Just Culture Guide

For health services

OFFICIAL

This guide provides an overview of just culture principles and how to apply them within your workplace. A key element of a just culture is a fair and balanced response to adverse patient safety events. This guide outlines the key actions that should be taken after an adverse event occurs, to ensure a just culture mindset is applied to the subsequent review process. This will contribute to a fairer review process and better outcomes for patients and families (from now on referred to as consumers), and staff.

How to use this Just Culture Guide

This guide is intended to be used preceding a review and does not replace the actual review process. Before you commence the review, complete the 3 actions outlined in this guide to support the implementation of a just culture mindset: make sure everyone is supported, consider systems, and manage cognitive bias.

What is just culture?

Just culture is part of safety culture, with the major features being:

- a systems-thinking mindset to adverse event review
- provision of a psychologically safe workplace where employees feel safe to report adverse events and near misses
- managing the innate cognitive biases we all have
- the concept of shared accountability between the organisation and the individual when adverse events occur.

More information can be found here: Just culture.

Just culture is not a no-blame culture

This is a common misconception.

- A just culture is built upon trust and shared accountability between individuals and the organisation responsible for designing and improving systems within the workplace.
- Organisational leaders need to implement fair processes and reward staff for providing safety information, and staff are responsible for reporting adverse events, speaking up for safety, and coming to work with good intentions.
- A crucial component of a fair and just culture is widespread organisational understanding about what behaviours will not be tolerated and the consequences for these behaviours should be consistently applied.

- People should not be blamed or punished for actions, omissions or decisions that are in line with their experience and training.

Why is safety culture important?

One patient is harmed in every 9 admissions to Australian health services.

- This harm has a high personal cost to consumers, and a high economic cost to the health system.
- Other safety-critical industries (e.g. aviation, mining, engineering) have significantly reduced adverse events by promoting safety as core business and applying a systems-thinking lens to adverse event review – healthcare is lagging behind.
- Positive safety cultures are consistently associated with a range of positive patient outcomes including reduced rates of mortality, falls and hospital acquired infections, and improved patient satisfaction.

More information can be found here: Leadership and safety culture.

What is systems-thinking?

The healthcare system is complex. It is made up of multiple layers, and each layer influences how care is being delivered to patients at the frontline.

- When adverse events occur, we need to look beyond the people that were involved. Human error is not a root cause. All layers of the system should be analysed for contributing factors towards the adverse event and recommendations targeted appropriately. Improving the system will improve care for the next patient.

Blaming the individual leads to shame and under-reporting of incidents due to fear of retribution, which reduces opportunities for the organisation to learn and improve.

More information can be found here: Introduction to human factors in adverse event reviews.

What are cognitive biases?

The way humans perceive situations is subjective. It is influenced by sociocultural factors as well as our own lived experience. Based on this, we develop mental shortcuts that help us to:

- deal with complex information and situations
- fill in gaps
- prioritise
- make decisions quickly.

While the outcomes of our mental shortcuts are usually successful, they can also contribute to distorted judgements and potential failures if they do not match the reality of the situation. This distorted judgement is called cognitive bias. It is important to recognise that everyone has cognitive biases, whether we are aware of these or not. Following an adverse event, it is these biases about the way things work or about staff and consumers, which can contribute to jumping to conclusions and lead to a blaming mentality.

More information about managing bias can be found here: Cognitive bias and adverse events.

A just culture approach to adverse event reviews

This practical guide helps you to apply just culture principles by balancing individual performance with a focus on how the wider system contributed to the adverse event – including goals and priorities of the organisation, the working environment, technology, resourcing and so on. Doing this well is not easy.

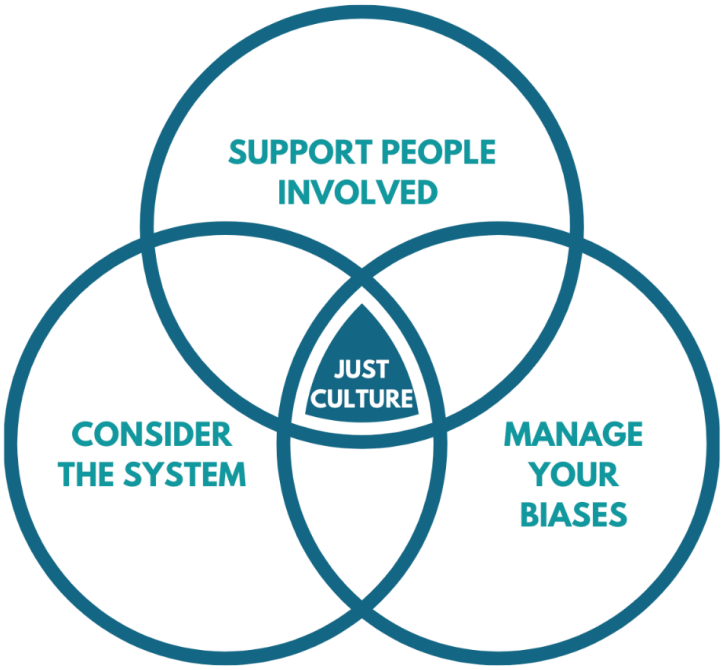
Adopting this approach will help improve the quality of your adverse event reviews and their outcomes. Working towards a just culture will foster an open and trusting environment where staff members can freely discuss safety issues, including the circumstances of how adverse events occurred. If staff know your review is aimed at learning from what happened, and that there will be a balance between individual and system accountability, they will be more willing to participate openly in adverse event reviews.

A just culture will also help to minimise secondary trauma in staff involved in an adverse event.

Adopt a just culture mindset

Prior to commencing a review, there are 3 actions required to ensure the team is adopting a just culture mindset.

Just culture mindset



Action 1: Support the people involved

Ask if everyone is OK. One of the most important aspects of a just culture is restorative. A restorative culture supports emotional healing of everyone involved in the adverse event by engaging all stakeholders. Thereby, restorative culture ultimately aids organisational learning and improvement.

Ensuring that everyone involved in the adverse event has received the support they need is critical for their recovery and to rebuild their trust in the health service. Therefore, the first action is to follow up with the consumers, as well as clinical and non-clinical staff involved in the event. Remember that staff members who have made a lapse or mistake will likely have a range of negative feelings and should be consoled at this point. This process should include:

- acknowledging the hurt of those involved. Consider the consumers as first victims but recognise that the health care workers involved in the incident can also be affected as second victims. There may be other community members who witnessed the incident, and these people need to be considered also
- asking what those who have been hurt need immediately and providing this for them. Communicate with all of those affected and consider together how to best meet their short-term needs. Consumers may require information or reassurance that a review process will be undertaken. Staff members may require psychological support and compassion. Community witnesses may require information and reassurance
- discussing how needs can be met over the longer term. The health service should determine a plan to support the ongoing needs of affected people and discuss how individuals may contribute in ways that are helpful to them. Consumers may wish to share their story and participate in the review process. Staff members might contribute information to the adverse event review process and support system improvement
- identifying how recovery of those involved will be monitored. This plan should be made in consultation with those people affected by the event and be specific to their individual needs.

Open disclosure to consumers is an important part of this process. It includes an apology and an explanation of what went wrong, ensuring compliance with Victorian duty of candour guidelines. Follow up should include feedback about what improvements have been put in place as a result of the event.

Action 2: Manage your biases

Putting yourself in the shoes of the staff member involved in the event can be one way to mitigate bias and ensure we are empathetic to those involved in adverse events. Ask the question: What made sense to the people involved at the time of the event (not in hindsight)? Could another person with similar knowledge and experience make the same decision?

Six common biases encountered in the review process

Confirmation bias: we seek out information that confirms our existing beliefs and knowledge. We ignore, fail to seek, undervalue and/or fail to remember disconfirming information (even if that would be more useful).

Availability bias: we focus on what comes easily to mind. Hypotheses are retrieved more easily if they have been considered recently or frequently. A hypothesis is considered more likely to be true if the information supporting it comes easily to mind.

Representative bias: if the information in this situation closely matches information typical for similar situations seen before, we tend to think it is like those similar situations and respond accordingly. Similarly, we tend to think of a person like others we know that belong to the same group (e.g. this doctor is like all doctors – stereotyping).

Hindsight bias: assuming knowledge we have now was known at the time. The tendency to see past events as being predictable at the time they happened.

Outcome bias: judging decisions based on outcome, instead of the quality of the decision at the time it was made.

Fundamental attribution error: the tendency to attribute someone else's behaviour in a given situation to their personality or other intrinsic qualities, rather than considering the influence of external factors (which we tend to use to explain our own behaviour).

	Strategies to manage cognitive biases
1.	Be aware of your internal thoughts and feelings after an adverse event. Notice when you focus on the person instead of the system or the environment.
2.	Demonstrate empathy for everyone involved in the adverse event. Put yourself in their shoes and ask why it made sense to them at the time and what systems issues were present that possibly impacted their performance.
3.	Avoid blaming language and resist the urge to think of people as perpetrators.
4.	Seek multiple perspectives on the same event (the patient as well as their family and carers, clinicians, and other staff members).
5.	Collate evidence for your review outcomes in a systematic way to avoid focusing on information that confirms pre-existing beliefs.
6.	Use data/statistics to determine the probability of events if you run at risk of misinterpreting an event due to recent experience.

Action 3: Consider the system

Rather than asking 'what were they thinking?' or 'how could they think this was ok?', it is important to consider the knowledge the involved person had at the time of the event, and how the factors within the system they were working in contributed to the action they took or decision they made. Why did it make sense to them at the time?

During the review process, each layer of the healthcare system should be considered while the team determines:

- which of these systems factors contributed to the event?
- which systems factors worked well, despite the adverse outcome?
- were any other systems issues identified, that may not have directly contributed to the event?

The layers of the healthcare system

Social and cultural factors	Race, cultural background, gender, disability, age, sexuality, socioeconomic status etc
Government, regulators and external influences	Regulations, funding, links with external health services and colleges
Organisational and management factors	Financial resources and constraints, organisational structure, policies and standards, safety culture
Work environmental factors	Staffing, workload and shift patterns, design of equipment and environment
Team factors	Communications, supervision, team structure, leadership
Task and technology factors	Task design and clarity, availability, and use of protocols, decision-making aids
Individual staff factors	Knowledge and skills, competence, physical and mental health
Patient factors	Condition (complexity and seriousness), language and communication and social factors

Near misses and adverse events will have multiple interacting contributing factors from many levels of the system. A just culture approach to patient safety will focus on systemic changes to drive improvement, rather than individuals.

Safer Care Victoria resources

Just culture

Leadership and safety culture

Introduction to human factors in adverse event reviews

Cognitive bias and adverse events

Duty of candour resources and legislation

Safer Care Victoria training sessions

Fundamentals of adverse patient safety event reviews

Incident review method: RCA^2

AcciMap training

Access training sessions

Other Recommended Reading

Kirkup, 2019 - NHS Improvement's Just Culture Guide: good intentions failed by flawed design

Boyson, 2013 – Just Culture: A Foundation for Balanced Accountability and Patient Safety

Reference List

Duckett and Jorm, 2018: *Safer care saves money: How to improve patient care and save public money at the same time.*

Taylor-Adams & Vincent, 2001: *London Protocol Contributing Factors Framework.*

Dekker, 2018: *Restorative Just Culture Checklist.* Available via: https://www.safetydifferently.com/wp-content/uploads/2018/12/RestorativeJustCultureChecklist-1.pdf

Kaur, Boer, Oates, Rafferty & Dekker, 2019: *Restorative Just Culture: a Study of the Practical and Economic Effects of Implementing Restorative Justice in an NHS Trust*.

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