Culture of Safety: Moving to Accountability

Ohio Patient Safety Institute Teleconference Series

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Background

- Medical errors and patient safety are a national concern
- We are legally and ethically obligated to hold individuals accountable for their competency and behaviors that impact patient care
- A punitive culture does not take into account systems issues and a blame-free culture does not hold individuals appropriately accountable

Culture Definition

- "Set of shared implicit assumptions that a group holds and that determines how it perceives, thinks about, and reacts to its various environments"
- In short, it is shared values, attitudes, and beliefs

Safety Culture

An environment that:

- Encourages reporting
- Ends blame
- Involves senior leadership, and
- Focuses on systems

Patient-Centric Safety Culture

- In order to foster a patient-centric safety culture there are 5 major sub-cultures that must be recognized and developed:
  - *Reporting Culture*
  - *Flexible Culture*
  - *Learning Culture*
  - *Wary Culture*
  - *Just Culture*

Reporting Culture

What does it look like?

The system encourages and readily reports errors and near misses. It reports errors so that others may benefit from shared learning.

Strategies

- Focus on events and near misses
- Failure Modes and Effects Criticality Analysis (FMECA)
- Discuss "close calls" and "good catches"
- Develop a documentation system that is easy to use
- Focus on story telling and knowledge sharing
- Use performance improvement to reduce errors and improve systems

Flexible Culture

What does it look like?

The system is nimble enough to keep pace with rapid changes.

Strategies

- Rapid Cycle Changes
- Ensure shared leadership--this becomes the hallmark of the organization
- Cultivate an environment of respect, collaboration and trust

Learning Culture

What does this look like?

The system is capable and ready to gain knowledge from experience and data. It is willing to implement major changes when warranted.

Strategies

- Foster learning through shared communication
- Develop the ability to adapt to a changing environment and be receptive to change
- Front-line staff are supported to take initiative to problem solve unique situations
- Individual performance is linked to team performance

Wary Culture

What does it look like?

All members are continuously "aware" of the unexpected. All are vigilant and recognize that at any given moment an untoward event can occur.

Strategies

- Go looking for trouble
- Conduct patient safety walk-arounds
- Become preoccupied with finding opportunities for improvement
- Challenge assumptions
- Embrace the concept that "best is the enemy of better"

Just Culture

What does it look like?

An environment of trust and fairness where it is safe to report and learn from mistakes and system flaws; where everyone is clear about the distinction between human error in unreliable systems, unintentional risky behavior, and intentional risky behavior.

Tenets of a Just Culture

- Reporting and learning are valued
- People are encouraged and rewarded for recognizing and reporting essential safety related information
- This approach to patient safety is evidence based
- Leaders and human resource systems are accountable to assure the system achieves it

Key Component of Just Culture

Just culture is not a non-punitive environment, but rather an environment where actions are analyzed to insure that individual accountability is established and appropriate actions are taken.

Our Long Journey Towards a Safety- Minded Culture

- Punitive Culture (Prior to 1990)
- Blame-Free Culture (By mid 1990's)
- Just Culture (21st Century Strategy)

Swinging Pendulum

- We have moved from "name, shame, and blame", to an "amnesty for all" approach, and now we a sitting at a mid-point-"Just Culture".

Obstacles to Achieving a Fair and Just Culture

- Persuasion of senior leadership of need and commitment of adequate resources
- "Right " kind of respected people with the passion and the energy to run the system
- Too much irrelevant data-Princess Diana
- Getting and keeping staff on board
- Societal/legal "**someone must pay**" expectation in healthcare
- Criminalization of Medical Errors-Wisconsin Case

Strategy to Develop a Just Culture

- Implement an Accountability Model designed to shift the focus from errors and outcomes to system design and behavioral choices.
  - *David Marx, Just Culture Algorithm*
  - *James Reason, Unsafe Acts Accountability Model*

Employees are Accountable

- For performance consistent with role and organizational values
- To act in ways that avoids risk to patients
- For respectful behavior
- To report critical events and good catches
- To stop any potentially unsafe act
- To identify unsafe systems or accidents waiting to happen
- To know what resources are available to help assure safe, reliable care
- To identify bad policies/procedures
- To participate when adverse events happen to help prevent similar future events
- To contribute to the design of reliable systems

Leaders are Accountable

- To role model all employee accountabilities
- To promote a fair and just culture
- To assure respectful behavior for all
- To set high performance standards, coach to improve performance, provide resources to achieve success
- To develop teamwork skills
- To note when behaviors drift from safe to at-risk to actively seek and listen to employee concerns about unsafe systems and to take appropriate action
- To role model leadership behaviors when things go wrong- both immediate and related to disclosure

Three Types of Behavior Involved in Error

- Human Error
- At-Risk Behavior
- Reckless Behavior

❖ *Each type of behavior has a different cause, so a different response is required.*

Human Error

- Unintentional and Unpredictable
- Arise from weaknesses in the system
- Manage through process, system, or environment changes
- Discipline is not warranted or effective

Manage Human Error by:

Consoling the worker and shoring up systems to prevent future errors

At-Risk Behaviors

- "To Drift is Human"- we are programmed to drift into unsafe acts
- Lose perception of risk attached to everyday behaviors
- Driven by perception of consequences
  - Immediate and certain consequences are strong
  - Delayed and uncertain consequences are weak
  - Rules are generally weak

Drift to Unsafe Behaviors is Often Rooted in the System

- Safe behavioral choices may invoke criticism and at-risk behaviors may invoke rewards

- ***Unfortunate Reality***

Nurse who takes longer to administer medications may be criticized, but a nurse who is able to handle a half-dozen new admissions on a shift may be admired even if dangerous shortcuts are taken.

What is the Objective?

The solution is not to punish those who engage in at-risk behaviors, but to uncover the system based reasons for behavior and decrease staff tolerance for it.

"The best car safety device is a rear-view mirror with a cop in it".

Dudley Moore

Managing At-Risk Behaviors

- Managed by changing behavioral choices
  - Managed by adding forcing function (barriers to prevent non-compliance)
  - Managed by changing perception of risk
  - Managed by changing consequences

Reckless Behavior

- Workers who behave recklessly:
  - Always perceive the risk he or she is taking
  - Understand that the risk is substantial
  - Behave intentionally (unable to justify the behavior)
  - Know that others are not engaging in the same behavior
  - Make a conscious choice to disregard the substantial and unjustifiable risk

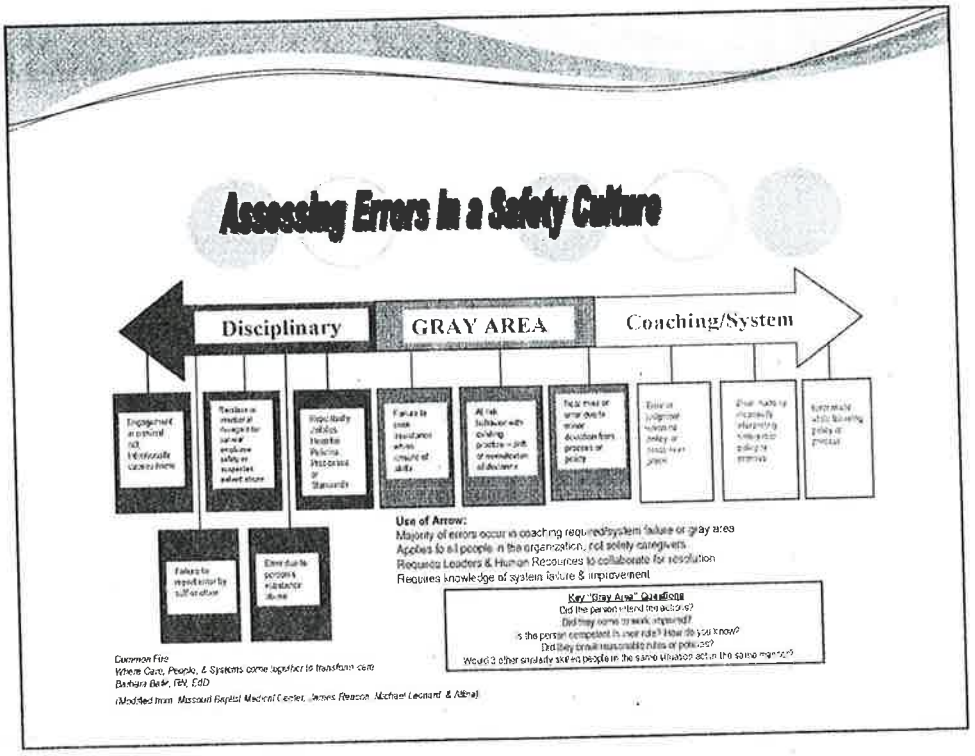
Difference Between At-Risk and Reckless Behavior

- **Speeding on the Highway**
  - 10 miles per hour over the speed limit is ***at-risk***
  - Driving 100 miles per hour or swerving in and out of traffic is ***reckless***

Managing Reckless Behavior

Healthcare workers rarely engage in reckless behavior. Reckless behavior is blameworthy behavior. As such, it should be managed by remedies or disciplinary processes.

Human Error	At-Risk Behavior	Reckless Behavior
"Product of our current system design"	Unintentional risk-taking"	Intentional risk-taking
Manage through changes in: Processes Procedures Transparency Design Environment	Manage through: Removing the incentive for at-risk behavior Creating incentives for healthy behaviors Increasing situational awareness	Manage through: Remedial Actions Disciplinary Actions



Action Plan to Move Forward

- Make patient safety a top organizational priority and develop all sub-cultures of the patient safety culture
- Encourage easy reporting of recognized risks and weaknesses
- Collect data to identify, assess, trend and measure patient safety improvements
- Strive for a culture that balances the need for a non-punitive learning environment with the equally important need to hold persons accountable for their actions
- Seek to judge the behavior, not the outcome, distinguishing between human error, at-risk behavior, and intentional reckless behavior
- Incorporate a just and fair Accountability Model into your organization's standard operating procedures
- Commit to a culture of inclusion and learning
- Collaborate to establish a state-wide culture of learning, justice, and accountability to provide the safest possible environment for patients

The Journey Continues...

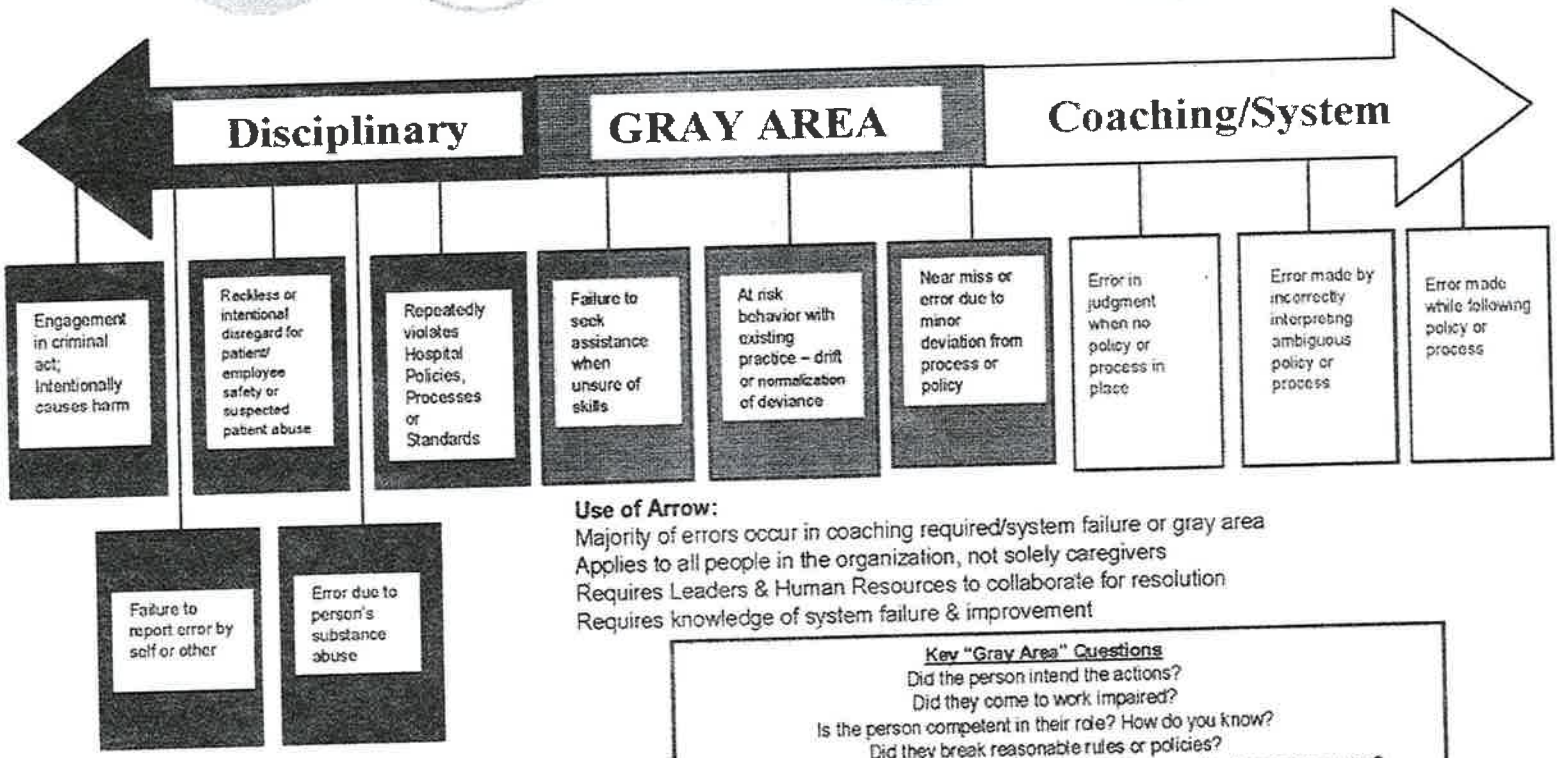
- Develop and cultivate a statewide Fair and Just Culture Initiative by bringing together hospitals, professional boards, practitioners, and other stakeholders
- Agree in principle on a model for system and practitioner accountability
- Provide statewide training
- Obtain regulatory and legislative support

It's about doing the right thing...

"It ought to be remembered that there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things. The innovator has for enemies all those who have done well under the old, and lukewarm defenders in those who may do well under the new..."

Machiavelli

Assessing Errors in a Safety Culture



Use of Arrow:

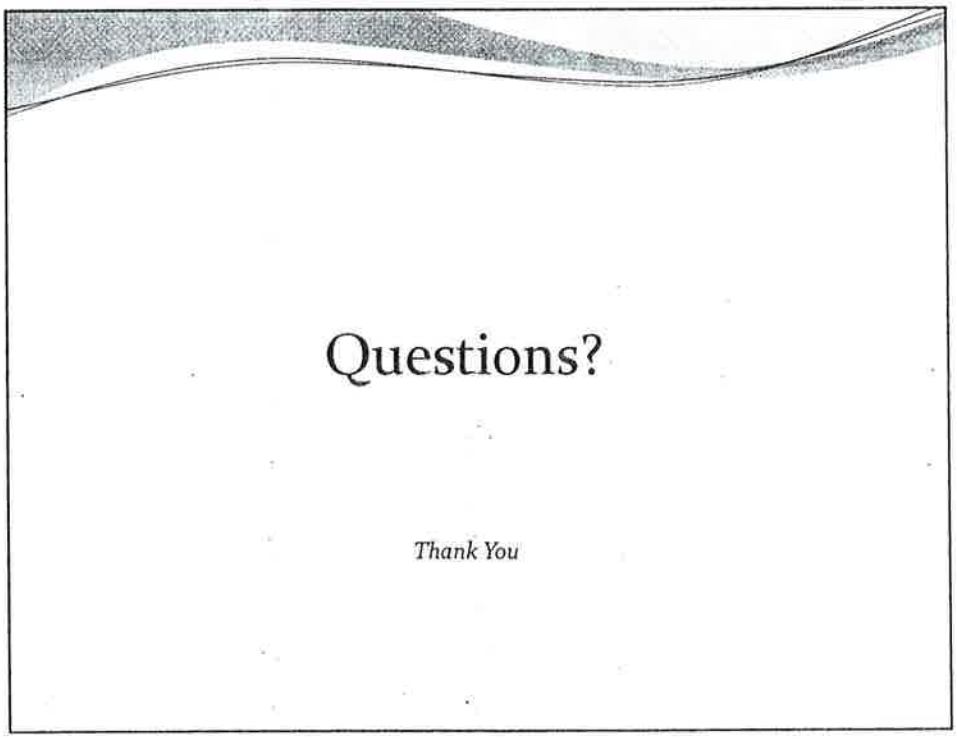
Majority of errors occur in coaching required/system failure or gray area
Applies to all people in the organization, not solely caregivers
Requires Leaders & Human Resources to collaborate for resolution
Requires knowledge of system failure & improvement

Key "Gray Area" Questions

Did the person intend the actions?
Did they come to work impaired?
Is the person competent in their role? How do you know?
Did they break reasonable rules or policies?
Would 3 other similarly skilled people in the same situation act in the same manner?

Common Fire
Where Care, People, & Systems come together to transform care
Barbara Balik, RN, EdD

(Modified from: Missouri Baptist Medical Center, James Reason, Michael Leonard, & Allina)


Questions?
Thank You