Culture of Safety and Human Factors

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Continuing Nursing Education

- 1 CNE offered for each webinar attended
- Upon completion of all 4 webinars, you will receive email with link for CNE
- Evaluation must be completed before you receive CNE certificate

Culture of Safety

Organizational Culture of Safety

Organizational Culture Infographic. Digital image. 2022. https://www.ahrq.gov/sops/about/patient-safety-culture.html.

Organizational Culture of Safety in Practice

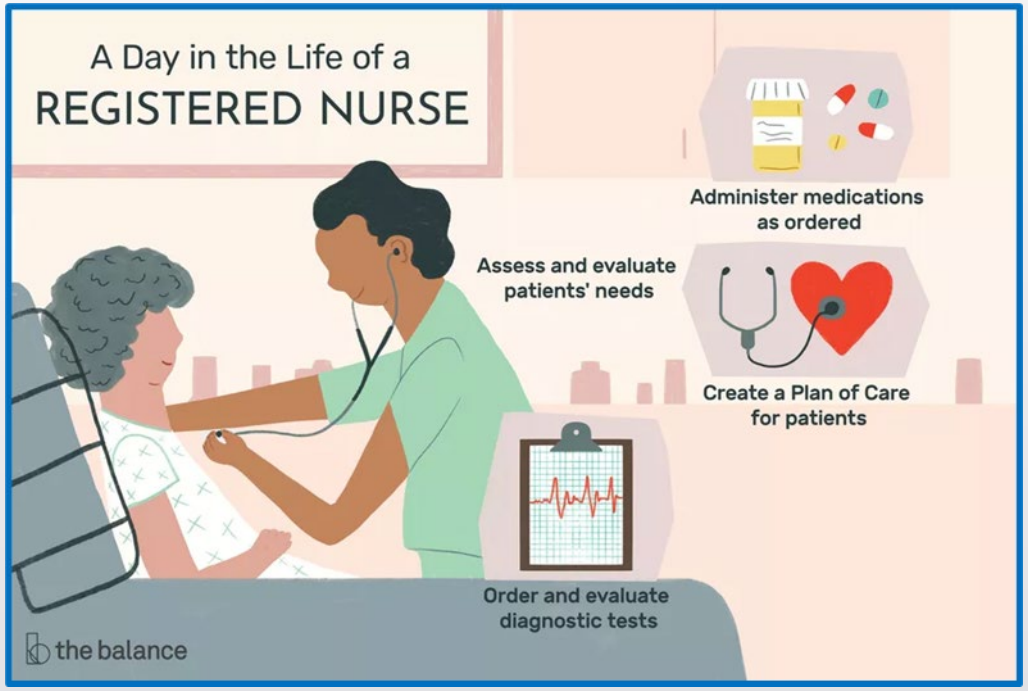
- Acknowledgement of the high-risk nature of health care
- Blame-free environment; Just Culture
- Collaboration across ranks and disciplines
- Open, 2-Way Communication

All Hands In Graphic. Digital Image. 2020. https://rms.rdale.org/discover/news/article/~board/robbinsdale-middle-news/post/rms-student-affinity-groups.

Human Factors

Definition

- ...a scientific discipline that aims to help people do their best work, improve resilience and overall system performance, and minimize errors. Human factors-based solutions make it "easy to do things right and hard to do things wrong." When errors do occur, they are less likely to lead to patient harm..." – Johns Hopkins Institute for Patient Safety and Quality



RN working with a patient in the healthcare system. Digital Image. 2019. https://www.thebalancecareers.com/registered-nurse-526062.

Terminology

Close call (near miss)- An unsafe event occurred but did cause patient harm

Incident- Patient harm resulted due to an unsafe event

Active Failures- Unsafe acts committed by frontline staff at the point of care

Latent Failures- Underlying weakness in systems or processes that may be caused by poor design, poor systems or poor leadership

Active failures

Unsafe acts committed by frontline staff at the point of care

Errors - Honest mistakes due to poor decision making, lack of skill or perceptual deficits

Violation - A deliberate disregard for safety regulations that either occur routinely or under exceptional circumstances

Humans are not Perfect!

Human Factor Types	Knowledge Based
	Rule Based
	Skill Based

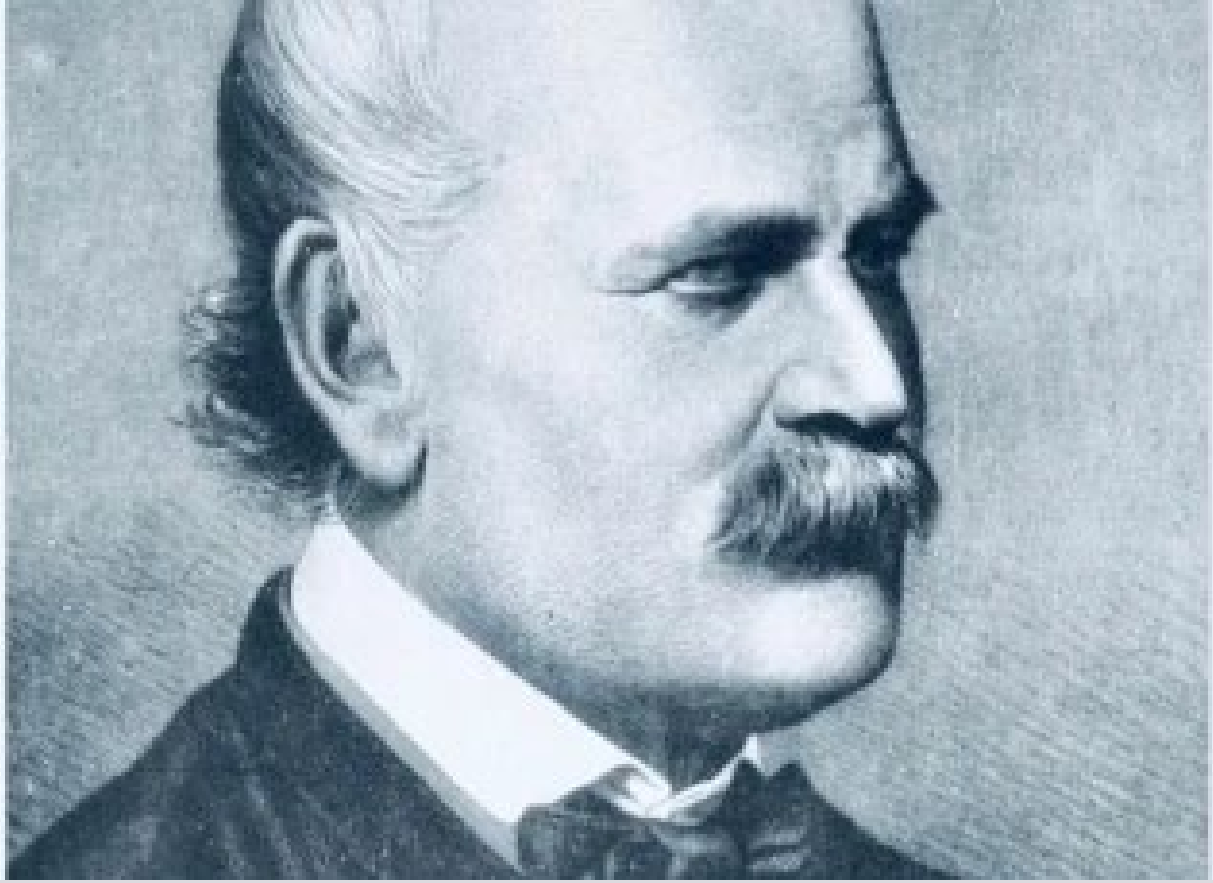
Latent Failures

Underlying weakness in systems or processes that may be caused by poor design, poor systems or poor leadership (subcategories include organizational factors, supervision issues and preconditions for unsafe acts)

Organizational factors – resources, culture, process

Supervision issues – failure to correct known problems, inadequate supervision

Preconditions for unsafe acts – environmental factors and human factors



It goes way back!

Handwashing in the 1840's and 1850's

Handwashing – What do you think?

Examples of Errors

- A bag of epidural pain medicine is administered through PIV line – IV bag and epidural bag looked the same AND the epidural bag had the functional ability to be connected to PIV catheter hub.

- Babies in NICU were given full dose heparin instead of low dose flushes – the two vials were identical and stocked next to each other in the automated dispensers at point of care.

- Patient experiences cardiac arrest; when code team arrives, they cannot physically connect the defibrillator pads to the defibrillator itself; multiple brands of defibrillators exist and differ in physical appearance. Hospitals may have various versions of defibrillators throughout house.

What do you see?

Different dosages

Used for same reason

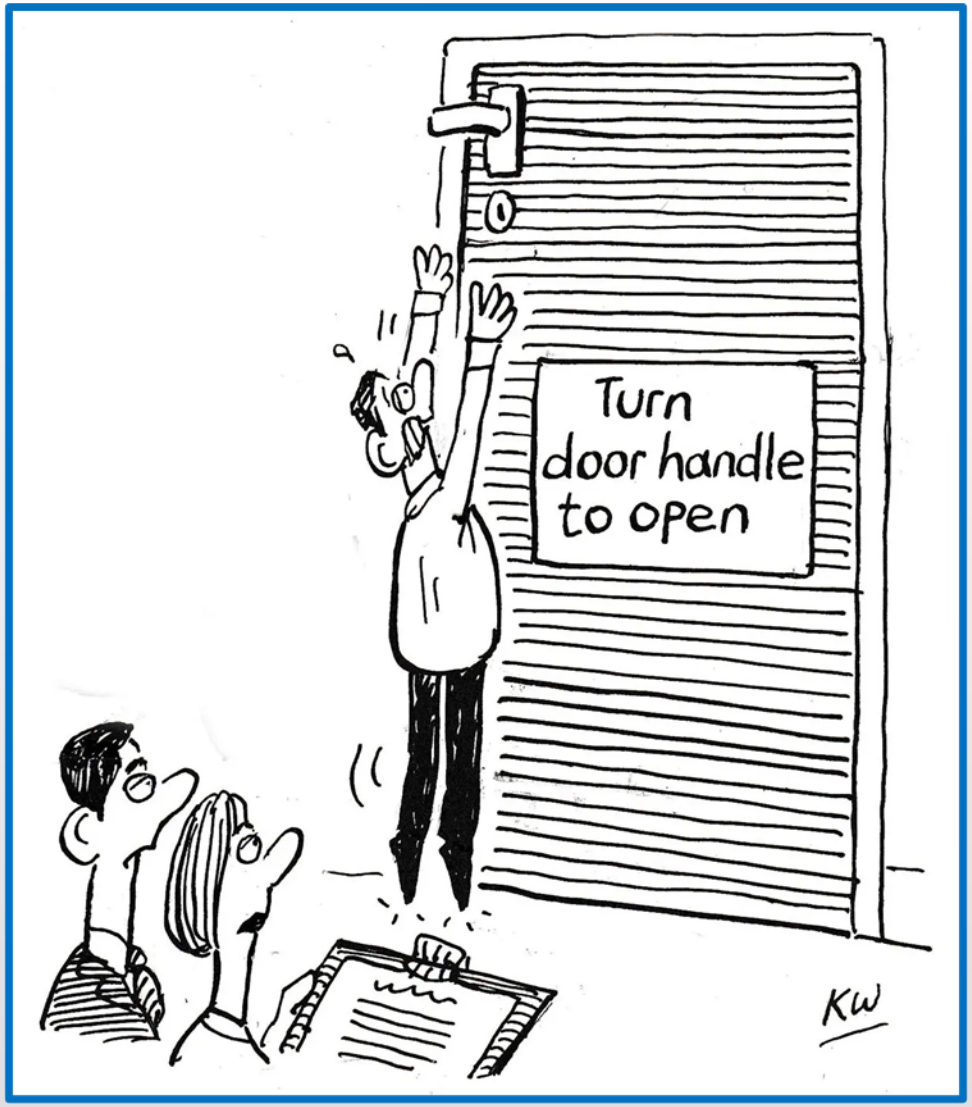
Putting it together

- Positive:
  - Pattern identification, anticipation of outcomes, critical thinking
- Negative:
  - Limitations of memory, time-constraints, multi-tasking, ergonomics, sequencing, location of supplies
- External Factors:
  - Noise, distractions/interruptions, task design, environment conditions, practice norms
- Internal Factors:
  - Fatigue, stress, anxiety, depression

Consider this...

- Research shows humans:
  - make 35,000 decisions *everyday*!
  - experience 3-6 errors every hour in "normal" conditions
  - can experience 11-15 errors per hour in "stressful, emergent, or unusual" conditions

More Than Communication and Teamwork

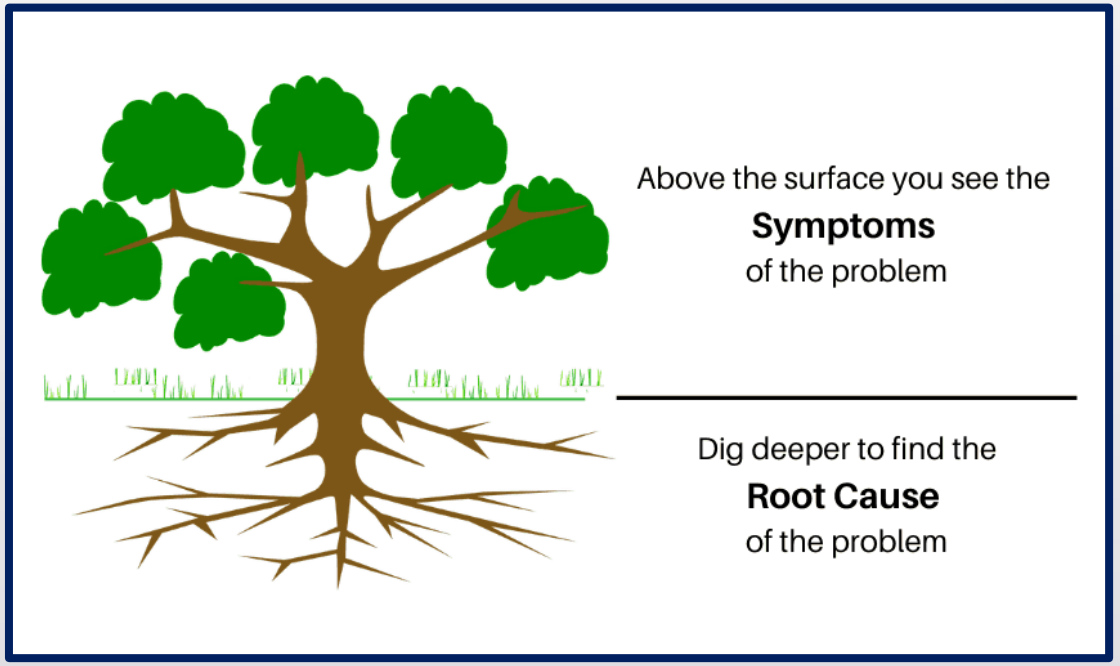


Human Factors Today

- Continued Research
- RCA^2

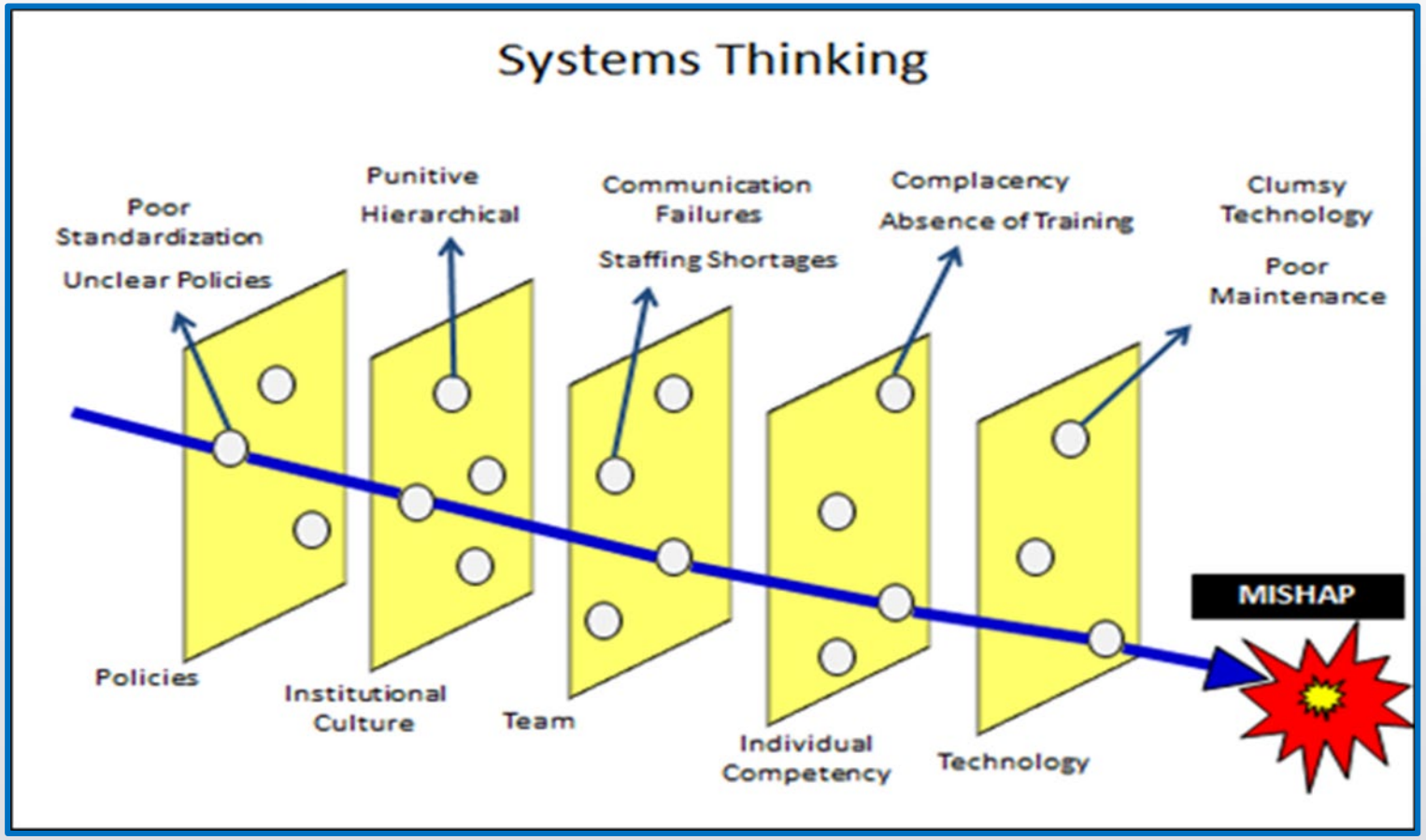
Event Investigation and Root Cause Analysis

- Deep dive into an event to identify failures and gaps in systems and processes
- Near miss or actual event



Root Cause Analysis. Digital image. 2019. https://upskillnation.com/root-cause-analysis/.

Systems Thinking



The other side of safety and errors

- Staff!
  - Support each other after an event
  - What resources are available?
  - Sometimes the hardest part of patient safety
- Second Victim

Supporting RN Staff Graphic. Digital Image. 2020. https://www.symplr.com/blog/the-most-important-element-of-patient-safety-is-usually-the-hardest-to-achieve.

YOUR Role in Patient Safety Culture

- Report!
- Provide Input and Feedback
- Serve as Champion or Coach
- Model Behavior
- Engage in Quality Improvement
  - Plan, Do, Study, Act (PDSA)
  - Root Cause Analysis (RCA)
  - Organization and Department Initiatives
  - Committees


Questions?

Thank you!

Resources

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