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Leadership and implementing a safety culture

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While it takes time to change the culture of an organisation, there are plenty of simple measures that strong leaders can implement to achieve some 'quick wins' as first steps towards advancing patient safety in primary care

Building a patient safety and improvement climate in primary care is now a major concern. Having considered the potential scale of the problem, and how systems fail and mistakes are made (*Practice Nurse* 2010; 40(8): 38–40), and looked at incident reporting systems and ways of preventing potential harm (*Practice Nurse* 2010; 40(9): 38–41), this article presents some tips for leaders implementing a strong safety culture.

STRONG LEADERSHIP

> '*When leaders begin to change their responses to mistakes and failure, asking what happened instead of who made the error, the culture within healthcare institutions will begin to change.*'[1]

In the UK, building a safety culture is the first step of the National Patient Safety Agency's (NPSA) seven-step guide to improving patient safety (Box 1). The 'safety culture' of a healthcare team or organisation is commonly defined as the combined individual and group values, attitudes, perceptions, competencies and patterns of behaviour that determine the overall commitment to patient safety. The prevailing safety culture influences the level of safe healthcare by motivating clinicians and staff to choose behaviours that enhance – rather than compromise – safety practices and thinking. The leadership commitment to patient safety within a practice is strongly linked to the maturity level of the prevailing safety culture.

Establishing a 'just' culture that enables the whole team to support and advance patient safety is only possible with strong leaders (Table 1). It is for the practice leadership – GPs, management and senior nursing staff – to facilitate and build a culture of trust that encourages effective teamworking, collective learning from significant events and strong communication across the clinical disciplines and administrative staff. They have both the responsibility and the authority to ensure that there is a continued focus on improving the safety of patient care – in essence to establishing safety as a cultural 'value' as well as a practice 'priority'.

BOX 1. THE NATIONAL PATIENT SAFETY AGENCY FRAMEWORK: SEVEN STEPS TO PATIENT SAFETY[24]

- Build a safety culture
- Lead and support your staff
- Integrate your risk management activity
- Promote reporting
- Involve and communicate with patients and the public
- Learn and share safety lessons
- Implement solutions to prevent harm

STRONG AND WEAK SAFETY CULTURES

Assessing, reflecting on and improving the safety culture (or climate) among the healthcare workforce are key elements in developing a focused approach to patient safety (Box 2). This is important because healthcare teams and organisations with a positive safety culture are more likely to learn openly and effectively from failure and adapt their working practices and systems appropriately. The opposite is true for those with a weak safety culture.

In many high-profile organisational failures a poorly developed safety culture was implicated as an underlying causal factor in the catastrophic incidents that

TABLE 1. LEADERSHIP INFLUENCE ON SAFETY CULTURE

Element of safety culture	Characteristics
Open culture	Clinicians and staff feel comfortable discussing patient safety incidents and raising safety issues with both colleagues and senior staff
Just culture	Clinicians, staff, patients and carers are treated fairly, with empathy and consideration when they have been involved in a patient safety incident or have raised a safety issue
Reporting culture	• Clinicians and staff have confidence in the local incident reporting system and use it to notify healthcare managers of incidents that are occurring, including near misses • Barriers to incident reporting have been identified and removed: – clinicians and staff are not blamed and punished when they report incidents – they receive constructive feedback after submitting an incident report – the reporting process itself is easy
Learning culture	• The practice: – is committed to learning safety lessons – communicates them to colleagues – remembers them over time
Informed culture	The practice has learned from past experience and has the ability to identify and mitigate future incidents, because it learns from events that have already happened (eg incident reports and investigations)

unfolded, for example the Piper Alpha oil-platform explosion, the space shuttle Challenger disaster, and the Zeebrugge ferry incident. Comparable NHS incidents would include the failings highlighted in Stafford hospital (high mortality rates from emergency admissions), Bristol Royal Infirmary (high infant surgical mortality rates) and the Vale of Leven hospital (deaths associated with *Clostridium difficile*).

Numerous media-highlighted failings in safety are commonplace in primary care, but are often related to individuals rather than to groups or organisations. It is really only in the past decade that we have begun to look seriously at how we can assess safety culture in healthcare settings to identify related issues (team working, communication, leadership, commitment to safety and so on) and consider their implications. Two different, but complementary, methods exist specifically to enable UK primary care teams to measure, reflect upon and improve their safety culture maturity: the Manchester Patient Safety Framework (MaPSaF)[2] and PC-SafeQuest, which was developed by NHS Education for Scotland.[3,4]

GET STARTED QUICKLY

Introduce some 'quick wins'

So how do you go about considering and improving the safety culture in your team? The first realisation should be that this is an evolving journey, often fraught with multiple challenges and obstacles – it can take time for attitudes to shift, behaviours to alter and cultural changes to embed.

But there is the possibility of introducing some 'quick wins' to your practice by keeping things simple. Offering pragmatic solutions to issues that most would judge to be commonsense interventions will help you to gain the trust of colleagues. Consider a few or all of the following examples of hazards or risks and their potential solutions, and how they relate to your practice:

- ensure that messages are taken safely through the use of a message system
- ensure that patients' records are accessed by date of birth and then full name
- in consulting rooms, place sharps boxes on a shelf out of the reach of children
- offer patients who do not attend for their warfarin checks a safer alternative
- make sure GP bags and on-call/emergency bags contain a sharps box
- search your practice information system for events that should rarely, if ever, happen (eg patients being

BOX 2. DEFINITIONS OF SAFETY 'CULTURE' AND 'CLIMATE'

- Safety 'culture' and 'climate' are interlinked concepts and the terms are often used interchangeably. There is ongoing debate about their differences and similarities.
- Safety culture has been defined simply as 'the way we do things around here' and is thought to help shape the discretionary behaviour of healthcare workers.
- Safety climate is considered to be the measurable, surface components that provide a 'snapshot' of the underlying safety culture. It has been defined as the shared perceptions of safety policies, procedures and practices held by a work group.

co-prescribed warfarin and aspirin or those who are co-prescribed two different non-steroidal anti-inflammatory drugs).

Are you confident that your team's patient care in these areas is completely safe and reliable? Given what we know about significant events and preventable harm in primary care, it is possible but probably unlikely that your supreme confidence is matched by the front-line reality in each of these areas. Why not consider taking one or more of these issues to colleagues – formally or informally – as a first stepping stone to engaging the team more explicitly with the patient safety agenda? Of course, you may have your own specific safety issue you wish to tackle.

Put 'patient safety' on the agenda

Increasingly in hospital-based care we are seeing a cultural change in the way NHS leaders and managers perceive the issue of patient safety. One manifestation of this is the introduction of 'patient safety' as a standing agenda item at board and other committee meetings. This conveys the very real message to patients, staff and the wider public that safety is taken seriously and that accountability for this issue goes straight to the top of the organisation.

It may be the case that your team has placed significant event analysis (SEA) as a standing item on the agenda at business or practice team meetings. Although this is commendable, the patient safety issue – as we have seen – is much broader than just SEA and therefore deserves greater recognition and respect. In the next 12 months – and with patient safety firmly established as a standing agenda item – the practice could consider some of the following tasks as one way of slowly developing the prevailing safety culture:

- create a manual or intranet-based log to capture significant events or important near misses
- gain the commitment of all clinicians to formally report at least one patient safety incident in the next 12 months
- begin to assess practice safety culture using a suitable instrument, repeating every 12–18 months
- appoint a 'patient safety champion' to galvanise and lead the team, eg the practice nurse
- try out a primary care trigger too[5] (see part 2) on 15 electronic patient records to identify safety-related learning needs
- interview a few regular patients or set up small focus groups (eg those taking warfarin) to enable you to begin exploring and capturing their experiences of healthcare.

ASSESS THE PATIENT EXPERIENCE

'We must step back from measuring everything that moves to measuring less but with a relentless focus on what matters: clinical quality, patient safety and, particularly, patient satisfaction with services.'
Andy Burnham
(Health Secretary, 2009)

Learning about our patients' experiences of primary care in order to better understand their needs and priorities is now viewed as an essential component of improving the quality and safety of healthcare. The evidence for involving patients in how we plan, monitor and improve the care we provide is strong.[6] We already survey some patients as part of the Quality and Outcomes Framework and this can be a useful way to get some quick feedback on specific aspects of the services provided. However, there are other effective methods of interacting with our patients and gathering arguably more meaningful – even emotionally powerful – feedback that can act as the catalyst for care teams to transform the way they deliver services, treat patients or interact with the public. Table 2 outlines some of the different levels and ways in which we can inform, consult and involve our patients. The Department of Health and others have published an abundance of guidance on creative ways for healthcare teams to engage with patients and the public as part of continuous improvement efforts.[7–9]

TABLE 2. WAYS TO ENGAGE PATIENTS FOR IMPROVEMENT

	Inform	Feedback	Involve
Individual level	Letter/email/ website	Survey/patient story/ interviews	Patient shadowing/ Expert Patient Programme
Collective level	Newsletter	• Focus groups • Interactive (online community)	• Critical friend groups • Citizen's jury

CONCLUSION

Primary care is only now beginning to draw upon some of the safety-related ideas, concepts and techniques that have been introduced into many secondary care settings in the past decade. Much of what is described here and in the previous articles[10–28] may appear new to readers, but it is either an innovative twist on a familiar theme or largely common sense.

It is not proposed that the approaches highlighted are undertaken in addition to the safety and improvement efforts that you are already contractually obliged to deliver on. However, you may find that some of these proactive tools and concepts are more suitable for the task at hand. For example, two safety-focused approaches to clinical audit (a compulsory practice activity) have been described in part 2 – the 'trigger tool method' and 'care bundles' – which can be adapted to your needs at no opportunity cost. Similarly, most modern practices have routine team meetings and dedicated learning time slots – assessing and reflecting on local safety culture during these sessions should not be difficult.

The big challenge is to think more critically and smartly about how the issues of patient safety and improvement are perceived and approached in the practice, and perhaps draw some inspiration from the principles and ideas outlined in this series of articles.

POINTS FOR PRACTICE

- The practice leadership ultimately creates the necessary workplace conditions to ensure that patient safety and care improvement are valued as everybody's business
- You can make simple changes and checks immediately to improve local safety culture
- Gaining valuable – and sometimes unique – insights from patients' experiences is essential to improving safety and care quality

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RESOURCES

- **Agency for Healthcare Research and Quality** www.psnet.ahrq.gov/index.aspx
- **BMJ Learning** http://learning.bmj.com/learning/main.html
- **Health Protection Agency** www.hpa.org.uk
- **Institute for Healthcare Improvement** www.ihi.org/ihi
- **Institute of Medicine of the National Academies** www.iom.edu
- **National Coordinating Council for Medication Error Reporting and Prevention** www.nccmerp.org/medErrorCatIndex.html
- **National Patient Safety Agency** www.nrls.npsa.nhs.uk
- **NHS Education for Scotland** www.nes.scot.nhs.uk/initiatives/significant-event-analysis
- **NHS Institute for Innovation and Improvement** www.institute.nhs.uk
- **NHS Quality Improvement Scotland** www.nhshealthquality.org/nhsqis/CCC_FirstPage.jsp
- **Patient Safety First** www.patientsafetyfirst.nhs.uk/content.aspx?path=/
- **Royal College of General Practitioners** www.rcgp.org.uk
- **Royal Australian College of General Practitioners** www.racgp.org.au
- **Scottish Patient Safety Alliance** www.patientsafetyalliance.scot.nhs.uk
- **The Health Foundation** www.health.org.uk
- **World Health Organization** www.who.int/en

The other two articles in this short series on safety in primary care are:
- Bowie P. Building a safety and improvement culture in primary care. *Practice Nurse* 2010; 40(8): 38–40
- Bowie P. Reporting and learning from harmful incidents. *Practice Nurse* 2010; 40(9): 38–41