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LETTER FROM THE LEADERSHIP

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I distinctly remember planning for one of my first employee counseling sessions as a new manager many years ago. OK, maybe eons ago. I called upon a mentor for advice and he asked me if my expectations were too high. It caused me to pause as I knew I had very high expectations. But if I lowered them, wouldn't it mean I would be accepting mediocrity?

Years later, the organization in which I work decided to adopt the "Virginia Mason Production System" based on the Toyota Production System and lean methodology. It struck a cord with me as one of the fundamental principles is "zero defects." One may ask if zero defects are possible, but consider a 99.9% error rate: a major airplane crash twice a week, a wrong surgery 500 times a week, 16,000 lost pieces of mail every hour, a wrong account deduction 22,000 times a day…you get the picture!

Are zero defects really possible, and if so, what does it take to get there? To help answer these questions, consider this: what if your spouse was given the wrong medication, or your mother had wrong site surgery? Zero defects are an imperative goal and an achievable one.

Whether you agree with that or not, you can't ignore that health care as a whole is at a critical juncture. The Institute of Medicine (IOM) estimates that 98,000 deaths happen in hospitals every year due to medical errors. It is estimated that 80 percent of medical errors are system-derived. (Frankel & Vega, 2004) The old ways of doing things won't work much longer, and the road ahead isn't entirely clear for anyone in the industry. External pressures for transparency, outcomes measurement and safety will only increase.

In its publication, *To Err is Human,* the IOM suggested that building a safer health system includes 1) a center for patient safety, 2) mandatory reporting, 3) performance standards and 4) a culture of safety. In focusing on the culture of safety, one must first define culture. Culture is pattern of shared beliefs and expectations that shape how individuals and groups act; or more simply stated, it's how we do things around

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here! (Sutcliffe and Weick, 2001) Unfortunately, health care has had a problem with the typical culture being one described with such negative terms as hierarchical, lack of trust, fear, victimization, frustration, anger, helplessness, hopelessness, resignation…the list goes on and on.

On a more positive note, "the safety culture of an organization is the product of individual and group values, attitudes, competencies, and patterns of behavior that determine the commitment to, and style and proficiency of, an organization's health and safety programs. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety and by confidence in the efficacy of preventive measures." (Reason, 1997)

Human factors researcher James Reason contends that a safety culture is an *informed culture*. An informed culture is "one in which those who manage and operate the system have current knowledge about the human, technical, organizational, and environmental factors that determine the safety of a system as a whole."

This is where the transparency comes into play. The best way to stay informed is to collect and share information about incidents, near misses, and the overall state of the system. Reason also contends that an *informed culture* requires four subcultures: 1) a *reporting culture* includes what is reported, willingness to report and how one is treated when reporting; 2) *just culture* is how blame is handled… encouraging and rewarding reporting, but knowing when to draw the line in defining unacceptable behavior; 3) *flexible culture* refers to the adaptability typically found in a flattened hierarchy when rank defers to expertise; and 4) *learning culture* is converting the lessons learned into usable and actionable information.

So how does one create a safety culture, a climate where people feel safe to question assumptions and to report problems candidly? The phrase *care and concern* comes form crisis researcher Nick Pidgeon's description of what it takes to create a good safety culture: "senior management's commitment to safety; shared concern for hazards and a solicitude over their impact on people; realistic and flexible norms and rules about hazards; and continual reflection upon practice through monitoring, analysis, and feedback systems." (Turner and Pidgeon)

It can seem a bit overwhelming, but it starts with a goal, a commitment to the patient with a major focus on creating a culture of safety through the following:

- Recognize and reward behaviors and activities that improve patient safety/ culture of safety.
- Recognize and reward reporting of errors and near misses (non-punitive response to reporting.)
- Increase executive leadership interactions with staff on patient safety issues.
- Enhance workforce knowledge about zero defects.
- Enhance skill set in communication of unanticipated outcomes.
- Increase the amount and quality of feedback to staff regarding changes made after incidents are reported.
- Ensure communication about and understanding of the organization's critical policies and implications for failure to comply.
- Implement processes that are convenient for broad staff participation.
- Engage patients and families.
- Identify a validated culture of safety survey instrument; monitor progress.
- Provide tools to assist managers and staff with the expectations for improvement.
- Report results throughout the organization with the goal of transparency.
- Create an audit/monitoring plan; report progress to the Board, executive leadership team and throughout the organization.

Specific practical examples of efforts I have been involved in that support building a culture of safety:

- Staff are expected to be "safety inspectors." To support and promote reporting potential defects, Virginia Mason Medical Center has developed a Patient Safety Alert System™.
- Have a patient safety brochure available that encourages patients and their families to be more involved in their health care and to also be "safety inspectors" by speaking up if something doesn't seem right or they don't understand what is happening.
- Openly share information with all staff about actual or potential defects in systems or behaviors that need to be corrected immediately.
- Conduct audits of critical safety processes to ensure that there is follow-through on a commitment to safety.
- Adopt "Executive Patient Safety Walk Rounds" in which staff are asked to call out safety concerns or near misses.
- Create an annual "Patient Safety Award" to recognize outstanding teamwork in making patient care safer.

We should be grateful that patients and families continue to trust us for their care. We need to work hard to be sure we are offering safe, high quality care; supporting a culture of safety will help us achieve that noble goal.

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