

Learning Best Practices:

Individual-level:

Self-reflection (reflective openness) – extended self-examination of near misses and mistakes, in particular around how the near miss or mistake is being conceptualized by the individual and the larger lessons to be learned from it.

Sharing experiences (participative openness) – communicating to others personal stories and experiences about near misses and mistakes committed.

Personal forgiveness – willingness to forgive oneself for committing a near miss or mistake, not excusing one's part in the incident but not letting the event create untrue or exaggerated beliefs in the individual's mind.

Habit of inquiry – willingness to engage surrounding individuals (superiors, peer colleagues, non-physician co-workers) with respect to asking questions around mistakes, patient safety, and correct ways of doing work. Tendency to ask “Why” in addition to “How” around the processes for identifying, investigating, and resolving mistake and near miss situations.

Acknowledgement of doubt/expressions of fallibility – willingness to reveal to one's self and others concerns over “knowing all the right things” or “making a mistake”.

Empathy towards others – expressing feelings and concern for those in the group who make mistakes and experience failure, a “there but for the grace of God go I” mentality that allows the individual to gain understanding from someone else's experience.

Systems thinking – thinking about or couching episodes of error or failure within the context of the total surrounding system of care, as well as contextual features of the individual's work life (e.g., fatigue) that may serve as contributory factors. Willingness to develop logics that link contextual factors to increased probability for the error or failure.

Group or team level: (includes faculty and residents as a single “team” or “group”)

Feedback – higher levels in the training hierarchy communicating down to lower-levels specific aspects of why something is a particular mistake or error. Whether or not that communication is positive, negative, or valuable to lower-levels, the communication provides information that allows the lower-levels to understand the point of view and “norms” of higher-levels.

Reciprocal communication – Communication moves both from top-down and bottom-up throughout the team, with less experienced members afforded equivalent chances of injecting their views, concerns, etc.

Support over blame – Within the group, emphasis is placed on dealing with mistakes through a supportive rather than blaming approach, the latter defined primarily by putting the onus for a mistake or near miss either completely on the individual or completely on one or more system aspects surrounding the individual.

Collaborative inquiry – adopting a collective approach to uncovering, examining, and resolving a mistake or near miss problem. Employing a flattened rather than purely hierarchical approach to gaining and assessing information around the problem.

Conflict management/creative tension – Disagreements in the group are tolerated, listened to, and resolved not by fiat but by trying to reach consensus, not limited to consensus of the most experienced individuals in the team. The group tolerates debate and disagreement where uncertainty is high around a mistake or near miss, using that disagreement to generate a variety of explanatory interpretations.

“Real-time” experimentation/ Risk-taking around seeing things in new ways
– willingness for the group as a whole, spearheaded by higher-levels in the training hierarchy, to recast mistake or error events in a way that questions the underlying assumptions upon which the work leading to that error or mistake is done.

Use of “real time” briefings – willingness of higher levels in the training hierarchy to, at the moment a mistake is discovered or heard about, take a constructive approach to educating lower-levels around ways to lessen the probability for such a mistake to happen again in the future.