The Development of a Just Culture in the HSE

23rd March 2022

Introduction

Commitment 2 of the 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].

Just culture is a concept related 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.

Definition of Just Culture

A just culture balances the need for an open and honest reporting environment with the end of a quality learning environment and culture. "Just Culture" 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[3,4].

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

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

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

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[5].

Paradiso et al., (2019)[6] 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[7] 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.*

Why do we need a Just Culture within Healthcare Organisations?

The absence of a just culture has serious implications for safety. It can inhibit incident reporting, contribute to a culture of blame, undermine the creation of a culture of safety, 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[8].

In an era when we need more transparency, staff will be reluctant to report incidents and near misses due to fear of blame and disproportionate repercussions. Even if incidents are reported, effective incident review and learning cannot occur in a culture of fear or blame. Disproportionate reactions to healthcare staff who are involved in incidents reduce morale on the frontline.

However, human biases make it difficult for healthcare leaders to learn from the mistakes of others. Too often, leaders assume that a catastrophic incident that has happened in another facility will not happen in their facility. If it does, leaders may be unable to effectively cope with it, underestimate its full effects, and resort to punitive personnel actions that are conveniently quick and easy, yet wholly

[5] 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.

[6] Paradiso L, Sweeney N. Just culture: It's more than policy. Nurs Manage. 2019;50(6):38-45. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6716556/

[7] 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

[8] *Another Round of the Blame Game: A Paralyzing Criminal Indictment that Recklessly "Overrides" Just Culture,* ISMP, February 14, 2019, https://www.ismp.org/resources/another-round-blame-game-paralyzing-criminal-indictment-recklessly-overrides-just-culture

ineffective and often unfair. Or, leaders and others, may overlook latent system failures that contributed to an incident and instead focus only on the active failure.

A just culture must urge leaders to recognize that incidents are inevitable. Leaders must be proactive with system design improvements by learning and benefiting from the lessons learned by others when incidents happen. Leaders are the owners of systems. Accountability for safety must be shared, and leaders are ultimately responsible for system design as well as subsequent design changes that are needed to improve safety within their organizations[9].

Healthcare leaders must avoid the severity bias and establish a Just Culture.

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. Although we have a tendency to view incidents leading to harm as more blameworthy and punishable than the same incidents that do not lead to harm, allowing a severity bias to drive the response is not fair to the workforce and does not maximize safety[10].

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. Within a Just Culture we need to not ask whether the individual consciously disregarded what he or she knew to be a substantial and unjustifiable risk. Most at-risk behaviours are caused by system failures that practitioners must work around, often on a daily basis, to get the job done[11].

Allowing the severity bias to drive responses to incidents is also ineffective with respect to safety improvements and severely hampers a health service's ability to learn from safety incidents. The "no harm, no foul" mentality of waiting for patient injury before taking action is detrimental to patient safety. Looking the other way when non-harmful incidents happen leaves the outcome to a matter of luck.

Ultimately, the literature stresses that we cannot wait for harm to address risky systems or behaviours. Nor can we repeatedly engage in risky choices then unjustly punish the unlucky few who have been involved in events that resulted in significant harm.

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.

[9] 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

[10] 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.

[11] The differences between human error, at-risk behavior, and reckless behavior are key to a just culture, July 1, 2020, ISMP Medication Safety Alert! Acute Care Edition. 2020;25(12). https://psnet.ahrq.gov/issue/differences-between-human-error-risk-behavior-and-reckless-behavior-are-key-just-culture

The Development of Just Culture to date

In 1990, James Reason[12] highlighted the notion of intent when considering the nature of error. Slips (eg, Freudian slips) lack intention; that is, the actions are not carried out as intended or planned. Lapses are missed actions or omissions, with the perpetrator often conscious of the action and believing that it will not lead to harm. Mistakes involve error, ie, faulty planning or intention; the individual involved believes the action to be correct. Corrective action and coaching, not punishment, are indicated for improving the system. At-risk behaviour includes both intention and the violation of rules, policies, and procedures and makes a system vulnerable, increasing risk. The individual should be coached to understand the risks resulting from his or her action. Reckless behaviour may be grounds for disciplinary action, and civil or criminal charges may be filed against the individual. Punishment, including termination, may be the appropriate consequence.

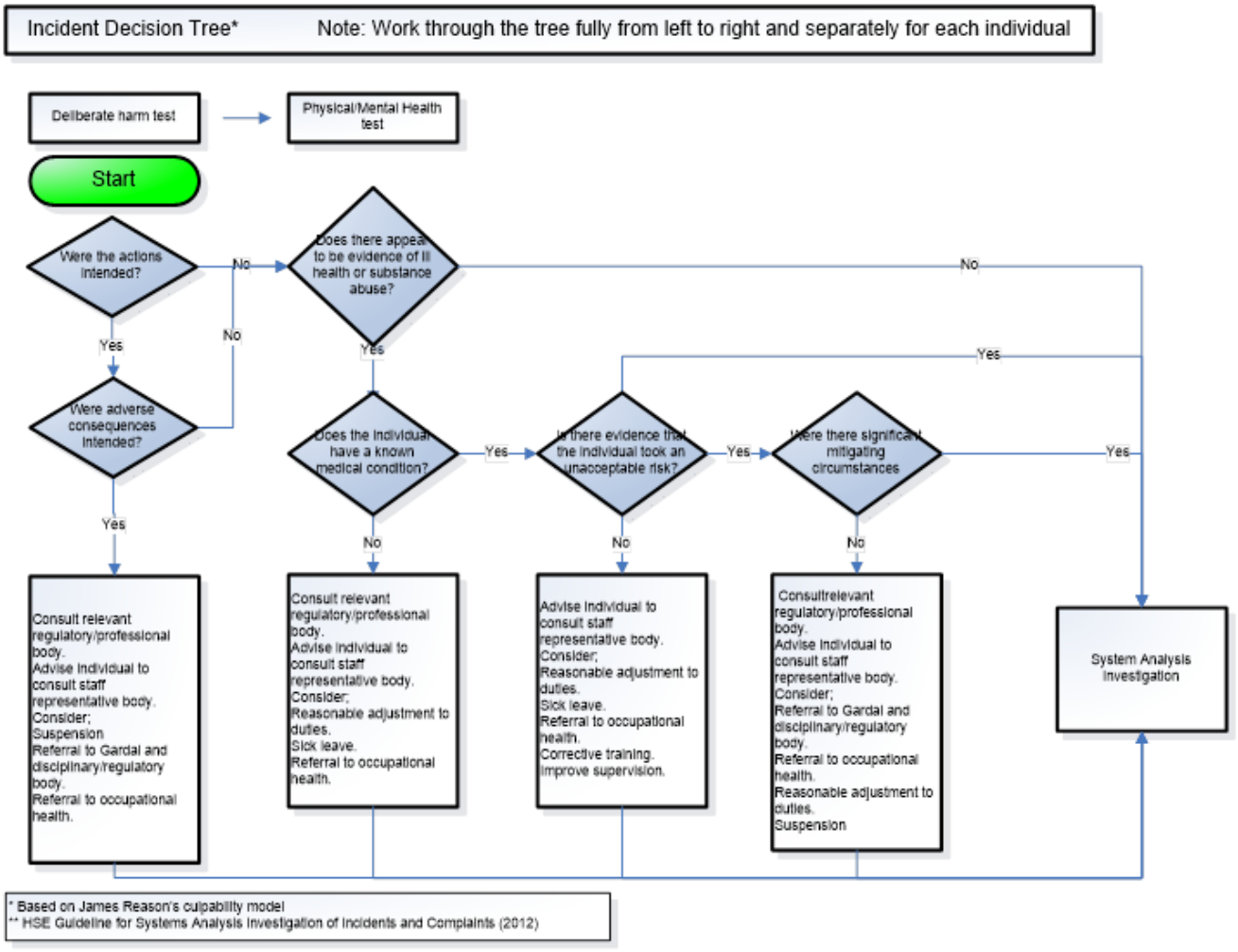
In 2010, Leonard and Frankel[13] developed a 3-step process to measure culpability. The first step analyses the individual caregiver's actions via 5 measures: impaired judgment, malicious action, reckless action, risky action, and unintentional error. The second step determines if other caregivers with similar skills and knowledge would react the same way in similar circumstances. The final step is the important determination of whether the present system supports reckless or risky behaviour and thus requires redesign.

HSE Safety Incident Management Policy 2014

Under this policy, the investigation of incidents in the HSE utilised a Systems Analysis approach which involved the consideration of system causes of incidents versus individual responsibility for an incident. The Policy highlighted that the establishment of the facts (including contributory system factors) surrounding a safety incident, and the analysis of these facts in a fair, impartial and objective manner, was essential. The Policy required that managers should consider the overall performance of an individual within the context of an employees documented performance appraisals under the HSE Performance Management Framework (2012) and not limit their assessment of an individual based on one incident. The Policy also highlighted that the results of a systems analysis investigation may show that another individual coming from the same professional group, possessing comparable qualifications and experience may have behaved in a similar way in similar circumstances, e.g. there may have been broader system deficiencies in training, supervision or policies, procedures or guidelines.

The HSE Safety Incident Management Policy, 2014, advocated the use of the Incident Decision Tree based on James Reason's culpability model. (see diagram below). The Incident Decision Tree required consideration of the Deliberate Harm Test and the Physical mental Health Test. If physical and mental health issues were discounted managers were advised to arrange for a systems analysis investigation to be conducted as soon as possible to determine if there were mitigating circumstances, e.g. was it likely that another individual coming from the same professional group, possessing comparable qualifications and experience, working in a similar environment may have behaved a similar way in similar circumstances.

[12] Reason J. Human Error. New York, NY: Cambridge University Press;; 1990.
[13] Leonard MW, Frankel A. The path to safe and reliable healthcare. Patient Educ Couns. 2010 Sep;80(3):288–292. Epub 2010 Aug 4.



NHS: A Just Culture Guide (Improvement.NHS.UK), 2018

The NHS states that the fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame.

The National Health Service (NHS) in the UK published a Just Culture Guide in 2018, based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree, to encourage managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way. The NHS website[14] states *that the fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated. In any organisations or teams where a blame culture is still prevalent, this guide will be a powerful tool in promoting cultural change.*

The website outlines that the guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely; it asks a series of questions that help clarify whether there truly is something specific about an individual that needs support or management versus whether the issue is wider, in which

[14] https://www.england.nhs.uk/patient-safety/a-just-culture-guide/

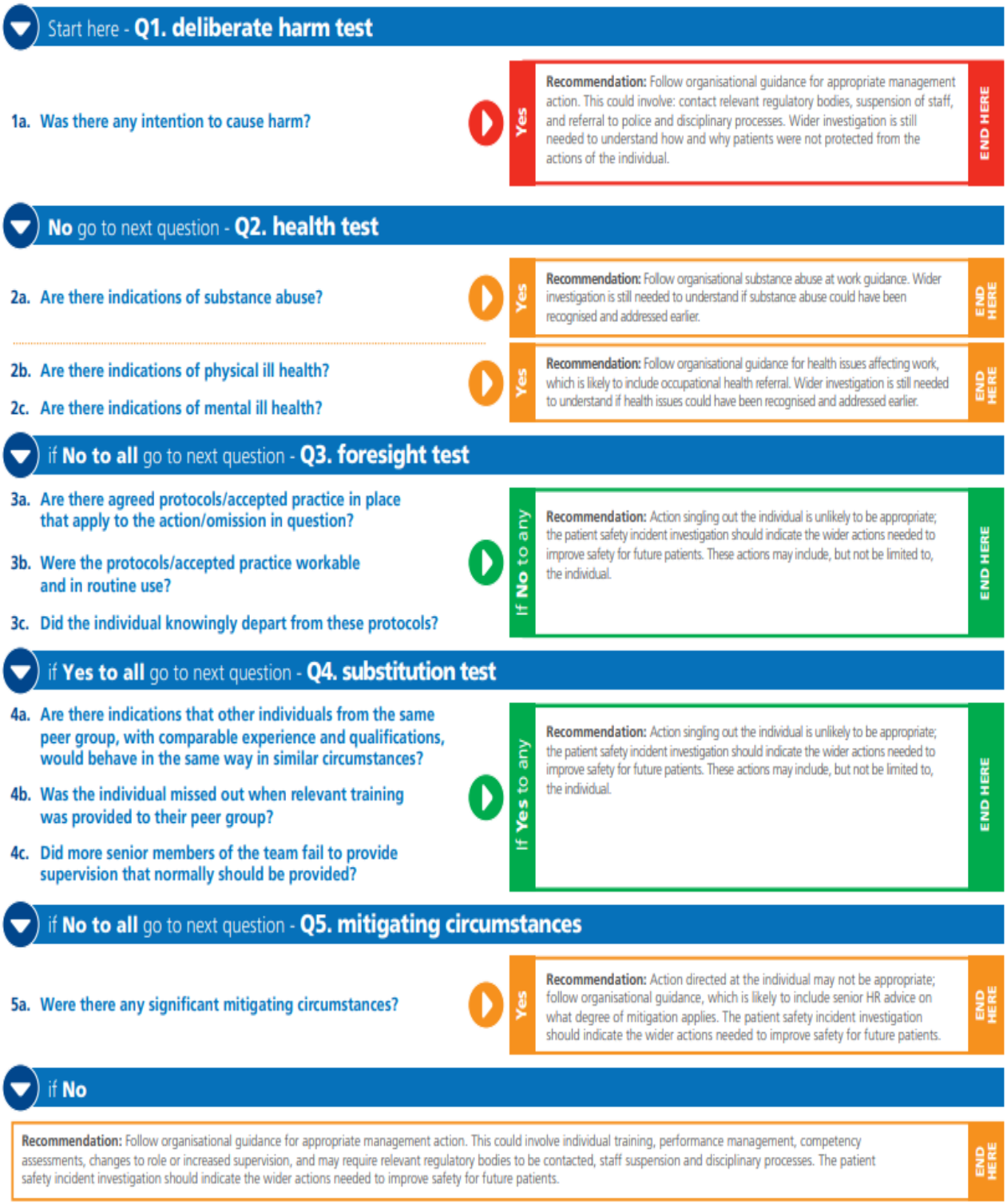
case singling out the individual is often unfair and counter-productive; it helps reduce the role of unconscious bias when making decisions and will help ensure all individuals are consistently treated equally and fairly no matter what their staff group, profession or background.

The NHS states that the guide should not be used routinely. It should only be used when there is already suspicion that a member of staff requires some support or management to work safely, or as part of an individual practitioner performance/case investigation.

It is stressed that the guide does not replace the need for patient safety investigation and should not be used as a routine or integral part of a patient safety investigation. This is because the aim of those investigations is system learning and improvement. As a result decisions on avoidability, blame, or the management of individual staff are excluded from safety investigations to limit the adverse effect this can have on opportunities for system learning and improvement.

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:

- **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?”



There is little literature available to date in relation to the review of the implementation and application of the Just Culture Guide. One available article by Bill Kirkup in 2019[15] stated that *while the intention of this policy is laudable; the execution lamentable. The problem arises from the disconnect between the logical sequence set out in the guide, a series of questions to identify a series of possible causes of a safety incident, and the relative frequency with which they occur.*

[15] Bill Kirkup, Independent Health Service Investigator, NHS Improvement's Just Culture Guide: good intentions failed by flawed design, Journal of the Royal Society of Medicine; 2019, Vol. 112(12) 495–497. https://journals.sagepub.com/doi/pdf/10.1177/0141076819877556

HSE Incident Management Framework

The HSE Incident Management Framework 2020[16] introduced a Just Culture Guide based on the NHS Just Culture Guide with some additional detail provided in relation to the questions to be considered.

The IM Framework states that

- A just culture guide is not a replacement for a review of a patient safety incident. Only a review carried out in line with the IMF can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- A just culture guide can be used at any point in a review, but the guide may need to be revisited as more information becomes available.
- A just culture guide does not replace HR advice and should be used in conjunction with organisational policy.
- The guide can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

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. These may need to be answered on the balance of probability—i.e., determining the most likely explanation—taking into account the information available at the time, although the importance of pausing to gather data is emphasised.

The questions move through four sequential "tests". These are:

- **Deliberate harm**
- **Health Test**
- **Foresight**
- **Substitution**

The Just Culture Guide concludes with a question about significant mitigating circumstances that might indicate consideration of broader issues that may explain what influenced the actions of the individual staff member. The Just Culture Guide emphasises that the outcome of a particular incident needs to be based on a consideration of individual circumstances. The importance of the manager applying judgment rather than slavishly following the tool is emphasised. The tool can be used for any employee involved in a patient safety incident, whatever his or her professional group. If new information comes to light during the course of a review, it can be worked through again and may or may not indicate a different outcome. See Appendix 1 for the HSE Just Culture Guide.

There has been no analysis of the implementation of the Just Culture Guide in Ireland to date.

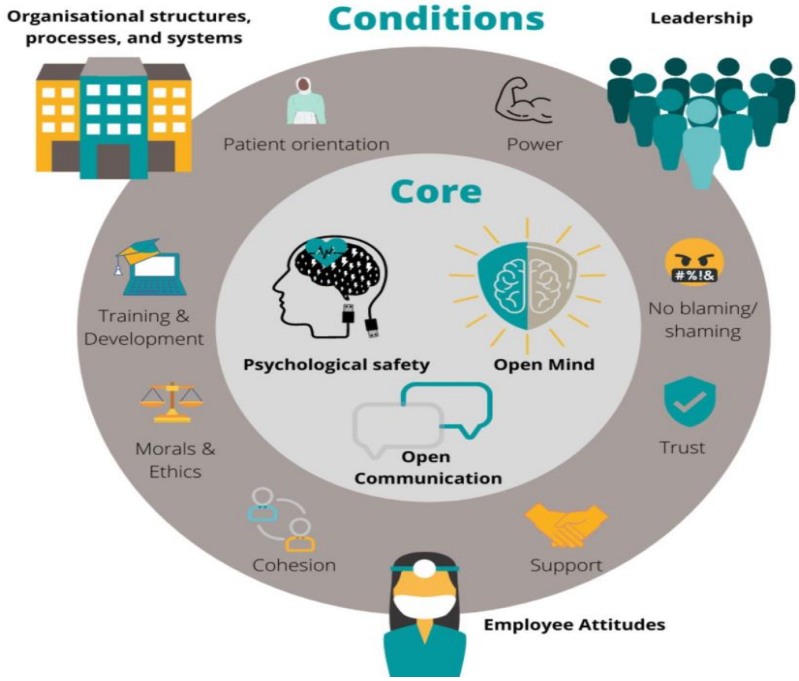
[16] HSE Incident Management Framework, 2020, https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/hse-2020-incident-management-framework-guidance.pdf

Requirement for an Open Culture

A recent publication by Malik et al., (2021)[17] highlighted that research on safety culture has been focussing mainly on the patient safety context while today's complex healthcare systems require increased focus on cultures that result in sustainable organisations, which includes retaining healthcare personnel. With exploring what open culture entails the authors provided guidelines for social processes beyond the patient safety scope that need attention. This includes employees' thoughts, emotions, attitudes, safety and well-being, as well as the organisational conditions that need to be met. The major tangible themes of leadership, organisational structures and processes, and employee attitudes seem to form the conditional layer that need to be facilitated before the intangible core layer of values influencing psychosocial dynamics and relationships can exist.

The authors state that the tangible themes 'leadership' together with 'organisational structures and processes', and the intangible themes 'psychological safety' in addition to 'open communication' play an important role in open culture, just like in other OCs, and are already extensively discussed in the patient safety literature. An interesting result of this study however, is a clear focus on engaging patients as part of OC and an increased responsibility of employees for the way they behave and think; their attitude and mind-set eventually determine the openness of OC.

The study concludes that an open culture encompasses much more than 'open communication' in the context of patient safety. Open culture refers to transparency and openness on system and microlevel. Open culture entails social processes in broad daylight beyond the culture literature, such as patient safety culture, by including an open attitude and open mind-set of employees and leaders, as well as other organisational conditions that need to be met. The statement set facilitates healthcare organisations to address these social processes beyond the patient safety context and work towards an open culture. The Core and Conditions of an open organisational culture are described in the diagram below.



[17] Malik RF, Buljac-Samardžić M, Amajjar I, et alOpen organisational culture: what does it entail? Healthcare stakeholders reaching consensus by means of a Delphi technique, BMJ Open 2021;11 https://bmjopen.bmj.com/content/11/9/e045515

Approaches to the Implementation of Just Culture

The framework of a just culture ensures balanced accountability for both individuals and the organization responsible for designing and improving systems in the workplace. Engineering principles and human factors analysis influence the design of these systems so they are safe and reliable.

The Agency for Healthcare Research and Quality (AHRQ, https://www.ahrq.gov/) states that establishing a just culture within an organization requires action on three fronts: building awareness, implementing policies that support just culture, and building just culture principles into the practices and processes of daily work[18].

A study[19] to explore perceptions of nurse managers in developing personal competencies in order to enable them to effectively implement a just culture in their units identified the following four themes: need for education of managers and employees, need for a variety of new skills for nurse managers, need to change attitudes from the long-standing punitive culture and fault of individual and challenges in implementation because of time constraints.

An article by Performance Health Partners[20] outlines 10 Elements of a Just Patient Safety Culture in Healthcare as follows:

1. Use a Transparent Approach
Use a transparent, non-punitive approach to report and learn from incidents, close calls and unsafe conditions. An increase in the number of incidents reported and effective reporting by all team members leads to improved patient outcomes and helps drive overall organizational change. This approach includes encouragement of collaboration across all ranks and disciplines to seek solutions to patient safety problems.

2. Define Set Processes
Use clear, just, and transparent risk-based processes for recognizing and distinguishing human errors and system errors from unsafe actions. The goal of every team member is Zero Harm to patients. In order to achieve Zero Harm, patient safety must be embedded into the organizational culture.

3. Lead by Example
In a true patient safety culture, all organizational leaders are expected to adopt and lead by example. When leaders display the appropriate behaviours, they can decrease feelings of intimidation and increase the probability of their staff reporting errors and safety concerns. Promoting a culture of safety is the responsibility of everyone in the organization, whether they are leaders, frontline staff, contract personnel or volunteers.

4. Put Policies in Place
Organizations are expected to create and adhere to policies that support their safety culture. This means setting up systems and policies around the reporting of adverse events, near misses and unsafe conditions that can lead to further patient injuries. Policies must be enforced, communicated and made easily accessible to all team members within the organization.

5. Focus on shared accountability
The Patient Safety Culture should also be a Just Culture, one which recognizes all team members who report incidents, events and near misses. Wrongdoings are almost always the result of system failures; therefore, blame should not be placed on individuals. A Just Culture also

[18] Making Just Culture a Reality: One Organization's Approach https://psnet.ahrq.gov/perspective/making-just-culture-reality-one-organizations-approach
[19] Freeman M. et al., Implementing a Just Culture: Perceptions of Nurse Managers of Required Knowledge, Skills and Attitudes, Nursing Leadership 29(4) December 2016 : 35-45.doi:10.12927/cjnl.2016.24985, https://pubmed.ncbi.nlm.nih.gov/28281449/
[20] https://www.performancehealthus.com/blog/10-elements-of-a-patient-safety-culture

recognizes those who identify unsafe conditions, or who have good suggestions for patient safety improvements. It is important that leadership shares information brought forward regarding these incidents, near misses and recommendations for safety improvements with all team members so all can learn from these "free lessons".

6. Use Validated Tools

The next important element to improve patient safety culture is to use validated tools to measure patient safety. An organization is expected to determine a baseline measurement on their safety culture performance using a validated tool. Two commonly used tools are AHRQ's Patient Safety Culture Surveys and the Safety Attitudes Questionnaire.

7. Act on the Data

Safety culture survey results are to be analysed from all departments to find opportunities for quality and safety improvement. Across the country, there is documented evidence of considerable variation in perceptions of safety culture across organizations and job descriptions. Understanding these variations in perceptions is valuable to the organization in developing and implementing interventions to comprehensibly address safety concerns.

8. Commit the Necessary Resources

Organizations must commit resources to address any patient safety concerns that arise from analysis of safety culture surveys. These resources might take the form of personnel, additional training, or increased funding. Funding is often necessary in order to develop and implement interventions that increase patient safety at the site of care.

9. Train Your Team

Safety culture team training is embedded into quality improvement and risk management projects and organizational processes to strengthen safety systems. An effective Just Culture encourages collaboration across ranks and disciplines to seek solutions to patient safety problems.

10. Regularly Assess Strengths and Weaknesses

Organizations must proactively assess system strengths and vulnerabilities, and prioritize them for enhancement or improvement. Historically, healthcare organizations have approached patient safety as a reaction to an incident that harmed a patient. A proactive incident reporting approach is to search for potential breakdowns in safety and address those potential breakdowns in order to consistently ensure patient safety.

Development of a Tool to measure Patient Safety Culture

Given the growing support for establishing a just patient safety culture in healthcare settings, a valid tool is needed to assess and improve just patient safety culture. A study was undertaken by Petschonek et al. in the US[21] to develop a measure of individual perceptions of just culture for a hospital setting.

Petschonek et al. concluded that in order to improve and further instil the elements of a just culture, it is first necessary to effectively measure one's current strengths and weaknesses. Measurement is the first step in the research-intervention cycle, which includes feedback on results, clarification of responses by using more in-depth methods such as interviews or focus groups, applying revisions to policies and processes, and repeat measuring at the appropriate time. The JCAT was developed to provide healthcare practitioners and researchers with a tool that can be used to measure and then direct one's resources toward improving various aspects of a just culture for patient safety.

The JCAC has six subscales reflecting key components of just culture: Feedback and Communication about Events, Openness and Communication, Fairness/Balance, Quality of the Safety-Related Reporting Event, Continuous improvement Process, and Fair Reporting.

The dimensions are detailed in the Table below.

[21] Petschonek S, Burlison J, Cross C, Martin K, Laver J, Landis RS, Hoffman JM.
Development of the just culture assessment tool: measuring the perceptions of health-care professionals in hospitals.J Patient Saf. 2013 Dec;9(4):190-7. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4214367/

PubMed Central, TABLE 3: J Patient Saf. 2013 Dec; 9(4): 190–197. doi: 10.1097/PTS.0b013e31828fff34 - Google Chrome

ncbi.nlm.nih.gov/pmc/articles/PMC4214367/table/T3/?report=objectonly

TABLE 3

Just Culture Assessment Tool (JCAT) Dimensions and Definitions

Dimension	Definition
Balance	One's perceptions of fair treatment within the hospital as it relates to errors, error reporting, and its systems approach to medical error.
Trust	The extent to which individuals trust the organization, their supervisors, and their co-workers.
Openness of Communication	The willingness of individuals to communicate event information upwards to supervisors and hospital administrators e.g., willingness to reveal events, share events information, and to make suggestions for improvement within the unit or the organization.
Quality of the Event Reporting Process	One's perceived quality of the event reporting system (which includes the process of entering reports and the ability to follow up on these reports), whether employees are given time to report, and to what extent the employees believe the reporting system is monitored and maintained.
Feedback and Communication About Events	One's beliefs regarding whether the organization does an effective job of sharing event information about the events and the outcome of evaluating events.
Overall Goal of Continuous Improvement	One's belief that the organization as a whole demonstrates a goal of continuous improvement, characterized by a willingness to learn from events and make improvements to the hospital system.

Table: Survey Items/ statements for JCAT Tool

Variable	Feedback and Communication	Openness of Communication	Balance	Quality of Error Reporting Process	Continuous Improvement	Trust
The management does a good job of sharing information about events.	0.743†					
We do not know about events that happen in our unit.	0.859†					
I often hear about event conclusions and outcomes.	0.749†					
Staff feel uncomfortable discussing events with supervisors.		0.583†				
Supervisors respect suggestions from staff members.		0.749†				
Staff can easily approach supervisors with ideas and concerns.		0.707†				
If I had a good idea for making an improvement, I believe my suggestion would be carefully evaluated and taken seriously.		0.714†				
I trust supervisors to do the right thing.‡		0.703†				
Staff members are usually blamed when involved in an event.			0.857†			
Staff members fear disciplinary action when involved in an event.			0.809†			
When an event occurs, the follow-up team looks at each step in the process to determine how the event happened.			0.836†			
I feel comfortable entering reports about events in which I was involved.			0.662†			
Staff members use event reporting to "tattle" on each other.‡			0.734†			
Coworkers discourage each other from reporting events.				0.560†		
The event reporting system is easy to use.				0.684†		
Reports are being evaluated and reviewed after they are entered.				0.757†		
I am given time to enter event reports during work hours.				0.744†		
My supervisors encourage me to report.				0.725†		
There are improvements because of event reporting.					0.641†	
The hospital devotes (time/energy/resources) toward making patient safety improvements.					0.524†	
By entering reports, I am making the hospital a safer place for the patients.					0.566†	
The hospital sees events as opportunities for improvement.					0.702†	
The hospital uses a fair and balanced system when evaluating staff involvements in events.						0.845†
I trust that the hospital will handle events fairly.						0.829†
The hospital adheres to its own rules and policies.						0.668†
I feel comfortable entering report where others were involved.						0.700†
I am uncomfortable with others entering reports about events in which I was involved.						0.532†

*This 7-factor model was composed of 6 subscales and 1 higher-order just culture dimension.

†Indicates significance at $P < 0.05$.

‡Indicates item reassigned.

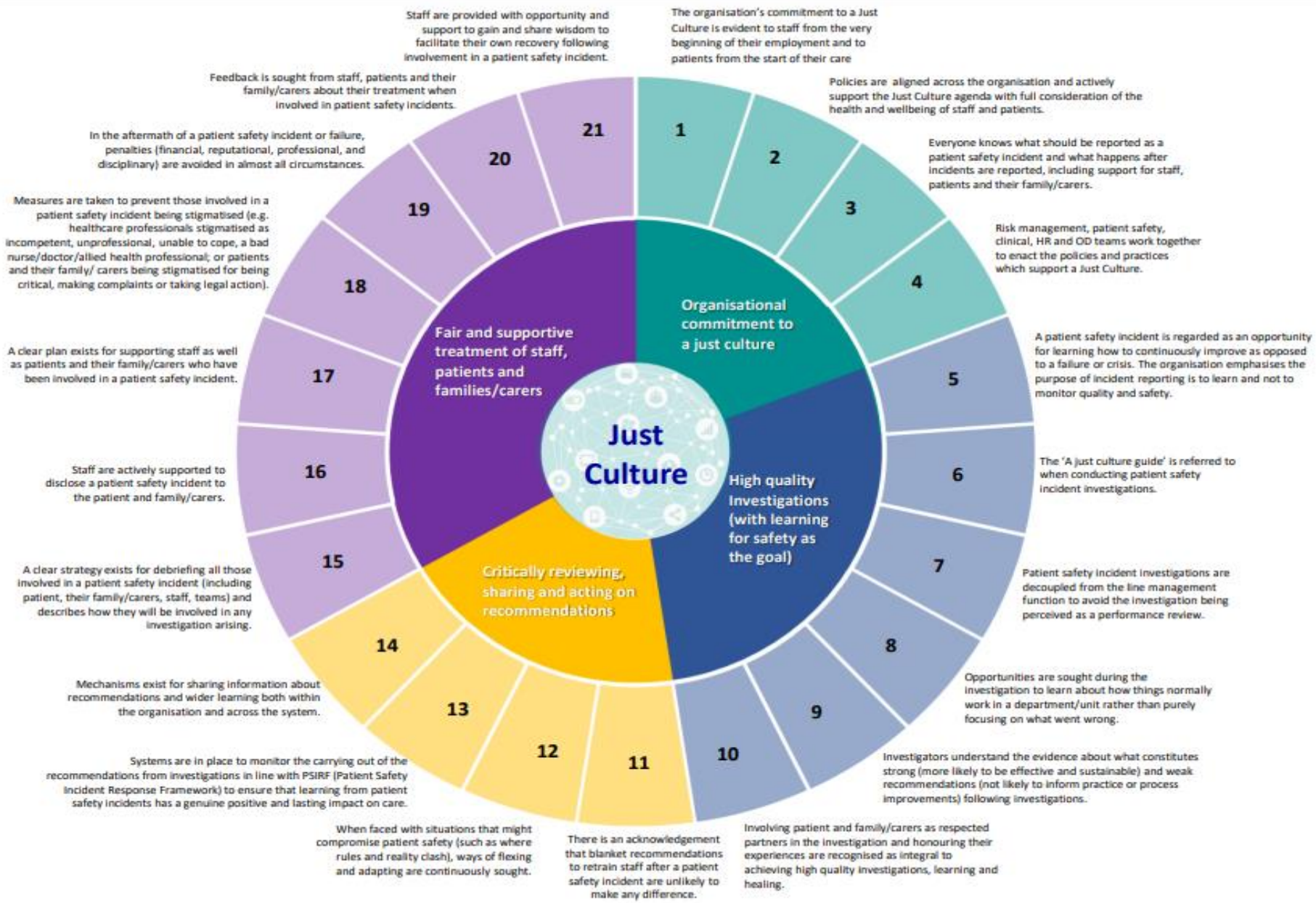
NHS Improvement Academy: Just Culture Assessment Framework

More recently, within NHS provider organisations, the need for more support to identify the most effective ways of implementing change to achieve a more 'Just Culture' was highlighted. We have The NHS Improvement Academy (https://improvementacademy.org/our-networks/just-culture-network.html) worked with the Yorkshire and Humber PSTRC to develop a Just Culture Assessment Framework (JCAF) to support organisations in measuring and improving their organisational culture.

The JCAF is adapted from Dekker (2012), the NHS Patient Safety Incident Response Framework (2020) and other research evidence in this area, in particular the 'Just Culture' measure developed by Petschonek et al (2013) which includes the following dimensions of a Just Culture: feedback and communication; openness of communication; balance; quality of event reporting process; continuous learning and improvement; trust.

The illustration above shows the four key domains within the JCAF. Linked to each domain are several standards which organisations can assess themselves against and use to identify areas for improvement which if action would lead to improvements in organisational Just Culture. 'The fuller version of the image which includes the 21 standards and how they map into the four domains can be viewed on the next page

The Framework is being piloted by members of the Yorkshire and Humber Improvement Academy's 'A Just Culture Network' member organisations and as such, the content may be further revised on the back of learning from Just Culture Network member feedback and pilot site implementation. The NHS Improvement Academy has given permission for the HSE to utilise this tool.


Just Culture
Organisational commitment to a just culture
High quality Investigations (with learning for safety as the goal)
Critically reviewing, sharing and acting on recommendations
Fair and supportive treatment of staff, patients and families/carers
1
The organisation's commitment to a Just Culture is evident to staff from the very beginning of their employment and to patients from the start of their care
2
Policies are aligned across the organisation and actively support the Just Culture agenda with full consideration of the health and wellbeing of staff and patients.
3
Everyone knows what should be reported as a patient safety incident and what happens after incidents are reported, including support for staff, patients and their family/carers.
4
Risk management, patient safety, clinical, HR and OD teams work together to enact the policies and practices which support a Just Culture.
5
A patient safety incident is regarded as an opportunity for learning how to continuously improve as opposed to a failure or crisis. The organisation emphasises the purpose of incident reporting is to learn and not to monitor quality and safety.
6
The 'A just culture guide' is referred to when conducting patient safety incident investigations.
7
Patient safety incident investigations are decoupled from the line management function to avoid the investigation being perceived as a performance review.
8
Opportunities are sought during the investigation to learn about how things normally work in a department/unit rather than purely focusing on what went wrong.
9
Investigators understand the evidence about what constitutes strong (more likely to be effective and sustainable) and weak recommendations (not likely to inform practice or process improvements) following investigations.
10
Involving patient and family/carers as respected partners in the investigation and honouring their experiences are recognised as integral to achieving high quality investigations, learning and healing.
11
There is an acknowledgement that blanket recommendations to retrain staff after a patient safety incident are unlikely to make any difference.
12
When faced with situations that might compromise patient safety (such as where rules and reality clash), ways of flexing and adapting are continuously sought.
13
Systems are in place to monitor the carrying out of the recommendations from investigations in line with PSIRF (Patient Safety Incident Response Framework) to ensure that learning from patient safety incidents has a genuine positive and lasting impact on care.
14
Mechanisms exist for sharing information about recommendations and wider learning both within the organisation and across the system.
15
A clear strategy exists for debriefing all those involved in a patient safety incident (including patient, their family/carers, staff, teams) and describes how they will be involved in any investigation arising.
16
Staff are actively supported to disclose a patient safety incident to the patient and family/carers.
17
A clear plan exists for supporting staff as well as patients and their family/carers who have been involved in a patient safety incident.
18
Measures are taken to prevent those involved in a patient safety incident being stigmatised (e.g. healthcare professionals stigmatised as incompetent, unprofessional, unable to cope, a bad nurse/doctor/allied health professional; or patients and their family/ carers being stigmatised for being critical, making complaints or taking legal action).
19
In the aftermath of a patient safety incident or failure, penalties (financial, reputational, professional, and disciplinary) are avoided in almost all circumstances.
20
Feedback is sought from staff, patients and their family/carers about their treatment when involved in patient safety incidents.
21
Staff are provided with opportunity and support to gain and share wisdom to facilitate their own recovery following involvement in a patient safety incident.

Examples of Implementation of Just Culture in Health care Organisations

United States: The Missouri Just Culture Collaborative (2007)[22]

The Missouri Just Culture Collaborative brought together health-care providers, regulators, and other key stakeholders to learn and implement the principles of Just Culture. A survey was used to determine baseline understanding of Just Culture. Under the leadership of the Missouri Center for Patient Safety, 67 health-care providers and regulatory agencies worked together to implement aspects of Just Culture. The collaborative led to an improved understanding between providers and regulators about barriers to implementing true Just Culture and how regulators can support provider efforts to improve the safety culture. Also, health-care leaders who more actively participated in the collaborative's interventions appeared to gain a better understanding of staff perceptions of their organization's safety culture. While implementation of Just Culture is a long journey, Missouri has set the stage for health-care providers and regulators to move together toward a true Just Culture to improve patient safety

Supporters of and participants in the Missouri Just Culture Collaborative signed a statement of support to indicate they support the following principles of Just Culture:

Statement of Support

- Medical errors and patient safety are a national concern to everyone involved in health-care delivery.
- Health-care providers and regulators are legally and/or ethically obligated to hold individuals accountable for their competency and behaviours that affect patient care.
- A punitive environment does not fully take into account systems issues, and a blame-free environment does not hold individuals appropriately accountable.

Organizations agree that:

- a culture that balances the need for a non-punitive learning environment with the equally important need to hold persons accountable for their actions should be a goal.
- behaviour, not outcomes, should be evaluated to differentiate human error, at-risk behaviour, and reckless behaviour.
- a learning environment should be established that encourages identification and review of all human errors, at-risk behaviours, near-misses, adverse events, and system weaknesses.
- a wide range of responses to safety-related events caused by lapses in human behaviour should be considered, including coaching, education or training, demonstration of competency, additional supervision and oversight, and counselling/disciplinary action (when appropriate) to address performance issues.
- systems that enable safe behaviour to prevent harm should be supported and implemented.
- organisations should collaborate to promote continuous improvement and establishment of a culture of learning, justice, and accountability to provide the safest possible environment for patients and staff.

Besides signing the statement of support, collaborating organizations signed a commitment form in which they agreed to:

- assign a champion for their organization
- identify team members, to include the chief executive officer, chief operating officer, chief financial officer, chief nursing officer, human resources director, selected clinical service directors and nurse managers, and patient safety officer/quality or risk manager
- complete the Just Culture for Managers™ online training program
- participate in the champion's training session
- take part in the regional team training sessions
- participate in pre- and post-collaborative assessments

[22] Miller R et al., A Statewide Approach to a Just Culture for Patient Safety: The Missouri Story, https://www.centerforpatientsafety.org/wp-content/themes/patient-safety/pdf/JNR0410_Miller_Final.pdf

- actively participate in collaborative activities
- Implement learning achieved through the collaborative.

The collaborative also included the following supportive activities:

- monthly teleconferences for champions and project teams that covered options and processes for implementation of Just Culture, implementation models by providers in other states, event investigation, Just Culture Algorithm use, coaching and mentoring, model human resource policies, and managerial accountabilities
- teleconferences with regulatory champions to address their unique needs
- in-person roundtable session with regulatory champions to discuss the unique issues and barriers facing regulatory implementation of Just Culture
- web network on which to post collaborative information, documentation, and frequently asked questions
- session of the Missouri Board of Nursing on event investigation

UK, NHS (Case Study, Mersey Care NHS Foundation Trust) [23]

In 2016, Mersey Care NHS Foundation Trust began to implement a 'just and learning culture' within their organisation. The culture fundamentally changed the way it responded to incidents, patient harm, and complaints against staff. 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**.**

Key benefits and outcomes

Mersey Care NHS Foundation Trust estimates 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.

What the organisation faced

Mersey Care's reliance on HR processes and practises which focused on rules, violations, and consequences were not seen to be working for its employee relations disciplinaries.
Costs associated with suspensions were rising. So too were legal costs, agency costs for backfill absenteeism, and staff turnover.
The organisation decided on a new approach. Steps to implement a just and learning culture were taken. This type of culture involves creating an environment where staff feel supported and empowered to learn when things do not go as expected, rather than feeling blamed.

What the organisation did

So far, the trust has trained over 400 individuals at Mersey Care in the just and learning culture way. The trust intends to provide further training across the organisation during the autumn. There has also been appetite from other trusts to learn from Mersey Care and in collaboration with Northumbria University, it has developed an accredited programme to enable other organisations to take part in the training too.

- Typically, training is provided face-to-face. Due to the COVID-19 pandemic, the trust delivered the training via a blended digital learning approach. Mersey Care worked closely with Northumbria University to develop engaging training in a virtual setting to help learners to get the most out of the new way of training.
- The programme is aimed at managers, patient safety leads, operations managers, staff side colleagues, OD and HR. It is requested that a board member commits to supporting those who attend the training and provides an opening comment or letter to attendees to endorse their attendance and permission to enact their learning.
- The programme includes four days of facilitated teaching over three weeks. It is delivered through a variety of live speaker and group facilitated sessions, self-directed learning through workbooks and filmed role plays and presenter sessions. This blended digital learning approach aims to retain an authenticity that could have been lost via an e-learning package.
- Considerations have also been given as to how to ensure that those who attend the training feel psychologically safe. This is more challenging in an online setting, so adaptions such as shorter days and less days per week of virtual training have been factored in. Training online is tiring and having no more than eight learners and a tutor is considered best practice to ensure meaningful engagement.

[23] https://www.merseycare.nhs.uk/working-us/our-just-and-learning-culture

- The course material can be completed individually or in small groups. Reflective learning is built into the programme. Upon completion of the third week, participants take three actions back to their organisations to work on. Six weeks after that, participants complete a post-programme action learning set. This is a new step to enable the trust to evaluate and understand what is working well with the programme, and what might need to be adapted to work better for learners.
- The aim of the programme work is to allow participants to implement what they have learnt into their own organisations and accelerate the transition from Mersey Care's experience.
- Mersey Care's staff survey shows safety, morale and performance have all improved.

Results and benefits

Research the trust commissioned 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.

Overcoming obstacles

Great strides have been taken at Mersey Care, but the trust admits it do not always get it right. When things do not go to plan, they take ownership and apologise for it, and they learn from it. The goal of the culture is ultimately to restore faith, but this is not always possible. This can lead to difficult conversations.

Takeaway tips

- When training online, use smaller groups of up to eight or nine people (including the presenter), this way everyone's face can be seen on the software and it makes the session more interactive.
- Get Board support to show the organisation's commitment to the training.
- It is easier to create a psychologically safe environment when everyone is in the same room, it is harder to do online, but just as important to the success of the training.
- Giving people the chance to analyse a situation with hindsight and by asking the question 'what happened and how can we understand it?' can be powerful as they understand all of the factors and context behind a decision.

The Implementation of a Just Culture in the HSE

The HSE must advocate for a more fair and just path for individuals involved in adverse events. It must also strongly advocate and implement an ethos 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.

Your Opinion Counts staff survey was undertaken in 2016, 2018 and was repeated in 2021 by Core Research, an independent market research company on behalf of the HSE Executive Management Team and National HR. The survey is anonymous and the information gathered is used to identify opportunities to improve and develop and to build a better health service for all.

Your Opinion Counts Employee Engagement Model includes four key quadrants: Involvement, Connection, Commitment and, added for the first time in 2021, Safety and Standards.
Key areas identified in the 2021 survey for improvement include:

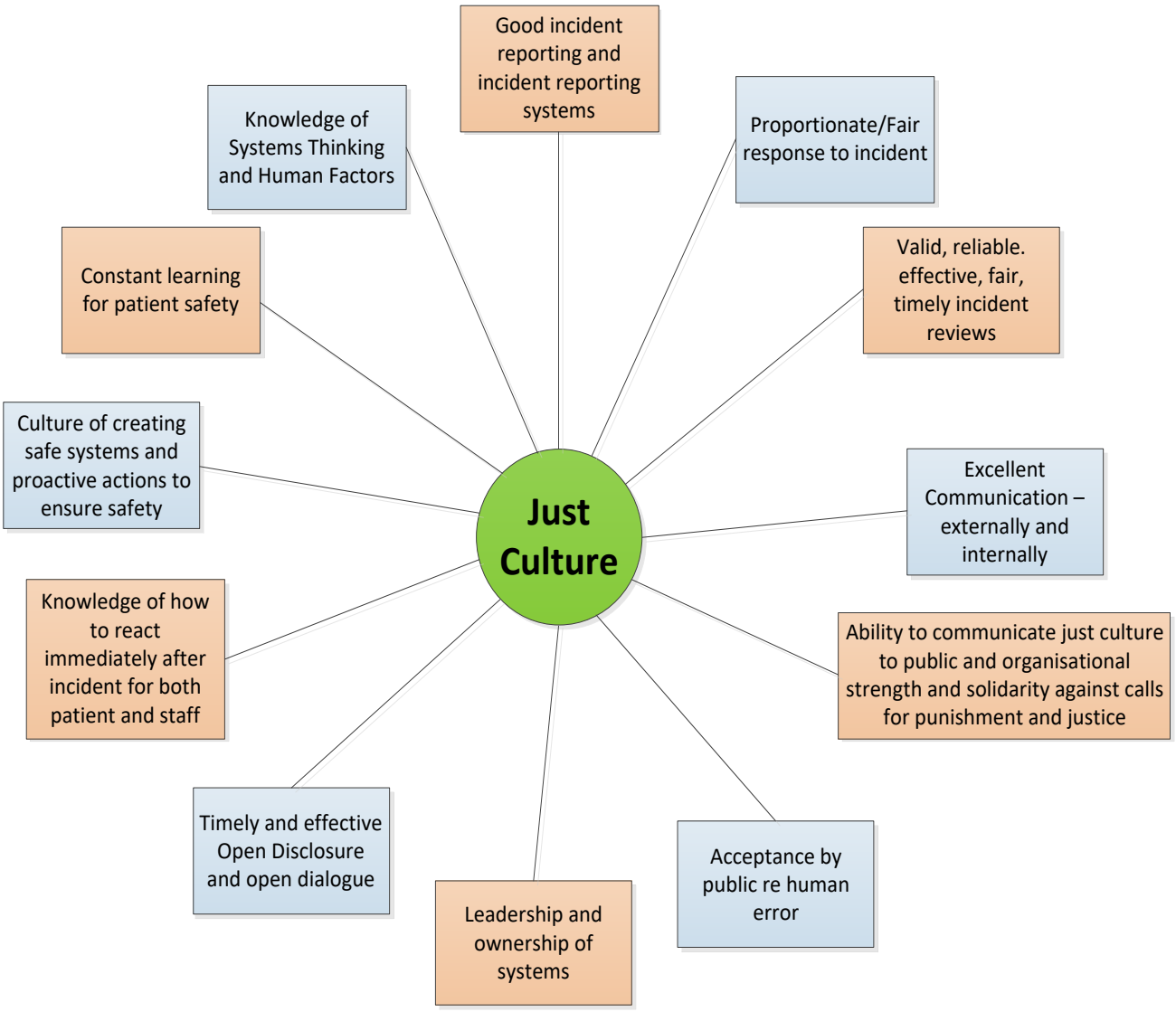
- Communication
- Action on Feedback
- Work/life Balance
- Work/life Culture

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 52% reported that they are given feedback about changes made in response to reported errors, near misses and incidents. The results of the 2021 survey are available at https://healthservice.hse.ie/staff/benefits-services/benefits/your-opinion-counts-staff-survey-2021.html and will be used to identify further improvements and actions to enhance employee experiences and relationships.

Our approach to the implementation of a just culture in healthcare must be multifaceted and will require the combined efforts of the QPSD Team, the Executive Management Team, QPS Leads, Healthcare staff and patients.

A just culture in the HSE requires, amongst many things, a strong quality and safety improvement culture, strong leadership that creates trust, effective incident reporting and management systems, a consistency in responses to an incident regardless of the severity of harm, timely and honest open disclosure, an understanding of systems, systems analysis and human factors, effective and timely incident reviews that are inclusive of all involved in the incident, learning from incidents, implementation of effective Risk Management Systems, and education and training to inform behaviours and to build an understanding of just culture at every level of the organisation.

Ultimately, the HSE needs to adopt, demonstrate and embed behaviours from the top down that removes the fear of reprisals if incidents are reported and builds trust that mistakes and errors will be managed proportionately and fairly with due consideration of the 2nd victims, healthcare staff. Many of the required elements for a just culture are detailed in the diagram below.


Just Culture
Good incident reporting and incident reporting systems
Proportionate/Fair response to incident
Valid, reliable. effective, fair, timely incident reviews
Excellent Communication – externally and internally
Ability to communicate just culture to public and organisational strength and solidarity against calls for punishment and justice
Acceptance by public re human error
Leadership and ownership of systems
Timely and effective Open Disclosure and open dialogue
Knowledge of how to react immediately after incident for both patient and staff
Culture of creating safe systems and proactive actions to ensure safety
Constant learning for patient safety
Knowledge of Systems Thinking and Human Factors

Appendix 1: Just Culture Guide, IMF 2020

Start here – Q1. deliberate harm test				
1a. Was there any intention to cause harm?´		Yes	**Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory body, suspension of staff, and referral to Gardaí and disciplinary processes. Wider review is still needed to understand how and why service users were not protected from the actions of individuals.	END HERE
No, **go to the next question** – Q2. health test				
2a. Are there indications of substance abuse?		Yes	**Recommendation:** Follow **HSE Policy and Procedure on the Management of Intoxicant Misuse**. Wider review is still needed to understand if intoxicant abuse could have been recognised and addressed earlier.	END HERE
2b. Are there indications of physical ill-health? **2c. Are there indications of mental ill-health?**		Yes	**Recommendation:** Follow HSE policy for health issues affecting work e.g. Managing Attendance Policy and Rehabilitation of employees back to work after injury or illness policy, and the need to make a referral to occupational health. Wider review is still needed to understand if health issues could have been recognised and addressed earlier.	END HERE
If No to all **go to the next question –** Q3. foresight test				

3a. Are there agreed protocols/accepted practice in place that applies to the action/omission in question? **3b. Were the protocols/accepted practice workable and in routine use?** **3c. Did the individual knowingly depart from these protocols?**	☐	If No to Any	**Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident review should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual	END HERE
If Yes to all **go to next question –** Q4. substitution test				
4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances? 4b. Was the individual missed out when relevant training was provided to their peer group? 4c. Did more senior members of the team fail to provide supervision that normally should be provided?	☐	Yes	**Recommendation**: Action singling out the individual is unlikely to be appropriate; the patient safety incident review should indicate the wider actions needed to improve safety for further patients. These actions may include, but not be limited to, the individual.	END HERE
If No to all **go to next question –** Q5. Mitigating circumstances				
5a. Were there any significant mitigating	☐	Yes	**Recommendation:** Action directed at the individual may not be appropriate; follow	END HERE

circumstances?			organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident review should indicate the wider actions needed to improve safety for future service users.	
If No				
Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident review should indicate the wider actions needed to improve safety for future patients.				END HERE