A Culture of Safety: It Takes a Community

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ECRI and* Annals of Long-Term Care: Clinical Care and Aging (ALTC) *have joined in collaboration to bring ALTC readers periodic articles on topics in risk management, quality assurance and performance improvement (QAPI), and safety for persons served throughout the aging services continuum. ECRI is an independent, nonprofit organization improving the safety, quality, and cost-effectiveness of care across all healthcare settings worldwide.

In aging services, a culture of safety is critical to ensuring safe, high-quality care and services. In fact, numerous studies show a link between a positive safety culture and improved safety within a health care organization.[1-6] The evidence is so convincing that the National Patient Safety Foundation lists leadership support for a safety culture as the most important of 8 recommendations for achieving safety.[7]

But what is a safety culture? Although definitions vary, a safety culture is the combination of attitudes and behaviors toward patient or resident safety that are conveyed when entering the organization. Importantly, attitudes and behaviors toward safety that influence the safety culture are not limited to just leaders or just employees. They include the attitudes and behaviors of all stakeholders, such as board members, residents, families, and visitors. The safety culture is also not limited to care. **Figure 1** illustrates how culture of safety encompasses and influences several other domains. Recognizing that a safety culture encompasses attitudes and beliefs across the entire organization is essential to the success of efforts to establish and maintain a culture of safety.

Secure Leadership Commitment

As with any organization-wide initiative, leadership support is essential for a safety culture's success. Leadership—consisting of the governing body, senior management, and clinical leaders—should communicate a single vision of the organization's approach and expectations.[8]

Without sustained leadership support for a safety culture, where is the impetus for staff in an organization to embrace it? By some estimates, up to 80% of initiatives that require people to change behaviors fail in the absence of effective leadership to manage the changes.[9] Leaders also play a key role in spreading "fluency" in safety (**Box 1**).

Lack of leadership support for a culture of safety could jeopardize patient safety. Experts say that a culture of safety is necessary before other patient safety practices can be successfully introduced.[10] Indeed, failure to create an effective safety culture is a contributing factor to many types of adverse events. Why? Without a safety culture, staff may be insufficiently motivated to report events that could be used to identify and address the causes of patient safety breakdowns. Additionally, staff may be unconvinced of the value of event reporting if there is no feedback about how the reports are used.[10] **Table 1** contains strategies leaders can implement to promote a culture of safety.

When leaders set the right tone for a safety culture, staff trust their leaders to listen to their concerns and are unafraid to speak up about unsafe conditions and hazards. They understand the importance of event reporting because they are told how the information is used to improve safety. As a result, staff understand that event reporting can make a positive difference in the quality of care and services provided at their organization.

An important offshoot from a strong safety culture is the effect it can have on staff morale. If staff feel engaged and

Figure 1. Elements interconnected within a culture of safety

AFFILIATION: *Patient Safety, Risk, and Quality—Aging Services, ECRI Institute, Plymouth Meeting, PA*
DISCLOSURES: The author reports no relevant financial relationships.
CITATION: *Ann Longterm Care*. 2020;28(4):11-13. doi:10.25270/altc.2020.12.00001

Languages are complex, with their own common concepts, jargon, understandings, nuances, inflections, and definitions, both formal and informal. Sitting in French class in high school, I had to translate from English to French or French to English in my head before saying anything. It was a clumsy and laborious process, often filled with mishaps and pitfalls.

At some point, I became aware of the translation processes that were going on in my head. I realized that native French speakers think in French like I think in English. Fluency happens, I discovered, when one begins to think in that language, interpreting the world around them in that language. This goes beyond spoken languages. For example, computer programmers work in languages filled with common understandings that seem mysterious to many of us. While I see gibberish when I look at code, they see a world of syntax and meaning as coherent as any novel. They think in that language—they are fluent in it.

So what about patient and resident safety, risk, and quality? I believe it is possible for those who accept the responsibility of providing care to others to become fluent in these concepts. Having a language shared by those who have a common purpose within an organization can help to make all stakeholders safer.

Language is important, and it can have good effects or ill. In the worst cases, it can fragment an organization. But in the best cases, it can help to create a common identity within an organization. By spreading fluency in safety—not just through formal training and processes but also in our daily interactions—leaders promote a shared vision of safety throughout the organization.

Box 1. Getting fluent in safety: lessons from French class

productive at their workplace, they are also more likely to find meaning in their work.[10]

Engage All Stakeholders

Leader commitment is critical to establishing and maintaining a culture of safety but so is the involvement of all stakeholders. Aging services risk managers can take several steps to cultivate and reinforce strong organizational cultures that promote safety-centric behaviors among all stakeholders.

Identify the Organization's Stakeholders

It is not enough to engage in safety culture efforts only with employees, as the results of such efforts are often limited. Instead, including all vested stakeholders—board members, employees, residents, families, and visitors—leads to better, more consistent performance. When a culture of safety is shared among all stakeholders, it more effectively encourages safe acts and discourages unsafe ones.

Expand Your Definition of Leader

Although safety literature often emphasizes the role of formal leaders, it sometimes overlooks the equally vital role that informal leaders within the organization play in shaping organizational culture.

People follow informal leaders because they have earned personal power, even though they do not have a formal position of authority within the organization. The individual's personality, expertise, job experience, or a combination of these factors earns the respect of others, thus giving them personal power.

All stakeholder groups include informal leaders. Engaging them in planning and implementing efforts to promote a culture of safety can help overcome resistance to change, enhance ownership and accountability, and operationalize new behaviors into daily organizational life.

Design Organizational Practices for Success

The organization's mission, vision, and core values are a good starting point for designing organizational practices to support a culture of safety. Directly linking safety to the mission, vision, or a core value can help leaders describe these connections tangibly and demonstrate the benefits to all stakeholders. Once these links have been established, organizational processes should be redesigned to underscore safety in the daily execution of all tasks.

Design Safety Into the Job

Safety should not be reserved only for disciplinary processes. Although emphasizing safety during disciplinary procedures may inhibit some individual unsafe acts, this approach fails to create a safety culture that values and rewards collective safety behaviors. When safety comes up only during discipline, there are no identifiable benefits to doing the right thing for the right reason—the only incentive is to avoid doing the wrong thing.

Instead, safety-specific responsibilities should be included in job descriptions for every department. This builds individual and organization-wide accountability to act safely and to respond to unsafe acts and conditions. These responsibilities should be clearly written, with staff told to:

- immediately report identified hazards or hazardous conditions to a supervisor;
- immediately report adverse events and near misses to a supervisor; and
- immediately complete and submit a work order to address a hazardous or unsafe condition.

Once these expectations have been designed into the job, they should be incorporated into performance appraisal and reward processes. This enables the use of safety-based standards to evaluate and reward performance. It also creates common safety expectations for employees and supervisors, enhancing coaching and outcomes when performance does not reflect desired safety behaviors.

Table 1. Leadership Attributes of and Strategies for an Effective Safety Culture[11]

Attributes	Sample Strategies
Continuous learning from patient safety events	▪ Encourage reporting of safety events and near misses ▪ Remove barriers to event reporting; make reporting easy for staff ▪ Highlight "good catches" of unsafe conditions identified from event reporting ▪ Identify and address systems issues that contribute to adverse events
Motivated staff to uphold a fair and just culture	▪ Protect staff from unfair targeting for safety incidents that are the result of system failures ▪ Adopt and practice a fair approach to evaluating accountability for safety incidents for which there are concerns about an individual action; ensure the approach is consistently applied ▪ Provide support for team members involved in adverse patient or resident events
A transparent environment in which quality measures and patient or resident harms are freely shared with staff	▪ Conduct leadership walkarounds on units to ask staff about barriers they encounter to delivering safe care ▪ Hold daily leadership safety huddles with managers to discuss patient safety issues and mitigating strategies ▪ Disseminate lessons learned from event reports ▪ Share organization- and unit/department-level safety data
Professional behavior	▪ Set a positive tone ▪ Think out loud to encourage a shared mental model with colleagues and staff ▪ Invite staff into safety discussions to hear their suggestions and concerns ▪ Use noncritical language to question people by saying, for example, "I just need a little clarity." ▪ Use people's names
Elimination of intimidating behaviors that interfere with safe behavior	▪ Adopt a zero-tolerance approach for intimidating behavior ▪ Implement a policy that addresses disruptive behavior ▪ Adopt mechanisms for staff to report disruptive behavior (including an anonymous reporting hotline) ▪ Enforce processes to promptly address disruptive and disrespectful behavior
Resources and training for improvement initiatives	▪ Offer simulation training to promote effective team behaviors and communication ▪ Allow time for staff to participate in performance improvement meetings

Involve Residents

Resident handbooks should outline safety expectations and reporting practices, communicating shared financial benefits for all and improvements to quality of life and quality of care. At admission and throughout residency, the organization should discuss with residents and families how honoring those responsibilities benefits everyone. It helps to be specific, such as describing how shared safety behaviors help to control costs and therefore rates and future rate increases for care and services.

Conclusion

In aging services, a culture of safety is key to safe, high-quality care and services. Leadership commitment to establishing and maintaining a culture of safety sets the stage and communicates the importance of safety to all the organization's stakeholders. But these efforts cannot stop with leaders. All stakeholders need to be engaged in safety. Involving everyone—board members, employees, residents, families, visitors, and leaders—in establishing and maintaining a culture of safety is what truly embeds safety into the organization's culture. By taking concrete steps, such as those discussed in this article, the organization can help ensure that a culture of safety pervades every area of the organization. ■

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