CHPSO
California Hospital Patient Safety Organization

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Introduction to Just Culture Webinar

A few phone lines are still available for a complimentary on-line session Oct. 8 from 9 AM–10 AM on "Just Culture," a system where both the hospital and staff share accountability for medical errors in a fair and just manner.

The Just Culture model is designed to help organizations place less focus on events, errors and outcomes, and more focus on risk, system design and management of behavioral choices. This introductory-level web seminar is designed to help organizations understand the benefits of a just culture and begin implementation.

The webinar speaker will be K. Scott Griffith, COO of Outcome Engineering, a Dallas-based risk-management firm specializing in helping high-consequence organizations worldwide improve operational and safety performance. Griffith has 25 years of experience at American Airlines as an international captain and managing director of corporate safety and quality evaluations. He also founded the Aviation Safety Action Partnership, a voluntary self-reporting and collaborative-improvement program for airline employees that fits within the Just Culture model and has set the standard for U.S. aviation safety.

The webinar is open to both CHPSO members and nonmembers. To register, send your name, e-mail address, title and organization to La Shon Tate at ltate@calhospital.org.

What Happens When Nothing Happens?

"No harm, no foul." Anyone who's ever played a pickup game of basketball knows this phrase well. Accidental contact that doesn't have an impact on a shot or ball control is forgiven; it never happened. Given the informal nature of the setting, there is no neutral third party assessing the incident; the outcome is largely secondary to the activity; and the stakes of an unfavorable outcome are trivial — it's an entirely appropriate system of justice.

But what if there is an organizational structure within which we're working? What if we can take an objective (re)view of the (non)event? What if the outcome is the primary goal of the activity? What if the outcome is non-trivial? These descriptors far more accurately describe the health care environment, and they are all sufficient reasons to eschew an outcome-based accountability model.

Outcome-based accountability is horribly unjust and, in the end, it actually guarantees that the organization will continue to suffer undesirable outcomes. If a physician is fully compliant with every protocol, algorithm, pathway, procedure, etc., does it really make sense to censure her because the patient developed a nosocomial infection? From an organizational perspective, wouldn't we learn more if we asked, "Why did this patient develop an infection when we did everything we're supposed to do?" Isn't this approach more likely to reveal weaknesses in our system?

The other problem with "no harm, no foul" is that this approach enables, sociologically, non-compliance with accepted best practices. This enabling creates an environment where the question is not "Will we have a sentinel event?" The question is "When and where will our next sentinel event be, and who will be involved?" I learned a wise response to deviance from best practices just last week. A nurse manager told me that when she becomes aware of non-compliant practices, she has the clinician handwrite a discussion about what they did, why they did it and what the consequences could have been.

This strategy is simple, yet sophisticated. Handwriting tasks the right side of the brain, the part of our brain that processes images, recognizes features and imagines. Put simply, the mechanics of writing instead of typing invoke visualization that allows the clinician to better understand what could have happened.

What happens when nothing happens is highly predictive of future outcomes. If your response is one of empathic curiosity and thoughtful teaching, you're more likely to improve the quality and safety of your patient-care processes.

— Steven Montague, Vice President, LifeWings, lifewings@verizon.net.

About This Newsletter

CHPSO Patient Safety News provides lessons learned from reviews of patient safety events and news of patient-safety activities in this state. We hope you will find it useful in your efforts to improve patient outcomes. This newsletter may be freely distributed in its original form. Copies of each newsletter are archived on the CHPSO website (www.chpso.org).

Teamwork in a Multicultural Society

On a foggy day in 2007, the Hong Kong-registered container ship *Cosco Busan* departed the Port of Oakland guided by a harbor pilot. The pilot became disoriented and directed the ship at the San Francisco-Oakland Bay Bridge support structure instead of the center channel. The impact and subsequent oil spill caused more than $70 million in damage and killed thousands of birds.

The National Transportation Safety Board's (NTSB) investigation found that the harbor pilot was severely impaired by prescription drugs, having purchased, within the prior month alone, seven different drugs that impair mental performance. There were several different events prior to the allision (collision between a moving vessel and a fixed structure) that made the ship's master uneasy about the pilot's competency.

But he did not question any of the pilot's actions even though the master remained responsible for the vessel's safe operation even when the pilot was aboard. Among the NTSB's conclusions was that "the interactions between the pilot and the master on the day of the allision were likely influenced by a disparity in experience between the pilot and the master in navigating the San Francisco Bay and by cultural differences that made the master reluctant to assert authority over the pilot."

Cultures vary not only between nations, as in this example, but also within countries; even within the same region. Cultures can differ in value systems, behavior and communication styles.

Multiculturalism is a hallmark of American society, and an important component of a successful health care organization. Care team cultural diversity is normal and expected. Understanding how to operate safely in this setting is important.

A recent paper by Barry Strauch of the NTSB describes the issues faced in complex "sociotechnical systems" — systems that require teams of skilled people and complex technology to succeed. Team members' social skills, including the ability to understand and work with cultural differences, are an important factor in the success of the team.

While there are many different dimensions to cultural differences, several, including reasoning and relationship styles, are of particular importance to team work in complex systems, such as:

- Power distance: acceptance of authority and status inequality in the group
- Individualism-collectivism: acceptance of group goals over personal goals
- Uncertainty avoidance: tolerance of ambiguity and lack of structure
- Conflict avoidance: seeking compromises versus identifying the correct person in the conflict

When things go well, cultural differences rarely affect performance. In times of stress, teamwork is more likely to break down. Team errors, including disruptive behavior, communication lapses and failure to respond to others' errors, will then be more likely if team members are unskilled at working in a multicultural environment.

While there still is much to learn about effective multicultural teams, certain factors are known to improve team performance, including good social skills, cultural sensitivity training, team training, and team longevity.

— Rory Jaffe, MD MBA rjaffe@calhospital.org

Reference

Strauch B. Can Cultural Differences Lead to Accidents? Team Cultural Differences and Sociotechnical System Operations. *Human Factors*: *The Journal of the Human Factors and Ergonomics Society*. 2010;52(2):246-263.

Medication Storage Safeguards

A recent Pennsylvania Patient Safety Authority advisory highlighted the role that pharmacy and patient care area storage practices have in medication errors. Their recommendations for pharmacies include:

- Remove and discard unnecessary hazardous bulk chemicals from the chemical/compounding storage area, particularly those that have not been used within the last 6 to 12 months. Ensure permanent, secure labeling of hazardous chemicals. Apply large cautionary labels to products as appropriate (e.g.,"MUST BE DILUTED," "FOR COMPOUNDING USE ONLY").
- Segregate those chemicals currently used for compounding, and continue

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to store them in a fully sequestered section of the pharmacy.

- Segregate and store electrolytes for IV compounding together in one location: the IV preparation area.

- Store sterile water bags away from medication supplies. Never allow IV compounding products to leave the pharmacy's sterile compounding area. Segregate these solutions, and store them with warnings to not distribute them outside the pharmacy.

- Sequester and affix warning labels to vials of neuromuscular blocking agents stocked in the pharmacy. Be sure the warning labels do not obscure the vial label in any way.

- Maximize the pharmacy's ability to provide patient-specific unit-dose solid and liquid medications (either commercially obtained or prepared by the pharmacy) throughout the institution.

- Ensure that all medications are stored in individual labeled bins within easy access (and visualization) for all staff.

- Investigate implementing technologies such as barcode on dispense in the pharmacy to reduce the risk of selecting the wrong medication from stock.

They also suggest that a pharmacist or pharmacy technician periodically review all storage areas in the organization, including the pharmacy and patient care areas (e.g., ED, radiology, OR, medication rooms) to identify potential storage issues.

Refer to the article for further recommendations and case discussions.

Calendar

The following upcoming events are still open for enrollment. For more information or to enroll, use the contacts listed below.

October

5: *BEACON*: Excel for Quality Improvement: Basics for Beginners. Fremont.

6: *BEACON*: Compass Series 2 of 4. South San Francisco.

6: *HASD&IC* (Hospital Association of San Diego & Imperial Counties): San Diego Patient Safety Council; Sepsis. San Diego.

7: *BEACON*: Practical Skills for Quality Improvement. Fremont.

8: *CHPSO*: Introduction to Just Culture Webinar. 9 AM–10 AM.

19: *CHPSO*: Just Culture Support Call. 11 AM–noon.

26: *BEACON*: Quarterly Meeting. Fremont.

November

9: *BEACON*: Compass Series 3 of 4. Redwood City.

16: *CHPSO*: Just Culture Support Call. 11 AM–noon.

16: *SCPSC* (Southern California Patient Safety Collaborative): Track I: Surgical Care Improvement Project, Sepsis, Hospital-Acquired Infections in the ICU Setting. City of Industry.

19: *BEACON*: Practical Skills for Quality Improvement. Fremont.

December

2: *SCPSC*: Track II: Pressure Ulcers. City of Industry.

3: *CAPSAC*: California Patient Safety Action Coalition Meeting. Torrance.

15: *HASD&IC*: San Diego Patient Safety Council; Sepsis. San Diego.

15: *BEACON*: Compass Series 4 of 4. South San Francisco.

16: *BEACON*: Practical Skills for Quality Improvement. Redwood City.

21: *CHPSO*: Just Culture Support Call. 11 AM–noon.

For further information on these events:

BEACON: Petrina Aiello paiello@hospitalcouncil.net or www.beaconcollaborative.org

CAPSAC: Theresa Frei FreiTH@sutterhealth.org or www.capsac.org

CHPSO: Rory Jaffe rjaffe@calhospital.org

HASD&IC: Lindsey Wade lwade@hasdic.org

SCPSC: Catherine Carson ccarson@hasc.org

Patient Safety Tidbit

71 percent of surveyed hospital staff felt that disruptive behaviors were linked to medical errors. 27 percent felt that disruptive behaviors were linked to patient mortality.

Rosenstein AH, O'Daniel M. *Jt Comm J Qual Patient Saf*. 2008:34;464-471.

Articles Welcome

Submit articles to rjaffe@calhospital.org. Typical length is 400–600 words.