



# The Just Culture: where are we?

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## Background

The Patient Safety Survey in 2010 conducted in KK Women's and Children's Hospital (KKH) by Ministry of Health Singapore and results revealed that there is 24% positive response for 'Non-punitive response to Error'. Thus, in 2015 a follow-up survey on "Just Culture" was conducted.

## Objective

- 1) To assess degree of Just culture being practiced among KKH healthcare staff
- 2) To identify gaps and to make recommendations for improving the Just culture

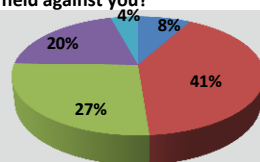
## Method

Questionnaire-based survey which was validated initially among a small sample of staff members. Feedback from them obtained where the final questionnaire was sent out to all KKH staff via email. Responses of 666 staff members were collated from 1 to 31 July 2015 and analysed.

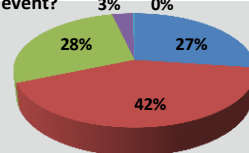
## Results

Legend: ■ Agree ■ Disagree ■ Neither ■ Strongly Agree ■ Strongly Disagree

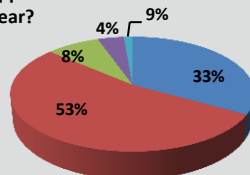
Do you feel your mistakes are held against you?



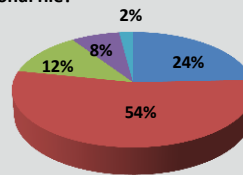
When you submit an incident report, do you feel that you will be held responsible for the event?



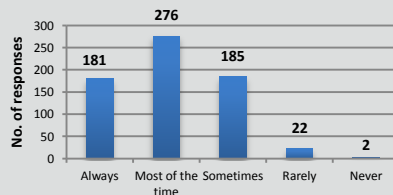
Do you worry that the mistakes you make will affect your performance appraisal at the end of the financial year?



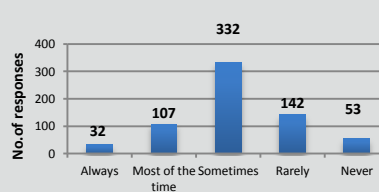
Are you concerned that any incident that you were involved in will be filed in your personal file?



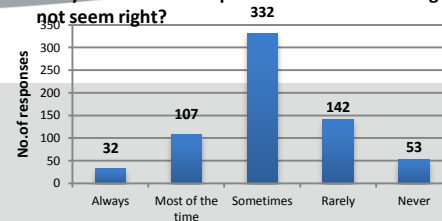
Will you freely speak up when you see something that will negatively affect patient care?



Are you comfortable to question the decisions or actions of those with higher authority?



Are you afraid to ask questions when something does not seem right?



## Lessons Learnt

Just culture balances the need for an open and honest reporting environment and requires a change in focus from errors and outcomes to system design and management. It should start with Speaking up for safety as it can improve and further enhance safety levels in the hospital

## Recommendations

- 1) Improve awareness of human factors in errors.
- 2) To improve uptake and utilisation of Root Cause Analysis in approaching errors
- 3) To inculcate a culture of speaking up within KKH