Safety

by Sophia Tutorial

WHAT'S COVERED

In this lesson, you will learn about patient safety in healthcare. Specifically, this lesson will cover:

1. Overview
2. High Reliability Organizations (HRO)
3. Establishing Safety
4. Frameworks and Theories
5. Transparent Leadership

1. Overview

Patient safety is the cornerstone and foundation in healthcare. Quality and safety enable the trust to become established between patient and healthcare providers.

How is safety created and sustained? It is an accumulation of frameworks and theories to prevent barriers and engage stakeholders by improving outcomes. So how does the bedside become a part of the safety and quality for improved patient outcomes? Safety and quality have a symbiotic relationship; therefore, it is the organizations and people who are elements raiding the quality of the care provided. Let us begin with the organization.

2. High Reliability Organizations (HRO)

The type of organizations that supports the creation of high quality and safety are often referred to as high reliability organizations. Organizations that are deemed as being highly reliable are committed to delivering high-risk services that can achieve and sustain low risks of harm.

There are five key characteristics associated with these healthcare systems;

- Preoccupation with failure
- Resist simple observations
- Committing to resilience
- Understanding operations

- Procuring expertise to provide zero harm

IN CONTEXT

The impetus or catalyst to drive healthcare systems into a beacon for patient quality and safety was derived from the Institute of Medicine (IOM)'s 1999 report *To Err Is Human*. The report enabled healthcare systems to improve quality and patient safety through the implementation of three elements: Technological advancement, standardization of procedures for all high-risk processes, and utilization of high reliability organizations to prioritize better patient outcomes.

3. Establishing Safety

Establishing safety within healthcare organizations rides on the presumptions for everyone to participate and be accountable for process improvement and patient safety. The Agency for Healthcare and Research Quality (AHRQ) and Quality and Safety Education for Nurses (QSEN) generates ongoing education and research to improve the process for patient safety and quality.

There are several components in which the healthcare members can mitigate adverse outcomes. QSEN's platform is to prepare nurses with knowledge, skills, and attitudes for ongoing improvement. The competencies of the QSEN platform and the ARHQ's Team STEPPS and Comprehensive Unit-Based Safety Program (CUSP) toolkits focus on patient-centered care, teamwork, evidence-based practice, and quality improvement, safety, and informatics. The approach is multi-pronged, although it utilizes the same principles predicated on the utilization of teamwork and effective communication.

THINK ABOUT IT

How does safety become hardwired into an organization? What is the role of the bedside nurse in this process?

The bedside nurse is the most important component within the healthcare team. Nurses can minimize errors as well as improve patient outcomes through the identification and utilization of evidence-based practice. Again, the creation of a common language for nurses and healthcare providers to gain an insight into quality measures and quality improvement supports a culture of safety and transparency.

The promotion of critical thinking awareness has been at the front for nursing education as a bridge from academia to clinical application. The competencies set forth from QSEN embody the impetus for building collaborative teams employing open, effective communication, mutual respect, and shared decision making. The focal point of the process is the integration to monitor quality and increase accountability through advanced research and technology to communicate and manage knowledge, mitigate error, and support clinical decision making. The foundation of this process is global education and awareness for application within the clinical setting. Some of the foundational theories and framework which support high-quality safety are best practice.

Video Transcription

Kareem is a nurse manager at a transitional care unit of a metropolitan hospital. As he arrives on the floor, he learns that a patient fell down this morning. Immediately, he pulls together everyone who could have been involved in any capacity including nurses, doctors, as well as physical therapists and housekeeping staff. This is called a safety huddle. And the goal is to discuss what exactly happened, what went wrong, and what can be changed to improve the outcome.

Patient safety incorporates a multidisciplinary approach as it is not just one individual or service that provides care for patients. In fact, it is the organizations and people who are elements that define the quality of care provided.

The type of organization which supports the creation of high quality safety are often referred to as high reliability organizations. There are five key characteristics associated with these organizations-- constant concern about the possibility of failure, resisting simple observations, committing to resilience, understanding operations, and procuring expertise to provide zero harm. Establishing safety within these organizations rides on the presumptions that everyone participates and is accountable for process improvement and patient safety.

A key component is holding a safety huddle, which is a short briefing for the people involved with caring for the patient where potential and existing safety issues are discussed. The main focus is to find the cause and discuss solutions in an open and safe manner, not to find faults and dole out punishment.

Nurses can minimize error and improve patient outcomes through the identification and utilization of evidence-based practice, the creation of a common language for nurses and health care providers, as well as the promotion of critical thinking awareness. Another advantage is promoting just culture where open reporting of safety issues helps improve both individuals and the organization.

It's also important to consider how informatics leverages technology to mitigate inefficiency for the clinical environment. That's because it has the potential to prevent errors in practice, improve delegation and priority setting, and enhance problem-solving and quality improvement initiatives.

One of the greatest contributions made to patient safety is the documentation of the care in the electronic health record or EHR. This allows nurses to access information quickly and to utilize that information to improve patient safety.

So what Kareem hopes is to turn a potentially negative situation into a valuable learning experience and to determine accountability in a safe, nonaccusatory environment. It's definitely important to ensure that employees not only feel safe to report errors and understand the need to complete the required incident report, but also identify the potential for error, proactively monitor the workplace, and participate in safety efforts.

Beyond just that, there should be a change in focus from errors and outcomes to managing the behavioral choices of all employees as well as continually learning, adjusting, and redesigning systems for safety.

4. Frameworks and Theories

Action learning methodology allows for the development to solve complex issues by fostering leadership skills in a clinical application. The process of change begins with urgency and need.

Kotter's Eight-Step Process for Leading Change underpins the focus for action. The beginning steps center upon a paradigm shift of action. The sense of urgency is the catalyst for forming a coalition and to communicate the vision. Highly reliable initiatives are germinated from adverse patient outcomes, which serve to facilitate and prioritize patient safety. The premise of Kotter's Eight Steps of Change is that anyone can lead change. The bedside nurse is in a position to see the need for urgency and take action to improve patient safety and the quality of outcomes. The process to engage the urgency must incorporate the adoption of the stakeholders and remove the obstacles.

So how can the nurse impart change among the stakeholders and leadership? The process is a three-prong application from the clinical bedside to incorporate change, effective communication, evidence-based practice (EBP), and transparency. Leadership sets in a natural state to organize process change, albeit it is the bedside nurse or clinical nurse leaders who recognize the urgency for change.

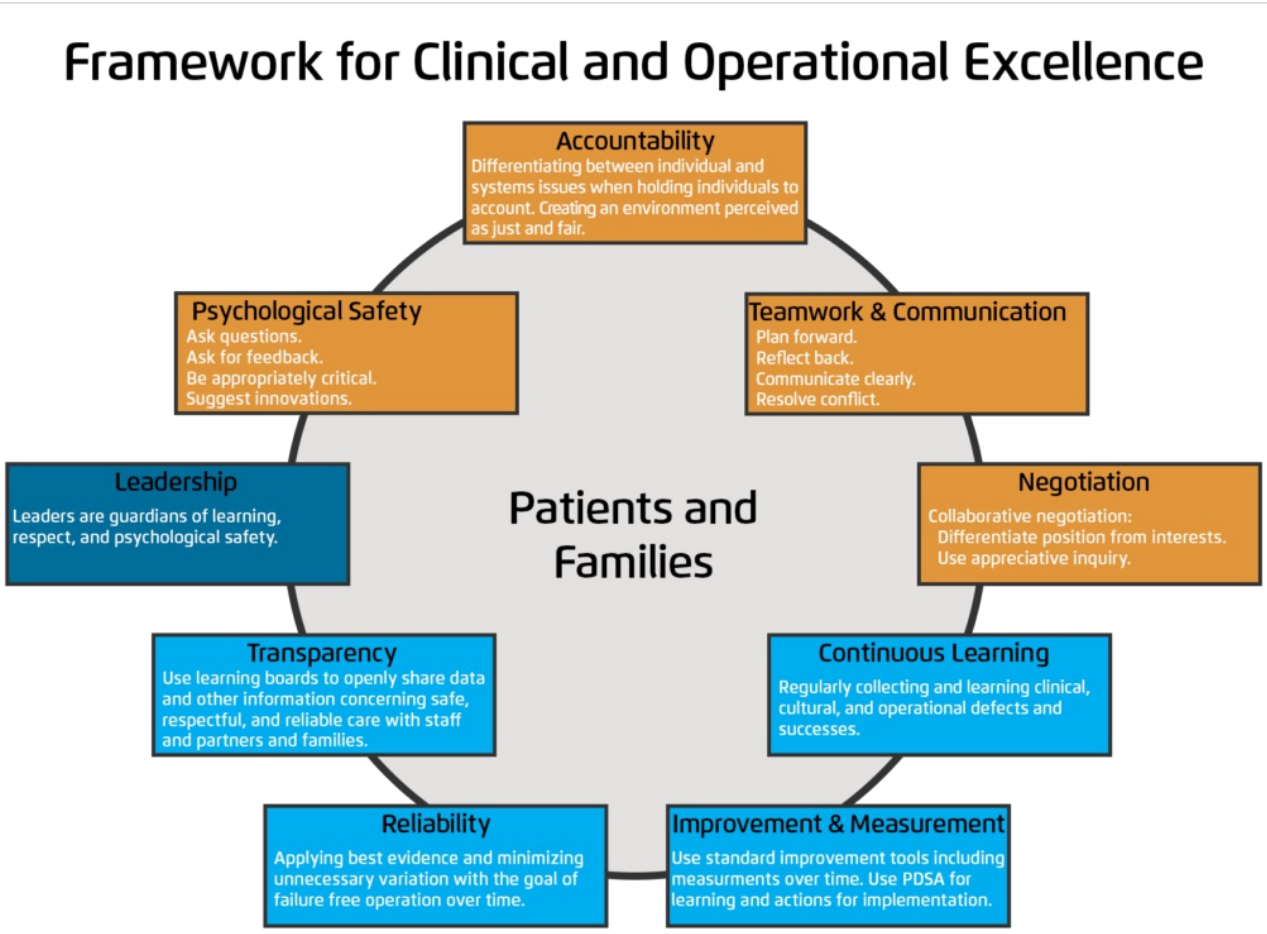
5. Transparent Leadership

Leaders are the pivotal catalyst within HRO's. However, you do not need to be in a position of leadership to create change. The process involves assessing and managing risk to evaluate the financial sequela of the situation.

Leadership also examines innovation by leveraging technology to provide higher quality care within the organization. Effective leaders within HROs are strong communicators who remain and provide transparency for staff and healthcare providers. High reliability organizations promote accountability, standardization, and innovation to ensure patient safety and quality. High reliability organizations encourage models of change with tools to support an overarching commitment of zero harm.

THINK ABOUT IT

The following diagram captures HRO operational focus. Compare your organization to the diagram. Is it similar?



Framework for Clinical and Operational Excellence.
Source: HealthCatalyst, 2018, www.healthcatalyst.com/insights/high-reliability-organizations-in-healthcare-framework

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Support

If you are struggling with a concept or terminology in the course, you may contact **NurseLeaderSupport@capella.edu** for assistance.

If you are having technical issues, please contact **learningcoach@sophia.org**.