Institute for Healthcare Improvement

Just Culture

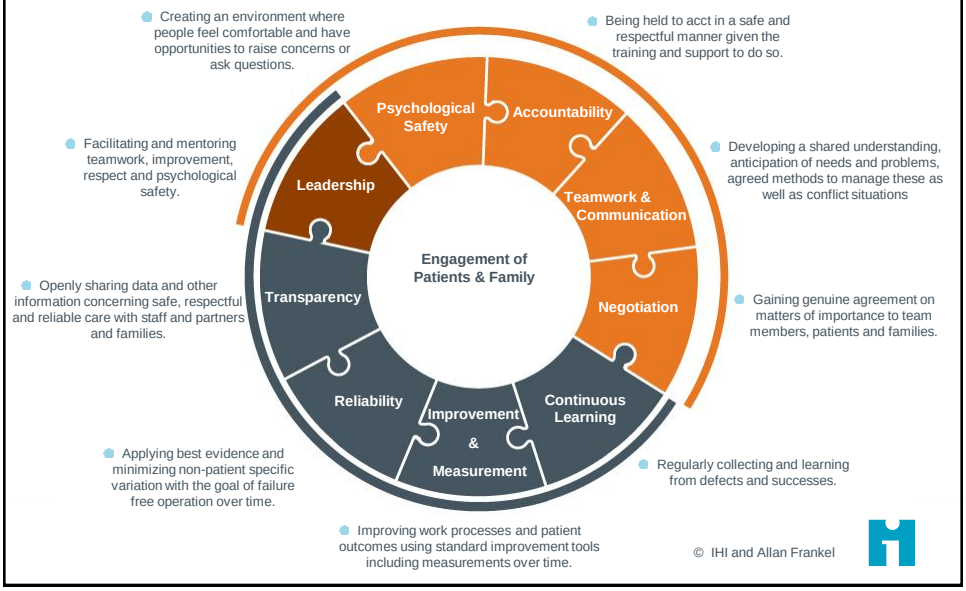
November 2016

Just Culture

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

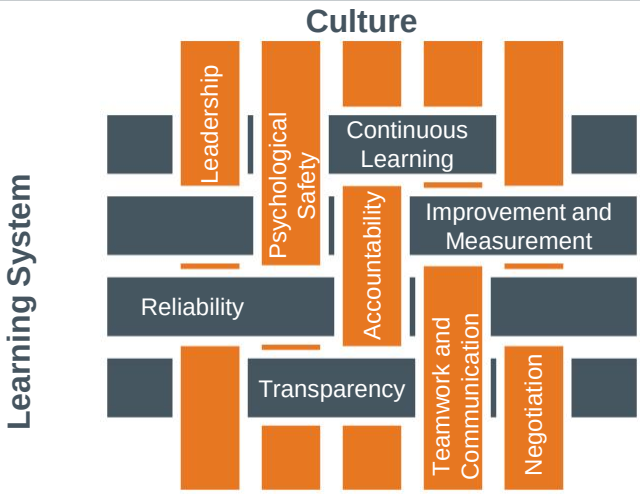
Dr Lucian Leape
Harvard School of Public Health

Framework for Clinical Excellence



Framework For Clinical Excellence

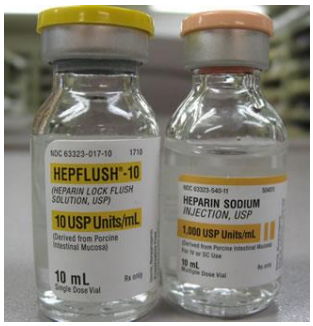
How it works in real life



Case One

- Box of heparin comes to the NICU, says 10 units/ ml on the outside, contains 1000 U/ ml vials
- Pharmacy tech is great, been there 20 years, “wouldn’t make a mistake”
- 9 people give 100 times too much heparin to very small children

Heparin Product Similarities Linked to Fatal Medication Errors



February 9, 2007 — The US Food and Drug Administration (FDA) and Baxter Healthcare Corp have warned healthcare professionals via letter regarding the potential for life-threatening substitution errors due to label colour similarities between 1-mL vials of 10,000 units/mL heparin sodium injection and the 10 units/mL preservative-free heparin lock flush solution (HEP-LOCK U/P).

Dennis Quaid files suit over drug mishap
The actor and his wife say the labelling of heparin by the manufacturer helped lead to the accidental overdose of their infant twins.


Lester Cohen, WireImage

Organizational Fairness / Just Culture

GENERATIVE Organization wired for safety and improvement	Real events are shared by leaders, true culture of accountability and learning.
PROACTIVE Playing offense - thinking ahead, anticipating, solving problems	Clear ways to differentiate individual v. system error, safe to discuss mistakes.
SYSTEMATIC Systems in place to manage hazards	Well understood algorithm, learning is the priority.
REACTIVE Playing defence – reacting to events	Depends who the boss is, blame and punishment are common.
UNMINDFUL No awareness of safety culture	Nothing good will come from talking about mistakes.

What does Just Culture look like?

- What are the rules that differentiate unsafe individuals from skilled people trying hard to do the right thing in a complex environment?
- What happens to the incident reports you file?
- What is your degree of confidence that the issues you raise will be addressed and fixed?

Inherent Human Limitations

- Limited memory capacity – 5-7 pieces of information in short term memory
  - Cognitive stacking
  - Why is your telephone number 7 digits?
- Inherent error rates
  - Errors of commission – 1/300
  - Errors of omission – 1/100
- Negative effects of stress
  - Error rates
  - Tunnel vision

Interruptions of Routine Procedures

- Automatic Routines, no explicit memory of the last step, environmental cues predominate
- Interruption leads to Skipped step
- Countermeasures- Explicitly note the interruption. Mindful use of Checklists. Salient reminders.

Perspectives on Human Error – Sidney Dekker

Old View

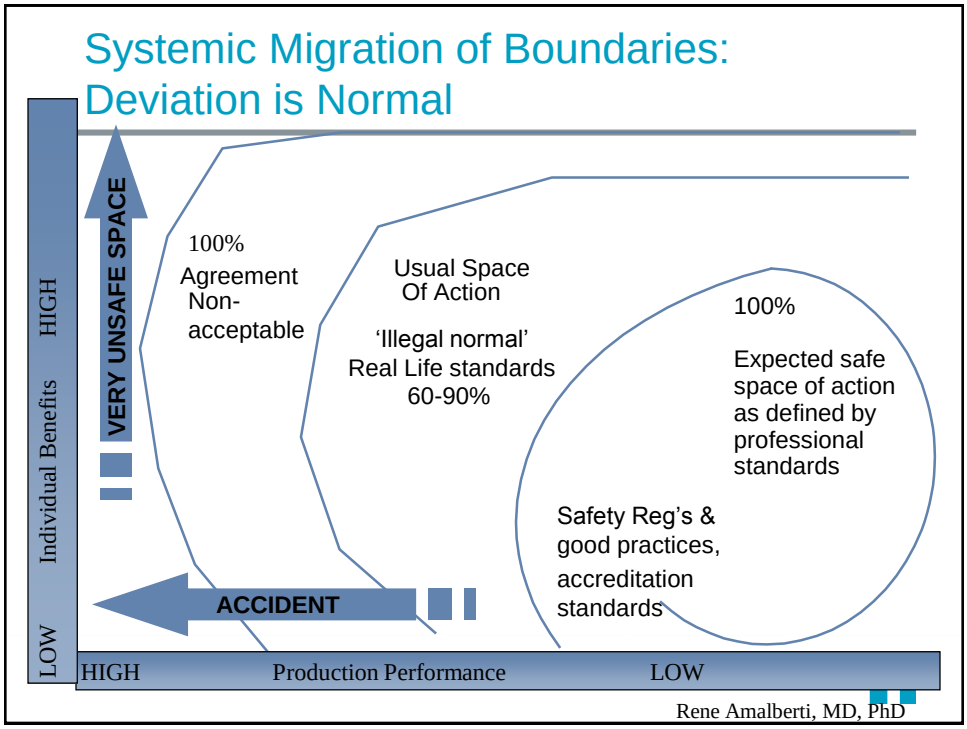
- Human error is a cause of trouble
- You need to find people's mistakes, bad judgments and inaccurate assessments
- Complex systems are basically safe
- Unreliable, erratic humans undermine system safety
- Make systems safer by restricting the human contribution

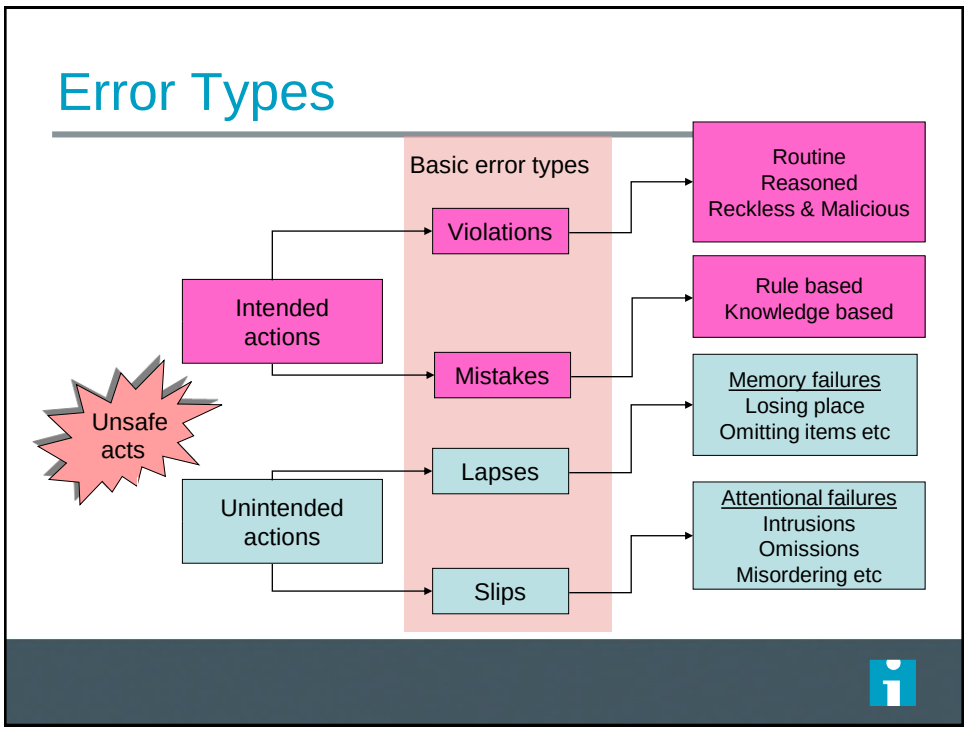
New View

- Human error is a symptom of deeper system trouble
- Instead, understand how their assessments and actions made sense at the time — context
- Complex systems are basically unsafe
- Complex systems are tradeoffs between competing goals — safety v. efficiency
- People must create safety through practice at all levels

Little Things Can Cause Big Problems

- Room 20
- Look out the window
- A simple knee scope
- He's OK – he's not too sedated - you go home
- What it says on the box is not what's in the box


Systemic Migration of Boundaries:
Deviation is Normal
Individual Benefits
HIGH
LOW
VERY UNSAFE SPACE
100%
Agreement
Non-
acceptable
Usual Space
Of Action
'Illegal normal'
Real Life standards
60-90%
100%
Expected safe
space of action
as defined by
professional
standards
Safety Reg's &
good practices,
accreditation
standards
ACCIDENT
HIGH
Production Performance
LOW
Rene Amalberti, MD, PhD


Error Types
Basic error types
Violations
Mistakes
Lapses
Slips
Intended
actions
Unintended
actions
Unsafe
acts
Routine
Reasoned
Reckless & Malicious
Rule based
Knowledge based
Memory failures
Losing place
Omitting items etc
Attentional failures
Intrusions
Omissions
Misordering etc

FACTOR TYPES	CONTRIBUTORY INFLUENCING FACTOR
Patient Factors	Condition (complexity & seriousness) Language and communication Personality and social factors
Task and Technology Factors	Task design and clarity of structure Availability and use of protocols Availability and accuracy of test results Decision-making aids
Individual (staff) Factors	Knowledge and skills Competence Physical and mental health
Team Factors	Verbal communication Written communication Supervision and seeking help Team structure (congruence, consistency, leadership, etc)
Work Environmental Factors	Staffing levels and skills mix Workload and shift patterns Design, availability and maintenance of equipment Administrative and managerial support Environment Physical
Organisational & Management Factors	Financial resources & constraints Organisational structure Policy, standards and goals Safety culture and priorities
Institutional Context Factors	Economic and regulatory context National health service executive Links with external organisations

Just Culture – Short Version

- Were they malicious?
- Was the individual knowingly impaired?
- Did they consciously engage in unsafe acts – unintentional, risky, reckless?
- Substitution test

Organizational Fairness

- Differentiate between:

Unsafe individuals
- Reckless behaviours
- Risky behaviours

Unsafe systems

The Fair Evaluation and Response Chart

HOW TO USE THIS CHART: This chart should be used to categorize an individual caregiver's actions, not groups or systems. Evaluate each factor that influenced the caregiver's actions separately. When determining accountability, consider the context in which the action occurred.

1. First, exclude individuals with impaired judgment or whose actions might be malicious. (These cases must be managed using other appropriate avenues – i.e. employee assistance programs for substance abuse and psychosocial problems, legal authorities for cases with possible criminal intent.)

IMPAIRED JUDGMENT The caregiver's thinking was impaired - by illegal or legal substances - by cognitive impairment - by severe psychosocial stressors	MALICIOUS ACTION The caregiver wanted to cause harm.
• Discipline is warranted if illegal substances were used. • The caregiver's mindset and performance should be evaluated to determine whether a temporary work suspension would be helpful. • Help should be actively offered to the caregiver.	• Discipline and/or legal proceedings are warranted. • The caregiver's duties should be suspended immediately.

2. Second, use best judgment to categorize each action as either Reckless, Risky or Unintentional based on the definitions in the Chart. The categorization determines the general level of culpability and possible disciplinary actions, however these general categories require further analysis as below prior to making a final decision.

RECKLESS ACTION The caregiver knowingly violated a rule and/or made a dangerous or unsafe choice. The decision appears to be self serving and to have been made with little or no concern about risk.	RISKY ACTION The caregiver made a potentially unsafe choice. Their evaluation of relative risk appears to be erroneous.	UNINTENTIONAL ERROR The caregiver made or participated in an error while working appropriately and in the patients' best interests
• The caregiver is accountable and needs re-training. Discipline may be warranted • The caregiver should participate in teaching others the lessons learned.	• The caregiver is accountable and should receive coaching. • The caregiver should participate in teaching others the lessons learned.	• The caregiver is not accountable. • The caregiver should participate in investigating why the error occurred and teach others about the results of the investigation.

3. Third, perform a Substitution Test by asking at least 3 others with similar skills if they, in a similar situation, would act similarly. If the answer is "No" the individual is accountable. If "We do it all the time" system influence is substantial. If the answers are divided, evaluators should assign accountability with a goal to ensure perceptions of fairness by others.

The system supports reckless action and requires fixing. The caregiver is probably less accountable for the action, and system leaders share in the accountability.	The system supports risky action and requires fixing. The caregiver is probably less accountable for the action, and system leaders share in the accountability.	The system supports error and requires fixing. The system's leaders are accountable and should apply error-proofing improvements.

4. Fourth, evaluate whether the individual has a history of unsafe or problematic acts. If they do, this may influence decisions about the appropriate responsibilities for the individual i.e. they may be in the wrong job. Organizations should have a reasonable and agreed upon statute of limitations for taking these actions into account.

LEONARD M, FRANKEL A; PAT EDUC COUNSELING, 80 (2010)

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Partially adapted from David Marx.

The Fair Evaluation and Response Chart

3. Third, perform a Substitution Test by asking at least 3 others with similar skills if they, in a similar situation, would act similarly. If the answer is "No" the individual is accountable. If the answer is "We do it all the time" or answers are divided, assign accountability per below - and remember that an important goal is to ensure others perceive responses as fair:

The system supports reckless action and requires fixing. The caregiver is probably less accountable for the action, and system leaders share in the accountability.	The system supports risky action and requires fixing. The caregiver is probably less accountable for the action, and system leaders share in the accountability.	The system supports error and requires fixing. The system's leaders are accountable and should apply error-proofing improvements.

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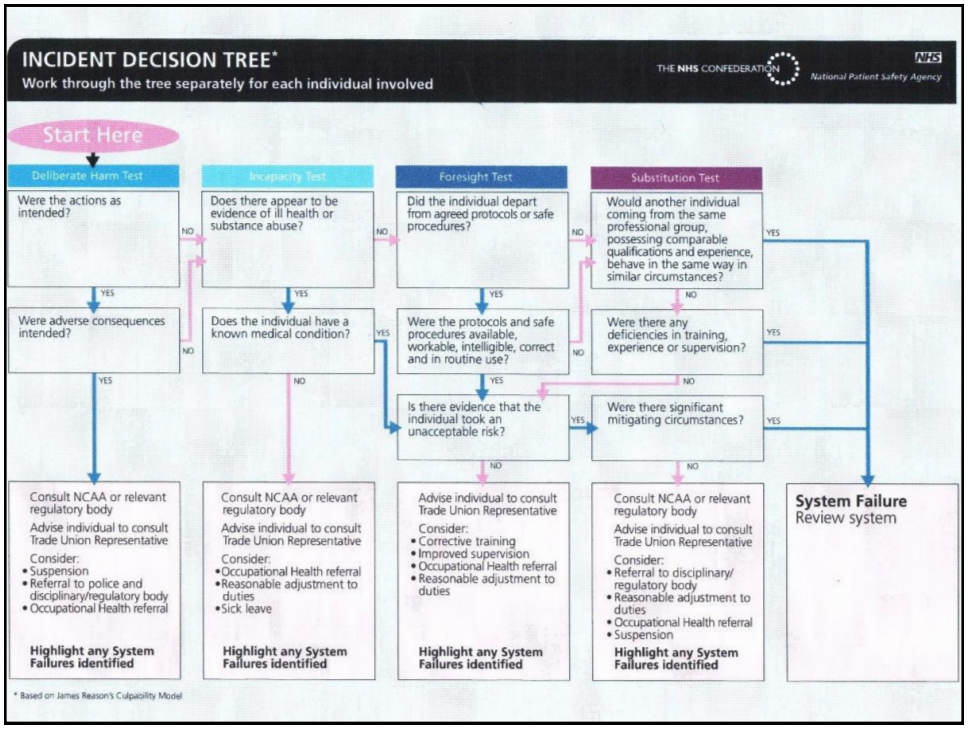
The Substitution Test is a concept of James Reason.



Case Two

- Please read the case report at your tables
- Discuss at the table
- Use what we have discussed and note all the contributing factors and run the decision aids
- Have someone from your table ready to give feedback in plenary

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Patient Safety