Just Culture Principles

Promoting a Culture of Safety

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Disclosure

- I have no financial or commercial conflict of interest(s) to report

Objectives – Pharmacists and Technicians

- Define a just culture and the three behaviors seen with errors
- Identify the appropriate response to each behavior as a mode of instilling a shared accountability into the culture
- Describe steps that may be taken to implement a just culture

Just Culture

- A learning culture that is constantly improving and oriented toward patient safety
- Learn about
  - Errors and the behavioral choices that cause them
  - System weaknesses
  - Why people drift

- There is a *balanced* accountability

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Proactive Learning

- Traditionally – errors seen as events to be *fixed*
  - discipline
- Opportunities to inform of our risk
  - System risk
  - Behavioral risk
- How do we apply our limited resources to minimize risk of harm

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Behaviors Involved in Errors

- **Human Error**: unintentional and unpredictable behavior; slip, lapse, mistake; inattentional blindness
- **At-Risk Behavior**: a behavioral choice that increases risk because risk is not recognized or mistakenly thought to be justified
- **Reckless Behavior**: conscious choice to disregard what is known to be a substantial and unjustifiable risk

Basic Principles of Human Error

- Humans are inherently flawed
- Human error is usually the result of circumstances beyond the control of those committing the error
- Most human errors arise from a weakness in the system
  - Systems must be built with this in mind

“Anatomy of an Error.” Patient Safety-Quality Improvement. http://patientsafetyed.duhs.duke.edu/module_e/module_overview.html Accessed. 26 July 2016.

Which way?

http://archive.boston.com/news/local/articles/2007/11/18/street_smarts/

https://static1.hotcarsimages.com/wordpress/wp-content/uploads/2018/06/traffic1.jpg?q=50&fit=contain&w=750&h=375&dpr=1.5

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At Risk Behavior

- We know “to err is human” but “to drift is human” too
- Drift into unsafe habits, lose perception of the risk or mistakenly believe the risk to be justified
- Workarounds to save time
- Normalization of Deviance

ISMP Medication Safety Alert. Our long journey towards a safety-minded Just Culture Part II: Where we're going. September 2006 https://www.ismp.org/newsletters/acutecare/articles/20060921.asp

Risky Behavior

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Reckless Behavior

- Conscious disregard of a substantial and unjustifiable risk
- Blameworthy behavior managed through remedial or disciplinary action
- Drug diversion, working under the influence

Just Culture and Its Critical Link to Patient Safety (Part I). ISMP May, 2012

How do we manage the three behaviors?

Human Error	At-Risk Behavior	Reckless Behavior
Console	**Coach**	**Discipline**
Cause: system design, processes, procedures, training	Cause: system inefficiencies (rework created, burdensome steps)	Cause: the individual
• Investigate processes and policies that may have led to error and correct them • Employee training – knowledge gap	• Remove incentives for at-risk behaviors by improving processes and procedures • Increase situational awareness	• Remedial and/or disciplinary action

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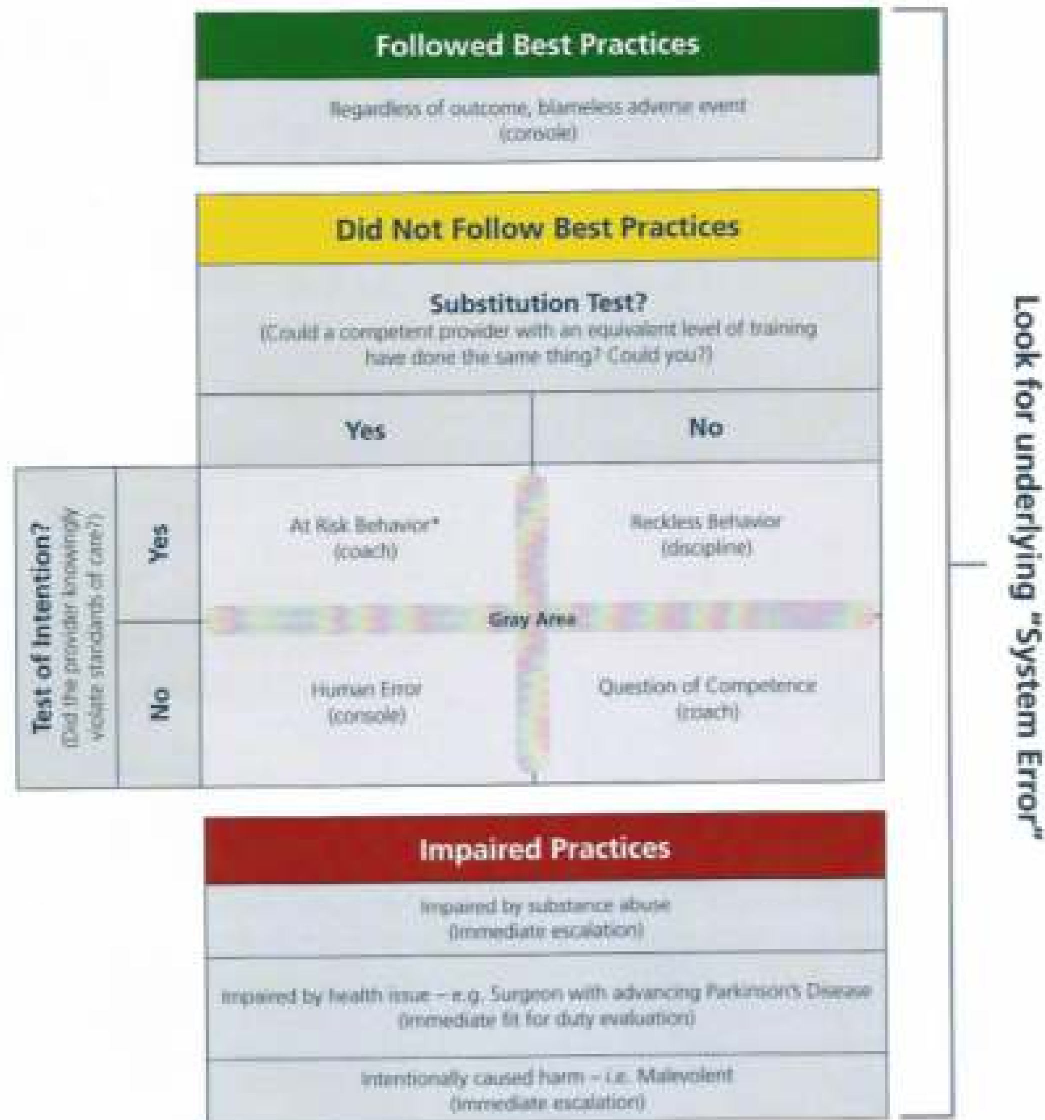
JUST CULTURE TOOL

Influenced by the works of James Reason[1] and David Marx[2,3]



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1. [illegible]
2. [illegible]
3. [illegible]
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Inspired Medicine

Coaching, Not Counseling

- Coaching: Conversation to raise situational awareness of the risk
- Counseling: Usually first step in disciplinary action. Employee is put on notice

- Proactively coach at-risk behaviors before harm occurs
- More than review of P&P – may need to have uncomfortable conversations
- Encourage peer-to-peer coaching

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The Differences between Human Error, at-Risk Behavior, and Reckless Behavior Are Key to a Just Culture. ISMP, 17 June 2020.

Establishing Just Culture in Your Organization

- Building awareness
  - Survey staff, managers, medical leaders
  - Education
- Multidisciplinary team
  - Nursing, providers, pharmacists, managers, senior execs, quality/risk management, etc.
- Implementing policies
  - Eliminate any policies that go against just culture principles
- Incorporating just culture principles into daily practices and processes

- *Must have leadership buy in*

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Maintaining a Culture of Safety

- Administrative WalkRounds
  - Connects senior leadership with frontline workers
  - Elicit useful information within a formal structure
  - Staff become part of the solution
- Feedback
  - Newsletters describing events and steps taken to mitigate or prevent recurrence
  - Creates transparency
  - Promotes reporting
  - Reaffirms their efforts are rewarded by changes in the work environment
- Cyclical Flow of Information

Frankel, Allan S et al. "Fair and just culture, team behavior, and leadership engagement: The tools to achieve high reliability." Health services research vol. 41,4 Pt 2 (2006): 1690-709. doi:10.1111/j.1475-6773.2006.00572.x

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Scenario A

- A nurse not wanting to disturb a sleeping patient, does not check the patient's ID band and administers an IV antibiotic to the wrong patient. The patient has an anaphylactic reaction and ends up ventilated in the ICU.

Scenario A Follow Up

- Was the nurse aware of the policy to check name bands? Yes
- Was it possible to check the name band? Yes
- Do all the nurses on the unit check name bands prior to administering medications? Not always
- Why didn't the nurse check the name band? Did she mistakenly believe it was better not to? Why?

- Customer satisfaction recently reviewed
- Sleep interruption #1 concern of patients
- The nurse violated the policy for what she believed to be a good reason – allowing the patient to sleep.

Scenario A cont.

- How do we address this nurse's choice to violate hospital policy and not check the patient's ID?
  - A) Console the employee
  - B) Coach the employee
  - C) Look for system improvements to help make the error more difficult to commit in the future
  - D) Discipline the employee for not following policy

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Scenario B

- NICU nurse goes to the ADC to retrieve heparin 100 units/ml for her patient. Without looking at the bin, she grabs a vial, draws up the medication and administers it to the patient. Unbeknownst to her, the pharmacy technician had refilled the bin incorrectly with heparin 10,000 units/ml.

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  - B) Coach the employee
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  - D) Discipline the employee for not following policy
  - E) B and C

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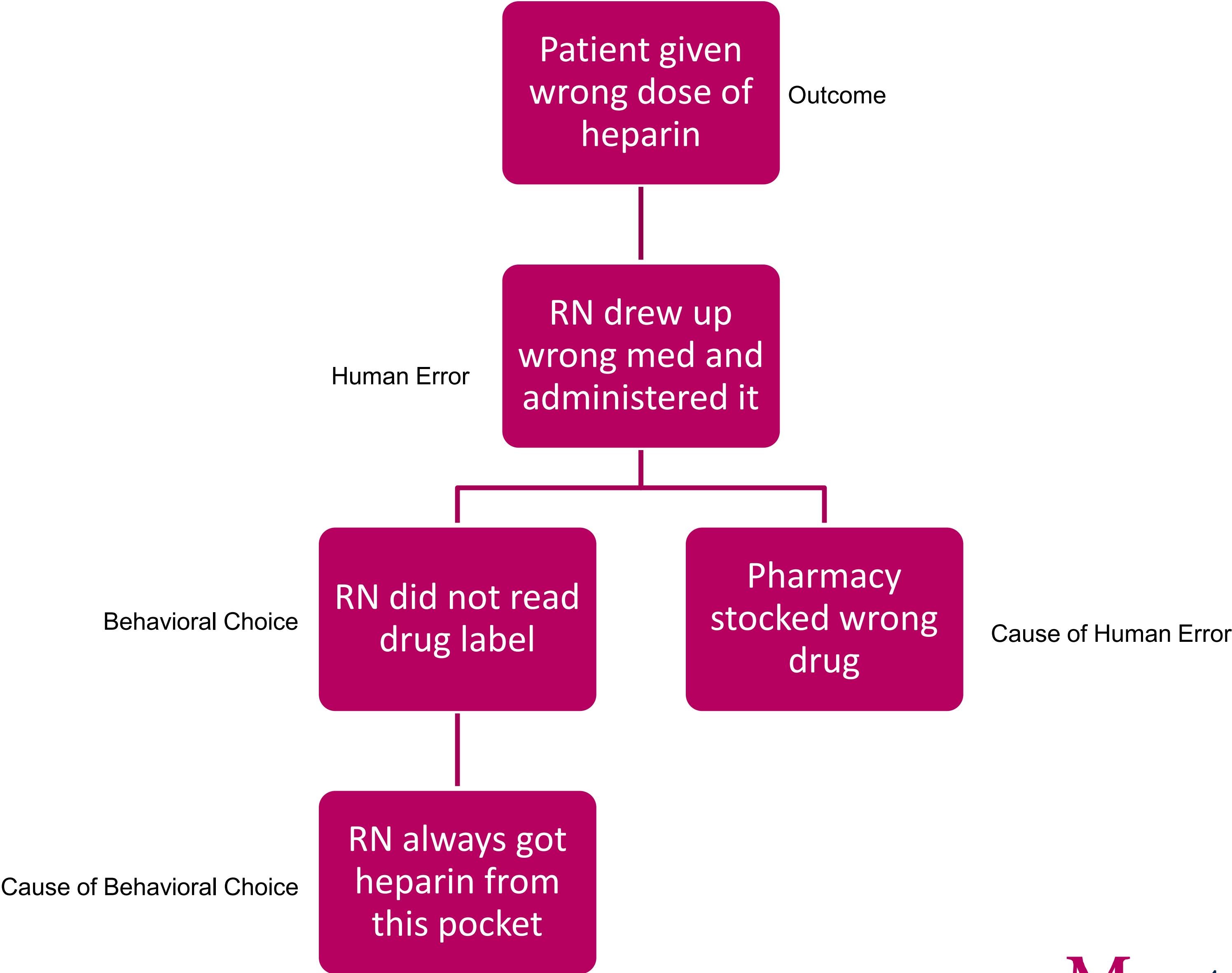
Determine the Causes



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