Getting That Just Culture – Speaking up safely and Fostering Acceptable Participation in Peer Learning

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Learning Objectives

• Understanding the importance of error reporting and overcoming its barriers

• Creating a just culture

• Fostering participation in peer learning
Introduction

Like high reliability industries, peer learning relies on error reporting to identify learning opportunities

- Aviation
- Nuclear Power plants
- Health care

... and requires
- error reporting systems
- culture of safety
Culture of Safety: Where are we in 2020?

Percentage of Staff comfortable with Error Reporting

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>0%</td>
<td>10%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Aviation 1983

1. Wheale J. Irish Air Line Pilot’s Assoc. 1983
4. Siewert B. Radiology 2018;283:693
## Table 1: Barriers to Speaking Up

<table>
<thead>
<tr>
<th>Barrier</th>
<th>All Respondents*</th>
<th>Those Who Always Spoke Up*</th>
<th>Those Who Did Not Always Speak Up*</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>High reporting threshold</td>
<td>149/290 (51.4)</td>
<td>35/124 (28.2)</td>
<td>113/163 (69.3)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Challenging authority</td>
<td>151/315 (47.5)</td>
<td>37/124 (29.8)</td>
<td>112/167 (67.1)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Lack of listening</td>
<td>121/292 (41.4)</td>
<td>33/123 (26.8)</td>
<td>88/169 (52.1)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Fear of disrespect</td>
<td>106/292 (36.3)</td>
<td>18/124 (14.5)</td>
<td>88/167 (52.7)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Witnessed disrespect</td>
<td>93/305 (30.5)</td>
<td>27/135 (20.0)</td>
<td>66/169 (39.1)</td>
<td>.0004</td>
</tr>
<tr>
<td>Fear of retribution</td>
<td>71/292 (24.3)</td>
<td>15/123 (12.2)</td>
<td>56/157 (35.7)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Toxic captain</td>
<td>66/289 (22.8)</td>
<td>19/131 (14.5)</td>
<td>47/167 (28.1)</td>
<td>.005</td>
</tr>
<tr>
<td>Responsibility in the team</td>
<td>61/288 (21.2)</td>
<td>15/124 (12.1)</td>
<td>46/161 (28.6)</td>
<td>.0008</td>
</tr>
<tr>
<td>Shy personality</td>
<td>48/279 (17.2)</td>
<td>8/128 (6.3)</td>
<td>40/163 (24.5)</td>
<td>.0001</td>
</tr>
<tr>
<td>Lack of language training</td>
<td>57/268 (21.3)</td>
<td>9/123 (7.3)</td>
<td>48/163 (29.4)</td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>

* Numbers are raw data, with percentages in parentheses.
Retribution: A Sign of a Punitive Culture of Safety

Fear of retribution most common reason for not speaking up in industry 70%¹

• Retribution against the reporting staff and/or the staff involved in the incident

Forms of retribution

• Losing one’s job
• Disadvantages in work/vacation schedules
• Getting bad evaluations
• Not being considered for promotion
• Not getting good letters of recommendation
• Being labeled a complainer/”difficult person”

¹KD Ryan, DK Oestreich. Driving fear out of the workplace
Culture: What is it anyway?

Culture, *definition*:

Set of shared beliefs, attitudes, values, goals and practices that characterizes an institution or organization

- held by organization’s personnel
- “the way things are done around here”

https://www.merriam-webster.com/dictionary/culture
Davies HT. Qual Health Care 2000;9:11
## Types of Culture of Safety

<table>
<thead>
<tr>
<th>Type of culture</th>
<th>Thinking about Errors</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expected Frequency</td>
<td>Types and Frequency</td>
</tr>
<tr>
<td>Punitive</td>
<td>None</td>
<td>Individual &gt;&gt;&gt; System</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Just</td>
<td>Few</td>
<td>System &gt;&gt; Individual</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;No blame&quot;</td>
<td>Many</td>
<td>System &gt;&gt;&gt; Individual</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

1 Abudajeh HH. JACR 2015;12:4-5
2 https://psnet.ahrq.gov/issue/just-culture-guide 2018
Principles of a Just Culture

System Errors
• system issues are the most common cause of adverse events
• Focuses on identifying and addressing systems issues that lead individuals to engage in unsafe behaviors

Individual Errors
• individual accountability is maintained
• distinguishes between types of human errors
  - unintentional human error
  - at-risk behavior
  - reckless behavior
  - malicious action
  - impaired judgement

https://psnet.ahrq.gov/issue/just-culture-guide 2018
Just Culture: How to respond to different Types of Individual Errors

❖ HUMAN ERROR: an inadvertent slip or lapse. Human error is expected, systems should be designed to help people do the right thing and avoid doing the wrong thing.

❖ AT-RISK BEHAVIOR: consciously choosing an action without realizing the level of risk of an unintended outcome

❖ RECKLESS BEHAVIOR (NEGLIGANCE): Choosing an action with knowledge and conscious disregard of the risk of harm

https://psnet.ahrq.gov/issue/just-culture-guide 2018
Just Culture and Leadership Accountability

Leadership is responsible for system errors
- contributing to individual errors

Substitution test:
Would another provider put in the same circumstances in the same systems make the same error?

Human error
- System leaders are accountable

Risky and reckless behavior
- System leader share accountability with individual staff

Leonard MW. Patient Educ Cons 2010;80:288
Score – based Peer Review
Cultural Implications

*Objective* evaluation of individual radiologist’s performance

- Little consensus on scores  
  → interobserver variability (Kappa 0.11\(^1\)-0.23\(^2\))
- Systems issues not considered
- Focus on individual error  
  → blames individual → isolation

*Anonymous* case submissions

- Submitter easily knowable → damages relationships

\(^1\)Bender LC. AJR 2012;199:1320
\(^2\)Verma N. AJR 2016;207:1215
Peer Learning
Cultural Implications

Focus on performance improvement of the group
• Collaboration and teamwork create community
• “Feels inclusive and non-punitive” (Likert scores 4.76 and 4.64)

Supportive environment
• for individuals involved in adverse events

Living in a Just Culture
• Systems and individuals share accountability
• Increased error reporting

Sharpe RE. AJR 2018;211:1
Operationalizing Just Culture

Starts with training
• Manager training in just culture algorithm (JCA)¹

Requires practice
• More consistent application of JCA
• More frequent use of “console” and “coach” responses
  - Enables institutional learning
• Fairer and more humane outcomes for employees while increasing patient safety

Takes time
• Slow awareness of Just Culture with frontline staff!
• ↑ in speaking up from 10-31% in 5 years²

¹Broder J. AJR 2019;213:986
²Maxfield D. 2010 www.silenttreatmentstudy.com
One Institution: One Culture or Many “Micro-cultures”?

Perceptions of safety culture vary within institutions

- between ICUs
- between staff groups: physicians, nurses
  - mean score 43-75
  - percent positive score 9-69
- leaders have higher perception of culture of safety by 16%
  - aware of QI and safety efforts

Huang D. Crit Care Med 2007;35:165
Challenges in Implementation of a Just Culture

Transparency and Visibility
• feedback on RCA to reporting and involved staff
• communication of strong action plans to all staff
• participation of frontline staff in RCA with just culture algorithm

Consistent Practice
• staff punished for system error or perception thereof undermines just culture efforts

http://www.ihi.org/resources/Pages/Publications/Leading-a-Culture-of-Safety-A-Blueprint-for-Success.aspx
Summary of Shared Beliefs and Practices of a Just Culture

- The culture fosters performance improvement ✓
- Individuals are not responsible for systematic failures ✓
- Disregard for patient safety risks is not tolerated ✓
- Competent professionals sometimes make mistakes ✓
- Staff members report errors* for continued learning of the community ✓*Including their own
# Further Considerations for Implementation of Peer Learning

## Create a learning improvement community

**Engaged leadership**

**Just Culture**
- Consistency is key
  - everybody - always
- long process (3-5 years)
- Establish trust in the process

## Peer Learning Systems

- Preserve anonymity of reporter
  - While collecting data on No of submissions per staff
- Provide feedback after case review
  - To reporting staff
  - To staff involved in case
- Build learning opportunity repository
  - searchable
Conclusion

Getting that Just Culture

Requires

• daily practice
• consistency
• transparency

and enables

• ↑ error reporting
• ↑ organizational learning
“Competent Professionals sometimes make Mistakes”

44,000-98,000 deaths annually related to medical errors¹

How do we learn to accept and become more comfortable with our own vulnerability?

• Peer learning meetings
• Leaders/esteemed providers share their mistakes
• Feedback for individual providers
  - anonymous, electronic

¹IOM. To Err Is Human, 1999
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Summary of Shared Beliefs and Practices of a Just Culture

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*Including their own
Peer Learning Data base Submissions by Submitter

N= 2711

Data from BIDMC

Radiology Staff
Radiology Self Report
Non-Radiology Staff
Patient/Health Care Quality
Risk Management
Other Hospitals
unknown