JUST CULTURE

CREATING AN ENVIRONMENT OF ACCOUNTABILITY

WHAT IS JUST CULTURE?

Just culture refers to a values-supportive system in which an organization is accountable for the systems it has designed to support the safe choices of the staff.

Just Culture is important to patient safety as it creates an environment in which people (employees and patients) feel safe to report errors and concerns about things that could lead to patient adverse events.

Employees, in turn, are accountable for the quality of their choices. Knowing that humans cannot be perfect, we strive to make the best possible choices.

PERSPECTIVES ON "HUMAN ERROR"

"No one comes to work wanting to do a bad job"

FACT: Humans do make mistakes

The point is not to see where people went wrong, but **WHY** what the person did made sense to them

Who did it?

HOW DO WE RESPOND?

BLAME PEOPLE

Learning from mistakes while maintaining accountability

The single greatest impediment to error prevention in the medical industry is "that we punish people for making mistakes" rather than asking

- Did the individual intend to cause harm?
- Did they come to work impaired or intoxicated?
- Could two or three peers have made the same mistake in similar circumstances?
- Does the individual have a history of involvement in similar events?

- Zero tolerance for blameworthy events such as purposely not following policies/protocols, working while impaired, intentionally causing patient harm.

WHICH OF THE THREE BEHAVIORAL TYPES IS A THREAT TO SAFETY?

Human Error

- Inadvertent action
- Inadvertently doing other than what should have been done
- Mistake, lapse in judgement

At-Risk Behavior

- A behavior choice that increases risk where risk is not recognized or is mistakenly believed to be justified
- Driven by the perception of consequences
- Most prevalent, occur more often and pose the most significant risk to safety.

Reckless Behavior

- A behavioral choice to consciously disregard a substantial and unjustifiable risk

ACCOUNTABILITY AND ERRORS

Console

Human Error

Manage through:

changes in -

- Processes
- Procedures
- Training
- Design
- Environment

Coach

At-Risk Behavior

Believed to be justified or insignificant

Manage through:

- Removing incentives for at-risk behaviors
- Create incentives for safe, quality care
- Increase situational awareness

Discipline

Reckless Behavior

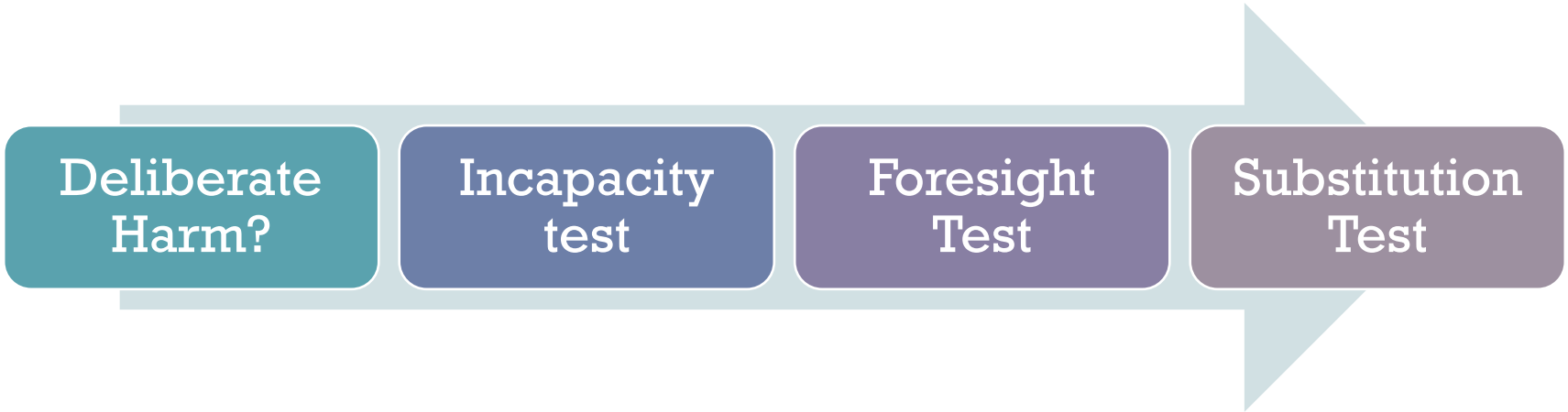
Conscious disregard to processes and policies

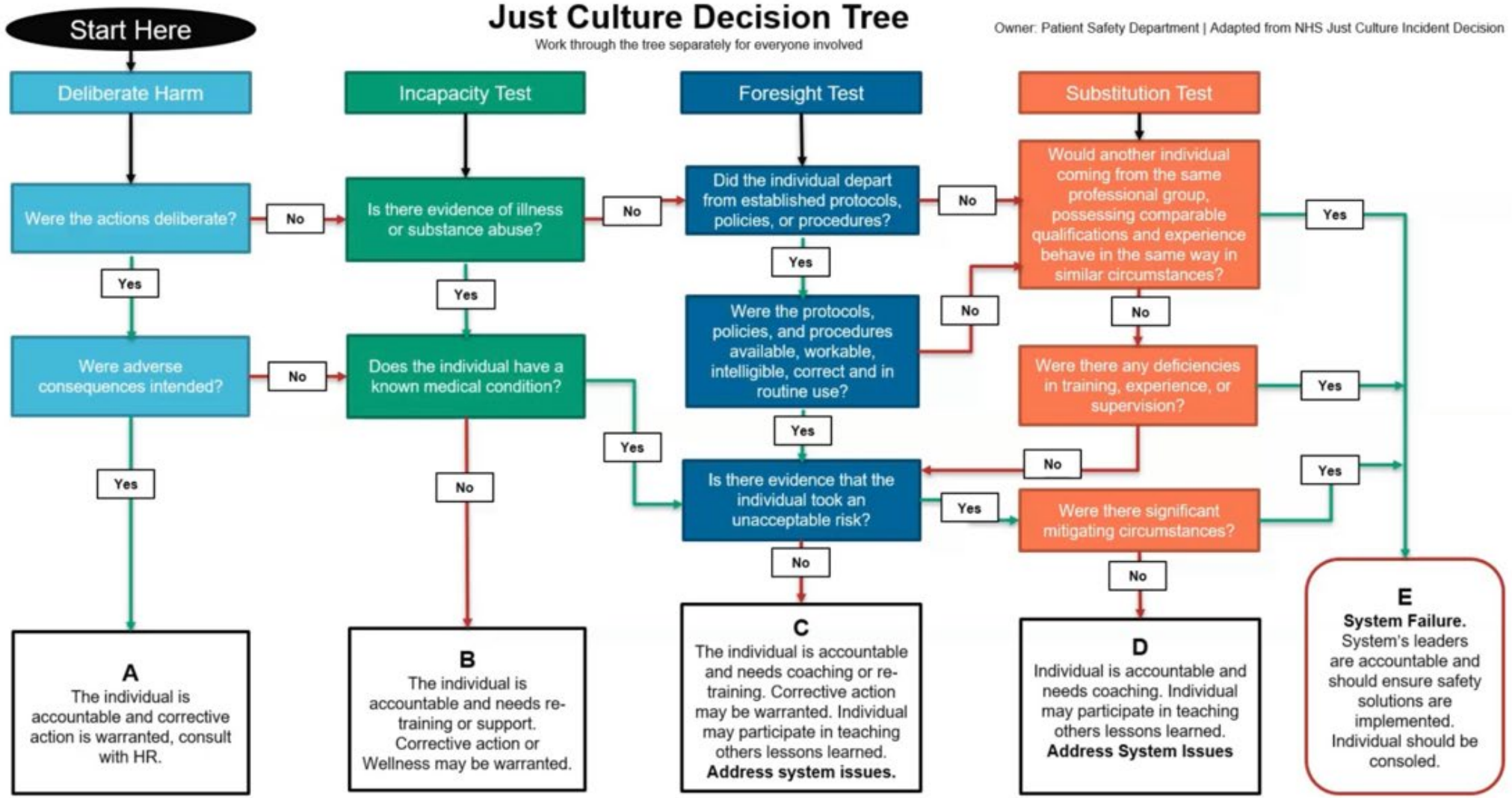
Manage through:

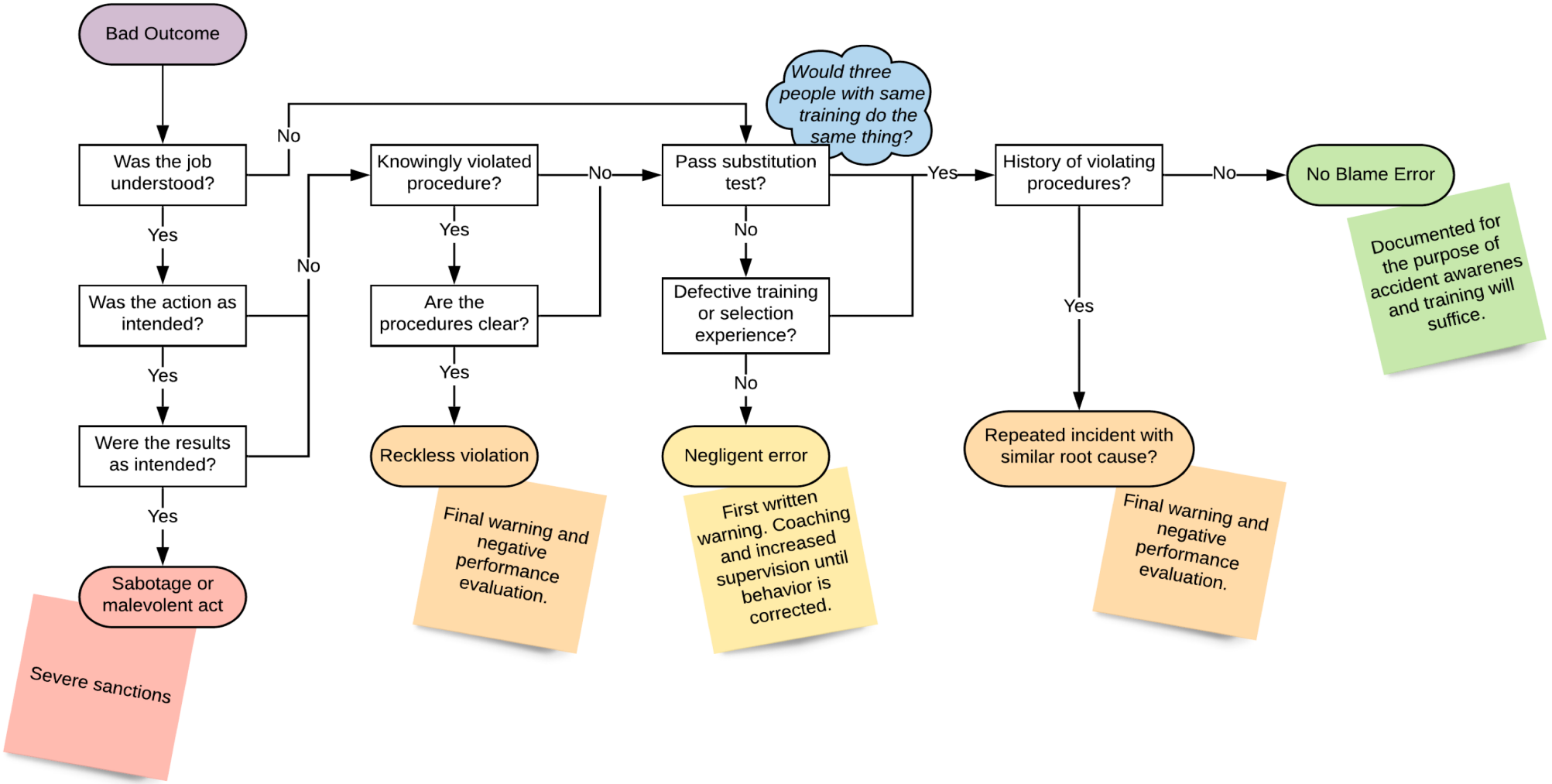
- Remedial Action
- Punitive Action

THE JUST CULTURE ALGORITHM

The algorithm provides unbiased guidance to evaluate human behaviors and guide leadership response to an error. All MHP Leadership will follow the Just Culture Algorithm to determine the cause of the mistake/error.




Just Culture Decision Tree
Work through the tree separately for everyone involved
Owner: Patient Safety Department | Adapted from NHS Just Culture Incident Decision
Start Here
Deliberate Harm
Were the actions deliberate?
No
Yes
Were adverse consequences intended?
No
Yes
A
The individual is accountable and corrective action is warranted, consult with HR.
Incapacity Test
Is there evidence of illness or substance abuse?
No
Yes
Does the individual have a known medical condition?
Yes
No
B
The individual is accountable and needs re-training or support. Corrective action or Wellness may be warranted.
Foresight Test
Did the individual depart from established protocols, policies, or procedures?
No
Yes
Were the protocols, policies, and procedures available, workable, intelligible, correct and in routine use?
No
Yes
Is there evidence that the individual took an unacceptable risk?
Yes
No
C
The individual is accountable and needs coaching or re-training. Corrective action may be warranted. Individual may participate in teaching others lessons learned.
Address system issues.
Substitution Test
Would another individual coming from the same professional group, possessing comparable qualifications and experience behave in the same way in similar circumstances?
Yes
No
Were there any deficiencies in training, experience, or supervision?
Yes
No
Were there significant mitigating circumstances?
Yes
No
D
Individual is accountable and needs coaching. Individual may participate in teaching others lessons learned.
Address System Issues
E
System Failure.
System's leaders are accountable and should ensure safety solutions are implemented. Individual should be consoled.


Bad Outcome
Was the job understood?
No
Yes
Was the action as intended?
No
Yes
Were the results as intended?
No
Yes
Sabotage or malevolent act
Severe sanctions
Knowingly violated procedure?
No
Yes
Are the procedures clear?
Yes
Reckless violation
Final warning and negative performance evaluation.
Would three people with same training do the same thing?
Pass substitution test?
Yes
No
Defective training or selection experience?
No
Negligent error
First written warning. Coaching and increased supervision until behavior is corrected.
History of violating procedures?
No
Yes
Repeated incident with similar root cause?
Final warning and negative performance evaluation.
No Blame Error
Documented for the purpose of accident awarenes and training will suffice.

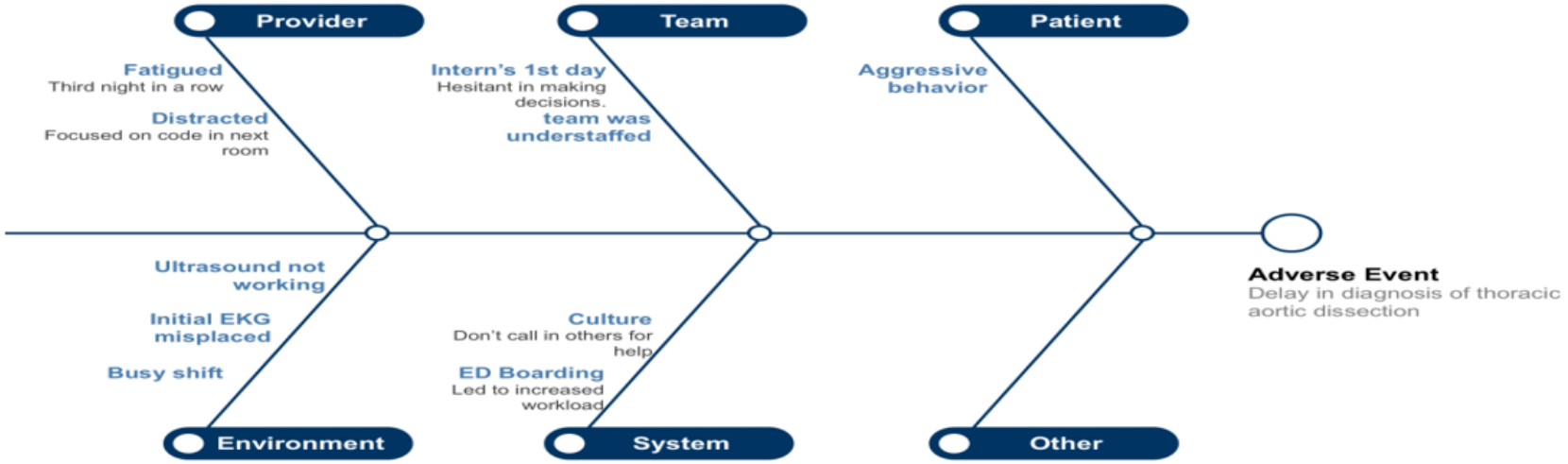
STEPS FOR ANALYZING MISTAKES

Assemble a team and create timeline

Collect Human Factors Data

Provider	Team
Patient	Environment
System	Other

Construct causes (Example)



THE FINAL STEP IN THE ALGORITHM

hierarchy of solutions
not all solutions are equally effective

Not all solutions are created equal. The ones that are easier to enact are often the least effective. The converse is unfortunately true, the most effective are the hardest to implement. Our goals, in order of effectiveness are to:

- How can we change the system to eliminate the hazard?
- How can we change the system to make it hard to do the wrong thing?
- How can we change the system to make it easy to do the right thing?
- How can we change individuals to make them do the right thing?

"It is not only what WE do, but also what WE do not do for which WE are accountable."

~John Baptiste Molière