

Developing a Just Culture in British Columbia's Health System:  
Recommendations for Policy and Implementation

Report prepared for:

Brian Sagar, Director, Patient Safety  
Health Authorities Division, BC Ministry of Health

Report prepared by:

Carling Helander  
School of Public Administration  
University of Victoria

March 25, 2013

## EXECUTIVE SUMMARY

### Objective

This purpose of this report is to assist the British Columbia Ministry of Health (the Ministry) in developing and implementing a province-wide strategy for enhancing a ‘just culture’ in the BC health care system. A just culture builds trust through fair treatment of health care providers after a patient safety incident, which improves patient safety because providers are more willing to help the organization identify and correct systemic hazards and risks. This report was prepared for the Ministry’s Patient Safety and Care Quality branch to support the branch in responding to a request from Dr. Doug Cochrane, Chair of the BC Patient Safety and Quality Council, to pursue the development of a just culture in BC.

The objective of this project is to develop a provincial just culture policy for the BC health authorities and develop a strategy for effective implementation of the policy. The primary research question of this project is: “what policy approaches and implementation strategies should the Ministry use to create a more just culture in the BC health care system?”

### Methodology

To answer the research question, the following methodology was used for the project. The researcher initiated the project by conducting a review of the academic literature relating to just culture. The academic literature was then supplemented by a search for grey literature using a Google search. Key sources cited within the academic and grey literature were also identified and reviewed.

The next step for the research was to conduct a cross-jurisdictional scan. The jurisdictions included in the scan consisted of Australia, the United Kingdom, Minnesota, Missouri, North Carolina, Alberta, Saskatchewan, Manitoba, and Ontario. These jurisdictions were selected for the comparability of their health system to BC and/or because they were identified in the literature review as having undertaken significant work on developing a just culture.

The researcher then reviewed the current policies of all BC health authorities in order to assess the current state of just culture policies in the province. The researcher also searched the websites of several major professional colleges for policies related to just culture.

The final aspect of the research was to conduct telephone interviews with representatives from two BC health authorities: Provincial Health Services Authority and Vancouver Coastal Health Authority. These organizations were chosen because they have stand-alone just culture policies in place. The purpose of the telephone interviews was to obtain the insights of these organizations about their experience with developing and implementing just culture policies.

### Results

The research methodology provided valuable information about what a just culture is and how to effectively build a just culture in an organization. According to the literature, the purpose of a just culture is to improve the safety of the health care system by developing a trusting environment in which providers know they will be treated fairly after a patient safety incident.

Treating providers fairly supports system safety because providers will be more willing to report patient safety incidents and participate openly and honestly in incident analysis. In turn, this enables the organization to make changes to the health care system so that similar patient safety incidents are avoided in the future.

The concept of a just culture is heavily based on the ‘systems approach’ to patient safety incidents. A systems-based approach accepts that humans are fallible and it is unrealistic to expect perfection. Latent conditions in the complex health care environment will inevitably cause occasional human error, even if the provider is as careful as possible. Designing a safe health care system requires a focus on identifying and correcting latent conditions in the system rather than punishing providers for making mistakes. An overly punitive approach to patient safety incidents makes providers fearful of reporting incidents and participating in incident reviews, and opportunities to learn from past incidents are lost.

Acknowledging the impact that systemic factors have on human error does not mean that a just culture is a ‘blame free’ culture. A just culture recognizes that sometimes providers engage in risky behaviour and increase the chances of a patient being harmed. Most often, this risky behaviour occurs because a provider does not recognize the risk or thinks that the risk is justified. This ‘at-risk’ behaviour is different from ‘reckless’ behaviour, which involves a conscious and unjustified disregard of a known and substantial risk.

In a just culture approach to patient safety incidents, providers who make an error without engaging in risky behaviour should be consoled rather than punished. At-risk behaviour, which is usually caused by behavioural ‘drift’ rather than intent to be risky, should be corrected through coaching and training to ensure the at-risk behaviour ends. Reckless behaviour is worthy of punishment because the risk taken was substantial and unjustified.

The most crucial aspect of developing a just culture is to have an incident management policy that is consistent with a just culture approach. This policy should ensure a fair outcome guided by the three categories of behaviour and response (console human errors, coach at-risk behaviour, and punish reckless behaviour). The use of a ‘decision tree’ can guide an organization’s management in determining the appropriate response.

In addition to producing a fair outcome for providers, incident management policies should ensure that a fair process occurs. A fair process requires consistency, confidentiality, effective communication, involving the provider and the provider’s peers in the analysis, and a clear separation of incident management and performance review. Including these features in an incident management process supports the provider’s perception of being treated fairly by the organization.

The literature review and cross-jurisdictional scan revealed several other suggested strategies for developing a just culture. Leadership support for a just culture, as well as communication and education for providers and managers about the organization’s just culture approach, are often suggested as key ways to enhance a just culture. Legislated confidentiality of incident analyses is also important, so that the punitive approach of the legal system does not undermine a just culture. Lastly, having an incident reporting system in place is recommended

so that the organization can maximize its learning opportunities from patient safety incidents and near misses.

Although there is widespread consensus in the literature and across jurisdictions about what a just culture is and the importance of a just culture approach, the jurisdictions reviewed for this project displayed varying levels of commitment to developing a just culture in the health system. The Alberta Health Service has provincial work underway for developing a just culture, but this work has not yet resulted in a provincial policy or implementation strategy. Based on publicly available information, Saskatchewan, Manitoba, and Ontario are not currently working to explicitly develop a just culture in their health systems. While Australia and the United Kingdom support a just culture in principle (evidenced by mention of just culture in high level policy documents), it is not clear whether or how these jurisdictions have attempted to translate this support into concrete action that has an impact on organizational culture.

The experiences of Minnesota, Missouri, and North Carolina in the United States are the most informative of the jurisdictions reviewed in the scan. These three jurisdictions have undertaken significant state-wide initiatives to develop a just culture. In all three states, the initiative was coordinated by the state's safety and quality council and employed the services of a well known contractor, David Marx. These initiatives largely focused on state-wide training and communication, as well as utilizing specific tools such as Marx's Just Culture Algorithm (similar to a decision tree) and 'toolkits' to help individual organizations develop a just culture. Although these initiatives appear to have been successful in increasing awareness of a just culture approach, they were not rigorously evaluated to determine whether they positively impacted patient safety in the states.

In BC, each health authority already has an incident management policy in place that includes a commitment to a just approach for patient safety incidents. However, only three of the six health authorities include specific steps in their policies that concretely support a just approach to incident management (for example, by utilizing a decision tree). Two health authorities, Vancouver Coastal and Provincial Health Services, have stand-alone policies that address just culture. Representatives from these two health authorities were interviewed by the researcher to gain insight on their experiences with developing a just culture.

The interviewees' comments were highly consistent with the findings of the literature review and cross jurisdictional scan. The interviewees indicated that policy alone is not sufficient to achieve culture change, and that leadership support, education, and communication are key aspects of developing a just culture. One interviewee highlighted several specific education strategies such as incorporating just culture concepts in manager training, orientation materials, and patient safety handbooks. The interviewees commented that the greatest challenge with developing a just culture is to get the message to resonate with front-line providers and managers, and to be patient and persistent with incremental culture change.

In addition to health authority policies, BC has several other policies and programs in place that help support a just culture. A provincial incident reporting system, the Patient Safety Learning System, is well established in BC and supports a just culture approach in its training modules. The data from the incident reporting system, as well as the patient safety culture

surveys conducted by health authorities through the accreditation process, can help provide data on whether efforts to develop a just culture have correlated with a strong perception of patient safety and with more open incident reporting. In addition, Section 51 of the *Evidence Act* provides the legislative confidentiality of incident analyses that is necessary to protect a just culture from the punitive influence of the legal system.

## **Recommendations**

BC is well-positioned to pursue further development of a just culture in the health system. The health authorities have already demonstrated an acceptance of a just culture approach in theory, as evidenced by existing references to just culture in each health authority's incident management policies. In addition, the existence of the Patient Safety Learning System and Section 51 of the *Evidence Act* means that two important and substantial pieces of work for developing a just culture are already in place in BC.

However, the current state of health authorities policies related to just culture indicate that further work is needed to ensure provincial consistency and enhance the role and impact of a just culture approach. To accomplish this, it is recommended that the Ministry issue a provincial Policy Communiqué to the health authorities to ensure that health authority policies include the key features of a just culture policy as identified by this research. The proposed policy is provided in Appendix C, and includes requirements to:

- Update incident management policies to describe a consistent and confidential incident management process that involves the impacted provider in the analysis;
- Determine culpability with the use of a decision support tool, whereby a provider's peers are involved in evaluating the provider's behavioural choices through the eyes of the provider at the time, without emphasis on the extent of harm that occurred;
- Continue to participate in and support the Patient Safety Learning System;
- Ensure all organizational policies (such as human resource policies) are consistent with a just culture approach;
- Develop an interdisciplinary team and communication strategy to spread knowledge and support for a just culture in the organization; and,
- Integrate just culture into patient safety education and communication materials.

In addition to issuing a provincial policy to the health authorities, the Ministry can undertake various other activities to foster the development of a just culture in the health system.

Recommendations for the Ministry include:

- Investigate opportunities for the BC Patient Safety and Quality Council to have a role in supporting just culture development;
- Maintain just culture as an ongoing topic in a provincial quality committee such as the Health Quality Network or Risk Management Committee;
- Engage with major professional regulatory bodies to encourage them to adopt a just culture approach;

- Monitor policy developments in other provinces and within the BC health system to identify opportunities to share knowledge and ensure other provincial policy work is consistent with a just culture approach; and,
- Use existing sources of data, such as patient safety culture surveys and incident reporting rates<sup>1</sup>, to evaluate whether the work to develop a just culture is correlated with improvements in reporting rates and provider perceptions of safety.

The proposed policy and recommendations are based on the available literature and experiences of jurisdictions and organizations with pursuing a just culture. They reflect best practices as currently known but have not been vetted through the BC health authorities, and as such do not reflect stakeholder consultation. Stakeholder consultation may be pursued by the Ministry outside of the scope of this project. In addition, it should be noted that current literature on just culture is based on well-accepted theory, but no quantitative studies are available to substantiate the claim that a just culture results in a safer health care system.

Despite these limitations, the recommendations presented in this report provide the Ministry with a sound starting point for pursuing a just culture in the BC health system. Because it takes time for a culture shift to take place, the Ministry should continually look for opportunities to enhance awareness of a just culture approach and evaluate whether efforts to develop a just culture are successfully contributing to a safer health system.

---

<sup>1</sup> In the short and middle term, an increasing reporting rate of low- and no-harm patient safety incidents could indicate that providers feel safer and more encouraged to report incidents that in the past they would attempt to conceal. Therefore, an increasing reporting rate may indicate that a more just culture is developing in the organization. Over the long term, a decreasing reporting rate may be desirable to indicate that the organization has been able to translate learning opportunities into a lower incidence of patient safety incidents.

## TABLE OF CONTENTS

|  |    |
|--|----|
| Executive Summary.....   | 2  |
| Objective.....   | 2  |
| Methodology.....   | 2  |
| Results .....  | 2  |
| Recommendations .....  | 5  |
| Table of Contents .....  | 7  |
| Introduction .....   | 9  |
| Project Client and Problem.....  | 9  |
| Project Objectives and Research Questions .....                                    | 9  |
| Background.....  | 10 |
| The BC Health System .....   | 10 |
| Terminology .....  | 10 |
| Research Methodology.....  | 11 |
| Part 1: Literature Review, Cross-Jurisdictional Scan, and Current BC Policies..... | 11 |
| Part 2: Telephone Interviews.....  | 11 |
| Literature Review .....  | 13 |
| Current Thinking in Quality Improvement.....                                       | 13 |
| John Reason’s Model of Errors .....  | 13 |
| Implications for Quality Improvement.....  | 14 |
| What is Just Culture?.....   | 15 |
| Building a Just Culture .....  | 16 |
| Incident Management Policies.....  | 16 |
| Determining Culpability.....   | 16 |
| Fair Processes .....   | 19 |
| Incident Reporting Systems.....  | 20 |
| Legislation and the Judiciary.....   | 21 |
| Implementation Considerations.....   | 21 |
| Cross-Jurisdictional Scan .....  | 23 |
| Canada .....   | 23 |
| United States.....   | 24 |
| Minnesota .....  | 24 |

|  |    |
|--|----|
| Missouri .....   | 26 |
| North Carolina .....                                     | 26 |
| United Kingdom .....                                     | 28 |
| Australia .....  | 28 |
| Current BC Policies and Programs .....                   | 30 |
| Health Authority Policies .....                          | 30 |
| Professional College Policies .....                      | 30 |
| Patient Safety Learning System.....                      | 31 |
| Culture Surveys .....                                    | 31 |
| Section 51 of the Evidence Act .....                     | 31 |
| Telephone Interviews .....                               | 32 |
| Leadership Support.....                                  | 32 |
| Role of Policy .....                                     | 32 |
| Education and Communication .....                        | 33 |
| Key Challenges.....                                      | 33 |
| Recommendations for Developing a Just Culture in BC..... | 35 |
| Proposed Policy .....                                    | 35 |
| Recommendations for the Ministry .....                   | 36 |
| Limitations.....   | 38 |
| Conclusion .....   | 39 |
| References .....   | 40 |
| Appendix A: Interview Guide .....                        | 44 |
| Appendix B: Summary of Health Authority Policies.....    | 45 |
| Appendix C: Proposed Just Culture Policy .....           | 46 |

## INTRODUCTION

### Project Client and Problem

It is estimated that 7.5% of the 2.5 million patients annually admitted to an acute care hospital in Canada experience at least one patient safety incident, and approximately 37% of these incidents are considered highly preventable (Baker et al, 2004, p.1683). Baker et al (2004) estimated that in the year 2000 alone, between 9,250 and 23,750 deaths in Canada were due to preventable patient safety incidents. In addition to the high human cost, patient safety incidents can also negatively impact the sustainability of the health system due to increased care costs and lawsuits.

In July 2012, Dr. Doug Cochrane, Chair of the BC Patient Safety and Quality Council, suggested that the Ministry of Health (the Ministry) improve patient safety by developing a ‘just culture’ in BC’s health care system. Dr. Cochrane’s suggestion was prompted by his 2011 investigation into medical imaging, credentialing, and quality assurance. The investigation revealed that a culture of fear among health care providers is negatively impacting patient safety because providers sometimes do not report risks to patient safety out of fear of retaliation or punishment (Cochrane, 2011, p.22,24). Although developing a just culture is not formally part of the Ministry’s Action Plan in response to Dr. Cochrane’s report (Ministry of Health, 2011), the Ministry accepted Dr. Cochrane’s additional suggestion to work on developing a just culture in health care.

The purpose of this research is to assist the Ministry in developing and implementing a province-wide strategy for developing a just culture. This research was completed for the Ministry’s Patient Safety and Care Quality branch.

### Project Objectives and Research Questions

The objective of this project is to develop a provincial just culture policy for the BC health system and develop a strategy for effective implementation of the policy. The primary research question of this project is: “what policy approaches and implementation strategies should the Ministry use to create a more just culture in the BC health care system?” In order to respond to this research question, it will be necessary to answer the following sub-questions:

- What is a just culture?
- What are the key features of an effective<sup>2</sup> just culture policy?
- How have health care organizations in other jurisdictions approached just culture?
- To what extent do just culture policies already exist in BC’s health care system?
- What implementation strategies can be used to make just culture policies effective?

---

<sup>2</sup> In this project, the ‘effectiveness’ of just culture policies refers to whether the policies are successfully able to create a just culture in the organization. Based on current thinking in incident management, it is widely theorized by patient safety experts that a just culture improves patient safety. This report will not address whether there is empirical evidence to support this theory. There are two reasons for this limitation: 1) the literature review revealed no scientific evidence on this matter in the health care field, and 2) the Ministry’s primary interest is *how* to develop a just culture, since it has already committed to undertaking this work.

## BACKGROUND

### The BC Health System

In BC, acute health care services (as well as many residential and long-term care services) are delivered by five regional health authorities<sup>3</sup>, the Provincial Health Services Authority<sup>4</sup>, and several denominational hospitals affiliated with the health authorities. Each health authority and affiliate organization develops its own organizational policies. As part of its stewardship role for the health care system, the Ministry may direct the health authorities and affiliate organizations to adopt certain policies by issuing a Policy Communiqué.

Patient safety in BC is supported by dedicated quality and safety program areas in the health authorities, the Patient Safety and Care Quality branch in the Ministry, and the BC Patient Safety and Quality Council. These three parties work collaboratively to address key patient safety issues in the province such as infection prevention and control and medication management.

Nationally, the Canadian Patient Safety Institute has a prominent role in supporting patient safety in Canadian health care. The Canadian Patient Safety Institute is a not-for-profit organization that aims to improve patient safety in Canada by raising awareness and facilitating the implementation of best practices (Canadian Patient Safety Institute [CPSI], 2012a). The work of the Canadian Patient Safety Institute is often reflected in BC's patient safety policies and practices.

### Terminology

This report will use terms consistent with the World Health Organization's International Classification for Patient Safety (World Health Organization [WHO], 2009). A 'patient safety incident' is "an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient" (WHO, p.15). 'Harm' refers to "impairment of structure or function of the body and/or any deleterious effect arising there from" (WHO, p.15).

This report will use the term 'provider' to refer to any health care worker or professional. This includes doctors, nurses, care aides, pharmacists, or anyone else involved in directly providing care to patients. Quoted material may use alternate terms such as 'staff' or 'employee', but for all intents and purposes these terms should be considered to have the same meaning as provider. The term 'provider' is most appropriate in the Canadian context because most doctors who work in hospitals have site privileges rather than an employee/employer relationship with a health authority.

---

<sup>3</sup> Interior Health Authority, Fraser Health Authority, Northern Health Authority, Vancouver Coastal Health Authority, and Vancouver Island Health Authority.

<sup>4</sup> Comprised of several province-wide agencies such as the BC Cancer Agency, BC Center for Disease Control, BC Children's Hospital, and BC Women's Hospital.

## RESEARCH METHODOLOGY

### Part 1: Literature Review, Cross-Jurisdictional Scan, and Current BC Policies

The researcher initiated the project by conducting a review of the academic literature relating to just culture. Using the University of Victoria library database, the researcher searched the combined terms “just culture” and “health.” The search results were then narrowed by excluding newspaper articles and newsletter articles, as a preliminary review of these types of sources proved them to be of little value. A total of fourteen articles and three books were selected for review. The academic literature was then supplemented by a search for grey literature using a Google search for the combined terms “just culture” and “health.”<sup>5</sup> Key sources cited within the academic and grey literature were also identified and reviewed.

The next step for the research was to conduct a cross-jurisdictional scan. The literature review provided some overlap with the cross-jurisdictional scan, as several academic sources related to the experiences of other jurisdictions, such as Alberta, Missouri, and North Carolina. The Google search also revealed sources relating to Minnesota. These jurisdictions were therefore included in the cross-jurisdictional scan.

The researcher conducted additional online searches for just culture policies in jurisdictions with health systems similar to BC: the Canadian provinces of Alberta, Saskatchewan, Manitoba, and Ontario; the United Kingdom; and Australia. For each of these jurisdictions, the researcher searched for the term “just culture” on the ministry of health websites, health quality council websites, and health authority websites as applicable. If no hits were found, a search was also conducted for the broader term “safety culture” in case just culture concepts are not specifically termed as such in the jurisdiction. No useful sources were found for Saskatchewan, Manitoba, and Ontario.

Lastly, the researcher reviewed the current policies of all British Columbia health authorities in order to assess the current state of just culture policies in the province. The health authority policies were available through the Ministry. In addition, the researcher searched the websites of several major professional colleges<sup>6</sup> for policies related to just culture.

### Part 2: Telephone Interviews

After gaining a thorough understanding of just culture principles and the experiences of other jurisdictions through the research described in Part 1, the researcher conducted telephone interviews with representatives from the Provincial Health Services Authority and the Vancouver Coastal Health Authority. These organizations were chosen because they have stand-alone just culture policies in place. The purpose of the telephone interviews was to

---

<sup>5</sup> The combined terms “just culture” and “patient safety” provided search results that were focused on patient safety issues more broadly, with little specific emphasis on just culture. The search for the combined terms “just culture” and “health” provided more relevant search results.

<sup>6</sup> The College of Physicians of Surgeons of BC, College of Registered Nurses of BC, College of Licensed Practical Nurses of BC, College of Pharmacists of BC, and the Royal College of Physician and Surgeons of Canada.

obtain the insights of these organizations about developing and implementing just culture policies, so that their knowledge and experience could help inform the province-wide approach to developing a just culture. The interview guide is provided in Appendix A.

## LITERATURE REVIEW

### Current Thinking in Quality Improvement

Historically, patient safety incidents (as well as safety incidents in other industries) have been viewed as an issue of individual human error (CPSI, 2012b, p.20). Incident investigations were limited to identifying the most obvious cause of an event. This often led to blaming an employee or provider for making a mistake without consideration for what led the employee or provider to make the mistake (CPSI, p.20).

Over the last 15 years, health care has moved away from a focus on human error and has increasingly adopted a systems-focused approach. A systems-focused approach “views human error as a symptom of broader issues within a poorly designed system, such as an adverse physical or organizational environment” (CPSI, 2012b, p.20). This approach is closely aligned with the concept of “human factors analysis,” which postulates that systems can be made safer if the work environment and equipment is designed to be easy to use and intuitive for its human operators (BC Patient Safety and Quality Council, 2010, p.19-20).

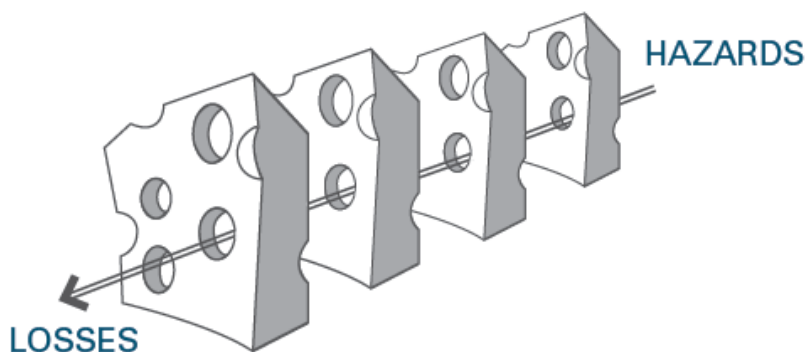
The beginning of the system-focused thinking in the health care field is often attributed to the Institute of Medicine’s 2000 report *To err is human: building a safer health system*. The Institute of Medicine’s report draws heavily on the earlier work of “noted expert” John Reason (Institute of Medicine, 2000, p.4), who has also been called the “father of modern error theory and ‘systems thinking’” (Wachter and Pronovost, 2009). The enduring influence of Reason’s 1997 book *Managing the Risks of Organizational Accidents* is evidenced by the fact that nearly all other sources identified this literature review extensively cite Reason’s work.

#### *John Reason’s Model of Errors*

The system-focus approach is based on the principle that “humans are fallible and errors are to be expected even in the best organizations because people are incapable of perfect performance every time” (CPSI, 2012b, p. 19). It is therefore impossible to eliminate the occurrence of incidents solely through the management of individual employee performance. Preventing incidents from occurring requires an organization to develop defenses or safeguards to prevent harm from occurring when human errors inevitably occur (CPSI, p.19).

Reason uses a “swiss cheese” model (Figure 1) to illustrate how harmful incidents occur (1997, p.9). The swiss cheese model demonstrates that harmful incidents occur when several different factors align to contribute to the overall failure of system defenses. Organizations usually have multiple layers of defenses in place in order to protect against harmful incidents. These defenses can be thought of as slices of swiss cheese, and the holes in the cheese represent the defense’s weaknesses and vulnerabilities.

Figure 1: Reason's "Swiss Cheese" Model (in CPSI, 2012b, p.19)



Normally, the various defenses in the system are able to patch up each others' weaknesses so that even if one or several defenses fail, another is successful at preventing harm from occurring. However, sometimes the weaknesses in each defense 'line up' at the same time, and an error is able to fully penetrate the defenses and cause harm. Reason emphasizes that the swiss cheese model is a "moving picture," because local conditions cause the holes in the defenses to constantly shift and change (1997, p.9). This can make it difficult, if not impossible, to design a perfect system of defenses. Including too many redundancies can negatively impact the safety of the system by incentivizing people to circumvent the defenses so that they are able to complete their tasks in the time and manner expected of them by management (Reason, p.51).

Local conditions influence not only the effectiveness of system defenses, but also the likelihood of an error occurring in the first place. Reason (1997) argues that errors nearly always involve two sets of factors: active failures and latent conditions. Active failures are the errors and violations committed by front-line providers, while latent conditions are the result of complex systemic factors that contribute to active failures (Reason, 1997, p.10). Improving patient safety requires an understanding of the latent conditions that contribute to errors. In the words of John Reason:

Though we cannot change the human condition, we can change the conditions under which humans work. [. . .] Unlike active failures, whose specific forms are often hard to foresee, latent conditions can be identified and remedied before an adverse event occurs. Understanding this leads to proactive rather than reactive risk management" (Reason, 2000, p.768-9).

#### *Implications for Quality Improvement*

Reason's model of error management has significant implications for quality improvement in health care. While in the past health care administrators thought they could improve patient safety by firing providers who made mistakes, it is now widely acknowledged that due to the existence of latent conditions in the system, firing individual providers does not address the root cause of incidents. Now, hospital administrators are encouraged to use patient safety incidents as an opportunity to identify and correct latent conditions so that the incident is less

likely to occur again (CPSI, 2012b, p.12). The primary goal of any investigation is to discover these latent conditions and figure out how to remove them.

Punishing individuals for making errors undermines an organization's ability to identify and correct latent conditions. In his testimony before the United States House of Representatives, Dr. Lucian Leape asserted that "rather than reduce errors, punishment increases them because it makes it difficult to uncover the underlying causes of errors and remedy them. The paradox is that the single greatest impediment to error prevention is that we punish people for making them" (1997, p.95). This attitude is echoed in the Canadian Patient Safety Institute's *Incident Management Framework*, which emphasizes that "incident analysis is most effective in a confidential environment where participants can safely report, participate, and express their opinions about underlying contributing factors to the incident without fear of reprisal" (CPSI, 2012b, p.18).

The negative impact that punishment has on the ability to improve system safety has given rise to the concept of a 'just culture.' Before turning our attention to just culture concepts, it is worth noting that a just culture is only one aspect of building a broader safety culture in an organization. Other aspects of a safety culture include an informed culture (there is knowledge about factors that determine system safety); a reporting culture (people are willing to report incidents and near-misses); a flexible culture (the ability to reconfigure processes and work structures in the face of danger); and a learning culture (the willingness and ability to learn from information systems) (Reason, 1997, p.195-6). There is a significant amount of interconnectivity between these various components of a safety culture, but having a just culture provides the necessary foundation from which the other elements of a safety culture can be built.

### **What is Just Culture?**

Many authors who write about just culture do not define it concretely. As a result, just culture is more often described than defined. Definitions offered by some authors include:

- The "balance between responding to calls for accountability and making improvements to safety" (Dekker, 2007, p.57);
- "An environment supportive of open dialogue to facilitate safer practices" (Khatri, Brown, and Hicks, 2009, p.315); and,
- "An atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety-related information – but in which they are also clear about where the line must be drawn between acceptable and unacceptable behaviour" (Reason, 1997, p.195).

Considered together, these definitions indicate that the purpose of a just culture is to improve system safety by building trust through fair treatment of employees after a safety incident. By treating employees fairly after an incident, employees learn to trust the organization's management and so are not afraid to report patient safety incidents and be actively involved in incident analysis (Dekker, 2007, p.133). This allows an organization to identify and correct latent conditions to help prevent future incidents (Frankel et al, 2006, p.1692). Treating

providers justly and fairly in the incident management process reinforces the feedback loop of continuous improvement described in Figure 2.

*Figure 2 – How a just culture supports continuous improvement*

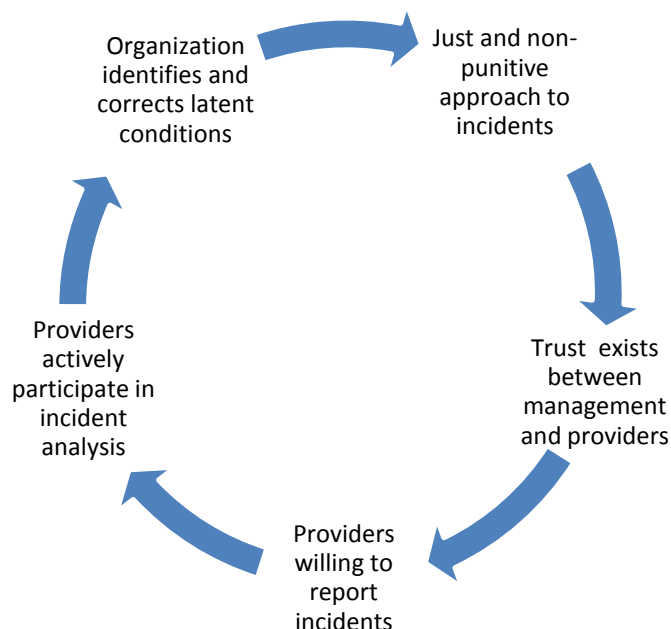


Figure 2 demonstrates the importance of treating providers justly in order to improve patient safety. There is widespread consensus about this point in modern patient safety literature. A more challenging issue is what it means to treat someone ‘justly.’

## **Building a Just Culture**

### *Incident Management Policies*

An organization’s response to patient safety incidents is the single most critical aspect of building a just culture. How management handles an incident will either build trust and encourage future reporting, or foster mistrust and undermine efforts to improve safety (Dekker, 2007, p.133).

### *Determining Culpability*

A ‘just’ response to patient safety incidents most obviously manifests itself in what consequences are faced by the provider(s) involved in the incident. Reason (1997) and Dekker (2007) argue that organizations must be able to draw a line between blameless and blameworthy behaviours and apply consistent principles for determining where this line is drawn (Dekker, p.57,84; Reason, p.205). The key principle for drawing this line in a ‘just’ way is to link discipline and accountability to a provider’s behaviour choices and risks rather than the extent of harm that occurs (Burhans, Chastain, and George, 2012, p.43; Gorzeman, 2008, p.310). A just culture moves the focus away from actual outcomes in recognition that

“we can only control our intended behaviours to reduce the likelihood of making a mistake, but we cannot truly control when and where human errors will strike” (Marx, 2001, p.13). When assessing the appropriateness of a provider’s choices and whether the provider calculated the risks correctly, investigators should attempt to view the situation through the eyes of the provider at the time without considering the actual outcome (Dekker, 2007, p.72). This helps to avoid hindsight bias, which can lead investigators to oversimplify causality, overestimate the likelihood of the outcomes, overrate the role of procedural violations, and misjudge the prominence or relevance of data (Dekker, 2007, p.66).

Proponents of just culture use three categories of behaviours to help differentiate between blameless and blameworthy acts. These three categories are described in Table 1.

*Table 1: Types of Behaviour*  
(Adapted from Marx, 2001, p. 6-7 and Mayer and Cronin, 2008, p.429)

| <b>Behaviour Type</b>                    | <b>Description</b>  |
|--|---|
| Human Error                              | The individual should have done something other than what they did; an unintentional action that caused or could have caused an undesirable outcome, whether because a planned action is not completed as intended or the wrong plan is used to achieve an aim.                       |
| At-Risk Behaviour<br>(Negligent Conduct) | A failure to exercise the skill, care, and learning expected of a reasonably prudent health care provider; mistakenly believing that taking a risk was justified. Involves conscious deviation from known rules and expectations, but without conscious intent to put others at risk. |
| Reckless Conduct                         | A conscious and unjustified disregard of a known and substantial risk.  |

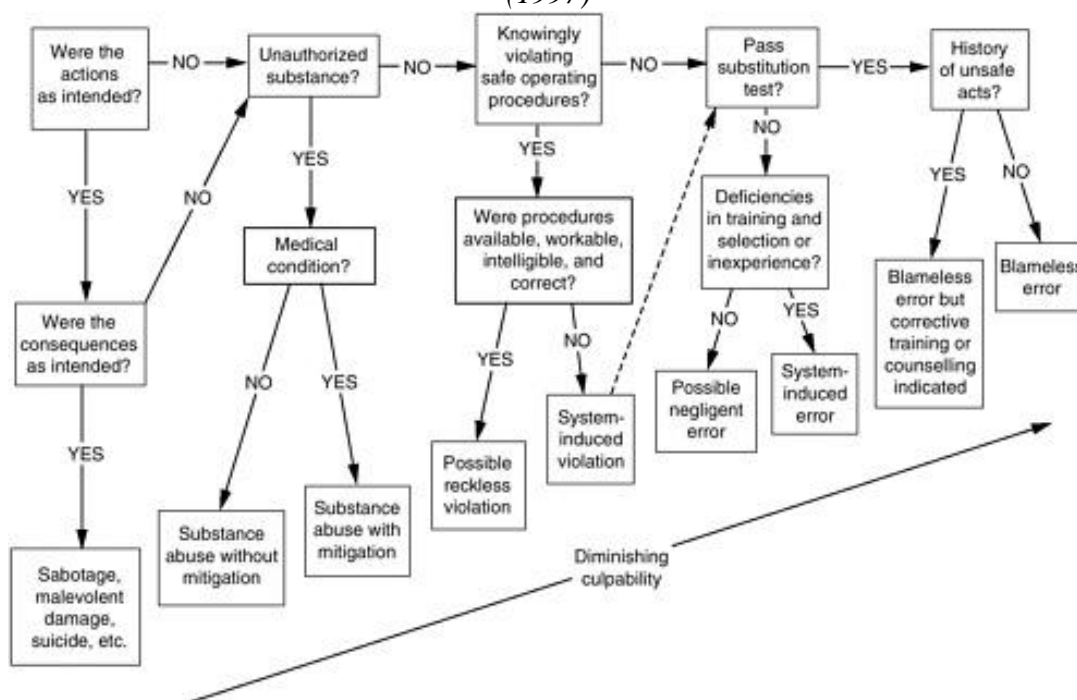
A just culture proposes that people should be punished for reckless conduct but not for human error, because latent conditions in the system can cause even the best providers to make an error (Reason, 1997, p.260; Frankel, Leonard, and Denham, 2006, p.1693). Human errors should be responded to by consoling the provider and identifying the latent conditions that triggered the error (American Nursing Association, 2010, p.4).

The appropriate response to at-risk behaviour is more ambiguous. At-risk behaviour usually results when “we convince ourselves that we are operating in a safe place, but where others observing our behaviour view the choice as unjustifiably risky” (Marx, 2009, p.33). If the health care practitioner deviated from established rules and procedures, investigators can consider whether there were mitigating or aggravating factors that influenced the behaviour (Burhans, Chastain, and George, 2012, p.46). Marx (2001) points out that “not all intentional violations are bad. [...] There will always be circumstances where the vast overlap of rules does not fit the circumstance facing the professional” (p.15). A ‘substitution test,’ whereby it is assessed whether another competent and responsible provider would have behaved the same way, can also be used to assess the appropriateness of a provider’s behaviour.

The guiding principle in addressing ambiguous situations is whether a certain response will improve the safety of future patient care. In some situations this may require disciplinary action to demonstrate that certain behaviours are not tolerated, while in other situations a disciplinary response would only serve to undermine trust and engender fear. In the latter cases, a more just response may be to improve procedures or provide coaching to the employee to correct the at-risk behaviour (Reason, 1997, p.209; Wachter and Provonost, 2009, p.1404).

Reason (1997) proposes the use of a decision tree to help determine the level of culpability in an individual's actions (p.209). Reason's decision tree, provided in Figure 3, is also used by the Canadian Patient Safety Institute in the *Incident Analysis Framework* (CPSI, 2012b, p.28).

Figure 3: James Reason's Decision Tree (1997)



The decision tree is intended to help the decision maker(s) assess the various considerations for determining culpability in a just manner. The decision tree includes a variety of questions with yes/no answers that guide the decision maker(s) to other relevant questions, eventually leading to one of a variety of assessments of culpability. For example, if a nurse administers medication to the wrong patient because she intentionally bypasses the process of checking two different patient identifiers in her eagerness to finish her shift and catch an earlier bus home, the decision tree would be used as follows:

1. Were the actions as intended? → yes (the nurse intentionally administered medication without checking two patient identifiers).
2. Were the consequences as intended? → no (the nurse did not intend to administer medication to the wrong patient).

3. Unauthorized substance? → no (there is no evidence that the nurse was under the influence of drugs or alcohol).
4. Knowingly violating safe operating procedures? → yes (checking two patient identifiers is a safe operating procedure knowingly violated by the nurse).
5. Were the procedures available, workable, intelligible, and correct? → yes (the two patient identifier policy is well known, clearly understood, well established as an effective way to prevent medication errors, and feasible to carry out [i.e. providers can check the patient's chart and wristband]).
6. Result: Possible reckless violation.

Note that the result is a 'possible' reckless violation. The decision tree does not provide a purely black-and-white guide to whether and how to punish a provider. A certain amount of judgement will still be required by the decision maker. In this example, the nurse's reason for bypassing the procedure is a poor one: she was rushing because she wanted to catch an earlier bus home. If the nurse's reason for rushing was that the ward was severely short staff and an emergency situation was arising elsewhere that needed her attention, then this circumstance points to a systemic latent condition (understaffing) that would make a serious punishment unjustified.

Although decision trees such as Reason's appear to be quite popular and well-utilized tools for supporting a just culture (they have been adopted by the Canadian Patient Safety Institute and by several other jurisdictions, which will be discussed below), not everyone agrees about their value. Most notably, Dekker (2007) argues that "decision trees are really only a tool to get a discussion started about whether something can be seen by a community of peers or judges as negligence" (p.85). Dekker emphasizes that instead of relying on decision trees, incident management policies should aim to "give people clarity about who draws the line, and what rules, values, traditions, language, and legitimacy this person uses" (p.84).

### *Fair Processes*

Although the consequences faced by providers will have a substantial effect on the perception of justice following an incident, the process of the investigation can also impact whether the response to an incident is perceived as just. Weiner, Hobgood, and Lewis (2008) point out that "people care not only about the fairness of the outcome they receive, but also about the fairness of the procedures used to decide the outcomes" (p.406). Weiner et al. go on to argue that a perception of fairness relies on three characteristics of the reporting process: fair distribution rules (people are treated equally), fair procedural rules (the process is fair), and fair social treatment (people are treated with respect and consideration) (p.407). Table 2 summarizes the key characteristics that should be included in an incident management policy to support a just culture from a procedural perspective.

*Table 2: Key Characteristics of Effective Incident Management Policies*

| <b>Characteristic</b>                               | <b>Rationale</b>  |
|---|---|
| <b>Consistency</b>                                  | Providers should be able to clearly understand and predict how incidents will be managed and investigated, because “deviation from the agreed-upon, system-focused approach has the potential to drive incident reporting underground” (CPSI, 2012b, p. 18).  |
| <b>Confidentiality</b>                              | A confidential environment helps providers feel safer when participating in an investigation (CPSI, 2012b, p.18).   |
| <b>Communication</b>                                | Providing feedback to providers throughout the investigative process will make providers feel that reporting incidents is worthwhile (Khatri et al., 2009, pp18).   |
| <b>Provider Involvement</b>                         | Empowering the provider involved in the incident during the investigation process helps investigators to understand the provider’s perspective and engage the provider in change and improvement (Dekker, 2007, p.133).   |
| <b>Peer Involvement</b>                             | A provider’s peers should be involved in determining the level of culpability in a patient safety incident (Dekker, 2007, p.140). Peers are in the best position to understand the context in which the provider made the choices he/she did and whether or not risks were justifiable given the circumstance (Dekker, 2007, p.119).                                |
| <b>Separation of System and Performance Reviews</b> | To maintain the trust of providers during investigations, the Canadian Patient Safety Institute recommends that any individual performance issues that arise during a system improvement review be pursued under a separate process (2012b, p.27). This maintains the integrity of system reviews so that they are not perceived as a guise for performance review. |

### *Incident Reporting Systems*

The literature discussed above highlights that the goal of a just culture is to encourage staff to openly report incidents and participate in incident analysis, so that the organization can learn from past mistakes. An incident reporting system provides the infrastructure for achieving this goal, because it provides the mechanism through which staff can bring incidents to management’s attention. Voluntary staff reporting increases the number of learning opportunities available to an organization and allows an organization to demonstrate to staff that reporting incidents will result in positive change rather than discipline (Reason, 1997, p.195). This creates a “‘virtuous cycle’ in which organizational members report all medical errors and search extensively for their causes in an open and trusting environment” (Khatri, Brown, and Hicks, 2009, p.317).

To support a just culture, the purpose and operation of a reporting system must be designed to gain knowledge, not administer punishment (Leape, 1997, p.97). Providers will feel more comfortable reporting incidents if there are clear and detailed policies for what to expect after making a report (Dekker, 2007, p.43). Additional key aspects of an effective reporting system are that it allows for confidentiality and de-identification, allows for a feedback mechanism to

exist between management and the reporter, and that the process for making a report is simple and quick (Reason, 1997, p.197).

### *Legislation and the Judiciary*

Dekker's book on just culture (2007) devotes nearly half of its content to discussing the impact of the legal system on just culture. An organization's efforts to develop a just culture can be significantly undermined if the judicial system gets involved. Dekker argues that "when a professional mistake is put on trial, safety almost always suffers" (p.21). Unlike the just culture approach, a trial's approach to finding the cause of an incident is adversarial and usually focuses on the role of one person rather than on the complexity of systemic factors (p.37). As a result, "judiciary involvement (or threat of it) can engender a climate of fear and silence. In such a climate it can be difficult, if not impossible, to get access to information that may be critical to finding out what went wrong, or what to do to not have it happen again" (p.93). Dekker highlights an example from the aviation industry in which there was a 50 per cent drop in the number of incidents reported in the year following a prosecution of air traffic controllers involved in a single incident (p.98).

In light of the potentially negative impact of the judicial system on patient safety, legislation that protects an organization's safety and incident data from outside probing is a key element of building a just culture (Dekker, 2007, p.141). Legislative protection of safety incident information allows an organization to build a climate of trust, reduce stigmatization of incidents, and increase the willingness of staff to report incidents, without these efforts being subsequently undermined by the legal system pursuing a prosecution (Dekker, p. 98).

### *Implementation Considerations*

The literature offers a few additional suggestions for successfully developing a just culture. The most fundamental is to have a committed and engaged leadership (Flemons, Eagle, and Davis, 2005, p.123). Perceptions of management's attitude toward safety will form the basis of employees' attitudes (Parker, Lawrie, and Hudson, 2006, p.553). The Canadian Patient Safety Institute (2012b) points out that "culture cannot be implemented solely based on policy or procedure; rather, it needs to be consistently fostered over time, and by example, at all levels of the organization" (p.17). Leadership can facilitate the trust-building cycle depicted in Figure 2 by following up on identified issues, acknowledging the safety concerns of providers, and providing ongoing feedback about how issues were resolved (Health Quality Council of Alberta, 2012, p.196). In addition, leadership commitment will help ensure that the necessary resources are in place to support a just culture (Reason, 1997, p.113).

Khatri et al (2009) argue that a just culture is more likely to thrive under a commitment-based management approach rather than a control-based management approach (p.315). Under control-based systems, "greater incidence of medical errors leads to greater control and regulation of employees behaviours, further strengthening the blame culture and finger-pointing" (Khatri et al, p.316). Alternatively, a commitment-based approach assumes that people are self-disciplined and work best when committed to the organization and given autonomy (Khatri et al, p. 316). A commitment-based management approach better fosters a

participatory learning environment where providers are motivated to search for ways to improve safety and quality (Khatry et al, p.317).

Another implementation issue to consider is the consistency of the organization's other policies with a just culture approach. Prior to issuing the relevant policies, procedures, and guidelines, Dekker recommends that the organization review all other policies and abolish any policy elements that contradict a just culture approach (2007, p.138). An example of a contradictory policy would be to apply an automatic financial or professional penalty on a provider following an incident (Dekker, p. 138). Such a policy would signal that providers are always to blame for an incident, which is inconsistent with a just culture approach where human error is not considered blameworthy.

After issuing the relevant policies, procedures, and guidelines, organizations should try to educate providers about what a just culture is and what the organization is doing to support it. Dekker feels that education about just culture should start during the basic education and training of the profession (2007, p.138). Failing this, it falls on the individual organizations to provide education and training to their staff. Educating mid-level managers is particularly crucial, because failure to do so "can have a detrimental effect on employees' acceptance of the principles [of a just culture]" (p.624).

Related to education is the importance of communication with staff. Shepard (2011) suggests formally communicating all policies, procedures, and guidelines to staff but also holding a 'town hall' forum so staff can ask questions and discuss concerns (p.48). Holding a celebratory event to reward self-reporters can also help reassure staff that reporting incidents is viewed positively by the organization (Shepard, p.48).

Most information about successful implementation of just culture policies comes from the firsthand experiences of other jurisdictions. The experiences of these jurisdictions will be discussed in the following section.

## CROSS-JURISDICTIONAL SCAN

### Canada

Pursuit of a just culture in Canadian health care is evident in the work of several national health care organizations, including the Canadian Patient Safety Institute, the Royal College of Physicians and Surgeons of Canada, and the Canadian Medical Protective Association. The Canadian Patient Safety Institute is the leading organization trying to support health care systems in developing a just culture. This support has come primarily in the form of the *Canadian Incident Analysis Framework*, which is a policy document and toolkit for using a systems-focused and just culture approach to incident analysis (CPSI, 2012b). The Canadian Patient Safety Institute has also provided online education sessions through the Incident Analysis Learning Program, which aims to “increase participants’ knowledge and skill in patient safety incident analysis and management [. . .] to ultimately increase the effectiveness of analysis in reducing harm” (CPSI, 2012c).

The Canadian Patient Safety Institute also incorporates just culture into its work on developing safety competencies in medical education (Frank and Brien, 2008). The Safety Competencies framework was developed in collaboration with the Royal College of Physicians and Surgeons of Canada as a way to incorporate safety culture and interprofessional learning into early and ongoing medical education (Frank and Brien, p.iv). Just culture is highlighted as an important component of contributing to a culture of patient safety (Frank and Brien, p.5). Unfortunately, a white paper developed by the Royal College of Physicians and Surgeons of Canada in 2011 points out that “uptake of Patient Safety Competencies, and other frameworks, among Canadian postgraduate medical education programs has been limited” (Royal College of Physicians and Surgeons of Canada [Royal College], 2011, p.4). The white paper goes on to suggest that uptake could be improved by providing a more explicit curriculum for educators to follow, developing toolkits for supporting educators in implementing the curriculum, and encouraging adult learning techniques such as simulation and experiential learning (Royal College, p.6).

The Canadian Medical Protective Association, a national organization that provides medical liability protection and risk reduction services for physicians, has also issued a policy supporting a just culture approach to incidents, drawing heavily on Reason’s work (Canadian Medical Protective Association [CMPA], n.d.; CMPA, 2009, p.19). In line with their role of protecting physicians from liability, the Canadian Medical Protective Association’s just culture policy frequently reminds physicians to be aware of whether the information they provide about an incident falls under legislation that protects confidentiality (2009, p.14). This reinforces the importance of such legislation in getting providers to speak openly and honestly during a quality review or incident investigation.

At a provincial level, there is little publicly available information about whether just culture policies are in place in various jurisdictions. The web sites of health quality councils, ministries of health, and health authorities in Alberta, Saskatchewan, Manitoba, and Ontario were searched for the terms ‘just culture’ and ‘safety culture.’ The search was only successful for Alberta. Prior to the amalgamation of all Alberta regional health authorities, the Calgary Health Region had a just culture policy in place (Calgary Health Region, 2006). This policy

outlined a broad commitment to conducting safety analyses and reviews in a just and trusting manner, and defined three categories of harm: errors, non-compliance, and intention to harm. The policy stated that errors should not result in discipline; non-compliance with policies and procedures should result in a review of the circumstances leading to the lack of compliance prior to considering discipline; and intention to harm should result in discipline and potentially a criminal investigation (Calgary Health Region, 2006).

After Alberta's health authorities were amalgamated into a single organization (named Alberta Health Services) in 2009, a just culture working group was established to create a new, province-wide just culture policy (Health Quality Council of Alberta [HQCA], 2012, p.190). In 2012, the Health Quality Council of Alberta recommended that this work be accelerated after a systematic review of the role and process of physician advocacy indicated that Alberta physicians feel a high level of mistrust towards Alberta Health Services (HQCA, p.189). Many physicians involved in the review specifically noted the absence of a just culture policy and felt it should be recognized in the Code of Conduct (p.179). The recommendation also stated that the just culture policy should "serve as a foundation for all of the organization's policies and procedures, including the medical staff bylaws" and that it "must be adequately resourced and supported" (p.191). A just and trusting culture is also one of six care patient safety principles outlined in Alberta's "Blueprint Project" for transforming patient safety education in Alberta (Flemons, Davies, Wright, Mikkelsen, and Harvie, 2010, p.7).

Although Alberta has, comparatively, shown the most provincial initiative in adopting a just culture policy, they are still in the development stage and therefore cannot yet offer any lessons learned for implementing a provincial just culture policy. In contrast, several organizations in the United States adopted just culture policies several years ago and can offer insights into the lessons learned of implementing such policies.

## **United States**

Of all the jurisdictions reviewed in this scan, the United States appears to be the most advanced in terms of their adoption of a just culture approach and the amount of effort and resources put into developing a just culture. Several states provide significant opportunities for learning about effectively spreading knowledge about, and adoption of, a just culture approach. These states are Minnesota, Missouri, and North Carolina.

### *Minnesota*

The Minnesota Alliance for Patient Safety (the Alliance) has been the leader of the just culture initiative in Minnesota. Although it is not clear exactly when the Alliance began work on just culture, documents relating to just culture date back to at least 2005 (Minnesota Alliance for Patient Safety [MAPS], 2005).

With the help of consultant David Marx, whose company specializes in improving organizational safety through system engineering, human factors and just culture (Outcome Engenuity, 2013a), the Alliance developed a just culture 'toolkit' to guide health care organizations in developing a just culture (MAPS, n.d.). The toolkit is divided into three

phases: planning, early implementation, and making good progress. The key steps in each of these phases are described in Table 3.

*Table 4: The Alliance Toolkit to Create a Learning, Just, and Accountable Culture (MAPS, n.d.)*

| Phase                | Key Steps  |
|----------------------|--|
| Planning             | <ol style="list-style-type: none"> <li>1. Convene a Steering Committee to test the concept.</li> <li>2. Garner leadership support.</li> <li>3. Identify champions.</li> <li>4. Identify an interdisciplinary team.</li> <li>5. Perform organizational gap analysis and/or organizational safety culture baseline survey.</li> <li>6. Review results of gap analysis and/or culture survey and identify next steps to move forward.</li> <li>7. Engage organizational-wide leadership.</li> </ol> |
| Early Implementation | <ol style="list-style-type: none"> <li>1. Engage medical and other credentialed staff.</li> <li>2. Develop orientation training for managers.</li> <li>3. Develop orientation training for clinical staff.</li> <li>4. Develop orientation training for all other employees.</li> <li>5. Evaluate existing policies and procedures.</li> <li>6. Establish system to learn about potential risk.</li> <li>7. Establish process to educate and communicate to patients and families.</li> </ol>    |
| Making Good Progress | <ol style="list-style-type: none"> <li>1. Establish and communicate expectations organization-wide.</li> <li>2. Concepts are infused and embedded in regular routines/practices throughout the organization</li> <li>3. Evaluating progress.</li> </ol>  |

Each of these steps is supported by additional suggestions such as who to involve in the steering committee, how to garner leadership support, how to engage medical staff, etc (MAPS, n.d.). The toolkit also provides links to additional resources such as learning videos, discussion guides, examples of goals and timelines, and flow charts (MAPS, n.d.).

Unfortunately, there is no information available online or through library databases regarding how the Alliance developed the toolkit and whether there is evidence to support the toolkit's steps as an effective way to develop a just culture in an organization. In addition, no information is publically available on what outcomes have been achieved as a result of the Alliance's just culture toolkit, and whether the toolkit had significant uptake within Minnesota health organizations. However, of all the jurisdictions reviewed in this scan, the Alliance's toolkit provides the most detailed and concrete guide for developing a just culture and its contents are well aligned with the concepts covered in the literature review.

### *Missouri*

In 2006, the Missouri Center for Patient Safety organized the Just Culture Collaborative, a group of 67 organizations from across the state who worked together to integrate just culture concepts into the state's health system (Miller, Griffith, and Vogelsmeier, 2010, p.3). The Just Culture Collaborative started by holding open educational sessions and stakeholder meetings to inform and educate others about just culture (Miller et al, p.3). The Just Culture Collaborative then trained 67 "champions" about the principles and application of just culture, followed by additional training interventions such as team training, regular teleconferences for champions and teams, in-person roundtable sessions, and an online network to share information (Miller et al, p.4-5).

The Just Culture Collaborative received dedicated funding of \$254,000 to support its work, which allowed it to engage the services of David Marx (Miller et al, 2010, p.3). Along with Marx's services for facilitating the training sessions, the Just Culture Collaborative purchased the use of Marx's trademarked "Just Culture Algorithm," a tool similar to a decision tree that guides organizations in following a just culture approach to incidents (Miller et al, p.4).

To assess the success of their work, the Just Culture Collaborative conducted a pre- and post-assessment of the level of understanding and application of just culture concepts (Miller et al, 2010, p.4-5). The results appear positive as "most participants indicated they had a deeper and clearer understanding of Just Culture concepts and principles after the collaborative" (Miller et al, p.5). The "champions" felt that the training and the Just Culture Algorithm were the most useful components (Miller et al, p.6). The "champions" also identified certain barriers to the implementation of a just culture in their organizations, including limited resources, lack of evidence of return on investment, change resistance, inconsistency among managers, and staff turnover (Miller et al, p.6). Despite these challenges, it appears the Just Culture Collaborative was able to achieve notable success in getting Missouri organizations to adopt a just culture approach.

### *North Carolina*

North Carolina has been working on developing a just culture in health care since 2001 (Outcome Engenuity, 2013). In 2006, North Carolina adopted an approach similar to Missouri's by creating a Just Culture Collaborative through the Center for Hospital Quality and Patient Safety (Outcome Engenuity, 2013b). A video summarizing North Carolina's approach to just culture highlights six key steps in the process, which are described in Table 4.

*Table 4: North Carolina's Six Key Steps to a Just Culture (Outcome Engenuity, 2013b)*

|   |
|---|
| 1. Get executive buy in to continually and consistently reinforce just culture principles.  |
| 2. Conduct the appropriate system and policy changes, such as reporting mechanisms, investigation procedures, and response protocols.   |
| 3. Train managers in helping to design safer systems and effectively coach and mentor staff.  |
| 4. Train staff as well, but only after the managers have had a chance to put their training into practice and start demonstrating just culture concepts to staff through their own behaviour. |
| 5. Have managers coach and mentor staff in choosing safe behaviours and contributing to safer systems.  |
| 6. Establish a mechanism for feedback and measurement so that leadership can see that change is occurring.  |

Similar to Minnesota and Missouri, North Carolina also utilized the services and tools of David Marx during its work on just culture (Burhans et al, 2012, p.44). Marx's Just Culture Algorithm was adapted by the North Carolina Board of Nursing into a Complaint Evaluation Tool to guide employers' reaction to nurses' involvement in patient safety incidents and determine whether the incident needs to be reported to the Board of Nursing as required by regulation (Burhans et al, p.44).

The Complaint Evaluation Tool uses a score-based matrix where behaviour is assessed in five different categories (general nursing practice, understanding/experience, internal policies/standards/orders, decision/choice, and ethics/credibility/accountability), with each category receiving a score on a scale from one (human error) to five (reckless behaviour) (Burhans et al, 2012, p.45-46). The tool then goes on to incorporate mitigating or aggravating factors (such as policies being unclear or previous disciplinary action) into the overall score. The overall score then determines the appropriate course of action (Burhans et al, p.45).

The Complaint Evaluation Tool was pilot tested in ten hospitals and two long term care facilities (Burhans et al, 2012, p.44). It was found to result in consistent and fair ratings that promoted patient safety, and it was "reported to be consistent with Just Culture philosophy, effective in evaluating practice events, and effective in guiding resolution" (Burhans et al, p.48).

What is most notable about North Carolina's experience with developing a just culture is the prominent role of the Board of Nursing, evidenced by their development of the Complaint Evaluation Tool and their active participation in the Just Culture Collaborative (Burhans et al, 2012, p.44). North Carolina's experience calls attention to the important role of professional regulators in supporting a just culture and ensuring alignment and consistency between the disciplinary approaches taken by the health authority or health care facility and the professional regulators.

## United Kingdom

Health care in the United Kingdom is managed by the National Health Service (NHS). A centralized patient safety function is carried out by the NHS Commissioning Board Special Health Authority, which recently took over the role from the National Patient Safety Agency (National Patient Safety Agency, 2012). In 2004, the National Patient Safety Agency published *Seven steps to patient safety: A guide for NHA staff*. Although it does not specifically use the term ‘just culture,’ the guide promotes the development of an open, fair, and non-punitive safety culture in NHS organizations (National Patient Safety Agency [NPSA], 2004, p.9). The guide also provides “action points” for organizations and teams to promote a non-punitive safety culture. These action points include:

- Having policies that are clear about roles, responsibilities, and processes following an incident;
- Using a safety assessment survey in the organization;
- Ensuring colleagues are encouraged to talk about and report incidents; and,
- Demonstrating that reports are treated fairly and used to improve patient safety (NPSA, p.9).

The National Patient Safety Agency also developed an electronic decision tree tool to guide managers in determining whether discipline is appropriate following an event (NPSA, 2004, p.10). A “root cause analysis” tool and training are also available to guide staff in investigating incidents in a systems-focused manner (NPSA, p.19).

Aside from providing the tools and guides mentioned above, it does not appear that ‘just culture’ is perceived as a stand-alone priority for health care in the United Kingdom. Rather, the just culture approach is subtly embedded within other initiatives, such as the development of a broader ‘safety culture’ and the utilization of patient safety-related data (NHS, n.d.).

## Australia

Health care in Australia is the responsibility of the state governments. Most of the states have made the development of a just culture a strategic priority in their safety, quality, and governance agendas (New South Wales Department of Health, 2005, p.10; Victorian Government Department of Human Services, 2008, p.2; Government of South Australia Department of Health, 2006, p.26). Of all the states, South Australia demonstrates the most concrete commitment to a just culture. The South Australia *Safety and Quality Framework and Strategy 2007-2011* requires all health organizations to articulate their approach to implementing a safe and just culture in policy and procedure (Government of South Australia Department of Health, p.26). Organizations’ commitment to a safe and just culture must also be included in a quality improvement plan (Government of South Australia Department of Health, p.90). However, there are no specific requirements for what an organization must do to support a just culture other than commit to supporting it in policy documents.

Based on publicly available resources, there is no indication that Australian health departments have a clear implementation strategy for developing a just culture<sup>7</sup>. For example, the search did not reveal any ‘toolkits’ or education modules. Although Australian governments appear to acknowledge the importance of a just culture, it is not clear whether this commitment has been supported by the necessary resources and whether any department has been able to achieve a just culture.

---

<sup>7</sup> Sources searched include the journal databases, Google, Department of Health web sites, and quality council websites in Australia.

## CURRENT BC POLICIES AND PROGRAMS

### Health Authority Policies

All health authorities in BC have incident management policies that include a commitment to a just culture. However, there is significant variation between the health authorities in regard to how explicitly a just culture is incorporated into policy and the extent of procedures and supports that are given to achieving a just culture. A summary chart of health authority policies is provided in Appendix B.

In Fraser Health Authority, Interior Health Authority, and Vancouver Island Health Authority, a stated commitment to a just culture is the sole way that just culture approaches are explicitly incorporated in their policies. Northern Health Authority, Vancouver Coast Health Authority, and Provincial Health Services Authority take this commitment further by providing additional details about *how* a just culture is supported in the organization. For example, Vancouver Coastal Health Authority explains who is in charge of determining accountability, and Provincial Health Services Authority explains that a separate performance review will occur when a provider has acted recklessly, with intent to harm, when impaired, or with willful deviation from policies/standards. Fraser Health Authority, Vancouver Coastal Health Authority, and Provincial Health Services Authority all use a decision tree to support the process of assigning accountability. In addition, the Provincial Health Services Authority commits to providing education and training to develop non-punitive interpersonal skills.

Although there is room to improve health authority policies to bring them more in line with the best practices identified in the literature review and cross jurisdictional scan, the current policies indicate that further development of a just culture in BC would not require a drastic shift in mentality for health authority executives. Rather than focusing on getting buy-in for the concept, further work on developing a just culture could focus primarily on enhancing the impact of a just culture by ensuring providers and management have the knowledge, skills, tools, and support they need to put just culture concepts into practice.

### Professional College Policies

As discussed in an earlier section, the Royal College of Physician and Surgeons of Canada has incorporated just culture into a broader initiative to promote safety competencies in medical education (Royal College, 2011). At a provincial level, the College of Registered Nurses of BC has recently acknowledged the importance of a just culture in a publication titled *Underlying Philosophies and Trends Affecting Professional Regulation* (Bayne, 2012). The document includes a section on just culture that explains what a just culture is and links it to a proactive approach to professional regulation (Bayne, p.11; College of Registered Nurses of BC, 2012). However, it appears that the just culture approach is fairly new thinking to the College of Registered Nurses of BC, as it is not mentioned elsewhere on the web site and is not explicitly reflected in the programs and tools available to registrants.

A review of the web sites of other major professional colleges in BC (the College of Physicians of Surgeons of BC, the College of Pharmacists of BC, and the College of Licensed Practical Nurses of BC) revealed no mention of just culture.

## **Patient Safety Learning System**

British Columbia has a province-wide electronic incident reporting system in place called the Patient Safety Learning System (PSLS). When the PSLS was pilot tested in 2004, it showed evidence of increasing the willingness of staff to report incidents and improving the effectiveness of managers in following-up on incidents and determining the contributing factors in the incident (Cochrane, Taylor, Miller, Hait, Matsui, Bharadwaj and Devine, 2009, p.151). The pilot test was followed by the provincial roll-out of the PSLS, which was completed in 2011 (PSLS, n.d.[a]).

The PSLS was designed to both receive incident reports and facilitate managers' ability to follow up on reports. The system allows managers to create, assign, and track actions for improving safety in response to incident reports [PSLS, n.d.[b]]. In addition, managers can generate customized reports that show data trends and indicate areas needing particular attention (PSLS, n.d.[b]). In all aspects, the PSLS is designed as a safety improvement tool rather than an accountability tool. The PSLS and its training resources are focused around encouraging and supporting a safety culture that treats providers fairly and justly after a patient safety incident (PSLS, n.d.[a]). As such, the PSLS is already aligned with a just culture approach and eliminates the need for the Ministry to develop an incident reporting system before pursuing just culture work further.

## **Culture Surveys**

Health authorities in BC conduct a survey of organizational patient safety culture every four years as part of the accreditation process through Accreditation Canada. Accreditation Canada's patient safety culture survey includes several questions regarding how patient safety incidents are handled and whether providers face negative consequences for making an error. Although these patient safety culture surveys cannot isolate the effect of developing a just culture approach from other measures to improve safety culture, it could nonetheless be used as a valuable indicator of whether the work to develop a just culture is having a positive effect in the health authorities.<sup>8</sup>

## **Section 51 of the Evidence Act**

In BC, the confidentiality of quality assurance information is protected under Section 51 of the *Evidence Act*. Section 51 ensures that the discussion and analysis of medical staff committees and specially constituted quality committees cannot be released in legal proceedings. Committees included in Section 51 protection are commonly those in charge of conducting investigations following patient safety incidents. Therefore, legislated protection of safety data as suggested by Dekker is already in place in BC.

---

<sup>8</sup> Information regarding Accreditation Canada's patient safety culture survey is not available publicly, but is known to the researcher through her position as a policy analyst in the Patient Safety and Care Quality Branch at the Ministry of Health.

## TELEPHONE INTERVIEWS

The two telephone interviews conducted for this project provided an opportunity to bring a BC-focused perspective to the research. The two interviewees were able to comment on their organization's experience with developing and implementing a just culture policy and the challenges and opportunities that that went along with their efforts.

### Leadership Support

Both interviewees highlighted the importance of leadership support in developing a just culture. One interviewee stated that the organization's leadership must 'walk the talk' for providers to feel confident in the organization's commitment to a just culture. Further, the interviewee stated that it is not enough for leadership to communicate to staff that the organization has a just culture policy in place. Leaders must continue to have the conversation about just culture and use examples to demonstrate to providers where it has been demonstrated in action.

Both interviewees indicated that initial efforts to develop a just culture were driven by the quality and safety department, but that it was not difficult to obtain executive support because the organizations' executives were already engaged with the systems approach to patient safety incidents. Explicitly supporting a just culture was seen as a natural extension of the organizations' existing efforts to improve patient safety. One interviewee commented on the importance of embedding just culture with an overall safety culture where every individual feels a duty to report hazards and contribute to safety. The interviewee feels it is beneficial to advance just culture as part of an interrelated set of safety policies rather than isolate it from other patient safety initiatives. This comment was echoed by the other interviewee.

### Role of Policy

Consistent with the findings of the literature review, both interviewees commented that a just culture policy is a necessary but not sufficient way to develop a just culture in an organization. One interviewee admitted to being "naively optimistic" about how much a policy would accomplish. Both interviewees remarked that a policy is a good signal of the organization's support for a just culture and that it is a valuable foundation for further efforts. However, the interviewees acknowledged that education and communication about just culture have the greatest impact on front-line providers and managers.

Both of the interviewees' organizations include a decision tree in their policy, and the interviewees indicated that the decision tree is a helpful tool. One interviewee stated that the decision tree is particularly helpful when talking to physician leaders about just culture. The other interviewee noted that the decision tree is a helpful reference guide, but that it is not the key focus of the organization's just culture policy. Rather, the focus of the policy on the principles behind just culture and ensuring that a non-blaming communication style is consistently used when reporting and analyzing a patient safety incident.

## **Education and Communication**

Both interviewees stated that education and communication was (and is) an important part of their organization's just culture journey. One interviewee provided several specific examples of the organization's educational initiatives relating to just culture. The examples include:

- Incorporating a “coach approach” in the training program for new managers, so that managers learn how to talk to providers in a non-blaming way;
- Incorporating just culture and other safety concepts into orientation materials;
- Developing a “patient safety handbook” for providers that addresses key patient safety topics such as just culture and patient disclosure; and,
- Using the national Patient Safety Week and the organization's accreditation process as opportunities to talk to providers about the organization's just culture policy and the safety improvements that have resulted from reported events.

The other interviewee indicated that the organization leveraged the PSLS training process to highlight just culture concepts and the importance of reporting patient safety incidents and near misses. However, this training occurred several years ago and the interviewee acknowledged that it would be beneficial to reinvigorate communication about just culture.

Both interviewees mentioned that preparing for the organization's accreditation process is a good opportunity to raise awareness with providers about just culture. Part of the accreditation process involves conducting the patient safety culture survey. The interviewees noted that the patient safety culture survey provides the organization with valuable data about the organization's safety culture, while at the same time starting a conversation within the organization about safety culture. This conversation about safety culture is perceived by the interviewees as a good opportunity to raise awareness about just culture and have a conversation with providers about the just culture approach in the organization.

## **Key Challenges**

The interviewees remarked that the biggest challenge with developing a just culture is to make it resonate with front line managers and providers in a way that genuinely triggers a culture change. Since it inevitably takes times for an organization's culture to change, one interviewee emphasized the need for patience and persistence, particularly with the ‘slow adopters’ in the organization.

One of the interviewees relayed an anecdote that provides insight on a challenge not mentioned in the literature review. According to the interviewee, several years ago a specific incident occurred in which systemic issues were identified as the primary cause, and as such the provider involved was not punished. However, a family member of the affected patient demanded to know why the provider involved was not fired. The patient then took the story to the media, which echoed the demand for the provider to be fired. The situation was then raised in the Legislature, where Opposition politicians (and subsequently the Minister of Health) again put pressure on the health authority to defend its decision to not fire the provider. It was after this high profile case, in which the health authority was forced to vigorously defend its actions, that the health authority decided to create an explicit, stand-alone just culture policy.

The lesson from this anecdote was echoed by the other interviewee as well, who indicated that if the Ministry is going to push the health authorities to enhance a just culture, the Ministry also needs to ‘walk the talk’ and support the health authorities in their just culture approach to patient safety incidents.

## RECOMMENDATIONS FOR DEVELOPING A JUST CULTURE IN BC

### Proposed Policy

Current health authority policies indicate that a just culture approach is familiar and would not require a substantial departure from the current perspective on incident management. However, there is significant variation between the health authorities in the degree to which a just culture approach is embedded in the organization. There is room for improvement in the consistency of just culture policies across the health authorities and in enhancing the role and impact of a just culture approach. To accomplish this, it is recommended that the Ministry issue a provincial Policy Communiqué to the health authorities to ensure that health authority policies include certain key features of a just culture approach as identified by this research. The proposed policy is provided in Appendix C. The proposed policy includes requirements to:

- Update incident management policies to describe a consistent and confidential incident management process that involves the impacted provider in the analysis;
- Determine culpability through the use of a decision support tool, whereby a provider's peers are involved in evaluating the provider's behavioural choices through the eyes of the provider at the time, without emphasis on the extent of harm that occurred<sup>9</sup>;
- Continue to participate in and support the Patient Safety Learning System;
- Ensure all organizational policies (such as human resource policies) are consistent with a just culture approach;
- Develop an interdisciplinary team and communication strategy to spread knowledge and support for a just culture in the organization; and,
- Integrate just culture into patient safety education and communication materials.

The proposed policy will establish minimum standards that the health authorities must follow to support a just culture while providing the health authorities with flexibility in exactly how their policies are crafted. Providing flexibility is desirable because each health authority structures their policies documents in different ways. For example, Vancouver Island Health Authority has a single incident management policy, Vancouver Coastal Health Authority has an incident management policy and a stand-alone just culture policy, and Northern Health Authority embeds a just culture approach in three separate incident management documents (a policy, a guideline, and a procedure). Since the literature gives no indication that one of these policy structures is preferable to another, it is sufficient to require the health authorities to revise their current policies to include additional aspects of a just culture approach. The alternative option, to require health authorities to adopt a provincial template policy, would be overly prescriptive and potentially create unintended consequences as it would not adapt to variations in health authority organizational structures.

---

<sup>9</sup> The peers must be required to keep all information about the incident analysis confidential, and when possible the provider's identity should not be revealed to the peers. Although it may be beneficial to involve more than one peer in this process, the total number of peers involved should be limited in order to protect the provider's privacy.

For some health authorities, the proposed policy will not require substantial changes to existing policies. For other health authorities, the changes may need to be more substantial and require alterations in existing processes for incident management. Given the existing support for a just culture approach (in principle), it is not likely that the health authorities will strongly object to any of the required standards for incident management policies and process for determining culpability.

A larger concern for the health authorities regarding the proposed policy will likely be the implementation requirements, such as developing an interdisciplinary team and updating education materials. One challenge for the health authorities may be insufficient manager and provider capacity to undertake these activities. Another concern may be that there are already too many issues and topics competing for the attention of providers through education initiatives and corporate communications. Although these are legitimate concerns, the literature indicates that these elements are crucial for successfully developing a just culture and are worthy of the time and effort required.

To help mitigate the anticipated concerns of the health authorities, the Policy Communiqué allows health authorities to incorporate just culture within existing patient safety education programs, training materials, and communications, rather than requiring completely new training and education initiatives to be developed. This approach requires less ongoing cost and manager time, and is consistent with the interviewees' comments that just culture should be integrated with other patient safety concepts. The health authorities could also choose to collaborate on the development of communication and education materials in order to reduce duplication of effort. Although the implementation requirements of the proposed policy will require a time commitment from health authority staff, it is not anticipated that they will require new budget allocations or resources at this time.

The proposed policy establishes timelines within which the health authorities must comply with the policy. Consistent with past Policy Communiqués issued by the Ministry, the health authorities will have six months to update their incident management policies. A longer timeline of one year is provided for the health authorities to complete the implementation requirements and provide the Ministry with documentation of actions taken. This timeline was selected in recognition that the health authorities have other initiatives underway and there is limited staff capacity to dedicate to just culture work.

As indicated in the literature review, cross-jurisdictional scan, and interviews, revising policy is a necessary but not sufficient way to develop a just culture in an organization. The proposed Policy Communiqué therefore addresses not only policy but additional activities the health authorities must undertake to develop a just culture. However, the health authorities are not the only ones who have a role to play in developing a just culture in the BC health care system. The Ministry can play a substantial role in facilitating this process and bringing together other stakeholders in the development of a just culture.

### **Recommendations for the Ministry**

Although the health authorities have the most direct influence on the development of a just culture, the Ministry is well positioned to facilitate additional activities in the province to

ensure that a just culture is consistently fostered throughout the health system. Recommendations for the Ministry are provided in Table 5.

*Table 5: Recommendations for the Ministry*

|  |
|--|
| 1. Issue the Communiqué after seeking endorsement/approval from the Health Operations Committee, Physician Quality Assurance Steering Committee, and Deputy Minister.  |
| 2. Engage with the BC Patient Safety and Quality Council to investigate opportunities for the Council to support developing a just culture in the health authorities (for example, through the annual Quality Forum, educational webinars, etc).   |
| 3. Engage with the major professional regulatory bodies in BC to encourage them to adopt a just culture approach to professional discipline.   |
| 4. Conduct quarterly teleconference meetings with the advisory group for one year to provide an opportunity for the health authorities to share knowledge and talk about progress, challenges, and successes. After one year, maintain just culture as an ongoing topic within another provincial quality committee, such as the Health Quality Network or Risk Management Committee, in order to continually identify opportunities to strengthen just culture in BC. |
| 5. Monitor just culture developments in other provinces, particularly Alberta, and look for opportunities to share knowledge, policies, and lessons learned.   |
| 6. Raise awareness about just culture within the Ministry and integrate a just culture approach in Ministry projects and initiatives wherever appropriate. In particular, ensure that a just culture approach is evident in the work relating to Physician Quality Assurance.  |
| 7. Use existing sources of data, such a patient safety culture surveys and incident reporting rates, to evaluate whether the work to develop a just culture is correlated with improvements in reporting rates and provider perceptions of safety.   |

In addition to issuing the Policy Communiqué, the Ministry can attempt to leverage the roles of the BC Patient Safety and Quality Council and major professional colleges such as the College of Physician and Surgeons of BC and the College of Registered Nurses of BC to support a just culture approach through their own policies, programs, and educational programs. Getting these organizations engaged in the just culture approach will ensure that providers hear a consistent message about just culture from multiple sources.

The Ministry can ensure that developing a just culture remains an area of focus in the province by facilitating provincial stakeholder meetings to share progress and lessons learned. The Ministry can also facilitate information sharing at the provincial level by monitoring the policies of other provinces as they are developed. In particular, when Alberta concludes its work on just culture there may be opportunities to share information and experiences between the provinces. The BC stakeholder group could potentially have a direct role in this information exchange.

Another key role for the Ministry is to ensure that all Ministry policies and initiatives are consistent with a just culture. In particular, the Ministry's Physician Quality Assurance

initiative, which aims to develop a robust performance management system for physicians, could potentially undermine a just culture approach if it takes an overly punitive focus on physician performance. The Patient Safety and Care Quality branch should work closely with the Physician Quality Assurance initiative to ensure that the initiative is consistent with a just culture approach.

Lastly, the Ministry can monitor data indicators such as patient safety culture survey results and incident reporting rates to evaluate whether or not efforts to develop a just culture have been successful. This data can potentially help the Ministry determine whether additional efforts are needed to develop a just culture or whether current efforts are sufficient. The patient safety culture survey data may be most instructive because it addresses how providers perceive the organization's culture. Incident reporting rates can complement the culture survey data by indicating whether provider perception of safety culture translates into greater willingness to report incidents. In the short and middle term, an increasing reporting rate of low- and no-harm patient safety incidents could indicate that providers feel safer and more encouraged to report incidents that in the past they would attempt to conceal. Over the long term, a decreasing reporting rate may be desirable to indicate that the organization has been able to translate learning opportunities into a lower incidence of patient safety incidents.

There are limits to the usefulness of these data sources that should be kept in mind. The data cannot isolate the effects of just culture work from other activities that may simultaneously affect patient safety culture or incident reporting. Therefore, the data can establish a correlation with the just culture work, but cannot conclusively determine whether just culture is the cause of changes in data trends. In addition, the patient safety culture survey is only conducted every four years, so it cannot necessarily provide data in a timely manner.

These recommendations are intended to be manageable in scope so that they can be pursued within the existing resource allocations of the Patient Safety and Care Quality branch. When combined with the requirements of the proposed Policy Communiqué, the recommendations will enhance provincial consistency and commitment to developing a just culture.

### **Limitations**

There are several limitations to the recommendations presented in this report that are worth noting. These recommendations are based on the available literature and experiences of jurisdictions and organizations that have first-hand experience in pursuing a just culture. They reflect best practices as currently known but have not been vetted through the BC health authorities, and as such do not have stakeholder endorsement. Stakeholder consultation may be pursued by the Ministry outside of the scope of this project.

In addition, it should be noted that the current literature on just culture is based on theory only. No quantitative studies have been published to substantiate the claim that a just culture results in a safer health care system. Despite the lack of quantitative evidence to support the efficacy of developing a just culture, patient safety experts consistently support a just culture and systems-focus approach to patient safety.

## CONCLUSION

Developing a ‘just culture’ is increasingly viewed by patient safety experts as a crucial component of improving patient safety. A just culture recognizes that it is unrealistic to expect perfection and that punishing providers for every mistake does not improve the safety of the health care system. A just culture encourages a non-punitive approach that nevertheless attempts to draw a line between blameless and blameworthy behaviour.

Many health care organizations in BC, Canada, and other countries have demonstrated their support for a just culture through position statements, white papers, strategic frameworks, and policy documents. The organizations that appear most successful in developing a just culture are those that have a committed leadership team and complement a just culture policy with education and communication initiatives.

BC is well-positioned to pursue further development of a just culture in the health system. Several health authorities already have robust just culture policies and education initiatives in place, and these efforts are complemented by a provincial reporting system for patient safety incidents and legislation that protects the confidentiality of quality reviews. The recommendations presented in this report provide the Ministry with a strategy for further enhancing the focus on a just culture in the BC health system.

Although a just culture approach is embraced by patient safety experts, those who are less familiar with a systems approach to patient safety incidents may struggle to understand why a provider was not fired after a serious patient safety incident. This may cause the health authorities and Ministry to feel pressured by patients, the public, and the media to bend to a punitive approach. In the face of these pressures, it becomes even more important for the Ministry and health authorities to consistently and firmly stand by a just culture approach.

Because it takes time for a culture shift to take place, the Ministry should continually look for opportunities to enhance awareness of a just culture approach and evaluate whether efforts to develop a just culture are successfully contributing to a safer health system. Engaging as many health system stakeholders as possible in the just culture journey will help make just culture a natural and inextricable part of people’s perception of patient safety incidents. A just culture will only truly develop when providers and managers see, hear, and experience a consistent message about just culture from the health authorities, the Ministry, professional bodies – and each other.

## REFERENCES

- American Nursing Association. (2010). *Just Culture Position Statement*. Retrieved from <http://nursingworld.org/psjustculture>
- Baker, G.R., Norton, P.G., Flintoft, V., Blais, R., Brown, A., Cox, J. Etchells, E., Ghali, W., Hébert, P., Majumdar, S.R., O'Beirne, M., Palacios-Derflingher, L., Reid, R.J., Sheps, S., & Tamblyn, R. (2004). The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada. *Canadian Medical Association Journal*, 170(11), 1678-1686.
- Bayne, L. (2012). *Underlying Philosophies and Trends Affecting Professional Regulation*. College of Registered Nurses of British Columbia. Retrieved from [https://crnbc.ca/crnbc/Documents/783\\_framework.pdf](https://crnbc.ca/crnbc/Documents/783_framework.pdf)
- BC Patient Safety and Quality Council. (2010). *An Introduction to Human Factors* (Presentation). Retrieved from <http://bcpsqc.ca/knowledge/an-introduction-to-human-factors/>
- Burhans, L.D., Chastain, K., & George, J.L. (2012). Just Culture and Nursing Regulation: Learning to Improve Patient Safety. *Journal of Nursing Regulation*, 2(4), 43 - 49.
- Calgary Health Region. (2006). *Just and Trusting Culture Policy*. Retrieved from [http://www.calgaryhealthregion.ca/policydb/ShowPolicy?policy\\_id=1628](http://www.calgaryhealthregion.ca/policydb/ShowPolicy?policy_id=1628)
- Canadian Medical Protective Association. (n.d.). *About the CPMA*. Retrieved from [http://www.cmpa-acpm.ca/cmpapd04/docs/about\\_cmpa/com\\_about\\_cmpa-e.cfm](http://www.cmpa-acpm.ca/cmpapd04/docs/about_cmpa/com_about_cmpa-e.cfm)
- Canadian Medical Protective Association. (2009). *Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions*. Retrieved from [http://www.cmpa-acpm.ca/cmpapd04/docs/submissions\\_papers/pdf/com\\_learning\\_from\\_adverse\\_events-e.pdf](http://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/pdf/com_learning_from_adverse_events-e.pdf)
- Canadian Patient Safety Institute. (2012a). Homepage. Retrieved from <http://www.patientsafetyinstitute.ca/English/Pages/default.aspx>
- Canadian Patient Safety Institute. (2012b). Canadian Incident Analysis Framework. Retrieved from <http://www.patientsafetyinstitute.ca/English/toolsResources/IncidentAnalysis/Pages/default.aspx>
- Canadian Patient Safety Institute. (2012c). *Incident Analysis Learning Program*. Retrieved from <http://www.patientsafetyinstitute.ca/English/news/IncidentAnalysisLearningProgram>

- Cochrane, D.D. (2011). Investigation into Medical Imaging, Credentialing, and Quality Assurance: Phase 2 Report. Retrieved from <http://www.health.gov.bc.ca/library/publications/year/2011/cochrane-phase2-report.pdf>
- Cochrane, D., Taylor, A., Miller, G., Hait, V., Matsui, I., Bharadwaj, M., & Devine, P. (2009). Establishing a Provincial Patient Safety Learning System: Pilot Project Results and Lessons Learned. *Healthcare Quarterly*, 12(Sp), 147-153.
- College of Registered Nurses of British Columbia. (2012). *How CRNBC works as a regulator*. Retrieved from <http://crnbc.ca/crnbc/Announcements/2012/Pages/WorkingasaRegulator.aspx>
- Conner, M., Duncombe, D., Barclay, E., Bartel, S., Borden, C., Gross, E., Miller, C., Ponte, P.R. (2007). Creating a Fair and Just Culture: One Institution's Path Toward Organizational Change. *The Joint Commission Journal on Quality and Patient Safety*, 33(10), 617 - 624.
- Dekker, S. (2007). *Just Culture: Balancing Safety and Accountability*. Burlington, VT: Ashgate.
- European Regions Airline Association. (2006). *Just Culture Policy*. Retrieved from [http://www.eraa.org/docman/doc\\_view/231-star-008-just-culture?tmpl=component&format=raw](http://www.eraa.org/docman/doc_view/231-star-008-just-culture?tmpl=component&format=raw)
- Flemons, W.W., Eagle, C.J., & Davis, J.C. (2005). Developing a Comprehensive Patient Safety Strategy for an Integrated Canadian Healthcare Region. *Healthcare Quarterly*, 8, 122 - 127.
- Flemons, W., Davies, J., Wright, D., Mikkelsen, A., & Harvie, M. (2010). Patient safety principles: definitions, descriptions, and rationale. Calgary: Health Quality Council of Alberta.
- Frank, J.R. & Brien S. (Eds) on behalf of The Safety Competencies Steering Committee. (2008). *The Safety Competencies: Enhancing Patient Safety Across the Health Professions*. Ottawa, ON: Canadian Patient Safety Institute.
- Frankel, A. S., Leonard, M. W., & Denham, C. R. (2006). Fair and Just Culture, Team Behavior, and Leadership Engagement: The Tools to Achieve High Reliability. *Health Services Research*, 41(4P2), 1690-1709.
- Gorzeman, J. (2008). Balancing Just Culture with Regulatory Standards. *Nursing Administration Quarterly*, 32(4), 308 - 311.
- Government of South Australia Department of Health. (2006.) *Safety and Quality Framework and Strategy 2007-2011*. Retrieved from <http://www.publications.health.sa.gov.au/cgi/viewcontent.cgi?article=1037&context=pp>

- Health Quality Council of Alberta. (2012). *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy*. Retrieved from <http://www.hqca.ca/assets/files/EDCAP%20FINAL%20REPORT.pdf>
- Institute of Medicine (2000). *To err is human: building a safer health system*. L.T. Kohn, J.M. Corrigan, & M.S. Donaldson (Eds). Washington, DC: National Academy Press.
- Khatri, N., Brown, G.D., & Hicks, L.L. (2009). From a blame culture to a just culture in health care. *Health Care Management Review*, 34(4), 312 - 322.
- Leape, L.L. (October 8, 1997). Testimony before the Subcommittee on Health of the Committee on Veterans' Affairs. *House of Representatives*, 105<sup>th</sup> Congress, First Session.
- Marx, D. (2001). Patient Safety and the "Just Culture": A Primer for Health Care Executives. Columbia University and the National Heart, Lung, and Blood Institute. Retrieved from <http://www.unmc.edu/rural/patient-safety/tools/Marx%20Patient%20Safety%20and%20Just%20Culture.pdf>
- Marx, D. (2009). *Whack-a-Mole: The Price We Pay for Expecting Perfection*. Plano, TX: By Your Side Studios.
- Mayer, C. M., & Cronin, D. (2008). Organizational Accountability In a Just Culture. *Urologic Nursing*, 28(6), 427-430.
- Minnesota Alliance for Patient Safety. (n.d.). *MAPS Toolkit to Create a Learning, Just, and Accountable Culture*. Retrieved from <http://www.mnpatientsafety.org/files/pdfs/maps-just-culture-provider-implementation-toolkit.pdf>
- Minnesota Alliance for Patient Safety. (2005). "Just Culture" Certification Training. Retrieved from: <http://www.mnpatientsafety.org/files/pdfs/963500.pdf>
- Ministry of Health. (2011, September 11). *News Release: Action Plan to Protect Patient Safety Unveiled*. Retrieved from [http://www2.news.gov.bc.ca/news\\_releases\\_2009-2013/2011HLTH0068-001211.htm](http://www2.news.gov.bc.ca/news_releases_2009-2013/2011HLTH0068-001211.htm)
- National Health Service. (n.d.) *Patient Safety*. Retrieved from <http://www.nrls.npsa.nhs.uk/>
- National Patient Safety Agency. (2012). *Transfer of Patient Safety function to the NHA Commissioning Board Special Health Authority*. Retrieved from <http://www.npsa.nhs.uk/corporate/news/transfer-of-patient-safety-function/>
- National Patient Safety Agency. (2004). *Seven steps to patient safety: A guide for NHA staff*. Retrieved from [http://www.clinicalgovernance.scot.nhs.uk/section5/documents/sevensteps\\_overview.pdf](http://www.clinicalgovernance.scot.nhs.uk/section5/documents/sevensteps_overview.pdf)

- New South Wales Department of Health. (2005). *Policy Directive: Patient Safety and Clinical Quality Program*. Retrieved from [http://www0.health.nsw.gov.au/policies/pd/2005/pdf/PD2005\\_608.pdf](http://www0.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_608.pdf)
- Outcome Engenuity. (2013a). *Who We Are*. Retrieved from <http://www.outcome-eng.com/who-we-are/about/>
- Outcome Engenuity. (2013b). *The North Caroline Just Culture Journey* (Video). Retrieved from <http://legacy.justculture.org/Misc1.aspx>
- Parker, D., Lawrie, M. & Hudson, P. (2006). A framework for understanding the development of organizational safety culture. *Safety Science*, 44, 551 - 562.
- Patient Safety Learning System (n.d.[a]). *BC PSLs across the province*. Retrieved from <http://www.bcpsls.ca/WhatsNew/BCPSLSacrosstheprovince/default.htm>
- Patient Safety Learning System (n.d.[b]). *Handler Resources*. Retrieved from <http://www.bcpsls.ca/HandlerResources/default.htm>
- Reason, J. (2000). Human error: models and management. *British Medical Journal*, 320, 768 - 770.
- Reason, J. (2007). *Managing the Risks of Organizational Accidents*. Burlington, VT: Ashgate.
- Royal College of Physicians and Surgeons of Canada. (2011). *Just Culture of Patient Safety. Competence by Design: Royal College White Paper Series*. Retrieved from [http://www.royalcollege.ca/portal/page/portal/rc/advocacy/educational\\_initiatives/competence\\_by\\_design](http://www.royalcollege.ca/portal/page/portal/rc/advocacy/educational_initiatives/competence_by_design)
- Shepard, L.H. (2011). Creating a Foundation for a Just Culture Workplace. *Nursing*, 41(4), 46-48.
- Victorian Government Department of Human Services. (2008). *Victorian clinical governance policy framework*. Retrieved from [http://docs.health.vic.gov.au/docs/doc/4C6559130DA88FD5CA257902000D5EFA/\\$FILE/clin\\_gov\\_pol\\_framework.pdf](http://docs.health.vic.gov.au/docs/doc/4C6559130DA88FD5CA257902000D5EFA/$FILE/clin_gov_pol_framework.pdf)
- Wachter, R.M. & Pronovost, P.J. (2009). Balancing "No Blame" with Accountability in Patient Safety. *The New England Journal of Medicine*, 361(14), 1401-1406.
- Weiner, J., Hobgood, C., & Lewis, M.A. (2008). The meaning of justice in safety incident reporting. *Social Science & Medicine*, 66(2), 403-413.
- World Health Organization. (2009). *Conceptual Framework for the International Classification for Patient Safety: Technical Report version 1.1*. Retrieved from [http://www.who.int/patientsafety/implementation/taxonomy/icps\\_technical\\_report\\_en.pdf](http://www.who.int/patientsafety/implementation/taxonomy/icps_technical_report_en.pdf)

## **APPENDIX A: INTERVIEW GUIDE**

- 1.** Can you please provide some background information on your organization's just culture policy, such as how long it has been in place and why your organization decided to implement it?
- 2.** What, if anything, has your organization done to support a just culture in addition to issuing the policy?
- 3.** What has been the biggest challenge with trying to develop a just culture in your organization?
- 4.** What do you think is the most important and valuable part of the just culture policy?
- 5.** How would you describe the impact that the policy has had in your organization?
- 6.** Is there anything that you wish your organization had done differently with the policy? If so, what?
- 7.** What, if anything, do you think could be done provincially to further enhance a just culture?
- 8.** Is there anything else you think I should know in the development of a provincial just culture policy?

## APPENDIX B: SUMMARY OF HEALTH AUTHORITY POLICIES

| Health Authority           | Policy Name(s)<br>(date last updated)   | Reference to Just Culture   | Tools and Procedures  |
|----------------------------|---|---|---|
| Fraser                     | Patients, Clients, and Residents Safety (2007)  | Just and trusting culture is an “underlying principle.” Commits to a “fair, supportive, and flexible” approach.   | None.   |
| Interior                   | Incident Management (2011)  | Commits to promoting a just and trusting culture of safety, evaluating systemic factors, and following a fair evaluative process.   | None.   |
| Northern                   | Disclosure of Adverse Events (2009)<br>Patient Safety Management System Policy, Guideline, and Procedure (2011) | Commits to promoting a just and trusting culture of safety, evaluating systemic factors, following a fair evaluative process, taking a non-punitive quality improvement approach, and avoiding a focus on provider error.   | Procedural document includes Reason’s decision tree.  |
| Provincial Health Services | Commitment to a Culture of Patient Safety (2012)<br>Non-Punitive Reporting (2012)                               | Commits to just treatment. Separate performance reviews occur when a provider has acted recklessly, with intent to harm, when impaired, or with willful deviation from policies/standards. Individual responsibility is assessed by manager/department head. Interviews must be conducted respectfully. | Uses a decision tree form the UK National Patient Safety Agency.<br>Commits to providing education and training to develop non-punitive interpersonal skills. |
| Vancouver Coastal          | Guidelines for a Just Culture (2012)<br>Management of Incidents Involving Patient/Clients (2003)                | Commits to a just culture and outlines seven principles of a just culture. Recognizes that mistakes will occur and commits to non-punitive investigations. Risk Management and the providers’ supervisor(s) determine accountability.   | Uses a decision tree adapted from Reason. Personal development plans are made when providers have engaged in at-risk behaviours.                              |
| Vancouver Island           | Incident Management (2012)  | Commits to a just and trusting culture.   | None.   |

## **APPENDIX C: PROPOSED JUST CULTURE POLICY**

### **POLICY OBJECTIVE**

- This policy is intended to promote a culture of patient safety by requiring a just and fair approach to safety analyses and incident reviews.

### **SCOPE**

- This policy applies to all health authorities and affiliate organizations.

### **DEFINITIONS**

- Just Culture: an atmosphere of trust created by balancing accountability with improving system safety, in which providers are treated fairly after a patient safety incident and empowered to contribute to safety improvements.
- Patient Safety Incident: an event or circumstance which could have resulted, or did result, in unnecessary harm to a patient.
- Provider: any health care worker or health care professional directly involved in patient care. Includes both employed staff and providers with site privileges.
- Substitution Test: a method for assessing the reasonableness of a provider's behavior by evaluating whether another provider in the same situation and with the same experience and qualifications would have behaved differently.

### **BACKGROUND**

- Patient safety incidents are most often the result of system-based contributing factors. In a complex environment such as health care, human error is often the symptom of broader issues within the design of the system.
- Improving patient safety requires a focus on identifying and correcting the conditions in the system that cause a provider to make an error or allow an error to result in harm to a patient.
- Opportunities for organizational learning and improvement are enhanced when providers feel safe and empowered to report patient safety incidents and near misses and actively participate in safety analysis.
- Treating providers in a fair and just manner after a patient safety incident will build trust between providers and management so that providers are willing to report patient safety incidents and participate in incident analysis.
- Fair and just treatment involves holding providers accountable for the quality of their choices, but not for system flaws that cause a provider to make a human error.
- It is neither fair nor just to punish all provider errors regardless of the origins or circumstance of the error.

### **POLICY**

- 1) Each health authority and affiliate shall include the following policy elements in its incident management and/or safety culture policies:
  - a) A clear and explicit commitment to a just and fair approach to managing patient safety incidents.
  - b) An incident analysis process that:

- i) Describes a consistent process for managing and analyzing patient safety incidents, so that providers will know what to expect after an incident;
  - ii) Protects the confidentiality of the persons involved in the incident and analysis<sup>10</sup>, so that an open and honest discussion about the incident can take place;
  - iii) Involves the impacted provider in the analysis of the incident, so that the provider can explain their perspective and be engaged in system improvement;
  - iv) Has a clear separation between incident analysis processes and performance review processes, so that provider trust in the incident analysis process is maintained; and,
  - v) Includes a mechanism for providing feedback about the results of the analysis to the person who reported the incident (within the confines of confidentiality), so that reporters know that reporting an incident is worthwhile and contributes to system improvement.
- c) A process for determining culpability that:
- i) Explains who is responsible for determining culpability after a patient safety incident;
  - ii) Links accountability to behavior choices rather than the extent of harm that occurs;
  - iii) Uses the decision support tool provided in Appendix 1 to guide the assessment of culpability;
  - iv) Requires the person(s) responsible for determining culpability to evaluate the quality of the provider's choices by viewing the situation through the eyes of the provider at the time, in order to reduce hindsight bias; and,
  - v) Commits to including one or more of the provider's peers in determining culpability via a substitution test.<sup>11</sup> Peers must be required to keep all information about the incident analysis confidential. If possible, the provider's identity should not be disclosed to the peers.
- d) All terminology and processes used throughout the policy must reinforce a just culture rather than a punitive, blame-based approach.
- 2) Each health authority and affiliate shall continue to support and participate in the provincial Patient Safety Learning System. The Patient Safety Learning System shall be used for quality improvement purposes and not for assigning accountability or blame.

## **IMPLEMENTATION**

- 3) Each health authority and affiliate organization shall review and update all human resources, patient safety incident, and risk management policies to resolve any conflicts with a just culture approach. An example of a conflicting policy would be to impose a mandatory suspension or financial penalty immediately after a patient safety incident (before an analysis of the incident has taken place).
- 4) Each health authority and affiliate shall develop an ongoing interdisciplinary team within the organization to develop strategies for spreading knowledge and support for just culture among the organization's managers and providers. The chair of the interdisciplinary team shall provide quarterly progress reports to the Board and/or a member of Senior Executive.

---

<sup>10</sup> Where possible, the analysis should take place within the legislated confidentiality protection provided by Section 51 of the *Evidence Act*.

<sup>11</sup> While it may be beneficial to include more than one peer in the substitution test, the total number of peers involved should be limited in order to protect the provider's privacy.

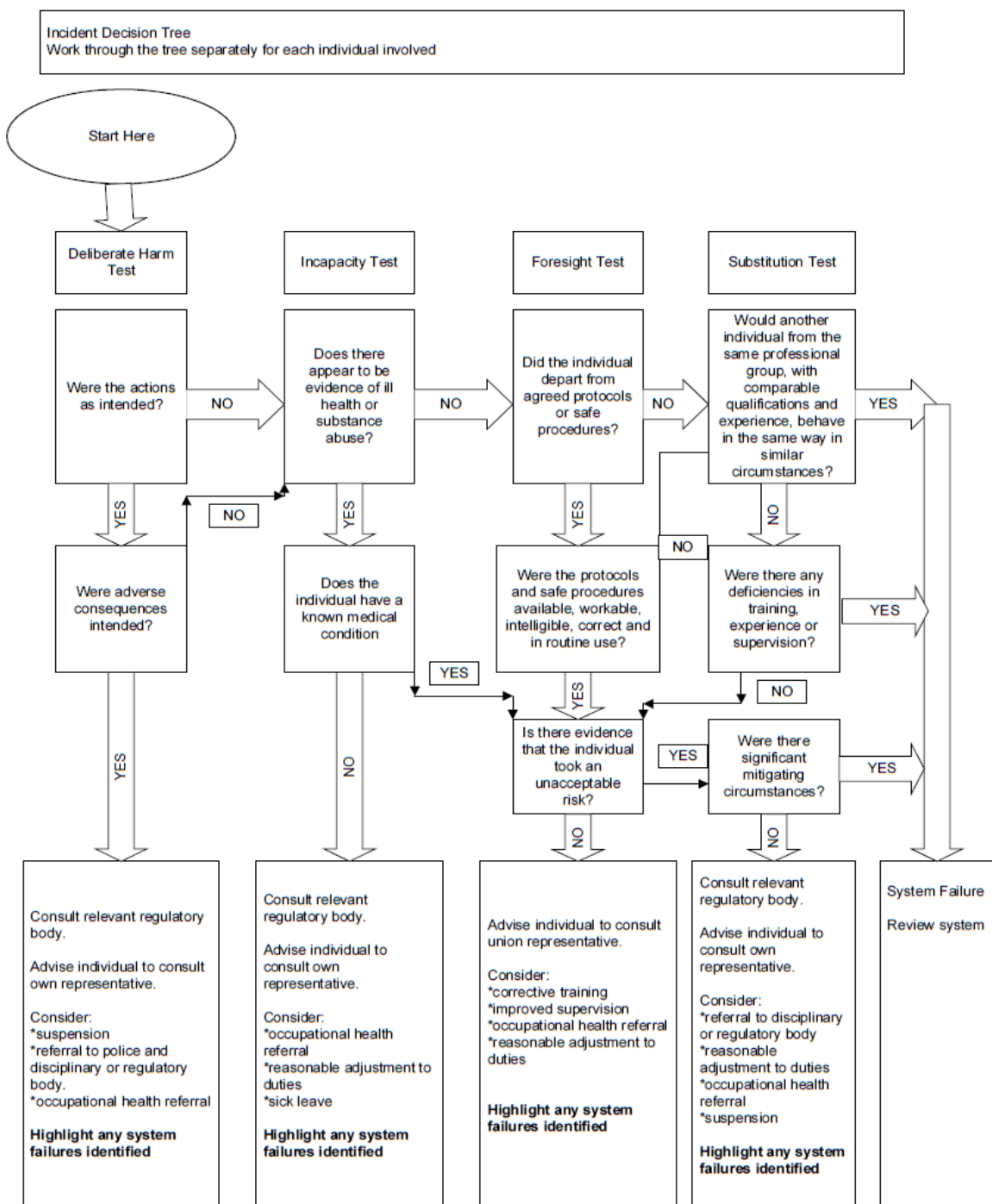
- 5) Each health authority and affiliate shall integrate just culture into its patient safety education and communication materials. At minimum, each health authority and affiliate must:
- a) Update new staff orientation materials to state the organization's commitment to a just culture and provide an overview of what a just culture means;
  - b) Address non-punitive communication skill development during manager training; and,
  - c) Periodically (at least once per year) integrate just culture and systems-approach concepts in an employee newsletter or similar publication, in order to raise awareness of the organization's commitment to a just culture and the positive change that results from incident reporting.

### **ACCOUNTABILITY**

- By [six months from issue date], each health authority must have a revised incident management and/or safety culture policy in place that complies with the requirements in the Policy section of this Communiqué.
- By [one year from issue date], each health authority must:
  - Have reviewed and updated all other organizational policies to ensure alignment with a just culture;
  - Convened the interdisciplinary team and develop a Terms of Reference for the team;
  - Have updated education and communication materials per section 5 of this Communiqué; and,
  - Provide the Ministry of Health with documentation of the above activities.
- Each health authority shall develop bi-annual reports from the Patient Safety Learning System to show the trend in the number of reported low- and no-harm incidents. These reports shall be provided to a member of the health authority's Senior Executive and the Ministry's Patient Safety Care Quality branch, in order to inform future decision making regarding just culture initiatives.

## Appendix 1

From the Provincial Health Services Authority, based on a framework developed by the UK National Patient Safety Agency



Based on original framework developed by the National Patient Safety Agency