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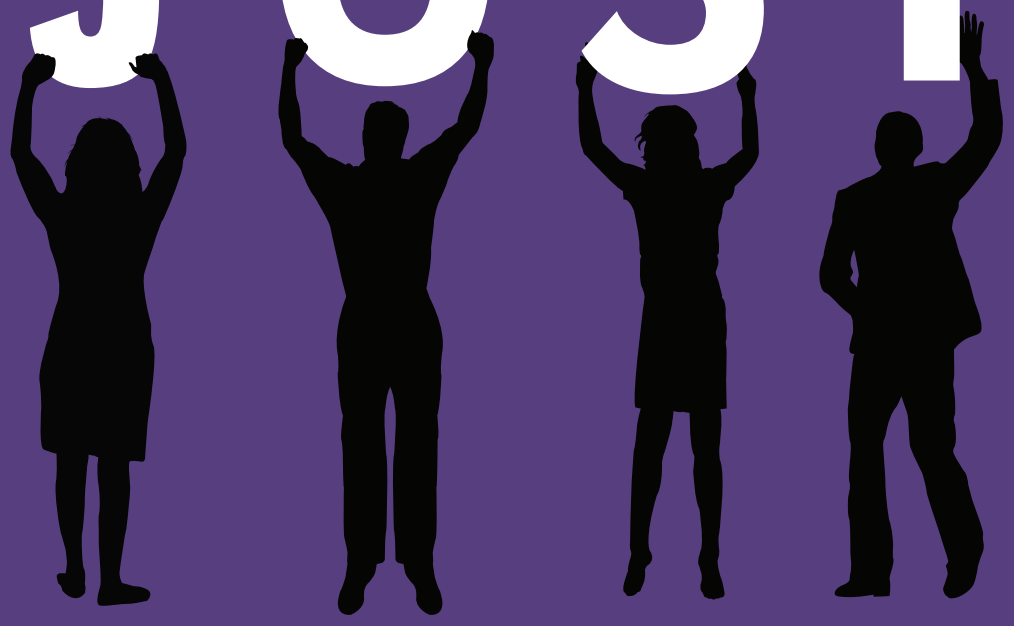

A Nurse Leader's Guide

VIVIAN B. MILLER, BA, CPHQ, LHRM, CPHRM, FASHRM

REVIEWED BY TERRY JONES, RN, PhD

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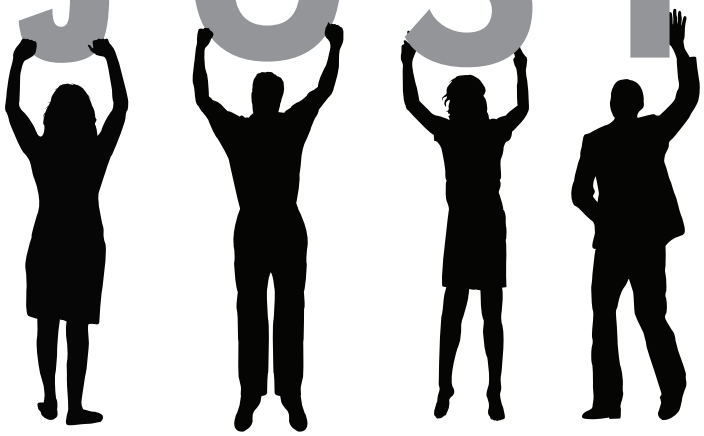

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Dedication

To my dad, Jack Barker, who has supported me since the day I was born, who taught me to be responsible for my own actions, has always loved me, no questions asked, whether I was right or wrong, good or bad. His continuous pride in me has always made me want to do my very best.

To my parents-in-law, Jack and Jennie Miller, who embraced me as their daughter from the minute I married their son, who were as proud of me as any parents could be of their child, and who I have been very blessed to have as an integral part of my family.

To my husband, Mike Miller, who has loved me since I was 15 years old. You are honorable and hardworking, encouraging and supportive of every educational and professional move I have ever made, and you are also a terrific father to our two sons. Know that I love you very much, and will be forever grateful you stayed.

Lastly, to our sons, David and Sean: Having you in our lives made our house a home. Your father and I like to think we did a pretty good job where you are concerned—we did our best to give you everything you needed and much of what you wanted, while at the same time, trying to teach you that you have to work for what you want and that there are consequences associated with every action taken. We thank the stars every day that you turned out to be strong, educated, self-sufficient, independent, and family-oriented. We are so proud of you both and we love you very much.

Preface

When I first began my career as the risk manager in a community hospital more than 20 years ago, incident reports were completed whenever there was a patient fall or a medication error or some other mistake that just couldn't be overlooked or ignored. The action taken most often documented by the unit manager or supervisor was that the employee involved was counseled. This traditional "blame and shame" punitive approach has always bothered me, particularly when I knew that the staff member, regardless of whether he or she was responsible for the occurrence, was absolutely doing the right thing by reporting the mistake, which was, by definition, an unusual event. This event was not ordinarily part of the routine course of his or her day. He or she reported the event to let risk management know of a potential exposure.

However, what the reporter usually got in return was disciplinary action. As a former clinician myself, I knew then, and the same is still true now even after all these years, that errors are made by people just like me—hardworking, educated folks who, for whatever reason, committed the error unintentionally without any anticipation of an adverse patient outcome, which usually occurs within the space of a just a few short minutes. The error usually occurs because of system flaws, such as the need to multitask, or to do a "work-around" from an established policy that is no longer reflective of current practice. Most of the time, there is no harm and no foul, but on occasion, the error can result in irreparable harm, not only to the patient and the patient's family, but also to the individual provider found responsible for the error.

I saw this firsthand when I managed the liability claims made against our hospital and providers. It was gut-wrenching to watch plaintiffs' counsel portray us as being insensitive and careless, and that

as a result of this carelessness and deliberate inattentiveness to detail, the patient was injured. They would argue that the hospital and the provider should pay for their sins.

That is why, to me, embracing and supporting a just culture means taking the more appropriate approach to managing errors. Although I have seen a positive shift toward a more nonpunitive approach, I have to admit that I am acutely aware that this change can be a slow process. In most instances, the change does not take place overnight. I cannot just make a wish and snap my fingers in the hopes that the light will suddenly come on and every healthcare provider will "get it—" in other words, that each one will understand and appreciate the need to change our focus from being not only technically skilled, but also to being more patient-oriented when providing care, and more analytical about why errors occur rather than asking the question, "Who did it?" But I can say that I do believe that these last 11 years since the Institute of Medicine published its famous report on patient safety, *To Err Is Human: Building a Safer Health System*, there has been a growing awareness of the need to:

- Be more collaborative with the entire team of professionals providing care to our patients
- Be more open, honest, and communicative with our patients and their families
- More effectively manage the error reporting process in a way that will more justly and fairly hold staff accountable for their actions while, at the same time, improve processes that will prevent errors from occurring in the first place

At the end of his latest book entitled *Whack-a-Mole: The Price We Pay for Expecting Perfection*, David Marx says: "We have it within our control to build a safer, more compassionate society. While we can't expect perfection, we can hold each other accountable for the quality of our choices."[1]

I honestly believe that this is true. We are perfectly capable of and can successfully carry out those three goals bulleted above. Rather than punish the individual(s) involved with making the error, we can, and should, fairly and compassionately work with the individual by holding him or her responsible for the action while, at the same time, find out why the error occurred. Changes should be developed and implemented to correct the defective process and we should continuously monitor the effectiveness of these changes. If we can do this, then we will be doing what we set out to do

when we chose healthcare as our profession in the first place: Continuously striving to provide consistently safe, skillful, high-quality patient care in a kind and professional manner.

There isn't a healthcare professional I know who has never made a medical mistake. As human beings, we are not perfect, and mistakes happen. Although hopefully not often, there may be a resulting adverse outcome, but as long as we know in our heart of hearts that every effort was made to put the patient's safety first—that we did the best we could to follow good policy and protocol and share our experiences with others without fear of reprisals so that improvements in processes can be made—then I can live with myself, and I believe others would agree.

There are several people, knowingly and unknowingly, who have influenced me as I have traveled down my professional road over the last 30 years, providing encouragement and advice, supporting my need to stay true to my work ethics and beliefs while, at the same time, teaching (or at least trying to teach) me to be patient and to listen to both sides before coming to any conclusions. These folks are:

Joann Rowell
James R. Walker
Karen E. Olscamp
Linda C. Jaecks
William Minogue, MD
Vahe Kazandjian

And for the rest of my family, friends, colleagues, and peers, thank you for being there whenever I asked or needed you to be there for me. Your support has always been, and will continue to be most appreciated.

Vivian B. Miller, BA, CPHQ, LHRM, CPHRM, FASHRM

Reference

1. Marx, David. *Whack-a-Mole: The Price We Pay for Expecting Perfection.* By Your Side Studios, 2009.

About the Authors

Vivian B. Miller, BA, CPHQ, LHRM, CPHRM, FASHRM

Vivian B. Miller, BA, CPHQ, LHRM, CPHRM, FASHRM, has more than 25 years of progressive consultative and managerial experience in professional liability claims, patient safety, quality, and risk management services within the insurance and healthcare delivery industries.

Miller is senior risk management specialist for the American Society for Healthcare Risk Management (ASHRM), serving as the internal staff resource on healthcare management content. Her personal knowledge, research and a professional network enhances the range and quality of ASHRM offerings. She identifies and develops risk management content to use as the basis for ASHRM programs, products and services; serves as an internal content consultant in the development of strategy initiatives, educational programs, communications campaigns, and other products and services, leading advocacy efforts; and serves as a risk management content resource to members and other constituents.

Miller is the former director of risk prevention for the University of Maryland Medical System (UMMS). Based in Baltimore, MD, the system is composed of corporate offices, an academic medical center, three specialty hospitals, five community hospitals; and is affiliated with three other community hospitals; and partners with the University of Maryland Schools of Medicine, Nursing, Pharmacy, and Dental Surgery, as well as offers specialty services to its community through its extensive physician network. Miller oversaw the risk prevention activities at the corporate level of the organization.

Prior to coming to UMMS, Miller was the research project manager and patient safety specialist for the Center for Performance Sciences, a research and consulting subsidiary of the Maryland Hospital Association, providing oversight for the Maryland Patient Safety Center's online, Web-based Adverse Event Reporting System offered to Maryland healthcare organizations as a way to collect and analyze data on adverse events and near misses. Prior to that, Miller has worked as a director of risk management in several acute care hospitals in the Baltimore–Washington, DC, metropolitan area. She obtained her Bachelor of Arts degree in Health Science and Policy from the University of Maryland, Baltimore County, in 1991 and is currently enrolled at the University of Maryland University College in the Master of Health Administration program. Miller is certified as a Professional in Healthcare Quality as well as in Risk Management, is a licensed risk manager in the state of Florida, and is a Fellow of the American Society for Healthcare Risk Management. She is an active member of the Maryland Society for Healthcare Risk Management, currently serving as treasurer; is chairperson of the American Society for Healthcare Risk Management's Foundation 2030 Fund; an active member of the National Association of Female Executives; and is listed in Manchester's Who's Who of Female Professionals.

Miller has written several articles and presented on numerous occasions on various patient safety and risk management topics.

Terry L. Jones, RN, PhD

Terry L. Jones, RN, PhD, is an assistant professor of nursing in the Department of Nursing Administration and Healthcare Systems at the University of Texas at Austin School of Nursing. Jones previously served as director of care management and interim vice president of nursing administration and chief nursing officer at Parkland Health & Hospital System in Dallas. She has been published nationally and has also presented nationally on various nursing topics.

Jones has been a registered nurse for more than 25 years.

Introduction

This handbook serves as a guide for healthcare organizations that are ready to shift to an organizational culture dedicated to incorporating a strategic patient safety program that will balance accountability with safety and performance improvement. An organization's culture is what drives behavior, which in turn drives outcomes; in other words, if the organization as a whole (including the board, senior leadership, and medical staff) has embraced a culture that encourages adverse-event reporting without punitive consequences, while at the same time requiring the assumption of responsibility when an adverse event has occurred, the end result is what is known as a "just culture."

This is a concept that reconciles professional accountability with the need to create a safe environment in which individuals are not afraid to report medical errors. This handbook provides healthcare organizations with a hands-on approach toward designing safe systems that reduce the potential for patient harm, promote safe behavior, and encourage adverse-event reporting, which in turn will ultimately lead to a safer environment not only for patients, but also for staff members and visitors.

The following is a summary of the highlights of each chapter:

- **Chapter 1: Elements of a Just Culture**—summarizes why the concept of a just culture came into being and explains the reasons behind reporting adverse events and the difference it has made to staff members and patients

- **Chapter 2: Assess Your Organization**—provides ideas and tools that can and should be used to help determine where an organization is in the just culture process and helps determine what still needs to be done

- **Chapter 3: Planning the Change**—identifies what actions and personnel specifically are needed in order to effect organizational change

- **Chapter 4: Just Culture Concepts: Reporting, QI, and Transparency**—discusses in detail what a just culture looks like, including how reporting can be effective, how quality improvement efforts can improve, and what part transparency plays in a just and safe culture

- **Chapter 5: Implementation Strategies**—offers ideas and recommendations for successful strategies used to implement a just culture approach

- **Chapter 6: Evaluating Change**—describes how to monitor and measure the effectiveness of the just culture concept

- **Chapter 7: Case Scenarios**—provides an example of an effective reporting process, a look at one hospital's efforts to reinvigorate its just culture efforts, and a touching personal story of a medication error

- **Chapter 8: Disclosure**—offers a discussion of "doing the right thing" in regard to the disclosure of adverse events

- **Appendix A: Nursing's Involvement in a Culture of Safety**—offers an in-depth literature-based resource for nursing's role in a culture of safety, including an expansive bibliography of resources

- **'Safe from Falls' Initiative Process and Outcomes Data Sample**—shows the actual data of one health system participating in the Maryland Patient Safety Center's "Safe from Falls" initiative. This is bonus material available at *www.hcpro.com/downloads/8752*.

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Readers of *Creating a Just Culture: A Nurse Leader's Guide* can download the figures included in this book by visiting the HCPro Web address below. At this link, you will find the following:

- Figure 1.1: States with adverse-event reporting systems
- Figure 2.1: Hospital survey on patient safety culture
- Figure 3.1: Dana-Farber Cancer Institute principles of a fair and just culture
- Figure 3.2: Incident reporting administrative policy
- Figure 3.3: Checklist for reviewing policies
- Figure 3.4: Staff education steps and checklist
- Figure 5.1: Just culture implementation timeline sample
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- Table 1: Domains of knowledge and skill sets to facilitate transformation to a culture of safety
- Table 2: Safety culture assessment survey tools
- 'Safe from Falls' Initiative Process and Outcomes Data Sample

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Elements of a Just Culture

LEARNING OBJECTIVES

- Describe a just culture
- Identify why reporting errors is a critical component to patient safety
- Recognize barriers to error reporting
- Recognize the differences between human error, at-risk behavior, and reckless behavior

The concept of a "just culture" is not a new one, nor did it originate in the healthcare setting. The idea comes from the aviation industry and specifically from United Airlines. Crew resource management (CRM), which is a procedural system used when human error can have devastating effects, was first used to describe programs expressly designed to emphasize the need to change and correct deficiencies in cockpit crew behavior, specifically when it came to lack of assertiveness by junior crew members and the authoritarian behavior by captains. In fact, the National Transportation Safety Board had distinctly singled out the captain's failure to accept input from junior crew members and a lack of assertiveness by the flight engineer as causal factors in a United Airlines crash in 1978.

The CRM theory continues to be used in the aviation industry today, and more than 30 years later, the concept of this type of collaboration has finally trickled over into the medical community, largely due to folks such as John Nance, whose book

about safety in human systems, *Blind Trust*,[1] is widely credited with helping to spark not only the universal acceptance of CRM principles in aviation, but also the earliest infusion of culture-changing lessons derived from aviation into medical practice. *Blind Trust* was instrumental in bringing to light for the American public some serious public issues in aviation safety. *Why Hospitals Should Fly: The Ultimate Flight Plan to Patient Safety and Quality Care*,[2] also authored by Nance, follows in that tradition. It discusses how these principles can be applied in the practice of medicine. CRM has evolved into what the medical community would now consider to be a just culture model, which has been expanded on by David Marx, an engineer and attorney who began his career as a Boeing aircraft design engineer. While at Boeing, Marx organized a human factors and safety group that proved to be quite successful. In 1997, he started a research and consulting practice focusing on the management of human error through the integration of systems engineering, human factors, and the law, otherwise known today as what he terms "a just culture."

These ideas have begun to infiltrate the healthcare field in new and exciting ways. A just culture can help your organization toward safer and better quality care, with a high potential of also creating a more satisfying place to work.

National Emphasis on Patient Safety

Ever since the Institute of Medicine (IOM) published *To Err is Human: Building a Safer Health System* in November 1999, there has been an ever-increasing focus on patient safety in the United States. According to the report, at least "44,000–98,000 people die in hospitals each year as a result of medical errors that could have been prevented."[3] To that end, a movement to improve patient safety across the country was initiated, particularly in light of several very publicized cases—the first being a medication error, specifically a massive overdose of a powerful anticancer drug that resulted in the death of 39-year-old Betsy Lehman in March 1995. The second was the amputation of the wrong leg of 51-year-old Willie King and the third was the death of 8-year-old Ben Kolb in December 1995 following a medication error that occurred during what should have been a relatively simple outpatient procedure. The fourth was that of miscommunication, resulting in the administration of three times the appropriate dosage of methadone that resulted in the death of 18-month-old Josie King in January 2001.

These events ultimately led to the passage of the Patient Safety and Quality Improvement Act of 2005. This act created patient safety organizations that collect, aggregate, and analyze event data that are reported voluntarily and confidentially in an effort to identify possible patterns and trends, which can then be used to develop and implement measures to prevent patient harm and promote patient safety without fear of reprisals.

With patient safety in the national spotlight, healthcare organizations have been forced to look at current practices and processes that may have facilitated the occurrence of an error rather than at the individuals who actually committed the error. Usually, nine times out of 10, the error was more process-related than people-related. Consequently, over the past 10 years there has been a growing trend toward creating leadership tracks in patient safety practices at conferences and seminars for healthcare professionals.

Reporting Errors for a Just Culture

Lucien Leape, MD, Harvard School of Public Health professor and patient safety expert, said in testimony before Congress on the Healthcare Research and Quality Act of 1999 that the "greatest impediment to error prevention is that we punish people for making mistakes."This is substantiated in the article entitled "The Perceptions of Just Culture Across Disciplines in Healthcare," which showed that when surveyed, at least 50% of the respondents acknowledge that when an incident occurs, someone will be blamed first, before an investigation has actually determined how and why the event occurred.[4]

And, if the medical community honestly acknowledged it, Leape's comments would, at least from the average community hospital nurse's perspective, definitely held true up until the past five to 10 years. Punishing people for making mistakes discourages them from reporting errors, preventing further error prevention.

The IOM report suggested the implementation of a two-tiered event reporting system: the mandatory approach, which requires state governments to oversee the collection of data pertaining to those adverse events that resulted in, or contributed to, the serious injury, illness, or death of a patient who was admitted to a hospital; and the voluntary approach, which focuses more on those

repetitive errors that occur much more often but usually result in minimal or no harm and usually occur as a result of a flawed systems process.

Additionally, to encourage more robust reporting of these types of events and to reassure reporters that the information contained in the report would not be used against them in a medical malpractice liability claim or disciplinary proceeding, the federal Agency for Healthcare Research and Quality (AHRQ) included provisions in the Patient Safety Act for ensuring the maintenance of the data's confidentiality, as well as the data's protection from discovery with respect to any information reported, both of which were included in the final congressional act that was passed.

History of reporting

Reporting an adverse event, or "incident reporting," was originally initiated by the medical malpractice insurance industry in the 1970s in response to the medical malpractice crisis at the time when, generally speaking, payouts to claimants exceeded premiums and hospitals were either closing or being bought out by conglomerates like HCA Healthcare and Tenet Healthcare Corporation and physicians were exiting their practices in droves because they could no longer afford to pay their premiums. The industry created the written reporting mechanism as a way for healthcare providers to notify the insurance company whenever they thought that what is known as a "potentially compensable event" occurred. This type of event could very well lead to a malpractice claim or lawsuit.

Reporting such events allowed the company to set a reserve, where a certain amount of money was set aside for possible settlement of a claim—the specific amount determined by the type of injury, sympathy factor of the claimant, what associated medical expenses could be expected and how much they would cost, the value of lost wages, and other factors. At that time, hospital risk management departments were established, more or less, to reactively manage claims that were already made or would most likely potentially be made against the hospital, and employees were encouraged to report events that could lead to claims or lawsuits.

Employees were not necessarily encouraged to proactively report those errors that occurred repetitively, as these were considered to be careless in nature and identifying them was construed as punitive. Additionally, if an employee actually did complete an incident report to let risk

management know of a potentially compensable event, or that the possibility that a lawsuit or claim might be filed, there was minimal, if any, effort to determine whether there was a system or process problem. It was just assumed that the individual involved was careless or not paying attention, and the action taken to address the issue at hand was usually to counsel, suspend, or even terminate the employee. This process did not allow for an evaluation of the event to determine whether there was actually a process problem versus a people problem, nor did it offer a mechanism by which a process improvement activity could be initiated once a cause was determined. There was no opportunity for the development of steps or an action plan that could be taken to ensure that there would not be a recurrence of such an event in the future.

State reporting

From an individual hospital's perspective, incident reporting is a critical component of any risk management program because it helps risk managers to be cognizant of unsafe systems that may need to be addressed, to analyze data and report findings of possible patterns and trends, and to track any actions taken to improve care once a problem has been identified. From a risk prevention perspective, this system is also used to report near misses—those events that could have reached the patient—not just those events that actually did reach the patient (whether or not there was harm). Reporting of these events allows risk management to investigate these types of events more closely to determine whether there are system breakdowns that contribute to their repetitive occurrence and address them before harm actually befalls a patient.

From a public reporting perspective, there are currently 26 states that have adverse-event reporting requirements, most of which require reporting of serious, most often preventable ,events that if made public would cause great concern to the community. Most states requiring the reporting of these types of events refer to the National Quality Forum's list of serious adverse events, which can be found online *(www.qualityforum.org/projects/completed/sre/fact-sheet.asp)*. There is no federal requirement for reporting. Each state that does require reporting has its own hospital-specific definitions of just what should be reported as serious events, which ultimately does not allow for even the most rudimentary aggregation of valid data. However, all states do have one thing in common: At the individual organizational level as well as at the state level, the organizations and the state authorities evaluate and analyze their own adverse-event data, identify the major areas of concern that need further investigation and analysis, and then work toward the design and

implementation of new and improved processes, all in an effort to promote patient safety and prevent patient harm.

See Figure 1.1 for a list of states with hospital adverse-event reporting requirements, including what is required to be reported.

FIGURE 1.1

States with adverse-event reporting systems

State	Year System Began	Reportable Event List	Agency Receiving Reports	Number of Adverse Events Reported in 2006
California	2007	Modified NQF*	Department of Public Health, Office of Licensing and Certification	N/A
Colorado	1988	State determined	Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division	391
Connecticut	2002	Modified NQF	Department of Public Health	240
District of Columbia	2007	Modified NQF	Health Regulation and Licensing Administration	N/A
Florida	1998	State determined	Agency for Healthcare Administration, Florida Center for Policy Analysis	716
Georgia	2003	State determined	Department of Human Resources, Office of Regulatory Services	136
Indiana	2006	NQF	Department of Health	79
Kansas	1988	State determined	Department of Health and Environment	22
Maine	2004	State determined	Department of Health and Human Services, Division of Licensing and Regulatory Services	24
Maryland	2004	State determined	Department of Health and Mental Hygiene, Office of Health Care Quality	174
Massachusetts	1980	State determined	Department of Public Health, Division of Health Care Quality	782
Minnesota	2003	NQF	Department of Health	140
Nevada	2005	State determined	State Health Division, Bureau of Health Planning and Statistics	188
New Jersey	2005	Modified NQF	Department of Health and Senior Services	450
New York	1985	State determined	Department of Health, Office of Health Systems Management	16,442
Ohio	2007	State determined	Department of Health, Office of Health Systems Management	N/A
Oregon	2006	Modified NQF	Patient Safety Commission	N/A [a]
Pennsylvania	2004	State determined	Patient Safety Authority	6,232 [b]
Rhode Island	1994	State determined	Department of Health, Division of Environmental and Health Services Regulation, Office of Facilities Regulation	271
South Carolina	1976	State determined	Department of Health and Environmental Control	N/A
South Dakota	1987	State determined	Department of Health	6
Tennessee	2000	State determined	Department of Health, Division of Healthcare Facilities	3,585
Utah	2001	Modified NQF	Department of Health	N/A
Vermont	2007	NQF	Department of Health	N/A
Washington	2006	Modified NQF	Department of Health	N/A[a]
Wyoming	2005	Modified NQF	Department of Health, Preventive Health and Safety Division	13

Source: Office of Inspector General analysis of States' legislation, statutes and regulations, forms, and 26 interviews, 2008.

* NQF is the National Quality Forum List of Serious Reportable Events.

a = States began collecting data in mid-2006 and, therefore, could not report complete data for the year.

b = This range does not include the number of near misses reported to Pennsylvania in 2006.

N/A = Not available; States did not provide the number of adverse event reports for 2006.

For example, in March 2004, Maryland mandated that every hospital had to have a formal patient safety program in place with a designated patient safety officer and required that all level 1 events be reported to the Department of Health and Mental Hygiene's Office of Healthcare Quality. Level 1 events are defined as those serious injuries, illnesses, or deaths either contributed by or resulting from the actions of hospital representatives, as determined by the organization, or conditions lasting longer than seven days and/or conditions that are still present at the time of discharge. Examples of the types of level 1 events are as follows:

- Death or serious disability related to the use of anticoagulants
- Death or serious disability related to the failure to maintain a patient's airway
- Death or serious disability as result of an unanticipated complication
- Death or serious disability related to a delay in treatment
- Unanticipated fetal or neonatal death or disability
- Misdiagnosis

The law also requires that a root cause analysis (RCA) of these events be conducted and an action plan be developed and submitted for evaluation and approval within 60 days of the date of the report.

Challenges to reporting

Suzanne C. Beyea notes in an article published in the April 2002 issue of *AORN Journal*, entitled "Reporting Medical Errors and Adverse Events," that the two main reasons errors are not reported as they should be are fear and a lack of belief that reporting can actually lead to improvements in the quality of patient care provided.[5] In fact, in one 2004 Institute of Safe Medication Practices survey conducted at the University of Alberta Hospital in Canada, when staff members were questioned about why they were uncomfortable with completing incident reports, "they readily admitted their reluctance to submit incident reports, citing concerns that they would be judged to be an inadequate practitioner and/or held responsible for the incident."[6]

In the past, healthcare workers have often been afraid that if they complete the report, they will face disciplinary action because, historically, patients generally believe that healthcare providers do not make mistakes. Many leaders in organizations believe in a culture of perfectionism and most providers feel enormous pressure to be right all of the time, with no exceptions, despite the fact that providers are human and will, at least one time in their careers, commit an error. When they do commit an error, most providers will spend a great deal of time feeling tremendous guilt and shame, failing to accept that there were system failures that allowed the provider to commit the error in the first place. Not to mention that if an error resulted in moderate-to-significant patient harm, there is the additional worry that a lawsuit will follow.

Many fear that whatever is documented in the incident report will be made available to the plaintiff's counsel and divulged in open court, leaving providers to believe their reputation is at stake. Additionally, if there is a payment made to the plaintiff, the provider will have to be reported to the National Practitioner Data Bank, creating an increase in medical malpractice insurance premium. In many cases, providers often end up either limiting privileges to lower-risk specialties or not performing potentially high-risk procedures—that is, if they stay in medicine at all.

This type of culture—in which medical professionals are viewed as infallible—is slowly but surely changing. The healthcare field is beginning to allow the reporting of events without reprisals while still holding persons accountable for what is determined as at-risk behavior. However, as much as healthcare organizations may want to change practices in order to more accurately reflect these current standards of care, providers are finding out that changing behavior and practice in order to improve the quality of care provided is a painstakingly hard road to follow. Data needs to be displayed, and information regarding any necessary follow-up actions must be communicated back to the provider. Additionally, actual improvements need to be seen in the provision of care or staff will often wonder why they bothered to report an event in the first place.

Case study: The effect of public reporting

Each of the past five years in Maryland reflects an increase in the number of events reported, which, according to the Office of Healthcare Quality (OHCQ), "does not necessarily mean that errors are occurring more frequently but may represent greater compliance on behalf of the hospitals and a

continued collaboration between OHCQ and Maryland hospitals, thereby increasing the reporting of events."[7] And, despite initial reticence on the part of the hospitals to share sentinel event information, over the years, Maryland hospitals have actually affirmed the need to critically analyze the cause(s) behind the errors, as this has definitely enabled them to more objectively evaluate and, if necessary, revise their systems and processes to ensure that proper checks and balances are in place to avoid mistakes reaching the patient.

These regulations have also resulted in hospital leadership taking a more "active role in reviewing the RCA submitted by their facilities in response to a Level 1 adverse event,"[8] and, as such, hospital leaders have now accepted the ultimate responsibility for ensuring that a change in culture must take place so that better quality care is provided to their community's patients. Senior leadership also acknowledges that:

> *Open communication among hospital disciplines and with the affected patient and family is key to a successful patient safety program. The inability or reluctance to disclose events is one of the most common root causes that can lead to system failures. Including the patient and the family in the RCA process can also be valuable in improving processes and future patient outcomes.*[9]

Additionally, the data collected by the OHCQ has provided some valuable information in regard to the types of events that are occurring across the state.

Maryland's Patient Safety Center follows how the AHRQ recommends state patient safety programs are to be structured. As discussed previously, the OHCQ requires mandatory reporting of specific events, while the Maryland Patient Safety Center (MPSC) focuses more on what is voluntarily reported. To that end, an electronic adverse-event reporting system was developed and offered to all Maryland hospitals, of which six have chosen to voluntarily report all events (actual, as well as near misses or good catches) that had the potential to cause a significant adverse outcome because of a process or system failure, but did not either through intervention or, in many cases, pure luck. These data are collected through the MPSC and aggregately reported at its annual patient safety conference, held every spring in Baltimore. This information helps the MPSC to identify patterns and trends regarding the types of errors occurring in what may be a statistically valid

representation of all Maryland hospitals, which is then presented at the conference. The information can then be utilized in institutions across the state to assist with developing better processes that will proactively and simultaneously prevent the error from occurring and promote patient safety.

When we first started collecting data back in July 2006, we identified that medication errors were the most reported type of event, followed by falls. It was also reported that 97% of medication errors resulted in no patient harm. However, we did find that in about 20% of falls reported, patient harm was noted. Injuries could have been as minor as an abrasion or as serious as a resulting subdural hematoma, but if there was documentation of a patient sustaining any type of injury, it was considered to be patient harm. Because there were only about 850 events reported, no other analysis or conclusions could be made.

In 2008, the 2007 aggregate data was presented at the annual patient safety conference and, again, the same findings were identified, only now there were more than 4,000 records. This time, it was noted that about 24% of patients who fell sustained an injury of some sort. That being said, just a short time later, we began to look specifically at the falls data to determine what other activities or opportunities we could explore at the state level that we could share with our member hospitals in an effort to reduce both the frequency as well as the severity of patient injuries.

One of the first things we did was to share the data with the OHCQ to determine whether there may be a correlation between Level 1 event data and the MPSC's voluntary reporting data, which proved to be extremely useful in the development of the state's "Safe from Falls" initiative. "Safe from Falls" is a statewide project introduced in September 2009 to address the increasingly alarming reports related to patient falls—both Level 1 events and those reported as near misses. The initiative includes data collection from the implementation of process measures. By healthcare entities putting into place consistent and standardized policies, procedures, and protocols, the hope is that reported outcomes, not only from hospitals but from long-term care and home care entities as well, will show improvement.

Although it is too soon to know whether this initiative has definitively had a positive effect on frequency and/or severity of the events reported, the awareness of the initiative itself, and the ability of the facilities to be able to collaborate with each other, share their best practices, and compare

themselves with similar facilities, has definitely shown that there is a shared culture of patient safety among all the participants, at least with respect to patient falls, and that makes for a huge win-win all across Maryland. A sample of reports provided to all MSPC falls initiative participants, which allow hospitals to see how they are progressing both individually as well as compared to the other participants, with respect to both outcomes and process measures, can be found in the 'Safe from Falls' Initiative Process and Outcomes Data Sample bonus material available at *www.hcpro.com/downloads/8752*.

It is important to note that in reviewing the incident data reported after the falls initiative was introduced, the amount of laboratory errors has seesawed back and forth, with falls for the second type of event most often reported. A similar finding has been reported by the Pennsylvania Patient Safety Authority, and that organization is looking more closely at the data to see if further action is warranted at the statewide level; it may be time for the MPSC to take similar action.

Defining Your Current Culture

Other recommendations made in the IOM report include defining, as well as raising, the performance standards for healthcare patient safety professionals and encouraging health insurance purchasers and insurers to set minimum safety requirements when making their contracting decisions, which in essence provides monetary incentives for the performance of safe, quality patient care.

The one recommendation in healthcare that has proved to be the most challenging for hospitals is that they must develop a "culture of safety" within their own entity, meaning they need to focus more on the concept of workforce performance improvement, specifically ensuring that the organization has made patient safety a strategic priority, a message that absolutely needs to be driven home over and over again from the top down—from board members to senior leadership to the medical staff to directors to supervisors to managers and, most importantly, to the frontline staff—because if they see that the commitment is there from the top down, there is more unity and buy-in for the concept. If managers do not tout the message, the message tends to lose importance.

However, before an organization can even begin to develop a culture of safety, it needs to determine just what the current organizational culture is, and that involves evaluating factors such as the current

state of beliefs, values, and attitudes that are shared by a group. In other words, the foundation of the culture within the organization, be it positive or negative, most assuredly acts as a guide as to how employees will behave in the workplace. Simply put, it is how things actually are done versus how things *should* be done.

Additionally, an organization needs to consider the culture of its individual employees as well as that of each department or clinical service. Obviously, behavior is influenced or determined by what actions are rewarded and acceptable within the workplace and what actions or behaviors are not. For example, if a pharmacist makes a dispensing error, and that error is caught as a near miss by another pharmacist, and the correct medication is then sent to the floor with no one the wiser, chances are it won't ever be reported as an incident. The belief is that this was not an error because it was caught before it got the to floor or to the patient. But a critical factor is ignored here: An error did occur and there should be questions asked about the error. Why did the error occur in the first place? Was this a one-time error or has it occurred with some frequency? Staff need to understand that the potential for patient harm is still present, because the same error might occur again due to a potential system error. There needs to be a willingness on the part of the pharmacy department to commit to changing their attitude and to acknowledge that an error occurred and that it needs to be reported so current processes can be evaluated.

By determining what the current culture is, the organization can begin to address how attitudes and behaviors can be changed and how the culture can be transitioned to one that is more patient safety focused. Keep in mind that an organization's transition to a more patient-safety-conscious culture will need to proceed by steps and this process will take time.

This process is described by R. Westrum in his article "A Typology of Organizational Cultures," published in *Quality & Safety in Health Care* in December 2004.[10] He describes the three phases as being pathological, bureaucratic, and generative. Pathological is when an organization is secretive and unwilling to share information, refuses to consider new ideas or concepts, and covers up any adverse outcomes or negative behaviors. The next phase is bureaucratic in nature. This is when an organization's leaders "talk the talk" but don't "walk the walk." The organization may say it has a just and patient-safety-focused culture, but in reality it merely tolerates when new ideas are brought

to the table; it will not act on them. In fact, this organization usually ignores the information provided in the first place. Eventually the organization gets to the next phase, known as the generative or learning phase. This is where the organization is always looking for information that will help them become a safer place for their employees, patients, and visitors. New ideas are welcomed and failures are evaluated for systemic issues, not just blamed on the employee involved in the event.

Leadership plays a critical role in making the case for patient safety, because without its support of the concepts and actions taken to promote patient safety and prevent patient harm throughout the organization, efforts will all be in vain and the program will be destined to fail. However, by establishing a culture that supports and advances patient safety and, more specifically, supports the discussion of errors so that lessons can be learned from them, the organization is supporting a just culture approach. This approach encourages a multidisciplinary communication process and a nonpunitive approach to event reporting.

A just culture also holds managers and staff members accountable and responsible for establishing reliable improvements to processes of care and adhering to them. In his book *Managing the Risks of Organizational Accidents*, James Reason says that a true culture of safety is, in fact, made up of several cultures that are just and fair—they report, learn, inform, and are flexible. According to Reason, a just culture is one in which the atmosphere is one of trust and it encourages and rewards staff members for providing essential safety-related information but, more importantly, is also very clear about what is acceptable and unacceptable behavior.[11]

David Marx says that errors occur because people exhibit one of the three following behaviors:

1. An inadvertent action of doing other than what should have been done, such as a slip or a mistake.

2. At-risk behavior, or an action that increases risk where either the risk isn't recognized or is believed to be justified, even when it is known to be the wrong action to take.

3. Reckless behavior, when the individual consciously chooses to disregard a substantial and unjustifiable risk. It is this behavior that is managed via remedial or disciplinary action, not the previous two behaviors.[12]

Once these behaviors are understood, there should be an ethical imperative for reporting adverse events to ensure that the management of the event occurred according to established protocols, to notify the proper personnel, to investigate why the event happened, to study the possible causes and contributing factors, and to design and implement better processes that will prevent the occurrence of similar events. Why? Because it is the right thing to do and we as healthcare professionals have a responsibility to our patients to keep them safe while they are under our care.

Recruitment and Staff Retention

One of the benefits of improving the quality of patient care is improved employee turnover rates. At Hackensack (NJ) University Medical Center, an excellent practice environment has resulted in a nurse employee turnover rate of 6.3%, below the national average, saving the hospital approximately $45,000–$68,000 in recruitment and training expenses for each nurse. There appears to be a direct correlation between the organization's turnover rate and its adoption of a culture that supports patient safety.[13]

It is widely known that healthcare professionals face a variety of work-related hazards during the course of their day, so it is no wonder they sustain musculoskeletal injuries, infections, and mental stress, just to name a few work-related occupational conditions. Healthcare workers also experience more stress and fatigue than many other occupations. They may feel overworked, with an ever increasing workload, and at times, they may work in what seem to them as unsafe conditions. When healthcare workers feel their environment is not conducive to being able to provide safe, high-quality care to their patients, they are usually unhappy. It becomes clear that employee well-being and how employees feel about their environment has a direct impact on patient safety. You see, it seems that if an employee works in an environment that does not promote patient safety, does not support just culture initiatives, does not address inadequate staffing, and does not promote effective communication, the more likely it is that the employee will commit an error, because systems failures are not evaluated. In other words, if an employee doesn't feel that the organization supports him or her in his or her efforts to do a good job, then why should the employee support the organization? Additionally, if the organization doesn't support patient safety initiatives, there is a good chance the employee will not stay long and will move to an environment more conducive to promoting patient safety and preventing patient harm.

To counter the previous discussion, it seems that low employee turnover rates appear to be directly related to "lower failure-to-rescue rates, lower inpatient mortality rates, shorter hospital stays, and fewer work-related injuries."[14] A happier, healthier workplace results in less stress to the employee, thereby eliminating those aspects of the workplace considered to be "toxic." So, what is considered to be a toxic work environment? In truth, any work environment can become toxic if, it includes, or even promotes, behavior that negatively affects others in the same workplace.

Not only that, but if this type of behavior occurs on a fairly routine basis, and is not addressed promptly and appropriately by the organization's leadership, it can affect far more than just employee retention—it can also affect how coworkers handle certain stressful situations. Negative behavior can also affect the long-range plans and reputation of the entire organization. Additionally, it makes it difficult to build a culture of teamwork, particularly when the employee retention rate is directly related to pervasive adverse behavior.

Symptoms of a toxic work environment can include increased absenteeism, health problems and accidents, more resignations, and the loss of talented employees. Although in some cases the toxicity can be related to just one individual, in many cases systemic factors can reinforce toxic behavior or practices, particularly if senior management chooses to look the other way or exhibits indifference to the inappropriate actions. The good news is that, most of the time, once the behavior is made known to human resources, the environment is usually turned around fairly quickly, particularly when senior leadership is made aware of the costs to the organization if these situations are not addressed, which include lost productivity, higher-than-expected employee turnover, and, of course, the potential legal liability.

On the other hand, when an employee feels that he or she works in a healthy work environment where the organization values both patient and employee safety, the employee is more likely to provide high-quality patient care. The bottom line is that supporting a positive workplace also supports quality patient care. To that end, we should do everything we can to make the work environment of our staff as welcoming and inviting as possible. The rewards will be beyond expectations, because when organizations have a reputation for "playing nice in the sandbox," relationships are established that, in most cases, will lead to better opportunities and almost always lead to improved patient care.

Staff and Patient Education

Lastly, the organization should educate patients about their own roles in protecting themselves from medical errors. By knowing about their illness or condition, which medications they are taking and what they look like, and reminding hospital personnel and the medical staff to wash their hands before and after the physical examination or assessment, patients are playing a part in ensuring a culture of safety throughout the organization, not to mention the direct impact in their own safety while in the care of others. This open communication between staff members and patients can make the difference between a positive outcome or an adverse event. In fact, staff should consider inviting patients and their families to speak directly to nursing about any perceptions they may have about the safety of their own care and to be willing to share experiences if, in fact, a medical error has occurred to them or to a loved one at some time in the past.

In fact, communication breakdowns between care providers themselves as well as between care providers and patients can, and often do, put patient safety at great risk when concerns about the safety of the care being provided are not made known clearly. Additionally, by empowering staff members with a clear understanding of their role in the promotion of patient safety, they will feel that they actually do make a difference in ensuring that patients are safe while in their care, their motivation to go beyond the call of their own professional duty increases, and they are encouraged to take responsibility for their own actions.

From the patients' perspective, by being actively engaged in patient safety efforts, they can and should be able to initiate conversations with their healthcare providers regarding simple things, such as asking the reason why a certain medication has been ordered for them or asking the provider to wash his or her hands before any examination.

Families should also be able to utilize communication efforts, such as calling a rapid response team whenever they suspect the patient's condition has changed or asking for instructions on how to take care of a patient's needs once he or she discharged. In 2007, The Joint Commission included in their scoring standards a requirement strongly encouraging interdisciplinary communication and collaboration that includes patients and their families, so that they are actively involved in their own care

as a patient safety strategy, known as their Speak Up™ campaign. (Information about this initiative can be found at *www.jointcommission.org/PatientSafety/SpeakUp*.) Additionally, the AHRQ has developed a program known as "Questions Are the Answer," along with a fact sheet entitled 20 *Tips to Help Prevent Medical Errors*. This four-page document (found at *www.ahrq.gov/consumer/20tips.htm*) is a helpful guide that can be referenced by patients and families. Preliminary studies seem to indicate that when patients take a more participative role in their care, their own safety seems to improve. Furthermore, when patients and staff are effectively and comfortably communicating about the care being provided, and staff is more confident about being able to discuss areas of concern without fear of being chastised, the more an organization demonstrates that it has embraced a just culture approach.

The First Steps of Your Journey

It is important for hospitals and staff members to be continuously reminded that the primary strategic focus for any healthcare entity should be patient-centered care that keeps patients safe. Patient-centered care should include a mechanism whereby hospital personnel and/or the medical staff are comfortable reporting any medical error through the appropriate channels in a continuous effort to improve the quality of care provided. It is also imperative that staff members be involved in the initiative for organizational cultural change, because if the staff isn't on board with the concept—even if the governing body and senior leadership are—the initiative will fail.

Now that the need for change is recognized, it is time to get started. This handbook will guide the way with a hands-on approach, providing information, techniques, and tools to assist organizations as they move through the process of culture change. This is an exciting journey, although at times it can be quite challenging. Still, staff members want to do the right things for their patients; they want to provide the right care to the right patient at the right time and in the right setting. We expect that this handbook will help to do just that, particularly with respect to those responsible for direct, hands-on patient care. The overall goal of a just culture is to look beyond the individual when an error occurs. Making the individual aware of outcomes and holding the individual responsible for learning from his or her mistakes and to performing according to preset expectations in the future, while at the same time evaluating the processes leading up to the error, identifying breaks in those

processes, and correcting them, the organization demonstrates its commitment to objectively understanding why the error occurred and to adopting a systematic approach for addressing errors without staff fearing there will be adverse consequences to them, personally or professionally.

Your action plan for getting started should include:

- Assessing your organization's current culture of patient safety via a survey of a patient safety culture.
- Once findings are received, developing a plan for addressing those areas identified as needing improvement.
- Once the plan has been implemented, communicating to staff just what the plan is, what is required of them to ensure its success, and publicizing efforts made throughout the organization.
- If policies, procedures, or protocols require revision, including staff in the revision process to ensure that practice reasonably adheres to policy.
- Communicating to and educating every staff member about all efforts currently being made to transition to a more just and patient-focused culture, including any changes in policy, expected performance, and behavior. A regular report on progress should be made to convey this throughout the organization. Encourage staff to ask questions about any specific areas of concern.

References

1. Nance, John. *Blind Trust.* William Morrow & Co., 1987.
2. Nance, John. *Why Hospitals Should Fly: The Ultimate Flight Plan to Patient Safety and Quality Care.* Second River Healthcare Press, 2008.
3. Kohn, Linda T., Corrigan, Janet M., and Donaldson, Molla S. *To Err Is Human: Building a Safer Health System, an Executive Summary.* National Academy of Sciences, Committee on Quality of Health Care in America, Institute of Medicine, p. 1.
4. von Thaden, Terry, etc. "The Perception of Just Culture Across the Disciplines in Healthcare." *Human Factors and Ergonomics Society Annual Meeting Proceedings,* Human Factors and Ergonomics Society, 2006. pp. 964–968(5)
5. Beyea, Suzanne. "Reporting medical errors and adverse events – research corner," *AORN Journal,* April (2002): 1.
6. Zboril-Benson, Leone, and Magee, Bernice. "How quality improvement projects influence organizational culture." *Healthcare Quarterly* 8, October Special Issue (2005): 1.
7. Office of Healthcare Quality, Department of Health and Mental Hygiene. *Maryland Hospital Patient Safety Program Annual Report Fiscal Year 2009,* 2009.
8. Ibid.
9. Ibid.
10. Westrum, R. "A typology of organizational cultures." *Quality & Safety in Health Care,* December (2004).
11. Reason, James. *Managing the Risks of Organizational Accidents.* Ashgate Publishing, 1997.
12. Marx, David. *Whack-a-Mole: The Price We Pay for Expecting Perfection.* By Your Side Studios, 2009.
13. Yassi, Annalee and Hancock, Tina. "Patient safety – worker safety: Building a culture of safety to improve healthcare worker and patient well-being," *Healthcare Quarterly* 8, October Special Issue (2005): 33.
14. Ibid.

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