CHART INSTITUTE

Back to Basics:
Transitioning from Public Health Emergency to Conventional Operations

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Prior to the pandemic, many CHART members were on a path to high reliability, supported by a strong culture of safety. This pathway reinforced improvement efforts aimed at increasing individual patient and workplace safety during conventional operations. According to a 2019 AHRQ study, similar efforts across the country resulted in a nationwide decrease in hospital associated conditions.[1] Shortly thereafter, the pandemic struck and healthcare priorities necessarily shifted to guide decision-making based on crisis standards of care during the Public Health Emergency (PHE). Today, as we face new and/or exacerbated challenges in care delivery, it is important to re-establish a strong culture of safety to support staff in transitioning back to the basics of protecting patients and the work environment during conventional operations. The intent of this article is to recall the basic tenets of a strong safety culture and provide related educational and operational resources.

Culture of Safety

A safety culture reflects the way patient and workplace safety is structured and implemented in an organization. It includes staff attitudes about safety and influences the workplace environment and clinical outcomes. More simply stated, culture defines *the way we do things around here when no one else is looking*.

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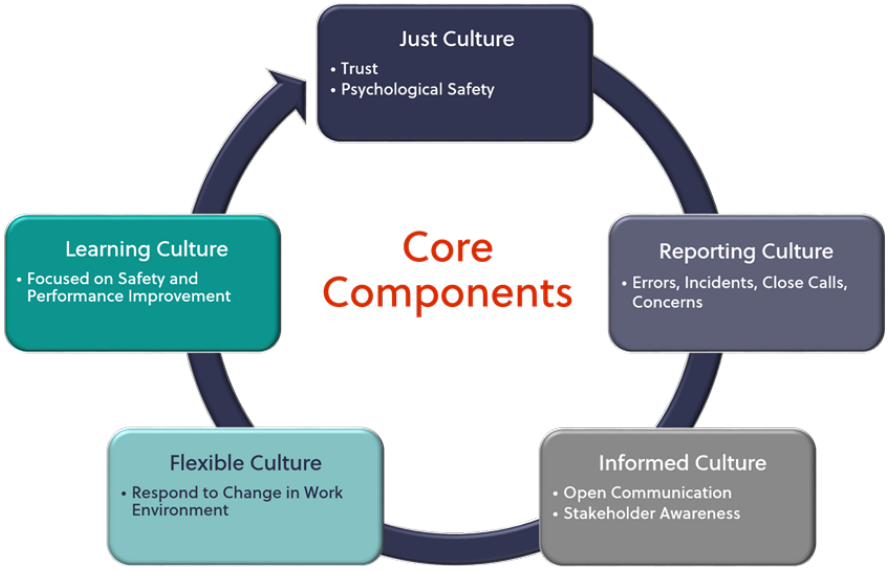
Introduced by James Reason, one popular safety culture model includes the interplay of five core components:[2]

- Just Culture
- Reporting Culture
- Informed Culture
- Flexible Culture
- Learning Culture



According to Reason, the core components work together in a cyclic manner to drive a safety culture. The cycle begins with an atmosphere of trust and psychological safety present in a Just Culture, encouraging and permitting staff to speak up when they witness hazards, risk exposures, or mistakes. When staff feel safe speaking up, they are likely to report incidents, errors, close calls, and concerns. A Reporting Culture provides opportunities to investigate and analyze adverse events. Findings from adverse event analysis (e.g., identified risks, causal factors, action plans) can then be shared with frontline staff and other key stakeholders through clear and accurate communication channels. The resultant Informed Culture prepares staff to flex and adapt by appropriately responding to changes in the work environment. The resiliency provided by a Flexible Culture supports a focus on safety and process improvement, resulting in a Learning Culture. In this way, the five components work together, enabling the culture of safety to grow and evolve.

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Conversely, in the absence of trust and psychological safety, staff will not feel safe speaking up or reporting incidents. Without the ability to investigate and analyze adverse events, close calls, or staff concerns, we are unable to keep key stakeholders informed of new risks or safety issues. In turn, they are unable to adapt to changes or apply lessons learned. The result is poor communication, a lack of actionable information and a rigid inability to apply lessons learned or improve the safety of systems and processes.

Studies show that breakdowns in safety culture reveal increased risks of experiencing unanticipated adverse events.[3,4] Examples of safety culture breakdowns in healthcare include, but are not limited to, the following:

- Communication breakdowns leading to delays and failures in diagnosis and/or treatment.
- Workarounds and drift from established safety practices (e.g., independent double-checks, barcode scanning, patient identification) resulting in care delivery errors and potential harm.
- Focusing on competing priorities (e.g., timeliness, costliness) rather than safety, increasing the risk of simple human errors.

The safety of healthcare operations depends on our ability to identify risks, communicate clearly, respond to environmental changes, and learn from our shared experiences. Refocusing efforts on supporting a culture of safety can provide foundational support for patient safety and risk mitigation efforts.

The CHART Institute offers safety culture resources to assist in transitioning from crisis standards of care back to conventional operations, including, but not limited to the following:

- Safety Culture Resource Bundle
  https://www.chartrrg.com/member_posts/safety-risk-safety-culture/
- Communication and Teamwork Resource Bundle
  https://www.chartrrg.com/member_posts/safety-risk-bundles-communication-and-teamwork/
- Just Culture Modules
  https://www.chartrrg.com/member_posts/just-culture-curriculum/
- Clinical Risk Management and Patient Safety Curriculum (including back-to-basic lessons on teamwork, communication, and reliable design)
  https://www.chartrrg.com/member_posts/clinical-risk-management-and-patient-safety-05-16-2022-05-15-2024/
- CHART On-Demand Education
  https://www.chartrrg.com/wp-content/uploads/protected/On-Demand-Education.pdf
- The Sullivan Group CME/CNE Offerings
  CHART-Institute-2023-2024-Courses-The-Sullivan-Group.pdf (chartrrg.com)
- AHRQ Hospital Survey on Patient Safety Culture
  https://www.ahrq.gov/sops/surveys/hospital/index.html

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[1] https://www.ahrq.gov/data/infographics/hac-rates_2019.html

[2] https://static1.squarespace.com/static/53b78765e4b0949940758017/t/5876f6cf197aea0e713442df/1484191456108/Achieving+a+safe+culture-James+Reason.pdf

[3] https://journals.lww.com/journalpatientsafety/Abstract/2010/12000/Exploring_Relationships_Between_Hospital_Patient.6.aspx

[4] https://www.ecri.org/components/HRC/Pages/RiskQual21.aspx