OR managers and their hospitals must create a culture where the staff is willing to come forward with information about errors so everyone can learn from mistakes. But the culture must also recognize the need for accountability and, in some cases, disciplinary action.

That is a “just culture” that improves patient safety, according to David Marx, JD. “We need to find a middle ground between ‘home-free’ and a punitive environment,” he says, “separating behavior from choices.”

Marx will speak on “The Role of an Open, Fair, and Just Culture” in a general session at 8 am, Thursday, Oct 4, at the Managing Today’s OR Suite Conference in San Diego. He is president of Outcome Engineering, LLC, Plano, Texas. Marx is author of Patient Safety and the ‘Just Culture’: A Primer for Health Care Executives (Columbia University, 2001). With a background in both aerospace engineering and law, he started a research and consulting practice in 1997 focusing on the management of human error through the integration of systems engineering, human factors, and the law.

He has been an advisor on patient safety to the Agency for Healthcare Research and Quality.

A just culture, he says, recognizes that competent professionals make mistakes and drift into shortcuts or what seem to be “routine” rule violations, but a just culture has zero tolerance for reckless behavior.

Marx has developed a Just Culture Algorithm that he says can apply as easily to parenting and coaching as to an OR suite. The basic principle is that when mistakes happen, responsibility rests with both the system and the choices of individuals within that system. There is shared accountability between the humans operating within the system and those who designed the system.

“Of course, human error will occur,” he says. “But that is not where the inquiry stops.”

Humans will also make choices—“at-risk” choices where they believe they are in a safe place, and reckless choices where they know they are taking unjustifiable risks.

“In the OR environment,” he continues, “the system will take care of the outcome if individuals make the right choices.”

Avoiding ‘drift’

The importance of avoiding ‘drift’ from compliance cannot be overstated, Marx says. “We find people often are getting lax about timeouts (referring to the pause before surgery to verify the surgical site). They make their choices based on the idea that they’ve had a lot of cases without an error, so they don’t need that timeout any more—and that’s when a mistake happens,” he said. “They think the system is fail-safe and don’t realize that the timeout is their contribution to that system.

“We look at the event, determine the system’s contribution and the individuals’ contributions, and then decide how the facility will deal with it,” Marx says. “The challenge is to create a culture where a professional can report an error, knowing he or she will be held accountable for individual choices but not scapegoated.

“How do we build a good system around knowingly fallible employees? One way is to follow the Just Culture tools, very prescriptive tools that separate error from at-risk or reckless behaviors.”
Starting this month, the Just Culture Community website (www.justculture.org) will provide free access to newsletters, forums, and special messages. The algorithm can be purchased separately or as part of the Just Culture Training for Healthcare Managers training package. The training package allows each manager to use the workbook in online as well as instructor-led training.

At his Managing Today’s OR Suite session, Marx will speak in general about Just Culture concepts and the algorithm. He said attendees will leave with an understanding of the 3 behaviors and 3 duties of a just culture.