

## Culture is Imperative

On March 23, 2005, a fire and explosion occurred at BP's refinery in Texas City, Texas, killing 15 workers and injuring more than 170 others. A multitude of equipment failures and human decisions contributed to the disaster. To date, BP's fines and victim compensation expenses are over \$1.7 billion.

One year after the event, BP's Senior Group Vice President, Safety & Operations, addressed the Second Global Congress on Process Safety.

His concerns and recommendations apply to health care as strongly as they do to oil refining. Lack of a robust safety culture and inappropriate focus on narrow measures each results in management being unable to properly assess organizational safety.

Many organizations struggle with the very same issues he describes below and are susceptible to the same unpleasant surprise that BP experienced.

### Take-home messages

- A robust safety culture is an organization's primary defense against bad events. All underlying causes discussed below and all but one of the lessons learned are related to organizational culture.
- Organizational safety measures need to assess overall organizational safety, with the ability to drill down to the overall safety of specific units. Good performance on specific measures, while valuable for addressing a specific problem, may miss big issues. Specific

successes may create a false sense of accomplishment.

### Excerpt from John Mogford's speech:

If this was March 22<sup>nd</sup> 2005 — the day before the explosion — and I was standing here addressing this audience [at the First Global Congress on Process Safety], my remarks to you would have been much different. For a start, my confidence in the BP Group's safety culture, safety standards, safety management systems and safety audit programs would have been evident. I'd have pointed to some statistics — for example, how in the previous five years the company had reduced its OSHA recordable injury rate by almost 70 percent and its fatality rate by 75 percent. I'd have argued that this positive trend reflected a concerted, systematic approach to safety. ... I can only speak for myself but I was shocked by the Texas City explosion. It seemed so out of character with what I believed was BP's prevailing safety culture. It was hard to understand how such an incident could have happened. ...

In the end we identified five main underlying causes:

- Firstly, over the years the working environment had eroded to one characterized by resistance to change and lack of trust, motivation and purpose. Expectations around supervisory and management behavior were unclear. Rules were not followed consistently. Individuals felt disempowered from suggesting or initiating improvements.
- Secondly, process safety, operations performance and systematic risk

reduction priorities had not been set nor consistently reinforced by management. Safety lessons from other parts of BP were not acted on.

- Thirdly, many changes in a complex organization — both of structure and personnel — led to a lack of clear accountabilities and poor communication. The result was workforce confusion over roles, responsibilities and priorities.
- The fourth cause focused on poor hazard awareness and understanding of process safety on the site — resulting in people accepting higher levels of risk.
- And finally, poor performance management and vertical communication in the refinery meant there was no adequate early warning system of problems and no independent means of understanding the deteriorating standards in the plant through thorough audit of the organization.

And to answer one of the questions I posed just now: many of the safety changes brought in during the previous three years at the refinery with hindsight look incomplete. I think the changes were real and did have impact. ... The problem was that they weren't looking at the whole picture, addressing the whole problem ... a kind of tunnel vision. ...

With an incident of this scale, the lessons learned are almost endless. But at the facility level seven stand out:

- The need to ensure plant leadership teams ... focus on day-to-day operations ...

- The need to capture the right metrics that indicate [critical] safety trends; do not get seduced by [other] measures, they have their place but do not warn of incidents such as this one.
- Procedures are ineffective if they are not up-to-date and routinely followed.
- The importance of two-way communication. If people believe leaders aren't listening or don't appear to be taking team members' concerns seriously, then soon they stop raising them. We must keep our promises to each other. It's the first step in rebuilding trust and the only way to earn the respect and obtain the commitment of the workforce. This is about staying in touch, being aware, being responsible and listening.
- The importance of investigating [seemingly minor] incidents ... the same way serious injuries are investigated.
- The value of having an effective feedback loop to capture and incorporate into operating procedures and training programs lessons learned from earlier incidents ...
- And lastly, [prospectively evaluate changes in dangerous areas for unexpected hazards needing mitigation].

... Texas City was a preventable accident but our lessons could help prevent others from falling into the same traps. ... Please learn from our mistakes.

— Rory Jaffe, MD MBA, [rjaffe@calhospital.org](mailto:rjaffe@calhospital.org)

## Reference

Mogford J. [The Texas City Refinery Explosion: The Lessons Learned.](#)

## Just Culture and CRM

Launching Crew Resource Management (CRM) training can help smooth the path toward a just culture. That's because CRM builds the behaviors and attitudes that increase patient safety. By learning about and practicing essential CRM and other human factor skills — which encourage safe behavior and reduce error — teams operate more effectively and efficiently in any safety culture. CRM strengthens this culture by helping you and your team:

- Assertively speak up about your errors, share what you've learned about them, and actively listen to other team members as they speak up about theirs.
  - Standardize your communication through critical language and assertion, closed-loop and SBAR (Situation-Background-Assessment-Recommendation) models, which improve understanding within the team.
  - Apply situational awareness to monitor behavior and performance, call attention to "red flags" and potential errors, and continually reassess how systems and the work environment can be improved.
  - Practice collaborative decision-making whenever possible and accept responsibility for all decisions that you and your team make.
  - Use team briefings to establish a shared mental model about what to expect about a task, what your role is, and how to plan for contingencies.
- Design team debriefings as learning and peer-to-peer coaching experiences on what went well (and not so well), what resources were required, and how to improve performance.
  - Manage and resolve conflicts swiftly so they don't affect teamwork or contribute to error.
  - Handle stress and fatigue properly so that they don't affect your shared focus or cause you to make unintentional errors.
  - Report disruptive behavior before it can result in intimidation or errors caused by negligence, recklessness or knowing violation.
  - Practice leadership skills to promote accountability and collaboration, facilitate mentoring to address and change risky behavior, and emphasize the importance of learning.
  - Perform with flexibility and adaptability when a system or procedure must change to ensure safety.

— David A. Marshall, President and CEO, [Safer Healthcare](http://SaferHealthcare.com), [dmarshall@saferhealthcare.com](mailto:dmarshall@saferhealthcare.com)

A pamphlet on Just Culture is available free of charge to CHPSO members upon request. Contact [info@saferhealthcare.com](mailto:info@saferhealthcare.com) to request a free copy.

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Questions or comments: Rory Jaffe, MD MBA [rjaffe@calhospital.org](mailto:rjaffe@calhospital.org)  
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## Medical Error Nurse Suicide

Information for this case was obtained from newspaper accounts. See references for details.

### Case

A 10-fold overdose of calcium chloride contributed to the death of an infant on September 19<sup>th</sup> of last year. According to the family, a nurse accidentally miscalculated the dose. After an investigation, the hospital changed its policy to allow only pharmacists and anesthesiologists to access calcium chloride in non-emergency situations.

Additionally, the nurse, Kimberly Hiatt, who had worked at that hospital for 27 years, was fired. The state nursing board placed her on probation. Ms Hiatt was unable to find another nursing job despite many job applications and inquiries. She took on some construction work.

Hiatt's mother commented: "It broke her heart when she was dismissed ... She cried for two solid weeks. Not just that she lost her job, but that she lost a child. ... [The hospital] had a baby that died. It was the result of a human error. They have to do something. But to me, there were other alternatives than firing someone who had been a good, faithful nurse, and did not have a record as a sloppy nurse."

The hospital and Hiatt entered into a confidential settlement in the aftermath of the firing. It is not clear what the settlement was. The hospital would not provide details and Hiatt's relatives are bound by a nondisclosure agreement.

Ms. Hiatt committed suicide April 3<sup>rd</sup>. Hundreds attended her funeral, including children she had cared for and their families.

### Commentary

Even when a patient dies from medical error, the employment response should be based upon the mechanism of error, not the severity of the outcome.

We do not have the information the hospital and nursing board used to make their decisions. An investigation into an individual's culpability should include questions such as: Was the individual knowingly impaired? Did the individual consciously decide to engage in an unsafe act? Did the caregiver make a mistake that individuals of similar and training would be likely to make under the same circumstances? Does the individual have a history of unsafe acts?

Many errors are not due to recklessness or substandard work, but are the normal slips and lapses that humans always have. And the caregiver is often significantly affected by the error as well. As Dennis Quaid stated in the wake of his twins' receiving heparin overdoses, "I don't blame any of the nurses ... human error occurs. If I make a mistake in my business, I get a take two. They don't. And when a mistake occurs, they need help as much as the victims as well, because they're traumatized by it."

Any large institution will occasionally find that an employee is unsuitable and will need to fire him. However, in most cases it is the system, not the employee, that failed the patient. In those cases, the system needs fixing, and the employee needs consolation and emotional support. In some cases, where the behavior was not reckless but showed drift outside of safe boundaries without the recognition that the behavior was unsafe, coaching may be useful as well.

Disciplining an employee for a human error does not make a hospital safer, as it does not address the risk for recurrence.

Conversely, the discipline may result in reduced ability of the hospital to know of and learn from employees' mistakes, resulting in missed opportunities to increase patient safety.

— Rory Jaffe, MD MBA, [rjaffe@calhospital.org](mailto:rjaffe@calhospital.org)

### References

Kalb C, Quaid D. [A father's quest](#). *Newsweek*. 4/13/2010.

Kang M. [Infant dies of accidental overdose at Children's Hospital](#). *KOMO News*. 9/30/2010.

Ostrom CM. [Nurse's suicide follows tragedy](#). *Seattle Times*. 4/21/2011.

## Peer Review and Patient Safety Privilege Call

The Patient Safety Work Product Privilege, a major benefit of working with a PSO, provides strong protections yet allows institutions to broadly share information to benefit patient safety. However, Patient Safety Work Product cannot be used in medical staff disciplinary hearings in California.

There are approaches that can allow both the patient safety and the medical staff discipline processes to proceed effectively. On May 18, 8 AM, CHPSO will be hosting a members-only call to discuss the legal implications and potential solutions. Ann O'Connell of Nossaman LLP will be our special guest. Target audience: counsel.

Contact La Shon Tate ([ltate@calhospital.org](mailto:ltate@calhospital.org)) to sign up.

— Rory Jaffe, MD MBA, [rjaffe@calhospital.org](mailto:rjaffe@calhospital.org)

## 2011 Annual CHPSO Meeting Planning

We are planning to hold a 2011 Annual CHPSO meeting late summer or early fall and are putting out a call for nominations be on the planning committee. If you are interested in participating please send your name and contact information to Bobbie Dietz, CHPSO Director Quality and Patient Safety, at [bdietz@calhospital.org](mailto:bdietz@calhospital.org) by May 18<sup>th</sup>.

The purpose of the planning committee will be to advise on meeting goals, speakers and to draft topics for the agenda. The planning committee will perform this work through a series of 3–4 one-hour conference calls during the next few months. In order to facilitate the annual meeting goals and agenda topics, sub-committee workgroups may be developed.

The first conference call with the planning committee will be the week of May 23<sup>rd</sup>. Once we have identified the committee members, Bobbie will contact them to determine which day/time would work best with their schedule for the first conference call.

— Bobbie Dietz, MHS, Director Quality and Patient Safety, CHPSO, [bdietz@calhospital.org](mailto:bdietz@calhospital.org)

## CHPSO Member Calls

Starting in June, the name of the monthly CHPSO calls will change from Just Culture Support Call to CHPSO Members Call. On these calls, we will be addressing both the Just Culture initiative and other topics. The schedule will remain the same: second Tuesday every month from 10–11 AM.

Due to a scheduling conflict with a national meeting, the May 9<sup>th</sup> Just Culture Support call is being rescheduled

to May 16<sup>th</sup> 10–11 AM. The presentation will be “Introduction to Just Culture.” Handouts are available at [www.chpso.org/present/20110516.pdf](http://www.chpso.org/present/20110516.pdf).

The June CHPSO Members Call will focus on the kickoff of a retained surgical items event analysis initiative.

We are assessing the Just Culture initiative in an effort to better serve our hospitals’ needs. A Just Culture Road Map that aims to assist all California hospitals is being developed. A draft of the Just Culture Road Map will be presented for member discussion on the July CHPSO Members Call.

— Bobbie Dietz, MHS, Director Quality and Patient Safety, CHPSO, [bdietz@calhospital.org](mailto:bdietz@calhospital.org)

## Pooling Experience: Retained Foreign Bodies

Starting in June, CHPSO members will be able to participate in an evaluation of retained foreign body (RFB) incidents. The purpose of this initiative is to assist hospitals in their root cause analysis process and help CHPSO identify common underlying causes of RFBs, particularly broken devices and fragments.

A conference call is scheduled on Thursday, May 20 2–3 PM to review pilot project results on data collection for RFBs and to ask for comments on the RFB incident data collection tool. Your comments on the data collection tool will be used to finalize the tool that will be launched on the June CHPSO Member Call.

If you would like to participate on the May call and provide feedback to finalize the data collection tool that you could use at your facility, please call in on May 20<sup>th</sup>.

May 20 2–3 PM  
Conference Dial-in: 712.432.3100  
Conference Code: 791488

— Bobbie Dietz, MHS, Director Quality and Patient Safety, CHPSO, [bdietz@calhospital.org](mailto:bdietz@calhospital.org)

## Calendar

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

### May

**10:** PSCSD&IC (Patient Safety Council of San Diego & Imperial Counties): Reduce Preventable Readmissions through Networking (PRN). San Diego.

**16:** (was May 9) CHPSO: Members Call. 10–11 AM

**18:** CHPSO: Peer Review and Patient Safety Privilege. 8–9 AM

**19:** PSCSD&IC: Ending Elective Deliveries Before 39 Weeks Gestation. San Diego.

**20:** CHPSO: Retained foreign bodies data collection tool evaluation. 2–3 PM

**24:** SCPSC (Southern California Patient Safety Collaborative): Perinatal Monthly Webinar. 12:15 PM

**24:** SCPSC: Track I — Hospital Acquired Infections in the ICU Setting, Sepsis and Surgical Care Improvement Project. Industry Hills.

### June

**13:** CHPSO: Members Call. 10–11 AM

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**17:** CAPSAC: California Patient Safety Action Coalition meeting. Pasadena.

**21:** PSCSD&IC: HAI Elimination. San Diego.

**21:** SCPSC: Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

**28:** PSCSD&IC: Standardizing Dosing Limits. San Diego.

**28:** SCPSC: Perinatal Monthly Webinar.  
12:15 PM

## July

**11:** CHPSO: Members Call. 10–11 AM

**13:** PSCSD&IC: Reduce Preventable Readmissions through Networking (PRN). San Diego.

**13:** SCPSC: Track III — Perinatal Care. Industry Hills.

## August

**8:** CHPSO: Members Call. 10–11 AM

**9:** SCPSC: Track I — Hospital Acquired Infections in the ICU Setting, Sepsis and Surgical Care Improvement Project. Industry Hills.

**16:** PSCSD&IC: HAI Elimination. San Diego.

**23:** SCPSC: Perinatal Monthly Webinar.  
12:15 PM

**24:** PSCSD&IC: Ending Elective Deliveries Before 39 Weeks Gestation. San Diego.

**30:** PSCSD&IC: Standardizing Dosing Limits. San Diego.

## September

**9:** CAPSAC: California Patient Safety Action Coalition meeting. Sacramento.

**12:** CHPSO: Members Call. 10–11 AM

**13:** SCPSC: Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

**14:** PSCSD&IC: Reduce Preventable Readmissions through Networking (PRN). San Diego.

**27:** SCPSC: Perinatal Monthly Webinar.  
12:15 PM

## October

**10:** CHPSO: Members Call. 10–11 AM

**18:** PSCSD&IC: HAI Elimination. San Diego.

**20:** PSCSD&IC: Standardizing Dosing Limits. San Diego.

**25:** SCPSC: Perinatal Monthly Webinar.  
12:15 PM

## November

**8:** SCPSC: Track I — Hospital Acquired Infections in the ICU Setting, Sepsis and Surgical Care Improvement Project. Industry Hills.

**9:** PSCSD&IC: Reduce Preventable Readmissions through Networking (PRN). San Diego.

**14:** CHPSO: Members Call. 10–11 AM

**15:** SCPSC: Track III — Perinatal Care. Industry Hills.

**15:** PSCSD&IC: Ending Elective Deliveries Before 39 Weeks Gestation. San Diego.

## December

**2:** CAPSAC: California Patient Safety Action Coalition meeting. Torrance.

**12:** CHPSO: Members Call. 10–11 AM

**13:** SCPSC: Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

**13:** PSCSD&IC: HAI Elimination. San Diego.

**15:** PSCSD&IC: Standardizing Dosing Limits. San Diego

*For further information on these events:*

CAPSAC: John Keats [John.Keats@CHW.edu](mailto:John.Keats@CHW.edu) or [www.capsac.org](http://www.capsac.org)

CHPSO: Rory Jaffe [rjaffe@calhospital.org](mailto:rjaffe@calhospital.org)

PSCSD&IC: Lindsey Wade [lwade@hasdic.org](mailto:lwade@hasdic.org)

SCPSC: Julia Slininger [jslininger@hasc.org](mailto:jslininger@hasc.org)

## 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](http://www.chpso.org)).

Prospective authors may submit articles to Rory Jaffe, MD, MBA: [rjaffe@calhospital.org](mailto:rjaffe@calhospital.org), 916.552.7568. Typical articles will be brief — between 200 and 600 words. A completed [publication agreement form](#) must be submitted prior to publication.