Just Do it—A Just Culture to Move From Blame to True Remediation

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Culture Eats Strategy for Lunch

An organization’s culture is what drives behavior, which in turn, drives outcomes. Professional accountability must be balanced with the responsibility to create a safe environment in which healthcare providers are not afraid to report medical errors.

Tipping the Scales

It has been estimated the number of people who die annually in the United States due to a healthcare acquired infection or iatrogenic error approaches 98,000. This is the rough equivalent of two jetliners crashing each day of the year, killing everyone on board. Yet, interestingly, we do not respond to these deaths with the same sense of urgency, indignation, and resolve.

• In the past, the threat of disciplinary action for errors was thought to be necessary; however, punitive measures were not effective, practices did not change and the desired effect of heightened awareness of patient safety did not occur.

Change the Culture...Change the Outcomes

The aforementioned evidence and our organizational results from the AHRQ Hospital Survey on Patient Safety prompted staff on a 30 bed medical-surgical unit to investigate and adopt the concept of a “Just Culture.” A strong shared governance model—illustrating the Magnet® model component ‘structural empowerment’--was the framework for designing Just Culture structure and processes.

• Leadership shares blinded errors with the Practice Council members to review.
• Algorithms for human error and at risk and reckless behaviors are carefully examined and appropriate actions taken.
• Actions often include a “gemba walk” by the leadership team to directly observe practice and, as necessary, re-educate and revalidate skills.

Balancing the Scales - Key Calibrations

• Labor Intensive Process—requires leadership support and involvement.
• Not a Free Pass—individual must be held accountable for errors.
• Thorough examination of error is essential to determine the individual’s level of responsibility.
• Aware of risk or mistakenly justified? Leadership team examines individual’s practice and follows algorithm.
• From immediate punitive response to examination and true remediation—Foundation of Just Culture.
• System flaws identified; educational opportunities transpire; and engagement of staff emerges.
• Investment of time pays dividends—Direct observations of practice promotes safety and builds levels of trust and transparency crucial to patient safety.

Maintaining Balance

References: