Making it Safe to Report

Safe to Report Sub-Committee
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Overview

• Building our Improvement Team
• Tying Just Culture to Safety Event Reporting
• Measuring Reporting Culture
• Performance Board Pilots
How do you improve your reporting culture?

- Which staff members report at your organization?
- How do you recognize and reward reporting?
- How are reports handled?
- How can organizations integrate Leape’s concept that the “single greatest impediment to error prevention is that we punish people for making mistakes”?


Patient Safety Theory and Safety Event Reporting

*Adapted from Patient Safety and the Just Culture*" a Primer for Health Care Executives
Safe to Report Sub-Committee

Hospitalist Division  Nursing  Risk Management
Human Resources  Nursing Safety Champion  Nursing Development
Social Work  Patient Experience  Respiratory Therapy

Committee Feedback

- Managers often receive poor quality incident reports
  - focused on assigning blame
- Providers not held to same accountability as other staff
- Vague memory of Just Culture
  - applies to HR situations not patient care
- How can we apply Just Culture to change reporting culture?
Why We Need Just Culture

- Have you ever made a mistake and worried that it was going to be used unfairly against you?
- Have you ever made or seen a mistake that you did not report?
- Have you ever seen a process that was broken and people were blamed but the errors could have been prevented by changing the process?
- Have you seen patterns of poor behavior where the individual was not held accountable?

Where we started...

- 2013 Safety Culture Survey
  - 25th percentile for “staff perception of non-punitive response to error”
- 2014 Employee Engagement Survey
  - 48% for holding staff accountable for low performance

In order to have a strong reporting culture, Just Culture must be present.
Just Culture Means...

- Staff are accountable for their actions but are not blamed for system failures beyond their control.
- Employees are held accountable, in a fair and equitable way for good performance and behaviors regardless of their position or level within the organization.

What is the Performance Management Decision Guide?
Our Plan

• Just Culture and the Performance Management Decision guide rarely used outside of Human Resources

Performance Management Decisions in a Just Culture

• Includes instructions to apply Decision Guide in clinical and non-clinical settings
• Accessible via Patient Safety intranet and the HR Manager Resource Kit via the organization’s central educational platform
Building our Just Culture

- Develop a training module
- Train hospital leaders and managers

Just Culture Training

Performance Decision Management Guide

- Set as an expectation
- Hardwire in Policy and Procedure

- Identify specific areas for improvement
- Monitor change over time

Safety Culture Survey

How do you measure your reporting culture?

- Surveys
  - Safety Culture Survey
  - Employee Engagement Survey
  - Human Resources

- Potential reporting metrics:
  - Volume
  - Diversity of submitters
  - Types or quality of reports submitted
  - First-time reporters
  - Anonymously authored reports
Anonymously Authored Reporting

- ~30% of all annual reports
- Decreases report usability
- Lost opportunity
- Serve as a proxy measure for a safe reporting culture

- Anonymous reporting “pulse check” with response themes:
  - Fear of retribution
  - Time
  - Confusion
  - Misperception that anonymous is preferred

Safe to Report Key Driver Diagram

Aim
Decrease Anonymously Authored reports by 1.5% by 2017

Drivers
Just Culture
Hospital Policy and Procedure
Anonymous Reporting
Unit Leadership

Interventions
- Management apply Just Culture Decision Tree
- Develop educational tool
- Management and staff training
- Identify relevant policy and procedures
- Hardwire Just Culture Decision Tree
- Staff training
- Suggests staff fearful to report
- Lost opportunity for follow up
- Performance board pilot on 3 units FY16-Q4
- Apply Just Culture Decision Management tree
- Include reporting in safety dialogue
- Reward reporting
Performance Board Pilot

- 3 Units: 4 Main, CICU, Respiratory Therapy for 90 days
- Interventions
  - Weekly graphs on reporting
  - Safety topic in staff meetings
- Pilot Aims
  - Total unit safety event reporting
  - Anonymous authored reporting
Performance Board Pilot Results

Aggregate Pilot Reporting Results

Performance Board Pilot Results

Anonymously Authored Pilot Reporting Results
Take Home Points

• Lessons Learned
  • Success due to creative partnerships
  • Low cost, data driven interventions can be effective

• Next Steps
  • Disseminate performance boards to organizational level
  • Monitor manager compliance with Just Culture Training
  • Link reporting performance with annual unit incentive goals
  • Increase engagement with non-clinical staff and trainees