C’mon! Not Another Initiative: Taking TeamSTEPPS into Just Culture and HROs
August 12, 2020
Rules of Engagement

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  o Through the phone (*Please mute your computer speakers)
  o Or through your computer

• All hyperlinks on the screen are active if you click on them

• Q&A session
  o Will be held at the end of the presentation
  o Written questions are encouraged throughout the presentation
    • To submit a question, type it into the Chat Area and send it at any time during the presentation
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**Webinar**
September 9, 2020 | 1:00 – 2:00 PM ET
Register for the webinar *Psychological Safety and Building Team Strength in Crisis*.

**Online Community Platform**
Join Mighty Network to access exclusive content and connect with your peers to share stories, tools, and content.

**Online Courses and Workshops – coming soon!**
Today’s Presenters

Tonya Martino, RN, BSN, ND
Clinical Director of Team Performance
UW Medicine - WISH

Ross Ehrmantraut, RN
Patient Safety and Team Training Consultant
Today’s Objectives

Participants will…

Discuss the components and impact of a just culture
Differentiate human error, at-risk behavior and reckless behavior
Understand how TeamSTEPPS and high reliability organization concepts can help foster a just culture
UW Medicine Community

- 2,400 faculty members in 30 departments
- 4,700 clinical faculty across WWAMI region
- 4,500 students and trainees
  - Medical students, residents, fellows
  - Schools of Nursing
  - Pharmacy, PA, Rehab Therapies, RT
  - Other Ancillary Health Sciences Schools
- 30,000+ employees
Let’s start with a case…

A patient is treated in the ED for sepsis. The physician ordered an antibiotic.

The ED nurse prepared the patient for transport to the inpatient unit and called report to the receiving nurse.

Simultaneously, the ED nurse intended to hang the antibiotic prior to transport but instead hung a bag of Heparin, which was intended for another patient. BCMA was available but the nurse did not utilize it.

When the patient arrives on the floor, the receiving nurse notices the bag of Heparin infusing and notifies the physician.

The infusion was stopped before the patient suffered any unintended consequences.
What if…

A patient is treated in the ED for sepsis. The physician ordered an antibiotic.

The ED nurse prepared the patient for transport to the inpatient unit and called report to the receiving nurse.

Simultaneously, the ED nurse intended to hang the antibiotic prior to transport but instead hung a bag of Heparin, which was intended for another patient. BCMA was available but the nurse did not utilize it.

When the patient arrives on the floor, the receiving nurse does not perform a bedside safety check, so does not notice that Heparin infusing. The patient receives the whole bag of heparin and no antibiotics.

The patient suffers major bleed and requires transfer to the ICU.

The patient’s sepsis progresses and the patient codes. The patient dies within 24 hours of admission.
# HRO – Team Training – Just Culture

<table>
<thead>
<tr>
<th>High Reliability Element</th>
<th>High Reliability Behaviors and Practices</th>
<th>Supporting Team Training Tools</th>
<th>Integrating Just Culture</th>
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</thead>
<tbody>
<tr>
<td>Sensitivity to operations</td>
<td>Front line employees are:</td>
<td>Situation Monitoring/Awareness, Check-back, Brief, Huddle, Debrief, Shared Mental Model</td>
<td>• Threshold questions (case investigation)</td>
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<tr>
<td></td>
<td>• Better positioned to recognize failure or potential errors</td>
<td></td>
<td>• 5 voices (objective being front line when applicable)</td>
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<tr>
<td></td>
<td>• Identify opportunities for improvement</td>
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<td></td>
<td>• Operations staff have a unique view of a current situation and unexpected situations</td>
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<td></td>
<td>• Big picture understanding</td>
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<td>Preoccupation with failure</td>
<td>• Any failure or deviation from the expected is reviewed for opportunities for improvement and to prevent continued failures</td>
<td>Brief, Huddle, Debrief, Situation Monitoring, Handoff tools, Mutual Support, Task assistance, CUS/Two Challenge</td>
<td>• Looking at the system as well as individual factors</td>
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<td></td>
<td>• It is necessary to address all technical, human, and process failures immediately and completely</td>
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<td>• 3R’s</td>
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<td></td>
<td>• Fixate on how things might fail even when failure has not occurred</td>
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<td>• Focus on reliable system design</td>
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<td>• Near misses are consider opportunities</td>
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<td>• Coaching</td>
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<tr>
<td>Deference to expertise</td>
<td>Authority does not necessarily mean expertise:</td>
<td>Team Structure, Brief, Huddle, Leadership transfer skills training, SBAR, Situational Awareness, CUS/Task Assistance</td>
<td>• 3 voices (objective view)</td>
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<td></td>
<td>• Expertise take precedence</td>
<td></td>
<td>• System design</td>
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<td></td>
<td>• On-the-ground subject matter experts help provide situational assessment and response</td>
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</table>
| Resilience                                      | • Anticipates failure or potential errors to effectively manage unexpected events  
|                                                | • Involves identifying errors and innovating simultaneously  
|                                                | • Dynamic process of correcting and creating solutions  
|                                                | Situation and cross-monitoring and task assistance, CUS/Two Challenge, Briefs, Huddles, Debriefs  
|                                                | Simulation scenarios of applied team training concepts allows for studying complex events and the latent and active conditions that contribute  
| Reluctance to simplify                         | • Coaching  
|                                                | • Consoling  
|                                                | • 3R’s  
|                                                | • System  
|                                                | Embrace the complexity of the organization  
|                                                | • Conduct detailed analyses like root cause analysis to understand problems  
|                                                | • Reject simple explanations for failure  
|                                                | Team Structure, Brief, Debrief, Handoff, Situation Monitoring  
|                                                | Simulation scenarios of applied team training concepts allows for studying complex events and the latent and active conditions that contribute  
|                                                | • Threshold questions  
|                                                | • 3 voices  
|                                                | • Address the three behaviors |
Situation Monitoring/Mutual Support

**Assumptions**

- Checked on Wikipedia
- Working with 3 newer authors
- Belief this is common knowledge
- Workload too heavy
- Assumed fact checking was already done

**Task Assistance**

- Author did not verify facts
- Fact checker skipped story
- Editor did not notice

**Briefs, Huddles**

- Inaccurate story gets printed

**Situation Awareness**

- A Cause of the Human Error
- Behavioral Choice
- Human Error
- A Cause of the Behavioral Choice
- The Undesired Outcome
The Continuum of Accountability
System Basis of Errors

• “People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right?...

• …Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue.”

Don Norman
The Design of Everyday Things
2000; 2013
Where we want to be…

What system of accountability best supports system values?
To Err is Human
To Drift is Human

CUS/Two Challenge
What is Just Culture?

The acknowledgement that all humans are destined to make mistakes and drift into at-risk behavioral choices regardless of how well the system is designed.

Shift focus from error and outcomes to system design and behavioral choices.
The Three “Voices”

**IMPOSER**
Enforcing the rules
Determines risk and tolerability

**SUBJECTIVE STANDARD**
What did the person perceive?
Why did the person act as such?

**OBJECTIVE STANDARD**
Reasonable Person Test (“similar person, similarly situated”)
For JC, preference is within your organization/unit culture

**OBJECTIVE STANDARD:**
Be wary of your (imposer’s) personal bias and past experiences.

“Only wear one hat!”
Threshold Questions

- What happened?
- What NORMALLY happens?
- What does the procedure require?
- Why did it happen?
- How was the organization managing the risk?
### Just Culture’s Three Behaviors*

<table>
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<th>Human Error</th>
<th>At-Risk Behavior</th>
<th>Reckless Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inadvertent action:</strong> slip, lapse, mistake</td>
<td><strong>A choice:</strong> risk not recognized or believed justified</td>
<td><strong>Conscious disregard of a substantial &amp; unjustifiable risk</strong></td>
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<td>Manage through changes in:</td>
<td>Manage through:</td>
<td>Manage through:</td>
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<tr>
<td>• Processes</td>
<td>• Removing incentives for at-risk behaviors</td>
<td>• Remedial action</td>
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<tr>
<td>• Procedures</td>
<td>• Creating incentives for healthy behaviors</td>
<td>• Disciplinary action</td>
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<tr>
<td>• Training</td>
<td>• Increasing situational awareness</td>
<td>• Punitive action</td>
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<td>• Design</td>
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<tr>
<td>• Environment</td>
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<tr>
<td>• Behavioral Choices</td>
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*From Outcome Engenuity*
Human Error

- It is inadvertent, and a result often associated with other factors:
  - Was there a “system” contribution to the error?
  - Were there personal performance factors?
  - Did the individual make a decision/choice upstream that increased the possibility of an error occurring?
- It is never JUST human error
## Human Error – Why Does it Happen?

### Personal Performance Shaping Factors:

- Human factors
- Fatigue
- Fitness for duty
- Stress
- Distractibility
- Experience
- Task tension and engagement
- Motivation
- Mental and physical hardiness

### System-Based Causes:

- Lack of patient/product information
- Failure to communicate
- Storage and access
- Device failure
- Lack of patient education
- Lack of staff education/orientation/supervision
- Environmental, workflow or staffing
- Culture
At-Risk Behavior

• A behavioral choice that increases risk without perceiving the risk or is mistakenly believing to be justified
• Driven by perception of consequences

This is where TeamSTEPPS can proactively impact culture
At-Risk Behavior – Why Does it Happen?

Why did the decision make sense at the time to the individual?

- Why was the decision made?
- Incentives to cut the corner?
- Barriers to correct behaviors?
- Perceptions of risk?
- Problem solving?
- How prevalent is the behavior? (What normally happens?)

What are the system-based causes?

- Lack of patient/product information
- Failure to communicate
- Storage and access
- Device failure
- Lack of patient education
- Lack of staff education/orientation/supervision
- Environmental, workflow or staffing
- Culture
Reckless Behavior

• Conscious disregard of substantial and unjustifiable risk
• Manage through:
  o Disciplinary action
  o What is in the best interest of your organization and its learning culture?
Attributes / Results of a Just Culture

Outcome Engenuity Just Culture Model
Putting It All Together!

HROs

TeamSTEPPS, HROs and Just Culture

Outcome Engenuity Just Culture Model
Key Takeaways

- Just Culture is about identifying risk, not finding fault
- Evaluate systems and behaviors, not outcomes
- Assess and mitigate bias throughout the process
- Integrating TeamSTEPPS, HRO and Just Culture is integral in creating culture of safety
  - Not individual initiatives
THANK YOU

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AHA Team Training

Questions? Stay in Touch!

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