Speaking Up for Safety to Decrease Patient Harm

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Background

Speaking up is a critical behavioral choice of patient safety that plays an important role for improving quality and patient safety in healthcare. It requires courage to express a patient safety concern. The Joint Commission predicts that miscommunication among healthcare workers leads to 80% of all serious safety events (BMC).

Many healthcare workers hesitate to voice patient safety concerns due to fears of retaliation, being incorrect, not being taken seriously, or shame, even when they are aware of the risks and their moral obligation to speak up (ISPM). Organizations must acknowledge and address these fears. With a strong culture of safety, people keep an eye out for potential errors so problems can be proactively addressed before harm occurs (IHI).

Sutter Davis Hospital is on a journey to improve the culture of safety in the Perioperative department by encouraging and empowering the team to speak up for safety to align with Sutter Health's goal of eliminating patient harm.

The team has typically viewed patient safety reports (PSRs) as punitive and of little value. PSRs were often submitted after safety events occurred instead of the team collaborating, communicating, and speaking up in real time to address potential safety concerns. Additionally, there was a significant increase in PSRs related to Universal Protocol (UP) and informed consent issues.

Purpose

- Empower our perioperative team to speak up and communicate when a potential safety issue or concern arises before patient harm occurs
- Recognize the team for speaking up for safety
- Increase reporting of good catches via PSRs
- Decrease Priority 1 events (patient safety events causing harm)
- Decrease UP and informed consent related events
- Share learnings of safety events, near misses, and good catches with frontline team members

Methods

The Quality and Patient Safety team collaborated with perioperative leadership, providers, frontline staff, administration, and risk management to encourage and empower our perioperative team to speak up:

- Implemented the Good Catch Award program to recognize, encourage and inspire staff and providers to speak up for safety and increase reporting of good catches
- Initiated a pilot for conducting post-procedure team debriefs to discuss team communication opportunities, successes, and learnings
- Conducted a Failure Mode Effects Analysis (FMEA) on the informed consent process based on PSR analysis
- Developed Safety Event Review Committee (SERC) Learnings to share learnings from safety events with frontline staff

Perioperative PSRs were analyzed to identify pre- and post-change conditions, including:

- Good catches and near misses (Significance A & B)
- Priority 1 events (Significance E and above)
- Event types related to UP and informed consent

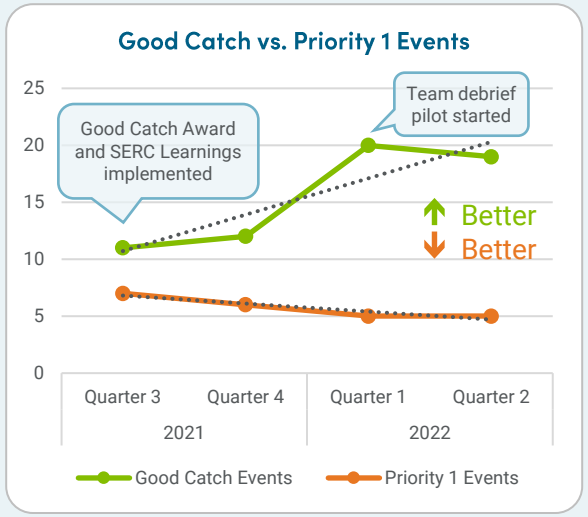
Results

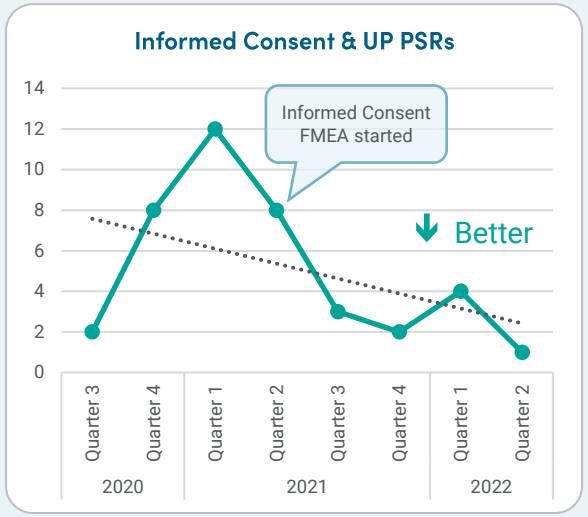
Between Quarter 3 2021 and Quarter 2 2022:

- Good Catch Events **increased** **73%**
- Priority 1 Events **decreased** **29%**

Between Quarter 1 2021 and Quarter 2 2022:

- Informed Consent & UP PSRs **decreased** **92%**





Discussion

The perioperative team has consistently increased reporting of good catches, and experienced decreased Priority 1, informed consent and UP events.

Out of 13 Good Catch Award winners, 7 perioperative team members have received the award, including 4 RNs, 1 tech and 2 physicians. The recognition has encouraged and empowered the team to speak up for safety.

The FMEA addressed UP and informed consent issues by ensuring consistency in processes and encouraging the perioperative team to speak up with safety concerns.

We recognize some staff may still be hesitant to speak up due to fear. A team debrief pilot was introduced to reduce these fears by providing a platform for staff to speak up and share opportunities for improvement, successes, and learning opportunities to improve patient safety.

Further research is needed to understand all the factors that influence and enable speaking up behaviors as this work is rolled out to more teams across the organization.

References

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