Our Commitment to Safety
In order to be trusted, we must be safe.

Fair and Just Culture
Scenario #1

- Mike is a nurse caring for Mr. Johnson. Mike enters the patient room to find Mr. Johnson on the floor between the bed and bathroom. As he quickly assesses Mr. Johnson, he notices he is moaning in pain and that his left leg seems shorter compared to the right leg. Mike further observes that he seems unable to move his left leg.
Discussion

• What are your initial reactions to the situation?
• What additional information would you explore once the patient is stable?
Scenario #2

- For the third time, Susan found a faxed document that contained Protected Health Information (PHI) lying at the department FAX machine for over four hours. Susan knew that PHI should never be in plain sight and the department policy was to immediately pick up faxes that contain PHI. Adding to her concern was the memory of the document she found last week which was never picked up and which she finally shredded at the end of the day.
Discussion

• What are your initial reactions to this situation?
• What type of follow up do you think should occur in this situation?
Scenario #3 (Optional in place of above scenarios)

• Customized to the work area
Discussion

• What are your initial reactions to this situation?
• What type of follow up do you think should occur in this situation?
Objectives

• Identify a Fair and Just Culture as part of Mayo Clinic’s *Our Commitment to Safety* program

• Understand the concepts and practices of a Fair and Just Culture in order to support and maintain a learning environment
  • Application of Fair and Just Culture principles
  • How to respond to incidents in a Fair and Just manner

• Review the Commitment to Safety Fair and Just Culture Decision Guide

• Practice applying the Fair and Just Culture Decision Guide
Our Commitment to Safety program and principles

• Our Commitment to Safety program is a multifaceted, ongoing effort to strengthen Mayo’s Clinic’s Safety Culture by supporting a harm-free experience for our patients, employees and visitors.

• Our Commitment to Safety Principles
  • Five Safe Behaviors
  • Fair and Just Culture
  • Psychological Safety
  • Team Behaviors
What we know

• We are human, we make errors
• The root cause of errors vary with circumstances
• Most errors, whether they cause harm or not, are due to breakdowns in systems; however, when an error takes place, there is a tendency to look for individual fault
• Blaming individuals unjustly creates a culture of fear and defensiveness
• Fear diminishes learning and the capacity to improve an organization’s culture of safety
A culture of safety exists when errors or near misses are responded to in a Fair and Just manner

- These responses include:
  - Making it psychologically safe to talk about incidents in order to learn and improve
  - Considering both the systems and the behaviors that led up to the incident
  - All involved being accountable for actions before, during and after the incident
Fair and Just Culture

Was it the behavior?
- Human Error
- Risky behavior
- Reckless behavior

Was it the system?
Faulty design or lack of system?

Consider both

Near misses or undesirable outcomes reviewed and responded to in a consistent manner

What can we learn from this to prevent future harm?

Accountability is not determined by the outcome

Error, event or Near Miss
Behavioral review & response

**Individual Behaviors**

- **Human Error** = inadvertent action (lapse, slip, mistake)
  - Console/Learn

- **Risky (Drift)** = behavioral choice that increases risk where risk IS mistakenly believed to be justified
  - Coach/Learn

- **Reckless** = behavioral choice to consciously disregard a substantial and unjustifiable risk
  - Corrective Action

Adapted from Outcome Engineering LLC Just Culture Training Slides
**Our Commitment to Safety Fair and Just Culture Decision Guide**

*Applies to consulting and administrative voting staff, allied health and non-allied health*

**What is a Fair and Just Culture? It is an organizational culture:**
- Where employees who make errors or witness errors feel safe disclosing them.
- Where employees aren't fearful of a punitive response when human error occurs.
- Where the emphasis is on learning from mistakes and using the knowledge gained to reduce or eliminate similar errors in the future.
- Where an acknowledgement is made that well intended systems (processes/policies/procedures/guidelines) can be faulty and lead to errors.

**What are the advantages of a Fair and Just Culture approach?**
- An environment exists whereby incidents/errors are brought forward more readily without the fear of punitive action.
- When errors occur, fair and just responses leading to changes that effectively reduce or eliminate the potential for future errors.

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**Step 1 – Investigate if the choice was Human Error. Was an inadvertent action, slip, lapse, or mistake made? If no, proceed to step 2**

**Recommendation (Individual)**
Learn what happened. Console the individual. Provide training if applicable.

**Recommendation (System)**
Learn whether others are making the same inadvertent actions, slips, lapses or mistakes. Evaluate the policy/procedure/guideline at the appropriate level (team, unit, department, division, organization, etc.) The investigation may indicate that wider actions are needed to improve safety for future patients.

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**Step 2 – Investigate if the choice was Risky (drift) Behavior. Was a behavioral choice made that increases risk where risk is not recognized or is mistakenly believed to be justified? If no, proceed to step 3**

**Recommendation (Individual)**
Learn from the individual why they made the choice. Why did the individual knowingly depart from the policy/procedure/guideline? Did the individual receive relevant training? Coach the individual to follow established policies/procedures/guidelines.

**Recommendation (System)**
Learn whether others are making this choice. Was the policy/procedure/guideline in routine use on the unit? Are 'work arounds' the norm? Are the processes workable? Evaluate the policy/procedure/guideline at the appropriate level (team, unit, department, division, organization, etc.) The investigation may indicate that wider actions are needed to improve safety for future patients.

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**Step 3 – Investigate if the choice was Reckless Behavior. Was a behavioral choice made or policy/procedure/guideline not followed where risk was consciously disregarded or unjustifiable?**

**Recommendation (Individual)**
Learn about what happened from the individual. It may be appropriate to utilize one of the more advanced steps in the corrective action process for the employee.

**Recommendation (System)**
Wider investigation is still needed to understand how and why a patient was not protected from the actions of the individual. Was there opportunity for a colleague to speak up and did it not occur, find out why?

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*Supervisors/managers partner with their direct supervisor/administrator and Human Resource Advisors to work through these decisions.*
Fair and Just Culture Decision Guide – Step 1

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Fair and Just Culture Decision Guide – Step 3

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Supervisors/managers partner with their direct supervisor/administrator and Human Resource Advisors to work through these decisions.
Scenario #1

• You are part of a multidisciplinary team caring for Mr. Johnson today. You enter the patient room to find the patient on the floor between the bed and bathroom. As you quickly assess the patient, you notice the patient is moaning in pain and that their left leg seems shorter compared to the right leg. You further observe that the patient seems unable to move his left leg.

• Could there have been systems at fault?

• Could there have been behaviors that contributed to the event?
Scenario #2

• For the third time, Susan found a faxed document that contained Protected Health Information (PHI) lying at the department FAX machine for over four hours. Susan knew that PHI should never be in plain sight and the department policy was to immediately pick up faxes that contain PHI. Adding to her concern was the memory of the document she found last week which was never picked up and which she finally shredded at the end of the day.

• Could there have been systems at fault?
• Could there have been behaviors that contributed to the event?
Scenario #3

• Discuss a scenario relevant to our work area.
• Brainstorm ideas
• Walk through the scenario – human error, risky behavior, reckless behavior
Resources

Fair and Just Culture

Our Commitment to Safety