# JUST CULTURE :

## *An Algorithm for Accountability*

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***13 October 2016***

# Human Errors

- Slips - *an unplanned action*
- Lapses - *not completing a planned action*
- Mistakes - *doing an action incorrectly*
  - *applying knowledge incorrectly*
- Violations - *not following procedures or rules*

# Human Errors Arise From ….

- Attention
- Memory
- Perception
- Habits
- Experience
- Knowledge
- Fatigue
- Stress
- ……

They also arise from -
Risk Taking and Reckless Behaviour

# Medical Preventable Death

Calgary, February 2004:

*The substitution of potassium for sodium chloride resulted in the unexpected deaths of two ICU patients undergoing continuous renal replacement therapy*

# Simply read the label …?

# Hand Hygiene

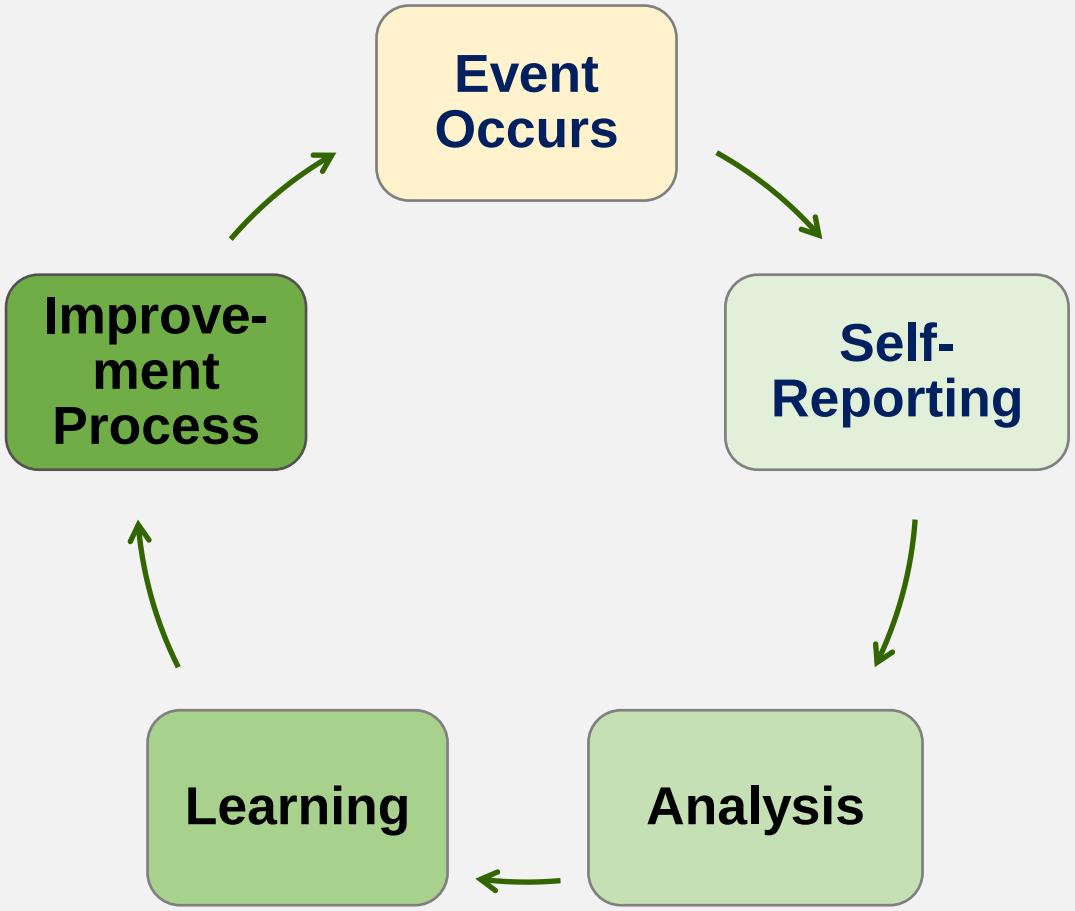
HQSC report 90% (*2016*) compliance with the guidelines for hand hygiene

What is it that is causing a 10% non-compliance with the desire to prevent patient harm through the simple act of practicing hand hygiene?

Surely evidence-based medical practice confirms that hand-hygiene is a quick and easy way to get a good Return-on-Investment for reducing potential patient harm?

**Is this At Risk or Reckless Behaviour?**

# How do we find out what is happening?



# *Actus Rea* and *Mens Rea*

- The concepts of the *Evil Hand* and the *Evil Mind* form the centrepiece of criminal law
  = the intent to cause harm
- 20th Century trend to holding individuals responsible for "harm" without intent or "evil-mind" = human error
- Evolution in the law arose from the Industrial Revolution = powerful and complex machines (including cars) can cause tremendous harm
- Criminal negligence became the norm = blurring the lines between intentional risky choices and inadvertent and predictable human fallibility
- Human error and at-risk behaviours preclude evil intent

Marx: *Whack-a-Mole*

# Responses to Bad Things Happening

## Blame & Shame

Blaming individuals is a common response to accidental harm in all sectors of society and its pervasiveness impedes the management of iatrogenic harm

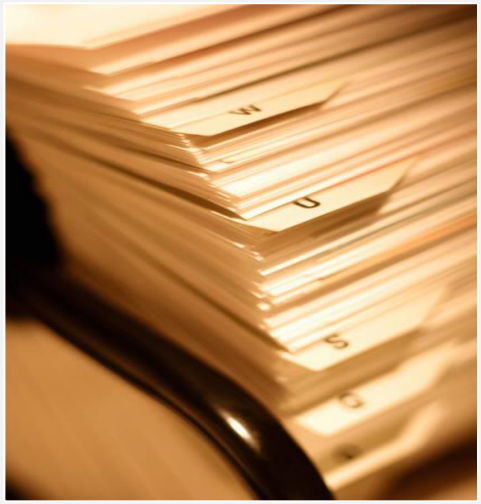
Runciman, Merry, & Walton: *Safety and Ethics in Healthcare*

The single greatest impediment to error prevention in the medical industry is "*that we punish people for making mistakes*"

Marx: *Patient safety and the Just Culture*

# “No harm no foul” thinking


# The Systemic Model of Error



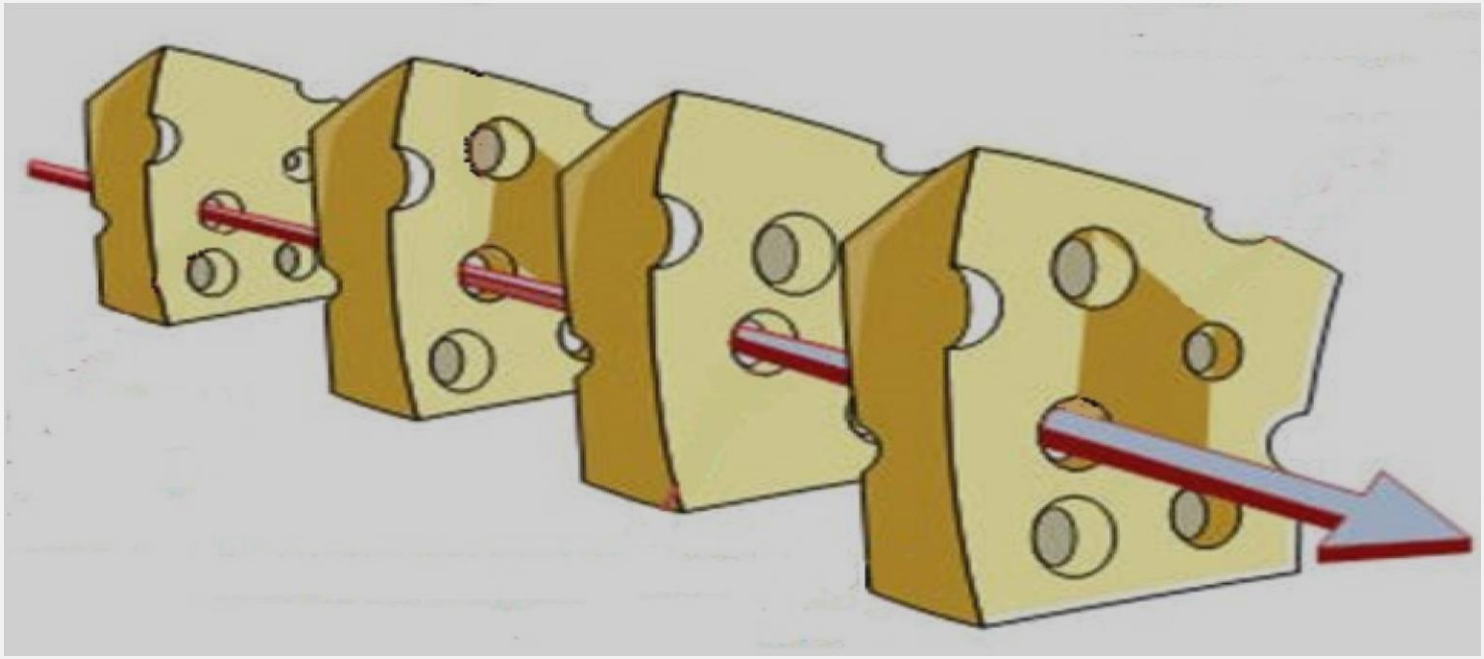
- Errors are a fact of life and sometimes cause adverse events
- People at the sharp-end are more likely to inherit an error than be the instigator
- Adverse events have multiple causal factors

Reason: *Errore Umano*

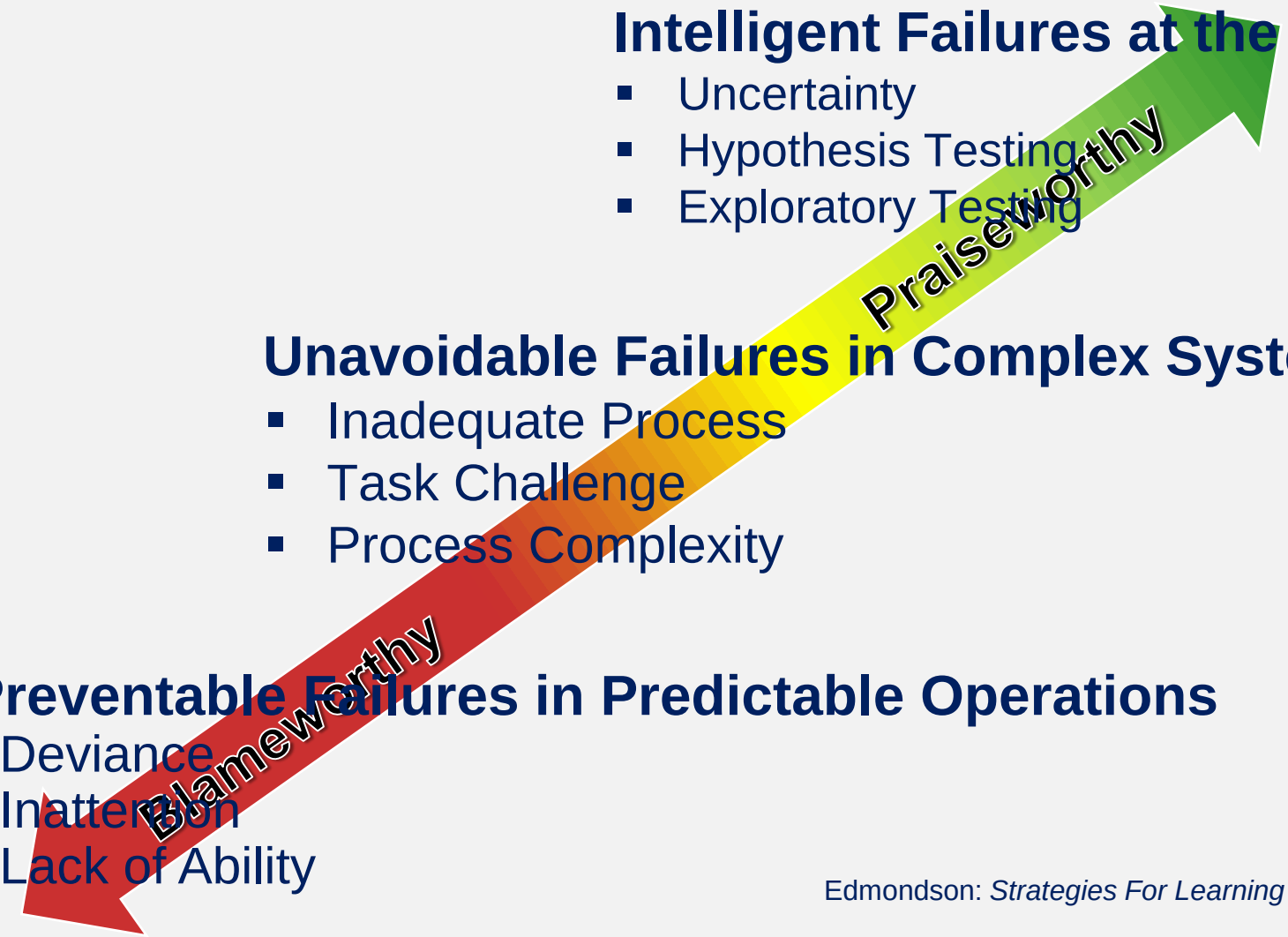
# “Swiss Cheese”

**Or:**

**Latent Factors and Active Errors**



# A Spectrum For Reasons For Failure




## Intelligent Failures at the Frontier

- Uncertainty
- Hypothesis Testing
- Exploratory Testing

## Unavoidable Failures in Complex Systems

- Inadequate Process
- Task Challenge
- Process Complexity

## Preventable Failures in Predictable Operations

- Deviance
- Inattention
- Lack of Ability

Edmondson: *Strategies For Learning From Failure*

# Human behaviours we can expect

# Takeoff Decision

# Takeoff Decision


*We need the person involved to explain their actions, thoughts and intentions*

# Interlocking elements


Reason: *Errore Umano*

# What do we *mean* by Just Culture?

A Just Culture:

- Recognises that individuals should not be held accountable for system failings over which they have no control
- Recognises that many errors represent predictable interactions between human operators and the systems in which they work, and that competent professionals make mistakes
- Acknowledges that even competent professionals will develop unhealthy norms (shortcuts, routine rule violations)

# Just Culture Definition:

"*A system of Natural justice that reflects what we now know of socio-technical system design, free will, and our inescapable human fallibility*."

# It's about a Proactive Learning Culture

Seeing events as opportunities to improve our understanding of risk

*(System risk and behavioural risk)*

# Core Beliefs

- To *err* is human
- To *drift* is human
- Risk is *everywhere*
- We must manage in support of our *values*
- We are all *accountable*

*DRIFT….?*


TOYOTA
KOMATSU
FATORIA 50

# Drift

## Developing unhealthy ‘norms’

- Creates a bigger risk than errors themselves
- Often tacit approval of certain at-risk behaviours by other staff and managers
- Dopamine reinforcer for successful “short cuts”

*….. and nothing Bad happened!*

# Designing for Drift

- **Barriers** – to prevent specific failure
  *(forcing functions)*
- **Recovery** – to catch failures before they cause harm
  *(checklists; emergency procedures)*
- **Redundancy** – to provide multiple options to achieve an outcome through another path if the first doesn't work
  *(two pilots; alternative diagnosis)*

# Just Culture Algorithm

- Tests for Intentions and Behaviours
- Tests for adherence to Duties
- Provides guidance on consequential actions

*Outcome Engenuity, www.outcome-eng.com*

# Behaviours

## Human Error

- Inadvertently doing other than what should have been done; a slip, lapse, mistake

## At-Risk Behaviour

- Increasing risk that is either not recognised, or mistakenly believed to be justified

## Reckless Behaviour

- Consciously disregarding a substantial and unjustifiable risk

## Repetitive Behaviour

- Individuals with a history of Human Error and/or At-Risk Behaviour

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## Malicious Intent

- Behaving with a conscious aim or purpose to cause harm

# The Three Duties

1. **Duty to Produce an Outcome**

   Employees have a responsibility to follow rules which specify the outcome to be achieved *where they themselves control that system*

2. **Duty to Follow a Procedural Rule**

   Employees have a *responsibility to follow procedures* put in place by their employer. Although the employer largely controls those procedures, employees have a *responsibility to be reliable components* within the system

3. **Duty to Avoid Causing Unjustifiable Risk or Harm**

   Employees have a responsibility not to cause *unjustifiable risk or harm* to themselves, other employees or their employer

# Actions (Outcomes)

**Substitution Test**

- "*Given the same circumstances, can you be sure that another employee would not have made the same decision"?*"

**Console**

- Accept that error has occurred and identify any means in which the system might be improved to either trap future errors or mitigate negative consequences

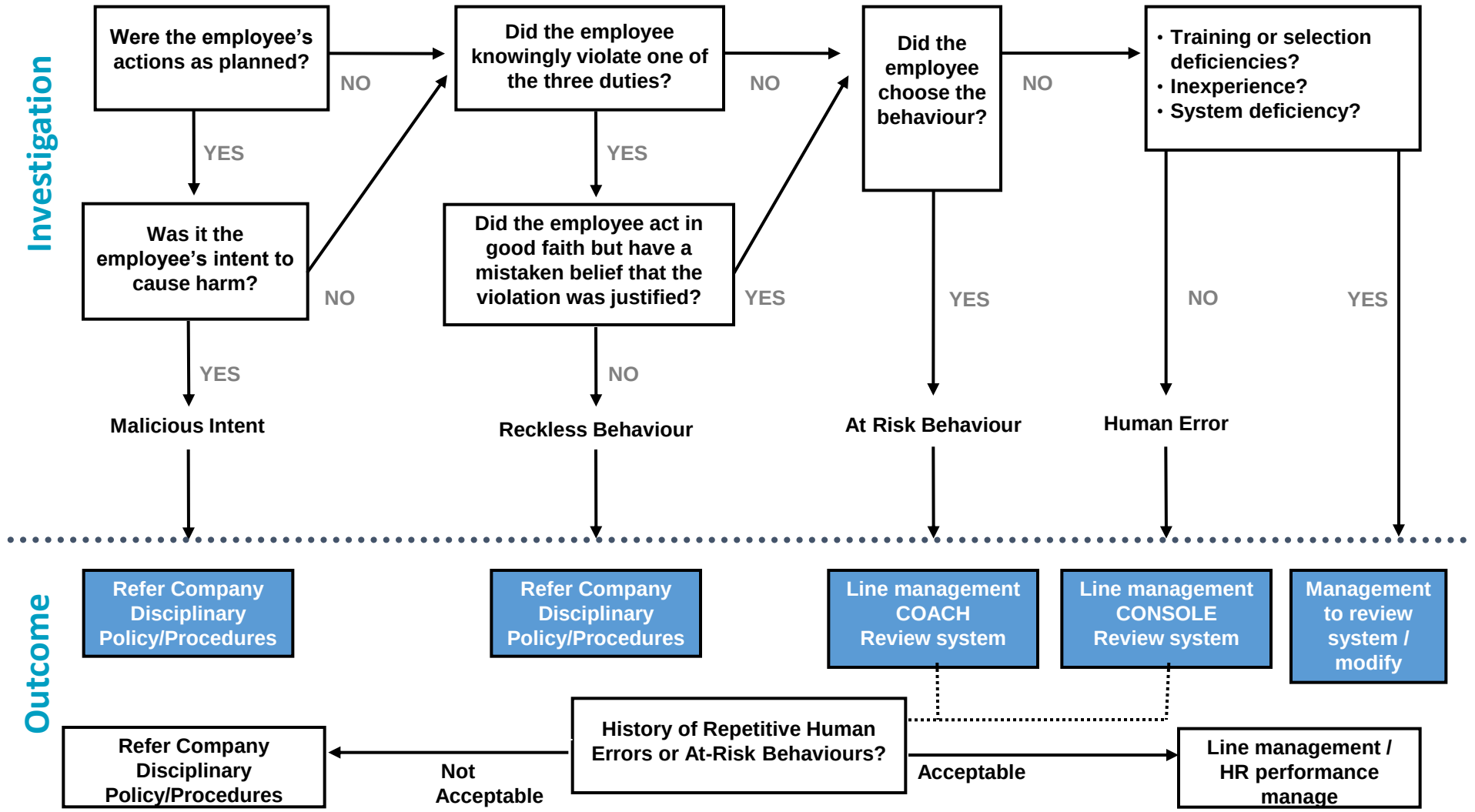
**Coach**

- Supportive discussion (an/or education and training) with employee on the need to make safe behavioural choices

**Disciplinary Action**

- A formal process undertaken in line with the Managing Poor Performance Policy and/or Disciplinary Policy

# Just Culture Flow Chart




Refer Group Airline Safety Policy

# Bad Things Happening

How to spend > $1.0M without really trying ….

# Investigation & Outcome

- Expectation (*Cognitive - mind set; confirmation bias*)
- Stress (*Person - task demands)*
- Task demands (*System - performance targets*)
- Training (*System – incomplete, inadequate*)
- Selection (*System - inadequacies*)

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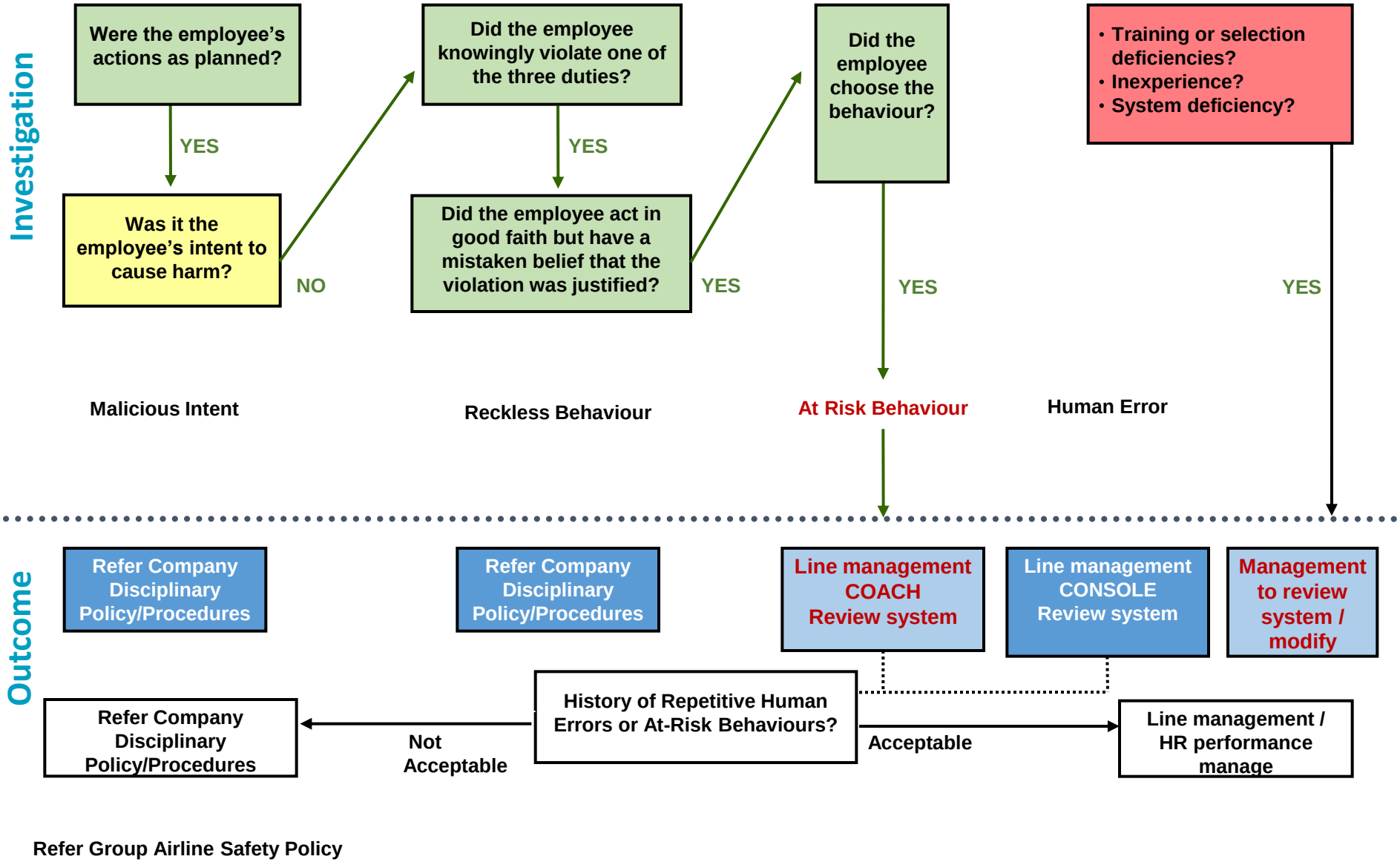


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- The individual was *coached* and *re-trained*
- Managers were *held to account* for the failures in selection and training processes
- The system performance targets were *reviewed and adjusted*

# Benefits of a Just Culture

- Changes and *improves* the way we manage our people
- *Balanced accountability* leading to improved communication, system design and behavioural choices
- *Reduced risk* due to the ability to predict and prevent events due to accurate reporting
- Focusing on the *conduct* not the outcome

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