PATIENT SAFETY
PROMOTING A "JUST CULTURE"

AMEDD Patient Safety Conference

San Antonio, TX

25-27 AUG 09

WHAT IS A "JUST CULTURE"?

- **All organization members are willing to come forward for the sake of patient safety**

- **Leadership and front-line employees are comfortable enough in the organization and are able to:**
  - Self-report their own individual human error and/or policy violation
  - Report human error and/or policy violations from within their facility

- **Organizational Attitudes, Values, Goals *visibly* committed to:**
  - Strong Patient Safety Culture
  - Outstanding learning focus for leadership and front-line employees
  - Balancing interests of communication with need for negative performance deterrence
  - Continuous evaluation and improvement
  - Learning from errors first, blaming the individual last

WHY IS A "JUST CULTURE" NEEDED?

- **Human errors in healthcare occur at alarming rates**
  - 1,000,000+ people injured yearly by medical errors*
  - Dentistry has HIGHEST numbers of sentinel events across DOD, mostly due to human error
- **Healthcare organizations' patient safety cultures demonstrate:**
  - Leadership Attitudes, Values, Goals (MEDCOM, DENCOM, REGION, DENTAC)
- **All organization members understand their roles in Patient Safety by how leadership interacts with them**

** Testimony, United States Congress, House Committee on Veteran's Affairs, Dr. Lucian Leape, 12OCT97*

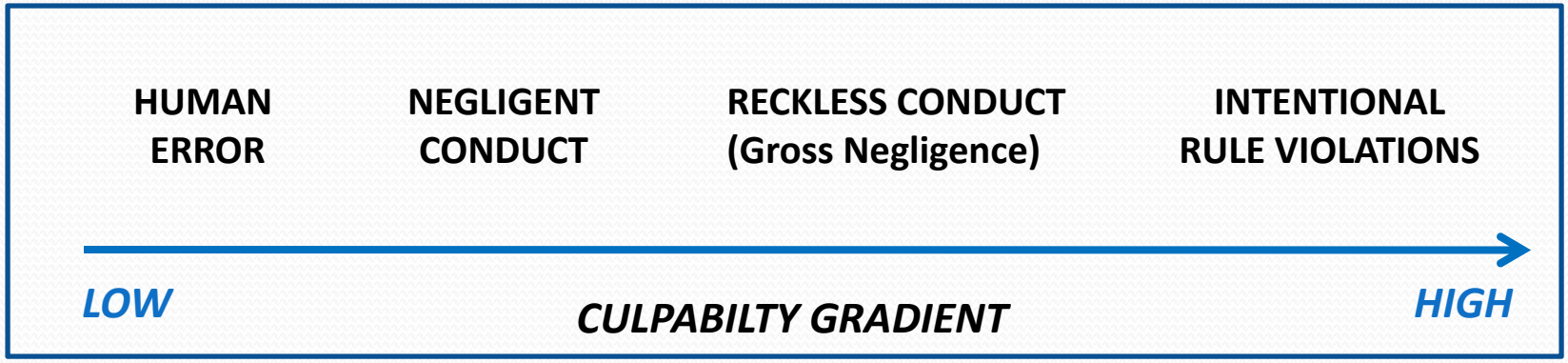
WHY CAN'T WE JUST ELIMINATE ALL ERRORS?

- **We are dealing with Human Behavior!**
- **4 Basic human behavioral concepts seen in patient safety errors**
  - Human Error
  - Negligent Conduct
  - Reckless Conduct (Gross Negligence)
  - Intentional Rule Violations
- **Error can *never* be eliminated completely**
- **Must focus instead on:**
  - Finding out what errors are occurring (Reporting needed)
  - Learning from errors first, blaming individuals last
  - Implementing focused effective changes where errors are occurring

WHY CAN'T WE JUST ELIMINATE ALL ERRORS?

- **4 Basic Human Behavioral Concepts in patient safety errors on a Culpability Gradient**

Culpability = How much an individual can be considered ***morally*** *or* ***legally*** responsible



WHY CAN'T WE JUST ELIMINATE ALL ERRORS?

- **Human Error**
  - Individual should have done other than what they did
  - Conduct inadvertently causes or could cause an undesirable outcome
  - Example: Anesthetize opposite side, i.e. #3 instead of #14

- **Negligent Conduct**
  - Failure to recognize a risk which should have been recognized
  - Failure to exercise skill, care and learning expected of a reasonably prudent health care provider
  - More culpable than human error

- **Reckless Conduct (Gross Negligence)**
  - Conscious disregard of visible, significant risk
  - Higher degree of culpability than human error or negligent conduct

- **Intentional Rule Violation**
  - Knowingly violate a rule while performing a task
  - Extremely high degree of culpability

HOW DOES LEADERSHIP FIT INTO A "JUST CULTURE"?

- **Front-line providers and staff understand their roles in the organization by *how leadership interacts with them***

- **What is communicated by DENTAC Leadership?**
  - Officially/Unofficially?
  - Verbally/Non-verbally?
  - Written/Off-the-record?

- **What is *perceived* by our leaders and all employees?**
  - Do we Respect or Disdain?
  - Do we Encourage or Punish?
  - Do we Educate or Discipline?

- **Truthful answers to these questions determine if we have a "Just Culture" or not**
  - Are all members of our Team comfortable enough to NOT hide errors?

HOW IS OUR CULTURE RIGHT NOW?

- **What is communicated by DENTAC Leadership?**
  - Do we Respect or Disdain our employees?
  - Do we Encourage or Punish?
  - Do we Educate or Discipline?
- **How does our Team perceive our culture?**
  - What is the team's perception of how we manage them after reporting an event?
  - What area in the survey is the weakest?
- **How are we doing on reporting near misses and actual events?**
  - How many reports are being submitted monthly?
  - What are the reports focused on? Equipment? Near misses? Actual events?
- **What are front line providers and staff saying "in the field"?**
  - Commander's Calls?
  - Complaints?
  - BOSS 6 complaints?
  - Union grievances?
  - Civilian Council meetings?
  - Sensing sessions?

Truthful answers to these questions help determine if we have a "Just Culture" or not

WHAT CAN HAPPEN IF WE CHANGE OUR CULTURE?

- Increased productivity
- Lower risk for patient safety events
- Improved communication
- Improved morale
- Improved job satisfaction
- Improved retention
- Improved team performance
- Increased learning
- Increased positive behaviors on the job

WHAT CAN HAPPEN IF WE CHANGE OUR CULTURE?

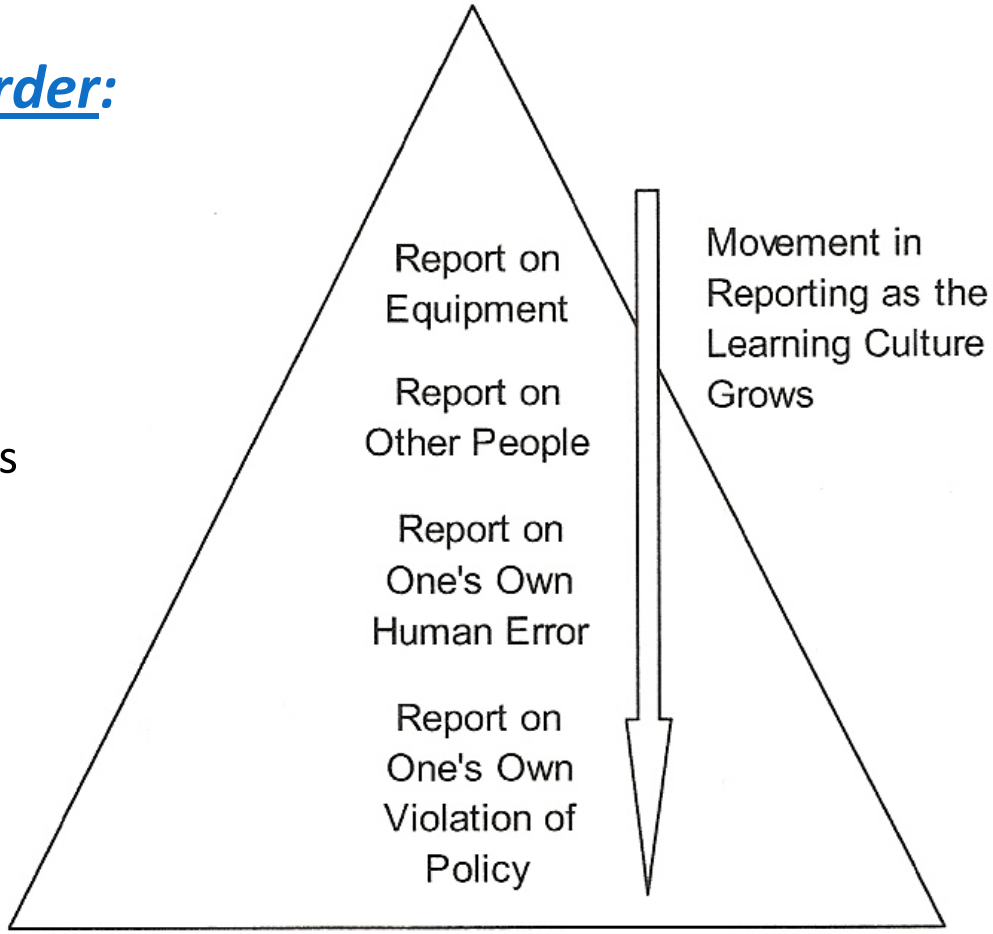
Reporting Increases in Order:

1st: Equipment
(People fear no retribution against broken equipment)

2nd: On other people's actions

3rd: One's own human error

4th: One's own violation of policy



Patient Safety and the "Just Culture": A Primer for Health Care Executives, David Marx, JD, 2001

WHERE DO WE START?

- **Review Patient Safety Culture Survey results**
  - What area is our weakest?
  - What action(s) can we take now to improve the weakest area(s)?

- **Assess current reporting system**
  - How many reports are being submitted monthly?
  - What are the reports focused on?
  - What action(s) can we take now to improve reporting from the field?

- **Analyze organization's response to actual events**
  - What is the process?
  - How do we determine "blame"? Are we focused on learning from the error? Do we blame the individual 1st?
  - Do disciplinary actions match amount of culpability appropriately? Overkill? Underkill?
  - What message are we giving our Team with these responses?
  - What action(s) can we take now to improve this process and the message(s) we are sending to the field?
  - Are we analyzing each event to determine blame? See Event Analysis Form (next slide)

- **What are front line providers and staff saying "in the field"?**
  - Obtain information from the field through:
    - Commander's Calls
    - Complaints
    - Union grievances
    - Civilian Council meetings
    - Sensing sessions
  - What action(s) can we take to improve these perceptions?

EVALUATE ACTUAL EVENT

DETERMINE INDIVIDUAL'S BEHAVIOR ON CULPABILITY GRADIENT

Human Behavior	Definition	Apply to this Event?	Description
Human Error	Should have done other than what they did		
Negligence	Failure to exercise expected care, should have been aware of substantial risk		
Reckless Conduct	Conscious disregard of substantial and unjustifiable risk		
Intentional Rule Violation	Knowingly violates a rule or procedure		