THE ROLE OF LEADERSHIP IN PROMOTING A CULTURE OF SAFETY IN HEALTHCARE SETTINGS

Hussain Qayid Ali Almansour[1*], Ali Mohammed Hussin Al Koleep[2], Mohammed Munasser Hazam Alyami[3], Mulfi Mohammed Hezam Alyami[4], Abdullah Hassan Motlk Al Wayili[5], Abdullah Saeed Ali Althaiban[6], Hamad Saleh Hamad Alkulayb[7]

Abstract

Most healthcare organizations are still striving to achieve high reliability, the ability to minimize adverse events while consistently providing high-quality care in the context of a rapidly changing environment. leaders at the sharp end are best positioned to identify hazardous situations and address system flaws. As the safety field has evolved, there is a growing recognition of the role that leadership plays in prioritizing safety, through actions such as establishing a culture of safety, responding to patient and staff concerns, supporting efforts to improve safety, and monitoring progress. Research using various methodologies has defined the relationship between leadership actions and patient safety and has begun to elucidate key organizational behaviors and structures that can promote (and hinder) safety efforts.H This shift in leadership philosophy requires a fundamental change in how leaders are identified, developed, and supported within the organization. As healthcare continues to evolve, it is imperative that leaders at all levels are equipped with the skills and knowledge to effectively identify and address safety concerns, engage in continuous improvement efforts, and foster a culture of open communication and collaboration. By embracing a distributed leadership model, healthcare organizations can tap into the collective expertise and experience of their workforce to drive meaningful and sustainable improvements in patient safety.

Keywords: leadership, culture safety, health care, leader.

[1*,4,5]Health informatics technician, Khabash Hospital, Najran, Saudi Arabia.
[2]Bio Medical Technician, Khabash Hospital, Najran, Saudi Arabia.
[3]Healthy Assistant, Khabash Hospital, Najran, Saudi Arabia.
[4,6,7]Pharmacy technician, Khabash Hospital, Najran, Saudi Arabia.
Pharmacist, Khabash Hospital, Najran, Saudi Arabia.

***Corresponding Author:** Hussain Qayid Ali Almansour
*Health informatics technician, Khabash Hospital, Najran, Saudi Arabia.

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Introduction

Without a doubt, healthcare managers play a crucial role in ensuring patient safety and maintaining high standards of care. It is both a moral and legal obligation for healthcare managers to ensure patient safety and provide top-notch treatment. As leaders, their responsibilities encompass developing new policies, revising existing ones, and making critical decisions on a daily basis. Creating a supportive work environment that empowers subordinates to deliver optimal care to patients is a key aspect of management's duties. The concept of patient safety has roots dating back to Hippocrates, who established the principle of "above all, do no harm" in ancient Greece. The increasing number of lawsuits filed against physicians and medical facilities underscores the need for administration to thoroughly investigate and address any allegations of medical errors, negligence, or procedural flaws that could jeopardize patient well-being. Research indicates that a majority of adverse hospital events can be prevented, with some stemming from management-related factors. Undoubtedly, there exists a strong link between effective management and patient safety. One of the pivotal factors influencing an organization's progress or decline is its management [1].

Various organizations have put forth definitions for the term "safety culture." According to Weaver et al., a safety culture is generally understood as the collective beliefs, values, attitudes, and shared views within an organization that contribute to fostering a commitment to safety and efforts to minimize harm. The attitudes and actions of a healthcare facility regarding patient safety that are apparent from the outset are collectively referred to as its "safety culture" [2].

One of the primary objectives of many initiatives aimed at enhancing patient safety and treatment quality in acute care settings is to cultivate a culture of safety. Numerous studies highlight the correlation between safety culture and related concepts such as safety climate and clinical practices, including error reporting, reduced adverse events, and lower mortality rates. The National Patient Safety Foundation has defined the promotion of safety culture as a Safe Practice, and accrediting organizations have outlined leadership requirements for assessing and enhancing safety culture. While the promotion of a safety culture has garnered considerable attention, genuine change can only be achieved by understanding the most effective strategies and the aspects of implementation that may influence their effectiveness [3].

The aspect of an organization's culture that can be characterized using social, organizational, and safety sciences is the patient safety culture [4]. It provides insights into the relative priority of patient safety compared to other objectives (such as throughput or efficiency), which influences the behaviors, attitudes, and thoughts of clinicians and staff in their roles [4]. Additionally, the culture shapes the perceptions of clinicians and employees regarding what constitutes "normal" behavior in terms of patient safety in their workplace. It influences opinions about what is considered acceptable or unacceptable, whether formally by area managers or informally by colleagues and other team members. Therefore, one's motivation to engage in safe behaviors and the extent to which this motivation translates into daily practice are influenced by the culture [5].

When organizational leaders embrace a safety culture, safety becomes their foremost concern. To demonstrate their commitment, leaders assist the organization in learning from mistakes and near-misses, investigating errors to identify their causes, devising plans to prevent recurrences, and educating employees about the importance of reporting concerns. Risk managers play a vital role in helping the organization foster a safety culture. A safety culture brings about an emphasis on error analysis and mitigation, which is crucial to risk management operations [6]. The shortage of healthcare staff is a major contributor to unsafe patient care. An imbalanced patient-caregiver ratio is believed to result from an estimated shortage of 2.4 million healthcare professionals globally [6].

Considerable effort has been directed towards assessing the patient safety environment over time, as safety culture can impact care processes and outcomes (7). While likely not sufficient, measurement and feedback are crucial tools for effectively nurturing a culture of safety. A prior systematic review revealed strong face validity for interventions aimed at promoting a safety culture in healthcare [8], although the findings on the effectiveness of these interventions were limited by the diversity of the studies, measurements, and settings. The safety climate survey measures may benefit from multidimensional, unit-based interventions and leadership walk rounds, according to the results. Another review by the Cochrane Collaboration looked at organizational culture-change interventions intended to improve patient outcomes and quality of care; only two studies were found to be included, both of which evaluated different outcomes, and the results were inconclusive [9]. Nevertheless, the review did not

evaluate effects on patient outcomes or care processes.

The fundamental components of a thriving safety culture

Thriving safety cultures necessitate a variety of frameworks and procedures, as delineated by conceptual models of organizational safety and empirical research on companies with exemplary safety track records. Three organizational elements work in conjunction to cultivate safety cultures: internal environment and procedures, employee attitudes and perspectives, and individual safety-related behaviors. These components intertwine to foster a robust and sustainable culture of safety within an organization [10].

Leadership's Dedicated Attention to Safety

The establishment of a safety culture inside an organization depends heavily on the leadership's dedication to safety. Despite the fact that management is best suited to unite and influence all groups within the organization (by defining norms, enforcing values, and offering rewards for desired behaviors), all organizational leaders (including governing boards and clinical leaders) must demonstrate this dedication [10].

Words by themselves are a poor leadership instrument. The dedication of a leader must be demonstrated by activities that are visible to the workforce. By regularly and closely monitoring patient safety at the institutions they are responsible for, boards of directors may show their dedication to this goal [11]. Among the leadership initiatives that management may undertake are the following: obtaining knowledge of safety culture principles and practices via formal training, Ensuring that the organization's strategic initiatives give safety first priority, Establishing facility-wide policies and procedures for patient safety that clearly outline strategies for supervisor accountability and responsibility and allow each worker to explain how their work impacts patient safety [10], Ensuring that the organization's safety rules are regularly reviewed to make sure they are appropriate for the situation both now and in the future, Putting a major issue on the agenda for meetings: safety, Encouraging staff members to be curious about safety-related matters, Setting personal goals to enhance safety directly in the spheres of managers' accountability, keeping an eye on safety trends to make sure that safety goals are being met. demonstrating a sincere interest in safety enhancements and rewarding those who succeed in doing so not limiting attention to circumstances when a safety issue exists, Establishing both short- and long-term safety objectives, as well as routinely reviewing the organization's safety status [12].

The organization's budget, which shows a desire to allocate funds for increased safety, is the last indicator of the leadership's dedication to safety. Leaders must show visible commitment to safety, not just through words but through consistent actions that prioritize safety and encourage staff to actively engage in safety initiatives. This includes setting clear safety goals, regularly reviewing safety procedures, and ensuring that safety is a top priority in all aspects of the organization's operations. Additionally, leaders should allocate funds for safety enhancements and reward those who contribute to improving safety standards [13].

Encouraging a Safety Culture as a Patient Safety Method

Assessing safety culture promotion initiatives in inpatient care environments is crucial for improving overall patient care. It is important to evaluate the effectiveness of various treatments, such as CUSP, executive walk rounds, multidisciplinary rounding, team training, and team communication tools. These interventions have been implemented in academic and community hospital settings, focusing on acute care units and surgical settings [3].

The main objective of these treatments is to improve how staff and clinicians perceive safety culture, including teamwork and the general safety atmosphere. Research shows that efforts to enhance safety culture can significantly improve clinical care procedures and reduce overall patient harm indices. However, most studies have used pre-post designs without control participants and have had relatively small sample sizes, with only a few exceptions. Additionally, there has been limited research on potential differences in safety culture views among different types of care providers. Therefore, it is essential to conduct further comprehensive research to fully understand the impact of safety culture promotion initiatives [3].

Different instruments to enhance understanding and transform safety culture

The initial step in identifying the primary concerns and developing effective ad hoc improvement plans involves accurately evaluating the culture of patient safety. As per the Health and Safety Commission of the United Kingdom, safety culture is defined as the culmination of an organization's individual and collective values,

attitudes, perceptions, competencies, and behavioral patterns that determine its level of dedication to health and safety management, as well as its approach and proficiency. Fostering safety culture necessitates active collaboration between hospital administration and medical staff [14].

The notion that organizational culture is not singular but rather comprises multiple "subcultures" has gained traction over time due to the efforts of numerous authors. Various authors have identified distinct "archetypes," each representing specific assumptions about risk, the causes of accidents, and methods for preventing them. These subcultures can coexist alongside a broader, overarching organizational culture, according to Phipps and Ashcroft [15]. For example, different departments within the same hospital may place varying emphasis on patients' involvement in the treatment process, which could have significant implications for risk management. Emphasizing that safety culture should be viewed as a local phenomenon, Provonost and Sexton [16] found that safety climate scores varied more within units within the same hospital than between different hospitals. Overall, a range of factors operating at different levels have shaped the safety culture. Despite the frequent confusion between the terms, several authors have distinguished between the concepts of "safety culture" and "safety climate." Patient safety climate, which is actually defined as "the measure of the safety status perceived by members of an organization in a specific place at a specific time," relates to employees' attitudes and perceptions of the priority given to safety, whereas safety culture pertains to the organization's norms and values. Based on these assumptions, it is feasible to define patient safety climate as the observable and quantifiable values and artifacts that the organizational culture has embraced, while the fundamental assumptions of culture are less easily accessible [14].

Typically, questionnaires are utilized to assess climate as they are a crucial tool for gauging how secure employees feel at work and for collecting precise benchmarking data. Internationally, instruments for evaluating safety climate have become widespread; among the most effective is the Safety Attitude Questionnaire (SAQ), which was developed by Sexton et al [17]. As a user-friendly and informative tool, the SAQ stands as one of the most widely used global safety climate surveys. The Manchester Patient Safety Framework (MaPSaF), designed to aid healthcare organizations in reflecting on their progress towards establishing a "mature" safety culture, serves as another widely utilized tool. It proves to be a valuable resource for fostering discussions about the advantages and disadvantages of safety culture, promoting contemplation on it, and driving the necessary changes to enhance safety. Alongside the Hospital Survey on Patient Safety Culture, the European Union Network for Patient Safety has recognized SAQ and MaPSaF as two of the three most suitable and recommended instruments for evaluating various aspects of patient safety culture [14].

Several studies have demonstrated a connection between an effective evaluation of the safety culture and employees' adoption of safe behaviors. Nevertheless, these instruments represent an analytical approach to evaluating safety culture, with all the interpretive constraints that this implies, as they are unable to access the most profound facets of culture. This criticality might be solved with an integrated review that makes use of a variety of tools and methodologies. The questionnaire authors themselves highlight how important it is to conduct an integrated evaluation with both quantitative and qualitative instruments in order to have a deeper knowledge of the underlying level of culture [18,19].

Leadership Effectiveness in Healthcare Settings

Patient outcomes, public health, and institutional benchmarks have emerged as the primary objectives of any healthcare system in recent years. The achievement of these goals is possible through the implementation of evidence-based strategies for disease prevention and treatment, as well as the maximization of available financial and human resources, particularly in underdeveloped areas. Effective healthcare leadership, conceptualized as a network in which team members closely align with leadership, can inspire actions that are in line with the organization's goals and aspirations. In a scenario where the team leader successfully increases team member awareness and participation, healthcare professionals improve their adherence to daily duties, leading to enhanced patient health within a framework of high-quality leadership. However, in an environment detrimental to workers' health and productivity, professionals' confidence may decrease, even if effective leadership enhances the functioning of healthcare systems and patient outcomes. Conversely, strong leadership may be necessary to prevent any negative factors that could hinder team productivity and healthcare system outcomes. Transitioning from traditional

and presumed leadership styles to a more dynamic and effective one remains challenging [20].

The traditional concept of leadership is evolving as the Informal Opinion Leadership style gains more traction in healthcare settings. This approach provides a leader without a formal position referred to as an "opinion leader", whose knowledge and conduct align with the workplace, aiming to utilize best healthcare practices to cultivate a more familiar and collaborative team. On the other hand, informal leadership initiatives have been shown to improve healthcare outcomes, according to Flodgren et al [21].

Today, various leadership styles are recognized and categorized differently; however, due to the diverse definitions of leadership in the literature, none are considered the best practice for healthcare systems. While Chen DS-S presented a standard leadership style categorization (charismatic, servant, transactional, and transformational), Goleman's leadership style classification took into account the behavior of leaders [23].

A leader should possess both the behavioral traits necessary for establishing trustful relationships and achieving healthcare system objectives, as well as a high level of expertise in healthcare leadership. This is true even though improving one's leadership style depends on the workplace's values and goals. In theory, every practitioner can adjust their emotional intelligence and professional/educational backgrounds to healthcare environments, political boundaries, economic conditions, and human resources. No organization in the modern era has a policy for selecting leaders in a specific healthcare environment. Despite the availability of a self-assessment leadership skills questionnaire for aspiring leaders and a leadership selection model by Dubinsky et al., there is a debate over a standardized and widely recognized approach for choosing leaders for healthcare organizations. The arduous use of leadership abilities and adaptive traits among team members may be the main cause of leadership failure. A possible contributing factor to this unfortunate incident is the absence of a uniform leadership curriculum . Therefore, for many medical professionals, the only way to implement a leadership style is through job experience in healthcare settings [20].

Conclusion

In summary, this review indicates that evidence supporting the potential effectiveness of interventions to promote safety culture. Notably, the most compelling evidence to date appears to involve strategies comprising multiple components that include team training and mechanisms to support team communication, as well as executive engagement in frontline safety walk rounds. Organizations should consider integrating these elements into efforts to promote safety culture, while also thoroughly evaluating such efforts across multiple outcomes. In any healthcare organization, leadership's foremost responsibility is to be accountable for effective care while safeguarding the safety of patients, employees, and visitors. Competent and thoughtful leaders contribute to improvements in safety and organizational culture. They recognize the existence of systemic flaws and the potential for failure at each step in a care process due to human error. Future research should also thoroughly investigate safety culture as a cross-cutting contextual factor that can moderate the effectiveness of other patient safety practices, such as the implementation of rapid response systems. Additionally, ongoing evaluation of the effectiveness of these interventions is crucial to ensure that efforts to promote safety culture are achieving the desired results. By addressing safety culture as a fundamental aspect of patient safety, organizations can enhance their overall safety performance and improve outcomes for both patients and healthcare providers. Addressing the leadership gap in healthcare in an evolving and challenging environment constitutes the current and future goal of all societies.

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