Does a “Just Culture” Improve Patient Safety?

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INTRODUCTION

Just Culture (JC) is a value supportive system of accountability where healthcare institutions are accountable for systems they design (AHRQ, 2018).

- JC includes staff, patients, and visitors and their choices in those systems.
- 3 categories associated with JC:
    - Human error, at risk behavior, and reckless behavior

JC makes it so if errors are made, regardless of the category it falls into, the one at fault feels they are able to come forward and discuss the error without fear of a resulting punishment (AHRQ, 2018).

SIGNIFICANCE

One hospital survey published by Battard (2017), showed that staff felt their mistakes are held against them and they’re written up instead of the problem.

Paradiso et al. (2019), found that nurses may be hesitant to voice concerns which can unknowingly cause risk to patients.

- They also conducted an interview with clinical nurses and nurse leaders where 39.3-39.6% of clinical nurses disagree to the following statements while only 8.3-11.5% of nurse leaders disagree:
    - Objective follow-up process regardless of involvement
    - Trusting supervisors to do the right thing

POSITION STATEMENT

Implementing a JC in healthcare and is important in keeping patients safe and saving lives as it supports open communication with non-punitive responses to errors in an environment that decreases fear related to taking responsibility for those errors.

SUPPORT FOR POSITION

When individuals are not afraid of the consequences, they are more likely to come forward about errors (HQCA, 2021). This will improve patient safety as the errors will be brought to attention much quicker.

The safety of patients is number one and making sure errors are reported is essential to providing that safety.

According to Allyn (2019), even professionals make mistakes and JC leads to open and safe error reporting. They also interviewed Dr. Larson who said:

- “a fair and JC improves patient safety by empowering employees to proactively monitor the workplace and participate in safety efforts in the work environment” (para. 7).

Safety culture is important for improving patient outcomes and views errors, close calls, and concerns about patient safety as potential weaknesses that needs to be addressed (HQCA, 2021).

Part of the solution to errors in healthcare is to maintain a JC and work towards implementing solutions rather than punishment (Rodziewicz et al., 2021).

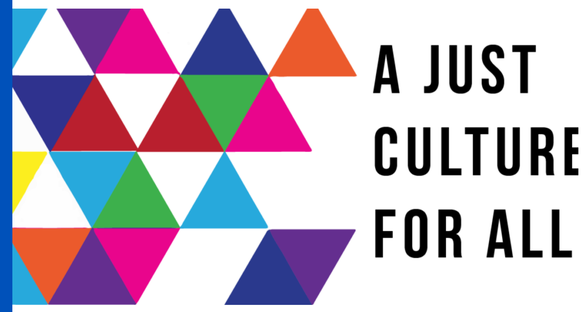
IMPLICATIONS FOR PRACTICE

According to Battard (2017), the following information can help to implement a JC:

- Using non-punitive environment training can help establish a strong infrastructure where nurses feel safe reporting safety concerns or errors in patient care.
- Having nurse directors and hospital leaders follow up with training provided can help reinforce support for non-punitive responses to errors and help the cause through leading by example.

The Center for Patient Safety (CPS) offers training for institutions that are trying to implement a JC. Some things they offer include:

- Providing and analyzing patient safety culture surveys to determine strengths and opportunities for improvement
- Providing onsite identification and session support to determine that facilities individual needs, as well as several other helpful training segments (CPS, 2020).



(Seui 721, 2021)

CONCLUSION

JC is a culture that supports the reporting of errors without punishment falling on the one at fault. Implementing a JC in the healthcare setting is essential for providing patients with a safe environment and keeping them free from harm.

Non-punitive incident reporting is essential for creating a positive working environment in promoting overall patient safety and positive outcomes.

(Battard, 2017)

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