Safe & Just Culture

Panel: Creating and Maintaining a Patient-Centered Culture of Quality and Safety

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Virtual Summit

Saturday, January 23, 2021

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Organizational Definition

A literature review didn't identify a consistent definition of just culture in healthcare; therefore, a nationally recognized training organization definition was utilized.

For this presentation, just culture was defined broadly as ***organizational accountability for the systems they've designed and employee accountability for the choices they make.***

Just culture isn't a blame-free culture, rather a culture of balanced accountability. Safe patient care outcomes include organizational system design and individual behavioral choices.

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Behavioral Definition

Another Definition:

Just Culture is an atmosphere of trust in which people are encouraged (even rewarded) for providing essential safety related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior.

The concept has been applied to many settings, including:

- Aviation
- Industry
- Healthcare

Roadmap to a Just Culture – Flight Safety Foundation

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Historic Applicability

In a landmark publication, Reason presented a detailed analysis of human error. Reason introduced his text by referring to the 1928 studies of Spearman but asserted that the decade prior to the publication of his book was characterized by public concern about the terrible cost of human error.

He lists the Tenerife runway collision in 1977, the Three Mile Island crisis in 1979, the Bhopal methyl isocyanate disaster in 1984, the *Challenger* and Chernobyl explosions of 1986, the capsize of the *Herald of Free Enterprise*, the King's Cross tube station fire in 1987, and the Piper Alpha oil platform explosion in 1988 as causes for a collective impetus to address error.

Without doubt, it is clear that the nature and scale of such tragedies impacted wide geographic areas and generations of humans.

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Errors v. Fault

People make errors. Errors can cause accidents. In healthcare, errors and accidents result in morbidity and adverse outcomes and sometimes in mortality.

One organizational approach has been to seek out errors and identify the responsible individual. Individual punishment follows. This punitive approach does not solve the problem. People function within systems designed by an organization. An individual may be at fault, but frequently the system is also at fault.

Punishing people without changing the system only perpetuates the problem rather than solving it.

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Just Culture v. Blame Culture

Just culture is a concept related to systems thinking which emphasizes that mistakes are generally a product of faulty organizational cultures, rather than solely brought about by the person or persons directly involved. In a just culture, after an incident, the question asked is, "What went wrong?" rather than "Who caused the problem?".

A just culture is the opposite of a blame culture.

This is in contrast to a "blame culture" where individual persons are fired, fined, or otherwise punished for making mistakes, but where the root causes leading to the error are not investigated and corrected. In a blame culture mistakes may be not reported but rather hidden, leading ultimately to diminished organizational outcomes.

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Just Culture v. Blame Culture

In a system of just culture, discipline is linked to inappropriate behavior, rather than harm. This allows for individual accountability and promotes a learning organization culture.

In this system, honest human mistakes are seen as a learning opportunity for the organization and its employees.

The individual who made the mistake may be offered additional training and coaching.

However, willful misconduct may result in disciplinary action such as termination of employment—even if no harm was caused.

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Relationship to Patient Safety

A patient care system is obligated to collect productive investigative data that can be analyzed and acted upon to improve patient safety. This process is not possible unless members of the organization remain vigilant and mindful and maintain continuous surveillance.

Similarly, people within the organization must believe that they are obligated to report errors.

However, medical institutions cannot afford a blame-free culture: Some errors do warrant disciplinary action. Finding a balance between the extremes of punishment and blamelessness is the goal of developing a just culture.

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Leap's Just Culture Considerations

Early Work in the Field:

Dr. Lucian Leape, a member of the Quality of Health Care in America Committee at the Institute of Medicine and adjunct professor at the Harvard School of Public Health

The single greatest impediment to error prevention in the medical industry is "that we punish people for making mistakes."

Leape indicated that in the healthcare organizational environment in most hospitals, at least six major changes are required to begin the journey to a culture of safety:

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Leap's Just Culture Considerations

- We need to move from looking at errors as individual failures to realizing they are caused by system failures
- We must move from a punitive environment to a just culture
- We must move from secrecy to transparency
- Care must change from being provider-centered (doctor-centered) to being patient-centered
- We must move our models of care from reliance on independent, individual performance excellence to interdependent, collaborative, interprofessional teamwork
- Accountability must be universal and reciprocal, not top-down

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Just Culture Considerations I System

People make errors, which lead to accidents. Accidents can ultimately lead to deaths.

The standard solution is to blame the people involved.

But if we find out who made the errors and punish them, are we solving the problems? No. The problem is seldom the fault of an individual; it is the fault of the system.

Changing the people without changing the system will perpetuate the problems.

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Just Culture Considerations II Reporting

How can we change systems to encourage individuals to report errors and learn from their mistakes?

A just culture seeks to create an environment that encourages individuals to report mistakes so that the precursors to error can be better understood in order to fix the system issues.

Individual practitioners should not be held accountable for system failings over which they have no control. In a just culture, individuals are continually learning, designing safe systems, and managing behavioral choices.

Events are not things to be fixed, but opportunities to improve understanding of the system.

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Just Culture Considerations III Administration

How do you get started with a just culture initiative and ensure that all staff members feel free to report errors?

There needs to be an administration that supports the concepts of a just culture and encourages staff to report errors. Highly reliable industries foster mindfulness in their workers.

Mindfulness is defined by Weick and Sutcliffe (2001) as being composed of five components:

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Just Culture Considerations IV Mindfulness

1. A constant concern about the possibility of failure even in the most successful endeavors
2. Deference to expertise regardless of rank or status
3. An ability to adapt when the unexpected occurs (commitment to resilience)
4. An ability to concentrate on a specific task while having a sense of the bigger picture (sensitivity to operations)
5. An ability to alter and flatten hierarchy as best fits the situation

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Occurrence Reporting

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Occurrence Reporting

Nonblaming incident investigation is the first pillar in developing the foundation of just culture.

Healthcare institutions have adopted nonpunitive incident management structures to improve patient safety outcomes.

This ideally creates an atmosphere of trust between the employee and employer and has a positive impact on staff members' willingness to report outcomes when results aren't as expected.

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Errors

In patient care delivery, individuals can make multiple inconsequential errors. These errors arise from conditions that exist within an organization's systems, such as staffing challenges, delays, and equipment failures.

Most clinicians have limited opportunity to change the systems in which they work. They need to be error identifiers to recognize and resolve system issues that may become mistakes.

This alert to leadership creates a safer organization. In this study, speaking up was defined as the willingness of individuals to communicate actual or potential error or event information upward to supervisors and hospital administrators.

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Errors

Organizations often determine the response to an error based on its severity.

Errors causing no harm are minimized or ignored and those resulting in injury or death are highly punitive.

All types of error hold equal importance in a just culture, not just those with poor outcomes. To build trust, error identification and reporting are encouraged to provide opportunities for staff education and system redesign.

As an organization transitions to a learning environment through event disclosure, it fosters trust for improvement rather than mistrust from blame.

This is considered critical to becoming a highly reliable organization.

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Three Types of Behaviors

Establishing a just culture at your organization requires building awareness, implementing and developing policies that support just culture, and building the tenets of just culture into daily work practices

There are three types of behaviors to be expected at any organization:

Human error – Inadvertently doing something wrong, a slip or lapse

At-risk behavior – Increasing risk where it's not recognized or where it's believed to be justified

Reckless behavior – Consciously disregarding a serious and unjustifiable risk

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Practical Steps to Building a Fear-free, Accountable Culture

It starts with *how* you form performance expectations.

There is no easy answer to creating performance goals that stretch the organization to do its best, but not beyond. There is risk that goals developed from the "bottom up" will be too conservative and goals set from the "top down" will be too ambitious and fail to recognize the realities of the local environment. Consider a process in which goals are set through dialogue supported by as much data as possible, to help build shared commitment to aggressive but realistic levels of performance.

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Practical Steps to Building a Fear-free, Accountable Culture

Start with inquiry, not blame.

As with issues of patient safety, the response to variation in performance starts with inquiry not blame.

The first level of inquiry should address whether the variation is in some way traceable to ineffectiveness on the part of the leader or if it is the product of other factors beyond the leaders real or perceived control.

If it is the latter, the work, together, is to address those factors.

If, for example, the root cause of patient experience scores on a nursing unit tracks back to delays in the emergency department, the organizational response should reflect that and establish a broader process to drive improvement.

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Practical Steps to Building a Fear-free, Accountable Culture

Develop a system for ongoing monitoring of predictive indicators.

An organizational climate of healthy accountability embraces data as a tool for improvement. In it lies information with which to recognize and diagnose, early on, factors impeding progress toward performance goals. Ongoing vigilance around key indicators creates a platform for meaningful inquiry and dialogue to determine the root cause of variance so appropriate corrective action can be taken.

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Practical Steps to Building a Fear-free, Accountable Culture

Maintain a timely, disciplined approach to addressing signs of performance variance.

The goal of a healthy accountability is improvement, not blame or explanation. In a just culture, information indicating variation from expected performance is addressed as soon as the organization becomes aware.

Too often, leaders hang back in the hopes that the situation will correct itself or believing a reasonable explanation after the fact will be sufficient to avoid blame.

This misses the point. The goal is to create a timely organizational response.

Leaders should be expected to come forward as soon as they see signs of unexpected variation, share their diagnosis and approach, seek support as needed, and work to adjust in time to correct or compensate for what has occurred.

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