

Article of the week

Safety Culture



By: Prof. Nabil Dowidar
Alexandria Patient Safety Alliance
Health Governance Unit
Medical Research Institute
Alexandria University, Egypt

Safety culture within a hospital is the result of individual and group behavior in relation to their commitment to safety. A hospital acquires a strong safety culture when its safety goals and objectives are aligned with its staff values and behaviors at all levels.

Hospitals with a positive patient safety culture, which is a subset of safety culture, are characterized by staff, both clinical and non-clinical, that are well informed, trust each other, and competent in their practices. On the other hand, hospitals with pathological cultures are not well informed, mistrust each other and have a tendency to blame their staff whenever an incident is encountered thus fail to learn from such incidents and as a result are unable to solve their problems and eliminate their underlying causes.

Crucial to an effective patient safety culture of a hospital is leadership commitment, the visibility of this commitment, good communication between leadership and staff, and the active participation of staff in the key elements that form patient safety cultures.

Effective Safety Culture :

1. Leadership commitment

This commitment produces higher levels of motivation and concern for patient safety throughout the hospital. It should be evidenced by the amount of resources (time, money, people) and support allocated to patient safety programs and the emphasis given to safety over production and cost.

2. Leadership visibility

Leaders at all levels need to be seen to lead by example when it comes to patient safety. Good leaders appear regularly in the wards and outpatient services, talk about patient safety and visibly demonstrate their commitment by their actions and prompt response to any safety shortfalls. It is important that leadership is perceived as seriously committed to patient safety¹, otherwise, staff will put other interests before patient safety.

3. Communication

In a positive safety culture questions about patient safety should be part of everyday work conversations at all levels. Leadership at all levels of the hospital should listen actively to what frontline staff have to say as they are the ones who are primarily involved in patient safety incidents and can also truly reflect on the effects of leadership decisions on patient safety.



Safety Culture Elements :

According to Reason a safety culture is composed of several elements all interacting together to create the desired safety culture.²

1. Open culture

Where staff feel comfortable discussing patients' safety incidents and raising safety issues with both colleagues and senior managers.

2. Reporting culture

Where staff have confidence in the local incident reporting system and use it to notify healthcare managers of incidents that are occurring, including near misses.

3. Learning culture

Where the hospital is committed to learn from safety incidents and communicates learnt lessons to others and remembers them over time (hospital memory).

4. Informed culture

Where the hospital has learnt from past experience and has the ability to identify and mitigate future incidents.

5. Just culture

Where staff, patients and families are treated fairly, with empathy and consideration when they have been involved in a patient safety incident or have raised a safety issue.

6. Flexible culture

Where the hospital, when faced with a safety incident, has the ability to shift from a hierarchical mode to a more flatter structure that gives control to their experienced staff regardless of their position.

In essence, when a hospital wants to achieve a positive safety culture it should aim at developing leadership at all levels that are characterized by behaviors that lead to the establishment of an organization that is open, just, flexible and informed, in which reporting and learning from error is the norm.

References :

1. Seven steps to patient safety. NPSA, NHS, 2004.
2. James Reason. Managing the risks of organizational accidents. Ashgate Publishing Company, 2008.