Developing a safety culture: The unintended consequence of a 'one size fits all' policy

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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that this thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition I certify that, all information sources and literature used are indicated in the thesis.

Signature of Candidate

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PEER REVIEWED PUBLICATIONS AND CONFERENCE PRESENTATIONS FROM THIS RESEARCH

A number of conference presentations and a peer-reviewed publication have resulted from this research.

Peer reviewed publication

Allen S, Homer C, and Chiarella M. (2008). Understanding the safety culture in Australian maternity services: Abstract International Forum on Quality and Safety in Health Care April 2008, Paris, France. *Safety and Quality in Health Care*, 17, E1.

Conference Presentations

Allen S, Homer C, Understanding safety culture in maternity services, a window to improving safety in maternity care. *Change Champions Improving the Delivery of Maternity Care: Sharing the Lessons Learnt,* Perth, February 2009.

Allen S, Homer C, Chiarella M. Understanding the safety culture in Australian maternity services. *International Forum on Quality and Safety in Health Care*, Paris, April 2008.

Allen S, Homer C. Understanding the safety culture in an Australian maternity service. *International Confederation of Midwives*, Glasgow, June 2008.

Allen S, Homer C. Understanding the safety culture in a maternity service. *15th Biennial Conference Australian College of Midwives*, Canberra, September 2007.

Allen S, Homer C, Chiarella M. Understanding the safety culture of a maternity service. *5th Australasian Conference on Safety and Quality in Health Care,* Brisbane 2006. (Poster)

ACRONYMS AND GLOSSARY

Acronyms

ACSQHC	Australian Council for Safety and Quality in Health Care
AHMC	Australian Health Ministers Conference
AHS	Area Health Service
AIHW	Australian Institute of Health and Welfare
CEC	NSW Clinical Excellence Commission
DoH	NSW Department of Health
ICE	Institute of Clinical Excellence
IIMS	Incident Information Management System
NSW	New South Wales
PSCQP	Patient Safety and Clinical Quality Program
RCA	Root Cause Analysis
RIB	Reportable Incident Brief
SAC	Severity Assessment Code
SAQ	Safety Attitudes Questionnaire
SCS	Safety Climate Scale
SIP	Safety Improvement Program
UK	United Kingdom
USA	United States of America
UTS	University of Technology Sydney
VMO	Visiting Medical Officer

Glossary of terms and definitions

For the purpose of this thesis the following terms and definitions apply:

Access block	Access block relates to overcrowding in emergency departments and where the length of stay of an admitted hospital patient in the emergency department is greater than eight hours (ACEM, 2004).
Adverse events	'An injury resulting from a medical intervention not due to the underlying condition of the patient' (Kohn, Corrigan, & Donaldson, 2001p.4).
Antenatal period	The period before giving birth.

Area Health Service	Corporations with a role in the provision of the planning, delivery and coordination of NSW public health services within their geographical service boundaries. These services are provided in the acute and community settings. Area Health Services are accountable to the NSW Department of Health.
Blame	**'**To hold at fault' (Runciman, 2006, p. S42).
Closing the loop	Processes by which institutions and individuals learn from mistakes and take action to prevent similar events in the future (Department of Health UK, 2000a).
Error	'Unintentionally being wrong in conduct or judgement. Errors may occur by doing the wrong thing (Commission) or by failing to do the right thing (omission)' (Runciman, 2006, p. S42).
Iatrogenic injury	Injury **'**arising from or associated with health care rather than an underlying disease or injury' (Runciman, 2006, p. S42).
Near miss	'Incidents which have the potential to result in harm but have not caused actual harm' (NSW Health, 2006c).
Patient Safety	'Is the avoidance, prevention and amelioration of adverse outcomes or injury from the process of heath care' (Vincent, Taylor-Adams, & Stanhope, 1998).
Quality	The degree to which health services increase the likelihood of desired outcomes and are consistent with the current professional knowledge (IOM, 2001).
Role Delineation	The classification used for NSW public hospitals to determine the level of staff experience profile, support services and minimum safety standards required for these services. The delineation also identifies the level of clinical complexity and acuity of services undertaken at each service (NSW Health, 2002).

Safety	'Freedom from hazard' (Runciman, 2006, p. S42).
Safety culture	**'**A product of individual and group values, attitudes, perceptions, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of an organisation's health and safety management' (Sexton, Helmreich et al., 2006).
Safety culture domain	The domains or dimensions that are considered to be an important influence on patient safety culture.
Sentinel Event	Events in which death or serious harm to a patient has occurred (ACSQHC, 2005d).

ABSTRACT

Developing a safety culture: The unintended consequence of a 'one size fits all' policy.

Background

Adverse events in maternity care are relatively common but often avoidable. Evidence suggests it is necessary to understand the safety culture of an organisation to make improvements to patient safety. The safety domains that are thought to influence safety culture in health care include: Safety Climate; Teamwork; Working Conditions; Perceptions of Management; Job Satisfaction; and Stress Recognition. Little is known about the safety culture in the Australian maternity setting, which was the impetus for this Study. This thesis reports an examination of the safety culture in a maternity service in New South Wales (NSW).

Setting

The Study took place in one maternity service located in two public hospitals in NSW, Australia. Concurrently, both hospitals were undergoing an organisational restructure.

Design

This mixed method research study used a concurrent triangulation design and included two Studies. The Policy Study explored the policy context in which the maternity service was situated; and, the Service Study examined the safety culture within the maternity service.

Data collection included:

- A policy audit and chronological mapping of the key policies influencing safety culture within the maternity service.
- Safety culture surveys, the Safety Attitudes Questionnaire and Safety Climate Scale (59/210, 28% response rate) that measured the following six safety culture domains; Safety climate; Teamwork climate; Job Satisfaction; Perceptions of management; Stress recognition and Working conditions (Sexton et al., 2004).
- Semi-structured interviews (15) with key maternity, clinical governance and policy stakeholders.

Results

The safety culture was found to be lacking across all six safety domains. The key finding was that the overarching policy context created unintended consequences for the maternity service and adversely influenced their capacity to have a positive safety culture. These unintended consequences reduced their available infrastructure and capacity to respond to adverse events;

and created a lack of leadership at all levels to drive the safety and quality agenda. The safety culture was also influenced by inadequate communication during the escalation of care; inadequate supervision of junior medical staff; difficulty ensuring the right staffing and skill mix, and low staff morale.

Conclusion

The safety culture in this maternity setting was complex, context-specific but importantly, influenced by the broader policy context in which it was situated. This Study provides evidence that the policy context needs to be included as a seventh safety culture domain in health care. This Study has demonstrated the importance of policy on the capacity to ensure patient safety.

Implications

The policy context has not been previously identified as being important when addressing the safety culture in health care. Considering the influence of the policy context in relation to safety culture is an important step to develop strategies to improve patient safety in other settings. This is an area for future research.