

Human
Factors
Reflections



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The Safety Culture Series

Communication about safety issues

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Let's talk about the Manchester Patient
Safety Framework...





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What is 'communication about safety issues'?

What communication systems are in place?

What are their features?

What is the quality of record keeping to communicate about safety like?



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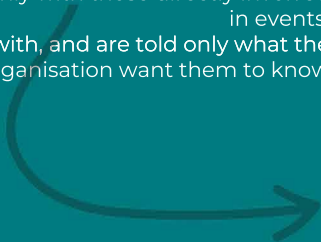
Levels of Culture

1. Pathological

- . Communication is poor- It's top down and staff are not able to speak up
- . Events are kept in-house
- . Organisation is closed.
- . Communication is negative and focuses on blame
- . Patients are given information to meet legal requirements only, which is provided only after significant pressure

2. Reactive

- . Communication is directive: Managers issuing instructions
- . Staff are only able to speak with managers after something went wrong
- . Communication is ad-hoc and only with those directly involved in events.
- . Patients are spoken at, not with, and are told only what the organisation want them to know



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Levels of Culture

3. Bureaucratic

- . There is a communications strategy. Policies and procedures are in place and records are kept.
- . A lot of information is collected but not effectively utilised resulting in information overloads.
- . A risk communication system exists but its efficacy has never been tested

4. Proactive

- . The communication system and record keeping are fully audited.
- . Communication happens across the organisation and supports bench marking
- . Staff of all levels are involved and robust mechanisms for feedback exist
- . Information is shared through regular briefings. Staff help shape the agenda
- . The organisation communicates with patient and public involvement groups.



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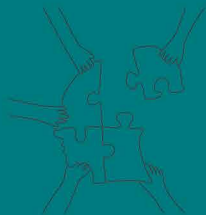
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Levels of Culture



5. Generative

- . Everyone communicates safety issues and learns from the experiences of others (both good and bad)
- . The organisation is transparent and focuses on patient participation in risk management policy development
- . Innovate ideas are encouraged and staff are empowered to implement them
- . The organisation communicates about both good and bad practice externally.



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How does your team and organisation fare?

Use these characteristics to reflect on:

- . What's your team's local culture (or climate) like?
- . What's the organisation's culture like?
- . How is it changing over time?

As a service user:

- . What evidence of these do you see in the services you use?



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Culture is critical!

Building a strong culture is critical,
but can take a long time.

If you would like advice and support
on improving your culture, comment
below and we'll be in touch

References

- Parker, D and Hudson, P (2001) Understanding your culture, Shell International Exploration and Production.
Westrum, R (1992) Cultures with Requisite Imagination in: Wise, J, Hopkin, D and Stager, P (eds.), Verification and validation of complex systems: human factors issues (pp. 401–416). Berlin: Springer-Verlag.
PARKER, D. (2009), Managing risk in healthcare: understanding your safety culture using the Manchester Patient Safety Framework (MaPSaF). *Journal of Nursing Management*, 17: 218–222. <https://doi.org/10.1111/j.1365-2834.2009.00993.x>

