The Just Culture

• A culture of shared accountability

• A culture where we shift the focus from severity of events and outcomes to choices and risk

Key Questions in a Just Culture

• What are the quality of our choices?

• How are we managing the risk?
The Just Culture Algorithm™

The Duty to Avoid Causing Unjustifiable Risk or Harm

Risk & Values Based
Quality of Choices
Organization’s Mgt of Risk

The Duty to Produce an Outcome
- Task Based
- Outcome Based
- Rate Based

OR

The Duty to Follow a Procedural Rule
- Process Based
- System Based
- Compliance Check

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The Just Culture

• It’s not just about the Algorithm
• It’s about so much more!

• Setting expectations
• Raising perception of risk
• Promoting key behaviors to manage risk
• Prioritizing our tasks to protect our values
• Engaging the workforce
• Making good choices and doing the right thing
• Collaborating for success....

.....for our employees, our organization and those we serve
expectations

You can expect:

• Introduction to concepts;
• Basis for further consideration;
• Change in perspective & expectations;
• More information in coming months.

You should not expect:

• Fully prepared to apply concepts;
• Begin to apply concepts immediately.
objectives

• Describe how the Just Culture model improves patient safety

• Understand how to reduce risk through managing behavioral choices and system redesign

• Describe the steps in an event investigation

• Apply Just Culture Algorithm to example cases

• Identify your role in creating a culture of safety

• Discuss next steps to implement Just Culture
David Marx introduces the Just Culture

daavid marx, jd
just culture
The Concepts
It’s About Doing This Well...

the mission

System Design

Good or Bad Outcomes

Behavioral Choices

Values and Expectations

Learning Systems

Justice and Accountability
We Must Manage in Support of Our Values
We are all Accountable

- Creating reliable ‘personal systems’
- The quality of our choices and management of risk
- Reporting issues and vulnerabilities
- Management are accountable for creating and maintaining reliable systems
- What we don’t correct – we condone!
Reliable Systems - Human Performance

• “Make no mistakes?”:
  – Perfection is not possible!

• Knowledge and skill: training & experience
  – Know your limits

• Performance shaping factors
  – Fatigue, distraction, environmental, stress

• Perception of high risk
  – Prioritization of task vs values
Controlling Contributing Factors
• Try to change the system pre-cursors to human error and at-risk behavior

Add Barriers
• Try to prevent individual errors

Add Recovery
• Try to catch errors downstream

Add Redundancy
• Try to add parallel elements
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.
# The Three Behaviors

<table>
<thead>
<tr>
<th>Human Error</th>
<th>At-Risk Behavior</th>
<th>Reckless Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product of Our Current System Design and Behavioral Choices</td>
<td>A Choice: Risk Believed Insignificant or Justified</td>
<td>Conscious Disregard of Substantial and Unjustifiable Risk</td>
</tr>
<tr>
<td>Manage through changes in: Choices, Processes, Procedures, Training, Design, Environment</td>
<td>Manage through: Removing incentives for at-risk behaviors, Creating incentives for healthy behaviors, Increasing situational awareness</td>
<td>Manage through: Remedial action, Disciplinary action</td>
</tr>
</tbody>
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## Console

## Coach

## Discipline
console human error

• **Two Questions:**
  – Did the individual make the correct behavioral choices in their task?
  – Is the individual effectively managing their own performance shaping factors?

• If yes, answer is to console & comfort in light of human fallibility.
manage by consoling

- Empathetic and/or sympathetic discussion.
- Occurs after human error.
- Purpose: comfort the individual in light of their human fallibility.
- Method: Acknowledging
  - the error
  - their emotions
- Facilitating the learning process for the individual around both their own fallibility and the system design.
coach at-risk behavior

- Driven by perception of consequences
  - Strong: Immediate and certain
  - Weak: Delayed and uncertain (Rules)
- Manage
  - Add forcing functions
  - Change perceptions of risk (coaching)
  - Change consequences
- System improvement opportunities.
manage by coaching

- Defined as a supportive discussion with the employee on the need to engage in safe behavioral choices.

- Purpose of coaching is to improve performance, often by eliminating, mitigating, or reducing risk.

- Achieved through raising awareness and/or changing the perceptions of risk, and establishing an understanding of the consequences.
Which of the following would be considered an at-risk behavior?

A. Misreading a critical accounting value.
B. Driving a company truck while intoxicated.
C. Purposefully ramming a forklift into a train.
D. Performing a critical procedure by memory.
consider punishment of reckless behavior

• Remediation is always available.

• Discipline: Actions beyond remedial, up to and including punitive action or termination.

• Punitive Action: To cause to refrain from undesired behavioral choices and to achieve realignment with values and expectations.

• How will you achieve the best outcome?
manage by discipline/punishment

- **Discipline:**
  Defined as actions beyond remedial, up to and including punitive action or termination.

- **Punitive action:**
  The purpose of the punitive deterrent to cause an individual or groups to refrain from undesired behavioral choices. Achieved through disciplining the individual to achieve realignment with the organization’s values and expectations and, in some cases, using punishment as a deterrent for others.
three scenarios

Version #1
On a snowy winter night, John had to run to the store to buy milk. His car was parked in the driveway. John got into the car and turned his head to back out of the driveway. Although he carefully looked at the path behind the car, his vision was limited. He inadvertently hit his neighbor’s mailbox and destroyed it.

Version #2
On a snowy winter night, John had to run to the store to buy a new formula for his colicky newborn. His wife had not slept in 24 hrs. so tension in the home was high. He got into the car and backed out of the driveway looking at his upset wife in the doorway, but not looking in his rear view mirror. In his haste, he hit his neighbor’s mailbox and destroyed it.

Version #3
On a snowy winter night… John yelled “yee haa,” closed his eyes and hit the throttle. He never saw his neighbor’s mailbox.
The Benefits
What’s In It for Us?

• It is a culture where there is **justice**
• It is a culture that is keen to **learn**:
  – where the reporting of risk is everyone's responsibility;
  – events are investigated to identify errors, choices, system contributors and personal performance shaping factors;
  – where we share lessons learned to improve the system and the workplace
• It is a culture that promotes **professionalism** and **accountability**
The Just Culture Manager

- Understands human fallibility, human reliability and drift; and how to respond to and manage behaviors
- Sets clear and consistent expectations:
  - For the result
  - The risk to be managed
  - To rules/guidelines to achieve it
  - The key behaviors to do it well
- Gives voice to the risk in the system
- Works daily to raise perception of risk
- Accords correct priority for tasks/results
Safe Choices

• Know your critical and important tasks and how to achieve them safely
• Know, understand and choose to follow Procedures
• Understand and manage the impact of personal performance shaping factors
• Limit Distractions
• Change Peer Pressure through Peer Coaching
• Manage interpersonal differences with co-workers
• Come forward when you see risk in the system
• Choose to do the right thing, the first time!
a just culture . . .

• Fosters shared accountability
• Supports a learning culture
• Focuses on proactive management:
  – System design
  – Behavioral choices
A scenario
Medication Error

The nurse goes to the medication room to retrieve Demerol for her patient. She reaches into the bin and grabs the vial in the bottom right corner of the drawer. Next, she draws up the medication and administers it to the patient.

The pharmacy had made a change and placed Morphine in the slot where the Demerol used to be kept. The nurse actually gave the patient Morphine.

The patient had an allergic reaction and coded. Although they were able to revive him, he suffered anoxic injuries that resulted in right-sided paralysis.
Our Response – The Event

• The severity of the outcome is not considered in how we manage justice and accountability
• Identify the system issues in the event
• Identify the behaviors in the event – human errors and choices
• Identify the duties owed for each behavior:
  o Because we can give the wrong medication, we create a procedure that requires us to read the label, to detect and correct errors – this is a procedural rule
• Evaluate the perception of risk at the time of the event
Our Response – The Nurse

• Use the Algorithm to evaluate
  – (Duty to Follow Procedural Rule)

• The nurse made an At-Risk behavioral choice
  – (Good faith but mistaken belief that the risk was insignificant or justified)

• At Risk behavior – where we drift from what should have been done because we have never had an adverse event = mistakenly believed to be justified

• What is everyone else doing? Are we all drifting?
Our Response – The System

• How did Pharmacy mis-stock the dispenser?
  – Was there a change to procedure?
  – Was it human error?
  – Was it a choice?

• Is the system (policy, procedure, training, communication, briefings etc) able to manage this risk?
  – If not, review how to raise perception of risk, clarify expectations for the group

• What is does our supervision and monitoring of this task require?

• What does our audit and event investigation review tell us of this risk?
Our Response – Our Actions

- Review the system
- Coach the employees involved
- Share lessons learned will all employees to improve perception of risk
- Encourage near miss reporting of errors – those captured by reading the label
- Demonstrate that the procedure is a reliable means of capturing human errors
- Provide in-time coaching to improve performance
- Encourage peer coaching and supporting to improve performance
What’s Just Culture About?

• It’s About Both Error and Drift
• It’s About 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 and Physicians
• It’s About Partnership With Clinical, HR and Quality
• It’s About Partnership With the Regulator
• It’s About Doing the Right Thing
• It’s About Producing Better Outcomes Together
The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes. No physician or nurse wants to hurt patients, and doctors, nurses, and other health workers are highly trained to be careful and take precautions to prevent mistakes.

Dr. Lucian Leape
professor at Harvard School of Public Health
Testimony before Congress, 2000
cornerstones

• Learning Culture
• Open and Fair Culture
• Design Safe Systems
• Manage Behavioral Choices
cornerstone I: 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
cornerstone II: 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
cornerstone III: 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
cornerstone IV: 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.
exchange of rights

Individual
• Life
• Liberty
• Pursuit of Happiness

Employer
• Perform job
• Produce outcomes
• Follow policies / procedures
• Embrace Mission, Vision, Values, Standards
If we cannot balance life, liberty, and the pursuit of happiness, we have imposers who will. Imposers enforce a set of standards.
imposers

• who are the different imposers?

• what is the role of the imposers?

• what are the tools of imposers?
texting bus driver

- Who are the imposers?

Texting While Driving

- What are their tools?
mission, values, and expectations
mission and values

Our Mission

Our reason for acting

Our Primary Values

Values that are in play – that can be threatened by an overly zealous commitment to the mission

What do you value that you want to protect?
south carolina hospital association

• **Vision**
  – South Carolina's hospitals will be national leaders in improving the quality and safety of patient care, and SCHA will be a national leader in advocacy.

• **Mission**
  – SCHA's mission is to support its member hospitals in creating a world-class health care delivery system for the people of South Carolina by fostering high quality patient care and serving as effective advocates for the hospital community.
aspirations and expectations

• An **Aspiration**
  ✓ A strong desire, longing or aim; ambition
  ✓ Social understanding that goal or desire may not be met. No penalty attached to failure to meet an aspiration.

• An **Expectation**
  ✓ to look for with reason or justification
  ✓ Social understanding that a failure to meet an expectation will be accompanied by a normally negative consequence or penalty.
competing rights and values

Three Duties

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

Individual Rights

- Life
- Liberty
- Pursuit of happiness

Organization Values

- Compassion
- Respect
- Caring
- Honesty
- Integrity
- Trust

Behavioral Choices

Outcomes

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The Just Culture Community
A nursing manager walks by a patient’s room, seeing the patient about to fall from his bed. She quickly runs to the bedside, lifting the patient back on to the bed before the patient actually falls. In doing so, the nurse manager failed to follow hand hygiene procedures prior to touching the patient.
Just Culture

MANAGING SYSTEM DESIGN
System design strategies

- Barriers
- Redundancy
- Recovery
- Perception of at-risk behaviors
system design strategies

- Performance Shaping Factors
  - Factors to directly manage the rate of human error
  - Factors to directly manage the rate of at-risk behaviors
  - 2 types: personal and system
  - Examples:
    - Stress
    - Fatigue
    - Lighting
    - Communication
    - Procedure design
    - Noise
    - Distraction
    - Graphical interface
system design strategies

- Barriers
  - Prevents the error from occurring
  - Prevents hazard from touching target
  - Examples:
    - Personal protective equipment
    - Covers/Shields
    - Interlocks
    - Control limits (preventing excess movement)
system design strategies

- Redundancy
  - Allows the error to occur but is caught by 2\textsuperscript{nd} or 3\textsuperscript{rd} strategy that is in place before event occurs
  - Relies on parallel system elements to perform function of failed system component
  - Examples:
    - Second person performing task
    - Backup supplies
    - Backup power
    - Parallel tests
**System design strategies**

- **Recovery**
  - Allows the error to occur
  - Relies on ability to detect initiating event and correct before the critical undesired outcome
- **Examples:**
  - ✓ Downstream checks
  - ✓ Downstream tests
  - ✓ Making the error visible through feedback
system design strategies

- Perception of High Risk
  - Fosters focus on specific task being worked
  - Acts to limit at-risk behaviors
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?
the basics of event investigation

What happened?

- Begin with open ended questions – simply start by asking “What happened?”
- Employee does most of talking
- You should be listening!
the basics of event investigation

What normally happens?

- Ask the erring individual, and others, to take you through the process – telling/showing you how the work is normally performed.
the basics of event investigation

What does procedure require?

- How the system was designed to work
the basics of event investigation

Why did it happen?

Two investigative rules

1. Seek to explain the causes behind each human error identified in the event

2. Search for an explanation for every at-risk behavior.
the basics of event investigation

How was the organization managing the risk?
common traps

- Guessing or assuming
- “I’ve seen this before.”
- Not doing an investigation
- Not talking to the people involved
- Arriving at a conclusion early
Let’s investigate

A patient is admitted to the floor and placed on contact isolation. Upon doing hourly rounding it is noted that the nurse has been in and out of the room not wearing protective equipment. When asked about the situation and the fact that policy requires you to wear PPE’s, the nurse states “we ran out of supplies up here and I needed to take care of my patient”. Upon further investigation you find that often times supplies are diminished and staff enter rooms with-out PPE’s.
let’s investigate…..

- What happened?
let’s investigate

- What happened?

Staff not wearing protective equipment.
let’s investigate.....

- What normally happens?
let’s investigate

- What happened?
  Staff not wearing protective equipment.

- What normally happens?
  Oftentimes supplies are diminished and staff enter rooms without PPE’s.
let’s investigate…..

- What does procedure require?
let’s investigate

- What happened?
  Staff not wearing protective equipment.

- What normally happens?
  Oftentimes supplies are diminished and staff enter rooms without PPE’s.

- What does procedure require?
  Policy requires staff to wear PPE’s.
let’s investigate.....

- Why did it happen?
let’s investigate

■ What happened?
  Staff not wearing protective equipment.

■ What normally happens?
  Oftentimes supplies are diminished and staff enter rooms without PPE’s.

■ What does procedure require?
  Policy requires staff to wear PPE’s.

■ Why did it happen?
  Oftentimes supplies are diminished.
Let’s investigate.....

- What happened?
- What normally happens?
- What does procedure require?
- Why did it happen?
- How were we managing it?
let’s investigate

• What happened?
  Staff not wearing protective equipment.

• What normally happens?
  Oftentimes supplies are diminished and staff enter rooms without PPE’s.

• What does procedure require?
  Policy requires staff to wear PPE’s.

• Why did it happen?
  Oftentimes supplies are diminished.

• How were we managing it?
  Ignore low supplies
do you see……

- Events as things to be fixed

- Events 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.
the just culture algorithm
algorithm steps

1. Obtain basic event investigation information.

2. Apply Duty to Avoid Causing Unjustifiable Risk or Harm and apply corresponding actions.

3. Apply either:
   a. Duty to Follow a Procedural Rule and apply corresponding actions.
   b. Duty to Produce an Outcome and apply corresponding actions.

4. Is the event repetitive? Use Repetitive Human Errors or Repetitive At-Risk Behaviors.
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
The Just Culture Algorithm™

The Duty to Avoid Causing Unjustifiable Risk or Harm

Risk & Values Based
- Quality of Choices
- Organization’s Mgmt of Risk

The Duty to Produce an Outcome
- Task Based
- Outcome Based
- Rate Based

The Duty to Follow a Procedural Rule
- Process Based
- System Based
- Compliance Check

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Putting organizational interest or value in harm’s way.

- Potential or actual harm to persons.
- Potential or actual harm to property.

A rule, process, or procedure is in place specifying how to perform the job.

The system is largely controlled by the employer.

The employee knows what the goal is (or the outcome expected) but is not told how to reach the goal (or how to achieve the outcome).

The system is largely controlled by the employee.
two specific classes of duty

- Meet me at 7:00 pm at 410 Chestnut Street.

- Leave the house at 6:45 pm. Go south on Independence Ave, turn right on Parker. At the third light, hang a left, go three blocks, turn right and go to the fourth house on the right.

The Duty to Produce an Outcome

The Duty to Follow a Procedural Rule
scenario: id badge

• a long-time employee shows up at work on one occasion without her company-issued id badge.
let’s investigate…..

- What happened?
- What normally happens?
- What does procedure require?
- Why did it happen?
- How were we managing it?
identify the duty breached

- **Procedural**  
  *Did the employee breach a duty to follow a procedural rule in a system designed by the employer?*

  **OR**

- **Outcome**  
  *Did the employee breach a duty to produce an outcome?*
Was the duty to produce an outcome known to the employee? 

- Yes: Was it possible to produce the outcome? 
  - Yes: Did the social benefit exceed the risk? 
    - No: Is the rate of failure to produce the outcome within the expectations to whom the duty is owed? 
      - Yes: Support employee in decision 
      - No: Accept outcome 
    - No: Investigate circumstances leading to impossibility 
- No: Investigate circumstances leading to failure to know of duty 

Assist employee in producing better outcomes, or consider punitive action.
duty to follow a procedural rule

- Was the duty to follow a rule known to the employee?  
  - Yes: Was it possible to follow the rule?  
  - Yes: Did the employee knowingly violate the rule?  
  - Yes: Did the social benefit exceed the risk?  
  - No: Did the employee have a good faith but mistaken belief that the violation was insignificant or justified?  
  - No: Investigate circumstances leading to impossibility

- No: Investigate circumstances leading to failure to know of duty

- No: No

- No: Yes: Console employee and conduct human error investigation

- No: Yes: Support employee for decision to violate rule

- Yes: Coach employee and conduct at-risk behavior investigation

- No: Consider punitive action

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duty to avoid causing risk or harm

Was it the employee’s purpose to cause harm?
  - Yes: Consider Punitive action
  - No: Did the employee knowingly cause harm?
    - Yes: Was the harm justified as the lesser of two evils?
      - Yes: Support employee in decision
      - No: Consider Punitive action
    - No: Did the behavior represent a substantial and unjustifiable risk?
      - Yes: Should the employee have known they were taking a substantial and unjustifiable risk?
        - Yes: Did the employee consciously disregard this substantial and unjustifiable risk?
          - Yes: Consider punitive action
          - No: Do not consider employee action
        - No: Coach employee and conduct at-risk behavior investigation
      - No: Do not consider employee action

Coach employee and conduct human error investigation

Consider punitive action

Console employee and conduct human error investigation

Do not consider employee action
A pharmacy technician was caught walking out of the building with 30 feet of clear oxygen hose taken from the supply cabinet. He claimed it was to help his son with a science project. He stated that he had worked many unpaid hours and believed that the oxygen hose was not a significant sacrifice for the hospital.
let’s investigate…

- What happened?
- What normally happens?
- What does procedure require?
- Why did it happen?
- How were we managing it?
what was the duty breached?

- Procedural
  
  Did the employee breach a duty to follow a procedural rule in a system designed by the employer?

- Outcome
  
  Did the employee breach a duty to produce an outcome?
Was the duty to produce an outcome known to the employee?

Was it possible to produce the outcome?

Did the social benefit exceed the risk?

Is the rate of failure to produce the outcome within the expectations to whom the duty is owed?

Assist employee in producing better outcomes, or consider punitive action

Investigate circumstances leading to failure to know of duty

Investigate circumstances leading to impossibility

Support employee in decision

Accept outcome

Yes

No

Yes

No

Yes

No
**duty to follow a procedural rule**

- **Was the duty to follow a rule known to the employee?**
  - Yes → **Was it possible to follow the rule?**
    - Yes → **Did the employee knowingly violate the rule?**
      - Yes → **Did the social benefit exceed the risk?**
        - Yes → **Consider punitive action**
        - No → No
      - No → No
    - No → **Did the employee have a good faith but mistaken belief that the violation was insignificant or justified?**
      - Yes → **Coach employee and conduct at-risk behavior investigation**
      - No → No
  - No → **Investigate circumstances leading to failure to know of duty**

- **Investigate circumstances leading to impossibility**

- **Console employee and conduct human error investigation**

- **Support employee for decision to violate rule**
duty to avoid causing risk or harm

Was it the employee’s purpose to cause harm?

Was the employee knowingly cause harm?

Did the behavior represent a substantial and unjustifiable risk?

Should the employee have known they were taking a substantial and unjustifiable risk?

Did the employee consciously disregard this substantial and unjustifiable risk?

Did the employee choose the behavior?

Was the harm justified as the lesser of two evils?

Support employee in decision

Consider Punitive action

Consider Punitive action

Consider punitive action

Consider punitive action

Coach employee and conduct at-risk behavior investigation

Console employee and conduct human error investigation

Do not consider employee action

Do not consider employee action

Yes

No

Yes

No
The bookkeeper in a Medical Group decides to skip a required confirmation he generally performs on the payroll data delivered to him by his outside payroll service. The payroll numbers have always been correct, and the bookkeeper considers the manager at the payroll service a personal friend. This skip in the check was found when the doctor’s annual review detected that the payroll service was making additional fraudulent charges to the Medical Group.
let’s investigate…

- What happened?
- What normally happens?
- What does procedure require?
- Why did it happen?
- How were we managing it?
what was the duty breached?

- Procedural

Did the employee breach a duty to follow a procedural rule in a system designed by the employer?

OR

- Outcome

Did the employee breach a duty to produce an outcome?
duty to produce an outcome

1. Was the duty to produce an outcome known to the employee?
   - Yes
   - No
     - Investigate circumstances leading to failure to know of duty

2. Was it possible to produce the outcome?
   - Yes
   - No
     - Investigate circumstances leading to impossibility

3. Did the social benefit exceed the risk?
   - Yes
   - No

4. Is the rate of failure to produce the outcome within the expectations to whom the duty is owed?
   - Yes
   - No
     - Accept outcome
     - Assist employee in producing better outcomes, or consider punitive action

Support employee in decision
duty to follow a procedural rule

- Was the duty to follow a rule known to the employee? No → Investigate circumstances leading to failure to know of duty
- Was it possible to follow the rule? No → Investigate circumstances leading to impossibility
- Did the employee knowingly violate the rule? No → Consider punitive action
- Did the social benefit exceed the risk? No → Support employee for decision to violate rule
- Did the employee have a good faith but mistaken belief that the violation was insignificant or justified? Yes → Coach employee and conduct at-risk behavior investigation
- Yes → Console employee and conduct human error investigation
duty to avoid causing risk or harm

Was it the employee’s purpose to cause harm? No

Consider Punitive action

Did the employee knowingly cause harm? Yes

Was the harm justified as the lesser of two evils? No

Consider Punitive action

Support employee in decision

Did the employee knowingly cause harm? Yes

Was the harm justified as the lesser of two evils? No

Consider Punitive action

Do not consider employee action

Did the behavior represent a substantial and unjustifiable risk? No

Do not consider employee action

Did the employee represent a substantial and unjustifiable risk? Yes

Should the employee have known they were taking a substantial and unjustifiable risk? No

Do not consider employee action

Did the employee consciously disregard this substantial and unjustifiable risk? Yes

Consider punitive action

Coach employee and conduct human error investigation

Did the employee choose the behavior? Yes

Console employee and conduct human error investigation

Did the employee choose the behavior? No

Do not consider employee action
scenario: all in the name of the game….

You are the imposer

• What say you?

http://www.youtube.com/watch?v=UvEobeNfGcc

“I am deeply and wholeheartedly regretful of my actions....I let my emotions get the best of me in a heated situation...This is in no way indicative of my character or the soccer player that I am.”
let’s investigate…..

- What happened?
- What normally happens?
- What does procedure require?
- Why did it happen?
- How were we managing it?
identify the duty breached

- Procedural
  
  Did the employee breach a duty to follow a procedural rule in a system designed by the employer?

- Outcome
  
  Did the employee breach a duty to produce an outcome?
**duty to produce an outcome**

- Was the duty to produce an outcome known to the employee? (Yes/No)
  - No: Investigate circumstances leading to failure to know of duty

- Was it possible to produce the outcome? (Yes/No)
  - No: Investigate circumstances leading to impossibility

- Did the social benefit exceed the risk? (Yes/No)
  - No: Support employee in decision

- Is the rate of failure to produce the outcome within the expectations to whom the duty is owed? (Yes/No)
  - No: Accept outcome
  - Yes: Assist employee in producing better outcomes, or consider punitive action

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duty to follow a procedural rule

- Was the duty to follow a rule known to the employee?
  - Yes
  - No

- Was it possible to follow the rule?
  - Yes
  - No

- Did the employee knowingly violate the rule?
  - Yes
  - No

- Did the social benefit exceed the risk?
  - Yes
  - No

- Did the employee have a good faith but mistaken belief that the violation was insignificant or justified?
  - Yes
  - No

- Investigate circumstances leading to failure to know of duty
- Investigate circumstances leading to impossibility
- Console employee and conduct human error investigation
- Support employee for decision to violate rule

- Coach employee and conduct at-risk behavior investigation
- Consider punitive action
duty to avoid causing risk or harm

- Was it the employee’s purpose to cause harm? (Yes/No)
  - Yes: Consider punitive action
  - No: Was the employee knowingly cause harm? (Yes/No)
    - Yes: Consider punitive action
    - No: Did the behavior represent a substantial and unjustifiable risk? (Yes/No)
      - Yes: Should the employee have known they were taking a substantial and unjustifiable risk? (Yes/No)
        - Yes: Coach employee and conduct at-risk behavior investigation
        - No: Do not consider employee action
      - No: Did the employee consciously disregard this substantial and unjustifiable risk? (Yes/No)
        - Yes: Consider punitive action
        - No: Was the harm justified as the lesser of two evils? (Yes/No)
          - Yes: Support employee in decision
          - No: Do not consider employee action

- Did the employee knowingly cause harm? (Yes/No)

- Did the behavior represent a substantial and unjustifiable risk? (Yes/No)

- Should the employee have known they were taking a substantial and unjustifiable risk? (Yes/No)

- Did the employee consciously disregard this substantial and unjustifiable risk? (Yes/No)

- Was the harm justified as the lesser of two evils? (Yes/No)

- Support employee in decision

- Coach employee and conduct at-risk behavior investigation

- Console employee and conduct human error investigation

- Do not consider employee action
Patient Information

An employee of Health Information is responsible for medical record coding and has access to medical records on a regular basis as part of her job responsibilities. Susan, who has been employed 3 months, is asked by the pastor of her church to find out how a member of their church (who is a patient on the oncology unit) is doing. The next day, while reviewing charts on the oncology floor, Susan reviews the patient’s medical record and then passes health information about the patient to their pastor. Other employees are aware of Susan’s actions but state the manager is aware of the concern of friends and family for these patients and ‘turns a blind eye’ to this practice.
let’s investigate...

- What happened?
- What normally happens?
- What does procedure require?
- Why did it happen?
- How were we managing it?
what was the duty breached?

- **Procedural**
  
  Did the employee breach a duty to follow a procedural rule in a system designed by the employer?

- **Outcome**
  
  Did the employee breach a duty to produce an outcome?
duty to produce an outcome

- Was the duty to produce an outcome known to the employee? Yes → Was it possible to produce the outcome? Yes → Did the social benefit exceed the risk? No → Investigate circumstances leading to failure to know of duty
  No → Investigate circumstances leading to impossibility

- Is the rate of failure to produce the outcome within the expectations to whom the duty is owed? Yes → Accept outcome
  No → Assist employee in producing better outcomes, or consider punitive action

Support employee in decision
duty to follow a procedural rule

- Was the duty to follow a rule known to the employee? Yes → Investigate circumstances leading to failure to know of duty
  No → Was it possible to follow the rule? Yes → Did the employee knowingly violate the rule? Yes → Did the social benefit exceed the risk? No → Consider punitive action
  No → No → No → Yes → Coach employee and conduct at-risk behavior investigation
  Yes → Support employee for decision to violate rule
  No → Console employee and conduct human error investigation
  No → Investigate circumstances leading to impossibility

- No → No → Investigate circumstances leading to impossibility
duty to avoid causing risk or harm

- Was it the employee’s purpose to cause harm? [Yes/No]
  - Yes: Consider Punitive action
  - No: Did the employee knowingly cause harm? [Yes/No]
    - Yes: Was the harm justified as the lesser of two evils? [Yes/No]
      - Yes: Support employee in decision
      - No: Consider Punitive action
    - No: Did the behavior represent a substantial and unjustifiable risk? [Yes/No]
      - Yes: Should the employee have known they were taking a substantial and unjustifiable risk? [Yes/No]
        - No: Do not consider employee action
        - Yes: Did the employee consciously disregard this substantial and unjustifiable risk? [Yes/No]
          - No: Do not consider employee action
          - Yes: Did the employee choose the behavior? [Yes/No]
            - No: Console employee and conduct human error investigation
            - Yes: Consider punitive action

- Consider punitive action
- Coach employee and conduct-at-risk behavior investigation
A nursing manager walks by a patient’s room, seeing the patient about to fall from his bed. She quickly runs to the bedside, lifting the patient back on to the bed before the patient actually falls. In doing so, the nurse manager failed to follow hand hygiene procedures prior to touching the patient.
let’s investigate…

- What happened?
- What normally happens?
- What does procedure require?
- Why did it happen?
- How were we managing it?
what was the duty breached?

- **Procedural**
  
  *Did the employee breach a duty to follow a procedural rule in a system designed by the employer?*

- **Outcome**
  
  *Did the employee breach a duty to produce an outcome?*
duty to produce an outcome

Was the duty to produce an outcome known to the employee?

Was it possible to produce the outcome?

Did the social benefit exceed the risk?

Is the rate of failure to produce the outcome within the expectations to whom the duty is owed?

Investigate circumstances leading to failure to know of duty

Investigate circumstances leading to impossibility

Support employee in decision

Accept outcome

Assist employee in producing better outcomes, or consider punitive action

No

Yes

Yes

No

No

Yes

No
duty to follow a procedural rule

1. Was the duty to follow a rule known to the employee?  
   - Yes: Did the employee knowingly violate the rule?  
   - No: Investigate circumstances leading to failure to know of duty

2. Was it possible to follow the rule?  
   - Yes: Did the social benefit exceed the risk?  
   - No: Investigate circumstances leading to impossibility

3. Did the employee knowingly violate the rule?  
   - Yes: Did the social benefit exceed the risk?  
   - No: Console employee and conduct human error investigation

4. Did the social benefit exceed the risk?  
   - Yes: Support employee for decision to violate rule  
   - No: Consider punitive action

5. Did the employee have a good faith but mistaken belief that the violation was insignificant or justified?  
   - Yes: Coach employee and conduct at-risk behavior investigation  
   - No: Consider punitive action
duty to avoid causing risk or harm

Was it the employee’s purpose to cause harm?

Yes → Consider Punitive action

No → Did the employee knowingly cause harm?

Yes → Was the harm justified as the lesser of two evils?

Yes → Support employee in decision

No → Consider Punitive action

No → Did the behavior represent a substantial and unjustifiable risk?

Yes → Should the employee have known they were taking a substantial and unjustifiable risk?

Yes → Consider punitive action

No → Do not consider employee action

No → Did the employee consciously disregard this substantial and unjustifiable risk?

Yes → Did the employee choose the behavior?

Yes → Coach employee and conduct at-risk behavior investigation

No → Console employee and conduct human error investigation
Carl Davis was on fifth day of his route, just outside Memphis when his truck veered off a two-lane road and into the barn of a small farm. The police estimated that the truck was going the posted speed limit of 65 mph when the accident occurred. Most drivers interviewed after the accident said that they would have been driving slower, say 45 – 50 mph, under the road conditions present at the time.
let’s investigate…

- What happened?
- What normally happens?
- What does procedure require?
- Why did it happen?
- How were we managing it?
what was the duty breached?

- **Procedural**
  
  Did the employee breach a duty to follow a procedural rule in a system designed by the employer?

- **Outcome**
  
  Did the employee breach a duty to produce an outcome?
**duty to produce an outcome**

1. Was the duty to produce an outcome known to the employee? **Yes**
   - Investigate circumstances leading to failure to know of duty
   - No

2. Was it possible to produce the outcome? **No**
   - Investigate circumstances leading to impossibility
   - No

3. Did the social benefit exceed the risk? **Yes**
   - Support employee in decision
   - No

4. Is the rate of failure to produce the outcome within the expectations to whom the duty is owed? **Yes**
   - Accept outcome
   - No

5. If no, assist employee in producing better outcomes, or consider punitive action.
duty to follow a procedural rule

- Was the duty to follow a rule known to the employee? **Yes**
  - No: Investigate circumstances leading to failure to know of duty

- Was it possible to follow the rule? **Yes**
  - No: Investigate circumstances leading to impossibility

- Did the employee knowingly violate the rule? **Yes**
  - No: Console employee and conduct human error investigation

- Did the social benefit exceed the risk? **No**
  - Yes: Support employee for decision to violate rule
  - No: Coach employee and conduct at-risk behavior investigation

- Did the employee have a good faith but mistaken belief that the violation was insignificant or justified? **No**
  - Yes: Consider punitive action
duty to avoid causing risk or harm

Was it the employee’s purpose to cause harm?

- Yes: Consider Punitive action
- No: Did the employee knowingly cause harm?
  - Yes: Was the harm justified as the lesser of two evils?
    - Yes: Support employee in decision
    - No: Consider Punitive action
  - No: Did the behavior represent a substantial and unjustifiable risk?
    - Yes: Should the employee have known they were taking a substantial and unjustifiable risk?
      - Yes: Do not consider employee action
      - No: Did the employee choose the behavior?
        - Yes: Coach employee and conduct human error investigation
        - No: Do not consider employee action
    - No: Did the employee consciously disregard this substantial and unjustifiable risk?
      - Yes: Consider punitive action
      - No: Do not consider employee action
  - No: Did the employee knowingly cause harm?
Late to Delivery

An obstetrician is paged that one of his expectant patients has just arrived at the hospital – appearing to be within an hour of giving birth. The physician calls the hospital and lets them know he will be there in 25 minutes. The doctor arrives in 45 minutes, 20 minutes later than promised. The doctor explained that he was caught in traffic. He also apologized to the labor and delivery manager for not calling when he knew he was going to be late. A labor and delivery nurse reported to the manger that she had seen the doctor in line at Starbucks where the line was at least 20 minutes long.
let’s investigate…

- What happened?
- What normally happens?
- What does procedure require?
- Why did it happen?
- How were we managing it?
what was the duty breached?

- **Procedural**
  Did the employee breach a duty to follow a procedural rule in a system designed by the employer?

- **Outcome**
  Did the employee breach a duty to produce an outcome?
duty to produce an outcome

Was the duty to produce an outcome known to the employee?

- Yes
  - Investigate circumstances leading to failure to know of duty

- No
  - Investigate circumstances leading to impossibility

Was it possible to produce the outcome?

- Yes
  - Did the social benefit exceed the risk?
    - Yes
      - Support employee in decision
    - No
      - Accept outcome

- No
  - Is the rate of failure to produce the outcome within the expectations to whom the duty is owed?
    - Yes
      - Assist employee in producing better outcomes, or consider punitive action
    - No
      - Accept outcome

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duty to follow a procedural rule

Was the duty to follow a rule known to the employee? Yes → Was it possible to follow the rule? Yes → Did the employee knowingly violate the rule? Yes → Did the social benefit exceed the risk? No → Did the employee have a good faith but mistaken belief that the violation was insignificant or justified? No → Consider punitive action

No → Investigate circumstances leading to failure to know of duty

No → Investigate circumstances leading to impossibility

No → Console employee and conduct human error investigation

Yes → Support employee for decision to violate rule

Yes → Coach employee and conduct at-risk behavior investigation

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The Just Culture Community
duty to avoid causing risk or harm

Was it the employee’s purpose to cause harm?

- Yes: Consider Punitive action
- No: Did the employee knowingly cause harm?
  - Yes: Was the harm justified as the lesser of two evils?
    - Yes: Support employee in decision
    - No: Consider Punitive action
  - No: Did the behavior represent a substantial and unjustifiable risk?
    - Yes: Should the employee have known they were taking a substantial and unjustifiable risk?
      - Yes: Consider punitive action
      - No: Do not consider employee action
    - No: Did the employee consciously disregard this substantial and unjustifiable risk?
      - Yes: Did the employee choose the behavior?
        - Yes: Console employee and conduct human error investigation
        - No: Do not consider employee action
      - No: Do not consider employee action
repetitive behaviors
An employee has been late to work 4 times in the past month. The employee has been placed on notice that future violations of the time and attendance policy would result in disciplinary action. On Monday, the employee was late for work once again. The employee claimed to have been stuck behind an accident on the freeway that caused the road to be closed – trapping a ½ mile stretch of cars on one section of the freeway. Television news reports verified that the freeway was closed for over an hour.

“are you late for work again?!”
If a series of human errors is not caused by system performance shaping factors, and is not correctable by changes in work choices or remedial education/training, the employee is put on notice that further errors may result in disciplinary action.
A highly regarded surgeon is doing rounds in the hospital. He enters one room where his patient is there asleep. Also in the room is the patient’s sister, who is a registered nurse. The surgeon approaches the patient when the sister of the patient politely asks the physician to wash his hands. The surgeon looks at the sister and says, “I assure you, there are no bugs on me.” The sister of the patient gets more assertive, “I must insist. Please use proper hand hygiene before you touch my brother.” The physician reacts by asking the charge nurse to remove the sister from the room. The sister files a complaint with the hospital. The investigation reveals that the physician has been coached recently on the need to follow hand hygiene protocol.
repetitive at-risk behaviors

- Are there system performance shaping factors that are causing the repetitive at-risk behavior?
  - Yes: Consider system redesign
  - No
    - Are there personal performance shaping factors causing the repetitive at-risk behavior?
      - Yes: Will employee address personal performance shaping factors?
        - Yes: Employee to remedy personal performance shaping factors
        - No: Consider punitive action
      - No: Consider punitive action

If a series of at-risk behaviors is not caused by system performance shaping factors, and the employee has not been responsive to behavioral coaching, the employee is put on notice that further at-risk behaviors may result in disciplinary action.
implementing a just culture
implementation of a just culture

Do you have these four cornerstones?

• Learning Culture
• Open and Fair Culture
• Safe System Designs
• Management of Behavioral Choices
core beliefs

• to err is human
• to drift is human
• risk is everywhere
• we must manage in support of our values
• we are all accountable
It’s About Doing This Well...

the mission

- System Design
- Good or Bad Outcomes
- Behavioral Choices
- Values and Expectations

Learning Systems
Justice and Accountability
the three behaviors

**Human Error**

*Inadvertent action: slip, lapse, mistake*

Manage through changes in:
- Processes
- Procedures
- Training
- Design
- Environment
- *Employee Choices*

**At-Risk Behavior**

*A choice: risk not recognized or believed justified*

Manage through:
- Removing incentives for At-Risk Behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

**Reckless Behavior**

*Conscious disregard of unreasonable risk*

Manage through:
- Remedial action
- Disciplinary action

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**Console**

**Coach**

**Punish**
the three duties

- Duty to Avoid Causing Unjustified Risk or Harm
- Duty to Follow a Procedural Rule
- Duty to Produce an Outcome
it’s an algorithm to follow

• One method that works across all values
• One method that works both pre and post event
changing expectations

• Leaders
  – Knowing risks
  – Design safe systems
  – Facilitating safe behavioral choices

• Staff
  – Look for the risks
  – Report errors, safety concerns
  – Design safe systems
  – Making safe choices
it’s about reinforcing the roles of risk, quality, and human resources

• Risk/Quality
  ✓ Helping improve the effectiveness of the learning process
  ✓ Providing tools to line managers
  ✓ Helping to redesign systems

• HR
  ✓ Protecting the learning culture
  ✓ Helping with managerial competencies
    • Consoling
    • Coaching
    • Punishing
implementation of a just culture

• Realignment of current procedures
  ✓ Human Resources policies and practices
  ✓ Removal of punitive expectations for errors
  ✓ Reporting and Case Reviews
  ✓ Shared Learning and transparency

• Education and Training
  ✓ Managers, Leaders, Representatives
  ✓ Staff
next steps to implement a just culture

• Baseline Culture of Safety Survey

• Leadership
  ✓ Align Expectations
  ✓ Commitment

• Identify Champions
  ✓ Just Culture Facilitator Training
Just Culture

• Leadership Commitment.
• Expectations / Practices
  • Remove punitive expectations;
  • Reporting and follow-up;
  • Shared learning.
• Education and Training
  • Managers;
  • Staff: “Safe Choices” video.
• Create a Learning Culture.
• Outcomes.
The Right Journey

• Expectations
  • 2-3 years for full adoption;
  • Multi-cycle change process;
  • Begin to apply principles.

Some refer to it as a “destination”.

Others refer to it as a “journey.”

It is the right thing to do.