Bringing High Reliability to the Bedside: Building a Culture of Safety

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Background

Patient safety tops the list of priorities in all venues of healthcare. Adopting the principles of High Reliability is a viable approach to not only decrease the occurrence of Hospital Acquired Conditions (HAC) and improve compliance of HAC prevention process measures but also to foster a culture of safety throughout the hospital. Attaining and maintaining a culture of safety is challenging due to the difficult nature of healthcare itself. The purpose of the work was to implement the principles of High Reliability in all inpatient care areas and achieve > 90% process measure reliability in all relevant HAC prevention bundles within a prescribed time frame. Through improved reliability and the establishment of safety as a core value in each area, human error is reduced, thus reducing the risk for patient harm.

Definitions

Patient Safety: The absence of failure: nothing bad happens despite a potentially hazardous environment. Deliberate work is required to assure nothing untoward occurs. Safety, then has been described as a "dynamic non-event."
High Reliability: Doing the right thing, right, in the presence of complexity, acuity: and intensity. Achieving the best outcomes through standard work.
Culture of Safety: The foundation needed to ensure high reliability. Includes the values, beliefs and behaviors that determine the extent to which team members stay attuned to reducing patient harm during the delivery of care.

Approach

In a multi-stage approach, physician champions, unit nursing leaders and all unit staff were educated about High Reliability principles, the benefits of Daily Safety Huddles and the importance of a team-focused approach to patient safety. Unit auditors were trained to conduct process measure interactions with bedside staff using evidence-based Kamishibai methodology. This face-to-face interaction provided observational assessment of understanding and reliability of the prevention interventions and an opportunity to deliver in-the-moment coaching when needed. Committed to transparency, unit leaders shared the results of these real-time audits at the daily Safety Huddles; celebrating successes and discussing opportunities for improvement when process compliance was not satisfactory or patient events had occurred.

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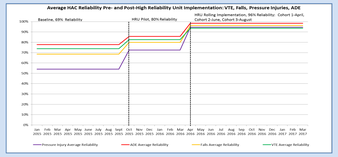
Results

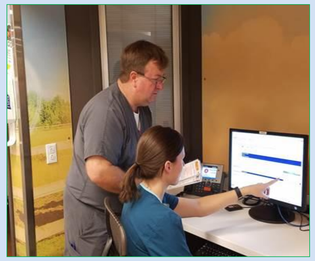
At the onset of this project, the average hospital-wide reliability of the HAC process measures across the eight targeted HAC's ranged from 61% to 91%. As each unit was brought on board as a High Reliability Unit, results showed immediate improvement in intervention reliability and ownership of the identified opportunities for improvement. Months later, as all units were functioning in High Reliability mode ,reliability for each HAC has reached the > 90% target.

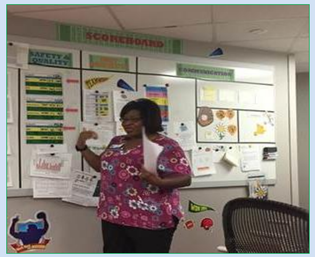
Hospital Acquired Conditions - Solutions for Patient Safety

Hospital Acquired Conditions	2013 Actual	2014 Actual	2015 Actual	2016 Actual	2017 Target	YTD 2017 (Jan-Mar)
% Bundle Reliability CAUTI-Maint	63%	87%	75%	93%	90%	92%
% Bundle Reliability CLABSI-Maint	59%	90%	76%	97%	90%	96%
% Bundle Reliability Falls		65%	69%	95%	90%	98%
% Bundle Reliability PU		84%	91%	93%	90%	95%
% Bundle Reliability SPS SSI	67%	87%	91%	97%	90%	96%
% Bundle Reliability VAP	61%	67%	72%	97%	90%	97%
% Bundle Reliability VTE Events		67%	76%	93%	90%	96%
% Bundle Reliability ADE		79%	81%	97%	90%	100%

Target goal is 90% for Reliability. Data collection not begun. Beginning May -2015 Reliability is assessed to SPS Standard or Recommended (if no standard) Elements. SPS SSI definition change in Jan 2017 now includes Colon, Hip, Hysterectomy, Knee. VTE definition change Oct 2016 now includes >6 months.







Discussion

Creating and sustaining a culture of safety is challenging due to the unique facets of healthcare delivery. Multiple providers, complex care plans and intricate, yet essential communication can quickly become barriers to safe and effective care. To successfully facilitate a safety culture enables change to an organization's attitudes pertaining to patient safety and the presence and prevention of patient harm. As each inpatient unit adopted the values of High Reliability, staff began demonstrating attitudes of resiliency with a commitment to align patient care activities with the standards of the HAC prevention bundles. These efforts have enabled staff to do the right thing, despite complexity and high-risk environment, achieve the best outcomes through standard work; and always focus on safety. Sustaining the achieved goal in all areas will further decrease HAC events and strive for zero harm through a commitment to doing the right thing with every patient, every time.

Conclusion

Trained units, working toward a common goal can promote and sustain a High Reliability Healthcare Organization. Our next steps include spreading this process to non-traditional care areas such as pharmacy, lab, radiology, central distribution, information technology, and others, to enable effective, safety-focused communication across the hospital. Simulation training is in development for new and existing interactors to validate inter-rater reliability and further the goal of High Reliability.

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References

Institute of Medicine. (2004). *Keeping patients safe: transforming the work environment of nurses. Washington DC: National Academies Press.*
Vogus TJ, Sutcliffe KN, Weick KE,(2010). Doing no harm: Enabling, enacting and elaborating a culture of safety in health care. *Academy of Management Perspectives 24,* (4), 60-77.
Weick K. and Sutcliffe K.(2015) *Managing the Unexpected,* (3rd ed). Hoboken, NJ: Wiley.