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A Just Culture:

The Impact of Trust and Error Management on Safety Performance

In this white paper, we explore the concept of a just culture and the pivotal role that trust and error management have in driving positive safety outcomes.

PART ONE:

Is a Just Culture as Fair as it Appears to Be?

The notion of having a just culture seems like a fool-proof idea. In simple terms, it's an organisational culture where individuals aren't blamed for honest mistakes, only for acts of sheer negligence or wilful misconduct (Frankel, Leonard & Denham 2006). That means that as long as you intend to do the right thing, if a mistake arises, you won't be punished for it. On the surface, it appears to be an effective system with punitive measures only being enforced when they're truly deserved.

However, a look beyond the surface reveals flaws within the system. When you take a step back and think about who gets to make that judgement call about whether or not something was due to an honest mistake, a major issue with the system becomes clear. While at its core, the principles behind a just culture are meant to support a fair and non-biased system, the reality is that a just culture relies heavily on the perspective and opinions of your organisation's leaders—which comes at an unexpected cost.

That's why in this white paper, we're going to walk you through the key factors that undermine the effectiveness of a just culture and how you can mitigate these risk factors to drive exceptional safety outcomes.

When it comes to incident management, who defines what's fair?

When thinking about how to deal with incidents that arise within a just culture, a great starting point is to utilise Marx's outcome engineering algorithm (Marx, 2001) to define the three basic duties of any worker and exactly how we can categorise a breach within each one.

The outcome engineering algorithm dictates that workers in any industry have three basic duties. These are:

- The duty to produce an outcome
- The duty to follow a procedural role
- The duty to avoid unjustifiable risk

With that framework in mind, a breach within any of these three categories can be judged to be caused by one of the following reasons.

1. **Human Error**
2. **At-Risk Behaviour**
3. **Reckless Behaviour**

Human Error - "I was trying to do the right thing, I don't know what went wrong"

The most honest of mistakes, human error breaches are caused by individuals who genuinely believe that they were taking the right action at the time of the breach. A common example of this would be a retail assistant who mistakenly hands out the wrong amount of change. As far as they were aware, they honestly believed that they had done the right thing and provided the customer with the right amount of change.

In these circumstances, the best approach to take would be to provide the worker with coaching and additional training to ensure that they're fully capable of executing their tasks without further errors in the future (Reason, 1990). Punishment would be counter-productive in these circumstances as the breach was completely unintentional, meaning that subsequent breaches may also happen unintentionally.

At-Risk Behaviour - "I thought this would be an easier way of doing things, but I didn't realise how risky it was"

This breach of duty occurs when a worker makes a conscious decision to break a rule, policy or procedure because they didn't understand the risks involved with that decision. Especially common when workers are attempting to improve efficiency, it's motivated by the notion that an act of non-compliance will have no major negative impact. Therefore, it wasn't worth the effort to adhere to it.

In these situations, the best approach would be to educate the individual as to the risks involved with their behaviour, mitigating the chances of them doing it again (Reason, 1990).

Reckless Behaviour - "I knew I wasn't meant to do it and I knew how risky it was, but I didn't think I would get caught"

The worst type of breach, reckless behaviour breaches are when an individual makes a conscious decision to violate rules, policies and procedures with full knowledge that their actions could lead to increased risks and potentially disastrous outcomes. In this case, swift punitive measures may be the best course of action, including disciplinary action and civil or criminal charges (Reason, 1990).

When a breach occurs, who defines which category it falls under?

As you can see, the distinction between the actions taken towards a worker following an act of human error differs greatly from the punitive measures implemented when they've engaged in reckless behaviour. As an employee in an organisation that adheres to a just culture, understanding how breaches in your workplace duties are categorised has a major impact on your behaviour across every level of your organisation.

A key question that arises is how accurately can your organisation's leaders evaluate which of these categories a breach falls under? Beyond that, how confident are workers in their leaders' ability to make a fair and reasonable evaluation of the circumstances involved when a breach occurs? The answers to these questions are some of the major undermining factors of a just culture.

This dilemma was clearly articulated when a group of employees in the aviation sector expressed their concerns to a European prosecutor about how simple human errors were being treated as criminal offences. In response, the prosecutor stated

> "You have nothing to fear if you've done nothing wrong. I can judge right from wrong. I know a wilful violation, or negligence, or a destructive act when I see it." (Dekker, 2012)

As an employee in the aviation sector who works in a fast-paced environment with countless decisions to be made in any given day, how confident would you be about reporting an act of human error when you know that it's up to the judge's opinion, whether or not you'd be charged with a criminal offence?

Even with the prosecutor's choice to use the word "see", it makes the crux of the problem with just cultures instantly clear. With this type of culture, a heavy reliance is placed upon the judgement of the leader evaluating the incident and it assumes that cases of "gross negligence" are easily distinguishable from cases of "wilful violations", much to the anguish of the individuals involved (Dekker, 2012).

A judgement isn't a fact, it's an opinion

Judgements are exactly what they are—subjective opinions about a circumstance. They aren't scientific facts, nor are they immune to individual biases which means that the effectiveness of a just culture can be undermined by something as variable as individual perspectives (Dekker, 2012).

Especially when a just culture is deeply rooted in the idea that errors should receive just repercussions, it means that the system relies on an individual being able to make a distinction between wilful and negligent acts (Dekker, 2012). However, there aren't any measures in place to prevent biases from influencing their decision-making process. That means that depending on who's making the judgements, employees may have a lot to fear when a breach in their duty occurs—even if it was truly a case of simple human error.

To ensure that breaches are categorised fairly, start with these five questions

Given the potential caveats of a just culture, consider these five questions during implementation to ensure that the fairest outcomes are reached.

Who gets to draw the line between acceptable and unacceptable behaviour? (Dekker, 2012)

Ensure that your employees know exactly who will be making the distinction between acceptable and unacceptable behaviour—giving them the reassurance that managerial actions will be consistent.

What level of expert opinion do you need to judge their behaviour accurately? (Dekker, 2012)

To minimise the risk of unfair judgements, ensure that domain experts play a key role in judging behaviour. Domain experts with experience performing similar tasks will have a much stronger viewpoint for interpreting the actions that were involved in a breach.

How protected is your safety data against external interference? (Dekker, 2012)

Especially in countries where non-domain officials may easily gain access to safety data, if safety data isn't protected, employees will be less willing to report errors due to a fear of negative repercussions from beyond your organisation. On the other hand, if this data is protected, employees will be more likely to report errors.

Do you have any measures in place to minimise the impact that judgements could have on workplace trust?

Given the importance of workplace trust and the potential for unjust decisions to negatively impact employees trust in leadership, consider the implementation of preventative measures to minimise any potential impact.

When errors occur, are they being managed fairly and effectively?

Even if you are making fair judgements on errors, employees will still be reluctant to admit to their mistakes if they feel like punitive actions are always taken as it reinforces a fear of negative repercussions. A more effective approach would be to emphasise a culture of positive error management, where incidents are viewed as potential learning experiences.

PART TWO:

Workplace Trust

The easiest way to think about a just culture is to think about a culture that's based on trust

At its core, a just culture is simply a culture that relies heavily on the basic principles of trust. A reference to our ability to rely on others based on the expectation that they have our best interests in mind, in its simplest form, trusting someone is simply the act of believing that they have the best of intentions (Rosseau, Stikin, Burt & Camerer, 1998).

In order for a just culture to be effective, you need to ensure that your employees have a strong level of trust in the opinions and actions of their leaders. Otherwise, the system doesn't work as instead of trusting and relying on your leaders' fair judgement, your employees will be motivated to hide any incidents that happen instead.

An often overseen aspect of workplace dynamics, trust in the workplace has an impact across every level of your organisation, including employee wellbeing and productivity. For example, studies have shown that a one-point increase on a 10-point scale of trust in management (where 1 is low trust and 10 is high trust) created the same amount of an increase in life satisfaction as a 36% increase in income (Helliwell, Huang and Putnam 2009). Especially when you consider the high costs involved with talent retention and ensuring employee wellbeing, it's easy to see just how important it is to ensure that you're actively fostering a sense of trust between your employees and their leaders.

Researchers have seen similar benefits across various industries including a relationship between trust in restaurant general managers and the facilities' sales and profits (Davis, Shoorman, Mayer & Tan 2000). A similar relationship has also been evidenced between trust and delivery timeliness, supply quality and supplier flexibility (Zaheer, McEvily & Perrone 1998).

The relationship between trust and safety

When it comes to your safety efforts, the importance of trust becomes ever more prominent. That's because trust has a direct relationship with psychological safety. That is, the intrinsic beliefs about how others will react when you put yourself on the line by asking a question, seeking feedback, reporting a mistake or proposing a new idea.

If your workers are confident that they won't be unfairly blamed for a safety incident, they're more likely to report a potential safety hazard. On the other hand, when their levels of trust in leadership are low, so too is their sense of psychological safety and the likelihood of them actually reporting an incident.

In essence, when an incident occurs, your workers ask themselves "Will I get in trouble for this?". If they aren't confident that they won't get in trouble, then they'll be more likely to hide that incident from you.

On the other hand, when they have a high level of trust in their leaders, they're more willing to listen and be influenced as they believe that their leaders have their best intentions in mind (Conchie & Donald, 2009).

Grant and Summanth (2009) reiterated this with their research that indicated that employees who viewed their leaders as trustworthy interpreted their leaders' actions as a signal that a task was important and in turn, they were more motivated to improve their own performance. This has a powerful impact on your safety results as it indicates that if your employees trust their leaders, then they're more likely to improve their safety performance.

The unexpected relationship between trust and focus

An often overlooked element of trust is the impact that it has on your employees' ability to focus on their work. Mayer and Gavin (2005) found that when employees trusted their leaders, they focused more on value-producing activities. They suggested that this might be due to the fact that when trust in leadership is low, employees may be unintentionally wasting their mental resources by monitoring their leader's behaviour in an attempt to "cover their back". Given their lack of trust in leadership, they might also be actively gathering and storing information about their performance to prove that they were being productive if they were ever called out, instead of focusing their attention on the tasks at hand.

Simply put, a lack of trust in leadership might be placing your employees in a distracted state of mind that's detracting from optimal levels of productivity. That means that improving their trust in leadership could have a direct impact on your production output, your safety performance and your bottom-line.

The factors that impact the formation of trust

Now that we know the importance of trust between employees and their leaders, let's break down a few key factors that impact the formation of trust.

Trusting Stance

Individuals with greater trusting stances tend to have higher initial trust levels when they meet someone new. This is influenced by their previous interactions with others

and the likelihood of them meeting people who were consistently reliable and well-meaning (Spector & Jones, 2004). In light of this, it's important to remember that in the face of new leadership, individual employees will have varying levels of initial trust due to differences in their trusting stances (Creed & Miles, 1996; Keller 2001; Williams, 2001).

Category and Role-Based Trust

Category-based trust refers to the tendency of individuals within the same organisational group to place higher levels of trust on each other than those who are outside of their group (Kramer, 1999). In a similar manner, role-based trust is the tendency to base trust of an individual on information about the type of role that they're in, rather than information about their personality (Kramer, 1999). As you can see, both of these factors are essentially defined by the labels attached to a given individual—be it which organisation they're from or the role that they're in.

As a leader looking to develop trust with your employees, be sure to reinforce the notion of being a team within your organisation and reiterate the expertise that's required to fill in specific leadership roles to increase levels of category and role-based trust.

Dependency

This relates to the need for individuals to rely on one another. A natural aspect of workplace relationships, studies have found that when employees had a greater level of dependency on an individual, they tended to trust them more (Wells and Kipnis, 2001).

The impact of demographical differences on trust

Demographics play a substantial factor in the formation of trust. Individuals are more likely to trust others if they share demographical features with them (Creed & Miles, 1996; Keller, 2001; Williams, 2001). In particular, substantial demographical differences arise when you examine union workers, and men and women.

The union worker effect

In general, union workers tend to rate trust in management at a lower level than non-union workers (Helliwell & Huang, 2011). For example, union workers have been found to rate trust in management at just under 6.0 on a 10-point scale (0 = no trust in management; and 10 = complete trust in management), whereas non-union workers were found to rate trust in management as a 7.1.

Beyond that, the increase in wellbeing associated with greater trust in management is higher for non-union workers than union ones. This indicates that while union workers might have lower levels of initial trust in management, developing their workplace trust could lead to a substantially happier workforce.

Gender differences

Compared to women, men are generally more distrustful. For example, men have been reported to possess a higher initial level of trust for other men than other women. For women, there's no difference as they're just as likely to trust a man as they are to trust a woman upon their first meeting (Spector & Jones, 2004).

Women also tend to have greater trust in management than do men (Helliwell & Huang, 2011). However, they're also more likely to be working in environments where trust in management is already at a higher level. Most interestingly, women tend to gain more than men, in terms of life satisfaction, from working in environments where trust in management is higher.

The other side of the trust equation

The only problem with trust is that when there is too much of it, you risk the potential of groupthink (Erdem, 2003). Groupthink refers to situations where a group ends up making irrational or non-optimal decisions in favour of maintaining harmony. As evidenced by Manz and Neck (1997), too much trust can prevent employees from engaging in effective decision making.

In fact, in workplaces where there are high levels of trust between employees, workers may become over-reliant on one another and their perceived personal responsibility in safety may be reduced (Conchie & Donald, 2009). Due to this, research has suggested that in order for trust to be useful to workplace risk regulation, there needs to be a sense of "critical trust" where a practical reliance on each other is coupled with a healthy level of scepticism (Pidgeon et al 2003).

PART THREE:

Error Management

How do you make your team feel safe enough to report incidents?

As you can see, despite the potential for untreated hazards and errors to lead to serious injuries, if workers don't feel a sense of psychological safety, they may be highly reluctant to report potential incidents.

Especially given our tendency as a society to enforce swift punishments on those who make mistakes, this issue is only further amplified when workers don't have much trust in the actions of their leaders. To mitigate the issue, leaders need to ensure that they're responding productively when errors arise in the workplace to ensure that it doesn't trigger a fear of negative repercussions around reporting.

The reality is that no matter how hard we try to prevent them, it's practically impossible to completely avoid errors. That's because on some level, organisational systems will always be reliant on human abilities which are heavily influenced by the limitations of the human brain (Edmondson, 1996; Frese & Zapf, 1994; Reason, 1997; van Dyck, Frese, Baer & Sonnentag., 2005). Be it through a lapse in judgement, a lack of skill or influenced by sheer fatigue, human abilities are highly variable which makes them wide open to errors— despite our best attempts to control them.

To make things worse, the more complex a task is, the more it has to rely on human ability and in turn, the more likely it is for an error to arise (Mitropoulos, Abdelhamid & Howell, 2005; Scharf, Vaught, Kidd, Steiner, Kowalski & Wiehagen, 2001). As such, instead of just viewing errors as mistakes to be prevented, it's important to reframe our perspective on errors to also view them as the valuable learning experiences that they are. (Cannon and Edmondson, 2004; Starkey, 1998; van Dyck et al., 2005). The fact is that whether or not we want them to happen, errors will inevitably occur. Therefore, it's crucial to have an effective error management strategy in place.

Effective error management

Error management refers to an organisation's utilisation of errors as key learning opportunities for its employees (Cigularoy, Chen & Rosecrance, 2010). The main goal of error management is to effectively deal with errors and their consequences, instead of only focusing on error prevention (Frese, 1995).

This can be achieved by:

1. Identifying, analysing and effectively communicating when errors occur
2. Actively reducing the impact that errors have on the workplace
3. Reframing errors as learning opportunities to prevent future mistakes

How effectively your organisation is able to achieve this goal is largely dependent on your error management climate and the effectiveness of your error management training programs.

Your error management climate

Your Error Management Climate (EMC) is a measure of the perceptions that your employees have about communications relating to errors (van Dyck et al., 2005).

1. **Willingness to report errors** - "We take pride in reporting incidents swiftly and effectively"
2. **Further thought about errors** - "People in our company think about how errors could have been prevented"
3. **Learning from errors** - "When mastering a task, people can learn a lot from their mistakes"
4. **Active error management** - "In our organisation, we try our best to fix errors when they arise before continuing on with a job"
5. **Communicating errors** - "When someone makes an error, they share it with others so they don't make the same mistake"

A positive EMC simply means that your employees have positive views around these five categories. (van Dyck et al., 2005) On the other hand, a negative EMC arises when your employees have negative or opposing views about these same categories.

Studies have shown that organisations with positive and constructive EMCs have better financial performance than those who have negative EMCs. In fact, an increase in just one standard deviation in EMC led to an increase in firm profits by 20% (van Dyck et al. 2005). In a similar manner, workgroups with more positive error management views and open lines of communication about them delivered better customer service than groups that did not (Cannon and Edmondson, 2001). These improvements in profitability and productivity are only the beginning.

EMC and your safety performance

To best iterate the impact that a positive EMC can have on your safety performance, we can take a look at the impact it's had on medical employees. It's estimated that in the United States alone, over 44,000 deaths a year are due to errors made by medical employees. That's more deaths than vehicle accidents, breast cancer or AIDS in the

United States (Kohn, Corrigan & Donaldson 2000). With such a major impact, you would be justified in assuming that error management was always a key aspect of safety improvement research.

However, up until the early 2000s, the vast majority of research related to improving organisational safety climates were solely focused on doing so through the improvement and enforcement of safety procedures (Hofmann, Morgeson & Gerras, 2003; Hofmann & Stetzer, 1996; Hofmann & Stetzer, 1998; Zohar, 2000; Zohar & Luria, 2005). This was despite the fact that earlier research had already indicated that nurses shared a fear of negative repercussions from safety reporting and as such, were hesitant to report or discuss any errors (Edmonson, 1996).

It wasn't until 2006 that researchers decided to investigate the impact that error management climates had on safety performance in nurses. Their findings revealed that when there were effective error management systems in place, there were far fewer back injuries and medication errors, increased patient satisfaction and higher levels of job satisfaction (Hofmann & Mark, 2006). That's when they concluded that error management was a key component of positive safety cultures as it allows employees to learn from errors, lowering the chances of the same errors arising again.

Error management training—your bridge to improved safety performance

Given the benefits that come with a positive error management climate, the good news is that it can be developed with Error Management Training (EMT). First developed in 1989, the core principle of EMT is that it acknowledges that workers are human and as such, they will inevitably make mistakes (Frese & Altmann, 1989). So, instead of viewing errors as being detrimental to an organisation's ability to function, EMT frames errors as a natural by-product of active learning that are opportunities for further learning and growth (Keith & Frese, 2008). The two key components of EMT can be broken down into 'active exploration' and 'error management instruction'.

The 'active exploration' element involves encouraging participants to find their own solutions to the problems provided without active guidance. Then, the 'error management instruction' element involves coaching participants to expect errors in the performance of their tasks and emphasises the importance of positive feedback processes when errors occur.

A common statement that you'll hear in these sessions is:

> "The more errors you make, the more you learn!"
>
> (Keith & Frese, 2008).

Through these processes, the core goal of EMT is for participants to reframe errors as being key learning opportunities and to provide them with practical strategies that they can use to better deal with errors in the future. It aims to detract from a fear of errors and to replace this with the notion that errors are valuable opportunities for learning and growth.

Where to from here?

To bring it all together, as a leader within an organisation that adheres to a just culture, it's crucial to remember that while a just culture might appear to be a fair system on the surface, it comes at the potential cost of your workers' trust in their leaders.

Beyond that, without a positive error management climate in place, it could amplify a fear of negative repercussions when safety incidents arise and reduce the likelihood of your employees actually reporting hazards.

So, to tip the scales in your favour and to drive improved safety outcomes within a just culture, here are a few key strategies that you could employ.

1. Actively Foster Trust in Leadership

Given that just cultures are reliant on the levels of trust that workers have for their leaders, foster this sense of trust by maintaining open lines of communication regarding the classification of an incident. Especially if punitive measures are taken, open communication mitigates the risk of any false beliefs becoming formed regarding why that call of action was taken.

Maintaining a sense of transparency regarding the factors surrounding a decision allows your workers to see exactly how a decision was made, especially in regards to negligence or wilful misconduct. In doing so, you can alleviate the fear that it was a biased decision and minimise the impact that it has on any trust in leadership.

2. Develop a Positive Error Management Climate (EMC)

When errors do inevitably occur, instead of brushing them under the table, make a stance by positively reinforcing your workers' choice to report. In doing so, not only are you indicating that you value effective error management on an organisational level, but you're also driving a sense of intrinsic motivation within your workers to continue to report future safety incidents.

Beyond that, when errors do arise, proactively learn from and implement measures to prevent the impact that they have on the workplace and to minimise the likelihood of them reoccurring. In doing so, you also signal to your workers that the choice to report safety incidents leads to improvements across the workplace.

3. Invest in Error Management Training (EMT)

Finally, to drive lasting change and develop a strong, positive EMC, consider investing in EMT programs to start reshaping your employees perspective on what it truly means when an error occurs.

Instead of viewing errors as unintended deviations that should be avoided at all costs, an effective EMT program helps your employees understand the important role that errors play in the learning process and exactly how they can leverage them as potential opportunities for growth.

While this paper covered many of the caveats of a just culture, it doesn't mean to say that maintaining such a culture is always ineffective. On the contrary, it can actually be a very effective system that's based on fairness and open communication. All it takes is a little conscious effort to ensure that the fairness of the system is upheld in the eyes of your employees by investing in the development of trust, having open lines of communication and maintaining crystal clear transparency.

Sentis specialises in safety culture measurement and transformation. Experts in applied psychology and neuroscience, Sentis helps organisations to enhance and move beyond compliance to empower employees to work safely—not because they have to, but because they want to. Offering training, coaching and consulting, Sentis has helped more than 300 companies and 150,000 people think differently about safety since 2003.

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