It’s All About Culture!

Creating non-punitive safety environments

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The single greatest impediment to error prevention in the medical industry is "that we punish people for making mistakes."

Dr. Lucian Leape
Professor, Harvard School of Public Health
Testimony before Congress on
Health Care Quality Improvement

"People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right?

Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue."

Don Norman
The Design of Everyday Things

Framework for Safe, Reliable and Effective Health Care

Leader-driven (ISO 9001)

Source: Frankel A, Haraden C, Federico F, Lenoci-Edwards J. A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available at ihi.org)

Reference: Frankel, A. et al. A Framework for Safe, Reliable, and Effective Care. IHI, 2017.

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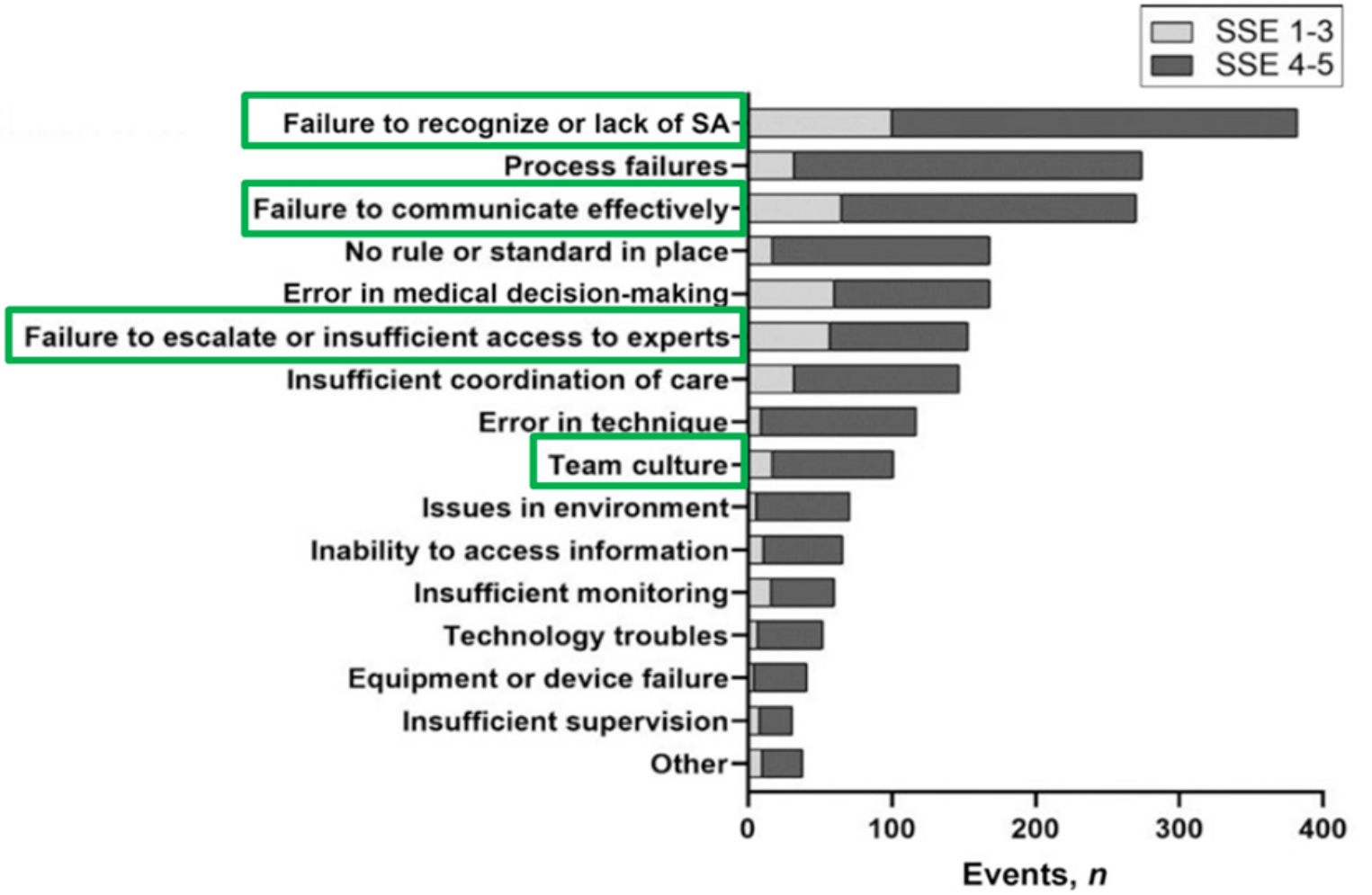
Serious Safety Event Contributing Factors



Reference: Burrus, S. et al. Factors Related to Serious Safety Events in a Children's Hospital Patient Safety Collaborative. Pediatrics, 20201, 148 (3).

Hudson Model of Safety Maturity

Reference: Workplace Safety Education Guide: Understanding Safety Culture. Xchanging, September 2015.

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- Often, Events are Seen as Things to be Fixed

- Events Should Be Seen as Opportunities to Inform Our Risk Model
  - System risk
  - Behavioral risk

Where management decisions are based upon where our limited resources can be applied to minimize the risk of harm, knowing our system is comprised of sometimes faulty equipment, imperfect processes, and fallible human beings

DNV and ISO 9001: 2015 Goal: Learning Organization

Learning is an essential attribute of high-performing organizations. Effective, well-deployed organizational learning can help an organization improve from the early stages of reacting to problems to the highest levels of organization-wide improvement, refinement, and innovation.

$ fixes everything!

Who needs a process!

Process reviews begin

Basic CAPS for NCs

Predictive risk assessments performed

Full prevention orientation from the beginning.

Organizational strategy!

Reference: 2021–2022 Baldrige Excellence Framework (Health Care), National Institute for Standards and Technology

Safety Culture and Leadership

What is a safety culture?

Safety culture is a combination of attitudes and behaviors toward patient safety that are conveyed when entering a health facility.

Why is a culture of safety important?

- Numerous studies show a link between a positive safety culture (where safety is a shared priority) and improved patient safety.[1]
- Leadership support for safety culture is cited as the most compelling strategy for achieving patient safety.[2]
- A culture of safety is necessary before other patient safety practices can be successfully introduced to a healthcare organization.

[1]Berry JC, Davis JT, Bartman T, Hafer CC, Lieb LM, Khan N, Brilli RJ. Improved safety culture and teamwork climate are associated with decreases in patient harm and hospital mortality across a hospital system. J Patient Saf 2016 Jan 7.

[2]National Patient Safety Foundation (NPSF). Free from harm: accelerating patient safety improvement fifteen years after To Err is Human. 2015.

Did you ask?

- Is safety everyone’s first priority in our organization?
- Has our organization adopted a consistent approach to fairly assess accountability for patient safety incidents by differentiating individual and system errors?
- Has our organization created an environment that is conducive for staff to report errors and unsafe conditions?
- Is out organization continually learning from patient safety events so if can function as a high-reliability organization?

Leadership Attributes and Strategies for an Effective Safety Culture[3]

Attributes	Sample Strategies
Promote continuous learning from patient safety events	• Encourage reporting of patient safety events and near misses • Remove barriers to event reporting; make reporting easier for staff • Highlight "good catches" of unsafe conditions • Identify and address systems issues that lead to events
Motivate staff to uphold fair and just culture	• Protect staff from unfair targeting for events that result from system issues • Adopt and practice fair approach to evaluating accountability for events that may have concerns about individual action; ensure the approach is consistently applied • Provide support for team members involved in adverse events
Provide a transparent environment in which quality measures and patient harms are freely shared with staff	• Conduct leader rounds on units to ask staff about barriers • Hold daily leadership safety huddles • Disseminate lessons learned from safety events • Share organization- and unit-level safety data
Model professional behavior	• Set a positive tone • Think out loud to encourage a shared mental model • Invite staff into patient safety discussions • Use noncritical language when questioning event • Use people's names
Eliminate intimidating behaviors that interfere with safe behavior	• Adopt zero tolerance approach to intimidation • Implement disruptive behavior policy • Adopt mechanisms for staff to report disruptive behavior • Enforce processes to promptly address disruptive behavior
Provide resources and training for improvement initiatives	• Offer simulation training to promote effective team behaviors and communication • Allow time for staff to participate in performance improvement activities

[3]**Health Research & Educational Trust. Culture of safety change package: 2018 update. 2018**.

Just Culture

What do we mean by Just Culture?

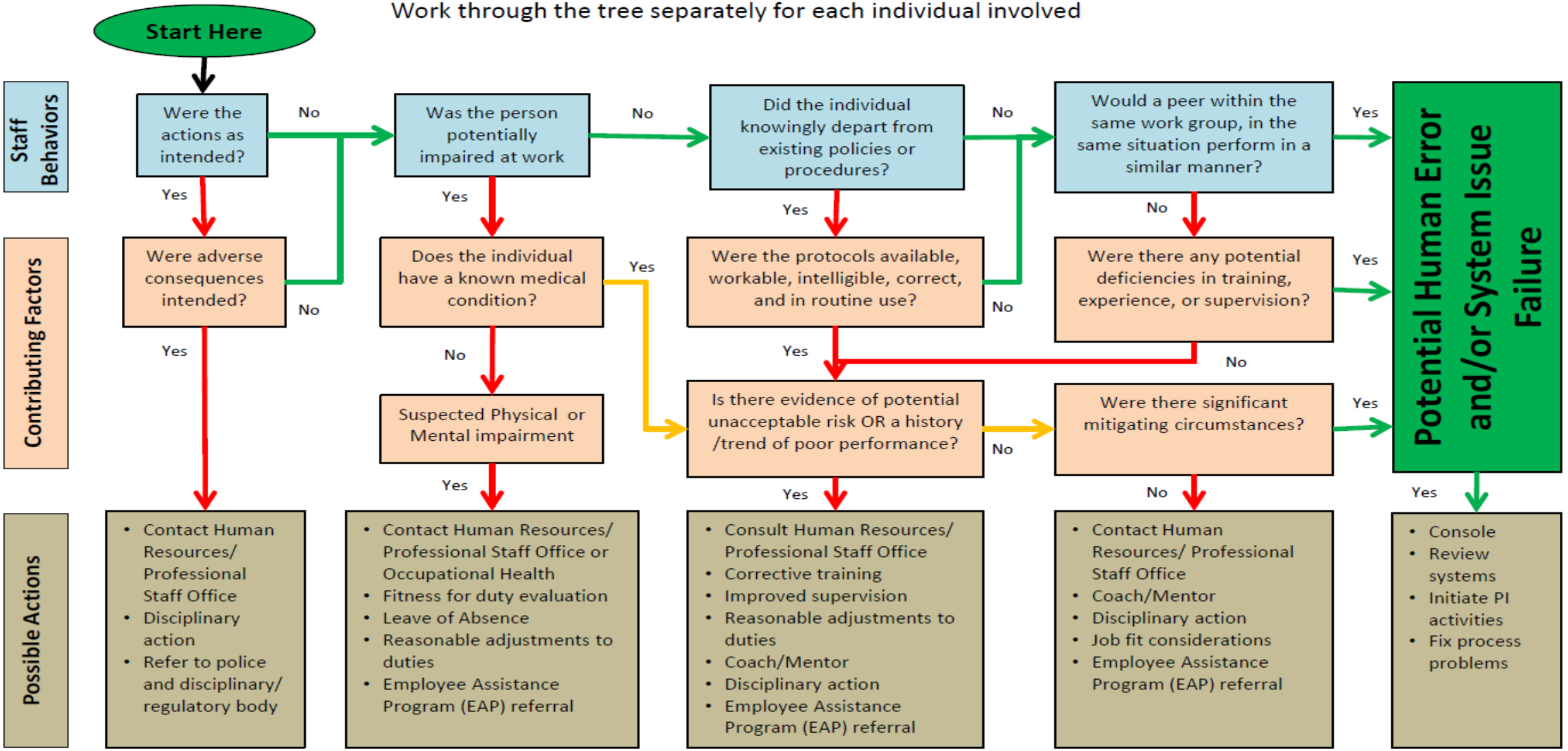
- Traditionally, health care's culture has held individuals accountable for all errors or mishaps that befall patients under their care
- A just culture recognizes that individual practitioners should not be held accountable for system failings over which they have no control.
- A just culture also recognizes many errors represent predictable interactions between human operators and the systems in which they work. Recognizes that competent professionals make mistakes.
- Acknowledges that even competent professionals will develop unhealthy norms (shortcuts, "routine rule violations").
- A just culture has zero tolerance for *reckless* behavior.

Behaviors We Can Expect

- Human error - inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake. **Console**
- At-risk behavior – behavioral choice that increases risk where risk is not recognized, or is mistakenly believed to be justified. **Coach**
- Reckless behavior - behavioral choice to consciously disregard a substantial and unjustifiable risk. **Discipline**

Event Decision Tree*

Work through the tree separately for each individual involved



NOTE: Based on James Reason's Decision Tree for Culpability of Unsafe Acts, Managing the Risks of Organizational Accidents.

Top 10 Action Recommendations[4]

1. Communicate leadership support for a culture of safety.
2. Model expected behavior within a safety culture.
3. Develop and enforce a code of conduct that defines appropriate behavior to support a culture of safety and unacceptable behavior that can undermine it.
4. Create an environment in which people can speak up about errors without fear of punishment; use the information to identify the system flaws that contribute to mistakes.
5. Apply a fair and consistent approach to evaluate the actions of staff involved in patient safety incidents.
6. Support event reporting of near misses, unsafe conditions, and adverse events.
7. Identify and address organizational barriers to event reporting.
8. Cultivate an organization-wide willingness to examine system weaknesses and use the findings to improve care delivery.
9. Promote collaboration across ranks and disciplines to seek solutions to identified safety problems.
10. Periodically assess the safety culture of an organization to track changes and improvements over time.

[4]Culture of Safety: An Overview. Health System Risk Management Guidance. ECRI. Updated 10/28/2019.