Just Culture After 20 Years

Kathryn Wire, JD MBA FASHRM CPPS

Executive Director, Center for Patient Safety

www.centerforpatientsafety.org

Center for Patient Safety

History

- 1997—James Reason: *Managing the Risk of Organizational Accidents*
- *2000– IOM Report: To Err Is Human*
- 2001—David Marx: “Patient Safety and the ‘Just Culture’: A Primer for Health Care Executives” focused on behavioral choices in more depth
- 2011—Sidney Dekker: many books over many years.
  - Focuses on the role of human error and human factors, avoid blame.
  - No algorithm.
- 2018—Joint Commission standards for safety culture:
  - Reporting
  - ID and improve system issues
  - Implement an individual accountability system (citing Reason and Marx)

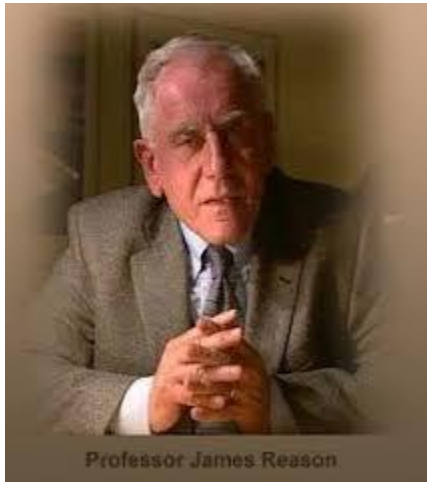
Results after 20 years

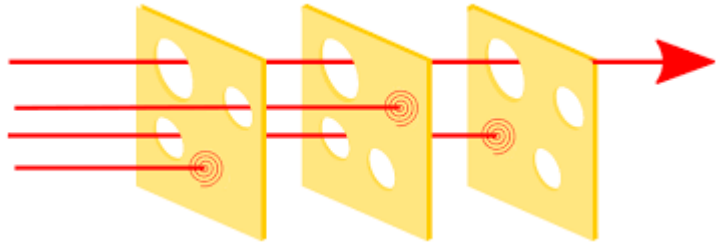
- Nearly 25% of patients have an adverse event, in- and outpatient
- One percent have a preventable event involving serious harm
- Don Berwick's response:
  "…these findings suggest that the safety movement has, at best, stalled."
- Martin Hatlie: "Who Killed Patient Safety?"
- Sutcliffe and Wears: *Still Not Safe: Patient Safety and the Middle-Managing of American Medicine*
- Continuing focus/study of events, not risk (latent harm)
  - <10% of CPS reports are safety concerns
  - ~15% of NPSD reports are safety concerns

AHRQ: NPSD Chartbook accessed 20240701 at Network of Patient Safety Databases Chartbook, 2023 (ahrq.gov); BatesDW et al., N Engl J Med 2023;388:142-53; Levine DM, et al., Ann Intern Med. 2024;177:738-748. Hemmelgarn C, Hatlie M; Journal of Pt. Safety and Risk Management Vol. 27(2) 56-58 (2022)

James Reason

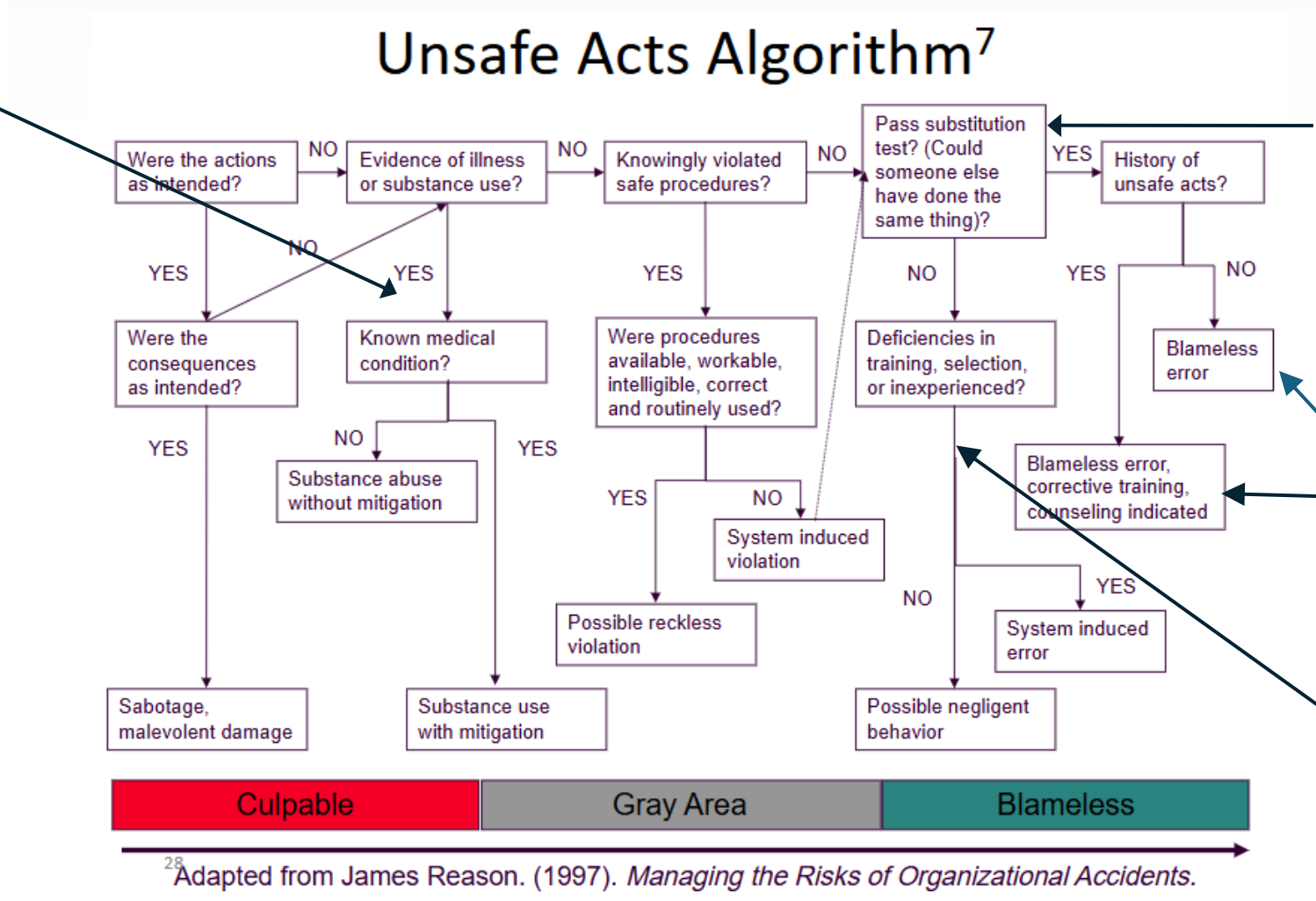
- Developed the first algorithm focused on event response
- Purpose: assess blameworthiness
- No subjective investigation of choices
- No required investigation of background systems outside of the event
  - Doesn’t look at what normally happens
  - Doesn’t look at what the organization was doing to manage the risk





All about the individual acts, not system

Why Stop Here



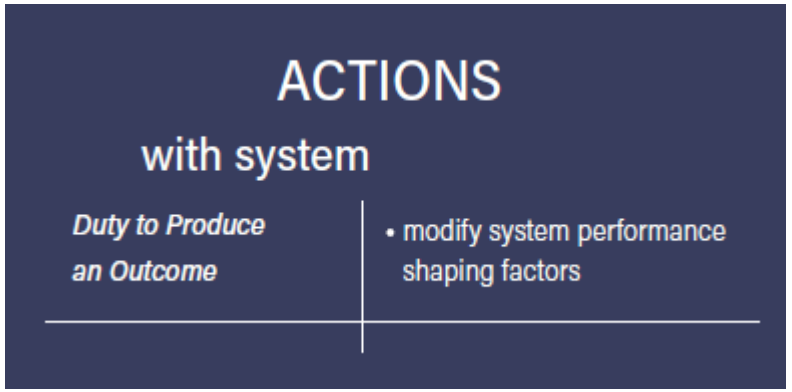
How the heck do you assess this? Subjective vs. Objective

No blame—no work on other system causes

NHS adds "mitigating factor" question

David Marx (Outcome Engineering /Outcome Engenuity/TJCC)

- Investigation focuses more on system operation
  - “What normally happens”
  - Did the individual believe what they did was OK? Why?
- “Modify system performance-shaping factors”
  - Only factors that affected this individual’s choices?



PERFORMANCE SHAPING FACTORS:
attributes that impact the likelihood of humnan errors or behavioral drift

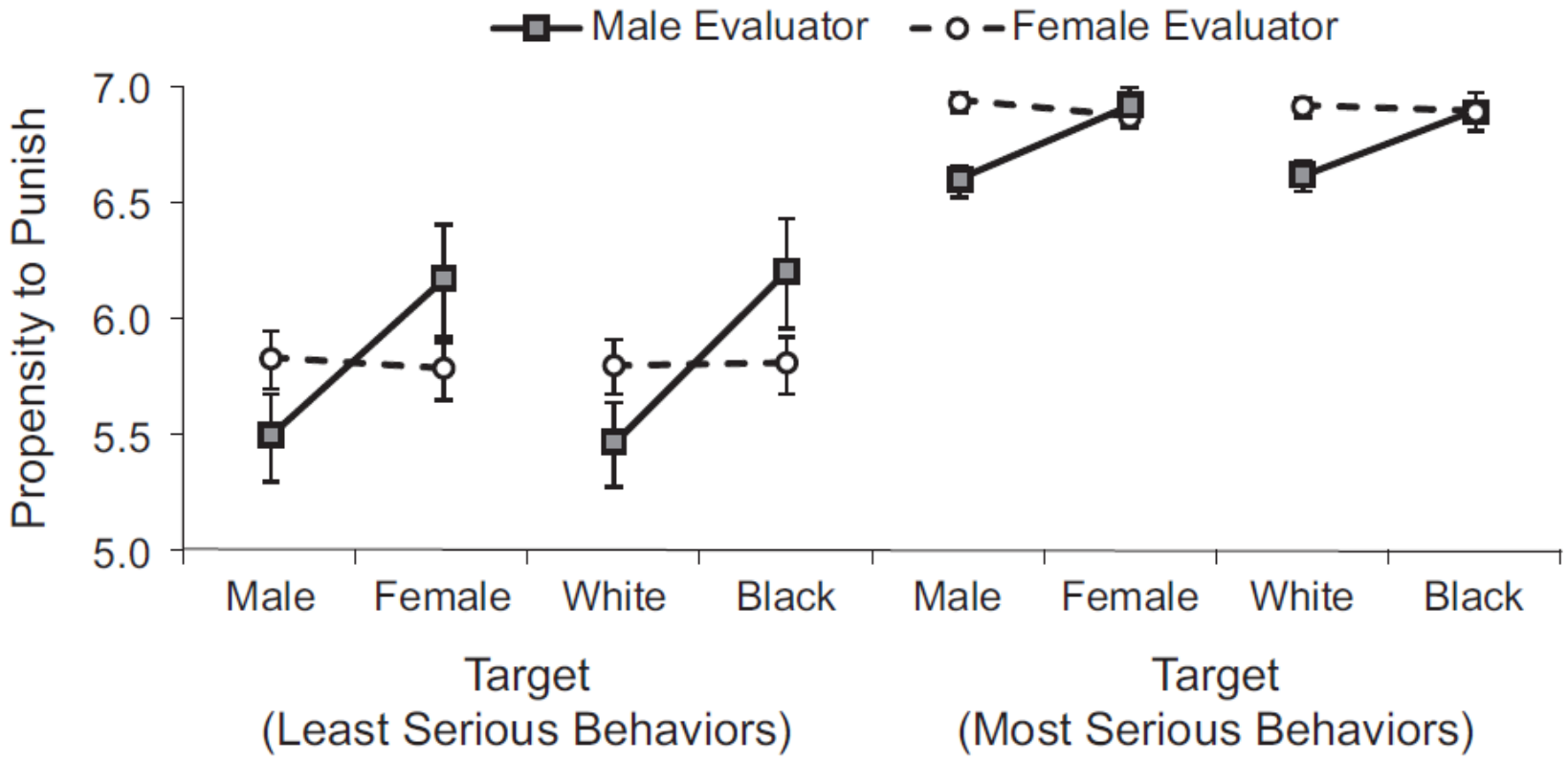
Sidney Dekker

- Unless perfectly applied (and it won't be), algorithmic JC is inherently unfair and unjust
  - Inconsistency
  - Bias
- Views actions focused on an individual to be retributive
- Restorative Just Culture:
  - Evaluate all the consequences and harm
  - What needs to be done
  - Who should do it?

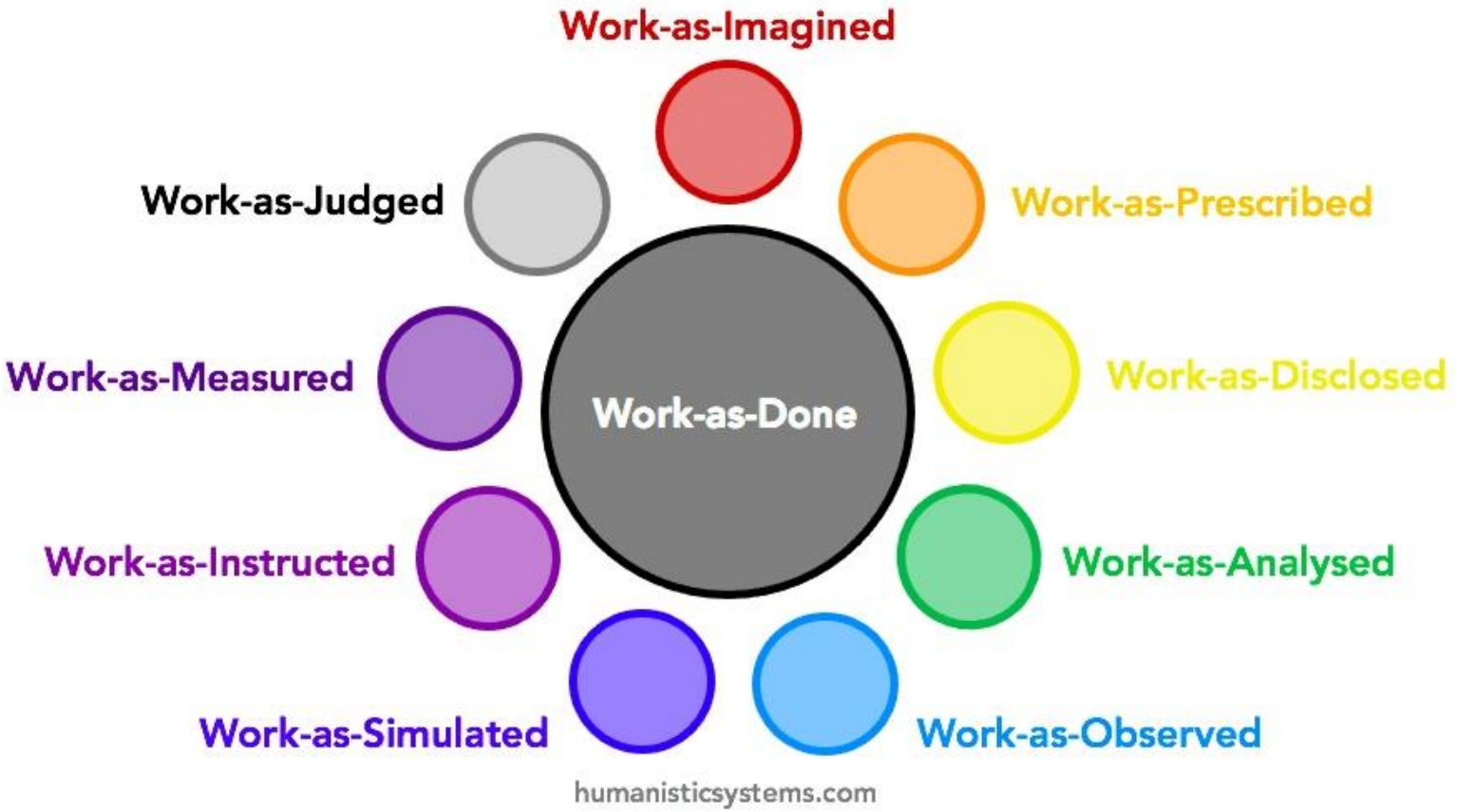
Dekker S, *Stop Blaming: Create a Restorative Just Culture, independently published (2023)*

Bias: Likelihood of Punishment

Bowles HR and Gilfand M; “Status and the Evaluation of Workplace Deviance, *Psychological Science* 2010 21: 49. https://journals.sagepub.com/doi/10.1177/0956797609356509

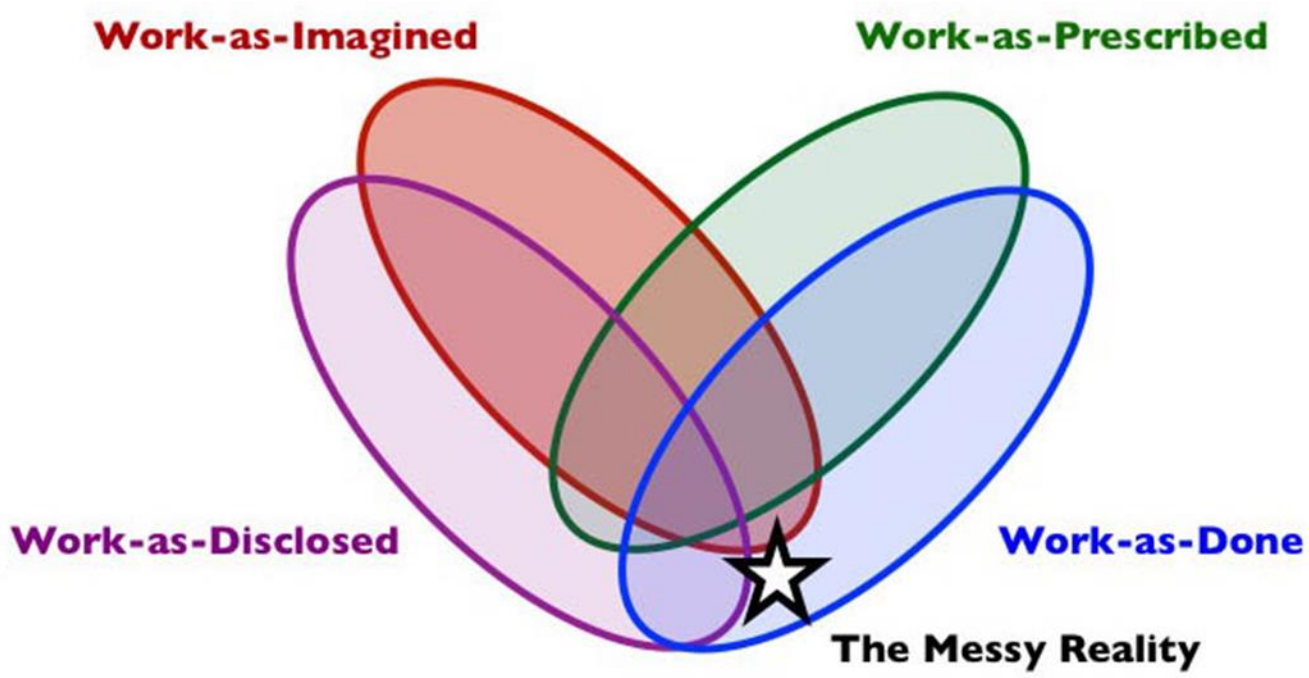


The Problem With Systems (including the Just Culture System)



Shorrock S; https://humanisticsystems.com/wp-content/uploads/2023/03/album-4-proxies-for-work-as-done-1.pdf

The Challenge



https://humanisticsystems.com/2017/01/13/the-archetypes-of-human-work/

Algorithms Alone Can’t Solve the Problem

- Are all interested constituencies represented?
- Do all those applying them have the right training?
- What assessment takes place to review consistency and accuracy?
- Who reviews system issue response?
- Are outcomes reviewed?

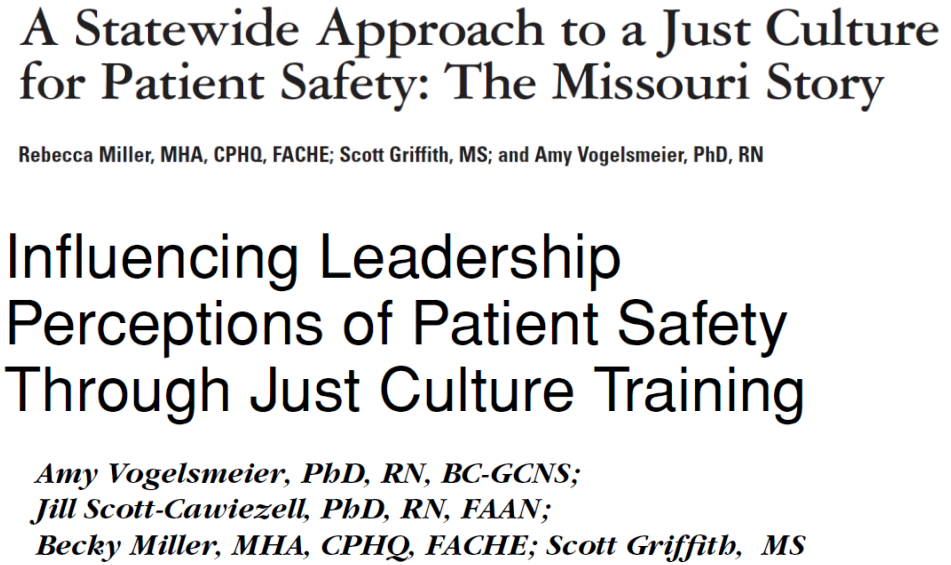
Collaborative Just Culture™

- Looks at reported risk, not focused on events
- Triad with unanimous decisions
  - Management
  - Human Resources
  - Quality/Risk/Safety
- Applies to all risk in the organization, not just safety
- Documented process, monitor, measure
- Review
  - Risk to be addressed
  - System
  - Environment and Culture
  - Competing Priorities
  - Behavioral Choices
- Standards for the program, subject to independent audit

K. Scott Griffith, *The Leader's Guide to Managing Risk,* Harper Collins (2024)

The MOCPS/OE Experience

- Sixty-three participating providers; 52 finished
- Four statewide regulatory agencies
- Four levels of intensity
- HSOPS: The most engaged leaders were much closer to staff scores; least engaged leaders had higher “after” scores
- Conclusion: Intensive JC experience helped close the gap
- Few were able to maintain their programs


A Statewide Approach to a Just Culture for Patient Safety: The Missouri Story

Rebecca Miller, MHA, CPHQ, FACHE; Scott Griffith, MS; and Amy Vogelsmeier, PhD, RN

Influencing Leadership Perceptions of Patient Safety Through Just Culture Training

Amy Vogelsmeier, PhD, RN, BC-GCNS;
Jill Scott-Cawiezell, PhD, RN, FAAN;
Becky Miller, MHA, CPHQ, FACHE; Scott Griffith, MS

What's Good?

- Avoiding blame as the solution
- Recognizing that human choices are not all the same
- Tools to help us analyze behaviors
- A better understanding of the role of the system
- Experience and learning about Just Culture tools and processes
- More likely to involve leadership in the process

What We Can Do Better

- Involve regulatory agencies
- Remember OE/TJCC began to address JC as a program to evaluate and manage risk.
- What are the risks? How do the system and the employee relate to them?
- Develop structures and practices to maintain consistency and competency: document, monitor, and measure (Griffith)
- Consider all harm (Dekker) and risk (Griffith)
- Apply throughout the organization

QUESTIONS

Center for Patient Safety

www.centerforpatientsafety.org

573.636.1014