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6 Essential Components of a "Culture of Safety" in the Operating Room

By Rachel Fields | May 18, 2011

As hospitals and governmental bodies place a greater emphasis on patient safety, operating room teams are working to build "cultures of safety" that reward compliance and encourage teamwork. But while most providers have good intentions when it comes to patient care, the "culture of safety" can disintegrate when unexpected events cause frustration and miscommunication. David Maxfield, author of "The Silent Treatment: Why Safety Tools and Checklists Aren't Enough to Save Lives," discusses how hospitals and other surgical facilities can work with OR team members to build trust, accountability and a culture of compliance.

To build a culture of safety, surgical facilities should develop various strategies focused on improving a core set of behaviors, Mr. Maxfield says. "The approach we find that works best when you are trying to change entrenched habits is to focus on vital behaviors — 2-4 behaviors that are central nodes," he says. "When you nudge those behaviors, they pull other things with them. You identify those behaviors and then throw everything you can possibly think of at those few behaviors."

For the operating room, Mr. Maxfield and his fellow researchers have identified four behaviors that are essential to ensuring patient safety:

- Every tool, every time. This means that it's not enough for physicians and staff to use most of the safety tools most of the time. To ensure the safest environment, compliance must occur 100 percent of the time.

- Everybody speaks and everybody listens. The surgeon and anesthesiologist should not be the only OR team members who feel comfortable raising an issue. Every team member should be able to point out a problem, and every team member should pay attention when someone else speaks.

- 200 percent accountability. "This means that I am 100 percent accountable for my own behavior and also 100 percent accountable for everyone else's behavior," Mr. Maxfield says. Everyone will slip up sometimes; the key is to encourage accountability between staff so that team members can point out when a mistake is made.

- Say thank you. "Holding each other accountable is very counter-cultural in a hospital," Mr. Maxfield says. In order to encourage accountability, team members should say thank you and make it easy for colleagues to gently remind them of the right processes.

Identifying these behaviors is just the first step, Mr. Maxfield says. If you want providers to adopt new behaviors and follow them consistently, you must identify the sources of people's motivation and ability. He says these sources can be broken down into six distinct categories:

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1. Personal motivation. Personal motivation can be defined as the personal characteristics of a team member that drive him or her to comply with safety regulations. This personal motivation could be driven by moral passion, enjoyment or personal identity. Mr. Maxfield says that hospitals often make the mistake of relying on verbal persuasion to enhance personal motivation. "Verbal persuasion means lectures, sermons, data dumps and rants — we've probably all committed that," he says.

Instead of lecturing a team member on the proper safety processes, he says hospitals should engage staff through a discussion of personal experiences. His team conducted a study on hand hygiene in which 1,000 nurses were asked, "If a physician entered the patient room and you were sure he had not washed his hands, would you say something?" They found that the average was around 12 percent — except with nurses who had experienced a hospital-acquired infection themselves or through a family member. Fifty percent of those nurses said they would speak up. Mr. Maxfield says this data points to a need for providers to share personal experiences regarding adverse events. Hospitals should set up time for OR teams to share stories, and ask a physician or anesthesiologist to share a relevant experience as well.

2. Personal ability. Once a team member is motivated to speak up about safety issues, they need to know how to do it effectively, Mr. Maxfield says. His team has found that simple scripting can help providers express their concerns without using personal attacks. He says hospitals should give OR teams some time to sit down and come up with their own words to identify a safety hazard. "Include some anesthesiologists and surgeons on the team so they can test the scripts out with each other and say, 'No, I wouldn't want you to say this. I'd rather you say this,'" he says. When every team member has input on the designated "safety" words, they are giving permission to other team members to use the words when an incident occurs.

3. Social motivation. Mr. Maxfield defines social motivation as the impact of a boss and colleagues on a provider's work habits. When a team is invested in the culture of safety, providers are more likely to comply because they know their team members will hold them accountable. Social motivation can also be encouraged by assigning a "champion" to every OR team. Mr. Maxfield asks teams to sit down and identify the formal and informal leaders in a hospital setting. The formal leaders would most likely be managers, while informal leaders might be physicians or anesthesiologists. He then asks those informal leaders to volunteer as project champions, who step in when accountability goes awry and team members run into conflict.

4. Social ability. Make sure that physician champions have the tools to step in and motivate team members when things go wrong. Mr. Maxfield recommends giving champions extra training on conflict resolution, personal motivation and safety policies, so that they can explain how processes work and help team members work through disagreements. Team members should understand that the physician champion is a real resource rather than simply a figurehead.

5. Structural motivation. Providers and team members are also motivated by the processes that exist within a hospital to encourage compliance, including career advancement, performance reviews, rewards and punishments. Mr. Maxfield says hospitals commonly err by pairing a facility rule with sanctions and rewards that are non-existent, inconsistent or overwhelming. If rules have no clear consequences, providers will quickly realize that the hospital has no way of enforcing bad behavior or rewarding effort, and they may become disillusioned. Instead, Mr. Maxfield says hospitals should try to use sanctions and rewards that ignite personal motivation and provide a context for social motivation. He gives the example of a Boy Scout's merit badge. While the badge itself is not worth much, earning the badge gives the Boy Scout an occasion to feel proud and gives his family members a chance to recognize his efforts.

Hospitals should try to reward providers in the same way, he says. If hospitals make the reward too great, team members are likely to pursue compliance for the sake of the reward rather than for the sake of safety. Instead, hospitals should design a method of recognition that is used sparingly and automatically lets people know that the employee has succeeded in their job. He says he has worked with hospitals who use an "OR safety badge" that providers can give to team members who point out safety hazards.

6. Structural ability. Structural ability concerns the way hospitals encourage providers and team members to deal with communication problems and report safety issues. Mr. Maxfield says that he recently worked with a hospital that was trying to reduce disruptive behavior in the OR. Through talking with physicians, his team found that physicians today are surrounded by "lines in the sand," legal and regulatory policies that increase bureaucracy and exacerbate physician frustration. The physicians said that when they express frustration in the operating room, it's usually because they have encountered the same issue 10 times previously, and the problem has simmered under the surface for months before coming to a head.

To reduce disruptive OR behavior, the hospital implemented a "triage system" that would deal with physician frustration. When a problem arose, a physician could approach the team leader and categorize the problem as one, two or three. A category one problem would be require immediate help; a category two problem would need a 24-hour turnaround time; and a category three problem would need prolonged attention and possibly funding. "It wasn't just saying, 'You can't blow your top in the operating room,'" Mr. Maxfield says. "It was saying, 'We want to lower the pressure in the operating room so you won't be tempted to blow your top.'" He says the debriefings allowed physicians to vent frustrations and discuss patient safety issues on a regular basis, rather than exploding after months of annoyance.