

# High reliability and just culture

*A powerful dyad*



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The Just Culture Company

# Learning objectives



- Review the core principles of just culture and high-reliability organizing and how they complement and align with each other to improve organizational culture and drive better outcomes.
- Understand the management and goals of socio-technological systems within a just culture/high-reliability organizing model.
- Apply the lessons of just culture and high-reliability organizing principles to building, embedding and sustaining a culture of psychological safety, resilience, justice and generative learning.

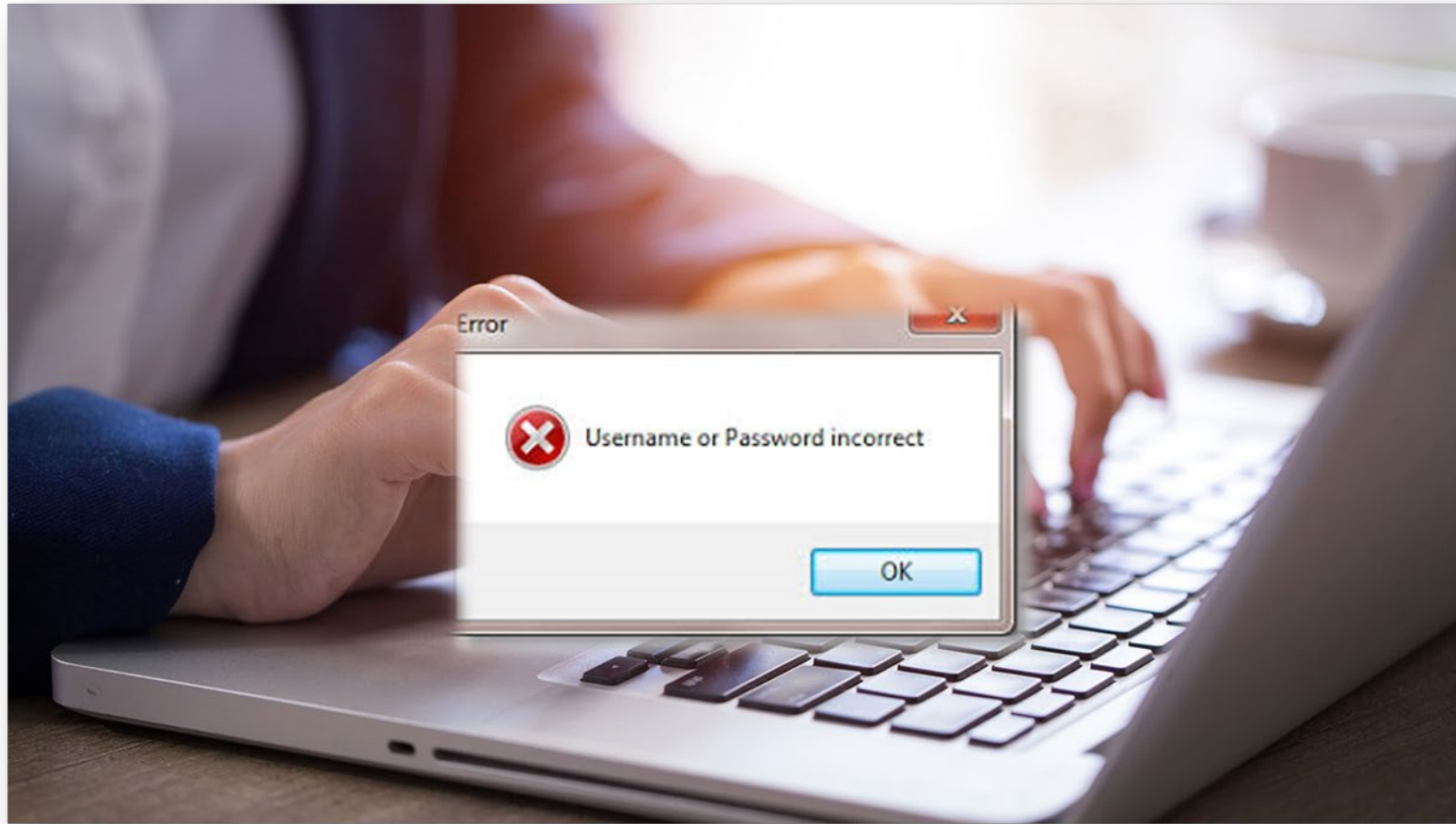
# Blended learning systems

**Just culture**

+

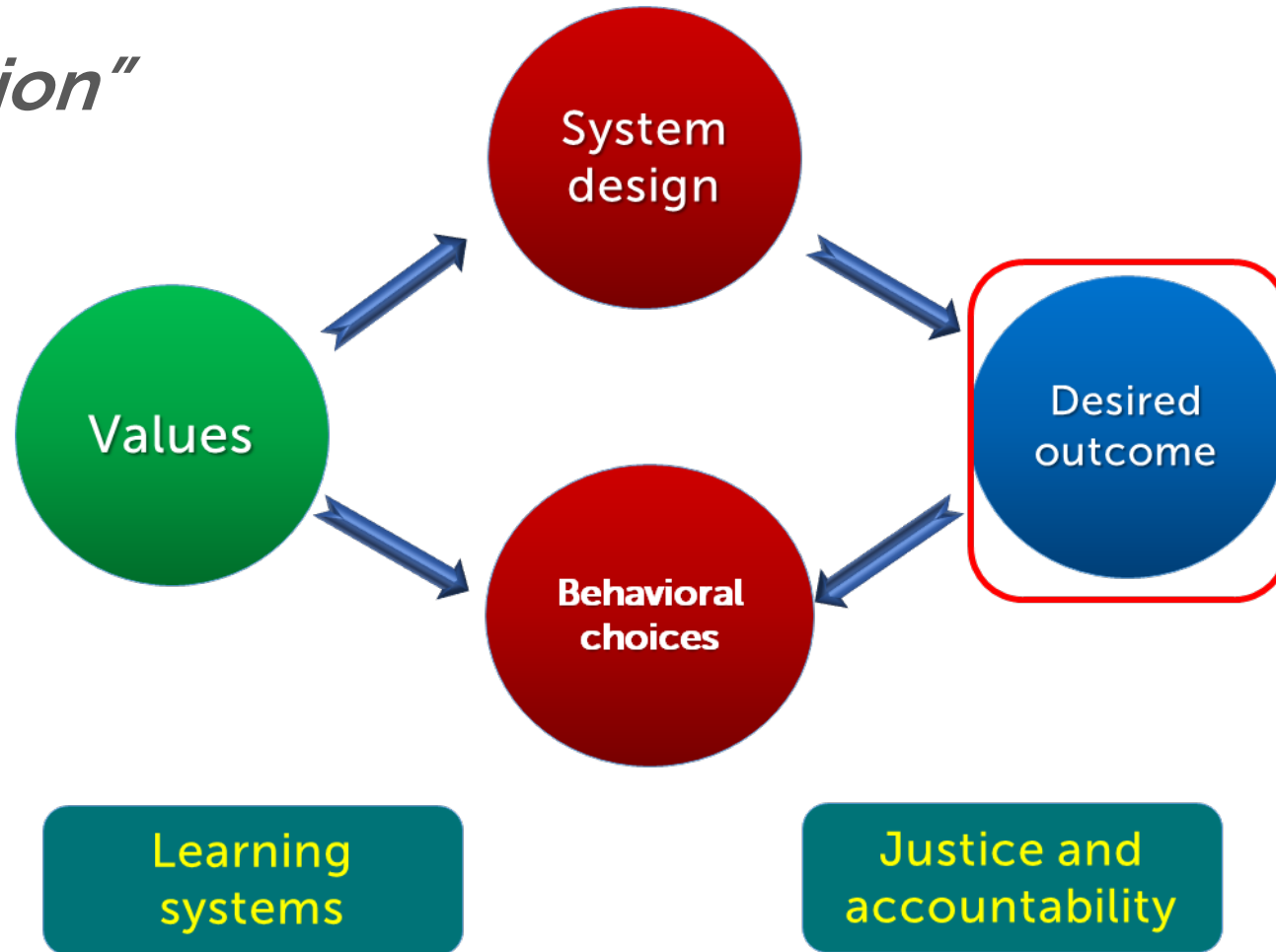
**High-reliability  
organizing**

# Username and password



# It's about doing this well

The *"Mission"*



# Importance of perspective



# Changing perspectives

## Legacy

- People are the problem
- Just follow the rules!
- Don't make errors
- Punish the error (especially if it causes serious harm)
- Focus on where things go wrong
- Just-in-time system adaptation

## Now

- People are the solution
- Do the RIGHT thing!
- Minimize and mitigate errors
- Accept and learn from the error (independent of any level of harm)
- Focus also where things go right
- Resilient system adaptation

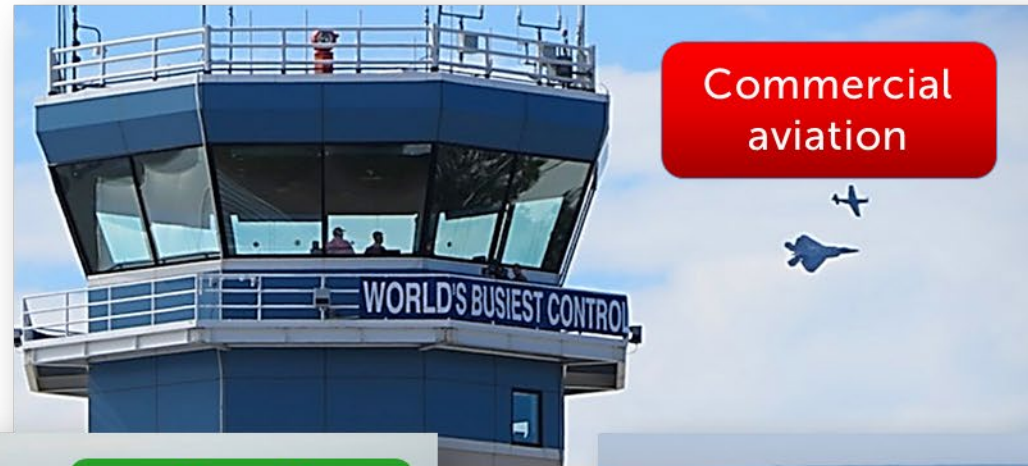
# Keys to success

High Reliability CULTURE  
+  
High Reliability BEHAVIORS

Good system design



# High risk, high consequence organizations

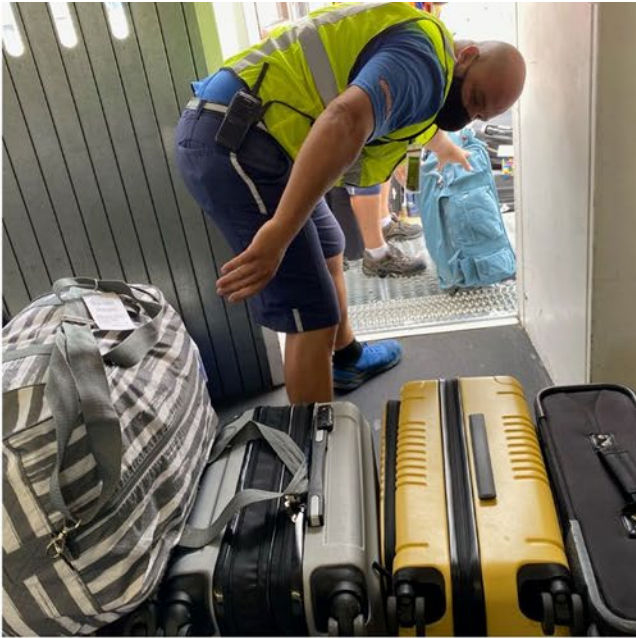


# THE WALL STREET JOURNAL.

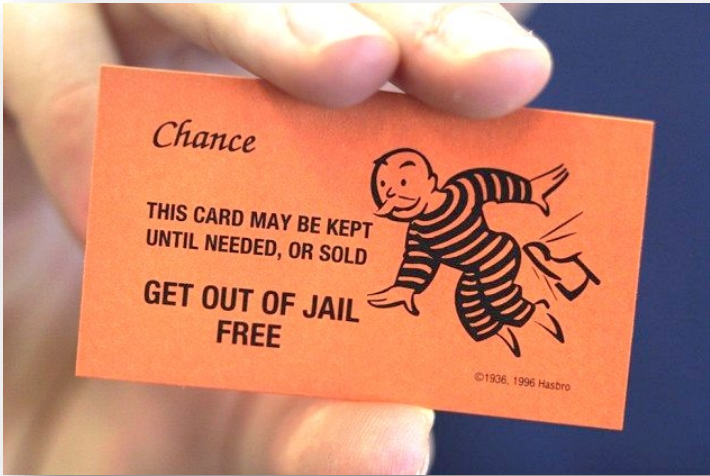
By [Benjamin Katz](#)

Aug. 15, 2023

“More workers are getting hurt on the tarmac”



# Just culture...what it is not



# Just culture...what it is

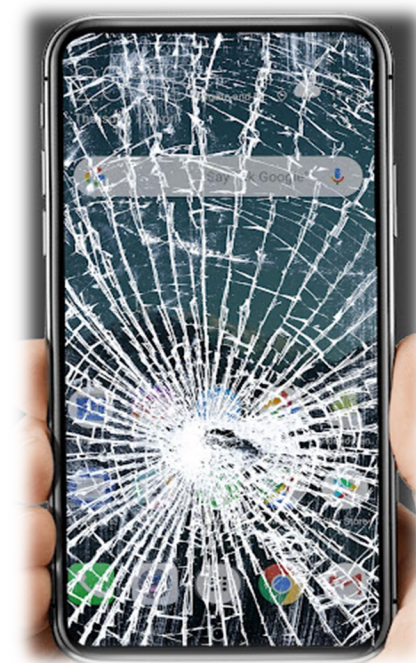
- **A system of justice to manage our:**
  - Inescapable human fallibility
  - Human free will
- **This system of justice serves to drive a culture of:**
  - Aligned values
  - Elevated accountability (200%)
  - Better behavioral choices
  - Better system designs
  - Psychological safety
  - Systematic learning

# Why things go wrong

Systems



Humans

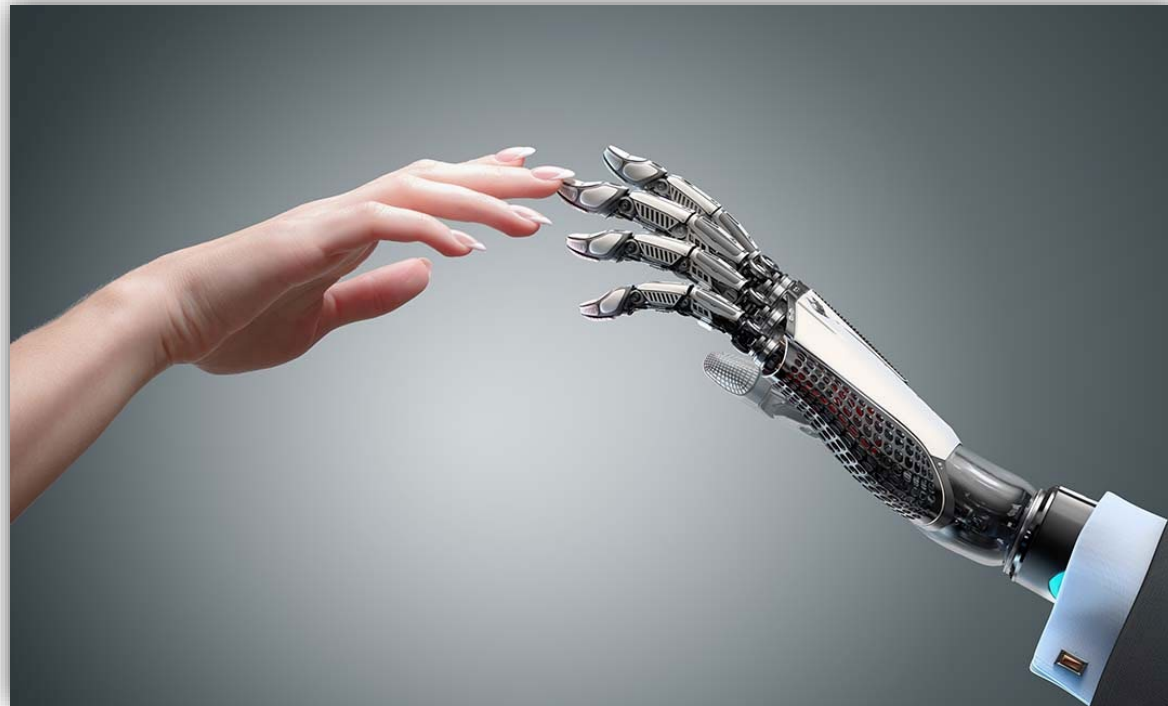


# An inseparable bond



**Humans**

**Systems**

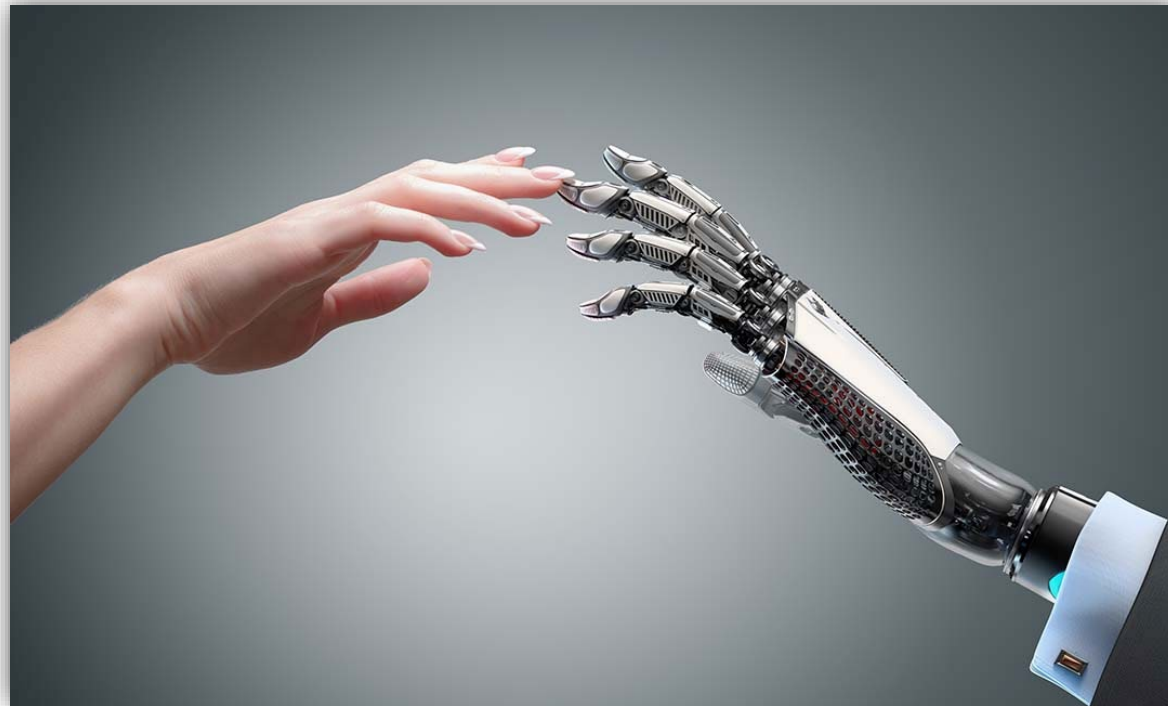


# Socio-technological system



**Humans**

**Systems**



# Your driving system





# On being human



Human error

*Not a choice*



Free will

*A choice*

# Spell

**S P O T**

# What do you see?

HUMPING TO CONCLUSIONS

# Managing error - Just two choices:

You can **Blame** and **Punish** *or*

You can **Learn** and **Improve**

*But you can't do both!*

# Error vs. choice



# Our internal “risk monitor”



# Our internal “risk monitor”



# Another at-risk behavior (*choice*)





# Neuroscience of human behavior

Sight

Sound

Smell

Taste

Touch

Memory

Pursuit of your Mission



Your Risk Monitor

GO

NO



Errrr!



Ahh!

Perception



Interpretation



Decision making



Action

# Swiss cheese model

- *James Reason*



# Managing the at-risk behaviors

- Coaching
- System engineering (human factors)



*The art of coaching is not telling someone “why” they should change a behavior...*

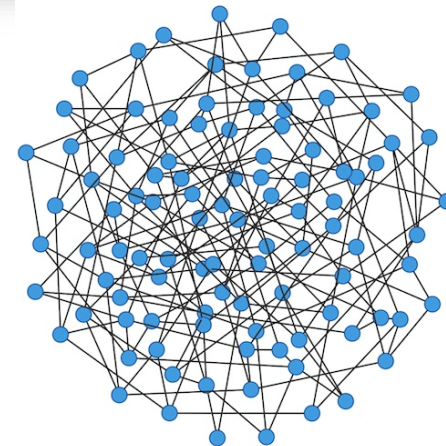
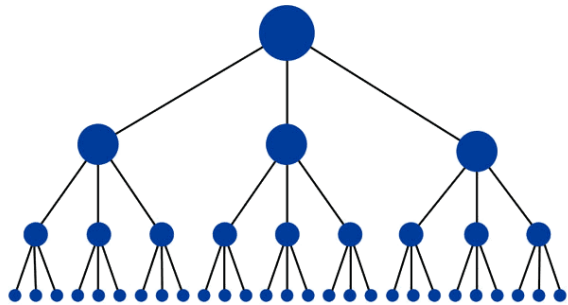
*The art of coaching is guiding someone “to see the why” for themselves.*



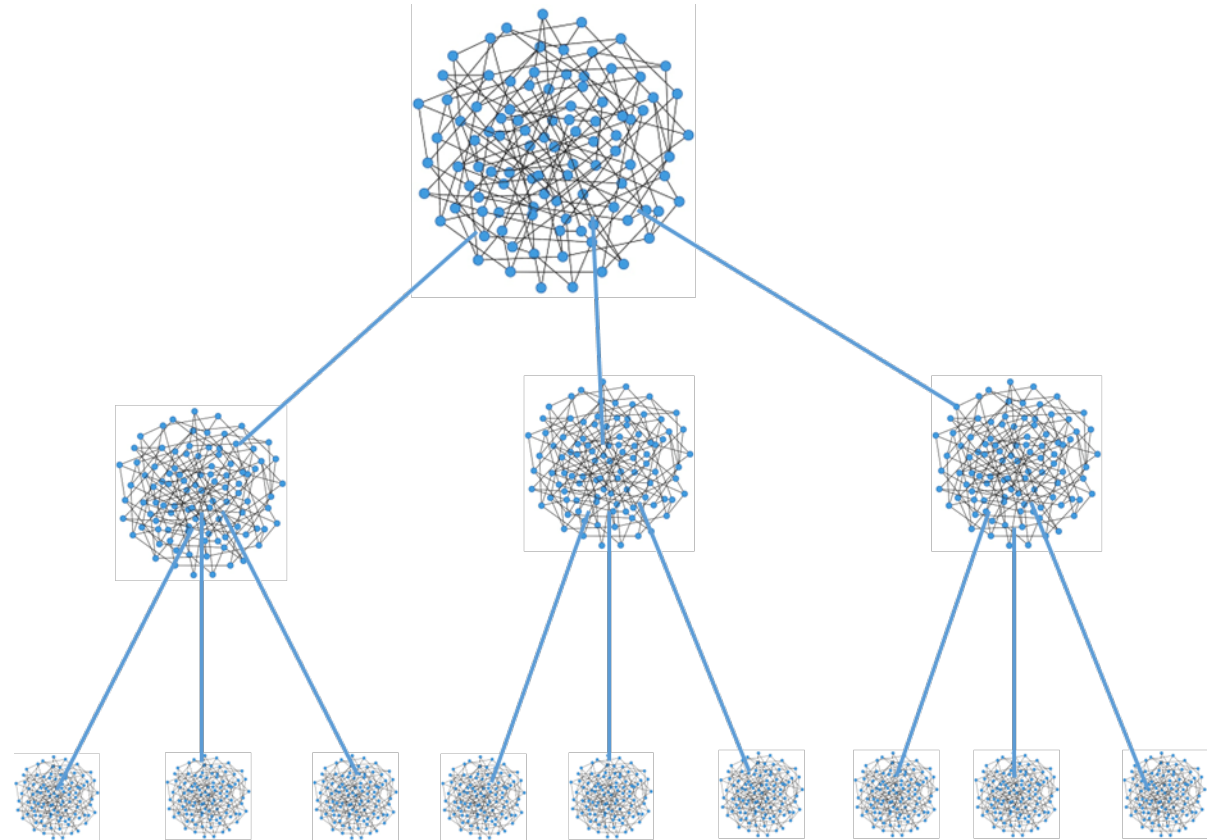
# Complicated



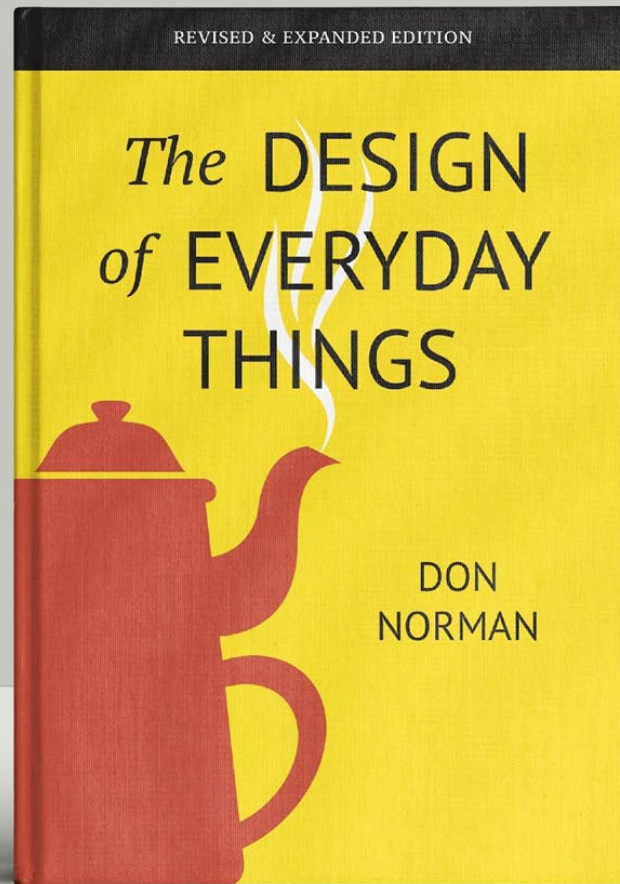
# Complex



# Human brain



# Human factors engineering



# Good system design





# There are no perfect systems



**Design the system to drive a behavior**





# You can't fix a system you don't see



Work as imagined  
vs.  
Work as done



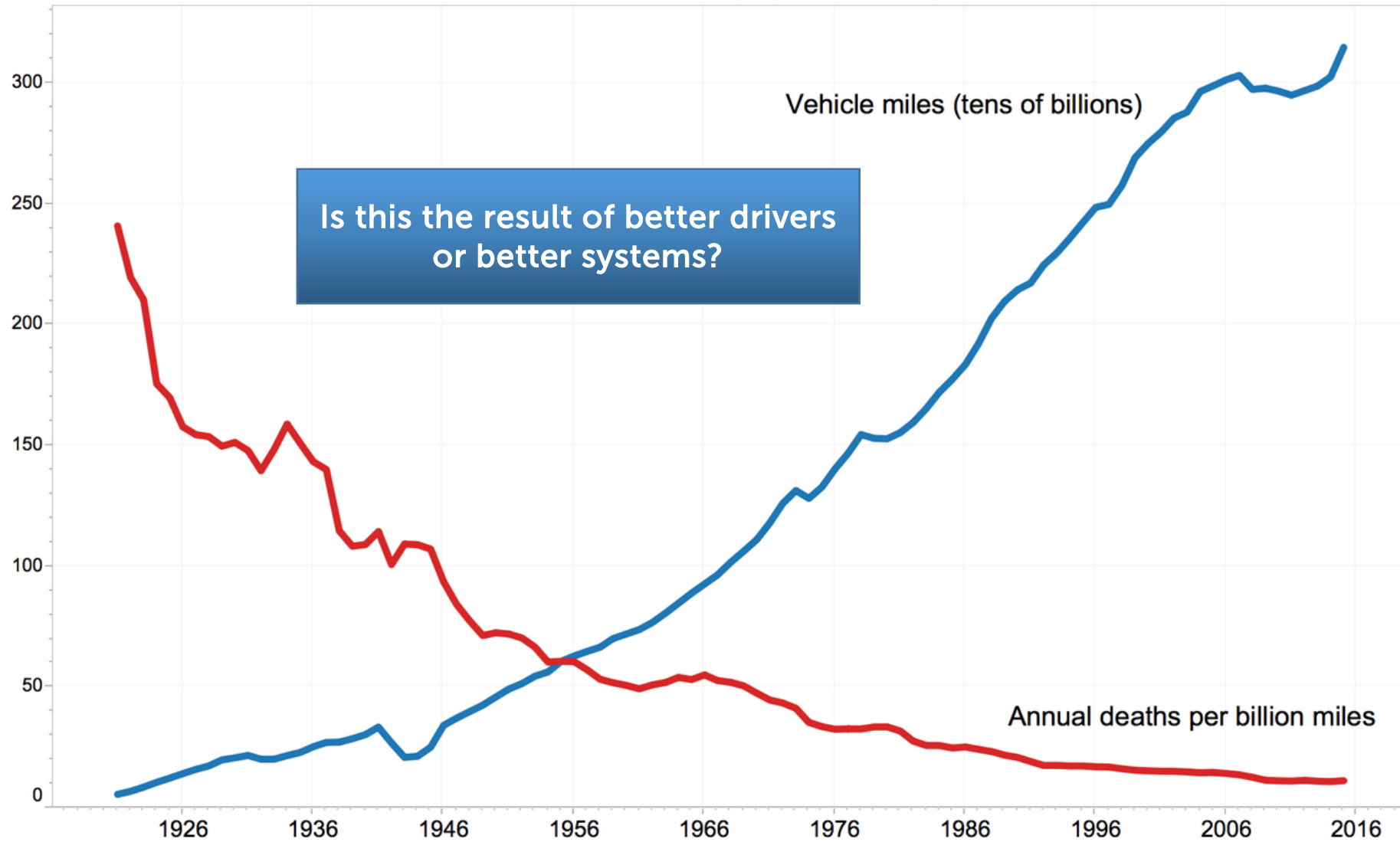
*We cannot change the human condition, but we can change the conditions under which people work.”*

*- James Reason*

# Safety is not the absence of accidents



US vehicle miles traveled and propotionate fatality rate



# System design strategies

## BARRIERS



## RECOVERY



## REDUNDANCY





# Safety learning systems

Pathological Blame, denial, misaligned values (i.e., cheaper/faster, weak DEI)

Reactive Safety efforts focus more attention *after* event  
Human error focused, outcome severity bias, learning is local

Proactive Risk-focused, anticipates and responds to risks in advance  
Aware of “latent pathogens” and “error traps” lurking within system  
Understands “*why things go right*” as much as “*why they go wrong*”

Generative (*The Place of True High Reliability*)  
Just, values-driven, ST-system focused, innovative, dynamic learning  
Prioritizes individual and organizational resilience and well-being  
- Drives for continuous improvement – *never content*

# Some final points



- Healthcare worker wellness is a priority – *Their idea of safety is more psychological than physical*
- Prioritize values over rules – *Support staff who choose to “Do the right thing”*
- Design systems to make it easier to do the right thing and harder to do the wrong thing
- Don’t wait for events – *Go see the systems in action (work-a-rounds?); go as a partner, not as police*
- Failing safely (no harm) is not a failure – *Embrace the opportunity to learn*
- Hold staff accountable for their errors but not through blame and punishment – *seek the cause*

# Thank you.

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***Go Change the World!***