

# ***Enhancing Patient Safety: The Infusion of Just Culture Behaviors into the Student Clinical Experience***

Barbara James, PhD, RN, CNE

Christine Sammer, DrPH, RN, FACHE

# ***Faculty Disclosure***

Faculty Name: Barbara James, PhD, RN, CNE  
Conflicts of Interest: None  
Employer: Southern Adventist University  
Sponsorship/Commercial Support: None

Faculty Name: Christine Sammer, DrPH, RN, FACHE  
Conflicts of Interest: None  
Employer: Adventist Health System  
Sponsorship/Commercial Support: None

# Goals and Objectives

- Session Goal:  
To demonstrate how faculty learn to model just culture behaviors when interacting with students who report errors or near misses within the clinical setting.
- Session Objectives:
  - #1: The learner will be able to summarize how the theory and concepts of just culture can be embedded into student learning activities.
  - #2: The learner will be able to demonstrate how clinical faculty are taught to create an environment supportive of students who report errors and near misses.
  - #3: The learner will be able to examine the contribution of just culture to the overall environment of patient safety.

# Southern Adventist University



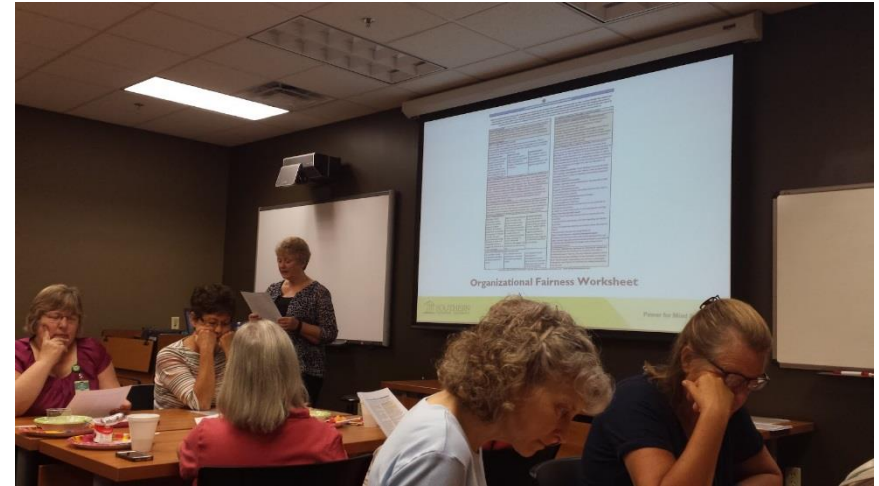
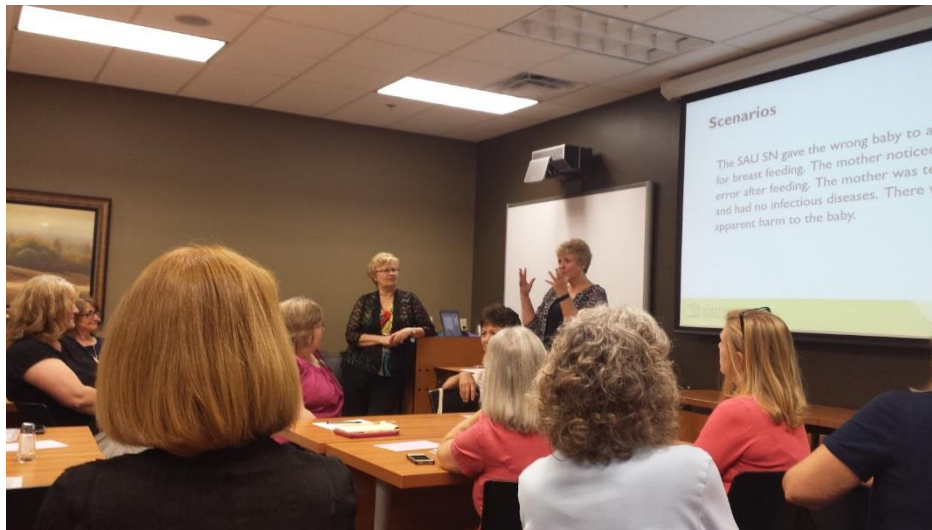


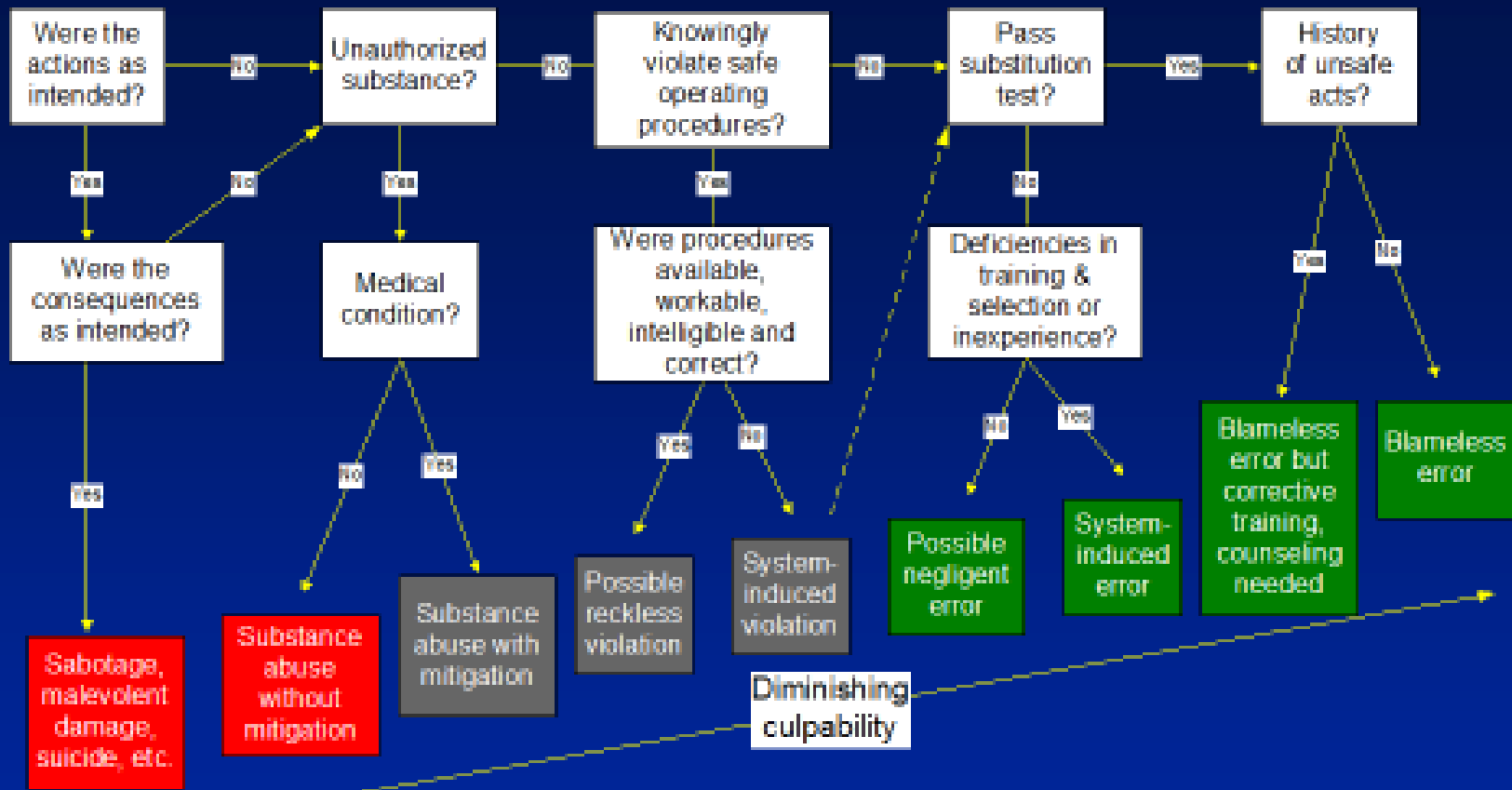
School of Nursing (SON)

# ***Educational Preparation of Clinical Faculty***

- Knowledge
  - Just culture as a framework
  - Definitions, policies, debriefing techniques, faculty responses to errors and near-misses
- Skills
  - Validated adverse event/near-miss algorithm
    - Training: what, why, who, when, how, goal
    - Self-reporting mechanisms within a safe environment
    - Case studies, simulation
    - Debriefs within post-conferences

- Attitudes
  - Psychological safety
  - Non-punitive environment
  - Culture of transparency
  - Share for learning
  - Organizational culture





## Decision Tree for Determining Culpability of Unsafe Acts

Adapted by A. Frankel

Reason, J., *Managing the Risks of Organizational Accidents*



# The Fair Evaluation and Response Chart

**HOW TO USE THIS CHART:** This chart should be used to categorize an individual caregiver's actions, not groups or systems. Evaluate each factor that influenced the caregiver's actions separately. When determining accountability, consider the context in which the action occurred.

<p>1. First, exclude individuals with impaired judgment or whose actions might be malicious. (These cases must be managed using other appropriate avenues – i.e. employee assistance programs for substance abuse and psychosocial problems, legal authorities for cases with possible criminal intent.)</p>		
<p><b>IMPAIRED JUDGMENT</b> The caregiver's thinking was impaired</p> <ul style="list-style-type: none"> <li>- by illegal or legal substances</li> <li>- by cognitive impairment</li> <li>- by severe psychosocial stressors</li> </ul> <hr/> <ul style="list-style-type: none"> <li>• Discipline is warranted if illegal substances were used.</li> <li>• The caregiver's mindset and performance should be evaluated to determine whether a temporary work suspension would be helpful.</li> <li>• Help should be actively offered to the caregiver.</li> </ul>	<p><b>MALICIOUS ACTION</b> The caregiver wanted to cause harm.</p> <hr/> <ul style="list-style-type: none"> <li>• Discipline and/or legal proceedings are warranted.</li> <li>• The caregiver's duties should be suspended immediately.</li> </ul>	
<p>2. Second, use best judgment to categorize each action as either Reckless, Risky or Unintentional based on the definitions in the Chart. The categorization determines the general level of culpability and possible disciplinary actions, however these general categories require further analysis as below prior to making a final decision.</p>		
<p><b>RECKLESS ACTION</b> The caregiver knowingly violated a rule and/or made a dangerous or unsafe choice. The decision appears to be self serving and to have been made with little or no concern about risk.</p> <hr/> <ul style="list-style-type: none"> <li>• The caregiver is accountable and needs re-training. Discipline may be warranted</li> <li>• The caregiver should participate in teaching others the lessons learned.</li> </ul>	<p><b>RISKY ACTION</b> The caregiver made a potentially unsafe choice. Their evaluation of relative risk appears to be erroneous.</p> <hr/> <ul style="list-style-type: none"> <li>• The caregiver is accountable and should receive coaching.</li> <li>• The caregiver should participate in teaching others the lessons learned.</li> </ul>	<p><b>UNINTENTIONAL ERROR</b> The caregiver made or participated in an error while working appropriately and in the patients' best interests</p> <hr/> <ul style="list-style-type: none"> <li>• The caregiver is not accountable.</li> <li>• The caregiver should participate in investigating why the error occurred and teach others about the results of the investigation.</li> </ul>
<p>3. Third, perform a Substitution Test by asking at least 3 others with similar skills if they, in a similar situation, would act similarly. If the answer is "No" the individual is accountable. If "We do it all the time" system influence is substantial. If the answers are divided, evaluators should assign accountability with a goal to ensure perceptions of fairness by others.</p>		
<p>The system supports reckless action and requires fixing. The caregiver is probably less accountable for the action, and system leaders share in the accountability.</p>	<p>The system supports risky action and requires fixing. The caregiver is probably less accountable for the action, and system leaders share in the accountability.</p>	<p>The system supports error and requires fixing. The system's leaders are accountable and should apply error-proofing improvements.</p>
<p>4. Fourth, evaluate whether the individual has a history of unsafe or problematic acts. If they do, this may influence decisions about the appropriate responsibilities for the individual i.e. they may be in the wrong job. Organizations should have a reasonable and agreed upon statute of limitations for taking these actions into account.</p>		

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# Just Culture Workshop Responses



# ***Summary***

Infusion of just culture principles into nursing curriculum empowers faculty to provide a safe learning environment when adverse events or near-misses occur in clinical settings.

Integration of just culture knowledge, skills, and attitudes acquired by faculty impacts clinical practice and prepares graduates to be contributors to safer healthcare delivery.

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