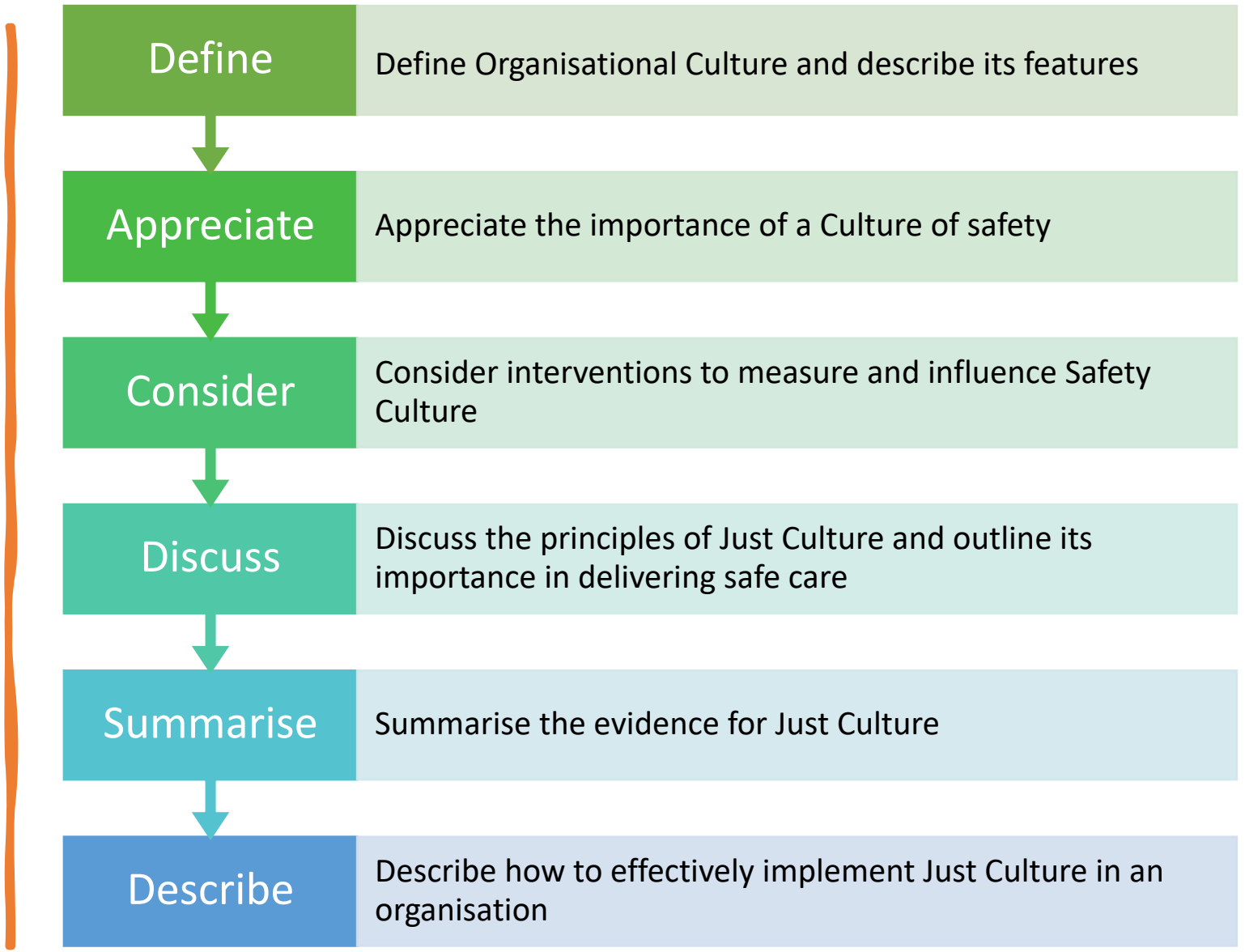
A Culture of Safety

Dr David Vaughan
Dr John Fitzsimons

Learning Outcomes A the end of this session you will be able to…

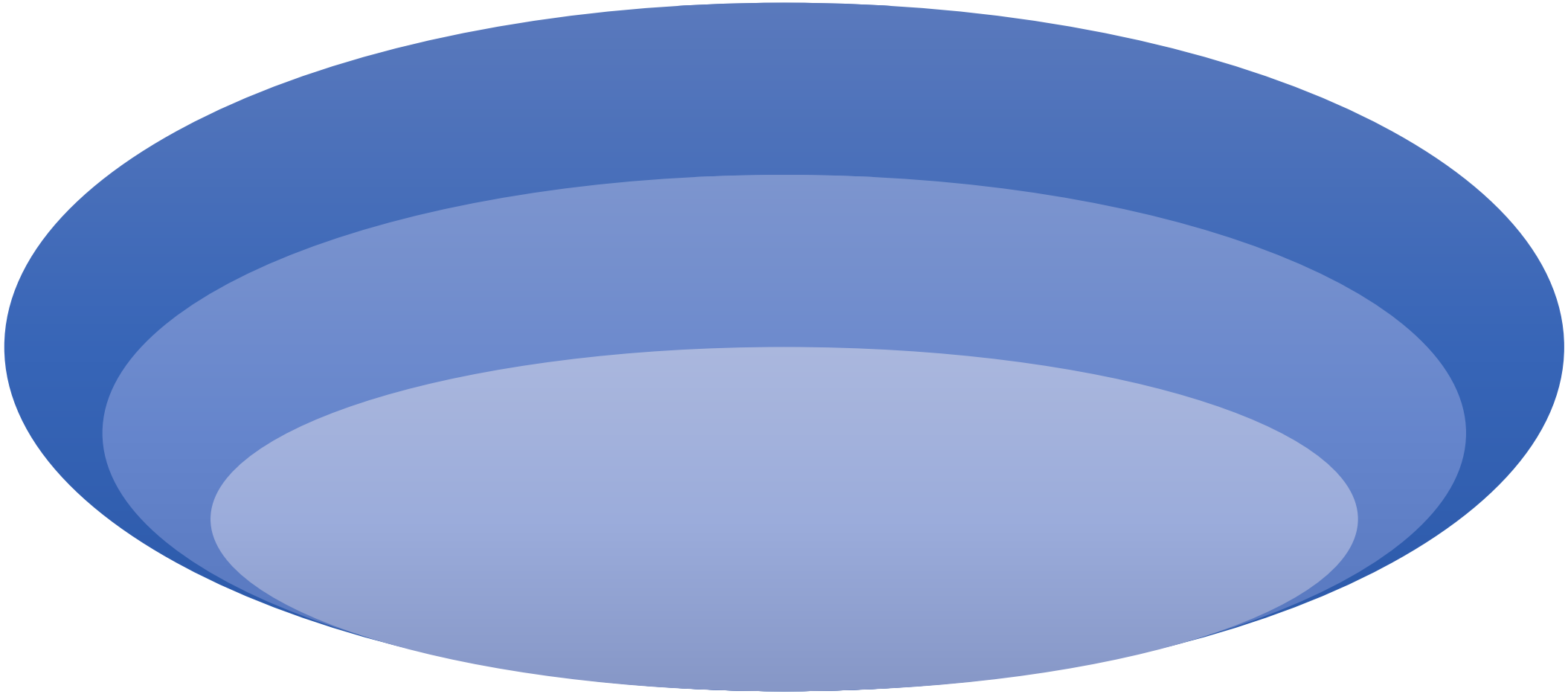


What is Organisational Culture?

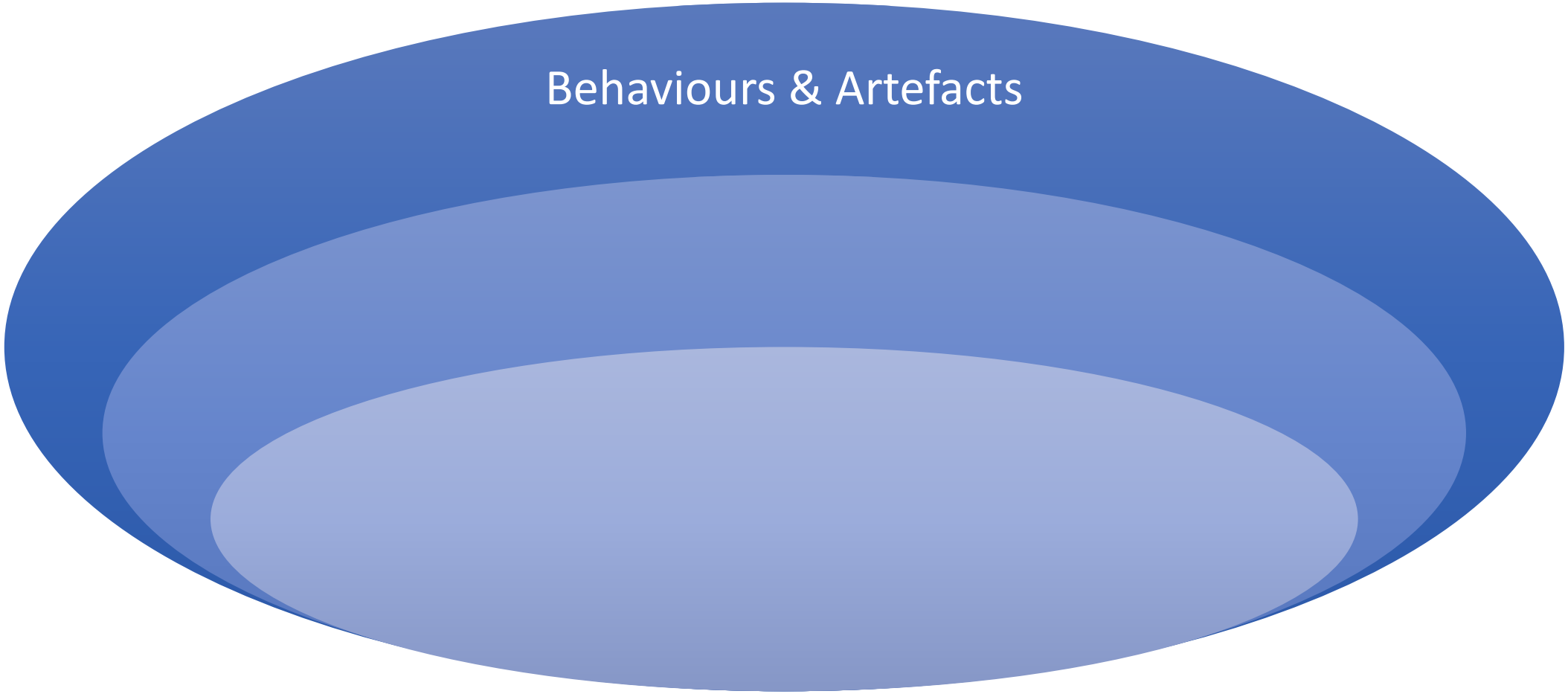
" A set of shared, often implicit assumptions, beliefs, values, and sensemaking procedures that influences and guides the behaviour and thinking of organizational members, and is in turn continuously enacted and reinforced - or changed - by the behaviour of organizational members"

Martin & Fellenz, 2010

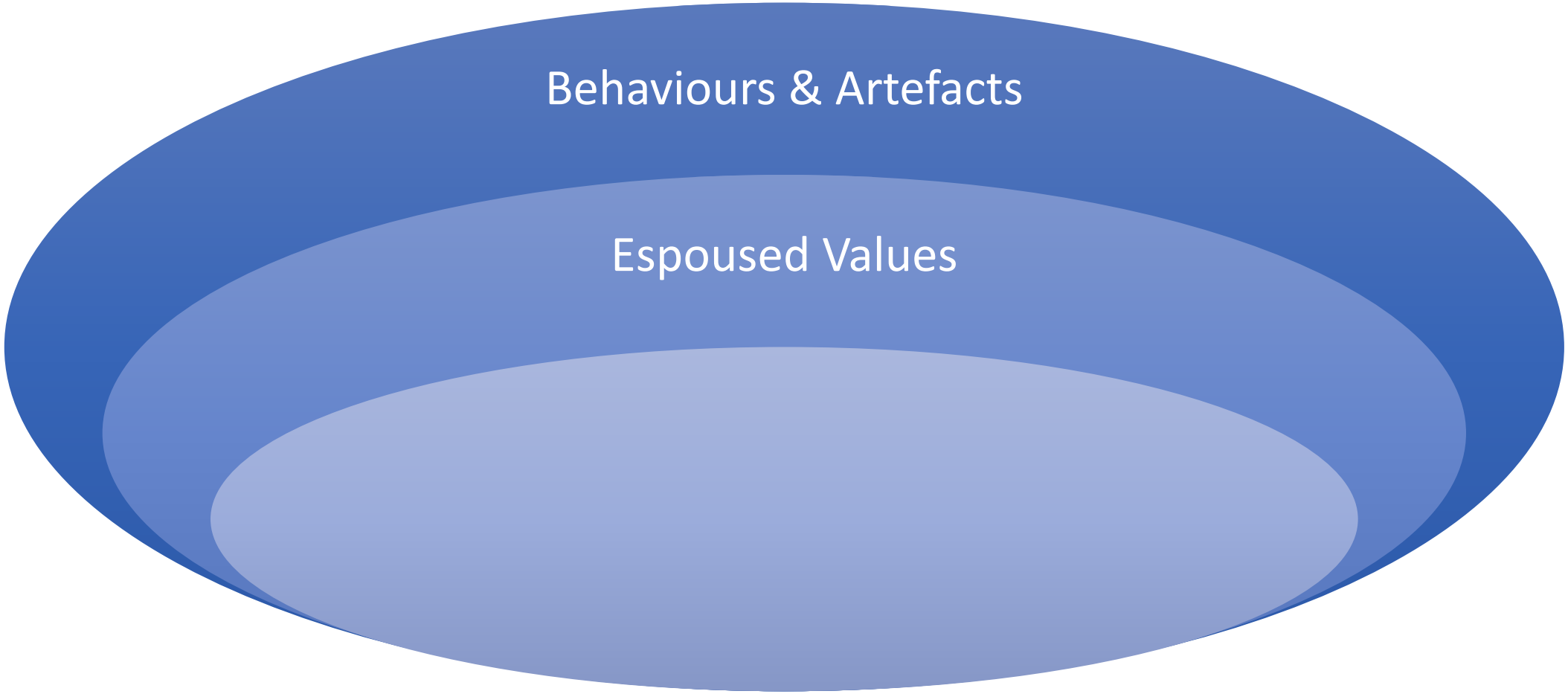
Edgar Schein’s – 3 levels of culture



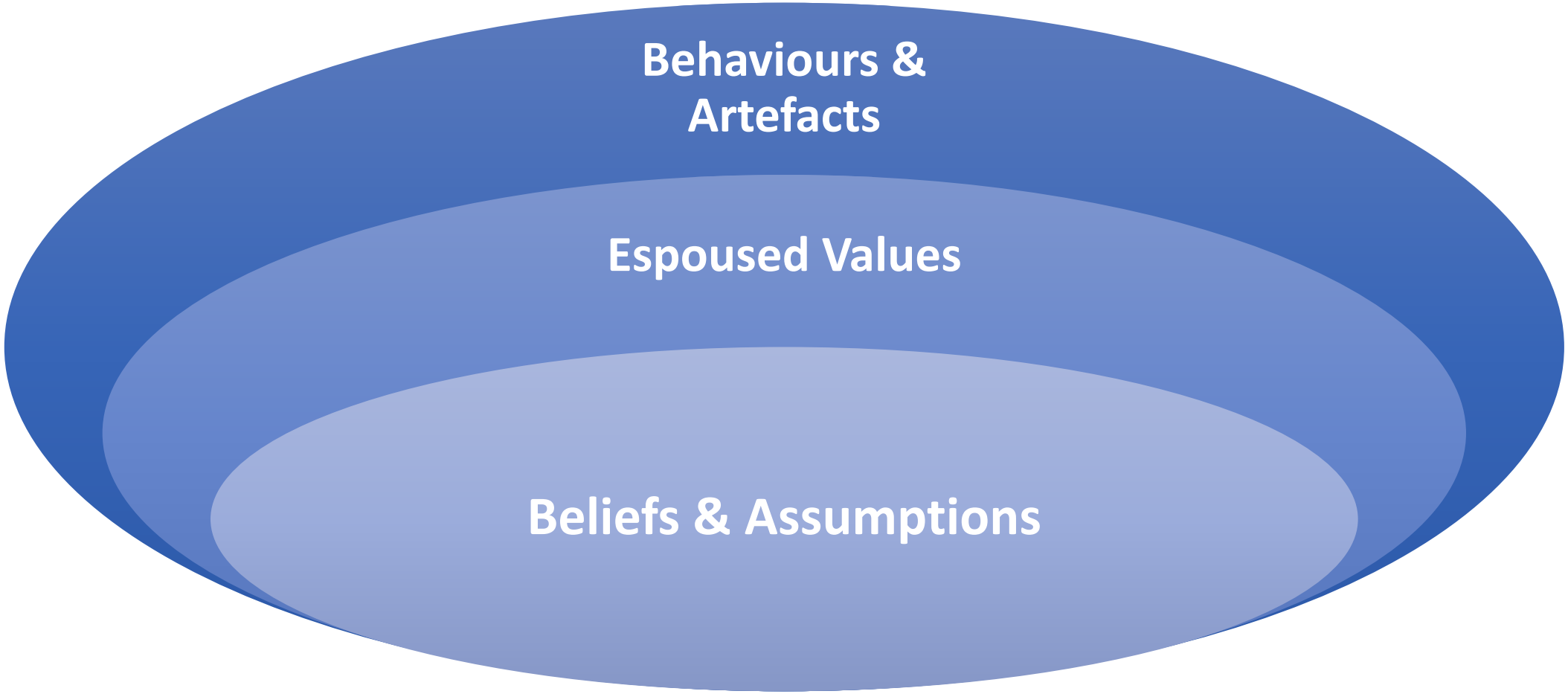
Edgar Schein – 3 levels of culture



Edgar Schein – 3 levels of culture

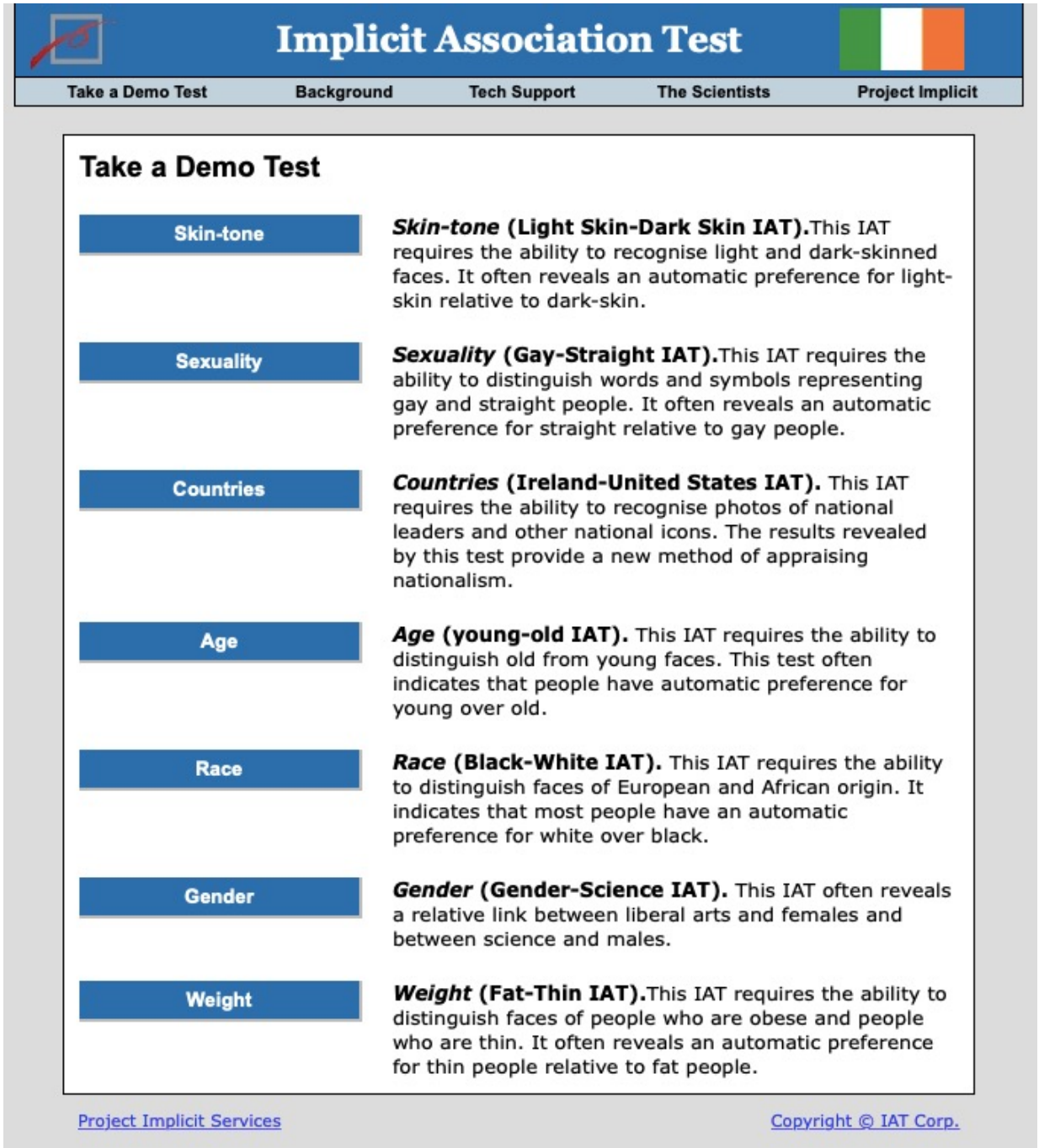


Edgar Schein – 3 levels of culture



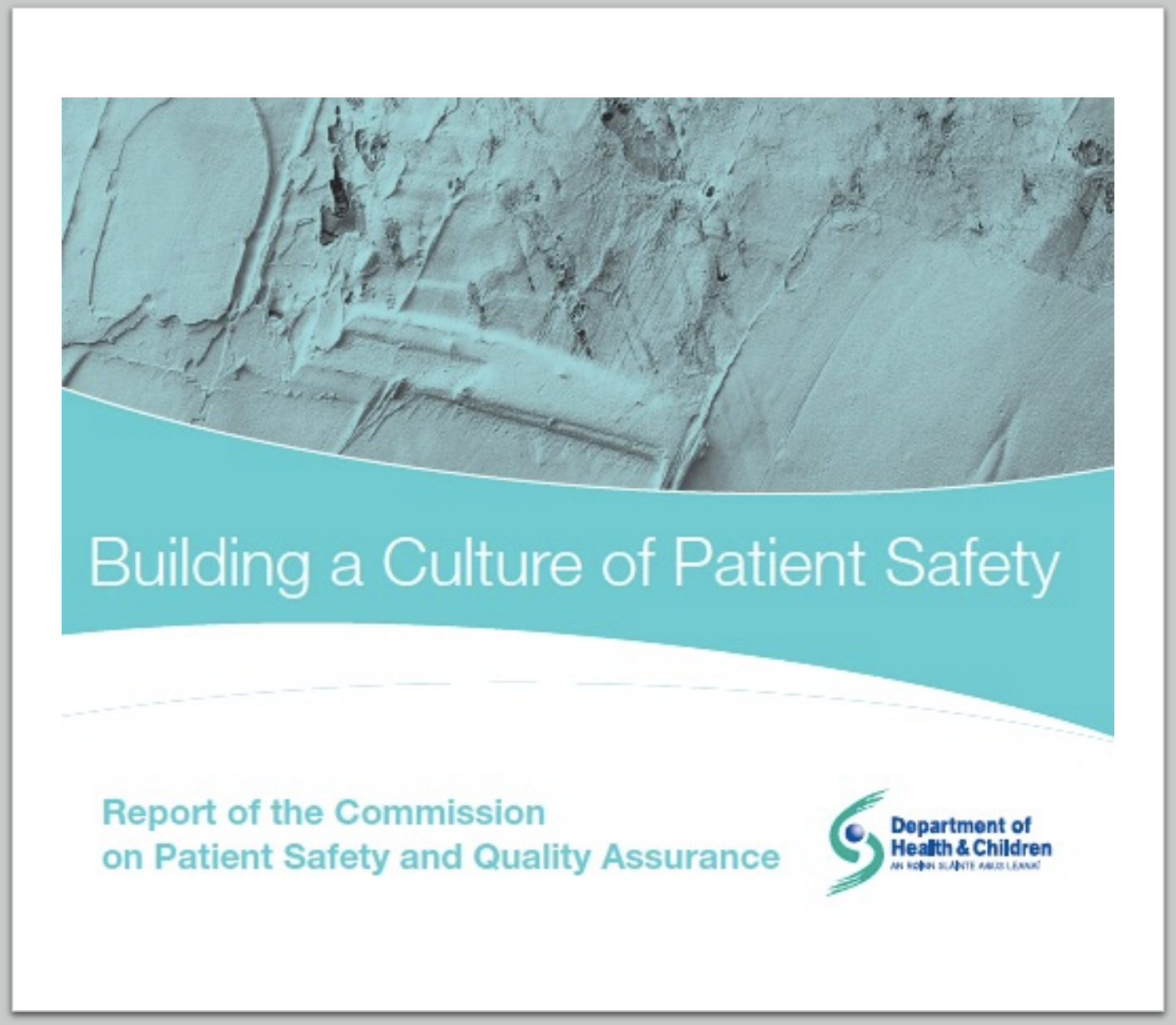
Project Implicit

www.implicit.harvard.edu/implicit/



Building a Culture of Patient Safety,
2008

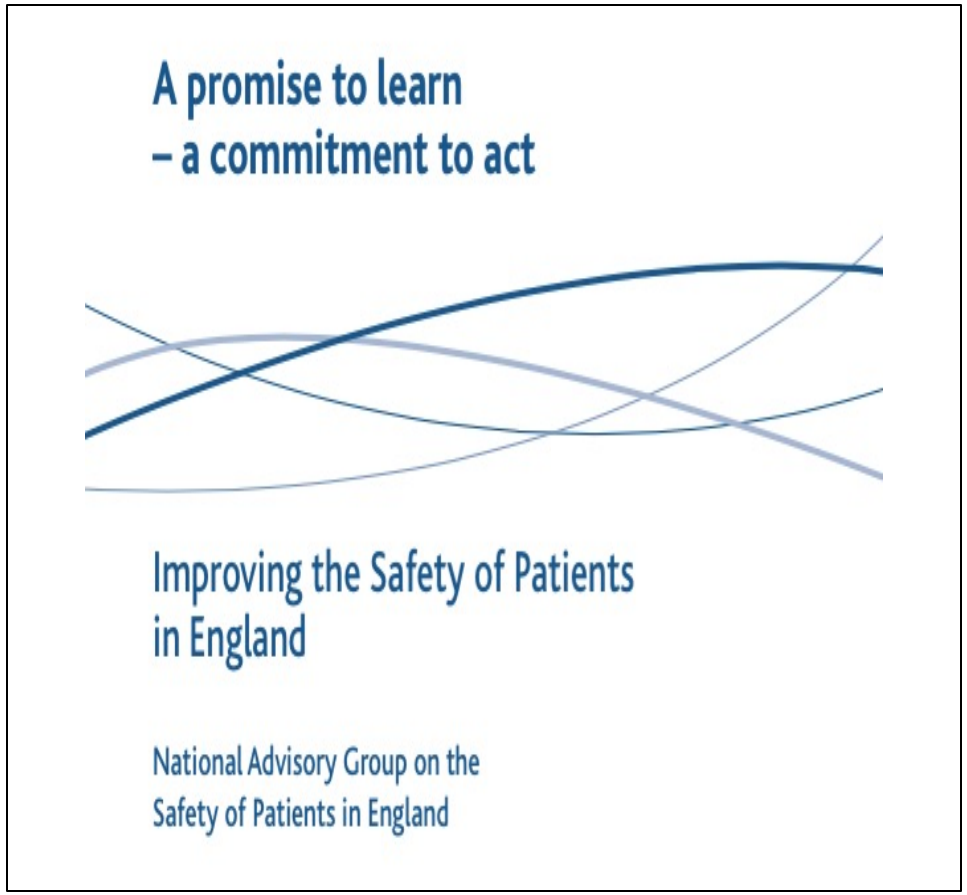
"Efforts are required to improve national, professional and organisational culture to ensure that **patient safety culture** is understood, promoted and supported at all levels"



Patient Safety Strategy 2019-2024

"Nurturing **a culture of patient safety** which places emphasis on a culture of transparency and organisational learning is key."

Importance of Culture



'In the end, culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime.'

Berwick Review, 2013, (p.11)1

What is Safety Culture?

“The product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour that determine the commitment to, and the style and proficiency of an organization's health and safety management”

Health and Safety Commission Advisory Committee on the Safety of Nuclear Installations, 1993

James Reason's 5 Components of a Safety Culture

- Informed culture
- Reporting culture
- Just culture
- Flexible culture
- Learning culture

Features of a Safety Culture…

- Always on (“never sleeps”), always looking to be safer (“never satisfied”)
- Includes everyone - people (patient & staff focused) – curious, respectful & trusting. Collective leadership.
- Safe to speak up, safe to step up, safe to screw up
- Continuously learning and changing

High Reliability Organisations

“HRO’s seek an ideal of perfection but never expect to achieve it

Demand complete safety but never expect it

Dread surprise but always anticipate it

Deliver reliability but never take it for granted

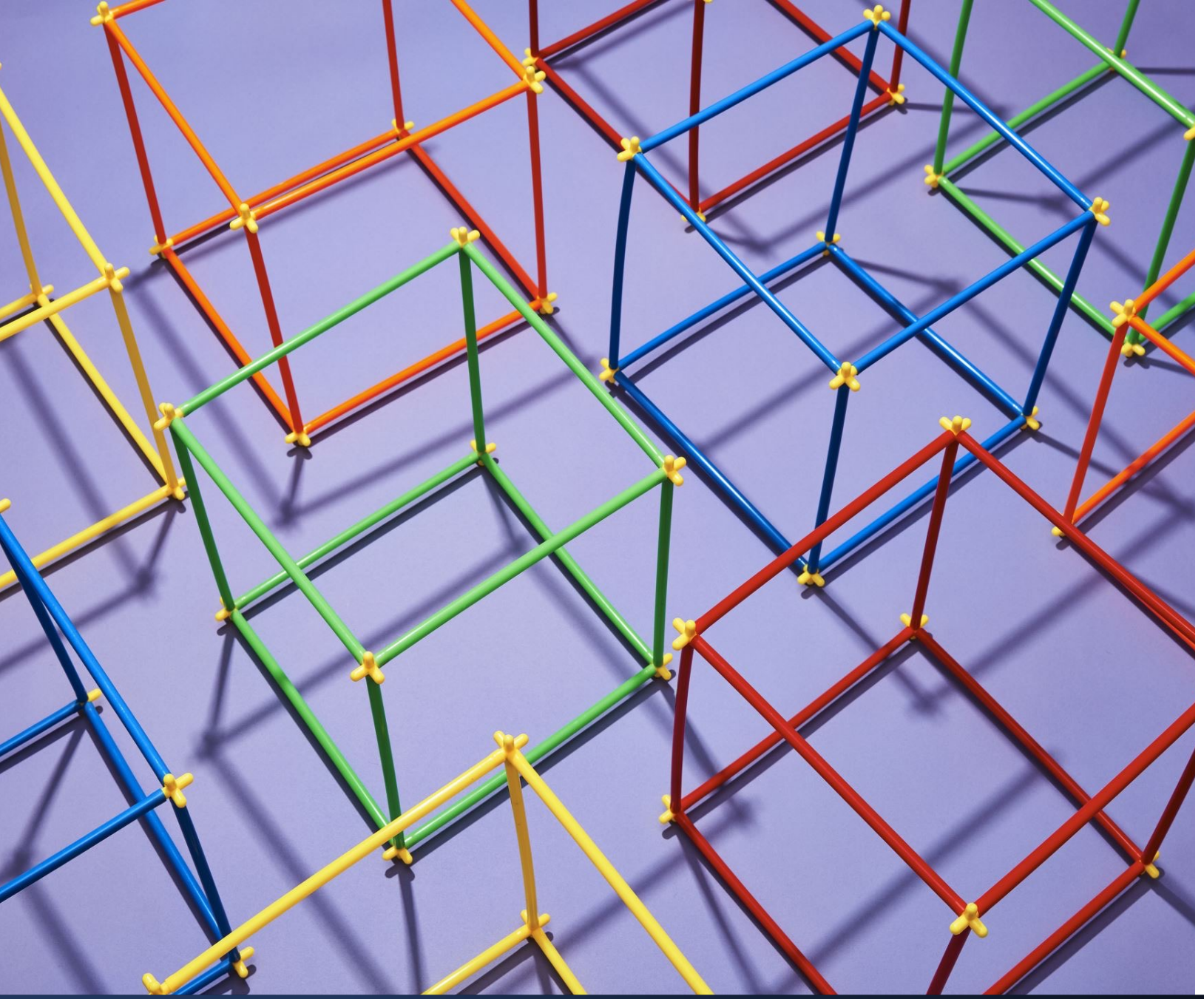
Live by the book but are unwilling to die by it”

Rochlin, 1993

Overheard

Attitudes and beliefs that do not indicate a Safety Culture

- “I’m in control”
- “This is not a problem for me - I’m very careful”
- “That would not happen here”
- “It won’t happen to me & if it does, I’ll be fine. I’m strong.”
- “It’s just not possible – I’m too busy, no time, they’re not interested, nobody else cares”



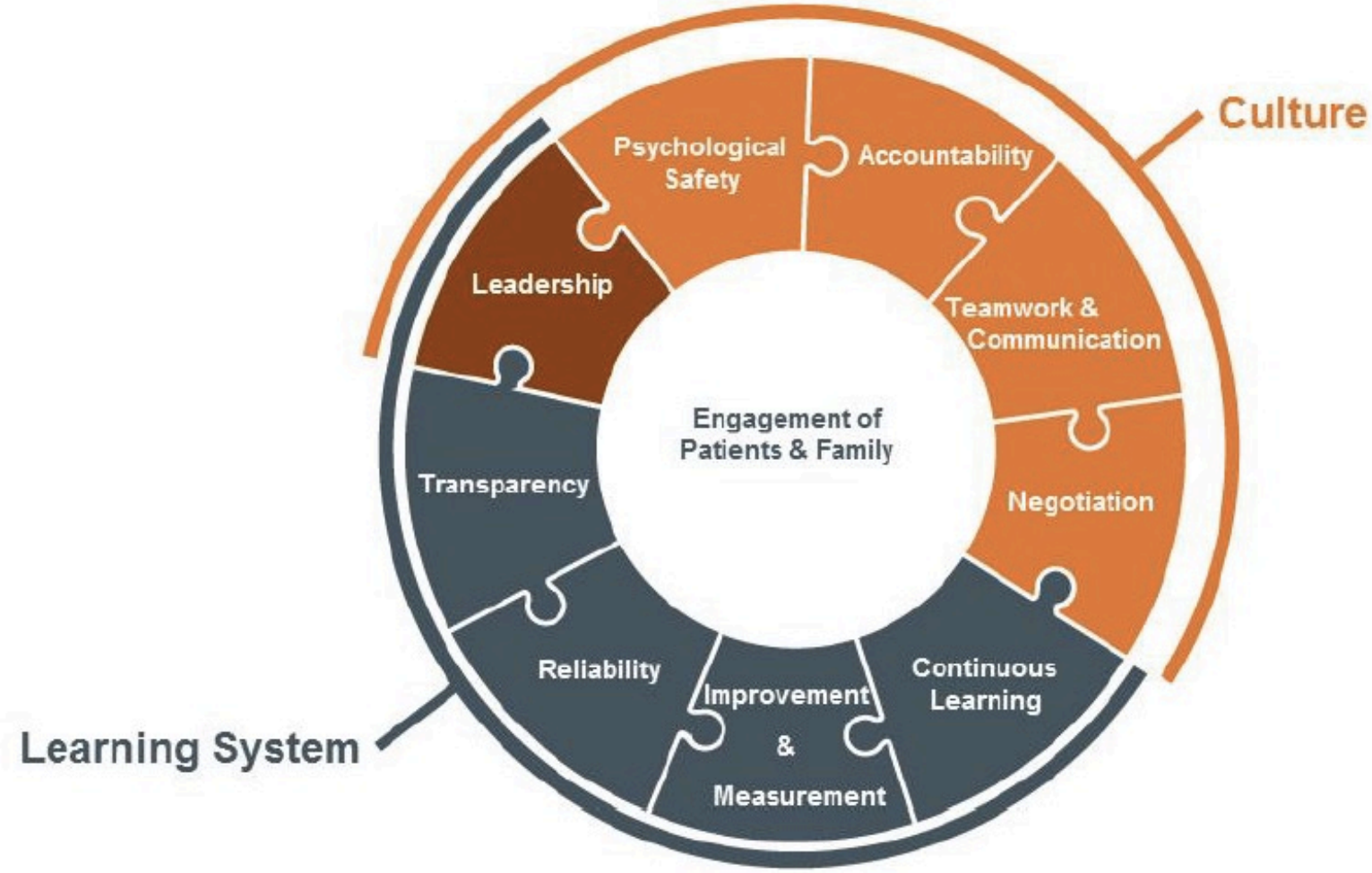
Building a Culture of Safety

- Leadership for Safety
- Learn about Safety & QI
- Supporting Structures & Methods

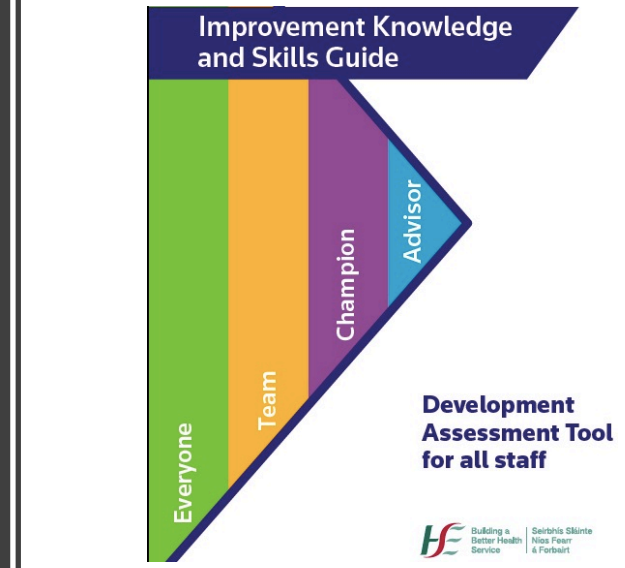
“The only thing of real importance that leaders do is to create and manage culture”

Edgar Schein

IHI Framework for Safe, Reliable, and Effective Care

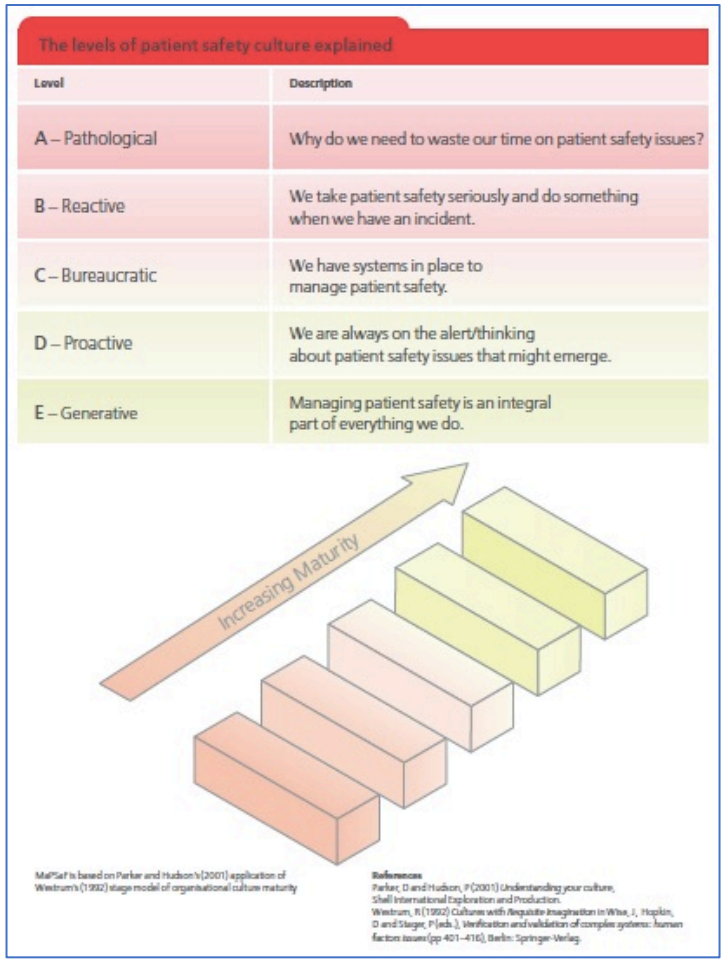


Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A Framework for Safe, Reliable, and Effective Care.* White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017.



Framework for Improving Quality
www.hse.ie/eng/about/Who/QID/

Manchester Patient Safety Framework (MaPSaF)

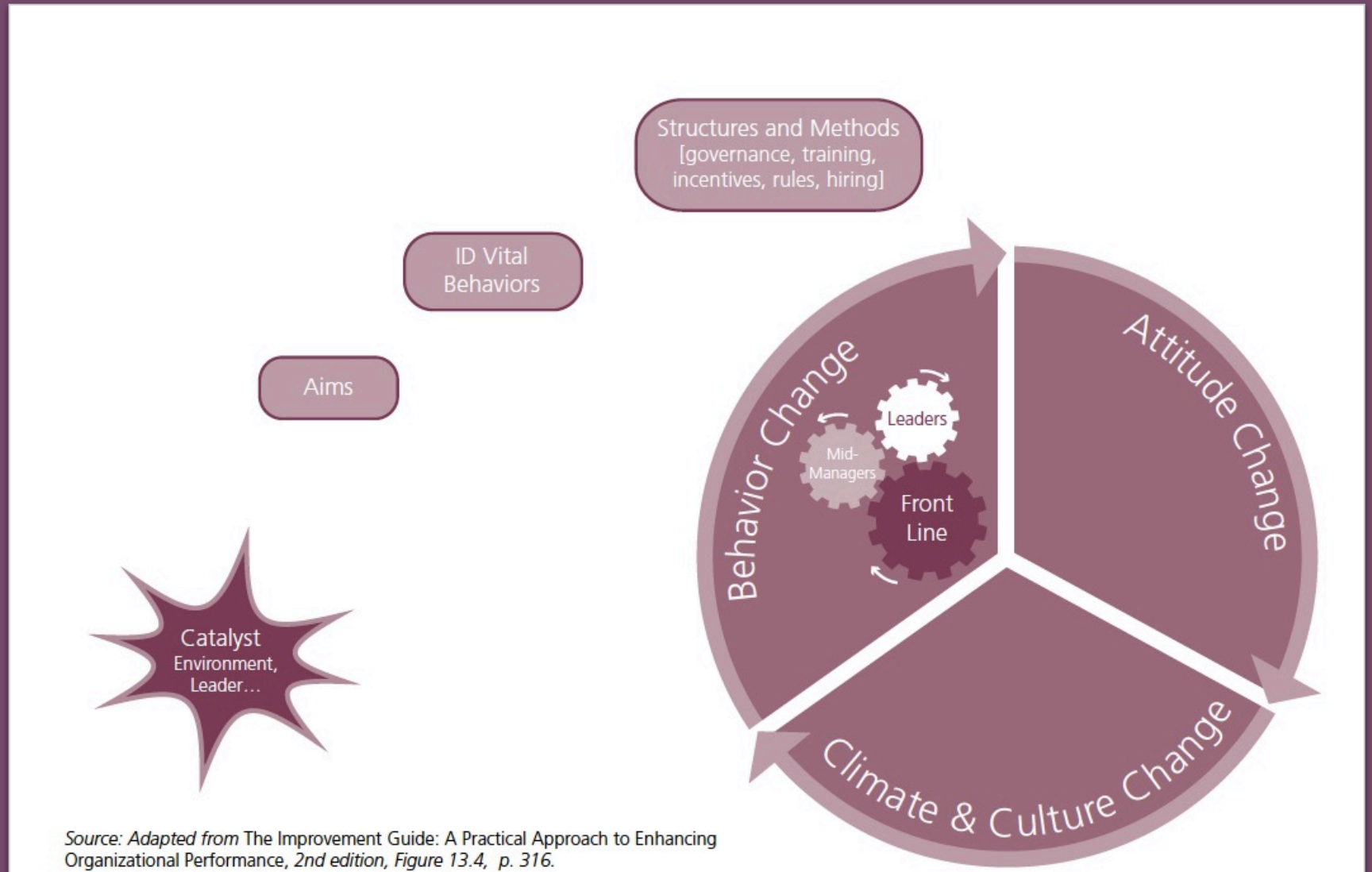


AHRQ Safety Surveys
https://www.ahrq.gov/sops/surveys/hospital/index.html

SECTION C: Communications

How often do the following things happen in your work area/unit?

Think about your hospital work area/unit…	Never	Rarely	Some-times	Most of the time	Always
1. We are given feedback about changes put into place based on event reports	☐1	☐2	☐3	☐4	☐5
2. Staff will freely speak up if they see something that may negatively affect patient care	☐1	☐2	☐3	☐4	☐5
3. We are informed about errors that happen in this unit	☐1	☐2	☐3	☐4	☐5
4. Staff feel free to question the decisions or actions of those with more authority	☐1	☐2	☐3	☐4	☐5
5. In this unit, we discuss ways to prevent errors from happening again	☐1	☐2	☐3	☐4	☐5
6. Staff are afraid to ask questions when something does not seem right	☐1	☐2	☐3	☐4	☐5



Source: Adapted from The Improvement Guide: A Practical Approach to Enhancing Organizational Performance, *2nd edition, Figure 13.4, p. 316.*

Importance of Structures and Methods to influence Culture

Structured Practices for a Culture of Safety

Appreciative Inquiry (Power of the positive)

- Uses appreciation for what is working well and why to discover organisational strengths

  (David Cooperrider, Learning from Excellence)

Humble inquiry (Power of the curious)

- Uses curiosity to help build respectful relationships.

  (*Edgar Schein, QSWR*)

Kindness & Compassion (Power of belonging)

- Uses ideas of kinship to build supportive and nurturing teams (*Penny Campling & John Ballart, Compassionomics, IHI Joy at Work, Schwartz Rounds*)

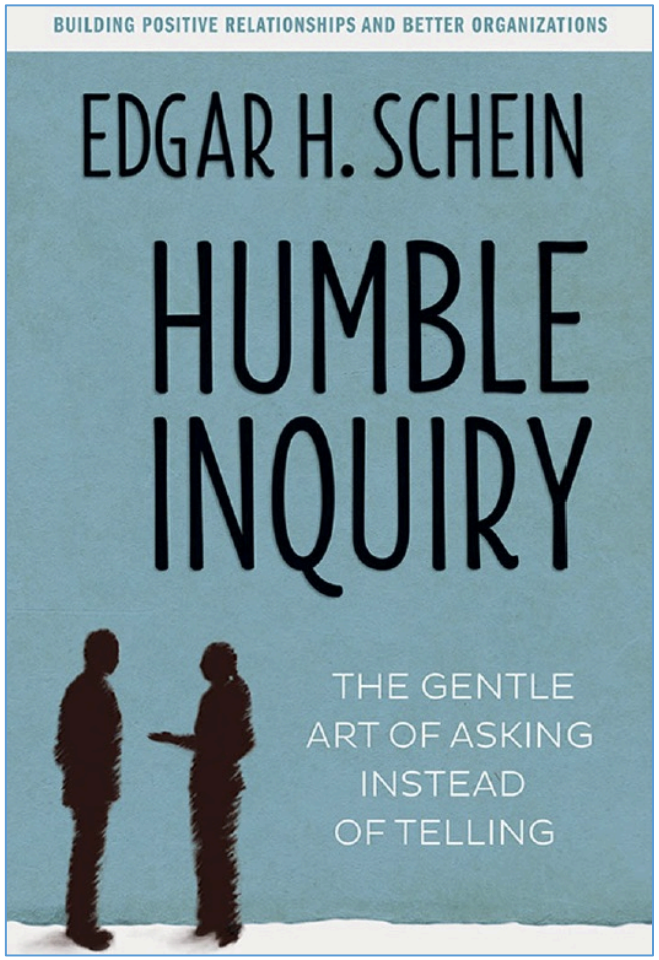
Psychological safety (Power of hearing everyone)

- Uses trust to create a sense of confidence that the team will not embarrass, reject or punish someone for speaking up

  (*Amy Edmondson*)

Humble Inquiry

The Gentle Art of Asking Instead of Telling

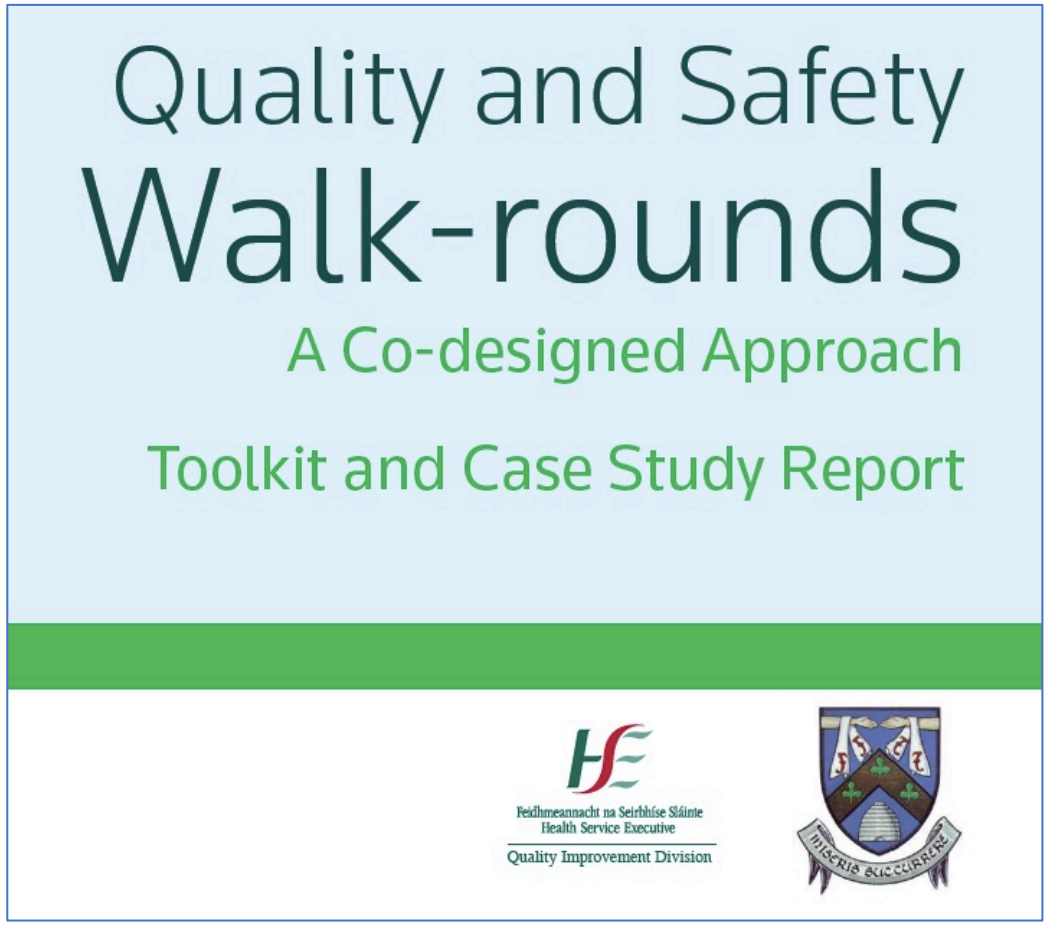


Humble Inquiry is the fine art of drawing someone out, of asking questions to which you do not already know the answer, of building a relationship based on curiosity and interest in the other person.

Edgar H. Schein

Quality & Safety Walk Rounds

www.hse.ie/eng/about/who/qid/governancequality/resourcespublications/

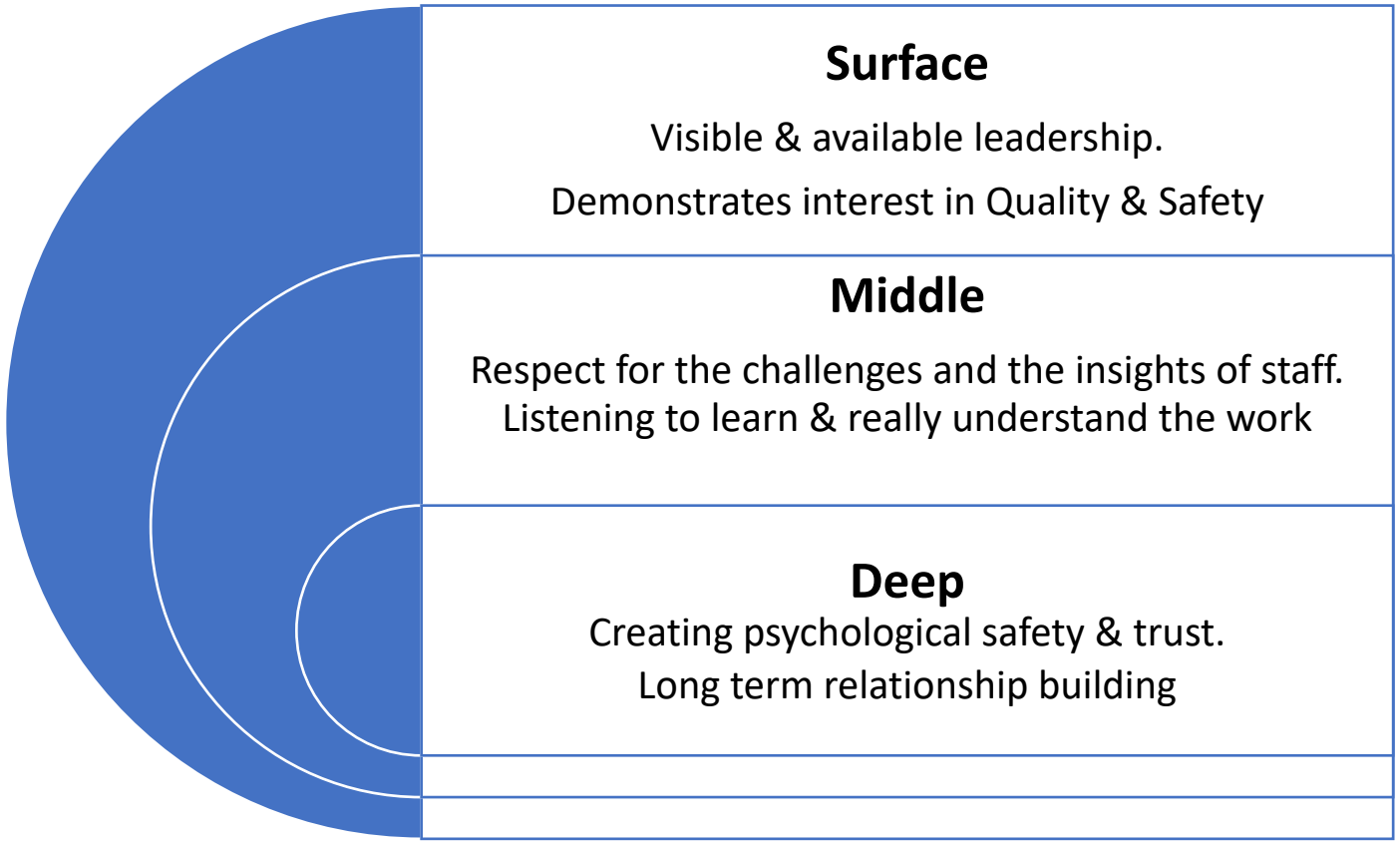


Exposure to Leadership WalkRounds in neonatal intensive care units is associated with a better patient safety culture and less caregiver burnout

J Bryan Sexton,[1,2] Paul J Sharek,[3,4,5] Eric J Thomas,[6] Jeffrey B Gould,[3,4,7] Courtney C Nisbet,[3,4] Amber B Amspoker,[8,9] Mark A Kowalkowski,[8,9] René Schwendimann,[2,10] Jochen Profit[3,4,7]

Providing feedback following Leadership WalkRounds is associated with better patient safety culture, higher employee engagement and lower burnout

J Bryan Sexton,[1,2] Kathryn C Adair,[3] Michael W Leonard,[4,5] Terri Christensen Frankel,[4] Joshua Proulx,[4] Sam R Watson,[6] Brooke Magnus,[7] Brittany Bogan,[8] Maleek Jamal,[9] Rene Schwendimann,[10] Allan S Frankel[4]



Quality & Safety Walk Rounds

3 Levels of Outcome

All can happen at the same time

Schwartz Rounds

Final Report of the Evaluation of the Introduction of Schwartz Rounds in Ireland

Executive Summary | May 2019

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Building a Better Health Service | Seirbhís Sláinte Níos Fearr á Forbairt
National Quality Improvement Team

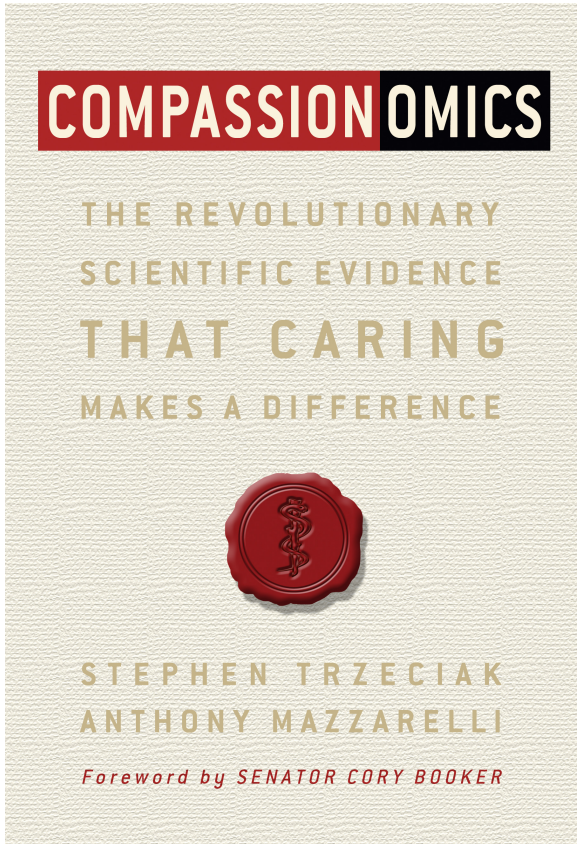
Building a Better Health Service | Seirbhís Sláinte Níos Fearr á Forbairt
National Quality Improvement Team

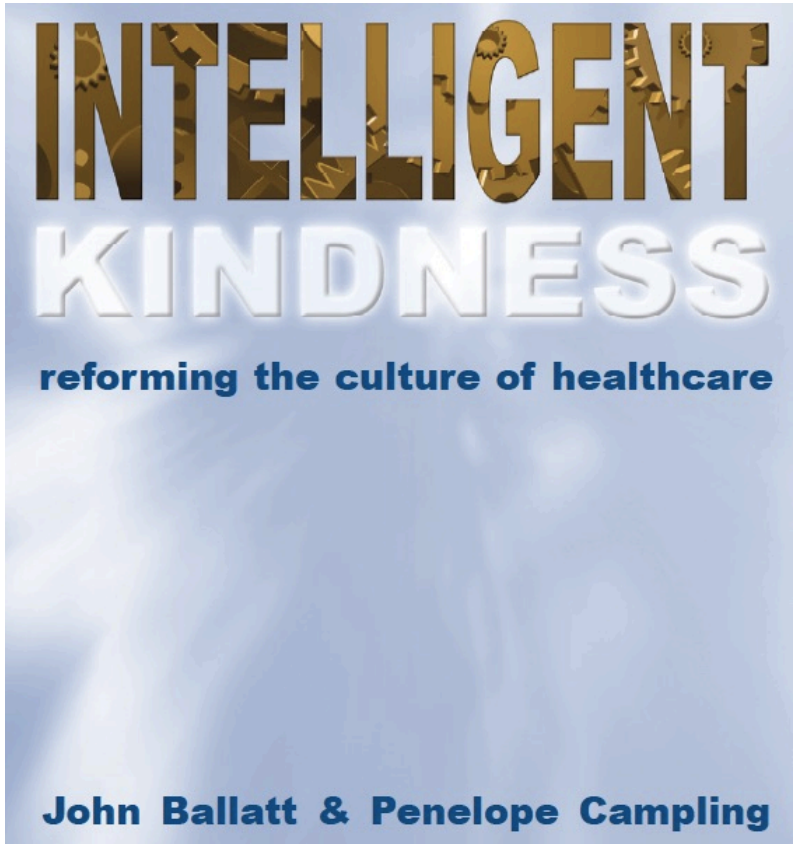
The Point of Care Foundation

What are Schwartz Rounds?

Schwartz Rounds are tightly structured, monthly meetings for multi-professional groups of staff working in health care environments. The Rounds provide an opportunity for staff from all disciplines across a healthcare organisation to reflect on the emotional aspects of their work. The focus is on the human dimension of care.

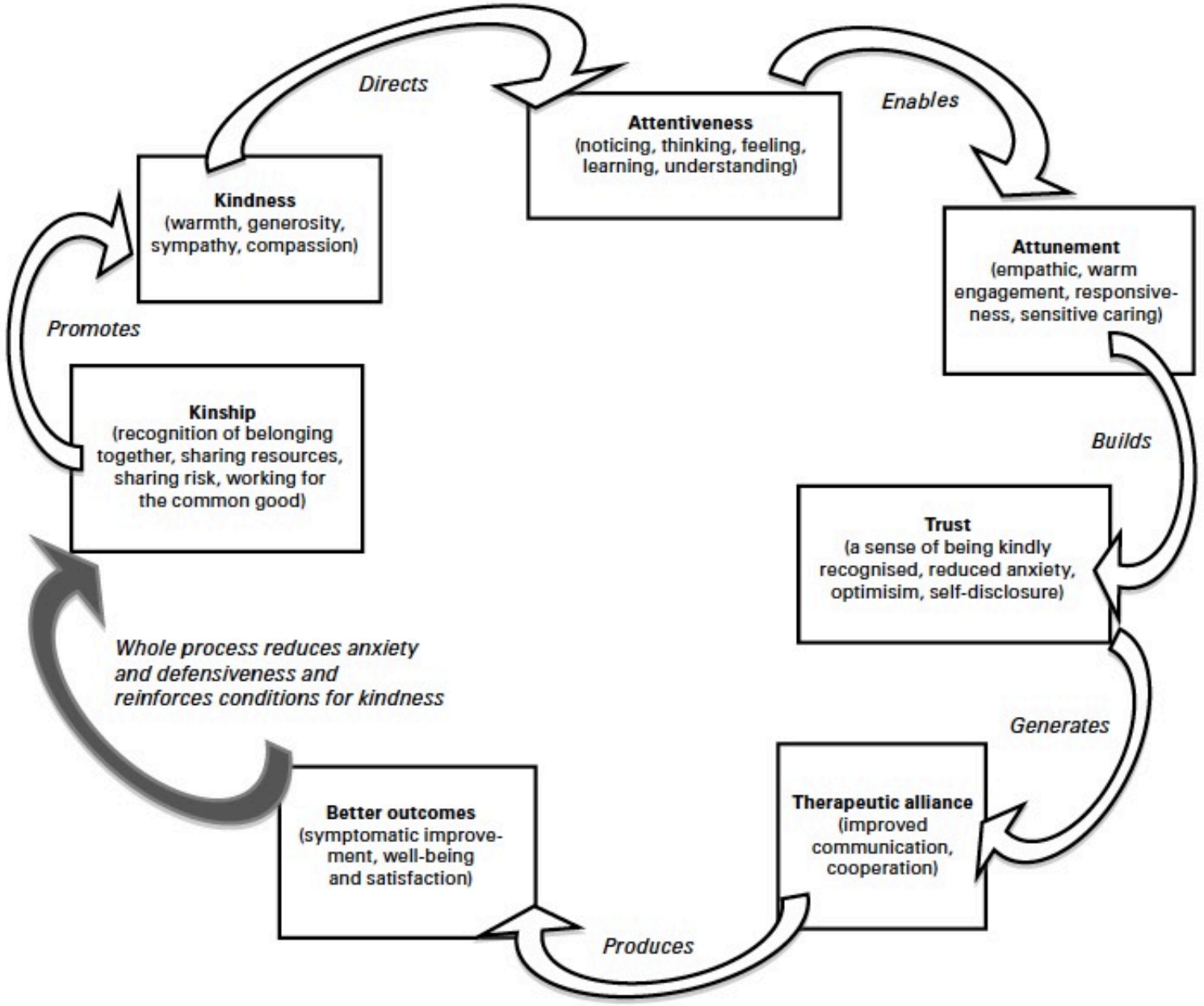
What are staff saying in Ireland about Schwartz Rounds





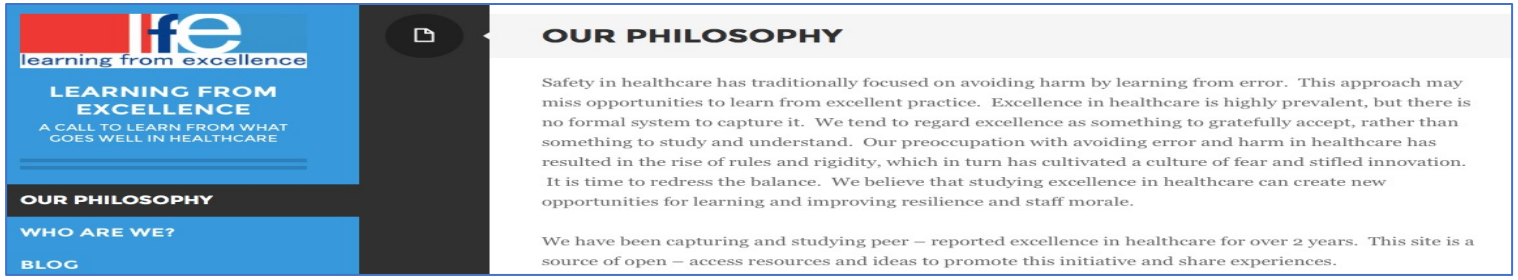
Kindness & Compassion

Virtuous Circle of Kindness



Learning from Excellence

@adrianplunkett



ADC Online First, published on May 4, 2016 as 10.1136/archdischild-2015-310021

Leading article

Learning from excellence in healthcare: a new approach to incident reporting

Nicola Kelly,[1] Simon Blake,[1,2] Adrian Plunkett[1]

> Tell me how you measure me, and I will tell you how I will behave.
>
> Eliyahu Moshe Goldratt[1]

EXCELLENCE IN HEALTHCARE SAFETY

The pursuit of patient safety is a key com-

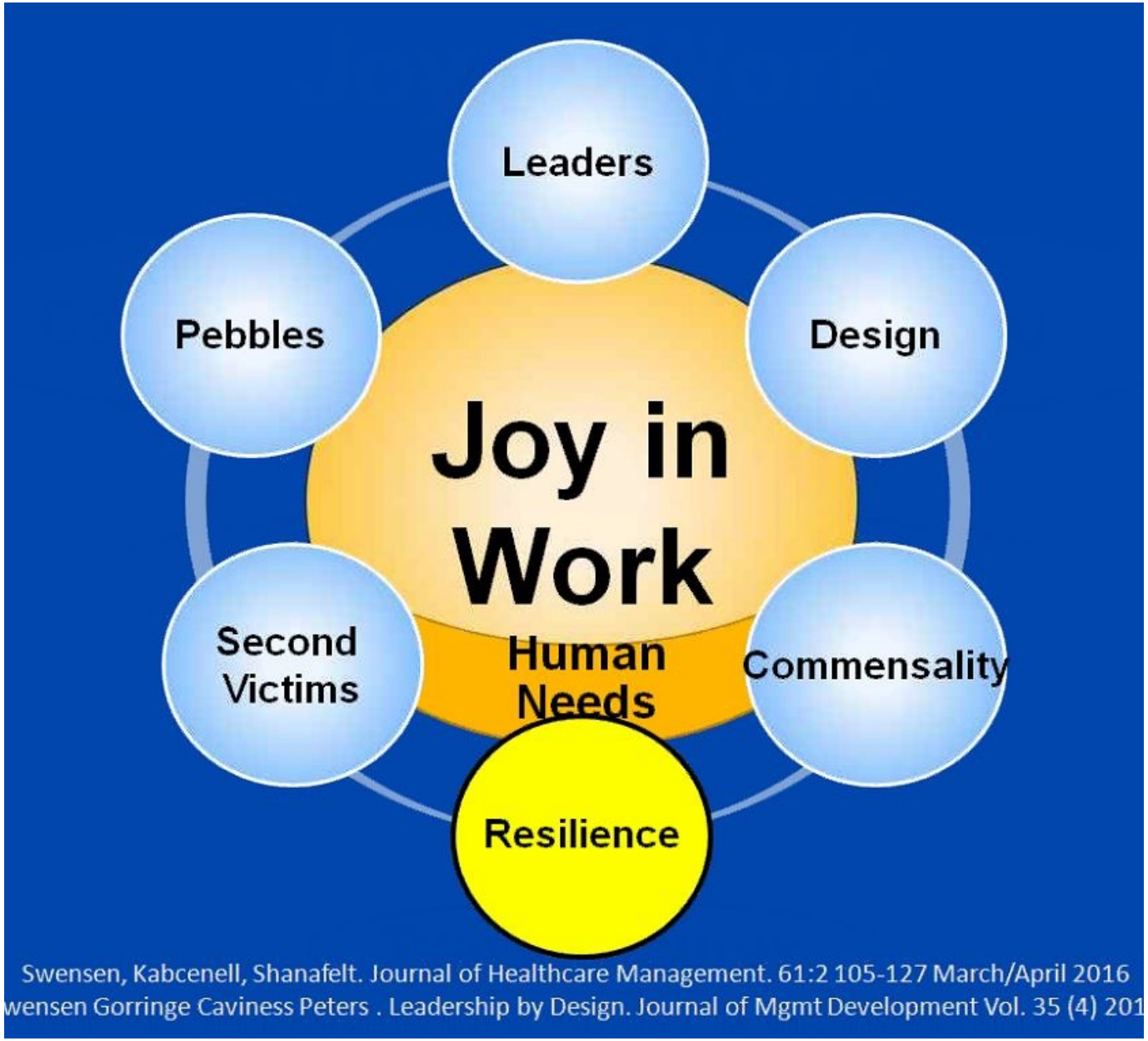
second-victim phenomenon.[10] Effects on second victims may include detachment, anxiety and depression, as well as reduced clinical confidence and cognitive functioning, potentially impairing that individual's clinical performance. Some may go on to

further cultivate a negativity bias within healthcare professionals.[21]

However, recent psychological research has revealed that people can learn effectively both from reflecting on failure (negative reinforcement) and success (positive reinforcement).[22] In fact, animal studies suggest that success and positive experiences have an enhanced positive influence on the brain compared with failure by triggering dopamine surges, thereby improving neural processing and future performance.[23]

Studies involving front-line healthcare

Joy in Work
Swensen et al



The New York Times Magazine

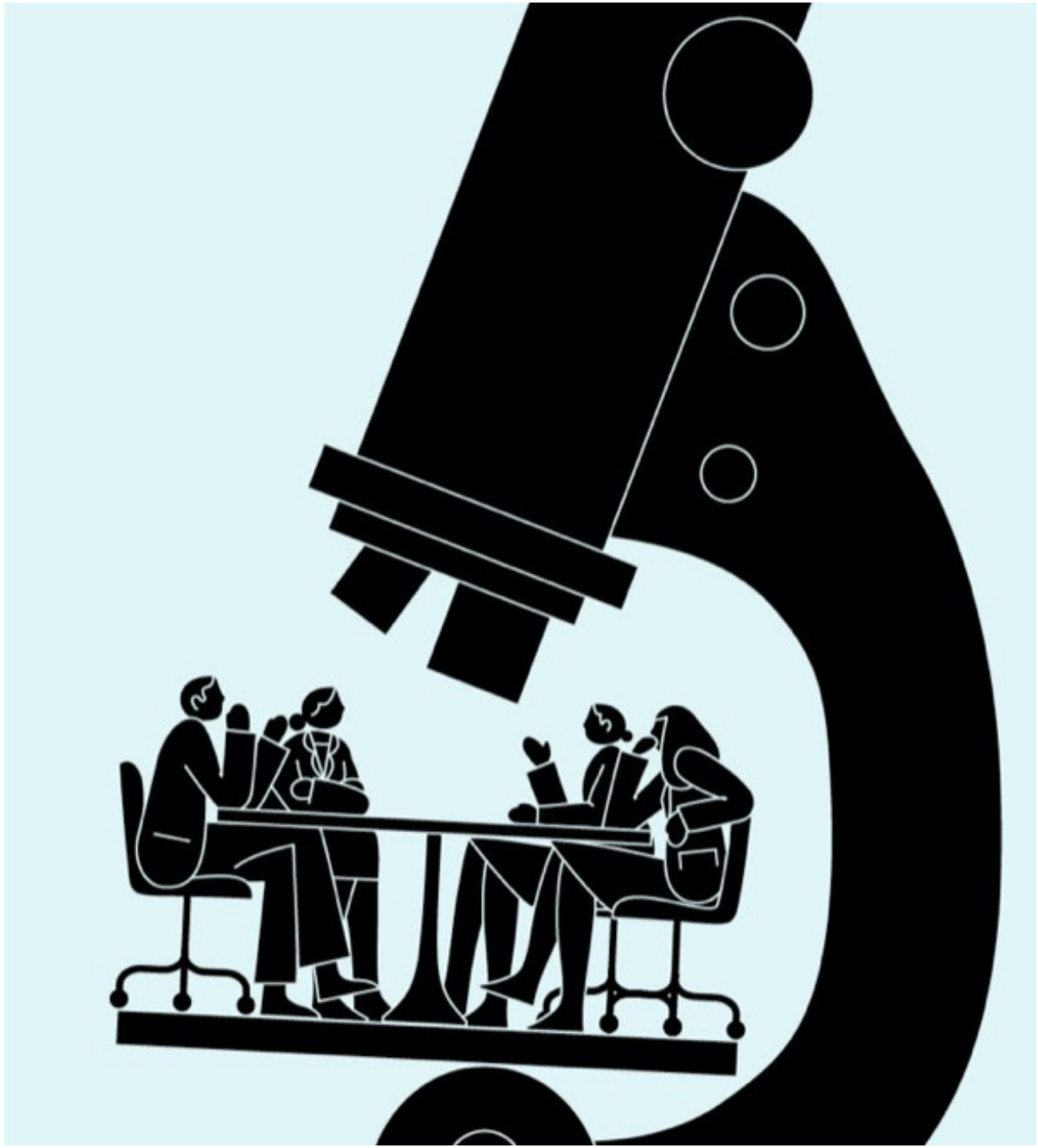
THE WORK ISSUE

What Google Learned From Its Quest to Build the Perfect Team

New research reveals surprising truths about why some work groups thrive and others falter.

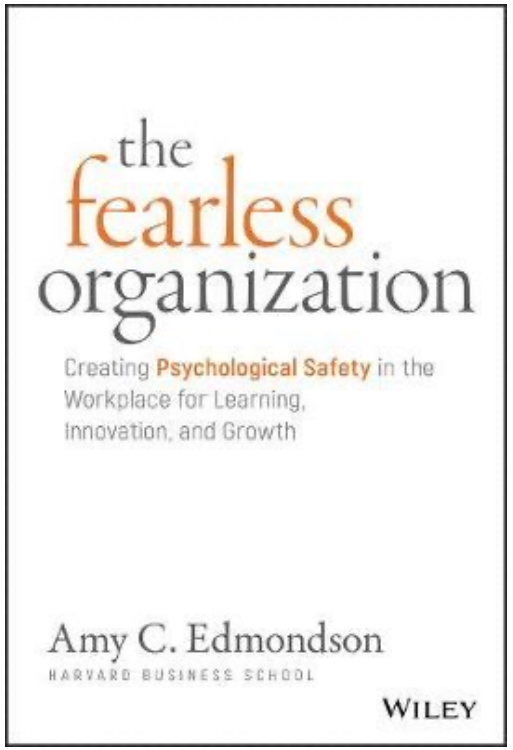
Charles Duhigg

Feb 26th 2016



Psychological Safety

Amy Edmondson



Psychological safety: *a sense of confidence that the team will not embarrass, reject or punish someone for speaking up*

Questions that demonstrate psychological safety:

- Can I ask questions without looking stupid?
- Can I be respectfully critical without looking negative?
- Can I seek feedback without seeming incompetent?
- Can I be innovative without looking disruptive?

Psychological Safety - Rescuing Team Failures

Volume 119 Number 4 Part 1 April 2000

The Journal of
THORACIC
AND
CARDIOVASCULAR
SURGERY

HUMAN FACTORS AND CARDIAC SURGERY: A MULTICENTER STUDY

Marc R. de Leval, MD[a]
Jane Carthey, PhD[a]
David J. Wright, PhD[b]

Objective: To study the role of human factors on surgical outcomes, with a series of 243 arterial switch operations performed by 21 surgeons taken as a model.

Culture needs a Stage

"Never start with the idea of changing culture. Always start with the issue the organisation faces…only when you are clear on this should you ask whether the culture aids or hinders the issue?

Always think of culture as your source of strength – it is the residue of your past successes. Even if some elements of your culture look dysfunctional, remember that they are probably only a few among a large set of others that continue to be strengths"

Edgar H. Schein

BMJ Quality & Safety Online First, published on 6 June 2013 as 10.1136/bmjqs-2012-001467

Huddling for high reliability and situation awareness

Linda M Goldenhar,[1] Patrick W Brady,[2,3] Kathleen M Sutcliffe,[4] Stephen E Muething[1]

► Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/bmjqs-2012-001467).

[1]James M. Anderson Center for Health Systems Excellence, Cincinnati Children's Hospital

ABSTRACT

Background Studies show that implementing huddles in healthcare can improve a variety of outcomes. Yet little is known about the mechanisms through which huddles exert their effects. To help remedy this gap, our study objectives were to explore hospital administrator

opportunities to stay informed, review events, make and share plans for ensuring well coordinated patient care.

Studies show that huddles can improve patient safety[1–4] and can reveal factors that contribute to potentially adverse patient outcomes, such as medication

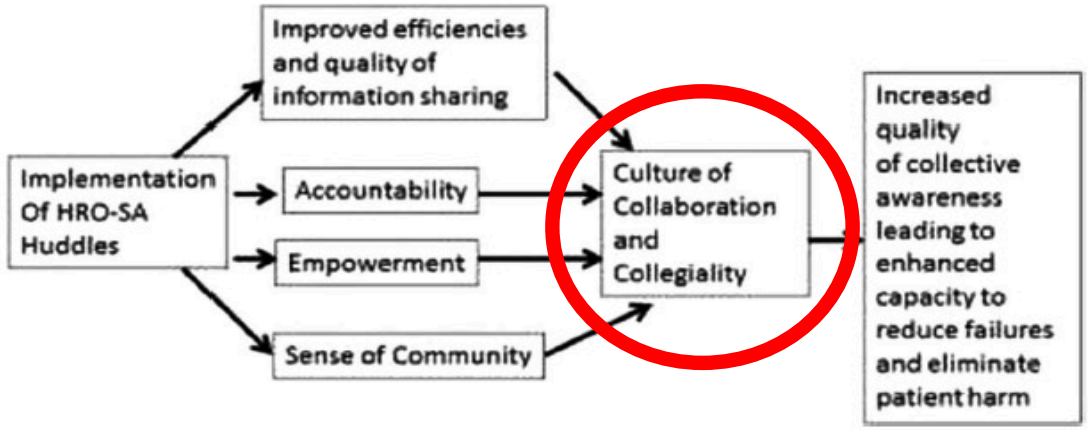
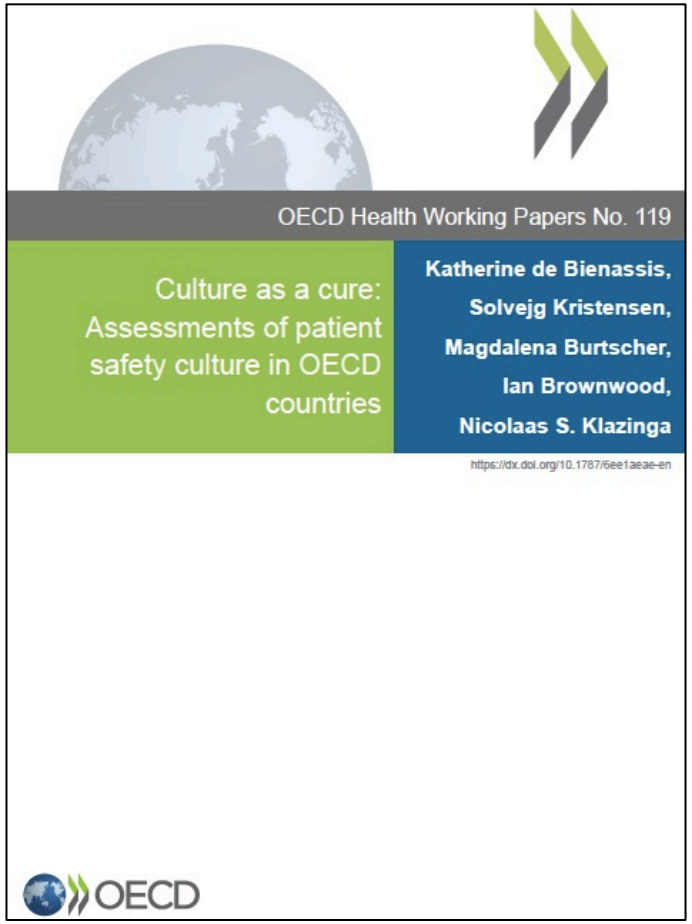


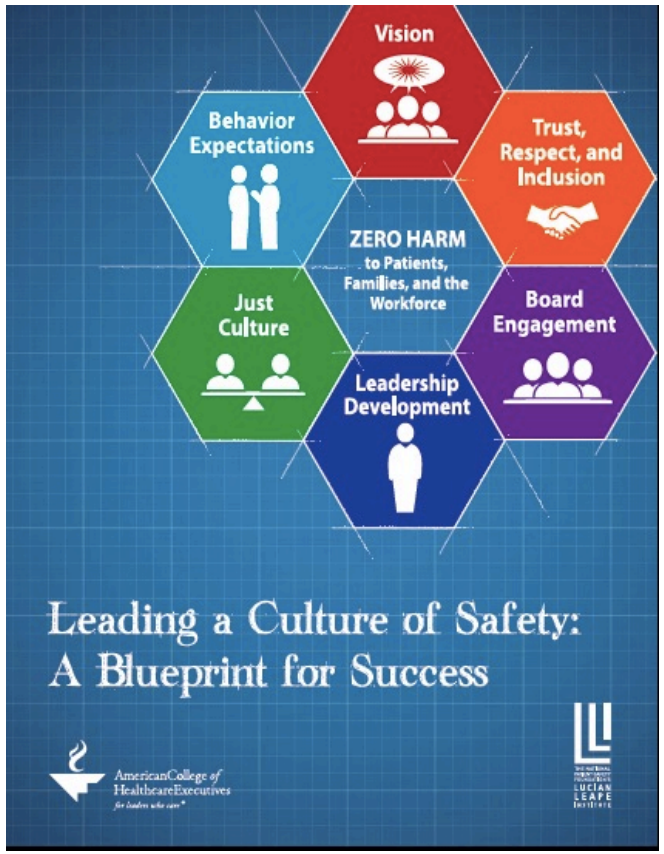
Figure 2 Proposed model of how emerging themes/concepts might work together to improve collective awareness, reduce failures and improve patient care. HRO, high-reliability organisation; SA, situation awareness.

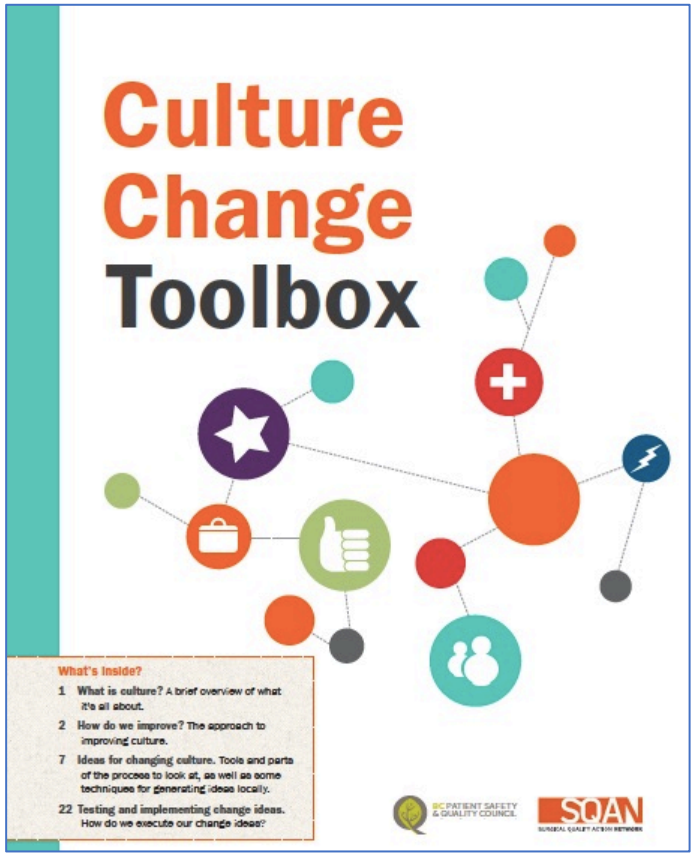
Culture as a Cure – OECD 2020

https://www.oecd.org/health/culture-as-a-cure-6ee1aeae-en.htm



Guides for Leading and Changing Culture





Healthcare Improvement & Leadership Resources

Resource	Website
HSE Framework for Improvement	www.hse.ie/eng/about/Who/QID/
Institute for Healthcare Improvement (IHI) - White Paper on Safe, reliable and effective care - White Paper on Joy in Work	www.ihi.org
Health Foundation - Vincent Framework for Measuring and Monitoring Safety	www.health.org.uk
NHS Leadership Academy	https://www.leadershipacademy.nhs.uk
Aurum Guide for Quality Improvement	Google for PDF – Available from several sites
Healthcare: A Better Way. Transformation Handbook	https://www.healthcatalyst.com/ebooks/healthcare-transformation-healthcare-a-better-way-ebook/
Leading a culture of safety – A Blueprint for Success (Lucian Leape Foundation)	https://www.osha.gov/shpguidelines/docs/Leading_a_Culture_of_Safety-A_Blueprint_for_Success.pdf
Culture Change Toolbox – Surgical Quality Action Network	https://www.patientscanada.ca/site/patients_canada/assets/pdf/culture-change-toolbox.pdf
Human Factors in Health & Social Care – White Paper 2018	https://www.ergonomics.org.uk
The Berwick Report, 2013	Google for PDF