Establishing a Statewide “Just Culture” for Patient Safety between Healthcare Providers and Regulators

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A Bit About the MOCPS

• Statewide Not-for-profit
• Founded by state medical association, hospital association and QIO
  – Serve as a statewide PSO
  – Serve as a statewide resource center
  – Provide education and training
  – Facilitate statewide safety activities among broad stakeholders
What does “just” mean to you?

• Fairness?
• Right?
• Equal?
• Good?
What is a “Culture of Safety”

A culture of safety is an *atmosphere* of *mutual trust* in which *all* staff members can *talk freely* about *safety* problems and how to *solve* them, *without fear* of reprisal.
Alternative Views of the Same Thing

How the customer explained it
How the Project Leader understood it
How the Analyst designed it
How the Programmer wrote it
How the Business Consultant described it

How the project was documented
What operations installed
How the customer was billed
How it was supported
What the customer really needed
The importance of culture

“The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes”
– Lucian Leape, Harvard School of Public health

“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, Apple Fellow

“It is through a Just Culture that we will begin to see, understand and mitigate the risks within the healthcare system”
– David Marx, Outcome Engineering
**What is a “Just Culture”**

**Definition:** just *(adjective) (from Dictionary.com)*

1. Guided by truth, reason, justice, and fairness: We hope to be just in our understanding of such difficult situations.
2. Done or made according to principle; equitable; proper: a just reply.
3. Based on right; rightful; lawful: a just claim.
4. In keeping with truth or fact; true; correct: a just analysis.
5. Given or awarded rightly; deserved, as a sentence, punishment, or reward: a just penalty.

*(others not listed)*
What is a “Just Culture”

Definition: cul·ture (noun) (from Dictionary.com)

1. the quality in a person or society that arises from a concern for what is regarded as excellent....
2. a particular form or stage of civilization, as that of a certain nation or period: Greek culture.
3. the behaviors and beliefs characteristic of a particular social, ethnic, or age group: the youth culture; the drug culture.
4. Anthropology. the sum total of ways of living built up by a group of human beings and transmitted from one generation to another.
5. the act or practice of cultivating the soil; tillage.
(others not listed)
The Model of a “Just Culture”?  
• Creating an open, fair, and just culture  
• Creating a learning culture  
• Designing safe systems  
• Managing behavioral choices
The Problem Statement

Support of System Safety

As applied to:
- Providers
- Managers
- Institutions
- Regulators

What system of accountability best supports system safety?

A “Just Culture” Answers

The Just Culture Community; Outcome Engineering
Thinking from a “just culture” perspective...

• Two nurses select the wrong medication from the dispensing system. One dose is given to the patient, resulting in shock; the other is caught at the bedside before causing harm. How do we treat these nurses?

• A Phlebotomist loses custody of a yet-unlabeled specimen, but chooses not to report the incident, fearing discipline. Do we forgive his actions given his legitimate reason for the phlebotomist’s fear?

• An entire surgical team defends skipping the pre-surgical time-out because no adverse event occurred. Do we condone this policy violation?

• A nurse complains that a physician knowingly violated a safety rule, although it was broken in order to save a life. Do we condone the rule violation?
The Missouri Story – The Why

- Seeking high impact, broad interest topic to introduce statewide
- Our champion - Missouri State Board of Nursing
- Training session desiring more
- Sought grant funding
The Missouri Story – The What

• Our Goals
  – To establish a more consistent understanding and management of human error, at-risk behavior, and reckless behavior between Missouri healthcare providers and regulators
  – Achieve an appropriate balance between a “blameless” culture and an “accountable” culture that supports patient safety improvement
The Missouri Story – The How

• Steps in Our Collaborative
  – Engaging key statewide stakeholders – September 2007
  – Recruitment of collaborators
  – Assessments of collaborator leadership teams (baseline)
  – Intervention
    • Champion and team training
    • Ongoing support - one-on-one, teleconferences, Web site
    • On-site additional training
  – Assessments post-intervention
  – Feedback from participants
The Missouri Story –
The Who

• Our Team
  – Project Facilitator – MSN, PhD Candidate
  – Researcher – MSN, PhD
  – Data Analyst – QIO
  – Educator – Outcome Engineering, LLC
  – MOCPS Staff
Our Stakeholders
Key Stakeholders

- Department of Health
- Division of Professional Registration
- Department of Mental Health
- Missouri Hospital Association
- Missouri State Medical Association
- Missouri Organization of Nurse Leaders
- Primaris (QIO)
- Business Health Coalition
- Health Systems
- Missouri Nurses Association
- College of Pharmacy
- College of Nursing
- Missouri Association for Healthcare Quality
Medical errors are a national concern

Obligation of providers and regulators to hold individuals accountable for competency and behaviors

Goal to balance punitive and blame free cultures, maintaining accountability

Evaluation of behavior to determine human error, at-risk behavior, reckless behavior

Consideration of range of responses to safety events

Support for systems to enable safe behavior

Collaboration promoting continuous improvement, culture of safety
Collaborators

**Type of organization**
- Acute care hospitals (42)
- Critical access hospitals (10)
- Regulatory agencies/association (5)
- Home health (3)
- Long term care (1)
- Specialty hospitals (3)
- Physician offices (2)
- Professional school (1)

**Geographic location**
- West (18)
- Central (18)
- South (12)
- East (19)
Collaborator Requirements

• CEO Commitment Statement
  ✓ Signed Letter of Support
  ✓ Allow Champion to actively and fully participate in training
  ✓ Identify a team of leaders to actively and fully participate
    ✓ Champion
    ✓ C-Suite
    ✓ Physician leader
    ✓ Risk/Safety/Quality
    ✓ Human Resources
  ✓ Use the concepts learned and continue to learn and utilize the concepts in an attempt to fully implement a “Just Culture”
  ✓ Acknowledge opportunity to apply for additional consultation as part of the collaborative, grant funding support, and organization’s commitment of staff time and travel expense.
The Missouri Story – The Results

• Assessments -
  – Baseline and post-intervention to assess changes in understanding and use of Just Culture principles

• Modified the AHRQ Hospital Culture Survey
  – Maintained domains for national comparisons
  – Added 3 questions to incorporate “Just Culture” concepts
  – Phrased questions for leaders

• Structured interviews with non-provider participants

• Feedback on collaborative, in general
Baseline Assessment

• Most leaders believe staff are comfortable reporting errors
  • Some acknowledge staff fear of retribution
  • Many believe staff only report errors that result in harm or significant events

• Many leaders believe staff are mindful of errors around them, but not of near misses or unsafe conditions

• Most leaders believe they focus on system issues when responding to error; however
  – Many look at the individual when an event occurs
  – Many indicate the response to an error depends on the scope and severity of the error
  – Most feedback strategies focus on individual education and/or counseling
Intervention – Number 1
Champions Training
Intervention-Number 2
Regional Training

• Team Training
  – Our Beliefs About Managing Risk
  – The Role of System Design
  – Management of Human Error, At-Risk and Reckless Behavior
  – The Role of Event Investigation
  – The Just Culture Algorithm™

• Informational Teleconferences
• Web Community
• Regulator Round Tables
• Board of Nursing – Complaint investigation session
• Department of Health Managers Training Session
Intervention-Number 3 – Additional Training

• 27 Collaborative Participants
• On site Consultation Options
  – Executive briefings
  – Management team training
  – Staff training – Safe Choices for Staff™
• In total trained ~3,600 individuals
Post-Intervention Assessment
– Overall Results

• All Perceptions Improved from Baseline
  – Teamwork Across Units (+8%)
  – Overall Perceptions of Patient Safety (+7%) – remains lower than national
  – Communication Openness (+7%) – became higher than national
  – Frequency of Event Reports (+7%) – remains lower than national
  – Feedback & Communication about Error (+5%)
  – Teamwork within Units (+5%)
  – Supervisor/Management Expectations & Actions Promoting Pt. Safety (+3%)
  – Organizational Learning-Continuous Improvement (+1.2%)
  – Non-punitive Response to Error (+1.2%)
  – Management Support for Patient Safety (< +1%)
  – Handoffs and Transitions (<+1%) – remains lower than national
  – Staffing (<+1%) - remains lower than national
Post-Intervention Assessment
– Interesting Finding

• Active participation in the Missouri Just Culture collaborative
  – Created more awareness of patient safety issues and culture by leaders at participating organizations.
  – Moved leadership perceptions about patient safety and culture closer to staff perceptions from national survey.
<table>
<thead>
<tr>
<th>Category</th>
<th>Least Engaged</th>
<th>Most Engaged</th>
<th>National Leader Response</th>
<th>National Staff Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff feel free to question decisions or actions of those in authority.</td>
<td>100%</td>
<td>57%</td>
<td>68%</td>
<td>45%</td>
</tr>
<tr>
<td>Staff freely speak up when they see something that would negatively affect patient care.</td>
<td>100%</td>
<td>77%</td>
<td>83%</td>
<td>75%</td>
</tr>
<tr>
<td>When a mistake is made that could harm the patient, but doesn’t, how often is it reported?</td>
<td>100%</td>
<td>61%</td>
<td>78%</td>
<td>76%</td>
</tr>
<tr>
<td>My manager does not overlook safety problems that happen over and over.</td>
<td>100%</td>
<td>84%</td>
<td>85%</td>
<td>76%</td>
</tr>
<tr>
<td>Staff do not feel like their mistakes are held against them.</td>
<td>75%</td>
<td>59%</td>
<td>69%</td>
<td>50%</td>
</tr>
<tr>
<td>Management is interested in patient safety even when an adverse event hasn’t occurred.</td>
<td>75%</td>
<td>68%</td>
<td>75%</td>
<td>55%</td>
</tr>
<tr>
<td>Our procedures and systems are good at preventing error from happening.</td>
<td>100%</td>
<td>70%</td>
<td>77%</td>
<td>66%</td>
</tr>
</tbody>
</table>

Excerpt from - J Nurs Care Qual, 2010; “Influencing Leadership Perceptions of Patient Safety Through Just Culture Training” Vogelsmeier, Scott-Cawiezell, Miller, Griffith
What We’ve Learned

• There is widespread interest in Just Culture
• Regulators are interested in working with providers on a Just Culture
• Opened discussions about to what extent
  – Does leadership perception = staff perception?
  – Do we proactively seek safety improvement?
  – Do we look at system issues when errors occur?
  – Do staff fear retribution for reporting errors?
  – Does action depend on result of error vs. behavior choice?
What We’ve Learned

- Education and interaction between leaders appears to narrow the gap between leader and staff perceptions of a safe culture
  - Leader perceptions from more actively engaged organizations were closer to staff perceptions
  - Leaders indicated being more “in tune” with staff
  - Leaders believed staff were more mindful of error
  - Leaders indicated performing more in-depth investigations regardless of level of harm incurred
  - Regulators improved understanding of provider issues
  - Regulators are interested in integrating concepts within their own processes
What We’ve Learned

• Barriers to implementing a Just Culture
  – Limited resources
  – No obvious return-on-investment to convince leadership
  – Limited commitment of administration and department heads
  – Resistance to new concepts
  – Staff turnover
  – Buy-in and support from Human Resources and front-line managers
  – Preconceived idea that punishment is the corrective action
  – Inconsistency among managers
  – Concern that blame and finger pointing will return
“Without the collaborative, I don’t know that we would be as far along with the change in our culture......physicians are even asking about the model and how to use it for peer review”.

“Thanks for getting Missouri on the right track!”
Into the Future....

• In Missouri
  – 18-month follow-up assessment
  – Integration into other MOCPS Projects
    • EMS PSO
    • *People, Priorities, Learning Together*
  – Certified Trainers
  – Ongoing Board of Nursing training
  – Potential for other provider groups
  – Consumer understanding

• Nationally
  – Federal legislation
  – National expansion
  – Health reform implications
Just Culture –
What’s Is It All About?

• Knowing the risks
  – Investigating the source of error and at-risk behaviors
  – Turning events into an understanding of risk
  – Creating a learning culture

• Designing safe systems

• Facilitating safe choices
  – Consoling the human error – addressing the system
  – Coaching the at-risk behavior – encouraging behavior change
  – Punishing the reckless behavior - appropriately
Our Just Culture Celebration – April 2009
THANK YOU!

Questions
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