

ICF/ID Culture of Safety

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Housekeeping FYIs:

- Release of Learning Tool on Building Respect for Lesbian, Gay, Bisexual, Transgender (LGBT) Older Adults.
- Crisis Team Responsiveness.
- Requests for Training submit through FSB mailbox (FSB@dhw.idaho.gov).

Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe what kind of culture your facility has and what you can do to make it better.

Facility Culture

- Values and behaviors that make it unique
- Shared attitudes, beliefs and customs
- Written and unwritten rules considered valid

<http://www.businessdictionary.com/definition/organizational-culture.htm>

Facility Culture (cont.)

Shown in:

- How it conducts business and treats its employees and customers
- How much freedom is allowed in decision-making, developing new ideas and personal expression
- How power and information flow through its hierarchy
- How committed employees are towards collective objectives

<http://www.businessdictionary.com/definition/organizational-culture.htm>

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Take a moment to think about your facility's culture. What is the motivation of the facility? What are individuals and staff really trying to do? Is it a collective effort to promote individuals' rights and independence or are people just trying to make it through the day? If the facility is not operating like you want it to, the facility's culture may be the problem.

Facility Culture (cont.)

- It affects the facility's performance, productivity, product quality and safety. It is unique for every facility and one of the hardest things to change.

<http://www.businessdictionary.com/definition/organizational-culture.htm>

The culture will impact all aspects of the facility. It is one of the most important facility factors and one of the most difficult to change.

Primary Lessons About Health Care

- No one intends to harm individuals

- Errors and unplanned adverse events occur because of:
 - Human factor – nobody is perfect

 - Flaws in systems

When looking at culture in health care, we start with the premise that no one intends to harm individuals. Granted there are some people who are abusive toward individuals, but that is the exception, not the rule. The vast majority of people working in health care, including ICFs/ID, really want to help people and really want to do a good job. When a negative event occurs, it is typically not intentional. It is typically due to unintentional human error and/or systems flaws.

Primary Lessons About Health Care

- Systems are developed and implemented to reduce the potential for human error:
 - Prevention and detection of abuse, neglect and mistreatment
 - Medication administration
 - IPP development, implementation and monitoring
 - Facility preventative maintenance and repair

Facilities develop systems to provide clear, consistent direction to staff, which helps reduce the potential for human error. However, human error will still occur.

Human Factor: We All Make Mistakes

- 3 classes of human fallibility (behaviors)
 - Inadvertent behavior: inadvertently doing other than 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 to be justified.
 - Reckless behavior: behavioral choice to consciously disregard a substantial and unjustifiable risk.

There are 3 basic classes of human error. The first class is simply making a mistake. Think about typos. We type, we know how to spell, we still make mistakes. This is an inadvertent behavior. Now if we have systems in place to have 2 people review a report prior to publishing it, we choose not to follow that procedure and only have one person review it, that is at-risk behavior. We have made a choice to deviate from a procedure that reduces the risk of errors being made. We may believe that a one person review is okay, because the person reviewing it has really good editing skills, so it's justified, but it still increases the risk for error. Reckless behavior is a blatant disregard of systems, such as not reviewing a report at all.

At-Risk Behavior

- Individual care is most frequently impacted by at-risk behavior
 - Comfort with a system will cause people to deviate from what they were taught to do with the belief they are acting safely.
 - “Cutting corners to get the job done.” (David Marx, J.D.)

Individual care is most frequently impacted by at-risk behavior. At-risk behavior occurs when people get comfortable and they think they know what they are doing but they really don't and/or start taking short cuts. At-risk behavior is not malicious or ill-intended, but it does have negative impacts on the individuals.

Some At-Risk Behaviors in ICF/ID

- Not implementing training programs and/or maximizing opportunities to increase independence.
 - **It saves time.**
- Not implementing behavior management programs.
 - **They know the individuals very well and this is what works for them.**
- Not checking medications against the MARs.
 - **The nurse checked them when they delivered medications.**
- Omitting hand hygiene after glove removal.
 - **They considered their gloves clean.**
- Not implementing emergency drills for anything but fires.
 - **No other potential hazards (earthquakes, floods, etc.) have been identified.**

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In ICFs/ID, staff will deviate from established procedures in a number of ways. Again, it is not ill-intended and there is typically a reason why staff are deviating from established procedures.

Some At-Risk Behaviors in ICF/ID

- Staff assigned to 2 individuals, John and Jill, on the a.m. shift and is the medication passer.
- One of the other individuals, Jamie, engages in maladaptive behavior for 20 minutes, resulting in the medication passer not being able to assist her with medications at the specified time.
- The medication passer knows John will be getting up in 5 minutes and will need assistance with his shower. So the medication passer makes a decision to punch Jamie's medications into a medication cup and leave them on the counter.

Think about morning medication pass. ICFs/ID are busy places in the mornings, even when the shift is fully staffed. The staff passing medications is usually required to pass medications to all individuals in the home and ensure the specific people they are working with make it through their morning routines (bathing, dressing, eating breakfast, brushing their teeth, etc.) and leave for work or school on time.

Some At-Risk Behaviors in ICF/ID

- The medication passer tells Jamie’s staff her medications are on the counter when she is ready for them. Jamie will take them independently and staff just need to ensure she doesn’t drop any of them.
- The medication passer then goes to assist John with his shower, Jamie’s staff hands her the medications, Jamie takes them and everyone makes it out the door on time.
- Nothing “bad” happened, so it’s okay right?

In this scenario, nothing bad happened. Everyone got everything done, everyone got their medications and staff saved a little time. Nothing “bad” happened, so it’s okay right?

Some At-Risk Behaviors in ICF/ID

- **WRONG.** It is not okay.
 - Deviating from the system placed all individuals at risk for medication errors.

It is not okay. Deviating from the system and leaving medications out on a counter places everyone at the facility at risk. Any of the individuals could have happened by, picked up the medications and taken them.

Some At-Risk Behaviors in ICF/ID

- Additional problems:
 - Short cuts can be very reinforcing
 - If it worked once without a bad outcome, it will work again.
 - Nothing happened, so there is nothing to report.

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At-risk behavior can result in additional problems. Short cuts to procedures can be extremely reinforcing to staff. In the medication scenario, staff can see the benefits of saving time and because there was no negative outcome if they find themselves short of time tomorrow, it may happen again, and the next day, and the next day, until it becomes every day practice. It can become the facility's cultural norm, even though it is not in accordance with the facility's established procedures.

Further, because nothing bad happened, staff will not always realize people were placed at risk. The deviation is rarely reported, because nothing bad happened. However, if five months later, when Jill happens by and takes Jamie's medications, which were left out on the counter, and goes to the ER for severe drug interactions, now we have a significant adverse event that could have been prevented and everyone is left asking "how did this happen?"

The Traditional “Blame/Shame” Culture of Health Care

- Staff at-risk behavior is rarely reported.
- When an error occurs, the person(s) responsible is sought out, blamed and punished.
- Fear of punishment and peer pressure causes people to remain silent.
- Errors, events and “near misses” are under reported.

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There are several factors that contribute to adverse events occurring. As previously stated, staff rarely report at-risk behavior. This happens because staff do not always recognize individuals are being placed at risk until it is too late and/or staff do not want to get into trouble.

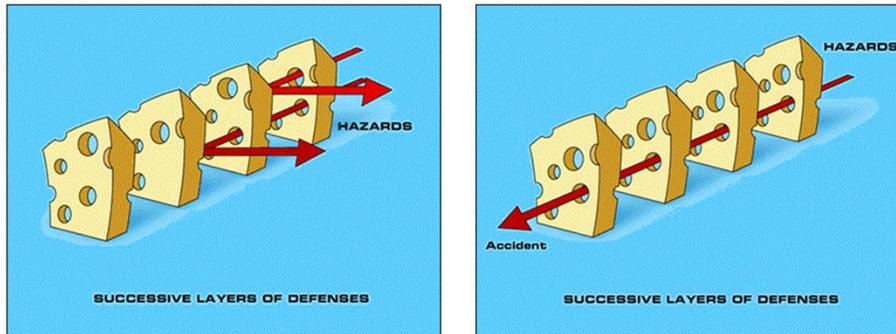
The health care industry has traditionally been a blame/shame culture. When an error occurs, the person responsible is sought out, blamed and punished up to and including termination. No one really likes being in trouble and staff need their jobs. Fear of punishment causes staff to remain silent. Beyond that, in an ICF/ID, staff on the same shift work together a lot. People do not want to be labeled as a “rat” or a “snitch,” which also contributes to a culture of silence. Again, these staff are not ill-intended, but they do allow for individuals to be put at risk.

The Traditional “Blame/Shame” Culture of Health Care

- We cannot fix something if we do not know it is broken.
- Fear prevents meaningful investigation into WHY something happened or almost happened.

Unfortunately, staff silence often results in problems not being identified, investigated and resolved until someone gets hurt. No one wants that, so what's the solution?

Systems



Errors/adverse events occur because protective barriers needed to prevent them have not been constructed or have failed.

Swiss Cheese Model of Error:

http://patientsafetypeduhs.duke.edu/module_e/swiss_cheese.html

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The first step in prevention is building systems that have more than one protective barrier. For example, on a global level ICF/ID facilities have the individuals as their first level, then direct care staff. They may also have shift charge staff or home managers as an additional level, so if direct care staff engage in at-risk behavior, the lead workers can address it. ICFs/ID also have QIDPs and administrators, so if at-risk behaviors are not recognized by the individuals, direct care staff or the leads, there's still another protective barrier in place. Some facilities have peer reviews and are starting to establish Quality Assessment/Performance Improvement staff so there's an additional level of safety. Finally, there's parents, guardians, teachers, other outside advocates and surveyors. On a global level there are a lot of protective barriers. Will there be times when something is missed by all of us? Yes, there will be, but the risk is minimized and there are ways we can minimize the risks even more.

A Facility-Wide “Culture of Safety” Will Protect Individuals

- Open, non-judgmental communication between ALL people who share the same goal of providing quality care for individuals (not blame/shame)

- Everyone has a “voice” and is listened to:
 - Individuals
 - Parents, guardians, family and friends
 - All levels of staff: direct care, maintenance staff, consultants, supervisors, administrators, etc.
 - Other service providers: school teachers, hospice staff, dialysis staff, etc.
 - Outside advocates: DRI, AP, CP, etc.
 - Surveyors

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One of the most important things that can be done to minimize risks to individuals is establishing a “culture of safety.” Changing culture is one of the most difficult things to do, but the effort is definitely worth it. When a culture of safety is established, it gives everyone a voice. People are less afraid to speak up and make suggestions because they are actively engaged in the process.

What Do We Mean When We Say “Listening to the Individual’s Voice”?

- As recipients of care, individuals have the best view of the facility culture, safety and quality.
- How does your facility educate individuals and engage them in facility practices?
- No individuals should fear retribution or reprisal for:
 - Asking questions or making suggestions
 - Pointing out breaches in safe practices
 - Filing a complaint or grievance

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The individuals have the best view of the facility’s culture. Everyone else goes home, the individuals are home. Has your facility asked the individuals what they think? Does the facility promote individuals providing feedback to the staff? Do staff engage in “do as I say, not as I do” behaviors, directing individuals to be appropriate but not modeling the same level of behavior? Do staff tell individuals not to sit on the arm of the couch, but sit on it themselves? Do staff tell individuals not to use swear words, but swear themselves? Do the individuals feel comfortable telling staff to wash their hands prior to providing care or cooking meals? If not, why not?

Remember, no individual should fear retribution or reprisal. It is their home and it is their life.

The Importance of Inclusion

- “Everyone is an expert in a highly specialized field...his or her own job. Odds are, each individual knows better than anyone how to improve it.” (Wolfe Schmitt, CEO of Rubbermaid)
- “The real experts about your organization are your own people, and the management challenge lies in tapping into this wealth of knowledge. The ideas people will support most are the ones they come up with themselves. Asking people for their input encourages both creativity and buy-in.” (Ed Oakley and Doug Krug, “Enlightened Leadership”)

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For staff and advocates, it is important to remember in health care no one intends to harm individuals. People really do want to do a good job. As stated by Wolfe Schmitt, “Everyone is an expert” in their own job and “knows better than anyone how to improve it.” Think about the staff who starts deviating from procedures, they are not trying to do a bad job. If you talk to that staff, the solution may be as simple as adjusting someone’s active treatment schedule. Talk to people. Ask everyone “how can we improve?”

The Road Goes Both Ways

- Open, non-judgmental communication between ALL people.
- Everyone has a “voice” and is listened to:
 - We expect individuals to listen to staff, do we expect staff to listen to individuals?
 - We expect staff to listen to management, do we expect management to listen to staff?
 - We expect providers to listen to surveyors, do we expect surveyors to listen to providers?

Please keep in mind, the road goes both ways. We already established that all of us are human and subject to human error. That means we can all use some constructive criticism and be open to examining our own practices regardless of the role we have. Culture of safety means always keeping your focus on what is in the best interest of the individuals regardless of who is voicing concerns or offering suggestions for improvement.

A Facility-Wide “Culture of Safety” Will Protect Individuals

- Clear systems and direction for staff of what is expected of them
 - Reduces human factor effect
 - Less reliance on memory

When you get everyone’s input, better, clearer systems emerge. The stronger systems minimize the risk of human errors as people have to rely less on memory.

A Facility-Wide “Culture of Safety” Will Protect Individuals

- Be proactive. Search for ways to improve.
 - Disaster preparedness
 - Natural hazards (e.g. earthquake, flood, severe storms, avalanche, landslide, drought, wildfire)
 - Technological hazards (e.g. power and/or utility outage, structure fire, on-site and/or nearby hazards that would affect the site, terrorism [chemical, biological, radiological, nuclear or explosive], dam failure, civil unrest, war)
 - Hazardous materials (e.g. transportation [truck, rail, pipeline, water or air], fixed facilities [close proximity or downwind/downhill from facility])

- Listen to other providers for things not thought of.

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We also know we need to be proactive and actively seek out ways to improve. Take disaster preparedness for example. We think about fire drills, but have we really thought about other potential disasters before they happen? There are a lot of hazards out there, some of which are more likely to occur than others. Take terrorism for example. While Idaho may not be a very likely target for global terrorism, we have had people break in to other provider types and threaten staff at gun point for prescription medications. It has happened in ALFs and in ASCs. Are your facilities and staff prepared to handle such an event? Would they know what to do? Remember everyone gets a voice. Listen to other providers, regardless of provider type. There may be things other providers have experienced which apply to the ICF/ID community, but we haven't experienced or thought of it yet. All of these things will help you build the strongest systems possible.

A Facility-Wide “Culture of Safety” Will Protect Individuals

- Reporting after someone has been harmed is too late.
- Comprehensive system for reporting, investigating and addressing causal factors of ALL abnormal events.

However, we also know no matter how strong our systems are, we are not going to safeguard against the human factor entirely. Things are still going to happen so the systems for addressing those things also needs to be in place.

Incident and accident reports are good and they are necessary, but they are typically generated after someone has already experienced a negative event.

Identification and Reporting

- Everyone knows what to report
 - Any unplanned event
 - “Near misses” and “close calls”
 - Variance from procedure
 - Variance from the IPP and active treatment schedules
 - Environmental hazards
 - Concerns about individuals (the direct care staff know them best)

- Everyone feels FREE to report
 - No fear of reprisal

If everyone, particularly individuals (because they are always there) and direct care staff (because they are with the individuals the most), reports close calls, near misses and the at-risk behaviors which occur, then investigation and corrective action can take place before anyone experiences a negative event. Again, this is not an easy point to get to. Everyone needs to feel free to report without fear of reprisal.

Primary Lessons About Health Care

- Not WHO did it, but WHAT and WHY did it happen?
- Understanding WHY and HOW bad things happen is key to preventing them.
 - Consider human factors.
 - Consider system flaws.

Near miss investigations focus not on who did it, but what happened and why it happened. During this process people often use “Root Cause Analysis” and look both at human and system factors.

“Five Whys” Example

- **Problem:** Programs are not being implemented.
 - 1. Why do program implementation rates appear low?**
 - Because staff didn’t take data.
 - 2. Why aren’t staff taking data?**
 - Because they do not have time until after individuals go to work in the morning or after they go to bed at night and then staff forget.
 - 3. Why don’t staff have time?**
 - Because there are too few staff on the floor.
 - 4. Why were there too few staff on the floor?**
 - Because staff have been calling in sick.
 - 5. Why have staff been calling in sick?**
 - Because the individuals and staff did not get flu shots this year.

<http://www.isixsigma.com/tools-templates/cause-effect/determine-root-cause-5-whys/>

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If you repeatedly ask the question why, you can get to the real reason or “root cause” of a problem. When you begin investigating, initial questions will often lead you to more questions. This technique of continuing to ask why is called the “5 Whys,” but you may find that you will need to ask the question fewer or more times than five before you find the root of the problem.

In the example given on the slide, the actual problem has little to do with data collection. Data collection is simply a symptom of the problem of staff calling in. In this situation if you stopped asking why and only addressed staff not taking data, you would never get to the real problem. This is sometimes called “putting a band-aid on a sucking chest wound;” yes, you took action, but it will do very little to really address the problem.

Inclusive Investigation and Problem-Solving/Addressing

- Any and all persons involved with an error/occurrence/event should be included in the investigation and resolution
 - Their point of view of WHY, HOW and WHAT will work to address and resolve
 - Not just investigator “impressions”
 - Staff who are involved in plans for correcting problems are more likely to adhere to them
- This concept is well-documented.

When you are working through to find the root of problems, we all know thorough investigation requires talking to everyone involved. However, how often is everyone included in the corrective action?

The Importance of Inclusion

“Tell me and I’ll forget; show me and I may remember; involve me and I’ll understand.”

- Chinese Proverb

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Remember, staff are experts at their own jobs and they know how to improve it better than anyone. The more people you involve in the corrective action the more likely it will be effective.

Evaluating the Strength of Corrective Actions

- **Weak:** dependent on staff.
- **Intermediate:** somewhat dependent on staff but includes tools to help staff and modifies existing processes.
- **Strong:** actions that do not depend on staff.

When developing corrective actions, you also want to look at how strong those corrective actions are going to be. The Veterans Affairs National Center for Patient Safety Hierarchy of Action, classifies corrective actions into 3 categories as stated on the slide.

Evaluating the Strength of Corrective Actions

- **Problem:** Staff are to document on the MAR when medications are given. However, at the end of the month, the nurse reviews the MAR and realizes medications are not being documented as given at the time of administration.
 - **Weak:** dependent on staff.
 - **Intermediate:** somewhat dependent on staff but includes tools to help staff and modifies existing processes.
 - **Strong:** actions that do not depend on staff.

Given the example on the slide, what corrective actions would you take? (Solutions may include weak interventions such as re-training the individuals and staff, intermediate interventions such as peer review, supervisory review, medication administration checklists, etc., or strong interventions such as electronic systems which lock staff out, disallowing them from moving forward until documentation is completed).

Evaluating the Strength of Corrective Actions

- Examples of intermediate and strong actions already in place:
 - Electronic QAPI data systems to monitor all other systems complete with quality indicator data and benchmarking.
 - Auto-generated email reminders for things such as quarterly fire drills, nursing assessments, pharmacy reviews and annual IPPs.

We do have providers who are already implementing intermediate and strong interventions in an effort to improve their systems and minimize the potential for human error. Some examples include electronic QAPI systems and auto-generated email reminders.

Evaluating the Strength of Corrective Actions

- Examples of intermediate and strong actions already in place:
 - Electronic behavior tracking systems which maintain a running analysis (charts, graphs, auto-coding) to provide QIDPs with easy to read, visual representations of behavior trends and the ability to directly plot changes to medication.

Electronic behavior tracking systems have also been implemented and are being utilized. Please be aware that some electronic systems, such as the behavior tracking system, currently use QIDPs to review raw data and enter the information which is not completely error-proof. However, it does eliminate the human error in basic math totaling, graphing, etc. Additionally, the provider is looking at expanding this basic system to include the auto-flag incidents that would require investigation, reporting or additional action. So not only are providers implementing strong systems, they are also thinking about natural progression (think of this like establishing primary and secondary needs in an individual's IPP).

Evaluating the Strength of Corrective Actions

- Examples of intermediate and strong actions being explored:
 - Electronic tracking systems which facilitate effective admission processes in order to improve placement outcome (safety, retention, etc.) and support the development of an accurate and effective initial plan of care.

Providers are also looking at implementing electronic systems for other areas such as admission and initial plans. Please understand these are just examples and electronic systems may not work for everyone. Ultimately, there is no one “right” way to develop corrective actions and improve facility systems. Facilities will need to do what works best for them.

Addressing Occurrences for Future Prevention

- Taking immediate action
 - Correcting hazards
- Implementing corrective action
- Monitor
- Re-assess the actions
 - Changing strategies if ineffective

Once corrective actions are identified, they need to be implemented, just like you would implement an individual's active treatment program. The action is implemented, monitored, re-assessed and adjusted as needed, again based on everyone's input.

Putting It All Together

- A facility-wide culture of safety improves individual safety and quality of life. **This is not reliant on one person. Systems must be strong enough to be sustainable despite changes in personnel and turnover.**
- The elemental components of a culture of safety are:
 - Open, non-judgmental, non-punitive communication between **all** people involved in the individuals' lives.
 - Clear expectations.
 - Comprehensive system of error/occurrence/near miss reporting.
 - Comprehensive investigation to get to the “root” of the problem.
 - Input regarding corrective actions sought from all involved people.
 - Continued monitoring and adjustments to ensure systems and corrective actions are effective.

A facility-wide culture of safety improves individual safety and quality of life. It is based on designing systems to minimize the risk of human error by giving everyone a voice and following the other elements listed on the slide. Please note, culture of safety is not dependent on one person. The culture and facility systems must be strong enough to be sustainable even when key staff leave.

Culture of Safety Questions for Governing Body Staff

- How do you ensure **open communication** with all individuals, staff and others?
- How are individuals and staff educated about and encouraged to **freely report** errors/occurrences/variances and "near misses/close calls" without fear of retribution?
- How are individuals encouraged to **freely voice** suggestions, concerns and complaints without fear of retaliation and how are their suggestions, concerns and complaints recorded and responded to?
- How are staff **encouraged to voice** concerns about, or ideas for, improvements in their work environment and how are their suggestions, concerns and complaints recorded and responded to?
- How do you **engage everyone** in improvement activities?

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As with most things, the facility's Governing Body is ultimately responsible for the operation of the facility. When looking at culture, there are a few questions to be asked as indicated on the slide. All of these really are geared toward improving the individuals' lives and lead to the ultimate question we should all be asking ourselves.

The Ultimate Question

What can I do to make it better?

Questions

- Please submit your questions, comments or suggestions to fsb@dhw.idaho.gov

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Should you have questions, comments or suggestions regarding this or other aspects of the ICF/ID program, please submit them to the Facility Standards email.

For More Information on Culture of Safety...

- Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network
<http://www.psnet.ahrq.gov>
- Veterans' Health Administration National Center for Patient Safety (VA/NCPS)
<http://www.patientsafety.gov/SafetyTopics.html>
- Institute for Healthcare Improvement (IHI)
<http://www.ihl.org>
- Health Research and Educational Trust (HRET)
<http://www.hret.org/quality/projects/patient-safety-leadership-walkrounds.shtm>
- The Joint Commission (TJC)
http://www.jointcommission.org/topics/patient_safety.aspx
- Duke University Medical Center
http://patientsafetied.duhs.duke.edu/module_e/swiss_cheese.html