Institute for Healthcare Improvement Open School

Patient Safety 106: Introduction to Culture of Safety
Summary Sheet

Lesson 1: The Power of Speaking Up

- A culture of safety is an atmosphere of mutual trust in which all staff members can **talk freely about safety problems and how to solve them, without fear of blame or punishment.**
- Why is hard to speak up in health care?
    - The typical culture of health care makes it hard to speak up because it is hierarchical in nature.
    - Further, health care has traditionally been a culture of individual experts.
    - When you're a junior staff member in a technical field such as health care, you may not feel confident that the problem you're observing is really a problem.
- It is **never okay** for others to make you feel hesitant about voicing a safety concern.
- A culture of safety includes:
    - **Psychological safety.** People know their concerns will be received openly and treated with respect.
    - **Active leadership.** Leaders actively create an environment where all staff are comfortable expressing their concerns.
    - **Transparency.** Patient safety problems aren't swept under the rug. Team members have a high degree of confidence that the organization will learn from problems and use them to improve the system.
    - **Fairness.** People know they will not be punished or blamed for system-based errors.

Lesson 2: What Is a Culture of Safety?

- In **psychologically safe** environments, people believe that if they make a mistake others will not penalize or think less of them for it.
    - They also believe that others will not resent or penalize them for asking for help, information, or feedback.
- **Active leadership** skills – sharing information, inviting other team members to contribute their expertise and concerns, and making oneself approachable – make it easier for everyone to speak up.
- A **transparent** organization is comfortable investigating errors and sharing the findings internally so others can learn and avoid a similar mistake.
- People will be transparent only if we think that we would be treated reasonably; that's where the concept of **fairness** comes in.
    - To determine if a mistake calls for system redesign or disciplinary action, you can use the Fairness Algorithm:
        - Did the individuals intend to cause harm?
        - Did they come to work drunk or impaired?
        - Did they do something they knew was unsafe?
        - Could two or three peers have made the same mistake in similar circumstances?
        - Do these individuals have a history of involvement in similar events?

Lesson 3: How Can You Contribute to a Culture of Safety?

- Even if you don't work in a safety-oriented culture, here are four concrete actions you can do right away that will quickly have an impact on your patients and your peers:
    - Actively set a positive tone when working with a team.
        - Set a common goal, invite everyone into the conversation, and make yourself approachable.
    - Routinely use structured types of communication.
        - SBAR, briefings, and debriefings can all be useful.
    - Learn how to differentiate between system error and unsafe behaviors.
        - Use the Fairness Algorithm that we discussed in Lesson 2.
    - Be respectful to all your colleagues and patients.
        - You need to be approachable for the benefit of the patient.
- And here are two actions you can try when you start to take on more responsibility and manage others within an organization:
    - Agree on specific language – also known as **"critical language"** – to be used when any team member has a safety concern.
        - This is essentially a code word or sentence that means, "Stop and talk to me – I think we have a problem!"
    - Discuss errors openly in order to learn from them. Encourage others to do so as well.
        - It takes confidence and humility to admit your own mistakes, but it's powerful for others – particularly those junior to you – to hear you do so.
- Here are four questions you should ask to get a good sense of the culture of an organization **before** you start working there:
    - Do the leaders here create an environment in which you feel safe speaking up? When someone voices a concern, do people stop, listen, and validate it?
    - When you do voice a safety concern, do people senior to you act quickly to remedy the unsafe situation?
    - Do you know how to tell the difference between unsafe behavior and unsafe systems?
    - Do people openly discuss mistakes as a source of learning?