Yale NewHaven Health Greenwich Hospital

Just Culture

Yale New Haven Health System

Strategic Safety Plan June 2019

Submitted by:

Stephen G. Jones, MD

YNHHS Medical Director, Safety

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Executive Summary

Introducing the Just Culture model to our healthcare system is the next important step to advancing our High Reliability Organization (HRO) efforts to improve safety for both our patients and staff.

The goal of the Just Culture model is to produce better outcomes through understanding and mitigating human error, proper system design, and helping employees make good behavioral choices in alignment with our established organizational values.

The Just Culture model does not excuse human error but understands that even the most well-intentioned and caring of us will occasionally experience an unintentional or inadvertent act that will result in other than what was intended – a slip, lapse, or fumble. The model values understanding and learning from unintended human errors over punishment.

The Just Culture model, which has been widely and successfully used in aviation and other high-risk, high-consequence industries, seeks to create an environment that encourages individuals to report mistakes so that the precursors to errors can be better understood in order to fix the system issues. It is a model that holds every employee, and the organization itself, to an elevated level of accountability.

The Just Culture model will serve to reinforce our commitment to excellence as it is fully aligned with the established mission, vision and values of the YNHHS.

The Joint Commission has strongly endorsed a Just Culture model for healthcare organizations with the publication of two recent Sentinel Event Alerts:

- "The Essential Role of Leadership in Developing a Safety Culture" (*Issue 57, March 1, 2017*)[1]
- "Developing a Reporting Culture: Learning from Close Calls" (*Issue 60, December 11, 2018)*[2]

These Joint Commission reports underscored the importance of an open reporting and learning culture and went on to say*, "Absolutely crucial is a transparent, non-punitive approach to reporting and learning from adverse events, close calls and unsafe conditions."*

Additionally, the American Nurses Association (ANA) published a position statement (2010)[3] strongly supporting the Just Culture concept and application in the healthcare setting.

The Just Culture model, much like our experience with building our HRO culture, is a multi-year journey that requires both good stewardship and patience.

Implementing a Just Culture model successfully is a challenging but highly rewarding task. It requires a total commitment and investment of organizational leadership. However the ROI for that commitment makes it a journey well-worth taking in bringing the Yale New Haven Health system to the forefront of safety leadership in this country and ultimately achieving our goal of zero harm to any patient or employee.

1. Introduction

1.1 Purpose of Plan

This report is intended as an overview as well as a roadmap for the introduction of the Just Culture model to the Yale New Haven Health System. In addition to outlining a path to Just Culture for YNHHS, it will review both the benefits and challenges of the model.

1.2 Overview of Just Culture Model

The 1999 landmark Institute of Medicine (IOM) report, *To Err is Human*, brought to light the profound level of preventable harm that was occurring in US healthcare estimating upwards of 98,000 deaths per year. A more recent study published in the British Medical Journal (BMJ) estimated the number of preventable deaths at greater than 250,000 per year placing medical error as the third leading cause of death in the US.

Over the last 20 years significant efforts have been made to address this problem including the introduction of high-reliability tools *(i.e. check lists, time outs, huddles, etc.).* Yet the level of preventable harm remains alarmingly high.

Any effective system of safety depends crucially on the willingness of employees to report errors and unsafe conditions. High reliability effort alone cannot provide the necessary corrective action in the absence of such reporting. Staff who fear retribution will generally only report those errors that they cannot hide. In order for employees to come forward and report errors, an organizational climate conducive to such reporting must exist – a Just Culture.

The aviation industry provides a powerful example of the impact on safety of having a robust reporting systems when they instituted the Aviation Safety Reporting System (ASRS) which provided an opportunity for pilots, air traffic controllers, flight crew, maintenance personnel and others to report errors with immunity. Errors and hazards, that in the past would have gone unreported and remained latent in the system, could now be addressed fixed in a timely manner.

The Just Culture model addresses the complex interplay between humans and systems (socio-technologic relationship). Understanding the science of how humans and systems fail and succeed is a key component of the model.

All humans are fallible and will inevitably make errors independent of intelligence, training or commitment to doing the right thing. Just Culture accepts this as a condition of the human experience and seeks to prevent harm and repetition of such errors through learning and system design.

Humans also have free will and choice. Organizations, and society itself, have expectations that people will comply with duties, rules, and laws. However, humans will often drift into “At-risk” behavior where they make a behavioral choice and fail to see the risk or wrongly believing the risk to be justified. Examples of “At-risk” behavior in society would be exceeding the speed limit by 8-9 mph or

failing to signal when turning. Examples in healthcare would be skipping two-step patient identification or failing to both wash-in and wash-out of a patient's room.

The Just Culture model sees this "At-risk" behavior to be the biggest threat to safety and the precursor to most errors. Although "At-risk" behavior seldom results in bad outcomes, it is for that reason it is so dangerous. It is self-reinforcing and eventually becomes the norm of practice and, at some unexpected point, resulting in an undesired outcome. Unlike unintentional human error, "At-risk" behavior is a choice that can be managed through coaching and, if not corrected, disciplinary action.

A just culture supports an open and honest reporting environment to drive a quality learning environment and culture. While the organization has a duty and responsibility to clearly define expectations and values to their employees, there is an equal expectation that employees will align their behavioral choices to comply with those expectations and values. All employees are held responsible for the quality of their choices. Just culture requires a change in focus from errors and outcomes to system design and management of the behavioral choices of all employees.

The framework of a just culture ensures balanced accountability for both individuals and the organization responsible for designing and improving systems in the workplace. Engineering principles and human factors analysis influence the design of these systems so they are safe and reliable

A fair and just culture improves patient safety by empowering employees to proactively monitor the workplace and participate in safety efforts in the work environment. Improving patient safety reduces risk by its focus on managing human behavior (or helping others to manage their own behavior) and redesigning systems. In a just culture, employees are not only accountable for their actions and choices, but they are also accountable to each other, which may help some overcome the inherent resistance to dealing with impaired or incompetent colleagues.

Secondary benefits of a just culture include the ability to develop a positive patient safety profile to respond to outside auditors such as The Joint Commission. When implemented, a just culture fosters innovation and cross-departmental communication. An example is the opportunity to revitalize the morbidity and mortality conference to cross specialty lines and develop a patient-centered focus.

In a just culture, both the organization and its people are held accountable while focusing on risk, systems design, human behavior, and patient safety

1.3 The Problem Statement

In testimony before congress, Lucian Leaped, MD, member of the Quality of Health Care in America Committee at the Institute of Medicine and adjunct professor of the Harvard School of Public Health, noted that:

"Approaches that focus on punishing individuals instead of changing systems provide strong incentives for people to report only those errors they cannot hide. Thus, a punitive approach shuts off the information that is needed to identify faulty systems and create safer ones. In a punitive system, no one learns from their mistakes"

As a result of a punitive work environment and because hospital personnel (as well as most of the public) tend to regard health care provider errors as evidence of personal carelessness, most hospitals are unaware of the extent of their errors and injuries. Dr. Leaped reported that only 2 to 3% of major errors are reported through hospital incident reporting systems. Health care workers often report only what they cannot conceal.

1.4 Objectives

- Introduce, educate, and embed the Just Culture model into the YNHHS as the next important step in supporting our high-reliability journey to zero harm
- Utilize the Just Culture model and its tools into system event investigation (i.e. RCAs, Serious Event Review Committee (SERC), Physician Peer Review Process, etc.)
- Encourage recognition and reporting of medical/health care errors and risks to patient safety without judgment or placement of blame
- Assist employees in making good behavioral choices in the workplace that align with YNHHS organizational values
- Ensure systems are designed to support the employees in successful outcomes by minimizing and mitigating error and at-risk behavior
- Provide a system justice and accountability for all staff that clear and equitable
- Support and maintain an active sharing learning system
- Produce better outcomes by reducing risk of preventable harm to patients and staff
- Define metrics to measure progress and impact of Just Culture on identified Outcomes

2. Definition and Principles of Just Culture

2. Definition of Just Culture

- The term “Just Culture” refers to a values and learning based system of shared accountability where organizations are accountable for the systems they design and for responding to the errors and behaviors of their employees in a fair and just manner.
- Employees, in turn, are accountable for the quality of their choices and for reporting both their errors and system vulnerabilities.
- Just Culture methodology is designed to establish a culture that encourages open reporting of adverse events and risky situations while still holding employees and the organization itself accountable but in a fair and just manner, and always with goal of ongoing learning and improvement.

*The term “Just Culture” was first used in a 2001 report by David Marx (Marx, 2001)[4], a report which popularized the term in the patient safety lexicon (Agency for Healthcare Research and Quality).

2.1. **Principles of Just Culture**

Just Culture begins with the organizational mission, vision, and values. Employees are expected to be in alignment with organizational expectations and behave in a manner that supports them. The responsibility of the organization is to design a system that allows employees to be successful in meeting these expectations by removing barriers and minimizing competing incentives (i.e. discharge before 11 AM and attentive medication reconciliation prior to discharge).

Specific to organizational risk, there are two things organizations have control over. The first being the reliability of the systems in which we place our employees. Systems must be designed to anticipate human error, capture errors before they cause harm, and demonstrate resilience in recovering from the undesired outcomes of error.

While organizations can anticipate human error, it is through management of employees behavioral choices that lead to an improved opportunity to achieve the outcomes desired. Just Culture holds good coaching an essential skill for leaders to drive reliable behaviors but recognize when remedial and disciplinary actions are needed.

Just culture promotes a learning culture as a foundational component of any high-reliability organization. It is a culture that seeks to understand risk at both the individual and organizational level. This requires active learning systems and an organizational commitment to encouraging an open and transparent reporting system. It is only through learning systems at the individual, unit, and organizational level that corrective action plans can have the greatest impact.

The enemy of a robust learning system is a culture that favors a punitive response to human error. The Just Culture is one where employees can admit mistake without fear of discipline. It is however a culture where all employees are accountable for their behavioral choices including reporting their errors.

Just Culture strikes a balance between system and individual accountability in a manner that best supports system safety and other organizational values.

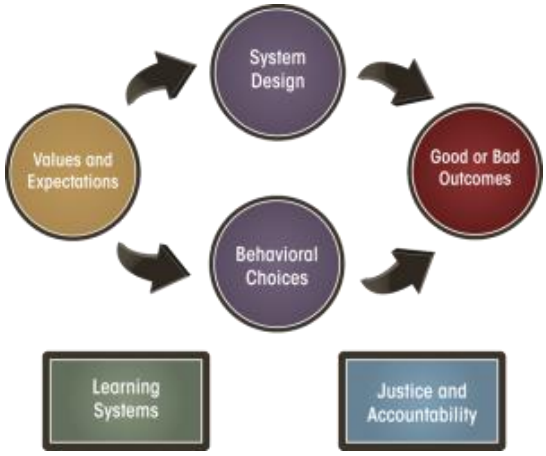
2.2. **The Core Five Skills**

Just Culture identifies the following five skills that make up the foundation of an organization's culture:

1. **Aligning Mission, Values and Expectations** – an organization must first define its mission. It then must determine what values it needs to hold up so that it can begin to establish reasonable expectations for its processes. In our imperfect, human world, perfection is not a reasonable expectation, so we must set goals that are realistically achievable.
2. **Good System Design** – we must design our systems so that they facilitate people making good decisions, the decisions that will best support them in getting a job done safely and correctly. We must anticipate human error, capture errors before they become critical, and permit recovery when the errors become critical.

The Core Five Skills (cont'd):

3. **Managing Behavioral Choices** – we must coach our employees to be consistent and honest in their behaviors, and help them make the best choices and learn from their mistakes. We must also learn how to use remediation and discipline to the best effect in order to shape the choices of our employees.
4. **Active Learning Systems** – we must work toward a learning culture, a culture which encourages early identification of risks in the system. It should promote honesty and forthright sharing of "near misses" in order to improve the overall success of the process. We cannot wait for negative outcomes to occur before we find ways to improve the system; the more we know beforehand, the more we can avoid the bad outcomes.
5. **Justice and Accountability** – the organization must promote fairness and justice in the disciplinary process. It must find the balance between assigning blame for simple errors and never holding anyone accountable for their choices. Sometimes the system is to blame rather than a human component of the system, and we can change the system accordingly to reduce the risk of error or negative outcomes.



The illustration above emphasizes, Learning Systems and a Culture of Justice and Accountability that serve as the core foundation of this model.

2.3. **The Three Core Behaviors**

1. **Human error**
   - Humans are not perfect, so any system we create should expect errors to occur and account for them as a normal part of the process. A slip, a lapse, a mistake can happen to the best of us, so **human error**, rather than being a punishable action**,** becomes an opportunity to learn and to improve our systems. Any system that is one failure away from harm, be it human error or equipment failure, is vulnerable.

2. **At-risk behavior**
   - Sometimes people get complacent and start to drift away from the rules (like driving a few MPH over the speed limit, for example); they begin to engage in **at-risk behavior**, placing themselves and others at risk. They could be trying to accomplish more than they normally could, or they could be telling themselves that "it can't happen to me." Simply put, they do not perceive the risk, or have temporarily forgotten it. In this case coaching and education are the answer, a reminder of the risks that may have been forgotten or mistakenly justified.

3. **Reckless behavior**
   - In very rare occasions, though, people engage in **reckless behavior**, choosing knowingly to place themselves or others in harm's way. They see the risk, and they understand the harm that can be done. They simply choose to place their own self-interest above the rest of the system. The individual(s) responsible for these choices obviously need to be subject to disciplinary action

2.4. **The Three Core Duties**

The Just Culture model evaluates and measures employee behavior based on three core duties balanced against organizational and individual values. The three duties are:

1. **Duty to Produce an Outcome**
   - A duty which is under the control of the employee who is expected to produce an expected outcome (i.e. being on time for work).
2. **Duty to Follow a Procedural Rule**
   - This duty requires the employee to follow the rules and policies as set forth by the organization (i.e. utilize two patient identifiers).
3. **Duty to Avoid Causing Unjustifiable Risk or Harm**
   - This duty is ever-present and supersedes all other duties. It is an obligation we owe to each other to never cause unjustifiable risk or harm to anyone at any time (i.e. driving while impaired)

2.6. **Finding Justice**

The open and fair culture should not be confused with either a "punitive" or "blame-free" culture. Neither a punitive nor a blame-free culture is compatible with a system learning and safety.

A punitive culture suffers from two major factors that fail to reduce risk and improve safety:

1. **Punishment strongly discourages reporting**
    - Punish people for making mistakes, and they will only report what they cannot hide. There is no learning and latent conditions that were in the system contributing to the undesired outcome fail to be identified and corrected.
2. **The "Outcome Severity Bias "**
    - A bias where punishment is determined by the "severity" of the outcome rather than the "quality" of the choice
    - A consequence of this bias is that in the absence of injury, a "no harm, no foul" approach fails to address the risk.

In a Just Culture:

- Human error is consoled not punished.
- At-risk behavior is coached.
- Reckless behavior is punished.

The Just Culture model also addresses repetitive human error and at-risk behaviors through reassignment or remedial measures if all corrective efforts have been exhausted.

2.7. **The YNHHS Just Culture Algorithm**

The Just Culture Algorithm (see appendix) is our primary tool for understanding and categorizing the choices of those in our organization. With it we can evaluate an event based on a set of duties inherent to the system in order to determine which of the three behaviors was most likely in play. This gives us the ability to address the event and the people involved in a constructive way rather than simply reacting to the outcome. It can also show us how multiple behaviors can be associated with a single event, so that we can evaluate each behavior separately in order to more effectively determine the root cause.

The algorithm is tool that must be utilized properly. The algorithm will be distributed for use only to those leaders who have completed Just Culture training

3. Benefits of a Just Culture

The benefits gained from engineering a Just Culture into an organization include measurable effects, such as increased reporting, decreased events of harm, and improved employee culture of safety scores, as well as intangible organizational and managerial benefits such as trust building and organizational resilience.

- The Joint Commission has sent a strong message on the importance of healthcare leadership committing to a Just Culture
- A Just Culture drives increased event reporting, particularly of previously unreported events.
- It has been estimated by our HPI/Press Ganey consultants that for every one event reported in organization presently, there are ten that go unreported.
- More robust event reporting will allow for increased identification of trends and provide more opportunities to address latent safety risk conditions.
- An increase in event in reporting does not indicate reduced organizational safety any more than a decrease in reporting is indicative of a safe organization.
- Establishing a well-defined, well-monitored Just Culture will help all members of the organization better define their roles and responsibilities in conjunction with the values and expectations of the YNHHS system.
- Staff will experience an increased sense of accountability and confidence in the workplace with the understanding that they will not be punished for an unintentional human error
- Reinforce and align with staff the organization's common vision and values.
- Fair and consistent application of organizational justice
- Aligns and reinforces HRO process to further reduce events of harm

4. Challenges of a Just Culture

Introducing change of any kind into a large organization is challenging, particularly in healthcare. The Just Culture model requires engagement of all employees, clinical and non-clinical, and on all levels.

- Implementing and sustaining the Just Culture model requires a strong commitment and investment of resources on the part of leadership for success
- The Just Culture model requires patience for measurable change and improved outcomes requiring a minimum of 2-3 years to take hold
- Employees are often skeptical at the outset until they see evidence of a non-punitive culture around error
- Despite an organization commitment to a non-punitive response to error, external oversight organizations may still enforce disciplinary measures.
- Undesired events with high severity outcome may find their way into the legal system where there is a culture of "criminalization" of error.

5. Implementing a Just Culture

5.1. **Executive Leadership Commitment**

Just Culture implementation is a top-down endeavor. It is imperative that the key executive leadership have a clear understanding of what the Just Culture model offers and the commitment and investment required.

The commitment to move ahead with the Just Culture journey and expectations for employees must be clear and shared across all levels of the organization. The Executive Leaderships role in the journey including formally announcing a commitment to Just Culture to the organization at large and strongly engaging the role of endorsing and reaffirming the commitment (i.e. speaking to it in visible venues such as meetings and morning safety report.

5.2. **Training**

All YNHHS employees will need to understand the fundamentals of the Just Culture Model. However only leaders overseeing frontline staff (i.e. directors and managers) will require formal training to fully understand the model and engage the employees they are supervising.

- Goal for remaining FY19 is to provide 3.5 hours of in classroom Just Culture training for 1,500+ YNHHS directors/managers available in over 50 training dates
- Training will be offered through FY19 at the Institute for Excellence at 300 George Street
- Training will also be offered at all Delivery Network sites through completion of FY19
- A pool of system Just Culture trained individuals will participate in a train-the-trainer program as well as a certification process to serve as instructors and stewards of the Just Culture education program
- The training schedule and logistics will be overseen be the Institute for Excellence at 300 George Street under the direction of Kathleen Quinn, Senior Manager, Talent Development, Safety and Physician Leadership Development
- The full schedule of classes across the YNHHS and instructions on registration can be found on the Intranet Home Page and (Appendix C)
- Dates and locations of all training classes can also be found in the Appendix of this document.
- Initial training session will be presented by Stephen Jones, until additional trainers can begin pending completion of Train the Trainer program (see next section).

5.3. **Train the Trainer Program**

The goal of this program component is to provide a small team qualified instructors in Just Culture to share the responsibilities of initial and new employee training. Identified key individual (see appendix) and representing elements of each delivery network from across the YNHHS system will be trained and certified as instructors using similar model successfully employed in our initial HRO rollout. Prior to teaching Just Culture independently, new instructors will be expected to:

1. Attend scheduled Just Culture session or dedicated teaching session
2. Audit a scheduled Just Culture session with teaching notes
3. Co-teach with a certified Just Culture Instructor
4. Receive certification from a Just Culture auditor

This process will be expedited to facilitate a transition to shared teaching of Just Culture across the system.

Training Plan and Timeline:

- Identify 8 individuals for training from across the system identified by April 30th. (Appendix B)
- Identify two training dates in May dedicated to training identified trainees in collaboration with the Institute for Excellence
- Begin incorporating trainers into schedule as they complete training and finalize by June 30th

5.4. **Provide Certification Training to Key Leadership**

A strong recommendation is to provide certification to key leaders (10 to 20) across the YNHHS as subject matter experts. Key areas to include in such training include Human Resources, Safety, and Risk Management with the goal being to have certified Just Culture experts at all delivery networks.

At this time, there are 3 YNHHS leaders certified in Just Culture:

1. Jodie Boldrighini, Executive Director, Human Resources (GH and BH)
2. Margaret Towers, Manager, Risk Management (GH)
3. Stephen Jones, MD (YNHHS)

- Certification in Just Culture is offered through the internationally recognized safety/risks consultant, Outcome Engenuity who, in addition to healthcare, have worked with NASA, aviation, rail, and other high-risk organization for over 20 years.
- Outcome Engenuity is the only firm that provides Just Culture training and certifies through testing that course attendees have the depth of knowledge to lead their organizations in cultural transformation to a Just Culture.
- Certification program are offered across the US throughout the year but certification is also offered on-site for larger organizations to reduce cost of travel and time away from the workplace.

(Please see Section 8 – Operating Budget for breakout of projected costs)

5.5. **Integrate Just Culture into New Employee Orientation**

The basics of the Just Culture model concept will be introduced into new employee orientation (NEO) before the end of FY19. The model aligns and naturally integrates into the YNHSS values already being introduced during NEO.

5.6. **Introduce Basics of Just Culture Model to All Employees**

While all employees do not require formal training, all employees do need to have a basic understanding of the Just Culture model as it relates to YNHHS expectations.

- Develop a Just Culture Learning Health Stream module for employee education
- Manager/Directors will introduce and review at departmental staff meetings
- Provide a short informational/educational video for staff

6. Marketing and Communications Plan

The Just Culture model initiative for FY19 was formally announced across the YNHSS at Leadership Kick-off sessions at each delivery network.

Presentations on the model were given to leadership at each delivery network as well as the Human Resource Executive Committee and System Quality Committee.

Robert Hutchinson, Amy Brenner-Fricke and Nancy Martin from Marketing and Communication have been assisting with plans for sharing opportunities. An information article on Just Culture was recently distributed for system-wide distribution.

Consideration of producing an informational/educational video on Just Culture for widespread distribution is under consideration.

YNHHS Safety Coaches will receive additional training on the Just Culture model at their meetings and will be encouraged to promote the model in their respective units.

7. Key Performance Indicators

It is important to track progress the Just Culture model measure outcomes across all elements of the YNHHS. As we saw with our HRO initiative, some outcomes will not be realized immediately.

Consideration of utilizing an organizational benchmarking survey tool to coincide with the launch of Just Culture model

The Organizational Benchmark™ Survey is designed to measure critical behavioral markers that show an organization's growth in culture around particular organizational values. The markers are the same for each value in that the basic elements of a learning and just culture.

The markers follow twelve areas of focus:

1. Organizational Values
2. System Design
3. Management/Subordinate Coaching
4. Peer/Peer Coaching
5. Outcomes
6. Open Reporting
7. Search for Causes
8. Internal Transparency
9. Response to Human Error
10. Response to Reckless Behavior
11. Severity Bias
12. Equity

The survey is free of charge and very short (5-10 minutes)

- **Progress Metrics**:

1. Number of YNHHS Leaders Trained though FY19 (Performance expectation below)
2. Number of Just Culture Trainers in place by June 30 (Goal 8)
3. Audit use of Just Culture algorithm through RL Solutions
4. Number of changes made to improve system design

Number of YNHSS Leaders Trained

- Completion of 3.5 hours of in classroom Just Culture training for 1,504 YNHHS leaders by the end of FY19

	Performance Level		
Baseline (1504)	**Threshold**	**Target**	**Stretch**
	75% (1128)	**80%** (1203)	**95%** (1428)

Outcome Metrics for FY20 and beyond:

1. Increased Safety Event Reporting (see below)
2. Meaningful reduction of events of potential or actual harm (PSEs + SSEs) as well as an increase in good catch near miss events (NMEs) utilizing Safety Index tool (see below)
3. Improved overall Culture of Safety scores in the FY20 YNHSS Engagement Survey
4. Targeted improvement in domains of "punitive response to error" reporting in Culture of Safety survey

Increased Safety Reporting

1. Demonstrate an increase in reported safety events in RL Solutions from 2018 baseline.

	Performance Level		
2018	**Threshold**	**Target**	**Stretch**
Baseline (21,763)	**2.5%** (22,307)	**5.0% (**22,851)	**7.5%** (23,395)

Improves Safety Index*

*Safety Index = Total (PSE +SSE)/Total NME

	Performance Level		
Safety Index	**Threshold**	**Target**	**Stretch**
(2018)	**2.5%**	**5.0**	**7.5%**
Baseline (1.68)	**(1.64)**	**(1.60)**	**(1.56)**

Safety Index Baseline (2018) = 13,657/8,106 = **1.6**

8. Operational Budget

Estimated budget for Just Culture:

	FY '19	**FY '20**
Refreshments for attendees	$5,048	$1,500
Supplies (algorithm, folders, printing)	$8,440	$1,000
Just Culture Certification (Based on 20 leaders and trainers in Year 1 and 10 in Year 2)	$30,900	$16,950
Train-the Trainer program	$5,000	$0
Training tools (Video produced by Tober Group)	$22,000	$0
On-line module (created internally by e-Learning team)	TBD	TBD
Total	$71,388	$19,450

9. Summary

The Yale New Haven Health System began its journey in 2012 to becoming a High Reliability Organization (HRO) and has seen significant improvements during that time including more than an 80% reduction in serious safety events. Yet while events of unintended harm have been significantly reduced, they still occur at an unacceptable level. The goal of our safety initiatives at YNHHS is to reduce events of harm (to both our patients, employees, visitors) to zero.

Introducing the Just Culture model into our high-reliability efforts is not only essential but key to approaching and ultimately achieving our goal of “no harm” to anyone, in any place, in our organization.

Just Culture serves as a powerful driver to encourage high-reliability behaviors and is a catalyst to an open reporting and robust learning system.

Additionally, organizations who have adopted the Just Culture model have seen significant improvements on outcome measure as well as meaningful improvements in both employee satisfaction and perception of safety scores.

It should be understood that Just Culture is not “blame free” or “non-punitive” model. There are times when a disciplinary process is necessary and appropriate. However, the model accepts the fact that even the best and most dedicated among us will occasionally make a human error that has an undesired outcome. The goal is to understand the error then “learn and improve” rather than “blame and punish."

The model focuses more on the behavioral choices employees make (i.e. not washing hands) that may result in unintentional harm (i.e. infection) and holds them accountable for those choices in a fair and just manner.

Justice and accountability go hand-in-hand in a Just Culture in an atmosphere that promotes active learning to improve systems, reduce error, and help people make better behavioral choices.

The utilization of a standardized Just Culture algorithm for evaluating an individual’s performance and behavior will help ensure a consistent and fair process for all independent of job title or event outcome.

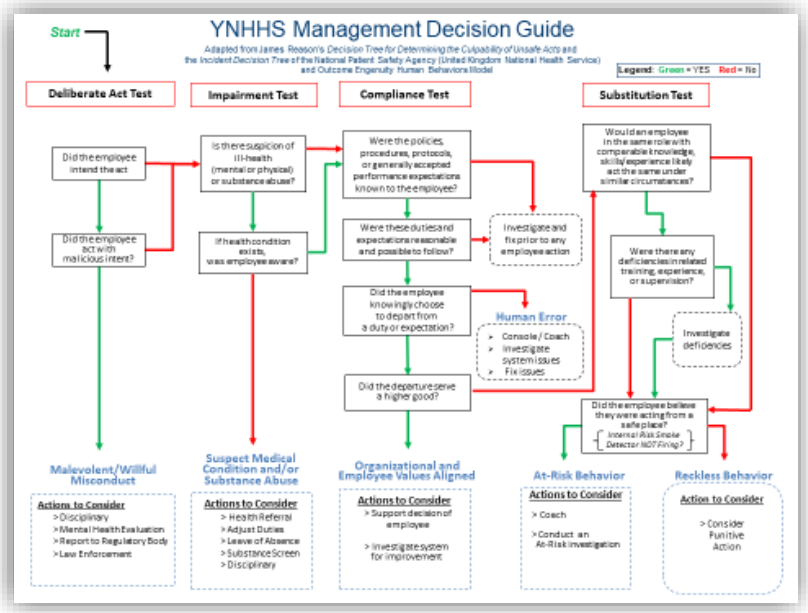
Implementing the Just Culture model successfully is a challenging task. It requires a complete commitment of organizational leadership of embedding a Just Culture as well as a commitment to the process of launching, implementing, and, most importantly, sustaining that culture.

However the Return on Investment for that commitment makes it a journey well worth taking in bringing the Yale New Haven Health System closer to the very forefront of safety leadership in this country and ultimately achieving the goal of zero harm.

10. References

1. The Essential Role of Leadership in Developing a Safety Culture, The Joint Commission Sentinel Event Alert (*Issue 57, March 1, 2017*)
2. Developing a Reporting Culture: Learning from Close Calls, The Joint Commission Sentinel Event Alert (*Issue 60, December 11, 2018)*
3. Position Paper supporting Just Culture, American Nurses Association (ANA), (2010)
4. Patient Safety and the "Just Culture": A Primer for Health Care Executives, Marx D, Report for Columbia University under grant provided by the National Heart, Lung, Blood Institute (2001)
5. Just Culture encourages error reporting, improves patient safety, Rideout D, OR manager. 29(7):13-5, 2013 UI: 23926642
6. Accountability for Medical Error: Moving beyond Blame to Advocacy. Bell SK; Delanco T; Anderson-Shaw L; McDonald TB; Gallagher TH. Chest 140(2):519-526, 2011 UI: 21813531
7. Nonpunitive Response to Errors Fosters a Just Culture. Battard J. Nursing Management 48(1):52-55, 2017 UI:28033214
8. The Patient Safety Culture: a Systematic Review by characteristics of Hospital Survey on Patient Safety Culture Dimensions. Reis CT; Paiva SG; Sousa P. International Journal for Quality in Health Care. 30(9):660-677, 2018 UI: 29788273
9. Transparency and Just Culture offer Significant Return on Investment. Lazarus IR. Journal of Healthcare Management. 56(4):223-7, 2011 UI: 21838020
10. Learning from Errors for Continuously Improving Patient Safety, Huang CW; Iqbal U; LI YJ. International Journal for Quality in Health Care. 30(2):81 2018 UI: 29506224

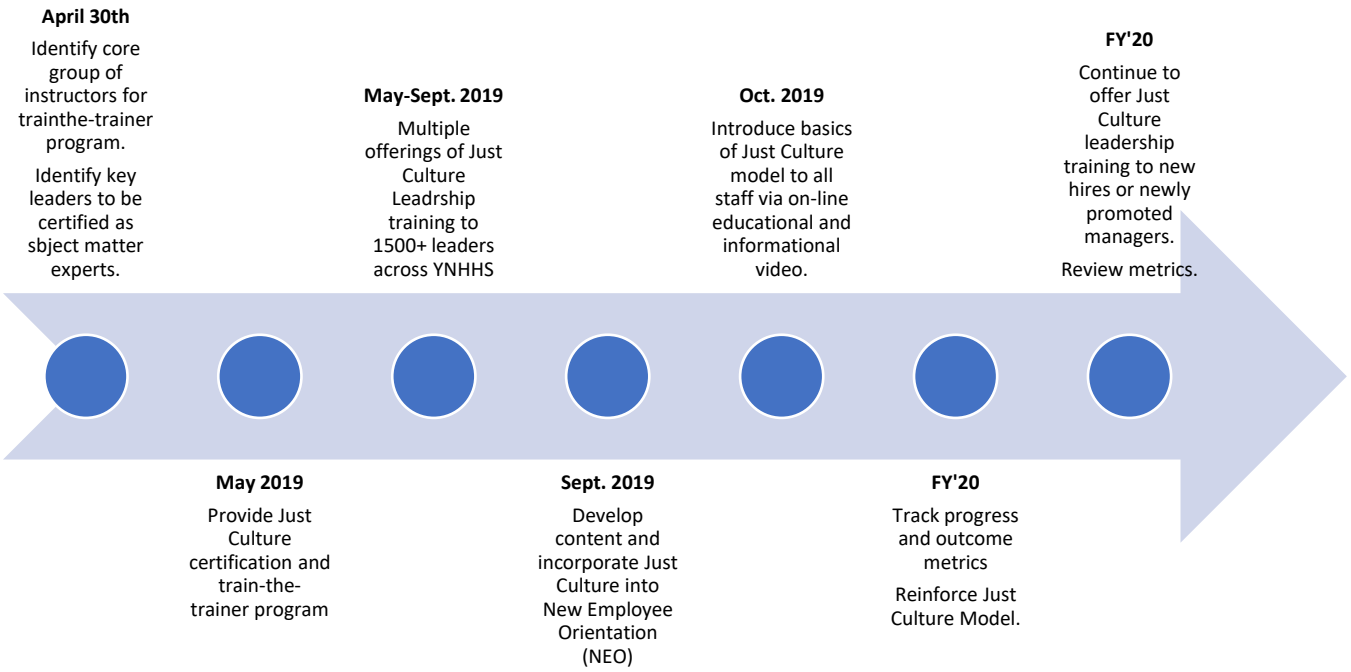
Appendix A – The YNHHS Just Culture Algorithm



Appendix B – Individual Identified for Certification to Teach Just Culture

1. Kathleen Quinn (YNHHS)
2. Dave Fachini (YNHH)
3. Marfuz Hoq, MD (BH)
4. Maureen Revel, RN (GH)
5. Robert McLean, MD (NEMG)
6. Kathy Mitas (YNHH)
7. Gloria Bidelglass,, RN (BH)
8. Jodie Boldrighini (YNHH)
9. Nyshi Jacob (YNHH)

Appendix C – Just Culture Implementation Timeline



Appendix D – Just Culture Training Calendar

Just Culture training will be offered in half-day sessions and attendance by all leadership including managers and directors is expected.

Instructions to register are below:

1. Go to the Intranet Home Page
2. Click on "Training" on top right to get to **"Learning Management –LMS**
3. Type **Just Culture** in Search box at top. Hit enter.
4. Click on blue **Just Culture** link (above the Status) for list of available classes
5. Register for your choice
6. You should see a pop-up that indicates you successfully registered for the class.

2019 Just Culture Training Schedule			**as of 4-29-2019**
Date	**Time**	**Location**	**Room**
5/9/2019	**8-12**	**Selina Lewis Bldg, Saint Raphael's Campus**	**Multipurpose Room**
5/15/2019	**8-12**	**Lawrence + Memorial Hospital**	**Baker Auditorium**
5/16/2019	**8-12**	**300 George Street, IFE, 1st Floor**	**156**
5/21/2019	**1-5**	**Bridgeport Hospital**	**Nursing School Auditorium**

5/22/2019	1-5	300 George Street, IFE, 1st Floor	156
5/29/2019	8-12	300 George Street, IFE, 1st Floor	156
5/31/2019	8-12	300 George Street, IFE, 1st Floor	156
5/9/2019	1-5	Selina Lewis Bldg, Saint Raphael's Campus	Multipurpose Room
6/4/2019	1-5	Selina Lewis Bldg, Saint Raphael's Campus	Multipurpose Room
6/7/2019	8-12	Bridgeport Hospital	Hollander Auditorium
6/11/2019	1-5	Lawrence + Memorial Hospital	Baker Auditorium
6/13/2019	8-12	Westerly Hospital	Nardone B
6/17/2019	8-12	Greenwich Hospital	Noble
6/18/2019	1-5	Bridgeport Hospital	Nursing School Auditorium
6/20/2019	1-5	300 George Street, IFE, 1st Floor	156
6/25/2019	8-12	300 George Street, IFE, 1st Floor	156
7/1/2019	1-5	300 George Street, IFE, 1st Floor	156
7/9/2019	8-12	Bridgeport Hospital	Nursing School Auditorium
7/10/2019	8-12	300 George Street, IFE, 1st Floor	156
7/15/2019	1-5	300 George Street, IFE, 1st Floor	156
7/19/2019	8-12	Lawrence + Memorial Hospital	Baker Auditorium
7/23/2019	1-5	Bridgeport Hospital	Nursing School Auditorium
7/24/2019	1-5	300 George Street, IFE, 1st Floor	156
7/31/2019	8-12	300 George Street, IFE, 1st Floor	156
8/6/2019	8-12	Bridgeport Hospital	Nursing School Auditorium
8/7/2019	8-12	300 George Street, IFE, 1st Floor	156
8/12/2019	1-5	300 George Street, IFE, 1st Floor	156
8/15/2019	1-5	Lawrence + Memorial Hospital	Baker Auditorium
8/21/2019	1-5	300 George Street, IFE, 1st Floor	156
8/22/2019	8-12	300 George Street, IFE, 1st Floor	156
8/26/2019	8-12	300 George Street, IFE, 1st Floor	156
8/28/2019	1-5	300 George Street, IFE, 1st Floor	156
9/6/2019	8-12	300 George Street, IFE, 1st Floor	156
9/11/2019	8-12	300 George Street, IFE, 1st Floor	156
9/12/2019	8-12	Greenwich Hospital	Noble
9/19/2019	8-12	Lawrence + Memorial Hospital	1.223 Center for Learning Conf Room
9/20/2019	8-12	300 George Street, IFE, 1st Floor	156
9/23/2019	8-12	300 George Street, IFE, 1st Floor	156
9/25/2019	8-12	Westerly Hospital	Nardone B
9/26/2019	1-5	300 George Street, IFE, 1st Floor	157