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Leading a Culture of Safety: A Blueprint for Success

Lead and Reward a Just Culture and Establish Organizational Behavior Expectations

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Six Domains


Leading for Safety
Vision
Behavior Expectations
Trust, Respect, and Inclusion
Zero Harm
to Patients, Families, and the Workforce
Just Culture
Board Engagement
Leadership Development
ORGANIZATIONAL LEARNING — CONTINUOUS IMPROVEMENT
Measurement • Analysis and interpretation • Change implementation • Feedback

Each Domain Includes:

- **Goal** to strive towards
- **Background** to develop understanding of importance and key characteristics of each domain
- **Strategies** for implementation at the CEO/senior leadership level
- **Tactics** that may be implemented to create change
- **Recommendations** to engage the workforce, clinical leaders, and patients and families
- **Metrics** to assess and track progress

Strategies and Tactics

Practical examples of tactics that can be implemented to create change in each domain

Divided into two categories:

- **Foundational**: basic tactics and strategies essential for the implementation of each domain
- **Sustaining**: strategies for spreading and embedding a culture of safety throughout the organization

What happens when…

A physician does not detect a life-threatening illness?

A unit clerk misreads an order?

A pharmacist pulls the wrong drug from the shelf?

A CFO underestimates the cost of a new EHR?

A nurse delivers the correct medication, but to the wrong patient?

So what about “culture”?

- How is it defined?
- Why is it important?
- How is it changed?

What is “just” culture?

- Fair?
- Non-punitive?
- Blameless?

What Just Culture is not…

What comes to mind when you think of “Just Culture”?

Non-Punitive?

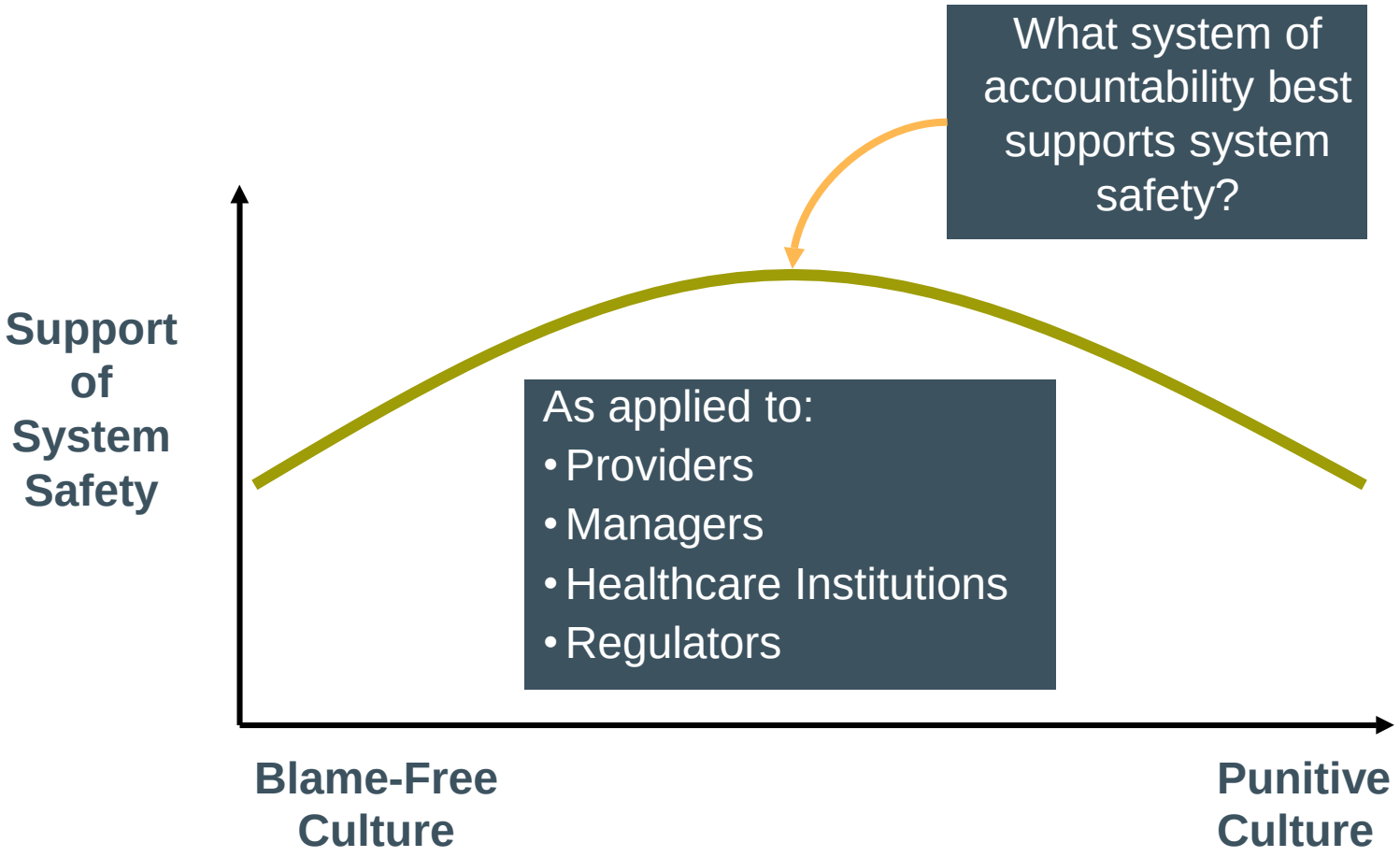
Blameless?

Punishment to fit the crime?

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

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

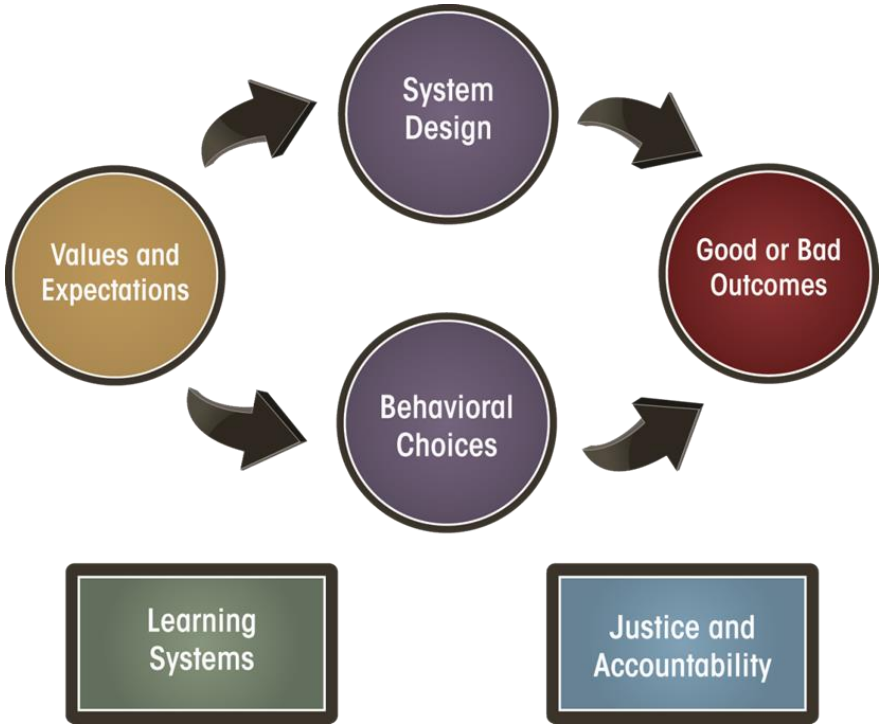
Problem statement



Really… what is it…

Framework

1. **Values and expectations**
2. System design
3. Behavioral choices
4. Learning systems
5. Justice & accountability



How does it work?

It begins with a mission, values and expectations…

While perfection might be the aspiration, it cannot be the expectation.

- Unknown

Things we can influence

- The ***reliability of systems*** in which we put our employees:
  - ✓ A system designed to be one human error away from harm is at some point destined to fail.
  - ✓ Systems must be designed to facilitate people to make good decisions.
- ***Behavioral choices***
  - ✓ Learn how to productively coach employees around reliable behaviors
  - ✓ Appropriately recognize when remedial and disciplinary actions will best serve organizational values

Behaviors we can expect

Human error - inadvertent action; inadvertently doing other that what should have been done; ***slip, lapse, mistake.***

At-risk behavior – behavioral choice that increases risk where ***risk is not recognized or is mistakenly believed to be justified.***

Reckless behavior (negligence) - behavioral choice to ***consciously disregard*** a substantial and unjustifiable risk.

Accountability for reckless behaviors

Human Error

(**Inadvertent action**: *slip, lapse, mistake*)

Managed through:

- Processes
- Procedures
- Training
- Design

CONSOLE

At-Risk Behavior

(**A choice**: *risk not recognized or believed justified*)

Managed through:

- Removing incentives for At-Risk Behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

COACH

Reckless Behavior

(***Conscious disregard*** of unreasonable risk)

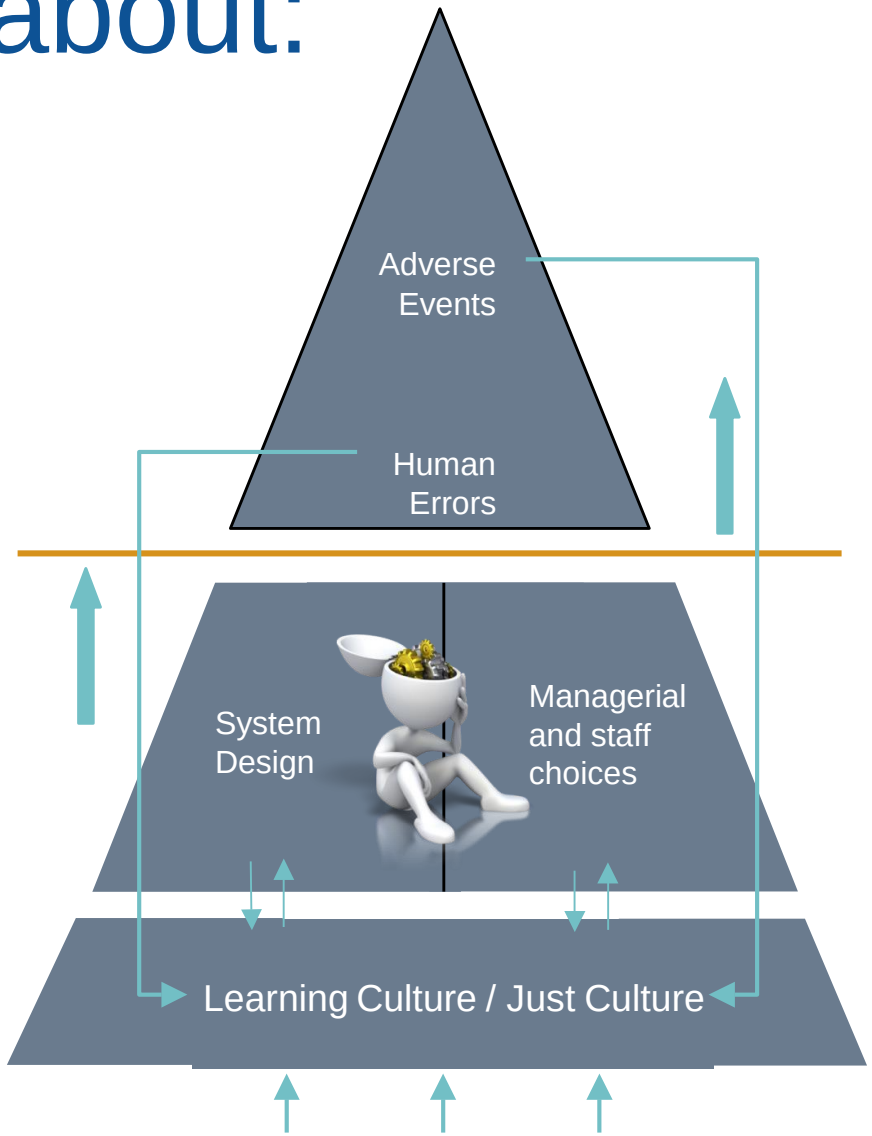
Managed through:

- Remedial action
- Punitive action

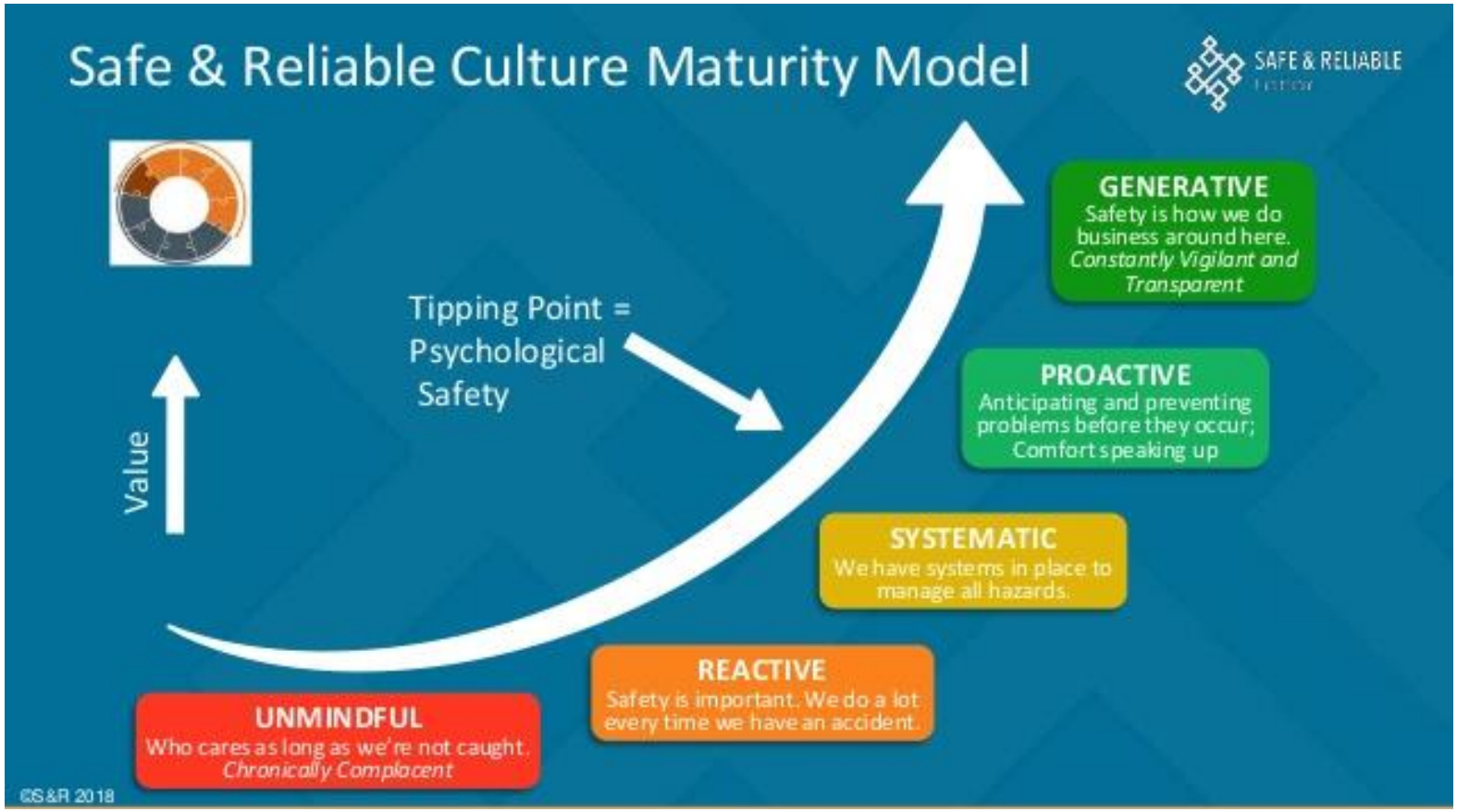
PUNISH

Just Culture is about:

- ✓ Creating an open, fair, and just culture
- ✓ Creating a learning culture
- ✓ Designing safe systems
- ✓ Managing behavioral choices



Developing a Culture of Safety



Frankel A, Haraden C, Federico F, Lenoci-Edwards J., 2017.

It's about a *proactive* learning culture

It's not seeing events as things to be fixed

It's seeing events as opportunities to improve our understanding of risk

- ✓ System Risk
- ✓ Behavioral Risk

It’s about changing managerial expectations

- Knowing my risks
  - Investigating the source of errors and at-risk behaviors
  - Turning events into an understanding of risk
- Designing safe systems
- Facilitating safe choices
  - Consoling
  - Coaching
  - Punishing

It’s about changing staff expectations

Looking for the risks around me
Reporting errors and hazards
Helping to design safe systems
Making safe choices

- Following procedure
- Making choices that align with organizational values
- Never signing for something that was not done

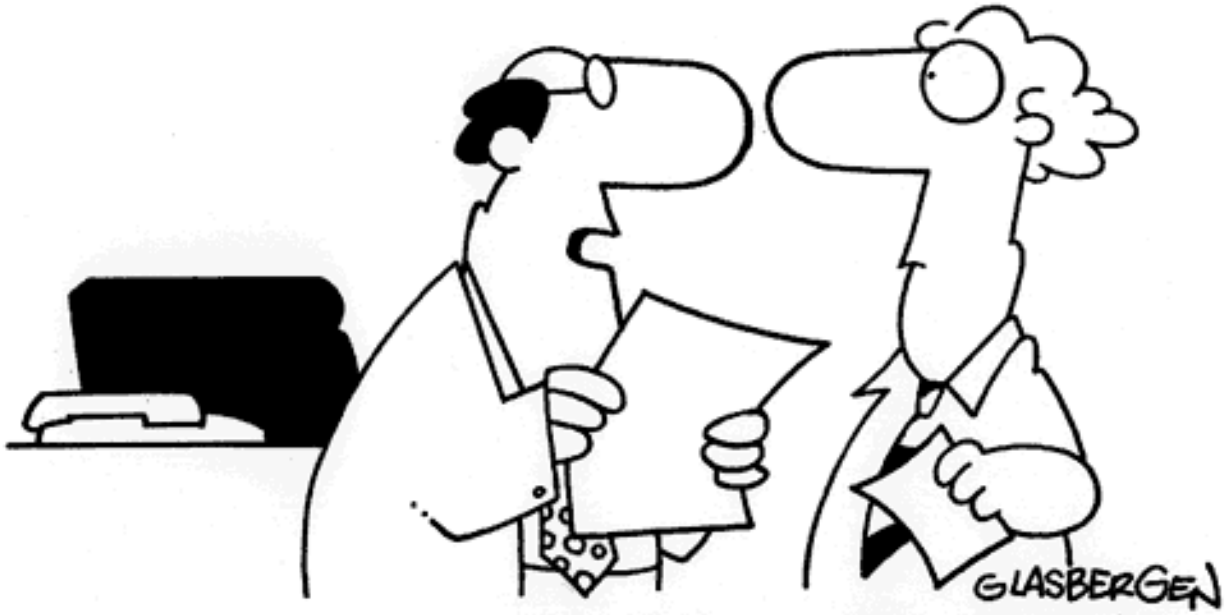
Imperfect systems, imperfect choices

Putting it into action

- What happened?
- What ***should*** happen? (think policy)
- What ***normally*** happens? (think shortcuts)
- Why did it happen?
- How was the organization managing risk?

Where the rubber meets the road

Setting Organizational Behaviours



"I want the public to think of us as 'The Company With A Heart'. But I want *you* to think of us as the company that will chew you up, spit you out and smear you into the carpet if you screw up."

CEO

- Creates, communicates and models accountability
- Establishes rewards for appropriate behaviours
- Develops and evaluates programs that improve behaviour
- Succession planning
- Encourages questions
- Holds leaders accountable
- Engages Board

Some Tactics

Huddles and/or scrums

“Stop the Line”

Patient Involvement

"You have to learn about thousands of diseases, but I only have to focus on fixing what's wrong with ME! Now which one of us do you think is the expert?"

Reward for appropriate behaviour

- Celebrate teams who engage in safety behaviour

Communication Training

Culture surveys

Teamwork Training

Physical & Psychological Safety

- Transparency
- Teamwork
- Active communication
- Timely feedback
- Respect
- Just culture

Assessing your organization

Questions to ask

1. Does your organization have a clearly defined reporting system and measure utilization of this system?
2. Are organizational behaviour expectations such as use of huddles, etc. regularly evaluated?
3. Are professional accountability standards in place and regularly evaluated?
4. Are specific tools to encourage teamwork and clear communication in place and regularly evaluated?
5. Are communication and resolution/reconciliation programs in place and regularly evaluated?

How they all fit together

Another concept to consider

- Safety 1

-focus on adverse events

-mechanistic thinking

-regulations/laws

-safety is the absence of failure

- Safety 2

-based on complexity science

-focus on creating success

-ability to adapt and achieve success when the unexpected inevitably occurs

Impact on People

- “A system preoccupied with its failures may be blind to how it achieves its successes.”

Dr. Andrew Smaggus

- Focus on **‘when things go right’** allows us to “identify the adaptations and improvisations that clinicians make to create the successes of everyday work”

‘When things go right’

- Investigating mechanisms of success creates:
  - Appreciation of clinician expertise
  - Higher esteem for clinicians
  - Clinicians hold the ingredients to attain safe, high-quality care

References

- Frankel A, Haraden C, Federico F, Lenoci-Edwards J. A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017.
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- Reason, James; Achieving a safe culture: theory and practice, Work & Stress, 1998, VOL, 12, NO. 3 293-306.