

Just Culture-Changing the Environment of Healthcare Delivery

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LEARNING OBJECTIVES

1. Describe four types of blameworthy behaviors identified in a *traditional work culture*.
2. Describe how blaming individuals for errors decreases patient safety.
3. Differentiate a *just culture* from a *no blame* culture.
4. Identify errors that should require disciplinary action within a *just culture* work place.

INDEX TERMS: personnel management; quality improvement; healthcare quality assurance

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Introduction

Given human nature, it is inevitable that people make mistakes, even in the medical laboratory. When a mistake occurs, there are two options to consider. Blame can be assigned to the person who made the mistake, or we can learn how to prevent future errors. An instinctive reaction that focuses on the person caught making the error may be satisfying, however it leaves underlying process flaws unaddressed, creating an opportunity for the same type of error to happen again.

One million people are harmed every year by healthcare errors, including an estimated 120,000 deaths.¹ The single greatest impediment to error prevention is our habit of punishing people for making mistakes.¹ Because traditional disciplinary approaches focus on

blame and punishment, few people willingly come forward to report their mistakes. Only 2-3% of major errors are reported through incident reporting systems,¹ leaving the remainder concealed. In order to improve the safety of healthcare by analyzing near-miss and adverse events, we must first increase the willingness of individuals to report their errors. Most laboratory scientists and other healthcare personnel—and much of the public—regard errors by healthcare providers as evidence of personal carelessness. As a result, individuals only report what cannot be concealed. This is not an effective solution to preventing human error.

Traditional Disciplinary Systems

In most laboratory settings, disciplinary action usually means punishment dispensed in order to deter future undesirable behavior, a traditional system. The most common forms of punishment include public condemnation and shame, documentation of disciplinary action in employee personnel files, loss of eligibility for promotion, suspension without pay, and termination.²

Four terms are commonly used socially and legally to describe conduct that traditionally has been considered deserving of reproach (blameworthy), and thus warrants disciplinary action (see Table 1).³ The simplest of these is *human error*, which refers to unintended slips or lapses. For instance, a medical laboratory scientist may intend to pull units of A-positive fresh frozen plasma from the freezer, but inadvertently removes and thaws O-positive plasma instead. These types of errors generally result in minimal consequences, although they may have the potential for serious outcomes, particularly if they are not caught before the next step in the process.

Table 1. Terms Used to Describe Traditional Blameworthy Conduct

Human Error	Mistakes, slips, lapses.
Negligent Conduct	Failure to exercise skill, care, and learning expected of a prudent healthcare provider. Failure to recognize unjustified risk.
Reckless Conduct	Conscious disregard for risk.
Intentional Rule Violation	The individual chooses to knowingly violate a rule or procedure while performing a task, unrelated to risk taking.

Source: Marx D. Patient Safety and the “Just Culture”: A Primer for Health Care Executives. New York, NY: Columbia University; 2001. Available at: http://www.mers-tm.org/support/Marx_Primer.pdf

Negligent conduct describes behavior in which an individual does not exercise the skill or care expected of a healthcare provider of her training and experience. An example of negligent conduct is the failure of a medical laboratory technician to phone a critical potassium level to the responsible physician as required by the organization’s policy for reporting critical values. The laboratorians described in this and the previous example would receive a formal reprimand for their mistakes under a traditional disciplinary system. From a systems safety perspective, it is not very effective to punish laboratory personnel who make these types of errors with the expectation that they will become more attentive, and thus avoid future punishment. It is more beneficial to encourage and allow personnel who make these kinds of mistakes or encounter near misses to feel safe to report these events, in order to learn from their experiences and improve the laboratory services delivery system.

Reckless conduct describes actions taken with conscious disregard for the risk involved, which deserves disciplinary action in both traditional and *just culture* disciplinary systems. An example of this type of behavior is an error made by a medical laboratory scientist who reported for work while under the influence of alcohol.

The fourth type of traditional blameworthy behavior is *intentional rule violation*, in which an individual chooses to knowingly violate a rule or procedure while performing a task.

Many organizations use a modified traditional accountability system in which inadvertent mistakes such as human errors are considered an opportunity to learn, while intentional rule violations always receive disciplinary action. Critical learning opportunities to improve safety may still be missed if an organization does not examine all errors for the reason they occurred. In a just culture disciplinary system, intentional rule violations are more difficult to classify, and must be fully investigated, as there may be some situations in which violating an existing rule is in the best interest of a particular patient. Intentional violations of rules and procedures occur daily in the laboratory. Most of these are the result of group norms developed over time. Examining why certain violations have become the norm provides valuable opportunities for improvement. A rule may not be appropriate for a particular situation, and thus need revision. An evaluation of each situation—inadvertent errors and intentional mistakes—with respect to discovering whether the employee understood the risks of their behavior, is a better, more just method to address errors made by laboratory personnel than using a blame-based disciplinary process that focuses upon punishment. Blaming individuals creates a culture of fear and defensiveness where errors are not reported, leading to decreased learning, and diminished capacity to improve processes for the organization.³

One problem with blaming individuals is that it removes unsafe acts from their system context. Recurrent error traps may exist within a current organizational process that inevitably results in errors. The same set of circumstances can lead to similar errors with different people involved. No one is exempt—smart professional people with the best of intentions will sometimes make errors if there are flaws in the process.⁴

The *Just Culture* Approach

A just culture is a disciplinary approach in which an organization learns and improves by openly identifying

and examining its own weaknesses.⁵ In a *no-blame* culture, all errors are attributed to system failure, with no individuals held accountable. The just culture work environment stresses finding a middle ground between a blame-free culture, and a traditional work environment that is overly punitive. A just culture holds individuals accountable for knowingly putting a patient or another employee at risk, and for adverse events associated with intoxication, malicious or illegal behavior.

The aviation industry achieved reductions in numbers of adverse events by creating a culture of positive reinforcement and changing their disciplinary practices to encourage employees to report their mistakes. In studying the increased number of reported errors, 90% were found to be blameless, due to system failures that identified opportunities to design safer processes.⁴

In a just culture, investigation of errors that would be considered negligent in a traditional disciplinary system always includes a critical analysis. The complexity of the situation is considered, determining factors that “allowed” or even “encouraged” the error. The individual involved receives constructive feedback and fair-minded treatment.⁶ Investigations should always begin by asking why an event occurred. Once that question is answered, ask why again, and again. It is usually necessary to ask why four to six times until the underlying cause for the event is identified, or what circumstances allowed or encouraged the event to occur.⁷ If the individual acted with reckless conduct, she should be held accountable with disciplinary action such as a final warning, referral to police, or other appropriate sanction identified in the organization’s established policies. If the event did not involve intoxication, illegal or malicious behavior, the range of choices for supportive action include identifying contributing system factors, coaching, mentoring, increasing supervision, developing performance improvement plans, or adjusting work duties.

When an error occurs, managers frequently choose a strategy of writing a new procedure or retraining staff as a means to prevent similar errors from occurring, without identifying the root cause of the error. The flaw with this strategy is that when errors are the result of a poor process, re-training staff to follow a new or

modified process designed without understanding the root cause results in little or no improvement in decreasing the risk of recurrence. Repetitive errors may be a clue that there is a flawed process. If only one individual continues to make the same error, retraining may be appropriate. Other options are altering work duties to a more suitable job function, or counseling for those individuals who have experienced post-traumatic stress or other significant life distractions.

To achieve excellence in delivering safe and error-free laboratory services, employees must be able to share information about problems or errors with their supervisors without fear of retribution. It must be a shared goal between management and employees to identify and discuss problems with curiosity, in a respectful manner at all levels of the organization.

Just Culture Tools

A number of just culture decision trees have been created to help guide decisions for how to hold individuals accountable when an error occurs. A decision tree is a tool that uses a tree-like graph or model to help a manager determine appropriate consequences to use based on the answers to a series of questions about an event that has occurred. Following the yes or no branches on the decision tree diagram leads to an appropriate accountability consequence for the individual. To use a just culture accountability tool,⁸ begin by answering the question: “were the actions malicious or illegal?” If the answer is yes, follow the branch of the diagram that leads to possible disciplinary actions appropriate for this type of behavior, which may include suspension, termination, adjustment to duties, or rehabilitation referral for substance abuse, all of which require involving the human resources department. When deciding if an act was malicious, consider if the act was intentional, and if so, did the individual intend to cause harm? For behavior in which the answer is yes, the act would be considered *reckless behavior*, and would deserve disciplinary action in a just culture disciplinary system. If the answer to the question: “was the action malicious or illegal?” is no, continue to the next branch of the decision tree diagram and answer the next question: “did the event involve medication use, substance use or abuse, or ill health?” Did the individual have a known

medical condition that may have influenced the outcome? If the answer is yes, the diagram leads to a consequence of *supportive action*. There are several places in most just culture accountability tools where supportive action is recommended. Supportive actions may include training or increasing supervision, adjusting work duties and assignments, or revising procedures or protocols. For those situations in which the decision tree leads to a blameless error, the focus of follow up of the event should be on reviewing the process in which the error occurred, to redesign it with additional safeguards to prevent errors in the future.

Improving the Safety of Laboratory Care

Establishing a just culture successfully requires implementing policies that are supportive, building awareness in leadership and staff, and incorporating just culture principles into the practices of daily work. Disciplinary action policies must support a just culture, and must not specify that individuals will be punished for making human errors such as unintended slips or lapses. Consider a situation where a phlebotomist misread a patient's name, resulting in the laboratory report being placed on the wrong patient's chart. The policy should not specify that individuals who make this type of error will be terminated. More appropriate consequences might be to console the employee, and design a safer system to prevent future errors.

Policies that support a just culture work environment will list behavior expectations, and consequences for inappropriate behavior. Behaviors considered to be reckless should be clearly identified, which will by definition be punishable actions regardless if the outcome caused harm or not. For example, in a policy regarding substance abuse, the policy should clearly state prohibited behaviors, and describe the consequences if an individual fails to comply with the policy. Disciplinary action must be consistently employed for those who engage in reckless behavior.

Training leaders in how to classify behavioral choices (human error, risky or negligent conduct, reckless behavior, and intentional rule violation) and use a just culture decision tree is an essential component of a just culture work environment. Leaders need to understand why people engage in risky behavior. When a

phlebotomist does not wake up a patient to check the name band before drawing blood, even though he knows it is not the right thing to do, he may not understand the risk of his behavior for the patient. Leaders need to be taught to investigate such scenarios by asking and answering questions such as: How prevalent is this behavior? Why are people doing this? How can systems be developed to encourage or force the correct behavior? How can employees be helped to understand the risks that exist in order to make the correct behavioral choices? The leader then works through answering the questions on the just culture accountability decision tree.

Training all laboratory employees about the importance of learning from mistakes to designing processes that can prevent future errors is a vital component of creating a just culture work environment.⁹ Laboratory leadership must demonstrate their commitment to fair treatment for those who self-report an error. Establishing trust is vital before employees will feel safe to disclose errors to their managers. Identifying employees' level of comfort in reporting errors can be determined by evaluating the level of trust in the workplace. The Agency for Healthcare Research and Quality,¹⁰ in partnership with the Department of Defense, American Hospital Association and Premier Inc., has sponsored the development of a survey on patient safety culture.¹¹ This survey tool can be used to assess the safety culture of a hospital as a whole, or for specific units within hospitals, as well as to track changes in patient safety over time and evaluate the impact of patient safety interventions. Several vendors also provide validated surveys of patient safety culture for healthcare organizations, such as Pascalmetrics¹² and Total Benchmark Solution, LLC.¹³

Each of the estimated 120,000 deaths every year caused by healthcare provider error is an opportunity to learn how to modify the healthcare system and to manage at-risk behaviors in order to reduce the rate of harm. To improve the safety of medical laboratory services, error prevention must be a major strategic objective for laboratorians. In order to be successful, punitive error reporting systems must be eliminated, so employees feel safe reporting their errors. Laboratorians must understand the value of learning from each error, and

then improving processes to reduce the chance of future errors and adverse events. This needs to include identifying and reporting errors, investigating circumstances, improving processes, and teaching with stories. Laboratories should track their errors, and the effectiveness of any corrective measures they put in place to decrease errors.¹⁴

Summary

Although errors cannot be totally eliminated, they can be reduced by adopting a system of accountability that requires employees to self-report errors in the interest of patient safety. Traditional laboratory accountability systems are based on a culture of blame, focusing on punishing individuals, and with little emphasis on learning lessons from the errors. Under a just culture laboratory accountability system, if factors in the environment or process contributed to an error, the individual should not be punished. Rather, they and the system can both identify improvements for processes so that this type of error does not reoccur. Using this approach, laboratory services can be made safer for current and future patients.

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