

## Leadership: Role in Improving Safety

Leadership can influence culture, and leaders through fostering appropriate culture can address underlying system causes of errors.

- setting strategic goals
- align organisational processes to achieve goals
- provide resources
- remove obstacles to staff pursuing goals
- require adherence to good practice in provision of safe care

## IHI Map of Leadership → Safety

### Step One

#### 1) Establish Patient Safety as a Strategic Priority

- make the case
- ensure an agenda
- relevant data routinely discussed
- do safety items have follow-up action plan?
- talk to staff about safety issues
- schedule feedback on safety projects and disseminate

## IHI Map of Leadership → Safety

#### 2) Assess Organisation Culture (SCI discussion)

#### 3) Establish A Culture that Supports Patient Safety

- a 'just' culture to overcome inherent health system barriers (blaming, clinician autonomy, lack of teamwork, lack of transparency, poor communication)

## IHI Map of Leadership → Safety

#### 4) Address Organisation Infrastructure

- patient safety lead (high profile, support from CEO)
- central point for review of safety issues to identify patterns
- integrate improvement and safety expertise (?lean?)

## IHI Map of Leadership → Safety

#### 5) Learn about Patient Safety & Methods for Improvement.

A variety but useful to have some knowledge and experience

#### 6) Engage!!

- the Board
- Clinicians
- all staff
- patients and carers

## The Safety Culture Index (SCI®)

"The combination of complexity, professional fragmentation, and a tradition of individualism, enhanced by a well entrenched hierarchical authority structure and diffuse accountability, forms a daunting barrier to creating the habits and beliefs of common purpose, teamwork and individual accountability for successful interdependence that a safe culture requires."

Leape and Berwick (2005)

Shared perceptions of the importance of safety not only form the basis of safety culture- but promote the acceptance and implementation of interventions. i.e. positive motivation or disposition to adopt attitudes and select behaviours that enhance patient safety.

## Key Elements of Patient Safety Culture

**Leadership commitment to safety**  
**Organisational resources for patient safety**  
**Priority of safety versus production**  
**Effectiveness and openness of communication**  
**Openness about problems and errors**  
**Organisational learning**

Singer (2003)

**NHS has no unified single culture, nor is there a single "good" or "bad" culture, more components that contribute.**

Two distinct conceptions of culture (Davis et al 2000, Mannion et al 2010)

- As descriptive metaphor - a limited perspective for intervention
- As a set of variables - more scope to manage change

## Facets of Culture

**ACHIEVEMENT** - focus on tasks, goal-orientated, purpose & direction, problem-solving, role clarity

**PARTICIPATORY** – focus on people, open, supportive, based on teamwork & consensus, collective decision making

**TRANSACTIONAL** – focus on control, monitoring, accountability, rules, policies, standards

**TRANSFORMATIONAL** – focus on change, dynamic, creative, freedom to explore, innovative

*Each of these may be relatively "safe" or "unsafe" depending on task context*

## Culture – Levels and Implications



## Culture – Levels and Implications

Culture may be viewed and assessed at different levels (Individual/ Team/ Organisation) and different perspectives (staff groups).

SCI incorporates these in the sub-scales (see handout)

Aim now is to make use of cultural profiles as context to consider the most appropriate approach to implementing interventions to improve safety.

## Structure of the SCI<sup>®</sup> Matrix

The SCI Matrix has 3 DIMENSIONS:-

- Individual
- Team
- Organisational

The SCI Matrix has 2 DIMENSIONS:-

- Task & Teamwork
- Maintenance & Improvement

The SCI Matrix has 4 CONTEXTS:-

- Task Focus
- People Focus
- Control Focus
- Change Focus

The SCI Matrix has 12 SCALES:-

- a1) – a3)
- b1) – b3)
- c1) – c3)
- d1) – d3)

	TASK & TEAMWORK		MAINTENANCE & IMPROVEMENT	
	Task Focus Scale a1)	People Focus Scale b1)	Control Focus Scale c1)	Change Focus Scale d1)
<b>INDIVIDUAL</b> (Maintain Safety Competence)	Coping with work demands Scale a2)	Participation in decision-making Scale b2)	Checking & accountability Scale c2)	Commitment to learning Scale d2)
<b>TEAM</b> (Enhance Safety & Productivity)	Purpose & direction Scale a3)	Working in collaboration Scale b3)	Sharing information Scale c3)	Blame-free climate Scale d3)
<b>ORGANISATIONAL</b> (Provide Safety Leadership)	Role clarity	Staff motivation	Standards monitoring	Vision & mission

\* Please see handout for definition of each scale

## Structure of the SCI<sup>®</sup> Matrix

	TASK & TEAMWORK		MAINTENANCE & IMPROVEMENT	
	Task Focus Scale a1)	People Focus Scale b1)	Control Focus Scale c1)	Change Focus Scale d1)
<b>INDIVIDUAL</b> (Maintain Safety Competence)	Coping with work demands Scale a2)	Participation in decision-making Scale b2)	Checking & accountability Scale c2)	Commitment to learning Scale d2)
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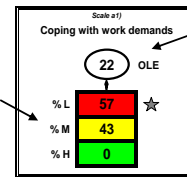
## SCI<sup>®</sup> Matrix – Correlates of 'Bad' Safety Culture

	TASK & TEAMWORK		MAINTENANCE & IMPROVEMENT	
	Task Focus	People Focus	Control Focus	Change Focus
<b>INDIVIDUAL</b> (Maintain Safety Competence)	Coping with work demands Scale a1) Getting things done takes precedence over safety concerns Routinely avoiding or failing to fully implement safety procedures Risky 'baiting of corners' due to work pressure and/or poor task planning	Participation in decision-making Scale b1) Little interest in discussing safety issues face-to-face with management Not keen to participate in decision-making or improving patient safety Reluctant to provide opinions or give input about safety issues	Checking & accountability Scale c1) Lack of knowledge/awareness about risks and hazards inherent in own job Insufficient attention to on-going monitoring of safety of work methods Not concerned to follow-up outcome of reported safety incidents	Commitment to learning Scale d1) Shallow reflection and learning from personal mistakes and errors Little or no effort to maintain/update safety knowledge and competence Individuals do not actively seek further guidance or training in needed areas
<b>TEAM</b> (Enhance Safety & Productivity)	Purpose & direction Scale a2) Low shared team purpose and little common understanding of team safety Inconsistent objectives challenge safety of joint working practices Staff provided with little or no clear information on relevant safety matters	Working in collaboration Scale b2) Limited explanation of work practices to look ways of improving team safety Low team engagement in making or supporting decisions about safety Group membership used as 'cover' to avoid taking personal responsibility	Sharing information Scale c2) Free informal safety discussions and poor attendance at safety briefings Unusually low levels of incident reporting rates from team members Relevant safety standards or updates not communicated or explained	Blame-free climate Scale d2) Lack of openness about discussing errors and disciplinary repercussions Fear of challenging others' risky decisions or unsafe work methods Faults are apportioned or insulated prior to any incident investigation
<b>ORGANISATIONAL</b> (Provide Safety Leadership)	Role clarity Scale a3) Staff roles and responsibilities for safety vague or not explicitly stated Safety training needs analysis not undertaken for all members of staff Leadership gives mixed messages re priority of safety over productivity	Staff motivation Scale b3) Inadequate provision for promoting accurate and timely hazard-spotting Organisational response to reported safety breaches is late or patchy Few incentives to empower staff to 'make a real difference' to safety	Standards monitoring Scale c3) Managers rarely undertake informal safety compliance tours in workplace The incident reporting procedure is too difficult or insecure to be useful Organisation safety performance not regularly reviewed at senior levels	Vision & mission Scale d3) Safety issues neither treated as high priority nor given sufficient attention Incidents and investigations are not used to shape effective interventions Failure to foster environment where safety issues can be openly discussed

## Example Results for One SCI<sup>®</sup> Scale

For each of the 12 SCI scales, the results matrix provides two sorts of summary score:

The percentage distribution of staff within the bottom (L), middle (M) and top (H) thirds of the SCI normative database for that particular scale. This provides a rapid means of examining both the levels and spread of safety culture perceptions. The star symbol indicates the particular normative band associated with the greatest proportion of staff



An Overall Level of Endorsement (OLE) of that scale by the staff group in question. This figure is based on the relative strengths of positive or negative scale endorsement and provides a single summary ranging from 0 to 100. As a rough guide OLE scores of more than 55 may indicate good safety practices whilst OLE scores of less than 45 may signal a need for improvement

## SCI<sup>®</sup> - Example of Matrix Results

Distribution of SCI<sup>®</sup> Scale Scores for Example Staff Group at Example Site (n = 24)

	TASK & TEAMWORK		MAINTENANCE & IMPROVEMENT	
	Task Focus	People Focus	Control Focus	Change Focus
<b>INDIVIDUAL</b> (Maintain Safety Competence)	22 OLE % L 57 ★ % M 43 % H 0	24 OLE % L 64 ★ % M 24 % H 12	67 OLE % L 17 % M 33 % H 50 ★	34 OLE % L 50 ★ % M 33 % H 17
<b>TEAM</b> (Enhance Safety & Productivity)	50 OLE % L 25 % M 50 ★ % H 25	45 OLE % L 33 % M 50 ★ % H 17	56 OLE % L 33 % M 32 % H 35 ★	56 OLE % L 17 % M 53 ★ % H 30
<b>ORGANISATIONAL</b> (Provide Safety Leadership)	56 OLE % L 13 % M 63 ★ % H 25	49 OLE % L 31 % M 41 ★ % H 28	70 OLE % L 25 % M 20 % H 55 ★	50 OLE % L 25 % M 49 ★ % H 26

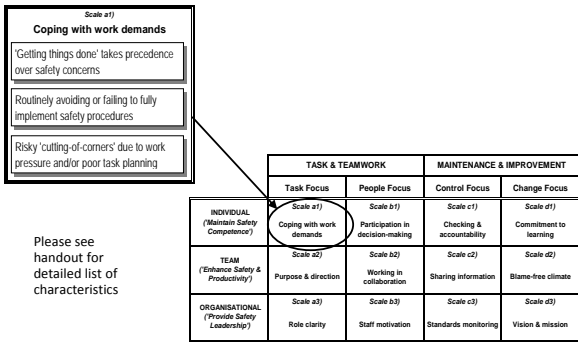
% L, % M, % H = Percentage of staff who fall within Low, Middle and High normative thirds.  
★ = Normative Band with largest percentage of staff  
OLE = Overall Level of Endorsement (1 - 100)

## SCI<sup>®</sup> Matrix Results – Example of OLE Bands

	TASK & TEAMWORK		MAINTENANCE & IMPROVEMENT	
	Task Focus	People Focus	Control Focus	Change Focus
<b>INDIVIDUAL</b> (Maintain Safety Competence)	● Scale a1) Coping with work demands	● Scale b1) Participation in decision-making	● Scale c1) Checking & accountability	● Scale d1) Commitment to learning
<b>TEAM</b> (Enhance Safety & Productivity)	● Scale a2) Purpose & direction	● Scale b2) Working in collaboration	● Scale c2) Sharing information	● Scale d2) Blame-free climate
<b>ORGANISATIONAL</b> (Provide Safety Leadership)	● Scale a3) Role clarity	● Scale b3) Staff motivation	● Scale c3) Standards monitoring	● Scale d3) Vision & mission

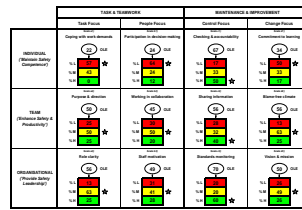
KEY: ● OLE score Under 45 = Possible need for improvement  
● OLE score Between 45 - 55 = May need to be monitored  
● OLE score Over 55 = Suggested safe working practices

### SCI® Matrix – Correlates of ‘Bad’ Safety Culture



### Steps in Interpreting the SCI® Results Matrix

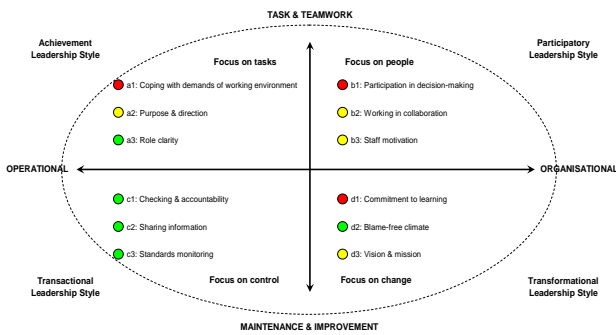
Distribution of SCI® Scale Scores for Example Staff Group at Example Site p.16



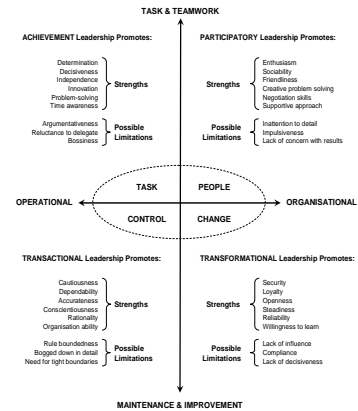
For each staff group in your results:

- STEP 1: Identify **SCALES** associated with positive or negative perceptions of safety culture
- STEP 2: Identify **LEVELS** associated with positive or negative perceptions of safety culture
- STEP 3: Identify **CONTEXTS** associated with positive or negative perceptions of safety culture
- STEP 4: Identify **DIMENSIONS** associated with positive or negative perceptions of safety culture

### SCI® - Associated Leadership Styles



### SCI® - Leadership Issues



### References:

- Botwinick, L., Bisognano, M. & Haraden, C. (2006) Leadership Guide to Patient Safety: Institute for Healthcare Improvement, Cambridge MA
- Flin, R., Burns, C., Mearns, K., Yule, S. & Robertson, E.M. (2006) Measuring safety climate in healthcare. Quality & Safety in Healthcare 15: p.109-115
- Leonard, M. & Frankel, A. (2012) How can you ensure everyone plays it safe? Health Services Journal, p.26-27 Oct
- Spurgeon, P., Clark, J. & Ham, C. (2011) Medical Leadership: From the dark side to centre stage. Oxford Radcliffe Press, Oxford

### • Questions

