OREGON NURSES ASSOCIATION
ACTION REPORT

Nurses' Contributions to Just Culture Organizations

Submitted by:
Cabinet on Nursing Practice and Research and
Cabinet on Human Rights and Ethics

Type of action report: Substantive

Recommended Actions:

1. Individual direct care and advanced practice registered nurses in ONA are urged to support Just Culture by:
   - Identifying situations, practices and problems which create an unsafe environment for patients, families, visitors and staff;
   - Reporting situations, practices and problems which create an unsafe environment for patients, families, and staff;
   - Participating or leading in unit-level discussions in which solutions to root cause-related practices are developed and implemented
   - Participating in discussions and decisions within his/her practice organization that identify solutions to unsafe practices;
   - Communicating with unit-level nursing colleagues whose nursing practices deviate from general and specialty-specific scope and standards in the unit; and
   - Engaging in situation-specific confidential peer-to-peer review and conversation in an environment of shared accountability.
2. ONA's program areas recommend that health care systems and organizations to adopt and practice the Just Culture concepts of no blame and shared accountability, respectful responsiveness, and thoughtful analysis of safety issues in the work environment and care delivery system.

3. ONA will support nursing research initiatives, which identify best practices and barriers to participation of direct care and advanced practice nurses when reporting gaps in safety and error.

Background and Rationale:

In 2001, the Institute of Medicine (IOM) report Crossing the Quality Chasm made explicit the scope and significance of health care-related medical error. Six imperative changes were called for: "…redesigned care processes, effective use of information technologies, knowledge and skills management, development of effective teams, coordination of care across patient conditions, services and settings over time, and use of performance and outcome measurement for improvement and accountability" (p.127). Then, in 2004, the IOM issued Keeping Patients Safe, a report which recognized that the practice and work environment of nurses was central to any progress related to quality and safety. In 2007, the IOM published Preventing Medication Errors, a report which analyzed traditional approaches to medication safety, the chain of hand offs from prescriber to the nurse who administers the medication. However, reports from the AHRQ indicate that limited progress has been made in reducing medical error (AHRQ, 2010). Over this time period, factors contributing to the slow progress in reducing care-related error have emerged. One factor is the reluctance within organizations to create non-punitive

approaches to error, thus – most errors are not reported and are hidden, effective response to unsafe situations is delayed and errors may be repeated. Concurrently an approach has emerged which focuses on Just Culture (Just Culture Community, 2008; Connor et al, 2007; Marx, 2001, 2009; Dekker, 2007; Khatri, Brown, Hicks, 2009; Gorzman, 2008).

Just Culture is an organizational paradigm based on maintaining the balance between safety and accountability. A Just Culture approach in an organization would be characterized by open reporting and analysis of situations and practices which potentially or actually could lead to error or harm to patients by creating an environment in which this information is respectfully received and approaches to reduce the harm, error or gap are addressed. This approach also recognizes that gaps or errors in patient care may occur due to lack of awareness, risky behavior or reckless behavior. For each type of behavior which can or had lead to a gap in safety, the organization responds through review, root cause analysis, coaching and potentially, punishment.

While a number of health care systems have adopted or supported Just Culture (Veterans Affairs, Minnesota Alliance for Patient Safety, North Carolina Center for Hospital Quality and Safety, Missouri Center for Patient Safety, American Organization of Nurse Executive, AORN, Illinois Nurse Association), there are barriers to real actualization of a Just Culture when critical elements are not present, e.g., lack of a champion, insufficient group-based and on-site leadership training, insufficient representation of key players in training. These challenges have been described by Vogelsmeier, A., Scott-Cawiezell, J., Miller, B., and Griffith, S. (2010).

In addition, the specific contributions of nurses to Just Culture such as a clear understanding of how nurses' ethics and scope and standards of practice obligate them to prevent error and harm as do the purposes of Just Culture, are missing from this literature and need to be identified and integrated.

1. The Code of Ethics for Nurses (2008) clearly obligates the nurse to be aware of threats to safety of the public in the community, and to practice in a way that upholds the safety of the patient. The nurse has an obligation to continued competency so as to prevent unsafe practice, to seek practice settings in which health and safety are upheld, and to avoid acquiescence to unsafe practices. (Code of Ethics for Nurses with Interpretive Statements, 2008)
2. Scope and Standards of Nursing Practice. This document describes the core scope and standards for professional nursing practice. Several of the standards specifically describe the obligation of the nurse to safety. The nurse must implement the plan of care in a safe and timely manner (Standard 5, pg. 26), include analysis of factors including safety (Standard 7, pg. 33), and include safety as a factor in analyzing resource utilization (Standard 14, pg. 42).
3. Oregon Nurse Practice Act (ONPA). Sections of the ONPA clearly identify professional practice (851-045-0060) and specific instances where conduct derogatory to the standards of nursing (851-045-0070) may be occurring. Thus, registered nurses in Oregon are not unaware or naïve as providers of direct care in a work and patient care environment to factors that weaken safety and quality of care.

Despite the obligations defined in these important documents, acting on these obligations by nurses in contemporary work environments has been challenged due to a) a limited appreciation of how nurses work, b) development of "work arounds" – processes used to cope with flawed work flow design and processes, equipment, and supplies, and c) process and practice redesign efforts that inadvertently or intentionally exclude the input of direct care registered nurses. However, Oregon's Nurse Staffing law (right number/right competency in a unit-level staffing plan), Transforming Care At the Bedside (TCAB), Releasing Time to Care (RT2C) project (CareOregon, Oregon Nurses Association, OAHHS, 2010), unit-level safety

huddles, unit redesign (Burnes-Bolton, 2010), safety rounds, first story/second story (Ebright, 2006), hourly rounds, unit-level nursing morbidity/mortality conferences, situation-specific confidential peer-to-peer safety-related conversations and safety debriefings, suggest that nurses would thrive in a Just Culture environment where balance exists between accountability and safety.

In summary, a clear picture of the contribution of nurses to Just Culture has been missing. This report takes the view that nurses belong within the Just Culture environment as full participants because they are obligated to function under the Code of Ethics, Scope and Standards (ANA) and the Oregon Nurse Practice Act. Thus, the interests of nurses match those of the organization. Further, safety practices of nurses suggest that not only can nurses be participants in a Just Culture, but they can make substantive contributions to the development of this concept and approach by taking a larger role within their organizations.

Implementation:

1. ONA will seek partnerships in a Just Culture Collaborative with the Oregon Association of Hospitals and Health Systems, the Oregon Patient Safety Commission and the Oregon State Board of Nursing;
2. ONA will foster and support clinical projects which have as their goal building a Just Culture in a setting; and
3. ONA Professional Services will provide educational offerings and tools for implementation of Just Culture environments in Oregon.

Financial impact:
The action report activities are currently covered within the Professional Services Program area staff and budget and in the budget allocations for the Cabinets on Nursing Practice and Research and the Cabinet on Human Rights and Ethics.

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