



EDUCATIONAL RESOURCES

Embedding Just Culture into System Design

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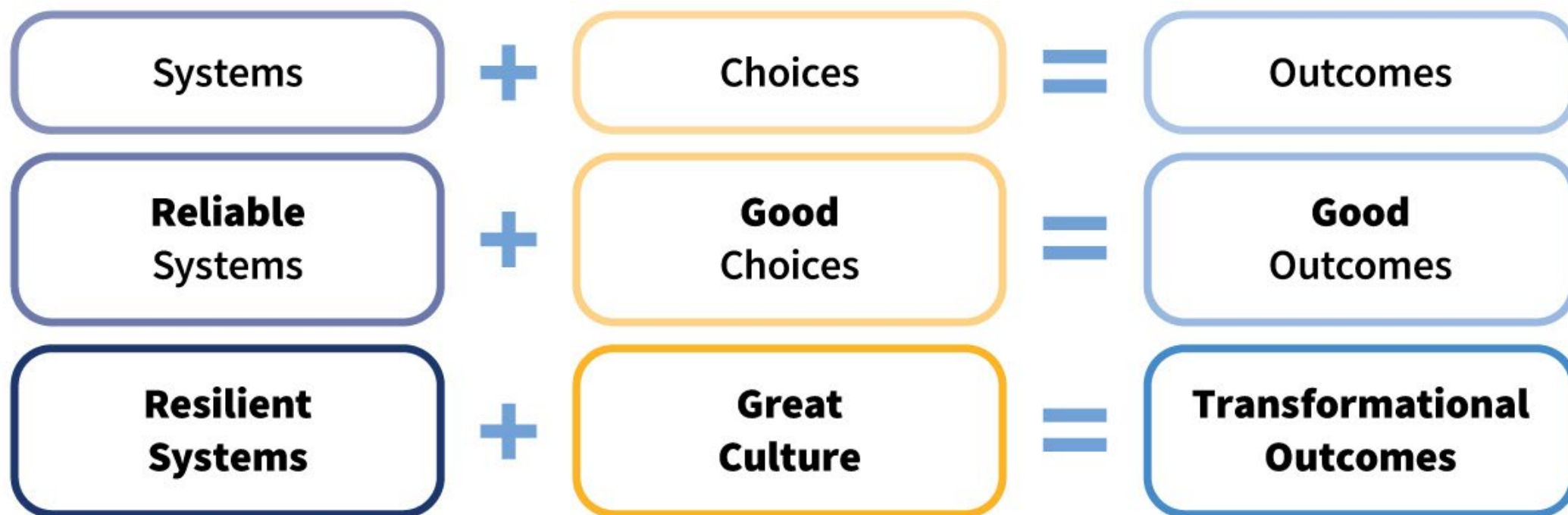
Objectives

- Identify and explain the rationale for adopting a human-centric, system-based approach to workplace justice in healthcare.
- Describe the nature of behaviors to be anticipated in the workplace.
- Differentiate and evaluate culpable versus non-culpable behaviors using Just Culture principles.
- Describe and analyze how Just Culture enables organizations to identify high-impact improvement opportunities and engage in reliable system redesign.
- Relate the value of specific safety tactics in realizing the benefits of system design and Just Culture.

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System Design + Choices Drive Outcomes

- Transformation only can be achieved with the right system design and a culture of accountability.



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Just Culture

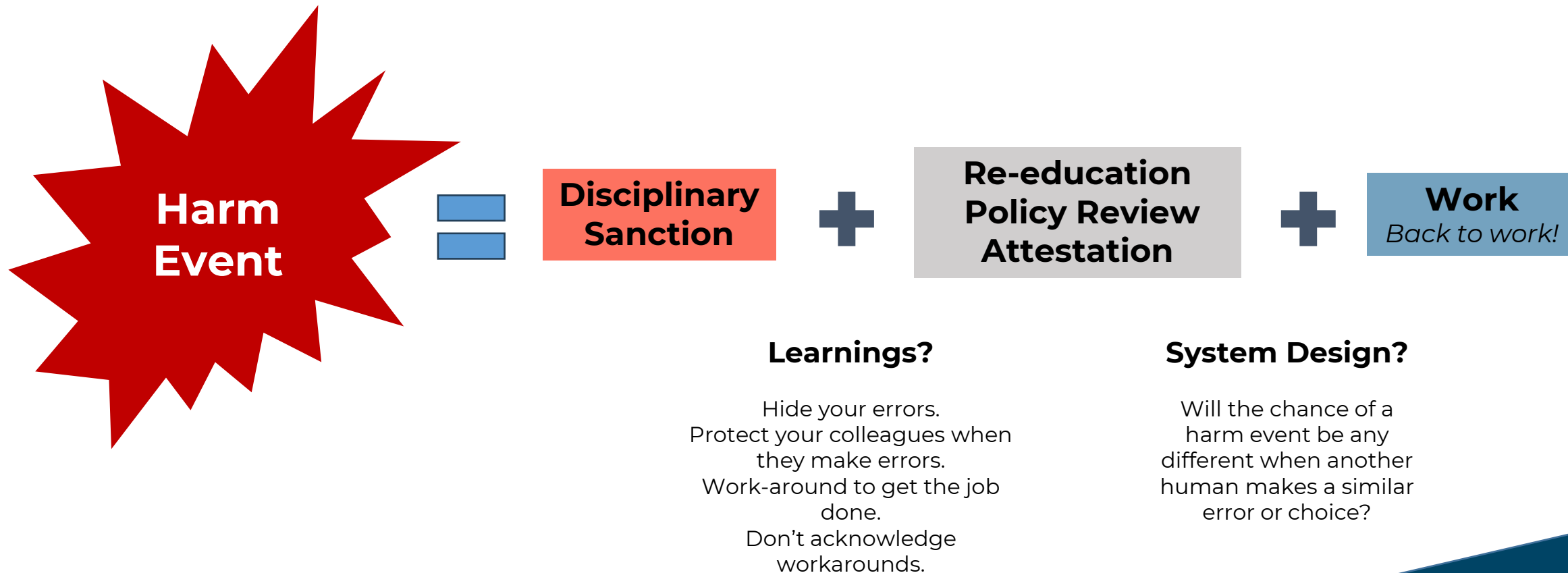
- Just Culture is a model of **workplace justice**.



recognize	
reward	
tolerate	
punish	

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Workplace Justice in Healthcare: SHAME, BLAME, RETRAIN



Just Culture

Just Culture is a **values-centric** model of **workplace justice**.



What is just?
What is substantively important?
What is procedurally fair and defensible?



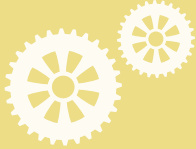
Jurisprudence




Behavioral Economics

What motivates people?

Just Culture



System Engineering



Human Factors

What conditions & circumstances optimize human performance?



How should work be designed?



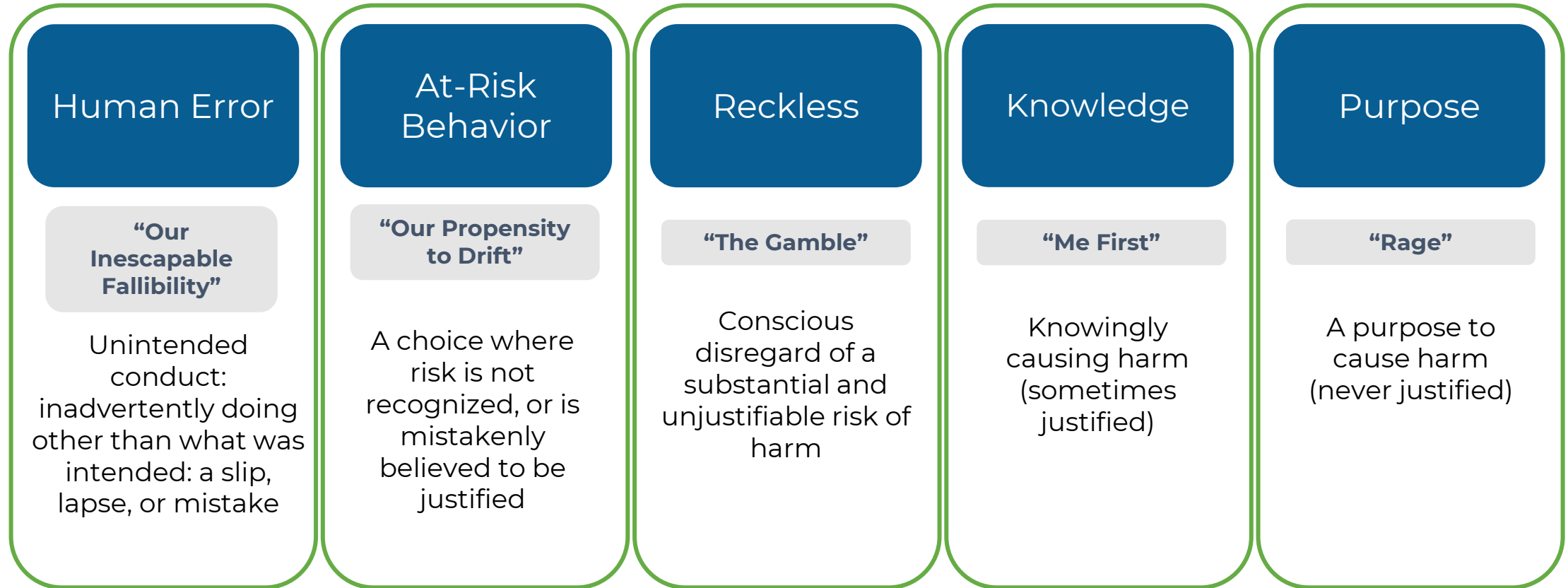
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Individual Accountability: Quality of Choice

ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



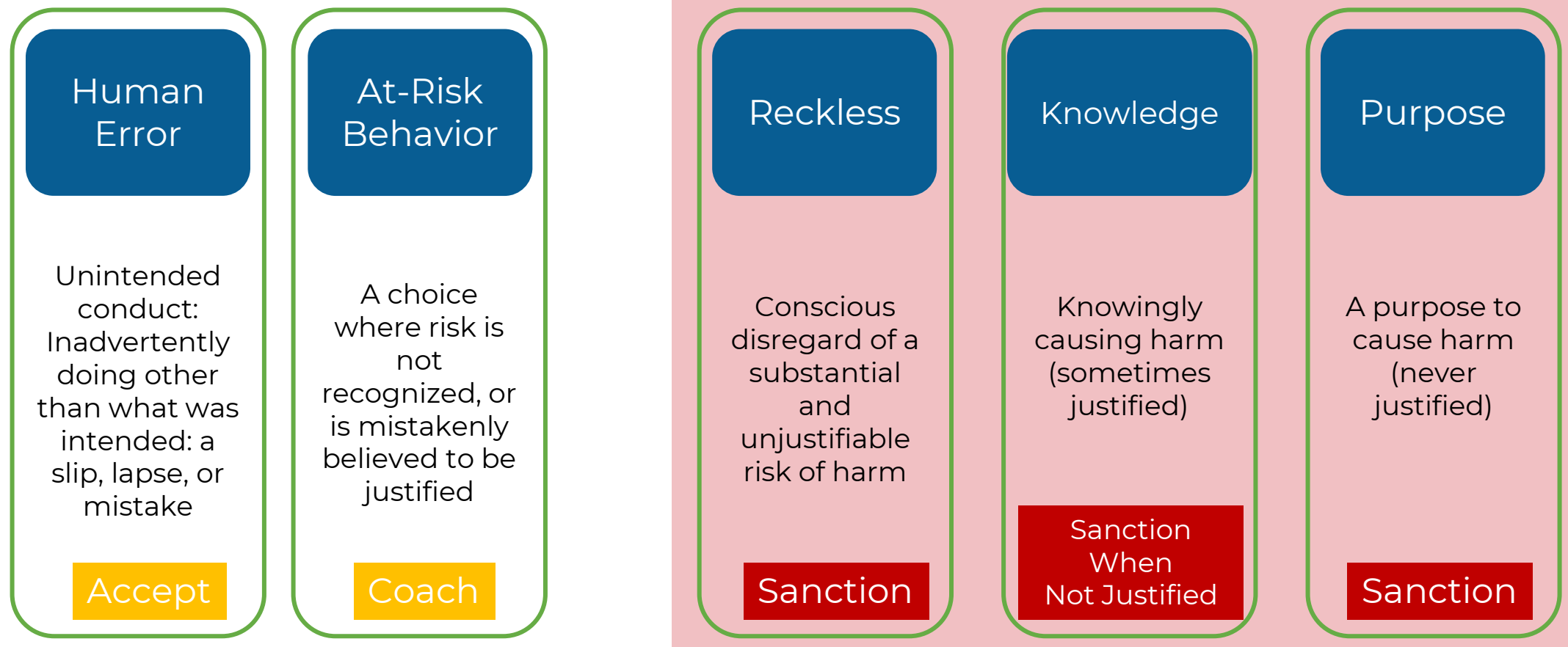
Evaluating the Quality of the Choice



Organizational Response is **Independent** of the Actual Outcome

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In a Just Culture, the **organizational response** to individuals is tightly coupled to the quality of their choices.

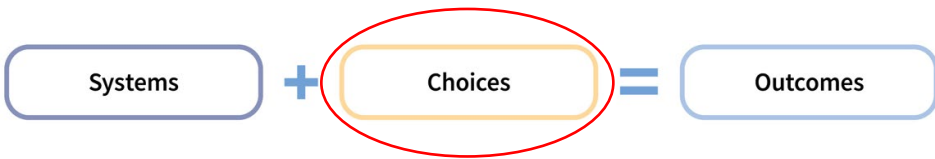


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The Organizational Response in a Just Culture



- Manage Human Error through better system design.
 - (Prevent or mitigate the consequences of error.)
- Manage At-Risk Behavior through better system design and coaching.



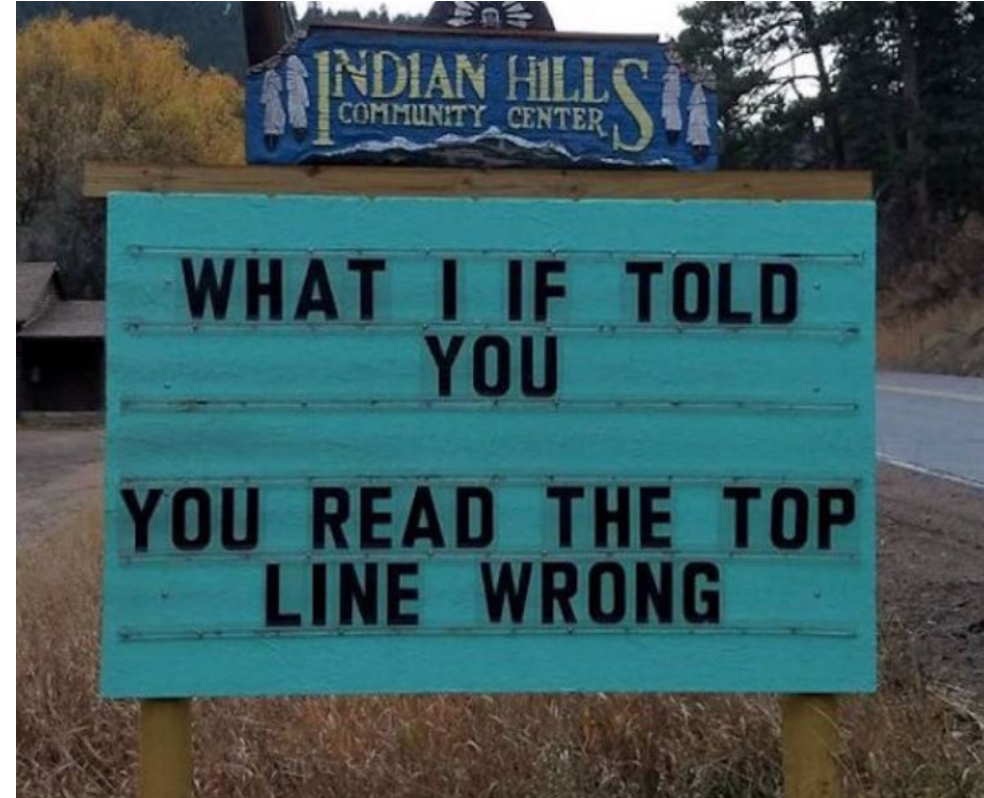
All Independent of the Actual Outcome

In a Just Culture, the **organizational response** to individuals is tightly coupled to the quality of their choices.

Human Error

Unintended conduct:
Inadvertently doing other than what was intended: a slip, lapse, or mistake

Accept



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In a Just Culture, the **organizational response** to individuals is tightly coupled to the quality of their choices.

At-Risk
Behavior

A choice
where risk is
not
recognized, or
is mistakenly
believed to be
justified

Coach

***Driving 63
in a 55-mph
zone.***

**SPEED
LIMIT
55**

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Relative Frequency of Behaviors in the Workplace

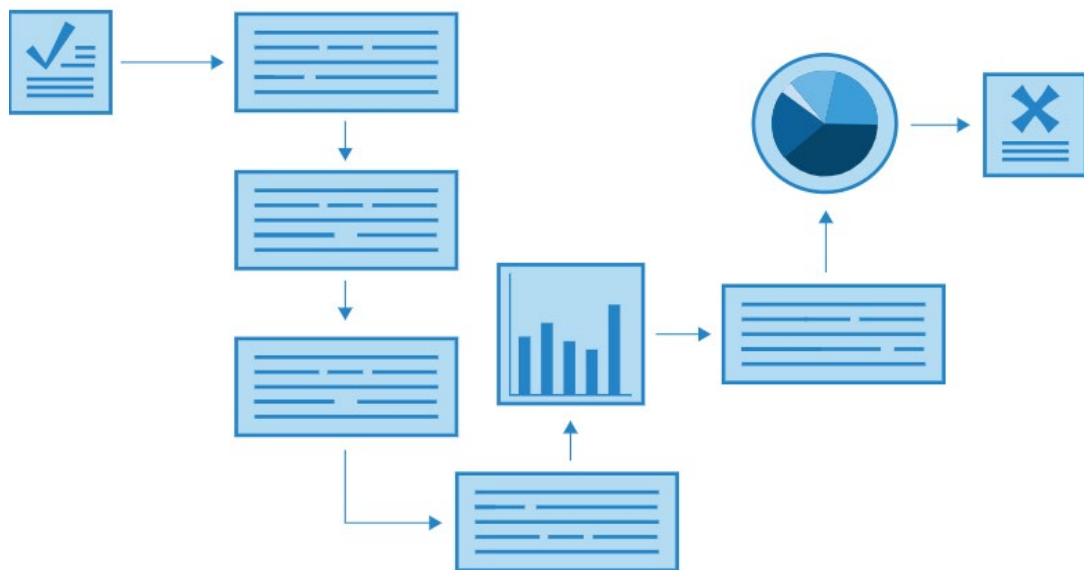


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System Accountability

Just Culture



- It is a culture that holds organizations accountable for:
 - The systems they design
 - How they respond to errors and choices in a way that is fair, predictable, and replicable



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Just Culture



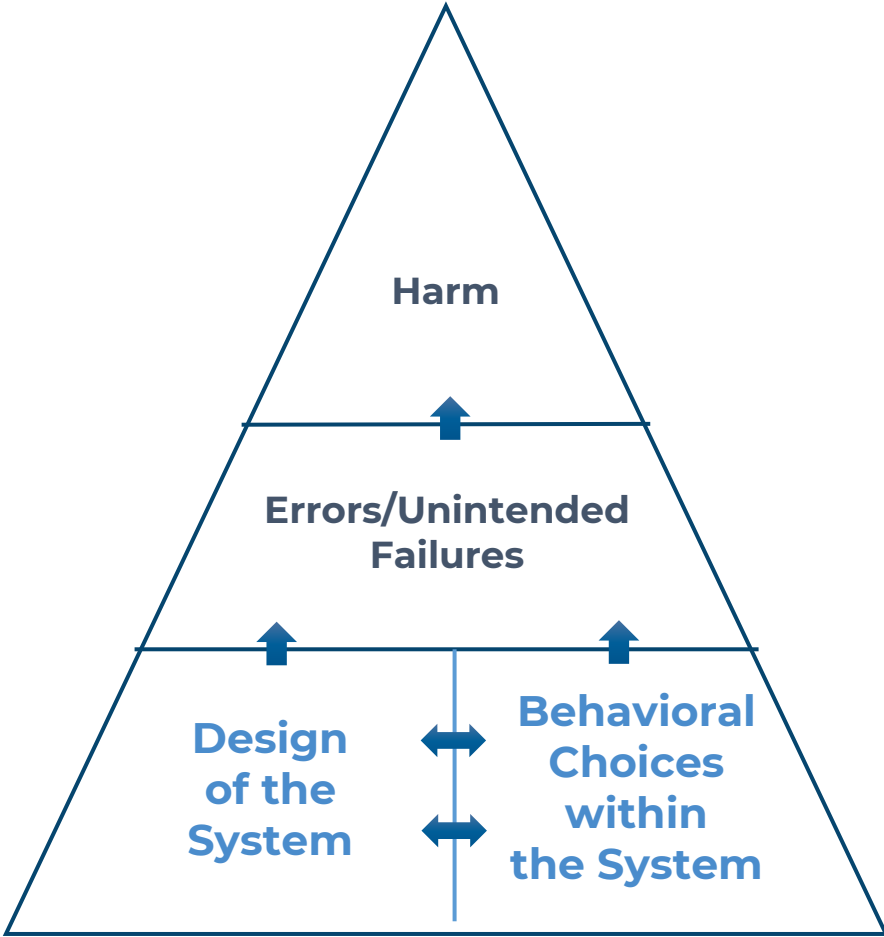
- It is a culture that holds individuals accountable for the quality of their choices.
- The model leverages what is currently known about *human capacity, decision-making, and fallibility*.
- Just Culture demands **improvement**, but **not perfection**.

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Outcomes Are Driven By...



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Just Culture Evaluation

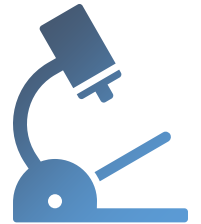
Case-Based Learning: Lost Specimen Event

Consider this Scenario

Setting: Ambulatory Surgery Center (ASC) at a large academic health system

- A patient with breast cancer undergoes a bilateral mastectomy with concurrent reconstruction. While in the OR, the surgeon placed an order for pathology testing.
- Over 24 hours after surgery completed, the lab questions the status of the specimens. They were never received in the lab for testing.

Outcome: The specimen is deemed to be lost. Pathology testing could not be completed, limiting the clinical team's ability to determine effective treatment and the patient from understanding details about her disease.



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Pertinent Details



Breach #1: Circulator nurse put both specimen containers into a single large, red biohazard bag



Circulator nurse transports red bag to the specimen room



Specimens were identified as missing

Surgical tech placed each breast specimen into individual large, labeled containers



Breach #2: Circulator nurse did not label the outside of bag



Breach #3: Circulator nurse did not document specimens in the specimen logbook



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Evaluating Conduct Violations using Just Culture

- Breach: Circulator nurse put both specimen containers into a single large, red biohazard bag.

1

Name each action/omission.

2

What is the harm/potential harm for each.

3

What is the value associated with each harm/potential harm?
[Does it matter to your organization?]

4

Select an algorithmic pathway.
[Procedural/Values]

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Five Questions in a Threshold Investigation are Applied to Each Breach

Breach: Circulator nurse placed both specimen containers into a single large, red biohazard bag.

What happened?

Circulator nurse placed both specimen containers into large red biohazard bag.

What normally happens?

Specimen containers are placed in clear specimen bags. When containers are too big for the bag, they are placed in a large red biohazard bag.

What does procedure require?
(if applicable)

Specimens are placed in a clear specimen bag.

Why did it happen?

The specimen containers would not fit in the clear specimen bags. Larger specimen bags were not stocked.

How is the organization managing the risk?

The organization did not see the risks. Staff had been using large red biohazard bags for specimens that were too large for the standard clear bags for some time. No one (on the circulating nurse team nor in the lab) had reported this as a workaround or risky practice.

Evaluating the Quality of the Choice

Breach: Circulator nurse placed both specimen containers into a single large, red biohazard bag.

Human Error

“Our Inescapable Fallibility”

Unintended conduct: inadvertently doing other than what was intended: a slip, lapse, or mistake

At-Risk Behavior

“Our Propensity to Drift”

A choice where risk is not recognized, or is mistakenly believed to be justified

Reckless

“The Gamble”

Conscious disregard of a substantial and unjustifiable risk of harm

Knowledge

“Me First”

Knowingly causing harm (sometimes justified)

Purpose

“Rage”

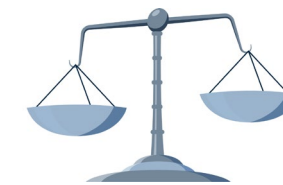
A purpose to cause harm (never justified)

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Just Culture



This model of shared accountability drives **psychological safety, continuous learning, and improvement.**



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Safety Tactics

From Concept to Practice

Culture of Safety



- **Culture of Safety**
 - Fair and just culture
 - Reporting culture
 - Learning culture
- Without a strong, just safety culture:
 - Near misses and mistakes due to system design problems are less likely to be reported
 - The organization has fewer opportunities to learn and improve

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Communication

- **Create dedicated, structured channels for people to speak up & identify workarounds**
- Briefing & Debriefing
 - Hold space for people to speak up
 - Real-time checkpoints
- Tiered Safety Huddles
 - Rapid escalation of concerns from frontline to executive level
- **Protect outcomes in imperfect systems**



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Safety Event Reporting

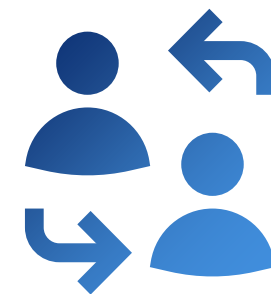
- **Use information to improve how the system is designed**
- Anticipate seeing an increase in reports
- Apply systems thinking in review
- Apply Just Culture in evaluation of choices



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Recovery & Resiliency

- **The ability of your system to *recover* and *learn* after an event is directly tied to how well you support the people involved.**
- Peer Support Program
 - Human reality: Feel bad regardless of cause (system flaw or human error)
 - Fosters and sustains trust
 - Prevents burnout/trauma



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Unified Approach

- Transformation only can be achieved with the right system design and a culture of accountability.



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Thank you!



Let's get started.

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