Acta Scientific MEDICAL SCIENCES (ISSN: 2582-0931)

Volume 7 Issue 1 January 2023

Mini Review

Strategies to Improve Safety Culture in the Hospitals

Iqbal Ratnani[1]* and Salim Surani[2]

[1]*Center for Critical Care, Houston Methodist Hospital, USA*

[2]*Texas A&M University, Corpus Christie Campus, Texas, USA*

***Corresponding Author:** Iqbal Ratnani, Center for Critical Care, Houston Methodist Hospital, USA.

DOI: 10.31080/ASMS.2022.07.1420

Received: November 25, 2022

Published: December 05, 2022

Abstract

This article addresses potential minefields of patient safety in healthcare organizations across the globe, particularly in the post-COVID era. This paper also suggests strategies at ground level to ensure a proper safety environment for staff as well as for patients. This article encompasses and addresses domains about patient safety and suggestions to provide a positive and viable working environment.

Keywords: Patient Safety; Healthcare Quality; Healthcare Leadership; Enabling Environment; Organizational Learning; Error Wisdom

Introduction

In the last few decades, hospitals worldwide have been struggling with challenges causing potentially unsafe safety environments. The COVID pandemic took the lid off these previously known but covert issues. Rising health costs, inflation, and the downturn of the economy have put an enormous burden on the health system. Emergency Department (ED) overcrowding, increased admissions/discharges ratio, increased length of stay (LOS), and turnover of the clinical and non-clinical staff has resulted in unsafe climates in the hospitals, particularly for patients. Once it seems achievable, it now looks like a distant dream, a vision of zero harm and implementation of the National Patient Safety Foundation's (NPSF) safety tools [1,2].

Domains that reflect positive strengths and their implementation may improve the safety climate across the institution

The most integral part of achieving a safe climate in any institution is to commit upper executive leadership toward patient safety and quality improvement. This commitment brings an engagement to two domains with positive strengths;

- Management support for patient safety
- Organizational learning - continuous improvement.

Management support for patient safety

At the end of the day, without leadership commitment, quality and safety cannot be improved [3]. Leadership inclusiveness is a prerequisite to the success of any organization. In all interventions proposed to enable, enact, and elaborate safety culture and reduce hospital errors, one of the significant internal motivators is the leadership's characteristics and behaviors [4]. If a hospital's management takes patient safety as a top priority and provides a climate of patient safety, this goes a long way in improvement plan.

Organizational learning - continuous improvement

Learning from errors is a foundation on which all safety measures can be built. It is huge if there is a positive perception that the organization is actively doing things via learning from its mistakes, and follow-up is pursued to see the effectiveness of corrective measures [5,6]. This domain falls into the character of the mindful organization. It creates resilience for long-term viability [7,8].

Domains that reflect negative values should be avoided to sustain an overall safe climate:

The two most negative domains that affect the safety culture in any hospital are:

- Low frequency of events reported due to fear
- Compromised teamwork across units

Events reported

This domain is a wild card for any healthcare entity. If there lies fear, repercussion and intimidation among the staff, no organization can learn from its mistake. It can never become a mindful organization. This event report also includes "near misses" where the error is made, but no potential harm occurred to the patient (or if harm could have reached the patient). Educating and encouraging staff to report an error as a learning tool is necessary. Without improvement in this domain of 'ERROR WISDOM,' the system cannot be made resilient [9,10].

Teamwork across units

Most sub-domains in this category, i.e., cooperation and coordination among hospital units and unified care of departments, are all vital. This coordination speaks of a 'moral' issue in the institution. Literature shows that if a 'teamwork' mindset is deficient, units' trust-building interventions are required [11]. Any given organization is a 'system thinking.' If all parts are not coordinated well, the output will not show any subjective or objective measurement, including patient safety [12]. Systems thinking is a holistic approach and can be defined as an attempt to put various disjointed systems into one viable, productive module. This coordination calls for an action to address the domain of strong "handoffs and transitions".

One vital domain which may make or break the safety culture in any healthcare organization – and strategies to improve:

One of the biggest challenges for the leadership of most healthcare organizations, mainly after the COVID pandemic, is to find an adequate "staffing level". Shortage of staffing has led to increased workload and increased burnout among staff [13]. Until this optimum 'staffing level' is achieved, the "Manager Expectations" will be the most vital domain to be examined. There is an urgent need in today's healthcare to train mid-management leaders to create an environment where staff feels that their concerns are heard.

Three strategies that may help to vitalize this domain can be labeled as enabling, enacting, and elaborating:

Human resource practices (Enabling)

There is an emergent need for careful selection, extensive training, and adequate staffing for any given task [14]. To provide a few examples, board-certified intensivists in ICUs and experienced mid-levels cover nocturnal shifts on floors and adequate rest periods in the schedule for staff. This one strategy can have the most comprehensive impact on the institution [15]. Careful hiring of managers for different units, their training to create smooth coordination among departments, and training them for transformational leadership to increase positive behavior towards the staff can go a long way towards solving patient safety challenges [16].

Interpersonal processes (Enacting)

As mentioned above, there is a critical need for 'trust' and 'communication' within units for any organization to have an ideal safety culture. This safety culture also calls for coordination between middle management. The strategy of Interpersonal processes with its components, i.e., teamwork, mindful organizing, relational coordination, and patient involvement, should help to build a positive and cohesive culture. Frequent meet-ups of different units are an effective technique to enhance enacting. This strategy will help to decrease medical errors, enhance quality performance, and improve the perception of desired behaviors among different units [8,17].

Operational improvement (Elaborating)

Concentrating on frontline systems and infrastructure improvement will fulfill two of the basic principles of a High Reliable Organization (HRO), i.e., deference to expertise and sensitivity to operations; it will also help satisfy the ground-level/frontline staff concerns [18,19]. Formation of committees in infrastructure dedicated to looking into specific issues raised by surveys and frontline staff will go a long way in enhancing patient safety [20].

Conclusion

Healthcare entities across the world faces severe challenge in the post-COVID era for patient safety due to increased patient load, lack of staffing, and marginal mid-managerial training. Challenges

can be addressed by upper leadership commitment, error wisdom, teamwork, enhanced human resource practices, interpersonal processes, and operational improvement.

Conflict of Interests

There was no conflict of interest for any of the authors.

Bibliography

1. NSPF 2017 Leading a Culture of Safety: A Blueprint for Success (2017).

2. Arredondo E., *et al*. "Tsunami of economic turmoil to hit the healthcare in 2021-2022. COVID-19 pandemic is just an earthquake". *Hospital Practice* 49.4 (2022): 232-239.

3. Nembhard IM and Edmondson AC. "Making it safe: the effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams". *Journal of Organizational Behavior* 27.7 (2006): 941-966.

4. Singer SJ and Vogus TJ. "Reducing hospital errors: interventions that build safety culture". *Annual Review of Public Health* 34 (2013): 373-396.

5. Carroll J and Edmondson A. "Leading organizational learning in health care". *Quality and Safety in Health Care* 11.1 (2002): 51-56.

6. Alonazi W. "Building learning organizational culture during COVID-19 outbreak: a national study". *BMC Health Services Research* 21 (2021): 422.

7. Vogus TJ and Sutcliffe KM. "The safety organizing scale: development and validation of a behavioral measure of safety culture in hospital nursing units". *Medical Care* 45.1 (2007): 46-54.

8. Vogus TJ and Sutcliffe KM. "The impact of safety organizing, trusted leadership, and care pathways on reported medication errors in hospital nursing units". *Medical Care* 45.10 (2007): 997-1002.

9. Reason J. "Human error: models and management". *BMJ* 320.7237 (2000): 768-770.

10. Reason J. "Beyond the organisational accident: the need for "error wisdom" on the frontline". *Quality and Safety in Health Care* 13 (2004): ii28-33.

11. Rosen MA., *et al*. "Teamwork in healthcare: Key discoveries enabling safer, high-quality care". *American Psychology* 73.4 (2018): 433-450.

12. Vincent C. "Patient Safety". (Chapter 7) 2nd edn. Oxford: Wiley Blackwell; (2010).

13. Shen K., *et al*. "Staffing patterns in US nursing homes during COVID-19 outbreaks". *JAMA Health Forum* 3.7 (2022): e222151.

14. Preuss G. "High performance work systems and organizational outcomes: the mediating role of information quality". *Industrial and Labor Relations Review* 56 (2003): 590-605.

15. West MA., *et al*. "Reducing patient mortality in hospitals: the role of human resource management". *Journal of Organizational Behavior* 27.7 (2006): 983-1002.

16. McFadden KL., *et al*. "The patient safety chain: transformational leadership's effect on patient safety culture, initiatives, and outcomes". *Journal of Operations Management* 27.5 (2009): 390-404.

17. Benzer JK., *et al*. "The relationship between organizational climate and quality of chronic disease management". *Health Service Research* 46.3 (2011): 691-711.

18. Weick Karl E and Kathleen M Sutcliffe. "Managing the Unexpected - Assuring High Performance in an Age of Complexity". San Francisco, CA, USA: Jossey-Bass (2001).

19. Pronovost PJ., *et al*. "Creating high reliability in health care organizations". *Health Services Research* 41.4 (2006): 1599-1617.

20. Piotrowski M., *et al*. "The safety case management committee: expanding the avenues for addressing patient safety". *Joint Commission journal on quality improvement* 28.6 (2002): 296-305.