JUST CULTURE FOR HEALTHCARE MANAGERS

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The Just Culture Community
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VILLAGE HOME HEALTH
Good people. Great care. Exceptional results.

LEARNING OBJECTIVES

- Describe how to build a learning culture that produces the best possible outcomes
- Discuss ways to promote openness and fairness and avoid overly punitive reactions to adverse events and errors
- Discuss ways to design safe systems
- Review ways to manage behavioral choices
- Provides managers guidance on how to make decisions when employees have acted inconsistent with organizational values and policies

WHAT IS A JUST CULTURE?

As managers of healthcare associates we seek to identify steps to determine cause of an error..

- Associate has made a mistake
- Acted inconsistently with your policies/procedures/values

What does a Just Culture help us do?

We strike the middle ground, balancing systems, individual accountability in a manner best supporting system safety and organizational values.

FOUR FOCUS AREAS

- Create a learning culture
- Create an open and fair culture
- Design safe systems
- Manage behavioral choices

Create a learning culture

- Produce best outcomes
- Hungry for knowledge
- Hungry to see risk at organizational & individual level
  - Risk seen through events, near misses, observing designs of systems, our own behaviors, behaviors of those around us

Without a learning culture we see

- Repeat of previous mistakes
- Missed opportunity (data)

"Be so busy fixing the small holes in our boat that we will miss the water streaming over the sides"

FOUR FOCUS AREAS CONT..

Create an open & fair culture

- Move away from overly punitive reaction to events/errors
- Recognize our own fallibility (drift from what we have been taught)
- Employees admit to their mistakes
- Line is drawn between human error, at-risk behavior, &reckless behavior
- All employees accountable for their behavioral choices

Don't confuse with an overly punitive culture or blame free culture where we take action on the severity of the outcome attached to the behavior or we convince ourselves no one should be held accountable for their actions.

FOUR FOCUS AREAS CONT..

Design of safe systems

- What's in our control as a manager:
  - Reliability of the system which our employees work in
    - Anticipate human error
    - Capture errors before critical point
    - Recover when consequences of our errors reach the patient
  - Design systems that facilitate employees making good decisions to support organizational values

FOUR FOCUS AREAS CONT..

Manage behavioral choices

- Allow us to achieve desirable outcomes
  - Cultures drift to unsafe places, drift can be seen through behavioral choices of those within that system
  - Employees following safety critical procedures?
  - Do they report when seeing a hazard or mistake or make the mistake themselves?
- Coach employees around reliable behaviors

Managers recognize the steps needed to get the results we desire.

- Remedial
- Disciplinary
- Punitive

QUESTIONS

What two things do we have influence over as a manager?

A. Your own behaviors and those of your staff
B. The system in which you put your employees, and their behavioral choices within that system
C. The time you arrive at work and the time you leave
D. The errors and outcomes of your employees

In the case of surgical counts, why is it ineffective to simply require that the surgeon not leave an instrument behind? Why not go without the scrub nurse and circulating nurse?

A. Having only one person limits the number of people we can hold accountable
B. The surgeon is destine to make a mistake—putting the patient only one human error away from harm
C. Nurses are more reliable than surgeons
D. All of the above

MANAGEMENT OF RISK

To implement Just Culture we must all share a specific set of core beliefs…….

- To Err is human

Realistic view that humans make errors despite HR policies making it against the rules

- To Drift is human

Behavioral choices that we make unknowingly that create unjustifiable risk

- Risk is everywhere

The product of the likelihood of occurrence and the severity of the outcome

- We must manage in support of our values

Behaviors must be consistent with our organizational values (safety, privacy, customer service)

- We are all accountable

What does accountability mean and how should we respond?

QUESTION

To drift is human.. What does this mean?

a. That we have no sense of purpose?
b. That we lose focus in meetings
c. That we will move away from strict compliance
d. That we make more mistakes as we get older

Remember… drifting refers to behavioral choices we make that can lead to risk.

We drift from what we were taught.

Why?

- **Our fading perception of risk as we become more comfortable and competent.**
- **Our desire to accomplish more**

Risk is everywhere. If we believe this, what strategy best corresponds to the to this belief?

A. Putting our heads in the sand
B. Actively seeking out risks in the work place
C. Giving up because we will never eliminate risk
D. Expecting employees to manage risk with no assistance

Not all risks are bad, evaluate if the risk is worth taking or provides no benefit . Always be looking for risk around you. Encourage employees to report when they have made a mistake or see a risk.

RISK ADJUSTMENT STRATEGIES

As managers we cannot directly create fewer errors or bad outcomes, however we can use these two tools

- Design good systems around employees
- Facilitate good behavioral decisions

Monitor and track adverse events:

The results of managing system design and staff behavioral choices will result in better outcomes and fewer errors.

How do we do this?

Analyze process, look for the risk and consistency

Put barriers in place

Oversight

Training and education

Review/align with policies and organizations values/mission

SYSTEM DESIGN

Does the design of the system work for your organization?

What will compromise the system?

Is the system fallible to human error?

How does the system itself impact the reliability of the individual human components in that system?

Is the system designed in a manner to give our employees the best chance of getting their job done right the first time?

Examples:

Scheduling systems

EMR/documentation/care plans

Process of getting doctors orders

Insurance verification

Make no mistakes

"Remember the most **unreliable** path is to simply tell our employees not to make mistakes. We are all human and prone to error. Yet, there are systems where the design does little to minimize the rate of human error and makes no attempt to mitigate the effect of human error."

Knowledge and Skills

We can actively control knowledge and skill

- Give knowledge (what they know)
- Give the skill (the ability to apply the knowledge

There are many high risk situations

Give your employees the opportunities to have the likelihood of a successful outcome.

PERFORMANCE SHAPING FACTORS

Goal: Control performance shaping factors within the work system

Identify attributes of the work system that seem to impact the likelihood of :

Human error

Engaging in behavioral drift (parts of the process that fall off, inconsistencies)

How can we control performance shaping factors?

- Reduce work related stress
- Improve a process, simplify if possible
- Improve the layout

Other examples: work flow process in intake dept. cannot move onto next step until previous is completed.

Consider the following strategies for design of systems, which is most reliable

A. Barriers in place to prevent the error
B. Modify performance shaping factors
C. Downstream check to catch the error
D. Instruct employees not to make mistakes

Examples of a strategy of controlling performance shaping factors

A. Reducing stress
B. Improving layout of controls
C. Improving procedure design
D. All of the above

DESCRIBE ONE OR TWO PRINCIPLES DESIGN STRATEGIES USED TO MANAGE THE RISK

Healthcare acquired infection

Patient seen for wound care by Home care agency

Several wounds being addressed

Wound gets worse because treatment is not working

Environmental factors, cleanliness in the home

Non-compliance with diet and poor nutrition

Non-compliance with dressing changes , family not assisting as agreed upon

Poor follow up with doctor appointments, unable to get to wound clinic.

several medical conditions present, circulation & diabetes

Poor follow through with weight shifting to promote pressure relief

- **Make no mistake**
- **Knowledge and skill**
- **Performance shaping factors**
- **Perception of high risk**
- **Barriers**
- **Recovery**
- **Redundancy**

CONTROL PERCEPTIONS OF RISK

Example : we train employees on the rules in protecting patient privacy along with the penalties associated with the choice to breach the rules, HIPPA.

Maintaining the perception of high risk is essential to prevent staff from drifting into at-risk behaviors.

Example: talking with friends and others about patients health information when not appropriate.

Perception of risks critical to the *JUST CULTURE model*-----*as* all employees are required to stay clear of any unreasonable risk in their path.

Seeing and identifying those risks are critical.

BARRIERS TO PREVENT HUMAN RISK

Put barriers in place to prevent human error!

- Password protection (HIIPA)
- Needle stick barriers
- Different connectors for oxygen verses air
- Medial supplies pt. specific and delivered to the home
- Protocols for infection control
- Gait Belts when ambulating a patient

RECOVERY

Catch upstream errors before leads to adverse outcome

Do with feedback, downstream tests or checks

Where do we use recovery in Healthcare? Where are the opportunities for recovery?

1. Diagnosis incorrectly (pt. detects illness not improving and re-visits the doctor)
2. Mistake in ordering medicine (pharmacist, nurse administering medication and patient are opportunities for recovery)

- **Detect and correct error before it leads to harm**
- **Use recovery as a strategy**
- **Know what processes you have in place that do not allow for recovery and put barriers in place to prevent critical errors**

REDUNDANCY

Creation of multiple paths to allow for success

Do not allow harm to be just one step away if equipment fails or there is human error

Goal: ***We will always have our patients our patients more than one human error away from harm.***

Have a back up plan

Different ways of double checking

Look at your current systems from two different views:

1.Does it produce the results you want? Does it use redundancy, recovery, and barriers?

2.How does it impact individual performance. Does system shaping factors lead to an increased likelihood of human errors or at risk behavioral choices?

MANAGEMENT OF HUMAN ERROR

As a healthcare manager you want to evaluate your associates reliability in preforming their work. Do you want certain task at 95% reliability?

Only your Agency can decide what reliability is appropriate relative to the impact of an improperly completed task on safety, cost, and your organizational values.

Managing human performance:

Too little work stress causes:

- Mentally off task
- Allows our mind to be cluttered with non-tasks thoughts
- Prone to error

Too much work stress causes:

- Too much activities on our mind
- Disorganization & poor memory

Our risk for human error increases if this is not balanced

Consider these factors that can shape the natural rate of error for the task preformed:

- Information
- Equipment
- Unique job & task considerations
- Qualifications
- skill
- Individual performance
- Fatigue
- Life changing events
- Environmental conditions
- Communication
- Supervision

WHAT IS OUR TASK OF MANAGEMENT OF PEOPLE?

- Provide your associates with the best opportunities to get the job done safely and done right the first time.
- Recognize human error is inadvertent
- The decision to take punitive or disciplinary action is not supported by the Just Culture model
- Managers should “console” the associate who has made the human error
- The fixes are in the system design------making the human error less likely to occur

If the task is safety critical and can have large economical loss, or the error can result in a state or federal regulation deficiency you will design barriers, redundancy, and recovery into your processes to reduce the impact of the inevitable error.

MANAGEMENT OF AT RISK BEHAVIORS

It is manageable, but most difficult to manage !

Behavioral choices that increase the risk where risk is not recognized, or is mistakenly believed to be justified. (Example: Driving)

- Deviate from what you have been taught
- Develop bad habits
- Look for quicker and easier ways to accomplish the task
- Previous successes doing a task lure us into at risk behaviors
- Greatest threat on safety
- Become habitual

The outcome we seek drives our conduct-----even more than rules. We weigh the incentives and/or consequences associated with each choice.

No absolutes in evaluating at risk behavior

"What one person perceives as a strong incentive to engage in a particular behavior, another person perceives as weak".

Associates lose awareness of risks that are associated with deviation.

Humans drift from rules and policies as they have increased comfort with the task they are preforming.

The Just Culture Model Coaches (talks) to associates about the at risk behavior choices. A supportive discussion on making safe choices.

Coaching is a positive discussion in attempt to help the associate who has begun to drift.

Look at the reasons as to why the behaviors exist.

Find solutions

Example: Supply ordering & billing fraud

SCENARIO

A home healthcare company's maintenance technicians had a large book in which the instructions for repairing equipment were located. Policy requires that the instructions be followed each time that a repair was preformed.

Last week a technician made a mistake on the repair of an infusion pump by omitting a required check upon re-assembly of the pump(relying on his memory to complete the task). This check, called out in the manual, would have confirmed that the infusion pump would not allow the free(unregulated) flow of medication under a particular mode of the pump.

The inoperable pump safety device was caught when a patient received a free flow of heparin, leading to death of the patient.

Investigation revealed that the technician regularly preforms this specific maintenance.

Investigation also revealed that other technicians were preforming the task by memory without the aid of the procedural manual.

MANAGEMENT OF RECKLESS BEHAVIOR

Associate engaging in reckless behavior recognizes the risk associated with the chosen behavior

- A conscious disregard of a substantial and unjustifiable risk of causing harm
- Expect our employees to absolutely avoid
- Punitive or disciplinary action used to correct undesirable conduct

Reasons vary as conduct does as well.

Will effect safety of fellow associates, customers, clients, patients, and geeral public.

take action to ensure that both reckless associate and they know where the line of acceptable behavior is drawn.

EVENT INVESTIGATION

Data collection:

What happened? Open ended question-----and listen

What normally happens? Have them tell and show you

What does procedure require? What policies and procedures cause automatic shutdown of communication. Find out what procedures require. How the system was designed to work.

Why did it happen? Look for cause of the error.

How was the organization managing the risk? What does the system design look like?

JUST CULTURE ALGORITHM

Tool to aid in determining right course of action

"Console the error…Coach the At –Risk…..Punish the Reckless

See handout

Human behavior in three distinct duties:

- Duty to produce an outcome
- Duty to follow a procedural rule
- Duty to avoid causing Unjustifiable Risk or Harm

Duty to produce an outcome:

We put our associates in control within the systems in which they work (example: Getting to work on time)

Duty to follow a procedural rule:

Associate working within the employers system. Obligation is to simply follow the rule. The associate is not accountable for the output of the system, only for being reliable and a successful component in the system.

CONTINUED..

Duty to avoid Causing Unjustifiable Risk or Harm:

Highest obligation and takes precedence over other duties. We owe this to one other

Always present and applicable all the time

Through the classification of these three duties as managers we will be given guidance of the proper course of action.

Questions: Which of the following duty is the most important duty?

a. The duty to produce an outcome?

b. The duty to follow a procedure rule?

c. The duty to avoid causing risk or harm?

d. Equally important

BENEFITS OF JUST CULTURE IN YOUR ORGANIZATION

Component in your risk management system

Plays in the overall culture of your organization

Considers the task of re-designing your work environment

Identifies your values

- Patient safety
- Timeliness of care
- Quality
- Customer service
- Process measure outcomes

Defines expectations around your values

Putting values in right balance

Design systems that meet our customers needs

Put barriers in place

Create more opportunities for recovery

More levels of redundancy

BENEFITS CONTINUED…..

Create a learning culture giving them opportunities to get the job done right

Coach for good behavioral choices and recognize drift

Reporting of events

Managers take action

Increased ability to see limitations within those systems

Data collection in learning systems to have the ability to measure impact

Immediate influence on systems in which you put your associates into and the behavioral choices they make within in that system

Help employees work at the highest level of reliability

Well designed system of accountability and support

FINAL QUESTION..

Why should a healthcare manager pursue creating a Just Culture within their organization or department?

To create better outcomes for patients

To create better outcomes for staff

To make you more effective as a manager

ALL OF THE ABOVE !

RESOURCES

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Thank you !

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