TAKING STEPPS TO SUSTAIN A JUST CULTURE

AHA Team Training Monthly Webinar

December 12, 2018

AHA Education

AHA Education | AHA Team Training

RULES OF ENGAGEMENT

- Audio for the webinar can be accessed in two ways:
  - Through the phone (*Please mute your computer speakers)
  - Through your computer
- A Q&A session will be held at the end of the presentation
- Written questions are encouraged throughout the presentation and will be answered during the Q&A session
  - To submit a question, type it into the Chat Area and send it at any time during the presentation

UPCOMING TEAM TRAINING EVENTS

2019 AHA Team Training
National Conference

June 12-14 ✪ San Antonio aha.org/teamtraining

Grab your cowboy boots and block your calendar - AHA Team Training is heading to San Antonio this June for our annual conference!

- Call for Proposals for speakers and poster authors is open until January 4.
- Registration will open in January 2019.

UPCOMING TEAM TRAINING EVENTS

2019 TeamSTEPPS course schedule now posted:

- Check out 2019 TeamSTEPPS Master Training course schedule on our website. Registration will open in January.

Monthly webinars:

- January 9: The What and Why of TeamSTEPPS: A New Way to Look at the Tools and Concepts
- Register for our free webinar

CONTACT INFORMATION

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TODAY'S PRESENTERS

Madeline M. Fricke, MPS, RN
TeamSTEPPS Master Trainer, Patient Safety & Leadership Specialist

Ronnie McKinnon, RN, JD, CPHRM, CPSO, CPPS
TeamSTEPPS Master Trainer, Certified Just Culture Professional

OBJECTIVES

- Participants will appreciate Just Culture and its impact on patient safety
- Participants will learn utilization of TeamSTEPPS to assess employee comprehension of key components of Just Culture
- Participants will be provided specific TeamSTEPPS tools to sustain Just Culture

JUST CULTURE TO REDUCE MEDICAL ERROR

NURSE SMITH AND JUST CULTURE

Nurse Smith worked in a large non-union hospital. She came in for an extra shift. She had plans to go out with friends, but there were 2 sick calls due to the flu and her Manager asked for help. She told her Manger she would come in but needed to leave on time to meet her friends. When she arrived, she was floated to a different unit since she had worked on that unit a few times in the past.

Late in her shift Nurse Smith had 2 admissions arrive from the ED at the same time she was trying to get her medication administration completed. She knew hospital policy required a second nurse to independently check and verify high risk medications, but she was anxious to finish her work and get out on time. Nurse Smith didn't see anyone other nurses, so she gave a patient a high-risk medication without following the verification process.

The patient spit the pill out and stated, "This isn't my medication, I don't take any pill this big! Are you sure you know what you are doing?" At that point Nurse Smith realized she made a medication error. The Nurse Manager overheard the patient and entered the room. She saw the pill the patient spit out and checked the patient's medication orders. The medication administered was contraindicated for the patient and could have caused a rapid drop in the patient's heart rate leading to cardiac arrest. Nurse Smith stated, "Well, it was lucky the patient spit it out and nothing happened."

WHAT SHOULD HAPPEN TO NURSE SMITH ?

1. She should be terminated immediately
2. She should receive suspension without pay for 2 weeks
3. She should be coached and reminded about risks of work-arounds
4. She should be consoled about the mistake, there was no negative outcome for the patient

MEDICAL ERROR

MODERN MEDICINE

The third-leading cause of death in US most doctors don't want you to know about

- A recent Johns Hopkins study claims more than 250,000 people in the U.S. die every year from medical errors. Other reports claim the numbers to be as high as 440,000.
- Medical errors are the third-leading cause of death after heart disease and cancer.
- Advocates are fighting back, pushing for greater legislation for patient safety.

Ray Sipherd, special to CNBC.com
Published 9:31 AM ET Thu, 22 Feb 2018 | Updated 9:39 AM ET Wed, 28 Feb 2018

CNBC

IMPACT OF MEDICAL ERROR

HUMAN ERROR, JUST CULTURE & PATIENT SAFETY

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

Dr. Lucian Leape Professor, Harvard School of Public Health

Testimony before Congress on Health Care Quality Improvement

WHY JUST CULTURE?

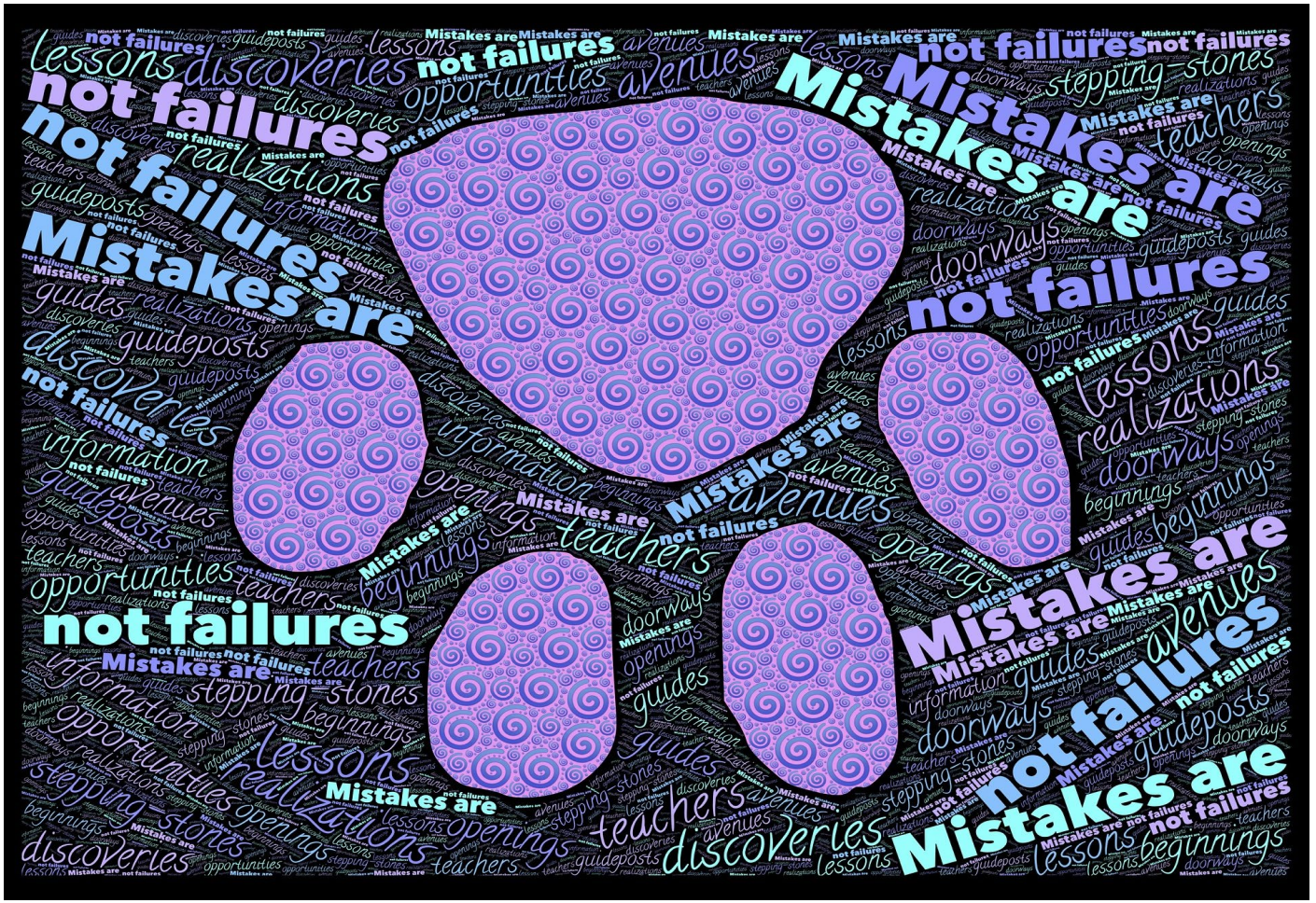
"People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right?

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

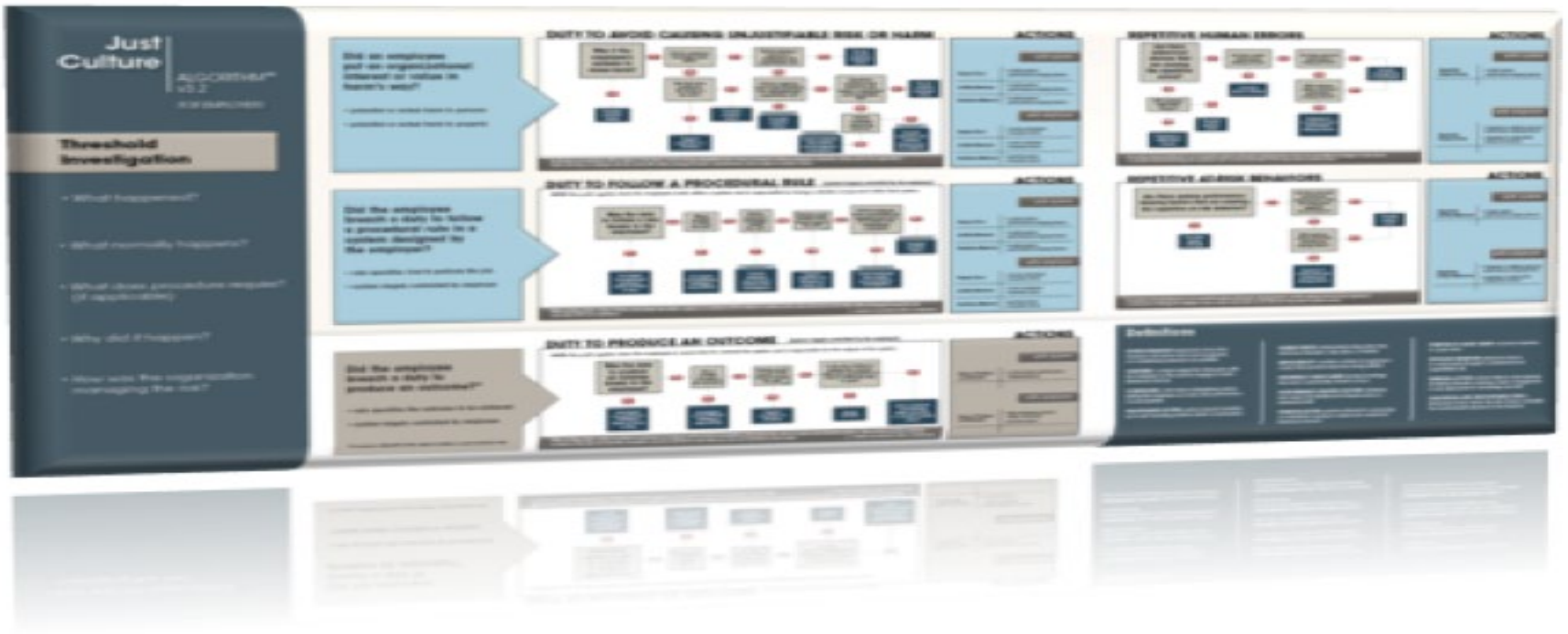
JUST CULTURE EXAMINES BEHAVIOR



WHAT IS JUST CULTURE?

- Holds employees accountable for behavior choices
- Employer accountable to design safe systems
- Recognizes human error – inescapable human fallibility
- Abandons “no harm, no foul” – replaces with workplace justice

JUST CULTURE = JUST AND FAIR RESPONSE



Outcome Engenuity: https://outcome-eng.com

BENEFITS OF JUST CULTURE: REDUCE BEHAVIORIAL AND SYSTEMS RISKS

- Creates an open, fair, and just culture —> safety culture
- Creates a learning culture —> mistakes are learning opportunities
- Gives insight into how errors occur —> designing safer systems
- Manage behavioral choices —> reduce risk of workarounds and drift

KEY COMPONENTS OF JUST CULTURE

THE THREE BEHAVIORS

Human Error

An inadvertent error, a slip, a lapse, a mistake

At Risk Behavior

Behavioral choice increases risk where risk is not recognized or mistakenly justified

Reckless Behavior

Behavioral choice to consciously disregard a substantial and unjustifiable risk

KEY COMPONENTS OF JUST CULTURE

THE RESPONSE TO THE BEHAVIOR

Human Error	At Risk Behavior	Reckless Behavior
Console	Coach	Discipline

JUST CULTURE DEFEATS OUTCOME BIAS

Outcome or Severity Bias…

The severity or outcome of an event plays a role in choosing HOW TO RESPOND to the event. Outcome dictates the response. This does nothing to improve patient safety or a culture of safety.

…versus Just Culture

In a **Just Culture** responses to events are not based on the outcome or severity—but rather are based on **behavioral choices** of the individual and **contributing factors of the System**—not on the severity of the results.

HEALTHCARE = MULTIPLE INITIATIVES

MANAGING MULTIPLE HEALTHCARE INITIATIVES

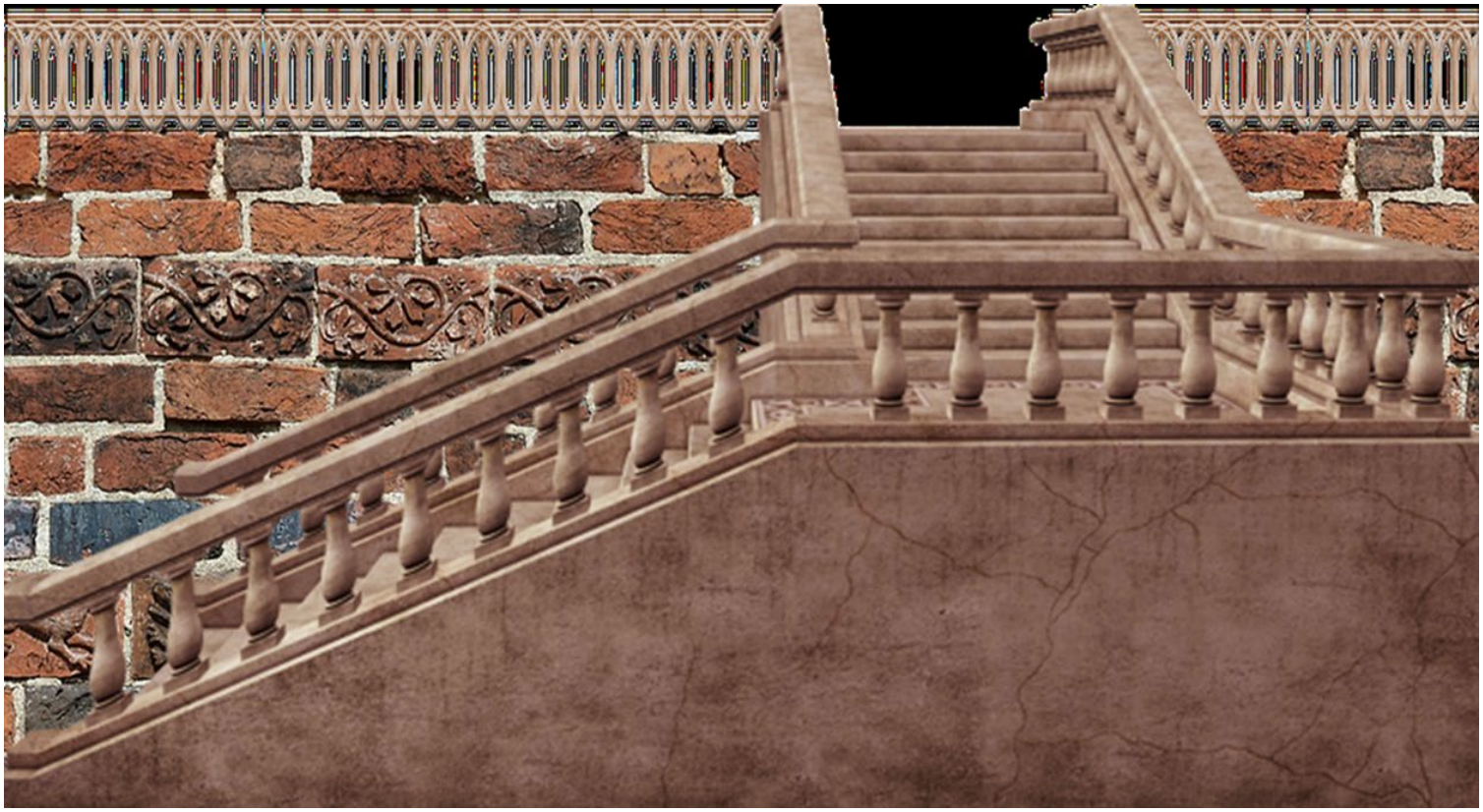
HOW CAN WE PREVENT THIS?

TEAMSTEPPS ANOTHER BRICK OR THE TOOLS AND MORTAR TO BIND INITIATIVES?

THE BASICS…

AHRQ, 2008

TEAMSTEPPS TO INTRODUCE AND SUSTAIN JUST CULTURE

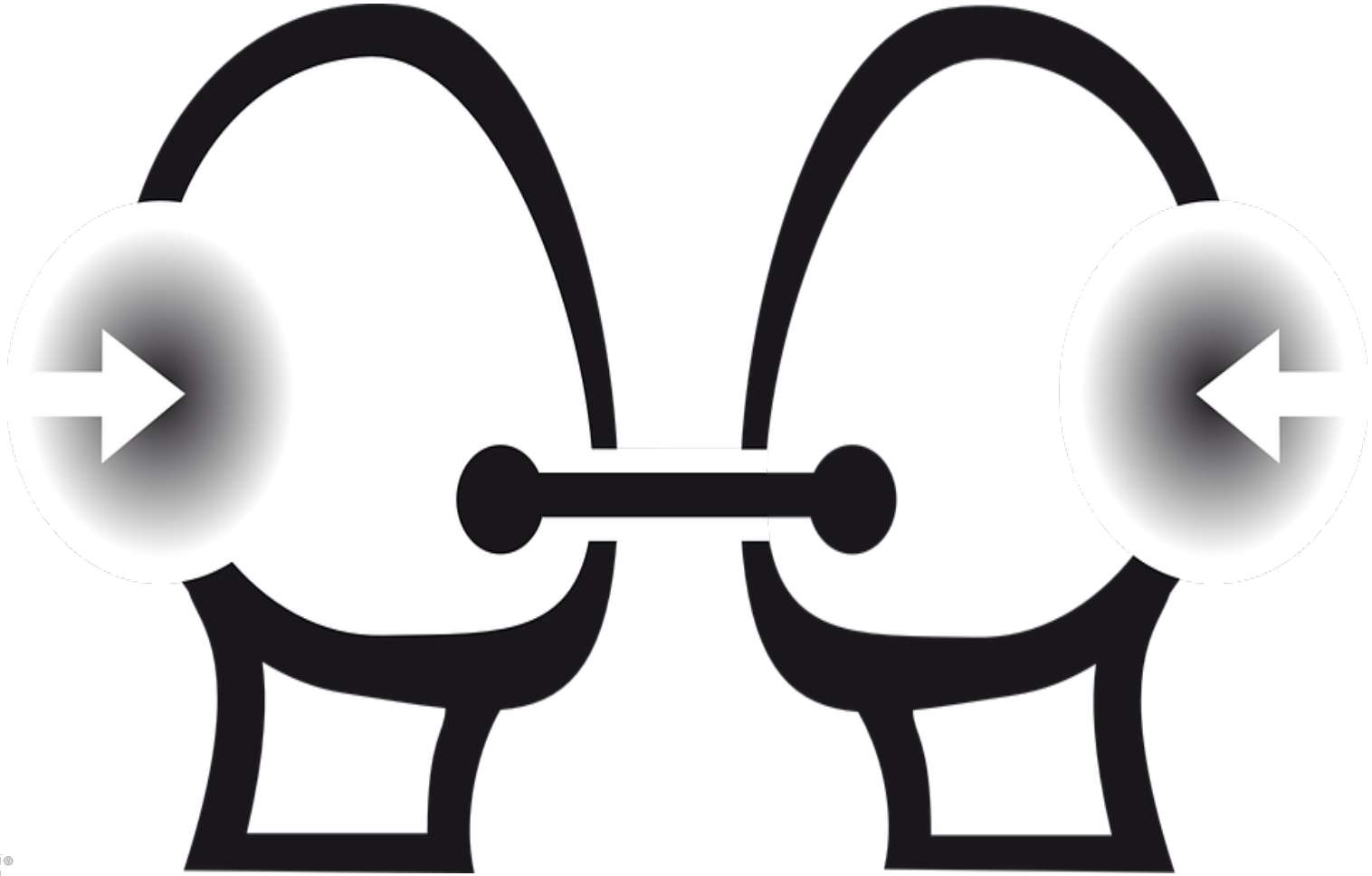


START BY TRAINING YOUR ENTIRE STAFF

CLOSE THE LOOP TO ENSURE A *SHARED MENTAL MODEL*

JUST CULTURE ≠ NO ACCOUNTABILITY

CHECK BACK AFTER TRAINING – DOES YOUR STAFF TRULY UNDERSTAND JUST CULTURE?



SITUATION MONITORING

CROSS MONITORING

- Monitoring actions of other team members.
- Providing a safety net within the team.
- Ensuring that mistakes or oversights are caught quickly and easily.
- "Watching each other's back."

TASK ASSISTANCE

MUTUAL SUPPORT

- Timely
- Respectful
- Specific
- Considerate

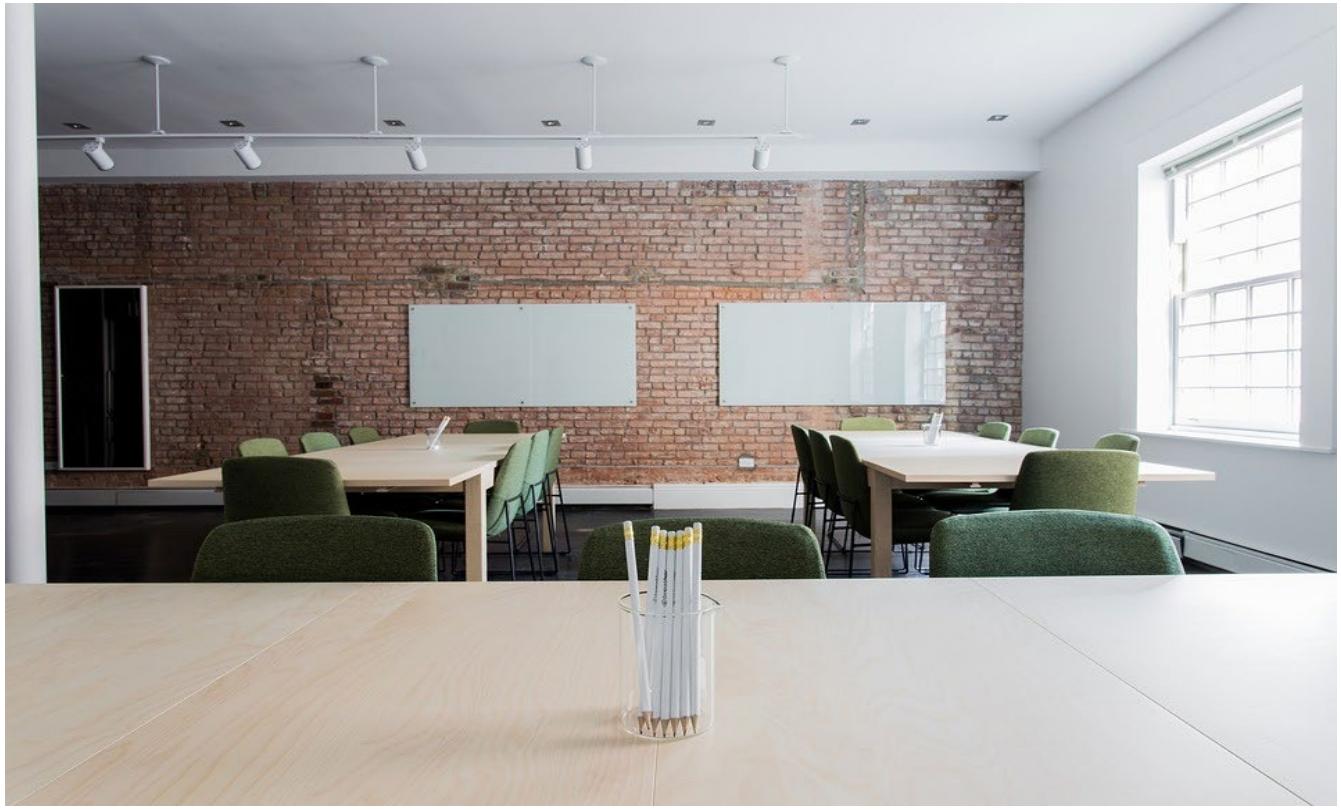
DEBRIEF

What did **WE** do well?

What could **WE** have done better?

What will **WE** do to improve our outcomes in the future ?

JUST CULTURE IS NOT JUST A CLASS



SUSTAINMENT REQUIRES COACHING

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DO YOU THINK TEAMSTEPPS MIGHT HAVE HELPED PREVENT THIS ERROR?

1. Yes
2. No

QUESTIONS?

- Stay in touch! Email teamtraining@aha.org or visit www.aha.org/teamtraining