Health PEI
One Island Health System

Patient Safety Culture

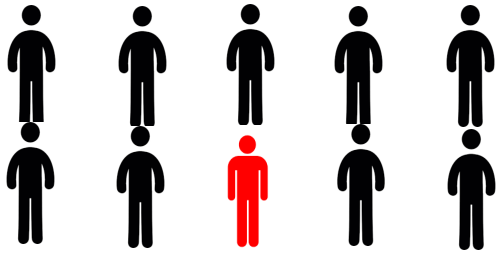
Quality & Safety Division
2019

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

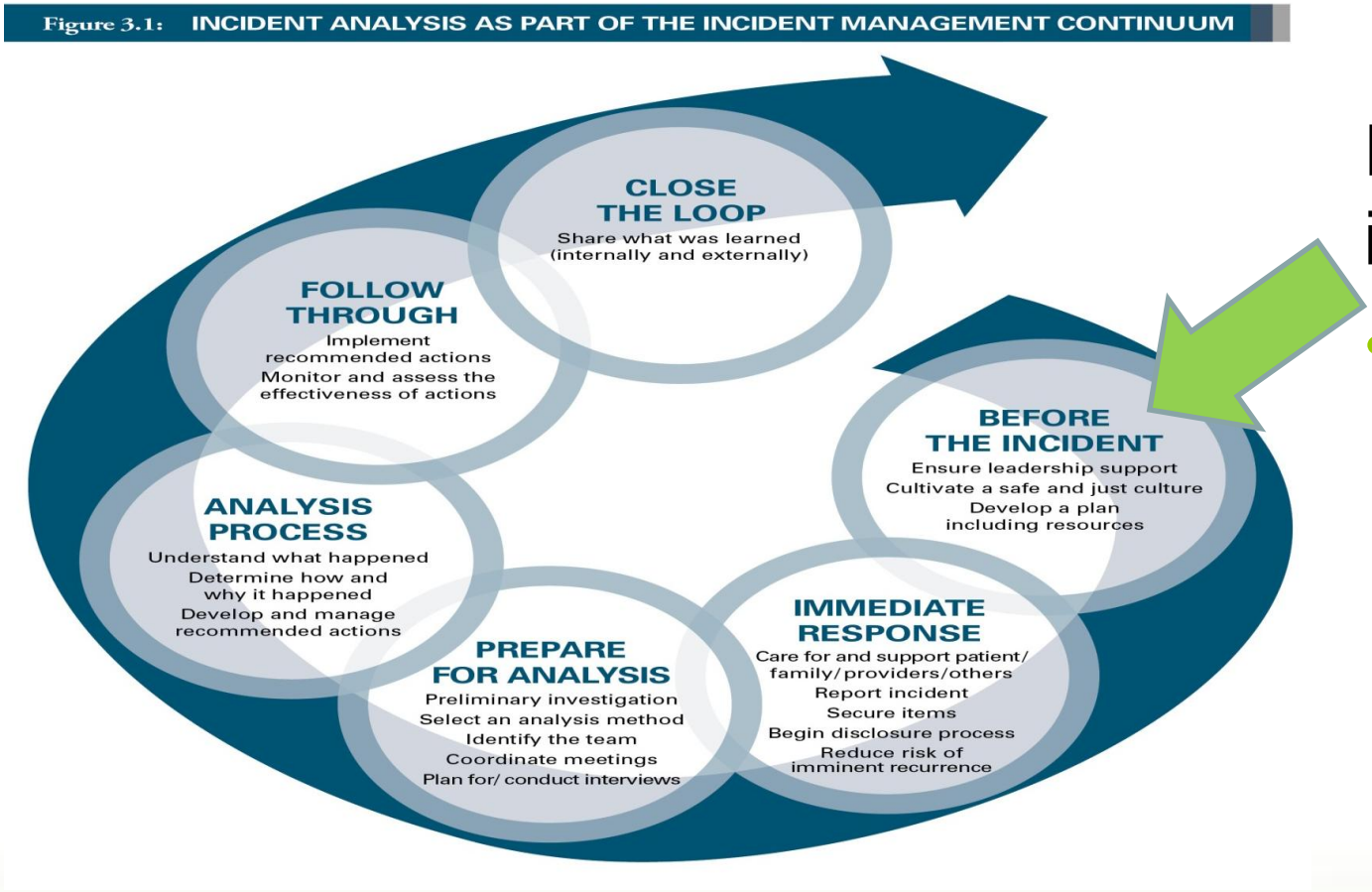


1 in 18 hospital stays in Canada results in preventable harm or death

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

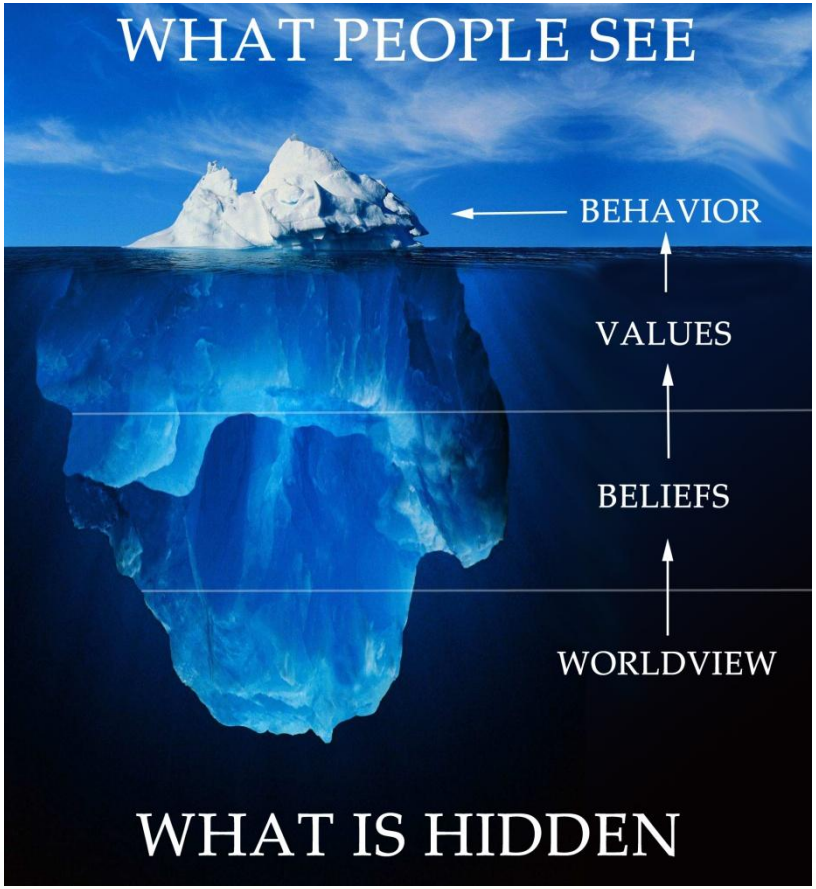


Before the incident:

- 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

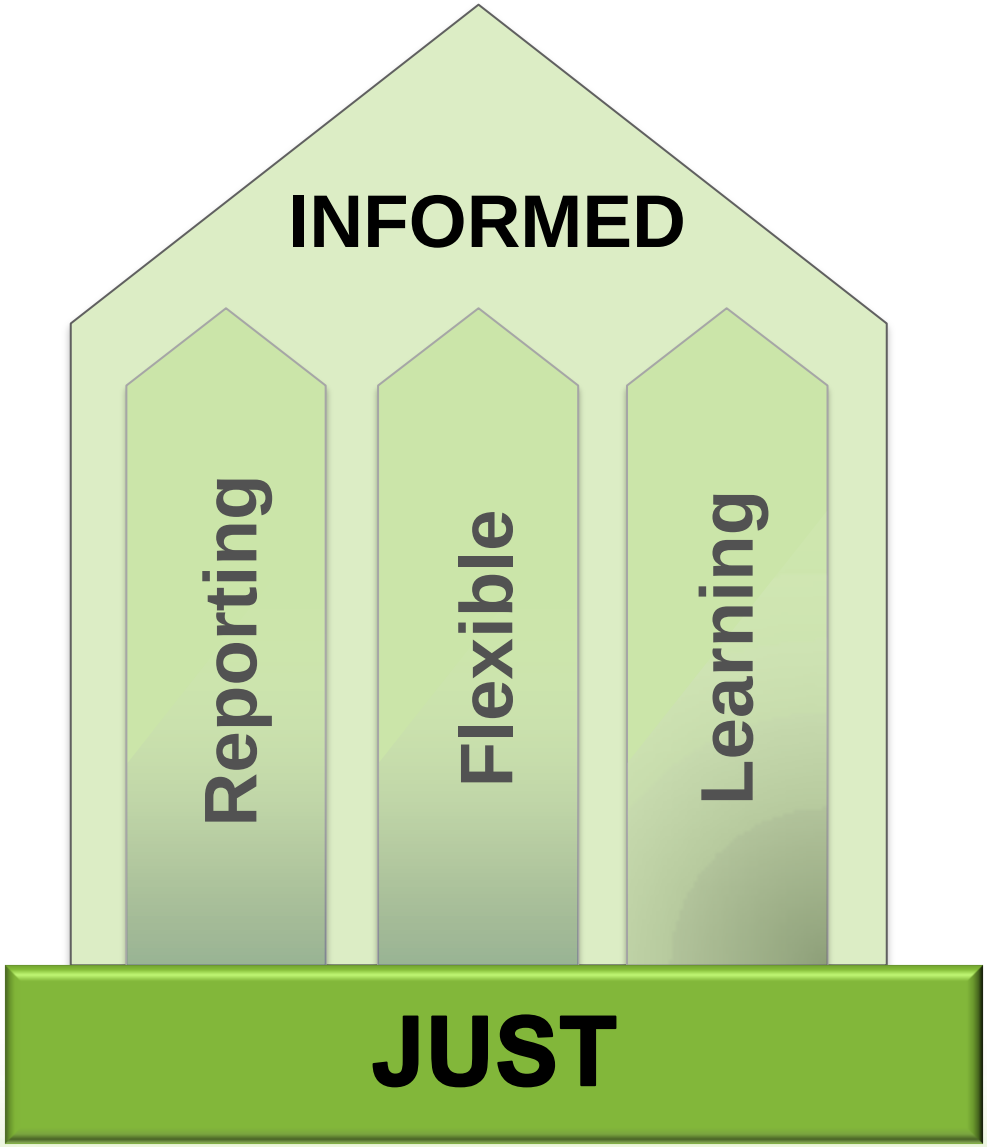


Patient safety culture

- 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

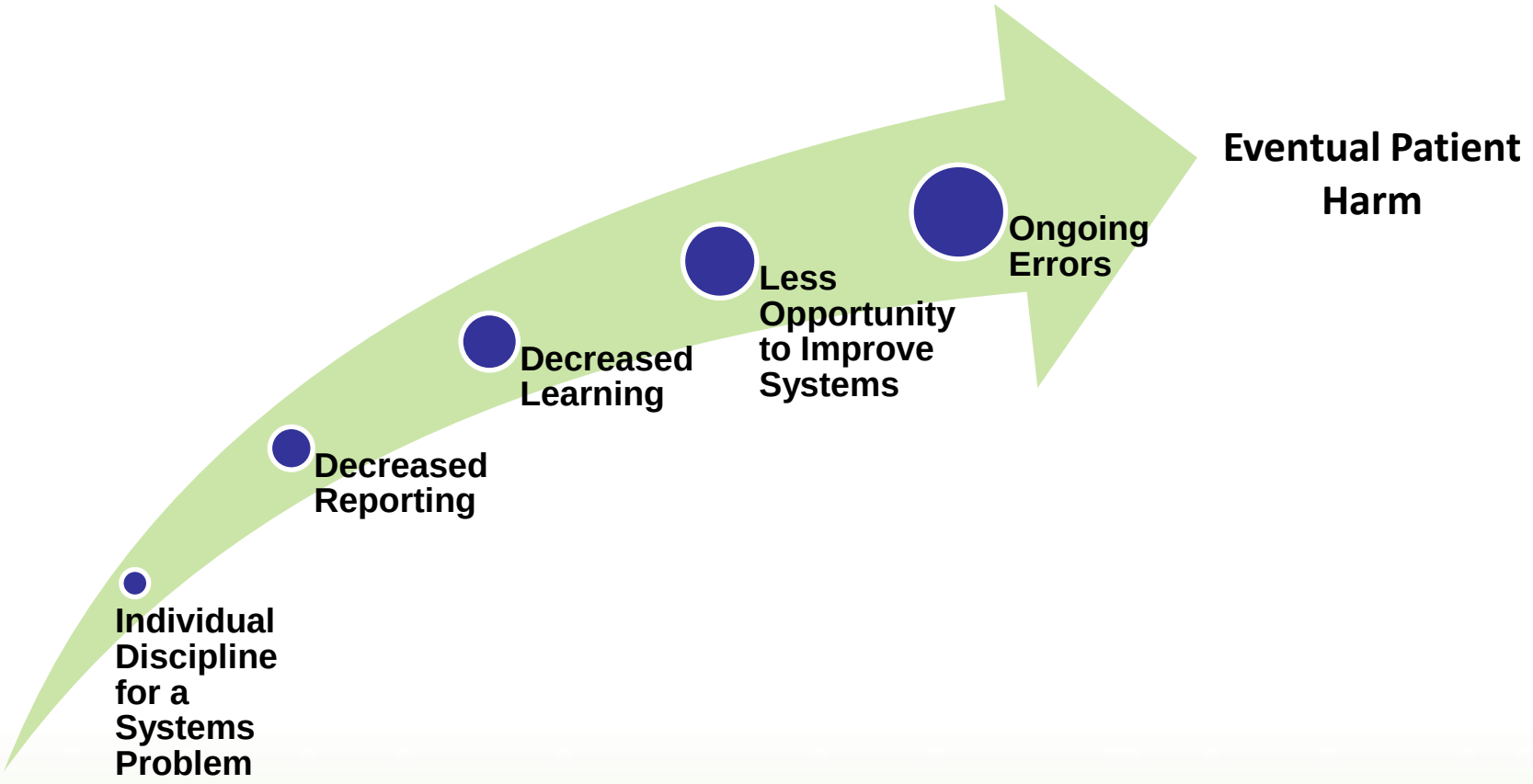


Just culture

- Fairly balancing an understanding of **system failure** with **professional accountability**
- 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



Just Culture – Managing Behaviours

Behaviour	Chose the behaviour?	Saw the risk?	Action
Human Error *Inadvertent action: slip, lapse, mistake*	**NO**	**NO**	**CONSOLE**
At-Risk *A choice: risk not recognized or believed justified*	**YES**	**NO**	**COACH**
Reckless *Conscious disregard of unreasonable risk*	**YES**	**YES**	**DISCIPLINE**

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

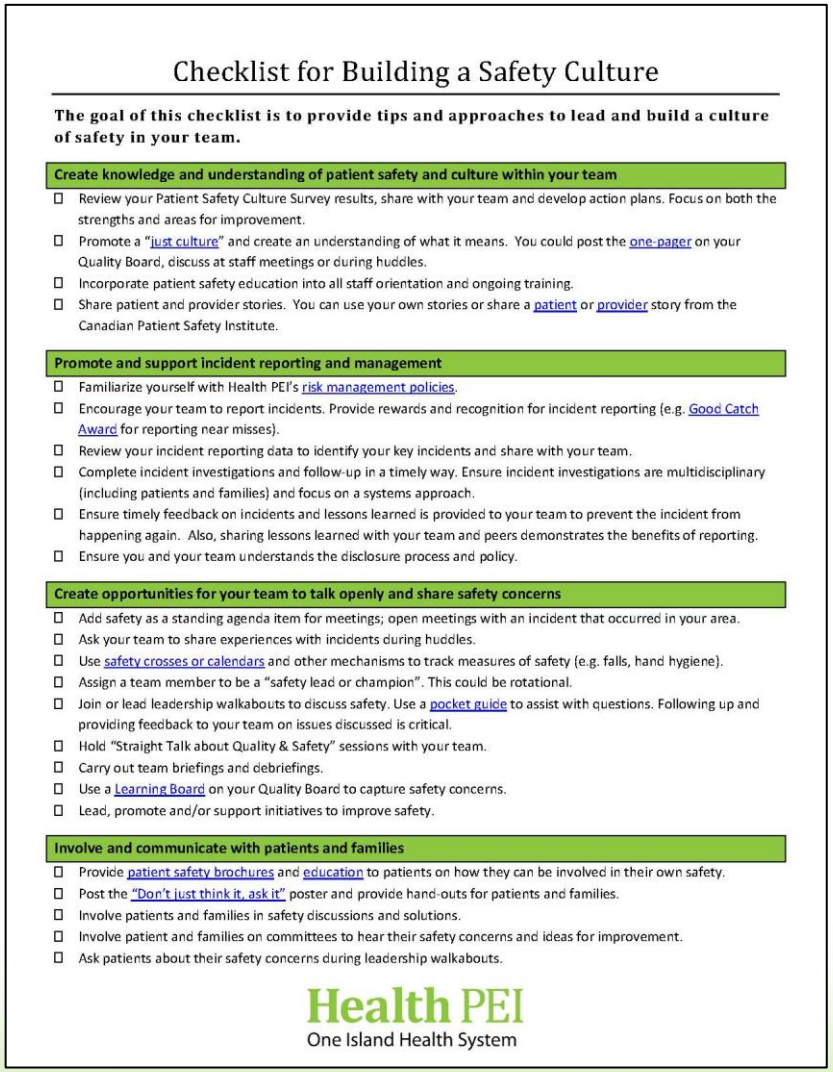
Report incidents

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



Checklist for Building a Safety Culture

The goal of this checklist is to provide tips and approaches to lead and build a culture of safety in your team.

Create knowledge and understanding of patient safety and culture within your team

- ☐ Review your Patient Safety Culture Survey results, share with your team and develop action plans. Focus on both the strengths and areas for improvement.
- ☐ Promote a "just culture" and create an understanding of what it means. You could post the one-pager on your Quality Board, discuss at staff meetings or during huddles.
- ☐ Incorporate patient safety education into all staff orientation and ongoing training.
- ☐ Share patient and provider stories. You can use your own stories or share a patient or provider story from the Canadian Patient Safety Institute.

Promote and support incident reporting and management

- ☐ Familiarize yourself with Health PEI's risk management policies.
- ☐ Encourage your team to report incidents. Provide rewards and recognition for incident reporting (e.g. Good Catch Award for reporting near misses).
- ☐ Review your incident reporting data to identify your key incidents and share with your team.
- ☐ Complete incident investigations and follow-up in a timely way. Ensure incident investigations are multidisciplinary (including patients and families) and focus on a systems approach.
- ☐ Ensure timely feedback on incidents and lessons learned is provided to your team to prevent the incident from happening again. Also, sharing lessons learned with your team and peers demonstrates the benefits of reporting.
- ☐ Ensure you and your team understands 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; open meetings with an incident that occurred in your area.
- ☐ Ask your team to share experiences with incidents during huddles.
- ☐ Use safety crosses or calendars and other mechanisms to track measures of safety (e.g. falls, hand hygiene).
- ☐ Assign a team member to be a "safety lead or champion". This could be rotational.
- ☐ Join or lead leadership walkabouts to discuss safety. Use a pocket guide to assist with questions. Following up and providing feedback to your team on issues discussed is critical.
- ☐ Hold "Straight Talk about Quality & Safety" sessions with your team.
- ☐ Carry out team briefings and debriefings.
- ☐ Use a Learning Board on your Quality 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.
- ☐ 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.

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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”.
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- Hold “Straight Talk about Quality & Safety” sessions.
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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…

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