Restoring Trust and Accountability
The Nurse Leader Role in Patient Safety Culture
Jamie Clendenin, BSN, RN-BC; Ore Ezeigbo, MSN, RN, CWCN; Kunjamma George, DNP, RN-BC, CMSRN, CNEcl; Claire Floyd, MSN, RN-BC; and Melita Forrester, MS, RN, VA-BC

NURSE LEADERSHIP INSTITUTE at the UNIVERSITY of MARYLAND SCHOOL OF NURSING

Background

It is estimated that nearly 400,000 deaths per year are attributable to medical errors, making this the third leading cause of death in the United States. Nurses, now more than ever due to the COVID-19 pandemic, need an environment where reporting incidents are seen as supportive and constructive. In environments that provide a positive perception of patient safety culture, the outcomes seen are lower rates of adverse events.

A patient safety culture, like Just Culture, creates an environment to permit open and honest reporting resulting in a quality learning environment and culture. Many organizations do have policies to describe their methods in response to patient safety events, however barriers continue to exist causing staff to fear a negative response and discipline from leadership. It is imperative for nurse leaders to fully understand the problem, because when the perception of both the leaders and clinicians can align, patient harm reduces, and the organization provides high reliability care.

Purpose of Project/Knowledge Gap

While nurse leaders have the ability to improve patient safety culture, clinical nurses do not view senior leaders as competent or supportive in creating a culture of safety. Ultimately, clinical staff is reluctant to report safety issues due to fear of direct punitive results.
Questions:
1. What are the barriers between nurse leaders and clinical staff?
2. Does the introduction of formal training in the Just Culture methodology change the perception of the safety culture?
3. How can nurse leaders improve the perception of reporting safety issues?

Discussion

Contributing factors to the existing barriers of obtaining Just Culture:
- The COVID-19 pandemic
  - Increased the likelihood of errors and near-misses occurring due to the ever-changing standards and guidelines.
- Direct caregivers' perception
  - A non-punitive incident reporting structure provided by a Just Culture framework enables providers to feel safe to report errors without fear of retribution.
- Nurse leader involvement
  - Nurse Leaders with a strong understanding of Just Culture and their staff's perceptions can engage in open and honest dialogues with their teams and work on building trust and incorporate the use of investigating routine, non-threatening issues to help remove any perceived stigma from the process.

- Limitations: the study length and small sample sizes of nurse leaders. However, the literature review results were consistent and supported findings from previous studies.

Figures

AHRQ Surveys on Patient Safety Culture™ (SOPS) Hospital Survey Composites in Descending Order of Improvement Among 536 Hospitals
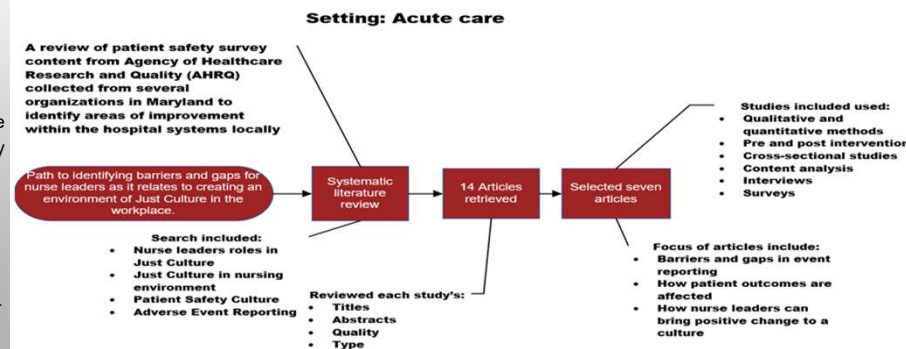
Composite	Score
Frequency of events reported	65.2%
Teamwork across units*	60.2%
Feedback and comm about error	66.6%
Handoffs and transitions*	46.6%
Nonpunitive response to error	44.7%
Overall perceptions of safety	66.6%
Teamwork within units	81.1%
Organizational learning	73.1%
Supervisor expectations & actions	75.8%
Staffing	56.4%
Management support for patient safety*	72.6%
Communication openness	62.2%

■ Improvement ■ Baseline Score

* Hospital-level composite.

Source: 2019 AHRQ Surveys on Patient Safety Culture (SOPS)

Composite	Average % positive response
Supervisor, manager or clinical leader support for patient safety	81
Teamwork	81
Communication openness	76
Reporting patient safety events	74
Organizational learning-continuous improvement	72
Communication about error	68
Hospital management support for patient safety	68
Response to error	61
Handoffs and information exchange	58
Staffing and work pace	56
Average Across Composite Measures	70

Method

Setting: Acute care

A review of patient safety survey content from Agency of Healthcare Research and Quality (AHRQ) collected from several organizations in Maryland to identify areas of improvement within the hospital systems locally

Path to identifying barriers and gaps for nurse leaders as it relates to creating an environment of Just Culture in the workplace. → Systematic literature review → 14 Articles retrieved → Selected seven articles

Search included:
- Nurse leaders roles in Just Culture
- Just Culture in nursing environment
- Patient Safety Culture
- Adverse Event Reporting

Reviewed each study's:
- Titles
- Abstracts
- Quality
- Type

Studies included used:
- Qualitative and quantitative methods
- Pre and post intervention
- Cross-sectional studies
- Content analysis
- Interviews
- Surveys

Focus of articles include:
- Barriers and gaps in event reporting
- How patient outcomes are affected
- How nurse leaders can bring positive change to a culture

Results

There is a significant difference between nurse's and leaders' perceptions of trust and just culture within the organization.
Barriers to promoting Just Culture include:
★ Communication
★ Mistrust
★ Faulty reporting systems
★ Lack of senior leadership engagement

Best ways for improving the perception of the safety culture for nurse leaders:
★ Providing education to nurse leaders to improve their own perception of just culture principles.
★ Nurse leaders owning the responsibility for promoting a positive perspective in contrast to the long-standing punitive culture and individual faults.

Best ways to improve perception of event reporting:
★ Open communication with nurse leaders
★ Access to nurse leaders
★ Visibility of nurse leaders

Conclusion

Many health care facilities are adopting the Just Culture framework in efforts to establish a high-reliability organization with zero-harm patient safety cultures.

Best ways to sustain a just culture:
★ Engage and educate nurse leaders to actively practice Just Culture, thereby creating:
  - opportunities to move event reporting from being viewed as an action taken to address problems or correct mistakes
  - an active Just Culture, using event recording as being part of the collective consciousness of the organization, a process that is always used and in all situations without fear of a negative response.

- A future review should be expanded to include more healthcare settings, surveys and narrative interviews

References