Just Culture: A Model for Workplace Justice

RRH Nursing Grand Rounds
January 11, 2024

Lori Paine, DrPH, MS, RN
VP, Patient Safety Officer
AGENDA

What is Just Culture (JC)?
Why does JC matter?
Case Study
Safe System Design
How you can promote a Just Culture?
After attending this session, the participants will be able to:

- Define characteristics of a Just Culture.
- Differentiate between organizational justice and criminal justice.
- Recognize the components of high reliability culture.
- Describe the patient safety risks in the case study.
- Identify risk mitigation strategies for safe handling of neuromuscular blocking agents.
The single greatest impediment to error prevention in the medical industry is that we punish people for making MISTAKES.”

—Dr. Lucian Leape (1999)
Professor, Harvard School of Public Health
High Reliability Science
Weick and Sutcliffe
Principles for Mindful Organizing

Logic 1
Anticipation / Prevention
- Preoccupation with Failure
- Reluctance to Simplify
- Sensitivity to Operations

Logic 2
Containment / Resilience
- Commitment to Resilience
- Deference to Expertise

Socio-Cultural Norms
- TRUST
- TRUST-WORTHINESS
- SELF-RESPECT
- MINDFUL INTERDEPENDENCY
- CLEAR GOALS
- ROLE ➔ GOAL CLARITY

HRO Socio-Cultural Environment

**Reporting Culture**
- What gets reported when errors or near-misses occur

**Flexible Culture**
- How readily we adapt to sudden and radical changes in pressure, pacing and intensity

**Learning Culture**
- How adequately we can convert the lessons that are learned into reconfigured assumptions, frameworks and action

**Just Culture**
- How/if people are blamed when something goes wrong
Just Culture

How people apportion blame when something goes wrong

—Weick & Sutcliffe (2007)
Vanderbilt nurse accused of mistakingly giving wrong drug to patient going to trial

A nurse in Nashville made a mistake and is accused of killing a patient (She faces not civil, but criminal charges), and now that controversial case is set for trial. There is no plea deal.

By: Nick Beres

Case Study
Vanderbilt Case Summary

In December 2017, Charlene Murphey died after receiving vecuronium in error at Vanderbilt University Medical Center. The nurse, RaDonda Vaught, was sent from the ICU to Radiology to administer pre-procedure midazolam to Mrs. Murphey. She retrieved the wrong drug and subsequently failed to detect and correct her mistake before administering the lethal dose. She left the care area without monitoring the patient and later recognized her error after the patient arrested. Vaught reported the error immediately. Mrs. Murphey died the next day. Vanderbilt terminated Vaught’s employment eight days after the patient’s death.
## Organizational Response & Consequence

<table>
<thead>
<tr>
<th>Organizational Response &amp; Consequence</th>
<th>Timeframe after event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disclosed error to the Murphey family</td>
<td>within 4 hours</td>
</tr>
<tr>
<td>Terminated RaDonda Vaught</td>
<td>8 days</td>
</tr>
<tr>
<td>Never reported the error to state or federal officials</td>
<td></td>
</tr>
<tr>
<td>Settled out-of-court with Murphey family</td>
<td>4-6 months</td>
</tr>
<tr>
<td>Anonymous tip to state and federal health officials about the unreported error prompts an unannounced CMS inspection resulting in immediate jeopardy</td>
<td>11 months</td>
</tr>
<tr>
<td>CMS report released and VUMC plan of Correction complete</td>
<td>11.5 months</td>
</tr>
<tr>
<td>VUMC admits to Tennessee Board of Licensing Health Care Facilities that their response was too limited. No disciplinary action against VUMC.</td>
<td>14 months</td>
</tr>
</tbody>
</table>
Consequences for RaDonda Vaught

• Vaught was arrested and charged with reckless homicide, negligent homicide and abuse of an impaired adult. (Feb 4, 2019)
• Tennessee Board of Nursing revoked Vaught’s nursing license. (July 23, 2021)
• Jury found Vaught guilty of criminally negligent homicide and gross neglect of an impaired adult. (March 25, 2022)
• She was sentenced to 3 yrs supervised probation. (May 13, 2022)
• Lost appeal to reinstate her nursing license (Nov 27, 2023)
Individual Breaches

- Chose to override to secure the medication from the ADC.
- Removed the wrong med (Vecuronium) instead of intended, ordered med (Versed) from ADC.
- Does not visually confirm the med in hand is the intended med immediately after removing from the ADC.
- Does not confirm the med in hand is the intended drug at the point of administration.
- Did not monitor the patient after administering the medication.

ROCHESTER REGIONAL HEALTH
Individual Breaches

Chose to override to secure the medication from the ADC

Removed the wrong med (Vecuronium) instead of intended, ordered med (Versed) from ADC

Does not visually confirm the med in hand is the intended med immediately after removing from the ADC

Does not confirm the med in hand is the intended drug at the point of administration

Did not monitor the patient after administering the medication

- Over-rides were common in this unit. Nurses in this ICU had administered >20 medications via over-ride to Ms Murphey during her stay.

- There was a known problem with a patchy ADC-EHR interface in the ICU. Nurses had been instructed to “over-ride” while the interface was optimized.
Individual Breaches

Chose to override to secure the medication from the ADC

Removed the wrong med (Vecuronium) instead of intended, ordered med (Versed) from ADC

Does not visually confirm the med in hand is the intended med immediately after removing from the ADC

Does not confirm the med in hand is the intended drug at the point of administration

Did not monitor the patient after administering the medication

- Verbal order for “Versed” given after patient arrived in Radiology.
- Midazolam (generic name for Versed) order entered into the EMR and appeared on the patient’s profile in the ICU ADC.
- RN does not recognize generic name.
- ADC drug search resulted with only 2 letters (V-E).
- The ADC warning that the nurse acknowledged was for “Over-ride” – NOT specific to a paralytic agent.
- ADC warnings for Vecuronium did not reflect 2016 ISMP best practice guidelines.
Individual Breaches

1. Chose to override to secure the medication from the ADC

2. Removed the wrong med (Vecuronium) instead of intended, ordered med (Versed) from ADC

3. Does not visually confirm the med in hand is the intended med immediately after removing from the ADC

4. Does not confirm the med in hand is the intended drug at the point of administration

- Insufficient additional visual cues were in place for paralytics agents. (shrink-wrap, lock box, extra labels, etc)

- The nurse had not administered Versed many times in the past. The drug was not commonly given in the Neuro-ICU.

- The nurse was orienting a new nurse and they were discussing their next assignment in the ED while at the ADC.
Individual Breaches

- Chose to override to secure the medication from the ADC
- Removed the wrong med (Vecuronium) instead of intended, ordered med (Versed) from ADC
- Does not visually confirm the med in hand is the intended med immediately after removing from the ADC
- Does not confirm the med in hand is the intended drug at the point of administration
- Did not monitor the patient after administering the medication

- Bedside Barcode Medication Administration (BCMA) technology was not available in the Radiology suite.
- The RN could not access the EHR in Radiology during med administration
- CMS cited Vanderbilt for failing to include safe med admin guidance for high alert drugs (e.g., use of BCMA or Independent Double Checks)
Individual Breaches

- Chose to override to secure the medication from the ADC
- Removed the wrong med (Vecuronium) instead of intended, ordered med (Versed) from ADC
- Does not visually confirm the med in hand is the intended med immediately after removing from the ADC
- Does not confirm the med in hand is the intended drug at the point of administration
- Did not monitor the patient after administering the medication

• CMS cited Vanderbilt for failing to include monitoring guidelines – for any drug, including high alert drugs – in their policy.
Workplace Justice

- Values
- Policies
- Duty

Criminal Justice

- Laws
- Courts
- Juries
Just Culture - Simplified

Human Error
- Unintended conduct: where the actor should have done other than what they did
  - Accept

At-Risk Behavior
- A choice where risk is not recognized, or is mistakenly believed to be justified
  - Coach

Reckless Behavior
- Conscious disregard of a substantial and unjustifiable risk of harm
  - Sanction

Knowledge
- Knowingly causing harm (sometimes justified)
  - Sanction

Purpose
- A purpose to cause harm (never justified)
  - Sanction

All Independent of the Actual Outcome
Drunk Driving Laws

How do we design a safer system?
Human Factors Engineering
How do Events Occur?

Unsafe System Design

EVENT

Unsafe Behavior Choices
Institute for Safe Medication Practices (ISMP)

June 2016

April 2022
ISMP Best Practices

Neuromuscular Blocking Agent (NMBA) Storage

- Store only where routinely needed (e.g., ICU)
- Store in locked or lidded bin
- Paralytic warning label on storage bin
ISMP Best Practices

ADC Functionality

• “Warning: Paralyzing agent” present on screen
• NMBA alert is interactive and requires user to verify patient will be or is intubated
• Brand and generic name presented on all searches
• Forced minimum character limit on drug name search
ISMP Best Practices

Barcode Medication Administration (BCMA) in Radiology

• Prior to administration, verify med via barcode scan for patients in Radiology
ISMP Best Practices

Anxiolysis Practices

• Standardized pre-procedural anxiolysis in Radiology
• Standard policy for monitoring IV sedation including anxiolysis
What can YOU do to promote a Just Culture?

• Encourage reporting
• Don’t rush to judgment – seek to understand
• Be mindful of your own behavioral choices
• Resist judgement based on outcome alone
• Coach others
• Facilitate learning discussions about events
• Help design a better system
References

• JHM Just Culture Practice Webinar, April 12, 2022 by The Just Culture Company. Breaches & system performance-shaping factors were identified using publicly reported data that includes these sources:
  
  
  
  
  • CMS Summary of Deficiencies 11-8-18: Vanderbilt University Medical Center 440039
  
  • [https://tdh.streamingvideo.tn.gov/Mediasite/Play/d4e0d6b971de40a7a361928bd1528e291d](https://tdh.streamingvideo.tn.gov/Mediasite/Play/d4e0d6b971de40a7a361928bd1528e291d)
  
  • [https://www.documentcloud.org/documents/24182613-vaughtfinalorder](https://www.documentcloud.org/documents/24182613-vaughtfinalorder)