the CENTER for PROFESSIONALISM and PEER SUPPORT

Why Safety Culture?

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Thank you

Hamad Medical Corporation

The Institute for Healthcare Improvement

Team Sport

CPPS Team

BWH Provider Services

CRICO/RMF

BWH CMO

Ethics Service

Medical Staff Credentialing Committee

Office of Advising Resources, HMS

Office of General Counsel

Risk Management

My story

Evolving understanding

Institutions are…

"where the human heart either gets welcomed or thwarted or broken."

Parker Palmer. Quoted in Living the Questions, Jossey-Bass, San Francisco, CA,2005.

Brigham and Women's Hospital

- 793-bed tertiary care facility
- Major teaching hospital for Harvard Medical School
- Physician and scientist faculty: 2,738
- Total employees: > 14,000

the CENTER for PROFESSIONALISM and PEER SUPPORT

The Center's mission is to encourage a culture that values and promotes mutual respect, trust and teamwork.

Urgent consensus:
Society, Joint Commission, ABMS, ACGME

Safety culture is vital

Safety Culture: Making the Case

- Culture drives safe care delivery
- Culture is about behaviors
- Domains of behaviors include:
  - Teamwork communication
  - Professionalism
  - Response to errors

This is, fundamentally, a *culture* change

This is, fundamentally, a *culture* change

"The organization's culture consists of patterns of relating that persist and change through ongoing interaction."

- Tony Suchman, MD

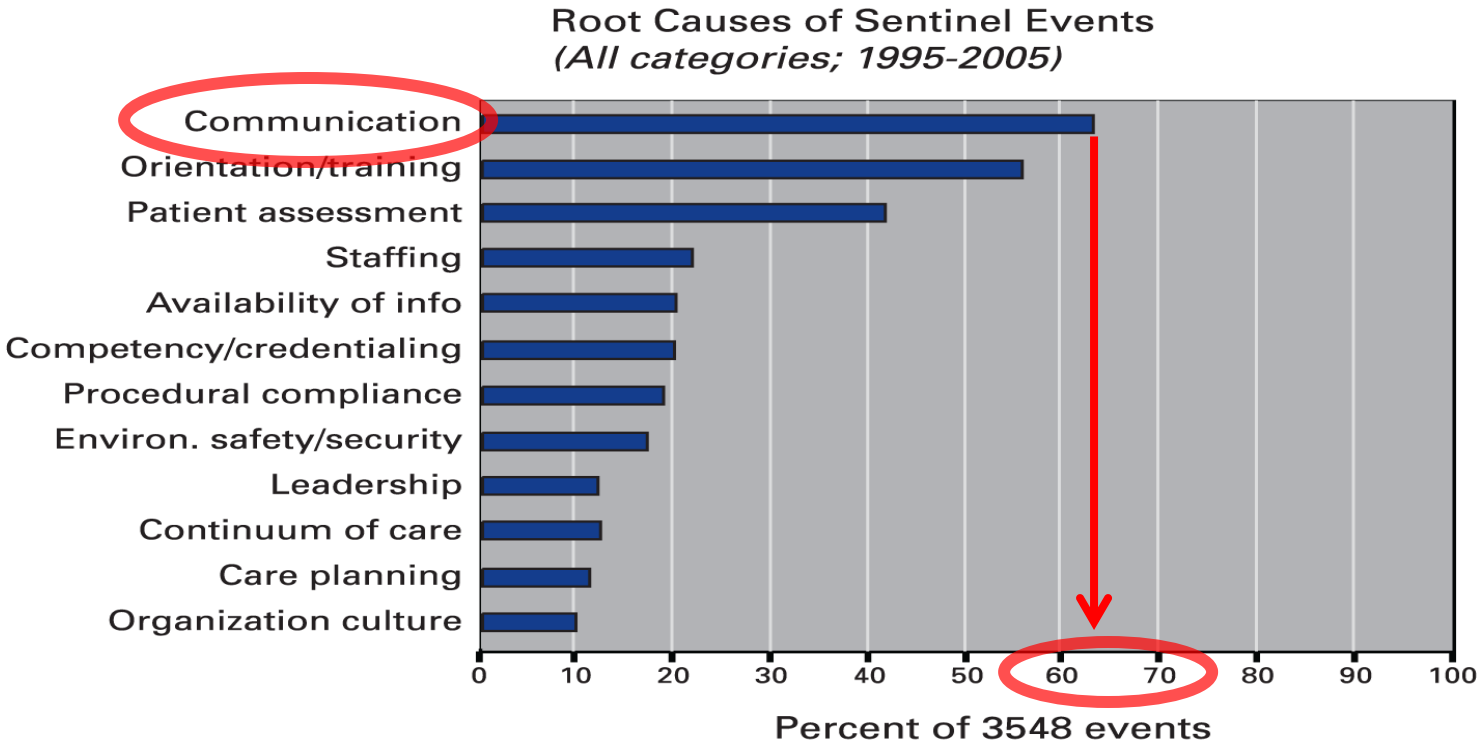
Unpacking culture

Safety is linked to effective *teamwork*

Aviation

Nuclear power

Teamwork in healthcare



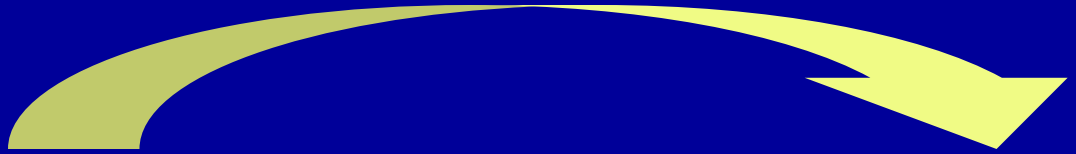
TJC Annual Report on Quality and Safety (2007)

Safety culture: Teamwork in medicine

- 300 surgical cases: pts whose surgical teams exhibited less teamwork behaviors were at higher risk for death and complications (Am J Surg. 2009 May;197(5):678-85)
- Reported levels of positive communication and collaboration with attending and resident MDs correlated with lower risk-adjusted morbidity

(J Am Coll Surg. 2007 Dec;205(6):778-84)

Teamwork: Relational Coordination



Shared goals

Shared knowledge

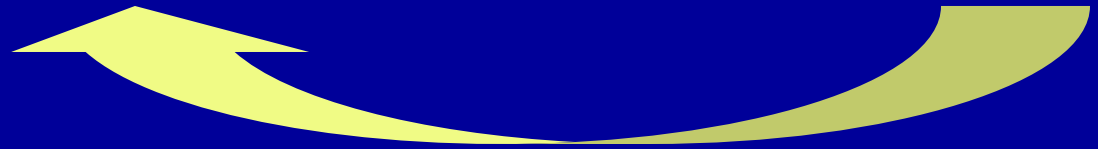
Mutual respect

Frequent communication

Timely communication

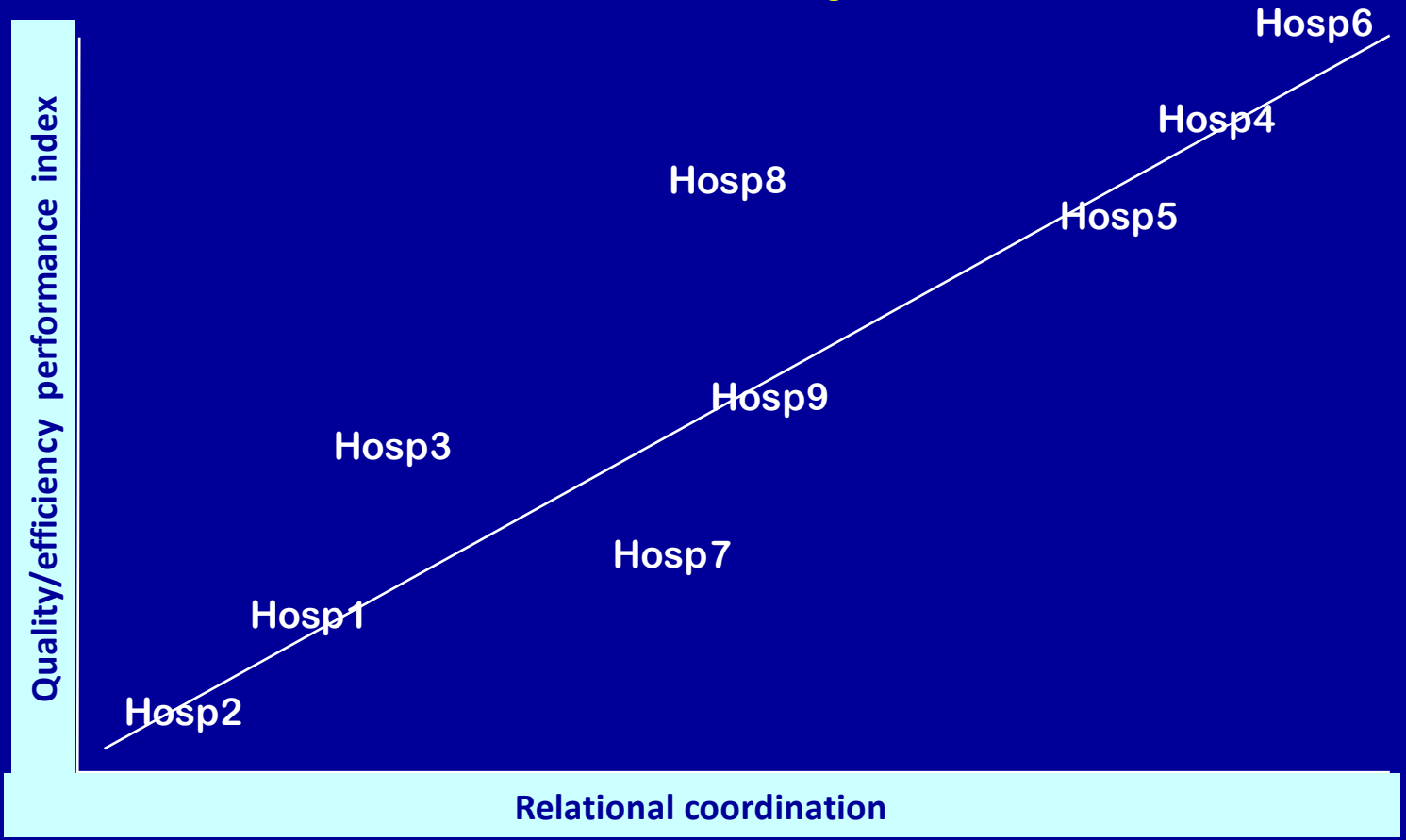
Accurate communication

Problem-solving communication



Hoffer Gittell J, et al. Medical Care 2000;38(8):807-819.

RC and total knee replacement



Hoffer Gittell J, et al. Medical Care 2000;38(8):807-819.

Unpacking culture

Best way to have safe care is to analyze and anticipate errors

- Must create a culture in which mistakes can be safely discussed
- Otherwise we will
  - Keep quiet, not knowing if we'll be punished or fired
  - Make the same mistakes over and over again

If we can't learn, we can't fix the problem

Leonard MW, Frankel A. Patient Education and Counseling 80 (2010) 288–292

Safety culture: How do we analyze events?

Human Error	At-Risk Behavior	Reckless Behavior
Product of Our Current System Design and Behavioral Choices	*A Choice: Risk Believed Insignificant or Justified*	*Conscious Disregard of Substantial and Unjustifiable Risk*
Console	**Coach**	**Discipline**

Balanced Accountability | **Consistency in Rules and Response**

The Joint Commission recommends

- Transparency
  examine all adverse events
- Safe
  for everyone to talk about errors and concerns
- Report
  vulnerabilities and failures without fear of punishment

The Joint Commission Sentinel Event Alert 2009 (Leadership committed to safety)

One of the biggest threats to safety culture is

Unprofessional behavior

Unpacking culture

PROFESSIONALISM

That’s not my job.

Professionalism

Ethical

collegial

Respectful

Altruistic

Cultural competence

Honest

Knowledgeable

Resource stewardship

Integrity

Trustworthy relationships

Unifying concept

Unprofessional

Intimidating

Disruptive

Disrespectful

Abusive

Demeaning

Bullying

So, what happens when we have *un*professional behaviors?

Unprofessionalism and patient care

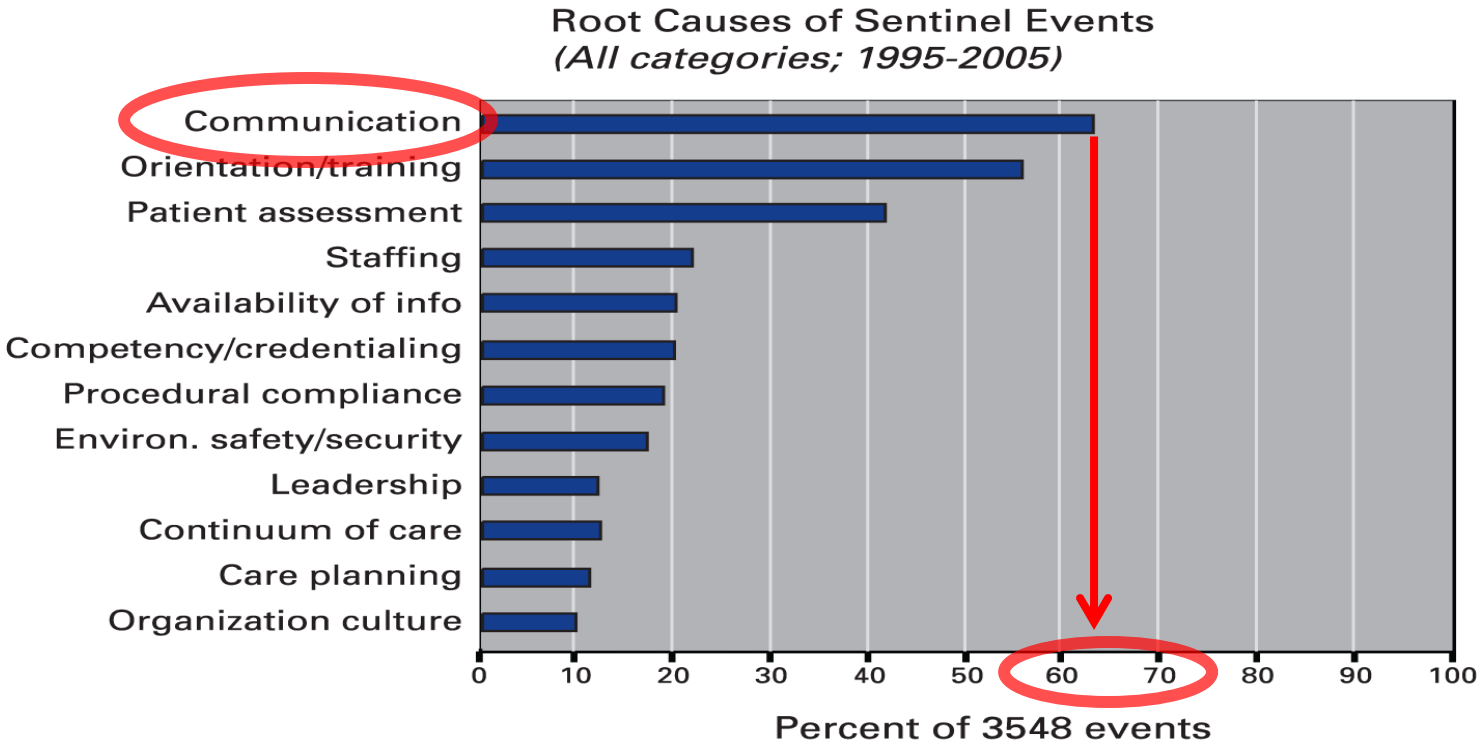
- 3-5% of MDs demonstrate behavior that interferes with patient care

(Ann Intern Med. 2006;144(2):107-115)

- National survey 3900 MDs/RNs/staff in 102 hospitals
  - 51% saw disruptive behavior correlate with compromises in patient safety
  - 71% with compromises in quality

(Jt Comm J Qual Patient Saf. 2008;34(8):464-471)

Communication failures



TJC Annual Report on Quality and Safety (2007)

Joint Commission Sentinel Event Alert

End intimidating and disruptive behavior among physicians, nurses, pharmacists, therapists, support staff and administrators

"behaviors that undermine a culture of safety"

"Behaviors that undermine a culture of safety"

- Verbal or physical threats
- Intimidation
- Reluctance/refusal to answer questions, refusal to answer pages or calls
- Impatience with questions
- Condescending language or intonation

Unpacking culture

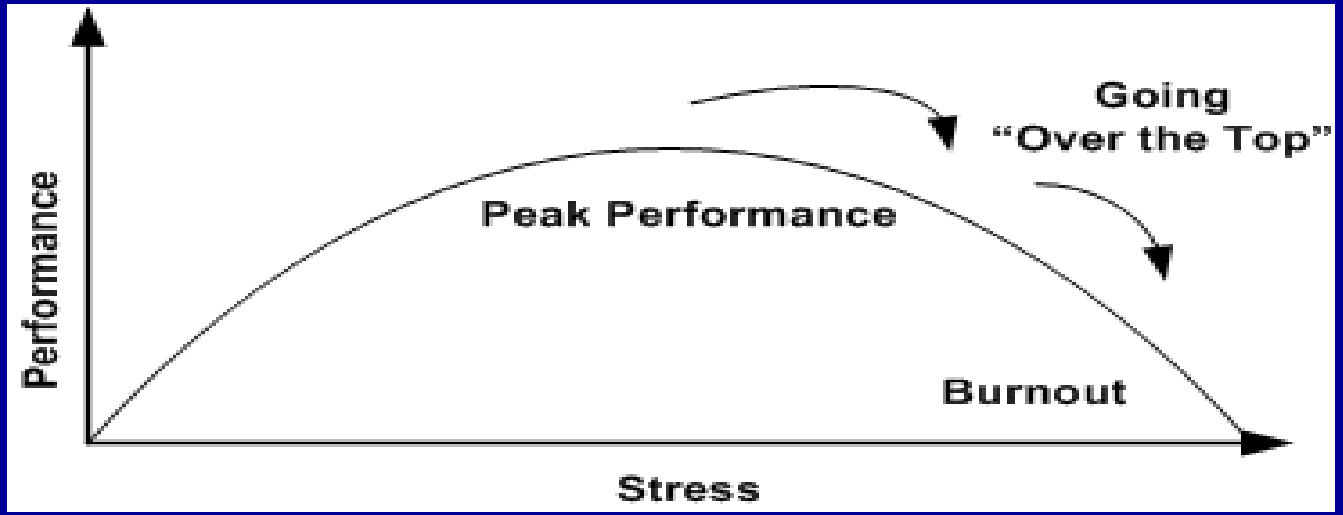
Impact on clinician health and wellbeing

Being bullied is common and *stressful*

- Somatic symptoms, depression, anxiety, and negative affectivity
- Lower social support from coworkers and supervisors
- Witnesses had more symptoms of anxiety and lower support from supervisor
- Concentrations of cortisol in saliva mirrors those with PTSD and chronic fatigue

Hansen AM, et al. Bullying at work, health outcomes, and physiological stress response. J Psychosom Res. 2006 Jan;60(1):63-72.

Stress and performance



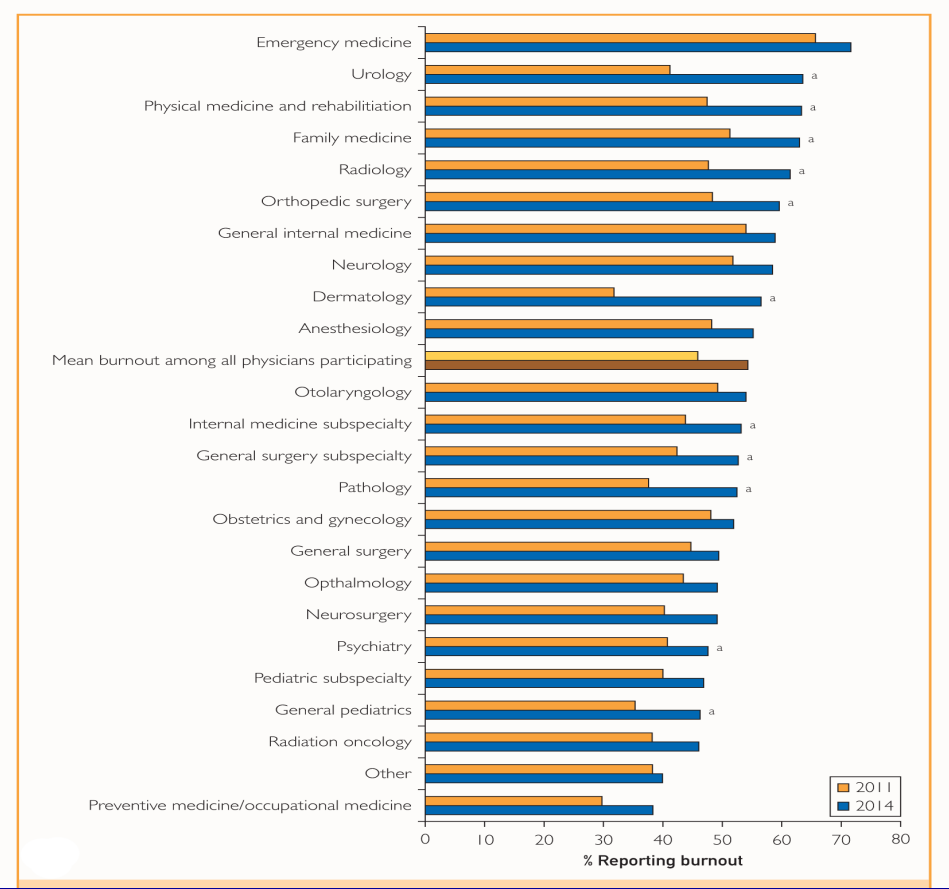
Yerkes Dodson Curve

Burnout

Burnout is a syndrome of depersonalization, emotional exhaustion and a sense of low personal accomplishment that leads to decreased effectiveness at work.

Shanafelt, TD, Bradley, KA et al.
Annals. of Internal Medicine, Vol. 136, no 5. 2002.

Physician burnout



In a 2014 study 54.4% of physicians reported at least one symptom of burnout

Shanafelt TD, et al. Mayo Clin Proc. 2015 Dec;90(12):1600-13.

Stress causes burnout

Causes of burnout

- ✓ **Stressful working conditions**
- ✓ Disproportionally high efforts (time, emotional involvement, empathy)
- ✓ Poor satisfaction

Iacovides A, et al. The relationship between job stress, burnout and clinical depression. J Affect Disord. 2003 Aug;75(3):209-21.

But we can decrease burnout

- Survey of 2,813 physicians
- Supervisor composite leadership score (e.g., treats me with respect and dignity, is interested in my opinion) strongly correlated with burnout/satisfaction
- Each 1-point increase in composite leadership score associated with a 3.3% decrease in likelihood of burnout and a 9% increase in likelihood of satisfaction

Shanafelt TD, et al. Impact of Organizational Leadership on Physician Burnout and Satisfaction. Mayo Clin Proc 2015;90(4):432-440.

Hierarchy of *Responsibility*

No Hierarchy of *Respect*

Why safety culture matters

Patient safety

Positive patient experience

Malpractice risk decrease

Learning environment

Retention, morale, productivity

Health care team wellness

***Not* doing this is *costly* on many levels**

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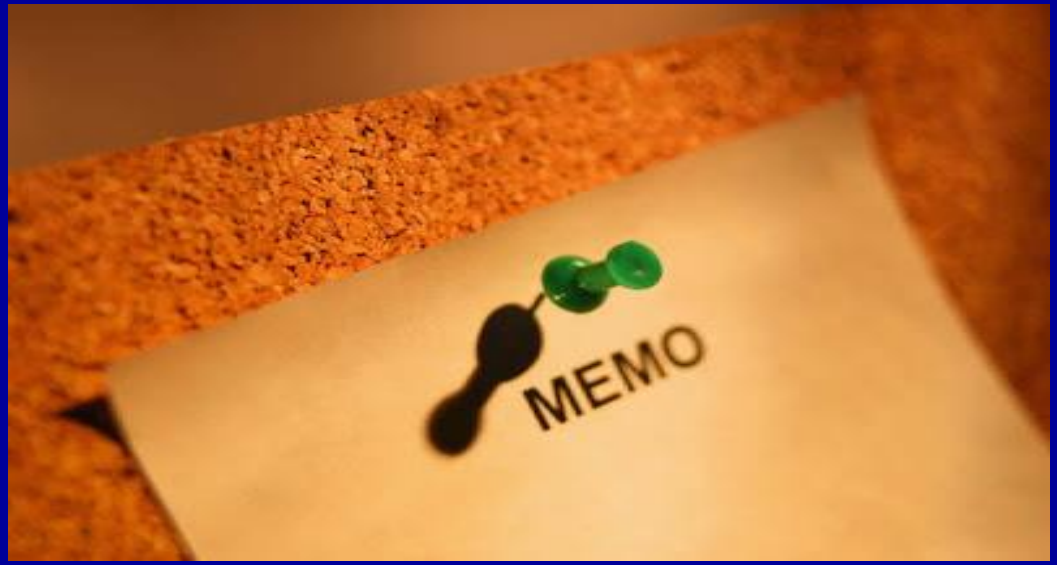
The Center's mission is to encourage a culture that values and promotes mutual respect, trust and teamwork.

You can’t just send a memo



Conflict management

No consent

- Pt w/ dementia and health care proxy
- To IR for drain replacement
- No consent
- RN assess: O x 2 – 1990's
- MD can't reach HCP – decides to consent pt
- RN speaks up, MD disagrees, RN gets supervisor

What is the conflict?

What is the conflict?

Getting the procedure done

Vs

Obtaining proper consent

Nurse’s point of view

Nurse's point of view

- Pt not qualified to give consent
- MD just wants to get case done, doesn't care about right and wrong
- I am ethical, he is not
- *These physicians are unprofessional and arrogant…*

Physician's point of view

Physician's point of view

- This pt needs the procedure, best thing for pt is to do procedure
- There probably was a consent with HCP but didn't make it into chart
- I'm an advocate for getting pt the care she needs v RN who is all about rules
- *These nurses are obstructionists…*

It's not as pure as we'd like

- Competing priorities
  - Patient comfort
  - Timely patient care
  - Production pressure
  - Rules and regulations
- Not understanding or respecting others' roles
- Role heroism: acting like I am the only one who cares about the patient

Difficult Conversations using Frame-Based Feedback

Think of a time when you wanted to speak up or give feedback and you either …

Did, and it didn't go well

or

Didn't do it

Why saying *Just Do It* doesn't work

Challenges

- Fear of the receiver's reaction, especially anger
- Afraid of damaging the relationship
- Skepticism regarding person changing behavior
- Underestimation of importance
- Perception of time commitment

And more challenges…

- Fear of the receiver's reaction, especially anger
- Afraid of damaging the relationship
- Skepticism regarding person changing behavior
- Underestimation of importance
- Perception of time commitment
- **Culturally unacceptable**

Giving and receiving feedback – positive and critical – should become a habit

And more challenges…

- Fear of the receiver's reaction, especially anger
- Afraid of damaging the relationship
- Skepticism regarding person changing behavior
- Underestimation of importance
- Perception of time commitment
- Culturally unacceptable
- **Safe/trusting environment?**

Creating a climate of *trust*

"The deepest principle in human nature is the craving to be appreciated."

William James

And more challenges…

- Fear of the receiver's reaction, especially anger
- Afraid of damaging the relationship
- Skepticism regarding person changing behavior
- Underestimation of importance
- Perception of time commitment
- Culturally unacceptable
- Safe/trusting environment?
- **Emotions**

Can I get a handle on my own emotions?

This means we may need to get over our *righteous anger*

Not giving feedback is NOT neutral …

"Without feedback, mistakes go uncorrected, good performance is not reinforced, and clinical competence is achieved empirically or not at all."

Ende J. JAMA 1983; 250:771-781.

… but destructive feedback is even worse than none at all.

Simulation

Doesn’t that sound better than role play?

What are various traditional approaches?

Control

Non-judgmental

Frame-Based Feedback

Trying to learn the other person's perspective through genuine curiosity and exploration.

- Rudolph J, Raemer D, Shapiro J. Clin Teach. 2013 Jun;10(3):186-9.

Frame-based feedback: algorithm overview

My Frame

- Setting context
- Specific behavior(s)
- Concern or appreciation

- Rudolph, et al.

Clarity

Sandwiches are not healthy in some settings

You can be *empathic*
and direct at the same time

You know *what* happened, but not *why* it happened

Therefore, you may not know how to prevent it from happening in the future

Frame-based feedback: algorithm overview

My Frame

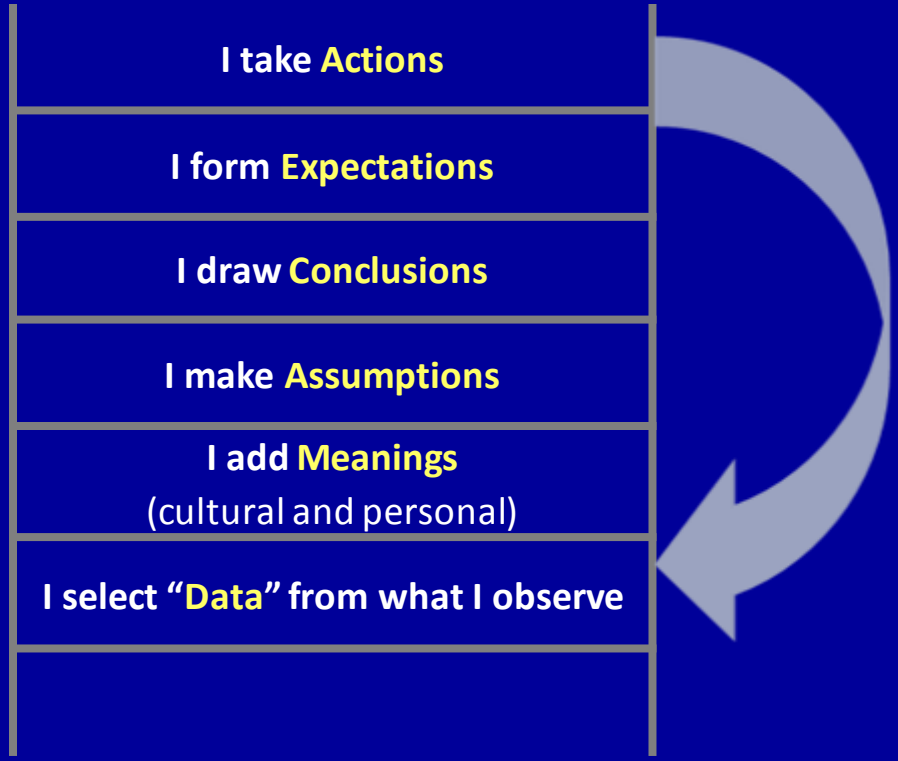
- Setting context
- Specific behavior(s)
- Concern or appreciation

Their Frame

- Short open-ended question (for starters)

- Rudolph, et al.

Ladder of Inference



The reflexive loop:

Our expectations and actions affect the data we perceive and select the next time…

Adapted from Ross R. The Ladder of Inference. In Senge P, Kleiner A, Roberts C Ross R, Smith B. *The Fifth Discipline Fieldbook*. New York: Doubleday, 1994, p243.

Basic Assumption: Intent vs. Impact

I assume that you are a dedicated person who shows up at work intending to do an excellent job.

Get curious

"When the going gets rough, turn to wonder."

Parker Palmer

Find the other's frame through a short, open-ended question or statement

Frame-based feedback: algorithm overview

My Frame

- Setting context
- Specific behavior(s)
- Concern or appreciation

Their Frame

- Short open-ended question (for starters)

Match your discussion to their frame

- Rudolph, et al.

Remaining questions or concerns?

Let’s give it another try

No consent

- Pt w/ dementia and health care proxy
- To IR for drain replacement
- No consent
- Nurse assessment: O x 2 – 1990's
- MD can't reach HCP – decides to consent pt
- Nurse speaks up. Attending upset

What might the physician say to the nurse?

What might the nurse say to the physician?

What if, instead of having this conversation, the physician had said…

"I am in charge here.

We are not taking a vote.

You need to do what I say. I also wonder about your clinical competence. This reminds me to discuss your performance with your supervisor."

(This wasn't the first time this physician had behaved this way to other healthcare team members.)

Realistically, what should the nurse do?

Speaking up and giving feedback is a discipline requiring

Rigor
Technical skill
Honesty
Persistence
Courage

"The problem is not a lack of skill, it is a lack of courage."

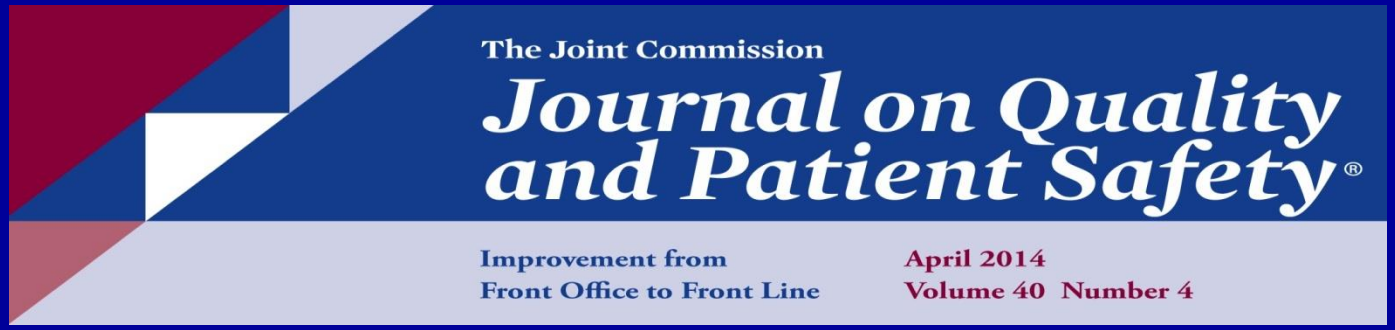
- Moxley, R. It also takes courage to lead. In, *Living the Questions*. Ed, S Intrator.

The “must remember” skills

- Get a handle on your own emotions
- Establish trust (hold Basic Assumption)
- Clarity: specific behaviors and concerns
- Frame-based: maintain curiosity
- Separate behaviors and character
- Set expectations
- Make feedback expected/routine

How can our leaders create a culture of safety?

Our Professionalism Program



Shapiro J, Whittemore A, Tsen LC.

Instituting a Culture of Professionalism: The Establishment of a Center for Professionalism and Peer Support.

Components of our Program

How can we as team members create a culture of safety?

Create the habit, time and space

To question and challenge

For teams to work together on solutions

To explicitly honor what is going well

Do I understand/respect your role?

Do you understand/respect mine?

How am I helping you to do your work?

What can I do better to help you get your work done?

What can you do to help me get my work done?

If we want people to perform at a high level in this challenging environment,

we have to think of a way for people to feel supported and valued.

Peer Support
Disclosure Coaching
Defendant Support


SYDNEY
OPERA
HOUSE
VAPS Project
OUR HOUSE RULES
I WILL.....
1. DO EVERYTHING I CAN TO GO HOME SAFE
2. NEVER FORGET RULE #1
3. RESPECT MY WORKMATES
4. COMMUNICATE POSITIVELY WITH THOSE AROUND ME
5. CHALLENGE MY MATES TO DO THE RIGHT THING
6. PRESENT FIT FOR DUTY & READY TO DO MY BEST
. NEVER TAKE SHORT CUTS AT THE EXPENSE OF SAFETY
8 LEAD BY EXAMPLE & BE PROUD OF MY WORK
9. SPEAK UP IF I SEE SOMETHING NOT QUITE RIGHT
10. STEP UP & HELP MY WORKMATES IF I SEE THEY NEED HELP

This is difficult but so important. It takes courage and skill.

Thank you for your commitment to this work