

Utilizing Just Culture Methodology to Improve Patient Safety and Physician Wellbeing

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Idea

Using the Just Culture methodology to analyze and solve issues effecting residents, improving patient safety, and promoting resident well-being.

Rational

Medical errors are one of the leading causes of morbidity and mortality in hospitals throughout the US today. A strong focus on the reporting of unexpected clinical events and “near misses” and the development of a strong patient safety focused culture are critical to achieving the goal of safer patient care. Developing a culture that recognizes human errors and behavioral choices as possible system failures that require investigation and evaluation is essential.

Just Culture is a methodology derived from industries which rely on high reliability and safety that uses algorithms to attribute the root cause of a critical event to either human error, at risk behaviors, or reckless behaviors. With the root cause identified, Just Culture produces actionable outcomes appropriate to the underlying cause. Applied to direct patient care settings, Just Culture allows for process improvement and overall system changes rather than focusing on punishing individuals. Residents participate in a longitudinal curriculum that focuses on accountability amongst all health care team members for behavioral choices, learning how to apply limited resources to minimize risk of harm in multiple settings. Acceptance of the concepts of human fallibility within a residency program creates a new mindset to promote professionalism as a value.

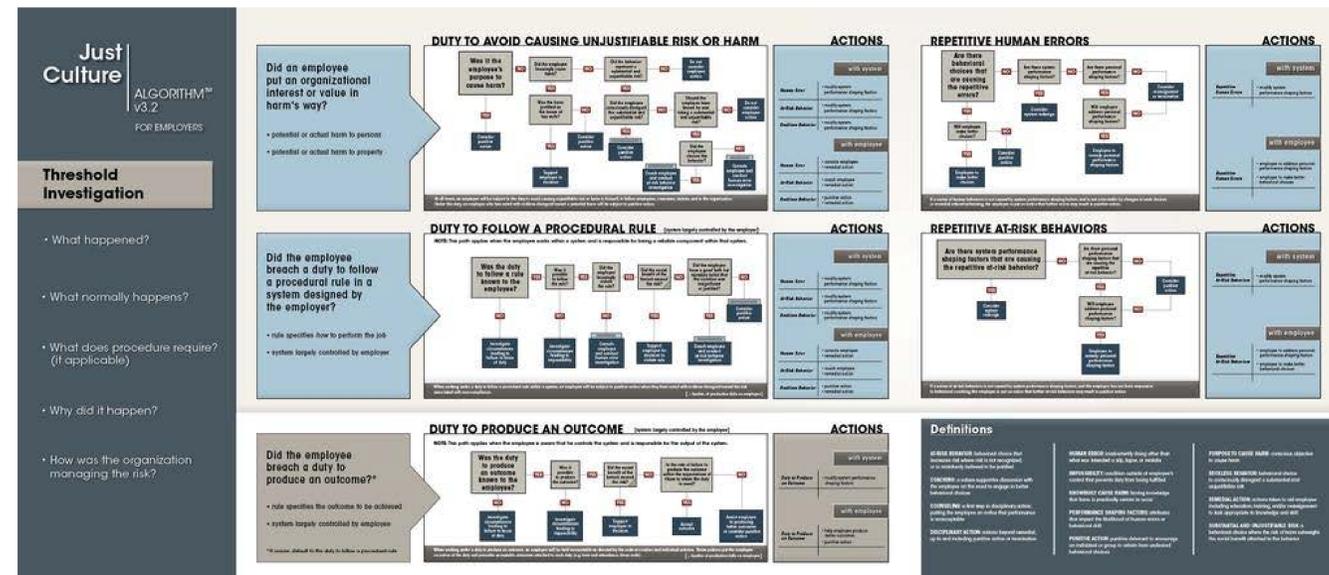


Methods

Residents are given expanded training in the Just Culture (JC) model from the Chief Patient Safety Officer and DIO. A “Just Culture Committee” of residents from all levels of training was created to apply the JC model to resident related issues, identify root causes and propose solutions. All team members are encouraged to bring forward topics for discussion during monthly meetings. The residents identify a JC champion annually who leads the committee. JC methodology is used to address five fundamental questions:

- What happened?
- What normally happens?
- What does procedure require?
- Why did it happen?
- How are we managing it?

Each case then is moved through a series of JC algorithms, which guide the conversation toward a root cause. A determination is made as to whether the event in question was a failure at an organization level, if it represents human error, or if the individual’s behavior was at risk or reckless.



The Three Behaviors



Action plans include proposing changes to policies and procedures, recommending individual coaching, remediation, or other appropriate disciplinary actions. Punishment is reserved for reckless behavior and/or repetitive errors or repetitive at risk behaviors that cannot be controlled or managed by other means. These plans are then sent to the Program Director, who considers the committee’s recommendations in making final decisions on situations affecting residents and residency program concerns.

Outcomes and Evaluation

Our goal in implementing the Just Culture Committee is to improve patient safety and build team cohesiveness by empowering all team members to voice their concerns in real time. Examples of changes made to the residency program include:

- Using a systematic approach, JC committee modified the existing resident care teams to improve patient continuity as well as workflow in the resident run clinic using input from residents, staff, and attending physicians.
- Previous resident delinquencies have been presented in JC committee before being given to the program director. This approach allows the committee to identify at risk behavior as well as systematic flaws.

In examining process and procedural improvements through the application of this model, we can gather data to compare previous rates of preventable adverse events. Thus, we can understand if the changes made by the team improve patient outcomes or increase patient safety. We also aim to evaluate the effect the process has on resident’s feeling of wellness related to patient safety and challenging decisions.

Impact

We ultimately seek to empower our residents to champion cultures of safety in their future positions. Directly applying the Just Culture model as part of their training provides a framework for doing so. Ultimately, this model can lead to enhanced patient outcomes, and improved physician wellbeing.

References:

- Boysen PG. Just culture: a foundation for balanced accountability and patient safety. *Ochsner J.* 2013;13(3):400-6.
- Frankel AS, Leonard MW, Denham CR. Fair and just culture, team behavior, and leadership engagement: The tools to achieve high reliability. *Health Serv Res.* 2006;41(4 Pt 2):1690-709.

