Safety Culture

A strong safety culture is an essential component of a successful patient safety system and is a crucial starting point for hospitals striving to become learning organizations. In a strong safety culture, the hospital has an unrelenting commitment to safety and to do no harm. *Among the most critical responsibilities of hospital leaders is to establish and maintain a strong safety culture within their hospital*. Joint Commission International's standards address safety culture in **Standard GLD.07.01**, which requires leaders to create and maintain a culture of safety and quality throughout the hospital.

The *safety culture* of a hospital is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety. Hospitals that have a robust safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.[12] Organizations will have varying levels of safety culture, but all should be working toward a safety culture that has the following qualities:

- Staff and leaders value transparency, accountability, and mutual respect.[5]
- Safety is everyone's first priority.[5]
- Behaviors that undermine a culture of safety are not acceptable and thus are reported to organization leaders by staff, patients, and families for the purpose of fostering risk reduction.[5,11,13]
- Collective mindfulness is present, wherein staff realize that systems always have the potential to fail, and staff are focused on finding hazardous conditions or close calls at early stages before a patient may be harmed.[11] Staff do not view close calls as evidence that the system prevented an error but rather as evidence that the system needs to be further improved to prevent any defects.[11,14]
- Staff do not deny or cover up errors but rather want to report errors to learn from mistakes and improve the system flaws that contribute to or enable patient safety events.[7] Staff know that their leaders will focus not on blaming staff involved in errors but on the systems issues that contributed to or enabled the patient safety event.[7,15]
- By reporting and learning from patient safety events, staff create a learning organization.

A safety culture operates effectively when the hospital fosters a cycle of trust, reporting, and improvement.[11,16] In hospitals that have a strong safety culture, health care staff trust their coworkers and leaders to support them when they identify and report a patient safety event.[11] When trust is established, staff are more likely to report patient safety events, and hospitals can use these reports to inform their improvement efforts. In the trust-report-improve cycle, leaders foster trust, which enables staff to report, which enables the hospital to improve. In turn, staff see that their reporting contributes to actual improvement, which bolsters their trust. Thus, the trust-report-improve cycle reinforces itself.[11] (*See* Figure 1.)

Figure 1. *The Trust-Report-Improve Cycle. In the trust-report-improve cycle, trust promotes reporting, which leads to improvement, which in turn fosters trust.*

Leaders and staff must address intimidating or unprofessional behaviors within the hospital, so as not to inhibit others from reporting safety concerns.[17] Leaders should both educate staff and hold them accountable for professional behavior. This includes the adoption and promotion of a code of conduct that defines acceptable behavior and undermines a culture of safety. Joint Commission International's **Standard GLD.07.01, ME 2** requires that leaders develop such a code (*see also* **Standard QPS.03.04, ME 6**). Intimidating and disrespectful behaviors disrupt the culture of safety and prevent collaboration, communication, and teamwork, which is required for safe and highly reliable patient care.[18] Disrespect is not limited to outbursts of anger that humiliate a member of the health care team; it can manifest in many forms, including the following[5,13,18]:

- Inappropriate words (profane, insulting, intimidating, demeaning, humiliating, or abusive language)
- Shaming others for negative outcomes or mistakes, or for asking questions or for assistance
- Unjustified negative comments or complaints about another licensed practitioner's care
- Refusal to comply with known and generally accepted practice standards, which may prevent other licensed practitioners from delivering high-quality care
- Not working collaboratively or cooperatively with other members of the interdisciplinary team
- Creating rigid or inflexible barriers to requests for assistance or cooperation
- Not returning pages or calls promptly, or directing anger or impatience toward staff when paged or called

These issues are still occurring regularly in hospitals worldwide. Of 4,884 respondents to a 2013 survey by the Institute for Safe Medication Practices (ISMP), 73% reported encountering negative comments about colleagues or leaders during the previous year. In addition, 68% reported condescending language or demeaning comments or insults, and 77% of respondents said they had encountered reluctance or refusal to answer questions or return calls.[19]

Further, 69% report that they had encountered impatience with questions or the hanging up of the phone.

Nearly 50% of the respondents indicated that intimidating behaviors had affected the way they handle medication order clarifications or questions, including assuming that an order was correct in order to avoid interaction with an intimidating coworker.[19] Moreover, 11% said they were aware of a medication error during the previous year in which behavior that undermines a culture of safety was a contributing factor. The respondents included nurses, physicians, pharmacists, and quality/risk management personnel.

Only 50% of respondents indicated that their organizations had clearly defined an effective process for handling disagreements with the safety of an order.

This is down from 60% of respondents to a similar ISMP survey conducted in 2003, which suggests that this problem is worsening.[19] Although these data are specific to medication safety, their lessons are broadly applicable: Behaviors that undermine a culture of safety have an adverse effect on quality and patient safety.

A Fair and Just Safety Culture

A fair and just safety culture is needed for staff to trust that they can report patient safety events without being treated punitively.[3,9] In order to accomplish this, hospitals should provide and encourage the use of a standardized reporting process for staff to report patient safety events, and implement efforts designed to encourage reporting as required by JCI's **Standard QPS.03.04, ME 6**.

This is also built into the JCI standards at **Standard GLD.07.01**, which requires leaders to provide and encourage the use of systems for blame-free reporting of a system or process failure or the results of proactive risk assessments (*see also* **Standard QPS.03.04**). Reporting enables both proactive and reactive risk reduction. *Proactive risk reduction* identifies and solves problems before patients are harmed, and *reactive risk reduction* attempts to prevent the recurrence of problems that have already caused patient harm.[11,16]

A fair and just culture considers that individuals are human, fallible, and capable of mistakes and that they work in systems that are often flawed. In the most basic terms, a fair and just culture holds individuals accountable for their actions but does not punish individuals for issues attributed to flawed systems or processes.[15,19,20] **Standard GLD.02.00** requires that leaders hold staff accountable for their responsibilities, in accordance with hospital policies, and laws and regulations, but assumes hospital leaders will use a process to discern whether a flawed system or process was primarily a root cause of the error rather than the fault of an individual.

A fair and just culture does hold staff individually accountable for intentionally disregarding policies and procedures or laws and regulations, while making a distinction between willful disregard of these versus errors related to flawed systems or processes. For some actions for which an individual is accountable, the individual should be held culpable, and some disciplinary action may then be necessary. (*See* Sidebar 1, below, for a discussion of tools that can help leaders determine a fair and just response to a patient safety event.) However, staff should never be disciplined or ostracized for *reporting* the event, close call, hazardous condition, or concern.