

Promoting Just Culture for Enhancing Hospital-Acquired Infections Prevention and Control



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Promoting a culture of safety within hospitals has become an essential pillar of the patient safety. Provision of healthcare is dynamic with an unpredictable nature which may cause health practitioners to unintentionally harm the individuals they are trying to help through inappropriate practices. Health care-associated infections (HAIs) can occur in healthcare depending on different factors associated with the patient conditions. They are considered among the most frequently adverse events during healthcare delivery as they can lead to increased morbidity, mortality, length of hospitalization and costs.^{1,2} WHO estimates that, at any given time, about 7 in 100 patients in developed countries and 10 in 100 patients in developing countries acquire an infection while receiving hospital care.³ Large proportion of HAIs can be prevented through effective Infection Prevention and Control (IPC) measures.

Literature shows that certain HAIs can be reduced by up to 70 percent by staff compliance with proper implementation of effective infection control measures.⁴ Since the care in healthcare settings is provided by humans,

some staff may unintentionally make errors. Approaches that focus on the “system” that led to the errors rather than on the “individuals” can make a great difference in terms of reducing HAI’s rates. Moving away from the culture of individual blame to clearly identify the root causes of errors is dependent on an effective IPC program in place that incorporates error analysis in its roles. Effective IPC program should conduct continuous monitoring and evaluation of the staff compliance with IPC measures and provide critical analysis to prevent future errors and ensure involvement of staff along with effective feedback. The IPC program should adapt the “just culture” approach that states person or persons should not be held responsible for the organizational errors over which they have no control.

A culture of individual blame is usually associated with fear and anxiety along with influencing the behavior to turn into defensive practices. This culture makes people less likely to share errors and minimize the level to which they are exposed.⁵ Balancing between patient safety and non-punitive culture is also required. Just culture, as non-punitive, doesn’t tolerate conscious non-compliance with infection prevention measures and does not declare the staff of responsibility for the error or risk that they can put the patient in, i.e. a staff member who intentionally ignored a policy mandating an aseptic technique of a procedure. The IPC programs in hospitals should analyze the behaviors of staff involved in safety risks and recognize their contribution to the overall cumulative risks.

An effectively functioning IPC program considering culture of safety is crucial in reducing HAIs and improving patient safety as the literature has suggested. By implementing a system approach to the patient safety issues to reduce HAI’s, the negligence of safe practices could be aligned to foster a non-punitive culture and enhance a collective accountability.^{6,7}

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