## Just Culture and the VHA: A Short History

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An evolving concept in healthcare and patient safety, **Just Culture** has been defined as "an organizational context in which health professionals feel assured that they will receive fair treatment when they report safety incidents."[1] This highlights a major difference between a culture that centers around blaming individual persons and one that values a just response to safety issues. A just culture seeks to ask, "What went wrong?" and "How can we—as an organization—improve?"

An organizational culture that values justice acknowledges that mistakes happen and that humans are fallible. It promotes continuous improvement in both system design and decision-making. A just culture is also a learning culture—one that values constant discovery and development, and seeks to avoid "blame and shame" and punitive action.[2-5]

The Veterans Health Administration (VHA) is a national leader in patient safety initiatives, which include cultivating organizational values and actions that prioritize fairness in patient safety reporting and management.[17] Improving patient safety is a motivation in VHA's on-going transformation into a High Reliability Organization (HRO)—a goal that many healthcare organizations now strive for.[6,7] Underscoring just culture's importance, the VHA made just culture one of the three pillars for their continuous healthcare transformation.[7]

### Background and Value of Just Culture

In the 1970s, the aviation industry began concerted efforts to transition away from a punitive culture in order to encourage error reporting.[8] This was an important transition for the airline industry, because aviation safety mistakes often lead to disasters with tremendous loss of life. Knowing that laying blame on staff members and firing employees would not prevent future incidents, they focused resources on identifying latent system design issues and designing more error-tolerant systems. Although the airline industry is still working toward a blame-free culture, lessons learned shared by aviation have provided valuable insight for other organizations.[9]

Healthcare was one of the first industries to maximize on the insights from aviation, including that a blame culture might hinder the development of a safer system, because a "finger-pointing" environment only reports the most blatant errors, which can demoralize staff, leave systems and designs largely unimproved, and fail to mitigate risks. In 2000, Lucian Leape and Don Berwick noted that the removal of punitive and shaming culture leads to eager participation from nurses, doctors, and pharmacists to improve safety and implement best practices.[10]

In 2001, David Marx mentioned "just culture" in a patient safety report for the Agency of Healthcare Research and Quality.[4] Just culture has been in the conversation ever since. Over the last twenty years, the healthcare industry has continued to adapt and adopt processes that are thought to cultivate organizations that prioritize fairness in patient safety reporting and management.

The American College of Healthcare Executives and the Institute for Healthcare Improvement now consider just culture as one of the core drivers to meeting the goal of zero harm.[11] Just culture is consistent with a continuously learning environment that must strive to foster trust among its employees and has the potential to move an organization towards adaptability and growth. For example, a study at a large teaching hospital in New York examined relationships between trust, just culture, and error reporting and found a positive correlation between trust and voluntary reporting of errors, especially errors that resulted in patient harm.[12] By decreasing medical errors, a just culture may save money, freeing up resources and energy for building a future instead of fixing the past.

Learning and improving are indispensable in cultivating fairness. But just culture concepts also challenge and motivate an organization to consider justice more generally in healthcare operations. An organization that values justice in safety management and incident reports is also one that considers fairness at a high level, keeping it at the forefront when evaluating conduct across the organization.[1]

**Just Culture in the VHA**

In a paper for the VHA National Center for Patient Safety (NCPS), Gary Sculli and Robin Hemphill claimed a just and fair culture is necessary for a culture of safety, defining such a culture as one "that learns and improves by identifying and examining its own weaknesses."[3] This is a culture where weaknesses are exposed as openly as areas of excellence and employees feel safe when voicing their concerns regarding their own actions or actions of others with regard to an actual or potential adverse event, as human error is not viewed as the cause of an adverse event but rather a symptom of deeper system issues."[13]

A just culture acknowledges an error and then looks into the intention that led to it. System deficiencies may lead to human mistakes and unintentional errors, but at-risk and reckless behavior may include intention to harm and should be addressed separately from other types of errors. Regardless of intent, it is important to find ways to improve systems that created an environment for errors and at-risk behavior.[3,13]

Through patient safety trainings and communications, NCPS has taught that a punitive culture that assigns blame and then takes disciplinary action based on an outcome does not always fix the underlying problems.[3] To adequately address the larger systemic gaps and failures, NCPS promotes the use of just culture-based actions to improve the behavior that led to the safety incident in the first place. VHA leadership has also developed error reporting mechanisms; tools for root cause identification, corrective action, and error management; and just culture initiatives across all VHA hospitals.[5,14] Understanding that just culture is more of a process than an outcome, the VHA continues to refine policies and introduce systems that not only support the idea of justice in safety events reporting, but also promote it as a cultural value across the organization.

**[INSERT TABLE 1 HERE]—VA PATIENT SAFETY INTIATIVE AND JUST CULTURE EVOLUTION OVER TIME**

**[INSERT TABLE 2 HERE]—SIX STEPS TO STARTING A JUST CULTURE**

**Lessons from Other Healthcare Systems**

Many healthcare organizations have worked to incorporate just culture practices.[11] Cincinnati Children's Hospital (CCH) introduced a 24/7 telephone safety reporting system. By allowing staff members to promptly report any incidents, this system led to a 300% increase in reporting in the first year. For training, CCH used a top-down approach—offering direct training to leadership and then assigning department leaders to train entire teams. For CCH, communication was the key to just culture sustainability. To cultivate awareness and encourage continuous learning, they organized monthly meetings to discuss patient safety events and lessons learned.[11]

Grounding their just culture initiatives in findings by Amy Vogelsmeier and colleagues that noted how front line staff perceptions of just culture can be very different from the leadership's perception, the University of California, Los Angeles (UCLA) Health worked to flatten its hierarchal training curve.[11,15] Instead of conducting top-down training, they recruited forty "culture champions" from all organizational levels to assemble training teams, which collaborated and shared concerns as peers. As a way to reward success and celebrate accomplishment, the teams handed out Good Catch Awards for any reporting that led to incident prevention or improvements in safety system design.

Cleveland Clinic launched their just culture campaign by incorporating a quick four question safety event questionnaire. Their safety department used daily huddles to discuss any new reported events, promoting just culture practices on a daily basis.

Jefferson Health-Abington also used increased communications to promote just culture. By openly providing reasons for any disciplinary action that followed a safety event through intranet direct messages, they reinforced their ongoing commitment to reporting and transparency. Jefferson Health-Abington also distributed quarterly highlights of key safety improvements made as a direct result of frontline employee involvement.[11]

It is important to note that cultivating communities that prioritize justice in patient safety management is a journey that likely is never complete. There will always be challenges to

overcome and new ideas to incorporate with just culture. Rather than representing a concrete destination, a just culture is an ideal to continuously work toward.

**Barriers and Limitations**

There are substantial challenges and limitations to moving toward a culture that values justice. Just culture is a fluid concept that contains multiple perspectives and policy considerations. It is not so much a group of ideas and practices set in stone and aimed at fixed goalposts but more of a dynamic continuum at play in various work environments. There are also varied perceptions on the idea of justice around incident reporting between front-line staff and leadership.[1]

As observed by Paradiso and Sweeney in "Just culture: it's more than policy," organizations struggle with promoting a culture that values justice across all levels of hierarchy.[12] This is especially true for an organization as diverse and complex as the VHA. Despite continued efforts by many healthcare organizations, the Agency for Healthcare Research and Quality's 2018 survey on patient safety culture found more than 50% of staff respondents believe their organizations still have punitive cultures.[11]

It is also difficult to maintain efforts that promote a just culture over time, and doing so requires active leadership engagement, front-line staff efforts, and dedicated HR projects. Enhanced reporting, timely safety issue identification, and active system redesign are also key to just culture maintenance.[11,12] This requires organizational agreement and focus to devote the necessary resources to the challenge.

When something goes wrong, casting blame is a natural human reaction, and it is a stubborn behavior to change. In some ways, as a concept and set of practices, just culture has also encouraged us to shift blame from humans to systems, but the blaming remains.

**The VHA, Just Culture, HRO, and the Future**

Just culture is a work in progress, and the VHA is committed to doing the work. Going beyond lessons learned from other healthcare organizations, the VHA is constantly transforming and

modernizing, aiming to grow into an HRO at a scale and scope not yet seen in healthcare. The VHA launched its HRO transformation efforts at eighteen VAMC sites in 2019 and is expanding to incorporate HRO and just culture practices at all sites.[6]

According to the Summer 2020 issue of *Forum*, a VHA online publication, the VHA will focus on six areas for just culture evolution and HRO transformation:[6]

- Baseline staff trainings
- Team training
- Continuous process improvement management systems with trackers
- Site-specific assessments
- Leadership coaching
- Experiential learning

Continuing to promote a culture that values justice is important to the future of healthcare. As industry pioneers who have learned valuable lessons along the way, the VHA will undoubtedly advance just culture to new levels as they continue their HRO journey.

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