

**Culture Eats Strategy...
Engaging Physicians and Leaders to
Improve the Culture of Safety**

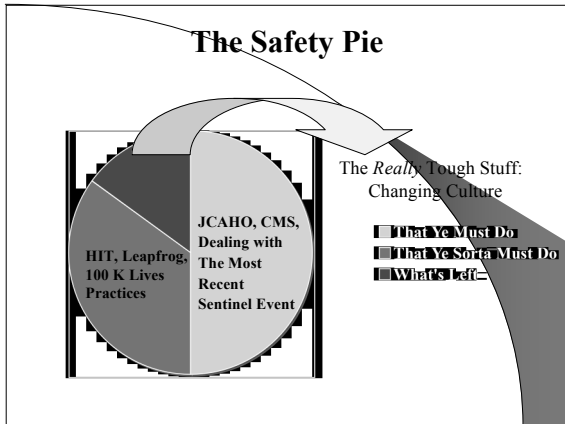
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**Culture:
The cry of men in face
of their destiny**



*Albert Camus
(1913-1960)*



Safety Culture: The Usual Questions

- Are errors reported?
- Is there a “systems focus”?
- Is there “no blame”?

Safety Culture: My Questions

- Are stories of errors turned into action?
- Are reasonable safety rules followed?
- Is there a “culture of low expectations”?
- How steep are the hierarchies?
- The extra credit question

The UCSF Patient Safety Fellows



Good Catch Campaign
Documenting patient care stories so that others can learn from them

- Have you been involved in a "near miss" where a patient was almost harmed?
- Do you know of a "good catch" where a colleague's thoughtful prevention averted a patient from harm?
- Do you have a patient care "story from the backlot" that your colleagues should know about?

If you answer either or answer questions for all the above, your stories need to be known to each other. The Patient Safety Program's "Good Catch Campaign" is designed to document patient care stories so that others can learn from your reports. Your stories help us to prevent future errors. Your Patient Safety Fellows will collect your stories and present them at each staff meeting. Your stories are essential to help your story so our patients can avoid the same mistake.

UCSF Medical Center | UCSF Children's Hospital

Safety Culture: My Questions

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Checklists and Other Systems



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QUALITY GRAND ROUNDS

Series Editors: Robert M. Wachter, MD, Kenneth C. Shojania, MD, Sanjay Saint, MD, MPH, Amy J. Markowitz, JD, and Mark Smith, MD, MBA

ACADEMIA AND CLINIC

The Wrong Patient

Mark R. Chassin, MD, MPP, MPH, and Elise C. Becher, MD, MA*

Among all types of medical errors, cases in which the wrong patient undergoes an invasive procedure are sufficiently distressing to warrant special attention. Nevertheless, institutions under-report such procedures, and the medical literature contains no discussions about them. This article examines the case of a patient who was mistakenly taken for another patient's invasive electrophysiology procedure. After reviewing the case and the results of the institution's “root-cause analysis,” the discussants discovered at least 17 distinct errors, no single one of which could have caused this adverse event by itself. The discussants illustrate how

these specific “active” errors interacted with a few underlying “latent conditions” (system weaknesses) to cause harm. The most remediable of these were absent or misused protocols for patient identification and informed consent, systematically faulty exchange of information among caregivers, and poorly functioning teams.

Ann Intern Med. 2002;136:826-833.
For author affiliations, see end of text.
See editorial comment on pp 850-852.
An expanded version of the text is available at www.ama-assn.org.

www.ama-assn.org

... at least 17 distinct errors, no single one of which could have caused the adverse event by itself.

The “Culture of Low Expectations”

“We suspect that these physicians and nurses had become accustomed to poor communication and teamwork. A ‘culture of low expectations’ developed in which participants came to expect a norm of faulty and incomplete exchange of information [which led them to conclude] that these red flags signified not unusual, worrisome harbingers but rather mundane repetitions of the poor communication to which they had become inured.”

Chassin and Becher
Ann Intern Med. 2002

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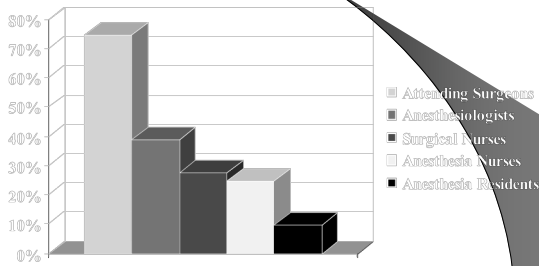
Tenerife, Canary Islands, 1977

On hearing this, the KLM flight engineer asked: “Is he not clear then?” The [KLM] captain didn’t understand him and [the engineer] repeated, “Is he not clear, that Pan American?” The captain replied with an emphatic, “Yes” and, *perhaps, influenced by his great prestige, making it difficult to imagine an error of this magnitude on the part of such an expert pilot*, both the co-pilot and flight engineer made no further objections.

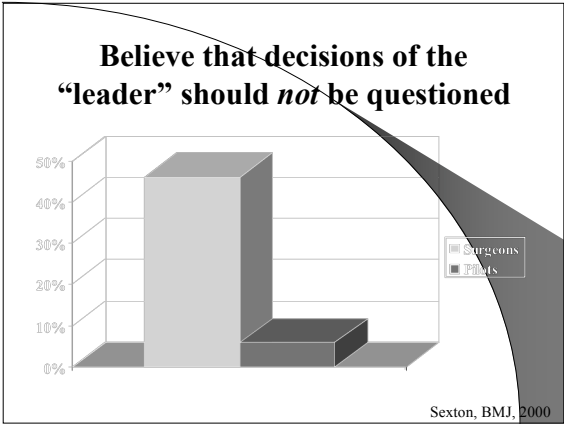


Official report of the Spanish Secretary of Civil Aviation on the Tenerife crash

Teamwork level felt to be “high”



Sexton, *BMJ*, 2000



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- Review of the Usual Questions**
- Are errors reported?
 - Who cares unless it leads to action?
 - Is there a “systems focus”?
 - Need to approach this broadly
 - Is there “no blame”?
 - Sometimes there *should* be blame

A Few Observations on What Works

- Teamwork training
 - Structure/Content/Personnel
 - Simulation?
- Executive Walk Rounds
- Adopt-a-Unit
- Other Strategies

A Few Observations on What *Doesn't* Work

- Emails from the CEO (though keep doing it)
- Mixing compliance with culture change
- Only stories
- No stories
- Only top down
- Only bottom up

When Everything Else is Fixed...





A Hypothetical Scenario

- Lowest person on the totem pole
- Something seems glitchy
- Head of CT or Neurosurgery
- He drives a Hummer
- He has a temper
- He's been known to throw things
- He's got good aim

The Extra Credit Scenario, cont.

She stops the presses, and it delays the first case in the OR...

and it turns out that everything was OK.

Here's the Question: What Happens to Her?

A) People whisper about her at the watercooler for the next few days

OR

B) The hospital CEO, CNO, or CMO (and the surgeon!) come by later that day to pat her on the back

