

Column: The Growth of a Just Culture

by K. Scott Griffith, chief operating officer, Outcome Engineering L.L.C.

Management dilemmas:

- Two nurses select the wrong medication from the dispensing system. One dose reaches a patient, causing him to go into shock, and the other is caught at the bedside before causing harm. Do we treat these nurses in the same way?
- An otherwise great pharmacist can't break an addiction to his afternoon smoke break. Do we give this person an exception to the no-smoking rule?
- A Phlebotomist loses custody of a yet-unlabeled specimen but chooses not to report the incident, out of fear of discipline. Do we forgive the breach, given the legitimate reasons for the phlebotomist's fear?
- A nurse complains that a physician knowingly violated a safety rule, although it was broken in order to save a life. Do we condone the rule violation?
- An entire surgical team defends skipping the presurgical time-out on the basis that no adverse event occurred. Do we condone this violation?

These are but a few examples of management dilemmas that might be addressed with the philosophy of a Just Culture. The Just Culture approach takes into account several important questions, including the following:

- How are we to account for the systems we create around caregivers?
- How are caregivers to account for their errors and their choices within those systems?
- Which ideas of workplace justice best support patient safety?

- What ideas of justice are fair given the predictable, inescapable fallibility of our managers and staff?

Health care professionals around the world are trying to find answers to these common questions—but that's easier said than done. Finding just, equitable, and efficient answers can seem illusive or even impossible. Though many organizations have tried adopting portions of the Just Culture, the fundamental concepts are often misapplied. Some have adopted a “blame-free” model of accountability, hoping that a “softer, kinder” approach will reduce adverse events or raise their patient safety survey scores.

In many organizations, managers have used academic models that oversimplify human behavior, focusing on procedural compliance over values or labeling behaviors as unsafe acts only after an adverse outcome occurs. At other times, these organizations turn a blind eye to risky choices, reinforcing the wrong lesson when no one is harmed. Each of these approaches, however well intended, falls short of hitting the mark. Just Culture is more than an adverse event-reporting system; it's more than a behavioral response to procedural noncompliance; it's more than an “unsafe acts” flow-chart. But beyond these descriptions of what it's not, exactly what is a Just Culture?

For health care managers, Just Culture refers to a values-supportive model of shared accountability. It's a culture that holds organizations accountable for the systems they design and for how they respond to staff behaviors fairly and justly. In turn, staff



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are accountable for the quality of their choices and for reporting both their errors and system vulnerabilities. In an organization with a Just Culture, we focus on our systems yet do not lose sight of physicians, managers, pharmacists, clerks, or nurses as components within our system. Through this balanced accountability, Just Culture provides better tools to manage the complicated risks within health care.

Rather than only react to the actual harm involved in discovered events, an organization with a Just Culture assesses the daily risks inherent in its operations and works toward maximum reliability to prevent future adverse events, relentlessly improving both system design and the quality of collective behavioral choices.

One of the defining qualities of a Just Culture is its commitment to values, including learning cultures, open and fair cultures, safe system design, and effective management of behavioral choices. A Just Culture fosters an environment where employees hunger for knowledge and eagerly seek to understand risk at both individual and

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organizational levels. Recognizing the impact of system design on patient safety, those within a Just Culture design safe systems that work proactively—not just reactively to harmful outcomes. Though systems cannot be designed to perfection, they can be created to anticipate and capture human errors before they become critical, while also permitting recovery in the event that an error does reach a patient.

In a Just Culture, openness and fairness must be present to facilitate effective and honest reporting within safe systems. While there are ample reasons why someone who makes an error might not come forward or report his or her participation in an event, a Just Culture strikes a balance, being neither “highly punitive” nor “blame free.” A Just Culture accepts that people make mistakes, but it also facilitates the differentiation and management of behavioral choices so that we improve our chances of achieving the outcomes we desire. Rather than just assume that a bad outcome has a bad person associated with it, we focus on the differences between human error, *at-risk behavior*, and *reckless behavior*—and administer justice based on the quality of the person’s choice.

To effectively manage human behavior, a Just Culture understands the “severity bias” that emerges when the level of actual harm determines whether someone is disciplined. This can often lead organizations toward a dangerous “no harm, no foul” view of accountability. However, a Just Culture recognizes that human error is inadvertent, while at-risk behavior and reckless acts are conscious choices, regardless of whether harm was intended. When all


Goals for a Just Culture

The Just Culture model sets goals for an organization, including the following:

- Creating an environment of internal transparency around risk
- Striving to understand why human errors occur within the organization
- Striving to understand why at-risk behaviors occur within the organization
- Learning to see common threads—to prioritize risk and interventions
- Working with staff to design systems that reduce the rate of human error and at-risk behavior or mitigate their effects
- Learning when to console and when to coach our employees
- Limiting the use of warnings and punitive actions to the narrow circumstances where such use benefits organizational safety
- Avoiding traditional organizational biases by focusing on the risks inherent in systems and behavioral choices, not the actual outcomes of events
- Using data to build both unit and organizational models of risk
- Learning to measure risk, at both the unit and organizational levels

three behaviors are managed consistently, a Just Culture shifts to focus on the quality of choices, not on undesired outcomes that may or may not result. An organization with a Just Culture is more concerned with the potential for risk—and catching it before harm occurs—than with punishing based on an outcome, which oftentimes is the result of human error alone.

A Just Culture recognizes that in order to achieve the best possible outcome, it must support each of its core values. Specifically in health care, the needs of privacy and access to care must be balanced with compassion, fiscal responsibility, and patient safety. An organization cannot guarantee perfect outcomes, but it can commit to maximizing its reliability around each of its core values and being the best steward of the limited resources it has.

Editor’s Note: *The views expressed in this article are those of the author and not of The Joint Commission or Joint Commission Resources.* 

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