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CLINICAL CONNECTION

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IMPROVING SAFETY THROUGH JUST CULTURE

"A Just Culture fosters an environment where employees hunger for knowledge and eagerly seek to understand risk"

Definition: Just Culture is one that learns and improves by openly identifying and examining its own weaknesses. Organizations with a Just Culture are as willing to expose areas of weakness as they are to display areas of excellence.

AHRQ defines just culture as one in which frontline staff feel comfortable in disclosing errors including their own while maintaining professional accountability

The concept or model of Just Culture has gained momentum lately, however the term is not new. As far back as 2001, there was discussion about Just Culture and safety. If one has to synthesize the concept about Just Culture, it would be "no blame" and creating a learning environment.

Why propose a just culture in healthcare?	Benefits of a Just Culture
Just culture is the foundation of what healthcare organizations are about, keeping	Engagement of everyone in the organization toward the goal of keeping patients safe
It embodies an organization's mission & values	Provides a pathway toward 0 errors
It is about accountability and consequences of	Defines the term accountability vs using the term accountability that has different meanings for different people
It is about continual growth through learning	
It moves the organization toward one of high-reliability	Tested and validated by other industries (FAA) that a Just Culture reduces errors

The Big Question: If there is no blame, what about progressive discipline? This is a personal reflection on the question. At various junctures of my career, particularly as a manager and then in Chief Nurse roles, one must determine how to address mistakes and errors. Are there any gray areas when dealing with human behavior? Personally, in this writer's opinion there are always gray areas since humans are fallible individuals. In a mature organization where Just Culture values have been embedded, the question isn't "Who did it?" but "How could the error have happened?" If a root cause analysis stops at "Who did it?" and blame is levied against an individual, system processes are not evaluated, and it is likely that the error will occur again thus reducing patient safety.

"People make errors, which lead to accidents. Accidents lead to deaths. The problem is seldom the fault of the individual; it is the fault of the system. Change the people without changing the system and the problem will continue."

Don Norman—Author, the Design of Everyday Things.

Again, reflecting on my career, it was brought to my attention twice that I had made an error; one was the wrong IV hung, and the second was as a student when an ampule of morphine broke in my hand. It's a long story that I won't bore you with. After 35 years as a nurse, I can confidently say that I am certain that I made more than two errors. Generally, there are three reasons why I only know of two occurrences. First, other errors were never discovered; second, my colleagues discovered the error, corrected it and never reported it, and third, my colleagues did not want to get me in trouble. Trouble is the operative word. Sadly, punishment has been the usual outcome of errors. With the inception of a Just Culture, blame and punishment can be an outcome of the past. There's work to do on many fronts, such as Boards of Nursing and regulatory agencies, to shift the paradigm.

Philosophical Change

David Marx is the first person who coined the term Just Culture as it relates to accountability and safety. Marx is a mechanical engineer and an attorney. His work began at Boeing where he performed failure mode and effects analyses on aircraft. Obviously, his work has contributed to aircraft safety. In addition, he has branched out to help health care organizations and regulators understand modern risk management methodologies. Marx developed the Just Culture Algorithm™ which provides a series of pathways to assist organizations in responding to errors.

He uses the term "simple errors" and defines these as "slips, lapses or trips" because he believes that competent people experience sensory overloaded or become distracted, thus causing the slips. Marx suggests looking at processes versus people when slips occur. It is his belief that barriers and redundancies cause the slips. Take a moment and think about this from a practical point of view.

Example: A patient presents to the ED stating that she is having an allergic reaction. A nurse takes her vital signs, blood pressure and pulse are elevated. The ED physician evaluates the patient, and orders Epi 0.3 cc sq. The nurse is assigned to a large number of patients since the ED is very busy, so she asks her colleague, a float nurse, to administer the Epi. The float nurse draws up the Epi and administers the medication through the patient's IV. The patient complains to the assigned nurse that her heart feels like it is pounding out of her chest and her face is cherry red. The patient says the other nurse gave her the medication in the tubing, and shows the assigned nurse where the medication was administered. The assigned nurse checks with the float nurse and they review the order. The float nurse insists she gave the medication sq as ordered. An investigation takes place, and the float nurse continues to say she administered the Epi sq. What do you do if you believe in a Just Culture?

Answer: According to the Just Culture model, the float nurse displayed reckless behavior. There was conscious disregard for usual and safe practice of checking the order and administering Epi for an allergic reaction sq. She did not determine the level of risk of her behavior which would justify remedial education along with progressive discipline.

Marx discusses four key behavior concepts which serve as the structure for the model:

1. Human error – affected by processes, environment, procedures, education
2. Negligence – choice is made that risk is believed to be justified or insignificant
3. Reckless conduct – conscious disregard for risk
4. Knowing violations – there is intentional violation of rules

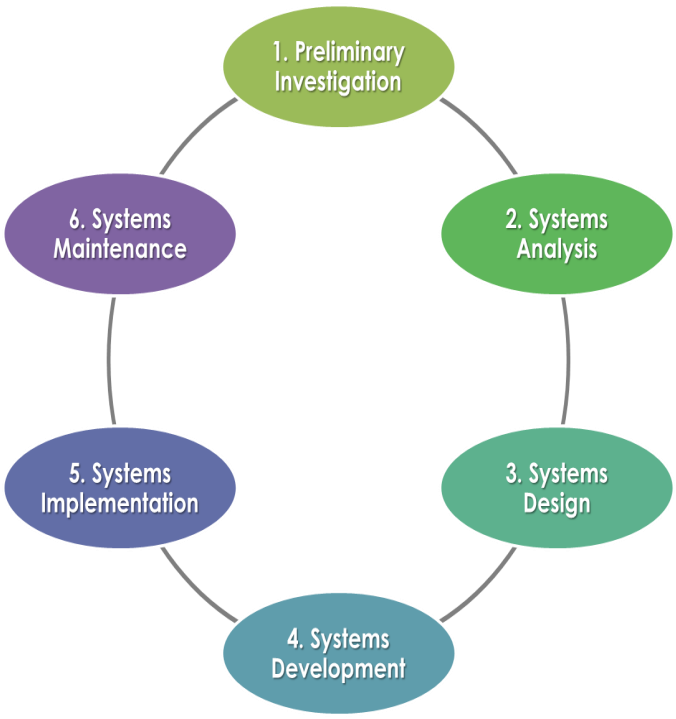
Each organization is responsible for keeping patients safe, designing safe systems, aligning cost with efficiencies and effectiveness of processes, providing equitable care in a dignified manner, and producing favorable outcomes.

Implementing a Just Culture – The Journey

Since most health care workers have "grown up" with a punitive system, it is critical to change the culture to one of continually improving processes that support patient safety, and eliminating blame. Naturally, it starts from the top. The Executive Team will need to make the decision to create a Just Culture along with living the journey remembering that a culture change can take 3-5 years.

Many who are reading this Clinical Connection probably recall the Miracle on the Hudson when a US Airways jet encountered a flock of birds that caused the engines to fail. Captain Chesley Sullenberger executed a successful landing on the Hudson River, but few know that in his suitcase there was a book on Just Culture. Interestingly enough, the airline industry has focused on developing a Just Culture, resulting in improved safety. During 2015, the airline accident rate was the equivalent of only one major accident for every 3.1 million flights, according to the International Air Transport Association that is the trade group for the world's carriers. The IATA also reported that the number of major accidents was down nearly 12% compared to 2014 and the number of fatalities caused by those accidents dropped to 136 deaths compared with 641. About 3.5 billion people flew safely on 37.6 million commercial flights in 2015. Health care should be able to learn from the successes of the airlines.

The first step of the journey is to maintain a commitment to safety at every level. The commitment allows the organization to respond proactively and minimizes a reactive approach to safety. The second step is to collect, analyze and develop strategies to reduce and ultimately eliminate adverse patient outcomes. Third, investigate Systems Analysis Theory that focuses on human behavior, and includes familiar topics such as root cause analysis, slips versus mistakes, and the Swiss cheese model. Finally, build the infrastructure to support the commitment to safety because without it you will not be able to accomplish your goals.



Further steps can include:

1. Raising the awareness of Just Culture for everyone including providers.
2. Provide education regarding the Just Culture Algorithm™ and the model and how the model relates to safety. (www.justculture.org)
3. Align organizational values and expectations with mission and vision.
4. Foster accountability through example and role modeling behaviors.
5. Remember, you cannot make others accountable.
6. Review policies to determine compliance with the Just Culture model.
7. Determine whether operational processes minimize barriers and simplifies procedures, especially redundancies.
8. Ask the right questions especially of those delivering hands on care. What is necessary (tools) to assure that safety governs everything you do? And deliver!
9. Continually evaluate and reevaluate improvement, and adjust efforts to assure progress.
10. Never give up! Always improve safety efforts.

The goal of a Just Culture environment is to design safe systems that will reduce the opportunity for human error and capture errors before they reach the patient. In a Just Culture, organizational systems assist staff in making good decisions along with making it more difficult to make errors. Ultimately, each individual must make a commitment to manage their own behaviors and the choices they make.

References

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