2020

Safety Promotion Via a Just Culture

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INTRODUCTION

Recently, there has been a surge of emphasis on creating a culture of safety, whether that be patient safety, or nurse and other health-care provider safety.

A Just Culture (JC) is defined as a culture that, “focuses on identifying and addressing systems issues that lead individuals to engage in unsafe behaviors, while maintaining individual accountability by establishing zero tolerance for reckless behavior” (Ulrich, 2017, p.207).

According to Ulrich (2017), JC helps differentiate between:

- Human error
- At-risk behavior
- Reckless behavior

Focuses on finding the best way to approach incidents in the workplace and how they are dealt with appropriately.

SIGNIFICANCE

Thousands of deaths occur annually due to medical error in the US and many go errors go unreported.

A 2018 report “reveals that healthcare worker ‘psychological safety’ is lacking in many hospitals, with 47% of respondents expressing concern that reporting unsafe conditions will be held against them” (AHC MEDIA, 2019).

“30% of staff disagreed with the statement, ‘I would feel able to talk openly with my line manager if I was feeling stressed while 56% would like to do more to improve staff well-being but didn’t feel they had the right training or guidance” (Foster, 2020, p. 381).

A 2016 study of 270 acute care hospitals showed that 211 (78%) have adopted JC in their setting (Edwards, 2018, p. 503).

Of those 211 hospitals, 86% reported a positive impact of JC (Edwards, 2018. p. 504).

POSITION STATEMENT

A “Just Culture” is without a doubt needed in order to promote a culture of safety in any health care environment. Without this “just culture”, patients and staff are not safe.

SUPPORT FOR POSITION

A JC allows healthcare workers to report system or process failures without the fear of punishment (Ulrich, 2017, p. 207).

- More disciplinary cultures often see medical errors go unreported (AHC MEDIA, 2019).
- Leads to vital information about system or process failures being ignored, limiting patient safety (Ulrich, 2017, p. 207).

A JC focuses on:

- Having the ability to speak up when you have done something wrong or have seen someone do something wrong (Foster, 2020, p. 381).
- Attempt to understand why failings occurred and how that active system led to sub-optimal behaviors (Foster, 2020, p. 381).
- The acknowledgement that humans make errors and looks at the factors related to the error and its processes (Ulrich, 2017, p. 207).
- No “blaming and shaming” behaviors are acceptable in any case (Ulrich, 2017, p. 207).

Not having a JC in place on a unit is an ethical issue (Dettwiller, 2020, p.7).

- A nurse is more willing to speak up if they are not afraid they will get in trouble, many do not speak up because they are afraid of the consequences (Dettwiller, 2020, p.207).
- Incidents that go unreported negatively affect patient outcomes.

IMPLICATIONS FOR PRACTICE

Implementation of a JC rests on the shoulders of a nurse supervisor and the cooperation of the RNs they are in charge of.

- Need to set the stage for staff to be able to raise awareness of the ethical problems they encounter (Dettwiller, 2020, p. 7).
- Set the platform and tone for employees to speak up, relating directly to the outcomes of the facility and safety of the patients and staff (Dettwiller, 2020, p. 7).

JC’s “no-blame” style will lead to a much more comfortable environment.

- The individual at fault receives constructive feedback and the focus shifts to the event rather than the individual themself (Dettwiller, 2020, p. 7).
- Ask why the event occurred until the underlying cause is identified.

If the individual acted with reckless conduct:

- “[They] should be held accountable with disciplinary action such as a final warning, referral to police, or other appropriate sanction identified in the organization's established policies” (Morris, 2011, p. 122)

If the event did not involve reckless or malicious behavior:

- Supportive action includes “identifying contributing system factors, coaching, mentoring, increasing supervision, developing performance improvement plans, or adjusting work duties” (Morris, 2011, p. 122).

CONCLUSION

A long term benefit of implementing JC will improve patient outcomes as a result of staff feeling more comfortable in openly bringing process and quality improvement opportunities forward to management. A JC intends to create a learning culture to help design and redesign systems to be safer and more effective. It should be mandatory on all units in order to maintain and improve patient safety, minimize healthcare errors, and learn from them if the do occur.

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