HealthManagement.org
The Journal
LEADERSHIP • CROSS-COLLABORATION • WINNING PRACTICES
VOLUME 17 • ISSUE 5 • 2017 • € 22
ISSN = 1377-7629

Sustainability

- SUSTAINABILITY, *U. KHAN*
- INNOVATIVE PROCUREMENT, *G. WHYLES & S. AGGER GANASSI*
- SUSTAINABILITY AT HEART OF HEALTHCARE COMPLEX, *A. SPENCE*
- AWARD-WINNING COGEN FACILITY PROVIDES INDEPENDENT GREEN HOSPITAL POWER, *D. CORONADO*
- PUTTING HEALTHCARE FOOD WASTE IN THE SPOTLIGHT, *E. O'LEARY*
- EMBEDDING SUSTAINABILITY INTO MEDICAL EDUCATION, *E. FARROW*
- FUTURE-PROOFING HEALTH TO MEET SUSTAINABLE DEVELOPMENT GOALS, *S.HEWSON*
- TURNING BURNOUT INTO BRIGHT FUTURES, *D. HILMI*

Building a new culture of safety

Providing employees with the right environment and skills

Human factors such as authority gradients are important barriers to safety event reporting in healthcare and warrant implementation of specific countermeasures and cultural change.

Bettina Siewert

Vice Chair for Quality and Safety
Department of Radiology
Beth Israel Deaconess Medical Center

bsiewert@bidmc.harvard.edu

Introduction

Safety event reporting is the cornerstone of all quality assurance and improvement efforts. Electronic reporting into databases is possible for many systems issues, however many safety concerns have to be reported verbally in the moment when patient safety is at immediate risk.

It has been well established that verbal reporting of safety concerns is subject to significant barriers and therefore frequently does not occur. The rate of not speaking up about a safety event, once an issue has been identified, ranges from 40% in the airline industry (Wheale 1983) to 90% in the healthcare industry (Maxfield et al. 2005). The most recognised barrier is an authority gradient between staff working together. Additional human factors include fear of retribution, fear of disrespect, fear of a "toxic captain" (an individual that is difficult to work with), a high reporting threshold, understanding safety as everybody's responsibility, lack of listening, and lack of language training.

In its recent sentinel event alert (The Joint Commission Sentinel Event Alert 2017) The Joint Commission underscored the importance of a culture of safety where all staff can report safety events without fear of consequences and are actively recognised for bringing safety concerns to somebody's attention. This article discusses human factor barriers to safety event reporting and provides suggestions on how to overcome them.

Fear of the "Toxic Captain"

The toxic captain is defined as a person who creates an uncomfortable work environment, who sets a negative tone around them, does not appreciate the talent and skills of others, does not listen to feedback and is unable to collaborate. The term originated in the airline industry where it has been identified as a safety risk which also applies to healthcare.

Removal of this barrier requires organisational commitment to high standards of professionalism for all staff and developing systems for intervention and remediation. Encouragingly, work on professionalism has shown that behavioural change in individuals is possible sometimes with as little as a single conversation. Raising awareness about this issue has allowed 65% of staff to reverse their behaviour (Hickson et al. 2002).

Lack of language training

While lack of language training is often reported as a minor barrier acknowledged by 2-29% of staff to interfere with speaking up, it does play a major role in clinical practice. St. Pierre et al. showed that safety issues that can be solved by action not necessitating verbal interaction are much more likely to be addressed than those that require a verbal communication (St. Pierre et al. 2012). In addition, only a fraction of verbal communications (11%) are unambiguous and pursued, i.e. clarified or repeated until the receiver has fully understood and recognised the concern. Most verbal communications are vague, only hinting at the issue, or even though the problem is stated clearly, it is only brought up once and not pursued if the receiver does not react to the message.

This language barrier can be addressed with the development of five-step language scripts that facilitate unambiguous communication:

1. The communication is initiated by addressing a specific person directly by name
2. The sender then states the observation without value judgement
3. The sender states the concern that she/he has arising from this action
4. She/he continues by proposing a different action
5. She/he asks for the receiver's opinion

Understanding patient safety as a common responsibility

Approximately one third of frontline staff do not consider patient safety a part of their work assignments, and are under the impression that the attending physician staff solely carry the responsibility for this aspect of patient care. While there is no doubt that the attending physician is ultimately responsible for a patient's safety, it is important to recognise that physician attending staff as human beings are vulnerable

to distraction, information deficit, and misunderstandings. Therefore, physicians and other team leaders need support from everybody on the team to provide additional potentially important information.

Removal of this barrier requires explicitly making patient safety a responsibility shared by everybody. This new understanding could be included in the organisation's mission statement, code of conduct and performance evaluations. Recognising staff who have demonstrated exemplary efforts in this regard, raises the overall awareness for this important task.

> “APPROXIMATELY ONE THIRD OF FRONTLINE STAFF UNDERSTAND PATIENT SAFETY AS A RESPONSIBILITY OF THE ATTENDING PHYSICIAN”

Fear of retribution

This barrier is well recognised in the literature and has been reported as the cause for not speaking up in 70% of safety events occurring in the manufacturing industry (Ryan et al. 1998). Specific fears include fear of receiving less desirable work assignments, not being considered for promotion, not getting a good letter of recommendation, and fear of losing one's job.

Transparent processes have to be created to counteract these fears. Transparency around work assignments and vacation time requests will offset the human tendency to search for causal connections between events, that may not necessarily be related. Along similar lines, team leaders have to be aware of their own body language and tone of voice when answering to safety events being brought up. For example, a harsh tone or abrupt body language due to stress on the manager's part may be misinterpreted as “having done something wrong” or “having offended the team leader” which would reinforce concerns for retribution on part of the sender. Transparency about causes for the team leader’s response will help prevent misunderstandings and avoid mixed messages.

Lack of listening

This has been identified as a barrier by more than 50% of staff. Listening is a complicated part of the communication process that is divided into five different components (Devito 2016): receiving, understanding, remembering, evaluating, and responding. Interruptions can occur at any stage by distraction due to physical noise, inability to share one another's meaning, reconstructive memory, bias, prejudice and assumptions, and lack of immediate feedback.

Removal of this barrier may be possible by instituting a practice of active listening:

1. Listening to what is said,
2. Rephrasing what one has heard,
3. Asking questions for clarification and
4. Obtaining confirmation that what was understood is correct.

Fear of disrespect

Disrespect in the workplace has risen over the last decades from 25% in 1998 to 90% in 2015. The impact of disrespect on performance is dismal: staff who experience disrespect demonstrate a 61% decrease in performance and a 58% decrease in creativity. But not only does disrespect influence the person at whom it is directed, it also negatively influences all those who witness it, decreasing performance by 22% and creativity by 28%.

To create a respectful work environment, it may be helpful to specifically review respectful and disrespectful behaviours with all staff (Meshanko 2012) and include behaviours supporting a culture of respect in the organisational code of conduct. A powerful starting point in the journey towards building a more respectful work environment can be the simple practice of thanking staff for bringing a safety issue to the attention of team leaders. This expresses respect and reassures frontline staff that bringing up safety concerns is valued by team leaders.

Challenging authority

The concern to challenge somebody in authority is common ranging from 40% in the airline industry to 90% in healthcare. It is worthwhile considering where the perception of challenge originates: from the content of the message, the way the message is delivered or the beliefs of the sender/receiver? The content of the message should not contribute, it merely contains important information that the receiver may need and may be unaware of. The way the message is delivered may contribute, if the message is phrased in an accusatory or offensive fashion, pointing out that an error is about to be made or expressing doubt about the competency of the team leader. However, the sender’s and receiver’s beliefs likely contribute the most to a perception of challenge: the receiver may automatically perceive any safety issue that is brought up as a comment on her/his lack of competency and the sender may fear that her/his message would be misunderstood that way.

Therefore, cultural change is needed for everybody to understand the calling out of safety issues as a positive event that ensures the patient's safety and ultimately the success of the healthcare team. Team

leaders no longer need to perceive a challenge to their authority and senders no longer need to be afraid to be misunderstood.

Reporting threshold

Most staff only consider bringing up a safety concern when they are entirely sure that their observation is correct and that their concern is justified. Maybe this is not surprising in today's medical culture. Its high technical development offers treatment for many diseases that were previously considered incurable and patients' expectations are high. The fact that somebody "does not know something" is incongruent and therefore perceived as unacceptable. However, with the exponential growth of medical knowledge over the last decades, the expectation that health care staff/physicians are all knowing is unrealistic: medical knowledge currently doubles every three years and by 2020 is expected to double every 73 days.

> "DISRESPECT IN THE WORKPLACE HAS RISEN OVER THE LAST DECADES FROM 25% IN 1998 TO 90% IN 2015"

As a profession we have to come to a new cultural understanding, reassuring staff that it is acceptable not to know something, and encouraging a low reporting threshold with everybody sharing uncertain observations in order to improve patient safety.

Conclusion

Establishing a new culture of safety where all employees are enabled to speak up, requires providing employees with additional skills as well as changes in the work environment. Additional employee skills include learning to follow language scripts, active listening skills, and understanding safety as a responsibility shared by all. Cultural changes require creating a work environment based on mutual respect, instituting a non-hierarchical team structure in regards to safety and encouraging a low reporting threshold. ■

KEY POINTS

- ✓ 40-90% of employees' experience barriers to safety event reporting that keep them from speaking up about safety concerns
- ✓ The most common barriers to speaking up in healthcare are high reporting thresholds, authority gradients, and fear of disrespect
- ✓ Additional barriers include lack of listening, fear of retribution, not understanding safety as a responsibility shared by all, lack of language training, and fear of an individual creating an uncomfortable work environment ("toxic captain")
- ✓ Establishing a new culture of safety where all employees are enabled to speak up, requires providing employees with additional skills as well as changes in the work environment
- ✓ Additional employee skills include learning to follow language scripts for speaking up, active listening skills (particularly for team leaders), and understanding safety as a responsibility shared by all
- ✓ Cultural changes require creating a work environment based on mutual respect, instituting a non-hierarchical team structure in regards to safety and encouraging a low reporting threshold

REFERENCES

Wheale J. Crew co-ordination on the flight deck of commercial transport aircraft. Proceedings of the flight operations symposium. Dublin: Irish Air Line Pilot's Association/Aer Lingus, 1983

Maxfield D, Grenny J, McMillan R, Patterson K, Switzler A. Silence kills: the seven crucial conversations in health care. Provo,UT: VitalSmarts, 2005 available at http://www.silenttreatmentstudy.com

The Joint Commission Sentinel Event Alert. The essential role of leadership in developing a safety culture Issue 57, March 1, 2017

Hickson GB, Federspiel CF, Pichert JW et al. Patient complaints and malpractice risks. JAMA 2002;287:295-7

St.Pierre M, Scholler A, Strembski D, Breuer G. Do residents and nurses communicate safety relevant concerns? Simulation study on the influence of the authority gradient. Anaesthesist 2012;61:857

Ryan KD, Oestreich DK. Driving fear out of the workplace. Creating the high-trust, high performance organization. 1998 Jossey-Bass publishers, San Francisco

Joseph A. Devito. Listening in interpersonal communication in: Joseph A Devito. The interpersonal communication book, 14th edition. 2016 Pearson, pages 147-168

Paul Meshanko. The respect effect. Leveraging culture, emotions and neuroscience to build a better business. 2012, Dog ear publishing, Indianapolis, IL