Just Culture

Todd Griffin, MD, MBA

In healthcare, it is inevitable that people will make errors. These errors will result in morbidity, adverse outcomes and possibly a patient's death. How an organization investigates and responds to these errors is critical to creating an environment that fosters patient safety.

Medicine has traditionally engaged in the name, blame and shame aspects of medical error. The person responsible for the error is named, blamed for the outcome and then shamed, which is somehow supposed to encourage them to perform better next time. This approach is counterproductive and rarely generates improvement. It also creates an environment where reporting errors and near misses is discouraged due to fear of this process and lack of psychological safety. Unfortunately, this leads to further adverse outcomes as institutions fail to learn from mistakes.

Just Culture requires a change in focus from individuals to one on healthcare systems design. A Just Culture realizes that most errors result from system weaknesses. The system may not be strong enough to:

1. minimize or, ideally, eliminate, the potential for human error
2. facilitate effective communication
3. minimize the risk of equipment failures
4. provide adequate staffing

When an error is deemed to be system-related then it is the responsibility of the organization to improve the system.

A Just Culture creates an open and honest reporting environment. Involved personnel report mistakes and near misses because critical event analysis is conducted transparently, is focused on the systems, and encompasses the full complexity of the situation. Individuals trust they will be treated fairly and, excepting substandard performance, celebrated for bringing forth the issues. A Just Culture also recognizes the need for accountability when substandard performance is revealed. After a careful and comprehensive review, if flawed medical decision-making or willfully negligent or reckless behavior is identified, corrective or disciplinary action may be warranted.

Examples:

1. A nurse selects the wrong vial of intravenous medication from the dispensing system. She draws up the medication. She is about to administer it when bedside arm band scanning identifies the error. She reports the medication wastage and near miss. The event review showed that there were opportunities to improve the system to make error less likely. The intended medication and the one drawn up were "look alike", "sound alike" medications – with

packaging similar in size, shape, color and print and similar names. In a Just Culture, the nurse would not be punished for drawing up the incorrect medication. Instead, she would be praised for reporting the "near-miss" and giving the organization the chance to improve the systems before a patient was harmed.

2. An attending physician directs a resident physician to order magnesium for a patient with preeclampsia. While they are logging in to place the orders, the resident is paged to an emergent delivery. They hurry to place the orders and rush off. Later, the first patient has an eclamptic seizure. The resident reviews the chart and realizes that they placed the orders on the incorrect patient. The resident reports their error. Full analysis of the event shows that the error resulted from systems weaknesses, including missed opportunities by other care team members to catch the error. The resident is supported and recognized for reporting the error. Improved communication among team members is promoted during the next round of simulations.

Reference Materials

Boysen PG 2nd. Just culture: a foundation for balanced accountability and patient safety. Ochsner J. 2013 Fall;13(3):400-6. PMID: 24052772; PMCID: PMC3776518