



The Just Culture  
Community

# Just Culture

## Building a Culture of Learning

Presentation to



**NABP 106<sup>th</sup> Annual Meeting**

**May 22-25, 2010**

**Hyatt Regency Orange County**

**Anaheim, CA**

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

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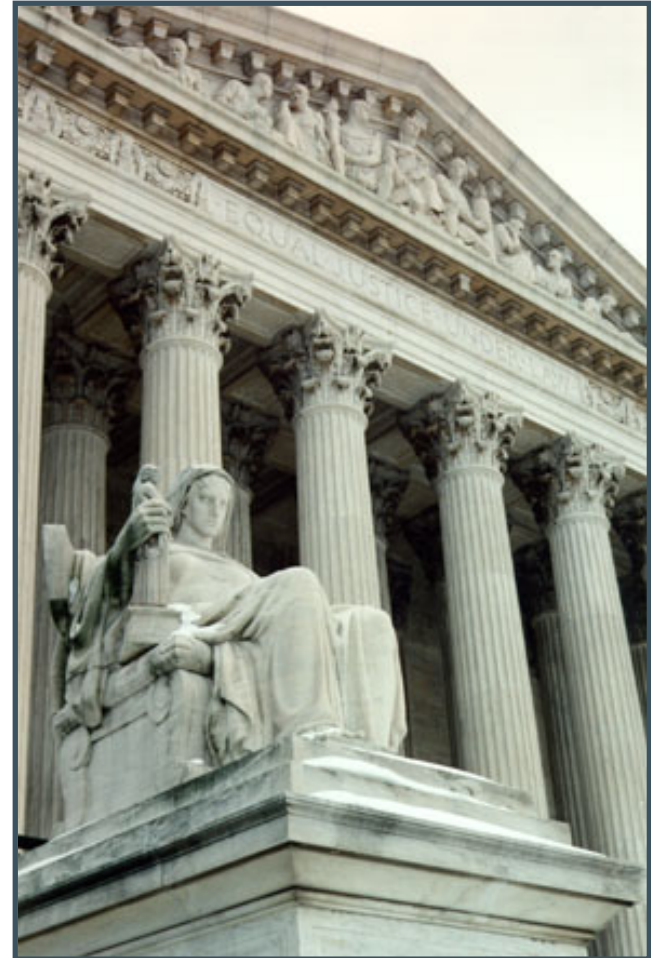
# Agenda

- **What is Just Culture**
- **Aligning Beliefs**
- **Managing System Design**
- **Managing Behavior**
- **Learning Through Events**
- **Enterprise Risk Management**
- **Just Culture Implementation**
- **Review and Wrap up**



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# Introduction to the Just Culture





# An Introduction to Just Culture

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*

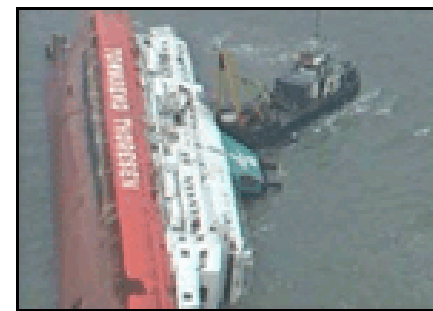


# An Introduction to Just Culture

“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





# An Introduction to Just Culture

“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?”

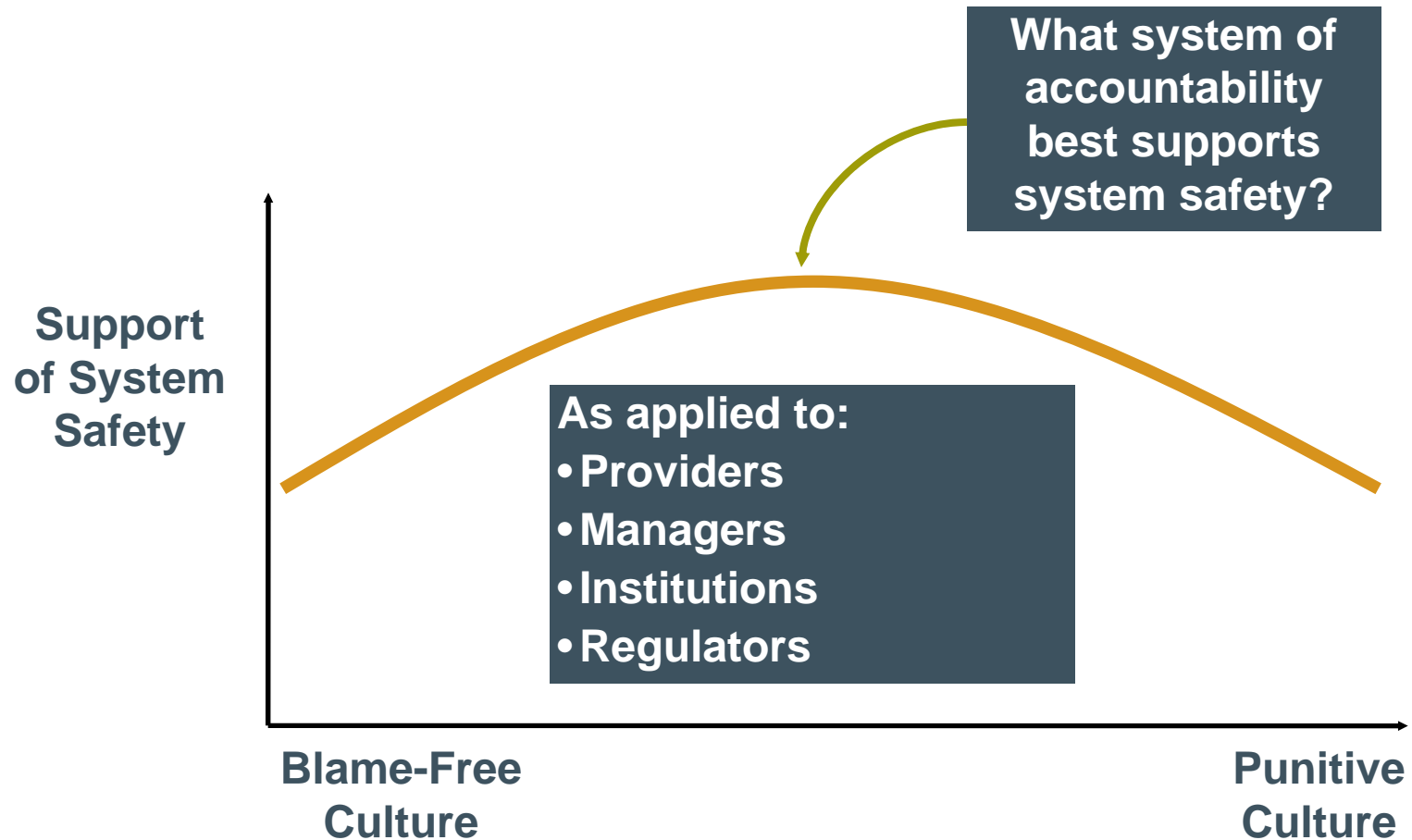
Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue.”

Don Norman  
*The Design of Everyday Things*





# The Problem Statement





# Four Cornerstones of a Just Culture

- **Create a Learning Culture**
- **Create an Open and Fair Culture**
- **Design Safe Systems**
- **Manage Behavioral Choices**



# Cornerstones of a Just Culture

- **Create a Learning Culture**
  - Eager to recognize risk at both the individual and organizational level
  - Risk is seen through events, near misses, and observations of system design and behavioral choices
  - Without learning we are destined to make the same mistakes



# Cornerstones of a Just Culture

- **Create an Open and Fair Culture**
  - Move away from an overly punitive culture and strike a middle ground between punitive and blame free
  - Recognize human fallibility
    - Humans will make mistakes
    - Humans will drift away from what we have been taught



# Cornerstones of a Just Culture

- **Design Safe Systems**
  - Reduce opportunity for human error
  - Capture errors before they become critical
  - Allow recovery when the consequences of our error reaches the patient
  - Facilitate our employees making good decisions



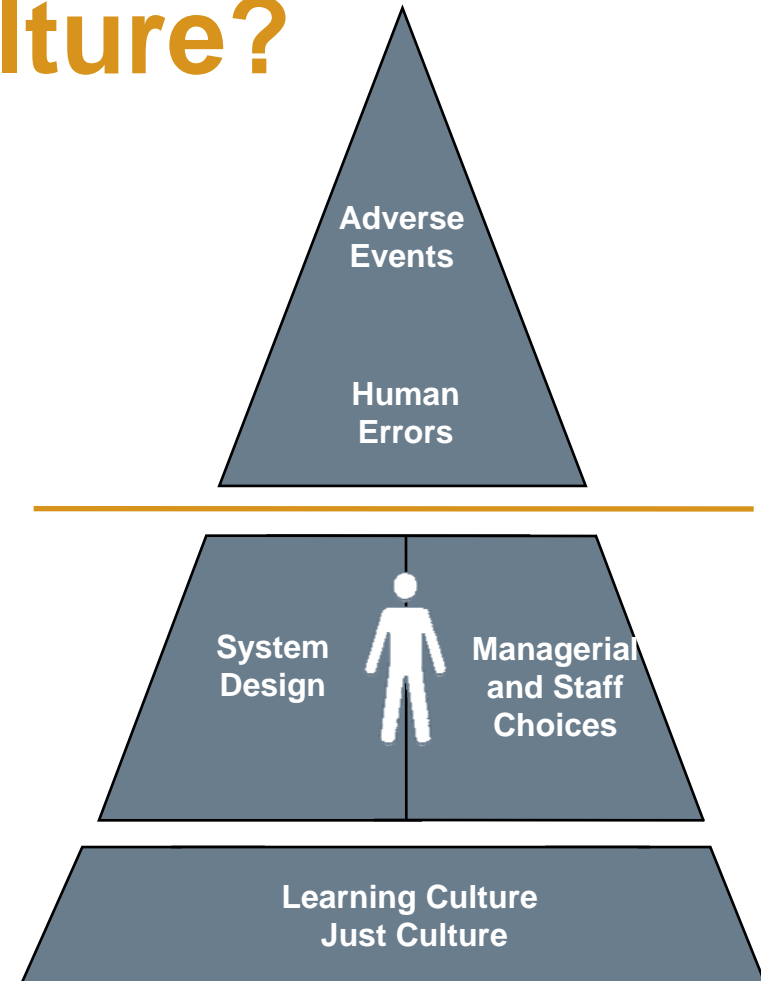
# Cornerstones of a Just Culture

- **Manage Behavioral Choices**
  - Humans will make mistakes. We must manage behavioral choices in a way that allows us to achieve the outcomes we desire
  - Cultures will drift into unsafe places
  - Coaching each other around reliable behaviors



# What is a Just Culture?

- Supports a learning culture
- Focuses on proactive management of system design and management of behavioral choices





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# What We Must Believe About the Management of Risk





# Our Beliefs About Risk Management

- **To Err is Human**
- **To Drift is Human**
- **Risk is Everywhere**
- **We Must Manage in Support of Our Values**
- **We Are All Accountable**



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# To Err is Human







# Risk is Everywhere

- Risk
  - Risk can be a perception
  - Risk can be an absolute
  - Risk is not inherently bad





# We Must Manage in Support of Our Values



- Risk = Severity x Likelihood
- Safety ~ Reasonableness of Risk



# Our Values

- Overlapping values?

**Yes**

- Competing values?

**Yes**

- Still – we must prioritize and balance our support of our values



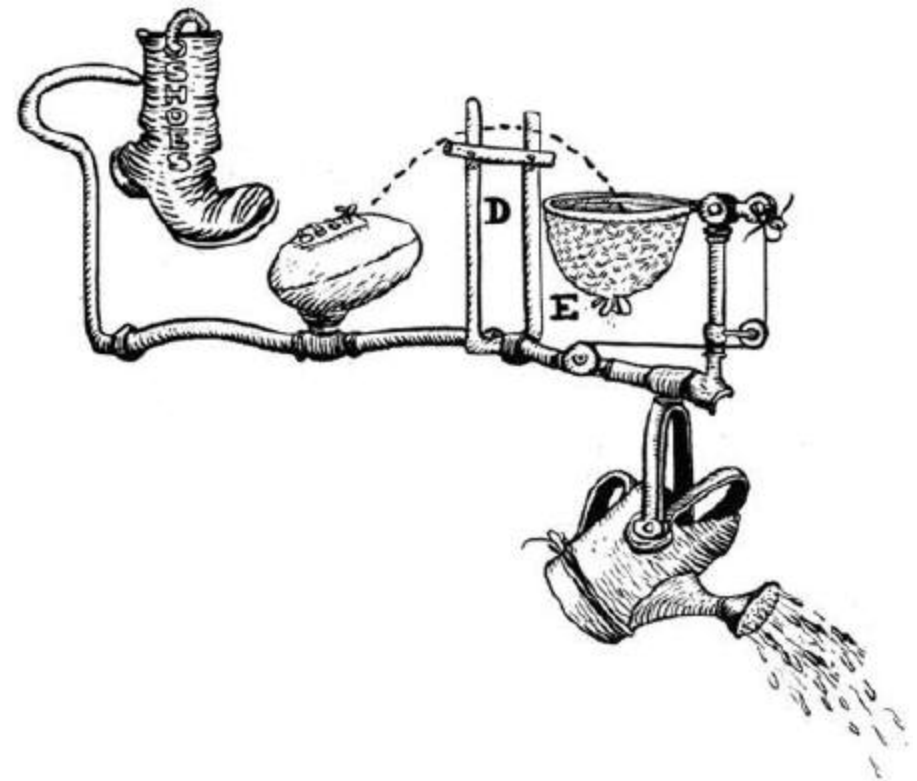


# We Are All Accountable

- **Across All Departments**
- **Across All Positions**
- **Across All Behaviors**
  - Human error
  - At-risk behavior
  - Reckless behavior



# Managing System Design

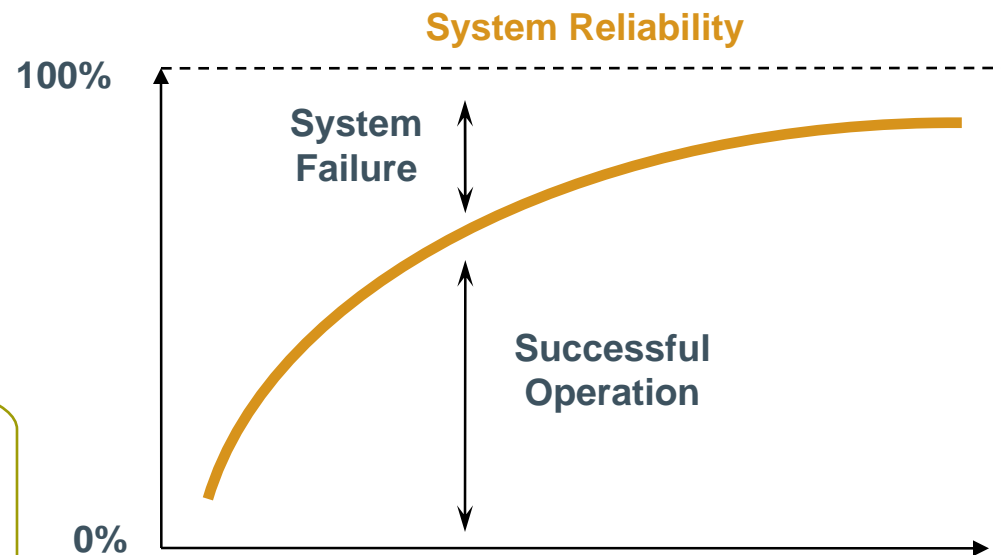




# The Safety Task: Managing System Reliability

## 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



Factors Affecting System Performance

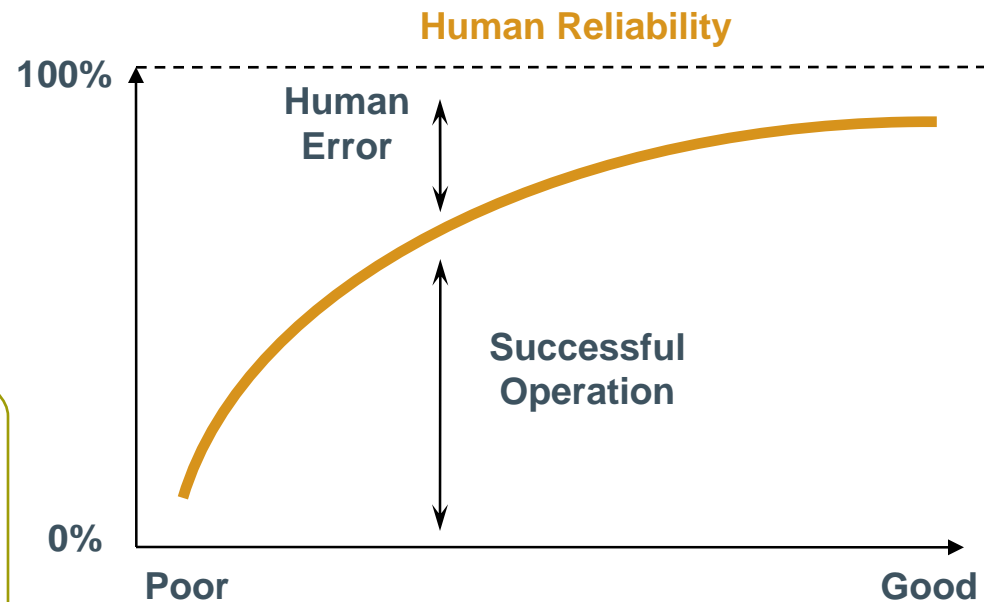
... knowing that systems will never be perfect



# 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



Factors Affecting Human Performance

... knowing humans will never be perfect



# Seven Design Strategies Important to Managing Risk

- “Make No Mistakes”
- Knowledge and Skill
- Performance Shaping Factors
- Barriers
- Redundancy
- Recovery
- Perception of High Risk



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# Managing Behavior





# The Behaviors We Can Expect

- **Human error** – an inadvertent action; inadvertently doing other than what should have been done; slip, lapse, 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 Behavior

## Human Error

Slip  
Lapse  
Mistake

Inadvertently doing  
other than what you  
should have done

Often a product of our  
current system design





# 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 – the error happened to them.



# 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?



# Managing Reckless Behavior

- Reckless Behavior
  - Conscious Disregard of a **Substantial and Unjustifiable Risk**
- Manage through:
  - Disciplinary action





# Managing At-Risk Behaviors

## At-Risk Behavior:

A behavioral choice that increases risk without perceiving the risk (unintentional risk taking), or he/she mistakenly believes the risk 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
  - Increasing situational awareness





# Managing At-Risk Behaviors

"The best car safety device is a rear-view mirror with a cop in it."

*Dudley Moore*



# The Three Behaviors

## Human Error

*Product of Our Current  
System Design*

Manage through changes in:

- 📖 Processes
- 📖 Procedures
- 📖 Training
- 📖 Design
- 📖 Environment

**Console**

## 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

**Coach**

## Reckless Behavior

*Conscious Disregard of  
Unjustifiable Risk*

Manage through:

- 📖 Remedial action
- 📖 Disciplinary action

**Punish**



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# The Role of Event Investigation





# The Basics of Event Investigation

What happened?

What normally happens?

What does procedure require?

Why did it happen?

How were we managing it?



Increasing  
value



# Just Culture Rules of Investigation

1. Causal statements should clearly show the “cause and effect” relationship.
2. Negative descriptors (such as “poorly” or “inadequate”) may not be used in causal statements.
3. Each human error should have a preceding cause.
4. Each procedural deviation should have a preceding cause.
5. Failure to act is only causal when there was a pre-existing duty.



# It's About a Proactive Learning Culture

- Often, events are seen as things to be fixed
- Events should be seen 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



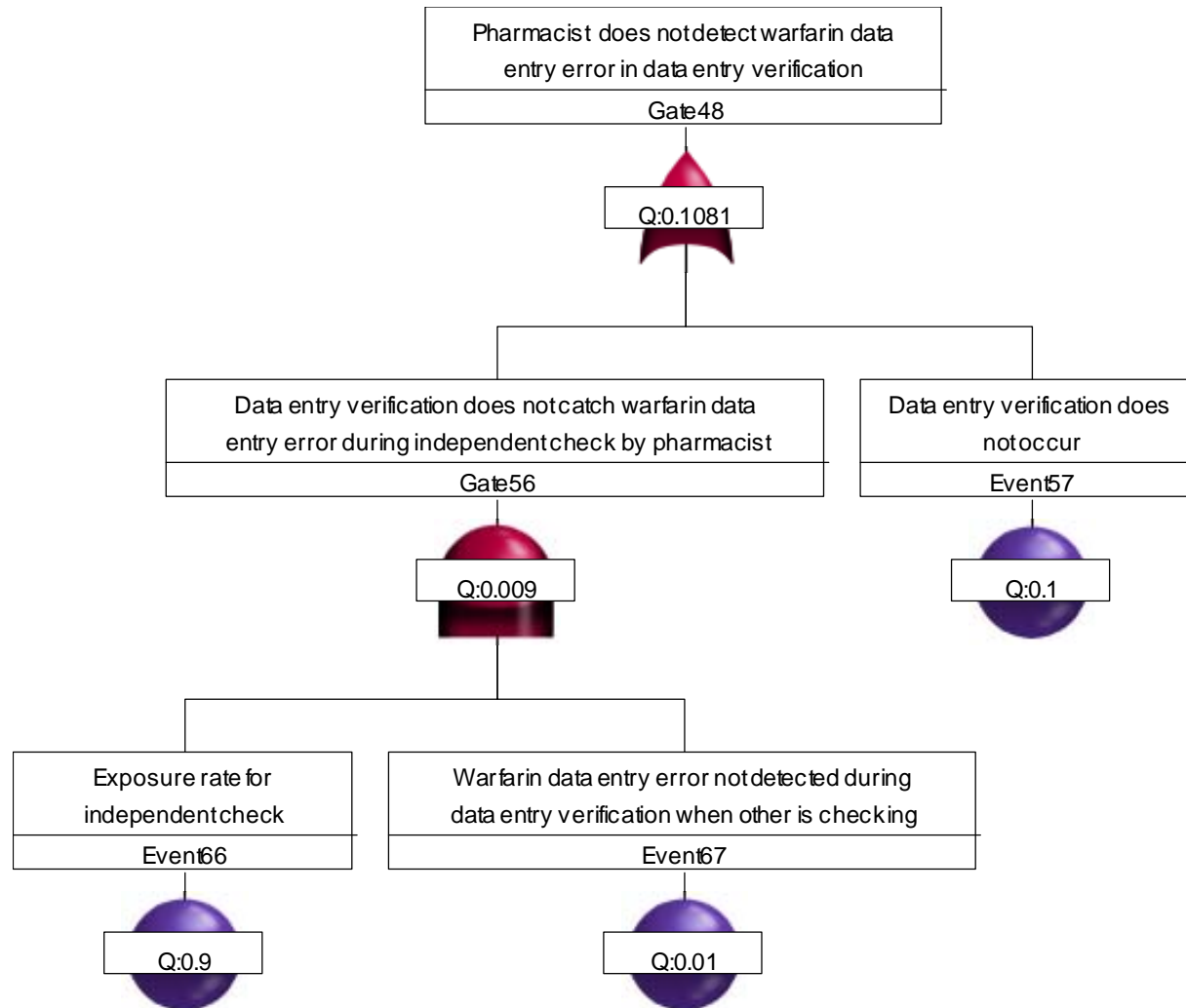
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# Enterprise Risk Management





## Community Pharmacy High Alert Medication ST-PRA





# Risk Reduction Tables for Community Pharmacy High Alert Medication Errors

## Sensitivity Analysis of Selected Actions on Adverse Events

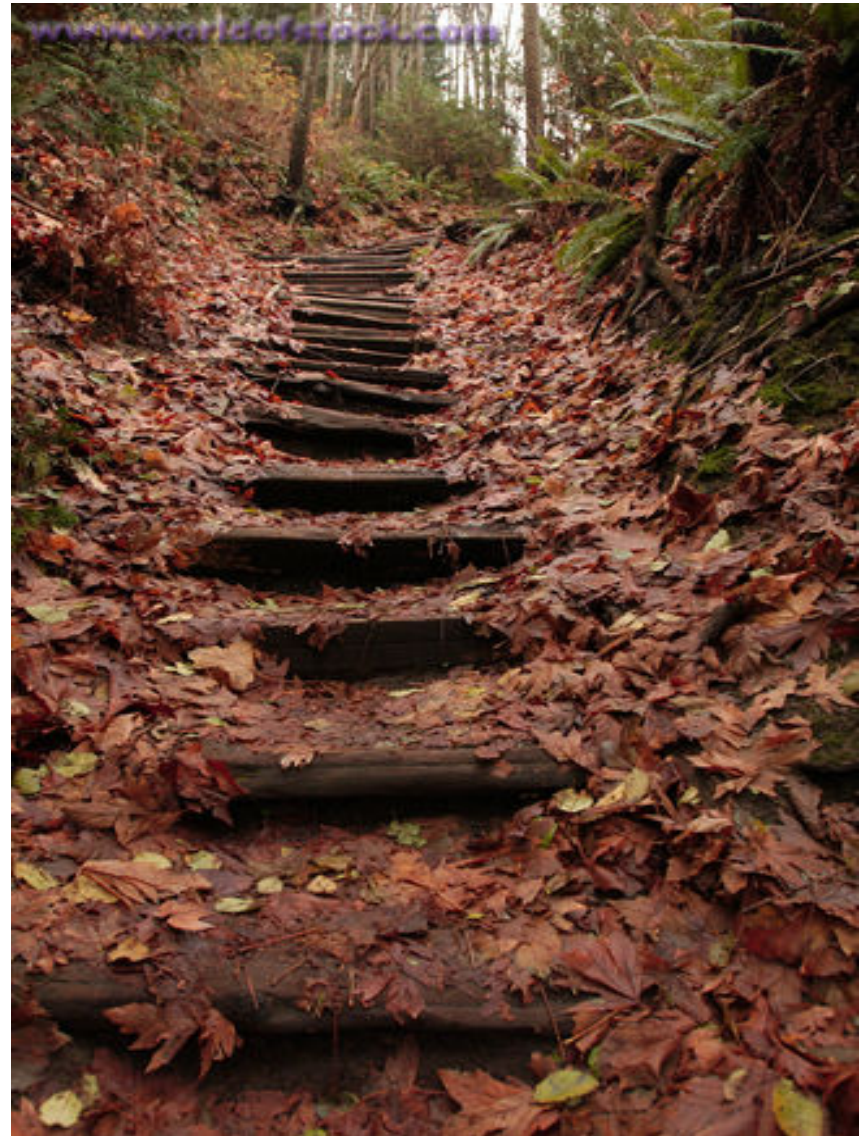
<b>Tested Actions</b> <i>Note: Most tests measure the positive impact of increasing an existing risk-reduction strategy or implementing a new risk-reduction strategy. A few of the tests measure the negative impact of reducing or eliminating an existing risk-reduction strategy.</i>	<b>Errors before Action</b> Per 1,000 prescriptions	<b>Errors after Action</b> Per 1,000 prescriptions	<b>Decrease in Risk</b> (Increase in Risk)
<b>Adverse Event: Wrong warfarin dose dispensed due to a data entry error</b>			
<b>A)</b> Reduce at-risk behavior of conducting data entry verification without due diligence from 1 in 10 to 5 in 100 prescriptions (requires changes in the system/environment to support a consistent, cognitive checking process)	1.83 (1.83/1,000)	1.19	35%
<b>B)</b> Increase patient counseling from 30 to 80 percent		0.600	67%
<b>C)</b> Increase the frequency of an independent double-check for data entry verification when a pharmacist enters prescriptions from 50 to 90 percent		0.865	53%
<b>D)</b> Conduct a second redundant data entry verification during the product verification step		0.366	80%
Action A <b>AND</b> Action B		0.393	79%
Action A <b>AND</b> Action B <b>AND</b> Action C		0.283	85%
Action A <b>AND</b> Action B <b>AND</b> Action C <b>AND</b> Action D		0.174	91%



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# Just Culture Implementation

## Taking the Necessary Steps





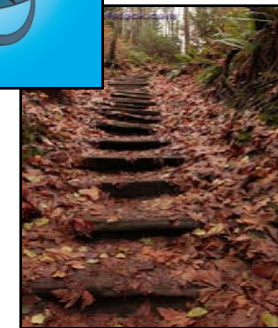
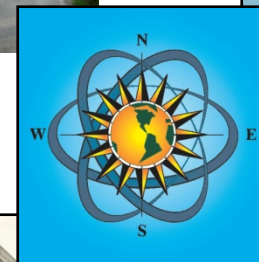
# What We Have Seen at Other Organizations

- There is a small (5%) population of the staff that is openly opposed to management
- There is a larger (20%) population that believes this is the right way to go
- The remainder (75%) have expressed that they believe the program will work, but likely will not buy into the program until they see management start to adhere to the philosophy



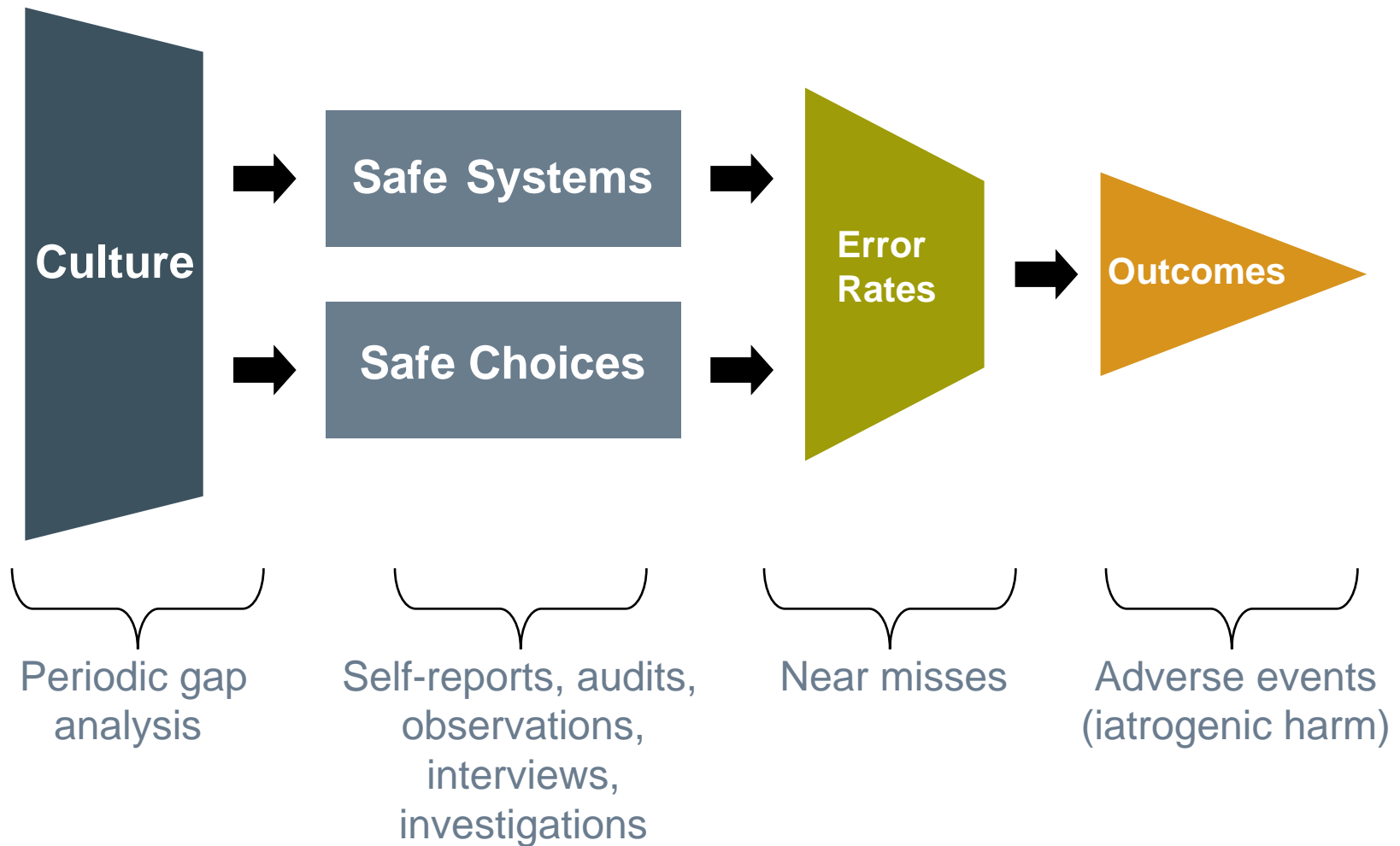
# Words to Describe Implementation

- A Journey?
- An Intervention?
- A Program?
- A Set of Tools?
- A Model?
- A Foundation?
- A Lifestyle?



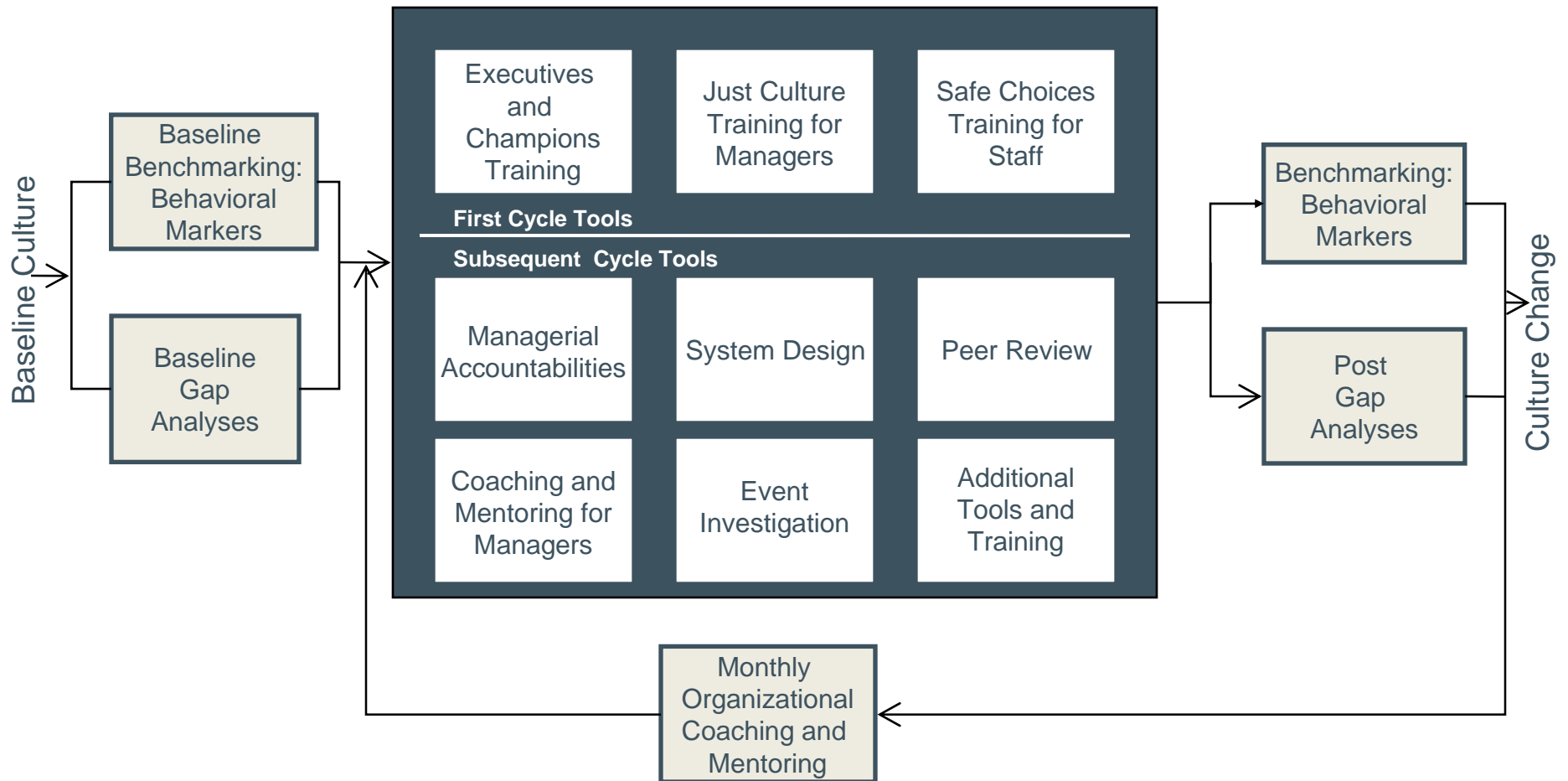



# Measurements of Success





# A Multi-Cycle Improvement Process



 Denotes measurement and/or feedback loop



# The Just Culture Algorithm





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# Review & Wrap Up





# Just Culture – What's it About?

- It's about both Error and Drift
- It's 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 Partnership with the Regulator
- It's About Doing the Right Thing



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# Doves or Hawks? Who Are We?





# Epilogue

“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*



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# Thank You

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