Building Your Safety Culture: A Job for Leaders

Mark R. Chassin, MD, FACP, MPP, MPH
President and CEO, The Joint Commission

Safety Culture Webinar
April 27, 2017
Griffin Hospital: Insulin pen misuse could have infected patients with diseases

3000 patients over 6 years
'You're taking out wrong kidney, surgeon was told'

by CLARE KITCHEN, Daily Mail

A surgeon accused of killing a patient by taking out the wrong kidney was warned he was making a mistake by a medical student watching the operation, a court heard yesterday.

Dr Mahesh Goel dismissed the concerns of student Victoria Fern and pressed on with the surgery, it was said.

Goel and consultant urologist John Roberts are accused of manslaughter over the 'appalling error' which left 70-year-old Graham Reeves with one diseased kidney.

The Korean War veteran died five weeks after the botched operation.

Roberts, 59, and Goel, 39, had shown a level of care far below that which is expected of competent surgeons, prosecutor Leighton Davies QC said.

'It was a drastic surgical error described by Mr Roberts himself in the aftermath as the worst thing he had done in his life,' said Mr Davies. 'He says it was an appalling error.'

Mr Reeves, who was single, was due to have his damaged right kidney removed. But the surgeons removed his left kidney and before the mistake was realised it was put in a jar of acidic sterilising agent.

'The right kidney was diseased for years and non-functioning,' Mr Davies told Cardiff Crown Court.

'The operation played a significant part in causing his death. It deserves to be condemned as gross negligence and therefore a crime.'
10. Failure to Embrace a Culture of Safety
Current State of Quality

Routine safety processes fail routinely
- Hand hygiene
- Medication administration
- Patient identification
- Communication in transitions of care

Uncommon, preventable adverse events
- Surgery on wrong patient or body part
- Fires in ORs, retained foreign objects
- Infant abductions, inpatient suicides
Current State of Improvement

We have made some progress
• Project by project: leads to “project fatigue”
• Satisfied with modest improvement

Current approach is not good enough
• Improvement difficult to sustain/spread
• Getting to zero, staying there is very rare

High reliability offers a different approach
• The goal is much more ambitious
• High reliability is not a project
High Reliability Healthcare

Our team has worked for 8 years with academics and experts from HROs (nuclear, aviation, military, amusement parks)

We have created a model for healthcare:

• Leadership committed to goal of zero harm
• Safety culture embedded throughout
• RPI (lean, six sigma, change management)

Everyone’s job is protecting patients

New resources, tools, and programs
High Reliability

Leadership

Trust

Improve

Report

RPI

Health Care

Safety Culture

The Joint Commission
Safety Culture

- Aim is not a “blame-free” culture
- HROs separate blameless errors (for learning) from blameworthy ones (for discipline, equitably applied to all groups)
- Prerequisites for safety culture in health care
  - Eliminate intimidating behaviors
  - Hold everyone accountable for consistent adherence to safe practices
- HROs balance learning and accountability
What Behaviors are Intimidating?

Wide range: impatience to physical abuse

Most common?

Refusal to answer questions or to return phone calls or pages; condescending tone or language; impatience with questions

2013 ISMP survey: 11-15% personally experienced these from MDs and non-MDs >10 times in past year
11 Tenets of a Safety Culture

Definition of Safety Culture
Safety culture is the sum of what an organization is and does in the pursuit of safety. The Patient Safety Systems (PS) chapter of The Joint Commission accreditation manuals defines safety culture as the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization’s commitment to quality and patient safety.
Behaviors that undermine a culture of safety

Intimidating and disruptive behaviors can foster medical errors,(1,2,3) contribute to poor patient satisfaction and to preventable adverse outcomes,(1,4,5) increase the cost of care,(4,5) and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. (1,6) Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.
Mean Girls of the ER: The Alarming Nurse Culture of Bullying and Hazing

It's not only threatening the profession, it's putting patients' lives at risk.
## Results from ISMP

<table>
<thead>
<tr>
<th>“At least once” in past year (%)</th>
<th>2003</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assumed order correct to avoid contact</td>
<td>39</td>
<td>33</td>
</tr>
<tr>
<td>2. Asked colleague to talk to prescriber</td>
<td>39</td>
<td>38</td>
</tr>
<tr>
<td>3. Pressured to act, despite safety concern</td>
<td>49</td>
<td>39</td>
</tr>
<tr>
<td>4. Assumed order safe due to reputation</td>
<td>34</td>
<td>30</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Past disrespectful behavior altered handling of order clarification or questions (% YES)</th>
<th>2003</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>49</td>
<td>44</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My organization deals effectively with disrespectful behavior (% NO)</th>
<th>2003</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>56</td>
<td></td>
</tr>
</tbody>
</table>
Bad News

Do you get bad news? Regularly?
• Do you encourage delivery of bad news?
• Do you or others “shoot the messenger?”

The routine identification and reporting of unsafe conditions, errors, and other forms of “bad news” are critical to improvement.

Karl Weick (renowned HRO scholar):
“There is always bad news. If you’re not getting any, someone is hiding something.”
Leadership and Safety Culture

Does the Board set expectations for improving safety culture?

How do you measure safety culture?

• Do you include safety culture goals in performance expectations for leaders?

• What about middle management?

“It doesn’t matter what the CEO says if my supervisor promotes an unsafe environment”
Eliminating Disrespectful Behavior

- How widespread is disrespectful behavior?
- Do you measure it?
- Code of conduct to eliminate intimidating behavior? (LD.03.01.01 EP 4)
  - Acceptable and unacceptable behaviors
  - Calibrated enforcement mechanisms
- Accountability: How do you deal with serial violators of safety protocols?

Are your disciplinary procedures equitable and transparent?
A Case Summary

80+ yo with multiple problems, admitted with order for phenytoin 300 mg TID
⇒ Resident consulted EDR for meds
⇒ Pharmacist caught error--told MD, RN
⇒ No follow through to next shifts
⇒ RN sees order, but no dispensed med
⇒ She uses another patient’s phenytoin
⇒ Continues for 3 days; patient delirious
Assessing Errors Systematically

How do we decide whether discipline should be considered in evaluating errors?

Critical to establishing trust is having the same process for all caregiver groups.

Use these four tests:

1. Deliberate harm test
2. Incapacity test
3. Foresight test
4. Substitution test
Nurse serial killer: estimated 400 murders in 9 NJ/PA facilities over at least 15 years
Foresight Test

Key question: Did the individual depart from agreed safe practices or protocols?

If yes, were the protocols or procedures:

- available
- intelligible
- workable
- correct
- in routine use

Were there mitigating circumstances?
Substitution Test

Would another person from the same professional group, with similar training and experience, behave the same way in similar circumstances?

Were there deficiencies in training, experience or supervision?

Were there mitigating circumstances?

Answers plus magnitude of risk taken by individual lead to different levels of severity of disciplinary options
Assessing Errors Systematically

Deliberate harm test

Were the actions intended?

Yes

Was harm intended?

No

Incapacity test

Does there appear to be evidence of ill health or substance abuse?

No

Yes

Were the actions intended?

No

Incapacity test

Yes

Did the individual depart from agreed protocols or safe procedures?

No

Substitution test

Would another individual coming from the same professional group, possessing comparable qualifications & experience, behave in the same way in similar circumstances?

No

Yes

Yes

Was harm intended?

Yes

Identify system failures

CONSIDER
• Summarily suspend/terminate
• Police
• Report to state quality investigation office
• Report to National Practitioner Databank (NPDB)

IDENTIFY
SYSTEM FAILURES

CONSIDER
• Discipline
• Potential adjustment to clinical duties
• Corrective training/education
• Improved supervision
• Refer to Employee Assistance Program

IDENTIFY
SYSTEM FAILURES

CONSIDER
• Discipline
• Report to NPDB
• Potential adjustment to duties
• Report to state quality investigation office
• Refer to Employee Assistance Program

IDENTIFY
SYSTEM FAILURES

CONSIDER
• Police
• Report to state quality investigation office
• Corrective training/education

SYSTEM FAILURE

Foresight test

Were the protocols and safe procedures available, workable, intelligible, correct and in routine use?

No

Yes

Were there any deficiencies in training, experience or supervision?

No

Yes

Were there significant mitigating circumstances?

No

Yes

SYSTEM FAILURE

Substitution test

Can another individual from the same professional group, possessing comparable qualifications and experience, behave in the same way in similar circumstances?

No

Yes

Yes

System failure
Accountability

- Health care also fails to apply disciplinary procedures equitably and uniformly
- Lack of uniform accountability also erodes trust, stifles reporting of unsafe conditions
- Belief in a completely “blame-free culture” further impairs progress toward accountability
- Striking the balance is critical:
  - Learning from blameless errors
  - Accountability for adhering to safe practices
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 on.
- Unsafe conditions are further upstream from harm than close calls.
- Proactive, routine assessment of safety systems to identify and repair weaknesses gets closer to high reliability.
High Reliability Initiatives

Learning from the nuclear industry: INPO

- Multi-part collaboration, including federal relations, standards, and survey methods
- Focus on safety culture

“Traits of a Healthy Nuclear Safety Culture”

- Personal accountability, questioning attitude, effective communication
- Leadership actions, decision making, work environment, management systems
Changing Organizational Culture

Safety culture can be addressed directly

It can also be established indirectly

- Multidisciplinary teams doing improvement
- “Diagonal slice” through the organization
- Promotes respect for different perspectives
- Breaks down silos within organization

Doing it right requires the right tools, methods

We use “RPI” at The Joint Commission
Robust Process Improvement

Systematic approach to problem solving: (RPI = lean, six sigma, change management)

The Joint Commission has fully adopted RPI
- Improve processes and transform culture
- Focus on our customers, increase value

The Joint Commission is adopting all components of safety culture

We measure RPI and safety culture and report on strategic metrics to Board
Lean and Six Sigma

- Lean empowers employees to identify and act on opportunities to improve processes
- Lean tools increase value by eliminating steps in processes that represent pure waste
- Six sigma improves outcomes of processes by identifying and targeting causes of failure
- Together they are a systematic, highly effective toolkit for process improvement

Lean and six sigma routinely produce 50%+ improvement
Technical Solution is Not Enough

Lean, six sigma provide technical solutions to standardize markedly improved processes

Why does improvement fail so often?

• Not for lack of a good technical solution
• Failures occur when organization fails to accept and implement a good solution it had

RPI addresses this challenge directly

Change management = a systematic way to implement and sustain good solutions
Technical Solution is Not Enough

Lean, six sigma provide technical solutions to standardize markedly improved processes.

Why does improvement fail so often?

- Not for lack of a good technical solution
- Failures occur when organization fails to accept and implement a good solution it had

RPI addresses this challenge directly

Change management = a systematic way to implement and sustain good solutions

Change management is the rocket science of improvement
Facilitating Change™

Key components of managing change

1. **Plan**: engage all stakeholders, identify sponsor, champion and process owner

2. **Inspire**: paint a convincing picture of how beneficial the change will be

3. **Launch**: initiate the change, intensify communication to stakeholders

4. **Support**: sustain the improvement; empower process owner

Change management is not linear
Getting Started

- Identify and engage all relevant stakeholders
- Highly effective catalyst for safety culture
- “ARMI” analysis
  - Approvers
  - Resources
  - Members
  - Interested parties
- Different roles at different phases of change
- Revisit periodically during change process
Training and Deployment

We have a large group of experts in lean, six sigma, and change management (RPI)

• Studied experience of major corporations (for example, GE, Lilly, BD, Cardinal)
• Extensive experience with 27 hospitals and systems applying RPI tools

We are training hospitals and systems to:

• Create the capacity to be self-sustaining
• Embed RPI throughout their organizations
RPI and Safety Culture

- RPI helps to produce a “system” culture
  - Greatly enhances teamwork, safety culture
  - Teaches respect for all perspectives
  - Staff take pride in their accomplishments
- One systematic approach to problem solving
- Focus RPI on most important strategic goals: quality, finance, patient experience
- Get Board members involved
Establishing a safety culture is vital for improvement for all health care organizations

- Eliminate disrespectful behavior
- Encourage reports of unsafe conditions
- Equitable, consistent accountability

Multifaceted approach most likely to succeed

- Adopt uniform approach to quality
- Involve all levels of staff in improvement

Joint Commission has many tools to help