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# Patient Safety Tip of the Week

# April 6, 2021

# ISMP on Just Culture

Perhaps the most important element of patient safety is culture – of the organization, the unit, and the individual. Many years ago, when there was an event with an adverse patient outcome, focus tended to be on finding someone to blame. With the birth of the patient safety movement in the 1980’s we began to recognize that system factors tend to dominate as root causes in most such incidents. Hence, a shift away from the “blame and train” approach. But, it was recognized that in some cases behavior of individuals went beyond typical human errors and included conscious disregard for safety and merited yet a different approach. Thus, the birth of “**Just Culture**”.

David Marx is the name most people associate with Just Culture. In a 2001 primer for health care executives on patient safety and Just Culture (Marx 2001) Marx described the “**4 evils**”:

- **Human error**
- **Negligent conduct**
- **Reckless conduct**
- **Knowing violations**

Marx also did a nice summary of Just Culture more recently (Marx 2019). There he describes **5 behaviors**:

- **Human error** – unintended conduct, where the actor should have done other than what they did
- **At-risk Behavior** – a choice where risk is not recognized or is mistakenly believed to be justified
- **Reckless** – conscious disregard of a substantial and unjustifiable risk if harm
- **Knowledge** – knowingly causing harm (sometimes justified)
- **Purpose** – purposely causing harm (never justified)

ISMP recently did one of the most concise, yet informative, reviews on Just Culture (ISMP 2021), describing the differences between human error, at-risk behavior, and reckless behavior with illustrative examples of each type. It begins by pointing out that some of the prior terminology or terms used in disciplinary policies can be problematic. For example, if individuals “knowingly disregard” any policies, procedures, or the usual

standard of practice, it frequently results in disciplinary action, even if the breach is widespread due to common system failures or was pursued in good faith due to a mistaken belief that the risk was justified or insignificant. Such "knowing violations" of policies and procedures thus are often considered reckless behavior but most are really at-risk behaviors.

There is one important question we always ask during root cause analyses or incident investigations to help distinguish between reckless and at-risk behavior: "**How likely is it that anyone else in our organization might have made the same choice in that set of circumstances?**". If the answer to that question is "yes", then the behavior was most likely "at-risk" behavior rather than being truly reckless.

ISMP goes on to discuss **human error**. This includes slips and cognitive biases that often occur in the context of multiple system issues that make error more likely. These are best managed through system redesign to make the system human error-proof or error-resistant.

They then go on to discuss **at-risk behaviors**. These are behavioral choices that are made when individuals have lost the perception of risk associated with the choice or mistakenly believe the risk to be insignificant or justified. ISMP argues that at-risk behaviors, along with any necessary system redesign, should actually be the primary focus of a patient safety program. **"At-risk behaviors are an organization's greatest safety challenge, as well as its greatest opportunity for improvement."**

They note we often develop unsafe habits for which we fail to see the risk. The rewards for risk taking, such as saved time, are typically immediate and positive, whereas possible adverse outcomes (e.g., patient harm) are often delayed and remote. **Shortcuts** and **workarounds** are classic examples of at-risk behaviors. ISMP points out that, over time, the risk associated with these behaviors fades and the entire culture becomes tolerant to these risks. "Individuals are not choosing to put patients in harm's way; instead, they feel they are still acting safely. In fact, the more experienced you are at what you do, the less likely you are to recognize that you are in a risky situation when engaging in at-risk behavior." We've given numerous examples in the past where our first impression of an individual who turns down the volume of an alarm is to label the behavior as "reckless", only to later recognize that such particular behavior had become commonplace on that unit and performed by many others. In fact, at-risk behaviors sometimes even get rewarded (such as praise for timely medication administration even though shortcuts were taken).

ISMP points out that most at-risk behaviors are precipitated by large and small system failures that individuals must work around, often daily, to get the job done. Therefore, recognizing these at-risk behaviors should lead to a search for underlying causes and fixes.

ISMP notes that the first step is admitting that at-risk behaviors are occurring. That has been difficult because people have often been harshly criticized or disciplined for

violating rules in the past. ISMP notes that, "in a Just Culture, the solution is not to punish those who engage in at-risk behaviors. Instead, managing at-risk behaviors requires removing the barriers to safe behavioral choices, removing the rewards for at-risk behaviors, and coaching individuals to see the risk associated with their choices." We have our own manner of identifying many at-risk behaviors. During Patient Safety Walk Rounds, we ask individuals (in a very non-punitive manner) what workarounds they might be employing. You'd be surprised how readily they will identify such workarounds when (1) they have assurance they won't be punished and (2) they know you'll try to find a fix for whatever system problem has led to the workaround.

To manage at-risk behaviors, ISMP relies heavily on **coaching**. This is different from counselling and is a constructive process. Read the full ISMP article for details on coaching. Another advantage of coaching is that individuals can go on to coach other healthcare workers they see with similar at-risk behaviors.

In addition to coaching, ISMP notes you need to **remove the rewards** inadvertently given to people with at-risk behaviors. And, most importantly, you need to **fix the underlying system problems** that led to the at-risk behaviors in the first place.

Lastly, **reckless behavior** is the conscious disregard of a substantial and unjustifiable risk. The individuals know the risk they are taking and understand that it is substantial. They know others are not engaging in the behavior (i.e., it is not the norm). Examples given by ISMP include drug diversion, performing surgery under the influence of alcohol or drugs, or retaliatory breaches in patient confidentiality. Remedial or disciplinary sanctions should be considered according to the organization's human resources policies to correct the undesired conduct.

One of the important facets of Just Culture is that any disciplinary actions taken are based upon the inappropriate behavior rather than the severity of any harm caused. Before Just Culture, people were often disciplined just because there was a bad patient outcome and the most serious behaviors were often tolerated because no harm had been done (i.e. the severity bias).

ISMP has done a good job in this article explaining Just Culture. We encourage you to read it in full. We also encourage you to read the 2019 article by David Marx (Marx 2019) and go to the Just Culture website for further information and resources.

**Some of our prior columns on the impact of "bad behavior" of healthcare workers**:

| | |
|---|---|
| January 2011 | "No Improvement in Patient Safety: Why Not?" |
| March 29, 2011 | "The Silent Treatment: A Dose of Reality" |
| July 2012 | "A Culture of Disrespect" |
| July 2013 | ""Bad Apples" Back In?" |
| July 7, 2015 | "Medical Staff Risk Issues" |
| September 22, 2015 | "The Cost of Being Rude" |

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| April 2017 | "Relation of Complaints about Physicians to Outcomes" |
| October 2, 2018 | "Speaking Up About Disruptive Behavior" |
| August 2019 | "More on the Cost of Rudeness" |
| January 21, 2020 | "Disruptive Behavior and Patient Safety: Cause or Effect?" |

**Some of our prior columns related to the "culture of safety"**:

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|---|---|
| April 2009 | "New Patient Safety Culture Assessments" |
| June 2, 2009 | "Why Hospitals Should Fly...John Nance Nails It!" |
| January 2011 | "No Improvement in Patient Safety: Why Not?" |
| March 2011 | "Michigan ICU Collaborative Wins Big"). |
| March 29, 2011 | "The Silent Treatment: A Dose of Reality" |
| May 24, 2011 | "Hand Hygiene Resources" |
| March 2012 | "Human Factors and Operating Room Safety" |
| July 2012 | "A Culture of Disrespect" |
| July 2013 | ""Bad Apples" Back In?" |
| July 22, 2014 | "More on Operating Room Briefings and Debriefings" |
| October 7, 2014 | "Our Take on Patient Safety Walk Rounds" |
| July 7, 2015 | "Medical Staff Risk Issues" |
| September 22, 2015 | "The Cost of Being Rude" |
| May 2016 | "ECRI Institute's Top Ten Patient Safety Concerns for 2016" |
| June 28, 2016 | "Culture of Safety and Catheter-Associated Infections" |
| April 2017 | "Relation of Complaints about Physicians to Outcomes" |
| April 2017 | "Joint Commission Sentinel Event Alert on Safety Culture" |
| October 2, 2018 | "Speaking Up About Disruptive Behavior" |
| August 2019 | "More on the Cost of Rudeness" |
| January 21, 2020 | "Disruptive Behavior and Patient Safety: Cause or Effect?" |

**Some of our prior columns related to workarounds**:

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|---|---|
| September 4, 2007 | "Workarounds as a Safety Issue" |
| May 2008 | "UK NPSA Alert on Heparin Flushes" |
| June 17, 2008 | "Technology Workarounds Defeat Safety Intent" |
| September 15, 2009 | "ETTO's: Efficiency-Thoroughness Trade-Offs" |
| August 24, 2010 | "The BP Oil Spill - Analogies in Healthcare" |
| March 6, 2012 | "Lab Error" |
| July 2, 2013 | "Issues in Alarm Management" |
| April 8, 2014 | "FMEA to Avoid Breastmilk Mixups" |
| October 7, 2014 | "Our Take on Patient Safety Walk Rounds" |
| April 5, 2016 | "Workarounds Overriding Safety" |
| June 2016 | "ISMP Article on Workarounds" |
| September 2020 | "More on Workarounds" |

**References**:

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http://www.chpso.org/sites/main/files/file-attachments/marx_primer.pdf

Marx D. Patient Safety and the Just Culture. Obstet Gynecol Clin North Am 2019; 46(2): 239-245
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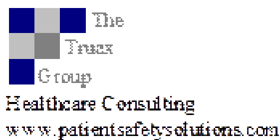
https://www.ismp.org/nursing/medication-safety-alert-march-2021

Just Culture website
https://justculture.com/

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