HRET HIIN Virtual Event
QI Fellowship

Developing a Culture of Safety

Frank Federico, Vice President, IHI
June 30, 2017 1PM CT
Welcome and Introductions

Mallory Bender, Program Manager, HRET
## Agenda

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<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter(S)</th>
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<tr>
<td>12:00-12:05</td>
<td>Welcome &amp; Introduction</td>
<td>Mallory Bender, HRET</td>
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<td>Lauren Macy, IHI</td>
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<td>Kathy Duncan, IHI</td>
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<td>12:05-12:30</td>
<td>Creating a Culture of Safety</td>
<td>Frank Federico, IHI</td>
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<td>• Describe what we mean by a ‘culture of safety’</td>
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<td>• Discuss the evolution of culture</td>
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<td>• Explain how the science of improvement can be used to change culture in an organization</td>
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<td>12:30-12:55</td>
<td>Office Hours Discussion</td>
<td>Frank Federico, IHI</td>
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<td>• Ask your questions and share your experiences in developing a just and fair culture in your hospital</td>
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<td>• Submit your questions in advance <a href="#">here</a></td>
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<tr>
<td>12:55-1:00</td>
<td>Bring It Home</td>
<td>Mallory Bender, HRET</td>
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How Did You Hear About Today’s Virtual Event?

A) HRET HIIN flyer
B) HRET HIIN website
C) HRET LISTSERV
D) State hospital association
E) QIN-QIO
F) Your organization/colleague
G) Other, please specify.
Objectives

• Describe what we mean by a culture of safety
• Discuss the evolution of culture
• Explain how the science for improvement can be used to change culture in an organization
• List three frameworks to use in a fair and just culture
1. On our recent Hospital Survey on Patient Safety Culture, we scored low on "Staff feel free to question the decisions or actions of those with more authority." What are some suggestions or best practices that will help us in this area?

2. What are the first steps an organization should take to begin the transition into a culture of safety; after the Culture of Safety Survey assessment and dissemination of results?

3. In your opinion, is Reasons fair and just culture algorithm the best?

4. How do you keep all staff updated and trained on a safety culture?

5. Please discuss the cross over between PDSA and DMAIC.

6. My CMO and I are contemplating how to create/energize around a culture of improvement. I think we are a bit a victim of our great clinical outcomes, and we haven't had a burning platform harm event.

7. What do you think would be the #1 most important thing to assure hospitals focus on to achieve a culture of safety?

8. What are your ideas for the tests of change that you would do in a PDSA process for improving a culture of trust?
Developing a Culture of Safety

• In a culture of safety, people are not merely encouraged to work toward change; they take action when it is needed.

• Leadership’s message about safety must be consistent and sustained, as it takes a long time for culture to change.
The Science of Improvement is:

• An applied science that emphasizes
  – innovation
  – rapid-cycle testing in the field
  – Spread in order to generate learning about what changes, in which contexts, produce improvements

• Multidisciplinary
• Combines subject matter experts with improvement methods
“There is no single design that is “safe” or “best” for all organizations and all times; rather, clinicians and managers must design and redesign for their organizations at different organizational stages.”

AHRQ

“Steal shamelessly; implement wisely”

IHI
Safety Cultures Evolve

Where Are You?

Attr: Patrick Hudson, Univ. of Leiden

GENERATIVE
Organizational Culture “Genetically wired” to produce safety

PROACTIVE
“We methodically anticipate” Prevent problems before they occur

SYSTEMATIC
Systems being put in place to manage most hazards

REACTIVE
“We safety is important. We do a lot everytime we have an accident”

UNMINDFUL
“We show up, don’t we?” Chomically Complacent

Where Are You?
Culture

National Culture

Corporate Culture

Safety Culture
Framework For Safe and Reliable Health Care

Engagement of Patients & Family

- Culture
  - Leadership
  - Psychological Safety
  - Accountability
  - Teamwork & Communication
  - Negotiation
- Learning System
  - Transparency
  - Reliability
  - Improvement & Measurement
  - Continuous Learning

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Joy in Work

Step No. 1: Ask staff, “What matters to you?”

Step No. 2: Identify the unique impediments to joy in work in the local context

Step No. 3: Commit to making joy in work a shared responsibility at all levels

Step No. 4: Use improvement science to test validated approaches in your organization
Applying the Joy in Work Steps to Changing Culture

Step No. 1: Ask staff, “What matters to you?”

Step No. 2: Identify the unique impediments to providing safe care in work in the local context

Step No. 3: Commit to making providing safe care a shared responsibility at all levels

Step No. 4: Use improvement science to test validated approaches in your organization
Framework for Safe and Reliable Health Care

Being held to act in a safe and respectful manner given the training and support to do so.

Engagement of Patients & Family

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

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Reflection

Have you developed a fair and just culture?

What are the challenges that you face(d)?
Understand that Skilled Humans Will Make Mistakes

- Do you know what the rules are if you make a mistake?
- Do you always feel safe reporting an error?
- How do we differentiate individual problems for good people working in unsafe systems?
Systemic Migration to Boundaries

INDIVIDUAL BENEFITS

VERY UNSAFE SPACE

‘Illegal-Illegal’ Space
Never/Sometimes

Never/Never

‘Real Life’
Legal

Usual Space of Action
‘Illegal-Normal’
Always/Sometimes

Expected safe space of action as defined by professional standards

ACCIDENT

Policy, Protocols, Regulation

Life Pressures

Technology

Market Demand

PERFORMANCE

American Hospital Association
Implementing a Fair and Just Culture

Focus on:
• The leadership culture that sets the tone and judges the behavior of others, and
• The culture at the point of care, or team culture

Raise Awareness:
• Survey staff
• Educate about the just culture concept
• Ensure that the highest level of leadership shows support
• Educate the staff
Implementing a Fair and Just Culture

• Examine practices and policies that conflict with Fair and Just Culture Model
• Incorporate the Fair and Just Culture practices into every day work
• Leaders must establish processes to know when someone is engaging in reckless behavior and be willing to punish those who engage in it.
• Fair and Just Culture applies to everyone in the organization
Were the actions as intended? 

no → Substance Use? 

yes → Were the consequences as intended? 

no → Substance Abuse with mitigation. Engage Employee Health 

yes → Prescribed? 

no → Knowingly violated safe operating procedures? 

yes → Pass substitution test? 

no → Deficiencies in training and selection, or inexperienced? 

yes → Recent history of unsafe acts or unintentional rule breaking? 

no → Deficiencies in training and selection, or inexperienced? 

no → yes → Blameless Error. Employee assists in process improvement. 

no → yes → Human error. Develop remedial and/or corrective action plan. Document verbal counseling and assign a preceptor/mentor to work with the employee. 

no → yes → System Induced Error. Employee assists in process improvement. 

yes → Intentional rule breaking. Investigate; initiate disciplinary process if indicated. 

yes → Substance Abuse without mitigation. Follow HR Policy 

no → Substance Abuse with mitigation. Engage Employee Health 

no → Possible recklessness violation. Initiate disciplinary process if indicated. 

no → System induced violation. Employee assists in process improvement. 

no → Possible Negligent Behavior. Investigation possible counseling, suspension, termination. 

From: James Reason “Managing the risks of organizational accidents” Modified by Allan Frankel and Lynda Hooper 2007
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Manage through</th>
<th>Response</th>
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| Human Error            | Inadvertent action: Slip, Lapse, Mistake                                     | • Processes  
• Procedures  
• Training  
• System design                                              | Support    |
| At-Risk Behavior       | A choice: risk not recognized or believed justified                          | • Removing incentives for At-Risk Behaviours  
• Creating incentives for healthy behaviors  
• Increasing situational awareness                          | Coach      |
| Reckless Behavior      | Conscious disregard of unreasonable risk                                    | • Role modeling  
• Remedial action  
• Punitive action                                               | Punish     |

## The Fair Evaluation and Response Chart

**HOW TO USE THIS CHART:** This chart should be used to categorize an individual caregiver’s actions, not groups or systems. Evaluate each factor that influenced the caregiver’s actions separately. When determining accountability, consider the context in which the action occurred.

### 1. Choose the column that best describes the caregiver’s mindset and actions. Read down the column for definition and recommended responses.

<table>
<thead>
<tr>
<th>IMPAIRED JUDGMENT</th>
<th>MALICIOUS ACTION</th>
<th>RECKLESS ACTION</th>
<th>RISKY ACTION</th>
<th>UNINTENTIONAL ERROR</th>
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<tr>
<td><strong>The caregiver’s thinking was impaired</strong></td>
<td><strong>The caregiver wanted to cause harm.</strong></td>
<td><strong>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.</strong></td>
<td><strong>The caregiver made a potentially unsafe choice. Their evaluation of relative risk appears to be erroneous.</strong></td>
<td><strong>The caregiver made or participated in an error while working appropriately and in the patients’ best interests.</strong></td>
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<tr>
<td>- by illegal or legal substances</td>
<td>- Discipline is warranted if illegal substances were used.</td>
<td>- The caregiver is accountable and needs re-training. Discipline may be warranted.</td>
<td>- The caregiver is accountable and should receive coaching.</td>
<td>- The caregiver is not accountable.</td>
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<td>- by cognitive impairment</td>
<td>- The caregiver’s duties should be suspended immediately.</td>
<td>- The caregiver should participate in teaching others the lessons learned.</td>
<td>- The caregiver should participate in investigating why the error occurred and teach others about the results of the investigation.</td>
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<td>- by severe psychosocial stressors</td>
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**Help should be actively offered to the caregiver.**

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**FURTHER EVALUATION OF THESE COLUMNS WILL HELP DETERMINE NEXT STEPS. CONTINUE BELOW:**

### 2. If three other caregivers with similar skills and knowledge would do the same in similar circumstances:

| The system supports reckless action and requires fixing. The caregiver is probably less accountable for the action, and system leaders share in the accountability. | The system supports risky action and requires fixing. The caregiver is probably less accountable for the action, and system leaders share in the accountability. | The system supports error and requires fixing. The system’s leaders are accountable and should apply error-proofing improvements. |

### 3. If the caregiver has a history of repeatedly making mistakes, the caregiver may be in the wrong position. Evaluation is warranted, and coaching, transfer or termination should be considered. The corrective actions above should be modified accordingly.

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**Leonard M. Frankel A; Pat Educ Counseling, 80 (2010)**
Culture of Safety Resources - IHI

- A Framework for Safe, Reliable, and Effective Care
- Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition)
- Creating a Culture of Safety (Interview with Lucian Leape)
- Conduct Patient Safety Leadership WalkRounds™
Culture of Safety Resources - HRET

- HRET HIIN Culture of Safety Change Package
- HRET HIIN Culture of Safety Resource Library
Thank You

Questions?

Contact Information

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Mallory Bender, Program Manager, HRET
THANK YOU!