

Developing a Culture of Safety

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The author discusses the founding beliefs, principles, and goals of the VA National Center for Patient Safety that result in a positive safety culture.



For this 30th anniversary year, Federal Practitioner is spotlighting a VA or DoD Center of Excellence each month. Each Center of Excellence has a unique mission, set of goals, resources, and research areas that improve the health care provided by VA and DoD facilities.

A positive safety culture is one in which the whole is more than the sum of its parts. Based on a collective commitment to success and mutual trust, staff members are encouraged to improve teamwork and communication. Regardless of professional background, technical expertise, or position within an organization, each employee is urged to maintain a questioning attitude and be responsive to change.

The opposite term is *negative culture*, based primarily on individual performance, which is only one aspect of successful patient care. Regardless of the complexity of a task or the risk involved, in such a culture professionals are expected to perform flawlessly; derided if they don't. Roles are strictly defined, top-down communication reigns, and input from subordinates is unwelcome. In such a culture, new ideas can become enveloped in cynicism, ie, "Nothing is going to change here. Don't bother."

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This approach to patient care has never worked. For too long, most were afraid to admit it; some, unfortunately, still are. Organizations based on a negative culture are simply drifting toward failure.

The Department of Veterans Affairs National Center for Patient Safety (NCPS) was founded on the belief that this faulty approach must be abandoned. The organization focuses on looking past that oversimplified answer so prevalent in a negative culture—that an adverse event is always someone's fault. The real cause is most often a chain of events that has gone unnoticed, leading to a recurring safety problem. It is seldom related to the actions of 1 individual.

Neither the VA nor any other health care system can or ever will be able to "eliminate all errors." Patient safety programs focused exclusively on eliminating errors will fail.

The real goal of a patient safety program should be to prevent harm to patients by significantly improving the probability that a desired patient outcome can be achieved. This goal can only be accomplished by taking a systems approach to problem solving, focusing on prevention, not punishment.

Several factors characterize organizations with a positive safety culture, such as unwillingness to subordinate safety to other performance objectives and clearly under-

stood and agreed upon goals.

But leadership is the key. It's the driving force behind a positive safety culture. For staff to believe that patient safety is a priority, that message must come from the chief executive officer and staff leaders, and not occasionally. It must be part of the way business is conducted daily.

One of the most conspicuous aspects of a negative culture is the belief that compliance with rules is adequate to achieve safety. This leads to a persistent failure to recognize poorly designed care systems. Since a hierarchical structure is a fundamental characteristic of such cultures, the lack of ability for team members to speak up compounds the dangers that patients face.

Such poor communication should in no way be taken lightly. Poor communication has been proven to put patients in jeopardy. In fact, communication failure is a leading source of adverse events in health care. "Insufficient communication" was the most frequently cited root cause of the nearly 3,000 sentinel events reported to the Joint Commission between 1995 and 2004. The most recent Joint Commission statistics indicate that communication failure continues to be cited as a major root cause in reported sentinel events, noted about 70% of the time from 2010 to 2012.

More than a decade ago, the VA

took the lead in developing programs and initiatives—rooted in successful approaches developed by highly reliable organizations such as aviation—that have been shown to enhance a positive safety culture.

As several VA studies and reports over recent years indicate, patient safety efforts can be significantly enhanced through the use of checklists, involving patients in their care, and initiatives that focus on improving teamwork and communication.

A 2010 VA study published in the *Journal of the American Medical Association* indicated a significant decrease in the annual surgical mortality rate in groups trained in collaborative methods originally developed for aviation.¹ Two studies published in the *Archives of Surgery* in 2011 showed further results from these methods, such as a de-

crease in the number of wrong-site surgeries in the VA.^{2,3}

The VA has also shown that systematic approaches to reporting, analyzing, and correcting patient care systems are essential to developing a positive safety culture. Whether it is through the use of human factors engineering methods, practice-based educational programs using high-fidelity simulators, or developing toolkits and cognitive aids, the goal has been the same: the reduction of harm to patients as a result of their care.

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