Creating a Just Culture in the Perioperative Setting

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ABSTRACT

There has been an increased perioperative focus on avoiding adverse events and providing safe patient care since *To Err Is Human: Building a Safer Health System* published in 2000. Adverse events continue to occur in perioperative areas and are likely underreported. The interdisciplinary nature and high cost of perioperative care may discourage personnel from speaking up for fear of retribution and punishment when reporting. Organization leaders can implement a just culture that focuses on improving patient care processes and safety rather than placing blame after an adverse event. A tenet of just culture is achieving balanced accountability between systems and individuals. Strategies for just culture implementation include leader support, policies and procedures for reporting, accessibility of reporting systems, provision of information for staff members, identification of support champions, and creation of a good catch program. Leaders also should measure and track progress associated with the just culture in their facility.

Key words: *adverse events, near misses, just culture, patient safety, balanced accountability.*

Efforts to improve patient safety have been a priority in the United States since the publication of *To Err Is Human: Building a Safer Health System*[1] in 2000. The report highlighted an estimate that medical errors result in death for between 44,000 and 98,000 patients annually.[1]

In 2016, researchers reviewed data used in the 2000 report and concluded that the estimate was likely low because it only considered the International Classification of Diseases codes on patients' death certificates.[2] The researchers then used data from studies conducted after the 2000 report and 2013 US hospital admission data to calculate the mean hospital mortality rate associated with medical errors. Despite the increased focus on patient safety initiatives after the 2000 report, the estimate increased to 251,454 deaths annually. The researchers compared their calculation with rankings from the Centers for Disease Control and Prevention and concluded that medical errors were the third leading cause of death in the United States at that time.[2]

In addition to *adverse events* that directly cause patient harm, *near misses*—defined as events, situations, or potential errors that are captured before reaching the patient[3]—can pose significant risks to patients, patients' families, second victims (ie, health care professionals [HCPs]), and the health care system. Organization administrators have responded by examining current practices associated with errors and near misses to find solutions to improve patient safety.

The 2000 report on errors in health care resulted in radical changes in the evaluation of errors. The concept of a nonpunitive, blame-free culture that recognizes the role of health care systems as a frequent cause of errors emerged, shifting the emphasis to identifying processes

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that contribute to errors rather than blaming individuals.[1] However, approximately 10 years after the 2000 report, it became evident that a blame-free culture posed risks to patient safety when HCPs habitually and willfully failed to adhere to safety standards despite education, counseling, and systems improvements.[4] Personal accountability needed to be balanced with systems accountability, leading to the emergence of *just culture* as a mechanism to support quality and safety in health care.

According to The Joint Commission, a safety culture comprises a just culture, a reporting culture, and a learning culture.[5] This article focuses on a just culture—the process of balancing systems accountability with individual accountability when addressing errors. Health care organization leaders support a just culture by encouraging error reporting without fear of punishment and by conducting investigations to determine the cause of errors to improve quality and learn from mistakes. The 2022 legal case in Tennessee in which a nurse was convicted of a crime for a shocking but accidental medication error that caused a patient death[6] destabilizes the foundation of just culture. In 2000, Dr Lucian Leape, a staunch advocate for patient safety, testified on medical errors during Senate hearings of the 106th Congress and stated, "We know that internal reporting does not happen if it is not safe. That is, if we punish people for reporting errors, they do not report."[7(p68)] Without a just culture where HCPs report adverse events and organization leaders investigate the reports to identify the root cause of the error and then focus efforts on preventing future mistakes rather than punishing involved team members, an HCP may conceal errors and potential risks, jeopardizing patient safety.[8] Reporting unsafe conditions and errors is crucial in perioperative settings where patients are vulnerable to injury because of the critical nature of the work and their inability to intervene on their own behalf.

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PERIOPERATIVE CULTURE

The perioperative area is a high-stress, fast-paced environment with numerous opportunities for errors. In 2022, the top five types of sentinel events reported to The Joint Commission (in descending order) were falls, delays in treatment, unintended retention of a foreign object, wrong surgery (ie, wrong site, wrong procedure, wrong patient, or wrong implant), and suicide.[9] Causes of the reported sentinel events include teamwork issues, communication failures, and inconsistent adherence to policies. When reviewing sentinel event data, it is important to realize that because "the reporting of most sentinel events to The Joint Commission is voluntary, no conclusions should be drawn about the actual relative frequency of events or trends in events over time."[9] Because sentinel events may be underreported, moving toward a just culture may support identifying and addressing root causes to decrease the frequency of such events.

The perioperative setting requires effective interdisciplinary teamwork among clinicians to meet patient needs. The perioperative workforce comprises contract and permanent HCPs, including medical staff members, anesthesia professionals, nurses, and surgical technologists; each individual has a specific role during procedures. The cost of doing business in perioperative areas is likely higher than other areas of the hospital (eg, inpatient nursing units) because of the need for large capital investments for equipment, supplies, and instruments for procedures and multiple staff members for each patient. On average, perioperative areas contribute up to 60% of a hospital's revenue,[10] and it is reasonable to conclude that multiple inefficiencies or a lack of effective management of perioperative services can have dire financial consequences for surgical facilities. The interdisciplinary nature of perioperative areas and the associated costs of providing care can contribute to a tense culture and strong barriers that hinder reporting.

Although there is published literature that focuses on the patient safety culture, literature on the just culture specific to the perioperative setting is limited. One published study involved use of the Patient Safety Climate in Healthcare Organizations survey to examine the safety culture of 30 Veterans Affairs hospitals.[11] Of 4,185 returned surveys, 324 (7.7%) were completed by personnel working in the OR and postanesthesia care unit (PACU). When compared to responses from other (unspecified) participants, key differences in the responses from the OR and PACU participants included their perceptions that the OR and PACU had a weaker safety culture and reports of witnessing their colleagues deliver unsafe care. Further, the responses showed that the participants believed senior leaders were

not concerned about quality of care and did not understand the risks in their environments.[11]

Results of a study on cardiac surgical team members' perceptions of safety culture that included a scale to measure nonpunitive responses to error suggested that there was an aversion to reporting errors because of the perception that blame for such errors would be ascribed to specific individuals.[12] Additionally, the findings showed that personnel from the various professional disciplines represented on surgical teams (eg, support personnel, surgeons, nurses, perfusionists, anesthesia professionals) perceived patient safety differently; the perceptions of the perioperative nurses were more negative than those of the surgeons.

Researchers at a single tertiary care hospital administered the Hospital Survey on Patient Safety Culture and analyzed the results from 431 perioperative staff members.[13] The findings aligned with previous study results and showed that perceptions of hospital safety culture differed by professional discipline and level of training (eg, medical staff members versus residents). Notably, for strength of the safety climate, surgeons had the highest composite average scores (64%); composite average scores for nurses and unlicensed personnel were lower (ie, 37% for both).[13]

Understanding the variations in reporting in perioperative settings is essential to creating strategies to support a just culture and improve the overall safety culture. Risk factors for errors in perioperative areas include a lack of standardized rules and regulations, communication gaps, use of unreliable systems or protocols (eg, shortcuts), and time pressures.[14] Although health care organizations likely have policies for reporting, leaders should identify specific barriers that prevent staff members from speaking up about unsafe patient care situations.[15] They also should collaborate to address practices and behaviors that impede the reporting of errors and concerns and hamper improvement.[16]

STRATEGIES

A just culture requires a balance between individual and systems accountability.[15] Work processes likely should be standardized and roles of personnel should be clearly defined to help reduce variability and improve outcomes and efficiency. Modifying leader responses to reduce the fear of repercussions associated with unintentional mistakes is a key tenet of creating a just culture.[8] National organizations, such as the Institute for Healthcare Improvement[17] and the Joint Commission Resources arm,[18] provide tools for a culture that enables staff members to speak up regarding safety concerns. The American Nurses Association's position statement on just culture takes this one step further by advising that reporting a mistake needs to be incentivized.[19] Administrators should be transparent with safety data, address issues when they occur, disseminate lessons learned, and remember to celebrate successes.[16] Perioperative leaders should understand that the shift toward a fair and just culture will take time and require ongoing education activities.

A just culture requires a balance between individual and systems accountability.

Leaders can inadvertently contribute to adverse events in a variety of ways, including failure to

- commit fully to a safety culture that promotes reporting,[20]
- respond to reported concerns,[20] and
- address burnout of personnel.[21]

Creating and maintaining a culture of safety is paramount to staff members feeling safe to speak up. It may be helpful to develop and use a standardized tool to promote fairness and transparency when an error occurs. The tool could highlight hypothetical substitution of personnel during the event to determine if the level of experience of personnel affected the outcome. The tool also could allow perioperative leaders to determine if the involved personnel circumvented the standard of care.

Creating and Using a Reporting System

A just culture can support voluntary event reporting.[22] When employees fear repercussions for adverse events or near misses, they are less likely to report such occurrences and then lose the opportunity to learn from mistakes and make changes that would prevent those errors in the future. An environment in which individuals feel safe to report without fear of punishment creates a culture

characterized by the understanding that safety is clearly the priority, with improvement as a primary goal.

Implementation of a reporting system that is easy to complete and understand likely will enhance the ability to capture an error or a near miss. Providing an option to submit a report anonymously for incidents that do not reach the patient may encourage employees who worry that they will be penalized for reporting events. The processes for reporting should protect the confidentiality of the reporter.[23] All perioperative personnel should have access to and knowledge of the reporting system and leaders should encourage them to use it. Collecting data through a reporting system allows for dissemination of information that contributes to process improvement to the entire staff and provides the opportunity for follow-up with individuals when needed.[23]

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Developing Policies and Procedures

Generally, health care organizations have policies to guide practice and promote uniformity of routine procedures, tasks, and operations. When developing a policy regarding adverse events, leaders should include mechanisms to provide transparency for individuals who report the events. Personnel should be provided with information clearly outlining the steps that will be taken after an incident is reported. After an incident occurs, the policy can be used to facilitate an analysis of the event[23] and determine its root cause.

Organizations should have a clear procedure that outlines standard debriefing steps after an event.[24] The debriefing should be framed as a "peer review" process[24] and include other staff members rather than only administrators or leaders. Peer review that includes all members of the team can help provide a supportive environment for reviewing the event and improve the safety culture of the organization.[25]

For medication errors, the follow-up procedure can include reporting the facts of the error to the Institute for Safe Medication Practices (ISMP) via their anonymous online error-reporting system.[26] Including this step promotes patient safety because the ISMP sends a nationwide alert to health care organizations and agencies (eg, the US Food and Drug Administration) when a particular type of error is reported repeatedly to increase awareness of the concern.[27] For frequently occurring errors, the ISMP assumes the role of champion and leads efforts to prevent future occurrences by supporting mitigation strategies, such as regulatory change and improved medication labeling.

Enhancing Safety Checklists

In 2004, The Joint Commission enacted the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery;[28] later that same year, the World Health Organization (WHO) created the World Alliance for Patient Safety in response to a World Health Assembly resolution on patient safety concerns.[29] Subsequently, the WHO began "The Second Global Patient Safety Challenge: Safe Surgery Saves Lives"[29] initiative, which included the Surgical Safety Checklist.

Compliance with The Joint Commission's Universal Protocol,[30] which includes a time out before incision, is a part of the hospital accreditation process in the United States. From an international perspective, the WHO Surgical Safety Checklist is the most widely recognized time-out process, although gaps in use continue to occur.[31] Allowing HCPs to customize safety checklists for specific patient care situations can encourage ownership and ensure applicability.[32]

An established hierarchy can inhibit OR situational awareness and speaking up before and during procedures.[33] Personnel should follow a preprocedure verification process,[30] which may include a briefing,[29] to encourage communication and reduce the hierarchical gradient between medical staff members and nurses, thereby promoting patient safety.

Measuring Attributes of a Just Culture

The Just Culture Assessment Tool (JCAT)[34] is a psychometrically sound 27-item survey that leaders can use to measure individual perceptions of just culture in hospital environments. The tool uses a Likert-type scale (ranging from strongly disagree [ie, 1] to strongly agree [ie, 7]) and measures the following dimensions of care:

- balance regarding error management;
- trust in organization leaders and peers;
- openness of communication;
- quality of the event-reporting process, including follow-up;
- feedback associated with the event; and
- quality improvement.[34]

Perioperative leaders can use the JCAT to collect baseline data and identify strengths and weaknesses.[34] The process for implementing or improving a just culture should be a response to the current perceptions and environment in an organization. Using the JCAT periodically may allow leaders to measure the effectiveness of the response and track progress.

Developing Education Initiatives

The process of educating HCPs can begin before they enter the workforce. For example, undergraduate schools of nursing can include information on just culture in the curriculum.[35] In perioperative areas, all HCPs (eg, surgeons, anesthesia professionals, nurses) likely would benefit from receiving a consistent and clear message on just culture during the onboarding process and routinely thereafter. Providing information to nurses on just culture (eg, through a journal club) can help them cultivate the knowledge, skills, and attitudes associated with the Quality and Safety Education for Nurses patient safety competency.[36] In addition, leaders can share information on just culture with HCPs during hospital-wide presentations, staff meetings, and daily huddles or in any venue where patient safety is discussed. Sidebar 1 lists a variety of education resources on patient safety and just culture.

Encouraging Reflection

Health care personnel can use daily reflection to identify practices that affect patient safety.[37] Nursing professional development practitioners (NPDPs) can include information on reflection and the processes for managing health care errors during clinician onboarding activities. The NPDP can emphasize providing and receiving constructive feedback as a routine practice to encourage open dialogue.[38] The NPDP should provide educational content that supports clinicians as they mitigate the potential for errors, such as developing routines for safety, avoiding shortcuts, and using strategies to prevent lapses in concentration. Clinicians can use reflection to evaluate patient care processes, determine what went well or poorly, and create opportunities for improvement.[37] Objective reflection supports personal and professional growth and allows individuals to consider how their own practice contributes to a safety culture.

Sidebar 1. Just Culture and Patient Safety Resources

Healthy work environment. American Nurses Association. Accessed October 2, 2023. *https://www.nursingworld.org/practice-policy/work-environment/*

Patient Safety Essentials Toolkit. Institute for Healthcare Improvement. Accessed October 2, 2023. *https://www.ihi.org/resources/tools/patient-safety-essentials-toolkit*

TeamStepps 3.0 Pocket Guide. Agency for Healthcare Research and Quality. Revised May 2023. Accessed October 2, 2023. *https://www.ahrq.gov/sites/default/files/wysiwyg/teamstepps-program/teamstepps-pocket-guide.pdf*

The Joint Commission. Safety culture assessment: improving the survey process. *Jt Comm Perspect*. 2018;38(6):1-4. Accessed October 2, 2023. *https://www.jointcommission.org/-/media/tjc/documents/accred-and-cert/safety_culture_assessment_improving_the_survey_process.pdf*

Identifying Support Champions

Perioperative leaders can identify champions for just culture to promote safety.[39] These champions can assist with providing safety information to their colleagues and serve as catalysts to forecast and remove obstacles to change. Champions can take an active role in providing support and encouragement to all involved HCPs after the reporting of an event or a near miss.

Although patients and their families are the obvious victims of health care errors, an HCP can be a second victim after a safety event and can benefit from a champion's support.[40] Results of an integrative review that focused on the second-victim phenomenon showed that nurses involved in health care errors experienced a wide variety

Key Takeaways

- Despite reports on opportunities to improve patient safety and prevent harm, adverse events and near misses continue to occur. In the United States, more than 250,000 deaths annually may be attributed to medical errors.
- Health care professionals may be less likely to report adverse events and near misses in a punitive and blame-focused culture. Therefore, implementation of a just culture that focuses on the system rather than the individual may encourage personnel to report patient care concerns.
- The complex nature of the perioperative area makes it susceptible to adverse events and near misses. Results of surveys in perioperative areas showed that surgeons' perceptions regarding the patient safety culture were more positive than the nurses' perceptions.
- Strategies for implementing a just culture in perioperative areas include balancing individual and systems accountability, creating and using a reporting system, developing policies and procedures, enhancing safety checklists, measuring just culture attributes, developing education initiatives, encouraging reflection, identifying support champions, and initiating a good catch program.

of emotions, including shame, guilt, remorse, anger, and feelings of injustice.[41] Additionally, second victims can fear repercussions from the event, including termination and litigation. Supporting second victims includes providing peer support throughout the investigative process and beyond.[42] Champions can use empathy,[43] show concern,[43] provide emotional support,[40] and serve as a "buddy" to the affected HCP to ensure that they do not become isolated.[40] A buddy system with champions for just culture is a proactive initiative that organization leaders can implement to provide peer support after safety events occur.

Initiating a "Good Catch" Program

When a near miss occurs, the potential error may have been prevented from reaching the patient because of a "good catch." In 2004, authors suggested that near misses occurred 7 to 100 times more frequently than serious events but were not reported.[44] When details of a near-miss event are shared with others, HCPs can bridge the safety gap to improve patient care. A good catch program rewards and recognizes staff members who report safety concerns because those reports provide opportunities to break a risk-prone cycle and improve patient safety.[45] Proactive reporting of concerns that could result in patient harm should be recognized and honored, even if the concern is an error made by the reporting individual.

A good catch program serves as an incentive for employees to report common failures or specific hazards during their normal daily routine. The program and reward structure should be aligned with the organization's mission and vision. Some common ways to acknowledge those who report or intervene would be to post their name on a hospital recognition board or web site and share the situation as a learning opportunity for others.[45] Recognition also can be associated with clinical ladder promotions or evaluations. Involving HCPs in the process of identifying risk or intervening when risk is present—and then recognizing them for doing so—improves processes and promotes transparency.

CONCLUSION

Perioperative areas are complex environments that require interdisciplinary teamwork to provide patient care. Despite implementation of a variety of safety initiatives (eg, time outs), adverse events continue to occur. Although some leaders may focus on the HCP when responding to such events, implementation of a just culture can promote improved patient safety processes. A just culture supports the reporting of unsafe situations and errors without fear of retaliation or punishment. Balancing systems accountability to provide safe work conditions designed to prevent errors with individual accountability to develop a safe routine for patient care is the hallmark of a safe and just culture. When implementing a just culture, leaders should provide an accessible reporting system, share information with HCPs on just culture and patient safety, encourage reflection, identify champions, and consider initiating a good catch program. A just culture should

Earn Contact Hours
Contact hours are available for this activity. Earn the contact hours by reading this article, reviewing the outcome and objectives, and completing the Learner Evaluation at *https://aorn.us/feb24-cea-v2*.

focus on improved patient safety and empower HCPs to report adverse events and near misses.

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AORN can help you keep up with the latest perioperative practices to maintain your license or certification requirements. Earn contact hours through *AORN Journal* continuing nursing education (CNE) articles, prerecorded webinars, tool kits, online courses, and hybrid events.

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AORN webinars present informative, educational content on important topics, such as patient and staff safety, patient care, and leadership and professional development. Individuals can access live interactive webinars or recorded webinars.

AORN tool kits address critical patient safety issues and help perioperative professionals implement evidence-based practices. Each tool kit contains a wealth of resources, including customizable policies and procedures, education slideshows, videos, posters, guides, and references.

AORN online courses provide evidence-based education for nurses throughout their perioperative career, including Periop 101, Periop 202, Periop Mastery 2.0, Prep for CNOR, Prep for Infection Prevention Certification, and more. Further your education online with essential topics such as infection prevention, preoperative and postoperative care, safe administration of moderate sedation, leadership development in the ambulatory setting, onboarding, the fundamentals of evidence-based practice, and an introduction to the Perioperative Nursing Data Set (PNDS).