H AHA Team Training

The Thin Blue Line: Drifting Reliably Towards a Safety Culture

April 10, 2024



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- Audio for the webinar can be accessed in two ways: 1) through your computer speakers or 2) dialing in by phone – listen only mode
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- Create a Duke OneLink account. You only need to create an account once you may
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In support of improving patient care, the Duke University Health System Department of Clinical Education and Professional Development is accredited by the American Nurses Credentialing Center (ANCC), the Accreditation Council for Pharmacy Education (ACPE), and the Accreditation Council for Continuing Medical Education (ACCME), to provide continuing education for the health care team.





Upcoming Team Training Events

Courses

- o In-person TeamSTEPPS Master Training
 - o May 21-22 at Tulane, New Orleans, LA
 - o June 11-12 at the American Hospital Association, Chicago, IL
 - o July 15-16 at Northwell Health, New Hyde Park, NY
- o <u>Virtual</u> TeamSTEPPS Master Training from April 18-June 6

Webinars

- May 8, monthly webinar registration coming soon
- Are you interested in speaking on one of our monthly webinars? Check out our <u>speaker interest</u> form to submit your webinar proposal!



Advisory Services

Custom TeamSTEPPS Advisory Services at Your Organization

TeamSTEPPS Master Training Course

Using a train-the-trainer model, **we give you the foundational tools** and concepts, and train your staff through this **two-day training** program. You will gain a team of Master Trainers ready to teach others in your organization.

Comprehensive TeamSTEPPS Programs

We help you along the way. After delivery of the two-day Master Training course, we continue to work with your team for **3-6 months**, building the internal capacity to hardwire TeamSTEPPS throughout your organization.

Learn More »

Our relationship with the TeamSTEPPS faculty and the on-site trainings were both phenomenal. **They did a great job of meeting us where we were** and customized a program that really helped us gain clarity about the problem we're trying to solve.

Melissa Riffe-Guyer
 Executive Director,
 Culture Cone Health





Today's Presenters



Jason Cheng, DO Medical Director, Safety The Permanente Federation

Dept of Anesthesiology, Kaiser Permanente Downey Medical Center





Christopher LeMaster, MD MPH CPPS Director of Patient Safety The Permanente Medical Group

Diplomate of ABEM and ABPM (Clinical Informatics) Kaiser Permanente East Bay Oakland Medical Center

Objectives

Understand the difference between work-as-done and work-as-imagined, and why marrying these perspectives is a powerful way to help your organization succeed.

Operationalize frontline teams to engineer resilience Develop a dynamic understanding of drift that enables teams to acknowledge and move beyond blame towards a learning culture









Healthcare is complex and unsafe



Relying on people to be perfect isn't working



Focusing on human error makes people feel blamed







Our staff are not our problem. They are our problem solvers.

We can learn or we can blame but we can't do both.











React or Respond?













Human and Operational Performance

Chevron Oil Company







Error is normal

1.

Chevron Oil Company







$rac{1}{2}$. Blame fixes nothing

Chevron Oil Company









Systems drive behavior



The Black Line and the Blue Line



Workers = "Masters of the blue line"

























Let's check our

hindsight bias



Success











PSYCHOLOGICAL SAFETY IS A SHARED BELIEF AMONG A GROUP OF PEOPLE THAT IT IS SAFE TO TAKE EMOTIONAL RISKS

Openness explains mortality rates among 137 English National Health Service Acute Trusts

1-point increase in the standardized openness score was associated with a
6.48 percent reduction in hospital mortality rates.

Toffolutti and Stuckler, Health Affairs, 2019





1. Error is normal

Blame fixes nothing

Systems drive behavior

Learning is essential

How we respond matters








We can learn or we can blame but we can't do both.

Our staff are not our problem. They are our problem solvers.





1999, Institute of Medicine Report

2016, National Academy of Medicine



"I think that much of the work that we have done has not focused as much on the environment, but on individual programs and interventions still at the individual level, rather than the systems level. I fear that without a focus on the organizational level, we should only expect marginal gains going forward."









"After an arduous and expensive education process, you are expected to get it right; consequently errors and stigmatized and equated with incompetence"









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AND

BLAME

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Association^{**} Advancing Health in America

American Hospital

AND BLAME

ANESTHESIA



KEEP CALM

BLAME

AND BLAM

"We will see that blame is, in many respects, a subversion of the narrative fallacy; an oversimplification driven by biases in the human brain. We will see that it has subtle but measurable consequences, undermining our capacity to learn and to find resolve from the pain we create for others and ourselves. "





Figure. Components of Socio-Technical Healthcare Systems



Compilation of socio-technical models adapted from Vincent, Taylor-Adams and Stanhope; Carayon et al.¹⁰; Harrison, Koppel and Bar-Lev¹¹; and Sittig and Singh.¹²











Original Article | Open Access | Published: 28 April 2021 Modeling Rasmussen's dynamic modeling problem: drift towards a boundary of safety

J. Bradley Morrison 🖂 & Robert L. Wears

Cognition, Technology & Work 24, 127–145 (2022) Cite this article

3867 Accesses | 2 Citations | Metrics

Abstract

We build a system dynamics model based on a conceptual model originally proposed by safety scientist Jens Rasmussen to explore the dynamics of a safety system subject to pressures for performance improvement. Rasmussen described forces that generate a drift in the boundary of acceptable performance that can push the organization towards "flirting with the margin" and thus operate at very high risk of catastrophic safety failure. Simulations of the model faithfully replicate the behavior described by Rasmussen and others in a variety of scenarios. Simulation experiments further illuminate the potential for risky behavior and point towards some approaches to better system safety.

1 Introduction

The influence on organizational performance of various organizational or individual objectives that are not entirely aligned is a common theme that appears in many streams of the scholarly and practitioner literature. Analyses of safety breaches as witnessed in tragic examples such







Figure 4: Boundaries of safe operation (Rasmussen 1997)

From: Modeling Rasmussen's dynamic modeling problem: drift towards a boundary of safety













Seeing INSIDE the black box...

"The main question for a just culture is not about matching consequences with outcome. It is this: Did the assessments and actions of the professionals at the time make sense, given their knowledge, their goals, their attentional demands, their organizational context?"

- Sidney Dekker, Just Culture: Balancing Safety and Accountability



Thinking OUTSIDE the black box

"The question that drives safety work in a just culture is not who is responsible for failure, rather, it asks what is responsible for things going wrong. What is the set of engineered and organized circumstances that is responsible for putting people in a position where they end up doing things that go wrong?"

- Sidney Dekker, Just Culture: Balancing Safety and Accountability



Close Calls

Managing Risk and Resilience in Airline Flight Safety

Carl Macrae



Heinrich's pyramid illustrates the correlation between an increase in performing at-risk behaviors and an increase in minor to catastrophic injuries. Images courtesy of the author.





Safety Science Education curriculum planner: Reporting near misses and events

Safety outcome:

Employees report safety incidents, including near misses, using the relevant process. This planner systematically guides you through the steps to develop a curriculum that will achieve the safety outcome described on the left.

The planner can be used to develop comprehensive educational programs but could also serve as a source for more targeted needs, such as training to a policy related to reporting near misses and events.

No matter where you are in your education planning, use this planner to inform and guide your work. Use it to develop curriculum, determine gaps in your current program, or to assess whether employees have the knowledge and skills necessary for their role.

This flowchart provides a high-level overview of the process to use for completing Safety Science Education curriculum planners.

Step 1: Choose the outcome of interest (for this planner: Report safety incidents/events, including near misses, using the relevant process/procedure).

Step 2: Identify target learner audience and associated performance objectives.

Step 3: Review any current instructional activities and/or design new ones to teach the enabling knowledge and skills.

Step 4: Develop the learning program.



Managing in a Just Culture



Complete recommended Manager actions based on outcome of steps 1-4.

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How could this be used to assess where drift may be occurring? What about the underlying level of psychological safety to assess individuals awareness of their own risks?

Revised 08-2-2016





Understand that frontline teams are the best source of learning about variation and work culture

Drift is a dynamic function of working environment and acknowledging it can help move towards high reliability You can blame or you can learn, but you can't do both



Questions?





Final Reminders

Evaluation

 Please complete the evaluation form that appears on your screen once the webinar ends

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Questions? Stay in Touch!

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