MSHP Annual Meeting 2016

**Just Culture: Just Culture:
From A Concept to A Practice**

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Objectives

- Distinguish between just, punitive and blame free cultures

- Identify key principles of Just Culture

- Apply Just Culture to patient safety cases

From The Headlines

Punitive Culture

- Beliefs
  - Unsafe acts are caused by people
  - People are solely accountable for the outcome of patients under their care
  - Bad things happen to bad people !

- Management Model
  - Corrective actions focused on reducing variability in human behavior
  - Severity of disciplinary action determined by severity of the undesirable outcome

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Non-Punitive Culture

- Beliefs
  - Humans are fallible
  - The same set of conditions can produce similar errors *regardless* of the people involved
  - The best people can make mistakes

- Management Model
  - Corrective actions focused on the why not the who
  - Focus on system improvements

Repercussions

- Repercussions of a punitive culture:
  - Drove reporting of medication errors underground
  - Prevented open communication
  - Impeded system-improvements

- Repercussions of a blame-free culture
  - Failed to discipline for repetitively unsafe practice
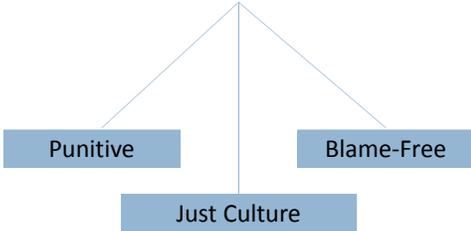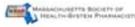 - Opposed employees sense of justice

A <u>punitive</u> culture resulted in:

- **A** An increase in medication event reporting
- **B** A focus on system improvements
- **C** A decrease in medication event reporting
- **D** An understanding that errors are to be expected

Just Culture

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             /  \
            /    \
    Punitive      Blame-Free
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          Just Culture
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Just Culture: Definition

"Just culture is one that has a clear and transparent process for evaluating errors and separating events arising from flawed system design or inadvertent human error from those caused by reckless behavior…It is important to preserve an appropriate balance of accountability"

Just Culture

- You want to create an open, fair and just culture
  - Staff feel comfortable to report and discuss errors
- You want to create a learning culture
  - We need to learn from our mistakes and make sure staff are aware of what happens at our facility
- You want to create safe systems
  - Time outs, point of care bar-coding
- You want to manage behavioral choices
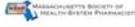
Key Principles of Just Culture

- Just culture emphasizes both learning and shared accountability
- Incorporates both improvement in system design and behavioral choices to produce better results
- Holds employees accountable for behavioral choices under their control
- Outcome does not determine accountability

Shared Accountability

Patient, Regulatory Agencies, Accountability, Team members, Organization

True or False

In a Just Culture shared accountability model, institutions are accountable for system design and for supporting safe choices by staff and employees are responsible for behavioral choices that are under their control.

- A True
- B False

How would you describe your department's current safety culture?

- A Punitive
- B Non-Punitive
- C Just Culture
- D Varies depending on severity of patient outcome

A Just Culture Strategic Vision

- □ Support the efforts of your team members
- □ Encourage open discussions on potential system vulnerability
- □ Promote interdisciplinary discussion and analysis of potential and actual adverse drug events
- □ Improve patient safety by implementing changes
- □ Assess success in building and maintaining a just culture
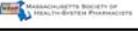
Key components of a just culture include:

- A Use of shared accountability model
- B Establishment of a reporting and learning environment
- C Improvements in system design
- D All of the above
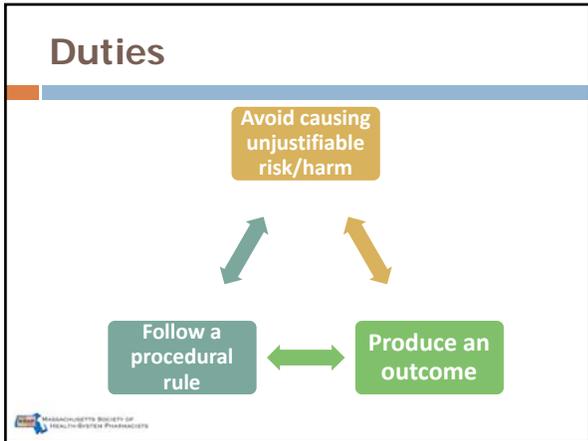
Human Behavior: 4 Shades of Gray

| Human Error | Negligent Conduct |
| Reckless Conduct | "Willful" Violations |

Human Behaviors

- □ Human-Error
  - ◻ Inadvertently doing other than was intended
- □ At-risk behavior
  - ◻ Behavioral choices 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

Duties

Avoid causing unjustifiable risk/harm

Follow a procedural rule ↔ **Produce an outcome**

Where does using a hoverboard fall?

Human Errors

- Slip or Lapses

- Confirmation Bias

- Inattentional Blindness

Human Factors

- Human factors (HF)
  - The study of how people use technology
  - It involves the interaction of human abilities, expectations, and limitations, with work environments and system design

- Human factors engineering (HFE)
  - The application of human factors principles to the design of devices and systems

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Active Failures

- Active failures are also referred to as "sharp end"

- Active errors occur at the point of contact between a human and some aspect of a larger system (human-machine interface)

- Errors that happen at the sharp end are noticed first because they are committed by the person closest to the patient


Latent Errors

- Latent errors are also referred to as "blunt end"

- Conditions which are present in the healthcare system and are less apparent

- The facility, equipment, and processes that contribute with the active failures to produce error or allow them to happen

Latent Errors

- Examples of latent errors:
  - Lack of computer warnings
  - Unclear policies and procedures
  - Incomplete patient information

- Latent errors be remedied with safety barriers before they contribute to an adverse event

Massachusetts Society of Health-System Pharmacists

Do You See What I See?

Massachusetts Society of Health-System Pharmacists
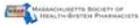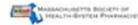
Patient Safety Case

- A patient is prescribed ceftolozane/tazobactam (Zerbaxa ™). Patient was to receive a 3 g dose, patient received a 4.5 gram dose instead.
- On further review, you discover that the labeling of ceftolozane/tazobactam reflects the individual active ingredients.
- Pharmacists are familiar with the convention for expressing the strength of beta-lactam/beta-lactamase antibacterial drugs as the sum of the two active ingredients.
- The pharmacist thought the vials were 1 g, the pharmacist used 3 vials instead of 2 vials to make the dose.

Massachusetts Society of Health-System Pharmacists

Ceftolozane/Tazobactam (Zerbaxa™)

Before	After

Note the use of 1 g/0.5 in the initial labeling versus 1.5 g in the revised labeling

Massachusetts Society of Health-System Pharmacists

How would characterize the pharmacist's behavior?

- A Human error
- B At-risk behavior
- C Reckless behavior
- D Willful violation

Massachusetts Society of Health-System Pharmacists

Applying Just Culture Principles

Human Behavior and Duties	Apply (Y/N)
Human error	Y
At-risk behavior	N
Reckless behavior	N
Did the employee put an organizational interest or value in harm way *knowingly*?	N
Did the employee breach a duty to follow a procedural rule *knowingly*?	N
Did the employee breach a duty to produce an outcome *knowingly*?	N

Massachusetts Society of Health-System Pharmacists

How would characterize the pharmacist's behavior?

- A Human error
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To Drift Is Human

- □ To Err is Human; and so is to DRIFT
- □ Drifting is the same as at risk-behavior
- □ Drifting is done for many reasons
  - □ Desire to accomplish things
  - □ Lack of perception of risk
- □ A behavioral choice that may create unjustifiable risk, yet the person may be convinced that they are operating in a safe place or under safe conditions


At-Risk Behaviors

- □ Why people adopt at-risk behaviors
  - □ Perception of reward vs. risk (immediate reward, low or remote risk)
  - □ Workarounds to address system-based issues
  - □ Examples
    - Cognitive: Overriding alerts
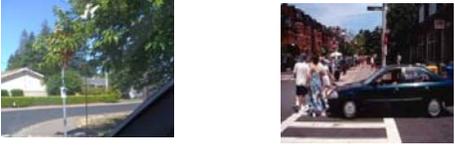   - Procedural changes: not-barcoding medications

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To Drift Is Human

You're late for work and the highway you're driving on has a speed limit of 65 mph

Driving 70 mph → Driving 95 mph

At-Risk Behavior   Reckless Behavior
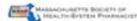
Distinguishing Human Behaviors

Patient Safety Case

During a review of a medication event, you discover that a pharmacist <u>chose</u> to override a drug-drug interaction alert due to alert fatigue, you consider this behavior to be:

- A Human error
- B At-risk behavior
- C Reckless behavior
- D Negligent conduct

Patient Safety Cases

- Pharmacist reviews and overrides a drug-drug interaction (DDI) resulting in patient harm

- Pharmacist reviews and overrides a DDI with the potential to cause patient harm, but did not result in harm

- Does the management of these scenarios vary based on outcome?

Applying Just Culture Principles

| Human Behavior and Duties	Apply (Y/N)
Human error	Y
At-risk behavior	Y
Reckless behavior	N
Did the employee put an organizational interest or value in harm way *knowingly*?	Complex
Did the employee breach a duty to follow a procedural rule *knowingly*?	Varies
Did the employee breach a duty to produce an outcome *knowingly*?	Complex

Duty to Avoid Harm

- Was it the employee's purpose to cause harm?
- Did the employee knowingly cause harm?
- Did the behavior represent a substantial and unjustifiable risk?
- Did the employee consciously disregard this substantial and unjustifiable risk?
- Should the employee have known he/she was taking a substantial and unjustifiable risk?
- Did the employee choose the behavior?
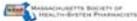
Patient Safety Case

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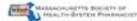- C Reckless behavior
- D Negligent conduct
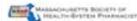
Reckless Behavior

- Reckless behavior:
  - Conscious disregard of unjustifiable risk
  - Perceives the risk that is being taken
  - Does not believe that the risk is justified
  - Unable to justify behavior
  - Disregard of risk without a perception of benefit
  - Harm is not necessary
  - Drift over time from at-risk behavior ---->Reckless behavior

Patient Safety Case

- A hospital pharmacy developed a new four-check step policy and procedure for chemotherapy. The new process was developed based on feedback from the staff.

- One day a nurse called the pharmacy requesting that a patient's cyclophosphamide dose come up as soon as possible. The order had already gone through the first initial check and Matt was supposed to do the second clinical check. Instead, he simply signed his initials on the clinical checking form without looking at the chemotherapy order.

- He also reviewed the final product, without going through the full procedure, and signed his name as the fourth check so that the cyclophosphamide dose could get up to the floor quickly.

- Later, it was discovered that the IV bag contained 2x the amount of the chemotherapeutic agent.

How would you characterize this behavior?

- **A** At-risk behavior
- **B** Human Error
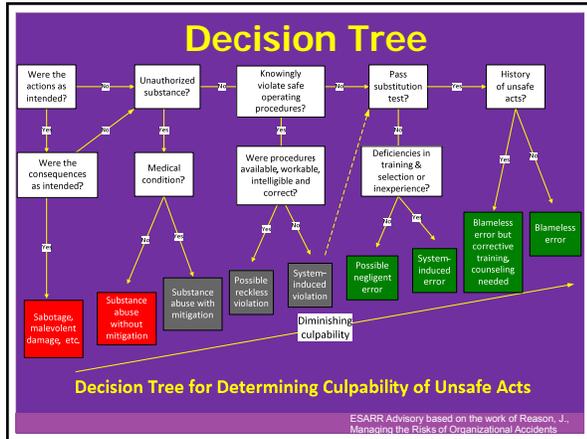- **C** Reckless behavior
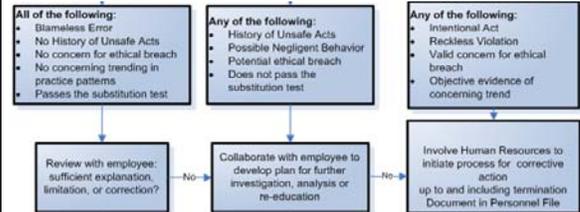- **D** Creative problem solving

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Just Culture Algorithms

- □ Did the employee intend to cause harm?
- □ Did the employee come to work drunk or equally impaired?
- □ Did the employee knowingly and unreasonably increase risk?
- □ Would another similarly trained and skilled employee in the same situation act in a similar manner?

Decision Tree

Decision Tree for Determining Culpability of Unsafe Acts

ESARR Advisory based on the work of Reason, J., Managing the Risks of Organizational Accidents

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Beth Israel Deaconess Just Culture Algorithm

Key Behaviors

Human Error	At-Risk Behavior	Reckless Behavior
Product of Our Current	A Choice: Risk Believed	Conscious Disregard

Manage these behaviors as stated **independent of outcome** produced

| Console | Coach | Punish |

Managing Human Error

- □ Changes in:
  - ▣ Processes and procedures
  - ▣ Training
  - ▣ Design
  - ▣ Environment
- □ Console

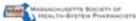## Managing Human Error

System design improvements

"We cannot change the human condition,
but we can change the conditions under which
humans work."

James Reason

Managing At-Risk Behaviors

□ Change perceptions of risk
□ Improve systems that are causing behaviors
□ Reduce barriers
□ Coach

Managing Reckless Behaviors

□ Remedial or punitive actions
□ Punitive action
  ▫ A deterrent to encourage an individual to refrain from undesired behavioral choices
□ Remedial action
 ▫ Includes education, training, and/or reassignment to task appropriate to knowledge and skill

The best management strategy for an employee involved in a human error is to:

A Manage through remedial or punitive action

B Console the employee and implement any necessary changes

C Coach the employee and increase situational awareness

D None of the above
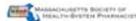
Patient Safety Case

□ During the compounding process for total parenteral nutrition (TPN), your hospital's policies and procedures require the employees to bar-code all ingredients when setting up the compounder
□ Due to many drug shortages and to conserve drug supply, some of the ingredients were drawn up individually and this process was purposefully not followed
□ After the drugs became available, the "old" process was re-introduced
□ To save time, the staff decide to continue with the process used during the drug shortages (not bar-coding the medications)
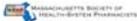
The best management strategy for this type of behavior is to:

A Manage through remedial or punitive action

B Console the employee and implement any necessary changes

C Coach the employee and increase situational awareness

D None of the above
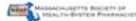
Key Takeaways

- Just Culture promotes open communication, learning opportunities, system improvements and accountability

- In Just Culture environment, staff are held accountable for choices and actions under their control, regardless of severity of outcomes

- Different behaviors can be involved in errors. Each behavior has a different cause, therefore, a different management style is needed

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