

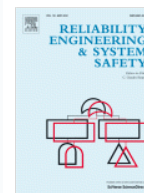
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# Reliability Engineering & System Safety

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## A novel tool for organisational learning and its impact on safety culture in a hospital dispensary

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### Abstract

Incident reporting as a key mechanism for organisational learning and the establishment of a stronger safety culture are pillars of the current patient safety movement. Studies have suggested that incident reporting in healthcare does not achieve its full potential due to serious barriers to reporting and that sometimes staff may feel alienated by the process. The aim of the work reported in this paper was to prototype a novel approach to organisational learning that allows an organisation to assess and to monitor the status of processes that often give rise to latent failure conditions in the work environment, and to assess whether and through which mechanisms participation in this approach affects local safety culture. The approach was prototyped in a hospital dispensary using Plan-Do-Study-Act (PDSA) cycles, and the effect on safety culture was described qualitatively through semi-structured interviews. The results suggest that the approach has had a positive effect on the safety culture within the dispensary, and that staff perceive the approach to be useful and usable.

### Keywords

Safety culture; Organisational learning; Safety management; Patient safety; Healthcare

### Figures and tables from this article:

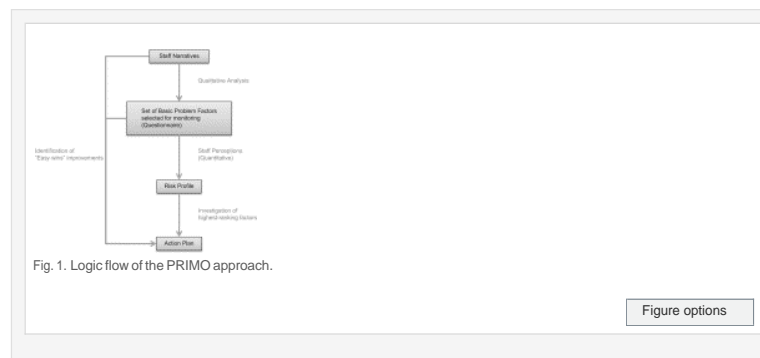


Figure options

14. How often? (Equipment & IT)	Not at all	1	2	3	4	5	Not applicable
How often do you check the design, usability and usability of equipment and IT devices you control, using your team?							
14.1 To what extent do you undertake or commissioning requirements of regulatory affairs your work? Example: Check of safety management systems (SMS) and other safety related activities that are done on a regular basis.	1	2	3	4	5		Not applicable
14.2 To what extent do the reliability and usability development of regulatory affairs your work? Example: Use system in design (Usability) and usability testing to ensure that the system meets the needs of the user and is usable in a safe and effective manner.	1	2	3	4	5		Not applicable
14.3 To what extent do the safety of regulatory affairs of regulatory affairs your work? Example: Conduct safety reviews of regulatory affairs and other safety related activities that are done on a regular basis.	1	2	3	4	5		Not applicable

Fig. 2. Example (Equipment & IT) from the prototype questionnaire.

Figure options

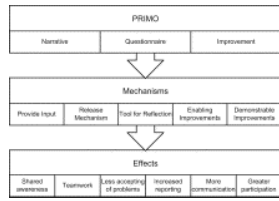


Fig. 3. Perceived effects of PRIMO on safety culture and possible mechanisms.

Figure options

Table 1. General Failure Types (GFT) identified in the Oil & Gas industry [19].

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Table 2. Set of Basic Problem Factors identified empirically from the narratives.

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Table 3. Mean scores for each Basic Problem Factor elicited during the initial nine-month period (scores ranging from 1: no hassle to 5: a lot of hassle). Two factors (4. Equipment & IT, 6. Work environment) were selected for improvement work following the May 2010 distribution.

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Table 4. Examples extracted from staff narratives relating to unavailable equipment and IT.

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Table 5. Excerpts from the semi-structured interviews – changes in safety culture.

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Table 6. Excerpts from the semi-structured interviews – mechanisms.

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Table A1. Set of questions used in the monitoring questionnaire.

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