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Patient safety culture in primary care: developing a theoretical framework for practical use

Susan Kirk, Dianne Parker, Tanya Claridge, Aneez Esmail, Martin Marshall

Objective: Great importance has been attached to a culture of safe practice in healthcare organisations, but it has proved difficult to engage frontline staff with this complex concept. The present study aimed to develop and test a framework for making the concept of safety culture meaningful and accessible to managers and frontline staff, and facilitating discussion of ways to improve team/organisational safety culture.

Setting: Eight primary care trusts and a sample of their associated general practices in north west England.

Methods: In phase 1 a comprehensive review of the literature and a postal survey of experts helped identify the key dimensions of safety culture in primary care. Semistructured interviews with 30 clinicians and managers explored the application of these dimensions to an established theory of organisational maturity. In phase 2 the face validity and utility of the framework was assessed in 33 interviews and 14 focus groups.

Results: Nine dimensions were identified through which safety culture is expressed in primary care organisations. Organisational descriptions were developed for how these dimensions might be characterised at five levels of organisational maturity. The resulting framework conceptualises patient safety culture as multidimensional and dynamic, and seems to have a high level of face validity and utility within primary care. It aids clinicians’ and managers’ understanding of the concept of safety culture and promotes discussion within teams about their safety culture maturity.

Conclusions: The framework moves the agenda on from rhetoric about the importance of safety culture to a way of understanding why and how the shared values of staff working within a healthcare organisation may be operationalised to create a safe environment for patient care.

SAFETY CULTURE IN CONTEXT

The notion that an organisation has a safety culture is not new, and there is much to be gained from looking at the way safety culture has been conceptualised outside healthcare. Safety culture is one element of the broader construct of organisational culture, about which there has been considerable sociological and organisational research. The concept of an organisation having a culture is contested by some people, and there is an ongoing polarised debate between those who see culture as a variable that can be manipulated (what an organisation has) and those who see it as a descriptive metaphor (what an organisation is). Nevertheless, evidence is emerging of a link between culture and organisational performance, although the nature and mechanisms underlying this link are uncertain.

In many high hazard industries a great deal of research effort has gone into defining, specifying and measuring safety culture. It is generally agreed that a safety culture arises from the shared safety-related values, beliefs and behaviours of the members of an organisation.
steps to patient safety, which identifies safety culture as the first step. Here we describe the development of a tool that aims to make the concept of safety culture more meaningful to clinicians and managers. The aims of our two-phase study were:

- In phase 1: to develop a framework document which would “unpack” the concept of safety culture in primary care, making it more accessible and reflecting practitioners’ understanding of the reality of safety culture in their organisations.
- In phase 2: to establish the face validity and utility of the framework using individual and focus group interviews.

PHASE 1: DEVELOPING THE FRAMEWORK

Theoretical basis

The theory underpinning the study was originally developed by Westrum,22,23 who proposed that one key way of distinguishing between organisational cultures is to examine the ways in which information is handled by the organisation. He proposed three different organisational cultures, which he called pathological, bureaucratic and generative. The most immature stage of organisation has a pathological culture, which is one in which information is hidden, failure is covered up and new ideas are actively crushed. There is active discouragement of sharing with and learning from others. A more mature organisational culture is one that has developed systems to handle the flow of information. In this—the bureaucratic organisation—information is collected but may then be ignored, new ideas are seen to create problems, and learning and sharing are tolerated but not encouraged. The generative organisation represents the most advanced state of cultural maturity. Here information is actively sought, and some staff members are specifically trained to collect it. New ideas are welcomed, and failure prompts inquiry rather than cover-up or blame.

Westrum’s tripartite typology was later extended to a five-level model and adapted by Parker and Hudson24 specifically with respect to safety culture (table 1). A safety culture assessment tool based on the five-level model was developed and is now widely used in the oil and gas industry.25 It was thought that taking the same approach, and adopting a methodology that has been successful in one high-risk industry, in healthcare might be beneficial. Therefore we used the extended five-level model as the theoretical basis for the present study.

Development of the dimensions of safety culture in primary care organisations

We undertook a comprehensive review of the peer-reviewed literature to generate a list of the dimensions, or key categories, describing safety culture in primary care organisations. Box 2 shows the search terms/strategies used for the review and the bibliographic databases that were searched. In addition, we reviewed key texts, reports and policy documents relating to patient safety and safety culture. A preliminary list of the dimensions identified was then sent to five national opinion leaders in patient safety and risk management for comments and adaptation. The final list of dimensions formed the framework for the interviews conducted with managers and clinicians working in primary care organisations (table 2). These included general practices (organisations in the UK

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**Box 1: Aspects of a positive safety culture**

- Communication based on mutual trust and openness
- Shared perceptions of the importance of safety
- Confidence in the efficacy of preventive safety measures
- Organisational learning
- Committed leadership and executive responsibility
- A “no blame”, non-punitive approach to incident reporting and analysis

**Box 2: Literature search terms and strategies**

- **Criteria:** 1990 onwards
- **Databases searched:**
  - Medline
  - Embase
  - HMIC (Health Management Information Circular)
  - CINAHL
  - E-PIC (Pharmacy Information)
- **Search strategy:**
  - Free text searches looking for keywords in title or abstract of records: (primary care or primary health care or general practice or family medicine or family practice) AND ((Risk near3 (management or assessment) or patient safety or medical error* or clinical risk* or safety culture (adverse near3 (event* or incident*)))
- **Thesaurus searches**
  - The following thesaurus terms were identified and searches carried out:
    - Medline
    - Primary-health-care and (risk management/or adverse-drug-reaction-reporting systems or medical errors/or iatrogenic-disease or malpractice)
    - CINAHL
    - Primary-health-care and (diagnostic-errors or medication-errors or treatment errors or risk assessment or risk-management or risk factors)
    - Embase
    - Primary-health-care and (iatrogenic-disease or error/or risk-assessment or danger, risk safety and related phenomenon)

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**Table 1 Levels of organisational safety culture (Parker and Hudson)**

<table>
<thead>
<tr>
<th>Level of organisational safety culture</th>
<th>Characterisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1: pathological</td>
<td>Why do we need to waste our time on risk management and safety issues?</td>
</tr>
<tr>
<td>Level 2: reactive</td>
<td>We take risk seriously and do something every time we have an incident</td>
</tr>
<tr>
<td>Level 3: calculative</td>
<td>We have systems in place to manage all possible risks</td>
</tr>
<tr>
<td>Level 4: proactive</td>
<td>We are always on the alert, thinking of risks that might emerge</td>
</tr>
<tr>
<td>Level 5: generative</td>
<td>Risk management is an integral part of everything we do</td>
</tr>
</tbody>
</table>

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www.qshc.com
The interview data were fully transcribed and coded at the interviewee’s permission and these data were supplemented depending on their role. The interviews were tape recorded with field notes.

Our aim was to capture the views of any of the personnel working in the PCT or local practices with a special interest in patient safety, and to ensure that the perspectives of both managers and clinicians from different professional groups were taken into account. In five of the six PCTs we interviewed the chief executive first, and asked them to identify the person with lead responsibility for risk management and the other individuals in the PCT/local general practices with expertise and/or responsibility in the area. We used the same snowball sampling technique with all interviewees until all of the key potential informants had been identified. In total we interviewed 30 people from a range of disciplines (table 3).

Participants were sent written information about the study and an invitation to participate. Approximately a week later, individuals were contacted by telephone to ascertain their willingness to participate and to arrange a convenient time for an interview.

Multisite research ethical committee approval for the study was obtained.

Data collection
We used a semistructured schedule to guide the interviews. The interviewer described the meaning of the levels and the dimensions at the start of the interview. The aim was to draw on participants’ experience and expertise to develop descriptions of what an organisation might look like for each of the nine dimensions at each of the five levels of organisational maturity. In addition, the face validity of the dimensions developed from the literature was explored. The interviewer made clear that the aim of the interview was not to examine or categorise the current safety culture in the participant’s own organisation, which could be general practice or the PCT, but to look beyond the organisation for collaboration or innovation?

Table 2 Dimensions of patient safety culture in primary care

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall commitment to quality</td>
<td>How much is invested in developing the quality agenda?</td>
</tr>
<tr>
<td>Priority given to patient safety</td>
<td>What is seen as the main purpose of policies and procedures?</td>
</tr>
<tr>
<td>Perceptions of the causes of patient</td>
<td>What attempts are made to look beyond the organisation for</td>
</tr>
<tr>
<td>safety incidents and their identification</td>
<td>collaboration or innovation?</td>
</tr>
<tr>
<td>Investigating patient safety incidents</td>
<td>Where does the responsibility lie for patient safety issues?</td>
</tr>
<tr>
<td>Organisational learning following a</td>
<td>As an opportunity for blame or improve?</td>
</tr>
<tr>
<td>patient safety incident</td>
<td>How are reports of incidents viewed?</td>
</tr>
<tr>
<td>Communication about safety issues</td>
<td>What sort of reporting mechanisms are there?</td>
</tr>
<tr>
<td>Personnel management and safety issues</td>
<td>What is the aim of the organisation?</td>
</tr>
<tr>
<td>Staff education and training about</td>
<td>Does the organisation learn from the event?</td>
</tr>
<tr>
<td>safety issues</td>
<td>How are safety issues managed in the workplace?</td>
</tr>
<tr>
<td>Teamworking around safety issues</td>
<td>How are staff problems managed?</td>
</tr>
<tr>
<td></td>
<td>What are recruitment and selection procedures like?</td>
</tr>
</tbody>
</table>

Data analysis
The interview data were fully transcribed and coded at the predetermined nine dimensions and five maturity levels using the framework approach26 to identify key themes and develop a thematic framework. We then analysed the thematic

Table 3 Phase 1 sample

<table>
<thead>
<tr>
<th>Professional group</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical governance manager/lead</td>
<td>8</td>
</tr>
<tr>
<td>PCT chief executive</td>
<td>5</td>
</tr>
<tr>
<td>PCT manager</td>
<td>5</td>
</tr>
<tr>
<td>Community nurse</td>
<td>3</td>
</tr>
<tr>
<td>General practitioner</td>
<td>3</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>2</td>
</tr>
<tr>
<td>Practice manager</td>
<td>2</td>
</tr>
<tr>
<td>Pharmacy adviser</td>
<td>1</td>
</tr>
<tr>
<td>Dentist</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
</tr>
</tbody>
</table>

PCT, primary care trust.
framework, to which all data had been charted, in terms of mapping the range and nature of the themes, comparing data coded to different maturity levels and developing initial descriptive statements for the dimensions at the five maturity levels. Two researchers independently assigned the data and developed the descriptive statements, and then edited them to produce brief consensus descriptions. These edited statements were then applied to the framework, which is a Guttman-type matrix with levels of maturity as one axis and dimensions of patient safety as the other.

**Results**

**The dimensions**

The nine dimensions were judged by interviewees to be comprehensive and valid. In terms of coverage, it was felt that there was overlap between two of the dimensions, one relating to the causes and one to the identification of adverse events/near misses, so they were merged early in the fieldwork. There was also some debate about whether “patient/user involvement” should be a separate dimension. However, most interviewees felt that user involvement was a component of all the dimensions and would be more evident in organisations with a relatively mature safety culture.

**The levels of maturity**

Overall, the participants regarded the underlying theory describing levels of organisational maturity as being a useful and appropriate way of categorising health service organisations and teams.

“The tool and the different levels provide a systematic method for organisations to assess and categorise themselves.”

**The framework**

Interviewees saw the framework as being applicable to primary care organisations. They had little trouble describing the dimension characteristics of reactive and calculative safety cultures, with some regarding these as being the prevalent safety cultures within primary care organisations. However, they had more problems describing the dimension characteristics of a generative safety culture and many felt that this was an unattainable state. Some participants doubted that pathological organisations could exist in the highly performance-managed environment of the National Health Service. Some also expressed concerns about the negative connotations of this term.

“I really dislike the term ‘pathological’. I think another term could be used, may be ‘no commitment’. I think people might find it insulting’

Conversely, in community pharmacy a pathological safety culture has been described as being perceived as the dominant culture.29 As an example the final descriptions for each level of two of the dimensions are presented in tables 4 and 5.

**PHASE 2: ASSESSING THE FACE VALIDITY AND UTILITY OF THE FRAMEWORK**

In phase 2 we aimed to assess the face validity and utility of the framework developed in phase 1 using individual (stage 1) and focus group interviews (stage 2).

**Stage 1**

**Sampling**

A total of 33 participants were purposely sampled from the phase 1 PCT sites to ensure a range of disciplinary backgrounds and management roles (table 6).

**Data collection**

The framework developed in phase 1 was reproduced as a professionally designed and printed document. The participants were interviewed to explore their views of the framework in terms of the dimension descriptors (comprehensiveness, clarity of language), the utility of the framework in primary care, its potential to operationalise the concept of safety culture and the presentation of the document itself. Interviews were tape recorded and selectively transcribed in relation to predetermined areas (see below).

**Data analysis**

Interview data were coded at the predetermined categories that were the focus of the face validity and utility testing (eg, characterisations of the causes of adverse events and near misses and their identification).

<table>
<thead>
<tr>
<th>Maturity level of safety culture</th>
<th>Dimension description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathological</td>
<td>In a pathological organisation, incidents would be seen as “bad luck” and outside the organisation’s control, occurring as a result of staff errors or patient behaviour. Ad hoc reporting systems would be in place with the organisation largely in “blissful ignorance”, unless serious adverse events occur. Incidents and complaints would be “swept under the carpet” if possible. There would be a high blame culture with individuals subjected to victimisation and disciplinary action.</td>
</tr>
<tr>
<td>Reactive</td>
<td>A reactive organisation would see itself as a victim of circumstances. Individuals would be seen as the cause of problems and solutions would focus on retraining or punitive action. There would be an embryonic reporting system, although staff would not be encouraged to report incidents. Minimum data on incidents would be collected and this would not be analysed. There would be a blame culture which would cause staff to be reluctant to report incidents. When incidents occurred there would be no attempt to support any of those involved, including patients and their relatives.</td>
</tr>
<tr>
<td>Calculative</td>
<td>A calculative organisation would be clearly defined with systems, not just individuals, contributing to incidents. The organisation would profess to not having a blame culture, but this would not be the perception of the staff. There would be a centralised anonymous reporting system in place with an emphasis on form completion. Staff would be encouraged to report incidents and near misses, but they would not feel safe to do so. Complaints would be considered with adverse events.</td>
</tr>
<tr>
<td>Proactive</td>
<td>Proactive organisations would accept that incidents are a combination of individual and system faults. Reporting of adverse events and near misses would be encouraged and they would be seen as learning opportunities. Accessible and “staff-friendly” electronic reporting methods would be used, allowing trends to be readily examined. The organisation would have a blame-free, collaborative culture and staff would feel safe to report near misses. Staff, patients and relatives would be supported from the moment of reporting.</td>
</tr>
<tr>
<td>Generative</td>
<td>In generative organisations, organisational failures would be noted but staff would also be aware of their own professional accountability in relation to errors. Reporting adverse events and near misses would be second nature as staff would have confidence in the investigation process and understand the value of reporting. Integrated systems would allow adverse events, near misses, complaints and litigation cases to be analysed together. Staff, patients and relatives would be actively supported from the time of the incident and the organisation would have a high level of openness and trust.</td>
</tr>
</tbody>
</table>
comprehensiveness of dimensions, clarity of language, structure of document, appropriateness). Key themes were then identified in the data at each category and compared data from different groups of participants. A second researcher checked data assignment to categories and the identification of key themes.

Results
Our results suggested that the tool had a high level of face validity. Participants reported that the tool would be acceptable and useful to primary care teams. They considered that “safety culture” would be a new and “alien” concept to many potential users of the framework. However, they also felt that one of the strengths of the framework was its usefulness as an educational tool, in that it presented a conceptualisation of patient safety culture with which managers and clinicians could engage. The participants believed that raising awareness of the complexity of organisational safety culture could encourage management activities and facilitate research into the effectiveness of interventions designed to improve safety culture that were sensitive to this complexity. Another potential strength of the framework design was seen in the emphasis on team use and communication processes. It was anticipated that this would contribute to an understanding that those at different levels in an organisation could hold varying perceptions of safety culture. The participants believed that this realisation could help to identify the problems and solutions that would lead to improvements in patient safety. The framework was also seen as a way of illuminating differences between professional groups, in terms of their perceptions of the existing safety culture of the PCT or practice, thus allowing the identification of potential levers for change. The participants felt that the conceptualisation of patient safety culture as a multifaceted framework, encompassing contextual factors, management characteristics, and general attitudes and beliefs was useful as it would encourage analysis of the deeper, systemic factors within an organisation that may be causing serious failures.

Suggestions for improving the framework were also made. The participants considered that the framework needed to include more recognition of patient involvement in the descriptors, and that a handbook would be a useful addition to support managers and clinicians in using the tool. Recommendations for rewording some of the descriptors were also made. These alterations and additions were made before stage 2 testing.

Stage 2
The aim of this stage was to assess whether the framework clarified the concept of safety culture for healthcare professionals, and how far it served as a useful stimulus for reflection within a group context.

Sampling
The participating organisations were four PCTs in the north of England, selected on the basis of their geographical location.

Table 5  Teamworking around safety issues

<table>
<thead>
<tr>
<th>Maturity level of safety culture</th>
<th>Dimension description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathological</td>
<td>Individuals mainly work in isolation but where there are teams they are ineffective in terms of risk management. There are tensions between the team members and a rigid hierarchical structure. They are more like a group of people brought together with a nominal leader and no direction</td>
</tr>
<tr>
<td>Reactive</td>
<td>There are teams but they are told to work together and only pay lip service to teamworking. People only work as a team following a patient safety incident. Teams get put together to respond to external demands. There is a clear hierarchy in every team corresponding to the hierarchy of the organisation as a whole. Teams do work together, but individuals are not actually committed to the team</td>
</tr>
<tr>
<td>Calculative</td>
<td>Teams are put together to respond to government policies but there is no way of measuring how effective they are. There is a risk management team. Teamwork is seen by lower grades of staff as paying lip service to the idea of empowerment. There is little sharing of ideas or information about safety issues across teams</td>
</tr>
<tr>
<td>Proactive</td>
<td>Team structure is fluid with people taking up the role most appropriate for them at the time. Teams are collaborative and adaptable and actively contribute to the risk management agenda within the organisation. There is evaluation of how effective the team is and changes are made when necessary. Teams may include those external to the organisation</td>
</tr>
<tr>
<td>Generative</td>
<td>Team membership is flexible, with different people making contributions when appropriate. Teams are about shared understanding and vision about safety issues rather than geographical proximity. This way of working is just the accepted way in the organisation. Everyone is equally valued and feels free to contribute. “Everyone is part of the risk management team”, this includes all levels of the organisation from board members through to those who have day-to-day contact with patients</td>
</tr>
</tbody>
</table>

Table 6  Phase 2, stage 1 sample

<table>
<thead>
<tr>
<th>Professional group</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
<td>3</td>
</tr>
<tr>
<td>Clinical governance manager</td>
<td>4</td>
</tr>
<tr>
<td>Risk manager</td>
<td>2</td>
</tr>
<tr>
<td>Human resource manager</td>
<td>2</td>
</tr>
<tr>
<td>Director of nursing</td>
<td>2</td>
</tr>
<tr>
<td>PEC member (various professionals)</td>
<td>7</td>
</tr>
<tr>
<td>District nurse</td>
<td>4</td>
</tr>
<tr>
<td>Health visitor</td>
<td>4</td>
</tr>
<tr>
<td>Community pharmacist</td>
<td>2</td>
</tr>
<tr>
<td>Podiatrist</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
</tr>
</tbody>
</table>

PEC, professional executive committee.

Table 7  Phase 2, stage 2 sample

<table>
<thead>
<tr>
<th>PCT</th>
<th>Group type</th>
<th>Focus group composition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 General practice</td>
<td>GP, health visitor, district nurse, practice manager</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PCT management</td>
<td>Clinical governance committee members</td>
</tr>
<tr>
<td></td>
<td>Specialist remit</td>
<td>Child protection team members</td>
</tr>
<tr>
<td></td>
<td>Single profession</td>
<td>District nurses</td>
</tr>
<tr>
<td>2 General practice</td>
<td>GP, receptionists, practice manager</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PCT management</td>
<td>Clinical risk committee members</td>
</tr>
<tr>
<td></td>
<td>Specialist remit</td>
<td>Rapid response team members</td>
</tr>
<tr>
<td></td>
<td>Single profession</td>
<td>District nurses</td>
</tr>
<tr>
<td>3 General practice</td>
<td>GP, practice manager</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PCT management</td>
<td>Nurse managers and clinical governance leads</td>
</tr>
<tr>
<td></td>
<td>Specialist remit</td>
<td>Infection control nurses</td>
</tr>
<tr>
<td></td>
<td>Single profession</td>
<td>District nurses</td>
</tr>
<tr>
<td>4 General practice</td>
<td>GP, general practitioner</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PCT management</td>
<td>Medicines management team</td>
</tr>
<tr>
<td></td>
<td>Specialist remit</td>
<td>District nurses</td>
</tr>
</tbody>
</table>

GP, general practitioner; PCT, primary care trust.
and size. Two of these trusts had been involved in the first phase of the study. Chief executives and risk managers were asked to nominate individuals and teams who could be invited to participate in focus group interviews.

Data collection
We conducted 14 focus groups which consisted of either single professional or multiprofessional groups, considered to be the management and operational teams that might use the framework in future (table 7). The size of the focus group ranged from 3 to 12 participants and they were conducted at either a general practice or the PCT premises.

Focus groups commenced with observation of how the groups used the framework. Participants were asked to read the dimension descriptions and identify those that they believed described the level of maturity of the patient safety culture in which they worked as a team and, if appropriate, an organisational level. They were encouraged to discuss their choices, challenge those of others and discuss ways to enhance the patient safety culture of the organisation in which they worked. Following this a semistructured guide was used to explore how the framework might be delivered and used. Focus groups were audio taped. One researcher moderated the discussion while a second researcher made contemporaneous field notes.

Data analysis
We coded and analysed the transcriptions using the framework approach to explore participants’ understandings of “safety culture” and their perceptions of the usefulness of the framework in primary care teams and organisations. Data were examined to identify any differences in understandings and perceptions between different groups of healthcare professionals or between frontline clinicians and those with a management role. Data from the field notes were also incorporated in the analysis.

Results
Understanding of “safety culture”
Using the framework to stimulate group discussion appeared to contribute to participants’ understandings of the concept of safety culture. Participants commented that reading relatively straightforward descriptions of the systems, behaviours and beliefs that contribute to safety culture helped them to understand what had previously been an abstract concept.

“There’s a desire within individual teams, individual people and maybe individual PCTs you know to be proactive or generative, they would all love to be there. But the national culture is calculative and that’s what we have got to work to: this team does have a different culture, I don’t think there are many teams or organisations with a culture like ours, we’re open with each other ... we’ve tried to share how we work, attended the meetings on the list, haven’t we? We’ve made suggestions and those suggestions haven’t been considered at Trust management level”

Using the framework
The participants found the framework to be a useful way of deconstructing the concept of patient safety culture and exploring its maturity within their teams/organisations. This was because they found the descriptions of the dimensions straightforward to understand and reflective of their own experience. Consequently they were readily able to locate their teams or trusts in terms of the five stages of cultural maturity, and to identify some of the factors that seemed to be stimulating or constraining progression such as targets, resources and established systems.

Indeed participants identified the framework’s main purpose to be as a facilitative educational tool that could enable different work groups gain insight into the safety culture of their team/organisation and promote discussion of how it might be improved at each dimension. They also saw that it had a use as a means of assessing whether improvements had occurred over time.

CONCLUSION
The framework developed in this study for assessing the safety culture in primary care organisations, which we have called the Manchester Patient Safety Framework (MaPSaF), helps to fill the gap between the policy makers who espouse the importance of safety culture and the practitioners who are charged with implementation of such a culture, yet find it a problematic concept to understand, engage with and improve. The framework is based on an established theory and has been developed using a qualitative approach to define the dimensions and test its face validity and utility in primary care. It acknowledges the multidimensional and dynamic nature of culture, and allows for the recognition of subcultures within a single organisation. This is important as subcultures within organisations act as powerful influences on detecting and learning from errors. In addition, we found that in assessing the safety culture of a team or organisation, there may be differences between the
Key messages

- This paper describes the development and testing of a framework that aims to enable primary care clinicians and managers to engage with and understand the concept of patient safety culture.
- The framework (MaPSaF) is based on a theoretical model of increasing maturity in organisational culture.
- The content of MaPSaF was derived from interviews with primary care clinicians and managers.
- Testing of MaPSaF has shown that it has a high face validity and that it is a useful way of stimulating discussion and exploring ways of improving patient safety culture in primary care trusts and teams.

perceptions of managers and frontline practitioners. This indicates the need for dialogue between these two groups.

In terms of improving patient safety it seems that the framework is best used as a facilitative educational tool by teams. It can be used in team discussions to:

- provide insight and promote discussion about patient safety culture;
- facilitate interactive self-reflection on the safety culture of the team and/or organisation and its strengths and weaknesses;
- help teams recognise the complexity and multidimensionality of safety culture;
- reveal and explore differences in perceptions between different staff groups or teams;
- help understand how a team/organisation with a more mature safety culture might look;
- evaluate interventions aimed at improving safety culture.

Our experience of using the framework to date suggests that staff readily engage with the exercise and find it both enjoyable and useful. The development of a version of the framework for use in community pharmacy adds support to these findings.

The framework seems to improve healthcare professionals’ understanding of the term safety culture, to engage frontline staff with the organisational aspects of safe practice and to stimulate discussion of ways of improving the safety culture of health organisations. It has recently been disseminated by the National Patient Safety Agency to the National Health Service and includes a facilitator guide as well as the framework itself which has now been adapted for use in a range of healthcare settings outside primary care.

Ultimately however, no single approach can provide organisations with a ready-made patient safety culture. MaPSaF can contribute to this by providing a valuable stimulus for discussion and reflection. Primary care organisations will need to work towards developing a positive patient safety culture and facilitate the progression of teams and organisations through the different levels of safety culture maturity. This is a complex process, and as our framework illustrates through its dimensions, requires development in several areas, such as communication, teamwork and leadership. There is no “quick fix” to transforming organisations in this way. It will take time and needs commitment but the benefits to both patients and staff could be considerable.

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