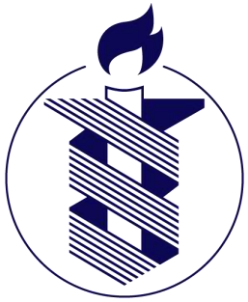
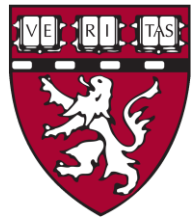


BETH ISRAEL DEACONESS
MEDICAL CENTER
A member of CAREGROUP

HARVARD
MEDICAL
SCHOOL



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

Bettina Siewert, MD
Associate Professor of Radiology
Vice Chair for Quality and Safety

Learning Objectives

- Understanding the importance of error reporting and overcoming its barriers
- Creating a just culture
- Fostering participation in peer learning

Introduction

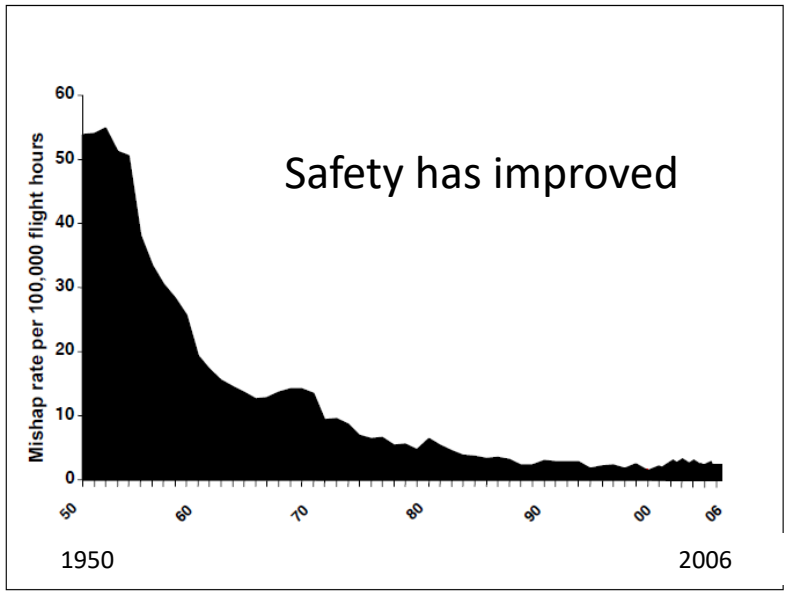
Like high reliability industries, peer learning relies on error reporting to identify learning opportunities

- Aviation
- Nuclear Power plants
- Health care

… and requires

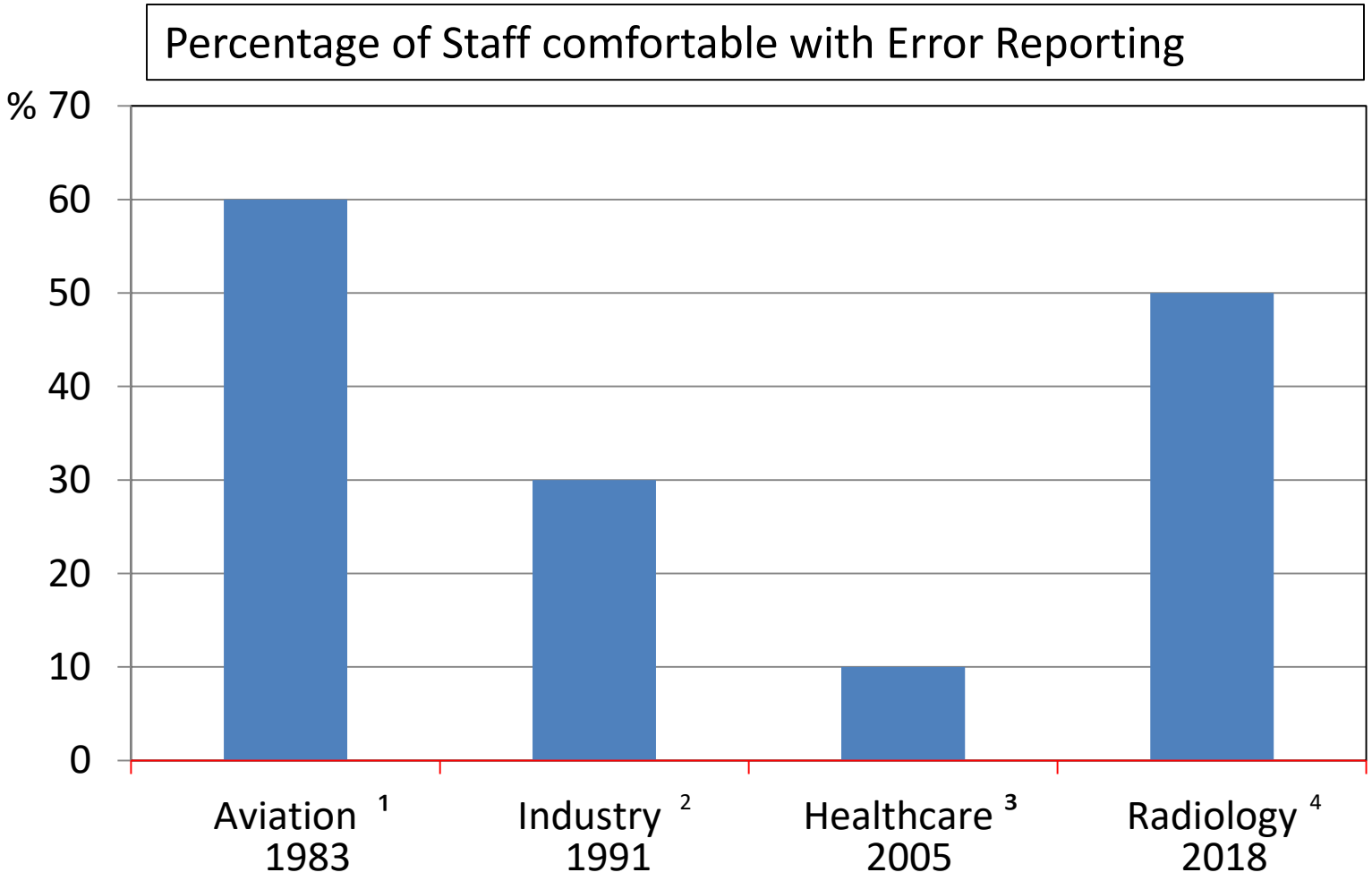
- error reporting systems
- culture of safety

Figure 1. U.S. Naval major aviation mishap rate (Naval Safety Center, 2007).



O'Connor P, O'Dea, A. (2007). Int J Appl Aviation Stud, 2007;7:312-328

Culture of Safety: Where are we in 2020?



[1]Wheale J. Irish Air Line Pilot's Assoc. 1983

[2]Ryan KD, Oestrich DK. Jossey-Bass 1991

[3]www.silenttreatmentstudy.com (2005)

[4]Siewert B. Radiology 2018;283:693

Cultural Barriers to Safety Event Reporting

Table 1: Barriers to Speaking Up

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

* Numbers are raw data, with percentages in parentheses.

Siewert B. Radiology 2018;283:693

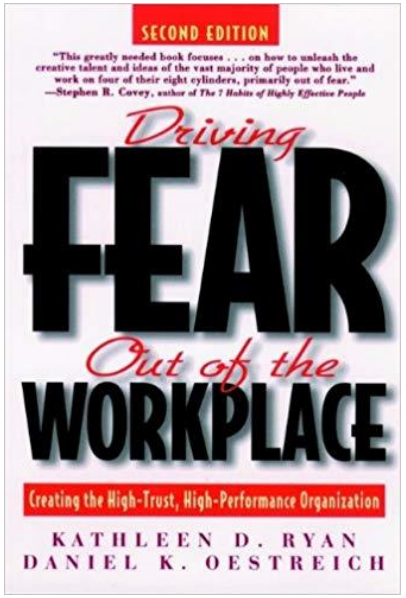
Retribution: A Sign of a Punitive Culture of Safety

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"



[1]KD 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

Type of culture	Thinking about Errors		Practice
	Expected Frequency	Types and Frequency	Staff Responsibility
Punitive	None	Individual >>> System	Yes Yes
Just[1]	Few	System >> Individual	No Yes/No
"No blame"[1,2]	Many	System >>> Individual	No No

[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

Perceived as punitive culture

[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

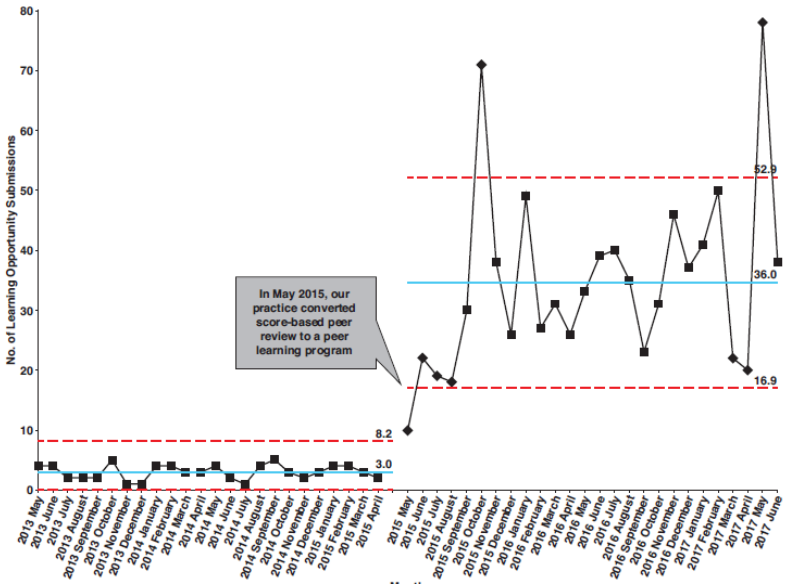
- Collaboration and teamwork create community
- “Feels inclusive and non-punitive” (Likert scores 4.76 and 4.64)

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 years[2]

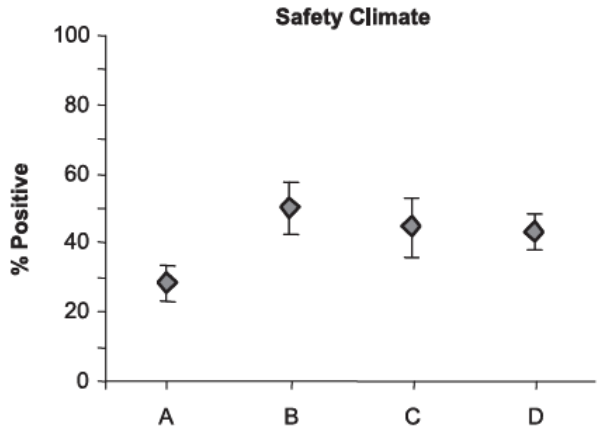
[1]Broder J. AJR 2019;213:986

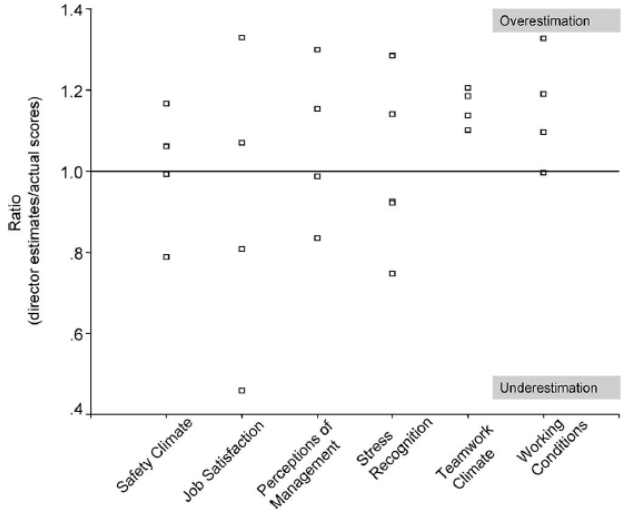
[2]Maxfield D. 2010 www.silenttreatmentstudy.com

One Institution: One Culture or Many "Micro-cultures"?

Perceptions of safety culture vary within institutions

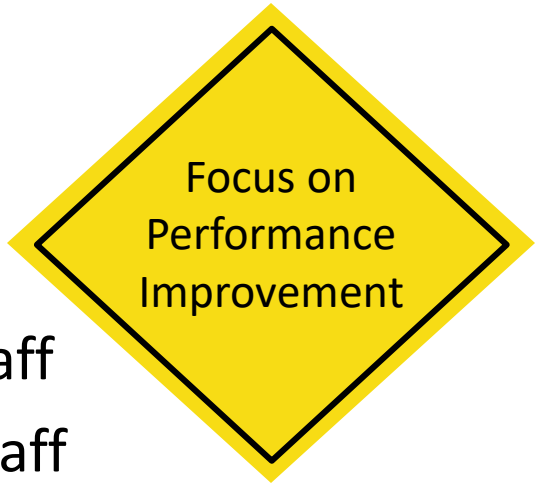
- between ICUs
- between staff groups: physicians, nurses
  - mean score 43-75
  - percent positive score 9-69
- leaders have higher perception of culture of safety by 16%
  - aware of QI and safety efforts





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

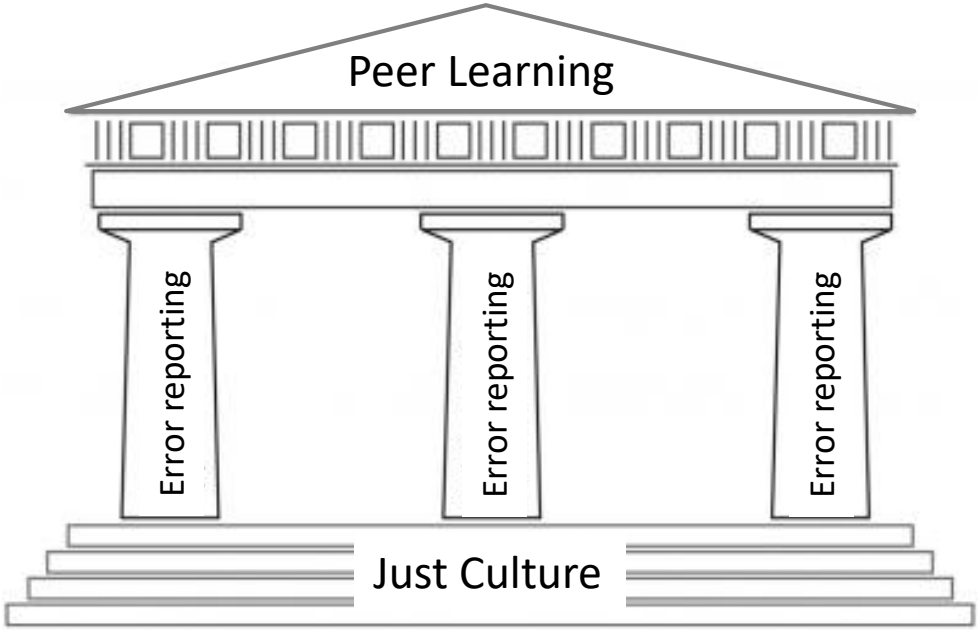
Getting that Just Culture

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 errors[1]

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

[1]IOM. To Err Is Human, 1999

Summary of Shared Beliefs and Practices of a Just Culture

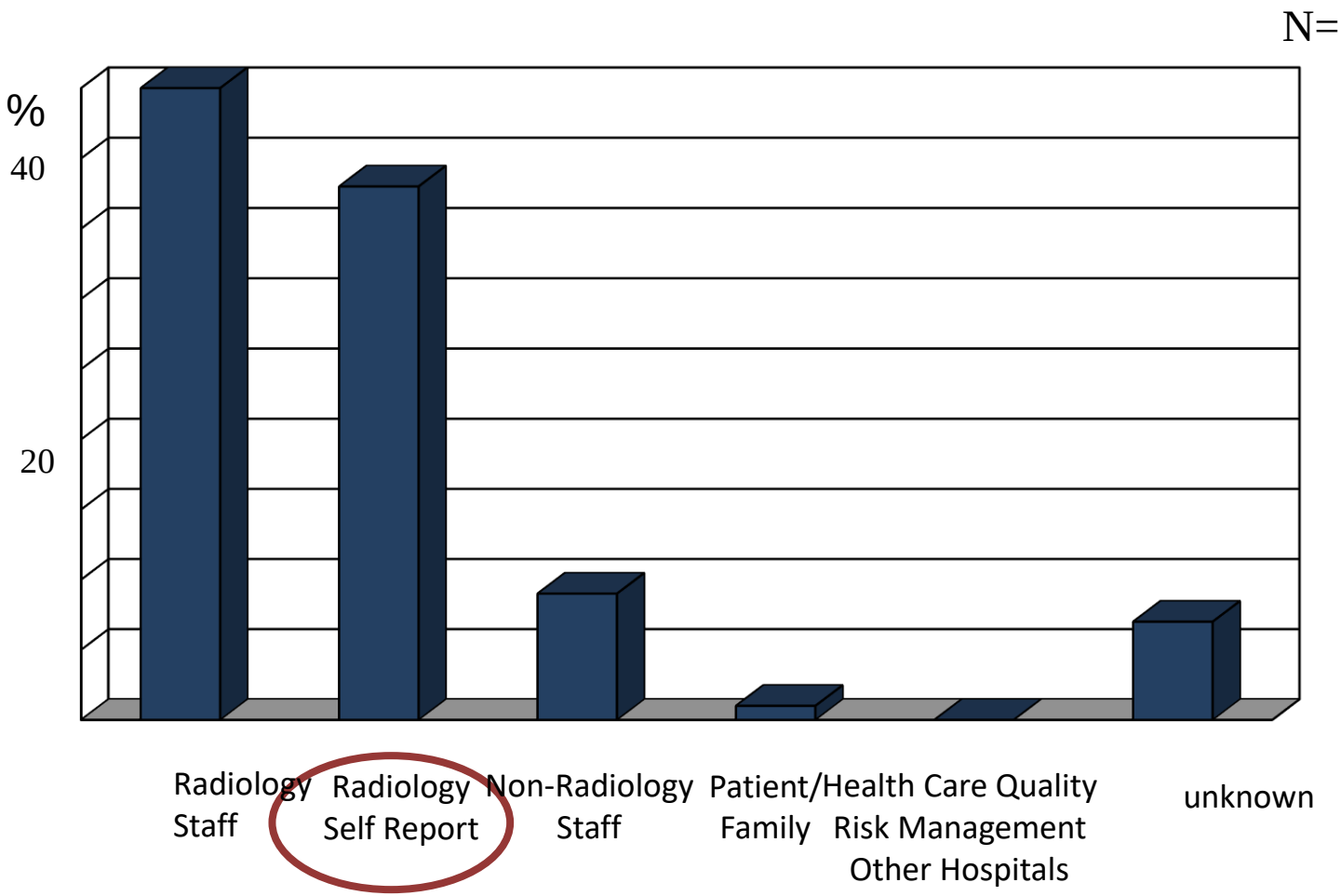
- The culture fosters performance improvement ✓
- Individuals are not responsible for systematic failures ✓
- Disregard for patient safety risks is not tolerated ✓
- Competent professionals sometimes make mistakes ?

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

Peer Learning Data base Submissions by Submitter



Data from BIDMC