Rooting an Error Review Process in Just Culture: Lessons Learned

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Repeated culture of safety surveys of the nursing staff at Children's Hospital of Philadelphia's main campus demonstrated lagging scores in the domain of nonpunitive responses to error. We had tried for many years to address the problem using a variety of strategies, including small group training sessions on just culture for staff and leaders, but had met with limited success. Finally, in 2015, we committed ourselves to trying something genuinely different—even perhaps disruptive—that might actually shift our stagnant metrics. Our novel, multifaceted program, implemented over a two-year period, yielded a 13% increase in staff rating scores that we have been able to sustain over the subsequent two-year period. The design and rollout of our program was neither simple nor smooth, but it has taught us valuable lessons about realistic, operational implementation of principles of psychological safety in a large and complex clinical organization. In this paper, we describe our program and the lessons learned in the journey from idea inception to post-implementation.

Keywords: *patient safety, safety culture, psychological safety, just culture, language of caring, safety event review*

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Organizational Background

Children's Hospital of Philadelphia (CHOP) was founded in 1855 and was the first hospital to exclusively practice pediatric medicine in the United States. The Main Hospital has over 600 beds and is staffed with 1,949 registered nurses, comprising 1,622 full-time equivalents. A 52-bed, second hospital opened in early 2022. The CHOP Care Network comprises 52 primary and specialty care locations and is the largest pediatric network in the country. Over 1 million inpatient and outpatient visits occur annually, with 16,000 employees making this possible.

Literature Review

The success of a just culture training program is critically dependent upon the underlying culture of the organization. Organizations with a hierarchical culture will have greater challenges to effectively implementing a program whereas organizations with a group-oriented culture are more likely to have success. In organizations with a hierarchical culture, efforts should first be put into place to address overall organizational culture before the time, money, and effort are put into just culture training.[1]

It is also important to ensure that the employees' perceptions match those of the leaders within an organization. When an organization has a true just culture, employees have a sense of trust in the organization and its leaders. They believe that everyone is treated fairly, and people are not blamed for mistakes. The trickle-down effect is that employees feel safe to speak up, report events, and ultimately improve patient safety outcomes.[2]

Relatively little published work details the actual operationalization of just culture principles in healthcare organization error reviews.[3] A Missouri collaborative found that participating organizations achieved sustained success when leaders and trained champions received one-directional education on just culture.[4]

The closest programmatic approach to CHOP's was rolled out in 2016 and included a component of peer mentorship aimed at nonpunitive dialog.[5]

Define, Diagnose, and Implement

The first step in our work was to get a better understanding of why so many of our staff continued to perceive the incident follow-up process as punitive, even after so many years of efforts to change it. To that end, starting in early 2016, our human resources division began scheduling focus groups in the nursing department. Over a two-month period, these discussions ultimately included 111 nurses representing two medical units, one critical care unit, and one procedural unit. Responses were distilled into themes which then became the launching point for a departmentwide initiative that involved both process-change and training components.

Based on these precedents, we used findings from our focus groups to revamp elements of our error review process and implement new training to build buy-in and support fidelity of implementation across the department. Our initiative, which we called Partnering for Just Culture, has reconfigured the interview process that precedes a more formal safety event review in nursing. These conversations ensure the employee's voice is heard during the information gathering phase, focusing on systems and not individuals.

Lessons Learned:

Lesson 1: Be Thoughtful About Who Performs Error Follow-Up

Participants in our focus groups had raised concerns related to the matter of personnel conducting incident review. For the most part, when staff were involved in safety events on a unit, the incident review would be conducted by their direct supervisor. This added tension into an already fraught process. The inherent power gradient, no matter how compassionate the supervisor, made it challenging for staff to feel truly psychologically safe to admit fallibility. We learned staff felt the impacts of these conversations could carry over long past the time of the actual event.

Partnering for Just Culture

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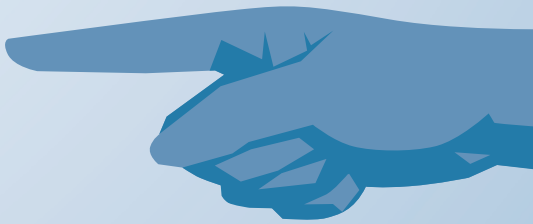
Among our first steps, we removed direct supervisors from the review process and asked each area manager instead to identify personnel who could serve as peer reviewers. Initially, managers and supervisors challenged this concept, as unit leaders feared they would be kept "out of the loop" of what was happening to their staff. Managers and supervisors were reassured that shifting direct incident review to a nonsupervisor would not diminish their supervisory responsibilities; rather, they would determine what level of error severity or employee practice trends would warrant their inclusion. We emphasized that the concept underlying the change was to address power gradients that may add to staff discomfort but encouraged them to provide post-review emotional support and coaching.



Lessons Learned:

1. Be Thoughtful About Who Performs Error Follow-Up
2. Preparation Matters
3. Be Respectful of Staff Members' Time and Privacy
4. Provide Skills for Navigating Difficult Conversations
5. Be Open and Transparent
6. Trial and Train the Content
7. Monitor Fidelity and Assess Your Progress
8. Executive Level Support is Pivotal

Lesson 2: Preparation Matters

Another concern raised in our focus groups was related to preparation for event review. Our focus groups indicated that in many cases, staff felt that supervisors conducting incident reviews were not sufficiently aware of the details of events or familiar with pertinent organizational policy. Emphasizing due diligence as a matter of basic ethics, we stressed that proper preparation is a prerequisite to fair review. All personnel involved in incident review would be expected to have reviewed charts; gained a thorough knowledge of event timelines; and familiarized themselves not only with policy and procedures, but also with operational understanding of local unit cultures and contexts. We also stressed that direct supervisors could be consulted on matters of performance concern.

Lesson 3: Be Respectful of Staff Members' Time and Privacy

Timing was another concern. Staff had reported they sometimes felt unprepared for an error review conversation, and that some were held in the patient care environment. There was wide variability in how, where, and when conversations were held between supervisors and staff following safety incidents. We reiterated that employees were to be notified in advance of any incident review meeting so they could prepare for the conversation. Timing and location of the error review discussion is critical, and consideration of a neutral location is recommended. A replicable and consistent process should be used with all staff.

Lesson 4: Provide Skills for Navigating Difficult Conversations

The aim of the event review process is to uncover the complex and sometimes hidden factors that may contribute to safety events. It is often difficult for employees to talk about their shortcuts, workarounds, and episodes of decreased situational awareness. From our focus groups, we knew we needed to improve the level of compassion and empathy in these difficult conversations. We utilized the Language of Caring framework (a branch of Planetree International) which guides the event reviewer to be present, remain neutral, and ensure the conversation does not feel like an interrogation.[6] This evidence-based platform shares proven skills and strategies that help people's natural care, compassion, and empathy shine through, especially when conversations may be challenging and/or difficult. Maintaining the emotional and psychological safety of the employee can promote their feelings of resilience.

Lesson 5: Be Open and Transparent

Among the most challenging concerns was transparency. Staff reported that they rarely knew much about the outcomes of event review and were not formally notified if system changes ultimately resulted. We began requiring reviewers to circle back to the involved staff, as well as the entire team, after completing investigations to report on the findings and explain the outcomes, including system changes or proposed communication or educational plans. We emphasized that communication with the team should focus on the event, not on individuals.

Lesson 6: Trial and Train the Content

Years of previous messaging about just culture had resulted in uneven application of the concepts (evidenced by focus group feedback) and we had not previously engaged in any measurement or assessment of training in this area. This time, however, we developed a formal curriculum aimed at building understanding and buy-in specifically about incident review, and we added assessment elements to monitor results. The intent was to embed the program in our culture, assure consistency of messaging across personnel, and enhance the likelihood of fidelity across units.

We refined the program lessons and educational plan by trialing them in three areas at the same time. To assure the program would meet the needs of different areas within the hospital, we selected the following areas: the emergency department, to learn from a high-stress environment with rapid patient turnover; an inpatient medical unit, to learn from the inpatient care setting; and the pharmacy department, to learn from a non-nursing unit. The trial ran for three months in each area that implemented the new program. We gathered feedback through surveys and focus group sessions with those

Pilot Locations

EMERGENCY DEPARTMENT
to learn from a high-stress environment with rapid patient turnover

INPATIENT MEDICAL UNIT
to learn from the inpatient care setting

PHARMACY DEPARTMENT
to learn from a non-nursing unit

implementing the new program and employees involved in a safety event review process. We used this information to further adapt and refine the program for those implementing it.

The finalized classes were developed to clarify new expectations and ensure that leaders would share consistent messaging on why the review process was changing and why just culture mattered in the organization. Prior to attending class, participants received a knowledge assessment on just culture coupled with video vignettes that shared leaders' personal experiences with clinical errors. Each session took 2.5 hours and gave continuing education credits. Classes were held with all leaders within a team to allow for discussion and application of the concepts and agreement on expectations by all moving forward. An expert on communication led the discussions on Language of Caring.[6] Safety and management experts led the learning around the key concepts of the program. We used pre- and post-surveys to ensure knowledge transfer occurred and staggered implementation throughout the department, starting with lowest performing areas on culture of safety survey metrics related to nonpunitive perceptions.

Lesson 7: Monitor Fidelity and Assess Your Progress

A few weeks after each training session, the program leads met with the unit nurse manager and trained reviewer(s) for a 30-minute huddle. We asked the nurse manager for their reflection on content covered, timeline to implementation, and identification of any barriers. We developed an anonymous survey for the reviewer to send to recipients of an error review discussion, framed around the tenets of the program. Follow-up sessions were held every few months until the area was in sustain mode, based on the feedback from the surveys. During these sessions the leads of the program provided coaching as needed and shared learnings across areas.

The personal approach took time but was key in embedding this new model into the culture of the department. This differed from prior leader training sessions where didactic content was taught but results were not measured, nor were there forums to discuss challenges with applying the new knowledge.

Lesson 8: Executive Level Support is Pivotal

The work was initially championed by the vice president of Quality and Safety and supported by the chief nursing officer throughout the department. The support of these key executives made it clear that the organization needed change and we needed to do something differently in our event review process. From trial through implementation, vetting took place across diverse frontline and leadership groups. Unit leadership also had to be engaged in the work. Like many other processes, change can be approached with apprehension, but executive confidence in the program helped to mitigate local leader concerns.

Impact and Outcomes

Five years after this program started, we continue to implement feedback loops as new leaders are trained in it. Despite the challenges of the pandemic, the nursing department did not waiver in their use of the program's concepts. To date, 489 of our staff who replied to a post-event review survey have shared that 91% of the events were reviewed by a nonsupervisor; 90% of the reviews were conducted in an empathetic manner; 88% of meetings were held in a private and neutral location; 92% of the events were felt to be focused on the system and not the person; and, most importantly, 96% of the staff felt it was not punitive.

Reviewers were honest in sharing that the new approach took more time, however they expressed that the added effort had a positive return on investment. The results referenced in the prior section further reinforced these anecdotal perceptions. We have a strong reporting culture at CHOP, which could be a factor in increases in reporting from pre-program sustainment

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until now for all events and near misses, which increased by 16% and 11% respectively. Based on the success we have seen, additional departments have sought this training. We hope that this approach can be utilized across the organization for any type of error, patient-related or not.

Conclusion

Rather than explaining away staff perceptions of a punitive environment, organizational self-reflection afforded an important glimpse into the employee experience. By committing resources of time and staff, CHOP has experienced gains in engagement and safety culture. The application of an error review framework rooted in just culture can enable other organizations to have similar success.

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References

1. David DS. The Association Between Organizational Culture and the Ability to Benefit From "Just Culture" Training. *J Patient Saf*. 2019;15(1). doi:10.1097/pts.0000000000000561

2. Paradiso L, Sweeney N. Just Culture. *Nurs Manage*. 2019;50(6):38-45. doi:10.1097/01.numa.0000558482.07815.ae

3. Barkell NP, Snyder SS. Just Culture in Healthcare: An Integrative Review. *Nurs Forum*. 2020;56(1):103-111. doi:10.1111/nuf.12525

4. Shabel W, Dennis JL. Missouri's Just Culture Collaborative. *J Healthc Risk Manag*. 2012;32(2):38-43. doi:10.1002/jhrm.21093

5. Korkis L, Ternavan K, Ladak A, Maines M, Ribeiro D, Hickey S. Mentoring Clinical Nurses Toward a Just Culture. *J Nurs Admin*. Published online July 2019:1. doi:10.1097/nna.0000000000000772

6. Language of Caring. Language of Caring Philosophy. Language of Caring website. https://languageofcaring.org/resource-category/language-of-caring-program-information. Accessed December 28, 2021.

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Kristin Neiswender has been a senior patient safety manager at Children's Hospital of Philadelphia since 2009. In this role, she is responsible for event reviews and safety-related education, and she co-leads an organizational refresh of safety behaviors. She also oversees several safety culture–based programs, including Just Culture and Good Catch. She has her Bachelor of Science in nursing from Penn State University and her Master of Science in nursing from the University of Phoenix. She holds certifications in TeamSTEPPS, psychological safety, and patient safety. Before her safety career, she was a staff nurse for 20 years.

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