

## Professional Accountability in a Just Culture

Cindy Sayre, MN, ARNP  
Lorie Wild, PhD, RN, NEA-BC




### Case Study #1

After surgery, a cancer patient was receiving IV antibiotics and fluids through a central venous catheter

A nurse mistakenly connected an insulin infusion instead of the antibiotic.

The error was not noticed for an hour when the patient complained of symptoms.




### Case Study #2

Mrs. S. is a 39-year-old woman admitted for exacerbation of multiple sclerosis. She needs a moderate degree of assistance for safe toileting. She has been using her call light each time she needs assistance.

Her nurse Jane ambulates the patient to the commode. She decides to retrieve the next Antibiotic dose from the med room while Mrs. S. uses the commode. Jane instructs Mrs. S. to use the call light when she is through.

After using the commode, Mrs. S. stands up on her own, slips and fractures her ankle.




### Case Study #3

Ms. Gomez, a 63-year-old Woman S/P hysterectomy is now Post-Op Day 1. She is on a morphine PCA.

The PCA pump alarms when the syringe is empty. The nurse gets a new syringe. She knows that the hospital has a "independent double check" policy.

The nurse wants to complete her shift and forgoes the double check. The next nurse finds the pump set for Dilaudid instead of morphine.



## Who's to Blame?

Blame  
"Free-for-All"  
Culture




Blame-Free  
Culture


**Professional Accountability**

## Blame "Free-for-All" Culture

- "Name, shame, blame" – Incident reports
- "Write you up"
- "...individual workers were fully, and sometimes solely, accountable for the outcomes of patients under their care, even if the underlying processes for achieving those outcomes were not under their direct control..."
- Perfect performance was expected and felt to be achievable through education, professionalism, vigilance, and care

## Blame "Free-for-All" Culture


 **Pro:** Addresses poor performance quickly, and dismissal of those individuals may prevent future errors


 **Con:** Squelches reporting of adverse events and errors secondary to fear of discipline

## Blame-Free Culture

- All problems thought to be system-related
- "Make it easy to do the right thing"

## Blame-Free Culture

 **Pro:** Allows organizations to take a "systems view" of issues without need to identify one individual to blame

 **Con:** Does not directly confront unsafe behavior

## The Case for a Just and Fair Culture

"On one side of the coin, **it is about creating a reporting environment where staff can raise their hand when they have seen a risk or made a mistake.** It is a culture that rewards reporting and puts a high value on open communication – where risks are openly discussed between managers and staff. It is a culture hungry for knowledge."

*David Marx*

## The Case for a Just and Fair Culture

"On the other side of the coin, **it is about having a well-established system of accountability.** A Just Culture must recognize that while we as humans are fallible, we do generally have control of our behavioral choices, whether we are an executive, a manager, or a staff member.

"Just Culture flourishes in an organization that understands the concept of shared accountability -- that **good system design** and **good behavioral choices of staff** together produce good results. **It has to be both.**"


*David Marx*

### A Model that Focuses on Three Duties Balanced Against Organizational and Individual Values

- The 3 Duties
  - Duty to produce an outcome
  - Duty to follow a procedural rule
  - Duty to avoid causing unjustified risk or harm
- Organizational and Individual Values
  - Safety
  - Cost
  - Effectiveness
  - Equity
  - Dignity
  - Patient- and Family-centeredness

### Duties of Health Care Professionals


***Produce an outcome.***



If an individual knows the desired outcome and should be able to produce it (e.g., medication teaching), failure to do so represents breach of this duty.

### Duties of Health Care Professionals

***Follow a procedural rule.***



If the individual *knows* the proper procedure *and it is possible* to follow the rule (e.g., the procedure for removing a foley catheter), failure to do so represents a breach of this duty.

### Duties of Health Care Professionals

***Avoid causing unjustifiable risk or harm.***




Breach of this duty occurs when an individual intentionally harms the patient or acts recklessly.

www.mers-tm.org/support/Max\_Primer.pdf

### Review: Case Study #1

After surgery, a cancer patient was receiving IV antibiotics and fluids through a central venous catheter




A nurse mistakenly connected an insulin infusion instead of the antibiotic. The error was not noticed for an hour when the patient complained of symptoms.

**What type of error was this?**

### Human Error

- Unintentional and unpredictable behavior that causes or could have caused an undesirable outcome
- Inadvertent action: slip, lapse, or mistake



## Addressing Human Error

### System may need to change:

- Processes
- Procedures
- Training
- Design
- Environment



### Disciplinary Action

- None. Employee may need to be consoled.

## Review: Case Study #2

Mrs. S. is a 39-year-old woman admitted for exacerbation of multiple sclerosis. She needs a moderate degree of assistance for safe toileting. She has been using her call light each time she needs assistance.

Her nurse Jane ambulates the patient to the commode. She decides to retrieve the next antibiotic dose from the med room while Mrs. S. uses the commode. Jane instructs Mrs. S. to use the call light when she is through.

After using the commode, Mrs. S. stands up on her own, slips and fractures her ankle.



### What type of error was this?

## At-Risk Behavior

- Failure to exercise expected care
- Risk is not recognized or believed to be justified



## Addressing At-Risk Behavior

### System may need to:

- Remove incentives for at-risk behaviors
- Create incentives for healthy behaviors
- Increase situational awareness

### Disciplinary Action

- Consider overall performance of employee. Coach employee as needed.



## Review: Case Study #3

Ms. Gomez, a 63-year-old woman S/P hysterectomy is now Post-Op Day 1. She is on a morphine PCA.

The PCA pump alarms when the syringe is empty. The nurse gets a new syringe. She knows that the hospital has a "independent double check" policy.

The nurse wants to complete her shift and forgoes the double check. The next nurse finds the pump set for Dilaudid instead of morphine.



### What type of error was this?

## Reckless Behavior


- Intentional risk-taking
- *Conscious disregard* of a visible, significant risk



## Addressing Reckless Behavior

**The system may need to:**


- Take remedial action
- Take disciplinary action



## The Conceptual Model

Human Error	At-Risk Behavior	Reckless Behavior
<i>Product of our current system design</i>	<i>Unintentional Risk-Taking</i>	<i>Intentional Risk-Taking</i>
Manage through changes in:	Manage through:	Manage through:
<ul style="list-style-type: none"> <li>• Processes</li> <li>• Procedures</li> <li>• Training</li> <li>• Design</li> <li>• Environment</li> </ul>	<ul style="list-style-type: none"> <li>• Removing incentives for At-risk Behaviors</li> <li>• Creating incentives for healthy behaviors</li> <li>• Increasing situational awareness</li> </ul>	<ul style="list-style-type: none"> <li>• Remedial action</li> <li>• Disciplinary action</li> </ul>
<b>CONSOLE</b>	<b>COACH</b>	<b>DISCIPLINE</b>

## Applying the Concept




A nurse is caring for a baby in the pediatric ICU. The baby has had seizures throughout the day.


The nurse administers the Dilantin that has been ordered via IV push. She administers the medication too quickly.

The baby has significant bradycardia and a rapid response is called. Fortunately, the baby's heart rate stabilizes quickly.


## What Type of Error Is This?



Human Error?



At-Risk Behavior?




Reckless Behavior?

**How should this nurse be disciplined?**

## Determining the Type of Error

- Was the nurse **aware** of the policy?
- Was it **possible** for the nurse to follow the policy?
- Do the **other nurses** on the unit follow the policy?
- Was there any **rationale** for not following the policy?



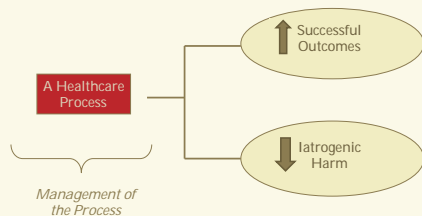
## Just Culture Algorithm

- What happened?
- What normally happens?
- What does the procedure require?
- Why did it happen?
- How was the organization managing the risk?

---

- Did employee put an organizational interest or value in harm's way?
- Did the employee breach a duty to follow a procedural rule in a system designed by the employer?
- Did the employee breach a duty to produce an outcome?

## Organizational Accountability



Producing results that align with our aims - safe, effective, patient-centered, timely efficient, equitable

## 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
- Communicating expectations
- Follow-through when errors occur
  - Consoling
  - Coaching
  - Disciplinary action when indicated

## What is a Just Culture?

### A Set of Beliefs

- A recognition that professionals will make mistakes
- A recognition that even professionals will develop unhealthy norms
- A fierce intolerance for reckless conduct
- An expectation that hazards and errors will be reported
- Accountability for choosing to take risk
- Expectation that system safety will improve

Inspiration: David Marx

© Baines Simmons Limited 2009

## What is a Just Culture?

### A Set of Duties

- To raise your hand and say "I've made a mistake"
- To raise your hand when you see risk
- To resist the growth of at-risk behavior
- To participate in generating learning from our every-day *bad experiences*
- To absolutely avoid reckless conduct

Inspiration: David Marx

© Baines Simmons Limited 2009

## Want more information?

- The Just Culture Community
  - [www.justculture.org/](http://www.justculture.org/)
- Patient Safety and the "Just Culture": A Primer for Health Care Executives
  - <http://psnet.ahrq.gov/resource.aspx?resourceID=1582>
- Just Culture from Aspiration to Reality
  - [www.raes-hfg.com/reports/21may09-Potential/21may09-baines.pdf](http://www.raes-hfg.com/reports/21may09-Potential/21may09-baines.pdf)