



PATIENT SAFETY

Patient Safety Outcomes: The Importance of Understanding the Organizational Culture and Safety Climate

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PATIENT SAFETY IS an important goal for all health care providers and administrators. However, many barriers may impede this goal. An example can be wrong-site surgeries, which are rare but very serious errors. The Joint Commission has stressed the importance of decreasing wrong-site surgeries through their Universal Protocol. Hospitals and ambulatory surgery centers have instituted policies and procedures both pre- and intraoperatively to eliminate wrong-site surgeries. Yet, wrong-site surgeries continue to be reported. As O'Leary and Jacott¹ commented, multiple health care providers are involved in this system-dependent process—from the nurses in the preoperative setting to the operating room team. Each of these people and areas provide an opportunity for an error to be caught, or not. The reality remains that every health care worker involved in patient care is prone to error.¹⁻⁴

Several of my colleagues and I were discussing recent patient safety initiatives and the topic of why so many errors and near misses continue to occur. The topic of organizational culture and safety climate arose among the group and how culture can influence decisions made by nurses at the bedside. Organizational culture is the assumptions, beliefs, attitudes, values, and experiences of the organization, and it often entails unwritten aspects. Organizational culture can change over time if

interventions are focused on the intended goal.^{3,4} Safety climate entails some key features, such as a blame-free environment (individuals are encouraged to report near misses and errors without the concern for punishment), promotion of collaboration among various disciplines in the health care arena, the allocation of resources for patient safety initiatives, and understanding that the organization operates within a high-risk nature.² Therefore, safety climate entails the health care provider's perception regarding the perception of patient safety.⁴

Evidence supports that organizations with higher levels of safety climate have fewer adverse events, higher reporting of errors and near misses, better communication among managers and staff, and higher patient safety.⁴ Organizations and units can measure their safety climate through various instruments, for example, the Agency for Healthcare Research and Quality has surveys that can be used, such as the Safety Attitudes Questionnaire and the Patient Safety Culture Surveys. These surveys request that the health care provider rate the safety culture of both their current unit and organization.² Interestingly, although not surprising, managers often report higher perceptions of safety climate compared with staff.³

Additionally, it is important to understand safety climate and its relationship to patient safety outcomes. A recent study³ investigated this relationship by examining safety climate in various areas, such as provision for safe care, overall emphasis on safety, senior management engagement, unit safety norms, problem responsiveness, organizational resources for safety, unit recognition and support for safety efforts, collective learning, fear of blame and punishment, and psychological

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safety. Findings illustrated that several individual dimensions of safety climate were related to specific patient safety indicators. Those hospitals that report a high perception of the fear of blame and punishment reported higher rates of decubitus ulcers and postoperative deep vein thrombosis and pulmonary emboli. The incidence of high failure to rescue was reported in hospitals with low perceptions of psychological safety. Facilities with high overall emphasis on safety reported lower incidences of iatrogenic pneumothorax and decubitus ulcers. The researchers also concluded that patient safety outcomes may be more strongly related to unit-specific processes and climate than to hospital-wide levels of processes and climate.³ More research is needed in examining these relationships, particularly at the unit level.

Although safety climate has been discussed frequently in the literature, little research has been conducted on the relationship between organizational culture and safety climate. One recent study⁴ focused on 30 Department of Veterans Affairs (VA) hospitals across the country and the relationships between organizational culture and safety climate. The authors noted four different types of culture domains and the outcomes associated with them with regard to patient safety⁴:

1. Entrepreneurial: risk taking, innovation, growth, and flexibility are key features. Hospitals are often changing policies and introducing new equipment into the organization. Evidence shows that stronger entrepreneurial culture produces better outcomes.
2. Hierarchical culture: structures, processes, standards, and regulations promote both predictability and efficiency. Evidence shows when rules and control are highly valued that the awareness of safety is diminished from a less than open flow of information from the frontline staff.
3. Group culture: collaboration, participation, empowerment, and shared beliefs. Increased group orientation can lead to better outcomes.
4. Rational culture: goal orientation and high pressure to have good results that maximize both speed and profit. Rational culture may decrease patient safety because the overall focus is on speed and profit.

The VA study inquired whether safety climate at the hospital level is affected by the key characteristics of the hospital's organizational culture (discussed above).⁴ The findings from the study showed that hospitals with higher levels of entrepreneurial and group cultures were associated with higher levels of safety climate ($P < .001$). Hospitals that reported higher hierarchical cultures had lower levels of safety climate ($P < .001$). Before the VA study,⁴ little was known about the connections between organizational culture and safety outcomes. The findings from the study are important to managers and staff because it provides direction on prioritizing and designing interventions to promote patient safety.⁴

What can perianesthesia staff nurses and managers do to improve patient safety within their hospitals? One easy mechanism would be to determine what the organizational culture and safety climate are within their particular unit. As alluded to earlier, patient safety outcomes may be strongly linked to the unit-specific safety climate. Having an understanding of how staff perceive the safety climate can provide managers an opportunity to improve the climate within their unit. Additionally, nurse managers should also take the survey and compare their perceptions of the safety climate with the staff's perception. Evidence has shown differences between staff and manager. This information can be a catalyst for change.

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