Just Culture

David Vaughan


EXXON VALDEZ

“I worked in an organization with a Just Culture, with a heavy emphasis on the Justice”

“The single greatest impediment to patient safety is that we punish people for making mistakes”

Lucian Leape; *Congressional Testimony 2000*

What it is and is not

A just culture “focuses on identifying and addressing systems issues that lead individuals to engage in unsafe behaviors, while maintaining individual accountability by establishing zero tolerance for reckless behavior.

Just organizations focus on identifying and correcting system imperfections, and pinpoint these defects as the most common cause of adverse events.

Just culture distinguishes between human error (e.g., slips), at-risk behavior (e.g., taking shortcuts), and reckless behavior (e.g., ignoring required safety steps), in contrast to an overarching ‘no-blame’ approach”

AHRQ PSNet (2016)

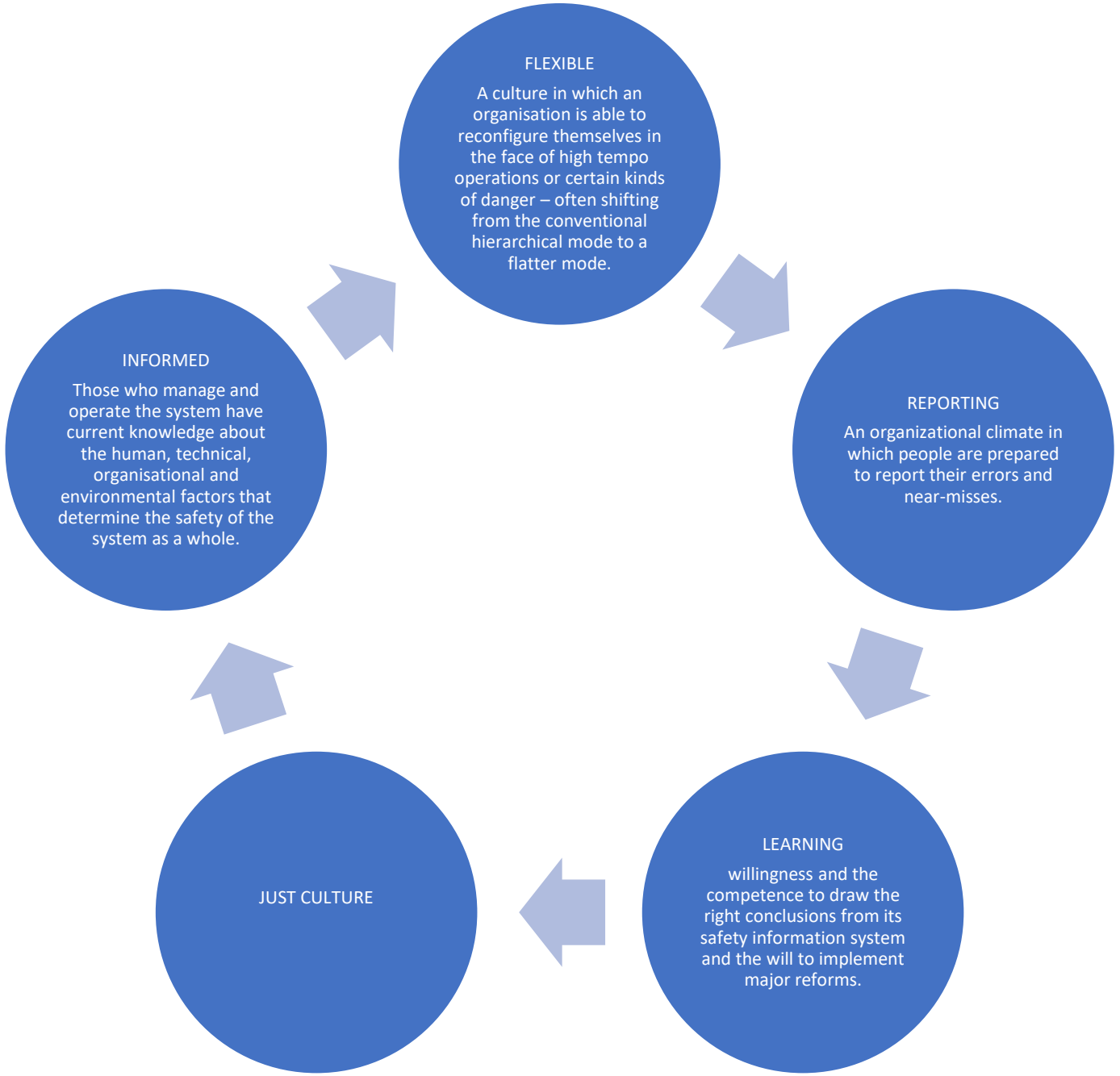
Safety Culture

Cultures do not exist in isolation-

- An informed culture.
- A reporting culture.
- A learning culture.
- A just culture.
- A flexible culture.

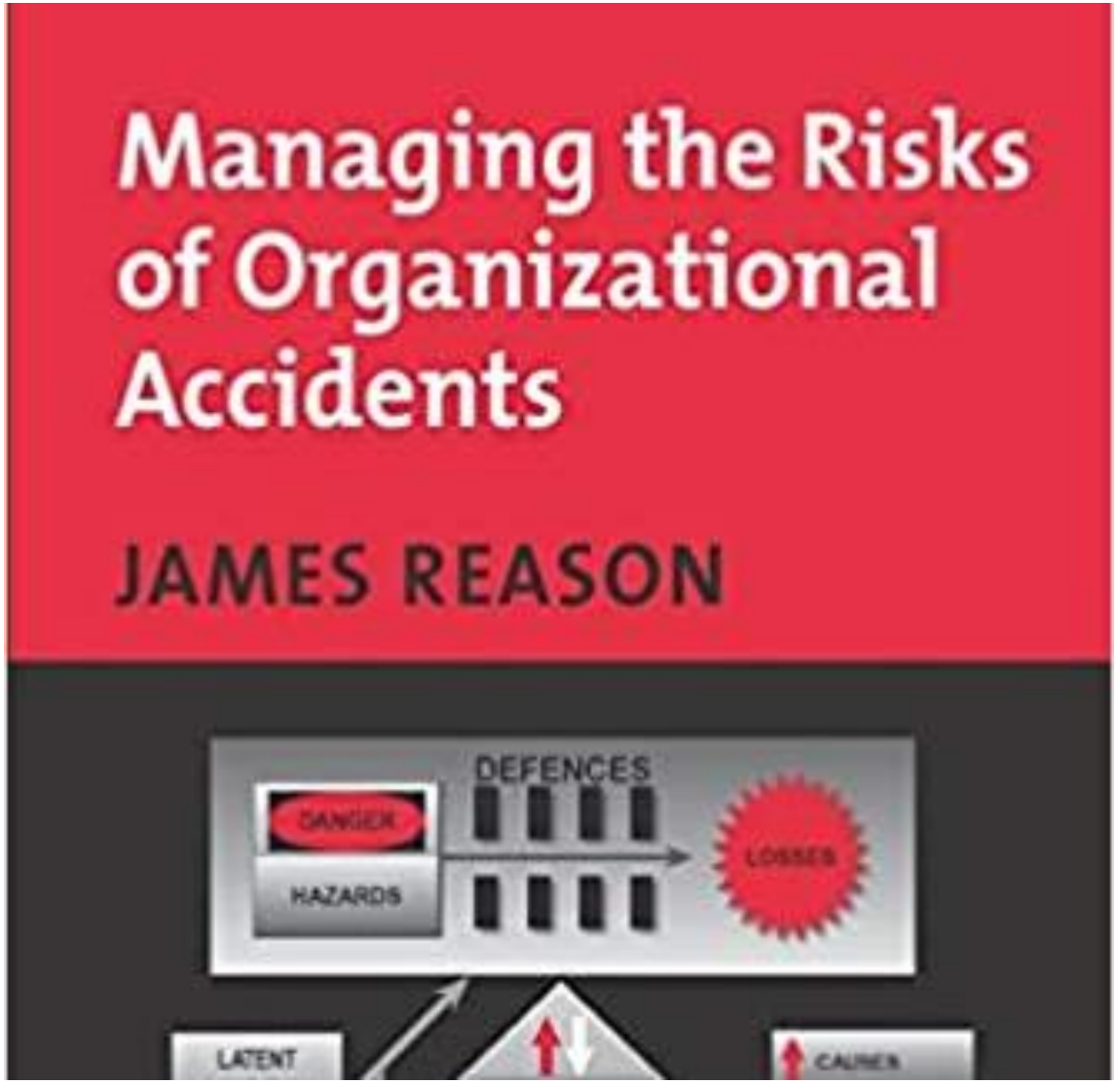
James Reason

https://www.airsafety.aero/Safety-Information-and-Reporting/Safety-Management-Systems/Safety-Culture.aspx


FLEXIBLE
A culture in which an organisation is able to reconfigure themselves in the face of high tempo operations or certain kinds of danger – often shifting from the conventional hierarchical mode to a flatter mode.
REPORTING
An organizational climate in which people are prepared to report their errors and near-misses.
LEARNING
willingness and the competence to draw the right conclusions from its safety information system and the will to implement major reforms.
JUST CULTURE
INFORMED
Those who manage and operate the system have current knowledge about the human, technical, organisational and environmental factors that determine the safety of the system as a whole.

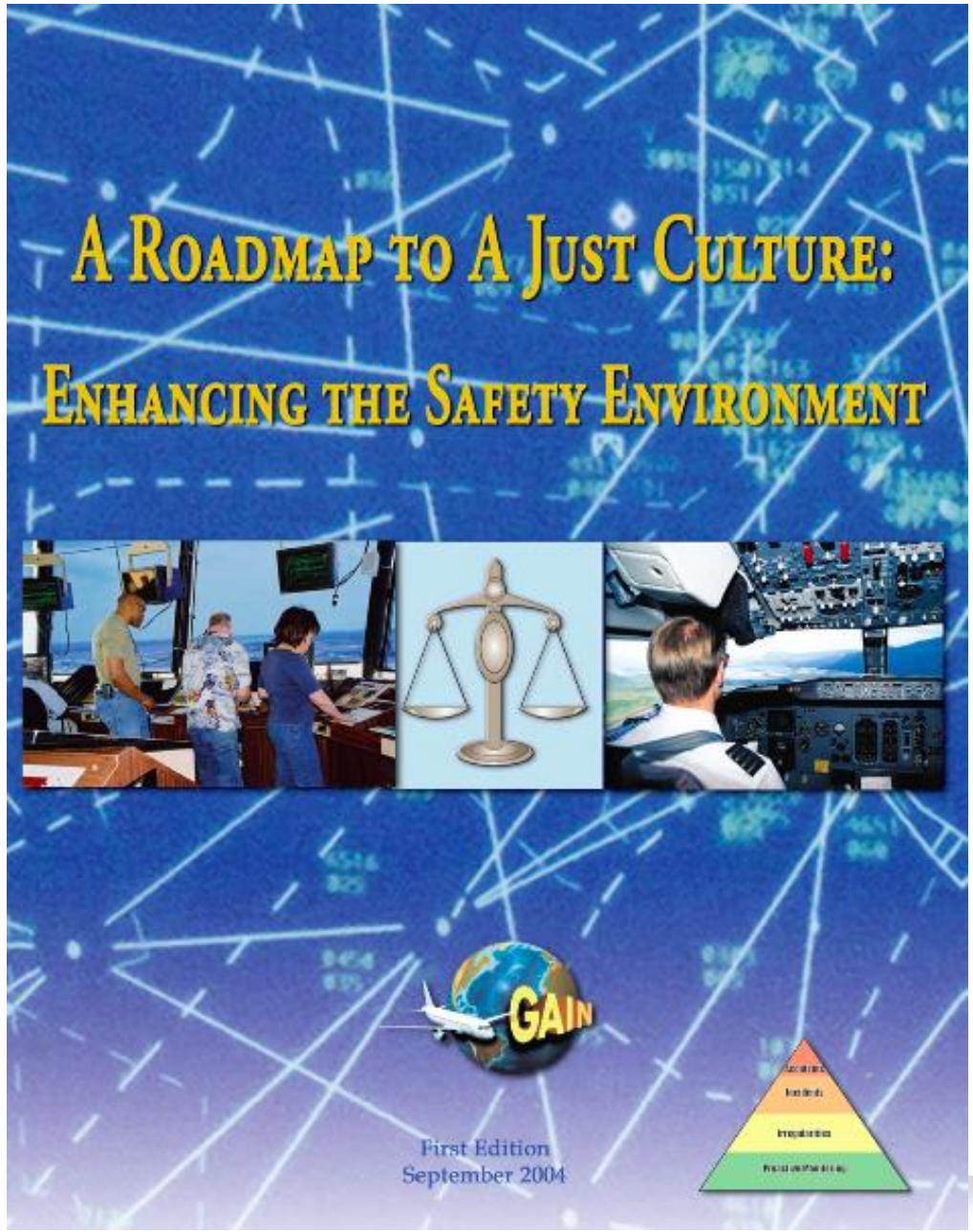
History

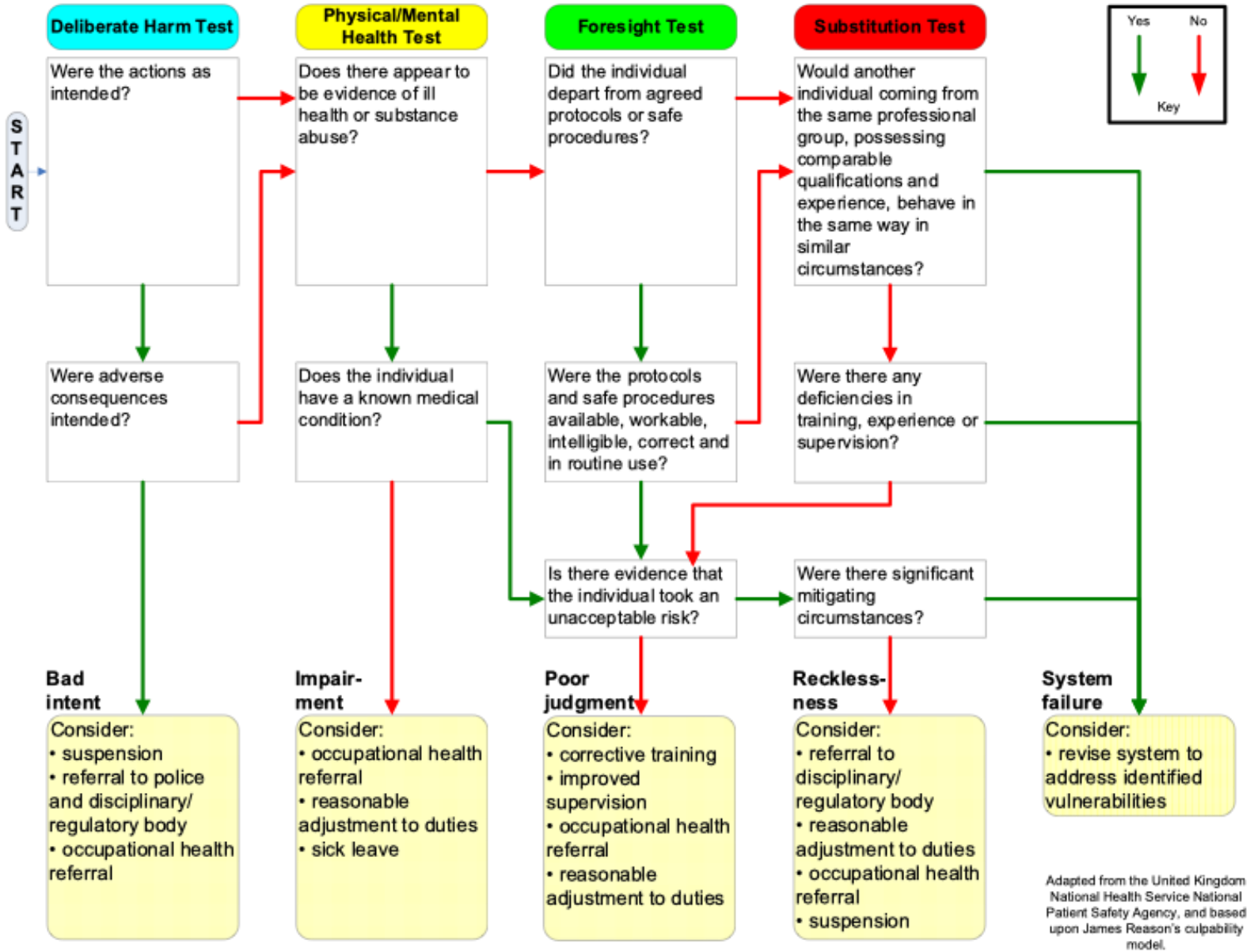
- Unclear when first described
- Most likely James Reason used the term in 1997



History

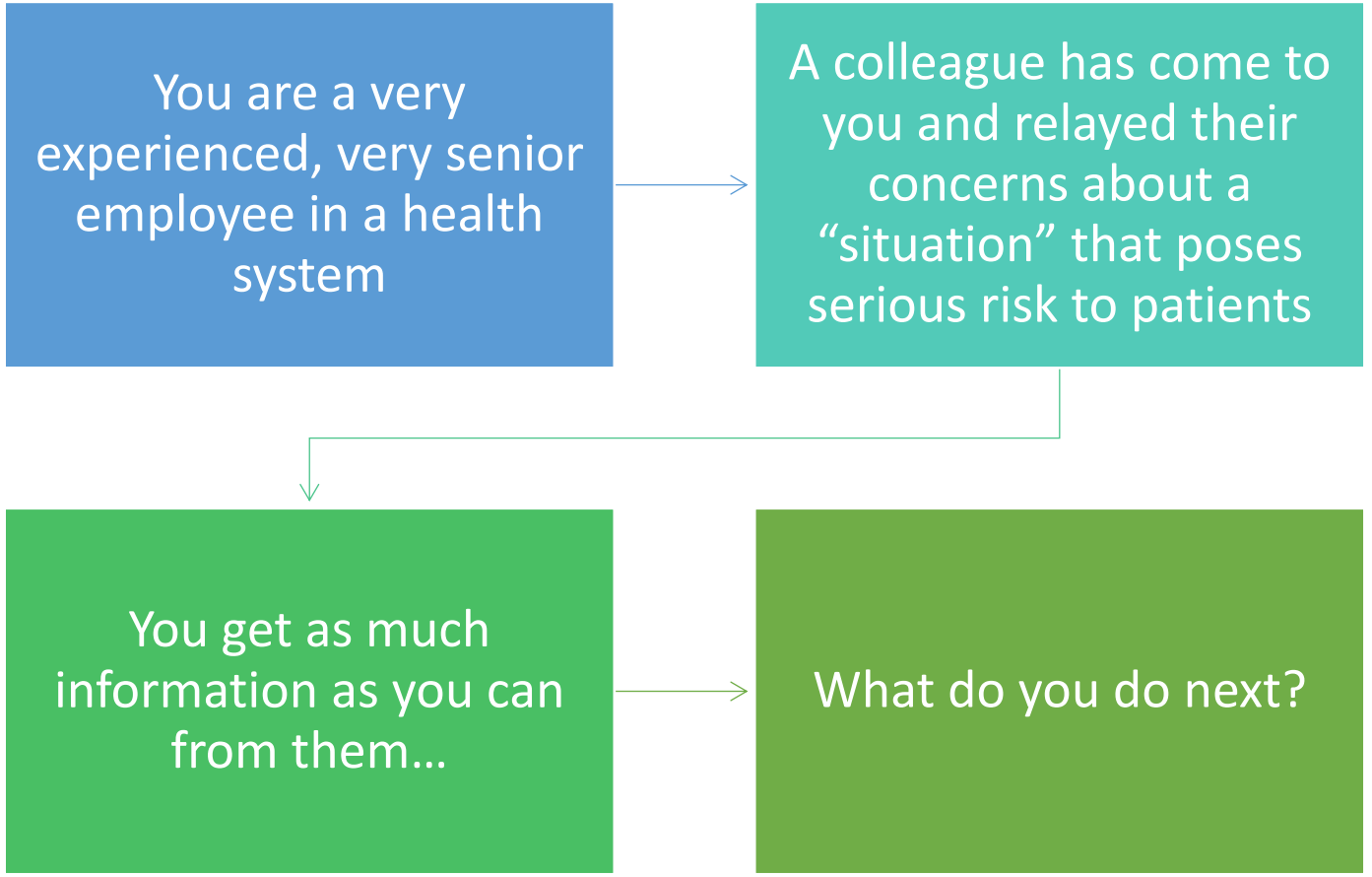
- Global Aviation Information Network 2004
- Identified 4 pioneers in Just Culture model- all Anglo Saxon





Adapted from the United Kingdom National Health Service National Patient Safety Agency, and based upon James Reason's culpability model.

Case Study


You are a very experienced, very senior employee in a health system
A colleague has come to you and relayed their concerns about a “situation” that poses serious risk to patients
You get as much information as you can from them…
What do you do next?

Case Study

You speak to the most senior people in the organization, outline the facts, and state that action must be taken to ensure no harm occurs

You are assured action will be taken

What do you do next…

Case Study

When you check a month later, no action has been taken

What do you do?

Case Study

Three months later, no action has been taken and there has been a serious incident

Senior staff are aware of the harm

What do you do?

Just Culture Principles

Human behaviors within a just culture can be described as follows:

- **HUMAN ERROR =** An inadvertent slip or lapse. Human error is expected, so systems should be designed to help people do the right thing and avoid doing the wrong thing.

  Response: Support the person who made the error. Investigate how the system can be altered to prevent the error from happening again.

- **AT-RISK BEHAVIOR =** Consciously choosing an action without realizing the level of risk of an unintended outcome.

  Response: Counsel the person as to why the behavior is risky; investigate the reasons they chose this behavior, and enact system improvements if necessary.

- **RECKLESS BEHAVIOR (NEGLIGENCE) =** Choosing an action with knowledge and conscious disregard of the risk of harm.

  Response: Disciplinary action.

(AHRQ PSNet 2016)


Develop just culture policy and align across systems and departments
Educate Board, leadership, and workforce
Utilize just culture principles in all event reviews and decisions
Develop metrics for just culture and hold workforce accountable
Treat gaps in culture as adverse events
Involve the media to explain errors, data, and decisions to the public

Just culture; Tactics to Implement	
Educate Board, leadership, and workforce about just culture through integrated training programs	Align systems and standards for just culture across all organizational departments, including Human Resources
Develop and implement a decision-making process and application of just culture that is behavior-based, rather than harm-based	Ensure employees are well-trained in just culture algorithm and tools and utilize them in daily activities and decisions
Ensure organization-wide leadership commitment to frameworks of just culture and accountability that are aligned across all departments	Publicly reward positive examples of just culture
Create an interdisciplinary just culture champion team to review organizational policies, provide training, and ensure policies are being followed at all levels	Identify metrics to track performance on just culture implementation

Just culture; Tactics to Sustain	
Educate organization to be responsive to and transparent about actions related to professional discipline	Involve the media as a way to explain errors, decisions, and data to the public
Implement a peer support program	Treat and respond to gaps in culture and expected safety behaviors as adverse events
Hold workforce accountable for implementing just culture principles in daily practice and decision-making	Expect that leaders utilize just culture tools in all situations, even those not significant or punishable, to ingrain principles and use into organizational norms
Include actual and mock scenarios on meeting agendas that demonstrate application of just culture principles	

Assess Effectiveness

YES/NO

- ✓ Do Board, leadership, and workforce development programs include training on just culture?
- ✓ Is there one set of defined behavioural standards for all individuals within the organization, including leadership, physicians, and the workforce?
- ✓ Is compliance with the established just culture framework part of regularly reviewed performance reviews, including career development plans, for leaders and the workforce?
- ✓ Does the organization use, evaluate, and define action plans related to measures of just culture on employee surveys?
- ✓ Is there an existing measure that is regularly evaluated for assessing frontline knowledge of just culture algorithm?

The NEW ENGLAND JOURNAL of MEDICINE

SOUNDING BOARD

Balancing "No Blame" with Accountability in Patient Safety

Robert M. Wachter, M.D., and Peter J. Pronovost, M.D., Ph.D.

Prerequisite	Example of Hand Hygiene
The patient-safety problem that is being addressed is important.	Rates of health care–associated infections are unacceptably high, resulting in serious morbidity and mortality.[19]
The literature or expert consensus strongly supports adherence to the practice as an effective strategy to decrease the probability of harm.	Many studies and long-standing expert consensus support the value of hand hygiene,[20] and health care–associated infections are now reported publicly and are subject to "no pay" initiatives.[29]*
Clinicians have been educated about the importance of the practice and the evidence supporting it.	Lectures, reminder systems, academic detailing, dissemination of literature, and other steps to educate caregivers have been completed.
The system has been modified, if necessary, to make it as easy as possible to adhere to the practice without disrupting other crucial work or creating unanticipated negative consequences; concerns by providers regarding barriers to compliance have been addressed.†	Hand-gel dispensers have been placed in convenient locations throughout the building; dispensers are never empty and work well (e.g., they do not squirt gel onto providers' clothes).
Physicians, other providers, and leaders have reached a consensus on the value of the practice and the process by which it will be measured; physicians understand the behaviors for which they will be held accountable.	Meetings have been held with relevant provider groups, including medical staff, to review the evidence behind hand hygiene, the rates of hospital-acquired infections, and the steps that have been taken to optimize the system.
A fair and transparent auditing system has been developed, and clinicians are aware of its existence.	Providers know that observers will periodically audit hand-hygiene practices; observers can determine whether providers adhere to the practices, even if hands are cleaned inside patients' rooms (including the use of video[23] or systems that sound an alarm when providers approach patients' beds without using nearby hand-cleaning dispensers).
Clinicians who do not adhere to the practice once or perhaps twice have been counseled about the importance of the practice, about the steps that have been taken to make it easy to adhere, and about the fact that further transgressions will result in punishment; the consequences of failure to adhere have been described.	A physician, for example, might receive a warning note or be counseled by a department chair after the first or second observed transgression.
The penalties for infractions are understood and applied fairly.	Chronic failure to clean hands will result in a 1-wk suspension from clinical practice, accompanied by completion of a 2-hr online educational module on infection prevention.

“No Blame”

“Just Culture”

to the real nature of the case.

The main charge made against the hospital is that the child, Elizabeth Sheridan, "met its death through the neglect of the hospital authorities, either through permitting contagion to enter the ward where she was, or that the accident and contagious diseases wards are not properly isolated."

The child was admitted with a broken thigh on March the 15th. On the 22nd fever and symptoms of scarlatina of a mild type developed themselves. It is at least possible, considering the short time after her coming into hospital when these symptoms appeared, that the disease had been contracted prior to her admission, although this cannot be positively affirmed, as the incubation period of scarlatina is uncertain and variable. But, admitting that the disease was contracted in the hospital, and that it was not introduced into the children's ward by visitors (a not unlikely supposition at a time when scarlatina is epidemic), we deny most emphatically that there was neglect of any precaution which it was in our power to take in order to prevent the spread of contagious disease in the house. The children's ward is removed as far as

sides, the scarlatina wa
had subsided for many
During the time she
ward she was
utmost kindness an
obvious reasons, visitors a
fever wards, but the trea
carried on in hugger-mu
large class of students an
wards would make it imp
inattention to be practis
without its coming to light

At the end, the child's
suddenly, owing to a diff
which her enfeebled condi
her to grapple with.

As to the *post mortem* exa
by Mr Brabazon, who ne
by Dr Purser, who had ha
her life. The suddenness
plication of disorders fro
the examination of great
fication was admitted on
Johnson.

vey a most erroneous impression of what actually took place. Finally, we regret exceedingly that the board of the hospital thought fit not to answer Mr Sheridan's letter. At the time when it was received the Board referred it to us, and we sent up an answer substantially the same as that which we now give, and we believed that this answer had been sent to Mr Sheridan. Unfortunately, at Sir Patrick Dun's Hospital the medical officers are not represented on the board of governors. If it were not for this unique arrangement, Mr Sheridan's letter would not have remained unanswered.—We are, sir, your obedient servants,

EDWARD H BENNETT,
THOMAS EVELYN LITTLE,
JOHN M PURSER,
WALTER G SMITH,
J MAGEE FINNY,
J R KIRKPATRICK,
C B BALL,

} Medical Staff of Sir Patrick Dun's Hospital.

Husband of Coombe critic claims hospital trying to silence her

SIMON CARSWELL
Public Affairs Editor

The husband of a hospital consultant at the Coombe hospital has claimed that its board is trying to silence his wife over her criticism of the controversial Covid-19 vaccinations of relatives of staff.

Tom Fahey, a professor of general practice at the Royal College of Surgeons in Ireland, has written to Minister for Health Stephen Donnelly complaining about the hospital's treatment of his wife, Prof Deirdre Murphy, professor of obstetrics at Trinity College Dublin and a consultant at the Coombe, after she criticised the hospital's response to the vaccinations of the family members.

The board of the Dublin hospital has said the vaccinations of 16 relatives of staff with doses left over on the night of January 8th – including two family members vaccinated by a doctor at home – were "mistakes" and should not have happened.

The controversy has led to internal tensions within the hospital. Prof Murphy called for the master of the hospital, Prof Michael O'Connell, who had two family members vaccinated, to resign in an April 7th letter circulated to senior medics at the hospital.

She has also written to the Minister and Health Service Executive chief Paul Reid.

The chair of the Coombe board, Mary Donovan, wrote to Prof Murphy on April 14th, telling her that the circulation of her concerns to a significant number of people was "entirely inappropriate". She accused her of causing the hospital reputational damage and that "as an employee" there were "avenues available" for her to raise concerns internally and that "these must be followed".

Prof Murphy replied on April 20th telling Ms Donovan: "It would be helpful if the board focused on the source of the problem rather than on an individual who is attempting to salvage some integrity from this sorry episode."

Her husband, Prof Fahey, told Mr Donnelly in a letter sent on Monday that Ms Donovan's letter was an attempt to "threaten" and "isolate" Prof Murphy in the Coombe.

In response to queries, a spokeswoman for the hospital said the board took what happened with the vaccinations "extremely seriously and has started a process to address the implications".

"As that process is ongoing, the hospital has no further comment," she said.

Coombe vaccine controversy rumbles on: page 5

A “Restorative” Just Culture

1. Don’t ask who is responsible, ask what is responsible
2. Link knowledge of the messy details with the creation of justice
3. Explore the potential for “restorative justice”
4. Go from backward to forward- looking accountability
5. Put secondary victim support in place

Retributive vs Restorative Just Culture

Restorative

- Who is hurt?
- What do they need?
- Whose obligation is that?
- Accountability is *forward-looking.* Together, you explore what needs An **account** is something to be done and who should do it you tell and learn from

Retributive

- What rule is broken?
- How bad is the breach?
- What should consequences be?
- Accountability is backward-looking, An account is something finding the person to blame and imposing proportional sanctions you settle or pay

RESTORATIVE JUST CULTURE CHECKLIST

Restorative Just Culture aims to repair trust and relationships damaged after an incident. It allows all parties to discuss how they have been affected, and collaboratively decide what should be done to repair the harm.

WHO IS HURT?

ACKNOWLEDGED: NO YES

Have you acknowledged how the following parties have been hurt:

- **First victim(s)** – patients, passengers, colleagues, consumers, clients
- **Second victim(s)** – the practitioner(s) involved in the incident
- **Organization(s)** – may have suffered reputational or other harm
- **Community** – who witnessed or were affected by the incident
- **Others** – please specify:.....

WHAT DO THEY NEED?

EXPLORED: NO YES

Have you collaboratively explored the needs arising from harms done:

- **First victim(s)** – information, access, restitution, reassurance of prevention
- **Second victim(s)** – psychological first aid, compassion, reinstatement
- **Organization(s)** – information, leverage for change, reputational repair
- **Community** – information about incident and aftermath, reassurance
- **Others** – please specify:.....

WHOSE OBLIGATION IS IT TO MEET THE NEED?

IDENTIFIED: NO YES

Have you explored the needs arising from the harms above:

- **First victim(s)** – tell their story and willing to participate in restorative process
- **Second victim(s)** – willing to tell truth, express remorse, contribute to learning
- **Organization(s)** – willing to participate, offered help, explored systemic fixes
- **Community** – willing to participate in restorative process and forgiveness
- **Others** – please specify:.....

READY TO FORGIVE?

NO YES

Forgiveness is not a simple act, but a process between people:

- **Confession** – telling the truth of what happened and disclosing own role in it
- **Remorse** – expressing regret for harms caused and how to put things right
- **Forgiveness** – moving beyond event, reinvesting in trust and future together

ACHIEVED GOALS OF RESTORATIVE JUSTICE?

ACHIEVED: NO YES

Your response is restorative if you have:

- **Moral engagement** – engaged parties in considering the right thing to do now
- **Emotional healing** – helped cope with guilt, humiliation; offered empathy
- **Reintegrating practitioner** – done what is needed to get person back in job
- **Organizational learning** – explored and addressed systemic causes of harm

The rig survivors also said it was always understood that you could get fired if you raised safety concerns that might delay drilling. Some co-workers had been fired for speaking out, they said.

It can cost up to $1 million a day to operate a deepwater rig, according to industry experts.

Safety was "almost used as a crutch by the company," Barron said. He said he was once scolded for standing on a bucket on the rig, yet the next day, Transocean ordered a crane to continue operating amid high winds, against its own policies. "It's like they used it against us -- the safety policies -- you know, to their advantage.

"I don't think there was ever a plan set in place, because no one ever thought this was gonna ever happen," he added.

BP spokesman Robert Wine would not comment on

Thank You