Culture of Safety

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This term was originally developed in industry after the Chernobyl atomic energy accident and it was later adapted to medicine. Culture is a collection of ideas and thoughts that members of an organization develop based on shared events and experiences. Creating a "Culture of Safety" in healthcare relies on leadership implementing practices which prioritize patient safety above other factors. When an organization has a strong "culture of safety" its members' default response is to preserve the safety of patients and other healthcare workers. Members of the organization feel comfortable speaking up about problems, and leaders listen and respond appropriately to these safety concerns.

Example:
Dr. Alexander asks medical assistant, Judy, to administer a Tetanus Diphtheria Pertussis Vaccine (Tdap) to her patient who is 28 weeks gestation. Judy obtains a blue vaccine vial from the corner of the drawer where Tdap is always stored. After drawing up the vaccine, and checking the vial, she realizes that the vial with the blue label reads "MedroxyPROGESTERone Acetate," not Tdap.

Response:
Judy goes back to the pyxis and realizes that all of the vials with blue labels are depo medroxyprogesterone. Central supply has changed the brand of Tdap vaccine and Tdap labels are now yellow. She wastes the depo and administers Tdap to the patient. Next, she tells her fellow MAs, her clinic manager, and the physician about the error. Judy realizes she made a mistake by not reading the vial before drawing it up, but she is not focused on the idea of being punished. She prioritizes the culture of safety over her own culpability. This demonstrates a Just Culture where workers understand that properly functioning systems are essential for organizations to succeed.

Leadership:
The clinic leadership complements her identification of the problem. She is recognized in the afternoon huddle as a valued member of the group for her swift pick up and for bringing the issues forward. Her supervisor thanks her for being proactive so another MA didn't make the same mistake.

Further Reading
Agency for Healthcare Research and Quality: Patient safety primer
https://psnet.ahrq.gov/primer/culture-safety

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Leading a culture of Safety – a Blueprint for Success
https://www.osha.gov/shpguidelines/docs/Leading_a_Culture_of_Safety-A_Blueprint_for_Success.pdf

White Paper: A framework for safe, reliable and Effective Care
http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Safe-Reliable-Effective-Care.aspx