



The Just Culture  
**Community**

# Patient Safety and the Just Culture

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**Presented to:**  
**Virginians Improving Patient**  
**Care and Safety**  
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# Agenda

- Design of Socio-Technical Systems
- We Watch, We Judge
- Living with Our Fallibility
- The Just Culture Model
- Around the Country



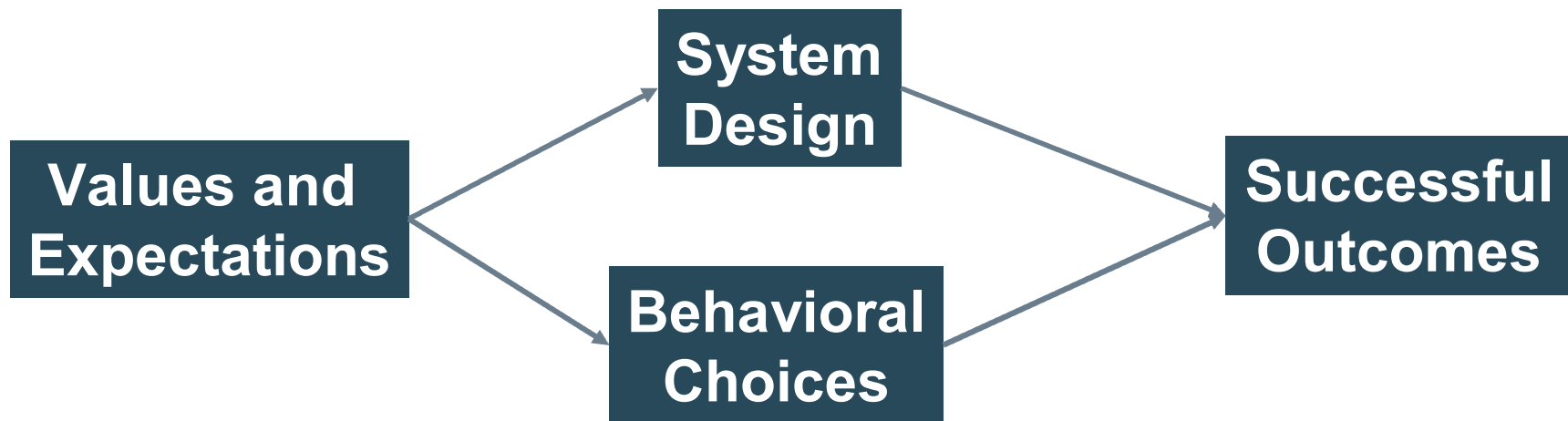
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# Design of the Socio-Technical System





# Inputs and Outputs





# The Two Key Elements of a Socio-Technical System

- System Design
  - Performance Shaping Factors
  - Barriers
  - Recovery
  - Redundancy
- The Behavioral Choices of Components within the System
  - Producing outcomes
  - Following procedures
  - Doing the “right thing”



# The Duty to Produce an Outcome

The duty to  
produce an  
outcome

- Be to work on time
- Bring badge
- Don't steal
- Don't sexually harass
- Don't use profanity at work
- Don't look in medical records that aren't your business



# The Duty to Follow Procedural Rules

The duty to  
follow  
procedural  
rules

- Two patient identifiers
- Hand hygiene
- Pump repair
- Dietary protocols
- Patient restraint
- Medication administration
- Accounting controls



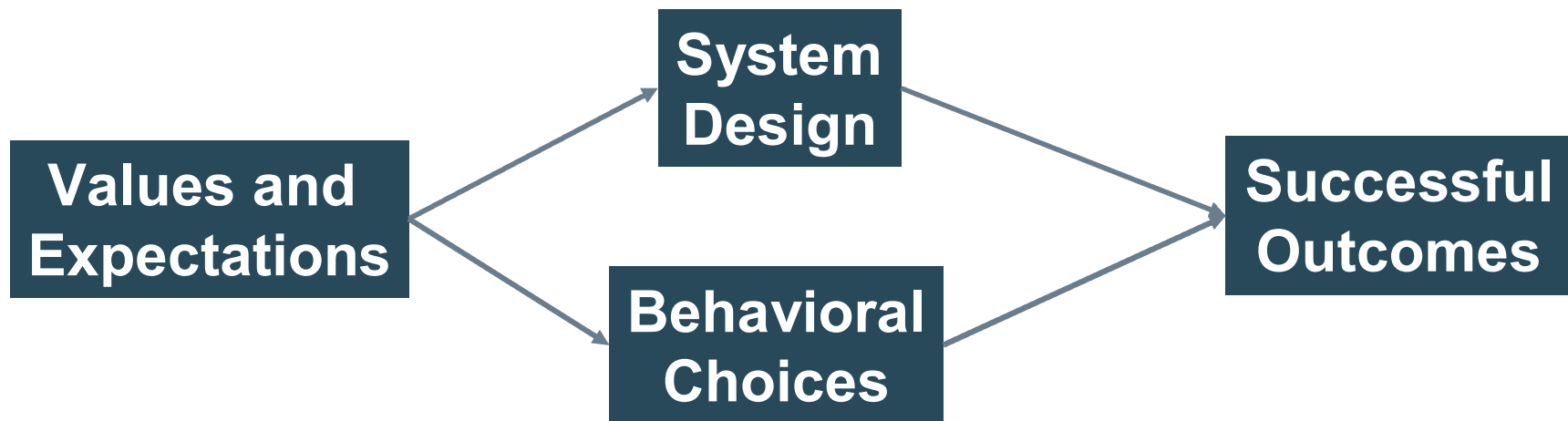
# The Duty to Avoid Causing Unjustifiable Risk or Harm

The duty to  
avoid  
causing  
unjustifiable  
risk or 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

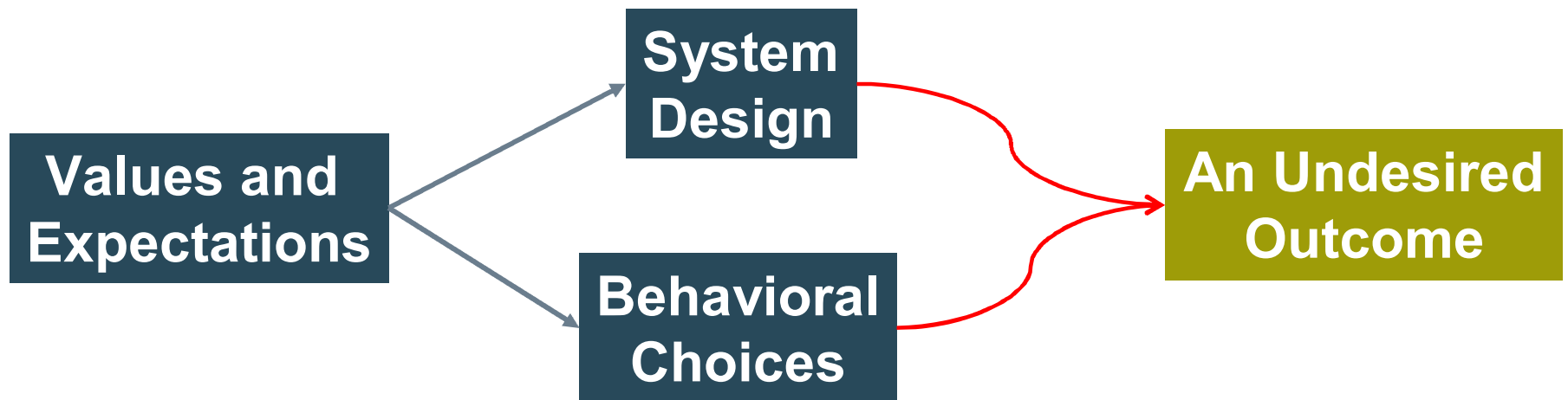


# Inputs and Outputs





## Sometimes, the System Does Not Appear to Work





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# So We Stand In Judgment...

of the providers,  
the hospital,  
the regulators,  
the healthcare system



# We Stand in Judgment

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*



# We Stand in Judgment

“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*





## We Stand in Judgment

“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*  
*Author, the Design of Everyday Things*



# We Stand in Judgment

“...No person may operate an aircraft  
in a careless or reckless manner  
so as to endanger  
the life or property of another.”

*Federal Aviation Regulations  
§ 91.13 Careless or Reckless Operation*



# We Stand in Judgment

“As far as I am concerned, when I say “careless” I am not talking about any kind of “reckless” operation of an aircraft, but simply the most basic form of simple human error or omission that the Board has used in these cases in its definition of “carelessness.” In other words, a simple absence of the due care required under the circumstances, that is, a simple act of omission, or simply “ordinary negligence,” a human mistake.”

*National Transportation Safety Board  
Administrative Law Judge  
Engen v. Chambers and Langford*



# We Stand in Judgment

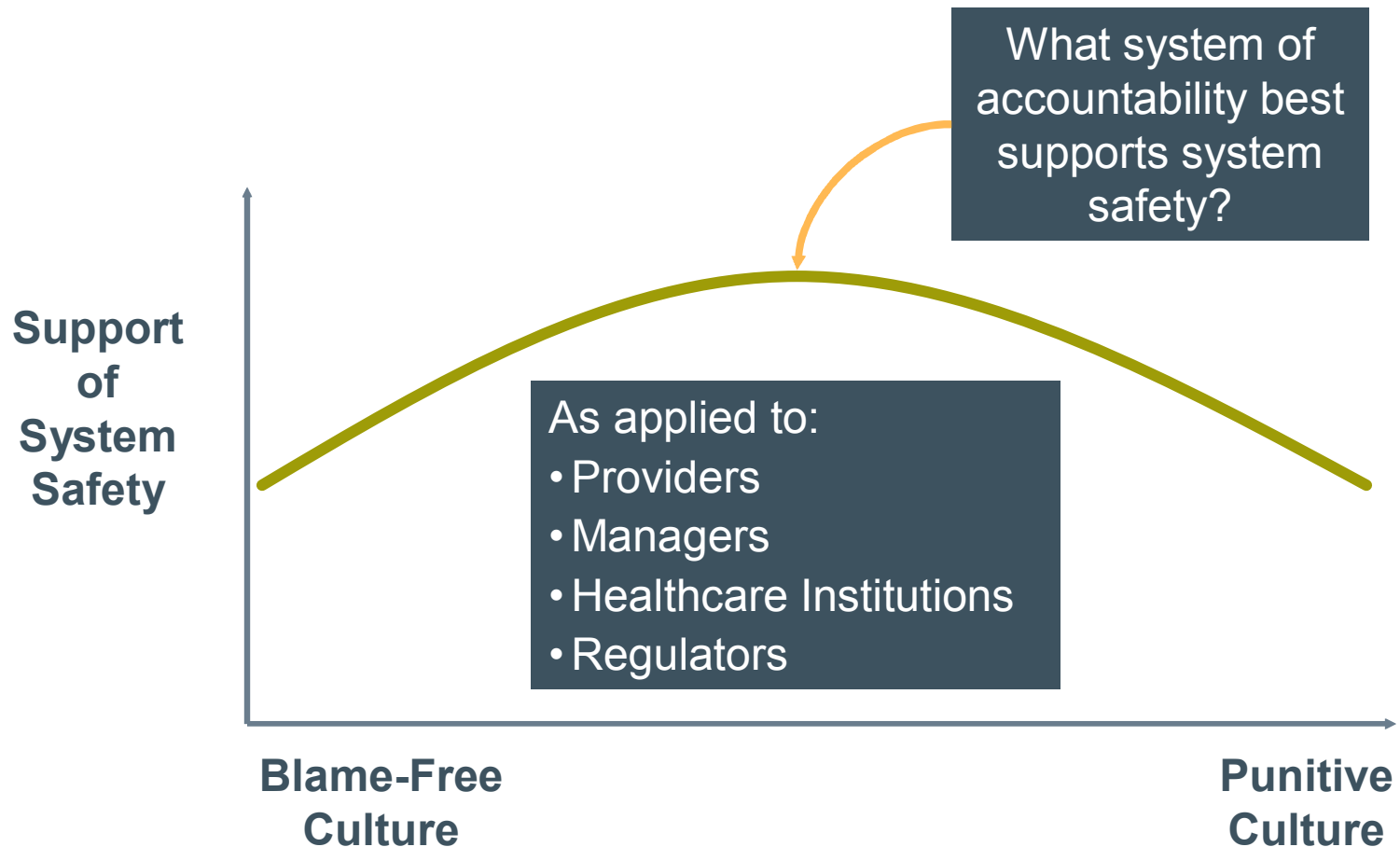
The following conduct, acts, or conditions constitute unprofessional conduct...

- The commission of any act involving moral turpitude, dishonesty, or corruption...
- Misrepresentation or fraud...
- The willful betrayal of a practitioner-patient privilege...
- Abuse of a client or patient or sexual contact with a client or patient...
- Incompetence, negligence, or malpractice which results in an injury to a patient or which creates an unreasonable risk that a patient may be harmed...

**RCW § 18.130.180 Unprofessional Conduct**



# The Problem Statement





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# Living with Human Fallibility



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# Our Fallibility – Human Error

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



# Our Fallibility – At-Risk Behavior

- At-Risk Behavior – behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified.



# Our Fallibility – Reckless Behavior

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



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# Justice, Accountability, System Safety



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## Our Response – Human Error

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

Console

Learn



## 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



# Our Response – Reckless Behavior

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

**Punish**



## The Three Behaviors

### Human Error

*Inadvertent action: slip, lapse, mistake*

Manage through changes in:

- Processes
- Procedures
- Training
- Design
- Environment

**Console**

### 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

**Coach**

### Reckless Behavior

*Conscious disregard of unreasonable risk*

Manage through:

- Disciplinary action
- Punitive action

**Punish**



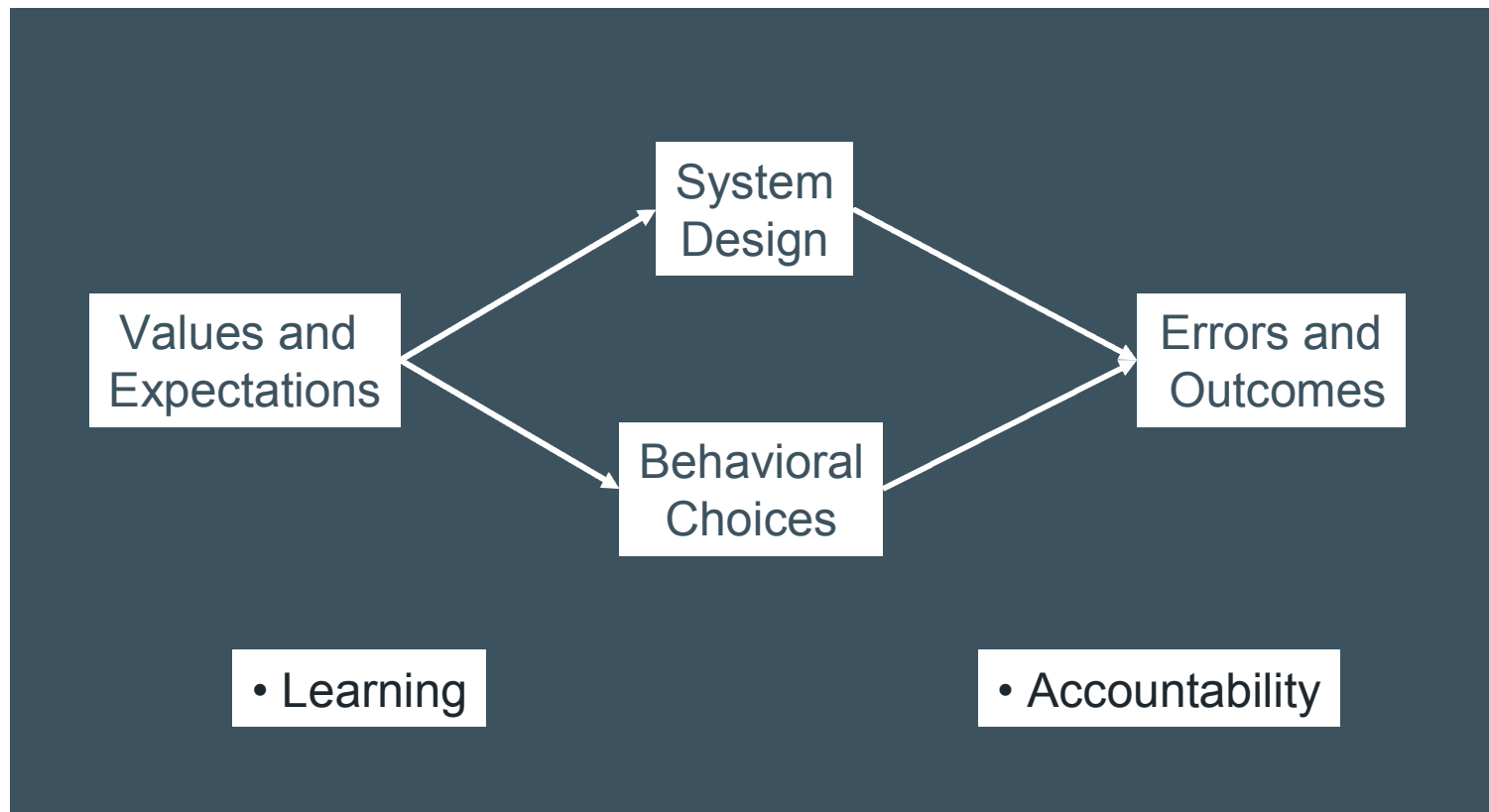
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# Implementing the Just Culture





# Its About Doing This Well





## It's About a Proactive Learning Culture

- It's not seeing events as things to be fixed
- It's seeing events as opportunities to improve our understanding of risk
  - System risk, and
  - 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



## It's About Reinforcing the Roles of Risk, Quality, and HR

- 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



# It's About Changing Managerial Expectations

- Knowing my risks
  - Investigating the source of errors and at-risk behaviors
  - Turning events into an understanding of risk
- Designing safe systems
- Facilitating safe choices
  - Consoling
  - Coaching
  - Punishing



## It's About Changing Staff Expectations

- Looking for the risks around me
- Reporting errors and hazards
- Helping to design safe systems
- Making safe choices
  - Following procedure
  - Making choices that align with organizational values
  - Never signing for something that was not done



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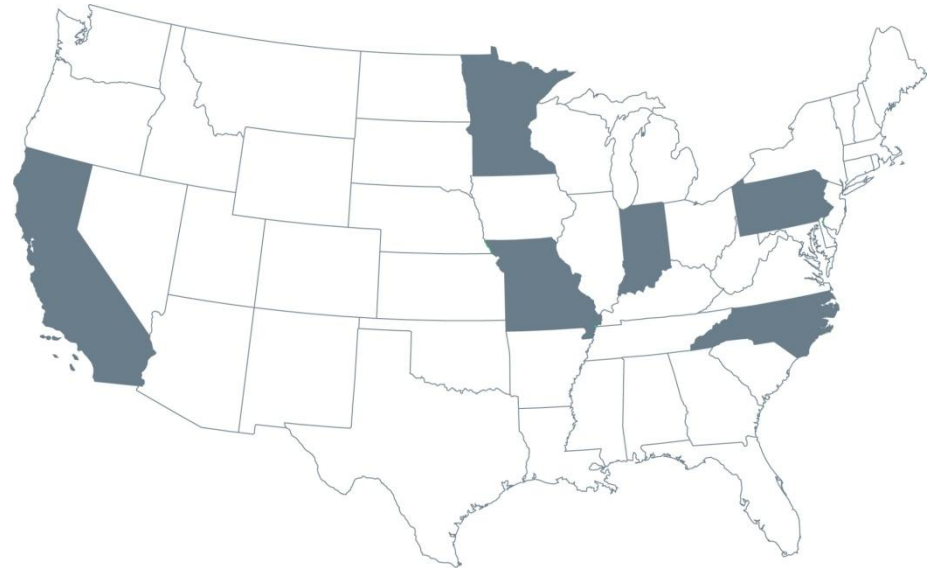
# Looking Around the Country





## Statewide Initiatives

- Minnesota
- North Carolina
- Missouri
- Pennsylvania
- Indiana
- California





# What's Happening...At the Local Level

- **Individual Hospitals**
  - Changing perspective
  - Giving new tools to managers
    - Coaching and mentoring
    - Event investigation / risk management
    - The Algorithm
  - Improving support to line managers
    - Human resources
    - Quality and risk management
  - Changing expectations of staff
- **The Results**
  - Better outcomes for patients
  - Better outcomes for staff
  - Better outcomes for the organization
  - **It's the right thing to do**



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# Thank You

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