Enablers and barriers to achieving a Just Culture in an NHS environment: a qualitative study on creating a patient safety-oriented environment

WARWICK MEDICAL SCHOOL

Overview and Objectives

A Just Culture is a key aspect of an effective safety culture, yet little research has been done on whether it has been successfully implemented within NHS Trusts. This qualitative research project examined attitudes and behaviours related to patient safety culture at a single West Midlands Trust. Our objective was to gain an understanding of staff's views regarding the culture within the Trust and of their attitudes and behaviours when reviewing clinical incidents and mortality and morbidity. Our aim was to identify the barriers and enablers to an organisation adopting a Just Culture.

Methods

- Semi-structured interviews were conducted with 13 doctors of all grades, 5 medical students and 2 managers.
- 5 meetings that reviewed clinical incidents and mortality were observed.
- This was done in a Trust in the Midlands.
- Data was thematically analysed using directed and inductive approaches.

> "*I think a lot of junior doctors, in particular, don't know the process. So, they have no idea what to expect and they've never been through anything like it, and it can be really, really, really scary.*" Registrar

Results and Discussion

Theme 1: There was no agreed vision of a Just Culture and the majority of the staff were unfamiliar with the term.When defining a Just Culture, most responses were related to equality and diversity rather than patient safety.

Theme 2: Negative perspectives relating to clinical incidents and their management persist amongst staff with many junior doctors having insecurities that echoed those reported by the Williams Review and Hamilton Report. Poor understanding of the way the Trust manages clinical incidents was a major factor.

Theme 3: There was an absence of formal training in the conduct of investigations and human factors. This may create variation in the outcomes of investigations.

Theme 4: A sizeable minority of staff believed that investigations into clinical incidents did not lead to corrective action. Poor communication of the outcomes of investigations and the changes implemented may have caused the negative perspective. Staff prefer face-to-face feedback.

Theme 5: Informal methods of reporting were favoured over formal methods. The perceived lack of timeliness and quality of corrective action following formal reports has led to staff preferring informal reporting.

> "*One of the critical points, so when a patient safety incident happens, you don't know what, you don't know what's happening. How's it been reported? What's the final thing? How has it been fed into… clinical practice. Do all the nurses need to know about it or the doctors or physiotherapists?*" Consultant

> "*Nobody will ever come up to you and say hey look, the reason that's wrong is because of this, look. This is how you should do it. No. What they'll do is send a DATIX. So, three weeks later you'll get a… You initially **** yourself 'cause you think 'Oh my God, I'm under investigation' or something. That's not the way to learn and that's the problem.*" Registrar

Recommendations

1. Engage with staff and patients to **agree a vision of what Just Culture means** to the Trust.
2. **Familiarise staff with the Trust's safety culture and clinical incident management processes.**
3. Consider establishing a Trust **clinical investigation team**.
4. Increase **face-to-face communication** of investigation and incident review outcomes to drive improvement.
5. **Educate staff on** reporting lines, their uses, the processes they initiate, and likely outcomes within **the Trust reporting system.**

Future Development

We have met with an Executive Director of the Trust to discuss our results and the implementation of many of the recommendations at a Trust and System level.

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