Developing a Reporting Culture

DFWHC Foundation Patient Safety Summit

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Disclosure of Conflicts of Interest

Coleen Smith has no real or apparent conflicts of interest to report.

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Today's Objectives

- Describe the elements of a reporting culture in health care
- Explain objective accountability evaluation/assessment tools and appraise their use at your organization or the potential for their use
- Define close calls and unsafe conditions and discuss the learnings that come from examining data of these event types
- Review action steps for your organization

One Shared Vision

All people always experience the safest, highest quality, best-value health care across all settings

A **high reliability** organization (HRO) is an organization that has succeeded in avoiding catastrophes in an environment where normal accidents can be expected due to risk factors and complexity.

High reliability in healthcare is "maintaining consistently high levels of safety and quality over time and across all health care services and settings"

Chassin & Loeb (2013)

High Reliability Health Care Maturity Model

Commitment to zero harm

Empowering staff to speak up

Systematic, data-driven approach to complex problem solving

Chassin MR, Loeb JM. High-Reliability Health Care: Getting There from Here. *Milb Q* 2013;91(3):459-90

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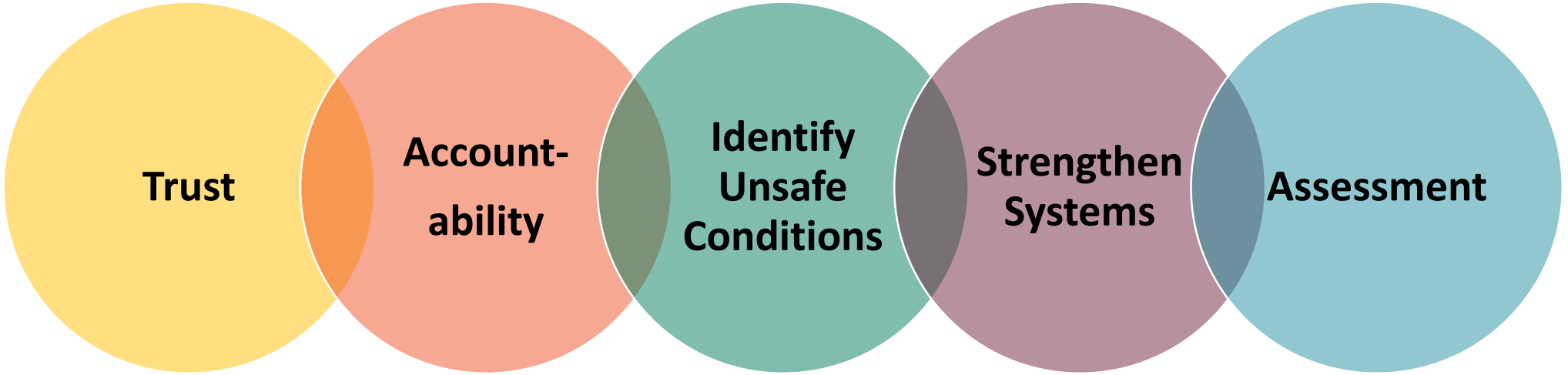
Safety Culture Components



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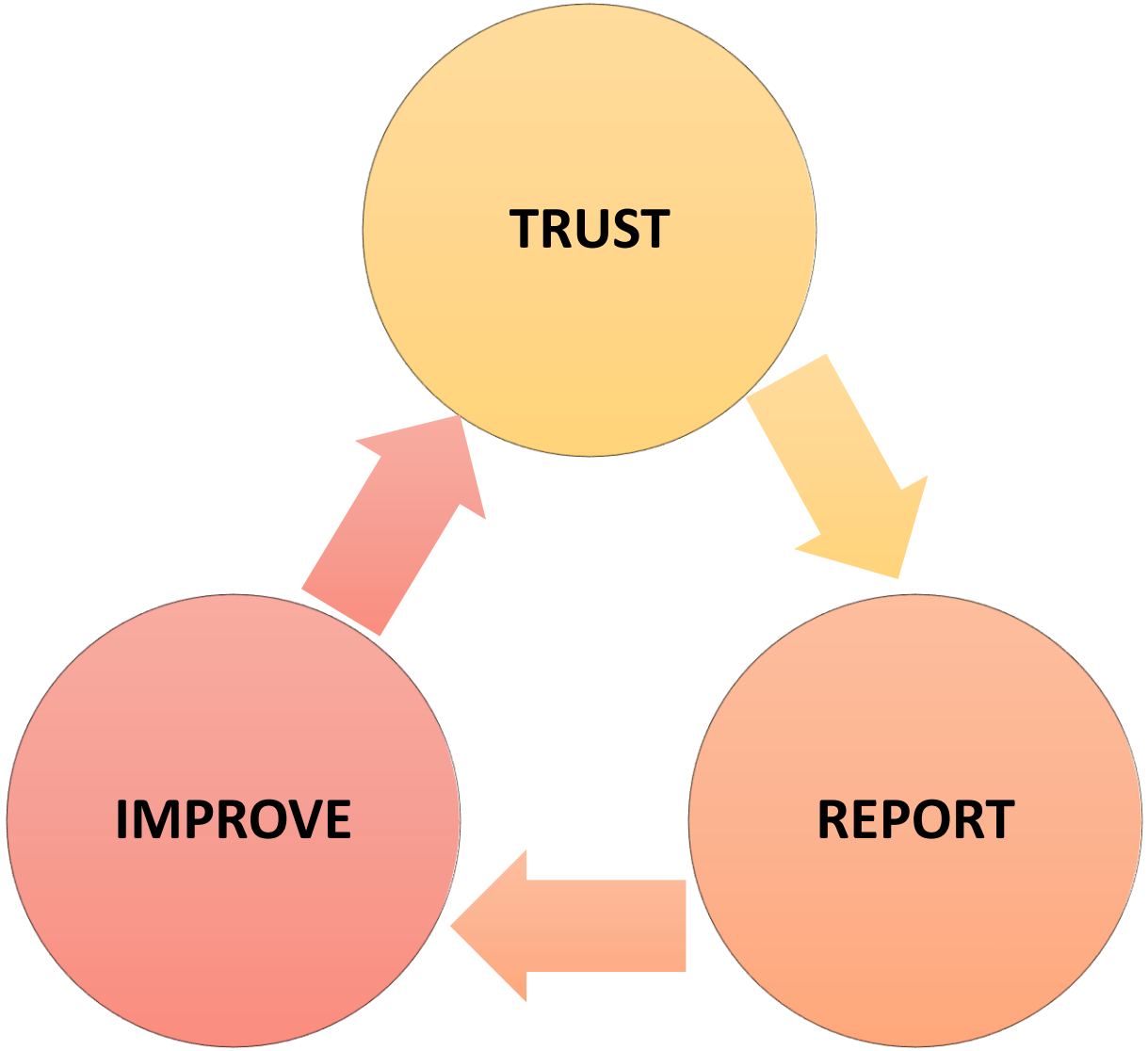
Trust essential to optimal reporting

- Create a psychologically safe environment with no fear of negative consequences for reporting mistakes.
- Create a positive recognition program: “Good Catch” or “Close Call Hero” or similar.
- Create mechanisms that close the feedback loop.

Change progresses at the speed of trust

Frankel A, et al. , 2017, A Framework for Safe, Reliable, and Effective Care



Adapted from Reason J and Hobbs A. Managing Maintenance Error: A Practical Guide. Ashgate. 2003.

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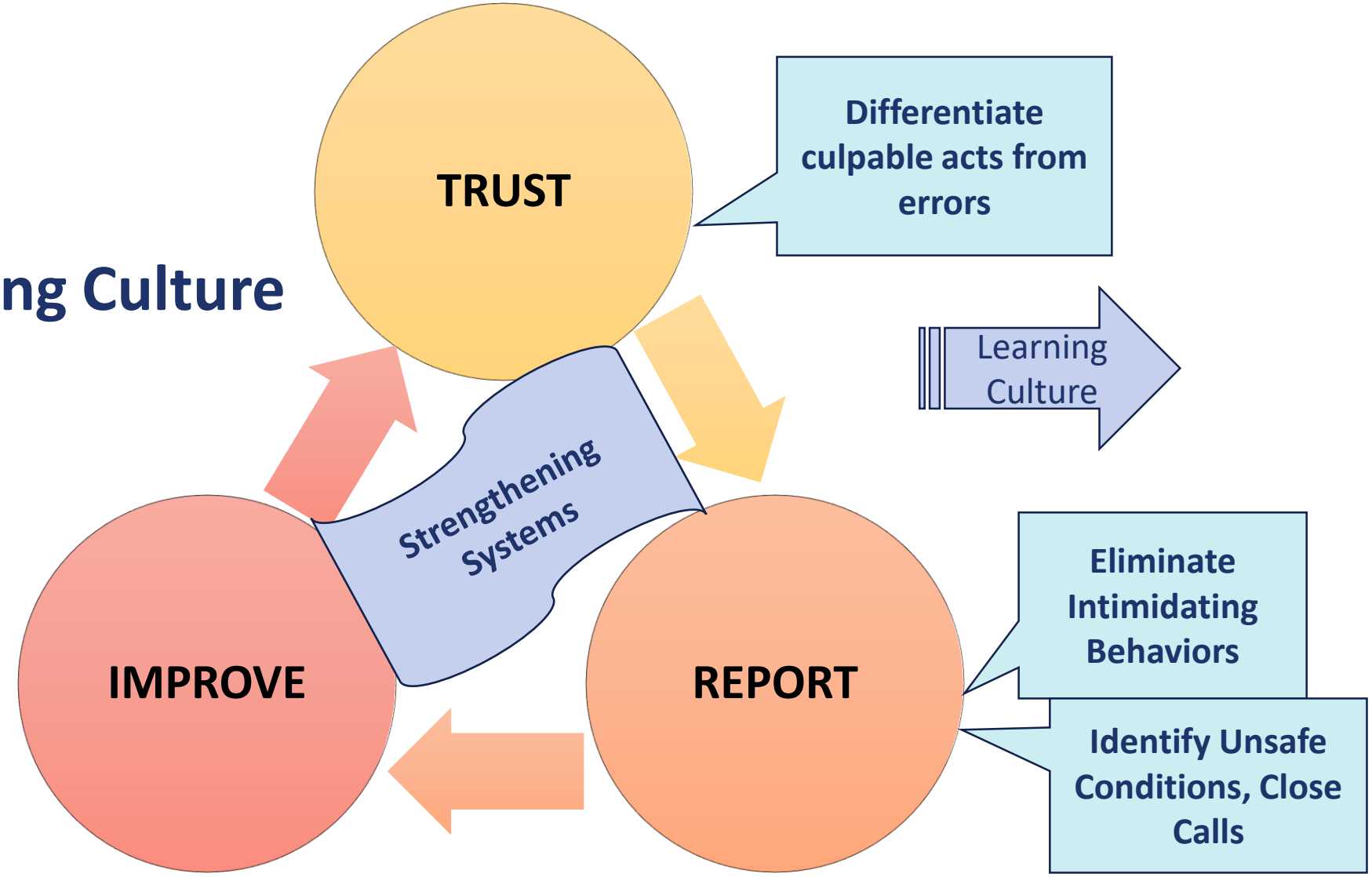
Creating a Learning Culture



Adapted from Reason J and Hobbs A. Managing Maintenance Error: A Practical Guide. Ashgate. 2003.

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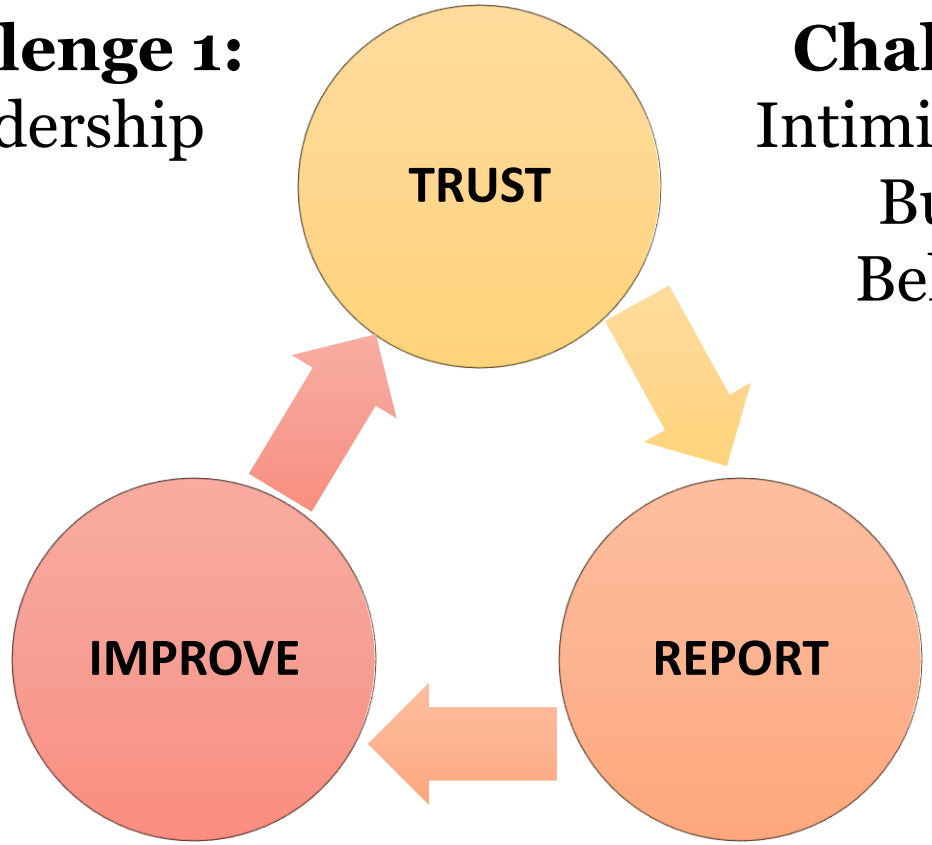
Challenge 1: Leadership

Challenge 2: Intimidating and Bullying Behaviors



Challenge 3: Identifying and Reporting Risks

Challenge 4: Learning from Errors and Sharing with Staff

Adapted from Reason J and Hobbs A. Managing Maintenance Error: A Practical Guide. Ashgate. 2003.

What is stopping reporting?

- Punishing people for making mistakes

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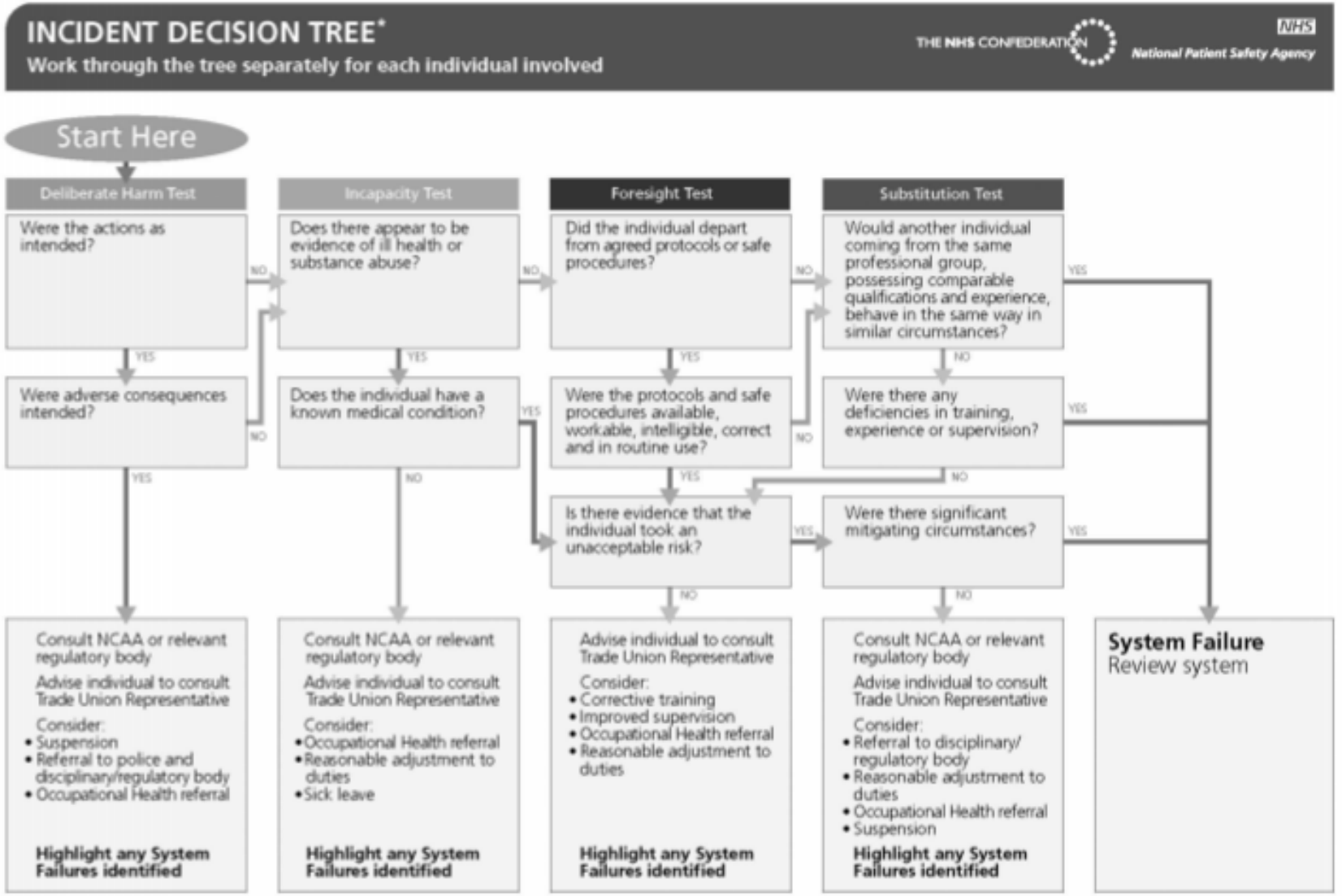
Objective Accountability Evaluation/Assessment Tools

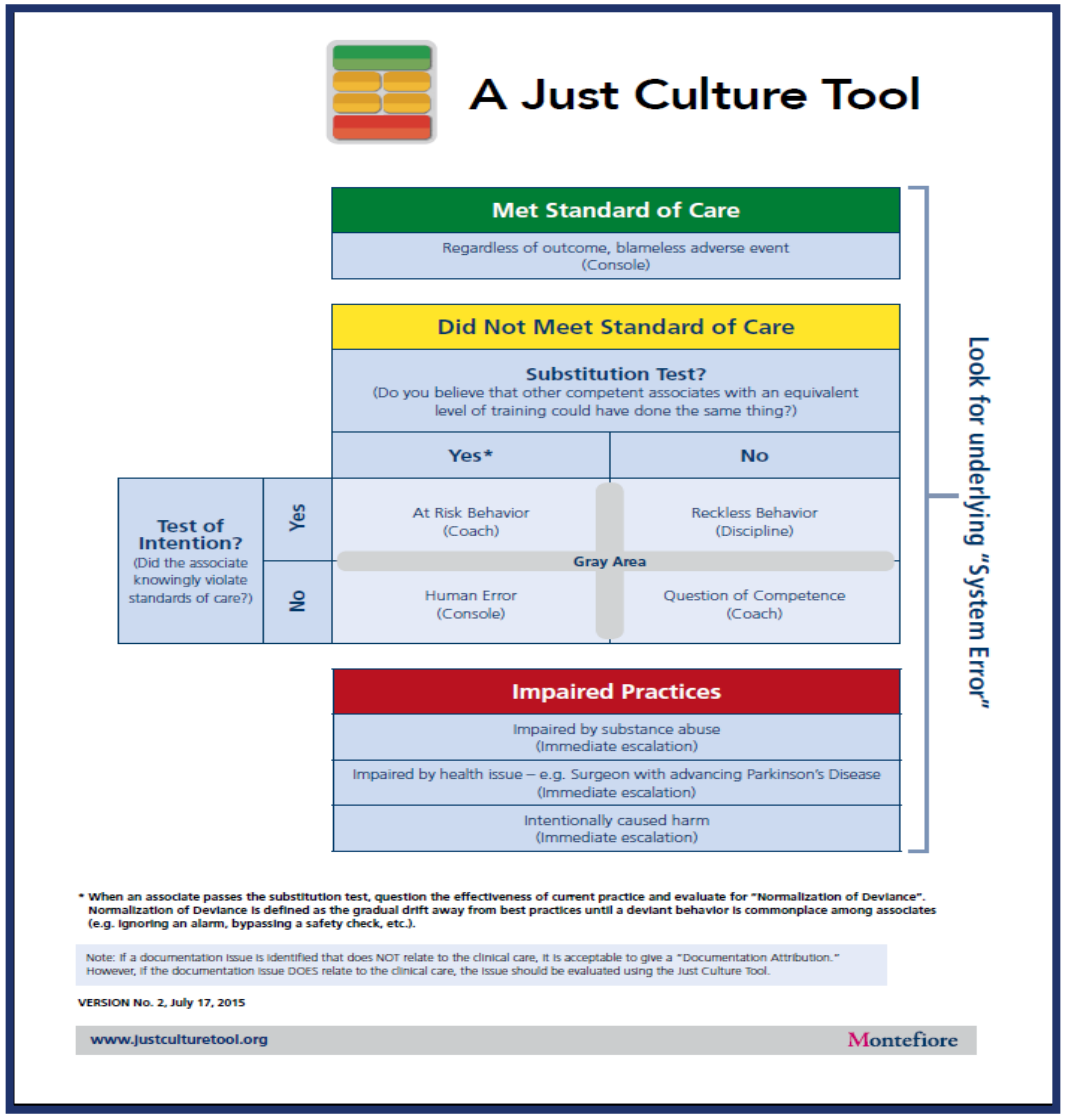
- Aim is not a “blame-free” culture
- A true safety culture balances ***learning*** with ***accountability***
- Must separate ***blameless*** errors (for learning) from ***blameworthy*** ones (for discipline, equitably applied)
- Assess errors and patterns uniformly
- Eliminate intimidating behaviors

Incident Decision Tree based on the work of James Reason

Figure 1. The National Health Service's Incident Decision Tree for responding to patient safety events



Montefiore Medical Center



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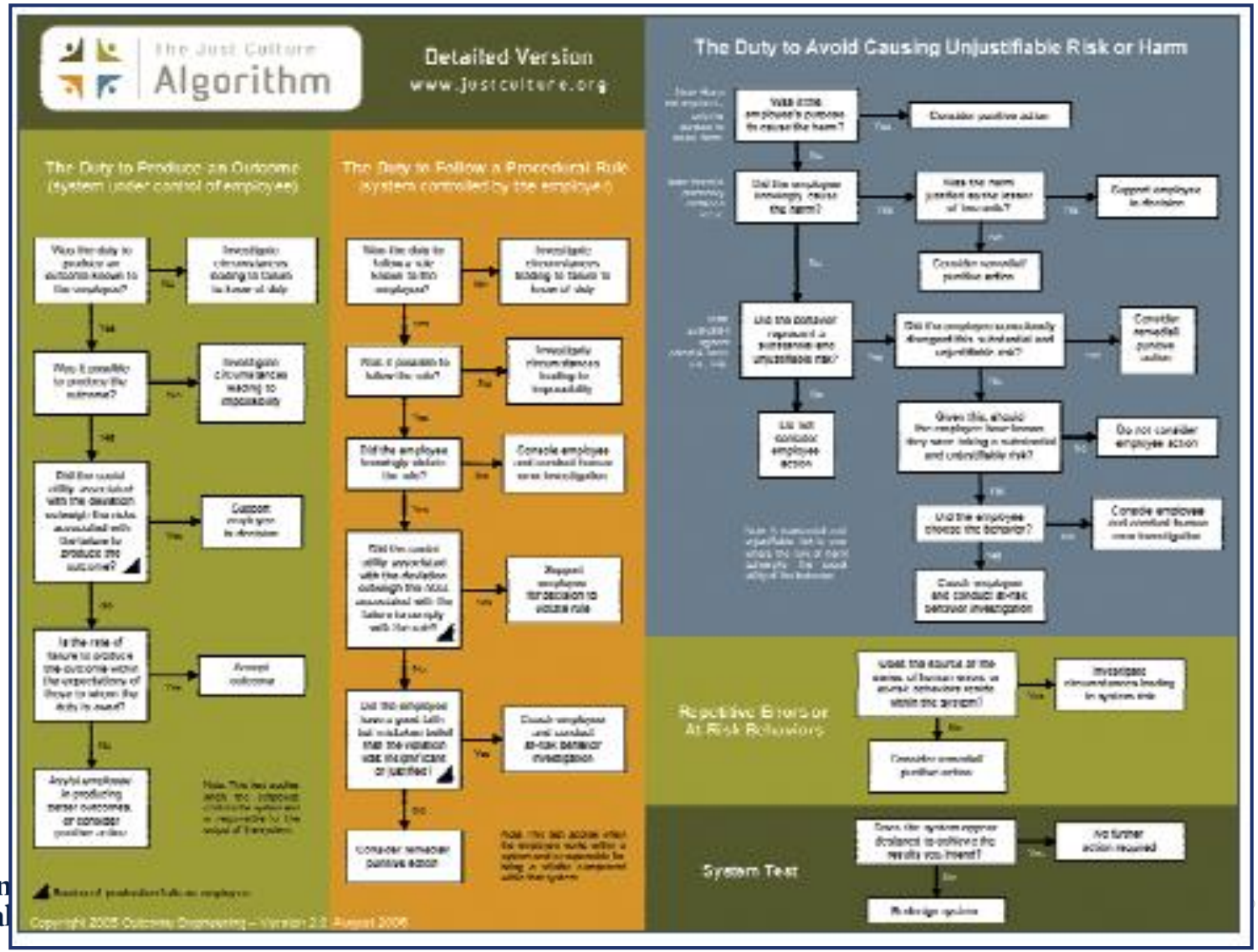
Outcome Engenuity Just Culture Algorithm™



Impact of Just Culture on Quality & Safety

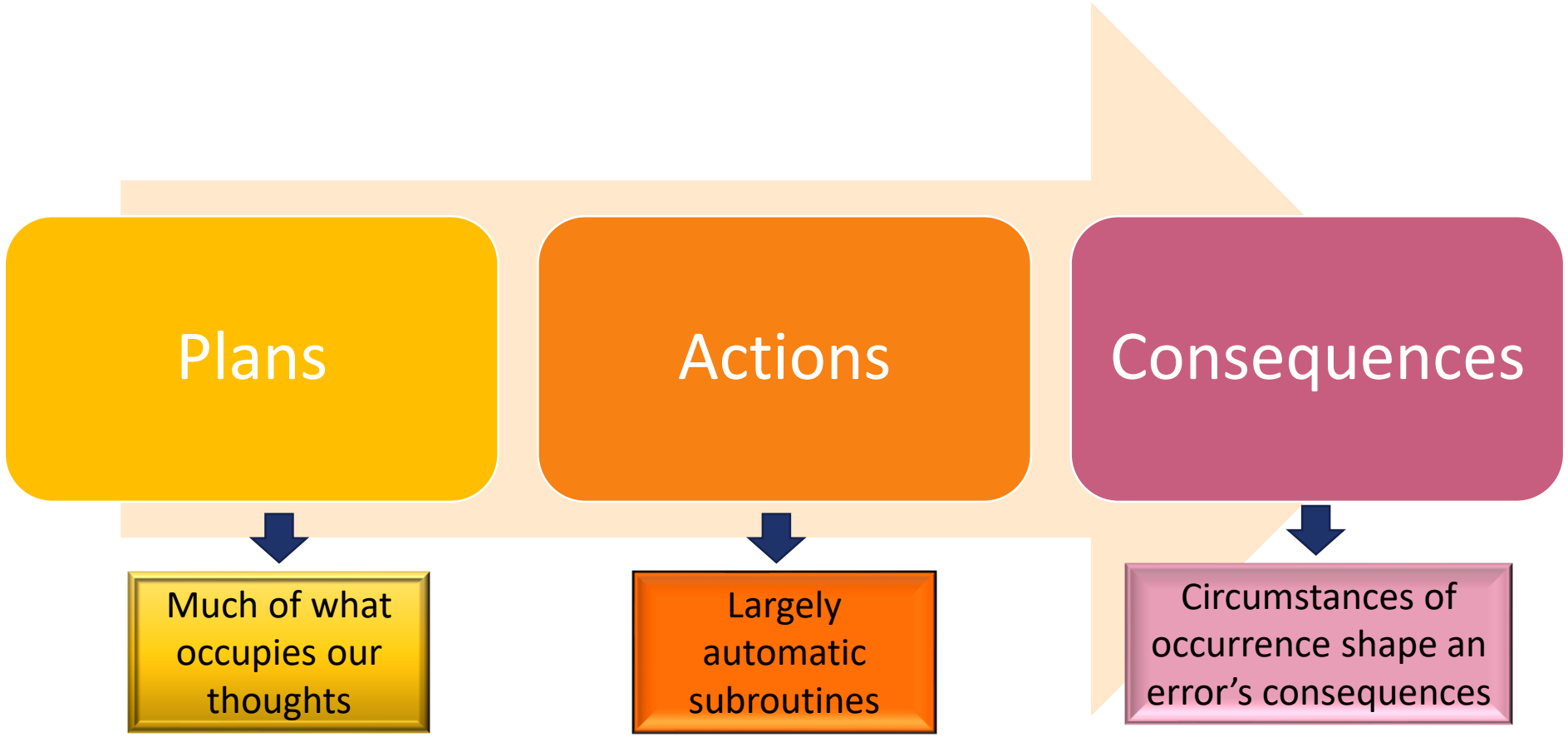
- Study indicates more than half of hospitals that adopted "just culture" believe it has had a positive impact
  - Associated with somewhat better peer review process
  - No association with objective measures of hospital performance (e.g. non-punitive response to error)
- Widespread adoption has not reduced reluctance to report or culture of blame Just Culture targets

Edwards MT. 2018 American Journal of Medical Quality

News Flash!

- The intended outcome of using a tool of this type is to *increase reporting!*
- Close calls happen at a rate of as much as 300 times that of harm events
- Close calls do not result in harm because they were identified, and addressed or eliminated
- Close calls include errors, mistakes, problems, violations or unsafe conditions

What are errors?

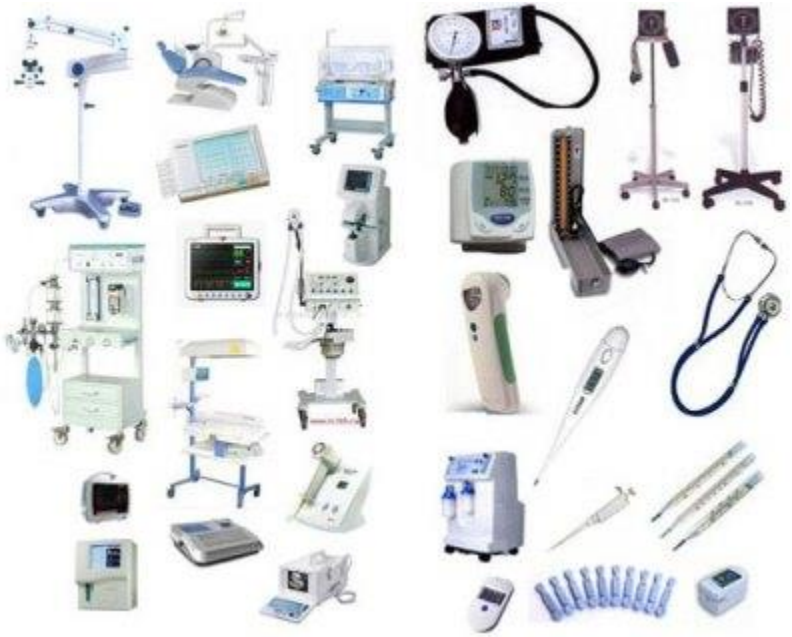


What are mistakes?

- Actions follow the plan exactly but the plan is inadequate to achieve the goal
  - Higher level processing like judging, reasoning, decision-making
  - Harder to detect because they are more subtle and complex

Everyday Annoyances or Problems

- Inability to do a task because something is unavailable when needed or something is present that should not be, thus interfering with the task:
  - Missing equipment, medications, linen
  - Distractions, multiple staff needing access to patient



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Tucker & Edmonson, 2003, Why Hospitals Don't Learn from Failures: Organizational and Psychological Dynamics That Inhibit System Change

A note about “what to report”

- Clearly define what types of issues should be reported. Staff may not recognize that a daily annoyance is actually an unsafe event or unsafe condition.

Mistake or Error?

The nurse, only out of school for a few months, was sent to cover a child in the Pediatric ICU who would be coming out to the nurse's regular unit later that day.

Upon arrival in the ICU, she was given report by the ICU nurse: "He's really easy, he's only got a few oral meds now and one IV med. He should be coming off his monitor later today and going out to the floor." The ICU nurse went over the medication list, gave the floor nurse a brief overview of the patient's vital signs and equipment and left to take care of a critical patient.

Noting a medication was due, the floor nurse administered the oral solution, Lasix. She then went to document the med and realized she had made a mistake and given the wrong medication. The boy had just received his Lasix an hour earlier.

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The most detrimental error is failure to learn from an error.

~James Reason

Ways to learn from close calls

- Aggregate, aggregate, aggregate:
  - Most common day or shift for close call or event type
  - Identify error-prone situations in organization
  - Identify how the issues was successfully prevented from harming someone → strengthen systems!
- Publish learnings and make widely available in multiple modalities

Leadership Engagement

- Leaders may know about a concern but may discount its severity because harm did not occur
- Increase in RFIs in the area of leadership during surveys confirms this
- Role model admission of mistakes or errors, help staff on units enter reports, listen to discussion of concerns on rounds and daily huddles

Action List!

- Review *Sentinel Event Alert #57 and #60*: commit to implementing a strong safety culture at your organization
- Communicate leadership's commitment to building trust and reporting (see video links in SEA 60)
- Develop a system that encourages reporting: easy to use, accessible to all staff, enables quick data analysis; define what should be reported; USE THE DATA

Action List…wait! There's more!

- Hold leaders and staff (where appropriate) accountable for addressing and eliminating errors:
  - Recognize reporters
  - Communicate safety improvement stories
  - Encourage communication of everyday annoyances
- If standardized accountability process is implemented or used, assure leaders at all levels apply it consistently:
  - Routine training of leaders
  - Measure consistent application

The 4 Es

- Establish Trust 
- Encourage Reporting 
- Eliminate Fear of Punishment 
- Examine errors, close calls and hazardous conditions 

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References and Resources

Sentinel Event Alert

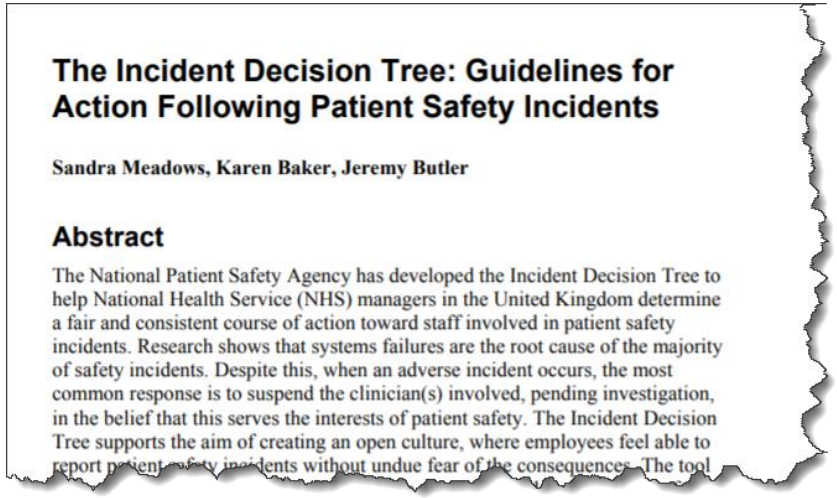
A complimentary publication of The Joint Commission

Issue 60, Dec. 11, 2018

Developing a reporting culture: Learning from close calls and hazardous conditions

While a pharmacy technician was preparing a pediatric nutritional solution, a two-liter sterile water bag she was using ran out. She obtained another bag that she presumed also was sterile water but was instead a similar looking bag containing Travasol, a highly concentrated amino acid that should not be used on pediatric patients. She proceeded to prepare the nutritional solution with the Travasol. As [illegible] was being [illegible] multiple locations, she realized that

Published for Joint Commission accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions.



The Incident Decision Tree: Guidelines for Action Following Patient Safety Incidents

Sandra Meadows, Karen Baker, Jeremy Butler

Abstract

The National Patient Safety Agency has developed the Incident Decision Tree to help National Health Service (NHS) managers in the United Kingdom determine a fair and consistent course of action toward staff involved in patient safety incidents. Research shows that systems failures are the root cause of the majority of safety incidents. Despite this, when an adverse incident occurs, the most common response is to suspend the clinician(s) involved, pending investigation, in the belief that this serves the interests of patient safety. The Incident Decision Tree supports the aim of creating an open culture, where employees feel able to report patient safety incidents without undue fear of the consequences. The tool

The 4 Es of a Reporting Culture

1. Establish trust
   - Leaders communicate their commitment to building trust and reporting through a safety culture.
   - Governance supports leadership commitment to establishing trust.

2. Encourage reporting
   - The organization's incident reporting system is accessible by all staff, easy to use, [illegible] to be done in a timely fashion, and includes reports of close calls

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