Just Culture in Schools of Nursing

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QSEN Long-Range Goal

– To reshape professional identity formation in nursing so that it includes commitment to the implementation of the IOM competencies

– Transform education to transform practice

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Culture of Safety

• **Goal** - safe, high quality patient care

• **Characteristics of culture of safety**
  – Just
  – Accountable
  – Promotes learning from mistakes and fixing what needs fixing
  – Effective teamwork
  – Flexible
What is a Just Culture?

• Fair, balanced approach to event reporting, learning from mistakes and holding persons and the organization accountable.
Approaches to Errors

- **Old way** - who is at fault and what should be the punishment
  - Fosters secrecy and hiding
    - 37% of RNs reported they had not reported error because of fear of reprisal. (Cohen, 2008)
    - 50% drop in air-traffic control incident reports after prosecution of air traffic controller involved in near miss (Ruitenberg, 2002)

- **New way** - focus on *what* went wrong, not *who* is the problem
  - Fosters trust and willingness to report errors, near misses
Barriers to Just Culture
(Pfeiffer et al, 2010)

• Attitudes
  – Concerned about being blamed
  – Concerned about being judged incompetent
  – Concerned about making colleagues look bad

• Reporting systems
  – Not know how to report
  – Not know where to report
  – Too time consuming
  – Don’t think anything will be done with the info

• No harm to patient - not understand importance of learning from a near miss
Managing Healthcare Risk - The Three Behaviors

<table>
<thead>
<tr>
<th>Normal Error</th>
<th>At-Risk Behavior</th>
<th>Reckless Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Product of our current system design</strong></td>
<td><strong>Unintentional Risk-Taking</strong></td>
<td><strong>Intentional Risk-Taking</strong></td>
</tr>
<tr>
<td>Manage through changes in:</td>
<td>Manage through:</td>
<td>Manage through:</td>
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<tr>
<td>• Processes</td>
<td>• Understand at-risk behaviors</td>
<td>• Disciplinary action</td>
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<tr>
<td>• Procedures</td>
<td>• Remove incentives for at-risk behaviors</td>
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<tr>
<td>• Training</td>
<td>• Create incentives for healthy behavior</td>
<td></td>
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<tr>
<td>• Design</td>
<td>• Increase situational awareness</td>
<td></td>
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<tr>
<td>• Environment</td>
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</tbody>
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Negligence? Coach

Recklessness Punitive Action

*David Marx – Just Culture
Components of a Just Culture

- **Attitude** - shared accountability model that promotes individual and system learning from mistakes
  - What happened?
  - Why did it happen?
  - How were we managing it?

- **Structure**
  - Reporting system
  - Response and feedback
  - Accountability
  - Commitment to safety
Components

- Leadership commitment to safety culture
  - Environment of transparency
  - Reporting mechanisms
- Employee empowerment to make safety a priority
- Accountability system - how held accountable for acting safely or unsafely
What We Know About Student Errors and Near Misses

• Not too much
  – MedMarx database - 1300 student med errors over 5 years, wrong patient, wrong time, wrong route. (Wolf, 2006)
  – 3 yr review of incidents in student files- 77 med errors, 43% inexperience reading MAR. Changed policy to school database and shared data with clinical agency (Harding, 2008)
  – 28 students, 9 made errors or near miss. Reasons - inadequate supervision, distractions/interruptions. Told not to fill out incident report as too time consuming. (Reid-Searle, 2010)
Nursing Education and Just Culture

- Often operating in the “old way” - who is at fault and what should be the punishment
  - Secrecy, shame and blame
  - Focus on student counseling, reprimand or dismiss
  - Faculty not sharing information on errors or near misses
  - Monitoring, tracking and anonymous reporting systems not in place
The QSEN Evolution -

• From a Course

• To the Curriculum

• To Culture Change

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• A just culture – “giving constructive feedback and critical analysis in skillful ways, doing assessments that are based on facts, and having respect for the complexity of the situation...providing fair-minded treatment, having productive conversations, and creating effective structures that help people reveal their errors and help the organization learn from them” (Connor et al, 2007)

• A just culture
  – balances accountability for errors with the inevitability of human mistakes and learning
  – Requires Attitude and Structure
  – Requires action at the individual faculty member, school and national levels
Core Principles of Just Culture in Schools of Nursing

- Students need to feel as accountable for, and prepared to, contribute to a safe environment as for delivering quality nursing care.
- Mistakes are part of learning and professional practice.
- Mistakes are not equal.
- Students should be held “accountable for their actions, but not blamed for system faults beyond their control.”
- Students who act recklessly may need to fail the course or be dismissed from the program.
Components of Just Culture in Schools of Nursing

• **Attitude** – a shared accountability model that promotes individual and system learning from mistakes

• **Structure** – a system of policies and processes that encourages data collection, analysis and learning essential safety-related information about errors and near-misses to continuously improve the curriculum
Necessary Attitudes

• Students will make mistakes
• Threats of punishment do not prevent errors – they prevent the reporting of errors
• The role of the faculty member:
  – create an environment in which students can admit to errors and near-misses
  – differentiate between errors/near-misses due to system failure, human error, at-risk and reckless behavior
  – support data collection and trend analysis of errors
  – use trended data to make appropriate changes in the curriculum and one’s own teaching
Just Culture Structures

• An organizational philosophy
• Leadership support and modeling
• Professional development for faculty
• Reporting mechanisms
  – Within the SON
    • A data base of student errors, near-misses
  – With clinical agencies
• Response and feedback systems

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Just Culture Applied to Nursing Schools (Frankel et al, 2006)

• The school learns and improves by openly identifying and examining its own weaknesses
• The school is willing to expose sources of weakness and areas of excellence
• Faculty feel that they are supported and safe when voicing concerns
• Faculty feel comfortable monitoring others working with them, and giving feedback on how to improve their performance
• Faculty create an environment in which information on errors and near-misses is shared so that learning can occur, and the curriculum can be improved
Content to be learned

- Human factors
- System complexity
- High reliability organizations
- Effective communication
- Teamwork
- QSEN competencies
- New teaching pedagogies
New Ways

Teaching Clinical Content

• Create a space for conversation without judging, blaming – seek to understand

• Assessing student competence in new ways, e.g., not while student mixing meds

• Expecting professionalism in the labs, e.g., preparation, serious learning
Characteristics of quality care

• Safe
• Timely
• Effective
• Efficient
• Equitable
• Patient-centered
Properties of a School of Nursing with a Just Culture

- Transparency
- Trust
- Accountability
- Respect
- Evidence
- Fairness

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Getting started

• Learn more about Just Culture
• Start the conversation
  – Is there a policy on student errors?
  – Do we have a database?
  – What’s the culture re: mistakes, student errors, sharing of information about them,
  – Academic/service partnerships - how to share information
• Conduct a survey on the culture
• Conduct a gap analysis on systems and processes
• Educate leadership and faculty
Blameless Reporting System

• In your school are these questions asked for a specific incident?
  • What happened?
  • Has it happened before?
  • Could it happen again?
  • What caused it to happen?
  • Who should be told?
Reporting Systems in Schools of Nursing

• What do you do with the information?
  – How is the situation analyzed?
  – What is the reporting process?
  – What if anything is entered into the student file?
  – What is the debriefing process with the student?
  – How are errors used as teachable moments with other students, if at all?
  • With other faculty, if at all?
Approaches to discipline (Marx, 2001)

• **Outcome based disciplinary decision-making**
  – The more severe the outcome, the more blameworthy the actor

• **Rule-based disciplinary decision-making**
  – Discipline for any rule violation, intended or not

• **Risk-based disciplinary decision-making**
  – Considering the intent of the individual, recklessness, negligence (culpable or not)
What do you think?

• 2 errors and the student is dismissed
• A student bringing a wrong medication preparation and the instructor catches it
• Incidents counted as errors only when there is a serious patient outcome
• Students coming unprepared
• A student doing a procedure as the clinical preceptor does but not as taught
• Inappropriate use of social networking
National Actions

• Engaging in dialogue with other faculty to exchange ideas and updates about what’s working and what’s not re: creating Just Cultures

• Working with QSEN to establish a national approach to data collection about student errors and near misses, and to develop recommendations to strengthen curricula
QSEN Forum Attendees

• Why are we here?
  • To create a sea change -

• Why is it important?
  • We need to prepare our graduates for today’s health care arena

• Why does it matter?
  • Patients lives are at stake
Change the world of health care

– Start where you are
– Use what you have
– Do what you can

A. Ashe

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