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2019

### Just Culture: It's More Than Policy

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# Just culture: It's more than policy

By Linda Paradiso, DNP, RN, NEA-BC, NPP,  
and Nancy Sweeney, PhD, APRN-BC

Any healthcare organization's top priority is effective and safe care. Despite this, medical error is the third-leading cause of death in the US.<sup>1</sup> Hospitals are imperfect systems where nurses have competing demands and are forced to improvise and develop workarounds. Errors rarely occur in a vacuum, rather they're a sequence of events with multiple opportunities for correction. Clinical nurses can have a significant impact on reducing errors due to their proximity to patients. When errors are identified, the events and impact on safe care need to be shared. Just culture is a safe haven that supports reporting. In a just culture environment, organizations are accountable for systems they design and analysis of the incident—not the individual.

Many organizations have policies that describe nonpunitive response to error. However, barriers to speaking up include negative response and risk of discipline from leaders.<sup>2</sup> Organizations must strive to understand whether their culture is trusting and just. An assessment of just culture concepts can determine whether there's a difference between the perceptions of nurse leaders and clinical nurses who need to be assured that they'll receive fair treatment when speaking up about safety near-misses, errors, and incidents. If clinical nurses perceive that their treatment isn't just, they may drive valuable safety-related information underground.

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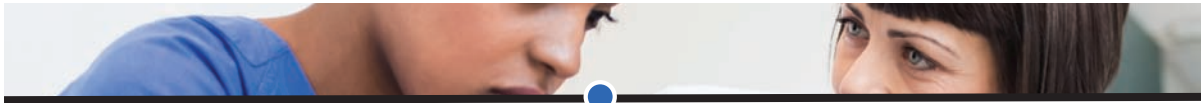
Leaders need to understand the nature and scope of errors, actively redesign faulty systems, and value voluntary reporting. When leaders' and clinical nurses' perceptions align, the organization can become highly reliable and reduce patient harm.

In this article, we present a study at a large, urban teaching hospital in Brooklyn, N.Y., examining the relationship between trust, just culture, and error

comes. This ideally creates an atmosphere of trust between the employee and employer and has a positive impact on staff members' willingness to report outcomes when results aren't as expected.<sup>4</sup>

Understanding the behavioral choices that a person makes is the second pillar of just culture. There are three types of behavioral choices made by people that can lead to errors: human error,

nurses will receive fair treatment from nurse leaders after an adverse event, regardless of their position in the hospital or the event's severity.<sup>7</sup> Humans can be both hazard and hero in adverse events because they're able to adjust, compensate, and improvise in an imperfect system.<sup>8</sup> In nursing, this ability is viewed as autonomy. However, if nurses don't speak up, it creates an illusion to leaders that systems work



### Implement visible and meaningful system improvements while ensuring that outcomes are communicated to clinical nurses to validate and encourage error identification.

reporting. The results offer practical implications to consider to improve trust in leaders.

#### Background

Although fairly new to health-care, just culture isn't a new concept. Industries such as aviation utilize nonblaming error reporting systems to improve safety and reliability. In the 1970s, the aviation industry's attention shifted from determining who made an error to identifying the circumstances under which an error was made.<sup>3</sup> By understanding the circumstances of the error, changes to prevent similar errors from occurring can be introduced. Air travel is now the safest mode of transportation.

Nonblaming incident investigation is the first pillar in developing the foundation of just culture. Healthcare institutions have adopted nonpunitive incident management structures to improve patient safety out-

at-risk behavior, and reckless behavior. Human error is a mistake or an inadvertent action. At-risk behaviors are those choices made where risk isn't recognized or believed to be justified. Reckless behavior is a choice made to consciously disregard risk, which is substantial and unjustifiable.<sup>5</sup>

A literature review didn't identify a consistent definition of just culture in healthcare; therefore, a nationally recognized training organization definition was utilized. For this study, just culture was defined as organizational accountability for the systems they've designed and employee accountability for the choices they make.<sup>5</sup>

Trust is critical to shared accountability. In this study, trust was defined as the extent to which individuals trust the organization, their supervisors, and their coworkers.<sup>6</sup> More specifically, trust in leaders was defined as the perception that clinical

effectively. In highly reliable organizations, clinical nurses routinely identify and report unsafe conditions and errors because they trust that their leaders want to know what isn't working and will implement visible and meaningful improvements with this information.<sup>9</sup>

The first staff survey used by hospitals to assess their culture of safety was released in 2004 by the Agency for Healthcare Research and Quality (AHRQ). Results from that survey and all subsequent surveys have remained consistent regarding nonpunitive response to error. Survey results from 2018 compiled data from 630 US hospitals. The findings continue to identify that one of the top three areas for potential improvement is nonpunitive response to error.<sup>2</sup> More than half of staff respondents reported the belief that event reports are held against them and mistakes are kept in their

personnel file.<sup>2</sup> These findings are significant to patient safety outcomes.

In patient care delivery, individuals can make multiple inconsequential errors. These errors arise from conditions that exist within an organization's systems, such as staffing challenges, delays, and equipment failures. Clinical nurses have limited opportunity to change the systems in which they work. They need to be error identifiers to recognize and resolve system issues that may become mistakes. This alert to leadership creates a safer organization. In this study, speaking up was defined as the willingness of individuals to communicate actual or potential error or event information upward to supervisors and hospital administrators.<sup>6</sup>

Organizations often determine the response to an error based on its severity.<sup>10</sup> Errors causing no harm are minimized or ignored and those resulting in injury or death are highly punitive. All types of error hold equal importance in a just culture, not just those with poor outcomes. To build trust, error identification and reporting are encouraged to provide opportunities for staff education and system redesign. As an organization transitions to a learning environment through event disclosure, it fosters trust for improvement rather than mistrust from blame. This is considered critical to becoming a highly reliable organization.<sup>11</sup>

## Methods

Following Institutional Review Board approval and consent waiver, this quantitative, correlational, cross-sectional study

## Research criteria

**Purpose:** This study examined whether there was a relationship between trust, just culture, and error reporting in nurse leaders and clinical nurses.

**Location:** The study site, located in Brooklyn, N.Y., is an independent teaching hospital with 711 licensed beds affiliated with several academic institutions and a large hospital system.

**Time frame:** March through May 2017

**Population:** The majority of nurses who responded to the survey were employed more than 10 years in the organization and provided direct care to patients. Critical care nurses comprised 23% of the sample, followed by medicine (16.1%), surgery (13.7%), and other (13.7%). Most nurses worked more than 6 years on their respective units, more than 90% of the respondents possessed a bachelor's degree or higher, were certified (55.3%), and have worked more than 6 years (65.8%) in their specialty. The average age of the respondents was 46.

**Collection tools:** JCAT, Survey of Hospital Leaders

**Sample size:** The convenience sample of nurses surveyed included 1,500 clinical nurses and 80 nurse leaders. At the end of the open enrollment, 185 nurses responded. The sample size exceeded the required number identified by power analysis and resulted in an 11.6% response rate. Twenty-four surveys were discarded due to omission of responses that measured the research questions.

recruited a convenience sample from 1,500 clinical nurses and 80 nurse leaders. (See *Research criteria*.) The self-administered, anonymous survey was the primary means of data collection. Two previously published instruments were utilized without modification: the Just Culture Assessment Tool (JCAT), designed to measure just culture in a hospital setting, and the Survey of Hospital Leaders, which measures perceptions of an organization's just culture.<sup>6,7</sup> Both were identified through a literature review and used with permission. The tools were administered as one survey utilizing a Likert scale.

## Analysis

The JCAT divides questions into six domains: feedback and communication, openness of communication, balance, quality of error reporting process, continuous improvement, and trust.<sup>6</sup> Analysis of the trust domain

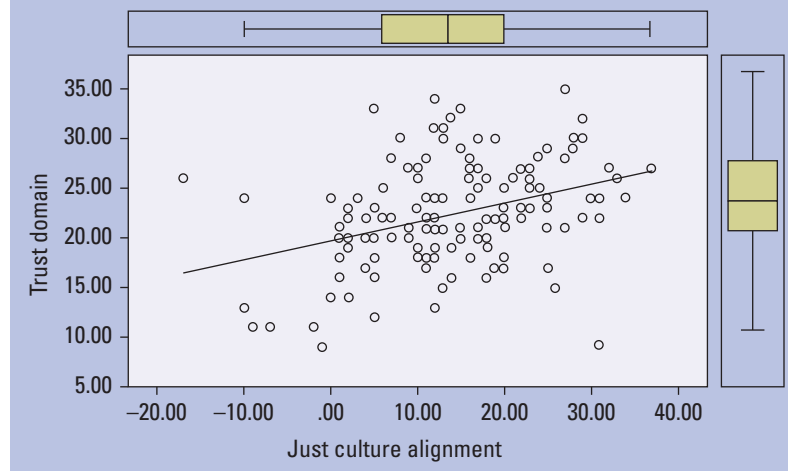
revealed a significant difference between the perceptions of nurse leaders and clinical nurses. The items "I trust that the hospital will handle events fairly" and "Each employee is given a fair and objective follow-up process regardless of his or her involvement in the event" identify that more than 90% of nurse leaders agree with these statements compared with less than 65% of clinical nurses. These differences were reinforced by other survey results. Most clinical nurses reported that they don't "trust supervisors to do the right thing" (60.7%), believe that "staff members are usually blamed when involved in an event" (76.1%), and "fear disciplinary action when involved in an event" (83.6%). Interestingly, 60% of nurse leaders and 50% of clinical nurses responded positively to the researcher-developed item "We know about events that happen on our unit that aren't

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reported," suggesting that unreported events are indeed occurring in the organization. This result is concerning and indicates an opportunity for analysis of near-misses, which aren't mandated to be reported. (See *Table 1.*)

Other significant findings from the JCAT were related to communication and evidence of improvements following investigation of a safety event. Nurse leaders and clinical nurses differed significantly regarding their responses to the items "Supervisors respect suggestions from staff members" ( $P = .003$ ), "Staff can easily approach supervisors with ideas and concerns" ( $P = .008$ ), "There are improvements because of event reporting" ( $P = .005$ ), "The hospital devotes time/energy/resources toward making patient safety improvements" ( $P = .011$ ), and "The hospital sees events as

**Figure 1: Correlation of trust and just culture**



opportunities for improvement" ( $P = .009$ ).

Moderately positive correlations were identified between trust and just culture ( $P = .001$ ). As the level of trust among nurse leaders and clinical nurses increased, the alignment with just

culture principles also increased. (See *Figure 1.*) When just culture is ingrained in the organization and its analysis of safety events, it's expected that fair treatment generates a sense of trust among employees. This may influence speaking up to report errors.

**Table 1: Perceptions of trust among nurse leaders and clinical nurses**

Question	Clinical nurses disagree %	Clinical nurses agree %	Nurse leaders disagree %	Nurse leaders agree %	Chi-square value	P value
Each employee is given a fair and objective follow-up process regardless of his or her involvement in the event.	39.6	60.4	8.3	91.7	8.438	.004
I trust that the hospital will handle events fairly.	34.9	65.1	4.3	95.7	8.493	.004
I trust supervisors to do the right thing.	39.3	60.7	11.5	88.5	7.234	.007
Staff members are usually blamed when involved in an event.	23.9	76.1	48.0	52.0	5.868	.015
Staff members fear disciplinary action when involved in an event.	16.4	83.6	38.5	61.5	6.373	.012
We know about events that happen on our unit that aren't reported.	50.0	50.0	40.0	60.0	.667	.414
Supervisors respect suggestions from staff members.	41.0	59.0	10.7	89.3	9.104	.003
Staff can easily approach supervisors with ideas and concerns.	33.6	66.4	7.7	92.3	6.968	.008
There are improvements because of event reporting.	36.8	63.2	8.0	92.0	7.720	.005
The hospital devotes (time/energy/resources) toward making patient safety improvements.	32.5	67.5	7.7	92.3	6.460	.011
The hospital sees events as opportunities for improvement.	23.0	77.0	0.0	100.0	6.777	.009

**Table 2: Correlation between trust and voluntary reporting of errors**

		Trust domain	Employees will report their own mistakes that <i>could</i> have resulted in patient harm	Employees will report their own mistakes that <i>did</i> result in patient harm
Trust domain	Correlation coefficient	1.000	.275	.157
	Sig. (two-tailed)		.001*	.052*
	N	154	154	154
Employees will report their own mistakes that <i>could</i> have resulted in patient harm	Correlation coefficient	.275	1.000	.518
	Sig. (two-tailed)	.001*		
	N	154	161	161
Employees will report their own mistakes that <i>did</i> result in patient harm	Correlation coefficient	.157	.518	1.000
	Sig. (two-tailed)	.052*		
	N	154	161	161

\*Indicates statistical significance

There was also a positive correlation between trust and voluntary reporting of errors. As the level of trust increased, employees were more likely to report mistakes that resulted in patient harm ( $P = .052$ ). More important, a stronger positive correlation was identified between trust and reporting errors that may have resulted in patient harm ( $P = .001$ ). (See *Table 2*.)

During onboarding and annually, nurses are educated about reporting actual safety incidents when identified. Potential events don't have the same mandatory reporting expectation but do provide the same learning opportunities; they're just as valuable in the quest toward building reliability. The correlation suggests that if clinical nurses trust their supervisors, they're more likely to speak up about potential errors or near-misses. Another survey item from the JCAT quality of error reporting domain, "Coworkers discourage each other from reporting events," was negatively associated with trust, which likewise suggests that nurses are more likely to encourage each other to report events as trust increases. When a nonpuni-

tive reporting process is in place, the organization can become highly reliable and learn from a careful analysis of all events.<sup>9</sup>

### Results

The study results revealed a statistically significant difference between nurse leaders' and clinical nurses' perceptions of trust and just culture within the organization. These findings are of concern as the organization perceives itself to have a just culture. When the culture of an organization is just, it's expected that fair treatment will generate a sense of trust in employees. Perceptions of unfair treatment and blame suggest a possible reluctance among clinical nurses to report, or worse, hide events. Open communication is the foundation of a reliable organization in which safety events serve as an opportunity to learn, rather than to hold an individual accountable.

The researcher identified possible processes that can contribute to this perception of blame. Despite identification of systemic problems during incident investigation, every plan of correction included education of nurses. The

individual clinical nurse or, on several occasions, the entire clinical nursing staff, was provided with retraining of policy and procedure. This is contrary to the organization's accountability for system design. If the event root cause is identified as systemic, then the organization is responsible to improve system design. Attributing an outcome to system design and attempting to resolve it by individually retraining the clinical nurse can be viewed as punitive regardless of the intent of the education.<sup>4</sup> Retraining should only be required when there's clear evidence that a lack of knowledge contributed to the event. If the system is contributing to risky behaviors, then improvements should be developed by actively engaging clinical nurses in exploring ways to improve the faulty system.

A just culture organization examines the system around the employee's behavioral choice and improves process designs when necessary to reduce risk.<sup>7</sup> An example of individual accountability for a systemic event occurred when a patient locked himself in a bathroom.

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All clinical nursing staff members were trained on how to “pick” five types of door locks. An organization with a just culture may have changed all the patient bathroom door knobs to a universal type, which could be easily opened in an emergency.

The focus on individual education and retraining outlined in corrective action plans supports a statistically significant finding of this research. Clinical nurses don't perceive that their supervisors respect their suggestions, their good ideas for improvements will be carefully evaluated or taken seriously, improvements occur from event reporting, or the hospital considers events as opportunities for improvement. These differences may hinder the organization's ability to implement changes to its systems to improve the patient safety culture. Clinical nurses may be reluctant to voice concerns and may develop behaviors that drift or unknowingly create risk in an effort to provide efficient patient care. Risky behaviors increase the likelihood of human error.<sup>5</sup>

Nurse leaders need to implement visible and meaningful system improvements while ensuring that the outcomes are communicated to clinical nurses to validate and encourage error identification. Closing this communication feedback loop is critical to confirm the value of clinical nurses' escalation of potential and actual error. Objective analysis of each event to identify inherent risks must include clinical nurses. Only when nurses “who do the work” are involved can subtle process issues be identified and meaningful improvements devel-

oped. An organization can recover when it can catch an upstream error before it leads to an adverse outcome.<sup>10</sup> This foundational performance improvement approach can put the organization on a trajectory toward high reliability.

Just culture isn't a blame-free culture, rather a culture of balanced accountability. Safe patient care outcomes include organizational system design and individual behavioral choices.<sup>2</sup> Nurse leaders need to look beyond the error to the systems in which clinical nurses work and the behavioral choices they make within those systems.

### Limitations

The study results support findings from previous studies and are consistent with the organization's 2016 and 2018 AHRQ Survey on Patient Safety Culture results.<sup>2,12</sup> Nonetheless, limitations exist. Although approximately 1,580 participants were contacted to complete the survey, the sample size was 185. This sample represented 17% of nurse leaders and 9% of clinical nurses. Another limitation was the survey's length. Staff members may have been reluctant to complete the survey due to time constraints and this may have contributed to the small sample size. A third limitation was related to the survey tools. Both utilized Likert scales with neutral choices and contained questions with reverse wording. The researcher noted reverse-worded items and the items were reverse scored. However, if respondents didn't carefully read each item and note the reverse wording, it's possible that they answered differently than their intended response. Despite these

identified limitations, the research questions were supported.

### Implications

The study's findings offer practical suggestions for organizations to develop a trusting and just culture. This can lead to an environment where incidents are analyzed based on the system in which clinical nurses function.<sup>13</sup> Incidents don't occur in professional silos; therefore, investigations should also not occur independent of each other. Initial investigation at the “scene” with all involved can produce a better understanding of the intermingled details. Including every member of the interdisciplinary team in the debriefing can also help destigmatize the incident and normalize the event. Collaborative debriefing following an incident helps the nurse understand why he or she made the behavioral choice, as well as identify opportunities for potential system redesign.

A fair and balanced approach to incident investigation includes the provision of education and training only when needed. If the best choice a clinical nurse can make is a risky one, then retraining doesn't impact the root cause. Leaders who utilize just culture principles of consoling staff and fixing faulty systems that create the risky behavioral choice foster trust. To decrease risky behaviors, leaders must acknowledge and manage workplace stress, which can result from chronic understaffing, supply shortages, and technology failure and, in turn, degrade performance by leading to risky behavioral choices. Frontline leaders can ensure that staff members have



the requisite tools to perform duties without taking short cuts. When behavioral choices and trust align, the approach to performance improvement becomes the standard work of all staff.<sup>9</sup>

Use of an objective algorithm assists leaders to investigate potential and actual incidents with fairness and transparency. This can strengthen the trusting environment and reinforce the value of being an error identifier. During onboarding of new employees, trainees must be made aware of the importance of error identification as a piece of systemic information beneficial to the organization. Stressing the partnership between the organization and clinical nurses in creating a culture of safety can support mutual trust. Griffith and Marx report that accountability is a fundamental component of a just culture, which emphasizes the human system components within the larger organizational system.<sup>10</sup>

The concepts of just culture and Magnet<sup>®</sup> recognition are well aligned. When just culture concepts are integrated into the Magnet Model, the organization can systematically improve the safety culture. Transformational leadership and structural empowerment provide a blueprint and process to unravel the complexities of an event, learn from it, and improve safety.<sup>11</sup> Nurses in Magnet facilities are more likely to identify errors because they feel empowered by the organizational culture and have higher levels of trust in leaders.<sup>14</sup> Just culture and Magnet recognition bind employees and leaders by creating shared accountability for patient safety

outcomes. Leaders should take advantage of consistent, unit-based teamwork by openly supporting and recognizing clinical nurses and frontline nurse leaders who value high-reliability principles and model optimal clinical outcomes.<sup>15</sup>

### Be part of the shift

The shift to a just culture is a slow process that takes years to develop and hardwire. Hospital-wide policies that incorporate just culture principles are a first step. Studies are needed to regularly assess trust and just culture perceptions among nurse leaders and clinical nurses. Ensuring alignment of nurses' perceptions of just culture and trust can increase employee satisfaction, improve patient safety outcomes, and ultimately reduce the third-leading cause of death in the US. **NM**

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The authors have disclosed no financial relationships related to this article.

DOI-10.1097/01.NUMA.0000558482.07815.ae