



The Just Culture
Community

Patient Safety and the Just Culture

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The Just Culture
Community

Agenda

- Design of Socio-Technical Systems
- We Watch, We Judge
- Living with Our Fallibility
- The Just Culture Model
- Around the Country



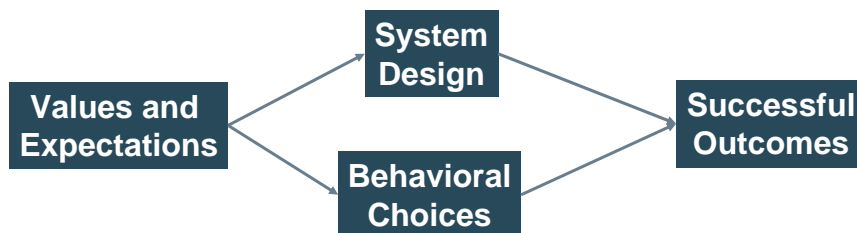
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Design of the Socio-Technical System



Inputs and Outputs





The Two Key Elements of a Socio-Technical System

- System Design
 - Performance Shaping Factors
 - Barriers
 - Recovery
 - Redundancy
- The Behavioral Choices of Components within the System
 - Producing outcomes
 - Following procedures
 - Doing the “right thing”



The Duty to Produce an Outcome

The duty to
produce an
outcome

- Be to work on time
- Bring badge
- Don't steal
- Don't sexually harass
- Don't use profanity at work
- Don't look in medical records that aren't your business



The Duty to Follow Procedural Rules

The duty to
follow
procedural
rules

- Two patient identifiers
- Hand hygiene
- Pump repair
- Dietary protocols
- Patient restraint
- Medication administration
- Accounting controls

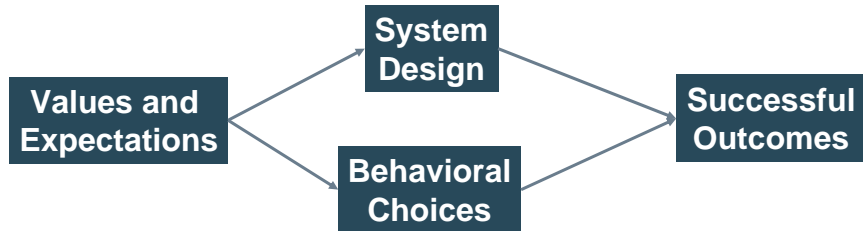


The Duty to Avoid Causing Unjustifiable Risk or Harm

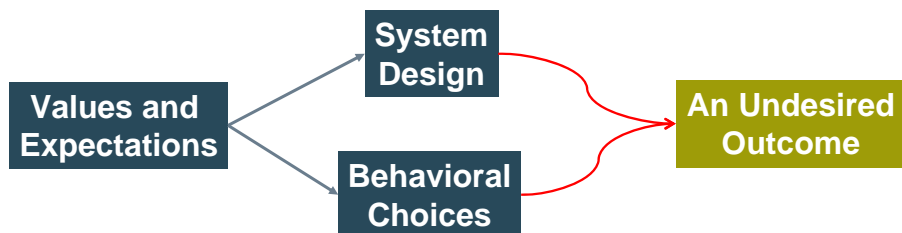
The duty to
avoid
causing
unjustifiable
risk or harm

- Do the right thing for the patient
- Do the right thing for coworkers
- Do the right thing for the family and visitors
- Do the right thing for the organization

Inputs and Outputs



Sometimes, the System Does Not Appear to Work





So We Stand In Judgment...

of the providers,
the hospital,
the regulators,
the healthcare system



We Stand in Judgment

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*



We Stand in Judgment

“There are activities in which the degree of professional skill which must be required is so high, and the potential consequences of the smallest departure from that high standard are so serious, that one failure to perform in accordance with those standards is enough to justify dismissal.”



*Lord Denning
English Judge*



We Stand in Judgment

“People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right? Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue.”

*Don Norman
Author, the Design of Everyday Things*



We Stand in Judgment

“...No person may operate an aircraft
in a careless or reckless manner
so as to endanger
the life or property of another.”

*Federal Aviation Regulations
§ 91.13 Careless or Reckless Operation*



We Stand in Judgment

“As far as I am concerned, when I say “careless” I am not talking
about any kind of “reckless” operation of an aircraft, but simply
the most basic form of simple human error or omission that the
Board has used in these cases in its definition of
“carelessness.” In other words, a simple absence of the due
care required under the circumstances, that is, a simple act of
omission, or simply
“ordinary negligence,” a human mistake.”

*National Transportation Safety Board
Administrative Law Judge
Engen v. Chambers and Langford*



We Stand in Judgment

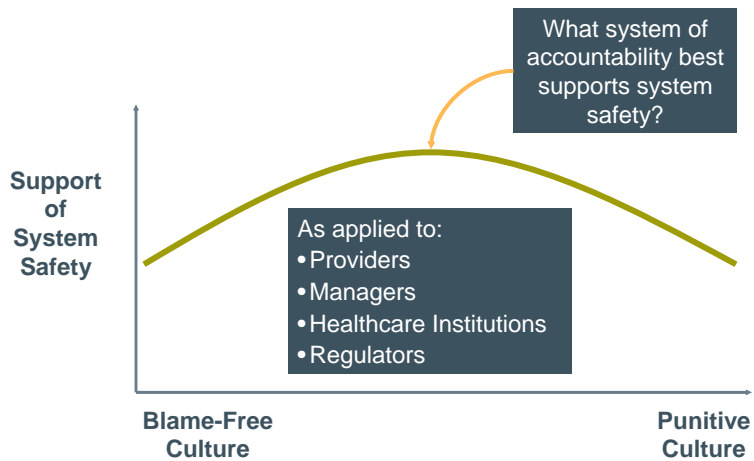
The following conduct, acts, or conditions constitute unprofessional conduct...

- The commission of any act involving moral turpitude, dishonesty, or corruption...
- Misrepresentation or fraud...
- The willful betrayal of a practitioner-patient privilege...
- Abuse of a client or patient or sexual contact with a client or patient...
- Incompetence, negligence, or malpractice which results in an injury to a patient or which creates an unreasonable risk that a patient may be harmed...

RCW § 18.130.180 Unprofessional Conduct



The Problem Statement





Living with Human Fallibility



Our Fallibility – Human Error

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





Our Fallibility – At-Risk Behavior

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



Our Fallibility – Reckless Behavior

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



Justice, Accountability, System Safety



Our Response – Human Error

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

Console

Learn



Our Response - 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



Our Response – Reckless Behavior

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

Punish



The Three Behaviors

Human Error	At-Risk Behavior	Reckless Behavior
<i>Inadvertent action: slip, lapse, mistake</i>	<i>A choice: risk not recognized or believed justified</i>	<i>Conscious disregard of unreasonable risk</i>
Manage through changes in: <ul style="list-style-type: none">• Processes• Procedures• Training• Design• Environment	Manage through: <ul style="list-style-type: none">• Removing incentives for at-risk behaviors• Creating incentives for healthy behaviors• Increasing situational awareness	Manage through: <ul style="list-style-type: none">• Disciplinary action• Punitive action
Console	Coach	Punish

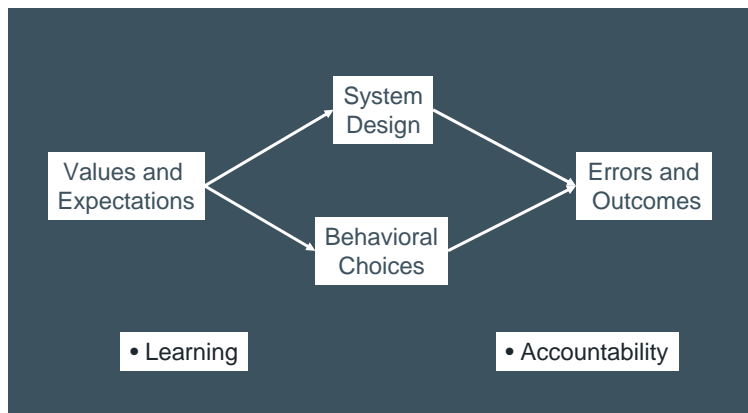


Implementing the Just Culture





It's About Doing This Well



It's About 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



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



It's About Reinforcing the Roles of Risk, Quality, and HR

- Risk/Quality
 - Helping improve the effectiveness of the learning process
 - Providing tools to line managers
 - Helping to redesign systems
- HR
 - Protecting the learning culture
 - Helping with managerial competencies
 - Consoling
 - Coaching
 - Punishing



It's About Changing Managerial Expectations

- Knowing my risks
 - Investigating the source of errors and at-risk behaviors
 - Turning events into an understanding of risk
- Designing safe systems
- Facilitating safe choices
 - Consoling
 - Coaching
 - Punishing



It's About Changing Staff Expectations

- Looking for the risks around me
- Reporting errors and hazards
- Helping to design safe systems
- Making safe choices
 - Following procedure
 - Making choices that align with organizational values
 - Never signing for something that was not done



Looking Around the Country



Statewide Initiatives

- Minnesota
- North Carolina
- Missouri
- Pennsylvania
- Indiana
- California



What's Happening...At the Local Level

- **Individual Hospitals**
 - Changing perspective
 - Giving new tools to managers
 - Coaching and mentoring
 - Event investigation / risk management
 - The Algorithm
 - Improving support to line managers
 - Human resources
 - Quality and risk management
 - Changing expectations of staff
- **The Results**
 - Better outcomes for patients
 - Better outcomes for staff
 - Better outcomes for the organization
 - **It's the right thing to do**





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Thank You

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