# Patient Safety and "Just Culture"

It is inevitable that people will make mistakes or experience misunderstandings in any work environment. When events occur that cause harm or have the potential to cause harm to patients or staff members, or that place the Institute at legal, financial or ethical risk, a choice exists: to learn or to blame. UCLA Health System is committed to creating a work environment that emphasizes learning rather than blame.

UCLA Health System recognizes the complexity and interdependence of the work environment in all aspects of its operations, including patient care, clinical operations, research, support services and administration. The intent is to promote an atmosphere where any employee can openly discuss errors of commission or omission, process improvements, and/or systems corrections without the fear of reprisal.

It is well documented that most errors, whether or not they cause harm, are due to breakdowns in organizational systems; however, when an error takes place, individual culprits are often sought. Blaming individuals creates a culture of fear and defensiveness that diminishes both learning and the capacity to constantly improve systems.

Most errors take place within systems that themselves contribute to the error. In spite of this, it is difficult to create an institutional culture that integrates the understanding that systems failures are the root cause of most errors. Learning from errors often points to beneficial changes in systems and management processes as well as in individual behavior.

In the context of promoting a fair and just culture, what does it mean? A fair and just culture means giving constructive feedback and critical analysis in skillful ways, doing assessments that are based on facts, and having respect for the complexity of the situation. It also means providing fair-minded treatment, having productive conversations, and creating effective structures that help people reveal their errors and help the organization learn from them. A fair and just culture does not mean non-accountable, nor does it mean an avoidance of critique or assessment of competence. Rather, when incompetence or sub-standard performance is revealed after careful collection of facts, and/or there is reckless or willful violation of policies or negligent behavior, corrective or disciplinary action may be appropriate.

A just culture recognizes that competent professionals make mistakes and acknowledges that even competent professionals will develop unhealthy norms (shortcuts, "routine rule violations"), but has zero tolerance for reckless behavior.

A Just Culture algorithm developed by David Marx at Outcome Engineering defines the guidelines for assessment and follow-up when potential or actual patient safety events are identified. According to this algorithm, there are three basic duties:

1. **Duty to produce an outcome**. If an individual knows the desired outcome and should be able to produce it (e.g., safe removal of an inflamed appendix), failure to do so represents breach of this duty.
2. **Duty to follow a procedural rule**. If the individual knows the proper procedure and it is possible to follow the rule (e.g., the procedure for inserting a central venous catheter), failure to do so represents a breach of this duty.
3. **Duty to avoid causing unjustifiable risk or harm**. Breach of this duty occurs when an individual intentionally harms the patient or acts recklessly.

If a duty has been breached, then the mechanism of the breach is identified. There are three identified causes:

1. **Human error**. This is an inadvertent act ("slip," "lapse" or "mistake").
2. **At-risk behavior**. Typically, this is a conscious drift from safe behavior, occurring when an individual believes that drift doesn't cause any harm. An everyday example is the willingness of

some drivers to roll through stop signs. Those drivers do not see that as risk-taking behavior, as, in their experience, nothing bad happened consequently.

3. **Reckless behavior**. In this case, the individual has chosen conduct that he knows poses a substantial and unjustifiable risk.

The response to an event (or near miss) is tied to the mechanism of error. An isolated human error is an opportunity to correct system weaknesses (e.g., confusing drug labels). The individual making the error should be consoled, rather than disciplined. At-risk behavior may also indicate a system vulnerability that should be fixed. However, the individual should be coached so that he understands the risks he has taken. Reckless behavior may be grounds for disciplinary action. The intent is to reduce the risk of future reckless conduct, and may include removing the individual from the organization.

Repetitive problems are often caused by system weaknesses, but sometimes are individual performance issues, particularly when coaching or additional training has not improved the problem. For example, repetitive human errors may be an indication that the individual is not capable of performing safely in his current job. Repetitive at-risk behaviors may be due to impairment (e.g., drug abuse) or unwillingness to follow proper protocols.

Applying these principles creates an opportunity to enact the core values of the UCLA Health System. In order to have the greatest impact and achieve the highest level of excellence, staff must be able to speak up about problems, errors, conflicts and misunderstandings in an environment where it is the shared goal to identify and discuss problems with curiosity and respect. To achieve excellence, unwanted or unexpected outcomes and inefficiencies of practice must be used as the basis for a learning process. Respect must be shown to all people at every level of the organization.

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