A SOCIOTECHNICAL APPROACH TO SAFE & RELIABLE CARE

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Safe & Reliable Healthcare
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Success in Healthcare Going Forward

• Effective population health that delivers on the promise to the community.
• The ability to deliver safe and reliable care.
• Engaged patients and families – engaged care givers.
• Systematic involvement of boards and senior leaders in engaging front line workers to help drive waste, harm and cost out of the system.
• Financial and operational stability
• In 2010 we spent $2.6 trillion on health care, or $8,402 per person.
• The share of economic activity (GDP) devoted to health care has increased from 7.2% in 1970 to 17.9% in 2009 and 2010.
• Health care costs per capita have grown an average 2.4% faster than the GDP since 1970.
• Half of health care spending is used to treat just 5% of the population.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.
Why do we need to think in a different way?

• 10,000 baby boomers turn 65 every day – one every 7 seconds
• 16% of the population by 2016
• 25% Medicare patients have 5 or more chronic conditions, see an average of 13 physicians and fill 50 prescriptions / year
• 41% of commercial patients now in high deductible plans, American business is getting out of the healthcare side
• 4% of patients with a 5K deductible met it in 2013, 11% with $2500
• That means I probably don’t want come see you, I may not pay you and you can’t tell me what it costs.
Our Conversation

• What is your definition of a culture of safety?
• Building and sustaining a Learning Organization
• The importance of a SocioTechnical Framework
• What does effective leadership look like?
• How to assess and improve culture
• Edgar Schein’s lessons
• How do I go home and practically apply what I learned about resilience?
A Culture of Safety

No one is ever hesitant to voice a concern about a patient

Action is taken, feedback reliably provided, changes are visible for staff and patients

Concerns raised by front line caregivers are taken seriously & acted upon

Skilled caregivers playing by the rules feel safe to discuss and learn from errors
The Ideal Unit
Improving Safety Requires a Learning System

- Safety is a characteristic of a **SocioTechnical system**
- System-level failures occur almost always because of unforeseen combinations of component failures

**FIGURE 3-1**
Sociotechnical system underlying health IT-related adverse events.

SOURCE: Adapted from Harrington et al. (2010), Sittig and Singh (2010), and Walker et al. (2008).
Reliability or Chaos?

Transitional Chaos or Enduring Harm? The EHR and the Disruption of Medicine

Lisa Rosenbaum, M.D.

A decade ago, a primary care physician I admired seemed to come undone. His efficiency had derived not from rushing between patients but from knowing them so well that his charting was effortless and fast. But suddenly he became distracted, losing his grip on the details of his patients’ lives. He slumped around, shirt half-untucked, perpetually pulling a yellowed handkerchief from his pocket to wipe his perspiring forehead. Everyone worried he was sick. His problem, however, turned out to be the electronic health record (EHR).

Ten years and nearly $30 billion of government stimulus later, the mandate to implement EHRs has spawned many similar stories, some of which Robert Wachter describes in The Digital Doctor: push to digitize medicine and the sanctity of the doctor–patient relationship. Wachter centers his EHR analysis around the story of an 18-year-old given a 39-fold overdose of Bactrim (sulfamethoxazole–trimethoprim) — a near-fatal error partially caused by an EHR. Investigating the root causes, Wachter discovers design flaws, such as defaulting to certain units for medication dosing and alerts rendered meaningless by their sheer number. But he concludes that the mistake stemmed less from the EHR itself than from its effects on workflow disruptions and healthcare providers.

For inhabitants of this upside-down world, Wachter’s “House of Horrors” tour is vindicating. There’s the critical care doctor who, unable to identify new information in daily notes, has begun printing them out and holding two superimposed pages up to the light to see what’s changed. There’s the cardiologist who says, “It could be worse. . . . I could be younger.” To these tales of EHR fallout, most of us could add our own. Physicians retiring early. Small practices bankrupted by up-front expenses or locked into ineffective systems by the prohibitive cost of switching. Hours consumed by onerous data entry unrelated to patient care. Workflow disruptions. And above all, massive intrusions on our medical relationships.

Safe & Reliable Healthcare
UNMINDFUL
“We show up, don’t we?”
Chronically Complacent

REACTIVE
“We methodically anticipate”— prevent problems before they occur

SYSTEMATIC
Systems being put into place to manage most hazards

PROACTIVE
Organizational Culture “Genetically-wired” to produce safety

GENERATIVE
Where is Yours?

Attribution: Prof. Patrick Hudson, Univ. Leiden
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<th>SocioTechnical People/Workflow Components:</th>
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COMMUNITY HOSPITALS

SOCIOTECHNICAL ASSESSMENTS: 7 DOMAINS IN 30 US HOSPITALS
Characteristics of The High Performers

• Leadership was present 2-3 hours every day on the front lines engaged in meaningful dialogue with frontline workers and patients.

• A coherent process to bring patients from primary care into the hospital.

• Medication reconciliation every time in the ED.

• Unit-based hospitalists building relationships

• Discharge planning began on admission

• Detailed care coordination for the discharge
SocioTechnical Framework

- Patient & Family Centered Care
- Leadership – Senior and Clinical
- Effective Teamwork
- Psychological Safety
- Organizational Fairness / Just Culture
- Reliable Processes of Care
- Learning System - Improvement
Reliable Processes of Care

- Safety is built at all levels of the organization, continuous risk assessment and learning
- Active situational awareness leads to early problem detection and resolution
- Healthcare systems are complex, risk must be actively managed
- Adverse events stem from human error – who did it?
- If smart people try hard and know what they’re doing, they won’t make mistakes
Patient & Family Centered Care

- **GENERATIVE**
  Organization wired for safety and improvement

- **PROACTIVE**
  Playing offense - thinking ahead, anticipating, solving problems

- **SYSTEMATIC**
  Systems in place to manage hazards

- **REACTIVE**
  Playing defense – reacting to events

- **UNMINDFUL**
  No awareness of safety culture

- Truly patient-centered care, a true partnership, all about them
- Structured process for patients and family at the table, visible results
- Care process visible, learning and feedback sporadic
- Customer service is the primary focus
- Care process built around the convenience of providers
Senior Leadership

- **GENERATIVE**
  Organization wired for safety and improvement

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- Cyclic flow of information with feedback and organizational learning
- Systematic engagement with dialogue, support and learning
- Process for interaction between senior leaders and front line staff
- They’re here – something bad must have happened
- We don’t know or see them
Why a Learning System is Essential

• You have really good people working in an environment that does not optimally support their efforts.
• Lots of first order problem solving in healthcare.
• We are generally not very good at process improvement.
• 30% of healthcare spending does not create value – lots of waste, harm and defects = opportunity.
• Constant defects and workarounds are frustrating and demoralizing.
The values of facility leadership are the same values that people in this work setting think are important.
Effective Leadership Practices

• Regularly scheduled, dedicated time to engage with front line workers.
• Structured dialogue that relates to work they do and the opportunity to raise the bar.
• Reinforcing the good work they do and how it aligns with the goals of the organization.
• Having the dialogue in front of the Learning Boards so it drives learning and increase the visibility of improvement efforts.
• Tracking what was discussed and improved so feedback is supported.
ABSTRACT  National policies to improve health care quality have largely focused on clinical provider outcomes and, more recently, payment reform. Yet the association between hospital leadership and quality, although crucial to driving quality improvement, has not been explored in depth. We collected data from surveys of nationally representative groups of hospitals in the United States and England to examine the relationships among hospital boards, management practices of front-line managers, and the quality of care delivered. First, we found that hospitals with more effective management practices provided higher-quality care. Second, higher-rated hospital boards had superior performance by hospital management staff. Finally, we identified two signatures of high-performing hospital boards and management practice. Hospitals with boards that paid greater attention to clinical quality had management that better monitored quality performance. Similarly, we found that hospitals with boards that used clinical quality metrics more effectively had higher performance by hospital management staff on target setting and operations. These findings help increase understanding of the dynamics among boards, front-line management, and quality of care and could provide new targets for improving care delivery.
Daily Operational Brief – DOB

• 15-20 minutes every morning with all departments represented to get the broad picture of what is happening in the hospital, the constraints and resources that can be brought to bear.

• It gets everyone on the same page. Having the big picture allows people to be more proactive.

• Subsequent surprises occurring during the day can be debriefed the following morning to promote learning.

• Everybody talks, it is structured and efficient.
Leadership Walkrounds - Why is it Hard?

• Many competing interests.
• I may not have domain expertise and feel uncomfortable in clinical areas.
• I don’t want to look incompetent.
• There are many challenges, and we have limited resources to fix them.
• Front line caregivers may raise difficult issues we can’t fix.
‘I think we should just listen and get out’: a qualitative exploration of views and experiences of Patient Safety Walkrounds

Leahora Rotteau, Kaveh G Shojania, Fiona Webster

ABSTRACT

Objective This article is an exploration of views and experiences of Patient Safety Walkrounds, a widely recommended strategy for identifying patient safety problems and improving safety culture.

Design and setting Qualitative analysis of semistructured, in-depth interviews with 11 senior leaders and 33 front-line staff at two major teaching hospitals with mature walkrounds programmes, collected as part of a larger mixed-methods evaluation.

Results Despite differences in the structure of the two walkrounds programmes, senior leaders at both institutions reported attitudes and behaviours that contradict the stated goals and principles of walkrounds. Senior leaders tended to regard executive visibility as an end in itself and generally did not engage with staff.

BACKGROUND

Patient Safety Walkrounds, also known as Executive Walkrounds or Leadership Walkrounds, has emerged as a promising strategy for identifying specific patient safety problems and, more generally, improving safety culture.1–9 Though details vary across institutions,1–5 9 10 walkrounds typically involve senior leaders meeting with front-line staff to discuss patient safety concerns,4 in a forum that is intended to be open and blame-free. These concerns may range from practical issues (eg, equipment availability or functionality) to deeper challenges (eg, adequacy of staffing or inter-professional communication problems). Based on the open, non-hierarchical nature of the conversations,
Why is Culture Important?

- Culture reflects the behaviors and beliefs within an organization.
- There are behaviors that create value individually, for the patient and the organization.
- There are behaviors that create unacceptable risk.
- These attitudes and behaviors are reflected in how people interact with each other both internally and externally with patients and their families.
- Culture is the social glue.
- Work as Imagined v. Work as Done
Attributes of the Market Leaders

- Mayo Clinic
- Virginia Mason
- Thedacare
- Mercy Hospital
- Billings Clinic
- Southwest Airlines
- Starbucks
- Nordstrom's

Lead the Way

Earn the admiration and respect of your employees with these simple workplace strategies.

Whether it's the supervisor who rewards you for working late, or the CEO who responds directly to your office memo, great workplaces start with people at the top. On the other hand, few things inspire job-hunting faster than telling away for an arrogant, domineering dictator. Bob Sutton, professor of management science and engineering at Stanford University and author of Good Boss, Bad Boss, shares ways to keep office murmurings to a minimum.

PROTECT YOUR PEOPLE
“Earn how to shut it up. Good leaders are perfectly assertive but in-tune with their employees. They know when to push and when to get out of the way,” William Clay, a former vice president at AT&T, once put it this way. “After you point a seed in the ground, you don’t dig it up every week to see how it’s doing.”

GET OUT OF THE WAY

THROW OUT BAD APPLES
“Will Fojo, an assistant professor at Erasmus University in The Netherlands, studied destructive personalities in the workplace. There were ‘picks’ who violated norms of respect, ‘deadbeats’ who slacked off, and ‘downers’ who were pessimistic. He found that teams containing just one of these types suffered performance loss of 30% to 40% percent compared to offices with no bad apples.”

MIND THE SPOTLIGHT
“Being in a position of leadership is the most visible way to become obvious and unexpectedly insensible. Fight this by remembering that you're under a spotlight. You'll be watched closely by the people you lead—even more so than how you're observing them.”

FIGHT FAIR
“Great bosses teach people how to have constructive ideas and win arguments over them in an atmosphere of mutual respect. Movie director Brad Bird said that during constructive conflict everyone will get humiliated and encouraged to gather.” Once a solution is chosen, however, let go of your personal opinions and implement! Sucking undermines progress.
The Ideal Unit
Clinical Leadership

**GENERATIVE**
Organization wired for safety and improvement

**PROACTIVE**
Playing offense - thinking ahead, anticipating, solving problems

**SYSTEMATIC**
Systems in place to manage hazards

**REACTIVE**
Playing defense – reacting to events

**UNMINDFUL**
No awareness of safety culture

- Leaders create high degrees of psych safety and accountability.
- Leaders model the desired behaviors to drive culture of safety.
- Training and support exists for building clinical leadership.
- Episodic, completely dependent on the individual clinician.
- Absent for the most part
Adaptive versus Technical Leadership

- Known v. unknown problems
- Differences in style
- Knowing when to shift your leadership style
A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population


ABSTRACT

BACKGROUND

Surgery has become an integral part of global health care, with an estimated 234 million operations performed yearly. Surgical complications are common and often preventable. We hypothesized that a program to implement a 19-item surgical safety checklist designed to improve team communication and consistency of care would reduce complications and deaths associated with surgery.

METHODS

Between October 2007 and September 2008, eight hospitals in eight cities (Toronto, Canada; New Delhi, India; Amman, Jordan; Auckland, New Zealand; Manila, Philippines; Dar es Salaam, Tanzania; London, England; and Seattle, WA) representing a variety of economic circumstances and diverse populations of patients participated in the World Health Organization’s Safe Surgery Saves Lives program. We prospectively collected data on clinical processes and outcomes from 3733 consecutively enrolled patients 16 years of age or older who were undergoing noncardiac surgery. We subsequently collected data on 89% consecutively enrolled patients after the introduction of the Surgical Safety Checklist. The primary end point was the rate of complications, including death, during hospitalization within the first 30 days after the operation.

RESULTS

The rate of death was 1.5% before the checklist was introduced and declined to 0.8% afterward (P=0.003). Inpatient complications occurred in 11.0% of patients at baseline and in 7.5% after introduction of the checklist (P<0.001).

CONCLUSIONS

Implementation of the checklist was associated with concomitant reductions in the rates of death and complications among patients at least 16 years of age who were undergoing noncardiac surgery in a diverse group of hospitals.

Introduction of Surgical Safety Checklists in Ontario, Canada

David R. Urbach, M.D., Anand Govindarajan, M.D., Refik Saskin, M.Sc., Andrew S. WIlton, M.Sc., and Nancy N. Baxter, M.D., Ph.D.

ABSTRACT

BACKGROUND

Evidence from observational studies that the use of surgical safety checklists results in striking improvements in surgical outcomes led to the rapid adoption of such checklists worldwide. However, the effect of mandatory adoption of surgical safety checklists is unclear. A policy encouraging the universal adoption of checklists by hospitals in Ontario, Canada, provided a natural experiment to assess the effectiveness of checklists in typical practice settings.

METHODS

We surveyed all acute care hospitals in Ontario to determine when surgical safety checklists were adopted. Using administrative health data, we compared operative mortality, rate of surgical complications, length of hospital stay, and rates of hospital readmission and emergency department visits within 30 days after discharge among patients undergoing a variety of surgical procedures before and after adoption of a checklist.

RESULTS

During 3-month periods before and after adoption of a surgical safety checklist, a total of 101 hospitals performed 105,341 and 106,370 procedures, respectively. The adjusted risk of death during a hospital stay or within 30 days after surgery was 0.71% (95% confidence interval [CI], 0.66 to 0.76) before implementation of a surgical checklist and 0.65% (95% CI, 0.60 to 0.70) afterward (odds ratio, 0.91; 95% CI, 0.80 to 1.03; P=0.13). The adjusted risk of surgical complications was 3.86% (95% CI, 3.76 to 3.96) before implementation and 3.82% (95% CI, 3.71 to 3.92) afterward (odds ratio, 0.97; 95% CI, 0.90 to 1.03; P=0.29).

CONCLUSIONS

Implementation of surgical safety checklists in Ontario, Canada, was not associated with significant reductions in operative mortality or complications. (Funded by the Canadian Institutes of Health Research.)
Wrong Site Surgery or Retained Foreign Body in 17 Operating Rooms

RN vs. Surgeon Safety Climate Attitudes
(Post-SAQ Scores)

Operating Rooms
Major article

Nurse staffing, burnout, and health care--associated infection

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Key Words: Hospital Workload Cost PHC4

Background: Each year, nearly 7 million hospitalized patients acquire infections while being treated for other conditions. Nurse staffing has been implicated in the spread of infection within hospitals, yet little evidence is available to explain this association.

Methods: We linked nurse survey data to the Pennsylvania Health Care Cost Containment Council report on hospital infections and the American Hospital Association Annual Survey. We examined urinary tract and surgical site infection, the most prevalent infections reported and those likely to be acquired on any unit within a hospital. Linear regression was used to estimate the effect of nurse and hospital characteristics on health care--associated infections.

Results: There was a significant association between patient-to-nurse ratio and urinary tract infection (0.86; P = .02) and surgical site infection (0.93; P = .04). In a multivariate model controlling for patient severity and nurse and hospital characteristics, only nurse burnout remained significantly associated with urinary tract infection (0.82; P = .03) and surgical site infection (1.56; P < .01) infection. Hospitals in which burnout was reduced by 30% had a total of 6,239 fewer infections, for an annual cost saving of up to $68 million.

Conclusions: We provide a plausible explanation for the association between nurse staffing and health care--associated infections. Reducing burnout in registered nurses is a promising strategy to help control infections in acute care facilities.
Burnout Climate Domain

Events in this work setting affect the lives of people here in an emotionally unhealthy way. (759)

People in this work setting are working too hard on their jobs. (765)

People in this work setting are frustrated by their jobs. (764)

People in this work setting are burned out from their work. (767)

People in this work setting are fatigued from their work. (766)

Source Data: July 2015
Institution: Demo Hospital
Work Setting(s): All Work Settings
Position(s): All Positions

Safe & Reliable Healthcare

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Events in this work setting affect the lives of people here in an emotionally unhealthy way.

Source Data: July 2015
Institution: Demo Hospital
Work Setting(s): All Work Settings
Position(s): All Positions
Effective Leadership

• Set a positive active tone
• Think out loud to share the plan – common mental model
• Continuously invite people into the conversation for their expertise and concern
• Use their names
Psychological Safety

- Primary responsibility of leaders, continuously modeled everywhere.
- Leaders model and expect the behaviors that promote psychological safety
- In some units it feels safe to speak up and voice a concern
- Personality dependent – it depends who I’m working with
- Fear based – keep your head down and stay out of trouble
Teamwork Domain

Disagreements in this work setting are appropriately resolved (i.e., not who is right but what is best for the patient). (14229)

Communication breakdowns are NOT common when this work setting interacts with other work settings. (14401)

In this work setting, it is NOT difficult to speak up if I perceive a problem with patient care. (13981)

Communication breakdowns are NOT common in this work setting. (14505)

It is easy for personnel here to ask questions when there is something that they do not understand. (14609)

Dealing with difficult colleagues is NOT consistently a challenging part of my job. (14472)

The people here from different disciplines/backgrounds work together as a well-coordinated team. (14581)

Source Data: June 2015

Safe & Reliable Healthcare
In this work setting, it is not difficult to speak up if I perceive a problem with patient care.
Psychological Safety

We are our own image consultants and best image protectors.

To protect one’s image, if you don’t want to look:

- STUPID: Don’t ask questions
- INCOMPETENT: Don’t ask for feedback
- NEGATIVE: Don’t be doubtful or criticize
- DISRUPTIVE: Don’t suggest anything innovative

PSYCHOLOGICAL SAFETY CHANGES THIS PARADIGM

Source: Amy Edmondson
Effective Teamwork

**GENERATIVE**
Organization wired for safety and improvement

**PROACTIVE**
Playing offense - thinking ahead, anticipating, solving problems

**SYSTEMATIC**
Systems in place to manage hazards

**REACTIVE**
Playing defense – reacting to events

**UNMINDFUL**
No awareness of safety culture

- Teamwork and continuous learning deeply embedded and central to our culture
- Teamwork methodically taught and modeled across the organization
- Training and tools available, partial implementation
- Focus on teamwork awareness / training in response to adverse events
- If people would just do their jobs we’d have no problems

Safe & Reliable Healthcare
Teamwork Domain

- Disagreements in this work setting are appropriately resolved (i.e., not who is right but what is best for the patient). (14229)
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- The people here from different disciplines/backgrounds work together as a well-coordinated team. (14581)

Source Data: June 2015

Safe & Reliable Healthcare
Teams

- **WHAT TEAMS DO:**
  - Plan Forward
  - Reflect Back
  - Communicate Clearly
  - Manage Conflict

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<tr>
<th>The associated behaviors:</th>
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<td>Brief (huddle, pause, timeout, check-in)</td>
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<td>Debrief</td>
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<tr>
<td>Structured Communication SBAR and Repeat-Back</td>
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<td>Critical Language</td>
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Debriefing – Linking teamwork and Improvement

• What did we do well?
• What did we learn so we can do it better the next time?
• What got in the way that needs to be fixed?
Organizational Fairness / Just Culture

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Playing defense – reacting to events

**UNMINDFUL**
No awareness of safety culture

- Real events are shared by leaders, true culture of accountability and learning
- Clear ways to differentiate individual v. system error, safe to discuss mistakes
- Well understood algorithm, learning is the priority
- Depends who the boss is, blame and punishment are common
- Nothing good will come from talking about mistakes

Safe & Reliable Healthcare
Safety Climate Domain

- My suggestions about quality would be acted upon if I expressed them to management. (93)
- In this work setting, it is difficult to discuss errors. (reversed) (93)
- Errors are handled appropriately in this work setting. (93)
- I would feel safe being treated here as a patient. (91)
- I receive appropriate feedback about my performance. (91)
- The culture in this work setting makes it easy to learn from the errors of others. (93)
Constructing and re-constructing narratives of patient safety

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Surgery

ABSTRACT

In the pursuit of enhanced patient safety, new forms of organisational learning have been introduced within healthcare services across the developed world. This paper examines how these systems contribute to the creation of knowledge about patient safety. The approach taken in this paper departs significantly from methods found within mainstream patient safety research. Rather than attempting to define clinical incidents through taxonomies or classifications, it considers how knowledge is socially constructed in clinical practice and through the processes of risk management. Specifically, it considers how narratives – the stories produced by staff in a large teaching hospital in the UK – about patient safety events are developed within the interactions of clinical practice, reflecting a dynamic mix of emotion and shared notions of responsibility. It then shows how these are re-produced as incident reports which transform knowledge through check-boxes and pre-defined categorisations leading to de-contextualised ‘narrow narratives’. The paper then examines how these accounts are further re-produced through risk management activities as they become de-authored and re-constructed to reflect managerial assumptions about learning. Through considering how patient safety narratives emerge through these processes, the paper highlights the contribution that ethnographic research, with a particular focus on narrative construction, can make to the study of patient safety. It offers an alternative to the current orthodoxy of policy and raises questions about the capacity of such systems to shape the production of knowledge to the determinant of service improvement and to act as a mechanism of organisational power.
### Perspectives on Human Error – Sidney Dekker

<table>
<thead>
<tr>
<th>Old View</th>
<th>New View</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human error is a cause of trouble</td>
<td>Human error is a symptom of deeper system trouble</td>
</tr>
<tr>
<td>You need to find people’s mistakes, bad judgments and inaccurate assessments</td>
<td>Instead, understand how their assessments and actions made sense at the time — context</td>
</tr>
<tr>
<td>Complex systems are basically safe</td>
<td>Complex systems are basically unsafe</td>
</tr>
<tr>
<td>Unreliable, erratic humans undermine system safety</td>
<td>Complex systems are tradeoffs between competing goals — safety v. efficiency</td>
</tr>
<tr>
<td>Make systems safer by restricting the human contribution</td>
<td>People must create safety through practice at all levels</td>
</tr>
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*Safe & Reliable Healthcare*
Drift = Risk

100% Agreement Non-acceptable

Usual Space Of Action

‘Illegal normal’ Real Life standards 60-90%

Expected safe space of action as defined by professional standards

Safety Reg’s & good practices, accreditation standards

100%

HIGH

Production Performance

LOW

ATTRIBUTION: Dr. Rene Amalberti
## Organizational Fairness and Professionalism

### Organizational Fairness and Professionalism Worksheet

<table>
<thead>
<tr>
<th>Event or Near Event</th>
<th>Complaint: Professional Behavior Evaluation and Intervention</th>
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**Step 1:** Evaluate the individual for a history of unsafe acts. Evaluate whether the individual has a history of unsafe or problematic acts. If they do, this may influence decisions about the appropriate responsibilities for the individual i.e. they may be in the wrong job. Organizations should have a reasonable and agreed upon statute of limitations for taking these actions into account.

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<tr>
<td>Review Event or Near Event. Reassign participants if evidence of:</td>
<td>Conduct confidential conversation with reporter regarding focus person (FP) behaviors. Categorize types of behaviors as well as frequency and severity. Conduct confidential interviews with others.</td>
</tr>
<tr>
<td>Malicious Behavior – HR, Legal, Impaired Judgment - CMO, CNO, HR, EAP</td>
<td></td>
</tr>
<tr>
<td>Unprofessional Behavior – Perform Professional Behavior Evaluation</td>
<td></td>
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**Step 2:** Assess Concerns. Evaluate if the situation is more complex, proceed to Step 2. If the concern is deemed an isolated incident, the FP has not had any other issues, and the reporter feels safe to do so, provide coaching for the reporter on how to give the FP direct feedback regarding behaviors. If the situation is more complex, proceed to Step 2. Assess Concerns. To validate the concerns and assess their frequency and severity, multisource interviews are conducted to provide comprehensive insight into and corroboration of alleged behavior.

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<td>Step 3: Assign level of intent: Use best judgment to categorize each action as either Reckless, Risky or Unintentional. The categorization determines the general level of culpability and possible disciplinary actions, however these general categories require further analysis as below prior to making a final decision.</td>
<td>Behavior categories include: Demeaning/angry, hypercritical, uncivil, shirking responsibilities, misconduct, sexual harassment, patient communication concerns, boundary issues, substance abuse, blaming, and otherwise act in a manner that undermines trust and learning.</td>
</tr>
<tr>
<td>RECKLESS ACTION</td>
<td></td>
</tr>
<tr>
<td>The caregiver knowingly violated a rule and/or made a dangerous or unsafe choice. The decision appears to be self-serving and to have been made with little or no concern about risk.</td>
<td></td>
</tr>
<tr>
<td>RISKY ACTION</td>
<td></td>
</tr>
<tr>
<td>The caregiver made a potentially unsafe choice. Their evaluation of relative risk appears to be erroneous.</td>
<td></td>
</tr>
<tr>
<td>UNINTENTIONAL</td>
<td></td>
</tr>
<tr>
<td>The caregiver made or participated in an error while working appropriately and in the patients' best interests.</td>
<td></td>
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**Step 4:** Promote learning and improvement. The caregiver should participate in teaching others the lessons learned.

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<td>Focus for improvement should be on system issues. Coaching and reflection on human factors and personal improvement strategies may be appropriate, especially if the Substitution Test is positive (others would have performed similarly). System leaders are accountable and should apply error-proofing improvements.</td>
<td></td>
</tr>
<tr>
<td>FOCUS</td>
<td></td>
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<tr>
<td>The caregiver is accountable and should receive coaching. If the Substitution Test is positive (others would have performed similarly) the system supports risky action and requires fixing. The caregiver is probably less accountable for the action, and system leaders share it in the accountability.</td>
<td></td>
</tr>
<tr>
<td>If Risky: The caregiver is accountable and should receive coaching. If the Substitution Test is positive (others would have performed similarly) the system supports risky action and requires fixing. The caregiver is probably less accountable for the action, and system leaders share it in the accountability.</td>
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<td>If UNINTENTIONAL</td>
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**Step 5:** Monitoring and Support. Conduct confidential conversation with reporter regarding support for the complaint. Support for the subject must be provided in a timely manner. This includes confidentiality, corroboration, and strategies for supporting the subject. The institution’s human resources department should be consulted.

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<td>Resources for facilitating behavioral changes</td>
<td></td>
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<td>Specific preventative measures</td>
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</tr>
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<tr>
<td>Follow up email is sent to the FP summarizing the meeting.</td>
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**Step 6:** Intervention to Address Subsequent Lapses. The institutional administration and legal counsel are involved.

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<tr>
<td>Keep process discrete and respectful to FP.</td>
<td></td>
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<tr>
<td>Have FP’s supervisor address any systems issues discussed in Step 4.</td>
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**Algorithm available on our website**
Learning System

- Unit level learning systems, continuous learning aligned with organizational goals
- Robust unit level learning and improvement is the norm
- Knowledge of testing, process improvement, collaborative work
- We try harder after process failures or adverse events
- Lots of first order problem solving, simple things don’t get fixed
In this work setting, the learning environment effectively fixes defects to improve the quality of what we do.
The Ideal Unit

Safe & Reliable Healthcare