Creating a Fair and Just Culture in Schools of Nursing

This article, part 2 of a two-part series, offers several useful strategies.

ABSTRACT

In recent years, health care organizations have been moving away from a culture that responds to errors and near misses with "shame and blame" and toward a fair and just culture. Such a culture encourages and rewards people for speaking up about safety-related concerns, thus allowing the information to be used for system improvement. In part 1 of this series, we reported on findings from a study that examined how nursing schools handled student errors and near misses. We found that few nursing schools had a policy or a reporting tool concerning these events; and that when policies did exist, the majority did not reflect the principles of a fair and just culture. This article, part 2 of the series, describes several strategies that nursing schools can use for creating such a culture.

Keywords: nursing education, patient safety

The quality and safety of patient care depends not only on what happens in clinical settings, but also on what happens in academic settings. How and what students learn—and how nursing faculty and their clinician partners approach teaching—matters. The prevailing culture at a nursing school has tremendous influence in this regard. Last month, in part 1 of this two-part series, we reported on the results of a national survey of U.S. prelicensure nursing programs regarding the existence of tools and policies for reporting and tracking student errors and near misses (to read part 1, go to http://links.lww.com/AJN/A82). Among the findings were the following:

- Half of the 494 responding schools indicated that they had no policy for managing students following a clinical error or near miss, and 55% indicated that they had no reporting tool for such events.
- School policies, when they did exist, often didn't fully incorporate the principles of a fair and just culture.
- Many faculty appeared not to understand the elements of a fair and just culture.

This month, in part 2, we discuss the characteristics of a fair and just culture, and describe several strategies for creating such a culture in nursing schools.

A FAIR AND JUST CULTURE

As we noted in part 1, a *fair and just culture* is one in which people learn and improve by openly identifying and examining their weaknesses, and feel safe and supported in doing so.[1,2] James Reason, a leader in safety science, has described such a culture as one characterized by "an atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety-related information—but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior."[3] This environment fosters open communication and allows mistakes, near misses, and potential hazards to be used to improve the systems and processes of care.

The notion of fairness is integral to a fair and just culture. It's understood that mistakes will occur, and that having a shared accountability model in place promotes both individual- and system-level learning from those mistakes. Individuals know they will be held accountable for their actions, but will not be blamed for system faults that lie beyond their control. They can trust that a fair process will be used to determine what went wrong. And they're likely

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Nursing students discuss safety challenges with their clinical instructor. Photo courtesy of the College of New Jersey.

to feel safer within such a culture, knowing that they can admit personal weaknesses and seek appropriate help. This is in stark contrast to the shame-and-blame culture that prevails in most health care organizations, in which individuals are blamed for their mistakes and a punitive approach is taken. That approach tends to result in the hiding of errors and the masking of problems, and does not encourage change.

In a fair and just culture, certain crucial values and principles are apparent, including accountability, reliance on an evidence base, fairness, respect, transparency, and trust. Two fundamental beliefs are recognized: that risk is ever present in health care, and that to err is human. And two goals are paramount: to prevent errors whenever possible, and to minimize the impact of those that do occur.

To accomplish this, explicit policies, processes, and structures must be in place in order to ensure the continuous improvement of health care delivery. First, such policies, processes, and structures must encourage the reporting of errors and near misses, the collection and analysis of such data, and further learning about relevant safety-related information. Second, they must provide for a continuous flow of information between clinicians and leaders regarding potential hazards, potential vulnerabilities (such as distractions and interruptions), and actions taken to improve dangerous situations. And third, they must clearly define the roles and responsibilities of leaders at all organizational levels in creating and sustaining a fair and just culture.

Characteristics of a fair and just culture in nursing schools. Frankel and colleagues have elaborated on these concepts as they apply in health care settings[4]; here, we offer them specific to nursing schools. A fair and just culture at a nursing school is characterized by the following:

- Faculty members believe they can learn and improve by openly identifying and examining their own weaknesses.
- They are as willing to expose areas of weakness as they are to display areas of excellence.
- They feel supported and safe when voicing concerns.
- They feel safe and emotionally comfortable while engaged in their work.
- They feel comfortable monitoring their colleagues and giving them feedback on how to improve performance.
- They feel accountable for creating and maintaining a psychologically safe environment in which information on errors and near misses is shared.

Moreover, certain attitudes and structures must be in place. These are shaped by underlying core principles, which include:

- Mistakes are part of learning and professional practice.
- Vigilance alone is not enough.

- Threats of punishment don't prevent errors—only the *reporting* of errors.
- Students should be held accountable for their actions—but not blamed for system faults beyond their control.
- Students should feel as accountable for creating and contributing to a safe learning environment as they do for delivering excellent nursing care.
- Students who act with recklessness (for example, repeatedly arriving unprepared for clinical skills class or falsely documenting a procedure as completed) should be appropriately and fairly disciplined. This may include dismissal from the program.

THE SHARED ACCOUNTABILITY MODEL

A shared accountability model offers a framework for students, faculty, and organizational leaders to use in creating a fair and just culture. In this model, everyone has responsibilities and collaboration is essential. (See Figure 1 for a simple graphic representation.)

Students are responsible for being fully prepared for clinical experiences, including laboratory and simulation assignments. They must be rested and mentally ready for a challenging learning environment. They must accept accountability for their part in contributing to a safe and favorable learning environment. They must be willing to acknowledge their own mistakes, and they must behave professionally at all times, keeping up to date with current evidence and adhering to ethical standards.

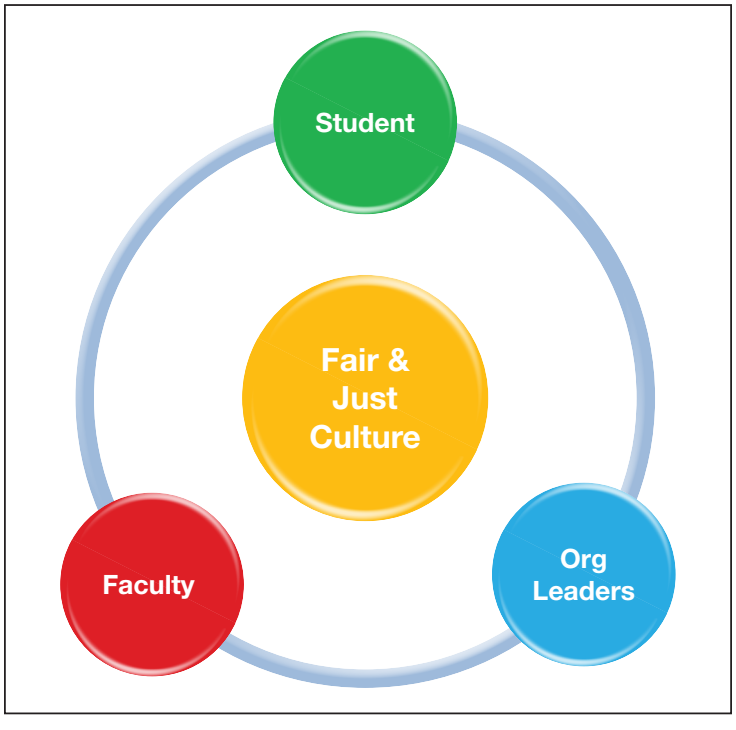
Faculty members are responsible for being knowledgeable about contemporary quality and safety principles. They should be familiar with the health care competencies that were first defined by the Institute of Medicine[5] and further developed for nursing professionals by the Quality and Safety Education for Nurses (QSEN) initiative.[6] Faculty members must be able to differentiate between errors and near misses, human error and system failure, and at-risk and reckless behaviors. They must support data collection, data analysis, and trend identification; and they must be able to use this information to change the curriculum and refine their own teaching, as appropriate. Perhaps most important, faculty members must create an environment in which students can admit to and learn from their mistakes without fear of being penalized for system errors.

Organizational leaders must be actively engaged in demonstrating their commitment to a fair and just culture, and to making the changes necessary to create and maintain it. They must ensure that certain vital structures are in place, including

- a statement expressing the organization's learning philosophy. This should address shared accountability and the roles and responsibilities of students and faculty; the importance of evidence-based education; an unwavering commitment to teaching and providing safe, high-quality care; and an unwavering commitment to a fair and just culture.
- tools and processes for tracking data and identifying trends with regard to unusual events such as errors and near misses. The use of clear, nonjudgmental language in such tools and processes is essential.
- policies that clearly define reckless or otherwise unacceptable student behavior.
- mechanisms for discussing unusual events with students and faculty and for making changes to prevent their recurrence.
- opportunities for faculty to discuss the transition to a fair and just culture and to address issues that arise.
- organizational support for a fair and just culture. Such support includes inviting new ideas, accommodating disagreement, and fostering shared decision making.

Moving an organization toward a fair and just culture requires significant investments of time and energy. For one, faculty members will need adequate time and opportunities to embrace new attitudes, and to learn content that may be unfamiliar to them in areas such as human factors analysis, system complexity, characteristics of high-reliability organizations, effective communication and teamwork, the QSEN core competencies, and new teaching content and

Figure 1. A Shared Accountability Model for Creating a Fair and Just Culture in Nursing Schools



methods. For example, faculty members may need to learn how to talk with students about errors and near misses in a new way—that is, without judgment or blame—in order to reach a fuller understanding of why these events occur and how to prevent them. (See *Examining an Error or a Near Miss: Five Essential Questions* for a useful framework for such conversations.) Faculty members may also need to adjust how they assess student competence. For example, studies of medication administration practices in clinical settings have found that errors are more likely to occur when the nurse is interrupted while preparing medications.[7] At many nursing schools, that's often the time instructors assess students' knowledge of the medications. Faculty members may need to change their timing and talk with students before medication preparation. Similarly, other factors known to contribute to errors and near misses should be considered when designing clinical learning and simulation experiences. QSEN has developed several creative simulation scenarios that place students in unexpected and difficult situations, affording them opportunities to learn how to respond to or prevent errors (see www.aacn.nche.edu/qsen/module-series).

DEVELOPING A FAIR AND JUST CULTURE

There are several steps faculty members can take to move their school programs toward a fair and just culture. Changing an organization's culture can be profound, and these steps can help to ensure success.

1. Secure leadership support. Senior leadership support is essential to introducing and reinforcing this new cultural initiative, marshaling resources, modeling new behaviors, and maintaining commitment. In many schools, support may come first from faculty who are enthusiastic about its potential and are willing to take the lead. But support from senior leaders is crucial during all phases.

2. Survey faculty and students about their perceptions and experiences. To our knowledge, there are no tools for assessing whether a nursing school has a fair and just culture or for evaluating the challenges involved in implementing such a culture. Petschonek and colleagues developed a 27-item Just Culture Assessment Tool in a pediatric hospital that assesses six areas deemed essential to a fair and just culture.[8] These areas include feedback and communication about events, openness of communication, balance with regard to individual and system accountability, quality of the event-reporting process, focus on continuous improvement, and trust. This tool could be easily adapted for use by nursing schools to survey students and faculty. The findings could provide information about the current status of the school's culture and provide direction for proceeding with changes.

3. Begin discussions with faculty. Using these survey findings as a starting point, conversations can be held regarding what constitutes a fair and just culture, what we know from safety science about responding to errors and near misses, what faculty members believe about such events, and how to ensure both patient safety and careful analysis of incidents. The faculty should also consider aspects specific to their school. After defining and describing their desired culture, they might discuss how the creation process should unfold; how to best involve students in that process; what role clinical agencies should play, if any; what reporting processes should be instituted for students, faculty, and student–faculty dyads; and what the challenges may be as the school moves forward. See *Resources* for a list of foundational articles and other useful resources that offer important background information.

Examining an Error or a Near Miss: Five Essential Questions

- What happened?
- Has it happened before?
- Could it happen again?
- What caused it to happen?
- Who should be told?

4. Engage students in a discussion about their perceptions of the school's culture. Little is known about nursing student experiences of errors and near misses in this regard. That said, Landgren and colleagues examined pediatric medical residents' reasons for not speaking up about such events.[9] The most common reported barriers were "perceived personal safety of speaking up (consequences, intimidation, and hierarchy concerns), individual barriers (communication skills and confidence), perceived efficacy of speaking up (feeling powerless), and contextual factors (high workload)." It seems likely that similar barriers affect nursing students. Indeed, separate studies by Clark and by Del Prato, investigating faculty attitudes and behaviors toward nursing students, found that rigid or unrealistic expectations, "weeding out" practices involving constant criticism, and overly subjective evaluations led to a lack of trust among students and presented challenges to achieving a fair and just culture.[10,11] Inviting students to share their experiences in open, honest discussions—with no threat of retaliation—is crucial to ensuring a fair and just culture.

5. Schedule educational sessions for faculty. Some faculty may not have been exposed to some crucial content areas during their formal or continuing education. These areas include findings from safety science, characteristics of high-reliability organizations and of fair and just cultures, human factors analysis, system complexity, and quality improvement, among others. Offering the faculty educational sessions and recommending online learning opportunities (such as

QSEN's modules, available at http://qsen.org/courses/learning-modules) can help faculty improve their understanding of and appreciation for these fundamental concepts.

6. Examine and update school documents. This step entails reviewing the relevant existing documents, assessing whether their language and tone reflect the principles of a fair and just culture, and conducting a gap analysis to determine what additional documents are needed. In part 1 of this series, we found that only 41% of the schools responding to our survey had a tool for reporting student errors and near misses, and only 31% had a written policy for follow-up with students following such events.

Documents that should be reviewed include the school's philosophy and mission, vision, and values statements; school policies; curricular frameworks; student performance assessments; and incident reporting tools, among others. Faculty recruitment tools and performance assessments are also relevant, since faculty attitudes and behavior also influence the development and maintenance of the desired culture. Once document review and gap analysis have been completed, work can move forward in revising existing documents and creating new ones.

7. Partner with clinical agencies. The value of academic–clinical partnerships has been widely described.[12, 13] It's often assumed that nurses in clinical agencies have a better understanding of safety principles and the need for a fair and just culture than nurses working in academia. This isn't necessarily true. Regardless, faculty leaders can let the school's partner agencies know that they're moving toward creating a fair and just culture and exploring what changes will be needed, and can ask the clinical agency how it wants to be involved. Specifically, one conversation might focus on determining what process the clinical agency wants the faculty to use in instances of student errors and near misses. For example, suppose the agency's position is "We expect students not to make errors." The faculty could respond by explaining that, despite everyone's best efforts to ensure that students practice safely, the evidence from safety science shows that humans will make errors. They might propose a process based on holding students accountable for their performance, but not for system errors beyond their control. Another conversation might focus on determining what process the clinical agency wants to use if a student or faculty member witnesses an unsafe act by someone on the agency's staff. Having such conversations *before* the next error or near miss occurs—that is, when there is no immediate problem and more thoughtful exchanges are possible—can go a long way in strengthening the academic–clinical partnership.

Such shared learning and collaborative work can be powerful factors in changing systems and improving patient safety. In addition to focused discussions, it might be helpful to jointly invite speakers to address specific aspects of safety science or of fair and just cultures. Both academic faculty and clinical agency staff could attend and learn together.

Collaborative efforts can also improve students' educational experiences and their patient care. In a three-year retrospective review of 77 medication errors by students in one school's baccalaureate program, Harding and Petrick found that 42% of the

Resources

Articles

Chassin MR, Loeb JM. High-reliability health care: getting there from here. *Milbank Q* 2013;91(3):459-90.

Disch J, Barnsteiner J. Developing a reporting and tracking tool for nursing student errors and near misses. *J Nurs Regulation* 2014;5(1):4-10.

Dolansky MA, et al. Nursing student medication errors: a case study using root cause analysis. *J Prof Nurs* 2013;29(2):102-8.

Penn CE. Integrating just culture into nursing student error policy. *J Nurs Educ* 2014;53(9):S107-S111.

Reason J. Human error: models and management. *BMJ* 2000; 320(7237):768-70.

Online Resources

Agency for Healthcare Research and Quality
TeamSTEPPS
A program for improving teamwork and collaboration.
www.ahrq.gov/teamstepps/instructor/index.html

American Association of Colleges of Nursing
QSEN Learning Module Series
Free modules for students on the six QSEN core competencies.
www.aacn.nche.edu/qsen/module-series

Codynamics
An introduction to the basic concepts of complexity science.
www.codynamics.net/intro.htm

Federal Aviation Administration
Aviation Maintenance Technician Handbook
Chapter 14: Human Factors
An excellent guide to the relationship between human factors and error.
www.faa.gov/regulations_policies/handbooks_manuals/aircraft/media/AMT_Handbook_Addendum_Human_Factors.pdf

QSEN Institute: Quality and Safety Education for Nurses
Faculty Learning Modules
Free modules for faculty exploring core quality and safety issues.
http://qsen.org/courses/learning-modules

errors of omission were related to inexperience in reading or interpreting the clinical agency's medication administration record.[14] As a result of their work, the school changed its policy such that instead of placing error reports in individual student files, they were placed in a general incident file for trend identification. The school also shared this information with its partner agencies in order to improve the medication administration record and collaborate on other error preventive strategies.

8. Conduct ongoing event tracking and trend identification. Instead of looking at each situation in isolation, some schools are developing standardized tools for reporting student errors and near misses,[15,16] and are creating systems for tracking such events and identifying trends. Some faculty members may argue that such systematic attention only condones errors. But in actuality it raises awareness about such events and helps everyone to focus on ways to reduce or eliminate them. As error patterns are identified, appropriate curriculum changes can be made.

Having someone designated as responsible for maintaining a school's database and for making periodic reports to faculty and administration can ensure that the systems are kept up to date. Cooper has described her experiences in creating the role of quality and safety officer at the University of San Francisco; in that role, she was able to improve the school's system for reporting and tracking errors and near misses, increase its use, and "increase the conversation about safety."[17] At the national level, the National Council of State Boards of Nursing is piloting an initiative for anonymous error and near miss reporting and tracking called Safe Student Reports (https://ssr.ncsbn.org/Home/Login). The initiative's national data repository can provide participating schools with confidential reports about such events in their programs, as well as periodic reports permitting comparison with national data.

9. Identify and incorporate behavioral expectations of faculty into faculty evaluations. As noted above, under the shared accountability model faculty have certain responsibilities in creating a fair and just culture. It's important to be clear about these responsibilities. Behavioral statements can be developed that describe what's expected of faculty in making this significant organizational change. Expected behaviors could include participating in discussions about a fair and just culture; incorporating key concepts into course syllabi and assignments; engaging students in conversations about such a culture and explaining their roles and responsibilities; developing a teaching tool for colleagues on some aspect of this culture; introducing a new lesson based on a safety science principle; and developing a tool for identifying trends in events that occur during a clinical course. Selected behavioral statements can then be incorporated into faculty evaluations and merit systems.

10. Establish ongoing communication feedback loops. Openness and transparency are essential to a fair and just culture. Yet to our knowledge, in most nursing schools, faculty members rarely share their expectations of student performance or of the program with each other. Faculty members may have either very low or unrealistically high expectations; some may be too lenient in evaluating performance, others too harsh. If such conflicting attitudes and approaches remain hidden, it will be difficult to attain a fair and just culture.

Creating opportunities for faculty to discuss their expectations can lead to increased harmony. Such information should be shared freely, to facilitate continuous improvement in what is being taught, how it's taught, and how progress is assessed. The school will likely need to establish new communication mechanisms in order to improve communication between students and faculty, faculty within and across departments, faculty and school leadership, and school and clinical agency leadership. For example, monthly all-faculty meetings could incorporate discussion of errors and near misses. Curriculum meetings could evaluate errors and near misses in order to identify possible contributing factors. If root-cause analyses were performed, the results could also be included in these discussions.

11. Evaluate the progress of the initiative. Periodic assessments and reports are essential to ensuring that an initiative to create a fair and just culture succeeds. Designating either one person or a committee as responsible for the initiative's oversight can ensure its sustainability. Cooper has described how, as her nursing school's quality and safety officer, she creates internal reports on student errors and near misses each semester and shares them with faculty and students.[17,18]

CONCLUSION

To improve the quality and safety of patient care in clinical settings, we must pay attention to what is happening in academic settings. Like clinicians, nursing students and faculty must be actively involved in learning about safety science and the QSEN competencies, among other relevant areas. Moreover, in nursing schools and clinical agencies alike, a fair and just culture is essential. Such a culture encourages students to speak openly on issues affecting their performance or the practice of those around them, without fear of reprisal. Creating a fair and just culture often requires the adoption of new attitudes and beliefs, curriculum content, teaching methods and practices, tools and processes, and partnerships. Such significant change will take time and energy. But it will also prove transformative, resulting in educational environments that enrich student learning, deepen faculty satisfaction, and lead to safer care and improved outcomes for patients and families. ▼

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REFERENCES

1. Marx D. *Patient safety and the "just culture": a primer for health care executives*. New York: Columbia University; 2001 Apr 17. http://www.chpso.org/sites/main/files/file-attachments/marx_primer.pdf.
2. Patrician PA, et al. Just culture and the impact on high reliability. In: Oster C, Braaten J, editors. *High reliability organizations: a healthcare handbook for patient safety and quality*. Indianapolis, IN: Sigma Theta Tau International; 2016. p. 139-56.
3. Reason J. *Managing the risks of organizational accidents*. Burlington, VT: Ashgate Publishing Company; 1997.
4. Frankel AS, et al. Fair and just culture, team behavior, and leadership engagement: the tools to achieve high reliability. *Health Serv Res* 2006;41(4 Pt 2):1690-709.
5. Kohn LT, et al. *To err is human: building a safer health system*. Washington, DC: National Academy Press; 2000. https://www.nap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system.
6. Cronenwett L, et al. Quality and safety education for nurses. *Nurs Outlook* 2007;55(3):122-31.
7. Yoder M, et al. The effect of a safe zone on nurse interruptions, distractions, and medication administration errors. *J Infus Nurs* 2015;38(2):140-51.
8. Petschonek S, et al. Development of the just culture assessment tool: measuring the perceptions of health-care professionals in hospitals. *J Patient Saf* 2013;9(4):190-7.
9. Landgren R, et al. Barriers of pediatric residents to speaking up about patient safety. *Hosp Pediatr* 2016;6(12):738-43.
10. Clark C. The dance of incivility in nursing education as described by nursing faculty and students. *ANS Adv Nurs Sci* 2008;31(4):E37-E54.
11. Del Prato D. Students' voices: the lived experience of faculty incivility as a barrier to professional formation in associate degree nursing education. *Nurse Educ Today* 2013;33(3):286-90.
12. Mundt MH, et al. A task force model for statewide change in nursing education: building quality and safety. *J Prof Nurs* 2013;29(2):117-23.
13. Smith KM, et al. Leveraging resources to improve clinical outcomes and teach transitional care through development of academic-clinical partnerships. *Nurse Educ* 2015;40(6):303-7.
14. Harding L, Petrick T. Nursing student medication errors: a retrospective review. *J Nurs Educ* 2008;47(1):43-7.
15. Disch J, Barnsteiner J. Developing a reporting and tracking tool for nursing student errors and near misses. *J Nurs Regul* 2014;5(1):4-10.
16. Penn CE. Integrating just culture into nursing student error policy. *J Nurs Educ* 2014;53(9 Suppl):S107-S109.
17. Cooper E. From the school of nursing quality and safety officer: nursing students' use of safety reporting tools and their perception of safety issues in clinical settings. *J Prof Nurs* 2013;29(2):109-16.
18. Cooper EE. A spotlight on strategies for increasing safety reporting in nursing education. *J Contin Educ Nurs* 2012;43(4):162-8.