FOUNDATION FOR Health Care Quality
WASHINGTON PATIENT SAFETY COALITION

Psychological Safety
July 2020
Minutes

Attendees- Steve, Kinsey, Valerie Lytle, Cat Mazzawy, Leila Amin, Danie & Russ, Christine Cottingham, Karen Brigham, Jessica Yanny-Moody, Jen Faultner, Gloria Brigham; Jamie Leviton; David Allison

- Comments from Minutes on Last Meeting?
  - No comments, minutes approved
- Action Items Follow Up
  - Item #1: Collect data from culture of safety surveys from workgroup members to see where to focus and factors contributing to safety culture that need work
    - If we feel comfortable with an idea of where to focus efforts, then this is enough, and we don't need to ask the larger group
  - Item #2: Engage PFE networking group directors; asked if they had patients interested in presenting to the group and being involved with group to help advise
    - 2 different directions
    - Improve environment for staff
    - Improve environment for patients
      - 3 patients have stepped forward, so Steve is following up and connecting with them.
  - Item #3: Research literature of psych safety, campaign and toolkits, etc..
    - Not a one-time action item
    - Continue to send information to us as you come across resources
    - Will be putting information on the website
      - Email Kinsey to get member login for website if you do not have it

- Circling Back to Action Item #1 for further discussion
- Thoughts on questions Steve sent out?
  - Focusing in on those areas that question relates too in order to determine where to go
  - Goal is to begin working on actual deliverable for what we want to do
    - Can we move forward and create deliverables to work on?
  - The workgroup scope as it stands is huge
  - Chris: questions are fairly representative to quantify willingness to speak up; one suggestion at UW Medicine uses medical office of safety – composite 7 on communication openness that could be included in question collection
  - Steve- page 3 put in the physician's offices; sent out revised questions on 6.30 with updated questions to possibly include what Chris is talking about
  - Has anyone been able to collect data?
    - Leila has summary on SCCA- shared with Chris & Jessica previously

- Used different survey questions that align with same themes
- Where do you see main domains that are most relevant?
    - 3 groups of questions that lead to
    - Prevention and reporting, pride and reputation; teamwork and resources
    - Data shows people aren't scared of reporting mistakes; when they enter PSN's the error's lead to positive changes; free to raise safety concerns
    - Below national benchmarks based on Press Ganey data base
    - In general, a lot of people would say they have difficulty implementing standardization across SCCA
- Opportunity that is presented in the findings: work units being adequately staffed
    - Leila doesn't have a ton of control over that
    - With any patient safety event they are always looking at staffing on that day
- Anecdotally it's been found there are a lot of areas where people are not entering PSN's and places for improvement
    - Empowering patients to speak up with patient experience director- was not well received when tried to pilot a few years ago
        - A lot of physicians might not encourage that type of engagement with patients
        - Communication between physicians and nurses is hard; challenging situations that come up and can impact patient safety
- Steve- Thinking about psychological safety- it appears that SCCA seems strong in that area?
    - Leila- per the data: Yes, that what it indicates and they have come a long way in 3 years surrounding education and training; working to socialize principles across the organization and working on system level improvements.
    - Still think there are pockets where we hear about situations where there are challenges; Ex. Encouraging patients to speak up for their safety
    - Need groundwork around open honest conversation
    - PSN numbers steadily increasing; have come a long way to get people to report- but still opportunities to improve visibility of when to enter PSN's
    - More PSN's where people report their own error and reporting near misses- where it doesn't reach the patient
    - Jen- difference between "I feel safe to report" vs. in the moment of saying "hey I noticed you didn't gel in when you

entered the room" it's a hard ask to have staff comment to each other and then also ask patients to call out staff

- Gloria- how can we help people wherever they are in the evolutionary process; asking questions and hearing "where are you right now and what would make it better"
    - It's a never-ending process and always improving communication
    - How to do it in a transparent way- channel it to get beyond survey questions and transition to teams
    - Engage people you work with to engage patients
    - Chris: love the idea to get at psychological safety for patients- what are you envisioning for getting metrics on this?
    - How do we determine whether patients feel comfortable speaking up or not?
        - Develop a survey that facilities send out to patients – has this been done?
        - Jessica- didn't find much in literature around patients; a lot around providers and maybe think about what an assessment would look like
        - This is an issue that PFE group discussed – how do we manage when patients find someone not wearing a mask? What avenue do that take and do they feel comfortable?
        - Jen- could you give me an idea of psychological safety for patients and families? Do they feel psychologically safe to disagree with treatment plan or safe to be part of treatment plan?
            - Defining patient psych safety- create an environment where a patient/family member can speak up about any topic without fear, they feel comfortable bringing up any issues
            - Staff side- reprisal is always a fear
            - Jen- patients and family do fear that reprisal will be a part of it; and that it will impact child's care and how receptive individuals will be to child's care in the future
- Gloria- had a provider appointment and 2 things happened
    - Provider in office was not wearing mask properly
    - Very young assistant type person started giving informed consent for procedure
        - Was hesitant to speak up for fear that care would be affected
        - Did bring both things up and 1 of the 2 was received effectively

        - "Informed" patients are still nervous and scared to bring this up
- We get back to the two directions we can go forward with
    - Creating psychological safety for patient
    - Creating psychological safety within institution for employees
    - Can we tackle both?
        - Two sides to same coin and we can't work on one without the other
        - With patients on board we can potentially shift work to them and act as advisors
    - How do we know which tools to bring?
    - Jessica- start slow; maybe start with conversation about what tool would be needed? What do patients need to feel safe for something as "I didn't see you wash your hands, you're not wearing a mask" etc..
        - Could be a little card or something with text on it to say
    - UW has done a lot around scripting; what are the "magic words"
    - What do healthcare providers need to hear? And what is easy and comfortable enough for patients to say
    - Leila: providers wear stickers or pins on lab coat that say "Ask me if I washed my hands"
        - Maybe a diagram about how to wear a mask?
    - Most institutions do not have a campaign going on right not
    - It's all staff at a healthcare institution; not just physicians
    - Can this group come up with small text or ideas then can we get marketing team on board to mockup and reach out the providers?
    - Campaign encouraging patients to inquire about test results- did not really take off
    - IS WSHA doing something regarding this?
        - They are not
        - Skill set to care team that invites that level of conversation and questioning
        - They need to feel psychologically safety and then they can invite questioning
    - Are hospitals using language like "I have a concern..." can we integrate that with language we teach patients
        - Tying common language that staff uses towards teaching the patients
        - Most of SCCA staff have taken TeamStepps training- maybe utilize that language with patients
        - Helps make it consistent
    - Direction-
        - work on patient side of psych safety
        - Promoting and improving an environment for the patient to speak up

- What deliverables can we produce for this?
    - Develop some type of assessment to give to patients/families
    - Develop a campaign that encourages patients/families to speak up
        - Leverage current safety language
        - Come up with safety language that we can trial on patients within institutions
        - Connect it to leader rounding –in order to get it to the greatest number of patients and then we can get feedback from patients about how this was received
    - Develop specific safety language that aligns with organizations safety culture
    - Pilot use of this safety language with patients at 5-6 hospitals
        - Need to ensure that pilot organizations have some sort of rounding process
        - How board or narrow? Speak up about one topic or everything?
            - If we go narrow it could get too narrow
            - Can gain confidence in you can speak up about hand hygiene then patients are possibly more likely to speak up about other things
            - How to measure and see progress if it's open to everything?
            - Follow up question to family member? Where you able to bring forward one concern to your provider about safety or quality of your care during your last visit?
            - Design simple language about any concern but then examples are around hand hygiene and masks to help model what they can do
            - Just one question to answer; don't frame in no/yes answer- make
                - Tell us about a safety/quality issue you were able to bring forward at your last provider visit

- **Next steps**
    - Can we identify some facilities and patient groups to include
        - What are key words that are used
        - Identify organizations
        - Identify language used
        - Create questions
    - Group identify 5 organizations to pilot this and then we move on from there
    - Steve to coordinate with group