

NATIONAL ACTION ALLIANCE
for Patient and Workforce Safety

Creating and Maintaining a Culture of Safety Series (Session 1)

Establishing Psychological Safety for Healthcare Workers

NATIONAL WEBINAR SERIES

February 18, 2025

Housekeeping Instructions

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

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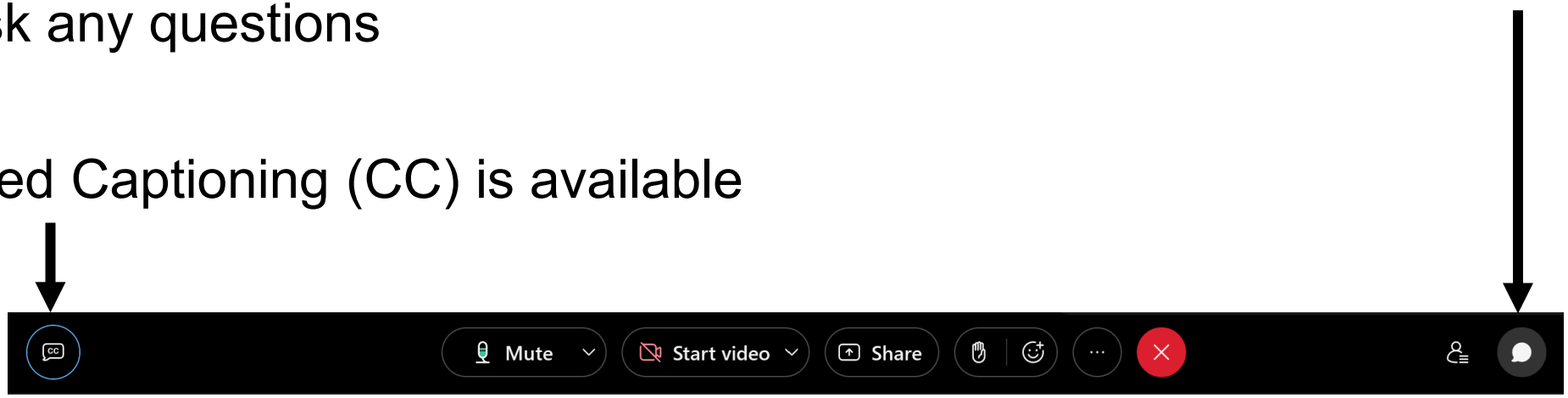

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

Thank You for Your Commitment To Advance Patient and Workforce Safety!

Creating and Maintaining a Culture of Safety Series

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

In the three-part webinar series (Feb–April ‘25), we will focus on—

1. **Establishing Psychological Safety for Healthcare Workers**
2. **Teamwork and Patient Safety Norms**
3. **Safety Culture: Measuring and Responding**

What is Culture?

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Simply – “The way we do things around here”

Culture eats strategy for lunch

Influencing Safety Culture

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ORIGINAL RESEARCH

Exposure to Leadership WalkRounds in neonatal intensive care units is associated with a better patient safety culture and less caregiver burnout

J Bryan Sexton,[1,2] Paul J Sharek,[3,4,5] Eric J Thomas,[6] Jeffrey B Gould,[3,4,7] Courtney C Nisbet,[3,4] Amber B Amspoker,[8,9] Mark A Kowalkowski,[8,9] René Schwendimann,[2,10] Jochen Profit[3,4,7]

For numbered affiliations see end of article.

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At the time of this research, Dr Profit was a faculty member at Baylor College of Medicine, in the Department of Pediatrics and conducted his research at the Houston Veterans Affairs (VA)

ABSTRACT

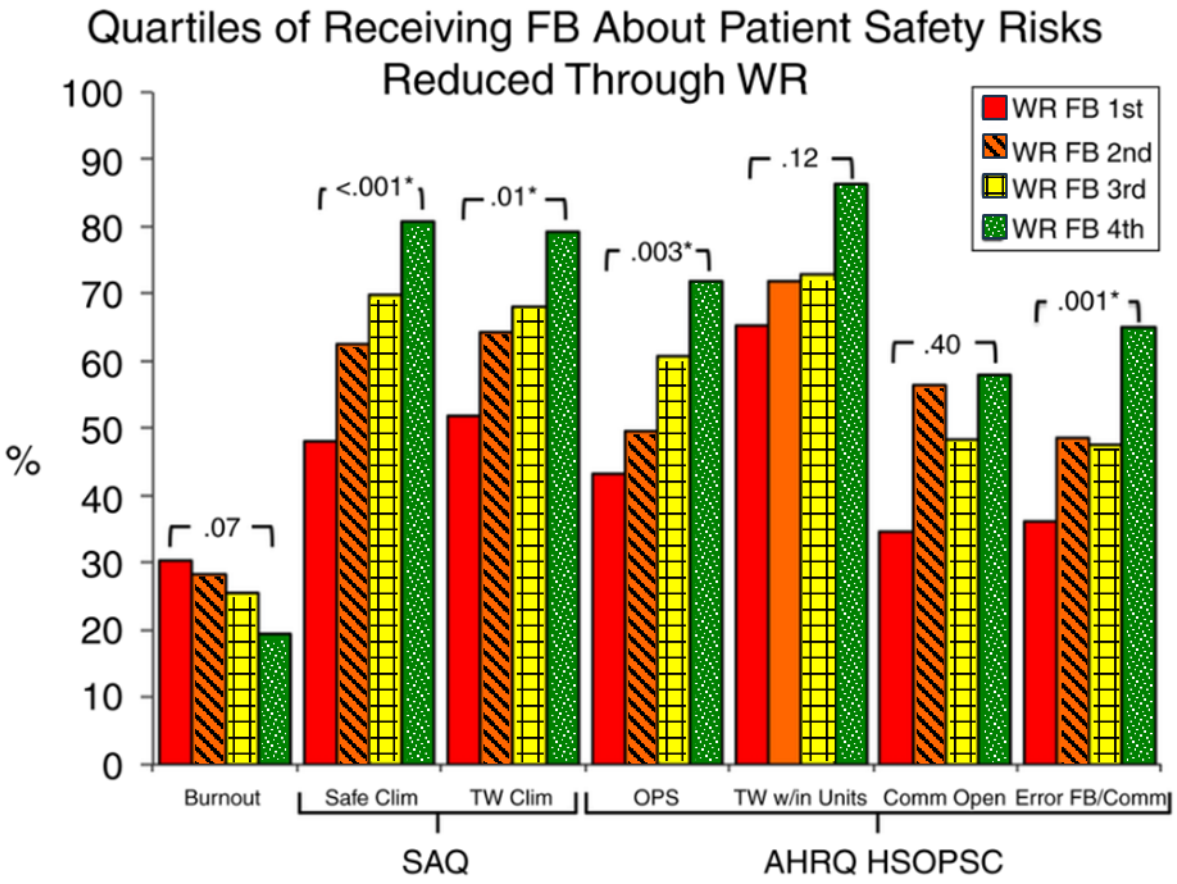
Background *Leadership WalkRounds (WR)* are widely used in healthcare organisations to improve patient safety. The relationship between WR and caregiver assessments of patient safety culture, and healthcare worker burnout is unknown.

Methods This cross-sectional survey study evaluated the association between receiving feedback about actions taken as a result of WR and healthcare worker assessments of patient safety culture and burnout across 44 neonatal intensive care units (NICUs) actively participating

as a tool to enhance patient safety in perinatal care.[2]

WR have enabled hospital leadership to sustain good relations with frontline caregivers, promote conversations to identify hazards and gather information to enhance decision making around patient safety.[3] To date, however, relatively little research has been conducted on WR, and the best practices and aims of WR continue to evolve.

Experiences of clinicians and executives indicate that WR help educate leadership



SCORE Survey Is an Actionable Metric for Determining Psychological Safety

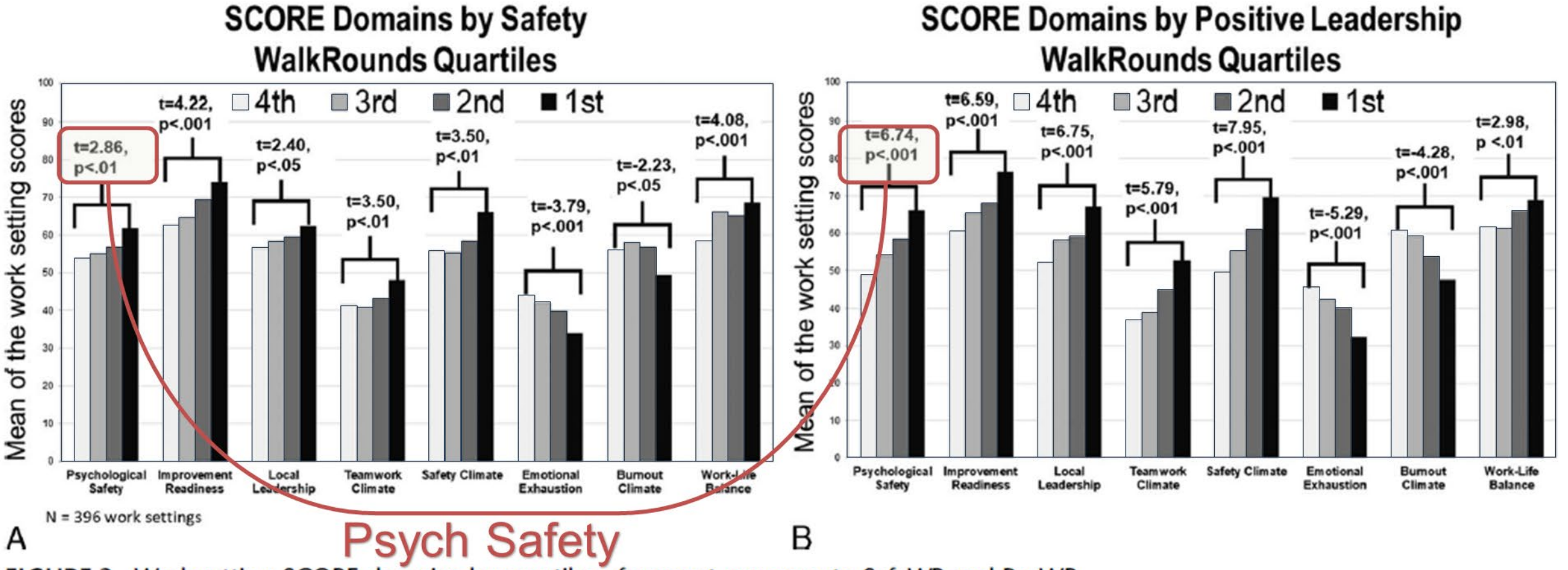


FIGURE 3. Work setting SCORE domains by quartiles of percent exposure to SafeWR and PosWR.

Adair et al. Journal of Patient Safety 18(6):p 513-520, September 2022.

Questions to Run On

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- **What specific strategies can be used to create and maintain psychological safety?**
- **What outcomes can be impacted by improving psychological safety?**

Speaker Welcome

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Tracy Gosselin, PhD, RN, AOCN, NEA-BC, FAAN

Memorial Sloan Kettering Cancer Center

Rounding with Purpose

Tracy Gosselin, PhD, RN, AOCN, NEA-BC, FAAN
Chief Nursing Officer, Senior Vice President, Enid A. Haupt Chair of Nursing

February 18, 2025

Memorial Sloan Kettering
Cancer Center

Leadership Rounds

Health care–associated infections

- Why: Reduction of health-care associated infections (HAI)
- Methods:
  - Setting: case study at large academic medical in the Midwest, 19 inpatient units with unit-level observations
  - Data collection: 22-unit level observations over 7 months, semi-structured key informant
  - Data analysis: structure of rounds, who attends, scheduled, location, infection data. Consolidated Framework for Implementation Research for leader rounding questions and for definitions and emergent themes.
- Results:
  - HAI leader rounds with executives led to engaged staff-staff members who were not afraid to discuss challenges on the unit
  - Reflecting and evaluating noted 161 times
  - 368 observed events of staff problem solving and 353 events when staff disclosed issues and problems related to HAIs

Knobloch MJ, et al. (2018). *Am J Infect Contro,* 46(3):303-310.

Positive Leadership WalkRounds

Safety culture and and workforce well-being

- Why: interventions are needed to decrease burnout and increase well-being in health care workers (HCW)
- Methods:
  - Cross-sectional survey of > 13,000 HCWs in an academic health system
  - Leader training on positive interactions and rounding
  - Part of a Safety, Communication, Operational Reliability, and Engagement (SCORE) survey
    - *"Do senior leaders ask for information about what is going well in this work setting (e.g., people who deserve special recognition for going above and beyond, celebration of successes, etc.)? (Yes; No; Not Sure)."*
- Results:
  - 81.5% response rate, predominately day shift
  - 63.1% reported exposure to Positive WalkRounds (PosWR) in their work setting
  - 1st quartile reported a higher % of good patient safety norms, good readiness to engage inf QI, good leadership accessibility and feedback behavior, good teamwork norms, and good work-life balance norms

Sexton B, et al. (2021). *Jt Comm J Qual Patient Saf*. 47(7): 403-411.

Framing up the Why

Ask yourself…

Creating and contributing to a culture of high reliability

Is there a Daily Management System

Psychological safety

Escalation, triage, and problem solving

Intent of Leadership Rounds

Purposeful

Relational

Engagement

Understanding

Listening > Talking

“About the people who care for the people…”

How and Where Do I Start

Making Space for What Matters

- Commitment
- Time
- Maturity of your culture and your system
- Understanding your comfort zone
- Areas/units
- Partnership

Some questions you may want to ask…

Has anyone seen these boots before?

- Do you have the supplies you need?
- Are you aware of any “near misses” in your area that could have caused harm?
- Do you and your colleagues report events when they occur?
- Can you share three things that are going well in your unit?
- What could we do as an organization to prevent the next X from happening?
- Do patients and families share safety concerns with you?
- What would make these rounds more effective?
- Anyone we should celebrate from your unit?
- Specific to something you are improving or interested in?
  - What obstacles are in your way from preventing central line infections?

Adapted from: Frankel A, et al. 2003. *Jt Comm J Qual Saf*, 29(1):16-26;
Sexton B, et al. (2021). *Jt Comm J Qual Patient Saf*. 47(7): 403-411.

What do I do with what I hear and learn?

- Document
- Analysis
- Trends
- Share
- Comparative review
- Inform future work

Next Steps

- Find other like-minded individuals
- Review the data, identify an area/s of concern
- Keep it simple to start
- Develop standard questions
- Think through your approach
- Determine your path forward

Resources to Get Started

Articles

- Foster M, et al. (2023). Impact of leadership walkrounds on operational, cultural and clinical outcomes: a systematic review. *BMJ Open Quality*, 12:e002284. doi:10.1136/ bmjoq-2023-002284
- Frankel A, et al. (2003). Patient safety leadership walkrounds. *Jt Comm J Qual Saf*, 29(1):16-26;
- Knobloch MJ, et al. (2018). Leadership rounds to reduce health care–associated infections. *Am J Infect Contro, 46*(3): 303-310.
- Murray J, et al. (2024). Leader rounding for high reliability and improved patient safety. *Fed Pract*, 41(1);16-21.
- Sexton B, et al. (2021). Safety culture and workforce well-being associations with positive leadership walkround. *Jt Comm J Qual Patient Saf*. 47(7): 403-411.

Websites

- https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapileadershiproundingtool.pdf
- https://www.ihi.org/resources/white-papers/ihi-framework-improving-joy-work

Speaker Welcome

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

Thomas Gallagher, MD, MACP
University of Washington

Responding to Harm Events in Healthcare: A Stress Test of Psychological Safety

Thomas H. Gallagher, MD, MACP
Professor and Associate Chair, Department of Medicine, University of Washington
Professor, Department of Bioethics and Humanities, University of Washington;
Executive Director, Collaborative for Accountability and Improvement

The PACT Collaborative

ARIADNE LABS | Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT | Institute *for* Healthcare Improvement

How Would You Respond?

You are a hospitalist and admit a 60-year-old unhoused patient with hemoptysis. Admission CT scan shows multiple lung masses consistent with metastatic lung cancer. You remember this patient from an admission 1 year ago for pancreatitis. An abdominal CT scan shortly before the patient left the hospital against medical advice commented on an incidental, suspicious mass in the left lung base. You mentioned this finding in your discharge summary, but it does not appear anyone followed up on it.

How likely are you to:

- Submit an incident report about what happened?
- Discuss the prior CT scan results with the patient?
- Reach out to the patient's PCP?

The Ultimate Stress Test for Psychological Safety

- Transparency is a pre-condition for patient safety*
- Clinicians involved in harm events face multiple challenging decisions
- A bidirectional relationship
  - The presence/absence of psychological safety within a culture of safety plays powerful role in how clinicians respond to harm events
  - Responding to harm events with accountability, transparency, and compassion reenforces psychological safety

*Credit: Julie Morath

Why Do We Struggle to Respond to Harm Events?

Human nature to want to keep problems to ourselves, to avoid difficult discussions

Fear of punitive consequences, shame/ embarrassment, lack of skills

Mixed messages from institutions/status quo

Lack of tools/different elements of response not integrated and hard-wired

What Is a CRP and Why Should You Care?

Communication and Resolution Program (CRP) is:

- Principled
- Comprehensive
- Systematic
- Compassionate

PACT Pathway to Accountability, Compassion, & Transparency

National Action Alliance to Advance Patient Safety

Safer Together Recommendation 9: Promote a culture of trust and respect for patients, families, and care partners

- Tactic 9b: Implement and maintain programs for providing appropriate ongoing support in the aftermath of harm.
- Tactic 9c: Institute communication and resolution programs for patients, families, and caregivers.

Safer Together Self-Assessment Tool

SCORE:	Unsure	0	1 – Beginning Must meet all Score 1 criteria	2 – Making Progress Must meet all Score 2 criteria	3 – Significant Impact Must meet all Score 2 and 3 criteria	4 – Exemplary Must meet all Score 2, 3, and 4 criteria	ROW SCORE	Optional Comment
5. Communication and Resolution Program (CRP)	Do not know or not aware of	Does not meet Score 1	☐ **General Approach:** Some departments use a communication and resolution approach to respond to patient safety events; however, there is not yet an organization-wide policy and practice and standard use of a program.	☐ **Organization-Wide:** The organization has made a commitment to and has implemented an organization-wide policy on the use of a CRP to ensure timely response to patient safety events. ☐ **Training:** Department staff are trained in the CRP policy and methods for appropriate and early response to patient safety events.	☐ **Evidence-Based:** The organization's CRP policy and program includes a set of proactive evidence-based best practice elements to achieve an amicable and fair resolution, including: • Harm event identification • Open and ongoing communication with patients and designated family caregivers about the harm event • Event investigation, prevention, and learning • Care for involved workforce team members • Financial and non-financial reconciliation • Patient and family caregiver engagement and ongoing support ☐ **Support Programs:** Support programs are developed and available for patients and family caregivers, clinicians, and staff who are impacted by safety events.	☐ **Monitor and Action:** The organization regularly monitors and evaluates data on CRP usage as well as feedback from involved patients and designated family caregivers on the approach and effectiveness of the CRP to identify trends and opportunities. Action plans are developed and monitored for resolution and continuous improvement. ☐ **Governing Body Report:** The governing body receives a report on key metrics, trends, learning, and actions from the CRP.		

Practical Tools and Resources

Measurement Tools:

- PACT Measurement Guide
- PACT Data Tracking Tool
- PACT Patient/Family Experience Measures
- PACT Provider Experience Measures

Communication Tools:

- PACT Patient and Family Communication Tip Sheet
- PACT Communication Coaching Guide
- Eliciting the Patient Narrative
- Sharing Event Review Findings with Patients and Families

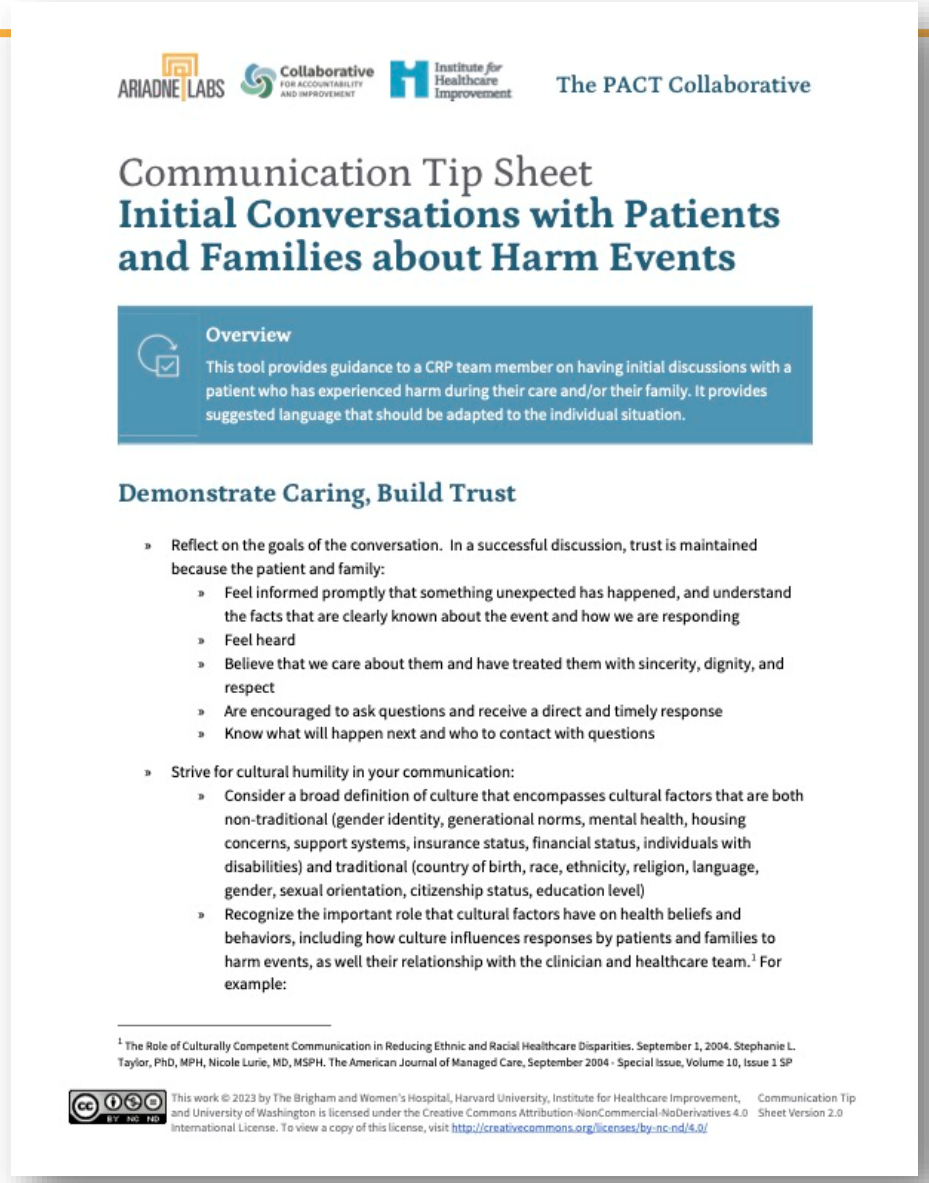
Process Tools

- Patient and Family Support Program Guide
- Patient and Family Peer Support Network (Betsy Lehman Center)
- Psychological Safety Tip Sheet
- Resolution Toolbox
- PACT Guide for CRP Policy
- PACT Harm Event Checklist

Tools for Patients and Families:

- PACT Patient and Family Brochure
- PACT Patient and Family Pathway

PACT Harm Communication Tip Sheet



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Communication Tip Sheet
Initial Conversations with Patients and Families about Harm Events

Overview

This tool provides guidance to a CRP team member on having initial discussions with a patient who has experienced harm during their care and/or their family. It provides suggested language that should be adapted to the individual situation.

Demonstrate Caring, Build Trust

- Reflect on the goals of the conversation. In a successful discussion, trust is maintained because the patient and family:
  - Feel informed promptly that something unexpected has happened, and understand the facts that are clearly known about the event and how we are responding
  - Feel heard
  - Believe that we care about them and have treated them with sincerity, dignity, and respect
  - Are encouraged to ask questions and receive a direct and timely response
  - Know what will happen next and who to contact with questions
- Strive for cultural humility in your communication:
  - Consider a broad definition of culture that encompasses cultural factors that are both non-traditional (gender identity, generational norms, mental health, housing concerns, support systems, insurance status, financial status, individuals with disabilities) and traditional (country of birth, race, ethnicity, religion, language, gender, sexual orientation, citizenship status, education level)
  - Recognize the important role that cultural factors have on health beliefs and behaviors, including how culture influences responses by patients and families to harm events, as well their relationship with the clinician and healthcare team.[1] For example:

[1] The Role of Culturally Competent Communication in Reducing Ethnic and Racial Healthcare Disparities. September 1, 2004. Stephanie L. Taylor, PhD, MPH, Nicole Lurie, MD, MSPH. The American Journal of Managed Care, September 2004 - Special Issue, Volume 10, Issue 1 SP

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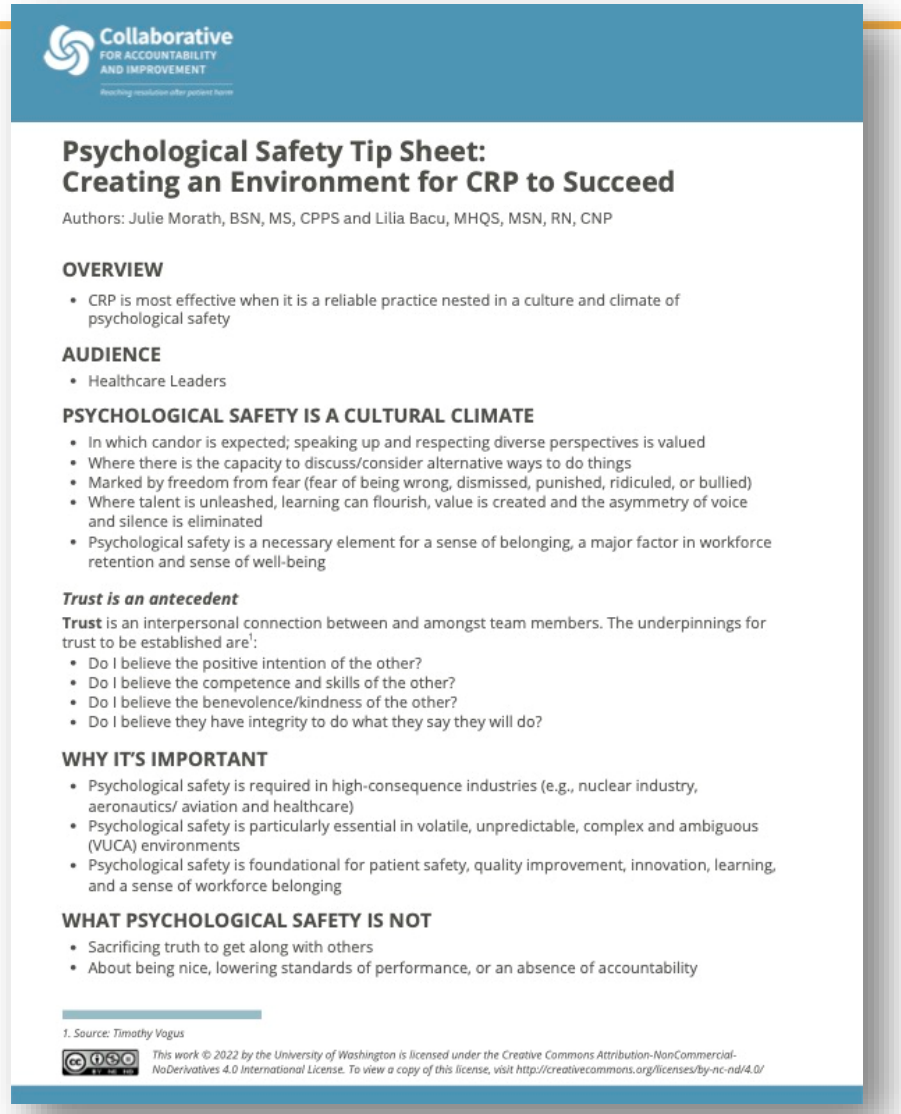
Psychological Safety Within CRPs



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

Reaching resolution after patient harm

Psychological Safety Tip Sheet: Creating an Environment for CRP to Succeed

Authors: Julie Morath, BSN, MS, CPPS and Lilia Bacu, MHQS, MSN, RN, CNP

OVERVIEW

- CRP is most effective when it is a reliable practice nested in a culture and climate of psychological safety

AUDIENCE

- Healthcare Leaders

PSYCHOLOGICAL SAFETY IS A CULTURAL CLIMATE

- In which candor is expected; speaking up and respecting diverse perspectives is valued
- Where there is the capacity to discuss/consider alternative ways to do things
- Marked by freedom from fear (fear of being wrong, dismissed, punished, ridiculed, or bullied)
- Where talent is unleashed, learning can flourish, value is created and the asymmetry of voice and silence is eliminated
- Psychological safety is a necessary element for a sense of belonging, a major factor in workforce retention and sense of well-being

Trust is an antecedent

Trust is an interpersonal connection between and amongst team members. The underpinnings for trust to be established are[1]:

- Do I believe the positive intention of the other?
- Do I believe the competence and skills of the other?
- Do I believe the benevolence/kindness of the other?
- Do I believe they have integrity to do what they say they will do?

WHY IT'S IMPORTANT

- Psychological safety is required in high-consequence industries (e.g., nuclear industry, aeronautics/ aviation and healthcare)
- Psychological safety is particularly essential in volatile, unpredictable, complex and ambiguous (VUCA) environments
- Psychological safety is foundational for patient safety, quality improvement, innovation, learning, and a sense of workforce belonging

WHAT PSYCHOLOGICAL SAFETY IS NOT

- Sacrificing truth to get along with others
- About being nice, lowering standards of performance, or an absence of accountability

1. Source: Timothy Vagus

PACT Pathway to Accountability, Compassion, & Transparency

Credit: Julie Morath

Putting the Tips Together

Category	Setting the Stage	Inviting Participation	Responding Productively
Leadership tasks	**Frame the Work** • Set expectations about failure, uncertainty and interdependence to clarify the need for voice **Emphasize Purpose** • Identify what's at stake and why it matters	**Demonstrate Situational Humility** • Acknowledge gaps **Practice Inquiry** • Ask good questions • Model intense listening **Set up Structures & Processes** • Create forums for input • Provide guidelines for discussion	**Express Appreciation** • Listen • Acknowledge and thank **Destigmatize Failure** • Look forward • Offer help • Discuss, consider, and brainstorm next steps **Sanction Clear Violations**
Accomplishes	Shared expectations and meaning	Consider that voice is welcome	Orientation toward continuous learning
Stance	Humility	Curiosity	Empathy

Credit: Amy Edmondson

Practical Steps You Can Take

- Clinical leaders
  - Conduct gap analysis on current CRP
  - Ensure CRP is hard wired, deploy metrics
  - Communicate to clinical staff about importance of CRP, resources to support clinicians when harm events happen
- Risk, quality, safety, patient relations experts
  - Seek clarity on your role within the CRP process
  - Strengthen your harm communication coaching skills
- Frontline healthcare workers
  - Understand the importance of CRP, your role in the process, how to access local support

Contact Information

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Questions & Answers

Share With Us!

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Based on what you have learned today,

What would you like to do differently or better to improve the psychological safety of your staff?

***Please submit your response in the chat**

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Upcoming Events of Interest

Thank You!

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

Announcing the Next NAA Monthly National Webinar

Creating and Maintaining a Culture of Safety Series (Session 2):
Improving Safety Culture Using Teamwork and Patient Safety Norms

Tuesday, March 18, 2025 (Noon–1:00 PM ET)

Registration is open and can be found on the NAA website
https://cma.ahrq.gov/naamar2025

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