Title:
Implementing a High Reliability Safety Culture Cycle to Improve Patient Safety Outcomes

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ACCEPTED

Session Title:
Rising Stars of Research and Scholarship Invited Student Posters

Slot:
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Applicable Category:
Clinical, Leaders

Keywords:
High Reliability Organizations, Patient Outcomes and Safety Culture

References:


Abstract Summary:
Despite the many safety regulations in place, patient safety continues to be a serious concern. On an inpatient geriatric unit, will the implementation of a High Reliability Safety Culture Cycle result in improved patient safety outcomes?

Content Outline:
1. Case Study
2. Clinical Problem and Setting Identification
   1. Clinical Issue of Concern
      1. Despite safety interventions and regulations, adverse events continue to be a persistent problem and these interventions are not consistently followed or implemented for various reasons.
   2. Background of Clinical Issue
      1. In 2001, the Institute of Medicine challenged healthcare organizations to improve practice models to increase patient safety and quality care.
  3. Significance
     1. Some organizations have seen a positive impact on mortality rates and quality of life and attribute their success to the implementation of High Reliability Organization Theory to improve their culture of safety.
  4. Problem Statement
1. Despite the implementation of safety interventions, medical errors still persist. Beyond the financial strain it imposes on the healthcare organization, and the negative impact on morale of nursing staff, medical errors can adversely impact the patient.

5. Description of the Setting

1. The proposed intervention will be implemented on an inpatient geriatric unit. This unit consists of 38-beds and specializes in medical-surgical patients ages 65 and older.

3. PICOT Question

1. On an inpatient geriatric unit, will the implementation of a High Reliability Safety Culture Cycle result in a reduction in hospital acquired conditions, adverse patient events, length of stay, improved patient/family satisfaction and increased staff perception of safety culture compared with the current lack of an intentional safety culture over a twelve-month period?

2. Project Objective

1. The objective of this evidence-based change in practice is to reduce patient harm and improve safety outcomes for geriatric inpatients.

3. Fit of the Proposed Change

1. This proposed change relies on a collaborative culture, which the organization is well known for. The mission of the organization is, “Our commitment to excellence in healthcare, with patients and families at the heart of all we do,” therefore a proposal that places patient safety first will be supported by leadership and embraced by its employees.

4. Research Support - Body of Evidence

1. Systematic Literature Review Methods

1. During the review of the literature, two main themes emerged

   1. Theme 1: Safety Culture and Patient Outcomes
   2. Theme 2: High Reliability Organizations Strategies to a Culture of Safety

2. Synthesis of the Body of Evidence

1. When healthcare workers perceive safety interventions as critical to maintaining patient safety, a culture of safety exists.

2. The correlation between patient safety and healthcare organizations that implemented interventions modeled after High-Reliability Organizations was explored.
5. Theoretical Framework for the Evidence Based Change
   
   1. High Reliability Organization Theory
      
      1. Preoccupation with Failure
      2. Reluctance to Simplify
      3. Sensitivity to Operations
      4. Commitment to Resilience
      5. Deference to Expertise

6. Evidence-Based Change Description
   
   1. Proposed Evidence Based Change
      
      1. High Reliability Safety Culture Cycle is an evidence-based approach to establishing and maintaining a culture of safety.

   2. Components of the Proposed Evidence Based Change
      
      1. Shift Safety Briefing
      2. Interdisciplinary Rounds
      3. Post-Event Debrief
      4. Event Reporting
      5. Event Investigation
      6. Findings Shared with Staff

7. Educational Plan
   
   1. Learners
   2. Learner-Centered Objectives
   3. Learning Theory Guiding Educational Plan
   4. Suggested Teaching/Learning Strategies
   5. Frequency of Offering

8. Translation to the Clinical Setting
   
   1. Clinical Setting
      
      1. The Safety Culture Cycle care delivery model will be implemented on a 38-bed ACE unit within a Magnet designated hospital.
      
      2. Process for Implementing Clinical Changes
1. The ACE unit exists within an organization that utilizes a shared governance structure for decision making.

3. Evidence Based Culture
   1. Recent EBP Activity
   2. Healthcare Team Support of EBP
   3. Staff Nurse Attitudes and Readiness

4. Facilitators and Barriers

9. Implementation Plan
   1. Change Theory
      1. Kotter and Cohen’s Model of Change
   2. Application of Change Theory to Evidence Based Change
      1. Urgency
      2. Team Selection
      3. Vision and Strategy
      4. Communicating the Vision
      5. Empowerment
      6. Interim Successes
      7. Ongoing Persistence
      8. Nourishment
   3. Time Frame for Implementation of Proposed Change
   4. Costs Related to the High Reliability Safety Culture Cycle
      1. A correlation exists between a lack of safety culture and poor patient outcomes related to preventable errors.

10. Costs and Benefits
    1. Costs of the Practice Change
       1. Last year, the ACE unit sustained two hospital acquired infections and six falls with moderate or greater injury, costing the organization an average of $257,000 in one year. If the $12,000 proposed change were approved and successful, the organization would save about $245,000 in one year.

    2. Feasibility of Implementation Plan
1. The vision of the organization states, “We deliver Medicine of the Highest Order in a community hospital where compassion, quality, and patient-and-family centered care are our guiding principles.” The High Reliability Safety Culture Cycle will be a unit-based implementation that aligns with the organization’s vision.

11. Evaluation Plan

1. Outcome Measures
   1. Reduced hospital acquired conditions
   2. Reduced adverse patient events
   3. Reduced length of stay
   4. Improved patient/family satisfaction
   5. Increased staff perception of safety culture

2. Data Collection
   1. Measurement Tools
      1. Event Reporting Tool
      2. Electronic Medical Record Reports
      3. Press Ganey Survey
      4. Safety Culture Survey

12. Sustaining the Gain

1. Methods to Sustain the Change
   1. Empowerment
   2. Interim Successes
   3. Ongoing Persistence

2. Internal and External Dissemination of Results of the Project
   1. House-wide presentation
   2. Presentation at local conference
   3. Presentation at national conference

13. Final Discussion

1. Impact on nursing knowledge and practice
Abstract Text:

In 2001, the Institute of Medicine challenged healthcare organizations to improve practice models to increase patient safety and quality care. Despite this challenge and the many safety regulations in place, patient safety continues to be a serious concern. Currently, on an Acute Care for the Elderly unit, elements of a culture of safety exist, although there is no formal process for identifying and addressing potential problems or reviewing, sharing, and learning from adverse events. The PICOT question is: On an inpatient geriatric unit, will the implementation of a High Reliability Safety Culture Cycle result in a reduction in hospital acquired conditions, adverse patient events, length of stay, improved patient/family satisfaction and increased staff perception of safety culture compared with the current lack of an intentional safety culture over a twelve-month period? The objective of this evidence-based change in practice is to reduce patient harm and improve safety outcomes for geriatric inpatients. A High Reliability Safety Culture Cycle, an evidence-based approach to establishing and maintaining a culture of safety, will be implemented. This approach is based on the High Reliability Organization Theory, consisting of five components: 1) preoccupation with failure, 2) a reluctance to simplify, 3) sensitivity to operations, 4) a commitment to resilience, and 5) a deference to expertise. The Safety Culture Cycle is comprised of six phases: (a) shift safety briefing, (b) interdisciplinary rounds, (c) post-event debrief, (d) event reporting, (e) event investigation, and (f) findings shared with staff. The components of the High Reliability Safety Culture Cycle are implemented sequentially and cyclically. All phases are nurse-led and conducted in a collaborative manner with the support of leadership. The cycle addresses the fact that despite all best efforts, adverse events can still occur. Kotter and Cohen’s Change Theory will guide implementation while outcomes will be measured through event reports, electronic medical record reports, Press Ganey surveys, and Safety Culture Surveys.