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Healthcare's just culture journey:

a long and winding road

Martin Bromiley OBE

Chair, Clinical Human Factors Group

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Healthcare's just culture journey:

Part 1 - Exploring the culture by looking at the symptoms of the culture

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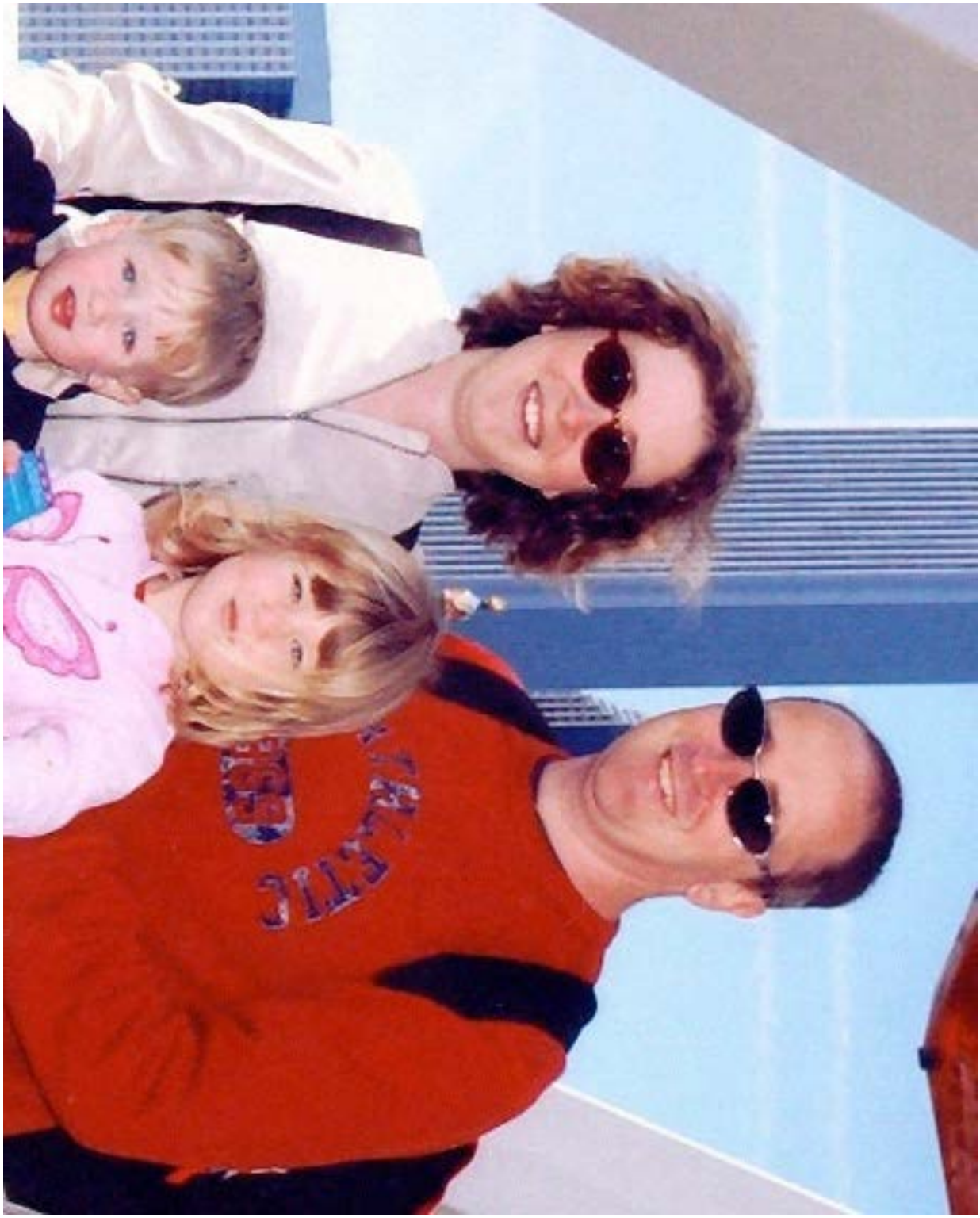

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What's happened since 2005 at the frontline?

- Greater recognition of "safety"
- Use of tools such as checklists
- Use of simulation & CRM training
- Better recognition of non-technical skills

Colleagues/teamwork

Cognitive capacity

Personal stress, alertness, tiredness etc

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Equipment

Culture & organisation

Tasks

Colleagues/teamwork

Workspace

Cognitive capacity

Rules & protocols

Supervision

Personal stress, alertness, tiredness etc


WELCOME !
SCHOOL

The context

- In one year 3,283 patients dead through preventable error, in England alone
- ~1 in 10 patients suffer some form of unintended harm
- ~1 in 300 hospital admissions will die as a direct result of error

(Data from Parliamentary Inquiry into Patient Safety 2009 and DH/NAO publications 2005-2009)


TORKILD TANGESEN
ZACA

"We have a Just Culture, we Just blame whoever did it" -

Doctor, Oct 2014

"...families faced delay, denial and obfuscation in their search for the truth" - *Secretary of State for Health, RT Hon Jeremy Hunt MP Mar 2015*

"My hospital asked a retired Doctor to come back to help them. They've got over 60 investigations outstanding and if they don't get completed soon the Hospital will be in trouble. He'll do a good job but the Board don't care about that, they just want the backlog cleared"

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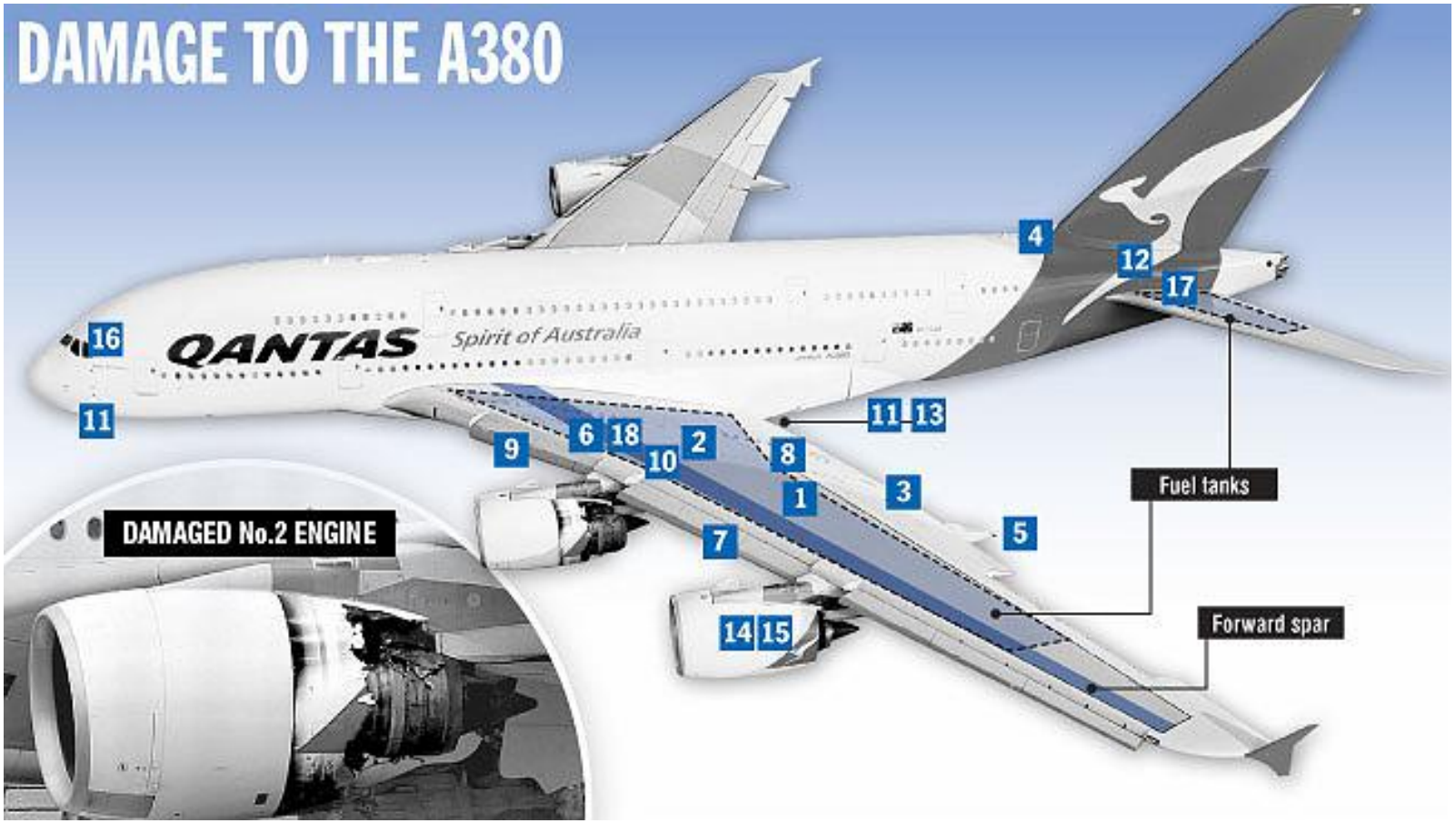
Consultant, Nov 2016

"I didn't share mistakes as I was told good nurses don't make them" - *Nurse, 6 Sep 2016*


DAMAGE TO THE A380
QANTAS
Spirit of Australia
DAMAGED No.2 ENGINE
Fuel tanks
Forward spar
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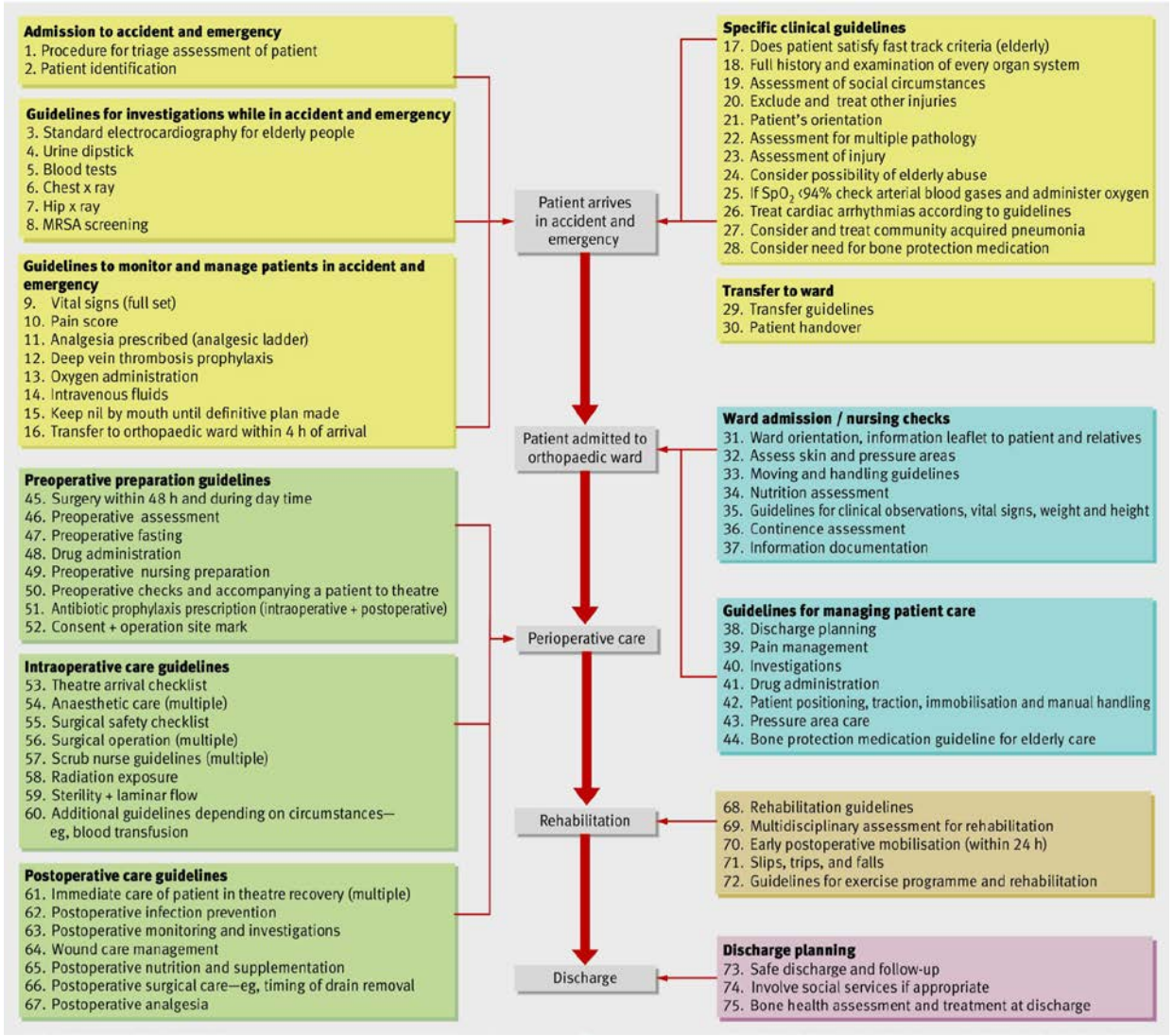
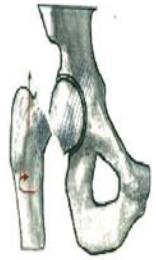
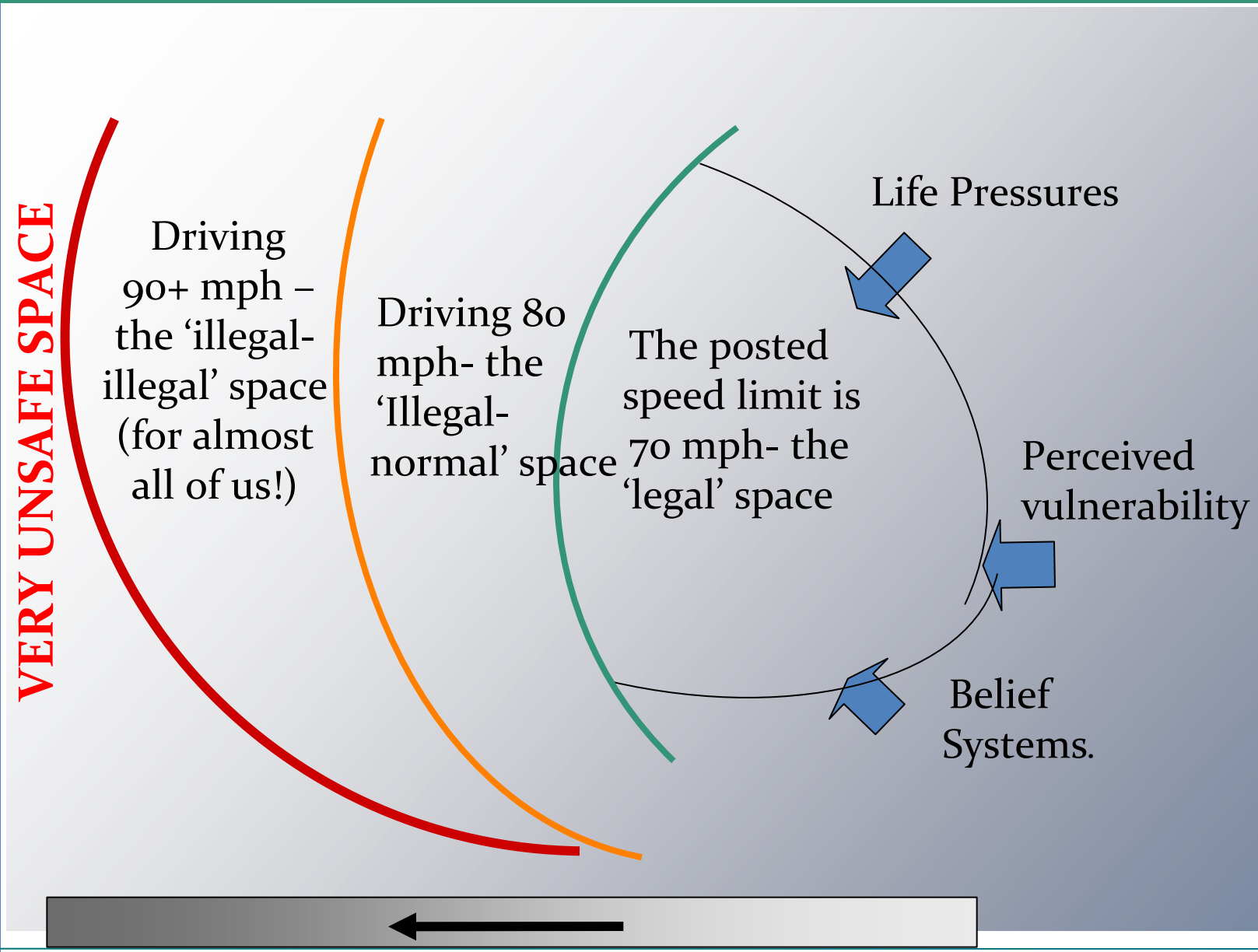
Procedural complexity increases non-compliance





Carthey et al., 2011. Breaking the rules: understanding non-compliance with policies and procedures

Systemic Migration to Boundaries



Amalberti, 2006

Three contrasting approaches to safety

Ultra adaptive
Embracing risk

Context: Taking risks is the essence of the profession:
Deep sea fishing, military in war time, drilling industry, rare cancer, treatment of trauma.

Safety model: Power to experts
to rely on personal resilience, expertise and technology to survive and prosper in adverse conditions.

Training through peer-to-peer learning shadowing, acquiring professional experience. knowing one's own limitations.

Priority to adaptation and recovery strategies

High reliability
Managing risk

Context: Risk is not sought out but is inherent in the profession:
Marine, shipping, oil Industry, fire-fighters, elective surgery.

Safety model: Power to the group to organise itself, provide mutual protection, apply procedures, adapt, and make sense of the environment.

Training in teams to prepare and rehearse flexible routines for the management of hazards.

Priority to procedures and adaptation strategies

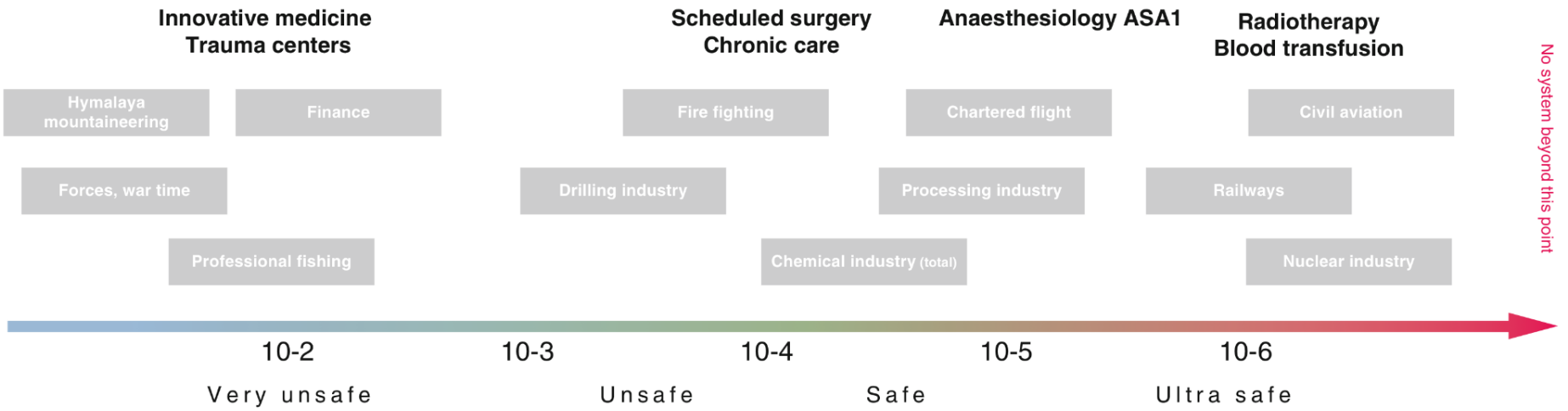
Ultra safe
Avoiding risk

Context: Risk is excluded as far as possible: Civil aviation, nuclear Industry, public transport, food industry, medical laboratory, blood transfusion.

Safety model: Power to regulators and supervision of the system to avoid exposing front-line actors to unnecessary risks.

Training in teams to apply procedures for both routine operations and emergencies.

Priority to prevention strategies



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Healthcare's just culture journey:

Part 2 - What would a Just Culture look like and achieve for healthcare

"By pinning the blame on individuals, we sometimes duck the bigger challenge of identifying the problems that often lurk in complex systems and which are often the true cause of avoidable harm" - *Rt Hon Jeremy Hunt MP, Secretary of State for Health, 3 March 2016*

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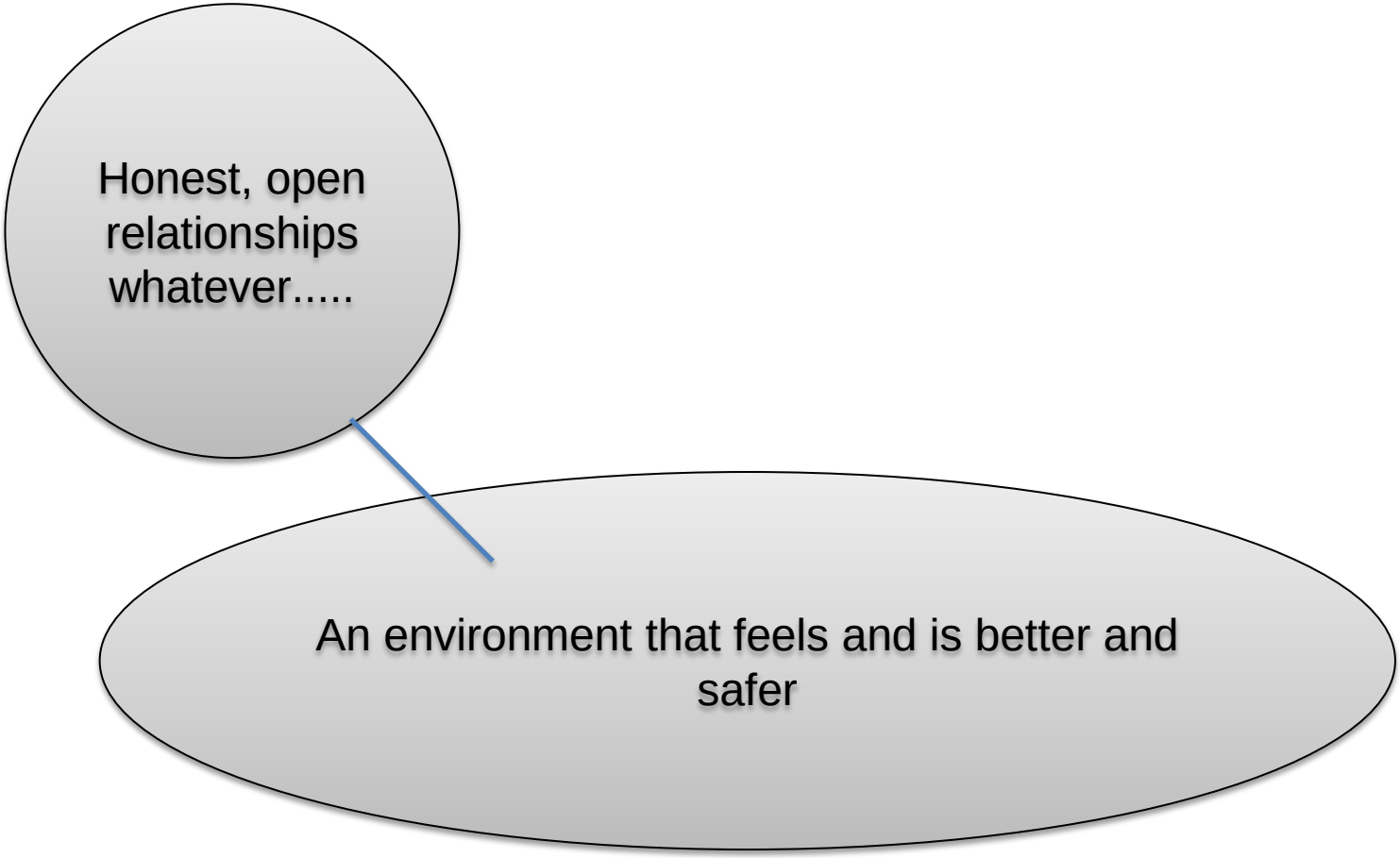
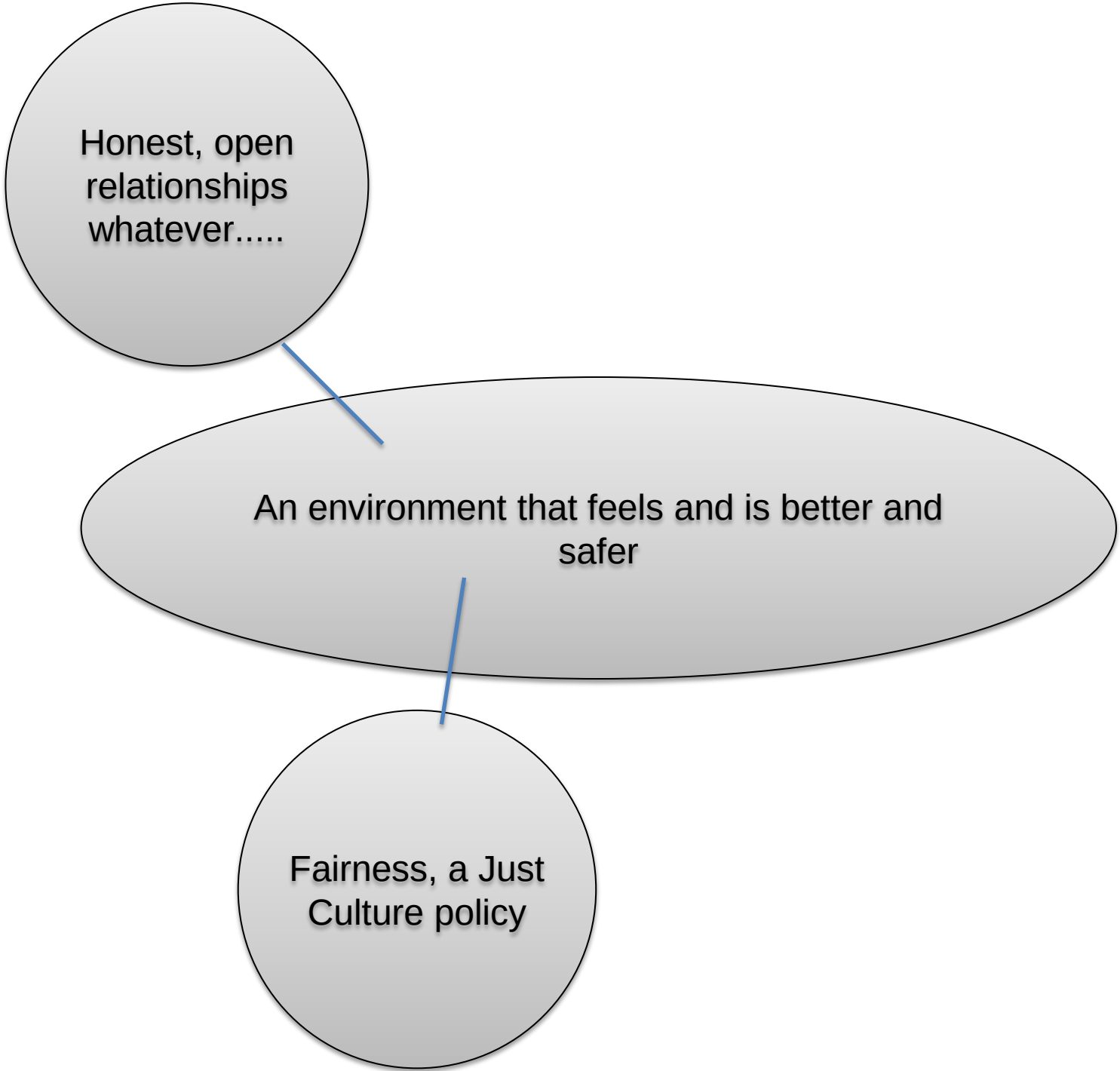
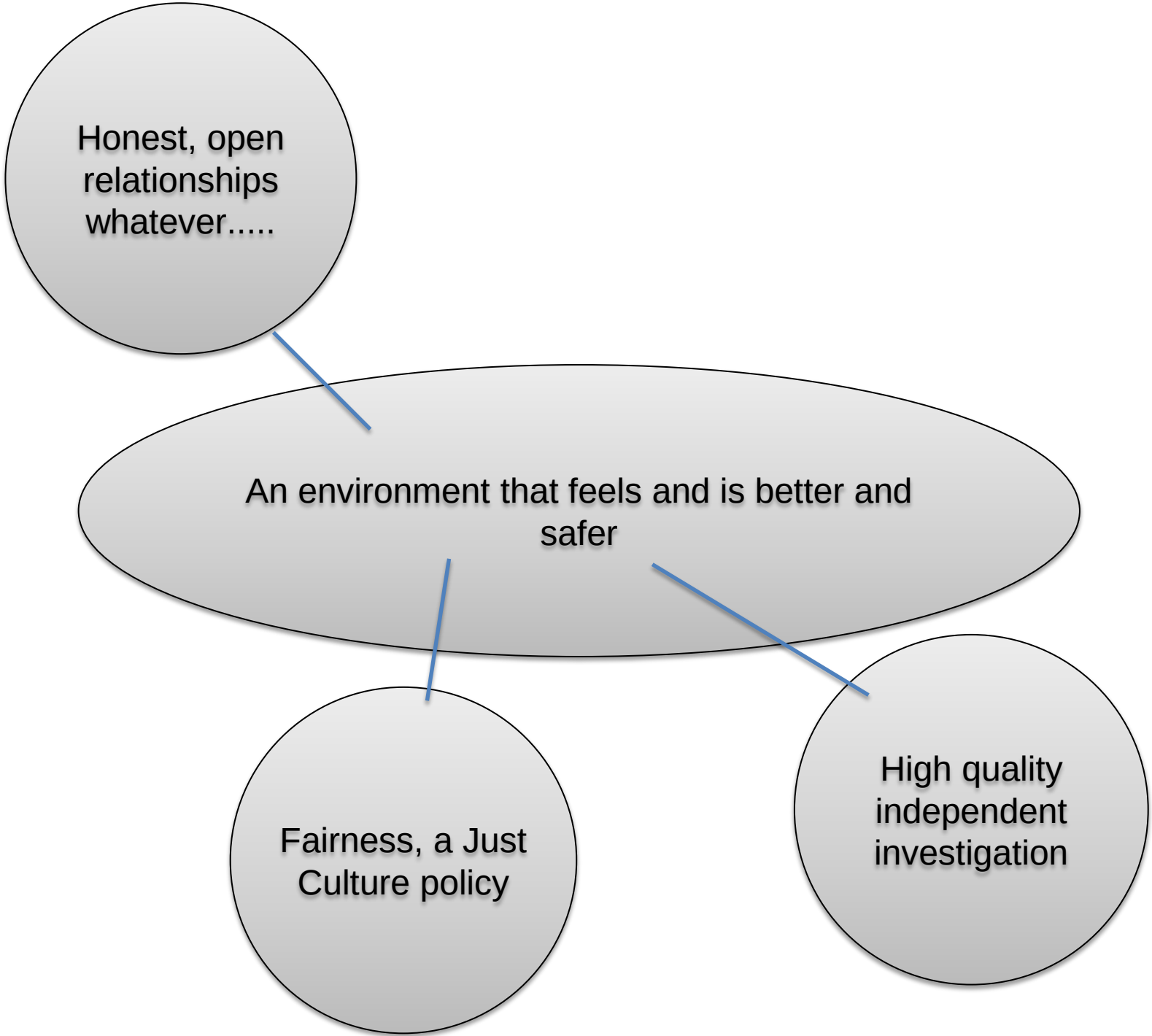
" A just culture depends on establishing a clear distinction between the 'honest mistakes' of well intentioned healthcare workers where punitive responses are neither warranted nor helpful; and the rare acts that involve reckless neglect or mistreatment" - *EAG report into establishing HSIB, May 2016*

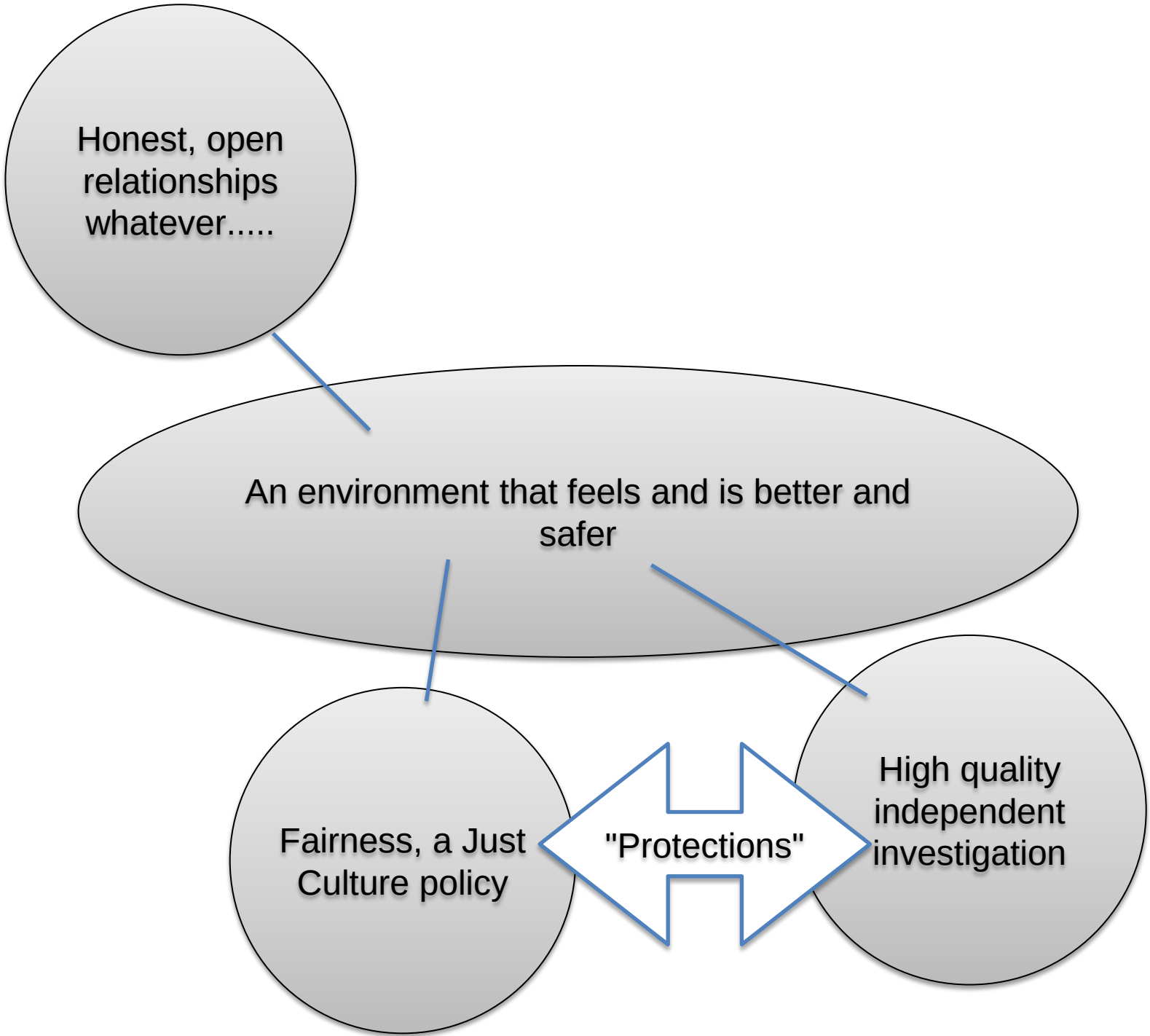
Is just culture a thing, a policy, or is it a feeling?


An environment that feels and is better and safer









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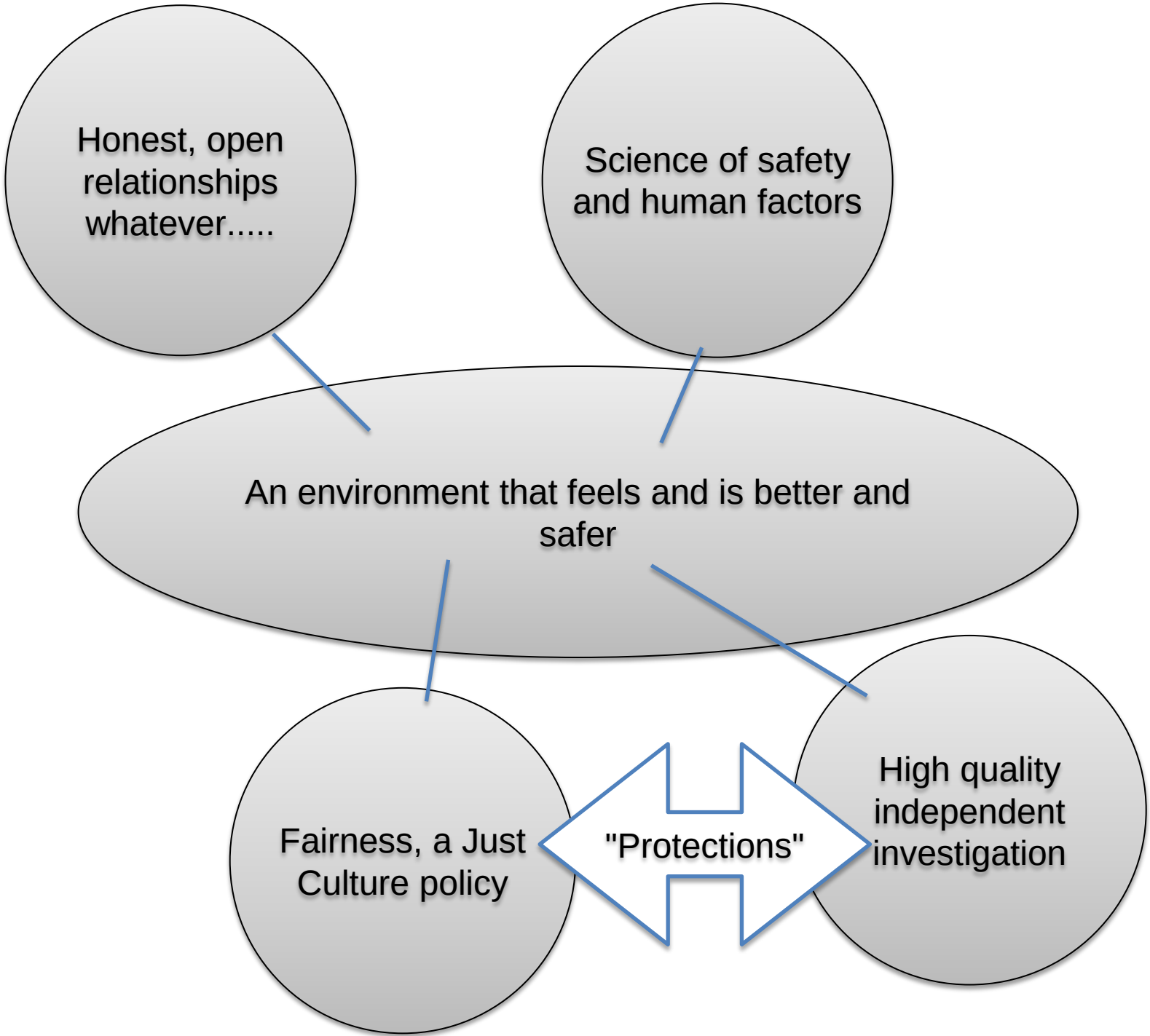

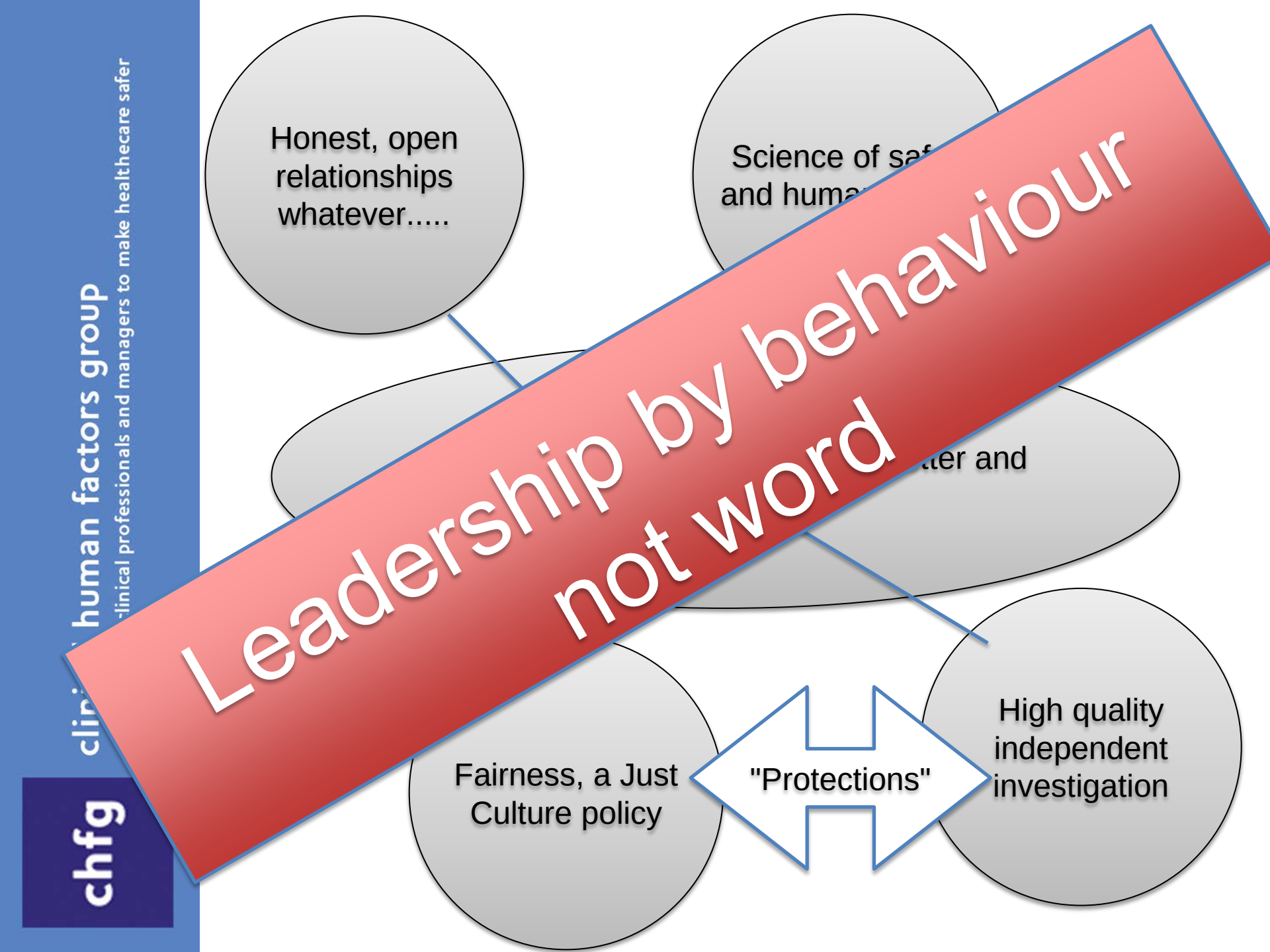
Honest, open relationships whatever.....
Science of saf
and huma
ter and
Leadership by behaviour not word
Fairness, a Just Culture policy
"Protections"
High quality independent investigation

"We recommend a Just Culture Task Force be established….This should determine the appropriate policies, practice and institutional arrangements that are required to move the healthcare system firmly towards a just culture of safety"

- EAG report into establishing HSIB, May 2016

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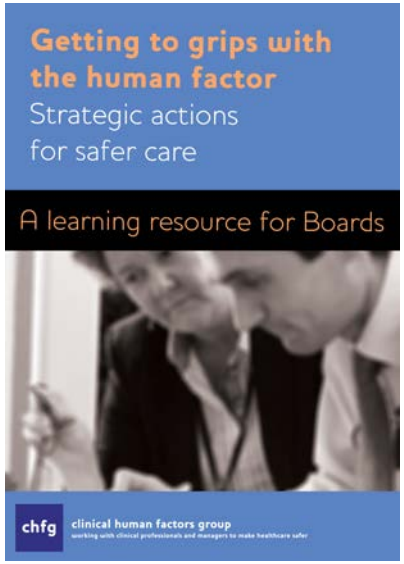
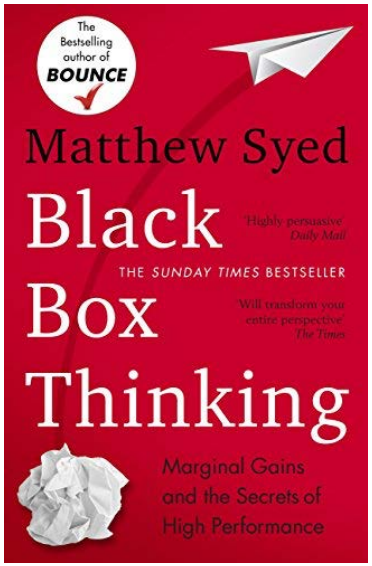
Thank you





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