ORIGINAL ARTICLE

Concept Analysis: Just Culture

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ABSTRACT

Background: Traditionally, healthcare's culture has held individuals accountable for all errors or mishaps that befall patients under their care. This punitive approach creates the culture of fear among practitioners that withheld information that is needed to identify faulty systems and create safer ones. As an alternative to this traditional system, application of a model which is widely used in aviation industry known as the Just Culture Model seeks to create an environment that encourages individuals to report mistakes so that the precursors to errors can be better understood in order to fix the system issues (ANA, 2010).

Methods: This concept analysis that utilized the Walker and Avant method aims to (a) observe the basic elements of the concept under study i.e., defining attributes, antecedents, consequences and empirical referents; (b) develop an operational definition that is meaningful across different discipline and participants that can be easily understood and useful across research, policy and practice; and (c) highlight implications for research of the future. Defining Attributes: According to this analysis, the occurrence of a just culture environment involves three main features which include (a) encouragement of error disclosure through open communication; (b) a well-established balanced accountability; and (c) a collaborative learning environment. These attributes reinforces the implicit claim of just culture that it is inevitable for practitioners to commit mistakes that even the most experienced individual is capable of making mistakes. It is also implied in just culture that punishment is not an assurance that workers will not be making mistakes and that perfecting a performance is impossible and can never be sustained.

Conclusion: Based on the attributes extracted by this concept analysis, just culture is hereby operationally defined as an environment that reflects a well-established balance accountability supporting collaborative learning that stems from the encouragement of error-disclosure attained through open communication. Having the concept operationally defined and despite the recognized importance of a just culture, not every healthcare institution has adopted this type of approach.

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Background and Significance

Nursing has always been viewed as a complex discipline where multiple philosophies merge into one to understand its multi-factorial milieu. However, it is note-worthy that most errors take place within complex systems .This environmental complexity of nursing then makes it inevitable for nurses to commit errors that may be intentional or unintentional in nature. Nurses, like any other humans, are vulnerable to fallibility that results to either positive or negative outcomes. When errors occur, however, the immediate solution is to blame an individual for the error. Blaming individuals creates a culture of fear, discourages open reporting and discussion of errors, and does little to prevent future errors or improve the safety of the health care system (NCBON, 2011).

Traditionally, healthcare's culture has held individuals accountable for all errors or mishaps that befall patients under their care. According to Leape (2000), as cited by American Nurses Association (2010) these approaches that focus on punishing individuals instead of changing systems provide strong incentives for people to report only those errors they cannot hide. Thus, a punitive approach shuts off the information that is needed to identify faulty systems and create safer ones. In a punitive system, no one learns from their mistakes. Many observers attribute underreporting to the punitive (''name and blame'') approach that many healthcare organizations have taken with regard to safety incidents. By inculcating a sense of fear, the punitive approach discourages reporting and, in doing so, prevents organizational learning and improvement (Barach & Small, 2000; Blegen et al., 2004; Kadzielski & Martin, 2002; Kingston, Evans, Smith, & Berry, 2004; Manasse, Eturnbull, & Diamond, 2002; Wakefield et al., 2001, 1999). As an alternative to this traditional system, application of a model which is widely used in aviation industry known as the Just Culture Model seeks to create an environment that encourages individuals to report mistakes so that the precursors to errors can be better understood in order to fix the system issues (ANA, 2010).

Development of the concept and meaning in published works

In 1997, as mentioned by ANA (2010), John Reason wrote that a Just Culture creates an atmosphere of trust, encouraging and rewarding people for providing essential safety-related information. A Just Culture is also explicit about what constitutes acceptable and unacceptable behavior. Therefore a Just Culture is the middle component between patient safety and a safety

culture (Reason, 1997). However, the term "Just Culture" was first used in a 2001 report by David Marx (Marx, 2001), a report which popularized the term in the patient safety lexicon (Agency for Healthcare Research and Quality, n.d.). Further he argues that discipline needs to be tied to the behavior of individuals and the potential risks their behavior presents more than the actual outcome of their actions (Marx, 2001). Its model, as named by ANA (2010) addresses two questions: 1) What is the role of punitive sanction in the safety of our health care system and 2) Does the threat and/or application of punitive sanction as a remedy for human error help or hurt our system safety efforts? The model acknowledges that humans are destined to make mistakes and because of this no system can be designed to produce perfect results. Given that premise, human error and adverse events should be considered outcomes to be measured and monitored with the goal being error reduction (rather than error concealment) and improved system design (Marx, 2001).

Just Culture, as defined in aviation industry, is a culture in which front line operators are not punished for actions, omissions or decisions taken by them that are commensurate with the experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated (Eurocontrol, 2014). Reason (n.d), as quoted by Skybrary (n.d) claimed that it is an atmosphere of trust in which people are encouraged, even rewarded for proving essential safety-related information but in which they are also clear about where the line must be drawn between acceptable and unacceptable behaviour.

In the health care arena, Medscape (n.d) emphasized that Just Culture recognizes that human error and faulty systems can cause a mistake and encourages an investigation of what led to the error instead of an immediate rush to blame a person. A just culture, expert say, is a ''non-punitive'' environment in which individuals can report errors or close calls without fear of reprimand, rebuke, or reprisal (Blegen et al., 2004; Karadeniz & Cakmakci, 2002; Kingston et al., 2004; Pizzi, Goldfarb, & Nash, 2001; Wakefield et al., 1999; Wild & Bradley, 2005). Moreover, just culture is not a "blame-free" approach. It is a strategy that gets into the root of the problem, whether it is a worker wilfully contributing to the error or the system providing inadequate support to the worker's need. Furthermore, it is a system of justice that involves both investigatory action and disciplinary action. Hence, a "just culture" stands between a ''blaming'' or punitive culture, on the one hand, and a ''no-blame'' or ''anything-goes'' culture, on the other. This view reflects the connotation of balance typically associated with the terms ''just'' or

''fair.' (Weiner, Hobgood & Lewis, 2007). It balances the need to learn from mistakes and the need to take disciplinary action where appropriate.

Purpose of Analysis

A just culture is seen by some experts as an integral aspect of a broader culture of safety (Institute of Medicine, 2003; Kizer, 1999). Indeed, Reason (1997) considers it the foundation of a culture of safety. Surprisingly, despite the importance ascribed to it, no concise definition of just culture exists. This concept analysis that utilized the Walker and Avant method aims to (a) observe the basic elements of the concept under study i.e., defining attributes, antecedents, consequences and empirical referents; (b) develop an operational definition that is meaningful across different discipline and participants that can be easily understood and useful across research, policy and practice; and (c) highlight implications for research of the future.

Definition and defining attributes of just culture

Although the term ''just culture'' can be construed broadly, the term is often more narrowly used to refer to the beliefs, assumptions, and expectations that govern accountability and discipline for unsafe acts (e.g., near misses, medical errors, and adverse events) (Weiner, Hobgood & Lewis, 2007). To make this approach work, it is vital to deduce the underpinnings of the concept from eclectic literature. As such, it allows one to comprehensively understand the concept thus eradicating misconceptions. According to this analysis, the occurrence of a just culture environment involves three main features which include (a) encouragement of error disclosure through open communication; (b) a well-established balanced accountability; and (c) a collaborative learning environment.

In a setting where just culture is implemented, encouragement of error disclosure is emphasized through open communication. As stated in Skybrary (2014) the personnel is clear, that in the interest of safety, the organisation wants to know, at all times, about unsafe events, unsafe situations that have presented themselves or could arise. They are keen to step forward and speak up when they perceive a situation as dangerous, think of a procedure as risky, or any other issue in their daily tasks that they judge as potentially harmful and is yet without good remedy. This specifically includes any situation or event that involves them. Just culture creates an environment where employees/practitioners are not afraid to disclose any error committed. This system makes sure the staffs are motivated to report and the trend must be maintained. This is achieved through an open dialogue and that individuals

are not immediately blamed for errors. Moreover, whenever there are reports, the organization assures that they are acknowledged, discussed properly and provided with appropriate feedbacks. It focuses on the behavioural choices of the individual, the degree of risk-taking behavior, and whether the individual deliberately disregarded a substantial risk. It holds the individual accountable who makes unsafe or reckless choices that endanger clients or others.

When errors occur, the person who committed the error is not blamed instantly. He or she is not punished outright but rather a safety investigation is initiated to determine the proper disciplinary action. This claim shows that the organisation has well-established balance accountability. For in just culture, it looks into behavioural choices rather than the error and the outcome of the error itself. It is way of safety thinking that promotes a questioning attitude, is resistant to complacency, is committed to excellence; foster both personal accountability and corporate self-regulation in safety matters (Coloradofirecamp.com, n.d). As denoted in Skybrary (2014), when it becomes apparent that staff has made an error, the organisation will neither assume nor seek personal fault or guilt. There is a strong belief that punishment is counterproductive to safety. The organisation investigates why this error was made and what can be done to avoid them or to mitigate the effects for future operations. The workforce is protected as best as possible from negative consequences resulting from human error or subsequent investigations and in principle the organisation will defend and support people should external prosecutions or litigations target them. The organisation attempts to repair the situation as best as possible and restore the operations to normal. The organisation provides compensation for those that have experienced personal loss or damage. The organisation tries hard to prevent that same event from happening again. A case is not closed by condemning or finding the guilty one, but by discovering the underlying problems in the system, by rectifying this and by repairing the damages done (Skybrary, 2014).

When the problem is discovered, rectified and repaired, the organisation then communicates the situation with confidentiality to all the members of the group. This dissemination intends not to humiliate somebody but rather provides a learning platform for everyone. In just culture, the error that has happened was seen not as something to be fixed but rather an opportunity of learning and ironing the system. It creates an environment of introspection while errors are discussed and collectively outlines improved policies, protocols and/or guidelines. It also shapes a venue for the enrichment of managerial competencies.

These attributes reinforces the implicit claim of just culture that it is inevitable for practitioners to commit mistakes that even the most experienced individual is capable of making mistakes. It is also implied in just culture that punishment is not an assurance that workers will not be making mistakes and that perfecting a performance is impossible and can never be sustained.

Model case

To exemplify the concept of just culture, this model case is hereby presented using the situation quoted by Erickson (2012):

Nicol is working with a hospital system in Alabama to implement Just Culture and improve medication processes, from the time a physician thinks about writing an order until the medication is being monitored in the patient's body. Nicol reviewed the hospital's scanning rates for bedside bar coding. Although the hospital's leadership thought nurses were doing a great job of scanning, "it turns out that the nurses hardly ever truly scanned the arm band on a patient," she said. "We had to look deeper to understand the reasons behind this behavioral choice." It turns out that the nurses weren't scanning the bar codes on the patients' armbands because often the bar codes don't work. Sometimes this is a result of a printer error or the band getting wet or torn. "The nurses said, 'I know I need to confirm and scan the bar codes, but the system doesn't work for me,'" said Nicol. Once she identified the barriers to complying with the bar code scanning process, the hospital began working on fixing the underlying problems so the process will work for the nurses.

Upon discovering the problem, it is rectified through collaborative process enhancement. The implementation of the enhanced process would then be one of the agenda on the next hospital personnel meeting especially on division of nursing.

Borderline case

The hospital has a new program to coincide with the IHI 100,000 lives campaign on reducing surgical site infections. In order to guarantee that antibiotics are given with in one hour of the incision, the responsibility for administering antibiotics has been put in the hands of the anesthesia provider in the operating room. There is one exception – if the patient needs a special antibiotic protocol requiring more than one antibiotic, the regime is started in the pre surgical unit.

Brian is an experienced pre-op nurse. It is a very busy morning. One of his colleagues has called in sick. He looks over the schedule of patients for the first

cases and notices that Mr. Brown is scheduled for a new procedure that requires three antibiotics be given before surgery. He also knows that one of the antibiotics must be given slowly so he begins his care with Mr. Brown. After his initial assessment, Brian hangs the first antibiotic, Vancomycin 1 GM and signs the medication administration sheet. He returns in 90 minutes and hangs the second antibiotic, Gentamycin 80 mg. The surgical resident who is new to the service stops in the preoperative unit to read the chart of the patient. The resident takes the paper record to the conference room. Brian returns to the bedside and checks his order on the CPOE for the final antibiotic and hangs the Ancef, 1 GM. The paper MAR is with the chart so he makes a mental note to sign the MAR before the patient goes to the OR.

The antibiotic infusion is finished but Brian forgets to go back to the chart since his usual practice is to sign the MAR when he hangs the medication. An orderly comes to pick up the patient for the OR. Upon entering the OR, THE CRNA notices that 2 of the 3 antibiotics have been administered and proceeds to hang Ancef prior to the procedure. The patient receives the duplicate dose before the presurgical nurse (Brian) remembers he did not sign the MAR and calls into the room. The patient had no adverse outcome (AORN, n.d).

Brian wrote an incident report about what happened and verified the incident with the persons involved. After hearing all sides, no one was suspended but the head hoped it serves a lesson to those involved. A new process was devised and is set to be implemented next week. However, the head further asked all of them to keep what happened within them and not to tell anyone.

Related case

American Operating Room Nurses (n.d) provided another scenario which will serve as a related case for this analysis

Patient C is brought to the PACU following a lengthy procedure during which he exhibited periods of hypotension. An epidural catheter had been placed during surgery for postoperative pain control. The anesthesia provider debated about extubating the patient at the end of the case but decided the patient was currently stable enough to have the tube removed. However, she did not want to start the epidural infusion until she was sure the patient continued on a stable post op course. Routine pain management medications were ordered.

The PACU nurse Karen, is a caring for Patient C. She is aware of the plan of care and has assessed than

her patient is awake and vital signs have remained stable. She is anxious to start the epidural infusion so that her patient can remain alert and pain free. She realizes she has a small window of opportunity for the anesthesiologist to see Patient C in-between her OR cases.

In anticipation of the visit from anesthesia, Karen removes the epidural infusion from the automated medication dispensing machine while she is getting her first dose of postoperative antibiotics.

While Karen was preparing to hang the antibiotic, the anesthesiologist arrived at the bedside and began to assess the patient. Karen wanted to hang the piggyback ASAP so she could assist the anesthesiologist as necessary. She inadvertently picked up the epidural infusion instead of the antibiotic and proceeded to hang it. As she was completing the task the anesthesiologist asked for the epidural infusion. As Karen reached for the bag, she saw it was the antibiotic. She immediately shut off the epidural infusion and then froze as the error sank in. The anesthesiologist again asked for the infusion and the nurse turned around to see that the patient was starting to loose consciousness. The nurse immediately told the anesthesiologist she had hung the wrong medication.

The anesthesiologist reversed the patient and assisted his breathing for a few minutes. The patient did not need to be reintubated but spent a prolonged time in the PACU to ensure complete reversal of the medication.

Contrary case

There is a recommendation from the ISMP that some high risk medications should always have a double check before being administered. The Director of Perioperative Services has identified that there have been several near misses involving heparin solutions on the sterile field and that the operating room staff should embrace this recommendation.

Surgical Tech Edward is nearing completion of his orientation. The usual staffing pattern calls for him to scrub and his preceptor, Faith, who is an RN to circulate.

The case is considered "minor". It is the insertion of a mediport. There is a shortage of staff to do lunch reliefs so the team leader for the pediatric service, Mary, assigns herself to circulate on this case. The team leader Mary has a history of intimation of new staff and a sense that the new rules do not add any value to patient safety and only take away from efficiency. The

team leader usually provides the second check of calculations for circulating nurses in her assigned area.

Mary calculates the dosages of heparin infusion for both the irrigation and the flush doses on the sterile field. The surgical tech, Edward, accepts the meds and does not question Mary as he is nervous that he is alone without his usual preceptor and does not want to anger the team leader. Mary documents both his initials and those of the absent circulating nurse in the perioperative record.

Upon return from lunch, the circulating nurse, Faith, reviews the documentation for completeness before signing off the record. She notices her initials on the medication check and informs the nurse manager (AORN, n.d).

The nurse manager immediately reprimanded Mary and went immediately to the chief nurse and medical director and recommended for Mary's suspension.

Antecedents, consequences and empirical referents

The following antecedents are identified in the concept analysis of a just culture: (a) established incident reporting system; (b) trust between employer and employee; (c) just culture policy communicated throughout the organization and (d) root cause analysis. These factors are said to be qualifications to foster a just culture environment. With the presence of these variables, just culture is created and maintained.

By contrast, a just culture situation would result to the following consequences: (a) improved organization/care delivery system; (b) successful implementation of safety regulations; (c) safe environment; (d) producing better outcomes; and (e) quality patient care. Moreover, to empirically verify such outcomes, the following indicators are outlined: (a) increased client satisfaction; (b) increased employee job satisfaction; (c) increased event reports; (d) well-defined job performance expectations; and (e) clear guidelines and/or protocols of the organization.

Operational definition implication of just culture

Based on the attributes extracted by this concept analysis, just culture is hereby operationally defined as an environment that reflects a well-established balance accountability supporting collaborative learning that stems from the encouragement of error-disclosure attained through open communication. This definition is

supported by Weiner, Hobgood and Lewis (2007) when they referred just culture as the beliefs, assumptions, and expectations that govern accountability and discipline for unsafe acts.

Having the concept operationally defined and despite the recognized importance of a just culture, not every healthcare institution has adopted this type of approach. ANA (2010), in their position paper about this concept officially endorse the Just Culture concept as a strategy to reduce errors and promote patient safety in health care. In their efforts to endorse this "non-punitive" approach, they promote and disseminate information about the Just Culture concept in ANA publications, through constituent member associations, and ANA affiliated organizations. Hence, the feasibility of incorporating this approach in the present system must be taken into consideration.

However, the adopting organization must develop its own strategies in implementing just culture. It is because no single method fits all in applying the just culture. This concept when used as an approach in improving the quality of care must be contextualized depending on the acceptance and capability of the institution to implement this model. Once this approach is incorporated in the system, ANA (2010) encourages continued research into the effectiveness of the Just Culture concept in improving patient safety and employee performance outcomes.

Summary

Just culture is one of the concepts that makes up the safety culture construct. Little literature has been published that tackles the concept that, as cited by Weiner, Hobgood and Lewis (2007), even the safety literature offers little guidance on how to create a just culture. Still according to them, although the term ''just culture'' can be construed broadly, the term is often more narrowly used to refer to the beliefs, assumptions, and expectations that govern accountability and discipline for unsafe acts (e.g., near misses, medical errors, and adverse events) .Thus, it supports the notion that it is inevitable for humans to commit mistake. And this inevitability of human fallibility has led traditionally to blaming and punishing humans for the errors committed. Only through promoting a culture that supports critical analysis, constructive feedback and productive dialogue will we ever be able to learn from errors and improve safe patient care. In order to move toward a fair and "Just Culture", where learning can occur, we must provide a forum where errors or unanticipated outcomes can be used as the basis for a learning process, rather than grounds for punishment (NCBON, 2011).

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