

Building a Just Culture

Organizations that operate with a Just Culture are ones that properly differentiate between human error, at-risk behavior, and reckless behavior, all of which can impact patient safety.

Human error is an unavoidable, unpredictable, and unintentional deficiency in the way we perceive, think, or behave. We do not choose to make errors; it is not a conscious decision. There are two types of human error:

- Execution error – skill-based mistake, missing steps in a process, or mental slips
- Planning failure – rule-based mistake or a knowledge deficit

Human errors are either **endogenous**, resulting from a random and unpredictable event, or **exogenous**, system-based in which the environment contributes to the cognitive mistake. Endogenous errors are affected by anxiety, stress, fatigue, distractibility, fear, sensory deficits, and other psychosocial factors. Exogenous errors are impacted by low lighting, loud noise, interruptions, fatigue, technology issues, and lack of job aids. Perceptual biases affect both endogenous and exogenous errors and include:

- Confirmation bias – seeing what you believe
- Change blindness – inability to see alterations in plain sight
- Inattentive blindness – failure to see information due to a focus on something else
- Cognitive bias – influence how people respond to errors
 - Hindsight bias – see past events as predictable
 - Normalcy bias – believe it will never happen
 - Severity bias – base the severity of the response on the outcome

In a Just Culture, human error is managed by redesigning systems to make them error-resistant, more reliable or reducing the risk of patient harm. High level strategies include forcing functions and implementing fail-safe features.

At-risk behaviors are choices that are made when a person does not realize the risk can result from the choice or believes the risk to be insignificant or justified. It's natural for us to develop unsafe habits when the rewards are immediate. Taking shortcuts to save time is often associated with efficiency and perceived as positive. Some examples of at-risk behaviors include programming an infusion pump outside of the drug library, preparing intravenous drug solutions instead of waiting for pharmacy to mix them, or overriding an automated dispensing cabinet (ADC) to obtain medications irrespective of an emergency. This behavior is often tolerated, and these clinicians are typically labeled as being “efficient”.

System failures such as technology glitches also lead to at-risk behaviors as nurses attempt to find workarounds to dysfunctional processes. Examples include missing patient medications on the unit, difficult and time-consuming access to the ADC, and barcode scanning failures. Nurses will violate policies and procedures and find ways to overcome obstacles in order to deliver patient care.

Reference

1. Institute for Safe Medication Practices. (2021). *Nurse Advise-ERR*. Retrieved from Institute for Safe Medication Practices: <https://www.ismp.org/nursing/medication-safety-alert-march-2021>

Managing at-risk behaviors in a Just Culture requires removing obstacles to safe practices and avoiding rewards for at-risk behaviors. We must admit that at-risk behaviors exist and provide positive coaching to individuals who engage in these unsafe practices. Goals of coaching include raising awareness of the at-risk behavior, discovering the reasons for these choices, and aligning expectations to make safer decisions in the future.

Reckless behavior is the conscious disregard of a significant and unjustifiable risk. These individuals know the risk they are taking and that it is substantial. They behave intentionally and are aware that their behavior is not the norm. The individual acting recklessly is self-centered, putting their own needs ahead of others. Examples of reckless behavior include drug diversion, breaches in patient confidentiality, or performing surgical procedures under the influence of drugs or alcohol.

In a Just Culture, reckless behavior is not tolerated, and disciplinary actions are taken based on the facility's policies and procedures which can range from counseling to termination of employment. To determine if an individual's behavior is reckless, question whether the individual consciously disregarded what he/she knew to be a substantial and unjustifiable risk.

Safety programs should target at-risk behaviors and critical system redesigns as these are often an organization's most important challenges and opportunities for improvement. Administrators should establish a culture that rewards safe choices and practices.

Reference

1. Institute for Safe Medication Practices. (2021). *Nurse Advise-ERR*. Retrieved from Institute for Safe Medication Practices: <https://www.ismp.org/nursing/medication-safety-alert-march-2021>