Stop the Silo: Making the Most of Patient Safety Compliance Programs

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Health care organizations understand the importance of being a high reliability organization, Yet, patient safety models, such as Just Culture[1], often fall short if they are too focused on the clinical side of implementation. While clinical and compliance leaders may understand these patient safety models, such Safety Culture models likely will be ineffective when others in the organization (including executive leadership, human resources, and in-house counsel) do not.

The Joint Commission's Sentinel Event Alert #60—*Developing a reporting culture: learning from close calls* and hazardous conditions and Sentinel Event Alert #57—*The essential role of leadership in developing a safety culture* reiterate how shared accountability models only work when leadership fosters an environment where fear of negative consequences for reporting mistakes is removed from the equation. In this guidance, the Joint Commission identifies several components to a successful Safety Culture, including transparency, risk-based processes that drive decisions with respect to punitive actions, eradication of intimidating behaviors, communication by leadership to all staff about Safety Culture, training, and continued assessment of an organization's Safety Culture processes.

What does this guidance mean in reality from a health care employer perspective? It means that only those organizations who truly integrate Safety Culture throughout the entire organization will reap the benefits. Too often, only some clinical staff are trained on Safety Culture model compliance—leaving key stakeholders out of the loop. In other words, one hand of the organization is working to implement a Safety Culture but because the other hand does not understand what that means from an employment perspective, the model cannot reach its true potential.

Taking The Joint Commission's example, a pharmacy technician prepares a pediatric nutritional solution incorrectly, realizes this potentially serious error, reports the mistake and, using an objective accountability assessment tool, leadership determines that there are systemic reasons for the error. As a result, the reporting technician should be thanked with no resulting disciplinary action.

In reality, and what often happens is, human resources investigates the error, determines that the pharmacy technician received prior disciplinary action (albeit for other issues), and a front-line supervisor, along with human resources—neither of whom has been trained on Safety Culture models—decide that disciplinary action is appropriate. Other pharmacy technicians hear what happened to the pharmacy technician at issue and receive the message—self-reporting may result in adverse consequences. Any efforts elsewhere in the organization to create a Safety Culture are slowly rendered futile. None of this is to say that disciplinary action of this particular pharmacy technician is not appropriate but when these decisions are ultimately made without an understanding of the larger Safety Culture model in place, that is when the patient safety compliance suffers.

Here are five takeaways health care employers should know to get the most out of shared accountability patient safety models:

- Obtain executive leadership buy-in. Without all leadership (including non-clinical) understanding the Safety Culture methodology and what it means from an employee-relations perspective, shared accountability models cannot fully take root. This approach requires training and communication to in-house counsel, compliance, human resources, and other non-clinical leadership about what it means to be a high reliability organization and how the specific Safety Culture model is to be implemented. Leadership needs to communicate the organization's commitment to this model to employees and, importantly, continue to do so for any model to be successful.

- Front-line managers and human resources professionals need to understand how the Safety Culture model works and consistently put the model into practice. If individuals advising on employee relations matters don't understand (or consistently apply) the specific Safety Culture model used in an organization, it won't be successful.

- Pay attention to physician implementation. Physicians may require specific consideration—from both a supervision perspective and as an employee. Often, physicians don't consider themselves a "supervisor"

because they don't perform tasks often associated with supervision (e.g., performance reviews, disciplinary action, determining compensation). Yet, in the realm of patient safety and related compliance efforts, physicians are critical in creating a Safety Culture. Physicians are also highly impacted by Safety Culture models as employees, whether it be in the context of patient harm implicating a physician's action (or inaction) and/or through the peer review process. If an organization designates itself as a Just Culture employer but does not follow this model through in the physician peer review process, the organization may not be truly meeting its high reliability objectives.

- Focus on the additional benefits of creating a high reliability organization, especially when getting buy-in from non-clinical leadership. For instance, in addition to achieving the underlying goal of enhanced patient safety, truly successful Safety Cultures may lead to increased moral, physician and employee engagement, less turnover, positive public relations, and other tangible employee relations benefits. Critical to a Safety Culture is the term "Culture". Employee relations initiatives go hand-in-hand with these methodologies. Organizations that understand this intersection are going to see the results.
- Understand Safety Culture models' limits. There are countless benefits to implementing a Safety Culture, but health care employers who have implemented these measures understand there is often pushback and limitations to these concepts. Just Culture or related models' processes may lead to oversimplifying employee disciplinary decisions but it is not as easy as following a formula when dealing with people. Instead, an organization's Safety Culture model should be a framework for managers and employee relations professionals to then determine what resulting employment action may look like, as well provide a dialogue about potential systemic reasons for the resulting harm. Also, understand that the shift away from punitive measures in cases of patient harm takes time and that, sometimes, there are other factors at play in the analysis that may drive a different result. Ensuring that all individuals involved in these decisions are attuned to the Safety Culture model, while recognizing other operational or employment law realities, leads to a balanced approach that works.

Whether in the initial stages of creating a true Safety Culture or implementing a model for years, all health care organizations would benefit from a review of their practices across the organization to ensure that they are not falling into the silo trap. Remember, creating a Safety Culture takes time, consistency, and buy-in across an organization.

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1. Understanding that human errors will happen, the Just Culture concept is a shared accountability compliance model focused on analyzing adverse events, not from an outcome-driven lenses but, rather, using an evaluative tool focused on system design and individual employees' behavioral choices and accountability. Both are evaluated in determining whether instances of patient harm were caused by individual employees' behavioral choices or whether system design failure also contributed to the resulting human error, thereby, warranting system redesign as opposed to focusing purely on punitive action towards the individual.