



## Fostering Path To A Just Culture In Healthcare Organizations: Influential Factors And Challenges

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## **ABSTRACT**

*In healthcare, fostering a just culture is vital for patient safety. This study, following PRISMA 2020 guidelines, systematically reviewed research from 2019 to 2023 on just culture in healthcare organizations. It aimed to understand the process, influencing factors, and challenges. To nurture a just culture, it's crucial to differentiate human errors from reckless behaviors. This encourages incident reporting without fear of blame. Key factors include organizational characteristics (safety climate and just culture) and individual factors, especially among nurses. Challenges involve privacy-protecting policies hindering open communication and trust issues resulting from safety incidents. Five crucial factors emerged: Awareness, Empowerment, Organizational Factors, Leadership, and Communication. Challenges include privacy-protecting policies impeding open dialogue and trust issues, leading to emotional consequences from safety incidents. Continued research is needed to explore implementation processes' impact on patient safety culture, incident reporting, system enhancements, and responsible behaviors in healthcare organizations. In summary, promoting a just culture is essential for patient safety, with factors and challenges guiding this journey.*

*Keywords: fostering just culture; patient safety; healthcare*

## **ABSTRAK**

*Dalam dunia kesehatan, memupuk budaya yang adil sangat penting untuk keselamatan pasien. Studi ini, mengikuti panduan PRISMA 2020, secara sistematis meninjau penelitian dari tahun 2019 hingga 2023 tentang budaya yang adil dalam organisasi kesehatan. Tujuannya adalah untuk memahami proses, faktor-faktor yang memengaruhi, dan tantangannya. Untuk menumbuhkan budaya yang adil, sangat penting untuk membedakan antara kesalahan manusia dan perilaku sembrono. Hal ini mendorong pelaporan insiden tanpa rasa takut akan kesalahan. Faktor kunci melibatkan karakteristik organisasi (iklim keselamatan dan budaya yang adil) dan faktor individu, terutama di antara perawat. Tantangannya melibatkan kebijakan perlindungan privasi yang menghambat komunikasi terbuka dan masalah kepercayaan yang timbul akibat insiden keselamatan. Lima faktor kunci muncul: Kesadaran, Pemberdayaan, Faktor Organisasi, Kepemimpinan, dan Komunikasi. Tantangan melibatkan kebijakan perlindungan privasi yang menghambat dialog terbuka dan masalah kepercayaan, yang dapat mengakibatkan konsekuensi emosional dari insiden keselamatan. Penelitian lanjutan diperlukan untuk mengeksplorasi dampak proses implementasi terhadap budaya keselamatan pasien, pelaporan insiden, perbaikan sistem, dan perilaku yang bertanggung jawab dalam organisasi kesehatan. Secara ringkas, mempromosikan budaya yang adil adalah hal penting untuk keselamatan pasien, dengan faktor-faktor dan tantangan pada topik ini.*

*Kata kunci: membangun budaya adil; keselamatan pasien; layanan kesehatan*

## **INTRODUCTION**

A "Just Culture" fosters an environment characterized by fairness and transparency, facilitating honest error reporting. It places significant emphasis on differentiating among human error, reckless conduct, and behavior endangering others, assessing the fairness of an employee's decision-making process. Positioned between a "punitive culture," which penalizes rule violations, and a "blame-free culture," where everyone assumes responsibility for their actions, a "Just Culture" strikes a balance. It achieves this equilibrium by focusing on three behaviors. These behaviors encompass human errors, risk-taking, and carelessness. Among these, at-risk behavior involves a deliberate choice, while recklessness occurs when someone undertakes a risk either without full comprehension or because they perceive the risk as justifiable (Forster et al., 2019; Rogers et al., 2017). Despite healthcare professionals' unwavering dedication to providing optimal care, there are occasions when patients may experience harm or, tragically, loss of life within the healthcare system. Recent research highlights the importance of acknowledging and comprehending the concept of safety culture as a pivotal step in transitioning from a culture of blame to one that emphasizes learning (Brattebø & Flaatten, 2023).

Patient safety has been a top priority in healthcare, and there's a growing recognition of its paramount importance in the healthcare system (Armstrong, 2019). A "Just Culture" is indispensable for improving the quality of healthcare and ensuring patient safety (Hays & Kruse, 2022). The evolution

of contemporary thinking about a just culture has been driven by the needs of high-risk, high-reliability organizations. Valuable lessons often emerge from mistakes, but there is equal value in studying successful catches within organizational just culture. The concept of a "good catch" deserves special attention as it serves to highlight and analyze successful behaviors, address systemic issues, bridge knowledge gaps, and prevent harm to patients. The persistent goal in healthcare remains the reduction of medical errors, reflecting the foundational principle that reminds perioperative nurses to prioritize patient care, placing safety and the commitment to "do no harm" at the forefront of their duties (Monahan, 2018).

Prioritizing the restoration of trust in conjunction with incident investigations is crucial to prevent the exacerbation of harm for all parties involved (Lounsbury & Sujun, 2023). Daily interdisciplinary huddles were implemented to improve communication, reduce errors, and enhance patient and employee satisfaction. Over time, near-miss reporting notably increased, reflecting a positive trend. Patient satisfaction regarding staff collaboration in care delivery also showed significant and progressive improvement. Employee satisfaction and perceptions of workgroup communication, collaboration, and psychological safety improved, though not reaching statistical significance (McCain et al., 2023). Adopting a "just culture" is essential for advancing patient safety. The first step in this endeavor is understanding the prerequisites for effectively implementing its principles and protocols (Murray et al., 2023). A "just culture" requires an impartial approach to assessing human errors and fosters trust within the organization. This trust encourages reporting and rectification of medical errors, preventing them from compounding and causing harm or fatalities. Establishing a "just culture" that promotes safety necessitates a clear understanding of its role in fostering error reporting and developing a safety-oriented culture (Small et al., 2022).

Patient safety is a paramount concern in healthcare, and fostering a just culture is essential for promoting accountability and improving clinical judgment. This study sets out to explore the factors that influence to fostering of a Just Culture on patient safety outcomes and to gain a deeper understanding of its importance within healthcare environments. In particular, the study aims to shed light on which factors are important for building a just culture and the challenges involved. As patient safety remains a pressing issue, understanding the role of a just culture in enhancing safety measures becomes increasingly urgent. This investigation delves into these critical aspects to contribute to the ongoing efforts to improve healthcare practices and patient well-being.

## **METHOD**

This systematic review adhered to the updated guidance provided by the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA 2020) for its reporting (Page et al., 2021).

### **Search strategy**

In April 2023, searches were conducted using five electronic databases (Scopus, ScienceDirect, ProQuest, PubMed, and Sage Journals). We only included English papers published between 2019 and 2023 in the study. The most recent data and findings were gathered from a five-year-old published publication. "Just culture" and "patient, safety, and healthcare" were united. A manual search of references was conducted using this combination in all of the chosen studies. Also, any pertinent information in the papers' lists of references was identified by hand.

### **Study selection**

The three phases of the PRISMA 2020-recommended selection method are identification, screening eligibility, and included study. The inclusion criteria were quantitative studies on just Culture and patient safety, as stated in Table 1. We eliminated review studies (such as literature or systematic reviews) in this study. Once all the possibilities are found, we eliminate duplicates and begin

screening the titles, abstracts, and keywords. The unrelated study was taken out, and the eligibility of the full-text papers was assessed using the inclusion and exclusion criteria. Also, any pertinent information in the papers' lists of references was identified by hand.

PICOS	Inclusion Criteria	Exclusion criteria
Population	Healthcare workers (hospital, primary care, nursing home, etc.)	Students or lecturers
Interventions	Just culture and patient safety	Patient safety culture
Comparators	N/A	N/A
Outcomes	Primary focus: patient safety and just culture	Studies focus on the disease or events
Study design	A quantitative study, qualitative study, and mixed method	Feature studies, Article reviews, and case reports
Publication Type	Studies published in English in databases chosen from 2019 – 2023 and open access	Single site reports

Table 1. Inclusion and exclusion criteria

## Study Screening

The study authors searched journal titles and abstracts, organized relevant full-text publications into a table, and compiled essential details. A reviewer extracted and cross-checked the data for accuracy, resolving discrepancies through author discussions. The selected articles centered on "Just Culture and Patient Safety in Healthcare" for analysis and discussion.

## Study Quality Assessment and Data Extraction

The evaluation techniques were used to assess the appropriateness of the research framework in the selected papers. STROBE, a method for evaluating the acceptability of observational studies in epidemiology, was utilized to determine the eligibility of selected studies for inclusion in the final data synthesis and analysis. This evaluation tool is suitable for cross-sectional, observational, and cohort research. During the quality evaluation, the researchers responded to the appraisal-tool questions with a yes/no system because they believed that the criteria for evaluating whether a study should be included in the final dataset did not fit with a scoring system. Before deciding which research to select for data synthesis and analysis, they constantly debated the importance and caliber of each publication. This instrument comprises 22 questions about study questions and objectives, samples, interventions, outcome assessments and follow-ups, and statistical methodologies. Measurement, information, and selection bias are all explored with a connection to bias risk. A consensus was established on any divergent conclusions after a discussion among the authors. Table 2 presents data collected about quality evaluation. A data extraction table was created to collect information on the authors, the publication's year, the participants, the intervention used, and the outcomes in Table 3.

## RESULTS AND DISCUSSION

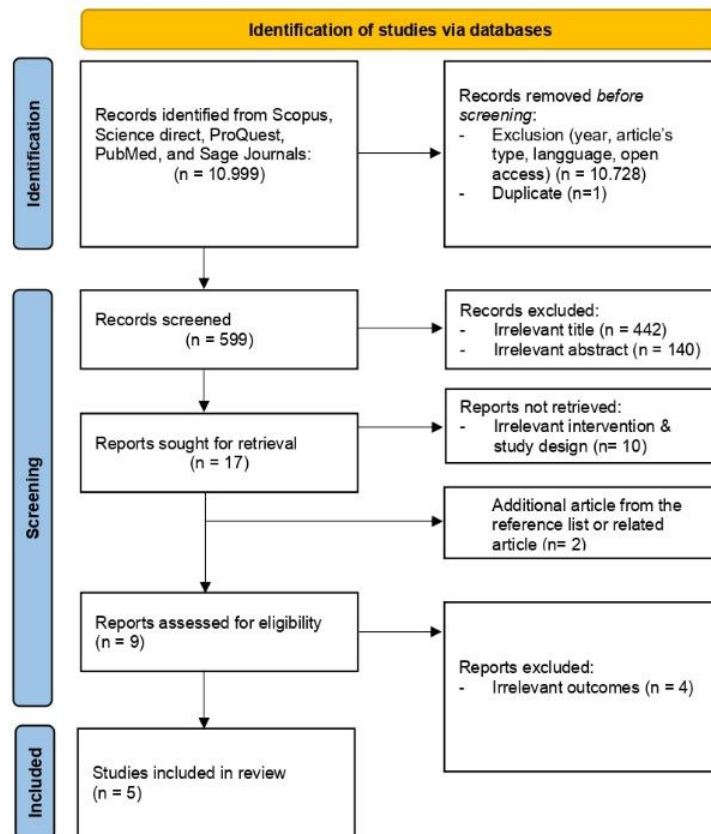


Figure.1 Diagram flow selection process

This research primarily centers on the "just culture" paradigm pertaining to error reporting in healthcare facilities and its profound implications within healthcare contexts. It explores the fundamental concept that employees should experience equitable treatment when dealing with patient safety issues, emphasizing the crucial function of such equity in maintaining equilibrium between organizational frameworks and individual responsibility.

### Search results

Figure 1 shows 10,999 studies identified from databases and removed before screening duplicates, leaving 599 studies for the title and abstract screening. The study sought for retrieval was 17 after excluding irrelevant titles and abstracts. Nine studies were assessed for eligibility, leaving five included in the review after screening from study methods, participants, accessibility, and study discussion.

Sections	Items	(Kim & Yu, 2021)	(Weenink et al., 2022)	(Yoon & Lee, 2022)	(van Baarle et al., 2022a)	(Tasker et al., 2023)
Title and abstract	1a	Y	Y	Y	Y	Y
	1b	Y	Y	Y	Y	Y
Introduction	2	Y	Y	Y	Y	Y
	3	Y	Y	Y	Y	Y
Methods	4	Y	Y	Y	Y	Y
	5	N	Y	Y	N	Y
Participants	6a	Y	Y	Y	Y	Y
	6b	Y	N	Y	N	Y
Variables	7	Y	Y	Y	Y	Y
Measurement	8	Y	Y	Y	Y	Y
Bias	9	N	CD	CD	N	CD
Study size	10	Y	Y	Y	Y	Y
Quantitative variables	11	Y	Y	Y	Y	Y
Statistical methods	12a	Y	Y	Y	Y	Y
	12b	Y	Y	Y	Y	Y
	12c	CD	CD	CD	CD	CD
	12d	Y	Y	Y	Y	Y
	12e	CD	CD	Y	CD	CD
Results	13a	Y	Y	Y	Y	Y
	13b	Y	Y	Y	Y	Y
	13c	N	N	N	N	N
	14a	Y	Y	Y	Y	Y
	14b	Y	Y	Y	Y	Y
	14c	CD	CD	CD	CD	CD
	15	Y	Y	Y	Y	Y
	16a	CD	CD	CD	CD	CD
	16b	Y	Y	Y	Y	Y
	16c	CD	CD	N	N	N
17	N	N	N	N	N	
Discussion	18	Y	Y	Y	Y	Y
	19	Y	Y	Y	Y	Y
	20	Y	Y	Y	Y	Y
	21	N	N	N	N	N
Other information	22	Y	Y	Y	N	Y

Table 2. Study quality assessment

Note: Y (yes); N (no); CD (cannot determine)

### Study characteristics

Table 3 presents a comprehensive breakdown of the included studies, encompassing details such as authorship, publication year, research methodologies, participants, intervention used, and observed outcomes. The five incorporated studies, spanning the publication period from 2019 to 2023. The employed research methodologies predominantly follow a qualitative approach, characterized by the utilization of data collection methods such as interviews, focus groups, and observational techniques (Tasker et al., 2023; van Baarle et al., 2022b; Weenink et al., 2022) and a quantitative study using a cross-sectional approach (Kim & Yu, 2021; Yoon & Lee, 2022). The participants in the included studies are hospital nurses (Kim & Yu, 2021; Yoon & Lee, 2022), healthcare providers (Tasker et al., 2023; Weenink et al., 2022), and healthcare organizations (van Baarle et al., 2022b).

Author, year	Methods	Participants	Intervention	Outcomes
(Kim & Yu, 2021)	Cross-sectional study	189 hospital nurses	<ol style="list-style-type: none"> <li>1. The Korean Just Culture Assessment Tool (K-JCAT)</li> <li>2. The Psychological Empowerment Scale developed by Spritzer</li> <li>3. The 40-item instrument covers the nurse's following patient safety duties.</li> </ol>	<p>Fostering a just culture within healthcare involves several key components as highlighted in the study. Firstly, nurses working in general hospitals should actively seek to expand their understanding of what constitutes a fair culture. This foundational knowledge is essential for nurturing a just culture that promotes patient safety and equitable treatment.</p> <p>Secondly, empowerment plays a pivotal role in this endeavor. Empowering nurses results in positive shifts in their attitudes and behaviors, ultimately leading to improved decision-making abilities and a higher standard of nursing care provided to patients. Empowerment emerges as a critical element in the cultivation of a just culture.</p> <p>Furthermore, the study emphasizes the importance of empowering staff nurses, not just managerial figures. This finding suggests that a bottom-up approach, where front-line staff actively engage with and advocate for just culture principles, can be highly effective in fostering a culture of fairness and accountability.</p> <p>In addition, creating a just culture requires a concerted effort to enhance the organizational climate surrounding patient safety. This includes improving safety reporting systems and subjecting them to rigorous testing and refinement. Such measures contribute significantly to the establishment of a just culture where incidents are reported transparently and without fear of reprisal.</p> <p>Lastly, the study recognizes the vital role played by unit managers, who, due to their diverse nursing practice experiences, possess a profound understanding of just culture and empowerment. Their awareness and sense of accountability further bolster the cultivation of a just culture within their respective units.</p> <p>In summary, fostering a just culture in healthcare necessitates a multifaceted approach encompassing education, empowerment, and organizational enhancements. These components collectively contribute to the development of a culture characterized by fairness, accountability, and an unwavering commitment to patient safety.</p>
(Weenink et al., 2022)	Qualitative study: interviews and focus groups	61 healthcare providers in two hospitals	<ol style="list-style-type: none"> <li>1. There were interviews to find out how inspectors understand the idea of a just culture and what they think their role is.</li> <li>2. Focus groups were conducted to talk about</li> </ol>	<p>Fostering a just culture within healthcare organizations involves several significant considerations, as highlighted by the respondents in this study.</p> <p>Firstly, the role of regulations is a key factor in promoting a just culture. Respondents emphasized two critical aspects regarding regulations: the reputation of the regulator and the rigor of its forms and procedures. These regulatory elements can significantly impact</p>

			<p>fostering a just culture and the function of rules in the participating organizations.</p>	<p>the organization's efforts to cultivate a just culture. Therefore, healthcare institutions must carefully consider the influence of regulations in their pursuit of fairness and accountability.</p> <p>Secondly, respondents recognized that a just culture is multi-layered and relational, existing at different levels within the healthcare organization. This perspective underscores the importance of interactions among individuals at various hierarchical levels, both within and outside the organization. These interactions can either support or hinder the establishment of a just culture.</p> <p>Thirdly, within this relational and layered nature of a just culture, two crucial components were identified. The first is the presence of relationships built on mutual trust, which was deemed essential for fostering a just culture. Trust among stakeholders, including healthcare professionals, supervisors, and regulatory bodies, plays a pivotal role in creating an environment where fairness and accountability thrive.</p> <p>Lastly, respondents highlighted the significance of publicity and laws in influencing a just culture within healthcare organizations. The role of regulatory frameworks and their implementation is crucial in shaping the fairness of these organizations. Healthcare institutions must consider how regulations, publicity, and laws impact their efforts to build a more just culture.</p> <p>In conclusion, fostering a just culture in healthcare organizations necessitates a thorough examination of the impact of regulations, the recognition of its multi-layered nature, and the cultivation of trust-based relationships among stakeholders. Additionally, organizations must navigate the complexities of regulatory frameworks and their role in promoting fairness and accountability within the healthcare context.</p>
(Yoon & Lee, 2022)	Cross-sectional study	303 nurses in eight hospitals	<ol style="list-style-type: none"> <li>1. A self-administered questionnaire using HSOPSC</li> <li>2. Just Culture Assessment Tool (JCAT)</li> <li>3. Authentic Leadership Questionnaire (ALQ)</li> <li>4. Safety Attitudes Questionnaire Short Form</li> <li>5. Patient Safety Competency Tool</li> <li>6. Safety Motivation Tool</li> </ol>	<p>Fostering a just culture within healthcare settings encompasses various key findings derived from the study. Firstly, the research unveiled the significant influence of organizational factors, including safety climate, culture, and nurses' knowledge of patient safety, on military nurses' reporting of patient safety events. This intricate web of factors underscores the multifaceted nature of reporting within healthcare organizations.</p> <p>Secondly, the study underscores the pivotal role of organizational efforts in promoting patient safety. It highlights that organizational factors wield greater impact on nurses' reporting of patient safety incidents compared to individual factors. This underscores the necessity for healthcare institutions to prioritize comprehensive organizational initiatives and enhancements to bolster patient safety in hospitals.</p>

			<p>Thirdly, the research explores the relationship between leadership, safety inspiration, and reporting behaviors. Surprisingly, no distinct correlation emerges between these factors and the reporting of patient safety incidents. This suggests the need for further investigation into the intricate dynamics between leadership, inspiration, and the reporting process.</p> <p>Furthermore, the study delves into the reporting patterns of military nurses. It reveals their inclination to report negative outcomes, no-harm incidents, and adverse events more frequently than near misses. These patterns shed light on the reporting behaviors and priorities of healthcare professionals.</p> <p>Additionally, the research illuminates the interconnection between the safety climate and a just culture within healthcare organizations. This linkage emphasizes the significance of fostering a positive safety climate as a means to support and nurture a just culture.</p> <p>Moreover, the study brings to the forefront the indirect influence of a just culture on the reporting of patient safety events through the safety climate. This underscores the far-reaching impact of cultivating a just culture on the broader organizational safety climate and reporting culture.</p> <p>Lastly, the study observes that the actual leadership of nursing managers does not result in substantial alterations in the safety culture or the reporting of patient safety events. This surprising finding calls for a more in-depth examination of the role of leadership in shaping reporting behaviors within healthcare organizations.</p> <p>In summary, fostering a just culture in healthcare settings necessitates a comprehensive understanding of the intricate interplay between organizational and individual factors, the impact of leadership, and the intricate patterns of reporting behavior. These insights can serve as valuable guidance for healthcare institutions in their endeavors to create a culture that champions fairness, accountability, and continuous improvement in patient safety.</p>
(van Baarle et al., 2022a)	Qualitative study: interviews and focus groups	Five healthcare organizations	<ol style="list-style-type: none"> <li>1. Data was gathered through stakeholder interviews, focus groups, and observation of project group meetings within the organizations.</li> <li>2. Participation in a pilot project to develop a more</li> </ol> <p>Fostering a just culture within healthcare settings, as highlighted by the participants in the study, encompasses addressing several critical facets. Firstly, the participants stressed the utmost importance of open communication in the establishment of a just culture. This necessitates that healthcare organizations prioritize transparent and accessible communication channels, allowing employees to express concerns and report incidents without the fear of facing repercussions.</p> <p>Secondly, there is a call for management to proactively consider the well-being of their employees, particularly in the aftermath of disasters</p>

		<p>just culture was requested of organizations.</p> <p>3. The participating healthcare organizations were asked to select an activity, theme, or topic that best suited their needs.</p>	<p>or incidents. Recognizing the potential emotional and psychological impact on staff and providing adequate support and resources becomes imperative for employee welfare.</p> <p>Thirdly, participants acknowledged the challenges associated with close management relationships, highlighting the difficulty in objectively addressing behavior when management has a strong connection with workers and team dynamics. Striking a balance between effective leadership and maintaining impartiality emerges as a complex task in fostering a just culture.</p> <p>Fourthly, navigating privacy rules designed to safeguard individual employees sometimes impedes open communication. Healthcare organizations must skillfully navigate these regulations to promote transparency while respecting privacy concerns.</p> <p>Furthermore, concerns were raised about the openness of individuals in authoritative positions, both internally and externally. This underscores the need for leadership and regulatory bodies to demonstrate unwavering commitment to transparency and equity when addressing incidents.</p> <p>Additionally, privacy procedures intended to protect individuals can occasionally obstruct open communication among team members. Healthcare organizations must devise strategies that strike a balance between safeguarding privacy and facilitating the sharing of information pertaining to patient safety and learning.</p> <p>Lastly, the participants emphasized the need to move away from the blame-focused approach often sought by the external world or top-level management. Instead, fostering a just culture demands a shift towards systemic improvements and a dedication to learning from incidents.</p> <p>In summary, fostering a just culture in healthcare organizations necessitates overcoming challenges related to open communication, employee well-being, management relationships, privacy regulations, authority transparency, privacy procedures, and the avoidance of a blame-centric mentality. These challenges underscore the intricacies of cultivating a culture that places a premium on fairness, accountability, and continuous enhancement in patient safety.</p>
(Tasker et al., 2023)	Qualitative study: interviews and observation	<p>There are five medical students, two managers, and thirteen doctors of all levels. Five meetings were</p>	<ol style="list-style-type: none"> <li>1. Clinicians and managers participated in twenty semi-structured interviews.</li> <li>2. Ms Teams was used to conduct and record one-on-</li> </ol> <p>Fostering a just culture within healthcare organizations encompasses addressing several critical points, as identified in the study. Firstly, enhancing communication through face-to-face meetings emerges as a powerful means to promote a just culture. These meetings not only facilitate the implementation of organizational changes but also</p>

observed to review clinical incidents and mortality.	one interviews that lasted 21 to 75 minutes.	<p>mitigate negative perceptions among staff, fostering familiarity with the investigation process and bolstering their confidence.</p> <p>Secondly, trust is recognized as a cornerstone in promoting a fair approach to handling incidents. Staff members interviewed during the study expressed positive sentiments regarding the attributes associated with a "Just Culture." Building and sustaining trust within the organization constitute essential elements in nurturing such a culture.</p> <p>Thirdly, the study highlights the importance of establishing an incident investigation unit. This unit could provide briefings on handling incidents during Trust orientations, enhancing individuals' comprehension of the trust's operations. Additionally, offering face-to-face feedback post-investigations plays a pivotal role in the effective implementation of investigation results.</p> <p>Fourthly, addressing certain barriers is crucial in promoting a just culture. These barriers encompass divergent definitions of "Just Culture," varying levels of awareness, and the absence of formal training for trust investigators. Such discrepancies can lead to disparities in how staff involved in clinical incidents are treated. Overcoming these challenges requires a shared understanding of a just culture and investments in training to ensure consistent practices.</p> <p>In summary, the promotion of a just culture in healthcare organizations necessitates measures such as improved communication through face-to-face meetings, the cultivation of trust, the establishment of specialized incident investigation units, and the proactive addressing of barriers related to definitions, awareness, and training. These concerted efforts contribute to the creation of an organizational culture that prioritizes fairness, accountability, and continuous enhancement in patient safety.</p>
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Table 3. Included study characteristics extraction

Fostering a just culture is essential in healthcare, as patient safety is paramount. Despite ongoing efforts, patient safety remains a contentious issue globally, primarily due to errors made by healthcare professionals. A "just culture" is crucial for employees' psychological well-being when dealing with safety incidents, emphasizing equitable treatment and a focus on system and behavior improvements. This concept, originating from early patient safety culture studies, prioritizes responsible culture development over error fixation. It has applications in safety-conscious industries like aviation, mining, and healthcare (Kim & Yu, 2021; Yoon & Lee, 2022). The prevailing belief is that embracing a just culture can significantly contribute to elevating healthcare standards and enhancing safety. However, defining and operationalizing the concept of a just culture presents challenges, with diverse interpretations and conceptualizations evident in both scholarly literature and medical practice (Weenink et al., 2022). Evaluating employees' perceptions of a just culture is a critical undertaking. This assessment should occur both before and after the implementation of just cultural concepts and procedures to track changes over time. The adoption of the Just Culture Assessment Instrument (JCAT) has gained significant traction, particularly in the field of nursing education, where it serves as a valuable tool for evaluating organizational culture. JCAT comprehensively assesses various dimensions, including effective communication, receptiveness to feedback, the reporting of medical errors, personal accountability, and overall trust in the healthcare system. Notably, JCAT exhibits robust psychometric properties, rendering it instrumental for academic and healthcare institutions in pinpointing areas for improvement and directing resources toward enhancing patient safety (Kim & Yu, 2021; Yoon & Lee, 2022).

The key findings of this systematic review shed light on the multifaceted nature of fostering a just culture within healthcare organizations. This endeavor involves understanding foundational principles, expanding knowledge, and empowering healthcare professionals to bring about positive shifts in attitudes and behaviors. Patient safety takes center stage in healthcare, given the significant impact of adverse outcomes resulting from inadequate care. Despite years of efforts, patient safety remains a contentious issue, primarily due to errors made by healthcare professionals. Understanding and implementing the concept of a "just culture" is essential for the psychological well-being of employees dealing with patient safety incidents. This concept emphasizes equitable treatment, striking a balance between organizational structure and individual accountability. The findings are categorized into five themes: awareness and empowerment, organizational factors, leadership, communication, and the role of a just culture in patient safety. Each theme provides valuable insights into the complex interplay of factors that influence the cultivation of a just culture in healthcare settings.

### **Awareness and empowerment**

The key aspects of awareness and empowerment play a central role in the endeavor to strengthen the cultivation of a just culture within healthcare organizations. This multifaceted approach involves several critical components. First, increasing awareness of the foundational principles that underlie a just culture is foundational. It is essential for healthcare professionals, particularly nurses, to have a deep understanding of the core tenets of a just culture within the context of healthcare settings. This awareness forms the basis for building a culture that prioritizes patient safety and equitable treatment. Second, empowering healthcare professionals is another pivotal component. It goes beyond mere awareness and entails progressively enabling nurses to effectively carry out their responsibilities in ensuring patient safety. Empowered healthcare workers have the confidence and autonomy to make informed decisions and take actions that enhance patient safety.

The study provides robust evidence of the positive correlations between these components and the concept of a just culture. When healthcare professionals perceive a just culture and feel empowered, they exhibit enhanced performance in patient safety tasks. This empowerment leads to distinct attitudes and behaviors that positively impact clinical decision-making and, consequently, elevate the

overall quality of nursing care provided to patients. Furthermore, it's essential to note that organizational factors, including safety climate, organizational culture, and healthcare professionals' knowledge of patient safety, play a significant role in shaping these elements. These factors directly and indirectly influence the reporting of patient safety events by healthcare professionals, particularly military nurses, as emphasized in recent research. In essence, creating awareness and fostering empowerment are fundamental steps in building a just culture that prioritizes patient safety and quality care within healthcare organizations (Kim & Yu, 2021; Tasker et al., 2023; Yoon & Lee, 2022).

### **Organizational factors**

The promotion of a just culture within healthcare settings is profoundly influenced by various organizational factors, which are pivotal in shaping the overall patient safety environment. These organizational factors encompass; first, a robust safety climate within healthcare organizations is a cornerstone in fostering a just culture. It refers to the prevailing attitudes, beliefs, and values related to safety and patient care. An organization with a positive safety climate encourages healthcare professionals to prioritize safety and report safety events without fear of reprisal. This aspect directly influences the reporting of patient safety events by nurses. Second, transparency is another critical organizational factor. Creating a culture of transparency involves being open about safety incidents, acknowledging errors, and facilitating candid discussions about how to prevent recurrences. However, achieving transparency can be challenging due to tight timelines for investigating and reporting sentinel events, leaving limited room for thoughtful reflection. Third, regulatory bodies play a significant role in influencing a just culture within healthcare organizations. The reputation and rigor of procedures followed by these regulatory bodies can impact how healthcare institutions approach patient safety. Organizations need to carefully consider how they interact with regulatory bodies, as these interactions can affect the fairness and accountability of healthcare practices.

The study findings emphasize the substantial impact of these organizational factors on the reporting of patient safety events by nurses. It's noteworthy that these organizational factors often have a more substantial influence than individual factors. Additionally, the study highlights the role of a safety atmosphere and safety climate within healthcare organizations. These factors not only affect how nurses report patient safety events but also influence their safety-related behaviors (Weenink et al., 2022). Furthermore, the research underscores the indirect influence of a just culture on the reporting of patient safety events, with this influence being mediated through its effects on the safety climate. In summary, organizational factors are critical in shaping the patient safety culture within healthcare organizations, impacting the reporting of safety events and influencing overall safety-related behaviors among healthcare professionals. These insights underscore the need for healthcare institutions to prioritize creating a robust safety atmosphere and embracing the principles of a just culture to enhance patient safety practices and promote transparent reporting of safety events (Yoon & Lee, 2022).

### **Leadership**

Leadership plays a pivotal role in nurturing a just culture within organizations, particularly in healthcare settings. This multifaceted role encompasses various management positions, including team leaders, medical directors, department heads, and more. The study highlights several key aspects of leadership's influence on fostering a just culture; first, open Communication: Managers are responsible for fostering open communication within their departments. They achieve this by facilitating discussions, encouraging intervision (collaboration and mutual learning among peers), and providing opportunities for constructive feedback. Effective communication is crucial for building trust and ensuring that safety concerns and incidents are reported transparently. Second, unit managers stand out due to their high self-confidence and profound awareness of their responsibilities

toward patients. They are perceived to possess a robust understanding of just culture and empowerment, often drawing from their extensive nursing practice backgrounds. Their effectiveness in promoting a culture of transparent and constructive communication is particularly noteworthy. Third, competence in leadership roles is essential to the success of these efforts. Competent managers can effectively implement strategies that promote a just culture, facilitate open communication, and ensure that safety concerns are addressed appropriately.

The role of management is paramount in fostering a just culture within an organization, spanning various positions such as team leaders, medical directors, department heads, and more (van Baarle et al., 2022b). Managers assume the responsibility of nurturing open communication within their respective departments by facilitating discussions, promoting intervision, and providing avenues for constructive feedback. Interestingly, unit managers, due to their high self-confidence and profound awareness of their responsibilities toward patients, are perceived to possess a robust understanding of just culture and empowerment, often drawing from their extensive nursing practice backgrounds (Kim & Yu, 2021). Their effectiveness in these roles significantly contributes to the establishment of a culture that places a premium on transparent and constructive communication. Competent management is essential in this context, ensuring that these efforts are successful (Yoon & Lee, 2022). However, it's worth noting that while genuine leadership and safety motivation would be expected to have a substantial impact on patient safety event reporting, this study did not find a direct influence of nursing managers' sincere leadership on patient safety incident reporting or the safety climate within the organization.

## **Communication**

The importance of open communication in fostering a just culture within healthcare organizations cannot be overstated. Open communication promotes an environment where individuals refrain from making hasty judgments, welcome diverse perspectives, and collaborate to explore structural and cultural issues without resorting to assigning blame to specific individuals. Striking a balance between accountability and responsibility, without unfairly targeting individuals, is a key principle in this context. Furthermore, privacy protection protocols, while crucial for safeguarding individuals, can sometimes hinder collaborative teamwork by impeding the free flow of information. There is often a desire at higher organizational levels or from external stakeholders to identify a "culprit" when incidents occur, which can run counter to the learning process's objectives. It's essential to recognize that incidents trigger reactions at various levels, both internally and externally, and that open communication can have wide-reaching implications beyond the immediate context. Given that healthcare professionals work in emotionally charged environments, the study underscores the need to address the emotional impact of incidents on colleagues within the organization. This includes instances of boundary transgressions and the potential for emotional repercussions to affect individuals and teams. Emotions are intricately linked with the immediate consequences of incidents and how the internal environment, including the media and regulatory bodies, responds. Balancing these emotional aspects is paramount in creating and sustaining a just culture within healthcare organizations (van Baarle et al., 2022b).

This review provides a comprehensive summary of five studies on the concept of a Just Culture and its associated challenges. It underscores the potential benefits of a Just Culture in improving patient safety while also highlighting the complexities it presents to healthcare organizations. A Just Culture approach promotes shared accountability between management and staff, categorizes actions into human error, reckless behavior, and at-risk conduct, and encourages transparent error reporting, maintaining a delicate balance between fostering a blame-free environment and addressing punitive measures (Forster et al., 2019; Gaur et al., 2022; Murray et al., 2022; Rogers et al., 2017). Healthcare organizations are urged to develop strategies aimed at enhancing their Just Culture, increasing error

and near-miss reporting, and expanding learning opportunities. These efforts are essential for advancing patient safety (Barkell & Snyder, 2021).

Leaders within a Just Culture framework should acknowledge that staff will inevitably make mistakes, including human error, and the challenge lies in addressing at-risk behaviors. Providing mentoring and opportunities for behavior change can be effective, although their impact may be limited if staff members are unresponsive to coaching or corrections (Rogers et al., 2017). Dealing with reckless behavior among management should involve the imposition of penalties on those responsible, as this course of action is necessary when individuals knowingly put the organization, its clients, or its employees at risk. Demonstrating a willingness to take such action is crucial in assuring all staff members that risky behavior will be addressed, regardless of their role (Forster et al., 2019). Prioritizing employee safety yields broad benefits, positively impacting patient safety and overall organizational performance. This commitment arises from leaders' dedication to the physical and mental well-being of employees, fostering trust in investigations involving patients or staff.

The establishment of a Just Culture can be challenging, especially under performance pressure, which often leads to a swift assignment of blame. However, maintaining open communication and facilitating discussions about incidents and their root causes remain vital for all team members. Cultivating a Just Culture is a collective endeavor that involves every manager and employee. Managers can set an example by expressing appreciation for staff contributions, promoting care and productivity improvements, and encouraging the adoption of a Just Culture. Establishing an environment where employees exchange ideas and solutions further enhances the workplace. Seeking staff input reduces stress levels and empowers them. Ultimately, the commitment of managers and leaders at all organizational levels is vital to foster a Just Culture (Barkell & Snyder, 2021; Duffy, 2017).

In a culture characterized by trust and justice, adverse events serve as significant opportunities to understand underlying factors and acquire valuable insights, rather than resorting to immediate blame assignment. Numerous healthcare organizations are undergoing a fundamental shift away from a culture of blame, signifying a paradigm change. A just culture effectively harmonizes individual and systemic accountability while promoting a shared sense of fairness among individuals who report adverse incidents (Barkell & Snyder, 2021; Murray et al., 2022).

In a "just culture," staff must feel safe and empowered to report medical errors, focusing on learning, behavior management, and secure systems to prevent recurrence. Leaders play a vital role in promoting this culture by being accessible and setting strong examples for patient safety. Accountability is universal in organizations embracing a "just culture," transcending roles, with every team member responsible for situational awareness and addressing patient safety concerns. Integrating this concept into daily operations enforces staff accountability, often through annual performance reviews (Murray et al., 2022). As an organization strives to establish patient-centered services, implementing realistic standards, imparting safety principles, and fostering workplace accountability will collectively contribute to the promotion of a just culture (Rogers et al., 2017).

Significantly, this comprehensive study revealed the absence of any published research examining the connection between a just culture and patient safety results. The limited empirical focus on Just Culture and its benefits may be a contributing factor to the lack of advancements in healthcare safety. Consequently, future research should investigate Just Culture, its implementation, and its impact on patient outcomes.

## **LIMITATION OF THE STUDY**

In the course of conducting our systematic review, we have rigorously addressed and endeavored to minimize potential sources of bias. Nevertheless, it is essential to candidly acknowledge certain inherent limitations that pertain to our study. It is conceivable that our study may be subject to publication bias, a phenomenon wherein studies with statistically significant or positive results tend to have a higher likelihood of being published. This could potentially lead to an overrepresentation of such studies within our review. In our effort to mitigate this bias, we conducted a thorough and extensive search across multiple databases. Importantly, we adopted an inclusive approach, encompassing studies irrespective of their publication status. Despite these comprehensive measures, the possibility remains that certain pertinent studies may have eluded our scrutiny.

These limitations notwithstanding, our systematic review stands as a valuable contribution to the discourse surrounding the concept of a just culture within healthcare organizations. By delving into the core elements of this concept, its determinants, and the attendant challenges, our findings offer substantive insights. We posit that the insights proffered in this review serve to enhance our collective comprehension of how healthcare organizations can effectively champion patient safety through the cultivation and implementation of a just culture.

## **CONCLUSIONS AND SUGGESTIONS**

This research underscores the critical importance of a "just culture" in healthcare organizations for promoting patient safety and addressing recurring safety errors. It emphasizes the need for equitable treatment of employees, balancing organizational structures and individual responsibility. The study highlights key factors in fostering a just culture, including awareness, empowerment, organizational elements, leadership, and communication. Effective leadership and open communication are pivotal in fostering a "just culture" where staff members feel safe to report incidents. The challenges faced include privacy-protecting policies that may hinder open communication and trust factors, as emotional consequences can arise from safety incidents. Future research in this area should explore the impact of a just culture on patient outcomes and delve deeper into the complexities of its implementation within healthcare organizations. Understanding the interplay between a just culture and patient safety outcomes is crucial for advancing healthcare standards and safety. In conclusion, embracing and fostering a just culture is paramount for healthcare organizations to enhance patient safety, improve healthcare quality, and promote a culture of fairness, accountability, and continuous learning in the pursuit of better healthcare practices and patient well-being.

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