Culture of Safety: A Physician Perspective

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Background

- Culture of safety is critical to prevention
- Allows workers and processes to focus on improving the reliability of patient care
- Prevention trumps reaction

Goals

- High Reliability Organizations
- Safety Culture changes
- Assessment and Approaches
- What we do?

Health Care Reform - 2010

- Accountable Care Organizations
- High Reliability Organization
- Lean / Six Sigma
- New Payor paradigm
- Physician Employment

High Reliability Organization

- Preoccupation with failure
- Reluctance to simplify: errors and close calls are reflections of deeper flaws
- Commitment to resilience: acknowledge that there will be flaws and problems
- Deference to expertise
- Sensitivity to operations

Weick KE, Sutcliff KM. Managing the Unexpected: Assuring High Performance in an age of Complexity. San Francisco, Jossey-Bass, 2001.

High Reliability Organization

- Process auditing
- Reward system (disciplinary actions)
- Quality assurance – policies/procedures
- Risk management – organizational perception and infrastructure, reduce individual blame
- Command & Control – focus on systems

Physician Challenges

- Physicians are traditionally weak in teamwork and communication
- Physicians fear disclosure/malpractice
- Individualism and autonomy
- Time/Reimbursement
- Lack of data, evidence based practices

W.Sutker. The physician's role in patient safety: What's in it for me? Proc(Bayl Univ Med Cent) 2008;21:9-14.

Core Competencies

- **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
- **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
- **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

Core Competencies

- **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals
- **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
- **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value

Safety Culture in 2010

OLD CULTURE	NEW CULTURE
Total autonomy	Shared expectations
Organizational protection	Mutual accountability
Entitlement	Professional respect for all
Hierarchy	Everyone adds value
Silos	Collaboration, shared outcomes
Personal needs	Organizational needs

Patient Safety Practices

- Practices that reduce the risk of adverse events related to exposure to medical care
- DVT prophylaxis, peri-operative beta-blockers, central line infection prevention, antibiotic prophylaxis, VAP, pressure ulcer prevention, anticoagulation management, nutrition, wrong site surgery, medication error prevention, EMR

Teamwork Domains

- Quality of Collaboration – trust, mutual respect
- Shared Mental Models - shared goals, shared perception of situation, shared understanding of team structure, task, roles, etc.
- Coordination – adaptive coordination (new members, task change, information change)

Teamwork Domains

- Communication – openness, quality of communication (shared frames of reference), communication practices (team briefing)
- Leadership – style (value contributions from staff, participation in decision-making, etc.), adaptive leadership (explicit leadership in critical situations)

T Manser. Acta Anaesthesiologica Scan. 2009; 53: 143-151.

Quality of Teamwork

- RN < MD
- Trainee MD < Senior MD
- Primary Care MD < Specialty MD
- Surgeon, RN, Anesthesia Study – similar perceptions, different (less) responsibilities for resolution
- RN > MD perception of collaboration

Lingard, et al. Acad Med 2005; 80:S75-9.

Communication

- Perceived communication openness among team members predicts the degree to which individuals reported to understand patient care goals
- Relational coordination = strength of shared goals, frequency of communication, degree of mutual respect → improved quality of care, reduced post-op pain, decreased LOS

Hindmarsh, et al. Organization Stud 2007; 28:1395-416.

Communication

- Decrease interruptions
- Decrease tensions (time, safety and sterility, resources, work roles)
- Knowledge/Training differences

Eisenberg, et al. Commun Monogr 2005; 72: 390-413.
Stein-Parbury, et al. Am J Crit Care 2007;16: 470-7.
Melia. Soc Sci Med 2001; 53: 707-19.

- Safety Briefings

Coordination Strategies

- Knowledge of work roles and procedures
- Work environment assessment
- Standardization of work process = more implicit coordination, less leadership
- Explicit coordination during critical situations

Entin, et al. Adaptive Team Coordination, Hum Factors, 1999; 41: 312-25.

Joint Commission

- LD.03.01.01
  - EP 4 – Hospital has a code of conduct that defines acceptable behavior
  - EP 5 – Leaders create and implement a process for managing disruptive and inappropriate behaviors
- MS.4 process – six core competencies

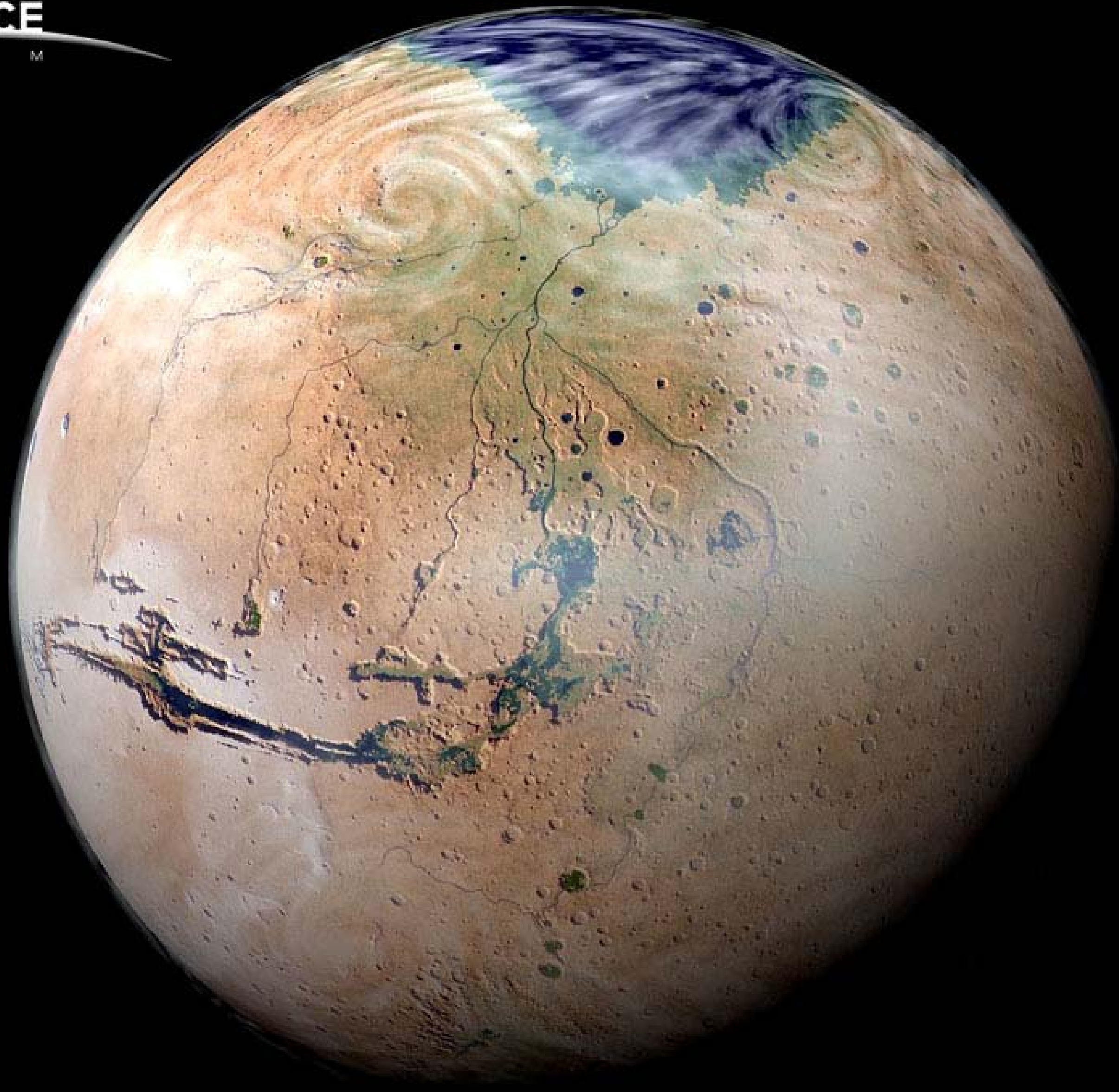
TJC, Sentinel Event Alert, Issue 40, July 9, 2008
www.jointcommission.org/sentinelevents/sentineleventalert

Key Physician Indicators

- Peer Review
- EMR
- Medical Staff Leadership Training
- Physician outcome data
- Patient Hand-offs
- Universal Protocol
- Disruptive Behavior

What to do?

- Education, Simulation
- Feedback processes- peer review
- Generational Differences
- Data- reporting mechanisms
- Medical Director/Leadership Models
- Communication/Teamwork Training
- Care Process Management
- Champions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