“Good Catch”: Why Physician Participation in Safety Event Reporting Matters More Than You Think

South Carolina Medical Association

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Roles and Disclosures

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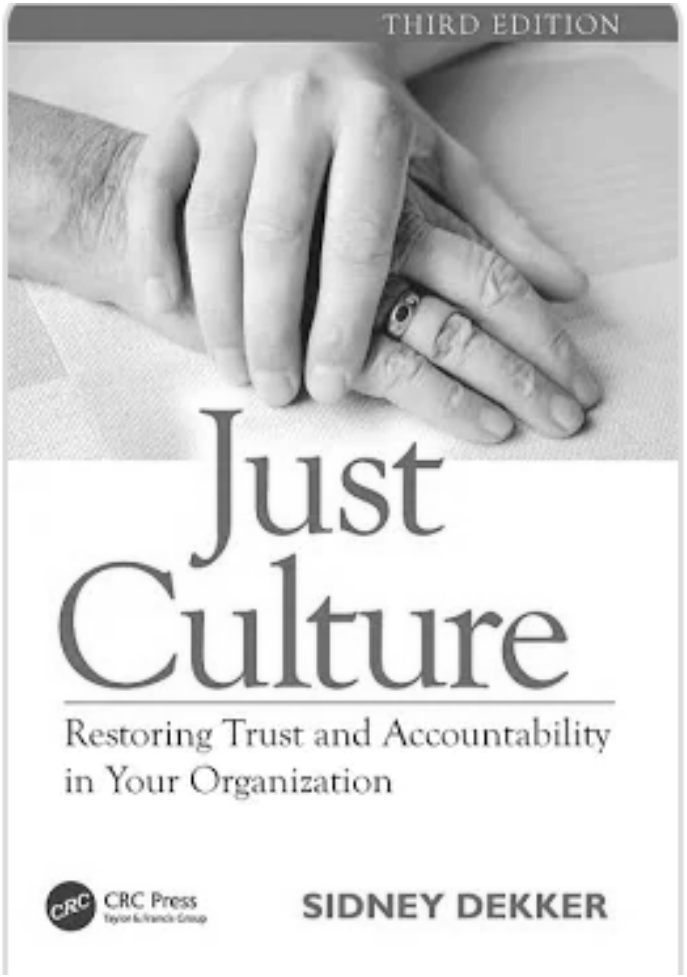
- No relevant financial disclosures

Objectives

- Setting the stage: Define "Just Culture"
- Identify key characteristics, benefits and potential unintended negatives of safety event reporting (SER) by physicians
- Define strategies to maximize the system benefits of SER using foundational concepts of Just Culture


THIRD EDITION
Just Culture
Restoring Trust and Accountability in Your Organization
CRC Press
SIDNEY DEKKER

Pop Quiz: Just Culture is…

A. A cool new coffee shop on Upper King Street

B. A mindset that uses errors to minimize negative impact and maximize learning

C. An approach to errors that avoids individual blame or accountability

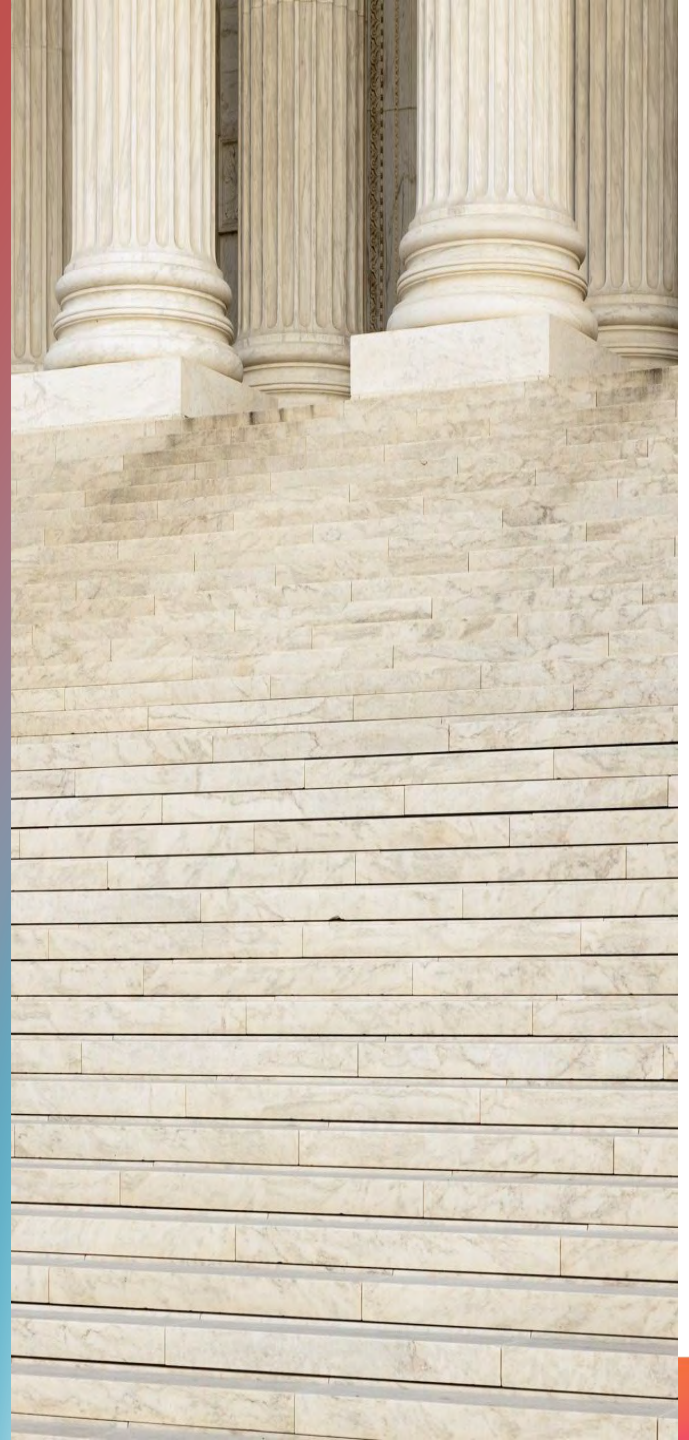
D. Only effective if reporting is completely anonymous

Just Culture Defined

- "Having our own profession unblinkingly deem some behaviors as unacceptable, with clear consequences, will serve as a vivid example of our professionalism and thus represent our best protection against such outside intrusions. But the main reason to find the right balance between "no blame" and individual accountability is that doing so will save lives." (Wachter RM, NEJM 2009)

- "The framework of a just culture ensures balanced accountability for both individuals and the organization responsible for designing and improving systems in the workplace." (Boysen, PG. Oschner J, 2013)

- "To create better patient safety outcomes, a Just Culture shifts the focus from errors and outcomes to system design and the facilitation of good behavioral choices." (Marx, D. Obstet Gynecol Clin North Am. 2019)



Two proposed systems of "justice"

- **Retributive Justice**
  - "Punishment should fit the crime"
    - Unintentional error – support/coach
    - Repetitive/intentional deviations result in consequences
- **Restorative Justice**
  - "Who was harmed and what are their needs?"
- **The ideal system combines the two**
  - Identify the victims and provide for their needs
  - Can still coach the source of the error

In the interest of accountability, what's wrong with being "punitive"?

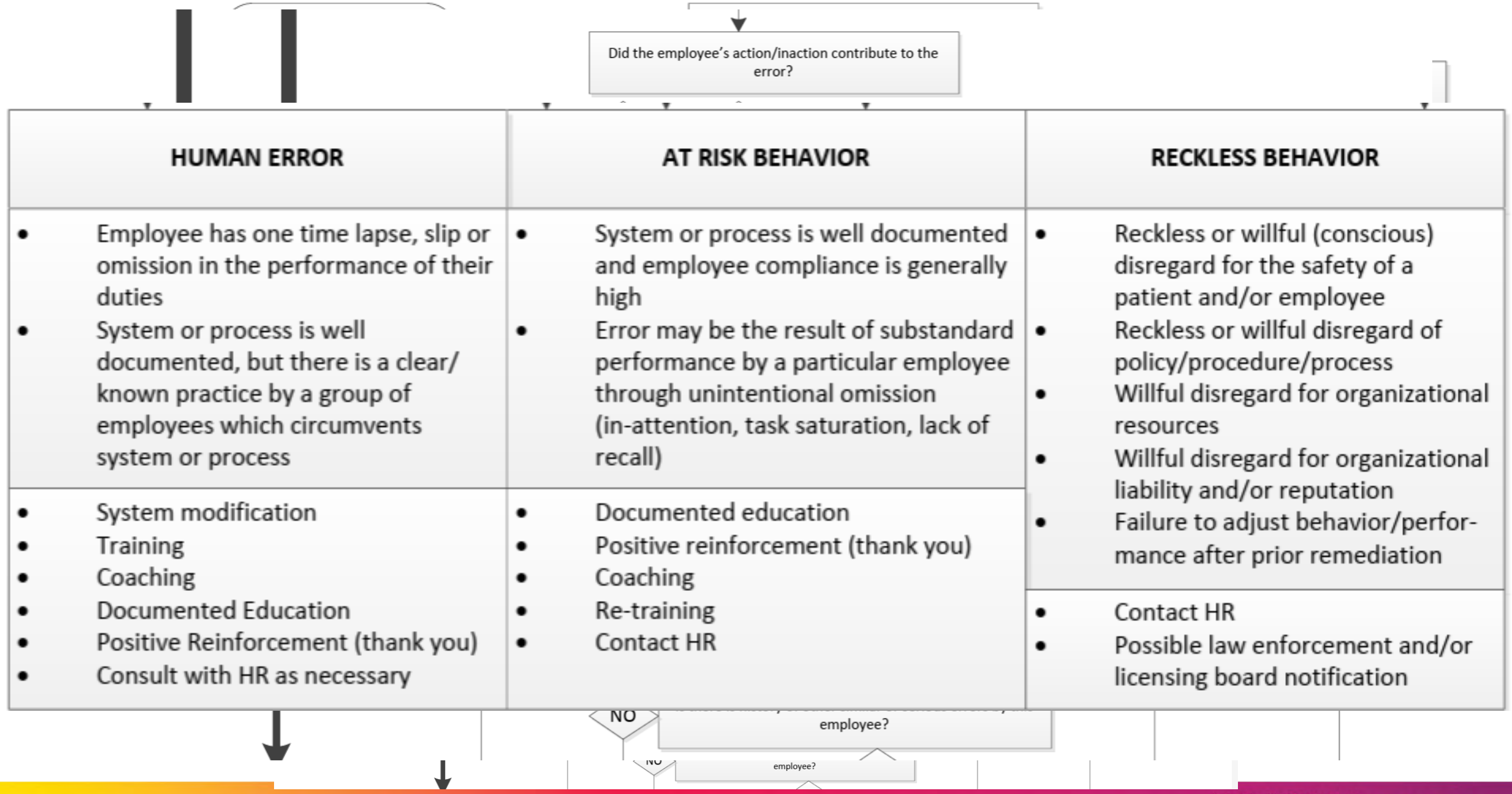
Inappropriate primary focus on the involved individual(s)

Blame in reporting

Action plan focused on **individual level interventions**

Translating Just Culture to Safety Event Reporting

- Successful SER systems utilize JC with a **System Focus**
- Evaluating each event from perspective of **individual actions** that contributed
- Determine whether **standard processes** facilitated the event
- Simultaneously **address the individual and the system**
- Additional incorporate **restoration** as appropriate



HUMAN ERROR	AT RISK BEHAVIOR	RECKLESS BEHAVIOR
• Employee has one time lapse, slip or omission in the performance of their duties • System or process is well documented, but there is a clear/ known practice by a group of employees which circumvents system or process	• System or process is well documented and employee compliance is generally high • Error may be the result of substandard performance by a particular employee through unintentional omission (in-attention, task saturation, lack of recall)	• Reckless or willful (conscious) disregard for the safety of a patient and/or employee • Reckless or willful disregard of policy/procedure/process • Willful disregard for organizational resources • Willful disregard for organizational liability and/or reputation • Failure to adjust behavior/perfor-mance after prior remediation
• System modification • Training • Coaching • Documented Education • Positive Reinforcement (thank you) • Consult with HR as necessary	• Documented education • Positive reinforcement (thank you) • Coaching • Re-training • Contact HR	• Contact HR • Possible law enforcement and/or licensing board notification

Just Culture Based Safety Event Reporting: 4 Key Attributes

- **Reports should be received from a *broad range of personnel*.**
- Institution must have a *supportive environment* for event reporting that *protects the privacy of staff* who report occurrences.
- A *structured mechanism* must be in place for reviewing reports and *developing action plans*.
- *Summaries* of reported events must be *disseminated* in a timely fashion.

AHRQ Patient Safety Network

“Voluntariness”

- Balancing incentivizing reports with coercing them
  - What is the impact of requiring a volume of reports on
    - Type/significance of issues reported
    - Quality of information contained
    - **Potentially diluting other issues of interest**
      - **Perspective from which the issue is presented**
  - 4 individuals (who were assigned responsibility for submitting) submitted 36% of all reports received

J Patent Saf 2009

If you are never reporting, odds are you will feel like you are always being “reported on”

Who is reporting?

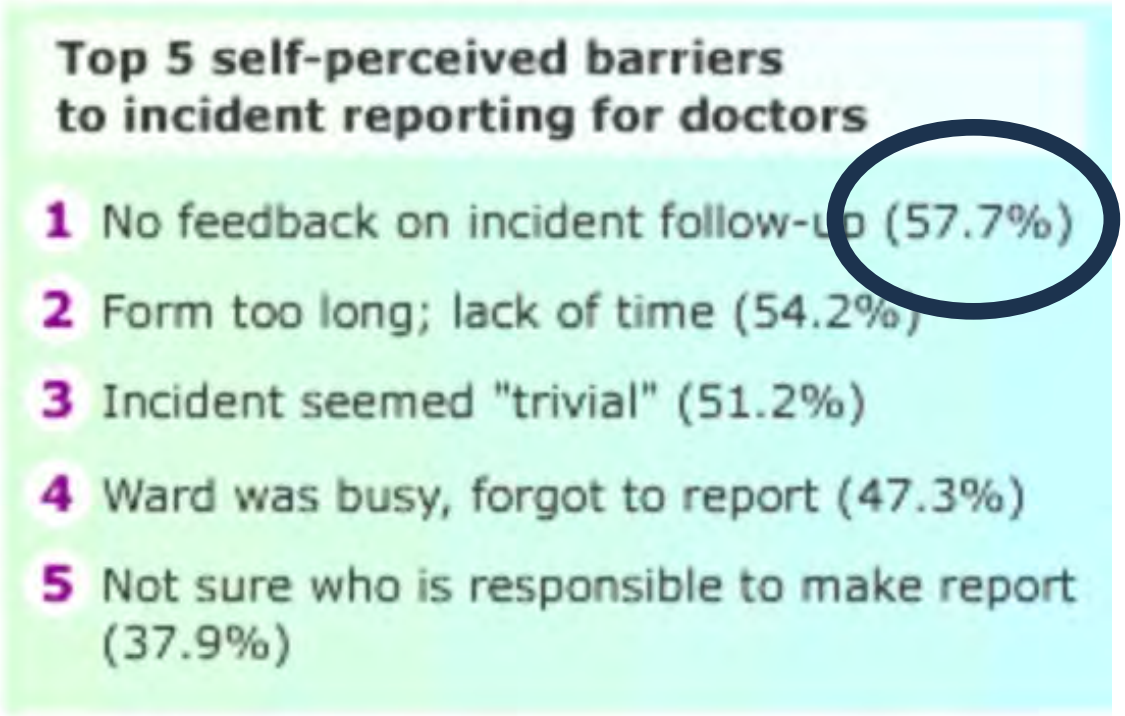
- Academic/community hospital 2001 (Qual Saf Health Care 2007)
  - 16,900 patients, 9% with at least one reported incident
    - 89% nurses, 8.9% other personnel, 1.9% physicians
- Brigham and Womens 2004-2006 (J Pat Safety 2009)
  - Of 10,000 eligible personnel, 29% submitted reports
    - 2.9% were physicians
      - More likely to report "severe events"
- A "successful" intervention to increase physician event reporting
  - Baseline rate 1.12% of reports by physicians
  - Post intervention rate was 2.65% of reports by physicians
    - Intervention was "personalized feedback" (BMJ Open Quality 2022)

Why don't physicians report?

- Time
- Knowledge of how to report

- Fear of "blame frame" (if self reporting)
- Fear of "tattletale frame" (if reporting peers) J Patient Saf 2017

- Lack of confidence that reporting produces positive change
  - Infrequent or absent feedback about outcomes



Qual Saf Health Care. 2006

Potential factors that influence likelihood of voluntary reporting of safety events (from AHQR Hospital Survey of Patient Safety Culture)

J Patient Saf . 2020

Patient Safety Culture Dimension
Communication openness
Feedback about error
Nonpunitive response to error
Organizational learning
Staffing
Manager expectations for safety
Teamwork within units
Handoffs and transitions
Management support for safety
Teamwork across units

How do physician reports differ?

- More likely to report events resulting in serious harm
  - Focus freq
    judgemen
- Less likely to
- Less likely to
- Less likely to report on operational inefficiencies

Quality of physician safety event reporting

- Low volume of reports limits ability to assess
- In general, physicians should have advanced ability to understand and suggest system change
  - Long history of physician involvement in event review (M&M)
  - Reports that are **framed in terms of the system** may be more likely to result in change

Does Safety Event Reporting “Work”?

“use errors to minimize negative impact and maximize learning”

J Patient Saf. 2022 Jan 1;18(1):e189-e195. doi: 10.1097/PTS.0000000000000725.

Sustaining the Gains: A 7-Year Follow-Through of a Hospital-Wide Patient Safety Improvement Project on Hospital-Wide Adverse Event Outcomes and Patient Safety Culture

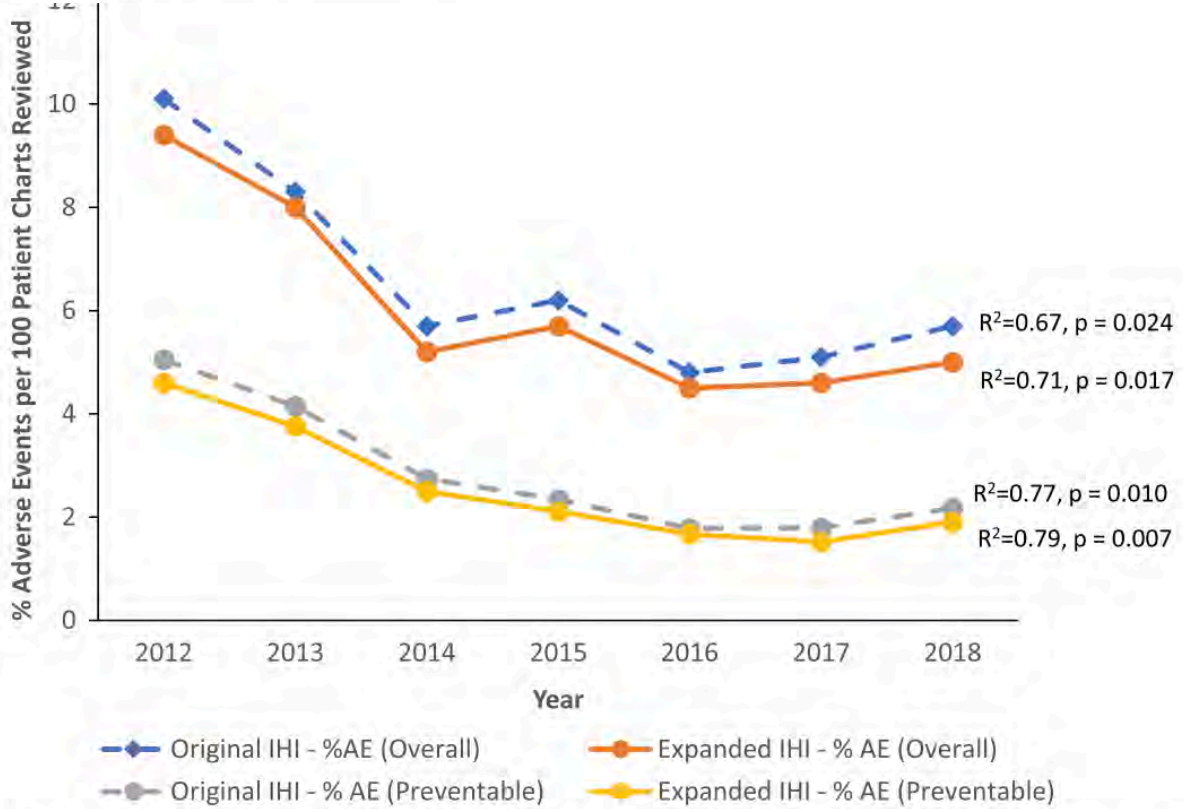


FIGURE 3. Comparison of AEs rates based on original and expanded IHI sampling method displayed similar decreasing trends from 2012 to 2018.

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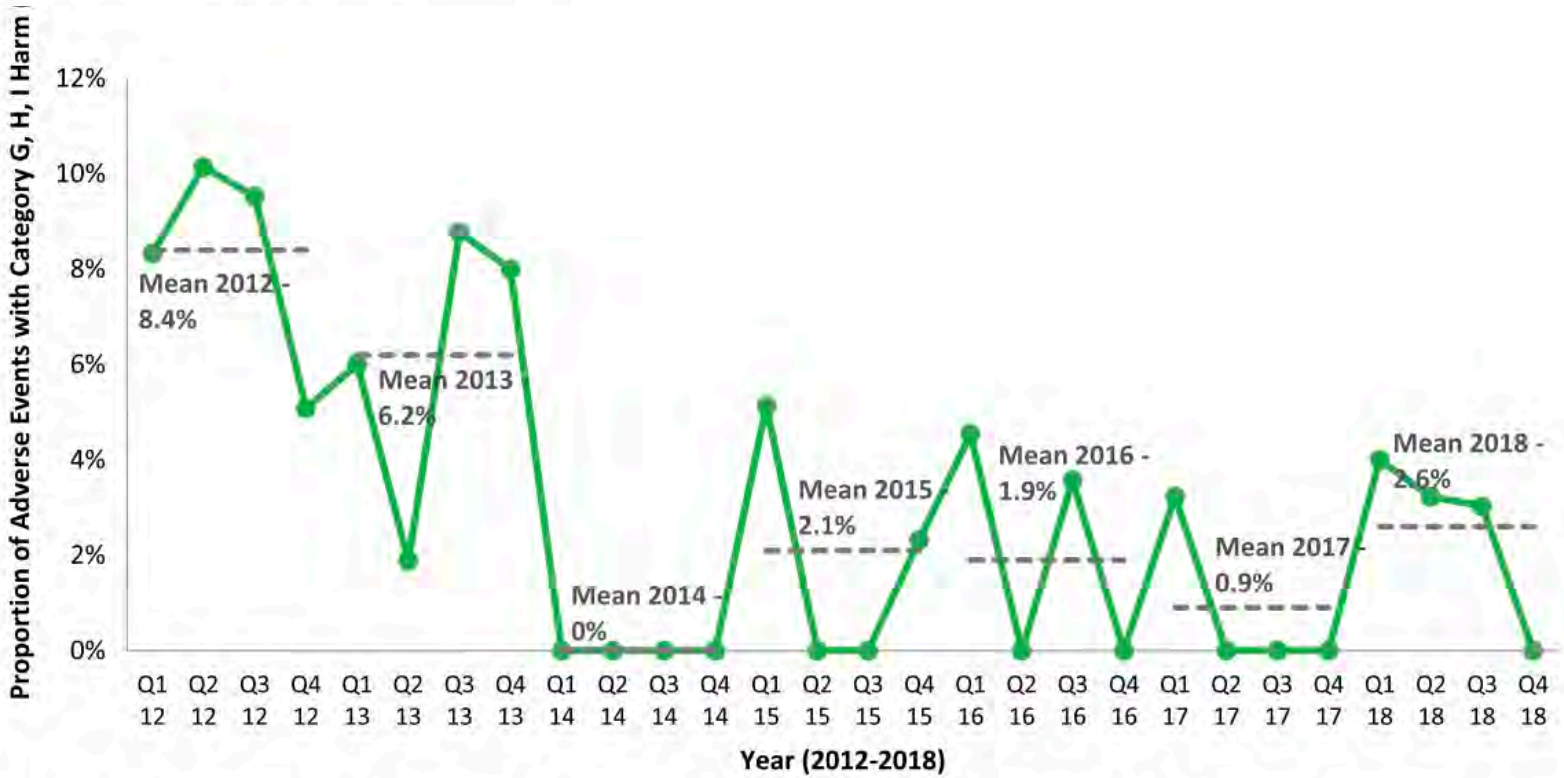


FIGURE 2. Severity of AEs, which occurred, decreased steadily from 2012 to 2018 (expanded IHI population).

Why were AEs reduced?

- Comprehensive, **system/process-focused** strategy:
  - Phase 1: identify specific targets, track indicators
  - Phase 2: RCA/SWOT ⟶ standard unit-based protocols
  - Phase 3: uncommon clinical decompensation scenarios
    - Simulation exercises for involved clinical units
      - Goal of ensuring consistent prevention/management strategies

What's the risk in SER?

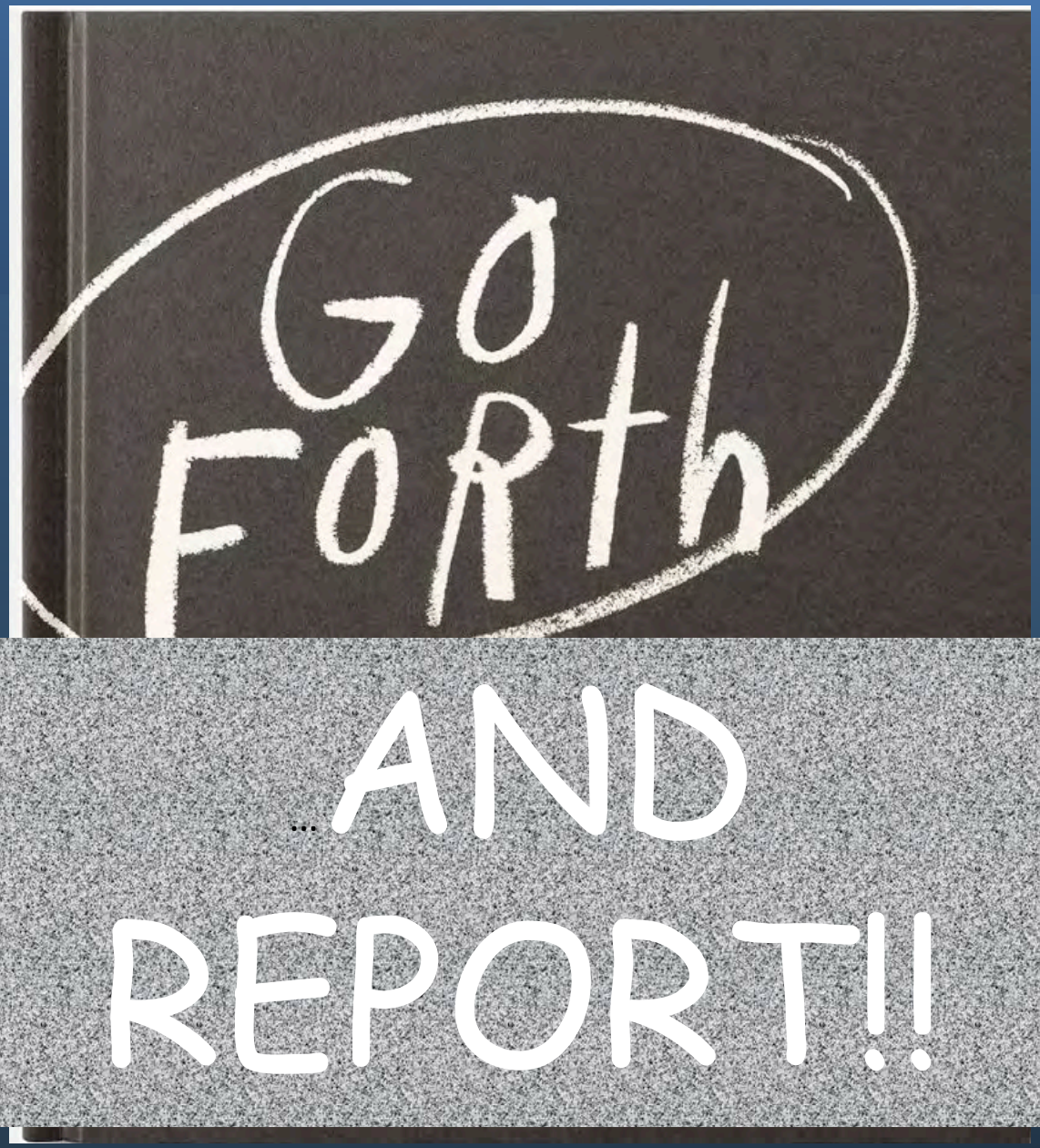
- Patient Safety and Quality Improvement Act of 2005
  - Healthcare providers can CONFIDENTIALLY submit data about patient safety events, near misses, and unsafe conditions to federally listed PSOs
  - Data is considered "patient safety work product" (PSWP).
    - Encompasses data, reports, records, memoranda, analyses, or written/oral statements
  - PSWP is legally privileged and cannot be used in most civil, criminal, or administrative proceedings

Shifting the focus back to Just Culture

- Retributive Justice
  - "Punishment should fit the crime"
    - Unintentional error – support/coach
    - Repetitive deviations result in consequences (to individuals if warranted) AND to the system
- Restorative Justice
  - "Who was harmed and what are their needs?"
- The ideal system combines the two
  - Identify the victims and provide for their needs
  - Can still coach the source of the error
  - **Engineer opportunity for error out of our systems**

Conclusions and recommendations

- Safety event reporting improves important measures such as
  - Incidence and severity of AEs
  - Reduced healthcare cost
  - Improved patient safety grades
- Reporting using a combination of retributive and restorative just culture principles helps to ensure **individual** and **system accountability**
- **Physicians significantly underreport**, despite potential for better recognition of serious and system related issues
- Providing **feedback** about system change resulting from SER is critical to improving reporting rates


GO
FORTH
...AND
REPORT!!