Safety Culture

Establishing processes to support trust and accountability for risk reduction

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Regardless of the phase of care, many patients being treated for cancer have complex needs related to the effects of high-risk drug regimens with inherent toxicities and narrow therapeutic indexes. Two key aspects of quality cancer care are safe handling of agents with hazardous characteristics and verification of regimen dosing. Just as an incremental overdosing error may result in life-threatening patient harm, underdosing errors may lead to substandard treatment outcomes (American Society of Clinical Oncology, 2017; Edwards & Bencheikh, 2016). With the additional consideration of coexisting conditions and diverse psychosocial needs, safety risks are ever-present. A significant safety event may diminish patient outcomes, cause undesirable public attention and financial effects, increase insurance costs, and affect the psychosocial status of staff and patients. Therefore, strategies that result in interprofessional collaboration and accountability through a systems approach are needed to reduce risk and recognize safety concerns before they affect patients (Lennes et al., 2016; Shulman, 2015).

Accountability

Without prioritizing a culture of safety, a system is highly vulnerable to adverse events. At the system level, leaders must demonstrate a commitment to ensuring safety above all else. Safety goals should encompass error reduction with the understanding that safety-related events likely will never be eliminated (Benzer, Charns, Hamdan, & Afable, 2017). The integral components needed to transform practice and facilitate safe cancer care are grounded in an environment and culture that cultivate excellence, support staff needs, and mitigate risk and harm (Institute of Medicine, 2013; Joint Commission, 2017). Infrastructure, processes, and clinical decision tools must demonstrate a proactive approach to event recognition and reporting, with policies and procedures that support safe care. Responsive and evaluative processes that outline a nonpunitive investigative process aimed at reducing the chance for repetitive events should also be in place (Fyhr, Ternov, & Ek, 2017; Surbone & Rowe, 2015).

The context of the care environment may influence the safety of medication administration. Work cultures may be prohibitive to event reporting, sometimes evoking fear of retribution and punitive action (Brady, Malone, & Fleming, 2009; Farag, Tullai-McGuinness, Anthony, & Burant, 2017). The context of each oncology care setting varies because staff characteristics, patient demographics, and care delivery models differ. However, pharmacovigilance and safety reporting are likely to be easier in a culture that is respectful, that does not cast blame, and where training and experience in event-prevention strategies are prioritized (Joint Commission, 2017; McNab, Bowie, Ross, & Morrison, 2016). A lack of unit-based safety goals may contribute to undesirable patient events through personal attitudes and perceptions, care distractions and interruptions, lack of resources and education, poor collaboration and communication, inadequate care transitions,
and ineffective policies and procedures (Hung, Chu, Lee, & Hsiao, 2016; Weber & Sidorov, 2014). A safe and just culture cultivates an environment that encourages safety reporting without fear, responds to safety issues promptly and effectively, and constantly works to improve the safety and quality of care.

**Nurse and Patient Roles**

Nurses are ideal drivers of quality and safety because they have unique relationships with patients and are the final checkpoint prior to care and treatment delivery. Little is known about how nursing leadership, collaboration, and empowerment affect patient safety (Richardson & Storr, 2010). However, ensuring patient safety is inherent in professional nursing practice, licensure regulations, codes of ethics, and practice scope and standards. Individual nurses hold responsibility to accept, adopt, advocate for, and embrace change that promotes evidence-based practice and optimization of safe care. For example, oncology standards expect nurses to be accountable for developing and maintaining competence in the treatment consent, pretreatment verification, treatment administration, and post-treatment monitoring processes (Brant & Wickham, 2013; Neuss et al., 2017; Polovich, 2015). Oncology nurses can champion patient safety and nurture a safe and just culture in the workplace by developing critical behaviors that lead to better recognition and reporting of safety concerns (Surbone & Rowe, 2015).

The role of the patient in safety and risk prevention is gaining attention. Some drug safety and quality improvement experts advocate for innovative risk identification strategies that include assessing for and appropriately integrating patient and family engagement in risk communication (Smith & Benattia, 2016). This patient-centric approach is rooted in the incentivization of quality and safety reporting outcomes. Patients and family members may be able to identify issues contributing to safety events, such as staff, safety procedures, and communication. They can also assist in early recognition of problems and recommend subsequent changes to improve safety concerns (Etchegaray et al., 2016; Famolaro et al., 2016).

**Recommendations for Practice**

The Agency for Healthcare Research and Quality (AHRQ) reports annual data on safety issues in the publicly available Hospital Survey on Patient Safety (HSOPS) Culture User Comparative Database Report (Famolaro et al., 2016). In addition, accrediting agencies set standards and provide recommendations for safety improvement. A Joint Commission (2017) sentinel event alert discourages the assumption that systems are safe, because this assumption may increase the likelihood of adverse events. The Joint Commission (2017) recommendations focus on strengthening trust and accountability, along with processes that support the identification of unsafe conditions and continual risk assessment throughout an organization.

**Promoting Trust and Accountability**

To advance trust in leadership, the overall perception of patient safety must include behaviors that do not intimidate or cause reluctance to report concerns out of fear. The Joint Commission (2017) recommends “a transparent, nonpunitive approach to reporting and learning from adverse events, close calls and unsafe conditions” (p. 3). This can be achieved through openness in communication, ongoing feedback, and establishing a non-punitive response to safety events with an anonymous and accessible reporting system, observational vigilance, and attention to event triggers (Famolaro et al., 2016; Surbone & Rowe, 2015).

**Identifying Unsafe Conditions Through Continual Risk Assessment**

Establishing efficient safety reporting, risk assessment, and event investigation processes provides the integral components needed to transform practice for optimal patient safety. Adopting baseline quality measures across the organization for continuous evaluation will assist in identifying opportunities for quality and safety improvement. These should include proactive risk assessment of medication management procedures and the efficacy of electronic systems in communicating safety alerts. The AHRQ's HSOPS or the Safety Attitudes Questionnaire are examples of benchmarking tools for process improvement (Famolaro et al., 2016; Joint Commission, 2017).

**Strengthening System Processes**

The information gained from safety assessments must lead to the development and implementation of quality improvement initiatives that address gaps and concerns. Examples of high-risk activities noted in the HSOPS include safety reporting, staffing resources, patient handoffs and transitions, and communication and teamwork across and within units, both during and between work shifts (Famolaro et al., 2016). Quality improvement projects are intended to address and revise organizational and unit-based processes that strengthen safety

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systems, and may include education, technology and equipment training, and more efficient design of policies and procedures that clearly demonstrate patient safety is a priority (Farag et al., 2017; Hung et al., 2016). Subsequent evaluation of the changes through additional risk assessment every 18–24 months is recommended to sustain improvement (Famolaro et al., 2016; Joint Commission, 2017).

Conclusion
The effective reduction of safety risks must be fully supported through strong organizational leadership that ensures a culture of trust and accountability. Applying and analyzing continual risk assessment to improve processes, policies, and procedures informs evidence-based practice change throughout an organization. As a result, the commitment to prioritize safety transcends through all levels and is demonstrated within all disciplines.

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REFERENCES

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