A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents
It could happen anywhere......

https://improvement.nhs.uk/resources/patient-safety-review-and-response-reports/
Ultra-safe (uniformity + reliability)

Ultra-safe

Adaptive

Ultra-adaptive

Adaptive

Ultra-safe

Adaptive

Ultra-adaptive
Ultra-safe

Adaptive

Ultra-adaptive

(hercic)
Examples from your area of healthcare?

Ultra-safe

Adaptive

Ultra-adaptive
ERROR TYPES – based on the work of James Reason

Rule-based mistake = Following-the-wrong-rule
Knowledge-based mistake = Not-having-the-knowledge
Violation = Knowingly breaking a rule

Intended actions → Mistakes → Violations

Unsafe acts

Unintended actions → Slips & Lapses → Skill based errors

Rule-based errors = Following-the-wrong-rule
Knowledge-based errors = Not-having-the-knowledge
Violation = Knowingly breaking a rule

Routine
Reasoned
Reckless
Malicious

Skill based errors
Memory or attention failures
Reckless in the eyes of your peers?
People within systems – an example of how we use this thinking in alerts
Is it a good match?

True =

1. Education session to prevent a slip or lapse
2. Checklist to prevent a slip or lapse
3. Taking lunch breaks to prevent a slip or lapse
4. Education session to prevent a don’t-have-the-knowledge-mistake
5. Consultant review to detect a don’t-have-the-knowledge-mistake
6. Direct supervision to prevent a reckless violation
Medical error

How to avoid it all going wrong and what to do if it does

Police Line Do Not Cross

Patient Safety Alert

Resources to support safer modification of food and drink

27 June 2018

Actions

Who are responsible for the safety of food served to patients?

- Doctors
- Nurses
- Midwives
- Hospital managers
- Dietitians

What is good practice and what can be done to ensure it happens?

- Label food with the date it was received
- Use food labelling software
- Use separate noon-time areas
- Use separate utensils
- Use separate trolleys
- Use separate refrigeration units

What should be done if a patient has been harmed?

- Report the incident
- Review the process
- Implement changes

This is a Joint Patient Safety Alert from BDA and Patient Safety
Improvement Group, with support from NHS Improvement

See page 10 for references. Consultation engagement and action on the joint patient safety alert should be directed to:

BDA Head Office 020 7428 2500

Patient Safety Improvement Group

See bda.org/patient-safety
I am truly sorry – I care, we all care – sometimes we fall short of what we intend to achieve.
NG placed [date, time]. No stomach aspirate, therefore CXR requested. Reviewed by ward doctor. Verbal confirmation of correct position and feed started. Reviewed on ward round following morning, drop in oxygen saturations, increased MEWS from 6-9…….CXR requested. CXR showed NG tube in right main bronchus.

Doctor in question recognised error and [has had] discussion with clinical supervisor, educational supervisor informed. Advised [to undertake] training and reflection.
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We know response to an incident is only one small part of a just culture.
‘A’ just culture guide – part of wider focus

• Professor Sir Norman Williams review

• Dame Clare Marx on the GMC commissioned review of gross negligence manslaughter

• Just culture ‘taskforce’

• ‘Basket’ of just culture items led to the title
What we changed, how, and why

- Our evaluation highlighted how human factors terms were commonly misinterpreted. e.g. ‘unacceptable risk’; ‘systems’
- Iterative testing of changes with frontline users
- Eliminating redundant steps from the original model and simplifying the flow
- Update and future proof recommendations
A just culture guide
Formally endorsed by…

...and supported by many more
Why we are sticking with the James Reason model….

<table>
<thead>
<tr>
<th>Questions</th>
<th>Our thoughts</th>
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| Why base the model on James Reason?                | • Greater experience / evidence-base available  
• Better prospects of cross system support  
• With this update, avoids common pitfalls that creep into other versions (e.g. two strikes you’re out, protocol violation from industries where it is exceptional, or technical human factors lingo)  
• Others are welcome to experiment but should be mindful of unintended consequences |
| Is there a risk that JCG creates undue focus on individuals? | • A JCG should not be used every time an incident occurs—it should only be used when there is already some suspicion that a member of staff requires some management to work safely.  
• A patient safety investigation should always ask what went wrong, not who is at fault. A just culture guide is not a replacement for a patient safety investigation  
• There will be times when an even an open and honest individual does require some unique action to work safely and a JCG helps ensure that process happens fairly.  
• Organisations using the IDT have reported reduced suspensions and have found the tool helpful to challenge unconscious bias |
A video that pulls it all together

https://www.youtube.com/watch?v=zje765OEggs
Group work: setting the scene

Scenarios based on real incidents (combined, fictionalised) and shaped towards what the NHS told us was most challenging:

• Not just clinical staff close to the incident but actions by others in the weeks or months before
• Linking back to organisational systems for safety that should have been in place
• Expecting old heads on young shoulders
• Staff who are not ‘bad’ but are not like their peers in terms of ability to acquire knowledge and skills or atypical in their attitude
• Misplaced focus on consequence, not behaviour
• Repentance ≠ certainty it won’t happen again
• Teams/units with a different custom and practice
Group work: over to you

• Split into SMALL groups (ideally three people)
• Pick one of the four scenarios
• Read the instructions on the JCG – especially the need to take one action (or inaction) by one person through the JCG at a time
• Repeat for more inactions/people/scenarios as long as time allows
• Discuss not only if it would make you/your teams think differently about the individual* – but whether it would make you/your teams think differently about wider investigation and action plan

* or be able to articulate your existing wisdom more clearly

No need to capture notes
Next steps and sharing your experience

If you are using (or will now use) *A just culture guide*, we want to learn from you!

- How have organisations brought it into use?
- How has it helped (examples appreciated)?
- Can you help us to reach more audiences – do you have communication routes that you’d like us to contribute to?
- Would you like to be involved in supporting future iterations?
- Any further questions we didn’t have time to answer?

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