

AORN Guidance Statement: Creating a Patient Safety Culture

Introduction

The purpose of this guidance statement is to assist managers and clinicians in developing policies and procedures related to creating a patient safety culture.

Since the Institute of Medicine (IOM) report released in 1999, the vast majority of patient safety initiatives have focused on micro issues, such as medication errors and wrong-site surgery, with little emphasis on the macro issue of culture. Edgar Schien, professor of management at the Sloan School of Management, Massachusetts Institute of Technology, defines *culture* as the set of shared, implicit assumptions that a group holds and that determines how it perceives, thinks about, and reacts to its various environments.¹ In broader terms, culture is a mindset centering on shared values, attitudes, or beliefs within an organization. As defined in the health care literature, a safety culture is an environment that encourages reporting,² ends blame,³ involves senior leadership,⁴ and focuses on systems.⁵

Lucian Leape, adjunct professor of health policy, Harvard School of Public Health, Harvard University, Boston, has stated the single greatest impediment to error prevention is that “we punish people for making mistakes.”⁶ Medical errors are grossly unreported across the country; only 2% to 3% of major errors are reported,⁶ and when reported, they don’t create stories or generate action.⁷ Analytical methods such as root cause analysis (RCA) and the failure mode and effects analysis (FMEA) will not work in detecting the causes or errors if health care workers are bound by a “code of silence,” fear of retribution, or are uncomfortable revealing imperfection in a process for which they are responsible.⁸

To date, most of the work in patient safety has been reactive. As the culture matures with increased information and trust, the emphasis will switch to a more proactive or generative approach.

Background

In review of the literature, few hospitals have assessed their organizations’ safety culture, nor have many actually measured the impact of interventions. One study, conducted in April 2001, reported that

15 California hospitals conducted a safety culture survey with two objectives: (1) measure attitudes toward patient safety and organizational culture; and (2) determine how the culture of safety varied among the hospitals and between the various types of health care workers.⁹ The majority of the participants in the study responded in ways that indicated a positive safety culture; however, senior leadership gave fewer problematic responses than frontline workers, and clinicians—in particular nurses—were more pessimistic.¹⁰

Johns Hopkins Hospital conducted a systematic assessment on safety and developed a strategic plan to improve safety.¹¹ Its study revealed a comparable culture of safety as compared to the airline industry, but identified several areas for improvement. Key messages identified were that senior leaders need to be more visible to frontline caregivers when addressing safety; safety planning must be proactive; physicians are less aware of safety initiatives than nurses; and physicians must actively participate in the education process.¹¹

Preamble

The intention of this guidance statement is to provide a framework from which perioperative teams can foster a patient-centric safety culture and assist with the development of policies and procedures that will support that culture. A patient-centric safety culture consists of five major subcultures: reporting, flexible, just, learning,⁵ and wary² (**Figure 1**).

Reporting Culture

A reporting culture is a culture in which all members of the perioperative team readily report errors and near misses. A reporting culture can be assessed by the types of errors reported by staff. As the safety culture matures, there is increased risk-taking associated with errors reported. In a true reporting culture, individuals report events to allow all staff in the organization to learn from the experience.

Suggested strategies⁵⁻⁷

- Focus on both actual events and near misses.
- Use FMEA proactively to anticipate and prevent potential error.
- Discuss close calls, “good catches,” and how