An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phriomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

PEOPLE PROCESS PERFORMANCE
Centre for Innovative Human Systems

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Building a Just Culture in Healthcare:

a HSE Dialogue

Croke Park Conference Centre, Dublin

23rd May 2023

Building a Just Culture in Healthcare: *a HSE Dialogue*

Session 3

Current Research, initiatives and moving forward.

Chair: Dr John Fitzsimons, Consultant at CHI, Temple St and Clinical Director for QI, NQPSD HSE

Building a Just Culture in Healthcare: *a HSE Dialogue*

Building a Safe & Just Culture: Lessons from other sectors

Professor Sam Cromie Director of the Centre for Innovative Human Systems in Trinity College Dublin

Professor Marie Ward, Human Factors researcher at St James's Hospital and Adjunct Assistant Professor at the Centre for Innovative Human Systems, Trinity College Dublin






Building a Safe & Just Culture: Lessons from other sectors

What contributes to a good Safety Culture?

HILAS
2005 - 2009

Lei Wang & Ruishan Sun (2014) development of James Reason model Safety Culture in HILAS

Aircraft Maintenance Spoiler Incident & Investigation

Influence of the customer on the investigation process

Double standard in the focus of the investigation

Double standard in the work

Problems with task performance

Blame culture

Contributions to human factors from three case studies in aircraft maintenance

OPEN ACCESS

SHARE

File Type:
PDF

Item Type:
thesis

Date:
2006

Citation:
Marie Ward, 'Contributions to human factors from three case studies in aircraft maintenance', [thesis], Trinity College (Dublin, Ireland). School of Psychology, 2006, pp 386

Download Item:

Ward TCD THESIS 8546 Contributions to.pdf **(PDF)** 286.9Mb

Functional System

Let's 'Get Serious Now'

Understanding functional system

..takes massive investment

Safety as property of all of the system (clinical, operational) – need to understand system

All make mistakes, all even possibly wilfully violate procedures – desire to be helpful, to navigate the system, work around the red tape

Best staff….WIPIDO

Inefficiencies anywhere in the system will impact safety issues and vice versa

Ergonomics

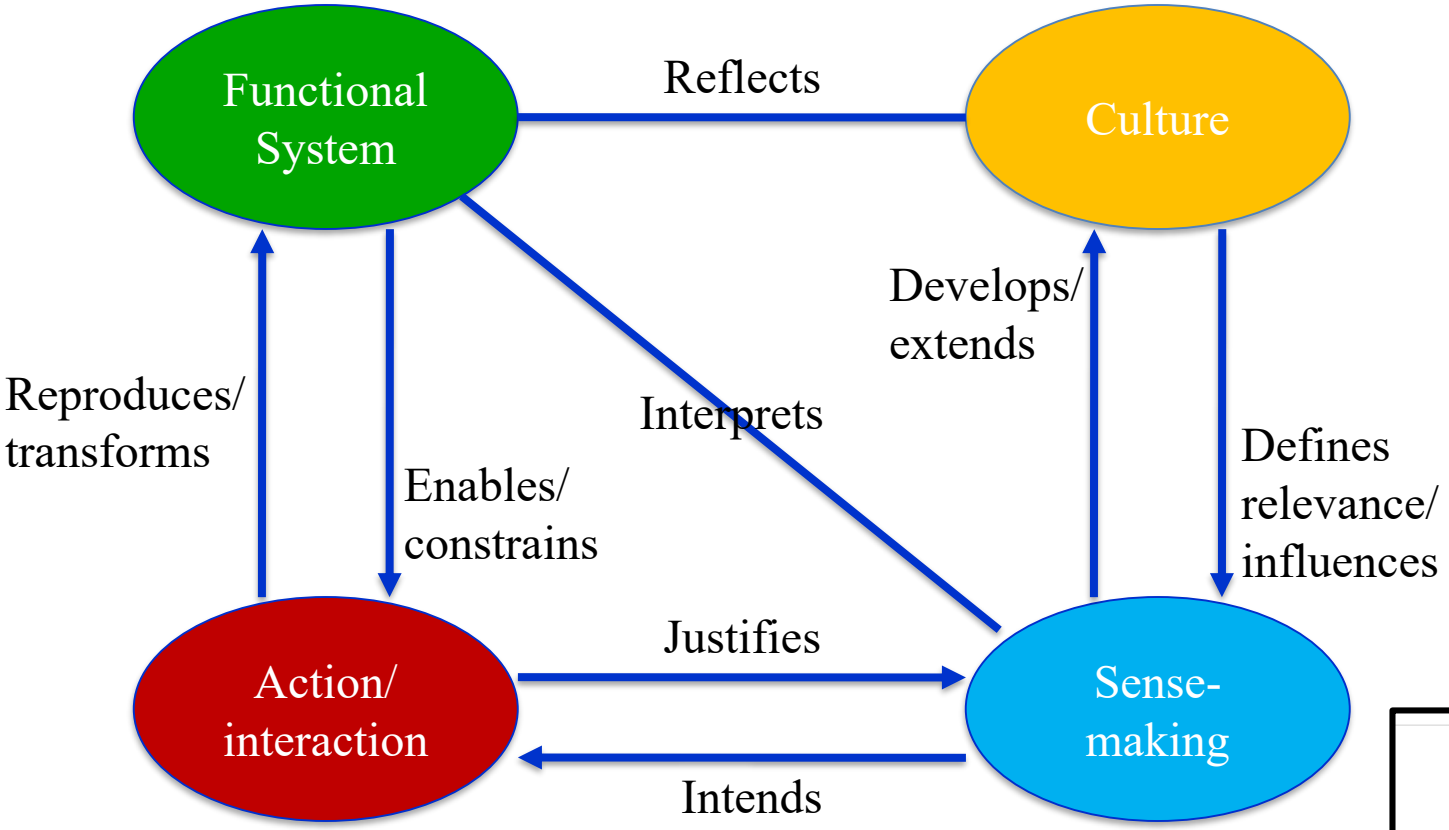
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/terg20

A performance improvement case study in aircraft maintenance and its implications for hazard identification

Marie Ward [a] , Nick McDonald [a] , Rabea Morrison [a] , Des Gaynor [a] & Tony Nugent [a]

[a] HILAS Project, Aerospace Psychology Research Group, School of Psychology, Trinity College Dublin, Republic of Ireland

Culture as one part of our system



Int J Environ Res Public Health. 2022 Jan 22;19(3):1246. doi: 10.3390/ijerph19031246.

A Case Study of a Whole System Approach to Improvement in an Acute Hospital Setting

Marie E Ward [1], Ailish Daly [2], Martin McNamara [3], Suzanne Garvey [2], Sean Paul Teeling [3 4]

Affiliations + expand

PMID: 35162269 PMCID: PMC8835196 DOI: 10.3390/ijerph19031246

Free PMC article

Sense-making

Different dialogues are needed

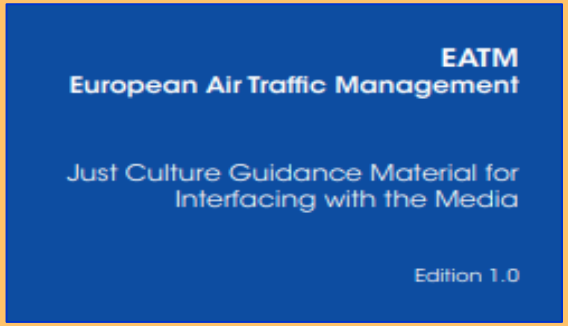
LEGAL SYSTEM & REGULATORS

EU Occurrence Reporting Legislation 2015 requires aviation organisations to adopt and maintain a proactive Just Culture to facilitate the collection of key safety data & information

MEDIA

CEO Danish Air Traffic Controllers
National TV 2000

"…it is essential that the press understand why the system does not immediately search for people to blame, but instead searches for the underlying cause" Eurocontrol, 2008



PATIENTS & CARERS, PUBLIC Understanding of Human Factors (HF) Citizens Assembly on HF in healthcare?

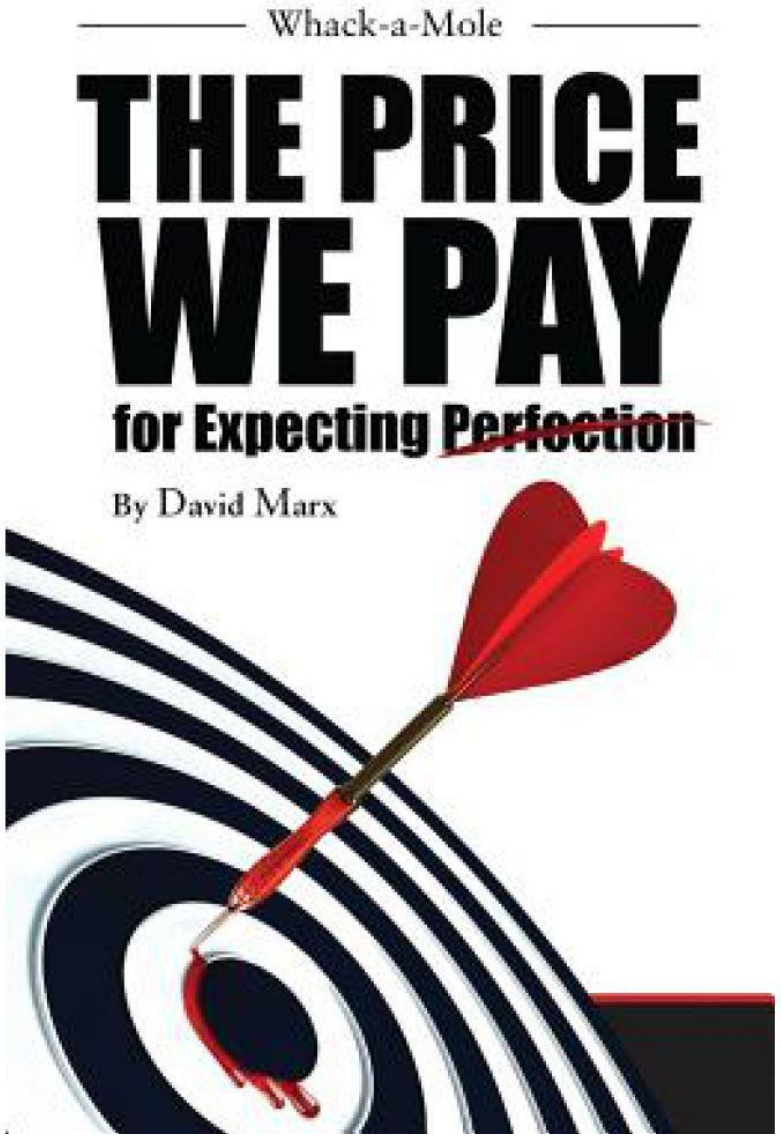
Action/ interaction

A Commitment to Learn and to Change

‘We are all fallible human beings, susceptible to human error and behavioural drift. As your employer, we must design systems around you in recognition of that fallibility. When errors do occur, you must raise your hand to allow the organization to learn’. (David Marx, 2009)

Importance of designing systems to support people

If staff do report mistakes, the organisation must act on those and commit to constantly changing and improving the system



Action/ interaction

Being in Right Relationship

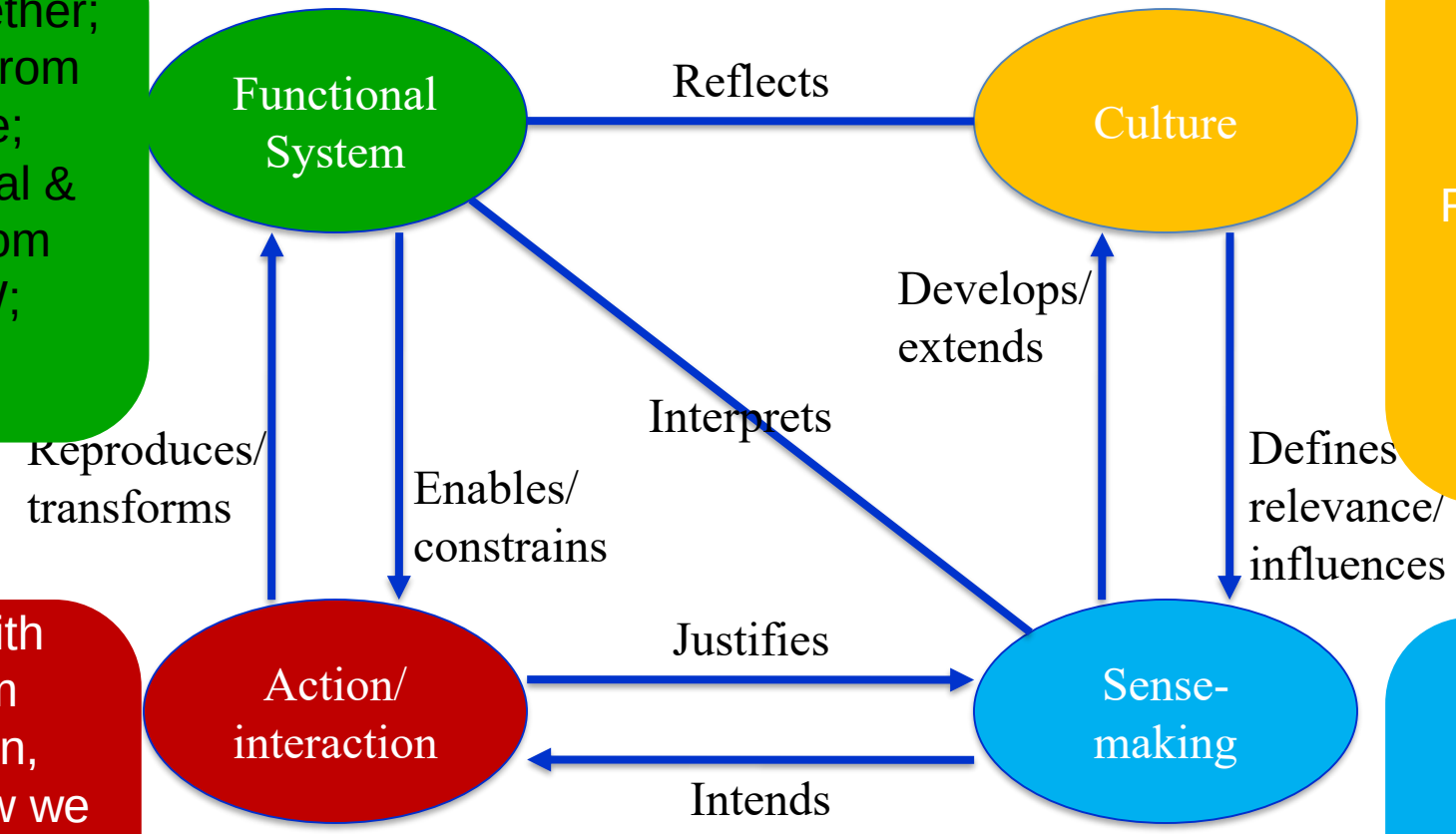
Justice might be the greatest, most complete, virtue because it guides individuals in "*their relations to their neighbour*" (Aristotle)

Justice for the individual is incomplete without comprehending what is justice for the community of individuals who are related to the issue. This is justice as right relationship.

What would it take for us as organisations, as individuals to be in right relationship with each other?

Culture is one part of our system

Understanding how processes come together; Designing systems from safety perspective; Understanding formal & normal; learning from Excellence/WWW; High Reliability Organisation



Understanding Safety Culture; Psychological Safety; Just Culture; Speaking up for Safety; Respect/Kindness/Civility; Transparency; Person-centred Culture; Shared Decision Making; Belonging

How we interact with each other - Team working, Simulation, Communication; How we interact with tools and technology, EPR; How we understand and measure our performance

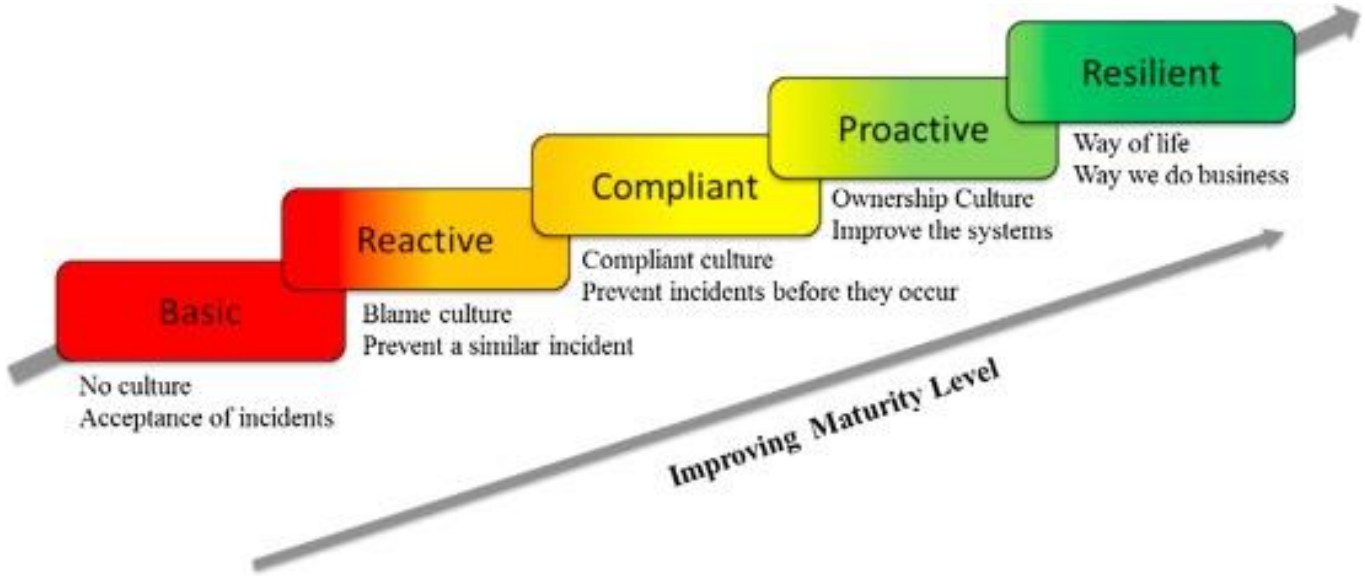
How we make sense of our world/work; Checklists - Risks & Benefits; Situational Awareness; Decision Making; Safety Huddles; From Data to Wisdom; Training and Education

Remember: Safety Culture in a journey

"Never start with the idea of changing culture. Always start with the issue the organisation faces…ask whether the culture aids or hinders the issue?

Always think of culture as your source of strength – it is the residue of your past successes. Even if some elements of your culture look dysfunctional…others continue to be strengths."

Edgar H. Schein (2009)



Safety Culture Maturity Model
Fleming et al., 1999

Just Culture and the shifting line in the sand

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Sam Cromie
Centre for Innovative Human Systems

PEOPLE
PROCESS
PERFORMANCE

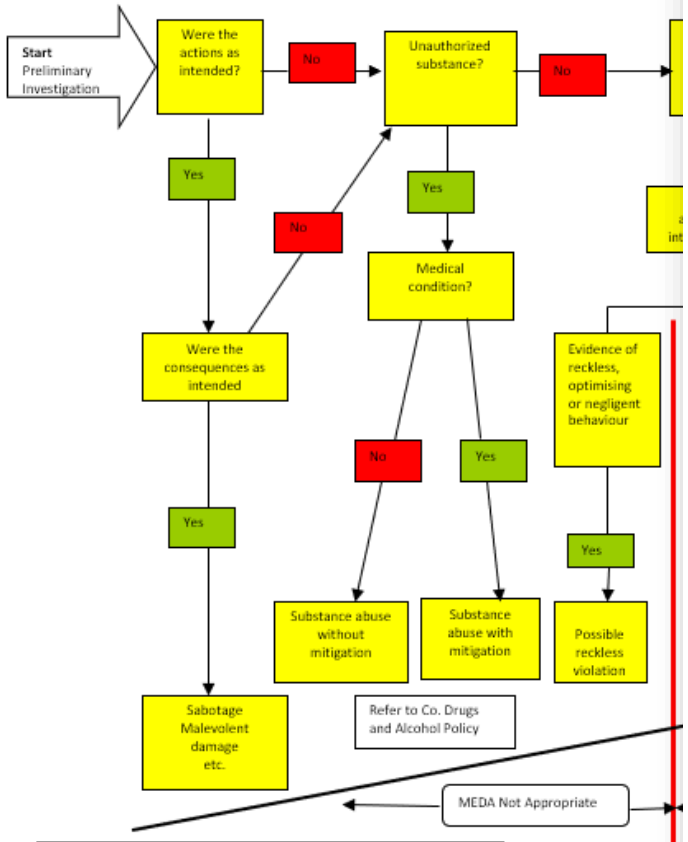
To blame or not to blame, that is the question…

Who should we blame, when and why?

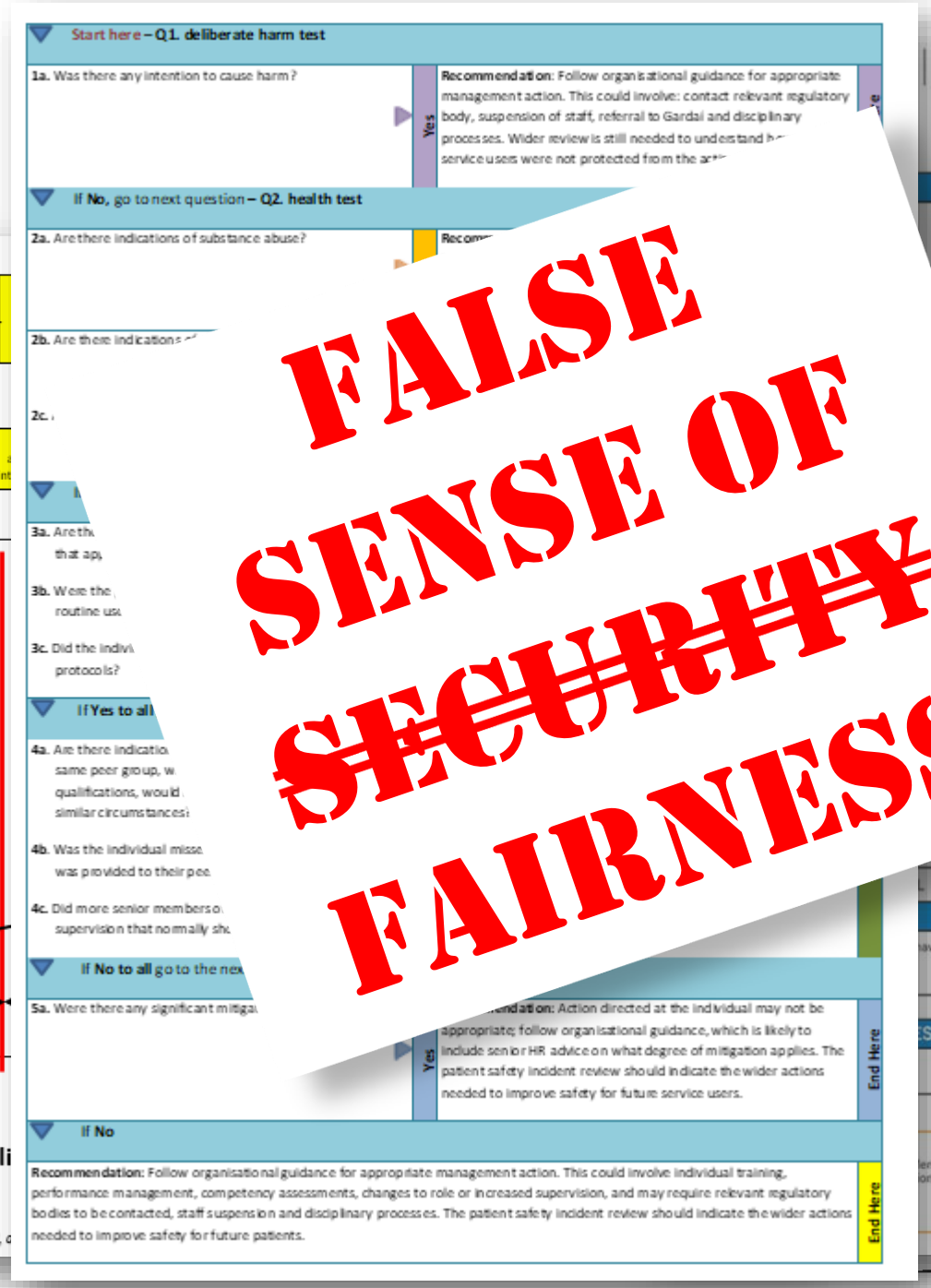
How do be blame them?

What discipline is appropriate?

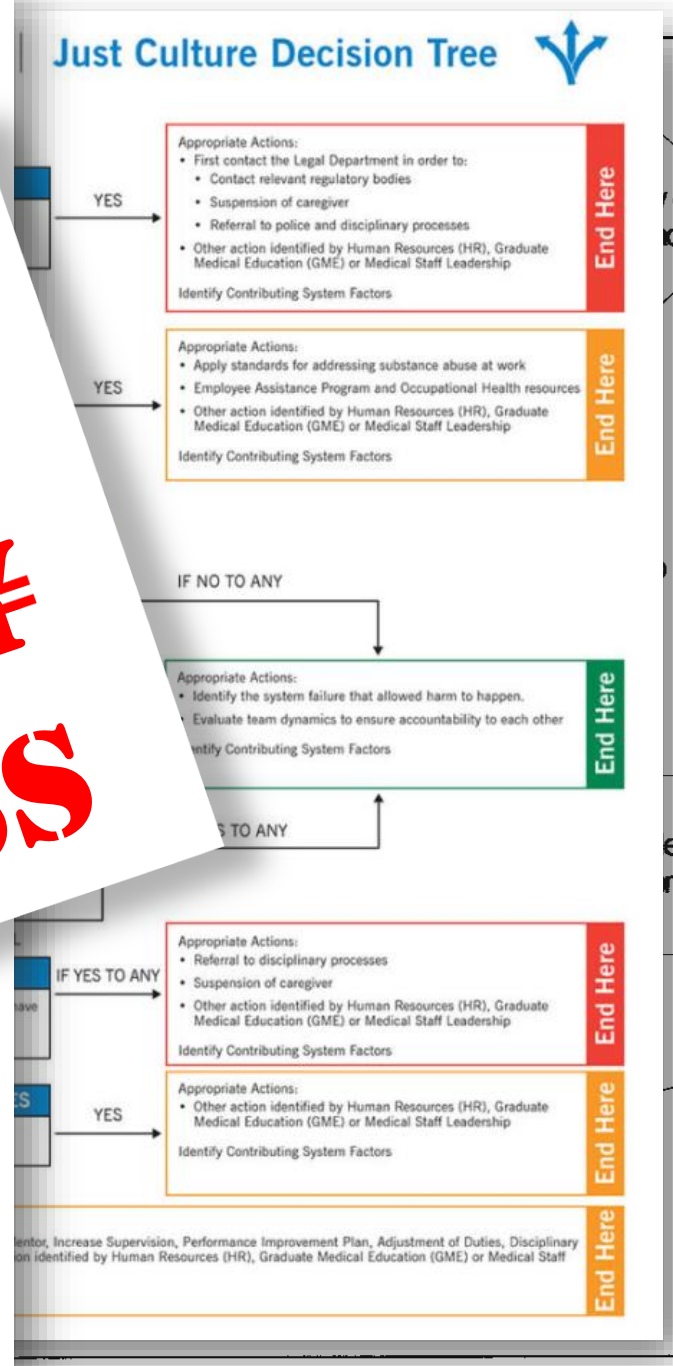
The Decision Tree Solution



Original source: Prof. James Reason, this version with permission of QANTAS Airlines Limited,



FALSE SENSE OF ~~SECURITY~~ FAIRNESS



The shifting line in the sand

The assumption is that it is possible to **consistently**, and with reasonable **objectivity**, analyse an incident and **determine culpability.**

“The problem is guidance that suggests that a just culture only needs to ‘‘clearly draw’’ a line between culpable and blameless behavior.

Its problem lies in the false assumption that acceptable or unacceptable behavior form stable categories with immutable features that are independent of context, language or interpretation”.
(Dekker, 2009 p.179)

Safety Science 86 (2016) 258–272

Contents lists available at ScienceDirect

Safety Science

journal homepage: www.elsevier.com/locate/ssci

Just culture's "line in the sand" is a shifting one; an empirical investigation of culpability determination

Sam Cromie *, Franziska Bott

Centre for Innovative Human Systems, School of Psychology, Trinity College Dublin, Ireland

An online survey asked 3136 aviation maintenance personnel from one company to judge the appropriate level of discipline in three incident scenarios. Five pieces of "mitigating" contextual information were subsequently presented per scenario and the participants given the opportunity to re-assess their response.

Scenario 3

George is a junior technician He carried out a task using an unapproved tool The part was damaged because the wrong tool was used. This cost the company $200,000

What level of discipline is appropriate for George?

No Discipline	Verbal Warning	Written Warning	Final Written Warning	Dismissal

Safety Science 86 (2016) 258–272

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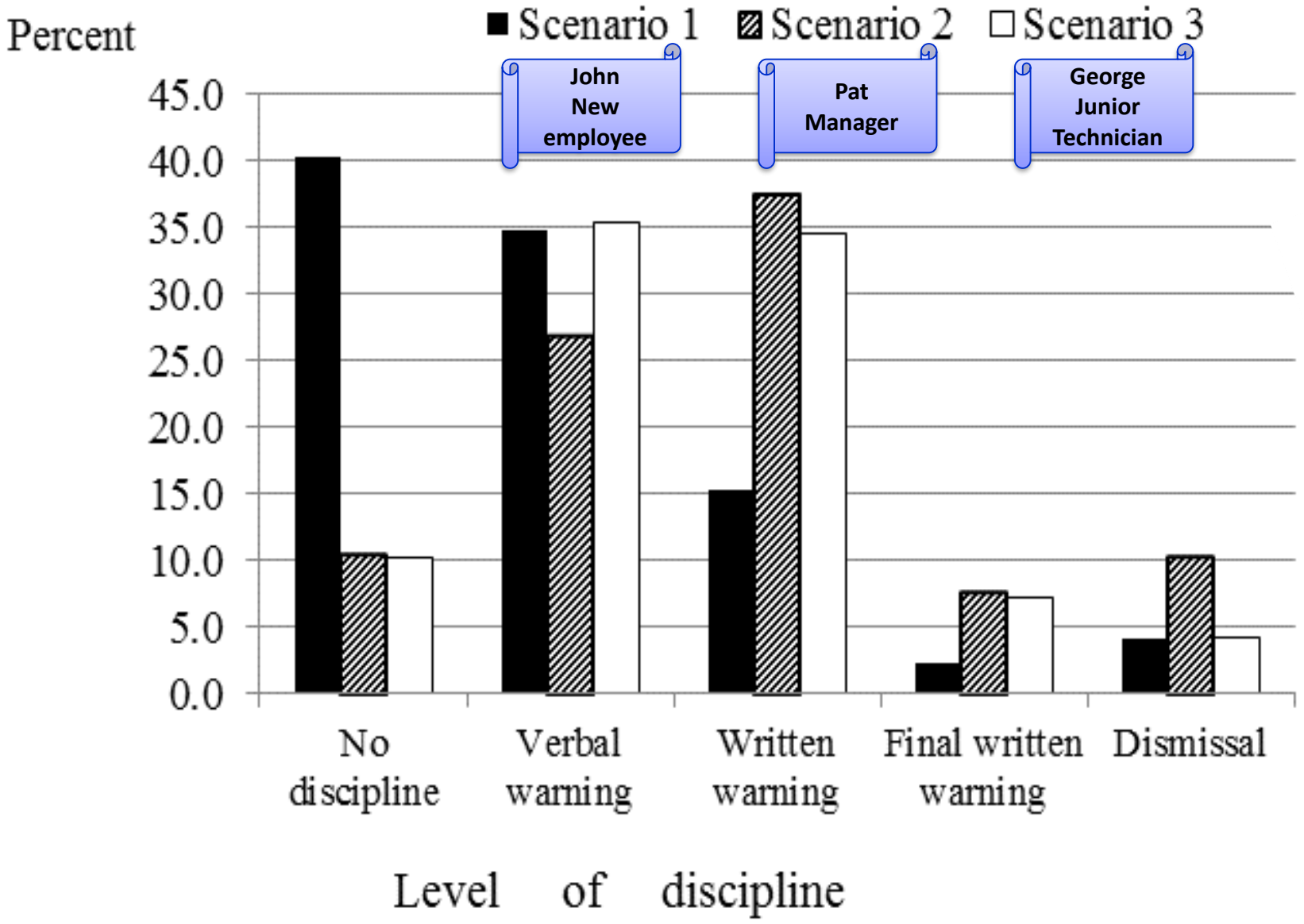
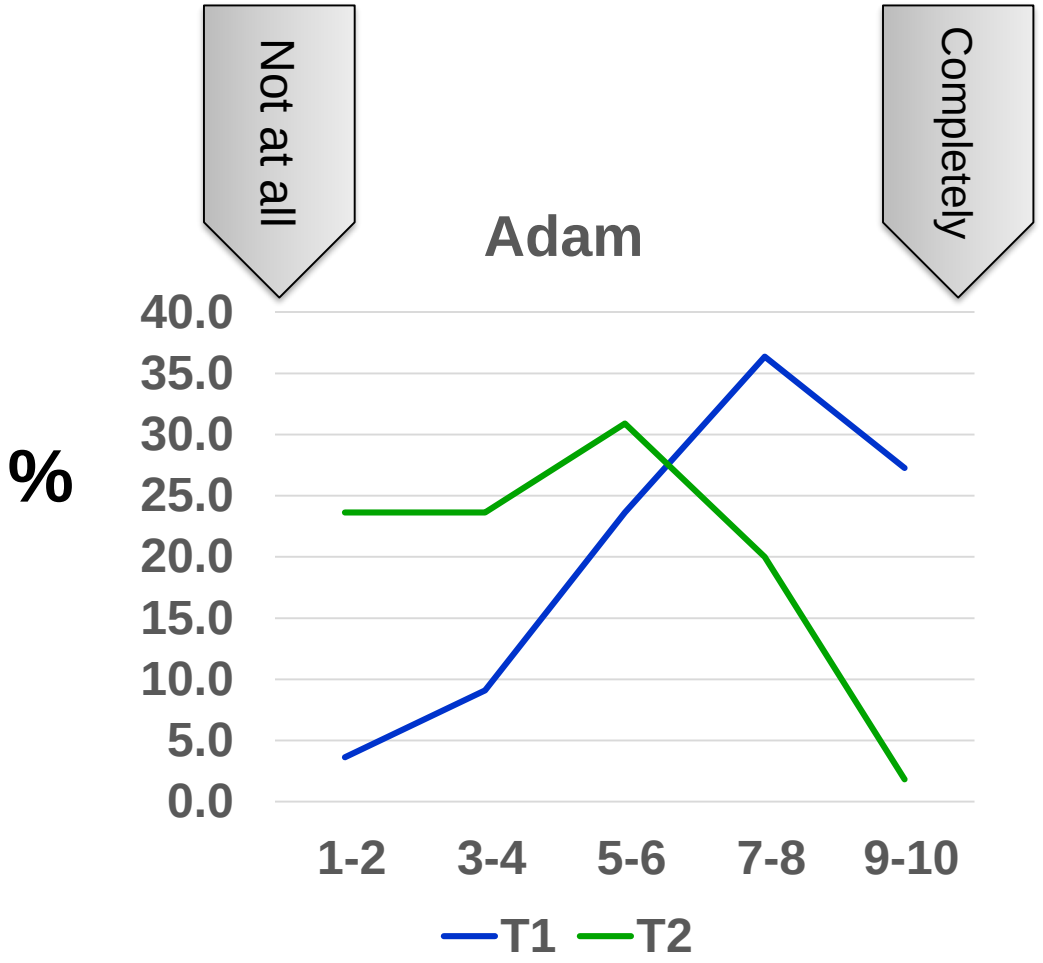
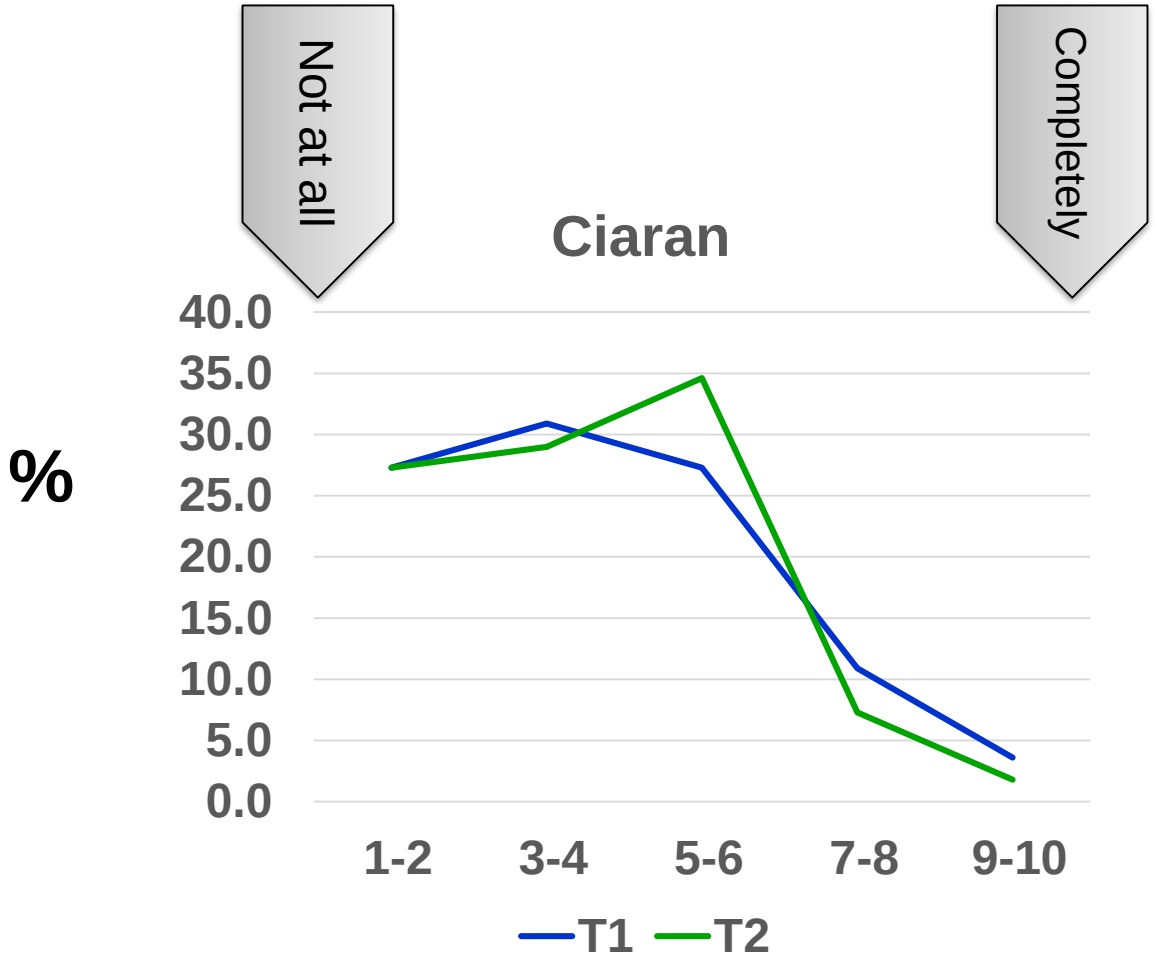


LARGE INDIVIDUAL VARIABILITY

How much are Adam / Ciaran to blame?





Scenario 3

George is a junior technician He carried out a task using an unapproved tool The part was damaged because the wrong tool was used. This cost the company $200,000

1. The correct tool is expensive and only one was kept in stock
2. The correct tool was being used in another unit and the wait to get the tool would have been one hour
3. George has seen his more senior colleagues frequently using the unapproved tool
4. The last words he heard from his manager before he went to a safety board meeting were “that task better be done when I get back”
5. That morning George got a letter from his Doctor to say that he needed to go for further tests on a small lump on his head

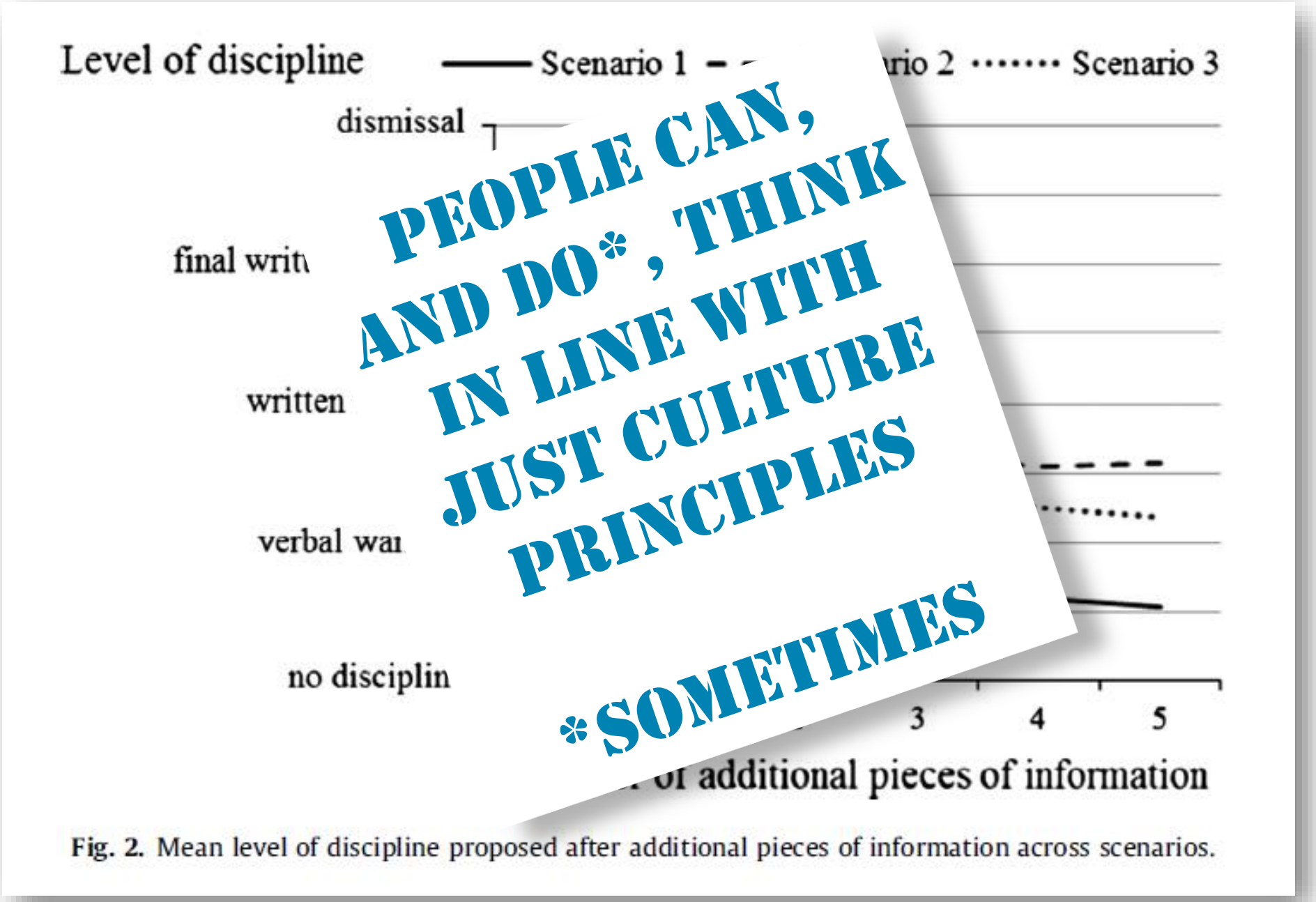
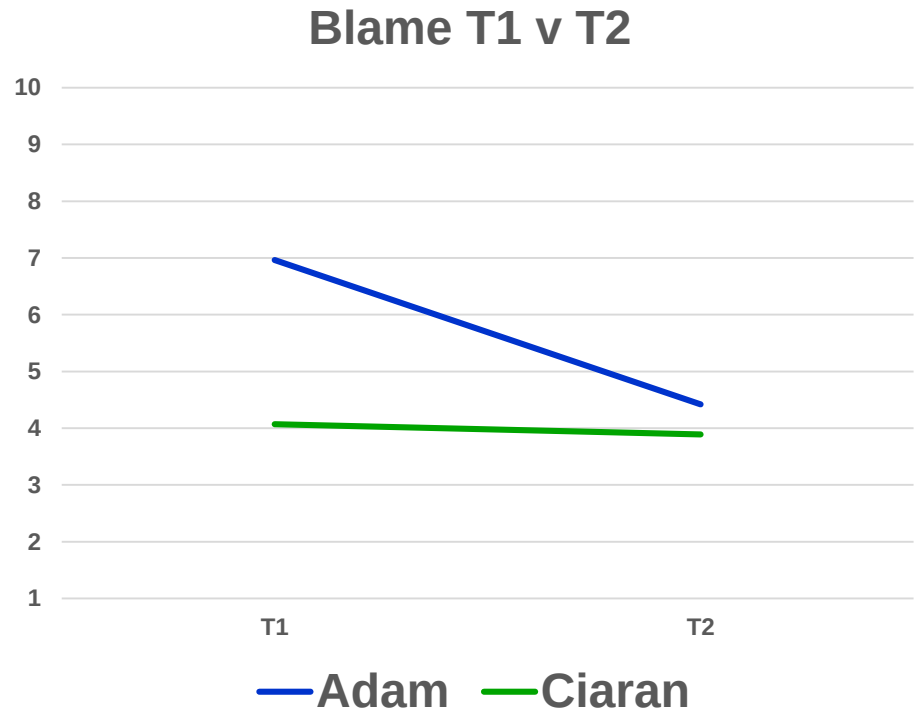
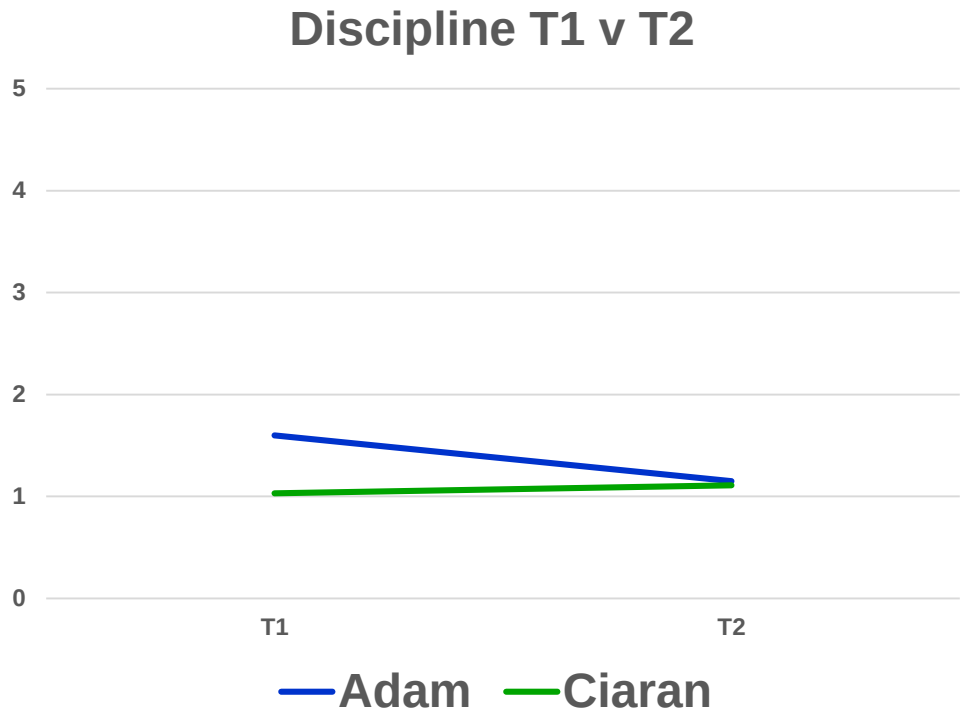
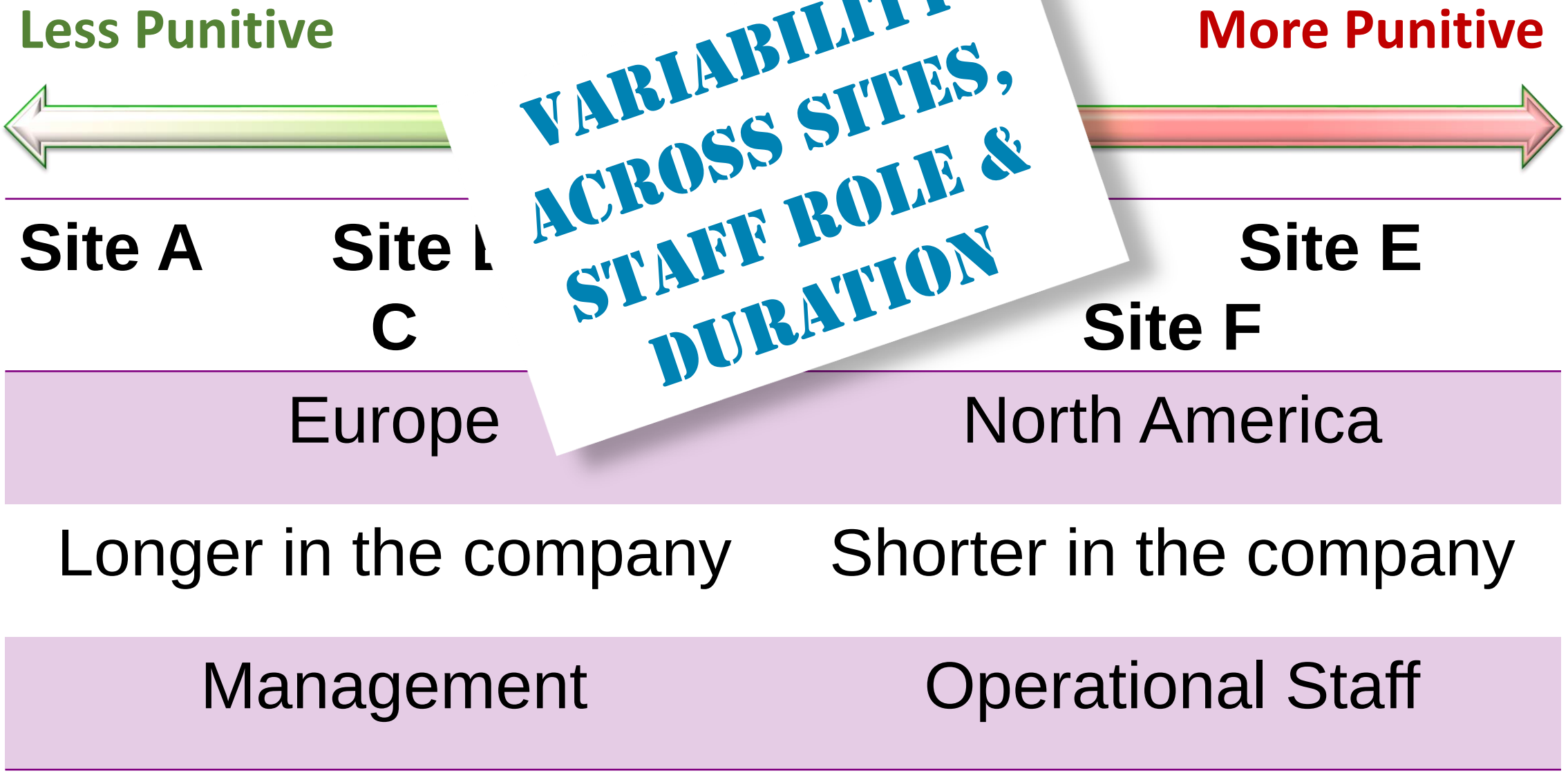


Fig. 2. Mean level of discipline proposed after additional pieces of information across scenarios.

Adam v Ciaran

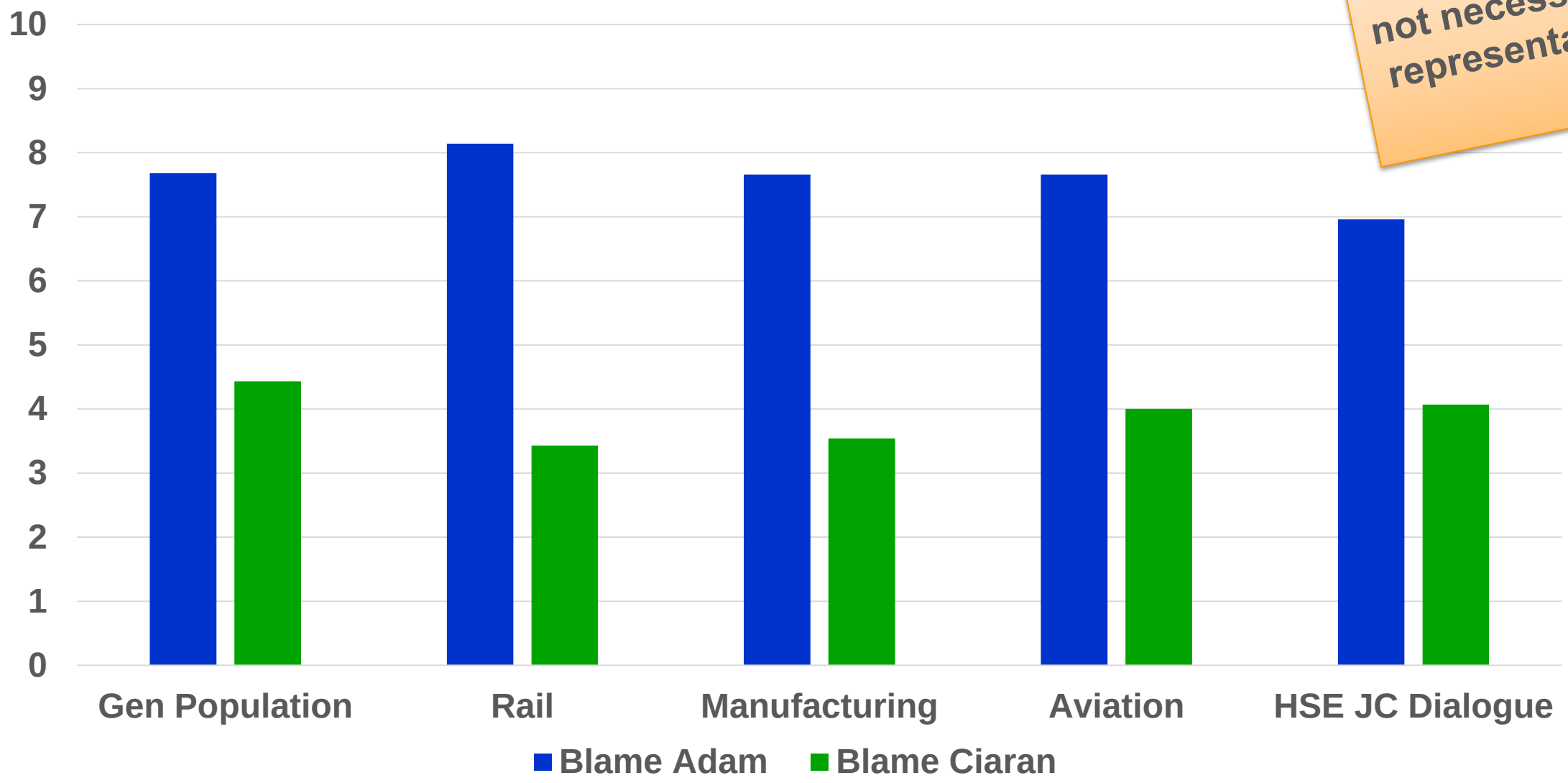




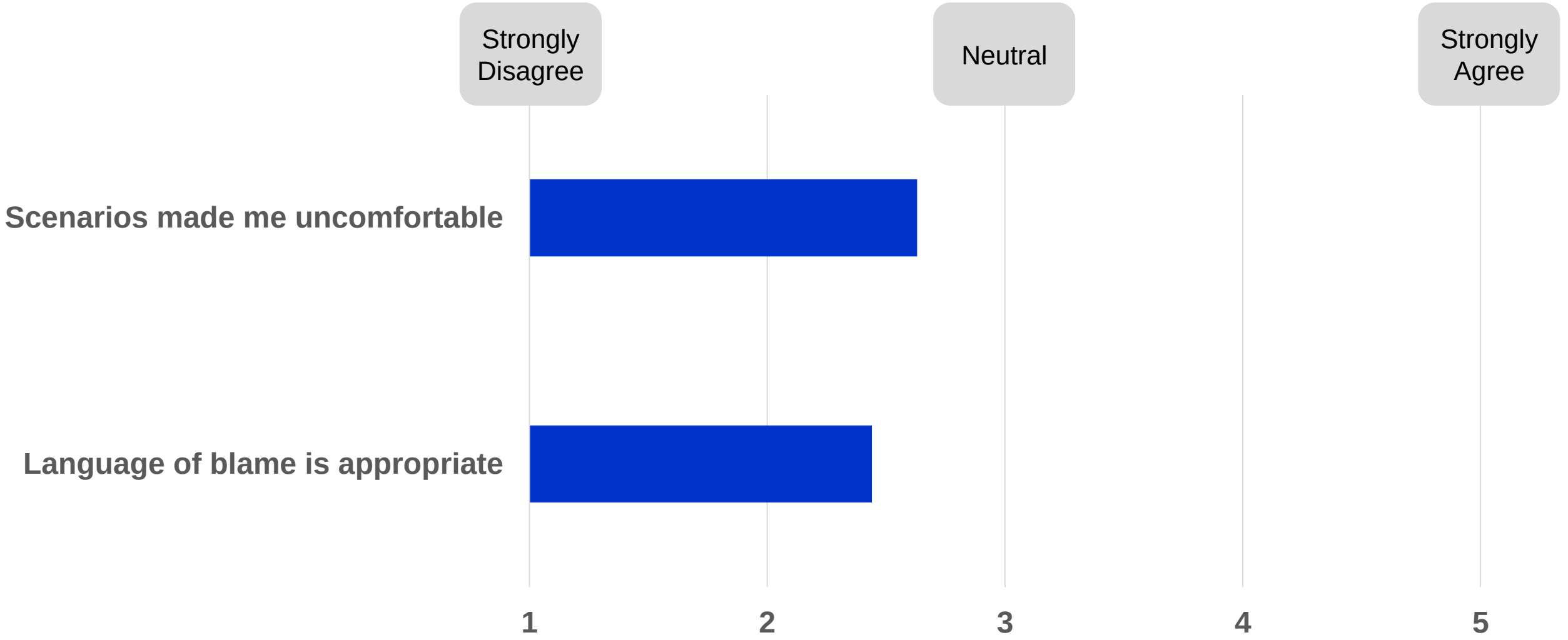

Less Punitive
More Punitive
VARIABILITY ACROSS SITES, STAFF ROLE & DURATION
Site A
Site B
Site C
Site E
Site F
Europe
North America
Longer in the company
Shorter in the company
Management
Operational Staff

Comparisons

Note: Samples not necessarily representative

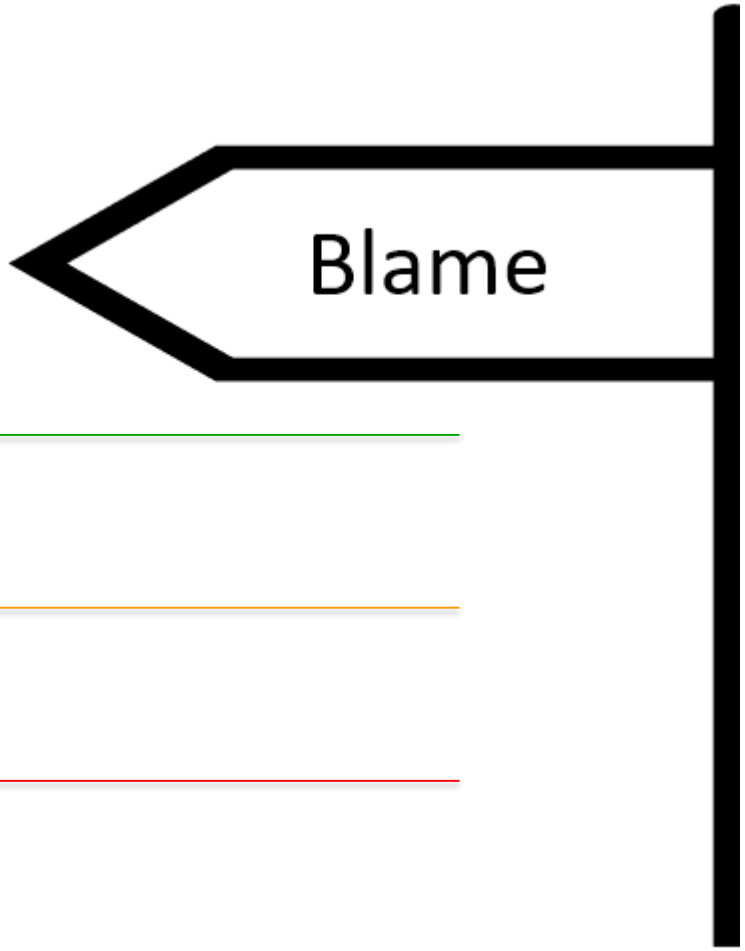


How did you feel about the scenarios?



Blame

Fairness



Knee-jerk response

Limited investigation

Simplistic Thinking

Group Think

Fundamental Attribution Error

I was trying to manage so many patients

I was sooo exhausted!

The two drugs were in such similar packages

The consultant was already annoyed at me for being slow

This was the first time I didn't double check

She is just sloppy

Fairness

- Considered response
- Thorough investigation
- Sophisticated Systems Thinking
- “In their shoes” exercise
- Principled decision making
- Restoration mentality

Incivility

Incivility

Blame

High power distance

Individualistic

Always rushing

Bullies unchallenged

Always-on

Competitiveness

Kindness the norm

Shared responsibility for success and failure

Time and space

Fairness

Collaborative decision making

Humility

Improvement mentality

Shared responsibility

Key question:

Leaving aside the just / restorative culture infrastructure, does your organisation push you towards fairness or blame?

Why might medical student empathy change throughout medical school? a systematic review and thematic synthesis of qualitative studies

Jeremy Howick[1*], Maya Dudko[1], Shi Nan Feng[2], Ahmed Abdirashid Ahmed[1], Namitha Alluri[3], Keith Nockels[4], Rachel Winter[1] and Richard Holland[1]

Howick et al. BMC Medical Education (2023) 23:270
https://doi.org/10.1186/s12909-023-04165-9

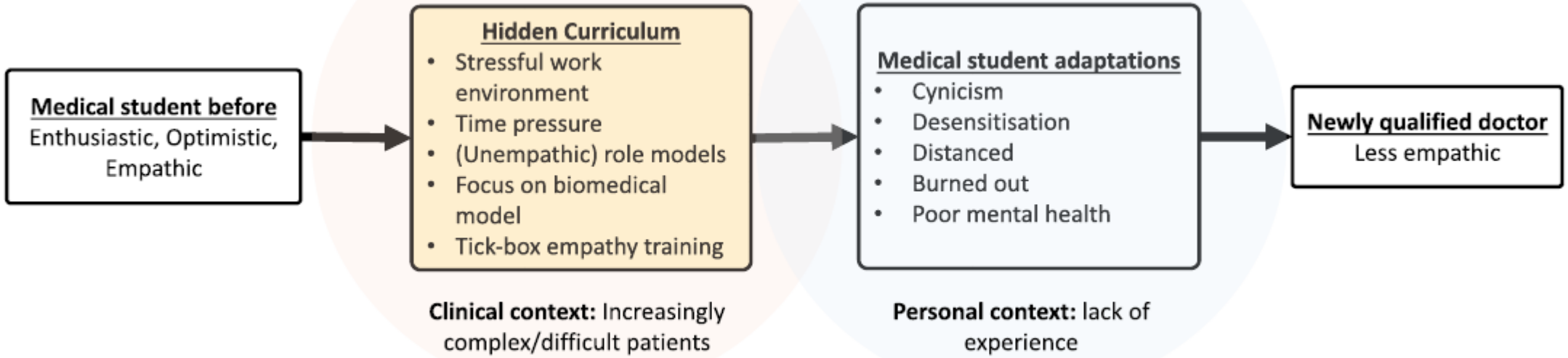


Fig. 2 Why empathy declines throughout medical school

Thank you!

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Centre for Innovative
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PEOPLE
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Building a Just Culture in Healthcare: *a HSE Dialogue*

We are not starting from scratch: current work in HSE to support a Just Culture

Ms Lorraine Schwanberg, Assistant National Director,

Dr Samantha Hughes

QPS Incident Management Team

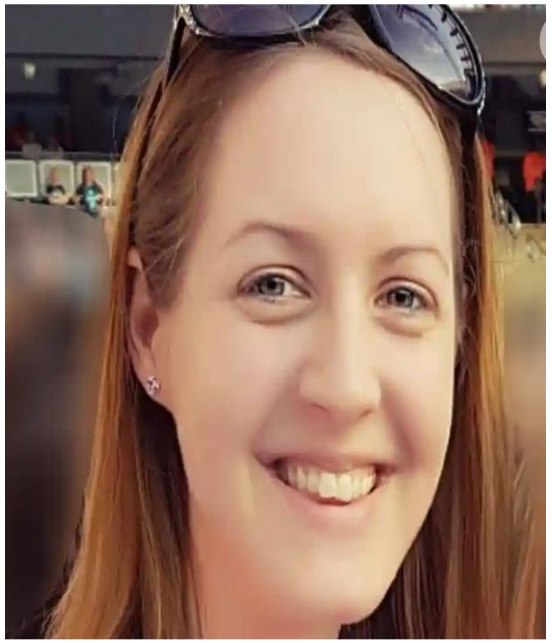
Building a Just Culture in Healthcare: *a HSE Dialogue*

"No Passion so effectively robs the mind of all its powers of acting and reasoning as fear"

Edmund Blake, 1756

Psychological Safety .. *A climate in which people are comfortable expressing and being themselves…When people have psychological safety at work, they feel comfortable sharing concerns and mistakes without fear or embarrassment or retribution. They are confident that they can speak up and won't be humiliated, ignored, or blamed. They know they can ask questions when they are unsure about something. They trust and respect their colleagues…mistakes are reported quickly so that prompt corrective action can be taken; seamless coordination is enabled, and potentially life changing ideas for innovation are shared.*

The Fearless Organisation: Creating Psychological Safety in the Workplace for Learning, Innovation and Growth. Amy C. Edmondson, Harvard Business School



So what are we currently doing in the HSE to implement a Just Culture in our organisation?

- *Not starting from scratch – much work already underway*
- *Recognition that this is a journey - a never ending and dynamic journey*
- *Lots of innovation and creativity*
- *Increasing Patient and Service User involvement & partnership*
- *Acknowledgement that moving forward requires collaboration and coordination of all efforts, bravery and leadership*

From Poster Display:

- Implementation of a just and fair culture in St. John's Hospital by focusing on the systems approach within the Incident Management Framework
- Creation of a bespoke support programme for frontline workers affected by adverse events in ULHG.
- Development of a mechanism for direct engagement with service users and family members/carers in Galway/Roscommon Mental Health Services, Community Healthcare West.
- Enhancing the understanding and involvement of nurse practitioners in patient safety by clarifying patient safety concepts within everyday nursing practice (University of Limerick study).

From Poster Display:

- HSE Mid-West Community Healthcare: Development of a resource pack to assist the Staff Liaison Persons to provide practical assistance to staff affected by serious incidents.
- Wexford General Hospital: Implementation of education sessions and supports for staff involved in incidents
- Evidence to support the implementation of a treatment escalation plan in to the adult acute healthcare sector to improve experience and outcomes
- Exploring a Safety Culture and Just Culture in an Intensive Care Unit (ICU) in St. James's Hospital, Dublin
- Investigation in to midwives' personal conceptualisations of longevity and resilience, identify modifiable workplace factors, inform policy & practice to improve retention

NQPSD:

- Reconfiguration of the **National Quality and Patient Safety Directorate**. The goal of NQPSD is to work in partnership with HSE operations, patient representatives and other internal & external partners to improve patient safety and the quality of care.

NQPSD

- Patient Safety Strategy
- Incident Management Framework – systems approach/learning from NIMS
- Human Factors approach – education and support
- Just Culture
- Open Disclosure Support and Webinars
- Introducing Restorative Practice
- Prospectus of Education and Learning Programmes
- National Centre for Clinical Audit
- QPS Talktime
- Quality Improvement tools and support
- Common causes of harm
- Research (ICAARE)

Open Disclosure

- Ensure that the impact of patient safety incidents on patients/service users, their relevant person and staff is recognised and managed in a caring, supportive and compassionate manner.
- ASSIST ME resource on open disclosure website which includes contact lists of supports
- Employee Assistance Programme/Critical Incident Stress Management/Occupational Health Service

PartientSafetyTogether@hse.ie

Patient Safety Digest
Listing of recently published QPS journal articles & reports relevant to anyone with an interest in improving patient safety.

Patient & Staff Stories
Learning from the experience of Patients/Service Users & Staff through stories and videos

Patient Safety Together:
learning, sharing and improving

HSE National Patient Safety Alerts
High priority communications requiring services to take specific action(s) to strengthen patient safety

Patient Safety Supplements
Sharing relevant QPS information in a timely way for learning purposes

Patient Safety Community
National community hosted by 'Q' to enable staff working in QPS to share learning and to provide peer support and networking opportunities

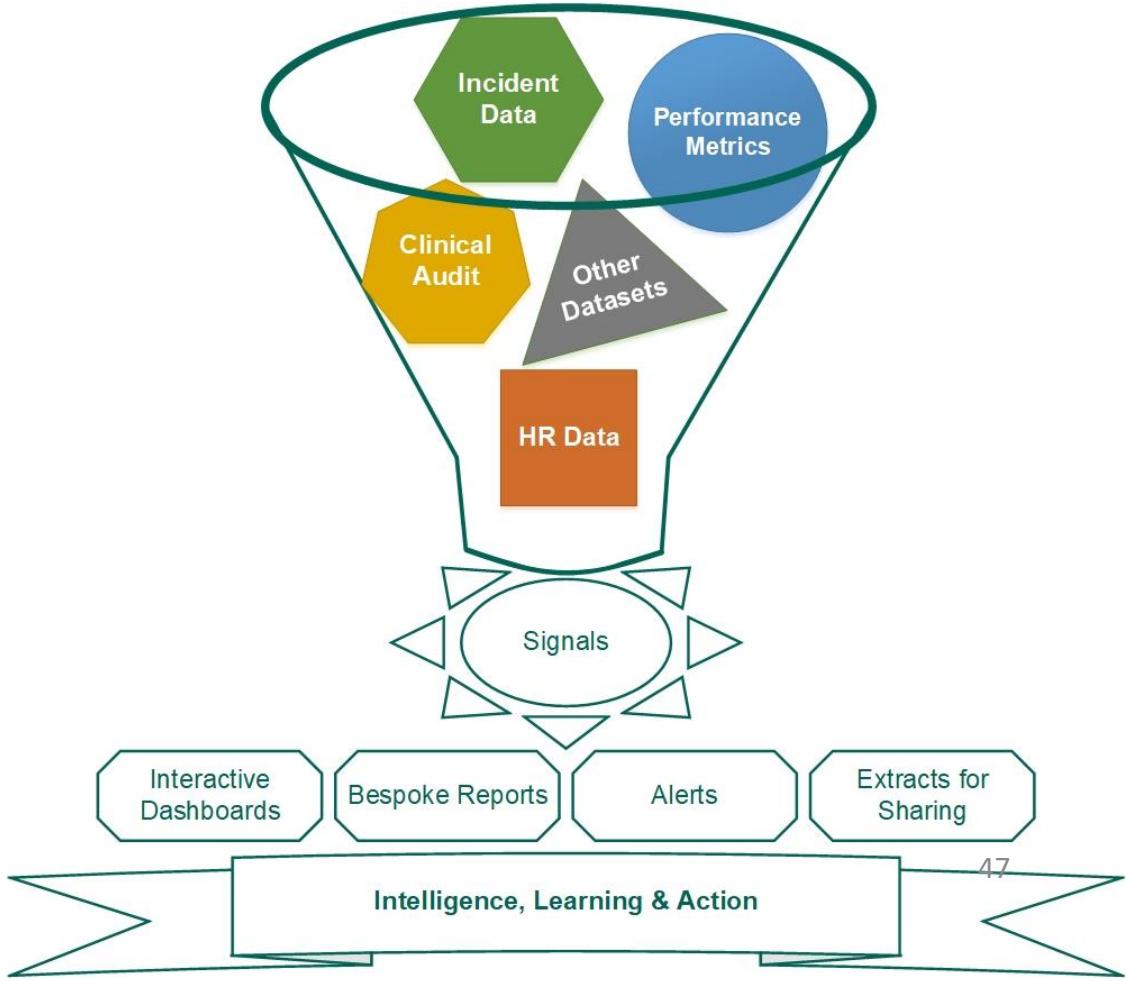
Quality and Safety Signals

National Women & Infants Health Programme

Purpose

Provide an online system that optimises the use of available data for patient safety surveillance and quality improvement

The Quality and Safety Signals Programme has commenced development with a Sláintecare funded proof of concept in Maternity Services (Jan '23 – Dec '24), in partnership with the National Women and Infants Health Programme



Partnerships

- Patient and Public Partnership Strategy 2019-2023 (National Screening Service)
- National Patient Representative Panel
- Patients for Patient Safety Ireland
- Representatives on many project groups and working groups
- Two patient partners on the management team of NQPSD
- More to do…….

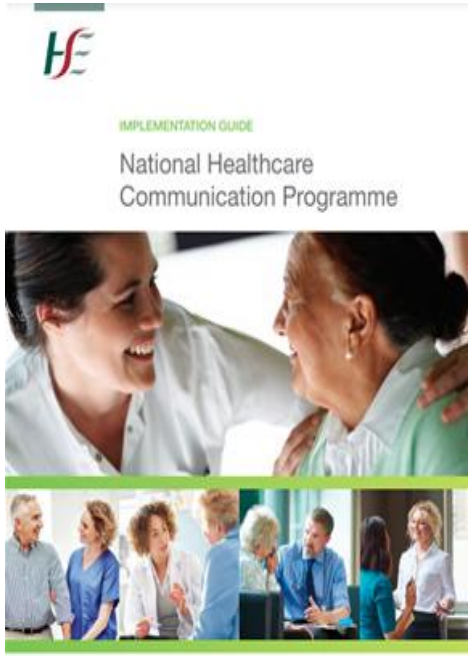
National Healthcare Communications Project

The National Healthcare Communication Programme is designed to support healthcare staff to learn, develop and maintain their communication skills with patients, their families and with colleagues. The Programme is underpinned by the Core Values of Care, Compassion, Trust and Learning and builds on these values with a focus on Person-Centred and Clinical Communication Skills.

For more information contact winifred.ryan@hse.ie,

https://www.hse.ie/eng/about/our-health-service/healthcare-communication/

Follow on Twitter and Instagram @NHCProgramme



Situational Awareness for Everyone, SAFE

National Quality and Patient Safety Directorate
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Oifig an Phriomhoifigigh Cliniciúil

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

SAFE Situation Awareness For Everyone

6-month collaborative patient safety education programme facilitated by RCPI

Applications open now until 8 June 2023 for new cohort of SAFE Collaborative, funded by HSE NQPSD for clinical teams.

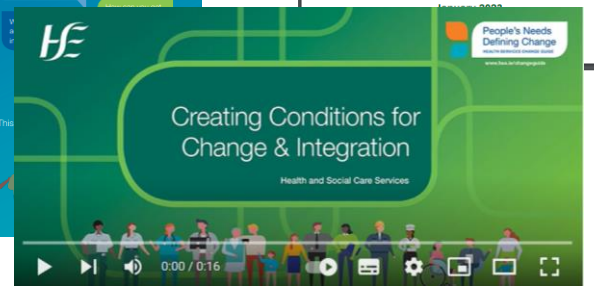
Multidisciplinary teams of 4 from frontline healthcare

Marries the theory of prediction with the Irish early warning tools

Improve safety, communicate effectively, heighten recognition & response in your setting

Implement or improve a bespoke patient safety huddle

- Values in Action, Culture and Engagement, National HR
- Developing Organisational Culture, a Guide for the Health Service, Engagement and Culture Team, National HR
- People's Need Defining Change, HSE Change Guide, National HR
- Trust and Confidence in the HSE, HSE Communications
- HSE Staff Survey



HSE Just Culture Working Group - Just Culture Framework

The NHS Improvement Academy (https://improvementacademy.org/our-networks/just-culture-network.html)

Just Culture - HSE.ie

New Developments: Regional Health Areas

Vision

RHAs will function as part of a strengthened regional health and social care service, with their own budget, leadership team, and increased local decision-making

RHA patient benefits include:

- care closer to home
- services based on the region's population
- consistent quality of care
- patient involvement in their own care and treatment
- strengthened governance and accountability

Sláintecare and RHA objectives include:

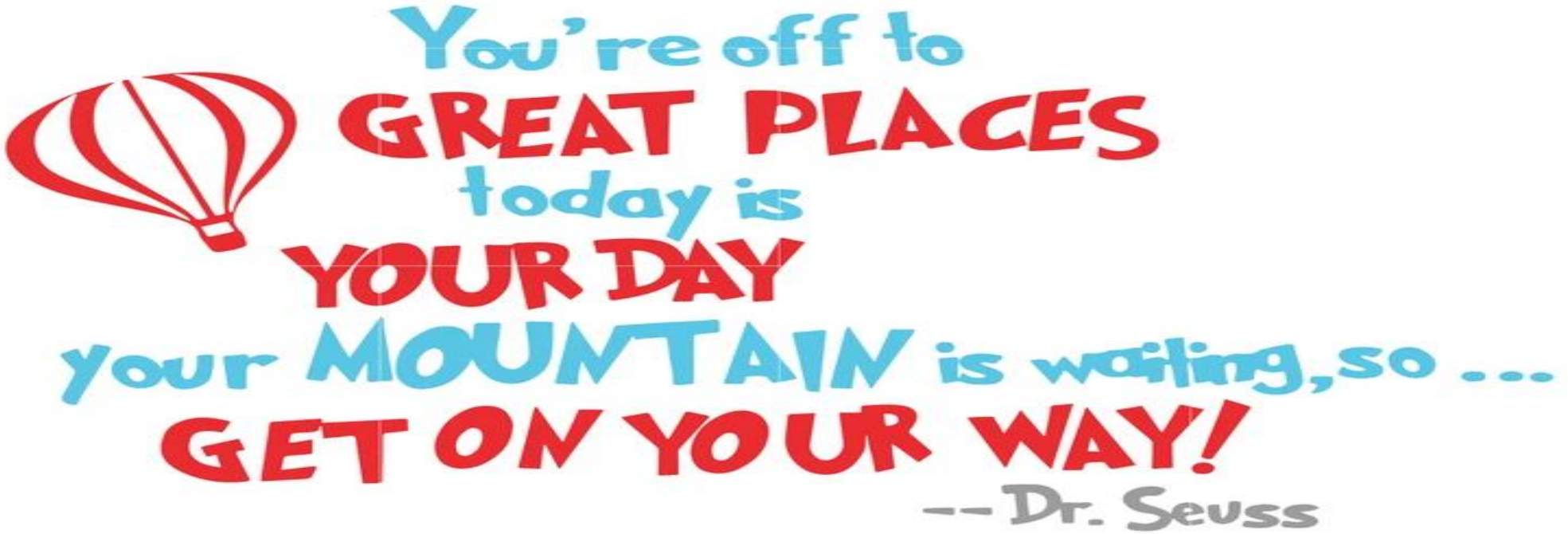
- improving access and performance
- ensuring timely implementation
- building public confidence

.

And so much more…..

- What is happening in your area?
- How can we join up all this work?
- What can you do to implement a Just Culture in your service?

QPSIM@hse.ie


You're off to
GREAT PLACES
today is
YOUR DAY
your MOUNTAIN is waiting, so ...
GET ON YOUR WAY!
-- Dr. Seuss

Thank you

Building a Just Culture in Healthcare: *a HSE Dialogue*

Mr Bernard Gloster
CEO, HSE

Building a Just Culture in Healthcare: *a HSE Dialogue*

Interactive Dialogue: How do we implement Just Culture and what needs to happen next?

Building a Just Culture in Healthcare: *a HSE Dialogue*

Poster Awards and Closing remarks

Dr Orla Healy, National Clinical Director of Quality and Patient Safety, NQPSD, HSE

Building a Just Culture in Healthcare:

a HSE Dialogue

Croke Park Conference Centre, Dublin

23rd May 2023

Thank You