Just and Accountable Culture (JAC): An Introduction

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Objectives

• Describe the four cornerstones of a Just and Accountable Culture.

• Compare the components of a Just and Accountable Culture with the perceived culture related to evaluation of incidents, accountability, and communication at Harris Health System today.

• Identify 3 expected outcomes related to implementation of Just and Accountable Culture.

• Describe the three elements of evaluation used to determine accountability for behaviors and what type of “management” action each may incur.
The single greatest impediment to error prevention in the medical industry is “that we punish people for making mistakes.”

Dr. Lucian Leape
Professor, Harvard School of Public Health
Testimony before Congress on Health Care Quality Improvement
Group Scenario
Outcome/Severity Bias

When an organization allows the severity of the outcome or level of harm to drive its response to an event:

- Punish when someone doesn’t deserve it
- Allow risky behaviors to continue unchecked
- Overreact to singular events while underreact to risk

TRAGIC EFFECTS OF OUTCOME BIAS

Survey Results
Learning Culture in Healthcare

- Surgeon uses new equipment w/o approval and training
- Surgeon punctures patient’s bowel
- Increased risk of patient harm

WHY?

- 70-80% of human error go unexplained
- 70-90% of at-risk behaviors go unexplained

OR staff does not stop action of surgeon

A Cause of the Behavioral Choice

Behavioral Choice

Human Error

The Undesired Outcome
Harris Health Culture (Current State)

* in regards to errors

**Evaluation**
- Inconsistent – varies by manager
- Inequitable

**Accountability**
- All or none
- Blame and shame mentality
- Hit or miss – contributing factors may be missed

**Communication**
- Closed - final outcomes unknown
- Staff fearful of being blamed
Just Culture is about...

• Creating an open, fair, and just culture
• Creating a learning culture
• Designing safe systems
• Managing behavioral choices
Harris Health Culture of Safety

Life Wings
how we prevent errors

Just Culture
how we react to and manage errors

Patient

Time Outs
Hand Hygiene
People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right...

Humans will make "Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue."

The goal is to LEARN from mistakes and make system changes as needed to prevent reoccurrence.
Are you a Risk-taker
Just Culture identifies 3 behavioral choices

- Human Error
- At-Risk
- Reckless
Human Error

• A slip, lapse, or mistake
• Inadvertent action
At-Risk Behavior

• Unintentional risk taking

• Believing the risk to be justified
Reckless Behavior

- Choosing an action that knowingly puts people in harms way
### Three Types of Behaviors

<table>
<thead>
<tr>
<th>Human Error</th>
<th>At-Risk Behavior</th>
<th>Reckless Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Product of our current System Design</strong></td>
<td><strong>A Choice: Risk believed insignificant or justified</strong></td>
<td><strong>Conscious disregard of unjustifiable risk</strong></td>
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<tr>
<td>Manage through changes in:</td>
<td>Manage through:</td>
<td>Manage through:</td>
</tr>
<tr>
<td>• Processes</td>
<td>• Removing incentives for at-risk behaviors</td>
<td>• Remedial action</td>
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<tr>
<td>• Procedures</td>
<td>• Creating incentives for healthy behaviors</td>
<td>• Disciplinary action</td>
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<td>• Training</td>
<td>• Increasing situational awareness</td>
<td></td>
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<tr>
<td>• Design</td>
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<td></td>
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<tr>
<td>• Environment</td>
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#### Console
- Coach
- Punish
<table>
<thead>
<tr>
<th>Secrecy</th>
<th>→ Transparent reporting</th>
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</thead>
<tbody>
<tr>
<td>Stagnant</td>
<td>→ Learning</td>
</tr>
<tr>
<td>Individual</td>
<td>→ Interdisciplinary teams</td>
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<tr>
<td>Individual practice</td>
<td>→ Interdependent practice</td>
</tr>
<tr>
<td>Provider-centered</td>
<td>→ Patient-centered</td>
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<tr>
<td>Hierarchical</td>
<td>→ Flat</td>
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<tr>
<td>Compliance-based</td>
<td>→ Employee engagement</td>
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<tr>
<td>Reactive</td>
<td>→ Proactive</td>
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<tr>
<td>Distrust</td>
<td>→ Trust</td>
</tr>
<tr>
<td>Who did it?</td>
<td>→ Why/how did it happen?</td>
</tr>
<tr>
<td>Behavior outcomes</td>
<td>→ Behavior intentions and choices</td>
</tr>
<tr>
<td>Blaming culture</td>
<td>→ Fair and just culture</td>
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</tbody>
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Benefits of a Just & Accountable Culture

• Increased error reporting
• Increased team member satisfaction
• Increased provider satisfaction

• Improved analysis and management of errors
• Improved processes

IMPROVED PATIENT SAFETY!
Coming Soon…

• Good Catch Program
• Analysis and evaluation of error reporting structure
• Establishment of a standardized tool/ process for evaluating and managing errors
• Leadership training
• Organizational education to all employees
Just & Accountable Culture Steering Committee

Co-chair: Maureen Padilla, RN – System CNE
Co-chair: Yvonne Chu, MD - BCM
Facilitator: Lourie Moore, RN – Director, Nursing Knowledge Management
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