A FRAMEWORK FOR HABITUAL ORGANIZATIONAL EXCELLENCE

Culture is behavior over time

Teamwork is an effective mechanism to structure and practice the desired behaviors

Continuous learning and improvement allows us to embed team behaviors in the clinical work we care about
EVOLUTION OF A CULTURE OF SAFETY AND RELIABILITY

PATHOLOGICAL
Who cares as long as we’re not caught
Chronically Complacent

REACTIVE
Safety is important. We do a lot every
time we have an accident

CALCULATIVE
We have systems in place to manage all
hazards

PROACTIVE
Anticipating and preventing problems
before they occur

GENERATIVE
Safety is how we do business around
here
Constantly Vigilant

Increasing Awareness & Trust

Where are you?

*Adapted from Safeskies 2001, “Aviation Safety Culture,”
Patrick Hudson, Centre for Safety Science, Leiden University
CULTURE

“The way we do things around here.”

The visible attributes
The espoused values
The hidden values

—Edgar Schein
The Critical Role of Effective Leadership
Psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes.

A shared sense of psychological safety is a critical input to an effective learning system


Amy Edmondson
PSYCHOLOGICAL SAFETY IS LOCAL

In this clinical area, it is difficult to speak up if I perceive a problem with patient care.

Note: Use the multicolored bars to see how you fit with the benchmark archive. If you have less red and more green than the benchmark, you are more positive than the benchmark. If the colors all match up, you are about the same as the benchmark.
PSYCHOLOGICAL SAFETY

We are our own image consultants and best image protectors.

To protect one’s image, if you don’t want to look:

<table>
<thead>
<tr>
<th>Stupid</th>
<th>Ask questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incompetent</td>
<td>Ask for feedback</td>
</tr>
<tr>
<td>Negative</td>
<td>Be doubtful</td>
</tr>
<tr>
<td>Disruptive</td>
<td>Be innovative</td>
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</table>

Source: Amy Edmondson
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Social and Environmental Conditions Creating Fluctuating Agency for Safety in Two Urban Academic Birth Centers

Audrey Lyndon

ABSTRACT

Objective: To identify processes affecting agency for safety among perinatal nurses, physicians, and certified nurse-midwives.

Design: Grounded theory, as informed by Strauss and Schatzman.

Setting: Two academic perinatal units in the western United States.

Participants: Purposive sample of 12 registered nurses, 5 physicians, and 2 certified nurse-midwives.

Findings: Agency for safety (the willingness to take a stand on an issue of concern) fluctuated for all types of providers depending on situational context and was strongly influenced by interpersonal relationships. While physicians and certified nurse-midwives believed that they valued nurses' contributions to care, their units had deeply embedded hierarchies. Nurses were structurally excluded from important sources of information exchange and from contributing to the plan of care. Nurses' confidence was a key driver for asserting their concerns. Confidence was undermined in novel or ambiguous situations and by poor interpersonal relationships, resulting in a process of redefining the situation as a problem of self.

Conclusions: Women and babies should not be dependent on the interpersonal relationships of providers for their safety. Clinicians should be aware of the complex social pressures that can affect clinical decision making. Continued research is needed to fully articulate facilitators and barriers to perinatal safety.

JOGNN, 37, 13-23, 2008. DOI: 10.1111/J.1552-6909.2007.00204.x

Accepted October 2007
CULTURE OF SAFETY

No one is ever hesitant to voice a concern about a patient

Caregivers - capable, conscientious and playing by the rules – feel comfortable to speak up regarding errors, near misses and adverse events

When people do speak up, they have a high degree of confidence that the organization will act on their concerns and demonstrate such.

There is a cyclic flow of information that leads to analysis, action and feedback - a learning organization – to reinforce well defined behaviors and values
WRONG SITE SURGERY OR RETAINED FOREIGN BODY IN 17 OPERATING ROOMS

RN vs. Surgeon Safety Climate Attitudes (Post-SAQ Scores)

Operating Rooms
Patient Safety: Reportable Stage 3+ Hospital

Safety Climate

≤ 65

≥ 65

2.9

0.4

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The larger the circle, the more people in the work setting.
What Distinguishes Top-Performing Hospitals in Acute Myocardial Infarction Mortality Rates?

A Qualitative Study

Leslie A. Curry, PhD; Erica Spatz, MD; Emily Cherlin, PhD, MSW; Jennifer W. Thompson, MPP; David Berg, PhD; Henry H. Ting, MD, MBA; Carole Decker, RN, PhD; Harlan M. Krumholz, MD, SM; and Elizabeth H. Bradley, PhD

Background: Mortality rates for patients with acute myocardial infarction (AMI) vary substantially across hospitals, even when adjusted for patient severity; however, little is known about hospital factors that may influence this variation.

Objective: To identify factors that may be related to better performance in AMI care, as measured by risk-standardized mortality rates.

Design: Qualitative study that used site visits and in-depth interviews.

Setting: Eleven U.S. hospitals that ranked in either the top or the bottom 5% in risk-standardized mortality rates for 2 recent years of data from the Centers for Medicare & Medicaid Services (2005 to 2006 and 2006 to 2007), with diversity among hospitals in key characteristics.

Participants: 158 members of hospital staff, all of whom were involved with AMI care at the 11 hospitals.

Measurements: Site visits and in-depth interviews conducted with hospital staff during 2009. A multidisciplinary team performed analyses by using the constant comparative method.

Results: Hospitals in the high-performing and low-performing groups differed substantially in the domains of organizational values and goals, senior management involvement, broad staff presence and expertise in AMI care, communication and coordination among groups, and problem solving and learning. Participants described diverse protocols or processes for AMI care (such as rapid response teams, clinical guidelines, use of hospitalists, and medication reconciliation); however, these did not systematically differentiate high-performing from low-performing hospitals.

Limitation: The qualitative design informed the generation of hypotheses, and statistical associations could not be assessed.

Conclusion: High-performing hospitals were characterized by an organizational culture that supported efforts to improve AMI care across the hospital. Evidence-based protocols and processes, although important, may not be sufficient for achieving high hospital performance in care for patients with AMI.

Primary Funding Source: Agency for Healthcare Research and Quality, United Health Foundation, and the Commonwealth Fund.


For author affiliations, see end of text.
Perceptions of Hospital Safety Climate and Incidence of Readmission

Luke O. Hansen, Mark V. Williams, and Sara J. Singer

Objective. To define the relationship between hospital patient safety climate (a measure of hospitals’ organizational culture as related to patient safety) and hospitals’ rates of rehospitalization within 30 days of discharge.


Data Collection. Robust multiple regressions used 30-day risk-standardized readmission rates as dependent variables in separate disease-specific models (acute myocardial infarction [AMI], heart failure [HF], pneumonia), and measures of safety climate as independent variables. We estimated separate models for all hospital staff as well as physicians, nurses, hospital senior managers, and frontline staff.

Principal Findings. There was a significant positive association between lower safety climate and higher readmission rates for AMI and HF ($p \leq .05$ for both models). Frontline staff perceptions of safety climate were associated with readmission rates ($p \leq .01$), but senior management perceptions were not. Physician and nurse perceptions related to AMI and HF readmissions, respectively.

Conclusions. Our findings indicate that hospital patient safety climate is associated with readmission outcomes for AMI and HF and those associations were management level and discipline specific.
Effect of a Comprehensive Surgical Safety System on Patient Outcomes

Eefje N. de Vries, M.D., Ph.D., Hubert A. Prins, M.D., Ph.D.,
Rogier M.P.H. Crolla, M.D., Adriaan J. den Outer, M.D.,* George van Andel, M.D., Ph.D., Sven H. van Helden, M.D., Ph.D.,
Wolfgang S. Schlack, M.D., Ph.D., M. Agnès van Putten, B.Sc.,
Dirk J. Gourna, M.D., Ph.D., Marcel G.W. Dijkgraaf, Ph.D.,
Susanne M. Smorenborg, M.D., Ph.D., and Marja A. Boermeester, M.D., Ph.D.,
for the SURPASS Collaborative Group†

ABSTRACT

BACKGROUND

Adverse events in patients who have undergone surgery constitute a large proportion of iatrogenic illnesses. Most surgical safety interventions have focused on the operating room. Since more than half of all surgical errors occur outside the operating room, it is likely that a more substantial improvement by targeting the entire surgical pathway.
EFFECTIVE COMMUNICATION AND TEAMWORK REQUIRES:

<table>
<thead>
<tr>
<th>Structured Communication</th>
<th>Briefing, Checklist, SBAR, Debriefing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assertion/Critical Language</td>
<td>Key words, the ability to speak up and stop the show</td>
</tr>
<tr>
<td>Psychological Safety</td>
<td>An environment of respect</td>
</tr>
<tr>
<td>Effective Leadership</td>
<td>Flat hierarchy, sharing the plan, continuously inviting other team members into the conversation, explicitly asking people to share questions or concerns, using people’s names</td>
</tr>
</tbody>
</table>
**TEAMS**

**WHAT TEAMS DO:**
- Plan Forward
- Reflect Back
- Communicate Clearly
- Manage Conflict

**The associated behaviors:**
- Brief (huddle, pause, timeout, check-in)
- Debrief
- Structured Communication SBAR and Repeat-Back
- Critical Language
INITIAL IMPRESSION
Arun Chaudhuri, Medical Director, Acute Medicines Unit
Ninewells Hospital, Dundee, Scotland
ICU Percent of Patients Receiving all Four Aspects Of Ventilator Bundle

- Marked beds at 30 degree angle
- Fact Sheet for staff education
- Poster with weekly data feedback
- Vent bundle posted in all vent patient rooms
- Began initial trials of Daily goal sheet and pre-extubation sheet
- Initiated Powerpoint education for RT/RN
- Initiated Clinical Pharm rounds
- 1st test of multidisciplinary rounds
- Expanded use of Pre-extubation sheet
- Staff education on Goal sheet; mini inservices on unit on SBT and Pre-extubation sheet
- Incorporated Goal Sheet into Multidisciplinary Rounds
- Impact Extravaganza (staff/MD education)
- Expanded multidisciplinary rounds to include additional disciplines
- Check compliance on night shift past 2 weeks
- New sign at HOB
- One on one follow up by Nursing & RT managers on collaboration in weaning process

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THE LEARNING BOARD

OPPORTUNITIES IDENTIFIED DURING DEBRIEFINGS

CLINICAL
Couldn’t find blood pressure cuff for patient yesterday.

BEHAVIORAL
No debriefing at end of meeting last week, although meeting didn’t go well. Some members quiet.

OPERATIONAL
No parking for patients or staff – both late in getting into clinic.

DEBRIEFING ISSUES IN PROCESS

ACTION
Action: Angela testing a checklist during briefing.
Briefing done, but team members didn’t come away with an understanding of the game plan. Similar problem last week.

COMPLETED

<table>
<thead>
<tr>
<th>Complete</th>
<th>Resolved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete</td>
<td>Resolved</td>
</tr>
<tr>
<td>Complete</td>
<td>Complete</td>
</tr>
<tr>
<td>Improved</td>
<td>Improved</td>
</tr>
</tbody>
</table>
DEBRIEFING

ASK 3 QUESTIONS:

• What did we **do well**?

• What could we do **better**?

• What do we **want to do differently** tomorrow or next time?
<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Defects</td>
<td>117</td>
</tr>
<tr>
<td>% of Defects Completed</td>
<td>43%</td>
</tr>
<tr>
<td>% Of Defects In Progress</td>
<td>41%</td>
</tr>
<tr>
<td>% of Defects Not in Progress</td>
<td>11%</td>
</tr>
<tr>
<td>Defects without movement in &gt;30 Day</td>
<td>33</td>
</tr>
<tr>
<td>Defects without movement in &gt;60 Day</td>
<td>27</td>
</tr>
</tbody>
</table>
MERCY ANDERSEN HOSPITAL, CHP

Melissa

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