# Position Statement

## *Just Culture*

**Effective Date:** January 28, 2010

**Status:** New Position Statement

**Originated By:** Congress on Nursing Practice and Economics

**Adopted By:** ANA Board of Directors

**Related Past Action:**

1. ANA Position Statement (2007): *Safety Issues Related to Tubing and Catheter Misconnections*
2. ANA Position Statement (2006): *Assuring Patient Safety: The Employers' Role in Promoting Healthy Nursing Work Hours for Registered Nurses in All Roles and Settings*
3. ANA Position Statement (2006): *Assuring Patient Safety: Registered Nurses' Responsibility in All Roles and Settings to Guard Against Working When Fatigued*
4. 2000 ANA House of Delegates Report Adopted: *Building Safe Health Care Systems for Informed Patients*

**Purpose:** The purpose of this position paper is to interpret the *Just Culture* concept and its application for nursing and health care in a variety of settings.

**Statement of ANA Position:** The American Nurses Association (ANA) supports the *Just Culture* concept and its use in health care to improve patient safety. The ANA supports the collaboration of state boards of nursing, professional nursing associations, hospital associations, patient safety centers and individual health care organizations in developing regional and state-wide *Just Culture* initiatives.

**History/Previous Position Statements:** This is the first ANA position on the *Just Culture* concept. In regard to patient safety, ANA has published the positions *Safety Issues Related to Tubing and Catheter Misconnections (2007), Assuring Patient Safety: The Employers' Role In Promoting Healthy Nursing Work Hours for Registered Nurses in All Roles and Settings (2006)*, and *Assuring Patient Safety: Registered Nurses' Responsibility in All Roles and Settings to Guard Against Working When Fatigued (2006).* ANA through its National Center for Nursing Quality has long been working with patient safety initiatives, including the National Database for Nursing Quality Indicators, Handle With Care Campaign, Safe Staffing Saves Lives Campaign, and its work with the National Quality Forum, the Joint Commission, and the National Priorities Partnership. The 2000 ANA House of Delegates adopted the report "Building Safe Health Care Systems for Informed Patients".

**Supportive Material:** In testimony before congress, Lucian Leape, MD, member of the Quality of Health Care in America Committee at the Institute of Medicine and adjunct professor of the Harvard School of Public Health, noted that "Approaches that focus on punishing individuals instead of changing systems provide strong incentives for people to report only those errors they cannot hide. Thus, a punitive approach shuts off the information that is needed to identify faulty systems and create safer ones. In a punitive system, no one learns from their mistakes" (Leape, 2000).

As an alternative to a punitive system, application of the *Just Culture* model*,* which has been widely used in the aviation industry, seeks to create an environment that encourages individuals to report mistakes so that the precursors to errors can be better understood in order to fix the system issues. The term "*Just Culture*" was first used in a 2001 report by David Marx (Marx, 2001), a report which popularized the term in the patient safety lexicon (Agency for Healthcare Research and Quality, n.d.).

Traditionally, healthcare's culture has held individuals accountable for all errors or mishaps that befall patients under their care. By contrast, a *Just Culture* recognizes that individual practitioners should not be held accountable for system failings over which

they have no control. A *Just Culture* also recognizes many individual or "active" errors represent predictable interactions between human operators and the systems in which they work. However, in contrast to a culture that touts "no blame" as its governing principle, a *Just Culture* does not tolerate conscious disregard of clear risks to patients or gross misconduct (e.g., falsifying a record, performing professional duties while intoxicated).

## Development of the *Just Culture* Concept

In 1997, John Reason wrote that a *Just Culture* creates an atmosphere of trust, encouraging and rewarding people for providing essential safety-related information. A *Just Culture* is also explicit about what constitutes acceptable and unacceptable behavior. Therefore a *Just Culture* is the middle component between patient safety and a safety culture (Reason, 1997). Marx argues that discipline needs to be tied to the behavior of individuals and the potential risks their behavior presents more than the actual outcome of their actions (Marx, 2001).

The *Just Culture* model addresses two questions: 1) What is the role of punitive sanction in the safety of our health care system and 2) Does the threat and/or application of punitive sanction as a remedy for human error help or hurt our system safety efforts? The model acknowledges that humans are destined to make mistakes and because of this no system can be designed to produce perfect results. Given that premise, human error and adverse events should be considered outcomes to be measured and monitored with the goal being error reduction (rather than error concealment) and improved system design (Marx, 2001).

In addition, the model describes three classes of human behavior that create predictability in error occurrence. The first is simple human error - inadvertently doing other than what should have been done. The second, at-risk behavior occurs when a behavioral choice is made that increases risk where risk is not recognized or is mistakenly believed to be justified. Finally, reckless behavior is action taken with

conscious disregard for a substantial and unjustifiable risk.

Under the *Just Culture* model, creating an open, fair and *Just Culture* relies on developing managerial competencies that appropriately hold individuals accountable for their behaviors, and investigates the behavior that led to the error. With regard to human error, managers console the individual, then consider changes in processes, procedures, training and design. At-risk behavior suggests the need for coaching and managing through removing incentives for at-risk behavior; creating incentives for healthy behaviors; and increasing situational awareness. With reckless behavior, it is necessary to manage through remedial action and/or punitive action (Marx, 2001).

Ultimately, the *Just Culture* model is about creating an open, fair and *Just Culture*, creating a learning culture, designing safe systems, and managing behavioral choices. The model sees events not as things to be fixed, but as opportunities to improve understanding of both system risk and behavioral risk. It is also about changing staff expectations and behaviors to ones such as looking for the risks in the environment; reporting errors and hazards; helping to design safe systems; and making safe choices, including following procedure; making choices that align with organizational values; and never signing for something that was not done.

To mitigate errors, Marx created the *Just Culture* Algorithm, a methodology for considering what a manager should do when a breach occurs and suggests actions to address the breach from both the system and employee perspective (Marx, 2008).

*Application to Nursing*

The American Nurses Credentialing Center (ANCC) has developed the *Five Model Components* for the Magnet Recognition Program® that reflect the focus of the healthcare organization on achieving superior performance as evidenced by outcomes. The components stress that outcomes of an infrastructure developed for excellence are essential to a culture of excellence and innovation, of which safety is a prime component. The components include Transformational Leadership; Structural

Empowerment; Exemplary Professional Practice; New Knowledge, Innovations and Improvements; and Empirical Outcomes (ANCC, 2008). Although not referred to as such, *Just Culture* is congruent with this model. Transformational Leadership conveys a strong sense of advocacy and support on behalf of staff and patients by all nursing leaders. Professional Engagement, one of the Sources of Evidence for this component, promotes structure and processes that enable nurses to actively participate in organizational decision making groups. This would allow staff to be integral in promoting a *Just Culture* environment. Exemplary Professional Practice promotes nurse control over staffing and scheduling processes and encourages that the nursing staff work in collaboration with their interdisciplinary partners to achieve high quality patient outcomes. The New Knowledge, Innovations and Improvements component establishes and implements effective, efficient care, which would include a culture of safety. A Magnet ® organization continually assesses and monitors the empirical measurements relative to nursing leadership and clinical practice.

The *Just Culture* concept correlates with nurses' critical thinking skills and the nursing process in determining the root cause of an error. Since nursing relies heavily on assessing a situation, diagnosing a problem, and creating a plan to improve or avoid that problem, the *Just Culture* concept is a natural fit for any environment where nursing care is delivered.

For staff nurses and students, the concept gives the opportunity to feel more at ease reporting problems, and a sense of accountability for system improvement. For nurse administrators and educators, the *Just Culture* concept represents an opportunity to improve care delivery systems for patients/individuals, and to improve the environment for those that work in that system, including nurses but extending to all others that work within it.

Intimidation and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more

professional environments. Safety and quality of patient care is dependent on teamwork, communication and a collaborative work environment. To ensure quality and promote a culture of safety, healthcare organizations must address the problem of behaviors that threaten the performance of the health care team. (Joint Commission, 2008).

All healthcare organizations should implement a zero tolerance policy related to disruptive behavior, including a professional code of conduct and educational and behavioral interventions to assist nurses in addressing disruptive behavior (Center for American Nurses, 2008).

The *Just Culture* concept establishes an organization-wide mindset that positively impacts the work environment and work outcomes in several ways. The concept promotes a process where mistakes or errors do not result in automatic punishment, but rather a process to uncover the source of the error. Errors that are not deliberate or malicious result in coaching, counseling, and education around the error, ultimately decreasing likelihood of a repeated error. Increased error reporting can lead to revisions in care delivery systems, creating safer environments for patients and individuals to receive services, and giving the nurses and other workers a sense of ownership in the process. The work environment improves as nurses and workers deliver services in safer, better functioning systems, and that the culture of the workplace is one that encourages quality and safety over immediate punishment and blame.

**Recommendations:**

1. That the ANA officially endorse the *Just Culture* concept as a strategy to reduce errors and promote patient safety in health care.
2. That the ANA promote and disseminate information about the *Just Culture* concept in ANA publications, through constituent member associations, and ANA affiliated organizations.

3. That the ANA promote the collaboration of state government, boards of nursing, all healthcare professional associations, and hospital and long term care associations in the development and implementation of *Just Culture* initiatives in each state.
4. That the ANA encourage continued research into the effectiveness of the *Just Culture* concept in improving patient safety and employee performance outcomes.
5. That nurse administrators in any level of oversight act on their dual role as representatives of nursing and stewards of the organization to promote safe systems in the spirit of *Just Culture* to promote safe patient outcomes and protect employees from failure.
6. That direct-care registered nurses advocate for the use of the *Just Culture* concept in their practice settings.
7. That educators incorporate *Just Culture* concepts into nursing curricula at every level, and adhere to the *Just Culture* concepts in the academic setting.
8. That ANA collaborate with other health care professionals to develop *Just Culture* joint statements.
9. That the ANA encourage all healthcare organizations to implement a zero tolerance policy related to disruptive behavior, including a professional code of conduct and educational and behavioral interventions to assist nurses in addressing disruptive behavior

**Summary:** For many years, the *Just Culture* concept has proved effective in error reduction and improvement in safety in aviation and other industries where errors have dire and sometimes catastrophic repercussions. The *Just Culture* concept is an ideal fit for health care systems, where errors have just as serious consequences. By promoting system improvements over individual punishment, a *Just Culture* in healthcare does much to improve patient safety, reduce errors, and give nurses and other health care workers a major stake in the improvement process.

Examples of *Just Culture* Initiatives in Health Care

*Federal and state initiatives*

The following are examples of efforts to incorporate and promote the *Just Culture* concepts into healthcare at the federal and state levels.

Veterans Affairs

The National Center for Patient Safety (NCPS) exists to improve the safe delivery of healthcare to America's veterans. The Department of Veterans Affairs National Center for Patient Safety was established to lead Veteran's Affairs (VA) patient safety efforts and to develop and nurture a culture of safety throughout the Veterans Health Administration. Its multi-disciplinary team is located in Washington, DC, Ann Arbor, MI, and White River Junction, VT. It offers expertise on an array of patient safety and related health care issues. Patient safety managers in all 154 VA hospitals actively participate in the program, as well as do patient safety officers in all 23 network headquarters. Internally, the NCPS provides employees with agency guidelines, directives, education, training, tools, products, initiatives, studies, publications, dialogue and conferences.

Minnesota

The Minnesota Alliance for Patient Safety (MAPS) provides a comprehensive active partnership among the Minnesota Hospital Association, the Minnesota Medical Association, the Minnesota Department of Health and more than 50 public-private health care organizations working together to improve patient safety. MAPS is governed by an executive committee, a steering committee, and subcommittees/task forces operating under a set of governing principles. MAPS published a statement of guidance and toolkit for health care organizations under the banner of *Just Culture*. It has also developed a statewide informed consent form and policy envisioning this form as Minnesota's universal documentation of informed consent, and that health care organizations statewide will use the informed consent form with no variation. MAPS

produced a My Medicine List wallet card, published in six languages, to enable consumers/individuals to carry clear notes on the medications they take (Minnesota Alliance for Patient Safety, n.d.).

North Carolina

The North Carolina Center for Hospital Quality and Patient Safety facilitates a collaborative of several state hospitals implementing the *Just Culture* in their facilities. The North Carolina Board of Nursing supports the "*Just Culture*" collaborative, and has a pilot project to partner with participating hospitals to promote consultation and discussion of events in a positive manner. The pilot will serve to assist employers in identifying events that can be addressed in the practice setting versus those that would benefit from board consultation. The purpose of the pilot project is to provide a mechanism for employers of nurses and the regulatory board to come together to promote a culture that promotes learning from practice errors while properly assigning accountability for behaviors, consistently evaluating events, and complying with mandatory reporting requirements (George, Chastain, & Burhans, 2008).

Missouri

A grant from the National Council of State Nursing Boards brought together Missouri regulators and health care providers to improve patient safety in September, 2007. The grant funds the *Just Culture* Collaborative, an effort led by the Missouri Center for Patient Safety (MOCPS) to establish an understanding of why medical errors happen and establish a common understanding of aspects of culture to improve methods for preventing them. Statewide, the following health care leaders have signed statements of support for the project: Healthcare Services Group, Missouri Hospital Association, Missouri Nurses Association, Missouri Organization of Nurse Leaders, Missouri State Board of Healing Arts, Missouri State Board of Nursing, Missouri State Medical Association, Missouri Association for Healthcare Quality, Missouri Department of Health & Senior Services and 33 hospitals, agencies, and health care systems in the state as participating organizations (MOCPS, n.d.).

California

In a state where strict laws mandate medical error reporting, the California Patient Safety Action Coalition (CAPSAC) is attempting to ensure errors are dealt with using the *Just Culture* concepts. CAPSAC conducts trainings and promotions striving to influence healthcare leaders to incorporate a concept called "Fair and *Just Culture*" as part of the environment of patient safety, and to create a system where prevention and learning are stressed, regardless of the severity of the incident (CAPSAC, 2008). At the local level, the Los Angeles County Department of Health Services, which serves more than 10 million people and is the second largest health department in the U.S., adopted and abides by the *Just Culture*, and was one of the earliest health care entities in California to do so (CAPSAC, 2008).

*Professional Associations*

The following are examples of attempts by professional associations to promote and incorporate the *Just Culture* concepts.

American Organization of Nurse Executives

The American Organization of Nurse Executives (AONE) states in the document *Guiding Principles: The Role of the Nurse Executive in Patient Safety* that "the role of the nurse executive in patient safety is to help lead best practices and establish the right culture across multiple disciplines within the organization" (AONE, 2006a). AONE goes on to state that one of the principles for the nurse executive is to lead cultural change (AONE, 2006b). A major part of this role is to transform the culture from one of a silent, hierarchical structure of blame to an open team-oriented culture to improve patient safety. Reason argues that an informed culture requires a reporting culture, *Just Culture*, flexible culture, and learning culture. Together these subcultures form a blameless culture that encourages and rewards reporting (Reason, 1997).

Another role of the nurse executive is to develop leadership competencies which include culture of safety competencies. The competencies most related to *Just Culture*

are: “Timely, fair, appropriate actions that are carried out equitably when blameworthy behaviors have occurred”; and “Assign accountability, determine goals, avoid blame, thank those that share concerns and perceived patient safety risks” (AONE, 2007).

Association of periOperative Registered Nurses

The Association of periOperative Registered Nurses (AORN) issued a position statement which stated that “all health care organizations must strive to create a culture of safety. Such a culture will provide an atmosphere where the perioperative team members can openly discuss errors, process improvements, or systems issues without fear of reprisals.” (AORN, 2006). Further, AORN recommends that health care organizations adopt a disciplinary system theory approach in promoting a *Just Culture* that freely reports errors. These disciplinary policies must balance the benefits of a learning culture with the need to retain personal accountability and discipline (AORN, 2007).

Illinois Nurses Association

The Illinois Nurses Association (INA) has recommended that “professional nursing organizations and the State Board of Nursing investigate the adoption of the *Just Culture* Algorithm” in a recent position paper on patient safety (INA, 2008).

## References

Agency for Healthcare Research and Quality. *Patient safety network glossary.* Retrieved July 27, 2009, from http://www.psnet.ahrq.gov/glossary.aspx#J

American Nurses Credentialing Center. (2008). *Magnet Recognition Program ® manual - Recognizing nurse excellence.* Silver Spring, MD: Author.

American Organization of Nurse Executives. (2007a). *Guiding principles: The role of the nurse executive in patient safety.* Retrieved February 22, 2009, from http://www.aone.org/aone/resource/PDF/AONE_GP_Role_Nurse_Exec_Patient_Safety.pdf

American Organization of Nurse Executives. (2007b). *Role of the nurse executive guiding principles toolkit.* Retrieved February 22, 2009, from http://www.aone.org/aone/pdf/Role%20of%20the%20Nurse%20Executive%20in%20Patient%20Safety%20Toolkit_July2007.pdf

Association of periOperative Registered Nurses. (2007). *AORN position statement on patient safety.* Retrieved February 22, 2009, from http://www.aorn.org/PracticeResources/AORNPositionStatements/Position_PatientSafety/

Association of periOperative Registered Nurses. (2006). *AORN Just Culture tool kit.* Retrieved February 22, 2009, from http://www.aorn.org/PracticeResources/ToolKits/JustCultureToolKit/DownloadTheJustCultureToolKit/

California Patient Safety Action Coalition. (August 20, 2008). *Press release: California Patient Safety Action Coalition (CAPSAC) charts new path in preventing medical errors*.

Center for American Nurses. (n.d.). *Lateral violence and bullying in the workplace.* Retrieved November 11, 2009 from http://centerforamericannurses.org/associations/9102/files/LATERALVIOLENCEBULLYINGFACTSHEET.pdf

George, J., Chastain, K., & Burhans, L. (2008). The North Carolina Board of Nursing *Just Culture* pilot project toolbox. (Unpublished work).

Illinois Nurses Association. (2008). *Position paper on patient safety and medication errors.* Retrieved May 21, 2009 from http://www.illinoisnurses.com/

Joint Commission. (2008). *Sentinel event alert*. Retrieved October 3, 2009 from http:/ /www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_40.htm

Leape, L. (January 25, 2000). Testimony, United States Congress, United States Senate Subcommittee on Labor, Health and Human Services, and Education.

Marx, D. (2001). *Patient Safety and the "Just Culture": A Primer for Health Care Executives*. New York, NY: Columbia University.

Marx, D. (2008). *The Just Culture Algorithm*. Outcome Engineering, LLC.

Minnesota Alliance for Patient Safety. (n.d.). *Minnesota statement of support for a statewide culture of learning, justice, and accountability.* Retrieved February 22, 2009 from www.mnpatientsafety.org

Missouri Center for Patient Safety. (n.d.). *Missouri Just Culture Collaborative.* Retrieved February 22, 2009 from http://www.mocps.org/initiatives/index.asp

Reason, J. (1997). *Managing the risks of organisational accidents.* London: Ashgate Publishing.