

# Just Culture

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#### Just Culture?

- Is this just a culture issue?
- "Just" as in "Justice"
- Just defined:
  - Based on or behaving according to what is morally right and fair
- What does a Just Culture look like?



# Three Manageable Behaviors

- 1. Human Error
  - Entirely unintentional
- 2. At-Risk Behavior
  - Aware of risk, though believed to be insignificant or justified
- 3. Reckless Behavior
  - Conscious disregard of substantial and unjustifiable risk



#### Three Behaviors - Human Error

- We all make mistakes
- Slips and lapses
- Free of intention (inadvertent actions)
- Examples:
  - Spilling coffee/juice while reading the newspaper
  - Look-alike/sound-alike medications



#### Three Behaviors - At-Risk

- Accepting a known risk for overriding reasons or lack of awareness of a known risk
- Intentional action but unintended outcome
- Examples:
  - Illegible written Rx when EHR is down (rationale: patient still needs meds)
  - Not using an available checklist to save time before a procedure (perceived as unnecessary)



#### Three Behaviors - Reckless

- Knowingly putting your self or others at risk
- Intentional action with probable outcome, though not desired
- Examples:
  - Relying on the EHR for transitions in care rather than providing a verbal and written warm hand-off
  - Disregarding inaccurate sponge/instrument count in surgery (self-assured of accuracy)



#### Just Culture Responses

Human Error	At-Risk Behavior	Reckless Behavior
Product of Our Current System Design and Behavioral Choices	A Choice: Risk Believed Insignificant or Justified	Conscious Disregard of Substantial and Unjustifiable Risk
Manage through changes in: • Choices • Processes • Procedures • Training • Design • Environment	<ul> <li>Manage through:</li> <li>Removing incentives for at-risk behaviors</li> <li>Creating incentives for healthy behaviors</li> <li>Increasing situational awareness</li> </ul>	Manage through: • Remedial action • Punitive action
Console	Coach	Punish



# Applying Just Culture

- Adverse Events
- Managing Systems
- Supervising People



### Event Investigation

- Identify root causes
- Apply Human Factors Analysis and Classification System (if available)
- Ask "why?" 5 times
- Final step: identify Breaches of Duty



# Breaches of Duty

- 1. Duty to Avoid Causing Unjustifiable Risk or Harm
- 2. Duty to Follow a Procedural Rule
- 3. Duty to Produce an Outcome

Categories of Breach:

- A. Insufficient prevention, diagnosis, or treatment of patient disease or condition
- B. Harm caused incidental to the practice of medicine
- C. Inappropriate conduct not directly related to the practice of medicine



# Breach of Duty – Unjustifiable Risk or Harm

- Applies to a healthcare provider's/staff's actions, in any situation, that might lead to harm of persons or property.
- Includes:
  - A. Not ordering or following an order for an indicated diagnostic test
  - B. Ordering/dispensing/administering a contraindicated prescription
  - C. Disruptive behavior



# Breach of Duty – Follow a Procedural Rule

- Applies when a healthcare provider/staff works within a system and is responsible for following a procedural rule created by the system.
- Includes:
  - A. Failure to use approved order sets
  - B. Not participating in a required pre-procedural time-out
  - C. Not completing documentation according to a procedure

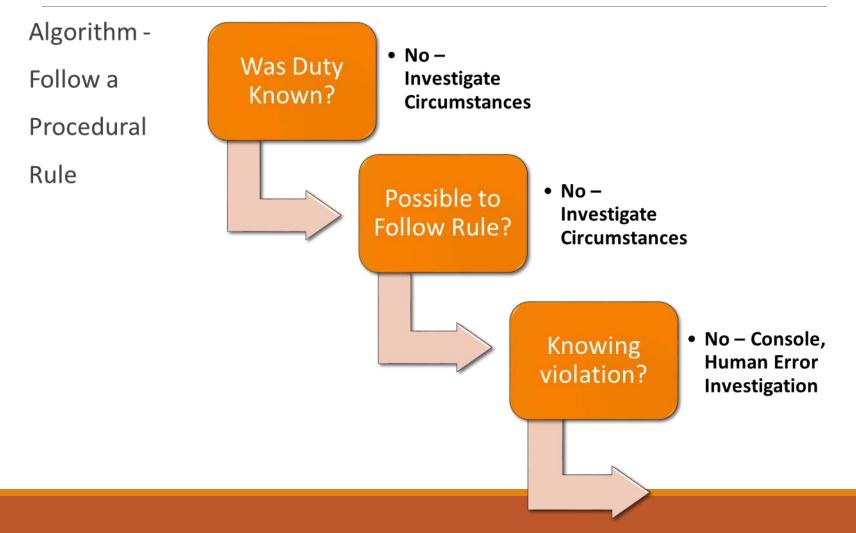


# Breach of Duty – Produce an Outcome

- Applies when a provider/staff is largely in control of the system by which the outcome is produced.
- Includes
  - A. High patient return rate to the Emergency Dept
  - B. High prescription order/dispense/administer error rate
  - C. Violations of time and attendance

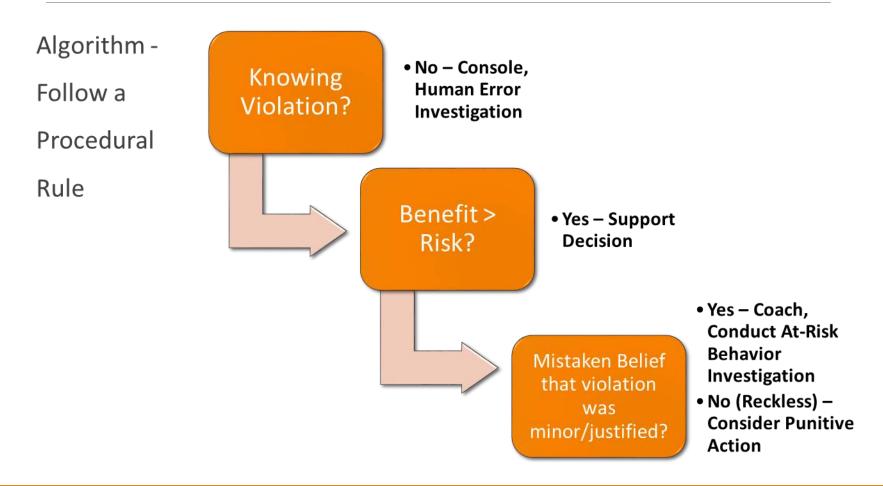


#### **Decision Making**





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# Why Change?

- How do we currently respond to breaches?
- Does this impact:
  - Morale?
  - Retention?
  - Recruitment?
  - Quality?
  - Safety?



#### Benefits of a Just Culture

- Fair and consistent application of organizational justice
- Reduces fear of undue punishment
- Increases reporting of events
- Leads to increased reporting of risk prior to events
- Just Culture is the foundation upon which Safety Culture is developed



### How to get there

#### **10 Step Process**

- 1. Leadership Commitment
- 2. Build Champion Team
- 3. Champions Lead Change
- 4. Update Policies
- 5. Update Practices
- 6. Train all Leaders
- 7. Develop Learning Culture
- 8. Refine Learning Systems
- 9. Train All Employees
- **10.** Measure Progress



#### Summary

- What a Just Culture looks like
- Three Behaviors
- Three Duties
- Applying Just Culture
- Developing a Just Culture
- Benefits of a Just Culture



#### Conclusion

# It's not just a culture, it's a Just Culture.



#### Questions?

#### Thank You