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Collaboration, knowledge sharing, workplace safety, and employee success

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Abstract
In an effort to increase patient safety, this article's authors want to persuade healthcare leaders to adopt a "learning organization" mentality by promoting teamwork and education.
The research strategy included a literature review of relevant works in the fields of hospital administration, organizational psychology, and human resource management.
Conclusions Healthcare administrators should promote a culture of patient safety by creating an environment where employees are rewarded for identifying major errors and where a culture of collaborative learning replaces a focus on blame.
It is important to understand how hospital personnel may learn from other organizational contexts, particularly those outside of the healthcare sector, since healthcare workers are being pushed to provide increasingly sophisticated medical services with less resources.
Innovative/useful This study offers recommendations for enhancing patient safety, gleaned from the health and business management literature.

Keywords Patient safety, Organizational learning, Collaborative team learning, Health services sector, Learning organizations, Team working .

Introduction

The healthcare community and the general public are becoming more concerned about patient safety. Critical comments on patient care and quality and recommendations for additional empirical data to indicate enhanced safety are two examples of the types of research that have been conducted (Anderson et al., 2006; Gregory et al., 2007). However, researchers are beginning to realize that the context in which healthcare is provided is a critical perspective that is lacking patient safety discussions (Mwachofi et al., 2011; Pronovost et al., 2006). This includes understanding organizational culture, communication failures, the degree to which an environment is conducive to change, and most importantly, workers' ability to learn from preventable adverse events and view these as learning opportunities (Hayes et al., 2011). Although it has been hypothesized that creating a "learning organization" would lead to increased patient safety, the relationship between the learning organization idea and patient safety has received surprisingly little empirical scrutiny. Our goal is to do a literature study on patient safety culture, organizational learning, teamwork, and cooperation in order to construct and propose a conceptual framework that connects these ideas. A more comprehensive approach to patient safety requires a conceptual framework that takes into account several factors. Based on this conceptual model, we propose several research topics that might expand our knowledge and lead to better patient safety culture and results.

Examining Patient Security

Researchers in the field of patient safety have increasingly observed that the status quo method of enhancing patient safety has yielded subpar outcomes. According to a 1999 study by the Institute of Medicine (IOM) titled To Err Is Human (Kohn et al., 2000), between 45,000 and 98,000 Americans die each year due to avoidable medical mistakes, thus improvement has been unsatisfactory at best. Canada's "Canadian Adverse Events Study" (Baker et al., 2004) found that around 7% of hospital admissions (about 185,000 annually) experience an adverse event, of which about 38% are avoidable. Efforts have been made to provide the trustworthy systems that patients and medical professionals need (Moumtzoglou, 2010). Regulations, new reporting systems and measurements, IT, and malpractice systems are all examples of initiatives (Mwachofi et al., 2011). But the cumulative effect of these is small and worrying (Longo et al., 2005). This limited effect, according to Kaissi (2006), is the result of an overemphasis on organizational variables. This new trend is encapsulated by the following statement by Kaissi (2006, pp. 292-3): "[...] the patient safety movement has failed to reach its goals of eradicating or at least significantly reducing errors because of an inappropriate focus on provider and patient level factors with no real attention to the organizational factors that affect patient safety."Such factors include poor management decisions and ineffectively structured organizations. Increasingly, this literature has focused on several organizational factors that appear to influence patient safety outcomes. These include patient safety culture, organizational

learning and flexible organizational structures such as a collaborative teamwork environment that is less hierarchical (Elder *et al.*, 2008; Hellings*et al.*, 2010; Travaglia *et al.*, 2011). There is also a need to study patient safety culture across different healthcare settings to develop effective interventions for different contexts. Teamwork, collaboration and organizational learning have strong roots in theorganizational behavior and organizational theory literature. Most research has takenplace in private and public sector organizational contexts. Only recently have healthcare researchers been interested in these concepts and their relevance to healthcare organizations, especially in relation to patient safety management (Hellings *et al.*, 2010).

Patient safety culture

Promoting a safety culture as opposed to a blame culture is considered by many to be an important organizational variable affecting patient safety (Hoffman and Mark, 2006; Kaissi, 2006; Odwazny *et al.*, 2005). The argument is that a blame culture (which usespunishment, blaming individuals for errors and weak error-reporting, where errors arenot seen as opportunities for learning) has failed to improve patient safety outcomes (Mwachofi *et al.*, 2011). Instead, it leads to ineffective counter measures such as morechecking, disciplinary action and initiating new procedures that do not motivate highlytrained and professional healthcare workforce (Hellings *et al.*, 2010). In contrast, safetyculture emphasizes a more focused and systems approach to dealing with errors. Theassumption is that humans are fallible and errors are expected but we can change theconditions under which we work so that all accept responsibility for patient safety. Safety ought to be prioritized and individuals should be encouraged to identify and communicate any mistakes, so that the focus is on what happened and not who did it(Kaissi, 2006). This also requires strong leaders to promote safety, appropriate resources and an effective accountability system. This safety culture will result in reduced medicalerrors and also influence organizational learning (Mohr, 2005).

The conceptual literature also argues that a safety culture and learning are closelylinked, where a safety culture can also promote collective learning. A culture that does nothide risks and minimizes fear or reprisals for reporting errors promotes prevention and aquick response to dealing with mistakes before they result in patient injuries. As Chuang*et al.* (2007) argue, a strong patient safety culture may be synonymous with learning frompreventable adverse events. Accordingly, they argue that organizations with a culturethat values patient safety will be more likely to learn from preventable events. They conclude that a safety culture will have a positive impact on organizational learning.

Khatri *et al.* (2009, p. 315) argue that healthcare needs to move from a blame to a just orlearning culture, which they define as "an environment supportive of open dialogue tofacilitate safe practices". This requires a comprehensive understanding of the organizational attributes or antecedents that can cause blame or just cultures. Based on a literature review, they conclude that blame cultures tend to arise when managerspredominantly focus on hierarchy and compliance-based functional managementsystems. In contrast, a commitment-based management approach, where members feel empowered, take pride in the organization's mission, morale is high and turnover is low, isessential to a just culture. This culture encourages greater initiative and innovative employee behavior as it creates a safety culture for them to take action. Furthermore,Khatri *et al.* (2009) argue that this creates two beneficial effects, namely learning and motivation. This learning effect increases learning from mistakes in which organizational members report all medical errors and search extensively for their causes in an open and trusting environment. Because there is high trust, employees can engage in such behaviorwithout interference from or dependence on management, which fosters positive emotions. The final result enhances service quality and safety (Khatri *et al.*, 2009).

Despite this strong inference in the literature that organizational culture is important, there have been few empirical studies. Most that discuss patient safety culture are based on secondary data (Rivard *et al.*, 2006), single intervention case studies such as (Odwazny *et al.*, 2005) and surveys that focus only a specific target group such as nurses. Hoffman and Mark (2006) found that safety culture had an impact on some key healthcare outcomes such as medication errors, back injuries andpatient satisfaction. Also, Odwazny *et al.* (2005) found that fostering a patient safety culture resulted in better adverse event reporting, better decisions, overallimprovements in care and improved financial result for the institution, whichsuggests that patient safety culture can have an impact on both employee outcomes and safety performance indicators. Based on a nation-wide patient-safety culture study, the Agency for Healthcare Research and Quality focused on 12 areas, including:

(1) communication openness;
(2) feedback and communication about error;
(3) event frequency;
(4) handoffs and transitions;
(5) management support for patient safety;
(6) non-punitive response to error;
(7) organizational learning-continuous improvement;
(8) overall patient-safety perceptions;
(9) staffing;
(10) supervisor/manager expectations and actions promoting safety;
(11) teamwork across units; and
(12) teamwork within units (Sorra *et al.*, 2010).

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Another body of literature based on a survey developed by Singer *et al.* (2007) attempted to measure hospital patient safety climate (similar to safety culture) and safety outcomes. They argue that a strong safety climate that promotes a safety culture can result in positive patient safety outcomes. Some empirical studies have shown that there is a positive relationship between safety climate and hospital unit-level outcomes (Hoffman and Mark, 2006; Katz-Navon *et al.*, 2005; Neal and Griffin, 2006; Vogus andSutcliffe, 2007). However, as Rosen *et al.* (2010, p. 591) state:

In general, these studies have been limited to small representative samples, self-reported clinical outcomes, or selected dimensions of climate.

One study showed a strong link between a strong safety climate and patient safety outcomes at the hospital level (Singer *et al.*, 2009b) and another had more modest and weaker results in a Veterans Health Administration Hospital study (Rosen *et al.*, 2010).Colla *et al.* (2005) summarized nine published patient-safety climate surveys; five common themes across these surveys included leadership, policies and procedures, staffing, communication and reporting. There are also different views regarding the main critical safety-culture components. For example, safety culture can be defined as:

An integrated pattern of individual and organizational behavior based upon shared beliefs and values that continuously seek to minimize patient harm that may occur from the processof care delivery (Aspden *et al.*, 2004, p. 174).

Hellings *et al.* (2007) suggest that safety culture has four critical components: justice or fairness; flexibility; learning and systematic reporting. In another study, a measure was developed to assess patient safety culture (Singer *et al.*, 2007). Results suggest that patient safety culture is a multidimensional construct with factors such as senior manager engagement, unit safety norms, blame fears and learning. The literature, therefore, suggests that patient safety culture can have an impact on employee and institutional outcomes such as performance indicators. The literature also suggests that organizational learning is an important variable that could have a positive impacton patient safety culture. safety culture that takes into account major issues such as reasonable workingconditions, improving communications, support from leaders and colleagues, psychological safety (perceptions about interpersonal risks in sharing an idea ormistake), situational awareness, system efficiency and effectiveness (Bohomol *et al.*,2009; Chiang *et al.*, 2010; Edmondson, 1999). A patient safety culture necessitatessystemically viewing the error and paying attention to individual and group triggersso that essential steps can be taken to minimize, if not eliminate, medication errors(Cannon and Edmondson, 2001; Edmondson, 2002, 2004). There is some consensus inthe healthcare literature that top managers' unequivocal support for patient safety,non-punitive work culture and a focus on organizational learning could facilitate apatient safety culture that is crucial for eradicating medication errors (Hellings *et al.*,
2007, 2010; Katz-Navon *et al.*, 2005).

To date there are piecemeal frameworks that relate patient safety culture to organizational learning and teamwork and collaboration. However, we believe a moreintegrated framework is necessary as patient safety is a macro-level outcome that is strongly influenced by underlying micro-level aspects including organizational structures, team collaboration and organizational learning environment. The relationships between concepts in our framework need examining systematically. Testing this framework will add new knowledge to understanding the importance of latent errors and their effect on patient safety climate and healthcare employee outcomes such as job satisfaction, which has implications for staff turnover. This knowledge enables us to design health information technology and educational material to support safe care delivered by collaborative teams. Future research may also want to test empirically the effect and interactions of these factors in healthcareinstitutions and the potential effect they can have on both patient safety and healthcare provider job satisfaction. How important are these organizational factors in influencinga patient safety culture and other outcomes? Some possible research questions are:

- To what extent do factors such as organizational learning capacity, teamworkand collaboration have an impact on patient safety culture?
- Does patient safety culture have an impact on employee outcomes such as jobsatisfaction and organizational outcomes such as patient safety indicators?

Preliminary empirical work by Singer *et al.* (2009a) provides partial and initial support for this approach to understanding patient safety. They found a positive relationship between patient safety climate, an emphasis on group participation and less hierarchy. That is, a hospital with a stronger group-oriented culture where teamwork and group problem solving are encouraged tended to have a better patient safety climate. A less hierarchical organizational climate also has positive effects, probably through encouraging innovation and change that can facilitate an organizational learningcapability. However, the study had some limitations: it was a cross-sectional survey and measure reliabilities were low. This study points to a promising start for empiricalresearch that links organizational behavior and management concepts such as organizational culture to patient safety culture.

Conclusion

This patient safety literature review suggests that approaching this problem from an organizational and

management lens can add a needed perspective to better understand how to manage patient safety in healthcare institutions. The key is to develop an appropriate and effective patient safety culture. We suggest that buildingan organizational learning capability and an emphasis on collaboration and teamworkamong healthcare professionals can have an important influence on patient safety culture. This implies that healthcare institutions should provide more support to focuson managing this process and not just the technical medical practice factors that can contribute to patient safety. In future, a comprehensive empirical study to test the relational strengths among these variables in the conceptual framework would add further insight and knowledge to understanding how to improve patient care and safety in healthcare institutions.

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