Does a “Just Culture” Improve Patient Safety?

MISERICORDIA UNIVERSITY

Alexis Hockenberry

INTRODUCTION

- Errors can occur in healthcare settings causing adverse outcomes and sometimes death (Boysen II, 2013, p. 400).
- Organizations then seek out individuals responsible for the errors which results in individual punishment (Boysen II, 2013, p. 400).
- The punishment does not solve the problem from happening in the future because it is solely focused on the individual being punished (Boysen II, 2013, p. 400).
- Instead there should be focus on the error itself and how to prevent it in the future (Sorra, 2003).
- However medical institutions must find a balance between punishment and blamelessness and that is where the development of a just culture comes into place (Boysen II, 2013, p. 400).

SIGNIFICANCE

- Over 90% of nurses identified that patient safety is an important aspect of health care(VanGeest, 2003, p. 13).
- 88% of nurses agreed that everyone in healthcare shares the same responsibility for patient errors (VanGeest, 2003, p. 13).
- Over 90% of nurses indicated interest in receiving education in patient safety (VanGeest, 2003, p. 16).
- 69.1 % of nurses agreed that a nonpunitive environment and system for reporting error would better patient safety (VanGeest, 2003, p. 18).

POSITION STATEMENT

People make errors, and errors can cause adverse outcomes as well as possible death in the health care systems. A nonpunitive work environment with a system for reporting errors would allow for better patient safety.

SUPPORT FOR POSITION

According to VanGeest,

- “Efforts to improve patient safety must include teaching health professional new skills. Our research suggests that this can be done with a systematic approach and a comprehensive curriculum” (VanGeest, 2003, p. 19).
- “Physicians and nurses must cooperate in promoting a change in the system from the current “culture of blame” to a “culture of safety.” This comprehensive curriculum must encourage a multidisciplinary approach to patient safety by fostering an environment of collaboration and continuous problem-solving among healthcare team members” (VanGeest, 2003, p.19).
- “Clinical effectiveness and quality of care are important components of patient safety and must be constantly reassessed and reevaluated. Health professionals need to be comfortable learning from error. Efforts that identify error and improve safety must be guided by a primary focus on systems and not individuals” (VanGeest, 2003, p.19).

IMPLICATIONS FOR PRACTICE

There needs to be education for health care systems on how to deal with the correction of error resulting in improved patient safety. If providers and nurses can work together to change the current state of a culture of blame to a culture of safety for the patients, it would be more beneficial. This allows for open communication between employers and employees to reduce the risk of adverse outcomes and death in patients. It also allows for a collaborative environment to problem solve among members of the healthcare team. Quality of care also needs to be reassessed and reevaluated to continuously maintain proper care of the patient. Together if the health care team works together it can allow them to be more comfortable learning from their errors and fixing them from happening in the future. Fixing the problem does not depend on individuals but the team working together to improve patient safety (VanGeest, 2003).

CONCLUSION

Nonpunitive work environments that have a system for reporting errors is crucial to patient safety because it allows an environment for employees to talk about their mistakes and fix them for the future. After talking about the error it will improve patient safety because the whole team will learn how to not make that mistake again. A trusting environment puts health care works at ease talking about the error without risk of losing their job and a decrease in feeling bad about their mistakes to improve patient safety in the future. Open communication between employers and employees allows for the team to build their trust in one another improving patient safety.

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