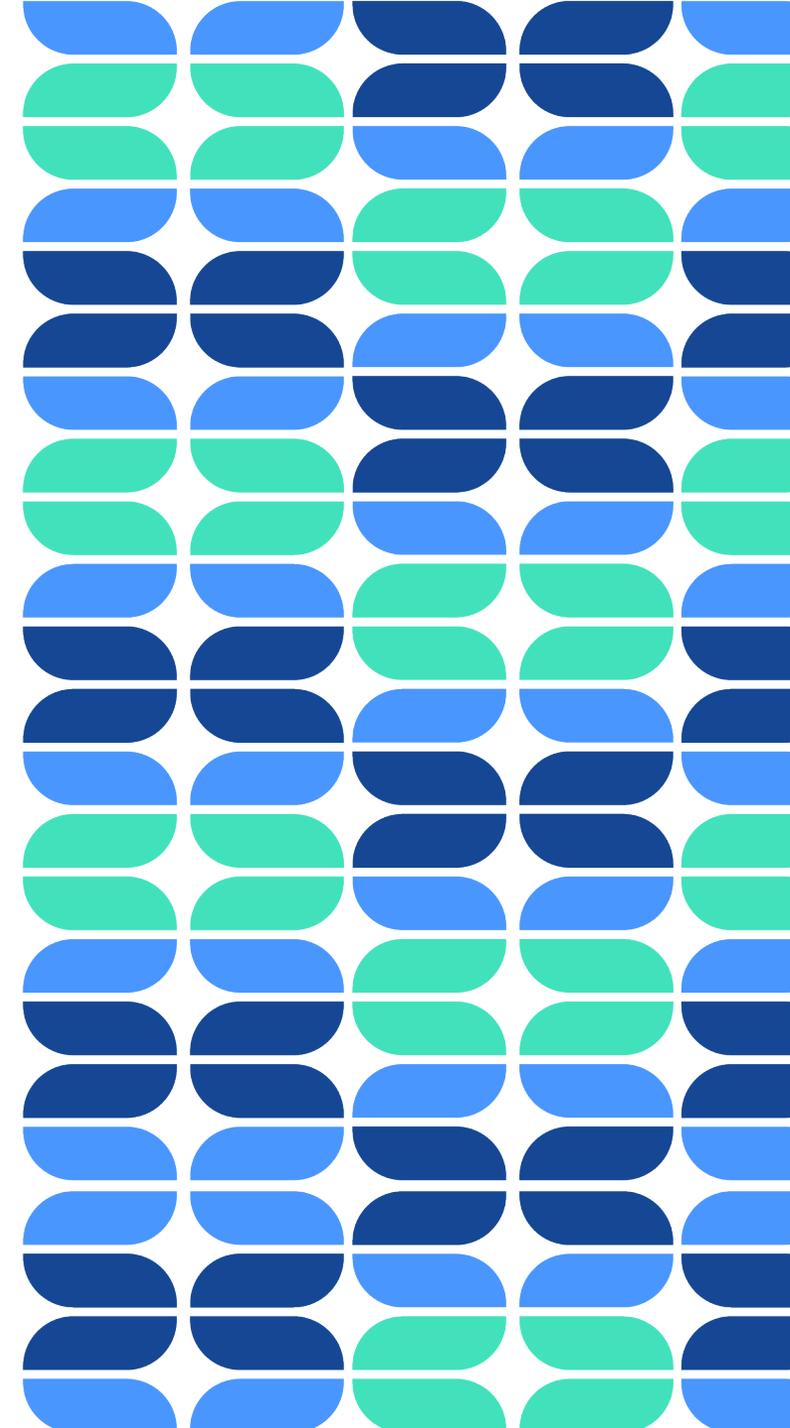




Fostering a Culture of Safety, Trust, and Wellbeing

FEBRUARY 22, 12-1:30PM

[Recording Link](#)



Housekeeping



Chat in questions at any time or unmute during the discussion



You're welcome to turn on your video for this session



Make sure your Zoom name includes your organization



The meeting will be recorded for those who cannot attend

Agenda

Welcome and Program Reminders	<i>Amanda Clarke</i> SNI
Expressions of Culture on Healthcare Teams	<i>Gail Armstrong, PhD</i> Professor and Faculty Development Coordinator University of Colorado College of Nursing
The Nature and Theory of Error	<i>Daniel Hyman, MD</i> Chief Safety and Quality Officer, Children's Hospital of Philadelphia Clinical Professor of Pediatrics, University of Pennsylvania School of Medicine
Breakout #1: Four Categories of Psychological Safety	<i>All</i>
Rebuilding a Foundation of Trust	<i>Gail</i>
Breakout #2: Making Space for Error (case study)	<i>All</i>
Wrap-up and Reflections	<i>All</i>

Workforce Wellbeing

- ✓ **Kick-off Webinar: Program Sneak Peek and Overview.** Aug 22
- ✓ **State of the Field & Evidence-Based Interventions.** Sept 28
- ✓ **Measurement Approaches to Workforce Wellbeing: Part 1.** Oct 24.
- ✓ **Measurement Approaches to Workforce Wellbeing: Part 2.** Nov 14
- ✓ **Developing a Culture of Wellbeing: A New Leadership Imperative.** Dec 7
(in-person workshop)

- Leadership, Culture and Wellbeing:
 - **Essential Leadership Practices to Strengthen the Workforce.** Jan 30
 - **Fostering a Culture of Safety, Trust, and Wellbeing.** Feb 22
 - **Connecting Wellbeing with Diversity, Equity, and Inclusion Efforts.** *TBA*
- Maximizing Efficiencies to Promote Wellbeing:
 - **Redesigning Workflows**
 - **Digital Tools and Optimization**
- Wrap-up and Reflection

SNI Webinar Recap

Wellbeing Measurement Approaches: Part 2

On November 14, 2022, SNI hosted a webinar featuring Dr. Christine Sinsky, VP of Professional Satisfaction at the American Medical Association (AMA), and Dr. Elizabeth Harry, Senior Medical Director of Well-being at UHealth. The webinar slides and recording are available [here](#). Below are key takeaways from the session.

Validated Tools to Measure Burnout

The National Academy of Medicine recommends the following [validated and reliable survey instruments to measure burnout, well-being, and other work-related dimensions](#):

- Maslach Burnout Inventory (MBI)
- The Well-Being Index
- Stanford Professional Fulfillment Index
- Mini-Z Single Item Burnout Question
- Oldenburg Burnout Inventory
- Copenhagen Burnout Inventory
- The Patient Health Questionnaire-9 (PHQ-9)

Key takeaway: Pick a tool that is recommended by the National Academy of Medicine or Surgeon General and use it



Align wellbeing measurement with existing structures

- Identify wellbeing measures that align with and improve existing Key Performance Indicators.
- Make a list of other surveys that your institution uses to ensure there's no overlap. Ideally, an organization should consolidate all surveys into one with smart logic that only displays the relevant questions.

WEBINAR RECAPS

[Landscape](#)

[Measurement Approaches: Part 1](#)

[Measurement Approaches: Part 2](#)

[Essential Leadership Practices to Strengthen the Workforce](#)

Reminder – Coaching Opportunity

- Optional coaching, sponsored by SNI
- Up to & **10** hours per system
 - Hours subject to change based on total # of systems
- Each system proposes a project for coaching support
 - “Project” used broadly – very flexible
- Real Examples:
 - Gaining Executive Buy-In; Creating a Wellbeing Budget
 - Developing Trainings for Managers and Supervisors

If interested, contact
aclarke@caph.org.
Requests considered on
a rolling basis.

Fostering a Culture of Safety, Trust and Wellbeing

Gail Armstrong, PhD, DNP, ACNS-BC, RN, FAAN

Professor, Faculty Development Coordinator at University of Colorado College of Nursing

Daniel Hyman, MD, MMM

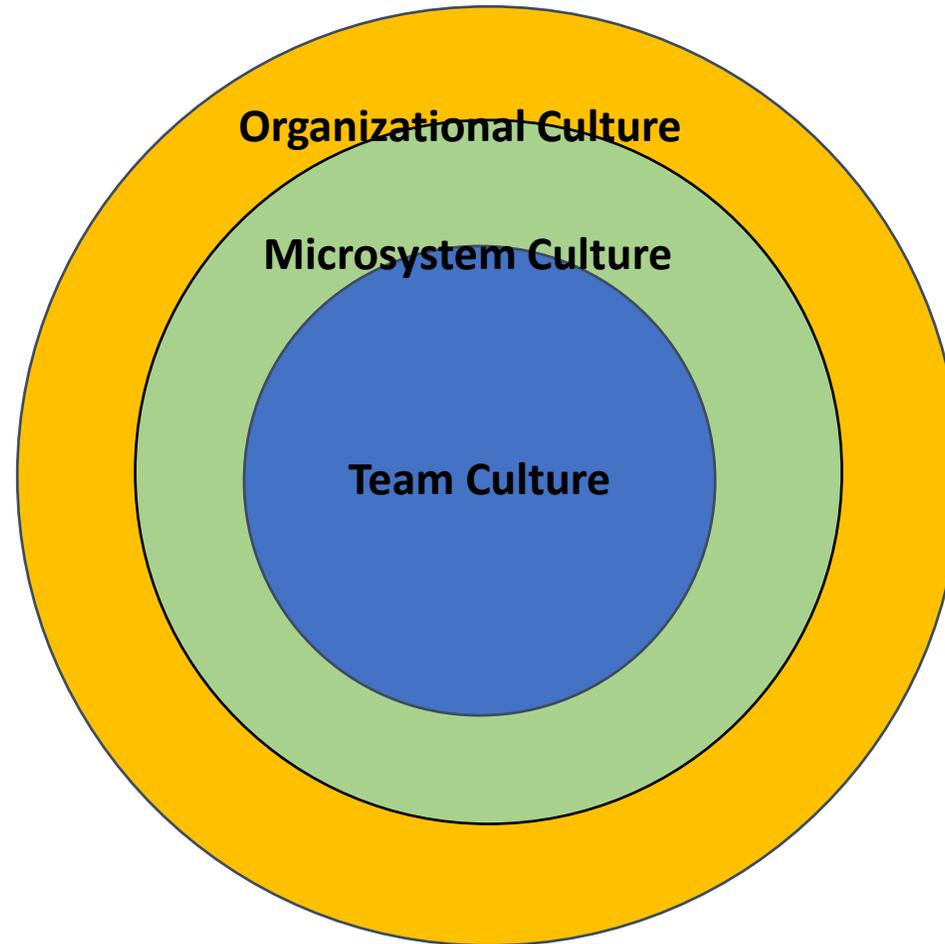
Chief Safety and Quality Officer – Children’s Hospital of Philadelphia

Clinical Professor of Pediatrics – Perelman SOM at University of Pennsylvania

Session Objectives

- Participants in today's session will be able to:
 - Describe a conceptual model for considering organizational or microsystem culture and its application to their own leadership work
 - List the categories of human error and their contribution to risk in health care systems
 - Define Fair and Just Culture and Psychological safety and describe the importance of promoting them in our roles as health system leaders
 - Describe the importance of trust between front line staff and leadership and strategies to build/rebuild it

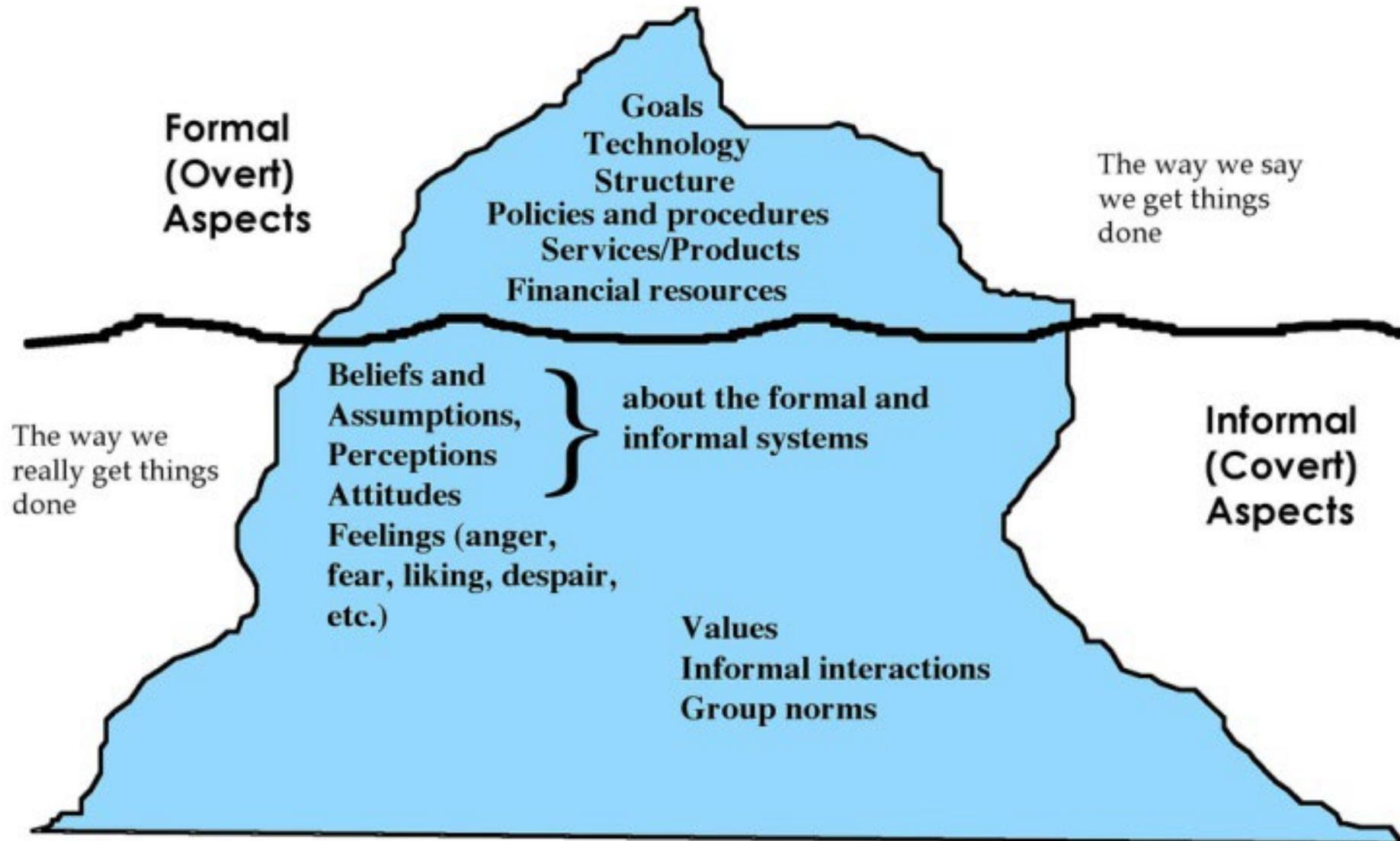
Interconnected Spheres of Culture



We **have** a culture of _____

We **want** a culture of _____ (How will we know when we have a culture of _____)

Cultural Iceberg



Created by Stanley N. Herman. TRW Systems Group, 1970

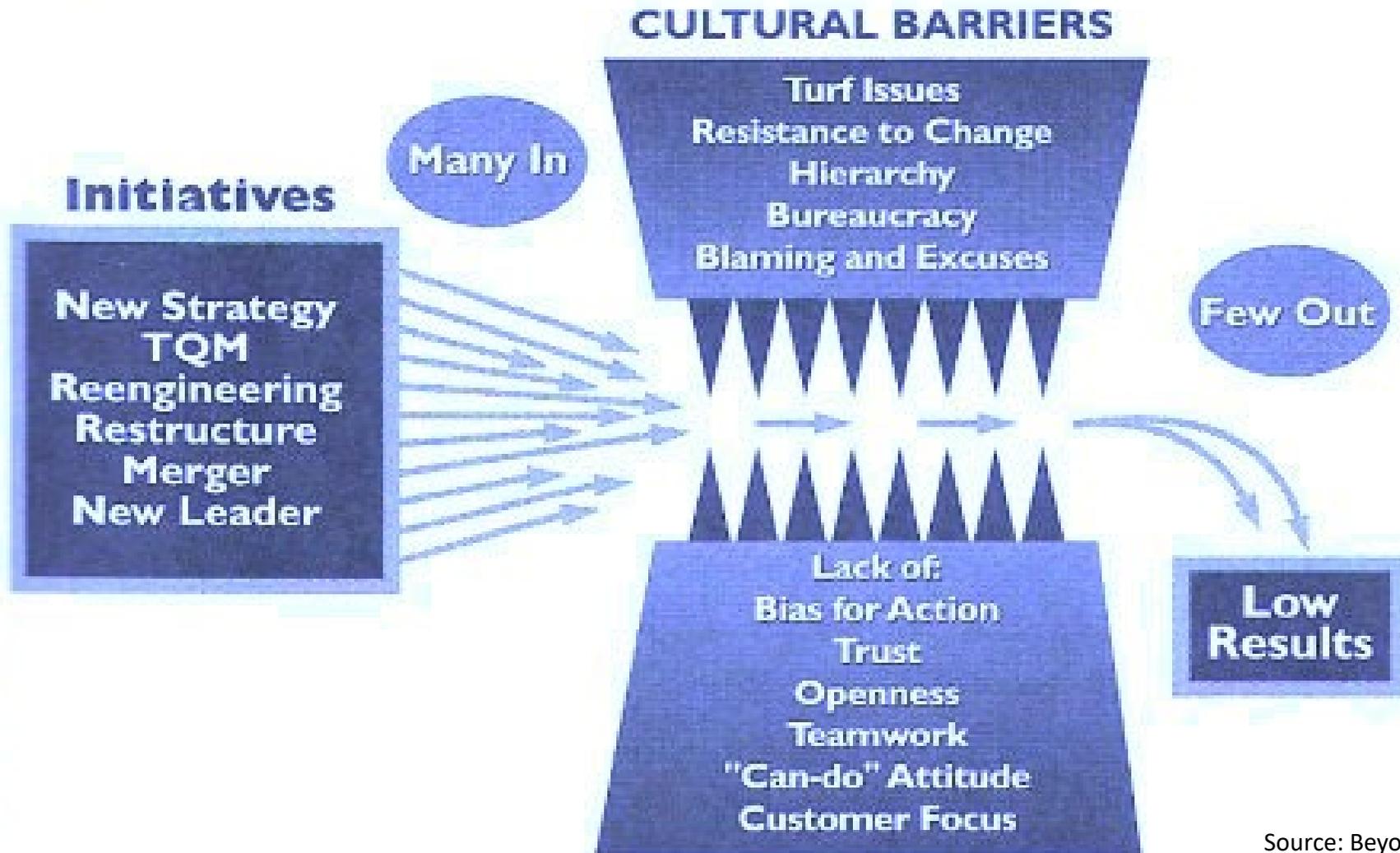


Deconstructing
Your
Culture

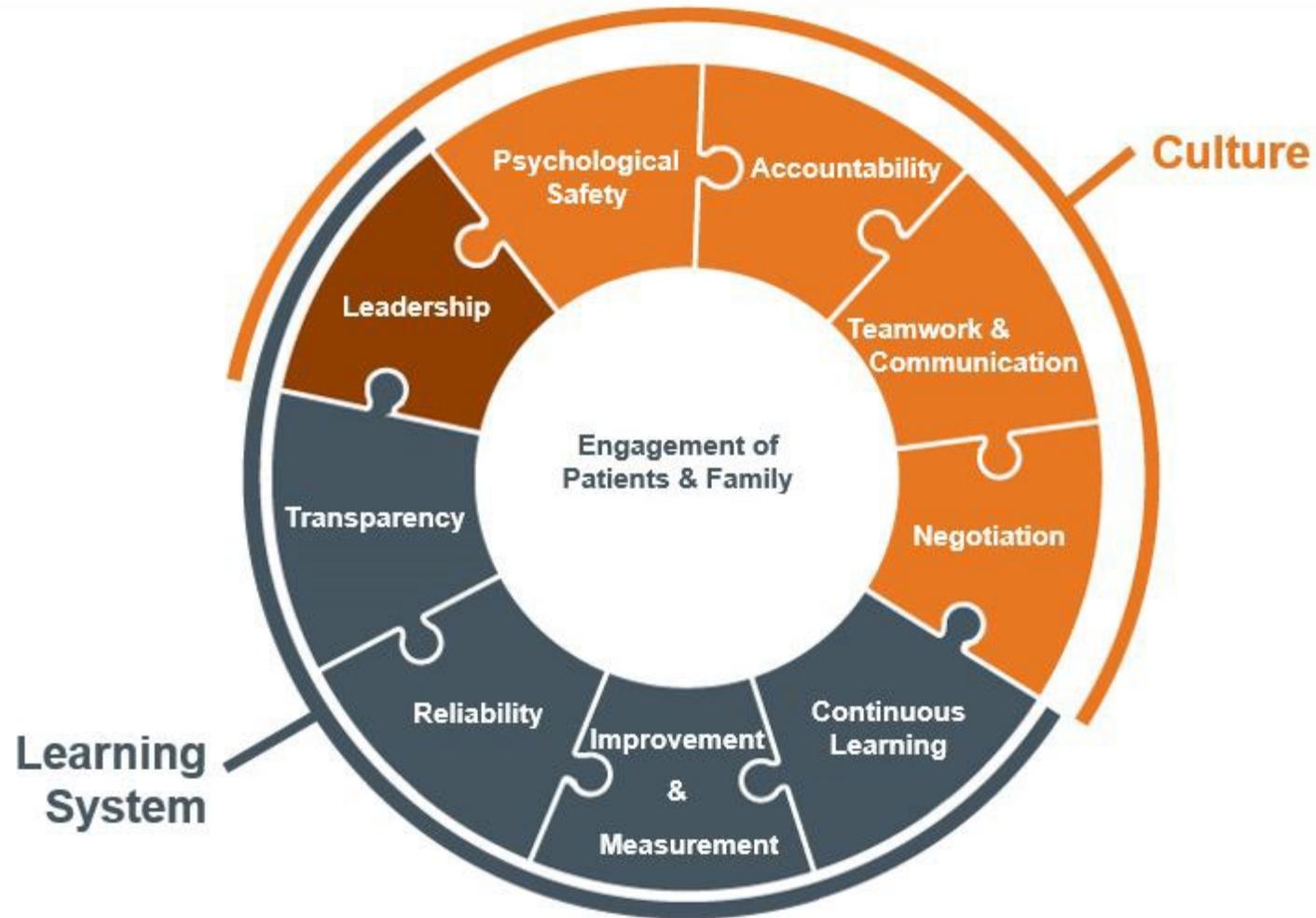
WHAT MIGHT CULTURE LOOK LIKE?

A Culture of....	Underlying Beliefs	Observable Behaviors
Competition	“The best are rewarded” “The strong are valued” “There is not much room at the top” “Success is only valued when it is visible”	Lack of collegiality Withholding of information Sabotaging others’ work “Showboating” one’s success Lack of trust on teams Individual success celebrated
Shame	“Someone is to blame for all errors” “Mistakes should not happen”	Reluctance to report errors Lying about errors Individual error punished Lack of trust on teams
Elitism	“You must be part of the inner circle to be valued”	Abundance of gossip Heavy politics Lack of trust on teams
Support	“We are all in this together” “If one fails, we all fail”	Back-Up Behaviors Team success celebrated
Growth	“We are all learning” “You have expertise I need”	Healthy interdependence

How Culture Eats Strategy



Framework for Safe, Reliable, and Effective Care



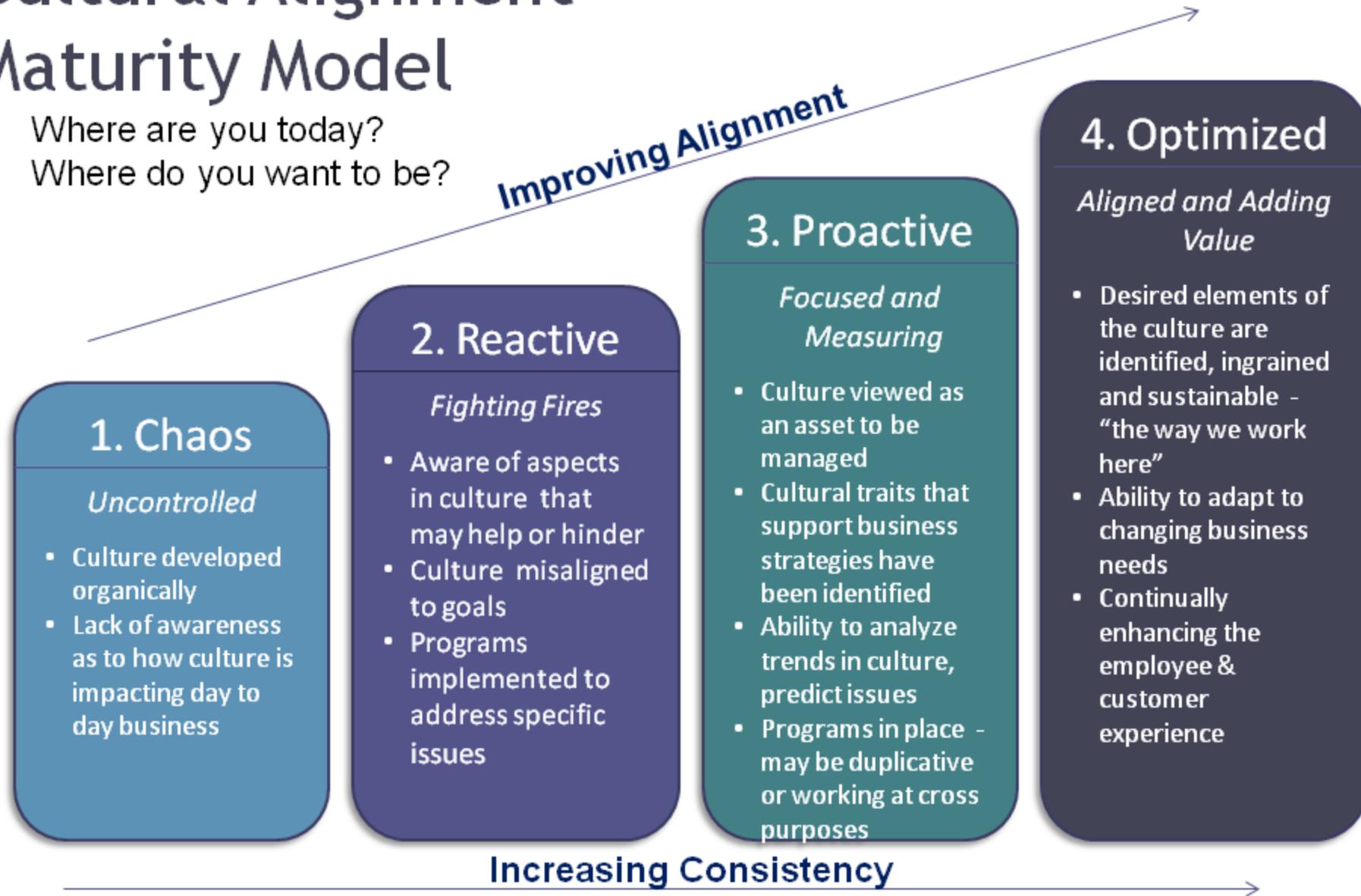
© Institute for Healthcare Improvement and Safe & Reliable Healthcare

Source: Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A Framework for Safe, Reliable, and Effective Care*. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available on ihi.org)



Cultural Alignment Maturity Model

- Where are you today?
- Where do you want to be?



Take time to reflect on your microsystem culture with your team

- We have a culture of _____
- We want a culture of _____
- ***In the next 2-4 weeks, we will try _____ to move toward the culture we want. Be specific: What will you do? When will you try it? How will you learn if it was effective? How will you debrief?***

Your thoughts on culture?

- Would anyone like to share a notable experience of healthy team or microsystem culture?
- What are the unique challenges to healthy culture in today's systems?



Image from: <https://www.pexels.com/photo/pagoda-in-gray-scale-shot-301614/>

The Nature of Error



Take home points (in case you need to leave early!)

- It is possible to significantly improve the safety culture within clinical microsystems even though system wide change is slow
- Learning from adverse events is essential; doing it while promoting just culture is challenging, but necessary
- Transparency is essential
- One needs to understand and apply theories of human error in promoting just culture
- One needs to understand and apply theories of cognitive bias in understanding and learning from diagnostic error
- There may be differences in how we approach learning when an event is due to diagnostic error that we still need to understand and address in better ways
- I can't prove it- but believe our culture work has greatly contributed to our safety success



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

Dr. Lucian Leape, Harvard School of Public Health

Just and Fair Culture



Human Error

- Inadvertent action
- Unintentional deviation
- Slip
- Lapse
- Mistake

CONSOLE

Examples:

- I got distracted by a phone call and forgot to give the patient the educational materials I promised them
- I thought the patient had a viral syndrome and was reassured by her normal laboratory tests.
- I was placing an ng tube and it went into the lung and caused a pneumothorax



“The system” does not prevent it

At-Risk Behavior

- Behavioral choice that increases risk
- Risk is not recognized, is minimized (impact/caught), or is believed to be justified

COACH

“The system” may enable it

Examples:

- I tend to roll through this stop sign on my way home. I’ve never seen anyone crossing and I slow down enough to make sure it’s safe.
- I know this family so well; I really don’t need to double check the child’s date of birth again.
- I trust this resident; I don’t really need to read his whole note; I can just sign it



Why do team members take risks?

To avoid
needing assistance
from others

Ease:
Humans are
inherently self-
serving...ALL of
us

Efficiency:
Save time

Productivity:
Getting more done
with less

Expediency:
Convenience



Reckless Behavior

- Choice to consciously disregard a rule or standard
- Creates substantial and unjustifiable risk.

DISCIPLINE

Examples:

- “This is an emergency procedure; I don’t have time to do your stupid time-out. Give me the scalpel!!”
- I know I am not thinking clearly because of the medication I am taking but I have to work because I’m out of PTO.
- Speed limits are for wusses.
- The exceedingly rare example of intent to harm



What is a “Just and Fair” Culture”?

A Culture Where....

- There is a clear understanding and acceptance that highly-trained, well-intended professionals make mistakes
- There is a focus on learning - not blaming the person/people involved in adverse events: systems thinking is primary
- Team members feel safe disclosing errors
- There is an appropriate balance between support and accountability

A Balanced Approach

Leaders must find the balance between being tolerant and understanding and holding accountability to standards of expected practice.

- Reduced likelihood to report events, errors, and mistakes
- Missed opportunities to find and fix problems impacting performance and outcomes.



Performance of other individuals and of the team as a whole will decline over time.

Expectation for Leaders: Just Culture

1. Protect those whose speak up

- Say “thank you” when anyone reports an error, mistake, or event
- Any sign that you are upset or displeased could suppress future reporting

2. Learn from what happened

- “How do you think this happened?”
- “What can we learn from this?”
- What will you do differently next time?

When using the Just Culture algorithm:

Don't rush to action
Gather your facts

Take time to reflect
Involve your peers & HR

Just Culture

Leader Responses

Human Error

- Inadvertent action
- Unintentional deviation
- Slip
- Lapse
- Mistake



Console

At-Risk Behavior

- Behavioral choice that increases risk
- Risk is not recognized or is believed to be justified



Coach

Reckless Behavior

- Choice to consciously disregard a rule or standard
- Creates substantial and unjustifiable risk.



Discipline

Exploring the Bidirectional Relationship Between Psychological Safety & Just Culture

By recognizing that most errors are made by people meaning to do good in an imperfect system, Just Culture allows individuals to speak up and admit mistakes without fear of unfair punishment.



When people share mistakes, concerns, questions, and half-baked ideas without the fear of being dismissed, embarrassed, or punished, we can identify systemic issues more easily and ensure a fair determination of shared accountability.

Jonathan.Cohen@moffitt.org
[@JonathanCohenMD](#)

Amy Edmondson on Psychological Safety

- <https://www.youtube.com/watch?v=eP6guvRt0U0>
- 4 potential cultures one might be working in:
 - Apathy zone- no commitment to excellence or to psych safety
 - Comfort zone- psychological safety but no commitment to excellence
 - Interpersonal anxiety zone- committed to excellence but low psych safety
 - Learning/high performing zone- committed to excellence and to psych safety

Break out room #1

- Think about an organizational microsystem in which you currently work. Is it closest to Amy Edmondson's description of an apathetic, comfortable, anxiety-creating or learning/high performing environment? Why?
- To the extent that it could be closer to being high performing/learning, what are 1-2 things you could do to promote that transformation? What might discourage you from doing those things?

Nurse Executive Council (NEC) Model of Trust in Healthcare

Background:

- Clustering of concerns by Chief Nurse Executives → work done by The Beryl Institute's Nurse Executive Council (NEC) → Call to action grounded in rebuilding foundation of trust
- "...we seek to strengthen healthcare delivery environments that shape physical and psychological safety for everyone."
- Three core components of trust
- Recommendations on rebuilding a foundation of trust



Rushton, C.H., Wood, L.J., Grimley, K., Mansfield, J., Jacobs, B., & Wolf, J.A. (2021). Rebuilding a foundation of trust: A call to action in creating a safe environment for everyone. *Patient Experience Journal*. 8(3):5-12. doi: 10.35680/2372-0247.1651.

If one believes trust is built and broken behaviorally, the key elements required to restore trust among people include attention to:

- **Trust of character**
 - Being a person who can be relied on and depended upon
 - A stance of mutually serving intentions
 - Illustrated by managing expectations, having clear boundaries, consistency in behavior, keeping promises and agreements and delegating responsibly.
- **Trust of communication**
 - Openly, honestly transparently sharing information
 - Admitting and taking responsibility for missteps or mistakes
 - Giving and receiving feedback in a respectful manner
- **Trust of capability**
 - An individual knows and honors their own skills, abilities and limitations
 - Recognizes the capabilities of others
 - Expresses appreciation for the contributions of others
 - Involves people in decision making
 - Encourages an environment of learning.

Recommendations to rebuild trust

(more detail in the article)

1. Invest in human needs
2. Understand the needs of all individuals
3. Intensify human connection
4. Create open spaces for listening
5. Begin the healing process
6. Move from transactional to relational communication
7. Invite thoughtful input
8. Transform the current narrative
9. Dissolve silos
10. Commit to transforming the human experience in healthcare
11. Elevate nurse leadership

Breakout Room #2

Summary:

- Improving workforce well-being is about culture change and culture change requires trust.
- Yet getting to a culture of well-being means challenging norms, taking risks, and falling short at times... which may further erode trust.

Question:

What are some concrete steps you can take to build trust in your organization or team? How can you create a culture where psychological safety to speak up, take risks, and make mistakes is part of that trust journey?



Thank You!

Please take a few minutes to complete the survey