Just Culture: A Balance Between Punitive and Blame Free Cultures to Create Cultures of Safety

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Adapted from presentations and resources from:
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California Patient Safety Action Coalition (CAPSAC) and www.justculture.com
“There are activities in which the degree of professional skill which must be required is so high, and the potential consequences of the smallest departure from that high standard are so serious, that one failure to perform in accordance with those standards is enough to justify dismissal.”

Lord Denning
English Judge
The Reality

“People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right? Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue.”

Don Norman
The single greatest impediment to error prevention in the medical industry is “that we punish people for making mistakes.”

Dr. Lucian Leape
Professor, Harvard School of Public Health
Testimony before Congress on Health Care Quality Improvement
The Problem: Labeling The Behavior

“As far as I am concerned, when I say “careless” I am not talking about any kind of “reckless” operation of an aircraft, but simply the most basic form of simple human error or omission that the Board has used in these cases in its definition of “carelessness.” In other words, a simple absence of the due care required under the circumstances, that is, a simple act of omission, or simply “ordinary negligence,” a human mistake.”

National Transportation Safety Board
Administrative Law Judge
Engen v. Chambers and Langford
The Tension

• To improve patient safety, we must make better use of minor human error events
• The threat of corporate disciplinary action and regulatory enforcement is a major obstacle to event reporting and investigation
• The role of disciplinary action must be addressed
The Four Evils?
The Words You Use Today

- Human Error
- Negligent Behavior (carelessness)
- Reckless Behavior (gross negligence)
- Knowing Violations
Distinguishing Negligent and Reckless Behavior

• Negligence
  – Should have been aware of a substantial and unjustifiable risk
  – Equivalent to social definition of human error
  – A compensatory concept in the law

• Recklessness
  – Conscious disregard of a substantial and unjustifiable risk
  – A punitive concept in the common law
A Just Culture

• A Set of Beliefs
  – A recognition that professionals will make mistakes
  – A recognition that even professionals will develop unhealthy norms
  – A fierce intolerance for reckless conduct
A Just Culture

• A Set of Duties
  – To raise your hand and say “I’ve made a mistake”
  – To raise your hand when you see risk
  – To resist the growth of at-risk behavior
  – To participate in the learning culture
  – To absolutely avoid reckless conduct
The Behaviors We Can Expect

• Human error – *inadvertent action*; inadvertently doing other than what should have been done; slip, lapse, mistake.

• At-risk behavior – *behavioral choice* that increases risk where risk is not recognized, or is mistakenly believed to be justified.

• Reckless behavior - *behavioral choice* to consciously disregard a substantial and unjustifiable risk.
# The Three Behaviors

## Human Error

*Product of Our Current System Design*

Manage through changes in:
- Processes
- Procedures
- Training
- Design
- Environment

## At-Risk Behavior

*A Choice: Risk Believed Insignificant or Justified*

Manage through:
- Removing incentives for at-risk behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

## Reckless Behavior

*Conscious Disregard of Unjustifiable Risk*

Manage through:
- Remedial action
- Disciplinary action
Leadership Accountabilities

• Provides the vision—demonstrates a commitment to safe, reliable delivery of high quality care
• Establishes a sense of urgency around managing risks
• Creates an environment of internal transparency around risk
• Demonstrates an open, fair and learning culture, including response to behaviors, errors, and events
• Encourages trust and participation to improve safety and other core values
• Uses data to measure performance and build both unit and organizational models for the allocation of resources
Just Culture
Does not Exist in A Vacuum

• Create an Open and Fair Culture
  – Move away from an overly punitive culture and strike a middle ground between punitive and blame free
  – Recognize human fallibility
    • Humans will make mistakes
    • Humans will drift away from what we have been taught

• Create a Learning Culture
  – Develop culture that is eager to recognize risk at both the individual and organizational level
  – Risk is seen through events, near misses, and observations of system design and behavioral choices
  – Without learning we are destined to make the same mistakes
Just Culture
Does not Exist in A Vacuum

• Design Safe Systems
  – Reduce opportunity for human error
  – Capture errors before they become critical
  – Allow recovery when the consequences of our error reaches the patient
  – Facilitate our employees making good decisions

• Manage Behavioral Choices
  – Humans will make mistakes. We must manage behavioral choices in a way that allows us to achieve the outcomes we desire
  – Cultures will drift into unsafe places
  – Coaching each other around reliable behaviors
Implementing a Just Culture
Create a Safety-Supportive Policy

- State the Purpose
- Set the Expectations
Modify Your Toolset

• Safety-oriented event investigation
  – Explain every error
  – Explain every violation
  – What do events say about “future” risk

• Begin thinking prospectively
  – Chronic unease
  – Failure Modes and Effects Analysis
  – Probabilistic Risk Assessment
  – Proactive At-Risk Behavior Analysis
Train the Management Team
(an example curriculum)

- Just Culture and Patient Safety
- An Intro to Human Error
- Managing Normal Error
- Managing At-Risk Behavior
- Managing Reckless Behavior

- Event Reporting and Investigation
- The Investigation Process
- Making System Changes
Even the best of us are going to make mistakes...
Think of A Just Culture......

• It is more of what we teach our kids
  – An expectation that errors will be reported (transparency)
  – No expectation of perfection
  – Accountability for choosing to take risk
  – Expectations set at system level
  – Expectation that system safety will improve

David Marx