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Patient Safety Culture: The Nursing Unit Leader's Role

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Abstract

Discussions about a culture of patient safety abound, yet nurse leaders continue to struggle to achieve such a culture in today's complex and fast-paced healthcare environment. In this article the authors discuss the concept of a patient safety culture, present a fictional scenario describing what happened in a hospital that lacked a culture of patient safety, and explain what should have happened in the above scenario. This discussion is offered within a framework consisting of seven driving factors of patient safety. These factors include leadership, evidence-based practice, teamwork, communication, and a learning, just, and patient-centered culture. Throughout, an emphasis is placed on leadership at the unit level. Nurse managers will find practical examples illustrating how leaders can help their teams establish a culture that offers the patient quality care in a safe environment.

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Key words: Patient safety culture, safety culture survey, nursing leadership, nurse manager, multidisciplinary, transformation, patient-centered, advocacy, teamwork, evidence-based, communication, just culture, communication, learning culture

It has been more than 10 years since the Institute of Medicine (IOM) released its report, *To Err is Human: Building a Safer Health System.* This report, edited by Kohn, Corrigan, and Donaldson (2000) laid out a four-tiered approach for improving patient safety: (a) establish a national focus to create leadership, research, tools, and protocols around patient safety, (b) identify and learn from errors, (c) raise performance standards for improvements through the action of oversight organizations, purchasers of healthcare, and professional groups, and (d) create safety systems at the delivery level. Because creating safety systems at the point-of-care delivery was the ultimate target of all the IOM recommendations, the IOM committee continued to emphasize that healthcare organizations should create an environment in which safety was a top priority. It described a safety culture as one that focused on preventing, detecting, and minimizing hazards and error without attaching blame to individuals (Kohn, Corrigan, & Donaldson). The report emphasized the need for leaders at the clinical, the executive, and the governing board levels to take ownership for patient safety.

The IOM report (Kohn, Corrigan, & Donaldson, 2000) quickly elevated awareness of patient safety. Within weeks of the report's release, the United States (U.S.) Congress initiated hearings on medical errors and patient safety issues (Leape, Berwick, & Bates, 2002). The National Quality Forum (NQF), the Joint Commission (TJC), and the Agency for Healthcare Research and Quality (AHRQ) developed and/or continued to accelerate work around patient safety. The Quality and Safety Education for Nurses (QSEN) project developed guidelines that would enable future nurses to have the knowledge, skills, and attitudes necessary to improve the quality and safety of the healthcare systems within which they work (QSEN, n.d.). These groups, along with many other federal, state, and professional organizations, recognized that a patient safety culture was integral to improved safety outcomes and became the drivers for new policies and standards. In this article the authors will discuss the concept of a patient safety culture, present a fictional scenario describing what happened in a hospital that lacked a culture of patient safety, and explain what should have happened in this scenario. This discussion will be offered within a framework

consisting of seven driving factors of patient safety culture. These seven factors are presented in the Figure, originally published by Sammer, Lykens, Singh, Mains, & Lackan (2010). Throughout**,** an emphasis will be placed on leadership at the unit level. Nurse managers will find practical examples illustrating how leaders can help their teams establish a culture that offers the patient quality care in a safe environment.

Patient Safety Culture

The AHRQ describes culture as a critical component of healthcare quality and safety. An organizational culture consists of the values, beliefs, and norms that are important in the organization. A culture of safety includes the attitudes and behaviors that are related to patient safety and that are expected and appropriate to promote patient safety (Agency for Healthcare Research and Quality [AHRQ], n.d.). It is important that nursing leaders adequately assess the safety culture in their workplace and clearly articulate a framework to guide personnel as they work to increase safety within their work settings.

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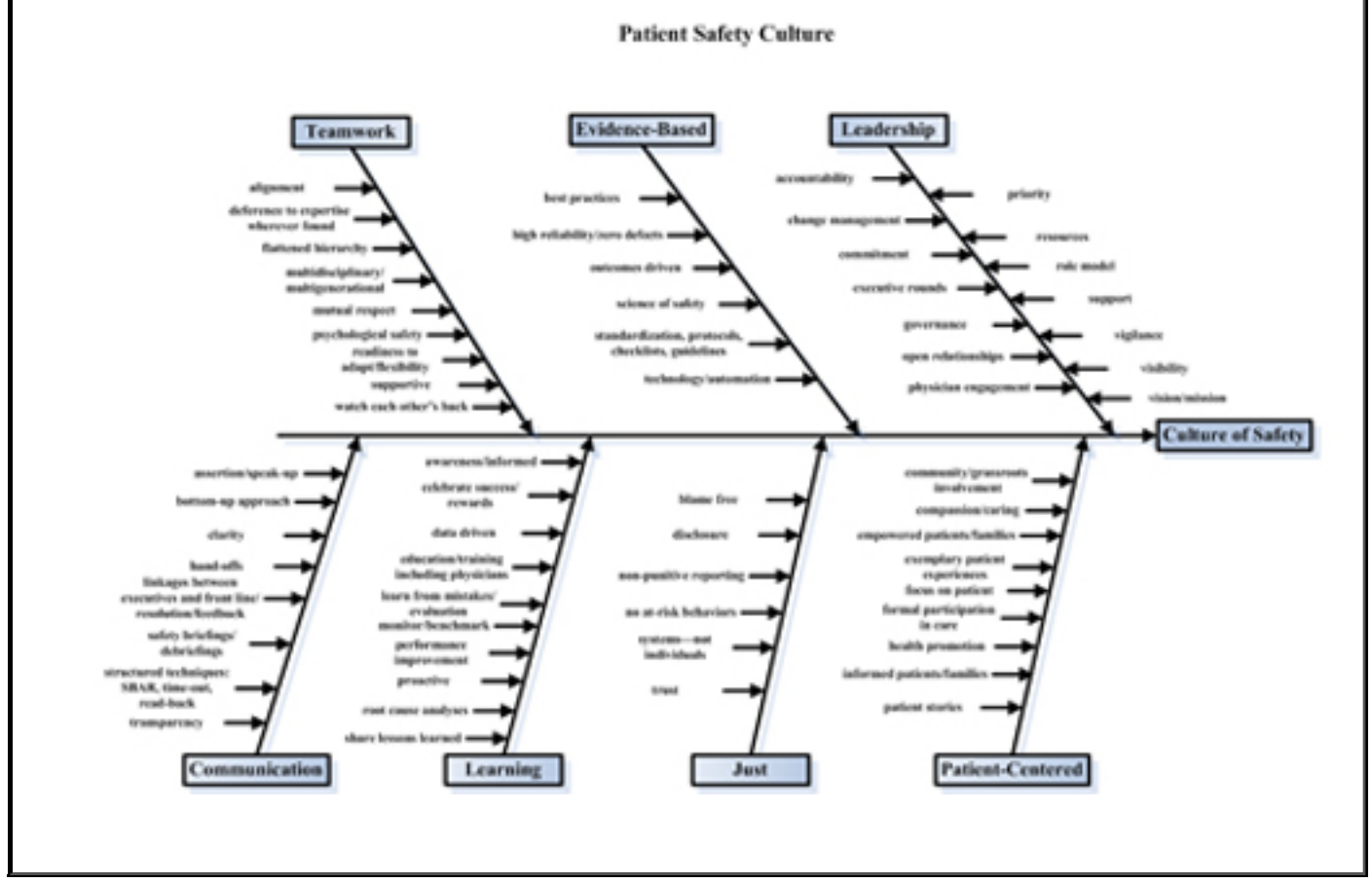
The Joint Commission holds hospital leaders responsible and accountable for regularly assessing the safety culture within their organizations (TJC, 2011). A safety culture survey, specifically a unit-based survey, can assess conditions in a work setting that may lead to adverse events and patient harm. This type of cultural assessment can raise awareness about patient safety issues, assess the current status of the culture related to safety, prompt interventions, and track the effectiveness of improvements over time. Two valid and widely used survey instruments that are available to healthcare leaders are the Hospital Survey of Patient Safety Culture (HSOPSC) (AHRQ, 2011) and the Safety Attitudes Questionnaire (SAQ) (University of Texas, n.d.).

Regular, front-line cultural measurements related to safety, followed by action, allow healthcare organizations to compare their safety record with other organizations, promote safety-focused attitudes, initiate interventions, and measure intervention effectiveness (Sexton, 2006). A strong patient-safety culture has been shown to be a successful predictor of medication errors and falls injuries (Vogus & Sutcliffe, 2007), outcomes for AHRQ-patient-safety indicators (Singer, Lin, Falwell, Gaba, & Baker, 2009), treatment errors (Katz-Navon, Naveh, & Stern, 2005), and accidents and injuries in the work place (Hofmann & Stetzer, 1996).

> ...understanding culture and creating a given type of culture within a healthcare organization can be elusive, baffling, and challenging.

Culture shift does not occur by chance. Because culture is often viewed as somewhat nebulous in nature, a patient safety culture tool, such as a framework, may help the nursing unit leader enhance the unit's patient safety culture by making more tangible the specific driving factors of a culture of safety. One framework available to nursing leaders offers seven driving factors related to a patient safety culture. These factors include: (a) leadership, (b) evidence-based practice, (c) teamwork, (d) communication, (e) a learning culture, (f) a just culture, and (g) a patient-centered culture (See Figure).

Figure. Hospital Culture of Patient Safety.
Reprinted with permission from "What is Patient Safety Culture? A Review of the Literature," by C.E. Sammer, K. Lykens, K.P. Singh, D.A. Mains, & N.A. Lackan, 2010. Journal of Nursing Scholarship, 42(2), p. 158. Copyright 2010 by Sigma Theta Tau International. (see pdf version of figure)



The following scenario, gleaned from a study of patient safety and the experiences of nursing unit leaders, describes a fictional hospital (Hospital Hope) and the hospital experience of a fictional patient (Mrs. Jackson). As the story unfolds, the reader is permitted multiple opportunities to witness both individual actions and system-wide occurrences that led to negative outcomes. In the subsequent section (Leadership Response) the actions of a nursing leader, as demonstrated by the fictional SICU nurse manager, illustrate how performance within the framework of a safety culture could have yielded different results.

Scenario: Hospital Hope--What Happened

Mrs. Jackson, a 73 year old widow, mother of two adult daughters, grandmother of four, and great-grandma to three children, was admitted to Hospital Hope, a typical suburban hospital viewed by the community as a good hospital. As a newly admitted patient, Mrs. Jackson had no reason to suspect either that nearly one in every 20 hospitalized patients in the US each year develops a hospital-acquired infection or that central-line-associated blood-stream infections (CLABSIs) are among the most deadly types of hospital-acquired infections with a mortality rate of 12-25% as reported by the Centers for Disease Control and Prevention (CDC) (2011c).

Mrs. Jackson was active in her community, volunteered at the local library, and enjoyed sharing blooms from her showcase flower garden. She was proactive in maintaining her health through regular activity, such as walking and water aerobics, and by healthy eating. She had not been a hospitalized patient since an abdominal hysterectomy 20 years previously.

Mrs. Jackson did have a well-documented, Grade 6, systolic heart murmur stemming from a childhood illness. She had been asymptomatic her entire life until recently when she experienced two episodes of ‘passing out’ with only minimal exertion. She was admitted to Hospital Hope for diagnosis and treatment and soon scheduled for an aortic valve replacement. The surgery was uneventful and Mrs. Jackson was admitted to the Surgical Intensive Care Unit (SICU) for recovery and post-operative care.

During her eight-day SICU stay, Mrs. Jackson, who had a 10 year history of type 2 diabetes, developed hospital-acquired pneumonia, experienced three episodes of hypoglycemia (including one blood glucose level of 39 mg/dL), and developed a CLABSI requiring removal and re-insertion of her central line. Her recovery was slow and her two daughters, one a nurse educator and the other a lawyer, were at her bedside as often as SICU visiting hours allowed. They were eager to help in their mother’s recovery by assisting her with bathing, feeding, and ambulation. However, the doctors and nurses appeared to be reluctant to involve them in their mother’s daily plan of care. After eight days in the SICU and 5 days in the step-down unit, Mrs. Jackson was discharged to an extended care facility for continued recovery and rehabilitation and eventually returned to her home.

Mrs. Jackson survived hospitalization without permanent injury despite experiencing three preventable conditions during her hospital stay, namely pneumonia, a central line infection, and episodes of hypoglycemia, all of which could have been prevented if established, evidence-based care had been practiced. Her story did not make headlines; her case did not get anyone’s attention. Yet she was harmed in not one, but three instances. The costs associated with her care, in terms of dollars, psychological stress to Mrs. Jackson and her family, and the discomfort and inconvenience of her preventable morbidity, were unnecessarily high.

Leadership Response: Hospital Hope--What Should Have Happened

Hospital Hope's mission was to be the community pace setter for providing patient-centered care with the highest safety and quality standards. The Governing Board of Hospital Hope understood that leadership drives culture. The Board members understood that their role included not only responsibility for the financial health of the hospital, but equally as important, for assuring patient safety and the provision of quality care (Conway, 2008). The Board was also aware of The Joint Commission (2011) leadership standard that specified the Board's role in quality and safety oversight.

The hospital's senior executive leadership believed that safety culture measurement and improvement processes could act as the tipping point for superior patient safety. To that end, the hospital leadership administered a patient safety survey, the SAQ, to the front-line staff to assess the existing culture. The survey results were clear: fewer than 50% of SICU care providers believed there was a strong culture of safety and teamwork within their unit.

Hospital Hope leadership determined to advance the hospital's mission by becoming an evidence-based organization. In an effort to reach this goal, the hospital joined the Institute for Healthcare Improvement (IHI) Protecting 5 Million Lives from Harm Campaign (IHI, n.d.a), a nationwide effort to significantly reduce morbidity and mortality in American healthcare. Leaders embraced the challenge; the SICU nurse manager envisioned what the ideal SICU would look like if 100% of the care providers believed that the unit culture, "the way we do things around here" (Bower, 1966; Deal & Kennedy, 1982, pp. 4 & 210), provided the safest possible environment for their patients. In a unit meeting the SICU nurse manager asked the front-line staff to identify their patient safety concerns. She discovered that some of the nurses had attended a continuing education program on the prevention of CLABSIs and that these nurses had become increasingly concerned about the incidence of CLABSIs on the unit. The nurse manager asked these nurses to give a report at the next SICU staff meeting on what they had learned. In this way the entire team learned that CLABSIs are now considered mostly preventable and that each CLABSI carries excess healthcare costs of $16,550 and a mortality rate of up to 25% (CDC, 2011a). That meant that one of every four patients who developed a central line infection was at risk of dying! The SICU staff was determined to reduce the rate of infections in their unit. They asked the nurse manager to provide them with additional information on evidence-based best practices for preventing CLABSIs.

While searching the nursing and healthcare literature, the nurse manager learned about the Comprehensive Unit-Based Patient Safety Program (CUSP), a structured framework for safety improvement developed by Johns Hopkins Hospital (Pronovost et al., 2006). She found the CUSP principles, described in an on-line tool kit, to be a helpful resource for training her entire multidisciplinary team, including physicians. The team learned how to increase patient safety and learn from mistakes by integrating safety practices into their daily work flow (Safer Care, n.d.). The SICU team embraced the evidence and incorporated the central line insertion standards, consisting of good hand hygiene, full barrier precautions, skin preparation using chlorhexidine for disinfection, avoidance of the femoral artery, and a daily evaluation for line necessity (CDC, 2011b), into their daily routine.

The staff began embracing the driving factors of a safety culture, such as teamwork and evidence-based care.

Transformation began! The staff began embracing the driving factors of a safety culture, such as teamwork and evidence-based care. They collaborated with the unit respiratory therapists to standardize care with the goal of preventing hospital-acquired pneumonia. They asked the nurse manager to arrange an inservice with the diabetes educator so they could learn more about preventing hypoglycemia.

Situation-Background-Assessment-Recommendation (SBAR) communication became the standard reporting practice. Handoffs, whether shift-to-shift, unit-to-unit, or between multidisciplinary team members, became clear and transparent. Mutual respect among all the team members allowed for structured information exchange opportunities, such as a quick debriefing following a near miss adverse event (Leonard, Graham, & Bonacum, 2004).

The nurse manager knew that patient safety was driven, in part, by a learning culture. She began to collect, analyze, and report quality data to drive performance improvement and to share lessons learned with nurse manager colleagues throughout the hospital. The SICU nurses agreed to hold each other accountable for improved

outcomes on their unit through teamwork and good communication. Techniques included showing mutual respect for comments or queries from any and all team members, from the young nursing students to the chief of staff. For example, a new graduate nurse, upon observation of a doctor who was not following best practice for infection prevention while inserting a central line, felt safe speaking up and asking the doctor to follow safety standards. The nurse was confident she would be respected and supported by the unit manager and by executive leadership. In this ideal culture of safety, the physician deferred to the evidence-based expertise presented by the new graduate.

The SICU nurse manager and the staff were pleased with the safety changes that were occurring. The nurse manager became even more determined to continue building a safety culture within her unit. She wanted her staff to feel safe to report not only patient safety issues, but also errors and patient harms. She wanted to develop trust between herself and her staff and among her staff members. She heard someone talking about 'just culture' and asked an older staff nurse, who was taking night classes for a Master's degree, if she would be interested in researching the topic. The staff nurse was pleased to be asked and prepared an informative presentation for her colleagues. She reported that a 'just culture' is a culture where incidents or errors that occur within a work setting are considered 'opportunities for learning and improvement.' A 'just culture' addresses the delicate tension between human fallibility and individual personal accountability; it offers culpability models for unsafe acts that can guide the nurse leader in finding the line between acceptable and unacceptable behaviors (IHI, n.d.b). Following the presentation, the SICU nurse manager encouraged the staff to share ideas for safe reporting of errors and to describe what it would feel like to work in a non-punitive environment. The staff acknowledged that using a non-arbitrary and transparent model to guide in decisions related to human fallibility would help to build trust.

...a new graduate nurse, upon observation of a doctor who was not following best practice for infection prevention...felt safe speaking up and asking the doctor to follow safety standards.

Soon the energy around enhancing safety and quality in the SICU was palpable. The entire SICU multidisciplinary team designed a Safety and Quality Bulletin Board which they placed in a central location that was easily visible to care providers and visitors alike. The nurse manager was responsible for keeping the data reports current and for including national and state benchmarks. At first, the staff was hesitant to post outcomes that could reflect poorly on the care they were providing. However, as they continued to embrace a culture of safety, they learned that transparency leads to awareness and awareness leads to change.

The SICU nurse manager wanted to assure that the patient was always the center of care even in the face of all the culture changes that were being made. At a staff meeting she reminded the SICU nurses of the final phrase of the Nightingale pledge. This phrase, "and devote myself to the welfare of those committed to my care" (ANA, n.d.), embodies the centrality of patient-centered care. She asked them to consider ways they could truly serve as advocates for their patients by identifying with the "person at the end of the bed" (Benner, Sutphen, Leonard, & Day, 2010, p. 166).

The SICU nurses committed to using their knowledge, skills, and attitudes to: (a) understand the patient's perspective; (b) support and empower the decision-making process; and (c) and honor patients' decisions. Just as the nurse manager had empowered her nurses to lead in patient care, the staff nurses committed to empowering their patients, and families, to be partners in their own care. As a unit, the nurses chose to implement one process they believed would demonstrate a compassionate, caring approach to patient-centered care. They chose to review daily, with the patient, his or her plan of care for the day and to encourage family participation in the care as appropriate.

The nurse manager was thrilled with the growth of her staff! She asked the marketing department to create beautiful plaques with the segment of the revised ANA social policy statement, noting "nursing is the pivotal health care profession, highly valued for its specialized knowledge, skill, and caring in improving the health status of the public and ensuring safe, effective, quality care" (2010, p. 1). She also arranged a celebratory event at which she presented each nurse with a plaque.

The senior leaders at Hospital Hope knew that great things were happening in the SICU! They knew staff nurses were taking ownership of patient care and were leading from 'wherever they stood.' These leaders demonstrated support and commitment by becoming visible outside of the executive suite; and the SICU staff, eager to demonstrate the safety improvements they were making, looked forward to regular rounding by senior leaders.

Celebration! One year following Mrs. Jackson's hospital admission, Hospital Hope leadership re-administered the cultural assessment survey. This time, 87% (well within the goal range of 80% or greater) of the SICU staff responded positively to the teamwork and safety culture, hand-off communication, and non-punitive reporting items on the assessment. The staff had worked hard in transforming the SICU into a unit where patients were safe. They had developed into a cohesive team that viewed patient safety as a priority and "the way we do things

around here."

Conclusion

While culture can be easily defined as "the way we do things around here," understanding culture and creating a given type of culture within a healthcare organization can be elusive, baffling, and challenging. Yet, the success of providing patients with the safest and highest quality of care is becoming recognized as being dependent upon a strong cultural foundation at the unit level (Smits, Wagner, Spreeuwenberg, van der Wal, & Groenewegen, 2009). This article has provided a model of the driving factors that are important in creating a culture of patient safety.

> ...a patient safety culture framework...defines safety culture driving factors as leadership, evidence-based practice, teamwork, communication, and a learning, just, and patient-centered culture.

Assessing the culture is the first step. Choosing a validated and widely used safety culture assessment instrument offers nursing leaders the opportunity to not only learn about the safety culture within their units, but also to address specific behaviors and values that need to be strengthened and to work with their staff in developing action an plan for improvement.

In this article, a hypothetical scenario has illustrated how nursing leaders can translate theory into practice at the bedside. It has used a patient safety culture framework that defines safety culture driving factors as leadership, evidence-based practice, teamwork, communication, and a learning, just, and patient-centered culture. It is recognized that this scenario may well be unrealistic in terms of the nurses' immediate willingness to change their behavior. The scenario was presented in this manner, however, to serve as a useful model to guide nursing leaders as they lead their patient care units toward increased nursing satisfaction, improved patient experiences, and safe and excellent quality outcomes.

The story of Hospital Hope, and the hospital's challenging journey of preventing harm to their very ill SICU patients, is a story of leadership—a story of leadership that began with the Governing Board and Senior Executive Leadership, yet, and most vitally, was implemented through the leadership of the SICU manager and her front-line staff. This story exemplifies the importance of the nursing unit leader and validates the notion that nurses are leaders whether in the board room or at the bedside—they lead from wherever they stand.

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