Shifting from Blame-&-Shame to a Just-and-Safe Culture

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Conflict of Interest

- I have no conflicts to disclose.

Objectives:

- Identify characteristics that differentiate a Blame & Shame Culture from a Just & Safe Culture.
- Identify some tips to improve the safety culture of your organization or team.

The Blame & Shame Punitive Culture

- Individual workers held fully accountable for patients outcomes.
- Perfect performance is achievable through education, professionalism, vigilance and care.
- Threat of disciplinary action for errors thought necessary to maintain proper safety vigilance.
- Error follow-up focused on individual weaknesses.
- Focused on weeding out of "bad apples"!

Impact of Punitive Culture

- Decreased incident reporting re: self and colleagues.
- Decreased reporting of near-misses and hazards.
- Creation of work-arounds…introduces new risks.
- False sense of security.
- Missed opportunities to learn about risks and implement changes.

Blame-Free Culture

Institute of Medicine's "TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM" first identified the failure of the Punitive Culture:

"One of the report's main conclusions is that the majority of medical errors do not result from individual recklessness or the actions of a particular group--this is not a "bad apple" problem. More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them. For example, stocking patient-care units in hospitals with certain full-strength drugs, even though they are toxic unless diluted, has resulted in deadly mistakes."

Blame-Free Culture

- Acknowledges human fallibility.
- Recognizes systems issues that may contribute to error.
- Understands there is little benefit to punishing workers for unintentional acts.

Down Side of a Blame Free Culture

- But fails to confront individuals who:
  - willfully make unsafe behavioral choices.
  - knowingly disregard risk.

How does a Just & Safe Culture act?

What is this CULTURE thing???

- A pattern of basic attitudes shared by a team/organization:
  - Value - What is important to us in our work day?
  - Beliefs - What do we believe about the work we do?
  - Behaviors - How do we go about our work?

These are ‘taught’ to staff in both explicit and implicit ways.

How does a Just & Safe Culture act?

- The belief and the practice of placing patient safety at the centre of everything we do in healthcare.
- An exact definition of a culture of safety is still emerging in healthcare…
- Using themes from high-reliability organizations (HROs) like aviation, nuclear power production, etc. can get us there.

How does a Just & Safe Culture act?

- Strategic emphasis on safety
  - A palpable passion for safety, grounded in a healthy acknowledgment of the high-risk nature of healthcare.
  - Preoccupation with failure/safety.
- Just culture
  - Supports reporting and investigation of hazards and errors.
  - Staff trust each other and their leaders and report hazards and errors without fear of retribution or embarrassment.

How does a Just & Safe Culture act?

- Feedback loops
  - Have established, meaningful, feedback systems that keep staff informed about safety, errors and causal trends.
  - Leaders hold discussions with staff to learn about barriers to safe work, to build trust and to demonstrate that safety is a priority.

How does a Just & Safe Culture act?

- Learning organizations
  - Enhance capacity through real-life experiences gained over time.
  - Staff see learning as inseparable from everyday work and a necessary precursor to change.

How does a Just & Safe Culture act?

- Desire to change
  - Profound change comes from commitment, not management-driven compliance that directs to staff to ‘just do it’.
  - Staff carry a great deal of power when it comes to either maintaining the status quo or changing.

Approach to Safe Culture Improvement

- 2 fundamental assumptions underlying much of the safety culture research
  - A positive safety culture is associated with improved safety performance.
  - It is possible to improve the culture of a team/organization.

Approach to Safe Culture Improvement

Maturity Level	Approach to Improving Safety Culture
Pathological	Why do we need to waste our time on safety?
Reactive	We take patient safety seriously and do something WHEN we have an incident.
Calculative	We have rules, policies and procedures in place to manage patient safety.
Proactive	We are always on the alert/thinking about safety issues that might emerge.
Generative	Managing safety is an integral part of everything we do.

Approach to Safe Culture Improvement

- Avoid organizational arrogance.
- Actively pursue what is unknown.
- Make information & data available.
  - Use available technology.
- Empower staff to recognize and respond to system abnormalities.
- Design redundancy – make it easy to do the right thing.

Approach to Safe Culture Improvement

- Set an environment that supports teamwork and communication.
- Use of Structured Communication Techniques:
  - Briefings/ Time-outs/Huddles
  - SBAR/ DARP
  - Common Language
  - Debriefings

Approach to Safe Culture Improvement

- Set the tone for teamwork & situational awareness.
- Shared understanding of:
  - What's going on?
  - What's likely to happen next?
  - What to do if what is supposed to happen doesn't?

Approach to Safe Culture Improvement

Situational Awareness Strategies

- Use concise, specific and timely communication.
- Ensure every team member knows the game plan.
- Acknowledge and demonstrate common understanding (e.g. repeat-back).
- Talk to one another as events unfold so the team can monitor and verify perspectives.
- Anticipate the next steps and discuss contingencies.
- Constructively assert opinions and perspectives.
- Verbalize any red flags.

Approach to Safe Culture Improvement

Bottom Line:

- Good communication… talk to each other & your patients…
- Talk about safety issues and learn from the experiences of others (good and bad).

Approach to Safe Culture Improvement

- In the hospital setting we've had good success with the use of safety huddles.
  - Teams, patient care areas, etc. start their day with a 10-minute huddle and discuss the day ahead; error prone situations, anticipated stressors, etc.
  - Time is always on short supply… huddles are manageable chunks of time!

Approach to Safe Culture Improvement

- Trust & Support…
  - Staff are empowered and freely participate in all safety discussions without judgement.
  - Support and follow-up after an incident has occurred.
- Our regional safety committee is at a point where sharing of vulnerabilities is a teaching moment for all… solutions are found together!
  - Does not happen immediately! Trust has to be earned.

References

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