

“Just Culture”: A Key to Quality and Safety

Alison H. Page, MHA, MSN, FACHE
Chief Executive Officer
Western Wisconsin Health

Disclosures

The following faculty and planning committee staff have no financial disclosures:

Name	Institution
Alison H. Page, MHA, MSN, FACHE	Western Wisconsin Health
Bette Braem, MSSW, CMQ/OE (ASQ)	NMDP/Be The Match
Ruth Bakken, RN, BSN, CHTC	NMDP/Be The Match

Goal for today

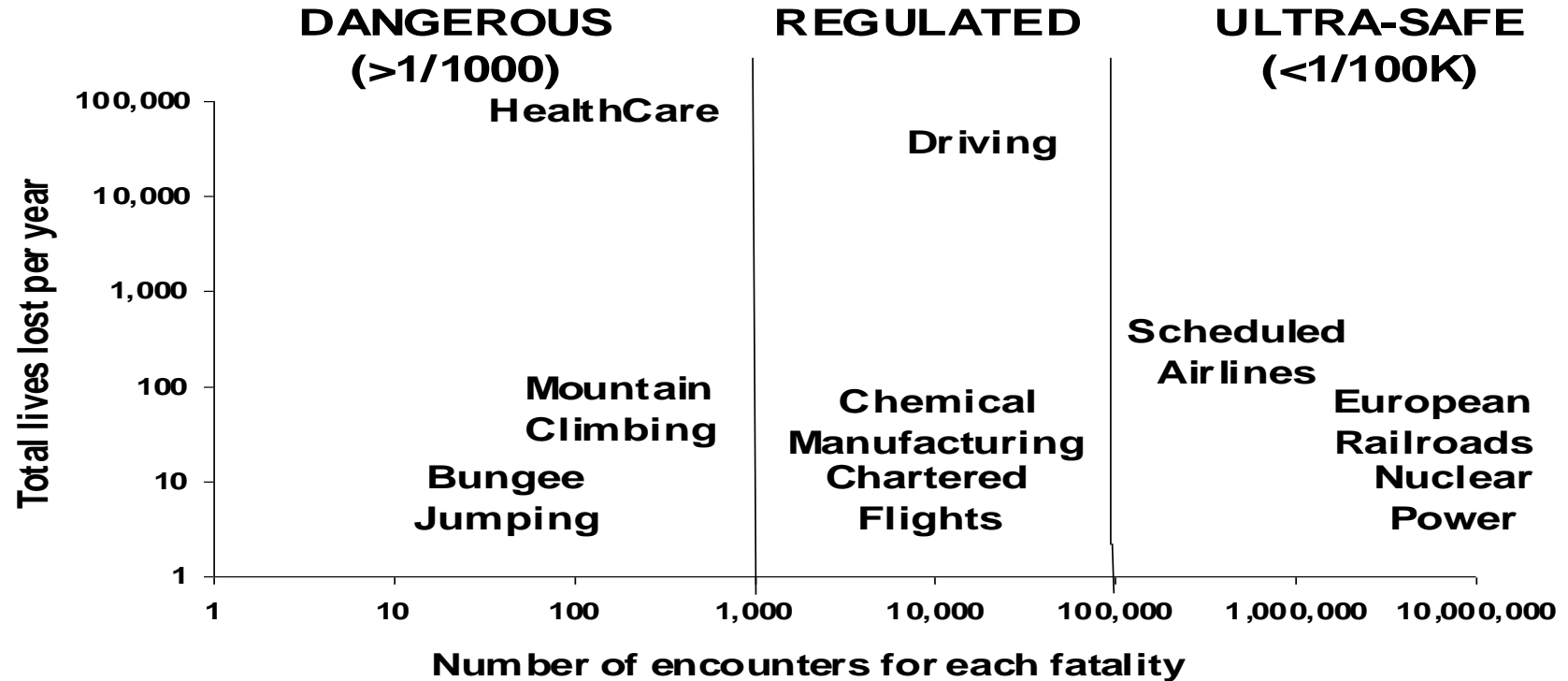


Learning objectives

At the conclusion of this session, attendees will be able to:

- Examine the philosophy and key elements of a Just Culture
- Describe how a Just Culture can impact quality and safety
- Differentiate between human error, at-risk behavior, and reckless behavior
- Identify appropriate organizational response to human error, at-risk behavior, and reckless behavior

How Hazardous Is Health Care?



Lucian Leape, 2/2001

We've all been there.....

Medication error

Failure to check patient identification

Why did these accidents happen?

What can we do to prevent them from happening again?

How do we judge the clinicians involved?

Just Culture –It is about

- Creating a common philosophy
- Using a common language
- Resulting in a common experience for participants

The Problem Statement

- Accountability
 - Who is responsible for the system performance?
 - Who is responsible for individual performance?
- Punishment
 - Where does it work?
 - When is it needed?

Culture assessment: How would your organization deal with a surgeon who used an unauthorized piece of equipment?

Percentage of those who believe the organization would discipline the surgeon....if:

NO harmful outcome

- **19% of staff**
- **0% of managers**
- **11% of executives**
- **0% of physicians**

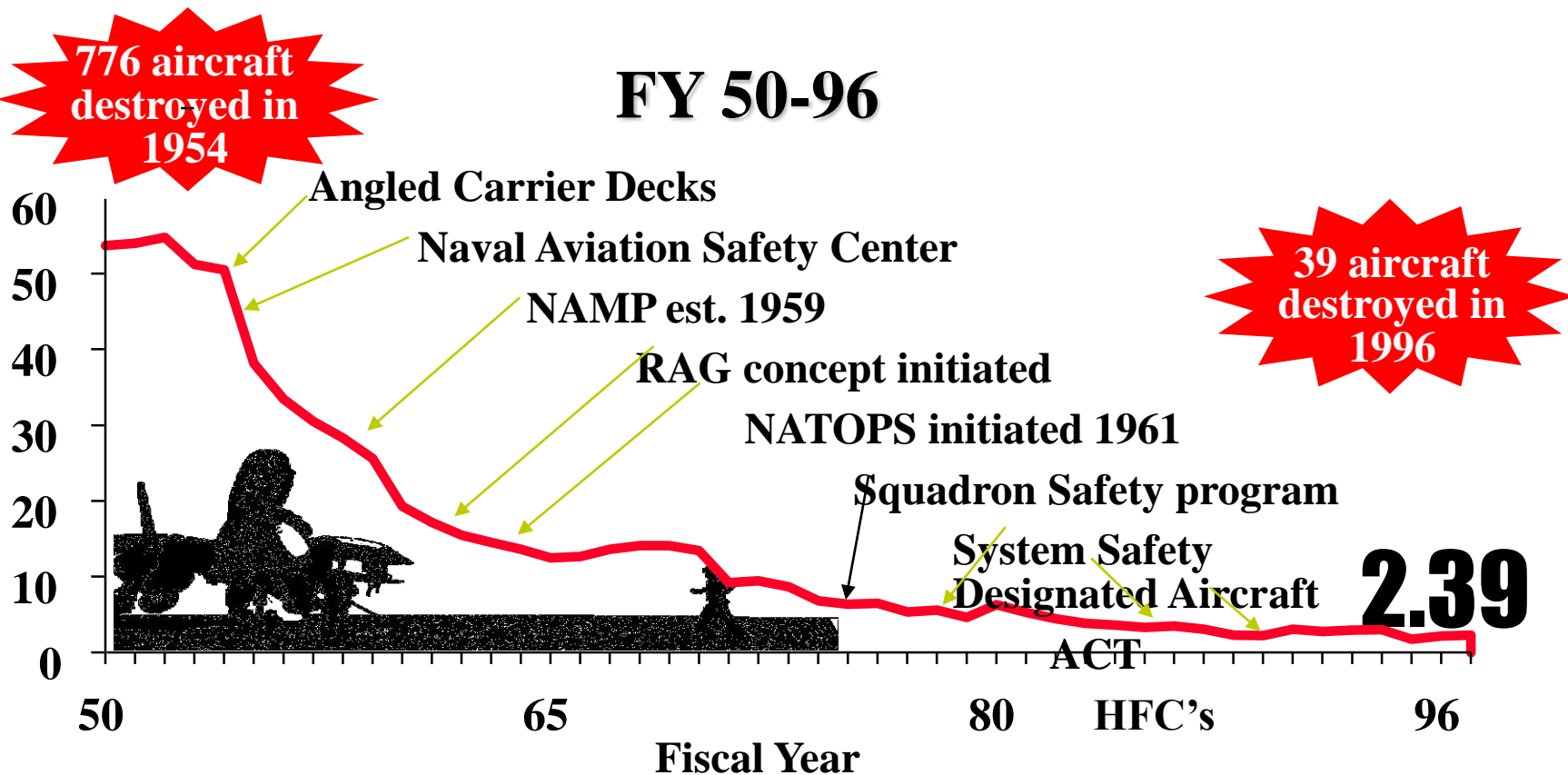
Harmful outcome

- **29% of staff**
- **50% of managers**
- **14% of executives**
- **45% of physicians**

NAVAL AVIATION MISHAP RATE

FY 50-96

Class A Mishaps/100,000 Flight Hours



We can do two things:

1. Design **systems** to accommodate human beings
2. Manage **human behavior** within the systems

Managing Systems

“Systems produce precisely the outcomes they are designed for.”

Don Berwick



inulin, 40 units lente 120 units regular q.a.m.

(12)

~~12~~

day 2 (1/12/01)

140 mg in 500cc NS
w. 12.5 ^{gm} mannitol 2V may 30
minutes ~~Admission sheet~~ NS 250cc ~~flow~~

X 4 hr, then NS 150 cc ~~flow~~

(13)

day 2 (1/12/01)

containing 5 mg Plavix 1V

(14)

day 2 (1/12/01)

admission 653 mg

slow 1VP

2000 Presidential Election

Florida Ballot

(REPUBLICAN)				(REFORM)	
GEORGE W. BUSH - PRESIDENT	3 ➡			← 4	PAT BUCHANAN - PRESIDENT
DICK CHENEY - VICE PRESIDENT					EZOLA FOSTER - VICE PRESIDENT
(DEMOCRATIC)					
AL GORE - PRESIDENT	5 ➡			← 6	(SOCIALIST)
JOE LIEBERMAN - VICE PRESIDENT					DAVID McREYNOLDS - PRESIDENT
(LIBERTARIAN)				← 8	MARY CAL HOLLIS - VICE PRESIDENT
HARRY BROWNE - PRESIDENT	7 ➡				(CONSTITUTION)
ART OLIVIER - VICE PRESIDENT				← 10	HOWARD PHILLIPS - PRESIDENT
(GREEN)					J. CURTIS FRAZIER - VICE PRESIDENT
RALPH NADER - PRESIDENT	9 ➡				(WORKERS WORLD)
WINONA LaDUKE - VICE PRESIDENT					MONICA MODREHEAD - PRESIDENT
(SOCIALIST WORKERS)					GLORIA La RIVA - VICE PRESIDENT
JAMES HARRIS - PRESIDENT	11 ➡				
MARGARET TROWE - VICE PRESIDENT					
(NATURAL LAW)					
JOHN HAGELIN - PRESIDENT	13 ➡				
NAT GOLDHABER - VICE PRESIDENT					

Point of controversy

WRITE-IN CANDIDATE
To vote for a write-in candidate, follow the directions on the long stub of your ballot card.





Epinephrine Ephedrine

Dopamine

Dobutamine

EPInephrine

EPHEDrine

DOPamine

DoBUTamine

Seven Organizational Strategies Important to Managing Risk

1. Knowledge
2. Skill
3. Performance Shaping Factors
4. Barriers
5. Redundancy
6. Recovery
7. Maintaining a Perception of High Risk

Strategies #1 and #2

- **High level of Knowledge and Skill**
 - Knowledge – what I know
 - Skill – the ability to apply the knowledge

Strategy #3

- **Performance Shaping Factors**
 - Factors that impact the rate of human error
 - Factors that influence the rate of at-risk behaviors
 - Stress
 - Fatigue
 - Vision
 - Hearing
 - Noise
 - Lighting
 - Distraction
 - Procedure design

Strategy #4

- **Barriers**
 - Prevents the error from occurring
 - Prevents hazard from touching target
 - Examples:
 - Personal protective equipment
 - Forcing functions
 - Connectors
 - Cars gears and brakes

Strategy #5

- **Redundancy**
 - Error may occur by one actor
 - A parallel system performs the same function and identifies the error before any action is taken
 - Examples:
 - Second person performing task – double check - blood
 - Backup supplies / Backup power

Efficacy of Double-Checks

Double Checks Required

Reliability rate of system	Reliability rate of single double-check		
	25%	75%	95%
95%	10	3	1
99%	16	4	2
99.9%	24	5	3

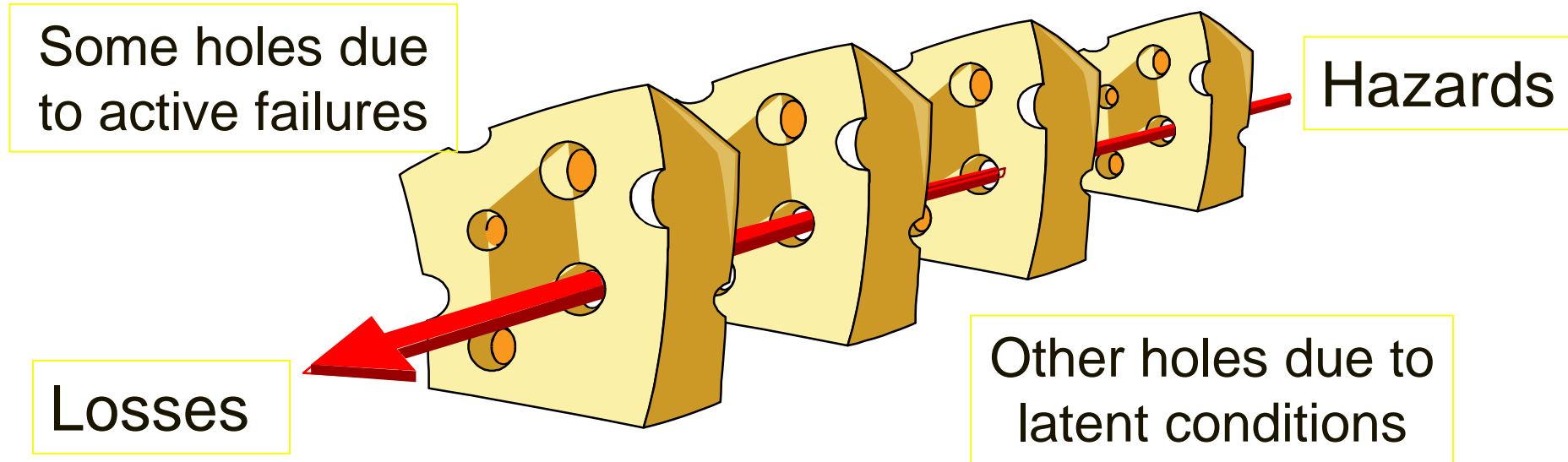
Strategy #6

- **Recovery**
 - Allows the error to occur
 - The error is corrected by someone downstream before the critical undesired outcome occurs
 - Example:
 - Downstream checks (pharmacy dose checks)

Strategy #7

- **High Perception of Risk**
 - Acts to limit at-risk behaviors by making actors aware of the risk that surrounds them
 - Examples:
 - Posting error data, infection rates
 - Story telling
 - Stuff happens
 - Stuff can and will happen to you
 - Here is how you can prevent stuff from happening

The framework we start with: Reason's 'Swiss cheese' model – our defences, barriers and safeguards are imperfect.

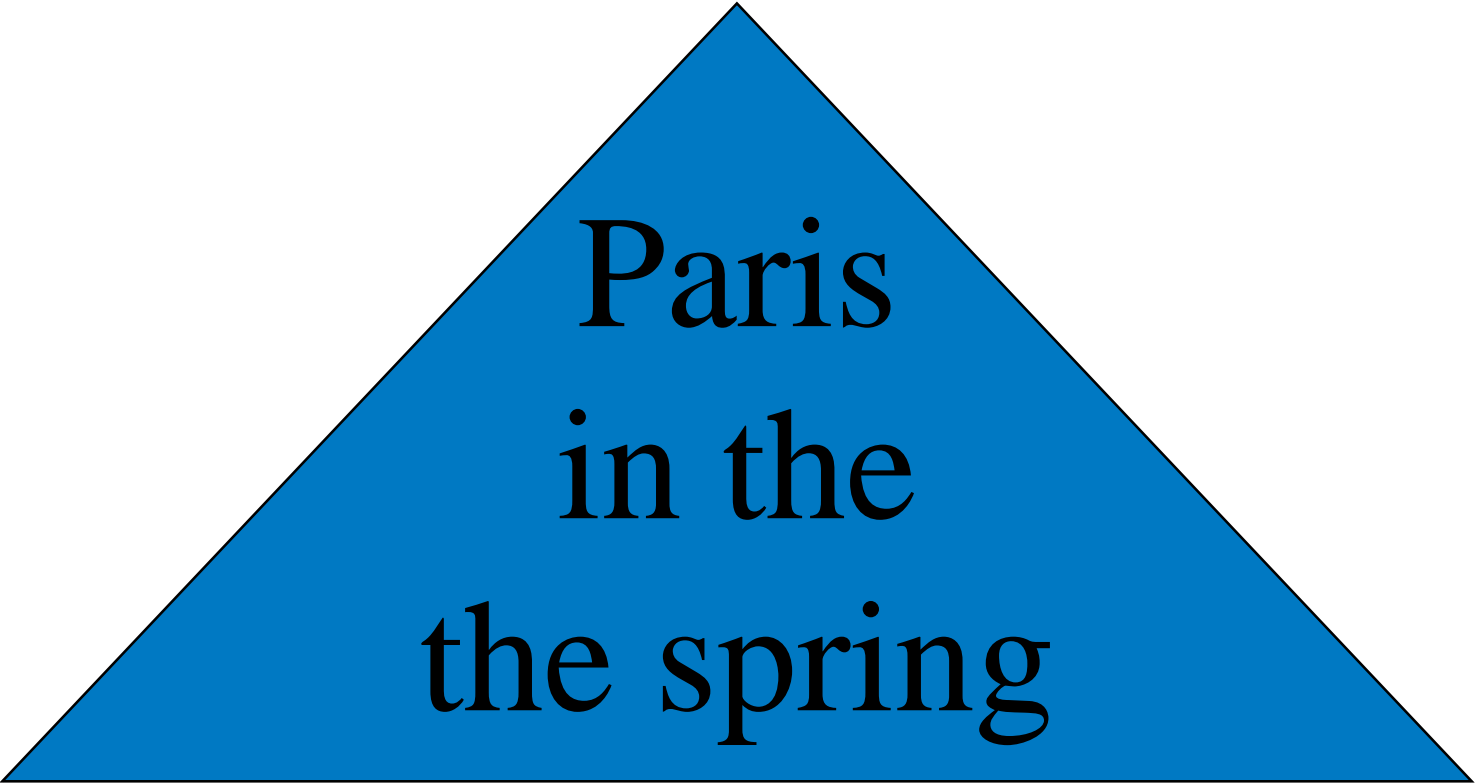


Managing human
behavior is
a bit harder.

Why?

Because – to error is human





Paris
in the
the spring

Nominal Human Error Rates

Activity	Probability
Error of commission (misreading a label)	0.003
Error of omission without reminders	0.01
Error of omission when items imbedded in a procedure	0.003
Simple math error with self-checking	0.03
Monitor or inspector fails to detect error	0.1
Personnel on different shifts fail to check hardware unless required by checklist	0.1
General error in high stress when dangerous activities occurring rapidly	0.25

Aoccdrnig to rscheearch at
Cmabrigde Uinervtisy,
it deosn't mttar inwaht oredr the ltteers in a
wrod are, the olny iprmoetnt tihng is that the
frist and lsat ltteer be at the rghit pclae. The rset
can be a total
msee and you can sitll raed it
wouthit porbelm. Tihs is bcuseae the huamn
mnid deos not raed ervey lteter by istlef, but the
wrod as awlohe.

The human brain cannot have multiple simultaneous foci of interest. This lack of cognitive resource is the single limiting factor of human activity.

Francois Clergue

Lessons from Human Factors Research

- Errors are common
- The causes of errors are known
- Errors are byproducts of useful cognitive functions

“We can’t change the human condition,
but we can change the conditions
under which humans work”

James Reason

We know....to error is Human



But....To Drift is also Human



Why do we drift?

- To accomplish more
- Because we do not see the risk

Consequences of behavior

GO THE SPEED LIMIT

Desired behavior

- Satisfaction of being a law abiding citizen
- Reduce chance of accident

SPEED

Undesired behavior

- Save time now

However....

Humans are accountable for
their behavioral choices



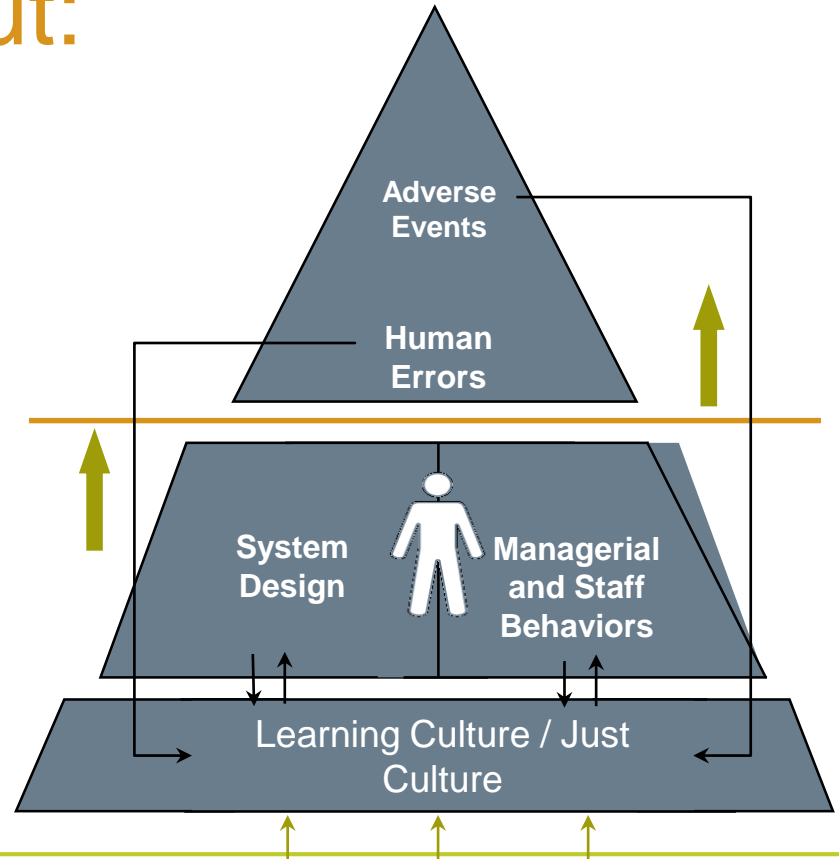
Just Culture

David Marx, JD

<https://www.outcome-eng.com/>

Just Culture is about:

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



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
 - Excellence
 - Integrity
 - Service
 - Teamwork
 - Safety
 - Stewardship

Two Specific Classes of Duty

- Meet me at 7:00 pm at Sally's Bar

The Duty to
Produce an
Outcome

- Leave your apartment at 6:45 pm. Go south on Oak Street, turn right on Washington. Do not cross the river. It will be on your left.

The Duty to
Follow a
Procedural Rule

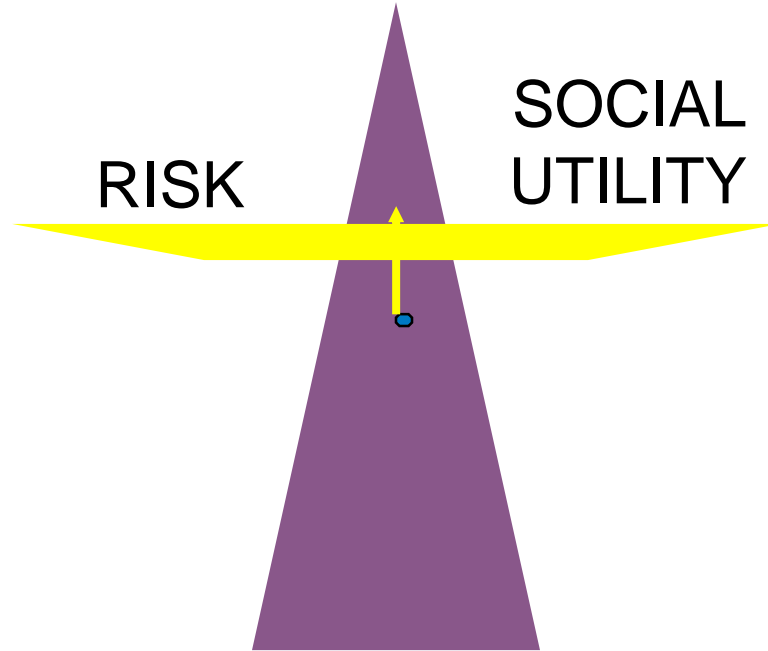


My Husband

- Father of many
- Dentist
- Nice guy



Managing Behavioral Choices: Everyone Takes Risks, Every Day



The Behaviors We Can Expect

- **Human error** - inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake.
- **At-risk behavior** - behavior 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.

Examples

Failure to check the name band

Accountability for our Behavioral Choices

Human Error

Product of our current system design

Manage through changes in:

- System Design
- Processes
- Procedures
- Environmental factors

Console

At-Risk Behavior

Unintentional Risk-Taking

Manage through:

- Removing incentives for at-risk behaviors
- Creating incentives for healthy behaviors
- Increasing perception of risk

Coach

Reckless Behavior

Intentional Risk-Taking

Manage through:

- Remedial action
- Disciplinary action

Punish

Managing Human Error

- Two questions:
 - Did the employee make the correct behavioral choices in their task?
 - Is the employee effectively managing his/her own performance shaping factors?
- If yes, the only answer is to console the employee – the error happened to him / her

Managing Multiple Human Errors

What is the source of a pattern of human errors?

- The system? If yes, address the system.
- If no, can the repetitive errors be addressed through non-disciplinary means?
- If no, how will disciplinary sanction reduce the rate of human error?

Managing At-Risk Behaviors

- A behavioral choice
 - Driven by perception of consequences
 - Immediate and certain consequences are strong
 - Delayed and uncertain consequences are weak
 - Rules are generally weak

Managing At-Risk Behaviors

- A behavioral choice
 - Managed by adding forcing functions (barriers to prevent non-compliance)
 - Managed by changing perceptions of risk
 - Managed by changing consequences
 - Coaching

Why not punish “at-risk” behavior?

Because....

1. Somewhere along the line your organization has likely tacitly approved certain at-risk behaviors.
2. If you punish at-risk behavior people will likely not be honest about the at-risk behavior next time

Often you did not fully recognize the at-risk behavior until an event occurs.

Who judges risk and behaviors?



- Risk = Severity of Possible Outcome x Likelihood
- Safety ~ Reasonableness of Risk

Managing Reckless Behavior

- Reckless Behavior
 - Conscious disregard of substantial and unjustifiable risk
- Manage through:
 - Disciplinary action

Managing Behavioral Choices

Human Error

Product of our current system design

Manage through changes in:

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- Processes
- Procedures
- Environmental factors

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Reckless Behavior

Intentional Risk-Taking

Manage through:

- Remedial action
- Disciplinary action

Punish

Doves and Hawks



Questions?

Alison Page
715-684-1100
alison.page@wwhealth.org



Evaluation Reminder

Please complete the Council Meeting 2017 evaluation in order to receive continuing education credits and to provide suggestions for future topics.

We appreciate your feedback!