Safety, Life and a Just Culture

NATASHA NICOL, PHARM D, FASHP
DIRECTOR OF GLOBAL PATIENT SAFETY AFFAIRS
CARDINAL HEALTH
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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.
So what does this tell us?

We are royally screwed up
Human Error Happens All The Time
Anyone recognize these twins?
Kimberly Hiatt – 2011, Seattle
Emily Jerry – 2006, Ohio
15-year old Lewis Blackman – 2000, MUSC
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
Healthcare will never be alone....
California Commuter Train Wreck - 2008

25 dead

Philadelphia Amtrak Train Wreck - 2015

8 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
Arizona - 2014
This is true also for:
2012
2013
2014
2015
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.
Poor system – *poor cat!*

Pawleys Veterinary Hospital
9722 Highway 17
Pawleys Island, SC 29585-6500

Dear **Gilmi**, this is a reminder that you are due for the following:
- 6/12/2011 Neuter - Feline
- 6/12/2011 Annual Examination

Please bring a fecal sample at the time of your appointment! Call 237-7385 to make boarding reservations with our Boarding & Day Care facility.

**1ST REMINDER**
To schedule an appointment, please call our office:
Pawleys Veterinary Hospital
843-237-1848

*----------------*AUTO**5-DIGIT 29585*
NATASHA NICOL
35 REDTAIL HAWK LOOP
PAWLEYS ISLAND SC 29585-7780

20221 000144 00000169 00049408
Poor (husband) system
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
PARIS IN THE SPRING
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
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?
Scenario

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.
Avoid Severity Bias

Harm vs. no harm

“no harm, no foul” doesn’t work in a Just Culture
RN always got right heparin from this pocket; felt no need to read label

RN did not read the label on drug

RN drew up wrong med and administered it

Patient given wrong dose of heparin

Why?

Pharmacy stocked the drug incorrectly

Probable Cause

Direct Cause

(cause of the behavioral choice)

(behavioral choice)

(human error)

(outcome)

(cause of the human error)
Just Culture Algorithm (abbreviated)

Step 1
Was the error/event intentional?
- Yes
- No

Was the harm intentional?
- Yes
  - Contact HR, Risk Management
  - May need to contact authorities
- No

Step 2
Substance abuse involved?
- Yes
- No

Did the employee knowingly violate a policy/procedure?
- Yes
  - Contact HR, Risk Management
  - May need to contact authorities
- No

Step 3
Could the same event occur with another person?
- Yes
- No

Could the same event occur with another person?
- Yes
- No

Was the person properly trained?
- Yes
  - Was the policy/procedure clear?
  - Was the policy/procedure correct?
  - Does this person have a record?
- No
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

If you can't afford a doctor, go to an airport - you'll get a free x-ray and a breast exam, and; if you mention Al Qaeda, you'll get a free colonoscopy.