

Summary of Q&A Portion of
“A Sense of Urgency: Patient Safety,”
A Webinar Conducted on August 23, 2006, for the Arizona ROSC Hospitals.

The presenter was Suzanne Anders, RN, BSBA, CPHQ, and the moderator was Judith Richard, RN, MS, CPHQ. Both are Clinical Quality Specialists at Health Services Advisory Group. The identities of the participating hospital representatives have been suppressed

Judith: At this time, I'd like to open up the phone lines for all of you out there, so please ask your questions. If you're on mute, just "unmute" your phone: you can do that by pressing *7. We'd love to hear any questions that you have or any concerns.

Hospital: I was wondering if you knew anything more about the Crucial Conversations opportunity?

Judith: Yes, thanks for bringing that up. HSAG gave all the Arizona ROSC hospitals a set of audio CDs of the four one-hour Crucial Conversations Webinars to give the hospitals an overview of the Crucial Conversations training. What will happen next is that HSAG will supply each of the hospitals with the Crucial Conversations book and the audio training CDs so that the hospital staff members will have an opportunity to learn the skills. We are also looking into the possibility of partnering, so there may be a possibility for all of the ROSC hospitals to be able to send staff to the 2-day workshop. I started getting very interested in Crucial Conversations when I read the book and listened to the audio training CDs. However, it wasn't until I went to the workshops that I was able to put it all together, and I am continuing to learn and realize the value of it.

Developing a culture of patient safety doesn't happen overnight. We're going to go somewhat slow with getting everybody comfortable with what is offered with Crucial Conversations and the importance of it. The more you know about it, you'll see it in every area. So you'll be getting the book and the audio training CDs, and we're looking into the possibility of the 2-day training for the ROSC hospitals. Does that answer your question?

Hospital: Yes. Thank you.

Judith: How about other questions or concern?

Hospital: I have a question related to blame-free environments. I think I know the answer to this, but I'd like to hear the opinions of others. If you have some repeat occurrence of errors—say, specifically, medication errors—and if you find out that the same person or persons are repeatedly making the same errors, is this a competency issue or is it something else?

Suzanne: Certainly sometimes it can be a competency issue, but there may be other factors that are creating or leading to that error. Say you have a nurse that consistently pulls the wrong drug out of the Pyxis or other medication delivery system. Is she pulling the wrong drug because she can't read the label and relies on the color of the label, which the manufacturer has recently changed? Or is she pulling it out and not following the five Rights that she was taught in nursing school? A just culture does not mean that

you don't punish; it means that, as an organization, you create a system where punishment is handed out in a fair and consistent manner after the facts have been investigated. It is important that the organization first make sure that there are not poor organizational processes that led to the error. Was the nurse passing medications at 3 o'clock in the morning, in the dark, and didn't want to disturb the patient by turning on a light? What contributed to the error? Does the same thing occur over and over?

The other thing that you have to look at in your organization is determining what a fair response is once you determine that you have a nurse who is not following established processes. Is the way the nurse is handled the same on the second floor as on the third floor, the same on the west wing as on the east wing? Or does one unit director take her into the office and say, "Hey Sally, I know you made a mistake: Please don't do it again," while a director from a different unit, in the same situation, says, "Hey Sally, you've screwed up one time too many; there's the door and don't come back."

I'd be interested in hearing your opinion. What do you think you should do with a nurse who, over and over again, makes medication errors?

Hospital: I really don't know what to do. [Unintelligible.] Either you have a corrective action or a termination. [Unintelligible.] Depending on how you handle it, it can affect the entire staff.

Judith: I think that one of the main points here, as Suzanne was saying, is to investigate the big question of "Why?" And again, and excuse me for repeating myself, this is where Crucial Conversations skills come in. Keep yourself curious as to why this error is occurring. Be 100 percent honest and respectful as you determine the cause of the problem before you start thinking about solutions. The cause could be many things. Has that dialogue occurred in your facility? Do you have the skills to even attempt such a dialogue? If your patients are being placed at risk, that is an urgent situation that must be handled quickly.

Suzanne: I think the other thing you have to look at is that a blame-free environment doesn't necessarily mean it's a no-punishment environment. I don't know if you are familiar with the term "Red Rules," or not. These address certain behaviors that an organization simply will not tolerate. You would not tolerate a nurse deliberately harming a patient. You would not tolerate a nurse drinking alcohol at work or coming to work drunk. There are certain things that you just say, as an organization, you are not going to put up with. Yes, sometimes punitive action is warranted. However, before you reach that point you have to investigate thoroughly and make sure that it wasn't an organizational process that contributed to the error. Are others making the same error? Are they making the same error and not reporting it? I'm sorry to be providing so many different alternatives, but it is not a simple, clear-cut situation: If we have a nurse that makes multiple mistakes, do we keep her or fire her? There are lots of things that go into that.

Judith: One thing I would like you all to start thinking about is this: How do you actually define a culture of patient safety? For example, what are the components? How do we envision this culture of patient safety so we know it when we get there? For example,

if someone says, “Do you have a culture of patient safety in your hospital?” and you say, “Why yes, we do!” how is that demonstrated? What are the components of it? Can you envision it? I think we need to do that as we embark on this transformational change to develop a culture of patient safety. How do we actually envision it? Can any of you give some examples of components of patient safety culture?

Hospital: I’d say maturity. Thinking of the nurses we have at our hospital, many of them have been around for 20–25 years and they are just very good and very mature.

Judith: So that is a component of patient safety, that nurses are mature and have the skills and experience to go with it.

Does anyone else have another component of how you envision the culture we are trying to develop?

Hospital: [Unintelligible.]

Judith: Blame-free, nonpunitive, the importance of getting people to report near misses and actually thanking them for doing so. Do you have a system of thanking them? What they are giving us is so important when a near miss occurs.

Suzanne: If you make it punitive, people aren’t going to tell you the truth.

Judith: Right, we have to encourage them. Our patients’ lives are at stake. We must consider not only our patients, but also the employees. Is the environment safe for the employees? Are they working overtime; are they tired? We’re looking at safety all over the hospital. With a culture of patient safety, we’re hoping that it is the top priority of the entire organization. The concept is that, wherever you look, you see patient safety issues and address them. Once you get into the mindset of it, there is so much to be done.

One of the things I envision is that we open up our senses so that everything that we see that affects the patients we are addressing, even environmental issues. For example, if you are walking down a corridor and you see something on the floor, do you just wait for housekeeping to get to it or, in your culture, do you pick it up because you don’t just see a piece of paper—you see a potential fractured hip? That is the way we see things within a culture of patient safety.

It is important to be able to use the Crucial Conversations skills so that we can address all the issues that we have been avoiding for so long. Some of those issues are very difficult, such as when you work with someone who has not been washing his or her hands between patient contacts. Have we been avoiding having this conversation? This must be addressed to protect our patients.

These are just some of the components of patient safety culture that I envision when I think about what I would want for my hospital. I encourage you to consider the vision of patient safety that you want for your hospital, and we can share more when we have our teleconference on the 29th.

Is there anything else you would like to share?

Hospital: I have a comment regarding blame-free, nonpunitive work environments. When we received our hospital’s patient safety survey results, our scores in the area of

nonpunitive work environment were not exactly where I thought they should be. I didn't think that we had a punitive work environment. Since then, I have struggled with this and discussed it with my team. An observation that I made the other day is that a punitive environment is not necessarily something that comes from management down. Sometimes it is created in a peer-to-peer fashion. If a report of a near miss involves other departments, depending on how it is addressed, the punitive response may be created by other staff. This concept helps me to look at different ways of talking about it. I don't know if anyone else has encountered this problem. For example: lab versus nursing rather than management versus nursing.

Hospital: No, I never looked at it that way, but I think that you could quickly get into a crucial conversation situation at a staff-to-staff level.

Judith: You raise such a good point. One, you mentioned that you were really concerned about your survey results for the punitive environment area. You know, having your staff tell you about this through the survey is really a gift. They are saying, "Here is our perception of our patient safety culture, and we might not be so keen on reporting near misses." Now the hospital knows that it needs to intervene in this area. Suzanne Anders mentioned a document, "Just Culture." That entire document will be shared with you as part of the ROSC Toolkit. It describes things you might do to create a just culture that is not punitive. It includes many suggestions of what can be done. There is an example given of an organization that uses a punitive approach and one that uses an approach that is not punitive.

That was also a good point that was made regarding speaking peer-to-peer. That is what Crucial Conversations training is about. Crucial conversations aren't always with a supervisor; it is about empowering staff. Once your staff knows Crucial Conversations techniques, they are empowered to talk to anyone, being 100 percent honest and 100 percent respectful. When a positive outcome occurs after having a crucial conversation, staff find that the relationships between people and departments have been enhanced. It really is a transformational change in the way we communicate that affects our organizational culture.

Are there any other concerns? I know we will be speaking at length over the next several weeks and months.

Again, thank you Suzanne Anders for your excellent presentation, and thank you, ROSC hospitals, for your participation. If there is nothing else, then I am going to thank you all again and say goodbye.

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