Quality Improvement in Long-term Care

The purpose of this column is to discuss innovations and quality improvement efforts in a variety of long-term care settings. These issues are of importance to healthcare professionals as our nation faces the burgeoning growth of the aging population, creating increased demand for improved and innovative long-term care services. This column is coordinated by Marilyn J. Rantz, PhD, RN, FAAN, NHA, e-mail: rantzm@missouri.edu.

A Just Culture
The Role of Nursing Leadership

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The Institute of Medicine report *To Err Is Human* sparked a nationwide focus on medical errors and the risk to patient safety. Importantly, the Institute of Medicine confirmed that the majority of medical errors are not the fault of people but rather faulty systems, processes, and conditions that lead to medical errors. Leadership efforts to promote disclosure of these faulty systems, processes, and conditions are under way. The American Association of Nurse Executives has a priority established to promote a culture of safety through error disclosure. In addition, the Institute of Healthcare Improvement strategic plan includes recommendations to reward error reporting and to share report analysis with staff. The attempt to disclose medical errors is an important first step.

While efforts to disclose medical errors are certainly worthwhile, the missing voice of frontline staff remains at the forefront. Frontline staff know about the faulty systems, processes, and conditions that exist. Therefore, the vigilance and voice of frontline staff in error disclosure becomes paramount. However, in most healthcare organizations, frontline staff are not speaking out because of the continued existence of punitive work environments.

**PUNITIVE WORK ENVIRONMENTS**

Despite efforts to remove punitive work environments in healthcare, evidence suggests that they still exist. In part, frontline staff fear repercussion from both managers and peers when an error occurs. In a study funded by the Agency for Healthcare Research and Quality, exploring technology and focused quality improvement efforts to reduce medication errors, a form of medical error, Scott-Cawiezell and colleagues found that nursing homes have punitive reporting systems for medication errors. Study participants voiced concern about reporting medication errors for fear of being assigned “disciplinary points.” This system of blame hindered staff’s desire to disclose medication errors to organizational leaders. Yet, these same study participants talked openly about medication errors when provided a forum of open communication without fear of repercussion.

Staff perception of fear coupled with the reality that leaders do not protect staff when
negative consequences occur\(^9\) contributes greatly to the disconnection between seeking to learn and improve from potentially unsafe events and protecting one’s job. This is further exacerbated in healthcare environments where many believe that state surveyors are seeking evidence of individual disciplinary action when untoward events occur.\(^{10}\) More important is the consideration that potential criminal action may be taken when an individual is involved in a medical error.\(^{11}\) No wonder the movement toward safety in healthcare remains slow.\(^5\)

**CREATING A JUST CULTURE**

Safer healthcare requires healthcare organizations to become transparent in error disclosure. Transparency in healthcare implies “having no secrets” where errors are openly discussed and information regarding error flows freely.\(^{12}\) In a transparent healthcare environment, work processes are made visible and information about safety is disclosed.\(^{13}\)

Transparency leads to accountability of healthcare professionals where work processes are done openly and the results of work are known.\(^{14}\) Transparency builds trust through disclosure of the problems.\(^{12}\) However, for transparency to occur, a “just culture” must exist. It is a culture in which learning from disclosure is promoted while individual accountability for improvement is maintained.\(^{15}\)

The idea of a just culture is gaining recognition as a way to move toward safer healthcare. This culture is achieved when all members of the organization value safety and maintain vigilance toward threats to safety. In a just culture, all members are mindful of their behaviors and work to get the job done right. Organizational leaders, managers, and staff members are each held accountable for ensuring safety.\(^{10}\)

**The role of nurse leaders**

Creating a culture to support patient safety must be a shared value between leaders and staff. A shared value of patient safety includes an environment where mistakes can be examined and learning can occur.\(^{16}\) Nurse leaders can create an environment in which every member of the team feels a responsibility and is accountable for ensuring that the value of keeping patients safe is upheld.

Moving toward a just culture requires that nurse leaders hold themselves and staff accountable as errors are disclosed. This accountability includes understanding why errors occur and identifying what systems, processes, and conditions are at fault. Nurse leaders are also accountable to manage staff so that at-risk behaviors are identified and managed to reduce risk of error.\(^{10}\)

Nurse leaders should liberate staff to do the right thing, using their own skills and talents. Healthcare organizations should leverage their workforce so that many eyes are searching for errors and that everyone feels comfortable identifying and reporting safety concerns.\(^{17}\) Nurse leaders should focus on creating an environment in which frontline staff are not afraid to be heard.\(^7\) Both leaders and frontline staff must work together to solve problems through open discussion of the challenges and barriers that occur within existing work processes (A. Vogelsmeier, J. Halbesleben, and J. Scott-Cawiezell, unpublished data, 2007). Nurse leaders can create an environment of accountability by including staff in the solutions that are sought as problems are identified.

**CONCLUSION**

A just culture, an environment in which errors are disclosed, is an important element for patient safety to become a reality. Transparency within an organization increases the likelihood that staff and leaders will detect and address systems problems, thus preventing potential harm. Nursing leadership is a key influence to establishing systems that promote open communication to facilitate error disclosure.
REFERENCES
