Assessing Safety Culture in Your Health Center

Andrew J. Halperin, MD, Clinical Surveyor
High reliability in healthcare is “maintaining consistently high levels of safety and quality over time and across all health care services and settings”

Chassin & Loeb (2013)
Activities that are highly error-producing:

- Aircraft maintenance
- Delivering health care

Health care is highly error-provoking yet reporting errors is stigmatized and care givers are not trained in error management or detection.

What Would 99% Reliability Mean?

- One hour of unsafe drinking water every month.
- Two unsafe plane landings per day at O’Hare.
- 22,000 checks deducted from the wrong bank account each hour.
- 16,000 pieces of mail lost every hour.
- 20,000 incorrect prescriptions every year.
- 500 incorrect operations each week.

* Adapted from VA National Center for Patient Safety, Oct. 2008
Your Organization’s Commitment to Zero Harm is Important!

- Everyone working in the health care industry - no matter their role - needs to be accountable for safety and quality.

- Reject the idea that some level of harm is okay.

- Clearly communicate your commitment to zero harm within your organization and to your leadership.
How Does a Health Care Organization Achieve Zero Harm?

- Ensure leadership is committed to a goal of zero harm.
- Develop and adopt a safety culture.
- Incorporate process improvement tools and methodologies into your work.
- Demonstrate how everyone is accountable for safety and quality.
HIGH RELIABILITY MODEL FOR HEALTHCARE

Leadership

Commitment to zero harm

Safety Culture

Empowering staff to speak up

Robust Process Improvement®

Systematic, data-driven approach to complex problem solving

Safety Culture Components

- **Trust**: Eliminate Hierarchy & Intimidation issues
- **Accountability**: Balance learning with accountability
- **Identify Unsafe Conditions**: Further upstream from harm
- **Strengthening Systems**: I.D. and repair weaknesses proactively
- **Assessment**: Formal and routine measurement
Sentinel Event Alert: Issue 60

The 4 Es of a Reporting Culture

1. Establish trust
   - Leaders communicate their commitment to building trust and reporting through a safety culture.
   - Governance supports leadership commitment to sustaining trust.

2. Encourage reporting
   - An organization’s incident reporting system is accessible by all staff, easy to use, and encourages unsafe incidents to be reported.
   - The organization’s recognition program includes a feedback loop to staff know that actions are being taken to address the safety problems they have identified.
   - The organization’s policy defines what types of incidents should be reported. Staff may not recognize that a risky occurrence is actually an unsafe event or unsafe condition.

3. Eliminate fear of punishment
   - Those who report human errors and at-risk behaviors are NOT punished, so that the organization can learn and make improvements.
   - Those responsible for at-risk behaviors are coached, and those committing reckless acts are disciplined fairly and equitably, no matter the outcome of the reckless act.
   - Senior leaders, unit leaders, physicians, nurses, and all other staff are held to the same standards.

4. Examine errors, close calls, and hazardous conditions
   - Data is used to identify error-prone situations, the frequency of which they occur, and their potential severity.
   - Data are used to identify success stories of the staff and the system.
   - Learnings are used to help determine what to address, to strengthen the protective processes within the system, and to help staff identify the factors that lead up to a situation and what to look for in similar situations in the future.

See Sentinel Event Alert Issue 60, “Developing a reporting culture: Learning from close calls and hazardous conditions.” For more information, including examples of establishing trust, achieving a just culture to encourage reporting, learning from close calls reporting, leadership engagement and accountability, as well as links to online tools that show leadership communicating, committing to just reporting and learning culture.

https://www.jointcommission.org/assets/1/6/The_4_ES_of_a_Reporting_Culture_SEA_60_Infographic_FINAL.pdf

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Trust
Accountability
Identify Unsafe Conditions
Strengthening Systems
Drive out fear and create trust
- W. Edwards Deming
Safety Culture Challenges

• Aim is not a “blame-free” culture
• A true safety culture balances learning with accountability
• Must separate blameless errors (for learning) from blameworthy ones (for discipline, equitably applied)
• Assess errors and patterns uniformly
• Eliminate intimidating behaviors
Becoming a Learning Organization

— Patient (individual) safety events are opportunities for learning and improvement—high reliability organizations are learning organizations

— Adopt a transparent, nonpunitive approach to reporting

— Every event (from close calls to major harm events) should be reported

— LD.04.04.05
Evolution of Safety Culture

• Today, we mostly react to adverse events

• **Close calls** are “free lessons” that can lead to risk reduction - if they are recognized, reported and acted upon

• **Unsafe conditions** are further upstream from harm than close calls

• Ultimately, proactive, routine assessment of safety systems to identify and repair weaknesses gets closer to high reliability
Assessing Errors Systematically

—When evaluating an error for learning versus discipline address these four questions:

• Was harm intended?
• Evidence of illness or substance abuse
• Could the harm have been foreseen? (Foresight test)
• Would another staff person with similar training have acted in the same way? (Substitution test)
Learning from the Ordinary

- Increasing evidence shows that patient safety work should focus on the ordinary, everyday performance.
- Building understanding of “Work as Done”—the ways trade-offs and performance adjustments are made—will only be possible through a study of the ordinary.

What efforts are in place to recognize patterns of causal factors across the organization?

Efforts to catalog and prioritize system weaknesses--proactively

- **Reactive**
  - Responding to events that have already happened

- **Proactive**
  - Active identification of unsafe conditions through analysis of processes

- **Predictive**
  - Ability to accurately foresee potential problems based on system analysis
A Proactive Approach to Preventing Harm

— Proactive risk assessments are required for most programs (not OME or BHC) but are a high reliability practice regardless of requirements (LD.04.04.05).
  - Sidebar 3 in the Chapter identifies strategies for an effective risk assessment
— The “Strengthening Systems” component in the Safety Culture domain aligns with this concept and is an area of opportunity for the majority of organizations that have taken the Oro 2.0 assessment.
<table>
<thead>
<tr>
<th>Safety Culture</th>
<th>Beginning</th>
<th>Developing</th>
<th>Advancing</th>
<th>Approaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>No assessment of trust or intimidating behavior</td>
<td>First codes of behavior adopted in some clinical departments</td>
<td>CEO and clinical leaders establish a trusting environment among all staff by modeling appropriate behaviors and championing efforts to eradicate intimidating behaviors</td>
<td>High levels of (measured) trust exist in all clinical areas; self-policing of codes of behavior in place</td>
</tr>
<tr>
<td>Accountability</td>
<td>Emphasis on blame; discipline not applied equitably or with transparent standards; no process for distinguishing &quot;blameless&quot; from &quot;blameworthy&quot; acts</td>
<td>Beginning recognition of importance of equitable disciplinary procedures; some clinical departments adopt these procedures</td>
<td>Managers at all levels accord high priority to establishing all elements of safety culture; adoption of uniform equitable and transparent disciplinary procedures begins organization-wide</td>
<td>All staff recognize and act on their personal accountability for maintaining a culture of safety; full adoption of equitable and transparent disciplinary procedures</td>
</tr>
<tr>
<td>Identifying unsafe conditions</td>
<td>Root cause analysis limited to adverse events; close calls (&quot;early warnings&quot;) not recognized or evaluated</td>
<td>Pilot &quot;close call&quot; reporting programs begin in few areas; some examples of early intervention to prevent harm</td>
<td>Staff in many areas begin to recognize and report unsafe conditions and practices before they harm patients</td>
<td>Close calls and unsafe conditions routinely reported, leading to early problem resolution, before patients are harmed; results routinely communicated</td>
</tr>
<tr>
<td>Strengthening systems</td>
<td>Limited or no effort to assess system defenses against quality failures and remedy weaknesses</td>
<td>RCAs begin to identify same weaknesses in system defenses in many clinical areas; systematic efforts to strengthen them are lacking</td>
<td>System weaknesses catalogued and prioritized for improvement</td>
<td>System defenses proactively assessed; weaknesses proactively repaired</td>
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<tr>
<td>Assessment</td>
<td>No measures of safety culture</td>
<td>Some measures of safety culture undertaken but are not widespread; little if any attempt to strengthen safety culture</td>
<td>Measures of safety culture adopted and deployed organization-wide; beginning efforts to improve</td>
<td>Safety culture measures part of strategic metrics reported to Board; systematic improvement initiatives underway to achieve fully functioning safety culture</td>
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The Role of Leaders

— Leaders must provide and encourage use of systems for blame-free reporting. (LD.04.04.05)

— System holds individuals responsible for their actions; does not punish for flawed processes. (LD.04.04.05, EP4 other than OBS)

— Related areas of the Maturity Model: “Trust”, “Accountability”, “Identifying Unsafe Conditions”, and “Strengthening Systems” within the Safety Culture domain
Leadership Session - The purpose of the Leadership Session is to explore where the organization is on the journey to high reliability. This is a facilitated discussion of the characteristics of a high reliability organization, specifically:

- Leadership commitment to improvement of quality and safety
- Creating a culture of safety
- Robust process improvement
- Survey findings that suggest underlying system issues

Tracer Methodology - Using tracer methodology from the Opening Conference, through individual and system tracers, to the Leadership Session and Exit.
Standards

Assessment - LD 03.01.01 EP1: Leaders regularly evaluate the culture of safety and quality.

Strengthening Systems -
- LD 03.01.01 EP 2. Leaders prioritize and implement changes identified by the evaluation (of safety culture).
- LD 03.01.01 EP5. Leaders create and implement a process for managing behaviors that undermine a culture of safety.

Trust/Intimidating Behavior - LD 03.01.01 EP4. Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.

Identifying Unsafe Conditions - LD 04.04.05 EP 3. The scope of the safety program includes the full range of safety issues, from potential or no-harm errors to hazardous conditions and sentinel events.

Accountability/Just Culture - LD 04.04.05 EP 6: The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. Note: This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for their blameworthy errors.
Leadership

- How do you provide a culture of safety?

- What actions do you take to improve your organization’s safety culture, and do you include this as part of the expectations of performance?

- Do you feel your staff would be comfortable reporting close calls, medication errors, or other safety issues that they commit or see?
Leadership

- How are safety issues and close calls reported?
- How do you separate a blameless effort from a blame worthy event?
- Does the organization have a code of conduct and how do you deal with a violation of disrespectful behavior?
- How would you deal with retaliation for reporting a safety event or close call?
- What QI projects has the organization done to improve safety?
Do you feel leadership instills a culture of safety? Why or why not?

Have you ever completed a survey on safety culture?

How comfortable would you feel reporting a close call or safety issue?

What is the mechanism for reporting a close call or safety issue?
When an error occurs, do you feel Leadership will take an appropriate look at how the system or process is the reason versus an individual?

Are you afraid of retribution or retaliation if you report something?

Would you feel uncomfortable reporting intimidating behavior and is there a mechanism to report?

When you realize you are understaffed what kind of changes do you see take place?
<table>
<thead>
<tr>
<th>Question</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>F</th>
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<tbody>
<tr>
<td>How would you rate the overall Patient Safety Grade for this department?</td>
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<td>A- Agree   N-Neutral   D- Disagree</td>
<td>A</td>
<td>N</td>
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<td>Does this department provide learning opportunities and continuous Improvement to promote patient safety?</td>
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<td>Is there open communication within the department to encourage staff to speak freely when circumstances or issues related to patient safety arise?</td>
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<td>Are there clear expectations for reporting safety issues?</td>
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<td>Are staff suggestions heard and addressed?</td>
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<td>Is there feedback and opportunities to review patient safety events?</td>
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<td>Do you feel like events reported are held against you- Nonpunitive Response to Error</td>
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<td>Is there appropriate staffing in this department to promote patient safety?</td>
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<td>Does the department provide a climate that supports patient safety?</td>
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<td>Do team members in this department work together, support each other and treat each other with respect?</td>
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<tr>
<td>Please identify what you consider to be the top 2 safety issue for this department</td>
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<td>2.</td>
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<td>Goals- Please identify one safety goal for this department</td>
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Using Assessment Results

- Leadership mistake:
  ✓ Asking what staff think (i.e., via survey) and then deciding what they said.

- Appreciative inquiry to understand by asking ‘why they said what they said’.
Safety Culture Assessment

Key factors:

- Frequency and distribution important
- Results are used to make improvements
- Metrics around improvement efforts reported to senior leadership/Board
What to look for

− Examples of things we might see on survey that exemplify the “learning organization”:
  − Daily safety briefings
  − Unit-based or department based huddles
  − Senior leadership rounds
− How is the organization using this information to improve safety in the organization?
− What PI tools are used to help learn?
− Is there leadership visibility to the frontline to help improve trust?
Using Data to Improve Performance

 Organizations sometimes struggle to connect their data with their performance improvement priorities.

- What are the biggest quality and safety problems an organization is facing?
- How do they know?
- Are the PI projects aligned with their data?
- Are proactive safety assessments based on data?
- Is outcomes data used to recreate (simulate) problematic situations?
Resources:

11 Tenets of a Safety Culture
Patient Safety Systems (PS)

Introduction
The quality of care and the safety of patients are core values of The Joint Commission accreditation process. This is a commitment The Joint Commission has made to patients, families, health care practitioners, staff, and home care organization leaders. This chapter exemplifies that commitment.

The intent of this “Patient Safety Systems” (PS) chapter is to provide home care organizations with a proactive approach to designing or redesigning a patient-centered system that aims to improve quality of care and patient safety, an approach that aligns with the Joint Commission’s mission and its standards.

The Joint Commission partners with accredited home care organizations to improve home care systems to protect patients. The first obligation of health and home care is to “do no harm.” Therefore, this chapter is focused on the following three guiding principles:

1. Aligning existing Joint Commission standards with daily work in order to engage patients and staff throughout the health care system, at all times, on reducing harm.
2. Assisting home care organizations with advancing knowledge, skills, and competence of staff and patients by recommending methods that will improve quality and safety processes.
3. Encouraging and recommending proactive quality and patient safety methods that will increase accountability, trust, and knowledge while reducing the impact of fear and blame.

Quality and safety are inextricably linked. Quality in health and home care is the degree to which its processes and results meet or exceed the needs and desires of the people it serves. Those needs and desires include safety.

The components of a quality management system should include the following:

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Questions?