
The authors, who are employed in Patient Safety at the Minnesota Hospital Association, describe the development and continuing work of the Minnesota Alliance for Patient Safety (MAPS) founded in 2000 by the Minnesota Hospital Association (MHA), the Minnesota Medical Association, and the Minnesota Dept. of Health. MAPS pioneered a statewide model of a “just” culture. MAPS helped pass legislative changes in 2001 revising the Minnesota peer review law to allow hospitals to share key safety information through electronic databases such as the MHA Patient Safety Registry. In 2003 the Minnesota Adverse Health Care Event Reporting Act was passed which encourages reporting of root cause analysis. MAPS has also educated hundreds of healthcare providers on best practices on topics such as health literacy, just culture, partnering with patients, and prevention of pressure ulcers, and also developed *My Medicine List* thus transforming Minnesota’s health care safety culture.


Dr. Clancy wrote this a decade after the Institute of Medicine’s (IOM’s) report, *To Err is Human: Building a Safer Health System*. That report emphasized that medical harm results largely from the systemic problems rife in health care. The IOM recommended setting national goals for patient safety, developing evidence-based knowledge and understanding of errors in health care, and voluntary and mandatory reporting efforts. The IOM called on health care providers to commit to patient safety improvement by providing leadership, implementing non-punitive systems for reporting and fixing errors in their organizations, and incorporating proven safety principles and teamwork. The IOM also called for a 50 percent reduction in medical errors within 5 yrs. And that was not attained. Dr. Clancy states that hospitals have been left to individually take on these challenges. It has been difficult to measure progress without national benchmarks and without mandatory reporting. Fear of reprisal from litigation or disciplinary actions, the voluntary nature of all reporting, and lack of agreement on standardized definitions of reportable errors all hamper effective event reporting. Dr. Clancy states that as of December 2009 more than half of the states have instituted mandatory reporting of serious events. The progresses that have been made include: the Patient Safety Act, development of the AHRQ in Oct, 2008, the AHRQ’s suite of patient safety culture surveys, TeamSTEPPS, patient Safety checklists, emphasis on MRSA, an AHRQ toolkit to help hospitals reengineer their discharge processes to prevent readmissions, and AHRQ research on medical resident fatigue. The challenge now is going forward.
Mr. Goodman, Assist Professor, Health Care Administration at Texas Woman’s University, Houston, TX, notes the history of the National Patient Safety Foundation, which is interesting. It was founded in 1996 by the American Medical Association, CAN HealthPro, 3M and contributions from the Schering-Plough Corporation. It is an independent, nonprofit research and education organization, and is an unprecedented partnership of healthcare practitioners, institutional providers, health product providers, health product manufacturers, researchers, legal advisors, patient/consumer advocates, regulators and policy makers committed to making health care safer for patients. He points out the high rate of nonfatal occupational injuries in health care in one calendar year (2000)...556,000. The author maintains that often emphasis is on patient safety but other aspects of health care organizational safety may be excluded. He also identifies compartmentalizing problems as a deterrent. In the environment of care safety committee, accidents are discussed; whereas in the patient safety realm, errors are discussed. He maintains that development of a safety culture necessitates the process be organization-wide, comprehensive, pervasive, and very visible. He calls for a focus on safety, not occupational safety or patient safety. The author mentions two high-hazard industries for models, including the aviation and the construction industry.

http://findarticles.com/p/articles/mi_m0FSW/is_1_22/ai_n17206602/


This is the first of a series of articles by the Chief Operating Officer of Outcome Engineering LLC, the organization with which David Marx, father of the just culture movement, is president. Additional articles in the series are available for download on the Outcome Engineering website at www.justculture.org.

Other issues in the series:


Harder, R. (2006). A “just culture” proves just right, Nursing Management,

Mr. Harder emphasizes three guiding principles of leadership: being fair, firm, and friendly. His belief is that creating a workplace that promotes a nonpunitive environment following the exposure of patient
safety issues can result in major misunderstandings of intent if an employee is subject to corrective or disciplinary action. The author believes that recreating the event through discussion and simulation can quickly identify flaws in the process, individual performance, or both. Harder emphasizes the need for staff input. When individual performance is the culprit of a bad outcome, then discipline is the result. The key is that each incident is vigilantly reviewed, and just culture fosters a culture of mutual accountability between nurse and healthcare facility.


In clinical work, practitioner collaboration is often fraught with political, professional and ideological divergencies. Often there are organizational and professional agendas. The authors report on a method that has allowed health care practitioners to critically engage with their own practice, and the practice of colleagues, to enable them to negotiate and mitigate their differences and divergent opinions and practices. The authors use video reflexive methods by which health care practitioners articulated systematizing or ‘meta discursive’ solutions to address previously taken-as–given organizational and clinical (handover) practices. All authors are employed in Sydney, Australia. Handover represents the intersection between shifts, units, organizations, professions, ranks, and different professional functions including teaching, caring, and curing. They refer to the established formats, such as SBAR (Haig et al, 2006); however, the complexity of clinical work generally does not permit adherence to these procedures and guidelines. The premise was that when clinicians watch footage of their practices they come to realize the extent to which their practices embody their own peculiar logic, which has slipped from conscious view, and clinicians are able to observe themselves in the complexity and indeterminacy of what they do, and their practical wisdom which they had come to take for granted.

Through several vignettes, staff developed an ability to discuss handover as a process, an evolving process. Viewing one’s work on the screen is enabling in and for itself and taking viewers well beyond what is shown. In essence, the footage enabled practitioner to gain a view of the broader system of practice of the systemic space within which it operates, and of the opportunities for change that this systemic perspective brings into view. The video is the catalyst as the video introduces a different view on what happens.


This issue addresses the punitive culture of patient safety prevalent prior to the 1990s and that culture proved counter-productive in achieving accurate reporting and analysis of errors. The drawbacks of a blame-free culture are discussed. The article concludes with a discussion of a “just culture” which limits excessively punitive treatment for unintentional and/or system errors while holding the reckless
behavior accountable. A culture perceived as just is much more likely to engender accurate and timely reporting of errors and near misses so that appropriate examination of the error and corrective action can be taken.

http://www.ismp.org/Newsletters/acuteacare/articles/20060907.asp?ptr=y


This article analyzes the three types of human behavior involved in error: human error, at-risk behavior, and reckless behavior. Each type of behavior requires a different response in the algorithm of just culture.

http://www.ismp.org/Newsletters/acuteacare/articles/20060921.asp?ptr=y


The article identifies a set of organizational attributes that perpetuate a blame culture and those that foster a just culture in health care. The authors maintain that to move from blame to just requires a comprehensive understanding of organizational attributes or antecedents. They state that health care organizations need to build organizational capacity in the form of HR management capabilities to achieve a just culture. This is a conceptual article. Health care management literature was reviewed to ascertain if a consistent pattern existed in organizational attributes that lead to either blame or just cultures, and to find ways to reform a blame culture. The authors conclude that (a) a blame culture is more likely to occur in health care organizations that rely predominately hierarchical, compliance-based functional management systems, (b) a just or learning culture is more likely to occur in health organizations that elicit greater employee involvement in decision making; and (c) human resource management capabilities play an important role in moving a blame culture to a just culture. The authors call for a harnessing ideas and ingenuity of health care professionals by employing a commitment-based management philosophy, rather than strangling them by over regulating their behaviors using a control-based philosophy.


The authors are employed at the Univ, of North Carolina Health Care, Chapel Hill, NC. The article describes systems Factors well. System factors refer to the way the elements independently and collectively function and interact with each other and in response to the environment (physical & social) within which they exist. The authors state that patient safety can only exist in a culture of safety, and describes a learning culture, a reporting culture, and a just culture. Barriers of a just culture are explained with a glossary of terms. The article describes system analysis and concludes that the greatest responsibility and accountability for a just culture reside with organizational leaders.

The authors conclude that greatest responsibility and accountability for a just culture resides with organizational leaders. The patient safety movement continues to mature and evolve over time. The article recognizes Peter Pronovost for his work with the Institute for Healthcare Improvement for its work to eliminate hospital-acquired infections. Mayer maintains that preventable patient harms that almost occur go unreported approximately 50% of the time. The goal is to move to a “reporting culture” in which “almost events” will be reported to promote a “learning culture” in which there is dynamic, continual improving and seeking of new opportunities to protect patients from harm.


Mr. Plawecki is a Registered Nurse at a Rehab. Hospital in Indianapolis, IN. Dr. Amrhein is Resident Physician in Family Practice Medicine in Muncie IN. They state no financial interests. The authors cite the Institute of Medicine’s 1999 publication of To Err is Human: Building a Safer Health System, as the first mainstream article calling for a change in the culture of health care and the eradication of preventable medical errors. The article reviews what has been accomplished in the ten year period from 1999 to 2009. In 2001 the U.S. Congress appropriated an annual budget of $50 million for patient safety research. The Agency for Healthcare Research and Quality (AHRQ) was codified as the agency to oversee patient safety. The National Quality Forum (NQF) was created in 2007 and listed 27 serious reportable events, referred to as “never events”. In 2005, the AMA released a report by Leape and Berwick detailing the effects of the original IOM report, and it discussed how the focus of patient care had shifted from a fixing blame to implementing a culture of safety. This report recommended the four areas in which health care needed to advance over the second 5 yrs.

1) Recommended implementation of electronic medical records

2) As more methods are implemented, newer & safer practices will be proven.

3) There will be newly learned information disseminated and training of workers will continue to evolve & improve,
4) Health care professionals should be able to admit mistakes, apologize, and improve communication with patients.

The authors then list several states and progress they have made. In 2006, The Centers for Medicare & Medicaid (CMS) spoke for the first time about never events. CMS provided its plan in April 2008, when is ceased payment for 8 specific kinds of never events. Many geriatric patients are treated in state regulated facilities. The article calls for nurses to research best practices, current law and forecast state and federal trends, and promote safety and prevention of error.


Article-at-a Glance: Patients experience adverse events more frequently than the public appreciates. A number of health systems have led the movement toward open, prompt, and compassionate disclosure of adverse events. In 2006 Baystate Health (BH) formed a disclosure advisory committee to design and implement an enhanced program to support prompt and skillful disclosure of adverse events. The proposed model for a disclosure and apology program resembled a consultation service, similar to a hospital ethics consultation service. BH hired an outside trainer to teach coaches/facilitators. Emotional support services were formalized and expanded not only for patients and families but also clinicians. Implementation of a formal disclosure and apology program has placed internal pressure on the organization to more promptly determine causality of adverse events and to respond to patient/family requests for information and/or assistance. Root causes and degree of system culpability are often not clear early after an event and sometimes are debated among the clinical team and trained coaches/facilitators and risk managers. After a medical error, patients and families expect the organization to make changes to the system to prevent other patients from being harmed by the same mistake. To minimize the chance that patients and families feel that their suffering has been “in vain,” health care systems will need to put systems in place to deliver on the promise to reduce the risk of future harm. Some of the challenges in sustaining such a program include the ability to promptly investigate, to accurately determine liability, to communicate empathetically even if unable to meet all patient/family expectations, and to ensure establishment of a just culture.


Abstract: A critical incident is described as any sudden unexpected event that has the power to overwhelm the usual effective coping skills of an individual or a group and can cause significant psychological distress in usually healthy persons. A Just Culture model to deal with critical incidents is an approach that seeks to identify and balance system events and personal accountability. This article
reports a critical incident that occurred at the Neonatal Intensive Care Unit, Methodist Hospital of Indianapolis, when 5 infants received an overdose of heparin that resulted in the death of 3 infants. Although care of the family after the critical incident was the immediate priority, the focus of this article was on the recovery and reintegration of the NICU staff after a critical incident based on the Just Culture philosophy.


Two of the authors are PhD’s at Columbia University and the last is a M.D. and Assoc. professor at Cornell University, NY. It is pointed out that To Err is Human focused on micro issues, and that attention is also needed on a macro issue: an organization’s culture and leadership. The authors address the precursors of medical errors and developing interventions to prevent them. They describe culture as the glue that holds the organization together. The authors cite Kotter’s (1990) list of 6 key tasks that must be performed in any organizational change, with the first three promoting movement, and the latter three which are aimed at producing order on established dimensions. They explore normal accident theory and admit that many errors arise from system failures (Leape, 1997). They discuss numerous causation models and Reason’s paradigm (The Swiss cheese) model of defenses, and his two categories of active failures, and latent conditions. High-Reliability Organization Theory is discussed, as well as ways to instill a culture of safety. They describe components of a safety culture based on Reason (2000). The authors offer several ideas for improving the safety culture and conclude by naming two groups that have been active in reducing errors and improving safety: the Institute for Healthcare Improvement and the AMA’s National Patient Safety Foundation. They mention a checklist for hospital executives to begin to instill a culture of safety called Strategies for Leadership (Conway 2001). The article accents the importance of expanding the scope of safety culture to the entire continuum of care, including outpatient, nursing home or other subacute facilities.


This is a research article with the objective of comparing safety climate between diverse U.S. hospitals and Veterans Health Administration (VA) hospitals, and to explore the factors influencing climate in each setting. Data sources include surveys of hospital personnel and secondary data from the AHA’s 2004 Annual Survey of Hospitals. Researchers used the Patient Safety Climate in Healthcare Organizations (PSCHO) survey to collect data on employee’s perceptions of safety climate. The PSCHO instrument is the only one with established reliability and validity in both U.S. and VA hospital settings. Prior to the studies approval was granted by relevant Institutional Review Boards. The sampling
frames in U.S. and VA hospitals consisted of 36,375 and 9,309 personnel, respectively. This is a cross-sectional study of 69 U.S. and 30 VA hospitals. Hierarchical linear models used safety-climate scores as the dependent variable and respondent and facility characteristics as independent variables. Regression-based Oaxaca-Blinder decomposition examined differences in effects of model characteristics on safety climate between U.S. and VA samples. Principal Findings included substantial overlap in safety climate among U.S. and VA hospitals. Characteristics of individuals influenced safety climate consistently across settings. Working in southern and urban facilities corresponded with worse safety climate among VA employees and better safety climate in the U.S. sample. Decomposition results predicted 1.4 % points better safety climate in U.S. than in VA hospitals: -0.77 attributable to sample-characteristic differences and 2.2 due to differential effects of sample characteristics. The study concluded that safety climate is linked more to efforts of individual hospitals than to participation in a nationally integrated system or measured characteristics of workers and facilities. Overall, there was no difference in safety climate between U.S. and VA hospitals on average, based on descriptive statistics. Higher nurse staffing ratios were associated with lower PPR (Percent Problematic Response). The researchers suggest continued efforts to improve safety climate in hospitals. They suggest that other factors, such as hospitals’ emphasis on creativity and innovation and their leaders’ abilities to motivate, implement, and sustain improvement, may be more significant.


This article discusses healthcare’s journey since the publication of the IOM’s *To Err is Human*...from a culture of blame, then no blame, and finally, to one the beginnings of accountability and justice. The journey continues.


The author, who is at the Dept. of Human Sciences, Loughborough University in Loughborough, UK, examines research not on human error (which he states has been the focus of research to the present) but on review of systems approach. The author reviewed 360 papers using certain strict criteria. Most of the articles focused on individual error, fewer on team errors, and none on what might be labeled “organizational” errors. Few studies appear to provide details of the connections that exist between different system levels. He believes the systems approach has over the years sometimes has proved to be misinterpreted and misconstrued by those purporting to use it. He summarizes there is no one prescribed systems approach; rather, there is a set of shared characteristics and components.

Abstract: Safety experts contend that to make incident reporting work, healthcare organizations must establish a “just” culture – that is, an organizational context in which health professionals feel assured that they will receive fair treatment when they report safety incidents. Although healthcare leaders have expressed keen interest in establishing a just culture in their institutions, the patient safety literature offers little guidance as to what the term “just culture” really means or how one goes about creating a just culture. Moreover, the safety literature does not indicate what constitutes a just incident reporting process in the eyes of the health professionals who provide direct patient care. This gap is unfortunate, for knowing what constitutes a just incident reporting process in the eyes of front-line health professionals is essential for designing useful information systems to detect, monitor, and correct safety problems.

In this article, we seek to clarify the conceptual meaning of just culture and identify the attributes of incident reporting processes that make such systems just in the eyes of health professionals. To accomplish these aims, we draw upon organizational justice theory and research to develop a conceptual model of perceived justice in incident reporting processes. This model could assist those healthcare leaders interested in creating a just culture by clarifying the multiple meanings, antecedents, and consequences of justice.


This article defines just culture and discusses the major concepts associated with implementation of the culture.