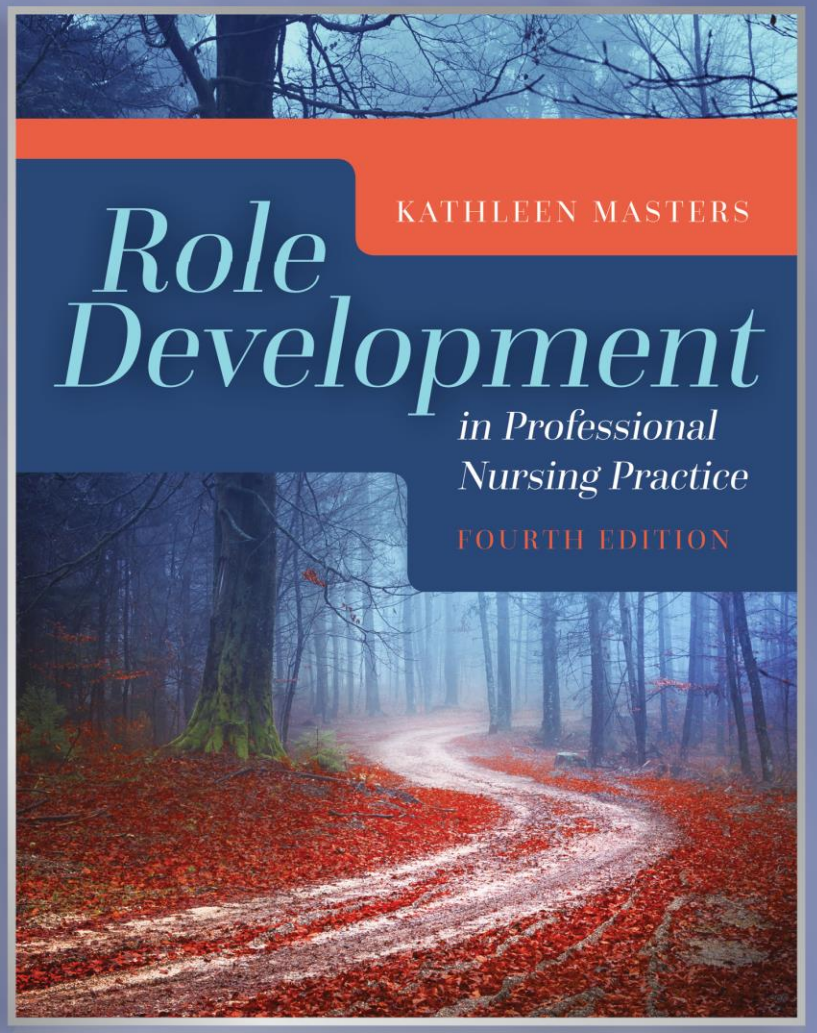
Chapter 8

Patient Safety and Professional Nursing Practice



Patient Safety

- Ensures that nursing practice is safe, effective, efficient, equitable, timely, and patient-centered (ANA)
- Minimization of risk of harm to patients and providers through both system effectiveness and individual performance (QSEN & NOF)

To Err is Human: Building a Safer Health System (IOM, 2000)

- At least 44,000 and possibly up to 98,000 people die each year as the result of preventable harm
- Cause of the errors is defective system processes that either lead people to make mistakes or fail to stop them from making a mistake, not the recklessness of individual providers

Error

- Error is the failure of a planned action to be completed as intended, or the use of a wrong plan to achieve an aim with the goal of preventing, recognizing, and mitigating harm
- Common errors include drug events and improper transfusions, surgical injuries and wrong-site surgeries, suicides, restraint-related injuries or death, falls, burns, pressure ulcers, and mistaken patient identities (IOM, 2000)

Event Analysis

- Individual approach or system approach
  - Culture of blame
  - Culture of safety
  - Just culture
- Root-cause analysis
- TERCAP
- Reason's Adverse Event Trajectory

Classification of Error

- Type of error
  - Communication
  - Patient management
  - Clinical performance
- Where the error occurs
  - Latent failure and active failure
  - Organizational system failures and system process or technical failure

Human Factor Errors

- Skill-based
  - Deviation in the pattern of a routine activity such as an interruption
- Knowledge-based
- Rule-based
  - Conscious decision by the nurse to "workaround" or take a shortcut, so the system defense mechanisms are bypassed, thereby increasing risk of harm to patient

To Err is Human: Building A Safer Health System (IOM, 2000) (1 of 2)

- User-centered designs with functions that make it hard or impossible to do the wrong thing
- Avoidance of reliance on memory by standardizing and simplifying procedures
- Attending to work safety by addressing work hours, workloads, and staffing ratios
- Avoidance of reliance on vigilance by using alarms and checklists

To Err is Human: Building A Safer Health System (IOM, 2000) (2 of 2)

- Training programs for interprofessional teams
- Involving patients in their care; anticipation of the unexpected during organizational changes
- Design for recovery from errors
- Improvement of access to accurate, timely information such as the use of decision-making tools at the point of care

Crossing the Quality Chasm: A New Health System for the 21st Century (IOM, 2000)

- STEEEP
  - **S**afe
  - **T**imely
  - **E**ffective
  - **E**fficient
  - **E**quitable
  - **P**atient-centered
- 10 rules for redesign
  - Rule #6: Safety is a system property

Keeping Patients Safe: Transforming the Work Environment of Nurses (IOM, 2004)

- Chief nursing executive should have leadership role in the organization
- Creation of satisfying work environments for nurses
- Evidence-based nurse staffing and scheduling to control fatigue
- Giving nurses a voice in patient care delivery
- Designing work environments and cultures that promote patient safety

Preventing Medication Errors: Quality Chasm Series (IOM, 2006)

- Paradigm shift in the patient-provider relationship
- Using information technology to reduce medication errors
- Improving medication labeling and packaging
- Policy changes to encourage the adoption of practices that will reduce medication errors

Joint Commission National Patient Safety Goals

- Reviewed and updated annually, focuses on system-wide solutions to problems
- 2015 goals: Identify patients correctly, use medications safely, improve staff communication, use alarms safely, prevent infection, identify patient safety risks, and prevent mistakes in surgery

National Quality Forum Goals

- Improve quality health care by setting national goals for performance improvement
- Endorsement of national consensus standards for measuring and public reporting on performance
- Promoting the attainment of national goals

National Quality Forum Safe Practices

- Endorsed safe practices defined to be universally applied in all clinical settings in order to reduce the risk of error and harm for patients
- 34 practices have been shown to decrease the occurrence of adverse health events
- Also endorses list of 29 preventable, serious adverse events for public reporting

Sentinel Events

- An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof
- Examples include wrong patient events, wrong site events, wrong procedures, delays in treatment, operative or postoperative complications, retention of foreign body, suicides, medication errors, perinatal death or injury, and criminal events

Progress

- Healthcare organizations have responded to incentive programs, accreditation standards, and public opinion
- Professional organizations have responded with revisions to standards that place more emphasis on healthcare quality and patient safety
- Educators have responded by infusing quality and safety concepts into student didactic and clinical experiences guided by initiatives such as the QSEN and *Nurse of the Future*

Patient Narratives

- A short video sharing the story of Josie King is available at: https://youtu.be/Mp8Kq3ajv3w
- A short video about The Betsy Lehman Center for Patient Safety and Medical Error Reduction is available at: https://youtu.be/wwB88zF4wvU
- The *Chasing Zero: Winning the War on Healthcare Harm* video is available at: https://youtu.be/MtSbgUuXdaw
- The *Transparent Health−Lewis Blackman Story* video is available at: https://youtu.be/Rp3fGp2fv88

Why Is Critical Thinking Important in Nursing Practice?

- Essential to providing safe, competent, and skillful nursing care
- The inability of a nurse to set priorities and work safely, effectively, and efficiently may delay patient treatment in a critical situation and result in serious life-threatening consequences

Thinking Like a Nurse

- Clinical judgment
- Clinical reasoning
- Mindfulness

Clinical Judgment (1 of 2)

- Clinical judgments are more influenced by what nurses bring to the situation than the objective data about the situation at hand
- Sound clinical judgment rests to some degree on knowing the patient and his or her typical pattern of responses, as well as engagement with the patient and his or her concerns

Clinical Judgment (2 of 2)

- Clinical judgments are influenced by the context in which the situation occurs and the culture of the nursing unit
- Nurses use a variety of reasoning patterns alone or in combination
- Reflection on practice is often triggered by a breakdown in clinical judgment and is critical for the development of clinical knowledge and improvement in clinical reasoning

Critical Thinking and Clinical Judgment in Nursing

- Purposeful, informed, outcome-focused thinking
- Carefully identifies key problems, issues, and risks
- Based on principles of the nursing process, problem solving, and the scientific method
- Applies logic, intuition, and creativity
- Driven by patient, family, and community needs
- Calls for strategies that make the most of human potential
- Requires constant reevaluating

Characteristics of Critical Thinking

- Rational and reasonable
- Involves conceptualization
- Requires reflection
- Includes cognitive skills and attitudes
- Involves creative thinking
- Requires knowledge

Characteristics of a Critical Thinker (1 of 2)

- Flexible
- Bases judgments on facts and reasoning
- Doesn't oversimplify
- Examines available evidence before drawing conclusions
- Thinks for themselves
- Remains open to the need for adjustment and adaptation throughout the inquiry

Characteristics of a Critical Thinker (2 of 2)

- Accepts change
- Empathizes
- Welcomes different views and values examining issues from every angle
- Knows that it is important to explore and understand positions with which they disagree
- Discovers and applies meaning to what they see, hear, and read

Approaches to Developing Critical Thinking Skills

- Nursing process
- Concept mapping
- Journaling
- Group discussions

Nursing Process

- Assessment
- Diagnosis
- Outcome identification
- Planning
- Implementation
- Evaluation

Concept Mapping

- Visual representation of the relationships among concepts and ideas
- Useful for summarizing information, consolidating information from different sources, thinking through complex problems, and presenting information in a format that shows an overall structure of the subject

Journaling

- Allows you to view your own thinking, reasoning, and actions
- Helps create and clarify meaning and new understandings of experiences
- Should be able to recall what you did or would do differently and reasoning when you encounter a similar situation

Journaling Suggestions

- What happened?
- What are the facts?
- What feelings and senses surrounded the event?
- What did I do?
- How and what did I feel about what I did?
- What was the setting?
- What were the important elements of the event?
- What preceded the event, and what followed it?
- What should I be aware of if the event recurs?

Group Discussions

- Cooperative learning occurs when groups work together to maximize learning
- Explore alternatives
  - Different scenarios of “What if?”, “What else?”, and “What then?”
- Arrive at conclusions
  - Connect clinical events or decisions with information obtained in the classroom