CULTURE OF SAFETY: THE NURSE’S ROLE

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OBJECTIVES

- Cultivate an understanding of the culture of safety
- Identify 3 factors related to adverse patient outcomes
- Identify barriers related to the culture of safety
- List strategies to improve the awareness of the culture of safety
NURSING AND HEALTHCARE DUTY

- Medical Errors – 3rd leading cause of death
- Awesome responsibility & opportunity to provide care
- Sick and injured
- Life place in our hands
- Trust
- Nurses are “frontline” to healthcare
- Confident that we will protect them from errors while in our care
- We want patients to feel 100% confident in our care
PATIENT CARE

- Safety is basic component of healthcare
- Priority of care
- Duty and Responsibility
- Courage to Care.....truly care
"Culture is not something you fix, cultural change is what you get after you put new processes or structures in place to tackle tough business challenges like reworking an outdated strategy or business model."

- Culture evolves as you do the work

CULTURE OF SAFETY

- Blame-free environment
- Staff feel comfortable reporting errors/near misses
- Seeks root cause of error
- Supports nurses and health care providers
- Non-punitive
- Emphasizes
  - Accountability
  - Honesty
  - Integrity
  - Mutual respect
CULTURE OF SAFETY
CULTURE OF SAFETY

- Patient and employee safety is the priority
- Organization leadership is committed
- Develops over a period of time
- Stages
CULTURE OF SAFETY

- Leadership priority
- Organizational goal
- Rules & Regulations
- Policies & Procedures
- Safety performance is seen as dynamic
- Staff engagement
- Empowerment
- Continuous improvement
FOCUSES ON **WHY** AN ERROR WAS MADE RATHER THAN **WHO** MADE THE ERROR

ENCOURAGING STAFF MEMBERS TO VOICE THEIR CONCERN RELATED TO A **SAFETY RISK**

EMBEDDED WITHIN A CULTURE OF SAFETY IS **JUST CULTURE**
CULTURE OF SAFETY

CULTURE OF BLAME VERSUS CULTURE OF SAFETY

VOICE CONCERN

I AM CONCERNED
I AM UNCOMFORTABLE
THIS IS A SAFETY ISSUE
CULTURE OF SAFETY

- Work together for change
- Take action when needed
- Peers and leaders working together
- Avoid “finger pointing”
CULTURE OF SAFETY

• Leaders visibly committed to change
• Enable staff to openly share safety information
• Without culture – staff reluctant to report unsafe conditions
• Senior Leaders must drive the culture change
• Demonstrate their commitment
  • Safety & providing resources
  • Consistent message
  • Perception of organizational culture
JUST CULTURE

- Embedded within a “culture of safety”
- Culture that is fair to those who make an error
- Improves patient safety
- Encourages nurses to learn from each other’s mistakes
- Encourages to report all events/near misses without fear
- System approach
- Standardization
CULTURE OF SAFETY

Nurse leaders and managers can “promote a process of mistake or error mitigation that recognizes that errors may be the result of system breakdowns or failures to build a good system, as opposed to putting the total blame on individuals”

(ANA, 2015b, p. 6)
1999 Ground breaking report

*To Err is Human: Building a Safer Health System*

Patient safety and quality of health care

- 44,000 – 98,000 preventable medical errors
- Emphasized pivotal role of system failures
- Benefits of strong safety culture
2 additional reports by IOM

- 2004 Patient Safety: Achieving a New Standard for Care
- 2004 Keeping Patients Safe: Transforming the Work Environment
Investigations conducted

Example: U.S. Department of HHS
780 Medicare beneficiaries
13.5% experienced adverse events
13.5% temporary harm during hospitalizations
44% events were preventable
IOM

- Additional investigations
- Revealed 210,000 - 400,000 deaths occur each year in hospitals in U.S. hospitals
- National initiative
- Cultural issues
- System issues
Nurses are in key positions impacting patient safety & quality health care.
Ethical obligation to promote safe and quality care.
IOM

- Assessing the culture
- Teamwork
- Patient involvement
- Systems
- Openness
- Transparency
- Accountability
"The nurse promotes, advocates for, and protects the rights, health, and safety of the patient"

"Nurses have vested authority, and are accountable and responsible for the quality of their practice"

(ANA, 2015a, p. 9)
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

- Department of Health & Human Services
- Make health care safer, higher quality
- Improved access
- Equitable
- Affordable
- Patient Safety Network (PSNet)
INSTITUTE FOR HEALTHCARE IMPROVEMENT (IHI)

- United States & Globally
- Initiative to remove improvement roadblocks
- Launch healthcare improvements
- Reduce morbidity & mortality
- Development of rapid response systems/teams
- Myocardial infarction improvements
- Medication reconciliation
- Central line bundles
- Prevent ventilator acquired pneumonia (VAP)
THE JOINT COMMISSION (TJC)

- Non-profit organization founded in 1951
- Accreditation and certification
- Ensuring patient safety, quality of care
- “Best-valued health care across all settings”
- Speak Up Campaign
- National Patient Safety Goals (NPSGs)

[Image: Sentinel Events reported to JCAHO (1996-2006)]

- [https://www.jointcommission.org/](https://www.jointcommission.org/)
WORLD HEALTH ORGANIZATION (WHO)

- Patient safety global health initiative
- “Absence of the preventable harm to a patient during the process of health care.”
- High 5’s Project
  - Medication accuracy
  - Correct procedure at correct site
  - Use of concentrated injectable medicines
  - Communication during patient handovers
  - Health-care associated infections
ADVERSE EVENTS

- 1:10 harmed while receiving healthcare
- 43 million patient safety incidences annually
- $42 billion annually related to medication errors
- 500,000 falls annually
- 1:20 hospitalized patients acquire HAI
  - CLASBI
  - CAUTI
  - HAP
  - SSI
FACTORS ASSOCIATED WITH ADVERSE OUTCOMES

• Staffing ratios
• Competency
• Short cuts
  • Failure to use barcoding
  • Patient & medication scanning
  • Blood administration
• Failure to use checklists
• Falls
• Failure to follow policy/procedure
ADVERSE PATIENT OUTCOMES

- Poor communication has been the leading causes of serious adverse events in healthcare
- Patient identification
- Patient handoff
- Stopping the Line
- Time out procedures
- In appropriate systems/processes
- Medication errors
- Wrong surgical site
- Failure to “stop the line”
What is a Sentinel Event?

- Resulting in death or serious injury
- Patient, staff, visitor
BARRIERS

- Lack of leadership commitment
- Lack of accountability
- Failure to respond to identified opportunities
- Poor reporting system
- Punitive culture
- Poor patient/consumer engagement
- No systematic processes
2016
TEN TOP PATIENT SAFETY ISSUES

- Medication errors
- Diagnostic errors
- Discharge practices
- Workplace safety
- Hospital facility safety
- Reprocessing issues
- Sepsis
- Superbugs
- Cyber insecurity
- Transparency
STRATEGIES TO IMPROVE AWARENESS

- Communication
- Focus on Systems and Processes
- Focus on Patients
- Focus on Collaboration (Team Work)
- Focus on data
- Checks and Balances
- Quality Improvement (QI)
  - Interprofessional team
  - Foster attitude, behaviors, & processes for change
STRATEGIES FOR IMPROVEMENT

- Leaders promote a culture that focuses on patient and staff safety
- Encouraging error reporting
- Error reduction
- Patient safety
- Methods of continuous improvement
- Patient safety incidents and Near Misses are opportunities for learning and improvement
I'm Safe Checklist

1. Illness—Do I have any symptoms?
2. Medication—Have I been taking prescription or over-the-counter drugs?
3. Stress—Am I under psychological pressure from the job? Worried about financial matters, health problems, or family discord?
4. Alcohol—Have I been drinking within 8 hours? Within 24 hours?
5. Fatigue—Am I tired and not adequately rested?
6. Eating—Am I adequately nourished?

Figure 9-3. Prior to flight, pilots should assess their fitness, just as they evaluate the aircraft’s airworthiness.
WHY REPORT

- Trend and identify system failures
- Prevent incidents from occurring
- Identify opportunities for Process Improvement
- Educate the changes or lessons learned
- Review of processes
- Continuous improvement
WHAT IS YOUR ROLE

- Participate in Patient Safety Rounds
- Proactive behavior
- Prevention
- Encourage coworkers to report incidents and near misses
- Mentor new staff
- Serve as a role model
- Patient advocacy
CURRENT EVENTS

- 2 patient suicides in 8 days reported at hospital
- Staffing concern in ED places hospital at high-risk
- Becker’s Hospital Review
  - https://www.beckerhospitalreview
- Univadis
IMPROVEMENT MODEL

• IHI Model of Improvement
• What are we trying to accomplish?
• How will we know that a change is an improvement?
• What changes can we make that will result in an improvement?
• Plan-Do-Study-Act (PDSA) cycle
ROOT CAUSE ANALYSIS

- RCA
- Formalized investigation
- Problem solving approach
- Identifying and understanding the underlying causes of an event as well as potential events that were intercepted
ROOT CAUSE & CHANGE

- RCA – used to find root cause of an error

- PDSA – used to implement change aimed at improving or alleviating the cause
FOUNDATION TO IMPROVE SAFETY

- Focus on customer
- Process oriented
- Change driven by data
- Communication
- Empowerment
- Courage to care... truly care
Often times it is the idea of the staff that brings about change -- new and improved solutions to everyday issues.

Staff deals with issues at front of the line.

Questions?