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Strategies for Building a Culture of Safety



Strategies for Building a Culture of Safety

1. Assessing our culture of safety and promote readiness for implementation of team training
2. Identifying barrier and strategies to sustaining teams and effective communication
3. Strategies for transforming our culture to promote organizational learning and prioritize opportunities for improvement



Creating and Sustaining a Culture of Safety

Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures (Health and Safety Commission 1993; Denham, 2007)





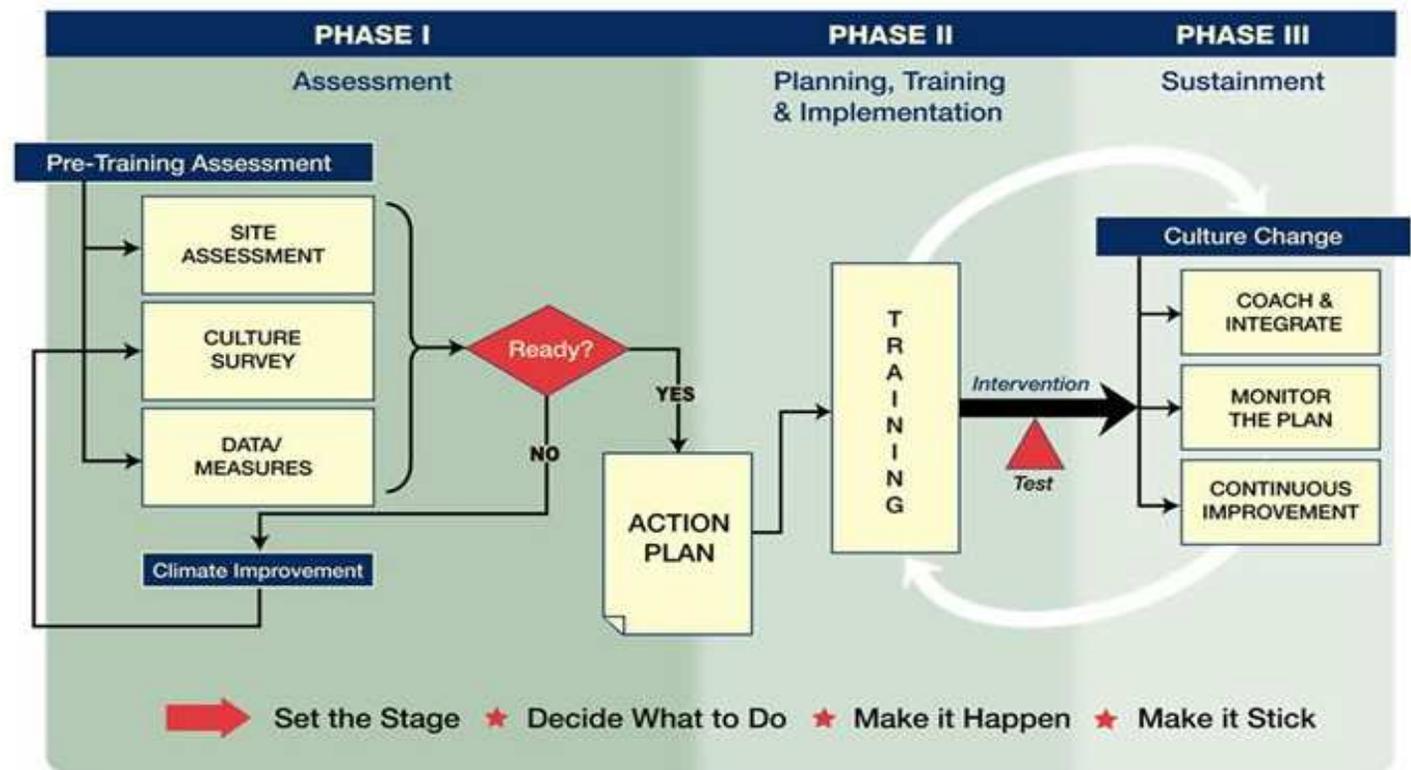
National Quality Forum Best Practices for Safer Healthcare 2009

- Chapter 2: Improving Patient Safety by Creating and Sustaining a Culture of Safety
 - **Safe Practice 1:** Leadership structures and systems
 - **Safe Practice 2:** Culture measurement, feedback, and intervention
 - **Safe Practice 3:** Teamwork training and skill building
 - **Safe Practice 4:** Identification and mitigation of risks and hazards



Safety Culture, Leadership, and Teamwork Training

- Implementing and sustaining enhanced communication and teamwork strategies through a comprehensive approach:
 - Assessment
 - Identification and prioritization of opportunities for improvement
 - Skills training
 - Evaluating effectiveness
 - Providing feedback





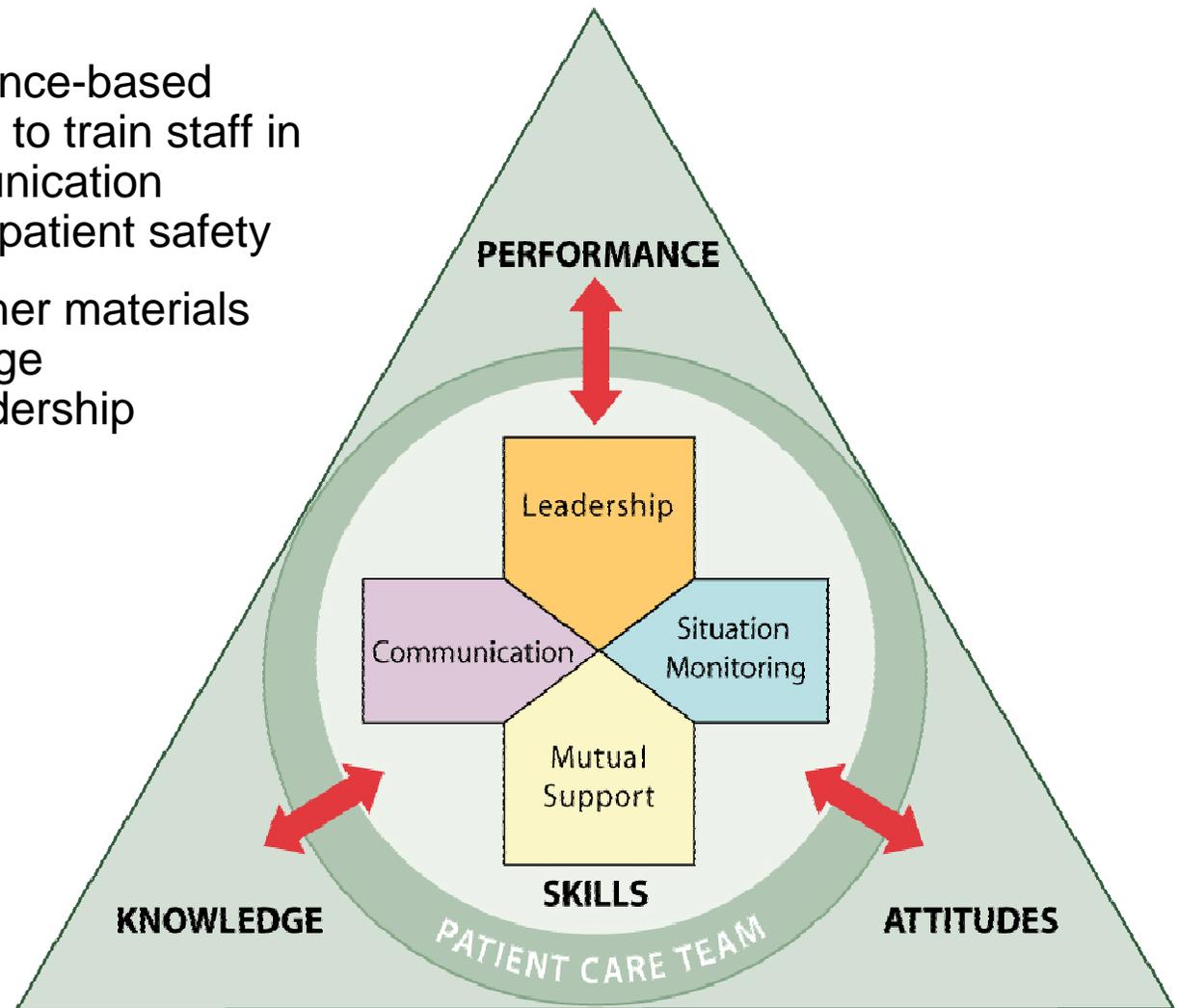
Strategies for Promoting Teamwork

- Team training or training in principles of crew resource management
 - Recognizes impact of human factors in a complex setting such as healthcare and the relationship to medical error
 - Acknowledges the role of communication as the predominant root cause of medical errors (The Joint Commission Sentinel Event Database)
 - Seeks to enhance communication and teamwork to promote safety through training of clinicians and other staff and implementation of specific strategies



Strategies for Promoting Teamwork

- TeamSTEPPS™
 - Comprehensive evidence-based multimedia curriculum to train staff in teamwork and communication strategies to promote patient safety
 - Includes train-the-trainer materials and modules on change management and leadership





Enhanced Communication and Teamwork Strategies

- Examples of strategies
 - **Interdisciplinary rounds**
 - **SBAR**—**S**ituation, **B**ackground, **A**ssessment, **R**ecommendation
 - Structured methodology for communicating changes in the patient's condition and for hand-offs
 - **Briefs**—short discussion to communicate plan, assign roles, anticipate outcomes and contingencies, and answer questions
 - **Huddles**—ad hoc planning to modify plan or reinforce plans already in place as indicated and re-establish situational awareness
 - **Cross monitoring**—error reduction strategy; monitoring the actions of other team members
 - **Inter and multidisciplinary drills and simulation exercises**



Barriers to Successful Implementation of Teamwork Strategies

- Inadequate leadership support and ongoing engagement in the project
- Lack of a team-based interdisciplinary approach
- Lack of clear definition and communication of goals of the improvement plan/strategy. **What are we trying to accomplish?**
- Failure to communicate the imperative to all stakeholders and provide ongoing feedback
- Inadequate understanding of safety culture strengths and weaknesses



Barriers and Corresponding Strategies

- **Inadequate leadership support**

- Implement as part of an organizational performance improvement initiative
- Educate leadership on the evidence-base
- Report regularly on progress and metrics to leadership
- Leaders should discuss the initiative with staff routinely during meetings and during rounds



Barriers and Corresponding Strategies

- **Lack of team-based interdisciplinary approach**
 - Create a steering committee that includes representatives from each discipline
 - Select your champions
 - Designate a facilitator or team leader
 - Educate the steering committee
 - Evidence-base for teamwork
 - Leadership, change management, and feedback
 - Conduct training in interdisciplinary teams





Barriers and Corresponding Strategies

- **Lack of clear goals and communication of the improvement plan**
 - The Steering Committee should clearly agree upon the improvement goals
 - Define meaningful goals based on improvement objectives
 - Based on goals identify process and/or outcome measures—more on this later
 - Communicate goals and ongoing progress to all stakeholders



Barriers and Corresponding Strategies

- **Failure to communicate the imperative to all stakeholders and provide ongoing feedback**
 - Change is challenging—clearly communicate the evidence-base and the internal and external data that supports the need for improvement
 - Share progress at all staff and operational meetings
 - Discuss adverse events and near misses and share the identified contributory and underlying causes
 - Post data in a meaningful format
 - Celebrate successes



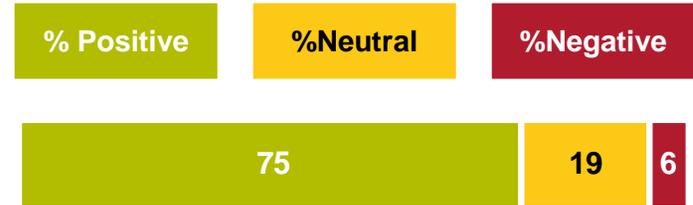
Barriers and Corresponding Strategies

- **Inadequate understanding of safety culture, strengths and weaknesses**
 - Assessing readiness by evaluating leadership support and service line commitment
 - Evaluate staff attitudes and perceptions regarding safety, communication, and team work
 - Validated tools available
 - Survey must be completed by all disciplines
 - Maximizing return rate
 - Communicating findings to staff
 - Developing an improvement plan based on the findings
 - Several validated tools available
 - Agency for Healthcare Research and Quality
 - University of Texas Safety Attitudes Questionnaire (Sexton Tool)



Examples of Survey Findings—Communication Openness

1. Staff will freely speak up if they see something that may negatively affect patient care (C2)



2. Staff feel free to question the decisions or actions of those with more authority (C4)



^R3. Staff are afraid to ask questions when something does not seem right (C6)



Source: AHRQ Hospital Survey of Patient Safety Culture.

^R Indicates reversed-worded items.

Note: The item letter and number in parentheses indicate the item’s survey location.



Measuring Effectiveness and Continuous Improvement

- Using data to sustain improvements and continuously improve –
 - Survey should be part of an improvement strategy
 - Findings and improvement plans must be shared
 - Process measures
 - Interdisciplinary rounds—number of days conducted with all disciplines present/number of days in month
 - SBAR-direct observation—number of specific components used/number of observations
 - Outcome measures
 - Improvement in scores in specific survey domains
 - RAND Report: *Outcome Measures for Effective Teamwork in Inpatient Care Final Report. 2008.*
 - Examples
 - Time elapsed from decision to incision for urgent cesarean section
 - Unplanned intubation
 - Venous thromboembolism



Final Comments

- Implementation of practices will require ongoing coaching and feedback
- Strategies will not succeed without a comprehensive organizational approach to safety that includes:
 - A just culture approach to review of events and near misses
 - An interdisciplinary approach to continuous improvement
 - Strategies to minimize and manage disruptive behavior



Key Points

- A culture of safety is necessary in order to achieve lasting systemic changes that promote safety in an organization
- A culture of safety has specific attributes, including a non-punitive approach to error management, emphasis on learning, and minimal authority gradient
- Disruptive clinician behavior violates the principles of a culture of safety and endangers patients
- Disruptive clinician behavior must be managed with a comprehensive approach that includes setting expectations, training, and progressive discipline



True Quotes

“It’s no big deal—that’s just the way he/she is. We’ve just learned to work around him/her.”

“RN did not call MD about change in patient condition because he had a history of being abusive when called. Patient suffered because of this.”

“I don’t have a problem with anger. I have a problem with idiots.”



The Indianapolis Star

March 5, 2005

Doctor Must Pay In Bullying Case

By Eric Martin

In a potentially landmark case involving workplace bullying, a jury in Marion Superior Court on Friday ordered St. Francis Hospital's chief heart surgeon, Dr. Daniel H. Raess, to pay a former hospital employee \$325,000. The award to Joseph E. Doescher, 44, stemmed from a Nov. 2, 2001, confrontation between the two men during which Raess was accused of screaming and lunging toward Doescher. Doescher worked at the hospital as a perfusionist, operating equipment that oxygenates the blood during surgery. The jury declined to award additional punitive damages against Raess in what one expert said was the first workplace bullying case in history. **This is the first time a workplace bullying case has been heard in the United States according to Gary Namie, director of the Workplace Bullying and Trauma Institute in Bellingham, Wash.** Laws making workplace bullying illegal have been introduced in Hawaii and Washington state.



Defining Disruptive or Maladaptive Behavior

- The American Medical Association (AMA) has defined disruptive behavior as a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care*
- The AMA reminds physicians of their ethical obligation to recognize their responsibility not only to patients, but also to society, to other health professionals, and to self
- Physicians are urged to recognize that the symptoms of stress, such as exhaustion and depression, can negatively affect their health and performance, and are encouraged to seek the support needed to help them regain their equilibrium

*AMA H-140.918 Disruptive Physician Policy



Portion of Code of Ethics for Nurses—ANA 2006

- Respect the inherent worth, dignity, and human rights of every individual
- Maintain compassionate and caring relationships with colleagues and others with a commitment to the fair treatment of individuals, to integrity-preserving compromise, and to resolving conflict
- Support and assist nurses who report unethical, incompetent, illegal, or impaired practice and to protect the practice of those who choose to voice their concerns





Examples of Disruptive and Maladaptive Behavior by Any Staff

- Inappropriate anger or resentments
- Intimidation
- Abusive language—profane or disrespectful
- Blames or shames others for possible adverse outcomes
- Seductive, aggressive, or assaultive behavior
- Racial, ethnic, or socioeconomic slurs
- Lack of regard for personal comfort and dignity of others
- Unnecessary sarcasm or cynicism
- Threats of violence, retribution, or litigation



Why do We Care? Exposure and Impact from Disruptive Behavior

- Professional liability
- General liability
- Property
- Workers' compensation (WC)
- Director's and officers' liability (D&O)
- Employment practices liability (EPL)
- Reputational risk



Frequency of Disruptive Behavior

- Involves less than 5 percent of physicians (Weber)
- Experienced by 64 percent of nurses (McMillin)
- 23 percent of nurses report something thrown (McMillan)
- Reported by 96 percent of nurses (Rosenstein 2002)
- 68 percent reported disruptive nurses (Rosenstein 2005)
- A survey on intimidation conducted by the Institute for Safe Medication Practices found that 40 percent of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator.

Rosenstein AH. Nurse-physician relationships: Impact on nurse satisfaction and retention. *American Journal of Nursing*, 2002; 102 (6): 26-34.

Rosenstein AH, O'Daniel M. Disruptive behavior and clinical outcomes: perceptions of nurses and physicians. *American Journal of Nursing*, 2005; 105(1): 54-64.



Impact of Disruptive Behavior—Costly, Literally and Figuratively

- Workforce:
 - Single biggest factor in job satisfaction for nurses
 - 31 percent knew at least one nurse who left because of it (Rosenstein, 2005)
 - 18 percent turnover attributed to verbal abuse (Cox, 1987)
 - 9 percent of MDs Accounted for 50 percent of Complaints (6-year study period)

Rosenstein AH, O'Daniel M. Disruptive behavior and clinical outcomes: perceptions of nurses and physicians. *American Journal of Nursing*, 2005; 105(1): 54-64.

Cox HC. Verbal abuse in nursing: report of a study. *Nursing Management*, 1987; 18: 47-50.



Industry Responses

- Joint Commission leadership standards:
 - LD.3.10 Leaders create and implement a process for managing disruptive and inappropriate behaviors
- Joint Commission Sentinel Event Alert—July 9, 2008
 - “Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions.”
 - Health care organizations that ignore these behaviors also expose themselves to litigation from both employees and patients



What Drives Disruptive Behavior?

- Stress—financial, job performance
- Press
- Pressure
- Perfectionism
- Inability to separate home from work stressors
- Lack of familiarity among team members—culture
- Anger mis-management
- Mismatched skills and placement
- **Not always drug or alcohol abuse**



Why Do We Tolerate This Behavior? Fear and Reluctance

- 49 percent of respondents to The Institute of Safe Medication Practices (ISMP) survey reported pressure to administer drug despite serious unresolved safety concerns
- 40 percent kept quiet about a safety concern rather than question a known disrupter
- Only 33 percent of hospitals took action regarding identified problems with disruptive behavior
 - 24 percent of those reported improvement! (Rosenstein & O'Daniel, 2005)

Rosenstein AH, O'Daniel M. Disruptive behavior and clinical outcomes: perceptions of nurses and physicians. *American Journal of Nursing*, 2005; 105(1): 54-64.



What Is Needed?

- Clear expectations about acceptable behavior
- Training, coaching, and mentoring for those who struggle with parameters
- Active Monitoring
 - Rounds
 - Surveys
 - Focus groups





Steps to Deal with Behavior Challenges Leadership Must “Own” the Oversight

- Training, coaching, and mentoring
- Early intervention for even “mild” allegations of violations
- Consistent, systemic response and enforcement
- Policy and procedures enforcing clear expectations for **all**
- Communicate with the person—what is behind the behavior?
- Rehearse the conversation/confrontation

Ultimate Goal: Early intervention and support



Rehearsing A Conversation/Confrontation

- Review circumstances—just the facts
- Invite colleague's version
- Engage colleague in corrective action plan and follow up
- Express appreciation
- Document the meeting and advise colleague that it is being documented including the action plan
- **Give Positive Feedback!**



Leadership Must Own This Issue

- Universal Code of Conduct
- Training and follow up
- Review of violations
- Recommendations for response/follow-up
- Identification of system causes of conflict
- Actively monitor for code violations:
 - Rounds
 - Surveys
 - Focus groups



Clear Expectations—Universal Code of Conduct

- Clearly define what you want from **all staff**:
 - Respect
 - Teamwork
 - Safe environment for asking questions
- Clearly describe what you **don't** want:
 - Intimidation
 - Undermining confidence
 - Name-calling
 - Assault
 - Retaliation





In Summary

- Spread the word about zero tolerance for these behaviors
- Be consistent with action plans and follow up
- Remember that this impacts patient safety, employee safety, employee morale and will increase bottom line revenues as a bonus!
- Be open, honest and direct when confronting practitioners
- Focus on building a **learning** culture, not a punitive one



Cornerstone of Risk Management Event/Near Miss Reporting

- Before the 1990s—shame and blame
- The threat of disciplinary action for errors was thought to be necessary to maintain proper safety vigilance
- By the mid-1990s—blame-free
- Culture shift to “no-blame”—acknowledged human fallibility and the impossible task of perfect performance
- By the late 1990s—just culture
- Willingness to learn from events and investigation of systems and process not just staff involved
- It is Not **who** caused the event but **what** caused the event?



“Just Culture”

- Designed to address both system issues and individual behavior
 - Shift from focus on errors and outcomes...to system design and behavioral choices
 - Achieve a culture where frontline staff feel comfortable disclosing errors
- Plan and design for patient safety
 - FMEA
 - Protocols
 - Communication tools
- Key Elements
 - Create a learning culture
 - Create an open and fair culture
 - Design safe system
 - Manage behavioral choices



Creating a Learning Culture

- Atmosphere of mutual trust, all staff can talk freely about safety problems and how to solve them
- No fear of blame or punishment for system errors
- Learn from our mistakes
- Conduct an assessment of the current culture—how well does your culture support and promote safety efforts?



Creating an Open and Fair Culture

- Accountability for safety across all levels of the organization
- Safety is everyone's job
- Team training—how best to work together
- Standardized communication techniques
 - Briefing
 - Huddles
 - SBAR
- Interdisciplinary rounds





Design Safe System

- Anticipate error
- Redundancy in high-risk procedures
- Vigilant for system weaknesses
- Talk about patient safety at every staff meeting
- Consider why rules may be broken



Manage Behavioral Choices

- **Human error**—a slip, a mistake, or mistakenly doing something other than what should have been done
- **At-risk behavior**—a choice is made that increases risk where there was none previously
 - Not checking patient identification using two identifiers
 - Unnecessary use of verbal orders
 - Inadequate staffing based on patient acuity
- **Reckless behavior**—conscious disregard for substantial and unjustifiable risk



Consider This Case

A nurse charged with criminal neglect for the medication error-related death of a 16-year-old woman during labor. The nurse of 16 years who was highly regarded by her peers, accidentally administered a bag of epidural analgesia y intravenous infusion to her patient instead of penicillin.

The incident occurred during her morning shift after working two consecutive 8-hour shifts the previous night. After plea bargaining, the nurse was placed on 3 years criminal probation, received a suspension of her nursing license for 9 months, and is prohibited from working long hours for at least 2 years.



Just Culture Checklist

- Avoid blame
- Work on fixing the system, not the person
- Steer clear of complexity in process design
- Include redundancy, especially in high-risk procedures (checks and rechecks)
- Make expectations clear
- Work to mitigate risk, such as fatigue, distractions, overload, and complexity
- Always involve staff before making changes
- Focus on process and behavior that puts patients at risk
- Use coaching to correct knowledge deficit and risky behaviors
- Use discipline for reckless behavior that puts patients at risk
- Address skill issues—competency isn't optional
- Use errors as a learning experience
- Ensure solid orientation for new staff
- Make sure that all staff members are up-to-date on practice issues and improvements
- Be vigilant for system weaknesses
- Proactively address system short- and long-term solutions
- Remember that neither people nor systems are perfect
- Talk about patient safety at every staff meeting
- Staff “right” and provide contingency safety help if staffing isn't optimal
- Consider why rules may be broken—maybe they're bad rules or there's pressure to work around the rule
- Measure it
- Emphasize that safety is everyone's job.

Nursing Management 2007



Building a Culture of Safety





Questions





Resources

Agency for Healthcare Research and Quality

3 surveys on patient safety culture—nursing home, hospital and medical office.

<http://www.ahrq.gov/qual/patientsafetyculture>

American Hospital Association

Patient safety Leadership WalkRounds

<http://www.hret.org/walkrounds>

Iowa Healthcare Collaborative

Culture of safety toolkit

<http://www.ihconline.org/toolkits/cultureofsafety.cfm>

John Hopkins Center for Public Health Awareness

Patient safety: the quality imperative (patient safety modules)

http://www.jhsph.edu/ctlt/training/patient_safety.html



Strategies for Building a Culture of Safety

- Reminders
 - Please complete the program evaluation
 - Need everyone to “register”—send an email to denise.m.fitzpatrick@marsh.com or fax a list of attendees (name and email address) to Denise Fitzpatrick 312-627-6786.
 - Certificates of participation can only be sent to registered participants.
- Today’s webinar is available for re-play
<https://marsh.webex.com/marsh/onstage/g.php?d=755318376&t=a&EA=denise.m.fitzpatrick%40marsh.com&ET=78fb1fe21df1b7bd4a2393517e7640b8&ETR=f44658a9c6ebfe0de5d6d5154e116f10>
- Power point presentation from today can be found on the Fund website
<http://www.oci.wi.gov/pcf.htm>.
- Our next Webinar on **disclosure** will be November 17, 2009 at noon. So mark your calendar now and watch for the registration information in October.
- Thank you again for participating in this program.

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