Safety, Life and a Just Culture

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About me

- I am someone’s mother, wife, daughter, granddaughter, sister, aunt, cousin and niece.
- I am married to a physician and have a sister and niece who are nurses.
- I am educated.
- I am a good pharmacist.
- I have a story to tell you.
“Medicine used to be simple, ineffective, and relatively safe. Now it is complex, effective, and potentially dangerous”

-Sir Cyril Chantler
Boeing 747

- 450 would have to crash every year to equal medical deaths
- That’s more than ONE A DAY!
Only 44% of employees are confident they wouldn’t be punished if they reported an error.
Anyone recognize these twins?
Richard Smith – 2010, Florida
15-year old Lewis Blackman – 2000, MUSC
17-year-old Jesica – 2003, Duke
Emily Jerry – 2006, Ohio
Wikipedia says:

- Common estimates for sustained attention to a freely chosen task range from about five minutes for a two-year-old child, to a maximum of around 20 minutes in older children and adults.

Rhode Island = wrong side brain surgery (x3)
58-year old Jeanette McAllister – 1997, Florida
Is the healthcare industry alone?
California Commuter Train Wreck - 2008

25 dead

Zip line accident
Patricia – Maui, Hawaii 2014
I-35W Minneapolis bridge collapse 2007
Number of US bridges in danger of collapse:

>7,700

Source: 2013 Federal analysis
Massey Mine Explosion - 2010

29 dead

http://www.topicboss.com/topic/massey-coal-mine/

Arizona - 2014
What we all have in common

- Fallible humans and human behaviors
- Imperfect systems
- Potential for faulty equipment
- A set of values (individual and/or corporate)
Great systems everywhere (including airport bathrooms!)
...and some not so great...

IF YOU REMOVE A BODY FROM THE MORGUE, PLEASE CONTACT THE HOUSE SUPERVISOR AT #3903, #3906, #4799 or #4800. THANK YOU!!!

THIS IS VERY IMPORTANT FOR US TO LOG, DATE AND TIME
Creating a Just Culture: where do you start?
Just Culture definition

Workers trust each other, are rewarded for providing safety information, and are clear about their responsibilities regarding safe behavioral choices.

There is a *shared* accountability.
Types of behavior involved in errors

- **Human Error**: an inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake

- **At-Risk Behavior**: a behavioral choice that increases risk where risk is not recognized, or is mistakenly believed to be justified

- **Reckless Behavior**: a behavioral choice to consciously disregard a substantial and unjustifiable risk
Consoling – Human Error

- **A Conversation to Learn**

- Help by comforting the employee

- Manager also investigates the system and makes changes as appropriate

***The employee made the *mistake*, not the *choice*
Human Factors
Repetitive Human Error: Counseling

Take action:

• let the employee know that performance is unacceptable
Which way again?
Risky Business

• Do you text and drive?
It’s all about the perception of risk

Coaching at-risk behavior

• Create a learning opportunity:
  - understand their point of view
  - describe the at-risk behavior
  - explain how this behavior isn’t aligned with our values
  - create an action plan
Drinking and Driving – *clearly* Reckless

Reckless Behavior is a **conscious disregard** of a **substantial** and **unjustifiable risk**

>13,000 deaths per year
Managing reckless behavior

- Disciplinary action
- Punishment
- Punitive action

Yes, I said “punitive” !!!!!
We need a *Learning* Culture

- Learn about errors and the behavioral choices behind them
- Learn where the system is weak
- Learn why people drift
Public perception… or truth?
Investigation of Events

• Do not regard an event as “something to be fixed”
• An event is an opportunity to understand risks
  - system
  - behavioral
• Keep in mind, the system is comprised of sometimes:
  - faulty equipment
  - imperfect processes
  - fallible humans
Questions to ask

• What happened?
• What normally happens?
• What does procedure require?
• Why did it happen?
• How were you managing it?
The NICU nurse goes to the automated cabinet to retrieve heparin 1,000 units/ml for her patient. Without looking into the bin, she grabs a vial. She draws up the medication and administers it to the patient. Unbeknownst to her, the pharmacy technician had refilled the bin incorrectly with 10,000 unit/ml heparin.

Choose your own adventure:

a. The child was not harmed
b. The child suffered severe bleeding and his survival is in question
Avoid Severity Bias

- Harm vs. no harm
- How do you handle the situation?
- “no harm, no foul” doesn’t work in a Just Culture
Determine the causes

Probable Cause
- RN always got right heparin from this pocket; felt no need to read label
- RN did not read the label on drug
  (behavioral choice)

Direct Cause
- RN drew up wrong med and administered it
  (human error)
- Patient given wrong dose of heparin
  (outcome)

Why?
- Pharmacy stocked the drug incorrectly
  (cause of the human error)
Just Culture Algorithm (abbreviated)

**Step 1**
Was the error/event intentional?

- No → **Step 2**
- Yes → **Step 2**

**Step 2**
Substance abuse involved?

- No → **Step 3**
- Yes → Yes

**Step 3**
Did the employee knowingly violate a policy/procedure?

- No → Could the same event occur with another person?
- Yes → Was the person properly trained?

**Could the same event occur with another person?**

- No → Visit [www.justculture.org](http://www.justculture.org)
- Yes → Was the policy/procedure clear?

**Was the policy/procedure correct?**

- Yes → Visit [www.justculture.org](http://www.justculture.org)
- No → Visit [www.justculture.org](http://www.justculture.org)

**Was this person have a record?**

- Yes → Visit [www.justculture.org](http://www.justculture.org)
- No → Visit [www.justculture.org](http://www.justculture.org)
Find the causes

It is the *causes* of the error that give us the data we need in order to begin to work on and build risk-reduction strategies.
The sensible Health Care Plan

http://media.photobucket.com/image/wile%20e%20coyote%20health%20tip/acme_armament/wile_e_coyote_health_tip_by_dalibabe91-d4bdjh.jpg