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Just Culture in Nursing Education: Supporting Practice Readiness

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Presenter has no Conflicts of Interest and Disclosures that relate to this presentation.

Objectives

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1. Discuss the impact of error response and management on individual practitioners.
2. Identify principles of Just Culture as a mechanism to support quality and safety competency.
3. Demonstrate approaches to bridge the gap between practice and academia for how individual mistakes and errors are addressed and managed.
4. Discuss strategies academia can adopt to model best practices used by clinical partners in developing nurses fully engaged in just culture and patient safety initiatives.

Critical Question:

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"What can we learn?"

NOT

"Who can we Blame?"

Error Prevention

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"The single greatest impediment to error prevention is that we punish people for making mistakes."

-Lucian Leape, 1997

Need to implement non-punitive responses to errors

Error: Someone does something other than what should have been done

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Marx, 2001

Human Error	Negligent Behavior	Reckless Behavior	Intentional Violations
• Slips; lapses; forgetfulness • Distracted	• Doesn't recognize risk • Reasonable expectations not met; lacks knowledge, skill, or caring attitude	• Conscious disregard for rules and expectations • Participates in dangerous situation	• Risky behavior • Causes intentional harm

What is a near miss?

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A near miss is an event that might have resulted in harm but the problem did not reach the patient because of timely intervention by healthcare providers or the patient or family, or due to good fortune. Near misses may also be referred to as "close calls" or "good catches." ...

Institute of Medicine

Humans will always make mistakes

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Shame and Blame

Individual is responsible

Blame-free

Individual is not responsible

Just Culture

Balances safety and accountability

What is Just Culture?

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Definition: A culture in which employees can admit to their mistakes and system and individual accountability can be balanced to best support system safety and other organizational values. Marx, 2001

Tenets of Just Culture

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- Competent professionals can make mistakes
  - People are well intended
- Competent professionals develop unhealthy work habits
  - Routine shortcuts
- Reckless behavior is not acceptable
- Just Culture should be manifested in the clinical peer review process

Balancing Accountability

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- System Accountability
  - ✓Safe work environment
  - ✓Support services
  - ✓Safe processes in place
  - ✓Commitment to quality
  - ✓Welcomes a questioning attitude

- Individual Accountability
  - ✓Behavior
  - ✓Knowledge
  - ✓Skill
  - ✓Attitude
  - ✓Willing to accept responsibility

Just Culture Organizations

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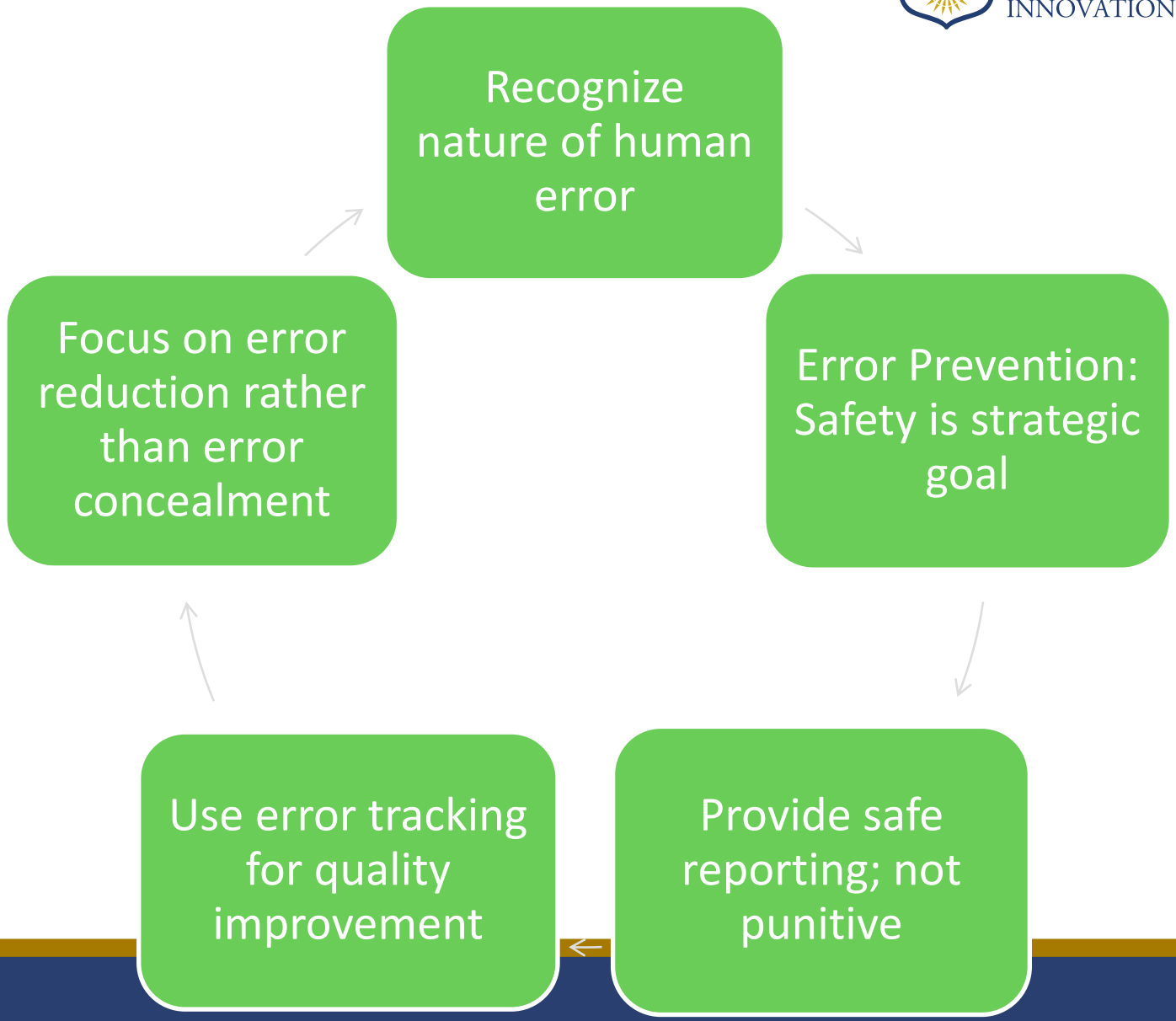

No Blame Safety Culture

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- Key Themes:
  - Most errors are committed by good, hardworking people trying to do the right thing
  - The traditional focus on identifying who is at fault is a distraction
  - It is more productive to identify error-prone situations and settings and implement systems that
    - prevent caregivers from committing error
    - catch errors before they cause harm
    - mitigate harm from errors that do reach patients

Accountability

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Balancing "No Blame" with Accountability in Patient Safety. Wachter, R., Pronovost, P. The New England Journal of Medicine 361.14 (Oct 1, 2009): 1401-6

Article Proposal:

- No Blame allows people to come forward and identify errors and near misses so systems can be fixed
- Failure to adhere leaves the world of "No Blame" and enters the domain of accountability
- A single lapse should not result in punishment unless deliberate, egregious, or willful disregard
- Punishment should be proportional and just and equal for all types of caregivers

Moving from "No Blame" Culture to Just Culture

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Purpose:

- Differentiate blameworthy from blameless acts
- Focus on situations where action (or inaction) of individuals pose a clear risk
  - Hand Hygiene-System is improved; now it is up to individual accountability
  - Pre-op "Time-out"
  - Marking surgical sites to prevent wrong-site surgery
    - (52 reported to TJC in 2019; 68 reported for 2020)
  - Using checklist to reduce bloodstream infections (CLABSI)

Using the Fairness Algorithm to Analyze Error

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1. Did the individuals intend to cause harm?

2. Did they come to work drunk or impaired?

3. Did they do something they knew was unsafe?

4. Could two or three peers have made the same mistake in similar circumstances?

5. Do these individuals have a history of involvement in similar events?

Application

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- **In 2006, a tragic case took place at Methodist Hospital in Indianapolis. An experienced pharmacy technician accidentally stocked a drug cabinet in the newborn intensive care unit with the wrong dose of heparin. The cabinet was supposed to hold vials containing 10 units of heparin, but it was instead stocked with vials containing 10,000 units of heparin. Five nurses then administered the wrong dose to six newborns – and three of the babies died.**

- **Applying the Fairness Algorithm**
  - http://www.youtube.com/watch?v=8le7vYPUwaM

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Accountability VS Blame

- **Accountability**
  - Follows protocols and everyone does their job
  - Focus on system level problem analysis-RCA
  - Focuses attention to the problem and how to improve performance

- **Blame**
  - Reactive
  - Emotional response
  - Focuses on individual
  - Punitive toward individual involved

Partnering on All Levels

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- ✓Safety is a shared mindset
- ✓Breaks down silos
- ✓Open and honest communication on and between all levels
- ✓No-fault approach to error-Seek the root cause
- ✓Non-adversarial (us VS them)
- ✓Recognizes and encourages honesty in reporting

Willingness to self-report problems is a hallmark of a safe practitioner and a safety culture

Just Culture

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- https://www.youtube.com/watch?v=5mR6e-uhR7c

NPSF
National Patient Safety Foundation®

A Just Culture Tool

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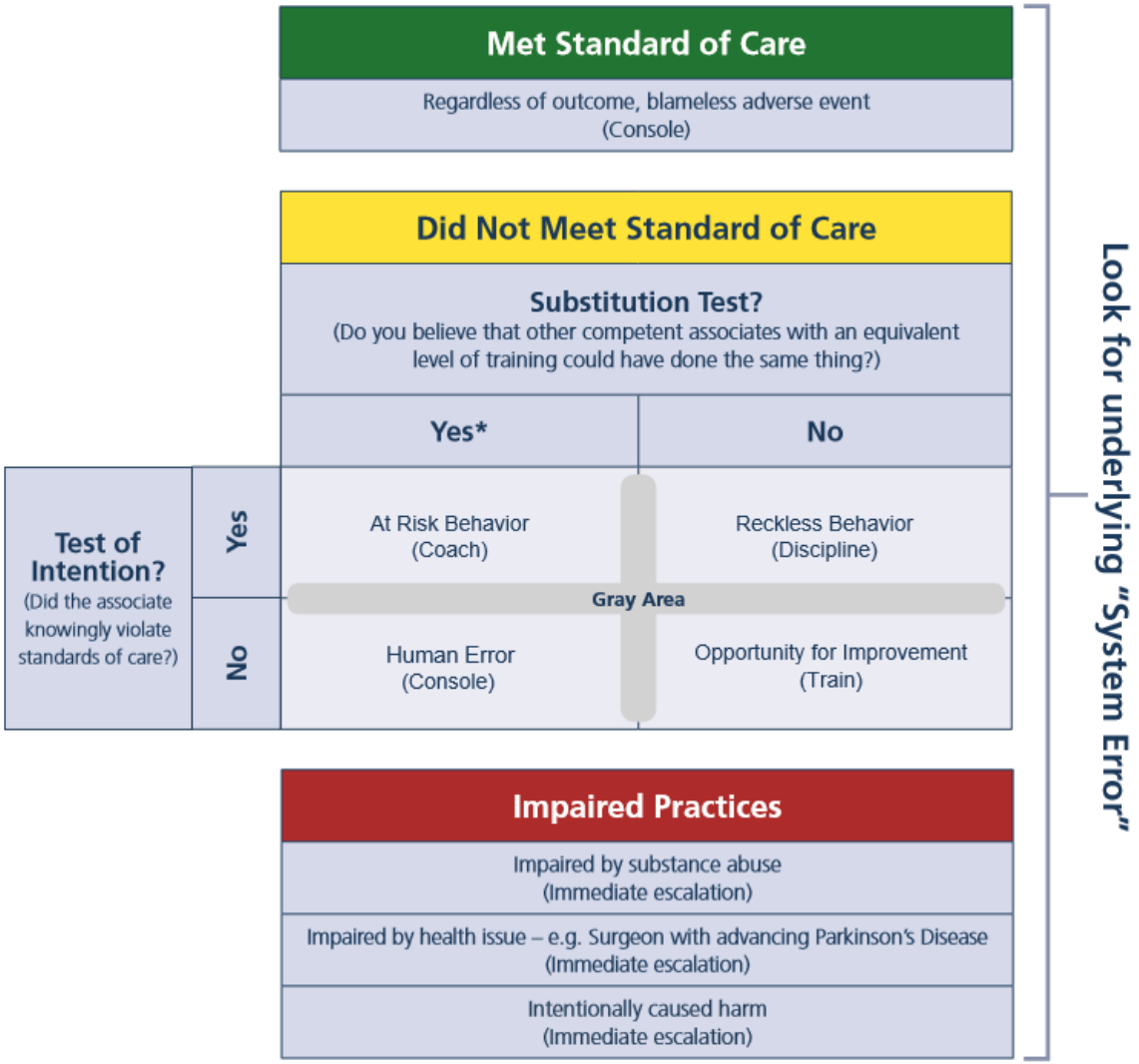

Nurses Reporting…..

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- Low rate of reporting-only about 10% of adverse events are reported

  DHHS: Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, 2010

- No increase noted in performance measure: Nonpunitive Response to Error and Frequency of Events Reported

  AHRQ: Hospital Survey of Patient Safety Culture, 2017

Just Culture Evolution

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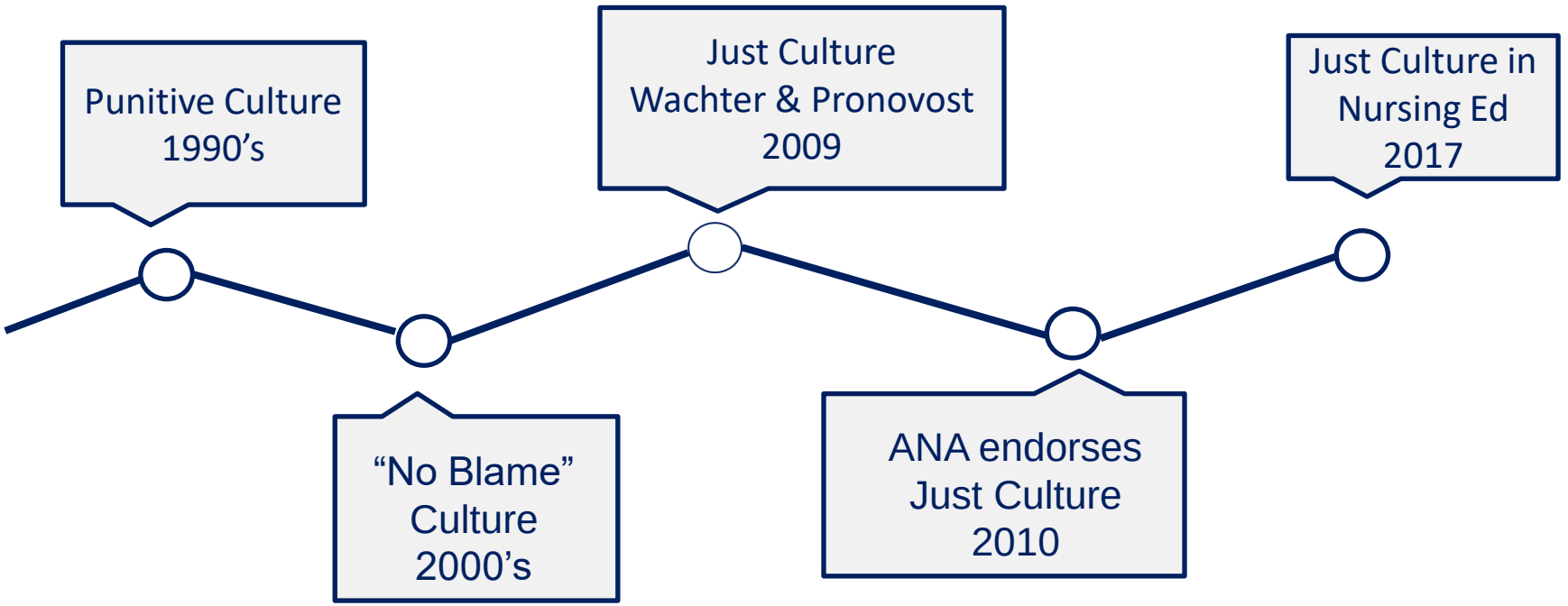

Just Culture Assessment Tool (JCAT)

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- 27-item survey instrument
- Uses seven-point Likert scale "Strongly Disagree (1)" to "Strongly Agree (7)"
- Includes six important dimensions of just culture:
  - balance
  - trust
  - openness of communication
  - quality of the event reporting process
  - feedback and communication
  - quality improvement.
- Internal consistency of the JCAT is greater than alpha =.70 for all dimensions except "quality of the event reporting process" (alpha =.63).

Petschonek, D., Burlison, J., Cross, C., Martin, K., Laver, J., Landis, R. S., Hoffman, J. M. (2013). Development of the just culture assessment tool (JCAT): Measuring the perceptions of healthcare professionals in hospitals. J Pt safety; 9(4): 190-7

Just Culture Assessment Tool- Nursing Education (JCAT-NE)

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- 27-item survey instrument
- Seven (7) point Likert scale
- Includes six important dimensions of just culture:
  - Balance, trust, openness of communication, quality of event reporting, feedback, QI
  - CVI calculated at 1.
  - High coefficient of reliability(Cronbach's a=.75)

Walker, D., Altmiller, G., Barkell, N., Hromodik, L., Toothaker, R. (2019). Development and validation of the just culture assessment tool for nursing education (JCAT-NE). Nurse Educator, 44(5), 261-264.

1. Members of the school administration (nursing faculty instructor/ safety officer/ director, and/ or dean) do a good job of sharing information about safety related events.
2. We do not know about safety related events that happen within our nursing program.
3. I often hear about safety related event conclusions and outcomes.
4. Students feel uncomfortable discussing safety related events with nursing faculty/ instructors.
5. Nursing faculty/ instructors respect suggestions from students.
6. Students can easily approach nursing faculty/ instructors with ideas and concerns
7. If I had a good idea for making an improvement, I believe my suggestion would be carefully evaluated and taken seriously.
8. I trust nursing faculty/instructors to do the right thing.
9. Students are usually blamed when involved in a safety related event
10. Students fear disciplinary action when involved in a safety related event.
11. When a safety related event occurs, a follow up team looks at each step in the process to determine how the safety related event happened.
12. I feel comfortable reporting about safety related events in which I was involved.
13. Students use safety related event reporting to "tattle" on each other.
14. Peers discourage each other from reporting safety related events.
15. The safety related event reporting system is easy to use.
16. Safety related event reports are being evaluated and reviewed after they are submitted.
17. When a safety related event occurs, I am given time to submit safety related event reports during clinical hours.
18. My nursing faculty/instructors encourage me to report safety related events.
19. There are improvements because of safety related event reporting.
20. The nursing program devotes time, energy, and/or resources toward making safer learning experiences and improved patient safety.
21. By submitting safety event related reports I am making the clinical setting safer for patients and students.
22. The nursing program sees safety related events as opportunities for improvement.
23. The nursing program uses a fair and balanced system when evaluating nursing student involvements in safety related events.
24. I trust that the nursing program will handle safety related events fairly.
25. The nursing program adheres to its own rules and policies.
26. I feel comfortable reporting about safety related events where others were involved.
27. I am uncomfortable with others reporting about safety related events in which I was involved

JCAT-NE Multi-site Study

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- 15 Nursing programs in 8 states
- 849 students completed survey-79% completion rate
- Cronbach's *a* = .936

	Median	Mean (SD)	Range
JCAT-NE Total Score	127.4	127.4 (23.6)	42 - 182

- Students at the beginning of their nursing program had the highest JCAT-NE total score [M= 133.6 (20.52)]
- The lowest JCAT-NE total scores were reported by the students at the end of their program ([M= 122.22 (25.43)]
- **Award from Sigma Theta Tau**

2020 Generating Evidence for Nursing Education Practice Award

JCAT-NE available at: https://qsicenter.tcnj.edu/just-culture-assessment-tool-nursing-education-jcat-ne/

QSEN INSTITUTE
Quality and safety education for nurses
Academic Task Force

QSEN INSTITUTE REGIONAL CENTER at THE COLLEGE OF NEW JERSEY

Template for Debriefing Following a Student Error Using Reflection and Quality and Safety Competencies.

Step	Actions to Address Individual Accountability	Rationale	Alignment with QSEN Competencies
1.	Gather information about error from involved instructor		
2.	Meet with student outside of clinical site	Provide privacy away from environment where error occurred	
3.	Question: Tell me about what happened	Allow student to share perceptions of event and impact on patient care	**Quality Improvement** Recognize that nursing and other health professions students are parts of systems of care and care processes that affect outcomes for patient and families.
4.	Question: If you were the patient and you knew this happened, would you feel you were receiving safe care?	Allows student to consider the perspective of the patient	**Patient Centered Care** Value seeing health care situations "through patients' eyes".
5.	Question: How did your actions/inactions contribute to what happened?	Opportunity for reflection on individual practice	**Safety** Appreciate the cognitive and physical limits of human performance.
6.	Question: What strategies can you use in your own practice to minimize the risk for this type of error in the future?	Identify standardized practices and strategies that support safe practice	**Safety** Value the contributions of standardization- reliability to safety.
7.	Question: Would you be willing to share your experience with your colleagues in your clinical group so that they can learn from this mistake?	Understand there is opportunity to improve safety by reporting/sharing information about errors	**Quality Improvement** Appreciate the value of what individuals and teams can do to improve care.
8.	Question: What outcome do you want to see after this?	Allows for identification of personal and professional goals	**Safety** Value own role in preventing errors.
9.	Question: Do you have any questions?	Opportunity for clarifications	
10.	If medication error, with student submit description of error to ISMP Medication Error Anonymous Reporting System https://www.ismp.org/	Emphasizes the impact event reporting can have on patient safety and improvement	**Safety** Use organizational error reporting systems for near-miss and error reporting
Step	**Actions to Address System Accountability**	**Rationale**	**Alignment with QSEN Competencies**
1.	Share information with involved instructor regarding meeting and student reflection	Partnership between clinical instructor and theory instructor/course leader supports student learning	**Teamwork and Collaboration** Appreciate importance of intra- and interprofessional collaboration
2.	Contact Simulation Coordinator to discuss implementation activities to address knowledge and skill deficits associated with the error	Address gaps between local and best practices	**Teamwork and Collaboration** Value the influence of system solutions in achieving effective team functioning
3.	Contact Fundamentals of Nursing course coordinator to discuss integrating activity to address knowledge deficits associated with the error	Address gaps between local and best practices	**Quality Improvement** Appreciate the value of what individuals and teams can do to improve care
4.	Identify area within student's current course where activity can be included to address knowledge deficits associated with the error	Address gaps between local and best practices	**Quality Improvement** Appreciate that continuous quality improvement is an essential part of the daily work of all health professionals

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Template for Debriefing After Student Error

https://www.ncsbn.org/safe-student-reports.htm

Sentinel Event Alert #57

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The Essential Role of Leadership in Developing a Safety Culture

Action #1: "Absolutely crucial is a transparent, non-punitive approach to reporting and learning from adverse events, close calls and unsafe conditions."

1) Just Culture; 2) Reporting Culture; 3) Learning Culture

https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-57-the-essential-role-of-leadership-in-developing-a-safety-culture/

Best Practices: The Evidence-based QI Model

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- Standardization of peer review process
  - Make it a core business process
  - Peer review without threat to licensure/livelihood
  - Cannot simply target one discipline
- Use Rapid Response Team activations for generic reviews
- Identify opportunities for improved performance (as opposed to casting blame) non-punitive
- Promotion of self reporting of adverse events, near misses, and hazardous conditions
- Quality of case review; timely performance feedback
- Recognition of clinical excellence-"Patient Safety Heroes" "Good Catch Programs"
- Solid connection between peer review program and the organizations QI process
  - Expectation that all high-level meetings will begin with open discussion of safety issues

Academia Bridging to Practice

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- School-based recognition of clinical excellence-"Patient Safety Heroes" "Good Catch Programs"
- Principles of Just Culture are taught throughout program using scenarios of error in classroom and simulation
- Make it safe for students to report mistakes & near misses
- Differentiate between a single lapse, negligent patterns of behavior, and recklessness
- Identify opportunities for improved performance (as opposed to casting blame) non-punitive
- Standardize the process to manage errors
  - Have a template for debriefing that fits your program
  - Use fairness algorithm

Teach students what they can do

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- Participate in school committees where Just Culture principles can be discussed and developed as school policies
- Use reflection to identify opportunities for improved performance
- Practice and support peer review-give constructive feedback to peers and colleagues
- Promote self reporting of adverse events, near misses, and hazardous conditions
- Use strategies that work to prevent slips, lapses, or forgetfulness-checklists, notes, interruption prevention….
- Standardize individual practice as much as possible; develop a routine of safety

One Final Thought

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- Aviation's breakthrough resulted from making it safe for pilots to self-report problems.
  - There was no differentiation for blameless VS blameworthy

- James Reason: There is no clear value to punishment for unsafe acts except in cases of malicious intent, gross negligence, or habitual offense. 1997

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