



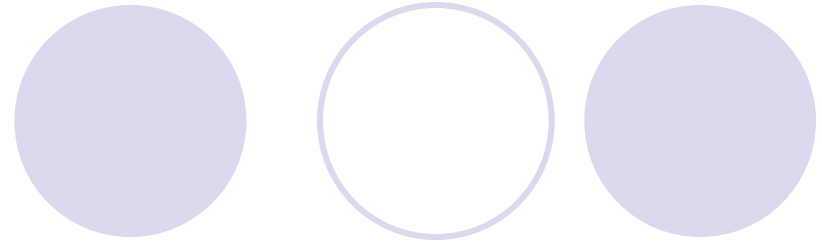
Strategies for Moving to a Fair & Just Culture

Barbara Balik

New Mexico Hospital Association

September 20, 2007

Fair & Just Culture



Why Care

Lessons for Leaders

Action Steps

Fair & Just Culture



Why Care?

Complex systems are basically unsafe

Culture is key to getting & keeping patients safer

You can't get to your mission or strategy

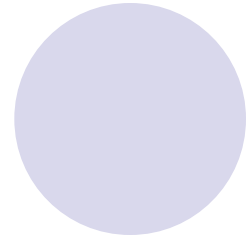
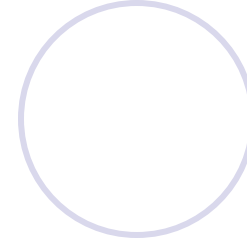
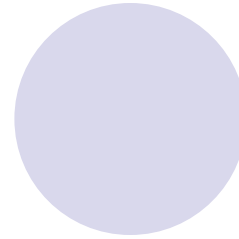
Risk Prevention

Beliefs

- Faced with a bad, surprising event, we change the event or the players in it ...
 - Rather than our basic beliefs about the system that made the event possible

• Dekker, 2002

Fair & Just Culture Lessons for Leaders



Eye on the Prize

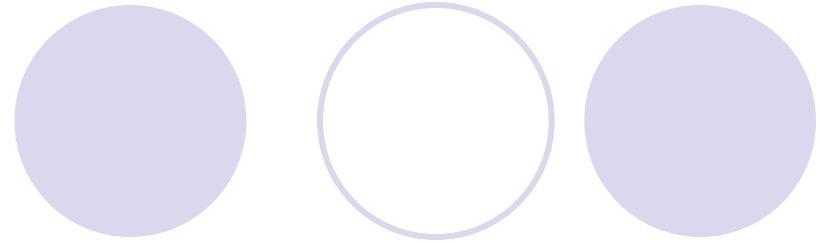
Be Courageous

Simple Not Easy

Don't Let Best Get in the Way of Better

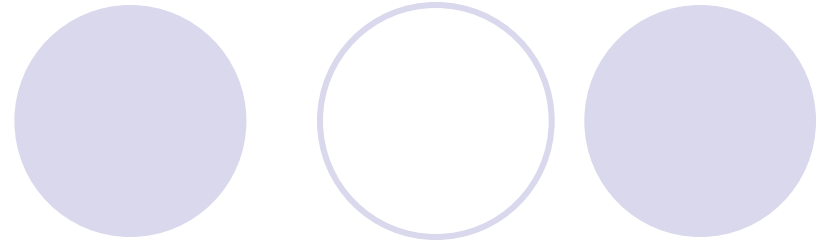
Celebrate the Mile Markers

Fair & Just Culture
Lessons for Leaders



Eye on the Prize

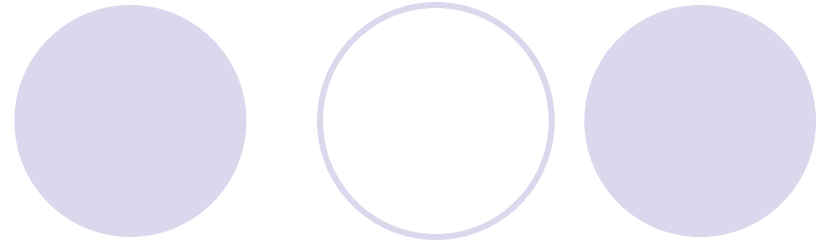
Fair & Just Culture Lessons for Leaders



Be sure to put your feet in the right
place, then stand firm

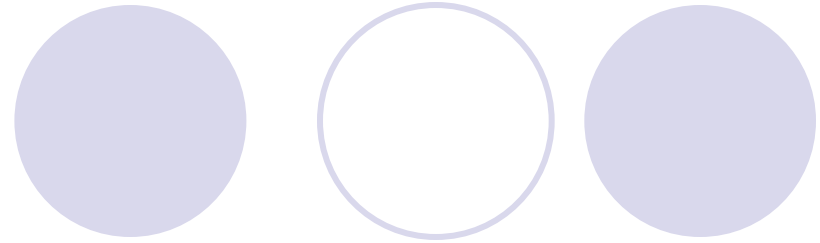
Abraham Lincoln

Fair & Just Culture Lessons for Leaders



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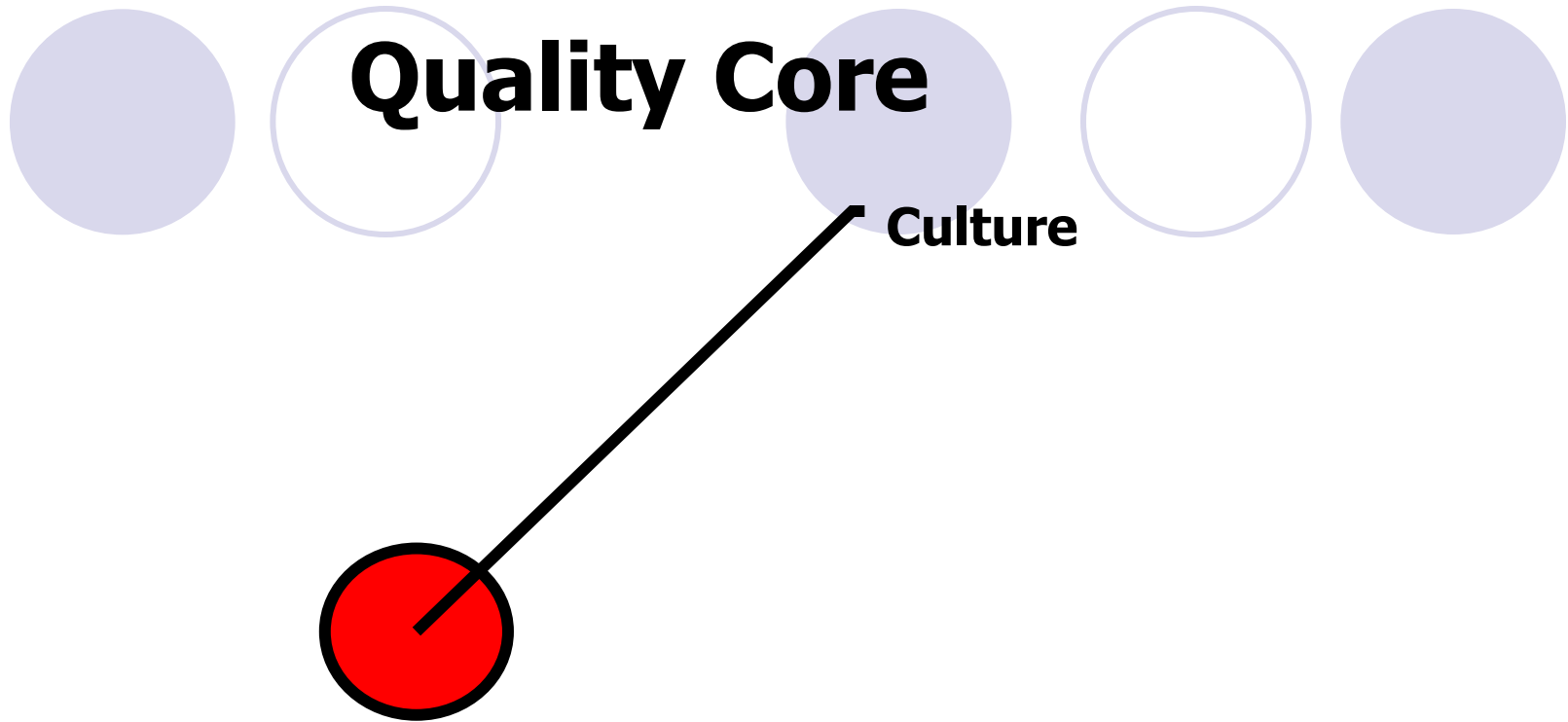
Fair & Just Culture Lessons for Leaders



Fair & Just Culture definition -

An environment of trust & fairness where it is safe to report and learn from mistakes and system flaws;
Where we are clear about the difference between human error in unreliable systems and intentional unsafe acts

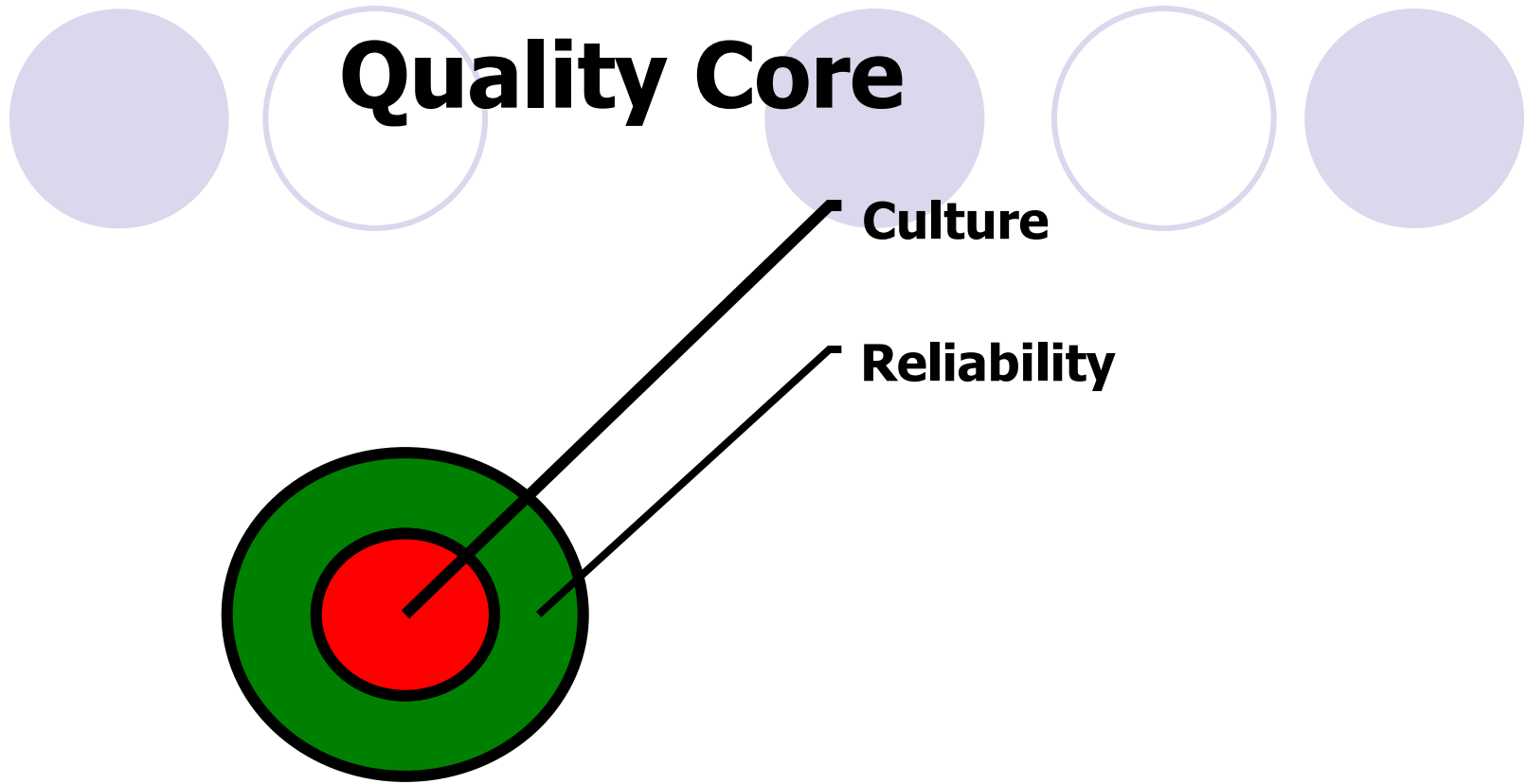
- Fair & Just Culture is also:
 - Where reporting & learning are valued; where people are encouraged & rewarded for providing essential safety-related information
 - An evidence based requirement to achieve healthcare safety
 - Where leaders & human resource systems assure we achieve it



Common Fire
Where Care, People, & Systems come together to transform care
Barbara Balik

Culture's core is

- * **Fairness & Justice**
- * **Teamwork**
- * **Transparency**

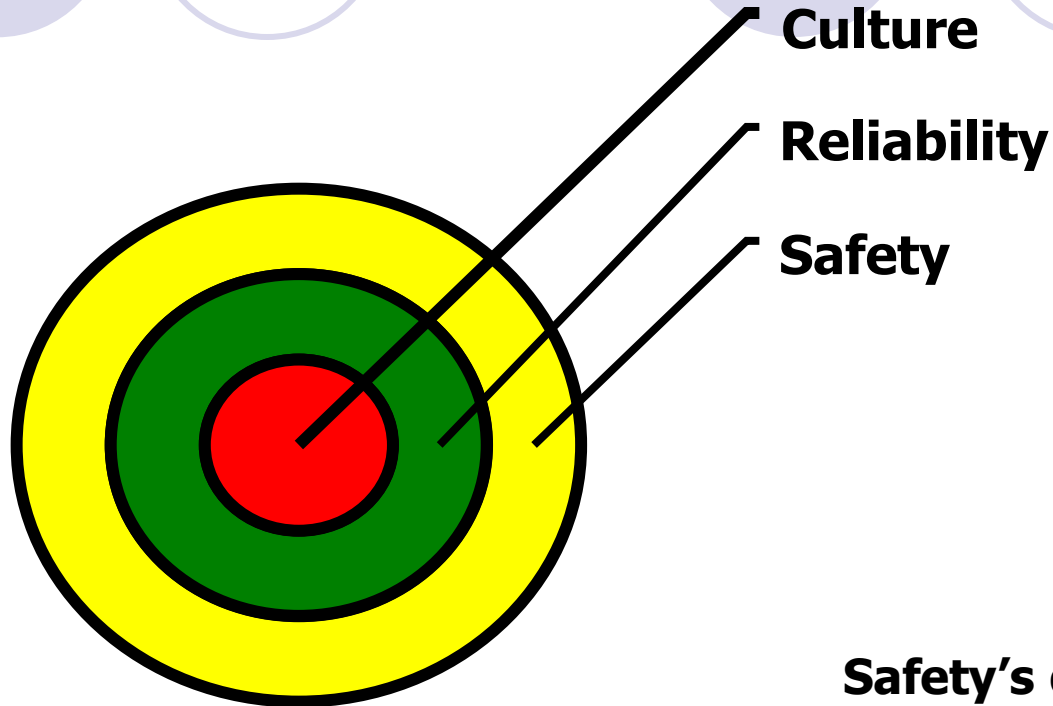
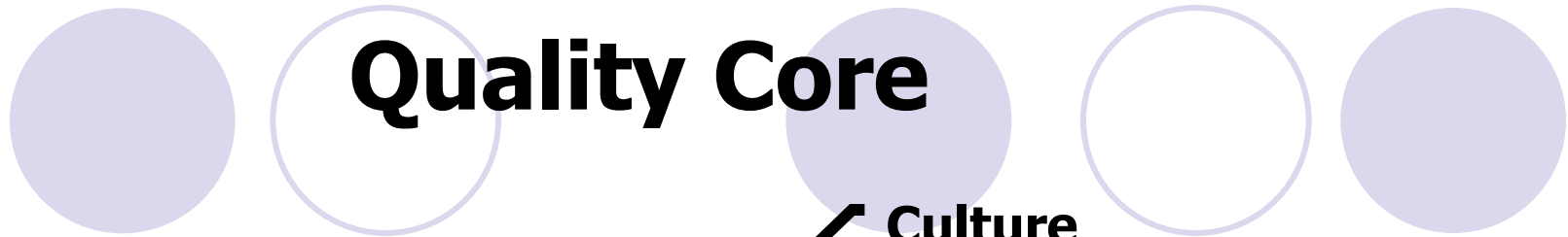


Reliability's core is **Culture**

Culture's core is

- * **Fairness & Justice**
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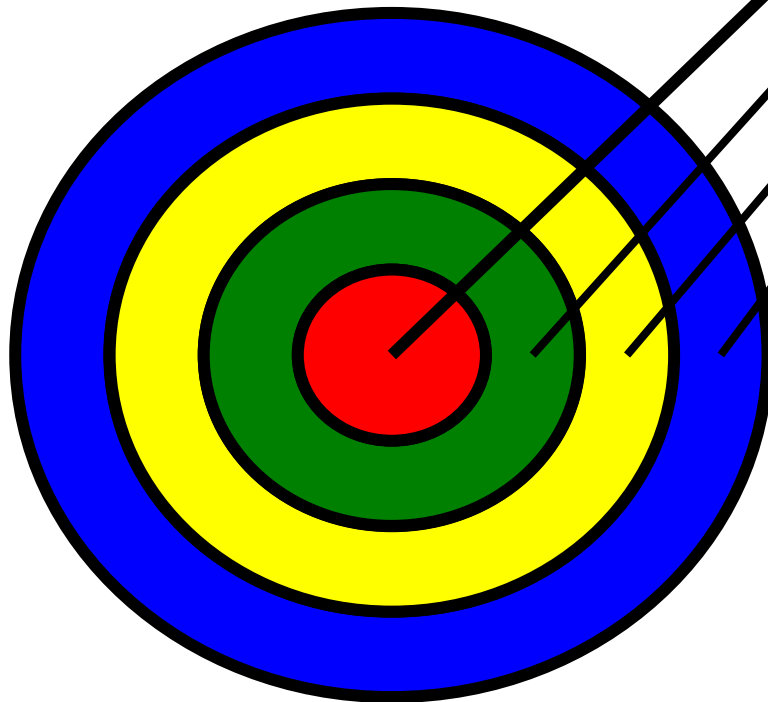
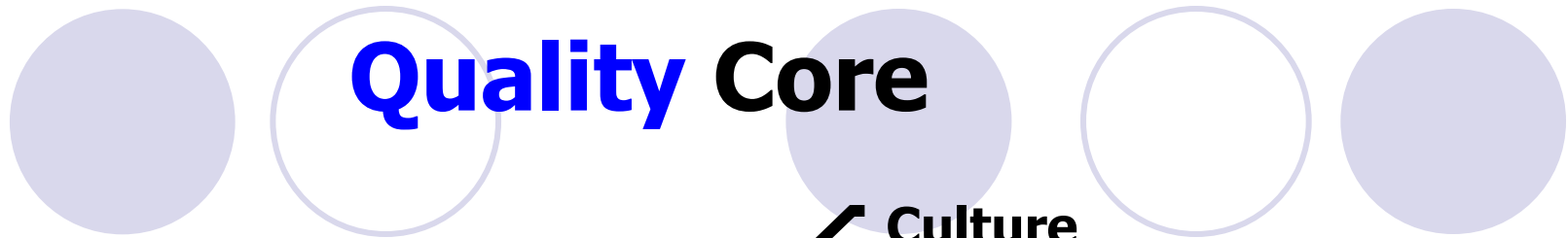


Safety's core is **Reliability**

Reliability's core is **Culture**

Culture's core is

- * **Fairness & Justice**
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- * **Transparency**



Culture

Reliability

Safety

Quality

Quality's core is **Safety**

Safety's core is **Reliability**

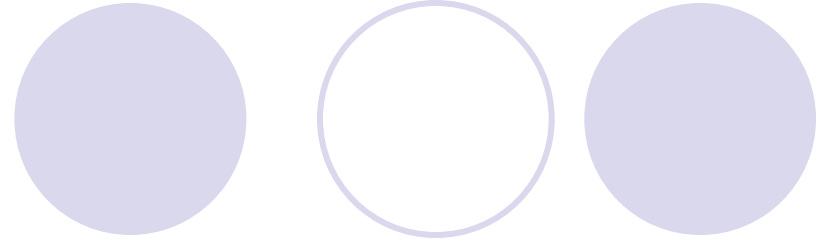
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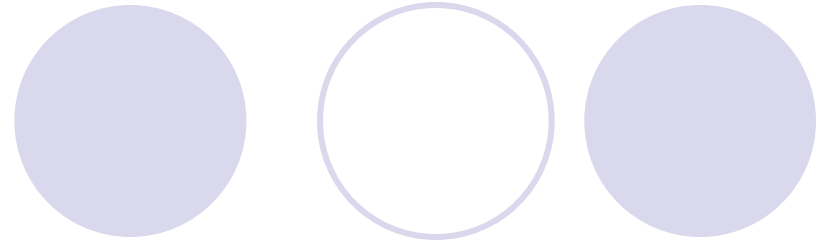
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Fair & Just Culture
Lessons for Leaders



Be Courageous

Fair & Just Culture Lessons for Leaders

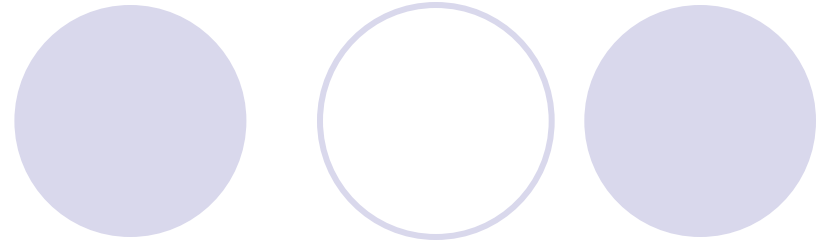


The great enemy of the truth is very often not the deliberate, contrived, dishonest – but the myth – persistent, pervasive, & unrealistic

We enjoy the comfort of our opinion without the discomfort of thought

J.F. Kennedy

Fair & Just Culture Lessons for Leaders



But who is accountable?

Just Culture Accountabilities



- **Employees are accountable:**

- for our own performance consistent with our role & with organizational values
- to act in ways that avoids harm to patients
- for respectful behavior
- to report critical events & good catches-our own & others
- to stop any potential unsafe act
- to identify unsafe systems or accidents waiting to happen

Just Culture Accountabilities



- **Employees are accountable:**
 - to know what resources we have to help us with our work to assure safe, reliable care & to use them - colleagues, leaders, policies/procedures
 - Identify bad policies/procedures - those that do not help
 - to participate fully when adverse events happen to learn what went wrong & how to prevent in the future
 - to contribute to the design & implementation of reliable systems for care & service

Just Culture Accountabilities



- Leaders are accountable:
 - to role model all employee accountabilities
 - to promote a fair & just culture
 - assure respectful behavior for all
 - to set high performance standards, enable employees to achieve the standards, & coach employees to improve performance; to provide equipment & resources so that each person can work safely & reliably
 - to develop teamwork skills
 - to note when behaviors drift from safe to at-risk

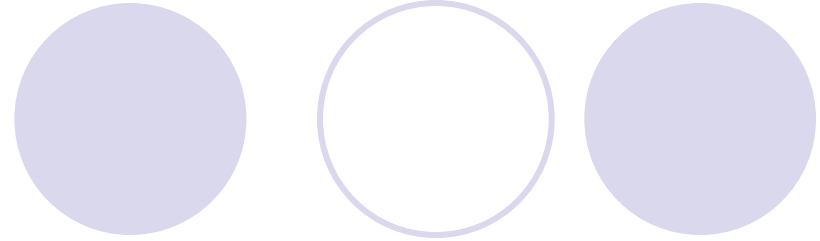
Just Culture Accountabilities



- Leaders are accountable:

- to actively seek & listen to employees concerns with unsafe systems that may harm patients or staff; to take action to address the concerns
- to develop reliable systems in partnership with staff, patients, & families
- to role model leadership behaviors when things go wrong – both immediate response & disclosure to patient/family
- to fully review & learn from all critical events & good catches with those involved - get to a deeper understanding of how the system failed or the 'second story'

Fair & Just Culture
Lessons for Leaders



Simple Not Easy

How Culture is Embedded

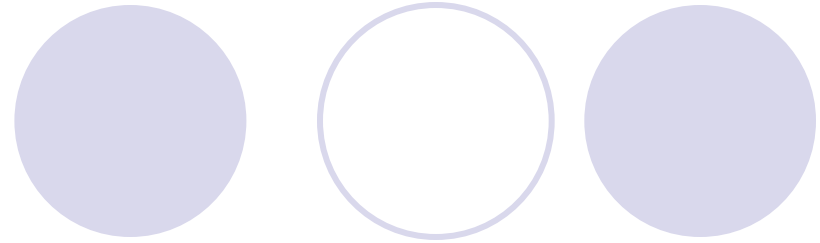
Primary:

- *What leaders do, pay attention to, measure and reward on a regular basis*
- *How leaders react to critical incidents and organizational crises*
- Deliberate role modeling, teaching and coaching
- Observed criteria by which leaders allocate rewards and status
- Observed criteria by which leaders recruit, select, promote, retire and terminate organizational members

Secondary:

- Organizational design and structure
- Organizational systems and procedures
- Organizational rites and rituals
- Design of physical space and buildings
- Stories, legends and myths about people and events
- Formal statements of organizational philosophy, values and creed

Fair & Just Culture Lessons for Leaders



- **Basic requirements:**

- Science of safety

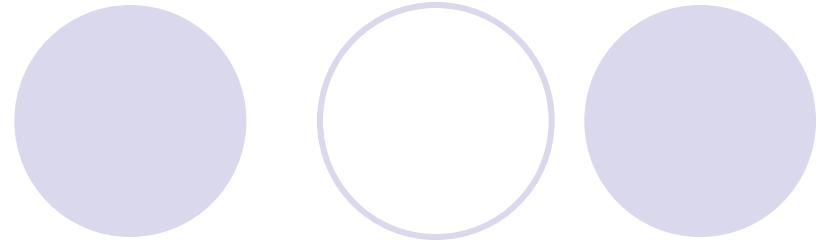
- Swiss Cheese Model
- Hindsight Bias
- Blunt end/Sharp Edge
- Reliability

- Safety Content experts - Staff & executive

- Teamwork & respectful communication skills

- Performance improvement skills

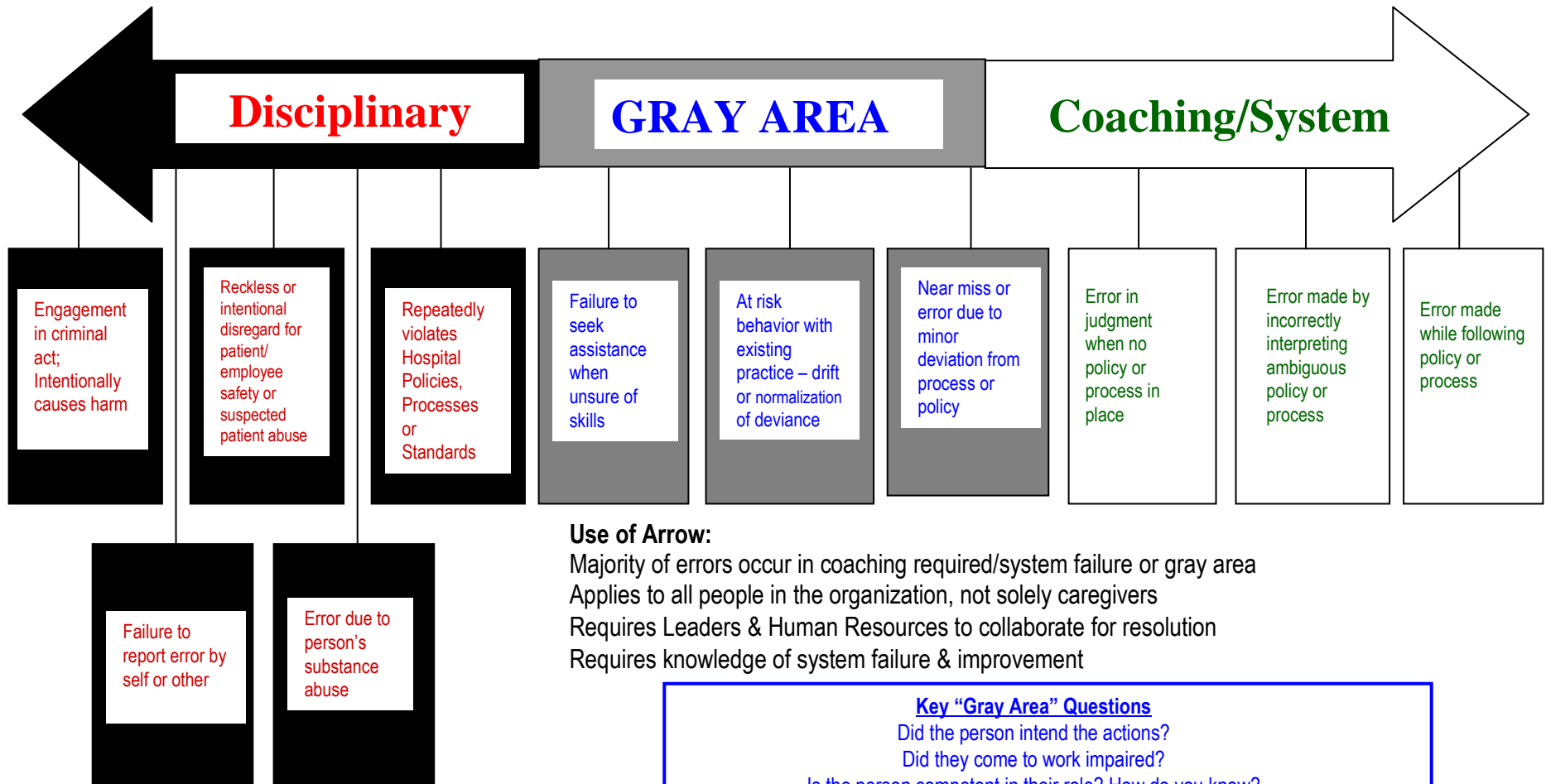
Fair & Just Culture Lessons for Leaders



- **Basic Requirements (cont)**

- When Things Go Wrong:
 - Immediate response systems
 - Transparency – disclosure & apology
 - Event reporting & analysis systems
 - Support for patients, families, & caregivers after an event
- Share the stories

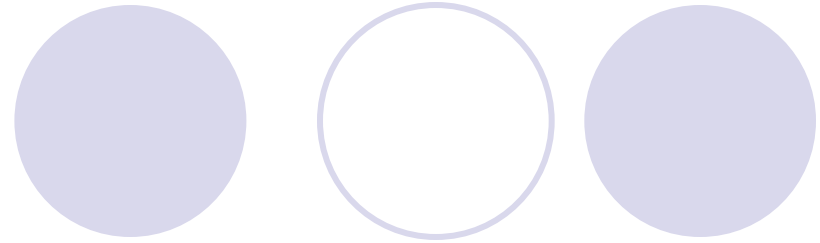
Assessing Errors In a Safety Culture



Common Fire
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Barbara Balik, RN, EdD

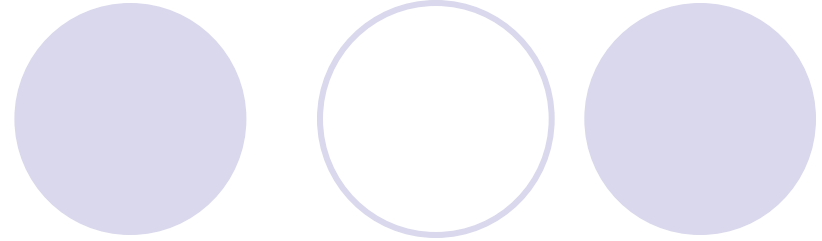
(Modified from: Missouri Baptist Medical Center, James Reason, Michael Leonard, & Allina)

Fair & Just Culture
Lessons for Leaders



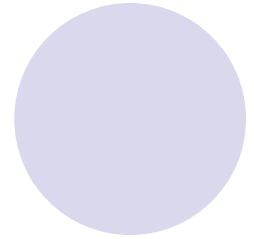
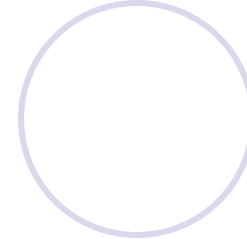
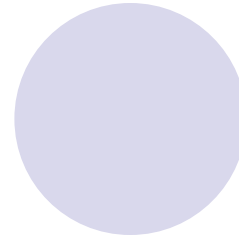
**Don't Let Best Get in the
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Fair & Just Culture
Lessons for Leaders



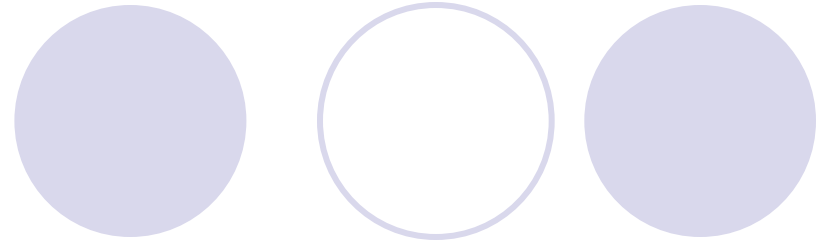
**Celebrate the Mile
Markers**

Fair & Just Culture
Lessons for Leaders



Actions

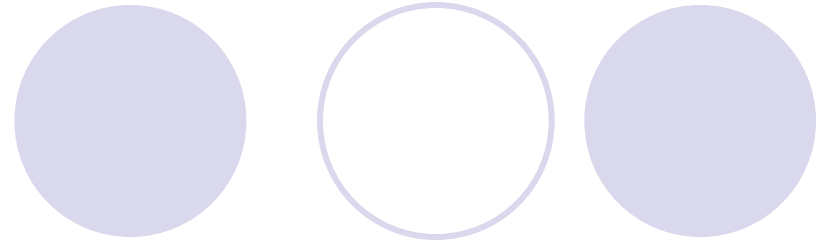
Fair & Just Culture Actions for Leaders



● Eye on the Prize

- Describe Fair & Just Culture to colleagues
 - Talk with the senior team about the fundamentals of a Fair & Just Culture; about your expectations
- Identify what actions you will take with an adverse event
- Watch *First Do No Harm 1* & discuss with colleagues

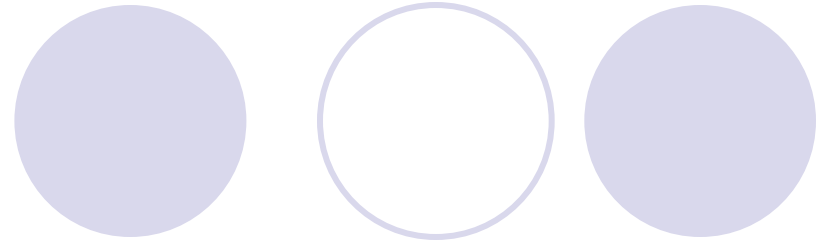
Fair & Just Culture Actions for Leaders



- Be Courageous

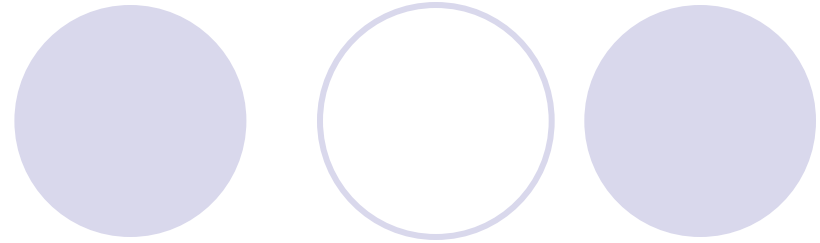
- Join a Causal analysis review as a learner
- Talk to a caregiver involved in an event
- Meet with a family to apologize after an event
- Teach Fair & Just Culture to the Board
- Talk with your healthcare media contact

Fair & Just Culture Actions for Leaders



- Simple Not Easy
 - Practice using the arrow with one event
 - Ask what happened with the last event
 - With those involved; with the causal analysis
 - Assure the fundamentals are in place
 - Accountabilities are in place & demonstrated
- Don't Let Best Get in the Way of Better
 - Expect changes today & ask about progress
 - Assure Human Resources has the skills
 - Train in communicating when things go wrong

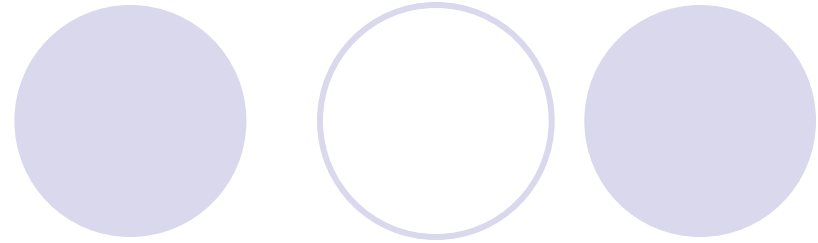
Fair & Just Culture Actions for Leaders



- Celebrate the mile markers

- Tell two stories of patient harm & what happened afterwards in the next two weeks
- Tell a story of learning from an error – your own & others
- Thank someone for speaking up; for telling the truth
- Share stories of harm & impact on the patient, family, & caregivers at the Board

Fair & Just Culture Lessons for Leaders



Resources

- Dekker, S. (2002). *The Field Guide to Human Error Investigations*. Burlington, VT: Ashgate Publishing.
- Clancy, C. & Reinertsen, J., eds. Keeping Our Promises: Research, Practice, & Policy Issues in Health Care Reliability, *Health Services Research*, Vol 41, No. 4, August 2006.
- First Do No Harm 1-3 Videos*. Partners for Patient Safety. www.p4p.org
- Institute for Healthcare Communication. www.healthcarecomm.org
- Langley, G., Nolan, K., Nolan, T., Norman, C., and Provost, L. (1996). *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. San Francisco: Jossey-Bass.
- Lazare, A. (2004). *On Apology*. New York: Oxford University Press.
- Leonard, M., Frankel, A., Simmonds, T. (2004). *Achieving Safe & Reliable Healthcare: Strategies & Solutions*. Chicago: Health Administration Press.
- National Patient Safety Foundation, Stand Up for Patient Safety Membership. www.npsf.org
- Page, A. ed. Institute of Medicine (2003) *Keeping Patients Safe: Transforming the Work Environment of Nurses*. Washington: National Academies Press.
- Reason, J. (1990). *Human Error*. Cambridge: Cambridge University Press.
- Reason, J. (1997). *Managing the Risks of Organizational Accidents*. Aldershot: Ashgate.
- Schein, E. (1999) *The Corporate Culture Survival Guide*. San Francisco: Jossey-Bass.
- Stone, D, Patton, B., & Heen, S. (1999). *Difficult Conversations: How to Discuss What Matters Most*. London: Penguin Books.
- VA Patient Safety Center. www.patientsafety.gov
- Weick, K. and Sutcliffe, K. (2001). *Managing the Unexpected: Assuring High Performance in an Age of Complexity*. San Francisco: Jossey-Bass.
- When Things Go Wrong: Responding to Adverse Events*. A Consensus Statement of the Harvard Teaching Hospitals. (2006). www.macoalition.org/publications.shtml

Just Culture Accountabilities



- Physicians are accountable:
 - As influential formal & informal leaders, physicians are accountable for many of the leadership accountabilities.
 - to role model all employee accountabilities
 - to promote a just culture
 - assure respectful behavior for all
 - to develop teamwork skills

Just Culture Accountabilities



- Physicians are accountable:
 - to develop reliable systems in partnership with & work with staff, patients, & families
 - to role model leadership behaviors when things go wrong – both immediate response & disclosure to patient/family
 - to fully review & learn from all adverse events & good catches with those involved – to get to a deeper understanding of how the system failed or the ‘second story’

Just Culture Accountabilities



- Human Resource Leaders are accountable:
 - for all Leadership Accountabilities
 - to design systems that support leaders & employees in achieving a Just Culture
 - for systems that include:
 - Leadership development based on Just Culture principles
 - Performance Management systems that assure skilled application of Just Culture principles, e.g. use of the Arrow
 - Respectful work environment systems & consequences for all