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### Discussion: Workplace Culture

I have also encountered a culture in which patient safety is actively promoted at Novant New Hanover Regional Medical Center, as opposed to blame. An electronic reporting system is available in my unit through which staff members report near misses and adverse events. Leadership touches on safety issues in daily or weekly huddles, and trends are analyzed in a positive way. When incidents are addressed, the attention is on finding weaknesses in processes rather than attributing personal blame. Such a practice supports the values of a just culture, where learning and system enhancement are more valued than punishment (White and Delacroix 9). My belief in the system has been boosted by observing how managers react calmly and respectfully to reported events. It conveys that reporting is considered a professional responsibility that facilitates safe care delivery. A just culture also differentiates between human error, at-risk behavior, and reckless behavior, ensuring that the staff members are treated fairly while still being held accountable. Such a balance between responsibility and encouragement is critical in establishing long-term trust in a healthcare team.

I did experience some hesitation with regard to filling in incident reports earlier in practice. What I feared was not punishment, but the fact that I might be evaluated by fellow employees or managers. Studies indicate that nurses usually avoid reporting errors due to the fear of blame, embarrassment, or adverse leadership response (Yousef et al. 2). That was my experience during the early days. At times, I questioned whether reporting would reflect poorly

on my competence. However, after I submitted a report regarding a near miss with medication timing, I observed how leadership handled it. The discussion focused on improving workflow and clarifying communication expectations. No one was singled out. That experience changed my perception. I started to realize that reporting enhances patient protection and encourages collective responsibility in the team.

Healthcare organizations can also minimize the stigma of incident reporting by strengthening the ability to report anonymously and offering meaningful feedback regularly after incident reports are examined. Trust is boosted when the nurses realize that their contributions cause actual policy or workflow alterations (Murray et al. 1596). Positive behaviors can also be supported by recognition of staff contributions to safety initiatives. Maintaining a just culture requires consistent leadership support and psychological safety. It means leaders must demonstrate fairness in both words and actions. At Novant, continued transparency, education, and supportive dialogue can strengthen the culture. How can leaders ensure that new nurses immediately feel safe speaking up without hesitation?

Works Cited

- Murray, John S., et al. "Implementing Just Culture to Improve Patient Safety." *Military Medicine*, vol. 188, nos. 7–8, 2023, pp. 1596–99.
- White, Robin M., and Romuald Delacroix. "Second Victim Phenomenon: Is 'Just Culture' a Reality? An Integrative Review." *Applied Nursing Research*, vol. 56, Dec. 2020, p. 151319. *ScienceDirect*, <https://doi.org/10.1016/j.apnr.2020.151319>.
- Yousef, Alaa, et al. "Medication Administration Errors: Causes and Reporting Behaviours from Nurses Perspectives." *International Journal of Clinical Practice*, vol. 75, no. 10, Oct. 2021, <https://doi.org/10.1111/ijcp.14541>.