Just Culture

Leading Through Shared Values and Expectations
Objectives

• Understand the concepts of “Just Culture”
• Identify three predictable behaviors
• Understand a “Just Culture” investigation
• Describe the use of modeling, mentoring, coaching, and counseling
Are There Issues?

– Duty to produce an outcome?
– Duty to follow procedure rule?
– Duty to avoid causing unjustifiable risk or harm?
Introduction to Just Culture

“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, The Design of Everyday Things
What do our patients expect from us?

• It’s this simple:
  – Take care of me
  – Don’t hurt me
  – Be nice to me

• This is the core critical task
  – As we talk about Just Culture, everything goes back to this simple, but critical primary goal
Primary Role of an EMS Leader

• Advocate for the company
• Advocate for the employee
• Facilitate change
Quality Leadership

• High degree of Emotional Intelligence
  – Ability to monitor your feelings and emotions, and feels and emotions of others to guide your thinking and behavior.

• Emotional Intelligent people can
  – Coach, mentor, and lead
  – Set an example for others to follow
Introduction to Just Culture

• Definition: A values supportive system of shared accountability
  – Organizations are accountable to the systems they design and responding justly and fairly
  – Employees are accountable to the quality of their choices and reporting both their errors and system vulnerabilities
Five Pillars of a Just Culture

• Set values and expectations
• Design and safe and effective system
• Help guide employees to make good choices
• Be willing to learn from your mistakes
• Be just and accountable in your decisions
An “Unjust” Culture

Complacency
  • That’s not my job

Conflict
  • Department v. department

Control
  • It’s done this way or else
Building Team Support

Functional Relationship
- Honest and transparent
- Shares ideas; not afraid of conflict
- Sets clear and reasonable expectations
- Hold self and others accountable
- Celebrates growth and results

Dysfunctional Relationship
- Hides weakness and mistakes
- Ignores conflict and finds other means to achieve results
- Unclear or changing expectations
- Easily offended and holds on to resentment
- Stagnate and unwilling to change
System Design

A manager/supervisor have control over:

– Reliability of the system
  • Test for errors and mistakes
– Design systems that facilitate success
  • Safe, efficient, and effective
Behavioral Choices

A manager/supervisor control behavior:

– By creating safe systems we can influence employee behavior:
  • Coach employee around reliable behaviors
  • Recognize when remediation is appropriate
  • Discipline in support of organizational values
Learning System

A learning culture is the foundation of reliability
- Eager to understand risks
- Striving for knowledge
- Willing to investigate mistakes

Without a learning culture -
- Repeat mistakes
- Unsafe systems
- Punitive/blame
Justice and Accountability

A Just Culture is dynamic and growing

A systems approach that embodies fairness and accountability.

- Response is based on behavior not outcome.
- Investigation looks at all contributing factors.

A punitive culture
- Take action based on severity
- Someone must pay
- Hide mistakes

A blame free culture
- No accountability
- Desire for contentment over cooperation
- Never report mistakes
Core of Just Culture

• Negative events happen in every organization
• Goal is to allocating responsibility for event
  – Was it caused by system conflict
  – Was it caused by behavioral choices

All events are predictable
EMS Samples

• A paramedic gives the wrong medication. Medication packaging is different due to new vendor and looks similar to other medication packaging.

• A dispatcher provides patient information to a reporter regarding an incident involving a local celebrity.

• A medical record billers uses a condition code known it will get a claim paid even though it is not what the field crew documented as the condition code.
Outcome Bias Effects Us All

• Damages and harm must end with some recovery
  – We over react
  – We avoid “No harm, no foul”
  – We blame
  – We cast judgment

• Strive for consistency not perfection
  – Address all at risk behavior
  – Understand all system issues
  – EMS is a critical profession where mistakes may lead to death
Risk Behaviors

• We must believe that:
  – To err is human
  – To drift is human
  – Risk is everywhere
  – We must manage in support of our values
  – We are all accountable
Human Error

• Human error is inadvertently doing something other than what should have been done (a lapse, slip or mistake)

• Factors affecting human performance and reliability
  – Stress
  – Fatigue
  – Knowledge
At-Risk Behavior

• A behavior choice that increases the risk where risk is not believed to be justified

• At-risk behavior represent greatest threat to adverse events where human error is a single incident, at risk behavior is repetitive behavior

• Why does behavior occur
  – Short cuts
  – Complacency (lack risk perception)
  – Norms (it’s how it is done, “attribution”)
Reckless Behavior

- The conscious disregard of a substantial and unjustifiable risk of causing harm.

- We should expect employee to avoid reckless behavior
  - Each employee should know the expectations (policy)
  - Each employee should know the risk (harm to company: physical, administrative, or perceived)
Just Culture Algorithm

Each behavior is a breach of duty
• The duty to produce an outcome
• The duty to follow a procedural rule
• The duty to avoid unjustifiable risk or harm

What are examples for each?
EMS is a High Risk Industry

- High probability of events that cause harm
- An adverse event will cause harm

When should an investigation be initiated?
Basic Human Understanding

We expect two things:
• people to follow the rules
• equipment to work

Don’t be tempted to stop an investigation once:
• a person to blame has been identified
• a failure in the system has been recognized

Keep investigation until you can determine how to prevent another incident.
Undesirable Outcomes

A single event may include multiple undesirable outcomes:

- **Realized** - human error, rule violation, mechanical failure
- **Potential** - at risk behavior, poor system design

We should investigate outcomes we are trying to prevent from reoccurring.

Violations, human errors, and equipment failures are interesting issues, but if it is not producing an undesirable outcome, it's not worth investigating.
Model Investigation

The three models of an investigation:

- **What happened?** Interview involved employees.
- **What normally happens?** Interview and ask for demonstration by other employees.
- **What should have happen?** Do current policies and procedures influence likelihood of mishap?
Leadership Biases

Don't let biases influence response to incident.

As leaders, we naturally want to:

• Protect employees
• Defend sound policy
• Stand behind a product
The Role of Investigation

An Overview

– Everything should be reported
– Every event that has potential for an adverse outcome should be investigated

We investigate to:

– Explain the cause of human error
– Explain the cause of at-risk behavior
– Explain the cause of system failure
– Learn from our mistakes
Eliminate Biases

Eliminate biases in investigation and final report

• **Negative Descriptors:** Point fingers and place blame (poor, unreliable, inadequate...)

• **Attribution Error:** Tendency to generalize behavior or person (lazy, aggressive, always...)

• **Severity Outcome:** Bad outcome requires harsh response.
# Investigation Tool

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is/are the undesirable outcome(s)?</td>
<td></td>
</tr>
<tr>
<td>Key Staff:</td>
<td></td>
</tr>
<tr>
<td>What happened?</td>
<td></td>
</tr>
<tr>
<td>What should have happened?</td>
<td></td>
</tr>
<tr>
<td>What normally have happens?</td>
<td></td>
</tr>
</tbody>
</table>

## Timeline of Events:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>
### What causal conditions existed at time of event?

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Error</td>
</tr>
<tr>
<td>Violation of Rules</td>
</tr>
<tr>
<td>Mechanical Failure</td>
</tr>
<tr>
<td>Other causal conditions</td>
</tr>
</tbody>
</table>

### Systems Issues:

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What were the preventable factors contributing to event?</td>
<td></td>
</tr>
<tr>
<td>Indicate recommended changes to system</td>
<td></td>
</tr>
</tbody>
</table>
### Behavioral Issues:

<table>
<thead>
<tr>
<th>Employee</th>
<th>Was there a duty to act (prevent harm, follow rule, produce outcome)? What behavior existed (error, at-risk, or reckless)?</th>
<th>Outcome (console, coach, formal correction)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevent Harm:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Follow Rule:</td>
<td></td>
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<tr>
<td></td>
<td>Produce Outcome:</td>
<td></td>
</tr>
</tbody>
</table>

### Recommendations:

1. Recommendation 1:
2. Recommendation 2:

**Investigation included:**

- Copy of
- Policy review
- Discuss with

**Investigation Conclusion**

This investigation was conducted by _____. The investigation was concluded on _____.

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**JUST CULTURE**
Just Culture

5 Core Believes

• To err is human
• To drift is human
• Risk is everywhere
• We must manage in support of our values
• We are all accountable
Decision Process

Approaching Intersection

- Perceive (Red light)
- Interpret (I need to stop)
- Decide (Start slowing down)
- Act (depress brake pedal)
Outcome Choices

• Response to undesired outcome or behavior:
  – Console Human Error (Review)
    • Event: Why did the error occur?
    • Emotions: Remove shame
    • Expectations: Focus on correcting behavior
  – Coach At Risk Behavior (Replicate)
    • Raise Awareness: Why does the risk exist?
    • Reminder of Consequences: Review desired outcome and response
    • Reset Expectation: Demonstration and hands-on scenarios
  – Punish Reckless Behavior (Resolve)
    • Investigate and discipline
Key Points

• Just Culture
• Behaviors – Human error, at-risk, and reckless
• Investigation Tool – Identify key factors
• Modeling, mentoring, coaching, and counseling
The First Steps

• Appoint a Just Culture Leader
• Complete On-line Just Culture Training for EMS (Outcome Ingenuity)
• Provide Training to All Leaders
• Develop at Just Culture Policy and Investigation Process