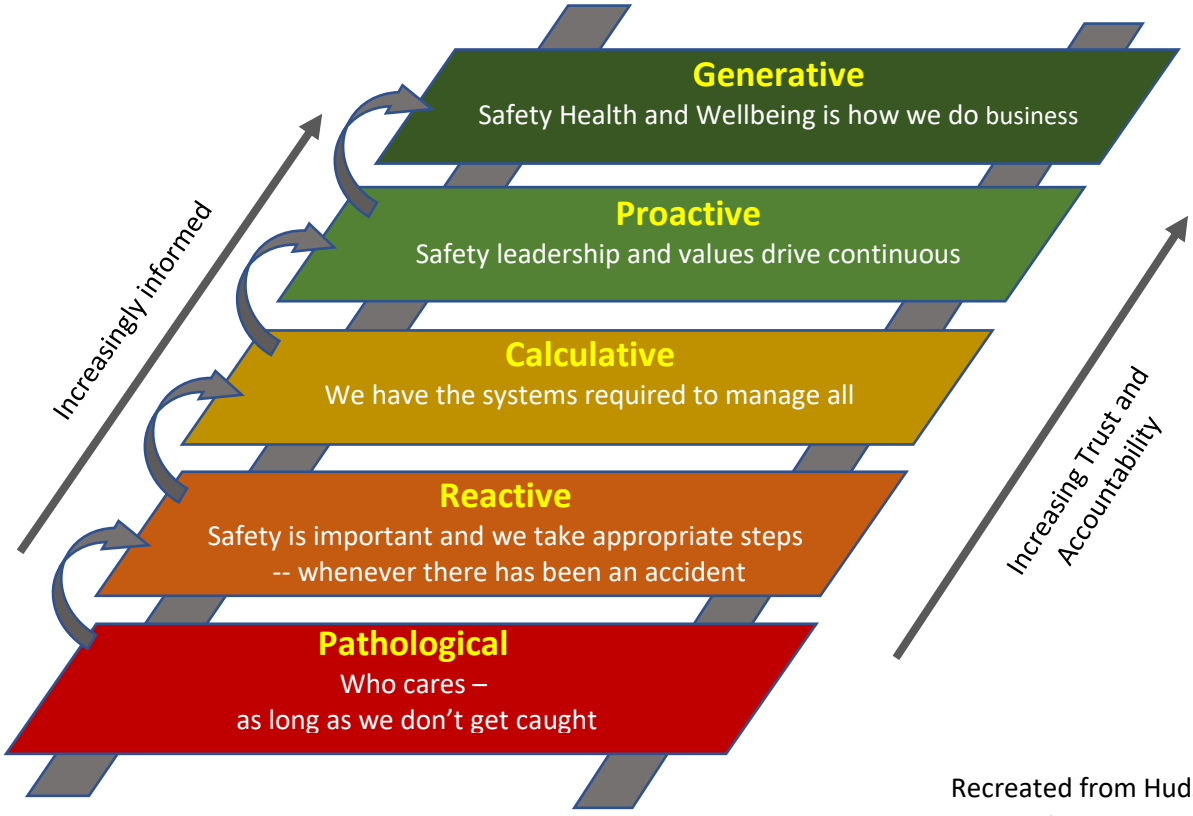
'Safety while we watch- What should a Patient Safety Culture in Anaesthesiology look like?'

Introduction

Ten percent of patients are harmed during hospital care, 50% of errors being preventable.[1] According to the report '*To Err is Human'* errors are often caused by *'faulty conditions leading people to make mistakes'* rather than by an individual's reckless behaviour or a weakness in established procedures.[2] Traditionally patient safety management has focused on processes with a view that safety incidents could be attributed to tangible failings in processes or individual behaviour. However, lessons learned from disasters in industry reveal that organisational culture has a more fundamental influence on safety incidents.[3]
Hudson's Safety Ladder clearly illustrates that it is the softer influences which determine where safety culture is on a spectrum from Pathological to Generative.



Recreated from Hudson's HSSE Safety Ladder

Every Anaesthesiology Department has a culture implying 'the way we do things around here'. It is the product of values, competencies, behavioural patterns that determine commitment to safety management.[4] Culture enables or supresses' behaviours, be they good or bad. Culture establishes what is acceptable regarding compliance with procedures and sets the bar for what is acceptable when no one is looking. Safety culture has a direct relationship

on patient outcomes which is the core objective in Anaesthesiology.[5] As illustrated below I would use five key attributes to describe what this culture should look like.

Shared Patient Centred Values

At the core of a strong generative patient safety culture are patient centred values, focused on respect for each patient as an individual, a person with a family. These values should not merely be espoused in glossy annual reports but lived daily within the clinical setting. For values to drive transformational safety culture they must be felt by everyone. Strong culture exists where these values underpin decisions and actions made by all Anaesthesiologists, even when not convenient, due to their conviction as to why patient safety is important to them. In a generative culture Anaesthesiologists choose to act as advocates for their patients. When sharing core patient values Anaesthesiologists would intuitively address behaviours and processes which may contribute to patient harm. It is important that the culture in the Department supports this behaviour.

Strong Safety Leadership:

Patient safety culture begins at the highest level of the Anaesthesiology Department with leadership that is authentic and inspires practises that are consistent with the Department's patient centred values.[6] This gives rise to a sequence of linkages whereby visible leadership on patient safety in turn encourages active engagement on patient safety initiatives and promotes acknowledgement of staff's contribution to patient safety. Ultimately safety culture is lead rather than managed and is the prevailing tone, set by Anaesthesiology Leadership that is followed- even when no one is looking. Where a tone of blame is perceived, dysfunctional behaviours evolve where safety incidents are hidden. In contrast where leaders recognising human error in incident reviews, it creates a psychologically safe environment, empowering staff to speak up with concerns on patient safety with a view to preventing reoccurrence.

Integral approach to Communication and Learning:

Development of a strong safety culture requires an integral approach to communication and learning within the Anaesthesiology Department.[7] Many of the competencies required (communication, listening, interpersonal skills, open disclosure, situational awareness, process appreciation, 'after incident' reflection) are not core to an individual's Anaesthesiology training. These require specific development and on the job reinforcement for the whole Anaesthesiology team. Integral to this is emphasis on organisational learning where safety incidents are treated as opportunities to learn and collaborate on improving processes. How lessons learned are openly communicated and good safety practices acknowledged create an environment where conversations are taking place about *"how things are done around here*". To ensure this organisational knowledge is passed to new staff it is important that existing staff are given the skills to articulate *why* patient safety is a core value, *how* past incidents contributed to the development of existing Anaesthesiology protocols and *what* is expected of new staff joining the Anaesthesiology team.

Trusted and Valued Staff:

The compassionate concern for patient's safety is inextricably linked to how staff members own welfare is valued and the importance placed on mutual respect and trust. For staff to deliver compassionate care they themselves need to experience a supportive work environment. Confidential fora, for staff to explore issues arising from work, such as Schwartz Rounds provide support to staff. They mitigate occupational burnout (due to stress, high workloads) leading to safer Anaesthesiologists.[8-9] and have positive impacts on staff and ultimately patient care.[10]

When mutual trust exists, staff can be confident that when safety near misses are reported the focus will be on lessons learned rather than rushing to attribute individual blame. An Anaesthesiologist should feel able to challenge colleagues, both peers and seniors, if he feels that safety is under threat but have the understanding that this practice is expected by the Anaesthesiology Department.

Feedback Loops from patients, staff and audit key performance indicators:

To close the loop, the final attribute of a strong safety culture is openness to regular review of lagging and leading indicators of patient safety. Audit of patient's outcomes, both good and bad, is a core feedback parameter that should merge with ongoing learning within the Anaesthesiology Department. Other leading indicators of staff engagement on patient culture are staff surveys of safety climate, good catch reporting and follow up analysis of the close out of safety issues raised.[11-12] Another important indicator is feedback from patients on their experience of care and safety whilst under Anaesthesiology care.

Conclusion:

The coat of arms of the College of Anaesthesiologists says *'Salus Dum Vigilamus'*-safety while we watch. Anaesthesiologists have a pivotal clinical role in ensuring patient safety but must also recognise the softer cultural features required so that patient safety prevails even when no one is looking. A strong safety culture cannot be left to chance. However changing

culture is a slow process- beginning with a shared vision for patient safety, led by senior Anaesthesiologists choosing to create an environment of good communication and learning, where staff feel valued, and where there is an openness to review and feedback.

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