JustCulture

HQCA
Health Quality Council of Alberta

Safety Culture Fact Sheet

Safety culture

A safety culture reflects an organizational understanding that the delivery of safe care requires an ongoing commitment to continuous improvement. This is the essence of the 'System Design Model' (Figure).[1]

Learning culture

An organization with a commitment to continuous improvement has a learning culture – the will to implement major reforms when their need is indicated.[2] To know what is needed an organization must strive to be informed. This requires a robust safety information system. In a learning culture, an organization is willing and able to draw the right conclusions from its safety information system.

Reporting culture

A safety information system depends on reports willingly submitted by the workforce, the people in direct contact with the hazards in their work environment and processes. This requires a reporting culture – an organizational climate in which people willingly report their errors and close calls.[2]

Just culture

To develop a reporting culture an organization must build trust with its workforce through the way it treats healthcare workers who are involved when patients are harmed by care delivery. A just culture is not a blame-free culture. Individuals are held appropriately responsible for their actions, and accountability is assessed in the context of the situation including contributing system factors.

Flexible culture

Many healthcare workers are part of an organizational hierarchy and perform most of their tasks according to defined procedures. Reason[2] described a flexible culture as one in which it is understood that when there is an emergency, control over actions passes to task experts looking after a patient. This often bypasses the usual organizational decision-making hierarchy. A flexible culture signals an organization that is crisis-prepared.[2]

Informed organization

Taken together, these four elements of an organization's culture – flexible, just, reporting, and learning cultures — characterize an "informed organization".[2] Organizations rich in safety information (gathered appropriately, learned from, and applied) are said to have a safety culture (Figure).

JustCulture

HQCA
Health Quality Council of Alberta

Figure 1. Just culture 'unlocking' a reporting culture which enables recognition of important information about unsafe conditions and making it available for continuous improvement (a learning culture)

JustCulture

HQCA Health Quality Council of Alberta

Table 1. **Barriers and Facilitators of a Just, Reporting and Learning Culture**

Just Culture	MAKES POSSIBLE	Reporting Culture	MAKES POSSIBLE	Learning Culture (Continuous improvement)	
Barriers	**Facilitators**	**Barriers**	**Facilitators**	**Barriers**	**Facilitators**
Blame (Focus on individual accountability)	Clear assessment & consequence policy and procedures that: • stipulate the types of actions that could or would be disciplined • highlights an appropriate accountability framework *(Focus on system contributing factors)*	Reporting system cumbersome to use	Electronic reporting system that provides easy access / fast to use	Unresponsive organization	Clear plan and accountability for improvement
Organization's and Regulator's discipline decisions based on patient outcome		Reports used for performance management	Clear policy and procedures that: • outline the purpose of reporting • keeps reports confidential	Lack of communication	Communication about: • receipt of report • prioritization of improvements Engagement of stakeholders
Lack of openness	Clearly communicate the assessment and consequence policy and procedures	Reports used for discipline		Lack of skills to adequately assess identified threats to patients' safety	Dedicated, trained safety management staff
Inconsistent assessment processes and decision-making about conse-quences	Have clearly defined criteria that align with a human factors based model	Lack of feedback to the reporter about receipt of report and actions taken	Well defined process for acknowledging the receipt of report and for telling the reporter how the report was used	Lack of commitment to improvement (hazard mitigation)	Leadership support for adequate resources to implement need-ed change

References:

1. Health Quality Council of Alberta. Healthcare quality and safety management: A framework for Alberta. Calgary, Alberta, Canada: Health Quality Council of Alberta; July 2017.
2. Reason J. Managing the risks of organizational accidents. Aldershot (UK): Ashgate Publishing Company; 1997.