Prologue

Culture and Redesign for Improved Patient Safety

James B. Battles, PhD

The articles in this volume explore issues of culture and the redesign of organizations and clinical practices to improve patient safety. Within this broad theme are four categories of related articles addressing (1) safety and organizational issues, (2) clinical process improvement, (3) systems redesign, and (4) collaboratives and patient involvement.

Creating a culture of safety has been a major goal of the patient safety movement. Only recently have instruments become available for use by organizations to assess their patient safety culture. Several articles in the first section of this volume describe the use of standard cultural assessment instruments and discuss the results and lessons learned from such assessments. Many organizations are finding that an assessment of the safety climate of culture within both individual clinical units and the organization as a whole can serve as a starting point to bring about organizational change and improvement. There are differences between various components of a health care institution that will differ at the clinical micro system or unit level. Understanding the nature of systems operating at both the overall macro level and at the micro level within an organization are essential for any improvement activity to succeed. Several of the articles in this first section explore the characteristics of the organization relative to patient safety improvement activities. The lack of a complete understanding of the organization at both the macro and micro levels will limit the effectiveness of improvement efforts.

The second section of this volume comprises articles that focus on the implementation of specific clinical process improvements. The authors address their experiences in introducing various clinical improvements targeted at identified risk and hazards at the clinical micro system level. Targeting improvement efforts on specific clinical processes as a change strategy seems to be an effective way to have measurable impact and achieve buy-in from the health professionals who work in a particular micro system. While each of the clinical improvements described are different, readers will be able to discern patterns in the change processes involved in making the improvements. Many of the issues and concerns raised in these papers related to clinical process improvement are similar from one clinical process to another. It is in the commonality of implementation issues that major lessons can be learned about the nature of clinical process improvement.

While most of the articles in section two represent clinical process improvements at the micro system level, the articles in section three of this volume examine redesigning systems of care at the more macro level. It has often been stated that overall quality and safety improvement requires major system redesign. Others say that the health care system was never designed in the first place, so the issue is system design, not redesign. The articles in this section describe the process of design and redesign that have been used to make major improvements. The authors focus on design as a deliberate and planned activity. The emphasis on design and design methods is a new and growing area of interest in quality and safety improvement. This emphasis stems

from the realization that quality and safety improvements can be made by thoughtful design and/or redesign of our systems of care.

The fourth and last section of this volume features articles that discuss organizations working together to bring about change. Collective or shared improvement activities are a relatively new phenomenon that has been emerging in patient safety. Institutions working together to solve common problems have shown us a powerful way for reinforcing and sustaining patient safety and quality improvement efforts. Members of a collaborative can and do share success stories and improvement strategies—as well as stories about unsuccessful efforts—so that the overall rate of improvement is higher across the entire collaborative. These articles serve as a series of case studies on the use of this approach in patient safety. The involvement of patients in solving patient safety issues is emerging as another promising approach within the patient safety movement. Patients are an important source of information about risks and hazards and about how care can be made safer. The voice of the patient as a partner in patient safety improvement is one that will be growing over time.

The articles in this volume represent an important group of case studies focused on issues of organizational culture and system redesign. Together, they help to paint a picture of present day patient safety improvement activities. There are lessons to be learned from the rich experiences expressed in each of these case studies.