Safer Care Victoria

Leadership and Safety Culture

- **Safety culture:**
  - **refers to an ongoing organisational commitment to safety by all staff within an organisation**
  - **requires constant vigilance to maintain, and must be promoted as organisational core business**
  - **acknowledges that healthcare is complex and that systems approaches are essential to improve safety**
- **Senior leaders are key to building, maintaining and promoting the principles of a safety culture across their organisation**

OVERVIEW

Safety culture is the product of individual and group values, attitudes and behaviours that determine commitment to organisational safety[1]. Organisations with a positive safety culture have common characteristics:

- communications founded on mutual trust
- shared perception of and commitment to safety by all staff
- confidence in the effectiveness of safety interventions
- prioritisation of safety culture by organisational leaders.

Safety culture is difficult to measure, and its underpinning values, attitudes and behaviours are dynamic concepts that change frequently and are not clearly visible. In contrast, safety climate is more tangible and describes the perceptions and attitudes towards safety at a particular point in time[2]. Safety climate can be measured using organisation-wide surveys.

LEADERSHIP

Leadership is critical to developing safety culture[3][4]. Senior organisational leaders must model their commitment to safety via their actions and decision-making, and by addressing behaviours that undermine a safety culture[5]. Good leadership prioritises person-centred care, openness, learning and continuous improvement, supported by effective clinical governance processes so that organisations and staff learn together. Leaders can influence a culture of safety by:

- actively encouraging employees to speak up, openly express safety concerns and use adverse event reporting systems
- promoting shared accountability for safety risks between individuals and organisational systems
- creating and championing systems that actively encourage and support consumers to speak up about safety concerns
- addressing safety concerns promptly
- giving systematic feedback when a safety issue has been addressed[6]
- reinforcing that consumer feedback should be treated as vital information and responded to accordingly.

A positive safety culture prioritises safety in decisions made across all levels of the organisation, from frontline staff to executives.

Safety culture is everybody's responsibility

While senior leadership, especially the Chief Executive Officer and health service boards, are essential in driving safety culture, everyone in the organisation has an important role in building and maintaining safety culture.

[1] Sexton B, Helmreich R, Neilands T, Rowan K, Vella K, Boyden J, et al. (2016). The Safety Attitudes Questionnaire: psychometric properties, benchmarking data and emerging research. *BMC Health Services Research, 6*(44):1–10

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[3] Hofmann, D. A., & Morgeson, F. P. (2004). The role of leadership in safety. In J. Barling & M. R. Frone (Eds.), The psychology of workplace safety (p. 159–180). American Psychological Association

[4] Ruchlin, H.S., Dubbs, N.L., Callahan, M.A. (2003). The Role of Leadership in Instilling a Culture of Safety: Lessons from the Literature

[5] McKenzie L, Shaw L, Jordan JE et al. (2019).Factors Influencing the Implementation of a Hospitalwide Intervention to Promote Professionalism and Build a Safety Culture: A Qualitative Study. *Jt Comm J Qual Patient Saf.* Oct;45(10):694-705.

[6] Leonard, M. & Frankel, A. (2012). How can leaders influence a safety culture? The Health Foundation, https://www.health.org.uk/sites/default/files/HowCanLeadersInfluenceASafetyCulture.pdf

RECOGNISING AND RESPONDING TO ADVERSE EVENTS

Safety culture can be described by five interrelated subcultures[6]. These subcultures all play an important role in the recognition and response to adverse events (see Table 1). Senior leadership is responsible for creating and enabling an environment where these five subcultures can thrive.

Table 1: Five subcultures of safety culture[7]

Flexible culture	• Responds and adapts to dynamic situations and unexpected interruptions • Adapts hierarchical structures swiftly to pass control to the most skilled staff when needed
Just culture	• Views accountability for safety as a balance between the organisation and the individual[8] • Applies systems thinking and robust processes to ensure fair review of events[9]
Reporting culture	• Cultivates an environment of trust where staff feel safe to report adverse events without fear of blame • Enables effective reporting by providing user friendly reporting systems, timely response to adverse events, and loop closure with staff involved
Learning culture	• Views adverse events as opportunities to learn and improve safety • Demonstrates commitment to sharing lessons learned within and beyond the organisation
Informed culture	• Robust systems are in place to continuously collect, analyse and respond to safety information • Maintains current knowledge about safety science to inform continuous improvement

PARADIGMS AND SAFETY CULTURE

Health care is complex. A safety culture acknowledges organisational complexity and is underpinned by the view that adverse patient safety events are rarely simple, straightforward or linear. Instead, it suggests that these events are the result of many interactions between the different elements of a complex system[10].

In order to build a safety culture, it is fundamental that healthcare leaders understand how adverse patient safety events occur in complex systems and apply this knowledge to the design of systems and processes. The following two safety paradigms are examples of how viewing adverse patient safety events as complex can influence safety culture in practice[3]:

- Normal Accident Theory (NAT)[11] acknowledges that adverse events reflect the complexity of health systems. Rather than assuming that all adverse events are preventable by identifying who was responsible, adverse events need to be reviewed using system-based methodologies accommodating complexity and developing system-based solutions accordingly.
- High Reliability Organisations (HROs)[12] have an exceptionally low rate of adverse events. HROs cultivate mindfulness and high sensitivity to safety issues. They notice even weak signals indicating potential safety risks and address those proactively before they can cause harm.

BUILDING A SAFETY CULTURE

The first step to building safety culture is strong commitment from senior leadership to understand and invest in each of the five safety subcultures. Establishing a safety culture is an ongoing process that requires nurturing over time from staff at all levels within an organisation. If driven by inspired leaders who demonstrate an unwavering commitment to safety with every communication and decision made, change can be rapid. Negative cultural change may also occur quickly, which is why safety culture requires constant vigilance and continuous fostering. Senior leadership needs to model its prioritisation of safety for staff and consumers as core business.

[7] Reason (1997). *Managing the Risks of Organisational Accidents.* Aldershot: Ashgate Publishing Limited

[8] Boysen, P.G. (2013). A foundation for balanced accountability and patient safety. *Ochsner Journal, 13*(3), 400-406.

[9] See Just Culture fact sheet for more information

[10] Safety Institute of Australia (2012). Models of Causation: Safety. Retrieved from https://www.ohsbok.org.au/wp-content/uploads/2013/12/32-Models-of-causation-Safety.pdf

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[12] Weick, K. E., & Sutcliffe, K. M. (2001). Managing the Unexpected: Assuring High Performance in an Age of Complexity. San Francisco: Jossey-Bass

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