Just Culture Toolkit
Scenarios

In order to promote a just culture where staff is comfortable in reporting errors or near misses, healthcare organizations must adopt a disciplinary system theory approach.

These scenarios have been created to assist the nurse in understanding this approach and in discerning the concepts of accountability and discipline and their relationship to patient safety. The names and situations depicted are purely fictions.

We must first define the behavioral concepts of human error, negligence, intentional rule violations and reckless conduct.

Human error can be demonstrated by this example: we miss the turnoff on the freeway that we have been making for the past year -- a simple mistake or lapse of memory. There is no intent involved.

Negligence is an action that is more culpable than a human error. This term is utilized when a patient has been harmed by the action. It is the failure to exercise the skill or care or learning that is expected of the healthcare practitioner. Negligence results when the practitioner fails to realize the risk involved.

Recklessness, on the other hand, is a conscious disregard of a significant and visible risk. One example would be the nurse who does not have another licensed practitioner double check the unit of blood before hanging it. There is more culpability attached to this act than to a purely negligent act.

When an individual chooses to ignore or violate a rule established by the facility or regulatory body, this is an intentional rule violation. The individual knew what the correct process was and deliberately violated that rule.

Below are three scenarios followed by a chart that shows how each level of error is determined. These scenarios can be used as discussion points in your facility. The charts have been completed for you.

Proposed Scenario _ Just Culture Tool Kit

Scenario 1 – The Memory Error

The hospital has a new program to coincide with the IHI 100,000 lives campaign on reducing surgical site infections. In order to guarantee that antibiotics are given with in one hour of the incision, the responsibility for administering antibiotics has been put in the hands of the anesthesia provider in the operating room. There is one exception – if the patient needs a special antibiotic protocol requiring more than one antibiotic, the regime is started in the pre surgical unit.

Brian is an experienced pre-op nurse. It is a very busy morning. One of his colleagues has called in sick. He looks over the schedule of patients for the first cases and notices that Mr. Brown is scheduled for a new procedure that requires three antibiotics be given before surgery. He also knows that one of the antibiotics must be given slowly so he begins his care with Mr. Brown. After his initial assessment, Brian hangs the first antibiotic, Vancomycin 1 GM and signs the medication administration sheet. He returns in 90 minutes and hangs the second antibiotic, Gentamycin 80 mg. The surgical resident who is new to the service stops in the preoperative unit to read the chart of the patient. The resident takes the paper record to the conference room. Brian returns to the bedside and checks his order on the CPOE for the final antibiotic and hangs the Ancef, 1 GM. The paper MAR is with the chart so he makes a mental note to sign the MAR before the patient goes to the OR.

The antibiotic infusion is finished but Brian forgets to go back to the chart since his usual practice is to sign the MAR when he hangs the medication. An orderly comes to pick up the patient for the OR. Upon entering the OR, THE CRNA notices that 2 of the 3 antibiotics have been administered and proceeds to hang Ancef prior to the procedure. The patient receives the duplicate dose before the presurgical nurse (Brian) remembers he did not sign the MAR and calls into the room. The patient had no adverse outcome.

Scenario 1 – Analysis of the Four Evils			
The Evil	**Definition**	**Apply to this event?**	**Rationale**
Human Error	Should have done other than what they did	Yes	Mar was missing when Brian gave the med/ "Forgot" to chart the med would classify as a human error.
Negligence	Failure to Exercise expected care. Should have been aware of substantial and unjustifiable risk.	Yes	Medication should be charted as soon as it is given
Recklessness	Conscious disregard of substantial and unjustifiable risk	No	Brian used his clinical judgment to determine the risk of not documenting was less risk than not giving the med on time
Intentional rule Violation	Knowingly violates a rule or procedure	No	No intentional rule violations are present

Scenario 2 – The Wrong Medication

Patient C is brought to the PACU following a lengthy procedure during which he exhibited periods of hypotension. An epidural catheter had been placed during surgery for postoperative pain control. The anesthesia provider debated about extubating the patient at the end of the case but decided the patient was currently stable enough to have the tube removed. However, she did not want to start the epidural infusion until she was sure the patient continued on a stable post op course. Routine pain management medications were ordered.

The PACU nurse Karen, is a caring for Patient C. She is aware of the plan of care and has assessed than her patient is awake and vital signs have remained stable. She is anxious to start the epidural infusion so that her patient can remain alert and pain free. She realizes she has a small window of opportunity for the anesthesiologist to see Patient C in-between her OR cases. In anticipation of the visit from anesthesia, Karen removes the epidural infusion from the automated medication dispensing machine while she is getting her first dose of postoperative antibiotics.

While Karen was preparing to hang the antibiotic, the anesthesiologist arrived at the bedside and began to assess the patient. Karen wanted to hang the piggyback ASAP so she could assist the anesthesiologist as necessary. She inadvertently picked up the epidural infusion instead of the antibiotic and proceeded to hang it. As she was completing the task the anesthesiologist asked for the epidural infusion. As Karen reached for the bag, she saw it was the antibiotic. She immediately shut off the epidural infusion and then froze as the error sank in. The anesthesiologist again asked for the infusion and the nurse turned around to see that the patient was starting to loose consciousness. The nurse immediately told the anesthesiologist she had hung the wrong medication. The anesthesiologist reversed the patient and assisted his breathing for a few minutes. The patient did not need to be reintubated but spent a prolonged time in the PACU to ensure complete reversal of the medication.

Scenario 2 – Analysis of the Four Evils			
The Evil	**Definition**	**Apply to this event?**	**Rationale**
Human Error	Should have done other than what they did	Yes	Karen hurried to hand the medication and did not properly check the 5 R's of medication administration
Negligence	Failure to Exercise expected care. Should have been aware of substantial and unjustifiable risk.	Yes	Karen should have been aware of the increase risk of mix up when pulling 2 medications at the same time and putting them side by side
Recklessness	Conscious disregard of substantial and unjustifiable risk	No	Hanging the worn medication was an unjustifiable risk – however the administration was inadvertent. Karen consciously took both medications at the same time but did not perceive a significant risk to that activity
Intentional rule Violation	Knowingly violates a rule or procedure	Yes	Medication administration policy requires checking medication at bedside prior to giving to patient.

Scenario 3 – The Reckless Team Leader

There is a recommendation from the ISMP that some high risk medications should always have a double check before being administered. The Director of Perioperative Services has identified that there have been several near misses involving heparin solutions on the sterile field and that the operating room staff should embrace this recommendation.

Surgical Tech Edward is nearing completion of his orientation. The usual staffing pattern calls for him to scrub and his preceptor, Faith, who is an RN to circulate. The case is considered “minor”. It is the insertion of a mediport. There is a shortage of staff to do lunch reliefs so the team leader for the pediatric service, Mary, assigns herself to circulate on this case. The team leader Mary has a history of intimation of new staff and a sense that the new rules do not add any value to patient safety and only take away from efficiency. The team leader usually provides the second check of calculations for circulating nurses in her assigned area.

Mary calculates the dosages of heparin infusion for both the irrigation and the flush doses on the sterile field. The surgical tech, Edward, accepts the meds and does not question Mary as he is nervous that he is alone without his usual preceptor and does not want to anger the team leader. Mary documents both his initials and those of the absent circulating nurse in the perioperative record.

Upon return from lunch, the circulating nurse, Faith, reviews the documentation for completeness before signing off the record. She notices her initials on the medication check and informs the nurse manager.

Scenario 3 – Analysis of the Four Evils			
The Evil	**Definition**	**Apply to this event?**	**Rationale**
Human Error	Should have done other than what they did	Possibly	The term human error is generally used for less culpable conduct
Negligence	Failure to Exercise expected care. Should have been aware of substantial and unjustifiable risk.	Yes	Identified high risk medication, several near misses have occurred which should make Mary aware of the risk
Recklessness	Conscious disregard of substantial and unjustifiable risk	Yes	Mary was aware of the requirement for a double check and falsified the documentation record
Intentional rule Violation	Knowingly violates a rule or procedure	Yes	It was knowingly a violation not to get a second nurse for the verification and to falsify the perioperative record.