HRET HIIN Virtual Event
QI Fellowship

Developing a Culture of Safety

Jennifer Lenoci-Edwards,
Executive Director, IHI
April 2018
Welcome and Introductions

Kavita Bhat, MD, MPH, Program Manager, HRET
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<th>Time</th>
<th>Session Title</th>
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<td>12:00-12:05</td>
<td>Welcome and Introduction</td>
<td>Mallory Bender, HRET</td>
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<td>Lauren Macy, IHI</td>
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<td>12:05-12:40</td>
<td>Creating a Culture of Safety</td>
<td>Jennifer Lenoci-Edwards, IHI</td>
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<td>• Describe what we mean by a culture of safety</td>
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<td>• Break down culture into five domains</td>
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<td>• Pose questions for you to consider about your organization</td>
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<td>• Explain how the science for improvement can be used to change culture in an organization</td>
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<td>12:40-12:55</td>
<td>Office Hours Discussion</td>
<td>Jennifer Lenoci-Edwards, 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</td>
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<td>12:55-1:00</td>
<td>Bring It Home</td>
<td>Mallory Bender, HRET</td>
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Objectives

• Describe what we mean by a culture of safety
• Break down culture into five domains
• Pose questions for you to consider about your organization
• Explain how the science for improvement can be used to change culture in an organization
What is Culture?

- From Merriam-Webster – Culture is the set of shared attitudes, values, goals, and practices that characterizes an institution or organization.
- It is the “how we do things in our organization.”
- Leadership sets the culture for the organization and is critical in making the shift when the culture is optimal.
Safety Cultures Evolve

Where Are You?

**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 show up, don’t we?” Chomically Complacent

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

Attr: Patrick Hudson, Univ. of Leiden
Developing a Culture of Safety

Framework for Safe, Reliable and Effective Care

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

Learning System

Culture

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I feel safe speaking up when I see something go wrong or when I spot something that can be improved.

I’m clear about my role in the team, I always feel like part of the team.

When I raise concerns, I know they will be prioritized and handled carefully, that changes will be made and I’ll get feedback.

Communication failures are rare, whether within this team or between teams.
Facilitating and mentoring teamwork, improvement, respect and psychological safety

Characteristics:
• Leaders are not identified by position or rank – organizations need leaders to exist at all levels and in all groups, including patients
• Leaders are guardians of the Learning System; they create and maintain an environment of psychological safety
• Leaders are approachable and competent, nurturing an environment of respect
• Leaders must be realistic about their improvement skills and understand enough about improvement to be able to support people, asking the right questions and removing barriers to improvement

Tools:
• Leadership Walkrounds
• Patient stories at leadership meetings
Questions for your consideration

• Does your staff know and understand the organizational vision? And their role in it?

• Do you see your leaders around the organization? If yes, what types of questions are they asking?

• Do you hear about system or hospital improvement decisions based on data?

• Do you receive feedback from your immediate leaders around safety or quality events?
Psychological Safety

Creating an environment where people feel comfortable and have opportunities to raise concerns or ask questions.

**Characteristics:**
- All team members know that it is safe to speak up and feel comfortable asking questions and raising concerns.
- Feedback is commonplace with team members regularly asking for and receiving feedback and feeling comfortable doing so.
- Criticism and compliments are shared appropriately.
- Team members feeling comfortable being innovative and making suggestions to improve work processes, care and outcomes.

**Tools:**
- Briefing and debriefing
- Structured and standard approach to feedback
Questions for your Consideration

• Would you feel comfortable sharing your concerns with a senior leader?

• Would your direct reports feel comfortable sharing with you?

• What is your stance/process on disruptive staff or patients?
Accountability

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

**Characteristics:**
- Supports psychological safety because employees believe that they’ll be treated fairly
- An objective test, such as Reason’s Substitution Test, is applied appropriately
- Team members are clear about what they are accountable for

**Tools:**
- Reason’s Substitution Test
- Role Clarity and Responsibilities
The Rule Abiders

Skating on Thin Ice

The Rule Breakers

Implementing a Fair and Just Culture

• A Just Culture is a mindset that can be translated into practice
• A Just Culture is one that responds to any harm events with a system lens before they blame the bad employee
• Leaders must establish processes to know when someone is engaging in reckless behavior and be willing to punish those who engage in it.
• Human Resources is a key player in the Just Culture
• Fair and Just Culture applies to everyone in the organization
• Employees need to understand a Just Culture
Managing the Risks

Decision Tree for Determining Culpability of Unsafe Acts

Reason, J., Managing the Risks of Organizational Accidents
Questions for your Consideration

• What is the organizational response to an harm? Do they look for the flaw in the system or the irresponsible employee?

• Do your employees think they have two jobs? Their own job and another to improve their job? Improve the system?

• For jobs with numerous responsibilities, are their efforts to get them to work to the top of their abilities and clarify their roles?
Teamwork and Communication

Developing a shared understanding, anticipating needs and problems, and using agreed methods to manage these as well as conflict situations

Characteristics:
• All members of the team agree upon specific behaviors and demonstrate these behaviors consistently in their interactions with patients, families and other team members.
• Good communication is apparent as transmission and reception of information is one and the same.

Tools:
• Plan Forward – Briefing/Pause/ Checklist/Huddle
• Reflect Back - Debrief
• Communicate Clearly - SBAR, Repeat Back
• Resolve Conflict - Critical Language
Questions for your Consideration

• Are you hiring for good team members?

• Are employees trained in teaming? TeamStepps or equivalent

• Are teams huddling in the organization? START Tomorrow

• What types of questions are they discussing in their huddles?

• Is there a standard approach to communication across all disciplines? Formalized Training? SBAR? IPASS?
Gaining genuine agreement on matters of importance to team members, patients and families

**Characteristics:**
- Patients and families are actively involved in decisions about the care they receive.
- Decisions take account of what is important to them.
- Team members are involved in changes to work processes and practices.
- Everyone has a voice and is heard.
- Decisions are reached in a constructive and inclusive way.

**Tools:**
- Use of the five types of negotiation: avoid, accommodate, compromise, compete, collaborate
- Skilled facilitation of discussions using phrases like “What else?” and “Tell me more?”
“Negotiation doesn’t seem to fit”

• Hierarchy of Medicine – Flattening the Hierarchy

• Every relationship has a push/pull based on what each member wants from the transaction

• Negotiation includes patients

• It starts with “What Matters to you?”
Questions for Your Consideration

• Do you approach conflict with the idea of “What Matters to you?”

• If you are working in direct patient care, do you try to understand “What matters to the patient?”

• Is there multidisciplinary representation in improvement groups? Is a patient represented?
How do I know...

What our organizational culture looks like and where there are opportunities for improvement?

Measure Formally
There are many tools that can be used (ex. AHRQ) to assess culture in the organization

Taking the Temperature Informally
• Asking your staff questions
• Look at turnover as a measure
• Exit surveys
• Reporting of incident reports
• Use the questions today to help you understand opportunities
What do I do?

• Many folks struggle with the results of culture surveys

• The key is convene key leaders, champions and take action

• Empower front line teams with improvement and work to move a big dot in a unit, service line or at the system level

• Identify units where the culture is great and learn why. Compare your assumptions with low performing units.
At the unit or front line level

Get teams to start asking 3 questions in the morning huddle.

- Where we safe yesterday?
- Are we safe today?
- How do we ensure we are safe tomorrow?
Warning!!!!

• This is a big dot to move

• It won’t move overnight but it will be a worthwhile investment
  – Turnover
  – Have the best hiring of best workforce
  – Best outcomes for patients
Thank You

Questions?

Contact Information
Jennifer Lenoci-Edwards
Jlenoci-Edwards@ihi.org
Resources

• A Framework for Safe, Reliable, and Effective Care
  http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Safe-Reliable-Effective-Care.aspx

• Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition)
  http://www.ihi.org/resources/Pages/IHIWhitePapers/SevenLeadershipLeveragePointsWhitePaper.aspx

• Creating a Culture of Safety (Interview with Lucian Leape)
  http://www.ihi.org/resources/Pages/ImprovementStories/CreatingaCultureofSafety.aspx

• Conduct Patient Safety Leadership WalkRounds™
  http://www.ihi.org/resources/Pages/Changes/ConductPatientSafetyLeadershipWalkRounds.aspx
### Human Error
Inadvertent action: Slip, Lapse, Mistake

### At-Risk Behavior
A choice: risk not recognized or believed justified

### Reckless Behavior
Conscious disregard of unreasonable risk

#### Manage through:
- Processes
- Procedures
- Training
- System design

#### Manage through:
- Removing incentives for At-Risk Behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

**Response**
- Support
- Coach

**Response**
- Punish
- Independently from outcome

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Bring it Home

Kavita Bhat, MD, MPH, Program Manager, HRET
THANK YOU!