The effect of organisational culture on patient safety


Abstract
This article explores the links between organisational culture and patient safety. The key elements associated with a safety culture, most notably effective leadership, good teamwork, a culture of learning and fairness, and fostering patient-centred care, are discussed. The broader aspects of a systems approach to promoting quality and safety, with specific reference to clinical governance, human factors, and ergonomics principles and methods, are also briefly explored, particularly in light of the report of the public inquiry into care failings at Mid Staffordshire NHS Foundation Trust.

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Aims and intended learning outcomes
This article aims to address the effect of organisational culture on patient safety. It draws specifically on examples from the findings of two influential reports: the account of the Bristol Royal Infirmary inquiry (Kennedy 2001) (Box 1) and the independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust (Francis 2010) (Box 2). After reading this article and completing the time out activities you should be able to:

- Describe the key attributes of organisational culture.
- Identify the key components of a safety culture.
- Discuss the effect of leadership, teamwork and an open and fair culture on patient safety.
- Identify the framework used in the NHS to promote quality and safety, and the potential contribution of human factors, and ergonomics principles and methods.

Introduction
Florence Nightingale noted in 1863 that the first requirement of a hospital is to do the sick no harm (Vincent 2010). Today, the issue of patient safety remains paramount, and is considered one of the most important challenges facing health care (Department of Health (DH) 2010). There is wide acceptance that the quality of healthcare provision, in terms of reducing unnecessary patient harm, needs to be improved significantly (Milligan and Dennis 2005). Factors such as managing uncertainty and risk and preventing adverse events are central to the delivery of safe care. However, much emphasis is also placed on the importance of cultural transformation.
in improving quality and safety (Konteh et al 2008). Several key reports over recent years (DH 2000, Kennedy 2001, Francis 2010, 2013) make reference to the need for the culture of health care in the NHS to develop and change. Complete time out activity 1

**Culture**

The concept of culture is multi-layered and complex. It was originally an anthropological term but, more recently, it has been used in organisational studies. Evidence of the complexity of the concept is highlighted by Konteh et al (2010), who refer to many definitions of culture in the literature. From an anthropological perspective, the term is generally used to refer to the customs and rituals that societies develop over the course of history. However, the term can also be used to indicate literary, artistic heritage and sophistication, for example describing someone as being ‘very cultured’ (Schein 2004).

The notion of culture associated with organisations came to popular attention in the 1980s. During this period, management experts were influential in instilling the notion that organisational culture was important in the management of organisational performance (Schein 2004). Over the past two decades, interest in organisational culture has grown significantly and has been studied extensively in many settings, including health care (Davies et al 2000). Complete time out activity 2

**Organisation and organisational culture**

The term organisation refers to a collection of people working together to achieve a common goal (Sullivan and Decker 1992). The term can be applied to a large and complex organisation such as the NHS, as well as to a hospital, ward, department or team of professionals.

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**BOX 1**

**Account of the Bristol Royal Infirmary inquiry**

In the late 1980s, some clinical staff at the Bristol Royal Infirmary began to raise concerns about the quality of paediatric cardiac surgery delivered by two general cardiac surgeons, suggesting that mortality rates were substantially higher than those in other comparable units. Between 1989 and 1994, there was considerable conflict and disagreement between cardiologists, anaesthetists, surgeons and managers about the high mortality rates. Eventually, agreement was reached that a paediatric cardiac surgeon should be appointed and that in the meantime, certain procedures should not be undertaken. However, in January 1995 and before the paediatric surgeon was appointed, a young boy died following surgery that had been undertaken against the advice of anaesthetists, some surgeons and the Department of Health. This led to an inquiry being commissioned, which was led by Ian Kennedy. The inquiry began in October 1998 and the report published in July 2001 contained almost 200 recommendations. It is important to be clear that this is not an account of healthcare professionals who did not care nor who wilfully harmed patients. Although dedicated and well motivated, some staff lacked insight and their professional behaviour was flawed. Consequently, there were failures in the care provided to unwell children. The findings from the report into events at Bristol Royal Infirmary provide insight into the ways in which quality and safety was compromised and how culture had a role in the harm caused to young patients.

(Adapted from Vincent 2010)

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**BOX 2**

**Account of the independent inquiry into care provided at Mid Staffordshire NHS Foundation Trust**

Concerns about mortality and standards of care provided at the Mid Staffordshire NHS Foundation Trust resulted in an investigation by the Healthcare Commission, which published a report in March 2009 (Healthcare Commission 2009). This was followed by two reviews commissioned by the Department of Health (Alberti 2009, Thomé 2009). These investigations gave rise to widespread public concern and a loss of confidence in the trust, its services and management. The independent inquiry, chaired by Robert Francis (2010) was set up primarily to give those most affected by poor care an opportunity to tell their stories and ensure that lessons would be learned. The review period was from January 2005 to March 2009. The inquiry concluded that patients were routinely neglected as a result of staff shortages and the trust had lost sight of its fundamental responsibility to provide safe care (Francis 2010). The organisation was preoccupied with cost cutting and targets. Indifference to patient need had become the norm, general professional behaviour was sadly lacking and a culture of fear was evident (Reid and Catchpole 2011). The report highlights the role of organisational culture in poor standards of care (Francis 2010).
who come together to provide health services. Organisational culture is a complex mixture of different elements that influence the way things are done, as well as the way things are understood, judged and valued. Culture is associated with more concrete elements such as the symbols, rituals, and language peculiar to an organisation. In addition, culture is associated with attitudes, values, beliefs and norms of behaviour (Schein 2004). Taken together, the different aspects of culture provide a lens through which an organisation can be understood and interpreted (Konteh et al 2008).

There are two major ways that culture has been studied in organisations: as a variable and as a root metaphor (Smircich 1983). Culture as a root metaphor is regarded as something an organisation is. Culture is seen as something that is not readily identifiable or separate from the organisation. This notion of culture as something an organisation is may help in understanding the processes of social construction at work, but ‘it offers less in terms of shaping change or assisting with management control’ (Davies et al 2000).

Another school of thought takes the view that culture is a variable (Smircich 1983), something an organisation has, where cultural attributes can be isolated, described and manipulated. Research on organisational culture may take one of these approaches or a combination of both.

This article supports the view that culture is something an organisation has (culture as a variable). The recommendations relating to the need for a change in culture in the recently published report of the Mid Staffordshire NHS Foundation Trust public inquiry (Francis 2013) also embody this view.

Symbols
Cultural symbols describe words or objects that convey meaning to individuals and groups in an organisation (Hannigan 1995). In the NHS, cultural symbols include, for example, the NHS logo, uniforms worn by different professional groups, and hospital buildings and equipment. Cultural symbols such as buildings and equipment can have an effect on quality and safety. This is highlighted by Kennedy (2001) in the report of the inquiry into children’s heart surgery at the Bristol Royal Infirmary. The dilapidated state of buildings and equipment was identified as one of the factors that compromised safe care for young patients. However, it should be noted that patient safety problems are complex and rarely caused by a single factor.

Safety is a systems issue and paying attention to the healthcare environment overall, including buildings and equipment, is necessary to enhance patient safety. The importance of integrating human factors, and ergonomics principles and methods in these efforts has been highlighted (Gurses et al 2011). Human factors and ergonomics specialists study the interactions between people and aspects of the systems within which they work, including the physical environment, tasks, tools, technologies and organisational conditions, and redesign systems while systematically considering these interactions. Researchers and patient safety experts recommend the use of human factors principles, theories, tools and methods to improve patient safety, and there is evidence that positive results can be achieved by their application in the healthcare setting (Gurses et al 2011).

Rituals
Ward rounds, patient handovers, record-keeping and drug administration rounds are examples of rituals or what Hannigan (1995) refers to as repeated sequences of activities that express the key values and goals of the organisation. The rituals that healthcare professionals engage in are important for quality and safety. For example, good record-keeping and appropriate handovers are essential to ensure that information about patients is shared from shift to shift, and between different clinical teams and departments (Francis 2010). The independent inquiry into care provided at Mid Staffordshire NHS Foundation Trust (Francis 2010) highlighted that record-keeping and handover were not carried out appropriately on many occasions, resulting in poor standards of care.

Attitudes, values and behaviours
While the more tangible aspects of organisational culture are significant in relation to quality and safety, the invisible and unconscious aspects of culture (Schein 2004) such as attitudes, values and behaviours are equally important. Values are integral to culture (Manley 2000), and underlie and influence attitudes and behaviours. Values are shaped and accepted by members of the organisation and passed on to new recruits (Manley 2000). Values determine what people think ought to be done, and influence the standards and goals of the organisation (Manley 2000).
Values incorporate moral and ethical codes, ideologies and philosophies (Konteh et al 2010). While these cultural elements may be invisible and unconscious, the forces and situations that derive from them can be positive, in that they can promote high standards of care, and negative, in that they can result in poor standards of care (Schein 2004). This is illustrated in findings from the independent inquiry into care provided at Mid Staffordshire NHS Foundation Trust (Francis 2010). General behaviour and attitudes, accepted ways of doing things, and the values adopted or accepted by staff in different care environments resulted in significant differences in the care received by patients. In some care environments, patients endured unnecessary suffering and humiliation, while in other wards, patients were placed at the centre of care and treated with compassion.

‘Patients in their journey through the healthcare system are entitled to be treated with respect and honesty and to be involved, wherever possible, in decisions about their care’ (Kennedy 2001). This statement reflects the concept of patient-centred care, which involves working in partnership with patients and is increasingly considered a means of delivering high-quality, appropriate and cost-effective health care (Pollock 2005). Patient-centred care is characterised by open communication, in which patients are encouraged to express their views and share decision making with practitioners. The inquiries undertaken by Kennedy (2001) and Francis (2010) highlighted both poor standards of communication and a lack of involvement of patients in decision making. Such deficiencies were detrimental to the wellbeing of patients and carers.

The National Institute for Health and Clinical Excellence (2012) published a new quality standard and guidance on patient experience in adult NHS services that provides ‘the evidence and the direction for creating sustainable change that will result in an NHS cultural shift towards a truly patient-centred service’. The guidance is comprehensive and points out that patients should be able to access care that is clinically effective and safe, and be treated with compassion, dignity and respect. In addition, patients should be given the opportunity to discuss their health beliefs, concerns and preferences, and be made aware that they have the right to accept or decline treatment and that their decisions will be respected and supported.

According to Sammer et al (2010), if culture is one of the media through which safe and high quality care can be attained, it is essential to define the term safety culture. Vincent (2010) defined the safety culture of an organisation as ‘the product of the individual and group values, attitudes, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organisation’s health and safety programmes. Organisations with a positive culture are characterised by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.’

Essentially, patient safety involves avoiding and preventing adverse outcomes or injuries that arise from the delivery of health care (Vincent 2010). Key components of a safety culture include leadership, communication and teamwork, and a learning and just culture (Sammer et al 2010, Halligan and Zecevic 2011).

Leadership, communication and teamwork

Effective leadership in a clinical setting is associated with improved quality and safety (Phillips 2010). With much attention directed towards creating healthier and safer practice environments, nursing leadership is called on to advance this agenda (Wong and Cummings 2007). Handy (1993) suggested that a leader is someone who is able to develop and communicate a vision that gives meaning to the work of others. Applying Handy’s (1993) definition to the clinical setting, a nurse leader is someone who can develop and communicate an ethical and compassionate vision of patient-centred care and inspire colleagues to emulate that vision. This involves role modelling the behaviours nurse leaders expect to see, setting standards for team performance and promptly addressing any lapses in patient care.

Leaders cannot be seen to cut corners or turn a blind eye to poor practice as this sets the pattern of behaviour for the whole team (White 2012). Inspiring colleagues to align themselves with a vision that brings meaning to their work involves helping them to develop their own leadership potential. This can be achieved through coaching and mentoring, and fostering mutual respect. Releasing the potential for all staff members to become leaders ‘based on ability and function in the context, rather than some title or professional qualification’ (Kennedy 2001) aligns with Handy’s (1993) view that leadership is too important to be left only to those at the top.
Learning zone patient safety

of organisations. Leadership is needed at all levels and in all situations (Handy 1993).

The leadership qualities referred to above are those of a transformational leader (Phillips 2010). There is evidence to support a positive relationship between transformational nurse leadership and patient safety in terms of reduced adverse events and complications (Wong and Cummings 2007). The differences in standards of care provided at Mid Staffordshire NHS Foundation Trust may be linked to leadership and explain in part why in some wards staff were committed to providing good care, whereas in others poor professional behaviour and indifference to patient need was identified (Francis 2010). In one of the wards where culture was deemed to be positive, reference is made to the transforming qualities of the nurse leader, including being visible, approachable and getting on well with staff (Francis 2010). According to Bass and Riggio (2006) transformational leadership is relevant to different settings and organisations.

Early research demonstrated that transformational leadership was a powerful source in military settings, but it has also been shown to relate positively to performance in private sector companies, government, education and non-profit organisations (Bass and Riggio 2006). The success of transformational leadership has been noted in North American and Russian companies, as well as companies in Korea and New Zealand (Bass and Riggio 2006). Furthermore, this type of leadership can result in culture change within an organisation, and transformational organisational cultures are more likely to bring about quality improvements (Bass and Riggio 2006).

Complete time out activity

Effective teamwork is considered the basis of good patient care (Reid and Bromley 2012). Teams, like individuals, can erode or create safety and a team that is not working well increases the possibility for error (Vincent 2010). In contrast, a team when working well has the potential to be safer than any one individual (Vincent 2010). It is important to be mindful that patients do not belong to any one professional and are the responsibility of all who take care of them. Consequently, teamwork involves the collective and collaborative effort of everyone involved in the care of patients (Kennedy 2001). Teamwork implies a multiprofessional approach and a sharing of responsibility. This is especially important since healthcare organisations are increasingly using more complex treatments and technologies, and treating patients with complex comorbidities (Sammer et al 2010).

According to Kennedy (2001), a significant cultural weakness in healthcare organisations and a powerful force that militates against teamwork is the sense of hierarchy that can exist in and between professional groups such as doctors, nurses and managers. This is something that is universally recognised, but rarely acknowledged (Reid and Bromley 2012). The report of the inquiry into children’s heart surgery at the Bristol Royal Infirmary (Kennedy 2001) highlighted how poor teamwork and poor relationships between professional groups compromised the care of young patients. The teams were not cross-specialty or multidisciplinary, they were not organised around the care of the patient and they were extremely hierarchical.

Kennedy (2001) recommended creating an environment of mutual understanding among professionals rather than attempts by one group to gain dominance over others. If one group dominates in a service that calls on the skills of many groups, the interests of patients will not be served (Kennedy 2001).

A learning and just culture

Woodward (2010) describes a ‘learning and just culture’ as an environment in which staff can speak out if they have concerns and are supported when they do so. The report following the inquiry into children’s heart surgery at the Bristol Royal Infirmary pointed out that the systems and culture made open discussion and review more difficult (Kennedy 2001). Staff were not encouraged to raise concerns or speak openly, and those who tried to speak out about standards of care found it difficult to get their concerns heard.

One of the most important elements in enhancing patient safety is the emphasis on a cultural shift away from blaming individual practitioners when things go wrong (Milligan and Dennis 2005) and recognising errors as systems failures rather than individual failures (Kennedy 2001). A shift away from a culture of blame does not condone reckless or malicious practice, but creates an environment where there can be open discussion about the things that go wrong and when, how, and in what context they occurred (Milligan and Dennis 2005). As Kennedy (2001) suggested: ‘Without knowing, there can be no learning. Without learning, there can only be risk that it will happen again.’
A shift towards an open and fair culture will encourage practitioners to report patient safety incidents, which in turn provide more opportunities for enhanced learning and improvements in service delivery. This cultural shift is already happening, but it is widely accepted that practitioners will need to change their work habits so that incident reporting becomes a priority (Milligan and Dennis 2005). In recent years, there has been much emphasis on whistleblowing, which the Care Quality Commission (2012) defines as raising a concern about a dangerous, illegal, or improper activity that employees become aware of through work.

A reluctance to whistleblowing is linked to what Kennedy (2001) refers to as a ‘code of silence’, which is an aspect of professional culture that causes individuals to close ranks and keep problems hidden within the group. Fear of reprisals that might affect career prospects and even livelihood are deterrents to whistleblowing. In cultures where fear of retribution and reprisal for speaking out are the norm, poor practice and breaches of safety practice will be common (Reid and Catchpole 2011). From a nursing perspective, the Nursing and Midwifery Council (NMC) (2010) makes it clear that nurses and midwives have a professional duty to put the interests of people in their care first and to act to protect them if they are deemed to be at risk.

The NMC (2010) provides guidance for nurses and midwives on the processes that should be followed when raising a concern. The NMC also provides information about the legislation relating to whistleblowing, and indicates where nurses and midwives can access support and advice. As part of a series of measures intended to highlight the importance of whistleblowing in the NHS, the NHS Constitution (DH 2012) has recently been updated to include expectations around whistleblowing. The constitution makes it clear that if an employee has a concern, it should be raised at the earliest opportunity. There is an expectation that NHS organisations will support staff by ensuring their concerns are investigated fully and that there is someone independent, outside of their team, to speak to. Finally, there should be clarity about the existing legal right of staff to raise concerns about safety, malpractice or other wrongdoing without reprisals (DH 2012).

**Clinical governance**

According to Vincent (2010), ‘understanding how to make health care safer is hard and actually making care safer is harder still’.

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**References**


Most clinical staff have always been safety-conscious in their practice. Patient safety, however, is a broader endeavour that requires thinking beyond the individual patient to consider the characteristics of the whole system of health care (Vincent 2010). Clinical governance (DH 1998), which was introduced into the NHS in 1999, takes a systems approach to improving quality and safety, and holds NHS organisations accountable for continuously improving standards of care. All healthcare organisations have a statutory duty to seek quality assurance (Scally and Donaldson 1998) by addressing the key components of clinical governance, including quality improvement and maintenance, professional and organisational accountability, and culture and safety (McSherry and Pearce 2002).

The clinical governance framework recognises the importance of culture in promoting quality and safety, and creating environments in which excellence in clinical care will flourish. A survey conducted by Konteh et al (2008) indicated that clinical governance managers increasingly view quality and safety improvement in cultural terms, and view culture management and transformation as key aspects of their clinical governance responsibilities. However, the survey also revealed that culture is difficult to change and there were aspects of the prevailing cultures that served as barriers to quality improvement. The survey reported that a significant number of NHS organisations had a considerable way to go before any meaningful culture change could be realised. The report of the Mid Staffordshire NHS Foundation Trust public inquiry (Francis 2013), which followed on from the report of the independent inquiry (Francis 2010), referred to throughout this article, calls for a fundamental culture change in the NHS and makes several recommendations to enhance the quality and safety of patient care.

Conclusion

Placing the safety of patients at the centre of healthcare delivery is considered one of the greatest challenges facing health care today. It is recognised that patient safety is complicated and requires a systems approach to improving quality and safety.

The clinical governance framework used in the NHS is an example of a systems approach that holds organisations accountable for continuously improving standards of care. The safety culture of the healthcare environment has an important contribution to make to the quality and safety of patient care. Key elements of a safety culture include effective leadership and teamwork, learning lessons from failure and creating an environment of trust. Finally, there is a suggestion that health care needs to address human factors, and ergonomics principles and methods to make further progress in improving patient safety.

References


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