Understanding safety culture - A window to improving maternity care

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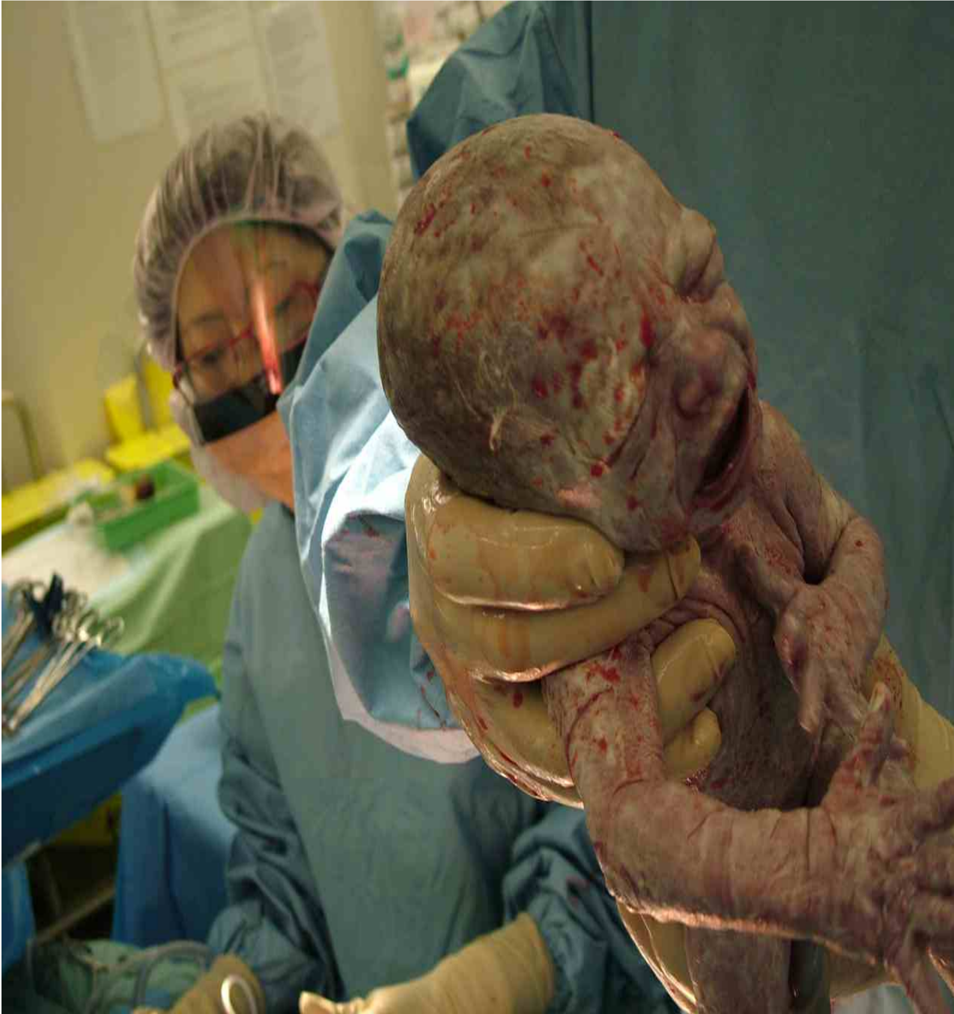
Overview of presentation

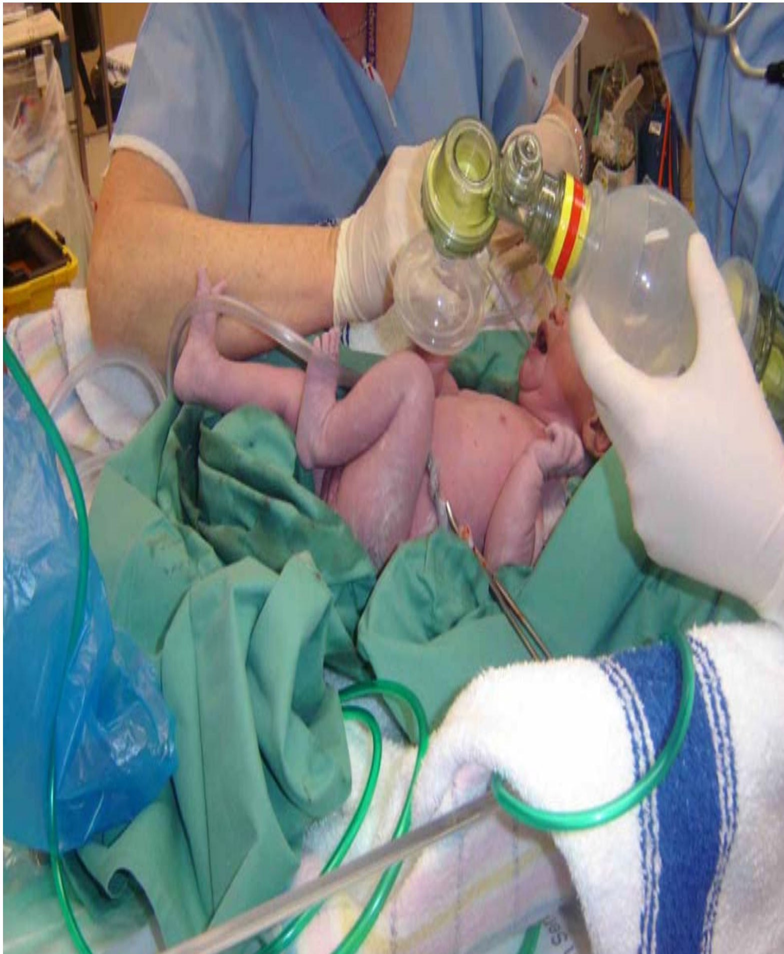
- Discuss a study examining the safety culture in a NSW maternity service
- Background
- Results
- Lessons

Adverse events in maternity care



- Common and often avoidable
- Causes
  - Multiple factors
  - Communication problems
  - Complexity and fragmentation

Understanding safety culture



- Improving safety culture is a key strategy to reduce adverse events
- Need to understand the safety culture in order to improve it
- Little is known about safety culture in Australian maternity care

What is safety culture?

- The complex framework of national, organisational and professional attitudes and values within which groups and individuals function that influence the safety of an organisation.
- Includes six safety culture domains which influence patient safety.

(Helmreich & Merrit, 2001; Sexton, et al, 2003)

Safety culture domains

Safety culture domains	System, organisational, individual factors
1. Safety climate	Incident management, reporting, acknowledgement, feedback, leadership commitment to patient safety
2. Teamwork	Teamwork, collaboration, communication, trust, role and experience
3. Job satisfaction	Morale, autonomy, burnout, enjoyment
4. Perception of management	Management decisions, staffing, equipment
5. Stress recognition	Influence and recognition of fatigue on error, working hours, over confidence
6. Working conditions	Training, supervision and disciplinary policy

Study – Aim

- To identify the safety culture in one maternity service in New South Wales including the influence of the policy context in this setting.

- Can gaining an understanding of this culture assist in the development of strategies to improve the safety and quality of maternity care?

The Study

- Setting
  - Public maternity service located at two NSW hospitals

- Context
  - State wide restructure of heath services
  - Implementation of a patient safety program

- Descriptive study using a mixed method research design
  - Policy Study – examined the policy context
    - Key policy development mapped chronologically

  - Service Study – examined the safety culture
    - Safety culture surveys (n= 59/209)
    - Interviews with key stakeholders (n= 15)

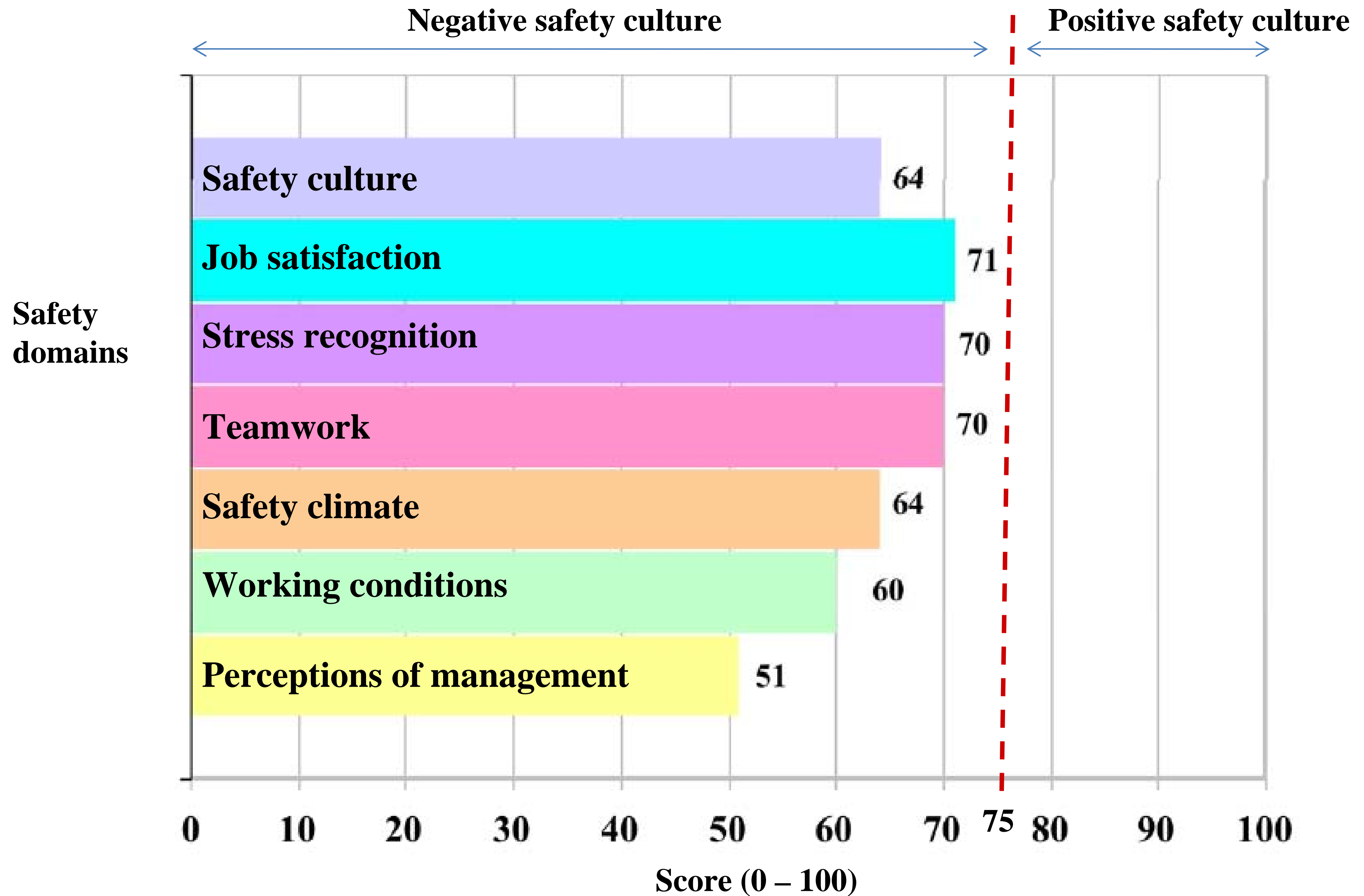
Data Analysis

- Survey
  - Mean scores for each safety culture domains
  - Scored from 0 to 100 points
  - Safety domains <75 points are not considered positive

- Interviews
  - Were analysed to provide a description of the safety culture

- Policy Audit
  - Analysed using policy cycle

Results of the SAQ by safety culture domains



Key interview themes	Strategies to improve safety
Perception of management domain	
➢ *Difficulty ensuring a safe unit*	
❑ Lack of adequate staffing	❑ Ensure adequate staffing
❑ Getting the right skill mix	❑ Improve skill mix
❑ Higher acuity	
Stress recognition domain	
➢ *Working longer*	❑ Reduce cycle of night shift ❑ Hand over when tired
Job satisfaction domain	
➢ *Low morale*	
❑ Work environment	❑ Improve staff morale
❑ Work schedules	❑ Develop continuity of care models

Difficulty ensuring a safe unit

- **The right skill mix**

  We are struggling to get a good skill mix all the time (Manager).

- **Higher acuity**

  Acuity is higher, we are getting higher risk patients, our birth rate is slightly increasing, our staffing numbers are staying the same. So we are having trouble trying to get a safe roster (Manager).

Key themes	Strategies how to improve safety
Teamwork domain ➢ *Need for Communication* ❑ Hand over and escalation ❑ Fear ❑ A lack of familiarity	❑ Improved communication ❑ Hand over teaching ❑ Simulation and skills training
Working conditions domain ➢ *Lacking supervision* ❑ Junior medical staff ❑ VMO model	❑ Improve junior staff supervision ❑ Increase VMO presence in labour ward ❑ Ward rounds

Lacking supervision

Needing communication

A clinical situation escalating so quickly that there's not time to get on the phone, or that the consultant actually needs to be on site rather than on the end of the phone (Midwife).

- **Supervision**

The biggest weakness that I worry about is the junior clinicians acting up in senior roles, and the responsibility of clinical decision making by junior clinicians (Midwife).

Key interview themes	Influencing factors
Safety Climate Domain	
➢ *In the past*	
❑ A robust system	❑ Having infrastructure
	❑ Emerging safety culture
➢ *In the Present*	
❑ The restructure	❑ Reduced infrastructure
❑ Not closing the loop	❑ Not responsive to adverse events
	❑ Not feeding back
❑ Not feeling valued	❑ Perception safety and quality not valued by the organisation
➢ *Barriers to reporting*	
❑ Not on the radar	❑ Technical difficulties
	❑ Not maternity specific

The restructure

Reduced infrastructure

It [system] has basically ceased to exist when they got rid of the quality manger last year (Doctor)

No longer closing the loop

I don't know that there is a good tight system. Have we started actioning it? As in closing the loop, really following up on things (Manager).

Policy Context Planning Better Health 2005

1. Restructure

- Area Health Service amalgamation
- Amalgamation of two maternity sites
- Increased acuity /births
- Streamlining administration/support
- All management positions spilled
- Savings frontline services

2. Sustainable Access Program

- Reduce hospital access block 20% by:
- Improving waiting lists
- Improving ED waiting times
- Tied to Chief Executive performance targets

3. Clinical redesign project

- Improve patient journey, waiting lists
- Priority target projects only
- No maternity projects initially

4. Patient Safety Clinical Quality Program

- Area based Clinical Governance Units
- Reduced sized CGU –reduced capacity
- Priority projects: falls, infections and medication errors
- Midwifery managers responsible for incident management

Key interview themes	Influencing factors
Policy context domain	
➢ *No one leading safety and quality*	❑ Reduction in size of clinical governance units ❑ Reduced capacity to support maternity services ❑ Reduction in leadership positions to drive the quality and safety agenda
➢ *Competing policies and priorities*	❑ Access block
➢ *Maternity not a priority*	❑ Maternity not a priority target area

No one leading safety and quality

No one left there…

The on ground local staff have been stripped bare. There is nobody left there running or leading the quality agenda (Clinical governance).

Lessons

- This study has provided a new knowledge about the safety culture in a maternity service and the impact of broader policy on local safety culture.
- Safety culture is complex and context specific but cannot be examined outside the broader policy framework.
- All of these factors should be considered when developing strategies to improve safety culture.
- Surveys alone are limited in describing safety culture as an improvement strategy.