The Governance Institute

Building a Reliable Culture of Safety

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Objectives

At the end of the session, participants will be able to:

i. **Identify three strategies for leading cultural transformation**

ii. **List the principles of high reliability and examples of how they look when implemented in a complex healthcare environment.**

i. **Discuss fundamental elements of building a psychologically safe environment.**

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Why Focus on A Culture of Safety and High Reliability?

Typical Cultural Assessment - Key Issues and Opportunities

- **Medical Errors and preventable harm in Healthcare Systems are just too high!**
- **Accountability** (or lack thereof) is a huge challenge associated with safety, reliability and quality outcomes.
- **Models of care delivery vary significantly** across s/Systems.
- **Roles of leaders lack clarity, substance and empowerment.** Nurse and physician leaders are not routinely partnered. Clinicians and Administration not partnered around common goals.
- **Competitive culture** among HSOs make building a high reliability culture across organizations difficult; therefore

…Medical Errors and preventable harm in Healthcare Systems are just too high!

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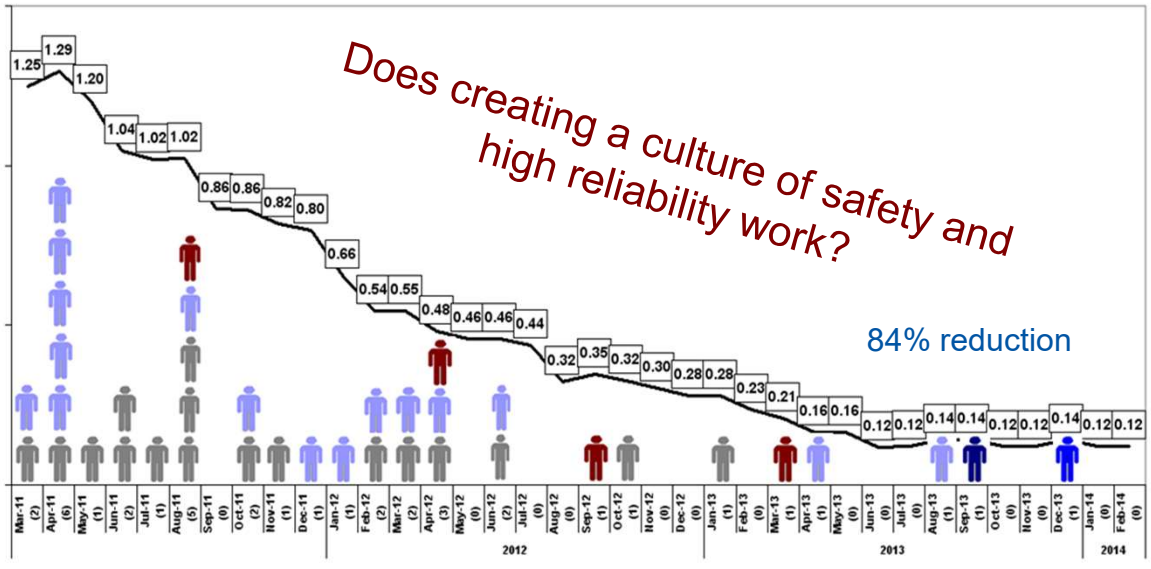
Preventable Harm Serious Safety Events- Results of Safety Culture Implementation



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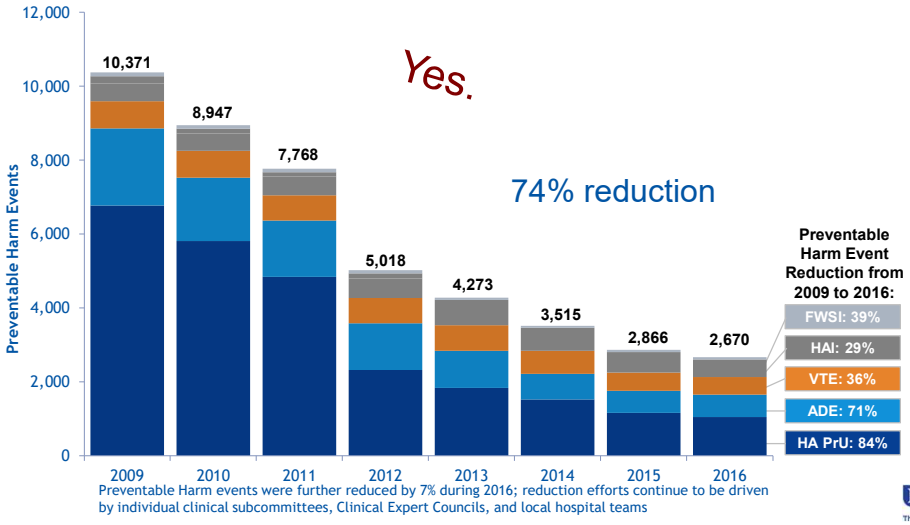
Preventable Harm Performance

BJC Annual Preventable Harm Performance
2009 to 2016



Preventable Harm events were further reduced by 7% during 2016; reduction efforts continue to be driven by individual clinical subcommittees, Clinical Expert Councils, and local hospital teams

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What is a Workplace Culture?

- The way we do things…how we act
- The way we treat others. How we work together.
- A set of ***values, attitudes and behaviors*** that define who we are, how we make decisions and problem solve.

Our BJC Values

COMPASSION
RESPECT
EXCELLENCE
SAFETY
TEAMWORK

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What is a High Reliability Organization?

A high reliability organization is an organization that has succeeded in avoiding catastrophes in an environment where normal accidents can be expected due to risk factors and complexity

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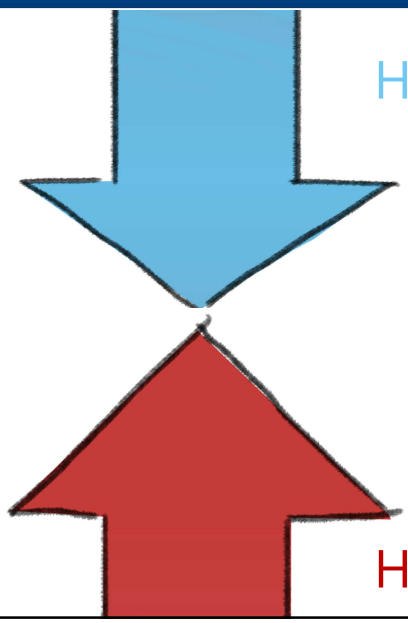
Why High Reliability in Healthcare?



High Reliability

We set behavioral expectations and design/manage systems to *consistently* deliver on what patients want – be safe, be healed, be treated kindly.

We work in a complex environment that can be subject to catastrophic accidents

High Risk

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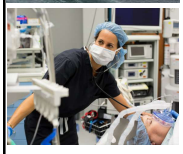
Reliability: *Not By System/Process Design Alone*





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10^{-5}
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Optimized Outcomes

Behavior Accountability
Behavior Expectations
Knowledge & Skills
Reinforce & Build Accountability

Integrated With

Process Design
Evidence-Based Best Practices
Technology Enablers
Intuitive Work Environment
Resource Allocation
Continuous Quality Improvement

HPI PRESS GANEY

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Three Strategies for Transforming Culture

Step 1: Set Clear Expectations

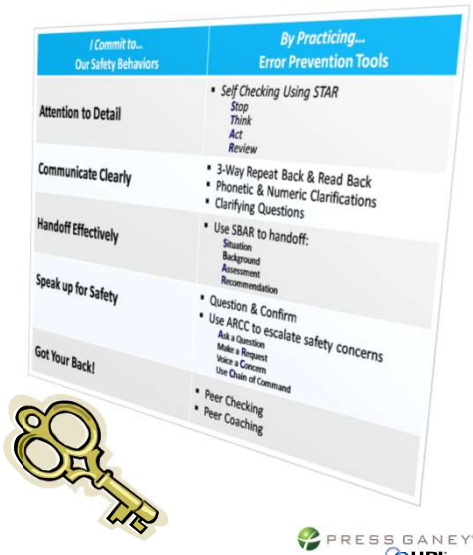
Define behavioral expectations, at every level of the organization, and practices that are proven to help reduce human error

Step 2: Educate

Provide the tools, education and training necessary to change meet behavioral expectations

Step 3: Reinforce & Build Accountability

Hold ourselves and others accountable to practice safety behaviors and make them our personal work habits



PRESS GANEY HPI

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Has your organization made safety culture a priority?

A. **Yes, we talk about the importance of safety culture**

B. **Yes, we have a major initiative (includes all or some of the following: culture survey, training, clear expectations, accountability)**

C. **No, we have not identified safety culture as a priority initiative**

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Role of Leadership in Reducing Harm in Healthcare

The Joint Commission Center for Transforming Healthcare found inadequate safety culture to be a significant factor contributing to adverse outcomes. Culture is shaped by leaders.

Inadequate leadership can contribute to adverse events through:

- ***Insufficient support of patient safety event reporting***
- ***Lack of feedback or response to those who report risk to safety***
- ***Allowing intimidation of staff who report events***
- ***Refusing to consistently prioritize and implement safety recommendations***
- ***Not addressing staff burnout***

Source: The Joint Commission Sentinel Event Alert; Issue 57, March 1, 2017

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Leader Actions to Improve Safety Culture

The Joint Commission recommends leaders take actions to establish and continuously improve five components of a safety culture:

1. *Trust*
2. *Accountability*
3. *Identifying unsafe conditions*
4. *Strengthening systems*
5. *Ongoing assessment*

Continuous Performance Improvement

Source: Chassin MR and Loeb JM. High-reliability health care: getting there from here. The Milbank Quarterly. 2013;91(3):459–490.

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Most Important First Step in Developing TRUST?

A. Adopt and model behaviors that demonstrate a safe-to-speak-up environment

B. Champion efforts to eradicate intimidating behaviors

C. Work with HR/Leadership to create accountability systems (e.g., Just Culture)

D. Understand and participate in performance improvement efforts

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Leaders Creating a Reliable Culture of Safety

"High reliability organizations are pre-occupied with failure, never satisfied that they have not had an accident for many months or years, and they are always alert to the smallest signal that a new threat to safety may be developing."

Source: Mark R. Chassin, MD and Jerod Loeb, MD. *High Reliability Healthcare: Getting There from Here*. The Joint Commission, 2013.

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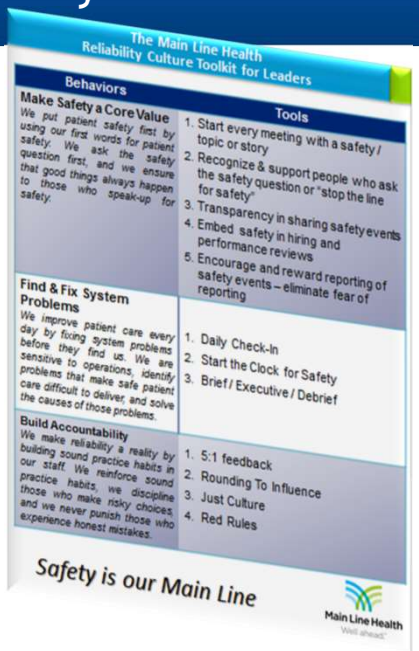
High Reliability Leaders ACT Differently!

1. Define and demonstrate **Safety as a core value!**
2. **Find problems** and **fix causes** in systems and processes
3. **Reinforce** and **build accountability** for behavioral expectations



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Principles of High Reliability

Specific Considerations	General Orientation	Impact on Processes	Ultimate Outcome
Sensitivity to Operations Preoccupation with Failure Deference to Expertise Resilience Reluctance to Simplify	State of Mindfulness	High Reliability	Exceptionally Safe, Consistently High Quality Care

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High Reliability in Health Care

- **Sensitivity to Operations**: Leader Rounding, Daily Operational Huddles (Find & Fix!)
- **Preoccupation with Failure:** Analyzing safety events to include pre-cursor events and near misses; staff check-ins ("What keeps you awake at night?"; "Where might our next error occur and why?")
- **Deference to Expertise:** Including Patient Care Technicians in clinical rounds, bedside shift report *with* patients and families.
- **Resilience*:** COVID-19 – learning as we go, sharing failures and lessons learned, helping each other deal with stress/exhaustion
- **Reluctance to Simplify:** Don't make assumptions about causation – conduct deep analysis ("our bloodstream infections must be up because it is June and new residents started!")

*Healthcare teams have had to redesign their care practices on short notice, then keep redesigning, to manage COVID-19**

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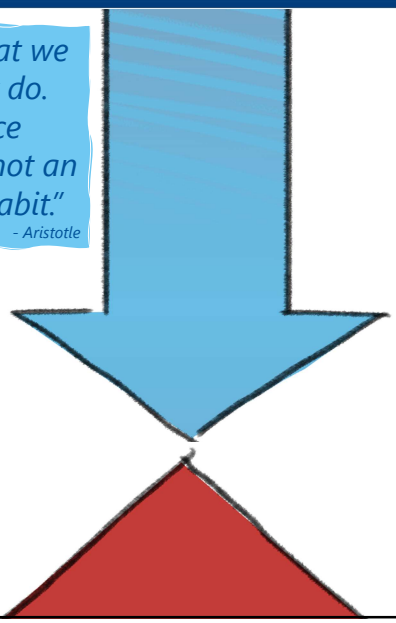
Achieving High Reliability

"We are what we repeatedly do. Excellence therefore is not an act, but a habit."
- Aristotle



To achieve High Reliability we must *consistently* perform work in ways that produce reliable outcomes and in ways that can be sustained.

This lowers risk for errors and harm.

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Leader Standard Work ➡ Consistency!

Leader Standard Work is the regular cadence leaders follow to develop their people and improve their processes so that we get better (more reliable) as an organization.

"High Reliability organizations have systems in place that make them exceptionally consistent."
-Quint Studer

See appendix for example of (BJC) leader standard work practices!

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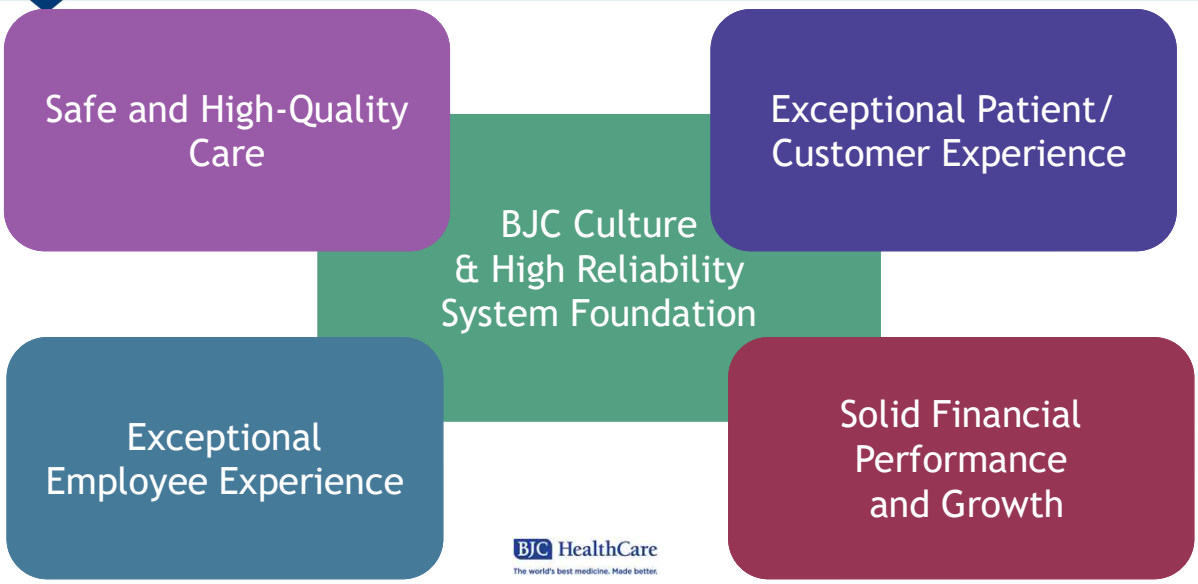
How Do We Measure Success? Experience and Outcomes.



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Institute of Medicine Defined Safe and High Quality Care

STEEEP was trademarked by Baylor Health Care System in 2001 (Now Baylor, Scott and White)

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How Are We Doing? Benchmark!

High Reliability

vizient™

NHSN National Healthcare Safety Network

HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems

Superior Capability and Experience

BEST HOSPITALS U.S.News & WORLD REPORT RANKINGS

ACS NSQIP®

NCI Designated Comprehensive Cancer Center

The Joint Commission National Quality Approval

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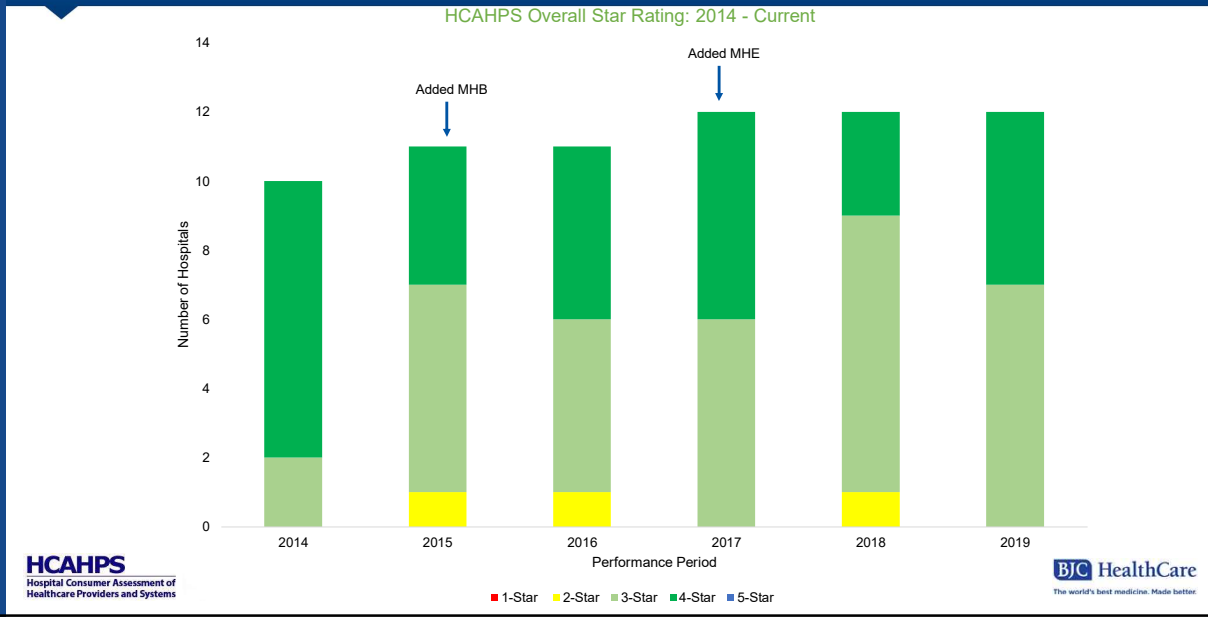
HCAHPS Star Ratings: Overall Star Rating



HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems

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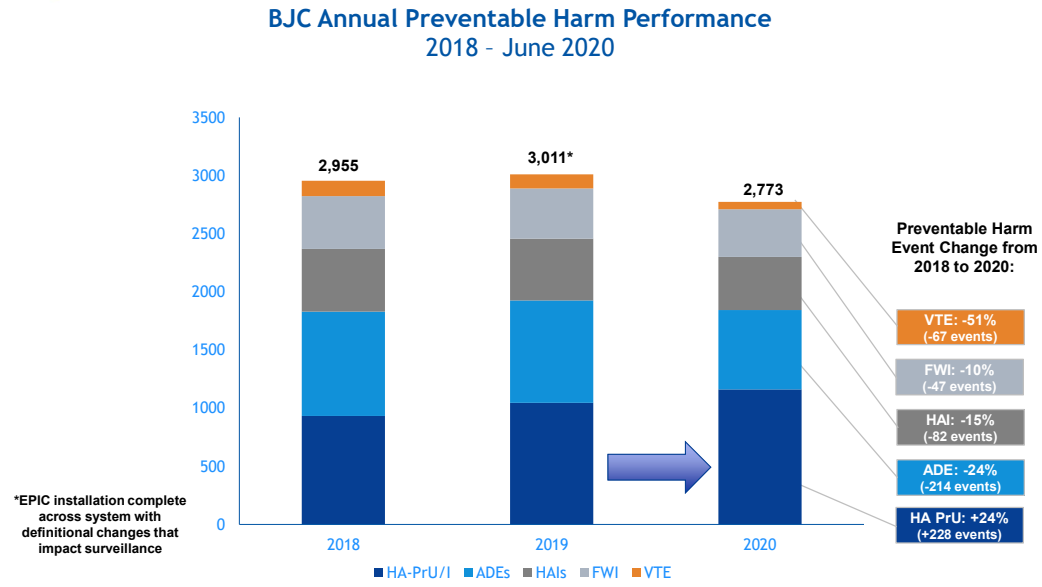
Preventable Harm Performance



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Continuous Performance Improvement

Measure	Action	Current Status
Readmissions	**Resume and prioritize**	Convening the leadership of the active HSO readmissions teams (9 HSOs + BJC Medical Group) on 8/7 to identify system priorities for the remainder of 2020. Additional structural work (e.g. development and deployment of transition of care standards) continues. A key action item is to develop reporting infrastructure to track critical lead metrics.
Sepsis	**Resume and prioritize**	Identified lead metrics with targets (initial lactate, blood culture, and Abx delivery within 3 hours). On-track to implement Epic workflow and documentation pilot in 2 HSOs.
Pressure Ulcers	**Resume and prioritize**	Working with system pressure ulcer team to identify priority areas for 2020, including new documentation and workflows. We are also re-evaluating the system pressure ulcer team structure to better position it to lead system-wide prevention efforts.
Falls	**Revise scope** - finalize measurement strategy	In-process of convening work group to make recommendations on new definition and measurement strategy.
SSIs	**Leverage High Reliability System;** Consider additional action	We continue to monitor our infection prevention performance because of its impact on patients, most importantly, and quality-based reimbursement performance. We are analyzing opportunities where gaps in process have been identified. Two HSOs have increased SSI and action teams are focused on process observation and measurement of the SSI prevention bundle.

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Measuring Employee's Perception of Safety Culture

- ***Communication openness***
- Feedback and communication about errors
- Frequency of events reported
- Handoffs and transitions
- Management support for patient safety
- Organizational learning (continuous improvement)
- Overall perceptions of safety
- Staffing
- Supervisor/manager expectations and actions promoting safety

Agency for Healthcare Research and Quality (AHRQ) - Hospital Survey on Patient Safety Culture

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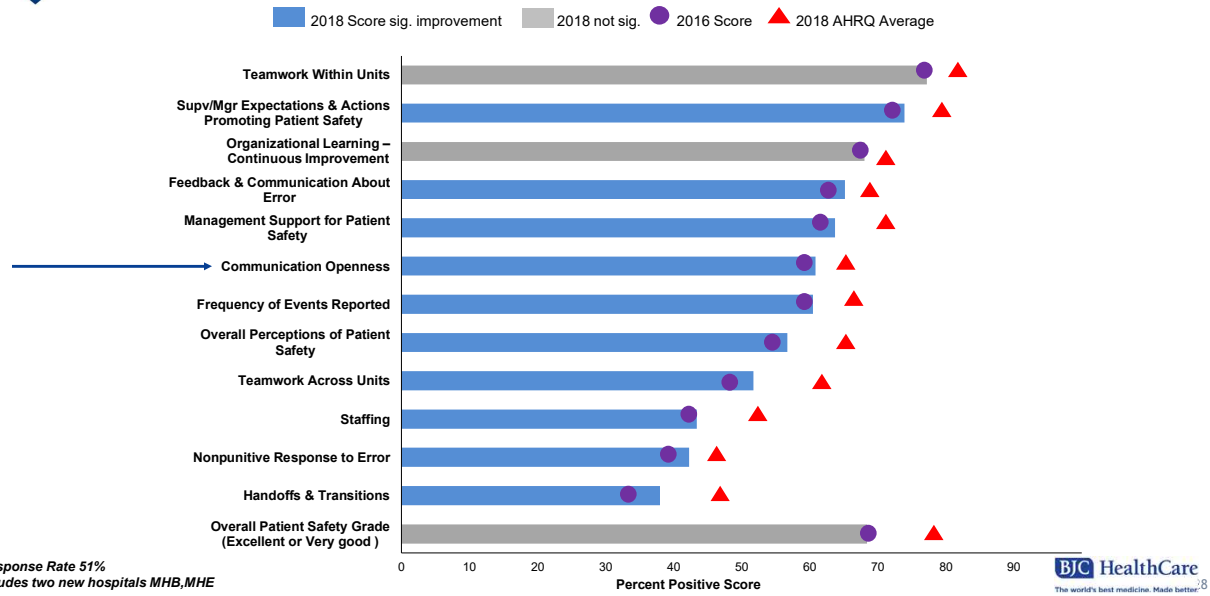
2018 AHRQ Hospital Patient Safety Survey Composites All BJC Hospitals



**Response Rate 51%*
Includes two new hospitals MHB,MHE

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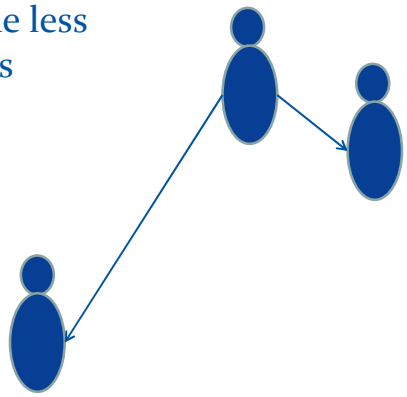
Most Important Cultural Intervention: *Speaking Up for Safety*

Power Distance is the extent to which the less powerful *expect* and *accept* that power is distributed unequally.

Authority gradient is the perception of power and authority as perceived by the subordinate.



Source: HPI *from* * Weick & Sutcliffe attribute of HRO's:5. Deference to expertise.

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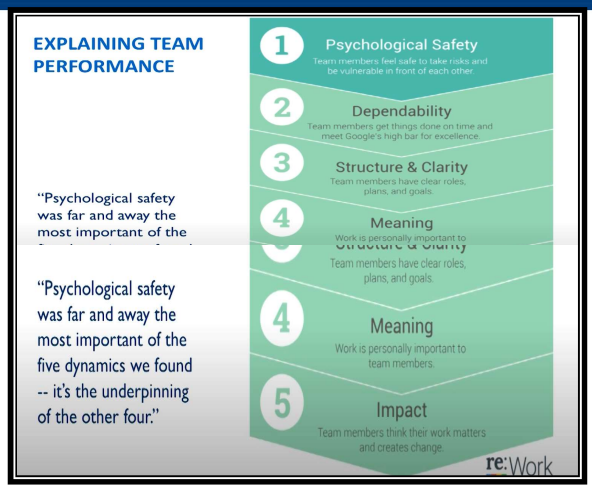
Psychological Safety

- Research in healthcare, factories, education, etc.
  Popularized by Amy Edmondson, PhD
- Google's Project Aristotle
  >180 teams evaluated -
  The single biggest predictor of team success was psychological safety, not team member intelligence



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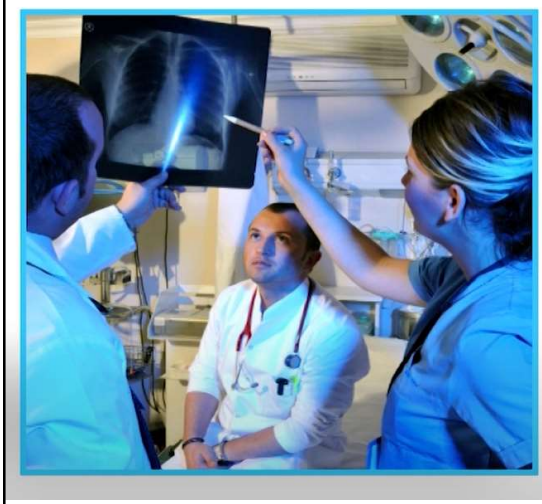
Psychological safety: a shared mental model



Psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes.

THINK OF IT AS FELT PERMISSION FOR CANDOR.

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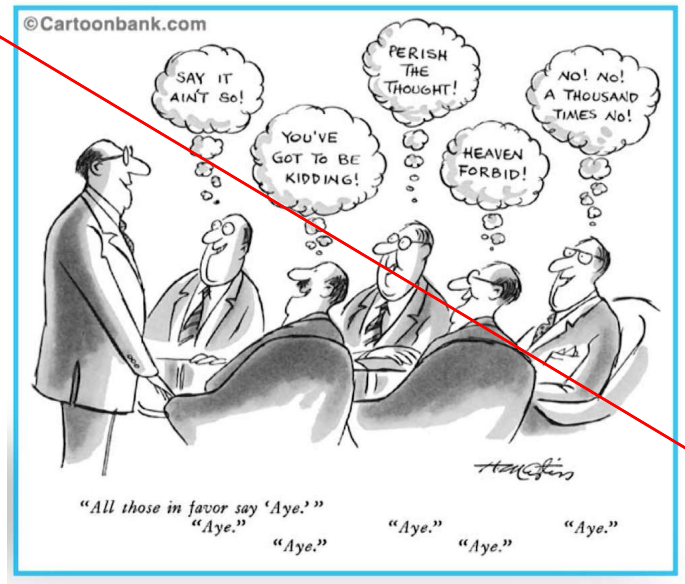
How Leaders Can Promote Psychological Safety



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How Leaders Can Promote Psychological Safety

Create Safe Spaces!

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A Psychologically Safer Space =

- *ALL* employees are allowed to bring their full self to work to contribute
- A supportive environment in which *all* voices are respected and heard
- An expectation of *all* employees to **speak up** and be heard especially when a fellow employee is seen putting him/herself at risk
- *All* respond with grace and gratitude
- 200% accountability

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Psychological Safety Fundamental Elements -

1. **Frame the work**
   a. Add meaning to the work
   b. Remind people of the nature of the work

2. **Invite others in with respect**
   a. Model fallibility ("I may miss something, I need your help.")
   b. Invite input

3. **Ask good questions and model curiosity**
   a. Practice respectful inquiry to broaden/deepen the discussion

4. **Embrace the messenger**
   a. Be clear on how we are all expected to behave
   b. Thank people for speaking up, display grace and gratitude

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How do Patients Benefit from Creating (Team) Safe Spaces?

A. Employees protect patients by speaking up about risk, before errors occur.

B. Patients speak up more to their care team about what they need.

C. In a safe space, team members have each others' back – feel accountable for protecting everyone's patient.

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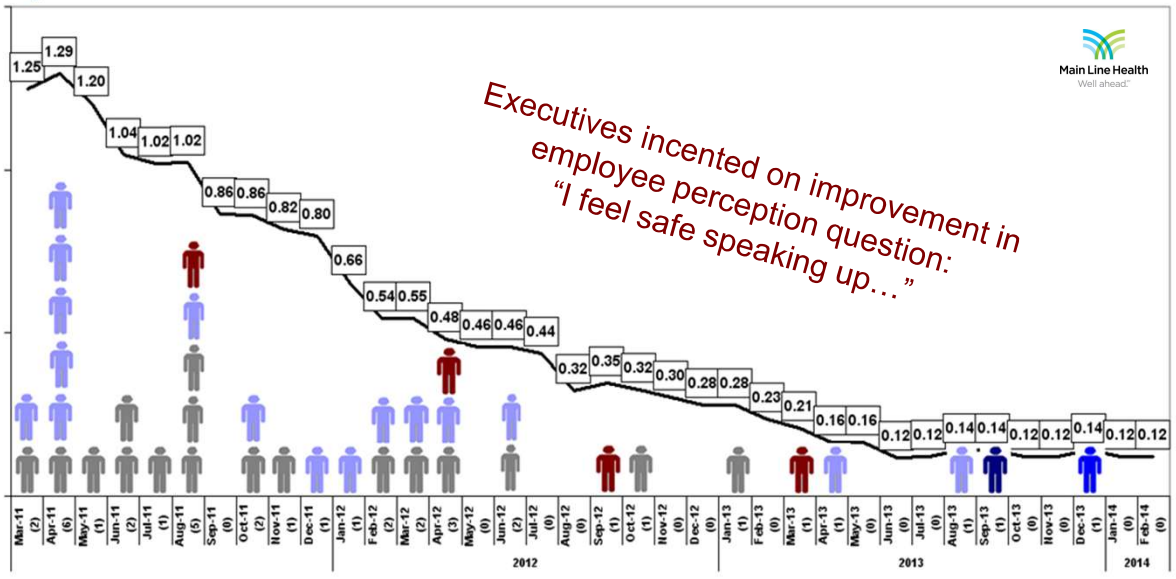
Preventable Harm Serious Safety Events- Speaking Up for Safety = Reduction in Harm



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Summary

- One of the most important roles of leadership and governance is assessing the organizational culture and it's impact on outcomes.
- Cultural transformation takes commitment. Doing three things, *in this order*, are strategies for success:
  - Set clear expectations
  - Provide education, tools and training to meet expectations,
  - Build and sustain accountability!
- High Reliability Organizations deal with complexity and risk for error by
  - Being sensitive to operations. Being present at the front line to know what's really going on.
  - Being pre-occupied with risk – alert for precursors to failure.
  - Deferring to expertise, not standing on title or hierarchy.
  - Being resilient. Leaders learn from failure and celebrate redesign and reinvention. They model self-care.
  - Avoiding simple answers to problems…they dig, they analyze (ask why? why? why?)
- Creating safe spaces, where all voices can be heard, works. When people feel safe to speak up, problems can be found and fixed - errors and harm can be prevented!

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Questions/Comments?

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APPENDIX

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- ❑ Example Scorecard for Patient Safety and Effectiveness (Reliability)
- ❑ BJC Foundational Leader Standard Work
- ❑ BJC Techniques for Speaking Up for Safety
  - Leader
  - Staff
- ❑ Promise to Create Safer Spaces (BJC/St. Louis Children's Hospital)
- ❑ Top Ten Warning Signs of Complacency (around safety & reliability)
- ❑ Ten Questions Board Members Might Ask to Ensure a Culture of Safety and High Reliability
- ❑ Measuring Maturation of Safety Culture

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Framework for a "Score Card" for Patient Safety and Effectiveness

Domain	Definition	Example	
How often do we harm patients?	Measures of health care-acquired infections using standardized definitions and measurement techniques	Catheter-associated blood stream infections	
How often do we provide the interventions that patients should receive?	Measure the proportion of patients that receive evidence-based interventions using either previously validated process of care measures or a validated methodology to develop new measures	Proportion of mechanically ventilated patients receiving elevation of head-of-bed and prophylaxis for peptic ulcers and deep venous thrombosis	Proportion of patients receiving appropriate sepsis and palliative care
How do we know we learned from defects?	What proportion of months does each patient care area/unit learn from mistakes	Proportion of months in which at least one sentinel event was reviewed and a policy was created/revised and/or staff awareness or use of that policy was measured	
How well have we created a culture of safety?	Annual assessment of safety culture at the unit level within a health care institution	Percent of patient care areas in which 80% of staff report positive safety and teamwork climate	

Source: Creating High Reliability in Health Care Organizations
Peter J Pronovost, Sean M Berenholtz, Christine A Goeschel, Dale M Needham, J Bryan Sexton, et al. Health Serv Res. 2006 Aug; 41(4 Pt 2): 1599–1617

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BJC Foundational Leader Standard Work Practices

Manager and Supervisor	Director	Executive
• Attend and coach huddles	• Attend and coach huddles	• Attend and coach huddles
• Recognition	• Recognition	• Recognition
• Rounding with employees	• Rounding with employees/physicians	• Rounding with employees/physicians
• Rounding with patients or customers	• Rounding with patients or customers	• Rounding with patients or customers
• Review staffing/productivity	• Review operational reports and metrics	• Review operational reports and metrics
• Review operational reports and metrics	• Reflect and plan	• Reflect and plan
• Reflect and plan	• Review annual goals (personal and hospital)	• Review annual goals (personal and hospital)
• Review annual goals (personal and hospital)	• Check-in with direct reports	• Check-in with direct reports
	• High Reliability System (HRS) Assessment and Coaching	• HRS Assessment and Coaching

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Leader Behavioral Expectations	Techniques for Speaking Up for Safety
Take personal ownership to prevent and report errors	1. Name and role • Introduce yourself and role to others • Encourage questions 2. Enhance communication • SWAG • **S**tate what you observed/your concern • **W**ait for a response • **A**sk questions that lead to dialogue • **G**ain agreement for next steps 3. Escalate when necessary
Promote high reliability	1. Leader rounding 2. Support Operating System - Tiered huddles, real-time problem solving 3. Use the Just Culture threshold questions and algorithm to assess and respond to an issue: • What happened? • What normally happens? • What does the procedure require • Why did it happen? • How was the organization managing the risk? 4. Take actions to prevent future errors • 5 why's • Champion and lead improvement events • Hold self and other leaders accountable to action plans

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Leader Behavioral Expectations	Techniques for Speaking Up for Safety
Provide Mutual Support	1. Recognize and celebrate great catches 2. Provide support and resources to those who are impacted by an error or safety event 3. Avoid outcome bias 4. Close the loop with those who have reported events/risks

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Staff Behavioral Expectations	Techniques for Speaking Up for Safety
Take personal ownership to prevent and report errors	1. Name and role • Introduce yourself and role to others • Encourage questions 2. Enhance communication • Listen to understand • Ask clarifying questions 3. Escalate and stop the line when necessary • Speak up in the moment • CUS • State Concern • Why you are Uncomfortable • Why this may be a safety issue or risky • Challenge twice then escalate 4. Report issues in SEMS, department huddles, leader rounds or directly to supervisor
Provide Mutual Support	1. Report and celebrate great catches 2. Seek support and resources if you are impacted by an error or safety event 3. Avoid speculation and assumptions

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At BJC, we promise to build safer spaces:

What I will promise	How I will do it
Promise to care about you	• Connect, ask, listen and act to improve • Demonstrate kindness, caring and concern • Seek to understand • Ensure equity & inclusion & honor differences • Find & fix problems for continuous improvement • Be relentless in pursuit of results • Create a safe environment • Seek to learn from failure • Build & embrace diverse teams • Demonstrate collaboration and partnership
Promise to treat you with dignity	
Promise to be my best	
Promise to keep you safe	
Promise to partner with you	

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Top Ten Warning Signs of Complacency Around Safety Culture

- ❑ Group Think
- ❑ Failure to systematically identify, prioritize and correct safety /quality/service concerns at every level of the organization
- ❑ Satisfaction with benchmarking data (comparing to the floor vs. the ceiling)
- ❑ Cost-containment impacts safety focus
- ❑ Increasing or stable Serious Safety Event reporting
- ❑ Reduction of Precursor/Near-Miss Safety Event reporting
- ❑ Low investment/effort in sharing lessons-learned
- ❑ Lack of common cause analysis and event trending
- ❑ Morale decreasing and/or work stress rising
- ❑ Leadership (operational and medical staff) not leading for reliability

PRESS GANEY
HPI

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The Board's Most Important Role: Ask Tough Questions

1. Why aren't we aiming for zero or 100% all the time? What makes achieving zero or 100% (top decile) so hard?
2. What are we doing to prevent the next error/undesired outcome from occurring?
3. What percent of errors/undesired outcomes are preventable?
4. Is "staffing" a factor when error/undesired outcome occurs? What's the staff' perspective?
5. When we improve, what are we doing to **sustain** the gains?
6. Do we know how our competitors are doing? Are our populations comparable (with competitors)? How do we know?
7. How transparent can we be from a legal/risk management perspective?
8. What achievements are "safe" to market?
9. Do we involve patients and/or families in our programs/improvement initiatives? If so, how? If not, when and how can we begin?
10. Are we a high reliability organization? If not, what are our plans to get there?

DMM 2010 48

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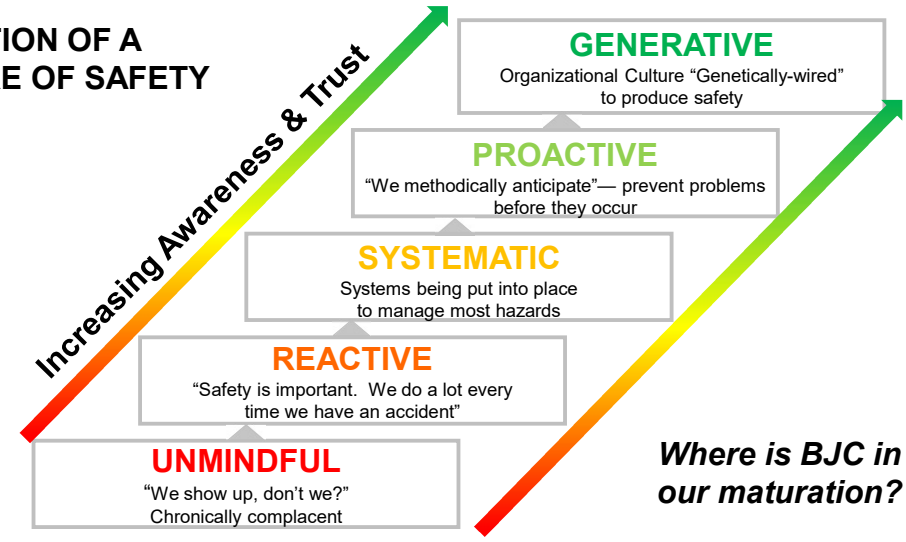
Maturation of a Culture of Safety – A Good Board Exercise

EVOLUTION OF A CULTURE OF SAFETY



Where is BJC in our maturation?

Adapted from Paschal Metrics, Socio-Technical Framework 49

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