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Embracing "Just Culture"

Responding to human error with humanity and accountability reduces errors and saves lives.

By J. Trout Lowen

Earlier this year, the Institute for Safe Medical Practices (ISMP) issued a press release[1] appealing to health care organizations to end a longstanding practice: the shaming and blaming of individual practitioners for unintentional medication errors. The ISMP, which works to improve medication safety, urged providers to instead focus on identifying and fixing the systemic flaws that allow such errors to occur. The ISMP's appeal came after criminal charges were filed against a Tennessee nurse who, in 2017, inadvertently administered the wrong medication to a patient who tragically died as a result.

The criminalization of human error, the ISMP argues, undermines safety by creating a climate of fear that discourages the reporting of medical errors. It also limits an organization's ability to learn from its mistakes and prevent future errors.

The ISMP is hardly alone in its opinion. Many health care organizations around the country, from acute care hospitals to senior living organizations, have already begun exploring the idea of creating a more forgiving culture based on a model called "just culture." The just culture model acknowledges that errors do, and will, continue to occur in complex health care settings—and when mistakes happen, a just culture first tries to ascertain why, then focuses on how to improve systems to minimize future errors.

But change, as most of us know from our own lives, can be difficult. And changing the long-standing culture of shaming and blaming that pervades the U.S. health care system is going to take time and require buy-in at every level, from the front line to the C-suite.

So far, adoption of the just culture model differs widely among health care organizations, says Kristi Eldredge, RN, JD, CPHRM, a senior risk and patient safety consultant for Constellation and a just culture trainer who received certification through Outcome Engenuity. "Health care organizations are all over the board," says Eldredge. "Most organizations are aware of the just culture concept, but many think they're going to take a one-day course or listen to a one-hour webinar and they're done. But that's not how the program works—it needs to be an ongoing process."

Just culture is a learning culture that is constantly improving and oriented toward patient safety, Eldredge explains. Establishing it requires significant effort, including clinician and care team time and energy, financial resources, and support

at the highest levels. "It's imperative that the C-suite buys in," she says, "because if you don't have C-suite buy-in, you're not going to be successful."

How just culture works

First developed by the airline industry, the principles of the model are fairly straightforward: When an error occurs, its cause is identified and a solution is implemented. Within this framework, errors are classified under three pillars:

- Human error: when a mistake is literally that, a mistake
- At-risk behavior: when a person does something without knowing the behavior carries risk of error, or knows the risk but believes it is justified
- Reckless behavior: an error caused by substantial, non-justifiable and conscious disregard of risk (gross negligence)

In the just culture model, each error type requires a different response, Eldredge explains. A human error type of mistake may indicate the need for additional education or a redesign of systems and safeguards. At-risk behaviors may require coaching and holding people accountable. Employees who engage in reckless behavior, however—such as being intoxicated at work or falsifying records— face disciplinary action.

It's likely that most errors fall into the human error category, Eldredge says. "Any time you have a human involved, you're going to have a chance for error because, guess what, even doctors are people," she adds. "A just culture recognizes that individual practitioners or staff should not necessarily be held accountable for systems that fail them over which they don't have any control."

For example, in the Tennessee case, the ISMP published an analysis of that event[2] in which it argued that system vulnerabilities contributed to the fatal medication error. In that incident, the patient's primary nurse was covering another nurse's patients and asked an "all-help" (i.e., float) nurse to administer intravenous Versed to a radiology patient who was getting a PET scan. The all-help nurse was unable to find Versed in the patient's profile in an automatic dispensing cabinet (ADC), so she used the ADC's override function to search for the drug by typing "VE"—the first two letters of the drug's brand name. She failed to notice when the machine dispensed vecuronium, a neuromuscular blocker used as part of general anesthesia, instead.

In its analysis, the ISMP listed a number of system vulnerabilities contributing to the error, including an ADC that populates a drug name search based on two letters of a medication name, the lack of additional safeguards to verify the removal and intended use of a neuromuscular blocker via the override function, and an ineffective warning on the vecuronium label. In the wake of the incident, the ISMP also issued new guidelines for managing ADC overrides.

Benefits of a just culture

In a punitive culture, when an error or near-error occurs, clinicians and team members are often afraid to speak up, and that makes it difficult if not impossible to determine why errors happen and how to prevent similar errors in the future, Eldredge says. "Nobody learns from their mistakes in a punitive culture. People get reprimanded. People get fired. People suffer reputation damage."

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In contrast, health care organizations that adopt a just culture model are likely to see a decrease in errors, an increase in self-reporting when an error or near-error occurs, and an increase in patient safety. Organizations that embrace the model's principles can also expect to see a decrease in medical professional liability claims, Eldredge says. Studies that have looked at why patients choose to file claims have found that money is often not the chief motivation. In many cases, she says, patients want an explanation of what happened, they want an apology and they want to prevent what happened to them from happening to someone else.

"If we as patient safety and risk consultants could convey the need for one thing to our customers, it would be just culture," Eldredge says. "If they work to make their culture just and reliable, many preventable medical errors and the resulting claims would be eliminated, and health care would be safer for patients."

References

1. Institute for Safe Medication Practices. 2019. **ISMP calls for a system-based response to errors, not criminal prosecution.** bit.ly/2LpCqw2 Published February 13, 2019. Accessed July 1, 2019.

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"Just culture" in senior living: What leaders need to know

Creating a "just culture" has the potential to improve team member morale and retention, a benefit particularly important to senior living and long-term care organizations, where high levels of turnover are commonplace.

Though the just culture model is still new in these settings, the basic principles are something the industry is already emphasizing, says Julie Apold, vice president of quality and performance excellence for LeadingAge Minnesota, the largest association of organizations serving Minnesota seniors, whose mission is to transform and enhance the experience of aging. Through its Safe Care for Seniors program, LeadingAge is working to reduce safety events, such as falls, medication errors and skin injuries that can occur in the course of caregiving.

"We are working to create a fair and just culture where people feel more comfortable speaking up, as well as using just culture principles to respond to staff behaviors when evaluating and responding to events that do occur," Apold says.

Changing culture isn't an easy task, she acknowledges. Senior living organizations may not have leaders and staff with experience in applying just culture principles, and administrative and operational leaders alike may see this as just one more thing they need to add to staff training. What's critical for leaders to understand, she says, is that just culture principles align with their existing goals of a safe and supportive environment for residents and staff, and that they likely have a strong foundation upon which to build.