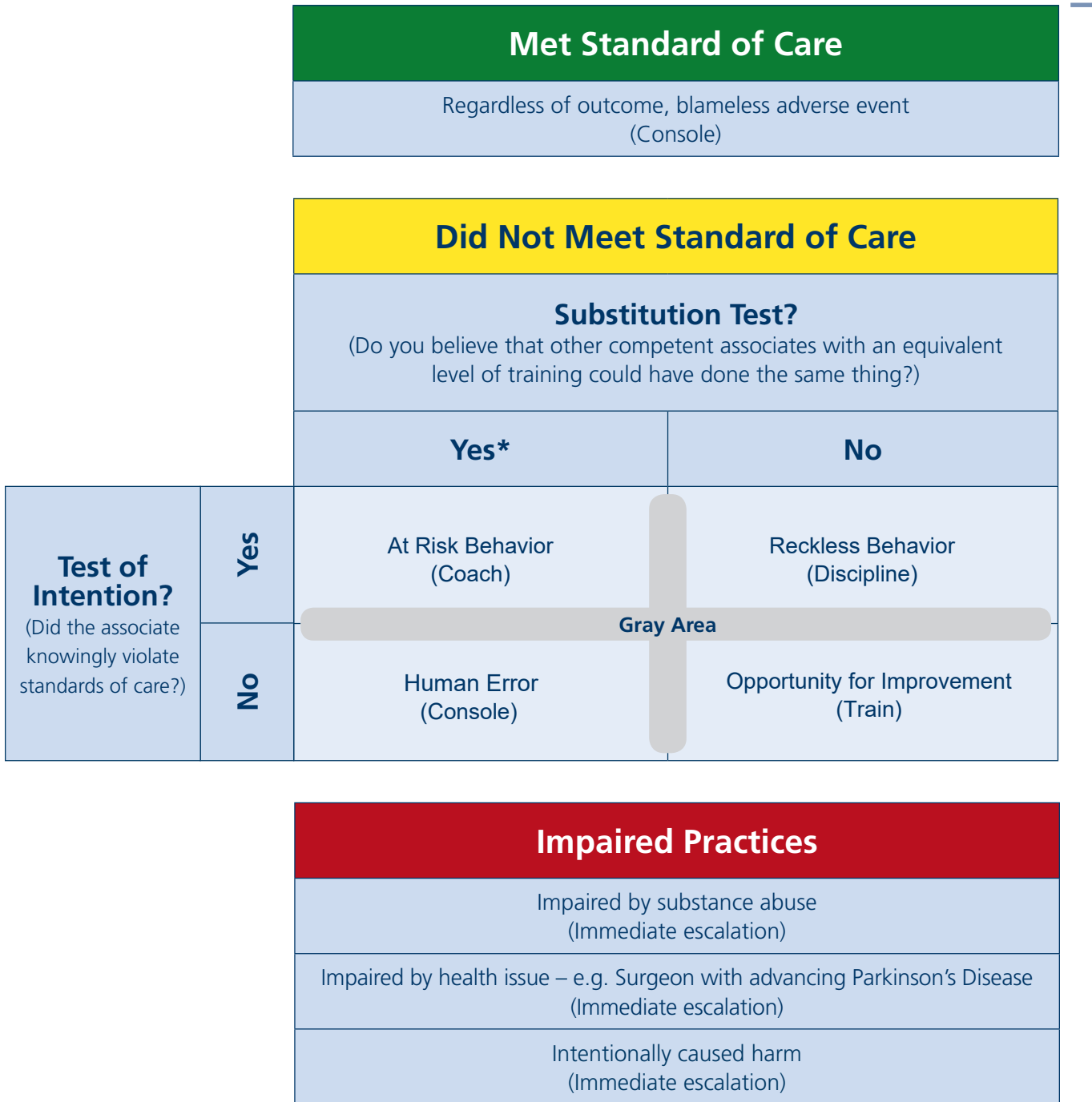


A Just Culture Tool



Look for underlying “System Error”

* When an associate passes the substitution test, question the effectiveness of current practice and evaluate for “Normalization of Deviance”. Normalization of Deviance is defined as the gradual drift away from best practices until a deviant behavior is commonplace among associates (e.g. ignoring an alarm, bypassing a safety check, etc.).

Note: If a documentation issue is identified that does NOT relate to the clinical care, it is acceptable to give a “Documentation Attribution.” However, if the documentation issue DOES relate to the clinical care, the issue should be evaluated using the Just Culture Tool.

"The common initial reaction when an error occurs is to find and blame someone. However, even apparently single events or errors are due most often to the convergence of multiple contributing factors. Blaming an individual does not change these factors and the same error is likely to recur. Preventing errors and improving safety for patients requires a systems approach in order to modify the conditions that contribute to errors. People working in health care are among the most educated and dedicated workforce in any industry. The problem is not bad people; the problem is that the system needs to be safer."
—*To Err is Human, Institute of Medicine, 1999*

"Most serious errors are committed by competent, caring people doing what other competent, caring people would do." —*Dr. Don Berwick, former founder and CEO of IHI, and former Administrator of the Centers for Medicare and Medicaid Services*

BACKGROUND

When evaluating an associate involved in a medical error, reviewers should keep in mind that associates are human and will occasionally make mistakes. Dr. Lucian Leape, a professor at Harvard School of Public Health and a Patient Safety expert, has argued that we need to dispel two myths:

The perfection myth: *if people try hard enough, they will not make any errors.*

The punishment myth: *if we punish people when they make errors, they will make fewer of them.*

The Just Culture Tool was created to help evaluate colleagues or employees involved in a medical error and to better understand the relative contribution of human and system factors in an error, near miss or unsafe condition. The goal is to evaluate errors without bias or judgment, and to learn from the errors and fix the underlying system issues in order to provide the safest environment for our patients.

It is important to note that when reviewing a medical error and determining an associate's culpability, there is no perfect algorithm that can automatically determine an associate's degree of responsibility. Applying the Just Culture Tool requires careful thought and consideration of the associate's intent, and consideration of what a competent associate with similar training would do in the same situation. The tool should be used as a guide in evaluation but there may be "gray" areas which can make categorization difficult.

Below are simple instructions for how to use the tool and best navigate these "gray areas".

INSTRUCTIONS

A. GREEN - Determine if the associate met the standard of care: Regardless of patient outcome, if an associate clearly met the standard of care, he/she should be consoled.

For example, *a pediatrician gives a child with strep throat amoxicillin, and subsequently the child becomes anaphylactic and dies. The child was not previously exposed to the medication and had no known allergies. The associate followed best practices and should be consoled.*

B. YELLOW - Determine if the associate did NOT meet the standard of care: When an associate does not meet the standard of care, the following two tests should be applied:

- 1. The test of intention:** After investigation including review of the chart and interviewing the associate, determine if the act of not following best practice was intentional (knowingly violated the standard of care).
- 2. The substitution test:** Determine if other competent associates with an equivalent level of training, faced with the same situation, could have done the same thing

The result of these 2 tests will categorize the provider's action in 1 of 4 quadrants in the 2x2 table.

■ ■ **Human Error** - If the answer to the substitution test is YES and the answer to the test of intention is NO, consider the associate made a human error and should be consoled.

For example, *a physician intends to order hydroxyzine but instead accidentally orders hydralazine. The patient's blood pressure drops, and he becomes light headed and falls, fracturing his hip. The error was largely due to the fact that the two medication names sound alike and were in close proximity to each other on the electronic order screen.*

■ ■ **At-risk behavior** - If the answer to the substitution test is YES and the answer to the test of intention is YES, consider there was at risk behavior.

For example, *to save time a nurse knowingly violates a policy and best practice and prepares medications for three patients at once. In doing this, she almost mixes up two patients' medications. This associate demonstrated risky behavior and should be coached.*

■ ■ **Opportunity for Improvement** - If the answer to the substitution test is NO and the answer to the test of intention is NO, question the associate's competency and train as needed.

For example, *a physician assistant with 5 years of experience misreads an EKG and misses classic "tombstone" ST elevations indicative of an acute myocardial infarction.*

■ ■ **Reckless Behavior** - If the answer to the substitution test is NO and the answer to the test of intention is YES, consider the associate acted recklessly and discipline the associate.

For example, *a surgical resident is called to place a femoral central line in a morbidly obese patient. The patient's fat pannus obstructed the femoral insertion site. Instead of requesting an assistant to facilitate performing the line insertion within known safety practice standards, the resident used his left hand to push the fat pannus out of the way while attempting to insert the central line by using just his right hand. The guide wire slipped out of his hand and was accidentally pushed into the patient.*

C. RED - Determine if the associate demonstrated impaired practices: If an associate was impaired due to substance abuse or disease or intentionally caused harm, escalation is indicated. Consult with Human Resources and Employee Health in coordination with the Vice President of Medical Affairs.

For example, *a surgeon is out having drinks with his wife and is called to the hospital because one of his patients has appendicitis. He comes to the hospital and operates while under the influence of alcohol. The associate should be disciplined and the issue escalated.*

NOTE ABOUT THE SUBSTITUTION TEST

When determining whether you or a comparable associate would have acted in the same manner as the associate being evaluated, there may not be a simple yes/no answer. The substitution test can be viewed as a continuum, subject to interpretation and

amenable to discussion and debate which the tool is intended to encourage. The gray area represents this area of uncertainty that can distinguish at-risk from reckless behavior (when an associate knowingly violated standards of care) and human error from opportunity for improvement (when an associate did not knowingly violate standards of care).

SYSTEM ERRORS & NORMALIZATION OF DEVIANCE

When evaluating errors, there will often be times where the true root cause of the mishap is an underlying system failure. In these cases, when best practice is not followed, regardless of whether the cause was a human error, risky behavior, incompetence or reckless behavior, healthcare leaders must strive to better understand the system in which the event occurred. Even in situations where there is a human component contributing to the error or near miss, often there is also a major system contribution. By focusing through this fairer lens, we can identify vulnerable points in processes, improve the underlying systems and prevent future harm. Examples of steps that can be taken to safeguard systems include safety checks, forcing functions, and culture change. Many more system improvements are needed before healthcare can be classified as a "high reliable" system.

One type of system error often found in healthcare is known as Normalization of Deviance, a concept in which there is a gradual drift away from best practices until a deviant behavior is commonplace among associates (e.g. ignoring an alarm, bypassing a safety check, etc.).

SECOND VICTIMS

Some associates who make a human error that results in an adverse event will take personal responsibility for the bad outcomes, even if the "true cause" was a poor system design in which the associate was set up to fail. In the most extreme cases, associates involved in medical errors have quit their job, are challenged with intense emotional turmoil, and may even impose physical harm on themselves. This is what we now refer to as a "second victim".

In order to avoid the "second victim" phenomenon, it is important to communicate to associates involved in a human error that we all make mistakes from time-to-time and that we are not looking to lay blame. Rather, we need to learn from the errors and build our systems to be robust enough to prevent these errors from reaching patients. These associates should be consoled and supported as soon as possible after the error is made and the focus on system improvement, instead of associate blame, should be reinforced.

"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, from his testimony before Congress in 2000.

CITATIONS

Just Culture techniques are well known in industrial applications.

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