Commission consultative cantonale pour la sécurité des patients et la qualité des soins (CSPQS)
Kantonale beratende Kommission für Patientensicherheit und Versorgungsqualität (KPSVQ)

CANTON DU VALAIS
KANTON WALLIS

JEUDI 2 OCTOBRE 2025
DE 13H30 À 17H30

4eme forum de la CSPQS

Promouvoir la Just Culture : vers une approche non-punitive de l'erreur en santé

Technopôle Sierre, salle Electra

Leadership et Culture Juste: facteur limitant ou facteur favorisant ?

Pr Guy Haller MD MSc PhD

Commission consultative cantonale pour la sécurité des patients et la qualité des soins (CSPQS)
Kantonale beratende Kommission für Patientensicherheit und Versorgungsqualität (KPSVQ)

CANTON DU VALAIS
KANTON WALLIS

DONNERSTAG, 2. OKTOBER 2025
VON 13:30 BIS 17:30 UHR

4. Forum der KPSVQ

Förderung der Just Culture: Auf dem Weg zu einem nicht sanktionierenden Ansatz bezüglich Fehler im Gesundheitswesen

TECHNOPÔLE SIERRE, SAAL ELECTRA

Leadership und Just Culture: Hindernis oder Förderfaktor?

Prof. Guy Haller, MD MSc PhD

Conflits d’intérêts

- Membre expert de la commission fédérale pour la qualité
- Membre du comité qualité et sécurité de la société européenne d’anesthésie
- Responsable projet national safety culture Switzerland

Interessenkonflikte

- Mitglied der Eidgenössischen Qualitätskommission (EQK)
- Mitglied des Qualitäts- und Sicherheitsvorstands der Europäischen Gesellschaft für Anästhesiologie und Intensivmedizin (ESAIC)
- Leiter des nationalen Projekts Safety Culture Switzerland

Résumé

- Définitions
- Identification de la culture juste dans une organisation
- Rôle du leader dans le changement de la culture organisationnelle
- Facteurs de tension
- Take home messages

Abriss

- Definitionen
- Identifizierung der Just Culture in einer Organisation
- Rolle des Leaders bei der Veränderung der Organisationskultur
- Behindernde Faktoren
- Take Home Messages

Définition de la culture juste dans le monde de la santé

La culture juste se réfère à la manière dont une organisation gère ses erreurs. Elle met l'accent sur l'apprentissage à partir des erreurs, l'identification et la résolution des problèmes systémiques qui conduisent les individus à adopter des comportements dangereux, ainsi qu'une approche équitable et non punitive de l'erreur humaine, sauf en cas de comportement imprudent ou inapproprié

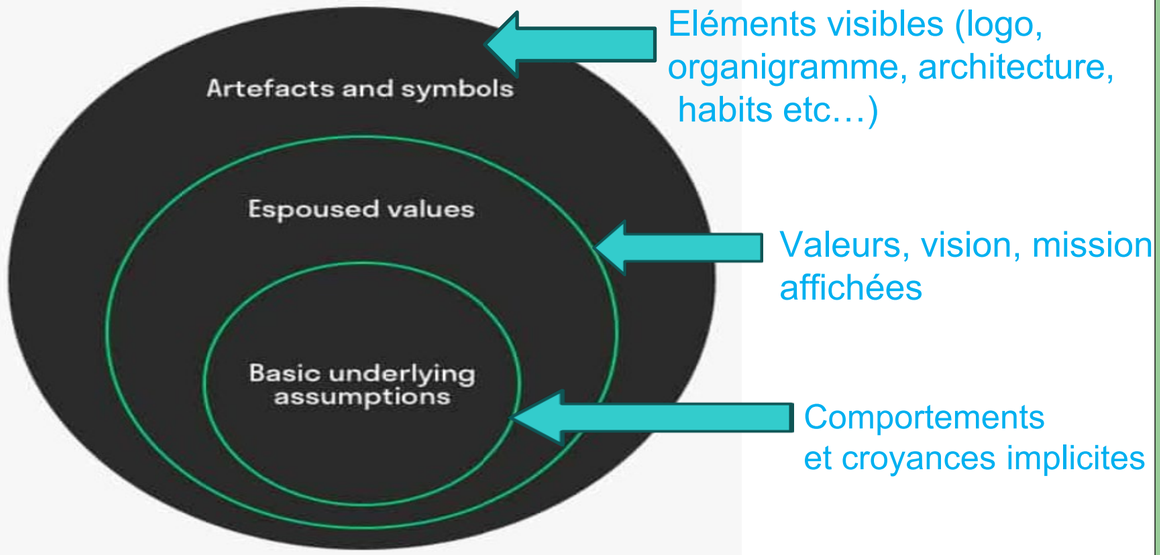
M. Kilcullen et al. 2002
Patientensicherheit Schweiz 2024

Definition von Just Culture im Gesundheitswesen

Just Culture bezieht sich auf die Art und Weise, wie eine Organisation mit Fehlern umgeht. In einer Just Culture wird der Akzent darauf gesetzt, aus Fehlern zu lernen, Systemprobleme, die Personen zu einem gefährlichen Verhalten führen, zu identifizieren und zu beseitigen, sowie einen gerechten und nicht bestrafenden Ansatz bei menschlichen Fehlern zu verfolgen, sofern kein unvorsichtiges oder unangemessenes Verhalten vorlag.

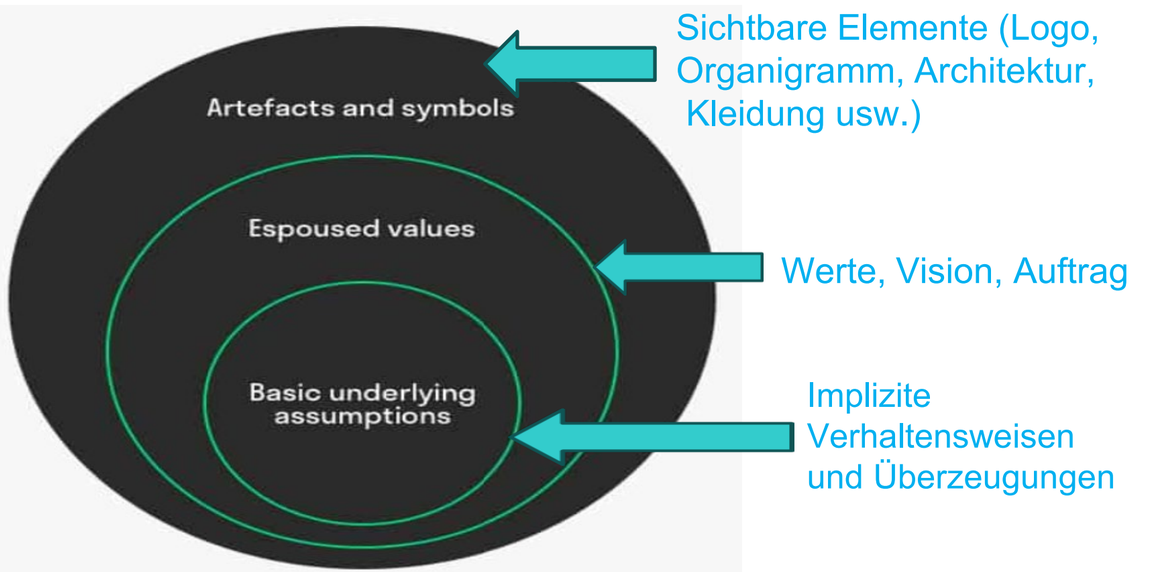
M. Kilcullen et al. 2002
Patientensicherheit Schweiz 2024

La culture d'une organisation: le modèle d'Edgar Schein



Schein, E. H. (2010). *Organizational Culture and Leadership*. Jossey-Bass.

Organisationskultur: das Modell von Edgar Schein



Schein, E. H. (2010). *Organizational Culture and Leadership*. Jossey-Bass.

Artefacts et symboles

En analysant les artefacts vestimentaires et symboles, quelle image reflète le mieux pour vous une culture juste autour de l’erreur dans l’organisation ?

Artekfakte und Symbole

Wenn Sie Artefakte wie Kleidung und Symbole analysieren – welches Image widerspiegelt für Sie am besten eine Just Culture in Bezug auf organisationsinterne Fehler?

Valeurs affichées

Le CHUV est un centre médical universitaire reconnu pour son excellence clinique et académique et un lieu privilégié de formation pour tous-tes les professionnel-les de la santé et les autres professions liées à l'activité de l'hôpital.

Cleveland Clinic

Nous adhérons à des principes moraux et à des normes professionnelles élevés en nous engageant à faire preuve d'honnêteté, de confidentialité, de confiance, de respect et de transparence.

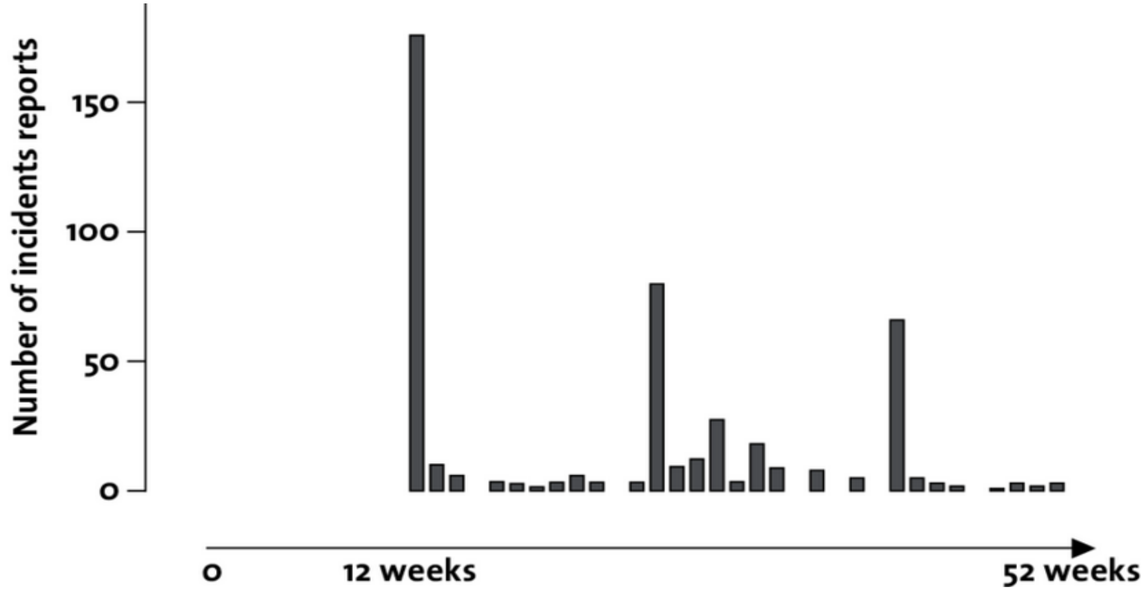
Bekundete Werte

Das CHUV ist ein Universitätsspital, das für seine klinische und akademische Exzellenz bekannt ist und ein bevorzugter Ausbildungsort für alle Gesundheitsfachkräfte und anderen Berufe im Spitalwesen ist.

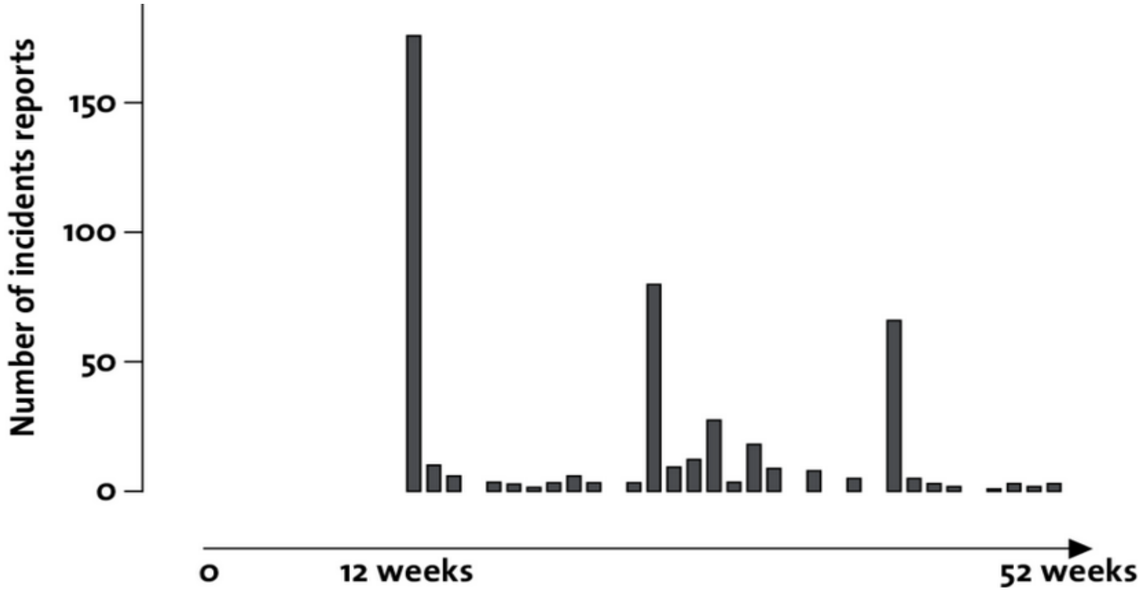
Cleveland Clinic

Wir halten uns an moralische Grundsätze und hohe berufliche Standards, im steten Bestreben, Ehrlichkeit, Vertraulichkeit, Vertrauen, Respekt und Transparenz an den Tag zu legen.

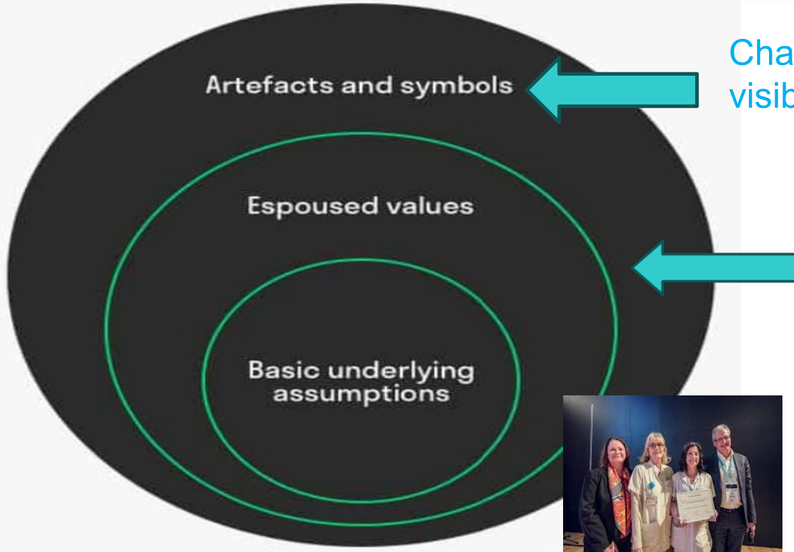
Comportements et croyances



Verhaltensweisen und Überzeugungen



Rôle du leader: un vecteur majeur de changement



Changement des éléments visibles

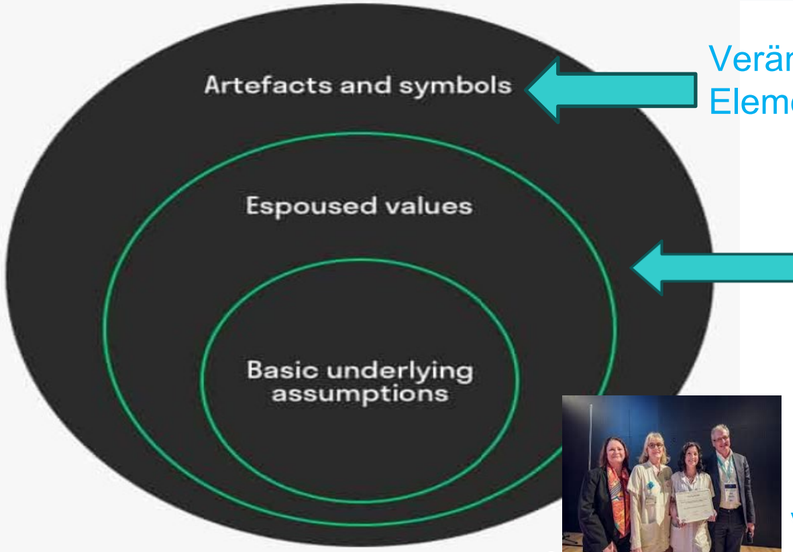
Changements de vision et valeurs

Changement des comportements implicites

Patient Safety: A Shared Vision for Manitobans

Integrating the Manitoba Institute for Patient Safety into Shared Health

Rolle des Leaders: ein wesentlicher Vektor für Veränderung



Veränderung der sichtbaren Elemente

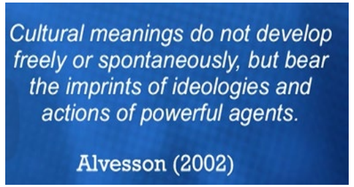
Veränderung von Vision und Werten

Veränderung der impliziten Verhaltensweisen

Patient Safety: A Shared Vision for Manitobans

Integrating the Manitoba Institute for Patient Safety into Shared Health

Comment réaliser le changement des comportements implicites



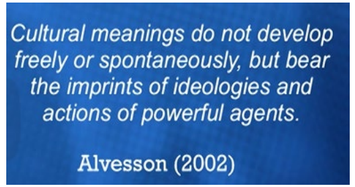
Le leader est l'un de ces puissants vecteurs de changement

Etape 1: Créer la motivation pour le changement

Exposer les bénéfices de la nouvelle approche
Valider l'anxiété et corriger toute information désécurisante.
Créer un confort psychologique

M Alvesson & AW Johansson (2002) .Professionalism and politics in management consultancy work. RA/Fox Publishing

Wie können implizite Verhaltensweisen geändert werden?



Der Leader ist einer der einflussreichen Vektoren für Veränderung

1. Etappe: Motivation für Veränderung schaffen

Die Vorteile des neuen Ansatzes aufzeigen
Ängste anerkennen und Unsicherheit stiftende Informationen korrigieren
Psychologisches Wohlbefinden schaffen

M. Alvesson & A. W. Johansson (2002). Professionalism and politics in management consultancy work. RA/Fox Publishing

Comment réaliser le changement des comportements implicites

Etape 2: Enseigner de nouveaux concepts et standards de jugement

Se comporter comme un « rôle-model »
Favoriser l'approche « trial and errors » avec une posture de mentor

Etape 3: Faire internaliser les nouveaux concepts et standards

Créer des nouveaux rituels et récompenser les comportements attendus

M Alvesson & AW Johansson (2002) .Professionalism and politics in management consultancy work. RA/Fox Publishing

Wie können implizite Verhaltensweisen geändert werden?

2. Etappe: Neue Konzepte und Beurteilungsstandards vermitteln

Mit einer Vorbildfunktion vorangehen
Mit einer Haltung als Mentor den «Trial and Error»-Ansatz fördern

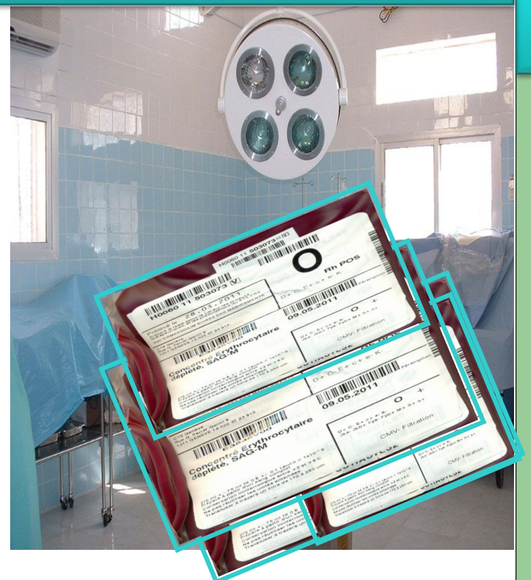
3. Etappe: Die neuen Konzepte und Standards verinnerlichen

Neue Rituale schaffen und die erwarteten Verhaltensweisen belohnen

M. Alvesson & A. W. Johansson (2002). Professionalism and politics in management consultancy work. RA/Fox Publishing

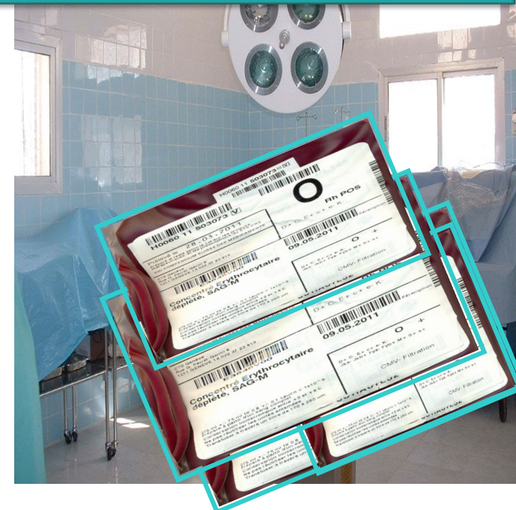
Exemple de changement des comportements implicites

Décentralisation des stocks de culots de sang



Beispiel für die Veränderung impliziter Verhaltensweisen

Dezentralisierung der Lagerung von Blutprodukten



Etapes

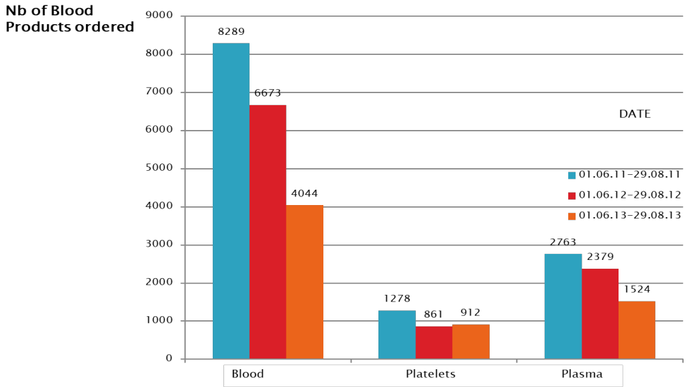
- Information large
  - Manques de CE
  - Audit Swiss Medic
  - Nécessité de redesigner le circuit du sang au niveau hospitalier
- Rassurer les équipes
  - Multiples tests pilotes
  - Publication des bons résultats des équipes de transport
- Désignation de porteurs de projet dans les blocs
  - Formations locales
  - Revues d'incident
  - Création de protocoles

Etappen

- Breit angelegte Information
  - Fehlende Erythrozytenkonzentrate (EK)
  - Swiss Medic-Audit
  - Blutlieferungs-Management im Spital muss neu organisiert werden
- Teams bestärken
  - Mehrere Pilottests
  - Veröffentlichung der guten Ergebnisse der Lieferteams
- Bezeichnung von Projektträgern in den Trakten
  - Lokale Schulungen
  - Reviews von Zwischenfällen
  - Schaffung von Protokollen

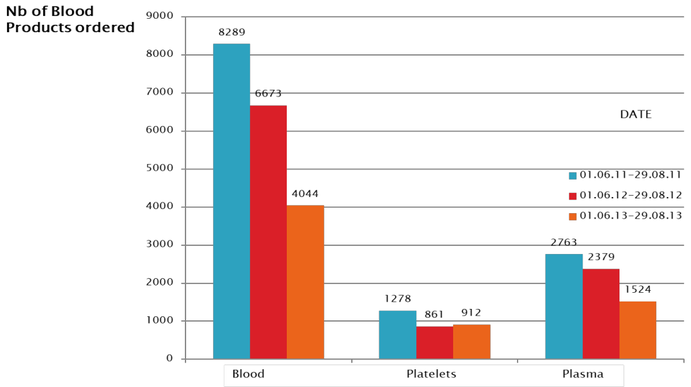
Etapes

- Création de nouvelles normes et récompenses
  - Indicateurs de temps de distribution
  - Mesure des CE « perdus »
  - Récompense par un prix qualité



Etappen

- Schaffung neuer Normen und Belohnungen
  - Indikatoren für die Lieferzeit
  - Messung «verlorener» EK
  - Belohnung durch einen Vorzugspreis



Facteurs de tension externes pour un leader

Politique

- Image institution
- Incitatifs sur d'autres priorités

Juridique

- Recherche de responsabilité
- Absence de protection pour les déclarants

Economique

- Rentabilité économique de la culture juste ?

Externe behindernde Faktoren für einen Leader

Politik

- Institutions-Image
- Anreize für andere Prioritäten

Rechtlich

- Haftungsfrage
- Fehlender Schutz für Meldende

Wirtschaftlich

- Wirtschaftliche Rentabilität der Just Culture?

Facteurs de tension internes pour un leader

Tensions dans l'organisation

- Priorités stratégiques vs professionnelles
- Turn over

Technique

- Outils
- Processus

Fausses croyances

- Multiples….

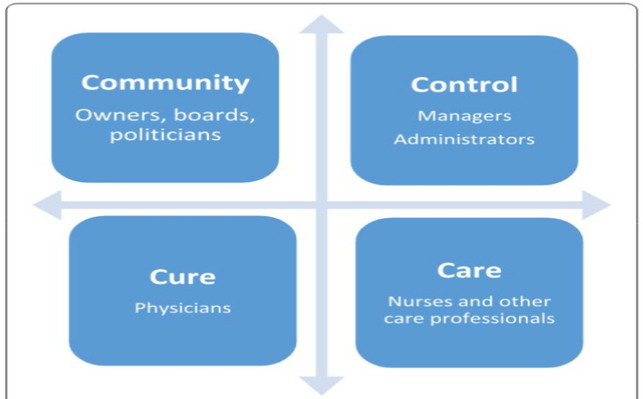


Fig. 1 The four worlds in the healthcare organization, adapted from Glouberman and Mintzberg (2001) [20]

Interne behindernde Faktoren für einen Leader

Spannungen innerhalb der Organisation

- Strategische vs. professionelle Prioritäten
- Turn-over

Technik

- Tools
- Prozesse

Irrglauben

- Vielfältige....

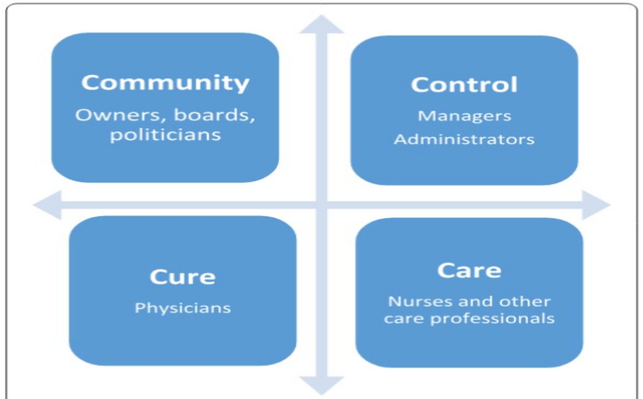


Fig. 1 The four worlds in the healthcare organization, adapted from Glouberman and Mintzberg (2001) [20]

Fausses croyances

- Les internes en formation déclarent moins souvent les incidents que leurs aînés

Vincent C et al. J Eval Clin Practice 1999
Barach P et al. BMJ 2000
Lawton R Qual and Saf Healthcare 2004

Irrglauben

- Assistenzärzte melden Zwischenfälle seltener als etabliertere Mitarbeitende.

Vincent C et al. J Eval Clin Practice 1999
Barach P et al. BMJ 2000
Lawton R Qual and Saf Healthcare 2004

En fait :

Table 2 Adjusted anaesthesia-related factors associated with the non-utilization of the incident reporting system. *An OR <1.0 indicates a reduced risk of non-utilization, and is adjusted for patient age, comorbidities, ASA score, and its interaction with type of anaesthesia and category of surgical procedure

Risk factor	OR (95% CI)*	P-value
Anaesthesia procedure characteristics		
General anaesthesia (with or w/o local/regional)	1.41 (0.90–2.22)	0.12
General anaesthesia with advanced monitoring)	0.58 (0.51–0.64)	<0.001
General anaesthesia with blood transfusion)	0.62 (0.52–0.74)	<0.001
Only local/regional	1.64 (1.03–2.62)	0.03
Sedation (with or w/o local/regional)	1.84 (1.17–2.89)	0.008
Duration of procedure		
Brief (<35 min)	1.0 (reference)	<0.001
Short (36–64 min)	0.88 (0.80–0.95)	
Intermediate (65–120 min)	0.81 (0.74–0.88)	
Long (>120 min)	0.85 (0.76–0.94)	
Timing and planning of procedures		
In-hours (07:00–18:59)	0.91 (0.81–1.02)	0.11
Late hours (from 07:00 to >18:59)	1.02 (0.84–1.25)	0.78
Emergency procedure	1.15 (1.05–1.27)	0.003
Weekend procedure	1.03 (0.92–1.16)	0.52
Physician characteristics		
Seniority		
Registrar: basic training	1	<0.001
Registrar: advanced training	0.86 (0.81–0.92)	
Consultant	1.71 (1.03–2.82)	
Team composition		
Consultant with one registrar	1	1.0
Consultant supervising several registrars (and in theatre suite)	0.94 (0.83–1.06)	0.36
Consultant with several registrars (but outside theatre suite)	0.91 (0.84–0.99)	0.03
Severity of anaesthesia-related complications		
No change in hospital course	1	<0.001
Reversible deficit with change in hospital course	0.75 (0.61–0.93)	
Death or irreversible deficit	0.54 (0.30–0.99)	

Les internes en formation déclarent plus souvent que leurs aînés

Haller G et al BJA 2011
Kreckler S et al Qual Saf Healthcare 2009

In Wirklichkeit:

Table 2 Adjusted anaesthesia-related factors associated with the non-utilization of the incident reporting system. *An OR <1.0 indicates a reduced risk of non-utilization, and is adjusted for patient age, comorbidities, ASA score, and its interaction with type of anaesthesia and category of surgical procedure

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Assistenzärzte melden Zwischenfälle häufiger als etabliertere Mitarbeitende.

Haller G et al BJA 2011
Kreckler S et al Qual Saf Healthcare 2009

Fausses croyances

- Les incidents graves sont cachés

Waring J Soc Sci Med 205
Barach P et al. BMJ 2000
Lawton R Qual and Saf Healthcare 2004

Irrglauben

- Schwere Zwischenfälle werden verheimlicht.

Waring J. Soc Sci Med 205
Barach P et al. BMJ 2000
Lawton R Qual and Saf Healthcare 2004

En fait:

Table 3 Litigation risk and non-utilization of the incident reporting system. *An OR <1.0 indicates a reduced risk of non-utilization, and is adjusted for patient age, ASA score, type of surgery and anaesthesia, supervision level, seniority of trainees, and emergency status

	OR (95% CI)*	*P*-value
Litigation risk		
Absent	1.0	<0.001
Intermediate or low	0.67 (0.54–0.83)	
High	0.65 (0.44–0.97)	

Les incidents graves sont plus souvent déclarés

Schmidek JM et al. Qual Saf Healthcare 2005
Haller G et al BJA 2011

In Wirklichkeit:

Table 3 Litigation risk and non-utilization of the incident reporting system. *An OR <1.0 indicates a reduced risk of non-utilization, and is adjusted for patient age, ASA score, type of surgery and anaesthesia, supervision level, seniority of trainees, and emergency status

	OR (95% CI)*	*P*-value
Litigation risk		
Absent	1.0	<0.001
Intermediate or low	0.67 (0.54–0.83)	
High	0.65 (0.44–0.97)	

Schwere Zwischenfälle werden häufiger gemeldet.

Schmidek JM et al. Qual Saf Healthcare 2005
Haller G et al BJA 2011

Fausses croyances

- Les systèmes de rapport d'incident améliorent la sécurité des soins

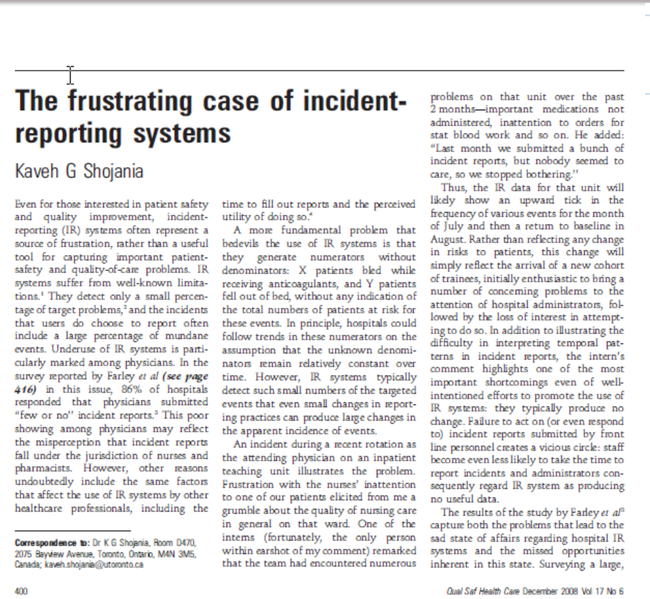
Mahajan RP BJA 2010
Leape L NEJM 2001
Barach P et al. BMJ 2000
Kaplan H et al. Qual Saf Health Care. 2002

Irrglauben

- Die Systeme zur Meldung von Zwischenfällen verbessern die Versorgungssicherheit.

Mahajan RP BJA 2010
Leape L NEJM 2001
Barach P et al. BMJ 2000
Kaplan H et al. Qual Saf Health Care. 2002

En fait :



The frustrating case of incident-reporting systems

Kaveh G Shojania

Even for those interested in patient safety and quality improvement, incident-reporting (IR) systems often represent a source of frustration, rather than a useful tool for capturing important patient-safety and quality-of-care problems. IR systems suffer from well-known limitations.[1] They detect only a small percentage of target problems,[2] and the incidents that users do choose to report often include a large percentage of mundane events. Underuse of IR systems is particularly marked among physicians. In the survey reported by Farley *et al* ***(see page 416)*** in this issue, 86% of hospitals responded that physicians submitted "few or no" incident reports.[3] This poor showing among physicians may reflect the misperception that incident reports fall under the jurisdiction of nurses and pharmacists. However, other reasons undoubtedly include the same factors that affect the use of IR systems by other healthcare professionals, including the time to fill out reports and the perceived utility of doing so.[4]

A more fundamental problem that bedevils the use of IR systems is that they generate numerators without denominators: X patients bled while receiving anticoagulants, and Y patients fell out of bed, without any indication of the total numbers of patients at risk for these events. In principle, hospitals could follow trends in these numerators on the assumption that the unknown denominators remain relatively constant over time. However, IR systems typically detect such small numbers of the targeted events that even small changes in reporting practices can produce large changes in the apparent incidence of events.

An incident during a recent rotation as the attending physician on an inpatient teaching unit illustrates the problem. Frustration with the nurses' inattention to one of our patients elicited from me a grumble about the quality of nursing care in general on that ward. One of the interns (fortunately, the only person within earshot of my comment) remarked that the team had encountered numerous problems on that unit over the past 2 months—important medications not administered, inattention to orders for stat blood work and so on. He added: "Last month we submitted a bunch of incident reports, but nobody seemed to care, so we stopped bothering."

Thus, the IR data for that unit will likely show an upward tick in the frequency of various events for the month of July and then a return to baseline in August. Rather than reflecting any change in risks to patients, this change will simply reflect the arrival of a new cohort of trainees, initially enthusiastic to bring a number of concerning problems to the attention of hospital administrators, followed by the loss of interest in attempting to do so. In addition to illustrating the difficulty in interpreting temporal patterns in incident reports, the intern's comment highlights one of the most important shortcomings even of well-intentioned efforts to promote the use of IR systems: they typically produce no change. Failure to act on (or even respond to) incident reports submitted by front line personnel creates a vicious circle: staff become even less likely to take the time to report incidents and administrators consequently regard IR system as producing no useful data.

The results of the study by Farley *et al*[3] capture both the problems that lead to the sad state of affairs regarding hospital IR systems and the missed opportunities inherent in this state. Surveying a large,

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Interventions to increase clinical incident reporting in health care

Elena Parmelli[1], **Gerd Flodgren**[2], **Scott G Fraser**[3], **Nicola Williams**[4], **Gregory Rubin**[5], and **Martin P Eccles**[6]

[1]Department of Oncology, Hematology and Respiratory Diseases, University of Modena and Reggio Emilia, Modena, Italy.

[2]Department of Public Health, University of Oxford, Headington, UK.

[3]Sunderland Eye Infirmary, Sunderland, UK.

[4]NHS Support Group, Centre for Statistics in Medicine, Oxford, UK.

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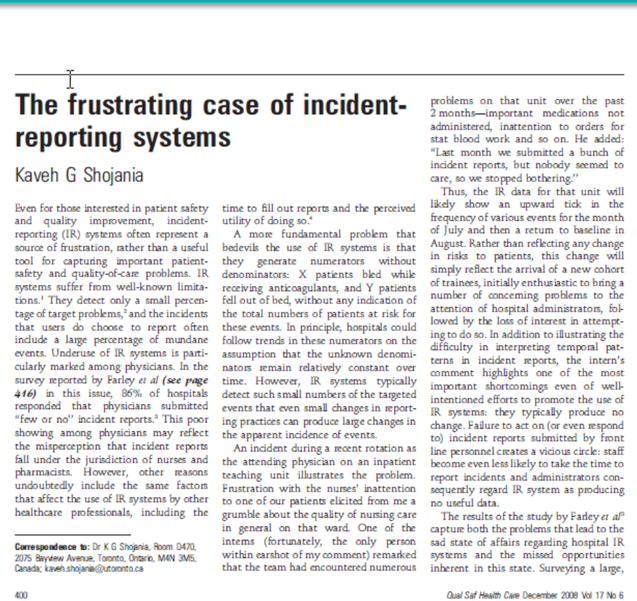
Le signalement des incidents améliore la culture sécurité et les pratiques de signalement. Le bénéfice sur la qualité et la sécurité globale des patients reste à démontrer formellement

In Wirklichkeit:



The frustrating case of incident-reporting systems

Kaveh G Shojania

Even for those interested in patient safety and quality improvement, incident-reporting (IR) systems often represent a source of frustration, rather than a useful tool for capturing important patient-safety and quality-of-care problems. IR systems suffer from well-known limitations.[1] They detect only a small percentage of target problems,[2] and the incidents that users do choose to report often include a large percentage of mundane events. Underuse of IR systems is particularly marked among physicians. In the survey reported by Farley *et al* ***(see page 416)*** in this issue, 86% of hospitals responded that physicians submitted "few or no" incident reports.[3] This poor showing among physicians may reflect the misperception that incident reports fall under the jurisdiction of nurses and pharmacists. However, other reasons undoubtedly include the same factors that affect the use of IR systems by other healthcare professionals, including the time to fill out reports and the perceived utility of doing so.[4]

A more fundamental problem that bedevils the use of IR systems is that they generate numerators without denominators: X patients bled while receiving anticoagulants, and Y patients fell out of bed, without any indication of the total numbers of patients at risk for these events. In principle, hospitals could follow trends in these numerators on the assumption that the unknown denominators remain relatively constant over time. However, IR systems typically detect such small numbers of the targeted events that even small changes in reporting practices can produce large changes in the apparent incidence of events.

An incident during a recent rotation as the attending physician on an inpatient teaching unit illustrates the problem. Frustration with the nurses' inattention to one of our patients elicited from me a grumble about the quality of nursing care in general on that ward. One of the interns (fortunately, the only person within earshot of my comment) remarked that the team had encountered numerous problems on that unit over the past 2 months—important medications not administered, inattention to orders for stat blood work and so on. He added: "Last month we submitted a bunch of incident reports, but nobody seemed to care, so we stopped bothering."

Thus, the IR data for that unit will likely show an upward tick in the frequency of various events for the month of July and then a return to baseline in August. Rather than reflecting any change in risks to patients, this change will simply reflect the arrival of a new cohort of trainees, initially enthusiastic to bring a number of concerning problems to the attention of hospital administrators, followed by the loss of interest in attempting to do so. In addition to illustrating the difficulty in interpreting temporal patterns in incident reports, the intern's comment highlights one of the most important shortcomings even of well-intentioned efforts to promote the use of IR systems: they typically produce no change. Failure to act on (or even respond to) incident reports submitted by front line personnel creates a vicious circle: staff become even less likely to take the time to report incidents and administrators consequently regard IR system as producing no useful data.

The results of the study by Farley *et al*[3] capture both the problems that lead to the sad state of affairs regarding hospital IR systems and the missed opportunities inherent in this state. Surveying a large,

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Interventions to increase clinical incident reporting in health care

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Die Meldung von Zwischenfällen verbessert die Sicherheitskultur und die Meldepraktiken. Der Nutzen für die allgemeine Qualität und Sicherheit der Patienten ist formell noch zu bestätigen.

Take Home Messages

Les leaders des organisations de santé ont de nombreux moyens pour mettre en place une culture juste

Les leaders sont soumis à de multiples contraintes, souvent conflictuelles, qui ne favorisent pas toujours l'émergence d'une culture juste

Il est essentiel pour faire émerger cette dernière, que tous les facteurs externes comme internes aux organisations de santé facilitent le travail du leader dans son action en faveur d'une culture juste

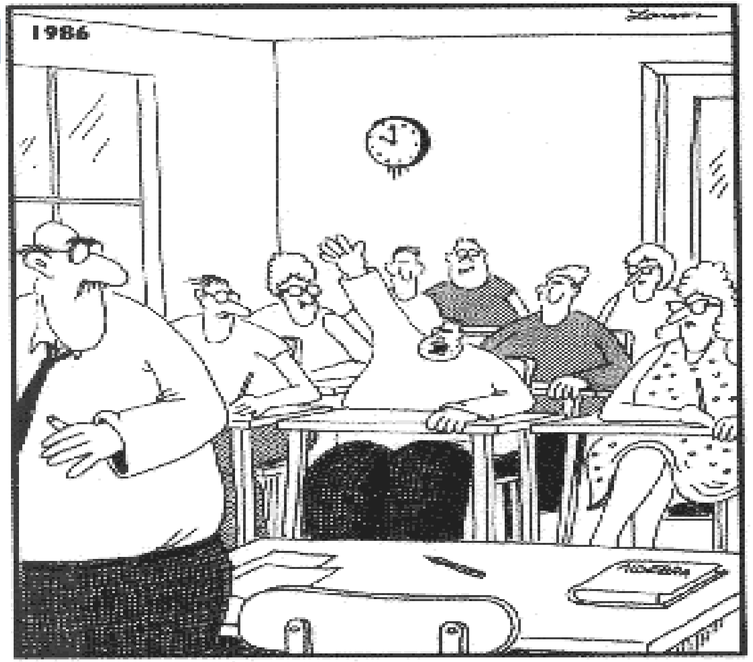
Take Home Messages

Die Leader der Gesundheitsorganisationen haben zahlreiche Möglichkeiten, eine Just Culture einzuführen.

Die Leader sind zahlreichen Einschränkungen unterworfen, die häufig mit Konflikten einhergehen, welche das Aufblühen einer Just Culture nicht immer begünstigen.

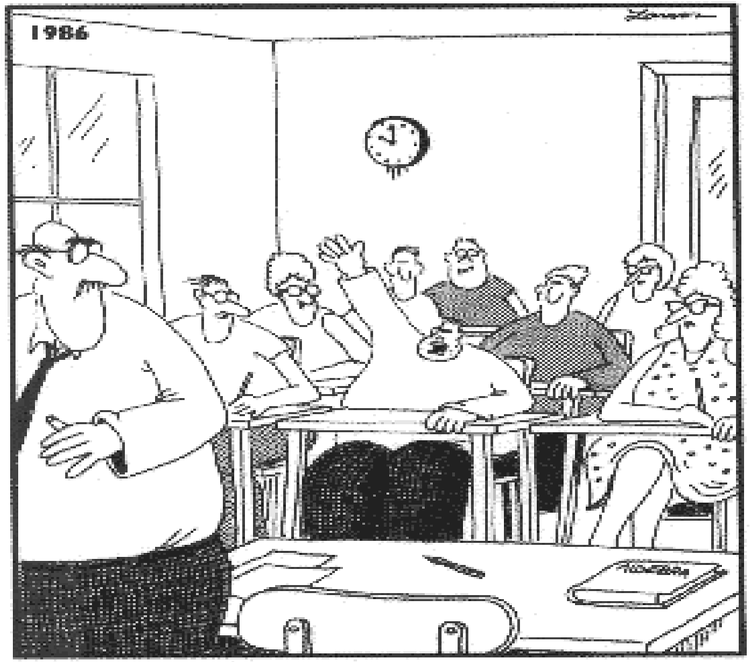
Um eine Just Culture aufzubauen, müssen unbedingt alle externen und internen Faktoren der Gesundheitsorganisationen die Arbeit des Leaders im Sinne der Just Culture erleichtern.

Questions



"Mr. Osborne, may I be excused? My brain is full."

Fragen



"Mr. Osborne, may I be excused? My brain is full."