Lessons from the Ashes:
The Critical Role of Leadership

Robert Sumwalt

April 29, 2023


Robert L. Sumwalt
Chairman, Board of Inquiry
CAPTAIN
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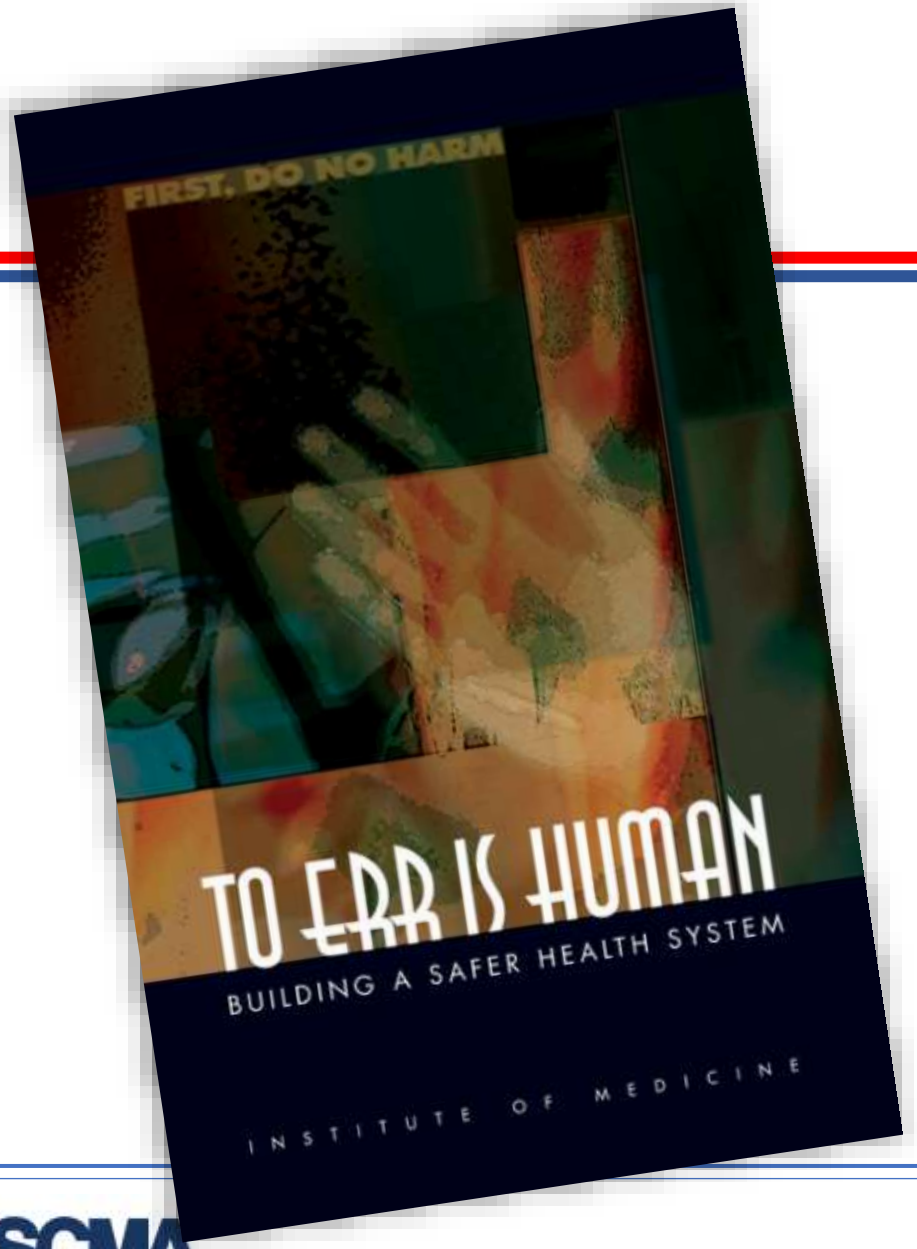
What is Leadership?

"Leadership is about influence. Nothing more. Nothing less."

- John Maxwell



"The problem is not bad people in health care--it is that good people are working in bad systems that need to be made safer."

Airlines

February 2009

6 Billion Passengers Safely Flown on US Airlines

April 2018

(2 million passengers a day)

Major Airlines in the US

- Have very successful incident reporting systems
- Monitor large percentages of their flights to look for undesirable events

- Openly share deidentified data with the regulator and other airlines

“lack of a positive safety culture”

Safety Culture

"Safety culture is the core values and behaviors resulting from a collective commitment by leaders and individuals to emphasize safety over competing goals to ensure protection of people and the environment."

Source: U.S. Nuclear Regulatory Commission

Do you have a good safety culture?

Do you have a good safety culture?

- "… it is worth pointing out that if you are convinced that your organization has a good safety culture, you are almost certainly mistaken."
- "… a safety culture is something that is striven for but rarely attained…"
- "… the process is more important than the product."

  - James Reason, "Managing the Risks of Organizational Accidents."

Some critical elements of a healthy safety culture

- Top Level Management Commitment and Support
- Informed Culture
  - Just Culture and Trust
  - Open Reporting Culture
- Chronic unease, obsession with possible failures, and avoiding hubris

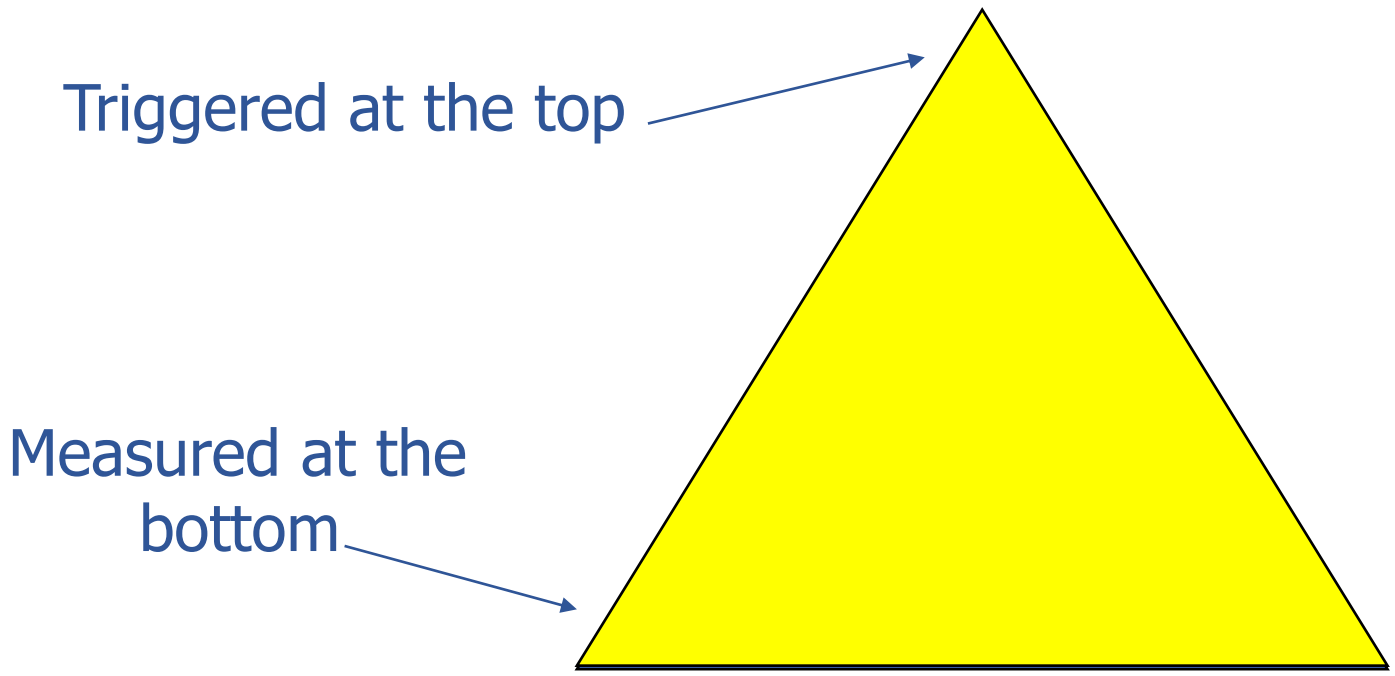
Top Level Management Commitment and Support

Leaders influence cultures by …

"…what they systematically pay attention to. This can mean anything from what they notice and comment on to what they measure, control, reward and in other ways systemically deal with."

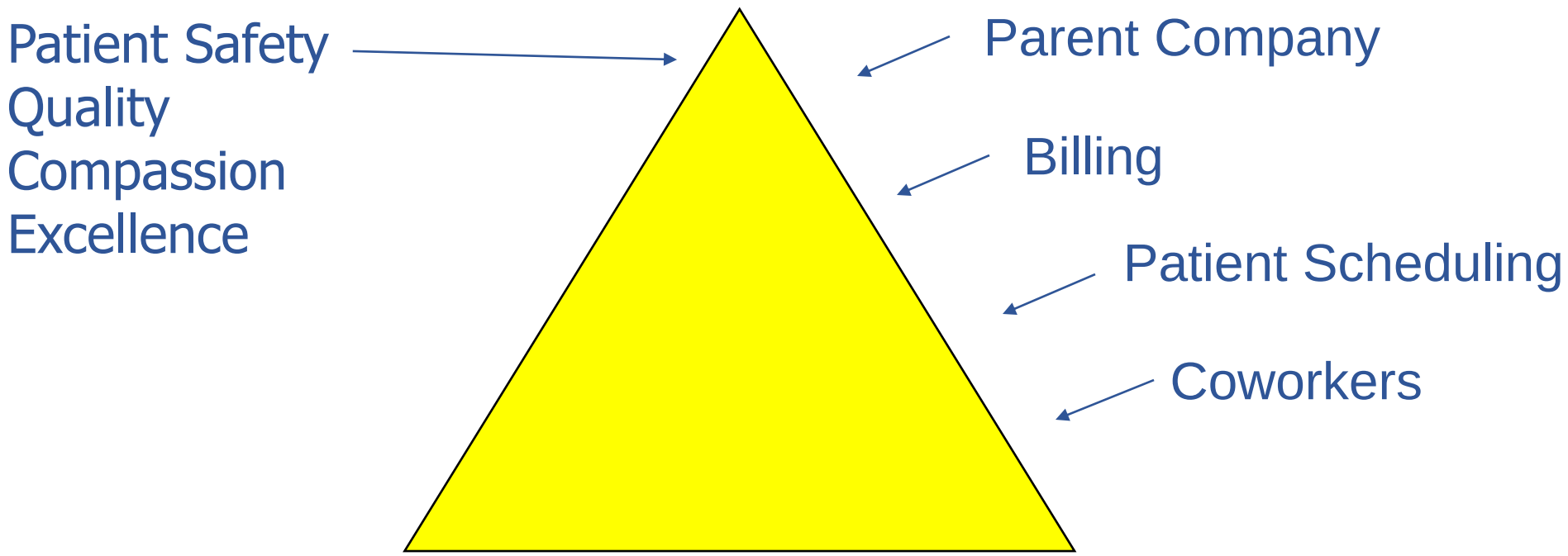
– Hopkins, Andrew. (2005). *Safety, culture and risk: the organizational causes of disasters*

Safety Culture is:



Safety culture starts at the top of the organization and permeates the entire organization.

Sometimes the Message gets Distorted



MOST IMPORTANT – Output!!!!

Maximize efficiencies!

Fear of retribution

Get job done at all costs

Unfair discipline

Patients: Get 'em in, and get 'em out

How leaders influence safety

"The safety behaviors and attitudes of individuals are influenced by their perceptions and expectations about safety in their work environment, and they pattern their safety behaviors to meet demonstrated priorities of organizational leaders, regardless of stated policies."

- Dov Zohar, as cited in NTSB Railroad accident report*: Collision of two Washington Metropolitan Area Transit Authority Metrorail Trains near Fort Totten Station, Washington, DC, June 22, 2009.*

WORD OF THE DAY

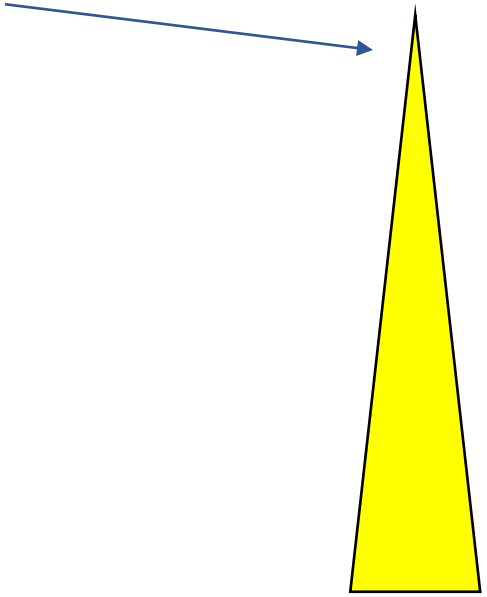
Saturday, April 29, 2023

align·ment *noun* \ə-ˈlīn-mənt\

Where the leaders and front line employees, and everyone in between, share and practice the same values.

Alignment

Patient Safety
Quality
Compassion
Excellence



Parent Company

Billing Department

Patient Scheduling

Coworkers

Quality

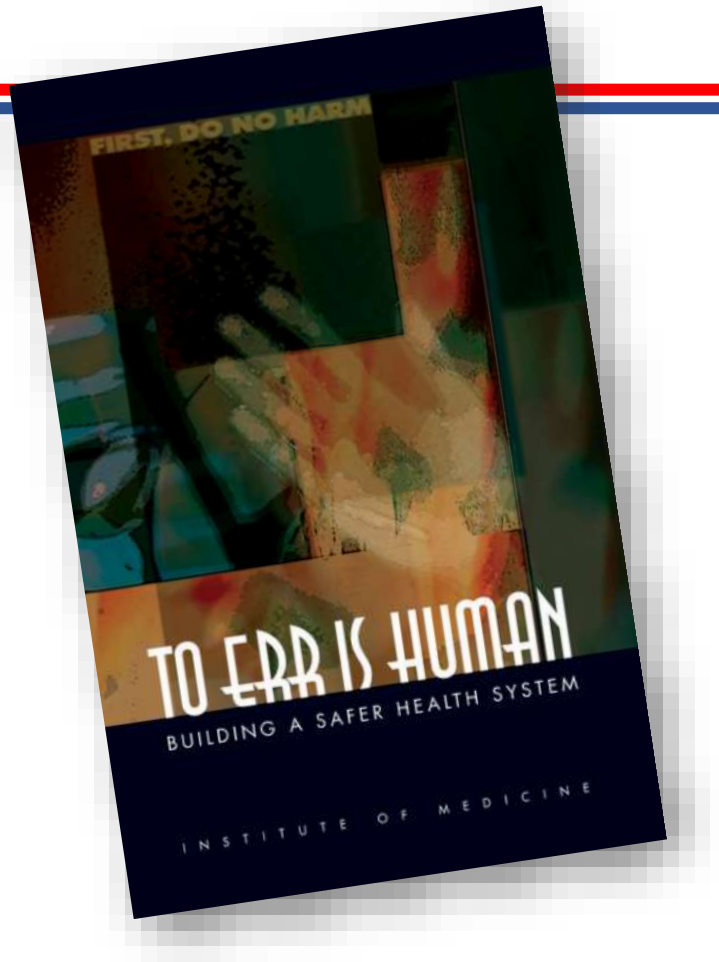
Compassion

Patient Safety

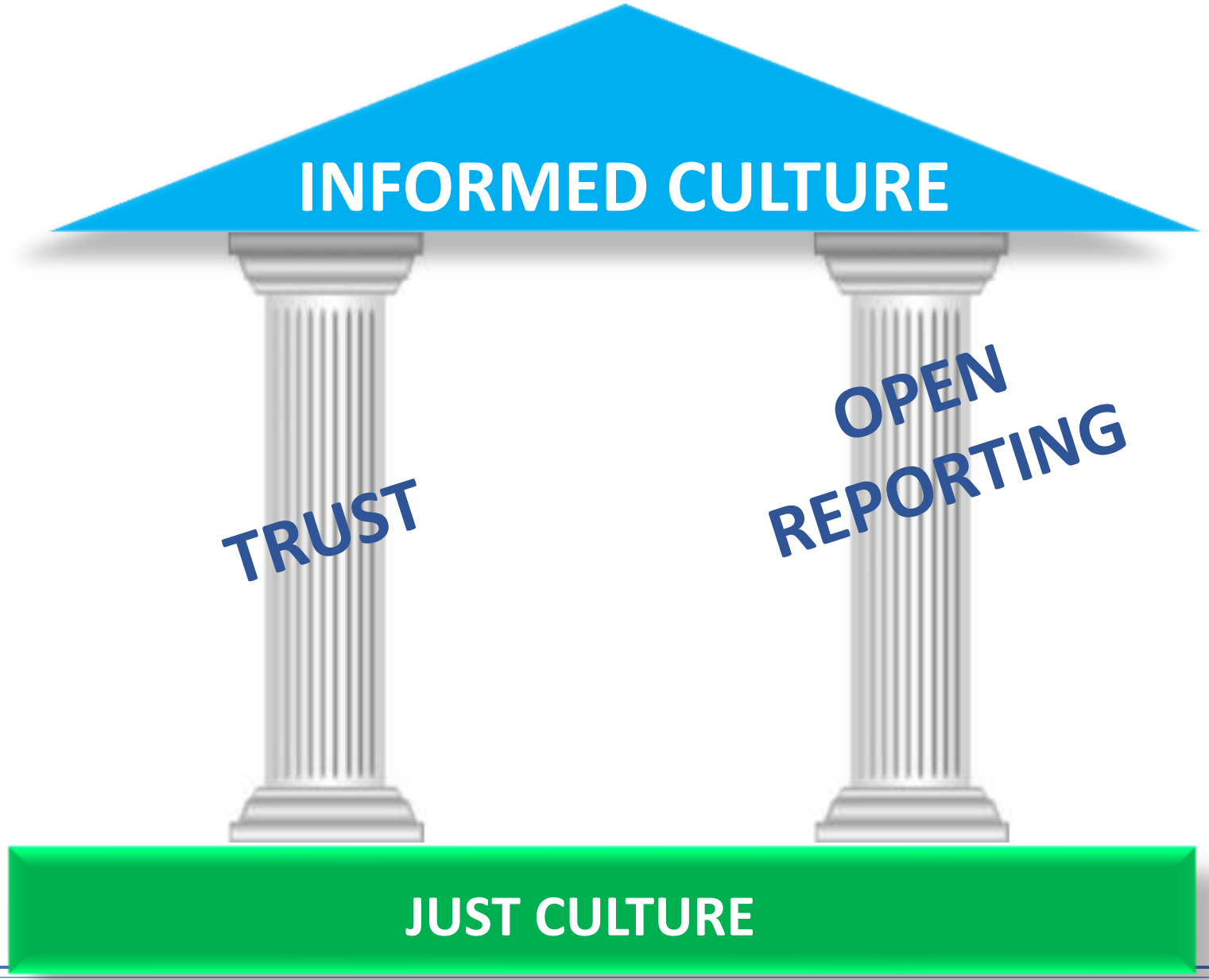
Excellence

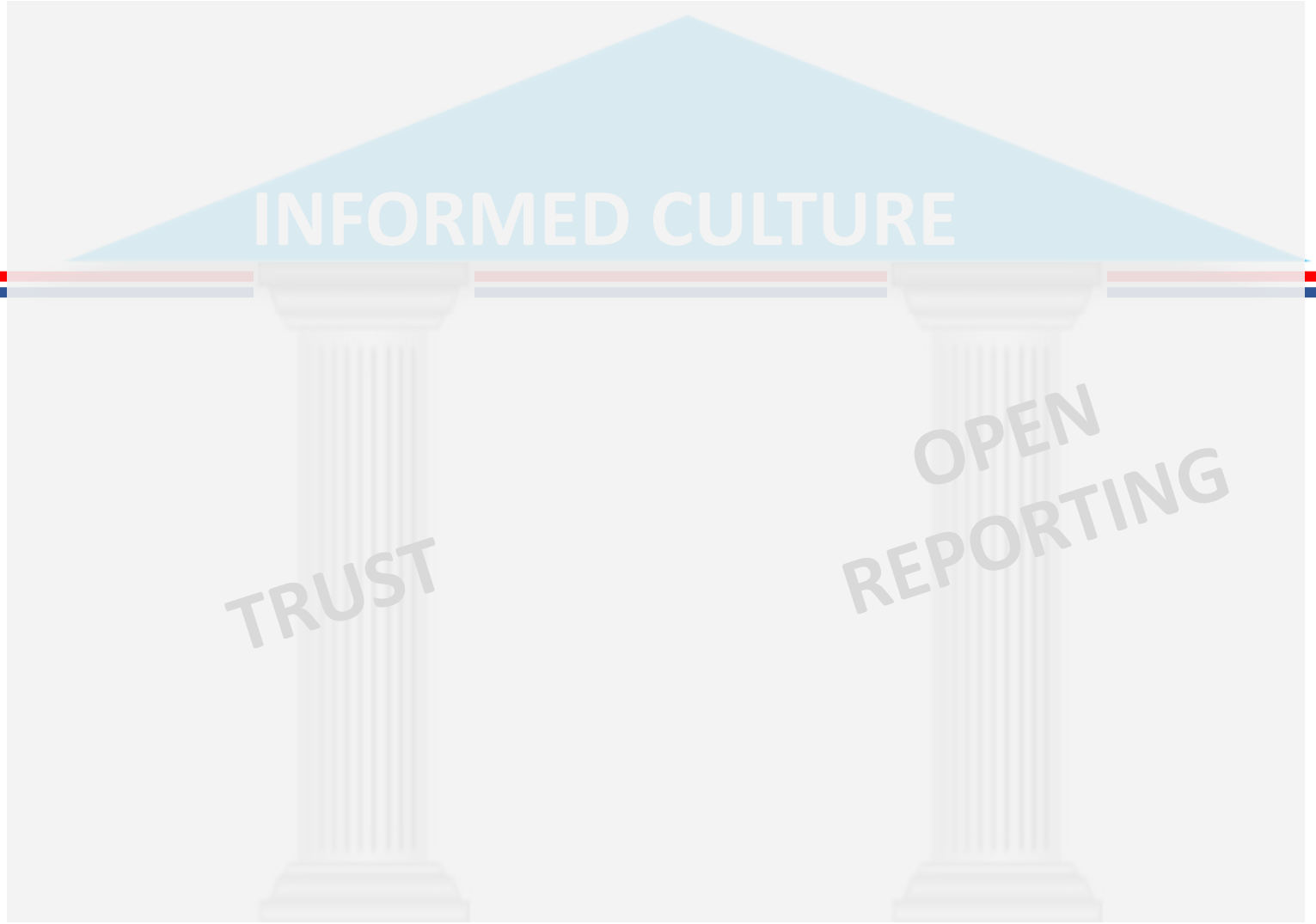
Informed Culture

Just Culture and Trust
Open Reporting Culture



"Another critical component of a comprehensive strategy to improve patient safety is to create an environment that encourages organizations to identify errors, evaluate causes and take appropriate actions to improve performance in the future."


INFORMED CULTURE
TRUST
OPEN REPORTING
JUST CULTURE



JUST CULTURE

Just Culture

- Basically, this means that employees realize they will be treated fairly
  - Not all errors and unsafe acts will be punished (if the error was unintentional)
  - Those who act recklessly or take deliberate and unjustifiable risks will be punished

Just Culture

"An atmosphere of trust in which people are encouraged (even rewarded) for providing safety-related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior."

Source: James Reason

Case study

- *A nurse administers the wrong medication because of similarities in the name of the medicine. Fortunately, it appears to have presented no obvious harm to the patient.*

- *In your organization, what is the likelihood that he/she will report the error?*

- *If he/she reported the error, what would be the likely response in your organization?*

Discipline

Harsh Counseling

Ignore it

Require the employee to write an article "How I made this mistake and how to prevent it.'"

Thank the employee for reporting it and investigate to determine if systemic issues may have led to the error

THE MILBANK QUARTERLY

A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

High-Reliability Health Care: Getting There from Here

MARK R. CHASSIN and JEROD M. LOEB

The Joint Commission

Context: Despite serious and widespread efforts to improve the quality of health care, many patients still suffer preventable harm every day. Hospitals find improvement difficult to sustain, and they suffer "project fatigue" because so many problems need attention. No hospitals or health systems have achieved consistent excellence throughout their institutions. High-reliability science is the study of organizations in industries like commercial aviation and nuclear power that operate under hazardous conditions while maintaining safety levels that are far better than those of health care. Adapting and applying the lessons of this science to health care offer the promise of enabling hospitals to reach levels of quality and safety that are comparable to those of the best high-reliability organizations.

Methods: We combined the Joint Commission's knowledge of health care organizations with knowledge from the published literature and from experts in high-reliability industries and leading safety scholars outside health care. We developed a conceptual and practical framework for assessing hospitals' readiness for and progress toward high reliability. By iterative testing with hospital leaders, we refined the framework and, for each of its fourteen components, defined stages of maturity through which we believe hospitals must pass to reach high reliability.

Findings: We discovered that the ways that high-reliability organizations generate and maintain high levels of safety cannot be directly applied to today's hospitals. We defined a series of incremental changes that hospitals should undertake to progress toward high reliability. These changes involve the leadership's commitment to achieving zero patient harm, a fully functional culture of

Address correspondence to: Mark R. Chassin, The Joint Commission, 1 Renaissance Boulevard, Oakbrook Terrace, IL 60181 (email: mchassin@jointcommission.org).

The Milbank Quarterly, Vol. 91, No. 3, 2013 (pp. 459–490)

"Unfortunately, health care organizations too often punish staff for blameless acts while failing to implement equitable disciplinary procedures for those who commit blameworthy acts."

– Chassin, M. & Loeb, J. (2013). *High-reliability heath care: Getting there from here*.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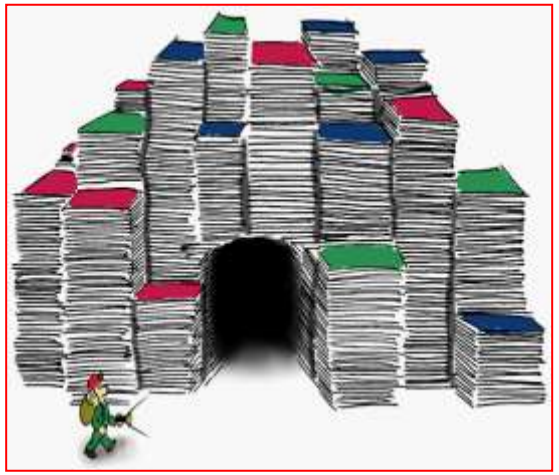
Safety Culture

- Aim is not a "blame-free" culture
- HROs separate blameless errors (for learning) from blameworthy ones (for discipline, equitably applied to all groups)
- Prerequisites for safety culture in health care
  - Eliminate intimidating behaviors
  - Hold everyone accountable for consistent adherence to safe practices
- HROs balance learning & accountability

The Joint Commission

Be informed, stay informed

- Collect and analyze “the right kind of data” to stay informed of the safety health of the organization
  - Create a safety information system that collects, analyzes and disseminates information on incidents and near-misses, as well as proactive safety checks.



How do you stay informed?

- Confidential incident reporting systems
- Employee feedback
- Internal safety audits
- External safety audits

Open lines for reporting

- Employees are open and encouraged to report safety problems
  - Assurance that information will be acted upon
  - Confidentiality will be maintained or the data are de-identified
  - Assurance they will not be punished or ridiculed for reporting
    - Non-reprisal policy signed by CEO

Non Reprisal Policy
December 2005

SCANA Aviation Department is committed to the safest flight operation possible. Therefore, it is imperative that we have uninhibited good faith reporting of any hazard, occurrence or other information that in any way could enhance the safety and efficiency of our operations. It is each employee's responsibility to communicate any information that may affect the integrity of flight safety.

We will not use this reporting system to initiate disciplinary proceedings against an employee who discloses in good faith a hazard or occurrence involving safety which is the result of conduct which is inadvertent, unintentional or not deliberate.

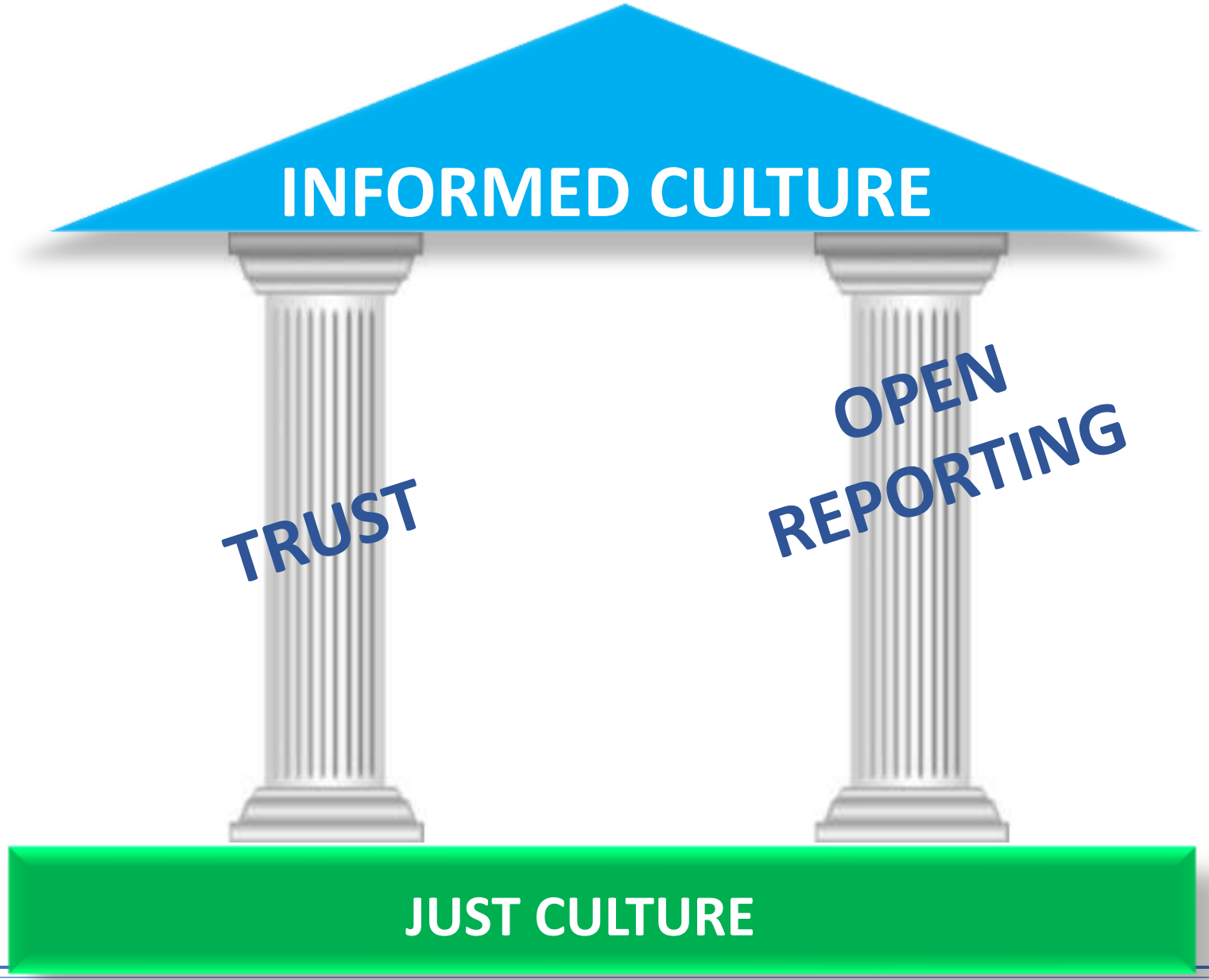
Hazard Reporting Procedure.]

To promote a timely, uninhibited flow of information, this communication must be free of reprisal. SCANA will not use this reporting system to initiate disciplinary proceedings against an employee who discloses in good faith a hazard or occurrence involving flight safety which is the result of conduct which is inadvertent, unintentional or not deliberate.

We urge all employees to use this program to help this Department be a leader in providing our passengers and our employees with the highest level of flight safety.

William B. Timmerman
Chief Executive Officer

Robert L. Sumwalt, III
Manager – Aviation


INFORMED CULTURE
TRUST
OPEN REPORTING
JUST CULTURE

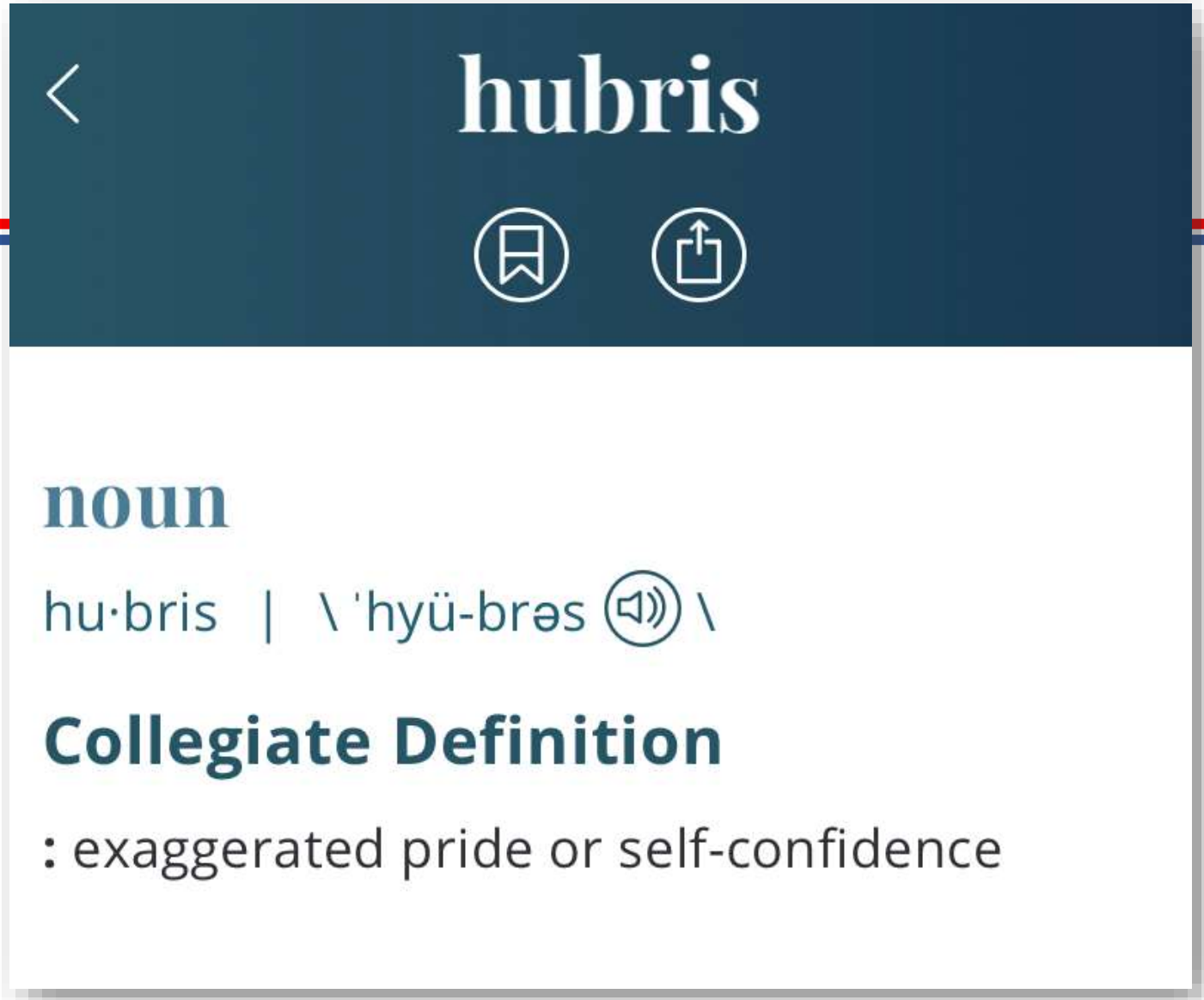
"The new way of thinking is that human error is a symptom of trouble deeper in the system"

– NTSB. (2010). *Railroad accident report: Collision of two Washington Metropolitan Area Transit Authority Metrorail Trains near Fort Totten Station, Washington, DC, June 22, 2009.*

Chronic unease, an obsession with possible failures, and avoiding hubris

"Think about
the unthinkable."

- Najm Meshkati, PhD.


hubris
noun
hu·bris | \ ˈhyü-brəs \
Collegiate Definition
: exaggerated pride or self-confidence

An Impressive Operation

Positive Audit Comments

- “The SMS of this operator is well-developed”
- “Best practices are consistently employed in all facets of the program”
- “Continuous SMS improvement is actively pursued”
- “The Flight Ops Manual is remarkably well-written and comprehensive”
- “Safety culture within the department is shared among all team members”
- “Open reporting of hazards is consistently encouraged by management”
- “Solid safety program, maturing nicely”

"You can fool the auditors, but never fool yourself."

- John Fenton

And, perhaps they even fooled themselves.


GUST
LOCK
FLAP

“Good can be Bad”

- With good safety performance, people/organizations can easily become complacent.
- Don’t ever believe that a lack of accidents means you are “safe.”
- To counter this complacency, there must be a leadership obsession with continuous improvement.

- Courtesy of Jim Schultz

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EMBRY-RIDDLE
Aeronautical University

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