

Serious Safety Errors: Transparency, Accountability & "Just Culture"

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Presentation Objectives

- Define today's current challenges around safe, high-quality care
- Discuss accountability within the context of "just culture"
- Describe why transparency and reporting are critical for future error prevention in learning organizations

2022: A Year of Challenges



CMS Revamps Quality Strategy

Focus on 4 main pillars:

- Establish clear and reasonable quality expectations through government standards and quality measures
- Improve oversight and enforcement of quality standards to ensure accountability
- Promote transparency, competition and consumer choice by sharing quality information with the public
- Modernize quality improvement efforts through advances in data analytics and technology

Source: Seema Verma, CMS Administrator Becker's Hospital Review, February 27, 2020

Top Five Safety Issues for Hospitals in 2022

- Foundational safety work
- Supporting the healthcare workforce
- Integrating equity into safety work
- Diagnostic harm
- Healthcare-associated infections

Source: Mackenzie Bean, Becker's Healthcare, January 3, 2022, 191

Top 10 Health Technology Hazards for 2022

1. Cybersecurity Attacks Can Disrupt Healthcare Delivery, Impacting Patient Safety
2. Supply Chain Shortfalls Pose Risks to Patient Care
3. Damaged Infusion Pumps Can Cause Medication Errors
4. Inadequate Emergency Stockpiles Could Disrupt Patient Care during a Public Health Emergency
5. Telehealth Workflow and Human Factors Shortcomings Can Cause Poor Outcomes

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Top 10 Health Technology Hazards for 2022

6. Failure to Adhere to Syringe Pump Best Practices Can Lead to Dangerous Medication Delivery Errors
7. AI-Based Reconstruction Can Distort Images, Threatening Diagnostic Outcomes
8. Poor Duodenoscope Reprocessing Ergonomics and Workflows Put Healthcare Workers and Patients at Risk
9. Disposable Gowns with Insufficient Barrier Protection Put Wearers at Risk
10. Wi-Fi Dropouts and Dead Zones Can Lead to Patient Care Delays, Injuries, and Deaths

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Aspiring Higher: Organizations' Quality & Safety Journey

Instability & Errors Initiatives in Progress Optimal Leadership & Staff Engagement

Searching for Stability → Building for Success → Achieving Superior Performance

Quality and Safety Continuum

Quality: Important Impacts

- Better Health**
 - Clinical outcomes (mortality, morbidity)
 - Patient reported outcomes (function, symptoms, pain, wellbeing, quality of life, avoiding serious health-related suffering)
- Confidence in System**
 - Satisfaction
 - Recommendation
 - Trust
 - Care uptake and retention
- Economic Benefit**
 - Ability to work or attend school
 - Economic growth
 - Reduction in health system waste
 - Financial risk protection

Key Healthcare Leader Impressions

Shortages

What impact have staffing shortages had on patient safety at your hospital?

Impact	Percentage
A moderate decline in patient safety	65%
No decline in patient safety	19%
I have not experienced staff shortages	1%
A significant decline in patient safety	15%

Hospital Safety Survey (nonrespondents), January 2022 Sage Growth Partners Research

Key Healthcare Leader Impressions

Burnout

What impact has staff burnout had on patient safety at your hospital?

Impact	Percentage
A moderate decline in patient safety	63%
No decline in patient safety	14%
A significant decline in patient safety	23%

Hospital Safety Survey (nonrespondents), January 2022 Sage Growth Partners Research

How Clinicians Experience Caregiving

Clinical Excellence

- Providing Quality Care
- Providing Safe Care

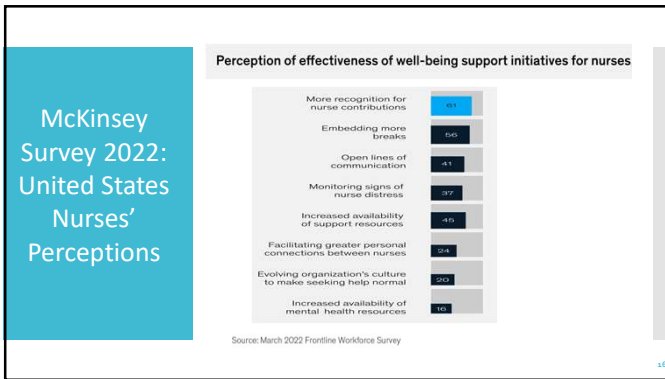
Operational Excellence

- Job Fit, Clarity, Pay/Benefits
- Work Training, Development
- Physical/Staff Resources
- Good Management
- Input, Feedback, Autonomy
- Leadership
- Communication

Culture

- Mission/Values
- Teamwork
- Patient-Centeredness
- Improvement Focus
- Safety as a Priority

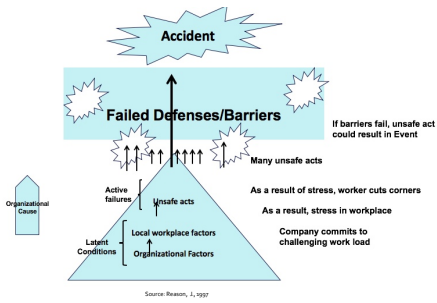
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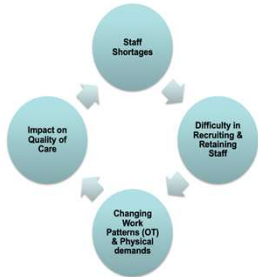
- ### What Keeps Nurses in Nursing?
- Practicing from inner core beliefs
 - Understanding others from within (a sense of empathy and connection to patients as persons)
 - Making a difference
 - Evolving as a professional nurse, willing to learn and open to others
- Adapted from Dunn, D. What Keeps Nurses in Nursing? *International Journal for Human Caring*, 2012, Vol. 16, No. 3.

- ### What Prevents or Diminishes Joy & Meaning at Work?
- Lack of organizational/unit support
 - Inability to provide quality care
 - Being overwhelmed with workload, exhaustion
 - Lack of challenge, boredom

Organizational Causes of Accidents



Contributing Factor: Staff Shortages



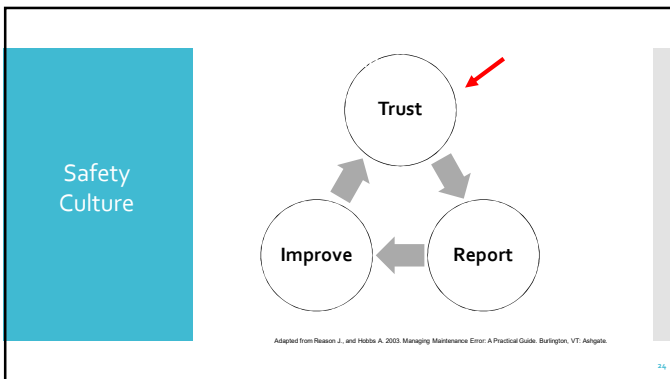
Costly and Dangerous Cycle When Workload-Staffing Imbalance Exists

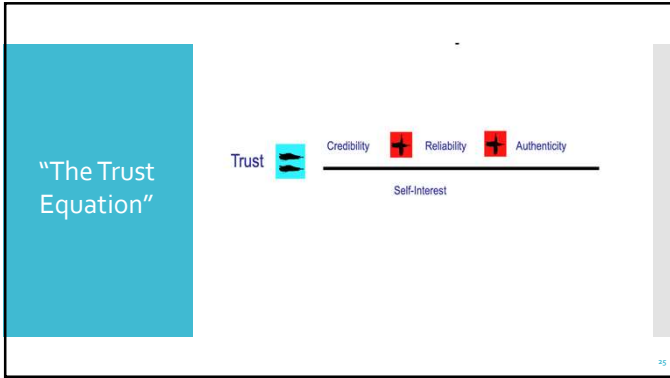


Source: Lerman et al, 2012, ACOEM Fatigue Risk Management

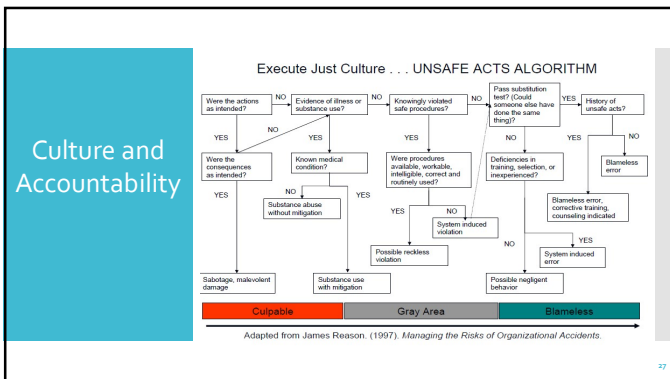


- ### The Principles of Error Management
- Human error is both universal and inevitable
 - Errors are not intrinsically bad
 - One cannot change the human condition, but you can change the conditions in which humans work
 - The best people can make the worst mistakes
 - People cannot easily avoid those actions that are unintentional









Foresight Test

Key question: Did the individual depart from agreed safe practices or protocols?

If yes, were the protocols or procedures:

- available
- intelligible
- workable
- correct
- in routine use

Were there mitigating circumstances?

Substitution Test

- Would another person from the same professional group, with similar training and experience, behave the same way in similar circumstances?
- Were there deficiencies in training, experience or supervision?
- Were there mitigating circumstances others would experience too?
- These answers plus magnitude of risk taken by individual lead to different levels of severity of disciplinary options

Key Elements of a Truly Safe Culture

- Tools & measures are used routinely to assess culture
- Current and past results of culture assessments and changes are made; results are communicated to staff
- Staff feedback and education occurs regularly ("Code of Conduct")
- Evidence of trust, such as how disruptive behavior was managed
- Systems exist to manage adverse events, close calls
- Willingness of individuals at all levels to discuss safety and how to improve

How Can Nurse Leaders Help?

- Deeply understand the work environment challenges for the staff
- Remove barriers to safe, high-quality care
- Be an active listener and problem-solver
- Develop initiatives to stimulate staff's sense of meaning and achievement in their work
- Use peer role models to help support
- Stop "fantasy thinking" about work-life balance
- Money alone won't provide joy & meaning

Out of intense complexities,
intense simplicities come.

Winston Churchill

Selected References

- AMN Healthcare. "Nursing and the Nation: Extreme Challenges, Extraordinary Impact 2021 Survey of Registered Nurses". Available at www.amnhealthcare.com
- Bean M, Carbajal E, Gleeson, C. "Nurses make exit plans after RaDonda Vaught's Conviction". *Becker's Healthcare Review*, May 6, 2022. <https://www.beckershospitalreview.com/nursing/nurses-make-exit-plans-after-radonda-vaught-s-conviction.html>
- IHI and LLI Statement About the Risks to Patient Safety When Medical Errors are Criminalized. March 30, 2022. Available at www.ihl.org
- Impact of the COVID-19 pandemic on the hospital and outpatient clinician workforce: challenges and policy responses(Issue Brief No. HP-2022-13). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. May 2022.
- Partners for Nurse Staffing Think Tank. AACN-ANA-AONL-HFMA-IHI. (2022). "Priority Topics and Recommendations". Available at www.ihl.org

Selected References (continued)

- Sampath B, Rakover J, Baldoza K, Mate K, Lenoci-Edwards J, Barker P. Whole System Quality: A Unified Approach to Building Responsive, Resilient Health Care Systems. IHI White Paper. Boston: Institute for Healthcare Improvement; 2021. Available at www.ihl.org
- State of Nursing in Massachusetts. Beacon Research Report (Commissioned by Massachusetts Nurses Association). April 26, 2022.
- United States Surgeon General. (2022). "Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce". Available at <https://www.hhs.gov/surgeongeneral/reports-and-publications/index.html>
- Whittington, KD et al. "Emotional exhaustion as a predictor for burnout among nurses". *Nursing Management*, January 2021, pp. 22-28.

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Faculty Biography & Contact Info

Ann Scott Blouin, RN, PhD, LFAACHE, is President of PSQ Advisory, a consultancy focused on quality and safety in healthcare.

Dr. Blouin has over 40 years of health care administration, consulting and nursing experience. She was a partner/principal/managing director at Ernst & Young, Huron and Deloitte. She currently serves on the boards of the Institute for Healthcare Improvement, Ensign Group, and three start-up healthcare technology companies-Vitalacy, Magvation and Elemeno Health. Ann is an editorial advisor for the *Journal of Nursing Administration* and assistant professor at Loyola University of Chicago, Marcella Niehoff School of Nursing.

Dr. Blouin earned her PhD and MBA from the University of Illinois, her MSN from Loyola University, and BSN from Lewis University. She is a Lifetime Fellow of the American College of Health Care Executives.

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