



Transforming a Culture of Blame to a Culture of Safety

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Objectives



- Discuss the benefits and pitfalls of punitive actions
- Identify the elements of Just Culture
- Apply the Just Culture paradigm to a variety of scenarios
- Utilize a Culture of Safety when responding to medical errors.

Aviation Background Information



- What happens in the cockpit stays in the cockpit
- Pilots began reporting incidents to NASA with limited immunity under strict provisions
- Valuable data was obtained on near-misses

Healthcare Background Information



- The Institute of Medicine (IOM) study “To Err is Human; Building a Safer Healthcare System”
- HHS study finds a high rate of Medicare patient deaths due to adverse events (AE)



Just Culture

An environment of trust and fairness where it is safe to report and learn from mistakes and system flaws to assure safety; where consistent clarity exists between human error in unreliable systems and intentional unsafe acts; the foundation for a thriving healthcare culture

Just Culture



Human
Error

Console

At-Risk
Behavior

Coach

Reckless
Behavior

Punitive

Just Culture

Human Error



- Humanity along with systemic flaws cause errors.
- How do we correct this?
 - Evaluate Policies & Procedures
 - Evaluate the environment
 - Evaluate training

Just Culture

At-Risk Behavior



- A choice that is perceived to be associated with an insignificant risk or justified purpose.
- How do we correct this?
 - Reduce incentive for the behavior
 - Increase incentive for healthy behavior
 - Increase situational awareness

Situational Awareness



WAIT FOR IT

.....Wait for it.....

Just Culture

Reckless Behavior



- Conscious disregard of policy and /or procedure regardless of risk.
- How do we correct this?
 - Remediation
 - Punitive action

Just Culture

Midazol-oops

A patient is being sedated for an endoscopy. The physician elects to administer 4 mg of Versed. The nurse administers it and the patient has no effects. The physician requests 8 additional mg of Versed and the patient informs you that there is no change.

Just Culture

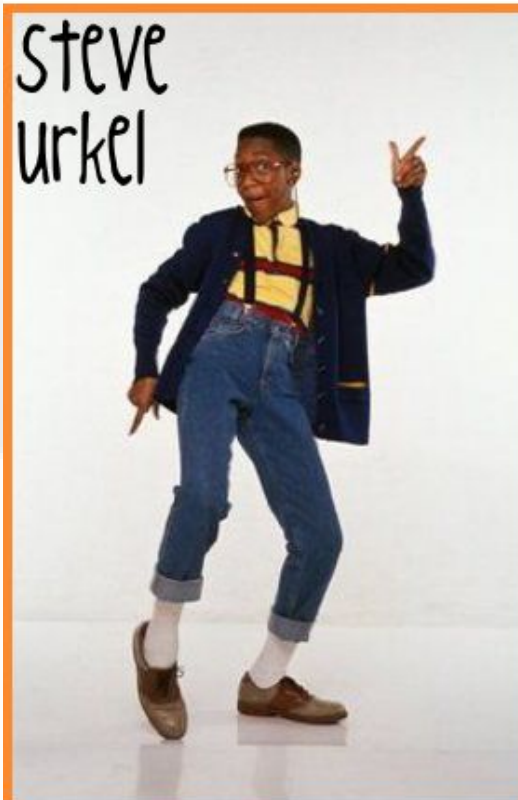
Midazolam



The physician has advised the nurse to administer a total of 22 mg of versed for a conscious sedation. The patient asks the nurse if the clamp is suppose to be on. The nurse says no and promptly opens the clamp.

Just Culture

Midazi-oops



"Did I
do
that?"



Just Culture

Check-Off Issue



A paramedic is transporting a patient on a ventilator from a critical access hospital to a regional medical center with ICU capabilities. The paramedic did the truck check-off at the beginning of the shift and there was 400 PSI of oxygen in the main tank. State regulations require 500 PSI.

Just Culture

Check-Off Issue



The transport is 1 hour and 20 minutes. The patient will be ventilated at 100 % with a rate of 14 and a tidal volume of 700 ml. About 45 minutes into the transport, the oxygen tank is depleting rapidly. The paramedic reduces the tidal volume to 600 and the rate to 12. The paramedic was able to make the transport

Just Culture

Check-Off Issue



**CAN'T SOMEONE ELSE
JUST DO IT?**

Just Culture

Self Reporting



Just Culture



- By creating an environment where providers can report errors, we can obtain data about our system
- Reliable data can help promote systemic change.
- However, punitive actions may need to be enacted depending on the situation



THANK YOU!