Psychological Safety: A Hallmark of Effective Teams

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3 Waves of Innovation in Patient Safety

Technical and procedural improvements have made surgery safer, but future innovations will focus on reliably organizing the work of patient care.

High Reliability in Health Care Requires:

- Leadership: Commitment to Zero Patient Harm
- Safety Culture: Empowering staff to speak up about patient risks
- RPI: Systematic data-driven approach to solving complex problems
Failure to Embrace a Culture of Safety

Healthcare organizations must have a culture of safety that both spans the entire organization and permeates each department.

Essential Elements: Culture of “Mindfulness” for Psychological Safety

- An atmosphere of trust in which errors and “near misses” are valuable lessons
- A “just” response to human errors, differentiating intentional from unintentional
- A system that provides for easy, de-identified reporting of unexpected events and errors, and that gives feedback and learning to those who report
- A learning system that not only shares feedback, but uses the learning to redesign the operations and challenge the assumptions that underlie the system itself
Getting to Zero Harm

“The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes.”

- Lucian Leape MD, member of the Quality of Health Care in America Committee at the Institute of Medicine and adjunct professor of the Harvard School of Public Health
# Safety Culture

## Principles and Traits

<table>
<thead>
<tr>
<th>Principle</th>
<th>Trait</th>
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</thead>
<tbody>
<tr>
<td>Everyone is personally responsible for safety</td>
<td>- Personal Accountability</td>
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<tr>
<td>Leaders demonstrate a commitment to safety</td>
<td>- Leadership safety values</td>
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<td>Trust permeates the organization</td>
<td>- Effective safety communications</td>
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<td></td>
<td>- Respectful work environment</td>
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<td></td>
<td>- Environment for raising concerns</td>
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<tr>
<td>Decision-making reflects safety first</td>
<td>- Decision-making</td>
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Adapted from: Traits of a Healthy Nuclear Safety Culture. INPO 12-012, April 2013. Copyright © 2012, 2013 by the Institute of Nuclear Power Operations
### Safety Culture Principles and Traits (continued)

<table>
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<tr>
<th>Principle</th>
<th>Trait</th>
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</thead>
<tbody>
<tr>
<td>Health care technology is recognized as special and unique</td>
<td>- Work processes automated</td>
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<tr>
<td>A questioning attitude is cultivated</td>
<td>- Questioning attitude applauded</td>
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<tr>
<td>Organizational learning is embraced resolution</td>
<td>- Continuous learning</td>
</tr>
<tr>
<td>-</td>
<td>- Problem identification &amp;</td>
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<tr>
<td>Patient Safety undergoes constant evaluation</td>
<td>- Continuous learning and fixes</td>
</tr>
<tr>
<td>-</td>
<td>- Problem identification</td>
</tr>
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A Psychologically Safe Culture: Interlocking Elements

Source: James Reason
Safety Culture Maturation

**Beginning**

- Trust and intimidating behavior are not assessed
- Emphasis is on blame; inequitable application of discipline
- Root cause analysis is limited to adverse events
- Limited or no efforts to assess system defenses against quality failures and remedy weaknesses
- No measures of safety culture exist

**Approaching**

- High levels of (measured) trust exist in all clinical areas
- All staff recognize/act on personal accountability; equitable disciplinary procedures
- Close calls/unsafe conditions routinely reported with early problem resolution
- System defenses proactively assessed; weaknesses proactively repaired
- Safety culture measures results routinely reported to the board; system improvement initiatives under way
Culture Change is Difficult

AHRQ Safety Culture Survey

1. Staff feel mistakes are held against them (% YES) 2007: 50 2012: 50

2. When event is reported, it feels like the person is being written up, not the problem (% YES) 2007: 57 2012: 54

3. Staff worry mistakes are kept in their personnel files (% YES) 2007: 65 2012: 65

2007 (n=382) 2012 (n=1128)
What Behaviors Are Intimidating?

- **Wide range**: from hanging up the phone instead of answering a question to verbal abuse (cursing, yelling) or physical abuse
- **Most common?**
  - Refusal to answer questions or to return phone calls or pages; condescending tone or language; impatience with questions
  - 2003: about $\frac{1}{4}$ of nurses and pharmacists personally experienced these from MDs more than 10 times in past year

Have we improved?
Sometimes the silence gets so loud, the only thing left to do is hope your heart is strong enough to beat it out.

Author: Rachel Wolchin
Bullying has no place in health care

Issue:
Civilility is a system value that improves safety in health care settings. The link between civility, workplace safety and patient care is not a new concept. The 2004 Institute of Medicine report, “Keeping Patients Safe: Transforming the Work Environment of Nurses,” emphasizes the importance of the work environment in which nurses provide care. Workplace incivility that is expressed as bullying behavior is at epidemic levels. A recent Occupational Safety and Health Administration (OSHA) report on workplace violence in health care highlights the magnitude of the problem: while 21 percent of registered nurses and nursing students reported being physically assaulted, over 50 percent were verbally abused (a category that included bullying) in a 12-month period. In addition, 12 percent of emergency nurses experienced physical violence, and 59 percent experienced verbal abuse during a seven-day period.

Workplace bullying (also referred to as lateral or horizontal violence) is repeated, health-harming mistreatment of one or more persons (the targets) by one or more perpetrators. Bullying is abusive conduct that takes one or more of the following forms:
- Verbal abuse
- Threatening, intimidating or humiliating behaviors (including nonverbal)
- Work interference – sabotage – which prevents work from getting done

There are five recognized categories of workplace violence:
- Threat to professional status (public humiliation)
- Threat to personal standing (name calling, insults, teasing)
- Isolation (withholding information)
- Overwork (impossible deadlines)
- Destabilization (failing to give credit where credit is due)

Drive out fear and create trust
- W. Edward Deming
Safety Culture

“The Trust Equation”
What Do Healthcare Staff Need for Psychological Safety?

- Respect and engagement
- Freedom from harm
  - physical
  - psychological
- Meaningful work
- Opportunities to learn and develop

How Clinicians Experience Caregiving

- Cared About
  - Belong
  - Respect
  - Trust
  - Job Security

- Connected
  - Enjoy Work
  - Recognition

- Clinical Excellence
  - Providing Quality Care
  - Providing Safe Care

- Operational Excellence
  - Job Fit, Clarity, Pay/Benefits
  - Work Training, Development, Physical/Staff Resources
  - Good Management Input, Feedback, Autonomy, Leadership
  - Communication

- Culture
  - Mission/Values
  - Teamwork
  - Patient-Centeredness
  - Improvement Focus
  - Safety as a Priority

Press Ganey®
Elements of Psychological Safety in Teams

- Trust teammates to support and help each other
- Respectful communications
- Assume good intentions – no “hidden agendas”
- Believe everyone’s goals are aligned
- Able to challenge others’ ideas in positive manner
- Hold each individual accountable for own actions
- Open to learning from mistakes
- Fear is absent
The Joint Commission
Customer Relations Department
Operating Principles

- Clearly communicate expectations; if instructions are not clear, receiver should clarify with sender
- Respect others in word and actions
- Treat others as you’d like to be treated
- Be honest in all interactions; respectfully approach the individual with any concerns privately
- Be transparent in all communications
- Watch each others “back” — be a good team player
- If uncertainty, difference of opinion, meet internally and problem solve
- We live and thrive as a team
- “No gossip” — confront (politely and privately) the person directly; be constructive
- Assume good intentions, respond professionally to any constructive feedback
- Everyone steps up to help when department workloads begin to increase as needed (one team, one goal)
- Exchange ideas that are creative, innovative and useful that can increase the efficiency and effectiveness of Customer Relations
- Build and maintain a culture that incorporates trust
Where to Start: A Simple Test

Can your staff answer yes to the following three questions?

1. Am I treated with dignity and respect everyday by everyone I work with?

2. Do I have the knowledge, skills, and tools to do my job?

3. Am I recognized and thanked for my contributions?
Role of Hospital Leaders in Building a Culture of Psychological Safety

- **Motivate** care teams to uphold a fair and just safety culture
- **Provide** a transparent environment in which patient safety events are honestly reported
- **Model** professional behavior
- **Remove** intimidating behavior that might inhibit a culture of safety
- **Provide** the resources and training necessary to take on improvement initiatives
What gets rewarded gets repeated

“Recognition”
It’s not a natural skill . . .
It must be taught!

“65% of Americans reported that they received no recognition for good work in the past year . . .”

Eight Recommendations for Achieving Total Systems Safety

1. Ensure that leaders establish and sustain a safety culture
   Improving safety requires an organizational culture that enables and prioritizes safety. The importance of culture change needs to be brought to the forefront, rather than taking a backseat to other safety activities.

2. Create centralized and coordinated oversight of patient safety
   Optimization of patient safety efforts requires the involvement, coordination, and oversight of national governing bodies and other safety organizations.

3. Create a common set of safety metrics that reflect meaningful outcomes
   Measurement is foundational to advancing improvement. To advance safety, we need to establish standard metrics across the care continuum and create ways to identify and measure risks and hazards proactively.

4. Increase funding for research in patient safety and implementation science
   To make substantial advances in patient safety, both safety science and implementation science should be advanced, to more completely understand safety hazards and the best ways to prevent them.
Eight Recommendations for Achieving Total Systems Safety

5. Address Safety Across the Entire Care Continuum

Patients deserve safe care in and across every setting. Health care organizations need better tools, processes, and structures to deliver care safely and to evaluate the safety of care in various settings.

6. Support the Health Care Workforce

Workforce safety, morale, and wellness are absolutely necessary to providing safe care. Nurses, physicians, medical assistants, pharmacists, technicians, and others need support to fulfill their highest potential as healers.

7. Partner with Patients and Families for the Safest Care

Patients and families need to be actively engaged at all levels of health care. At its core, patient engagement is about the free flow of information to and from the patient.

8. Ensure that Technology is Safe and Optimized to Improve Patient Safety

Optimizing the safety benefits and minimizing the unintended consequences of health IT is critical.