Applying Culture of Safety Principles

For Biomedical Technicians

Applying Culture of Safety Principles

For Clinical Nephrology Technicians

A Culture of Safety Defined by AHRQ

"The safety culture of an organization is the product of individual and group

values,

attitudes,

perceptions,

competencies, and

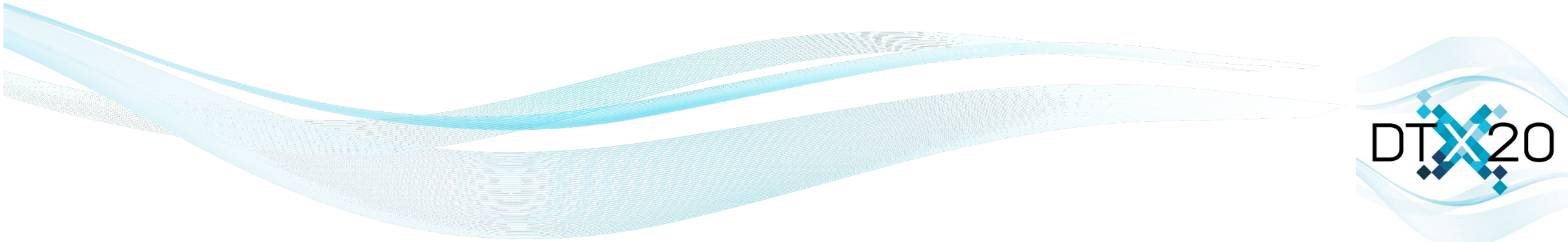
patterns of behavior

that determine the commitment to, and the style and proficiency of, an organization's health and safety management.

Organizations with a positive safety culture are characterized

- by communications founded on mutual trust,
- by shared perceptions of the importance of safety,
- and by confidence in the efficacy of preventive measures.”

Safety Event vs Safety Hazard



Top 10 Citations in 2019

- IC - WEAR GLOVES/HAND HYGIENE
- IC - CLEAN, DISINFECT SURFACES & EQUIPMENT/WRITTEN PROTOCOLS
- PE - EQUIPMENT MAINTENANCE -MANUFACTURER'S DFU
- MD RESP - ENSURE ALL ADHERE TO P&P
- MANAGE VOLUME STATUS

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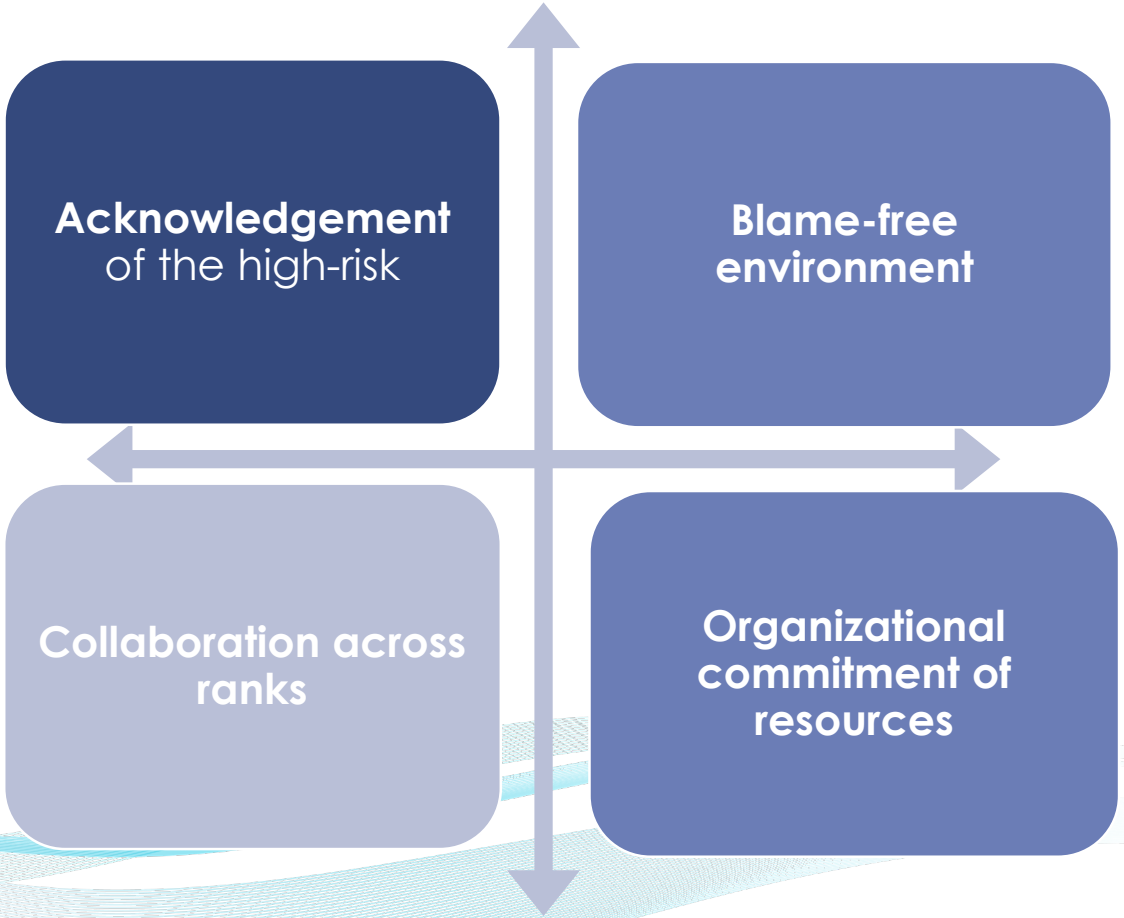
6-10 of Top Ten Citations

- APPROPRIATENESS OF DIALYSIS RX
- STAFF EDUCATION RE CATHETERS/CATHETER CARE
- ACHIEVE ADEQUATE CLEARANCE
- ASEPTIC TECHNIQUES FOR IV MEDS
- PE - SAFE, FUNCTIONAL,COMFORTABLE ENVIRONMENT

Critical Elements of Culture of Safety



Critical Elements of Culture of Safety

- **Acknowledgement** of the high-risk nature of dialysis and **determination** to achieve consistently safe operations
- **Blame-free environment:** staff are able to report errors or near misses without fear of reprimand or punishment
- **Encouragement of collaboration** across ranks and disciplines to seek solutions to patient safety problems
- **Organizational commitment of resources** to address safety concerns

Quint Studer's Characteristics of High Reliability Team Members

Sensitive to how operations are working

Reluctant to accept simple explanations for problems

Have a preoccupation with failure

Defer to Expertise

Are resilient

Acknowledgement of High Risk

Response to Errors

Just Culture: Accountability ≠ Blame

Focus on eliminating system risks and robust reporting

Blame-free environment: staff are able to report errors or near misses

Error Response in Just Culture

Human Error:

Console, build System Safety

At-risk Error:

INTROSPECTION on training, value conflicts and messaging

Reckless Error:

Remedial action or punishment. Review vulnerabilities in supervision

Collaboration

. **The power of teams**

- Mutual trust and respect,
- closed loop communication,
- shared mental models,

Key dimensions of effective teams:

team leadership
mutual performance monitoring
backup behavior
adaptability
team orientation

Which of these would a good strategy improve?

We are good

We are safe

We are ready

A simpler way to think about risk:

Are We Good?

What does the data show?

- Clinical Outcomes
- Patient satisfaction
- Patient Engagement

Are we improving or slipping?

A simpler way to think about risk:

Are We Safe?

What is does the data show?
Mortality?
Hospital Transfers from chronic Units?
Errors?
Deficient Practice?
Improving or slipping?

A simpler way to think about risk:

Are We Ready?

Are we prepared for clinical emergencies?
Are we prepared* for natural emergencies?
Are we prepared* for aggression?
Are we prepared for foreseeable hazards?

Organizational commitment

Efficiency is a legitimate part of decision making, ignoring what is inconvenient is not.

What types of lower resource strategies increase safety in cases of:

Staffing insufficiency in number or level of experience

Response times not realistic for geography

High failure rate in aging equipment

Strategies for strengthening teams

Teach effective communication strategies	Teaching structured methods of communication, such as ‘SBAR’ handovers, can improve patient outcomes.
Train teams together	Teams that work together should train together. Training that includes all members of the team improves outcomes.
Train teams using simulation	Using simulation is a safe way to practice new communication techniques, and it increases interdisciplinary understanding.
Define inclusive teams	Redefine the team of healthcare professionals from a collection of disciplines to a cohesive whole with common goals.
Create democratic teams	Each member of the team should feel valued; creating flat hierarchies encourages open team communication.
Support teamwork with protocols and procedures	Use procedures that encourage information sharing among the whole team, such as checklists, briefings and IT solutions.
Develop an organisational culture supporting healthcare teams	Senior champions and department heads must recognise the imperative of interprofessional collaboration for safety.

Your Team Challenge (select one)

Complete the Safety Intervention Plan for one of the following scenarios:

- Address any one of the top 10 citations
- Respond to an error in which a patient lost consciousness after a technician failed to check vital signs during the last hour of his treatment
- A new orientee is scheduled to perform independently and tells you, rather than her supervisor that she does not feel ready but is afraid that acknowledging that may jeopardize her continued employment.
- There have been two tornado warnings in your area which does not usually experience them and there is no emergency plan for tornados. Your are concerned that your large clinic has two walls that are windows.

Select a case
Choose a recorder and one or more presenters
Select an applicable "hint"
Discuss your responses to the Safety Intervention Plan Questions
Record the response agreed on by the team
Present your key finding to the group (presentation 30 seconds or less)
YOUR team process counts
A prize is involved