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A Just Culture

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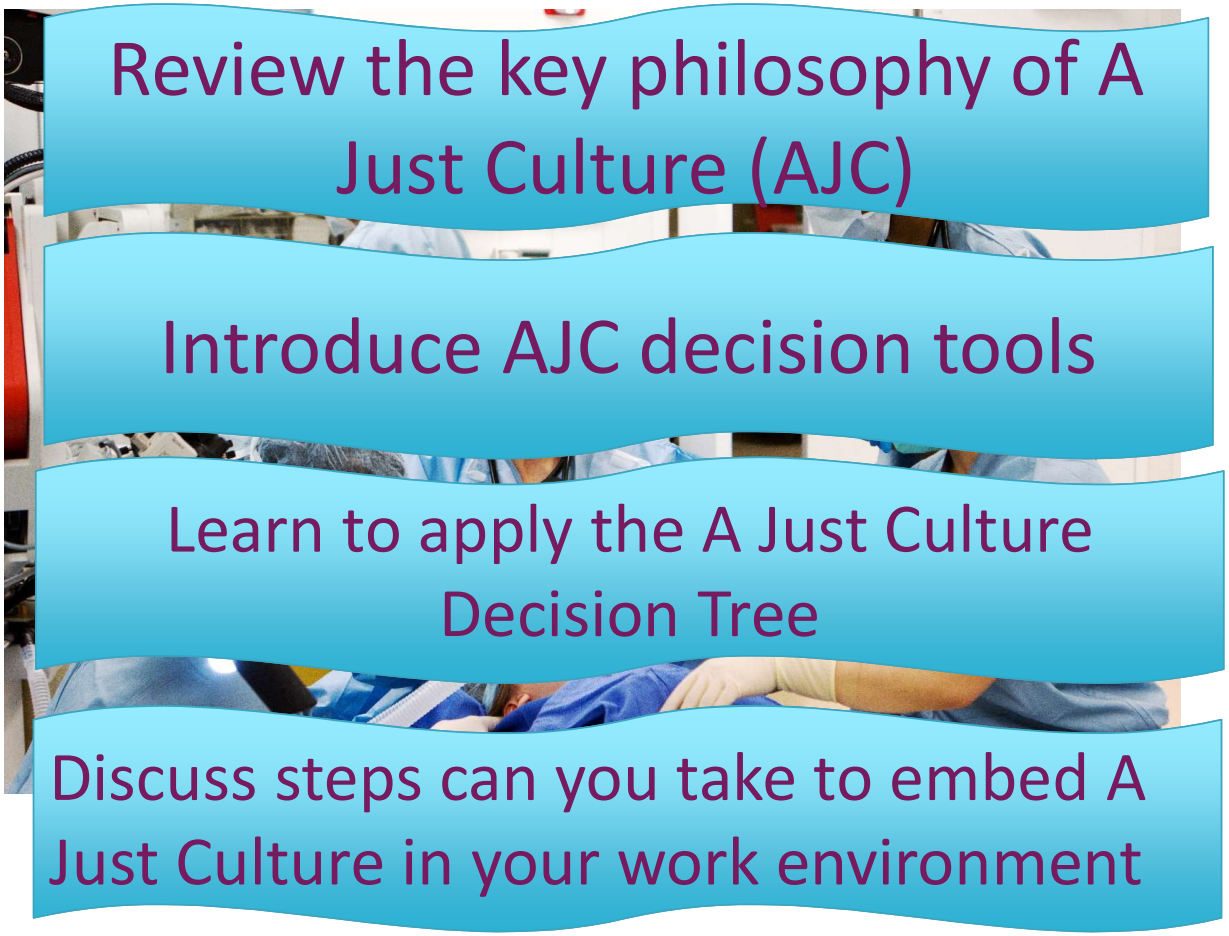
Learning Objectives



- Review the key philosophy of A Just Culture (AJC)
- Introduce AJC decision tools
- Learn to apply the A Just Culture Decision Tree
- Discuss steps can you take to embed A Just Culture in your work environment

Your Experience

- Have you ever observed a medical error?
- Have you ever observed another health care provider violate a safe practice?
- Have you ever been asked to do something in your work that you felt uncomfortable about?

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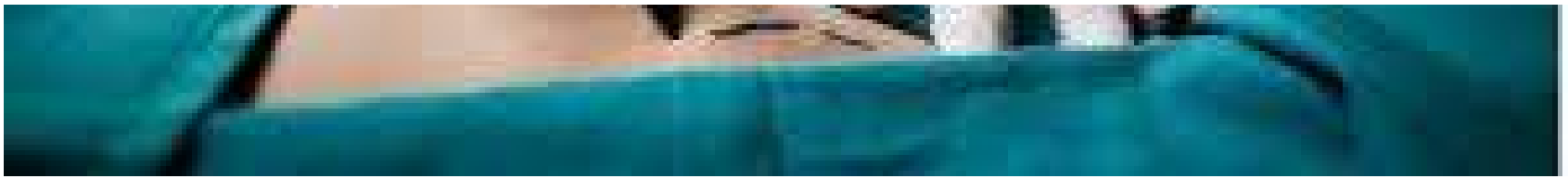
In 1999, the Institute of Medicine urged health care organizations to make improving patient safety a high priority goal. Why do you think they were so concerned?

Patient satisfaction, patient outcomes, and the success of patient improvement efforts are all impacted by our patient safety culture



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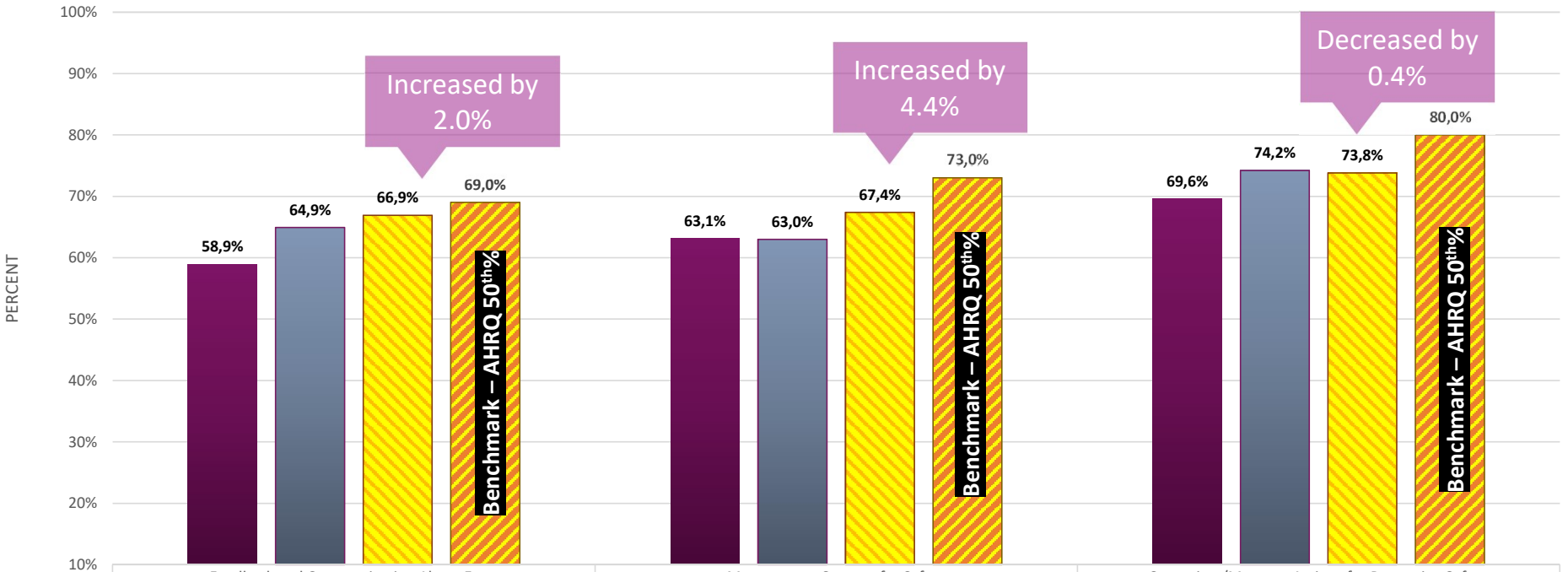
Reality of Patient Safety

- In 2013 the *Journal for Patient Safety* published that each year preventable adverse events (PAEs) lead to the death of 210,000-400,000 patients
  - Those figures would make medical errors the third leading cause of death behind heart disease and cancer (Centers for Disease Control and Prevention statistics)
- In a national study in 2014, 56% of hospital employees in the USA did not report any medical errors over a 12 month period (AHRQ, 2014)

Why is there hesitation to report?

2019 UPMC Culture of Safety Health Services Division Results

UPMC N = 45,526 (60 UPMC locations)
AHRQ N = 382,834 (630 Hospitals)



	Feedback and Communication About Error	Management Support for Safety	Supervisor/Manager Actions for Promoting Safety
UPMC 2014	58,9%	63,1%	69,6%
UPMC 2017	64,9%	63,0%	74,2%
UPMC 2019	66,9%	67,4%	73,8%
AHRQ 50%	69,0%	73,0%	80,0%

- Following 2017 surveying, (3) focus areas were identified for improvement opportunities and incorporated into the 2019 MyVoice employee pulse survey.
- For the 2021 MyVoice survey, all (12) AHRQ domains will be included for response.

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- At UPMC the majority of employees express concern about a punitive response to error.
- This is consistent with the quote:
- “The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes”
  - Lucian Leape, Professor, Harvard School of Public Health

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Punitive culture creates fear, destroys creativity, builds barriers, and DRIVES ERROR UNDERGROUND

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Linking Safety to Patient and Employee Satisfaction

Focus on the voice of the patient

+

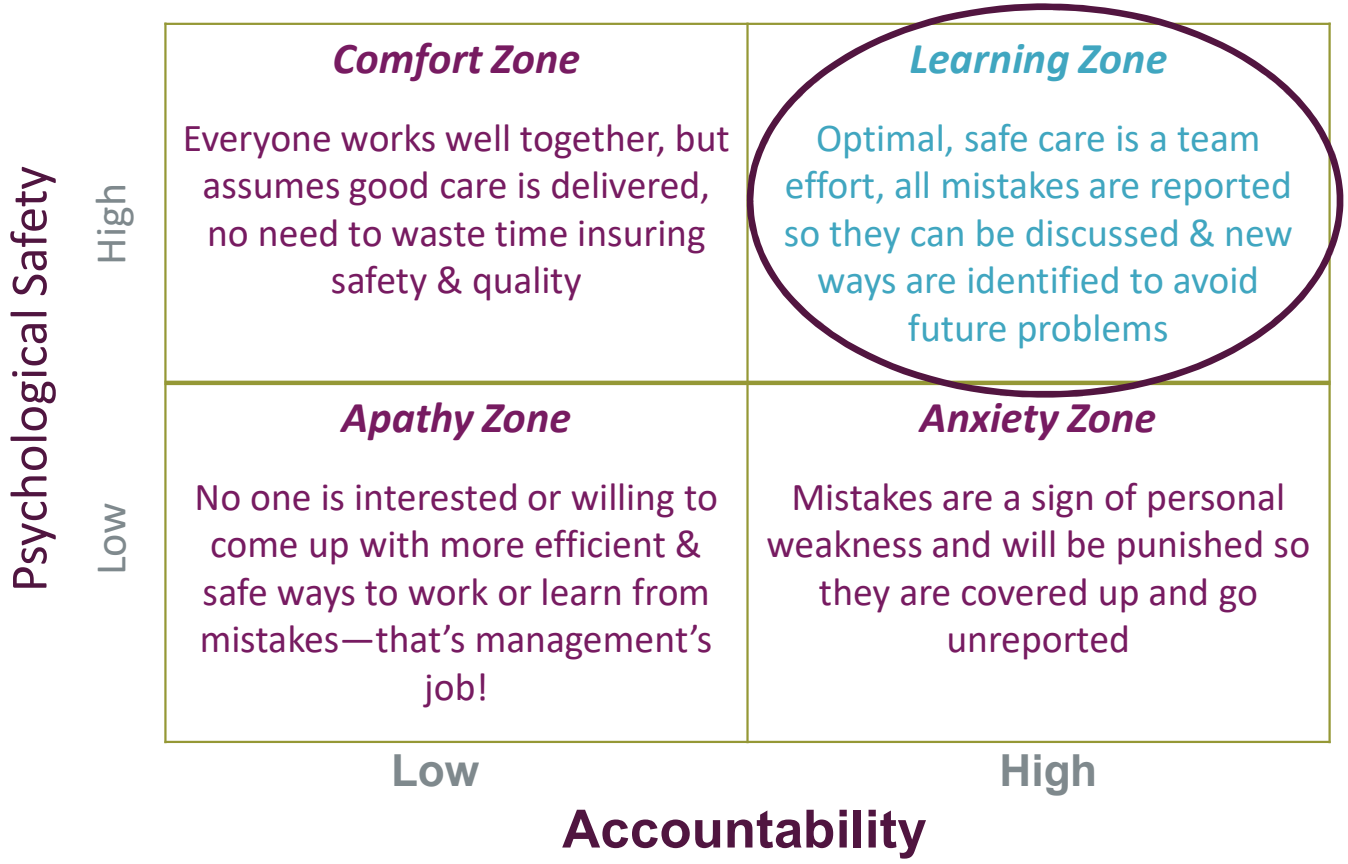
Focus on the voice of front-line staff

=

Improved Safety for All

Safety *is the crucial requirement of an extraordinary patient and family experience and employee satisfaction*

Fostering Learning: Psychological Safety + Accountability



Source: Edmondson, A.C. "The Competitive Imperative of Learning," *HBS Centennial Issue. Harvard Business Review* 86, nos. 7/8 (2008)

What is A Just Culture?

An environment of **trust and fairness** where:

- People are encouraged and feel safe to report mistakes and system flaws to ensure patient safety and clinical care;
- There are consistent distinctions between human error in unreliable systems and intentional unsafe acts;
- Leaders emphasize and role model the importance of reporting errors and the value of lessons learned;
- Lessons learned are shared broadly both within and outside the affected hospital/business unit.
- Achieving excellence in clinical practice and patient care is a holistic approach (e.g. leaders, physicians, clinicians, etc.)

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Blame vs. Punitive Cultures

ORGANIZATIONAL CULTURES

All errors are faults of the 'system,' not individuals

All errors are blamed on mistakes made by individuals

A Just Culture finds the middle ground between a blame-free culture and an overly punitive culture

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Characteristics of a Just Culture

- Atmosphere of trust & respect
  - Teamwork: "Have each other's backs"
- Reporting and discussing errors are encouraged
- Learning environment
- Accountability for behaviors but not system failures
  - Recognition that humans do make mistakes; non-punitive response
- Leadership supports a Just Culture

A Just Culture: A Change in Mindset

- **Common Thinking**
  - Mistakes should never happen
  - Knowledge and skill can prevent all errors
  - Find who is to blame
  - Punish according to severity of outcome

- **Just Culture**
  - To err is human
  - To drift away from policies and procedures is human
  - Look for system failure or behavior choice error
  - Each event is a learning opportunity to improve safety

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Examples

A Just Culture Decision Tree applies to . . .	A Just Culture Decision Tree does not apply to . . .

• Medication errors
• Mislabeling blood specimens
• Failure to follow:
  ▪ patient identification protocols
  ▪ Patient Falls policy
  ▪ protocol outlined in Prevention of Wrong Site, Wrong Procedure and Wrong Person Surgery or Invasive Procedure policy
  ▪ restraint/seclusion protocol
• Lack of compliance with infection control practices when providing care
	• Attendance issues
	• No-call/no-show incidents
	• HIPAA violations/breaches of confidentiality
	• Harassment
	• Theft
	• Fraud
	• Inappropriate/unprofessional conduct
	• Failure to comply with the Clean Air/Smoke- and Tobacco-Free Campus policy

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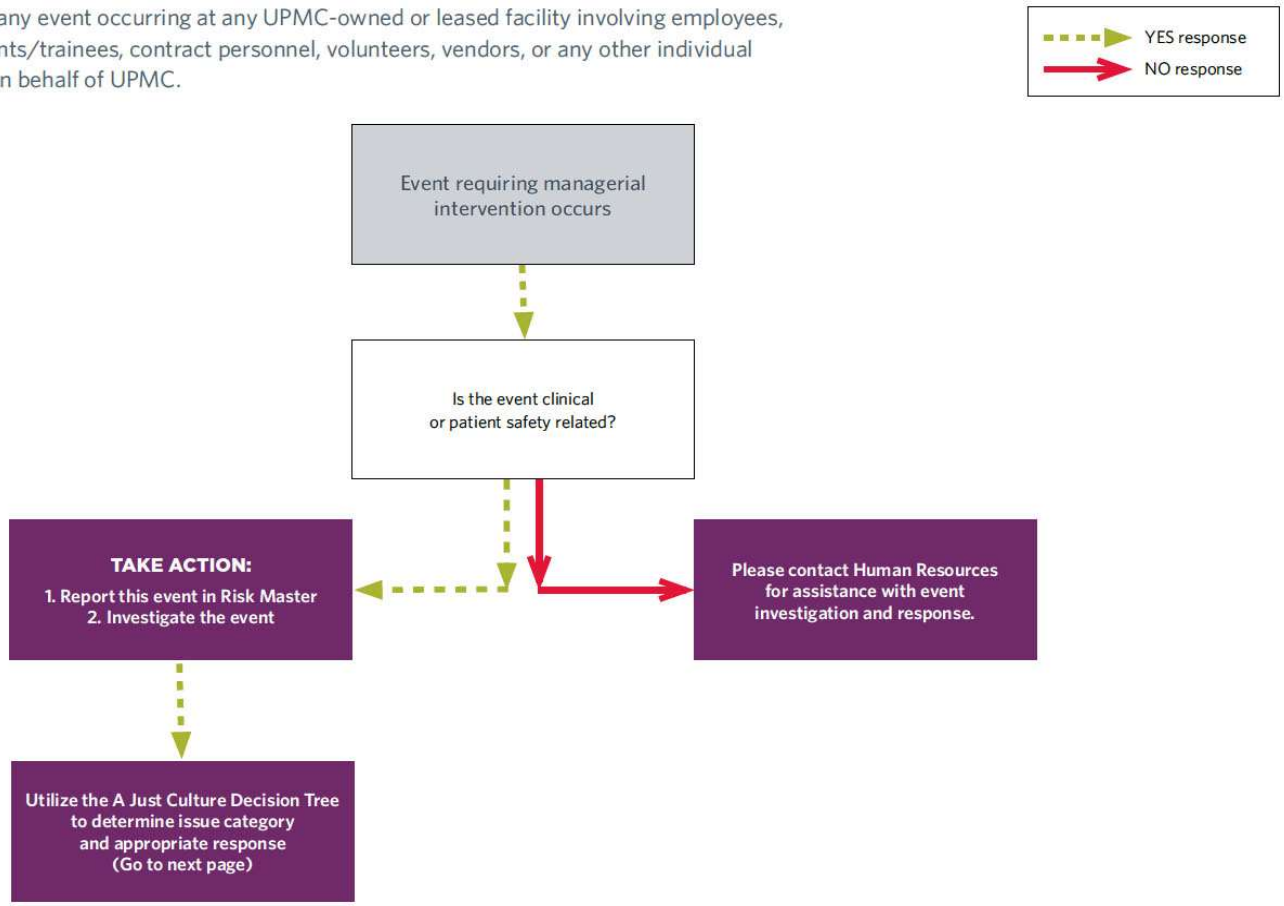
UPMC EVENT MANAGEMENT IN A JUST CULTURE: STAFF

This tool applies to any event occurring at any UPMC-owned or leased facility involving employees, medical staff, students/trainees, contract personnel, volunteers, vendors, or any other individual providing services on behalf of UPMC.



Consider this Scenario....

- While preparing a patient for a procedure, a nurse realizes the patient's Consent and History & Physical report do not match.
- This patient is first on a full schedule.
- The nurse calls the neurosurgeon for clarity and is yelled at on the phone.
- The nurse stops the process and says, "I need clarity."
- The case is delayed 30 minutes.
- An adverse event is prevented, and the patient is okay.

What happens to the nurse?

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‘A Just Culture’ Before and After View

BEFORE A JUST CULTURE

- People whisper about her.
- She is blamed by the charge nurse in the procedure area for messing up the entire schedule.
- The physician demands that a nurse cannot delay a case again.
- Some coworkers grumble within earshot that they will be here late as a result of the nurse’s actions.
- She says to colleagues: “I’m never doing that again.”

IN A JUST CULTURE

- She receives accolades from physician and coworkers for catching the error.
- The manager recognizes her “Good Catch” and makes sure the CEO, CNO, or CMO come by to congratulate her.
- Her action becomes a positive story, recognized in the organization.
- This event becomes a positive impetus for identifying system improvement opportunities.

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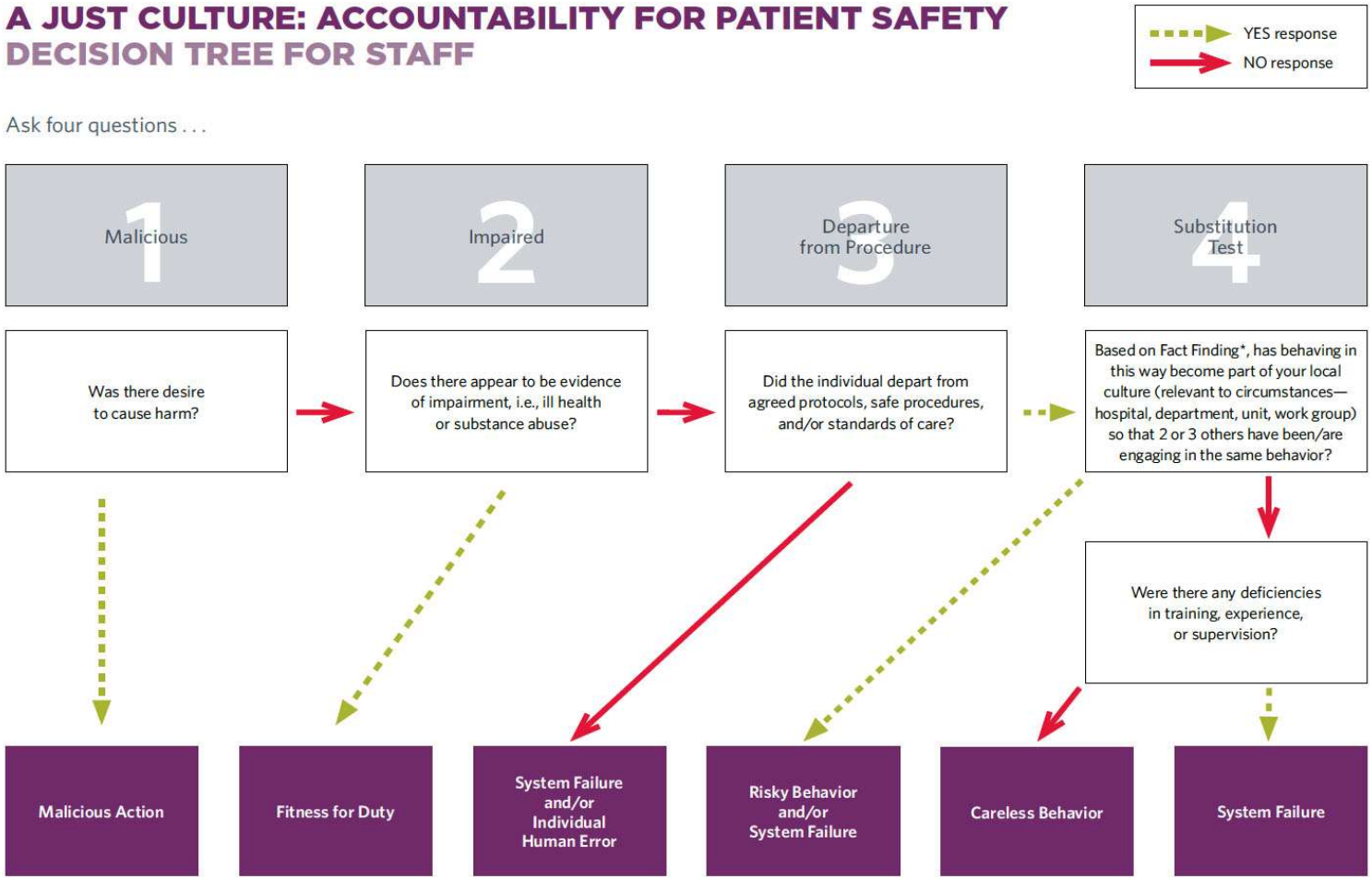
A JUST CULTURE: ACCOUNTABILITY FOR PATIENT SAFETY
DECISION TREE FOR STAFF



*Fact finding involves interviewing staff and/or reviewing prior incidents and events to establish local cultural norms. May consult HR to assist in this process.

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The Substitution Test

- The Substitution Test (Question 4) in the Decision Tree attempts to determine whether other individuals within the work group have or would have behaved/acted in the same manner as the person (or people) in question.
- Remember that behavior is influenced by typical work routines and practices that a specific work group adopts.
- Substitution Test Question: *"Based on fact finding, has behaving in this way become part of your local culture (relevant to circumstances – hospital, department, unit, work group) so that 2 or 3 others have been/are engaging in the same behavior*?"
- Fact Finding involves interviewing staff and/or reviewing prior incidents and events to understand cultural norms.

UPMC EVENT MANAGEMENT IN A JUST CULTURE: STAFF

Please note that the following Human Resources policies and *Life*Solutions services apply to employed staff. When applying the A Just Culture Decision Tree in instances involving non-employed staff, such as contract personnel, volunteers, or vendors, please contact your Human Resources representative for assistance.

Malicious Action	Fitness for Duty	Risky Behavior	Careless Behavior	System Failure and/or Individual Human Error
The staff member wanted to cause harm or engaged in a terminable offense as defined in policy. • Consult Human Resources. • May result in discharge and/or legal proceedings. • Suspend duties immediately. • Report as appropriate to Legal Services and licensing board.	The staff member's performance may be impaired by illegal or legal substances, cognitive or physical impairments, or other health issues. • Consult Human Resources. • Review and comply with the Fitness for Duty policy • Report as appropriate to Legal Services and licensing board.	The staff member made a potentially unsafe choice. • Consult Human Resources. • Verbal counseling to remediate behavior is warranted. • Progressive corrective action may be warranted for repeat unsafe acts. • Encourage staff member to check in with *Life*Solutions (EAP). • Formal referral to *Life*Solutions (EAP) is strongly recommended if a serious patient event occurs. • Address and fix applicable system issues. • Staff member may need retraining. • May teach lessons learned to others.	The staff member made an unsafe choice. • Consult Human Resources. • Progressive corrective action (minimum of written warning) is warranted. • Formal referral to *Life*Solutions (EAP) is strongly recommended. • Address and fix applicable system issues. • Staff member may need intense retraining. • May teach lessons learned to others.	Leaders are accountable to take initiative to fix the system to avoid future errors. Staff are accountable for assisting leaders in these initiatives and avoiding their own errors in the future. • Console staff member; coach staff member as applicable. • Performance Improvement Plan may be warranted for repeated human errors (performance issues); consult Human Resources. • Encourage staff member to check in with *Life*Solutions (EAP). • Formal referral to *Life*Solutions (EAP) is strongly recommend if a serious patient event occurs. • Address and fix applicable system issues. • Communicate system changes to staff members. • Staff member may need retraining. • May teach lessons learned to others.

Chart with recommended managerial responses for each root cause category

Note:
With Human Resources approval, managers retain the right to administer a mandatory referral to *Life*Solutions (EAP) if the circumstances warrant, especially to ensure the staff member's own safety and recovery from an event.

Risky Behavior and/or System Failure

- Consult Human Resources.
- Verbal counseling to remediate behavior is warranted.
- Progressive corrective action may be warranted for repeat unsafe acts.
- Encourage staff member to check in with *Life*Solutions (EAP).
- Formal referral to *Life*Solutions (EAP) is strongly recommended if a serious patient event occurs.
- Address and fix applicable system issues.
- Staff member may need retraining.
- May teach lessons learned to others.

Best Practices—Summary

- ✓ Investigate the incident.
- ✓ Ask the right questions.
  - Interview staff
- ✓ Use the Decision Tree as a tool.
- ✓ Involve Human Resources and the Employee Assistance Program as appropriate for:
  - ✓ policy
  - ✓ performance
  - ✓ and behavioral issues
- ✓ Document as appropriate.
- ✓ Be consistent.

Avoid simple answers