

OSC 12
Ohio Safety Congress & Expo

WELL AT HOME. SAFE AT WORK.

313 Increase Safety Reporting through a Just Culture

Joe Tulga

Wednesday, March 28, 11 a.m. to Noon

Ohio Bureau of Workers' Compensation

Increase Safety Reporting Through a Just Culture

Session #313



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Objectives

1. Define "Safety Culture",
2. Define "Just Culture",
3. Assess factors that contribute to safety events,
4. List factors to manage culpability of safety events.



Safety Culture



Traditional Safety Programs
Prevention Focused

- Employee/Department Orientation – Safety
- Safety Risk Assessments
- Failure Modes and Effects Analysis (FMEA)
- Safety Policies and Procedures
- Regulations and Standards (NPSG)
- Annual or Continuous Safety Education
- Worksite Inspections
- Safety Teams – Safety Committees
- Safety Communication

Traditional Safety Programs
Reaction Focused

- Medical Care – Worker's Compensation
- Incident Reporting – Documentation
- Accident Investigation of Incidents
- Apparent Cause Analysis (ACA)
- Root Cause Analysis (RCA)
- Safety Process Review
- Safety Education
- Incident Trending

Managing the Risks of Organizational Accidents, 1997

James Reason



Safety Culture

Shared values (what is important) and beliefs (how things work) that interact with the organization's structures and control systems that produce behavioral norms (the way we do things around here)." (Reason, 1997)

Safety Culture

- Safety management systems and programs (prevention or reaction) provide effective safety framework...but it is ultimately the
- Worker's perception of the value of safety to himself and the importance of safety to the organization that governs safety performance.

Culture and Safety



Culture is the shared values, beliefs, and attitudes of the individuals in the organization (the way we act when no one is looking)

Shared Values, Beliefs and Attitudes → Our Behaviors
 Our Behaviors → Outcomes

Stages to a Safety Culture

- Reactive Stage – Employees react to safety events instead of thinking how to prevent them.
- Independent Stage – Employees view safety as important to them and something they value. Practice because they want to do it...
- Interdependent Stage – Employees look out for each other and feel comfortable to "stop the line".

Just Culture



Florence Nightingale

“It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm”

- Florence Nightingale
Notes on Hospital, 1859

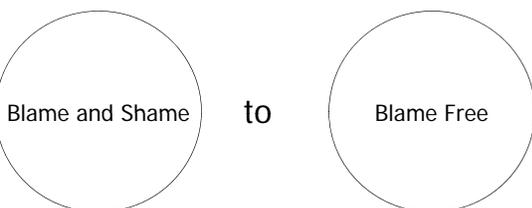


US Institute of Medicine (IOM)

- November 1999 – IOM report concluded that 44,000 to 98,000 people die each year due to preventable medical errors.



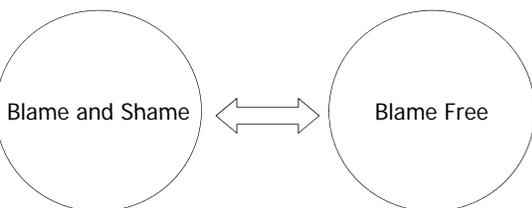
Culture of Reporting



What is a Just Culture?

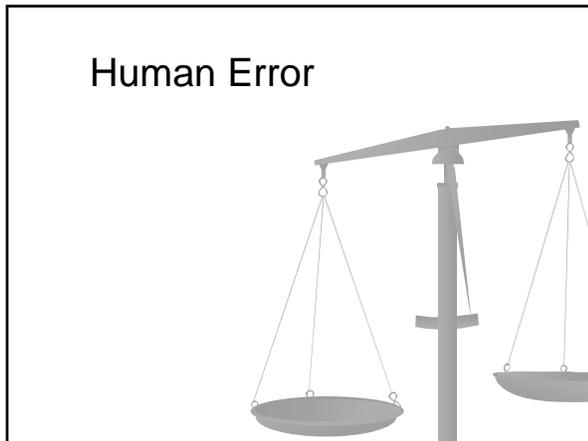
- A culture in which frontline employees feel comfortable disclosing errors, including their own, while maintaining professional accountability
- A culture that is open, fair, and based on **TRUST**
- A culture that is focused on learning
- A culture in which organizations seek to review contributing factors then determine accountability
- A culture in which organizations include human error factors and systems thinking
- A culture that promotes the reporting of safety events and near misses

Moves toward appropriate accountability (in between “Blame and Shame” and “Blame Free” environments)



Contributing Factors





Facts About Errors

- Everyone makes errors
- We work in a high risk environment
- We can avoid most errors by using low risk behavior
- Multitasking and time constraints make us feel the need to make shortcuts or workarounds
- Some near misses and significant events are due to process and system problems

High Risk Situation + High Risk Behavior = Safety Event

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Types of Errors

- Skill Based
 - Slip or lapse ("I forgot" distractions)
- Rule Based
 - Deviated from policy, intentional act, conscious choice to break rule
 - Incorrect rule (rule problem)
 - Misapplied Rule (information problem or misjudgement)
 - Rule Non-Compliance (compliance problem)
- Knowledge Based
 - Did not know, no training, competency issues, had training but did not know how to apply, lack of experience, thinks they know but do not

Inappropriate Behaviors

- Human Error
 - Did not intend to make the error (slip/lapse)
 - May or may not have caused an adverse outcome
- Negligent Conduct
 - Failure to exercise the skill, care and learning expected of a reasonably prudent health care provider
- Reckless Conduct
 - Conscious disregard for risk (gross negligence)
 - Much higher degree of culpability than human error
- Knowing Violations
 - Knowingly violates a rule
 - Intentional non-compliance with established policies, procedures and red rules

Systems Thinking

System – A group of independent and interconnected parts that interact and function together as a whole.

System Thinking – Understanding how the parts interact and effect systems, processes, and people.

The Anatomy of an Event

Multiple Barriers - technology, processes, and people - designed to stop active errors (our "defense in depth")

Active Errors by individuals result in initiating action(s)

Latent Weaknesses in barriers

EVENTS of HARM

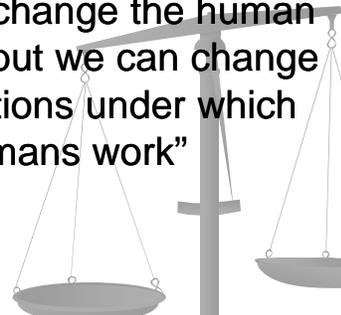
PREVENT
The Errors

Detect & Correct
The System Weaknesses

Adapted from James Reason, *Managing the Risks of Organizational Accidents* (1997)

“We can’t change the human condition, but we can change the conditions under which humans work”

- James Reason



However....

Humans are accountable for their behavioral choices

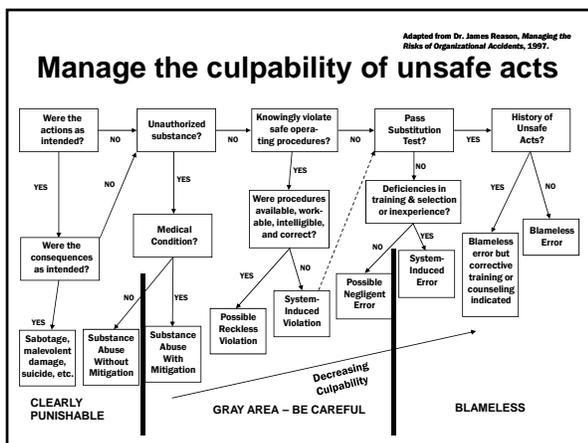


Manage Culpability of Safety Events



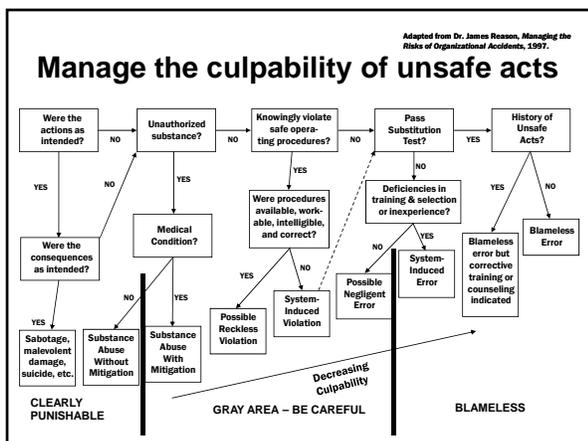
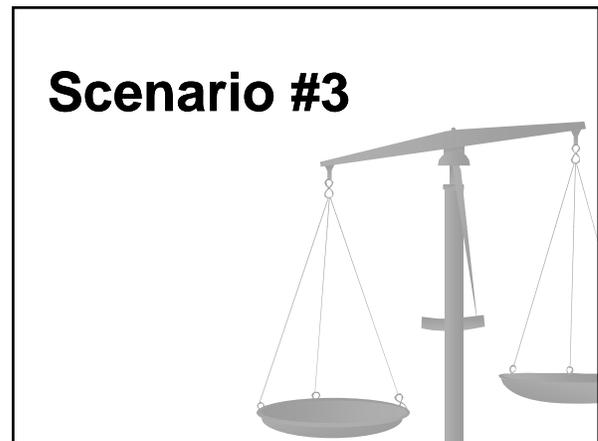
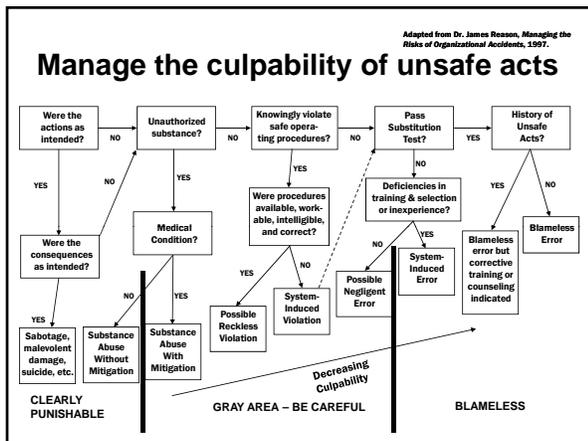
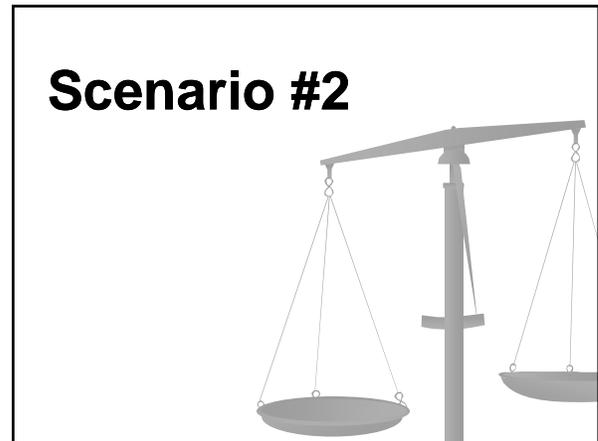
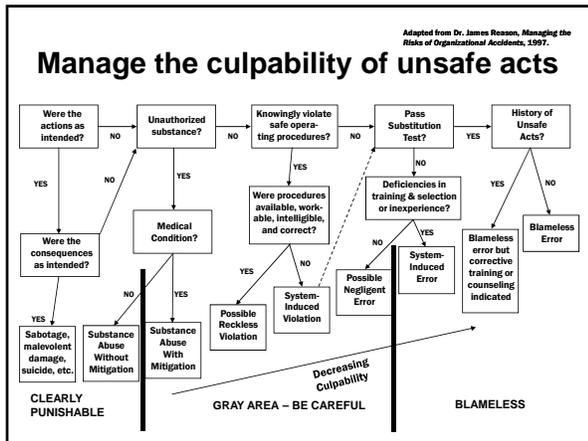
Managing Culpability

- Apply a consistent approach for determining degree of culpability (intent) when an error is made
- Follow an objective process for review of events
- Utilize an algorithm as a guide for managing unsafe acts
- Identify the type of error made
- Determine why the error occurred
- Apply appropriate actions (system or process improvement, corrective action, etc...)



Scenario #1





Safety Event Reporting

- Employees need to report safety events (accidents – injuries)
- We also need to have employees report the near misses, safety hazards, and unsafe conditions

Reporting Strategies

- Safety Education and Training Feedback
- Staff Meetings, Safety Huddles
- Safety Hotline, Safety Suggestion Boxes
- Good Catch Program
- Safety Inspections
- Safety Coaches (Behavioral Based Observations)
- Safety and Infection Control Liaisons
- Patient Safety Rounds
- Safety Committee, Infection Control Committee
- Ask Administration
- Incident Reporting

Questions

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