A just culture guide

‘Thinking differently’ event

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It could happen anywhere......
Ultra-safe (uniformity + reliability)

Ultra-safe

Adaptive

Ultra-adaptive
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

Violations

Routine
Reasoned
Reckless
Malicious

Rule based errors

Knowledge based errors

Unintended actions

Mistakes

Skill based errors
Memory or attention failures

Unsafe acts

Slips & Lapses
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

National Patient Safety Agency

Dangers in the medical term for making mistakes. Medical mistakes can lead to injury and death. To avoid mistakes, doctors and nurses must follow procedures. If you are a caregiver, you must be aware of the potential for mistakes and take steps to prevent them. This includes following protocols, using the right equipment, and being attentive to details. It is important to report any errors that you witness or are aware of. This can help to prevent similar errors from occurring in the future.
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.
A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents
A reporting and learning culture journey

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

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

**Recommendation:** Follow organisational guidance for appropriate management action. This could involve contacting relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual.

No go to next question - Q2. health test

2a. Are there indications of substance abuse?

**Recommendation:** Follow organisational guidance at work guidance. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual.

2b. Are there indications of physical ill health?

**Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health reviews. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual.

2c. Are there indications of mental ill health?

**Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health reviews. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual.

If No to all go to next question - Q3. foresight test

3a. Are there agreed protocols/accepted practice in place that apply to the actions/omission in question?

**Recommendation:** Action(s) taken out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual.

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

If Yes to all go to next question - Q4. substitution test

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

**Recommendation:** Action(s) taken out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual.

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

If No to all go to next question - Q5. mitigating circumstances

5a. Were there any significant mitigating circumstances?

**Recommendation:** Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff supervision and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients.

improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency’s Incident Decision Tree

Supported by:
- Academy of Medical Royal Colleges
- CQC
- General Medical Council
- Nursing and Midwifery Council
- NHS
- National Audit Office
Formally endorsed by…

...and supported by many more
### Questions

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<thead>
<tr>
<th>Our thoughts</th>
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<tr>
<td><strong>Why base the model on James Reason?</strong></td>
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<tr>
<td>• Greater experience / evidence-base available</td>
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<td>• Better prospects of cross system support</td>
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<td>• 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)</td>
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<td>• Others are welcome to experiment but should be mindful of unintended consequences</td>
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<td><strong>Is there a risk that JCG creates undue focus on individuals?</strong></td>
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<td>• 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.</td>
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<td>• 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</td>
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<td>• 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.</td>
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<td>• Organisations using the IDT have reported reduced suspensions and have found the tool helpful to challenge unconscious bias</td>
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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
• 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)?
- Would you like to be involved in supporting future iterations?
- Any further questions we didn’t have time to answer?
- Further resources under development (including insights from trusts with best staff survey scores for fair and effective response to incidents)

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