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SAUDI PATIENT SAFETY CENTER

Saudi Patient Safety Center

(SPSC)

Dose Blame make us Safe

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What is Blame

- Blame holds individuals responsible for events outside of their control.
- Blame is backward looking, focusing on changing the individual. We're no safer after the event than we were before.
- Accountability is forward looking, pursuing improvement through building robust systems.[8] When we learn from small events to achieve organization-wide change, we protect patients and support staff.[9]
- We need to build an accountable culture by seeking to understand and holding individuals responsible for their decisions.

https://journals.lww.com/nursingmanagement/fulltext/2018/11000/Blame__What_does_it_look_like_.5.aspx

Why is the Bad Apple theory of accidents so popular?

- Cheap and easy
- Saves face
- That's what good managers do
- Assures personal responsibility –not organizational

Dekker, The Field Guide to Human Error Investigation,2002

Background

- On March 17, 1987, the Los Angeles Times reported that the officials involved in the Chernobyl disaster were to be tried. The reality of the system failure leading up to the nuclear catastrophe was to come to light much later.As a result of a similar blame culture, the aviation industry has lost some conscientious pilots.
- The industry has since investigated the incidents, and has pioneered and revolutionized the way in which failings are handled. It has moved away from blaming individuals to recognizing the reality of systems failure and has made its internal error reporting and management of faults more robust.
- The Aviation Safety Reporting System[1]provides a platform to self-report safety incidents, with the incentive of immunity from prosecution.
- Recently, a system failure in a London hospital resulted in a young nurse taking her own life, fearing humiliation and blame.
- Many others in the health industry have lost jobs or have suffered serious stress and health issues after errors for which they were blamed.[2]
- Under the directive of its Chief Executive, the General Medical Council recently conducted an internal review of instances where doctors who were under fitness-to-practice investigations had committed suicide.
- The 28 suicides reported are believed to be merely the tip of the iceberg, because it is does not reveal the full scale of the stress suffered by many others under similar investigation.

Culture of blame in the National Health Service; consequences and solutions
S. Radhakrishna
BJA: British Journal of Anaesthesia, Volume 115, Issue 5, 1 November 2015, Pages 653–655, https://doi.org/10.1093/bja/aev152

Background

- Julie Thao, a senior midwife, was found guilty of manslaughter[6] for connecting an epidural bag i.v. to a 16-yr-old pregnant mother.
- That the nurse had worked for more than 16 h the night before, and the fact that the bags looked similar did not help her defence.
- It did not come to her aid that for 19 yr she had given a blemishless service to the health industry, when it was weighed against the emotions surrounding the death of a 16-yr-old young mother. The culture demanded that 'Someone should pay for this tragedy'. The nurse did.
- The fact that there have been several similar incidents in labour wards across the world is a pointer to the fact that the fault is inherent and embedded in the system and should be tackled differently. However, proponents of the medical paradigm would disagree

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Systems Paradigm

- The systems paradigm is based on the principle that humans are fallible and that human errors are likely to occur in the best organizations. Errors are the end result of a series of failures in the system and therefore they are consequences and not the causes.[5]
- This is best explained using a pyramid (Fig. 1). The pyramid shows the system and is made of several layers. Each of these layers in turn represents a particular layer of the organization. In a typical hospital set-up, these may be management, medical personnel, financial institutions, staffing levels, training structure, theatre set-up, ward set-up, and so on.
- On the sharp end of the pyramid are the medical staff, such as doctors, nurses, physiotherapists, or midwives, delivering care to the patient.
- Errors are generally reported at the sharp end. The systems paradigm looks at the error as a cause of failures at several levels. While the layers may have protocols and guidelines to prevent errors, they also have deficiencies. Each of these layers can be likened to the layers of cheese in the James Reason's Swiss cheese model. Each layer of cheese has active holes and latent holes.

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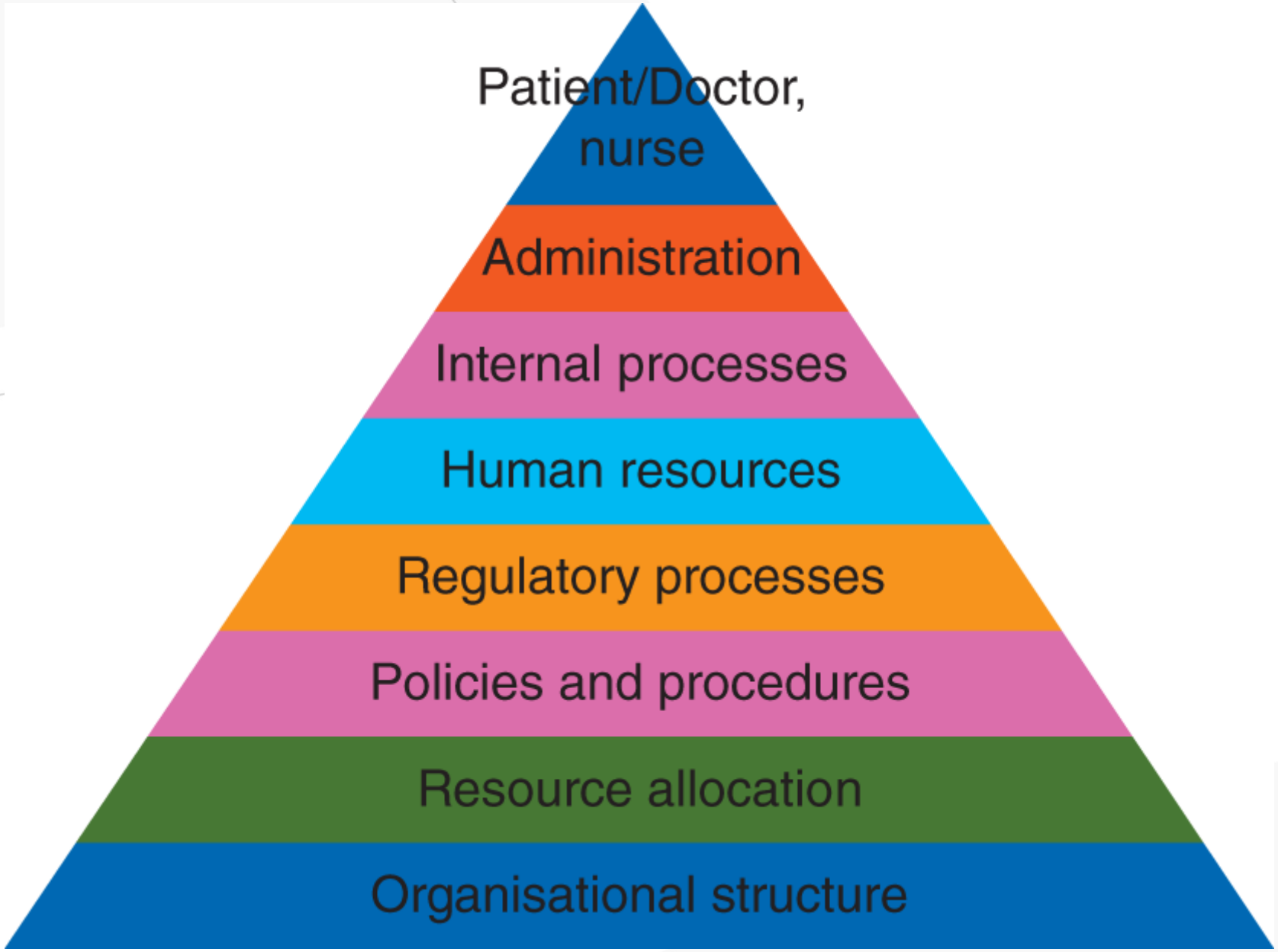

Patient/Doctor, nurse
Administration
Internal processes
Human resources
Regulatory processes
Policies and procedures
Resource allocation
Organisational structure

https://journals.lww.com/nursingmanagement/fulltext/2018/11000/Blame_What_does_it_look_like_.5.aspx

Culture of Accountability

- The goals of a just culture are to ensure that staff members aren't unfairly punished when an error occurs, achieve trusting relationships, and learn from events to make the organization safer.

https://journals.lww.com/nursingmanagement/fulltext/2018/11000/Blame__What_does_it_look_like_.5.aspx

A few signs that a culture of blame may have infiltrated your team include:

- *A general lack of accountability on the team.* If it's difficult to identify the single point of accountability for delivering a project, or if there seems to be ambiguity about responsibilities on the team, it's possible that some of this is the result of a culture of blame.
- *Hesitancy to admit mistakes, or frequent attempts to cover them up rather than fix them.* Everyone makes mistakes. If your team is really stretching itself to do great work, it will probably make many of them. But mistakes need to be dealt with, not disguised.
- *An overall lack of commitment to the excellence of the work or the needs of the client/organization.* Some of the most toxic blame-shifting is the kind that involves blaming the client or customer for the problems the team is facing. When this happens, it can cause a down-shift in the team's drive to go the extra mile.
- *Frequent "whispers in the hallway" or gossip.* These little side conversations are like cracks in a dam. Every one of them erodes the integrity of the team slightly and puts the entire team at risk.

https://accidentalcreative.com/teams/toxic-dealing-with-a-culture-of-blame/

How can we deal with this toxic culture of blame?

- *Make sure that every project has clear accountability, metrics and rails.* If expectations are clear throughout the process, it's very difficult to shift blame.
- *Be the first to admit mistakes and take responsibility for them.* This is especially crucial for leaders. The leader gets to take the most arrows, even if that means taking some for the team. If you're a team member, set the example for the team by holding yourself to a higher standard.
- *Squash the blame game.* If you notice a conversation shifting to the subject of blame, shift the topic or re-affirm where accountability for the project rests. No gossip, no whispers.
- *Don't play along.* To be prolific, brilliant and healthy you must maintain an accurate assessment of your successes and failures so that you can continue growing in your efforts. Self-delusion does you no good.

https://accidentalcreative.com/teams/toxic-dealing-with-a-culture-of-blame/

How can we deal with this toxic culture of blame?

- Patient Safety team continue to develop informed culture
  - Debriefs and Action Planning with:
    - Senior Leadership
    - Service Line/Department Leaders
    - Unit Leaders
  - How will front line staff know we heard?

Safety Culture Traits

- In a culture of safety, one finds **teamwork**, **open discussions of concerns** about safety and quality, and the encouragement of and reward for **internal and external reporting** of safety and quality issues.
- The focus of attention is on the performance of **systems and processes** instead of the individual – although **reckless behavior and a blatant disregard for safety are not tolerated**.
- Organizations are committed to **ongoing learning** and have the **flexibility** to accommodate changes in technology, science, and the environment.

Key Beliefs in a Safety Culture

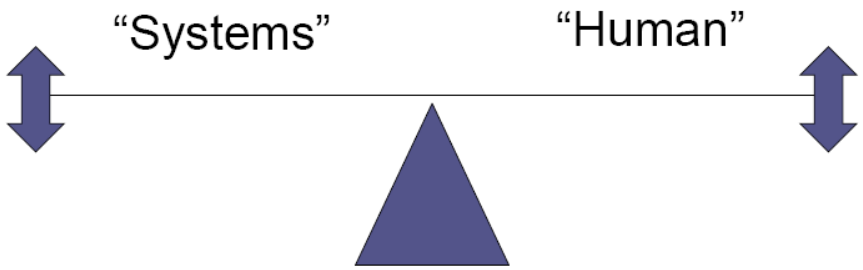
- Four key beliefs in a positive Safety Culture

1. Our processes are designed to prevent failure.
2. We are committed to detect and learn from error.
3. We have a just culture that disciplines based on risk.
4. People who work in teams make fewer errors.

Source: Institute of Medicine (2004)

Need to balance “no blame” and Accountability

- The “No Blame,” “It’s the System, Stupid” approach has been crucial
  - Most errors *are* “slips”—expected behavior by humans, particularly when engaged in “automatic behaviors”
  - Can only be fixed by improving systems (checklists, double-checks, standardization, IT, other new technology…)



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BOTTOM LINE: CLINICIANS, LEADERS AND ORGANIZATIONS WILL BE HELD ACCOUNTABLE FOR SAFETY

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How to Achieve a Just Culture On the Path to Safety Culture?

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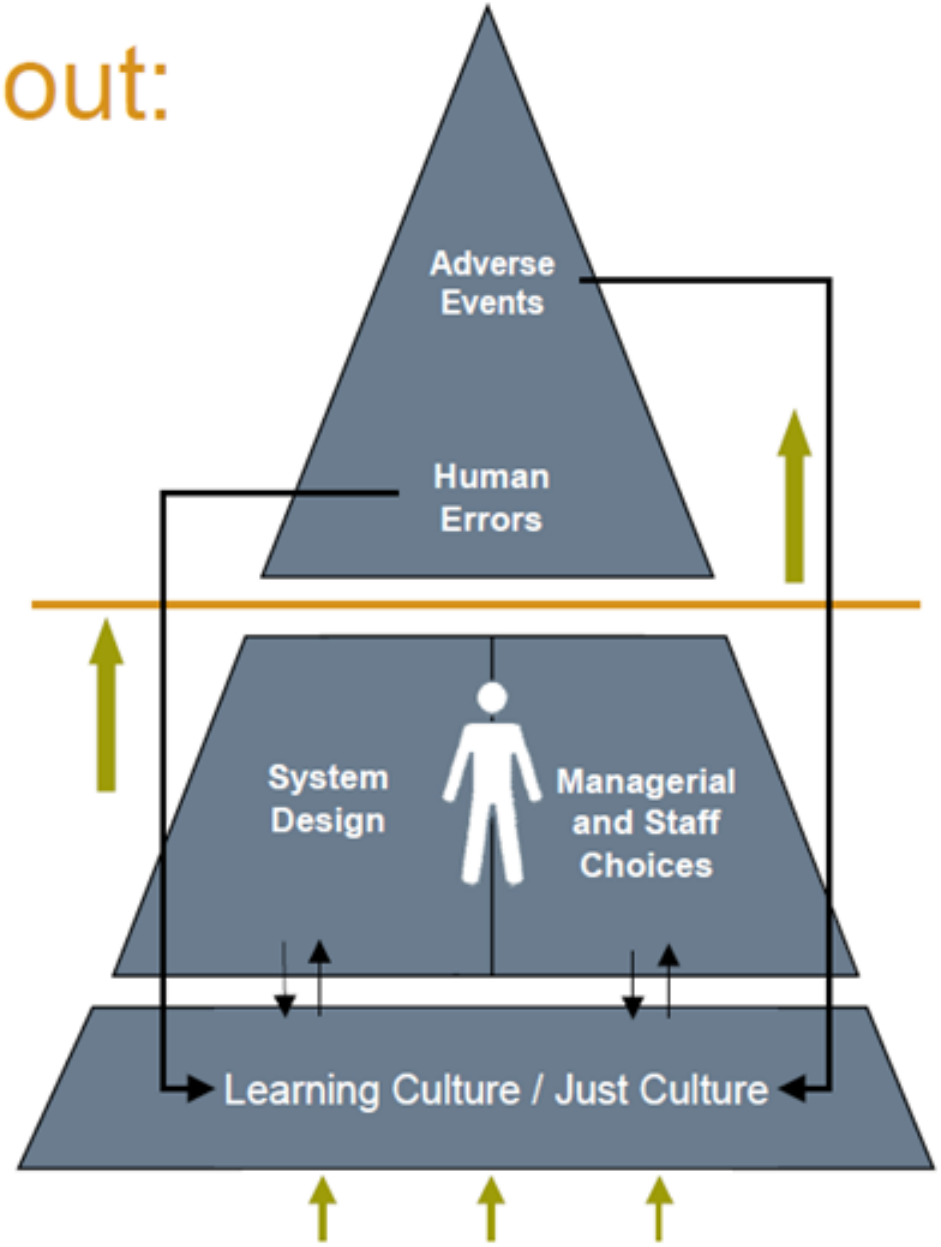
Just Culture is about:

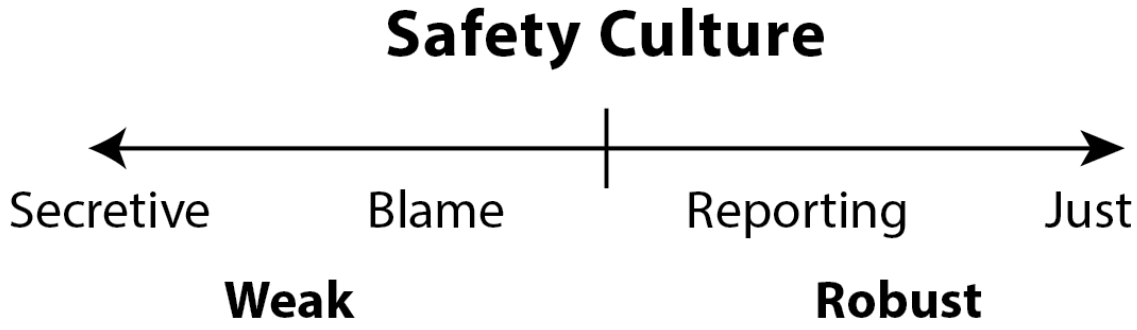
- Creating an open, fair, and just culture
- Creating a learning culture

- Designing safe systems
- Managing behavioral choices



Steps to Just Culture

- Understand current state
- Leadership essentials
- New mental models: How systems fail and reliability
- Just Culture accountabilities
- Safe people and HCPS
- Transparency and disclosure
- Respectful behavior



Algorithm Use

- Do you consistently use an algorithm to ensure clarity exists between human error in unreliable systems and intentional unsafe acts?
- Are all leaders and HR skilled in use of the algorithm?
- Is the algorithm used regardless of outcome of error or position in the hierarchy?
- Is it clear who to go to for help when facing a complex issue?
- Is use of the definitions of terms in the algorithm consistent and clear?

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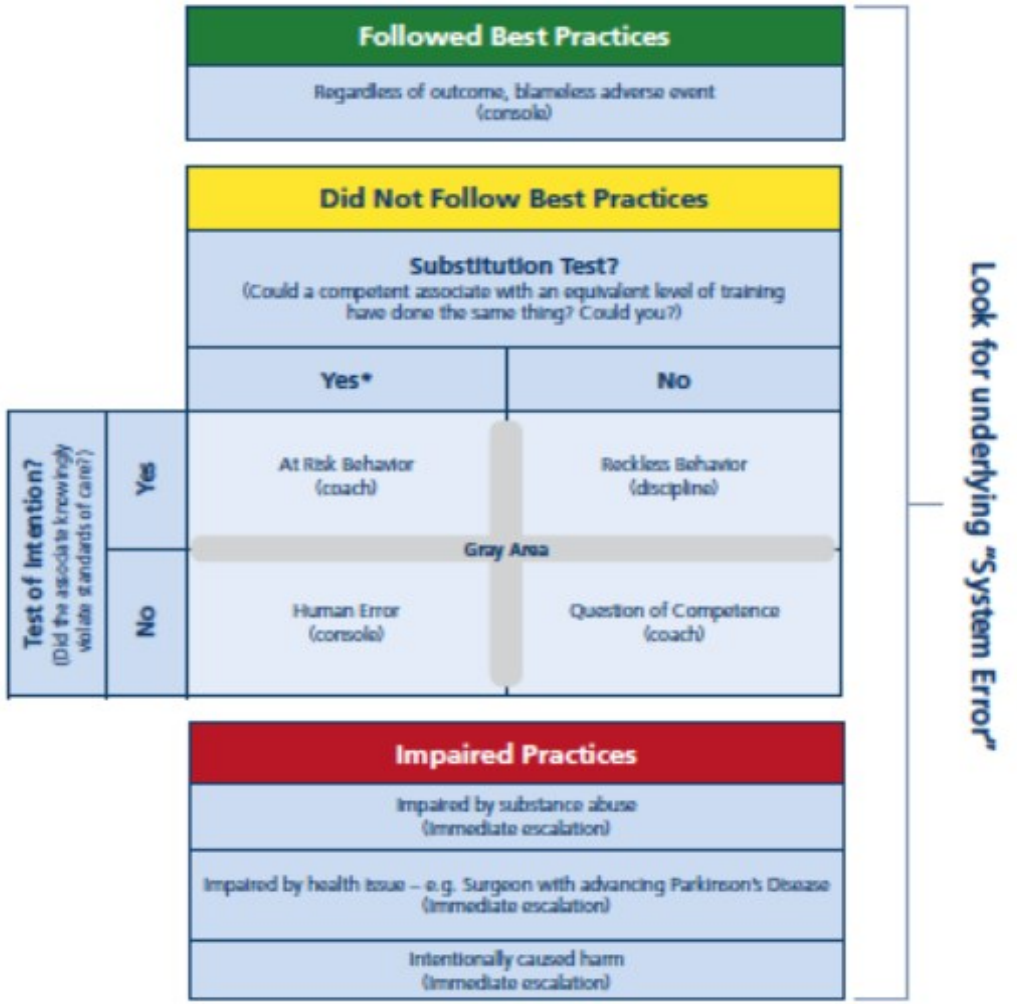
JUST CULTURE TOOL

Influenced by the works of James Reason[1] and David Marx[2,3]



* When a associate passes the substitution test, question the effectiveness of current practice and evaluate for "Normalization of Deviance".[4] Normalization of Deviance is defined as the gradual drift away from best practices until a deviant behavior is commonplace among associates (e.g. ignoring an alarm, bypassing a safety check, etc.).

1. Reason J. Managing the risks of organizational accidents. Aldershot: Ashgate Publishing Group; 1997
2. Marx D. Whack-a-Mole: The Price We Pay for Expecting Perfection. By Your Side Studios; 2009
3. Marx D. Patient safety and the "just culture": a primer for health care executives. New York: Trustees of Columbia University; 2001
4. Vaughan D. The Challenger launch decision: risky technology, culture and deviance at NASA. Chicago, IL: University of Chicago Press; 1996

Created by Montefiore's Patient Safety Program.
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Inspired Medicine

What behavior we should expect?

Outcome Engineering Algorithm

Human Error	At-Risk Behavior	Reckless Behavior
Product of Our Current System Design and Behavioral Choices Manage through changes in: • Choices • Processes • Procedures • Training • Design • Environment	*A Choice: Risk Believed Insignificant or Justified* Manage through: • Removing incentives for at-risk behaviors • Creating incentives for healthy behaviors • Increasing situational awareness	*Conscious Disregard of Substantial and Unjustifiable Risk* Manage through: • Remedial action • Punitive action
Console	**Coach**	**Punish**

The behaviors we can expect

- **Human Error:** Inadvertent action; inadvertently doing other that what should have been done; slip, lapse, mistake

- **At Risk behavior:** Behavioral choice that increases risk where risk is not recognized or is mistakenly believed justified

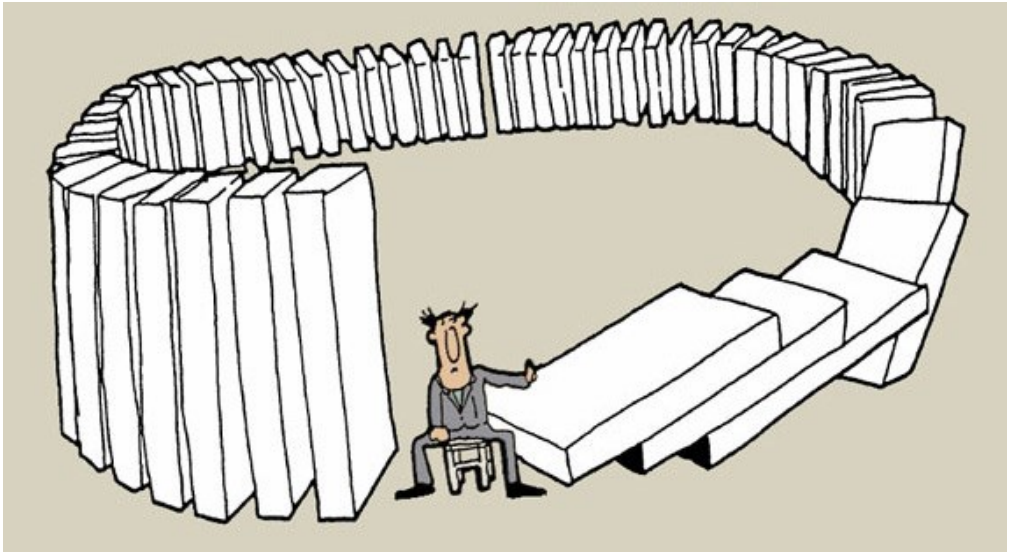
- **Reckless behavior:** behavioral choice to consciously disregard a substantial and unjustifiable risk

Behavioral Choices – "Drift"
"Normalization of Deviance"

- Develop comfort with inherent risks/threats.
- Underestimate risk of "drifting" from safety procedures; believe likelihood of harm is minimal.
- Continual reinforcement of underestimated risk supports continued drifting behavior.

Strength of Behavioral Incentives

- I will consider deviating if:
  - Consequences are weaker than the rules or other preconditions.
  - The consequences are uncertain
  - The consequences are delayed or not apparent



What we must learn....

- Fear causes individuals to push errors, mistakes, good catches, accidents underground…
- AND if blame is assigned to failure, all learning stops
- Opportunities to correct the underlying vulnerabilities in the system are lost
- And the same thing will happen again, and again, and again....

Dekker, *The Field Guide to Human Error Investigation,* 2002

Just Culture Accountabilities

- Leaders often assume Just Culture eliminates individual accountability –and thus object to Just Culture
- The dilemma is that many organizations fail to specify accountabilities –for employees and for leaders

Just Culture Accountabilities

Leaders are accountable:

- To role model all employee accountabilities
- To promote a Just Culture
- Assure respectful behavior for all
- To set high performance standards, enable employees to achieve the standards, and coach employees to improve performance
- To provide equipment and resources so that each person can work safely and reliably
- To develop teamwork skills throughout the organization

Just Culture Accountabilities

Leaders are accountable:

- To actively seek and listen to employees' concerns with unsafe systems that may harm patients or staff; to take action to address the concerns
- To develop reliable systems in partnership with staff, patients, and families
- To role model leadership behaviors when things go wrong –both immediate response and disclosure to patient/family
- To fully review and learn from all critical events and good catches with those involved –get to a deeper understanding of how the system failed

Just Culture Accountabilities

Employees are accountable:

- For their performance consistent with their role and organizational values
- To act in ways that avoid harm to patients
- For respectful behavior
- To report critical events and good catches –their own and others
- To stop any potential unsafe act
- To identify unsafe systems or accidents waiting to happen

Culture of Accountabilities

Employees are accountable:

- To know what resources are available to help assure safe, reliable care and to use them –colleagues, leaders, policies, procedures
- To identify and help improve bad policies/procedures –those that do not help or lead to confusion
- To participate fully when critical events happen to learn what went wrong and how to prevent in the future
- To contribute to the design and implementation of reliable systems for care

Safe and Engaged People

- “Workforce safety is inextricably linked to patient safety.”
- Can each person answer yes each day to:
  - Am I treated with dignity and respect by everyone?
  - Do I have what I need so I can make a contribution that gives meaning to my life?
  - Am I recognized and thanked for what I do?

LLI at NPSF, *Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care,*2013

Transparency and Communication

- **Transparency**
  - "The free flow of information that is open to the scrutiny of others"
  - Openness with caregivers, patients, and families about all health care activities –the risks, outcomes, and decisions required; fulfills the expectation "nothing about me without me"
- **Communication of Unexpected Outcomes**
  - A component of transparency
  - Definition: Prompt, compassionate, honest communication with the patient and family following an accident.

LLI at NPSF, *Shining a Light: Safer Health Care Through Transparency*, 2015

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THANK YOU

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