Only 50% of respondents indicated that their organizations had clearly defined an effective process for handling disagreements with the safety of an order.

This is down from 60% of respondents to a similar ISMP survey conducted in 2003, which suggests that this problem is worsening.[19] Although these data are specific to medication safety, their lessons are broadly applicable: Behaviors that undermine a culture of safety have an adverse effect on quality and patient safety.

A Fair and Just Safety Culture

A fair and just safety culture is needed for staff to trust that they can report patient safety events without being treated punitively.[3,9] In order to accomplish this, hospitals should provide and encourage the use of a standardized reporting process for staff to report patient safety events, and implement efforts designed to encourage reporting as required by JCI's **Standard QPS.03.04, ME 6**.

This is also built into the JCI standards at **Standard GLD.07.01**, which requires leaders to provide and encourage the use of systems for blame-free reporting of a system or process failure or the results of proactive risk assessments (*see also* **Standard QPS.03.04**). Reporting enables both proactive and reactive risk reduction. *Proactive risk reduction* identifies and solves problems before patients are harmed, and *reactive risk reduction* attempts to prevent the recurrence of problems that have already caused patient harm.[11,16]

A fair and just culture considers that individuals are human, fallible, and capable of mistakes and that they work in systems that are often flawed. In the most basic terms, a fair and just culture holds individuals accountable for their actions but does not punish individuals for issues attributed to flawed systems or processes.[15,19,20] **Standard GLD.02.00** requires that leaders hold staff accountable for their responsibilities, in accordance with hospital policies, and laws and regulations, but assumes hospital leaders will use a process to discern whether a flawed system or process was primarily a root cause of the error rather than the fault of an individual.

A fair and just culture does hold staff individually accountable for intentionally disregarding policies and procedures or laws and regulations, while making a distinction between willful disregard of these versus errors related to flawed systems or processes. For some actions for which an individual is accountable, the individual should be held culpable, and some disciplinary action may then be necessary. (*See* Sidebar 1, below, for a discussion of tools that can help leaders determine a fair and just response to a patient safety event.) However, staff should never be disciplined or ostracized for *reporting* the event, close call, hazardous condition, or concern.