Support HB3333
Workforce Stabilization and Staff Improvement Act

Problem

- The current, one-size-fits-all regulatory framework for child abuse or neglect investigations creates a persistent culture of fear among staff who deliver services in Oregon's child welfare and mental health sector.
- Of the thousands of reports made in 2021, only 183 were opened for formal investigation. Of these 183 cases, just 20 resulted in substantiated claims of abuse or neglect.
- 89% of staff were ultimately cleared of abuse.
- Being investigated, along with the assumption of guilt, leads to experienced and caring staff leaving the sector.
- Oregon's existing regulatory system has unintentionally resulted in a culture of fear for staff working with children and youth.

Just Culture: Within a safety setting, when an adverse event occurs, the focus is on what went wrong, not who is the problem.

Oregon's families, child caring agencies, and their workforce agree: Any employee who engages in abusive or neglectful behavior should be investigated and, if appropriate, terminated. But the current, one-size-fits-all regulatory framework for these investigations has created a persistent culture of fear and paranoia among staff.

Solution: HB3333 Workforce Stabilization and Staff Improvement Act

- This legislation both improves child safety and fosters a work culture of learning and growth by creating a post-screening process to account for unintentional human errors where there's no to little impact.
- Legislation proposes no changes to the current definitions of abuse or the investigation process and subsequent outcomes for staff who have committed abusive behavior.
- Takes lessons learned from decades of experience in healthcare and hospital settings, the airline industry, and others by reducing human errors through implementing a 'Just Culture' model towards safety.
- This legislation will support a work culture of learning and growth—improving the safety and quality of services to children, youth and their families.
- If an incident is unintentional human error, investigators will have an additional option to establish corrective measures that the individual would be required to accomplish (e.g. training, supervision, and other professional development opportunities).
- Organizations delivering services are required to report back to the state agency about progress and/or completion of any corrective measures.

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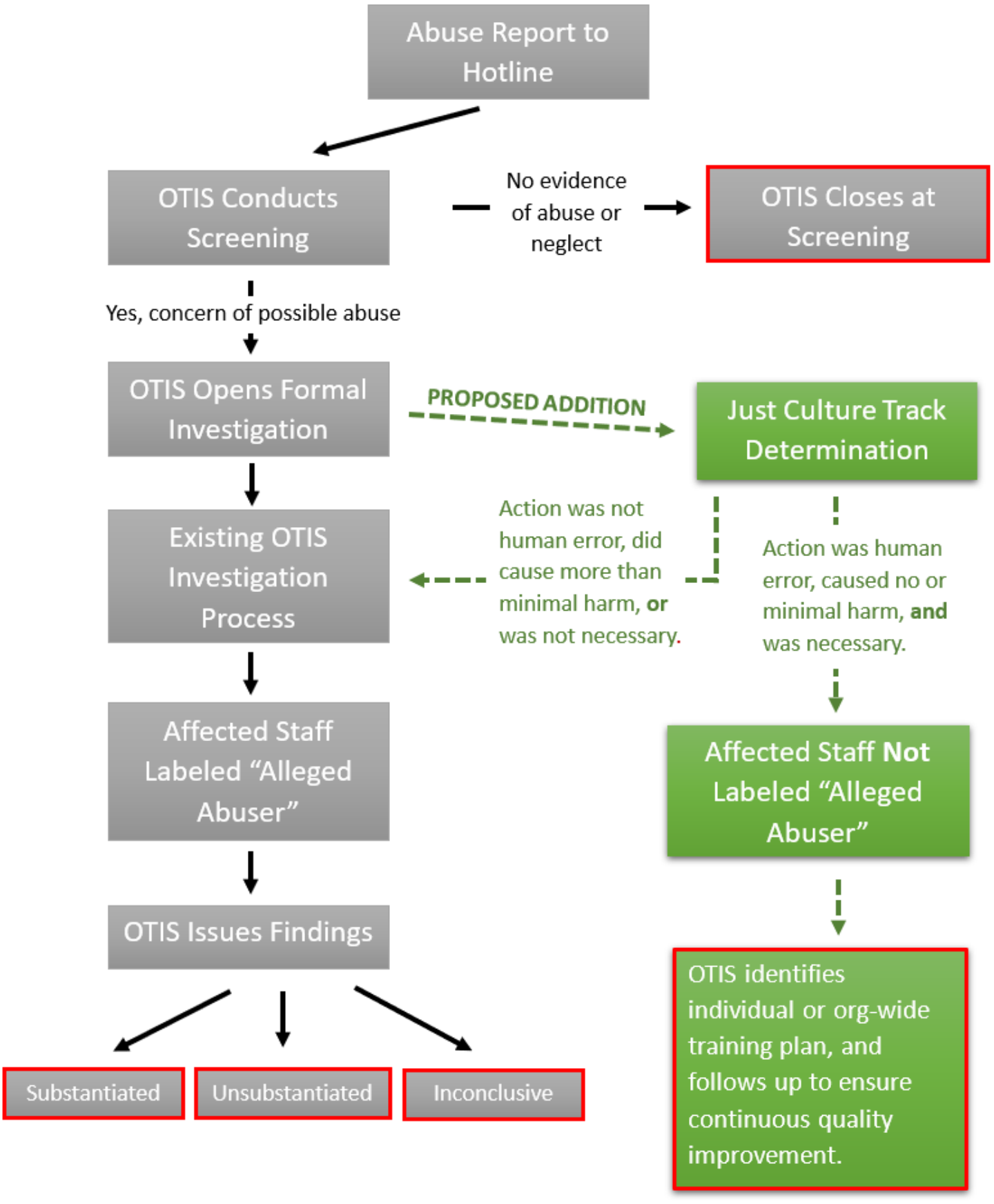

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What is Just Culture?

The simplest way to describe Just Culture is, "organizational accountability for the systems they've designed, and employee accountability for the choices they make."[1] To put it another way, a just organizational culture is one that balances the inescapable truth that even the most competent professionals sometimes make mistakes and the need to fairly and precisely respond to those mistakes and limit any harm that might result.

The principles and practices associated with Just Culture (sometimes referred to as "safety culture") originated in the aviation industry. Between 1970 and 1990, aviation accident investigators observed that airline staff consistently failed to report mistakes or dangerous situations for fear of professional or personal reprisal. In the half-century since, airlines have implemented a wide range of industry-wide policy changes in an effort shift from a culture of "blame and shame" to one of quality improvement, where employees can raise concerns without fear of retribution.[2,3]

A Just Culture does not let individuals off the hook for negligence or intentional harm (such as flying a plane while intoxicated); rather, it attempts to distinguish these types of behaviors from simple human errors (such as failing to notice an indicator light in the cockpit). Similarly, a Just Culture holds organizations accountable for their role in failing to prevent harm caused by their employees due to poor training, safety procedures, or lack of institutional safeguards.

How can Just Culture Help?

As additional fields have taken on the task of transitioning to a more Just Culture, the evidence supporting its efficacy has grown substantially. For example, a study from 2019 found that hospital nurses who believed they worked in a just culture environment were more likely to participate in patient safety activities (confirming a patient's identity, ensuring a safe environment, etc.).[4] Industry leaders like the Cleveland Clinic have followed Just Culture principles for years, and the American Nursing Association endorsed the concept all the way back in 2010.[5,6]

There is also evidence to suggest that once health care workers feel comfortable disclosing errors—and once investigations have been conducted to identify how and why they occurred—organizations operating under Just Culture principles have been successful in addressing those errors. For example, surgical checklists have been shown to effectively reduce the number of wrong-site surgical errors.[7]

In the words of one of the country's most prominent voices on reducing medical errors, Harvard professor Lucian Leape, "Approaches that focus on punishing individuals instead of changing systems provide strong incentives for people to report only those errors they cannot hide. Thus, a punitive approach shuts off the information that is needed to identify faulty systems and create safer ones. In a punitive system, no one learns from their mistakes."[8]

https://journals.lww.com/nursingmanagement/fulltext/2019/06000/just_culture__it_s_more_than_policy.9.aspx
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3776518/#i1524-5012-13-3-400-b07
https://flightsafety.org/files/just_culture.pdf
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8544452/
https://consultqd.clevelandclinic.org/nurse-leaders-have-meaningful-role-in-ensuring-a-just-culture/
https://www.nursingworld.org/~4afe07/globalassets/practiceandpolicy/health-and-safety/just_culture.pdf
https://www.sciencedirect.com/science/article/abs/pii/S0001209214005274
Leape, L. (January 25, 2000). Testimony, United States Congress, United States Senate Subcommittee on Labor, Health and Human Services, and Education.

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