NHS Education for Scotland

Safety Culture Discussion Cards

To help us think and talk about our Safety Culture

Introduction

What is Safety Culture?

Safety culture can be described as our:

1
Values
What is important

2
Behaviours
The way we do things around here

3
Beliefs
How things work

Safety culture has been shown to be a key predictor of safety performance in several industries. It is the difference between a safe organisation and an accident waiting to happen. Thinking and talking about our safety culture is essential for us to understand what we do well, and where we need to improve.

These cards are designed to help us to do this.

Introduction

Organisation of the Cards

There are several individual cards for each of the following 'safety culture elements'. Each card introduces a different issue for reflection or discussions by the Care Team.

Introduction

How to Use These Cards

You can use these cards in any way that helps you and your colleagues to think and talk about safety culture. If you are using the cards in a group, one person may need to act as discussion facilitator. You can use as many or as few cards as you like.

Five possibilities are described in the following cards:

Option 1: Comparing views	Option 2: Safety Moments	Option 3: Focus on…	Option 4: SWOT Analysis	Option 5: Influences
Compare similar and different views between groups	Discuss just one issue for 10-15 minutes	Discuss all of the cards in a particular element	Sort the cards into Strengths, Weaknesses, Opportunities and Threats	Organise cards into patterns to show how the issues relate to one another

Introduction

Option 1: Comparing Views

Different members of your team can sort cards into 2 piles: what we do well and what we need to improve (your 'team' may be your organisation unit, professional group, etc):

What we do well & what we need to improve

Then compare the piles and discuss:

- Where do we agree?
- Where do we disagree?
- What are the priority issues to address?
- What might happen if they are not addressed?
- How can this be done?
- Who needs to be involved (responsible, consulted, informed)?
- When does it need to be done?

Introduction

Option 2: Safety Moments

In a small group, take just one card – any card.
Discuss the card for a set time, e.g. 15-30 minutes.
Discuss a different card each time.

Alternatively, in a longer session, allow each person to choose one card from a small selection (e.g. from three cards,) and ask them to describe an experience that they have had concerning the issue.

What can be learned from their story?

Introduction

Option 3: Focus on...

Choose a specific element, such as ‘Resourcing’, and discuss each card in depth with your colleagues.

You may sort the cards or consider questions such as:

- What do we do well?
- What and where is our ‘best practice’ on this issue?
- Where have we improved?
- Where do we need to improve?
- What are we avoiding… where are our ‘blindspots’?
- What is stopping us from improving?
- How can we improve the situation?

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Option 4: SWOT Analysis

Sort the cards into the following piles.

The cards in each pile will tell you something about how safety culture can be improved, by drawing on current strengths, addressing current weaknesses, anticipating and tackling future threats.

Introduction

Option 5: Influences

Organise cards into patterns to show how the issues relate to one another.

For instance, some cards may have cause-effect relationships, or may influence each other in a more subtle way.

Discuss how these relationships work.

Leadership and Management Commitment

Who Cares About Safety?

Does it feel like your organisation or practice genuinely cares about safety?

The messages within an organisation determine whether people feel that safety is a genuine concern, a bureaucratic formality, or a hindrance.

What messages about safety do you receive…and give?

Leadership and Management Commitment

Commitment

Do you believe that your manager or leaders are committed to safety?

The decisions and communication of managers can send a strong message about safety – either positive or negative.

How can managers better understand and communicate their own commitment?

Leadership and Management Commitment

Priorities

What is the priority of safety for senior leaders compared to other objectives?

Safety has to be considered alongside capacity, cost-efficiency and the environment.

Is senior management getting the balance right?

Leadership and Management Commitment

Trust

How much do you and others trust leaders and management with regard to safety?

Trust is an important ingredient of the ‘glue’ that binds a culture.

Trust in the leadership and management is influenced by several factors, such as consistency, credibility and communication.

How can trust be nurtured?

Leadership and Management Commitment

Responding to Concerns

How do managers and leaders respond to staff safety concerns?

The level of support that staff receive from a manager and the action taken, will affect their willingness to raise concerns and speak up in the future.

How can staff feel more supported when they report safety concerns?

Leadership and Management Commitment

Credibility

Do managers and/or leaders demonstrate commitment to safety in what they say and do?

Words and actions have to be consistent in order to maintain trust and credibility.

How can managers and/or leaders ensure that they are perceived as credible?

Leadership and Management Commitment

Encourage Safety

Do managers and leaders encourage staff to use the safety processes available?

Processes such as safety checks, assessment, investigation, audits and surveys are essential for safety, but can be seen as a hindrance to everyday work.

How can we be sure that concerns that safety processes can be a hindrance are taken seriously by managers?

Leadership and Management Commitment

Front-line Safety First?

Are safety issues raised by front-line care staff given appropriate priority within the organisation or practice?

Issues that they raise need to be treated as priority.

How can we ensure that issues raised get the priority they deserve?

Resourcing

Get Help

Do we have sufficient specialist safety support?

Sometimes specialist safety is needed to properly integrate safety in the activities of the organisation.

How can we ensure we have the specialist support that we need?

Resourcing

Upskill

Do you have the training you need to help you understand the safety processes or procedures relevant to your work?

Is training available to help with safety activities such as safety assessment and occurrence investigation, to suit a variety of roles?

How can you make sure you have the skills you need?

Resourcing

Too Little, Too Much

Is there enough focus on safety?

Can there be too much?

Sometimes we may not realise that safety is slipping off the agenda.

Other times, people may get tired of too many safety messages, or feel that there is too much focus on one aspect of safety.

How can we give safety the attention it needs?

Resourcing

Do the Right Things Right

Are the safety processes we use adequate?

Which processes are working well, and which are not?

Safety processes and procedures must be appropriate for the level of risk involved in the change or activity.

How can we make safety as practical as possible?

Resourcing

Train for Change

Is adequate training provided when new systems and procedures are introduced?

Training for changes in systems or procedures need to be of adequate quality and duration, and at the right time.

How can we be better prepared for future changes?

Resourcing

Safety in Numbers

Do we have the right number of staff to deliver a safe service?

Having the right number of people to deliver a safe service – either in total numbers or in terms of organisation of rosters – is vital for safety.

How can we ensure that we get it right?

Resourcing

Prioritise

Are resources for safety where they are most needed?

Sometimes we need to take a step back to check that the resources for safety are still prioritised properly.

How can we make best use of the resources available?

Resourcing

Make Time for Safety

Do projects have enough time to consider safety? Is it considered from the start?

Safety in projects needs to be planned properly so that there is enough time to integrate safety properly without unnecessary impacts on timescales.

Are you making time for safety in your work?

Resourcing

Right Procedures

How do procedures compare with the way you actually do your job?

The way we work changes, and procedures need to reflect how we really work. In some cases, procedures can’t describe a task in detail, but should provide at least some guidance.

How can we ensure the procedures remain realistic and accurate enough?

Resourcing

Right Equipment

Does equipment support safe working?

The equipment, along with the people and procedures, has an obvious link to safety.

The consideration of safety in the concept, design, construction, operation and maintenance is critical.

How can we ensure that equipment is supporting safety?

Resourcing

Be Prepared

Do you have the safety-related refresher training you need?

Refresher training helps ensure that you are able to cope with the demands of critical or rarely performed tasks such as emergencies and degraded modes of operation.

What kind of refresher training is needed for operational and maintenance staff?

Just Culture, Reporting and Learning

Speak Up

Do you feel free to raise safety concerns?

How we all react to the safety concerns of others can influence whether or not they raise them in the future.

Is voicing concerns about safety encouraged?

Just Culture, Reporting and Learning

Follow the Trend

What are the most frequent incident types in your care setting?

Knowing the key incident trends can lead to a better understanding of the underlying conditions that need to be addressed to prevent serious incidents or accidents.

Do you know the key incident trends?

Just Culture, Reporting and Learning

Learn from Incidents

Do you and your team incorporate lessons from incidents into your work?

To learn from safety occurrences, we need to look carefully at the trends, serious incidents, recommendations, and how they might apply to our work.

How could you learn from incidents in your work?

Just Culture, Reporting and Learning

Make Just Culture Real

Staff should not be punished for actions that are in-keeping with their experience and training. Instead understand what happened, support those involved and **improve work systems** to reduce the risk of recurrence.

Is 'just culture' the way you do things or is it just a policy?

Just culture is not just a policy on the wall.

Make sure just culture lives and breathes throughout the organisation.

Do you talk about just culture?

Just Culture, Reporting and Learning

Unacceptable Behaviour

If a colleague regularly took unacceptable risks, what would happen?

Risky behaviour can be hard to define but unacceptable behaviour has to be understood and dealt with.

Who draws the line, and what is the best way for the organisation to deal with different types of unacceptable behaviour?

Just Culture, Reporting and Learning

Focus on the Issue

When a safety issue is raised, do you focus on the message or messenger?

Sometimes, we pay more attention to the person who raises a safety issue than the issue itself.

Our perception of the ‘whistleblower’, ‘troublemaker’, or simply responsible individual can affect our response.

How can we ensure that we focus on the message rather than the messenger?

Just Culture, Reporting and Learning

To Err is Human

How would a staff member who was involved in an incident that was a genuine ‘error’ be supported?

‘Human error’ is really just a by-product of normal variability in performance.

In a healthy safety culture, this is accepted and managed.

How can leaders better support people when normal errors become part of prosecution?

Just Culture, Reporting and Learning

Avoid the Blame Game

When people report safety-related occurrences, are they blamed or treated in a just and fair manner?

How people are treated when they report safety related occurrences, including ‘normal errors’ is a test for the just culture of an organisation.

How can we encourage a just culture within the organisation, and the team?

Just Culture, Reporting and Learning

Reporting for Safety

Does reporting safety occurrences improve safety?

Safety occurrence reporting is ultimately aimed at reducing reoccurrence, and so improving safety.

How can we make sure reports make a visible difference and so motivate people to report?

Just Culture, Reporting and Learning

How to Report

Do you know how to report situations that may compromise patient safety or your own wellbeing?

Knowing how to report occurrences should be simple, but it's not always the case.

How can reporting be simple and easy enough for everyone to understand and do?

Just Culture, Reporting and Learning

Feedback

Do people get timely feedback on the safety issues they raise?

Timely feedback to people who raise safety issues is critical. It keeps them informed and helps maintain their motivation to continue to raise safety issues.

What kind of feedback is best suited to the needs of those who raise safety issues, and when should this be given?

Just Culture, Reporting and Learning

Maintain Confidentiality

How confidential is the reporting and investigation process?

Confidentiality is an important issue for safety reporting, investigation and improvement.

What level of confidentiality is needed, and how can this be maintained?

Just Culture, Reporting and Learning

Share Experience

Are reports of occurrences readily available to you?

To learn from incidents, those who could find themselves in similar situations need to be able to access safety-related occurrence reports.

How would you like to receive or have access to such reports?

Just Culture, Reporting and Learning

Investigate to Improve

How well do we investigate safety occurrences?

A good safety investigation should describe and explain the occurrence and the factors that contributed to it, and present workable recommendations to reduce the chance that it will happen again.

What are the positives and negatives about how we investigate, and how could it be improved?

Just Culture, Reporting and Learning

Talk it Over

How do we talk about incidents?

With open and fair discussion, lessons can be learned quickly after occurrences.

How can we create the right environment for these discussions, so that we learn from experience?

Just Culture, Reporting and Learning

Time to Read

Do we read reports of safety occurrences that are relevant to your work?

We need to read occurrence reports so that we can learn from them. Many things can get in the way: the availability of reports, the length of reports and our motivation.

How can we ensure that we read the reports that we need to read?

Risk Awareness and Management

Safe Procedures

Do you often have to deviate from procedures?

Procedures should be designed to apply to most situations. When you often need to deviate from procedures, it can be a sign that things are ‘drifting into danger’.

How do you make sure the service remains safe?

Risk Awareness and Management

Know your Risks

Do you know the top five risks that are relevant to your work?

We need to be aware of the top risks that may be relevant to our work so that we can prioritise and manage them.

Are you aware?

Risk Awareness and Management

Balancing Safety

How do you balance safety against other requirements of your job?

Safety is the first priority in health and care, and this is reflected in decisions by frontline clinical and support staff, management and other specialist and technical staff. But it is not the only requirement.

How can we get the balance right?

Risk Awareness and Management

Taking Risks

Do you sometimes have to take risks that make you feel uncomfortable about safety?

It is hard to assess the level of risk involved in our own activities. But if we have to take risks that make us feel uncomfortable, it is time to stop and think.

How do you respond to risky activities?

Risk Awareness and Management

Maintaining Safety

Do frontline staff understand how equipment or procedural failures affect safe care and services?

These risks need to be identified, assessed and controlled, for instance via training, procedures, teamwork and communication.

How can we ensure that the risks are properly managed?

Risk Awareness and Management

Managing Risk?

How do we manage the safety risks of changes to the organisation, systems and procedures?

Many types of changes within health and care can present new safety risks, or changing existing risks may take us by surprise.

How can we best assess and manage the risk from the different types of changes?

Risk Awareness and Management

Blind Spots

Are you aware of care safety problems that are not being addressed sufficiently?

Sometimes problems seem so long-standing or difficult to resolve that they are ignored and become a ‘blind spot’.

How can you help to make sure that safety problems are resolved rather than ignored?

Risk Awareness and Management

Under Pressure?

Do you feel pressure to keep the service operating even when there are safety risks?

We all want to do the best job we can. But sometimes we can experience pressure to take or accept risks that make us feel uncomfortable.

How do you respond when the pressure is on?

Teamwork

Us, or Us and Them?

How well does your team work with other teams? Sometimes working relationships can threaten safety.

How does your team interact with other teams?

Teamwork

Working Together

How well does our team work together?
Teamwork will affect everything we do, including safety.

What are we doing well, and what could we improve?

Teamwork

Consult

How do frontline staff consult with relevant others to maintain equipment and procedures so that quality and safety of care is not negatively affected?

Knowing about the status of equipment and procedures is critical for safe care.

Teamwork

Talking about Systems

How do frontline staff provide information about system problems to more senior colleagues (and vice-versa) in order to keep systems working properly?

Is everyone getting the information they need?

Teamwork

Challenge Risk

If you see a risky or unsafe behaviour by a colleague, what would you do?

Unsafe behaviour needs to be challenged, regardless of whose behaviour it is. How would you intervene if you were uncomfortable about a colleague's behaviour, and how can we talk about what is acceptable and what is not?

Teamwork

Confidence in Colleagues

Do you have confidence in the people that you interact with?

Confidence and trust in colleagues is an important part of teamwork. Sometimes, you might feel that you are losing (or have lost) confidence in a colleague.

If this happened, how would you handle it?

Teamwork

Handling Negativity

How do you handle people who have a negative attitude to safety?

Occasionally, there are people whose attitude to safety is so negative that colleagues do not want to work with them.

What is the most productive way for you or the team to improve the situation?

Teamwork

Teamwork on the Front Line

How good is communication between frontline staff and more senior colleagues?

What improvements are possible to optimise this communication in your care setting?

Teamwork

Challenge Risk

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Unsafe behaviour needs to be challenged, regardless of whose behaviour it is.

How would you intervene if you were uncomfortable about a colleague's behaviour, and how can we talk about what is acceptable and what is not?

Communication

Share

How well do you, your team and your organisation share safety related information?

Open sharing of safety information is vital to highlight risks and good practices so that others can learn and act.

What can you do to open the lines of communication?

Communication

Get the Picture

Do you have the picture of current care safety performance in your setting?

Without good information on safety performance, we can't manage safety properly.

How would you like this information to be made available and understandable?

Communication

Stay in-communication

Are you aware of the safety-related change in your care setting that may be relevant to your work?

The world of health and care changes constantly and there can be implications for safety if we are not up-to-date.

How should safety-related changes be communicated?

Communication

Going up? Going down?

How well do management and staff communicate about safety?

Two-way communication between management and staff is important to ensure everyone is aware of changes, problems and solutions.

How would you like vertical communication about safety to be?

Communication

Look Outside

How well does your team communicate with other relevant organisations?

A good safety culture needs open and effective communication with external stakeholders.

How can we improve our communication?

Communication

Breaking Down Barriers

Can clinical and non-clinical staff share concerns quickly and efficiently?

It can be difficult to access clinical staff when necessary. Non-clinical staff often have information that is critical for safe patient care and needs to be communicated to clinical staff in a timely manner.

How do we make the clinical environment more accessible in a way that is acceptable to clinical staff?

Communication

What's the Plan?

Do you know the future plans for the development of the services you provide?

Knowing what is planned for the future allows us to give feedback to ensure the plan is good for safety, and to prepare yourself for change.

How would you like to be informed about future plans?

Communication

Know Where to Go

Do you know where to find the safety information that you need?

We can’t know everything that we might need to know about safety, but we should know how to find out.

How do you find out about care safety in your setting?

Responsibility

Know your Relevance

How is your work relevant to care safety in your setting?

Directly or indirectly, we are all supporting safety, whether we realise it or not. Recognising our contribution to care safety helps us to focus on the things that matter.

How could you better understand your role?

Responsibility

Take Responsibility

Whose responsibility is safety?

If people feel that safety is their responsibility, even if any possible safety consequences seem distant, then they are more likely to consider safety in their decisions and performance generally.

How can we ensure that everybody knows they are responsible for safety?

Responsibility

Colleague Commitment

How committed to safety are your colleagues?

The commitment to safety among direct colleagues can have a powerful effect on our attitudes. A safety-conscious individual can lose this focus if colleagues don’t take safety seriously.

How can we maintain the commitment to safety?

Responsibility

The Whole Picture

Do others understand how your job contributes to safety?

Do you understand how others contribute?

While we might understand how we contribute to safety, it is harder to understand others' contributions, especially further away from the 'sharp end' of safety, such as Human Resources, Finance, and Research & Development.

How can we improve understanding of our contributions to safety?

Responsibility

Speak Up

Would you speak up to your manager if you had safety concerns?

Authority should never prevent people from speaking up when they notice something is wrong.

How can we ensure that we feel safe to speak up when we need to?

Involvement

Get Involved

Are you sufficiently involved in safety-related activities?

Safety isn't someone else's job. We all need to participate in safety-related activities such as projects, procedures, surveys, training, or awareness campaigns.

How can you get more involved?

Involvement

We Make a Difference

How is your team influencing care safety in your setting?

It can be difficult for some staff to consider how their individual job can influence care safety. But it is more clear when we think of our whole team.

How can this impact be better understood by your team?

Involvement

Contribute to Change and Improvement

Are you sufficiently involved in system changes?

System changes need to be made with the user in mind.

How can we make sure that input from all staff groups helps to steer changes in the right direction?

Involvement

Assessing Everyday Risk

What is our role in care safety assessments?

Care safety assessments need the right input from the right people.

How can we ensure that we participate effectively in care safety assessments?

Involvement

Our Procedures

What is the role of frontline staff in changes to procedures?

Procedures, like systems, need to be designed for the intended users and with their expertise.

How can we ensure the right level of input, from the right people, to get the procedures right?

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