Creating a Culture of Patient Safety: Session 1

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Objectives

- Explain the concept of Total Systems Safety and how it applies to establishing an organization's culture of safety
- Define the characteristics of a Just Culture
- Categorize individuals' actions in events of harm as human error, at-risk, or reckless behavior.
- Summarize the impact of workforce safety (both psychological and physical) to patient safety.

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Assessment

ZOOM POLL

Please respond to the following statements:

Questions with a 1 – 5 rating are scaled so that 1 is low and 5 is high

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Definition: safety culture

The extent to which the beliefs, values, and norms of an organization support and promote patient safety. These beliefs extend to all levels of an organization (e.g. system, department, unit) and influence the actions and behaviors of staff throughout the organization.

AHRQ from Famolar et al.

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National Patient Safety Foundation's Recommendations for Achieving Total Systems Safety

1. Ensure that leaders establish and sustain a culture of safety.
2. Create centralized and coordinated oversight of patient safety.
3. Create a common set of safety metrics that reflect meaningful outcomes.
4. Increase funding for research in patient safety and implementation science.
5. Address safety across the entire care continuum.
6. Support the health care workforce.
7. Partner with patients and families for the safest care.
8. Ensure that technology is safe and optimized to improve patient safety.

From NSPF's *Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err is Human*, 2015

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National Patient Safety Foundation's Recommendations for Achieving Total Systems Safety

1. **Ensure that leaders establish and sustain a culture of safety.**
2. Create centralized and coordinated oversight of patient safety.
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5. Address safety across the entire care continuum.
6. **Support the health care workforce.**
7. Partner with patients and families for the safest care.
8. Ensure that technology is safe and optimized to improve patient safety.

The entire report may be found at:
https://www.ihi.org/resources/Pages/Publications/Free-from-Harm-Accelerating-Patient-Safety-Improvement.aspx

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What comprises a Culture of Safety?

Four beliefs present in a strong safety culture

- Our processes are designed to prevent failure
- We are committed to detect and learn from error
- We have a just culture that disciplines based on risk taking
- People who work in teams make fewer errors

From IOM, 2004

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What comprises a Culture of Safety?

Informed – safe, highly reliable organization

Flexible – the organization changes processes and systems to improve; team communications are optimized; there is psychological safety to speak up about safety related information

Learning – information from reports is used to understand risk in the organization and how systems and processes can be improved

Reporting – staff feel safe to freely report errors and unsafe situations; they understand how the information is used

Just –there is a fair, transparent, consistent system of managing events, demonstrating a shared accountability between system design and behavioral choices

From Reason, 1997

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Definition: just culture

A values-supportive system of shared accountability where organizations are accountable for the systems they have designed and for responding to the behaviors of their employees in a fair and just manner. Employees, in turn, are accountable for the quality of their choices and for reporting both their errors and system vulnerabilities."

From Outcome Engenuity LLC.

What behaviors are found in an organization that has a Just Culture?

- Healthcare workers are treated with respect, dignity, and compassion when they are involved in situations where a patient was harmed or nearly harmed.
- There is avoidance of blame and quick judgments about the actions of an individual.
- Healthcare workers are proactively informed about what it means to be held appropriately accountable for one's actions. Actions stemming from reckless behavior may be subject to discipline; intent to harm will result in legal action.
- People are held appropriately accountable for their actions by assessing their accountability in the context of the situation including contributing system factors.
- A systematic approach is followed to understand why people took the actions they did in the context of the situation.
- There is an awareness of hindsight bias ("if I knew then what I know now") and outcome bias (the greater the harm, the greater the consequences) and steps to minimize it are taken when assessing a person's actions.
- System factors that contributed to the situation where a patient was harmed or nearly harmed are actively sought. Changes are made to reduce the risk of the same problem happening again.

From the HQCA's What is a Just Culture

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Algorithm-based decision-making to manage behavior: human error, at-risk, reckless

Shared accountability: employees accountable for their behavior; management accountable for the systems employees are put into

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Three Core Human Behaviors

Human Error	At-Risk Behavior	Reckless Behavior
Inadvertent action: slip, lapse, mistake	*A choice: risk not recognized or believed justified*	*Conscious disregard of a substantial and unjustifiable risk*
Manage through changes in: • Processes • Procedures • Training • Design • Environment • Behavioral Choices	Manage through: • Removing incentives for at-risk behaviors • Creating incentives for healthy behaviors • Increasing situational awareness	Manage through: • Remedial action • Disciplinary action • Punitive action
CONSOLE HUMAN MANAGE SYSTEM	COACH HUMAN MANAGE SYSTEM	PUNISH HUMAN MANAGE SYSTEM?

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Primary Differences Between At-Risk and Reckless Behavior

At-Risk Behavior	Reckless Behavior
Perception	
Does not see the risk OR mistakenly believes the risk is insignificant or justified.	Always perceives the risk AND understands that the risk is substantial and not justified.
Behavior is often the norm within groups	Knows the behavior is not the norm within groups
Risk monitor does not alarm – mistakenly believes the choice is safe	Risk monitor alarms – knows the choice is unsafe
Does not consciously disregard what is known to be a substantial and unjustifiable RISK	Makes a conscious choice to disregard the substantial and unjustifiable RISK
Motivation	
Behavioral choice is often patient-, colleague-, or organization-centric (desire to help others)	Behavioral choice is often self-centered (desire to help oneself)
Puts patients, colleagues, organization first	Puts own needs ahead of others
Decision has social utility	Decision has no social utility

From ISMP

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What type of behavior does each example exemplify (Human Error, At-Risk Behavior, Reckless Behavior)?

The surgeon who performs cataract surgeries at your hospital arrived 30 minutes late today. There are 8 patients scheduled for the procedure this morning and so in order to keep on schedule he skips the pre-surgery timeout process on the first patient.

Reckless Behavior

The respiratory therapist that was a member of the Code Blue in the ED forgot to attach the endotracheal tube sensor. This sensor alarms if the patient is not receiving sufficient O2.

Human Error

A nurse used the override function to remove medication from the Automated Dispensing Cabinet. She did not investigate what the override message stated.

At-Risk Behavior

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National Action Plan to Advance Patient Safety

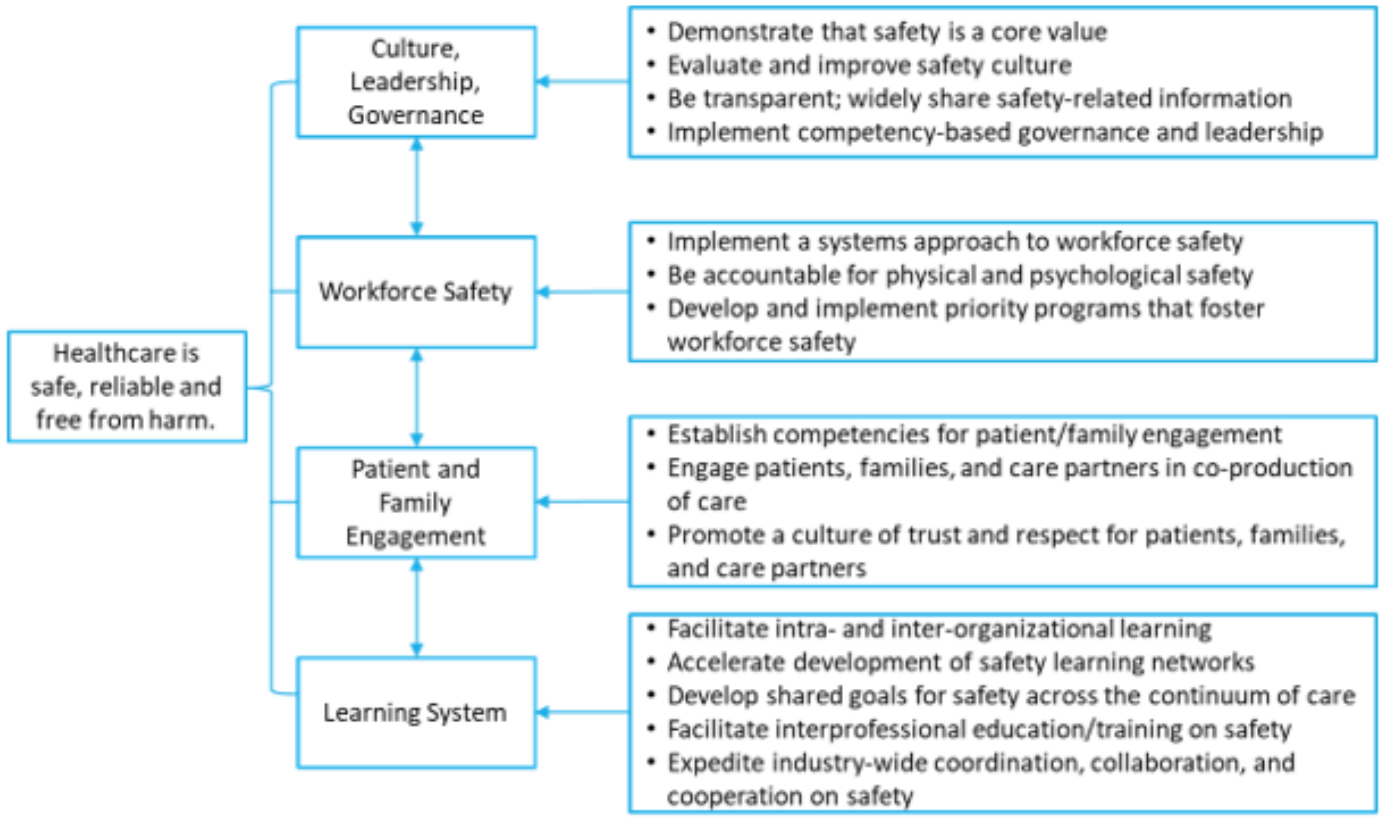

Figure 1. Four Drivers of Safe, Reliable Healthcare

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National Action Plan to Advance Patient Safety

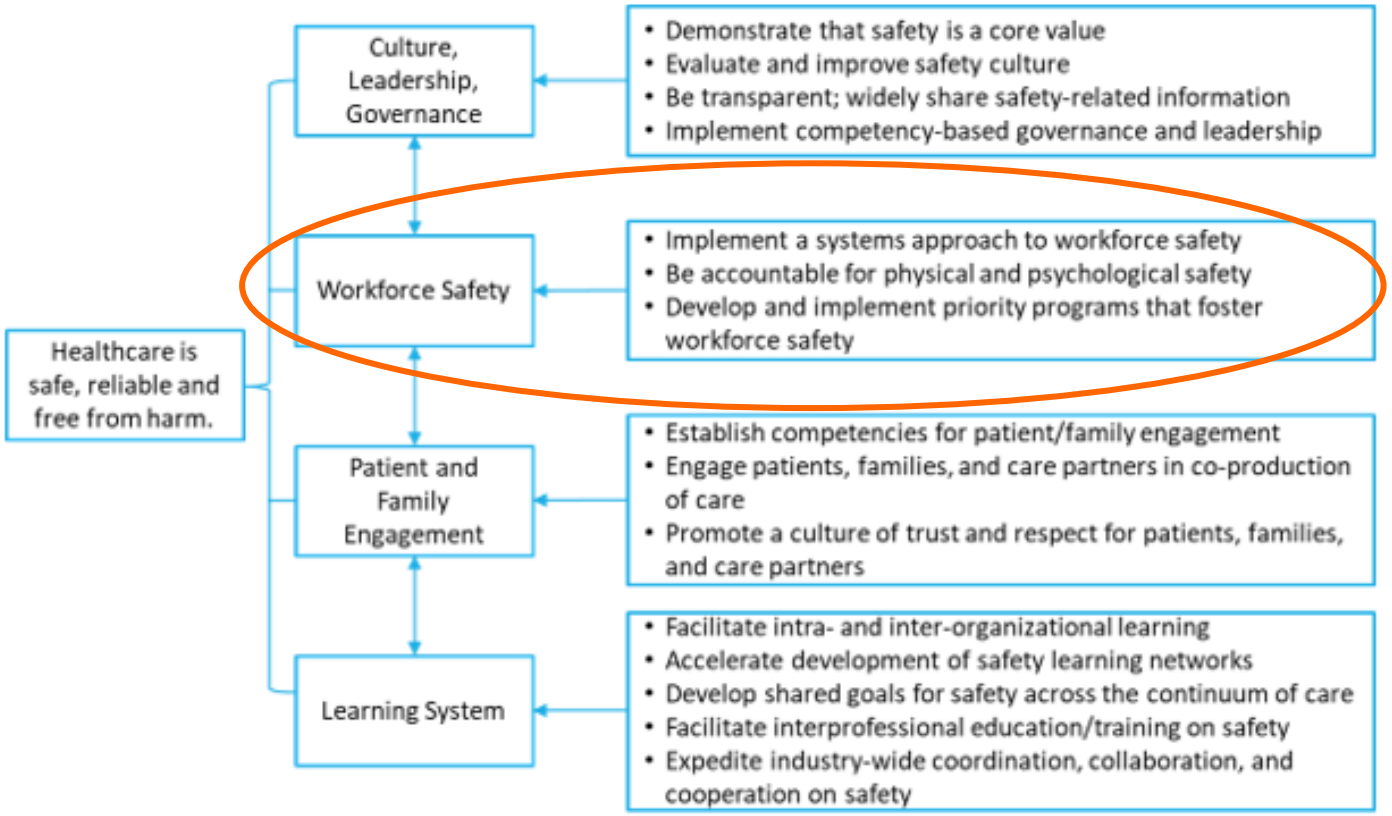

Figure 1. Four Drivers of Safe, Reliable Healthcare

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What comprises a Culture of Safety?

Informed – those who manage and operate safe, highly reliable organization

Flexible – the organization changes processes and systems to improve; team communications are optimized; **there is psychological safety to speak up about safety related information**

Learning – information from reports is used to understand risk in the organization and how systems and processes can be improved (includes RCAs)

Reporting – staff feel safe to freely report errors and unsafe situations; they understand how the information is used

Just –there is a fair, transparent, consistent system of managing events, demonstrating a shared accountability between system design and behavioral choices

From Reason, 1997

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Definition: psychological safety

"a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes, and that the team is safe for interpersonal risk-taking"

- Amy Edmondson

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Psychological Safety Facilitators

- Leader inclusiveness: introducing individuals to the team (team level)
- Open culture: nonjudgmental atmosphere (team level)
- Support in silos: identifying with a group of similar individuals (team level)
- Boundary spanner: an individual linking subgroups (team level)
- Interpersonal relationships: familiar long-tenure team members (team level)
- Small teams: individuals are more comfortable and confident in smaller groups (team level)
- Vocal personality: ability to voice opinions confidently (individual level)
- Chairing meetings: appointed meeting chairs are motivated to speak up (individual level)

From PSNet's Psychological Safety of Healthcare Staff, 2022

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Psychological Safety Barriers

- Hierarchy: higher ranking physicians were valued more (organizational level)
- Lack of Knowledge: lack of awareness of cases being discussed (team level)
- Authoritarian leadership: leaders devaluing ideas from team members (team level)
- Personality: dominant personalities overpowering conversations, or overly shy team members (individual level)

From PSNet's Psychological Safety of Healthcare Staff, 2022

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Physical Safety Resource List

The National Institute for Safety and Health, Workplace Violence Prevention for Nurses, on-line training, 2020. NIOSH. Available at: https://wwwn.cdc.gov/WPVHC/Nurses/Course Available at https://wwwn.cdc.gov/WPVHC/Nurses/Course

Occupational Safety and Health Administration, Guidelines for Preventing Workplace Violence for Healthcare and Social Service. Available at https://www.osha.gov/sites/default/files/publications/osha3148.pdf

Occupational Safety and Health Administration, Preventing Workplace Violence: A Road Map for Healthcare Facilities. Available at: https://www.osha.gov/sites/default/files/OSHA3827.pdf

Canadian Centre for Occupational Health and Safety. Violence in the Workplace Prevention Guide, 2016. Available at: https://www.ccohs.ca/products/publications/violence.html

Canadian Center for Occupational Health and Safety, Violence, and Harassment in the Workplace, 2021. Available at: https://www.ccohs.ca/oshanswers/psychosocial/violence_negative.html

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Reflection, Discussion, Q&A

What one thing did you learn?

Are there areas within your own organization where you can influence a Culture of Safety? A Just Culture?

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References

National Patient Safety Foundation. (2015) *Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err is Human.* Available at: https://www.npsf.org/free-from-harm

The Institute for Safe Medication Practice. (2020) *The differences between human error, at-risk behavior, and reckless behavior are key to a just culture*. Available at https://www.ismp.org/resources/differences-between-human-error-risk-behavior-and-reckless-behavior-are-key-just-culture

Health Quality Council of Alberta. (2021). *What is just culture?* Available at: https://justculture.hqca.ca/what-is-a-just-culture/

AHRQ Patient Safety Network. (2022). *Annual perspective: psychological safety of healthcare staff.* Available at: https://psnet.ahrq.gov/perspective/annual-perspective-psychological-safety-healthcare-staff

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Post Session Zoom Survey

Please respond to the following statements whose responses are formatted with the Likert scale of strongly disagree to strongly agree.

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Thank You

"The problem is not bad people; the problem is the system needs to be made safer."

- To Err is Human: Building a Safer Health System; Institute of Medicine, 1999

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