Patient safety from executive hospital management to wards: a qualitative study identifying factors influencing implementation

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Abstract

Aim: To examine the journey of safety initiatives from executive hospital management to ward.

Background: Hospital management teams are often responsible for identifying safety priorities and ensuring delivery of these.

Method: Naturalistic study design within a large NHS Hospital Trust. Using semi-structured interviews, focus groups and secondary data analysis, the study examines the implementation of safety initiatives.

Results: While hospital management developed five safety initiatives, only one of these (falls prevention) was actually seen to permeate all layers of the organisation. Other initiatives stopped one layer down. Both middle management and ward staff added to the list of initiatives developed, resulting in 16 priorities. A range of positive and negative influences to successful implementation are identified.

Conclusions: Safety initiatives need positive reinforcement at all levels to be addressed appropriately. The research suggests that a model related to improvement science may prove useful in ensuring that priorities are addressed.

Implications for nursing management: Care should be taken to ensure that safety initiatives are successfully implemented at all levels within an organisation. Identifying priorities with staff and sharing values and priorities are a key approach to leading such initiatives.

Key words: Safety culture; Implementation, Safety Priorities, Initiatives

Introduction

Patient safety is as much a concern today as it was in the time of Florence Nightingale, illustrated by the continuation of serious safety breaches, which have caused patient harm worldwide (Taylor, 2010; Lee, 1998; Cox & Flin, 1998). Dysfunctional healthcare organisational culture is often cited as the cause (Francis, 2013). However, a definitive link is hard to determine. Understanding how mistakes happen and how they can be prevented is an important step in reducing risks inherent in complex healthcare systems (National Patient Safety Agency (NPSA), 2015).

Nursing is the largest profession within healthcare and as such, has considerable influence on the safety of patients. How nurses view patient safety within the organisation and their subsequent behaviour are important considerations. The research described in this article explored the relationship between organisational culture and patient safety from a nursing perspective.

There is a dearth of research literature on patient safety initiatives from Executive Management Board to Ward within a hospital; from the Chief Executive Officer to the Health Care Assistant (HCA) on a ward. The term Board to Ward gained popularity from 2003 in the UK, initially with guidance trying to move NHS Executive Hospital Management Boards to focus on quality and clinical care (Machell, Gough and Steward, 2009) alongside their focus on finance and other aspects of governance. In England, the drive towards a Board to Ward approach to patient safety came from the 2013 publication *The Healthy NHS Board* (NHS Leadership Academy, 2013), which extolled the Executive Hospital Management Board's role in driving a patient safety culture through an NHS organisation. The aim of the research was to examine top-down safety initiatives and organisational culture to identify

how, or indeed whether, safety initiatives permeate throughout the layers of the organisation.

Literature review

In order to understand how safety initiatives are implemented it is important to consider the nature of organisational culture, and the development of safety culture. Despite its use in everyday language, there is ambiguity around the definition of the term 'culture'. Cultural definitions are often multi-factorial and context-dependant, i.e. they are often constructed by individuals around a particular context. Smith (2001) suggested that culture is surprisingly difficult to define. Arguably, each person has their own unique and individual culture. Hofstede, Hofstede and Minkov (2010) proposed that each person has their own thinking, feeling and way of acting that has been learnt throughout their lifetime. Therefore, as a social construction, culture is not only difficult to define but is difficult to change and mould.

The concept of a safety culture is often seen as a subcategory of organisational culture. The term 'safety culture' emerged following several catastrophic adverse incidents (Kohn, Corrigan & Donaldson, 2000). For example, the 1986 Chernobyl nuclear power plant accident (Taylor, 2010; Lee, 1998; Cox & Flin, 1998), the Kings Cross fire, the Piper Alpha disaster and the train crash at Clapham Junction (Health and Safety Executive, 1999). Guldenmund (2000) linked the notion of safety culture to organisational culture, stating that a safety culture is an aspect of organisational culture, one which will impact upon the attitudes and behaviour related to increasing or decreasing risk. Keen, Nicklin, Long et al (2018) undertook a study examining the flow of information between hospital boards and wards. The study looked at four hospitals NHS Trusts in the UK and involved telephone

interviews with nurses at multiple levels within the organisation. In addition, artefacts were examined as secondary data including reports, incident reports and ward and board minutes. The study found that the flow of safety and quality information had improved between wards and the hospital board over a four year period and this was partly down to re-designed systems and processes and the wider use of technology around reporting and audit.

Globally, there have been several studies which have examined the notion of a safety culture within healthcare. Mattson, Hellgren and Goransson (2015) undertook an examination of two approaches to leader communication using a survey of 221 employees from two hospitals. They identified that leaders who communicated values and safety priorities were more likely to have compliance with safety initiatives amongst the workforce. Mattson, Hellgren and Goransson (2015) went on to propose a model for leader communication which encouraged the communication of safety priorities, encouraging compliance and the reporting of incidents and near misses as well as promoting employee feedback to managers.

A Swedish study (Jangland, Nyberg and Ynhman-Uhlin, 2017) provides some insight from ward staff about the factors which influence patient safety. A series of reflective interviews were conducted with 10 key informants from three hospitals. The interviews suggest that the constant demands for increased efficiency impacted on the development of a safety culture because of constant change and development of services. The turnover of staff and a traditional hierarchical structure in hospitals also impacted on both the establishment and maintenance of a safety culture. Finally, the communication of vague goals around safety

initiatives was also perceived by staff as a barrier to effectively implementing such initiatives.

Alqattan, Cleland and Morrison (2018) conducted a survey based study of hospital departments in Kuwait. A total of 1008 surveys were completed exploring perceptions of the dimensions of a safety culture. The results suggest that the components of a safety culture are perceived differently by different professions and by individuals from different countries of origin. However, some aspects were strongly associated with how staff perceive safety cultures these included management support for safety, organisational learning and openness of communication. The result affirm the view that the notion of a safety culture is a subjective phenomenon constructed by individuals but there is some agreement about the key components which drive safety within an organisation.

Lee, Huang, Cheung, Chen and Shaw (2019) conducted a systematic review of safety climate interventions. From an initial 384 studies they found 19 papers which provided a quasi-experimental or mixed methods approach to evaluating safety initiatives. Of these 10 of the 19 initiatives concerned improving communication about safety or educational programmes designed to promote safer care. A key element of nine of the ten interventions examined in the review had at their core supervisors and managers working together to identify how to improve the safety culture. This suggests that a safety culture is something which is developed over time rather than something which is imposed on nurses and other health professionals by hospital management.

Ward at al (2017) studied the implementation of safety initiatives across 13 rural hospitals in Iowa through the implementation of an approach called TeamSTEPPS which involved training around safety. The study explored the approach using an improvement science

approach based on the Promoting Action on Research Implementation in Health Care Settings (PARIHS). Ward et al (2017 found that the context and facilitation elements of the PARIHS framework were most important in helping drive successful implementation of safety initiatives. This study is interesting at it suggests that culture, leadership, communication and the facilitation of safety initiatives are important elements in successfully these are implemented across an organisation.

Sovie (1993) suggested that improving a safety culture requires the promotion of a shared ownership and commitment to the values of the organisation by every individual working there, regardless of their role. As such, the creation of a safety culture requires permeation of the culture through every department and unit within an organisation. Sovie (1993) further suggested that permeation will help to ensure the organisation promotes and supports a structure where staff are encouraged to participate in problem solving and decision making.

Methods

The research sought to analyse the journey of safety information from Executive Hospital Management Board to Ward, and to explore how this permeated throughout the many layers within the organisation and what effect it had on staff. In selecting a research approach, it was important to choose a methodology that explored the social construction which staff created of the culture. The methodology focussed on people in their naturalistic context-bound environment; as highlighted earlier, it is the people that make up an organisation's culture. Wenger (2008) proposes that people within a social setting are interdependent on each other and thus share a culture. Naturalistic inquiry was chosen to

explore the inherent complexity of humans and their ability to create and shape their own experiences (Erlandson et al., 1993). It enabled us to study participants, organisational systems and their culture, allowing a more holistic approach overall (Lincoln and Guba, 1985). Ethical approval for the study was gained from the University Ethics Committee and then from the local NHS Research and Development Office covering the hospital (NHS-R&D-0076).

Sample

Table 1 shows the sample for the study. The study used purposive sampling (Polit and Beck, 2004) to select individuals from three levels within the organisation. Level 1 included members of the hospital executive and two board members were interviewed as part of the study. Level 2 included the Directorate Manager, the Chief Matron and two Matrons who made up the Directorate Management Team. The Directorate Management Team then selected two wards from acute medicine which formed sampling area for Level 3. The Level 3 sample included a Ward Manager, Ward Sister / Charge Nurse, Staff Nurse and two Health Care Assistants (at different pay scales). As a result the total sample at Level 3 was 10 participants. The sample at Levels 2 and 3 were self-selecting following an open invitation to the Directorate and Ward staff. Individuals were selected using purposive sampling to ensure appropriate spread across grades and wanting to interview individuals who were involved or responsible for the delivery of nursing services.

Methods

The methods for this study included interviews, focus groups, observations and secondary data, and were divided into three phases. Phase 1 involved semi-structured interviews with the Chief Executive, Director of Nursing, the Matrons (n = 3) and the Directorate Manager

(n=1). A total of 6 individual interviews were conducted in Phase 1 of the study. The Matrons were used as key informants to suggest possible wards for inclusion in the study once identified and recruited the study moved to the next phase. Phase 2 involved individual semi-structured interviews with selected ward staff. In this phase the sampling strategy wanted to obtain views from staff at all levels of the ward team. While all ward staff were invited to participate only five people were selected from each ward (n = 10 participants in total). Each individual interview included questions about:

- Perceived organisational culture and the development of a safety culture
- Identified safety priorities
- Communication and barriers and facilitators to ensuring congruence of priorities at all levels
- Safety messaging
- Perceptions around the operationalising of a safety agenda

The final phase of the study, phase 3 involved both non-participant observation and the collection of secondary data. Non-participant observation involved observing the shift handovers (called hand offs in some countries) at each shift change (n = 3 per day per ward) over a 5 day period for each ward. This resulted in observation field notes and records for a total of 30 handovers (n = 15 for each ward). The observation field notes and records noted where safety critical information about patients e.g. falls risk, early warning scores etc. and wider initiatives such as falls prevention had been discussed. In addition, a note was made of any wider patient safety messaging and the identification of safety priorities during handover. During phase 3 secondary data analysis used minutes of executive board (n = 12), management team (n = 12) and ward team meetings (n = 9) which related to a 12 month

period. These were used to examine the frequency and depth of discussion about safety priorities and initiatives.

Data analysis

Several data collection methods were used to capture the human experiences and to explore the breadth of permeation of safety culture through various layers of the organisation. The data were individually analysed qualitatively using thematic analysis to draw out key issues of relevance to the research (Tesch, 1990). Interviews were transcribed verbatim and the transcripts and interviews were reviewed as part of data familarisation. Following this initial open coding was used which was then developed into categories and then themes removing and collapsing categories until overall themes emerged.

Non-participant observation field notes and records were analysed to identify how frequently safety priorities were highlighted during shift handovers. In addition, secondary data from meeting minutes was subject to thematic content analysis looking for the frequency and detail of discussions around safety initiatives and priorities. Once all of the data had been analysed the data from all sources was considered to triangulate the results. This involved comparing and contrasting reported safety priorities at each level of the organisation and analysing whether these were borne out in the actions of staff during their day-to-day work.

Results

The data analysis revealed a number of themes related to factors which facilitate or hinder the implementation of safety initiatives at various levels within an organisation. The themes broadly fit into contextual issues such as organisational culture, leadership and

communication. The identification of safety initiatives was driven by various forms of evidence as well as outside influences such as reporting and monitoring. The study identified how some initiatives permeated the various levels of the organisation to a lesser or greater degree. This led to the identification of potential factors which allowed some initiatives to permeate all levels while others stopped one level down from the executive hospital management.

Contextual issues

The study identified that the executive hospital management and directorate management had a clear view of the type of organisational culture they were trying to develop. While they acknowledged that culture is not un-dimensional in an organisation and that sub-cultures do exist they identified that they were trying to develop a culture which strived to provide the best care and improve services for patients.

This perception of organisational culture was generally consistent throughout the management team, with the Chief Executive suggesting:

> *"a pretty vibrant, positive, a patient focussed culture. What we've been trying to do is build a culture about people wanting to do their best, improve things, try and get to a position where they are happy for their family to be treated here, and increasingly if they see a problem sort it out, let's not make a big thing of it, just sort it out"*
>
> CEO-263

This view was shared by other managers in a directorate with one Matron commenting:

> *"it's very much committed to do the best for patients, but not only support patients but support staff to be able to have the resources to provide that care. I feel that they take patient care seriously"*
>
> Matron-3-56

The Directorate Manager was philosophical when considering whether it was possible to create a uniform culture across a large organisation. He said:

> *"I can't say hand on heart that the culture filters down to all levels of the organisation because there's probably a number of people who just come in, and do their job and go home and they're not really connected with it all"*
>
> DManager-71

The ward staff were more concerned with the culture on their individual ward but one ward sister when asked about the culture of the organisation said:

> *"it's all about public perceptions, nobody cares whether it's the right thing or the wrong thing, it's all about public perceptions… it's to make the public think we're great"*
>
> Ward-Sister-B-89

Similarly a Senior Health Care Assistant said:

> *"at a Trust* [organisation] *level, I think they would replace you without thinking twice… I don't think they value people"*
>
> SeniorHCA-B-207

These views suggested a mismatch between the espoused culture at a senior level and the views of staff on the wards. This raises the issue of whether it is possible to have an organisational safety initiative when different levels have fundamentally different visions of what such initiatives are trying to achieve. Part of creating an organisational culture is having a shared set of values and beliefs it would appear that different layers of the organisation had varied views on what the organisations mission was and what is was trying to achieve.

Another significant contextual theme was that of leadership. The management team saw that leadership of the Trust comes from the Chief Executive:

"I think it is very important that the leadership for this organisation comes from the chief exec and his exec team… the director of nursing, medical director and the chief exec are seen as pivotal individuals. The non-execs that also sit on the board are then part of the business units as well, so they cascade that behaviour down, but particularly our chief exec's very visible and a very good role model and a very good leader, and I think that a lot of his behaviour certainly permeates through the whole organisation"

Matron2-71

Some of the management team saw leadership as a hierarchal structure:

"we've got the chief exec at the top, and then to our exec nurse, then our executive managers, and then it comes down to our operational managers, and then to the matron, and the matrons are actually more on a level with the wards and the areas that they cover"

Matron3-116

The Chief Executive was clear that his values as a leader flowed through the organisation and that he expected to be visible and for people to see that he espoused these values in his behaviours and approach.

"I've got a set of values, which flow through to all the staff…. But I would say, where I would like to be is that every member of staff should be able to say they know what makes me tick"

CEO-120

While the Chief Executive and the Director of Nursing were very visible on the wards the staff on wards felt that the directorate management's role was to check and reinforce rather than to support. While the Director of Nursing said:

"you work on the ground when you have to, and you do things on wards and if you see someone about to stumble you go and help a patient. If you're on call you go and help out and help them make beds"

DoN-114

This contrasted with the views of some clinical staff who reported less supportive management from middle managers, noting:

> *"If your score on audits is not 100% then the matron comes down straight away and says why is this not happening"*
>
> WardManager-A-490

Similarly ward staff felt that the range of initiatives and the pace were difficult and this led to poor implementation of initiatives because there was insufficient time and support to fully implement on thing before the next initiative was being introduced.

> *"I think it's too quick really… because we've just started on task and then there another one come out"*
>
> WardManager-A-236

The management approach appeared hierarchical rather than transformational in its approach and as a result ward staff felt that managers were there to check progress rather than to lead the transformation of culture or approaches.

The third major contextual theme was communication, specifically communication of safety initiatives. The executive hospital management felt that they set out the safety priorities well for all staff from the hospital board and when speaking directly to ward staff. The Directorate Manager recounts:

> *"when you hear the Chief Executive speaking it'll be all… it's all-around patient safety, you know quality can't be compromised"*
>
> DirectorateMgr-67

While the executive felt they set out and communicated the priorities they acknowledged that staff probably had difficulty filtering out and focusing on the priorities, the Director of Nursing stated:

"I think what's hard though for people is to filter out all the things and what's actually important. We need to work hard all the time to say these are the things to focus on because the system will tell everyone there are thousands of things to do all the time"

DoN-196

The senior team also acknowledged that there was an over reliance on email communication and that more face-to-face communication would help with safety messaging. The Director of Nursing stated:

"we're just going through a process of encouraging everybody to make sure you take the opportunity to sit down as a team, do as much face-to-face as possible and don't rely on email"

DoN-173

The over reliance on email was also cited a barrier by ward staff

"We get a lot of emails. I mean, I was off yesterday and the day before as my days off and I came back to 52 emails today, most of which I delete because I will only read the ones I have to properly action. So that information gets lost"

WardManager-B-264

The senior ward staff acknowledged that they do have face-to-face meetings with the matron but safety issues were still not getting discussed. The information flow could be improved but the senior ward staff did still receive paper-based communications.

The observation records and field notes revealed that the overall communication barriers then manifested themselves in communication about safety issues during actual patient care. One such example was:

"during the handover there was no discussion at all about falls or about anyone who had fallen or was at risk of falling. There was a lack of awareness of falls as a safety issue and the office board had falls risk indicators (Fallen star markers) which weren't assigned to at risk patients"

Ward-B-Obs-30

Analysis of the secondary data from meeting minutes and record revealed that the executive team discussed reports surrounding slips, trips and falls, serious untoward incidents and infection rates. However, pressure ulcer rates had only been discussed once in the year. There appeared to be a distinct lack of actions developed following the meetings. Similar inconsistencies were found at directorate and ward level.

Evidence for Safety Initiatives

There appeared to be a simultaneous two way mechanism of identifying safety priorities and initiatives. Firstly, the executive hospital management identified priorities through reporting, national campaigns and reporting against benchmarks, such as the NHS safety thermometer (Health and Social Care Information Centre (2015).

> *"I take all the facts and data but I'll go around and listen so it's a combination of those things which gets me to the point of thinking, yes we are doing that well, you can't rely on one or the other in themselves"*
>
> DoN-208

Secondly, staff were encouraged to identify initiatives at patient safety days where staff engaged in workshops looking at data and issues and exploring possible solutions.

> *"I went to the first patient safety day that they held,… you had to come up with an idea to improve safety at ward level"*
>
> WardManager-A-637

During the interviews, one of the executive members identified five safety initiatives as priorities within the Trust: falls, medications, infections, recognising the sick patient, and pressure sores. These initiatives mirrored those of the 'Safety First' Campaign by the NPSA (2015).

Safety initiatives and focus

The five safety initiatives developed by the executive team were prioritised to allow staff to focus, filtering out unimportant issues.

> *"I think what's hard thought for people is filtering out all the things and working out what is actually important. We need to work hard all the time, these are just the things to focus on because the system will tell you there are thousands of things to do all the time"*
>
> CEO-196

However, as you step down each organisational level, the number of initiatives is perceived to increase, thereby diluting the level of priority. The management team identified thirteen initiatives, while the ward staff felt there were too many safety initiatives but added in additional priorities. The highest priority was given to falls. This was identified from the executive team, through the organisational layers to the lower-grade staff on both wards, demonstrating permeation of the safety message throughout the organisation.

> *"…the big things we are focussed on at the minute are falls, probably the one that has the most focus at the minute is falls..."*
>
> CEO-185

It was also true that throughout the organisational layers to the lower grade staff on the wards, illustrated by a Health Care Assistant who stated:

> *"falls I think is a major thing on this ward at the moment"*
>
> SHCA-B-355

Table 2 shows that falls, as priority, flowed through all the layers of the organisation. All of the participants mentioned falls as a priority when discussing patient safety. While infection prevention also passed through the majority of the layers, but it was not highlighted as priority by the lower-grade staff on both wards. It appears that falls unlike other identified

priorities was relatively commonplace and staff could compare their performance against other hospitals.

> *"oh the falls on here are just horrendous… they just happen it like we are the worst Trust [hospital] and it's really embarrassing"*
>
> SeniorHCA-A-503

In addition, falls was highlighted in meetings and reports as a significant problem. The problem of falls was highlighted in the annual quality report as the number of falls resulting in serious harm had risen from 27 to 61 over a one year period. Falls as a safety issue had received a lot of attention with a myriad of interventions designed to reduce the number of patients falling.

> *"… falls is huge in the Trust [hospital], there is a specialist falls group, there are falls nurses, … there's a falls clinic, thousands of pieces of falls paperwork, prevention of falls care plans, falls referral pathways. Now if someone falls more than twice you've got to do a cause analysis – obviously falls is a massive thing"*
>
> WardManager-B-367

Despite the implementation of a range of interventions there was concern that they were not really making a difference in terms of falls incidence;

> *"I think there is a long way to go with falls, it's hugely complex… I think there's been lots of initiatives introduced but I'm not 100% sure what, if anything, is making a difference"*
>
> Matron-2-211

Falls was also a priority which appeared to be facilitated to some extent by other practitioners working with ward staff to offer training and support. Both of the ward sister and a Health Care Assistant cited how training and support were offered at a ward level.

> *"we've all got to go on al falls away day and we've all got to do the falls training".*

WardManager-B-451

"We get a specialist falls nurses who comes down".

HCA-B-556

"the falls team are coming around and spending half a day on each ward".

WardManager-A-811

Observation notes recorded variation in the implementation of the initiatives such as identifying at risk patients, communicating falls risk during handover and awareness raising suggesting that despite awareness of falls as an organisational priority this was not always translated into action;

"during the handover there was no discussion at all about falls or anyone who had fallen, or anyone at risk of falling or the falls status… a distinct lack of awareness of falls and on the board the fallen star markers were not associated with any patient"

Ward-B-Obs-30

Discussion

The literature review highlighted a study by Ward et al (2017) which examined the use of the PARiHS Framework (Promoting Action on Research Implementation in Health Care Settings) to guide the implementation of safety initiatives. The PARiHS Framework (Rycroft-Malone et al, 2004) was developed from a considerable body of theory and research. However, evidence directly testing the framework with regard to patient safety, particularly at multiple organisational levels, is somewhat limited. The study by Ward et al (2017) identified the important contextual, leadership and facilitation factors associated with successful implementation of safety initiatives in 13 rural hospitals. They found that there

was a strong relationship between contextual factors such as evaluation and facilitation but that there was little reliance on evidence during implementation.

This study has explored the factors associated with safety priority messaging across multiple levels of a complex NHS Hospital Trust. The results suggest that safety initiatives are only successful where they have a number of enablers including data from monitoring, communication and facilitation. This study suggests that attempts to implement a positive safety culture have had varying degrees of success the staff on the wards having a different view of the Trusts (Hospital) priorities and culture than the executive team or middle management. There appeared to be a mismatch between the senior manager's espoused values and the ward staffs perceptions of reality. Staff on the wards perceived management as less supportive, seeing their role as monitoring and checking that things were being done.

Both the literature review and the research results in this study support the view that safety initiatives are only successfully implemented if the leader communicates the priorities and his / her values (Keen, Nicklin, Long et al, 2018). However, what appears to be suggested via the literature and the findings is that a safety priority is likely to be more successfully communicated to all levels within an organisation if there is a sense of ownership. Mattson, Hellgren and Goransson (2015) and Solvie (1993) appear to suggest that this sense of ownership can only be achieved if staff at all levels in an organisation work together to determine the priorities and have a shared understanding and commitment to achieving them. In this study the safety initiatives developed by the Executive Hospital Management Board were designed to encourage focus and to filter out unimportant issues. It appears that the priorities were determined by the Management Board with little discussion with other managers or ward staff. As a result this research found that only one layer down, the

management team identified a further eight priorities in addition to the executive team initiatives. Despite this focus, even the management initiatives were reflected differently throughout the ward teams, who then added another three initiatives. The resulting myriad initiatives caused a lack of focus on the safety priorities of the organisation. Only one safety initiative flowed from Executive Hospital Management Board to Ward that was falls prevention. Despite everyone in this study citing falls as a priority there was varying degrees of compliance with interventions noted during observations. Once of the possible explanations for this could be the lack of facilitation of the initiatives. While staff had attended training and the falls team visited each ward weekly the interventions were not really facilitated and reinforced during day-to-day clinical practice. Rycroft-Malone et al (2004) cited how facilitation is a key element in the successful implementation of service improvements with high levels of facilitation being required to help practitioners make sense of the evidence and to develop a change the context (Ward et al, 2017).

As discussed, data showed that falls was the only safety initiative that permeated throughout the whole organisation, and identified as a priority by all staff. There was significant investment by the executive team in this safety initiative and it was discussed in their executive meetings. A number of measures and Key Performance Indicators surrounding falls allowed a reportable and visible method of recording and reporting the number and severity of falls. This system provides both evidence for improvement and assists in the evaluation of the effectiveness of interventions. Both of these areas have been identified as key facets of a framework for practice improvement.

Another key element from a contextual point of view is that of goal alignment which is seen as an important component in safety messaging (Ashkanasy, Wilderom and Peterson, 2000);

that is that each layer of the organisation is working to the same goals. This study also identified that the consistency of cultures at different levels in an organisation also played a role in how staff perceived safety initiatives. Alqattan, Cleland and Morrison (2019) details how staff perceive openness, an organisation willing to learn and management support for safety as important factors in developing a hospital based safety culture. Without these staff are unlikely to report errors or near misses or work proactively to address safety concerns.

The findings of the study and the literature suggests that nurse leader and managers could influence the communication of safety initiatives throughout a hospital by working with staff at all levels to identify and agree a set of shared priorities. Such priorities should be capable of being monitored and audited to ensure that success can be measured. Once the priorities are agreed these should be communicated throughout the organisation. However, rather than simply communicating the priorities nurse leaders and managers should communicate their values and why these areas are important. Sharing values is one of the ways in which a culture of openness and organisational learning can be developed. This requires a focus on leadership behaviours which need to match the values espoused (Crutchfield and Roughton, 2013). For example, focusing on fair or no blame, openness and developing a learning culture. Tsai (2011) found a strong correlation between leadership behaviours and the perceived values and beliefs which make up the culture of an organisation.

Beyond communication successful implementation requires continued and effective facilitation in order to ensure effective knowledge translation and buy-in from clinical staff. A study by Mahmood et al (2019) found that facilitation was an essential component of

implementation as it communicated not only the why but the how which promoted engagement, enthusiasm and buy-in from clinical staff.

Conclusion

Despite the executive's focus on five identifiable safety initiatives, only one initiative was successfully permeated through the organisation to ward level. This was in spite of the fact that these safety initiatives were chosen purposefully by the executive team and justified by the rationale that staff could focus on just a small number instead of 'hundreds' of issues. It was noted that each layer of the organisation 'added' further identifiable concerns to the initial list of five initiatives, increasing the number to 16 in total. Consequently, ward teams typically experienced confusion and frustration due to having too much to focus on and the attendant paperwork involved.

Despite awareness of falls as a priority at all levels within the organisation implementation of initiatives to prevent falls was variable across the wards. The missing element appeared to be effective facilitation of the initiatives and reinforcement of the how to prevent falls in day-to-day clinical practice.

The adoption of safety initiatives can be improved through a process of discussing and agreeing shared priorities with all staff within an organisation. The communication of values alongside the initiatives identified and by leaders developing an open culture based on organisational learning. The development of such cultures requires a focus on congruent behaviours alongside any espoused values.

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