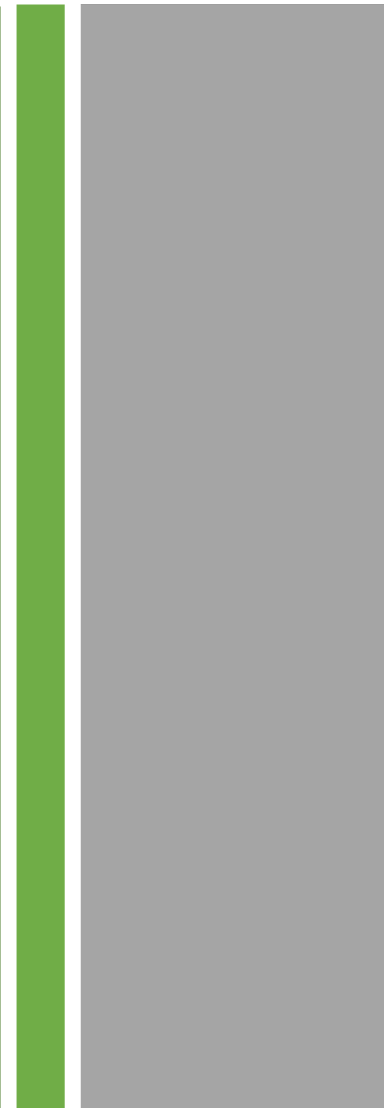


Culture of Safety and Improvement

Objectives

Define key elements in a "Culture of Safety"

Describe your role in the culture and process of safety

Identify three personal actions to improve team safety

Identify how these actions make the unit "survey ready"

Surveyor Role in Culture of Safety

Culture of Safety Review: Verifying the presence of a facility-wide culture that promotes and protects patient safety. The primary components are:

- a robust and proactive system for reporting and addressing errors/risks,
- open blame-free communication between all levels of staff and patients, and
- expectations of staff and patients clearly communicated.

Key to a Culture of Safety:

Open Communication

Robust Reporting

Focus On Safety

Open Communication

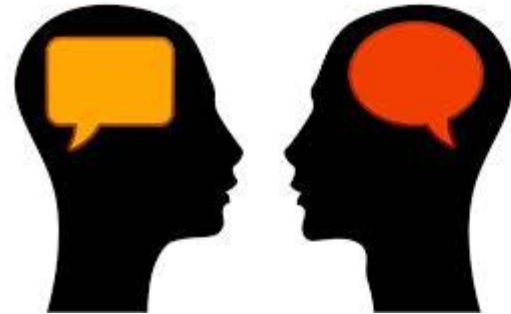
Surveyor Specifically Looks For

- Risk identification and reporting
- Patient engagement
- Staff Engagement

Open Communication: Staff Engagement

Eliminating the Reluctance to Speak

- Punishment and Reprisal
- Who has "expertise"
- Loss of approval, affection
- Communication Training
- Mechanisms
- Value and Action



Open Communication: Patient Engagement

Questions both you and CMS want to know:

- How do the staff at your facility **encourage patients to give input**? To report a complaint, within or outside of your facility?
- How do staff encourage patients to **participate in care planning** and consider their **needs, wishes and goals**?
- How do staff help patients address barriers to meeting goals (targets)?

Survey Questions for Technicians Staff Voice/Culture of Safety

What is your role in keeping patients safe?

What occurrences, errors or near misses are you expected to report and to whom?

How comfortable would you feel to report an issue or make a suggestion?

How does this facility address an error or near miss involving you or others?

Surveyor Decision Making
Is culture of safety present?

- Is there evidence the facility management and staff educate and encourage patients to verbalize suggestions and concerns in addition to written complaints/grievances?
- Are staff educated in how to respond professionally to patients' verbalized concerns, and report them to their supervisor for recording and follow up?
- Is there evidence the patient's concern that was reviewed was recorded, the circumstances investigated, and mutually acceptable resolution reached? Was the result communicated to the patient?

Surveyor Decision Making
Final Answer:

Based on your interviews during the survey with staff, patients, and the facility-based QAPI responsible person, and the above reviews in this “Culture of Safety” section, is there evidence that substantial efforts are being made to establish and maintain a facility-wide “culture of safety?”

Your Communication Challenge

What changes in your facility communication could improve safety and achievement of goals?

- Which voices could be better heard?
- Which questions are people reluctant to ask?
- Which problems need a fresh look?
- Which programs could be more effective with more input?

Culture of Safety: Engagement

Ideas for Patients

- Engage during rounds
- Detect adverse events
- Empower patients to speak up for safe care
- Include patient input

Ideas for Staff

- Include all levels in improvement teams
- Reward reporting
- Audit teams
- Reward ideas to improve safety
- Thwart spontaneous shortcuts!

Robust Reporting

Robust Reporting

Safety reporting includes those formal, regular:

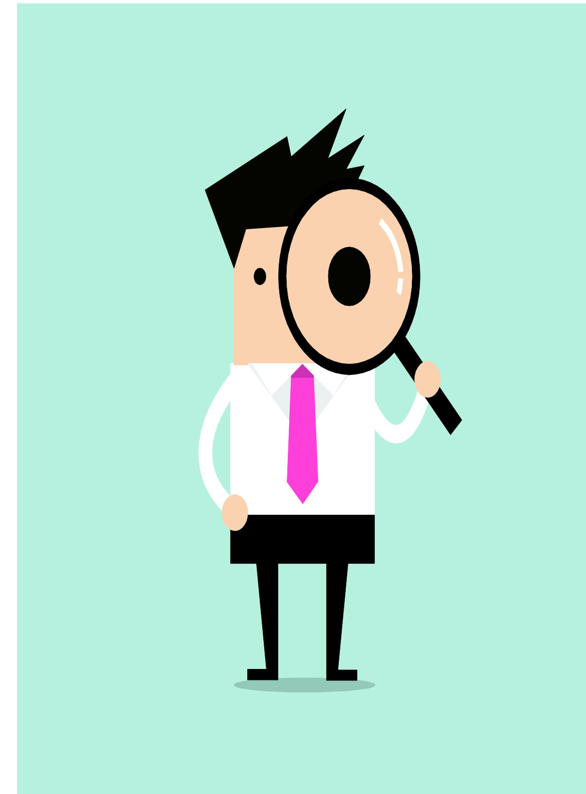
- Outcome Reports
- Equipment Logs
- Audits

Based on an error or near miss:

- Patient Event
- Treatment Error

Based on an observed risk

- Broken tile or burnt out light



Culture of Safety: Reporting Without Fear

- Reporting rewarded
  - Errors and "good catches"
  - Patient and staff complaints
- Non-punitive responses to adverse events/errors
  - If you use shame and punishment of all errors:
    - System vulnerabilities won't be identified
    - Errors will be concealed
- Accountability is balanced by a "just culture"

Barnsteiner (2011) Teaching the culture of safety. *OJIN: The Online Journal of Issues in Nursing. 16*(3) Manuscript 5.

“Just Culture”

- An atmosphere of trust
- People are encouraged/rewarded for reporting
- There is a line between acceptable/non-acceptable behavior

Meadows, S. (2005)
http://www.ncbi.nlm.nih.gov/books/NBK20586

Types of Errors

- Inadvertent or simple human error
- At risk behavior
- Reckless behavior

Simple Human Error

- Example: a nurse or PCT forgets to turn the blood pump to the prescribed blood flow rate at the beginning of treatment
- Management response: Console the PCT/nurse; consider ways to simplify task, improve training

Core Curriculum for Nephrology Nursing, 6th Edition, i

At Risk Behavior

- Example: a nurse or PCT, in the interest of time, leaves her first patient at a 200 BFR until she completes the initiation of all her patients. She then returns to set all the blood pumps to the prescribed blood flow rate, resulting in decreased adequacy of treatment for each patient where the ordered BFR was delayed.
- Management response: Coach the nurse/PCT; improve leadership messaging regarding the risks of decreased patient outcomes.

Reckless Behavior

- Example: a nurse or PCT comes in angry, leaves all her patients at a 200 BFR for the whole shift and does not monitor her patients' status during the treatment, resulting in decreased adequacy for all four patients and a drop in blood pressure for one patient

- Management response: Zero tolerance; remedial action; review vulnerabilities in supervision

Core Curriculum for Nephrology Nursing, 6th Edition,

Decision Tree

1. Were the actions intended?
2. Does there appear to be ill health or substance abuse?
3. Did the individual break protocol or procedure? Have access to protocol and needed supplies? Choose to act off protocol to reduce risk?
4. Would a comparably educated and experienced person be likely to behave the same way in similar circumstances? If not, were there deficiencies in training or supervision?

Meadows, S. (2005)
http://www.ncbi.nlm.nih.gov/books/NBK20586

Focus on Safety

Culture of Safety: Clear Expectations for Staff

- Role descriptions are clear
- Policies and procedures are up-to-date

"There is a right way, staff know that right way, and staff do their assigned work the right way."

--Glenda Harbert,
ESRD Network of Texas

Monitoring, Recognizing and Addressing in a Culture of Safety

Evidence of effective facility MONITORING the safety and effectiveness of facility operations, RECOGNIZING risks and opportunities and ADDRESSING them is a central theme of Quality Assessment and Performance Improvement.

A culture of safety powers up monitoring by increasing input, but effective analysis and response to that input is crucial to "closing the loop" and increasing safety

Surveyors and the Scope of Monitoring

Water & dialysate quality
Physical plant safety "rounds,"
Audits
Dialysis equipment repair and maintenance
Personnel qualifications and issues
ESRD Network relationship/communication
Patient modality choice & transplant referral
Health outcomes-physical and mental functioning (HRQOL)
Infection prevention & control
Patient satisfaction & grievance/complaints

Mortality: deaths & causes
Morbidity: hospitalizations, admitting diagnoses & readmissions
Fluid & BP management)
Dialysis adequacy
Nutritional status
Mineral and bone management
Anemia management
Vascular access
Hemoglobin, transfusions, TSAT%, ferritin
PD access-PD
Medical errors/adverse occurrences/clinical variances-in-center hemodialysis & home dialysis

Special Emphasis On:

Technical and Practice audits

- Water and Dialysate
- Dialysis Equipment

Mortality and Morbidity

- How many and Why?

Infection Control

- Infections
- Vaccinations
- Audits
- Patient Education

Monitoring Is (Only) a Start

When outcomes drop, or errors occur, did the facility recognize and address?:

- Did the facility
  - thoroughly **investigate root/multiple causes** of the issue
  - develop, implement, and monitor performance improvement plans?

Monitoring Is (Only) a Start

Does the **current QAPI documentation show improvements** have been attained and sustained?

- If not were plans revised?
- Did this occur promptly?
- Did near misses receive thoughtful review?
- How does this get to your plate?

Use, not simply collection of information is key

Know Your Facility

- Dialysis Facility Reports
- Infection Control Audits
- Laboratory reports: aggregate and specific to patients in your care
- Operational logs
- QAPI materials
- Personnel records
- Physician credential files

How can you make your facility effective, safe and ready?

Safe & Ready Tip

If At First You Don't Succeed…

Increase Input!

QUESTIONS?

THANKS FOR THE WORK YOU DO!

And thank you to Glenda Payne her patient long term collaboration

Selected References

Barnsteiner (2011) Teaching the culture of safety. *OJIN: The Online Journal of Issues in Nursing. 16*(3) Manuscript 5. doi:10.3912/ojin.Vol16No03Man05

Greenspan, B. (2015) *Core Curriculum for Nephrology Nursing*, 6th Edition, in process

Gregory, B. & Kaprielian,V. (2005). Anatomy of an error. Retrieved March 1, 2014 from http://patientsafetyed/duhs.duke.edu/module_e/basic_tenets.html

Institute of Medicine (1999) *To Err is Human.* available at http://www.nap.edu/books/0309068371/html/

Selected References

Levinson, D. (2012). Hospital incident reporting systems do not capture most patient harm. Report from the Office of Inspector General. Retrieved March 1, 2014 from https://oig.hhs.gov/oei/reports/oei-06-09-00091.pdf

Meadows, S., Baker, K., & Butler, J. (2005). The incident decision tree: guidelines for action following patient safety incidents. In Henricksen, K., Battles, J., Marks, E. et al. (Eds). *Advances in patient safety; from research to implementation: Vol 4 Programs, tools, and products*. Rockville (MD): Agency for Healthcare Research and Quality Last retrieved from http://www.ncbi.nlm.nih.gov/books/NBK20586

Selected References

Reason, J. (1997). *Managing the risks of organizational accidents*. Aldershot: Ashgate

Taylor, J. (2010). *Safety culture: Assessing and changing the behavior of organizations*. Surrey, England: Gower Publishing Limited