RISK NOTE

Just Culture

OVERVIEW OF ISSUE

A just culture is essential to building a culture of safety. Leaders must ensure a consistent, fair, and just process for assessing accountability and dealing with healthcare providers involved in adverse events. This requires an understanding of human error theory, systems thinking, and complex adaptive systems. Several leadership models incorporating these concepts have been developed to guide the assessment of actions by healthcare providers.

KEY POINTS

- Ensuring a consistent, fair, and just process for assessing accountability and dealing with healthcare providers involved in adverse events is key to building a safety culture.

THINGS TO CONSIDER

What is a Just Culture?

- A just culture recognizes that individual healthcare providers should not be held accountable for system failings over which they have no control.
- A just culture recognizes many individual or "active" errors represent predictable interactions between human operators and the systems in which they work. However, 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 patients or gross misconduct (e.g., falsifying a record, performing professional duties while intoxicated).

National Health Service Incident Decision Tree

- The National Health Service's Incident Decision Tree, modeled after Reason's "culpability tree" was developed to help leaders move away from asking 'Who was to blame?' to asking 'Why did the individual act in this way?'. It is comprised of four sequential tests and structured questions about staff actions, motives, and behaviour at the time of the incident. Recommended options are provided for each stage. The further along the sequence, the more likely the underlying cause will be found to be a systems failure. The four tests include:
  1. **Deliberate** – Were the individual's actions intended? Was the outcome intended? If harm was intended, immediate suspension, referral to the police and/or relevant disciplinary/regulatory authorities would be indicated.
  2. **Incapacity** – Was the staff member aware of their condition at the time (e.g. ill health or substance abuse)? Did they realize the implications of their condition? Did they take proper safeguards to protect patients?
  3. **Foresight** – Was there an agreed protocol/practice? Was it workable and in routine use? Was it ignored? If it was ignored, other contextual factors would be assessed including information availability and urgency of the situation.
  4. **Substitution** – How would a peer have acted in a similar situation? Deficiencies in training, experience, or supervision would also be explored.
- To provide further clarity in especially egregious situations, healthcare leaders would be required to refer any of the following incidents to the appropriate authorities:
  - Events thought to be the result of a criminal act;
  - Purposefully unsafe or malicious acts intending to cause harm;
  - Acts related to substance abuse;
  - Events involving suspected patient abuse of any kind.
- It should be noted that the model was not intended for use in determining "negligence", a complex legal determination.

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Marx's Just Culture Framework

- In Marx's "Just Culture" framework, a leader's response is dictated by the type of behaviour exhibited by the healthcare provider as per below:
  - **Human Error** – An inadvertent action, slip, lapse, mistake. Response is empathy and support.
  - **At-risk Behaviour** – Rationalizing and taking shortcuts that lead to increased patient risk. Response is coaching, mentoring, systems redesign.
  - **Reckless Behaviour** – Intentionally putting patients in harm's way. Response is punishment.

Accountability

- While recognizing that "most errors are committed by good, hardworking people trying to do the right thing" (p.1401), Wachter & Pronovost (2009) also support the concept of proportional and just discipline for certain types of actions, whether or not they lead to harm. "Once a reasonable safety rule is implemented and vetted (since some rules create unanticipated consequences or work-arounds and need to be reworked after initial implementation), failure to adhere leaves the world of "no blame" and enters the domain of accountability" (p.1402).

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