Patient Safety and the Just Culture: Checklists, Perfection, and our Inescapable Human Fallibility

Presented by:
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Agenda

• Life in the High Consequence Industry
• A Case Study: Wrong Site Surgery
• Setting System Expectations
• Setting Individual Provider Expectations
• Understanding Human Fallibility
• The Just Culture Model
• Just Culture Around the US
Life in the US

Expectations...
Life in the US

“We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life, liberty and the pursuit of happiness.”
Palsgraf v. The Long Island Railroad
(1928)

“The proposition is this. Every one owes to the world at large the duty of refraining from those acts that may unreasonably threaten the safety of others.”
Life in the High Consequence Industry

Expectations…
Setting Expectations

“...No person may operate an aircraft in a careless or reckless manner so as to endanger the life or property of another.”

*Federal Aviation Regulations*  
§ 91.13  *Careless or Reckless Operation*
Setting Expectations

“As far as I am concerned, when I say “careless” I am not talking about any kind of “reckless” operation of an aircraft, but simply the most basic form of simple human error or omission that the Board has used in these cases in its definition of “carelessness.” In other words, a simple absence of the due care required under the circumstances, that is, a simple act of omission, or simply “ordinary negligence,” a human mistake.”

National Transportation Safety Board
Administrative Law Judge
Engen v. Chambers and Langford
Setting Expectations

Gross Misconduct

Where an offense is so serious as to breach the basis of the employment contract, then this will be regarded as gross misconduct and will normally lead to summary dismissal, unless there are sound mitigating circumstances.

- Indecency
- Theft
- Fraud
- Assault
- Sexual Harassment
- Malicious Damage
- Corruption
- Being Unfit for Duty
- Serious Breach of Confidentiality

Also, Gross Carelessness / Negligence – any action or failure to act which threatens the health or safety of patient, members of public or other staff

Norfolk and Norwich Community Hospital
Setting Expectations

The following conduct, acts, or conditions constitute unprofessional conduct…

- The commission of any act involving moral turpitude, dishonesty, or corruption…
- Misrepresentation or fraud…
- The willful betrayal of a practitioner-patient privilege…
- Abuse of a client or patient or sexual contact with a client or patient…
- Incompetence, negligence, or malpractice which results in an injury to a patient or which creates an unreasonable risk that a patient may be harmed…

RCW § 18.130.180 Unprofessional Conduct
A Case Study: Wrong Site Surgery
The Expectation

“Doing surgery at the wrong site is rare. But even once is too often. The good news is that wrong-site surgery is 100 percent preventable.”

New York DoH
15 years ago at the Joint Commission…?

Wrong site surgery is a bad thing!

Let’s start collecting data, see what we can do.
Wrong Site Surgeries
Reported to the Joint Commission
We gotta get better!

We need a Sentinel Event Alert
Wrong Site Surgeries
Reported to the Joint Commission
We gotta get better!

Let’s issue a second Sentinel Event Alert
Wrong Site Surgeries
Reported to the Joint Commission
We gotta get better!

Let’s hold a summit, let’s design a checklist...
The Checklist

• A tool designed by the system to control the behavior of individuals
Wrong Site Surgeries
Reported to the Joint Commission
We gotta get better!

Let’s hold a second summit
Wrong Site Surgeries
Reported to the Joint Commission
So where are we left?

Despair for those in the action

Anger from those looking in from the outside

Hope from those who feel they have no choice
Despair: Why Don’t We Look Like Aviation?

U.S. and Canadian Operators Accident Rates by Year

Annual fatal accident rate (accidents per million departures)
Despair?

“I think it's safe to say the patient-safety movement also has been a great failure.”

Lucian Leape
AONE Annual Meeting
April 2010
Despair?

Lifespan Hospital President and Chief Executive Officer Timothy Babineau, M.D., acknowledges the most recent incident on the hospital's Web site, pledging ongoing safety improvement. He estimates that "wrong site surgical errors continue to occur at hospitals all over this country at a rate of nearly 40 per week."
How did we fix it?

**Hospital Fined for Wrong-Site Surgery**
By Kristina Fiore, Staff Writer, MedPage Today
Published: November 03, 2009

Rhode Island Hospital, located in Providence, will pay $150,000 and install video cameras in all of its operating rooms after performing its fifth wrong-site surgery since 2007, according to the state’s Department of Health.

The hospital will also have to open its ORs to an inspector who will observe surgical procedures and protocols for at least a year, the department said. On Oct. 22, Rhode Island Hospital notified the Department of Health that it had performed a wrong-site procedure on a patient who was scheduled to have elective surgery on two different fingers of the right hand.

Both procedures, however, were performed on the same finger, according to a department report. The hospital had been fined $50,000 in 2007 for errors in brain surgeries on three different patients and was reprimanded for a mistake in a cleft palate procedure last May.

**State reprimands surgeon, 2 nurses in wrong-site surgery case**
01:00 AM EST on Wednesday, February 18, 2009
By Felice J. Freyer
Journal Medical Writer

PROVIDENCE — The state has reprimanded a doctor and two nurses for their roles in operating on the wrong knee of a Miriam Hospital patient in September.

The error occurred when a nurse mistakenly prepared the wrong leg for surgery and no one re-verified the site before the elective, outpatient procedure. Dr. Robert M. Shalvoy, 50, the orthopedic surgeon, was found at fault for failing to verify that he was operating on the correct knee immediately before surgery. Susan Dilibero, 65, operating room nurse, was disciplined for preparing the wrong knee for surgery, failing to verify the surgical site immediately before the operation began, and then documenting that the surgical site had been verified. Robert Duhamel, 53, nurse anesthetist, was found guilty of failing to verify the surgical site.
Zero Tolerance... That’s the Answer

“Voicing ever stronger concerns that the health care community still is not doing enough to prevent wrong-site surgery, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently called on all providers to adopt a no-nonsense, zero-tolerance policy toward that grave error. There is no excuse for performing a procedure on the wrong body part, wrong person, or the wrong procedure on the right patient, say leaders from the Joint Commission...”
and, of course, the Lawyers heard you
Where Did We Go Wrong?

- System Expectations?
- Individual Expectations?

From where will substantial improvement come?
Where Did We Go Wrong?

• System Expectations?
  – Yes, we still expect too little

• Individual Expectations?
  – Yes, we expected the wrong thing
Setting System Level Expectations
Aviation Expectations

FAR § 25.1309 Equipment, systems, and installations.

(b) The airplane systems and associated components, considered separately and in relation to other systems, must be designed so that --

(1) The occurrence of any failure condition which would prevent the continued safe flight and landing of the airplane is extremely improbable… [1x10^{-9}]

Designed to one loss per one billion flight hours
Aviation Expectations

The RII Rule:
If the task could be performed improperly, or improper parts or materials could be used, and that could endanger the safe flight and landing of the airplane, it must be a required inspection item.

The Idea:
Let no one human mistake lead to harm: the work must be inspected by a second person with specialized training (the RII inspector).
But what of the Individuals?

Are they off the hook?
The National Debate

“There are activities in which the degree of professional skill which must be required is so high, and the potential consequences of the smallest departure from that high standard are so serious, that one failure to perform in accordance with those standards is enough to justify dismissal.”

Lord Denning
English Judge
The National Debate

“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
Author, the Design of Everyday Things
The Problem Statement

What system of accountability best supports system safety?

Support of System Safety

As applied to:
- Providers
- Managers
- Healthcare Institutions
- Regulators

Blame-Free Culture

Punitive Culture

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The Story of Donte Stallworth
The Search for Better Models?

“...there are islands of greatness that provide a guiding light for future leaders. In a recent treasured private moment this writer had with Dr. Don Berwick, president and CEO of the Institute for Healthcare Improvement, who has been a courageous visionary of the quality movement, he shared an inspirational story of outstanding leadership. He spoke of a nursing leader and what she does after an event when a nurse is involved in harming a patient. She asks one question, “Did you commit this error on purpose? When the nurse says no, she then says “Well then it is my fault...errors stem from systems flaws...I am responsible for creating safe systems.”

Journal of Patient Safety June 2008
Human Fallibility
Our Fallibility – Human Error

• Human Error - inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake.
Our Fallibility – At-Risk Behavior

• At-Risk Behavior – behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified.
Our Fallibility –
Reckless Behavior

• Reckless Behavior - behavioral choice to consciously disregard a substantial and unjustifiable risk.
The Just Culture Model
(exremely simplified)
The Core Concepts – Human Error

• Human Error - inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake.
The Core Concepts - At-Risk Behavior

- At-Risk Behavior – behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified.
The Core Concepts – Reckless Behavior

• Reckless Behavior - behavioral choice to consciously disregard a substantial and unjustifiable risk.
# The Three Behaviors

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<tr>
<th>Human Error</th>
<th>At-Risk Behavior</th>
<th>Reckless Behavior</th>
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<tr>
<td><em>Inadvertent action: slip, lapse, mistake</em></td>
<td><em>A choice: risk not recognized or believed justified</em></td>
<td><em>Conscious disregard of unreasonable risk</em></td>
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<td><strong>Manage through changes in:</strong></td>
<td><strong>Manage through:</strong></td>
<td><strong>Manage through:</strong></td>
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<td>• Processes</td>
<td>• Removing incentives for at-risk behaviors</td>
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<td>• Training</td>
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<td>• Environment</td>
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<td>• Choices</td>
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**Console**

**Coach**

**Punish**

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Its About Doing This Well

- Values and Expectations
- Behavioral Choices
- System Design
- Errors and Outcomes

- Learning
- Accountability
Just Culture Around the US
Just Culture around the US

• Individual organizations / provider groups

• Statewide Initiatives
  – Regulators
  – Organizations
  – Providers
  – Consumers

• The ANA and AONE Endorsements

• Other Industries
The American Nurses Association Position Statement

“The American Nurses Association (ANA) supports the Just Culture concept and its use in health care to improve patient safety. The ANA supports the collaboration of state boards of nursing, professional nursing associations, hospital associations, patient safety centers and individual health care organizations in developing regional and state-wide Just Culture initiatives.”
Just Culture around the US

The California Patient Safety Action Coalition

• Overall Goals:
  - “To enhance patient safety and increase reporting of near misses and medical errors through promoting a fair and Just Culture across the continuum of healthcare in California.”
  - “To educate regulatory agencies, legislators, consumers, healthcare providers, purchasers of healthcare and the media in the principle of a fair and Just Culture, with the desired outcome being a societal change in the perception and response to medical errors.”
Why Do Just Culture?
Why Do Just Culture?

• It’s the best path to better patient outcomes (justice as a secondary value)
  – It forces us to take our eyes off of the outcome and who did it?
  – It puts our eyes where it matters – on system design and behavioral choices

• It’s the right thing to do for your employees (justice as a primary value)
Thank You

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