

# JUST CULTURE

**Your Organization**



# OBJECTIVES

1. Define “Just Culture,” the Progression of development, and importance in organizational Safety Culture
2. List the evils of historical disciplinary theory, and how to determine culpability of unsafe acts
3. Identify organizational characteristics of Just Culture
4. List The Path to create a Just Culture
5. Outline Benefits and Obstacles in implementation
6. Identify the role of organizational leadership

# ***THE DEFINITION***

- Observable customs, behavioral norms, stories, rites
- Unobservable assumptions, values, beliefs, ideas shared by groups
- All aspects of culture linked to safety

# Development of *JUST CULTURE*

“No-blame culture” flourished in the 1990s and still endures today.  
Sought to replace “punitive cultures.”

It acknowledged that a large proportion of unsafe acts were ‘honest errors’ (the kinds of slips, lapses and mistakes that even the best people can make) and were not truly blameworthy, nor was there much in the way of remedial or preventative benefit to be had by punishing their perpetrators.

Two serious weaknesses.

1. It ignored—or, at least, failed to confront—those individuals who willfully (and often repeatedly) engaged in dangerous behaviors that most observers would recognize as being likely to increase the risk of a bad outcome.
2. It did not properly address the crucial business of distinguishing between culpable and non-culpable **unsafe acts**.

# LINE

between unacceptable behavior and  
blameless unsafe acts

HEALTHCARE AS  
A LARGELY  
PUNITIVE  
CULTURE.

You're smart, you try hard, you don't make mistakes. You make mistakes, you're stupid, you didn't try hard enough

NO BLAME  
CULTURE

Honest errors, slips, lapses, no remedial benefit in punishment



Prior to 1990's

1990's

When an incident  
occurs that impacts  
Patient Safety,  
someone will be  
blamed.

# SHORTCOMINGS

*NO BLAME CULTURE*

**Unacceptable  
Behavior**  
(willful, dangerous)

GREY AREA

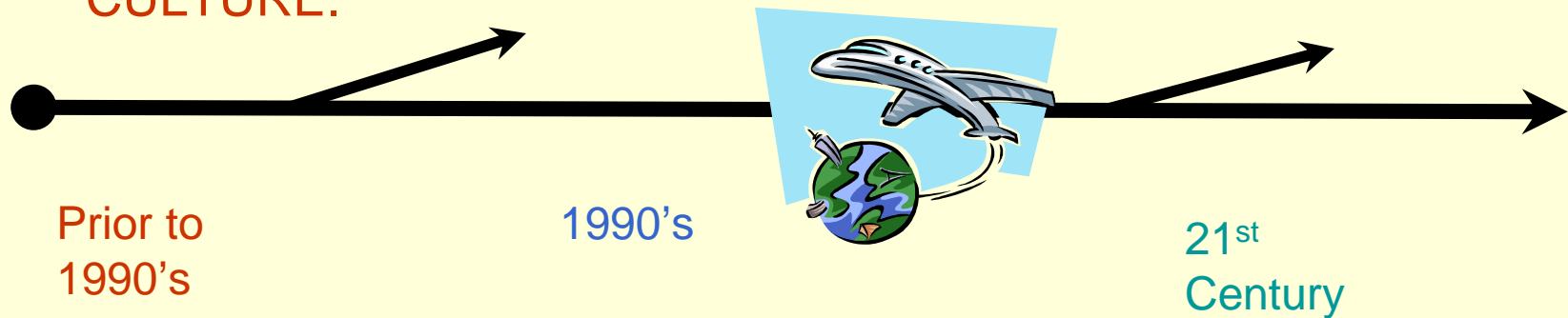
**Blameless  
Unsafe Acts**

# *The Progression*

HEALTHCARE  
AS A  
LARGELY  
PUNITIVE  
CULTURE.

NO BLAME  
CULTURE

JUST  
CULTURE



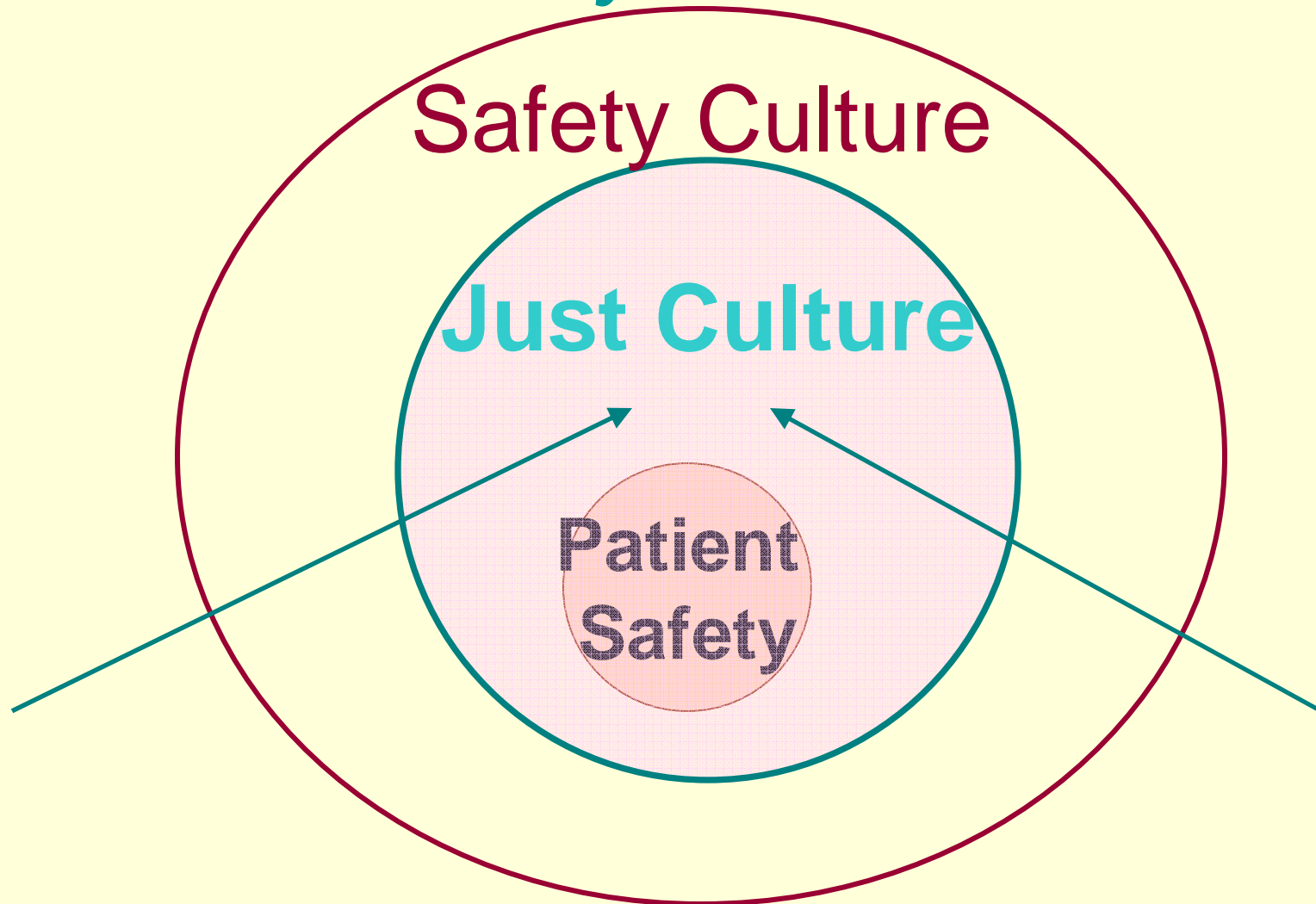
# *Just Culture* **BALANCE**

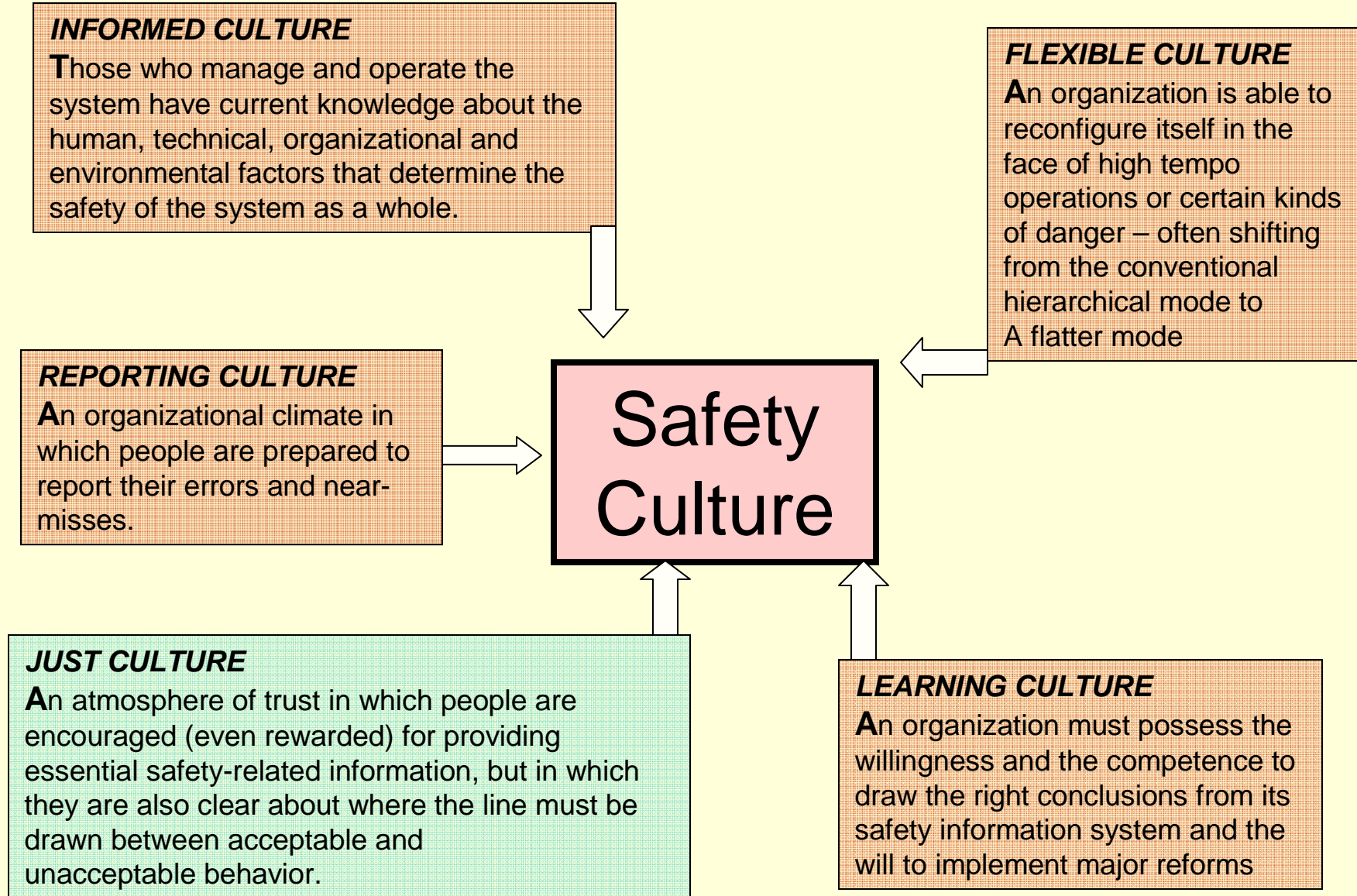
**No  
Blame**



**Accountable  
for All  
Errors;  
Punitive  
Culture**

***Resides within an organization's overall safety culture***





# *Just Culture – David Marx*

- Principles
  - Frontline personnel feel comfortable disclosing errors—including their own—while maintaining professional accountability.
  - Individual practitioners should not be held accountable for system failings over which they have no control
  - Recognizes many individual or “active” errors represent predictable interactions between human operators and the systems in which they work
  - Revised health care’s culture that used to hold individuals accountable for all errors or mishaps that befall patients under their care.
  - NOT “no blame” , but does not tolerate conscious disregard of clear risks to patients or gross misconduct (eg, falsifying a record, performing professional duties while intoxicated).

# *Just Culture*

- Recognizes that competent professionals make mistakes
- Acknowledges that even competent professionals will develop unhealthy norms (shortcuts, “routine rule violations”)
- Zero tolerance for reckless behavior

*HISTORICAL DISCIPLINARY  
THEORY*

# ***THE FOUR EVILS***

HUMAN ERROR

NEGLIGENT  
CONDUCT

RECKLESS  
CONDUCT

KNOWING  
VIOLATIONS

## DISCIPLINARY THEORY – Historical Model

### THE FOUR EVILS

#### HUMAN ERROR

SOCIAL LABEL

Individual should have done other than what they did, inadvertently causes or could cause an undesirable outcome

#### NEGLIGENT CONDUCT

Subjectively more culpable than human error.

Negligence (legal term) = individual harmed by the healthcare system.

**Negligence** = failure to exercise the skill, care, and learning expected of a reasonably prudent healthcare provider.

Failure to recognize a risk that should have been recognized

#### RECKLESS CONDUCT

Gross Negligence,  
Conscious disregard of visible risk  
Higher degree of culpability than negligence.

#### KNOWING VIOLATIONS

Knowingly violates a rule.  
Not necessarily related to risk taking, individual knew of or intended to violate a rule, procedure, or duty in the course of performing a task.

# To Deviate is Human

## HUMAN ERROR Inadvertent Action

- Manage:**  
*Changes in*
- *Process*
  - *Procedure*
  - *Training*
  - *Design*

## AT RISK BEHAVIOR Unintentional Risk Taking

- Manage:**  
*Remove incentives for  
at-risk behaviors  
Create incentives for  
healthy behaviors  
Increase situational  
awareness*

## RECKLESS BEHAVIOR Intentional Risk Taking

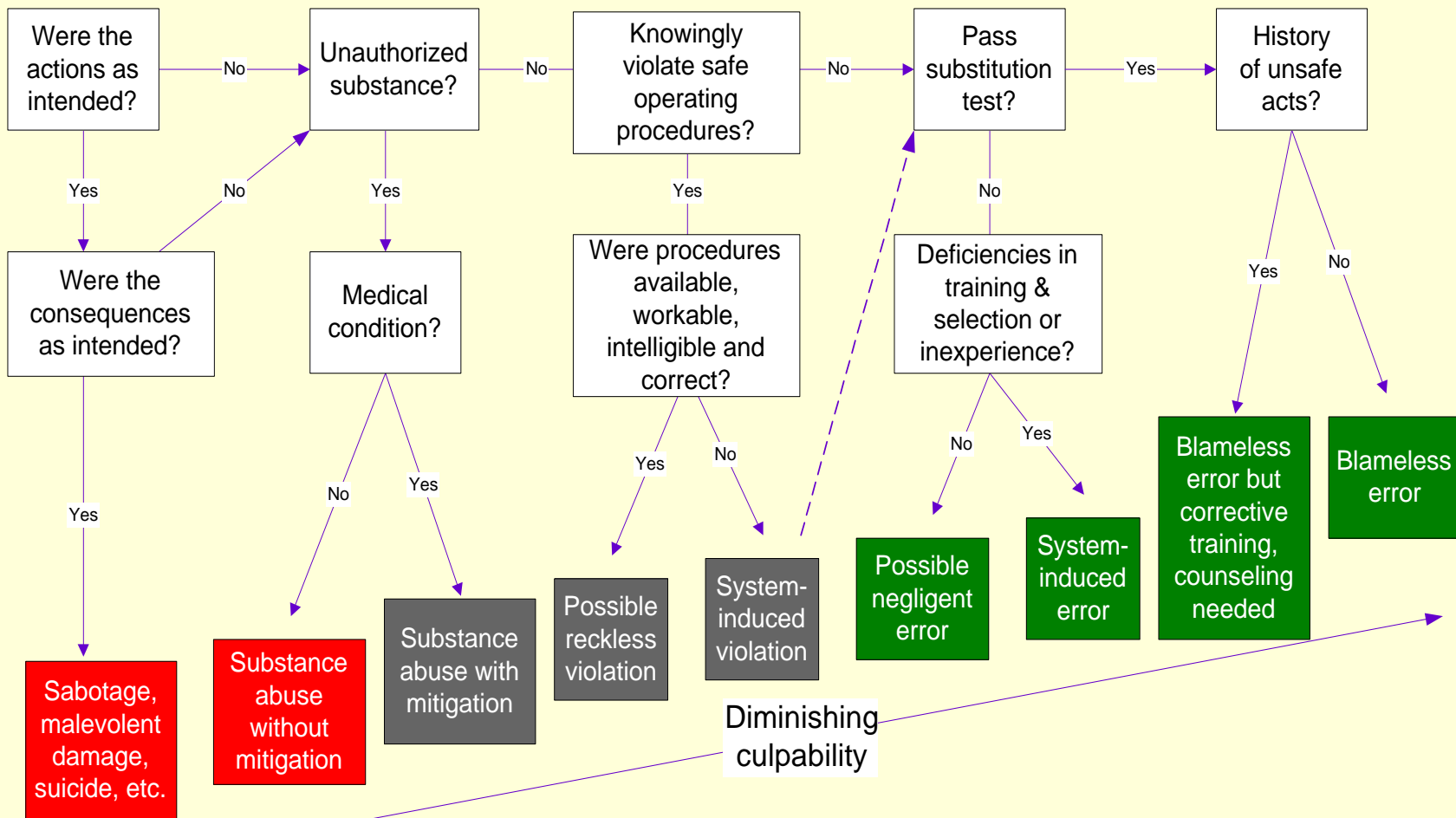
- Manage:**
- *Remedial action*
  - *Punitive action*

# *A Simple Arthroscopy*

- 45 y.o. woman, wanted to ski more
- Friday afternoon, last case for Chief Of Orthopedics
- OR running late
- 2 nurses moved to ortho to do **“NO BRAINER”**..... never worked orthopedics
- staff repeatedly interrupted
- anesthesia wanted more EKG paper
- doc didn't know nurses
- loud music in the room
- **“give me..... w/ epi”**
- nurses afraid to “speak up” to Chief of Orthopedics

# *Test the theory*

<b>Behavior</b>	<b>Choose The Behavior</b>	<b>See The Risk?</b>	<b>DUTY?</b>
<b>Human Error</b>	NO	NO	<b>CONSOLE</b>
<b>At Risk Behavior</b>	YES	NO	<b>COACH</b>
<b>Reckless Behavior</b>	YES	YES	<b>PUNISH</b>



## Decision Tree for Determining Culpability of Unsafe Acts

# *Dummying It Down*

- Did you mean to hurt someone?
- Did you come to work drunk or impaired?
- Did you think it was a bad idea?
- Could someone in a similar situation make the same mistake?

# ***FAIR AND JUST CULTURE***

- What are the rules?
- Does everyone know them?
- How do we differentiate an individual with a problem vs a good person set up to fail in an unsafe system?
- The critical importance of having one set of rules and avoid work-arounds
  - *NORMALIZATION OF DEVIANCY*

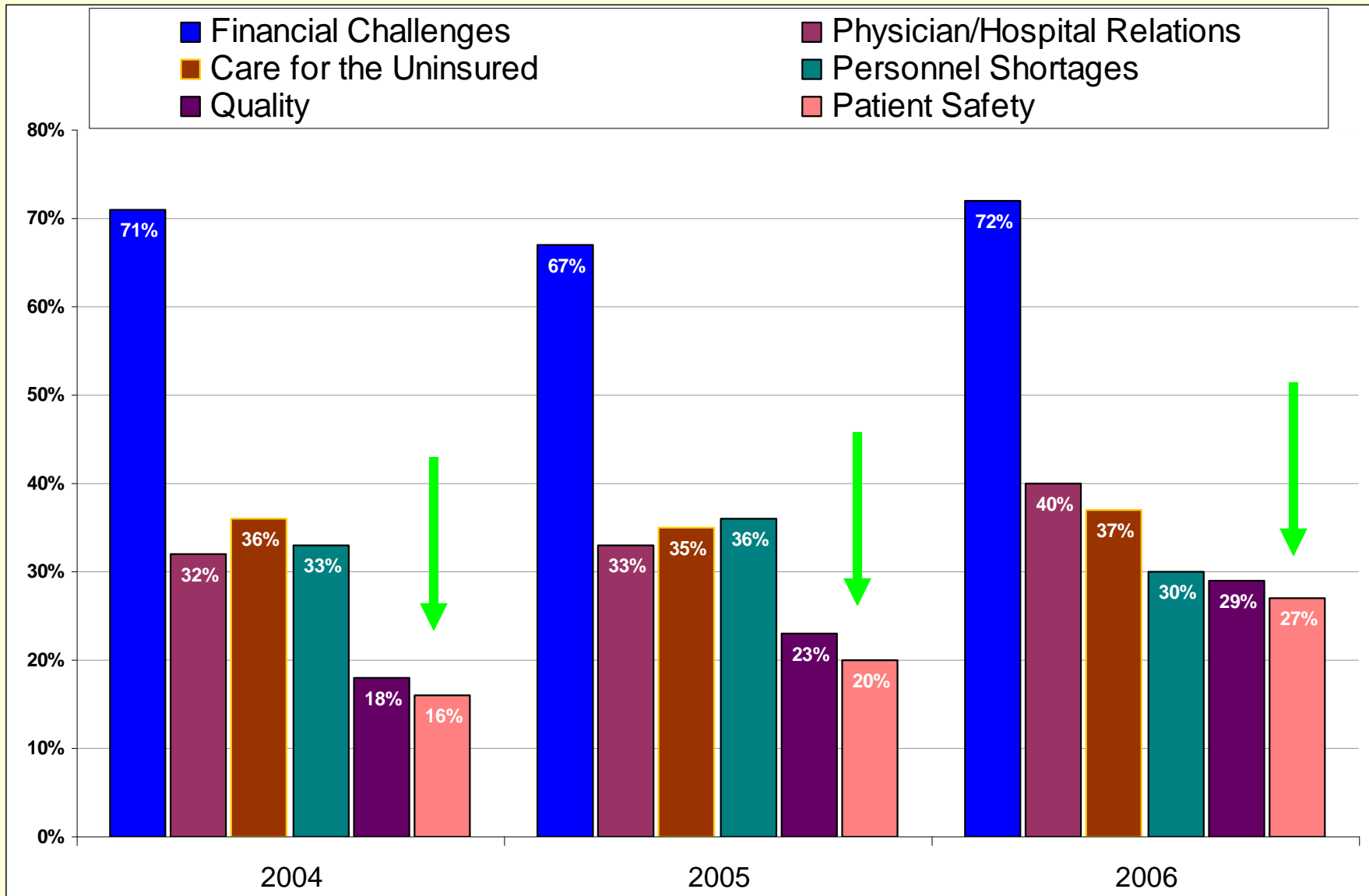
*“I never follow the policy”*

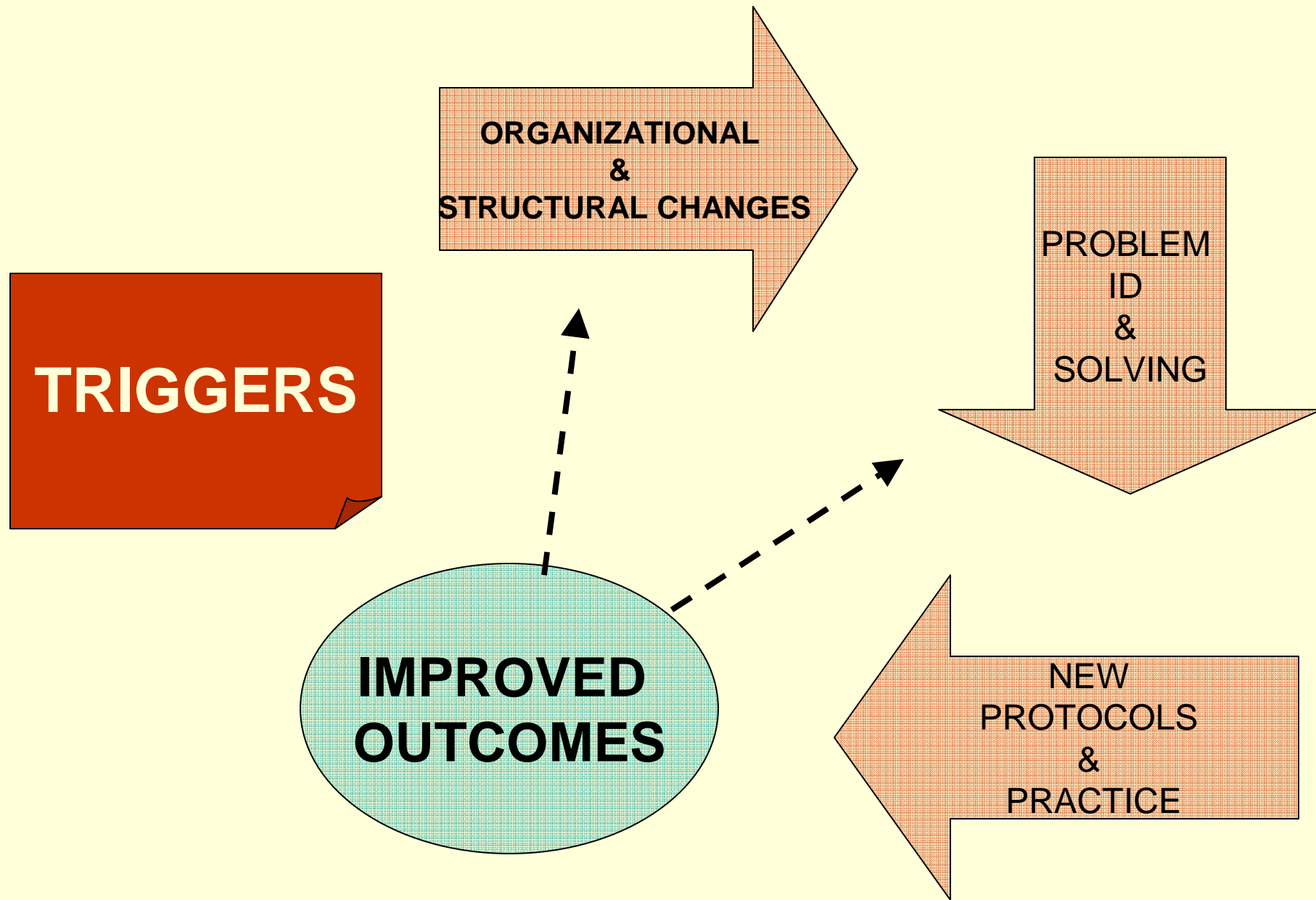
# WHY IS THIS IMPORTANT ?

- **To understand the scope of medical error and correct, create a climate that fosters trust**
- Healthcare professionals are encouraged and willing to report errors and incidents, near misses or “good catches”
- **Provides fair-minded treatment, creates effective structures that help people reveal their errors and help the organization learn**
- It is NOT non-accountable, nor does it mean avoidance of critique or assessment of competence
- **After careful collection of facts, if reckless or willful violation of policy, negligent behavior, corrective action may be appropriate**

# The Path to Improvement

# CEO's TOP CONCERN?





# ***BENEFITS***

1. Increased reporting
2. Trust building
3. More effective safety and operational management

# ***WHAT CHANGES?***

Two concepts:

- *Human error* is inevitable; system monitoring and improvement crucial to accommodate those errors
- Individuals are *accountable* for actions if knowingly violate safety procedures or policies

# ***THE PLAN***

- Time to undertake steps and sub-steps
- Estimated costs
- Who will undertake the work

# THE WORK

## Creating and Implementing a Just Culture

- **Legal Aspects**
  - change legal framework to support reporting of incidents,
  - indemnity against disciplinary proceedings
- **Policy and Procedure**
  - confidentiality /de-identification of reports
  - commitment to safety
- **Methods of Reporting**
  - rapid, useful accessible feedback
  - professional handling of investigations and lesson dissemination
  - mandatory vs. voluntary?
  - procedures for determining culpability
- **Template for Feedback**
  - what info should be disseminated
  - what should be kept confidential
  - how to and how often to disseminate
- **Plan for Education**
  - identify champions,
  - root cause analysis training,
  - present to ALL staff

# OBSTACLES

- **Societal/legal “someone must pay” in healthcare culture**
- **Persuasion of senior leadership of need and commitment of adequate resources**
- **“Right” kind of respected people with energy to run the system**
- **Too much/irrelevant data**
- **Getting and keeping staff interested, disseminate to wide-enough audience**

# Role of the Executive

- **Lead by example and mentoring**
- **Set strategic goals related to culture**
- **Secure funding for education**
- **Select measurement tools**
- **Diagnose, Implement, Measure**
- **Bring organization into state-wide initiatives (IHI, voluntary reporting)**
- **Work with others (professional organizations, state bodies) to replace punitive strategies with ones that support culture**

# Believe and Reinforce Every Day

## Focus on process vs. person

- **Staff understand responsibility to report errors**
- **Mgmt encourages staff to complete incident reports**
- **Leadership accountable to provide feedback to staff on trends identified thru incident reporting**
- **Reports are confidential**
- **Reports are used by all staff**

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