A quest for patient-safe culture: contextual influences on patient safety performance. Health Services Research and Policy 2011;16(suppl.1):57-64. doi:10.1258/jhsrp.2011.010093

A quest for patient-safe culture: contextual influences on patient safety performance

Abstract

Objectives: To use organizational change theory to explore the interplay of contextual influences on patient safety.

Methods: A multi-level comparative case study of eight NHS acute hospital Trusts in England including 144 depth interviews with senior managers, staff involved with risk analysis and reporting, middle managers, and senior and junior clinicians, supplemented with documentary data and observation of nine meetings. Organizational change theory was used to identify content, contextual and process influences on patient safety.

Results: Organisational stability and staff engagement appeared to influence patient safety and specific contextual factors appeared to influence both organizational stability and staff engagement, both of which were important for patient safety. These contextual factors comprised: environmental shocks; cultural characteristics; processes and structures supportive of patient safety; and Trust leadership style. A model is suggested that analyses the Trusts in terms of these factors and then groups them into four Trust types.

Conclusion: The study highlights the massive and unpredictable impact of both internal and external environmental shocks and how they destabilise Trusts distracting attention from patient safety. It also underlines the importance of regular self-assessment of internal and external risks and awareness of context.

Acknowledgements

This project was funded by the National Institute for Health Research Service Delivery and Organisation programme (project number SDO/92/2005).

The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NIHR SDO programme or the Department of Health.

Introduction

Patient safety is recognised as a major issue for health care organizations. Inquiries focusing on catastrophic and avoidable failures in health care highlight a range of strategies to address patient safety failures. Policymakers and researchers identify two approaches: one, a 'top down' approach focused on analysis of errors[1] leading to development of performance standards and processes to attribute accountability; and, a 'bottom up' approach which favours the development of a patient safe culture.[2] This paper attempts to unravel the contextual complexity of patient safety, and uses organisational change theory as a lens to analyse how content, contextual and process factors converge to influence patient safety. In so doing, it offers insight into how health care leaders may approach the task of promoting a patient-safe organizational culture as they steer around internal and external hazards.

Organizational culture and patient safety

Definitions of organizational culture are diverse and contested.[3] Some commentators view organizational culture as a variable capable of managerial manipulation[4], while others see it as a root metaphor or non-conscious, pervasive and embedded set of behaviours that are unlikely to change basic assumptions held by organisational

members.[5] We posit that different micro-cultures co-exist and are contested within health care organisations,[6] but that leaders may have a strong influence in stimulating a culture supportive of patient safety.[7] This takes on board Schein's definition of organizational culture that clusters the many dimensions of culture into three levels that relate to artefacts, values and basic assumptions, and acknowledges the existence of sub-cultures which may work alongside or co-exist with the broader organisational culture. [8]

The patient safety literature highlights a range of cultural dimensions that appear to influence safety. These include: a shared priority for the safety of patients;[9] an open and non-punitive environment where staff feel safe to report incidents,[9] where reporting of incidents and near misses is a norm;[1] and a just culture where trust is well established and where there is a well established collective understanding of accountability for actions.[10]

Broader contextual and process influences on patient safety

A range of broader contextual factors appears to influence patient safety. For example, Vincent *et al.*[11] identify seven types of factors: patients; tasks; technology; team; environmental; organisational and institutional factors. Similarly, Nieva and Sorra[12] identify the promotion of safety by management; the development of structures for teamwork in and across hospital units; open communication; effective transmission of communication; a no blame culture; adequate staffing levels; continuous learning; safety awareness; and hospital wide systems and processes to support safety. In addition, studies by West *et al.*[13] also link the sophistication of

appraisal systems, training and the percentage of staff working in teams to patient mortality rates.

The 'Receptive Contexts for Change Model'[14] suggests that organizational change receptivity may be influenced by eight contextual factors. These factors identify the importance of how: (i) quality and coherence of policy should link to a broad strategic vision that enables both commitment building and linking strategic goals to operational actions; (ii) key individuals must lead change, with an emphasis on the dispersed and collective nature of their roles, stability of leadership and the possession of personal skills; (iii) long term environmental pressure is likely to drain energy from organisational change processes and financial pressures harm morale; (iv) supportive organizational attributes are recognised; (v) effective managerial–clinical relationships involve clinicians in management; (vi) informal and purposeful networks that provide opportunities for training and commitment building draw together 'top-down' and 'bottom-up' concerns about safety; (vii) managers set clear and specific priorities; and (viii) the organisation's change agenda should fit with its locale.

Some prior attention thus focuses on identifying systemic causes of error and cultural attributes supportive of patient safety, but we argue that limited consideration has been given so far to understanding how contextual factors work in concert to mediate and influence patient safety. This paper aims to address this gap by using the lens of organizational change receptivity to explore the interplay of complex contextual factors influencing patient safety.

Methods

The paper draws from a study[15] which aimed to explore organisational culture change and wider contextual factors affecting patient safety and staff well-being in eight NHS acute hospital Trusts in England (referred to as Trusts A-H). Three project strands explored: senior leadership; the well-being of front-line workers (nurses); and a multi-faceted, multi-method organisational strand. The current findings are drawn from the organisational strand. The bulk of the fieldwork was conducted 2005-7. Trusts were purposively sampled and varied in terms of official performance criteria in relation to patient safety and staff well-being; size; status; and location, including geography, accessibility and population served, as well as foundation (more autonomous) or non-foundation (less autonomous) status (see Box 1). The organisational strand involved comparative case studies of Trusts. Four Trusts (A-C) were studied in depth and four in less detail (E-H).

In total, 144 interviews were conducted. These included: interviews with senior managers (Chief Executives of all Trusts or their Acting officers); others on the Executive Board including medical and finance directors; staff directly charged with patient safety, risk, human resources and/or staff well-being responsibilities; middle managers; and front line staff. Interview questions focused on issues related to the content, context and process issues affecting patient safety and staff well being.[16, 17] Change content issues related to staff perceptions of the scale, scope, character and magnitude of the cultural change. Consideration was given to staff interpretations of the goals, vision, and understanding of the change strategy. Contextual issues focused on identifying the influences of organisational structure, culture, history, staff well-being and resource constraints on patient safety performance. Process issues

focused on clinical governance processes, Trust leadership styles, incident reporting and analysis, and systems and processes supportive of patient safety and staff well-being. Interviews were digitally recorded, transcribed and anonymised.

Limited non-participant observation, both formal and informal, was undertaken. Nine meetings were observed including meetings of Trust Executive Boards, Governance, Risk and Legal Services, Health and Safety, and senior management teams. The researchers recorded their experiences and interpretations of the actions, interactions, roles, motives and perspectives of participants in a diary and in contemporaneous notes.[18]

Documentary analysis also served to enrich understanding of the Trusts' internal and external context. Trust documentary data included: annual reports, Executive Board minutes, policy documents, incident reports, complaints' reports, Health and Safety reports, and infection control reports. National data were also collected, such as Health Care Commission Annual Health Check information and NHS National Staff and Patient Survey information.

Trust performance was analysed using a range of data sources. Financial stability was described in Trust annual reports and final accounts. Quality of care was characterised from Annual Health Check ratings. Staff well-being was interpreted from measures included in the National NHS Staff Survey (percentage of staff suffering illness or injury as a result of work-related stress) as well as reported staff perceptions of well-being.

Patient safety performance was derived from official sources, and interview and Trusts' documentary data. Official sources included: measures in the National NHS Staff Survey (percentage of staff reporting errors or near misses); reported standardised mortality rates; and hospital-acquired infection rates. Staff interpretations of patient safety performance were derived from their reported perceptions of patient safety performance and their acknowledgement of patient safety initiatives.

Data collection and analysis were concurrent. Three researchers collected data, and were independently involved in coding, analysis, cross-checking and comparing interpretations and emerging themes. Transcribed and documentary data sources were input into Nvivo 7, qualitative analysis software. The processual framework[16 17] and the 'Receptive Concepts for Change Model'[14] provided the sensitising conceptual framework to guide analysis. One mini case study (Trust G) served as a pilot analysis. Concepts and key categories were interactively derived from the conceptual framework and emerging themes generated by the data.

Results

Characterising Trust performance

Box 1 summarises the performance and contextual features of each Trust. Consistent themes related to: limited understanding of the meaning of patient safety; severe environmental shocks affecting Trusts; reported cultural enablers and barriers to patient safety; reported organizational processes and structures supportive of patient safety; and staff members' perceptions of leadership roles and behaviours

supportive of patient safety. Boxes 3-7 provide examples from the interview data to illustrate each theme.

Limited common understanding of patient safety

Most Trust staff failed to use consistent and explicit language when defining patient safety. Staff spoke of patient safety in terms such as: ‘risk analysis’; ‘incident reporting’; and ‘no blame’. They also highlighted how definition of incidents lacked consensus. Clinical staff referred to ‘complications arising from practice’ which patients regarded as ‘incidents’. Only one Trust recognised a formal patient safety strategy (Trust A). Similarly, when asked to interpret patient safety, staff often referred to ‘quality of care’ and ‘quality improvement initiatives’.

Environmental shocks

Environmental shocks which affected organisational stability were commonly reported as limiting organisational capacity to address patient safety. External shocks were consistently perceived as: reorganisation of Primary Care Trust (PCT) catchments; cuts in PCT commissioning; and PCTs in financial deficit. Internal environmental shocks included: hospital-acquired infection outbreaks; instability of Trust leadership; and Trust mergers. Financial resource constraints were interpreted as affecting staffing. Staff reported that patient safety was affected by inadequate skill mixes and displacement of clinical staff to unfamiliar wards.

Barriers and cultural enablers of patient safety

Staff members suggested a range of barriers to patient safety: heavy workloads; staff communication failures; failure to follow and document procedures; poor staffing

levels; limited awareness of risk; and priority to achieve performance targets. Analysis indicated that more participative cultures with higher levels of staff participation in decision-making (Trusts A, H, C, D and F) were linked to better patient safety outcomes.

Cultural enablers included: positive staff attitudes to change and innovation; staff members' willingness to question; the existence of long-standing and high trust staff relationships; and, positive staff attitudes to accessing and transmitting organizational learning. These cultural characteristics were manifested in:

• strong involvement of senior clinicians in operational management and patient safety initiatives:

• senior leadership visibly supporting and prioritising patient safety;

• focus on allocation of time and space for informal social interaction;

• use of multiple methods of formal communication of Trust strategies; and

• examples of the adoption of innovative practices and technologies.

Trust leadership

Staff perceived that senior leadership behaviours that galvanised Trust staff were important in signalling patient safety and staff well-being priorities. These included: 'walkarounds'; open Trust-wide briefings; and use of role models in championing patient safety and staff well-being. Senior clinical staff also highlighted how they employed '*permission behaviours'* or verbal communication that encouraged junior staff engagement in decision making. Senior sisters or charge nurses, who were appointed as matrons[19], played an important part as visible and clinical leaders that made sense of patient safety problems, mobilised resources, and designed and

implemented solutions. In Trusts A & H Trust senior leadership successfully adopted a hybrid transformational/transactional style[20] which appeared to encourage participation in decision making.

Organizational structures and processes

Organizational structures and processes supportive of patient safety were emphasised in Trusts A, H, C, D & F. These included: processes and structures supporting the use of multiple methods of communication; and structures and feedback processes that linked clinical governance, risk reporting, risk management and complaints procedures. A range of practices was reported that supported patient safety. These included: the use of story-telling and incident reconstruction to communicate patient safety learning; Trust-wide involvement in the investigation of incidents; creation of social spaces to encourage informal interaction; and the use of matrons[19] to disseminate priority for patient safety, and to, follow up and diffuse potential complaints.

Contextual influences on patient safety performance: a typology of NHS acute hospital Trusts

Assessment of each Trust in terms of these contextual themes led to the development of an interpretive schema and typology of case study Trusts to make sense of the complex interplay of contextual influences on patient safety performance at a point in time (Box 2). Box 2 groups Trusts as ‘Resilient’ (A & H), capable of maintaining stability of operations; ‘Adaptive’ (C, D; & F), able to rapidly develop strategies to cope with major organisational shocks; ‘In Recovery’ (B &G), coping with crises in a piecemeal fashion; and ‘Conservative and Passive’, (E),

where staff lacked the impetus to involve themselves proactively in patient safety or change.

'Resilient' Trusts (Trusts A and H) possessed the highest number of 'change receptive' factors[14] which also linked to their relatively high performance for patient safety and staff well-being indicated in their performance ratings. The organisational cultures within Trusts A and H were perceived as 'consultative, participative, democratic' and encouraging staff engagement. This confirms existing theory that these cultural attributes may link to higher levels of performance[21]. Leadership in both Trusts was also reported as highly stable. It is suggested that this stability generated predictability of behaviours and high trust relationships which supported a patient-safe culture.

Both Trusts had been exposed to some environmental pressure.[14] Trust H had experienced a merger and Trust A had experienced a reconfiguration of its PCTs. However, Trust staff did not to emphasise these environmental issues during their interviews which may indicate that the leadership had managed to buffer any negative effects. The Chief Executive's style of leadership was also characterised as a mixture of democratic and directive styles, and reflected elements of both transactional and transformational leadership styles[20] , which have been linked to higher levels of performance [21].

The data suggest that the receptiveness of these Trusts to change was also linked to organisational capabilities which supported innovation and knowledge

management[22]. Trusts A and H possessed complex, efficient and integrated support processes covering clinical governance, risk management and complaints analysis. Likewise, diffusion of knowledge and organisational learning across these Trusts was facilitated by: open; multi-level communication and feedback channels; staff participation in decision making and a simplified incident reporting system; good quality relationships; stable leadership; and strong clinical-managerial relationships.

'Adaptive Trusts' demonstrated how strong environmental pressures had galvanised Trust leadership to become operationally involved in patient safety and infection control strategies. As a consequence, innovative strategies were developed to analyse and investigate incidents, and transmit best practice across the Trusts. This confirms the links posited between increased innovation and extreme environmental pressures [14, 22] during radical change. In Trusts C, D and F, senior leadership also exhibited transformational behaviours[20] , such as involvement in team briefs and 'walkarounds'.[23] Matrons were mobilised[19] as change agents to promote patient safety. They possessed an ability to absorb feedback and intuit local problems[24], anticipate risks, mobilise problem-solving and then translate customised solutions effectively back to staff.[25]

Cultural norms in the 'Adaptive Trusts appeared to indicate a shared and increased priority for patient safety and an emphasis on accessing, transmitting and using organisational learning[15]. Hence, these Trusts were able to learn from errors and effectively communicated this knowledge and insight via innovative practices such as 'table top' investigations (meetings convened by staff drawn from across the Trust to informally discuss a specific incident).

Trusts B and G, ('In Recovery') had experienced major environmental pressures and confirmed the proposition put forward by the 'Receptive Contexts Model'[14] that such extreme pressures can severely distract Trust leadership and limit its ability to respond to problems and change. Likewise, distrust between clinicians and senior management resulted in limited staff engagement in incident reporting. Similarly, environmental shocks arising from reconfiguration of PCT services (Trust B), and severe financial and infection control problems (Trust G) had resulted in poor staff morale and affected staff engagement in reporting patient safety incidents. Low perceived priority for patient safety also links to low performance outcomes for patient safety.

The Leadership was also perceived as failing to implement safety policy as the Trusts were overwhelmed by externally imposed change. Staff members were busy, dissatisfied and unable to access training which would have improved their competence and awareness of patient safety. Failure to access training appeared to link to limitations in staff awareness of patient safety breaches and patient safety performance. This confirms established links between performance and training.

The 'Conservative and Passive' Trust (E) appeared to focus on the achievement of government targets. The high level of environmental stability reflected the bureaucratic structure which was perceived to be resistant to change and characterises the 'safe culture' posited by Wiegmann *et al*.[26.] . Strong longstanding relationships also provided a buffer against stress and pressure. This Trust was also viewed as slow in decision-making, overwhelmed by change and unable to clarify

goals. This preference for continuity over innovation and change was also reflected in its failure to develop new practices and effectively transmit knowledge across the Trust.

Discussion

The evidence presented here largely confirms the propositions of 'The Receptive Contexts for Change Model'[14] with regard to the importance of organizational characteristics that support staff involvement in decision making (Trusts A &H) and contextual factors influencing organisational ability to respond to patient safety challenges (for example, how financial environmental pressures sap organizational capability (Trusts B&G)). The Model emphasises the role of senior leadership in building commitment, articulating a clear change vision and demonstrating transactional skills in translating policy into strategy (shown in Trusts A & H). Trusts A, C, D, F and H also demonstrated organizational capabilities in developing and using networks to access and transmit knowledge and learning to improve patient safety.

This study has some limitations. The detailed case studies generated some interesting associations between organisational and contextual factors, and patient safety performance, but it would be hazardous to generalise the findings. The aggregated findings may belie the unique nuances identified in each Trust. The study is also time-limited. Multiple patient safety initiatives are ongoing and many have been introduced since data collection. Interviews, the primary source of data, were predominantly with managers and staff responsible for incident reporting and risk analysis, and to a lesser extent with rank-and-file clinical staff. Hence, they tend

to reflect a leadership and managerial orientation. However, some members of the senior executive teams were clinicians, and participants involved in risk analysis and infection control were also clinicians.

The study extends understanding of the complex interplay of contextual and process factors that influence patient safety, and the development of an organisational culture supportive of patient safety. A typology of Trusts suggests how: organisational stability, the behaviour of senior leaders; and the presence of cultural attributes and organisational capabilities supportive of staff engagement appear to mediate patient safety performance. Attention is drawn to how severe environmental pressures can affect and threaten patient safety and staff well-being which then lead to staff being stressed, pressured and distracted, leading to further implications for patient safety. It emphasises how organisational cultural attributes and stability of Trust staff can mitigate these problems especially when supported by a collaborative culture focused on innovation and learning. Stability without these positive attributes was seen to have a negative effect on patient safety and staff well-being.

Conclusions

This study highlights the importance of health organizations assessing their internal and external risks and awareness of context. It emphasises the need to secure the continuity of CEO tenure and to develop senior leadership training that includes understanding of change management. Key to this is the capability of leaders to buffer their organisation from external environmental shocks. The study also identifies how patient safety and staff well-being strategies need to be coherent,

integrated and marketed. Overall, it shows the necessity for cultures and practices supportive of organisational learning and staff participation in decision making.

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Box 1: NHS acute hospital trusts studied

TRUST A
Annual Health Check
Quality Services - Excellent
Use of Resources – Excellent
Financial – Strong surplus
Patient satisfaction – Above average
Patient mortality – Well below average
Infection rates –Below average
NSS response rate – 66%
Foundation Trust
Population – 300K
P.Safety Initiatives – Many

TRUST B
Annual Health Check
Quality of Services - Excellent
Use of Resources – Excellent
Financial – Small surplus
Patient satisfaction – Above average
Patient mortality – Slightly below average
Infection rates – Well below average
NSS response rate – 47%
Non Foundation
Population – 800K
P.Safety Initiatives – Proactive risk assessment
Disputes with PCT

TRUST C
Annual Health Check
Excellent Quality of Services
Fair Use of Resources
Financial – Large Surplus
Patient satisfaction – Slightly below average
Patient mortality – Above average
Infection rates – Average; improving
NSS response rate – 61%
Non Foundation
Population – 2 million
Level of P.Safety Initiatives – Many infection control Initiatives

TRUST D
Annual Health Check –
Quality of services - Good
Use of Resources – Good
Financial – Modest surplus
Patient satisfaction – Average
Patient mortality – Slightly above average
Infection rates – Average; improving
NSS response rate – 49%
Non Foundation
Population - 500K
Level of P.Safety Initiatives – Many Initiatives

TRUST E
Annual Health Check
Quality of Services – Good
Use of Resources – Excellent
Financial – Modest Surplus
Patient satisfaction – About average
Patient mortality – Slightly below average
Infection rates – Average; improving
NSS response rate – 58%
Non Foundation
Population – 200K
Level of P.Safety Initiatives - limited

TRUST F
Annual Health Check
Quality of Services – Excellent
Use of Resources – Excellent
Financial - Surplus
Patient satisfaction – Below average
Patient mortality – Well above average
Infection rates – Below average
NSS response rate – 59%
Foundation
Population – 300K
Level of P.Safety Initiatives - Many

TRUST G
Annual Health Check
Quality of services – Improving from Fair to Good
Use of Resources – Improving from Poor to Fair
Financial – Poor
Patient satisfaction – Below average
Patient mortality – Well above average
Infection rates – Well above average
NSS response rate – 50%
Non Foundation
Population – 200K
Level of P.Safety Initiatives - limited

TRUST H
Annual Health Check
Quality of services – Good
Use of resources – Excellent
Financial -
Patient satisfaction – Above average
Patient mortality – Slightly below average
Infection rates – Well below average
NSS response rate – 62%
Foundation Trust
Population – 400K
Level of P.Safety Initiatives - Many

Box 2: Typology of case study Trusts based on impact of contextual factors on patient safety performance

COMPONENT CHARACTERISTICS	TRUST TYPES			
	RESILIENT (A&H)	ADAPTIVE (C,D & F)	CONSERVATIVE (E)	IN-RECOVERY(B &G)
MAGNITUDE OF ENVIRONMENTAL 'SHOCKS'	Low	High	Low	High
RECEPTIVITY TO ORGANISATIONAL CHANGE	*Open and receptive*	*Open – high level of staff consultation*	*Emphasis on continuity rather than innovation and change*	*Difficulties with change implementation – much resistance to change*
ORGANISATIONAL LEARNING	*High levels of organisational learning*	*High levels organisational learning – 'closing the loop'*	*Failures in transmitting organisational learning*	*Failures in sharing learning, and failures in feeding back*
CLINICAL PARTICIPATION IN DECISION-MAKING	*High levels of Clinical participation in decision-making*	*High levels of Clinical participation in decision-making*	*Moderate levels of clinical participation in decision-making*	*Low levels of clinical participation in decision-making*
MODES AND CHANNELS OF COMMUNICATION	*Multiple modes and channels of communication, matrons key communicators*	*Multiple modes and channels of communication, overwhelmed with communication*	*Failures in communication*	*Limited reference to communication*
PRIORITY FOR PERFORMANCE - TARGET FOCUSED	*High priority for performance*	*High priority for performance*	*High priority for performance*	*High priority for performance and focus on financial targets*
PERCEPTION OF STAFF WELL-BEING	*Positive perception of staff well-being*	*Negative perception of staff well-being – anxiety and stress.*	*Negative perceptions of staff well-being– anxiety, stress and pressured.*	*Negative perception of staff well-being – anxiety, stress and overloaded*
PERCEPTION OF PATIENT SAFETY	*Positive perception of patient safety – a high priority.*	*Major improvements in patient safety – increasing priority.*	*Positive perception of patient safety – a high priority*	*Negative perception patient safety – breaches, under reporting, patient safety an emerging priority.*
PERCEPTION Of ORGANISATIONAL CAPABILITIES - PATIENT SAFETY	*Positive perception organisational capabilities – Patient safety an integrated system.*	*Highly developed systems to support patient safety.*	*Blame culture exists, failures in incident reporting.*	*Improvements in patient safety by adopting 'lean' thinking'. A blame culture was reported.*
PERCEPTION OF – STAFF WELL-BEING	*Supportive occupational health systems*	*Improvements in occupational health systems*	*Supportive occupational health systems*	*Criticism of systems for supporting staff*
SENIOR LEADERSHIP STYLE	*Balance of directive and consensual.*	*Democratic and consensual.*	*Remote, bureaucratic and slow.*	*Trust G Democratic and consensual* *Trust B senior leadership not cohesive.*
CONTINUITY OF LEADERSHIP	*High continuity of leadership team.*	*Low continuity of leadership team.*	*High continuity of leadership but recent loss of CEO.*	*Low continuity of leadership team.*
OFFICIAL DATA MORTALITY RATES INFECTION RATES	*Below Average (A&H* *Well Below average (A&H)*	*Above average (F, C &D)* *Poor (F), Average (C&D)*	*Slightly below average (E)* *Average and improving (E)*	*Below average (B&G)* *Well above average (G), Poor (B)*

Box 3: Limited common understanding of patient safety

Language of patient safety

I just don't think we've used the words 'patient safety' in a regular and repetitive way. I think it's a bit like the word 'hygiene', 'hygiene' never featured in any documentation, **Nursing Director.**

Because I don't believe that (patient safety), it is not just the clinical governance, it is the organisational governance that needs to go with that and I don't believe we've got that within the structure. **Clinical Director**

Well I think people see the issues of quality, i.e. I want to do this procedure or use this drug or this kind of intervention but they don't, we don't translate that into some of the mundane routines that are about safety, about checking and having the systems that are fail safe, **Chief Executive**

Understanding of incidents

Because, let's say somebody goes to theatre and they're going to have, I don't know, their appendix out or something and during theatre, you know, something goes wrong, maybe the appendix is very stuck to the bowel ….. they nick the bowel while they're doing it so they have to over sew the bowel and maybe do a de-functioning colostomy, now they wouldn't see that as an incident, **Risk Manager.**

And secondly I think that genuinely some people come to work even in health cultures where they are completely oblivious to the consequence of what they do because they only see themselves in the context of what they do and not in the context of what they do and the impact it has on others, and they don't understand the chain of consequence, **Chief Executive.**

Box 4: Environmental shocks

There has just been absolutely no stability. All the Directors have changed. All the non-exec directors have also changed in the past couple of years, **Governance Manager.**

We are a bit in limbo because they have now been amalgamated and now we have got two PCT's, Manager Risk and Legal Services. The other five members of the team were already there when I arrived X years ago, **Chief Executive.**

But it does mean the organisation possibly facing a £X million deficit, but still hoping to go forward to Foundation Trust, **Legal Services Manager**.

We saw a sharp increase and it got to a stage where we didn't have the facilities like side rooms to isolate patients in and it was gosh we can't cope with this operationally, **Head of Nursing.**

Box 5: Examples of barriers to patient safety

Poor communication
I think one of the biggest things that I have said earlier is communication, poor communication is a big barrier and it is something that's so easy to put right. What other barriers? You see everything I think of in my head, all links to communication, **Matron**

Junior doctors failure to report
No I have never seen a doctor fill one out, never. Never, **Staff Nurse.**

Lack of Awareness
But not knowing - knowing what you don't know - is the hardest thing, **Chief Executive.**

Staff training
But staff members on the ward weren't trained, and it is a recognised problem and they can't train everybody in everything but at least you should be able to call on somebody who can if you need to. It has a long term negative effect on this patient as well as it being a relatively high risk situation because the staff on the ward didn't know how to clear the tube. They didn't know how to use suction, **Lead Patient Safety**

Staffing
I think the skill mix is wrong and I think with the changes that are happening in the NHS at the moment, reducing the length of stay obviously means the client group changes as well and their dependency changes as a result. Not only does the skill mix need to change in order to meet that demand in the dependency, but it's also the technological advances, so we've got a training issue, **Matron of Surgery.**

We get a fair amount of staffing incidents reported, probably oh about ten a month. It's quite a lot, **Clinical Midwifery Manager**.

Not following procedures
So you've got a trolley with all the notes from the patients who have been in the night before, with probably three or four sets of the eight o'clock admissions and then you've like got to chase everyone to find, and I think that's when things can get mixed up, **Staff Nurse.**

Box 6: Examples of enablers of patient safety

I am going to do a reconstruction of a critical patient safety incident, **Legal Affairs Officer**.

We have table top reviews and we develop action plans and we spend a lot of time giving thought to those, **Head of Health and Safety.**

Now people are more inclined to report and I think because it is easier to fill them in online, the forms, that people do more readily do it, **Head of Nursing.**

We have improved on it in recent months actually because we now get quarterly reports of our areas on our DATEX to see what's going on. I get every DATEX sent through to me from all of my areas, so I will then communicate with my ward sisters "what's going on? I am here and do we need to do this?" **Acting Matron.**

We came up with the methodology and we came up with a grading grid before the NPSA had come out with their grading grid. We used obviously information probably, the Australia New Zealand standard, **Deputy Director of Nursing**

So it's actually that embracing, people questioning, people wanting to change and creating an environment whereby people can change things without having to go through an elaborate permission system, **Matron.**

We have an official newsletter which has got an absolutely scurrilous back page and it is deliberately written in a sort of Private Eye style, specifically, because we know that people want to get a copy of it and they will read everything trying to find out what's where and what's written, **Clinical Director.**

Box 7: Leadership promoting patient safety

They do all the right things, I think; this is the senior management team. They signpost it early on, they give the message out, **Head of Patient Safety**.

The CEO invites lots of participation and engagement, invites lots of questions, **Director of HR**.

Culture, if it is a true culture is so deeply engrained, behaviourally and otherwise, the best you can do is modify certain behaviour, value certain behaviours and you can ignore others and that gradually produce culture shift, **Chief Executive**.

Over the last two years on strengthening leadership for Matrons and Ward Sisters and Charge Nurses, and one of the things that I recognised was that there had not been much investment directly in those professional groups, over the preceding few years, **Director of Nursing**.

Simply by visibility, corridor conversations are always quite an important thing, I always take advantage of anybody I bump into, I always engineer a conversation, particularly with clinicians. But also to, some of the fairly traditional approaches where people say if they want to see me then they get to see me straight away, **Chief Executive**.