Safer Care Victoria

Just culture in adverse event reviews

- **A just culture encourages balanced accountability between organisations and individuals, and application of systems-thinking principles to allow fair and just responses to adverse events**
- **People working within a just culture are more likely to achieve positive outcomes for patients**
- **Just culture restores trust of those involved after an adverse event**
- **Senior leadership plays a crucial role in the development and maintenance of a just culture**

OVERVIEW

A just culture recognises that human error is inevitable and that complex systems designed by humans will fail[1]. Just culture is underpinned by systems thinking, and views safety as a balance between the design of the broader system and the actions of people working within the system.

There cannot be effective safety culture without just culture

Just culture is one of the five sub-cultures required to achieve a safety culture. Safety culture is key to reach and sustain high levels of safety in complex systems such as health. Read the fact sheet *Leadership and Safety Culture* for more information.

JUST CULTURE MOVES AWAY FROM BLAMING ERROR ON HUMANS

There is an 'individual blame' mindset that is pervasive in healthcare, and accountability has traditionally been placed on clinical staff and/or consumers when adverse events occur. In a just culture, there is a recognition that the interaction between consumers and staff on the frontline is only a small part of the broader health system, and that human behaviour is shaped by context and cannot be viewed in isolation. Therefore, there is a shared accountability between individuals and the organisational systems they are working in when adverse events occur. However, a just culture is not a completely blame-free environment. Part of a just culture includes a widely known and accepted definition of deliberately negligent or destructive acts within an organisation, and the consequences of these rare actions.

JUST CULTURE AND ADVERSE EVENTS

Just culture includes shifting the focus from the individual towards the broader organisation[2]. This means that adverse event reviews are undertaken with a system thinking lens that places individual actions in the context of broader system factors present at the time. This will contribute to balanced adverse event review outcomes considering latent factors hidden in the system. Identification of contributory system factors is necessary to inform the development of meaningful recommendations, which will prevent future adverse events[3]. A number of system-based review methods support the implementation of just culture principles.[1] More information can be found in the Just culture guide for health services.

A just culture opposes a name, shame, blame, retrain mentality

It looks beyond human error as a root cause to identify system-based improvements that address contributing factors across all levels of the organisation[1].

JUST CULTURE STARTS WITH SENIOR LEADERSHIP

Building a just culture is only possible if senior leaders actively model just culture principles. They are responsible for actively embedding just culture values in

[1] See factsheet on Human Factors for more information

[2] Boysen (2013)

[3] See recommendations fact sheet for more information

their systems and processes across all levels of the organisation and making it clear that a blame culture is not tolerated[4].

JUST CULTURE PROMOTES LEARNING

Just culture means organisations and health systems are continuously learning and improving from adverse events and near misses. One of the largest barriers to improving safety in health is that people are punished for making mistakes [5]. The consequence is that adverse events may go unreported, ultimately leading to diminished organisational safety outcomes. To learn from adverse events or near-misses, a reporting culture needs to exist where staff can openly report incidents without fear of punitive consequences. This reporting culture is critical to achieve and sustain a just culture[2].

Just culture views adverse events as learning opportunities to inform system improvement

Demonstration of a just culture is when the question moves from "Who caused the problem?" to "What happened, why, and how can we learn from this?"

CORE PRINCIPLES OF JUST CULTURE

Just culture is based on mutual trust between senior leadership, frontline staff and consumers. Trust of senior leadership can be built when leaders are supportive and deploy fair and balanced processes following an adverse patient safety event. Senior leadership needs to trust that frontline staff come to work with good intentions and provide safety-related information honestly. A just culture also restores the trust of consumers involved in adverse events, and even the broader community. This is achieved when there are well-developed open disclosure processes, including an apology and information provision, consumers are invited to actively participate in adverse patient safety event reviews, and there is transparency and accountability for improvement in safety following adverse events.

BUILDING A JUST CULTURE

Health organisations need to make at least six transitions to build a just culture[4]. These include:

1. Viewing adverse events as system rather than individual failures
2. Developing honest and robust reporting environments rather than punishing people for adverse events
3. Embracing adverse event as opportunities to learn, and openly communicate this to consumers rather than maintaining secrecy
4. Placing consumers at the forefront and becoming truly patient-centred, rather than provider-centred
5. Moving towards collaborative work rather than relying on individual performance
6. Ensuring accountability at all levels of the organisation, rather than maintaining a hierarchical approach.

[4] See factsheet on leadership and safety culture for more information

[5] Leape, L.L. (2009). Transforming healthcare: A safety imperative. *Quality and Safety in Health, 18,* 424-428

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