

## White Paper on Safety

### Introduction

The 1999 IOM report *To Err is Human* marked a new era of accountability for health care providers around patient safety. Since that landmark publication, the focus on patient safety and outcomes of care has intensified. Pay for performance financial models have further motivated providers to take intentional action to improve safety for hospitalized patients. As attention becomes directed toward the environment of care and tenets of a culture of safety, the critical role of nurses as a prime negotiator for the patient in the hospital environment and often the final safety net for patients becomes paramount. Ensuing IOM reports maintained a focus on the need to address the environment of care, cultures of safety and individual characteristics of the nurse to accomplish improvements in patient safety.

### Background and Significance

The 1999 IOM report *To Err is Human: Building a Safer Health System* rocked the nation by exposing the prevalence of medical errors in health care and their unfortunate results. Subsequent reports looked deeper into the issue of safety in health care: *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century* (2001) and *Keeping Patient's Safe: Transforming the Environment for Nurses* (2004). These reports demand nothing less than an overhaul of internal hospital operations. Business as usual will not ensure patient safety.

The recommendations (IOM, 2004) challenge leaders at all levels of the organization to create work environments and cultures of safety through leadership structures and processes (Recommendation 1). Leaders must establish safety as a priority as reflected in allocated resources (Recommendation 4-2). Safety must be assimilated into every aspect and activity of the organization. Education and involvement of all staff is a necessary but insufficient component to establishment of a safe environment – safety must become woven in the cultural fabric of the organization.

A safe culture demands a change from established practices which target human error – the individual who makes a mistake (Recommendations 7-1 & 7-2). Blaming the individual limits reporting due to fear of repercussions, and, most importantly, limits the opportunity to learn from errors and near misses to prevent recurrence. A commitment to safety must involve a commitment to creating an atmosphere of trust which encourages widespread reporting of errors and near misses. Movement from a culture of blame to a “just culture” pays greater attention to how the error occurred than who made the mistake (Marx, 2001). The focus shifts from the individual to the organizational systems, processes and environments which may have contributed to the error. A just culture supports accountability of both the individual and the organization in promoting patient safety.

A safe environment also involves an evaluation of work embedded in systems and processes. The IOM (2004) reports recommend “designing out” errors; that is, revising processes and systems to reduce the possibility of error (Recommendation 6-2). The involvement of frontline staff closest to the process being redesigned is critical to success

of such endeavors (Recommendation 4-1 & 4-3). Programs such as “Transforming Care at the Bedside” which utilize direct care staff in fast tracked problem solving activities have been effective in achieving significant safety improvements (Rutherford et al, 2004; Marin et al, 2007). Strategies to reduce errors include use of technology to eliminate some human factors of errors, work space design to support safe work processes, and reduction of process variation.

Numerous studies consistently support the direct relationship between nurse staffing and patient outcomes in acute care and the important association between staffing and quality (Kane et al, 2007). Workforce issues therefore play a critical role in patient safety. Staffing practices must plan for adequate nurses to accommodate work flow, patient turnover and unpredicted changes in patient volume and acuity (Recommendation 5-2). Internal oversight and evaluation of staffing practices must occur (Recommendation 5-3). Additionally, IOM recommends (5-4) publication of staffing and turnover data. To ensure that staff have the necessary knowledge and skills to perform their role effectively in an ever changing environment, IOM recommends (5-5) that facilities budget for initial and ongoing education and training. Further, facilities should act to support collaborative practice within the interdisciplinary team (recommendation 5-6).

Because of the direct relationship between errors and fatigue, Recommendation 6-1 challenges regulatory bodies to limit hours of work for nurses to 12 hours in any 24 hour period and 60 hours in a 7 day period. Additional recommendations address reducing fatigue related to work design and identify handwashing and medication administration as the first processes to receive attention (Recommendations 6-2, 6-3). Finally, the IOM recommends (8-1) ongoing research to support patient safety for every patient every time.

### Conclusions

Hospitals are predisposed to errors due to their human nature and complexity; yet, hospitals have not kept up with other high risk industries in managing this risk. With the new millennium came a loud wake up call to health care organizations – definite, immediate and significant change must occur. The 2004 IOM report provides specific recommendations to assist hospitals in creating environments and cultures of safety. These recommendations impact the role of nursing in several ways.

Nurse leaders are called to create and sustain work environments of trust and open communication. Cultures known for relentless pursuit of root causes rather than individual fault will support open reporting and sharing of information about risks. Nurse leaders are responsible for involving staff in the development of a staffing plan which considers numbers of nurses and patients as well as individual characteristics of nurses and patients and contextual factors such as patient turnover, unit geography; this is consistent with the Nurse Practice Act of Texas. Nurse leaders can introduce process improvement efforts, such as “Transforming Care at the Bedside”, to assist staff in redesigning their work.

Staff nurses are not only critical to but determinative of patient safety and outcomes. Nurses must appreciate their role and share in the organization’s accountability for identifying processes that may contribute to errors, reporting near

misses, and participating in workplace improvement efforts. Nurses are accountable for responsible practice including monitoring their own hours of work.

The Texas Nurses Association (TNA) actively leads and supports workplace improvement efforts. TNA supported legislation requiring the development of organizational staffing plans jointly with staff nurses to ensure appropriate staffing on individual units. TNA supported revisions to peer review requirements so that minor incidents did not require reporting to the Board of Nursing, but instead could be evaluated by peer review groups and safety committees who will assess and address contributing factors. Through its membership, TNA will continue to initiate and support efforts that improve environments for nursing practice and patient safety.

## References

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