Surveys on Patient Safety Culture™

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

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(Presenter)

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Presentation:

Theresa Famolaro

Famolaro (opening), Slide 1
Theresa Famolaro: Good afternoon. Welcome to our Webcast entitled "Using Just Culture to Improve Hospital Survey on Patient Safety Culture Results." My name is Theresa Famolaro, and I'll be your moderator for today's Webcast. We are very excited about today's topic, and are glad to see that you share our enthusiasm.

Famolaro (opening), Slide 2
Next slide. If you need help at any time during this Webcast, use the Q&A icon. You can also join us by phone at any time by dialing 855-442-5743 and entering the conference ID 99643066.

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Famolaro (opening), Slide 3
Next slide. To help explore our topic today we're pleased to feature Celeste Mayer, who will talk about her experiences improving the Nonpunitive Response to Error composite on the Hospital Survey on Patient Safety Culture by using Just Culture initiatives. Dr. Celeste Mayer is the Patient Safety Officer for the University of North Carolina Healthcare System and has been in this role since 2003. She earned her Ph.D. in human factor psychology from North Carolina State University in 2002 and has over 20 years' experience as a registered nurse.

During her time as the Patient Safety Officer she has promoted and/or led the introduction and sustainment of electronic reporting of patient safety concerns, Just Culture principles in HR practices, regular measurement of patient safety culture, and transparency via Leapfrog Survey participation. She leads the analytics of all serious adverse events, and her current project schedule includes improving alarm safety, TeamSTEPPS, peer support learning following adverse events, and participation in the North Carolina Quality Center Patient Safety Organization.

I am Theresa Famolaro, and I manage the suite of databases for the AHRQ Surveys on Patient Safety Culture at Westat, in Rockville, Maryland, and I will be your monitor for today's Webcast.

Famolaro (opening), Slide 4
Next slide. So, before we begin the presentations, I would like to introduce you to our Webcast console. All the components on the console can be resized to fit your entire browser window, moved and minimized into the menu dock at the bottom of the console. If the slides are too small, click on the lower right-hand corner of the slide window and drag your mouse down to make it larger.

We are pleased to offer closed captioning, as well. To access the closed captioning please click on the icon called Closed Captioning that is at the bottom of your screen view, and after you click the icon a view window will display the captioning.

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The last 15 minutes or so of this Webcast are reserved for a discussion based on questions that you submit. You can submit questions at any time during the presentation. Simply click on the Q&A icon at the bottom of your screen and type your question into the Q&A box and select Submit. We welcome your questions and comments on the upcoming presentations and look forward to an engaging dialog.

Famolaro (opening), Slide 5
Next slide. Today's slides are available for download by clicking on the icon at the bottom of your screen that says Download Slides. This will generate a PDF version of the presentation that you can download and save as desired.

Famolaro (opening), Slide 5
Next slide. We have also additional resources available for you to access under the Resources icon. Here you will find a link to the Hospital Survey on Patient Safety Culture Web site, where you can download the Hospital Survey, Items and Composites and User's Guide. Also, there is a PDF of the 2016 Hospital Comparative Database Report.

We also have resources provided by our main presenter, Celeste Mayer, at the University of North Carolina Medical Center. These resources include their Corrective Correction Action Policy, a Correction Action Report, an Employee Counseling Report and a Pre-disciplinary Conference Notification Letter and Report.

Famolaro (opening), Slide 6
Next slide. So now that we've reviewed the console I'm going to give a brief background of the AHRQ Hospital Survey on Patient Safety Culture and how results from the survey relate to Just Culture. So what is patient safety culture? Well, it's really the way we do things around here. It's the beliefs, the values, the norms shared by staff, and is what is rewarded, supported and expected by the organization. Importantly, patient safety culture really exists at multiple levels, ranging from the system, the department, unit levels, and so it's basically at all of those areas.

Famolaro (opening), Slide 7
Next slide. So, what is Just Culture? The term "Just Culture" was first coined, or one of the first people that coined it, was James Reason in his book, Managing the Risks of Organizational Accidents. And he defined Just Culture as 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.

And then you might've also heard David Marx, from Outcome Engenuity, introduce Just Culture as an accountable care culture that sort of stabilizes or balances a blame-free environment and a punitive environment. And accountability takes into consideration elements of human behavior along with the actual organization systems and issues at different levels that include the health system management staff and providers.

Famolaro (opening), Slide 8
Let's go to the next slide. So here's a little background on the Hospital Survey on Patient Safety Culture. This survey has been around for some time now. The hospital survey includes 42 items that measure 12 composites of organizational patient safety culture in your hospital. And so, for example, we have Communication Openness, Feedback and Communication about Error, and, importantly for this webinar, Nonpunitive Response to Error. There are also two outcome items, Patient Safety Grade and Number of Events Reported in the Past 12 Months.

Famolaro (opening), Slide 9
Let's go to the next slide. So on the next slide we see that hospitals, or I could just tell you that hospitals that administer this survey can then voluntarily submit their data to the AHRQ Hospital Survey on Patient Safety Culture Comparative Database for comparison to other hospitals in support of patient safety improvement.

So here I'm showing you the lowest performing composite scores across all of the hospitals, on average, across all of the hospitals that submitted to the 2016 Database. And, as you can see, Nonpunitive Response to Error was the lowest performing composite across all participating hospitals, at 45 percent positive.

Famolaro (opening), Slide 10
Next slide. So, what is Nonpunitive Response to Error? What does it really consist of? Well, we define it as 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. So it's a little bit different than Just Culture, but it gets at some of the things that people are afraid of when making patient safety -- when working on patient safety within their hospital.

Famolaro (opening), Slide 11
Let's go to the next slide. And here are the three items. They're negatively worded items. And these three items are staff feel like their mistakes are held against them; when an event is reported it feels like this person is being written up, not the problem; staff worry that mistakes they make are kept in their personnel file. And if a respondent answers agree or strongly agree, that is considered a negative thing, and so their percent positive score would go down, rather if the respondent says they strongly disagree or disagree to any of these items, then their percent positive score, of course, increases.

Famolaro (opening), Slide 12
Let's go to the next slide. So I'd like to turn this next part of the presentation over to our main speaker. Celeste is going to be speaking to us about how she implemented Just Culture in her hospital and how Just Culture improved her scores specifically on Nonpunitive Response to Error, but potentially actually all of her other composites, as well. So I'm going to send this over to Celeste.

Celeste Mayer

Mayer, Slide 12
Thank you, Theresa. I'm so happy to be here with everyone

Mayer, Slide 13
Let's go to the next slide, and I'll start by sharing some information with you about the University of North Carolina Medical Center. It is a public academic medical center located in the center of the state of North Carolina in Chapel Hill, North Carolina. We have about 850 beds, and we have these hospitals as part of the Medical Center: our Memorial Hospital, Children's, Neurosciences, Women's and the Cancer Hospital.

In the photo of the Medical Center this is a view taken to the north. The building closest in perspective on the far right is our newest cancer hospital built in 2010. And there in the center just slightly to the left peeking through, the shorter brick building, is our original building, our original hospital built in 1952. All of the forested area beyond the hospital medical center, and you can see some of downtown Chapel Hill to the horizon, is actually residential areas in Chapel Hill. We love our trees in North Carolina.

Mayer, Slide 14
Next slide, please. Let me tell you just a little bit about my background and my role and where it resides at the Medical Center. I've been the Patient Safety Officer since 2003. I am the first Patient Safety Officer, but my time at UNC started back in 1988 when I came to the Medical Center in the role of an evening nursing supervisor. During that time in the mid-90s I went part time back to graduate school, and I got my Ph.D. in human factor psychology from NC State University in Raleigh.

But my reporting structure, that has changed over time. Initially I reported to the VP for Quality, and then for the longest reporting period I reported to the Chief of the Medical Staff, and this was a reporting relationship that I enjoyed and benefited from for the majority of my time here. Currently I report to the General Counsel for the Medical Center.

Mayer, Slide 15
Let's go to the next slide. Let's now talk about the Just Culture journey at the Medical Center, beginning with a look at the data of interest. If we look at this composite, the Nonpunitive Response to Error in our Hospital Survey on Patient Safety Culture, here are the results that we've seen at the Medical Center over time.

We have a long history with administration of the Hospital Survey on Patient Safety Culture. I remember I was at a conference, it was 2004, maybe 2005, walking around at the break, saw a table with something about a survey,

and I was handed the Hospital Survey on Patient Safety Culture User's Guide, a spiral-bound, blue front and back. I still have a copy of it, and I refer to it quite regularly. But that was my introduction to it.

And with that I had the opportunity to propose beginning the use of that survey tool in 2006, and we have continued since, surveying approximately every 18 to 24 months. You can see with our first survey our percent positive on the Nonpunitive Response to Error was pretty low. It was our first survey. We had lots of areas that we were looking at and studying. We didn't really understand what it meant, but we knew it wasn't good.

So I'm going to talk to you mostly about the time period between that 2008 when we saw still very low, 39 percent positive, and what happened in between 2008 and the 2009 survey when we saw that biggest jump, and what has continued this improvement in the percent positive perception of a Just Culture environment as measured by this dimension over time.

Mayer, Slide 16
Next slide. So probably like many of you I got an email. It was announcing a Just Culture Collaborative. This was going to be a partnership between the North Carolina Quality Center and Outcome Engineering, as it was known at that time, now Outcome Engineering with David Marx then and now as the CEO.

I knew about Just Culture from the writing of James Reason, and I also knew about David's work on Just Culture. I saw this as a great opportunity for the Health Care System, and I proposed that we participate in the Collaborative with the Chief of Staff that I reported to. And eventually we did, along with nine other hospitals from North Carolina. We participated in what was a year-long learning and sharing experience, and it started there in July 2006 and went through.

Mayer, Slide 17
Next slide. You might wonder how I pitched this to my boss, because this was a big engagement. I described it as inexpensive consulting. The information that came in that early email outlined what would be happening and what we would get as a result of the Collaborative participation. I could see that we were going to get some review of how apparent our culture was in documentations and in application of policy.

And we were already measuring and wanted to make this measurement through the Hospital Survey on Patient Safety Culture important. And so addressing what we were finding would be most meaningful, I thought that it was foundational, and a next step in our journey in creating a culture of safety at the Medical Center and being able to communicate about the culture of safety.

Mayer, Slide 18
Next slide, please. And, boy, was I lucky. As I have already alluded to, I had a wonderful relationship with the Chief of the Medical Staff. He was highly regarded, a skillful and respectful mediator. He was always supportive of me, and removed barriers. We talked about what we hoped to achieve with the Collaborative and who would be best participating, because we were expected to send a team, not an individual, because right from the beginning the Collaborative was proposed as this is going to be work that we are going to take you through over time, and it's going to require a team.

So the Chief of Staff, to help me with that, he was supportive, onboard, he reached out to the individuals that we thought would be most important, and he had those private conversations with them, starting with telling them how important they already were and how important their participation in the Collaborative would be. And he continued to support this work, and I'm going to share another example of something that was really important in our success that he -- an example of his support a little bit later.

Mayer, Slide 19
Next slide, please. So if I ask you who do you think would be good to be on a team like this I bet you would make a similar list, but this is who we sent: myself, the Patient Safety Officer; the Director for Risk Management; an attorney from the legal department, because they have a big involvement in how we apply corrective action, as does the Director for Employee Relations and HR.

We also sent the Director for Nursing Education, expecting to need that education expertise. And we sent two nurse managers who were very interested in this topic and would be eager to apply it early. We also sent two physicians, a pediatrician and an anesthesiologist. And this team worked together through the entire Collaborative and even today, what is it now, 10 years later, 50 percent of this team is still here in the organization and with a memory of how important that work was and that it continues.

As I remember, there were, of course I've said nine other hospitals. They were smaller hospitals. And I know in a collaborative you expect some sharing and learning from other hospitals represented, but I don't recall a lot of that. We were the biggest organization in the Collaborative, and I recall that we felt like we were different, and we just worked kind of independently but very dedicated to making the most of the Collaborative.

Mayer, Slide 20
Next slide, please. Let me go into a bit more detail of the pre-work. I'm the kind of person who saves some stuff. I don't save everything, but I save what I think is important, and the Just Culture Collaborative binder is important, and I was able to refer back to that so I can accurately share with you what that was like.

The pre-work was requested a month or two in advance of the actual first in-person meeting. And we were asked to give a sample, I think it was about a half a dozen root cause analysis event documentation summaries, de-identified, to collect them and prepare them for sending; to randomly select some documentation of employee corrective action reports, also de-identified, I think about 30 of them; and then any other activity related to patient safety that we were engaged in; a whole bunch of policies.

We were given some suggested topics that we might search for policies related to, like corrective action, our sentinel event policy, our adverse event reporting policy, our patient safety plan that was approved by the Health Care System Board and is annually approved, as well as things like the code of conduct, the employee handbook and medical staff bylaws.

So all of this was prepared and sent to the Collaborative leaders in advance, and we knew that during the in-person learning and sharing that we would get feedback on this, so that was really helpful. We would get a measure of what outsiders saw, outsiders with expertise in Just Culture, saw as the existence of our culture related to that as it was at the beginning of the Collaborative. So then we began three consecutive days of intense learning and sharing, followed by monthly conference calls.

Mayer, Slide 21
Next slide, please. The conference calls -- I'm sorry, I wanted to mention just a little bit more about the conference calls. It wasn't just random let's get together and talk, but the conference call topics followed what you would see in any good organizational change strategy. They included topics like each month would be, for example, plan for communication, then the next month aligning organizational beliefs, the next month building structure, the next aligning policy, etc. So it was very well designed to take you through the logical steps in making big organizational change.

So now we started. We started with talking and communicating about this planned change. We had -- we realized we had to acknowledge the shift, and it was the shift, not that we believed we had a punitive culture, but a shift somewhere in that spectrum between punitive and blame-free. These were concepts that maybe we weren't even talking about, but we knew that they would come up.

So where was this, was our proposed plan and operationalism of this Just Culture principle? So we talked about that and we used all of the usual formal communication channels. There are just, probably like in your organizations, there are newsletters to physicians, newsletters to hospital staff, electronic bulletin boards, and then the usual in-person opportunities at those regular monthly high-level meetings that was shared.

So we took advantage of all of our usual forms of communication. And remember those participants in the Collaborative from the Medical Center. They were very visible and leaders, recognized leaders in our organization. So they were also -- we were all talking about it at any opportunity and updating everyone that we could regularly on how the Collaborative was going.

We also took advantage of some high-profile, visible support outside of the organization, talking about how the Director for the North Carolina Quality Center thought this was important, provided this Collaborative for all hospitals in North Carolina and with a goal to raise us all in quality and safety. The President of the North Carolina Hospital Association also was supportive, so we would use his name.

And one other important thing, at the same time the North Carolina Board of Nursing was piloting incorporation of Just Culture principles into their discipline and compliance activity. And you can still see that very visible, very out front on the North Carolina Board of Nursing web page. So we used all of that to say these important people and organizations think this is where we need to go.

We started some education, and I'll give you more detail about that in another slide. But we were looking for all the ways to weave this into the fabric of the organization and change the policy.

The Collaborative participants, we took our existing corrective action policy and we drafted a revision incorporating Just Culture principles. And then we provided that to many different managers and got their feedback and incorporated that into another revision, and then that was turned over with all that feedback to those departments that would make the final changes and seek organizational approval.

Mayer, Slide 22
Next slide, please. But, oh, my goodness, this took a long time. From the beginning of the Collaborative till we finally had an approved revised corrective action policy it was two years. This was a very discouraging time for me. I was afraid we had hit an insurmountable road block. I didn't understand. I wasn't involved in the policy change, and I was very concerned. We had already started education. We had already shared with communication and with managers our goals and where we hoped to be, and this really scared me.

But I learned a lot. I learned from the experience that big change is hard, and sometimes it takes a long time, and it can be personally discouraging. But remaining steadfast on the message, the goal, and staying positive and surrounding yourself with other positive people will make a difference in the results and your sanity over time. We probably all have stories of when we have felt discouraged in trying to lead change.

Mayer, Slide 23
Next slide. But, hooray, the policy was passed, and the new corrective action policy had these fantastic, clear expectations for use of a tool to apply the principles of Just Culture. It was an algorithm. We had clear expectations in the policy for doing that. And we began mandatory training for new managers that continues today. And it became all very visible to staff.

It became visible to frontline staff in the requirements for managers to document when they counsel employees and to ensure another layer of safeguard that we were adhering to the Just Culture principles. When corrective actions reach a pretty serious level and you're approaching pre-dismissal, Employee Relations must be involved in the discussions with the manager and employee. And we do that to ensure that we are adhering to the Just Culture principles, that the employee understands that, and that it is clearly documented.

We have made the policy available to you, and I want to say I know it's not perfect, but it is what we have followed, with very little change, since 2008. And I think it's part of what's helped us see this improvement.

Mayer, Slide 24
Next slide, please. Let me give you some more specifics about the training, and then also talk to you about the significant role of a strong, committed leader. Back during the Collaborative the Director for Employee Relations and I, we provided multiple sessions, all comers but focused and directed to managers on the Just Culture principles and how we were planning on applying them in our organization.

And then about the same time, in the spring of 2007, the Medical Center launched a campaign to create a new message for the community and employees along with a new strategic plan, and we called it then, and still do call it, our commitment to caring. And the Chief of Staff realized this opportunity to again highlight and fold Just Culture into that strategic plan, to make it part and permanent of the way we did things.

He suggested that we bring David Marx to the Medical Center, and David came. He spent a day with us. I have notes that he did two one-hour introductory lectures for anybody who wanted to learn about Just Culture, and then a four-hour lecture on the application of tools and concepts that was mostly directed to those managers that would be applying the tools and concepts. We offer continuing nursing education credit for that.

We created what we call a cascade learning document for that experience so that those who attended could take this cascade learning document back to their staff and know the important points to communicate and share and to do it consistently across the organization. David also had meetings with senior leaders in separate sessions to answer their questions.

And from then and continuing now, Employee Relations still leads training for all new managers. It is mandatory training for managers. In an hour they go over the concepts and they practice the application of the Just Culture algorithm using a case.

This is what we say. We say frontline staff experience the Just Culture. We have never created specific training for frontline staff.

Mayer, Slide 25
Next slide. Let me share with you what I mean by staff experience Just Culture. It is visible to all staff. The algorithm that we use as a tool can be found I would say in 90% of any manager's office. In preparation for this webinar I just got out my list of managers' phone numbers where their offices are, and I thought, well, I'll just go down the list until I find a manager that is actually at his or her desk, answers the phone and will help me out. And it didn't take long and someone answered, and I said, "Do you have that algorithm on your bulletin board?" "Yes, I do." I said, "Well, I'll be right there. Can I come and interrupt whatever you're doing to take a picture?"

So here you have there is evidence, and what you'll find located in a very visible place somewhere in almost all managers' offices. So staff see that, and it will be taken off the bulletin board to go over and to understand in discussions with employees.

Mayer, Slide 26
Next slide, please. So I've referred to the algorithm, and this is the Just Culture algorithm that we received permission to use way back when during the Collaborative and we continue to use it today. In our corrective action policy, if you look at that, you will see there are 14 references to use the Just Culture algorithm.

Managers are required to document that they have used this in any counseling or corrective action session with an employee, and the employee sees and also signs this document. So we are absolutely certain that all those involved in any counseling or review of human behavior that they see the words Just Culture, they see the algorithm, they go through it together.

Mayer, Slide 27
Next slide, please. I just wanted to share with you a sample, and I've also provided the full documents for you to have. This is a sample of an employee counseling session. You can see on the document that it clearly indicates this does not constitute corrective action, because in the Just Culture principles we know that as humans we make mistakes, human error, and that does not warrant corrective action.

So you can see here where the manager has to identify the human behavior type that they're counseling the employee about, human error, at risk or reckless. And I want to say, like our policy, I've already said, it's not perfect, neither is this. I don't think a behavior can be all three. I don't think you can have all three at once. So that's another example of how this is not perfect. And if you're interested in these documents I hope that you will take them, use them as a model, and do them even better in your organizations.

Mayer, Slide 28
Next slide. So how are we sustaining today? Well, you can see that we continue to regularly measure using the Hospital Survey on Patient Safety Culture, and we, with every administration, focus on that particular composite, the Nonpunitive Response to Error, and of course other composites, as well. Survey results are shared at the Health Care System Board level all the way down to the unit level.

I provide reports in multiple ways, for example, unit compared to itself over time, compared to other units, or grouped by department. I also provide -- oh, you might have to read the rest of this yourself -- I also provide some additional analysis of the Nonpunitive Response to Error at the unit level compared to, for example, our employee engagement scores to see if there's a relationship. Nurse leadership is very interested in this.

And in the last administration, additionally, we added five questions. These are five questions that the North Carolina Quality Center provides to us for hospitals in North Carolina. And you can see they are very focused, targeted on Just Culture. So that's another example of how we continue to try and understand this and improve our perception of a Just Culture. Employee relations remains our standard bearer for the application of Just Culture principles in providing the consistent education as well as involvement when corrective action reaches a serious level.

Mayer, Slide 29
Next slide, please. So what is most important? What was and is? I just feel very fortunate to have a supportive and influential leader that I reported to that could remove barriers. The learning collaborative was a perfect opportunity at the exact right time. I don't know that we could've done this without that organization of the Collaborative in guiding us and keeping us on track as well as giving us that state-level prioritization of this for hospitals in North Carolina.

Mayer, Slide 30
I think incorporating the Just Culture principles into the corrective action policy and the documentation related to any corrective action or counseling is really key for us, because that was the weaving it into the way we do things around here. And the ability to use the Hospital Survey on Patient Safety Culture to continuously measure and know that we are getting a valid representation of where we are, whether as an organization or at the unit level, and sharing that within our organization has been what has made the difference for us.

With this I'll turn the presentation back over to Theresa, and I'll look forward to your questions.

Theresa Famolaro

Famolaro, Slide 31
Thank you so much, Celeste. That was really terrific. So it's really great to hear about how you're implementing Just Culture principles in your hospital to improve patient safety culture. So very, very exciting.

So I wanted to remind our audience participants that we're currently in the process of creating a new version of the hospital survey, also known as HSOPS 2.0. We're currently in the process of conducting cognitive testing of the survey to ensure that the questions are understood by our respondents and that they make sense.

We also will be conducting a pilot study of the full survey, HSOPS 2.0, along with an HIT Supplemental Item set, in the spring of 2017. And we expect to have the HSOPS 2.0 and an HIT Supplemental Item set released in early 2018.

So, among the many revisions that we're making, we are definitely making changes to the composite Nonpunitive Response to Error to what we call Response to Error, to include more Just Culture principles in the survey items. So I don't think there are any negatively worded items, or if there are, I have to double-check, it might just be a few, or one. We definitely don't have three negatively worded items like we did before. And then, so that should be a nice change to the new survey.

We're also opening up the next hospital database submission in June 2017, and this database will only accept data from the original hospital survey, so the current one that's on the AHRQ Web site and the one that Celeste has used or spoken about today.

Famolaro, Slide 32
Okay, let's go to the next slide. So, AHRQ also has resources for improving your hospital survey results. The AHRQ Action Planning Tool is recently pretty new, and it's available on the AHRQ Web site. We also have a resource list that actually gives specific online free resources by survey composite on the AHRQ Web site. There is a section for Nonpunitive Response to Error. And the 2016 Comparative Database Report you can download from the Web site. So, they're also in the Webcast Resources section.

Importantly, I just wanted to remind everyone that the UN resources that are listed on this slide, so the Corrective Action Policy, the Corrective Action Reports, etc., can also be downloaded in the Webcast portal by clicking on the Resources widget.

Famolaro, Slide 33
Let's go to the next slide. So we're now going to move on to the Q&A section. As a reminder, to submit questions simply click on the Q&A icon at the bottom of your screen, then type your question into the Q&A box and select Submit. So that we can answer as many questions as possible, we ask that you keep your comments brief and focused on today's topic.

Theresa Famolaro
Okay, let's start with the first question. So, I think this is a question for you, Celeste. How does Just Culture address the item staff worry that mistakes they make are kept in their personnel file?

Celeste Mayer
Yes, that's a good question. I certainly have looked at that item and realized that it doesn't exactly align with Just Culture principles, because of course a good manager is going to document if an employee has made a mistake or human error has occurred, but that does not mean corrective action is needed. But you need to document that as a good manager, because if the same or similar type of human error occurs in that particular employee

repeatedly, that might be evidence that this is not a good fit for that employee, maybe not the right work responsibilities.

When we look at our survey results on that particular item within the three items in that composite, we do see that that item is always about 10, 13 percent lower in positive perception than others. And I'm sure that those taking the survey focus on that question, worry, and that's certainly a negative emotion. So I'm aware that that one doesn't quite fit with the Just Culture.

Theresa Famolaro
Yes, I'm glad you brought that up, and I think that's why we were definitely going to implement or to revise the Nonpunitive Response to Error items so that they reflect more of the Just Culture principles and not just thinking negatively about a punitive culture or a blame-free culture.

So, we got a question here, and I think this is an interesting one. If we wanted to utilize your documents, which were, I guess, your Corrective Action Policy, and modify them for our institution, do we need to seek permission from you in writing?

Celeste Mayer
No, you don't. No, you do not. I hope that those documents will be a good start for you, and look at them critically, because I have said they are not perfect, and they're not exactly aligned. So when you study them you'll see where you can make improvements. Please, that's why they're there, for you to use.

Theresa Famolaro
Okay, great. And then here's another question. I think this is very interesting. I think we both can answer this, but I'll let you go first. Just Culture is also intended to improve event reporting. Did you see any significant improvement in HSOPS' Frequency of Events Reported category or in your hospital event reporting system?

Celeste Mayer
I think that's a complex effect to see improvement or an increase in the use of a voluntary reporting system. And it is important that staff feel safe to report, but over time we have not seen any changes. And I think that that is probably -- I'd be interested to know what other organizations see, but I don't think that we're that different in that the information that goes into our voluntary reporting system does not freely flow back out for learning which would reinforce reporting.

So I think there are other factors at play that impact staff's interest and motivation to use the voluntary reporting system. It's certainly important that we have a Just Culture, or if we regularly saw staff experience punishment as a result of sharing their own close calls I think we'd clearly see a drop. But it hasn't made a big change in the number reported.

Theresa Famolaro
Okay. So I'd just like to add to that saying that I know that your hospital in general has improved across all composites over time, correct?

Celeste Mayer
Yes.

Theresa Famolaro
And so I just want to point out to the participant that all of the composites that are in the Hospital Survey on Patient Safety Culture are related to one another, and we actually looked at just the correlation between Nonpunitive Response to Error and to all of the other composites, and we found a moderate to strong correlation, and they were all significant. So we definitely can say that if you improve Nonpunitive Response to Error if you use Just Culture it's going to affect your other composite results, because they're all related to one another. So I think it can only have a positive effect on your -- including your reporting.

Okay, so let's go to the next question here. Okay, so have you integrated Just Culture in physician peer review and engaged physicians in Just Culture principled learning?

Celeste Mayer
I don't have a good answer to that one, because my memory on that is not great, and I would have to check on that. But there is that item that we added in the additional questions which I was choked up so I couldn't go over them, but the additional questions that we added, there was one about everyone's treated fairly, whether it's a

physician or other staff in the hospital. So we are interested in that. But what the medical, the code of conduct for physicians has incorporated, I'm sorry, I can't answer that question. But it is a good one.

Theresa Famolaro
Okay. And then just another question, where do you think you're going next in your Just Culture journey at this point?

Celeste Mayer
I think next we'll have another period of looking at these additional questions. We're going to continue to use the Hospital Survey on Patient Safety Culture with the next version, and that will be very interesting, too. I would like to see an increased percent positive, and we use the data to always be evaluating ourselves and checking ourselves against that data.

Theresa Famolaro
Okay. And then another one is if you find that someone is doing reckless behavior, which is a Just Culture concept, so where the staff member willfully and deliberately acted in a way that jeopardizes patient safety, how do you have a Nonpunitive Response to Error in that case, or how do you handle the situation?

Celeste Mayer
Well, I can just -- I can talk about that, but in my role I am not involved or privy to those relationships between managers and employees. But reckless behavior, as Theresa said, like willful disregard for the outcome, willful disregard for the outcome or the safety of the patient, choosing to do something with knowledge that it could cause harm, that warrants corrective action. We don't want employees that are engaging in reckless behavior. So that's how we manage that. And we know that that is very rare behavior to see that reckless behavior.

Theresa Famolaro
Okay, and let's see. We have so many questions that are coming through.

Celeste Mayer
That's great.

Theresa Famolaro
Yes, so, oh, yes, you speak of the nursing and physician involvement. How were other disciplines involved in this journey?

Celeste Mayer
Well, there are managers in all other disciplines, pharmacy, respiratory therapy, radiology, all managers, no matter what discipline, receive the mandatory education in Just Culture. The managers in those areas and employees across the organization all use the same corrective action process and documentation regardless of what professional group they are part of.

Theresa Famolaro
Got it. And then here's another question. Can you briefly discuss why the process to implement changes to the corrective action policy took two years or so? Are there any lessons learned in this area that you want to share that perhaps can expedite the process?

Celeste Mayer
Well, first, in your own organization do you make policy changes quickly? Does it regularly take a lot of time? And this was a big change, and I was not involved in that, and maybe that was because I was still so new in my role, so I did not have input. I don't know whether that would've made a difference or not.

But I guess that the two years represented the internal angst that we had, and in this big change, and I think what was most difficult is saying the outcome does not determine how we manage human behavior. And that was a different approach, and that was probably discussed at great length. So what I've learned is, as I said, some things take a lot of time. Now, many years later, a different view of my role, abilities, capabilities in the organization, maybe we could do things differently. But at the time that's just the way it was.

Theresa Famolaro
And then did you work with your nursing union somehow to develop -- a nursing union to develop this policy?

Celeste Mayer
No, we don't have a union at this organization. But I mentioned the North Carolina Board of Nursing, which has some oversight over nursing practice. Remember, I mentioned that they at the same time of the Collaborative were piloting application of Just Culture principles in their disciplinary process. If a nurse was reported to the Board of Nursing that they would also look, what kind -- was this human error, at risk or reckless, and then apply the corrective action based on the principles of a Just Culture.

Theresa Famolaro
Okay. Here's another question. I think this kind of relates to some similar questions that we're getting. So one participant stated that they use a similar system like you use that they keep in their personnel file. However, employees still see this as kind of negative. So it's kind of like what we were saying earlier, that -- or what we were discussing, in that coaching can be seen as negative, or they can see this as still being kept in their personnel file. Do you have that issue, and how do you overcome it?

Celeste Mayer
I guess over time, because this has been so much a part of the way that we do things, we don't have an issue with that counseling being perceived as negative. For one thing, coaching is incorporated into lots of our work. We have TeamSTEPPS, and there's coaching in TeamSTEPPS. The debriefing in TeamSTEPPS includes coaching each other and compliments. The graduate medical department for residents talks and trains on how to coach appropriately and how important the role of coach or trainer or teacher is. So we don't have a negative idea around coaching.

And the counseling session that is documented, because it is important to document to hold even managers accountable for application of Just Culture principles, it includes consoling staff when something has happened or there's been a performance that could result in patient harm but it involves human error. So we also include consoling them, reassuring them and continuing to support them to make any improvements that they need.

And, as I pointed out, in that one particular example it clearly says on that document this is not corrective action. So I am not hearing that in the organization that that's considered a bad thing. It's considered the manager's responsibility to build employees and to help them make progress in their careers and in their work.

Theresa Famolaro
Well, Celeste, you certainly have made quite a big advancement in your scores and in your work and patient safety and Just Culture in your hospital. I'm really, really impressed, and I'm sure all of our other participants are very impressed, as well.

So I know we were able to answer many questions that came in, but not all of them. So I really appreciate all the questions that were sent to us and apologize for not getting to all of them. We only have a few minutes left, and I just want to move on to the closing segment of our Webcast today.

Famolaro, Slide 34
So let's go to the next slide. Okay, so if you are interested in receiving any email updates about the Patient Safety Culture Surveys, including announcements of future events, visit the AHRQ Web site and select Email Updates from the top navigation bar. You will be able to sign up for Patient Safety Culture Survey updates by the various survey settings, hospital, medical office, nursing home, pharmacy, and ambulatory surgery center.

Famolaro, Slide 35
And so let's look at the next slide. I'm afraid we are out of time today, and we have to bring this Webcast to a close. I'd really like to thank our presenter, Celeste Mayer, from UNC, and our audience. We invite you to visit the AHRQ Web site and contact us at any time, by email or phone, using the contact information on this slide. Remember to complete the Webcast evaluation. I think it's showing up now on your screen. It helps us to improve our offerings and plan future events that meet your needs.

So thank you so much, and thanks again for joining us.