Title:
Just Culture, Trust, and the Impact to Patient Safety

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Session Title:
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Just Culture, Patient Safety and Trust

References:


Petschonek, S. B. (2013). Development of the just culture assessment tool: Measuring the


Abstract Summary:
Nurses are error identifiers. Barriers to reporting are negative response and risk of discipline. Organizations with a Just Culture are accountable for systems they design and analysis of incidents not individuals. Direct care nurse perceptions of trust and Just Culture can differ from leaders. These differences can impact patient safety.

Learning Activity:

<table>
<thead>
<tr>
<th>LEARNING OBJECTIVES</th>
<th>EXPANDED CONTENT OUTLINE</th>
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<tbody>
<tr>
<td>The learner will be able to define three types of behaviors that lead to errors.</td>
<td>The purpose of the study will be presented to the learner. Key concepts, research questions, operational definitions, and theoretical model will be discussed.</td>
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<td>The learner will be able to identify the relationship between Just Culture and trust.</td>
<td>The survey tools will be explained. Data analysis will be presented visually in two tables and one figure, demonstrating relationships and outcomes based on the research questions. Limitations will be discussed for full disclosure, as well as implications for future study.</td>
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Abstract Text:

PROBLEM: Medical errors are now considered to be the third leading cause of death in the United States, estimated at more than 250,000 deaths per year. The Institute of Medicine’s landmark report, *To Err is Human*, identified that errors are not the fault of individuals, but systems, processes, and various conditions. In healthcare, the cornerstone of the process by which we learn from errors has been voluntary reporting. The primary barrier to reporting errors is the negative response from administrators, and the potential risk of disciplinary action. An environment of trust and fairness is known as “Just Culture” and is required to promote the culture of safety. Employees must perceive that they will receive fair and just treatment when reporting safety near-misses and incidents. This fosters a culture of safety, which encourages organizational improvements that impact patient safety.

PURPOSE: This study identified the relationship between the nurses’ perception of trust and voluntary reporting of incidents in an organization that identifies itself as having Just Culture principles.

EBP QUESTIONS: 1. Is Just Culture present in the organization?

2. Is there a difference in the perception of trust between nurse leaders and direct care nurses?
3. Is there a relationship between the level of trust among nurse leaders and direct care nurses and the Just Culture principles?

4. Is there a relationship between the level of trust among nurse leaders and direct care nurses and voluntary reporting of events?

METHODS: An anonymous survey was developed utilizing two published tools. A convenience sample of all direct care nurses and nurse leaders (1,580 participants) were recruited to complete the Just Culture Assessment Tool and the Survey of Hospital Leaders. These surveys were available to participants for an eight-week period.

OUTCOMES: The results of this study revealed that there was a statistically significant difference between the direct care nurses’ and nurse leaders’ perceptions of trust and Just Culture within the organization. The majority of direct care nurses did not perceive that they would be given a fair and objective follow up process regardless of involvement in an event, or that the hospital would investigate the event fairly. When involved in an event, direct care nurses perceived that they would be blamed, and feared disciplinary action. A Just Culture is not a blame-free culture, but fosters balanced accountability. Administrators and nurse leaders need to look beyond the errors, to the systems in which direct care nurses work, and the behavioral choices they make within these systems.

SIGNIFICANCE: The findings of this study offer practical methods to develop a trusting and Just Culture. The first step is to assess the Just Culture principles embedded in the organization. An understanding of strengths and weaknesses can assist nurse leaders to ensure a fair and balanced approach to incident investigation. When behaviors and attitudes are aligned, the approach to performance improvement becomes the standard work of all staff.