

Making Just Culture a Reality: One Organization's Approach

by Alison H. Page, MS, MHA

Perspective

We've all been there...something goes wrong, a patient is harmed, and we, as medical directors, managers, and administrators, are forced to judge the behavioral choices of another human being. Most of the time, we conduct this complex leadership function guided by little more than vague policies, personal beliefs, and intuition. Frequently, we are frustrated by the fact that many other providers have made the same mistake or behavioral choice, with no adverse outcome to the patient, and the behavior was overlooked. Quite understandably, the staff is frustrated by what appears to be inconsistent, irrational decision-making by leadership. The "[just culture](#)" concept teaches us to shift our attention from retrospective judgment of others, focused on the severity of the outcome, to real-time evaluation of behavioral choices in a rational and organized manner.

At Fairview Health Services, a large integrated delivery system in Minnesota, we identified addressing our culture as the primary opportunity to improve patient safety in 2001. We focused on two key areas of cultural concern: the leadership culture that sets the tone and judges the behavior of others, and the culture at the point of care, or team culture. In 2003, we worked with the Minnesota Alliance for Patient Safety (MAPS), a multi-stakeholder group founded by the Minnesota Hospital Association, the Minnesota Department of Health, and the Minnesota Medical Association, to establish a state-wide initiative to create a culture of justice and accountability. This effort includes hospitals, the professional boards, and the department of health.

Establishing a just culture within an organization requires action on three fronts: building awareness, implementing policies that support just culture, and building just culture principles into the practices and processes of daily work. Based on our experience over the past 6 years, let me give you examples of how you might do this.

Raising Awareness

Building awareness is the first step in any movement. To raise awareness we did two things.

First, with the assistance of [David Marx, JD](#), president of Outcome Engineering, we conducted a survey of staff, medical leaders, managers, and administrators asking them various questions about how they thought the organization would respond to a given behavior by a clinician (e.g., bringing unauthorized equipment into the operating room [OR] for use in a surgery) if that behavior resulted in harm. We then asked the same question, except this time the behavior resulted in no harm. The survey results were clear. Members of the organization had no clear sense of how people would be judged, or how they should be judged when their behavioral choice was the wrong choice. And respondents consistently judged people more harshly if the behavior resulted in harm ([Figure](#)). The survey results were a wake-up call for the organization's leaders.

Our second step to raise awareness was education. First, a small group of 10 key clinical and operational leaders attended a day-long session with David Marx to evaluate the just culture concepts and learn how we should proceed inside our organization and as a state. Following this, 60 Minnesota health care leaders attended a 2-day summit sponsored by MAPS, which included the professional boards and the department of health, to deepen understanding of just culture and to better understand the perspective of the professional boards and public agencies. The leaders who attended enthusiastically embraced the just culture concept, finding that it provides practical and useful principles and tools anyone can use.

We then conducted a "big bang" educational session for all operational and clinical leaders across the system. Our message: "anyone who finds himself/herself in the

position of judging the behavioral choices of other human beings" should attend the session. Three hundred and fifty people were educated in an 8-hour training session with David Marx. The education included an overview of the concepts, education on the use of a set of algorithms that guide people through the process of classifying behavioral choices as "error," "at-risk behavior," or "reckless behavior." Participants also practiced applying the algorithms to real-life scenarios. In hindsight, conducting this mass education was very effective. It caused the organizational perspective on justice and accountability to shift almost overnight. We did not conduct education sessions for front-line staff on just culture, but instead we have woven the expectations for staff behavior, along with the concepts of error, at-risk behavior, and reckless behavior, into orientation and unit education sessions.

The behaviors we can expect:

- **Human error**—inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake.
- **At-risk behavior**—behavior that increases risk where risk is not recognized, or is mistakenly believed to be justified.
- **Reckless behavior**—behavioral choice to consciously disregard a substantial and unjustifiable risk.

Implementing Policies that Support Just Culture

This might better be termed, "eliminate the policies that don't allow you to incorporate just culture." Policies that require punishment for errors, for example, won't work. Sentinel event investigation policies that say, "We will only look at systems and not human behavior" won't work. Ideally, the organizational policies related to employee behavior expectations, consequences for behavior, and event investigation would incorporate the language of just culture. Job descriptions, medical staff bylaws, and codes of conduct should incorporate the principles. This will take time, so start by removing the policies that are barriers to just culture and work incrementally to build the philosophy in as you go. Our organization is still in the

process of incorporating just culture principles into policies, but we have eliminated the policy barriers to using the principles. For example, if you have policies that authorize punishment (e.g., written reprimand or dismissal) after a certain number of errors, or that predicate punishment on the severity of the outcome, get rid of them.

Building Just Culture into Organizational Practices and Processes

Once the leadership group of the organization has grasped the concept and leaders buy in to the philosophy, you can begin to incorporate it into the work you do every day. I recommend not introducing just culture as a new initiative or it could become the "flavor of the month." Instead, leaders should look at the challenges they face and ask, "How would I apply just culture principles to this situation?"

If your organization's priority is reducing harm related to misidentification of patients, for example, how would you work with the staff to understand and categorize behavioral choices as "error," "at-risk," or "reckless"? How would you clarify what the organizational response will be to each type of behavior? If a person makes an *error*, he/she knew the right thing to do, intended to do the right thing, and followed the right process, but made a mistake (e.g., misreads a label); he/she should be consoled and we should figure out a system that will prevent future errors. If a person engages in *at-risk* behavior, he/she knows the right thing to do, but does otherwise because he/she does not see the risk or feels that the benefit of the chosen behavior outweighs the risk (e.g., does not wake a patient to check a name band), management must understand why people are engaging in this risky behavior. Leaders must ask hard questions like, "How prevalent is this behavior? Why are people doing this? How can we put systems in place that will encourage or force the correct behavior? How can we help people perceive the risk that exists so they will make the right behavioral choice?" Lastly, the organization and clinical leadership should identify which behaviors will be considered *reckless* and are, therefore, punishable. Reckless behavior is punishable regardless of the outcome of the behavior. Leaders must establish processes to know when someone is engaging in reckless behavior and be willing to punish those who engage in it. A given behavior may be considered "at risk" in one situation or organization and be considered

"reckless" in another.

Consider this scenario. In hospital "A," a nurse, not wanting to disturb a sleeping patient, does not check a patient's name band and administers an IV antibiotic to the wrong patient, who was allergic to that drug. The patient has an anaphylactic reaction and ends up in the ICU on a respirator. How do we judge this nurse's behavioral choice not to check the name band before administering the medication? Do we punish her? Some organizations would punish the nurse (i.e., retrain, reprimand, or dismiss) because she violated the patient identification policy. A just culture would want to know:

- Was the nurse aware of the policy to check name bands?
- Was it possible to check the name band?
- Do all the nurses on the unit check name bands prior to administering medications?
- Why didn't the nurse check the name band? Did she mistakenly believe it was better not to? Why?

The error in this scenario is administering the medication to the wrong patient. We determined the nurse's behavior to be "at-risk" (and not "reckless") because the nurse violated the policy for what she believed to be a good reason—allowing the patient to sleep. It turns out that customer satisfaction scores had recently been reviewed at a staff meeting, and sleep interruption was identified as the number one concern of patients. In addition, the other nurses on the unit agreed that they have not awakened patients to check name bands many times.

Now consider another scenario. In hospital "B," a patient checks in. A name band is applied, and the patient is told that all staff will be asking patients to spell their names and give birth dates before providing care or treatment. The patient notes that all care providers and transport personnel follow the procedure. Now, let's say a nurse does exactly the same thing as the nurse in the first scenario. She enters the room, observes the patient sleeping, and decides not to wake the patient to check the

name band. A just culture would classify the nurse's behavior as "reckless." The policy was known, the policy was doable, and others were following the policy.

Within Fairview, we have incorporated just culture into our performance improvement initiatives, such as hand washing and patient identification. We identify what types of errors are made, what types of at-risk behaviors we see, and whether or not anyone is engaging in reckless behavior. As we make improvements in the process, we make sure we design it to prevent error, make risk apparent, and discourage at-risk behavior. We also clarify what behavior will be considered reckless. Currently, we are incorporating just culture principles into team training.

Just culture principles will help you change your organizational culture. In 2001, an accident occurred in our interventional MRI room when a piece of equipment flew across the room and attached to the outside of the MRI while a patient was in the tunnel. The event investigation that followed focused on system solutions and staff behavior. The department established safe processes and expectations for staff training and behavior. All staff are screened for MRI safety themselves, participate in MRI safety training, follow check-in procedures, and wear pocketless scrubs to minimize the opportunity to forget something in a pocket. Six years later, in 2007, a physician entered the room wearing scrubs with pockets, disregarding the prompt from colleagues to stop. Administration was notified. The conversation that ensued among operational and medical leaders focused on categorizing the behavior as error, at-risk, or reckless and, from that, determining whether the physician should be consoled, coached, or punished. Since Fairview has implemented clear policies and behavior expectations, and others are able to follow the policies, the behavior was found to be reckless. The physician apologized for her behavior and was warned that future behavior of this type would impact her clinical privileges. Just culture principles and tools provide a useful and necessary construct to aid organizations in dealing with difficult cultural issues, particularly to determine when the generally appropriate focus on systems needs to give way to a focus on individual accountability.

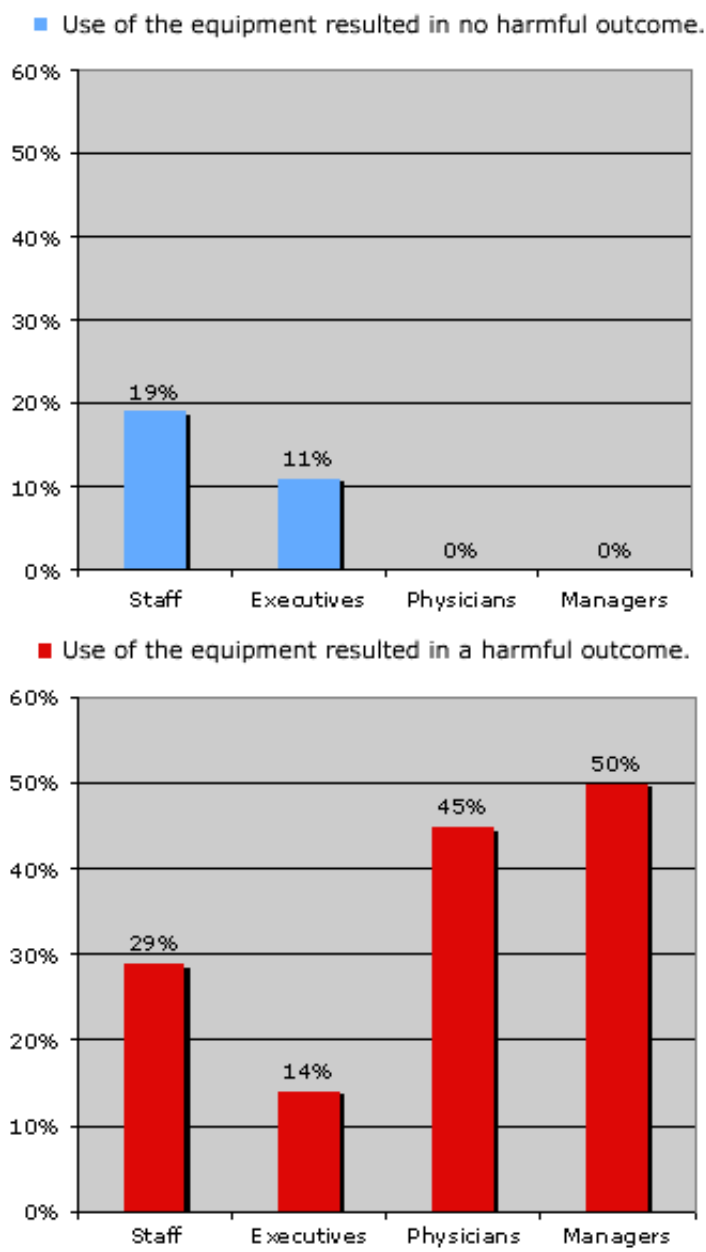
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Figure

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Figure. Survey question: How would our organization respond to a surgeon who uses an unauthorized piece of equipment in the operating room?
[\(Go to figure citation in perspective\)](#)

Percent of respondents who believed Fairview would discipline the surgeon if...



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