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How can you create and maintain a safety culture?

Accreditation Canada Webinar

15 January 2009

Presented by Graham Lowe

Webinar outline

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1. Evidence
2. Culture
3. Safety culture
4. Drivers
5. Strategy
6. Actions
7. Alberta
8. Discussion

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Survey goals and methods

Health Sciences Association of Alberta 2006 Work Environment Survey

- ✓ Obtain HSAA members' input on the quality of their work environment and needed improvements
- ✓ Enable the HSAA to take a leadership role in providing work environment solutions so that its members can provide the best quality services to patients and clients
- ✓ 5,131 completed responses = 43% response rate

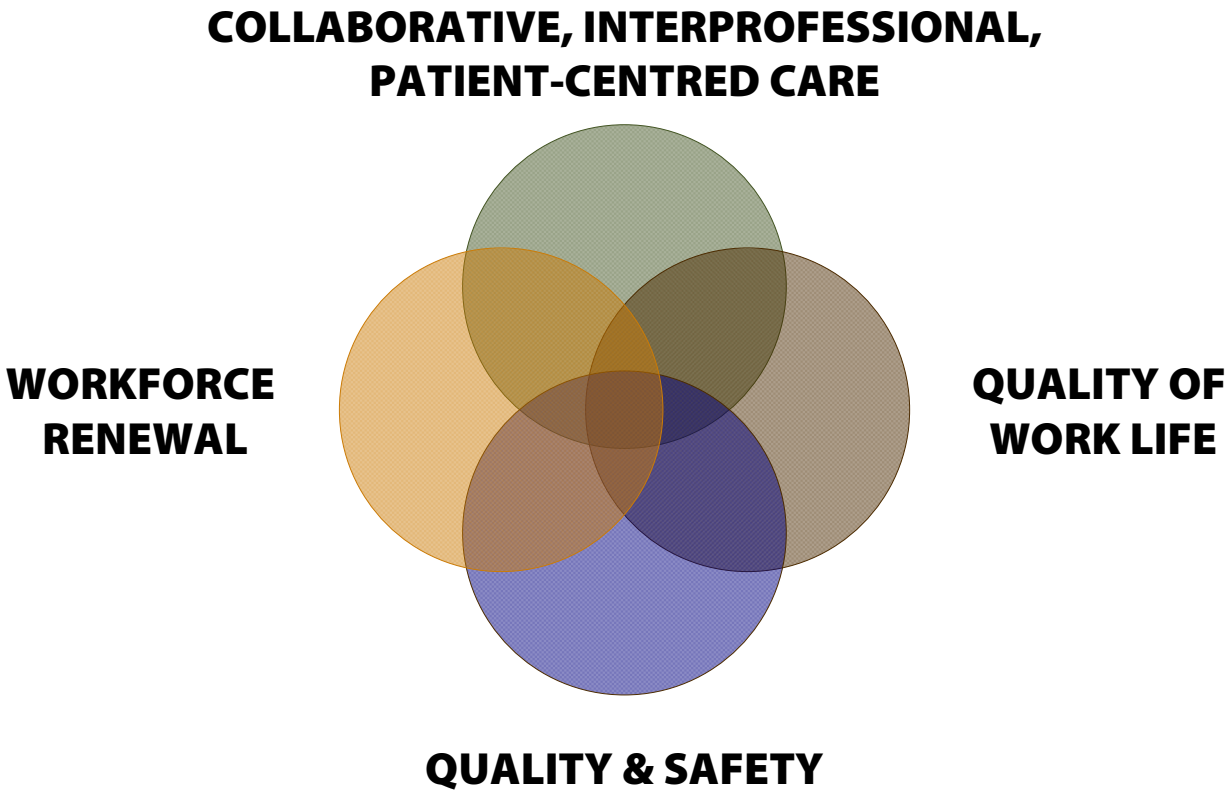
Focus today is on 4,347 respondents in 20 occupations with direct impact on patients/clients

Issues examined

- Work time
- Job conditions
- Training and professional development
- Work teams and relationships
- Supervisors and management
- Organizational change
- Patient and client safety
- Workplace and employee health
- Employees' work experiences
- Retirement
- Suggestions for improvement

•Comprehensive
•Holistic
•Integrative

The case for high-quality workplaces



Connecting the quality dots

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HSAA study raised important questions about the links between quality work environments and quality healthcare services

- ✓ Workers in healthy and safe work environments have:
  - higher levels of trust in management
  - are more engaged in their jobs
  - report that their team delivers high quality services
- ✓ Employer practices and policies have a major impact on:
  - employees' quality of work-life
  - job performance.

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What is culture?

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- Shared understanding of “how we do things here”
- Reflected in values, beliefs, assumptions, rituals, language, and myths
- Shapes behaviour

Culture as strategic advantage

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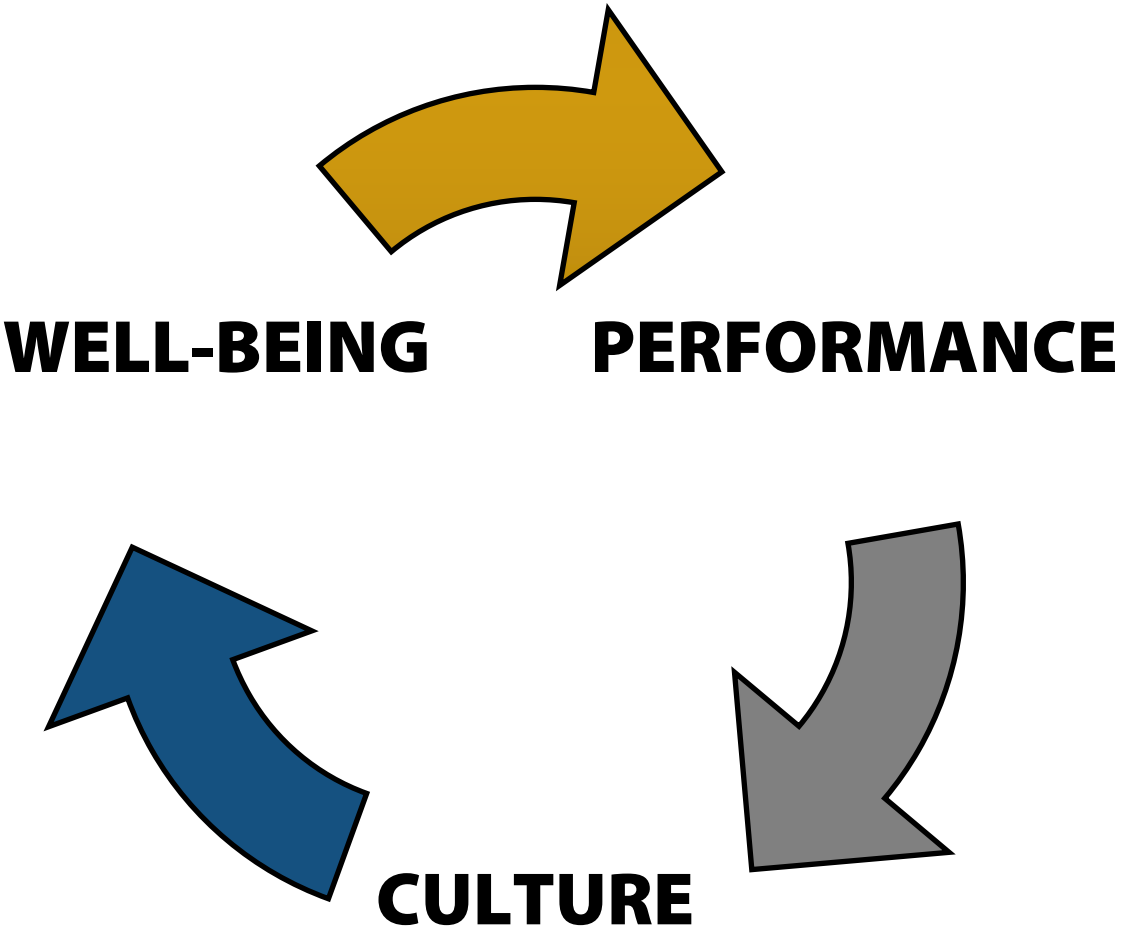
Culture will drive strategy.

OR

Culture will drag strategy.

Source: Al Stubblefield, CEO of Baptist Health, on the importance of creating and maintaining a people-centred culture. *The Baptist Health Care Journey to Excellence.* Wiley, 2005.

21st-century HR strategy



Revitalizing your culture

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- "You don't change cultures – you revitalize existing cultures. You can't take a company that has existed for years and just throw out its culture and drop a new one in place. What you do is bring back the energy that is still there."

Henry Mintzberg (quoted in The Globe & Mail, 30 October 2007, page B2).

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Difficult lessons

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- ✓ February 2003 Space Shuttle Columbia disaster
- ✓ Missing piece of foam was the immediate cause, but there were deeper organizational causes
- ✓ Main organizational cause: "failed safety culture"
- ✓ NASA's official policy at the time: employees were empowered to stop an operation if they detected even the hint of a problem
- ✓ "The silence of Program-level safety processes undermined oversight; when they did not speak up, safety personnel could not fulfill their stated mission to provide 'checks and balances'. A pattern of acceptance prevailed throughout the organization that tolerated foam problems ...." *Columbia Accident Investigation Board Final Report*, page 179.

National Aeronautics and Space Administration

Patient safety and work environments

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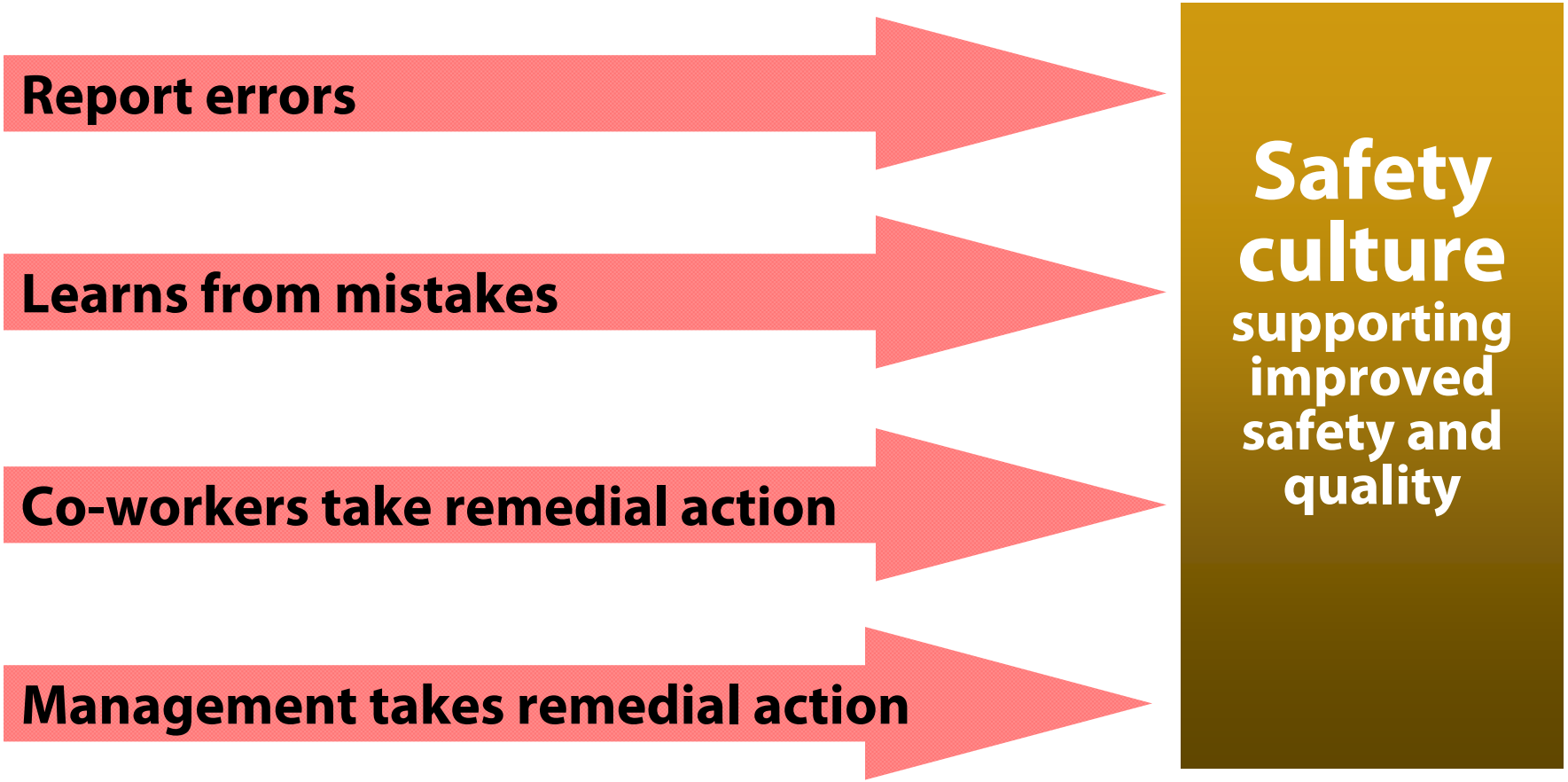
The Canadian Adverse Events Study:

"…experts suggest that the greatest gains in improving patient safety will come from modifying the work environment of health care professionals, creating better defenses for averting AEs and mitigating their effects."

Source: G. R. Baker, P. G. Norton, et al. The Canadian Adverse Events Study: The incidence of adverse events among hospital patients in Canada. *CMAJ* 170 (11) 2004: 1685.

Leading indicators of safety and quality



Assessing safety culture

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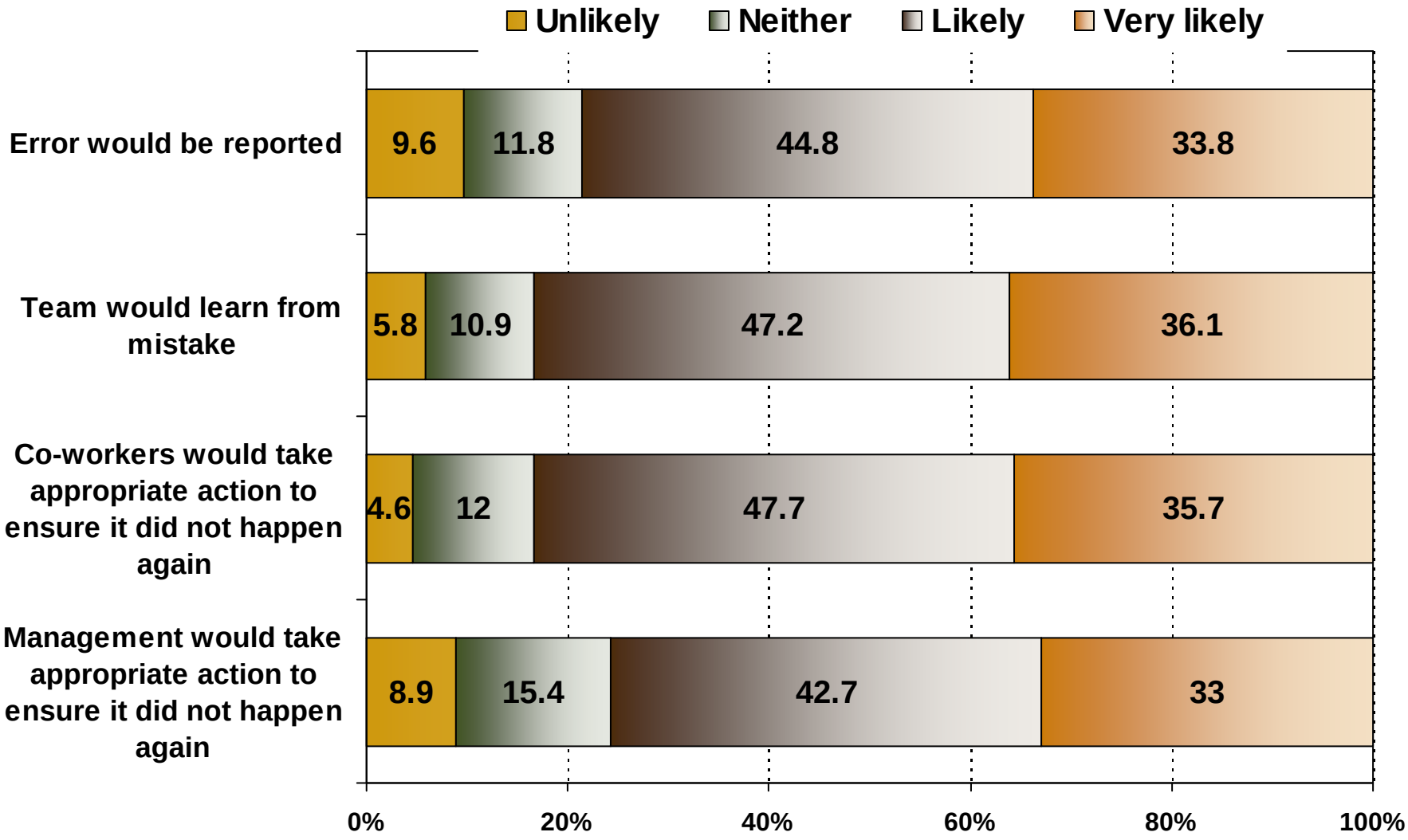
"If someone working in your area made an error that put patient or client safety at risk, how likely is it that…"



Does your organization have a safety culture?

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If someone working in your organization made an error that put patient or client safety at risk, how likely is it that:	**Select one response for each question:**				
	1 very unlikely	**2 unlikely**	**3 neither likely nor unlikely**	**4 likely**	**5 very likely**
The error would be reported?					
Work team would learn from the mistake?					
Co-workers would take appropriate action to ensure this did not happen again?					
Management would take appropriate action to ensure this did not happen again?					

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Work environment "drivers" of quality and safety

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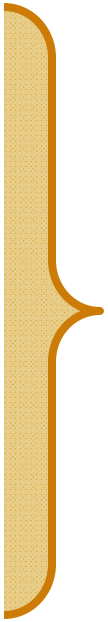
1. Teamwork
2. Fair processes
3. Supportive supervisor
4. People leadership
5. Learning environment



Patients *AND* employees win…

- Reduced risk of errors
- Improved service quality
- Improved HR outcomes
- Improved quality of work life

Teamwork diagnostics

Assess your own work unit / team

(**Response options:** strongly disagree; disagree; neutral; agree; strongly agree)

- ✓My co-workers are friendly and helpful.
- ✓My co-workers treat me with respect.
- ✓Communication is good among the people I work with.
- ✓There is a high-level of interdisciplinary collaboration.
- ✓There is adequate opportunity to discuss professional practice issues.

Fair processes diagnostics

Assess your work unit / organization

(**Response options:** strongly disagree; disagree; neutral; agree; strongly agree)

- ✓Rules and policies are fairly applied.
- ✓Rules and policies are consistently applied.
- ✓The hiring and competition process is fair.
- ✓Rules and policies make sense.
- ✓Work is assigned fairly and equitably.

Supportive supervisor diagnostics

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Assess your supervisor (or all supervisors in your organization)

(**Response options:** strongly disagree; disagree; neutral; agree; strongly agree)

- ✓ Listens to and acts upon your suggestions and ideas.
- ✓ Encourages teamwork.
- ✓ Encourages you to be innovative in how you do your job.
- ✓ Supports your career development.
- ✓ Provides timely and constructive feedback on your job performance.
- ✓ Helps you achieve work-life balance.
- ✓ Shares information.
- ✓ Creates a work environment free of harassment and discrimination.

People leadership diagnostics

Assess your senior management's people leadership

(**Response options:** strongly disagree; disagree; neutral; agree; strongly agree)

- ✓ Actively seek employees' ideas about how to do things better.
- ✓ Take employees' interests into account when planning changes.
- ✓ Make employees feel valued for the contributions they make to patients and clients.
- ✓ Effectively communicate to employees about changes that will affect them.
- ✓ Set realistic performance goals for your area.

Learning environment diagnostics

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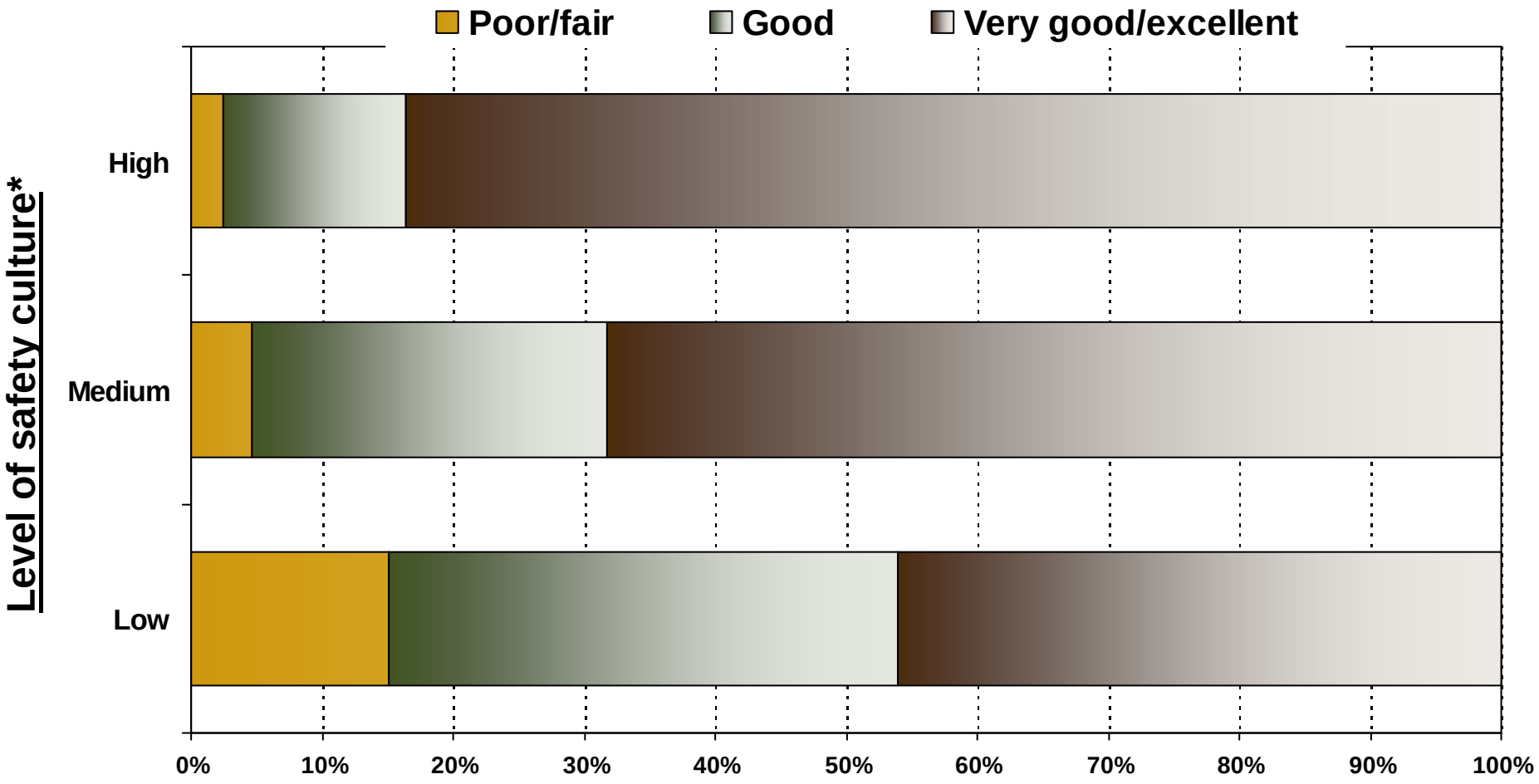
Assess your learning environment. How often do you…

(**Response options:** never; rarely; sometimes; often; very often)

- ✓Take initiative in your job.
- ✓Learn new ways to do your job better.
- ✓Feel that you fully contribute your skills, knowledge and abilities.

Relationship between safety culture and perceptions of overall quality of service

"Over the past 12 months, how would you rate the overall quality of the service provided by your team or area?"



Source: HSAA 2006 Work Environment Survey (n=4276)
* Differences statistically significant, Chi-square test, p=.000

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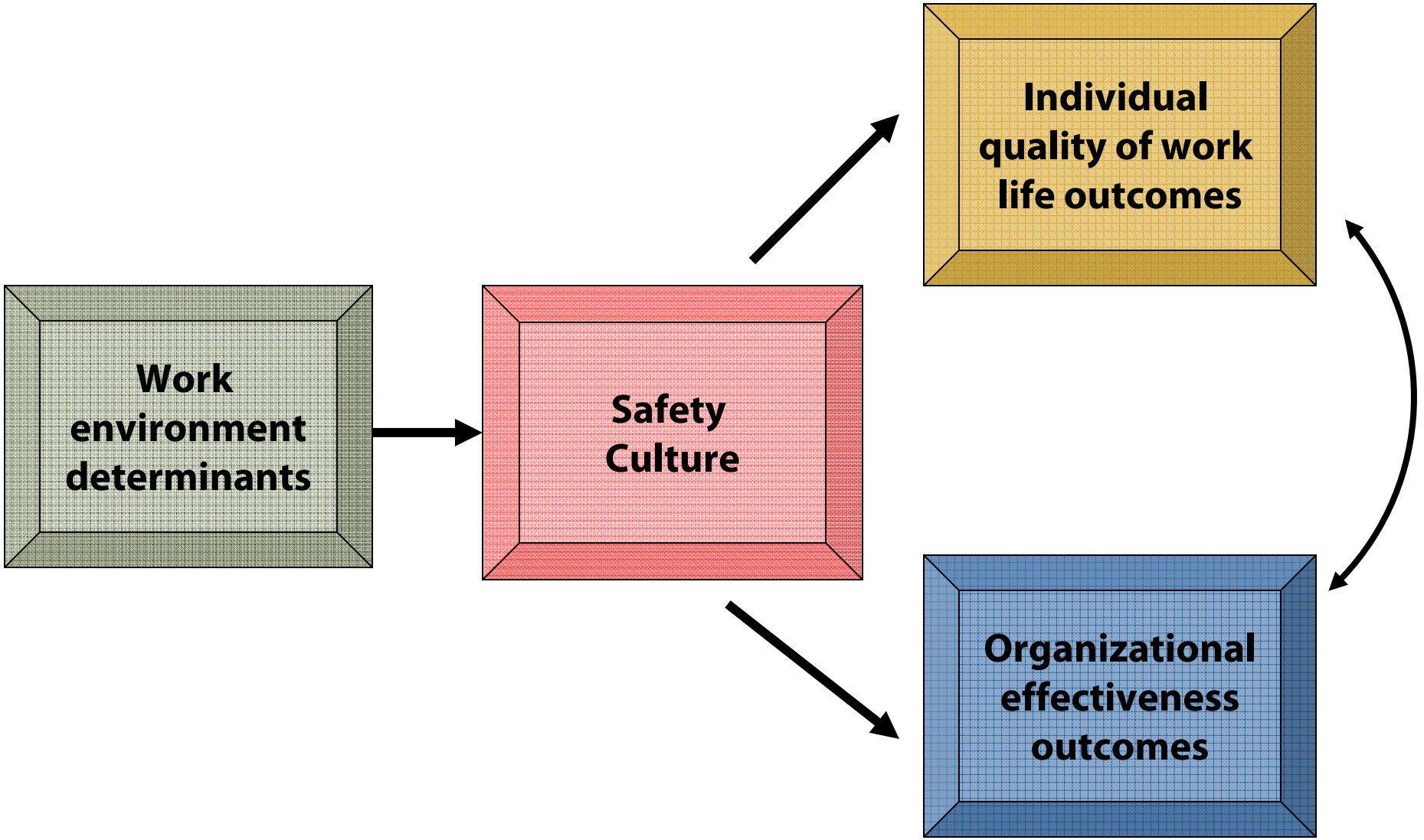
Safety culture strategy model



QUALITY DIMENSIONS

DIMENSION	TAG LINE
 POPULATION FOCUS	Working with communities to anticipate and meet needs
 ACCESSIBILITY	Providing timely and equitable services
 SAFETY	Keeping people safe
 WORKLIFE	Supporting wellness in the work environment
 CLIENT-CENTRED SERVICES	Putting clients and families first
 CONTINUITY OF SERVICES	Experiencing coordinated and seamless services
 EFFECTIVENESS	Doing the right thing to achieve the best possible results
 EFFICIENCY	Making the best use of resources

Source: Accreditation Canada (www.accreditation-canada.ca)

Assessing your organization's approach to quality and safety

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Does your organization have a any of the following…	YES	NO	PLANNED
1. A quality and safety committee.			
2. (If you have a committee) Representatives from HR, OHS or Wellness on that committee?			
3. A patient safety strategy that includes building a safety culture.			
4. A clear understanding among all staff of what 'safety culture' means in your context.			
5. Safety training that addresses the 'drivers' of safety culture.			
6. Supervisory / leadership training that addresses the 'drivers' of safety.			
7. Initiatives in the past 2 years aimed at improving work environments and/or quality of work life that included quality and safety goals?			
8. Senior managers who inspire staff with their vision of quality and safety.			
9. Do you conduct an employee survey that provides information on safety culture 'drivers'?			

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Closing the "knowing-doing" gap

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1. Make safety culture a shared responsibility.
2. Leaders must enable and champion.
3. Leverage people values.
4. Create a compelling quality vision.
5. Integrate and coordinate all quality initiatives.

Strengths to build on

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THE HSAA SURVEY IDENTIFIED THE FOLLOWING STRENGTHS:

- ✓ Employees' commitment to their work and their clients.
- ✓ Employees take initiative and contribute their skills and knowledge.
- ✓ Positive team relations.
- ✓ Training investments pay off.
- ✓ Workplace health promotion investments pay off.

The win-win-win scenario

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Employees win

- Time and funds for PD
- Job feedback
- Healthy and safe work environments
- Improved scheduling
- Control over workloads
- 2-way communication

Employers win

- Increased capabilities
- Improved productivity
- Reduced costs
- Reduced turnover
- Higher trust
- Higher commitment
- Good reputation

Clients/patients win

- Improved service quality
- Improved system efficiency
- Reduced risk of errors

Using employees' input for improvement

Example consultation questions	Quick win	2009 actions and goals	2010-2012 actions and goals
Most useful action by employer to support professional development			
One change that would contribute most to improving quality of work-life			
Best thing teams could do to improve error reporting, learning and remedial action			
Best thing management could do to improve error reporting, learning and remedial action			

Learning and development improvements

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THE HSAA SURVEY IDENTIFIED THE FOLLOWING ACTIONS :

- ✓ Feedback from supervisors to help employees do a better job.
- ✓ Time and financial support to maintain professional certifications.
- ✓ A stream-lined process for approval of PD requests.
- ✓ A wider range of training choices, especially job-specific courses.
- ✓ Annual performance appraisals, which include recognition, feedback on job performance, and support for learning and career plans.
- ✓ Organization-wide support for reporting errors, learning from them, and taking the appropriate action.

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Alberta presenters

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Interactive discussion

1. To what extent do decision-makers in your organization connect the 3 dimensions of quality we have been discussing (system outcomes, work environments, work-life)? How do they do this?
2. What is the most effective step your organization has taken to improve quality and safety outcomes? What was the impact on quality of work life?
3. What is the most effective step your organization has taken to improve work environments or work-life? What was the impact on quality and safety?
4. Have you learned lessons from unsuccessful quality and safety initiatives?

References

G. S. Lowe. *Creating a Quality Work Environment. Results from the HSAA 2006 Work Environment Survey*. Edmonton, AB: Health Sciences Association of Alberta, 2006. (www.grahamlowe.ca/documents/158/)

G. S. Lowe. The role of healthcare work environments in shaping a safety culture. *Healthcare Quarterly*. vol. 11, no. 2, 2008. (www.grahamlowe.ca/documents/213/)

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