

Just Culture

Part II



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The presenters have nothing to disclose

Objectives



1. **The Learner will be able to describe just Culture and its' components**
2. **The Learner will be able to implement Just Culture principles in the health care delivery setting**

PATIENT SAFETY

Decrease in
VAP, HAI, HAC,
Wrong Site Outcomes,
Absenteeism, Staff burnout
Core Measures

Outcomes

Critical Event Response,
RCA's, FMEA, EBP, IOM Six
Aims, Standard Work, EMR
Leadership Walk Rounds

Deliverables

Just Culture
Teamwork &
Communication

Foundation

Human Factors
System Failures

RELIABLE DESIGN



95%

Review Elements of A Just Culture




1. Just Culture supports and envelops learning
2. A Just Culture is one that learns and improves by openly identifying and examining its own weaknesses
3. Just Culture focuses on proactive management of system design and management of behavioral choices
4. Individual and Systems Accountability



Just Culture

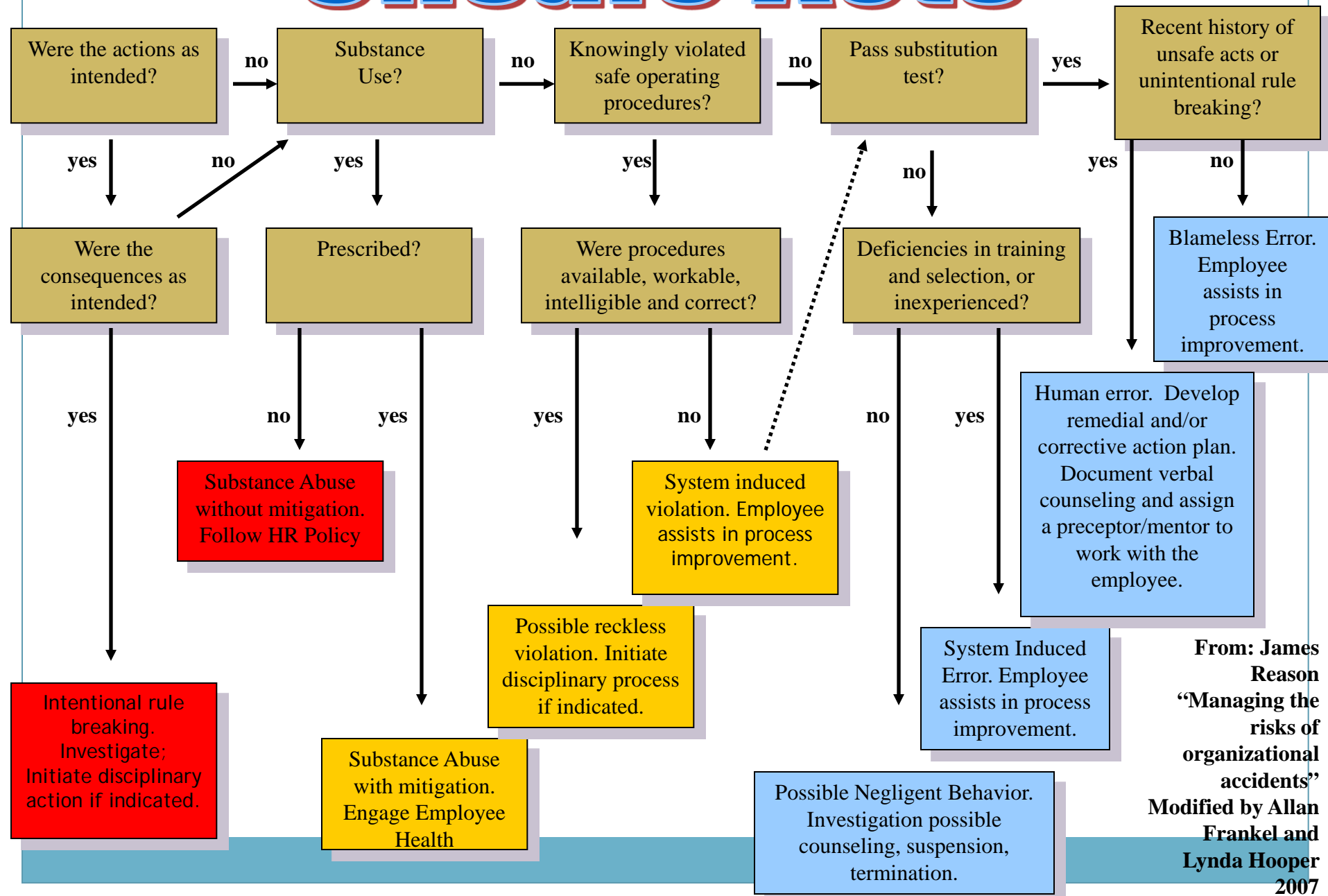


PRACTICE SCENARIO



95% of the errors that cause harm involve conscientious, competent physicians, nurses, respiratory therapists, pharmacists, and other staff who through a series of systems failures make mistakes that lead to unintended and sometimes catastrophic results

Unsafe Acts



References



The Joint Commission, (2007). Creating a Fair and Just Culture: One Institution's Path Toward Organizational Change . *Journal on Quality and Patient Safety*

Frankel, A.S., Leonard, M.W., Denham, (2010). Institute for Health care Improvement, Fair and Just Culture, Team Behavior, and Leadership Engagement: The Tools to Achieve High Reliability. *Health Research and Educational Trust*. DOI: 10.1111/j.1475-6773.2006.00572.x

Joint Commission Resources & Institute for Healthcare Improvement, (2009). *The Essential Guide for Patient Safety Officers*. Pp 1-28