Quality and Safety Matters

TCNJ Nursing's Quality and Safety Newsletter

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Responding to Error

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Class of 2016

Healthcare errors are devastating and as nurses, we constantly look for ways to prevent them. It is estimated that there are about 400,000 deaths in the U.S. each year from preventable harm[1]. Often people think that these errors are the result of one person's wrongdoing. In reality most errors cannot be linked to a single individual's performance but are actually the result of a flawed system of errors, which led to unsafe circumstances. As healthcare professionals, we are bound to come across errors, near misses, and harm at some point during our career and our response could make the difference in preventing future errors. So how should you respond to healthcare errors?

Avoid the "blame and shame" approach. When healthcare error occurs, sometimes it is easier to put the blame on one person, but does the "blame and shame" approach really solve the problem that led to the error? Blaming does not take back the error nor does it prevent future errors from happening. A health care system that uses the blame and shame approach, punishes the individual, without fully investigating to determine if the error was the result of a systems issue. That approach leads to a weakened safety culture where the staff is less likely to talk openly to report and learn from the errors that occur, which ultimately could perpetuate a cycle of errors.

Differentiate between blame and accountability. Although blaming individuals for errors and unintended occurrences is not an appropriate response to errors, it is critical to distinguish between errors that are unintentional versus deliberate events. The underpinnings of a "just culture" support that individuals are not held accountable for mistakes due to systems failures while still holding individuals accountable for reckless behavior. A just culture is a safety culture that balances system accountability with individual accountability.

Examine the events that led to an error. By critically examining the events that contributed to the error, changes can be made to the system to prevent the occurrence of a similar mistake. Looking for a systematic fix is the key to reducing the amount of errors that occur. Healthcare workers are humans and no matter how careful, humans will always mistakes. The best way to prevent error is to "human-proof" the system so errors are less likely to occur or so that they can be caught before they lead

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Creating a Just Culture

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You're a new nurse juggling four patients and a new admission when the doctor orders a stat dose of 10 units of insulin for your diabetic patient recovering from an episode of diabetic ketoacidosis. As you're drawing up the insulin, the patient care technician on the floor comes in to tell you that your new patient is vomiting. Just as you go to administer the insulin you catch yourself; you didn't draw up 10 units-you drew up 100 units! You discard it and draw up the correct dose. Phew, that was a close one, you think as you continue through your day.

Unfortunately, this situation is not an uncommon one as the work environment for nurses becomes busier and wrought with distractions. However, the nature of an unplanned event such as the one described above, that didn't reach the patient but could have resulted in harm if it did, also known as a near miss, is an event that must be reported to risk management in order to prevent future risks for patients. Getting nurses and physicians to admit to almost or actual mistakes is an incredibly difficult task as many fear the blame and possible punishments that come with admitting to error. Recognizing this fear, but knowing that reporting is essential to improvement, many hospitals adopted a blame-free culture in recent years. A blame-free culture promotes a non-punitive response to unintentional mistakes, encouraging the reporting of errors and adverse events. Its fundamental concept supports correcting the system so that errors are not easily made, instead of blaming the individual involved.

A blame-free culture supports patient safety because it makes reporting possible without fear of punishment but many have argued that it promotes an environment where there is little accountability. Because of this, blame-free culture eventually evolved into just culture, where shared responsibility is fundamental between administrators and clinicians in order to allow doctors and nurses to safely do what they already want to do, provide safe, high quality healthcare. A just culture sees adverse events as opportunities to identify the root cause of error and to improve understanding of risk. Its creation aligns individual responsibility to be safe practitioners with improved systems and processes that make it hard to make an error.

Of course, reckless behavior that leads to an adverse event is handled far differently than an unintentional human error, and even in a just culture, irresponsible behaviors must be identified to support accountability. Nurses play an essential role in promoting a system that responds to healthcare error by investigating the events that lead to the occurrence. Nurses have the capacity to be agents of change by reporting unsafe situations and by encouraging their colleagues to do the same[1]. In addition, they can take the lead in improving processes that keep patients safe and advocate for system improvements by attending hospital meetings on safety initiatives and taking part in root cause analysis when adverse events occur. Nurses can support processes that prevent errors, such as error tracking, using checklists, and initiating independent double checks.

In a just culture, both the hospital and healthcare team members are held accountable for their actions but a no-fault approach to investigating error allows for the root cause to be identified and adjustments to be made so that the system is safer for patients. The continuing work of nurses in forming and preserving a safe environment, identifying risk, and supporting improvement creates a healthcare system where all healthcare team members feel safe in reporting their errors and near misses as a means to improve patient safety initiatives and outcomes[1].

1. Miranda, J. S., & Olexa, G. A. (2013). Creating a just culture: Calibrating our Culture of Patient Safety. The Pennsylvania Nurse, 68(4), 4-10.

IHI's Model for Improvement

PSDA

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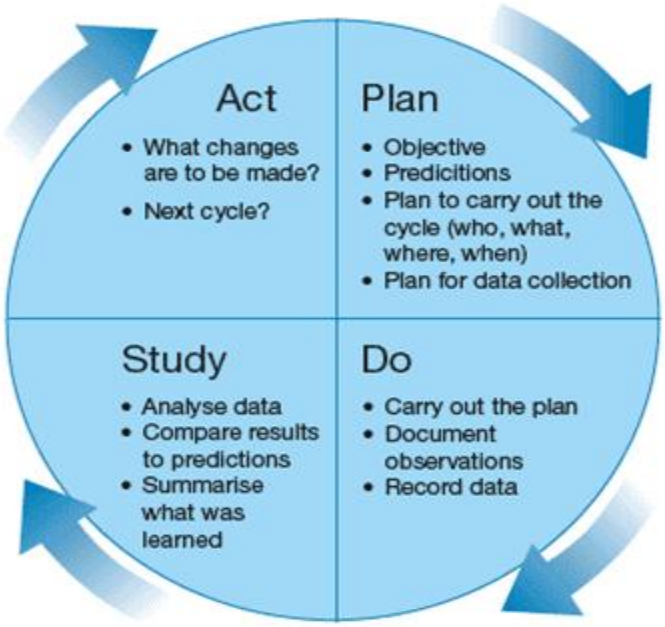
The Institute for Healthcare Improvement (IHI) is a non-profit organization focused on improving healthcare for all people. IHI uses The Improvement Model as a framework to guide improvement work. In this model, PDSA cycles, which were originally developed for industry, drive the change aimed at improvement. The acronym stands for Plan-Do-Study-Act and provides a learning approach for testing new change ideas on a small scale. The PDSA cycle is made up of a series of interdependent steps with key principles in each step. It uses a cyclic action to test new ideas and as quality becomes central in healthcare, many hospitals now follow this method when making changes to improve the quality of care.

The framework of this model includes three key questions used to establish the aim of the change, followed by the PDSA cycle for testing new change ideas. The three key questions are: (1) "What are we trying to accomplish? (2) How will we know if a change is an improvement? And (3) what change can we make that will result in improvement.[1] These questions are then followed by the PDSA's four-stage learning approach to regulate changes aimed at improving quality of healthcare for patients.

The 'plan' stage calls for identifying a change aimed at improving quality. In this stage, an objective is identified, as well as questions, predictions, and a plan to carry out the cycle. The next stage is 'do,' wherein the change is actively executed and unexpected observations are documented so data analysis can begin. In the 'study' stage, the data is analyzed and compared to the original predictions. This stage evaluates the success of the change, and summarizes what was learned. The final 'act' stage identifies needed adjustments and the next steps required in order to begin a new and improved PDSA cycle[1].



These four stages reflect the scientific experimental method of formulating a hypothesis, collecting data to test the hypothesis, analyzing and interpreting the results, and making inferences to repeat the cycle for a continually updated quality of care. The principles of PDSA cycles promote a small-scale approach to enable rapid assessment and allow flexibility to alter the plan according to feedback. Because healthcare is continuously changing as new knowledge becomes available, change will be a continuous theme in our careers. Understanding PDSA cycles will allow us to hit the ground running as we work to improve the quality of care for the patients we serve.

1. Taylor, M., Mcnicholas, C., Nicolay, C., Darzi, A., Bell, D., & Reed, J. (2013). Systematic review of the application of the plan-do-study-act method to improve quality in healthcare. BMJ Quality & Safety, 290-298.

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to patient harm. Learning from adverse events can improve patient safety in addition to preventing future errors.

Improve the Culture of Safety. How can you contribute to the culture of safety? Be comfortable talking about near misses, errors, and patient harm. Discussing it openly promotes learning from mistakes and enhances the culture of safely. Understand that reporting safety issues or errors will lead to improvement in the system. Reporting problems will lead to redesigned systems, reducing the chance for errors. In a culture of safety, caregivers can voice their concerns, hopefully preventing patient harm.

Something else you can do is change the way you respond to healthcare error in order to prevent further mistakes. It is important to look at the system for a root cause rather than at the individual. At the same time, as practitioners, we have to understand that we accept individual accountability to provide care that is safe and consistent with standard practice. When an error occurs, we should examine the events that led up to the mistake in order to find flaws in the system that can be corrected. Be a part of the culture of safety and talk openly about mistakes so others can learn from them. Responding to errors in these ways supports a just culture where safety is a priority and institutional goals are aimed at reducing errors and patient harm through system effectiveness.

1. Classen, D. C., Resar, R., Griffin, F., Federico, F., Frankel, T., Kimmel, N., Whittington, J. C., & Frankel, A. (2011). 'Global Trigger Tool' Shows that Adverse Events in Hospitals May Be Ten Times Greater than Previously Measured. Health Affairs, 30(4), 581-589. doi: 10.1377/hlthaff.2011.0190