



### VA NCPS Topics in Patient Safety

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### A Road Map to Just Culture

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An organizational culture of safety affects employees' attitudes, beliefs, perceptions and values as well as their behaviors and levels of engagement related to safe practices. In 1999, the Institute of Medicine (IOM) published recommendations in *To Err Is Human: Building a Safer Health System*, urging organizations to implement a set of actions to improve safety culture and reduce preventable medical errors. Despite the IOM's recommendations and safety culture requirements from the Joint Commission, health care organizations continue to struggle to establish a positive culture of safety.<sup>1</sup> Studies have shown correlations between employee perception of fear and willingness to report issues, and an organization's safety culture, including subcultures.<sup>2</sup> A just culture is a culture of safety that fosters transparency, trust and open communication; all which promote the delivery of highly reliable, quality care. A just culture creates an environment of shared accountability among senior leadership, middle managers and employees in

maintaining safe practices. Establishing a just culture also facilitates an appropriate investigation of adverse events, one which clearly differentiates between human errors, system failures and risk-taking behaviors. Key components of a just culture include psychological safety, anticipation of risks, accountability, a mission-driven organization, and the non-biased investigation of errors.<sup>3</sup>

#### Implementing a Just Culture

The creation of a just culture is a journey, not a destination. It is a journey of discovery where organizations learn the true depth of their commitment and capabilities in creating and sustaining the habits of high reliability.<sup>4</sup> The journey towards a just culture, described below, will take you through a series of steps designed to help an organization reach critical milestones (see Figure 1). These steps are intended to be a guide and should alleviate the perception that a just culture in health care is merely theoretical, without application and structure.

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### FIGURE 1. Steps to Just Culture

|   |
|---|
| 1. Perform an Organizational Assessment             |
| 2. Create Awareness                                 |
| 3. Develop an Implementation Plan                   |
| 4. Implement Training                               |
| 5. Sustain Just Culture in Organizational Practices |
| 6. Measure Success, Celebrate Success               |

The just culture journey is a relevant and practical one that can be tailored to each organization’s vision and goals.

**Define Vision and Goals**

Start the just culture journey by clearly defining your organization’s vision and goals. Culture change is a top-down approach requiring time and commitment to unravel unhealthy behaviors and re-establish a path forward driven by the stated mission, beliefs and values of the organization.<sup>5</sup> Therefore, just culture implementation requires a conscious, visible commitment and strong support from senior leadership. Just culture implementation also needs a team of motivated and passionate employees who are going to move the initiative along. The team should be comprised of senior leadership (sponsor), a human resource representative, physician and nurse champions, middle managers, education staff, administrative staff, and union representatives. From the outset it is important to designate who will be the driver (leader) of the implementation team and its efforts. It is vital that senior leadership and all team members enter this journey with an adequate baseline knowledge of just culture concepts. As well, a clearly defined mission statement and goals specific to the just culture initiative should be written into the organization’s existing strategic plan, and should address senior leadership’s vision of the organization’s safety culture in three to five years from starting the journey. At the Bronx VA Medical Center, the mission statement is:

*To create an environment of trust and shared accountability in which employees feel safe and are encouraged to report safety-related information. Employees trust that they will not be held accountable for system failures;*

**FIGURE 2. Just Culture Bundle**

| Just Culture Bundle                      | Areas of Assessment   |
|--|---|
| Environment of Psychological Safety      | Culture of speaking up or “Stop the Line”<br>Policy alignment with just culture language and with clear examples<br>Measurements of staff safety survey scores  |
| Use of Just Culture Algorithm            | Standardized algorithm for consistent error investigation and identification of human error, at-risk behavior and reckless behavior<br>Consistent use of algorithm across services<br>Guidance/tools for consoling and coaching staff |
| Systems Approach                         | Staff involvement in root cause analysis<br>Organization engagement in proactive risk management and process improvement<br>Ongoing safety education  |
| Reporting of Actual and Near-Miss events | Incident and near-miss reporting patterns and perceptions<br>Availability of anonymous reporting system<br>Access to user-friendly incident reporting system<br>Feedback to staff on reported incidents and actions taken             |

*but, also take accountability for their behavioral choices.*

**Perform an Organizational Assessment**

An organization cannot travel to a new place unless it knows where it currently resides. To this end, performing an organizational assessment will provide a gap analysis and baseline data which can be used to identify improvement targets. The assessment can be accomplished via informal and honest input garnered by the implementation team, past culture surveys, and an analysis of system safety practices and processes. There are four main concepts associated with a just culture (see Figure 2). These concepts comprise what should be referred to as the “just culture bundle,” as they are all essential for successful implementation.<sup>6</sup> It is prudent to assess your organization’s current status and readiness under each bundle element as this will help

the team prioritize and set specific objectives along with measureable outcomes to address the gaps. This organizational assessment should be viewed as a framework for building a just culture and a method to understand current safety practices, only changing processes as needed, and not as a separate initiative.

**Create Awareness**

Raising awareness throughout the organization at the beginning of the just culture journey will help employees stay engaged, provide opportunity for open dialogue, and help with the sustainability of the cultural transformation. A strong message should be developed that includes the organization’s just culture definition and mission, reason for adapting a just culture model, and the roles and responsibilities of employees. There are several methods and venues available for dissemination including all staff commu-

nication campaigns, patient safety activities, committee meetings, staff meetings, town halls, intranet postings, and printed materials to inform and engage staff at all levels. Awareness creates opportunities to gain staff feedback and enlightenment on potential barriers to implementation. In order to produce sustainable cultural change, employees must feel included, supported and empowered to adapt the just culture model.

### **Develop an Implementation Plan**

The implementation plan should include developing a staff education program along with a clear and usable just culture-decision algorithm. In a just culture, it is imperative to utilize a consistent, fair, objective, and human factors-based process to investigate errors and decide what the organizational response will be. This avoids a singular focus on individual acts and the hasty assignment of blame.<sup>7</sup> An objective process also avoids severity bias (which has no place in a just culture), where leaders and managers react to an incident based on the severity of patient harm rather than the intent of those involved. There are several published algorithms that aid in identifying human error, at-risk behavior, reckless behavior, and/or system failures associated with adverse events.<sup>3,8,9</sup> The just culture principle is based on identifying these behaviors and initiating an appropriate organizational response such as: consoling human errors, coaching at-risk behaviors, and punitive actions for reckless or malicious behaviors. Senior leadership input must be considered when either choosing an existing decision algorithm or creating a new one. Leaders must set the tone and outline what behaviors are acceptable and unacceptable, being careful to avoid defaulting to punishment when significant patient injury occurs. The Bronx VA Medical Center

just culture algorithm guides managers and employees through seven investigative categories/steps:

- Individual's intent
- Equipment failure
- Peer action of similar experience
- Training issues
- Competency evaluation
- Individual risk awareness
- System barriers

Using the organization's needs assessment conducted earlier in the process, the implementation team along with staff education personnel must develop an education plan and objectives. Planning for interactive and multimodal workshops is recommended to promote adult learning and staff participation. The workshops provide staff with the theory to understand just culture concepts and the tools to apply these concepts in their daily practice.

### **Implement Training**

Just culture training must be provided to senior leadership, middle management and staff in all services. It should be incorporated in new employee orientation, new supervisor/manager orientation, ongoing staff and manager education, resident education, and all elements of employee training. It is important for senior leadership to be visible during the training process and provide recognition to services or units that are actively engaged in the just culture education process. The Bronx VA Medical Center found success in providing individual service-level training by bringing the training to the unit or place of work. It was also helpful to train staff separately from managers and leaders to allow for better staff engagement and a more open and honest dialogue during the sessions.

### **Build and Sustain Just Culture in Organization Practices**

Building policies and processes that support the just culture model takes time. This can be accomplished by taking small steps towards aligning processes and policy language with just culture principals. These may include human resource policies that are heavily based on counseling and reprimanding employees versus coaching when appropriate; or patient safety policies that don't define what risk-taking behaviors are and how to manage them. As organizations begin to create, promote and adhere to a just culture framework in daily practice, staff will become more mindful and decrease risk-taking behaviors over time.<sup>10</sup> The Bronx VA Medical Center has incorporated the just culture model in the incident review process. As an example, when an incident occurs involving the mislabeling of a specimen, the manager reviews the incident objectively using the just culture algorithm to identify any system failures, at-risk behaviors and/or reckless behaviors. This affords the organization an opportunity to identify system issues while simultaneously allowing managers the latitude to engage in discussion and coaching of employees. Currently, the Bronx VA Medical Center is in the process of incorporating just culture principals into existing policies.

### **Measure and Celebrate Success**

It is important to measure process as well as outcomes along the just culture journey. In the organizational assessment stage measurable objectives are developed which can be reprioritized during the different stages of implementation. Key measures should include staff perception of safety along with incident and near-miss reporting trends. Celebrating milestones of success will em-

power staff to continue to embrace culture change.

**Looking Forward**

The just culture model has the potential for becoming the gold standard in providing a framework for patient safety. Just culture implementation requires senior leadership to model and communicate safety as a top priority; and promote organizational learning to reduce errors and increase risk awareness.<sup>11, 12</sup> Over time staff attitudes about reporting, and the need to partner with leadership in the name of safety, will improve. With strong commitment from all levels in the organization, and shared values across services, the just culture journey will continue, moving all towards the goal of a safer system.

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**VA NCPS Launches New Program**



Creating High Reliability  
Through a Fair and Just Culture

In the next issue, NCPS will formally present "My Voice Matters," a comprehensive program encompassing multiple elements that, if implemented fully, will enable your facility to create and sustain a just and fair culture. A highlight of the program is the Just Culture Seminar for Leaders. The seminars are presented by NCPS to top-, mid- and service line-level leaders. Materials and tools are shared completely with facilities for dissemination to the front line.

## Patient Medication Information Sheet Redesign Project: A Patient Safety Initiative Identified by the Patient-Centered Prescription Label Study

By Tim Arnold, PharmD and Keith W. Trettin R.Ph., MBA, VA National Center for Patient Safety

The patient-centric prescription label and medication information redesign movement is a collaborative effort between the VA National Center for Patient Safety (NCPS), Pharmacy Benefits Management (PBM), Patient Safety Managers (PSMs), and VA pharmacists. Minimization of medication errors and standardization of the data elements on the prescription label and medication information sheets are the goals of this redesign effort. In 2010, NCPS and the PBM joined forces to conduct a study testing suspicions that current prescription label formatting made Veteran comprehension of drug information and instructions difficult. It was anticipated that the study would also provide key insights into the reformatting of prescription label information, and the redesign of the outpatient pharmacy prescription label. This effort identified and confirmed three areas in need of further exploration:

- 1) Prescription label format
- 2) Patient instruction word selection
- 3) Patient medication information sheet format

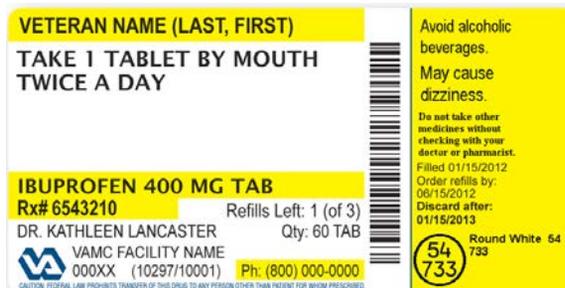
In 2011, the patient-centric prescription label study was conducted; this included the participation of over 400 Veterans representing 11 VA care sites and over 600 pharmacy staff.<sup>1</sup> Recommendations from an

expert advisory panel guided the initial label redesign. Participants' ability to comprehend prescription label information was assessed and their preferences with regard to spatial organization were collected. The results of this study guided the format of a redesigned label for piloting at VA medical centers. In 2012, VISNs 6, 7, 8 and the Charleston Central Mail Order Pharmacy (CMOP) were selected as pilot sites to trial the new label. After completion of the trial, the patient-centric label was authorized by the VISN pharmacy executives and subsequently adopted as the standard VA-wide. The CMOPs are currently in the process of implementing the label and VA medical center implementation is now complete.

The next phase of this effort addresses the redesign of the Patient Medication Information (PMI) sheets. The PMI sheets, provided by VA and supplied with each prescription, provide Veterans with important drug information, such as indications, side effects, precautions, and drug interactions. The current PMI sheet was examined using several readability evaluation methods, and it was found that its content requires a high-school education to comprehend. In addition, the typography and format of the PMI influences

legibility and readability, of particular concern to the visually impaired, which directly affects comprehension and motivation to read. In this study, the PMI sheets were redesigned using principles similar to those described by the U.S. Food and Drug Adminis-

### Patient-Centric Prescription Label

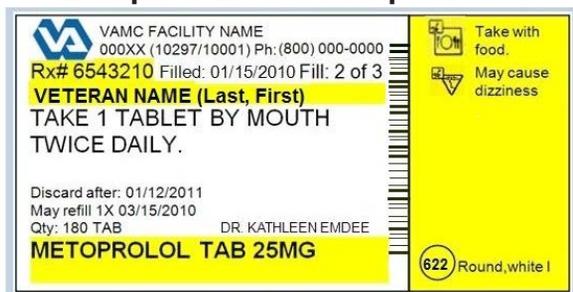


tration and its partners.<sup>2</sup> The study aims to determine the impact of PMI typography, format, and content selection on preference and comprehension in Veterans. To ensure an adequate cultural and geographical sampling, evaluations are being conducted at sites where the patient-centric label study was also carried out. Currently half-way through the data-collection phase, study completion is scheduled for the end of calendar year 2016. The results of this initiative will be instrumental to the decision-making processes, influencing future PMI design and implementation efforts.

This is a story of the initiative and vision that ultimately led to a national collaborative to redesign and standardize the pharmacy prescription label and PMI within the VA system. Through a disciplined project management approach, and the support of Veterans and VA personnel, the effort to create a safer medication delivery system by improving Veteran comprehension of prescription related information, has become a reality.

For more information on the patient-centric label project, VA employees can go to <https://vaww.cmo-pnational.va.gov/cmop/PBM/Prescription%20Labels%20Patient%20Centric/Forms/AllItems.aspx>

### Example of an Old Prescription Label



CAUTION: FEDERAL LAW PROHIBITS TRANSFER OF THIS DRUG TO ANY PERSON OTHER THAN PATIENT FOR WHOM PRESCRIBED

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**Putting a Face to a Name: Your Patient Safety Team**



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**Remembering One of Our Own, "Gertie" Gibson**

**REMEMBERING A TRUSTED FRIEND TO PATIENT SAFETY**

"Gertie" Gibson, Patient Safety Manager, Salt Lake City died unexpectedly on December 7, 2015. "Gertie" was so well known in our organization most people didn't know or need to know her last name. She was a person you recognized by a single name, much like Madonna or Cher!

Gertie worked at the Salt Lake City VA Healthcare System over 25 years in roles as a nurse, rehab nurse manager, coordinator for contracted nursing homes and in the perfect role for her as the patient safety manager for the past five years. Recently someone was talking about her and described her approach as the "magic" of Gertie-- she was friendly, yet firm--one of those persons who could communicate key points so clear to anyone in the organization. She had an indelible spirit of service, a tremendous work ethic, a genuine passion for all people and an unforgettable laugh. Gertie touched countless lives throughout our organization and she elevated the culture safety without a doubt. We miss her and were blessed to have her friendship and leadership in patient safety.

*Some people come into our lives and quietly go. Others stay for a while and leave footprints on our hearts and we are never the same.*

