FROM CONCEPT TO PRACTICE

PSYCHOLOGICAL SAFETY BUILDS HIGH RELIABILITY

PRESENTERS

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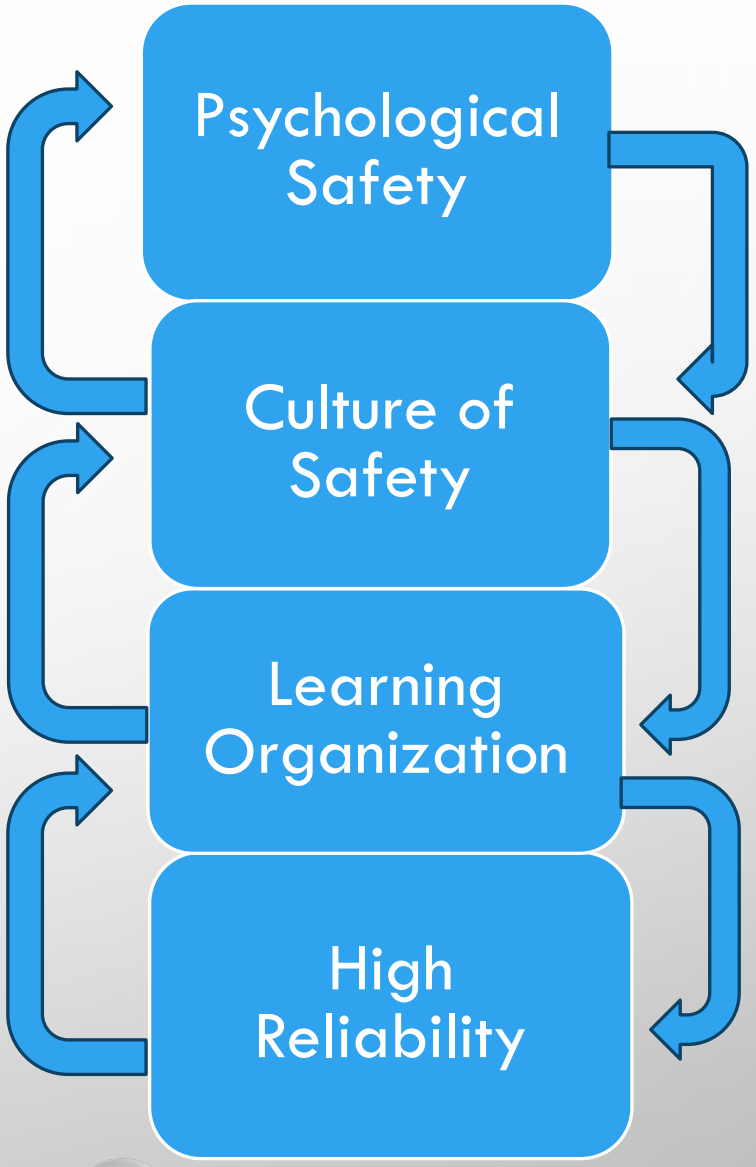
OBJECTIVES

By the end of the presentation, attendees will be able to:

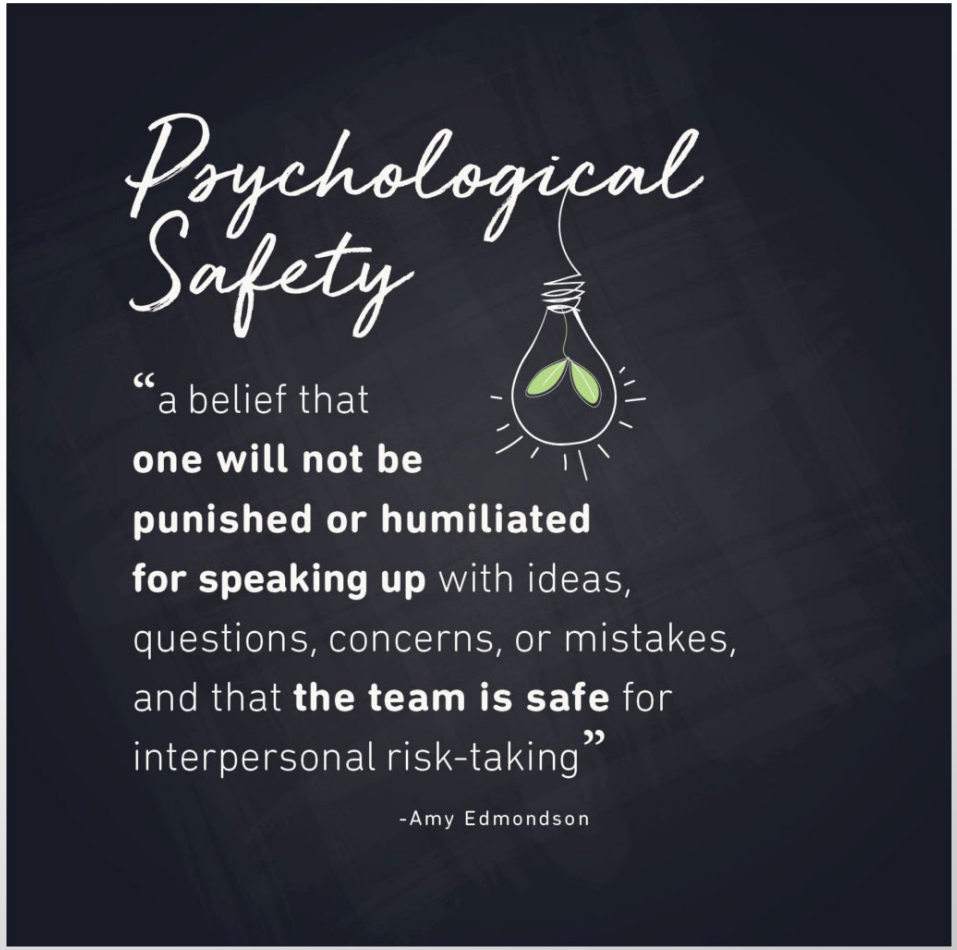
- Describe psychological safety and how it is demonstrated in an organization
- Discuss incorporating high reliability (HR) learning concepts within the organization
- Provide a framework for developing and implementing practices that foster psychological safety and foster high reliability (HR)

THE ULTIMATE GOAL



THE CONCEPT

DEFINITION OF PSYCHOLOGICAL SAFETY



Source: Amy C Edmundson
Harvard Business Review

WHY FOCUS ON PSYCHOLOGICAL SAFETY

- Improves communication
  - Better discussion about issues we're facing
- Facilitates effective, powerful decision making
  - Hearing diverse opinions, perspectives
- Helps teams/organizations to solve problems better
  - Receiving input from those delivering care
- Improves outcomes
  - Safety, clinical, staff retention
- Ultimately improves the lives of patients

CONNECTING CONCEPTS TO PRACTICE

Psychological safety is cornerstone of fostering high reliability

- Establish secure, open environment
  - Staff feel secure to share ideas, report errors without retribution
- Create a strong foundation
  - Leadership commitment to zero-harm goals
  - Establish positive safety culture
  - Institute robust process improvement culture

The Joint Commission "High Reliability in Health Care Is Possible," High Reliability | Joint Commission Resources

Patient Safety + Risk management + Performance improvement = High reliability

CHALLENGES TO CREATING A CULTURE OF PSYCHOLOGICAL SAFETY

- Catastrophic events are rare
- Belief that…
  - Errors are associated with poor performance
  - It won't OR can't happen to me
  - Failure to appreciate the impact of systems and processes on risk of error – NEED to identify root causes
  - Failure to appreciate the impact of human factors
  - Lack of a team mentality: "we are in this together"

HOW TO FOSTER PSYCHOLOGICAL SAFETY

- Promote Open Communication
- Cultivate Trust and Respect
- Embrace Failure as a Learning Opportunity
- Promote Inclusivity and Belonging
- Lead by Example

5 Steps to Psychological Safety: Creating a Secure Work Environment. NeuroLaunch. September 14, 2024

ASK THE STAFF - ASK YOURSELF

- If you make a mistake on this team, will it be held against you?
- Are the members of this team able to bring up problems and tough issues?
- Do members on this team sometimes reject other members for being different?
- Is it difficult to ask other members of this team for help?
- Would anyone on the team deliberately act in a way that undermines efforts?
- Working with members of this team, are unique skills and talents valued and utilized?

RECENT HEADLINES

Many Hospitals are Facing a Crisis. It Could Cost Employees

Insurer for Nearly 50,000 Poor, Elderly, Disabled People in Mass. Running Out of Money Boston Globe 3/4/2025

Security Guard Injured in Shooting at Scottsdale Hospital, Suspect Arrested and Facing Felony Charges AZ Daily News 3/4/2025

Texas Measles Outbreak: Cases Spread to Florida and Eight Other States Forbes 3/5/2025

Health Insurance Agency Laying Off 196. Closing Sunrise Headquarters
Sun Sentinel 3/2025

'This should never happen': Shooter targeted UPMC Memorial ICU with zip ties and a handgun

WHY FOCUS ON HIGH RELIABILITY

- Greater staff engagement
- Safer work environment (with psychological safety)
- Ability to better manage unexpected events
- Improved patient safety by minimizing errors
- Employee and patient satisfaction

THE 5 HIGH RELIABILITY PRINCIPLES

HRO Principles	Simply Put
Preoccupation with Failure	▪ Leaders & employees assume things will go wrong -> be proactive! ▪ What works today may not work tomorrow
Reluctance to Simplify	▪ Threats to safety are complex ▪ Resist oversimplification, not all areas are the same
Sensitivity to Operations	▪ Leaders have a true understanding of what's happening on the "front line" ▪ Front-line requires psychological safety to report drift from expectations
Commitment to Resilience	▪ Mistakes and adverse events happen -> Need capabilities to 'bounce back' ▪ There is a true commitment to transparency and shared learning
Deference to Expertise	▪ No one knows the work better than those doing the work -> including how it isn't working well the and the solutions that will

People make mistakes

Blame fixes nothing

Context drives behaviors

Learning is vital

Leadership response matters

Huggins, Elaine, Gray, Celine. Having Fun While Enculturating the High Reliability Principles for Zero Harm, AHA Team Training, January 8, 2025

HRO Principles		HRO Practices		Healthcare Practices
Preoccupation with Failure	Regarding small, inconsequential errors as a symptom that something's wrong	**Naval Aviation:**	All carrier landings "graded" – near misses discussed and documented	Reporting near-miss events
Sensitivity to Operations	Paying attention to what's happening on the front-line	**Nuclear Power**	Daily check-in	Daily Safety Briefings & Tiered Huddles
		Naval Aviation	Walk the deck	
Reluctance to Simplify	Encouraging diversity in experience, perspective, and opinion	**NASA**	Requirement for someone to represent the minority or dissenting view ("devil's advocate")	Promote questioning attitude
Commitment to Resilience	Developing capabilities to detect, contain, and bounce-back from events that do occur	**Nuclear Power**	Mandatory adoption of lessons learned from all utilities	Share generalized RCA findings broadly
Deference to Expertise	Pushing decision making down and around to the person with the most related knowledge and expertise	**Manufacturing**	"Stop the line" capability on the production line	Time-out/stop-the-line authority

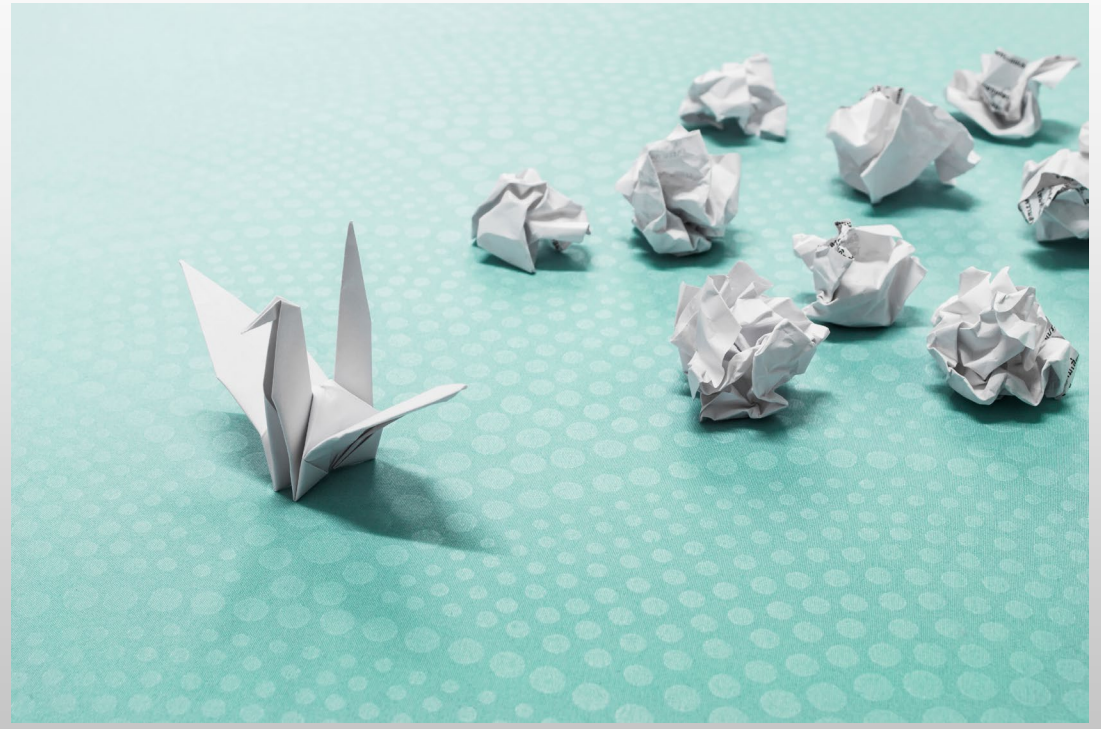
CONSIDER

"To do things differently, we **must see things differently**. When we see things, we haven't noticed before, we can ask questions we didn't know to ask before."

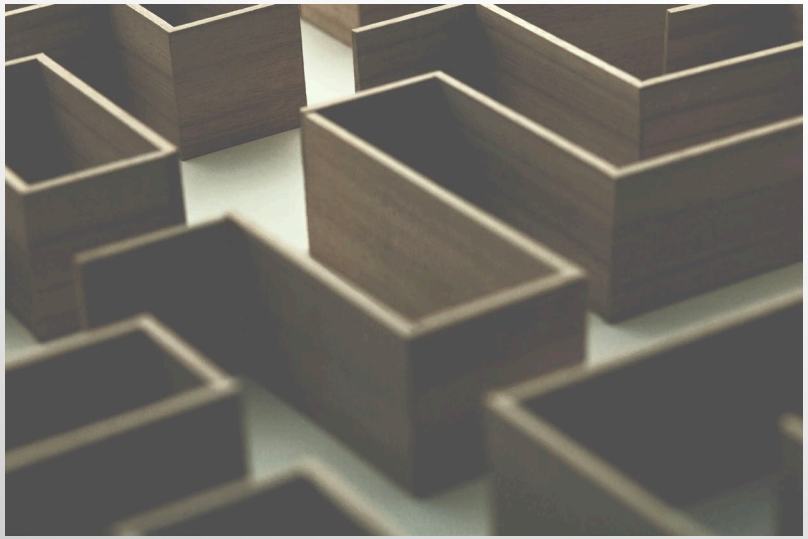
John Kelsch, Xerox

THE PRACTICE:

BUILDING HIGH RELIABILITY INTO YOUR ORGANIZATION



CHALLENGES TO CREATING HIGH RELIABILITY



- Cultural resistance
- Leadership engagement
- Healthcare system complexity
- Data and Measurement
- Resource constraints
- Staff burnout
- Patient Complexity
- Continuous improvement

ROLE OF LEADERS

- **Celebrate learning** from mistakes and build "lessons learned" debriefing sessions into every project
- Lead by example to show how to raise problems and tough issues for discussion in a constructive**, nonjudgmental** manner
- Encourage **all team members** to raise problems or tough issues that may be on their minds
- Applaud **thoughtful** risk taking and demonstrate it yourself
- **Publicly** recognize and celebrate the unique skills and talents brought by each member of the teams you lead

ROLE OF ORGANIZATION

- Train leaders and managers on **concrete steps** for fostering psychological safety
- Examine the organization to see if there are unnecessary hierarchies, chains-of-command, or professional boundaries that discourage communication from front-line workers to upper management
- Provide ways to **recognize and celebrate** employees' unique skills and talents in organization-wide communications
- Repeatedly emphasize that the organization will not tolerate any employee deliberately undermining the efforts of another employee

ROLE OF STAFF - EMPLOYEES - MEDICAL STAFF

- Focus on **finding solutions** with questions like “what can we all do to help solve this problem?”
- **Ask others for their opinions**—with questions like “I’d love to get your feedback on that idea”
- **Actively listen** to the ideas shared by your colleagues and ask respectful questions.
- Extend **kindness and respect** when team members share ideas even if you disagree with them
- Provide feedback in a **respectful, thoughtful** way

DEMONSTRATABLE HIGH RELIABILITY PRACTICES

Visibility across the organization

- Return on Investments (ROI) – Reports to Board; Executive Leadership; Directors
- Presenting at new employee orientation
- Patient safety champion program with training
- Patient Safety Rounds ASK: What helps you provide safe patient care?
- Leadership rounding with staff ASK: What 3 things are improving patient safety on the unit/department/hospital? What is one thing that needs to improve patient safety?

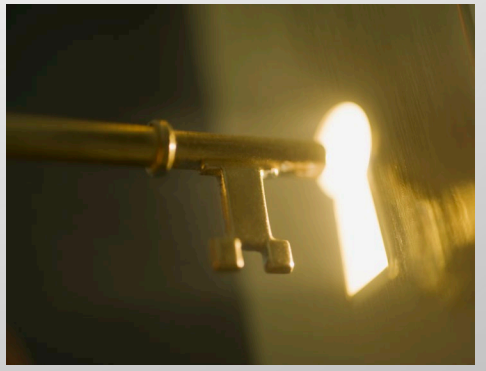
DEMONSTRATABLE HIGH RELIABILITY PRACTICES

Effective, transparent, honest, regular communication

- Regular emails – initiatives/update, institution events, progress
- Direct staff feedback to concerns, ideas
- Conduct "Town Halls"
- Regular staff surveys on patient safety culture – ACT on results
- Implement SBAR and I-PASS
- Huddles & briefings
- How's and why's
- Communicating the successes – Great catch program

THE KEYS…

- Promoting “safe” reporting – incidents and near misses
  - Ensuring psychological safety
- Increasing knowledge of actual processes & events
- Sharing of information (relationship)
- Establishing clear role in the safety of our patients
- Demonstrating belief in the system
- Surveying the culture



WHO OWNS A CULTURE OF PATIENT SAFETY?

It's not only about patient care providers

Everyone plays a critical role in patient safety

Some initiatives require entire facility involvement

Patients as Partners in Patient Safety

Lucian Leape Institute

Partnering with Patients and Families for the Safest Care Report, "Safety is Personal"

- Centrality of patient and family centered care
- Family is part of care team
- Patients share in decision making
- "Nothing about me without me"

National Patient Safety Foundation (NPSF), Lucian Leape Institute. 2014.
http://www.ihi.org/resources/Pages/Publications/Safety-Is-Personal-Partnering-with-Patients-and-Families-for-the-Safest-Care.aspx

HEALTH CARE'S HIDDEN WORKFORCE

Caregivers are the glue in a fragmented system of health care and support services for a ballooning population of aging Americans

Hopkins Bloomberg Public Health, Spring/Summer 2024,Melony Schreiber, pg 96

Institute for Patient and Family Centered Care (IPFCC)

Patients for Patient Safety Project (PFPS - Pivot)

AHRQ "Be the expert on you" tool

Q & A

MAY YOU BE SUCCESSFUL IN YOUR JOURNEY TO FILL YOUR POOL WITH DROPLETS!

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- Learning Organizations https://www.learningeverest.com/learning-organizations-the-essential-disciplines/

RESOURCES

American Society for Healthcare Risk Management https://www.ashrm.org

Live education; Online learning; Webinars; Playbooks; Tip sheets

Agency for Healthcare Research and Quality https://.ahrq.gov

PSNet; toolkits

Institute for Healthcare Improvement https://www.IHI.org

Centers for Medicare & Medicaid Services https://www.CMS.gov

Patient Safety Structural Measures

RESOURCES

ECRI https://home.ecri.org

Top 10 Patient Safety Concerns 2025

Crucial Conversations https://cruciallearning.com/

Books series; newsletter; blog

American Hospital Organization https://aha.org

AHA Well-Being Playbook 2.0; Strengthening the Healthcare Workforce: Strategies for Now, Near and Far