Check for updates

Received: 25 July 2022 | Revised: 27 June 2022 | Accepted: 13 July 2022

DOI: 10.1002/jhrm.21521

ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

OPERATIONS

Leadership behaviors, attitudes and characteristics to support a culture of safety

Susan L. Montminy EdD, MPA, BSN, RN, CPHRM, CPPS

Correspondence
Susan L. Montminy, Director of Risk Management for Coverys.
Email: smontminy@coverys.com

Abstract

It has been estimated that medical errors are the third highest-ranking cause of death in the United States. A patient safety culture has been touted for many years as best practice to reduce medical error. While there is a general agreement of its importance, it has remained elusive for many. This study sought to learn how strengthening leadership skills within a health care organization could catalyze patient safety culture improvement. The research asked the following to gain an appreciation for that question: How does a leader ensure consistency in policies, practices, and protocols to create a patient safety culture? What attitudes, beliefs, and collective efficacy are needed to produce a patient safety culture? What leadership characteristics are needed to create a patient safety culture? The research participants were the employees who make up the patient safety department in a large academic health care system. Information was gathered to capture their view of leadership's role in patient safety culture and to gain knowledge relative to their individual experiences following a medical error.

INTRODUCTION

The Institute of Medicine (IOM) first reported that 98,000 Americans were dying each year due to medical errors.[1] More recently, it is estimated that medical errors may account for as many as 251,000 patient deaths annually in the United States.[2] Overall, two in five Americans say they have either personally experienced a medical error or had a medical error occur in the care of someone close to them.[3] Patients are not the only ones hurt by medical errors; health care providers are harmed as well, known as second victims in the literature. Following their involvement in medical error, providers can experience anger, guilt, depression, and in extreme cases, suicide.[4]

In addition, there are associated financial costs. The Betsy Lehman Center for Patient Safety, a Massachusetts-based advocacy group, reported that 62,000 medical errors were responsible for over $617 million in excess health care insurance claims in just one year.[5] In the United States, it is approximated that 400,000 hospitalized patients experience some type of preventable harm annually at a cost of over $4 billion.[5] Criminalizing medical errors will increase the associated human and financial costs.

The American Hospital Association issued a statement in response to the recent decision finding RaDonda Vaught RN, the former Vanderbilt nurse, guilty of criminally negligent homicide following an unintentional medical error.

> "The verdict in this tragic case will have a chilling effect on the culture of safety in health care. The Institute of Medicine's landmark report 'To Err Is Human' concluded that we cannot punish our way to safer medical practices. We must instead encourage nurses and physicians to report errors so we can identify strategies to make sure they don't happen again. Criminal prosecutions for unintentional acts are the wrong approach. They discourage health caregivers from coming forward with their mistakes, and will complicate efforts to retain and recruit more people in to nursing and other health care professions that are already understaffed and strained by years of caring for patients during the pandemic."[6]

These words ring true. Humans err. As risk management professionals, it is time for us to go back to the beginning of the

© 2022 American Society for Healthcare Risk Management of the American Hospital Association.

patient safety movement and refocus our attention to patient safety culture. Action is needed and it begins with leaders. In this article, I will share findings from my recent research that probed into the role of leadership on patient safety culture. The results will be categorized by the study's three research questions and conclude with suggested actions based on the findings.

METHODS

The study participants were the leaders of the patient safety department in a large academic health care system including an executive vice president, vice president, director, manager, and two patient safety specialists. Each was interviewed to achieve an understanding of the role leadership plays in the formation and maintenance of patient safety cultures. They are well-positioned to provide insight into the topic as they are often the first persons to respond to and investigate medical errors.

Strengths and weaknesses of the study

In this qualitative study, a purposeful sampling approach that allows for discovery and insight from a sample from which the most can be learned was employed. It focused on one organization with already established efforts to create a patient safety culture. This could be considered both a strength and a weakness. The strength relates to the fact that the participants are knowledgeable about patient safety and positioned well to speak with authority about the topic, important for a purposeful sampling based study. The weakness is that it offered only one group's experience within a very large and complicated organization. Further research in smaller organizations, those without established patient safety resources to attain patient safety culture, and other departments outside of patient safety would be helpful to ascertain if different characteristics and approaches to achieve it might emerge. As with all research studies, I trust the individual reader will determine the usefulness of the findings for their work.

A return to patient safety culture basics

Patient safety culture is the extent to which an organization's beliefs, values, and norms support patient safety. It is a culture where errors are reported to allow for learning and improvement and people are not punished for them.[7] Leadership interventions that promote individual and teamwork behavior changes[8] and focus on system improvement[9] can advance the existing culture. Staff is more likely to learn from errors in organizations with patient safety cultures and supportive leaders. When leaders respond to errors in a non-punitive manner, there is an increased employee willingness to report them and an associated reduction in second victim distress.[10,11] Table 1 provides a high level summary of the key components of a patient safety culture.

TABLE 1 Summary of key components of a patient safety culture[7,12,13]

Alignment with Mission:

The organization's policies, procedures, beliefs, values, and norms support patient safety. Staff collaborates for improved and safer patient care delivery. Organizational, individual, and group values are aligned. Employees believe their values are similar to those held by the organization.

Trust:

Members of the organization trust their leaders. Staff feels safe to self-report errors and near misses. Leaders respond to errors in a non-punitive manner. Staff is not punished for reporting or committing errors.

Learning Environment:

Errors are framed as learning opportunities. Staff learns from patient safety events to continuously improve. Organizational leaders engage frontline staff in patient safety initiatives.

Staff Support:

Leaders promote nonjudgmental, open dialogue following a medical error. Staff receives support following involvement in a medical error. Teamwork and supportive working relationships lead to situational awareness for prompt recognition and reporting of identified patient safety concerns.

RESULTS: ANALYSIS THROUGH THE RESEARCH QUESTIONS

RQ 1: How does a leader ensure consistency in policies, practices, and protocols to create a patient safety culture?

Several interview questions were asked to gain an appreciation for leadership approaches to ensure consistency in policies, practices, and protocols in the quest for a patient safety culture. Actively engaging with the data produced several main categories that answer this question. They include the leadership's responsibility to understand, communicate, and behave per the patient safety-related policies, practices, and protocols. Direct quotes and connections to organizational documents are included to provide validity for the findings in each of the categories sections.

Leadership's responsibility to understand

A senior leadership level participant opined that culture creation begins with leaders "who really see safety as a priority, from a value perspective (…) as part of an organization that's willing to invest the resources to drive it." The data revealed it is not enough to speak the patient safety language, the organization has the responsibility to put resources behind it and ensure it possesses leaders who understand their role within it.

Four out of six participants posited that each leader must develop an understanding of patient safety issues in their area of responsibility through a data lens. This includes reporting rates in each leader's department that reveal consistent reporting as well as a lack of reporting. One participant added that it is a "statistical anomaly to think that you're not going to be

20400861, 2022, 2, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/jhrm.21521 by Uncl University Of Nebraska, Wiley Online Library on [08/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

making little errors, little mistakes, that for some people, they think are insignificant, but when you start adding them up, [they are not].” Departments without error or near-miss reporting would not be expected in an organization with a patient safety culture. Another participant presented executive leadership rounds as an example of an additional method for leadership to gain an understanding of what is going on in the organization outside of data. Leadership awareness and understanding at all levels are key.

Five out of the six patient safety department members assert that leaders must be knowledgeable of the content within the organization’s patient safety-related policies, protocols, and procedures to reduce variability in practice and use them to guide practice. The decision algorithm, present in the organization’s *Staff Responsibility for Safety* policy was adopted to help evaluate employees involved in a medical error to understand the contribution of human and system factors.[14] One participant indicated that adopting a non-punitive approach while maintaining mindfulness that “willful disregard of policy and procedure with no mitigating circumstances will not be tolerated” is a necessary balance a leader must strive to maintain. Adoption of this tool assists leaders to make this determination objectively.

All participants agreed that the written policies assist with the communication of expectations, document best practices, and guide expectations and surrounding behaviors for staff to follow. Said one participant at the management level, they “eliminate the gray” to hold staff accountable and are useful in medical error investigations to direct the discussion. According to Dr. Don Berwick, former founder and Chief Executive Officer (CEO) of the Institute for Healthcare Improvement (IHI), “Most serious errors are committed by competent, caring people doing what other competent, caring people would do.”[15] This understanding was noted in the totality of participant responses and is illustrative of the leader’s responsibility to understand the organization’s policies, protocols, and procedures as a basis to know what that competence is. In organizations with a strong patient safety culture, decisions that affect safety are systematic and thorough. Leaders who practice by them, use them to analyze systems, and coach staff to follow them lead to a learning culture that helps implement reform when needed.[16]

Leadership’s responsibility to communicate

Patient safety must be communicated throughout the organization, with consistent messaging in alignment with the associated policies, practices, and protocols. Several participants commented on the importance of leadership’s adoption of multiple and creative approaches to communicating patient safety as a priority. Four out of the six participants iterate that communication should celebrate those who have reported near misses, or other potentially hazardous situations on a routine basis during formal events, such as Patient Safety Awareness week and new employee and manager orientation. Near miss reporting, before a medical error has been committed, is the preferred method to examine a potentially faulty system.

Two of the patient safety department’s senior-level leaders stressed that when a near-miss or medical error is reported, the communication loop should be closed so there is no appearance of the report “falling into a black hole.” One of the two leaders stated that the person who takes the time to report deserves to know “that we actually look at every single event and do something about it.” The second of the two added that by providing feedback following a report, the reporter feels “like they’re participating in the (…) safety culture because they’re speaking up.” The black hole description was stated verbatim by these leaders and is an example of a practice that would lead to a reduction in error reporting. If employees do not feel their reports are acted upon, there would be less incentive to report them. In their study, Sexton et al. found employee engagement and participation in decision-making highest in settings where leaders participate in active communication with their staff.[17] Feedback to the medical error or near-miss reporter to express appreciation and inform them of the positive change that resulted from their submitted report emerged as instrumental to creating an environment of consistent reporting and safety awareness.

While formal communication had its purpose, the patient safety specialists at the management level stressed that communication should also promote awareness at the unit level through the use of data, storyboards, and huddles. Huddles were defined as brief, purposeful gatherings with management and employees to share patient safety-related concerns and assess goals and anticipated challenges to achieve a comfort level of preparedness for the shift. By inviting the employee’s perspectives and seeking feedback, the employees can feel more confident in their ability to respond to the potential challenges that lie ahead. In their study, Horwitz and Horwitz found a positive correlation between patient safety culture and structural empowerment,[18] with structural empowerment referring to staff’s ability to mobilize resources and achieve goals through access to information, support, and resources.[19] Huddles and other avenues of informal communication at the unit level are the vehicles to provide that opportunity. The leader as a communicator in both words and actions is crucial to the maintenance of a patient safety culture.

Leadership commitment to patient safety behaviors

Patient safety culture is developed with intent, however, tends to be informally created among its members and built upon the foundation of mutual goals and behaviors. Role modeling patient safety behaviors emerged through the data analysis process as an important element of patient safety culture. Leaders must see small errors as opportunities for improvement and, according to one senior-level participant, must “commit to doing everything they can so as not to cause harm [and ensure that their staff view reporting as a] non-punitive, blameless opportunity to tell us what they have seen.”

20400861, 2022, 2, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/jhrm.21521 by Uncl University Of Nebraska, Wiley Online Library on [08/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

TABLE 2 Summary of responses in support of RQ1

They understand: They consistently follow policies, practices, and protocols and are committed to being fully knowledgeable of their content. They use data and direct observation to focus on individual areas of responsibility to lead to awareness and shine a light on areas of opportunity for improvement within them.

They communicate: They get out of their office, are visible, and interact with staff to observe and solidify patient safety behaviors according to the policies, practices, and protocols' content. They communicate in creative and engaging ways to further the message that safety is an organizational priority.

They exhibit patient safety behaviors: They communicate and behave in alignment with the patient safety principles embedded in the related policies, practices, and protocols. They hold staff accountable in a consistent, objective manner using the policies, practices, and protocols as a guide and create safe environments to increase reporting of unsafe conditions and other patient safety concerns.

At the senior level where policy is written, it was underscored that leaders must build safety systems with double checks and forethought. They should not allow for opportunities for people to fall into a situation where they could make a mistake. The organization's *Quality and Safety Improvement Plan* documents its expectations of leaders, "Operational leaders from each organizational department and service, share with senior leaders across the system the responsibility to ensure optimal, high quality of patient care and/or service delivery within a safe environment." Table 2 is presented to summarize the key points gleaned from the collective interviews that answer the first research question.

RQ2: What attitudes, beliefs, and collective efficacy are needed to produce patient safety culture?

Several interview questions were asked to better understand the role of attitudes, beliefs, and collective efficacy on the production of a patient safety culture. Data align with the literature on transformational leadership principles, specifically, the enhancement of personal relationships in pursuit of collective efficacy, possession of strong morals and values, and focus on authenticity and communication.[20–22] A synopsis of the findings is presented in the three main areas addressed in the research question; leadership attitudes, leadership beliefs, and leadership's ability to attain collective efficacy.

Leadership attitudes

Leadership needs to demonstrate an attitude of humanness as it pertains to medical error. Two participants, one from the senior level and one from the management level shared that leaders who tell stories with examples of their vulnerability, to elicit a response that, "Oh my God, that could have been me" and no one is "perfect" display an attitude of connection. Many staff members are perplexed about who they can turn to for support and guidance following medical error.[23] When leaders share similar experiences that happened to them, they open the door for others to do the same. These leaders present as role models of the desired behaviors required to achieve a patient safety culture, namely, an environment of nonjudgmental, open dialogue following a medical error.[8,13,14]

Five of the six participants impart that leaders must reveal an attitude of caring and compassion after a medical error. The organization's *Event Reporting System, Management, and Analysis* policy support this construct with a reminder that involved staff may need emotional support or formal referral to an employee assistance program after a medical error. A participant at the management level affirmed that the leader should take care of the immediate safety needs of the patient while recognizing at the same time that the employee may need support as well, specifically that "they need to be consoled, there's a lot of grief and a lot of guilt that comes when, you know, an error is made." Two of the senior-level participants iterated the importance for the leader to react to medical errors with consistency and apply the just culture principles outlined in the *Staff Responsibility for Safety* policy or risk a hesitation to come forward after a medical error. Said one, "we do have to educate leaders (…) to the decision algorithm around what you do in response to reporting" and according to another participant, "everybody has to come up with a standard way (…) of holding our employees accountable." The *Staff Responsibility for Safety* policy includes a statement that there will be a "fair and just response by balancing a non-punitive approach while holding all staff responsible" for safety following a medical error.

Leadership plays a key role in a learning environment when an observation of behavior that falls outside of the patient safety guidelines is made. When there is a witnessed deviation from practices, policies, and protocols, in an organization with a patient safety culture, leaders coach staff in a caring, empathetic manner, and as one senior-level leader described, hold people "answerable to the outcomes" by engaging in nonjudgmental conversation in real-time. One senior level leader relayed a situation she observed that exemplifies this concept. It involved a nurse manager who saw a nursing assistant bypass a step in the patient identification process who privately pulled them aside for a coaching moment.

> Hey, I just watched you and I'm sure (…) you believe you know this patient (…) our expectation is that we double check (…) two identifiers, every patient, every time we draw labs, and you know, let me just tell you why we do that, (…) we've had examples across the organization where, in error, (…) we've sent the wrong blood down and you know, we could be treating the wrong patient for something and really cause harm and I watched this nursing assistant really get it, it was like, Oh, my goodness, I didn't even think that that could happen. But it was a very coaching, positive, collaborative and it wasn't (…) beating the person up

20400861, 2022, 2, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/jhrm.21521 by Uncl University Of Nebraska, Wiley Online Library on [08/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

> or berating them in a negative way and I said, wow this is really great.

Employees who observe a consistent coaching style develop trust in their leaders and an increased propensity to adhere to patient safety practices. In their cross-sectional survey employing a convenience sample of 31 hospitals in Michigan, Sexton et al. found that the percentage of respondents who worked in a hospital that engaged in routine leadership walk rounds with real-time feedback had the strongest relationships with their leaders and high scores for participation in decision-making and improvement readiness.[17]

Leadership beliefs

Leadership must hold the belief that all staff is accountable for patient safety. A senior-level leader indicated that following a medical error, leaders should be inquisitive and "as gently as possible try to understand what was happening at the time" to prevent future occurrences. They should gather facts, but be objective and neutral, ask to understand as one senior-level leader described, "not to chastise." A leader at the management level maintained that leaders should start by asking how they failed the employee and support them through the investigation process, to move towards a nurtured, trusting relationship. The organization's beliefs, in sync with the Joint Commission, find that leadership should profess a fair and equitable measure of accountability for all.[24] All six participants affirm the importance of holding staff accountable for patient safety. This stance is documented in the policy entitled, *Staff Responsibility for Safety*:

> All staff, regardless of their position, are responsible for: avoiding behaviors that may cause risk or harm; reporting real or potential safety events using internal mechanisms; practicing safely by following policies and procedures; making decisions that are aligned with a culture of safety, and participating in activities which support and improve safety.

As noted by a participant at the senior level,

> Just because we have words on a paper that say this is the way we do it, the policy by itself isn't going to change the culture, it's how our leaders across the organization evaluate behavior as compared to the policy, and coach, and make sure that people are following [what's in it.]

Felt accountability, also known as simple accountability, is based on perceptions that one's decisions or actions will be evaluated by a salient audience and that rewards or sanctions are contingent on this expected evaluation.[25] Staff must believe that an account-giving (explanation) might be required following a decision.[26] When feedback is delivered consistently, staff will understand their roles and responsibilities and expect that their actions will be evaluated accordingly.

Leadership's ability to achieve collective efficacy

To move toward collective efficacy, leaders need to foster employee connections to build trust within their teams to collectively move towards a patient safety culture. One senior-level participant stressed that to achieve that, leadership at all levels has to "play off each other" and as a management-level participant described, "give consistent information." Multiple levels of leadership must be in alignment and communicate event reporting data according to a management level leader, "who can then sell it to their staff and get them to understand the importance, how it relates specifically to their unit and to them" as a team. Three of the six participants declared that staff needs to see leadership getting out and walking around praising patient safety behaviors. According to another, effective leaders "find somebody who has the leadership qualities (…), not like an official leader (…) one of their staff members to champion" patient safety in their units. This further builds teamwork in support of patient safety. There is always a leadership presence.

The leaders' messaging also creates teamwork and according to one senior-level participant reminds "employees we are all in this together (…) they're all our patients." According to another senior-level leader, an effective team "would have members who feel like every other member of the team has their back" and begins with environments that foster opportunities for colleagues to get to know each other, to find "shared interests outside of the work environment (…) it kind of humanizes members of the team." Another participant furthered that effective leaders "encourage interaction and really constructive communication among members of the work units [and] highlights accomplishments and successes among [them]," identifies areas of potential conflict, and encourages resolution which involves "basically pulling them together and working it out and not letting things fester." At the management level, one participant added that successful leaders role model and encourage communication and collaboration between disciplines, in further support of teamwork. Transformational leaders demonstrate a priority for safety through their behavior and develop trust within their teams that leads to enhanced interpersonal relationships.[20] Team strengthening naturally follows. Table 3 is presented to summarize the key points gleaned from this section that answer the second research question.

RQ3: What leadership characteristics are needed to create patient safety culture?

Several interview questions were asked to ascertain what leadership characteristics are needed to create a patient safety culture. The findings reveal leaders who successfully create a patient safety culture and accompanying learning environment can

20400861, 2022, 2, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/jhrm.21521 by Uncl University Of Nebraska, Wiley Online Library on [08/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

TABLE 3 Summary of responses in support of RQ2

Attitudes: Leaders demonstrate humanness as it pertains to medical error. When they witness a deviation from practices, policies, and protocols, leaders coach staff in an empathetic manner. Leaders exhibit an attitude of compassion for their employees and provide emotional support after a medical error has occurred.

Beliefs: Leadership believes all staff is accountable for patient safety. Leadership professes fair and equitable measures of accountability for all. They understand, implement, role model, and coach staff to patient safety culture components.

Collective Efficacy: Leaders foster employee connections to build trust within individual teams. They help staff understand the importance of teamwork and how it relates specifically to their departments. They encourage communication and collaboration between disciplines.

TABLE 4 Summary of responses to RQ3 related to leadership characteristics

Category	Leadership characteristics
Alignment with Mission	Visionary gets people excited and feeling good, good communicator, ability to motivate, articulate expectations in a manner that can be translated behaviorally
Trust	Draws people to them, they have a presence, can connect with people, transparent, honest, steps up and does the right thing, shows interest in employee's personal life, empathetic, warm, compassionate, fair and open-minded, have to be seen, visible, emotional intelligence
Learning Environment	Can communicate why patient safety is important, come from a real-world bedside background, possesses integrity, a role model of desired behaviors, sense of accountability
Staff Support	Supportive, willing to listen, approachable, positivity, calmness

impact the organization's mission in a charismatic manner and build trust with their staff. In this environment, if an error is made, employees expect to be supported and have the ability to learn from it. The participants listing of individual characteristics gleaned through the interview process are categorized in Table 4.

Patient safety culture is built on trust and a shared vision for patient safety; errors are viewed as learning opportunities and staff is supported following adverse events and medical error. The organization's policies on patient safety outline leadership expectations, roles, responsibilities, and processes surrounding medical error reporting and management of unexpected events. Embedded in the organization's policies is a statement outlining related staff support:

> Staff involved in a serious adverse event is sometimes understandably upset. Supervisors should assess staff's ability to continue working safely and make appropriate arrangements for patient care. Involved staff may also need emotional support.

Changing from an organizational focus on patient safety to one of employee safety having equal importance is supported by the literature as an important element of a patient safety culture. According to Scott et al., staff involved in a medical error often desire emotional first aid but are uncertain about whom to ask for support.[27] Leaders must proactively anticipate this need and initiate the conversation post medical error. Having an organizational foundation to assist leaders with adequate resources to help with this conversation is imperative. Connection and compassion for employees is a key leadership characteristic to create a patient safety culture. A trusting relationship with one's supervisor is ideally formed well before the incidence of medical error.

Necessary leadership characteristics to maintain a patient safety culture are based on the ability to behave in alignment with the mission, form trusting relationships, create learning environments, and support staff. It starts with what one participant described as the leader's consistent behaviors, where one can observe that "what they say and what they do match." According to one participant, leaders who are "visionary" and create excitement around the prospect of a safe place to deliver patient care and are, as another described, "empathic and open and inviting and approachable" are positioned well to orchestrate a patient safety culture. Connection with staff as shared by a participant at the management level is crucial, "we've had, you know, some high up leadership that will go to the different units and talk with the nurses, and talk with the staff, and [make] eye contact when they're walking through the hallways" and "it makes a big, big difference." Another participant agrees and iterates "in order to be approachable (…) you go out and you're visible and you make eye contact."

A management level participant stressed how vital it is to have patient safety messaging start at the top "from the President down" adding if executive leadership is "engaged and visible" the better the chance of employee engagement. According to a senior level participant, a leader "has to be that person that's like honey, not like vinegar" who embodies patient safety and "always steps up and does the right thing. As another describes, "The leader has to be able to communicate to the staff (…) why patient safety is important. Patient safety culture cannot be achieved without the presence of leaders who possess these character traits.

Suggested action

The study's findings suggest an important question to consider: how can a leader be expected to create a patient safety culture without an understanding of how to do it? Organizational change can only happen when the individuals within them change. There must be an investment to develop new skills of the individuals who create and sustain culture. Healthcare leaders know what constitutes a patient safety culture, they need strate-

20400861, 2022, 2, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/jhrm.21521 by Uncl University Of Nebraska, Wiley Online Library on [08/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

gies that will help them create environments where employees feel safe to share patient safety concerns and report a medical error. One strategy would be to offer coaching and leadership training on this topic.

Research suggests that trust within an organization is a valuable resource because it makes possible collaborative behaviors and cooperation to continually foster them.[26] The greater the trust among staff, the more effective the cooperative efforts tend to be.[28] Education in an environment with trust at its base would allow for effective peer learning without fear of embarrassment or punishment.[29] Reporting a medical error requires the reporter to make themselves vulnerable. Knowing that the leader will act in their best interest and protect them from negative consequences will lead to a willingness to report a medical error and provide an opportunity to learn from it.[30]

CONCLUSION

The research study aimed to identify leadership characteristics, attitudes, and beliefs that create a patient safety culture in alignment with the organization's policies, practices, and protocols. Conducting data analysis through the research questions revealed the importance of leadership's responsibility to understand, communicate, and behave per the patient safety-related policies, practices, and protocols. The role of attitudes, beliefs, and collective efficacy on the production of a patient safety culture was discussed with the emergence of the leader's humanness and vision as necessary to create connections and encourage medical error and near-miss reporting. A light was shined on the importance of communication in the form of success stories, within disciplines, at the unit level, through policies, procedures, and protocols, and between all levels of leadership to impart a consistent approach to patient safety. Accountability and responsibility was an important theme gleaned through the interviews and document review. To successfully create a patient safety culture, cognitive, emotional, and behavioral aspects of leadership dimensions must be considered. According to Kotter, nothing undermines change more than behavior by leaders that are inconsistent with their words.[31] Medical error harms patients, their families, and the well-intended providers who commit them. A patient safety culture has emerged as a suggested method to create a culture where employees feel safe to report errors and near-miss errors with the confidence that their reports will be reviewed and acted upon. The reports allow for learning to happen and present opportunities to improve systems. Creating a patient safety culture requires thoughtful and transformational leaders who behave in concert with the organization's policies, protocols, procedures, and alignment with patient safety culture principles. According to the National Safety Foundation's Lucian Leape Institute, safety needs to be embraced as a core value of an entire organization and as a moral and ethical imperative in health care.[7]

There has been much discussion within the patient safety literature regarding the components of a patient safety culture and suggested actions to achieve it. Framing the actions with a focus on the leaders who are the ones that orchestrate the changes in a change model that applies to the individual is a new notion worthy of further exploration. By engaging all leaders in the training with feedback, role modeling, and opportunities to practice the new skills, a groundwork of accepted behaviors that support a patient safety culture will be embraced by all. Leadership development should bring together a balance of "knowing (the acquisition of information), doing (the application and practice of new skills), and being (the values, identity, and purpose that animate leaders.)"[32]

It has been more than 20 years since *To Err is Human*, the groundbreaking report that started the patient safety movement, encouraged organizations to achieve a patient safety culture. The call to action put forth by the report was to remove the silence that surrounded medical errors by not pointing fingers at caring health care professionals who make honest errors. The criminalization of medical error may have a negative effect on patient safety culture, bringing back a fear of reporting reminiscent of times before the report was released. Humans err, therefore, it is incumbent upon organizations to continue the work to create a patient safety culture where medical errors can be reported without fear. There is much more work to be done to achieve that goal.

REFERENCES

1. Wakefield M. To err is human: an Institute of Medicine report. *Prof Psychol Res Pr*. 2000;31(3):243-244.
2. Anderson JG, Abrahamson K. Your health care may kill you: medical errors. *Stud Health Technol Inform*. 2017;234:13-17. doi: 10.3233/978-1-61499-742-9-13
3. NORC at the University of Chicago and IHI/NPSF Lucian Leape Institute. Americans' experiences with medical errors and views on patient safety. Institute for Healthcare Improvement and NORC at the University of Chicago; 2017.
4. Rodziewicz T, Houseman B, Hipskind J. Medical error reduction and prevention. *StatPearls*. StatPearls Publishing; 2021. https://www.ncbi.nlm.nih.gov/books/NBK499956/
5. Palmer JL. Report analyzes cost of medical errors despite healthcare progress. *Patient Safety and Quality Healthcare*. 2019; https://www.psqh.com/analysis/lehman-report-analyzes-cost-of-medical-errors-despite-healthcare-progress/
6. AHA issues statement on ruling in nurse patient safety case. 2022; http://www.aha.org/news/headline/2022-03-29-aha-issues-statement-ruling-nurse-patient-safety-case
7. National Patient Safety Foundation (NPSF). Free from harm: accelerating patient safety improvement fifteen years after to err is human, 2015. www.npsf.org/free-from-harm
8. Weaver SJ, Lubomksi LH, Wilson RF, Pfoh ER, Martinez KA, Dy SM. Promoting a culture of safety as a patient safety strategy: a systematic review. *Ann Intern Med*. 2013;158(5):369-374. doi: 10.7326/0003-4819-158-5-201303051-00002
9. Helo S, Moulton CE. Complications: acknowledging, managing, and coping with human error. *Transl Androl Urol*. 2017;6(4):773-782. doi: 10.21037/tau.2017.06.28
10. Donaghy C, Doherty R, Irwin T. Patient safety: a culture of openness and supporting staff. *Surgery (Oxford)*. 2018;36(9):509-514. doi: 10.1016/j.mpsur.2018.07.005
11. Quillivan RR, Burlison JD, Browne EK, Scott SD, Hoffman JM. Patient safety culture and the second victim phenomenon: connecting culture to staff distress in nurses. *J Qual Patient Saf*. 2016;42(8):377-384. doi: 10.1016/s1553-7250(16)42053-2

20400861, 2022, 2, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/jhrm.21521 by Uncl University Of Nebraska, Wiley Online Library on [08/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

12. Joint Commission Resources. Comprehensive accreditation manual for hospitals update 2; 2016. https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/psc_for_webpdf.pdf?db=web&hash=1D79BF046A319BE99A20BE459982387F016/S1553-7250(16)42053-2
13. ECRI. Culture of safety: an overview. *Health Syst Risk Manage*. 2019. https://www.ecri.org/components/HRC/Pages/RiskQual21.aspx
14. National Patient Safety Foundation (NPSF). A just culture tool, 2016. 222.npsf.org/justculturetool
15. AHRQ. Patient Safety 101, 2019, https://psnet.ahrq.gov/primer/patient-safety-101
16. Joint Commission Resources. Comprehensive accreditation manual for hospitals (Spi Lslf Edition), 2015. https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/psc_for_webpdf.pdf?db=web&hash=1D79BF046A319BE99A20BE459982387F
17. Sexton JB, Adair KC, Leonard MW, et al. Providing feedback following leadership WalkRounds is associated with better patient safety culture, higher employee engagement, and lower burnout. *BMJ Qual Saf*. 2018;27(4):261. http://doi.org.libproxy2.usc.edu/10.1136/bmjqs-2016-006399
18. Horwitz SK, Horwitz IB. The effects of organizational commitment and structural empowerment on patient safety culture. *J Health Organ Manag*. 2017;31(1):10-27. doi: 10.1108/jhom-07-2016-0150
19. Moura LN, Camponogara S, Santos J, Gasparino RC, Silva R, Freitas EO. Structural empowerment of nurses in the hospital setting. *Rev Lat Am Enfermagem*. 2020;28:e3373. doi: 10.1590/1518-8345.3915.3373
20. Clarke S. Safety leadership: a meta-analytic review of transformational and transactional leadership styles as antecedents of safety behaviors. *J Occup Organ Psychol*. 2013;86(1):22-49. doi: 10.1111/j.2044-8325.2012.02064.x
21. Institute of Medicine (US) Committee on the Work Environment for Nurses and Patient Safety; Page A, editor. *Keeping patients safe: transforming the work environment of nurses*. National Academies Press (US); 2004. https://www.ncbi.nlm.nih.gov/books/NBK216194/
22. Northouse P. *Leadership: theory and practice*. 7th ed. Sage Publishers; 2016.
23. Scott S. The second victim. *Textbook of rapid response systems*. Springer; 2011:321-330. doi: 10.1007/978-0-387-92853-1_28
24. The Joint Commission: the essential role of leadership in developing a safety culture. *Sentinel Event Alert*. 2017;57:1. https://www.ncbi.nlm.nih.gov/pubmed/28353329
25. Hall AT, Frink DD, Buckley MR. An accountability account: a review and synthesis of the theoretical and empirical research on felt accountability. *J Organ Behav*. 2017;38(2):204-224. doi: 10.1002/job.2052
26. Frink DD, Hall AT, Perryman AA, et al. Meso-level theory of accountability in organizations. *Healthc Hum Resour*. 2008;27:177.
27. Scott SD, McCoig MM. Care at the point of impact: insights into the second-victim experience. *J Healthc Risk Manag*. 2016;35(4):6-13. doi: 10.1002/jhrm.21218
28. Johnson DW, Johnson RT, Smith K. The state of cooperative learning in postsecondary and professional settings. *Educ Psychol Rev.* 2007;19:15-29. doi: 10.10007/210648-006-9038-8
29. Ngo A, Stanescu AL, Swenson DW, Moore MM, Sze RW, Iyer RS. Practical considerations when implementing peer learning conferences. *Pediatr Radiol.* 2019;49:526-530
30. Moorman R, Grover S. Why does leader integrity matter to followers? An uncertainty management based explanation. *Int J Leadersh Educ.* 2009;5(2):106. http://www.regent.edu/acad/global/publications/ijls/new/vol5iss2/IJLS
31. Kotter JP Leading change: why transformation efforts fail. *Harv Bus Rev.* 1995; https://hbr.org/1995/05/leading-change-why-transformation-efforts-fail-2
32. Garman A, Harris Lemak C. National Center for Healthcare leadership White paper; 2011.

AUTHOR BIOGRAPHY

Susan Montminy is the Director of Risk Management for Coverys. Her extensive clinical experience and varied healthcare leadership and regulatory positions make her a passionate advocate for promoting cultures of both patient safety and compassionate care for our caregivers. Prior to Coverys, Susan worked as a registered nurse for over 30 years in medical, surgical, and oncology environments. She has held director-level leadership positions in nursing, risk management, and quality; has provided oversight of clinical and employee health departments; and has served as a nurse investigator for the Rhode Island Department of the Attorney General. Her breadth of experience ranges from ambulatory care settings to academic health systems, which includes hospitals, level-one trauma centers, behavioral health clinics, ambulatory surgical centers, and outpatient clinics. Susan received a doctoral degree focusing on organizational change and leadership from the University of Southern California. She has earned a Master of Public Administration, a Bachelor of Science in nursing, and a post-graduate Certificate in Occupational Health and Safety. In addition to her academic achievements, she has several professional certifications, including the Certified Professional in Patient Safety, Master TeamSTEPPS Trainer, and a Certified Professional in Healthcare Risk Management. She has been professionally published and the guest speaker at numerous conferences. Throughout her career, Susan has received several awards for her untiring work in patient and employee safety, including the U.S. Food & Drug Administration (FDA) Center for Devices and Radiological Health's Director Special Citation, the Agency for Healthcare Research and Quality (AHRQ) citation for dedicated service to Patient Safety Improvement, and the American Association of Occupational Health Nurses (AAOHN) National Governmental Affairs Award.

How to cite this article: Montminy SL. Leadership behaviors, attitudes and characteristics to support a culture of safety. *J Healthc Risk Manag*. 2022;42:31–38. https://doi.org/10.1002/jhrm.21521

20400861, 2022, 2, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/jhrm.21521 by Uncl University Of Nebraska, Wiley Online Library on [08/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License