EC PAEDIATRICS
Review Article

Just Culture: Review Article

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Abstract

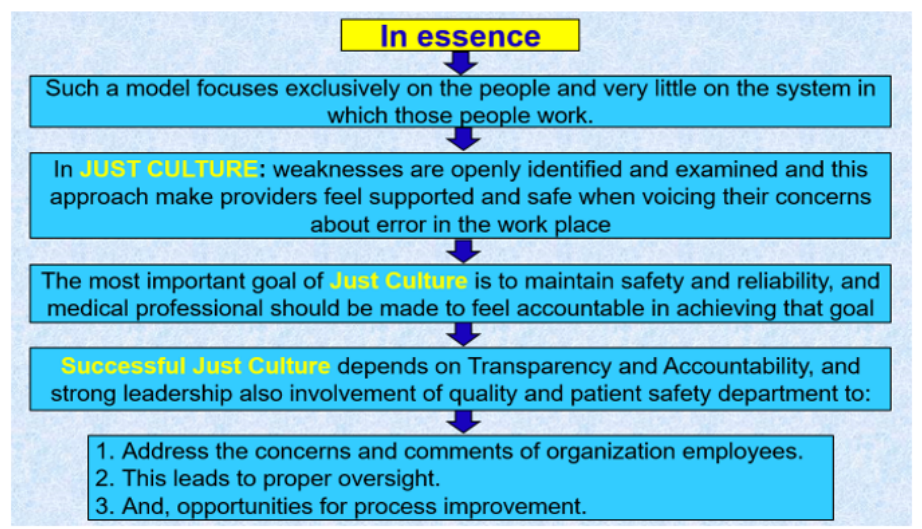
- David Max is the father of just culture concept "Attorney and Engineer".
- Disciplinary system.

A medical professionals are punished for making mistakes fails to improve patient safety.

A medical professionals are blamed and punished for their mistakes which are often unintended.

So, this intolerance for error serves as disincentive to providers sharing their mistakes with medical community.

And also this punitive approach to medical errors discourage transparency and presenting a significant road block to the improvement of patient safety.



Keywords: *Just Culture; Medical Professionals; Patient Safety*

Introduction

Medical errors must be evaluated based on their quality:

- Human error: Consoled
- At risk behavior: Is coached
- Reckless behavior: Is punished.

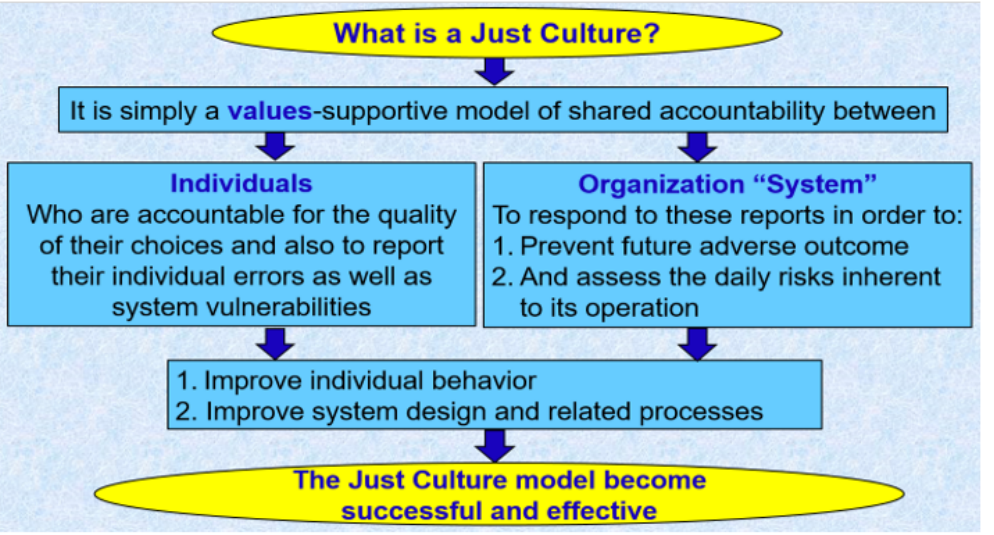
In brief

The just culture concept

Shift attention from retrospective judgement of individual behaviors and the severity of outcomes to a real time, assessment of behavioral decisions in a rational and organized way.

And reassess the system in which the error occurs.

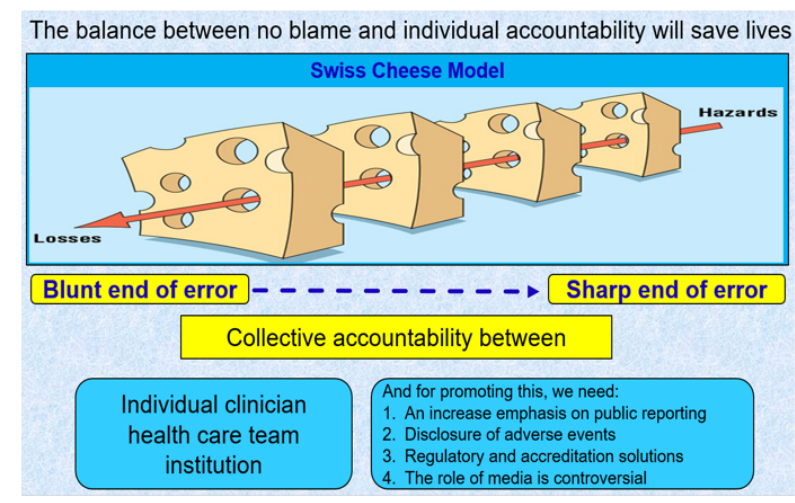
Discussion



Values:

1. Learning
2. Openness
3. Fairness
4. Safety: Patient Safety remains the primary aim of a just culture
5. Incentives: For providers honestly reporting of medical errors "good catch"

6. Organization shifts from no blame no shame to Justice: Discipline is employed only when the quality of a person's choice requires it [provider engages in reckless conduct or knowingly violates a rule] apart from the degree of bad outcome.

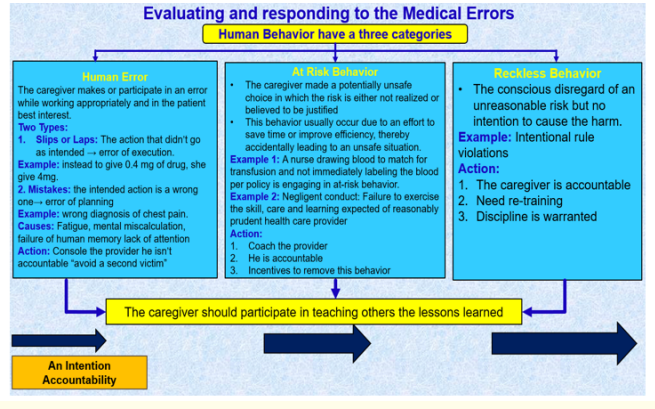


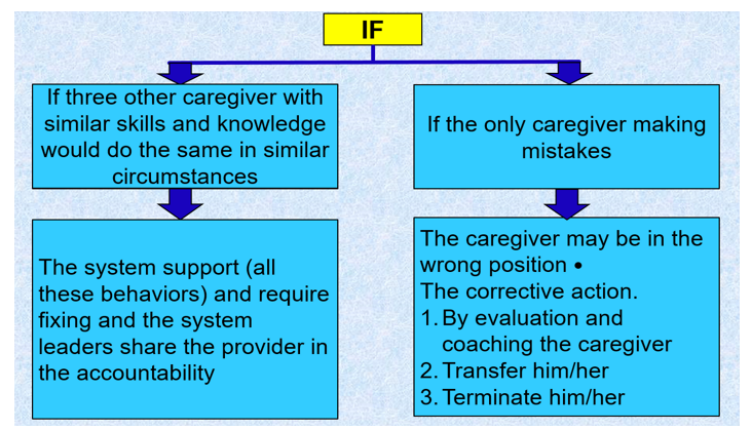
All under the umbrella of 3 duties:

- Avoid causing unjustified risks or harm
- Produce an outcome
- Follow a procedural rule.

Some extra benefits of just culture:

1. Increase trust within an organization
2. Increase transparency between providers and patients, and medical professionals themselves
3. More OVR reporting
4. More concentration on system design and approach to error.





Other examples of bad behaviors

Impaired judgement:

Due to either: 1- Illegal substances; 2- Cognitive impairment; 3- Severe psychosocial stressors.

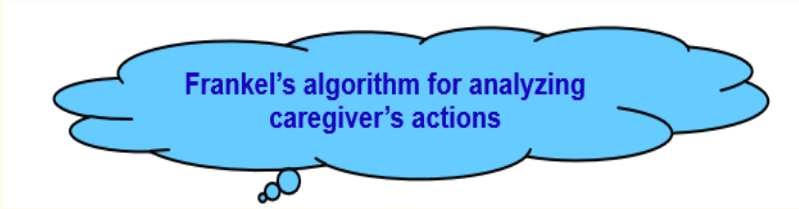
Management:

- Discipline
- Temporary work suspension
- Help and treat the caregiver.

Malicious action: Intentionally cause harm

Management

- Suspend the caregiver duties immediately
- Discipline and/or legal proceeding.



The tools necessary for effectuation of just culture:

- First: Important tool, is the clear articulation of just culture principle intended to be implemented.

- Second: The important tool for use in implementation of a just culture is the Frankel's algorithm of unsafe acts.
- Third: Open commitment to "just citizenship" this means that health care providers and staff committed to support transparency and open communication.
- Fourth: Safety concepts should be incorporated in training and evaluation of hospitals staff to establish a just culture (as part of new employee orientation, nursing competencies and physician credentialing).
- Fifth: Engagement of Hospital leadership (quality, safety, risk management)
    1. Walk rounds concept
    2. Teamwork training by simulation
        - Need for structured language like SBAR
        - S: Situation
        - B: Background
        - A: Assessment
        - R: Recommendations
    3. Psychologic safety: To ensure that people can voice their concerns without fear of judgement to encourage them to recognize and report an opportunity for improvement.
- Sixth: Simulation: Provide an incredibly useful learning tool.

  Example: An interactive classroom training.

NHS create a modified incident decision tree

- Developed by James Reason to manage human error and system failure in the aviation industry.
- Used by health care managers or executives to determine the health care workers behavior but:
    - It shouldn't be used routinely
    - It should be used only when there is already suspicion that a member of staff requires some support or management to work safely.

Q1: Deliberate harm test?

Was there any intention to cause harm?

NO: → Go to health test

YES:

→ Suspend health care workers

→ Contact regulatory agencies

→ Referral to legal bodies

→ Follow the organizational policy.

Q2: Health test

Are there indications of substance abuse?

NO: → Go to health test

YES:

→ Follow organizational substance at work guidance • is the substance abuse contributed to the patient safety event

→ Work suspension.

Are there indications of physical ill-health?

Are there indications of mental ill-health?

NO: → Go to Foresight test

YES:

→ Follow organizational guidance referral to occupational health

→ Need help.

Q3: Foresight test

3-a: Are there agreed protocols/ accepted practices in place that apply to the action/omission in question?

3-b: Where the protocols/accepted practice workable and in routine use

3-c: Did the individual knowingly depart from these protocols?

No to any:

→ No disciplinary action is appropriate

→ Need a more comprehensive investigation to redesign systems and processes to improve patient safety

Yes to all: → Go to the substitution test.

Q4: Substitution test

4-a: Are there indications that other individuals from the same group (with comparable experience and qualifications) would behave in the same way in similar circumstance.

4-b: was the individual missed out when relevant training was provided to their peer group?

4-c: Did more senior members of the team fail to provide supervision that normally should be provided?

NO to all: → Move to mitigating circumstance

YES to any:

→ No disciplinary action is appropriate

→ A more comprehensive investigation is required to redesign systems and processes to improve patient safety.

Q5: Mitigating circumstances

Where there any significant mitigating circumstances?

NO:

→ *Follow organizational guidance

→ *Assessing competency

→ Managing performance

→ Training health care workers

→ Increasing supervision

→ Contacting regulatory bodies

→ *A comprehensive investigation is required to improve patient safety.

YES: → Include senior HR in the investigation, who will provide advice regarding mitigating degrees.

A more comprehensive investigation is required to redesign systems and processes to improve patient safety.

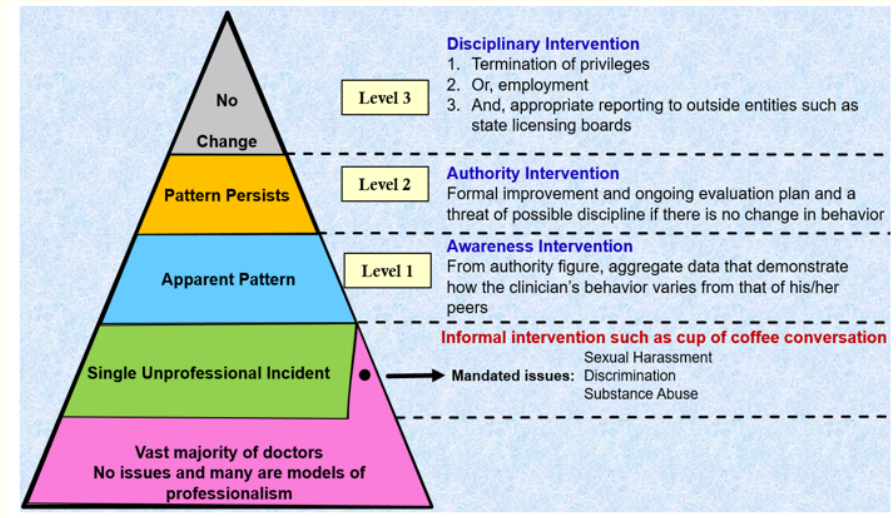
Golden rules

1. The further you proceed in the modified incident decision tree, the more probability that the system's failure has caused the event.
2. Ask assistance from a line manager, or senior human resources or others.
3. Gather as much as information as possible, don't rely on your best judgement.
4. Don't make assumptions.
5. Adaptation of Zero-Tolerance policy related to disruptive behavior, including professional code of conduct.

Hickson's disruptive behavior pyramid

For identifying and assessing also dealing with unprofessional behavior.

Disruptive behavior: Behaviors that show disrespect for others or interpersonal interactions that impede the delivery of patient care.



Practical example for applying the NHS modified incident decision tree

Example: Hand hygiene

- The patient safety problem is addressed and the literature or expert consensus, strongly supports adherence to the practice.

- Also many studies support the value of hand hygiene, in decreasing the HAI.
- Clinicians have been educated about the importance of the practice and the evidence, supporting it, by lectures, reminder system and others.
- Hand gel dispensers have been placed in convenient locations throughout the building, dispensers are never empty and work well.
- Physician understand the behaviors for which they will be held accountable.
- And they should know that observers will periodically audit.
- Hand-hygiene practices.
- A physician for example might receive a warning note, or be counselled by a departmental chair after the second observed transgression.
- Chronic failure to clean hands will result in a one-week suspension from clinical practice accompanied by completion of a 2-hour online educational module on infection prevention.

Another example

DANA-FARBER cancer institutes principles of a fair and just culture

After a two tragic incidents involving chemotherapy overdoses, one cause death and the other one cause cardiac toxicity.

They do RCA and approach the error from a system wise, not only individual one: involving all related departments:

1. Pharmacy
2. Nursing
3. HR
4. Quality
5. Legal department
6. Management.

After that, they granted seven principles of just culture.

7 principles of just culture

- First principle: Set out the organizations core values of impact, excellence, respect, compassion and discovery in the work place.
- Second principle: The organization established its standards for transparency and accountability and for understanding and recognizing errors made.
- Third principle: Specified that individuals were to be held accountable for only their own performance flaws and not for system failure.
- Fourth principle: Promoted an open discussion between disciplines within the organizations.
- Fifth principle: Aimed to improve all areas of the workplace by implementing changes based on analysis of existing problems having the potential to cause harm.
- Sixth principle: Committed the organization to a culture of inclusion and education.

- Seventh principle: Continuous monitoring of implementation of these principles intended to create a culture of safety and support.

All these principles are trained to all organization employee and add to the orientation of new staff with strong leadership commitment.

Gradual system changes

Example: When an adverse event does occur.

Now: An OVR written and directed to risk management department where the case is studied and reviewed and RCA is performed if necessary and an action plan created.

Before: When an adverse event occurred a disciplinary process was immediately activated and the organization failed to better understand potential deficiencies in its process.

DFCI's give a 5 recommendations to any health care organizations need to implement just culture

- 1st: The employee should understand that a blame-free culture doesn't absolve individuals of accountability.
- 2nd: The organization should include the value of respect in their founding principles for achieving a Just Culture "raising awareness".
- 3rd: Advices that executive leader and board members both understand and support the Just Culture principles.
- 4th: Measure the effect of implementing Just Culture principles on the Organization's delivery of health care.
- 5th: To educate all employee about the practical implications of Just Culture principles as well as their founding ideals.

Conclusion

Key Points:

1. Although the systems focus is the (correct) underpinning of the modern safety movement, incompetent or dangerous providers and institutions must also be held accountable.
2. Healthcare tends to "protect its own" which undermines public trust in the medical professions.
3. Some clinician's behavior is sufficiently disruptive to create a patient safety risk. Organizations need a strategy to manage such behavior which sabotages teamwork, communication and job satisfaction among colleagues.
4. Vehicles to determine and enforce accountability can be local: Such as hospital credentials committees or involve outside organizations such as state licensing boards or national professional organizations.
5. Several Just Culture algorithms have emerged to help organizations and managers determine which acts represent human errors, at risk behaviors or negligence only the latter should lead to punishment.

6. The media can play an important role in ensuring accountability especially if reporting on errors is seen as fair and reflective of our modern understanding of patient safety [1-3].

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