An Introduction to 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
A Healthcare Scenario to Consider

An experienced surgeon sees a new piece of equipment at a conference. Back at the hospital, a sales representative persuades him to use the equipment for a procedure. He has never used the equipment before and accidentally punctures the patient’s bowel. The surgeon repairs the bowel and the patient recovers fully. The OR has a policy that says new equipment will be officially approved and training will be conducted prior to its use.
The Severity Bias

Uncertainty in the Outcome and a Strong Severity Bias
Where We’re At Today in Healthcare – the Learning Culture

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

What system of accountability best supports system safety?

As applied to:
- Providers
- Managers
- Institutions
- Regulators

Support of System Safety

Blame-Free Culture

Punitive Culture
What is a Just Culture?

• Supports a Learning Culture

• Focuses on proactive management of system design and management of behavioral choices
What We Must Believe About the Management of Risk
To Err is Human
To Drift is Human
We Must Manage in Support of Our Values

- Overlapping Duties? Yes
- Competing Duties? Yes
- We Must Prioritize and Balance in Support of Our Values
The Safety Task: Managing System Reliability

Design for system reliability...

- Human factors design to reduce the rate of error
- Barriers to prevent failure
- Recovery to capture failures before they become critical
- Redundancy to limit the effects of failure

... knowing that systems will never be perfect

Factors Affecting System Performance

System Reliability
The Safety Task: Managing Human Reliability

Design for human reliability...

- Information
- Equipment/tools
- Design/configuration
- Job/task
- Qualifications/skills
- Perception of risk
- Individual factors
- Environment/facilities
- Organizational environment
- Supervision
- Communication

... knowing humans will never be perfect
Managing Behavior
The Behaviors We Can Expect

• **Human error** – an inadvertent action; inadvertently doing other than what should have been done; a slip, lapse, or mistake.

• **At-risk behavior** – a behavioral choice that increases risk where risk is not recognized, or is mistakenly believed to be justified.

• **Reckless behavior** – a behavioral choice to consciously disregard a substantial and unjustifiable risk.
Managing Human Error

• **Two Questions:**
  – Did the employee make the correct behavioral choices in their task?
  – Is the employee effectively managing their own performance shaping factors?
• If **yes**, the only answer is to **console** the employee – that the error happened to them
• Examine the system for improvement opportunities
Managing Multiple Human Errors

• What is the source of a pattern of human errors
  – In 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 Behavior

- **At-Risk Behavior**
  - A behavioral choice that increases risk without perceiving the risk (i.e., unintentional risk taking), or is mistakenly believed to be justified
  - 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 (Coaching)
  – Managed by changing consequences
  – Examine the system for improvement opportunities
Managing Reckless Behavior

• Reckless Behavior
  – Conscious Disregard of Substantial and Unjustifiable Risk

• Manage through:
  – Punitive action
# The Three Behaviors

## Human Error

*Product of Our Current System Design and Behavioral Choices*

Manage through changes in:

- Choices
- Processes
- Procedures
- Training
- Design
- Environment

## At-Risk Behavior

*A Choice: Risk Believed Insignificant or Justified*

Manage through:

- Removing incentives for at-risk behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

## Reckless Behavior

*Conscious Disregard of Substantial and Unjustifiable Risk*

Manage through:

- Remedial action
- Punitive action
The Just Culture Algorithms

• One method that works across all values

• One method that works both pre- and post-event
It’s About a Proactive Learning Culture

- It’s not seeing events as things to be fixed
- It’s seeing events as opportunities to inform our risk model
  - System risk
  - Behavioral risk

Where management decisions are based upon where our limited resources can be applied to minimize the risk of harm, knowing our system is comprised of sometimes faulty equipment, imperfect processes, and fallible human beings.
Just Culture Implementation

Taking the Necessary Steps
Our Experience

In Each Organization…

– There will be a small population of the staff that will be openly opposed to most management initiatives

– There will be a larger population that believe that Just Culture is the key to future organizational success

– The remainder will believe the Just Culture will work, but likely will not buy into the program until they see management start to adhere to the philosophy
Key Implementation Steps

• Educate Senior Leadership

• Identify and Mentor Champions
  – Initial Classroom Training
  – Monthly Webinars: Coaching and Mentoring, Combined with Self-Assessments

• Conduct Gap Analyses
  – Policy Alignment, Event and RCA Reviews, and Online Cultural Survey

• Educate Managers
  – One-Day Just Culture Classroom Instruction plus Online Training
  – Event Investigation Online Training
  – Coaching and Mentoring Online Training

• Train Managers and Staff
  – Featuring the Movie, No Small Consequence and the Producer’s Commentary
  – Six Video Vignettes

• Measure Success
  – Benchmarking Surveys

• Continue Improvement Cycles
The Just Culture
For Healthcare Managers

- Entry point for managers to learn how to create a value-supported culture that balances open reporting and accountability
- Covers use of the Just Culture Algorithm v3.0 as a decision-making aid
- Approximately four hours of subsequent online training
What’s It About?

- It’s About Both Error and Drift
- It’s About Both Pre- and Post-Event
- It’s About Executive Commitment
- It’s About Values and Expectations
- It’s About System Design and Behavioral Choices
- It’s For All Employees
- It’s About Partnership With the Regulator
- It’s About Doing the Right Thing
- It’s About Producing Better Outcomes Together
“Most healthcare providers choose a life of service. They put themselves in harm’s way to care for others. They expect a lot of themselves as professionals. Yet, they remain fallible human beings, regardless of any oaths to do no harm. They are going to make mistakes and occasionally drift into risky places (see hand hygiene). The future of our nation’s health depends upon our ability to learn from their errors and at-risk behaviors.”

David Marx, JD

*Whack-a-Mole*
Thank You!

Please visit us at:

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[www.justculture.org](http://www.justculture.org)