Promoting a culture of safety within your medical staff

2018 AMA-OMSS Interim Meeting
November 10, 2018
Learning objectives

Upon completion of this session, you will be able to:

• Illustrate the behaviors, attitudes and beliefs that encompass a culture of safety.

• Describe how culture changes.

• Identify tactics to implement and sustain the behaviors, attitudes and beliefs of a safety culture with your medical staff.
What is a high reliability organization?

• “A high reliability organization (HRO) accomplishes its mission while avoiding catastrophic events despite significant hazards, dynamic tasks, time constraints, and complex technologies.” (Anesthesia Patient Safety Foundation)

• Examples: Aviation and air traffic control, aircraft carrier operations, commercial nuclear power, amusement parks, etc.
Principle features of an HRO

• High-hazard and complex activities
• High technical competence
• Hazard-driven adaptations
• Positive design-based redundancy
• High performance and close oversight
• Constant search for improvement
Principle features of an HRO (cont.)

• High pressures and expectations for reliability
• No substitutes for reliability
• Limitations on trial-and-error learning
• Culture of reliability
• Flexible authority during emergencies
• Mindfulness

(Roe and Schulman, 2008)
High reliability in health care

• Patients still suffer preventable harm in hospitals every day.

• Medical errors are the third-leading cause of death in the United States, accounting for more than 250,000 deaths per year. (Makary and Daniel, 2016)

• Our goal: **Zero** preventable harm
Components of a high reliability health care organization

- Leadership Commitment
  - Board
  - CEO/Management
  - Physicians
  - Quality Strategy
  - Quality Measures
  - Safe Adoption of IT

- Adoption of Safety Culture
  - Trust
  - Accountability
  - Identifying Unsafe Conditions
  - Strengthening Systems
  - Assessment

- Robust Process Improvement®
  - Methods
  - Training
  - Spread

Source: The Joint Commission
What is safety culture?

- Safety culture: 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. (Joint Commission accreditation standards, Patient Safety Systems chapter)

- In a nutshell, safety culture encourages honesty and learning while balancing accountability. Physician leaders are crucial to fostering these behaviors, attitudes, and beliefs within their medical staff.
Tenets of a safety culture

1. Apply a transparent, nonpunitive approach to reporting and learning from adverse events, close calls and unsafe conditions.

2. Use clear, just, and transparent risk-based processes for recognizing and distinguishing human errors and system errors from unsafe, blameworthy actions.

3. CEOs and all leaders adopt and model appropriate behaviors and champion efforts to eradicate intimidating behaviors.

(Joint Commission Sentinel Event Alert 57: The essential role of leadership in developing a safety culture)
Tenets of a safety culture (cont.)

4. Policies support safety culture and the reporting of adverse events, close calls and unsafe conditions. These policies are enforced and communicated to all team members.

5. Recognize care team members who report adverse events and close calls, who identify unsafe conditions, or who have good suggestions for safety improvements. Share these “free lessons” with all team members (i.e., feedback loop).

6. Determine an organizational baseline measure on safety culture performance using a validated tool.
Tenets of a safety culture (cont.)

7. Analyze safety culture survey results from across the organization to find opportunities for quality and safety improvement.

8. Use information from safety assessments and/or surveys to develop and implement unit-based quality and safety improvement initiatives designed to improve the culture of safety.

9. Embed safety culture team training into quality improvement projects and organizational processes to strengthen safety systems.
Tenets of a safety culture (cont.)

10. Proactively assess system strengths and vulnerabilities, and prioritize them for enhancement or improvement.

11. Repeat organizational assessment of safety culture every 18 to 24 months to review progress and sustain improvement.
Discussion and report back

• Identify tactics to implement and sustain the behaviors, attitudes and beliefs of each safety culture tenet
  • Barriers you had to overcome?
  • Successes?
  • Lessons learned?

Group 1: Tenet 1
Group 2: Tenet 2
Group 3: Tenet 3
Group 4: Tenet 4
Tenet #1

- Apply a transparent, non-punitive approach to reporting and learning from adverse events, close calls and unsafe conditions
Tenet #2

• Use clear, just and transparent risk-based processes for recognizing and distinguishing human errors and system errors from unsafe, blameworthy actions.
Tenet #3

- CEOs and all leaders adopt and model appropriate behaviors and champion efforts to eradicate intimidating behaviors.
Tenet #4

• Policies support safety culture and the reporting of adverse events, close calls and unsafe conditions. These policies are enforced and communicated to all team members.
Tenet # 5 - 11

- Tenet #5: Recognize care team members who report adverse events and close calls, who identify unsafe conditions, or who have good suggestions for safety improvements. Share these “free lessons” with all team members (i.e., feedback loop).

- Tenet #6: Determine an organizational baseline measure on safety culture performance using a validated tool

- Tenet #7: Analyze safety culture survey results from across the organization to find opportunities for quality and safety improvement

- Tenet #8: Use information from safety assessments and/or surveys to develop and implement