Culture of Safety

What Are the Risk Exposures?

The word "culture" has various meanings. A book published in 1952, *Culture: A Critical Review of Concepts and Definitions*, listed 164 definitions for the word culture. A definition that accurately describes culture when referring to the healthcare setting is, "*Culture* is the shared attitudes, values, goals, and practices that characterize an institution or organization."[1] As has also been written, "A safety culture exists within an organization [when] each individual employee, regardless of their position, assumes an active role in error prevention and that role is supported by the organization."[2] Failing to have a culture of safety in place could lead to an adverse event happening if staff members are hesitant or uncomfortable to bring up identified issues.

High-reliability organizations (HROs), which are organizations that perform complex and hazardous work but have few adverse events, first developed the concept of a safety culture.[3] In 1999, the Institute of Medicine published *To Err is Human: Building a Safer Health System*, which exposed the high incidence of adverse events and patient deaths resulting from medical errors occurring in hospitals. In response to this highly publicized critique of the patient care industry, healthcare organizations began looking to HROs for guidance about improving patient safety. Quint Studer, founder and chairman of the board at the Studer Group, defines HROs as "organizations with systems in place that are exceptionally consistent in accomplishing their goals and avoiding potentially catastrophic errors."[4] High-reliability organizations maintain a commitment to safety at all levels, from frontline providers to managers and executives.[5]

A variety of initiatives, programs, and tools have been used to create, assess, and/or enhance the culture of safety at healthcare organizations. Many of these have common elements, such as conducting culture surveys; training staff members on patient safety, teamwork, communication, and high-risk presentations; involving multiple disciplines; identifying and analyzing unsafe processes; simulating high-risk situations; and practicing new skills.

When Is This a Risk Issue?

Risk management professionals and hospital leaders must work together to identify elements of the existing culture that offer the greatest opportunities for improvement within the organization and prioritize those initiatives accordingly.

Culture of Safety

According to the Agency for Healthcare Research and Quality (AHRQ), "poor perceived safety culture has been linked to increased error rates."[6] Achieving and sustaining improvements within the realm of a safety culture can be challenging. Accordingly, it is important for healthcare

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institutions to measure their safety culture on a regular basis, identify areas of weakness, and take action to improve the culture of safety and enhance the quality of care.

In a culture of safety, safety is a priority, even over productivity and efficiency. Staff members are rewarded for working in a safe manner. For example, rather than being reprimanded for taking longer to identify a patient because they check at least two identifiers, staff members receive positive recognition for following patient safety practices. Staff members at all levels are free to discuss concerns and are encouraged to report safety and quality issues. Teamwork and communication are key factors and individuals are treated with respect.

Measuring Safety Culture

The Joint Commission's Element of Performance 1 for Standard LD.03.01.01 in the Hospital Accreditation Program states, "Leaders regularly evaluate the culture of safety and quality using valid and reliable tools."[7] The National Quality Forum and the Leapfrog Group advocate conducting safety culture assessments. AHRQ encourages institutions to conduct safety culture surveys and has developed tools to assist with doing so.

Hospital Survey on Patient Safety Culture

AHRQ developed the Hospital Survey on Patient Safety Culture tool in 2004. This tool measures the perceptions of the safety culture by staff members, both in their particular work area and in the hospital as a whole.

AHRQ surveys are also available for medical offices, nursing homes, community pharmacies, and ambulatory surgery centers. The AHRQ surveys are very popular for a number of reasons, including that they are considered to be valid and reliable and thereby meet The Joint Commission's requirements on assessing the culture of safety. A popular feature of AHRQ surveys is that they are free and readily available on the AHRQ website.

Other attractive features include:

- The surveys are designed to be used by all staff members, including clinical and nonclinical staff members. The surveys may be used throughout the hospital or in select departments or units.
- The hospital survey tool is comprehensive and broad in scope. An analyst may scrutinize survey results to identify categories with the poorest aggregate scores, which may also offer the greatest opportunities for improvement.
- The surveys are relatively easy to use. AHRQ provides a toolkit that includes the following materials:
    - Survey forms.
    - Survey items and dimensions.

- A survey user's guide that provides step-by-step instructions on how to select a sample, administer the survey, obtain high response rates, and analyze the report results.
- A survey feedback report in a PowerPoint template that may be customized to display survey results for administrators and staff members throughout the organization, and also used for presentation purposes.
- A data entry and analysis tool that uses Microsoft Excel, making it easy to input individual-level data from the survey.[8]

AHRQ also provides access to a comparative database report which aggregates the survey results submitted from hospitals across the country. Hospitals may compare their own survey results to the aggregated results in the database. AHRQ databases may be accessed on the AHRQ website at https://www.ahrq.gov/.

High-Reliability Science

Press Ganey® uses high-reliability science to help guide organizations with a transformational approach to culture. They offer a proprietary safety culture survey as well as AHRQ's Hospital Survey on Patient Safety Culture. Their use of reliability science and best practices can help an organization on its way to "zero harm" through facilitating the creation and the sustaining of a culture of patient safety, the improvement of human performance, and organizational excellence.[9]

Governing Body

The hospital's governing body has the most influence on the organization's culture. The governing body is responsible for setting the mission, vision, and goals of the organization and strategically planning how goals will be accomplished. They control the organization's resources and set policy in an effort to reach the goals. Senior leaders must drive the culture change by demonstrating their own commitment to safety and providing the resources to achieve results.[10]

The Institute for Healthcare Improvement (IHI) recognizes the importance of the governing body in influencing safety and quality. One of the initiatives in the IHI's 5 Million Lives Campaign is titled *Get Boards on Board*. The goal of the initiative is to get governing bodies more involved in an organization's quality and safety initiatives The IHI encourages governing bodies to spend at least 25% of their meeting time on quality and safety issues.[11]

A study of 350 hospitals found that there was a strong correlation between governing bodies spending time to address quality and safety issues and actually having better performance in these areas.[12] According to Dr. James Reinertsen, this correlation exists because the choices leaders make regarding how to spend their time communicates what is important to the rest of the organization.[13]

Leadership WalkRounds™

Senior administrative leaders also have a strong influence on an organization's culture. Administrative leaders must send a message to all staff members that patient safety is a priority in the organization and that leaders are committed to building a culture of safety. One way to do that is to conduct the IHI's Leadership WalkRounds™.[14] Leadership rounds involve a team of leaders visiting units of the hospital to observe care and to talk with frontline staff members about safety concerns. The team of leaders generally includes the CEO or a senior executive, the risk manager or patient safety officer, and the department/unit manager. The team may also include a physician leader, a member of the governing body, and a scribe. The scribe documents the information that is gathered during the visits so that it may be effectively acted upon later.

The leadership team is interested in learning how systems and processes may be improved to make it easier for staff members to perform their responsibilities safely. Team members must ensure that they capture the information that is provided by the staff members and act upon it whenever possible.

Reporting Barriers

Reporting actual and potential adverse events is imperative when establishing a culture of safety. In organizations with a proactive culture of safety, leaders focus on the systems and processes that contribute to adverse events occurring, rather than focusing on individuals. The organization supports learning from mistakes and provides positive recognition and feedback to employees who report events. There can be barriers to reporting. For example, employees may not report an event if the reporting mechanism is cumbersome and/or time-consuming.

Another barrier to reporting is a fear of being punished. At one time, it was not uncommon for managers to place copies of incident reports in an employee's personnel file so that incidents could be discussed at the employee's annual evaluation. This "blame and shame" approach often resulting in discouraging employees from reporting errors, thereby making it more difficult for the organizations to gather important information about adverse events and other patient safety issues.[15]

Healthcare facilities eventually came to realize that crucial opportunities to address patient safety issues were being missed as a result of the "blame and shame" approach, and a new approach was developed. The new approach was touted as a "blame-fee culture" in which human factors were not considered in adverse event analyses, even if the behavior was risky, reckless or would knowingly or purposefully cause harm. Soon after, analysts realized that a failure to consider human factors when analyzing adverse events could compromise patient safety, primarily due to missed opportunities to investigate the cause behind the behaviors. Hence, organizations began embracing a "just culture" model.[16]

Just Culture Model

Over the last decade, many hospitals have embraced the just culture approach in analyzing medical errors and adverse events. Just culture principles provide for shared accountability of leaders and staff members in order to improve patient safety and reduce the risk of medical errors. Responsibility may be assigned as follows:

- Leaders are responsible for creating systems that are safe for patients and staff members, and also for responding to staff members in a fair and just way.
- Staff members are responsible for reporting errors and safety concerns and for making safe choices.[17]

Human Error

In a just culture, it is understood that competent healthcare providers can make a mistake. It is also recognized that healthcare providers sometimes develop unsafe practices (e.g., workarounds, shortcuts, "routine rule violations"). A just culture focuses on analyzing processes and systems that lead to human error and then making corrections while also maintaining individual accountability for unacceptable behavior. Behaviors may be classified as human error, at-risk behavior, reckless behavior, knowledge of harm and the purpose to cause harm. A description of each classification follows:

- **Human error** – inadvertent action; inadvertently doing other than what should have been done; a slip, lapse, mistake.
- **At-risk behavior** – behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified.
- **Reckless behavior** – behavioral choice to consciously disregard a substantial and unjustifiable risk.[18]
- **Knowledge of harm behavior** – behavioral choice where you know that harm is practically certain to occur.[19]
- **Purpose to cause harm** – behavior where there is an intentional goal or purpose to cause harm.[20]

Human error may occur when individuals are distracted or experience sensory overload. A lack of barriers to prevent the error is also a contributor.

The difference between at-risk behavior and reckless behavior may be subtle or obvious. An example of an obvious at-risk behavior is following a unit-practice workaround, such as silencing an alarm. Determining differences between at-risk behaviors and reckless behaviors may require a review of the circumstances. For example, would the failure to read back a verbal phone order for a high-risk medication be considered at-risk behavior or reckless behavior? The answer depends on the specific circumstances; in fact, it may turn out to be a judgment call. It is important for managers to thoroughly investigate the circumstances to determine the behavioral choices of the employee. It is important to distinguish the employee's intention towards their

behavior or conduct from their intentions toward that of an undesired outcome. If the individual was unaware of a policy to read back verbal orders, did not believe there was an opportunity to read back the order, thought that the particular situation called for not reading back the order, or was practicing a common workaround for the unit, the action may be considered at-risk behavior.

On the other hand, if the individual was aware of the policy to read back an order and no barriers for reading back orders existed, the behavior may be considered reckless, even if the action did not result in harm to the patient. In a just culture, individuals who are involved in human error or choose an at-risk behavior receive counseling or coaching. Individuals who demonstrate reckless behavior may be subject to disciplinary actions.[21]

Just Culture Education

Fairview Heath Services in Minnesota began by evaluating a smaller number of key operational and clinical leaders and then conducting a "big bang" educational program geared for all operational and clinical leaders.[22] The organization reported that this approach was very successful and resulted in a sudden change in their culture.[23]

Formal education on just culture was not provided directly to staff members.[24] Instead, the expectations for staff member behavior were incorporated into patient safety activities and information was provided during unit-based educational programs and at the time of employee orientation.[25]

Re-Surveying

The best mechanism to determine whether the just culture implementation plan was successful is by re-surveying staff members and leaders. Re-surveying is an effective way to measure the change in the perceptions of patient safety and reporting.

Studies indicate that the most engaged organizations demonstrated a consistent pattern of perceptual change among leaders and frontline staff members.[26] These studies support the philosophy that implementing a just culture opens the lines of communication between frontline staff members and leaders, resulting in leaders having a more accurate perception of the patient safety challenges throughout the organization.

Implementing a fair and just culture takes time, commitment, and planning. Leaders must be engaged and fully understand and embrace the principles and practices of creating safe systems, as well as identifying a fair approach when errors occur. Frontline staff members must recognize the importance of reporting unsafe situations to leaders and be assured that errors will be reviewed through a fair and accountable approach. Implementation plans should be developed using the lessons learned by other organizations that have successfully implemented a just culture. Important implementation steps include creating an oversight team/committee,

surveying, setting expectations for your culture of safety, educating leaders and staff members, reviewing/revising policies and procedures, monitoring the results of just culture implementation, and re-surveying. Creating a just culture speaks to your organization's commitment to providing safe patient care, promptly identifying and resolving adverse events, and providing a fair and accountable approach to managing adverse events and near misses.

Communication and Teamwork

Good communication and teamwork are essential in a culture of safety. The Joint Commission has identified communication problems between providers and between providers and patients as root causes in many sentinel events.[27] There are many initiatives, programs, and tools that may be used to improve an organization's communication and teamwork.

Hand-Off Communication

Communications between providers is receiving increased emphasis to ensure that there is a commitment to reciprocity, clarity, and harmony in professional dialogues about patient care. As stated on The Joint Commission's Blog Detail Page:

> A successful hand-off is defined as, "the transferring and accepting of the responsibility of a patient's care through effective communication." This includes transfers that occur within departments of a facility, or transfer to other outside providers.[26]

Unclear hand-off communication carries the risk that highly significant clinical information can be overlooked and thus not applied in crucial clinical decisions, or that a detrimental delay could occur in recognizing and treating a patient's serious clinical deterioration. Communication should offer an explicit opportunity to ask questions and verify any received information.

The Joint Commission's Center for Transforming Healthcare partnered with 10 hospitals and health systems in 2009-2010 on a hand-off communication project. The group identified causes of inadequate hand-offs through performance improvement methods such as Lean Six Sigma and change management.[29] Some of the identified problems include:

- Lack of teamwork and respect.
- Not enough time to share information about the patient.
- Lack of standardized communication tools.
- Inaccurate or incomplete information.
- Competing priorities.
- Senders [of hand-off communications] having little knowledge of the patient.
- Inability to contact the intended receiver [of the hand-off information].
- Receivers unaware of patient transfer.
- Receivers having little knowledge of the patient being transferred.

- Inability to follow-up with the senders for additional information.[30]

The Joint Commission's Center for Transforming Healthcare and the 10 partnering hospitals then developed targeted solutions to hand-off problems using the acronym SHARE to encapsulate the principles.[31] The SHARE acronym is further explained in the recommendations portion of this chapter.

SBAR

SBAR stands for Situation, Background, Assessment, and Recommendation. The SBAR tool is designed to standardize and improve general communication between healthcare providers. SBAR is a structured communication technique designed to convey a large amount of information in a succinct and brief manner. This is important, as providers have different styles of communicating, varying by profession and other factors.

P.U.R.E.

According to an obstetrics-related *Sentinel Event Alert* from The Joint Commission, communication issues were at the top of the list of identified root causes, at 72%.[32] The perinatal services department is an area that is at higher risk for communication breakdowns. Accordingly, a new SBAR-based communication tool has been specifically developed for obstetrics. The acronym for the new tool is P.U.R.E., which stands for Purpose/prepared, Unambiguous, Respectful, and Effective. More information about P.U.R.E may be accessed at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3388549/.

To date, SBAR is the most popular and widespread standardized communication tool in use; however, there are other standardized communication tools, including:

- S-A-F-E (Situation, Assessment, Find and Figures, Express and Expected); Baylor University.
- S-H-A-R-E-D (Situation, History, Assessment, Request, Evaluate, Document); Northwest Community Hospital, Arlington Heights, Illinois.
- S-T-I-C-C (Situation, Task, Intent, Concern, Calibrate); U.S. Forest Service.
- N-B-A (Needs, Background, Assessment); Crew Resource Management.
- I-P-A-S-S the B-A-T-O-N (Introduction, Patient ID, Assessment, Situation, Safety concerns, Background, Actors, Timing, Ownership, Next steps); U.S. Department of Defense.
- I-M-S-T-A-B-L-E (ID, Mechanism of injury, Status, Treatment, Allergies, Background, Last, Extras); Vanderbilt University.[33]

Undermining Behavior

It is recognized that some behaviors can undermine the culture of safety. Some behaviors among staff may be inconsistent with organizational values be it safety, privacy or customer satisfaction. We must proactively look for and manage both system design and employee

behaviors that are inconsistent with the organizations values. Nurses may be less likely to alert others about subtle changes in the patient's condition, or to immediately speak up (often referred to as "stop the line") if they have a concern that doing so may lead to retaliation against them. Retaliation can undermine a culture of safety. Behaviors that undermine a culture of safety should not be tolerated. Productively coaching employees around reliable behaviors and learning to utilize remedial and disciplinary action when indicated, will best serve organizations values and enhance the culture of safety. The Joint Commission has published a *Sentinel Event Alert* which provides recommendations on how an organization may take steps to manage and prevent such behaviors.[34]

Teamwork

Effective teamwork has been recognized as a viable method for improving the culture of safety.[35] Effective teamwork involves team members coordinating their functions and responsibilities in order to achieve a goal. For example, the goal may be to create an environment that is free from medical errors. For teams to be successful, team members must be able to communicate and have adequate resources and support. Performing as a member of a team does not happen naturally in the healthcare setting. Staff members should receive training about teamwork and how to work as a team. Several team training programs are available for the healthcare setting. For example, AHRQ has published *Medical Teamwork and Patient Safety*, which offers guidance on designing an effective team training program. The publication also outlines several training methodologies and programs that can help improve a culture of safety.

Unit-Based Programs

Some programs are designed to improve the culture of safety hospital-wide, such as just culture. Other tools are designed to improve the culture within a unit or department. Hospitals should use both approaches to achieve a culture of safety.

CUSP

The Johns Hopkins Hospital developed its Comprehensive Unit-Based Safety Program (CUSP). As a result of the program's interventions:

- Safety culture survey results improved in all domains except for "stress recognition."
- The turnover rate of nurses decreased.
- The efficiency and timeliness of rounds increased, as did the access of nurses to physicians.
- Hierarchy was lessened, while collaboration and coordination among clinical disciplines were improved.[36]

CUSP is a methodology that may be used in other healthcare organizations to improve culture. It provides structure, yet it is flexible enough to allow units to focus on the risks that pose the greatest threats.[37]

Triad for Optimal Patient Safety (TOPS) Project

At the University of California in San Francisco, leaders implemented a program designed to improve unit-based multidisciplinary teamwork and communication in an effort to enhance the culture of safety in adult medical units.[38]

The project was called the Triad for Optimal Patient Safety (TOPS). The steps that were taken are similar to the steps taken in a CUSP. The program was initiated in intensive care units (ICUs) at The Johns Hopkins Hospital. The ICU multidisciplinary team developed and implemented the following interventions to reduce central line-associated bloodstream infections (CLABSIs):

- Instituting a vascular access device (VAD) policy, which requires all providers to receive education on evidence-based infection control practices and successfully complete a post-test as preconditions to inserting catheters.
- Creating a catheter insertion cart—known as the "line cart"—with standardized supplies needed to meet infection control guidelines for sterile insertion of central lines (physicians previously had to find supplies located in eight different places, an unnecessary barrier to compliance).
- Using a checklist to ensure adherence to evidence-based guidelines for safe catheter insertion: inserting a line only when needed, washing hands, using full barrier precautions, cleaning the insertion area with chlorhexidine, and avoiding the femoral site if possible.
- Empowering nurses to intervene if guidelines are violated, involving a negotiated change in teamwork behaviors on behalf of patient safety.
- Adding an item to the daily goals sheet that prompts the ICU team to ask the physician during daily patient rounds whether catheters may be removed (since central lines are sometimes left in the patient longer than clinically needed).[39]

As a result of implementing the CUSP and the CLABSI interventions, the following outcomes were demonstrated:

- Improvement in safety culture survey results.
- Elimination of catheter-related bloodstream infections.
- Decrease in length of stay and deaths.
- Elimination of medication errors in transfer orders.
- Increase in staff member understanding of the goals of care.[40]

The Johns Hopkins Hospital expanded the use of the CUSP model to a surgical inpatient unit. The implemented interventions included the following:

- Grouping patients from the same clinical service together to increase physician presence.

- Using team-based goal sheets to improve communication and coordination of daily goals of care.
- Conducting patient rounds with an interdisciplinary team that includes nurses.
- Adding white boards to patient rooms.
- Writing discharge instructions in advance.
- Upgrading the paging and wireless computer systems.
- Scheduling meetings with new residents, the pain management team, and interventional radiology personnel to improve communication.[41]

The TOPS program was implemented in three different units at the facility.[42]

How Can I Reduce Risk?

There is no single initiative, program, or tool that will change an organization's culture all by itself. Changing an organization's culture requires a toolbox full of assessment and implementation instruments, as well as the passage of sufficient time for the change to occur. A culture of safety also requires constant monitoring and nurturing to ensure that it is changing in a positive direction.

Understand the Culture of Safety	

Understand safety	• Understand the key features of a culture of safety, including:
	  ○ Acknowledgment of the high-risk nature of an organization's activities and the determination to achieve consistently safe operations.
	  ○ A blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment.
	  ○ Encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems.
	  ○ Organizational commitment of resources to address safety concerns.[43]
	• Ensure the leaders of the organization commit to following the four characteristics present in a strong safety culture:
	  1. Everyone is empowered and expected to stop and question when things just don't seem right.
	  2. Everyone is constantly aware of the risks inherent in what the organization does.

Understand the Culture of Safety

3. Learning and continuous improvement are the true values.
4. Teamwork is a requirement to work in this organization.[44]

- Understand that hospitals with a strong safety culture:
  - Conduct patient safety-focused Leadership Walkarounds™.
  - Create a reporting system.
  - Designate a patient safety officer.
  - Involve patients in patient safety initiatives.
  - Relay safety reports at shift changes.
  - Appoint a safety champion for each unit.
  - Simulate possible adverse events.
  - Conduct safety briefings.
  - Create an adverse event response team.[45]

Reward safety

- Make safety a priority, even over productivity and efficiency.
- Reward staff members with positive recognition for following patient safety practices and working in a safe manner.
- Encourage staff members at all levels to report safety and quality issues.
- Create a culture of teamwork and respect.
- Treat individuals with respect.
- Evaluate identified safety issues for system weaknesses.
- Analyze errors to identify opportunities for learning.
- Coach and mentor employees to improve behavioral choices.
- Learn when disciplinary action is needed.
- Hold individuals accountable only if their behavior was intentional or reckless.
- Manage in ways that are supportive of organizational values.

Measure the Perceptions of a Culture of Safety	

Measure perceptions	• Understand that the first step in creating a bona fide culture of safety is by measuring perceptions.
	• Use cultural assessment to accomplish the following:
	  ○ Raise staff awareness about patient safety.
	  ○ Diagnose and assess the current status of the patient safety culture.
	  ○ Identify strengths and areas for patient safety culture improvement.
	  ○ Examine trends in patient safety culture change over time.
	  ○ Evaluate the cultural impact of patient safety initiatives and interventions.
	  ○ Conduct internal and external comparisons.[46]
	• Consider the following patient safety assessment tools:
	  ○ AHRQ's Hospital Survey on Patient Safety Culture.
	  ○ The Safety Attitudes Questionnaire (SAQ).

Recognize the Influence of Governing Body Engagement	
Recognize influence	• Recognize that the hospital's governing body has the most influence over the organization's culture. • Understand that the role of the governing body is to act as leaders, listening, asking questions, and setting quality goals for the organization.[47]
Implement a Leadership Walk-Around Program	
Implement program	• Conduct leadership rounds weekly, with the team visiting a different department each week. • Schedule the visits up to a year in advance so that there are no surprises for the unit managers or employees. • Base the visit time of day on staff member availability rather than leadership convenience.

Implement a Leadership Walk-Around Program	

Facilitate communication	• Understand that shift changes and physician rounding activities may not allow staff members to be available to participate in discussions with the team.
	• Include an introductory statement from the most senior leader on the team, questions for the staff members regarding safety issues, and a closing comment.
	• Understand that the introductory statement provides an opportunity for the leader to reassure staff members that the purpose of the visit is to facilitate open communication in a confidential manner.
	• Ensure that the leadership team asks staff members questions related to safety. For example:
	  ○ What concerns do you have regarding patient safety in your unit?
	  ○ What do you think could be the next adverse event in your unit? Why?
	  ○ Have any near miss events occurred on the unit recently?
	  ○ What do you think could be done to prevent an adverse event from happening in the future?
	  ○ What can leaders do to make patient care safer?
	• Have a system in place for providing feedback regarding the actions that are taken to all stakeholders, including the frontline staff members, managers, administrators, and the governing body.

Implement Initiatives for a Just Culture	

Implement initiatives	• Implement initiatives to establish a fair and just culture, such as the Minnesota Alliance for Patient Safety (MAPS) toolkit that outlines the following seven-step process:
	  1. Convene a Steering Committee to test the concept.
	  2. Garner leadership support.
	  3. Identify champions.

Implement Initiatives for a Just Culture	
	4. Identify an interdisciplinary team. 5. Perform organizational gap analysis and/or organizational safety culture baseline survey. 6. Review results of gap analysis and/or culture survey and identify next steps to move forward. 7. Engage organization-wide leadership.[48]

Create team/committee	• Identify a team or committee to oversee the organization-wide just culture initiative.
	• Clearly define committee membership and responsibilities.
	• Ensure that the committee is multidisciplinary and includes the patient safety officer, a quality manager, a risk manager, a human resources manager, and nurses.
	• Be certain that the committee is charged with evaluating the organization's response to errors and near misses, and that in addition they:
	  ○ Review survey results.
	  ○ Are responsible for education and training regarding a just culture.
	  ○ Review and revise policies and procedures.
	  ○ Analyze occurrence reporting data.

Educate staff	• Plan the initiative education and training carefully. • Plan the timing of the training to correspond to when managers have had the opportunity to change their approach to unsafe behaviors, but not so long afterwards that staff members do not understand their roles and responsibilities.[49]
Review and revise	• Develop or revise policies that address the various aspects of patient safety and ensure that the policies are consistent with just culture philosophies and practices. • Ensure that the policies address employee behavior expectations and consequences, manager responsibilities, event reporting, and event investigation.

Implement Initiatives for a Just Culture	

	• Recognize that policies, procedures, and other documents may need to be developed or reviewed, including the following:
	  ○ Medical staff bylaws.
	  ○ Job descriptions.
	  ○ Code of conduct.
	  ○ Quality and patient safety plan.
	  ○ New employee orientation and annual competencies.
	  ○ Human resources policies and procedures addressing employee discipline.
	  ○ Patient safety/incident/occurrence reporting policies and procedures.
	  ○ Adverse/sentinel event investigation policy and process.
	• Continue the process of reviewing all policies on a regular bases (e.g., annually) and make revisions as needed.

Set expectations	• Set expectations for a just culture of safety, and include:
	  ○ Defined authority.
	  ○ Accountability and responsibility for identifying and reporting actual and potential safety hazards, adverse events, and near misses.
	  ○ Compliance with established patient safety priorities (e.g., read-backs, double-check processes).
	  ○ Responsibility to take action for the safety of the patient.
	  ○ Following the chain of command protocol for patient safety concerns and completing annual competencies related to the safety culture.

Monitor results	• Monitor the results of just culture implementation. • Establish a baseline of reported potential safety hazards, near misses, and patient adverse events prior to implementing the just culture model. Compare

Implement Initiatives for a Just Culture	
	results at defined time intervals (e.g., one, three, and six months after implementation). • Review the processes that are used for reviewing, investigating, and responding to reported safety hazards, near misses, and patient adverse events. • Evaluate whether the just culture model was effectively and appropriately used. • Address any issues that are discovered.
Re-survey leaders and staff	• Re-survey leaders and staff members to determine whether the just culture implementation plan was successful. • Compare findings with the prior survey results.
Use Tools That Improve Communication and Teamwork	
Use tools	• Understand that good communication and teamwork are essential in a culture of safety. • Use some of the many tools that are available to help improve an organization's communication and teamwork.
Improve hand-off communication	• Recognize examples of when hand-off communication should occur, such as the following: ○ Physicians transferring responsibility for patients to the physician on call. ○ Nurse-to-nurse shift reports. ○ Transferring responsibility when a staff member leaves the unit on lunch break. ○ Admitting a patient to an inpatient unit from the emergency department. ○ Patient is temporarily transported to an ancillary department.
Embrace SHARE acronym	• Embrace the SHARE acronym, developed by The Joint Commission and the 10 partnering hospitals, in an effort to reduce hand-off problems. • Understand that the SHARE acronym stands for the following: ○ **Standardize critical content**, including:

Use Tools That Improve Communication and Teamwork

- Providing details of the patient's history to the receiver.
- Emphasizing key information about the patient when speaking with the receiver.
- Synthesizing patient information from separate sources before passing it on to the receiver.

- **Hardwire within your system,** including:
  - Developing standardized forms, tools, and methods, such as checklists.
  - Using a quiet workspace or setting that is conducive to sharing information about a patient.
  - Stating expectations about how to conduct a successful hand-off.
  - Identifying new and existing techniques to assist in making the hand-off successful.
- **Allow opportunities to ask questions,** including:
  - Using critical thinking skills when discussing a patient's case.
  - Sharing and receiving information as an interdisciplinary team (e.g., a pit crew).
  - Expecting to receive all key information about the patient from the sender.
  - Exchanging contact information in the event there are any additional questions.
  - Scrutinizing and questioning the data.
- **Reinforce quality and measurement,** including:
  - Demonstrating the commitment of leaders to successful hand-offs.
  - Holding staff members accountable for managing a patient's care.
  - Monitoring compliance with use of standardized forms, tools, and methods for hand-offs.
  - Using data to determine a systematic approach for involvement.
- **Educate and coach**, including:

Use Tools That Improve Communication and Teamwork	
	▪ Teaching staff members what constitutes a successful hand-off. ▪ Standardizing training on how to conduct a hand-off. ▪ Providing real-time performance feedback to staff members. ▪ Making successful hand-offs an organization priority.[50]
Know the SBAR tool	• Recognize that the SBAR tool is a structured communication technique designed to convey a great deal of information in a succinct and brief manner.

Address Behavior That Undermines the Culture of Safety	
Address undermining behavior	• Address behaviors that may undermine the organization's culture of safety, including the following: ○ Verbal outbursts and physical threats. ○ Refusing to perform assigned tasks. ○ Uncooperative attitudes during routine activities (e.g., pre-surgical checklist). ○ Refusal to answer questions, return phone calls, or answer pages. ○ Condescending language or voice intonation. ○ Impatience with questions. • Create a zero tolerance policy with regard to such behaviors. • Enforce this policy consistently across the organization. • Follow The Joint Commission's behavior standards for leaders that are specific to the culture of safety, including: ○ Leaders develop a code of conduct that defines acceptable behaviors and behaviors that undermine a culture of safety. ○ Leaders create and implement a process for managing behaviors that undermine a culture of safety.[51]

Improve Teamwork Skills and Communication	

Improve skills	• Recognize that team members need adequate support and resources to be successful.
	• Use team training programs that are tailored to the healthcare setting, such as the program by AHRQ called TeamSTEPPS®, which stands for Team Strategies & Tools to Enhance Performance & Patient Safety.[52] TeamSTEPPS® is:
	  ○ An evidence-based teamwork system designed to improve communication and teamwork skills.
	  ○ Includes ready-to-use training materials designed to increase team member awareness and to clarify the roles and responsibilities of team members.

Embrace Unit-Based Safety Programs	
Embrace unit programs	• Consider implementing the CUSP method to "help clinical teams make care safer by combining improved teamwork, clinical best practices, and the science of safety."[53] • For more information, visit AHRQ's website on the CUSP Method.

References:

1. Thompson EM. Defining a culture of safety. *OR Nurse*. 2011;5(1):3. Available at: https://www.nursingcenter.com/pdfjournal?AID=1106801&an=01271211-201101000-00001&Journal_ID=682710&Issue_ID=1106800
2. Ibid. Citing Wiegmann D, Zhang H, von Thaden T, Sharma G, Mitchell A. A synthesis of safety culture and safety climate research. Technical Report ARL-0203/FAA-02-2, prepared for Federal Aviation Administration. 2002.
3. U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality, Patient Safety Network (PSNet). Culture of safety. https://psnet.ahrq.gov/primers/primer/5/culture-of-safety. Last updated January 2019. Accessed April 10, 2019.
4. Gamble M. 5 traits of high reliability organizations: how to hardwire each in your organization. Becker's Hospital Review. April 29, 2013. Available at: https://www.beckershospitalreview.com/hospital-management-administration/5-traits-of-high-reliability-organizations-how-to-hardwire-each-in-your-organization.html
5. U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality, Patient Safety Network (PSNet). Culture of safety.
6. Ibid.

7. The Joint Commission. *Accreditation Requirements – Hospital Program*. Oakbrook Terrace, IL: The Joint Commission, Joint Commission Resources; Effective January 1, 2019.
8. Sexton JB, Helmreich RL, Neilands TB, Rowan K, et al. The safety attitudes questionnaire: psychometric properties, benchmarking data, and emerging research. BMC Health Services Research. April 3 2006. Available at: https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/1472-6963-6-44. Accessed May 26, 2020.
9. Press Ganey®. Workforce engagement: building a sustainable improvement culture. Available at: https://www.pressganey.com/blog/workforce-engagement-building-a-sustainable-improvement-culture. Published September 4, 2018. Accessed March 12, 2021.
10. Institute for Healthcare Improvement. Develop a culture of safety. http://www.ihi.org/resources/Pages/Changes/DevelopaCultureofSafety.aspx. Accessed April 10, 2019.
11. 5 Million Lives Campaign. *Getting Started Kit: Governance Leadership "Boards on Board" How-to Guide*. Cambridge, MA: Institute for Healthcare Improvement; 2008. Page 4. Available at: https://psnet.ahrq.gov/perspective/conversation-withjames-l-reinertsen-md. Accessed March 12, 2021.
12. U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality, Patient Safety Network (PSNet). In conversation with...James Reinertsen, MD. https://psnet.ahrq.gov/perspectives/perspective/45/in-conversation-with-james-l-reinertsen-md. Published July-August 2007. Accessed April 10, 2019.
13. Ibid.
14. Institute for Healthcare Improvement. Patient Safety Leadership WalkRounds™. http://www.ihi.org/resources/Pages/Tools/PatientSafetyLeadershipWalkRounds.aspx, Accessed April 10, 2018.
15. Institute for Safe Medication Practices, Our long journey towards a safety-minded culture – part 1: where we've been. *ISMP Medication Safety Alert*. September 7, 2006. Available at: https://www.ismp.org/resources/our-long-journey-towards-safety-minded-just-culture-part-i-where-were-going
16. Ibid.
17. Vogelsmeier A, Scott-Cawiezell J, Miller B. Griffith S. Influencing leadership perceptions of patient safety through just culture training. *J Nurs Care Qual.* 2010;25(4):289-294.
18. Marx D. *Just Culture for Managers.* Version 2.0 (build 177), Chapter 4. 2020.
19. Ibid.
20. Marx D. *Patient Safety and the 'Just Culture"*. The Just Culture Community. Slide Presentation. 2007. Available at: https://www.unmc.edu/patient-safety/_documents/patient-safety-and-the-just-culture.pdf.
21. Ibid.
22. Page AH. Making just culture a reality: one organization's approach. *Perspectives on Safety*. October 2007. Available at: https://psnet.ahrq.gov/perspectives/perspective/50/making-just-culture-a-reality-one-organizations-approach
23. Ibid.
24. Ibid.
25. Ibid.
26. Vogelsmeier A, Scott-Cawiezell J, Miller B, Griffith S.
27. Vaidya A. The Joint Commission: 10 most frequently identified root causes of sentinel events. Becker's Clinical Leadership & Infection Control. April 25, 2015. Available at: https://www.beckersasc.com/asc-quality-infection-control/the-joint-commission-10-most-frequently-identified-root-causes-of-sentinel-events.html

28. Joint Commission Center for Transforming Healthcare. *Hand-off Communications Targeted Solutions Tool.* Available at https://www.centerfortransforminghealthcare.org/what-we-offer/targeted-solutions-tool/hand-off-communications-tst/. Accessed May 26, 2020.
29. The Joint Commission. Joint Commission Center for Transforming Healthcare tackles miscommunication among caregivers. Press Release. October 21, 2010. Available at: https://www.fiercehealthcare.com/healthcare/joint-commission-center-for-transforming-healthcare-tackles-miscommunication-among.
30. Ibid.
31. Joint Commission Center for Transforming Healthcare. *Facts about the Hand-Off Communications Project*. February 2016. Available at: https://www.centerfortransforminghealthcare.org/assets/4/6/CTH_HOC_Fact_Sheet.pdf.
32. Gephart SM, Cholette M. P.U.R.E. communication: a strategy to improve care-coordination for high risk birth. *Newborn Infant Nurs Rev*. 2012;12(2):109-114. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3388549/
33. Ibid.
34. The Joint Commission. Behaviors that undermine a culture of safety. *Sentinel Event Alert*. Issue 40. July 9, 2008.
35. Timmel J, Kent PS, Holzmueller CG, et al. Impact of the Comprehensive Unit-Based Safety Program (CUSP) on safety culture in a surgical inpatient unit. *Jt Comm J Qual Pat Safety*. 2010;36(6):252-260.
36. Ibid.
37. Ibid
38. Blegan MA, Sehgal NL, Alldredge BJ, et al. Improving safety culture on adult medical units through multidisciplinary teamwork and communication interventions: The TOPS Project. *Quality and Safety in Healthcare*. 2010;19(4):346-350.
39. Ibid.
40. Ibid.
41. Ibid.
42. Ibid.
43. U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality, Patient Safety Network (PSNet). Culture of safety.
44. Bergendahl HW. The 4 characteristics of a strong safety culture. Becker's Infection Control and Clinical Quality. https://www.beckershospitalreview.com/quality/the-4-characteristics-of-a-strong-safety-culture.html. April 28, 2014. Accessed April 10, 2019.
45. Institute for Healthcare Improvement, Develop a culture of safety.
46. U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality. SOPS surveys. https://www.ahrq.gov/sops/surveys/index.html. Last reviewed March 2019. Accessed April 10, 2019.
47. U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality, Patient Safety Network (PSNet). In conversation with...James Reinertsen, MD.
48. Minnesota Alliance for Patient Safety (MAPS), MAPSToolkit to Create a Learning, Just, and Accountable Culture. Slide Presentation. Available at: https://www.mnhospitals.org/Portals/0/Documents/ptsafety/perinatal/maps-just-culture-provider-implementation-toolkit.pdf
49. Ibid.
50. Joint Commission Center for Transforming Healthcare. *Facts about the Hand-Off Communications Project*.
51. The Joint Commission, *Accreditation Requirements – Hospital Program*.

52. U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality. About TeamSTEPPS®. https://www.ahrq.gov/teamstepps/about-teamstepps/index.html. Last reviewed March 2019. Accessed April 10, 2019.
53. U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality. The CUSP method. https://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/index.html. Last reviewed March 2018. Accessed April 10, 2019.