

## FOUNDATIONS FOR A CULTURE OF SAFETY

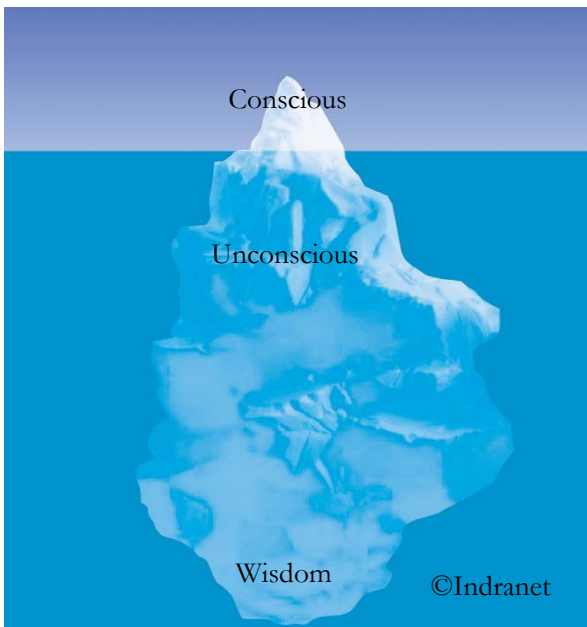
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The Institute for Healthcare Improvement ([www.ihi.org](http://www.ihi.org)) in the US defines a culture of safety as “an atmosphere of mutual trust in which all staff members can talk freely about safety problems and how to solve them, without fear of blame or punishment.” The web site has many leadership and provider tips, strategies, and tools for enhancing safety. Safer Health Care Now ([www.saferhealthcarenow.ca](http://www.saferhealthcarenow.ca)) in Canada is focused on the clinical interventions to enhance safety. Clearly, many hospitals are dedicating considerable resources to increase their patient safety and decrease the number of preventable adverse events but progress is slow and long term sustainability questionable. I think we need to take another look at what is required at a foundational level to create a culture of safety and the leadership required to achieve it.

A closer look at the IHI definition shows the complexity of developing a culture of safety. IHI identifies that mutual trust is essential to improving patient safety in any organization. The word ‘mutual’ suggests that it is at least a two way phenomenon and maybe multidimensional. The word ‘trust’ suggests that it is a dynamic between individuals, groups, or organizations. Wikipedia ([www.wikipedia.org](http://www.wikipedia.org)) defines trust as a relationship of reliance. I’ve noticed trust comes up regularly in conversations in health care. Generally the conversation has a theme along the lines of desperately wanting to be trusted (relied on) but being reluctant to trust (rely on) others. Finally, the word ‘freely’ suggests safety and without fear. From this simple examination of this definition, it seems that the foundation of a culture of safety is really about interface between intrapersonal and intergroup dynamics. The group can be a team, an organization, and/or a system.

In my consulting work in health care organizations, I have been using Deep Democracy as a theory for understanding individual, group, and organizational behaviors and a set of tools and processes for managing them. This theory brings together the world of psychology and quantum physics and was first developed by Arnold Mindell (1992). This work was further evolved including the development of tools and applications by Mryna Lewis ([www.deep-democracy.net](http://www.deep-democracy.net), 2008).

Generally in organizations, groups, and committees only a small fraction of the views, values, beliefs, and emotions are known by all in the group. That which is known by all in the group is said to be in the conscious and that which is only known by one or some of the group is said to be in the unconscious of the group. Decision making is enhanced by increasing the percentage of information, views, values, beliefs, and emotions that are in the consciousness of the group. The iceberg can be a useful metaphor for describing this phenomenon. The level of the water line or the level at which people feel safe to speak up is influenced by a number of factors including:



- The degree of autocracy of the leader(s). The more dictatorial the leader the less likely individuals will surface concerns, perspectives, or emotions.
- The level of perceived risk of retribution from colleagues or others in the organization. The greater the perceived potential personal consequences, the less likely individuals will voice their true views.
- Degree of transparency. Increased transparency increases what is known by all and thus decreases the water line.

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- Rank differences such as CEO versus manager, nurse versus physician, staff versus management, patient versus providers, etc. The greater the perceived rank difference the higher the water line.
- Degree of predictability. The more predictable situations are over time, the lower the water line (e.g. is a key player(s) likely to be stable for a period of time or are they transient).
- The degree to which people think surfacing their view will make a difference. If past experience has demonstrated that surfacing a concern or perspective falls on deaf ears, people are less likely to waste their energy.

Fear is a common element in many of these factors and thus it is worth elaborating a little further on the concept of fear. Fear as it relates to group dynamics has two aspects, fear of speaking up and voicing one's views and fear of listening and truly hearing what others are trying to tell us. This combination of fear results in both perspectives not being surfaced and not being heard. Remember, perspectives that are voiced or surfaced are said to be in the consciousness of the group and those that are not voiced are said to be in the unconscious of the group (Lewis, 2008). It is only those that are surfaced that can contribute to effective decision making.

Much work is being done in an effort to increase the safety in healthcare. At the same time, there seems to be a general trend of rising 'water lines' undermining the good safety work. Let me conclude by surfacing the perspective that paying attention to the factors that impact the level of the 'water line' is a high leveraged activity senior health care teams and health care leaders should regularly engage in.

#### Questions for reflection

1. What do you need to start doing as a senior/leadership team and as an organization to lower the "water line"?
2. What are you currently doing that increases the water line?
3. How is your own fear impacting both what you say and what you hear?

#### References

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