

Intro to a Just Culture

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The Three Behaviors

Human Error	At-Risk Behavior	Reckless Behavior
Product of Our Current System Design and Behavioral Choices Manage through changes in: • Choices • Processes • Procedures • Training • Design • Environment	A Choice: Risk Believed Insignificant or Justified Manage through: • Removing incentives for at-risk behaviors • Creating incentives for healthy behaviors • Increasing situational awareness	Conscious Disregard of Substantial and Unjustifiable Risk Manage through: • Remedial action • Punitive action
Console	Coach	Punish

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Key Principles of Lean

- Lean is a way of thinking
- Lean is a way of doing more with less...
 - less human effort
 - less equipment
 - less material
 - less time
 - less space
- Get the customer what they want, when they want it
- Lean programs must have flexible, motivated, invested team members continuously solving problems

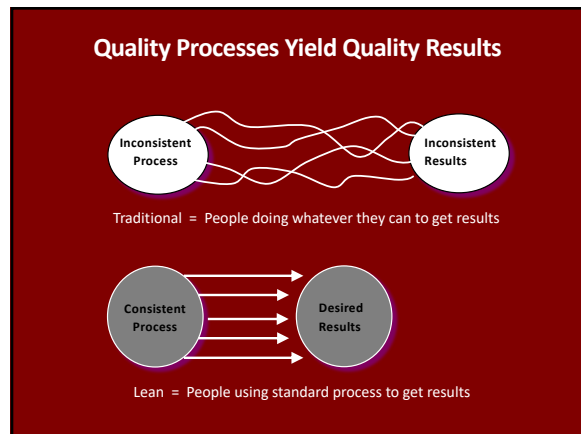
All waste can and should be eliminated

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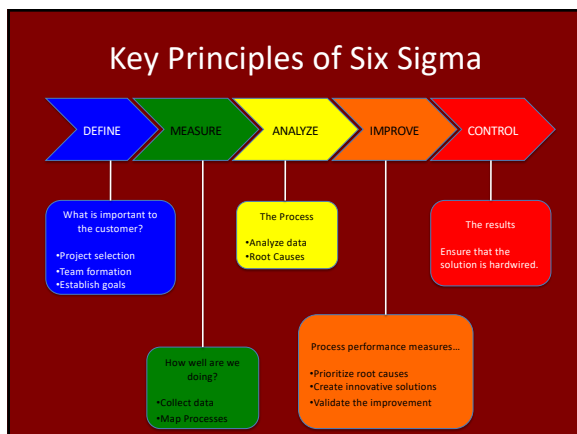
Traditional vs. Lean cultures

TRADITIONAL	LEAN
Functional Silos	Interdisciplinary teams
Managers direct	Managers teach/enable
Benchmark to justify not improving; "just as good"	Seek the ultimate performance, the absence of waste
Blame people	Root cause analysis
Rewards: individual	Rewards: group sharing
Supplier is enemy	Supplier is ally
Guard Information	Share information
Volume lowers cost	Removing waste lowers cost
Internal focus	Customer focus
Expert driven	Process driven

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Six Sigma

- Solves Problems with
 - A defined Scope
 - That are linked to the Customer
- Change is managed by Influencing stakeholders
- Selected Projects are
 - Aligned to overall Strategic Plan
 - Have a business Case

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Process Sigma (σ)

Process Sigma	DPMO	Percent
1.0	691,500	30.9%
2.0	308,500	69.2%
3.0	66,800	93.3%
4.0	6,200	99.4%
5.0	320	99.98%
6.0	3.4	99.9997%

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Root Cause Analysis

Clinical Uses:
Any patient-care related incidents, including near-misses (e.g., medication errors, falls)

Operational Uses:
Any incident impacting the ability of our organization to maintain status quo operation of a service or department (e.g., ability to produce accurate bills, equipment failure).

The Objective is NOT:

- to make it into a “Blame Game”
- a Witch Hunt
- or a method to find out who screwed up.

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