Invigorating Nursing Peer Review through Integration of Just Culture Human Factors and Principles

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Creating Healthy Work Environments 2017
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Conflict of Interest

• The presenters for this presentation have disclosed no conflict of interest related to this topic.
Objectives

• Describe the current status and challenges of nursing peer review.
• Describe how a Professional Practice Model (RBC) informs nursing peer review
• Describe Human Factors and Just Culture principles and how to apply into a nursing peer review process.
• Discuss the sustained clinical outcomes provided by the new process in one community hospital.
Centura Health

- A faith-based, nonprofit health care organization formed in 1996 by Catholic Health Initiatives and Adventist Health System – now in two states

- Colorado’s fourth largest private employer with nearly 16,000 associates and 5000 of those are RNs

- The Centura system includes 25 operating entities:
  - 17 hospitals
  - 7 senior living communities
  - Centura Health at Home, Hospice, Health Network
  - Centura Health Physician Group
Castle Rock Adventist Hospital

• Located in a rapidly growing community
• Opened in 2013
• 55 inpatient beds
• > 14,000 ED visits annually
• Specialties
  – Women’s Services
  – Orthopedic Services
  – Complex Medicine
• Magnet® Journey bound
Key Concepts

- Nursing Peer Review
- Relationship Based Care
- Restorative Just Culture
- Human Factors
What is Nursing Peer Review?
ANA Guidelines for Peer Review

• A peer is someone of the same rank.
• Peer review is practice-focused.
• Feedback is timely, routine, and a continuous expectation.
• Peer review fosters a continuous learning culture of patient safety and best practice.
• Feedback is not anonymous.
• Feedback incorporates the nurse’s developmental stage.
Why Nursing Peer Review (NPR)?

• Professionals need to do it!!!
  – Mechanism for self regulation of a profession in order to be accountable to society and to ensure quality
  – All professions are expected to use peer review but few require it (George & Haag-Heitman, 2015)

• **NPR is essential** to a Magnet® culture, Safety culture, and Healthy Work Environment
What challenges are faced with nursing peer review?

• Can be Punitive
• Focus on individual not system
• Not completed timely
• Used as performance review
• No link to professional practice model
• Strong interventions can be lacking
• Evidence base for decisions not evident
• Sources of bias not recognized
Transformation: Start with a Nursing Professional Practice Model

• What is it we want as nurses for patients/our colleagues/ourselves?

• Relationship Based Care (RBC) (Koloroutis, Felgen, Person & Wessel, 2008)
  – Focuses attention on relationships (patient, self, colleagues)
  – Transforms culture
  – Principles that shape behavior and change culture
  – Based on a change process I2 E2
I₂E₂: The Blueprint for Achieving and Sustaining the Vision
Step 1: I₁
Vision and Inspiration

• What is Nursing Peer Review at CRAH?
  Brainstorm Guiding Philosophy and Principles
  “Amazing outcomes do not JUST Happen”
Visioning: NEAT

Peer Review is:
• A peer is someone of equal standing
• Nursing care is measured against evidence based professional standards of practice
• Face to face feedback
• Relationship building
• Support the first (patient) and second victim (staff member)
• Looks for Root Cause- avoids bias
• Recognizes current safety science
• Supports strong interventions

What peer review is not...
• Annual performance review
• Given or completed by manager
• Punitive or disciplinary process
• Kept in employee file

• Traditional....So we changed our name to NEAT
• Nurse Excellence Advocacy Team
Old Safety Thinking versus New Safety Thinking

OLD
• People are a problem to control
• Safety is the absence of negatives
• Control, constrain, human deficit

NEW
• People are a solution to harness
• Safety is the presence of positives to make things go right
• Empower, diversity, human opportunity

Dekker, 2016
Restorative Just Culture
Building NOT Breaking

Retributive-Paying
• Asks “who” is responsible?
• What sanctions need to be imposed?
• A “judge” decides
• Reinforces rules and authority
• Meets hurt with more hurt

Restorative-Healing
• Asks “what” is responsible?
• Who is hurt and what are their needs?
• All affected tell their account
• Invests in relationship
• Meets hurt with healing

Dekker, 2016
Second Victim: Focus on Thriving

• Scott (2011) described 6 stages of recovery for the second victim

• Stage 6 options
  – Dropping out: Changing professions
  – Surviving: Still feeling guilty; on going trauma
  – Thriving: learning from the mistake and making a difference for the future
Concepts of Human Factors
We are not perfect and never will be!

• Human Factors applies the knowledge of human frailties (fatigue distraction etc.) to the design of equipment they use, environments in which they function, and jobs they perform”

• In order to prevent error, we need to create systems that account for the fallibility of humans with guardrails for their safety!
Human Error is the beginning of the investigation not the end...

• Human error is a symptom of the problem, not the problem
• Look deeper for the second story
  – Ask “why” 5 times
• Understand work at the “frontline”

Woods, Dekker, Cook & Johannesen, 2010
Human Factors Principles

• Avoid Reliance on Memory
• Simplify
• Standardize
• Use Constraints and Forcing Functions
• Use Protocols and Checklists Wisely
• Use Technology to enhance and provide guardrails
Examples of Strong Interventions

• Strong – mistake proofing; taking away an error prone product
  – Forcing the correct way and placing a barrier to the incorrect

• Weak - education;
• “be more careful”
# Integrating the Philosophy into Practice

| Relationship Based Care | • With patient  
|                         | • With self  
<table>
<thead>
<tr>
<th></th>
<th>• With colleagues</th>
</tr>
</thead>
</table>
| Restorative Just Culture| • People are solutions to harness not problems to control  
|                         | • Positive/healing |
| Nursing Peer Review     | • Second Victim  
|                         | • Face to face  
|                         | • What can we learn; not who can we blame?  
|                         | • What can we learn as a team? |
Step 2: $I_2$ Infrastructure

• How do we hardwire our philosophy into practice?

• Components of Infrastructure
  – Strategy: big picture; create the charter
  – Operational: who is on the committee?
  – Tactical: How do we do our work? Forms
Strategy: Charter

Castle Rock Adventist Hospital
Nursing Peer Review Charter
3/30/16

**Goal:** To develop individuals and systems through a review of care events and near misses in an objective/non punitive manner in order to identify opportunities for continuous performance improvement, promote professional peer feedback and optimize outcomes for our patients.

**Purpose**
Establish evidence based guidelines to review professional practice, to improve patient care and enhance patient safety
Identify areas of exemplary care and professional practice
Recommend changes in system or process that will reduce the risk of a similar event in the future.
Incorporate Just Culture principles into review
Operational: Team/Meetings

• One nursing rep. from all areas
• Good standing; >2 years exp.
• Nurse Scientist
• Ad-hoc physician/pharmacist
• No managers
• Elected Chair and Co-chair
• Meetings monthly
Tactical: Process and Forms

- Education sheet to staff
- Just Culture screening
- Human factors checklist
- Interview Guide for reviewers
- Group review and decision guide
- Referral list
- Process flow sheet
- Follow up letter
Referrals

- Near misses
- Code Blue or RRTs
- Falls
- CAUTI/ CLABSI
- Pressure injury
- Medication errors
- Unexpected transfers to ICU
- Returns to surgery
- Patient or family complaints
- Core measure fall outs
<table>
<thead>
<tr>
<th>Process step</th>
<th>Key Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Referral to NPR</td>
<td>Adverse events; SOC issues</td>
</tr>
<tr>
<td>❑ Screening for just culture</td>
<td>Human error; risky choices can be NPR</td>
</tr>
<tr>
<td>❑ Assignment of category- adverse event; unexpected outcomes etc.</td>
<td>What question are we trying to answer?</td>
</tr>
<tr>
<td>❑ Assignment of case to expert</td>
<td>Prefer like unit; Add EBP review</td>
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<tr>
<td>❑ Investigation- Formal tool to guide questions</td>
<td>Feedback must be obtained from staff member “What happened”</td>
</tr>
<tr>
<td>❑ Outcome review by team (Rating)</td>
<td>Human factors checklist; All must agree on outcome</td>
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<tr>
<td>❑ Feedback to staff member</td>
<td>Individual accountability/ Closing the loop</td>
</tr>
<tr>
<td>❑ System referrals</td>
<td>System accountability/ Sustainable change</td>
</tr>
<tr>
<td>❑ Feedback to referee</td>
<td>Let them know of outcome</td>
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Just Culture Screening Prior to NPR

**Was this human error?**

- due to system design and human choices made in the moment?
  - Refer to NPR-system issues
  - Second victim

**Was this a risky choice?**

- the risk to the patient was not known or was thought to be justified
  - Refer to NPR-system issues; discuss choices
  - Second victim

**Was this reckless behavior?**

- conscious disregard of substantial risk
  - NOT NPR
  - Refer back to management
The Interview Guide

Nursing Excellence Advocacy Team (NEAT) Worksheet-CRAH—PROPERTY OF NEAT

CONFIDENTIAL INFORMATION FOR QUALITY IMPROVEMENT
DO NOT SHARE OR PLACE IN EMPLOYEE FILE

Standard of care issue and date of event:

Introduction: I would like to talk to you about ______ event. The purpose is to learn and improve care as a hospital system.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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</thead>
<tbody>
<tr>
<td>What happened from your perspective?</td>
<td></td>
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<tr>
<td>What factors influenced your action or decision?</td>
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<tr>
<td>What do you think should have or was supposed to happen?</td>
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<tr>
<td>Do you think others could make the same mistake?</td>
<td></td>
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<tr>
<td>What solutions do you suggest to prevent this from happening again at CRAH?</td>
<td></td>
</tr>
<tr>
<td>Do you need any support?</td>
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If you think of something else, please call. We will circle back with you for feedback after we discuss the event and solution at the next NEAT meeting.

Learning and healing; not punishing
Avoiding bias
Involving the person in the solution assisting with decreasing second victim distress
Support
Human Factors Questions

• Ask about distraction; boredom, rushing
• Ask about communication barriers..
• Ask about situational awareness- not paying attention to the big picture..
• Ask about confirmation bias- seeing what you expect to see....
Human Factors Checklist
(Adapted from FAA)

- Lack of Communication
- Assumptions
- Complacency
- Lack of Knowledge
- Distraction
- Lack of Teamwork
- Fatigue

- Lack of Resources
- Rushing-Go Fever
- Lack of Assertiveness
- Confirmation bias
- Stress
- Lack of Situational Awareness
- Normalization of deviance
How is a decision reached?

• **Assessment of care:**
  – Exemplary. No deficient care
  – Acceptable care
  – Non-routine but acceptable care
  – Human error
  – Risky behavior/risky choices
  – Reckless behavior (found during investigation—refer immediately to supervisor)

• **Recommendations:**
  – Refer to other department for system issue
  – Refer to other discipline for peer review
  – Education/Training
  – Suggest policy or protocol revision
  – Other

• **Committee review:**
  – More information needed
  – No action
  – Needs feedback and plan with staff member involved: Due date__________
Avoiding Bias

- **Hindsight bias** - “Could’ve predicted that”
- **Outcome bias** - “judgment is harsher when outcome is bad”
- **Use “Local Rationality”** - see situation with the information known at the time and try to understand why actions made sense at the time

- Risky choice
- Who is hurt?
- Healing for nurse
- Signage “did you turn BA on?”
- NEAT
- Face to face
- Coaching on choices
- System fix
Step 3: Evaluation 1 Education

- Challenge- How to coach??
- Approach- Seek to understand; not judge

“We are contacting you to better understand the case. We would like your insight on the care of this patient”

“Tell me about the circumstances that led to the your decision/actions?”

“What do you think would have prevented this?”

“What went right?”
Feedback and Reflection

• **After each session** feedback is received from the peer reviewer and the reviewed:
  – What did you learn?
  – What did we change?
  – Did you feel supported?
  – What can we do better?
Step 4: $E_2$ Evidence
Reduction in Falls
Increase in RRT Rate
Decrease in Code Blue Rate

RRT and Code Blue Trending

More RRTs should lead to less Code Blue outside of ICU.
Problem: Staff were felt to be criticized for calling the RRT.
Interventions:
- Simulation of Codes and RRTs
- ACLS training
- Emphasis on support for RRT calls

- Code #
- Code rate
- RRT #
- RRT rate

FY 14 | FY 15 | FY 16
--- | --- | ---
Code # | Code rate | RRT # | RRT rate
Safety Culture Improvement
Non-Punitive Response to Error

- Mistake held against
- Focus on person not problem
- Mistakes kept in personnel file

2015 vs 2017
Insights

• “It has added a constructive way to address nursing issues that have come up and now staff feels there is a forum to find working solutions”

• “Empowering staff allows nurses to come together building a stronger team and making strides in the care we provide for our patients”
Key Points

• Base NPR on a nursing philosophy and current science
• Face to face conversation
• Avoid bias- “local rationality” – Why did the action make sense?
• Seek to learn and understand
• Remember the Second Victim
• Close the loop- follow up with referrer
• Make change visible
• Start small and show outcomes
Questions???
References


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