SUSAN THOMAS ART, MA

BCSLS TELEHEALTH VIDEO BROADCAST

January 21, 2010

To develop an understanding of patient safety culture through an understanding of the:

- Definitions of culture
- Safety culture experience in industries other than healthcare
- Key characteristics of a culture of safety
- Social behaviors, learning and re-engineering required to support and sustain a framework of policies, processes and procedures

When did we start to think in terms of a 'safety culture'?

- International Nuclear Safety Advisory Group - Report on Chernobyl 1988
- Institute of Medicine – 'To Err is Human' 1999
- CCHSA – 2004 Patient Safety Culture and ROP
  - http://www.accreditation.ca/en/default.aspx
- Canadian Patient Safety Institute
  - http://www.patientsafetyinstitute.ca/English/Pages/default.aspx
- BC Patient Safety and Quality Council
  - http://www.bcpsqc.ca/about-us/whats-new/default.htm

"It is widely accepted that the desired improvements to patient safety require a change in culture" (Mark Fleming, 2005)

How do we define it?

The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management. Organizations with a positive safety culture are characterized by communications founded on trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventative measures (ACSNI, 1993).

CULTURE

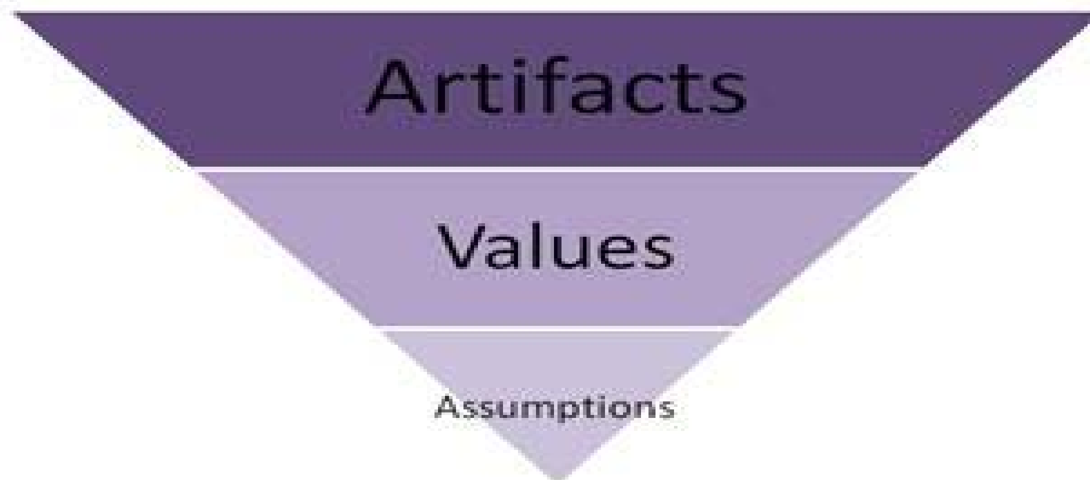
How do we define it?

Edgar Schein:

Culture arises from shared history and experience … culture is local … culture arises in part: (1) around functional units; and (2) around levels of hierarchy

Identified 3 levels – Core, Espoused Values, and Behaviors and Artifacts

3 Levels in a Corporate Culture



How do we define it?

Schein’s 3 levels of culture:

1. <u>Core Assumptions:</u>
   - The basic assumptions and beliefs held by a group of people
   - This is what people take for granted unconsciously as their reality
   - Each new person in a group comes with their assumptions and values based on their life/work experience and what they believe to be true

How do we define it?

<u>Core Assumptions – cont.:</u>

Create an emotional reaction because they:

- Are what we pay attention to
- Help us define what things mean
- Tell us what actions to take when

How do we define it?

Schein’s 3 levels of culture:

2. <u>Espoused Values</u>

- Reflected in peoples’ values, attitudes and perceptions
- Determines how people decide to behave
- Leadership defines and states these in an organization and maintains them
- Shared espoused values within a group can become assumptions over time

How do we define it?

Schein's 3 levels of culture:

3. <u>Behaviors and Artifacts</u>
   - The outward expression of the local culture
   - This doesn't tell us why people act they way they do
   - It is what people talk about, what they see, hear, feels and believe to be true
   - Visible - dress code, language people use, work environment, rewards and recognitions, discipline, stories, etc.

How do we define Safety Culture?

Culture is the way we do things around here …. *safety* culture is a product of social learning, leadership and reporting - the ways in which people think and behave focused on patient safety

A culture *has*: Systems, policies, processes and procedures (structure issues)

A culture *is*: Learned and shared assumptions, beliefs, values, and behavioral norms (social issues)

CULTURE CLASSIFIED

"Within a healthcare context, safety culture influences patient safety by motivating healthcare professionals to choose behaviours that enhance rather than reduce patient safety" (Nieva and Sorra, 2003)

3 Types of culture (Ron Westrum):

1. Pathological
2. Bureaucratic
3. Generative

Which culture is a patient safety one?

CULTURE CLASSIFIED

Pathological	Bureaucratic	Generative
Don’t want to know	May not find out	Actively seek it
Failure is punished or Concealed	Failures lead to local ‘repairs’	Failures lead to far-reaching reforms
Responsibility is shirked	Responsibility compartmentalized	Responsibility is shared
New ideas discouraged	New ideas present problems	New ideas welcomed
Messenger is ‘shot’	Messengers are listened to if messenger arrives	Messengers are trained and rewarded

LEARNING FROM OTHERS

Highly Reliable Organizations (HROs) – who are they? what can we learn?

Airline Petrochemical Nuclear Air Traffic Control

1. High risk and dynamic;
2. Complex systems, processes and procedures;
3. Failure and mistakes can have devastating consequences;
4. There is a lot of potential for variability;
5. They measure their culture.

LEARNING FROM OTHERS

1. Must be a core value and strategic imperative
2. Must be implemented across the whole organization
3. There is typically a disparity in perception
4. Culture is local
5. A ‘patient safe’ environment is an ‘employee safe’ environment

CULTURE

Highly *__Reliable__* Organizations - reliability is a key concept to patient safety.

What is reliability?

Safety is more than what a culture *has* – the systems, policies, processes and procedures (structure issues).

What are the next steps?

“Systems are perfectly designed to deliver the results they achieve” (Berwick)

“

KEY CHARACTERISTICS OF A CULTURE OF PATIENT SAFETY

5 Commonly Recognized Key Characteristics:

1. Communication Openness
2. Teamwork
3. Incident Reporting and 'Just' Response to Error
4. Organizational Learning and Continuous Improvement
5. Leadership

CHARACTERISTIC #1
COMMUNICATION OPENNESS

What is important is people's perception that they are ***personally safe*** in:

1. Questioning the decisions of those with more authority
2. Suggesting improvements to increase patient or staff safety
3. Speaking up when a situation doesn't 'feel' right or when they identify a potential safety problem

COMMUNICATION OPENNESS

What a culture IS --- is about behavior patterns which demonstrate personal ownership of patient safety.

Maryland Hospital

http://www.westgard.com/essays-9.htm

Stop the Line

CHARACTERISTIC #2 TEAMWORK

What is important is people’s perception that they are *respected, supported and trusted.*

Teams are identifiable *social work units* with: (1) dynamic social interaction with meaningful interdependencies; (2) shared and valued goals; (3) a discrete lifespan; (4) distributed expertise; (5) clearly assigned roles and responsibilities (Salas et al. 2007).

TEAMWORK

Does your lab have Teamwork problems?

Communication?

Unresolved interpersonal conflicts?

Inequitable workload?

Delays in TAT ?

Unacceptable behaviors?

Everyone is working as a Team for one reason – to ensure the patients' experience is as safe as it can be.

CHARACTERISTIC #3 INCIDENT REPORTING AND A 'JUST' RESPONSE TO ERROR

"Errors are to be expected … errors are seen as consequences … having their origins not so much in the perversity of human nature as in the upstream system factors." (Reason, 2000)

What assumptions do we make in a culture of (patient) safety?

What are disincentives for reporting?

INCIDENT REPORTING

Key *disincentives* to reporting:

- Fear of reprisal for me or another person
- Lack of trust especially of those in more authority
- Too much work to make a report; I have no extra time
- No visible follow up/positive change in response to reporting – what's the value in reporting?
- No confidentiality
- No clear rules on what will be punished and what not

INCIDENT REPORTING

What is important is people's perception that they are *respected, supported and trusted.*

Critical:

1. Type – near-miss and incident
2. Consistency
3. Number
4. Progression of culture change as evidenced through what people report and how.

If you don't have time to solve problems, how come you always have time to do it wrong again?

NON-PUNITIVE AND A 'JUST' RESPONSE TO ERROR

"We cannot change the human condition – we must change the conditions under which humans work … the important issue is not who blundered, but how and why the defences failed" (Reason).

- Non-punitive is incorrectly called 'no blame'.
- People need to *perceive and trust* that they and all their colleagues will be treated fairly and equitably - consistently
- An incident caused by system issues (those issues outside of the control of the individual involved in the incident) should not be held against the individual.

What are system issues?

NON-PUNITIVE AND A 'JUST' RESPONSE TO ERROR

Some system issues that enable 'human errors':

- Workplace design and environment – space, noise, temp, distractions and interruptions
- Complexity of tasks
- Equipment – design. noise, technology
- Fatigue and boredom
- Scheduling
- Workload
- Change
- Communication
- Hiring practices
- Training
- Personal factors

NON-PUNITIVE AND A ‘JUST’ RESPONSE TO ERROR

A ‘Just’ culture within a non-punitive patient safety culture deals with incidents caused through behaviors that are culpable:

1. Negligent – a failure to exercise skill, care and learning
2. Reckless – a choice to disregard a substantial or unjustifiable risk
3. Intentional conduct – a choice to knowingly violate a rule

A ‘Just Culture’ is one of accountability for actions.

CHARACTERISTIC #4
ORGANIZATIONAL LEARNING AND CONTINUOUS IMPROVEMENT

… its is all about positive change -----

“The world we have made as a result of the level of thinking we have done … creates problems we cannot solve at the same level of thinking at which we created them” (Albert Einstein)

“When asked what single event was most helpful in developing the Theory of Relativity, Albert Einstein replied: “Figuring out how to think about the problem” (W. Edwards Deming).

ORGANIZATIONAL LEARNING AND CONTINUOUS IMPROVEMENT

A culture of patient safety:

1. Connects with the patient
2. Demonstrates personal ownership behaviors
3. Actively seeks and discusses patient safety issues, incidents and suggestions for improvements

ORGANIZATIONAL LEARNING AND CONTINUOUS IMPROVEMENT

A culture of patient safety:

4. Makes visible change in response to patient safety issues; monitors; evaluates; communicates
5. Has leaders at all levels who model, inspire, coach, engage staff, listen, and ensure shared learning
6. Supports all staff through relationships that are trustful, respectful and motivating

CHARACTERISTIC #5
LEADERSHIP

What can *<u>you</u>* do to influence the change to a culture of patient safety?

1. Relationships built on trust and respect
2. ‘Walk the talk’; be persistent and consistent
3. Create an common understanding of values, purpose and expected behaviors
4. Deliver a consistent message that always applies
5. Collaborate with PS initiatives at the system level – be visible
6. Link with patient outcome

7. Design supportive systems, work environment, procedures and structure
8. Focus on small local change first – where do you and your workplace need to develop:

    communication openness (personally safe)

    teamwork (respected, supported, trusted)

    incident reporting and a Just culture (accountable)

    learning and CI (positive change)

    leadership (setting the values and purpose; influencing)

Systems, policies, processes, procedures are the structure issues which provide a visible framework for the implementation, maintenance, improvement and demonstration of what a culture of patient safety has.

A patient safety culture is social in nature: it is one in which all personnel value, expect, perceive and demonstrate appropriate attitudes and behaviors:

Mutual trust and respect	Teamwork
Ongoing learning	Authentic communication
The meaningfulness of work	Rewards and recognitions
Highly visible committed leadership	

Tell me and I'll forget;

show me and I may remember;

involve me and I'll understand

Chinese Proverb

Remember – culture change is about social change.
It is more than processes and procedures.

"In the confrontation between the stream and the rock, the stream always wins – not through strength, but through persistence" (Anonymous)

THANK YOU