ENGAGE WITH QUALITY IMPROVEMENT AND PATIENT SAFETY (E-QIPS)

One Safe Act: Promoting A Proactive Safety Culture

American Urological Association

QUALITY OR SAFETY PROBLEM

There is no doubt that everyone who works in health care arrives each day committed to avoiding patient harm. Yet, when we discuss patient safety we frequently hear (and feel) that it is punitive, unresponsive, and retrospective. A clear vulnerability exists as our existing patient safety efforts focus retrospectively on error reporting and safety event analysis and fail to advance a proactive culture of safety. As health care begins its journey toward becoming a high reliability organization, it is essential to build an organizational culture that views patient safety as celebratory, collaborative, empowering, and responsive. However, there has yet to be a process or tool that situates patient safety within these ideals. Our ŏOne Safe Actŏ will be this tool. To begin this momentous change, we need to inspire our colleagues to think about patient safety not only when safety events occur - but also when they do not occur - and how and why their actions led to that good outcome.

BACKGROUND

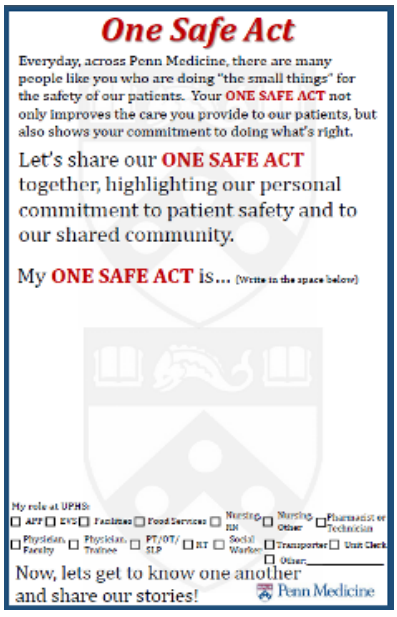
The most commonly resourced safety science literature focuses primarily on reducing adverse events through investigation. As Hollnagel et al state ensuring that ŏas few things as possible go wrongŏ.[1] This is now referred to as Safety 1 thinking. However, very little attention both in practice and in the literature has been paid to proactive safety behaviors, which can be studied and reinforced to further promote safety. Again, as Hollnagel et al state the focus should be on promoting ŏas many things as possible go rightŏ.[1] This paradigm is referred to as Safety 2 thinking. In it is in this framework that we situation our ŏOne Safe Actŏ activity.

PROJECT OBJECTIVES

The objective is to generate discussion and dissemination of personal actions and behaviors that promote patient safety. The specific aims are to (1) facilitate interprofessional teaming of staff who work in a shared environment; (2) encourage self- and group-reflection of proactive behaviors done to ensure or promote patient safety; and (3) identify, catalog, and distribute learnings of common or universal proactive safety behaviors that can be adopted across the organization.

INTERVENTION

The "One Safe Act" initiative would generate discussion and dissemination of personal actions and behaviors that promote patient safety. At first, we envision an in-person facilitated dialogue with a multidisciplinary group of staff who work in a shared clinical environment. This group would be introduced to the "One Safe Act" initiative, briefly socialized, and provided a time-limited period for reflection on their own "One Safe Act" (Figure). A facilitated dialogue would allow for idea exchange to build a shared appreciation and understanding of those actions that coworkers perform daily to improve patient safety.



MEASURES OF SUCCESS

Our measures of success will be staff member participation rates, safe acts stories/behaviors cataloged, and acceptance of the intervention through short-form attitudinal survey.

METHODOLOGY

Our project evaluation will have four components. The first component will be comprised of data collected in "One Safe Act" discussions and will include reporting of staff member participation, safe acts stories/behaviors, and acceptance of the intervention through short-form attitudinal survey. We will catalog these behaviors by role, and use thematic analysis to elucidate common categories of behaviors that can be rapidly applied and incorporated into practice. A companion website will be developed to enable further expansion via self-directed story/behavior uploads. The second component will be responses to the hospital Patient Safety Culture Survey which is a national, validated tool distributed every other year to all staff. We will be particularly attentive to the domains of communication openness and teamwork within units, which have been identified as areas with declining scores and lagging indicators. As data is available at the unit level, we will also evaluate how domains scores are affected in high and low performing environments. A third area for analysis will be the study of pre- and post-intervention submission patterns of safety event submissions on units who participate in the activity. Of interest will be events that are categorized as "near misses" or "unsafe conditions" as these may better correlate with a proactive safety culture.

OUTCOMES

The "One Safe Act" activity was piloted with 20 participants from 10 different units. Following the general model detailed above for the activity, the pilot group reported behaviors ranging from personally reconciling a patient's orders at each and every transition of care to increasing communication and engagement among operating room staff during the pre-operative huddle and timeout. A total of 30 unique behaviors were collected. Despite these seemingly different behaviors, clear themes emerged, including searching for the truth in the source data, such as orders/notes/radiology studies when making clinical decisions and intra- and inter-team communication around transitions of care. Additionally, participants shared sentiments of enthusiasm and empowerment and expressed a sense of personal responsibility and commitment to the community. Moreover, at a time when burnout among healthcare professionals is at an all-time high, we believe that personal and positive discussions relating to patient safety presents a novel strategy to help mitigate this burden.

POTENTIAL IMPACT AND SCALABILITY

It is well-established that promoting safe care is not only the right thing to do, but it is also a financially successful and sustainable strategy. Improving safety culture/perception of safety is associated with improved patient outcomes across a wide range of metrics. Although admittedly difficult to directly measure, it would be reasonable to surmise that improvement in safety culture through our campaign will translate to financial gain for the health system by reducing harm and improving patient and staff outcomes.

SUSTAINING THE CHANGES

We plan to eventually design a large-scale multiple format crowd-sourcing campaign around the "One Safe Act" vision. Initially, project management and consultative expertise will be valued to develop a comprehensive, tiered strategy for a crowdsourcing campaign. Technical/AV support will also be required for website design and video-recording to feature select staff stories. The development of a facile, mobile-based interface would also require design and hosting resources. Additionally, to leverage this collection of safe behaviors for later learning and/or dissemination as a highly visible and attractive product, the interface will need to allow for aggregation and classification of these narratives.

PROJECT LEAD CONTACT INFORMATION

Justin B. Ziemba, MD MSEd
Assistant Professor of Urology in Surgery
Perelman School of Medicine at the University of Pennsylvania
justin.ziemba@pennmedicine.upenn.edu

REFERENCES

1. Hollnagel E., Wears R.L. and Braithwaite J. From Safety-I to Safety-II: A White Paper. The Resilient Health Care Net: Published simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia.