Just culture in healthcare

Prof. Suzette Woodward

population

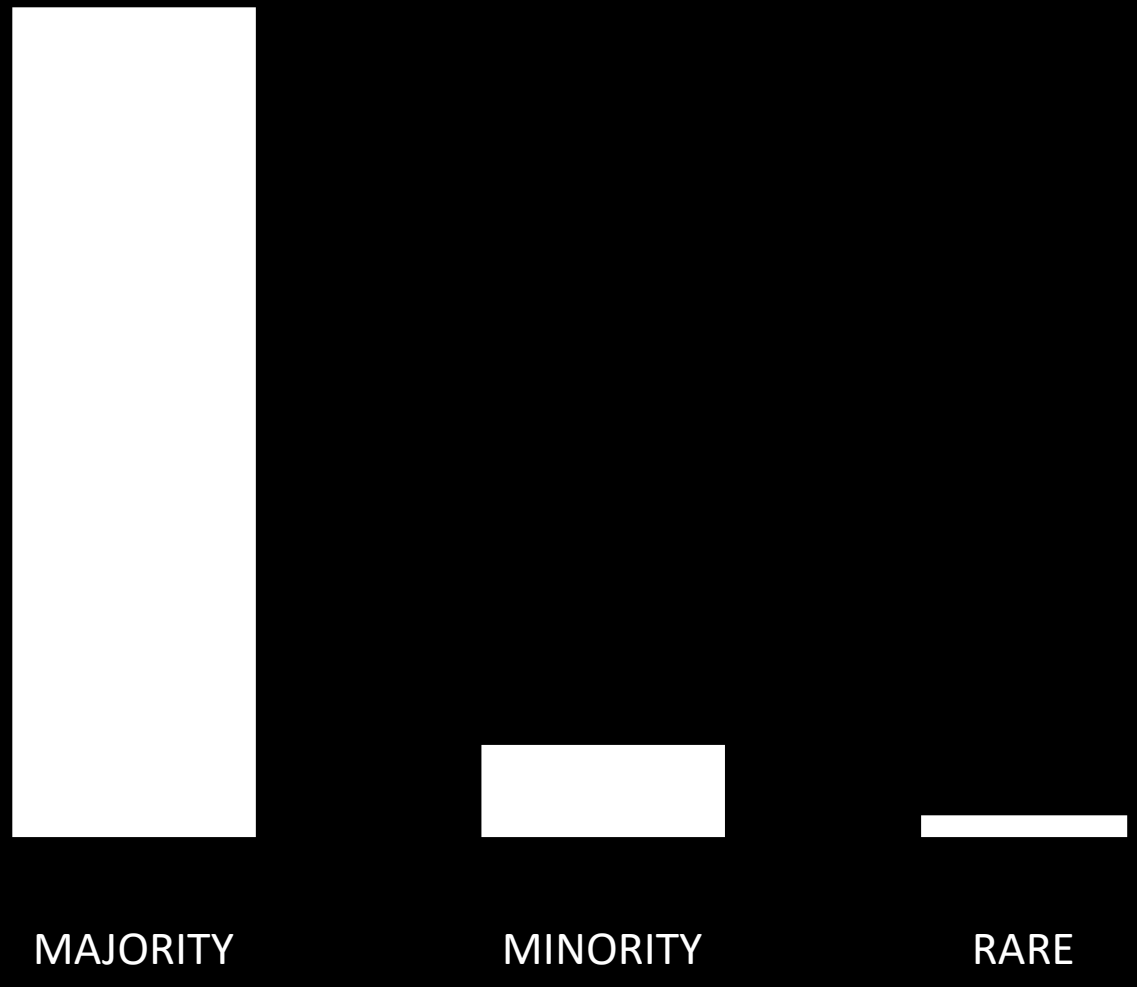
NHS 1.3 million

Copenhagen 1.3 million

Dublin 1.2 million

Cologne 1.1 million

Oslo 1 million


MAJORITY
MINORITY
RARE


MISTAKES
POOR PERFORMANCE – LACK OF DUTY OF CARE
CRIMINAL INTENT


SUPPORT AND LEARN
MANAGE AND POSSIBLE SANCTION
REFER TO EXTERNAL BODIES E.G. POLICE

Human beings

“The single greatest impediment to error prevention is that we punish people for making mistakes”

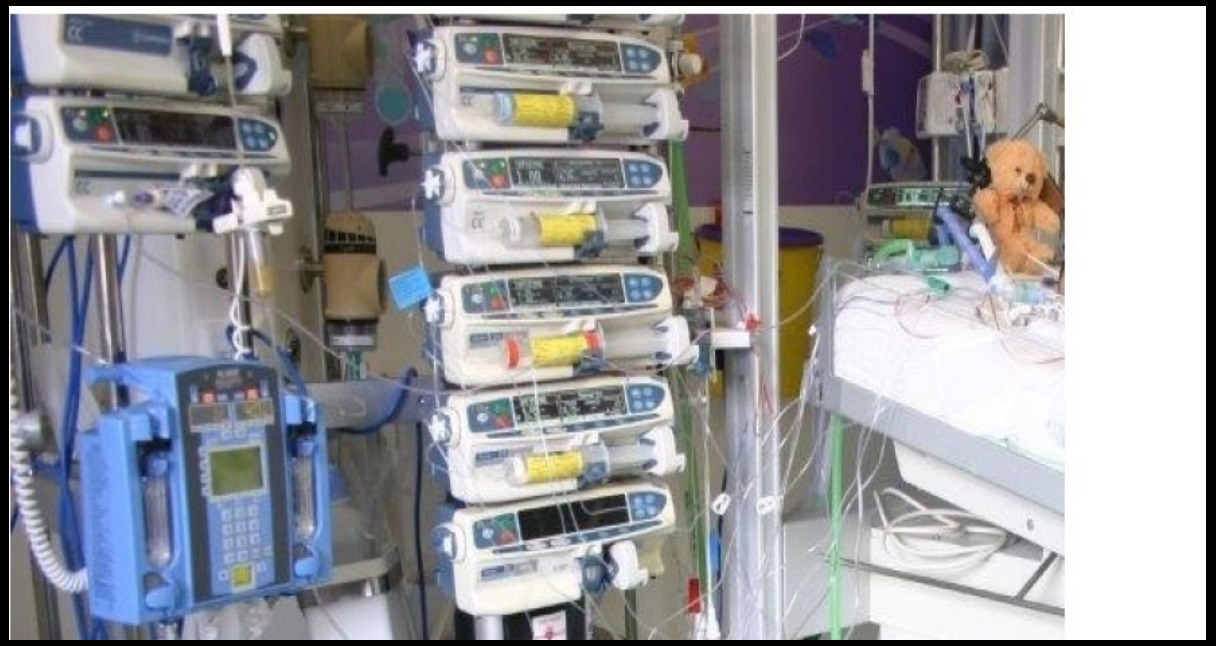
Dr Lucian Leape

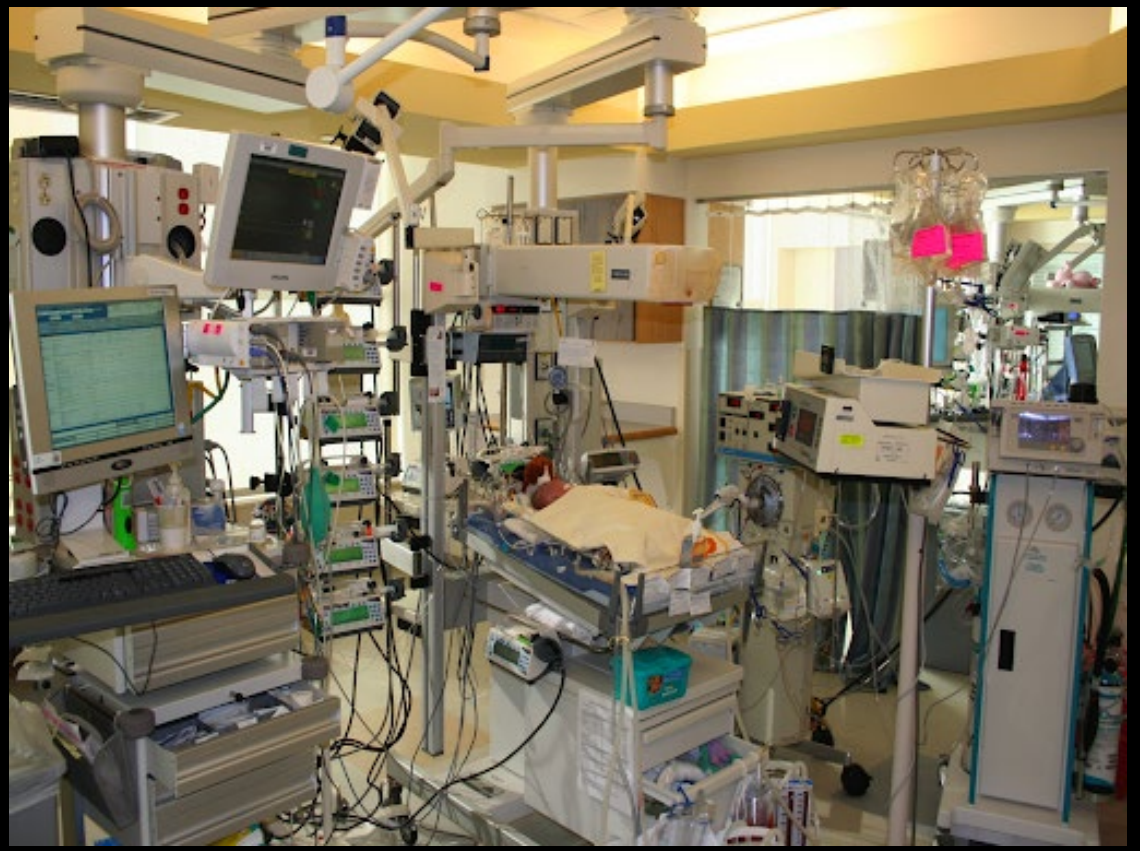
Night 3

10 x

- Personalization: thinking that the event is all your fault
- Pervasiveness: thinking that the event is going to ruin every aspect of your life
- Permanence: thinking you are going to feel this bad forever

BY LIZ FOSSLIEN AND MOLLIE WEST DUFFY



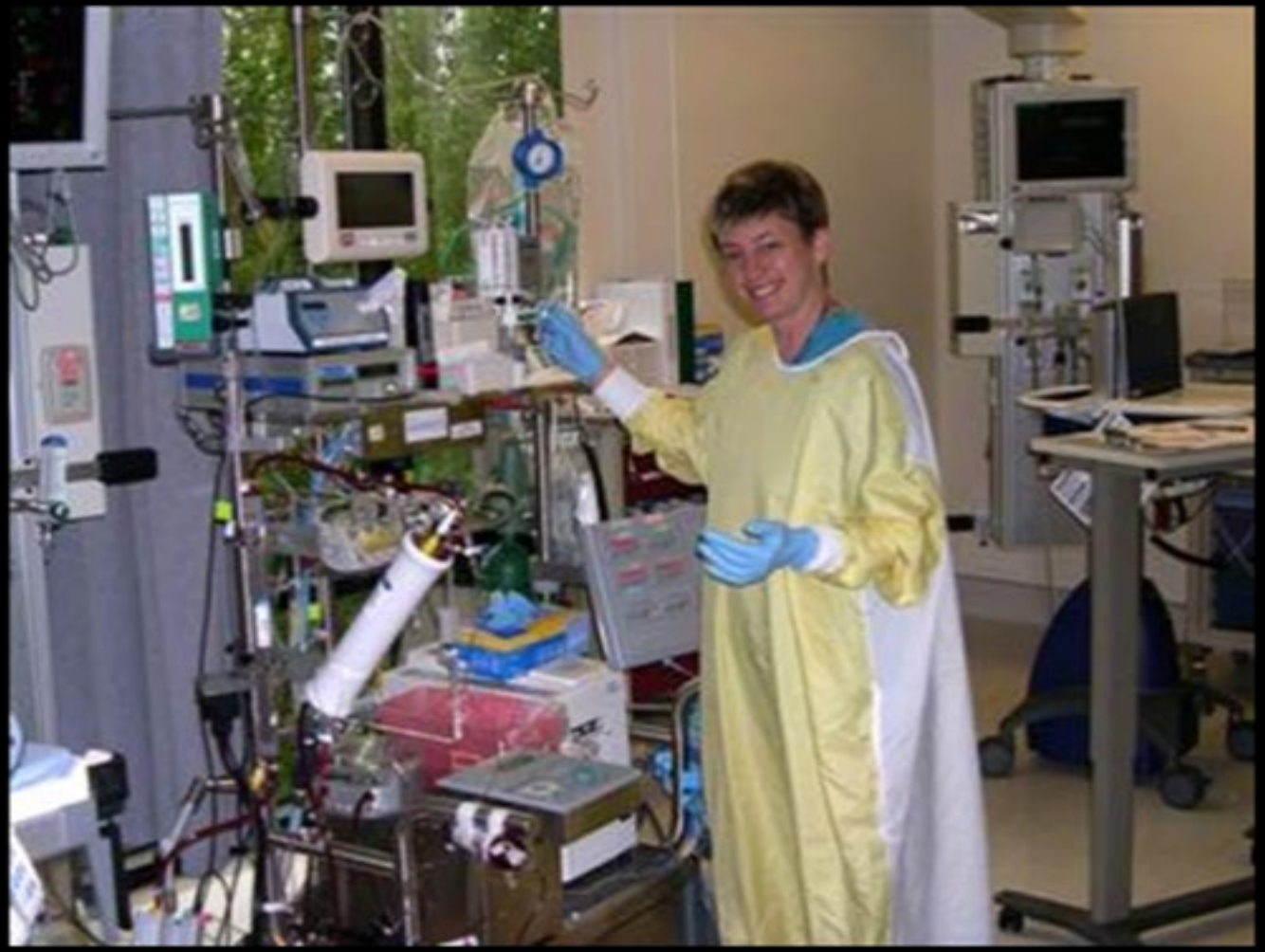


I've given thousands of drugs to thousands of patients

I was distracted constantly

I miscalculated the dose or pressed the wrong decimal point

I will be more careful in the future



I messed up, I've been giving calcium chloride for years

I was talking to someone while drawing it up

I miscalculated in my head

I will be more careful in the future

40 years

When something has gone wrong ..

- It is probably true to say it has gone right many times before
- And that it will go right many times in the future
- Yet people are judged by one error or incident for the rest of their careers
- This is at the heart of a poor safety culture - we need to urgently change this – the following is how we might go about doing that

How many of us would survive the microscopic scrutiny of our actions?

There is almost no human action or decision that cannot be made to look more flawed and less sensible

To achieve a just culture we need to pay attention to

Incivility and bullying	Psychological safety	Equality and inclusivity
Kindness and justice	Accountability and responsibility	Response and restoration

5 things every one wants

1. To be listened to and heard
2. To be involved and informed
3. To learn
4. To move from a retributive to a restorative culture
5. To truly care for all the people caught up in incidents

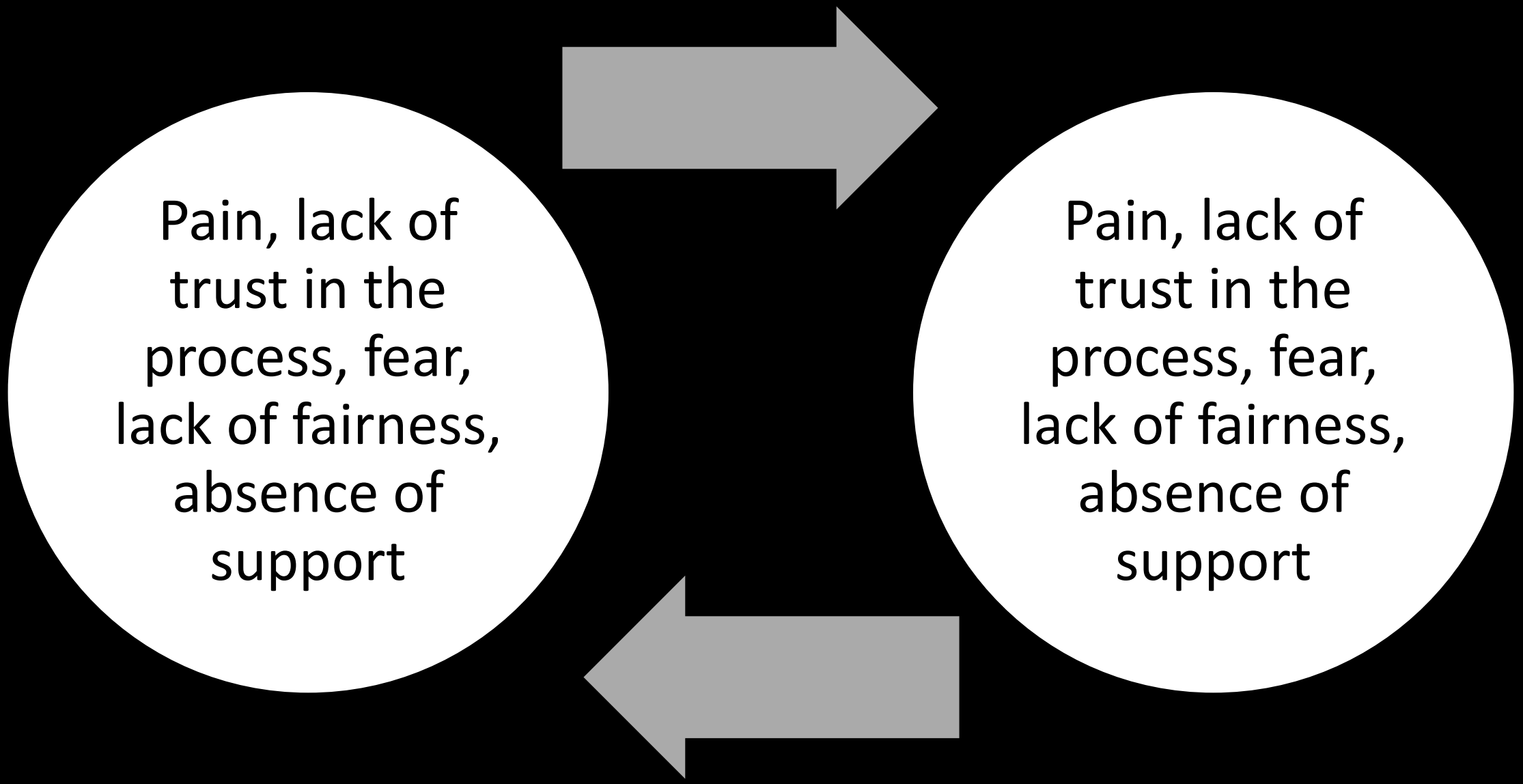
1

To be listened to and heard

- Its not the responsibility for the person to speak up
- Its everyone's responsibility to make the space and opportunity to make that happen
- Listening should start as soon as possible
- Build trust and confidence in the people and the process

2

To be involved and informed


Pain, lack of trust in the process, fear, lack of fairness, absence of support
Pain, lack of trust in the process, fear, lack of fairness, absence of support

Harmed Patients Alliance

3

To learn

Root cause analysis

- Undertaken by people who are not trained in RCA
- Causes more harm than good
- Forced to write in short points so struggle to describe complexity
- Pressured to come up with recommendations in a short period of time
- Default recommendations ‘pay attention to human factors’, ‘communicate better’ etc

4

To move from a retributive to restorative culture

- Everyone is doing the right thing from their perspective
- They don’t intend to do the wrong thing
- Need to understand what it is that makes them do what they do, or did what they did

5

To truly care for all the people caught up in incidents

- Humans will never be perfect
- Systems will never be perfect
- The best people can make the worst mistake

Care for the people that care

Just culture in healthcare

Question time