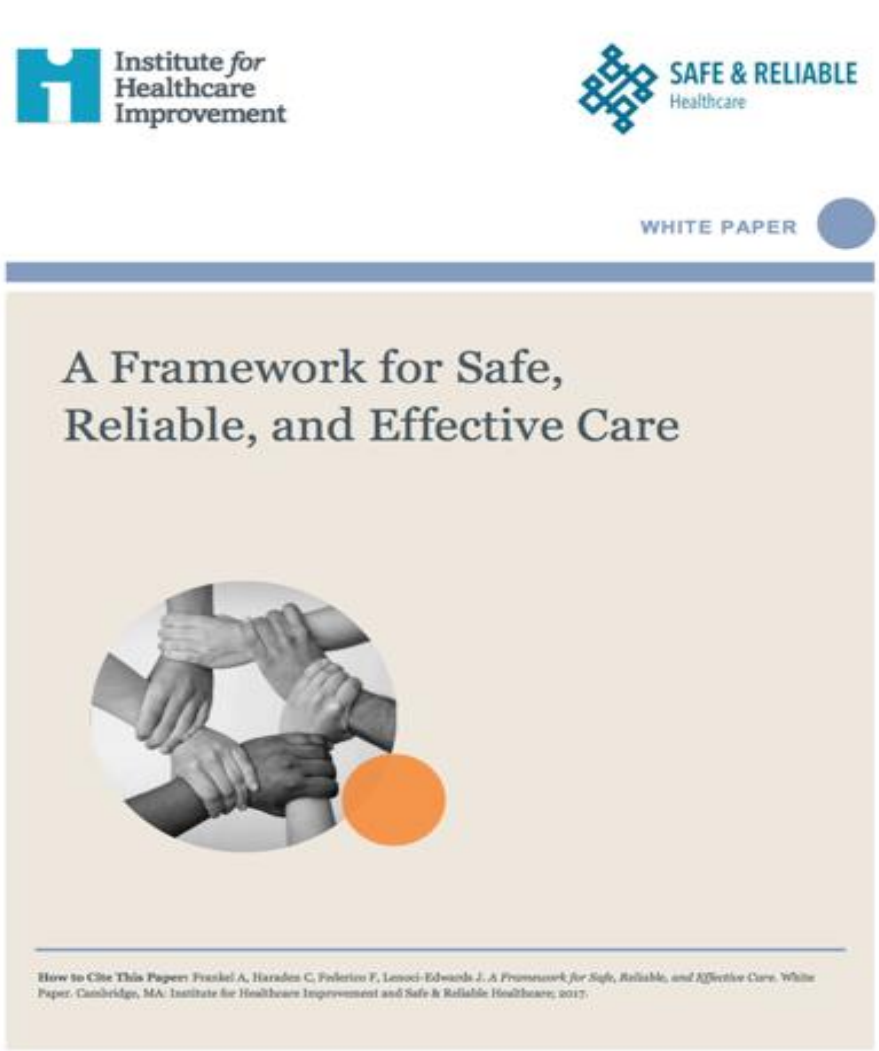
A Systematic Approach to Safe and High Reliability Care

Michael Leonard, MD
HCIF & PASHRM
April 4, 2019



Why is This Work Critically Important?

SAFE & RELIABLE Healthcare

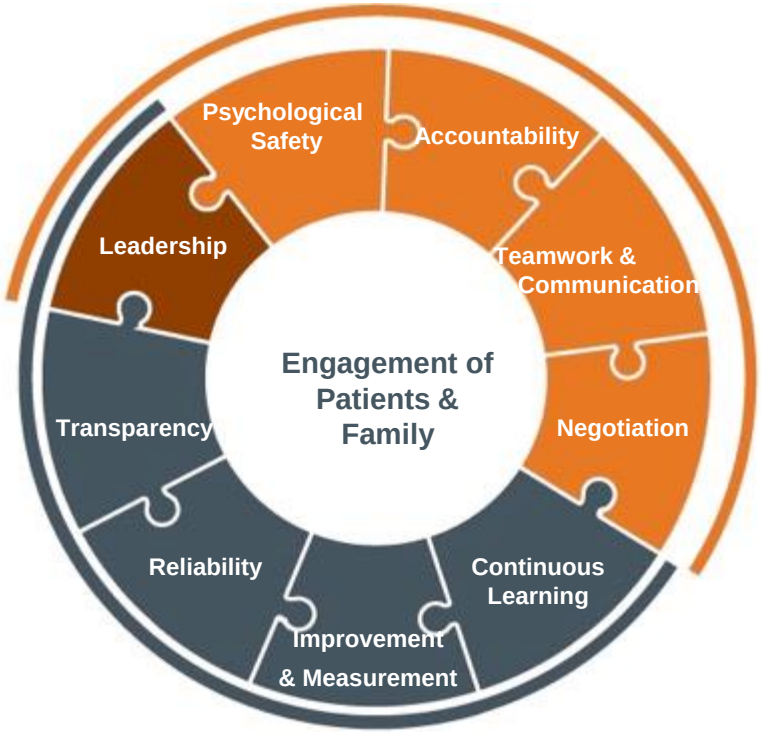
It provides a framework to integrate all your initiatives, and the foundation to successfully execute them.

Clear focus on culture, which is essential for world class care and sustainable value creation. Culture is the social glue – it reflects the attitudes and behaviors of the people delivering care.

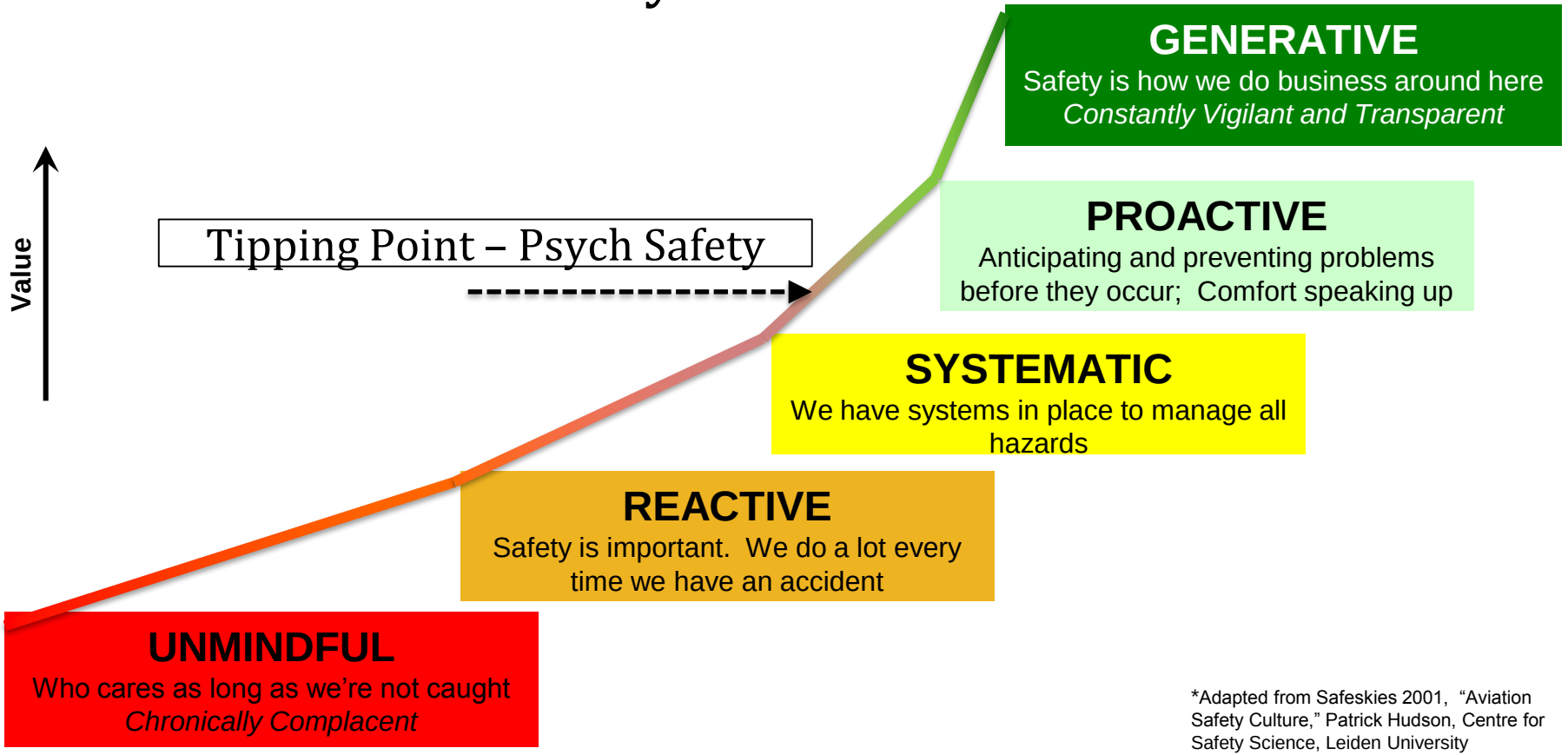
It not only enhances your ability to care for your patients, but also your caregivers

This is not more work to do, but a systematically proven method of integrating your work, and making it easier to deliver on the mission.

Framework for Clinical Excellence



Cultural Maturity Model

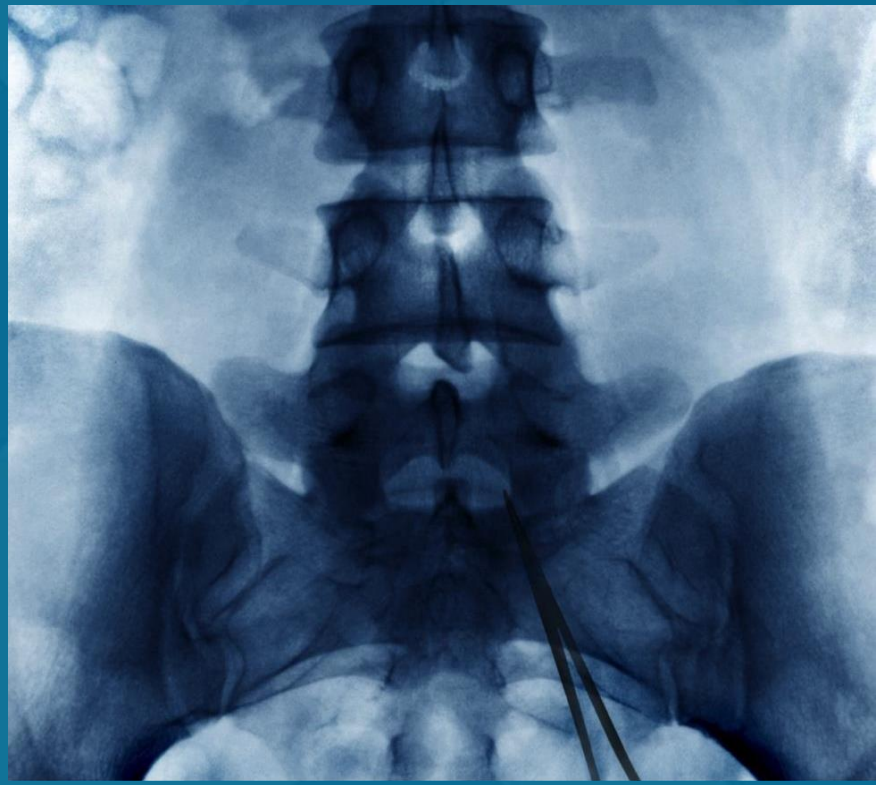


*Adapted from Safeskies 2001, "Aviation Safety Culture," Patrick Hudson, Centre for Safety Science, Leiden University

Avoidable Patient Harm

SAFE & RELIABLE Healthcare

- 30% of hospitalized patients have something happen to them that you and I wouldn't want to happen to us
- 10% are harmed seriously enough to stay in the hospital longer and go home with a disability



Emerging Epidemic: Healthcare Burnout & Psychological Safety

34%

of staff unable to speak up to share ideas or concerns about patient care

47%

of US healthcare workers are Burned Out

¼ RNs leave in 1st year practice

1 in 10

of US patients experience preventable harm in leading healthcare systems

>>200K fatalities per year

Burnout is a huge priority everywhere

46% CEOs say Culture of Safety high priority

The legacy of harm in healthcare

SAFE & RELIABLE Healthcare

Historically medicine was based on the individual expert model – highly skilled practitioners trying hard and paying attention would not make mistakes.

Harm was considered an unfortunate but acceptable price for all the positive therapeutic interventions – “the price of progress”

Patient safety and the High Reliability Organizations (HRO) brought a different perspective – the goal needs to be be zero avoidable harm

The HRO legacy

In the 1980's researchers realized there were certain organizations that managed risk and hazards exceeding well. They operated under high production pressures with hazardous conditions quite safely.

The prevalent safety model prior to this was the Natural Accident Theory, which accepted that accidents, failures and harm were inevitable outcomes of managing risk.

What about healthcare?

SAFE & RELIABLE
Healthcare

High Reliability in Medicine (HRO)

Effective Leadership

Culture of Safety

Effective Teamwork & Communication

Reliable processes of Care & Data

Continuous Learning & Improvement

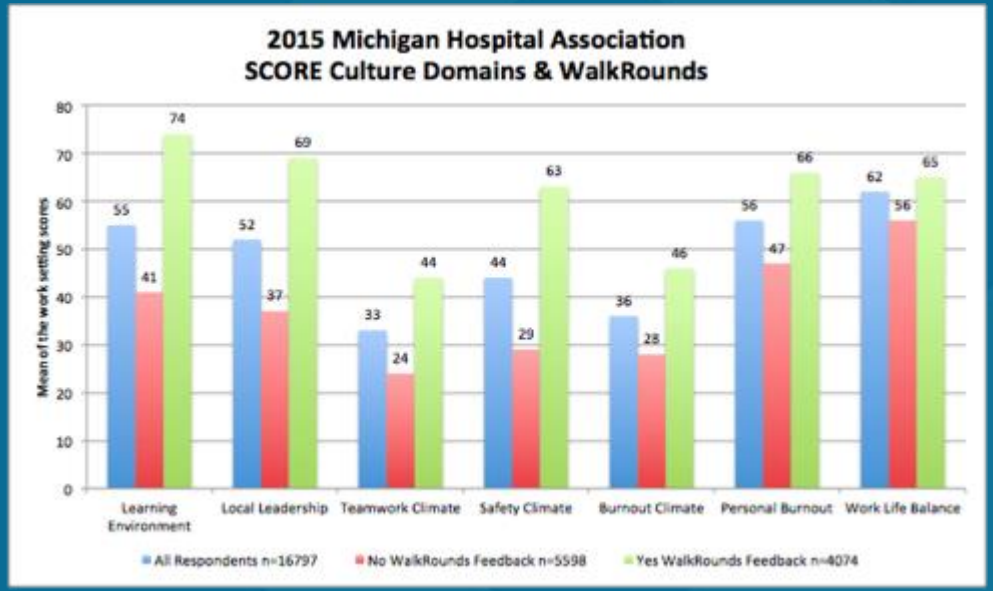
Measuring Culture - SCORE

- Integrated instrument – Safety, Burnout, Engagement
- Best psychometrics – highly validated
- Leapfrog, Magnet certified
- Aligns with Framework - Diagnostic and actionable
- Adjusts to caregiver type
- Safety and Teamwork climate allow legacy SAQ comparison

Published Best Practice: Visible Unit-Level Improvement Systems With Structured Teamwork Drive Measurable Transformation

SAFE & RELIABLE Healthcare

Michigan SCORE Survey Data with and without Closing the Loop on Ideas and Concerns from the Frontline



ORIGINAL RESEARCH

Providing feedback following Leadership WalkRounds is associated with better patient safety culture, higher employee engagement and lower burnout

J Bryan Sexton,[1,2] Kathryn C Adair,[1]
Michael W Leonard,[4,1] Terri Christensen Frankel,[5] Joshua Proulx,[5]
Sam R Watson,[5] Brooke Magnus,[5] Brittany Bogan,[5] Maleek Jamal,[5]
Rene Schwendimann,[7,8] Allan S Frankel[5]

23%↑ Culture & Engagement

Better Culture, Burnout and Engagement measures when WalkRounds feedback is provided

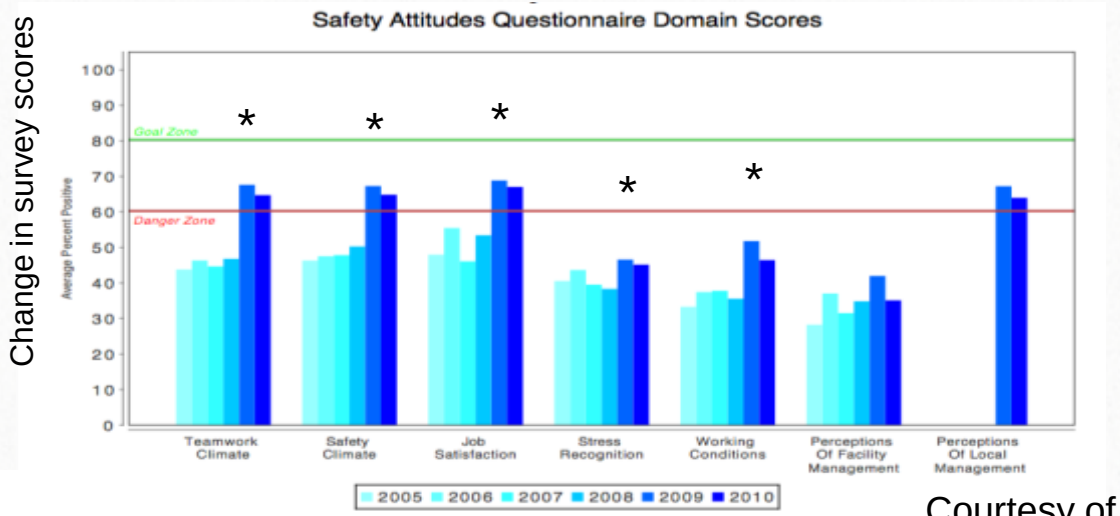
n=16,797 respondents

http://qualitysafety.bmj.com/content/early/2017/10/09/bmjqs-2016-006399

The Impact Of Acting on Safety Culture Data In Rhode Island ICUs

Rhode Island Quality Institute

ICUs that DEBRIEFED	ICUs that did not DEBRIEF
Reflected on culture scores and took action 1. >15% culture score increase in 5/7 domains 2. >10% BSI reduction 3. >15% VAP reduction	Did not reflect on SAQ scores nor take action 1. 5% culture score drop in 5/7 domains 2. No reduction in BSIs 3. 5% increase in VAPs



Courtesy of Margaret Vigorito

RESEARCH ARTICLE Open Access

The improvement readiness scale of the SCORE survey: a metric to assess capacity for quality improvement in healthcare

Kathryn C. Adair[1,2*], Krystina Quow[3], Allan Frankel[4], Paul J. Mosca[5,6], Jochen Profit[7], Allison Hadley[8], Michael Leonard[4] and J. Bryan Sexton[1,2]

Abstract

Background: Quality improvement efforts are inextricably linked to the readiness of healthcare workers to take them on. The current study aims to clarify the nature and measurement of Improvement Readiness (IR) by 1) examining the psychometric properties of a novel IR scale, 2) assessing relationships between IR and other safety culture domains 3) exploring whether IR differs by healthcare worker demographic factors, and 4) examining linguistic differences in word type use between high and low scoring IR work settings from their free text responses.

Methods: Of 13,040 eligible healthcare workers across a large academic health system, 10,627 (response rate 81%) completed the 5-item IR scale, demographics, safety culture scales, and two open-ended questions. Psychometric analyses, correlations and ANOVAs tested the properties of IR. Linguistic Inquiry Word Count software assessed comments from open-ended questions.

Results: The IR scale exhibited strong psychometric properties and a one factor model fit the data well (Cronbach's alpha = .93; RMSEA = .07; CFI = 99; TLI = .99). IR scores differed significantly by role, shift, shift length, and years in specialty. IR correlated significantly and in expected directions with safety culture scales. Linguistic analyses revealed that people in low versus high IR work settings used significantly more words in their responses, and specifically more past tense verbs (e.g., "ignored"), negative emotion words (e.g., "upset"), and first person singular ("I"). Workers from high IR work settings used significantly more positive emotions words (e.g., "grateful") and social words (e.g., "team").

Conclusion: The IR scale exhibits strong psychometric properties, is associated with better safety and teamwork climate, lower burnout, and predicts linguistic differences in high versus low IR groups.

Keywords: Improvement readiness, SCORE, quality improvement, Qualitative responses, Learning environment, Safety culture survey

Why is Culture Important?

SAFE & RELIABLE Healthcare

Culture reflects the behaviors and beliefs within an organization.

There are behaviors that create value; behaviors that create unacceptable risk.

Culture is the social glue

Work as Imagined v. Work as Done

CULTURE IS RELATED TO…

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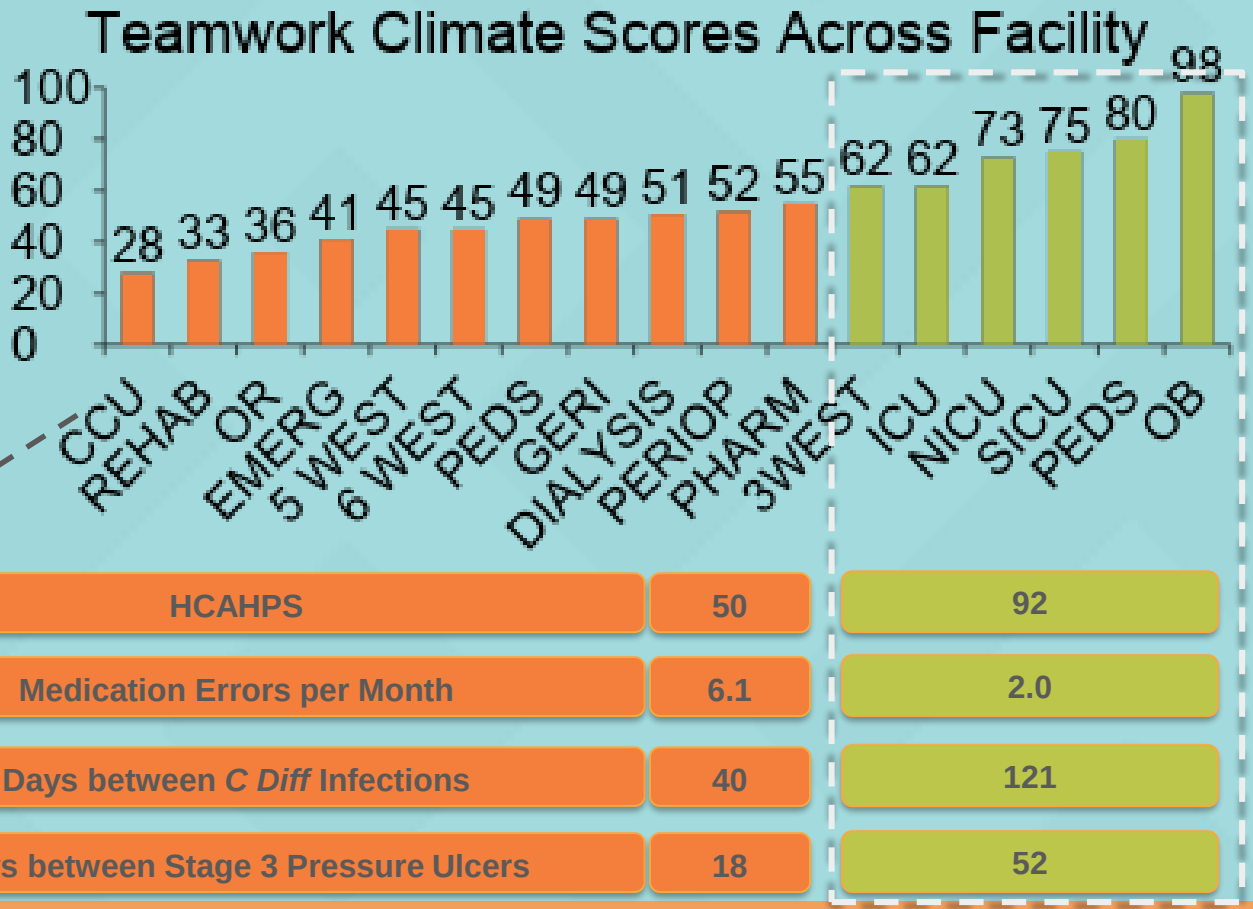

HCAHPS	50	92
Medication Errors per Month	6.1	2.0
Days between *C Diff* Infections	40	121
Days between Stage 3 Pressure Ulcers	18	52

Illustrative Data: Extracted from Blinded Client Data

……And Employee Outcomes

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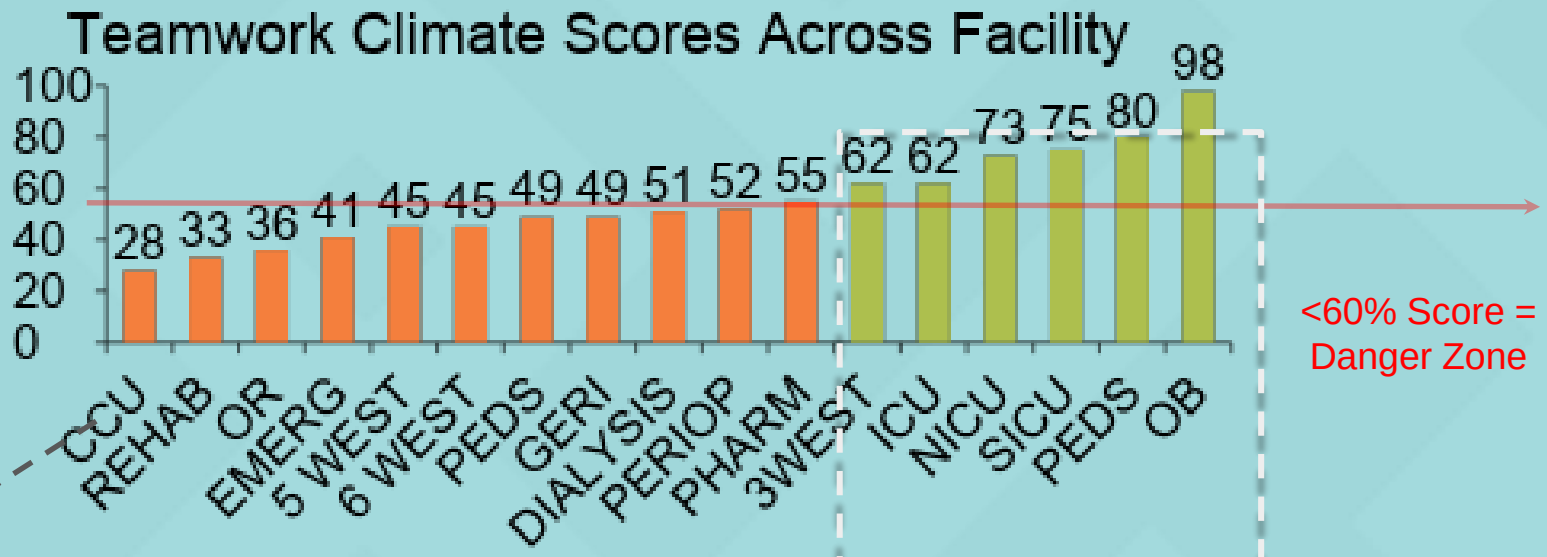
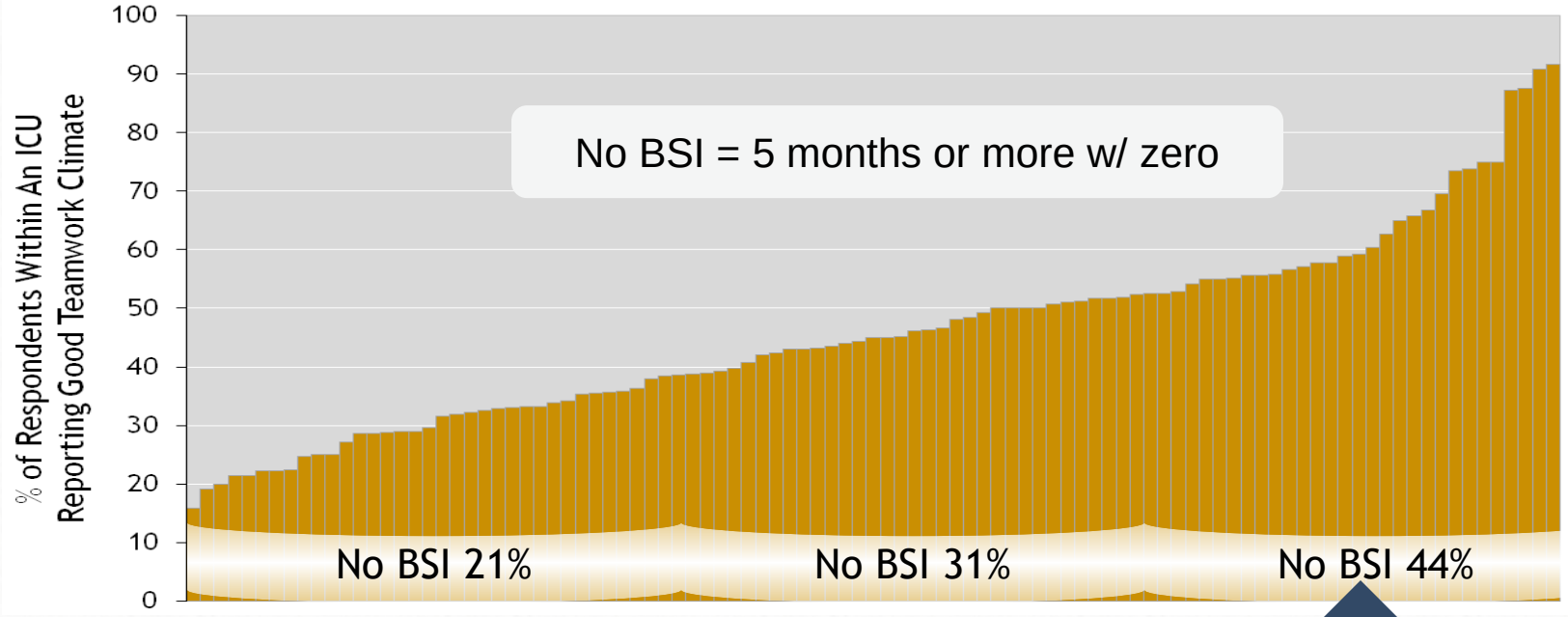


<60% Score = Danger Zone

Employee Satisfaction	55	91
Employee Injury per 1000 days	16	0.1
Employee Absenteeism per 1000 days	15	10
RN Vacancy Rate	9	1

Illustrative Data: Extracted from Blinded Client Data

Teamwork Climate Across Michigan ICUs



The strongest predictor of clinical excellence: caregivers feel comfortable speaking up if they perceive a problem with patient care

Attribution Bryan Sexton

Where Would You Rather Have An Operation?

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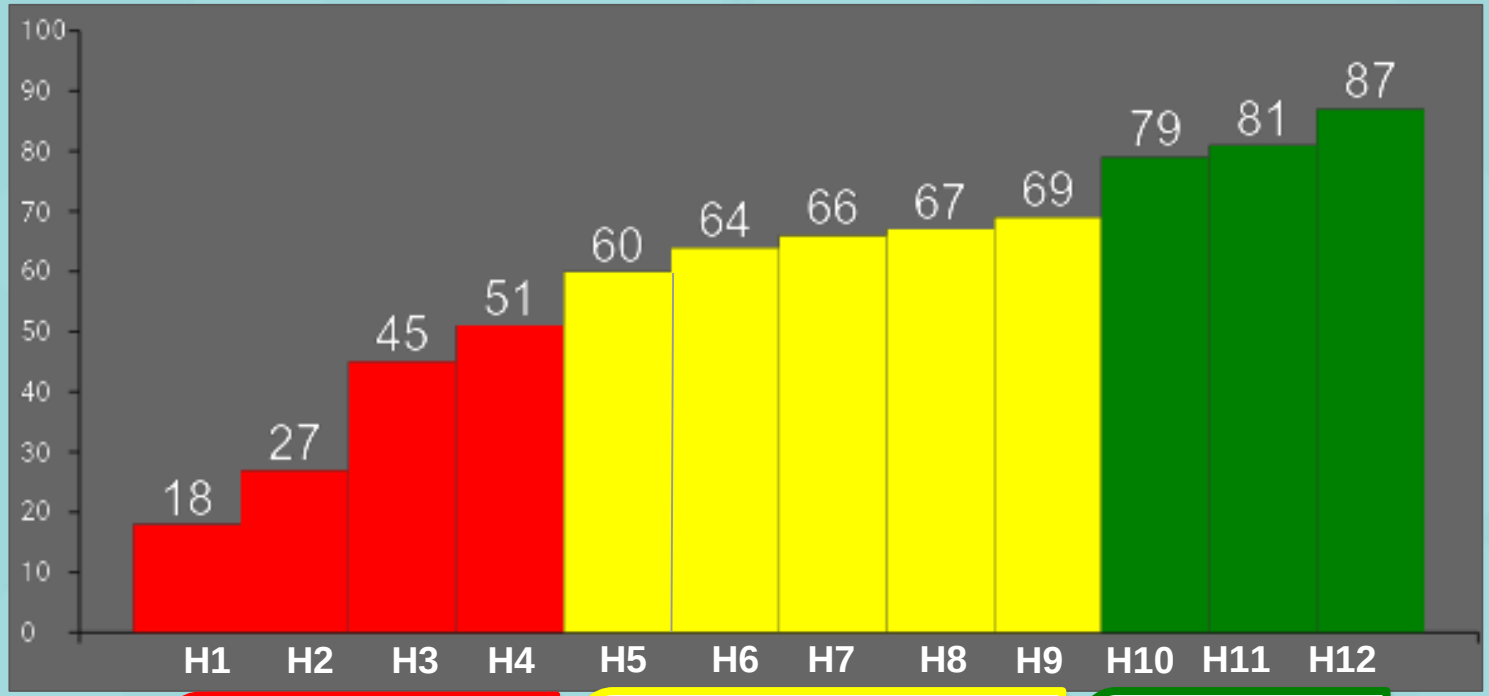

Months between Wrong Sites Surgeries or Retained Foreign Bodies

6	12	40

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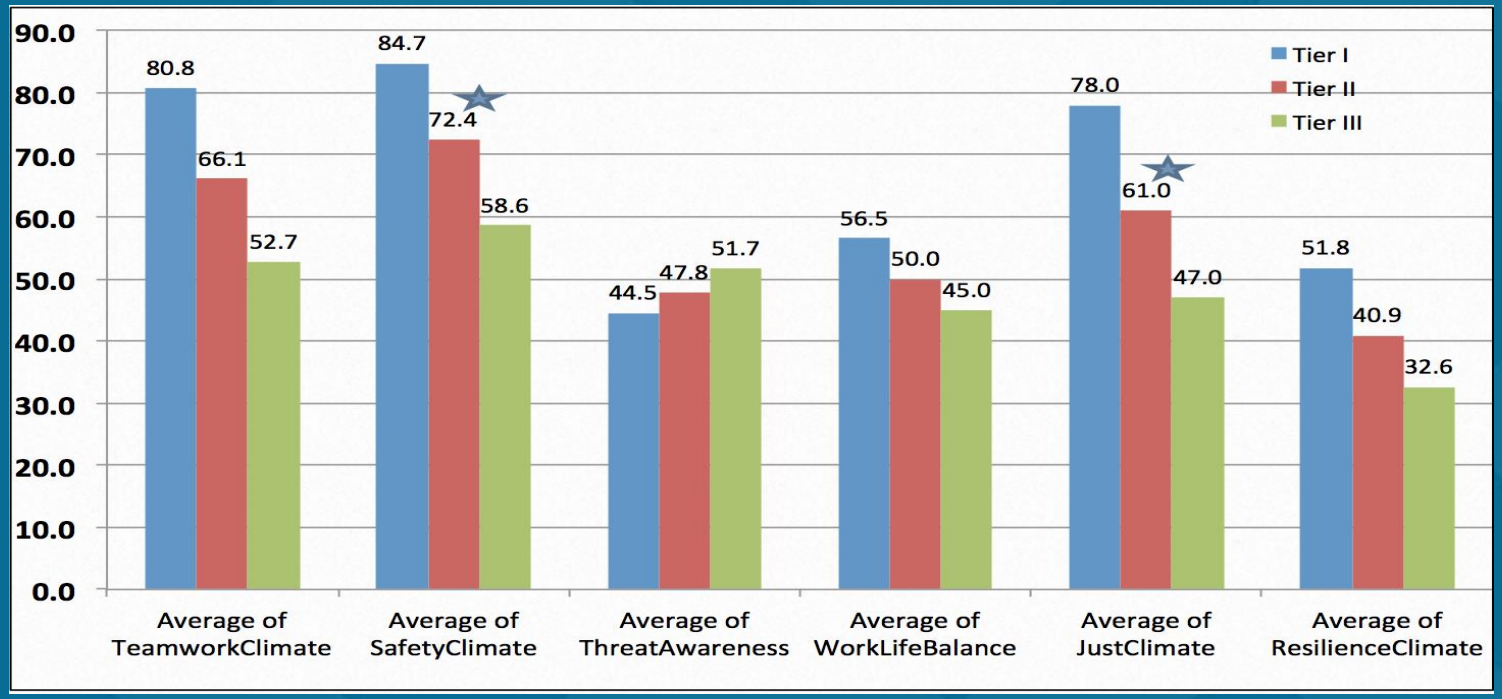
Why Integrated Culture Measurement ?

Safety Score



Courtesy Dr. Bryan Sexton, Duke University

Valuable Cultural Lessons

SAFE & RELIABLE Healthcare

Culture matures over time

There are essential elements necessary to build and sustain a culture of safety

Culture is the social glue to deliver safe, highly reliable care. Technical expertise alone is inadequate

Measuring well, providing feedback and building a Learning System are essential components

Senior Leadership

SAFE & RELIABLE Healthcare

GENERATIVE
Organization wired for safety and improvement

PROACTIVE
Playing offense - thinking ahead, anticipating, solving problems

SYSTEMATIC
Systems in place to manage hazards

REACTIVE
Playing defense – reacting to events

UNMINDFUL
No awareness of safety culture

Cyclic flow of information with feedback and organizational learning

Systematic engagement with dialogue, support and learning

Process for interaction between senior leaders and front line staff

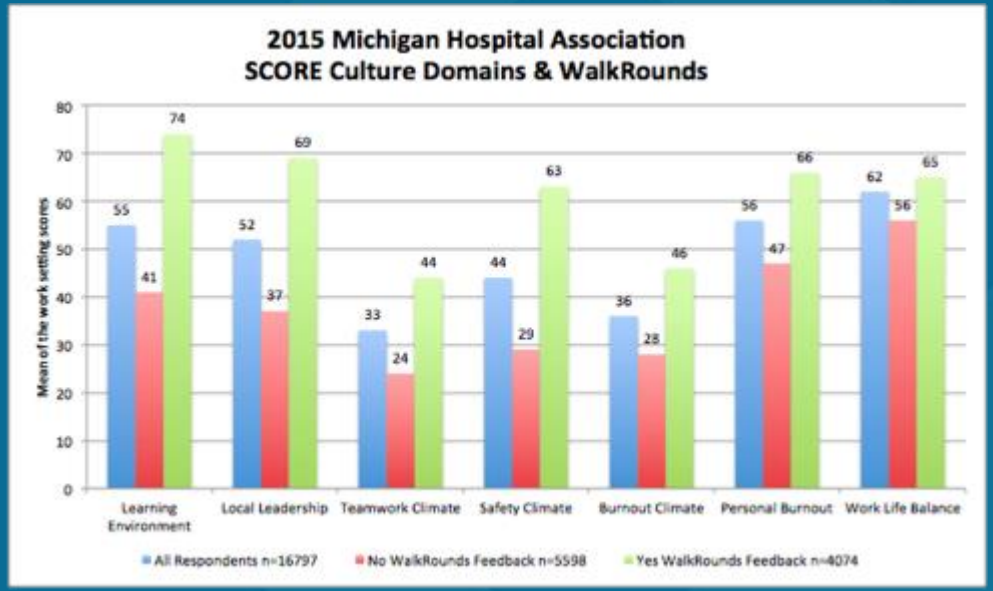
They're here – something bad must have happened

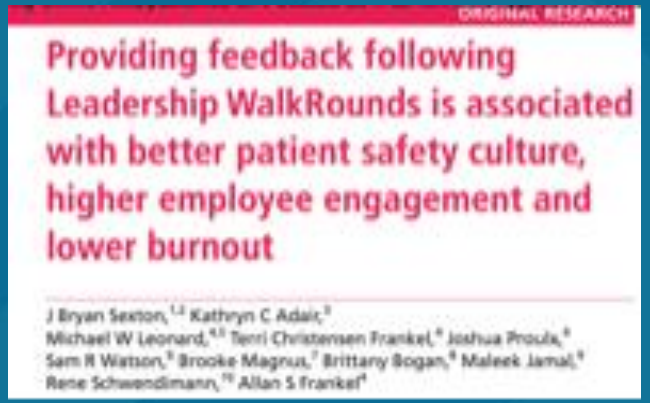
We don't know or see them

Published Best Practice: Visible Unit-Level Improvement Systems With Structured Teamwork Drive Measurable Transformation

SAFE & RELIABLE Healthcare

Michigan SCORE Survey Data with and without Closing the Loop on Ideas and Concerns from the Frontline

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Better Culture, Burnout and Engagement measures when WalkRounds feedback is provided

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http://qualitysafety.bmj.com/content/early/2017/10/09/bmjqs-2016-006399

Local Leadership

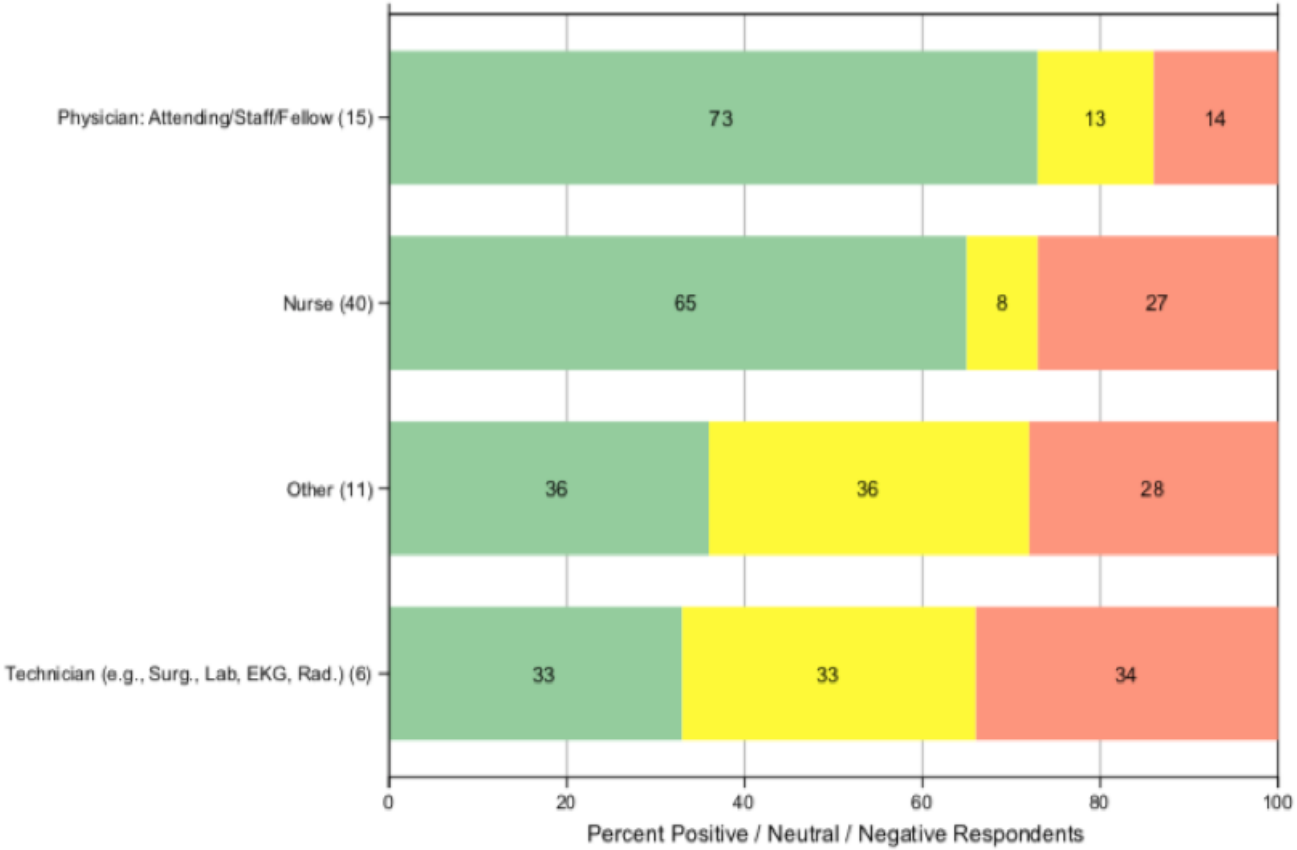
SAFE & RELIABLE Healthcare

GENERATIVE Organization wired for safety and improvement	Leaders create high degrees of psych safety and accountability.
PROACTIVE Playing offense - thinking ahead, anticipating, solving problems	Leaders model the desired behaviors to drive culture of safety
SYSTEMATIC Systems in place to manage hazards	Training and support exists for building clinical leadership
REACTIVE Playing defense – reacting to events	Episodic, completely dependent on the individual clinician
UNMINDFUL No awareness of safety culture	Absent for the most part

Reliable feedback is essential for a healthy unit culture

Source Data: Sep 2018

In this work setting, local leadership regularly makes time to provide positive feedback to me about how I am doing.



Source Data: Jun 2018

SAFE & RELIABLE
Healthcare

A wide variety of skills across the middle

SAFE & RELIABLE Healthcare

10%

Absent
Burned Out
Socially Inept
Psychopathic
Disinterested

80%

Clinically excellent
Well meaning
Socially Adept

Inadequately Trained

10%

Engaged and
Knowledgeable in
Organizational development
Whole system change
Measurement to manage
Know culture IS a process

Source: Bohmer R, Leading Clinicians and Clinicians Leading, New Eng J Med, April 2013

SAFE & RELIABLE Healthcare

Culture and Leadership

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population

Alex B. Haynes, M.D., M.P.H., Thomas G. Weiser, M.D., M.P.H., William R. Berry, M.D., M.P.H., Stuart R. Lipsitz, Sc.D., Abdel-Hadi S. Breizat, M.D., Ph.D., E. Patchen Dellinger, M.D., Teodoro Herbosa, M.D., Sudhir Joseph, M.S., Pascience L. Kibatala, M.D., Marie Carmela M. Lapitan, M.D., Alan F. Merry, M.B., Ch.B., F.A.N.Z.C.A., F.R.C.A., Krishna Moorthy, M.D., F.R.C.S., Richard K. Reznick, M.D., M.Ed., Bryce Taylor, M.D., and Atul A. Gawande, M.D., M.P.H., for the Safe Surgery Saves Lives Study Group*

ABSTRACT

BACKGROUND

Surgery has become an integral part of global health care, with an estimated 234 million operations performed yearly. Surgical complications are common and often preventable. We hypothesized that a program to implement a 19-item surgical safety checklist designed to improve team communication and consistency of care would reduce complications and deaths associated with surgery.

METHODS

Between October 2007 and September 2008, eight hospitals in eight cities (Toronto, Canada; New Delhi, India; Amman, Jordan; Auckland, New Zealand; Manila, Philippines; Ifakara, Tanzania; London, England; and Seattle, WA) representing a variety of economic circumstances and diverse populations of patients participated in the World Health Organization's Safe Surgery Saves Lives program. We prospectively collected data on clinical processes and outcomes from 3733 consecutively enrolled patients 16 years of age or older who were undergoing noncardiac surgery. We subsequently collected data on 3955 consecutively enrolled patients after the introduction of the Surgical Safety Checklist. The primary end point was the rate of complications, including death, during hospitalization within the first 30 days after the operation.

RESULTS

The rate of death was 1.5% before the checklist was introduced and declined to 0.8% afterward (P=0.003). Inpatient complications occurred in 11.0% of patients at baseline and in 7.0% after introduction of the checklist (P<0.001).

CONCLUSIONS

Implementation of the checklist was associated with concomitant reductions in the rates of death and complications among patients at least 16 years of age who were undergoing noncardiac surgery in a diverse group of hospitals.

From the Harvard School of Public H (A.B.H., T.G.W., W.R.B., A.A.G.), M chusetts General Hospital (A.B.H. Brigham and Women's Hospital (A.A.G.) — all in Boston; Univer California–Davis, Sacramento (T. Prince Hamzah Hospital, Minis Health, Amman, Jordan (A.-H.S.B. versity of Washington, Seattle (E College of Medicine, University Philippines, Manila (T.H.); St. Ste Hospital, New Delhi, India (S.J.); St cis Designated District Hospital, I Tanzania (P.L.K.); National Instit Health–University of the Philip Manila (M.C.M.L.); University of land and Auckland City Hospital, land, New Zealand (A.F.M.); Im College Healthcare National Healt vice Trust, London (K.M.); and Uni Health Network, University of To Toronto (R.K.R., B.T.). Address repr quests to Dr. Gawande at the D ment of Surgery, Brigham and Wo Hospital, 75 Francis St., Boston, MA or at safesurgery@hsph.harvard.ed

*Members of the Safe Surgery Save Study Group are listed in the App

This article (10.1056/NEJMsa081011 published at NEJM.org on January 14

N Engl J Med 2009;360:491-9.

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Introduction of Surgical Safety Checklists in Ontario, Canada

David R. Urbach, M.D., Anand Govindarajan, M.D., Refik Saskin, M.Sc., Andrew S. Wilton, M.Sc., and Nancy N. Baxter, M.D., Ph.D.

ABSTRACT

BACKGROUND

Evidence from observational studies that the use of surgical safety checklists results in striking improvements in surgical outcomes led to the rapid adoption of such checklists worldwide. However, the effect of mandatory adoption of surgical safety checklists is unclear. A policy encouraging the universal adoption of checklists by hospitals in Ontario, Canada, provided a natural experiment to assess the effectiveness of checklists in typical practice settings.

METHODS

We surveyed all acute care hospitals in Ontario to determine when surgical safety checklists were adopted. Using administrative health data, we compared operative mortality, rate of surgical complications, length of hospital stay, and rates of hospital readmission and emergency department visits within 30 days after discharge among patients undergoing a variety of surgical procedures before and after adoption of a checklist.

RESULTS

During 3-month periods before and after adoption of a surgical safety checklist, a total of 101 hospitals performed 109,341 and 106,370 procedures, respectively. The adjusted risk of death during a hospital stay or within 30 days after surgery was 0.71% (95% confidence interval [CI], 0.66 to 0.76) before implementation of a surgical checklist and 0.65% (95% CI, 0.60 to 0.70) afterward (odds ratio, 0.91; 95% CI, 0.80 to 1.03; P=0.13). The adjusted risk of surgical complications was 3.86% (95% CI, 3.76 to 3.96) before implementation and 3.82% (95% CI, 3.71 to 3.92) afterward (odds ratio, 0.97; 95% CI, 0.90 to 1.03; P=0.29).

CONCLUSIONS

Implementation of surgical safety checklists in Ontario, Canada, was not associated with significant reductions in operative mortality or complications. (Funded by the Canadian Institutes of Health Research.)

From the Institute for Clinical Evaluative Sciences (D.R.U., A.G., R.S., A.S.W., N.N.B.), the Department of Surgery (D.R.U., A.G., N.N.B.) and Institute of Health Policy, Management and Evaluation (D.R.U., N.N.B.), University of Toronto, the University Health Network (D.R.U.), Mount Sinai Hospital (A.G.), and Keenan Research Centre, Li Ka Shing Knowledge Institute, Department of Surgery, St. Michael's Hospital (N.N.B.) — all in Toronto. Address reprint requests to Dr. Urbach at 200 Elizabeth St., 10-214, Toronto, ON M5G 2C4, Canada, or at david.urbach@uhn.ca.

Drs. Urbach and Baxter contributed equally to this article.

N Engl J Med 2014;370:1029-38.
DOI: 10.1056/NEJMsa1308261

Effective Leadership

SAFE & RELIABLE Healthcare

- Set a positive active tone
- Think out loud to share the plan – common mental model
- Continuously invite people into the conversation for their expertise and concern
- Use their names

Psychological Safety

SAFE & RELIABLE Healthcare

GENERATIVE
HRO - wired for safety and

PROACTIVE
Playing offense - anticipating,

SYSTEMATIC
Systems in place to manage hazards

REACTIVE
Playing defense – reacting to events

UNMINDFUL
No awareness of safety culture

- Primary responsibility of leaders, continuously modeled everywhere.
- Leaders model and expect the behaviors that promote psychological safety
- In some units it feels safe to speak up and voice a concern
- Personality dependent – it depends who I'm working with
- Fear based – keep your head down and stay out of trouble

The NEW ENGLAND JOURNAL of MEDICINE

MEDICINE AND SOCIETY

TEAMWORK — PART 2
Debra Malina, Ph.D., *Editor*

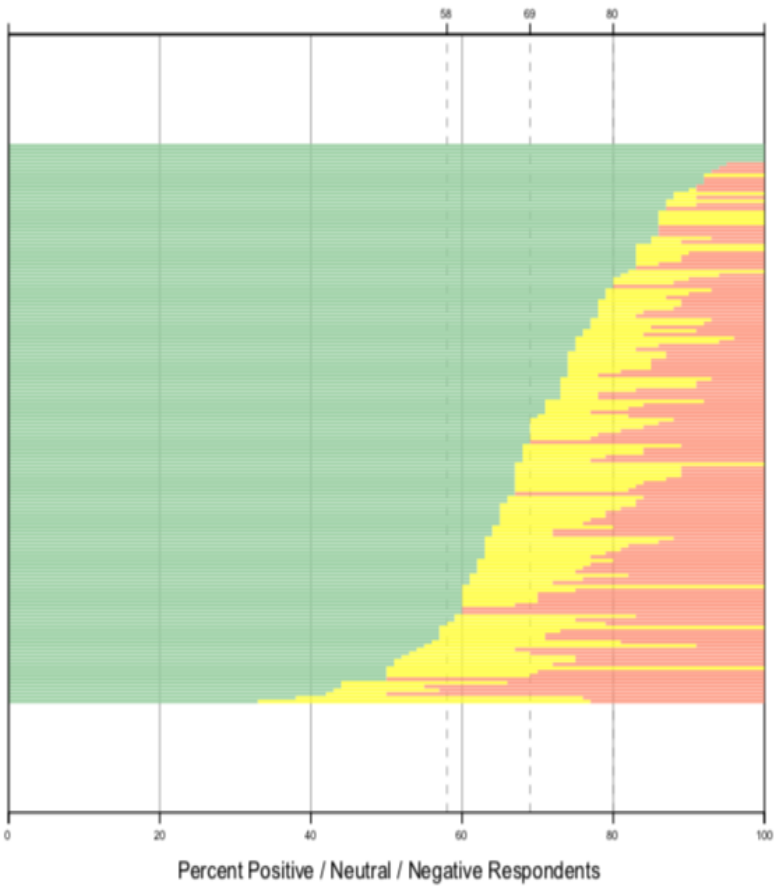
Cursed by Knowledge — Building a Culture of Psychological Safety

Lisa Rosenbaum, M.D.

On Christmas Day about a decade ago, Thor Sundt, now chief of cardiac surgery at Massachusetts General Hospital, was urgently summoned to transplant a heart into a young man with ischemic heart disease. Sundt's satisfaction with the man's hemodynamic stability turned to horror when, the next day, the patient didn't wake up. An air embolism had formed during surgery; the man was brain dead. Depressed for months afterward, Sundt tried to console himself: *He was so sick.* And *I gave it my best shot.* But no attempt at self-absolution could obscure the painful truth:

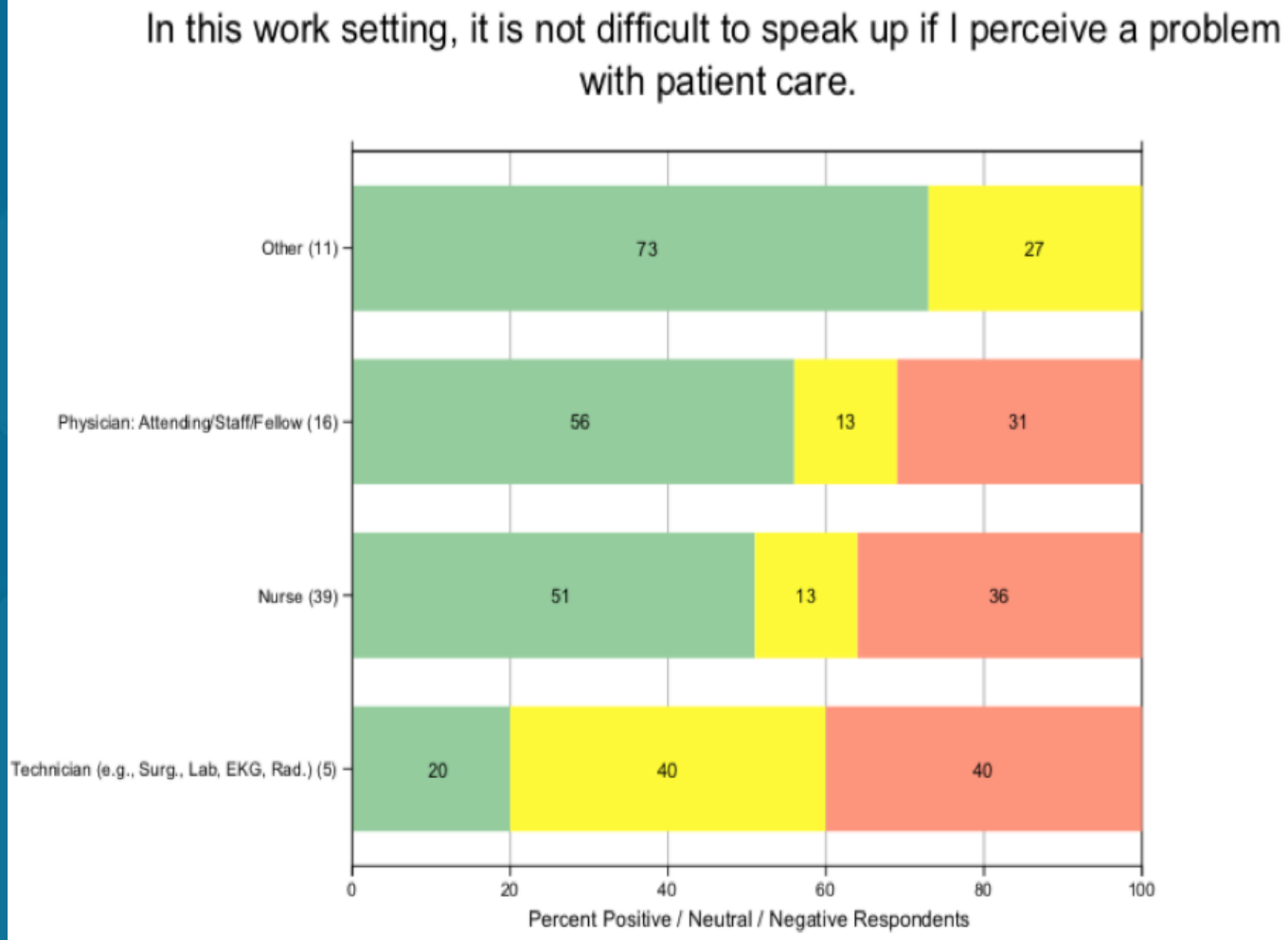
This willingness to take interpersonal risks at work, whether to admit error, ask a question, seek help, or simply say "I don't know," is part of what organizational psychologists refer to as "psychological safety." Edmondson has spent two decades elucidating why psychological safety is critical to effective collaboration in environments involving dynamic teams, high stakes, and significant interdependence — environments, that is, like the hospital. On a macro level, medicine endorses seeking help (calling for a consult, for example). But what makes psy-

Safe, Optimal Care Requires Psychological Safety



Source Data: Sep 2018

Caregivers in the same unit seeing the world quite differently



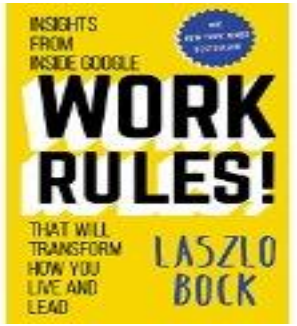
Source Data: Jun 2018

Psychological Safety

What are the things that make it hard to speak up here?

What are the 1-2 things we can do to make it better? Describe them in a way that they are actionable, visible and measureable.

Google



Laszlo Bock

Culture is imminently measurable

Julia Rozovsky

Two attributes of great teams:

1. Everyone speaks up in equal amounts
2. Team members are attuned to how others o
   intelligence".

Effective Teamwork

SAFE & RELIABLE Healthcare

Teamwork and continuous learning deeply embedded and central to our culture

Teamwork methodically taught and modeled across the organization

Training and tools available, partial implementation

Focus on teamwork awareness / training in response to adverse events

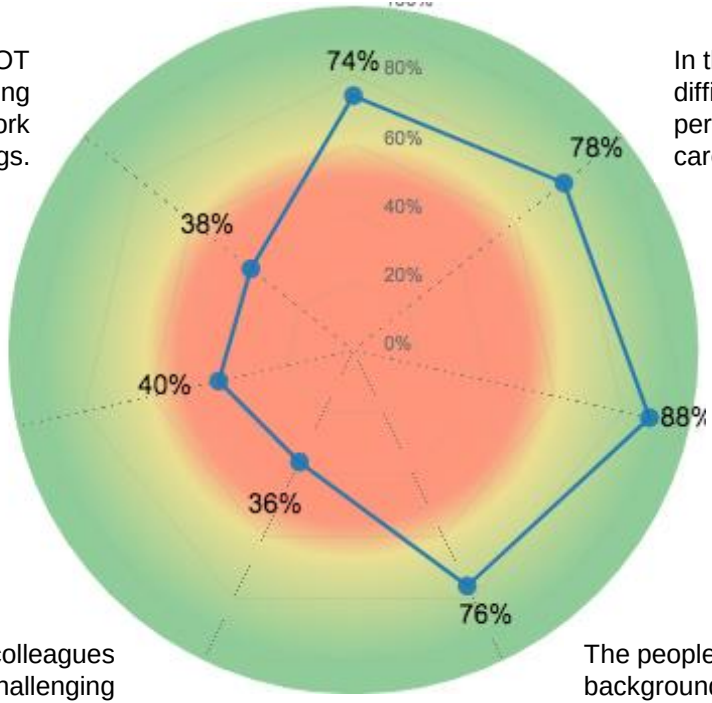
If people would just do their jobs we'd have no problems

Teamwork Domain – All Items

Disagreements in this work setting are appropriately resolved (i.e., not who is right but what is best for the patient).

Communication breakdowns are NOT common when this work setting interacts with other work settings.

In this work setting, it is NOT difficult to speak up if I perceive a problem with patient care.



Communication breakdowns are NOT common in this work setting.

It is easy for personnel here to ask questions when there is something that they do not understand.

Dealing with difficult colleagues is NOT consistently a challenging part of my job.

The people here from different disciplines backgrounds work together as a well coordinated team.

Percentage who agreed slightly or agreed strongly with each question.

What Teams Do:

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	The associated behaviors:
Plan Forward	Brief (huddle, pause, timeout, check-in)
Reflect Back	Debrief
Communicate Clearly	Structured Communication SBAR and Repeat-Back
Manage Conflict	Critical Language

Critical Language

A PHRASE THAT STOPS THE WORK

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“I need a little clarity.”

“I am concerned or unclear. This is unsafe.”

Teamwork Item

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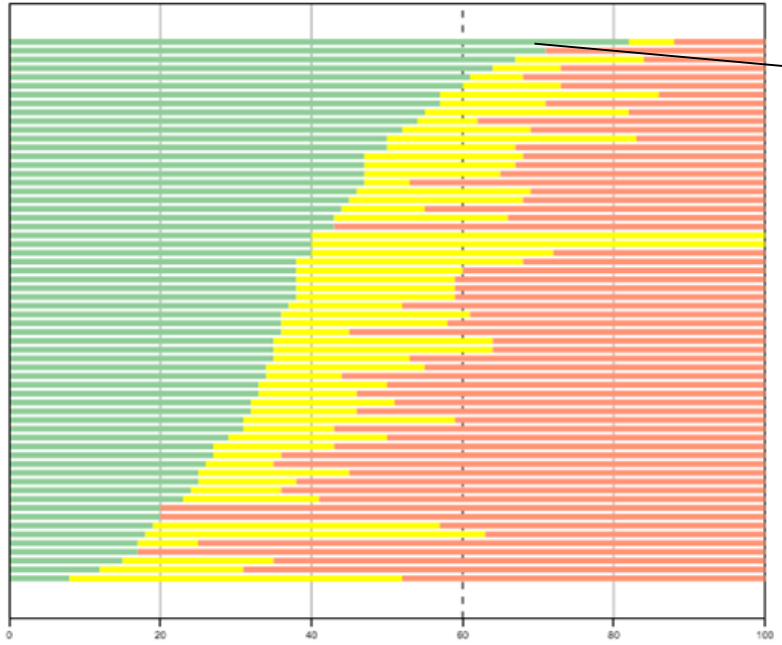
Dealing with difficult colleagues is not consistently a challenging part of my job.



Benchmarks: 2017 Q1
25th: 30% 50th: 43% 75th: 58%
Percent Positive Percentiles
n = 161027 responses
From 2895 units/departments

We work very hard on working with each other and being a family. We pride ourselves every time someone comes in and says "wow everyone is so happy here".

”A fair amount of the doctors are bullys. There are no sort of reprimands for them if they demean or act cruelly to the staff. In my 60 day orientation I watched a video about work place bullying that describes their actions perfectly.“

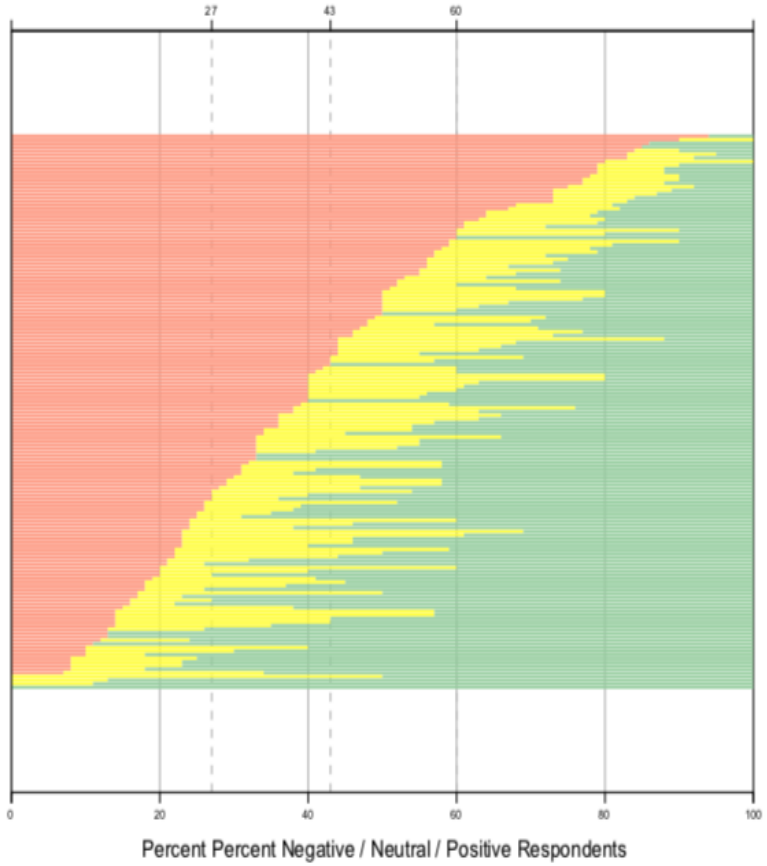
SAFE & RELIABLE
Healthcare

Burnout & Resilience

Burnout is a significant issue

If we can't take care of people providing care, we're not going to effectively take care of the people needing care

People in this work setting are burned out from their work.



Benchmarks: 2018 Q1 US Hosp.
25th: 60% 50th: 43% 75th: 27%
Percent Negative Percentile(s)
n = 151305 responses
From 6079 units/departments

Source Data: Sep 2018

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Burnout is associated with:

Infections

Cimiotti, Aiken, Sloane and Wu. Am J Infect Control. 2012 Aug;40(6):486-90.

Lower Patient Satisfaction

Aiken et al. BMJ 2012;344: e1717 Vahey, Aiken et al. Med Care. 2004 February; 42(2 Suppl): II57-II66.

Medication Errors

Fahrenkopf et al. BMJ. 2008 Mar 1;336(7642):488-91.

Higher Standardized Mortality Ratios

Welp, Meier & Manser. Front Psychol. 2015 Jan 22;5:1573.

Christina Maslach, PhD
author of the
Maslach Burnout Inventory (MBI)
Professor Emeritus, Berkeley

MBI 3 Pillars of Burnout:

- Emotional Exhaustion (overwhelmed, drained, unable to meet demands)
- Depersonalization (callousness, seeing others as objects)
- Inefficacy (diminishes sense of accomplishment)

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Influencing Factors in Burnout / Resilience

- Do I feel valued by the organization?
- Do I have a voice?
- Do I feel supported in the work I do?
- Do I have the tools and resources to do my job?

Just Culture

Real events are shared by leaders, true culture of accountability and learning

Clear ways to differentiate individual v. system error, safe to discuss mistakes

Well understood algorithm, learning is the priority

Depends who the boss is, blame and punishment are common

Nothing good will come from talking about mistakes

Just Culture Model

Organizational Fairness and Professionalism Worksheet

Reliably excellent patient centered care is dependent on healthcare departments that are effective learning systems; they routinely identify their defects and then eliminate or ameliorate them. Individuals bring to light defects only when they trust others and feel safe about voicing their insights and concerns. Professionalism and Just Culture create trust and psychological safety and are the essential foundation for all learning systems. The job of the Just Culture & Professionalism Committee is to safeguard Professionalism and Just Culture in order to protect and promote robust learning systems.

Event or Near Event

Step 1: Identify participants, and exclude those with impaired judgment or whose actions might be malicious. If impaired judgment refer to senior leaders and HR department. If malicious, refer to Risk and HR departments. If unprofessional behavior is a component in any way, perform **Professional Behavior Evaluation.**

Step 2: Assign initial level of intent:
Use best judgment to categorize each action as either Reckless, Risky or Unintentional. The categorization determines the general level of culpability and possible disciplinary actions, however these general categories must be modified using Steps 3 and 4 below.

RECKLESS ACTION	RISKY ACTION	UNINTENTIONAL
The caregiver knowingly violated a rule and/or made a dangerous or unsafe choice. The decision appears to be self serving and to have been made with little or no concern about risk.	*The caregiver made a potentially unsafe choice. Their evaluation of relative risk appears to be erroneous.*	*The caregiver made or participated in an error while working appropriately and in the patients' best interest.*

Step 3: Evaluate systems influences to modify level of intent by performing a Substitution Test: Ask 3 others with similar skills if they, in a similar situation, would behave or act similarly. If the answer is "No" the test is negative and the individual is likely accountable. If the answer is "Yes" the test is positive and system influence is likely substantial. Evaluators may ask about system factors such as schedules leading inevitably to fatigue, unrealistic expectations regarding memory, inability to effectively follow policies or procedures, an unsafe learning environment, or distractions or interruptions. If answers are divided, evaluators should assign accountability with a goal to ensure perceptions of fairness by others.

Step 4: Evaluate the individual for a history of unsafe acts: Evaluate whether the individual has a history of unsafe or problematic acts. If they do, this may influence decisions about the appropriate responsibilities for the individual i.e. they may be in the wrong job. Organizations should have a reasonable and agreed upon statute of limitations for taking these actions into account.

Step 5: Final evaluation:

RECKLESS: If the Substitution Test is positive, the system supports reckless behavior and system leaders are accountable. The caregiver's behavior is unsafe; they are accountable warranting discipline. A history of unsafe behavior may suggest the individual is in the wrong job.	**RISKY:** If the Substitution Test is positive, the system supports risky behavior and system leaders are accountable. The caregiver's behavior is unsafe; they are accountable and should receive coaching. A history of unsafe behavior may suggest the individual is in the wrong job.	If **UNINTENTIONAL**: Focus should be on correcting system issues and coaching on human factors. System leaders are accountable. A negative Substitution Test and a history of unsafe behavior suggests the individual may be in the wrong job.

Step 6: Promote learning and improvement

The caregiver should participate in teaching the lessons learned to others.	The caregiver should participate in teaching the lessons learned to others.	The caregiver should participate in investigating why the error occurred and teach others about the results of the investigation.

Professional Behavior Evaluation and Intervention

Receive Report of Concerning Behavior.

Step 1: Conduct confidential conversation with reporter regarding Focus Person (FP) behaviors. Categorize types of behaviors as well as frequency and severity. Conduct confidential interviews with others.
Behavior categories include: Demeaning/angry, hypercritical, uncollegial, shirking responsibilities, misconduct, sexual harassment, patient communication concerns, boundary issues, substance abuse, blaming, and otherwise acting in a manner that undermines trust and learning.

Step 2: Feedback Conversation Coaching: If the concern is deemed an isolated incident, the FP has not had any other issues, and the reporter feels safe to do so, provide coaching for the reporter on how to give the FP direct feedback regarding behaviors. If the situation is more complex, proceed to Step 3.
Step 3: Assessing Concerns: To validate the concerns and assess their frequency and severity, conduct multisource interviews to provide comprehensive insight into, and corroboration of, alleged behavior.
Step 4: Involve Supervisor: Share findings of assessment with FP's manager, department chair, division chief, or supervising physician. Discuss a plan for feedback intervention (Step 5) if deemed necessary.
Step 5: Feedback Intervention
Involved Supervisor and professionalism representative meet with FP to discuss/review:
- specific disruptive behaviors
- FP's perspective on factors (including systems) that may be contributing to the behavior
- resources for facilitating behavioral changes
- plans for monitoring behavior
- unacceptability of retaliation
- (if applicable) potential consequences for not adhering to behavioral expectations

A follow up email is sent to the FP summarizing the meeting.
Step 6: Monitoring and Support
- Inform those reporting concerns that an intervention has occurred.
- Inquire of them and others over time regarding subsequent behaviors.
- Have FP's supervisor address any systems issues discussed in Step 5.
- Keep process discrete and respectful to FP.

Step 7: Intervention to Address Subsequent Lapses
Develop a plan of action with institutional administration and legal counsel. Selected institutional administrators meet with FP to detail expected behavioral changes and consequences, including termination.

Final Step: Evaluate the individual for a history of unsafe acts: Evaluate whether the individual has a history of unsafe or problematic acts. If they do, this may influence decisions about the appropriate responsibilities for the individual i.e. they may be in the wrong job. Organizations should have a reasonable and agreed upon statute of limitations for taking these actions into account.

Just Culture

Malicious

Knowingly Impaired

Choices – Unintentional / Risky / Reckless

Substitution Test

Frequent Flier – Repetitive Events

Inherent Human Limitations

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Negative influence of fatigue and other physiological factors

- procedural integrity

- complex decision making

Limited ability to multitask: - cell phones / texting

Inherent Human Limitations

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Limited memory capacity – 5-7 pieces of information in short term memory

Inherent error rates - errors of commission – 1/300

- errors of omission – 1/100

Negative effects of stress – increased error rates – task fixation

What Happens If You Make An Error?

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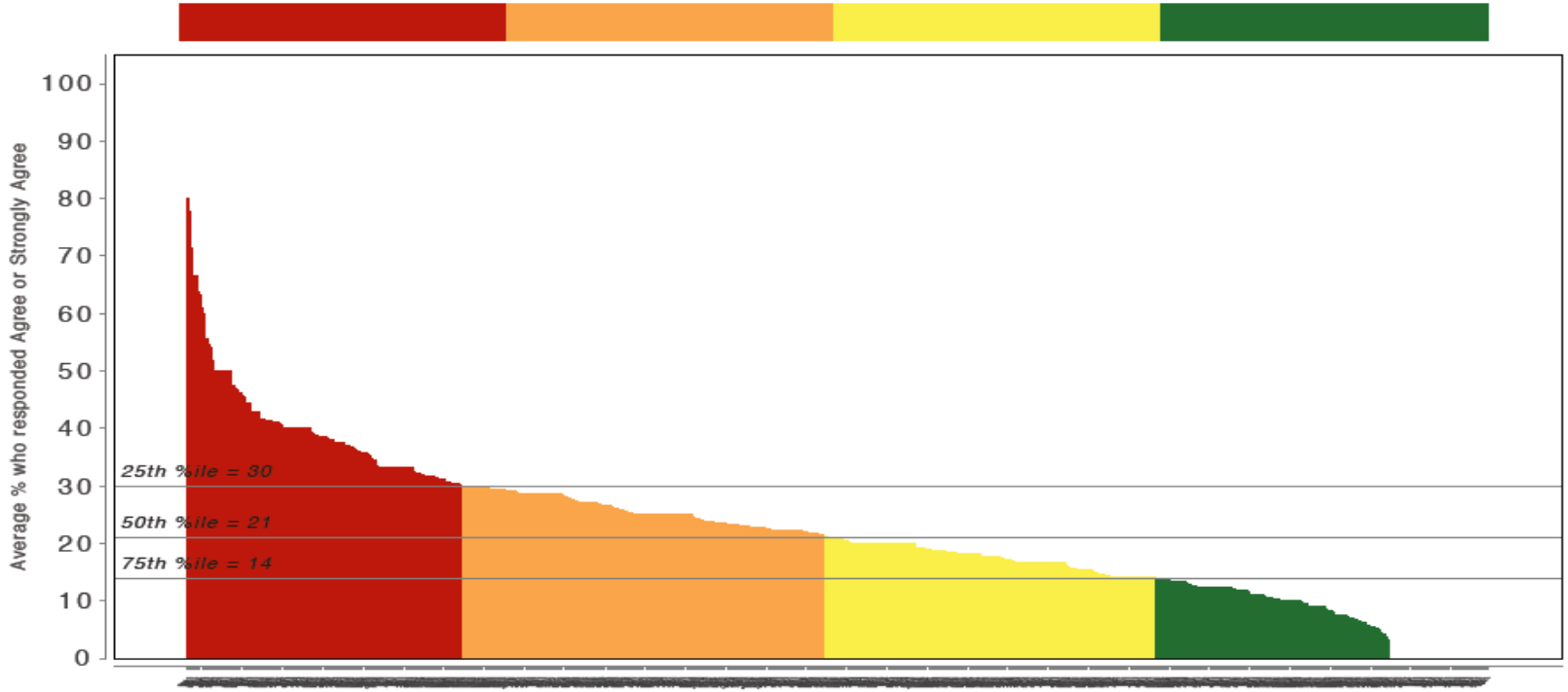
In this work setting, it is difficult to discuss errors.

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.



Perspectives on Human Error – Dekker

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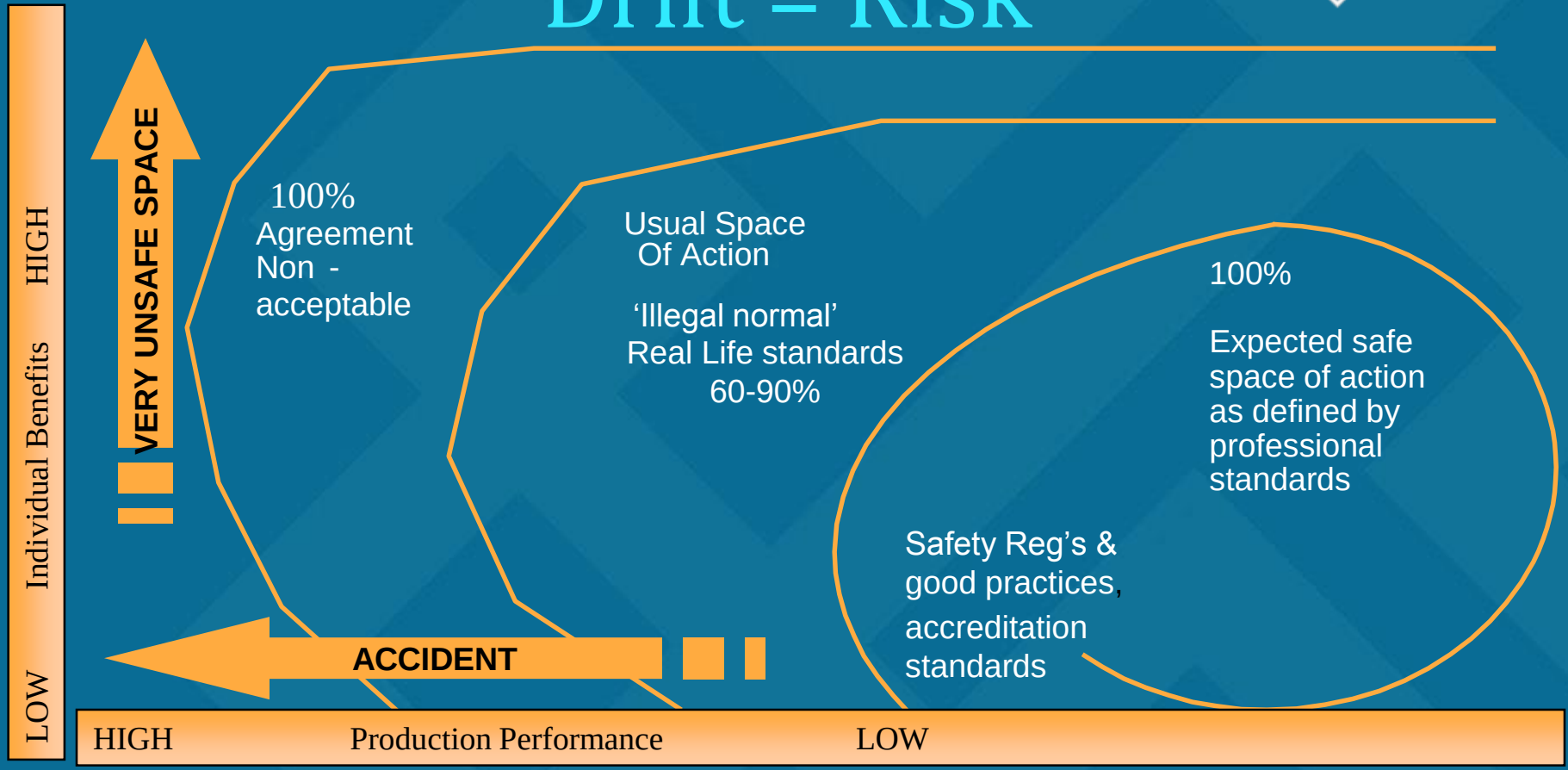
Old View

- Human error is a cause of trouble
- You need to find people's mistakes, bad judgments and inaccurate assessments
- Complex systems are basically safe
- Make systems safer by restricting the human contribution

New View

- Human error is a symptom of deeper system trouble
- Instead, understand how their assessments and actions made sense at the time — context
- Complex systems are basically unsafe
- People must create safety through practice at all levels

Drift = Risk



Attribution: Dr. Rene Amalberti

Professionalism

Slides Courtesy of Jo Shapiro

Professionalism

Do you have issues of unprofessional behavior in your facility?

Is there confidence that the behavior will be addressed and resolved when reported?

Is there one standard or set of rules that applies to everyone, regardless of job title?

The Joint Commission Journal on Quality and Patient Safety

Safety Culture

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

Jo Shapiro, MD, FACS; Anthony Whittemore, MD, FACS; Lawrence C. Tsen, MD

Leaders of medical institutions are responsible for creating environments in which physicians, scientists, and other health care professionals are able to sustain their deep capacity for high-quality, compassionate care. Creating such environments depends on supporting a culture of trust, which has been identified as the core of successful leadership.[1–3]

The mission statements of both academic and community-based medical centers and hospitals characteristically reflect high aspirations for excellence in patient care. Yet, despite significant resources directed toward improving the delivery of health care, the rate of preventable and iatrogenic patient injuries has not improved significantly.[4,5] Although a number of reasons have been cited for this lack of progress,[6,7] there is growing recognition that an environment in which professionalism

Article-at-a-Glance

Background: There is growing recognition that an environment in which professionalism is not embraced, or where expectations of acceptable behaviors are not clear and enforced, can result in medical errors, adverse events, and unsafe work conditions.

Methods: The Center for Professionalism and Peer Support (CPPS) was created in 2008 at Brigham and Women's Hospital (BWH), Boston, to educate the hospital community regarding professionalism and manage unprofessional behavior. CPPS includes the professionalism initiative, a disclosure and apology process, peer and defendant support programs, and wellness programs. Leadership support, establishing be-

“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

Jo Shapiro MD, BWH

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The Aim:

Hierarchy of *Responsibility*

No Hierarchy of *Respect*

Common responses	Appropriate feedback
Inadequate data *Exactly who said this?*	Not a court of law
Personal sabotage *Dr. X is trying to discredit me*	Not an isolated incident
Other people like me	You shouldn't have a disruptive working relationship with anyone
I am special and talented *I do work that no one else is qualified to do*	Not a performance evaluation
This is a systems problem *If this whole system functioned better…*	Yes, and you still are responsible for your behavior

Common responses	Appropriate feedback
Unfair process *I'm being singled out because …*	We hold everyone to the same standards
Patient advocacy *Others aren't responsible for patients the way I am*	Disruptive behavior is a safety risk
Prove harm *Give me one example …*	We don't need to
Personal style *I don't mean anything by it*	Impact not intent
I am no worse than others *I am certainly not the only one*	We are focusing on your issues right now

Jo Shapiro MD, BWH

Reporting Concerns – What Should Happen:

Confidential discussion with Director

Investigation

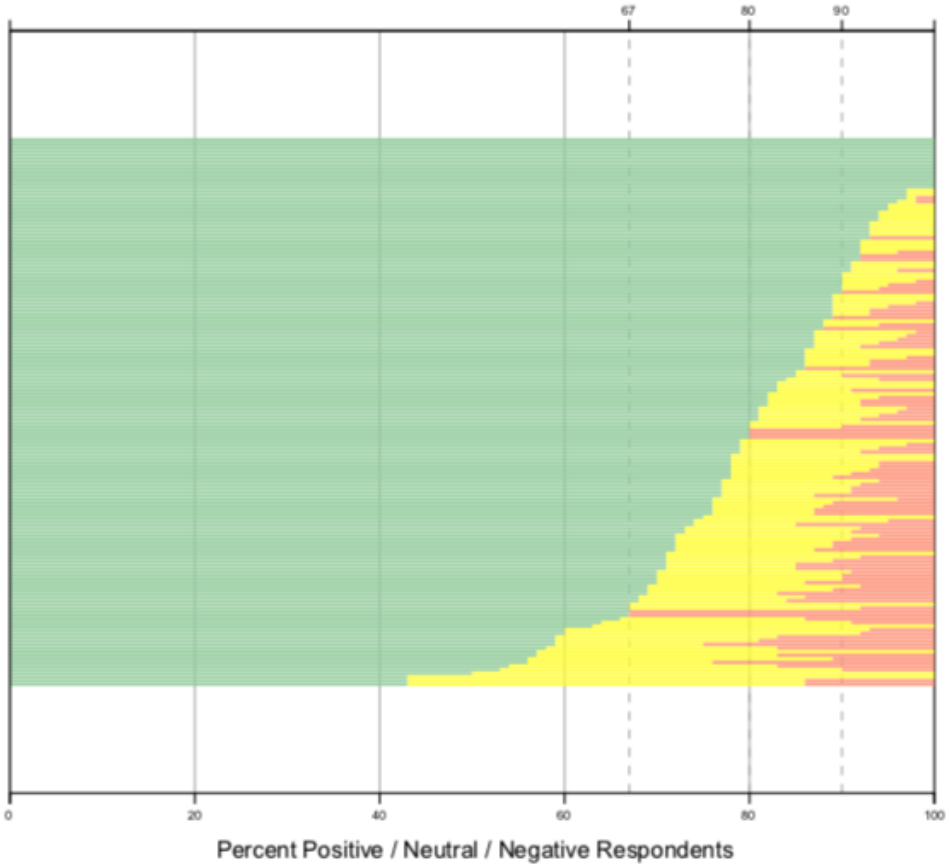
Discussion with supervising leaders/manager

Meeting with disruptor

Document all interactions

Jo Shapiro MD, BWH

I would feel safe being treated here as a patient.



Benchmarks: 2018 Q1 US Hosp.
25th: 67% 50th: 80% 75th: 90%
Percent Positive Percentile(s)
n = 148626 responses
From 6045 units/departments

Source Data: Sep 2018

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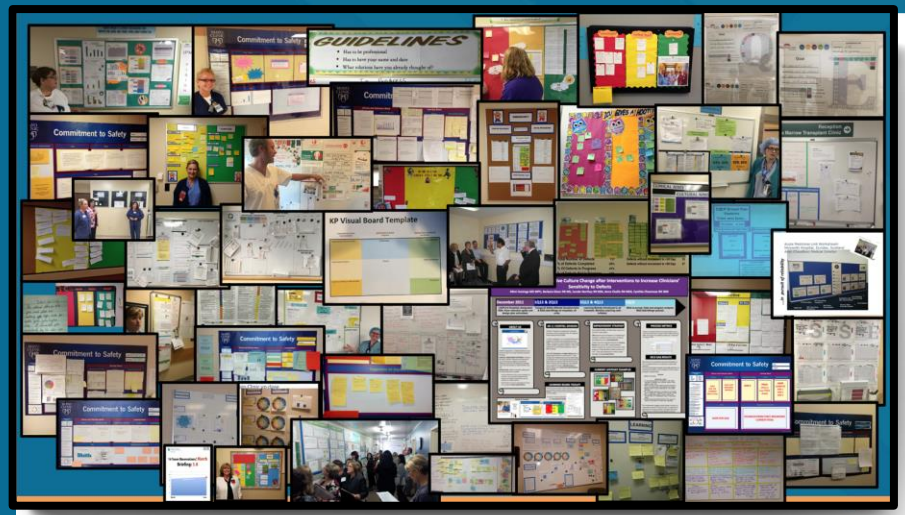
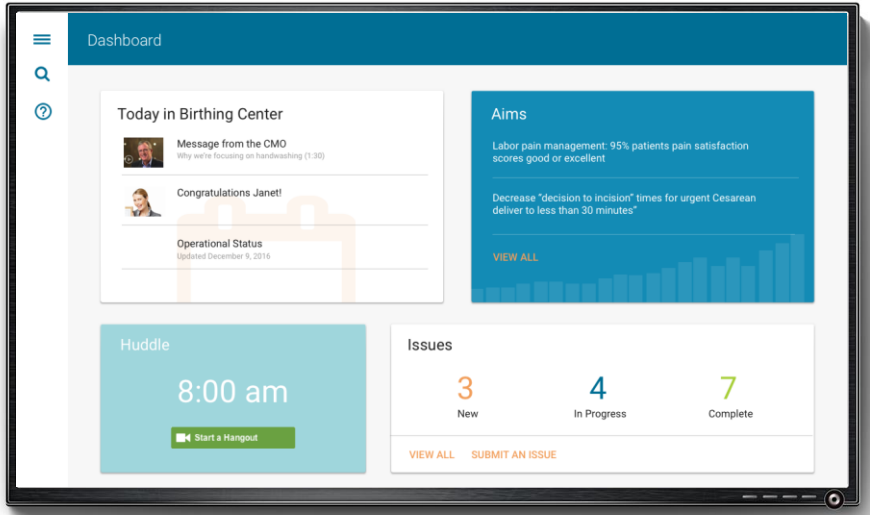
Learning Systems

- Build organizational trust through identifying and resolving defects
- Make learning visible – feedback is key
- This requires ownership and infrastructure
- Always move toward higher order problem solving

Learning boards capture ideas and issues from everyone





ANALOG: proven results

DIGITAL: available everywhere on any device.

LENS
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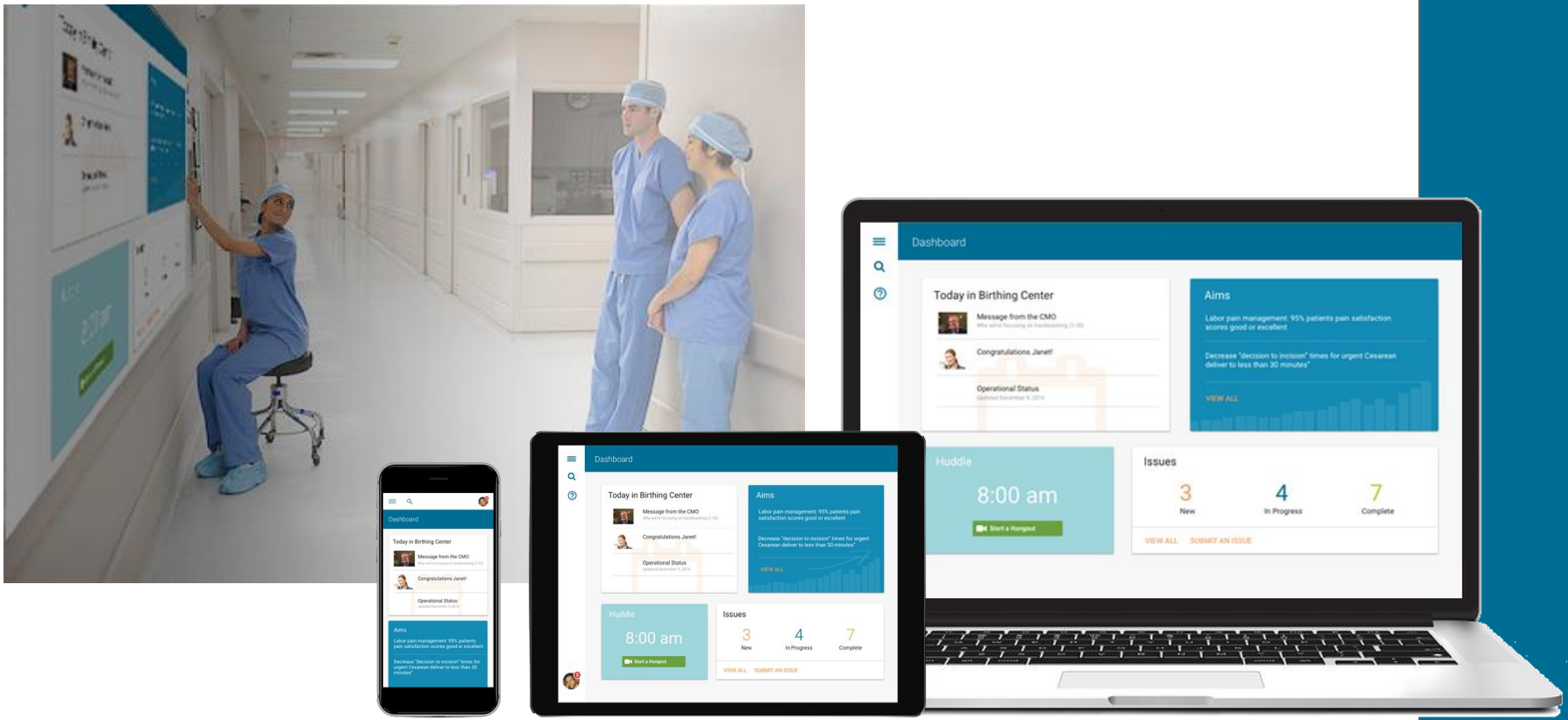
Connecting on key topics, during and between huddles



LENS: Using Learning Boards to Drive Sustainable Improvement

Voice of the frontline

Improvement

Putting it all together

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Effective Leadership – present, learning, providing feedback, building trust

Culture – clearly defined behaviors that support teamwork, collaboration and patient centered care

Learning systems – units that plan forward/ reflect back, capture issues and defects for resolutions, and have clear aims to improve - cultural, operational, clinical