SAFETY CULTURE 'DOWN UNDER'

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BACKGROUND

Patient safety in primary care

Patient safety is a major public health issue in the developed world.[1] The systems approach is advocated to improve patient safety.[2] 'Safety culture', the 'shared attitudes, beliefs, values and assumptions that underlie how people perceive and act on safety issues', is key to this approach.

Manchester Patient Safety Framework

The Manchester Patient Safety Framework (MaPSaF) was developed to assess safety culture in the UK. The primary care version facilitates team discussion and helps practice teams learn about 'safety culture' and identify strategies for change.[3] The MaPSaF has been endorsed by the UK's National Patient Safety Agency for use as a 'team-based self-reflection and education exercise'.

AIM

To assess the adaptability and utility of the MaPSaF in New Zealand.

METHOD

Adapting the MaPSaF to New Zealand

MaPSaF phrases unfamiliar to frontline staff in New Zealand or unique to the UK were deleted or substituted with their New Zealand equivalents. MaPSaF statements were shortened to enable the framework process to be completed within one hour.

Data Collection

Data were collected in 12 randomly selected Dunedin practices at baseline and 3 months. Dunedin is located on the south east coast of New Zealand and has a population of 120,000.

For each MaPSaF dimension, participants chose the statement that they felt best reflected the safety culture in their practice. The practice team discussed each dimension and chose a consensus statement for their practice.

Data analysis

Team discussions were recorded, transcribed and analysed for the MaPSaF's adaptability, acceptability and utility.

RESULTS

Participating practices had between 1100 and 18,000 enrolled patients. In each practice 4 – 23 participants took part in the MaPSaF process, including doctors, nurses, managers, receptionists, dentists, counsellors, student nurses and registrars.

Participant 'scores' were a starting point for discussion rather than an indicator of a practice's actual level of safety culture maturity.

Adaptability

Participants from smaller practices questioned the need for the 'systems' promoted in the MaPSaF.

… often everyone's involved in some incident too, so you have to know about them, you know . . .

In a little place… you can talk to each other, so you don't have quite the same… We have 'discussion' but we don't actually have the 'systems' in place.

Acceptability

Most participants found the process 'useful' and 'thought provoking'.

From our point of view it's been a good process.
It's made us think about it.

Some found the process 'threatening'.

And were we defensive? Too bloody right.
This is a 'learning tool'.
But it is natural to be defensive… But it's also a learning experience as well… Everyone sort of says "Oh we're not defensive, it's learning"… Of course we're defensive.
I think everyone is defensive.

Some expressed concern about time and priorities.

We just got busier and busier and the paperwork got greater and greater… there's not the time to do it …

Utility

Education:

The framework helps practice teams learn about 'safety culture' and 'patient safety incidents'.

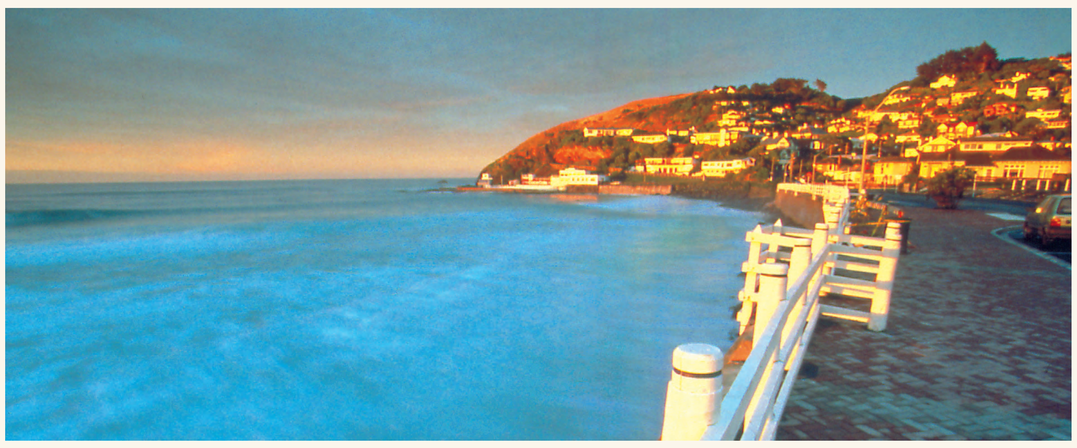
We actually do, do that… at every meeting we ask if there are any 'Health and Safety issues'…
The 'Health and Safety issues'… they were often about the building …
They are 'Health and Safety issues'…
Yeah, yeah, yeah... which is slightly different from 'patient safety incidents'.

Change:

We've started a patient called 'Mr Patient Safety' and we've recorded a fair number of incidents. We had a meeting recently… so that has improved things, it's made us more aware.

Team communication:

Umm, the 'equally valued' and 'free to contribute'…
Do you feel that people aren't equally valued?
Sometimes, yes.
In what way?
Ah, just mainly attitudes really.
From patients or from other staff or…?
Mostly other staff…



CONCLUSION

- The MaPSaF can be used in New Zealand
- MaPSaF strengthens safety culture by:
  - educating practice teams about 'safety culture'
  - facilitating team communication
  - helping practice teams identify changes
- The framework can be used to provide a qualitative audit of practice safety culture

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