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Influencing Leadership Perceptions of Patient Safety Through Just Culture Training

Amy Vogelsmeier, PhD, RN, BC-GCNS;
Jill Scott-Cawiezell, PhD, RN, FAAN;
Becky Miller, MHA, CPHQ, FACHE; Scott Griffith, MS

There are differences in perceptions of safety culture between healthcare leaders and staff. Evidence suggests that an organization's actual safety performance is more closely reflected in staff perceptions suggesting that frontline staff may be more aware than the leadership of actual patient safety challenges within their organization. Closing the perception gap between healthcare leaders and staff is critical to aligning the resources and strategies required to create a true culture of safety. **Key words:** *healthcare leadership*, *just culture*, *patient safety*

MORE THAN 10 YEARS have passed since the Institute of Medicine's report, *To Err Is Human*, called attention to the nation's unacceptably high rate of deaths and adverse events related to medical error.[1] Regulators, researchers, and healthcare providers continue to bring attention and resources to the challenges of medical error, yet adverse events related to medical error continue to be on the rise.[2] While the refractory nature of medical error prevention has been considered through different lens,[3,4] most would agree that an organization's culture toward safety is critical to support an environment in which prevention of medical error can occur.

Author Affiliations: *Sinclair School of Nursing, University of Missouri, Columbia (Dr Vogelsmeier); University of Iowa College of Nursing, Iowa City (Dr Scott-Cawiezell); Missouri Center for Patient Safety, Jefferson City (Ms Miller); and Outcome Engineering LLC, Plano, Texas (Mr Griffith).*

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Corresponding Author: *Amy Vogelsmeier, PhD, RN, BC-GCNS, S314, Sinclair School of Nursing, University of Missouri, Columbia, MO 65211 (vogelsmeiera@missouri.edu).*

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With evidence suggesting that organizational culture has an impact on patient safety practices,[5] several studies have considered the implications of both a culture of safety and a culture of blame.[6-8] Through this exploration of cultural impact on patient safety practices, experts have discussed the leader's influence on the organization's ability to uncover medical error and related opportunities to improve.[1,9] A concern, however, is while many healthcare leaders declare patient safety as an organizational priority and are convinced they see evidence of safety,[10] frontline staff continue to report concerns about actual safety practices and priorities.[8,10-12]

Perhaps the divergence in patient safety perceptions between leaders and staff is rooted in a culture of blame. Early patient safety discussions focused consistently on medical error as being linked to individuals (blame).[13,14] This long-standing focus on blame has inadvertently dampened the willingness of frontline staff to bring forth medical error, near misses, and opportunities for improvement.[10,11] As such, because safety issues are not brought forth by those at the interface of care, leaders may have a false sense that their organizations are actively managing patient safety issues.

A new approach to medical error management has evolved over the past decade with many efforts pointed toward uncovering organizational systems that set up staff for unsafe practices.[5,9] However, despite efforts to focus on systems, many staff continue to be fearful of blame when medical errors occur.[8,10,11] Thus, the question remains, where are we in terms of creating a culture of safety in healthcare organizations across the country? If frontline staff members continue to perceive individual blame, then we have not achieved a shared commitment and approach to patient safety.

A shared commitment and approach to patient safety can occur in a just culture. Just culture emphasizes shared accountability between leaders and staff to support error disclosure and organizational learning from mistakes.[5] In a just culture, leaders are accountable to create an environment supportive of error disclosure and to manage organizational issues brought forward by staff that impede safe care. In turn, staff members are accountable to share information and experiences encountered with errors and error-prone systems. Because staff and leaders share information, leaders better understand the organizational realities experienced by staff and staff better understand the leaders' efforts toward improvement. Perhaps this shared understanding created through a just culture can close the perception gap between leaders and staff. The purpose of this article is to describe the influence of Just Culture training on leaders' perceptions of their patient safety culture and to explore how those perceptions align with staff across the nation.

JUST CULTURE COLLABORATIVE

With the desire to improve the culture of safety in Missouri, the Missouri Center for Patient Safety engaged 63 healthcare provider organizations of varied size and setting to participate in a statewide collaborative called the Missouri Just Culture Collaborative. In addition, 4 statewide regulatory agencies including the State Board of Nursing, professional schools, and state nursing associations participated. Of the 63 healthcare organizations, 52 completed the 20-month collaborative. The collaborative, funded by the National Council State Boards of Nursing and approved by a local institutional review board, was formed to assist leaders from healthcare organizations in identifying and managing organizational systems and human issues that lead to medical error. The collaborative partnered with Outcome Engineering LLC to provide Just Culture training to leadership staff from healthcare systems, acute care and critical access hospitals, physician practices, and nursing homes.[15]

As noted in Table 1, Just Culture training emphasizes a system of shared accountability among organizational leaders and staff. Through the education, healthcare

Table 1. Overview of just culture training

Champion and healthcare leader training
The management of risk
Role of systems design
Management of human error
Management of at-risk behavior
Management of reckless behavior
Role of event investigation
Just culture algorithm
Duty to produce an outcome
Duty to follow a procedural rule
Duty to avoid causing unjustifiable risk or harm
Case scenarios with applied decision-making algorithms
Audio conferences (select topics)
Just culture implementation
Event investigations
Managing human resources
Managerial accountabilities
On-site training
Executive medical staff briefing
Training for healthcare managers and supervisors
Safe choices for staff

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organizations considered healthcare leaders' accountability for designing safe systems and responding to staff in a fair and just manner. In addition, participants considered how staff members are also accountable for making safe choices and reporting errors and bringing forward opportunities for improvement.[16]

The 52 participating healthcare organizations engaged in the Just Culture Collaborative in 1 of 4 ways (ie, 4 levels of intensity). Four healthcare organizations chose to minimally engage and simply sent 1 organizational champion to the initial Just Culture training. Sixteen healthcare organizations chose to take 1 more step and attended a second training session, which included educating a group of their organizational leaders such as executive staff, medical directors, and management staff. Fifteen healthcare organizations chose to engage at a third level that included monthly audio conferences in addition to the previously mentioned Just Culture training for a group of their organizational leaders. Finally, 17 healthcare organizations fully engaged by participating in all opportunities noted above and additionally participating in an on-site Just Culture training session, which included training for frontline staff. Thus, the higher the level of engagement, the more members of the organization were involved and exposed to discussions related to just culture.

EXPLORING LEADER PERCEPTIONS OF THEIR PATIENT SAFETY CULTURE

To explore how leaders' perceptions of their patient safety culture might be influenced by Just Culture training during the collaborative, leaders from participating organizations enlisted a wider variety of their leadership team to participate in an adaptation of the Agency for Healthcare Research and Quality's Hospital Survey on Patient Safety Culture (HSOPSC) before and after the collaborative. The HSOPSC, a valid and reliable survey, is designed to assess hospital staff perceptions of a patient safety culture measured across 12 dimensions of safety.[17] The HSOPSC, modified for this collaborative to include 3 open-ended questions specific to error reporting, leadership response, and feedback to error, was used to measure change in leadership perceptions of their organization's patient safety culture as influenced by the Just Culture training intervention.

A variety of leadership staff, predominantly nurse executives, nurse managers, and nursing supervisors from the 52 healthcare organizations completed the Agency for Healthcare Research and Quality safety culture survey; 485 leadership staff completed the survey before the collaborative and 439 leadership staff completed the survey after the collaborative. The project team, led by a nurse researcher (Scott-Cawiezell), selected 14 items from 8 of the 12 survey dimensions that the team considered most influenced by content included in the Just Culture training. The 8 dimensions included communication openness, feedback and communication about error, frequency of error reported, manager expectations/actions promoting patient safety, management support for patient safety, nonpunitive response to error, organizational learning, and overall perceptions of safety.

Exploring select survey items from these 8 dimensions, the project team initially attempted to compare changes in participants' perceptions as noted before and after the collaborative. However, it quickly became evident that focusing on "change scores" was providing neither meaningful information nor reasonable explanations for the actual changes in perceptions noted throughout the collaborative. As the survey results were considered, it was immediately evident that the most fully engaged organizations were not showing the same pattern of perceptual change as the least engaged organizations. For example, when considering questions related to an organization's nonpunitive response to error, the most engaged healthcare organizations showed a positive change of only 1.1% while the lesser engaged healthcare organizations showed a positive change of more than 17%, moving toward strongly agreeing that nonpunitive approaches were the standard approach of the organization. The

pattern continued as the team explored the remaining select items of the safety culture survey.

With these intriguing findings, the project team then aligned leadership staff scores from the least engaged organizations and the most engaged organizations with the 2009 HSOPSC national findings.[18] The 2009 results reflect the perceptions of nearly 150 000 hospital management and staff including 13 750 leaders and 66 261 nurses and serve as a national database for healthcare organizations. Based on the evidence suggesting that frontline staff perceptions of patient safety reflect more accurately an organization's safety performance,[5] the HSOPSC database provided an important comparison between collaborative leadership participants and frontline staff, particularly nurses from across the country.

As noted in Table 2, benchmarking against the national scores revealed that leaders' perceptions from the most fully engaged organizations approximated more closely with the perceptions of nurses across the country for the selected items than those of the least engaged organizations. For example, when considering communication openness, the statement, "Staff feel free to question the decisions or actions of those with more authority," 57% of leaders from the most engaged organizations either agreed or strongly agreed that their staff perceived this freedom. This response more closely approximated to the national benchmark of nurses, at which only 45% agree or strongly agree that they had this freedom. This is in contrast to perceptions of the least engaged leaders who all believed their staff would feel free to question decisions or actions.

Another statement, "Staff (do not) feel like their mistakes are held against them," explored leadership perception of punitive reporting within their organizations. Only 59% of leaders from the most engaged organizations agreed with this statement and more closely aligned with 50% of nurses across the country who also agreed with it. This is again in contrast to the least engaged leaders of whom 75% believe their staff do not feel their mistakes are held against them. This pattern of comparison between the most and least engaged organizations was consistent across each of the 8 survey dimensions.

Furthermore, when we explored responses from the open-ended questions, the difference in perceptions between the most and least engaged organizations was further validated. Leaders from the most engaged healthcare organizations more often recognized organizational barriers to open communication and staff hesitancy to report errors; many also believed "pockets of employees" still fear blame. This was in contrast to participants who were least engaged who rarely cited error reporting barriers nor believed their staff feared blame.

CLOSING THE GAP BETWEEN LEADERSHIP AND STAFF

At first glance, findings from this collaborative seem counterintuitive because organizations most engaged in the Just Culture training showed the least amount of positive change in their perceptions of a safety culture, whereas, those least engaged had the greatest amount of positive change. Moreover, leaders from the most engaged organizations reflected a less positive perception of their patient safety culture than the least engaged organizations whose leaders' perceptions were consistently positive. This pattern held true across each of the 8 selected dimensions of safety.

Initially, one might jump to the conclusion that this negatively reflects on the organizations most exposed to discussion and education about leadership and staff accountability in patient safety. However, when benchmarking against national findings where perceptions of nurses and other frontline healthcare providers are considered, those organizations most fully engaged were most aligned with the perceptions of staff, specifically nurses from across the nation. Furthermore, the written responses of the fully engaged healthcare organizations provide clear and consistent acknowledgment of barriers to error

Table 2. Comparison of most engaged and least engaged healthcare organizations benchmarked with selected national responses

Select items for comparison (scores reflect % of positive responses of strongly agree/agree)	Least engaged	Most engaged	National responses leaders only (13 750)[18]	National responses nurses only (66 261)[18]
Communication openness				
Staff will freely speak up if they see something that may negatively affect patient care	100	77	83	75
Staff feel free to question the decision or actions of those with more authority	100	57	68	45
Feedback and communication about error				
We are given feedback about changes put into place based on event reports	75	61	64	51
In this unit, we discuss ways to prevent errors from happening again	100	83	82	66
Frequency of events reported				
When a mistake is made but is caught and corrected before affecting the patient, how often is it reported?	75	41	58	48
When a mistake is made that could harm the patient, but does not, how often is this reported?	100	61	78	76
Manager expectations/actions promoting patient safety				
My manager (does not) overlook patient safety problems that happen over and over	100	84	85	76
Management support for patient safety				
Management provides a work climate that promotes patient safety	100	90	89	73
Management (does not) seem interested in patient safety only after an adverse event	75	68	75	55
Nonpunitive response to error				
Staff (do not) feel like their mistakes are held against them	75	59	69	50
Organizational learning-continuous improvement				
Mistakes have led to positive changes here	100	82	80	60
Overall perceptions of safety				
It is (not) just by chance that more serious mistakes do not happen here	75	66	72	59
Our procedures and systems are good at preventing error from happening	100	70	77	66

reporting and frightened and hesitant front-line staff. Recognition of underreporting and fear suggests that fully engaged healthcare organizations may have developed a clearer understanding of the realities experienced by their nurses and other healthcare providers. In contrast, less engaged healthcare organizations continued to hold on to the illusion that "we have no real problems here." The perception that "no real problems" exist appears to align with the perceptual gap explicated between leaders and staff in earlier studies.[8,10,12]

Because training for the most fully engaged healthcare organizations included both leadership and staff coming together, the shared dialogue and education provided a platform for shared experiences to be discussed and explored. Furthermore, because just culture principles emphasize shared accountabilities among leaders and staff for managing error and risk for error, Just Culture training may have facilitated staff willingness to share experiences that lead to error and error risk within their organizations. The open discussion, thus, may have enlightened leaders to the true challenges that staff members encounter in ensuring patient safety. In contrast, because the least engaged healthcare organizations did not fully benefit from Just Culture training, specifically on-site training, leaders and staff did not have the opportunity to share in these critical discussions and critical insights. As such, a divergence in patient safety perceptions between leaders and staff may remain.

Several studies have attempted to shed light on the differences between organizational leaders' and staff's perceptions of patient safety.[6,10,12,19] Singer and colleagues[10] provide more evidence to clarify the differences in leaders' and staff's perceptions. These authors found that an organization's actual safety performance was more closely reflected in staff's perceptions of safety, suggesting that staff more closely align with the realities of organizational patient safety challenges. Thus, the ongoing challenge remains, how do we close the perceptual gap to more closely align leaders with staff so substantive changes can result in sustainable improvement?

CONCLUSION

While findings from this collaborative are important for recognizing how leadership staff perceptions may have been influenced by Just Culture training, there are limitations. First, the survey was limited to leaders' perceptions and did not include internal staff comparisons. While the results were compared with a national database, it is possible that staff within these organizations may have responded differently. Second, organizations engaged voluntarily in varying levels of the project so those organizations most engaged made a commitment to do so. As such, the most fully engaged organizations were likely more open to leadership and staff interactions before the collaborative. Finally, the small number of least engaged organizations poses some limitations to the findings. However, despite the small numbers, the consistency of positive responses clearly indicates a pattern of agreement among the least engaged leaders.

Despite the limitations, findings from this collaborative provide important insight into the opportunity to close the gap in perception between leadership and staff. Closing the perceptual gap can lead to a shared priority for patient safety. Because just culture emphasizes a shared accountability between leaders and staff to make patient safety a priority,[16] perhaps the shared training between leaders and staff emphasized those accountabilities and opened up a new series of discussions. Minimizing a culture of blame, in which leaders accept accountability for safe systems, and creating an environment in which staff feel free to openly report errors and systems vulnerabilities must start with leadership acknowledgment that barriers exist. Once leaders and staff have a shared understanding of the organizational challenges to providing safe care, perhaps a true safety culture can exist.

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