Session 2

- The Three Behaviors
- Management of each behavior
- Event Investigation
- Just Culture and Rot Cause Analysis
- The Just Culture Algorithm
- Application with case scenarios
- Just Culture journey at Bringham & Womens Hospital

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The Three Behaviors

Human Error

At-Risk Behavior

Reckless Behavior

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Human Error

- Inadvertent action
- Slip, lapse, mistake

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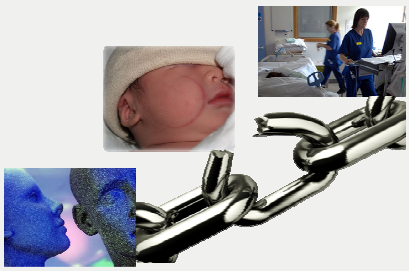
Human Errors in Healthcare



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Management of Human Errors

CONSOLE

Source: David Marx, *Patient Safety and the "Just Culture*, Outcome Engineering, LLC, 2007.

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Management of Human Errors

Changes in:

- Processes
- Procedures
- Training
- Design

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ARC Toolkit

- Administrative Controls
- Design Controls
- Elimination controls

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Administrative Controls

- Policy/procedure change
- Education/training

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Design Controls

- "Tall-man" lettering
- Colored tubing
- Needleless IVs

HyrOXYzine	HydrALAzine
Hydroxyzine	Hydralazine
Hydroxyzine	Hydralazine

Source: https://www.google.com/search?q=tall+man+lettering&tbm=isch&tbo=u&source=univ&sa=X&ved=0ahUKEwixre7guKfWAhVM0YMKHaMzDx0QsAQIPQ&biw=1019&bih=871#imgdii=rZmhFz2CH_cv-M:&imgrc=3YxX_RJGanDzRM:

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Elimination Controls

- Discontinue equipment
- Close or discontinue a service

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At-Risk Behavior

- A choice
- Complacency
- "Drift"
- Perception of risk

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At-Risk Behavior in Healthcare

Omitting the "time-out" for a procedure

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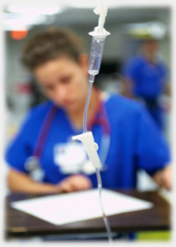
At-Risk Behavior in Healthcare

- Omitting a double-check for a high-risk medication
- Not following the "8 rights" of medication administration



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Management of At-Risk Behavior

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Management of At-Risk Behavior

COACH

Source: David Marx, *Patient Safety and the "Just Culture*, Outcome Engineering, LLC, 2007.

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Management of At-Risk Behavior

By:

- Removing incentives for risky behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

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Removing Incentives for At-Risk Behavior

Reduce time pressures

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Creating Incentives for Healthy Behaviors

Reward employees for reporting errors and “near-misses”

Source: National Safety Council and Alliance, An OSHA Cooperative Program, *Near Miss Reporting Systems*, May 2013.

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Increasing Situational Awareness

- Share case examples
- Perform a root cause analysis of “near-miss” and actual events
- Learn from mistakes

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Reckless Behavior

- A conscious decision to violate a procedural rule
- Continuing “at risk” behaviors, despite coaching

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Reckless Behavior

Performing surgery while intoxicated

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Reckless Behavior

Not reporting a medication error to the physician

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Management of Reckless Behavior

- Discipline
- Punishment

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The Just Culture Algorithm

- David Marx – Outcome Engenuity
  - Tool to understand and categorize your employees choices
    - Objective framework
    - Guides consistent, objective, and fair evaluations of behavior leading to errors or events.

Available for purchase at: https://staging.outcome-eng.com/the-just-culture-algorithm/

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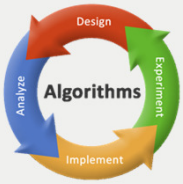
The Just Culture Algorithm

- Use to evaluate events, near misses or risky behavior
- Use to evaluate conduct when the behavior of the employee does not match the values of the organization
- Use to assess system contributions and accountability



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Event Investigation

Non-punitive approach

Evaluation

Prevention plan

Communication

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Interview

- Show empathy
- Get the facts
- Save the most difficult questions for last

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Just Culture and RCA

Root cause analysis (RCA^2)

RCA^2
Improving Root Cause Analyses and Actions to Prevent Harm

Source: The National Patient Safety Foundation, "RCA2: Improving Root Cause Analyses and Actions to Prevent Harm," http://c.ymcdn.com/sites/www.npsf.org/resource/resmgr/PDF/RCA2_v2-online-pub_010816.pdf, 07/11/2016. http://c.ymcdn.com/sites/www.npsf.org/resource/resmgr/PDF/RCA2_v2-online-pub_010816.pdf

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Blameworthy *Events*

- Substance abuse
- Patient abuse
- Criminal acts
- Intentional harm

Source: The National Patient Safety Foundation, "RCA2: Improving Root Cause Analyses and Actions to Prevent Harm," http://c.ymcdn.com/sites/www.npsf.org/resource/resmgr/PDF/RCA2_v2-online-pub_010816.pdf, 07/11/2016.

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Just Culture and RCA^2

- Persons involved in the error are not on the RCA team
- Interviews are conducted

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Just Culture Case Scenarios

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Scenario Guide

Breach of Duty

- Duty to produce an outcome
- Duty to follow a procedural rule
- Duty to avoid causing unjustifiable risk or harm

Type of Error

- Human error
- At-risk behavior
- Reckless behavior

Repetitive Human Errors

What is repetitive?

- Are there:
  - System performance shaping factors?
  - Are there personal performance shaping factors?

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Repetitive At-Risk Behaviors

What is repetitive?

Are there:

- System performance shaping factors
- Performance shaping factors

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Transitioning to Just Culture - Management

- Create an open learning environment
- Learn when to console and when to coach employees
- Commit to the limited use of warnings and punitive actions in the limited circumstances where it benefit system values
- Strive to understand why human errors occur
- Strive to understand why at-risk behaviors occur

Source: David Marx, *Patient Safety and the "Just Culture*, Outcome Engineering, LLC, 2007

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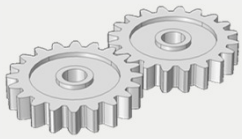
Management Transitioning

- Learn to see what's common to prioritize risk and interventions
- Work with staff to design systems that reduce the rate of human error and at-risk behavior, or mitigate their effects
- Learn to measure risk, at both the unit and organizational level



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Transitioning for Providers and Staff

- Look for risks in the systems in which we work
- Look for risk in our own behavioral choices
- Evaluate risk versus benefit – looking for the risks that do not provide value to those we serve
- Report hazards and adverse events
- Participate in the learning culture – being open and honest about what happened
- Always make safe choices

Source: David Marx, *Patient Safety and the "Just Culture*, Outcome Engineering, LLC, 2007

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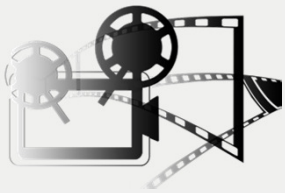
Just Culture Video



Bringham & Women's Hospital

https://www.bing.com/videos/search?q=Bringham+womens+hospital+just+culture+video&&view=detail&mid=7FB1ED7721C133A89E3E7FB1ED7721C19E3E&FORM=VRDGAR

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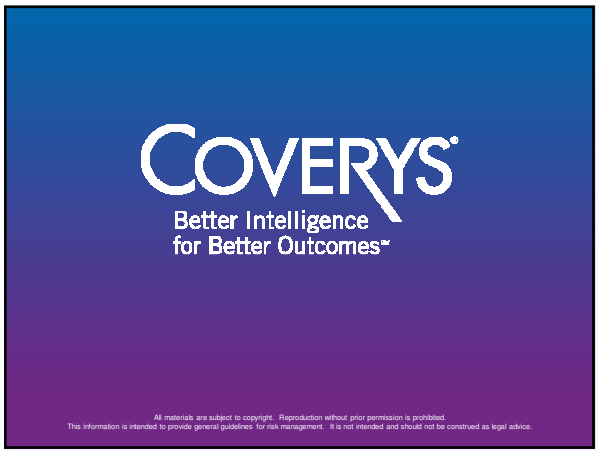
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