Just Culture in 2017 and Beyond

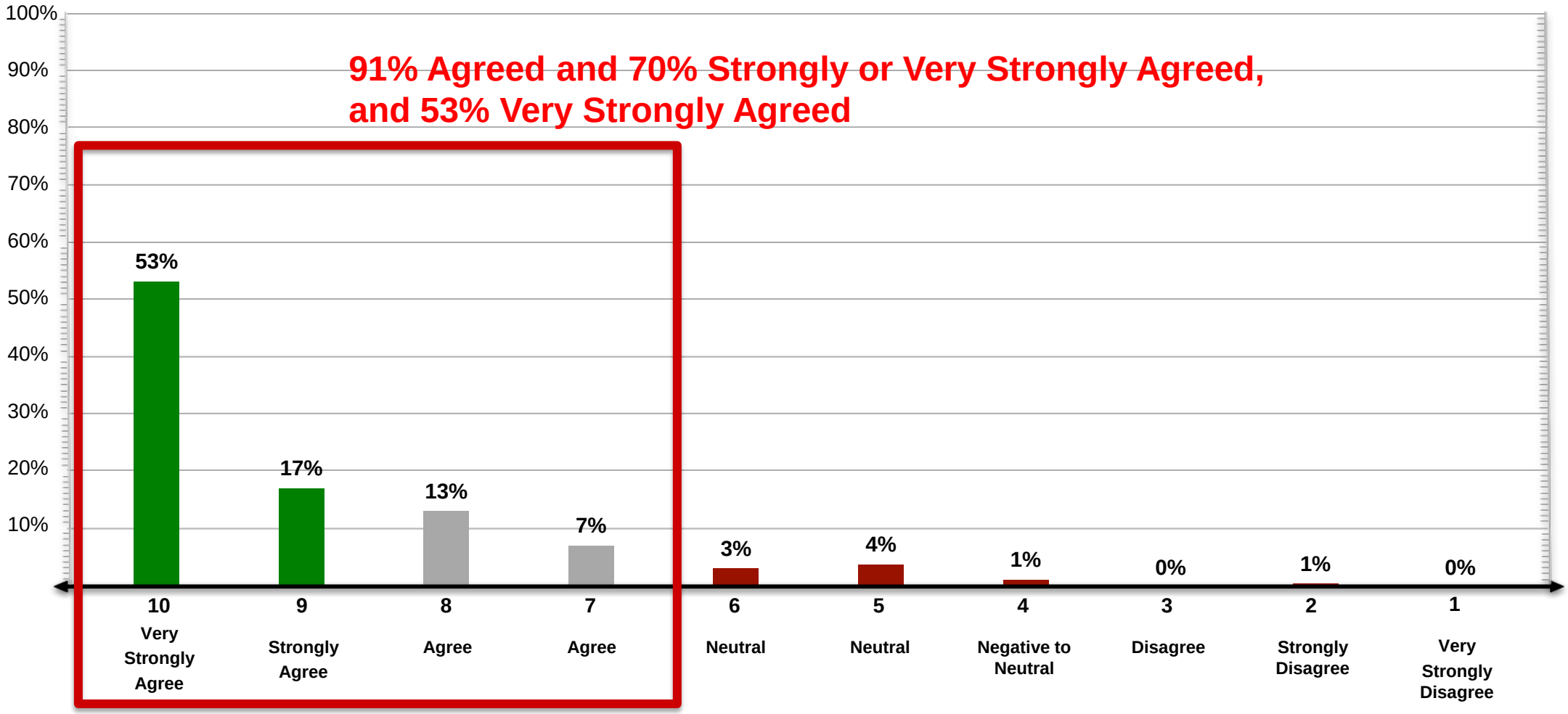
December 21, 2017
Webinar Month 109

For resource downloads go to:

www.safetyleaders.org

Anonymous Survey Questions

I am interested in MORE DETAIL regarding: Just Culture Implementation



Source: TMIT High Performer Webinar Series; Health Information Technology: Just Culture in 2017 and Beyond: – December 21, 2017

Specific Just Culture Related Information I would like to be FURTHER covered includes:

- Implementing in a health system and engagement of medical staff
- How to encourage people to come forward with at risk behaviors
- How to change the at risk behavior? How do I get people to wash their hand EVERY time
- Examples from other healthcare organizations who have hardwired a reporting culture
- Decision algorithm for error vs at-risk vs reckless
- Best ways to address the drift involving technology, bypassing alerts, etc.
- 3 core behaviors
- How to change co-workers thought processes towards just culture. How do you teach the just culture?
- Ideas to help improve a speaking up culture.
- How to build a just culture in a large organization
- Reckless behaviors and the lack of understanding in staff members
- Incorrect identification of lab specimens, ESP T&C
- How to implement in a state that has a risk management statute that has specific definitions and actions that do not support just cultures.
- Delve deeper into the specific just culture algorithms E.G., Rules based, repetitive errors.
- Specifics examples of how it is implemented is helpful as we are pretty far along the implementation path as solid partners with hr.
- I have challenges fully understanding negligence vs malpractice in nursing practice. Particularly whether patient harm is required for an action or lack of action would be classified as negligent behavior.
- Working through he, arb and reckless scenarios
- How to systematize the correct actions and curtail human error.
- Methods to engage staff in the just culture - i have done orientation, team meetings, unit meetings and created patient safety rooms. Need other innovative ideas
- Algorithm or decision tree with case scenarios differentiating human error from at-risk behavior vs. Reckless behavior
- Tools for middle managers
- Algorithms
- Case studies
- David's touch on current topics in news paired with the talk was very good.
- Is there a just culture formal algorithm?
- Collaboration with labor union to implement just culture
- How to align regulators (CMS, DPH) with these concepts.
- At our organization i often hear "I'm going to just culture that employee. "How do we change that language and attitude? How do you evaluate the success or appropriate status of your own JC climate? We use the AHRQ culture of safety survey, is there a way to correlate JC climate and implementation from that data?
- How to incorporate just culture methodology within ongoing and focused professional practice evaluations.
- How do you get top management and HR to work towards a just culture
- The www of coaching for risky behavior
- More scenarios in healthcare and with physicians on at risk behaviors and human error-accountability before harm
- How a large system can role out and sustain
- How does reporting to national data bank and report and actions of medical licensing entities
- Medication errors in ambulatory setting
- How do we deal with the "weaponizing of HR" by institutions against caregivers after an adverse event?
- Improving self reporting
- Critical thinking and decision making process appreciation
- Blame vs. Holding accountable in context of improving only when harm occurs; how to increase reporting;
- We have adopted JC and train all leaders to use the algorithm. We are currently developing processes to assist managers who are using the algorithm so that they become more skilled. Looking for ideas on simulation, scenarios, remediation.

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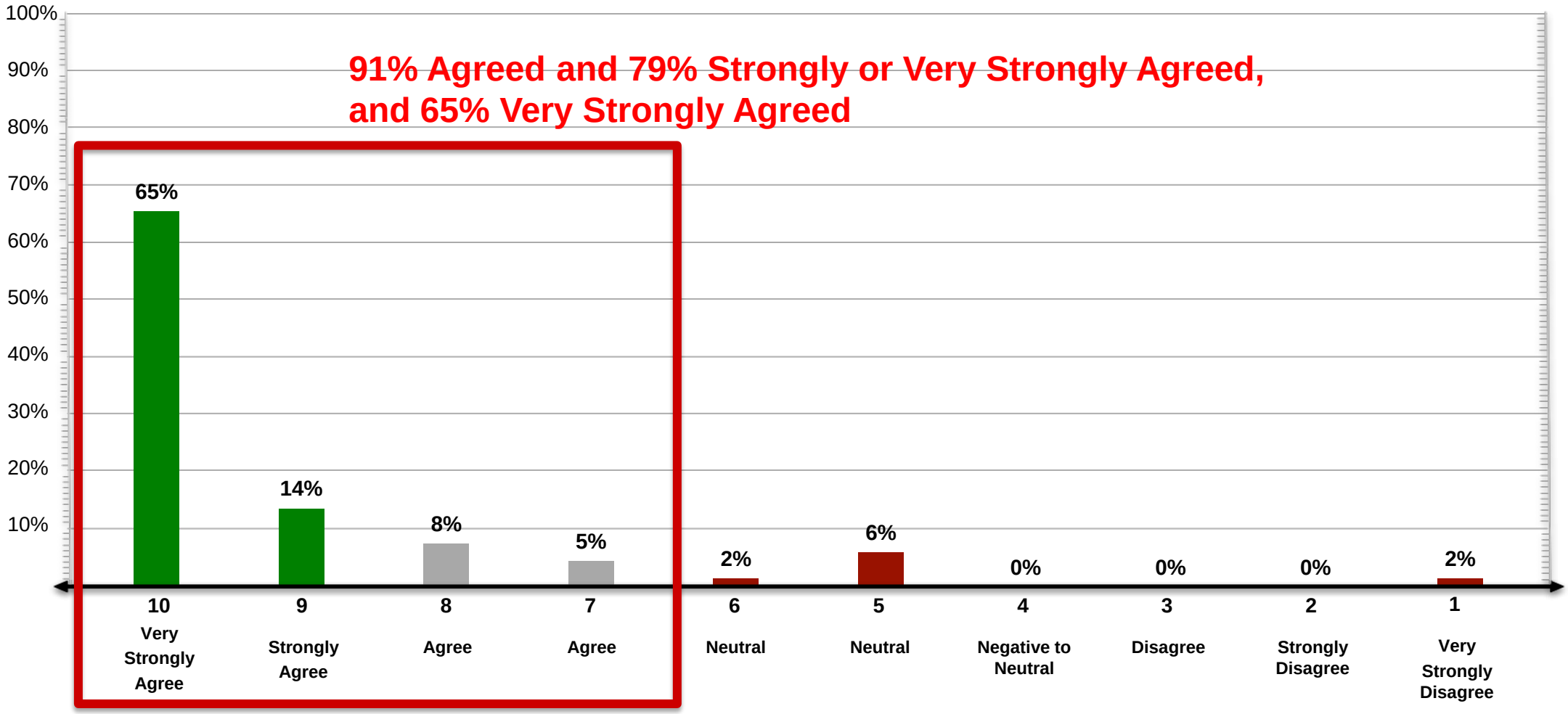
I would like to hear webinar speakers from FRONT LINE INSTITUTIONS THAT HAVE IMPLEMENTED JUST CULTURE



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Specific Just Culture IMPLEMENTATION-SPECIFIC Related Information I would like to be FURTHER covered includes:

- Yes
- What methodology and tools are used to train leaders who must implement/administer just culture are folks using? Would anyone be willing to share the condensed versions?
- Operational best practice tools and templates
- How to create consistency among departments/leaders (i.e. One dept. educates while another might implement "progressive guidance" for the same event)
- How has it measurably improved patient outcomes/safety, patient experience and employee engagement/reduce burnout?
- I am Leary to hear from other organizations because sometimes I think the organization has an unrealistic perception of how they are doing. My own organization thinks they are doing great at this but I don't think that would be true if you asked the colleagues.
- I would like to hear from those who have on how do you handle those who have reckless behaviors that has become the normal behavior to change this to a new normal with a just culture
- Within healthcare and in particular having implemented with physicians
- Yes ! this would be helpful .Storytelling is very effective!
- Ow and what
- Strongly agree
- How do you get the administrators involved? What about governance boards? Whose budget does the program come from.
- How to encourage staff to hold management accountable for fairness at work place? How to break fear barriers?

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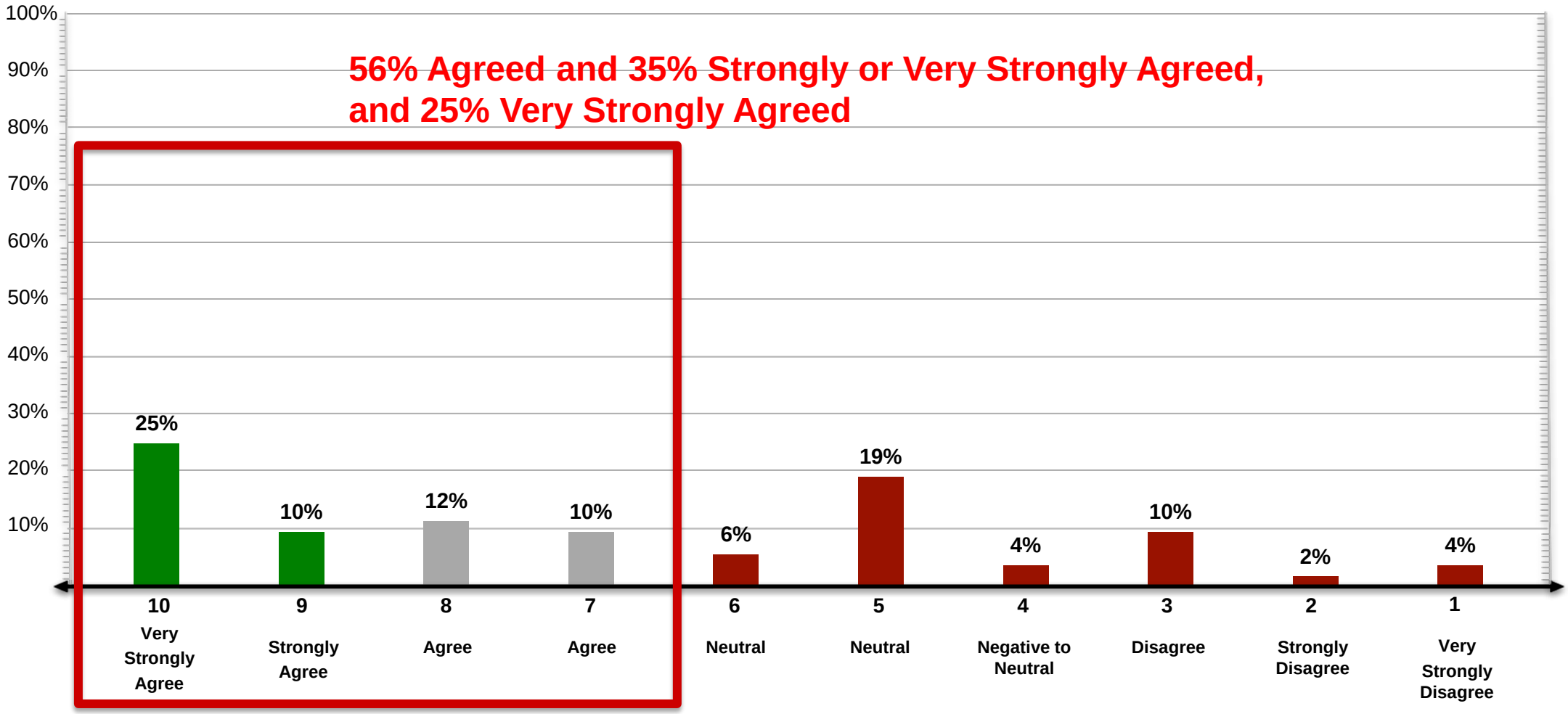
I am interested in MORE DETAIL regarding: MED TAC Bystander Care Program



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Specific MED TAC RELATED Information I would like to be FURTHER covered includes or Recommended Organizations To Contact Are:

- Yes
- No preferences
- Nursing human error, even when a serious event from a regulatory standpoint, not necessarily direct patient safety impact.
- In general how/who implements such programs in a community of 30,000
- As promised to have a program for education of lay folks
- How do we get involved in the program? Do you have one for healthcare institutions?

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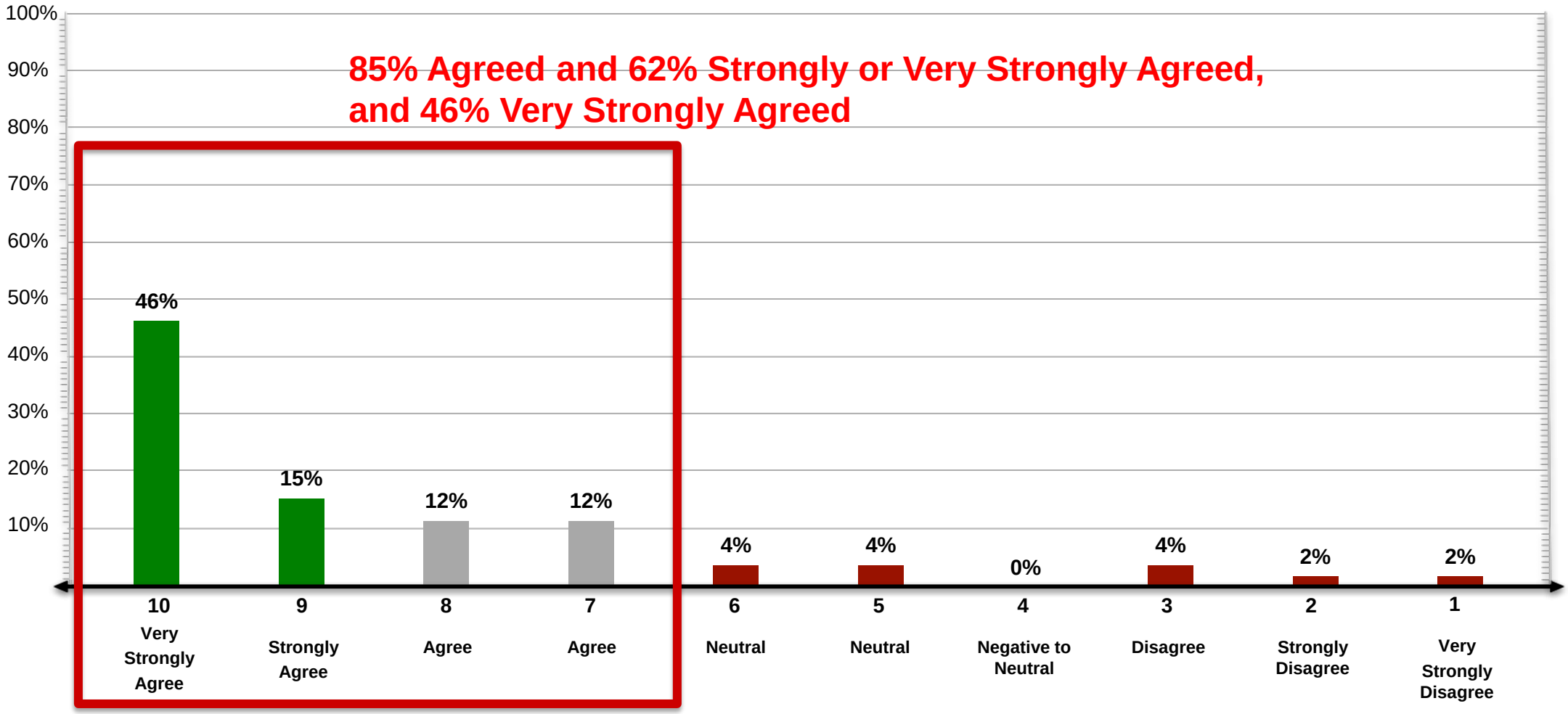
Anonymous Survey Questions

I would like to hear webinar speakers about
PROTECTING CAREGIVERS after a PATIENT SAFETY ACCIDENT



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Specific Information I would like to be covered regarding PROTECTING CAREGIVERS after a PATIENT SAFETY ACCIDENT includes:

- Yes
- Second victim or critical incident debriefing
- Caregiver support programs
- Direct front line caregivers in relation to events where events are systems/process, but not recognized as such by others.
- How is this individualized to the person/event/learning for others to prevent future errors like this.
- Harm, and death
- Process for sitting with someone who has caused harm as well as sitting with someone who hasn't caused harm.
- How do we protect nurses who are the most vulnerable caregivers?
- Caregivers recovery processes
- Interviewing witnesses and participants and properly documenting findings while preserving quality confidentiality of the review process. Who can be present? Should you attribute statements to individuals? How do you share the lessons of the case without destroying the confidential nature of the review, especially in a small/medium hospital where everyone knows everyone.
- How to promote healing and learning
- Interested in second victim and how organizations are dealing with this. Helping these second victims understand human error vs negligence especially when caregivers are trying to do the right thing and inadvertently harm patients

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Please run FUTURE Webinars covering the following issues that are KEEPING ME UP AT NIGHT:

- Prevention, management/treatment of delirium
- Implementation of high reliability through out a hospital to all departments not just to hands on patient care units.
- Yes
- C. Difficile infections and sepsis reduction initiatives, interventions, etc.
- Liability of pharmacists in practice
- Incivility in the healthcare profession. Both lateral and vertical.
- Rca2
- Active shooter
- Failure to make organization-wide education and changes for all levels to understand, but expecting better results. Talk the talk, but not walk the walk.
- Glycemic management in hospitalized patients with both iv and subcutaneous insulin-specifically how to get physicians to buy in.
- Documentation improvement - say this not that - how do you document a safety event (frontline documentation) without throwing the team under the bus.What goes in the chart and what goes in the quality/risk case review?
- Concern when a provider's health issues could or does impact one's decision-making or action
- Care team models in the ambulatory setting

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