Establishing Psychological Safety in the Workplace: Key Driver of Patient Safety and CRP

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Disclosures

I work with national and international organizations to develop and sustain wellbeing programs

I acknowledge my privilege and fallibility

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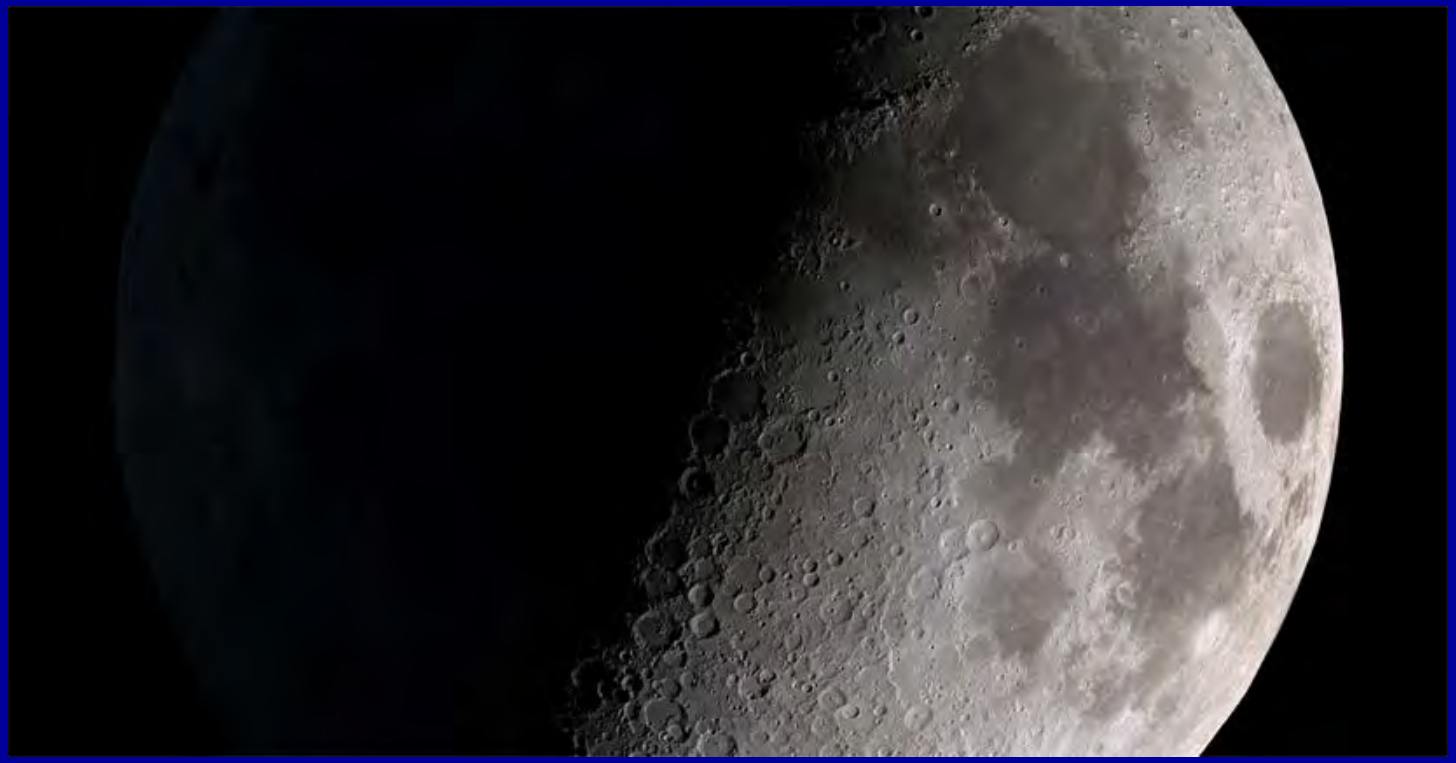
Think of a time …

The dark side



Dr. Dismissive

You are called by an anesthesiologist with complaints about an interventional cardiologist:

Can be demeaning and hostile to various team members

- *Chastises them for not moving the cases along fast enough*
- *Dismissive of clinical concerns*
- *Refuses to discuss operative plans*
- ***Blames others when things go wrong***
- *Demeaning: tone, content (you all are just on the clock)*

Punishment Central

There's been an AE and you are called by the organization to justify your actions

You try to explain the reasoning for your choices at the time, but the focus is on the bad outcome

You feel isolated and demoralized

You are fearful of how this will affect your career

Culture of Psychological Safety: Foundational to CRP

What is Culture?

"The organization's culture consists of patterns of relating that persist and change through ongoing interaction."

- Tony Suchman, MD
J Gen Intern Med. Jan 2006

Team Psychological Safety

shared belief in interpersonal safety within the team

"…sense of confidence that the team will not embarrass, reject, or punish someone for speaking up."

"…stems from mutual respect and trust among team members."

A. Edmondson Psychological Safety and Learning Behavior in Work Teams 350/Administrative Science Quarterly, 44 (1999): 354

Safety culture:
Learning and growth mindset

- All feel safe talking about error
- Do not punish for human error (or for choices made in the face of legitimate competing priorities)
- Find and fix vulnerabilities in our systems and behaviors

Leonard MW, Frankel A. Patient Education and Counseling 80 (2010) 288–292

High Reliability Culture

- **“Failure-free, stable over time”**
- Clinical
- Operational
- Cultural
-

Mindfulness:

- the ***current state***
- everyone’s ***expertise***
- the ***complexity*** that exists when humans and systems interact
- ***risks and defects*** that could cause failures
- **tendency to simplify** situations and solutions
- the need for ***continuous learning***, even during high-demand events

Unpacking Components to Psych Safety

Professionalism

Trustworthy relationships

Unprofessionalism and Patient Care

3-5% of MDs

Demonstrate behavior that **interferes with patient care**

(Ann Intern Med. 2006;144(2):107-115)

National survey of 3,900 MDs, RNs, staff in hospitals

51%

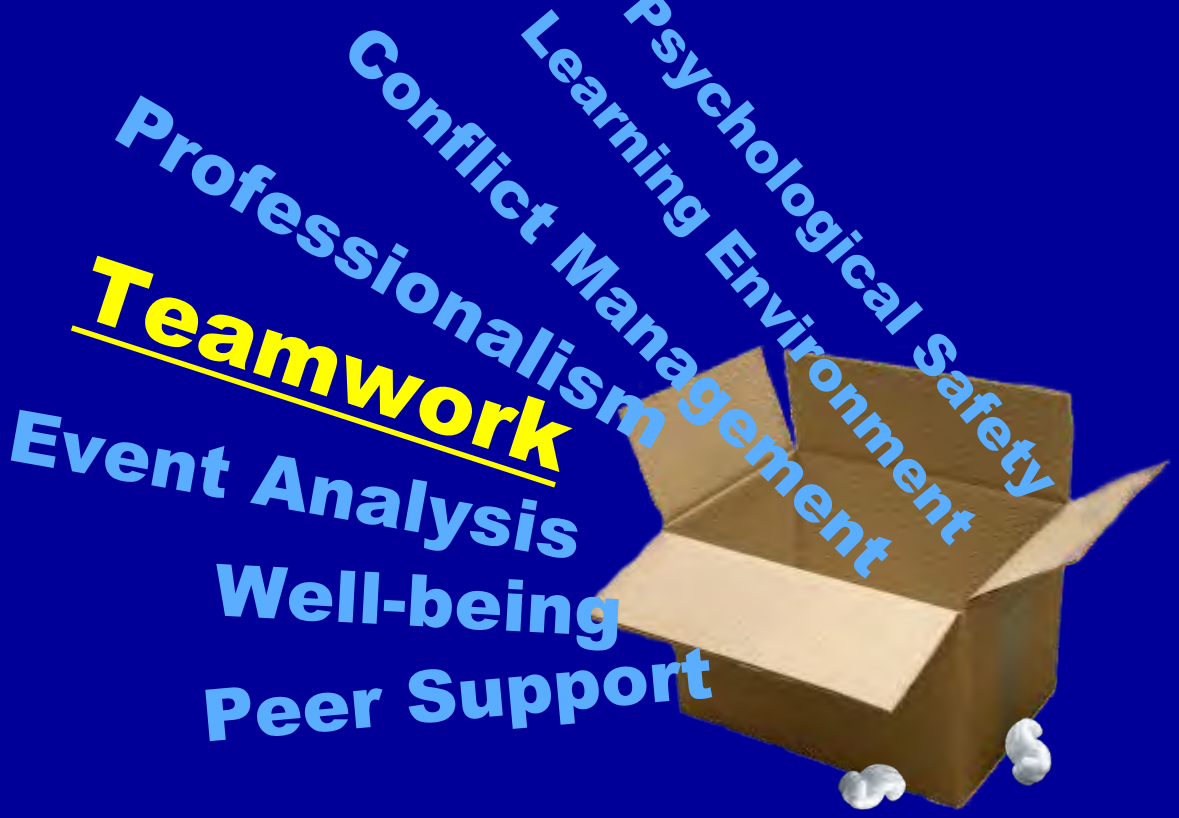
Disruptive behavior
correlates with
patient safety compromise

71%

Disruptive behavior
correlates with
quality compromise

(Jt Comm J Qual Patient Saf. 2008;34(8):464-471)

Unpacking safety culture



Teamwork:
The dark side …

300 surgical cases: pts whose surgical teams exhibited less teamwork behaviors were at higher risk for death and complications

(Am J Surg. 2009 May;197(5):678-85)

Joint Commission Sentinel Event Alert

End intimidating and disruptive behavior among physicians, nurses, pharmacists, therapists, support staff and administrators

"behaviors that undermine a culture of safety"

Why have we tolerated this for so long?

$

Fear (retaliation/litigation) and lack of training

Justifications: tradition, role modeling, holding high standards, myth of pedagogic rationale

Lack of knowledge re effect on others (including our own behaviors)

Cultural relativism

Unpacking Cultural Domains

Emotional impact of errors on clinicians

- *Sadness*
- *Shame*
  - *Self-doubt*
- Fear
- Anger
- Isolation

Helmreich's observations:
Similarity between medicine and aviation

"…[both stress] the need for perfection and a deep perception of personal invulnerability…"

Helmreich, Davies.
Culture, Threat and Error: Lessons From Aviation.
Can J Anesth 2004; 51:6

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- *Sadness*
- *Shame*
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Fantasy

No more shame and blame

Internal and external regulatory judgment and punishment

- Event analysis: M&M, RCA
- Department of Public Health
- Board of Registration in Medicine
- Inspectorate
- Royal College of Physicians and Surgeons
- Court of law
- Media

Disclosure Impact

Do we think that any of these emotions might have an effect on our discussions with patients and families?

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How could they ***not*****?**

Relationship Between CRP and Psychological Safety

- Reporting errors
- Speaking up
- Transparent and compassionate conversations with patients and families
- Learning mindset

Leadership

Leadership

- Non-Negotiable Respect
- Guardians of Learning
- Models of Healthy Culture
- Visible Action

Culture

- Courage
- Agency
- Community
- Collaboration

Learning

- Self-Reflecting
- Improvement-Capable
- Sustainable

Knowledge

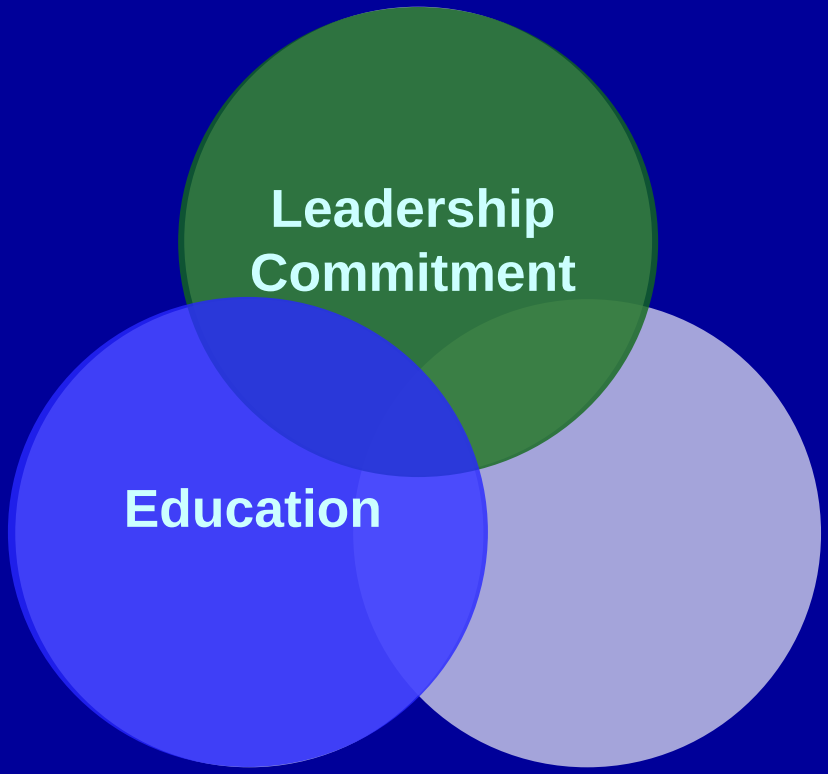
- Clinical, Operational, & Cultural Measurement
- Up-to-Date & Visible

Building a program

Organizational Initiatives to Support Psychological Safety

- Professionalism program
- Leadership training
- Communication coaching
- Peer Support

Building a program



Training to Prevent Harassment/Disruptive Behavior

You are likely to be a
victim,
perpetrator and
bystander

The Bystander

"It's tempting to take the side of the perpetrator. All the perpetrator asks is that the bystander do nothing…" whereas "the victim…asks the bystander to share the burden of pain."

J Herman. Trauma and Recovery

Silence = Complicity

Academy of Communication in Healthcare (ACH)

Frame-Based Feedback and Conflict Management

Trying to learn the other person's perspective through genuine curiosity and exploration.

- Rudolph J, Raemer D, Shapiro J. Clin Teach. 2013 Jun;10(3):186-9.

Building a program

Need a safe, relational environment for raising concerns

Enables early feedback and chances for *remediation*

Protects reporters

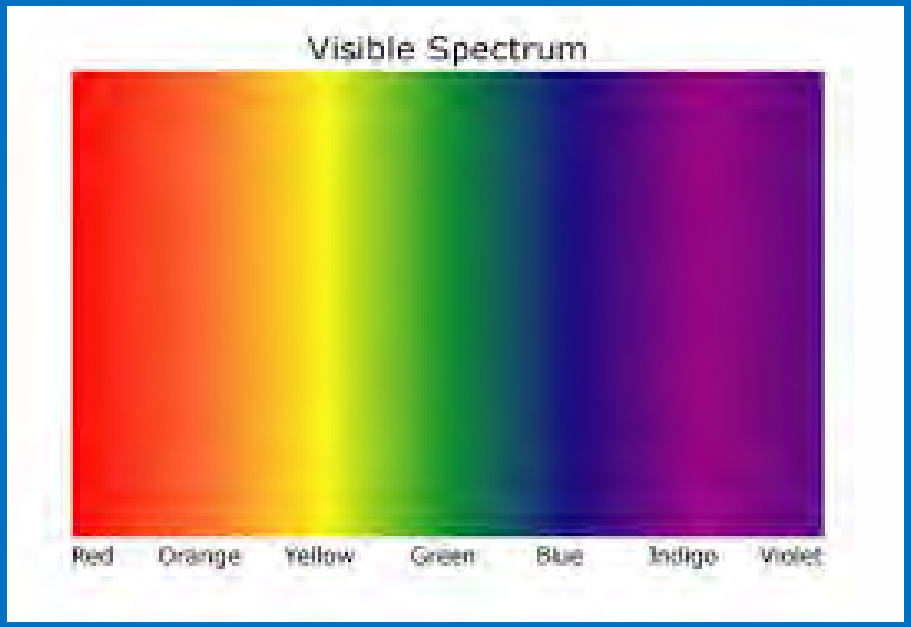
Fair to individuals

Not reliant on SRS…

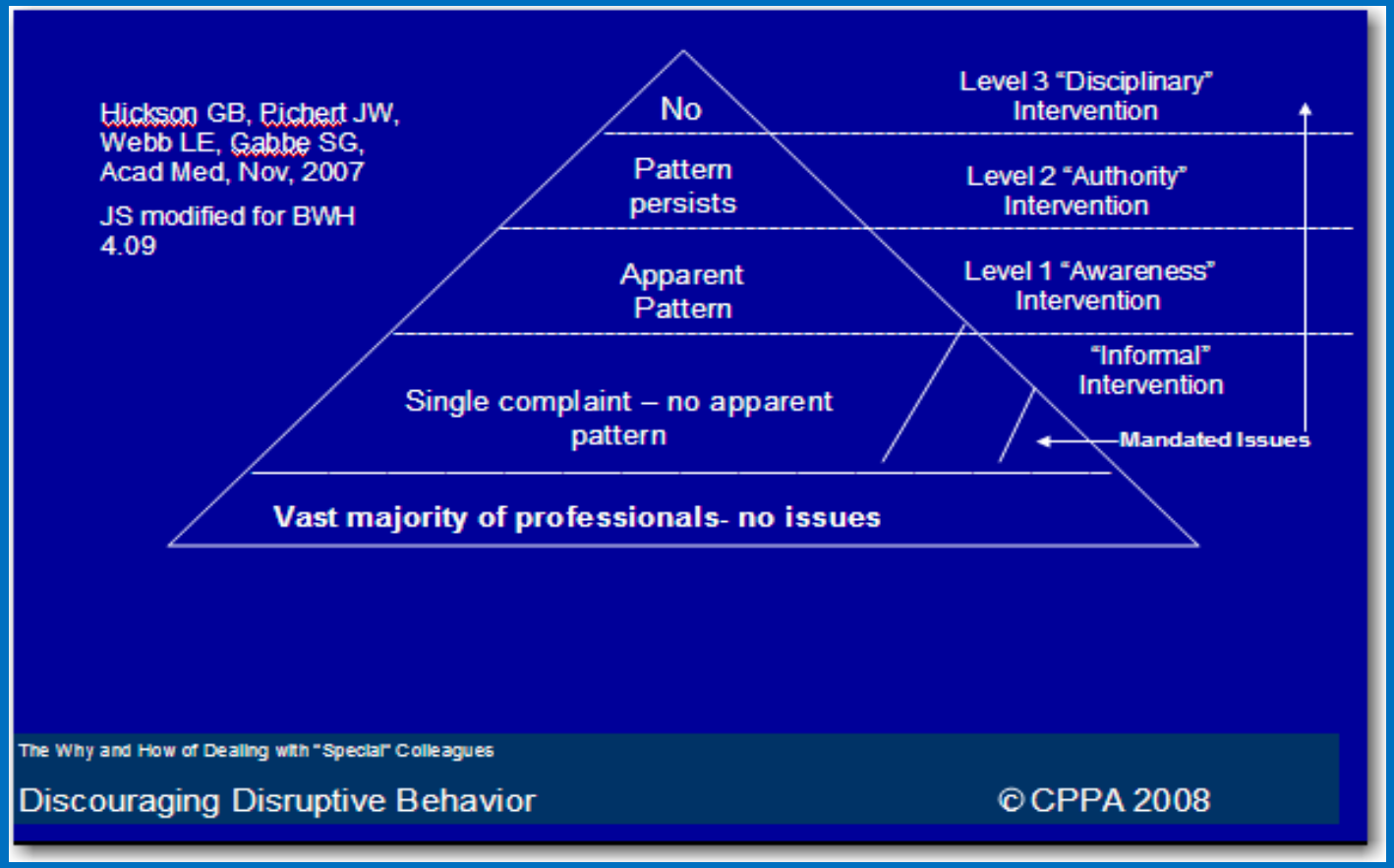
Online safety reporting systems

"gotcha"

Occasional → Pattern → Egregious incident



Escalating consequences



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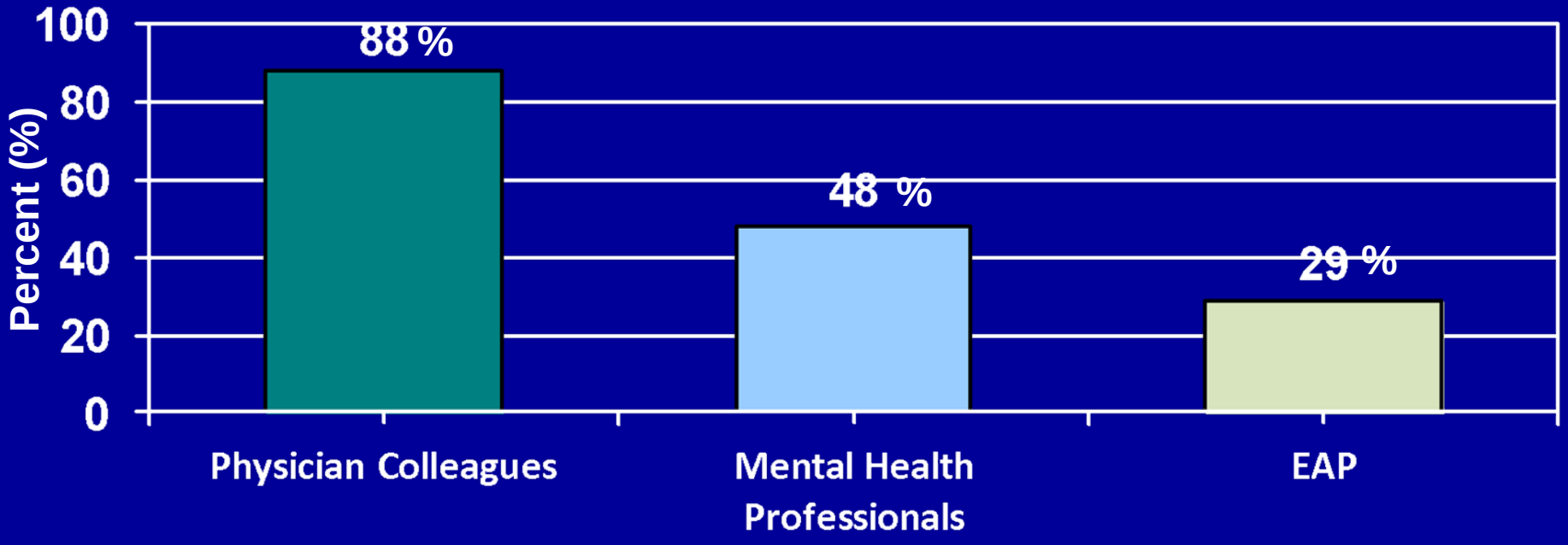
Sources of support



Hu Y, et al. Attitudes and needs of physicians for emotional support: The case for peer support. *JAMA Surg 2012*

Peer Support

Sometimes an entire team is affected

Communication Coaching

Engineering Psychological Safety

Nuclear Navy

75 Years Without an Accident

"I am always chagrined at the tendency of people to expect that I have a simple, easy gimmick that makes my program function.

Any successful program functions as an integrated whole of many factors. Trying to select one aspect as the key one will not work. Each element depends on all the others."

ADMIRAL HYMAN G. RICKOVER

Photo by Jo Shapiro, MD (2014)