



The Just Culture
Community

Just Culture: The Key to Quality and Safety



MASSACHUSETTS
GENERAL HOSPITAL



MASSACHUSETTS GENERAL
PHYSICIANS ORGANIZATION

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Agenda

- The Need for a New Approach
- The Just Culture Model
- Applications to MGH/MGPO and SRH Community
- Questions?



Why talk about “Just Culture”

- A Just Culture supports a “learning organization”
- We all encounter issues, large and small, where a uniform and systematic approach to interpreting the situation would be valuable



Why is this important?

Medical error has always been with us:

FATAL MISTAKE AT THE MASSACHUSETTS GENERAL HOSPITAL.—The *Boston Traveller* contains a long document from Dr. J. C. WARREN, in relation to a death by chloroform, accidentally administered at the Massachusetts General Hospital. It appears that chloric or sulphuric ether is used in the hospital, in preference to chloroform. Three operations were performed on Saturday, Oct. 30. The first was for a contracted hand, and the patient was etherised with what was supposed to be chloric ether. The operation was performed, and the patient escaped without any other inconvenience than a slight soreness of the throat. The second case was for a tumor on the right side of the face. During the operation the patient came very near dying, but was saved. The third case, which proved fatal, was that of a young man, about twenty years old, a native of Ireland, who had his arm entangled in the machinery of a bark mill about five days before. He refused to have it amputated until mortification had taken place. On Saturday the operation was performed. Etherisation was carefully made, and the operation was accomplished in about two minutes. Just as it was finished it was perceived that his pulse was rapidly falling. Every effort was made to save him, but the patient breathed his last without an effort or convulsion. Dr. WARREN adds:

“On the following morning an examination of the body was proposed, but his friends arriving, objected, and although we urged the importance of ascertaining the immediate cause of his death, they continued to object decidedly.

“Immediately after the occurrence of alarming symptoms in this case, it was discovered that the substance which had been used was not chloric ether, but chloroform: and not till then did we understand the extraordinary phenomena which presented themselves in this and the preceding cases. This patient died with the usual phenomena of chloroform poison.

The New York Times

Published: November 23, 1852

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How do we interpret events?





Where We're At With Accountability

An experienced surgeon sees a new piece of equipment at a conference. Back at the hospital, a sales representative persuades him to use the equipment for a procedure. He has never used the equipment before and accidentally punctures the patient's bowel. The surgeon repairs the bowel and the patient recovers fully. The OR has a policy that says new equipment will be officially approved and training will be conducted prior to its use.



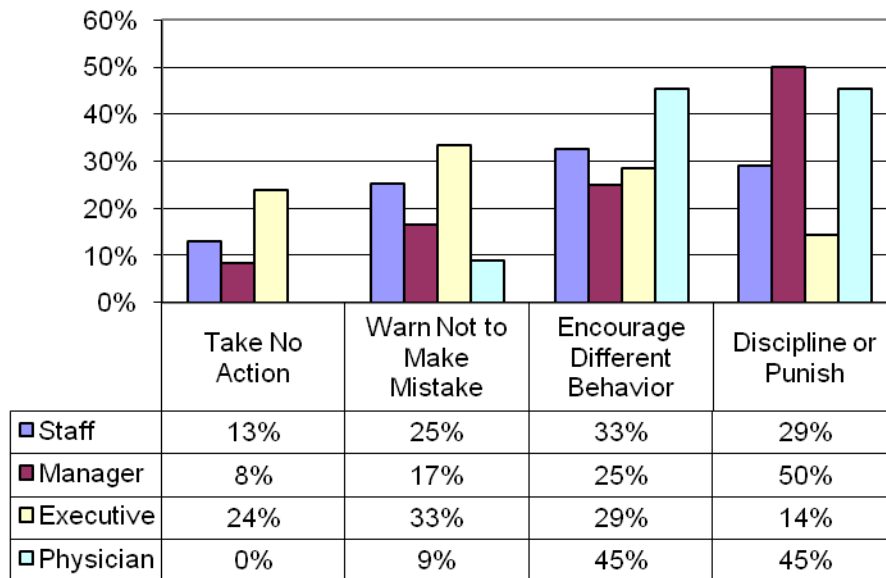
Your Options

- Take no action
 - Warn against doing it again
 - Encourage different behavior/coach
 - Discipline/punish
-
- Does the outcome make a difference?

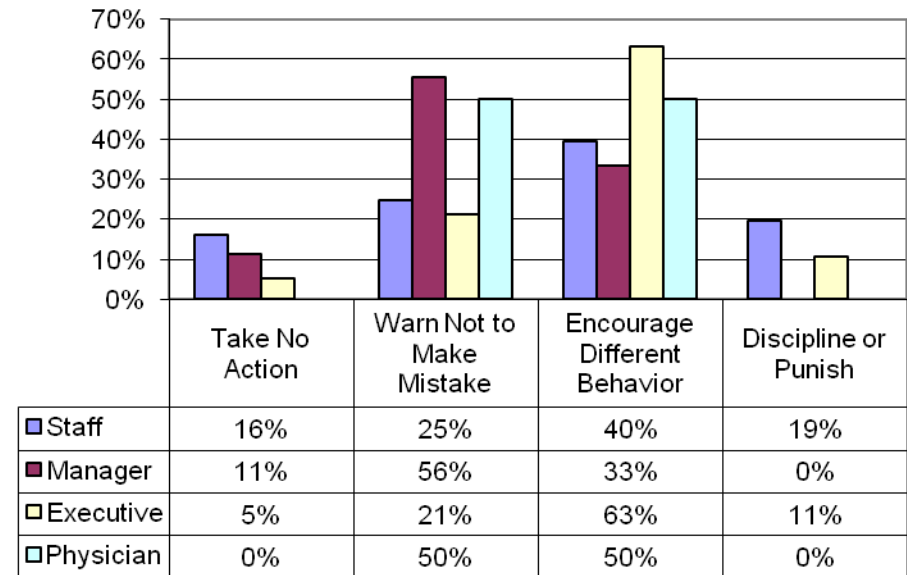


Where We're At With Accountability

Surgeon Use of Unapproved Equipment - Harmful Outcome



Surgeon Use of Unapproved Equipment – No Harmful Outcome





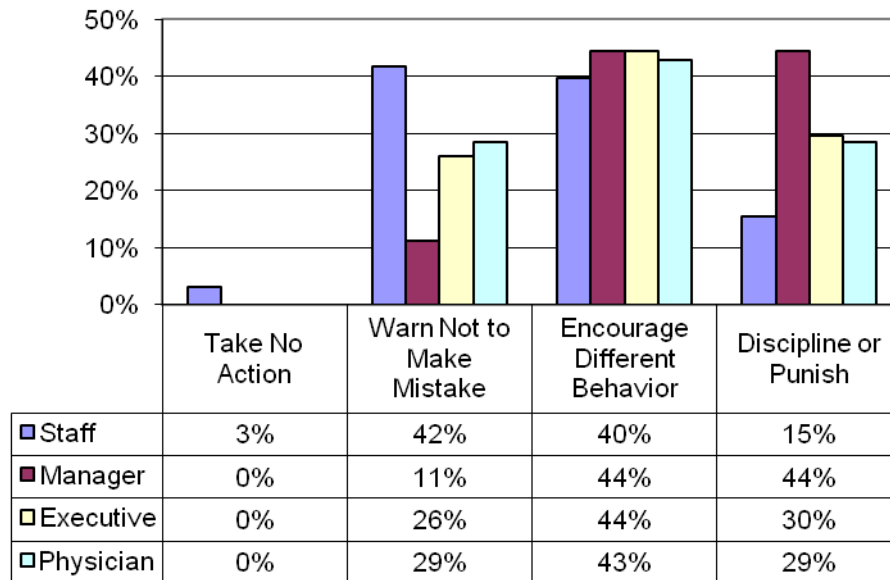
Where We're At With Accountability

The hospital has recently revised and upgraded its infection control protocols. Calstat, sinks, soap, and paper towels are now available near every patient area and there are no barriers to compliance that the staff can name. The staff is well educated on the risk of spreading infection and the danger of hospital infections to their patients' health. One month after the interventions are complete, the nurse manager observes practices in the ICU and finds that compliance has greatly improved, except for one nurse who routinely does not practice hand hygiene between patients. When questioned, the nurse states he does not have time to clean his hands between every patient contact.

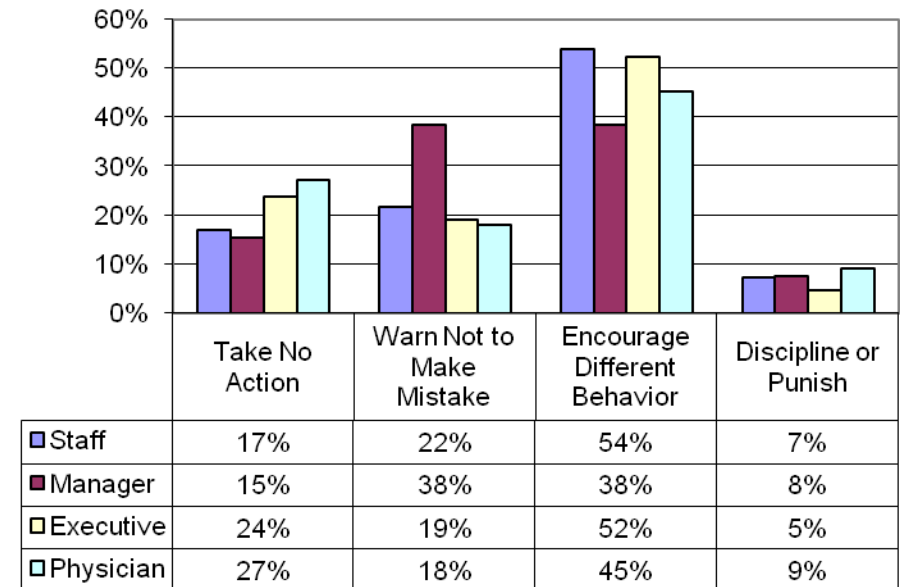


Where We're At With Accountability

Hand Washing Noncompliance - Nurse



Hand Washing Noncompliance - Physician





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The Limitations of “No Harm No Foul”



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MGH Credo

- ***As a member of the MGH community and in service of our mission, I believe that:***
 - The first priority at MGH is the well-being of our patients, and all our work, including research, teaching and improving the health of the community, should contribute to that goal.
 - Our primary focus is to give the highest quality of care to each patient delivered in a culturally sensitive, compassionate and respectful manner.
 - My colleagues and I are MGH's greatest assets.
 - Teamwork and clear communication are essential to providing exceptional care.

- ***As a member of the MGH community and in service of our mission, I will:***
 - Listen and respond to patients, patients' families, my colleagues and community members.
 - Ensure that the MGH is safe, accessible, clean and welcoming to everyone.
 - **Share my successes and errors with my colleagues so we can all learn from one another.**
 - Waste no one's time.
 - Make wise use of the hospital's human, financial and environmental resources.
 - Be accountable for my actions.
 - Uphold professional and ethical standards.



MGH Boundaries

As a member of the MGH community and in service of our mission, I will never:

- **Recklessly ignore MGH policies and procedures.**
- Criticize or take action against any member of the MGH community for raising or reporting a safety concern.
- Speak or act disrespectfully toward anyone.
- Engage in or tolerate abusive behaviors.
- Look up or discuss private information about patients or staff for any purpose outside of my specified job responsibilities.
- Work while impaired by any substance or condition that compromises my ability to function safely and competently.



Bo's Law

- The fastest way to get yourself killed on a manned space flight is to not follow standard operating procedure
- The second quickest way to get yourself killed is to always follow standard operating procedure

Karol Joseph "Bo" Bobko





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



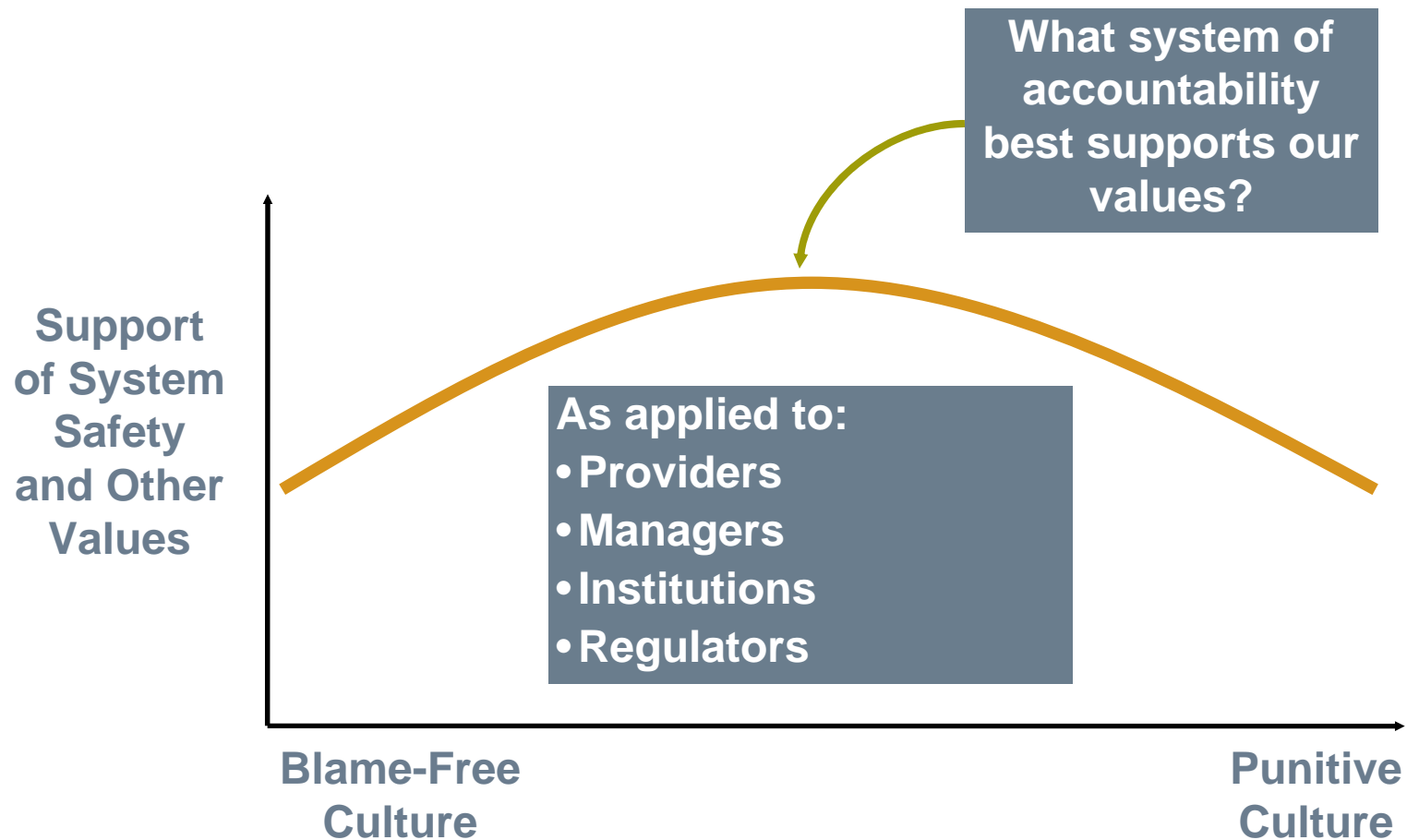


What do we mean by “Just Culture”?

- Traditionally, health care’s culture has held individuals accountable for all errors or mishaps that befall patients under their care
- A just culture recognizes that individual practitioners should not be held accountable for system failings over which they have no control.
- A just culture also recognizes many errors represent predictable interactions between human operators and the systems in which they work. Recognizes that competent professionals make mistakes.
- Acknowledges that even competent professionals will develop unhealthy norms (shortcuts, “routine rule violations”).
- A just culture has zero tolerance for *reckless* behavior.



A Balanced Accountability





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

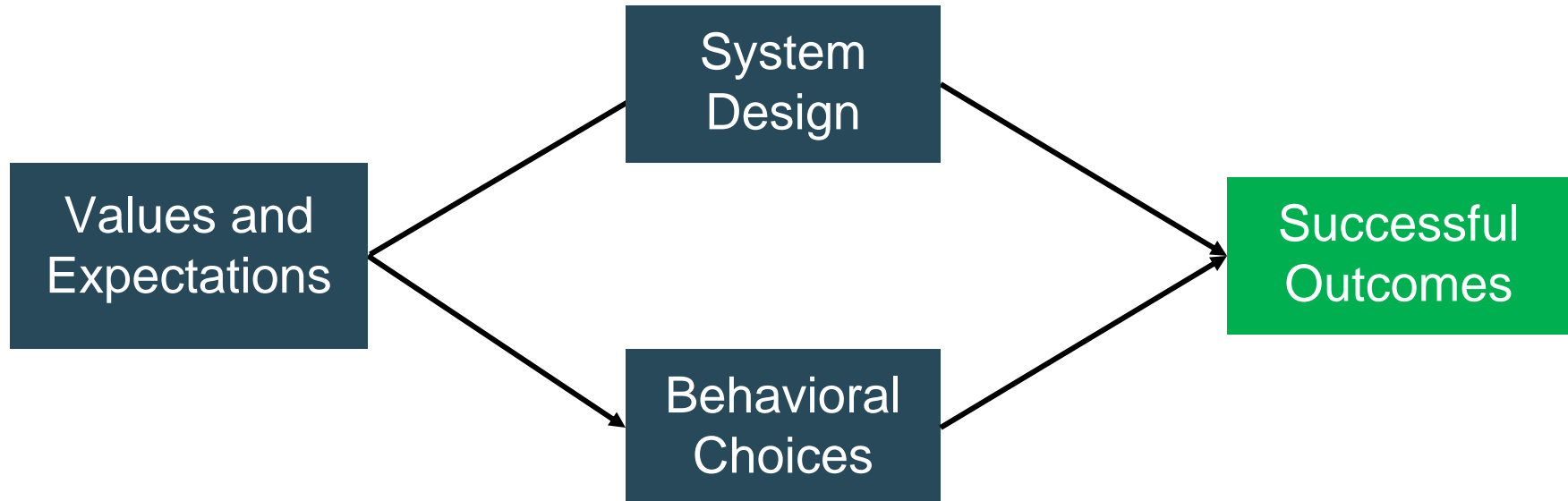


3 Perspectives Creating The Just Culture Model

- Engineering
- Human Factors
- Legal

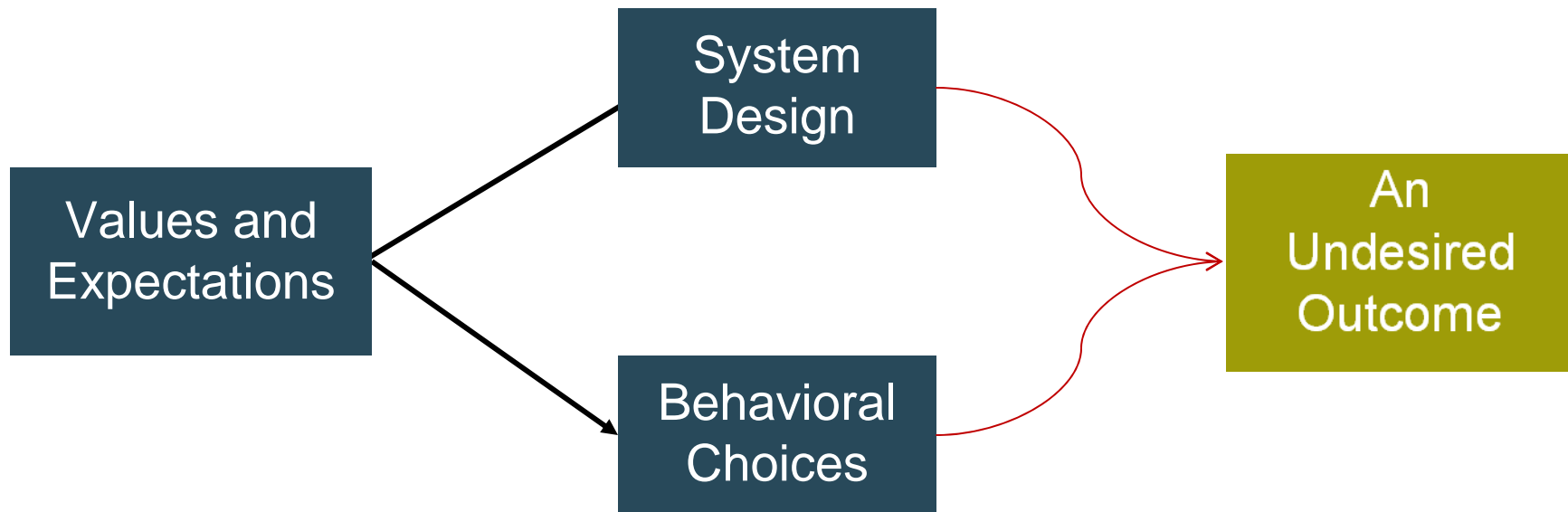


Inputs and Outputs





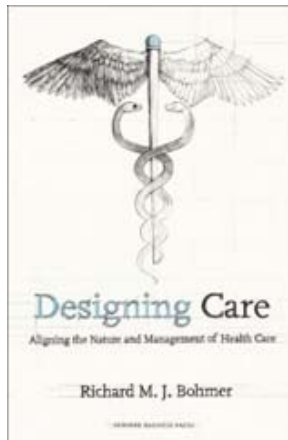
Sometimes, the System Does Not Appear to Work





Realities of System Design

- Systems are never 100% reliable or “fool proof”
 - The space shuttle design is to have failures of less 1/100 times (but there are tradeoffs)
 - Health systems are often far less reliable

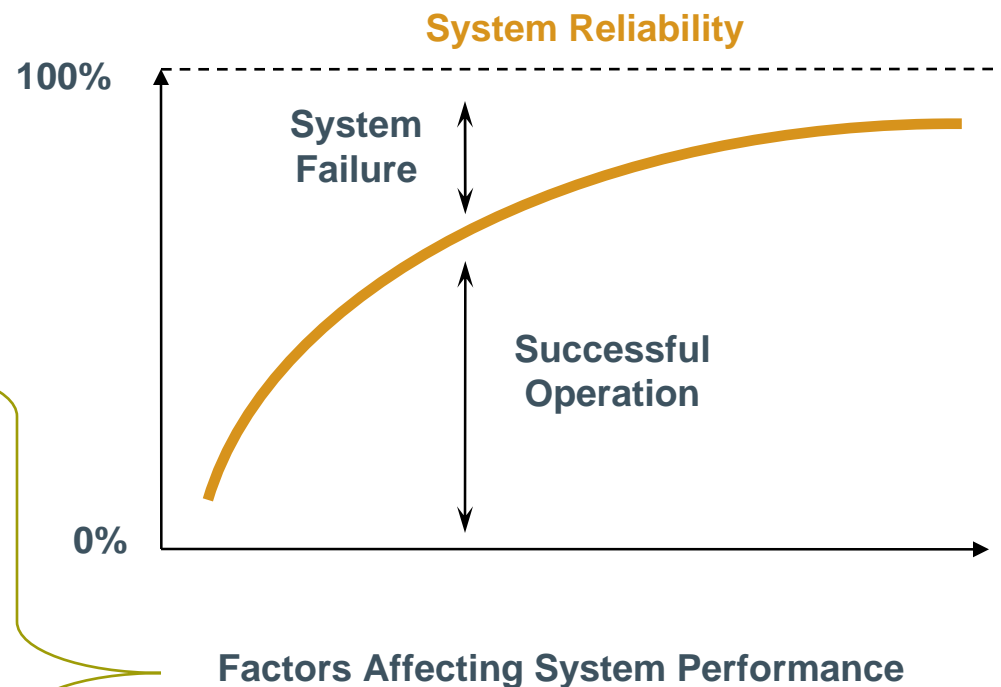




The Safety Task: Managing System Reliability

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



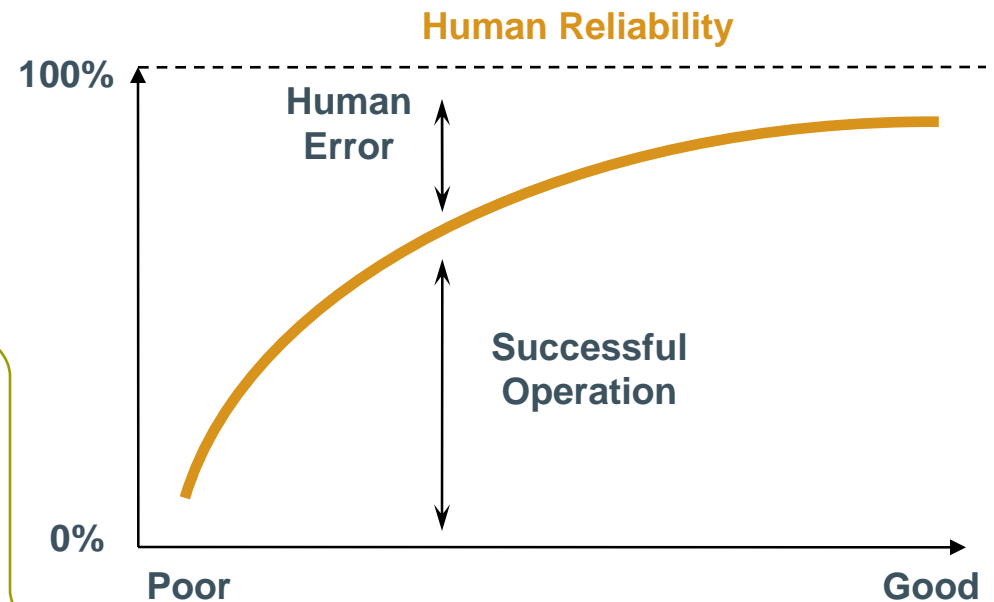
... knowing that systems will never be perfect



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

***80 hour work week for residents tradeoff with handoffs**



The Behaviors We Can Expect

- Human error - inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake.
- At-risk behavior – behavioral choice that increases risk where risk is not recognized, or is mistakenly believed to be justified.
- Reckless behavior - behavioral choice to consciously disregard a substantial and unjustifiable risk.



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To Err is Human



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Rasmussen's Model of Human Error

- Skill based behavior
- Rule based behavior
- Knowledge based behavior



Our Response – Human Error

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

Console

Learn



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To Drift is Human



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To Drift is Human





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



Human Error and Drift Interaction

- At risk behaviors we choose make us more prone to human error
 - e.g. driving in a residential neighborhood
- Performance shaping factors also make us more prone to human error
 - e.g. fatigue





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Reckless is Reckless





Our Response – Reckless Behavior

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

Punish



Importance of Being Just and Consistent

- Legal frameworks may not always be helpful
 - E.g. Wisconsin law states that you can have 5 DUI's before mandatory prison but 1 DUI leading to death leads to mandatory prison
 - What is the implicit message?
 - Importance of addressing the behavior before it becomes a harm producing event



The Three Behaviors

Human Error

Product of Our Current System Design and Behavioral Choices

Manage through changes in:

- Choices
- 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 Substantial and Unjustifiable Risk

Manage through:

- Remedial action
- Disciplinary action

Discipline



Move to just, not shame/blame

- A just culture recognizes that individual practitioners should not be held accountable for system failings over which they have no control.
- A just culture also recognizes many errors represent predictable interactions between human operators and the systems in which they work. Recognizes that competent professionals make mistakes.
- Acknowledges that even competent professionals will develop unhealthy norms (shortcuts, “routine rule violations”).
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Applying Just Culture At Home





Hamlet on Just Culture

“for there is *nothing either good or bad*, but thinking makes it so”

But how do we think in a fair, systematic, reproducible, and reliable way?



Applying Just Culture

- Reinforcement of Mission, Credo, and Boundaries
- Incorporation into review of safety events
- Discussion during PCAC case reviews
- Component of physician reimbursement decisions when a patient suffers a serious event



Summary

- Takes focus off of errors and outcomes
 - And puts focus on the quality of system design and the quality behavioral choices puts it on systems and behavioral choices
- Systematic and uniform process designed to support practice
- A More “Just” Culture for Providers



Take Home Messages In a Just Culture

- **Staff can admit their mistakes**
- **Staff are held accountable for their behavioral choices**
- **Clear line: human error, at-risk behavior, and reckless behavior**



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Thank You!

If you are interested in learning more
contact Akin Demehin, CQS , MGH or
check out:

www.justculture.org