Just Culture:
Voices from the Frontline

February 15, 2018
Webinar Month 111

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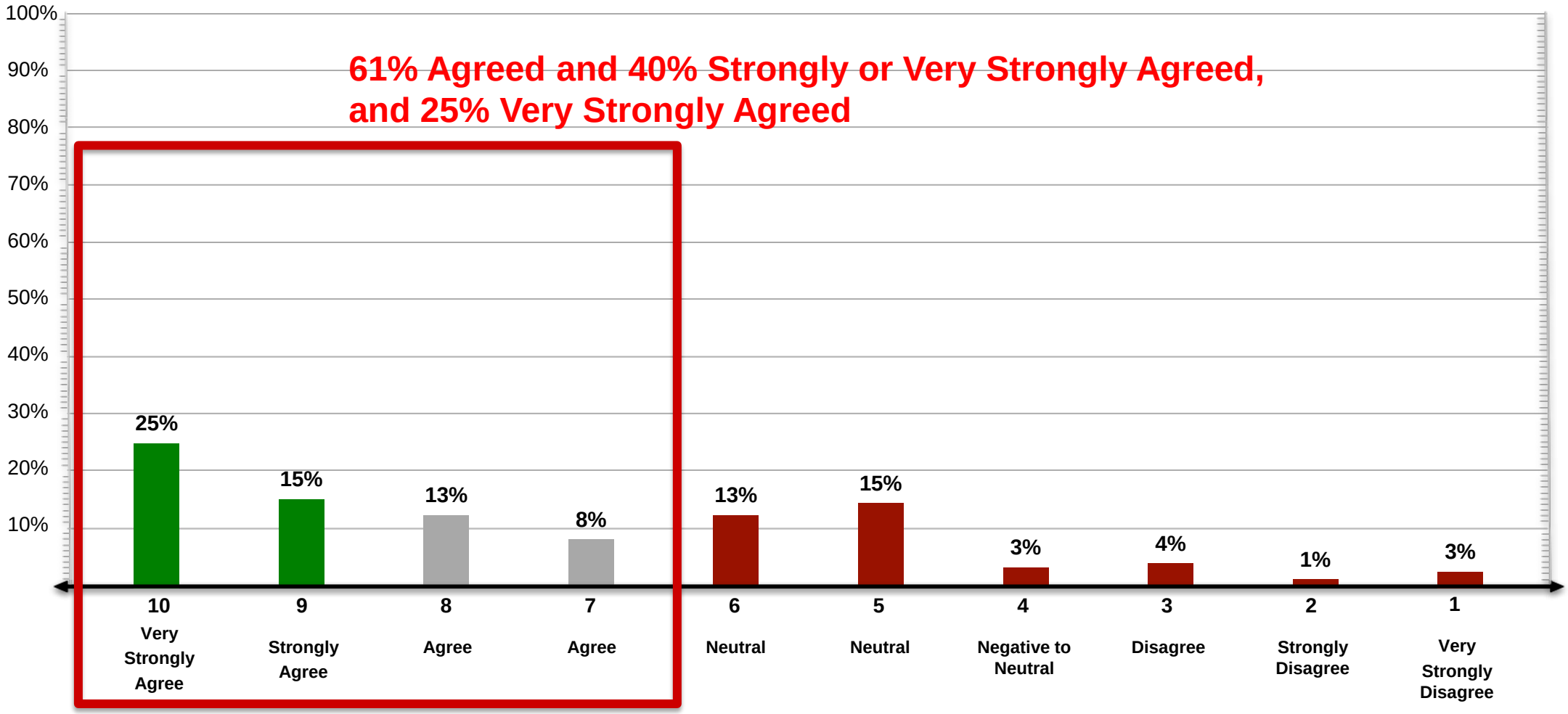
Anonymous Survey Questions

I am interested in MORE DETAIL regarding: STOP THE BLEED



Source: TMIT High Performer Webinar Series; Health Information Technology: Just Culture: Voices from the Frontline – February 15, 2018

Specific STOP THE BLEED Information
I would like to be FURTHER covered includes:

- ALL topics
- How it can be landed here?
- I would like the training at my company
- Train the trainer
- How to launch training within schools
- Start with an overview.
- A good overview
- How to implement
- We already have this initiative being implemented.
- Program implementation
- I would like all of the information about it. I don't really have any experience with this
- Where one can get the training
- How to implement in the community
- Where to obtain?
- We already have this program.
- Overview first then perhaps a series of focus sessions
- Info
- Kit program
- Processes for outside of healthcare settings
- More details
- Duration of training, commitment for ongoing certification
- What is it in more details
- Best way for buy in to sustain
- Costs, case study of successful community implementation
- Outcome data from this initiative
- More specifics re specific types of businesses/workplaces (i.e., schools)
- I DON'T NEED INFORMATION, OUR FACILITY DOES COMMUNITY TEACHING ALREADY
- How to market the program in a community that does not recognize the program
- Bleeding control kit and all
- How to start a local movement
- To see how it has been implemented at hospital sites as well as outside the hospital setting such as schools, sports complexes, stores, malls etc.
- How to implement; what are resources necessary
- How to implement and which department usually implements this.
- Use in public settings
- Education
- How to get community buy in
- The med tac
- Med training program

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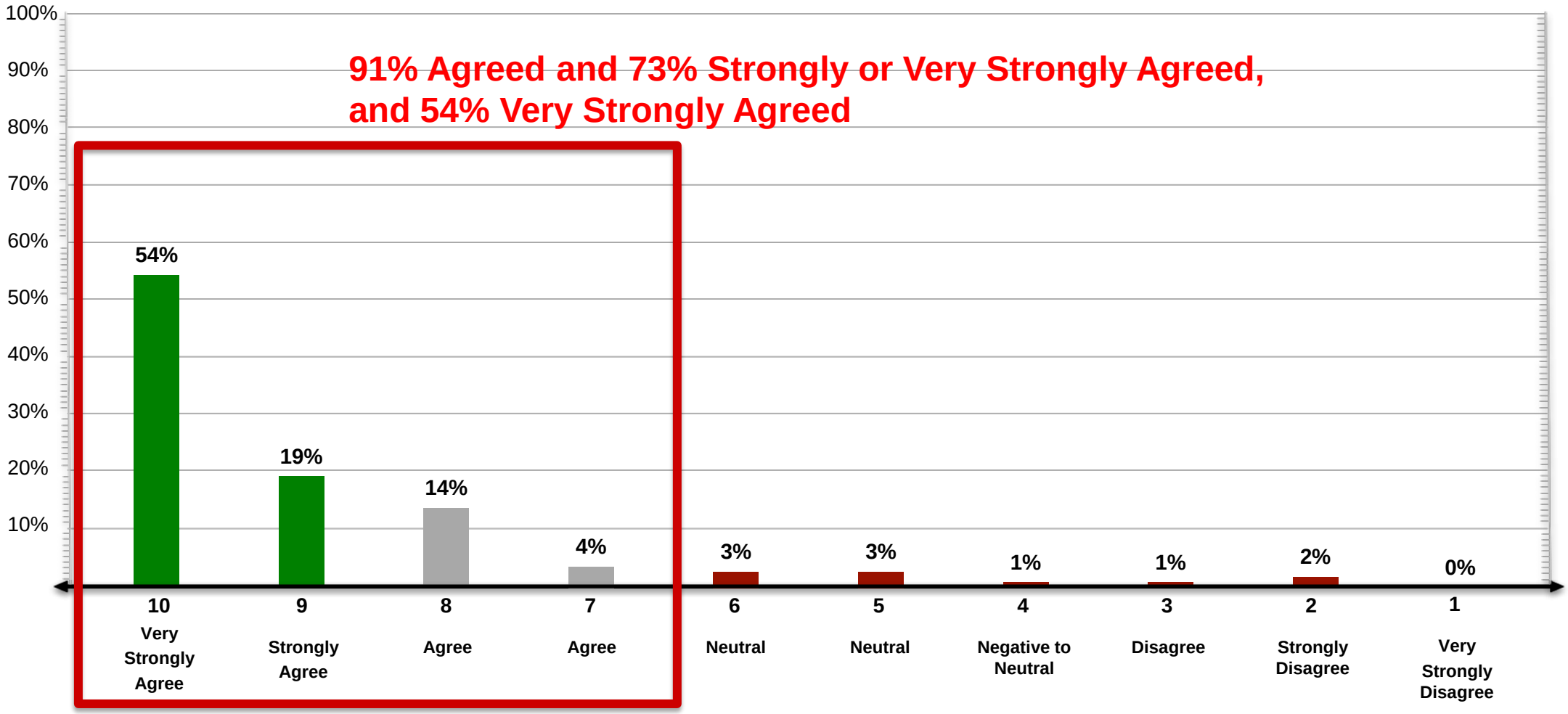
Anonymous Survey Questions

I am interested in MORE DETAIL regarding: JUST CULTURE CASE STUDIES



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Specific JUST CULTURE Information
I would like to be FURTHER covered includes:

- How you handle sentinel and never events
- Implementation
- All topics
- Case studies that walk through the algorithm
- Employee at risk behavior, employee reckless behavior, and medication errors
- I think the case studies would provide the details needed to implement a just culture in our organization. The actual presentation was extremely vague
- Challenges with implementation in a union environment
- Case studies of errors, at-risk, and reckless
- Community pharmacy setting
- Implementation strategies within large HMO and juncture between physician and hospital leadership
- Healthcare event involving multiple disciplines
- Overview and then specific examples of implementing core key principles.
- How the cases were investigated, response work, etc.
- Case discussion, types of coaching
- Case specific examples of the just culture model application and policy examples.
- Case studies please
- Case studies, implementation plan, keeping just culture momentum
- How to jump start at organizational level
- Examples of actual incidents and how just culture was applied
- More details about implementation strategies, especially for larger systems
- More examples
- N/A
- Roll outs and sustainability, tools provided that were used
- Updated algorithm
- Different case studies where just culture was utilized and applied.
- How to explain to providers from a surveyors perspective. What can the provider do to improve their just culture.
- Stories/scenarios with details to contrast how it may have been handled vs. How it was
- Discussion of some of this tools used
- Case studies then using the JC algorithm would further understanding and how to use and apply principles
- Leadership sustainability
- Train the trainer, certification
- Implementing just culture across a vast organization/system
- Specific measures for maintaining
- Everything. Structure the starting point
- Manager training
- How to deal with provider correction as no fault
- Case studies are great
- Just culture in the mediation/arbitration process. Case law supports old methods of discipline.
- How specifically did leader get buy in

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Specific JUST CULTURE Information
I would like to be FURTHER covered includes:

- 2nd victim theory; PTSD in those involved
- Barriers to implementation; can it be done without CEO leading it, can it succeed by spread from one site to another versus all at once in a multihospital system, estimated costs (training, time, resources, etc.)
- Strategies to implement just culture, dealing with resistant push-back, data on outcomes in terms of harm reduction, impact on near misses.
- My facility utilizes and has implemented this approach already
- How to sustain just culture environment once implemented and change of upper management staff.
- How to kick start just culture in my own department, information that i can share with my fellow leaders.
- Effective coaching tools/techniques
- Managers trainers
- Resources and case studies
- The case studies would be very valuable to review.
- Selling it to leadership effectively
- Best practices on how to implement, as i am having a hard time finding information on this. Specifics on training mgmt (what tools to use), and what types of focus groups should we form in our investigation of current state.
- Coaching mechanism
- Would like to hear from more organizations and how they implemented a just culture program
- Case studies
- Coaching, root cause analysis and investigation, do you have staff involved participate in the RCA process investigation discussion action plan for the future. Investigating and discipline for reckless behavior. Do you believe RCAs should be discoverable in a lawsuit.
- None at this time
- Specific examples, training materials
- Case studies and application. How to apply to near miss cases or where harm did not occur. Disclosure practices, and how to hardwire within the organization and medical staff. What department generally owns just culture implementation?

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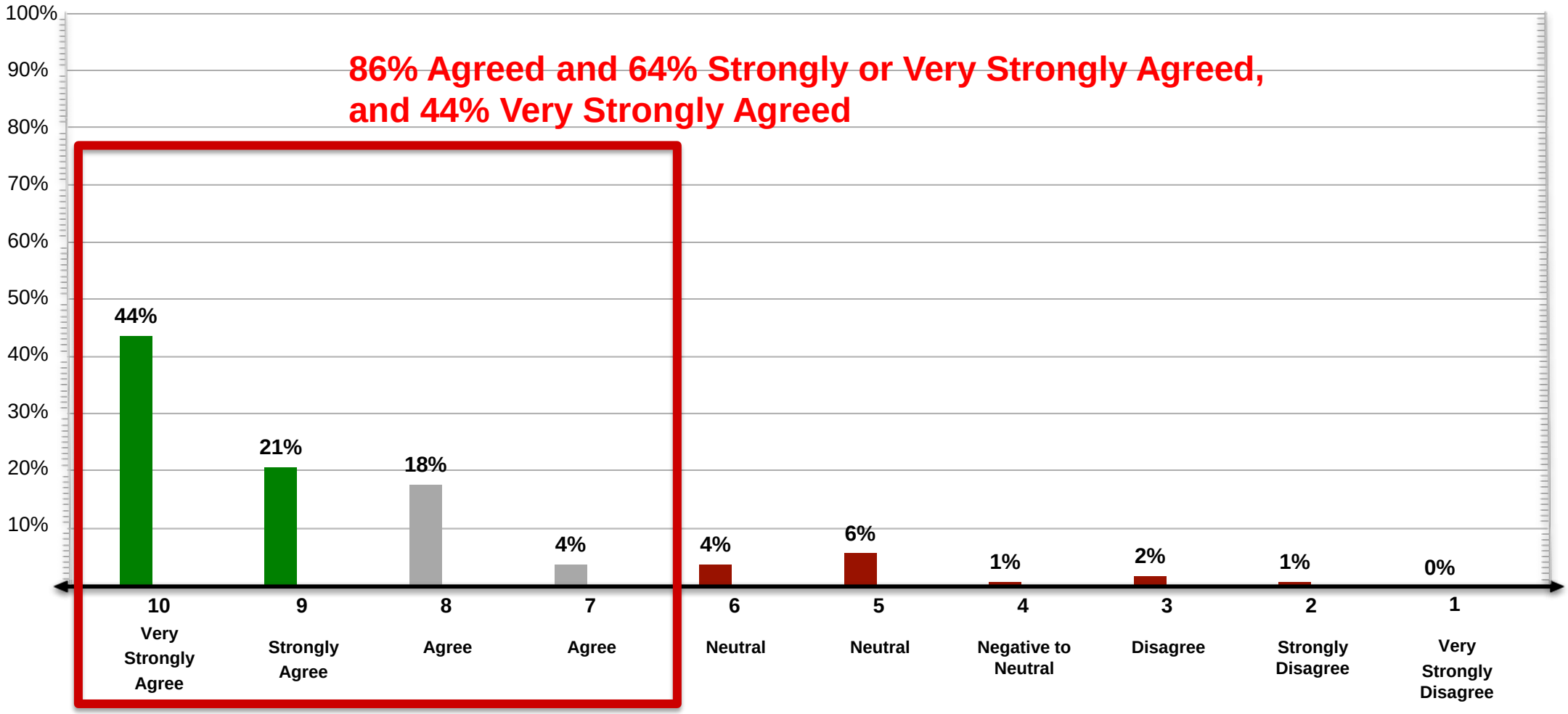
Anonymous Survey Questions

I am interested in: WHAT TO DO AFTER PATIENT SAFETY INCIDENT such as care of the caregiver and Name-Blame-Shame Cycle.



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Specific WHAT TO DO AFTER PATIENT SAFETY INCIDENT Information I would like to be FURTHER covered includes:

- All interventions and preventive measures
- Any
- How to handle with just culture mindset, tools or scripts that were helpful
- Elements of a good RCA process
- Process
- 2nd victims
- More about human factors, 2nd and 3rd victim responses
- Use for learning, improvement
- Reporting systems
- Any information you can provide
- Timing for disclosure vs. Investigation
- How to make people feel comfortable to be honest and come forward
- Roadmap to use so that we don't miss anything.
- How to address those who are not "on board" with just culture, as you defend your staff.
- How do the human resources policies change to cover just culture - how do we change staff views?
- Trying very hard to break old patterns of responding to issues. Structure of just culture committees and tools for responding to incidents/issues
- How to balance disciplinary action with accountability with coaching
- How to collect data
- How to help someone rebuild confidence following an event.
- Who are the best people to interact with the patient after an event
- How to maintain communication with patient / family involved; how far to go
- Second victim tools
- Where does the patient come into the process after the incident occurs? What is the practice?
- We already have a care for the care giver program and trained staff to serve in this role
- How to promote a protective environment for total open discussion on what has occurred during a safety incident
- How do we get other facility leaders to buy in?
- How to teach practical application of 2nd victim/care of the caregiver concepts.
- RCAs guidelines
- Process and structure
- To see what other organizations do for the 2nd victim support.
- Applying just culture
- Roles of both the reporter and person receiving report
- Mechanism utilized to share the key learnings across the organization on a consistent basis
- Again, would like to hear from more organizations
- Case studies, especially around disclosure
- Apologies and disclosure to patients,

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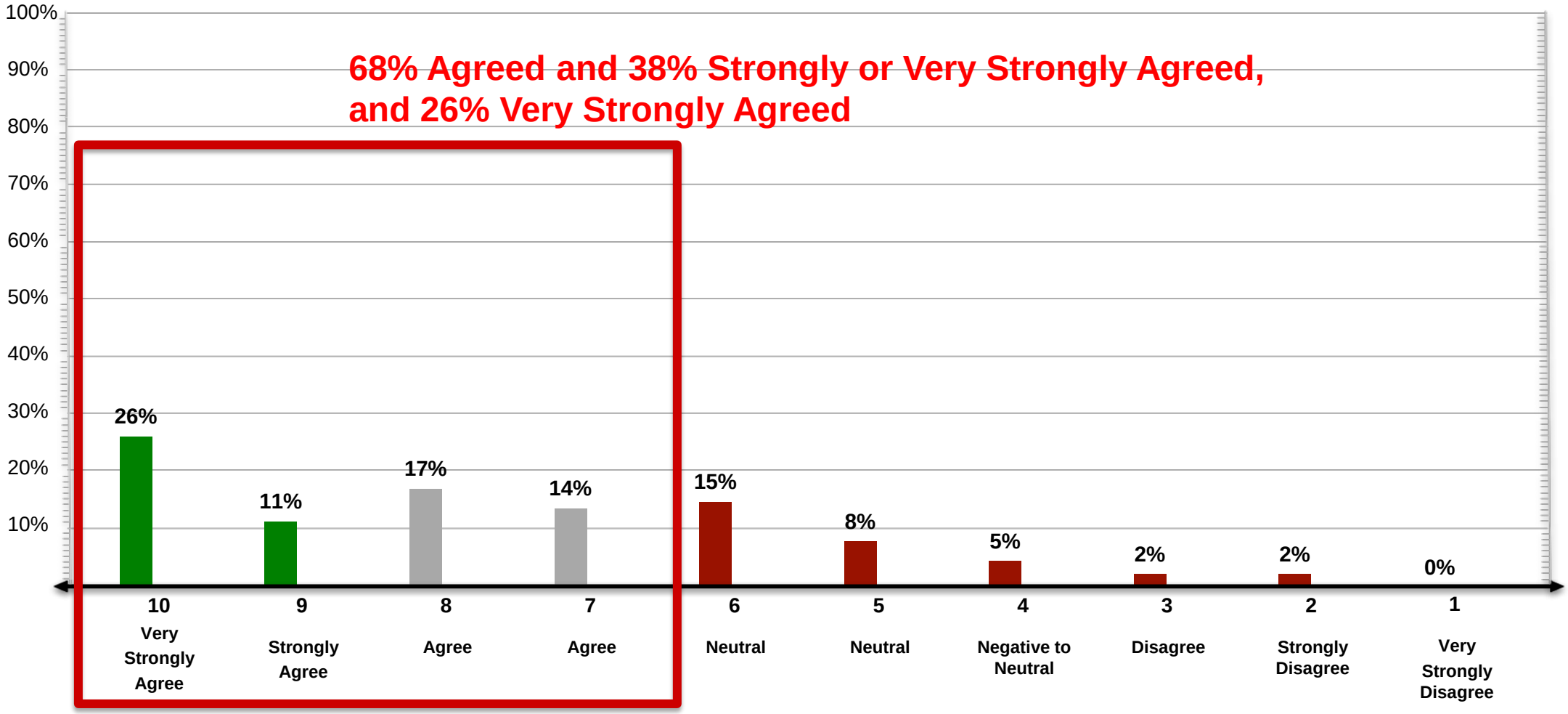
Anonymous Survey Questions

I am interested in: ALL CAUSE INSIDER – OUTSIDER THREATS that can impact Patient and Caregiver Safety



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Specific ALL CAUSE INSIDER – OUTSIDER THREATS Information I would like to be FURTHER covered includes:

- All impacts
- Staff experiences.
- Unsure
- Behavioral health incidents for patient and team member safety
- Not so interested in this topic
- Best practice - drills
- What types of things to watch for to be a more trained eye to spot threats of all kinds.
- From a surveyor perspective and the information we can give to our providers
- Cyber security
- Do other organizations employee the allice program. Are there others?
- Cybersecurity
- We too are more focused on patients and families and forgetting staff. How, again, to conquer old patterns of response. How do we tie in out event reporting, RCA and other standard tools.
- Define
- What do we see in health care
- Latest threats and approaches to mitigate.
- How to be vigilant without being offensive to visitors/family members
- Unable to answer #8 want to respond with a 10
- I don't really know much about this subject matter.
- Share what is done nation-wide. Systems that have been established that may be different than ours to determine opportunities and close those "Swiss cheese" holes and make a more reliable system. Make it easy to do the right thing.
- Understand concept and implementation
- External factors that contribute to error.
- In general
- More information in general; nothing specific.
- More real time examples
- Violent hospital incidents-shooter , er challenges, response to terrorism acts
- Examples of such situations and how to respond.

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