The Power of a Just Culture

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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

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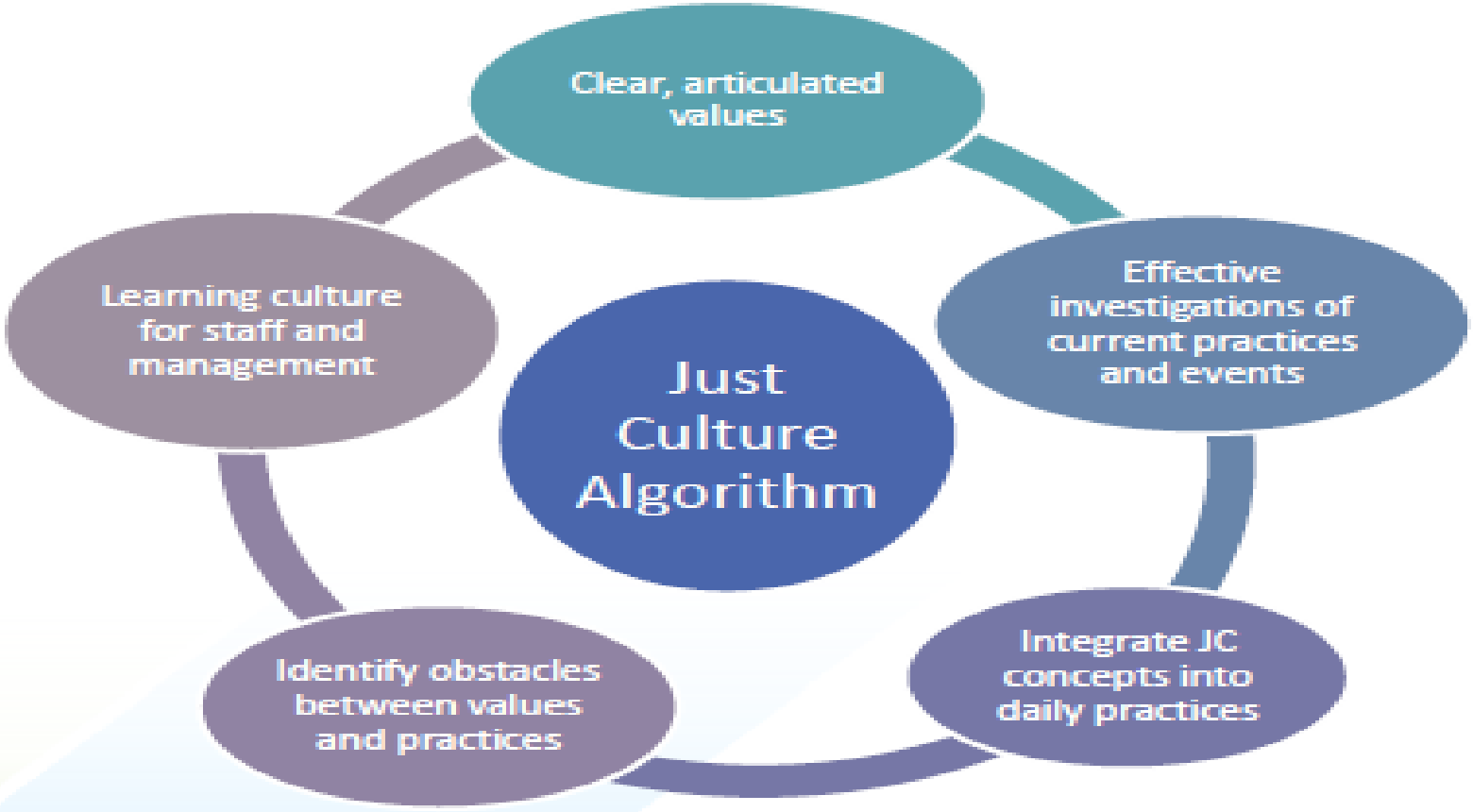
What We Hope You Will Take Away

- What is a Just Culture
- How to promote a Just Culture in your organization
- Learn how Just Culture could interplay with a recent case study


Clear, articulated values
Effective investigations of current practices and events
Integrate JC concepts into daily practices
Identify obstacles between values and practices
Learning culture for staff and management
Just Culture Algorithm

Where We Are Today in Healthcare –

- 70-80% of human errors go unexplained
- 70-90% of at-risk behaviors go unexplained

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Just Culture: Beliefs About Risk

- To Err is Human
- To Drift is Human
- Risk is Everywhere
- We Must Manage in Support of Our Values
- We Are All Accountable

To Err is Human

To Drift is Human

Three Types of Human Behaviors: #1- Human Error

Behavior:

- Inadvertent actions-
  - Slips
  - Lapses
  - Mistakes

Response: CONSOLE

Manage:

- through changes in:
  - Processes
  - Training
  - Design
  - Environment
  - Behavior choices

Three Types of Human Behaviors: #2- At-Risk Behavior

Behavior:

- A Choice- risk not recognized or believed justified

Response:

- Root cause analysis, train and COACH

Manage through:

- Removing incentives for at-risk behavior
- Creating incentives for healthy behavior
- Coaching to change perception of risk
- Implementing systems to prevent errors
- Input from those closest to the error
- Accountability

Why it's better NOT to punish At-Risk Behavior?

- It is likely that we or our system has allowed it in the past
- Punishment may cause fear of reporting next time
- Focus on learning from it

Three Types of Human Behaviors: #3- Reckless Behavior

Behavior:

- Conscious disregard for a substantial and unjustifiable risk

Response: PUNISH

Manage:

- Remedial action
- Disciplinary action
- Punitive action

Recently, I was asked if I was going to fire an employee who make a mistake that cost the company $600,000. No, I replied, I just spent $600,000 training him. Why would I want somebody to hire his experience?

~ Thomas J. Watson

Just Culture- What is it about for your Organization

- Knowing the RISKS
  - Investigating the source of errors and at-risk behaviors
  - Turning events into an understanding of risk
  - Creating a learning culture
  - Involving those closest to the problem

Just Culture- What is it about for your Organization

- Respond to Level of Human Error
  - Consoling the human error
  - Coaching the at-risk behavior
  - Punishing the reckless behavior
- Designing Safe Systems
  - Root Cause Analysis
  - Trust but Verify

How to make this part of your culture- our story

- “What can we learn from this?”
- Encourage sharing of near misses
- Respond quickly but pause on reactions until the story unfolds
- We’ll figure it out/ go with it
- Move on
- Support each other
- Don’t hide
- Don’t blame

How to make this part of your culture- our story

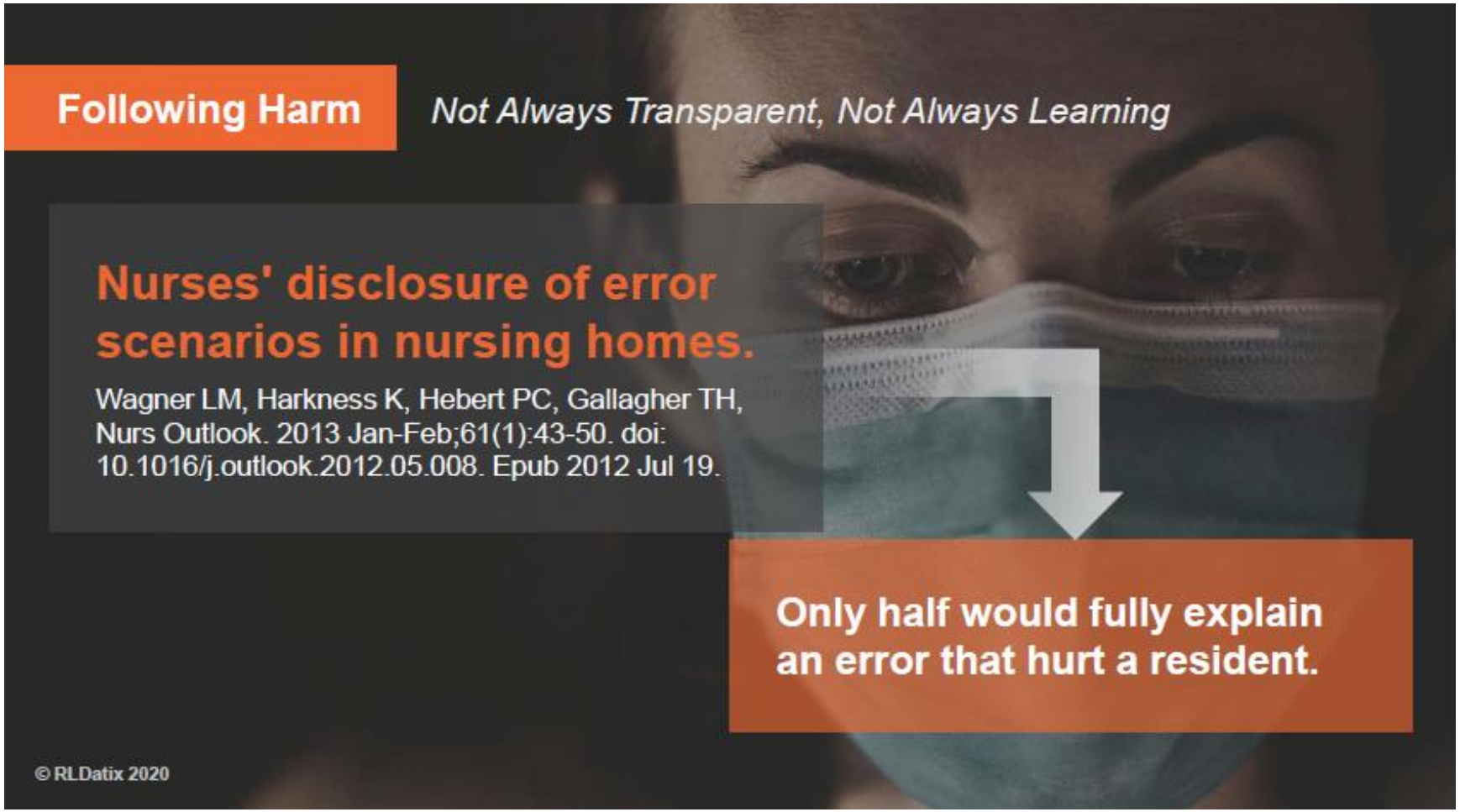
- Essence of you- it's about "who we are" as opposed to following rule
- Essence of culture- hiring, reinforcing, materialize it
- Live it. Exemplify. Look at it in everything we do
- EQ- no shame- do internal work- self awareness/ triggers
- GRACE

Traits at the Top of Safe Organizations

- Shared sense of purpose for [safety] and quality
- Leaders lead by example
- Focus on results
  - Develop and use data
  - Share and celebrate
- Collaborate: Everyone contributes
- Accountability system
  - Prioritizing/incentivizing
  - Developing measures
  - Setting goals and targets
  - Avoid punishing mistakes

Source: University Health System Consortium

Disclosure


Following Harm
Not Always Transparent, Not Always Learning
Nurses' disclosure of error scenarios in nursing homes.
Wagner LM, Harkness K, Hebert PC, Gallagher TH, Nurs Outlook. 2013 Jan-Feb;61(1):43-50. doi: 10.1016/j.outlook.2012.05.008. Epub 2012 Jul 19.
Only half would fully explain an error that hurt a resident.
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Culture of Disclosure

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The Paradigm Shift

Principled Response Triggered By Harm

Reporting	• from delayed • to immediate
Communication	• from delay, deny and defend • to immediate and ongoing
Event Review	• from shame, blame, and train • to human factors process redesign
Care for the Caregiver	• from suffering in isolation • to immediate and ongoing support
Resolution	• from having to "fight for it" • to early offer

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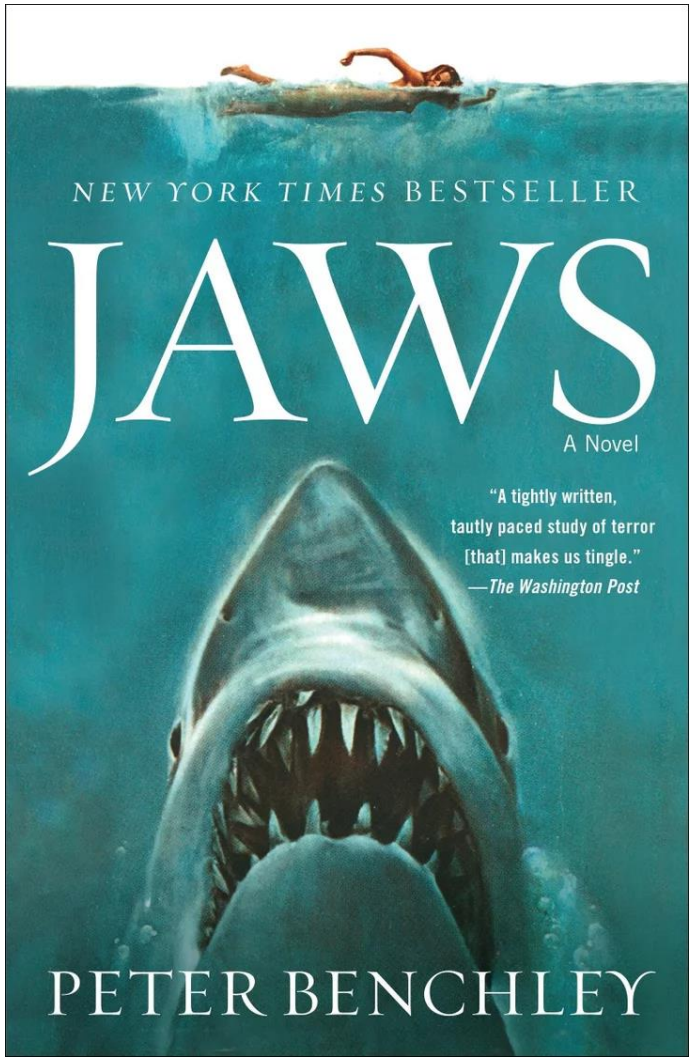

Disclaimer for Case Study

- Based on a true story
- Not necessarily factual
- Fictionalized
- Do not know the whole story
- Example to understand the power of a just culture

Case Study

RaDonda Vaught, 36 was charged with reckless homicide for accidentally administering the paralyzing drug Vecuronium to a patient instead of the sedative Versed on Dec. 26, 2017.

Details of case

- Nurse admitted error immediately
- Nurse ignored warning from med machine, but system routinely needed to be overwritten (ignored)
- Nurse ignored warning on medication bottle
- Nurse had worked at Vanderbilt successfully for two years
- Initially cleared by Tennessee Board of Nursing, then RN license revoked three years later
- Nurse admits to being distracted. Was orienting a new nurse that day
- Case went criminal by DA- very unusual
- Jury changed charge from reckless to negligent homicide

Details of case- hospital response

- Fired the nurse because of the error and reported her to Board of Nursing
- Did not report it to State or Federal entities
- Did not report it to Joint Commission as a sentinel event
- Medical examiners listed “natural causes” as cause of death
- Settled out of court with family and used non-disclosure agreement to prevent communication
- Ten months after error, responded to CMS with action plan to correct and prevent medication errors after anonymous tip to CMS led to investigation and CMS citing Immediate Jeopardy and threatening to remove CMS reimbursement
- Hospital received no punishment

Breakout questions
Be Ready to Report Back

What level of human behavior was this medication error? Was it Human Error, At-Risk Behavior or Reckless Behavior? Why or why not?

Did the hospital respond in a Just Culture way? Why or why not?

Discussion

- What would have made a difference if handled in a more Just Culture way?
- If you were the hospital, what would you do differently next time?
- If you were the nurse, what would you do differently next time?
- Was hiding the case an additional error?
- What are the lessons for all of us?

Take Aways

- What ideas did you learn today that you are going to take back to your organization?

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