective Safety Communication
Communications support a focus on safety

Leadership Responsibility
Leaders demonstrate a commitment to safety in their decisions and behaviours

Decision-making
Decisions are systematic, rigorous, thorough, and prudent

Respectful Work Environment
Trust and respect permeate the organization

Continuous Learning
Learning is highly valued

Problem Identification and Resolution
Issues potentially impacting safety are systematically identified, fully evaluated, and promptly resolved according to their significance

Environment for Raising Concerns
Personnel feel free to raise safety concerns without fear of retaliation, intimidation, harassment, or discrimination

Work Processes
The process of planning and controlling work activities is implemented so that safety is maintained

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References: *Organisational culture and patient safety*

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