Creating and Maintaining a Just Culture in Your Program

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WRMC 2020

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What is “Just Culture”

- **Exceptional**
  - Going above and beyond expectations
  - Yes
  - Recognise

- **Human Error**
  - Making an honest mistake, slip or lapse
  - Yes
  - Support

- **At Risk**
  - Violating procedures due to what’s perceived as a justifiable risk
  - Yes
  - Train & Coach

- **Reckless**
  - Taking shortcuts for personal gain
  - Taking reckless action without regard for consequences
  - Yes
  - Discipline
# Another Look

## To Err is Human...

<table>
<thead>
<tr>
<th>Human Error</th>
<th>At-Risk Behavior</th>
<th>Reckless Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Product of our current system design</strong>&lt;br&gt;“I forgot to do the 2-hour check”</td>
<td><strong>A Choice: Risk believed insignificant or justified</strong>&lt;br&gt;“I did a one person transfer with a resident who requires a two-person transfer because the resident needed to use the bathroom and everyone else was busy”</td>
<td><strong>Conscious disregard of unjustifiable risk</strong>&lt;br&gt;“I knowingly avoided completing a treatment because it is complex and time-consuming”</td>
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Manage through changes in:
- Processes
- Procedures
- Training
- Design
- Environment

Manage through:
- Removing incentives for at-risk behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

Manage through:
- Remedial action
- Disciplinary action

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**CONSOLE**

**COACH**

**PUNISH**

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Why is this relevant to our field?

Humans make mistakes, lapses occur, situations are dynamic...

No human is infallible*

*(sorry to be the bearer of bad news)*
Blame (Shame) Culture

- Finger pointing
- Someone must be held responsible
- Limits Learning
- Increases likelihood of errors
- Decreases opportunity for self reporting
- Decreases likelihood of near miss reporting
Side by Side Comparison

**Blaming**
- Fault-finding
- Focus on individual
- Ask “Who?”
- Zero in on function
- Make assumptions
- Blame
- Control
- Inspect/sort

**Non-blaming**
- Fact-finding
- Focus on process
- Ask “Why?”
- Look for systems issues
- Determine needs
- Hold accountable
- Assist
- Improve capability
Why adopt a “Just Culture”? …The data supports it.

Tenerife airport disaster 1977, 583 fatalities

40 years after CRM (Crew Resource Management)
5 year fatality rate of .24/million flights

The substitution of potassium for sodium chloride resulted in the unexpected deaths of two ICU patients.
Near Miss and Incident Reporting
Post Program Evaluation
Review Process
Pause/Reflect

Think about your own organization:

• Where do you think your program lies between Blame and Just Culture? Why?

• What do you currently do that supports a Just Culture?

• What else could you do to support a Just Culture?
Breakout Scenario Part 1

You learn that one of your staff provided a gift to a 14 year old participant in your program. You learn this when you receive a call from an angry parent that their daughter was given a playlist of music that was shared via text, and this parent finds this behavior questionable and thinks your instructor was behaving inappropriately with their child. The mother says all of the songs have romantic undertones. They want them terminated and they have contacted law enforcement.

How do you proceed and if this happened in your program what would you do?

Discuss in your breakout room for 5-10 minutes.
Breakout Scenario Part 2

From talking with the staff member, you learn an activity was set up to reward participation and effort during the program. The staff in question offered up a playlist of their favorite songs to whomever completed the most educational challenges. The staff member was aghast when they learned of the parent’s accusation.

What now?

How do you train on this?

What possible systems changes could you make?

Discuss in a small group of 5 for 5-10 minutes.
How do you go about creating and/or maintaining a Just Culture?

- Check the pulse: Send out a survey to staff
- Introduce Just Culture----assets and resources
- Examine Existing Practices for incident review
- Review your metrics
Next Steps

• What are 3 actions you can do to change or maintain your current culture?

• Take the time to write them down.
Sources and References

• Sidney Dekker https://sidneydekker.com/
• https://omny.fm/shows/rethinking-safety/episode-4
Thanks!

Questions?

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