Delta Region Community Health Systems Development (DRCHSD) Program
Quality Improvement Webinar Series:
Just Culture
National Rural Health Resource Center

The Center's Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

DRCHSD Program Supported by FORHP and DRA

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Diversity, Equity, Inclusion, & Anti-racism

Building a culture where difference is valued

The Center is committed to DEI and anti-racism. We create an environment that reflects the communities we live in and serve; a place where everyone feels accepted and empowered to be their full, authentic selves; and where everyone belongs.

We understand the impact of and seek to defeat racism and discrimination in ourselves, our workplace, and the world. This guides how we cultivate leaders, build our programs and resources, and deliver our technical assistance.

We are an organization that honors, celebrates, and respects all dimensions of diversity. These principles are central to our mission and to our impact.

https://www.ruralcenter.org/about/dei

DRCHSD Upcoming Webinars

- DRCHSD Hospital and FQHC Application and Eligibility Webinar
  - June 6 from 11:00 – 12:00 pm CT

- DRCHSD RHC and Small Clinic Application and Eligibility Webinar
  - June 29 from 11:00 – 12:00 pm CT

Pre-Polling Questions

1. I am ___ in my understanding of the fundamentals of a Just Culture.

2. I am ___ in my understanding of how to construct a roadmap for establishing an organizational Just Culture.

3. I am ___ in my understanding of how events are responded to within a Just Culture.

Today's Speakers

Cameron Smith, MBA, CPHQ
Consultant
Stroudwater Associates

Carla Brock Wilber, DNP, RN, NE-BC, CATC
Senior Consultant
Stroudwater Associates

JUST CULTURE IS SHARED ACCOUNTABILITY

DRCHSD Quality Webinar Series

OBJECTIVES

DEFINE “JUST CULTURE”

CLARIFY THE BENEFITS OF A JUST CULTURE

DESCRIBE THE THREE MANAGEABLE BEHAVIORS

EXPLAIN HOW A JUST CULTURE RESPONDS TO BEHAVIORS

EXPLAIN THE JOURNEY TO A “JUST CULTURE”

WALK THROUGH THE EVENT INVESTIGATION PROCESS

RAISING AWARENESS

- How would our organization respond to a surgeon who uses an unauthorized piece of equipment in the OR?

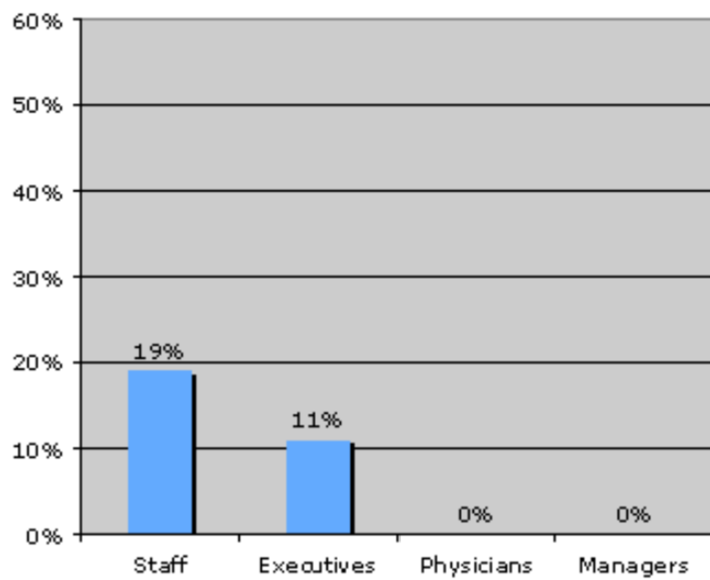
- Percentage of respondents who believed HOSPITAL would discipline the surgeon if ....

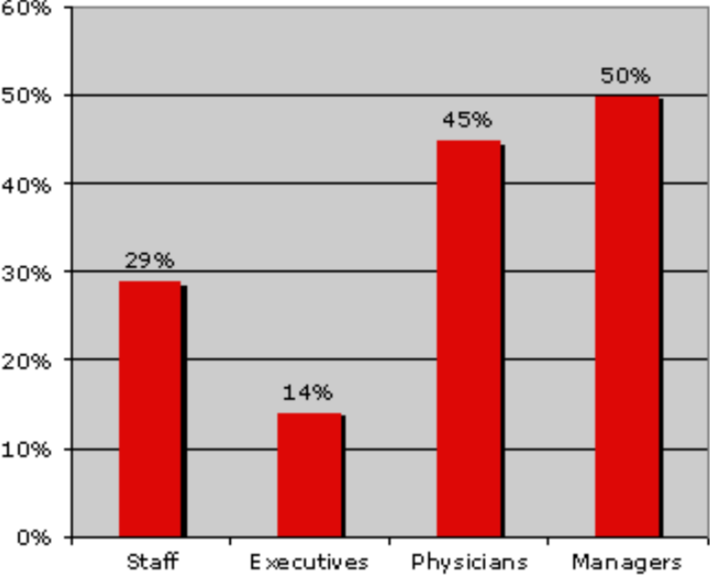
The behavior resulted in NO HARM.

The behavior resulted in HARM

https://psnet.ahrq.gov/perspective/making-just-culture-reality-one-organizations-approach

PERSPECTIVES-





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JUST CULTURE FUNDAMENTALS

WHAT IS JUST CULTURE

- "Just Culture" was popularized in the patient safety lexicon by a report that outlined the principles for achieving a culture in which frontline personnel feel comfortable disclosing errors including their own while maintaining professional accountability
- A Just Culture organization is one that:
  - Holds itself accountable
  - Holds staff members accountable
  - Has staff members that hold themselves accountable
- A shift in focus from errors and their outcomes to system design and behavioral choices

THREE MANAGEABLE BEHAVIORS

Human Error

- Entirely unintentional

At-Risk Behavior

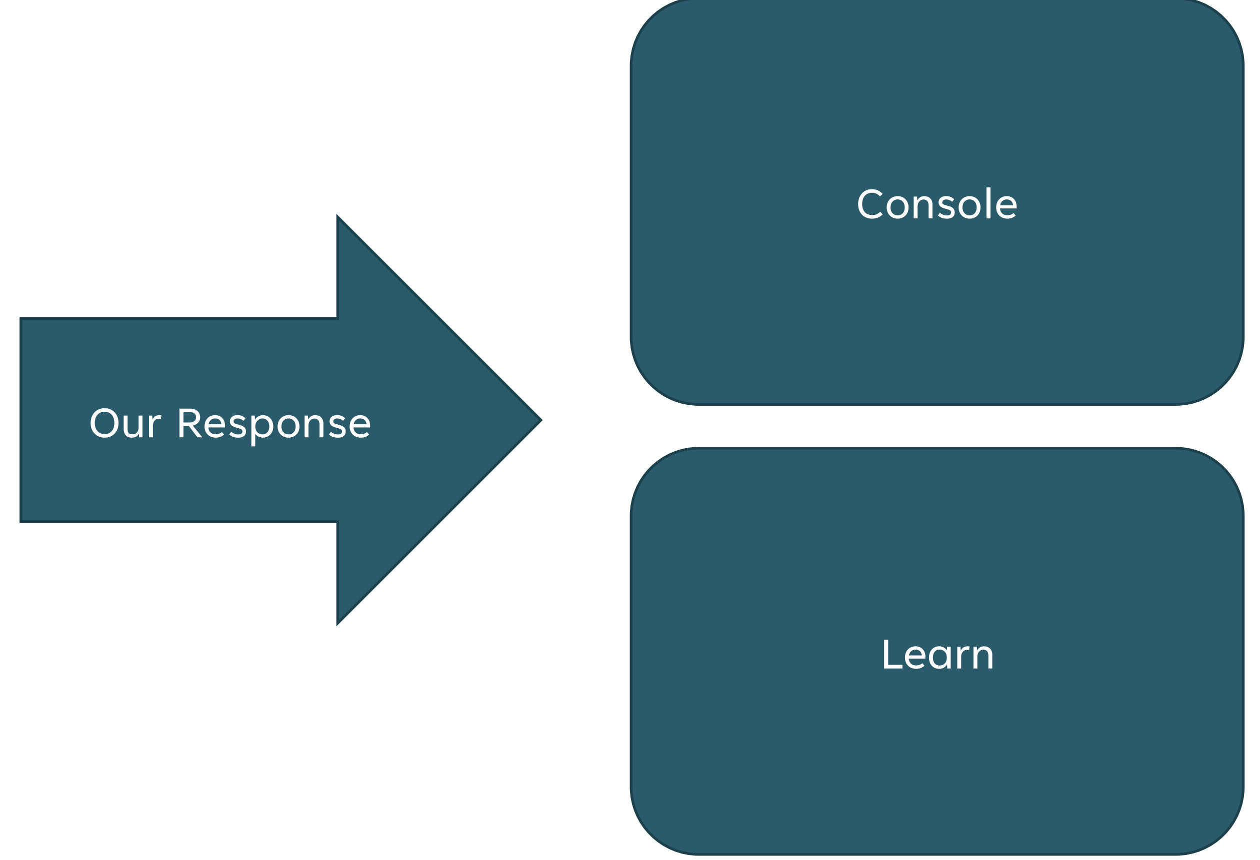
- Aware of the risk, though believed to be insignificant or justified

Reckless Behavior

- Conscious disregard of substantial and unjustifiable risk

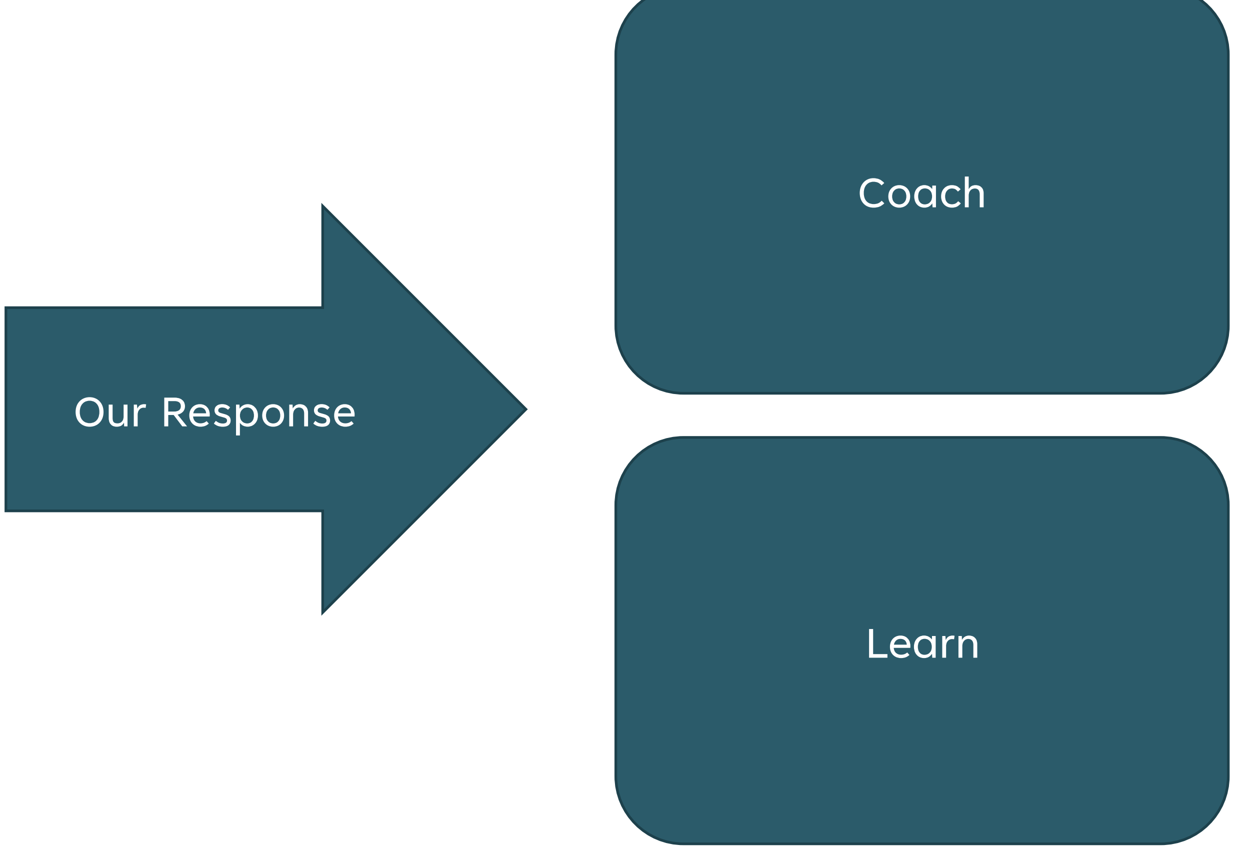
HUMAN ERROR

- Slips and lapses
- Inadvertent action (free from intention)
- Managed through changes in:
  - Processes
  - Procedures
  - Training
  - Design
  - Environment
  - Choices



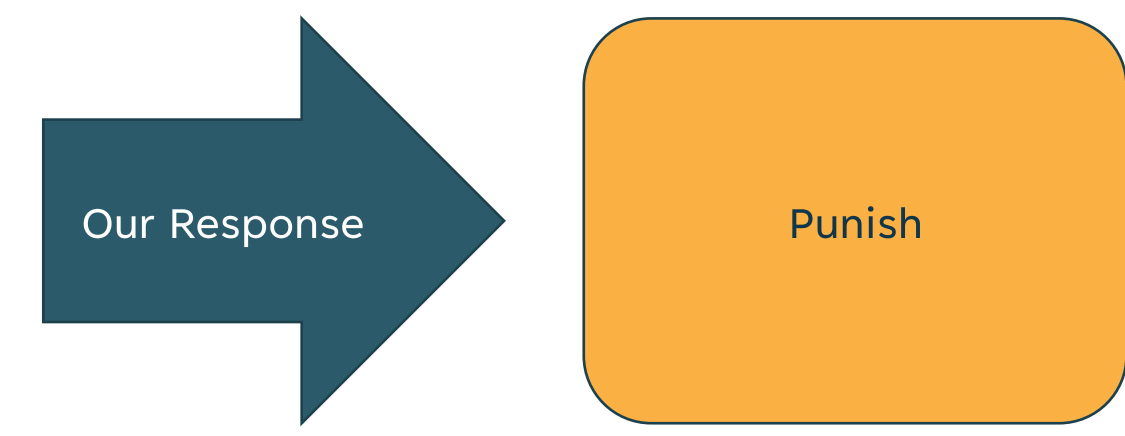
AT-RISK BEHAVIOR

- Behavioral choice associated with a belief that the risk is insignificant or justified
- Intentional action, unintended outcome
- Humans will “drift” from known processes to the path of least resistance
- Examples include:
  - Taking shortcuts to known processes to save time
  - Speeding a few miles over the speed limit
- Managed through:
  - Removal of incentives for at-risk behaviors
  - Creation of incentives for behaviors that reinforce a safe, learning culture
  - Increasing situational awareness



RECKLESS BEHAVIOR

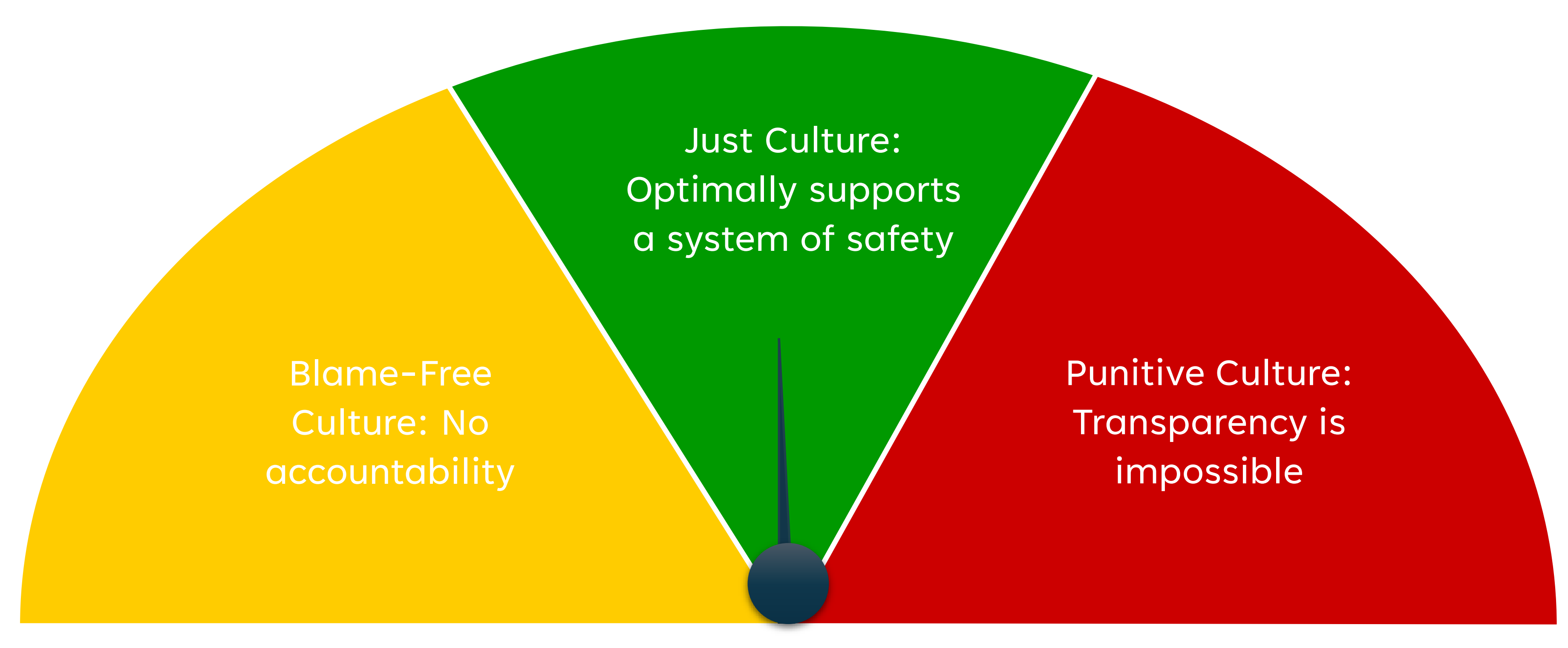
- The conscious disregard of a substantial and unjustifiable risk
- Intentional action
- Examples include:
  - Failure to perform post-surgery instrument count
  - Leaving your one-to-one patient alone without ensuring a handoff has occurred
- Managed through:
  - Remedial action
  - Punitive action



THE THREE BEHAVIORS SUMMARIZED

Human Error	At-Risk Behavior	Reckless Behavior
Product of Our Current System Design and Behavioral Choices Managed through changes in: • Choices • Processes • Procedures • Training • Design • Environment	A Choice: Risk Believed Insignificant or Justified Managed through: • Removing incentives for at-risk behaviors • Creating incentives for healthy behaviors • Increasing situational awareness	Conscious Disregard of Substantial and Unjustifiable Risk Managed through: • Remedial action • Punitive action
Console	**Coach**	**Punish**

BALANCE – SYSTEM DESIGN AND BEHAVIOR CHOICES



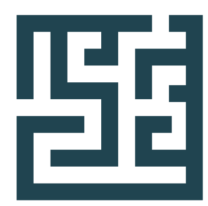
THE JUST CULTURE JOURNEY

THE JUST CULTURE JOURNEY, CONTINUED

- Ensure the mission and vision of the organization are clearly defined for all to understand
- Engage leadership
- Set performance expectations
- Develop a system for continuous monitoring of predictive indicators (High Reliability)
  - Be sensitive to operations
  - Be reluctant to accept the simple explanations
  - Be preoccupied with failure
  - Defer to expertise
  - Be relentless in the journey
- Integrate policies
- Standardize communication
- Build a team to promote Just Culture and change
- Continuously learn and grow

SET THE "WHY"

Clearly define the mission and the vision for the organization



Once everyone knows the way, they can make decisions to go the way

This will be the foundation many decisions are weighed against

LEADERSHIP EXPECTATIONS

- Have procedures in place for team members to follow
  - Be aware of opportunities for team members to drift from written processes, but be open to redesign
- Ensure team members are properly trained
  - Set clear expectations up front
- Offer positive reinforcement when team members speak up for safety and actively engage in creating the desired culture
- Hold fellow leaders accountable
- Senior leadership is crucial to lead the example of a truly “just” culture

HIGH RELIABILITY

Just Culture supports the journey to High Reliability

Be sensitive to operations

- Embrace data as a tool. Embrace transparency and encourage learning from mistakes.

Be reluctant to accept the simple explanations

- Just Culture asks us to focus on processes, not people. Thorough event investigations should be conducted to make it harder for repeat behaviors to occur in the future.

Be preoccupied with failure

- Take preventative steps to help prevent team members from making mistakes
- Conduct reviews of high-risk processes (FMEA, VSA, HOQ)

Defer to expertise

- Ensure those who are closest to the work are involved in the discussions

Be relentless in the journey

- “The only real mistake is the one from which we learn nothing.” – Henry Ford

POLICY INTEGRATION

- Policies are used to both reinforce and define expectations and actions as they relate to quality and safety. Most accrediting bodies consider policies to be binding, which makes institutions committed to enforcing their content.
- Policies not only support staff, but help leadership emphasize their commitment to Just Culture practices through official processes and documentation
- Developing a policy to support Just Culture may be an effective tool in communicating the value of cultivating a Culture of Safety, and in providing staff with the appropriate tools to empower open and honest reporting

STANDARDIZE COMMUNICATION

Effective communication should include the following components regardless of where your hospital is in the Just Culture process

- **It is complete** – it communicates all relevant information, avoiding excessive details or 'noise'
- **It is clear** – it uses plain, accessible languages that can be understood by all departments
- **It is concise –** it uses a short essential message
- **It is timely** – new processes or changes are communicated as soon as possible, allowing staff time to acclimate to changes in reporting requirements, review structure, or other aspects of the Just Culture process

CREATING A TEAM TO PROMOTE JUST CULTURE

An ideal team:

- Understands that patient safety culture is local
- Composed of engaged frontline providers who take ownership of patient safety
- Includes staff members who have different levels of experience
- Tailored to include members based on clinical intervention
- Meets regularly (weekly or at least monthly)
- Has adequate resources
- Has senior leadership support

CHARTER

- It is important to ensure there is a charter that defines the purpose, scope, objectives, and deliverables of a team focusing on reviewing events and implementing Just Culture throughout a system. Without measurable goals and a defined scope, consistency will be hard-won.

Committee: Just Culture Event Review Team
Meeting Date/Time: Mondays and Thursdays 10:00 AM – 11:00 AM
Purpose: To help create a safer environment for our patients by working with team members to get to the root cause of system issues within our health system
Scope: All inpatient and outpatient related services offered within the organization are considered in scope for the purposes of event investigation; physician specific events are tasked to organizational peer review
Committee Members: • Chief Operating Officer • Chief Medical Officer • Chief Nursing Officer • Human Resources • Directors of Nursing • Director of Quality • Hospital Educator • Pharmacy Director • Physician Services Leader • Ad Hoc Team Members involved in events.
Objectives: • Review potential harm and actual harm events. • Educate the organization on Just Culture and its importance. • Foster a sense of organizational unity by empowering team members to solve problems. • Move the organization closer to being a fully realized highly reliable organization.
Deliverables: • Improve employee satisfaction survey results by X% over prior CY. • Review 100% of harm and potential harm events within 48 hours of notification. • Develop a Just Culture new employee orientation model by the end of the CY. • Improve employee event reporting by X% over prior FY. • Reduce harm and potential harm events by X% over prior FY.

MAINTENANCE

Introduce Just Culture during orientation

This can be done on the units, at general orientation, and included in onboarding information	Examples of Just Culture in action will help showcase an organizational commitment

Hospitals can also develop and share standard systems change reports with the frontline staff. This delivers a message to the frontline staff that the hospital believes in addressing system-level issues instead of blaming individuals.

Encourage team members to challenge the status quo and speak up when they feel there is an opportunity for improvement

EVENT RESPONSE

INVESTIGATION OF EVENTS

Sometimes systems do not work as intended. Any undesired outcome should be investigated fully.

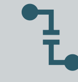
A team of individuals should be brought together to conduct a Root Cause Analysis (RCA)

This should consist of the people who were involved in the event, if possible

A Root Cause Analysis can take many different routes or use multiple tools. Examples include:

- 5 Whys
- Ishikawa Fishbone Diagram
- Reality Tree

A throughout RCA should consider human-centered design principles and factors affecting human performance



Often the root cause of an event is not centered around the person, but the process

DEBRIEF

- It is important to debrief as a care team following the event
  - This ensures critical information about the patient, and the process are discussed in real time to gain a clear understanding of what happened
  - A more formal investigation typically follows but this sets the stage for further discussion
  - It is imperative to ensure the patient is safe and stable before debriefing; it is also important to ensure team members have the immediate support they need – it should always be assumed no one comes to work intending to do something wrong
- A debrief should be effective and efficient, no more than 15-30 minutes depending on the event to review key process breakdowns and the patient's condition. Information from the debrief should be entered into a formal tracking log or event tracking database.
- Typically, organizations will have standardized debrief forms for certain types of events such as cardiac arrests or falls

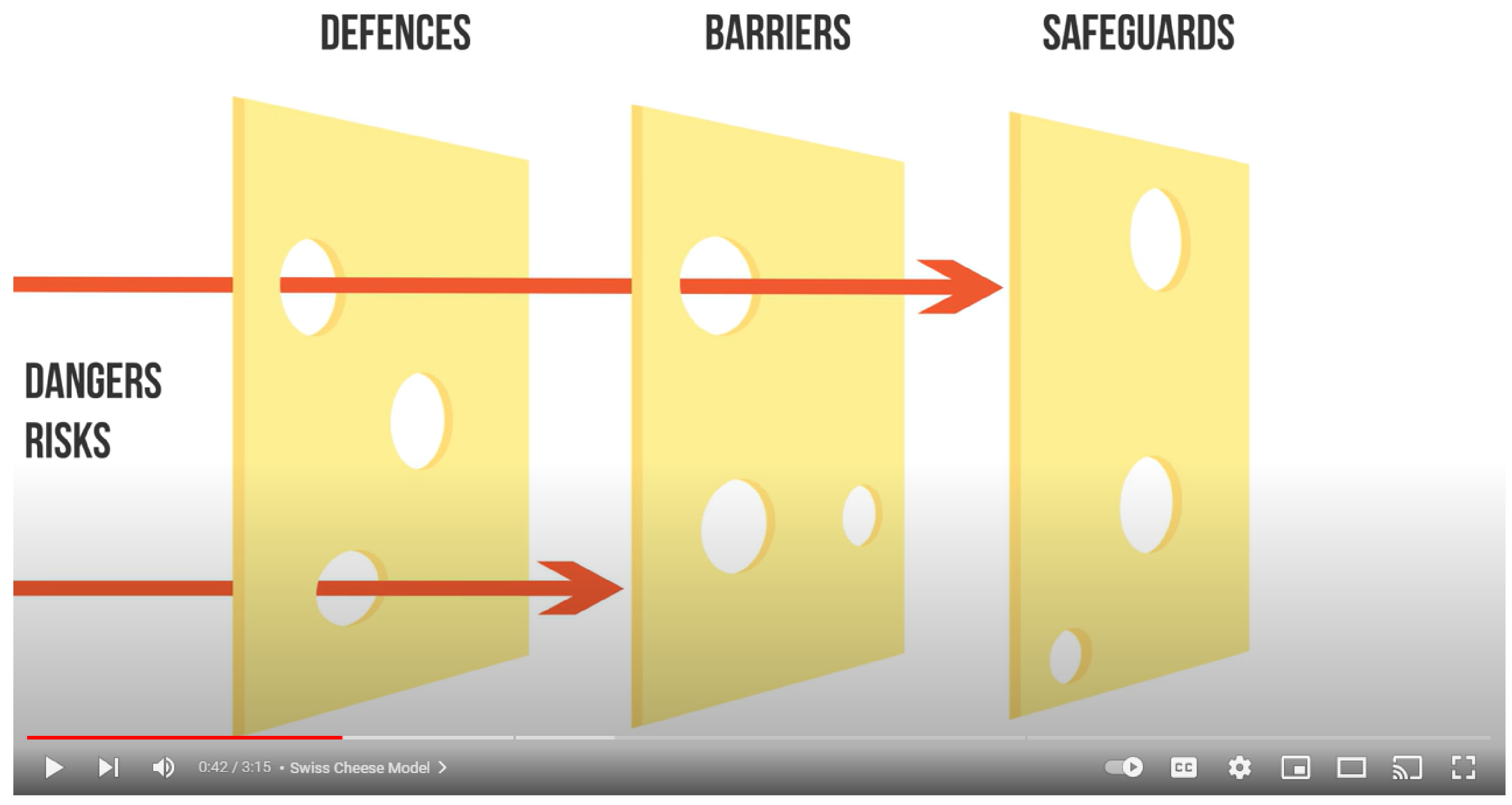
SWISS CHEESE MODEL

This model of reviewing errors shows how system blind spots/failure modes (holes) lead to adverse outcomes in a system

This model can be applied to many facets of the healthcare landscape from infection control regulation to administrative processes such as patient registration

Multiple interpretations and examples of this model can be found online to demonstrate the application

SWISS CHEESE MODEL (cont.)



Reasons Swiss Cheese Model

Clinical Leadership Solutions Ltd., 2019

THOROUGH INVESTIGATION

When reviewing events where there was an unintended outcome it is important to complete a thorough investigation, and put processes in place to reduce the chances of error in the future

Three key questions are critical to understanding operations

What happened?

What normally happens? (How the process currently operates)

What should have happened? (How the process was designed to work)

Knowing how people interact with the system is key to improving it for users

BREACHES OF DUTY: THREE DUTIES

Duty to Produce an Outcome

- This system is largely controlled by the employee. There are rules specific to the outcome that needs to be achieved.
- This applies when the employee is aware they control the system and is responsible for the output of the system

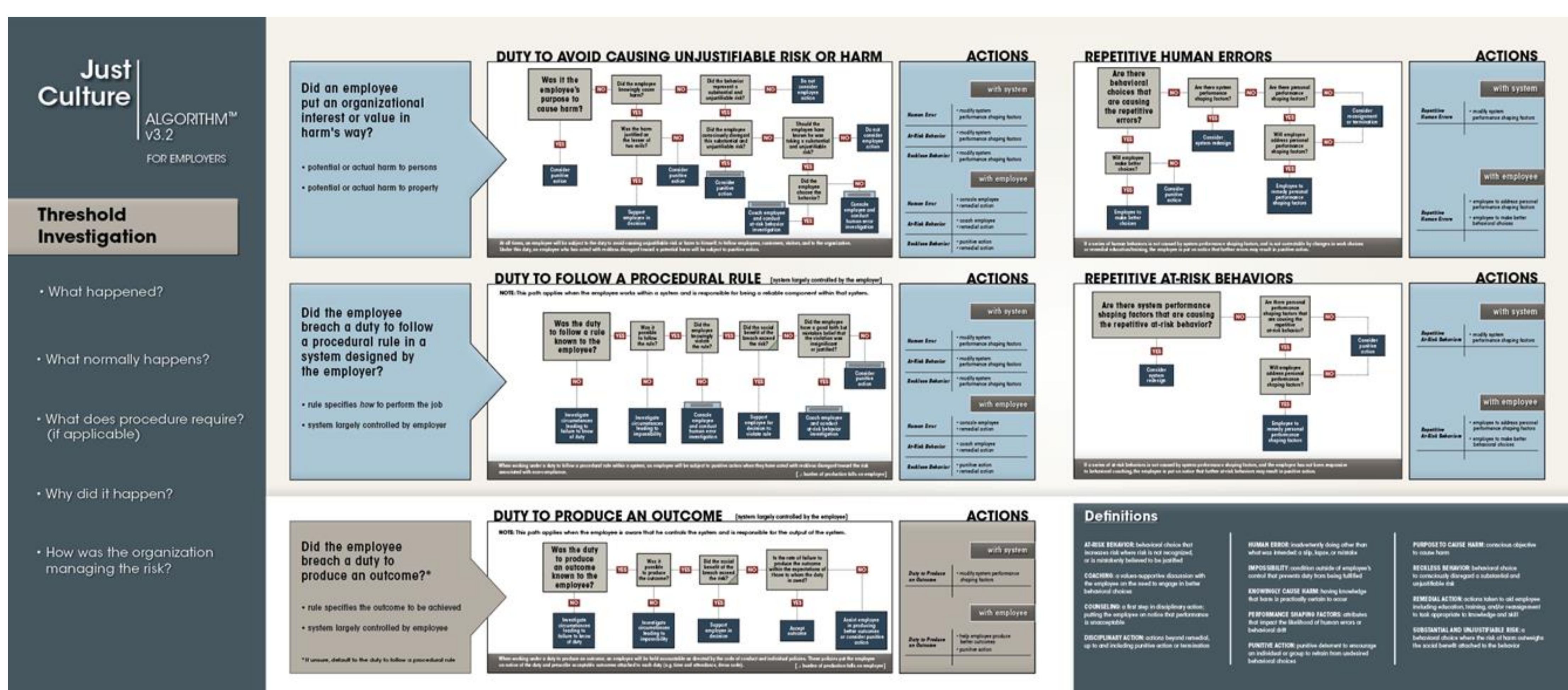
Duty to Follow a Procedural Rule

- Largely controlled by the employer. Focus on rules regarding how to perform a job.
- This path applies when the employee works within the system and is responsible for being reliable and competent in said system

Duty to Avoid Causing Unjustifiable Risk or Harm

- This algorithm is used when there is potential or actual harm to a person or property

THE ALGORITHMS



https://outcome-eng.com/wp-content/uploads/2013/10/alg.png

CASE STUDY # 1

The Emergency Department team was notified of an incoming STEMI patient. In preparation for the patient's arrival, the pharmacy removed STEMI medication (heparin, aspirin, and ticagrelor) from the automated dispensing cabinet along with medications for rapid sequence intubation (etomidate, succinylcholine, and rocuronium). All medications were placed in the medication preparation area in the trauma room. Upon arrival, the patient was coding and required emergent intubation. Airway medications were requested by the pharmacist and administered. Based on the recommendation of Cardiology in consultation with the patient's family, treatment was not pursued, and STEMI medications were not necessary. Upon patient transfer, it was discovered that the heparin and etomidate vials were the same size and have similar labeling. In the rush to care for the patient, it was discovered that heparin rather than etomidate had been drawn up and administered to the patient.

CASE STUDY #1

1. What types of errors occurred?
   A. Skill based
   B. Rule based
   C. Knowledge-based
2. Was there an intention to cause harm?
   A. Yes
   B. No
3. Following a discussion with the staff involved, it is determined that there are aspects of both human error (mistakenly using the wrong vial) and at-risk behavior (not carefully reading the label). What next steps may be appropriate? Choose all that apply
   A. Console the employee
   B. Coach the employee
   C. Complete a record of the conversation and place it in the employee's personnel file
   D. Look for any system improvements to help make a human error difficult to commit in the future
   E. Discuss the case in a confidential manner at a team M&M or Performance Improvement conference

CASE STUDY #1 ANSWERS AND DISCUSSION

1. **A**

   The pharmacist in her second year of residency training, mistakenly used the incorrect vial when preparing the requested etomidate dose in an urgent and chaotic code situation.

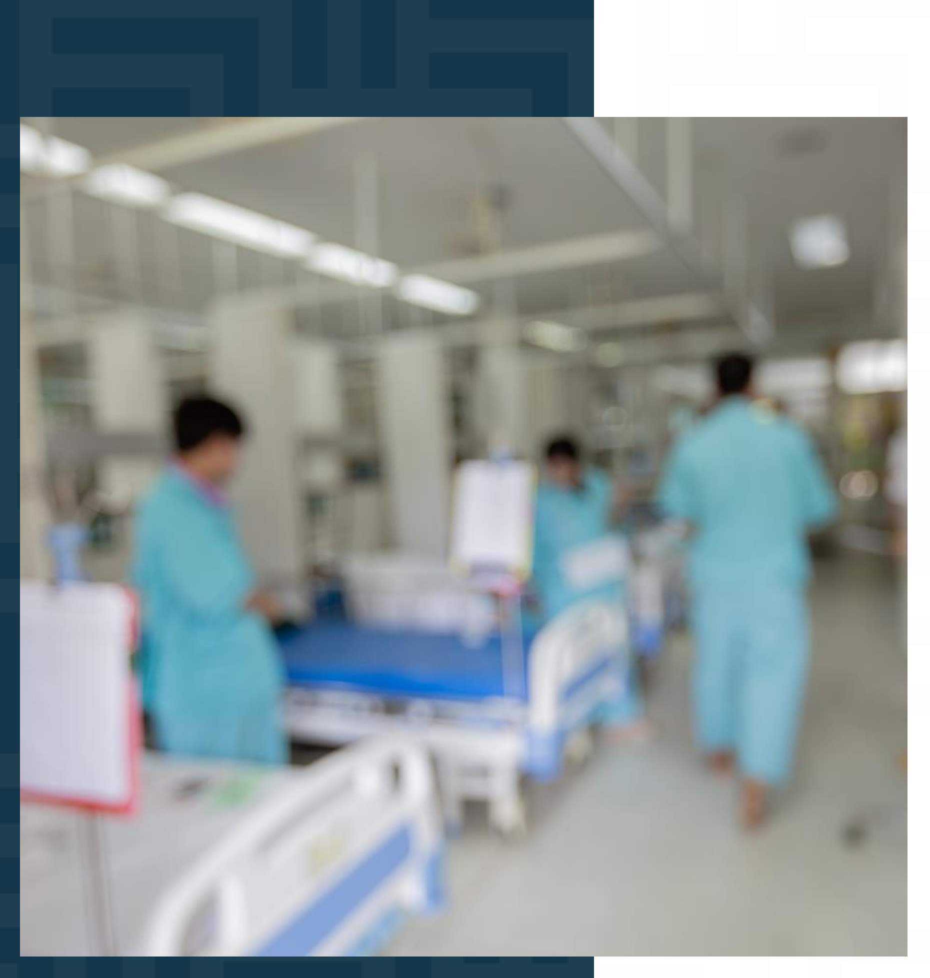
2. **No**

   There was no intent to cause harm to the patient.

3. **A, B, D, and possibly E**

   - Consoling an upset staff member for a human error of drawing up the wrong medication is an important place to start the conversation.
   - Coaching and reminding the staff member on the importance of reading the label before drawing up the medication and completing a verbal handoff to the person administering the medication, is a key safe practice that needs to be followed, even in an emergent situation.
   - Identifying opportunities for improvement with the staff involved is crucial. In this case, opportunities for improvement included better organization of medication preparation in the trauma room. Specific practice recommendations may include not pulling all medication at once or improving the separation of medication in the crowded medication preparation area.
   - Discussing aspects of the case and potential system improvement in a confidential and safe manner may be of value to team members beyond those involved in the specific incident with an emphasis on learning and improving.

CASE STUDY #2



Two nurses select the (same) wrong vial of intravenous medication from the medication dispensing system. One nurse administers the drug to the patient, causing cardiac arrest. The other nurse realizes the switch when drawing the solution from the vial into the syringe at the bedside. These were two different patients.

CASE STUDY #2, CONTINUED

1. What types of errors occurred?
   A. Skill based
   B. Rule based
   C. Knowledge-based
2. Was there an intention to cause harm?
   A. Yes
   B. No
3. Following a discussion with the staff involved, it was determined that there are aspects of both human error (mistakenly selecting the wrong medication) and at-risk behavior (not reading the label and not scanning the medication prior to administration). What next steps may be appropriate? Choose all that apply.
   A. Console the employee
   B. Coach the employee
   C. Complete a record of the conversation and place it in the employee's personnel file
   D. Look for any system improvement to help make a human error difficult to commit in the future

CASE STUDY #2 ANSWERS AND DISCUSSION

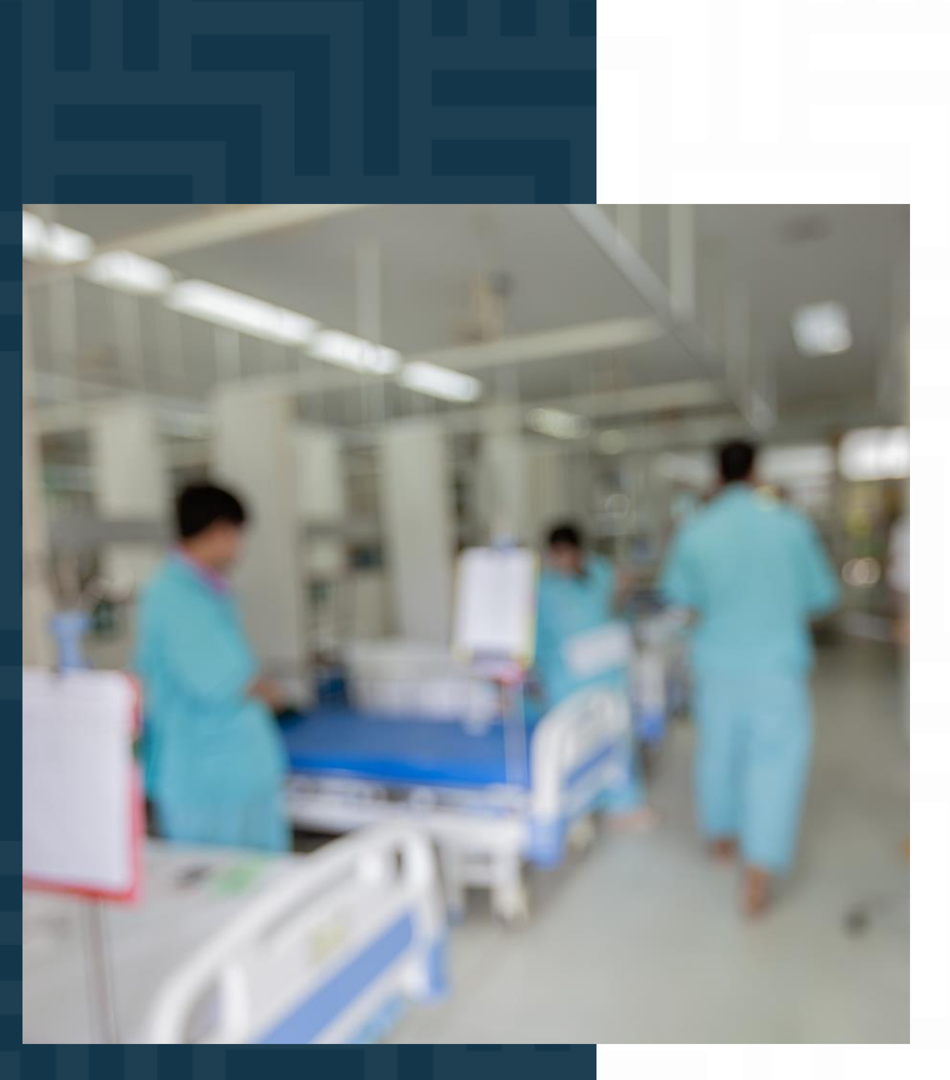
1. **A**

   The nurse inadvertently selected the incorrect medication from the automated dispensing cabinet which is a skill-based error.

2. **No**

   There was no intention to cause harm.

3. **A, B, and D**
   - Caring for the caregiver and consoling the distraught staff members is important in any situation where a human error is made.
   - Coaching the nurse on the importance of verifying medication prior to administration is a critical component for at-risk behavior.
   - Looking for system improvements such as placement within the medication dispenser of the dextrose and lidocaine and monitoring of override rate should be considered.
   - It was discovered with this specific error that the medication in question looked like the medication that should have been given in shape, size, color, and name. This was an error waiting to happen. It is imperative to complete a deeper system investigation to determine the root cause of the issue and to make it harder to do this in the future.



CASE STUDY #3

During an accreditation survey, it was discovered that biomedical equipment examined has a notably high number of past due maintenance service stickers. However, in the biomedical equipment database the equipment is all accounted for and has been serviced properly.

It is a policy requirement that all service dates are accurate on equipment used for patient care. Further investigation discovers it is one engineer who has been forgetting to put service date stickers on equipment. The engineer has had repeated coaching on this topic.

CASE STUDY #3 QUESTIONS

1. What types of errors occurred?
   A. Skill based
   B. Rule based
   C. Knowledge-based
2. Was there an intention to cause harm?
   A. Yes
   B. No
3. What next steps may be appropriate? Choose all that apply.
   A. Console the employee
   B. Coach the employee
   C. Consider a written warning if a verbal warning has already occurred and has been documented
   D. Look for any system improvement to help make a human error difficult to commit in the future

CASE STUDY #3 ANSWERS AND DISCUSSION

1. **B**

   The engineer is aware of the rule to place service stickers on equipment to ensure the equipment information matches the system information.

2. **No**

   There was no intention to cause harm.

3. **B, C, and D**

   - Coaching the engineer on the importance of staff members being able to easily identify equipment that is safe to use is just as important as the database being correct.
   - It is important to remind the team member that repeat errors will not be tolerated if the error being made is within the team members control to address, which this is.
   - It may be helpful to work with this team member to have them create a process to make it easier to complete this process moving forward. One option is to also work with other engineers to see how they are effectively completing this requirement and create standard instructions.

CASE STUDY #3, CONTINUED

A surgical team does not perform a surgical time-out because no adverse events have occurred in the past. This is a well-known best practice in the healthcare setting and the hospital clearly has an outlined and defined policy on surgical timeouts and their importance.

CASE STUDY #4

1. What types of errors occurred?
   A. Skill based
   B. Rule based
   C. Knowledge-based
2. Was there an intention to cause harm?
   A. Yes
   B. No
3. It is known that time-outs are a hospital policy and clearly defined best practice in care. What next steps may be appropriate? Choose all that apply.
   A. Console the employee
   B. Coach the employee
   C. Consider punitive action for the employees involved
   D. Look for any system improvement to help make a human error difficult to commit in the future
4. It is later discovered that a physician has been pressuring the surgical teams to skip time outs to increase overall throughput. This physician brings in significant revenue for the hospital and has been in practice in the community for nearly 25 years.

CASE STUDY #4 ANSWERS AND DISCUSSION

1. **B**

   The surgical care team knowingly violated hospital procedures, policies, and best practices.

2. **No**

   There was no intention to cause harm. However, an argument can be made regarding the justifiableness of the actions performed

3. **C and D**

   The care team knew there were clear policies and procedures in place regarding the importance of time-outs. It is the care team's imperative duty to practice beneficence in all actions and protect the best interests of the patients. In this instance, the care team clearly violated generally accepted best practices, evidence-based best practices, and hospital policy.

   Given the widespread nature of this issue, the hospital should also conduct a thorough investigation and potentially an FMEA to make it harder for system failures like this to occur in the future

4. The physician should be called into peer review. All patient caregivers have a responsibility to act in the best interests of the patients. Training may need to be done for the surgical division and leadership presence on the unit may need reevaluation as there is a deeper cultural issue occurring to allow all parties involved to believe not performing a best practice and hospital-stated policy is okay.

CASE STUDY #5

A hospital has noticed an increase in surgical site infections. During this time, the central services department has noted a change in the consistency of the cleaning material they have historically used to clean surgical tools. However, materials management ensured them that it is the same detergent they have always received. It was later discovered the detergent had been improperly restocked and shipped to the hospital by a distributer. It was not safe for cleaning surgical instruments.

CASE STUDY #5 QUESTIONS

1. What types of errors occurred?
   A. Skill based
   B. Rule based
   C. Knowledge-based
2. Was there an intention to cause harm?
   A. Yes
   B. No
3. Staff in central services raised concerns to the leaders and to other departments but were ensured that it was, okay? Only later did the issue get investigated more intensely once Risk Management was made aware. How should leadership respond to the team members? Choose all that apply.
   A. Console the employee
   B. Coach the employee
   C. Consider punitive action for the employees involved
   D. Coach the leadership team on the importance of investigating team member concerns
   E. Look for any system improvement to help make a human error difficult to commit in the future

CASE STUDY #5 ANSWERS AND DISCUSSION

1. **C**

   The central services team had no way to escalate the issue further up the chain of command and no reason not to trust the materials management team

2. **No**

   There was no intention to cause harm

3. **A, D and E**

   There were no fail safes in place to prevent this error from occurring other than team member judgement and expertise in the moment. There was no intent to cause harm and the health system had no polices or procedures in place to address this concern. The manager of the department should be coached to investigate team member concerns more in depth to ensure all proper chains of command are notified. Finally, a system should be implemented in materials management and in central services to ensure materials are properly vetted before use on equipment or patients.

SUMMARY

Just culture recognizes that competent professionals make mistakes and acknowledges that even competent professionals will develop unhealthy norms (shortcuts, "routine rule violations"), but has zero tolerance for reckless behavior

Systems are never 100% reliable

Every event should be viewed as an opportunity to learn

"People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right?

Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue."

Don Norman

The Design of Everyday Things

DISCUSSION-COMMENTS-QUESTIONS

Post-Polling Questions

1. I am ___ in my understanding of the fundamentals of a Just Culture.

2. I am ___ in my understanding of how to construct a roadmap for establishing an organizational Just Culture.

3. I am ___ in my understanding of how events are responded to within a Just Culture.

4. I am ___ that I will apply the knowledge gained from this educational training to impact the quality of care that my organization's patients receive.

THANK YOU

Carla B. Wilber, DNP, RN, NE-BC, CATC
Senior Consultant
Cameron Smith, MBA, CPHQ
Consultant

1685 Congress Street, Suite 202
Portland, Maine 04102
336-425-3837
cwilber@stroudwater.com
csmith@stroudwater.com

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RESOURCES

- Just Culture Event Algorithm

Just Culture Event Algorithm

- Just Culture Toolkit

Just Culture Toolkit

- Just Culture Example Policy

Just Culture Policy Example

- Just Culture Article

Just Culture Article