Patient safety: culture eats strategy for breakfast

'One morning recently, a professor conducted a ward round on an elderly medicine ward in a London teaching hospital. The entourage stopped at an 82-year-old man's bed. The elderly patient was confused and so, unfortunately, was the junior doctor who presented the case. The professor became very agitated and turned to the round saying: "I'm fed up dealing with these stupid patients!" Not knowing what to say, everyone on the round looked at their shoes, apart from a newly qualified nurse who challenged the professor as he was about to leave the ward, saying: "No-one speaks to a patient like that on my ward, professor". The professor stopped in his tracks, apologised to the nurse, saying he had had a row with his teenage children over breakfast and suggested that he and the nurse both apologise to the patient. That story got around the hospital in 15 minutes and around the entire region in 4 hours, and no-one sent an email!'

When I tell this story, audiences invariably consider that the young nurse was brave and, indeed, are not surprised that she was promoted soon afterwards to be the youngest sister on that ward. The uncomfortable reality was that she left nursing 18 months later as a consequence of criticism from her nursing colleagues who felt her behaviour had been inappropriate.

This story resonates with health-care audiences who intuitively recognize the ambivalence of the context. We are repeatedly told in the NHS that 'safest and best patient care is our priority'. We know that it is not. Why is there such a gap between what we say is important and what we do? The Colin-Thome (2009) Department of Health review of the lessons learnt from the Mid Staffordshire NHS Foundation Trust Inquiry states that: 'all clinicians must speak up for patients, when they witness poor quality care. It is our over-arching duty'.

So easily written and so infrequently done. It is so comfortable to offer guidance at a distance. However, there is nothing more immediate than the moment you are in. Inevitably, in that moment, unconsciously, we do not see things as they are, we see them as we are. It is effortless to preach and yet, our everyday reality, despite ourselves, is that culture eats good intentions for breakfast. Safety in theatres, on a ward round, in a multidisciplinary team meeting, happens in those moments, in the choices doctors, nurses and others make, in the courage they show and, more than any other thing, in their felt belief that they should do the right thing, particularly on a difficult day. But how can they do that if they do not believe that patient safety is truly the trust's number one priority? The NHS has a remarkable history, but how can it help patient safety if we do not learn from it?

And yet, the context of modern health care is that the distance medicine has travelled in 50 years is almost inconceivable for us who enjoy so much of the benefits today.

The importance of people and relationships

The lessons from the Mid Staffordshire Inquiry, as from all previous patient safety inquiries, centred on two critical issues: people and relationships. The soft stuff is the hard stuff. Staff felt disempowered – when they recognized wrongdoing, they did not feel able to intervene. They were poorly communicated with, they felt isolated and disconnected, there was inadequate leadership and inadequate systems and processes. People averted their gaze, were indecisive and there was a culture of fear.

There is little that is more difficult than to offer constructive criticism to colleagues. There is little more difficult than to tell the truth to power. Among the more common responses to sharing unpleasant or damning safety stories are: 'there are two sides to every story… and I'm not being defensive'; 'what happens in theatres stays in theatres'; 'I don't want to get anyone into trouble'; 'they are doing their best'; 'we don't have any choice…'.

Because of guilty knowledge at management level, the true nature of this culture is too often regarded as undiscussable and is therefore rarely addressed.

Despite all the guidance, publications, regulation and investigations, underpinned with a plethora of complex performance score cards, the practice of medicine remains, for all practical purposes, invisible. There is often a clear paradox of paper safe and performance weak. Morale and attitude are a consequence of the confidence staff have in the trust leadership. The real measure of patient safety is how safe the staff believe their hospital is. The things that are hardest to say are always the things worthwhile saying.

The evidence is overwhelming that to have a patient safe, high reliable organization, which has at its heart an open culture, that hospital should never be beyond criticism, should resist denial and have a low tolerance for fear. It should be resilient and reluctant to over-simplify root cause analysis, be sensitive to frontline worker knowledge and insights, and be quick to invite external expertise (Weick and Sutcliffe, 2001).

The simple yet priceless values of pity, tolerance and unselfishness underpin the attributes of compassion, caring, honesty, kindness and humility. How many more investigations do we need to know that the treatment of old people in the NHS is all too often unsafe and uncaring? This consistent finding has most recently been reported by the Care Quality Commission and some months ago also by the NHS Ombudsman and, before that, by the Patients Association, all consistent with the Mid Staffordshire Inquiry findings.

Only those who deliver care can change it and make it safe. We get the behaviours we train for. We get the behaviours we incentivize. Teams need leaders. The organization as a machine is an outmoded conceptual model. This metaphor leads to the creation of detailed blueprints for desired changes, invites unrealistic expectations of control, and creates anxiety, fear, blame and defensiveness when events inevitably do not proceed according to plan.

It is important that we understand that medicine's complexity has exceeded our individual capabilities as doctors (Halligan, 2011). Previously, professional education was characterized as 'fragmented' and 'concerned on developing individuals' *vs* emphasizing group precision and execution. System problem solutions such as checklists, ordinary and lowly as they appear, make a significant difference to patient safety (Haynes et al, 2009).

Combining checklist implementation with the acquisition of team working and leadership skills acts as a force multiplier to achieving an open and safe culture. Health care is dominated by the extreme, the unknown and the very improbable with high impact consequences, conditions that demand leadership and yet we spend our time focusing on what we know and what we can control. Educating staff on the use of After Action Review (a debriefing tool first used by the US Marines) enables team working and cues behaviours through allowing an emotional mastery of the moment and learning after doing (Darling and Parry, 2001; Leonard et al, 2004).

The combination of the checklist methodology with the debriefing skills acquired through using After Action Reviews offers a set of seemingly simple, low cost solutions that do not require legislation, regulation, management consultancy or interventions that alter economic incentives. Those 'penny dropping' insight moments impact on morale and energy and on the invisible architecture of everyday service delivery. This work needs to be complemented by developing capable, motivated clinical leaders who know what right looks like, especially on a difficult day, and who feel at ease with themselves (Halligan, 2010).

Conclusions

In a health service that is characterized by uncertainty, complexity, ambiguity and volatility, and where patient safety is gaining more and more prominence, there is a need to move from the concept of a hospital as a machine, which is now outmoded. Culture management is as critical to good results as performance management. People and relationships, attitudes and behaviours have as significant an impact on patient safety as robust and surgical techniques, information technology and pharmacological breakthroughs.

There is nothing more certain though that if we always do what we have always done, we will always get what we always got. BJHM

KEY POINTS

- All previous patient safety inquiries centred, in their conclusions, on two critical issues: people and relationships.
- Only those who deliver care can change it and make it safe.
- We get the behaviours we train for.
- Culture management is as results critical as performance management.

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