

Just Culture in the Clinical Laboratory

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Hello and welcome to this lecture on Just Culture in the clinical laboratory.

In the fast-paced and high-stakes environment of healthcare, it is vital to promote a culture that encourages learning from mistakes, fosters accountability, and ensures patient safety. Just Culture is a key framework that aims to strike a balance between holding individuals accountable for their actions while acknowledging the influence of systems in which they operate.

It involves establishing an organization-wide mindset that positively impacts the work environment and work outcomes in several ways. Before we dive in, let's take a moment to define the term and what we mean when we say *just culture*.

Just Culture is a concept that originated from the aviation industry and has been adapted for healthcare, including clinical laboratories. It revolves around the principle of fairness in response to human errors, at-risk behaviors, and system failures. It represents a shift from a blame culture which consists of "a set of norms and attitudes within an organization characterized by an unwillingness to take risks or accept responsibility for mistakes because of a fear of criticism or admonishment by management. This culture cultivates distrust and fear, and people blame each other to avoid being reprimanded or put down, resulting in no new ideas or personal initiative because people do not want to risk being wrong." - Khatri, Naresh, et al. "From a Blame Culture to a Just Culture in Health Care." *Health Care Management Review*, vol. 34, no. 4, 2009, pp. 312–22. JSTOR.

In stark contrast, in Just Culture, the goal is to create an environment where employees feel comfortable reporting errors and near-misses without fear of punishment. This reporting culture is essential for identifying and mitigating potential risks and improving overall patient care through more accurate testing.

So, let's spend some time looking at the traits of a Just Culture:

In Just Culture, the clinical laboratory fosters a professional atmosphere that is open, trusting, and supportive. It acknowledges that mistakes will be made and has systems in place to guard against human error. Employees are encouraged and rewarded for reporting mistakes, and there is a tolerance of human error within the organization. During investigations, the focus is on identifying contributing factors and making organizational improvements. Staff believe they will be supported by seniors throughout the investigation process, and they are viewed as professionals who may have made an unintentional error with no malicious intent. The outcomes of investigations involve addressing organizational factors and communicating findings, with possible recommendations for further training or improvements.

On the other hand, in a Blame Culture, negativity, fear, cautiousness, and a 'club culture' prevail in the atmosphere. There is an expectation of infallibility and attitudes towards mistakes are characterized by shame and embarrassment. Reporting mistakes may be discouraged or met with suspicion.

Investigations tend to focus on individual culpability rather than identifying organizational factors, and support during investigations is minimal. Staff expect to be viewed with suspicion, and their capability

may be questioned. Outcomes of investigations often revolve around individual innocence or guilt, with little consideration or communication of organizational factors. Blame is prevalent in the culture, with individual culpability suspected until evidence suggests otherwise. Unacceptable behaviors such as deliberate mistakes and gross negligence may not be adequately recognized or addressed within the blame culture.

Traits of a Just Culture

	Positive traits (Just Culture)	Negative traits (Blame Culture)
Professional atmosphere	Open, trusting, supportive	Fear, cautiousness, 'club culture'
Attitudes to mistakes	Acceptance that mistakes will be made, systems in place to guard against human error.	Shame, embarrassment.
Attitudes to reporting mistakes	Tolerance of human error, staff encouraged or rewarded to report mistakes	Expectation of infallibility.
Focus of investigations	Organizational factors, improvements	Individual culpability.
Support provided during investigation	Staff believe they will be supported by seniors. Staff expect to be viewed as a professional who behaved with no malicious intent.	Staff do not believe they will be supported by seniors. Staff expect to be viewed with suspicion and have their capability questioned.
Outcomes of investigation	Identify contributing factors. Organizational factors will be addressed and communicated. May be recommendations for further training.	Individual innocence or guilt. No consideration or communication of organizational factors.
Treatment of blame	Recognizes that majority of human errors will be mistakes and blame is not appropriate. Recognizes unacceptable behaviour such as deliberate action and gross negligence.	Blame culture—blame is prevalent and individual culpability will be suspected until evidence suggests otherwise. No-blame culture does not recognize and address unacceptable behaviour.

Source: Tasker A, Jones J, Brake S How effectively has a Just Culture been adopted? A qualitative study to analyse the attitudes and behaviours of clinicians and managers to clinical incident management within an NHS Hospital Trust and identify enablers and barriers to achieving a Just Culture BMJ Open Quality 2023;12:e002049. doi: 10.1136/bmjopen-2022-002049

The reality of working in a clinical laboratory is that testing errors do sometimes occur. In the past, testing or medical errors were handled promptly with linear thinking that lead to immediate punishment of the individuals that made the mistakes. However, punishment reduces the chance that mistakes and errors will be reported in the future. Moreover, errors do not occur only as a result of individual behavioral choices: they also occur as a result of system failures.

Just culture promotes a process where mistakes or errors do not result in automatic punishment, but rather a process to uncover the source of the error. Of course, punitive action can/will be taken if

someone intentionally makes testing errors. Just culture is also rooted in the concept that EVERYONE is responsible for safety and the reporting of errors.

We can also use systems thinking and accountability to help us integrate just culture into our laboratories. Systems thinking is a powerful tool that helps us understand the interdependencies and interactions between various elements within a complex system. In the clinical laboratory, this system includes personnel, processes, equipment, and technology, all working together to deliver accurate and reliable results. Systems thinking allows us to analyze how errors occur, what factors contribute to them, and how the system can be designed to prevent or mitigate their impact.

Accountability is another critical aspect of Just Culture, and it is essential to distinguish between human error and intentional reckless behavior. When an error occurs, it is crucial to assess whether it resulted from a genuine mistake, an at-risk behavior, or a willful disregard for established protocols. In cases of unintentional errors or at-risk behaviors, it is essential to focus on learning, education, and process improvement rather than punitive measures.

The Just Culture Continuum

Just Culture exists on a continuum that classifies behaviors into three categories: human error, at-risk behavior, and reckless behavior.

Types of Behavioral Choices and Remedies

Behavior	Description	Remedies
Human error	A mistake or an inadvertent action that is unintentional	Console the individual involved and explore improvements, such as system redesign, that would prevent a similar error from occurring again in the future.
At-risk behavior	Choices made where risk is believed to be insignificant or justified	Coach the individual involved to see the risk associated with a behavioral choice that was seen as being insignificant or justifiable.
Reckless behavior	Choices made to consciously disregard risk, which is substantial and unjustifiable	Discipline the individual involved according to organization policies and procedures.

Source: John S Murray, PhD, MPH, MSGH, RN, CPNP-PC, CS, FAAN, USAF, NC (Ret.) and others, Implementing Just Culture to Improve Patient Safety, Military Medicine, Volume 188, Issue 7-8, July/August 2023, Pages 1596–1599, <https://doi.org/10.1093/milmed/usac115>

- **Human Error:** This category includes unintended mistakes that occur despite employees following established protocols. Human errors are inevitable and can often be attributed to factors such as fatigue, distraction, or lack of knowledge and/or training.
- **At-Risk Behavior:** At-risk behaviors refer to actions that may deviate from standard protocols but are typically taken to get the job done more efficiently. These behaviors are not malicious but can still introduce risks.

- **Reckless Behavior:** Reckless behavior involves a conscious disregard for protocols or safety measures. This category involves intentional actions that endanger patient safety and warrant appropriate disciplinary action.

Applying Just Culture Principles:

So, how does a manager implement Just Culture in the clinical laboratory? They engage leadership, set expectations, require accountability, implement training, and assess staff perceptions.

- **Reporting and Learning:** Encouraging a reporting culture is the cornerstone of Just Culture. Employees should be motivated and confident to report errors and near-misses, knowing that the focus will be on identifying system vulnerabilities and implementing improvements.
- **Non-punitive Response:** For human error and at-risk behavior, the response should be non-punitive, focusing on education, training, and process improvement. Understanding the underlying reasons behind these incidents helps prevent their recurrence.
- **Accountability for Reckless Behavior:** Reckless behavior demands accountability. Employees who willingly and knowingly put patients at risk must be held responsible for their actions, while the organization must continually assess and improve the system to minimize the potential for such behavior.

Advantages of Just Culture:

There are several benefits of Just culture. First, Just Culture fosters a culture of open reporting, allowing for the identification and mitigation of potential risks, more accurate testing, and ultimately improved patient outcomes. Next, it enhances team morale and fosters a positive work climate. Employees feel supported and more engaged in their work when they know their organization values learning and continuous improvement over blame. Third, it increases accountability amongst your staff. Just Culture instills a sense of personal responsibility in employees, encouraging them to adhere to best practices and take ownership of their actions. And last, it allows for effective quality improvement by examining errors through a systems thinking lens. Thus, the organization can make data-driven changes to enhance process efficiency and accuracy.

Case Example

Let's consider an example of how Just Culture works in a clinical laboratory setting. In a busy clinical laboratory, a technologist accidentally reports a value for a patient's potassium level as 7.0 mEq/L instead of the correct value, which was 4.0 mEq/L. This error occurred because the technologist misread the value on the analyzer due to distractions in the lab at that moment.

In a Just Culture environment, how would we respond to this error? Well, let's look at it through a few different lenses: error reporting, root cause analysis, systems thinking, corrective action,

- **Error Reporting:** The laboratory has a robust reporting culture, where employees are encouraged to report errors and near-misses without fear of punishment. The technologist realizes the mistake and immediately reports it to their supervisor.
- **Initial Assessment:** The laboratory supervisor, upon receiving the error report, conducts an initial assessment to understand the nature of the error and its potential impact on patient care. The supervisor also takes note of any contributing factors, such as distractions in the lab, which might have influenced the error.
- **Root Cause Analysis:** To address the incident thoroughly, the laboratory initiates a root cause analysis. A team of experts, including the technologist involved, the supervisor, and

representatives from different areas of the laboratory is formed to investigate the underlying causes of the error.

- **Systems Thinking:** During the Root Cause Analysis, the team applies systems thinking to examine all the factors that contributed to the error. They identify issues such as inadequate training on the analyzer, distractions in the lab, and lack of redundancy checks in the reporting process.
- **Non-punitive Response:** The laboratory acknowledges that the technologist made an unintentional human error while reporting the critical value. Since the error falls under the category of human error in the Just Culture continuum, a non-punitive response is applied.
- **Corrective Actions:** Based on the findings of the Root Cause Analysis, the laboratory implements corrective actions to prevent similar errors in the future. These actions may include providing additional training on analyzer use, establishing protocols to minimize distractions during critical tasks, and introducing a double-check verification process for critical values.
- **Education and Learning:** The laboratory uses the incident as a learning opportunity for all staff. Lessons learned from the Root Cause Analysis and the implemented corrective actions are shared during staff meetings, training sessions, and also during Lab Huddles. The focus is on educating employees about potential risks, emphasizing the importance of vigilance in critical value reporting, and reinforcing the value of error reporting.
- **Continuous Improvement:** The laboratory fosters a culture of continuous improvement by regularly evaluating the effectiveness of the implemented corrective actions. Any new insights gained from subsequent incidents or near-misses are used to refine and enhance existing processes continually.

Conclusion

In conclusion, Just Culture in the clinical laboratory setting goes hand-in-hand with systems thinking. It emphasizes learning from mistakes which occur within a larger systems framework and promotes a culture of safety and improvement. This allows for individual accountability and promotes a learning culture where honest human mistakes are seen as a learning opportunity for the organization and its employees. The individual who made the mistake may be offered additional training and coaching. By implementing Just Culture principles, we create a laboratory that is more effective and accountable, and one that provides more accurate testing. Thank you for listening.