AORN Guidance Statement: Creating a Patient Safety Culture

Introduction

The purpose of this guidance statement is to assist managers and clinicians in developing policies and procedures related to creating a patient safety culture.

Since the Institute of Medicine (IOM) report released in 1999, the vast majority of patient safety initiatives have focused on micro issues, such as medication errors and wrong-site surgery, with little emphasis on the macro issue of culture. Edgar Schien, professor of management at the Sloan School of Management, Massachusetts Institute of Technology, defines *culture* as the set of shared, implicit assumptions that a group holds and that determines how it perceives, thinks about, and reacts to its various environments.[1] In broader terms, culture is a mindset centering on shared values, attitudes, or beliefs within an organization. As defined in the health care literature, a safety culture is an environment that encourages reporting,[2] ends blame,[3] involves senior leadership,[4] and focuses on systems.[5]

Lucian Leape, adjunct professor of health policy, Harvard School of Public Health, Harvard University, Boston, has stated the single greatest impediment to error prevention is that "we punish people for making mistakes."[6] Medical errors are grossly unreported across the country; only 2% to 3% of major errors are reported,[6] and when reported, they do not create stories or generate action.[7] Analytical methods such as root cause analysis (RCA) and the failure mode and effects analysis (FMEA) will not work in detecting the causes or errors if health care workers are bound by a "code of silence," fear retribution, or are uncomfortable revealing imperfection in a process for which they are responsible.[8]

To date, most of the work in patient safety has been reactive. As the culture matures with increased information and trust, the emphasis will switch to a more proactive or generative approach.

Background

In review of the literature, few hospitals have assessed their organizations' safety culture, nor have many actually measured the impact of interventions. One study, conducted in April 2001, reported that 15 California hospitals conducted a safety culture survey with two objectives: (1) measure attitudes toward patient safety and organizational culture; and (2) determine how the culture of safety varied among the hospitals and between the various types of health care workers.[9] The majority of the participants in the study responded in ways that indicated a positive safety culture; however, senior leadership gave fewer problematic responses than frontline workers, and clinicians—in particular nurses—were more pessimistic.[10]

Johns Hopkins Hospital conducted a systematic assessment on safety and developed a strategic plan to improve safety.[11] Its study revealed a comparable culture of safety as compared to the airline industry, but identified several areas for improvement. Key messages identified were that senior leaders need to be more visible to frontline caregivers when addressing safety; safety planning must be proactive; physicians are less aware of safety initiatives than nurses; and physicians must actively participate in the education process.[11]

Preamble

The intention of this guidance statement is to provide a framework from which perioperative teams can foster a patient-centric safety culture and assist with the development of policies and procedures that will support that culture. A patient-centric safety culture consists of five major subcultures: reporting, flexible, just, learning,[5] and wary[2] (Figure 1).

Reporting Culture

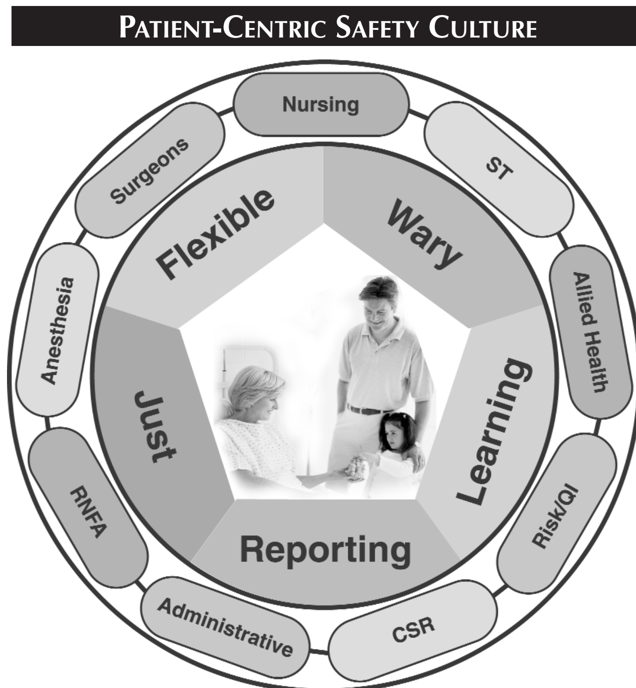
A reporting culture is a culture in which all members of the perioperative team readily report errors and near misses. A reporting culture can be assessed by the types of errors reported by staff. As the safety culture matures, there is increased risk-taking associated with errors reported. In a true reporting culture, individuals report events to allow all staff in the organization to learn from the experience.

Suggested strategies[5-7]

- Focus on both actual events and near misses.
- Use FMEA proactively to anticipate and prevent potential error.
- Discuss close calls, "good catches," and how harm to the patient was avoided or minimized.
- Develop a documentation system that is easy to use.
- Develop a reporting system that focuses on storytelling and knowledge-sharing.

Figure 1

PATIENT-CENTRIC SAFETY CULTURE



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- Focus on individual cases that provide learning opportunities.
- Identify ways to circulate stories and lessons learned throughout the facility.
- Provide feedback to the staff on all issues reported.
- Develop metrics for success (eg, increase number of reports).
- Prioritize improvement initiatives based on themes discovered and potential risks revealed.
- Use a process that emphasizes quality improvement (eg, Plan, Do, Check, Act).

Flexible Culture

A flexible culture is a culture that is nimble enough to keep pace with the rapid changes in health care.

Suggested strategies[7,9-11]

- Identify model for improvement programs that focuses on rapid cycle change.
- Develop processes that ensure shared leadership.
- Shared leadership is a hallmark of the organization.
- An environment of respect, collaboration, and trust exists between all team members and leadership.

Learning Culture

A learning culture is a culture that is capable and ready to gain knowledge from experiences and data, and that is willing to implement major changes as indicated from safety information systems. A learning culture is informed and learns from incidents and near misses.[8]

Suggested strategies

- Foster learning opportunities through open communication.
- Develop the ability to adapt to the changing health care environment and be receptive to change.
- Frontline staff is engaged to use initiative to problem-solve unique situations.
- Individual performance is linked to team performance.

Wary Culture

A wary culture is a culture in which the all members of the perioperative team are continually aware of the unexpected. Being vigilant is a healthy state that is a combination of being informed and aware that, at any given moment, an untoward event can occur. Healthy reporting, learning, and flexible cultures will facilitate a wary culture.

Suggested strategies[5,7,12,13]

- Go "looking for trouble"; conduct executive walk-arounds in all perioperative areas.
- Become preoccupied with opportunities for improvement.
- Be willing to challenge assumptions.
- How can we "stop the line" and still stay efficient?
- How can we get better when we know we are the best?

Just Culture

A just culture is a culture that provides an environment of trust where all members of the perioperative team are encouraged to provide safety-related data and are acutely aware of the distinction between acceptable and unacceptable behavior. Errors and mistakes must be evaluated in a manner such that contributing factors are reviewed first, and then accountability is determined in relation to actions. A just culture is not a nonpunitive (ie, blame-free) environment, but rather an environment where actions are analyzed to ensure that individual accountability is established and appropriate actions are taken.[12]

Health care organizations must adopt a disciplinary system theory approach in promoting a just

culture that freely reports errors. To understand the interrelationship between discipline and patient safety, four behavioral concepts are examined: human error, negligence, intentional rule violations, and reckless conduct.[7]

When evaluating an adverse event, care must be taken to determine whether human error or misconduct has occurred. Historically, most disciplinary actions are based upon the outcome of the mishap; if a patient is harmed, then that health care worker is considered blameworthy. By assigning blame, the health care organization stands to lose an opportunity to learn from the error and the error may reoccur. Disciplinary policies must balance the benefits of a learning culture with the need to retain personal accountability and discipline.[12] Adverse event investigation tools may be created to augment the use of the suggested strategy identified below.

Suggested strategy

James Reason, professor of psychology, University of Manchester, United Kingdom, created a model to assist managers to determine culpability after an untoward event has occurred.[13] (Figure 2 is an adaptation of the Reason model applied to the perioperative setting.) Perioperative leadership should apply this model when investigating incidences to determine whether disciplinary action is warranted. Six basic steps are used. It is important to focus on the error and not the outcome.

Step 1. The first line of questioning is to establish intent. Was this action or omission deliberate? If there was deliberate intent, the action or omission is culpable.

Step 2. If no intent is established, then determine whether substance use or abuse was involved. If abuse is determined, culpability is established. If the health care worker is taking a medication for medical reasons and is aware that he or she could be impaired, culpability is present; however, it is not as egregious as abuse.

Step 3. If the health care worker is not under the influence of drugs or alcohol, the next determinant is whether he or she knowingly violated safe operating procedures. This aids in determining reckless behavior. The threshold for reckless behavior is met when procedures are available, correct, and workable, but still are violated by the health care worker. If there are no adequate procedures in place, a systems error has occurred. When evaluating the situation, care must be taken to determine whether "normalization of deviance" is taking place—that is, whether there is a policy or procedure in place, but it not widely followed.

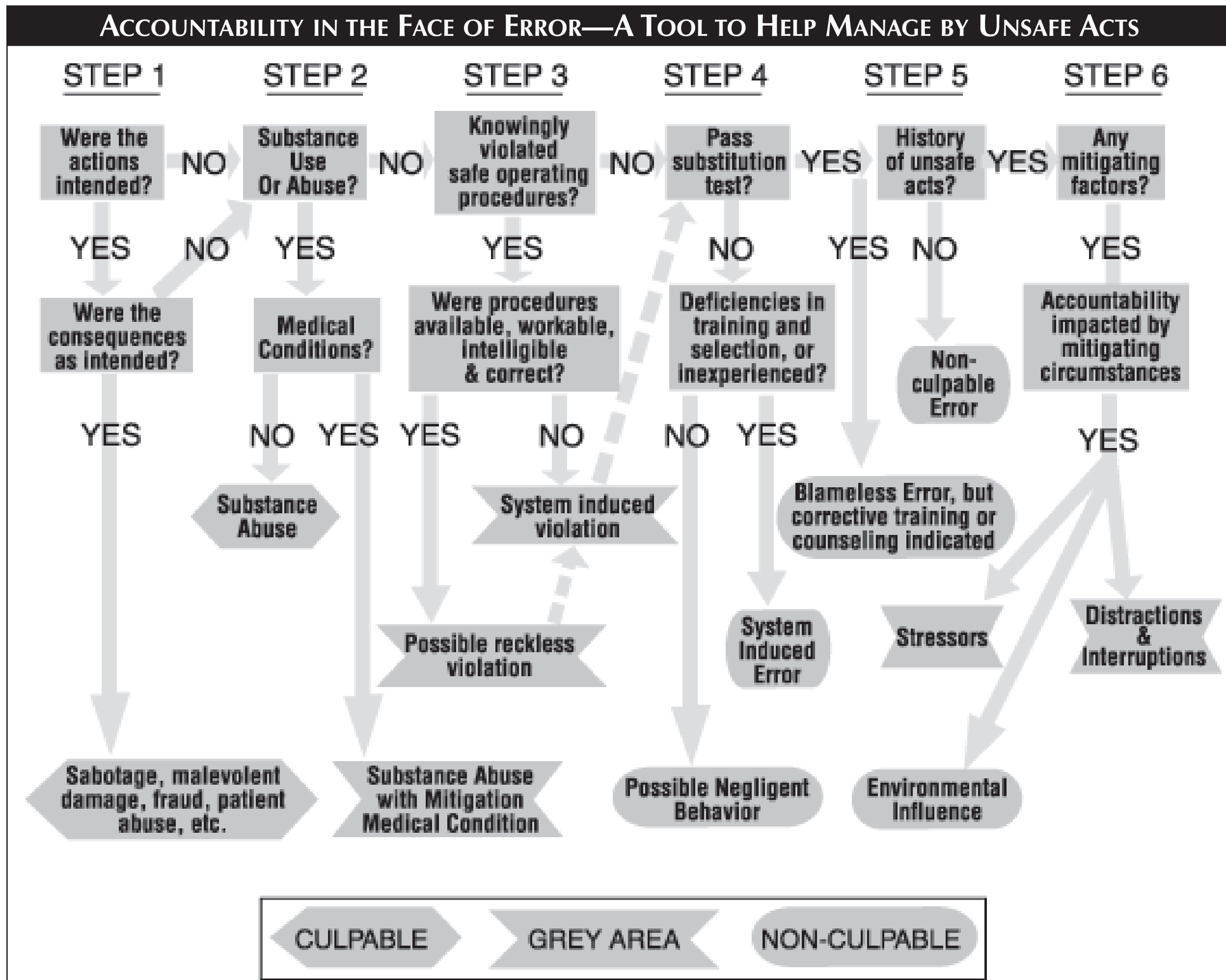
Step 4. If a policy or procedure is violated, a substitution test is conducted. Peers are asked how they would behave in a similar situation. If the peers respond the same as in the error in question, a systems-induced error is established. If they respond differently, possible negligence should be considered.

Step 5. The next question is whether the health care worker has a history of unsafe acts. If the questions in steps 1 through 4 are unsubstantiated, and there is no history of unsafe acts, then it is human error with no culpability. If the health care worker does have a history of unsafe acts, this particular incident may not be culpable; however, the organization should review the record for trends and may consider moving the health care worker to a lower-risk environment.

Step 6. The last question and assessment is where the possibility of mitigating circumstances is examined. Possible factors include stressors (eg, anger, fear, personal issues), distractions, and interruptions (eg, pagers, music, environmental temperature, extraneous conversation, overhead paging). Environmental influences include but are not limited to, physical plant and wrong size room for operative and other invasive procedures (eg, overcrowded, not ergonomic).

It is important to note that the accountability model does not evaluate or determine the proof legally required to prove reckless behavior or criminal negligence. This model should not be used for performance rating of surgical team members. It should be utilized by leadership after all the facts have been gathered, but as soon after the event as possible. If more than one person is involved, the model should be applied separately for each person.

Figure 2



Summary

AORN believes all health care organizations must strive to create a culture of safety. Such a culture will provide an atmosphere where all members of the perioperative team can openly discuss errors, process improvements, or system issues without fear of reprisal. A culture of safety places an emphasis on flexibility and learning as a means of improving safety and reducing errors. Characteristics of a culture of safety include the following:

- communication is open and honest;
- the emphasis is on the team rather than the individual;
- standards and practices are developed in a multidisciplinary framework;
- staff members are helpful and supportive of each other;
- staff members trust each other;
- surgical team members have a friendly, open relationship emphasizing credibility and attentiveness;
- the environment is resilient, encourages creativity, and is patient outcomes-driven;
- the focus is on work flow and process; and
- these attributes are supported by an informed culture that learns from incidents and near misses.

A commitment to safety must be articulated at all levels of the organization. Safety must be valued as the top priority, even at the expense of efficiency. Health care organizations must allocate an appropriate amount of resources and provide the necessary incentives or rewards to promote a robust patient safety culture. AORN recognizes that most patient safety initiatives will fail in the absence of a viable safety culture.

Glossary

Accountable: Responsible for one's actions or conduct.

Adverse event: Experiencing harm from error.

Culture: The shared norms, values, and practices associated with a nation, organization, or profession.[14]

Error: Failure of a planned action to be completed as intended, or the use of a wrong plan to achieve an outcome.

Failure mode and effects analysis (FMEA): A proactive tool used to anticipate and prevent the potential for product or process failure.

Just culture: An environment where actions are analyzed to ensure that individual accountability is established and appropriate actions are taken.[15]

Medical error: An adverse event or near miss that is preventable with the current state of medical knowledge.[16]

Near miss: An event or situation that could have resulted in an accident, injury, or illness, but did not, either by chance or timely intervention.[17]

Negligence: Failure to use such care as a reasonable prudent and careful person would use under similar circumstances.[17]

Root cause analysis (RCA): A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.[18]

Safety: Freedom from accidental injury.

Safety culture: An environment that encourages reporting,[2] ends blame,[3] involves senior leadership,[4] and focuses on systems.[5]

Notes

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