MANITOBA INSTITUTE FOR PATIENT SAFETY

Make It Personal: Interview Series

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An Interview with Heather Campbell

In this interview, I had the pleasure of meeting Heather Campbell, a Quality & Patient Safety Coordinator for the Interlake-Eastern Regional Health Authority. While Heather has many different responsibilities, she has focused a lot of energy on creating a patient safety culture, as she believes this is the main factor in achieving safe quality care. In conversation with her, I learned that she is a fountain of knowledge on this topic, from the historical development of patient safety culture, to the key ingredients in a flourishing patient safety culture.

Patient Safety Culture: Where We Have Been, Where We Are Going

To understand what we are trying to achieve in patient safety culture, it is helpful to understand where we have come from. Heather explains that healthcare environments used to be steeped in a ***blaming and shaming culture***, where it felt unsafe for healthcare providers and administrators to acknowledge and address mistakes. Once this culture was recognized to be problematic, there was a large effort to shift healthcare culture towards a ***no blame*** culture. The ***no blame*** movement improved safety by acknowledging errors, which allowed the healthcare system to focus on improving care to avoid similar errors. The downside of the ***no blame*** culture was a lack of focus on health professionals' personal accountability in providing safe quality care. Heather explains that this is where a j***ust culture*** comes in. "A j***ust culture*** is powerful because it gives clear accountabilities and expectations of individuals. But, when people make mistakes, administration will approach the individual in a fair way and give the person all the information they need to make improvements. Everyone makes mistakes, we're only human. Hopefully our mistakes won't result in harm, but if they do, everyone can expect to be treated fairly."

The Key Ingredient to Developing a Just Culture

Heather has supported many different initiatives to promote patient safety, from ensuring patient safety is addressed in orientation of staff, to supporting programs in responding to critical incidents. But she says one of her most impactful activities has been developing relationships. "We've worked on relationships to elevate patient safety at all levels of the healthcare system – from direct care providers to high level leadership." Patient safety will only work if everyone is engaged.

Heather has ensured that programs see her as a supportive resource who will help them reach their goals, rather than someone who will critique their work. She does this by being empathetic to the high demands on staff and programs, and finding how she can help. For example, she says, "An acute care program is very busy and so it is challenging to have the energy, time and focus for quality improvement work. At the request of leadership our program was able to prepare an action planning session with clinical leaders to streamline their actioned patient safety improvement activities."

Building a strong foundation takes time

Heather says, "The key building block to safe patient care and better outcomes is in building that foundation of patient safety culture in the region. When you take a look at our healthcare systems, you will see that they are very complex. It is not as easy as you would think to have optimal outcomes every day, so we promote positive outcomes by building a culture of safety where staff feels comfortable and confident bringing forward their concerns." Just like in building a skyscraper, the foundation takes the longest to construct. "To see the really rewarding outcomes you need to persevere –I see some great impacts now after six years in this position. I'm glad I stuck it out to see these positive changes in patient safety. It's given me even more drive to do this work." We at MIPS are glad Heather has stuck it out too. We can't wait to see the skyscraper that is bound to emerge in our health systems with Heather as one of the architects.

The Manitoba Institute for Patient Safety (MIPS) is an independent, not-for-profit corporation established in 2004 to promote and coordinate activities that improve patient safety and enhance quality healthcare in Manitoba.

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