Does culture matter for safety?:

How can surgeons lead the team to high reliability

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My job today...

To use contemporary evidence to:

1. challenge your beliefs about the relationship between the leader, team culture and outcomes;

2. provide practical steps you can take today to improve team culture and patient outcomes.
Walk in their shoes...

What does a new surgical trainee on your unit say about you after the first day?


Influence of surgeon behavior on trainee willingness to speak up: a randomized controlled trial. Barzallo Salazar MJ¹, Minkoff H¹, Bayya J¹, et al.
What is culture?

“I want the public to think of us as ‘The Company With A Heart’. But I want you to think of us as the company that will chew you up, spit you out and smear you into the carpet if you screw up.”
The Infrastructure of Every Organization

Physical
(Processes, Tools, & Structures)

Infrastructure
(Strategy, Systems, Measurements, and Rewards)

Behavioral
(What Groups and Individuals Do)

Cultural
(Deeply held Assumptions, Values, Beliefs, and Norms)

INCREASINGLY INFORMED

GENERATIVE
Safety is how we do business round here.

PROACTIVE
We work on the problems that we still find.

CALCULATIVE
We have systems in place to manage all hazards.

REACTIVE
Safety is important, we do a lot everytime we have an accident.

PATHOLOGICAL
Who cares as long as we’re not caught

INCREASING TRUST

It's a long way to the top: The evolution of a safety culture.

Hudson P.
2006
The relationship between leader, culture and outcomes

At smallest unit of work – clinical microsystem

Evidence Scan: Does improving safety culture affect patient outcomes? Health Foundation 2011
What is it about the culture of healthcare that prevents us from reaching high safety and reliability?
Amalberti’s five barriers to ultrasafe healthcare

- No limitation in production → Increasing safety margins
- Excessive autonomy of actors → Becoming a team player
- Craftsman’s attitude → Accepting transition to equivalent actors
- Ego-centered safety protections, vertical conflicts
- Loss of visibility of risk

- Fatal iatrogenic adverse events
- Cardiac surgery in patient in ASA 3–5
- Medical risk (total)
- Anesthesiology in patient in ASA 1

- Himalaya mountaineering
- Microlight aircraft or helicopters
- Road safety

- Chartered flight
- Commercial large-jet aviation
- Railways
- Nuclear industry

- Blood transfusion

- Chemical industry (total)

- 10^{-2} → Very unsafe
- 10^{-3}
- 10^{-4}
- 10^{-5}
- 10^{-6} → Ultrasafe

Accepting endorsement of residual risk
Accepting questioning of success and changing strategies
No system beyond this point
High Reliability Organisations

High hazard and extremely low frequency of event i.e. Six Sigma reliability.

High Reliability Organization

- Preoccupation with failure
- Reluctance to simplify interpretations
- Sensitivity to operations
- Deference to expertise
Ok... enough theory – lets get practical

Practical tips for you to make a difference in team culture through your behaviours...
Challenge #1 – Get skilled up in art of leadership

Building our leaders from the ground up!

- Senior Clinicians
  - High Impact Leadership Program
    - Builds on existing leadership capabilities with an emphasis on self-awareness, and a key focus on cultural improvement to overcome professional silos and strengthen relationships

- Clinician Directors, Managers & Team Leaders
  - Manage Improvement Program
    - Builds leadership and management confidence and capabilities to support improvements in health service delivery, through gaining a broader understanding of how the health and business systems operate simultaneously

- Early Career Clinicians
  - Step Up Leadership Program
    - Focuses on developing and strengthening the skills clinicians need to motivate and lead a healthcare team

- Junior Doctors
  - Learn2lead - Junior Doctors Development Program
    - Inspires clinicians to gain an insight into their leadership capability, and to develop their personal leadership style and potential
Challenge #2 – Measure your team culture

How can we map progress?

Manchester Patient Safety Framework (MaPSaF)

- Facilitate reflection on patient safety culture
- Stimulate discussion about the strengths and weaknesses of the patient safety culture
- Reveal any differences in perceptions between staff groups
- Help understand how a more mature safety culture might look
- Help evaluate any specific intervention needed to change the patient safety culture

@SAFE_QI

www.nrls.npsa.nhs.uk › Home › Patient safety resources
Challenge #3 – Live the team: model positive leader behaviours

- Get to know team members day 1
- Be clear on expectations
- Ask them to speak up – always thank them
- Give feedback promptly – coaching approach
- Lead introductions of whole team
- Brief/debrief/readback/graded assertiveness!
- Train together - simulation and NT skills tx
- If something goes wrong – be there... support
- If possible, some downtime together helps!
Challenge #4 – Manage it like you mean it

It matters what leaders do or don’t do

“The culture of any organization is shaped by the worst behavior the leader is willing to tolerate.”

Gruenter and Whitaker
Use the team to define *above* and *below* the line behaviours.
Act on unacceptable behaviours – no exceptions

Figure 1 The disruptive behavior pyramid for identifying, assessing, and dealing with unprofessional behavior.

Hickson G et al 2007
Closing thought...

The only thing of real importance that leaders do is to create and manage culture. If you do not manage culture, it manages you, and you may not even be aware of the extent to which this is happening.

— Edgar Schein —
Thank you