



A JUST CULTURE FOR PATIENT SAFETY

Statewide Collaborative

“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.

“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, Apple Fellow

The Goal

To establish a more consistent understanding and management of human error, at-risk behavior and reckless behavior between Missouri healthcare providers and regulators.

- **Human error** – inadvertent action; inadvertently doing other than what should have been done; a slip, lapse, mistake – manage by consoling the employee – the error happened to them
- **At risk behavior** - behavior that increased risk where risk is not recognized, or is mistakenly believed to be justified – manage by adding forcing functions to reduce the potential for error, changing perceptions of risk, changing consequences, coaching
- **Reckless behavior** – behavioral choice to consciously disregard a substantial and unjustifiable risk – manage through disciplinary action

The Collaborative

- Engage key statewide organizations to learn about a Just Culture and seek support
- Obtain healthcare provider organizations and regulatory agencies as collaborators
- Survey of collaborators to identify the baseline culture of safety
- Provide Regional training of collaborators in a Just Culture
- Provide on-site consultation with collaborators to integrate Just Culture
- Perform a post-intervention survey of collaborators to identify change in a culture for safety
- Provide ongoing support to sustain a Just Culture

The initial stakeholder meeting will occur fall 2007 with the collaborative running through December 2008

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“It is through a Just Culture that we will begin to see, understand and mitigate the risks within the healthcare system.”

Design Safe Systems – the first cornerstone of patient safety

- systems must be designed that anticipate human error, capture errors before they become critical and permit recovery when errors do reach the patient

Manage Behavioral Choices – the second cornerstone of patient safety

– as humans we must anticipate that we will make mistakes – it is the management of behavioral choices that allows us to achieve the safety outcomes desired

Create a Learning Culture – the foundation of patient safety

– a culture hungry to see risk at the individual and organizational level

Create an Open, Fair and Just Culture

- organizations must move away from an overly-punitive reaction to events and errors to create a learning environment – we must recognize fallibility
- that we will make errors and drift away from what we have been taught

Adapted from An Introduction to the Just Culture, Outcome Engineering, 2005