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PeriAnesthesia Nurses Can Drive a Culture of Safety

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Definitions

- Accountability
- Bullying
- Culture of Safety & Just Culture
- Civility & Incivility
- Lateral & Horizontal Violence
- Psychological Safety
- Transparency

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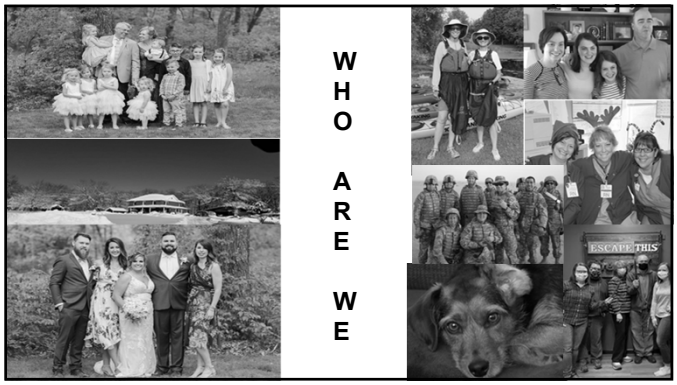

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What are the elements of a culture of safety?

Trust
- Communication
- Teamwork
- Transparency

Accountability

Identifying unsafe conditions

Strengthening systems

Assessment

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Story of the Impact of a Leader

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What do organizations say about a robust culture of safety?

- Joint Commission- High Reliability Organization
- ECRI
- Agency for Healthcare Research Quality (AHRQ)
- ANCC/Magnet
- IHI –Institute of Healthcare Improvement

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ASPAN Position Statement on PeriAnesthesia Safety

- Communication
- Advocacy
- Competency
- Efficiency/Timeliness
- Teamwork

ASPAN is committed to providing the support perianesthesia nurses need to develop, maintain, and work in a culture of safety.

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AANA American Association of NURSE ANESTHESIOLOGY | AORN SAFE SURGERY TOGETHER | ASPAN American Society of PeriAnesthesia Nurses

AANA, AORN, ASPAN Position Statement on Workplace Civility

POSITION STATEMENT

American Association of Nurse Anesthesiology (AANA), the Association of PeriOperative Registered Nurses (AORN), and the American Society of PeriAnesthesia Nurses (ASPAN) support the development of collaborative, comprehensive facility policies that address the identification, mitigation, evaluation, and reporting of uncivil behavior; intervention and accountability for uncivil behavior; and maintaining professionalism in the perianesthesia and perioperative environment.

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Quadruple Aim – Strategies to Improve Quality

1	2	3	4
Improving Population Health	Reducing Cost of Care	Enhancing the Patient Experience	Improving Staff (Nurses, Providers, others) Satisfaction

TIED to SAFETY CULTURE!!!

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Results of a Healthy Healthcare Climate: Patient Outcomes

- Reduced infection rates
- Fewer readmissions
- Better surgical outcomes
- Reduced adverse events
- Decreased mortality
- Increased Satisfaction/Service scores

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Basic Concepts of Just Culture

- To Err is Human
- To Drift is Human
- Risk is Everywhere
- We must manage in Support of Our Values
- We are All Accountable

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Results of a Healthy Healthcare Climate: Staff Outcomes

- Longevity
- Happy staff
- Engagement
- Multiple applicants for openings
- Confidence in the team
- Recommend to others

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Tools

- Joint Commission sentinel event alert notes
- Safety culture surveys
- Reporting

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Current Challenges in Healthcare

- Impact of Incivility
- Errors due to incivility
- Employee injuries & absences
- Patient safety
- Patient satisfaction
- Culture of safety surveys
- Violence

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Story of the Impact of Culture on Patients

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High Reliability Organizations

- Preoccupation with failure
- Reluctance to simplify
- Sensitivity to operations
- Commitment to resilience
- Deference to expertise
- Assess the Culture of Safety through surveys

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What does it look like when the organization has "arrived"?

- Board commits to the goal of high reliability (i.e., zero patient harm) for all clinical services.
- Management aims for zero patient harm for all vital clinical processes; some demonstrate zero or near-zero rates of harm.
- Physicians routinely lead clinical quality improvement activities and accept the leadership of other appropriate clinicians; physicians' participation in these activities is uniform throughout the organization.

Chassin MR, Loeb JM. High-reliability health care: getting there from here. Milbank Q. 2013;91(3):459-490. doi:10.1111/1468-0009.12023

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What does it look like when the organization has "arrived"? (continued)

- Quality is the organization's highest-priority strategic goal.
- Key quality measures are routinely displayed internally and reported publicly; reward systems for staff prominently reflect the accomplishment of quality goals.
- Safely adopted IT solutions are integral to sustaining improved quality.

Chassin MR, Loeb JM. High-reliability health care: getting there from here. Milbank Q. 2013;91(3):459-490. doi:10.1111/1468-0009.12023

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Organizational Opportunities

- Data sharing for clinical and operational
- Learning generated by defects
- Data generated from near misses
- Solutions
- Dedicated time and resources
- Feedback loops
- Commitment to proactive in safety and culture

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Just Culture *refers to*

a values-supportive system

of shared accountability where

organizations are accountable for the systems they have designed and

for responding to the behaviors of their employees

in a fair and just manner.

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Leader Strategies

Adopt the Principles of Just Culture

Healthcare workers come to work wanting to "do the right thing" by their patients

The single greatest impediment to error prevention in the medical industry is "that we punish people for making mistakes."

Dr. Lucian Leape Professor, Harvard School of Public Health Testimony before Congress on Health Care Quality Improvement

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Strategies: What can Leaders do?

- Role model
- Foster trust
- Leader rounding
- Policies for disruptive behavior
- Engage staff in process improvements
- Anonymous reporting hotline
- Communicate lessons learned from event reports

ECRI. Culture of safety: an overview. Health Syst Risk Manage 2019 Jun 14. https://www.ecri.org/components/HRC/Pages/RiskQual21.aspx

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Role of Event Investigation

- What happened?
- What normally happens?
- What does procedure require?
- Why did it happen?
- How was the organization managing the risk?

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Outcome Bias

The Event Outcome is not the determinate of the organization response:

The behavioral intention **of the team member is the determinate.**

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Human Error	At-Risk Behavior	Reckless Behavior
Inadvertent action: slip, lapse, mistake	A choice: risk not recognized or believed justified	Conscious disregard of unreasonable risk
Manage through changes in: -Processes -Procedures -Training -Design	Manage through: -Removing incentives for at-risk behaviors -Creating incentives for healthy behaviors -Increasing situational awareness	Manage through: -Remedial action -Punitive action
CONSOLE	**COACH/COUNSEL**	**DISCIPLINARY ACTION**
Accidently run a stop sign not seen	**Speeding on a highway so as not to be late**	**Drunk driving**

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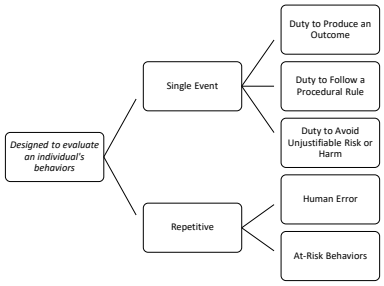
Just Culture Algorithms



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Story of Impact of Just Culture Approach

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Medical adverse events in the US 2018 mortality data

- Accurate measurement of adverse event rates is critical to patient safety improvement efforts. 0.16-1.13% of deaths are attributed to an adverse event.
- Procedure-related complications contributed to the majority of adverse event deaths.
- The risk of death due to adverse event was higher for younger patients and Black patients.

Oura P. Medical adverse events in the US 2018 mortality data. Prev Med Rep. 2021;24:101574. doi: 10.1016/j.pmedr.2021.101574

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Advocacy


Frederick Health

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Time Out

Story

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Strategies: What can we DO?

- Bring Your Strongest Self to Work
  - Self Assessment
- Arm Yourself with Learned Responses to Incivility
- Check Your Mental Pulse

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Take Action & Speak Up

De-escalation
Feedback
Code words
DESC: Describe, Explain, State outcome, Consequences
Cognitive Rehearsal
CUS: Concerned, Uncomfortable, Safety

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Take Action

Assume positive intent
Curiosity
Listen
Respect
Empathetic care

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Nurses can drive the culture of safety

- Local
- State
- National
- International

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How to find a high reliability organization

Environment

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Go forth

Nurses:
Most trusted profession

We need to change

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Be inspired

Walk with courage

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Question 1

What are 3 elements of a culture of safety?

a. Trust
b. Accountability
c. Strengthening Systems
d. All of the above and more

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Question 2

What is the topic of the Position statement that ASPAN endorsed with AANA and AORN?

a. Workplace Civility
b. Nurse: Patient Ratios
c. Certification
d. Advanced Practice Nurses

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Question 3

What can PeriAnesthesia Nurses DO to create a culture of safety?

a. Bring Your Strongest Self to Work
b. Arm Yourself with Learned Responses to Incivility
c. Check Your Mental Pulse
d. All of the above and more

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References

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- Patient Safety Events and the Role of Patient Safety Organizations During the COVID-19 Pandemic. Accessed January 12, 2022 at https://psnet.ahrq.gov/psnet-collection/perspectives

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