Human Error and Just Culture

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"Just culture refers to a values-supportive system of shared accountability where organizations are accountable for the systems they have designed and for responding to the behaviors of [members] in a fair and just manner. [Members], in turn, are accountable for the quality of their choices and for reporting both their errors and system vulnerabilities." - Outcome Engenuity LLC (2012). Just culture: Training for managers.

Working together for safety supports a healthy and safe environment for our members and for taking care of our equipment. Our readiness, reliability, and reputation depend on an environment of trust where members know what safe practices and behaviors are, how they are critical to everyone's wellbeing, and how we all must be accountable to each other for following our ideal safety requirements and processes – this is called "Just Culture," and it is an important part of CAP's Ideal Safety Culture.

The characteristics of an ideal just culture include people…

- Understanding acceptable and unacceptable behaviors.
- Being positively acknowledged for raising safety concerns.
- Cooperating fully in safety reviews and knowing they will be treated fairly and justly.
- Being accountable for truly negligent, reckless actions.

Focus on Behavior

Not all behaviors are equal when finding and addressing the factors that contributed to a safety occurrence. Often, an organization's response to a safety occurrence is based on the severity – or possible severity – of the outcome. A major accident is treated more aggressively than a minor "fender-bender." In an ideal just culture, addressing gaps in our safety management system and any non-ideal human behaviors should be our main focus and not only on the severity of the outcome.

One way to think about human behavior within a safety system like CAP's is in terms of human error, at-risk behavior, and reckless behavior. The descriptions for these terms below are from The Institute for Safe Medication (The Differences Between Human Error, At-Risk Behavior, and Reckless Behavior Are Key to a Just Culture | Institute For Safe Medication Practices (ismp.org)).

Human Error is an unintentional action or inaction resulting from limitations in the way we perceive, think, and behave. It is not a behavioral choice - we do not choose to make errors, but we are all fallible.

At-Risk Behaviors are different from human errors. They are behavioral choices that are made when individuals have lost sight of the possible loss of safety associated with the choice or mistakenly believe the risk to be insignificant or justified.

Reckless Behavior is the conscious disregard of a substantial and unjustifiable risk. Individuals…know the risk they are taking and understand that it is substantial.

Human Error

In cases of human error, factors that can contribute to unsafe outcomes stem from human limitations associated with stress, fatigue, distraction, and more. For example, not getting enough sleep is a significant contributor to workplace error. Without adequate sleep, humans

tend to be more forgetful, less focused, and even less ethical (The impact of sleep on employee performance | Deloitte Insights). According to the CDC, lack of adequate sleep also contributes to motor vehicle accidents and making more errors at work resulting in “a lot of injury and disability each year” (Sleep and Sleep Disorders | CDC).

Since we cannot “make” people get adequate sleep, regulatory agencies like the Federal Aviation Administration and others publish and enforce rules for ensuring that people have adequate opportunities to rest between work shifts.

Human error as a contributing factor should usually lead to revising current safeguards or introducing new ones that reduce the likelihood of a human error contributing to a negative safety outcome. Within CAP's human factors categories, those safeguards can be found in the systems we use to communicate, train, supervise, develop checklists or processes, establish regulatory requirements, and more. The focus of any action should be on reducing the likelihood of the error causing an unsafe outcome in the future, not on deterring human behavior with punitive measures.

At-risk Behavior

In occurrences where at-risk behaviors are a factor, conscious choices to work around rules, restrictions, or difficulties can lead to unsafe outcomes. These workarounds usually occur when a person focuses more on their individual needs or preferences versus the requirements of the organization ((12) Practical Drift is Safety's silent adversary | LinkedIn). According to Flight Safety Foundation, “most accidents occur not because of a lack of procedures, policies, checklists, etc., but rather because those procedures and policies are not being used,” (The Safety Space and Practical Drift - Flight Safety Foundation). The further from the requirement one “drifts,” the more likely a safety significant outcome can occur.

To address these factors, first look at the requirement before assuming an at-risk behavior. What led to the person working around it or taking shortcuts? In some cases, that requirement may be too difficult or cumbersome to follow in certain situations. In cases where the requirement wasn’t a factor, look at the circumstances that may have led to the deviation. For example, a pilot may not complete a post-flight inspection of an aircraft because they are late for an appointment. Whether a “one-off” occurrence or a routine shortcut, failing to complete a post-flight inspection can lead to unreported damage which delays getting the airplane repaired, potentially reducing our readiness for the next mission.

Address at-risk behavior by revising organizational requirements, when needed, and by refocusing and realigning behaviors with organizational expectations. Usually, realigning behaviors is accomplished through recurring training, audits, equipment checks, remedial training, and supervision when necessary. Ignoring or condoning at-risk behaviors can lead to extremely serious safety occurrences and every member must understand the importance of adhering to CAP requirements and the need to speak up about difficult or overly-restrictive requirements before working around them.

Reckless Behavior

An ideal just culture does not mean a “no responsibility” culture. At-risk and reckless behavior must be addressed quickly. An example of potentially reckless behavior might be choosing to drive a van after taking a medication that is known to the driver to cause drowsiness. If such a behavior were to be observed or reported, once the factors are discovered and regardless of the outcome, action must be taken quickly and decisively. The risk of operating a vehicle in this condition is likely substantial and unjustifiable and must not be tolerated.