Surveys on Patient Safety Culture™

Implementation of an Event Reporting and Learning System Leads to Improvements in Patient Safety Culture at UNC Medical Center
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Presentation:

Laura Gray
Gray (opening), Slide 1
Hello and welcome to our webcast from the Agency for Healthcare Research and Quality, Implementation of an Event Reporting and Learning System Leads to Improvements in Patient Safety Culture at UNC Medical Center. My name is Laura Gray and I'll be your moderator for today. I am a Senior Study Director at Westat and I serve as the Project Manager for the AHRQ's Surveys on Patient Safety Culture or SOPS.

Gray (opening), Slide 2
Before we begin, I have just a few housekeeping details to go over with you. If you are having any difficulty hearing the audio from your computer speakers, you can go ahead and switch the audio selection by having WebEx call you at a phone number that you provide and then you can connect your audio through your telephone. In the event that your computer freezes at any point during the presentation, you can try logging out and then logging back into the WebEx to refresh the page. Please do know that there might just be a little lag in the advancement of slides due to your internet connection speed. If you need help at any time during this webcast, you can use the Q&A icon to ask questions or to request help.

Gray (opening), Slide 3
To do that, again, if you have any further technical difficulties or you just want to ask a question for our speakers, you use this Q&A feature. So depending on the browser that you're using, your screen might look slightly different than what we have here, but just look for the Q&A icon and then be sure that the dropdown selection displays all panelists so that you can ask the question to our entire team. Today's session is being recorded and a replay of today's webcast and the slides will be made available on the AHRQ website.

Gray (opening), Slide 4
I'd like to welcome and introduce you to the speakers that we have today. First, we have Dr. Caren Ginsberg who directs the Agency for Healthcare Research and Quality's work on the Consumer Assessment of Healthcare Providers and Systems, and Surveys on Patient Safety Culture. An anthropologist and demographer, Dr. Ginsberg has broad-based experience in patient experience, patient safety and public health. In her position at AHRQ, she focuses on program development, implementation, operations and evaluation with specialty in survey design and development and qualitative evaluation and assessment.

I'm also delighted to welcome three speakers from the University of North Carolina to share their improvement story with us today. Dr. Lukasz Mazur has a background in industrial and management engineering and is currently an Associate Professor and a Director of the Healthcare Engineering Department at the Radiation Oncology Department in the UNC School of Medicine. His research interests include engineering management as it pertains to continuous quality and patient safety efforts in healthcare and human factor engineering with a focus on workload and individual performance during human machine interactions.

Alison Amos is a Clinical Assistant Professor in the UNC Chapel Hill Radiation Oncology department and the UNC School of Medicine and a member of the department's division of healthcare engineering. Her current role supports outpatient oncology clinics to implement, train and coach on infrastructure for continuous quality improvement, utilizing lean-based process improvement and patient safety methodologies. She also supports institutional efforts to align quality, risk management and training groups to each other and to clinical practitioners, students and trainees.

Stephenie Fenton-Wilhelm serves as the Vice President of Risk Management for UNC Health Care. Stephenie oversees all risk management strategy and operations including clinical risk management, management of the self-insurance and commercial insurance programs, as well as claims and litigation. Stephenie uses her experience as a healthcare risk manager, attorney and insurance broker to design effective risk management programs and strategies to improve patient safety and reduce risks for UNC Health Care. And as I mentioned earlier, my name is Laura Gray and I'm serving as your moderator for today's webcast.

Gray (opening), Slide 5
So here's our agenda for today's call. We'll be starting off with Dr. Caren Ginsberg, giving a brief overview from AHRQ, and then we will hear the improvement story today from the University of North Carolina, beginning with an overview of the Culture of Safety Improvement within UNC Radiation Oncology, the culture of Safety Improvement Project being implemented more broadly at UNC Medical Center and their next steps. And lastly, we hope to have some time at the end for answering your questions. So without further ado, I will hand it off to Caren.

Caren Ginsberg
Ginsberg, Slide 6
Hello everyone and welcome. I'm Caren Ginsberg and I direct the Agency for Healthcare Research and Quality's work on the Surveys on Patient Safety Culture or SOPS. And I'm delighted to bring this program to you today on the University of North Carolina's work on Factors Influencing Patient's Safety Culture Change at the UNC Medical Center. We welcome this research-based and innovative approach to improving culture which uses different approaches and measures change with the Hospital SOPS Survey. And so, while this work is specific to UNC Medical Center, there are implications of this work for other settings in the organizations as you'll hear. Before we start, I'd like to give you an overview of AHRQ's mission and patient safety work at AHRQ and the SOPS program to provide some context for today's presentation. And I think we have quite a few attendees today who are new to SOPS and the SOPS program. So I hope this background is helpful for you.

Ginsberg, Slide 7
AHRQ's mission is to improve the life of patients by helping healthcare systems and professionals deliver care that's of high quality, high value and is care that's safe. AHRQ is science-based agency. And so, as such, what we do is invest in research and evidence to make healthcare safer and improve quality. We create tools for healthcare professionals to improve care for their patients and we generate measures and data that are used by providers and policymakers to improve performance and evaluate the progress of the US healthcare system. We feel it's important to push our science to implementation and to get our tools and products out to you our users.

Ginsberg, Slide 8
Our patient safety priorities at AHRQ are to focus on areas of greatest impact, to extend patient safety improvements to all settings, prevent healthcare associated infections and reduce antibiotic resistance, build

capacity in the system to accelerate safety improvements, improve communication and engagement between clinicians and patients, and generally make the safe thing the easy thing to do.

Ginsberg, Slide 9
The SOPS program has been funded by AHRQ since 2001. And what we're most known for are the Surveys of Patient Safety Culture, these are validated, instruments that use the best methods in their development and testing. And in addition to our surveys, the SOPS program also conducts research to further our understanding of patient safety culture, how to measure it, how to improve it. We also focus our efforts on quality improvement using SOPS data.

Ginsberg, Slide 10
Just to give you a little bit more background, I'd like to tell you how AHRQ defines patient safety culture. We define patient safety culture as the beliefs, values and norms that are shared by healthcare providers and staff in an organization. Patient safety culture determines the behaviors that are rewarded, supported, expected and accepted within an organization as it relates to patient safety. And when you get into looking at the surveys, you'll see how they measure these concepts. It's also important to note that culture can exist at multiple levels; from the unit level to the department level, to the organization and system levels as well.

Ginsberg, Slide 11
We have five SOPS surveys. And again, these are surveys of providers and staff about the extent to which their organizational culture supports patient safety. The settings for our surveys are hospitals, nursing homes, medical offices, community pharmacies, ambulatory surgery centers. You can see the dates that we release these surveys and we have databases in which data submitters can voluntarily, if they choose to submit data. And well, you'll hear more about that later through 2020 as we open databases.

Ginsberg, Slide 12
Some of the uses for SOPS surveys are to raise awareness among staff about patient safety, assess patient safety culture to identify strengths and areas for improvement, examining trends over time, evaluating the impact of patient safety initiatives. I just want to say, I just brought up databases a moment ago. I want to say that before we transition to the main program that we are going to be having a SOPS one-on-one webcast yearly, we had one last year.

Our next one will be February 19th, 2020, 2:00 to 3:00 Eastern if you'd like to attend. And at this webcast, we're going to talk about our plans for 2020, including data submission for both the HSOPS Survey version one, and our newly released version two, we will open the database for both of those as well as for our Nursing Home SOPS Survey. To stay current on these and to know when the deadlines are, you'll subscribe to our GovDelivery messages to keep informed about these activities. We'll tell you how to do that at the end of the webcast. So, thanks again for joining us and I'm going to turn this over to Lukasz now.

Lukasz Mazur
Mazur, Slide 13
Well, thank you very much. First of all, I would like to thank the AHRQ, Westat, to Dr. Caren Ginsberg, Darby Quave, and Laura Gray and all other staff that contributed to this webinar for hosting us today and allowing us to share our story with all of you.

Mazur, Slide 14
My name is Lukasz Mazur and I will begin our presentation with our work conducted within Radiation Oncology Department.

Mazur, Slide 15
Our department is located in the UNC Medical Center within the North Carolina Cancer Hospital that you see on the picture. Our department treats approximately 120 patients per day and we have approximately 110 staff members, including nurses, doctors, physicists, dosimetrists, therapists, administrative staff and researchers.

Mazur, Slide 16
Radiation oncology is a relatively complex process with most work being done electronically over the health information technology. Our care delivery processes often involve 200 plus major steps, many prone to human error in communication, documentation, coordination of care, et cetera. Overall, radiation therapy is used to treat approximately 50% of patients with cancer. And there is, in radiation, the delivery are estimated to occur in approximately 5% of the approximately 600,000 patients receiving RT per year in the US, with serious lethal

events occurring in approximately one of 1000 to 10,000 patients. So it's imperative to have a strong culture of patient safety in our department.

Just like in most health care settings, our work starts with a consultation with patients followed by treatment planning where radiation oncologists are working with dosimetrists to develop a treatment plan, followed by comprehensive quality assurance spearheaded by our physics team, and finally treatment ranging from one, the high dose, to 40 plus as needed to deliver highest and safest care to our patients.

Mazur, Slide 17
On this slide I would like to highlight to you our positive results in changing our culture of patient safety based on the SOPS scores. I mostly would like you to focus on the pattern in improvement from 2009 to 2013, and from 2013 to 2019. On the Y-axis, you can see the percent positive responses, representing Agree and Strongly Agree answers on the SOPS Survey. On the X-axis, you can see years and in the parentheses, the number of people that took the survey each year. It is important to note that the number of people that took the survey increased over time from 20 people in 2009 to over 80 starting in 2015, which itself is an important indicator of the positive change that took place in our department.

As you can see on the graph, all three constructs, namely: overall perception of patient safety and quality, patient safety and quality issues, and total positive responses improved over time with virtually each reaching highest scores around 2013 after all our interventions were initiated, followed by a reasonable sustainability of our results over the remaining years. My goal for the remaining of this presentation is to highlight to you the key intervention that allow us to gain and sustain these results.

Mazur, Slide 18
First, let me talk about the inspiration behind our journey towards patient safety. Inspiration came from the concept of stopping the line from the Toyota production system. We actually learned about this concept directly from Dr. Gary Kaplan, chairman and CEO of the Virginia Mason Hospital, one of the first hospitals that successfully implemented and sustained lean concepts.

What you see on the picture is a car, Prius, moving through one of the stations on the assembly line. The football field-like hash marks on the floor act as a clock, allowing workers to understand how much time they have left to complete the work as paced by takt time. At the top of the picture, you can spot two cords hanging from the ceiling, one on each side of the car. When workers spot a defect that needs to be corrected, the cords can be pulled once to slow down the line. If the defect cannot be corrected within allotted time, the cord is pulled again to stop the line, not allowing the defect to progress to the next station.

This concept, fairly simple concept of stopping the line, became our inspiration and since then we were looking for ways to instill this concept into our culture of patient safety. So what have we done?

Mazur, Slide 19
First, our chairman, Dr. Marks, incorporated the stop the line concept into daily morning conference where a multidisciplinary team of radiation oncology professionals each day has a chance to review and bring up any concerns regarding each new plan before patient's first treatment. Speaking up of discomfort is analogous to stopping the line. Each year hundreds of adjustments, so major have been proposed and incorporated into our patient's care plans.

Mazur, Slide 20
Second, at the individual level of interactions between the providers, we strongly encourage all of our staff to question any possible shortcomings in the care plan. No assumption should be left unanswered. This requires continuous development and nurturing of psychological safety; the idea of being able to bring up issues without fear of negative consequences of self-image, status or career. On the picture, you can see a dosimetrist lively questioning a physician, Dr. Chera during a timeout, our final step before handing over the plan to physicist for quality assurance.

Mazur, Slide 21
Third, we initiated quarterly safety rounds to further ask our employees where improvements could and should be made to improve quality in patient safety. The goal is always to implement as many suggestions as possible, showing responsiveness and commitment to change. On this picture, you can see our department chair, Dr. Marks, and our education program director, Dr. Robert Adam, speaking to therapist during one of the safety rounds.

Mazur, Slide 22
Finally, we needed to organize a more formal incident reporting in CQI program; CQI standing for Continuous Quality Improvement. The graphic represents a simplified version of our improvement cycle. The program starts with the premise of no blame culture. It asks people to report good catches, providing a more positive spin on reporting incidents.

The goal is to use good catches to monitor process performance, aid targets for improvement, modify the processes, define standard work and through its consistent use, produce reliable outcomes. At the center of this program is a QSC committee that meets once a week for 90 minutes, an investment of 90 minutes per week to review all good catches, check on the status of existing improvement projects, approve new projects and to spearhead, just do it, as needed to improve our care delivery processes.

Mazur, Slide 23
Here's a picture of our QSC committee. It is a bit outdated because you don't see Alison, our co-speaker today and current embedded coach for this QSC. Importantly, the committee is led by a physician, Dr Chera, sited on the bench with a bow tie, supported by our chair, Dr. Marks, seated on the bench next to Dr. Chera. It involves a multidisciplinary team including nurses, dosimetrists, physicists, therapists and administrators and all supported by embedded coach. The importance of the embedded coach is to make the work happen in between meetings, to make the change happen and to spearhead the improvement.

Mazur, Slide 24
Our idea to use the term good catch was to cast a wide net for submissions. We wanted our staff to report any defects including minor documentation and communication errors, any unsafe conditions, situations that could or did result in harm, delay, rework, waste or any error. We collected our first good catches while walking around the department and asking people if they would know or would be willing to share any defects. It took us two weeks to get our first submission. To make the submission process easier, we developed in house department-specific electronic software to support submissions.

Mazur, Slide 25
We started to track our good catches electronically in the mid2012. Before our interventions, very few reports were submitted. And when submitted, they were directed to our Risk Management Department and mostly representing incident that involved patient harm. As you can see on the graph, from 2013 to now, we have experienced a healthy rate of submissions averaging approximately 30 per month, with some seasonality, with some peaks in 2016 and 17 and dips around January timeframe, most likely influenced by holidays and other activities. Please know that each good catch is always reviewed by our committee. Feedback is provided and improvement ideas are being generated as needed.

Mazur, Slide 26
Finally, on this slide you can see a picture of Dr. Chera giving a monthly state of the union progress reports on quality and safety on patient safety issues. He reviews good catches, provides lessons learned, talks about improvement projects, recognize best submissions, awards people, analysis self-reports, and shares his passion for patient safety. The room is often full with good discussion and positive energy.

Mazur, Slide 27
In summary, here are the key concepts that helped us improve and sustain our culture of patient safety. We would not be able to do it without Dr. Marks and his vision and support, our chairman. We develop our program around good catches initially. We ensure that our people feel psychologically safe to report errors and that they receive feedback on their submissions. We invested 90 minutes per week, and again, 90 minutes per week into reviewing submissions and improvement projects with multidisciplinary team. We allocated time to improvement efforts with dedicated coach. We celebrate improvement activities, provided through rewards and recognitions. And then finally many people lead by example. Thank you.

Stephenie Fenton-Wilhelm
Fenton-Wilhelm, Slide 28
Thank you Lukasz.

Fenton-Wilhelm, Slide 29
This is Stephenie and I'm going to shift a little bit to less of a focus on radiation oncology and focusing more of across the entire medical center. I joined the organization in middle of 2017 and one of the things I was looking for is, what is our safety culture and how are we utilizing reporting? Some of the first four things you see on this slide are what I kind of found just from my own investigation. I felt that we were a low reporting organization in general as it appeared that most of the reports were for risk management and harm events rather than looking for near misses, good catches, and non-harm events.

I also determined that there was really a lack of standard of process. Here we had a great department and rad onc that was utilizing a robust process and capturing good catches and getting feedback, et cetera. Then there were other pockets that were not so standard or didn't have a process at all or had a very different process. And then there would seem to be a lot of confusion about what do people report in general. So that's kind of the initial perspective that I had about our reporting culture.

Fenton-Wilhelm, Slide 30
We then turned to our SOPS data to further determine where we were needing to improve. And our event reporting is slightly below average at the time, our Non-punitive Response was well above average, but I think everyone continues to... we need to work on that metric. And our Feedback About Error was just slightly above average. So we were just kind of in the middle of other teaching hospitals and felt that we definitely needed to work on these aspects.

Fenton-Wilhelm, Slide 31
Some of the initial steps that we took was surveying the frontline users to determine what their barriers are, and I'll talk to you about that on a later slide. We also found influencers and champions with the understanding that if we couldn't find senior leaders and physician leaders that would help us and engage in this project, that we wouldn't get very far. We also evaluated what else was going on across the system.

I think I mentioned it just a minute ago that there was pockets of very different types of event reviews going on in across the medical center. And once we kind of determined that we formed a work group between Lukasz and Alison and I, discovering what they were doing in rad onc and trying to take some of their tools and see, how could we apply it across the organization. Resources are different amongst different units and departments, how can we make it sustainable for others?

Fenton-Wilhelm, Slide 32
Well, first off we did this survey as I spoke to you about, where were the barriers for our folks that felt in the medical center. Funny enough, they were very similar, almost exactly the same as an AHRQ-funded study from 2008 that surveys 1600 hospitals to look at the barriers to event reporting. Here we are in 2017 and they still existed for us. So, there was a lack of feedback in the essence of putting something into the black hole and never hearing about it again. Our software wasn't user friendly, being also that our reporting form was too long. Those kind of go hand in hand.

We had kind of an out of the box, not customized software. And there still was that hint of punishment for reporting. And then again, the confusion as to what to report. So we felt that our barriers were the same as many other hospitals.

Fenton-Wilhelm, Slide 33
So that led us to, what were we going to work on: the Just Culture, the reporting culture, and the learning culture. We wrapped leadership around that because we knew that we needed that support.

Fenton-Wilhelm, Slide 34
Our working project goal was to redesign our framework to one that supports culture of safety, establishes operations and structure for analyzing reports and monitoring action plans and their effectiveness. We would provide timely feedback to our staff who submit event reports and then also to continue that relationship alignment with risk management and CQI in our Quality and Patient Safety Department. Utilizing an effective software and with goals to double our submissions in three years and to have statistically significant increases in our SOPS scores by 2021. I'm going to turn it over to Alison, who was our Project Manager for this project and do a lot of the heavy lifting to drive the bus as we went along.

Alison Amos
Amos, Slide 35
Thank you, Stephenie. I'm going to share some of the details on how we approached redesigning our patient safety reporting system. Stephenie and Lukasz were the sponsors for this group and as Stephenie mentioned, I kind of oversaw the work of the three workgroups I'm going to talk about here. We also put together a steering committee of our entity leadership that we took barriers and recommendations to throughout this work. The first thing we did is kind of look at dividing the patient safety reporting system and the three main workgroups.

The first is a culture of safety workgroup whose focus was on developing operations and infrastructure for supporting a culture of safety. We had a software usability workgroup, which focused on optimizing our event reporting platform, an interface for improved engagement in reporting, review of files, documentation and analytics around submissions. And then we had a third workgroup who's focused on developing the standard work for the patient safety reporting systems through our policies and procedures.

And these three workgroups included representation from team members across varying departments, service lines, units, our different quality groups, our risk management team, frontline staff, all the through managers and leadership. In the next several sides, I'm going to walk through some of the highlights and recommendations that were produced from these three groups.

Amos, Slide 36
The first is our culture of safety workgroup. This group conducted numerous interviews and surveys across our frontline staff to our executive leadership and made some recommendations in these three areas. Accountability, dashboard, additional resources, and all that kind of included more visible expectations for implementing safety culture principles, creating a dashboard for having better visibility of data related to safety culture, and then additional resources needed to run and utilize results from our SOPS survey and other surveys related to our safety scores.

Amos, Slide 37
From our software usability workgroup, this group recommended a number of technical changes that we made to our reporting software interface that improved its ease of use. This group conducted over 55 hours of design and data collection on how individuals interacted with the reporting platform; anything from how long it took to submit a report to the number of clicks, where that user was looking when trying to submit or document in the software. And from this study about 17 changes were recommended to enhance the usability of the reporting platform. Those recommendations went to our risk management teams, our information services department to then look at feasibility for implementation.

And these changes really ranged anywhere from kind of moving fields around in the reporting form, based on the order of information users were reporting, to using smart logic to separate inpatient and outpatient locations so users don't have to filter through, the location is not relevant to them, to using picklists where possible to minimize scrolling.

Amos, Slide 38
And then one of the largest changes we were able to make was to add the ability to submit directly from our EHR to facilitate quick submissions from providers, clinicians by pre-populating some of the patient demographics that get submitted as part of the file. Getting the direct submission to our reporting platform was the longest and most difficult of changes but in August of this year we went live with that and we're hearing some good feedback around that so far.

Amos, Slide 39
Our third workgroup, their goal was really to create a standard program for the reporting and communication: the analysis, the feedback, that brings alignment to all these groups involved and that uses the reporting software platform as our portal. So they really were creating a process map, corresponding policies and procedures for how to engage in the patient safety reporting system using now state of our current state, which Stephenie spoke to a bit, as well as some recommended best practices from some of the high functioning areas within our institution as well as outside organizations.

Amos, Slide 41
The main product of this group is shown here. In the top middle of the slide, we have a reporter who's submitting to the patient safety reporting system, and the report is auto-routed both to the department or unit level, as well as their risk management teams. So this is a high level information flow from how what happens after a report gets

submitted. On the department and the unit side, so on the left hand side of the diagram, the leadership and designated reviewers take an initial review within 72 business hours and assigns a safety assessment code score which determines if it needs to go to a local committee for review or can be handled by initial reviewers. And I'll talk about that safety assessment code in a couple of slides.

Reports that are reviewed by a local committee that need further escalation or should be communicated across different parts of the organization can go to a centralized patient safety committee, which is on the bottom right hand corner of this diagram, but it can also engage continuous improvement teams. So there's an arrow off to the left of the local committee that connects a continuous quality improvement team and we can engage them in root-cause analysis and implementation of action plans and/or improvement projects.

At one or more points in this process, we want to make sure that we get feedback communicated back to the submitter to thank them for submitting, but also to give an update on any discussion or action items. We ask that the local committee or the departmental leadership make sure that that feedback gets back to that submitter.

Amos, Slide 42
This slide is showing a bit more of a detailed example of what we used on the previous slide. It's meant to compliment the previous slide that I just went over, but just shows a more step-by-step approach, decision points and then in a swimlane diagram fashion what role those steps fall to.

Amos, Slide 43
As I mentioned a couple of slides ago, we instituted a Safety Assessment Code, or SAC, score into this process as a trigger for identifying reports that need to go to a local committee for further review beyond the department and the unit leadership. This SAC score asks the reviewer to categorize not only the severity of an individual file or report, but then also the frequency and probability of occurrence. And one of the intents of scoring this is to ensure that near misses or incidents that don't reach the patient but have a high probability of occurrence don't get lost in that kind of one off report where the severity for that particular incident was minor but at a higher frequency, or in a different situation, could potentially pose a much higher risk.

So this is a way to help in that initial review escalate that for additional help or look if it needs to be looked into by some other folks. And right now we're using this SAC score as a way to escalate to a local committee, all 2s and 3s is what we're trialing, but that any SAC score of a 1 can also go to that local committee or a centralized committee by requests. And just as a reminder that SAC score is added as part of the department or unit's initial review within that 72 hours of submission.

Amos, Slide 44
As we closed out the work of those three workgroups for redesigning that patient safety framework, we then looked to launch the new process in a handful of areas initially to test out. We had a road show marketing the new process to help choose initial launch areas. We created some new committees or integrated this process into existing committees. We went live with trialing the SAC score as well as introduced a couple of other tools as needed to help with analysis and action planning for those reports.

Amos, Slide 45
In summary, here's where we are today. We have optimized the reporting software submission forms, integrated submissions directly into our EHR, created a new process for that event review, launched that new process in about seven areas across inpatient and outpatient here at the medical center with plan to continue to expand that launch as part of this work, we relaunched our patient safety committee to align with the new process, and one of the outcomes we've seen so far is we've reached our initial reporting goal in about half the time expected. So I'm going to turn it back over to Stephenie to close out our last couple of slides.

Stephenie Fenton-Wilhelm
Fenton-Wilhelm, Slide 46
Thanks Alison. So this is a little bit of where, this is where we are today with regard to reporting. The green dot signifies when we started having our first conversations about wanting to enter into this project, and the red dot is when we stopped the project and began the launch process. So you can see we had a really significant jump in the summer months of May, June and we've been able to sustain those. In December, we're looking to be above 1400 again. We had decided we were going to do that within three years and it took us about a year to do that.

Fenton-Wilhelm, Slide 47
What's next is, that one seems to be the most effective part so far, but we're continuing to build our safety culture training modules. We've developed a Just Culture module that's been given to several units in the hospital and we've been tweaking it to try to get it as concise as we can so it be most effective for folks, and we are targeting the areas that have the lowest scores on the Non-punitive responses on our SOPS to start giving that presentation and working with those groups directly to help them improve their Non-punitive response on SOPS. And we are working with our patient safety improvement team to implement the process throughout all areas in the medical center within one year.

Fenton-Wilhelm, Slide 48
So that's our presentation for today. We thank you all for listening and we're happy to answer any questions.

Laura Gray
Gray, Slide 49
Thank you so much to our speakers. As Stephenie mentioned, we'll now turn into the Q&A portion of our agenda.

Gray, Slide 49
As a reminder, you can type a question in the Q&A box and to access that you might need to select the button shown with the three dots at the bottom of your screen and then pick the question mark for the Q&A to appear on the side. And again, please be sure to send your question to all panelists so we can all see that. And depending on the browser you're using, your screen might look a little different here, but just look for that Q&A. We did get some questions come in during the webcast. I'm going to start with those and just be reading those aloud to our speakers and we'll try our best to get through your questions today. The first question that I have for you all is, how long did it take to ramp up or get started?

Stephenie Fenton-Wilhelm
Yeah, this is Stephenie. I think, so a little bit from the last slide, but we started probably in February. It took us about three months before we had our launch meeting where we had gathered who all was going to be part of the work groups. We, I think, had somewhere around 50 to 60 people at one point in time involved in the project. And then in addition to that, our leadership steering committee. So it took us about three months to do that initial investigation, get our presentations together and start the project.

Laura Gray
Great. Thank you. Did you have any issues with clinician buy-in or leadership buy-in? And if so, how did you handle that?

Stephenie Fenton-Wilhelm
I think I can speak to the inpatient side and then I'll let Lukasz talk for the rad onc side. I think we first engaged our Chief Medical Officer who was an executive sponsor of this project and a true champion. We knew that he would be able to help us open doors with other physicians. He had us in meetings, we met with department chairs of the school of medicine, their service line leaders, our medical directors, and he was passionate about this the same as we were. Knowing his enthusiasm, he presented with me at several events in promoting this work and gaining interest in improving our culture on reporting. So he was really, from the entire medical center side, important to us getting this work done. I'll Lukasz speak to rad onc.

Lukasz Mazur
Very similar in Radiation Oncology. We already have a very engaged Chairman, Dr. Marks, who really have the vision for it, but we felt he was critical in the early stages to recruit another physician who could run the Quality and Safety Committee that would support the work. So that was Dr. Chera in his early stages of the career. He received some protected time, which I think is also important on the Wednesday to run that 90 minute meeting, but also have some of the other time, couple hours, on those Wednesdays to really dig deeper into some of those concerns. As a physician, he was directly communicating with other physicians in the department about the issues, bring important information and so on and so forth. And that spearheaded, I believe, kind of the engagement of other physicians into this work.

Stephenie Fenton-Wilhelm
I will touch on something that Lukasz said. Rad onc has such an embedded process already with a lot of engagement and a lot of time devoted to it. And we haven't wanted to scare other departments with that time investment. Of course it's essential. But we all started working with folks as what can you do, and just chipping away at, you have a committee that's already established, let's work within that committee. You don't have to

create a new committee. If you have these folks that are currently doing one thing, let's just add a little bit to that so that as people got enthusiastic and we built upon that, we were able to kind of start small and sort of build in those departments that are utilizing it currently to have a more robust process. But not everyone across our organization would have that 90 minutes off the bat to be able to do that. They have a 30 minute meeting where they're just sitting and going over events. So we've tried to tailor as best we can so that it would be sustainable across the organization.

Laura Gray
Thank you. That's really great. The next question we have here is, we find that staff are scared to report. How did you make your reporting system non-punitive for staff and providers?

Stephenie Fenton-Wilhelm
We have a pretty, I think, good culture. As you can see from our SOPS scores, we were way above the average on Non-punitive Response. I think we already had something that we could build upon. Our Patient Safety Officer, like I said, has built Just Culture modules that we're rolling out. And I think one of the pieces of Just Culture that I think are kind of lost sometimes is the way that a report is written. Sometimes they can be written out of frustration or just unhappiness.

And it's also that peer-to-peer punishment. And if you feel like even if you haven't gotten any repercussion from your supervisor, your leader I mean, it was a systems issue and we talked it through and maybe fixed the process here and there or something versus having someone write something negative about the nurse or the physician that did X or Y wrong in their view, I think that's kind of more upsetting I think to people than them really getting any sort of punishment out of it.

So we've added an aspect of that in our talks just to start talking to people about how we're treating each other in taking a step back and looking about not putting an event report in anger or frustration and trying to be very objective about what we're writing. But we already had a pretty good start, but I think that we are continuing to do that. And like I said, targeting those areas with our education that have more room to improve that others. I don't know if you wanted to add anything.

Alison Amos
I'll just add one additional thing. This is Alison. Similarly to kind of that peer-to-peer and language aspect that Stephenie is alluding to, I think there's an aspect of that from your managers and leaders that is just as important as well. When you have a report that comes in and somebody is looking into that, it's just as important to have it written in a non-punitive way as it is for that follow-up to occur in a similar way.

We've also worked with managers and leaders to help kind of bring some of that process focused language in and help, kind of even role play sometimes, through how you can approach submitters or people involved in a way that there is true interest in understanding the process behind this to make sure that we keep that culture blame-free. So that's another piece of that as well that help encourage that non-punitive system.

Laura Gray
Great. Thank you. This next question has a few different pieces to it. You mentioned that you provided feedback to your event reporters. Can you elaborate how you provided this feedback, i.e., email, face-to-face conversations, et cetera. Can you provide specific examples of feedback provided to frontline staff regarding event reporting? And then the last piece, and I can repeat these if it's too much to give you at once, but was asking if you tracked how your employees responded to the feedback. Some really good questions about providing feedback to your event reporters.

Lukasz Mazur
Yeah, I can provide few examples. As you know, we have a multidisciplinary team during those meetings where we review good catches and we look into the reports and as the meeting ends, the managers that are out there, they have their staff meetings and this is the opportunity for them to reach out in a group settings to the individuals or they can walk down and virtually, within a department because it's a walkable distance, approach the individual and discuss these things further with the feedback that he was reviewed and what are the next steps.

We also, that I showed I think on my last slide, Dr. Chera has this monthly meeting where he spends about a good 30 minutes reviewing a lot of submissions, recognizing people for the submissions, including self-reports. And these are difficult submissions for a lot of people. So we are very open in our department to share, talk about them and really celebrate these submissions.

Stephenie Fenton-Wilhelm
I would add, from the rest of the medical center, we have a variety of ways, is number one, utilizing our software system. So there is an email that goes out to them notifying them that their submission is being reviewed. The staff meetings where data is presented about the event reports and reviewed amongst the staff. There are certain indirect or direct face-to-face conversations I speak to the residents once a month and get a lot of feedback from them about, because I always want to check, are they receiving information back? And they indicate that they do from their attending or nurse leaders talk about the events that were submitted.

There's also an aspect of our reporting system that allows the person, if they didn't hear anything or they want to know what's happened to their report, they can log in and see their report and see who's opened it and when it was opened and where it sits. So, we encourage the fact that we're showing the data and talking about the numbers of reports and assuring them that not only is their leadership looking at them, but risk management and quality folks, that if a face-to-face gets missed or a feedback gets missed, that they feel comfortable that it's being reviewed.

Alison Amos
And I would just add to the variety of feedback is a good thing. We see that the more ways that you can provide that feedback through staff meetings, through verbal conversations, through electronic conversations in your reporting platform, is really beneficial to a scalable and sustainable type of operation. We encourage people to think about the different ways that they share information, what sharing forums already exist, but then also what ways don't exist and try to add one of those so that people can associate that work with something new.

You hear it from not just maybe your manager. Sometimes we encourage or we ask somebody else's manager or somebody from a different team to share that feedback. Different people receive feedback in different ways, and so there are a number of different ways that you can approach that. But we have found that utilizing a variety of ways is the most sustainable and the most flexible and agile for people as well.

Laura Gray
Okay, great. Thank you. The next question is, what software was used to report events?

Stephenie Fenton-Wilhelm
Well, we use RL. We originally had, it's been implemented for a while here and we had it just kind of out of the box. No one had really taken the time or the effort to look at their reporting forms and their structure. So when we had started, there could have been 49 fields on some of the forms that we really got down to, between 12 and 17, depending upon what you're clicking. We've seen other presentations and such where people are showing their quick submit forms and things of that nature.

We've been able to really tailor our forms so they're sometimes less than folks who use quick submit. We wanted to be actionable because that's obviously one of the things that people complain about is too many fields. I mean, we're still looking at fields that we would, do we really need this field? We haven't really gotten good information from it. And so, it's very customizable for us, so we are still continuing to look at ways that we can improve as well.

Laura Gray
Great. Thank you. And just someone asked to repeat that. It was called RL. Is that right?

Stephenie Fenton-Wilhelm
Well, it's RL Solutions, but it's like RLDatix now, I think, because they combined with Datix. But it's RL Solutions or RLDatix, yeah.

Laura Gray
Okay. Thank you. And then another related question. What is the average time that it takes up frontline staff member to complete an incident report?

Stephenie Fenton-Wilhelm
We did some initial, I have to go back and think about what those numbers were, but it was a lot less time. Time they went, they sometimes thought it was, and I think it was a few minutes.

Alison Amos
A couple of minutes.

Stephenie Fenton-Wilhelm
Is that what we had on average? That's one of the things that I've been looking at recently is, should we even reduce the amount of characters that are in our descriptions? Because sometimes people write way more than they need to necessarily. And it takes them a lot of time and it takes the reviewer a lot of time to read all of that when they could have done it in a shorter period. The system has the ability to do an incomplete file where you can walk away and walk back. So, I think the average was a few minutes for us at the time.

Laura Gray
Okay, thank you. Next question is, what were the barriers to interfacing the event reporting within your EMR?

Stephenie Fenton-Wilhelm
Well, one was getting, motivating IST, our IT department and for them to have the bandwidth to do it, I mean, it would be a new project for them. Also, it was the fact that at this time more than a year ago, we are assisted, but we had several of our hospitals also using the same Epic interface as we did. So any changes that we made to it, it will be made for them as well. And at the time, not everyone used our same reporting system or had the same functionality.

Today that we're using the same reporting platform, but at the time we were not. So, the question was, we were going to have to make a change to our EHR that would affect some other people. So, how did we work around that; and working with IST, with our IT department, and figuring out the ways that we could hide it and not hide it and just getting it kind of through the bureaucracy of committees and approval was really the big barrier there for us.

Laura Gray
All right, thank you. And then the next question, was there a legal concern about discoverability of event reports with the reporting system link being made available in the EMR?

Stephenie Fenton-Wilhelm
It didn't, it just changed them from having to access it through our internet versus accessing it through the EMR. So there wasn't any difference if you manually typed in or did the search for a medical record number or the name, which is what you would normally had to do versus it just pre-populates it, is all it does. It stops you from having to login, so you don't have to exit where you are, pull up to the internet site and log in and then submit your report and then have to fill in the patient information so that we could do an investigation and look into it.

It would, automatically you're logged in because you're already in the EHR, and then once you click on the icon that you've... the type of file that you want to submit, the patient information is already there. So that's not something they have to hunt down either. So it's really just much faster for them to submit a report that way.

Laura Gray
Great. Thank you. The next question is, what do you think was key in overcoming the fear of reprisal for reporting?

Lukasz Mazur
Fear to reporting?

Stephenie Fenton-Wilhelm
Yeah. What did we do to overcome that or what do you think was a good factor there?

Lukasz Mazur
Well, I mean, we can kind of maybe draw a little bit on the research that's out there, this literature. A lot of papers and look, I mean, the larger studies are telling us that the feedback component is critical. People that would put a report and don't hear anything for a while. That builds probably some sort of an anxiety maybe not knowing what's going on. So that positive feedback that is explained that there is no blame culture, that we are really looking at the process and the system and why it happened and what contributing factors really existed; because nobody comes to work thinking about, "Today I'm going to make an error on purpose," right? That's very unusual. So, being able to really close that loop, I think, is critical. We've done a lot of things to recognize people and reward them for these submissions and talk about the improvement efforts that are taking place really to prevent human errors from happening again. So that's kind of maybe one way of looking at it.

Stephenie Fenton-Wilhelm
I think and having the leaders saying and using these words in our big department meetings where we have all of our managers and directors in one meeting and having our president and our CMO and folks talking about Just Culture, it's within our policies that we utilize the Just Culture framework. Having other people give good stories about the experiences that they have and kind of just continuing to whittle away from that.

It's also explaining a little bit that Just Culture doesn't mean no accountability at all. There may be a coaching session, there may be that you're taught, you're spoken to about an event, but that doesn't mean you've been punished. You're not getting anything written up, they're just a conversation to look at the system and what we can improve upon. So, it's the continual use I think of the language as well and reinforcing of that and then getting our leaders as well educated on these concepts and so they repeat them and are very familiar with them. If everything comes to their radar, what they're delivering down, it will flow down to directors and managers as well.

Laura Gray
Great. Thank you. The next question is, how integral was risk in this process change as they had previously been the owner of this data and process?

Stephenie Fenton-Wilhelm
Very integral because we're still the kind of the owner of it. What kind of happened is, there was clearly a disconnect between the Risk Department and what events were being used for and quality patient safety type departments or areas. And it was really, I started here and this was my perspective and our teams work really well together now, we are hand-in-hand in this project and our work group was led on the process side by our director of our performance improvement patient safety team.

Our Director of Risk was with her hand-in-hand working on that, coming up with a process together. We meet with that team. They now understand how the system works and are integrated and helping as well. People utilize it. And we're even continuing to do that, I have a big meeting with them tomorrow to go over some new aspects of things that they may not have been familiar before so they can become more adept and be super users.

So, we've really, I don't know, it's kind of through communication that we all have the same goal. We all want to improve patient safety and patient care and stop errors from happening, and focused on that and stopped worrying about where the data's sitting and who's looking at it and that sort of thing. We've opened up a lot of that information and some of the dashboard, I mean, we have a nice dashboard in our software that people can see what's going on in their units and just having them utilize that more. It's just a much more open environment, I think, than it was previously.

But it was everyone's kind of just coming together. It was Lukasz and Alison from their perspective. It was our CMO who was about a year in when I started, it's our CNO, it was all of these folks just kind of coming together as a group and saying, "We all have the goal," and getting to know each other and communication in those relationship building as well, kind of really turned us in a different direction so that we work really well together now, I think.

Alison Amos
Yeah, I agree.

Laura Gray
Gray (closing), slide 51
Well, thank you all so much. I think that's going to put a wrap on our question portion and I have just a couple of closing slides here, but really appreciate you taking the time to answer all these great questions that came in. Before we adjourn today, I also wanted to just encourage everyone listening in that you can sign up for periodic email announcements. This is what Caren mentioned earlier. We send out information on various SOPS products such as upcoming webcast, data submission timelines, other news, and you can sign up for these by going to the top right corner of the AHRQ website and choosing email updates associated with the Surveys on Patient Safety Culture.

Laura Gray
Gray (closing), slide 52
And then I did want to point out our technical assistance contact information here. Feel free to contact us at any time. We're happy to answer any questions that you have about the SOPS surveys or products. Our email address on the screen, SafetyCultureSurveys@westat.com, and our phone number 1-888-324-9749 and then also please visit us on AHRQ website at www.ahrq.gov/sops.

Laura Gray
Gray (closing), slide 53
And lastly, I just would like to say that we would really appreciate your feedback on a brief webcast evaluation that will pop up when you close out from today's webcast. Please take a brief moment to complete it so that we can improve our offerings and plan future events that will meet your needs. Thank you all so much for joining us today. This concludes today's presentation.