Creating A Just Culture A Nurse Leaders Guide

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Creating A Just Culture A

Enterprises are increasingly moving online as part of the process of digital transformation. Migrating to the cloud makes it easier to deploy and manage new capabilities to meet business needs, ...

Creating A Cloud-Based Culture Of Security In Modern Enterprises

Much has been said and written over the years about how critical values are in creating corporate identity, and importantly, culture. They are the guiding "why" for companies and the promise made to ...

The Secret to a Strong Company Culture Is Creating Success Criteria
There are already at least three areas where artificial intelligence can easily support a more empathetic workplace environment.

How AI can help create a more caring company culture
Little Black Book, As 2020 saw a huge transformation at Tag, we speak to the leaders who gave young women a senior team to look up to and get their advice on what our industry needs to do to nurture n ...

'Don't Let Them Get Left Behind': Meet The Women at Tag Who Took 'Boy's Club' Culture Out of The Equation
Just because you may not be seen as a fit for one workplace situation does not rule out that you may be the ideal fit for another.

Workplace culture: Can I be fired for not fitting in? Ask HR
Little Black Book, After coming out on top at Cannes Lions, The One Show and D&AD, AMV BBDO's CCO Alex Grieve tells LBB's Alex Reeves about the factors that contributed to the London agency's current ...

The People. The People. The People: How AMV BBDO's Agency of the Year Triple Is About More than Just the Work
As federal agencies adapt to hybrid operating models, agency and IT leaders will need to consider more than whether the videoconferencing tools work.

Technology Inclusivity, Maintaining Culture Will Factor into Feds' Shift to Hybrid Work
No matter how the establishment media likes to portray things, it is the Left, not conservatives, that is mounting an aggressive and transgressive culture war, against which Middle America reacts only ...

Why Middle America is resisting the Left's culture war
It's the inflamers, the arsonists who are responsible for the "war" part of the culture war. Yes, the scores of millions of people who create cultural change in the daily comings and goings of their ...

Who's Actually Responsible for the "Culture War"?
The second installment of a new safety webinar series from the editors of Heavy Duty Trucking will explore how fleets can implement

practices that maintain a driver’s commitment to a fleet’s safety ...

Upcoming Webinar to Cover What It Takes to Create Safe Drivers

Tahmima Anam's new novel is about a married couple who found a tech startup. The platform's success turns the husband into a messiah figure — even though it was his wife who designed it.

'Startup Wife' Satirizes Tech Culture And Boardroom Sexism — From Experience

Bookmark Indy’ highlights Hoosier literary culture INDIANAPOLIS (WISH) — A local nonprofit is working to highlight literary culture in Indianapolis — “Bookmark Indy.” Lauren Schregardus, an ...

Indianapolis Moms: ‘Bookmark Indy’ highlights Hoosier literary culture

"What can an efficient, confidence-building salon do for women who look like me? That's my 'why," White told CNN. "That's the drive. I'm just so excited to be a revolution in haircare." It's a ...

These women are creating blow dry salons for women with textured hair

One summer night in August, 1935, a young Soviet miner named Alexei Stakhanov managed to extract 102 tonnes of coal in a single shift.

This was nothing short of extraordinary (according to Soviet ...

How a Soviet miner from the 1930s helped create today's intense corporate workplace culture

Shows like Jason Sudeikis' "Ted Lasso," "Mare of Easttown" and "WandaVision" get a lot of buzz but they don't have huge audiences.

The TV hit isn't just dying — it may already be dead, along with our common culture

Tinker Hatfield, longtime Nike designer and one of the most influential figures in the sneaker scene over the last 40 years, has found a new way to bring his creativity to the basketball world but ...

Legendary designer Tinker Hatfield discusses revolutionary impact on sneaker culture, latest projects

Richard Donner helped define or create the modern superhero movie, the modern action film, the prestige horror flick and the YA adventure picture.

How Richard Donner's Most Famous Movies Helped Create Modern Pop Culture

Bathscaping – ever heard of this term? We hadn't either, until quite recently. This is also one of those picturesque Instagram micro trends that you just can't get enough of! It seemed to have emerged ...

Bathscaping 101: Bath accessories and styling to create your own zen haven

The Navy's surface warfare community is weighed with a culture that values administrative chores over training to fight, ship commanders that are micromanaged and an aversion to risk, according to a ...

Lawmakers Survey: 94% of Sailors Say 'Damaging Operational Failures' Related to Navy Culture, Leadership Problems

There are already at least three areas where artificial intelligence can easily support a more empathetic workplace environment.

Creating a Just Culture: A Nurse Leader's Guide Vivian B. Miller, BA, CPHQ, LHRM, CPHRM, FASHRM Step-by-step guidance to create and sustain a just culture at your facilityThis practical resource explains the process of creating and sustaining a just culture in which staff members are encouraged to report adverse events to improve quality

care. You ll get sure-fire strategies to gain buy-in from leadership, improve employee satisfaction, and turn mistakes and near-misses into useful data to improve processes and reporting. Help your nurses understand it s not the who but the what that went wrong. This book will help you: Overcome potential roadblocks to culture change with successful strategies from accomplished patient safety, risk, and nursing experts Motivate staff to report adverse events Discover how a just culture increases patient safety, nurse satisfaction, and retention Evolve your current culture into a just culture using the easy-to-understand, step-by-step instructions You also receive helpful tools such as: Sample timeline for just culture implementation Just culture policy from a leading hospital Staff education checklist Take a look at the table of contents Chapter 1: Why a Just Culture? National Emphasis on Patient Safety Avoiding Toxic Work Environment Your Professional Duty Why Staff and Patients Should Care Enhancing Recruitment Retaining Staff Get Ahead with Public Reporting Chapter 2: Assess Your Organization Policy and Procedure Mandatory Reporting Policy and Regulation Assess Your Staff s Knowledge Undertake a Cultural Assessment Chapter 3: Plan the Change Leverage Current Strengths Identify Stakeholders Identify Champions Establish Symbols of Change Chapter 4: Identify Desired Outcomes Increasing Occurrence Reporting Reporting New Errors Open

Discussions of Change Use of FMEA Chapter 5: Implementation Strategies Provide Training Supporting Errors Occurring Within Your New Culture Emphasizing Values of Courage, Honesty, and Integrity Teaching Peers To Support and Comfort Streamlining Error Reporting Chapter 6: Evaluate the Change Benchmarking Within and Outside of Your Organization Resurveying Your Hospital Monitoring Your Progress Chapter 7: Case Scenarios and Expert Advice Chapter 8: Weighing Ethical Decisions Cultural Barriers to Disclosure Items to Include in Disclosures Who Should Disclose Exceptions to Disclosure "

While many organizations see the value of creating a just culture they struggle when it comes to developing it. In this Second Edition, Dekker expands his views, additionally tackling the key issue of how justice is created inside organizations. Dekker also introduces new material on ethics and on caring for the' second victim' (the professional at the centre of the incident). Consequently, we have a natural evolution of the author's ideas.

Building on the success of the 2007 original, Dekker revises, enhances and expands his view of just culture for this second edition, additionally tackling the key issue of how justice is created inside organizations. The goal remains the same: to create an

environment where learning and accountability are fairly and constructively balanced. The First Edition of Sidney Dekker's Just Culture brought accident accountability and criminalization to a broader audience. It made people question, perhaps for the first time, the nature of personal culpability when organizational accidents occur. Having raised this awareness the author then discovered that while many organizations saw the fairness and value of creating a just culture they really struggled when it came to developing it: What should they do? How should they and their managers respond to incidents, errors, failures that happen on their watch? In this Second Edition, Dekker expands his view of just culture, additionally tackling the key issue of how justice is created inside organizations. The new book is structured quite differently. Chapter One asks, 'what is the right thing to do?' - the basic moral question underpinning the issue. Ensuing chapters demonstrate how determining the 'right thing' really depends on one's viewpoint, and that there is not one 'true story' but several. This naturally leads into the key issue of how justice is established inside organizations and the practical efforts needed to sustain it. The following chapters place just culture and criminalization in a societal context. Finally, the author reflects upon why we tend to blame individual people for systemic failures when in fact we bear

collective responsibility. The changes to the text allow the author to explain the core elements of a just culture which he delineated so successfully in the First Edition and to explain how his original ideas have evolved. Dekker also introduces new material on ethics and on caring for the' second victim' (the professional at the centre of the incident). Consequently, we have a natural evolution of the author's ideas. Those familiar with the earlier book and those for whom a just culture is still an aspiration will find much wisdom and practical advice here.

A just culture is a culture of trust, learning and accountability. It is particularly important when an incident has occurred; when something has gone wrong. How do you respond to the people involved? What do you do to minimize the negative impact, and maximize learning? This third edition of Sidney Dekker's extremely successful Just Culture offers new material on restorative justice and ideas about why your people may be breaking rules. Supported by extensive case material, you will learn about safety reporting and honest disclosure, about retributive just culture and about the criminalization of human error. Some suspect a just culture means letting people off the hook. Yet they believe they need to remain able to hold people accountable for undesirable performance. In this

new edition, Dekker asks you to look at 'accountability' in different ways. One is by asking which rule was broken, who did it, whether that behavior crossed some line, and what the appropriate consequences should be. In this retributive sense, an 'account' is something you get people to pay, or settle. But who will draw that line? And is the process fair? Another way to approach accountability after an incident is to ask who was hurt. To ask what their needs are. And to explore whose obligation it is to meet those needs. People involved in causing the incident may well want to participate in meeting those needs. In this restorative sense, an 'account' is something you get people to tell, and others to listen to. Learn to look at accountability in different ways and your impact on restoring trust, learning and a sense of humanity in your organization could be enormous.

Building on the revolutionary Institute of Medicine reports To Err is Human and Crossing the Quality Chasm, Keeping Patients Safe lays out guidelines for improving patient safety by changing nursesâ€™ working conditions and demands. Licensed nurses and unlicensed nursing assistants are critical participants in our national effort to protect patients from health care errors. The nature of the activities nurses typically perform â€" monitoring patients,

educating home caretakers, performing treatments, and rescuing patients who are in crisis â€" provides an indispensable resource in detecting and remedying error-producing defects in the U.S. health care system. During the past two decades, substantial changes have been made in the organization and delivery of health care â€" and consequently in the job description and work environment of nurses. As patients are increasingly cared for as outpatients, nurses in hospitals and nursing homes deal with greater severity of illness. Problems in management practices, employee deployment, work and workspace design, and the basic safety culture of health care organizations place patients at further risk. This newest edition in the groundbreaking Institute of Medicine Quality Chasm series discusses the key aspects of the work environment for nurses and reviews the potential improvements in working conditions that are likely to have an impact on patient safety.

This unique and engaging open access title provides a compelling and ground-breaking account of the patient safety movement in the United States, told from the perspective of one of its most prominent leaders, and arguably the movement’s founder, Lucian L. Leape, MD. Covering the growth of the field from the late 1980s to 2015, Dr. Leape details the developments, actors, organizations, research, and

policy-making activities that marked the evolution and major advances of patient safety in this time span. In addition, and perhaps most importantly, this book not only comprehensively details how and why human and systems errors too often occur in the process of providing health care, it also promotes an in-depth understanding of the principles and practices of patient safety, including how they were influenced by today's modern safety sciences and systems theory and design. Indeed, the book emphasizes how the growing awareness of systems-design thinking and the self-education and commitment to improving patient safety, by not only Dr. Leape but a wide range of other clinicians and health executives from both the private and public sectors, all converged to drive forward the patient safety movement in the US. Making Healthcare Safe is divided into four parts: I. In the Beginning describes the research and theory that defined patient safety and the early initiatives to enhance it. II. Institutional Responses tells the stories of the efforts of the major organizations that began to apply the new concepts and make patient safety a reality. Most of these stories have not been previously told, so this account becomes their histories as well. III. Getting to Work provides in-depth analyses of four key issues that cut across disciplinary lines impacting patient safety which required special attention. IV. Creating a Culture of Safety looks to the future,

marshalling the best thinking about what it will take to achieve the safe care we all deserve. Captivatingly written with an “insider’s” tone and a major contribution to the clinical literature, this title will be of immense value to health care professionals, to students in a range of academic disciplines, to medical trainees, to health administrators, to policymakers and even to lay readers with an interest in patient safety and in the critical quest to create safe care.

Radiology has been transformed by new imaging advances and a greater demand for imaging, along with a much lower tolerance for error as part of the Quality & Safety revolution in healthcare. With a greater emphasis on patient safety and quality in imaging practice, imaging specialists are increasingly charged with ensuring patient safety and demonstrating that everything done for patients in their care meets the highest quality and safety standards. This book offers practical guidance on understanding, creating, and implementing quality management programs in Radiology. Chapters are comprehensive, detailed, and organized into three sections: Core Concepts, Management Concepts, and Educational & Special Concepts. Discussions are applicable to all practice settings: community hospitals, private practice, academic radiology, and government/military practice, as

well as to those preparing for the quality and safety questions on the American Board of Radiology's "Maintenance of Certification" or initial Board Certification Examinations. Bringing together the various elements that comprise the quality and safety agenda for Radiology, this book serves as a thorough roadmap and resource for radiologists, technicians, and radiology managers and administrators.

An essential guide that offers an understanding of and the practices needed to assess and strengthen process safety culture Essential Practices for Developing, Strengthening and Implementing Process Safety Culture presents a much-needed guide for understanding an organization's working culture and contains information on why a good culture is essential for safe, cost-effective, and high-quality operations. The text defines process safety culture and offers information on a safety culture’s history, organizational impact and benefits, and the role that leadership plays at all levels of an organization. In addition, the book outlines the core principles needed to assess and strengthen process safety culture such as: maintain a sense of vulnerability; combat normalization of deviance; establish an imperative for safety; perform valid, timely, hazard and risk assessments; ensure open and frank communications; learn and advance the culture. This important guide also reviews leadership

standards within the organizational structure, warning signs of cultural degradation and remedies, as well as the importance of using diverse methods over time to assess culture. This vital resource: Provides an overview for understanding an organization's working culture Offers guidance on why a good culture is essential for safe, cost-effective, and high quality operations Includes down-to-earth advice for recognizing, assessing, strengthening and sustaining a good process safety culture Contains illustrative examples and cases studies, and references to literature, codes, and standards Written for corporate, business and line managers, engineers, and process safety professionals interested in excellent performance for their organization, Essential Practices for Developing, Strengthening and Implementing Process Safety Culture is the go-to reference for implementing and keeping in place a culture of safety.

The vast majority of healthcare is provided safely and effectively. However, just like any high-risk industry, things can and do go wrong. There is a world of advice about how to keep people safe but this delivers little in terms of changed practice. Written by a leading expert in the field with over two decades of experience, Rethinking Patient Safety provides readers with a critical reflection upon what it might take to narrow the implementation gap between the

evidence base about patient safety and actual practice. This book provides important examples for the many professionals who work in patient safety but are struggling to narrow the gap and make a difference in their current situation. It provides insights on practical actions that can be immediately implemented to improve the safety of patient care in healthcare and provides readers with a different way of thinking in terms of changing behavior and practices as well as processes and systems. Suzette Woodward shares lessons from the science of implementation, campaigning and social movement methods and offers the reader the story of a discovery. Her team has explored an approach which could profoundly affect the safety culture in healthcare; a methodology to help people talk to each other and their patients and to listen through facilitated safety conversations. This is their story.

This book reviews and critically analyzes the current legal framework with regard to a more just culture for the aviation sector. This new culture is intended to protect front-line operators, in particular controllers and pilots, from legal action (except in the case of willful misconduct or gross negligence) by creating suitable laws, regulations and standards. In this regard, it is essential to have an environment in which all incidents are reported, moving away from

fears of criminalization. The approach taken until now has been to seek out human errors and identify the individuals responsible. This punitive approach does not solve the problem because frequently the system itself is (also) at fault. Introducing the framework of a just culture could ensure balanced accountability for both individuals and complex organizations responsible for improving safety. Both aviation safety and justice administration would benefit from this carefully established equilibrium.