Understanding & Improving Safety Culture

Amelia Brooks, Director, Patient Safety & Europe Region, IHI
Allan Frankel, Managing Partner, Safe & Reliable Healthcare

Monday December 11th 2017
8:30 – 4:00

#IHIFORUM
@ameliaIHI
Disclosure:
Safe And Reliable Care (SRH) is a cultural assessment and design group dedicated to the pursuit of perfect care through transformational change.

Allan Frankel MD
www.safeandreliablecare.com
Goals for Today:

1. How do we define safety culture, its attributes and impact?
2. How effective are your team behaviors, and what should they look like to support safety culture? What to do if professionalism or negative behaviors are eroding trust in your organization?
3. How do you create effective middle managers who can run the self-reflecting learning systems to manage change and ensure operational excellence?
4. How do we incorporate safety culture into improvement work?
5. How should senior leaders/board members engage with work settings and with the work setting managers?
6. How to embed just culture your organizations?
Let’s get to know each other

• Get to know the person sitting next to you
• Share your names and something surprising or interesting about yourself – not about work!
• What would you like to get from today?
• Take 5 mins
Defining Safety Culture; Attributes and Impact
What does a culture of safety mean to you?
What is Safety Culture?

AHRQ defines a culture of safety as one “in which healthcare professionals are held accountable for unprofessional conduct, yet not punished for human mistakes; errors are identified and mitigated before harm occurs; and systems are in place to enable staff to learn from errors and near-misses and prevent recurrence” (AHRQ PSNet Safety Culture 2014). The leaders of organizations must set and, more importantly, demonstrate the behaviors and expectations essential to a safe and transparent culture.

Leading a Culture of Safety: A Blueprint for Success
No one is ever hesitant to voice a concern about a patient

Concerns raised by frontline caregivers are taken seriously & acted upon

Skilled caregivers playing by the rules feel safe to discuss and learn from errors

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

‘How the organization behaves when no one is watching’
Zero harm to patients and the workforce is only possible with both a robust culture of safety and an embedded organizational learning system.
Exercise

• You are assigned responsibility to evaluate a unit in a healthcare organization.
  *(Unit = Department, Division, Section – a delineated group working together)*

• The unit is new to you.

• You are to evaluate the unit for its ability to achieve safe, reliable, patient-centered operational excellence.

• What will you assess?
A Familiar Framework

1. Risk Factors
2. Exercise
3. Nutrition
4. Health Literacy
5. Etc

1. Cardiovascular
2. Pulmonary
3. Gastrointestinal
4. Musculoskeletal
5. Etc
Framework for Safe, Reliable, Effective Care

- Transparency
- Leadershio
- Psychological Safety
- Accountability
- Teamwork & Communication
- Negotiation
- Reliability
- Improvement & Measurement
- Continuous Learning
- Engagement of Patients & Family

Learning System

Culture

© IHI and Allan Frankel
Framework For Safe, Reliable and Effective Care

Culture

Leadership
Psychological Safety
Continuous Learning
Accountability
Improvement and Measurement
Teamwork and Communication
Negotiation

Learning System

Reliability
Transparency

© IHI and Allan Frankel
Framework for Safe, Reliable, Effective Care

Framework for Safe, Reliable, Effective Care

“I’m accountable for my actions but won’t be held accountable for current system flaws.”
Framework for Safe, Reliable, Effective Care

- Leadership
- Psychological Safety
- Accountability
- Teamwork & Communication
- Negotiation
- Engagement of Patients & Family
- Transparency
- Reliability
- Improvement & Measurement
- Continuous Learning

Plan forward. Reflect back. Communicate clearly. Manage risk. © IHI and Allan Frankel
Framework for Safe, Reliable, Effective Care

Collaborate – grow the pie. Know positions from interests. Appreciatively inquiring.

© IHI and Allan Frankel
Framework for Safe, Reliable, Effective Care

Regularly collecting and learning from defects and successes.

© IHI and Allan Frankel
Framework for Safe, Reliable, Effective Care

Improving work processes and patient outcomes using standard improvement tools including measurements over time.

© IHI and Allan Frankel
Framework for Safe, Reliable, Effective Care

Applying best evidence and minimizing non-patient specific variation with the goal of failure free operation over time.
Framework for Safe, Reliable, Effective Care

Openly sharing data and other information concerning safe, respectful and reliable care with staff and partners and families.

© IHI and Allan Frankel
Guardians of the Learning System.
Exemplars of the Culture.
Psychological Safety.
Respect.

Engagement of Patients & Family
Continuous Learning
Improvement & Measurement
Reliability
Transparency
Leadership
Psychological Safety
Accountability
Teamwork & Communication
Negotiation
Lessons and Behaviors from HROs

- In HRO **interpersonal skills are equally as important** as technical expertise.
- Huddles are an opportunity for caregivers other than physicians and nurses to theorize about what is going on with their patients.
- **Professional heterogeneity is usually advantageous for collective learning,** improving the range, depth and integration of information considered.
Balance

System and Process

Technical

People and Culture

Non-Technical
"Champions do extra. They sweep the sheds. They follow the spearhead. They keep a blue head. They are good ancestors. Legacy goes deep into the heart of the world's most successful sporting team, What are the secrets of success - sustained success?

'Better people make better All Blacks'
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INTENTIONALLY
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Team Behaviors & Professionalism
Teamwork Climate Across Michigan ICUs

The strongest predictor of clinical excellence: caregivers feel comfortable speaking up if they perceive a problem with patient care.

Attribution: Bryan Sexton
Consider places you have worked in, or that you have encountered, where:

1. The output is stellar.
2. Employees choose to stay.
3. Outsiders want to join.

If you asked workers why the place is special and why they choose to stay what would they say?
Improvement Readiness
(The Learning System)

- Knowing the plan - predictability
- Feeling safe to speak up
- Knowing that when you do speak up, someone cares and the team will respond appropriately
- Planning forward / reflecting back through debriefing to feed the Learning System
Effective Teamwork

- 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
Culture and Teamwork

‘How the organization behaves when no one is watching’
A Team

‘A group of people working cooperatively towards a shared goal’
**NASA / UT Teamskills**

<table>
<thead>
<tr>
<th>Briefing</th>
<th>Leadership / Followership / Concern for the Task</th>
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<td>The effective briefing will be operationally thorough, interesting and will address coordination, planning and potential problems.</td>
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<td>Team members advocate, with appropriate persistence, the course of action they feel is best, even if it involves disagreement.</td>
<td>This is a rating of time and workload management. It reflects how the team distributes tasks, avoids overload and distractions.</td>
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Interpersonal Relationships / Group Climate
Reflects the quality of relationships among the team, the overall climate in the workplace

What do you do to make a positive contribution?
What else could you do?
Personality & Behavior

• Technical and non technical skills
• Personality is personal
• Behavior is shared
Hierarchy
The Authority Gradient

Sir Cloudsley Shovell
Authority Gradient

• Pros and Cons of:
  – Steep authority gradient
  – Shallow gradient
  – When each would be useful
• **Approachability**
  - What does it look like?
  - How do you make yourself approachable?
  - Intent / Capacity

• **Assertiveness**
  - What does it look like?
  - How do you ‘do’ it?
  - Licence / Capacity / Adult / Language
Context

• Busy
• Too many things to do
• Running late
• Short on sleep
• Pressure to perform
• Hungry
• Angry
Performance & Culture

Demands to Think

Limit of Capacity

In Control

Out of Control

Demands to Act

Amalberti
What Teams Do

- **Plan Forward**
  - Brief (huddle, pause, timeout, check-in)

- **Reflect Back**
  - Debrief

- **Communicate Clearly**
  - Structured Communication SBAR and Repeat-Back

- **Manage Conflict**
  - Critical Language
Team Behaviors

• Where do you think you are in embodying teamwork as described?

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?
Behaviors that undermine a culture of safety

- Verbal or physical threats
- Intimidation
- Reluctance/refusal to answer questions, refusal to answer pages or calls
- Impatience with questions
- Condescending language or intonation

Jo Shapiro MD, BWH
The Aim:

Hierarchy of **Responsibility**

No Hierarchy of **Respect**

Jo Shapiro MD, BWH
### TABLE 2. Physician Career Satisfaction, Burnout, Depression, and Quality of Life 2014 Relative to 2011

<table>
<thead>
<tr>
<th>Variable</th>
<th>2014</th>
<th>2011</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Burnout indices</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional exhaustion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>25.0</td>
<td>21.0</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>% low score</td>
<td>2299 (34.1%)</td>
<td>3041 (42.2%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>% intermediate score</td>
<td>1283 (19.0%)</td>
<td>1433 (19.9%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>% high score</td>
<td>3165 (46.9%)</td>
<td>2734 (37.9%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td><strong>Depersonalization</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>7.0</td>
<td>5.0</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>% low score</td>
<td>2951 (44.0%)</td>
<td>3601 (50.1%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>% intermediate score</td>
<td>1434 (21.4%)</td>
<td>1476 (20.5%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>% high score</td>
<td>2325 (34.6%)</td>
<td>2116 (29.4%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td><strong>Personal accomplishment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>41</td>
<td>42</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>% high score</td>
<td>4064 (61.2%)</td>
<td>4758 (66.6%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>% intermediate score</td>
<td>1495 (22.5%)</td>
<td>1495 (20.9%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>% low score</td>
<td>1085 (16.3%)</td>
<td>887 (12.4%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td><strong>Burned out</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% low score</td>
<td>3680 (54.4%)</td>
<td>3310 (45.5%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td><strong>Depression</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screen positive for depression</td>
<td>2715 (39.8%)</td>
<td>2753 (38.2%)</td>
<td>.04</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal ideation in the last 12 mo</td>
<td>438 (6.4%)</td>
<td>466 (6.4%)</td>
<td>.98</td>
</tr>
<tr>
<td>Common responses</td>
<td>Appropriate feedback</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inadequate data</strong></td>
<td>Not a court of law</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Exactly who said this?</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Personal sabotage</strong></td>
<td>Not an isolated incident</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Dr. X is trying to discredit me</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other people like me</strong></td>
<td>You shouldn’t have a disruptive working relationship with anyone</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>I am special and talented</strong></td>
<td>Not a performance evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>I do work that no one else is qualified to do</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>This is a systems problem</strong></td>
<td>Yes, and you still are responsible for your behavior</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>If this whole system functioned better...</em></td>
<td></td>
<td></td>
<td></td>
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<th>Common responses</th>
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</thead>
<tbody>
<tr>
<td><strong>Unfair process</strong></td>
<td>We hold everyone to the same standards</td>
</tr>
<tr>
<td><em>I’m being singled out because …</em></td>
<td></td>
</tr>
<tr>
<td><strong>Patient advocacy</strong></td>
<td>Disruptive behavior is a safety risk</td>
</tr>
<tr>
<td><em>Others aren’t responsible for patients the way I am</em></td>
<td></td>
</tr>
<tr>
<td><strong>Prove harm</strong></td>
<td>We don’t need to</td>
</tr>
<tr>
<td><em>Give me one example …</em></td>
<td></td>
</tr>
<tr>
<td><strong>Personal style</strong></td>
<td>Impact not intent</td>
</tr>
<tr>
<td><em>I don’t mean anything by it</em></td>
<td></td>
</tr>
<tr>
<td><strong>I am no worse than others</strong></td>
<td>We are focusing on your issues right now</td>
</tr>
<tr>
<td><em>I am certainly not the only one</em></td>
<td></td>
</tr>
</tbody>
</table>

Jo Shapiro MD, BWH
Reporting Concerns – What Should Happen:

- Confidential discussion with Director
- Investigation
- Discussion with supervising leaders/manager
- Meeting with disruptor
- Document all interactions
Your turn: Professionalism

• What mechanisms exist in your organizations to ensure that professionalism and peer support are effective?
Leaders, Managers & Their Role in Improvement & Culture
Cultural Maturity Model

**UNMINDFUL**
Who cares as long as we’re not caught
Chronically Complacent

**REACTIVE**
Safety is important. We do a lot every time we have an accident

**SYSTEMATIC**
We have systems in place to manage all hazards

**PROACTIVE**
Anticipating and preventing problems before they occur; Comfort speaking up

**GENERATIVE**
Safety is how we do business around here
Constantly Vigilant and Transparent

*Tipping Point*

---

*Adapted from Safeskies 2001, "Aviation Safety Culture," Patrick Hudson, Centre for Safety Science, Leiden University*
# Senior Leadership

<table>
<thead>
<tr>
<th>GENERATIVE</th>
<th>Organization wired for safety and improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROACTIVE</td>
<td>Playing offense - thinking ahead, anticipating, solving problems</td>
</tr>
<tr>
<td>SYSTEMATIC</td>
<td>Systems in place to manage hazards</td>
</tr>
<tr>
<td>REACTIVE</td>
<td>Playing defense – reacting to events</td>
</tr>
<tr>
<td>UNMINDFUL</td>
<td>No awareness of safety culture</td>
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</table>

- 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
Local Leadership

<table>
<thead>
<tr>
<th>GENERATIVE</th>
<th>Leaders create high degrees of psych safety and accountability.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization wired</td>
<td></td>
</tr>
<tr>
<td>for safety and</td>
<td></td>
</tr>
<tr>
<td>improvement</td>
<td></td>
</tr>
<tr>
<td>PROACTIVE</td>
<td>Leaders model the desired behaviors to drive culture of safety</td>
</tr>
<tr>
<td>Playing offense -</td>
<td></td>
</tr>
<tr>
<td>thinking ahead,</td>
<td></td>
</tr>
<tr>
<td>anticipating,</td>
<td></td>
</tr>
<tr>
<td>solving problems</td>
<td></td>
</tr>
<tr>
<td>SYSTEMATIC</td>
<td>Training and support exists for building clinical leadership</td>
</tr>
<tr>
<td>Systems in place</td>
<td></td>
</tr>
<tr>
<td>to manage hazards</td>
<td></td>
</tr>
<tr>
<td>REACTIVE</td>
<td>Episodic, completely dependent on the individual clinician</td>
</tr>
<tr>
<td>Playing defense –</td>
<td></td>
</tr>
<tr>
<td>reacting to events</td>
<td></td>
</tr>
<tr>
<td>UNMINDFUL</td>
<td>Absent for the most part</td>
</tr>
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<td>No awareness of</td>
<td></td>
</tr>
<tr>
<td>safety culture</td>
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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

SAFE & RELIABLE Healthcare
Learning Environment Domain vs. Local Leadership Domain

Source Data: July 2015
Institution: Demo Hospital
Work Setting(s): All Work Settings
Position(s): All Positions
A wide variety of skills across the middle

10%
Absent
Burned Out
Socially Inept
Psychopathic
Disinterested

80%
Clinically excellent
Well meaning
Socially Adept
Inadequately Trained

10%
Engaged
Knowledgeable in:
• Organizational development
• Whole system change
• Measurement to manage
• Relentlessly focused on process
• Know culture IS a process

Edgar Schein

- Visible Attributes
- Espoused vs Demonstrated Values
- Hidden Values and Tacit Assumptions
- How we spend our time…
Question

Summarizing Berry: “Operational excellence is dependent on volunteerism, the willingness of employees to give above and beyond what they are paid to do.”

What are the determinants of volunteerism?
The Determinants of Volunteerism

Alignment of **Espoused** versus **Actual** Values

“Work as Imagined versus Work as Done”

The values of facility leadership are the same values that people in this work setting think are important. (4167)
The Determinants of Volunteerism

The relationship I have with my direct Supervisor

Learning Environment

Administrator/Director
Manager
Supervisor

Nursing
Technologist
Admin Support

SAFE & RELIABLE Healthcare
The Determinants of Operational Excellence

Do I have voice?

Do my team members care about me?

What Google Learned From Its Quest to Build the Perfect Team

New research reveals surprising truths about why some work groups thrive and others falter.

By CHARLES DUHIGG  
FEB. 25, 2016

The New York Times Magazine
Effective Leaders

- Create psychological safety
- Calibrate drift to minimize shortcuts and workarounds
- Drive effective team performance
- Model the values and behaviors that create value and reduce risk
Your turn: Self-Reflecting Learning

- Are your Managers, Directors, Chairs and Chiefs etc. consciously aware that they run learning systems (improvement readiness is their primary charge)? If yes, how, and if not, why?
- Where are they on the Cultural Maturity Model Curve?
- How culturally varied are your work settings?
• **Strategy**
  (ALWAYS focused on *Improvement Ready Work Settings.*)

• **Education and Org. Development Department**

• **Office of Clinical Excellence**

• **Office of Professionalism and Peer Support**

• **Communication and Marketing Departments**

• **IT Prioritization Office**
Impact of Good Leadership on Survey Data Across Michigan

WalkRounds feedback leads to huge improvement in cultural health across all domains of culture.

n=16,797 respondents

Published 2017 with DUKE: JB Sexton et al, British Medical Journal
Cultural health determines the ability to improve clinical processes, quality and outcomes.

BSI = Blood Stream Infection from Central Lines

Impact of Teamwork on the Ability to Improve a Process

NEJM 2004 Pronovost, Sexton
Impact of Good Leadership on SCORE Data Across Michigan

WalkRounds feedback leads to huge improvement in cultural health across all domains of culture.

n=16,797 respondents

IN PUBLICATION with DUKE: JB Sexton et al, British Medical Journal

What this means for an organization that wants to achieve high reliability?

Cultural health determines the ability to improve clinical processes, quality and outcomes.

BSI = Blood Stream Infection from Central Lines

NEJM 2004 Pronovost, Sexton
Learning boards capture ideas and issues from everyone

ANALOG: proven results

DIGITAL: available everywhere on any device.
Engage: Mayo/SRH TEM Model

↓50%
Adverse Events

92%
Sustain Method 5yrs Later
Examples: Rounding

Maine Medical Center

Cincinnati Childrens’ Hospital

Situation Awareness Model

- Intern
- Watchstander
- Senior Resident
- Watchstander
- PCF/Manager
- Attending

- Family concerns
- High risk therapies
- PEWS>5
- Watcher
- Communication concern

- Bedside Team
- Microsystem Team
- Organization Team

SAFE & RELIABLE Healthcare
Technology that Enables Culture

(The culture we want!)
Your turn: Self-Reflecting Learning

• What is the “true north” value that drives strategy in your organization?

• Are you adequately configured to support your work settings as described?

• Explain your answer?

Strategy
(ALWAYS with Improvement Ready Work Settings at the center.)

Education and Org. Development Department
Office of Clinical Excellence
Office of Professionalism and Peer Support
Communication and Marketing Departments
IT Prioritization Office

SAFE & RELIABLE Healthcare
Just Culture
Cultural Maturity Model

**UNMINDFUL**
Who cares as long as we’re not caught
Chronically Complacent

**REACTIVE**
Safety is important. We do a lot every
time we have an accident

**SYSTEMATIC**
We have systems in place to manage all hazards

**PROACTIVE**
Anticipating and preventing problems before they occur; Comfort speaking up

**GENERATIVE**
Safety is how we do business around here
Constantly Vigilant and Transparent

*Adapted from Safeskies 2001, “Aviation Safety Culture,” Patrick Hudson, Centre for Safety Science, Leiden University*
Organizational Fairness / Just Culture

**GENERATIVE**
Organization wired for safety and improvement

**REAL EVENTS**
Real events are shared by leaders, true culture of accountability and learning

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

**CLEAR WAYS**
Clear ways to differentiate individual v. system error, safe to discuss mistakes

**SYSTEMATIC**
Systems in place to manage hazards

**WELL UNDERSTOOD**
Well understood algorithm, learning is the priority

**REACTIVE**
Playing defense – reacting to events

**DEPENDS**
Depends who the boss is, blame and punishment are common

**UNMINDFUL**
No awareness of safety culture

**NOTHING GOOD**
Nothing good will come from talking about mistakes
### 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</td>
<td>Instead, understand how their assessments and actions made sense at the time — context</td>
</tr>
<tr>
<td>and inaccurate assessments</td>
<td></td>
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<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</td>
<td>People must create safety through practice at all levels</td>
</tr>
<tr>
<td>contribution</td>
<td></td>
</tr>
</tbody>
</table>
In your Institution:

- How are events reported?
- How long does it take?
- Do they feel safe?
- What is the feedback loop?
- What happens in the absence of feedback?
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

Attribution: Dr. Rene Amalberti
Penetration of Just Culture

• What are the rules?
• Can you explain them in an elevator ride?
• If you asked 10 people in the hallway to explain just culture – how would they distinguish an unsafe individual from a skilled caregiver set up to fail in a complex system – how many could answer the question?
Inherent Human Limitations

• Limited memory capacity – 5-7 pieces of information in short term memory
• Negative effects of stress – error rates
  – Tunnel vision
• Negative influence of fatigue and other physiological factors
• Limited ability to multitask – cell phones and driving
Accountability – Fair and Just Culture

• Clear, simple rules - “one set” that apply to everyone.
• Four questions
  • - Was there malice involved?
  • - Was the individual knowingly impaired?
  • - Was there a conscious unsafe act?
  • - Did the person(s) make a mistake that someone of similar skill and training could make under those circumstances?
A Systematic Approach to Safe & Reliable Care

• **Leadership** - systematic engagement, feedback, improvement, dialogue with front line caregivers discussing real cases – “This happened in our hospital”

• **Safety Culture** – unit level, broad themes across the organization; measurable, actionable items identified at a unit level

• **Fair and Just Culture** – the rules are clear between individual accountability and system failures, and people feel safe to speak up and tell us.

• **Risk Mitigation** – manage and reduce risk – minimizing avoidable harm and its consequences – keep everyone safe
Organizational Fairness and Professionalism Worksheet

Reliably excellent patient centered care is dependent on healthcare departments that are effective learning systems; they routinely identify their defects and then eliminate or ameliorate them. Individuals bring to light defects only when they trust others and feel safe about voicing their insights and concerns. Professionalism and just Culture create trust and psychological safety and are the essential foundation for all learning systems. The job of the Safety and Reliability Committee is to safeguard Professionalism and just Culture in order to promote and facilitate robust learning systems.

<table>
<thead>
<tr>
<th>Event or Near Event</th>
<th>Complaint: Professional Behavior Evaluation and Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify Participants</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>Review Event or Near Event. Reassign participants if evidence of: Malicious Behavior – HR, Legal, Impaired Judgment - CMO, CNO, HR, EAP Unprofessional Behavior – Perform Professional Behavior Evaluation</td>
<td>Behavior categories include: Demeans/anger, 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>
</tbody>
</table>

**Step 1: 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.

**RECKLESS ACTION**
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.

**RISKY ACTION**
The caregiver made a potentially unsafe choice. Their evaluation of relative risk appears to be erroneous.

**UNINTENTIONAL**
The caregiver made or participated in an error while working appropriately and in the patients’ best interests.

**Step 2: Evaluate systems influences**
Perform a Substitution Test: Ask or consider whether 3 others with similar skills or in a similar situation would behave or act similarly. Ask whether systems factors were present that would affect all individuals similarly, such as schedules leading inevitably to fatigue, unrealistic expectations regarding memory, inability to effectively follow policies or procedures, an unsafe learning environment, or distractions or interruptions? If “Yes” system influence is likely and warrants evaluation. If “No”, continue evaluation of the individual.

**Step 3: IF RECKLESS:** The caregiver is accountable and needs re-training. Discipline may be warranted. If the Substitution Test is positive (others would have performed similarly), then the system supports reckless action and requires fixing. The caregiver is probably less accountable for the action, and system leaders share in the accountability.

**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 in the accountability.

**IF UNINTENTIONAL:** Focus for improvement should be on system issues. Coaching and feedback 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.

**Step 4: Promote learning and improvement**
The caregiver should participate in teaching others the lessons learned.

**Final Step: 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.

Jo Shapiro MD and Allan Frankel MD, ©2015, Safe and Reliable Care Inc., www.safeandreliablecare.com

Algorithm available @ safeandreliablecare.com
The job of those entrusted to safeguard Professionalism and Just Culture is to protect and promote robust learning systems. Reliably excellent patient centered care is dependent on healthcare departments that are effective learning systems. They routinely identify their defects and then eliminate or ameliorate them. They routinely highlight good ideas and act on them. Individuals bring to light defects and ideas only when they trust others and feel safe about voicing insights and concerns. Professionalism and Just Culture create trust and psychological safety, essential foundations for all learning systems. Evaluators should consider system and human factors in their assessments of the events and actions. When possible, the caregiver should participate in the investigation and analysis of the event, and in teaching the lessons learned to others.
Event or Near Event

Step 1: **Exclude** those with impaired judgment or those whose actions were malicious.

- Impairment may result from legal or illegal substances, cognitive impairment, or severe psychosocial stressors. Refer to Human Resources, Risk, Senior Leaders or Professionalism Office.
Step 2: Characterize participant actions as either **RECKLESS**, **RISKY** or **UNINTENTIONAL** defined below. Consider every action independently.

<table>
<thead>
<tr>
<th>RECKLESS ACTION</th>
<th>RISKY ACTION</th>
<th>UNINTENTIONAL</th>
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<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 concern about risk.</td>
<td>The caregiver made a potentially unsafe choice. Their evaluation of relative risk appears to be erroneous.</td>
<td>The caregiver made or participated in an error while working appropriately and in the patients' best interest.</td>
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Step 3: Perform a Substitution Test to evaluate system influences: Ask 3 others with similar skills if they, in a similar situation, would have behaved or acted similarly.
Step 4: Evaluate whether the individual has a history of unsafe or problematic acts.

- Organizations should have a reasonable and agreed upon statute of limitations for taking these actions into account.
Step 5: Combine the Evaluation of Individuals and System to determine next steps.

A: If actions are
  • RECKLESS: Retraining and/or disciplinary responses are warranted.
  • RISKY: Coaching is warranted.
  • UNINTENTIONAL: Focus on correcting systems issues to better support individual action.

B: If there is a history of repeated evaluations for problem actions, consider if individual is in the wrong job.

C: Finally, apply the Substitution Test. Individuals are:
  • MORE accountable if others would not act similarly, and
  • LESS accountable if others would act similarly.
  • Leader accountability increases as individual accountability lessens, because the system supports reckless behavior OR risky behavior OR an environment that is not effectively supportive of personnel.
• An Anesthesiologist, rather than reversing a muscle relaxant near the end of an operative procedure, mistakenly gives the patient more paralytic medicine causing a prolongation of the anesthetic at the end of the operative procedure. The patient emerges from the anesthetic uneventfully, but the case takes 2 1/2 hours rather than 90 minutes in the operating room.

• Anesthesiologist explains that the color of the vial tops had changed, so he mistakenly pulled out the wrong vial.
Nurse took ~2 cough syrups from pyxis for a patient.

After getting meds, nurse went to dietary to get prune juice for another patient.

Nurse then entered the first patient’s room, sanitized hands and let patient know the reason for visit. The nurse administered the cough syrup to the first patient.

When she entered the second patient’s room, the patient asked for the cough syrup she had requested earlier. Upon checking the MAR, the first patient did not have cough syrup ordered and had not been coughing.

The Meds were not scanned.

The first patient’s son complained since there was a medication allergy, and brought the medication container from the trash can.

Nurse denied ever administering cough syrup to the first patient. Scanning was not done on either patient’s medications that day.
• 4 year-old girl is admitted with a two-week history of viral illness. The child has not ingested fluid or food for over 24 hours, is not passing urine, covered in a rash, significantly unwell.

• Resident prescribes IV fluids, antibiotics and close monitoring. The Attending withdraws plan for IV fluids and antibiotics, prescribing oral fluids and regular weight monitoring. The RNs hear from Attending and Resident their differing concerns about the child.

• The child and mother are admitted to a private room at the end of the ward because no open beds are near the nursing station and the Charge RN chooses to not disrupt other patients to make a bed switch.

• When they enter the room, the RN and PCA taking care of the child see that both mother and child are sleeping and do not disturb them during the night to take vital signs.

• The next morning the mother cannot rouse the child, and seeks the RN for help. The RN pages a Junior doctor who goes to the room, opens the door and sees only that a child is asleep and leaves so as to not miss Rounds, planning to come back later when child wakes.

• The nurse goes to the room and, now concerned, calls for more help. The Attending arrives and starts resuscitation, and then leaves the resuscitation to Junior medical staff so that he can manage the remaining morning ward rounds. The group continues, but it takes extra time to get IV access, and finally an RN, over objections, calls the Rapid Response Team and the child is quickly transferred to ICU.

• **Investigation:** Independent clinical leaders partner with Risk Officer to investigate. Clinical team attends review meeting but Attending declines. All contribute but there is a sense that things aren’t being said. With probing the flood gates open about extensive concerns about the Attending. No one is willing to share their concerns outside of the room for fear of being seen as criticizing a colleague. The leads inform the Medical Director who reports that he has been concerned for some time about the Attending.

• The Attending is taken off the acute on-call rotation pending investigation and also offered support and counseling. Further investigation indicates that the Attending tried to influence the choice of investigator (tried to ensure someone who was junior to him would lead), and contacted the family to tell them that there was no learning and nothing could have been done differently in the management of the child.

• The Attending is removed from the acute care rotation and reassigned to the ambulatory clinic.
A 65 year old male, in the ICU, has bright red rectal bleeding. He has a history of alcohol and cigarette use and has alcoholic cirrhosis and COPD. All agree that he should go to Interventional Radiology for an angiogram and embolization of the bleeding vessels. His Coags are elevated and he’s ordered for, and receives, Fresh Frozen Plasma. The patient arrives in IR and the IR Nurse and Tech see the elevated Coags and voice concern because they’ve had recent bad experiences in the IR area. The Fellow thinks that the still elevated Coags are from before the FFP. The RN and Tech voice their concerns to the Fellow, and the Fellow relays those concerns to the Attending - but they proceed because IR is swamped with cases and the Attending wants to get this complex add-on case done. As soon as the procedure gets underway, the patient gets a huge femoral hematoma and then rapidly deteriorates, dropping BP and becoming increasingly less responsive. The RN calls for the Rapid Response team to help resuscitate the patient. The patient’s condition worsens over the next 24 hours.
Patient had 81 mg Aspirin, 60 mg oral Morphine, and 100 mg Metoprolol ordered for 10:00 am. RN informed student nurse that she had already given these medications. Student had already pulled medications from Pyxis with instructor and had been quizzed on medications prior to RN sharing this information. Student did not notify nursing instructor (or return meds to nursing instructor upon receiving these instructions from RN.) Student nurse administered all medications to patient. Student stated that she did scan medications in but that computer gave alert that "medication was not due at this time". Despite this alert, she still gave medications. Patient received a total of 120 mg Morphine by mouth, 162 mg Aspirin, and 200 mg of Metoprolol. Nursing instructor immediately notified nurse, clinical leader, primary care MD and cardiologist.
On May 27, 2017 I had a patient in room 307 who had a scheduled second troponin, the first having been within normal limits. At approximately 9:30 am the lab called me with a critical value of 0.48. As per protocol an EKG was ordered STAT. Once I had the results I phoned Dr XXXXXX. From the very start of the phone call he was already yelling into the phone. He was yelling that he was going to cath the patient the following day and "it doesn't matter." I told him I had ordered an EKG and he yelled "you don't need an EKG!" I told him it is protocol and I tried to read him the result. He told me "I don't care, don't call me." The EKG showed non-specific ST & T wave abnormality but he would not hear me out.

The third troponin came in at 217pm, and it was even more elevated at 0.80. I called Dr XXXXXX again and he was livid. He cut me off during the conversation, he told me he told the other person not to call him (me, by the way). I told him as an RN I have to call him with critical results.

I also told him if he didn't want any more calls then he needs to ask us to put in a provider order stating this. He told me to do it. I complied.

The second call was even more stressful but it was required per hospital protocol, nursing ethics and best practice. I need to add that he was even more verbally abusive during the second call.
Wrap Up
Managing Transitions by William Bridges
Goals for Today:

1. How do we define safety culture, its attributes and impact?
2. How effective are your team behaviors, and what should they look like to support safety culture? What to do if professionalism or negative behaviors are eroding trust in your organization?
3. How do you create effective middle managers who can run the self-reflecting learning systems to manage change and ensure operational excellence?
4. How do we incorporate safety culture into improvement work?
5. How should senior leaders/board members engage with work settings and with the work setting managers?
6. How to embed just culture your organizations?
Framework for Safe, Reliable, Effective Care

- Transparency
- Leadership
- Psychological Safety
- Accountability
- Teamwork & Communication
- Negotiation
- Reliability
- Improvement & Measurement
- Continuous Learning
- Engagement of Patients & Family

Learning System

Culture
Thank you!

Questions?
Comments?

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allan@safeandreliablecare.com