Using Just Culture to Improve Hospital Survey on Patient Safety Culture Results

Webcast

November 9, 2016
1:00-2:00 ET
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Today’s Speakers

Celeste Mayer, PhD
University of North Carolina Health Care System, Chapel Hill, NC

Theresa Famolaro, MPS, MS, MBA
Westat, Rockville, MD
Using the Webcast Console and Submitting Questions

Click on the “Q&A” icon to get the Q & A window to appear.

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Accessing Presentation

Surveys on Patient Safety Culture

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Click on the “Download Slides” icon for a PDF of the slides
Accessing Resources

To access the event materials and resources, click on the “Resources” icon.
What is Patient Safety Culture?

The way we do things around here.

Exists at multiple levels:

- **System**
- **Organization**
- **Department**
- **Unit**

Beliefs, values & norms

Shared by staff

What is:
- Rewarded
- Supported
- Expected
What is Just Culture?

“An atmosphere of trust in which those who provide essential safety-related information are encouraged and even rewarded, but in which people are clear about where the line is drawn between acceptable and unacceptable behavior” (Reason, 1997)

Just Culture is an Accountable Culture
(Outcome Engenuity)

System issues

Human behavior

Levels of accountability
- System
- Management
- Staff
- Providers
Hospital Survey on Patient Safety Culture

- 42 items assess 12 dimensions of patient safety culture
  - 1. Communication openness
  - 2. Feedback & communication about error
  - 3. Frequency of event reporting
  - 4. Handoffs & transitions
  - 5. Management support for patient safety
  - 6. Nonpunitive response to error
  - 7. Organizational learning--continuous improvement
  - 8. Overall perceptions of patient safety
  - 9. Staffing
  - 10. Supv/mgr expectations & actions promoting patient safety
  - 11. Teamwork across units
  - 12. Teamwork within units

- Patient safety “grade” (Excellent to Poor)
- Number of events reported in past 12 months
Lowest Performing Composite Results – 2016 AHRQ Comparative Database

<table>
<thead>
<tr>
<th>Patient Safety Culture Composites</th>
<th>% Positive Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Staffing</td>
<td>54%</td>
</tr>
<tr>
<td>11. Handoffs &amp; Transitions</td>
<td>48%</td>
</tr>
<tr>
<td>12. Nonpunitive Response to Error</td>
<td>45%</td>
</tr>
</tbody>
</table>

Opportunity for improvement – lowest scoring composite

Defining Nonpunitive Response to Error

The extent to which staff feel that their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file.
Nonpunitive Response to Error Survey Items

– Staff feel like their mistakes are held against them.
– When an event is reported, it feels like the person is being written up, not the problem.
– Staff worry that mistakes they make are kept in their personnel file.
University of North Carolina Health System

Celeste Mayer, PhD
University of North Carolina Health Care System, Chapel Hill, NC
UNC Medical Center

- Public Academic Medical Center
- Memorial, Children’s, Neurosciences, Women’s and Cancer Hospital
- ~850 beds
- Chapel Hill, NC
My Role

• Patient Safety Officer since 2003

• At UNC since 1988

• Reporting structure
  – Chief of Staff – 2007 - 2014
  – General Counsel – 2014 - present
<table>
<thead>
<tr>
<th>Survey Administration Period</th>
<th>UNC Medical Center Average % Positive</th>
<th>Database Teaching Hospitals Average % Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006 July</td>
<td>36%</td>
<td>41% (2007)</td>
</tr>
<tr>
<td>2008 June</td>
<td>39%</td>
<td>42% (2009)</td>
</tr>
<tr>
<td>2009 December</td>
<td>46%</td>
<td>42% (2011)</td>
</tr>
<tr>
<td>2011 October</td>
<td>48%</td>
<td>41% (2012)</td>
</tr>
<tr>
<td>2013 December</td>
<td>51%</td>
<td>42% (2014)</td>
</tr>
<tr>
<td>2015 October</td>
<td>53%</td>
<td>43% (2016)</td>
</tr>
</tbody>
</table>
North Carolina Just Culture Collaborative 2006/2007

• What it was – Partnership between the NC Quality Center and Outcome Engineering

• How I got involved – saw the opportunity

• Proposed the idea for participation to the Chief of Staff

• 10 NC Hospitals participated in a year-long learning and sharing experience - July 2006 to April 2007
How I pitched this to my boss

- Inexpensive consulting
- We were measuring
- Foundational, next step work
Fortuitous Serendipity
The UNC Collaborative Team

- Patient Safety Officer
- Director for Risk Management
- Attorney from the Legal Department
- Director for Employee Relations
- Human Resources Associate
- Director for Nursing Education
- Two Nurse Managers
- Pediatrician
- Anesthesiologist
The Collaborative

• Prework
  – RCA Event documentation
  – Employee Corrective Action Reports
  – Patient Safety Activity Documentation
  – Policies; Corrective Action, Sentinel Events, Adverse Event Reporting
  – Patient Safety Plan
  – Code of Conduct, Employee Handbook, Medical Staff Bylaws

• In-Person Learning/Sharing – 3 Days

• Monthly conference calls
Creating Change

- Acknowledge the shift
- Many formal communications
- Used visible support from high-profile leaders and organizations
- Education
- Weaving into the fabric of the organization
- Policy Change
Practice into Policy

Two years to change the Corrective Action Policy
Policy into Practice

- Clear expectation for use of the Just Culture Algorithm
- Mandatory training for new managers
- Visibility to all staff
- Requirements for documentation
- Employee Relations involvement
Training

• Manager and all comer training near the end of the collaborative (Feb/March 2007)
• David Marx lead training for leadership and managers (May 2007)
  – Serendipity again – Organizational “Commitment to Caring” kickoff and folding Just Culture into the strategic plan
  – Offered Continuing Nurse Education credit for managers
  – Created a “cascade learning” document for managers to guide the sharing with staff
• And since then Employee Relations leads training for all new managers
  – 1 hour concepts
  – Application practice using a case
• Frontline staff experience Just Culture
Visibility to Staff

• The algorithm – can be found displayed in most managers’ offices
Employee Counseling Session

Employee's name

Employee's Department

Employee/Supervisor Counseling Session Documentation – THIS DOES NOT CONSTITUTE CORRECTIVE ACTION.

Enter date of counseling: ____________________________
Enter date of incident: ____________________________

☐ Unacceptable personal conduct
☐ Unsatisfactory job performance

Please check all that apply:  ☐ Human Error  ☐ At-Risk Behavior  ☐ Reckless Behavior

If you (the supervisor) believe a system problem contributed to the Human Error or At-Risk Behavior, you are obligated to submit a report to the Patient Occurrence Reporting System. If applicable, please initial here to indicate this has occurred. ___
Sustainment Today

- Regular measurement and Focus
- Added 5 additional questions in 2015

1. My supervisor emphasizes learning rather than blame when staff make mistakes.

2. When staff take shortcuts that put patient safety at risk, supervisors or managers work with them to change their behavior.

3. Staff who see other staff doing something unsafe for patient care tell them it is unsafe.

4. Regardless of a person's job position, management applies the same disciplinary policy to everyone working in this hospital, including physicians.

5. When a patient safety event happens, hospital management looks at more than staff actions to determine what led to the event.
What Was and Is Most Important

- Supportive and influential leader
- The perfect learning collaborative opportunity
- Incorporating Just Culture Principles into the Corrective Action policy
- Incorporating Just Culture Principles into Counseling/Corrective action documentation
- Regular measurement and sharing
Updating the Hospital Survey and Nonpunitive Response to Error

• **HSOPS 2.0**
  – Conducting cognitive testing and a pilot study
  – Version 2.0 to be released in early 2018
  – Revising the Nonpunitive Response to Error composite to reflect Just Culture concepts

• **Next HSOPS database submission June 2017**
  – Original 1.0 version
Resources

AHRQ Resources
1. Action Planning Tool
2. Improving Patient Safety in Hospitals: A Resource List for Users of the AHRQ Hospital Survey on Patient Safety Culture
3. 2016 Hospital Comparative Database Report

UNC Resources
1. Corrective Action Policy
2. Corrective Action Report
3. Employee Counseling Report
4. Pre-Disciplinary Conference Notification Letter and Report
To Ask a Question

Click on the “Q&A” icon to get the Q & A window to appear.

To submit a question, type your question here and hit submit.
Thank you!

Additional questions or comments?

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Phone: 1-888-324-9749

Website: www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html