Shifting Organizational Culture:
The Link Between Transparency and Patient Safety

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Organizational Culture

“The values and behaviors that contribute to the unique social and psychological environment of an organization.”

http://www.businessdictionary.com/definition/organizational-culture.html
Transparency

“…shifting Organizational Culture towards one that encourages clear and open communication when patient safety may be in jeopardy.”
Barriers

Barriers to nurses’ reporting both actual and potential threats to patient safety:

- Fear of repercussions
- Unsupportive organizational climate
- Labeling
- Blame

Impact of Transparency on Organizational Culture

American Nurses Association’s Code of Ethics for Nurses with Interpretive Statements
Culture of Safety

- Taking Action
- Committing to Change
- Driving Change
Ensuring a Strong Safety Culture

- Conduct Patient Safety Leadership WalkRounds™
- Create a Reporting System
- Designate a Patient Safety Officer
- Reenact Real Adverse Events from Your Hospital
- Involve Patients in Safety Initiatives
- Relay Safety Reports at Shift Changes
- Appoint a Safety Champion for Every Unit
- Simulate Possible Adverse Events
- Conduct Safety Briefings
- Create an Adverse Event Response Team

http://www.ihi.org/resources/Pages/Changes/DevelopaCultureofSafety.aspx
CONDUCT PATIENT SAFETY LEADERSHIP WALKROUNDS™
INVOLVE PATIENTS IN SAFETY INITIATIVES
APPOINT A SAFETY CHAMPION FOR EVERY UNIT
CREATE A REPORTING SYSTEM
What is a Just Culture?

- Atmosphere of trust
- Behavioral choices
- System issues
- Safety focus
What is *Just Culture*?

- A model for judging the behavior of others in complex systems
- A better way to manage risk and prevent adverse outcomes
- Holds people accountable for their actions
Just Culture Core Beliefs

- To Err is human
- To Drift is human
- Risk is everywhere
- We are all accountable
Three kinds of behaviors

- Human Error
- At-Risk Behavior
- Reckless Behavior

Behavior is a choice
Human Error

“We know we make mistakes even when we try our best”
At-Risk Behavior

“We drift away from safety behaviors—our perception of risk fades and we try to accomplish more with fewer resources and less time”
Reckless Behavior

“Humans will put their own self-interest ahead of those they serve”

Accountability for reckless behavior rest solely on the individual that chooses the reckless act
Responses to behaviors

- Human Error - Console and learn
- At-Risk Behavior - Coach and learn
- Reckless Behavior - Punitive (disciplinary action)
How is this Applied?

- Behavioral choice and/or system failure will be determined
- Algorithms are utilized
- Resulting in fair and consistent results
- Independent of Outcome
The Just Culture Model…..

Defines three kinds of behaviors:

- **Human Error** – Inadvertently doing other than what should have been done (lapse, slip)

- **At-Risk Behavior** – Choice that increases risk where risk is not recognized, or is mistakenly believed to be justified

- **Reckless Behavior** – Choice to consciously disregard a substantial and unjustifiable risk
Repetitive At-Risk Behaviors

- Employee choice to continue to deviate from standard practice or rule
- Coaching emphasis on potential for progressive discipline
Scenario

Betty works in the radiology department performing portable x-ray scans at night. She frequently takes a coffee break after performing an x-ray before she returns the machine to the department and processes the film. In order to support the timely processing of the film, she has been instructed by her manager that she must return the film to the department before she takes a break. She has been coached twice, but continues to deviate from her manager’s instructions.
Shaping Factors

- **System Performance Shaping Factors**
  Attributes of the work system that impact the likelihood of human errors or behavioral drift

- **Personal Performance Shaping Factors**
  Attributes of the employee that impact the likelihood of human errors or behavioral drift
1. Which of the following is an example of Just Culture?

a. A nurse accidentally gives an overdose to a patient and reports it. An investigation is performed to determine whether systematic problems contributed to the error.

b. A nurse accidentally almost gives a patient an overdose of medicine, but catches her mistake and keeps it to herself out of fear of punishment.

c. A nurse accidentally gives an overdose to a patient, reports it, and is immediately punished. No further review of the incident is conducted.
2. Why is the reporting of errors critical to a Just Culture?

a. Reporting helps identify who made the mistake, and then organizations will know whom to punish.

b. Once errors are reported, systematic flaws can be identified and fixed to help prevent the same errors from occurring in the future.

c. Reporting errors is not critical to patient safety.
3. Which of the following is a barrier to error reporting?

a. Ability of staff members to see their organization improve over time.

b. A leadership team that actively encourages reporting.

c. An organization in the learning phase of just culture in which failures are evaluated for systemic issues.

d. Individual staff members’ fear of punishment for admitting an error.
4. We are all accountable. What does this mean for leaders?

   a. Putting our employees in a reliable system.

   b. Facilitating good behavioral choices among our staff.

   c. Counseling employees not to make mistakes.

   d. Both the first and second answer.
5. To err is human. What does this mean?

a. That humans will make mistakes.

b. That employees are no longer accountable for their errors.

c. That human error is an unmanageable aspect of business.

d. None of the above.
6. To drift is human.
   What does this mean?

   a. That we will have no sense of purpose.

   b. That we lose focus in meetings.

   c. That we will move away from strict compliance.

   d. That we will make more mistakes as we get older.
7. Which of the following would be considered an at-risk behavior?

a. Misreading a critical accounting value.

b. Driving a company truck while intoxicated.

c. Purposefully ramming a forklift into a train.

d. Performing a critical procedure by memory.
8. Which of the following will most influence the presence of at-risk behavior?

a. Perceptions of risk
b. Laziness of our staff
c. Desire to do more
d. Both the first and third answer
9. What is generally the source of reckless conduct in the workplace?

a. Poor training.

b. When employees put their own interests ahead of the safety of patients, customers, or their fellow employees.

c. Laziness.

d. An overstressed and fatigued workplace.
10. Which of the following duties is the most important duty?

a. The duty to produce an outcome.

b. The duty to follow a procedural rule.

c. The duty to avoid causing unjustifiable risk or harm.

d. They are all equally important.
SCENARIO #1
SCENARIO #2
Review and Discussion
References

- Getting to Know Just Culture https://www.justculture.org/getting-to-know-just-culture/