ELSEVIER

Social Science & Medicine 66 (2008) 403–413

SOCIAL SCIENCE & MEDICINE

www.elsevier.com/locate/socscimed

# The meaning of justice in safety incident reporting

Bryan Jeffrey Weiner[a,*], Cherri Hobgood[b], Megan A. Lewis[c]

[a]*Department of Health Policy and Administration, University of North Carolina at Chapel Hill, 1102-C McGavran-Greenberg Hall, Chapel Hill, NC 27510, USA*

[b]*Office of Educational Development, School of Medicine, 322 MacNeider Building, CB 7530, University of North Carolina at Chapel Hill, Chapel Hill, NC 27599-7530, USA*

[c]*RTI International, 3040 Cornwallis Road, P.O. Box 12194, Research Triangle Park, NC 27709-2194, USA*

Available online 18 October 2007

**Abstract**

Safety experts contend that to make incident reporting work, healthcare organizations must establish a ''just'' culture—that is, an organizational context in which health professionals feel assured that they will receive fair treatment when they report safety incidents. Although healthcare leaders have expressed keen interest in establishing a just culture in their institutions, the patient safety literature offers little guidance as to what the term ''just culture'' really means or how one goes about creating a just culture. Moreover, the safety literature does not indicate what constitutes a just incident reporting process in the eyes of the health professionals who provide direct patient care. This gap is unfortunate, for knowing what constitutes a just incident reporting process in the eyes of front-line health professionals is essential for designing useful information systems to detect, monitor, and correct safety problems.

In this article, we seek to clarify the conceptual meaning of just culture and identify the attributes of incident reporting processes that make such systems just in the eyes of health professionals. To accomplish these aims, we draw upon organizational justice theory and research to develop a conceptual model of perceived justice in incident reporting processes. This model could assist those healthcare leaders interested in creating a just culture by clarifying the multiple meanings, antecedents, and consequences of justice.

© 2007 Elsevier Ltd. All rights reserved.

*Keywords:* Patient safety; Just culture; Incident reporting; Organizational justice

## Introduction

To improve patient safety, healthcare organizations are implementing incident reporting systems in order to collect information directly from health professionals about near misses, medical errors, and adverse events—hereafter referred to generically as safety incidents (Barach & Small, 2000; Wald & Shojania, 2001). Obtaining such information is considered crucial for identifying risky situations, analyzing underlying causes, taking corrective action, and implementing prevention efforts (Institute of Medicine, 2000). Those directly involved in patient care are said to possess important safety-related information that cannot be obtained through retrospective peer review or computerized surveillance systems (Barach & Small, 2000; Olsen et al., 2007; O'Neil et al., 1993; Reason,

*Corresponding author. Tel.: +1 919 966 7375; fax: +1 919 966 6961.

*E-mail addresses:* weiner@email.unc.edu, bryan_weiner@unc.edu (B.J. Weiner), hobgood@med.unc.edu (C. Hobgood), melewis@rti.org (M.A. Lewis).

0277-9536/$ - see front matter © 2007 Elsevier Ltd. All rights reserved.
doi:10.1016/j.socscimed.2007.08.013

2000; Wald & Shojania, 2001; Welsh, Pedot, & Anderson, 1996).

Although healthcare organizations have expended substantial effort to promote incident reporting, studies suggest that underreporting is pervasive (Cullen et al., 1995; Kopp, Erstad, Allen, Theodorou, & Priestley, 2006; Wald & Shojania, 2001). Many observers attribute underreporting to the punitive (''name and blame'') approach that many healthcare organizations have taken with regard to safety incidents. By inculcating a sense of fear, the punitive approach discourages reporting and, in doing so, prevents organizational learning and improvement (Barach & Small, 2000; Blegen et al., 2004; Kadzielski & Martin, 2002; Kingston, Evans, Smith, & Berry, 2004; Manasse, Eturnbull, & Diamond, 2002; Wakefield et al., 2001, 1999). By comparison, the ''non-punitive'' approach that the airline industry has taken with regard to incident reporting is seen as a significant contributing factor to the industry's impressive safety record (Marx, 2001; Reason, 2000).

To make incident reporting work, safety experts contend, healthcare organizations must establish a ''just'' culture—that is, an organizational context in which health professionals feel assured that they will receive fair treatment when they report safety incidents (Beyea, 2004; Institute of Medicine, 2003; Kizer, 1999; Marx, 2001). In the United States, healthcare leaders have expressed considerable interest in establishing a just culture in their institutions (Agency for Healthcare Research and Quality, 2005; Emery Center on Health Outcomes in Quality, 2004; No Author, 2002; O'Leary, 2003; University of Michigan Medical School, 2005). Yet, many are grappling with the questions of what the term ''just culture'' really means and how one goes about creating a just culture (Beyea, 2004). At present, the patient safety literature provides little guidance on either issue. Importantly, the patient safety literature does not indicate what constitutes a just (or fair) incident reporting process in the eyes of health professionals who work on the ''sharp end'' of the delivery system. This lacuna is unfortunate, since incident reporting processes work only if those on the front-lines perceive the design and operation of such processes as just (or fair). This is true for both voluntary and mandatory incident reporting systems (Barach & Small, 2000; Reason, 1997). Knowing what constitutes a just incident reporting process in the eyes of health professionals is therefore essential for designing useful information systems for detecting, monitoring, and correcting safety problems.

In this article, we seek to clarify the conceptual meaning of just culture and identify the attributes of incident reporting processes that make such systems just (or fair) in the eyes of health professionals. To accomplish these aims, we draw upon organizational justice theory and research to develop a conceptual model of perceived justice in incident reporting processes. This model could assist those healthcare leaders interested in creating a ''just culture'' by clarifying the meaning, antecedents, and consequences of justice.

## The concept of a just culture

A just culture is seen by some experts as an integral aspect of a broader culture of safety (Institute of Medicine, 2003; Kizer, 1999). Indeed, Reason (1997) considers it the foundation of a culture of safety. Surprisingly, despite the importance ascribed to it, no concise definition of just culture exists. The more general term ''organizational culture'' refers to the shared pattern of beliefs, assumptions, and expectations that are held by organizational members and that shape their interaction with each other and with stakeholders outside the organization (Bowditch & Buono, 2001). A just culture, then, is one in which the beliefs, assumptions, and expectations that govern behavior in an organization conform to generally held principles of moral conduct.

Although the term ''just culture'' can be construed broadly, the term is often more narrowly used to refer to the beliefs, assumptions, and expectations that govern accountability and discipline for unsafe acts (e.g., near misses, medical errors, and adverse events). A just culture, expert say, is a ''non-punitive'' environment in which individuals can report errors or close calls without fear of reprimand, rebuke, or reprisal (Blegen et al., 2004; Karadeniz & Cakmakci, 2002; Kingston et al., 2004; Pizzi, Goldfarb, & Nash, 2001; Wakefield et al., 1999; Wild & Bradley, 2005). At the same time, they assert, a just culture is not an environment wherein no accountability exists (Beyea, 2004). Failing to discipline those who commit unsafe acts due to incompetence or recklessness is just as much a violation of widely accepted moral principles as is punishing those who commit honest mistakes. A just culture, therefore, stands between a ''blaming'' or punitive culture, on the one hand, and a

Download English Version:

https://daneshyari.com/en/article/954714

Download Persian Version:

https://daneshyari.com/article/954714

Daneshyari.com