

# **“Nonpunitive Response to Error”**

## **The Fair and Just Principles of the Aurora Culture**

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# Objectives

- Describe Aurora's approach to creating of a culture of safety
- Review the action steps for addressing the “Nonpunitive Response to Error” dimension in the SOPS survey

# *A Culture of Safety: Aurora's journey*

- Aurora system-wide Patient Safety Team (2002)
- AHRQ SOPS survey (2005,2007,2008)
- Leadership Engagement
  - David Marx presents to BOD, Executive Leaders
    - “Patient Safety: Culture and Practice” (2004)
- “Fair and Just Principles” committee (2007)

# Action Steps

1. Identify the problem
  - Measure current state
2. Select interventions
  - Review evidence-based 'best practices'
3. Develop implementation plan
  - Designate project leaders
  - Align with strategic goals
  - Educate and train staff
4. Set goals and targets
5. Measure success

# 1. Identify the problem

- **AHRQ Survey on Patient Safety Culture (SOPS)**
  - 2005 (9,235 hospital and clinic staff, response rate 46%)
  - 2007 (8,900 hospital and clinic staff, response rate 43%)
  - 2008
- **Employee Survey (Pulse)**
  - Patient Safety Index includes 2 questions:
    - If I became aware of a patient safety concern, I would feel very comfortable reporting it
    - If I became aware of a patient safety concern, I would know where to go to report it
  - **Third safety related question:**
    - The leadership of Aurora Health Care does not knowingly compromise patient safety concerns for productivity.
- **Patient Satisfaction Surveys**
  - HCAHPS- hospitals
  - Press-Ganey- clinics

# 1. Identify the problem

## SOPS, 2005

### Nonpunitive Response to Error

13. Staff feel like their mistakes are held against them.

17. When an event is reported, it feels like the person is being written up, not the problem.

21. Staff worry that mistakes they make are kept in their personnel file.

### % of Employees with \*Positive Response

Benchmark	AHC	Hospital	Clinic
<b>43%</b>	<b><i>35%</i></b>	<b><i>33%</i></b>	<b><i>38%</i></b>
47%	<b><i>42%</i></b>	<b><i>40%</i></b>	45%
54%	<b><i>37%</i></b>	<b><i>36%</i></b>	<b><i>40%</i></b>
33%	<b><i>25%</i></b>	<b><i>24%</i></b>	<b><i>28%</i></b>

#### \*Positive Response Defined As

Questions 13, 17 and 21 = Strongly Disagree/Disagree

Blue underline text indicates a 5% higher score than the AHRQ Benchmark survey, red italic text indicates a 5% or lower score.

# 1. Identify the problem

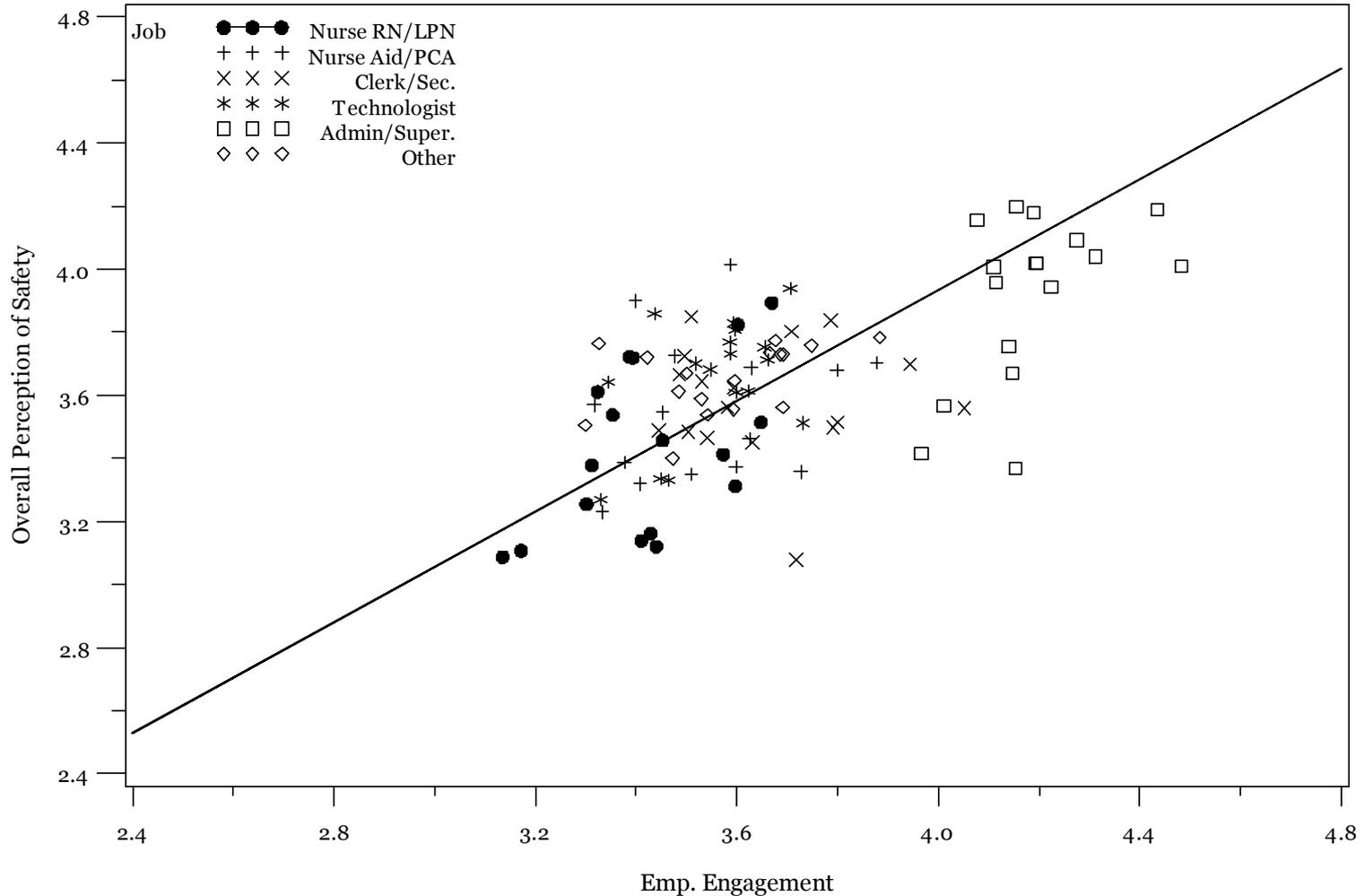
## SOPS Nonpunitive Response to Error, 2005

*Average score by Job category*

- Administration/ Management • 3.5
- Registered Nurse • 3.1
- Unit Clerk • 2.9

# 1. Identify the problem

Aurora Health Care -AHRQ Safety Survey and Employee Pulse Survey  
Safety y-axis, Pulse x-axis by Job Category & Facility, Correlation  $p < 0.001$



# 1. Identify the problem

## Patient Satisfaction survey analysis

### Behaviors that foster patient loyalty

- **Safety: Made patient feel safe from medical errors**
- Didn't act bothered when asked for something
- Were decisive and confident
- Were proud to be working at the hospital
- Did not say negative things about other staff
- Were cohesive as a team
- Explained things well

- Were not condescending
- Responded to patient's needs quickly
- Were decisive and confident
- It was easy to do business with the hospital
- Listened carefully to me
- Treated me with kindness
- Asked about my emotional well being
- Helped me to bathroom when needed
- Showed compassion by using touch
- Managed my pain

Professionalism/  
Clinical Excellence

**Loyalty**

Patient Centered  
Experience

### Outcome of loyal patients

- Higher rating of quality of care
- Trust in doctors, nurses and staff
- Say good things about hospital
- Would recommend hospital
- Make extra effort to use hospital
- Switch PCP to use hospital
- Pay more per month for insurance to use
- Greater number of referrals to hospital
- More users of hospital in household

## 2. *Select interventions*

- David Marx
  - “Just Culture and Aurora Health Care” (2007)
- Midwest Airlines
  - Aviation industry and safety culture
- Planetree
  - Patient-centered care
- Dana Farber Cancer Institute
  - Principles of a Fair and Just Culture
    - Connor. Jt Com J Qual Saf, 2007

### *3. Develop implementation plan*

- Steering Committee (2007)
- Define Aurora's approach to managing error
- Develop education and training
- Pilot the program

### *3. Develop implementation plan*

## The Fair and Just Principles of the Aurora Culture

1. Create an open, fair and just environment
2. Learn from adverse events
3. Implement safe systems
4. Make safe behavioral choices

## 3. *Develop implementation plan*

- **Train the Trainer Agenda**
  - A culture of safety
  - Management of Risk
  - Behavioral choices
  - Event analysis
  - Applying Fair and Just Principles after an event
  - Staff roles and expectations

# 3. *Develop implementation plan*

## Staff roles and expectations:

- **Human Resources**
  - Help with Managerial Competencies
  - Monitor the use of disciplines
  - Help staff understand their duties/expectations
- **Risk Managers/Quality Directors**
  - Facilitate event analyses
  - Assist with system redesigns
- **Managers**
  - Create an open, learning environment
  - Educate staff about safe behavioral choices
  - Learn when to console, coach or discipline
- **Staff**
  - Report all errors, hazards and near misses
  - Make safe behavioral choices

### *3. Develop implementation plan*

#### Fair and Just Principles Integration into Aurora

- Leadership principles
- Manager training
- Staff orientation
- Physician and resident orientation
- Annual Safety Review (all staff)
- Caregiver Rounding
- HR policies and procedures

# 4. Set goals and targets

## Patient Safety Dashboard - 2008

Indicators		2005	2006	2007	2008	2008 Target
<b>Reduce Complications</b>						
<b>NEW FOR 2008</b> - Hospitals, Clinics, AVNA <i>Decrease MRSA - Organization-wide approach for MRSA screening and treatment (data source: new system-wide policy)</i>						Practices developed
Hospitals <i>Increase the use of blood clot prevention strategies (data source: Surgical Care Improvement Project data)</i>				82%		81%
<b>Create Culture of Safety</b>						
<b>NEW FOR 2008</b> – Hospital and Clinic Employees <i>Improve effective communication and teamwork</i>						
<ul style="list-style-type: none"> <li>Improvement in the employee's beliefs, attitudes and experiences re: <b>Handoffs and Transitions</b> (data source: AHRQ culture survey)</li> </ul>		46%		49%		50%
<ul style="list-style-type: none"> <li>Improvement in the employee's beliefs, attitudes and experiences re: <b>Communication Openness</b> (data source: AHRQ culture survey)</li> </ul>		58%		60%		61%
Hospital and Clinic Employees <i>Implement a 'just culture' – improvement in the employee's beliefs, attitudes and experiences re: Aurora's <b>Non Punitive Response to Error</b> (data source: AHRQ culture survey)</i>		35%		39%		43%
<b>Medication Safety</b>						
Hospitals <i>Improve medication management - Patient leaves the hospital with a complete list of their medications (data source: HCAPHS survey)</i>				Acute care hospitals: 93% APH: 95%		95%
Hospitals <i>Improve medication management - Complete medication reconciliation form within 48 hrs of admission (data source: WHA CheckPoint)</i>			73 – 99 points	27 – 99 points		96 points
Clinics <i>Improve medication management - Accurate medication list on the clinic chart (data source: patient interviews)</i>		75%	77% (Walworth County AMG)	78%		80%
<b>Patient-Centered Care</b>						
Hospitals and Clinics <i>Increase the level of patient participation in quality/safety project (data source: # of projects with patient involvement)</i>			5+	5+		1 project per Hospital 1 project – Clinics (AMG, AUWMG) 1 project – AVNA 1 project – Retail Pharmacy

# 5. Measure Success

## SOPS, 2007

### % of Employees with Positive Response

	Benchmark	AHC	Hospital	Clinic
<b>Nonpunitive Response to Error</b>	<b>44%</b>	<b>39%</b>	<b>38%</b>	<b>40%</b>
13. Staff feel like their mistakes are held against them.	51%	<b>46%</b>	<b>45%</b>	<b>48%</b>
17. When an event is reported, it feels like the person is being written up, not the problem.	45%	42%	41%	44%
21. Staff worry that mistakes they make are kept in their personnel file.	36%	<b>29%</b>	<b>28%</b>	<b>30%</b>

Positive Response Defined As:

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# 5. Measure Success

## SOPS, 2008 Preliminary Results

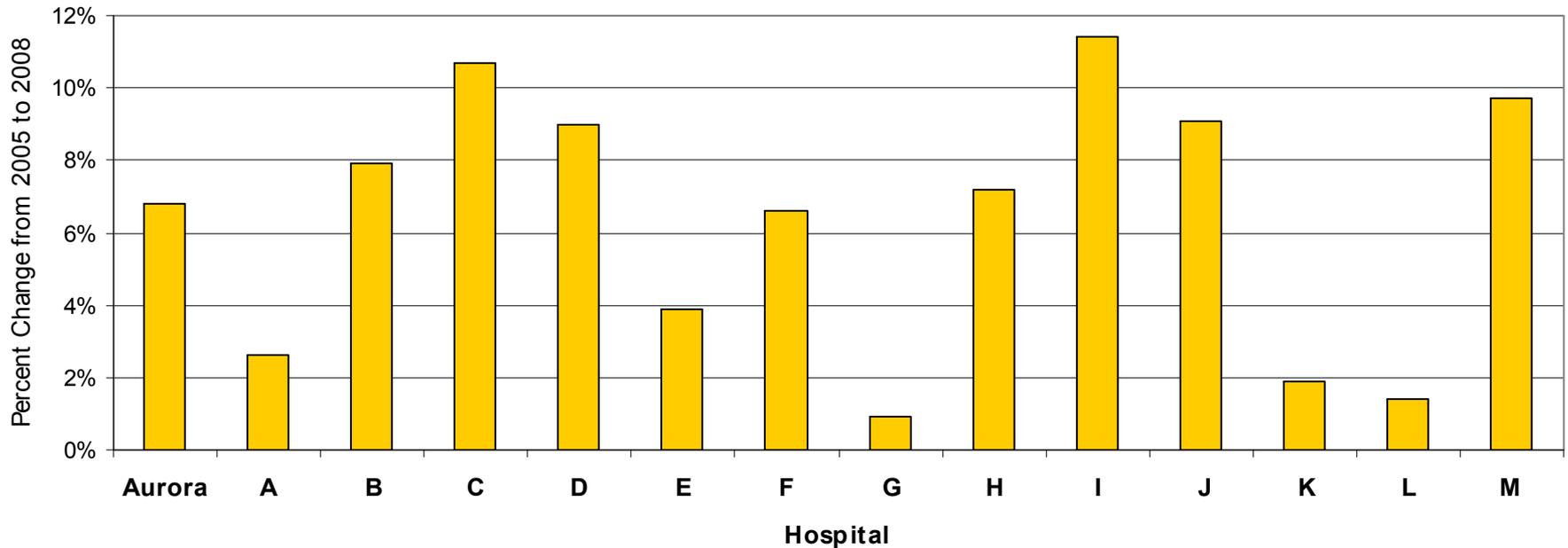
	% of Employees with Positive Response	
	Benchmark	Hospital
<b>Nonpunitive Response to Error</b>	<b>44%</b>	<b>40%</b>
13. Staff feel like their mistakes are held against them.	51%	<b>45%</b>
17. When an event is reported, it feels like the person is being written up, not the problem.	45%	44%
21. Staff worry that mistakes they make are kept in their personnel file.	36%	<b>30%</b>

Positive Response Defined As:

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# 5. Measure success

**AHRQ Patient Safety Culture Survey  
Index: Nonpunitive Response to Error  
% Change from 2005 to 2008**





# Conclusion

To err is human, to forgive divine.

Alexander Pope, *An Essay on Criticism*. English poet and satirist, 1688-1744

It is not only what we do,  
but also what we do not do,  
for which we are accountable.

Moliere. French Playwright,  
1622-1673