



Just Culture Implementation

Alison H. Page, MHA, MSN
Chief Executive Officer
Baldwin Area Medical Center

A Just Culture:

A culture of safety requires us to have
safe systems....

And....methods to manage human
behavior.

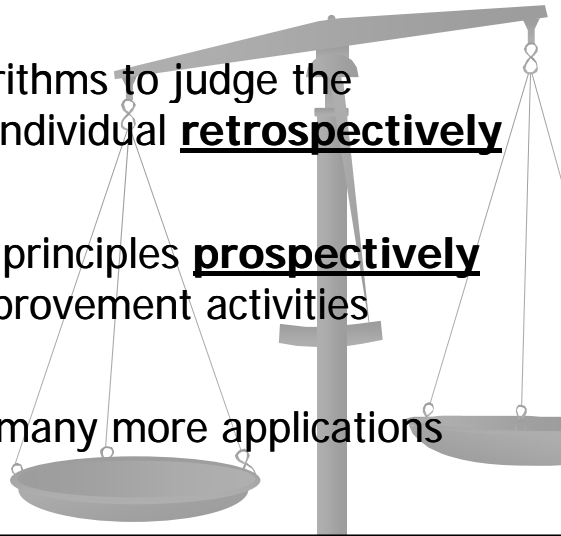
Including....a thoughtful system of
applying justice and accountability

... retrospectively and prospectively

We will discuss two applications of the just culture model

- Use of the algorithms to judge the behavior of an individual **retrospectively**
- Embedding the principles **prospectively** into process improvement activities

Note: There are many more applications



Case Studies



Moving your organization to a Just Culture

- *Create Awareness & Set a Vision*
- *Establish "just" policies*
- *Embed "just" practices*



Establish "just" policies

- *Embedded principles into system policies*
 - *Policies:*
 - *Corrective action*
 - *Performance appraisal*
 - *Problem resolution process*
 - *Management rights and responsibilities*
 - *Wording changed to incorporate "just culture" language*
 - *Categorize behavior – error, at-risk or reckless*
 - *Management response – console, coach or punish*

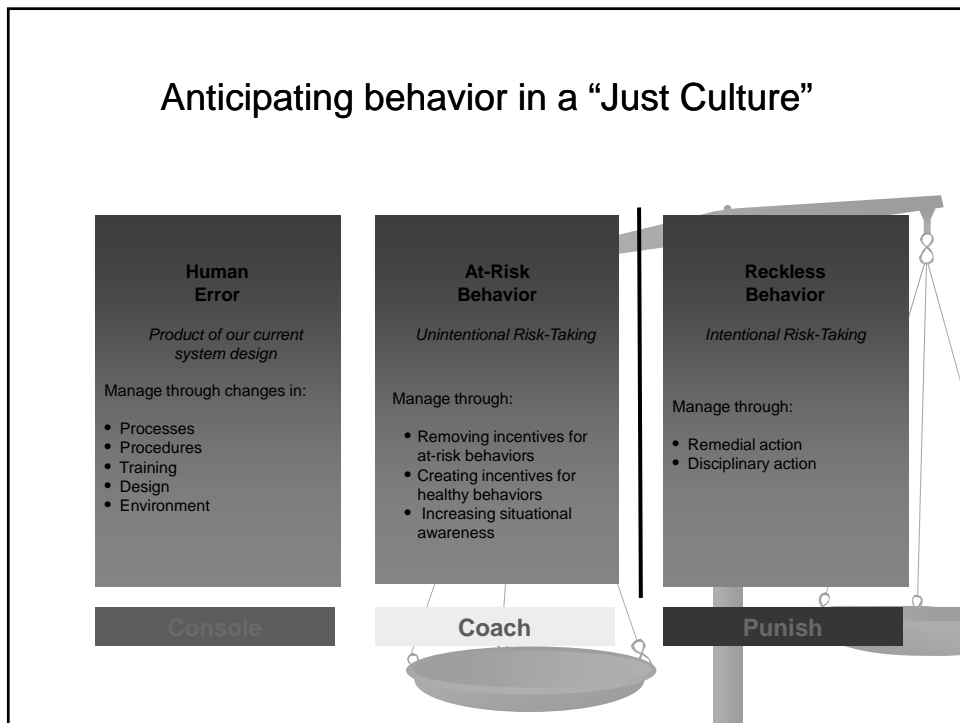
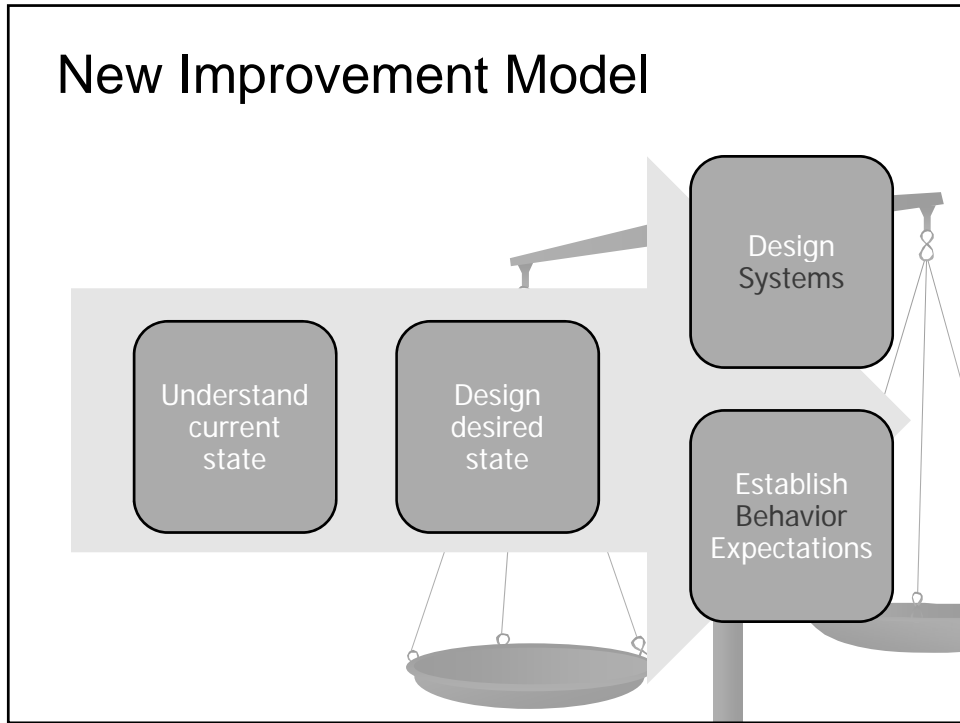


Embed “just” practices

- *New employee orientation*
- *New manager training*
- *Medical leadership training*

- *Incorporate into system-wide initiatives*
 - *Hand washing*
 - *Patient identification*
 - *Team training (TeamSTEPPS)*

Incorporating Just Culture Principles into Improvement Projects



Embed “just” practices – Hand Washing Initiative

Human Error

Product of our current system design

- Staff member thought he/she was using the correct product, but applied the wrong one

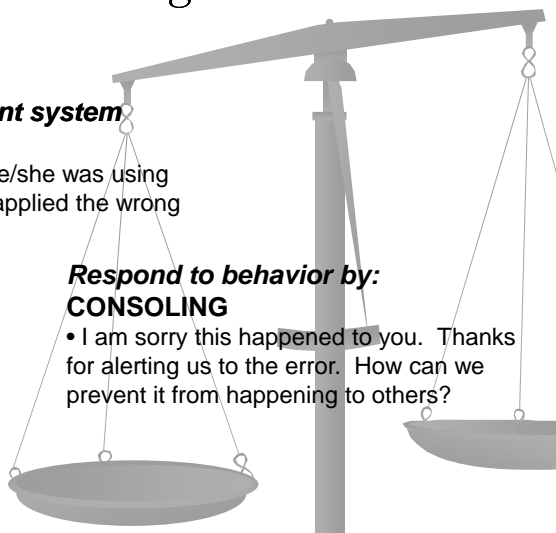
Manage through:

- Processes
- Procedures
- Training
- Design

Respond to behavior by:

CONSOLING

- I am sorry this happened to you. Thanks for alerting us to the error. How can we prevent it from happening to others?



Embed “just” practices – Hand Washing Initiative

At-Risk Behavior

Unintentional risk-taking:

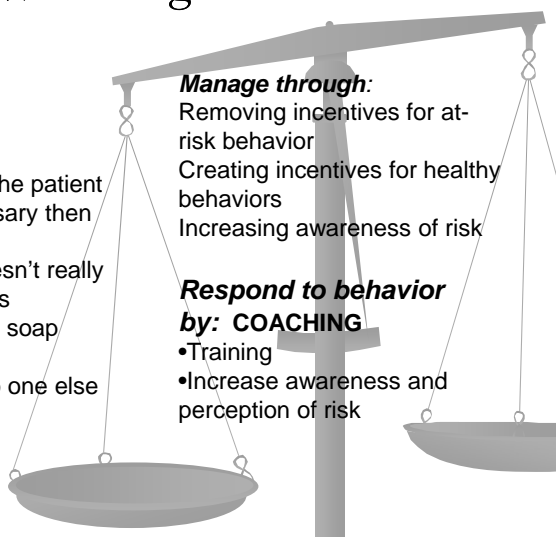
- Perception that getting into the patient room faster was more necessary than washing hands
- Perception that infection doesn't really come from not washing hands
- Doesn't wash hand because soap containers empty
- Rationalizes (or believes) no one else washes hands

Manage through:

- Removing incentives for at-risk behavior
- Creating incentives for healthy behaviors
- Increasing awareness of risk

Respond to behavior by: COACHING

- Training
- Increase awareness and perception of risk



Embed “just” practices – Hand Washing Initiative

Reckless Behavior

Intentional risk taking

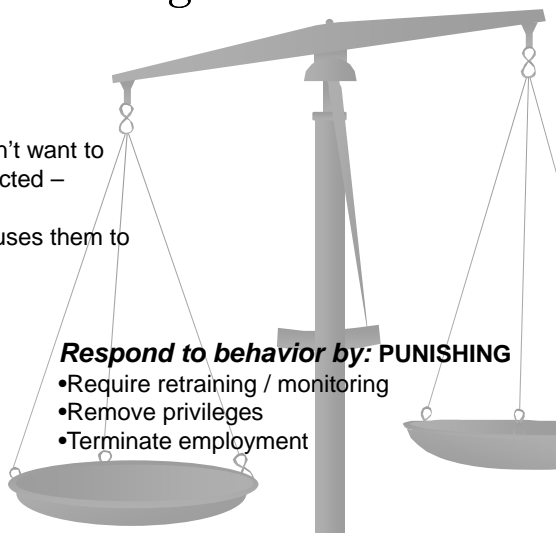
- Just didn't wash hands - didn't want to
- Knows patient could get infected – doesn't care
- Washing hands so much causes them to crack – they look ugly

Manage through:

- Remedial action
- Punitive action

Respond to behavior by: PUNISHING

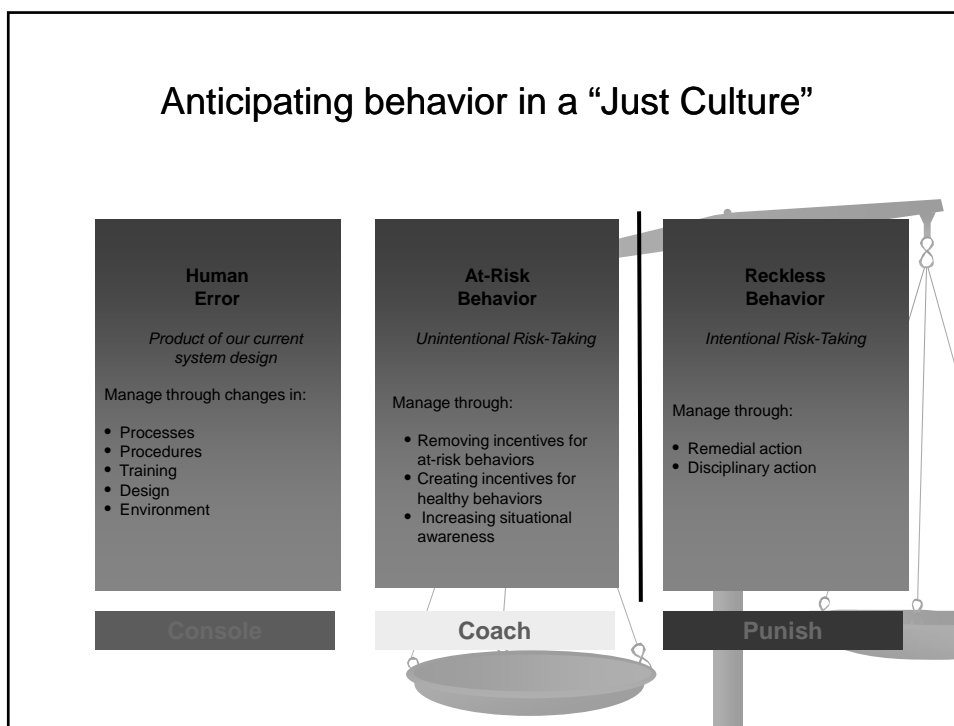
- Require retraining / monitoring
- Remove privileges
- Terminate employment



Name Your Project

How will staff error? What systems can / will we put in place to prevent errors?	How will staff drift? What systems can/ will we put in place to prevent drift? What behavior expectations will we put in place? How will we manage behaviors?	What will we consider to be reckless behavior? How will we respond to it? Can we change the behavior without using punishment? What will the punishment look like?
---	--	---

Anticipating behavior in a “Just Culture”



Additional Resources:

Minnesota Alliance for Patient Safety
<http://www.mnpatientsafety.org/>

Outcome Engineering
 Tel: (214) 778-2010
info@outcome-eng.com