Creating a Safe Learning Organization

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THE FEATURE ARTICLES in this issue of *Frontiers of Health Services Management* by Bagian at the Veterans Health Administration and by Winokur and Beauregard at William Beaumont Hospital highlight improvements in patient safety that need to be made by healthcare professionals and their organizations. We can learn several specific lessons from the articles based on what they have accomplished, such as creating a vision for safety, providing strong visible leadership, and finding the right mix of tools for analysis and actions for change. In general, these articles bring into focus the need to create a culture of safety and, more broadly, the need to create a learning organization.

Bagian asserts that "very little has changed since patient safety burst into the public's and general medicine's consciousness." Indeed, when we think of how far we must go to achieve the level of patient care currently provided by the few "ultrasafe" healthcare organizations, it does seem that very little has changed. However, the small changes to date have been consequential changes, as observed by Leape and Berwick (2005). They summarize the progress we have made as occurring in the following three broad categories:

1. Viewing the task of error prevention (i.e., how health professionals think and talk about medical errors and injury)
2. Enlisting the support of key stakeholders
3. Changing practices

Leape and Berwick acknowledge that while key stakeholders exist at multiple levels, from the federal government to accrediting bodies, the most important stakeholders are the physicians, nurses, therapists, and pharmacists who have answered the call to improve safety in their own hospitals and clinics for their own patients.

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The Veterans Health Administration has become a national example of safe practices and training programs through its patient safety program. Bagian's article illustrates that it is possible to bridge the gaps between the macroorganization, the mesoorganization, and the microsystem. In this case the macroorganization is the Veterans Health Administration, the mesoorganization represents the departments within individual VA medical centers, and the microsystem is the front line of care where patients and providers meet.

A Culture of Safety

During the past several years of the growing patient safety movement, it has become increasingly clear that assessing and transforming the organizational culture is a key component toward realizing potential improvements in quality and safety of care. The Institute of Medicine (2001) holds that "the biggest challenge in moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are not treated as personal failures but as opportunities to improve the system."

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How do we create an environment in healthcare that fosters safety? Whereas national cultures arise largely out of shared values, an organizational culture is shaped mainly by shared practices. Culture can be defined as the collection of individual and group values, attitudes, perceptions, and assumptions that guides the group members' behaviors (Schein 1990; Helmreich and Merrit 1998). Characteristics of a strong safety culture include a commitment of the leadership to discussing and learning from errors, founding all communications on mutual trust, sharing perceptions of the importance of safety, encouraging and practicing teamwork, and using systems for reporting and analyzing adverse events (Pronovost et al. 2003).

Striving toward a safety culture is a process of collective learning—personal learning as well as organizational learning. A classic model of safety culture describes the elements or subcultures as reporting, learning, flexible, and just (Reason 1997). Providers must know what to report, how and why to report it, and do so safely with rapid-cycle feedback to keep the reporting coming. The organization must honor learning above blame and improvement over the status quo and use all available means to learn, including "safety imagination" about what *could* happen given known risks and near-miss data. As Bagian points out, "as far as patient safety is concerned, the reporting system should be looked at as a vulnerability detector, not as a measurement of incidence or prevalence."

Leadership for Safety

Undoubtedly, leadership is a key theme in improving patient safety and an inherent part of a safety culture. Leading an organization that is committed to providing safer care requires overcoming the common traps in thinking about error, such as blaming individuals, ignoring the underlying systems factors, and blaming the bureaucracy of the organization. Leaders must address the system issues that are at work within their organization to allow individual and organizational learning to occur. Leaders need to create learning organizations in which they integrate a safety vision and systems thinking around error and safety throughout the

organization. Winokur and Beauregard write that leadership for safety at William Beaumont Hospital comes from all levels of the organization—the chief executive officer, senior executives, managers, and frontline staff. In addition to leadership at all levels of the organization, leadership for safety must extend to the governing board of the organization, which has an important role in ensuring the safety of the organization by holding the leadership accountable for defining and meeting the goals of a safety plan (Mohr, Abelson, and Barach 2002). The potential effect of including the board is demonstrated at William Beaumont Hospital when a simple presentation to the board about the IOM report proved to be the launching pad for their Patient Safety Vision, a Corporate Performance Improvement and Patient Safety Plan, the Corporate Patient Safety Council and Patient Safety Cabinet, and the appointment of a Chief Patient Safety Officer at each of their two hospital divisions.

The Learning Organization

When defining leadership in terms of creating a learning organization, the role of the leader is to take responsibility for learning as a designer of the learning process and a steward of the vision, as well as that of a teacher by fostering the learning throughout the organization (Senge 1990). Detecting and correcting errors in a reactive mode—what Argyris (1991) refers to as single-loop learning—is the stage at which many organizations find themselves in their journey to improve safety. The ability to assess the environment and make changes is single-loop, or passive, learning. In contrast, double-loop learning builds on single-loop learning by detecting and correcting the error and then proactively changing the organization's underlying paradigms, policies, and objectives. Leadership for patient safety depends on this active, or double-loop, learning, where errors and near misses are viewed as opportunities to advance the organizational learning and change.

Challenges as We Continue the Journey

As we think about moving toward a culture of safety and creating learning organizations, it is important to understand the tension between what we can accomplish today and what we can accomplish in an ideal tomorrow. For example, we have been waiting for the panacea of technology for a long time. Whether the expectations for technology's impact on patient safety served as an excuse not to improve quality in the 1980s, 1990s, or more recently, we have held on to the belief that technology will be our savior if we wait for just the right moment to strike.

While mounting evidence indicates that certain technologies such as computerized provider order entry and electronic health records may reduce the likelihood of patient harm, in practice many institutions have been frustrated with the challenges of implementing these technologies in the day-to-day processes of patient care. Research in human factors engineering has shown that if the potential benefits of technology are to be fully realized, we must carefully design the implementation plans so that they take into consideration how the technology fits into the current workflow, the changes that will need to be made in the workflow, and the needs of the end user (Karsh 2004). Winokur and Beauregard have it right when they say,

"waiting for these new technologies and not addressing flaws in currently written medication orders is not acceptable in our culture."

We need more examples from the field describing the successes, as well as the challenges, in improving patient safety, such as those described by Bagian and by Winokur and Beauregard. Let these articles be a call to action for the rest of us as we continue to face the challenges that are inherent in improving patient safety in our institutions and as we strive to create safe learning organizations.

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References

Argyris, C. 1991. "Teaching Smart People to Learn." *Harvard Business Review* 69 (3): 99–109.

Helmreich, R., and A. Merrit. 1998. *Culture at Work in Aviation and Medicine: National, Organizational, and Professional Influences.* No. 176. Aldershot, Hampshire, U.K.: Ashgate.

Institute of Medicine. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academies Press.

Karsh, B.-T. 2004. "Beyond Usability: Designing Effective Technology Implementation Systems to Promote Patient Safety." *Quality and Safety in Health Care* 13 (5): 388–94.

Leape, L., and D. Berwick. 2005. "Five Years After To Err is Human: What Have We Learned?" *Journal of the American Medical Association* 293 (19): 2384–90.

Mohr, J., H. Abelson, and P. Barach. 2002. "Creating Effective Leadership for Improving Patient Safety." *Quality Management in Health Care* 11 (1): 69–78.

Pronovost, P. J., B. Weast, C. G. Holzmueller, B. J. Rosenstein, R. P. Kidwell, K. B. Haller, F. R. Feroli, J. B. Sexton, and H. R. Rubin. 2003. "Evaluation of the Culture of Safety: Survey of Clinicians and Managers in an Academic Medical Center." *Quality and Safety in Health Care* 12 (6): 405–10.

Reason, J. 1997. *Managing the Risks of Organizational Accidents.* Aldershot, Hampshire, U.K.: Ashgate.

Schein, E. 1990. "Organizational Culture." *American Psychologist* 45: 109–19.

Senge, P. 1990. *The Fifth Discipline.* New York: Doubleday.