Do You Think You Have a "Just Culture" in Your Hospital?

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A question has come up many times and generated a wide range of responses that are so inconsistent. What is "just culture"? Actually, it's not an easy question to answer; it's mostly intended to trigger valuable dialogue on the topic. Many healthcare professionals use this term to denote safety culture.

What is a "Just Culture"?

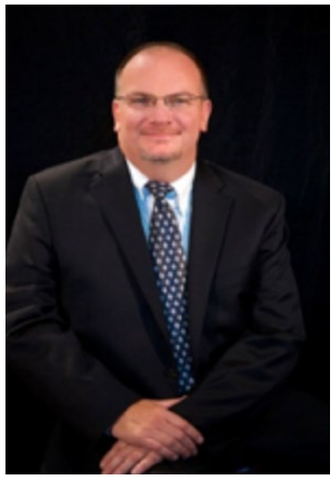
"Just Culture" is a defined set of values, beliefs, and norms about what is important, how to behave, and what behavioral choices and decisions are appropriate related to occurrences of human error or near misses.

- In a "just culture", open reporting and participation in prevention and improvement is encouraged.
- In a "just culture", there is recognition that errors are often system failures (not individual failures) and a focus on understanding the root of the problem allows for learning, process improvement, and changes to design strategies and systems to promote prevention.
- A "just culture" is not a "blame-free" culture. Rather, it is a culture that requires full disclosure of mistakes, errors, near misses, patient safety concerns, and sentinel events in order to facilitate learning from such occurrences and identifying opportunities for process and system improvement.
- A "just culture" is a culture of accountability in which individuals will be held responsible for their actions within the context of the system in which they occurred; such accountability may involve system improvement or individual consoling, coaching, education, counseling, or corrective action.
- A "just culture" balances the need to learn from mistakes with the need to take corrective action against an individual if the individual's conduct warrants such action.
- A "just culture" is one in which nurses and other caregivers are cognizant of, and look for, the risks around them, report errors and hazards, make the right choices, and help design safe systems to prevent mistakes.
- A "just culture" is a middle ground between a blame free culture with no personal accountability and a culture in which individuals are blamed for all mistakes. While it discourages blame, it is not a "no-fault" system. (1)

Pioneers of "Just Culture"

To learn more about the "just culture", three names should become familiar to us because of their contribution to "just culture" in hospitals: David Marx, Lucian Leape, and Peter Pronovost.

David Marx



David Marx is considered the father of "just culture" and the founder of The Just Culture Community. As a system safety engineer with a Juris Doctor in law, David has dedicated his professional work to bring safety science and law together to help improve operational safety and performance. David encourages and teaches methods of culture change management in order to help organizations learn from within.

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The Just Culture Community was formed with the help of partners in aviation and healthcare to combine resources to allow for the development of increasingly better methods and tools. The Just Culture Community aims to collectively improve patient safety, reduce risk, and avoid punishing the blameless. This Community brings these tools to organizations as large as an airline, and as small as an independent nursing facility.

Lucian Leape

An adjunct professor of health policy at Harvard School of Public Health. He is a pediatric surgeon and health policy innovator at Harvard Medical School. He is the founder of the American Pediatric Surgical Association, and he participated in the establishment of the National Patient Safety Foundation.

His work is focused on the application of systems theory to health care, improving disclosure and apology following medical harm, and changing medical culture to be more respectful and patient-centered. In 2007, the Lucian Leape Institute was established to further strategic thinking in patient safety. When talking about discipline, Dr. Leape believes that "The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes."

Peter Pronovost

Is the Sr. Vice President for Patient Safety and Quality and Director of the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine. Peter Pronovost is a practicing anesthesiologist and critical care physician dedicated to find ways to make hospitals and healthcare safer for patients. Dr. Pronovost has developed a scientifically proven method for reducing the deadly infections associated with central line catheters. He serves in an advisory capacity to the World Health Organization's World Alliance for Patient Safety.

Dr. Pronovost was named by the Time magazine as one of the world's 100 "most influential people" for his work in patient safety. Dr. Pronovst added the dimension of accountability to the error prevention approach.

Implementing "Just Culture" in Your Hospital

The Patient Safety Network of the Agency for Healthcare Research in Quality (AHRQ) explains that the "just culture" does not tolerate conscious disregard of clear risks to patients or gross misconduct (e.g., falsifying a record, performing professional duties while intoxicated). A "just culture" recognizes that competent professionals make mistakes and acknowledges that even competent professionals will develop unhealthy norms (shortcuts, "routine rule violations"), but has zero tolerance for reckless behavior. (2)

According to the AHRQ, in a "just culture" the frontline staff will feel comfortable in disclosing errors including their own while maintaining professional accountability.
Do you believe your hospital operates within a "just culture"? To assess the extent of implementing a "just culture", AHRQ conducted a survey during 2012 on a representative sample of American hospitals and concluded the following:

Organizational Values:

Safety should always be a primary value. It should be clear to workers that safety should not be sacrificed to achieve secondary goals such as productivity. Yet, 26% of respondents from hospitals that participated in the AHRQ culture survey said that, whenever pressure builds up, managers want staff to work faster, even if it means taking shortcuts. Fifty percent said they work in crisis mode, trying to do too much too quickly, and 36% reported that safety is sacrificed to get more work done.

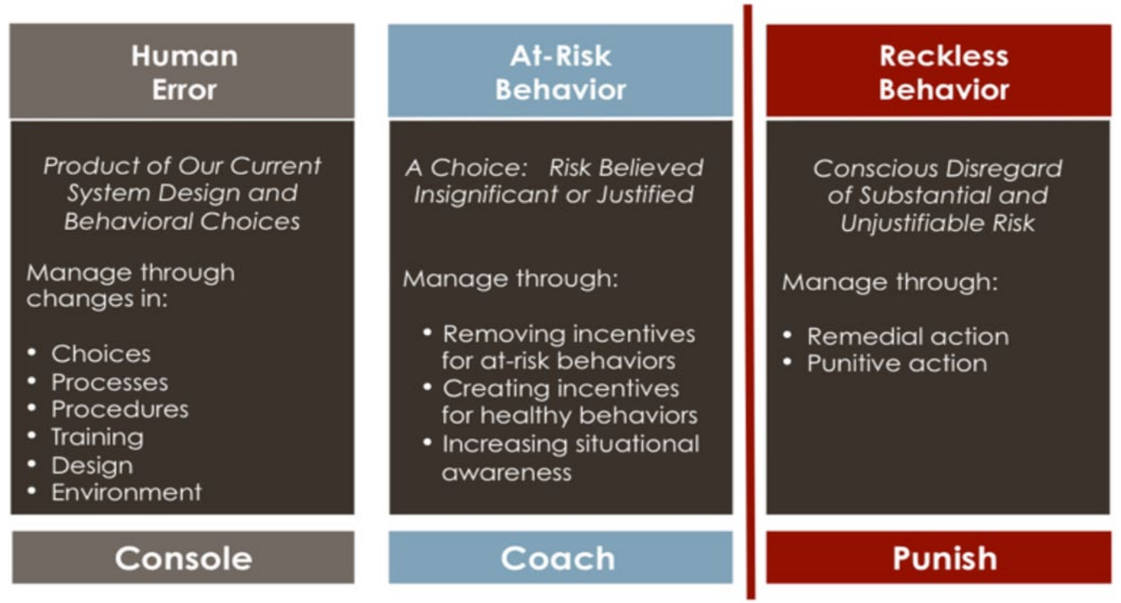
Open discussion of safety as a high value, and seeing leaders and managers behave in a manner that demonstrates that safety comes first, encourages and supports staff decisions to do the same. But, about a quarter of respondents to the AHRQ survey reported that managers overlook repetitive safety problems and do not act in a way that demonstrates to staff that safety is a top priority.

The"Just Culture" Behaviors?

James Reason notes that hospitals should aim at cultures that are just, that report, learn, inform and are flexible. Reason notes that a "just culture" creates an atmosphere of trust, encouraging and rewarding people for providing essential safety-related information. (3)

Human error: Humans are not perfect, so any system we create should expect errors to occur and account for them as a normal part of the process. A slip, a lapse, a mistake can happen to the best of us, so human error, rather than being a punishable action, becomes an opportunity to learn and to improve our systems.

At-risk behavior: Sometimes people get complacent and start to drift away from the rules. They begin to engage in at-risk behavior, placing themselves and others at risk. Many times healthcare workers do not perceive the risk, or have temporarily forgotten it. In this case coaching and education are the answer, a reminder of the risks that may have been forgotten or mistakenly justified.



At-risk behaviors represent the greatest risk to patients. In a "just culture", the solution is not to punish those who engage in at-risk behaviors, but to identify and report these behaviors, determine the scope of the behavior, uncover and remedy any upside-down rewards and the system-based causes for the behaviors, and decrease staff tolerance to risk-taking.

Within a "just culture", at-risk behaviors are reduced by removing the barriers to safe behavioral choices, removing the rewards for at-risk behaviors, and coaching staff to reduce their tolerance to risk and encourage a decision-making process that results in the desired safe behavioral choices. Unlike "counseling," which is typically a downward discussion that entails putting the employee on notice regarding potential disciplinary action, coaching involves manager-to-staff, peer-to-peer, and staff-to-manager coaching.

Reckless behavior: In rare occasions, people engage in reckless behavior, choosing knowingly to place themselves or others in harm's way. They see the risk, and they understand the harm that can be done. The individual(s) responsible for these choices obviously need to be subject to disciplinary action. (4)

Hospitals that operate within a "just culture" have defined and communicated individual accountabilities so all staff understand what is expected of them. Staff at all levels are held accountable for making safe behavioral choices and decisions that promote safety. Hospital employees are judged on the quality of their behavioral choices, not the outcome or potential outcome of a hazard or mishap. If an error happens, employees should know that they will be treated fairly when they report their mistakes, and that they will be accountable for the quality of their choices, and not simply the outcome.

Balancing Safety and Accountability

In his book " Just Culture- Balancing Safety and Accountability" Sidney Dekker of the Lund University, School of Aviation in Sweden emphasizes the importance of creating a work safety culture that is fair and not vindictive, open to change and not closed to scrutiny. (5)

It is important to preserve an appropriate balance of

accountability. Peter Pronovost and Robert Wachter talk about accountability in their JAMA article in Oct 2009. (6)

What Should We Do?

Thaden and Hoppes prescribe the following steps to achieve a "just culture" in our hospitals:

- Organizational Commitment: the organization's commitment to safety, as expressed by upper management
- Managerial Involvement: the active involvement of mid level managers or supervisors in promoting safety
- Employee Empowerment: the degree to which individual employees are empowered to make safety a priority
- Accountability System: the system by which employees are held accountable for acting unsafely
- Reporting System: the quality and usability of the system for reporting and processing safety information. (7)

To implement an effective "just culture" in our hospitals, we must promote learning from mistakes, rather than focus on blame. It is hoped that this review of available knowledge on the "just culture" would provide hospital executives in our region with an insight to re-examine their value system in order to incorporate patient safety among their primary values.

It is believed that most errors are human related. Healthcare professionals need to be encouraged to report errors and provided the time to do so. The hesitancy to report is mainly due to fear of negative repercussions. People do feel, whether justified or not, that there is a blaming culture. Healthcare organizations should strive to create a culture of patient safety that encompasses the following elements:

- Patient safety should be valued as a top priority, even at the expense of productivity
- A just culture is a healthcare environment where actions are analyzed to ensure that individual accountability is established and appropriate actions are taken
- A commitment to safety must be articulated at all levels of the organization, from the executive suite to the direct interaction with patients at the floor level.

We want to create an open, fair and just culture where the staff feel comfortable to report and discuss errors. We want to create safe systems and train the staff to follow safe practices and ensure that time outs, bar coding, double checking of high alert medications are being done systematically. We want to avoid the effects of staff fatigue where nurses and residents do not work over 60 hours a week.

We should learn from our mistakes and make sure that hospital staff are aware of what happens at our facilities. We want to manage the behavioral choices of hospital staff to avoid short-cuts and promote a blame-free culture

References

1. http://nursing2015.files.wordpress.com/2010/02/what-is-a-just-culture4.pdf
2. http://psnet.ahrq.gov/popup_glossary.aspx?name=justculture
3. Reason, J.: Managing the Risks of Organisational Accidents. Hants, England, Ashgate. 1997.
4. https://www.justculture.org/what-is-just-culture/
5. Dekker, Sidney: Just Culture-Balancing Safety and Accountability, Ashgate, 2012
6. Wachter, R, and Pronovost, P, "Balancing "No Blame" with Accountability in Patient Safety" The New England Journal of Medicine, Oct. 2009
7. Terry L. von Thaden & Michelle Hoppes: Measuring A Just Culture in Healthcare Professionals: Initial Survey Results, University of Illinois at Urbana-Champaign, Savoy, IL and The Risk Management & Patient Safety Institute, Lansing, MI

Infos

Pour Rester Belle ou Beau, Dormez!

Une étude publiée dans le *British Medical Journal* confirme pour la première fois de manière scientifique que le sommeil embellit. Nous savons qu'après une nuit sans dormir, festive ou de labeur, le miroir nous renvoie l'image d'un visage fatigué, creusé, doté de cernes sombres et d'un teint sans éclat.
Les chercheurs de l'Institut Karolinska, en Suède, ont entrepris de photographier 23 jeunes gens (filles et garçons) âgés de 18 à 31 ans, après une bonne nuit, et après une privation de sommeil. 65 observateurs ne connaissant pas l'objet de l'étude ont classé les photos selon le degré de séduction qui s'en dégageait. Résultats: la majorité des observateurs a estimé que **les photos après un manque de sommeil affichaient moins de séduction, moins d'éclat et plus de fatigue.** Si le sommeil est indispensable à la mémoire, l'argument beauté devrait, lui, plus inciter les jeunes filles à se coucher tôt!