ICF/IID Culture of Safety

Bureau of Facility Standards
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

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
Facility Culture

- 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
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
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
Human Factor: We All Make Mistakes

- Three 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.
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.)
Some At-Risk Behaviors in ICFs/IID

- 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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Some At-Risk Behaviors in ICFs/IID

– Staff is assigned to 2 individuals, John and Jill, on the a.m. shift and is also 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.
Some At-Risk Behaviors in ICFs/IID

- 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?
Some At-Risk Behaviors in ICFs/IID

- **WRONG.** It is not okay.
  
  - Deviating from the system placed all individuals at risk for medication errors.
Some At-Risk Behaviors in ICFs/IID

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

Swiss Cheese Model of Error:
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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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
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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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?
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
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.
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.
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
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.
“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.

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.
The Importance of Inclusion

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

- Chinese Proverb
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.
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.
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.
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.
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.
Addressing Occurrences for Future Prevention

– Taking immediate action
  • Correcting hazards

– Implementing corrective action

– Monitor

– Re-assess the actions
  • Changing strategies if ineffective
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.
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?
The Ultimate Question

What can I do to make it better?
For More Information on Culture of Safety...

- Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network  
  https://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.ihi.org
- Health Research and Educational Trust (HRET)  
- The Joint Commission (TJC)  
  http://www.jointcommission.org/topics/patient_safety.aspx
- National Center for Biotechnology Information  
Questions

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