“Just” Culture? Lessons Learned and Strategies for Implementation

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Outcome Engenuity conducted our Just Culture Certification Course.
Our Team

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11 NCPS Member Hospitals who participated in the Just Culture Collaborative
Objectives

1. Describe the key elements of a just culture

2. Discuss strategies and lessons learned for just culture implementation
A Just Culture

A Quick Refresher on Key Elements of a Just Culture
A ‘Just’ Culture

- A system of *shared* accountability

**Organizations**

- *Systems* they design
- Respond in a *just* and *fair* manner to employee behavior

**Employees**

- The *quality* of their *choices*
- *Reporting* their errors and system issues
Inputs and Outputs

System Design

Behavioral Choices

Outcomes

Errors
The Five Skills

- Values & Expectations
- System Design
- Behavioral Choices
- Learning Systems
- Justice and Accountability

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Overcoming Outcome Bias

Accountability Based on *System Design* and *Behavioral Choices*

Accountability Based on the *Severity of the Outcome*
Behavioral Choices and Organizational Responses

**Human Error**

*Product of Our Current System Design and Behavioral Choices*

Manage through changes in:
- Choices
- Processes
- Procedures
- Training
- Design
- Environment

**At-Risk Behavior**

*A Choice: Risk Believed Insignificant or Justified*

Manage through:
- Removing incentives for at-risk behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

**Reckless Behavior**

*Conscious Disregard of Substantial and Unjustifiable Risk*

Manage through:
- Remedial action
- Punitive action
The Just Culture Approach

- Event reporting
- Event investigation
- Event analysis
  - What were the expectations?
    - Duty to avoid causing unjustifiable risk or harm
    - Duty to follow a procedural rule
    - Duty to produce an outcome
  - System design
  - Behavioral choices
- Modify systems and hold individuals accountable
- Communicate and track your findings
Just Culture Implementation

10 Tips for Success and Lessons Learned from our Just Culture Collaborative
11 Hospitals in the Just Culture Collaborative

60 Events reported to NCPS

33 Certified Just Culture Champions

1500 Approximate number of hospital employees educated in just culture concepts
1. A Compelling Reason “Why”

- The problem
- Your need
- Data
- Stories
- Vision
- Sense of urgency
2. Just Culture is **Not** ‘Just Another Program’

- Outcome Bias (no symbol)

- System Design
- Behavioral Choices

- Blame
- Accountability
3. Commitment from Leadership and Management

- Senior Leadership and Board
- Front-Line Leaders
- Management
- Senior Leadership and Board
4. Resources
5. Plan for Implementation

**Organization**

**Initiation**
- Agenda Setting/Need
  - Identify need for innovation (diagnose performance gap)

**Decision**
- Matching
  - Design innovation to address need and bridge gap
- Redefining
  - Re-invent innovation to match context, restructure organization to fit innovation
- Clarifying
  - Make roles and tasks associated with innovation clear

**Implementation**
- Routinizing
  - Hard-wire: audits, policies, procedures, job descriptions, performance appraisals

**Individuals**

**Knowledge**
- Awareness—it exists
- How-to
- Principles—how it works

**Persuasion**
- Relative advantage
- Compatibility
- Complexity
- Trialability
- Observability

**Decision**
- Adopt
- Reject

**Implementation**
- Re-invention: Modification to fit an existing environment

**Confirmation**
- Recognize benefits
- Make it routine
- Promote it to others

6. Effective Training and Education

Results (impact)

Transfer (new knowledge transferred to behavior in the work environment)

Learning (immediate and retained changes in knowledge, demonstration of skill)

Reaction (satisfaction and utility judgment)

Transfer Problem: much of training does not result in behavior change in the work environment.

Reliable change

Role modeling

Opportunities to practice

Motivated learners

“I will use this training…”


Who Needs Just Culture Education?

- Board
- Leadership and Management
- Healthcare Professionals and Hospital Staff
- Physicians
Key Concepts in Just Culture Education

Five just culture skills

- Values and Expectations
- System Design
- Behavioral Choices
- Learning Systems
- Justice and Accountability

Three duties

- Produce an outcome
- Follow a procedural rule
- Avoid causing unjustifiable risk or harm

Behavioral choices

- Human error
- At-risk behavior
- Reckless behavior

Responses to behavioral choices

- Console the human error
- Coach the at-risk behavior
- Punish the reckless behavior

Algorithm

- Its elements
- Proper use
- Practice, practice, practice
- Competency assessment

System design

- Identify the system issues
- Be willing to make the fix
7. Expect Resistance

50 Reasons Not To Change

Behavioral Choices in our Imperfect Systems

Outcome Bias
8. Integrate Just Culture into your **Human Resource and Performance Management Policies and Procedures**

- Defining expectations: duties, behaviors, responses, etc.
- Clarifying event investigation processes
- Integrating just culture into job descriptions and performance appraisals
9. Use Your Measurement Strategy to Track Progress Toward Routinization

Audit appropriate use of just culture algorithm
Identifying correct:
✓ Duties?
✓ Behaviors?
✓ Responses?

Frequencies and rates of behavioral choices
✓ Human error?
✓ At risk behavior?
✓ Reckless behavior?
Change in any of these rates over time?

Changes made to improve system design

Number of events reported
Event rates and patient outcomes
Perceptions of safety culture
Perceptions of responses to adverse events and experiences in event investigations
Employee Behaviors Contributing to Reported Adverse Events

- Human Error: 67%
- At Risk Behavior: 30%
- Reckless Behavior: 3%

N = 88 employee behaviors from 60 event reports
Frequency of Appropriate Responses to Employee Behaviors Contributing to Reported Adverse Events

- **Console Human Error**
  - \( n = 59 \) behaviors
  - **75%**

- **Coach At Risk Behavior**
  - \( n = 26 \) behaviors
  - **100%**

- **Punish Reckless Behavior**
  - \( n = 3 \) behaviors
  - **100%**

\( N = 88 \) employee behaviors from 60 event reports
Greatest Changes in Percent Positive HSOPS Dimension Scores by Extent of Just Culture Adoption

- Non-Punitive Response to Error: Adoption Not Observed -10%, Adoption Observed 5%
- Frequency of Events Reported: Adoption Not Observed -8%, Adoption Observed 5%
- Supervisor/Mgr Exp. & Actions Promoting Safety: Adoption Not Observed -8%, Adoption Observed 6%
- Feedback & Communication About Error: Adoption Not Observed -7%, Adoption Observed 7%
- Communication Openness: Adoption Not Observed -6%, Adoption Observed 8%
- Management Support for Patient Safety: Adoption Not Observed -3%, Adoption Observed 8%
- Organizational Learning & Continuous Improvement: Adoption Not Observed -2%, Adoption Observed 8%

- Hospitals Completed Just Culture Training and Individuals Do Not Observe Adoption of Behaviors Consistent with Just Culture (n = 141-153)
- Hospitals Completed Just Culture Training and Individuals Frequently Observe Adoption of Behaviors Consistent with Just Culture (n = 264-277)
10. Participate in a Community to Support Your Journey