Creating A Fair and Just Culture: What Will it Take?

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Objectives

• Define the elements of “a fair and just culture” (FJC)
• Apply the principles of a FJC to schools of nursing and the practice setting
• Identify recommendations for creating a FJC.
“Medical errors are third-leading cause of death in U.S. “

(Makary & Daniel, 2016)
Where are we?

“In the 16 years since To Err is Human, evidence that care is getting safer is scant or absent. Progress has mostly set the stage for the vital work that remains. The path to safer care is daunting. It involves changing nearly every aspect of health care delivery.”

(The Rand Corporation, 2014)
IOM/QSEN Competencies – what every practicing nurse should demonstrate

- P/FCC
  - Evidence-based Practice
  - Teamwork & Collaboration
  - Quality Improvement
  - Informatics
  - Safety
Safety

Old – focus on individual performance, vigilance to keep patients safe.
New - Minimize risk of harm to patients and providers through both system effectiveness and individual performance
Clinicians acknowledge *not* reporting

- Physicians – 16.9% minor error  
  3.8% major error  (Kaldjian et al, 2008)
- Nurses - 37% for an error that might be personally or professionally damaging  (Cohen, 2008)
- Health care workers – 56% feel that their mistakes and events are held against them, and kept in their personnel files  (AHRQ, 2014)
- 86% of errors with harm not reported  (CMS, 2012)
Barriers to Reporting Nursing Errors and Near Misses (ENMs) (Pfeiffer, 2010)

- Attitudes
- Concerns about the reporting systems
- Not receiving feedback after reporting
- Perceptions (e.g., why bother if no harm to the patient)
ELECTROCAUTERY BURNS: EXPERIENCE WITH THREE CASES AND REVIEW OF LITERATURE

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SUMMARY. This brief report highlights three cases of iatrogenic electrocautery burns with review of the relevant published literature. The aim is to prompt awareness among surgeons and theatre staff regarding this avoidable hazard associated with the equipment frequently used for the purpose of electrocautery. This may serve as a reminder to professionals to be cautious about the pitfalls that lead to such preventable injuries.

Keywords: iatrogenic burns, electrocaogulation, burn injury, electrocautery, electrourgery

Introduction

Over the last century electrocautery has emerged as an imperative adjunct to surgery across the entire range of surgical disciplines. A diathermy machine converts electricity of the main supply (240V; 50 Hz) into high frequency current (>100,000 Hz) to minimize the risk of electrical shocks. In monopolar mode, the current from the diathermy enters the patient through the active electrode and exits through the grounding pad. In bipolar mode the current passes between the two prongs of the electrode without any significant flow through the patient and there is no need for the grounding pad.

Bovie deserves acknowledgement for his outstanding pioneering role in designing the first surgical diathermy machine in 1928. Since then cautery has been increasingly employed in surgery for cutting and coagulating, ensuring efficient haemostasis during surgery. It has become popular even for making skin incisions, given its quickness, effective haemostasis and associated lesser pain and minimal scarring. Although most of the newest diathermy machines are largely safe, the electric fields they generate are still inherently hazardous for the patient, operating surgeons, and theatre staff. They can cause burn injury, electrocution, operating room fire, smoke inhalation, and gene mutation. Several newer electomedical devices, laparoscopic diathermy and fiberoptic retractors are now emerging, and these pose the same hazards as cautery. The fire triangle consists of three elements necessary for initiation of an operating room fire, i.e. a heat source (e.g. electrocautery unit, laser), fuel (e.g. body tissues), and an oxidizer (supplemental oxygen). Iatrogenic cautery burns during surgery may result from one of the following four mechanisms: direct contact burns from the active electrode resting on the patient’s skin or contacting the operating staff, burns at the site of the grounding electrode; burns resulting from electrode heating of pooled solutions such as spirit, and burns occurring outside the operative field as a result of circuits generated between the active electrode and an alternate grounding source.

We report our experience with three patients who presented to us with full-thickness deep burns following haemorrhoidectomy, surgery for coronary artery bypass grafting, and orthopaedic surgery. Our aim is to prompt awareness among the surgical staff regarding this avoidable hazard and promote a proactive attitude on the part of the surgical team towards prevention.

Case Histories

Case I. A 21-year-old lady presented to our outdoor department with a one-week history of haemorrhoidectomy under spinal anaesthesia in lithotomy position. The operating time was 1 hour. The grounding pad had been applied over the distal thigh on posterolateral aspect. The grounding pad was found to have a deep burn after re-

<table>
<thead>
<tr>
<th>Normal Error</th>
<th>At-Risk Behavior</th>
<th>Reckless Behavior</th>
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<tbody>
<tr>
<td><strong>Product of our current system design</strong></td>
<td><strong>Unintentional Risk-Taking</strong></td>
<td><strong>Intentional Risk-Taking</strong></td>
</tr>
<tr>
<td>Manage through changes in:</td>
<td>Manage through:</td>
<td>Manage through:</td>
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<tr>
<td>• Processes</td>
<td>• Understanding our at-risk behaviors</td>
<td>• Disciplinary action</td>
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<tr>
<td>• Procedures</td>
<td>• Removing incentives for at-risk behaviors</td>
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<tr>
<td>• Training</td>
<td>• Creating incentives for healthy behavior</td>
<td></td>
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<tr>
<td>• Design</td>
<td>• Increasing situational awareness</td>
<td></td>
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<tr>
<td>• Environment</td>
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Normal (Human) Error

- Unintentional and Unpredictable
- Can result from mistakes, lapses or slips
- Can arise from weaknesses in the system

• Manage by:
  • Consoling the person
  • Making process, system or environmental changes
At – Risk Behaviors

• Lose perception of risk attached to everyday behaviors
• Driven by perception of consequences
  • Delayed and uncertain consequences
  • Rules are generally weak
• Pressure to get the work done -
People who behave recklessly
• Understand the risk is substantial – and yet think they are clever/experienced/knowledgeable
• Behave intentionally
• Know others are not engaging in the same behavior
• Occasionally do it for the thrill
• Make conscious choice to disregard the substantial and unjustifiable risk
Managing Reckless Behavior

• Healthcare professionals rarely engage in reckless behavior.

• Reckless behavior is blameworthy behavior and should be managed by disciplinary processes.
Factors contributing to incident causation

Corporate Governance
- conflicting objectives
- unclear priorities
- unclear expectations
- focus on commercial targets

- loose culture
- condone non-compliance
- lack of consequent management
- focus on cost reduction

- inadequate control of business processes
- uncontrolled change management
- not open for ‘bad’ news
- focus on slips, trips & falls (TRCF)

Organisation & systems
- inadequate standards & procedures
- inadequate design
- unclear roles & responsibilities

- lack of resources
- workload
- inadequate HEMP process
- inadequate ER system

- poor audits and reviews
- maintenance back-log
- production pressure

- time pressure
- lack of competence
- pushing operating window

- lack of supervision

Immediate causes at sharp end
- human error
- no intervention
- acceptance of high risks

- poor communication and hand-over
- equipment failure
- non-compliance

- lack of hazard awareness

Incident
What do we know about errors in health care?

• Vigilance is not the solution
• Prevention requires a complex set of system protections – and “all hands on deck” mentality
• Often a culture of silence exists
  • If you are a good nurse you won’t make mistakes
  • If you talk about mistakes, you condone them
• Many clinicians are not familiar with safety science and human factors
When are errors likely to occur?

• When people are stressed
  - learning something new
  - interrupted
  - multi-tasking
  - fearful
• When the environment is chaotic
• When there’s absent/poor communication
• When it’s not clear what’s the right thing to do
A basic premise: We all make mistakes
In health care

• We know there’s more at stake
• Vigilance is not enough
• Threats to safety are endemic
• Change is constant

• The whole culture has to change
“A bad system will beat a good person every time”

W. Edwards Deming
Changing the Culture

Moving from -

• Culture of **Blame** -
  ➢ identifying the individual
  ➢ providing discipline for every error
  ➢ hiding errors and near-misses
  ➢ preventing improvement

“Shame and blame”
- **to a fair and just culture**

an atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety-related information - but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior.

- Creating a learning culture
- Designing safe systems
- Managing behavioral choices

*(Koren et al, 2007): EPP to EPE from error-prone person to error-prone environment*
Blameless Reporting System

• Confidential reporting
• Voluntary and anonymous
• Transparency of errors and latent conditions
• Event analysis
  • Guard against blame, attribution and hindsight bias
• Identify improvements with system of feedback
• Disclosure and truth-telling
If an error occurs in a blameless reporting system

• What happened?
• Has it happened before?
• Could it happen again?
• What caused it to happen?
• Who should be told?

Then determine appropriate course of action
6 components of a Fair & Just Culture

(Petschonek et al, 2013)

• Feedback and communication
• Openness of communication
• Balance
• Quality of the event reporting process
• Continuous improvement
• Trust
A few indicators . . .

• Management does a good job of sharing information about events
• I trust supervisors to do the right thing
• My supervisors encourage me to report
• There are improvements because of reporting
• I trust that the hospital will handle events fairly

• Staff feel uncomfortable discussing events with supervisors
• Coworkers discourage each other from reporting events
A fair and just culture is *NOT*

- a culture of **no-blame** – where individuals can act carelessly or recklessly without fear of consequences

Rather -

- a **balance** between individual accountability and that individuals will not be punished for system flaws beyond their control

- a **sense of fairness** so that caregivers feel physically and emotionally safe, and that fair processes will be used to examine situations and determine actions to be taken.
Annie’s story -

https://www.youtube.com/watch?v=zeldVu-3DpM
What do We Know about Schools of Nursing?

• Often a culture of silence exists
  • If you’re a good faculty member, your students don’t make mistakes
  • If you talk about mistakes, you condone them
  • If you share information about student performance, you influence another faculty member’s perception of a student
  • If students make mistakes, clinical agencies will stop allowing clinical placements

• Many faculty are not familiar with safety science and human factors
What is the process when an error takes place with a student?

• How is the situation analyzed?
• What is the debriefing process with the student?
• What is the reporting process?
• What, if anything, is entered into the student file?
• How are errors used as teachable moments with other students, if at all?
  • With other faculty, if at all?
  • With clinical partners, if at all?
Fair and Just Culture Study

- collect and analyze information on current practices and policies for reporting and trending errors and near-misses by pre-licensure students in schools of nursing to
- create an electronic reporting tool and a national data repository for tracking and trending errors and near-misses by nursing students in pre-licensure programs

Funding: National Council of State Boards of Nursing
Phase I

- Web-based survey of U.S. pre-licensure nursing programs
  - Demographic information
  - Do you have...?
    - a policy for reporting and follow up of student errors and near-misses
    - a tool for reporting student errors
  - If so, send a copy
- Web-based survey sent to 1667 schools
  - 557 (33%)
  - 900 pre-licensure nursing programs
    (Some schools with > one type program)

(Disch & Barnsteiner, AJN, 2017)
Type of Institution

- Public (n = 355) - 65%
- Private/Religious (n = 112) - 21%
- Private/Secular (n = 59) - 11%
- Proprietary (n = 17) - 3%
Program Types

- Baccalaureate (n = 265)
  Enrollment Mean = 329
- Associate (n = 260)
  Enrollment Mean = 184
- LPN to RN (n = 122)
  Enrollment Mean = 34
- Accelerated BSN (n = 96)
  Enrollment Mean = 129
- Other (n = 70)
  Enrollment Mean = 93
- Accelerated MSN (n = 41)
  Enrollment Mean = 102
- Diploma (n = 46)
  Enrollment Mean = 138
Responses re: existence of SON tool and/or policy

- 86 (16%) had a tool and/or policy
- 6 error/near-miss policy only
- 7 reporting tool only
- 73 both a policy and a tool
  - In 9 schools, the tool did not fit the policy
Purpose of Tools

- **Document Incident (n = 47)**: 55%
- **Report & Track (n = 12)**: 11%
- **Report & Counsel (n = 9)**: 14%
- **Counsel (n = 8)**: 4%
- **Track & Trend (n = 3)**: 9%

- 47% of tools completed by a faculty member
- 33% completed by the student
- 15% completed by both faculty and student
Names of tools/policies

- Incident report
- Clinical advisement notice
- Safety reporting tool – error report
- Event discovery report
- Violation of policy form
- Critical incident report
- Student occurrence report
- Variance report form
- Learner prescription for remediation
Statements Reflecting the Culture of the Learning Environment

“...purpose is to prepare professionals for current and future practice domains [and] effectively link classroom and clinical experiences with expectations for competence, compassion, and justice in health care”

“The purpose...is a guide for students and faculty to optimize learning”

“The Nursing Program reserves the right to refuse or discontinue enrollment at any time, of any student if the student violates the Nurse Practice Act of the State of _____ .... or if faculty deems student to be unsafe
Follow-up with student

• Errors do not automatically lead to discipline
• On the other hand, some lead to immediate suspension or termination
• “Student completes report on how they will change behavior so X doesn’t happen again, and attend remediation lab”
• “Student counseled by instructor and receives Unsatisfactory for the week”
• “...if safety issue is extreme and resulted in patient demise, student may be dismissed after first occurrence”
• “3 strikes and the student is out”
Phase 2: Develop Occurrence Reporting Tool

(Disch & Barnsteiner, JNR, 2014)
<table>
<thead>
<tr>
<th>Type of Incident</th>
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<tbody>
<tr>
<td>Medication error</td>
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<tr>
<td>Needle stick</td>
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<tr>
<td>Inadequate preparation for providing patient care</td>
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<tr>
<td>Blood/pathogen exposure</td>
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<tr>
<td>Fall event</td>
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<tr>
<td>Outside scope of practice</td>
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<tr>
<td>Injury to body</td>
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<tr>
<td>Change in patient condition</td>
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<tr>
<td>Deviation in protocols</td>
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<tr>
<td>Equipment or medical device malfunction</td>
</tr>
<tr>
<td>Environmental safety – for self, patient, or others</td>
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<tr>
<td>Inappropriate or inadequate communication by: Faculty, preceptor, other student,</td>
</tr>
<tr>
<td>health care team, patient, or visitor</td>
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<tr>
<td>Breach of confidentiality</td>
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<tr>
<td>Other</td>
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Phase 3: Establish a National Data Repository

- Anonymous reporting of errors and near-misses via online tool
- Schools would be members
  - Data tracking and trending
  - Benchmarking
  - Identifying best practices
  - Bases for research and curricular revision
  - Provide data for accreditation and other reports
  - Promote a fair and just culture

Not for disciplinary purposes but quality improvement for nursing education
An Innovative Reporting and Tracking Tool for Nursing Student Errors: A Research Study

https://www.ncsbn.org/SSR-mailer-v2.pdf
A fair and just culture in a SON
(Frankel et al, 2006)

• Everyone learns and improves by openly identifying and examining his/her own weaknesses
• Faculty feel that they are supported and safe when voicing concerns
• Faculty feel comfortable monitoring others working with them, and giving feedback on how to improve their performance
• Faculty create an environment in which information on errors and near-misses is shared so that learning can occur, and the curriculum can be improved
What’s needed for a fair and just culture?

• Structures
• Processes
• Attitudes
• Courageous leadership
Structures

• A philosophy statement about Accountability, Evidence-based Education, the Role of Students and Faculty, Safety and Quality (can use QSEN), the frameworks that guide thinking and decision-making

• Clear systems and processes for tracking and trending data on unusual incidents, occurrences

• Policies that clearly spell out reckless and unacceptable behavior

• Mechanisms for discussing errors and near-misses, and for creating needed change (QI)

• Adequate opportunities for dialogue about faculty concerns and issues needing attention

• Support for an open, respectful culture that invites new ideas, healthy disagreement, shared decision-making
A word about policies – and unintended consequences

• Outcome based disciplinary decision-making
  • The more severe the outcome, the more blameworthy the actor

• Rule-based disciplinary decision-making
  • Discipline for any rule violation, intended or not

• Risk-based disciplinary decision-making
  • Treating recklessness and negligence

• What’s needed are fair and just processes –
Attitudes

• Nurses need to feel as accountable for, and prepared to, *contribute to a safe environment* as for delivering quality nursing care.

• Mistakes are part of learning and professional practice.

• Nurses should be held “accountable for their actions, but not blamed for system faults beyond their control.”

• Nurses who act recklessly may need disciplinary action up to and including termination.

• Threats of punishment do not prevent errors – they prevent the *reporting* of errors.
Processes

• Reporting and learning from errors, near-misses, trends
• Tracking and trending data from errors and near-misses
• Establishing forums for discussing progress and performance
• Creating professional education opportunities
• Developing policy – not just about who to blame but avoiding unintended consequences
• Disciplining – not just about someone committing an error but examining the context and extenuating circumstances
Content to be learned – by all nurses, students and faculty

• QSEN competencies
• Human factors
• System complexity
• High reliability
• Effective communication
• Teamwork
• New teaching pedagogies
For faculty: Adopt new ways for teaching clinical content

- Create a space for conversation without judging or blaming – seek to understand
- Include discussions in post-clinical conferences of what students experienced/saw – how were incidents handled
- Assess student competence in new ways, e.g., not while student mixing meds
- Expect professionalism in the labs, e.g., prep before, serious learning, dress
- Have students practice giving each other feedback, speaking up when noticing something
- Talk with clinical leaders about how student errors should be handled, and how observations that students make about staff should be handled
Personal Self-Assessment  (Always, Sometimes, Never)

• I work in an environment where people help each other avoid mistakes whenever possible.

• I work in an environment where people are recognized/rewarded for speaking up if something does not seem right.

• During my career I failed to report one or more med errors because I thought reporting an error might be professionally or personally damaging.

• When working with med administration technologies like bar coding, or medication pumps, I have bypassed or worked around built-in safety features.

• I initiate an event report when I catch another clinician’s mistake.
Courageous leaders

• Tangible and explicit commitment from the senior leaders
• Adequate resources
• Visible presence at key events
• Modeling open, transparent communication
• Creating a new culture
The HSSE Culture Ladder & SMS

**GENERATIVE** (High Reliability Orgs)
HSE is how we do business round here

**PROACTIVE**
Safety leadership and values drive continuous improvement

**CALCULATIVE**
We have systems in place to manage all hazards

**REACTIVE**
Safety is important, we do a lot every time we have an accident

**PATHOLOGICAL**
Who cares as long as we're not caught

(Delft University of Technology, 2013)
Accountability at several levels

Clinician/Student

Safety

CNO/Faculty

HCO/School
Nurses -

- Come to work fully prepared and rested
- Know own limitations and when to ask for help
- Stay current in the evidence bases for practice
- Collaborate effectively with colleagues from all disciplines and backgrounds
- Contribute to a healthy working environment
- Speak up when threats to safety or quality appear
- Recognize own accountability for both high quality patient care and working to improve the systems of care
Clinical leaders/faculty

1. Become familiar with contemporary safety science
2. Engage staff in discussions about the principles of a fair and just culture
3. Use the Just Culture Assessment Tool to establish a baseline assessment
4. Work with staff to prioritize changes to be made, e.g.
   1. Communication channels
   2. Continuing education topics
   3. Processes for reviewing and reporting errors and near-misses
5. Establish ongoing feedback loops
6. Model safety practices

7. Faculty: encourage your SON to sign up for the SSR project
Senior leaders

1. Express commitment to creating a fair and just culture
2. Review and revise key policies and documents, e.g. clearly stating what is reckless and unacceptable behavior; how to report errors or near-misses
3. Create respectful and transparent processes for analyzing incidents and determining fair outcomes
4. Establish mechanisms for talking directly with front-line staff about issues threatening quality and safety, and getting back to them
5. Provide adequate resources for education and safe staffing
6. Incorporate performance on culture work in recognition and reward programs
At the student level -

• Be prepared for clinical practice
• Approach simulation labs and practice sessions as you would clinicals
• Be rested
• Accept accountability
  • for contributing to a safe environment as much as for delivering quality nursing care
  • for contributing to a positive learning environment
  • for acknowledging one’s mistakes
  • for acting in a professional manner
Getting started
(Barnsteiner & Disch, AJN, 2017)

1. Secure leadership support
2. Survey faculty and students about their perceptions and experiences
3. Begin discussions with the faculty
4. Engage students in a discussion about their perceptions of the safety culture
5. Schedule educational sessions
- and other steps to take

6. Examine and update school documents
7. Partner with (clinical/academic) agencies
8. Conduct ongoing tracking and trending of incidents
9. Identify expected faculty behaviors, and incorporate these into faculty evaluations and reward systems
10. Establish ongoing feedback loops for communication
11. Evaluate the progress of the initiative
1. It’s about creating a Culture, not a Program

It takes time –

It requires leadership support
  
  CNO and Senior Leadership Support
  Medical staff support, the Board of Trustees

It requires resources
  
  Technology, staff time, education

It requires a total rethinking of ‘how we do business’

  • Policies, procedures, position descriptions
  • Professional development, clinical advancement systems
  • Reward systems
  • Practice and Quality Improvement Committees
2. It’s about creating a Culture of Safety

• Acknowledge high-risk nature of our work and commit to achieve consistently safe operations
• Provide blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment
• Engage nurses in identifying problems and seeking solutions
• Decrease hierarchy & encourage collaboration across ranks and disciplines to seek solutions to patient safety problems
• Commit organizational resources to address safety concerns
3. It’s about creating an environment that supports nurses practicing nursing

• Help all nurses learn and use current evidence
• Provide access to online sources of evidence at all work areas
• Assure adequate staffing and scheduling for release time to participate in education and practice development activities
4. It’s about creating an environment that offers high quality, safe patient care – to every patient, every time
CHANGE THE WORLD OF HEALTH CARE

• Start where you are
• Use what you have
• Do what you can

(A. Ashe)
References


