Patient Safety Culture
Presentation outline

• Describe “patient safety culture” with a focus on “just culture”

• Briefly review Health PEI’s patient safety culture

• Discuss key elements to a patient safety culture

• Introduce a “Checklist for Building a Safety Culture”
How often do patient safety incidents happen?

1 in 10 patients are harmed when receiving care in hospital – WHO and USA

1 in 18 hospital stays in Canada results in preventable harm or death

Up to 13% of people in Canada receiving homecare experience a harmful incident

Falls, medication and behaviour incidents are the top 3 in Health PEI. What incidents occur in your area?
Canadian Incident Analysis Framework

Before the incident:

- Cultivate a safe and just culture
Organizational culture

- Culture is “the way we do things around here” – shared values and beliefs that interact with a system’s structure to produce behavioural norms.
- “Hidden Curriculum” – normal day to day practice in your work unit that often undermines formal education and organization policies.
Patient safety culture

- An integrated pattern of individual and organizational behaviour, based upon shared beliefs and values, that continuously seeks to minimize patient harm that may result from care delivery processes.

- In healthcare settings where there is a safety culture, the people (providers, staff, administrators AND patients/families) are engaged, encouraged and supported to make care safer.
Components of a patient safety culture

- Reporting
- Flexible
- Learning

JUST

Health PEI

One Island Health System
Just culture

- Fairly balancing an understanding of **system failure** with **professional accountability**
- [https://www.youtube.com/watch?v=BcC9YSTa8B8](https://www.youtube.com/watch?v=BcC9YSTa8B8)
- Emphasis on quality and safety over blame and fault finding
- People believe they can question existing practices, express concerns, and admit mistakes without ridicule or punishment.
- Errors do not result in automatic discipline – instead try and determine root causes and system breakdowns.
Just Culture

Inverse relationship between discipline and reporting

- Individual Discipline for a Systems Problem
- Decreased Reporting
- Decreased Learning
- Less Opportunity to Improve Systems
- Ongoing Errors
- Eventual Patient Harm

Health PEI

One Island Health System
## Just Culture – Managing Behaviours

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Chose the behaviour?</th>
<th>Saw the risk?</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Human Error</strong></td>
<td>NO</td>
<td>NO</td>
<td>CONSOLE</td>
</tr>
<tr>
<td><em>Inadvertent action: slip, lapse, mistake</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>At-Risk</strong></td>
<td>YES</td>
<td>NO</td>
<td>COACH</td>
</tr>
<tr>
<td><em>A choice: risk not recognized or believed justified</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reckless</strong></td>
<td>YES</td>
<td>YES</td>
<td>DISCIPLINE</td>
</tr>
<tr>
<td><em>Conscious disregard of unreasonable risk</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Health PEI**

One Island Health System
2015 Patient Safety Culture Survey Results - Three ‘Red’ Flags

- Staff worry that making a serious error would lead to disciplinary action from management.
- Staff feel that making a serious error would limit career opportunities around here.
- Staff feel that making a serious error may cause a staff member to lose his/her job.
- Overall perceptions of patient safety at the unit level have improved since 2012; whereas overall perceptions at the organizational level have declined.
Patient safety culture: key contributors

- Leadership, board commitment and ongoing visibility (at organization and team levels)
- Priority of safety versus “production” or “efficiency”
- Organizational resources and rewards for patient safety
- Patient/family engagement
- Effectiveness and openness of teamwork and communication
- Openness of all team members, including patients/families, in reporting incidents and problems when they occur
- Organizational learning – focus on improving system performance versus individual blame
What can you do...

- **Speak up** when you see an unsafe situation
- Be a **safety advocate** – encourage and support others
- **Speak openly** during incident investigations
- **Report incidents**
- **Share ideas** on improving safety
- **Bring patients and families** into the conversation
Checklist for building a safety culture

• Goal: to provide tips and approaches to lead and build a culture of safety in your team.

• Think of 2-3 items that you can implement in your workplace to continue building your culture.

• Download at: http://www.healthpei.ca/src/patientsafety
Create knowledge and understanding of patient safety and culture within your team

- Promote a “just culture” and create an understanding of what it means.
- Incorporate patient safety education into all staff orientation and ongoing training.
- Share patient and provider stories.
Promote and support incident reporting and management

• Familiarize yourself with Health PEI’s risk management policies.

• Encourage incident reporting. Provide rewards and recognition for incident reporting.

• Review incident reporting data to identify key incidents and share with your team.

• Complete multidisciplinary (including patients and families) incident investigations and follow-up in a timely way.

• Ensure timely feedback on incidents and lessons learned is shared.

• Ensure understanding of the disclosure process and policy.
Create opportunities for your team to talk openly and share safety concerns

- Add safety as a standing agenda item for meetings.
- Share experiences with incidents during huddles.
- Use safety crosses or calendars to track measures of safety.
- Assign a team member to be a “safety lead or champion”.
- Join or lead leadership walkabouts to discuss safety.
- Hold “Straight Talk about Quality & Safety” sessions.
- Carry out team briefings and debriefings.
- Use a Learning Board to capture safety concerns.
- Lead, promote and/or support initiatives to improve safety.
Involve and communicate with patients and families

- Provide patient safety brochures and education to patients on how they can be involved in their own safety.
- Post the “Don’t just think it, ask it” poster and provide hand-outs for patients and families.
- Share the “5 Questions to Ask About Your Medications” poster.
- Involve patients and families in safety discussions and solutions.
- Involve patient and families on committees to hear their safety concerns and ideas for improvement.
- Ask patients about their safety concerns during leadership walkabouts.
Moving forward:
Think about 2-3 things you can do to improve your safety culture…
References


The Canadian Medical Protective Association (CMPA). *Learning from Adverse Events: Fostering a just culture of safety in Canadian hospitals and healthcare institutions.* Ottawa, ON: CMPA; 2009.


