Promoting a Patient Safety Culture in our Hospitals

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Patient safety professionals identify changes in hospital culture as critical to creating safer patient care (Flin, 2007). Yet there is limited understanding of how to best study, evaluate and make changes to patient safety culture. The literature on organizational culture and health safety research suggests varying perspectives on studying culture and an evolving approach to creating tools to measure the cultural change in hospitals. Healthcare managers want to create patient safety cultures that support safer patient care. But the question lies on how leaders know that they have created safety culture change. The research literature describes numerous safety culture measurements aimed at identifying and diagnosing problematic areas in safety culture (Singer et al., 2003). The use of these tools is generally in response to regulatory bodies which require periodic assessments to demonstrate a culture shift and many of the tools continue to be met with theoretical and methodological problems (Flin, 2007).

In recent years the study of medical errors and adverse events has highlighted a lot of problems relating to patient safety in the health care system. The issue of adverse events is not merely a national problem, but rather a global concern. A main study that brought attention to the issue of errors in medical practice was the Institute of Medicine report "To Err is Human". This report brought the issue to public attention and has encouraged the development of policy agendas and research in several countries. Since 2004, the World Health Organization has released several documents expressing the need to engage in patient safety culture research. Furthermore, **the release of the World Alliance for Patient Safety (WHO, 2006) identified specific action areas in patient safety. These actions include: i) initiating a global patient safety challenge, ii) enhancing involvement of the patient and consumer, iii) focusing on reporting and learning, iv) developing a taxonomy for patient safety, v) promoting research in patient safety, vi) translating knowledge into practical solutions, vii) spreading best practices for change to patient safety, viii) focusing on the opportunities for technology to improve patient safety, ix) focusing on the care of acutely ill patients and x) sharing knowledge between member states or countries.**

In the past, the explanation of how and why medical errors occur focused on the individual's human error. The tendency to blame individuals perpetuated a culture of punishment and individual accountability among medical professionals (Weinberg, 2002). As a result of the heightened attention toward improving patient safety over the past decade, health authorities have looked to the safety science literature to help explain safety culture and provide direction for creating safety management systems (Flin, 2007). There should be a main focus on the culture of safety as a starting point from which to create a safer system. The safety culture of the hospital is an encompassing concept that is drawn from high reliability organization theory. It has been most notably translated by Reason (1997) and Weick (2001) into guiding dimensions and constructs. This focus on the culture of safety is linked to Reason's description of the "Swiss Cheese" model. The model depicts the idea of multi-causation to describe how numerous organizational and individual layers result in structural holes; the alignment of these holes at one time subsequently allow for an error to occur. Reason (1997) also discusses organizational factors that impact adverse events and emphasizes that organizations should not persist with the historical perspective of blaming individuals for poor safety outcomes. Within this discussion the distinction between active and latent failures in the environment are described. Active failures are those errors and failures at the "sharp end" of the system where there is interaction and contact between the human and the system in which he or she is working. In contrast, latent conditions are those organizational factors that impact the trajectory of the error; these include poor design, shortfalls in training and inadequate tools, all of which allow for active failures to occur. These latent conditions "lie dormant for a time causing no particular harm until they interact with the local circumstances to defeat the system's defense" (Reason, 1997).

Complementary to the research by Reason (1997), Weick (2001) outlines concepts of mindfulness that create a culture of safety. **According to Weick (2001), mindfulness is seen in five core characteristics of high reliability organizations. These core characteristics are preoccupation with failure, reluctance to simplify, sensitivity to operations, commitment to resilience and deference to expertise, all of which need to be integrated within the everyday work of the organization in order to facilitate optimal safety management.**

Despite discrepancies and lack of clarity around conceptualizations of patient safety culture, there are numerous tools that have been developed to assess patient safety culture. Many have been met with issues of reliability and validity (Fleming & Hartnell, 2007, Milne et al., 2010) as well as debates about the origins of development and application of these tools (Waterson et al., 2010). In addition, individuals have often stated that rather than using such quantitative tools, qualitative approaches are better suited to studying the complexity of culture given that it is a product of the social context in which it exists (Lewis, 2008).

In summary, it continues to be worthwhile and important to explore patient safety culture measurement and culture change. The focus on patient safety culture is a relatively new area of research beginning in the late 1990s and requires that experts continue to propose new perspectives for the study and the understanding of this area. This will consequently push the field forward to gain further insights that will be of importance to it.

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