PSNet
PATIENT SAFETY NETWORK

Culture of Safety

September 16, 2024
Culture of Safety. PSNet [internet]. 2019.
https://psnet.ahrq.gov/primer/culture-safety

PSNet primers are regularly reviewed and updated by the UC Davis PSNet Editorial Team to ensure that they reflect current research and practice in the patient safety field. Last reviewed in 2024.

Background

Patient safety culture is the extent to which an organization's culture supports and promotes patient safety. It refers to the values, beliefs, and norms that are shared by healthcare practitioners and other staff throughout the organization that influence their actions and behaviors. Patient safety culture can be measured by determining the values, beliefs, norms, and behaviors related to patient safety that are rewarded, supported, expected, and accepted in an organization. It is also important to note that culture exists at multiple levels, from the unit level to the department, organization, and system levels.

The concept of safety culture originated outside health care, in studies of high reliability organizations, which are organizations that consistently minimize adverse events despite carrying out intrinsically complex and hazardous work. High reliability organizations maintain a commitment to safety at all levels, from frontline providers to managers and executives. This commitment establishes a "culture of safety" that encompasses these key features:

- acknowledgment of the high-risk nature of an organization's activities and the determination to achieve consistently safe operations
- a blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment
- encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems
- organizational commitment of resources to address safety concerns

Achieving a culture of safety within health care is an essential component of preventing or reducing errors and improving overall health care quality. Studies have documented considerable variation in perceptions of safety culture across organizations and job classifications. In prior surveys, nurses have consistently complained of the lack of a blame-free environment, and providers at all levels have noted problems with

organizational commitment to establishing a culture of safety. The underlying reasons for the underdeveloped health care safety culture are complex, with poor teamwork and communication, a "culture of low expectations," and authority gradients all playing a role.

Measuring and Achieving a Culture of Safety

Safety culture is generally measured by surveys of providers at all levels. Available validated surveys include AHRQ's Surveys on Patient Safety Culture™ (SOPS®) and the Safety Attitudes Questionnaire. These surveys ask providers to rate the safety culture in their unit and in the organization as a whole. Versions of the AHRQ Patient Safety Culture™ (SOPS®) survey are available for hospitals, medical offices , nursing homes, community pharmacies, and ambulatory surgery centers. AHRQ provides updated benchmarking data from the hospital survey on an annual basis.

Poor perceived safety culture has been linked to increased error rates. However, achieving sustained improvements in safety culture can be difficult. Specific measures of safety culture, such as teamwork training, leadership walk rounds, and establishing unit-based safety teams, have been associated with improvements in safety culture measurements and have been linked to lower error rates in some studies. Other methods (e.g., rapid response teams, structured communication methods such as SBAR) are being widely implemented to help address cultural issues such as rigid hierarchies and communication problems, but their effect on overall safety culture and error rates remains unproven.

The culture of individual blame is still a pervasive problem in health care and undoubtedly impairs the advancement of a safety culture. One issue is that while "no blame" is the appropriate stance for many errors, certain errors do seem blameworthy and demand accountability. In an effort to balance the twin needs for no-blame and appropriate accountability, the concept of just culture is now widely used. A just culture focuses on identifying and addressing systems issues that lead individuals to engage in unsafe behaviors, while maintaining individual accountability by establishing zero tolerance for reckless behavior. It distinguishes between human error (e.g., slips), at-risk behavior (e.g., taking shortcuts), and reckless behavior (e.g., ignoring required safety steps). In a just culture, the response to an error or near miss is predicated on the type of behavior associated with the error, and not the severity of the event. For example, reckless behavior such as refusing to perform a "time-out" prior to surgery would merit punitive action, even if patients were not harmed.

Safety culture is fundamentally a local problem, in that wide variations in the perception of safety culture can exist within a single organization. The perception of safety culture might be high in one unit within a hospital and low in another unit, or high among management and low among frontline workers. Research also shows that individual provider burnout negatively affects safety culture perception. These variations likely contribute to the mixed record of interventions intended to improve safety climate and reduce errors. Therefore, organizational leadership must be deeply involved with and attentive to the issues frontline workers face, and they must understand the established norms and "hidden culture" that often guide behavior. Many determinants of safety culture are dependent on interprofessional relationships and other local circumstances, and thus changing safety culture occurs at a microsystem level. As a result, safety culture improvement often needs to emphasize incremental changes to providers' everyday behaviors.

Current Context

The National Quality Forum's Safe Practices for Healthcare and the Leapfrog Group both mandate safety culture assessment. AHRQ also recommends yearly measurement of safety culture as one of its "10 Patient Safety Tips for Hospitals."