Medication Safety, Life, and a Just Culture

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Disclosure

• I do not have a vested interest in or affiliation with any corporate organization offering financial support or grant monies for this continuing education activity, or any affiliation with an organization whose philosophy could potentially bias my presentation.

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• Dept of Health and Human Services’ Office of Inspector General report:
  - 1 in 7 Medicare patients experience serious harm
  - 180,000 die each year

Boeing 747

• 450 would have to crash every year to equal medical deaths
• That’s more than ONE A DAY!

2011 Hospital Survey on Patient Safety Culture by AHRQ

• Only 44% of employees are confident they wouldn’t be punished if they reported an error.

“Medicine used to be simple, ineffective, and relatively safe. Now it is complex, effective, and potentially dangerous”

- Sir Cyril Chantler
Anyone recognize these twins?

17-year-old Jesica – 2003, Duke

Emily Jerry – 2006, Ohio

Wikipedia says:
• Common estimates for sustained attention to a freely chosen task range from about five minutes for a two-year-old child, to a maximum of around 20 minutes in older children and adults.

Rhode Island = wrong side brain surgery (x3)

Is the healthcare industry alone?
California Commuter Train Wreck - 2008
25 dead

BP - Deepwater Horizon Oil Rig Explosion – April 20, 2010
11 humans dead

Massey Mine Explosion - 2010
29 dead

January 21, 2011

What we all have in common
- Fallible humans and human behaviors
- Imperfect systems
- Potential for faulty equipment
- A set of values (individual and/or corporate)

Creating a Just Culture: where do you start?
Just Culture definition

Workers trust each other, are rewarded for providing safety information, and are clear about their responsibilities regarding safe behavioral choices.

There is a *shared* accountability.

Types of behavior involved in errors

- **Human Error**: an inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake
- **At-Risk Behavior**: a behavioral choice that increases risk where risk is not recognized, or is mistakenly believed to be justified
- **Reckless Behavior**: a behavioral choice to consciously disregard a substantial and unjustifiable risk

Performance Shaping Factors

- These must be managed when designing systems
- Affect the rate of human error (and at-risk behavior):
  - stress
  - fatigue
  - environment
  - distractions
  - procedural design
  - communication

Managing Human Error

- **Console** the individual – the error *also* happened to them **AND**
- Examine the system for improvement opportunities

Consoling – Human Error

- **A Conversation to Learn**
- Help by comforting the employee
- The manager also investigates the system and makes changes as appropriate

***The employee made the *mistake*, not the *choice***

Repetitive Human Error: Counseling

Take action:

- let the employee know that performance is unacceptable
Risky Business

- In those states that have enacted laws against texting while driving, has the accident rate gone up or down?

How are you managing your risk?

- Do you know your vulnerabilities?
- Your employees do!
- What At-Risk behavior is occurring?
- At-Risk Behavior is a choice: Risk believed to be insignificant or justified

It’s all about the perception of risk

Coaching at-risk behavior

- Create a learning opportunity:
  - understand their point of view
  - describe the at-risk behavior
  - explain how this behavior isn’t aligned with our values
  - create an action plan

Homework

- List the top 3 risks in your department/business unit
- Describe what you are doing to manage these risks
- Confirm you aren’t managing those risks through LUCK

Question to ponder

Is it ever ok to knowingly violate a rule?
Drinking and Driving – clearly Reckless

Reckless Behavior is a conscious disregard of a substantial and unjustifiable risk

>13,000 deaths per year

Managing reckless behavior

- Disciplinary action
- Punishment
- Punitive action

Yes, I said “punitive” !!!!!

Creating Safer Systems

- Identify and minimize risks
- Understand and accept: perfection is NOT possible
- Systems can be designed to be more reliable (but we need to be able to learn)

Designing more reliable systems:

- Manage human factors (humans will never be perfect)
- Ensure skills/competency
- Standardization and protocols
- Automation of tasks
- Introduce barriers
- Introduce redundancy

We need a Learning Culture

- Learn about errors and the behavioral choices behind them
- Learn where the system is weak
- Learn why people drift

Public perception…. or truth?
Administrative Walk-rounds

- Promotes a Just Culture
- Where else should leadership spend their time?
- Ask questions of employees and patients
- Invite them to be a part of the solution
- Provide immediate feedback

It Happened Here

- Newsletter describing events and steps taken to mitigate/prevent recurrence
- Promotes reporting
- Provides feedback (elusive in healthcare)

Investigation of Events

- Do not regard an event as “something to be fixed”
- An event is an opportunity to understand risks
  - system
  - behavioral
- Keep in mind, the system is comprised of sometimes:
  - faulty equipment
  - imperfect processes
  - fallible humans

Questions to ask

- What happened?
- What normally happens?
- What does procedure require?
- Why did it happen?
- How were you managing it?

Scenario

The NICU nurse goes to the automated cabinet to retrieve heparin 1,000 units/ml for her patient. Without looking into the bin, she grabs a vial. She draws up the medication and administers it to the patient. Unbeknownst to her, the pharmacy technician had refilled the bin incorrectly with 10,000 unit/ml heparin.

Choose your own adventure:
- a. The child was not harmed
- b. The child suffered severe bleeding and his survival is in question
Avoid Severity Bias

- Harm vs. no harm
- How do you handle the situation?
- “no harm, no foul” doesn’t work in a Just Culture

Determine the causes

- Probable Cause: RN always got right heparin from this pocket.
- Direct Cause: RN did not read the label on drug (behind the label).

Find the causes

It is the causes of the error that give us the data we need in order to begin to work on and build risk-reduction strategies.

The sensible Health Care Plan

If you can’t afford a doctor, go to an airport - you’ll get a free x-ray and a breast exam, and, if you mention Al Qaeda, you’ll get a free colonoscopy.

Discussion

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