What will we do to prevent the next patient from being harmed?

Step 1. Systems contributors. In evaluating the case, what system breakdowns contributed to the adverse event? Tools: Fishbone diagram

Step 2. Provider/staff actions. In evaluating the case, were there provider/staff actions that contributed to the outcome? Tools: Individual Action Algorithm

Step 2.1 Provider actions.

  Do these actions best fit into category of . . .

  • Human error (slip or lapse)

  • At-risk behavior (a short cut, “drift,” or inexperience)

  • Reckless behavior (willfully ignoring safety steps that are workable within the system, clearly spelled out, and routinely used)

Step 2.2 Provider actions. Substitution test.

  • When evaluating provider/staff actions, could three other reasonable provider/staff with similar skills and training do the same action under similar circumstances?

Step 3. Event response.

3.1 What steps can be taken to improve faulty systems that contributed to this event? How would these steps be implemented practically?

3.2 What steps can be taken to provide direct and timely feedback to the involved provider(s)/staff?

3.3 How will we support the involved provider(s)?

3.4 Disclosure to the patient
Quality and Peer Review
Individual Action Algorithm

Adapted from work of James Reason, David Marx, Michael Lenear, Allen Frimel
Advocacy

High

Testing: "Here's what I say. What do you think of it?"

Dictating: "Here's what I say, and never mind why." (dysfunctional)

Asserting: "Here's what I say, and here's why I say it."

Explaining: "Here's how the world works and why I can see it that way."

Bystanding: Making comments which pertain to the group process, but not to content.

Sensing: Watching the conversation flow without saying much, but keenly aware of all that transpires.

Withdrawing: Mentally checking out of the room, and not paying attention. (dysfunctional)

低

Observing

Skillful discussion: (Balancing advocacy and inquiry, genuinely curious, making reasoning explicit, asking others about assumptions without being critical or accusing)

Dialogue: (Suspending all assumptions, creating a container in which collective thinking can emerge)

Politics: Giving the impression of balancing advocacy and inquiry, while being close-minded (dysfunctional)

Interrogating: "Why can't you see that your point of view is wrong?" (dysfunctional)

Clarifying: "What is the question we are trying to answer?"

Interviewing: Exploring others' points of view and the reasons behind them.

High

Inquiry
Concepts and Frameworks

“Conversational turn-taking,” and “social sensitivity,” to enhance psychological safety.

Demonstrating vulnerability as a leader.

Moving toward the generating quadrant in the “conversational palette.”

Using a Just Culture framework to analyze when things go wrong:
- Where and why does Drift occur in your environment?
- When things go wrong, how do people in your environment respond?

How Will You Apply These to Enhance Psychological Safety and Continuous Learning in Your Environment

(a) as a Team
(b) as an Individual

How does the team currently review and analyze instances where care or processes do not work or where there are patient safety issues?

How does that support or undermine psychological safety and continuous learning?

What might you do as a team to enhance psychological safety and continuous learning when things go wrong?

What specific actions might you take as an individual to promote the psychological safety on your team?

What does “leading with vulnerability” look like for you as a leader?