Fostering a Culture of Safety, Trust, and Wellbeing

On February 22, 2023, SNI hosted a webinar featuring Gail Armstrong, PhD at the University of Colorado College of Nursing and Daniel Hyman, MD at the Children's Hospital of Philadelphia and University of Pennsylvania School of Medicine. The webinar slides and recording are available here. Below are key takeaways from the session.

Organizational Culture

"What is most evident about a practice or clinic culture is usually the least influential. The real drivers of culture are going to be the things that aren't as obvious, so people's beliefs, their perceptions, their attitude, and their feelings about how work really gets done."
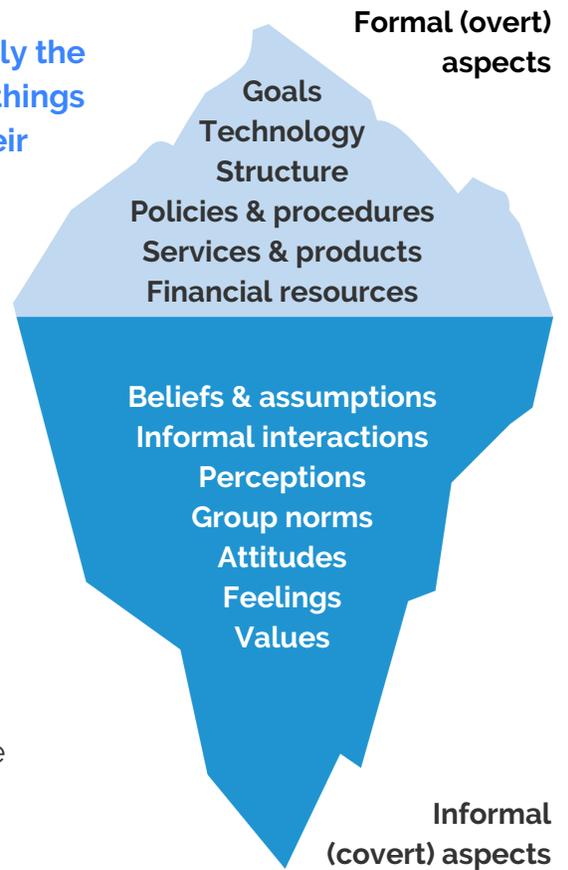
– Gail Armstrong, PhD

Prompts to use to expose an organization's culture:
- How are decisions made?
- What happens when there's conflict?
- What do you do operationally and behaviorally to flatten your hierarchy?

Take time to reflect on your 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.

Formal (overt) aspects
- Goals
- Technology
- Structure
- Policies & procedures
- Services & products
- Financial resources

- Beliefs & assumptions
- Informal interactions
- Perceptions
- Group norms
- Attitudes
- Feelings
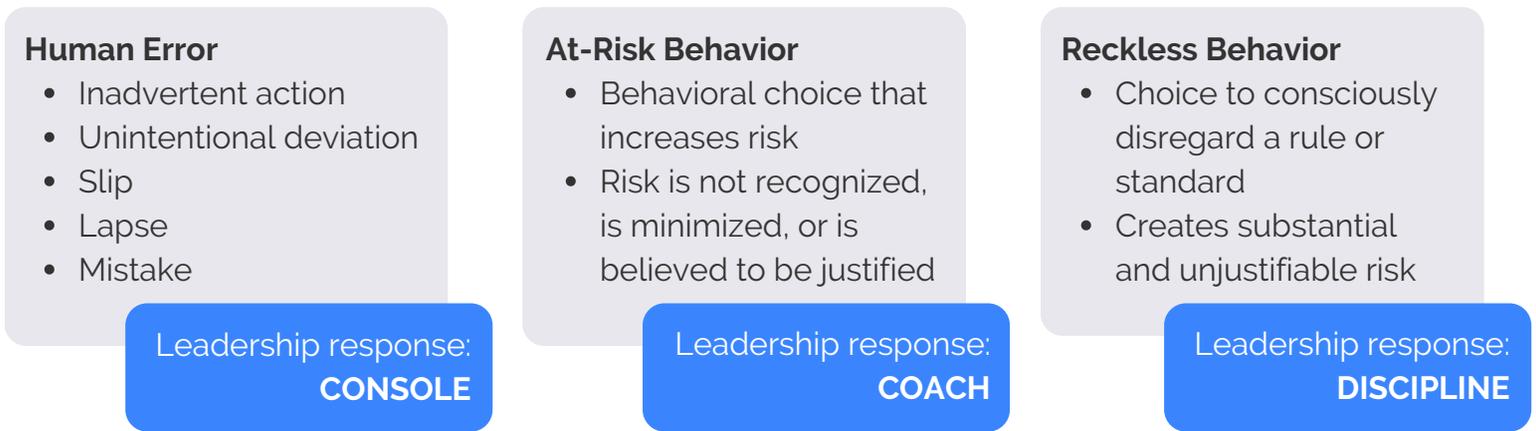- Values

Informal (covert) aspects

A "fair and just" culture is one where...

- ✓ There is a clear understanding and acceptance that highly-trained, well-intended professionals make mistakes.
- ✓ There is a focus on learning, not blaming.
- ✓ Leaders prioritize modifying the system over punishing individuals in order to reduce the risk of mistakes.
- ✓ Team members feel safe disclosing errors.
- ✓ There is an appropriate balance between support and accountability.

Leadership Responses in a Fair and Just Culture

"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

Recommended leadership responses for the three categories of error:

Human Error	At-Risk Behavior	Reckless Behavior
• Inadvertent action • Unintentional deviation • Slip • Lapse • Mistake	• Behavioral choice that increases risk • Risk is not recognized, is minimized, or is believed to be justified	• Choice to consciously disregard a rule or standard • Creates substantial and unjustifiable risk
Leadership response: **CONSOLE**	Leadership response: **COACH**	Leadership response: **DISCIPLINE**

Trust in Healthcare

The Beryl Institute's Nurse Executive Council (NEC) put forth a call to action to address growing concerns around patient, family, and staff safety at the system level. The council ultimately propose that trust is the foundation for for the above concerns and that "if one believes trust is built and broken behaviorally, the key elements required to restore trust among people include attention to trust of character, communication, and capability.

The council also shared the following tangible steps to rebuild trust using the Reina Trust Model as a foundation:

- Invest in human needs
- Understand the needs of all individuals
- Intensify human connection
- Create open spaces for listening
- Begin the healing process
- Move from transactional to relational communication
- Invite thoughtful input
- Transform the current narrative
- Dissolve silos
- Commit to transforming the human experience in healthcare
- Elevate nurse leadership