THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Promoting a Culture of Safety

Liz Carlton, RN, MSN, CCRN-K, CPHQ, CPPS

Vice President Quality & Safety The University of Kansas Health System

Past President Kansas Association Risk & Quality Management

KARQM

Kansas Association of Risk and Quality Management

Objectives

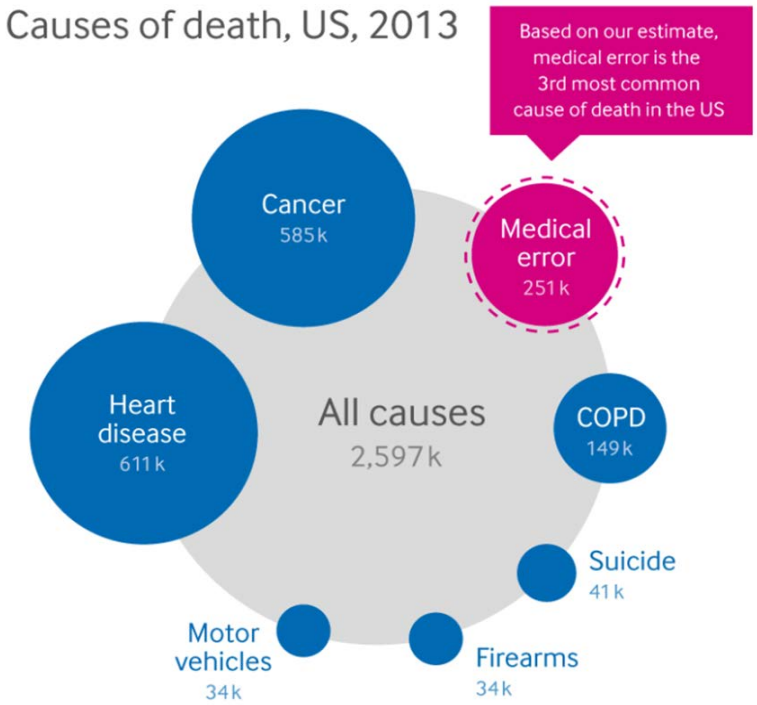
- Identify the core components of a culture of safety
- Link high reliability principles to a safety culture
- List methods and actions that contribute to strengthening and promoting a safety culture

The Basics of Safety

- Receiving safe care is a patient's expectation
- Feeling safe at work, and equipped to provide safe care, is the expectation of every healthcare employee

DANGER

ENTER AT YOUR OWN RISK



"Medicine used to be simple, ineffective and relatively safe. Now it is complex, effective, and potentially dangerous."

Sir, Cyril Chantler. Lancet (1999)

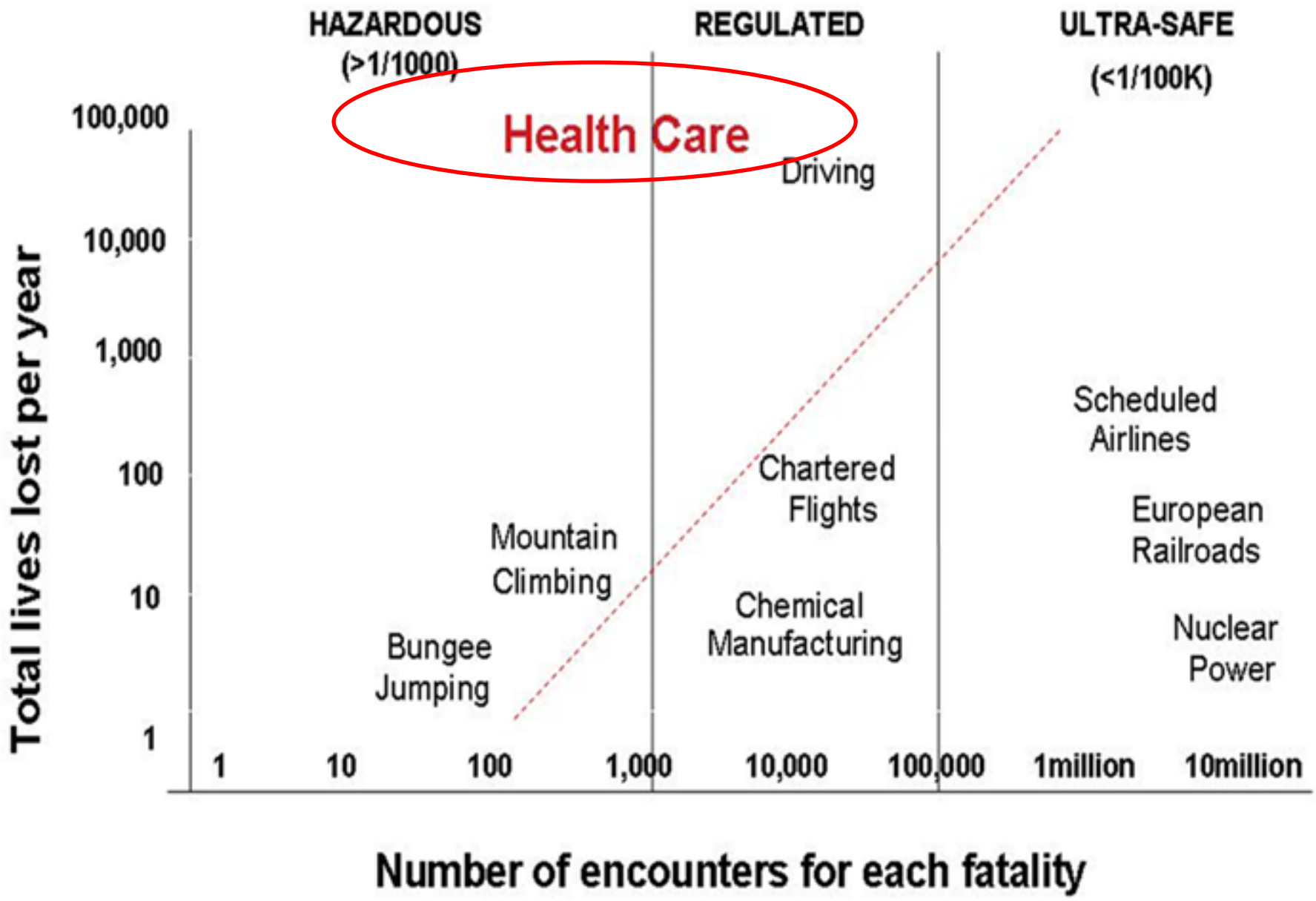
Reliable Care

Delivering what the patient needs when they need it each and every time

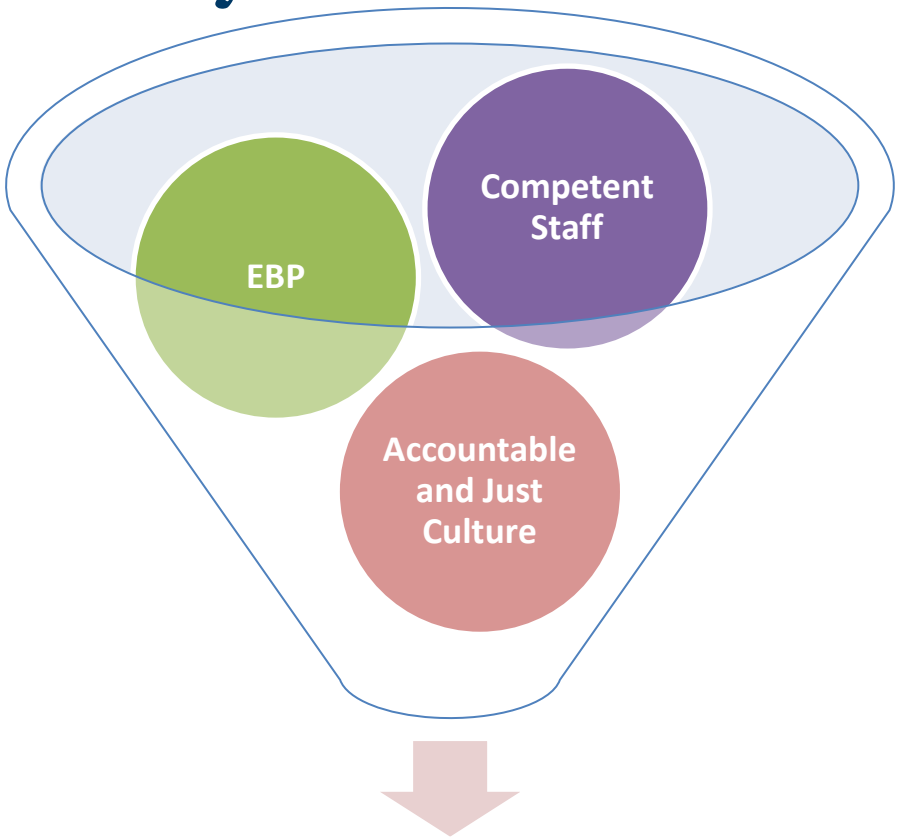
Probability that a system will perform correctly

Perfect performance minus the error rate

Is healthcare highly reliable?

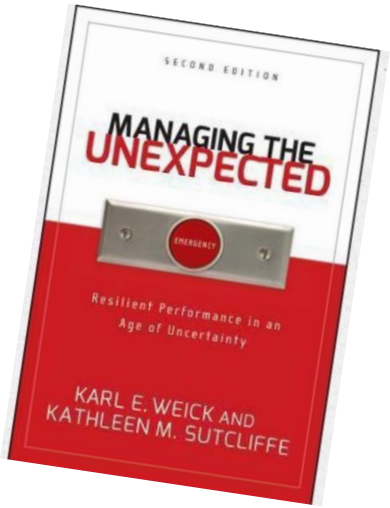

HAZARDOUS
(>1/1000)
REGULATED
ULTRA-SAFE
(<1/100K)
Health Care
Driving
Scheduled Airlines
Chartered Flights
European Railroads
Mountain Climbing
Chemical Manufacturing
Nuclear Power
Bungee Jumping
Total lives lost per year
100,000
10,000
1,000
100
10
1
1
10
100
1,000
10,000
100,000
1million
10million
Number of encounters for each fatality

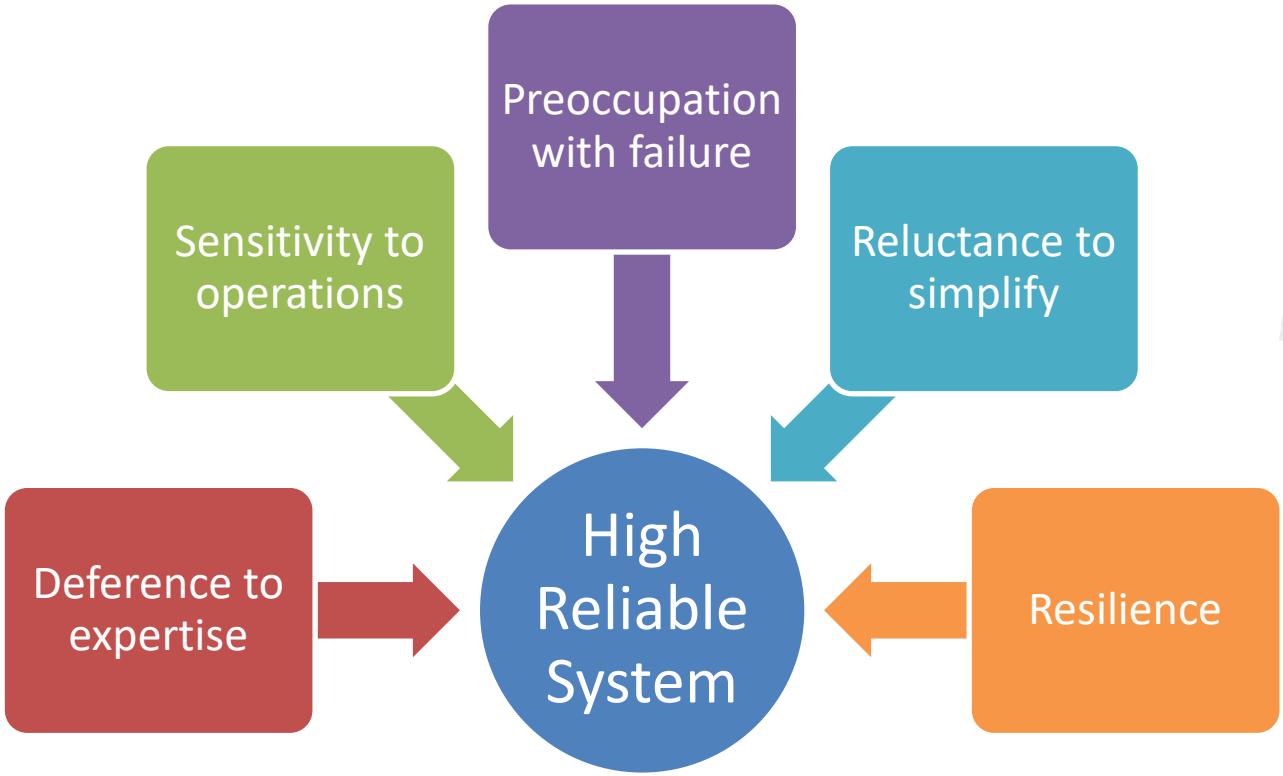
High Reliability Care



High Reliability Outcomes

High Reliability Organizations (HROs)





THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Components of Safety Culture

1. Reporting Culture
2. Just Culture
3. Flexible (Teamwork) Culture
4. Learning Culture

What is a reporting culture?

- Everyone is alert to potential risks
- People are actively engaged in safely reporting incidents
- Reporting numbers are high
- Unsafe situations in processes are easily addressed and improved

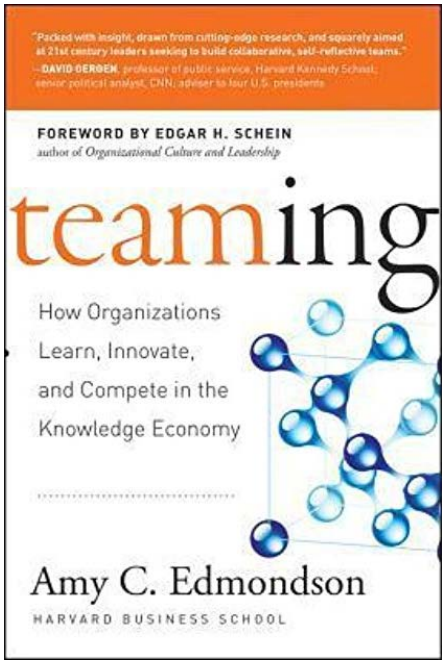
Just Culture- Psychological Safety

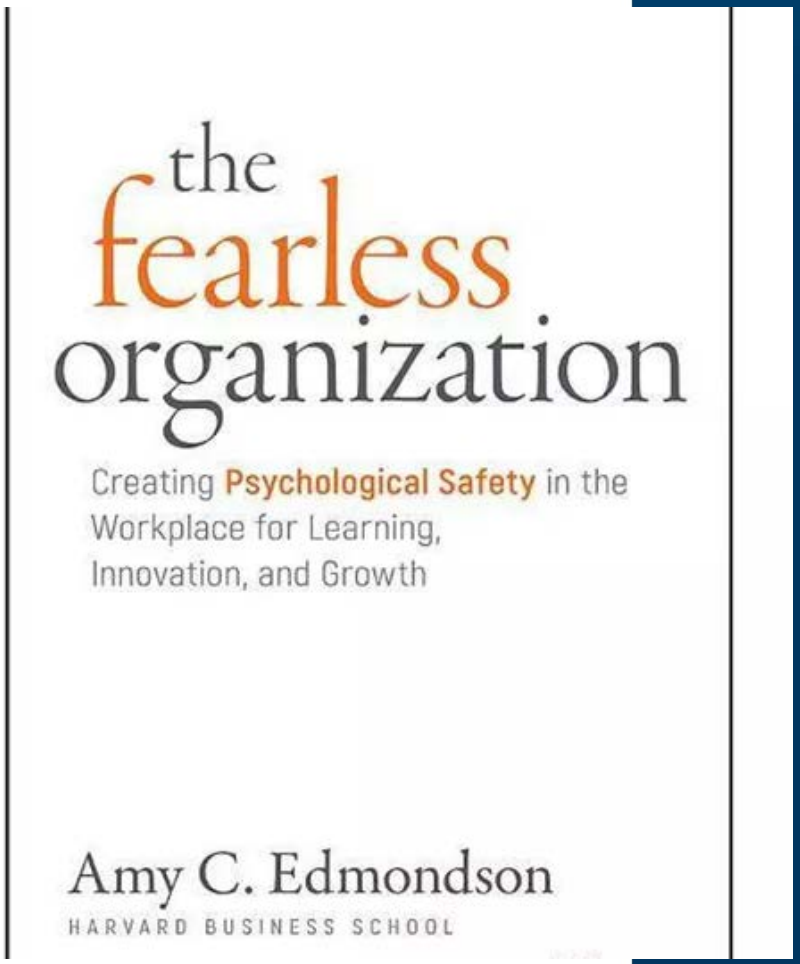
Climate in which people feel free to express relevant thoughts and feeling

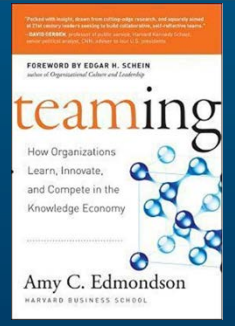
A belief that one will not be punished or humiliated for speaking up with ideas questions, concerns or mistakes

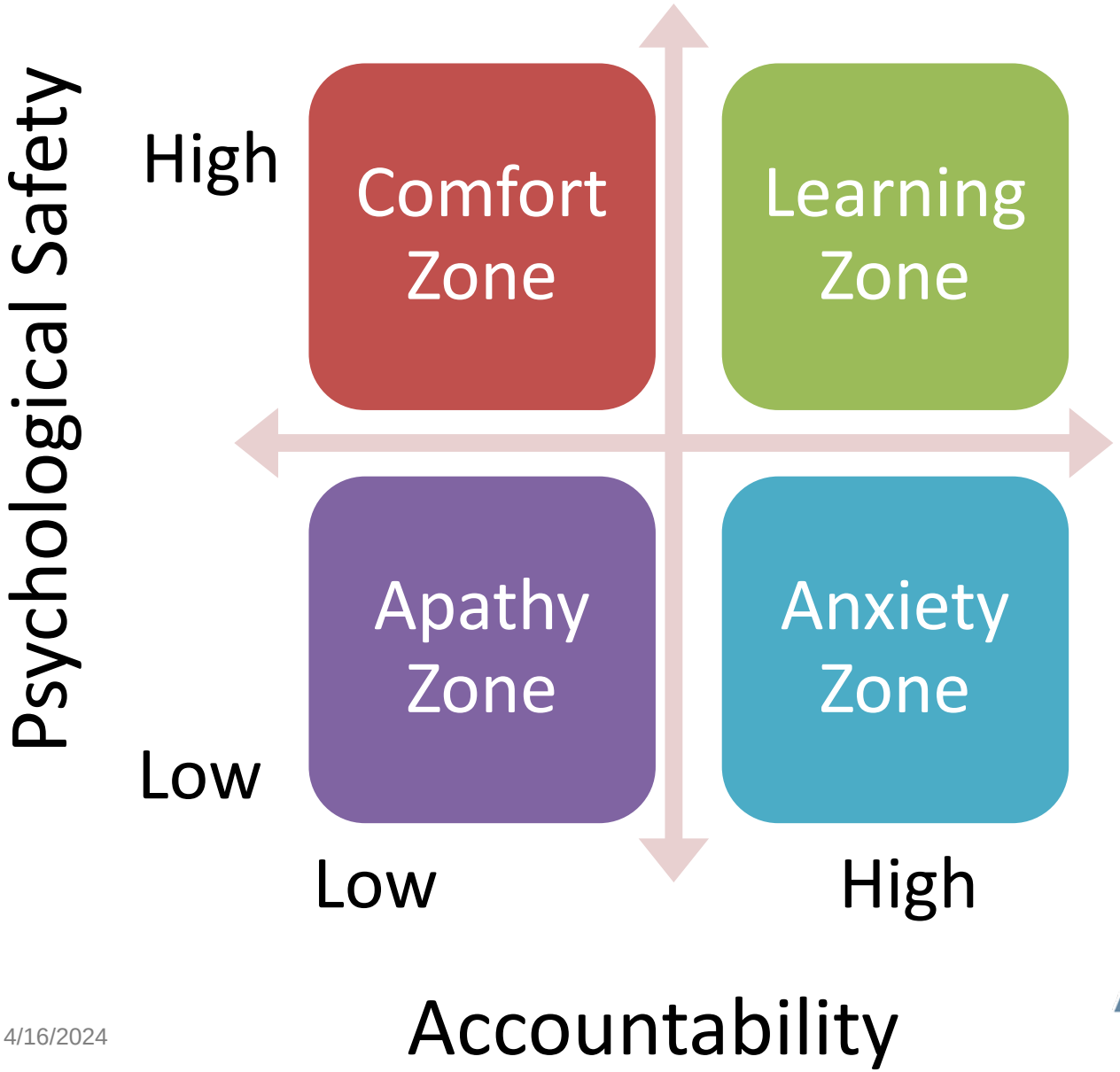
Essential to *teaming/ teams* and learning environments

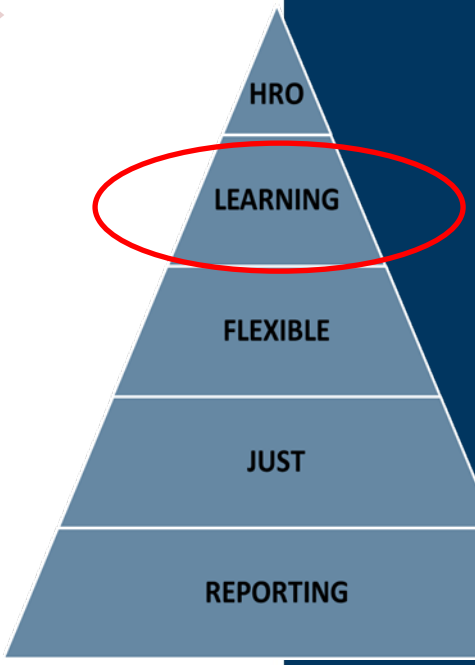
Team, teaming, teamwork






FOREWORD BY EDGAR H. SCHEIN
teaming
How Organizations Learn, Innovate, and Compete in the Knowledge Economy
Amy C. Edmondson
HARVARD BUSINESS SCHOOL


Psychological Safety
High
Low
Comfort Zone
Learning Zone
Apathy Zone
Anxiety Zone
Low
High
Accountability


HRO
LEARNING
FLEXIBLE
JUST
REPORTING

Just Culture & Psychological Safety

- Just Culture requires Psychological Safety
- Individuals trust that they can and should report errors
- Errors are explored organizationally as a learning opportunity and examined for process improvement
- Hard on the process, not on the people

Benefits of Psychological Safety

Encourages speaking up

Removes fear

Supports productive conflict

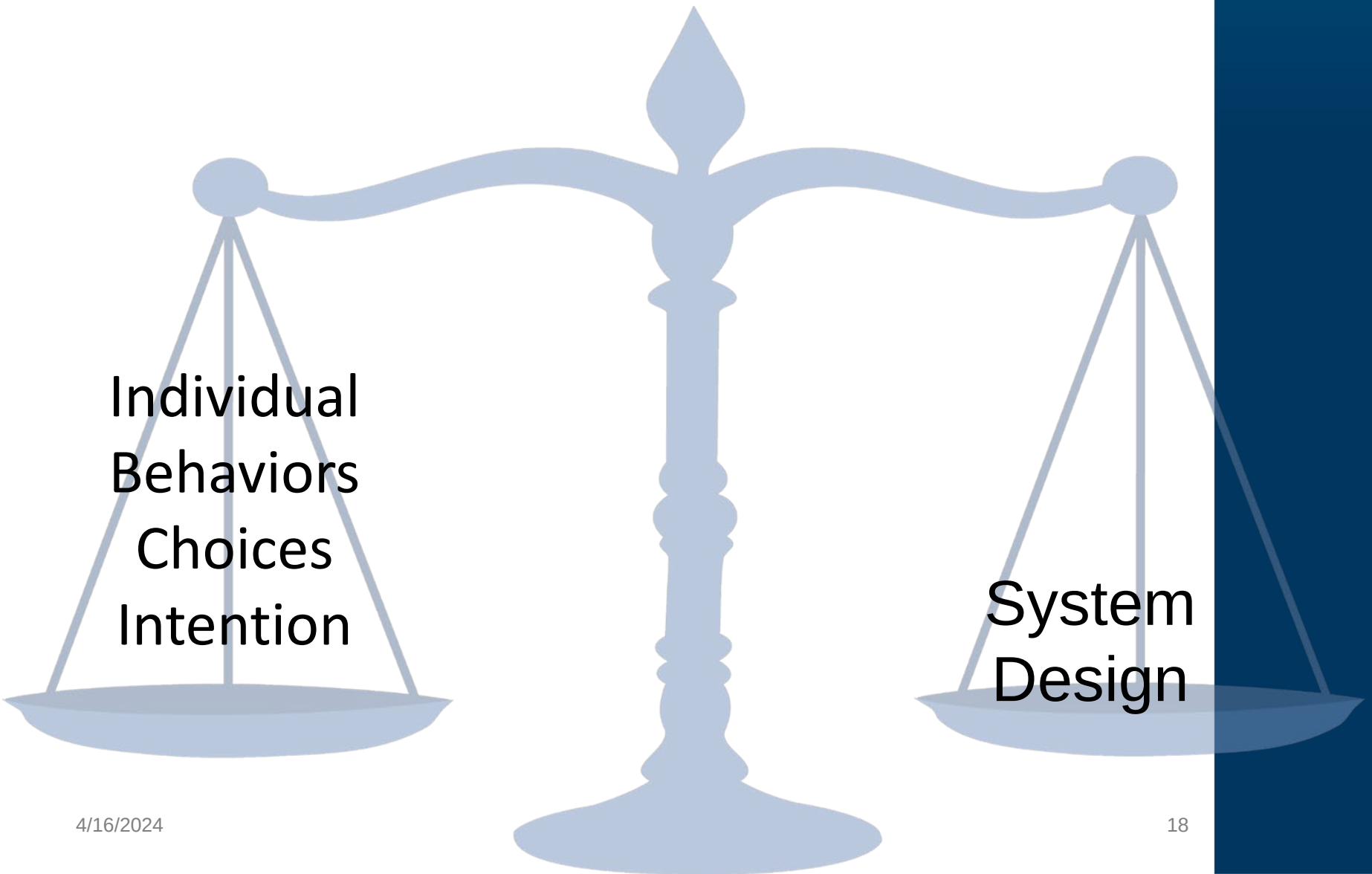
Mitigates failure –report & discuss errors

Just Culture

"An atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety-related information—but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior."

James Reason – Author, Scholar, Educator

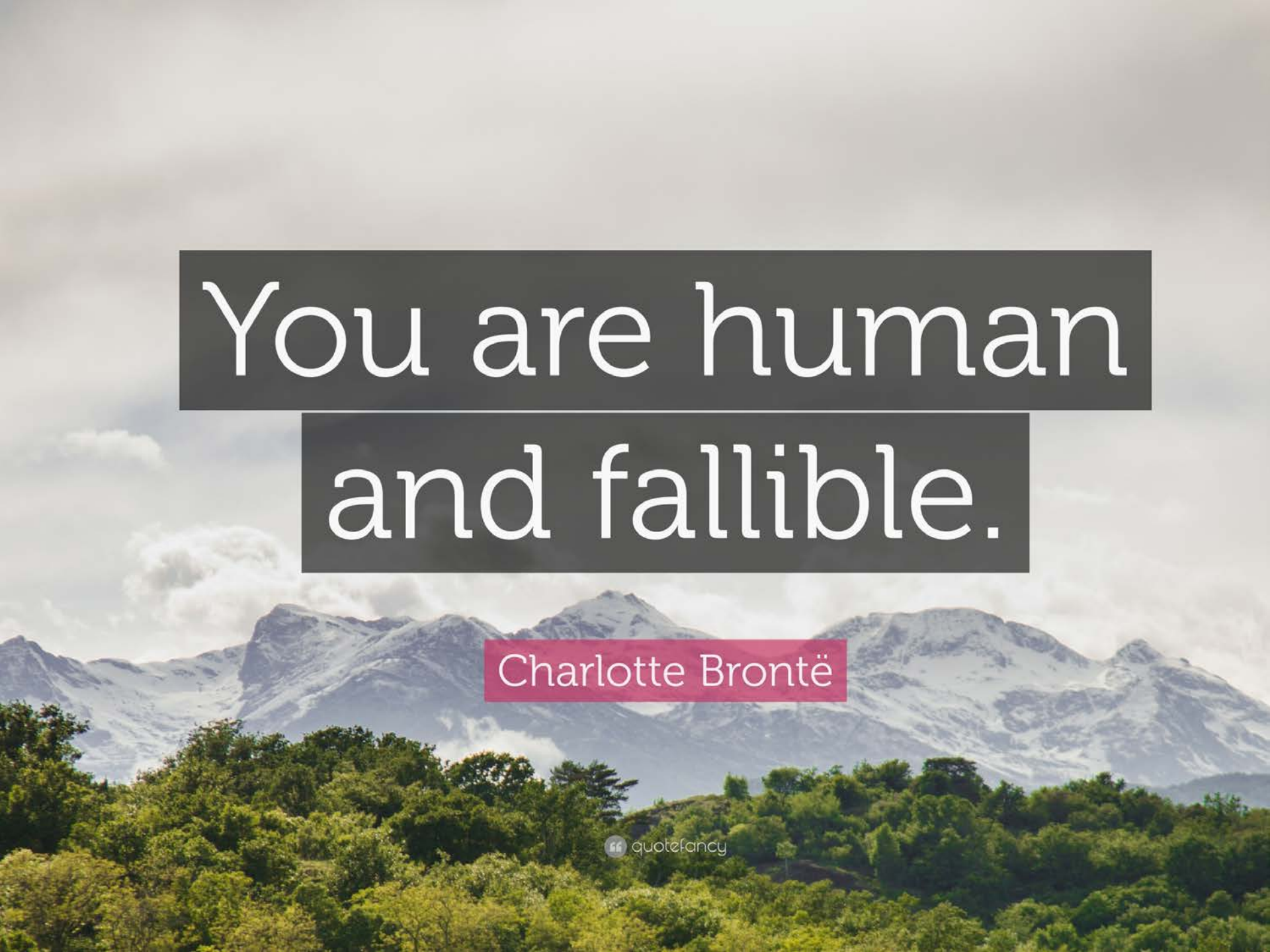
Just Culture



Ask the fundamental question…

Did the assessments and actions of the professionals at the time make sense, given their knowledge, their goals, their attentional demands, their organizational context?

Sydney Dekker


You are human and fallible.
Charlotte Brontë
quotefancy


Put a good person in a bad system and the bad system wins, no contest.
W. Edwards Deming
quotefancy

Punishing is Unproductive

- Hiding mistakes
- Encourage others to cover up mistakes
- Suppress the ability to learn from the event

End Result: Outcomes do not improve, and the quest for safe patient care is compromised.

Adopt "Just Culture"

A focus on the decisions employees make and the systems in which they operate.

Just Culture – Ask the Questions

~~WHO DID SOMETHING WRONG & HOW DO WE PUNISH THEM?!?!?~~

- Why did it happen?
- Did the system fail us?
- Did the outcome occur because a poor choice was made?
- What were the behaviors or choices associated with the error/harm?

Understanding Types of Employee Behavior

- **Human Error** – inadvertently doing other than what **should** have been done – a slip, lapse, mistake (ie - transcribing numbers) we do NOT choose to make errors, but we are all fallible.

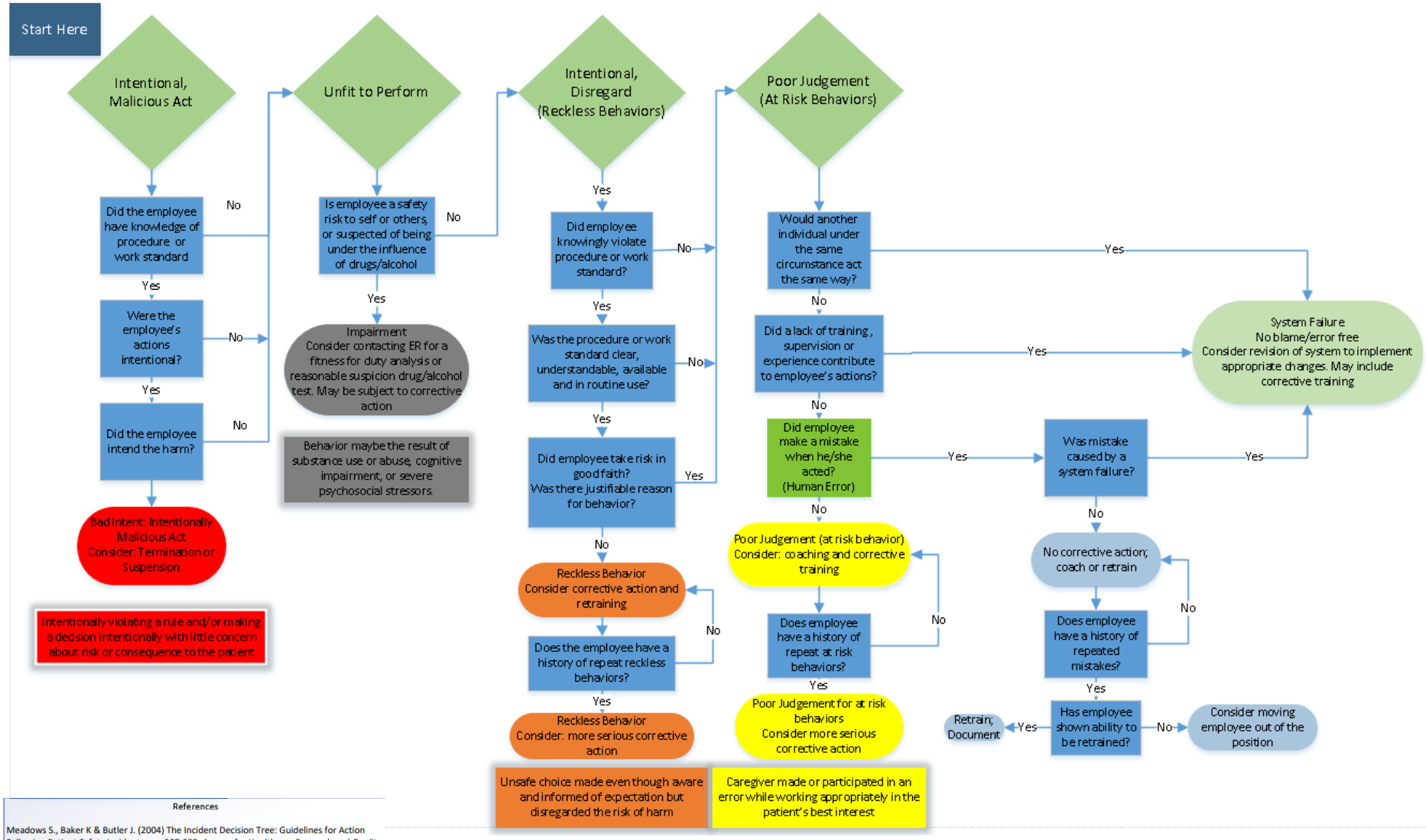
- **At Risk** - **behavioral choice** that increases risk – where risk is not recognized or mistakenly believed to be justified (ie – failure to follow the red rules, drift, normalization of deviance, shortcuts, blow by alerts, skip a double check)

- **Reckless** – **conscious disregard -** unjustifiable risk, intentional behavior (ie drug diversion , intentionally falsifying records, practicing punitive medicine towards patients)

THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Culture of Safety Decision Tree Tool

THE UNIVERSITY OF KANSAS HEALTH SYSTEM



References

Meadows S., Baker K & Butler J. (2004) The Incident Decision Tree: Guidelines for Action Following Patient Safety Incidents, pp. 387-399. Agency for Healthcare Research and Quality: U.S. Department of Health and Human Services, Rockville, MD.

Marx, D. 2001 Patient Safety and the "Just Culture": A Primer for Health Care executives. New York Trustees of Columbia University in the City of New York, Columbia University.

Frankel AS, Leonard NW, www.safeandreliablecare.com 2017

What is a Safety Culture?

Leadership	• Commitment to Zero Harm
Competent People	• Staff Have What They Need to Do The Work • Teamwork & Resilience
Psychological Safety	• Empowering Staff to Speak Up • People feel comfortable asking questions or sharing mistakes without fear of punishment or humiliation
Accountable & Just Culture	• Hard on the process, not on the people • Clear about what behaviors are acceptable and unacceptable
Learning Culture	• Each event is an opportunity to improve • Supported by Robust Performance Improvement Structures

Adapted from Chassin MR, Loeb JM. High-Reliability Health Care: Getting There from Here. *MILB Q 2013; 91(3): 459-90*

Culture of Safety: What Does Safe Look Like?

- ✓ **Safety = Free From Harm**
- ✓ **Preventing Defects from Causing Harm or Reaching a Patient or Employee**
  1. Look For Defects
  2. Report Defects
  3. Learn From Defects

What can leaders do to sustain/build the culture?

Define your goals

- Our Goal is to be the Safest Health System in the Country
- Be Proud but Never Satisfied—We Can Always Be Better
- Make Safety the Top Priority in Every Action We Take
- Safety is Everyone's Responsibility

THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Market your safety program

Know & Comply with RED RULES

- Define an expected priority in our work **– every patient, every time, every action**
- A commitment-based approach to reduce the probability of harm to our patients
- Associated with acts that have the highest level of risk to patient safety if not performed exactly each time
- Any deviation from a **Red Rule** should bring a halt to work – **STOP THE LINE** until compliance can be achieved
- **Red Rules** are NOT optional

Provide the tools

- Leadership & HR just culture training
- Culture of Safety Surveys
- CUSS
- Cross Check and Assist
- STAR
- Celebrate the wins
- Shift the paradigm

Communicate Clearly

Communicate clearly

- Be respectful.
- Handoff effectively.
- Ask questions to clarify.
- Speak up and listen using CUSS.

CUSS

I'm **C**oncerned
I'm **U**ncomfortable
This is a **S**afety issue
STOP the line

CUSS is a technique that uses a **gradual** assertiveness approach to communicating.

After the initial approach, use **CUSS** to focus the conversation on safety and to get the listeners attention.

This is a great tool to use when you are worried about a patient or situation and need to safely challenge what is happening or is about to happen.

The words "Concern, Uncomfortable, Safety & Stop" are a signal to the **receiver** as well

Partner

- Trust, But Verify
- Look Out For Each Other & The Patient
- Observe & Correct Unsafe Behaviors & Conditions
- Set The Next Person Up For Success
- Engage The Patient & Family

- PAUSE (1-5 seconds)
  - Is it safe for the patient?
  - Is it safe for you?
  - Am I following our standards?
  - Am I doing it right?
  - When in doubt – ASK!
- Self-checking reduces the probability of a skill-based error by a factor of 10 (10x) for a one-second pause.
- A two to five-second pause can result in a factor of 100 to 1,000 reduction in errors

STAR

STOP	Pause for one to two seconds to focus attention on the task at hand
THINK	Visualize the act and think about what is to be done
ACT	Concentrate and perform the task
REVIEW	Check for the desired result

Good Catch Program

Celebrate the wins

Pay attention to detail

- Be present in the moment.
- Follow our standards.
- Think about what you are doing.
- Check for results.

STAR

Stop
Think
Act
Review

SAFETY FIRST

THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Shift the Paradigm

Levels of maturity with respect to a safety culture

Ask me questions!!!!

lcarlton@kumc.edu

913.220.9750