Just Culture Transformation

Safe Choices

outcomengenuity
helping those who build a better world

The Just Culture

- A culture of shared accountability: We stand in judgment of *ourselves*…as an organization.
  - "We", not "They"
- A culture where we shift the focus from severity of events and outcomes to choices and risk
- Just Culture: Not a "Program", but a cultural strategy

Key Questions in a Just Culture

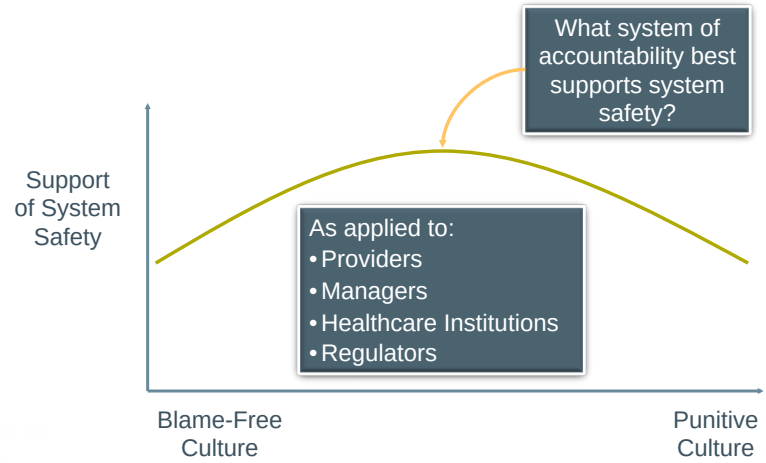
- What are the quality of our choices?
- How do our systems impact behaviors?
- How are we managing the risks?

The Severity (Outcome) Bias

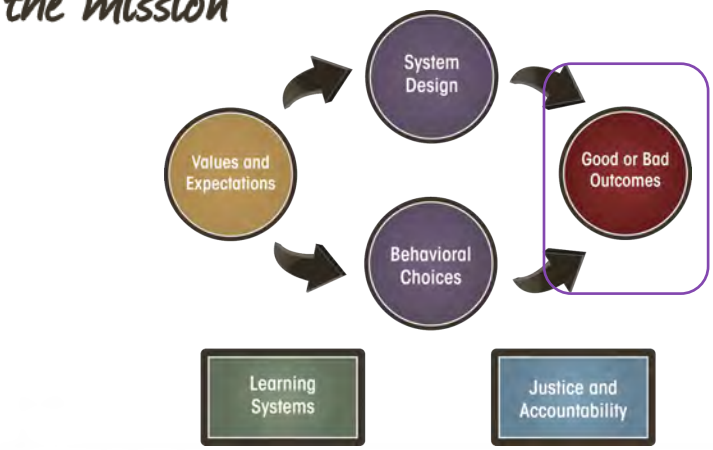
A decision to take action based on the severity of the outcome

- The severity bias affects our ability to develop systems that effectively:
  - Allow feedback loops from errors
  - Promote open communication about risk, system issues
- The severity bias causes us to "label" people, events, into categories that don't help us define performance issues

The Problem Statement

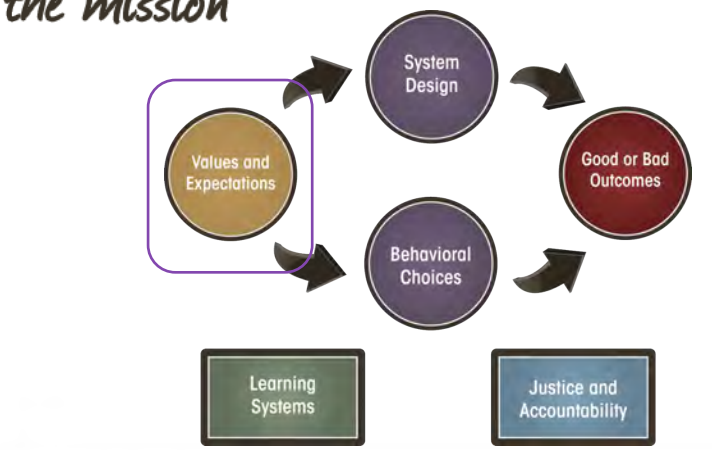


Five Focal Points



The Just Culture Community

Five Focal Points

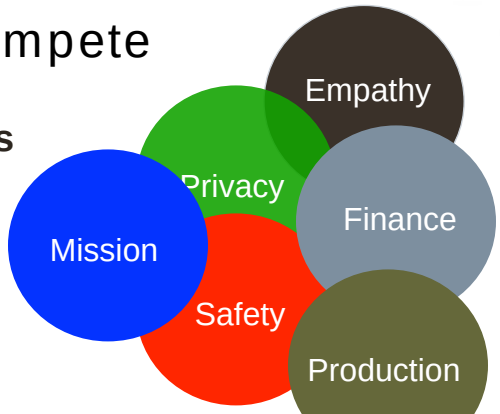


The Just Culture Community

Our Values Compete

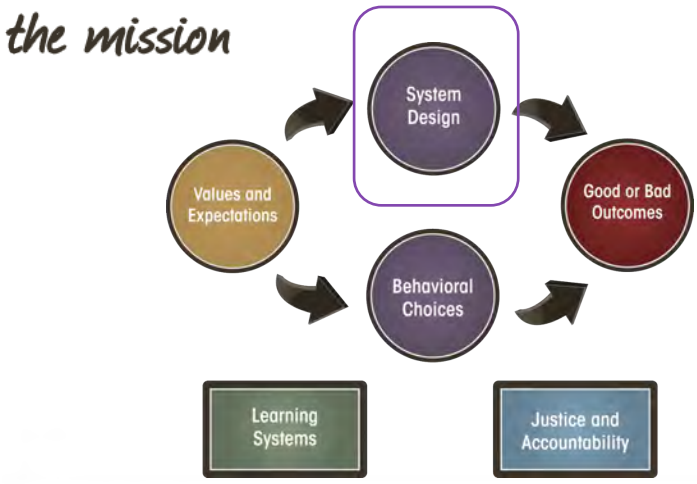
- **Overlapping Duties**
- **Competing Values**

Examples:



The Just Culture Community

Five Focal Points



The Just Culture Community

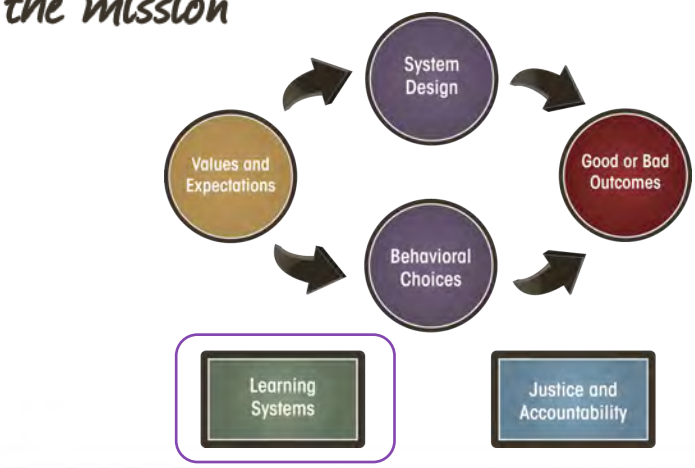
Managing System Design

Reliable Systems – System Design

- Controlling Contributing Factors
- Add Barriers
- Add Recovery
- Add Redundancy
- Knowledge and Skills
- Performance Shaping Factors
- Perceptions of Risk
- "Make no Mistakes"

The Just Culture Community

Five Focal Points



The Just Culture Community

Learning Systems

- Peer Review
  - Justice, Accountability, Learning
- CRM, "Team Steps"
  - Looking at errors and systems from the Team Perspective (what did individual contribute, what was a team dynamic)
- FMEA, STPRA, RCA, "Thin Slicing"
- Event Investigation

The Just Culture Community

Event Investigation

The Steps:

1. Identify the Undesirable Outcome
2. Begin the Search for Causes
3. Build a Cause and Effect Diagram
4. Test the Strength of Causal Links
5. Explain the Human Errors
6. Explain the Violations
7. Explain the Mechanical Failures
8. Explain Other Causal Conditions
9. Remove Non-Causal Data
10. Build a Narrative
11. Eliminate Possible Biases
12. Test the Final Product
13. Develop Risk Reduction Strategies

What happened?

What normally happens?

What's procedure require?

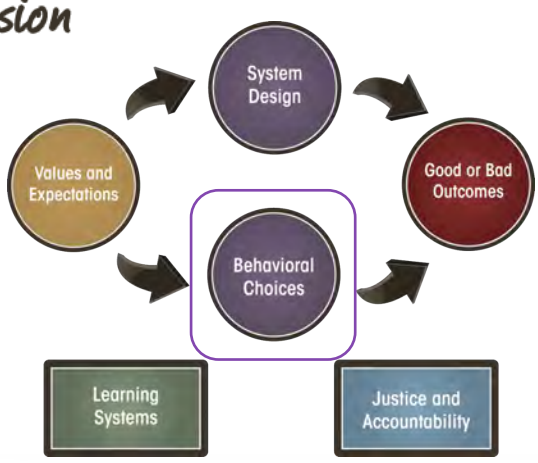
Why did it happen?

How were we managing it?

The Just Culture Community

Five Focal Points

the mission



The Just Culture Community

The Behaviors We Can Expect

- Human Error: an inadvertent action; inadvertently doing other that 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.

The Just Culture Community

The Three Behaviors

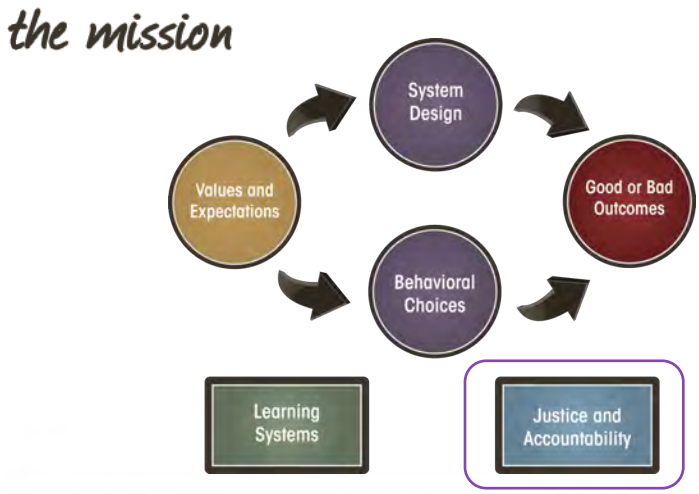
Human Error	At-Risk Behavior	Reckless Behavior
Inadvertent: Product of Our Current System Design and Behavioral Choices	*A Choice: Risk Believed Insignificant or Justified- Driven by Perception of Consequences*	*Conscious Disregard of Substantial and Unjustifiable Risk*
Manage through changes: • Choices • Processes • Procedures • Training • Design • Environment	Manage through: • Removing incentives for at-risk behaviors • Creating incentives for healthy behaviors • Increasing situational awareness	Manage through: • Remedial action • Disciplinary action
Console	Coach	Discipline

The Just Culture Community

At-Risk Behavior

- Cutting corners to save time
- Perception that rules are too restrictive
- Belief that rules no longer apply
- Lack of rule enforcement
- New workers see "routine violations"
  - Think this is the "norm"
- Insufficient Staff to perform tasks
- Right equipment is not available
- Extreme conditions
- Perception that practice is safe
- Least Effective Barrier: Rules

Five Focal Points



The Duty to Produce an Outcome

States an expectation or a desired outcome. Employee "owns" the system on how to accomplish the outcome.

- Be to work on time
- Bring badge
- Get the up-to-date history and physical to the hospital
- Keep email up and running (IT)
- Stop at a stop sign

The Just Culture Community

The Duty to Follow Procedural Rules

Describes a process, spelled out in detail or specific protocol. Employer creates and "owns" the system. Employee complies.

- Two patient identifiers
- Hand hygiene
- Filing patient records
- Admission Procedures
- Accounting controls

The Just Culture Community

The Duty to Avoid Causing Unjustifiable Risk or Harm

The highest duty. What we all owe each other. The duty that is breached when we place a VALUE, PERSON, or PROPERTY in position of potential or actual harm.

- Do the right thing for the patient
- Do the right thing for coworkers
- Do the right thing for the family and visitors
- Do the right thing for the organization

The Just Culture Community

The Patient Hand-Off Rule

- Outcome Duty
  - General Expectations
  - Expertise
  - Ambiguity
  - Professional Judgment

Ambiguity causes tendency to engage in outcome bias.

- Procedural Rule
  - Known risk mitigation strategies
  - Operationally proven methods
  - Consistent resources
  - Rarely time compressed

BEWARE of policy liability. "If they only followed the policy…"

Scenarios

Nuance in the Algorithm

- Think of it as a "Curiosity Tool"
- The concept of looking in the mirror…
- The algorithm is not *only* about justice and accountability:
  - It is about changing behavior
  - Understanding differences in expectations (Yours, theirs)
  - Identifying how people work within your system
  - And clarifying how well your learning system works.
- *"We stand in judgment of ourselves"*

Core Objectives

Manage Behavioral Choices

- Humans will make mistakes: Console
- People and Cultures will drift into unsafe places: Coach
- People will make choices that consciously disregard substantial and unjustifiable risk.

  Consider: Discipline

The Just Culture Community

Core Objectives

Design Safe Systems

- Reduce opportunity for human error
- Capture errors before they become critical
- Allow recovery when the consequences to prevent errors reaching the patient
- Facilitate our employees making good choices

The Just Culture Community


outcomengenuity
helping those who build a better world
•Please visit us at
•www.outcome-eng.com