Cultivating Psychological Safety and the Principles of High Reliability for Case Management Success

Case Management Society of New England
April 26th 2023

Objectives

- Identify barriers that inhibit the delivery of high quality care and healthy work environments
- Describe the history, definitions and prevalence of disruptive behaviors and strategies to address them
- Summarize research findings exploring the relationships among psychological safety, high reliability and safety reporting behaviors
- Discuss strategies to foster psychological safety, high reliability and successful case management practice

January 28th, 1986

Left to Right: Teacher-in-Space Christa McAuliffe and astronauts Gregory Jarvis, Judith Resnik, Mission Commander Dick Scobee, astronaut Ronald McNair, pilot Mike Smith, and astronaut Ellison Onizuka

The Challenger's Challenge

- Like aviation and aerospace engineering, health care is a high-risk industry
- Complex and unpredictable circumstances
- When under pressure, deviations and workarounds become normalized

Scan QR Code with Your Phone:

OR

Type the Link Below:

https://forms.gle/HELMh2S3LJ2FJcuV8

Polling and Reflection

Have you ever felt ridiculed, dismissed, judged, reprimanded or punished for asking a question, voicing a concern, sharing an idea or reporting a safety event/error?

Need for Connection

- Hard-wired to care about our connections with others
- Human evolution was dependent upon our inclusion in a community/group
- When our position in the group feels threatened (real or imagined) we redirect our energy toward risk management, pain avoidance and self-preservation (Clark, 2020).

Culture

- Experiences and environments shape our thoughts, feelings and behaviors
- Culture is a product of individual and group beliefs, values, attitudes, perceptions and patterns of behavior (Joint Commission, 2018)
- "Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared committed to safety and confidence in the efficacy of preventive measure" (Reason, 1997).

Caring

- All health care team members are required to create professional work environments that emphasize:
  - Civility
  - Respect
  - Dignity
- Caring is not limited to our patients and their families
- Need to care for:
  - Ourselves
  - Each other

Disruptive Behaviors (Bullying)

Repetitive offensive, abusive, intimidating, or insulting behaviors, or unfair sanctions from a person of higher position or power with the deliberate intent to cause psychological or physical harm. Recipients feel humiliated, vulnerable, or threatened, thus creating stress, and undermining their self-confidence.

Power

- Bullying requires a real or perceived power difference to exist between the perpetrator and the victim
- "The concept of power implies hierarchies in which some individuals possess more influence than others in a given situation" (Gibson, et al., 2014).

Behaviors

- Withholding information
- Excessive criticism
- Insults
- Shunning
- Unreasonable assignments
- Denied opportunities

Frequently "low grade"

Psychological Safety

Psychological Safety:

- View the workplace as supportive and secure
- Encouraged to share ideas
- Seek feedback
- Report mistakes
- Ask questions
- Constructive

Psychological Safety

- 1996, Edmondson explored how willing staff members were to discuss concerns, seek help and admit to mistakes
  - **High-functioning teams were not committing more errors—but were more willing to discuss them**
  - Unit climate significantly influenced an individual's perception of whether or not it was safe to discuss mistakes ($P<0.05$)

Group Reflection

- Have you ever felt ridiculed, dismissed, judged, reprimanded or punished for asking a question, voicing a concern, sharing an idea or reporting a safety event/error?
- Think about a time you felt nervous or hesitant to ask a question or share a concern/opinion. What factors influenced your decision?

Patient Deaths and Errors

- In 1999, The Institute of Medicine (IOM) published *To Err is Human: Building a Safer Health System*
- 44,000 to 98,000 Americans die annually due to medical errors
- Deaths are difficult to track and are underreported
- Number of U.S. deaths likely closer to 400,000

High Reliability Organizations (HROs)

- Organizations in high-risk industries are able to overcome challenges by focusing on 5 key principles
- All failures (including medical errors, near-misses) are seen as valuable learning opportunities

- A preoccupation with failure
- A reluctance to simplify
- A sensitivity to operations
- A commitment to resilience
- A deference to expertise

High Reliability Organizations (HROs)

Anticipation/Prevention

Principle 1: Preoccupation with Failure

- Expected to speak up for safety
- Continuously anticipating and monitoring for subtle signs of weakness or potential failure
- Serve as organizational watchdogs
- The reporting of near-misses is rewarded

High Reliability Organizations (HROs)

Principle 2: Reluctance to Simplify — Anticipation/Prevention

- Pay attention to detail
- Resist jumping to conclusions
- Recognize that our work is complex and high-risk
- Problems are solved by looking at the event from diverse viewpoints to develop a richer picture of the situation
- All specialties/disciplines have a seat at the decision-making table
- Encouraged to share differences of opinion
- Promote curiosity and "Questioning attitude"

High Reliability Organizations (HROs)

Principle 3: Sensitivity to Operations — Anticipation/Prevention

- Attention is paid to how the work **is** done rather than how the work **should** be done
- Recognize that workarounds are a symptom of an ineffective process
- Rather than try to force a protocol that isn't working, teams look at the "messy reality" of what actually happens in practice
- Committed to providing staff members with the resources and support necessary to optimally function during normal operations and during times of high-stress or strain.

High Reliability Organizations (HROs)

Principle 4: Commitment to Resilience — Resilience/Containment

- Focus on continuous learning and constructive feedback
- System failures and errors are seen as valuable opportunities to learn from
- Identifying additional supports and resources for similar events in the future
- Embrace an open and growth mindset
- Committed to knowledge acquisition, advancement, collaboration, effective communication and developing innovative approaches to complex problems

High Reliability Organizations (HROs)

Principle 5: Deference to Expertise **Resilience/Containment**

- All staff members, regardless of their background, experience or professional title are viewed as valuable and contributing members of the health care team
- When a problem arises, staff members with the most knowledge and experience working with similar situations are called upon regardless of their title or rank

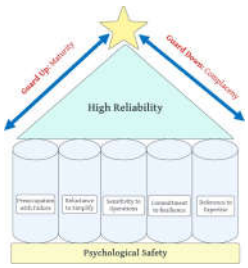
Relationships Among Psychological Safety, HRO Perception and Reporting Intentions

- Pediatric nurses with higher levels of psychological safety had higher safety event reporting intentions than nurses with lower levels of psychological safety ($p<0.01$)
- Pediatric nurses who perceive themselves as working in an HRO had higher safety event reporting intentions than nurses who did not perceive themselves to work in an HRO ($p<0.05$)

Relationships Among Psychological Safety, HRO Perception and Reporting Intentions

- 46% of participants discussed mistakes and ways to learn from them with colleagues
- 52% of participants spent time identifying activities that they did not want to go wrong
- 59% reflected that following an error, their team discussed ways to prevent similar events from happening again in the future

Strategies to Cultivate Psychological Safety in Case Management



- A key component for establishing high reliability involves establishing supportive and trusting relationships among colleagues
- Psychological Safety is the foundation

Cultivating Psychological Safety

- Quality of our interactions
- Familiarity among team members

(Clark, 2020)

Consistency

Contact **Context**

Strategies to Cultivate Psychological Safety

- **Build familiarity through engagement and regular contact**
  - Unit Rounding
  - Open-door policies
  - Discuss own mistakes
  - Informal and formal team events
  - Celebrate staff achievements

Strategies to Cultivate Psychological Safety

- **Quality of interactions**
  - Emphasize civility and accountability
  - Promote shared governance
  - Collect and review outcome and performance metrics
  - Establish transition support programs
  - Embracing vulnerability and own failures

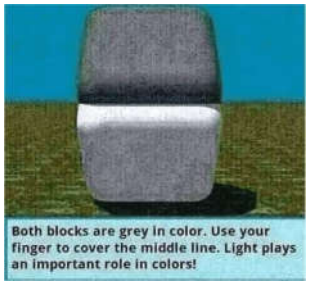
Shifting from A Blame Culture to High Reliability

- "Super Humans" → Unrealistic and unachievable expectation for perfection
- Errors typically occur from series of system lapses and multiple underlying factors
- In a blame culture, typically the last provider to touch the patient in the series of failures is faulted
- Many staff members work in environments where they are afraid to speak up about concerns and to report safety events

Growth Mindset

- Our skills and intelligence are not fixed and with effort and attention we can change/improve
- Learn from Constructive Feedback
- Embrace Challenges
- View mistakes as learning opportunities
- Committed to continuous learning

Perspective



Effective Communication

"Most people do not listen with the intent to understand; they listen with the intent to reply. They're either speaking or preparing to speak. They're filtering everything through their own paradigms, reading their autobiography into other people's lives." ~ Stephen Covey

Cultivating Psychological Safety and the Principles of High Reliability for Case Management Success

Q&A

Case Management Society of New England
April 26th 2023