Just Culture

From theory to application
What We will Cover

• Pre-requisite paradigms
• Basis for organizational response to mishaps
• Recognized Just Culture Behaviors
• Decision Support Tool
• Case Study and Debriefing
CRM Based Team Training

High Reliability

Safety Culture

Just and Fair Culture

Top Leader Engagement

Adapted from multiple sources:
USAF Thunderbird Mishap
Mt. Home, Idaho - 2003

G. L. Sculli 2016
Healthcare
Is zero error possible?
Are there certain errors that we can expect to never occur?
Paradigm #1 (Error)

• Human error is ubiquitous and inevitable
• Human error is not a behavioral choice
• No one is immune
System tolerates errors but still functions successfully...
Creating Error Tolerance

- Automation
- Technology
- Forcing Functions
- Fail Safes
- Redundancies

MITIGATE CONSEQUENCES OF ERROR

TRAP ERROR

AVOID ERROR

Just Culture
Immediate Reporting
Procedures for Resiliency

Acknowledgements (Closed Loop)
Redundant Double Checks
Time Outs
Team Monitoring & Crosschecking

Briefing
Debriefing
Checklist
Inquiry & Advocacy
Standardization
Fatigue Management

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Drift

Losing our way......
Vigilance - Complacency Continuum

Vigilance

Entry

Months

Years

Complacency

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Paradigm #2 (Drift)

- Drifting is ubiquitous and inevitable
- Drifting is a behavioral choice
- No one is immune

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Paradigm #2

Why do we drift into failure?

• Culture
  – Production Pressures
  – Hierarchy / Intimidation

• Absence of catastrophe
  – Becoming immune to the feeling of risk

• Lack of training
  – Standards and procedural knowledge gets stale

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2 Approaches - Pick one

• Approach 1 – Person or “Bad Apple” Theory
  – Focuses on the errors and unsafe acts of individuals
  – Blames individuals for forgetfulness, inattention and moral weakness

• Approach 2 – Systems
  – Virtually all unsafe acts have a causal history that extends back in time and up through the levels of the system
  – Human error and Drift are ubiquitous and inevitable
  – The best people can make the worst errors
Mishap Systems “Swiss Cheese Model”


- Administrative Decisions
- Rules and Procedures
- Culture

- Procedural Violations
- Mistakes
- Slips

- Latent Failures

- Unsafe Acts

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“People Report what they cannot hide”

Lucian Leape MD, Harvard School of Public Health

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Organizational Response
Disciplinary Decision Making Strategies

- Outcome – Based
- Rule – Based
- Risk – Based
Organizational Response
Disciplinary Decision Making Strategies

• Outcome – Based

• Rule – Based

• Risk – Based
Organizational Response

Disciplinary Decision Making Strategies

• Outcome – Based

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• Risk – Based

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Organizational Response
Disciplinary Decision Making Strategies

- Outcome – Based
  - YES
  - NO

- Rule – Based
  - YES
  - NO

- Risk – Based
  - YES
  - NO

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What’s worse?

1. Irwin Baby

2. ECMO Baby
   (Extra Corporeal Membrane Oxygenation)
Duty to Avoid Causing Unjustifiable Risk

- Highest duty owed
- Owed in the presence or absence of rules
Two schools of thought......

- Stakes too high
- Human failure
- Severity of outcome
- Discipline warranted
- **Punitive**

- Humans within fallible system
- System Accountability
- Discipline not warranted
- **No Blame**

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Balance

- Stakes too high
- Human failure
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- **Punitive**

Just Culture Finding Balance 21st Century

- Humans within fallible system
- System Accountability
- Discipline not warranted
- **No Blame**

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Just Culture
Defined

An atmosphere of trust in which people are encouraged (even rewarded) for providing essential safety-related information.

Individuals trust that they will not be held accountable for system failures; but, are also clear about where the line must be drawn between acceptable and unacceptable behavior.
## Establishing The Rules

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Human Error – An inadvertent mistake, cognitive slip or lapse that causes an outcome other than intended
# Just Culture

*How to respond*

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## Just Culture

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Alleviate grief, sorrow, or disappointment – providing comfort and solace

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The consoling conversation is one that acknowledges the event, the emotions of the employee and seeks to provide an appropriate comforting response.

Employee and manager may choose to discuss the error to better understand how it occurred and may be managed in the future.

Be prepared to look at the system to consider improvements to limit further errors (caveat here).
At Risk Behavior - Occurs when competent professionals develop unhealthy norms. **Behavioral choices** are shortcuts, “routine rule violations”. Risk is not recognized; or recognized but believed to be justified.
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At Risk Behavior.....

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# Just Culture

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### Just Culture

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*Teach and supervise, to act as a trainer, to give instruction*

*Remove incentives for “at risk” behaviors*

*Create incentives for “safety” behaviors*
It is a conversation that involves raising awareness and/or changing the perceptions of risk – not just knowledge of policies.

This may be as simple as explaining to an employee that a particular choice may create more risk than they see.
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Reckless Behavior - Behavioral choice to consciously disregard a substantial and unjustifiable risk.
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Reckless Behavior - Zero tolerance...
## Just Culture

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## Just Culture

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**Formal Discipline Punitive Action**

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DECISION SUPPORT TOOL
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EXAMPLE CASE
A resident physician is conducting morning patient rounds with her team and the attending (the chief). They stop at Mr. Platt’s room to discuss his treatment plan and status. The attending states that he would like Mr. Platt’s Coumadin (blood thinner) discontinued. The resident began entering the order. The medical center had a robust computerized physician order entry (CPOE) system and allowed providers to enter orders using hand held devices and smartphones in real time. At that moment she received a text from a friend about an upcoming party upon which she confirmed her attendance. The resident never completed the order and moved onto the next problem. The blood thinner continued for several days. Mr. Platt developed a pericardial effusion and required an emergency procedure – pericariocentesis. The patient expired during the procedure.
STEP 1: Choose the column that best describes the employee's action. Read down the column for recommended responses.

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STEP 2: If 3 other employees with similar skills and knowledge would do the same thing in similar circumstances.

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The system supports reckless action and requires fixing. The employee is probably less accountable for the action. Leaders share in the accountability.

The system supports risky action and requires fixing. The employee is probably less accountable for the action. Leaders share in the responsibility.

The system supports error and requires fixing. Leaders are accountable and should apply error management in the system via human factors-based improvements.

STEP 3: If history of repeated mistakes, the employee may be in the wrong position. Evaluation is warranted and coaching, transfer or termination should be considered. The corrective action should be modified accordingly.


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2 JUST CULTURE CASE EXERCISES
Case #1

Mr. Jones is a patient who came to the ER with chest pain, SOB and anxiety. After evaluation, the ER physician decides to admit the patient for further testing. Its been 6 hours. The ER is getting really busy and they need to send Mr. Jones to the Cardiac Floor. The ER nurse, after talking to the house supervisor to confirm bed placement, calls the floor to give report and move the patient. Unfortunately the house supervisor was called to deal with an emergency on another unit and did not notify the Cardiac Floor about the admission.
The Cardiac nurse refused to take the patient. Policy states that all admissions from the ER must be arranged and communicated by the house supervisor. The ER nurse explained both that she confirmed it with the supervisor and that the supervisor was dealing with an emergency. She also told the Cardiac nurse that Mr. Jones had been in the ER a long time and it was getting busy. The nurse simply said, “I follow the policy, when I get a call I’ll take the patient.” Mr. Jones ended up staying in the ER for another 2 hours. During that time he attempted to get off of his gurney and fell, hitting his head very hard on the floor.
Case #1

Explanations

Cardiac Nurse:

A. “I wanted to take the patient and almost did. But I decided not to. The last time I deviated from policy for what I thought was best for the patient, I was chewed out by the house supervisor. I was really upset about it.”

B. “Those ER nurses always do this!! They always hold onto patients then they want to turf them off on us towards the end of their shift. Anyway – I followed the policy”

Step 2 - Substitution Test:

More than 3

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**Behavior Choose Behavior?** | **See the Risk?** | **Response?**
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Human Error | NO | NO | CONSOLE Review System
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### STEP 2: If 3 other employees with similar skills and knowledge would do the same thing in similar circumstances.

- **The system supports reckless action and requires fixing.** The employee is probably less accountable for the action. Leaders share in the responsibility.
- **The system supports risky action and requires fixing.** The employee is probably less accountable for the action. Leaders share in the responsibility.
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Case #2

A phlebotomist is working the early morning shift and drawing a type and cross on Mrs. Smith. Mrs. Smith was sleeping soundly and is not happy about being awakened and having bright lights on in her room. The phlebotomist decides to turn off the lights. Procedure calls for all blood samples to be labeled at the point of care. The phlebotomist takes the tube samples to the nurses station. While he has his head down a nurse comes by and lays down an unlabeled tube of blood nearby. The phlebotomist grabs the tube thinking it is one he just collected and labels it for Mrs. Smith. Mrs. Smith has a severe transfusion reaction two days later. She survives but spends a month in the ICU.

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Case #2
Explanations

Phlebotomist:

“The patient was so angry. I encounter this all the time when I do the morning blood draws. She was already mad because it took 2 attempts to access a vein. I thought it would be fine. I just turned off her light and I went to the nurses station right outside the room. I feel terrible about this”

Step 2 - Substitution Test:

Several staff said that this was a common problem – patients being very unhappy during lab collection in the morning. While no one admitted that they had done the same thing, several said they feel pressure to do so – especially since the director has made it clear that patient satisfaction scores must improve.
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Disciplinary Policy Language

Marx, D (2009)

• You are a fallible human being, susceptible to human error and behavioral 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.
• When you make a mistake you will be consoled.
• When you drift into a risky place believing that you are still safe, we will coach you.
• When you knowingly put others in harm’s way, we will take appropriate disciplinary action.