Implementing a High Reliability Safety Culture Cycle in an Inpatient Geriatric Unit to Improve Patient Safety Outcomes

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Abstract

- The purpose of this presentation is to introduce an evidence-based nursing intervention for improving patient safety.
- In 2001, the Institute of Medicine challenged healthcare organizations to improve practice models to increase patient safety and quality care.
- 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.

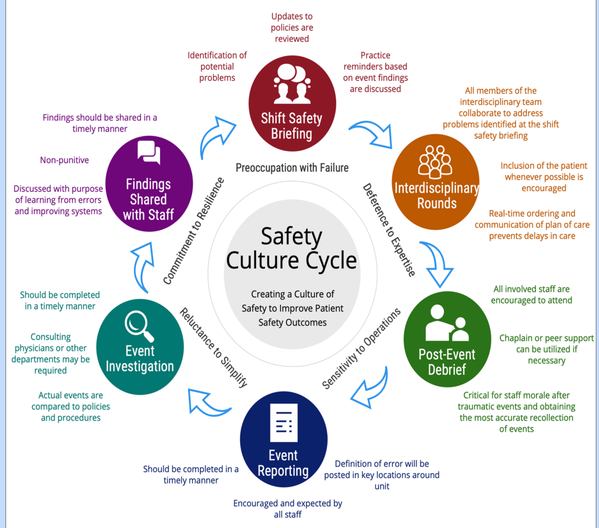
PICOT

PICOT: 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?

Review of Literature

- Two themes emerged during the review of the literature:
  - Safety Culture and Patient Outcomes
  - High Reliability Organization Strategies to a Culture of Safety

Evidence-Based Nursing Intervention



High Reliability Safety Culture Cycle

- Six phases to be implemented sequentially and cyclically

Implementation

Nursing Sensitive Outcomes

Outcomes	Measurement
Reduction in hospital acquired conditions	Event Reporting Tool (RL Solutions)
Reduced adverse patient events	Event Reporting Tool (RL Solutions)
Reduced length of stay	Electronic Medical Record Reports
Improved patient and family satisfaction	Press Ganey Survey
Increased staff perception of patient safety	Safety Culture Survey

Discussion

- Medical errors are associated with poor patient outcomes, increasing costs of healthcare, and high turnover.
- Despite safety changes and regulations, little progress has been made toward the path to zero harm.
- High Reliability Organization theory has been implemented in several organizations with great success in improving safety culture and patient outcomes.

References

Ausserhofer, D., Schubert, M., Desmedt, M., Blegen, M. A., De Geest, S., Schwendimann, R. (2013). The association of patient safety climate and nurse-related organizational factors with selected patient outcomes: A cross-sectional survey. *International Journal of Nursing Studies, 50*, 240-252.

DiCuccio, M. H. (2015). The relationship between patient safety culture and patient outcomes: A systematic review. *Journal of Patient Safety, 11*(3), 125-142.

Kotter International. (2017). *The 8-Step Process to Accelerate Change*. Retrieved from https://www.kotterinc.com/research-and-perspectives/8-steps-accelerating-change-ebook/

Lee, S. E., Vincent, C., Dahinten, V. S., Scott, L. D., Park, C. G., & Dunn Lopez, K. (2018). Effects of individual nurse and hospital characteristics on patient adverse events and quality of care: A multilevel analysis. *Journal of Nursing Scholarship, 50*(4), 432-440.

McFadden, K. L., Stock, G. N., & Gowen III, C. R. (2014). Leadership, safety climate, and continuous quality improvement: Impact on process quality and patient safety. *Health Care Management Review, 44*(10), 1-11.

Padgett, J., Gossett, K., Mayer, R., Chien, W., & Turner, F (2017). Improving patient safety through high reliability organizations. *The Qualitative Report, 22*(2), 410-425.

Ulrich, B. & Kear, T. (2014). Patient safety and patient safety culture: Foundations of excellent health care delivery. *Nephrology Nursing Journal, 41*(5), 447-457.

Weaver, S. J., Lubomski, L. H., Wilson, R. F., Pfoh, E. R., Martinez, K. A., & Dy, S. M. (2013). Promoting a culture of safety as a patient safety strategy. *Annals of Internal Medicine, 158*(5_Part_2), 369-375.

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