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# Psychological safety

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Jop Groeneweg

Technische Universiteit Delft - Universiteit Leiden - TNO

Amsterdam UMC conferentie 'Top & Teamspelers'

Amsterdam, 7 november 2019

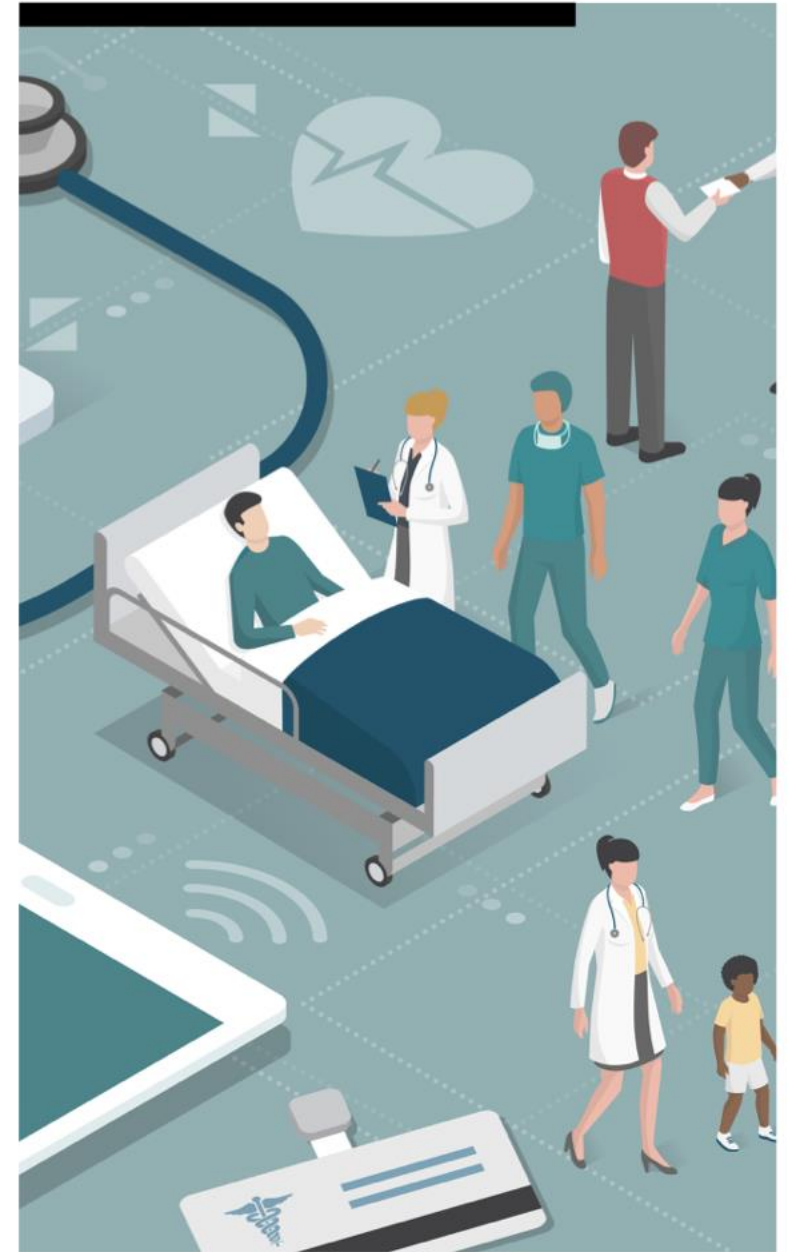


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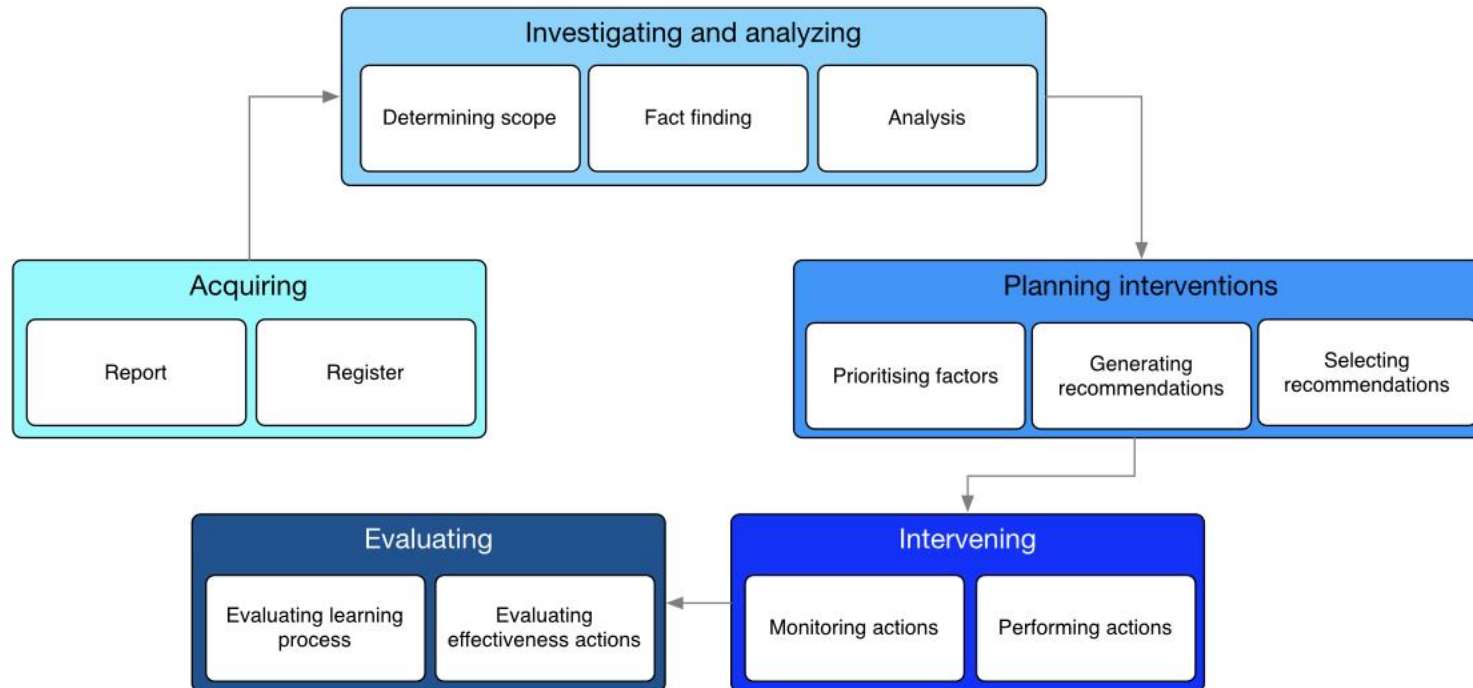
# Vraag

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- Welk percentage van de medewerkers (algemeen, niet specifiek UMC locatie VUmc) geeft de score 'Sterk mee eens' op de vraag 'mijn mening doet er toe'?



# Leren



## BMJ QUALITY & SAFETY

May 2017 Volume 26 Issue 5

Characterizing the  
with discharge su  
for hospitalised  
Predicting error p  
drug names



Root cause analysis: superficial  
recommendations consistently  
favoured over deeper changes  
[qualitysafety.bmj.com](http://qualitysafety.bmj.com)

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# Just culture

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- Vier benaderingen
- Reactief (na een voorval):
  - Just = Consistent, eerlijk
  - Just = Compassie en respect, 'second victim'
  - Just = Niet bang om (bijna) voorvallen te rapporteren
- Proactief (voor een voorval):
  - Just = Het is 'maar' een bijeffect van psychologisch veilige cultuur



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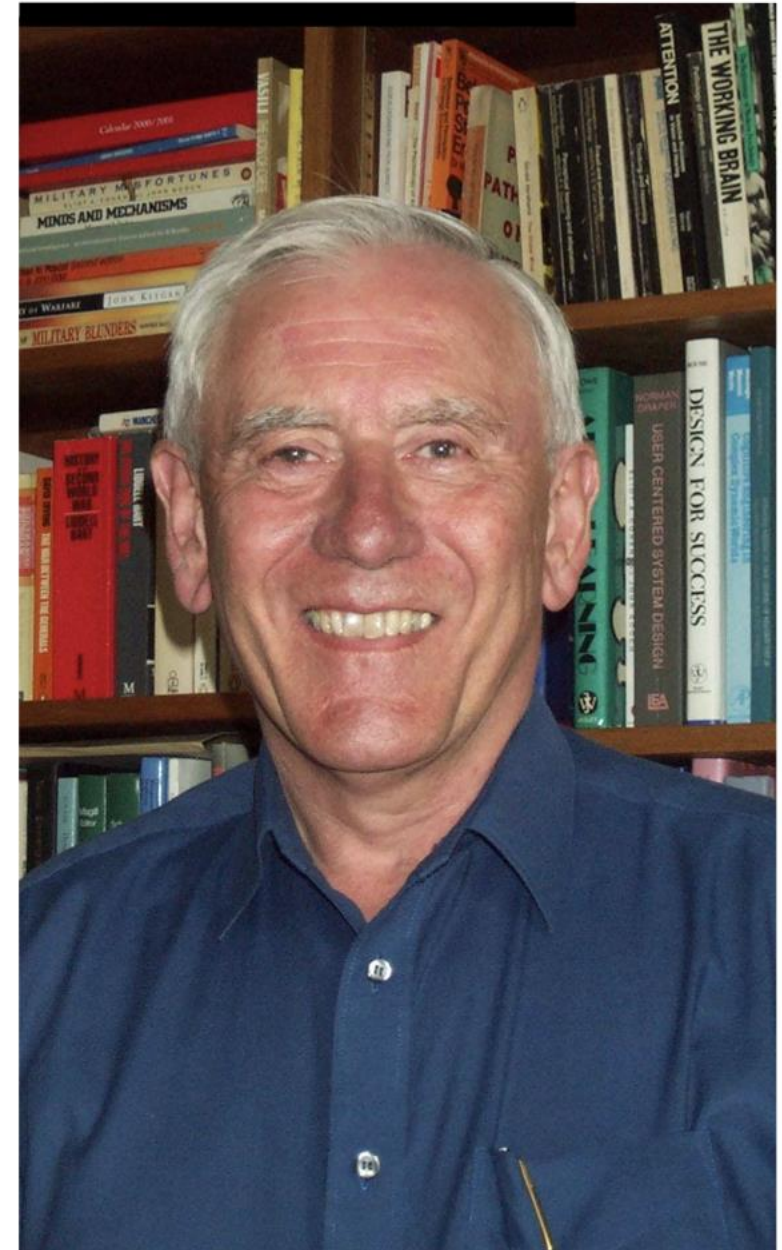
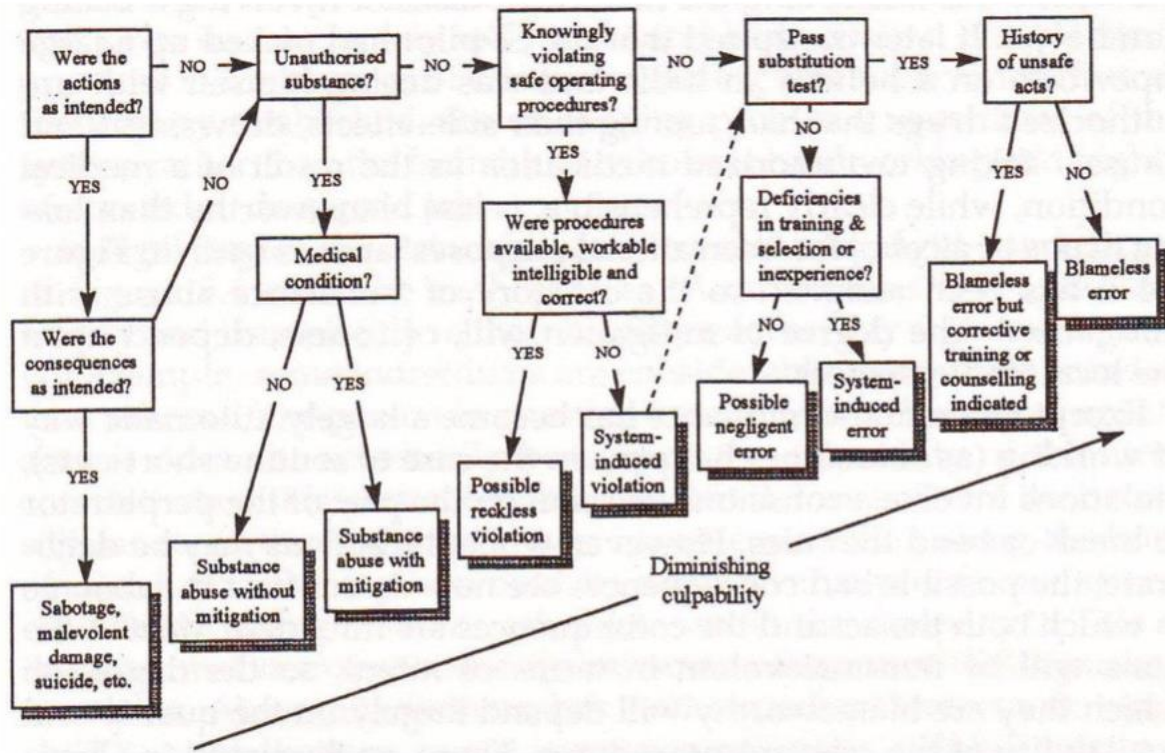
# Vraag

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- In welk percentage van de 'calamiteiten' is het gerechtvaardigd om betrokken medewerkers de schuld te geven van wat er is gebeurd?
- Welk percentage van calamiteiten wordt onderzocht op manier waaruit blijkt dat men op zoek is naar de schuld van de betrokken medewerkers?



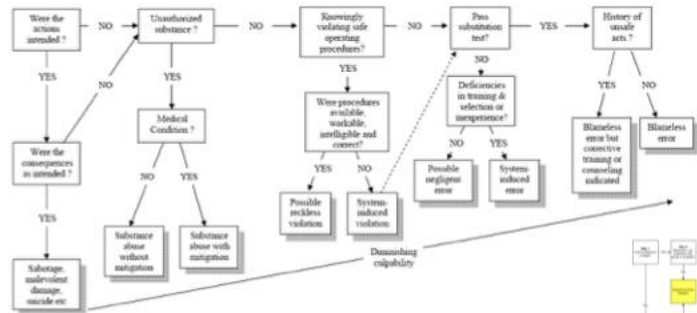
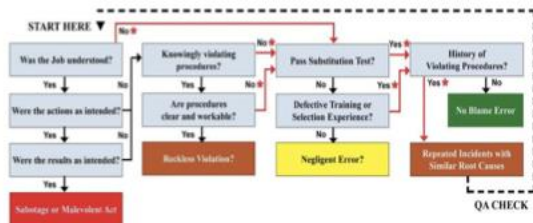
# 1: Flowchart (Reason, 1990)



# Erg populair

## "Just Culture" Decision Tree

Rules of Fair Play for Managers

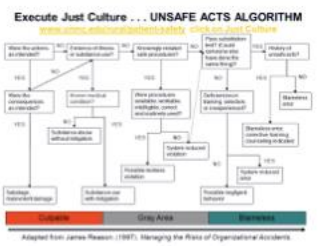


Issue	Guidance to Managers	Guidance to Employees
Issue 1: Safety violations that result in injury or death	1. Investigate the incident to determine the root cause. 2. Determine if the violation was a result of a system error or a human error. 3. If a system error, take corrective action to prevent recurrence. 4. If a human error, determine if it was a result of a system error or a human error. 5. If a system error, take corrective action to prevent recurrence. 6. If a human error, determine if it was a result of a system error or a human error. 7. If a system error, take corrective action to prevent recurrence. 8. If a human error, determine if it was a result of a system error or a human error. 9. If a system error, take corrective action to prevent recurrence. 10. If a human error, determine if it was a result of a system error or a human error.	1. Report the violation to your supervisor. 2. Cooperate with the investigation. 3. Do not cover up the violation. 4. Do not blame others. 5. Do not blame yourself. 6. Do not blame the system. 7. Do not blame the organization. 8. Do not blame the industry. 9. Do not blame the government. 10. Do not blame the public.
Issue 2: Safety violations that result in property damage	1. Investigate the incident to determine the root cause. 2. Determine if the violation was a result of a system error or a human error. 3. If a system error, take corrective action to prevent recurrence. 4. If a human error, determine if it was a result of a system error or a human error. 5. If a system error, take corrective action to prevent recurrence. 6. If a human error, determine if it was a result of a system error or a human error. 7. If a system error, take corrective action to prevent recurrence. 8. If a human error, determine if it was a result of a system error or a human error. 9. If a system error, take corrective action to prevent recurrence. 10. If a human error, determine if it was a result of a system error or a human error.	1. Report the violation to your supervisor. 2. Cooperate with the investigation. 3. Do not cover up the violation. 4. Do not blame others. 5. Do not blame yourself. 6. Do not blame the system. 7. Do not blame the organization. 8. Do not blame the industry. 9. Do not blame the government. 10. Do not blame the public.
Issue 3: Safety violations that result in environmental damage	1. Investigate the incident to determine the root cause. 2. Determine if the violation was a result of a system error or a human error. 3. If a system error, take corrective action to prevent recurrence. 4. If a human error, determine if it was a result of a system error or a human error. 5. If a system error, take corrective action to prevent recurrence. 6. If a human error, determine if it was a result of a system error or a human error. 7. If a system error, take corrective action to prevent recurrence. 8. If a human error, determine if it was a result of a system error or a human error. 9. If a system error, take corrective action to prevent recurrence. 10. If a human error, determine if it was a result of a system error or a human error.	1. Report the violation to your supervisor. 2. Cooperate with the investigation. 3. Do not cover up the violation. 4. Do not blame others. 5. Do not blame yourself. 6. Do not blame the system. 7. Do not blame the organization. 8. Do not blame the industry. 9. Do not blame the government. 10. Do not blame the public.

Issue	Guidance to Managers	Guidance to Employees
Issue 4: Safety violations that result in financial damage	1. Investigate the incident to determine the root cause. 2. Determine if the violation was a result of a system error or a human error. 3. If a system error, take corrective action to prevent recurrence. 4. If a human error, determine if it was a result of a system error or a human error. 5. If a system error, take corrective action to prevent recurrence. 6. If a human error, determine if it was a result of a system error or a human error. 7. If a system error, take corrective action to prevent recurrence. 8. If a human error, determine if it was a result of a system error or a human error. 9. If a system error, take corrective action to prevent recurrence. 10. If a human error, determine if it was a result of a system error or a human error.	1. Report the violation to your supervisor. 2. Cooperate with the investigation. 3. Do not cover up the violation. 4. Do not blame others. 5. Do not blame yourself. 6. Do not blame the system. 7. Do not blame the organization. 8. Do not blame the industry. 9. Do not blame the government. 10. Do not blame the public.
Issue 5: Safety violations that result in reputational damage	1. Investigate the incident to determine the root cause. 2. Determine if the violation was a result of a system error or a human error. 3. If a system error, take corrective action to prevent recurrence. 4. If a human error, determine if it was a result of a system error or a human error. 5. If a system error, take corrective action to prevent recurrence. 6. If a human error, determine if it was a result of a system error or a human error. 7. If a system error, take corrective action to prevent recurrence. 8. If a human error, determine if it was a result of a system error or a human error. 9. If a system error, take corrective action to prevent recurrence. 10. If a human error, determine if it was a result of a system error or a human error.	1. Report the violation to your supervisor. 2. Cooperate with the investigation. 3. Do not cover up the violation. 4. Do not blame others. 5. Do not blame yourself. 6. Do not blame the system. 7. Do not blame the organization. 8. Do not blame the industry. 9. Do not blame the government. 10. Do not blame the public.



Violation Type	Normal Compliance	Unintentional Violation	Routine Violation	Situational Violation	Optimizing Violation	Personal Optimizing Violation	Reckless Personal Optimization	Exceptional Violation
Description	Did they follow all procedures and best practices?	Did they think they were following the procedure and best practices?	Someone didn't do this the way it should be done. Don't do this!	It's not my fault. The procedure is flawed. I got the job done.	I thought it was better for the company to do it a certain way.	I thought it was better for me personally to do it a certain way.	I meant to do it my way.	Did we do that?
Management	Praise the worker. Fast feedback. But be aware, this may be unusual.	Why didn't people realize this was a problem?	Take active steps to identify this sort of violation. Use 5M's.	Get very active. There were good procedures. They got it wrong.	Set standards. Explain. This may be a real improvement.	Set standards. Explain. This may be a real improvement.	How did we let this happen?	Did we not expect such violations to occur? (MARS problem?)
Supervision	Praise the worker. Investigate and apply 5M's.	Investigate and apply 5M's.	Investigate. Must be to work.	Why is this not being recognized? Use 5M's. Allow variances.	Set standards. Recognize that such people are in weakness.	How did we let them get away with it?	Did we not expect such violations to occur? (MARS problem?)	
Workforce	Fast feedback.	Report if they discover they have violated a procedure.	Get involved in finding out if the procedure is necessary.	Must report all such impossible situations.	Report possibility. Be sure before work. Acquire competence.	Decide whether you wish to work here.	Leave company.	Did I check with supervisor and colleagues?
Discipline	None.	No blame for others.	Active coaching of all, at all levels, for continuing routine violation.	Blame everyone for not playing their part.	Blame everyone for not playing their part.	Starting letter to worker.	Summary. Dismissal.	Did they follow all procedures and best practices?
Coaching	Praise the worker. Use as an example for others.	Management needs to examine the quality of the procedure/system.	Everyone use 5M's to see if it's necessary and ensure compliance.	Coach people to tell workers and follow managers and supervisors.	Coach people to tell workers and follow managers and supervisors.	Coach managers and supervisors on setting standards.	Coach managers and supervisors to recognize and deal with such individuals.	Did they follow all procedures and best practices?



- Start here - Q1, deliberate harm test
- 1a. Was there any intention to cause harm? (1)
  - Recommendation: When a person is found to have intentionally caused harm, the usual route is to report the incident to the police, and to take appropriate disciplinary action. This is not a Just Culture issue.
- 2a. Are there indications of substance abuse? (1)
  - Recommendation: When a person is found to have used substances, the usual route is to report the incident to the police, and to take appropriate disciplinary action. This is not a Just Culture issue.
- 2b. Are there indications of physical ill health? (1)
  - Recommendation: When a person is found to have been physically ill, the usual route is to report the incident to the police, and to take appropriate disciplinary action. This is not a Just Culture issue.
- 3. No to all go to next question - Q3, foresight test
- 3a. Are there agreed protocols accepted practice in place that apply to the activity/practice in question? (1)
  - Recommendation: When a person is found to have violated a protocol or accepted practice, the usual route is to report the incident to the police, and to take appropriate disciplinary action. This is not a Just Culture issue.
- 3b. Were the protocols/accepted practice workable and in routine use? (1)
  - Recommendation: When a person is found to have violated a protocol or accepted practice, the usual route is to report the incident to the police, and to take appropriate disciplinary action. This is not a Just Culture issue.
- 3c. Did the individual knowingly depart from these protocols? (1)
  - Recommendation: When a person is found to have knowingly departed from a protocol or accepted practice, the usual route is to report the incident to the police, and to take appropriate disciplinary action. This is not a Just Culture issue.
- 4. Yes to all go to next question - Q4, substitution test
- 4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances? (1)
  - Recommendation: When a person is found to have violated a protocol or accepted practice, the usual route is to report the incident to the police, and to take appropriate disciplinary action. This is not a Just Culture issue.
- 4b. Was the individual assessed out when relevant training was provided to their peer group? (1)
  - Recommendation: When a person is found to have violated a protocol or accepted practice, the usual route is to report the incident to the police, and to take appropriate disciplinary action. This is not a Just Culture issue.
- 4c. Did more senior members of the team fail to provide supervision that normally should be provided? (1)
  - Recommendation: When a person is found to have violated a protocol or accepted practice, the usual route is to report the incident to the police, and to take appropriate disciplinary action. This is not a Just Culture issue.
- 5a. Were there any significant mitigating circumstances? (1)
  - Recommendation: When a person is found to have violated a protocol or accepted practice, the usual route is to report the incident to the police, and to take appropriate disciplinary action. This is not a Just Culture issue.
- 7. No

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## 2: Second victim

sidnexlekker.com





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# Calamiteitenonderzoek

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Welke vragen zijn gebruikelijk na een incident:

- Welke regel werd gebroken?
- Hoe erg was de overtreding?
- Welke consequenties moeten er zijn?

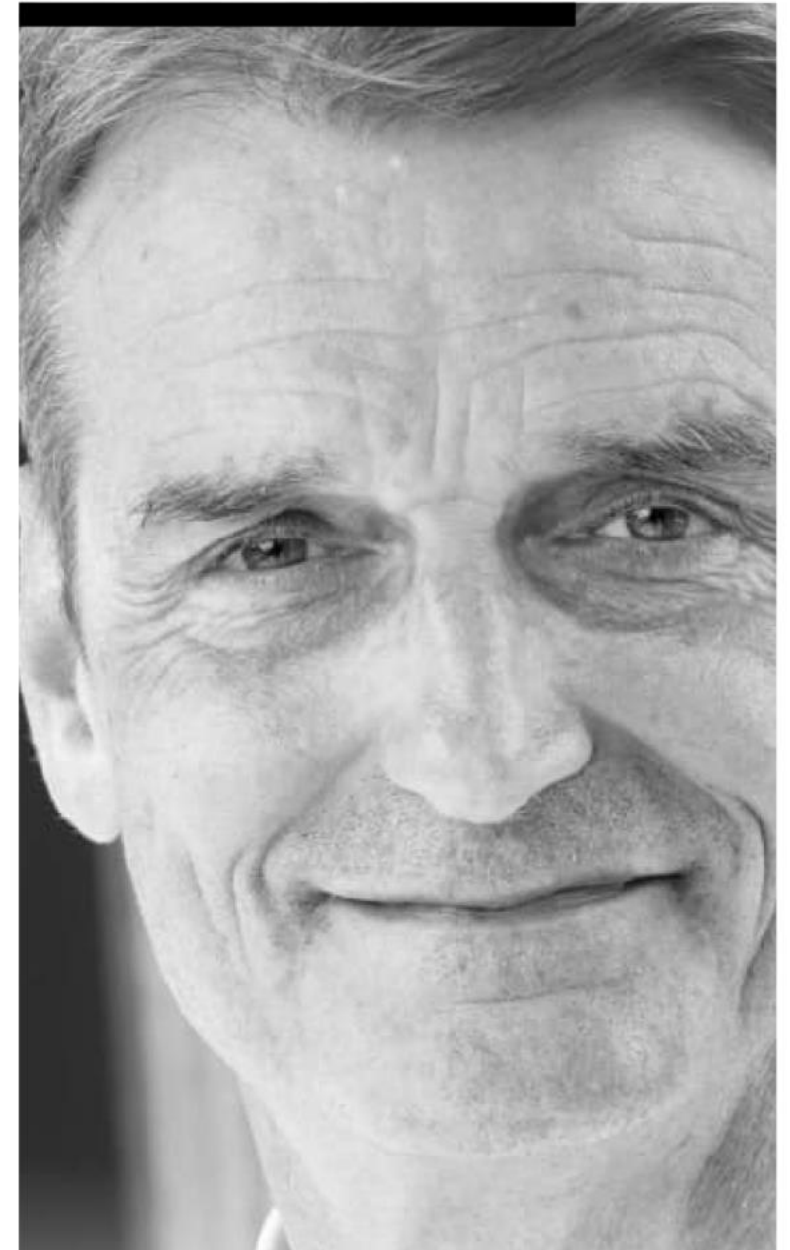
Volgens de JC zijn de juiste vragen:

- *Wie heeft er last van / is benadeeld?*
- *Wie is het slachtoffer (ook "second"?)*
- *Wat hebben ze nodig?*
- *Wie moet daarvoor zorgen?*

Chirurg Jaap Hamming maakt zich hard voor Just Culture

**‘Niemand maakt  
moedwillig fouten’**

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# 3: Veel melden

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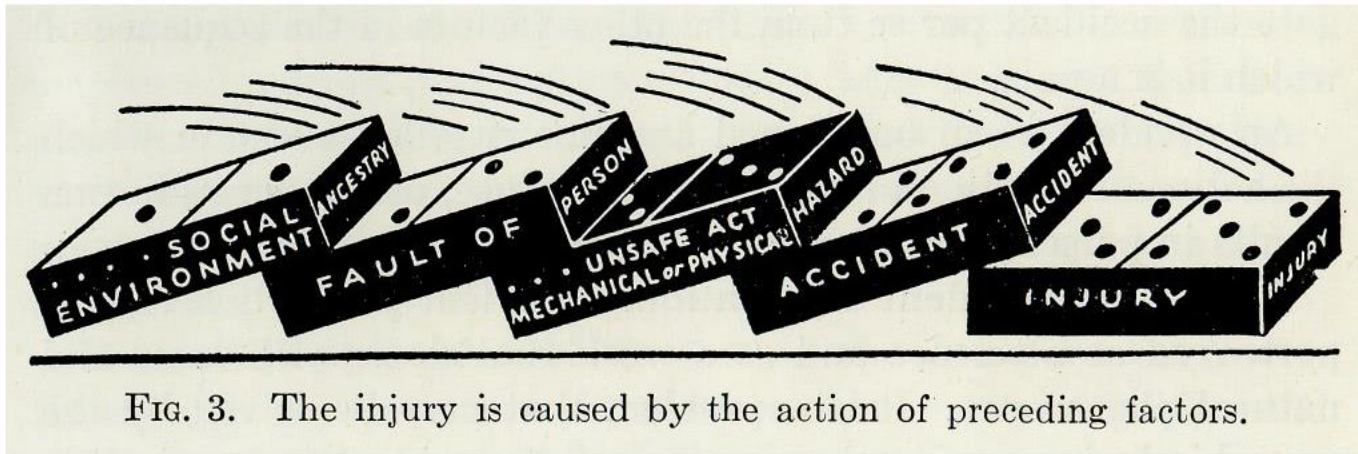


FIG. 3. The injury is caused by the action of preceding factors.



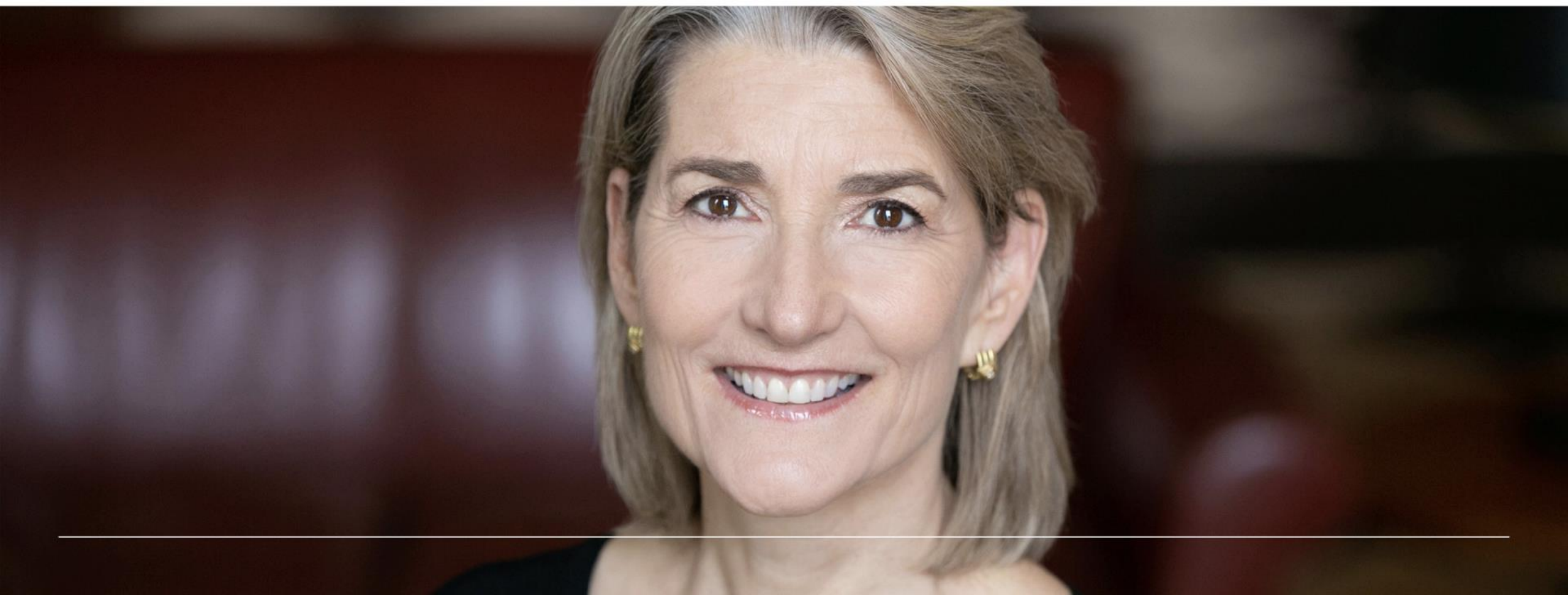


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# Amy Edmondson



# Harvard Business Review



# Met stip bovenaan



1

## Psychological Safety

Team members feel safe to take risks and be vulnerable in front of each other.

2

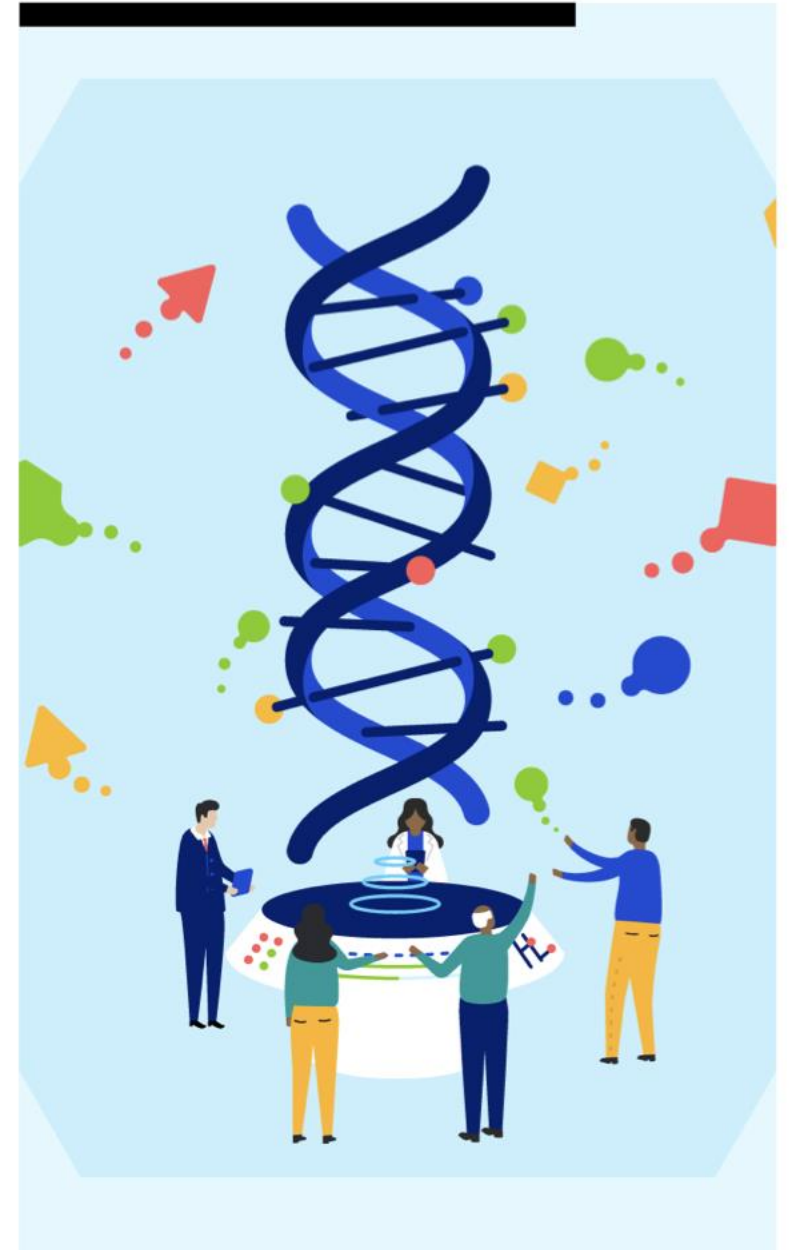
## Dependability

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# Psychological safety

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- Bewezen relatie met veiligheidsperformance en informatie delen
- Onderzoek: relatie met innovatief gedrag (beste beentje voorzetten)
- Helaas: hoe we kunnen verbeteren is nog niet helemaal duidelijk
- Invloeden:
  - Diversiteit in teams
  - Leiderschap
  - Gedrag
- Gedragsobservaties en interventies



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# Observatie Bingo

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Positief	Negatief
Persoonlijke aandacht	Gesloten lichaamshouding
Enthousiasme	Probleemvermijdend
Actief luisteren	Geef anderen de schuld / ontkenning
Stel open vragen	Onderbreken
Vraag om hulp	Sub-groepen vormen
Vraag en geef feedback	Geef zelfde mensen de vloer
Positieve reactie op ideeën	Reageer koel op ideeën
Deel ervaring kennis	Lees of werk tijdens bijeenkomsten
Beloon ook proces	Beloon alleen uitkomsten

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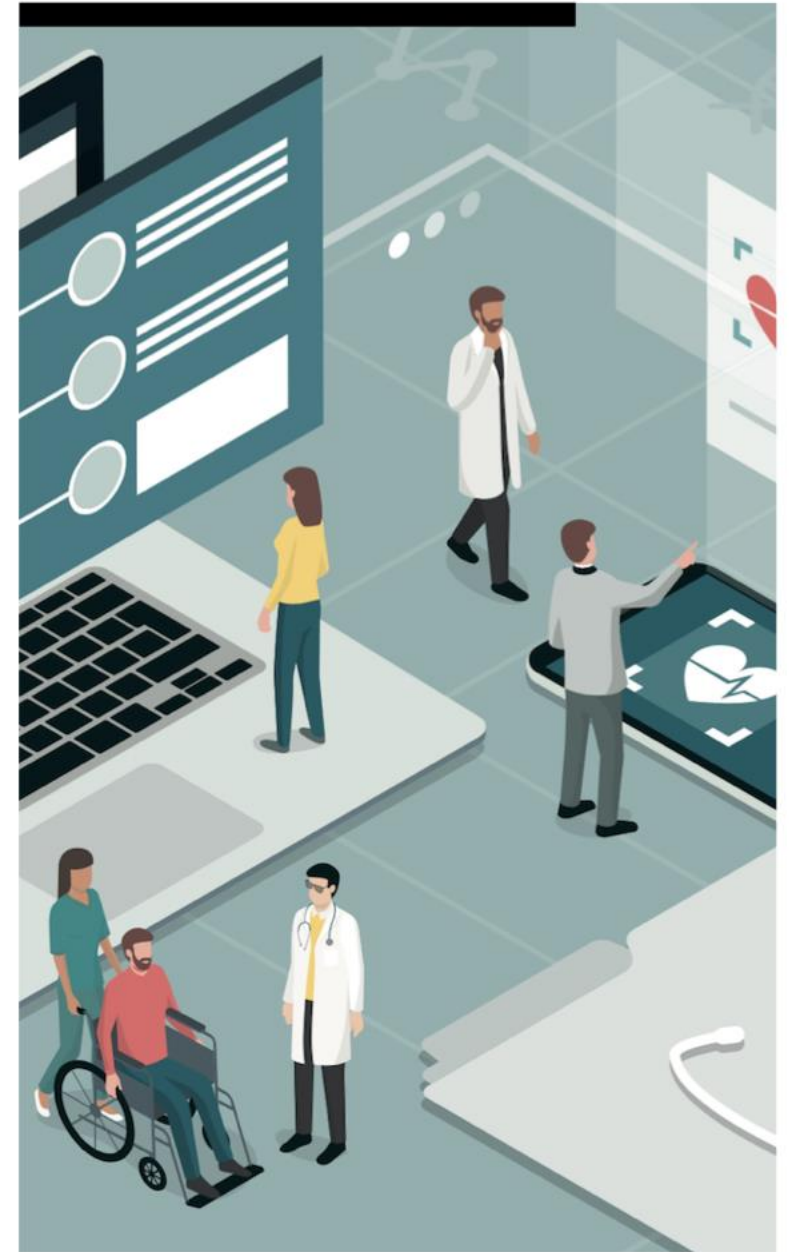


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# Conclusies

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- Goede zorg is onder andere een kwestie van samenwerken als team
- Om teamwork verder te verbeteren is een psychologisch veilige cultuur belangrijk waarin men 'sociale risico's durft te nemen'
- Dat geldt niet alleen voor 'negatieve' zaken als incidenten maar juist ook voor het durven inbrengen van innovatieve ideeën
- Psychological safety is eenvoudig te meten (5-7 vragen) en te observeren, maar....
- Uitdaging: toegankelijke interventies ontwikkelen die het teamwork in de zorg aantoonbaar verbeteren





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# Succes!

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