Ethics: Addressing Error: Partnership in a Just Culture

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Column

A just culture is one in which there is a partnership and shared accountability among all members. An organization with a just culture does not have a hierarchy of power but rather a trusting atmosphere of collective, team mindfulness that values transparent communication (Boysen, 2013; Fencl et al., 2021). A just culture organization is accountable for the systems they design and how they respond to safety events in a fair manner (Berlinger, 2016; 2017). Nurses are accountable and answerable for the decisions and actions taken in the provision of nursing care and obligated to sustain a culture of safety. When errors or safety events occur, employers expect nurses to report them to the appropriate authority and ensure their disclosure to patients. In a just culture, "Errors should be corrected or remediated, and disciplinary action taken only if warranted" (ANA, 2015, p.11-12). In this reciprocal relationship of employer and nurse, the employer owes protection and advocacy in supporting best practice and in responding to error.

Despite the adoption of a just culture framework including shared accountability and non-punitive response to error, employee expectations and incidents of unfair treatment or blame exist in many healthcare organizations (Edwards, 2018; Paradiso & Sweeney, 2019). Perception of a negative response, disciplinary action or loss of employment can undermine the dialogue needed to understand and correct the causes of error. The criminal prosecution of nurses RaDonda Vaught and DonQuenick Joppy, can result in a future shutdown of the reporting of such incidences "creating a cloak of silence rather than a culture of safety" (Emergency Care Research Institute (ECRI) & Institute for Safe Medication Practices (ISMP. 2022a, para 1). Professional nursing organizations, including the American Nurses Association, remain concerned about the effects of potential prosecution on an already exhausted healthcare workforce, the future of patient safety, and the existing nursing shortage crisis (AACN, 2022; ANA, 2022).

The details of the Vaught case and subsequent probation have been discussed extensively elsewhere (ANA, 2022; ISMP, 2021, 2022b; Marx, 2019). Joppy's recent similar experiences of employment termination, loss of RN license, charges of manslaughter and negligent death of an at-risk person, while dismissed, have received far less attention and support (Bradbury, 2022; Briggs, 2022). Joppy, a Black nurse, has filed a racial discrimination lawsuit against her former employer.

The purpose of this column is to highlight relevant aspects of these cases through an ethical lens of accountability and reciprocity, with implications for strengthening a just culture.

Organizations as Partners

Many healthcare organizations affirm a commitment to just culture together with diversity, equity and inclusion principles in their mission and vision statements. Just culture should also be embraced in everyday interactions with an obligation to the ethical principles of solidarity and reciprocity. In the healthcare system, solidarity between employers and nurses refers to the connections each has to the mission and through this to each other. Expecting highly skilled expert staff to work within complex systems for successful patient outcomes requires the active support, protection, and advocacy of the organization. Reciprocity describes the intentional relationship between employers and nurses to support and respectfully respond to each other in the provision of often challenging, lifesaving care. As an example, reciprocity includes providing N95 masks when nurses are asked to care for patients in infectious isolation. This principle also obligates organizations and nurse leaders to support and advocate for nurses both before an error, when a safety concern is identified, and after an error, to advise the nurse personally and professionally.

Reciprocity in healthcare organizational ethics through just culture includes priorities for both employers and nurses. These priorities include fluid adaptation to changing conditions, constant learning, transparent decision making and a mindfulness practice that empowers members to feel safe when providing care. Nurses are accountable for their actions and healthcare

organizations are accountable to address systemic problems and deficiencies, with respect and transparency while concurrently evaluating error and harm before any action is taken.

Workarounds: Valuable Solutions or Safety Concerns

Workarounds occur in overcomplicated complex systems and are often associated with rules and procedures developed to avoid harm. Workarounds are ubiquitous and inevitable in nursing and in healthcare. They may even be sanctioned by leadership or the organization and become embedded in patient care processes, accepted as the norm or "the way we do things here". Numerous types of workarounds exist. For example, those associated with operational failures that make it difficult to complete a task including resource issues or characteristics of a technology (EHR, BCMA, CPOE) that block or delay workflow. Some can pose hazards when they are used to circumvent an intentional safety barrier or manage an immediate problem without addressing the source (Berlinger, 2016; 2017; Debono et al., 2013; Seeman & Erlen, 2015). Others may improve outcomes through the provision of timely care, reduce adverse events and be incorporated into future practice (Deutsch, 2017).

Workarounds may be improvised by those who feel they are getting behind in their work and often involve seriously ill patients as they are the ones needing the most care. Workarounds are ethically important as they involve individuals making decisions about the risk to and safety of others (Berlinger, 2016; 2017). As the prevalence of workarounds increases as does the complacency to accept these as norms, awareness of risk may fade. All workarounds should be reviewed based on 1. the evidence they bring to improve or hinder practice, 2. risk or benefit for the patient; 3. the impact on time efficiency and 4. the urgent or emergent impact they provide when executed.

Nursing Leaders as Partners

Nursing Managers and Leaders are key partners to both nurses and healthcare organizations. They provide important oversight and advocacy to meet the mission of the profession, the organization, and the patient's desired outcomes. These managers and leaders are guided in practice by the Code of Ethics for Nurses with Interpretive Statements (2015) and the American Nurses Association Scope and Standards of Practice for Nurse Administrators (2016). "A primary challenge for the nurse administrator is creating an environment where the ethical and social obligations of nurses to deliver safe, quality services are balanced with protecting both the organization and its employees from failure and liability "(ANA, 2016, p. 8). In cases where there are conflicting loyalties, nurse managers need direction, is their loyalty to the health system or the nurse? Nurses themselves need strong advocates when they are in complex situations, especially when disclosure of harm is required.

Protecting a nurse from missteps and advising on professional and regulatory guidance in the face of unintentional error with or without harm, may be too challenging for the nurse manager. If so, then who advocates for the nurse at this moment? Provision 4 of the Code of Ethics for Nurses states, "The nurse administrator supports individual nurses in being accountable for their judgments, decisions, and actions in accepting responsibilities (2015). Similarly, the Nursing Administration Scope and Standards of Practice affirms that "Nurse administrators are responsible for assuring that nurses have access to the appropriate resources that affect the quality and safety of the patients they serve (2016, p.26). Clearly, there is an obligation for the nurse leader to support and protect the nurse. Research indicates however, that there can be a different perception of trust between leaders and nurses within a just culture organization.

According to Paradiso & Sweeney (2019), retraining is a common response by leaders to error. Nurses often feel this training is associated with blame rather than leaders being trustful and attentive to the nurse's suggestions for improvement or assuming accountability for any system wide design that added to the error. This lack of reciprocal accountability and paucity of direction for the nurse leader to advocate for the personal and professional protection of the nurse is inconsistent with a just culture.

Mindfulness Behaviors within a Just Culture

An organization with a just culture endeavors to be highly reliable, one in which exceptional safety performance is achieved through partnership and a collective or team mindfulness. By discouraging complacency and inertia, mindful behaviors enable an organization and team members to address evolving problems before they escalate. Team mindfulness may also support a community of practice. A group of individuals who are focused on the moment, mindful, and have respect for one another may have less conflict and be more productive. Mindfulness is foundational in a just culture that supports health professionals' ethical obligation to protect patients from preventable harm (Banja, 2019; Yu & Zellmer-Bruin, 2018).

Five characteristics of mindfulness associated with safe, high-quality patient care include sensitivity to operations, preoccupation with failure, deference to expertise, reluctance to simplify, and commitment to resilience. Sensitivity to operations means that staff, supervisors, and administration are aware of systemic issues or processes that can affect the organization and patient care. This situational awareness enables the system to provide resources at the appropriate time, understand the implications of the situation, and use this information to foresee potential future events. In preoccupation with failure, individuals are aware of things that have or could go wrong and are prepared to intervene before an event reaches the patient. Deference to expertise requires humility and an acceptance of insights and recommendations from those who are knowledgeable about a situation even if they are perceived as having less seniority or organizational rank. While simplifying work processes is often viewed as a way to increase efficiency, oversimplifying situations and using short-term solutions such workarounds can be risky (Agency for Healthcare Research and Quality [AHRQ], 2019; Fencl et al., 2021; Oster & Williams, 2018).

High reliability organizations "foster a climate of lean thinking and problem resolution with an attitude toward continual improvement" (Oster & Williams, 2018, p. 51). Continual improvement requires resilience and transparency. Organizations must be able to identify, admit and engage in error management in order to sustain a just, ethical culture where individuals feel safe to report an event (Fencl & Jackson, 2021; Oster & Williams, 2018; Polonsky, 2019).

In nursing, mindfulness is also described as an approach to reduce anxiety, increase personal resilience, and support ethical practice (Durham, 2020; Ekkens & Gordon, 2021; Rushton et al., 2020). Mindfulness is paying attention to what is happening in the current moment, without judgment, and stopping extraneous thoughts that may interfere or obscure concentration on the situation at hand. The use of mindful behaviors has also been associated with a decrease in the incidence of errors, including medication administration errors (Durham et al., 2016; 2020; Ekkens & Gordon, 2021). Although nurses value efficiency and the ability to multitask, brief, mindful medication administration strategies as described by Durham (2020), may help to avoid functioning on autopilot.

Conclusion

The Vaught and Joppy cases and similar healthcare events reminds us of "the potential fragility and vulnerability of just culture" (Zuzelo, 2022, p.261). Healthcare organizations and nurse leaders in partnership with nurses and members at all levels must evaluate how the tenets of a just culture supported by an environment of inclusivity and equity, move forward to strengthen our ethical commitment to shared accountability and safe patient care.

Corrigendum Notice: The authors of this column, Catherine Robichaux and Sarah Vittone, recently advised us of a potential misunderstanding by readers. The clarification provided by the authors was added on May 9, 2023 as follows:

In this column, the authors' intent is to focus on the characteristics of a just culture and the organizational response to nursing actions perceived or labeled as errors that result in penalties or prosecution. The brief reference to the Vaught and Beasley (Joppy) cases is provided to illustrate similarities in the response to very different cases. Ms. Beasley did not commit an error but was unfairly targeted and penalized. We apologize for any misunderstanding.

As noted, Ms. Beasley has filed a racial discrimination complaint in which the organizational and unit culture is described as allegedly hostile and racist. Although Ms. Beasley's license was reported to have been revoked (Briggs, 2022) this never occurred.

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