



Patient Safety

and the

“Just Culture”

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Agenda

- What is Just Culture?
- The Safety Task
- The Just Culture Model
- Statewide Initiatives



The Just Culture
Community

What is a “Just Culture?”

An Introduction to Just Culture

The single greatest impediment to error prevention in the medical industry is
“that we punish people for making mistakes.”

*Dr. Lucian Leape
Professor, Harvard School of Public Health
Testimony before Congress on
Health Care Quality Improvement*



An Introduction to Just Culture

“There are activities in which the degree of professional skill which must be required is so high, and the potential consequences of the smallest departure from that high standard are so serious, that one failure to perform in accordance with those standards is enough to justify dismissal.”



*Lord Denning
English Judge*





An Introduction to Just Culture

“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
Author, the Design of Everyday Things



An Introduction to Just Culture

“...No person may operate an aircraft
in a careless or reckless manner
so as to endanger
the life or property of another.”

*Federal Aviation Regulations
§ 91.13 Careless or Reckless Operation*



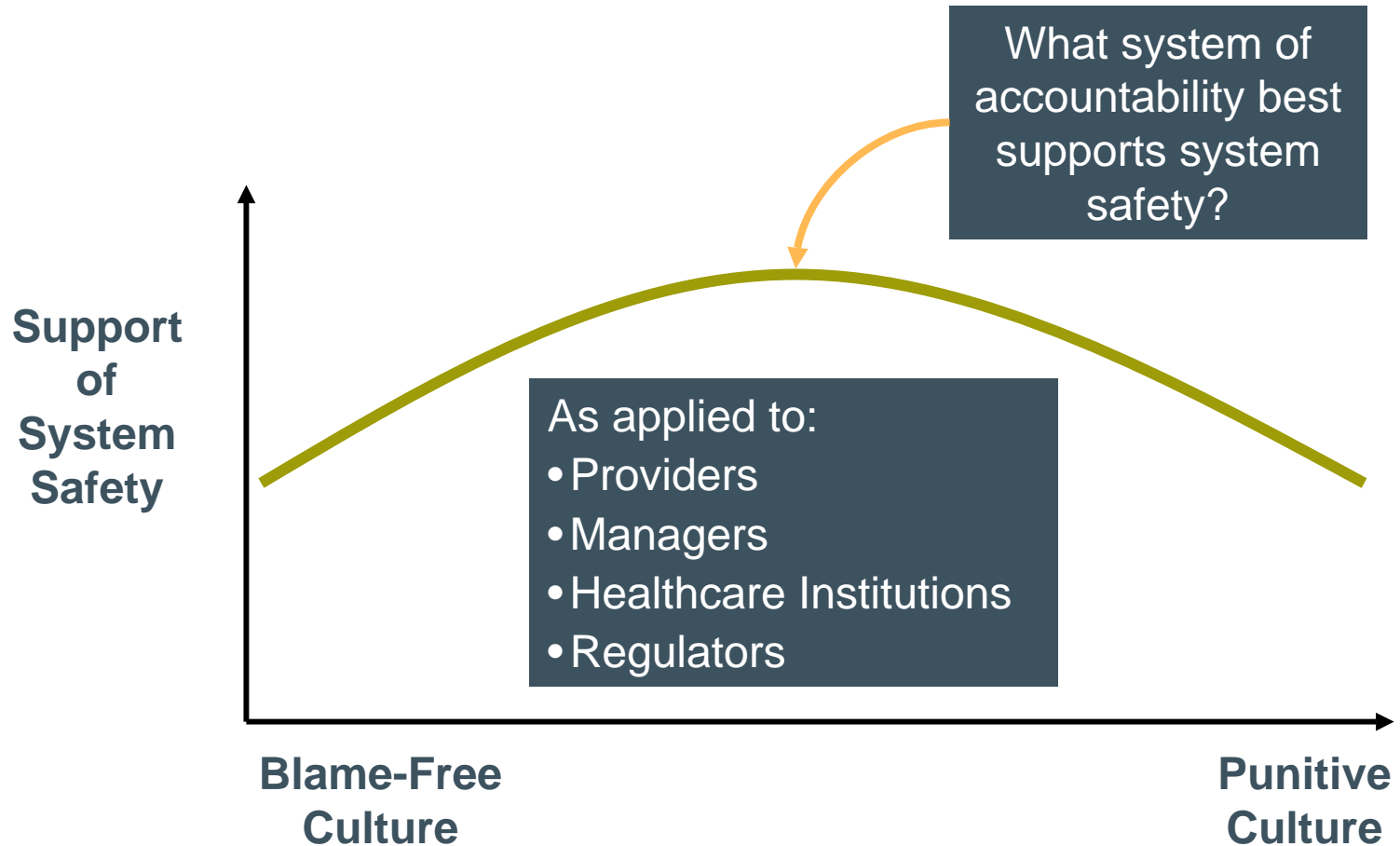
An Introduction to Just Culture

“As far as I am concerned, when I say “careless” I am not talking about any kind of “reckless” operation of an aircraft, but simply the most basic form of simple human error or omission that the Board has used in these cases in its definition of “carelessness.” In other words, a simple absence of the due care required under the circumstances, that is, a simple act of omission, or simply “ordinary negligence,” a human mistake.”

*National Transportation Safety Board
Administrative Law Judge
Engen v. Chambers and Langford*



The Problem Statement





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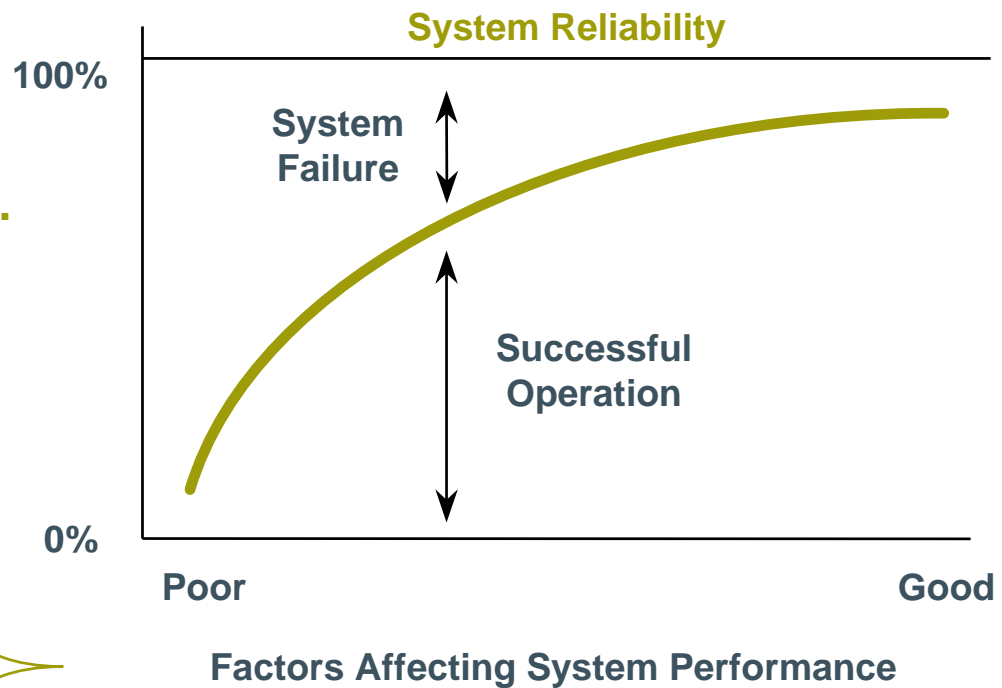
The Safety Task



Managing System Reliability

Design for System Reliability...

- Human factors design to reduce the rate of error
- Barriers to prevent failure
- Recovery to capture failures before they become critical
- Redundancy to limit the effects of failure



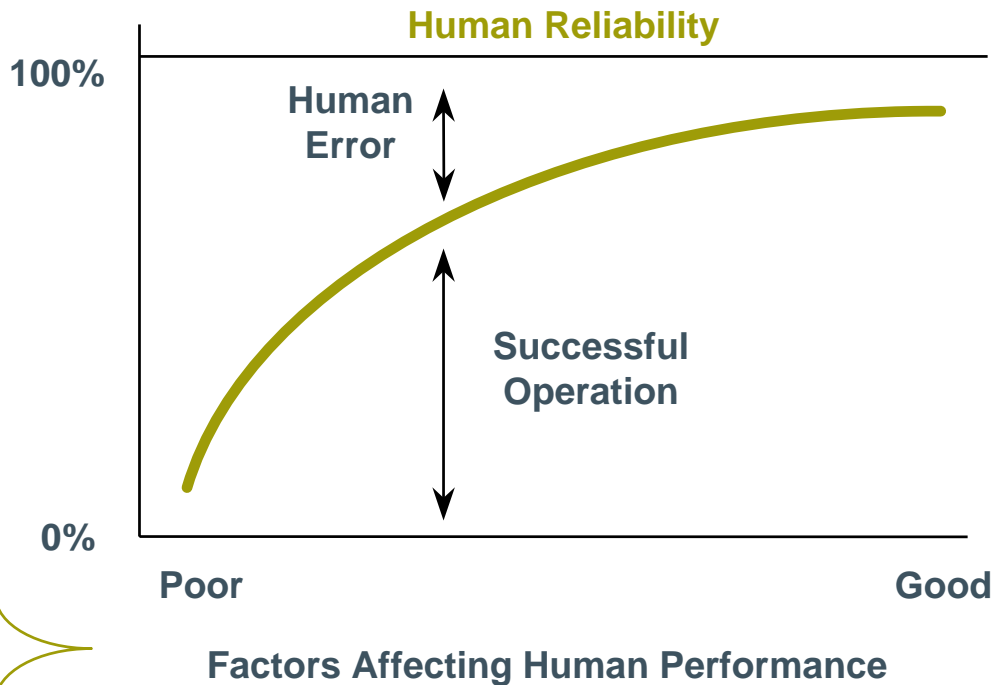
... knowing that systems will never be perfect



Managing Human Reliability

Design for Human Reliability...

- Information
- Equipment/Tools
- Design/Configuration
- Job/Task
- Qualifications/Skills
- Perception of Risk
- Individual Factors
- Environment/Facilities
- Organizational Environment
- Supervision
- Communication



... knowing humans will never be perfect



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The Just Culture Model



A Model that Focuses on Three Duties balanced against Organizational and Individual Values

- The Three Duties
 - The duty to avoid causing unjustified risk or harm
 - The duty to produce an outcome
 - The duty to follow a procedural rule
- Organizational and Individual Values
 - Safety
 - Cost
 - Effectiveness
 - Equity
 - Dignity
 - etc

The Behaviors We Can Expect

- Human error - inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake.
- At-risk behavior – behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified.
- Reckless behavior - behavioral choice to consciously disregard a substantial and unjustifiable risk.

Example

A nurse is going to administer a medication to a baby in the neonatal ICU. The ICU has an automated dispensing system. The automated dispensing system opens a drawer with four bins. As he has always done, he reached into the second bin where the vial of medication is, confirms the blue cap on the vial, grabs the medication and takes it to deliver the medication. At no time in the process did the nurse actually confirm the medication label, instead relying on the medication's location in the dispensing system and color of the cap to confirm the correct medication. In this case, pharmacy had dispensed the wrong dose in the dispensing system.



Accountability for Our Behaviors

Human Error

Inadvertent action: slip, lapse, mistake

Manage through changes in:

Processes

Procedures

Training

Design

Console

At-Risk Behavior

A choice: risk not recognized or believed justified

Manage through:

removing incentives for At-Risk Behaviors

reducing incentives for healthy behaviors

increasing situational awareness

Coach

Reckless Behavior

Conscious disregard of unreasonable risk

Manage through:

Remedial action

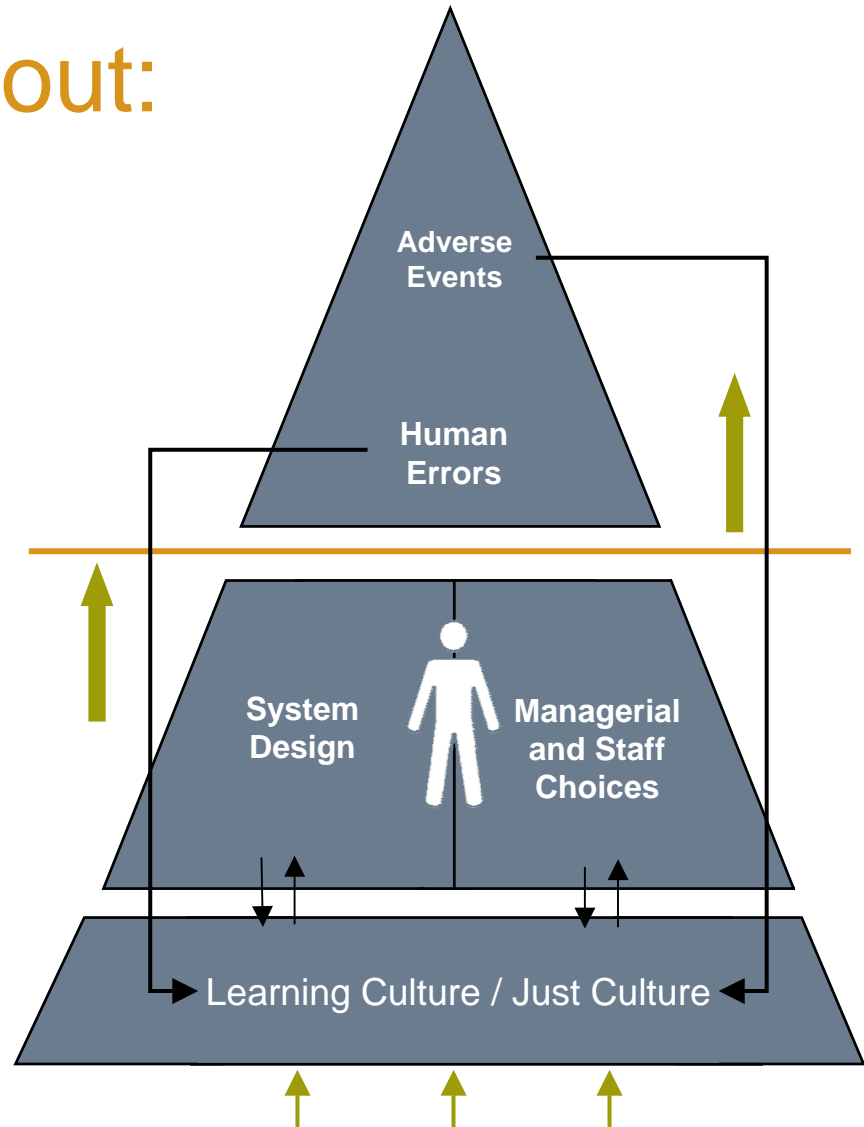
Punitive action

Punish



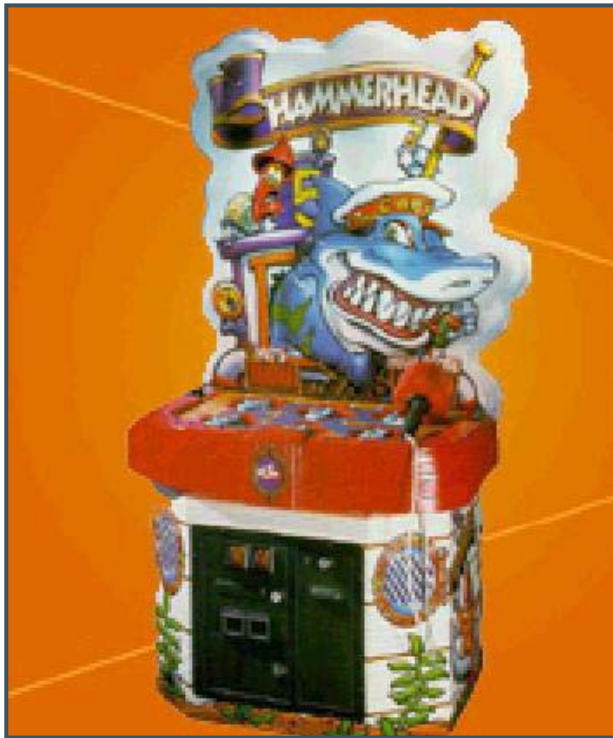
Just Culture is about:

- Creating an open, fair, and just culture
- Creating a learning culture
- Designing safe systems
- Managing behavioral choices



It's About a Proactive Learning Culture

- It's not seeing events as things to be fixed



- It's seeing events as opportunities to improve our understanding of risk
 - System risk, and
 - Behavioral risk

Where management decisions are based upon where our limited resources can be applied to minimize the risk of harm, knowing our system is comprised of sometimes faulty equipment, imperfect processes, and fallible human beings

It's About Reinforcing the Roles of Risk, Quality, and HR

- Risk/Quality
 - Helping improve the effectiveness of the learning process
 - Providing tools to line managers
 - Helping to redesign systems
- HR
 - Protecting the learning culture
 - Helping with managerial competencies
 - Consoling
 - Coaching
 - Punishing

It's About Changing Managerial Expectations

- Knowing my risks
 - Investigating the source of errors and at-risk behaviors
 - Turning events into an understanding of risk
- Designing safe systems
- Facilitating safe choices
 - Consoling
 - Coaching
 - Punishing

It's About Changing Staff Expectations

- Looking for the risks around me
- Reporting errors and hazards
- Helping to design safe systems
- Making safe choices
 - Following procedure
 - Making choices that align with organizational values
 - Never signing for something that was not done



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Statewide Initiatives

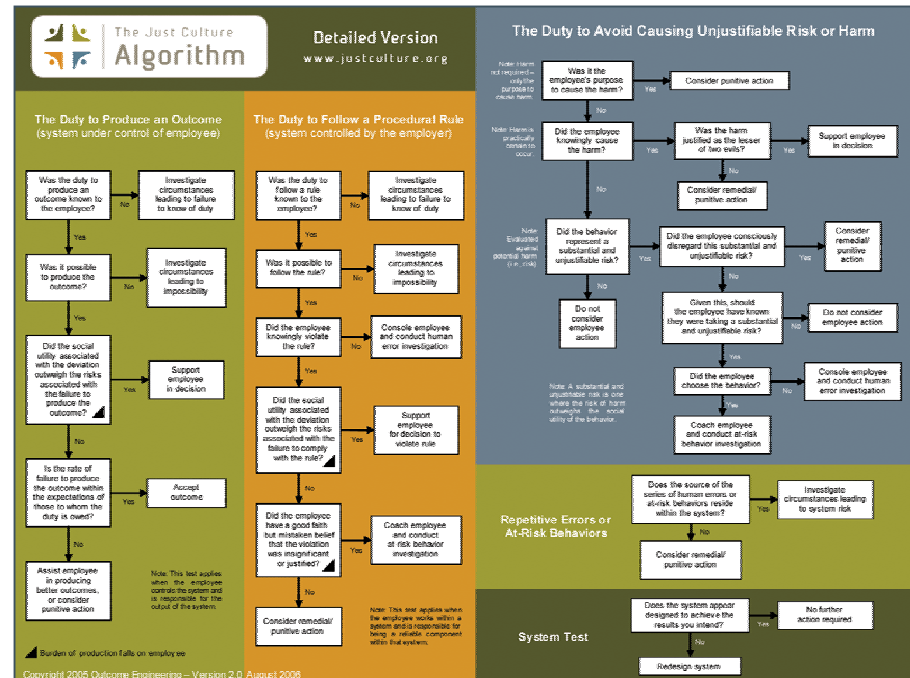


Statewide Initiatives

- A willingness of stakeholders to work together
 - Individual providers
 - Healthcare organizations
 - Professional boards
 - Departments of health
- One model of shared accountability
 - Protecting the learning culture
 - Safety-supportive accountability

An Algorithm to Follow

- One method that works across all values
- One method that works both pre and post event





Doves and Hawks – Who are we?





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Thank You

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