CULTURE AND THE ECONOMICS OF PATIENT SAFETY

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Key points

1. Organisational culture is a critical foundation for safety
2. Catalyst for, and function of, all policies & activities
3. We need to measure it & learn more about it
4. Leadership at all levels is critical (consistency, resourcing, communication...)

2
Collective values, principles, beliefs, attitudes, relationships, symbols, habits, behaviour, assumptions ...

Unwritten rules ‘how things are done around here’

“Houses of ritual”
- J. Ovretveit

... how power is distributed and managed?
‘patient safety culture’

- Respect & trust
- Teamwork
- Communication
- Leadership & vision (a goal)
- Transparency & consistency
- Learning & improvement
- Fairness & consistency

Industries where culture has influenced performance:
- Aviation
- Mining, O&G
- Nuclear industry
- Automotive industry
The eating habits of culture ...

• Health care – complex, adaptive, unpredictable, fast ....
  - Immensely difficult to decompose - and prescribe all necessary behaviours and actions
• Culture: nebulous & intractable.... this may be its power
  - permeates all activities
  - Permits adaptation & flexibility for unpredictable situations

‘Teach someone to fish...” ⇒ empower people to think, respond and collaborate in difficult circumstances towards achieving a shared goal
So how do we build it?

‘2.9 Building a positive safety culture’

**Academics:** 3.14/2.86 = 1.1

**Policy experts:** 4.5/3.07 = 1.46

**All:** 1.35 → mid range of results

Culture mentioned by every respondent in comments

“...a culture that is open, free from fear, buoyant, and ambitious...”
The most popular selections in Pt II

- 1.5 Professional education and training 14x
- 2.1 Clinical governance systems and frameworks 13x
- 1.1 Safety standards linked to accreditation and certification 11x
- 2.5 Person- and patient-engagement strategies 9x
- 1.6 EHR systems** 9x
- 1.9 National interventions based on specific safety themes 9x
- 1.7 No-fault medical negligence legislation 8x
- 1.10 A national agency responsible for patient safety 8x

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- 2.2 Clinical incident management and reporting systems 6x
- 2.9 Building a positive safety culture 6x
- 21.2 Public reporting 6x
- 1.3 mandatory reporting 6x
“...complications were associated with a $39,017 higher contribution margin per patient with private insurance and a $1749 higher contribution margin per patient with Medicare”

- non-Medicare → 3.2x profit
- Medicare → 2x profit

...a patient-centered culture was positively associated with fewer depression symptoms ... and better physical function scores.

WHO Surgical Safety Checklist
→ Positive change in OR culture (levelling of power asymmetries?)
→ Safer care

Teamwork climate; Collaborative model
Every system is perfectly designed to achieve the results it gets

- Paul Batalden, IHI […David Hanna, Arthur Jones ]
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References


IHI. Develop a culture of safety www.ihi.org/resources/Pages/Changes/DevelopaCultureofSafety.aspx


Thank you

Vielen Dank

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www.oecd.org/health