JUST CULTURE

MOVING BEYOND
"NO HARM, NO FOUL"

DAVID MARX

APRIL 28, 2015

AGENDA

Agenda Item	Time
Patient Safety and the Just Culture: An Introduction	*8:30 – 9:00*
Mission, Values, and Expectations	*9:00 – 10:30*
Break	*10:30– 10:45*
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Patient Safety

Safety Culture

Just Culture

DEFINING CULTURE

“the set of predominating attitudes and behavior that characterize a group or organization.”

The Dictionary

SO WHAT IS SAFETY CULTURE?

"assembly of characteristics and attitudes in organizations and individuals that, as an overriding priority, nuclear power plant safety issues receive the attention warranted by their significance."

International Atomic Energy Commission

"the product of the individual and group values, attitudes, competencies and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety programs.“

British Health and Safety Commission

Simply, it’s the choices we make to protect safety

DIFFERENTIATING SYSTEMS AND CULTURE





WHAT WOULD THIS SAY ABOUT YOUR SAFETY CULTURE?

You notice that one your favorite surgeons did not wash his hands after going to the restroom.

WHAT WOULD THIS SAY ABOUT YOUR SAFETY CULTURE?

A dietary technician is seen nibbling on the half-eaten dessert of a now asleep patient.

WHAT WOULD THIS SAY ABOUT YOUR SAFETY CULTURE?

A nurse from a med/surg floor comes to the ED to review the chart of the boyfriend of her daughter who she learns has come to the ED.

WHAT WOULD THIS SAY ABOUT YOUR SAFETY CULTURE?

You observe your hospital patient safety officer texting while driving out of the hospital parking lot at the end of the day.

WHAT WOULD THIS SAY ABOUT YOUR SAFETY CULTURE?

A male pharmacy technician begins to enter orders into the computer with his eyeglasses off, coincidentally after his attractive female colleague comments how nice he looks without glasses.

WHAT WOULD THIS SAY ABOUT YOUR SAFETY CULTURE?

In the nursery at 3:00 am, a highly experienced volunteer falls asleep while rocking a baby to sleep in a rocking chair. The baby falls to the floor.

WHAT WOULD THIS SAY ABOUT YOUR SAFETY CULTURE?

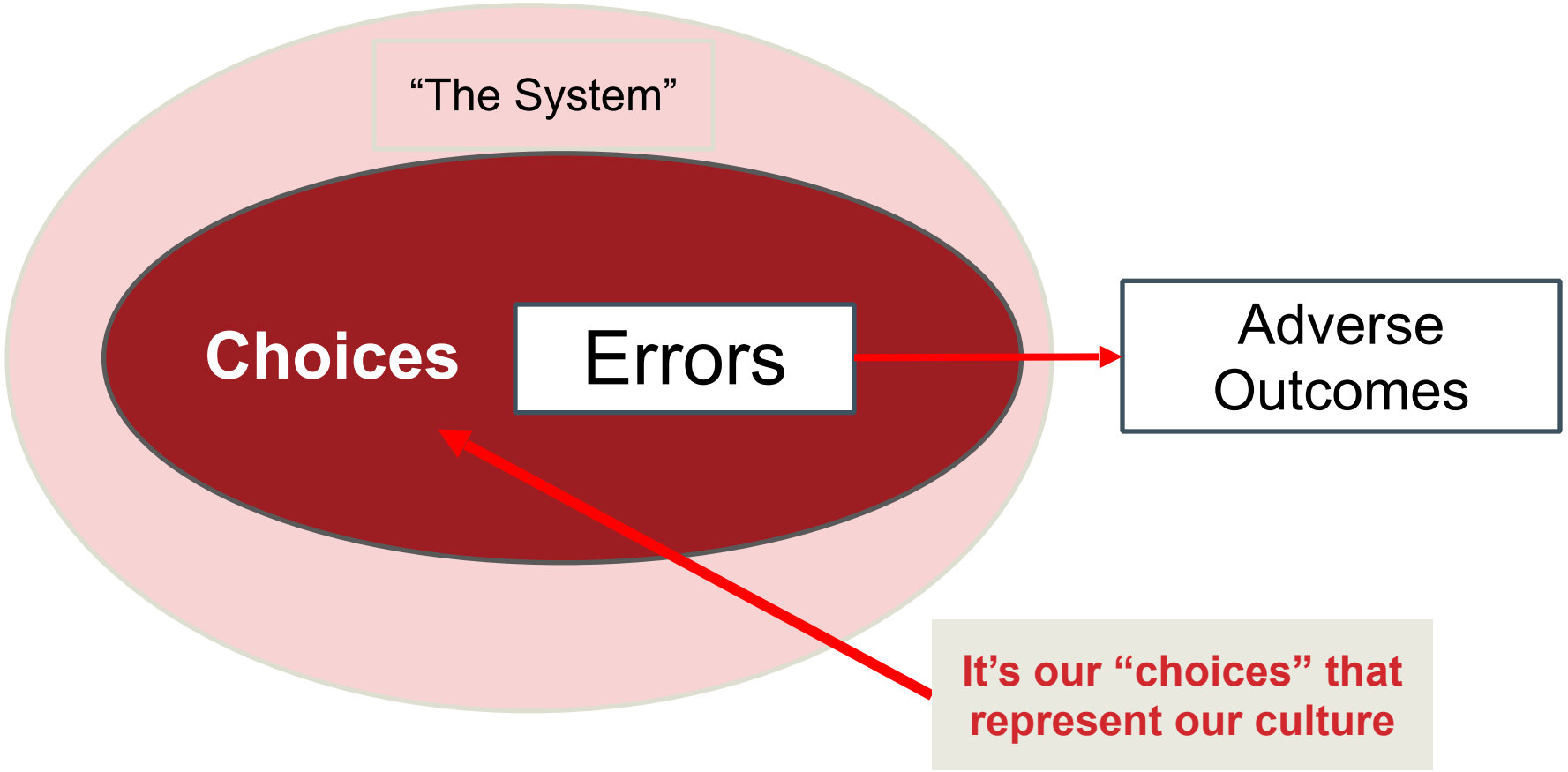


- 6 months in prison
- 6 months of home confinement with electronic monitoring
- 3 years probation
- 400 hours of community service
- a $5,000 fine, and
- payment of court costs

Ex-pharmacist Eric Cropp pleads no contest to involuntary manslaughter in death of Emily Jerry

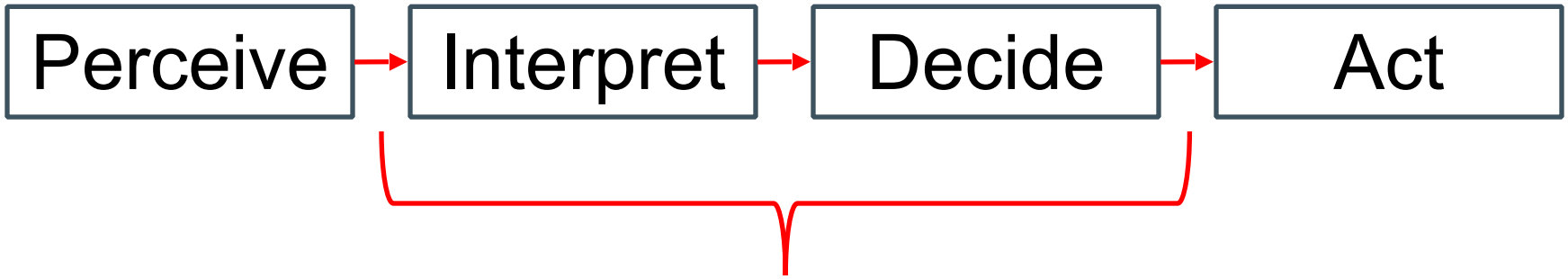


DIFFERENTIATING ERRORS, OUTCOMES AND CULTURE



INTERPRETATION AND DECISION-MAKING

A Simple Model of Human Behavior



Culture lies here

- The way we “interpret” the world around us
- How we “decide” to act in response

PROTECTING SELF V. PROTECTING OTHERS

Human beings are inherently self-protective

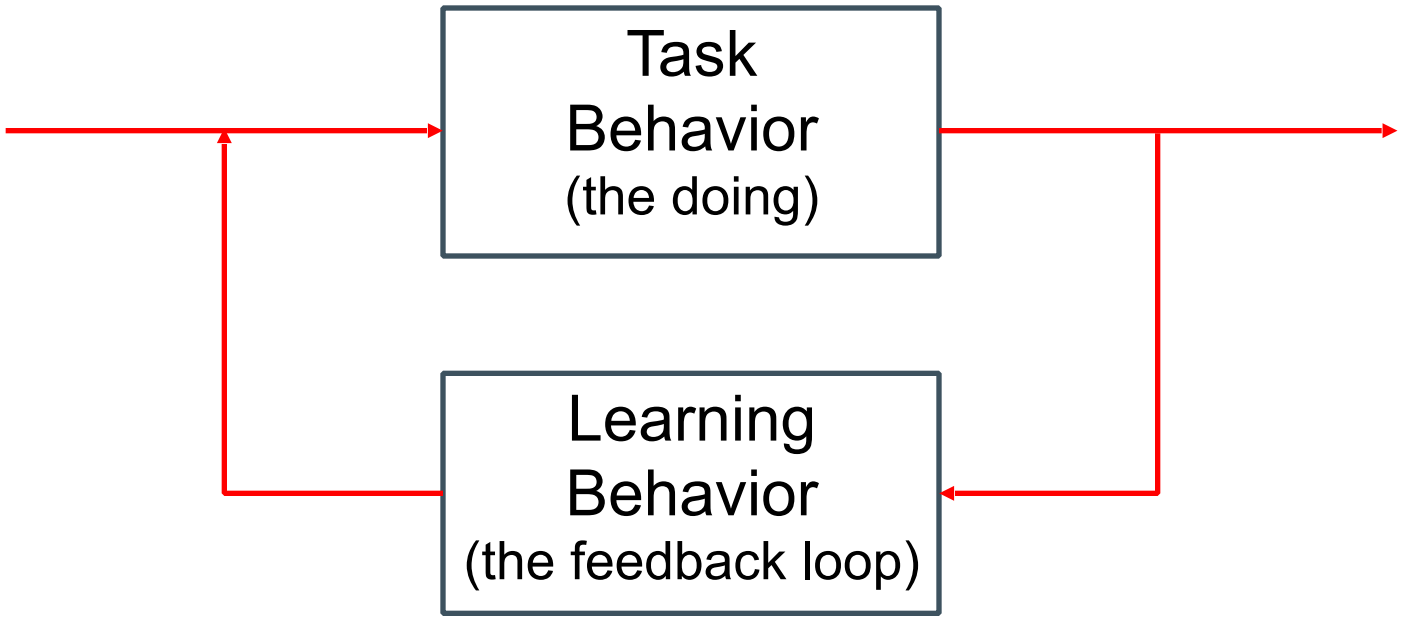
Measures of "safety culture" can and should be split:

- Employee's own safety
- The safety of other employees
- Patient Safety
- Family and Visitor Safety





TASK BEHAVIOR V. LEARNING BEHAVIOR



Safety culture resides in both:
task behaviors and reporting/investigation behaviors

THREE LEVELS – DO, SAY, AND RESPOND

Do –	**It's what we do to protect safety**
Say –	**It's what we say to others to help them protect safety**
Respond –	**It's how we respond when others talk to us about how we might protect safety**

A GRADIENT OF RISK

As "interpreted risk" rises, human beings are more inclined to act

Would a scrub tech coach a surgeon who chooses to:

- use an unsterile instrument?
- allow a surgery to continue without an up-to-date history and physical?
- close before the instrument count is complete?
- rush through the pre-surgical time out?
- disrespect the circulating nurse?

WHO DOES SAFETY CULTURE WELL?



Track Days

- 150 people
- 30 riders on the track at a time
- Learning sessions
- Track marshal and corner workers
- Black flags





Why?
because of a surgeon
I met at the track









BUILDING A STRONG SAFETY CULTURE

- Articulate safety as an organizational value
- Design your systems to support safety
- Audit (look for safety supportive choices)
- Be a role model (resolve dilemmas in a manner that demonstrates your commitment to safety)
- Mentor (help others resolve dilemmas in the right way)
- Coach (call it out when you see choices that are unsafe)
- Hold everyone accountable for the right choices (be safe, or get off the track)

Patient Safety

Safety Culture

Just Culture

THE JUST CULTURE

A system of substantive justice (disciplinary and enforcement action) that reflects what we now know of socio-technical system design, free will, and our inescapable human fallibility.

BEHAVIOR IN THE JUST CULTURE

Human Error -	**inadvertent action; inadvertently doing other that 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.**

THE CORE CONCEPTS – HUMAN ERROR

Human Error - inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake.

Console

Learn

THE CORE CONCEPTS – AT-RISK BEHAVIOR

At-Risk Behavior – behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified.

Coach

Learn

THE CORE CONCEPTS – HUMAN ERROR

Reckless Behavior - behavioral choice to consciously disregard a substantial and unjustifiable risk.

Punish

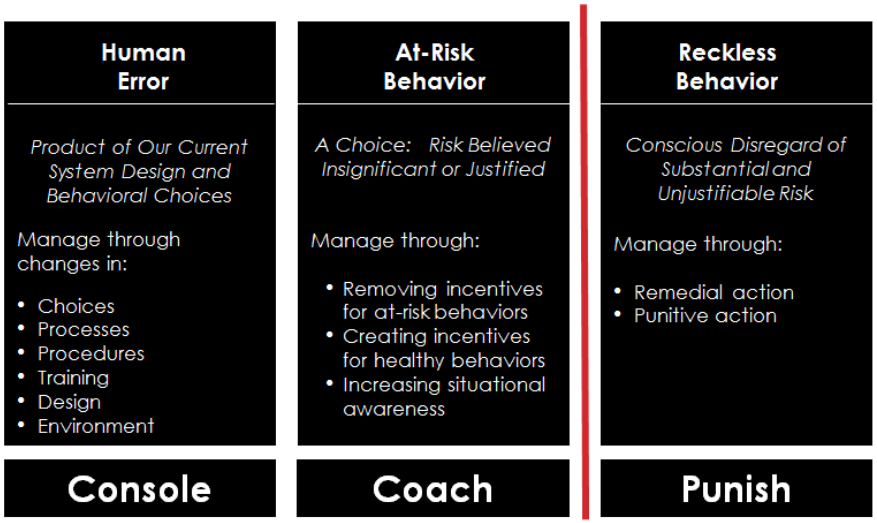
Learn

THE THREE BEHAVIORS

Human Error	At-Risk Behavior	Reckless Behavior
Product of Our Current System Design and Behavioral Choices	*A Choice: Risk Believed Insignificant or Justified*	*Conscious Disregard of Substantial and Unjustifiable Risk*
Manage through changes in: • Choices • Processes • Procedures • Training • Design • Environment	Manage through: • Removing incentives for at-risk behaviors • Creating incentives for healthy behaviors • Increasing situational awareness	Manage through: • Remedial action • Punitive action
Console	**Coach**	**Punish**

REPETITIVE ERRORS AND AT-RISK BEHAVIORS

A Single Event



Repetitive Events

Repetitive errors – yes, there is a process

Repetitive at-risk behaviors – yes, there is a process

Both may lead to disciplinary action…

SO WHAT DO WE JUDGE?



A combination of innate talent and that we've developed throughout our life

What we choose to do with our talent

Variability in the world, including our own inescapable fallibility

The results; good, bad, or indifferent

Judge Talent. Judge Choices. And, where appropriate, judge outcomes as measure of talent and choices.

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MISSIONS AND VALUES

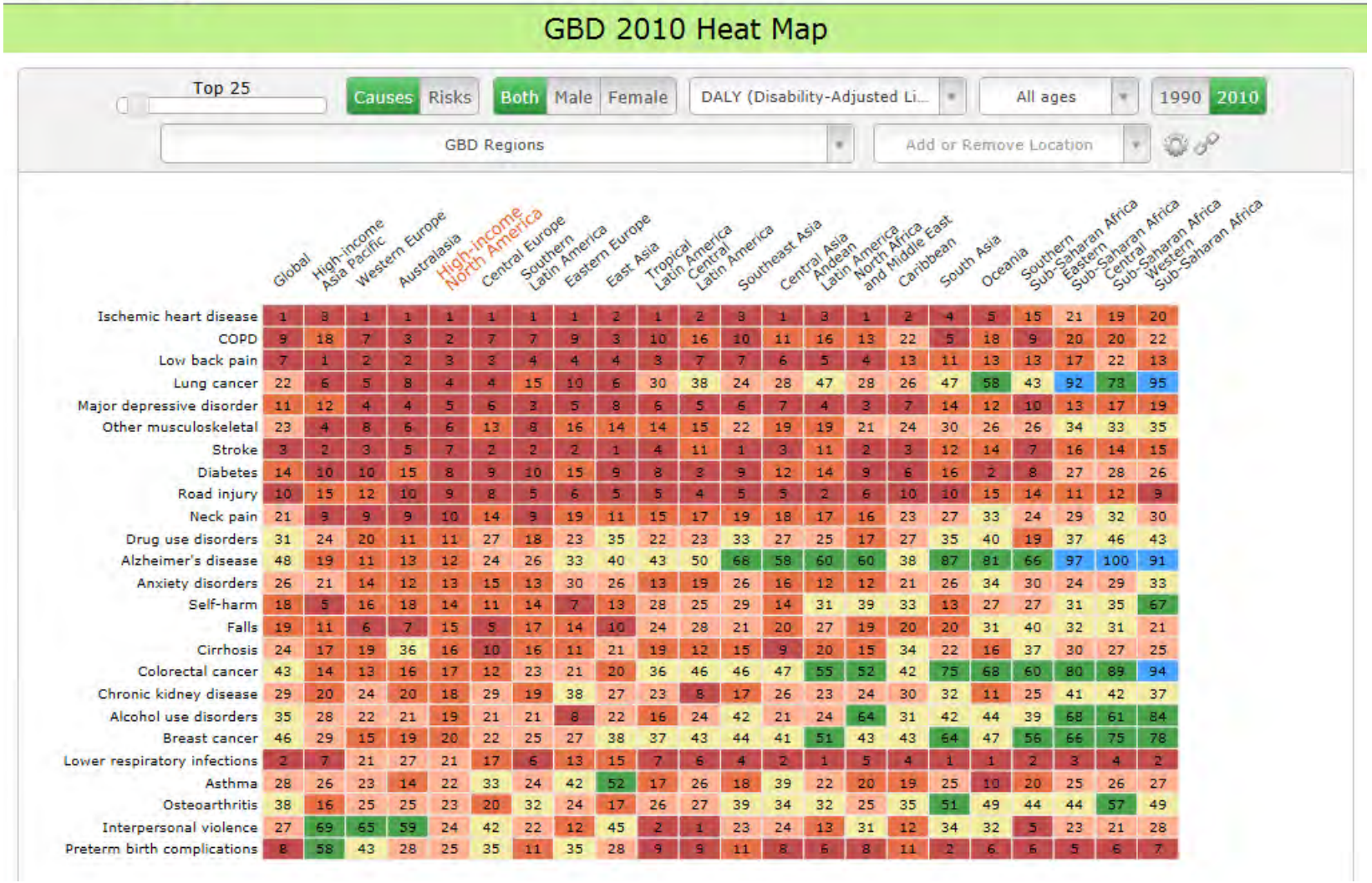
Mission

- Our reason for being
- As individuals, it's "pursuit of happiness"
- As organizations?

Value

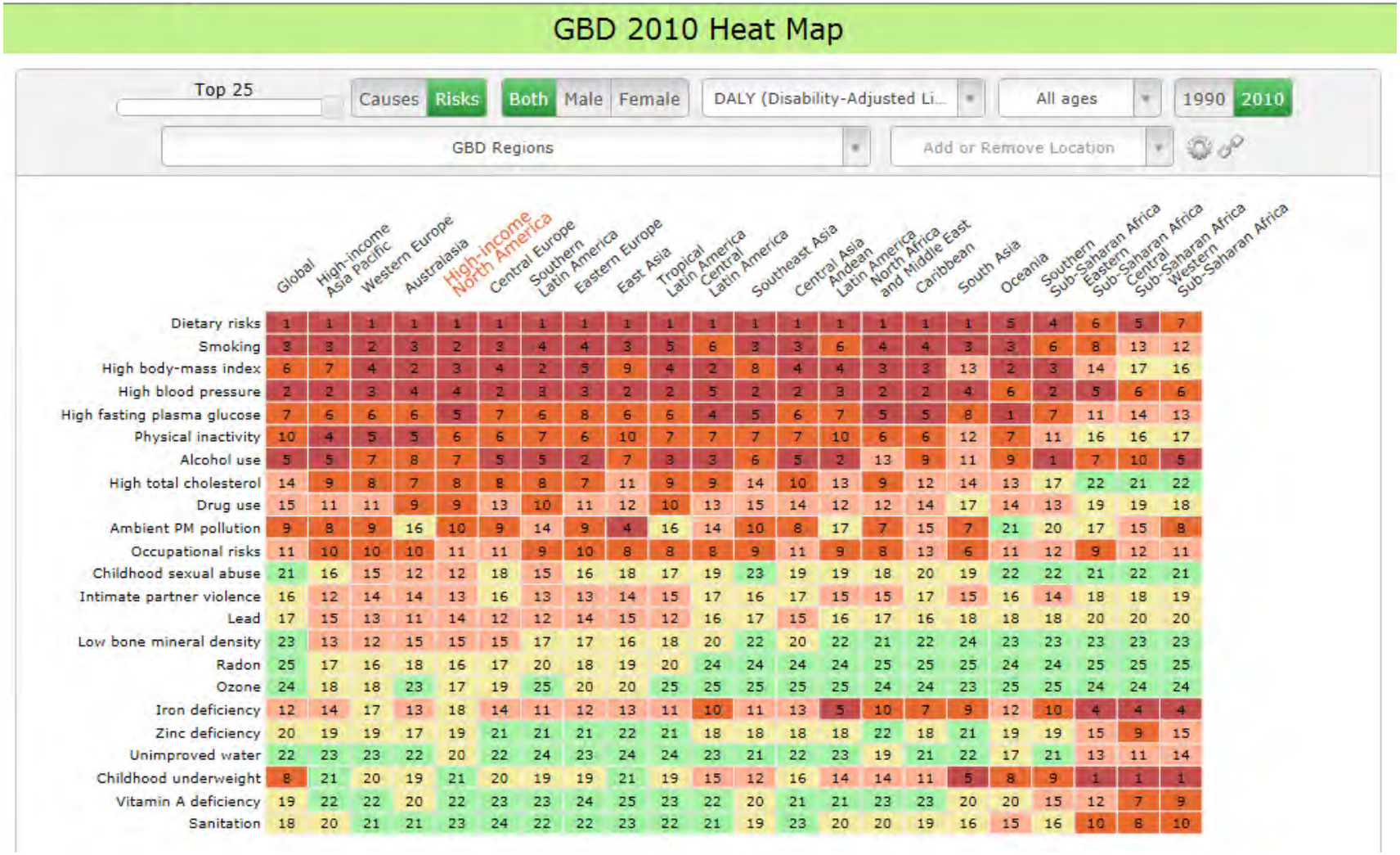
- A property interest that we strive to protect
  - Safety
  - Privacy
  - Dignity
  - Time
  - Oxygen?

GLOBAL BURDEN OF DISEASE - CAUSES

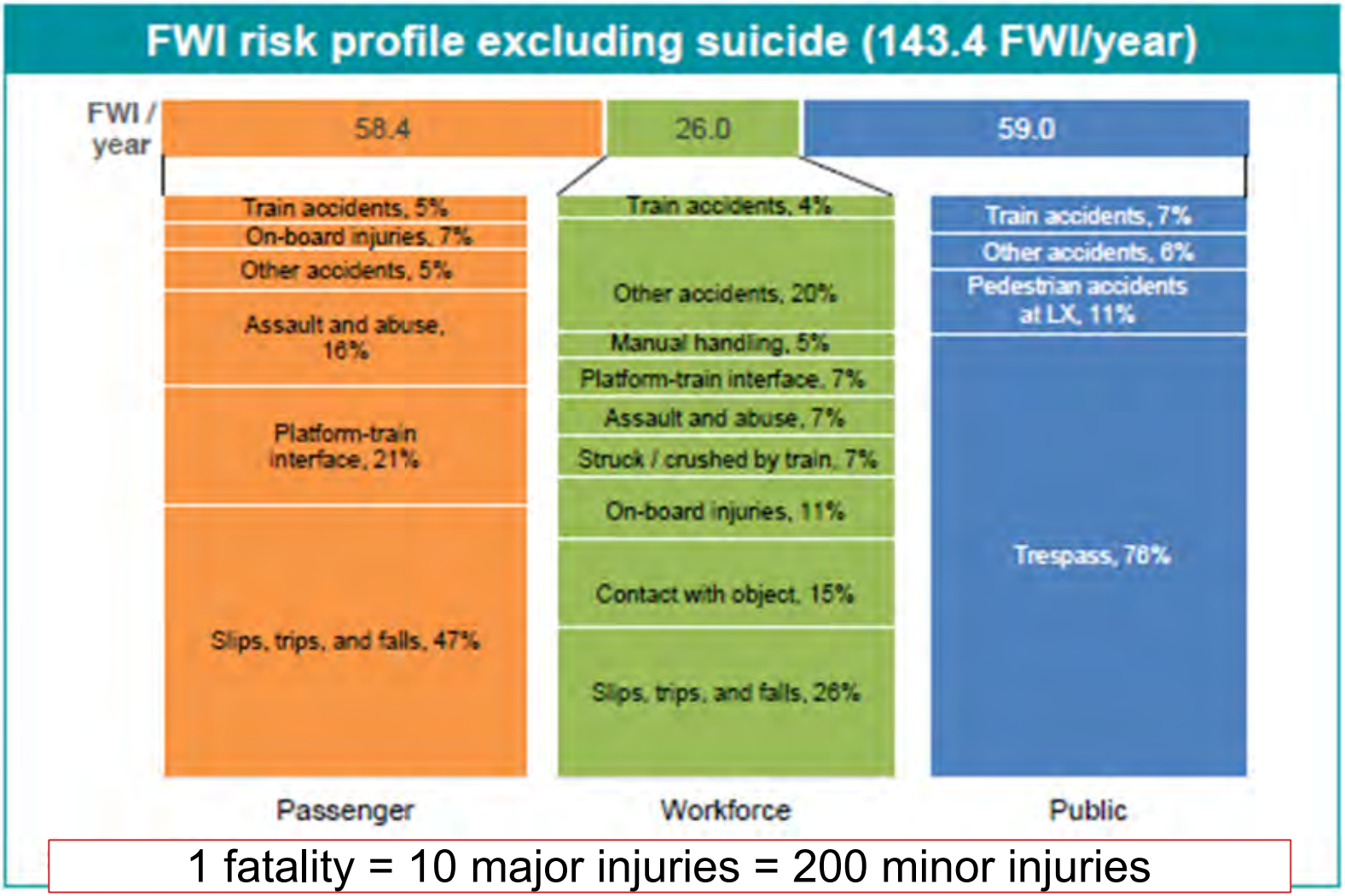


	Global	High-income Asia Pacific	Western Europe	Australasia	High-income North America	Central Europe	Southern Latin America	Eastern Europe	East Asia	Tropical Latin America	Central Latin America	Southeast Asia	Central Asia	Andean Latin America	North Africa and Middle East	Caribbean	South Asia	Oceania	Southern Sub-Saharan Africa	Eastern Sub-Saharan Africa	Central Sub-Saharan Africa	Western Sub-Saharan Africa
Ischemic heart disease	1	8	1	1	1	1	1	1	2	1	2	3	1	3	1	2	4	5	15	21	19	20
COPD	9	18	7	3	2	7	7	9	3	10	16	10	11	16	13	22	5	18	9	20	20	22
Low back pain	7	1	2	2	3	3	4	4	4	3	7	7	6	5	4	13	11	13	13	17	22	13
Lung cancer	22	6	5	8	4	4	15	10	6	30	38	24	28	47	28	26	47	58	43	92	78	95
Major depressive disorder	11	12	4	4	5	6	3	5	8	6	5	6	7	4	3	7	14	12	10	13	17	19
Other musculoskeletal	23	4	8	6	6	13	8	16	14	14	15	22	19	19	21	24	30	26	26	34	33	35
Stroke	3	2	3	5	7	2	2	2	1	4	11	1	3	11	2	3	12	14	7	16	14	15
Diabetes	14	10	10	15	8	9	10	15	9	8	3	9	12	14	9	6	16	2	8	27	28	26
Road injury	10	15	12	10	9	8	5	6	5	5	4	5	5	2	6	10	10	15	14	11	12	9
Neck pain	21	9	9	9	10	14	9	19	11	15	17	19	18	17	16	23	27	33	24	29	32	30
Drug use disorders	31	24	20	11	11	27	18	23	35	22	23	33	27	25	17	27	35	40	19	37	46	43
Alzheimer's disease	48	19	11	13	12	24	26	33	40	43	50	68	58	60	60	38	87	81	66	97	100	91
Anxiety disorders	26	21	14	12	13	15	13	30	26	13	19	26	16	12	12	21	26	34	30	24	29	33
Self-harm	18	5	16	18	14	11	14	7	13	28	25	29	14	31	39	33	13	27	27	31	35	67
Falls	19	11	6	7	15	5	17	14	10	24	28	21	20	27	19	20	20	31	40	32	31	21
Cirrhosis	24	17	19	36	16	10	16	11	21	19	12	15	9	20	15	34	22	16	37	30	27	25
Colorectal cancer	43	14	13	16	17	12	23	21	20	36	46	46	47	55	52	42	75	68	60	80	89	94
Chronic kidney disease	29	20	24	20	18	29	19	38	27	23	8	17	26	23	24	30	32	11	25	41	42	37
Alcohol use disorders	35	28	22	21	19	21	21	8	22	16	24	42	21	24	64	31	42	44	39	68	61	84
Breast cancer	46	29	15	19	20	22	25	27	38	37	43	44	41	51	43	43	64	47	56	66	75	78
Lower respiratory infections	2	7	21	27	21	17	6	13	15	7	6	4	2	1	5	4	1	1	2	3	4	2
Asthma	28	26	23	14	22	33	24	42	52	17	26	18	39	22	20	19	25	10	20	25	26	27
Osteoarthritis	38	16	25	25	23	20	32	24	17	26	27	39	34	32	25	35	51	49	44	44	57	49
Interpersonal violence	27	69	65	59	24	42	22	12	45	2	1	23	24	13	31	12	34	32	5	23	21	28
Preterm birth complications	8	58	43	28	25	35	11	35	28	9	9	11	8	6	8	11	2	6	6	5	6	7

GLOBAL BURDEN OF DISEASE - RISKS



UK RAILROAD RISK REGISTER



1 fatality = 10 major injuries = 200 minor injuries

EXPECTATIONS – HOW DO YOU MEASURE?

Value	Measurement
Protecting patient safety	*?*
Protecting patient privacy	*?*

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OUR FALLIBILITY

Human Error

(the thing I never intended to do)

- Often appears as random
- Inescapable
- Not fully preventable

Choices

(the product of our free will)

- Can be fully deliberate, conscious
- Can be automatic, subconscious

OUR TWO BRAINS*

System 1	System 2
Subconscious reasoning	Conscious reasoning
Operates quickly	Operates slowly
Multi-processing	One thing at a time
Automatic	Effortful
Active, eager	Lazy
Not unhappy being wrong	Hates being wrong
Hates dilemmas	Loves dilemmas

*** See Daniel Kahneman, Thinking Fast and Slow**

A RELEVANT MENTAL MODEL

Sight

Sound

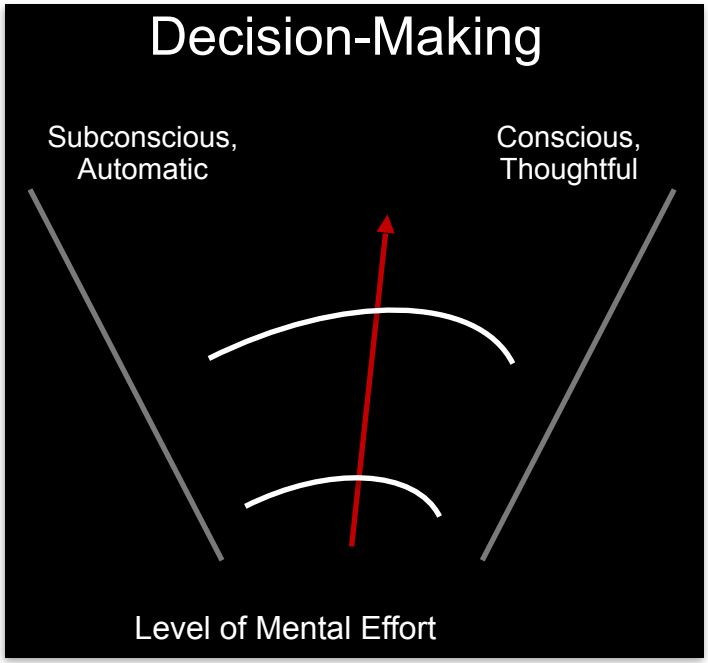
Smell

Taste

Touch

Standard interpretation (heuristics, mission focused)

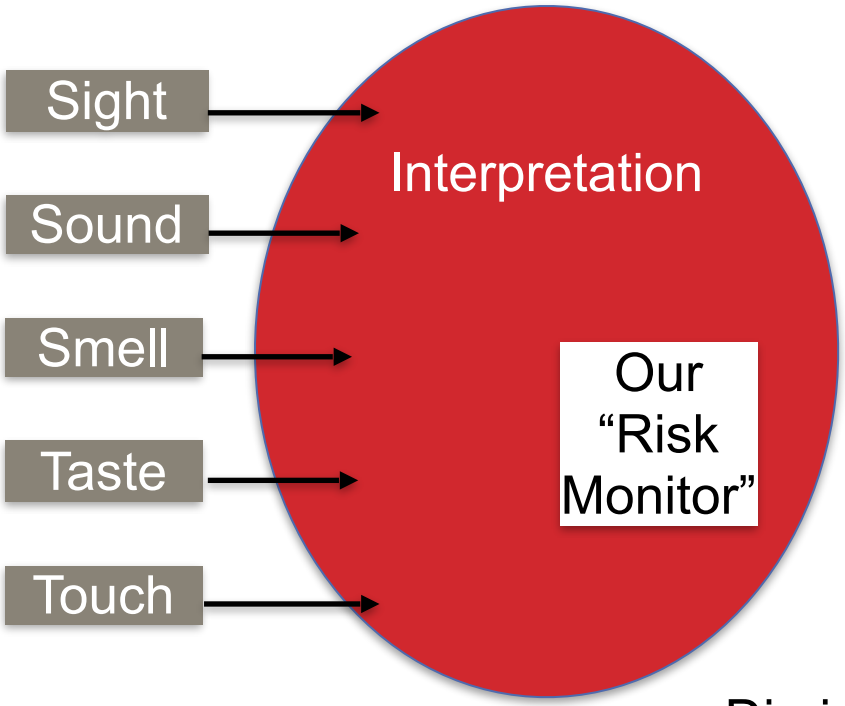
The "Risk Monitor" (background process, harm focused)





Perception → Interpretation → Decision-Making → Action

THE RELIABILITY OF OUR RISK MONITORS



Our active thought stays focused on the mission

It is our Risk Monitor that keeps us from harming ourselves and others

Diminished capacity of the Risk Monitor?

- Age, disease, substance abuse
- Lack of knowledge about the hazard
- Excessive time with the hazard
- Mission / values conflicts

THE RELIABILITY OF OUR RISK MONITOR

Where does it obviously alert?

1.

2.

3.

Where does it not, but it should?

1.

2.

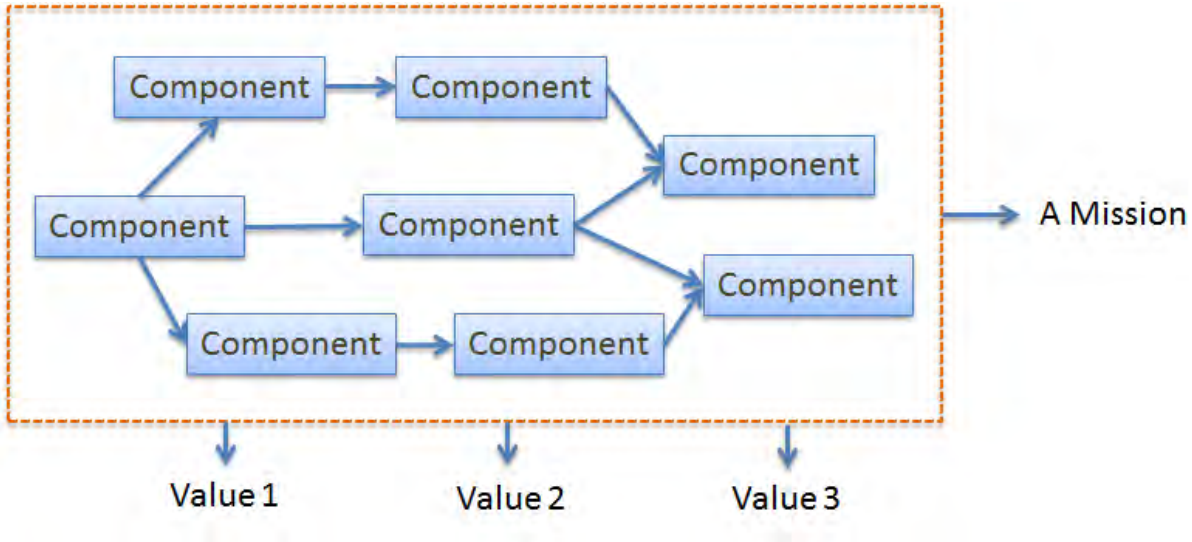
3.

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SYSTEMS

System: A collection of components (human , man-made, environment that work together to produce a result (fulfill a mission or protect a value).

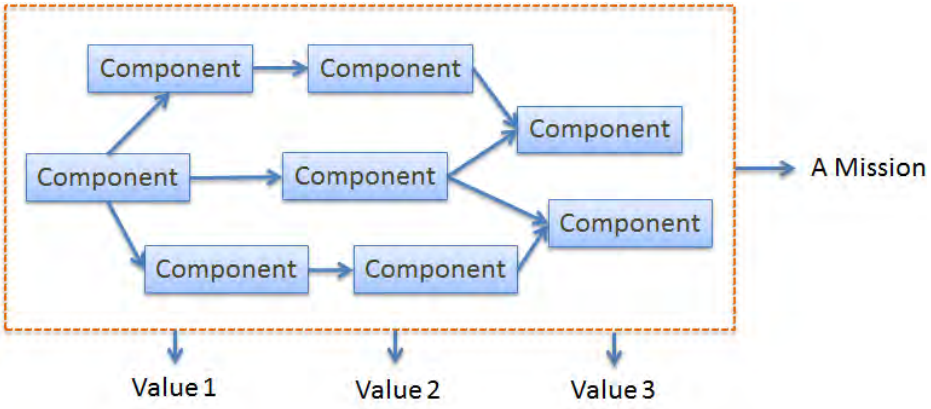


Mission Supportive
(expressed as a positive result)

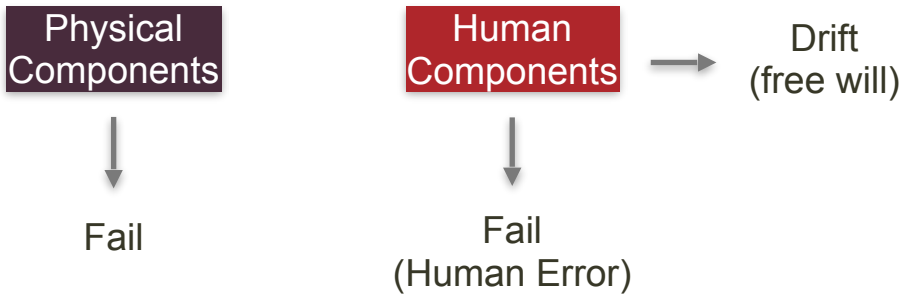
Value Protective
(expressed as an absence of harm)

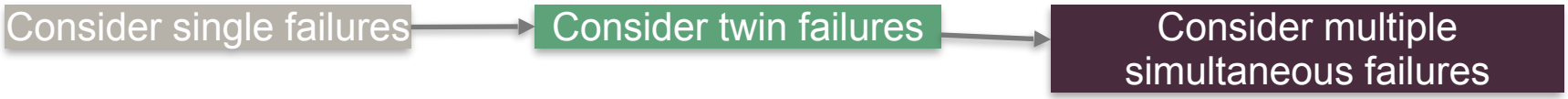
Optimal: Fulfill the mission, protect the values, and do it with a minimal use of resources.

SYSTEM ARCHITECTURE

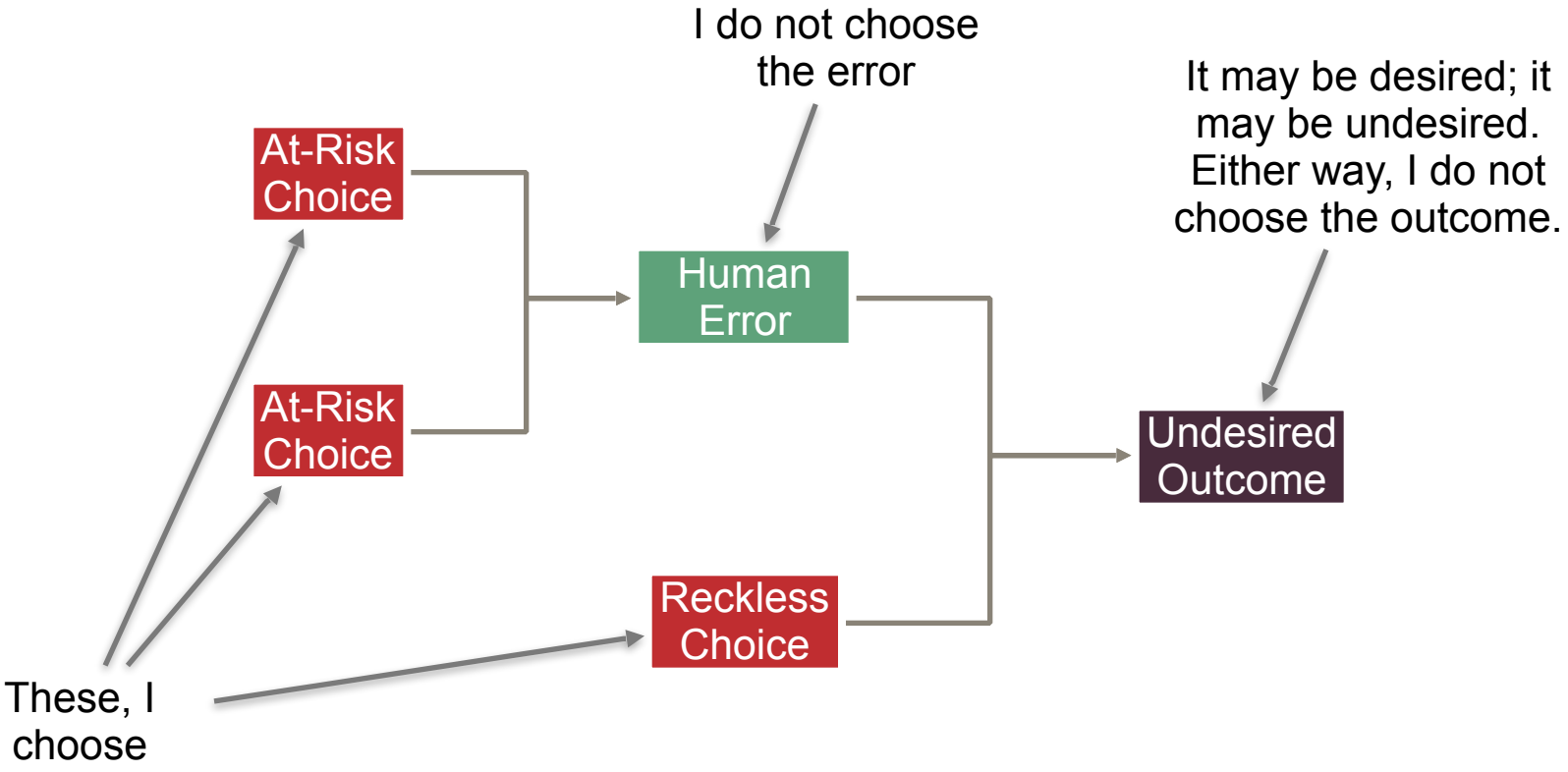


1. Design first for the mission
2. Identify failure modes and effects for each component
3. Assess impact on mission aspirations
4. Redesign to meet mission aspirations
5. Assess impact on each relevant value
6. Redesign to meet value expectations





KNOWING WHAT WE CAN MANAGE



So, where do I have control?

DESIGNING FOR DRIFT



a choice increasing the likelihood of human error

misperceptions of risk convince human that the error will not occur

a choice to skip a task intended to catch an earlier failure

seen as a non-value-added task

Both are considerable threats to system reliability

DEVELOPING INSTRUCTIONS AND RULES

Instructions

Needed for components (human and material) to know what to do

Instructions are guidance

Rules

Procedural Rules

To keep human on the most optimized path

Expressed as a "how to"

Values-based Rules

To keep human from engaging in undesired conduct

Expressed as a "don't do"

Rules involve expectations

Artificial danger imposed (the threat)

Sanction if breached in particular ways

USING DESIGN FEATURES

Barriers

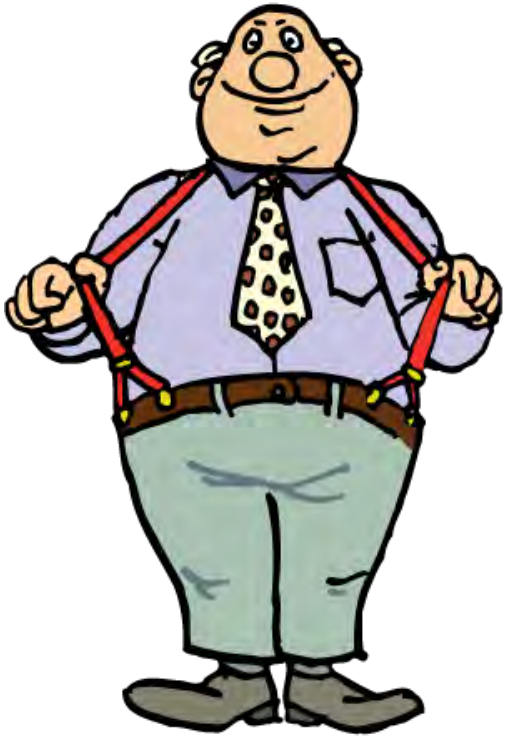
to prevent specific failure modes

Recovery

to catch failures before they cause harm

Redundancy

To provide multiple paths to a desired outcome



A SIMPLE EXAMPLE – PENS AND PENCILS



A MORE COMPLEX EXAMPLE - ENGINES

So, How Many Engines Should We Have?



Engine Shuts Down – $1x10^{-4}$ Engine Blows Up – $1x10^{-7}$

Hint: It can fly on only one engine, but one engine blowing up can take out the entire aircraft

RETAINED PEANUTS – WHAT'S THE STRATEGY?

- Barriers?
- Recover?
- Redundancy?



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LEARNING SYSTEMS

Inputs	Investigation and Analysis	Outputs
Employee self reports	Are we producing the outcomes we desire? - Mission - Values	Do nothing
Observations/Audit		System redesign
Customer feedback		
Regulatory oversight	Do we see risks that we do not intend to take? - Systems - Behaviors	Helping employees make better choices
Risk assessments		
Outcome data		

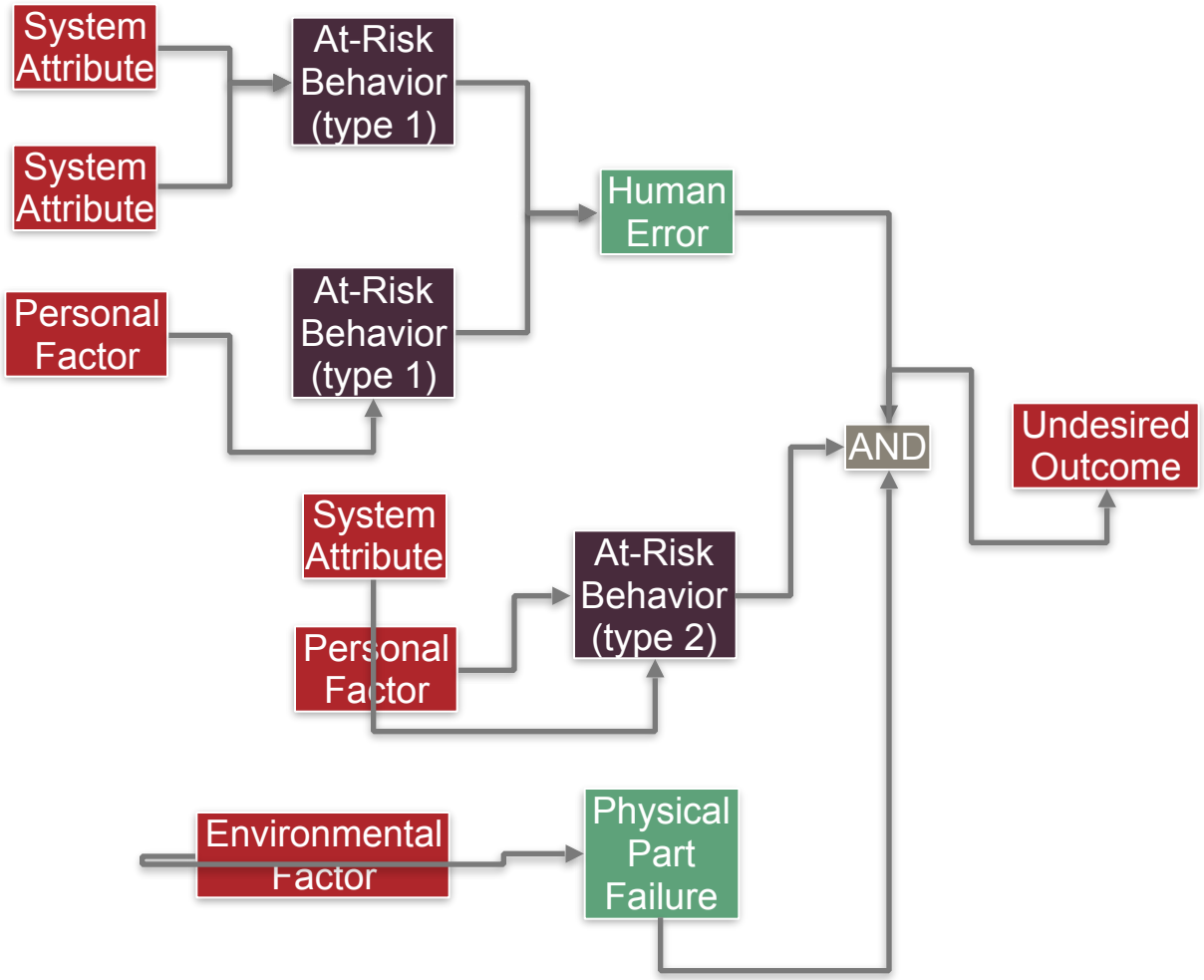
LEARNING V. JUSTICE

A system of workplace justice should promote each employee's reporting of hazards, choices, and near-miss events that are precursors to more harmful adverse outcomes – while still holding each employee appropriately accountable for their choices.

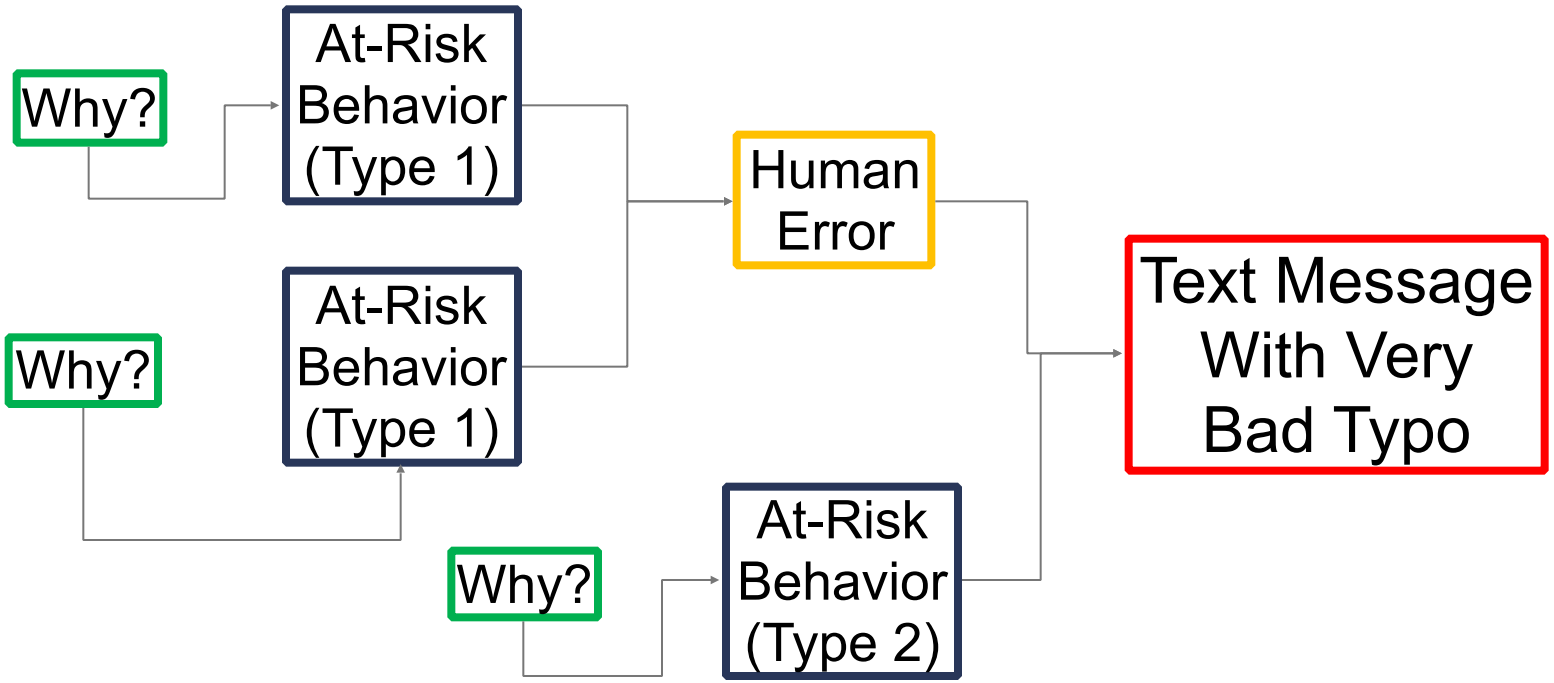
SEEING THE PRECURSORS TO OUTCOMES THROUGH A CAUSE AND EFFECT DIAGRAM

The Rules

1. Identify the undesirable outcome
2. Search for causes
3. Build a cause and effect diagram
4. Test the strength of causal links
5. Explain human errors
6. Explain behavioral choices
7. Explain physical failures
8. Explain other causal factors
9. Remove non-causal data
10. Build the narrative
11. Eliminate possible biases
12. Test the product
13. Develop risk reduction strategies

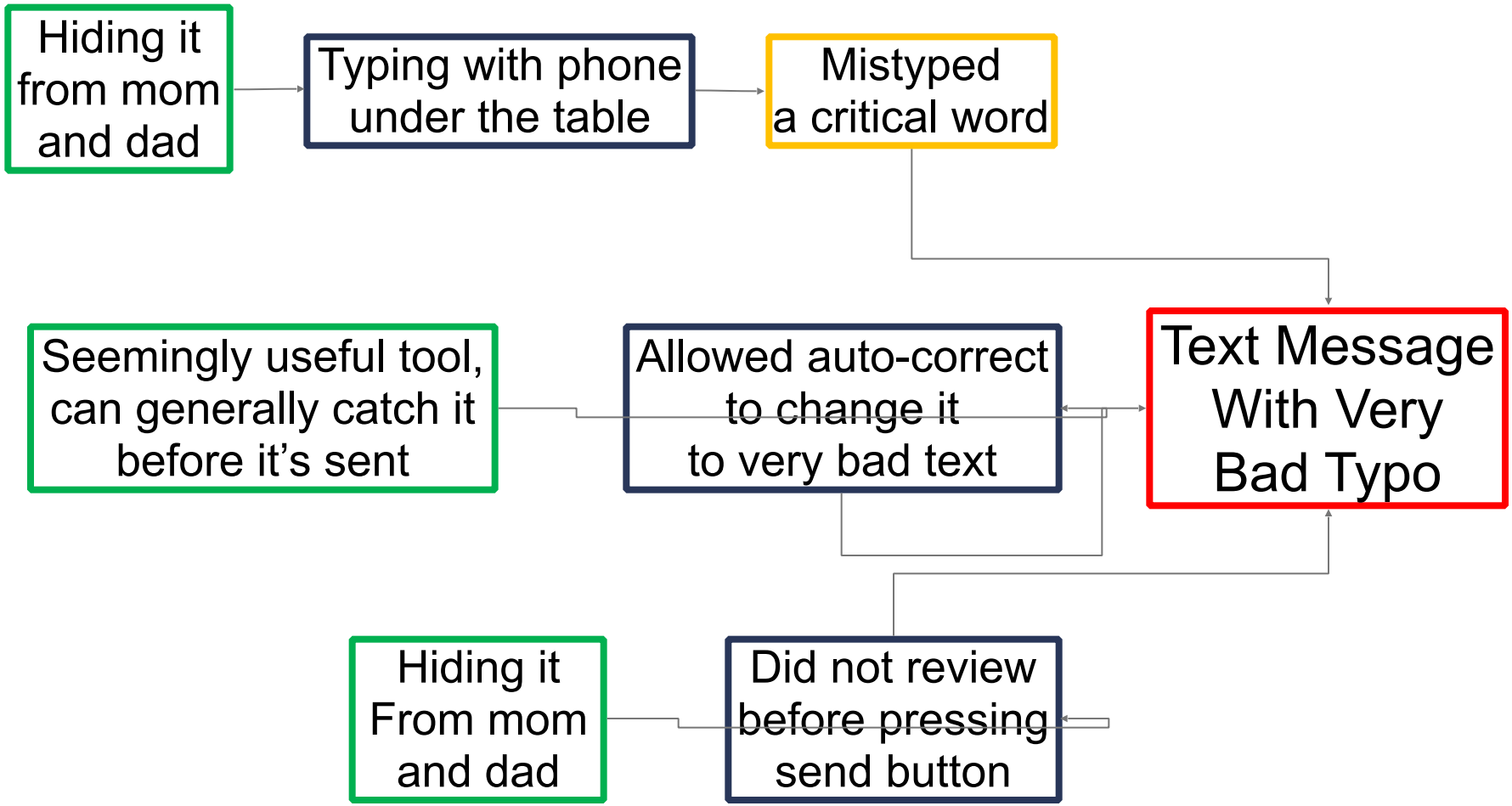


SEEING THE PRECURSORS

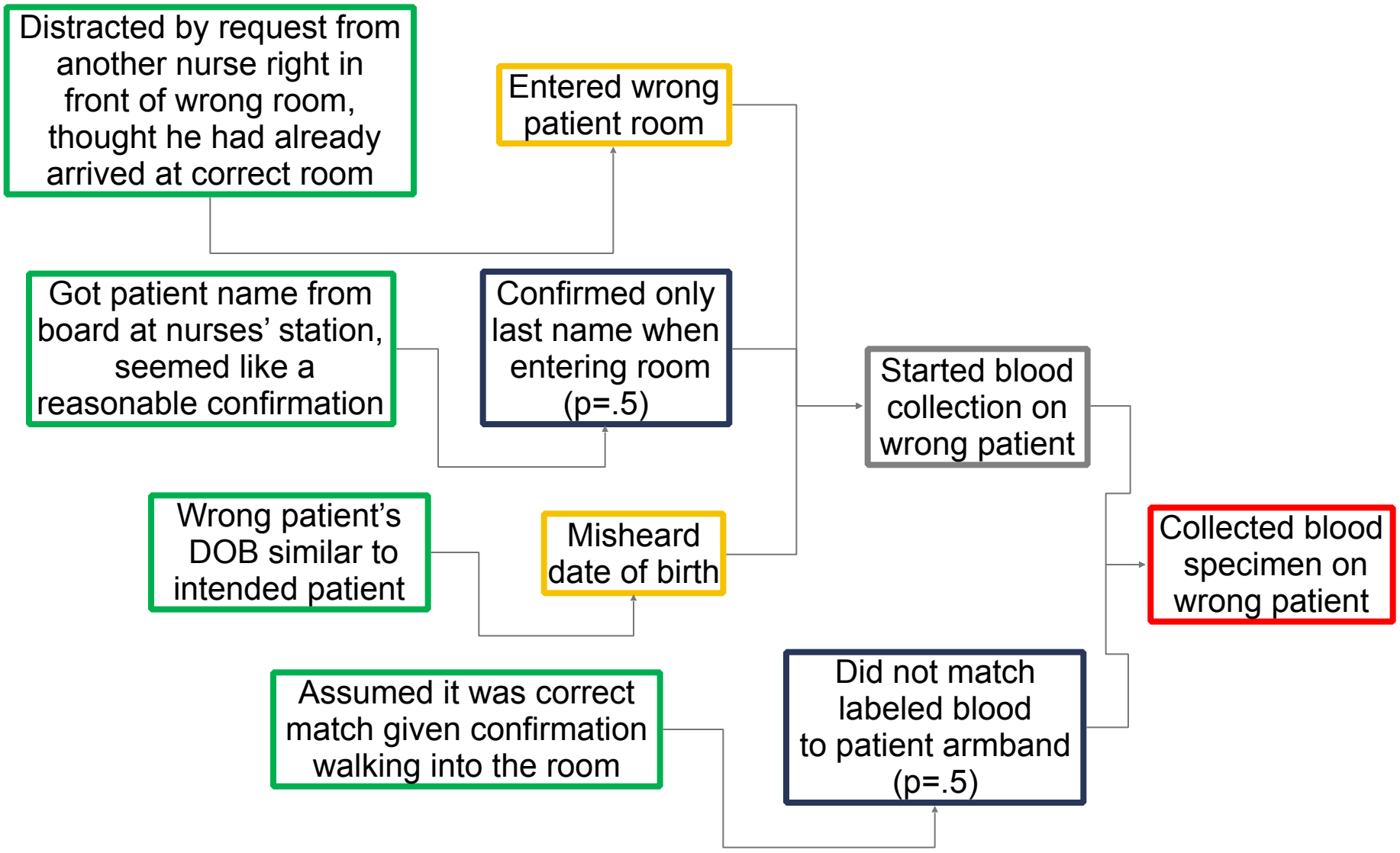


- Each Human Error should have a preceding cause
- Each At-risk Behavior should have a preceding cause

SEEING THE PRECURSORS



SEEING THE PRECURSORS



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



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PUTTING DISCIPLINARY ACTION IN CONTEXT

Being Helpful

All the things we do to the benefit of our employees

- Train
- Mentor
- Coach
- Accolade
- Off-hours education
- Time off
- Health benefits

The Narrow Role of Disciplinary Action

Sanction!

Stemming from expectations and their corresponding artificial danger

- Counseling to re-articulate the threat
- Progressive sanction to change individual employee choices
- Progressive sanction as a general deterrent

Ending the Relationship

Termination of employment when continued relationship is incompatible with the mission and/or values of the organization

JUSTICE DEMANDS FOLLOW-THROUGH

Disciplinary Actions

- Counseling (the threat)
- Fine
- Demotion
- Duty change



Legitimate Reasons for Disciplinary Action

- Specific Deterrence
- General Deterrence

- RETRIBUTION and REHABILITATION are not legitimate reasons for disciplinary action

Termination/Incapacitation is used when disciplinary action does not work

THE JUST CULTURE

A system of substantive justice (disciplinary and enforcement action) that reflects what we now know of socio-technical system design, free will, and our inescapable human fallibility.

BEHAVIOR IN THE JUST CULTURE

Human Error -	**inadvertent action; inadvertently doing other that 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.**

THE CORE CONCEPTS – HUMAN ERROR

Human Error - inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake.

Console

Learn

THE CORE CONCEPTS – AT-RISK BEHAVIOR

At-Risk Behavior – behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified.

Coach

Learn

THE CORE CONCEPTS – HUMAN ERROR

Reckless Behavior - behavioral choice to consciously disregard a substantial and unjustifiable risk.

Punish

Learn

SO WHAT DO WE JUDGE?



A combination of innate talent and that we've developed throughout our life

What we choose to do with our talent

Variability in the world, including our own inescapable fallibility

The results; good, bad, or indifferent

Judge Talent. Judge Choices. And, where appropriate, judge outcomes as measure of talent and choices.

SCENARIO A

A housekeeping worker was waxing the floors around 10:00 pm. He could not find a wet floor sign and would have had to have gone to another building to search for one. Believing he was alone in the building, he did not search for a warning sign. An accountant slipped on the wet floor and severely damaged his knee. The housekeeping staff frequently had to search for the wet floor warning signs which caused them to get behind on their work. The housekeeping manager was aware of the unavailability of signs, but did not take any action to purchase more.

SCENARIO B

A new operations manager is found to have lied on his resume. He did not have the college degree that he showed on his resume.

An investigation of why this oversight has occurred found that a human resources clerk did not do the required background check. The human resources manager had never had a candidate lie about a college degree in their 8 years of managing, and simply told his overworked clerk to skip the check. Corporate policies require that the check be completed. Both the clerk and the manager were aware of the policy.

SCENARIO C

The Engineering department has a large book in which the instructions for repairing equipment are located. Policy requires that these instructions be followed each time that a repair was performed. Last week a technician made a mistake on the repair of an infusion pump by omitting a required check upon re-assembly of the pump (relying on his memory to perform the task). This check, called out in the manual, would have confirmed that the infusion pump would not allow the free (unregulated) flow of medication under a particular failure mode of the pump.

The inoperable pump safety device was caught when a patient received a free flow of heparin, leading to the death of the patient. Investigation reveals that the technician regularly performs this specific maintenance. Investigation also reveals that other technicians were performing this task by memory, without the aid of the procedure manual.

SCENARIO D

A nursing manager walks by a patient's room, seeing the patient about to fall from his bed. She quickly runs to the bedside, lifting the patient back on to the bed before the patient actually falls. In doing so, the nurse manager failed to follow hand hygiene procedures requiring that hands be washed prior to touching the patient. The event came to light when a disgruntled nurse filed a risk report on the nurse manager.

SCENARIO E

An office assistant is tasked with booking travel for a group of hospital executives. Part of that travel task is to produce driving instructions from the hotel to the location of the executive's meeting. In the last 6 months, the office assistant has sent three executives off with directions that do not match the place the executives intended to go. Twice the assistant put in the incorrect zip code (leading to the incorrect city). Once the assistant got different trips mixed up, printing driving directions for a trip that would be taken a month later. The office manager has given the assistant tips to ensure correct driving instructions – including cross-matching the zip code and address, and confirming with the organization that the executive is going to visit. Yesterday, the office assistant made the mistake again (a fourth error), by creating driving directions to the wrong originating airport.

SCENARIO F

The IV pump of a patient starts to beep signaling an occlusion in the IV line. A nursing assistant notices the alarm and alerts the nurse on duty. Thirty minutes later the nurse has still not come in to investigate the situation. The pump continues to beep and the patient begins to hit the call light each time the alarm rings. Repeated attempts to get the nurse in the room are unsuccessful. Frustrated, the nurse assistant shuts the pump off to keep it from beeping and to keep the patient happy (by turning off the noisy pump) until the nurse can come in and fix the problem. Forty-five minutes later the nurse comes in the room, checks the IV and notices that the catheter is unable to flush.

Investigation reveals that the nurse was watching a much anticipated television episode in the break room.

SCENARIO G

A brand new nurse to the OR (watching and learning the processes and practices of her new employer) storms out of the safety timeout ahead of surgery and right in the Director of the OR's office. She blurts out, "Are you kidding me? The anesthesiologist is listened to his IPod with those little things in his ears. He's actually dancing a bit, you know, moving to the beat, nodding his lead when people look his way. I looked at everyone else in the timeout, and no one seemed to notice. They look like Zombies. Is this how we're going to treat patient's here? Do anesthesiologists get a pass? Does anyone care?"

SCENARIO H

An attending physician is about to perform minor surgery (removal of a cyst). Ahead of the surgery, the nurse comes in to have the consent signed by the patient. The patient states that the physician did not discuss the risks – therefore it would be inappropriate to sign the disclosure form. The nurse said, “Look, we can make a mistake and sometimes the outcome isn’t that great. Given that, you’re probably better off having the surgery. So, just sign the thing.” The patient complains to the physician, who says “well, did you sign the consent, or not?”

AGAIN,
WHAT DO WE JUDGE?



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FOR THE SAFETY OF YOUR PATIENTS

- **Build a Risk Register – a quantitative model of future events**
- **Set an expectation – how good do you want to be?**
- **Design your systems to meet that expectation**
- **Build a strong safety culture**
  - A Learning Culture
  - A Just Culture

FOR A LEARNING CULTURE

- **Audit systems (look for hazards)**
- **Audit behaviors (look for safety supportive choices)**
- **Enhance reporting (staff looking for hazards and safety supportive behaviors)**
- **Enhance investigations (to see the systems and choices that were the precursors to harm)**
- **Learn to better assess risk – tools to look into very, very complex systems**

FOR A JUST CULTURE

- **Review your current practices – eliminate inconsistent language, policies, and practices**
- **Train your managers – give them the tools**
- **Create champions – give assistance to local managers**
- **Train your staff – give them the language of error, at-risk, and reckless**
- **Keep it on the agenda – it's inherently unstable in today's larger culture**
- **Stay the course when the big events occur – know your staff are watching you**

FOR YOU

- **Show that Patient Safety is a strongly held value, by:**
  - Being a role model (resolve dilemmas in a manner that demonstrates your commitment to safety)
  - Mentoring (help others resolve dilemmas in the right way)
  - Coaching (call it out when you see choices that are unsafe)
  - Holding your managers and staff accountable (make safe choices, or get off the track)