An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

Building a Just Culture in Healthcare: a HSE Dialogue Croke Park Conference Centre, Dublin, 23rd May 2023

A Discussion Paper

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1. Introduction

Commitment 2 of the HSE Patient Safety Strategy[1] states *"We will work to embed a culture of learning and improvement that is compassionate, just, fair and open".* It also states that *"Creating and maintaining a positive safety culture and designing safe systems of care is central to the mission of our health and social care services. It is a culture where safety is seen as an organisational wide priority, there is learning from failures and successes, there is understanding of the current climate and its challenges and meaningful actions for improvement are implemented. Staff must be actively encouraged to speak up for safety, feel psychologically safe, be involved in decisions which affect the safe delivery of care and be provided with the skills, support and time to engage in patient safety improvement initiatives".*

In 1997, James Reason asserted that the most effective safety cultures are informed about best safety practices, able and willing to report safety related issues, staffed with employees who trust each other's commitment to best practices, flexible to adapt and alter best safety practices, and value safety related events as opportunities to learn from mistakes in order to make substantial system changes[2].

In a BMJ article in 2000[3], Reason stated that *Trust is a key element of a reporting culture and this, in turn, requires the existence of a just culture—one possessing a collective understanding of where the line should be drawn between blameless and blameworthy actions. Engineering a just culture is an essential early step in creating a safe culture.* This is a sentiment echoed by a number of safety and Human Factor experts worldwide who state that *it is crucial that the organizational culture is more likely to be perceived as a just one. However, it is also important for management staff to understand the line between unacceptable behaviour, deserving of disciplinary action, and the reminder where punishment is neither appropriate nor helpful in furthering the cause of safety. A prerequisite for a learning/ adaptive culture is a just and well-constructed reporting system*[4]. **However…..**

Your Opinion Counts staff survey was undertaken in 2016, 2018 and was repeated in 2021. In relation to specific safety questions, 80% of respondents reported that they are encouraged to report Errors, Near Misses and Incidents and 78% have clear guidance on how to do so. However, only 56% agreed that staff involved in errors, near misses and incidents are treated fairly and 48% reported that they are not given feedback about changes made in response to reported errors, near misses and incidents.

While further analysis is required to identify the reasons why staff would not feel that they would be treated fairly in the HSE, a recent study in the NHS[5] detailed concerns raised by junior doctors and medical staff related to whether they would be treated fairly if investigated, these included: feelings that organisational factors will not be appropriately considered, fear of being scapegoated with four interviewees citing the case of Dr Bawa-Garba and fear of racial discrimination.

2. What is Just Culture?

The first fully developed theory of a just culture was in James Reason's 1997 book, *Managing the Risks of Organizational Accidents*[2]*.* where Reason postulated that a just culture was one of the key components of a safety culture. Reason proposed that a just culture is required to build trust so that a reporting culture will occur, where all safety incidents are reported so that learning can occur and safety improvements can be made.

The concept of Just Culture relates to systems thinking which emphasizes that mistakes are generally a product of faulty organizational cultures, rather than being attributable to the person or persons directly involved. In a just culture, after an incident, the question asked is, "What went wrong?" rather than "Who

[1] HSE patient Safety Strategy 2019-2024 https://www.hse.ie/eng/about/who/nqpsd/patient-safety-strategy-2019-2024.pdf
[2] Reason J. Managing the risks of organizational accidents. Aldershot: Ashgate; 1997.
[3] Reason J. Human error: models and management. BMJ. 2000 Mar 18;320(7237):768-70
[4] Safety Science, Volume 108, October 2018, Pages 104-112
[5] Tasker A, Jones J, Brake SHow effectively has a Just Culture been adopted? A qualitative study to analyse the attitudes and behaviours of clinicians and managers to clinical incident management within an NHS Hospital Trust and identify enablers and barriers to achieving a Just CultureBMJ Open Quality 2023;12:e002049. doi: 10.1136/bmjoq-2022-002049

caused the problem?[6] A Just Culture requires an open and honest reporting environment alongside a quality learning environment and culture. It refers to a system of shared accountability in which organizations are accountable for the systems they have designed and for responding to the behaviours of their employees in a fair and just manner. While the organization has a duty and responsibility to employees (and ultimately to patients), all employees are held responsible for the quality of their choices. Just culture requires a change in focus from errors and outcomes to system design and management of the behavioural choices of all employees[7,8].

In 2012, Wachter *et al.,* stated that a fair and just culture improves patient safety by empowering employees to proactively monitor the workplace and participate in safety efforts in the work environment. Improving patient safety reduces risk by its focus on managing human behaviour (or helping others to manage their own behaviour) and redesigning systems. In a just culture, employees are not only accountable for their actions and choices, but they are also accountable to each other, which may help some overcome the inherent resistance to dealing with colleagues who are unable to meet the requirements of their role due to ongoing or transient competency, physical or mental health issues. In a just culture, both the organization and its people are held accountable while focusing on risk, systems design, human behaviour, and patient safety[9].

In his 2016 publication, Restoring Trust and Accountability in Your Organization[10], Sydney Dekker states that Just Culture is a culture of trust, learning and accountability – *wanting everything in the open, but not tolerating everything*. Paradiso *et al.,* (2019)[11] defined just culture as organizational accountability for the systems they've designed and employee accountability for the choices they make. This study concluded that *Just culture isn't a blame-free culture, rather a culture of balanced accountability. Safe patient care outcomes include organizational system design and individual behavioural choices. Nurse leaders need to look beyond the error to the systems in which clinical nurses work and the behavioural choices they make within those systems.*

The HSE Incident Management Framework[12] defines Just Culture as one which *refers to a values based supportive model of shared accountability* and proposes that *individual practitioners should not be held accountable for system failings over which they have no control. In a just culture, staff feel psychologically safe both to report errors and to ask for assistance when faced with an issue beyond their competence. They see these as contributing to both their individual learning and to the development of safer systems for service users.* The Framework states that *whilst a just culture recognises that individual practitioners should not be held accountable for system failings over which they have no control staff also recognise that it does not absolve them of the need to behave responsibly and with professionalism. In contrast to a culture that touts no blame as its governing principle, a just culture does not tolerate conscious disregard of clear risks to service users or professional misconduct, such as falsifying a record, performing professional duties while intoxicated, etc.*

The HSE Incident Management Framework 2020[13] introduced the **Just Culture Guide**, (adopted and adapted with permission from the NHS). The guide comprises an algorithm with accompanying guidelines and poses a series of structured questions about an individual's actions, motives, and behaviour at the time of the incident. The algorithm on which the decision tree is based identifies the role of an individual and the given specific outcome. The decision tree has 4 main elements:

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[6] Catino, M (2008). "A Review of Literature: Individual Blame vs. Organizational Function Logics in Accident Analysis". Journal of Contingencies and Crisis Management (Review). 16 (1): 53–62

[7] Dekker S. Just Culture: Balancing Safety and Accountability. Burlington, VT: Ashgate Publishing;; 2008. [Google Scholar]

[8] Marx D. (2001), Patient Safety and the Just Culture: A Primer for Health Care Executives. New York, NY: Trustees of Columbia University.

[9] Wachter R. Personal Accountability in Healthcare: Searching for the Right Balance. The Health Foundation. 2013 May 2012. http://www.health.org.uk/public/cms/75/76/313/3426/Personal%20accountability%20in%20healthcare%20searching%20for%20the%20right%20balance%20thought%20paper.pdf?realName=Al5J91.pdf.

[10] Dekker, S. (2016). Just Culture: Restoring Trust and Accountability in Your Organization, Third Edition (3rd ed.). CRC Press.

[11] Paradiso L, Sweeney N. Just culture: It's more than policy. Nurs Manage. 2019;50(6):38-45.

[12] HSE Incident Management Framework, 2020, https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/hse-2020-incident-management-framework-guidance.pdf

[13] HSE Incident Management Framework, 2020, https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/hse-2020-incident-management-framework-guidance.pdf

- **The deliberate harm test:** a conscious and deliberate breach of duty resulting in patient harm. The goal of the institution or system is to establish or refute this violation immediately as a first step.
- **The physical/mental health test:** a provider is impaired for any reason, including substance abuse. The impact of impairment or the patient outcome must be established.
- **The foresight test:** once the deliberate intent to harm and physical/mental health tests have been discounted, this analysis establishes whether protocols, policies, and procedures have been followed.
- **The substitution test:** this test asks the question, "Would another provider put in the same circumstances in the same systems environment make the same error?"

The HSE Just Culture Guide which is available on the QPSD Incident Management webpage at: https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/just-culture.html

3. Why is Just Culture important?

In his 2007 publication[14] Sydney Dekker reported on research that showed that not having a just culture was bad for morale; commitment to the organization; job satisfaction and willingness to do that little extra outside ones role. Dekker stated that Just Culture is necessary if you want to monitor safety of an operation, want to have an idea about the capability of the people or organization and to effectively meet the problems that are coming your way. Just culture enables us to concentrate on doing a quality job and making better decisions rather than focussing on individual liability and making defensive decisions. Just culture promotes long term investments in safety over short-term measures to limit legal or media exposure.

The absence of a just culture has serious implications for safety. It can inhibit incident reporting, contribute to a culture of blame, stigmatize an incident as something shameful rather than a learning opportunity, undermine the creation of a culture of safety, creates stress and isolation that makes practioners perform less well in their jobs, accelerate the exodus of practitioners from clinical practice, exacerbate the shortage of healthcare providers, perpetuate the myth that perfect performance is achievable, and impede system improvements.[13,15]

A just culture must urge leaders to recognize that incidents are inevitable. When a patient dies or is seriously injured as a result of an incident, it is human nature to react to the seriousness of the injury. To be fair, or just, human error should be consoled as long as the individual's behavioural choices were not reckless. The quality of one's behavioural choices should dictate accountability, not the human error itself or the severity of its outcome. Avoiding the severity bias and establishing a just culture is paramount to safety. In a just culture, both the organization and its people are held accountable while focusing on risk, systems design, human behaviour, and patient safety[16].

4. Benefits and Challenges of Implementing a Just Culture

A number of healthcare organisations have documented their experiences of implementing a Just Culture. In 2016, Mersey Care NHS Foundation Trust in the UK began to implement a 'just and learning culture' within their organisation[17]. Mersey Care's reliance on HR processes and practises which focused on rules, violations, and consequences were not seen to be working. Costs associated with suspensions were rising. So too were legal costs, agency costs for backfill absenteeism, and staff turnover.

[14] Dekker, S. (2007) Just Culture, Ashgate Publishing,
[15] Independent Review of Gross Negligence Manslaughter and Culpable Homicide. July 17, 2019, General Medical Council; GMC. https://psnet.ahrq.gov/issue/independent-review-gross-negligence-manslaughter-and-culpable-homicide
[16] Cromie. Sam & Bott, Franziska. (2016). Just culture's "line in the sand" is a shifting one; an empirical investigation of culpability determination. Safety Science. 86. 258-272. 10.1016/j.ssci.2016.03.012.
[17] https://psnet.ahrq.gov/perspective/making-just-culture-reality-one-organizations-approach

To address this, the organisation decided on a new approach. Steps to implement a just and learning culture were taken in order to create an environment where staff felt supported and empowered to learn when things did not go as expected, rather than feeling blamed. The Trust fundamentally changed the way it responded to incidents, patient harm, and complaints against staff.

To achieve this, the trust developed and rolled out training in the just and learning culture way to staff throughout Mersey Care. Considerations have also been given as to how to ensure that those who attend the training feel psychologically safe.

Results and benefits

Mersey Care NHS Foundation Trust estimated that, to date, the economic benefit of a just and learning culture in their organisation to be roughly £2.5 million. This is made up of:

- A reduction in suspensions by 95 per cent and disciplinary investigations by 85 per cent since 2014. At the same time the trust has increased its workforce by 135 per cent.
- An increase in reporting of adverse events.
- An increase in staff who felt encouraged to seek support.
- An increase in staff who felt able to raise concerns about safety and unacceptable behaviour.

Mersey Care's staff survey shows safety, morale and performance have all improved. Research commissioned by the Trust shows staff feel more engaged, open and able to speak up. There have been increases in staff morale and job satisfaction, staff engagement among senior leaders has increased and so has staff motivation. The research found there is an increased feeling from staff that they work in an 'open and accommodating work environment that facilitates honesty and learning'. This is directly linked to the just and learning culture and training the trust provides.

The trust continues to assess the economic benefit of a just and learning culture (estimated to be roughly one per cent of turnover) and look at the impact it has on women, black, Asian and minority ethic (BAME) staff and other underrepresented groups. Mersey Care NHS Foundation Trust's vacancy rate currently stands at 3.5 per cent. They have a waiting list for district nurses in some areas and other professions. The organisation's just and learning culture is seen to be a large part of that pull. After seeing the benefits in their own organisation, the trust partnered with Northumbria University to create a just and restorative learning training package for other organisations to follow.

Challenges

Implementing a just culture is complex and requires organisational wide commitment and leadership at every level of the organisation. A number of studies have highlighted the challenges to the implementation of a Just Culture:

- The requirement for support and commitment from leaders and staff at every level of the organisation
- Perception of leadership for culture change from the top of the organisation
- The requirement for education of managers and employees,
- The requirement for adoption of a variety of new skills for staff
- Lack of understanding of the Systems Approach
- Need to change attitudes from the long-standing punitive culture and fault of individual
- Management of scepticism due to previous experiences of poor incident management
- Challenges in implementation because of time constraints and day to day pressures in service provision.
- External pressures from those harmed, their families and media to "punish" those involved in incidents
- Lack of effective incident reporting systems