Just Cultures in Schools of Nursing

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Objectives

• Review the concepts of High Reliability Organizations (HRO) and Just Culture
• Apply HRO concepts to schools of nursing
• Examine preliminary data from a national survey of policies and tools for tracking nursing student errors and near-misses
• Identify implications for schools of nursing
Members of the team

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- Susan Connor, MSN, RN (research assistant)
- Fabiana Brogren, BA (project administrator)

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High Reliability Organizations

Safety is dependent upon systems and organizations,

Patients should be safe from injury caused by interactions with the systems and organizations of care.
High Reliability Organizations

• A culture of safety
• A learning environment
• Evidence-based care
• Positive working environments
• Committed to improving the safety and quality of care
• Transparency
Characteristics of HROs

• Direct involvement of top and middle leadership
• Safety and quality efforts aligned with the strategic plan
• Established infrastructure for safety and continuous improvement
• Active engagement of everyone across the organization
• A just culture
What is a Just Culture?

- Fair, balanced approach to event reporting, learning from mistakes and holding persons and the organization accountable.
Components of a Just Culture

- **Attitude** – shared accountability model that promotes individual and system learning from mistakes
  - What happened? Why did it happen?
- **Structure**
  - Reporting system, response and feedback
- **Leadership** commitment to safety
- **Employee** engagement to make safety a priority
Blameless Reporting System

- Confidential reporting
- Voluntary and Anonymous
- Transparency of errors and latent conditions
- Event analysis
  - Guard against blame, attribution and hindsight bias
- Improvements identified with system of feedback
- Disclosure and Truth Telling
Blameless Reporting System

- What happened?
- Has it happened before?
- Could it happen again?
- What caused it to happen?
- Who should be told?
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
Evolutionary Approaches to Errors and Near-Misses

• Shame and Blame
• System Errors
• Just Culture
Culture of Blame

Has been pervasive in healthcare

• focus - often to try to determine who has been at fault and, all too often, to mete out discipline.

• leads to hiding rather than reporting errors and is the antithesis of a culture of safety.
Culture of Blame and Shame

- Expectation of perfection
- Finger pointing
  - Identify *who did it* rather than *what happened*
- Defensiveness
- Fear of
  - legal liability
  - loss of credibility and reputation
  - Punishment
- Secrecy and cover up
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 (Ruitenbergen, 2002)

• **New way** – focus on *what* went wrong, *not who* is the problem
  – Fosters trust and willingness to report errors, near misses
### 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>&lt;br&gt;Manage through changes in:&lt;br&gt;• Processes&lt;br&gt;• Procedures&lt;br&gt;• Training&lt;br&gt;• Design&lt;br&gt;• Environment</td>
<td><strong>Unintentional Risk-Taking</strong>&lt;br&gt;Manage through:&lt;br&gt;• Understanding our at-risk behaviors&lt;br&gt;• Removing incentives for at-risk behaviors&lt;br&gt;• Creating incentives for healthy behavior&lt;br&gt;• Increasing situational awareness</td>
<td><strong>Intentional Risk-Taking</strong>&lt;br&gt;Manage through:&lt;br&gt;• Disciplinary action</td>
</tr>
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*David Marx – Just Culture*
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
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 faculty, student and system(s) learning from mistakes
- **Structure** – a system of policies and processes to collect and trend data on hazards, errors and near-misses
- **Leadership** – fully engaged, transparent
- **Faculty and students** – all working toward safe learning and performance
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
In a School Operating with a Just Culture  (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
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)
  – 3 years, 453 students, 10,206 ‘yes’ responses to hazards (59%) and near-misses (42%) (Currie et al 2009)
What do you think?

- An error and near miss in a clinical setting should be treated the same.
- Errors in simulation lab should be treated the same as an error in the clinical setting.
Creating a Data Repository for Tracking Nursing Student Errors and Near Misses

- Collect and analyze information on current practices and policies for reporting and trending errors and near-misses by pre-licensure students in schools of nursing to
- Create a national data repository for tracking and trending errors and near-misses by nursing students in pre-licensure programs.
Aims

• Conduct a **national survey** - information from nursing school faculty on the systems and processes for reporting and trending errors and near-misses by students.

• Design and trial **web-based tool for reporting** student errors and near-misses that can be used both internally within schools of nursing and nationally as part of a national data repository.

• Develop a **website for communication** about the project, and to present reports on aggregated student errors and near-misses on a recurring basis.

• Develop **educational materials on just culture**, the role of errors and near-misses in improving the quality of nursing education, and strategies that faculty can adopt in trending and analyzing error and near-miss data.
Methodology: Phase 1

- National electronic survey of all pre-licensure nursing programs in US
  - Presence of
    - a policy for reporting and follow up of student errors and near-misses
    - a tool for reporting student errors
    - a process and/or tools for trending of errors and near-misses, and
    - strategies for follow-up for support and/or discipline for faculty or students after an error or near-miss.
Responses

• Sent to 1667 schools
  – 447 schools responded (27%)
  – 684 programs (some schools with multiple programs)

• Sent two reminders

• No responses to date from Alaska, Rhode Island or Vermont
Types of programs (n=684)

- Associate: 211
- Diploma: 45
- BSN: 206
- LPN - RN: 76
- Accel BSN: 33
- Accel MSN: 95
- Other: 18
## Preliminary Sample Characteristics

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Survey Participants</th>
<th>Written Error Policy in Place n (%)</th>
<th>Error Reporting Tool Used n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate</td>
<td>206</td>
<td>87 (42%)</td>
<td>87 (42%)</td>
</tr>
<tr>
<td>Diploma</td>
<td>18</td>
<td>8 (44%)</td>
<td>9 (50%)</td>
</tr>
<tr>
<td>Baccalaureate</td>
<td>211</td>
<td>61 (29%)</td>
<td>85 (40%)</td>
</tr>
<tr>
<td>LPN to RN</td>
<td>95</td>
<td>33 (35%)</td>
<td>37 (39%)</td>
</tr>
<tr>
<td>Accelerated BSN second degree program</td>
<td>76</td>
<td>20 (26%)</td>
<td>36 (47%)</td>
</tr>
<tr>
<td>Accelerated MSN second degree program</td>
<td>33</td>
<td>9 (27%)</td>
<td>11 (33%)</td>
</tr>
<tr>
<td>Other</td>
<td>45</td>
<td>13 (29%)</td>
<td>19 (42%)</td>
</tr>
</tbody>
</table>
7 (highest) Number of Diploma Programs Reported
1 Program Reported
No Programs Reported
Respondent AD Programs

>10 ADN Programs Reported
5 to 9 Programs Reported
< 5 Reported Programs
No Reported Programs
4 Accelerated MSN Programs Reported
1 to 2 Programs Reported
No Reported Programs
Respondent LPN to RN Programs

- > 10 LPN to RN Programs Reported
- 5 to 9 Programs Reported
- < 5 Programs Reported
- 0 Programs Reported
Clinical Errors vs. Near-Misses Considered the Same

- Yes (n=89)
- No (n=222)
- No Consistent Standard (n=144)
- Don't Know (n=7)
Simulation vs. Clinical Errors Considered the Same

- Yes (n=47) - 20%
- No (n=247) - 65%
- No Consistent Standard (n=82) - 11%
- Don't Know (n=17) - 4%
### Policies and/or Tools in Place?

<table>
<thead>
<tr>
<th></th>
<th><strong>Policy</strong> in place for managing students after clinical error or near-miss</th>
<th><strong>Tool</strong> available for reporting clinical errors or near-misses</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>105</td>
<td>126</td>
</tr>
<tr>
<td>No Consistent Standard</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>No/Blank</td>
<td>314</td>
<td>314</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>447</strong></td>
<td><strong>447</strong></td>
</tr>
</tbody>
</table>
Names of tools/policies (n = 61)

- Incident report
- Clinical advisement notice
- Safety reporting tool – error report
- Event discovery report
- Violation of policy form
- Critical incident report
- Student occurrence report
- other names of tools

• Student continuous improvement report
• Unusual occurrence report
• Variance report form
• Learner prescription for remediation
• Clinical performance learning plan
• Medication error reporting form
Reported strategies for follow-up w/ faculty

- Discussion in faculty meeting
- Weekly report to the program director w f/u
- End of semester report
- Email/phone call from dean/director with response required
- Clinical faculty are scored on medication proficiency like staff nurses
- Course coordinator follows-up
- Errors followed up by faculty, Director of BSN program, Associate Dean and Dean
Reported strategies for clinical agency reporting

• Filling out agency report
• Faculty/agency rep/student sign a form
• Faculty/staff nurse/student analyze situation and determine what should be done
• Near misses not discussed with clinical agency – considered internal educational matters
Reported strategies for Follow-up with student

• Errors do not automatically lead to discipline
• Student completes report on how they will change behavior so X doesn’t happen again, and attend remediation lab
• Student counseled by instructor and receives Unsatisfactory for the week
Reported strategies for Follow-up with students (cont’d)

• Student gets Unsatisfactory for the day; meets with two full-time 1st or 2nd year instructors and program head, and written documentation goes in file...if safety issue is extreme and resulted in patient demise, student may be dismissed after first occurrence
Observations

• Few schools have mechanisms for tracking and trending
• Faculty vary greatly on approaches to errors and near-misses, and what to do with them
• General belief: *good* students do not make mistakes and students should be able to avoid mistakes
Content to be learned

- Human factors
- System complexity
- High reliability organizations
- Effective communication
- Teamwork
- QSEN competencies
- New teaching pedagogies
New Ways for 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
• Partnering with clinical agencies to determine how they want follow-up handled; how better clinical experiences can be offered
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
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
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?
Group Discussions

– How are errors used as teachable moments
  • with other students, if at all?
  • with other faculty, if at all?
What’s next with the study?

• Analyze the data
  – Please encourage your schools to participate
• Develop and pilot test reporting tool
• Develop national reporting website
• Create educational materials and learning opportunities on Just Cultures in SONs
• Spread the word

• Comments? Questions?