Developing Just Culture in the Radiology Department

By Jim Lipcamon [4]

A culture of patient safety and fewer medical errors.

Editor's Note: An earlier version of this article did not attribute the Just Culture model appropriately. The Just Culture methodology was developed by David Marx and Outcome Engenuity. The article has been corrected.

In a New York Times blog, Nicholas Bakalar wrote that it is estimated that medical errors may cause over 250,000 deaths per year; a staggering number. In fact, if medical errors were considered a disease, they would be the third leading cause of death in the United States, behind only heart disease and cancer. In an effort to improve patient safety, organizations are introducing “Just Culture.” Just Culture encourages self-reporting so that systems that cause errors can be fixed; yet holds people accountable for behaviors. The Just Culture methodology was developed by David Marx and Outcome Engenuity.

Just Culture is the balance between human and system accountability and is a hot topic in patient safety and for the reduction of medical errors. In order for a facility to learn how to prevent medical errors from occurring, the reporting of events by staff is important and necessary. The goal of the Just Culture approach is to improve patient safety in an environment where people are able to report errors or near misses without fear, and create collaboration among employees to seek out solutions to safety issues. In the Just Culture model there are three behaviors that lead to errors:
1. Human Error: Inadvertent action, slip, lapse, or mistake.
2. At-risk Behavior: Behavior that increases risk where risk is not recognized or believed to be justified.
3. Reckless Behavior: A behavior choice to consciously disregard a substantial and unjustifiable risk.

An example of this would be complete disregard of doing a time out during a CT-guided biopsy of a kidney to save time and the wrong kidney was biopsied.

How should the manager or director handle these behaviors and hold staff accountable when the behavior occurs?
Human Error: Console staff who have made an honest mistake. Look at making changes in the process and procedure. Evaluate training and design.
At-risk Behavior: Coach people to recognize the real risk. Focus on removing incentives for at-risk behaviors. Create incentives for healthy behaviors. Increase situational awareness.
Reckless Behavior: Punish the behavior choice to consciously disregard a substantial and unjustifiable risk of harm. Implement remedial and punitive action.

We realize how important safety is in the medical industry so how do we move to a Just Culture in which there is encouragement of reporting adverse events and near misses, yet still hold people and organizations accountable? The organization must be able to distinguish between a system that might create risks, human error which may result in a bad outcome, and reckless behavior that
intentionally disregards safety systems and puts lives or organizations at risk. In addition, it's critical to:

- Understand you cannot hide failure. Remove secrecy and be transparent so the department can learn from medical errors.
- Shift from looking at errors as individual breakdowns to errors caused by system failures and evaluate the process.
- Create an environment that is not punitive.
- Get front line staff involved with system failures and collaborate with the appropriate departments.

The facility I work at has put a great deal of emphasis on Just Culture since the beginning of the year. Just Culture reforms the understanding of accountability, the role of systems, and the role of human behavior, allowing facilities to distinguish human behaviors that help management attain a consistent way to establish a safe environment by managing the system and the behavior. In addition, we are creating an environment of transparency and it is understood that you cannot hide failure and take the opportunity to learn from system failure and improve the processes that caused it.

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